Board of Directors (In Public)

Schedule	Friday 1 December 2023, 9:15 AM — 1:30 PM GMT
Venue	Keystone Innovation Centre, Croxton Road, Thetford. IP24 1JD
Description	A meeting of the Board of Directors will take place on Friday 1 December 2023 at 9:15am.
Organiser	Ruth Williamson

Agenda

AGENDA

_WSFT Public Board Agenda - 1 December 2023 - Final.docx

1. GENERAL BUSINESS

9:15 AM — 1.1. Apologies for absence - Louisa Pepper
To Note - Presented by Jude Chin

1.2. Declaration of interests for items on the agenda
To Assure

1.3. Minutes of the previous meeting - 29 September, 2023
To Approve - Presented by Jude Chin

WSFT Minutes Open Board 29 Sept 2023 final draft.docx

1.4. Action log and matters arising
To Review

Item 1.4 - Action Points - Active.pdf

Item 1.4 - Action Points - Complete.pdf

9:20 AM — 1.5. Questions from Governors and the Public relating to items on the agenda
To Note - Presented by Jude Chin

9:35 AM	1.6.	Patient and Staff Story Disability history month runs from 16 November and we have therefore prioritised this month's staff story to hear from the disability network. Ceiridwen Fowles will present some examples of staff stories, including in relation to reasonable adjustments. To Review
10:10 AM	1.7.	Chief Executive's report To inform - Presented by Ewen Cameron Item 1.7 - CEO Board report - December 2023 FINAL.docx
	2.	STRATEGY
10:20 AM	2.1.	Prevention, Personalised Care and Health Inequalities Strategy To Approve - Presented by Paul Molyneux Item 2.1 - 231201 Board coversheet - PHIPC strategy.pdf Item 2.1 - WSFT PHIPC strategy 2023 - 2031 FINAL.pdf
10:35 AM	2.2.	Future System board report To Assure - Presented by Craig Black Item 2.2 - wsft public board december 23 FINAL.docx
10:50 AM	2.3.	West Suffolk Alliance and SNEE Integrated Care Board Gail Cardy & Jason Joseph in attendance To Assure - Presented by Peter Wightman Item 2.3 - WSA Update report 14 November 2023 v02.doc Item 2.3a - Dementia Strategy - final draft edited from feedback 201123.pdf Item 2.3b - Suffolk Board 01.12.2023 v2.pdf
11:10 AM	2.4.	Digital Programme Board Report To Assure - Presented by Craig Black Item 2.4 - Trust Board digital report Nov 2023.docx

3. PEOPLE AND CULTURE

11:20 AM **3.1. Involvement Committee report - Chair's Key Issues from the meeting**
To Assure

- Item 3.1 - Inv CKI October 2023 final.doc

11:30 AM **3.2. People and OD Highlight Report**
For Discussion - Presented by Jeremy Over

- Item 3.2 - People OD highlight Nov2023.docx

11:40 AM COMFORT BREAK

4. ASSURANCE

12:00 PM **4.1. Insight Committee Report - Chair's Key Issues from the meeting**
To Assure

- Item 4.1 - INSIGHT CKI report 19 Oct 2023 FINAL.docx
- Item 4.1 - INSIGHT CKI report 15 Nov 2023 FINAL.docx

4.2. Finance Report
To Assure - Presented by Craig Black

- Item 4.2 - Finance Cover - Public Board October 2023.docx
- Item 4.2a - Finance Report October 2023 FINAL.docx

12:30 PM **4.3. Improvement Committee Report - Chair's Key Issues from the meeting**
To Assure - Presented by Louisa Pepper

- Item 4.3 - CKI IMP Sep23.docx
- Item 4.3 - CKI IMP Oct23.docx
- Item 4.3 - CKI IMP Nov23.docx

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

- Item 4.4 - Safe Staffing SeptOct Final.docx

	4.4.1. Maternity Services Karen Newbury, Kate Croissant & Simon Taylor in attendance To Approve Item 4.4.1 - December2023 Maternity qualtiy safety and performance Board report BOARD COPY.docx
	5. GOVERNANCE
1:10 PM	5.1. Governance report To Assure - Presented by Richard Jones Item 5.1 Governance report.docx Item 5.1 Annex A Draft Board meeting agenda.docx
1:15 PM	5.2. Board Assurance Framework To Approve - Presented by Richard Jones Item 5.2 - BAF report Dec 23-Board.docx
1:25 PM	6. OTHER ITEMS
	6.1. Any other business To Note
	6.2. Reflections on meeting For Discussion
	6.3. Date of next meeting - 26 January, 2024 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

SUPPORTING ANNEXES

4.2 IQPR Full Report

- Item 4.2 - IQPR Cover Sheet v4_.docx
- Item 4.2 - IQPR Board Report September 2023.pdf

4.4.1 Maternity - Annexes

- Item 4.4.1 - B - Neonatal Medical Workforce Board Report BOARD Copy.docx
- Item 4.4.1 - C - Obstetric workforce Report Novmber 2023 Board Copy.docx
- Item 4.4.1 - D - Q2 ATAIN and TC report BOARD COPY.docx
- Item 4.4.1 - E - Neonatal Nursing Staffing Board Report BOARD copy.docx
- Item 4.4.1 - F - Midwifery Staffing report Oct 2023 BOARD COPY.docx
- Item 4.4.1 - G - Maternity & Neonatal Services - Safety Action 7 BOARD COPY.docx

AGENDA

NHS
West Suffolk
NHS Foundation Trust

WSFT Board of Directors – Public Meeting

Date and Time	Friday, 1 December 2023 9:15 – 13:30
Venue	Keystone Innovation Centre, Croxton Road, Thetford. IP24 1JD

Time	Item	Subject	Lead	Purpose	Format
1.0 GENERAL BUSINESS					
09.15	1.1	**Welcome and apologies for absence**	Chair	Note	Verbal
	1.2	**Declarations of Interests**	All	Assure	Verbal
	1.3	**Minutes of meeting** – 29 September 2023	Chair	Approve	Report
	1.4	**Action log and matters arising**	All	Review	Report
09:20	1.5	**Questions from Governors and the public relating to items on the agenda**	Chair	Note	Verbal
9.35	1.6	**Patient and Staff Story** Disability history month runs from 16 November and we have therefore prioritised this month's staff story to hear from the disability network. Ceiridwen Fowles will present some examples of staff stories, including in relation to reasonable adjustments.	Director of Resources	Review	Verbal
10.10	1.7	**CEO report**	Chief Executive	Inform	Report
2.0 STRATEGY					
10:20	2.1	**Prevention, personalised care and health inequalities strategy**	Medical Director	Approve	Report
10:35	2.2	**Future system board report**	Director of Resources	Assure	Report
10:50	2.3	**West Suffolk Alliance and SNEE Integrated Care Board**	West Suffolk Alliance Director and Director of Integrated Adult Health and Social Care In attendance: Gail Cardy Jason Joseph	Assure	Report

11:10	2.4	**Digital Programme Board Report**	Director of Resources	Assure	Report
3.0 PEOPLE AND CULTURE					
11.20	3.1	**Involvement Committee report** Chair's key issues from meeting	NED Chair	Assure	Report
11:30	3.2	**People and OD Highlight Report**	Director of Workforce	Discuss	Report
11:40 Comfort Break					
4.0 ASSURANCE					
12:00	4.1	**Insight committee report** – Chair's key issues from the meetings	NED Chair	Assure	Report
	4.2	**Finance report**	Director of Resources	Assure	Report
12:30	4.3	**Improvement committee report** – Chair's key issues from the meetings	NED Chair	Assure	Report
	4.4	**Quality and nurse staffing report**	Chief Nurse	Assure	Report
	4.4.1	**Maternity services report**	Chief Nurse Karen Newbury Simon Taylor	Approval	Report
5.0 GOVERNANCE					
13:10	5.1	**Governance Report**	Trust Secretary	Assure	Report
13:15	5.2	**Board assurance framework**	Trust Secretary	Approval	Report
6.0 OTHER ITEMS					
13.25	6.1	**Any Other Business**	All	Note	Verbal
	6.2	**Reflections on meeting**	All	Discuss	Verbal
	6.3	**Date of next meeting** 26 January 2024	Chair	Note	Verbal
	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				

PLEASE NOTE

During lunch there will be an opportunity to meet with radiology and maternity staff working at the facility in Thetford

Supporting Annexes

Agenda item	Description
4.2	IQPR full report
4.4.1	Maternity papers Annexes

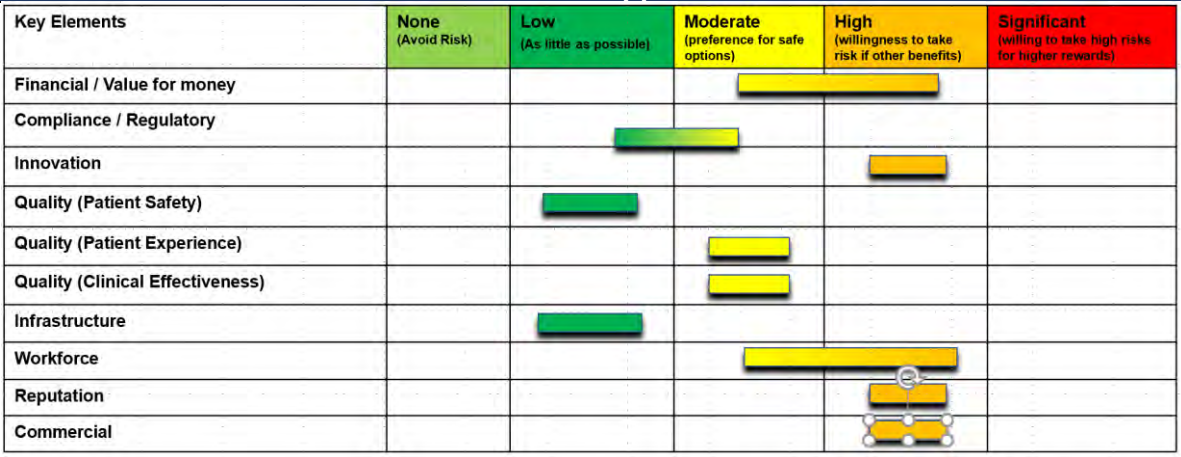
Guidance notes

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 - Louisa Pepper

To Note

Presented by Jude Chin

1.2. Declaration of interests for items on the agenda

To Assure

1.3. Minutes of the previous meeting - 29 September, 2023

To Approve

Presented by Jude Chin

WEST SUFFOLK NHS FOUNDATION TRUST

DRAFT MINUTES OF THE
Open Board meeting

Held on Friday 29 September 2023, 09:15 – 13:30
At Conference Rooms, Denny Brothers, BSE, IP32 7AR

Members:		
Name	**Job Title**	
Jude Chin	Chair	JC
Ewen Cameron	Chief Executive Officer	EC
Louisa Pepper	Non-Executive Director/Deputy Chair	LP
Antoinette Jackson	Non-Executive Director/ Senior Independent Director	AJ
Geraldine O'Sullivan	Non-Executive Director	GO'S
Tracy Dowling	Non-Executive Director	TD
Michael Parsons	Non-Executive Director	MP
Krishna Yergol	Non-Executive Director	KY
Roger Petter	Non-Executive Director/ Maternity and Neonatal Safety Champion	RP
Craig Black	Executive Director of Resources/Deputy CEO	CB
Nicola Cottington	Executive Chief Operating Officer	NC
Sue Wilkinson	Executive Chief Nurse	SW
Paul Molyneux	Medical Director/Maternity and Neonatal Safety Champion	PM
Jeremy Over	Executive Director of Workforce and Communications	JO
Clement Mawoyo	Director of Integrated Adult and Social Care Services	CM
Peter Wightman	West Suffolk Alliance Director	PW
In attendance:		
Richard Jones	Trust Secretary & Head of Governance	RJ
Pooja Sharma	Deputy Trust Secretary	PS
Helen Davies	Associate Director of Communications	HD
Renu Mandal	Project Manager – Transformation	RM
Anna Wilson	Patient Engagement & Equalities Manager (*item 1.6 only)*	AW
Julie Head	Head of Deteriorating Patient, Outreach & Resus (*item 1.6 only)*	JH
Martin	*(item 1.6 only)*	
Sam & Elliot	Parents of patient (*item 1.6 only)*	
Karen Newbury	Head of Midwifery *(item 4.4.1 only)*	KN
Simon Taylor	Associate Director of Operations (item 4.4.1 only)	ST

Kate Croissant	Deputy Clinical Director – Women & Children (item 4.4.1 only)	KC
Ruth Berry	FT Office Manager (minute taking)	RB
Apologies:		
Governors:		
Clive Wilson	Public Governor	CW
Liz Steele	Public Governor	LS
Jane Skinner	Public Governor – lead	JS
Florence Bevan	Public Governor	FB
Staff:		
Heidi Rolfe-Hill	Community Staff Side Lead	HRH
Members of the public:		
-	-	-

1.0 GENERAL BUSINESS		
1.1	**Welcome and apologies for absence**	**Action**
	The Trust Chair Jude Chin (JC) welcomed all to the meeting and the apologies for absence were noted.	
1.2	**Declarations of interest**	
	No declarations of interest were received.	
1.3	**Minutes of the previous meeting**	
	The minutes of the previous meeting 21 July 2023 were approved as a true and accurate record, subject to the following amendment: • adding Krishna Yergol, Non-executive director, to the list of attendees.	**RB**
1.4	**Action log and matters arising**	
	<u>3005 – CEO Report – prioritising a staff story from EIR meetings</u> - session postponed to December meeting, due to availability <u>3015 – Quality and Nurse Staffing Report – Safe Staffing Tool</u> - an increase in nurses and the rosters is in progress - **ACTION CLOSED** <u>3022 – West Suffolk Alliance and SNEE ICB – report on dementia</u> - schedule dementia strategy for meeting in December. Need transparency on the use of the Better Care Fund and discharge funding report to the urgent and emergency care governance group and through that to Insight. It was noted that 4 items from the action log have now been closed; 3018, 3019, 3020 & 3021	**PW**

1.5	**Questions from Governors and the public relating to items on the agenda**	
	Q. How can we be assured in the diversity and learning in the hospital, following the Letby case (item 8.1)? The Executive Director of Workforce and Communications Jeremy Over (JO) said that in developing culture at WSFT, the Trust has brought in tools to make learning more assessable for staff and have created a learning and development toolkit, where everything can be accessed in one place, to make it easier for staff to access training and learning programmes. Diversity and inclusion are everyone's responsibility. Overall staff turnover and sickness have reduced in the last period. A coaching programme for staff is now going ahead. Despite operational pressures, awaydays for training/development are happening to support positive culture across the organisation. Q In the IQPR paper, waiting list numbers are now 31,000, higher than in the past paper. Is this just from recent industrial action? Waiting lists numbers include a backlog from Covid, recent industrial action and an increase in the patient pathway in emergency access. The diagnostic pathway has also increased, due to aging equipment. **Action: To consider how we include total waiting list numbers in the IQPR**	**NC**
1.6	**Patient and Staff Story**	
	Background Izzy was a normal teenager, with no previous health worries. An incident in January 2022, lead to a diagnosis of a rare cancer. Izzy completed her chemotherapy treatment at the West Suffolk Hospital (WSH) and was provided with a high level of treatment and support throughout her rehabilitation. In October, Izzy had a very sudden relapse in her health. Scans confirmed that the cancer had spread, which meant little to no chance of survival. The paediatric team at WSH supported the family throughout and there was a very high level of trust that care would be provided by WSH. End of life care at WSH on 14 December 2022 On the evening of her death on 14 December, she was brought to the WSH by her parents, following a rapid decline in health. The Rainbow ward was told they were coming, so they could prepare.	

	The family were met by staff who didn't know about Izzy or her background and didn't have access to her care plan: - The nurse on duty reacted as best she could, with the information she was told by the parents. - The consultant on duty that was assessing her, didn't actually check Izzy, rather only asked questions about DNR. There appeared to be lot of doctors on the ward, but no one came into the room. Elliott reported that the staff would deal with her pain, but nothing else at this point. Following her death, it was discovered that the processes in place meant that the nurse wasn't able to care for Izzy properly. Processes that prevented care taking place. The parents stated that that night was about ticking boxes, not caring for the patient. The system let her down. Izzy's parents want assurances that systems are put in place – it needs to be the start of change at WSH. Sue Wilkinson, Executive Chief Nurse (SW) apologised on behalf of the Board for that evening and the way the family were treated. <u>Actions taken by WSFT since Izzy's death</u> Taken through patient safety incident framework, emerging incident review meeting and an after action review (AAR) was agreed as a way forward. Some of the findings from the AAR were: - Lack of communication; clinicians did not know what the management plan was. Management plans agreed at Addenbrookes hospital had not been loaded onto our electronic patient record system. Changes have now been made so that management plans like Izzy's are loaded up and assurance is provided that this has been done and shared. - Acknowledgement that staff were focused on things in the wrong order. We should have given Izzy medication to calm her down and then done the necessary paperwork around DNR. - We have also focused more in the wards on speaking up and feeling able to raise concerns.	

	Education to staff to raise the alarm and escalate issues rapidly if they feel they need help/have concerns. This includes calling the Clinical Care Outreach Team (CCOT). The parents confirmed that they have felt listened to since Izzy's death. Board needs reassurance that the actions mentioned are being implemented – which subcommittee will follow up on these action points. Some actions and improvements have been implemented, but there is a lot we need to improve for 'end of life' care at WSFT. **ACTION: Deep dive into 'end of life' for future board, linked to leadership/communication within team and with relatives/carers – improvement committee** Was the story too much for a board meeting? It is difficult to know in advance of how the story will affect those in attendance. **ACTION: Reflect on the impact of the story and how to balance hearing these stories with sharing in advance the content with board members and other in attendance.** The Board noted various concerns raised by the patient's parents and recognised the need to implement change based on the learnings and findings from the AAR. The board reiterated the importance of listening to patients and continue improving the leadership and culture across organisation.	**Improvement Committee** **JC**
1.7	**Chief Executive's report**	
	The report was taken as read and the Chief Executive highlighted the following: The Annual Members' Meeting on 26th September: Community Paediatric team were thanked for their insightful presentation on childhood development. RAAC in the press: Thanks was given to the ongoing work of the Estates team. The Board noted the report.	
1.8	**Reflection on the Letby case**	
	The Board noted that every Trust has reflected on the case since the verdict. Once the report from the enquiry is issued, it will be read and actioned by the Board. It is important to assess the degree to which structures and culture mitigate the risk of another significant event here at West Suffolk Foundation Trust (WSFT). The arrangements around speaking	

	up, mortality oversight, Medical Examiner Officer, incident monitoring, results management and review, grievances and complaints are laid out. Ongoing work is required to further develop speaking up, mortality oversight and results management and review through current governance arrangements. There is a need to consider and respond to the findings of a public inquiry when this is published. This will be important in understanding all of the contributory factors to the case and mitigations required. The Board has previously acknowledged the significant leadership concerns that took place which had an impact on the broader attitudes towards speaking up in the organisation. This is demonstrated in the national staff survey data whereby WSFT scores lie below the national average, whereas many other scores for WSFT are better than the national average. The culture change takes time and the 'speaking up' process is improving at the Trust. NHS England has asked that all Trust boards are fit for purpose, following this case. There have also been calls for increased regulation of boards in the press. In terms of WSFT, the Fit and Proper Person Tests are undertaken and in place for Board members, and there is work ongoing to include this within the recruitment process and in compliance with the new FPPT framework. The mortality data from NSFT indicated a failure of good governance. There were gaps and the data presented at board meetings changed over 7 different meetings. There is currently no requirement for deaths outside of the hospital to be counted. From April next year, it will be all deaths included in the mortality data. The Board noted that there is a gap between the data received and when it is available; for example, knowing about mortality numbers from winter period (previous). **ACTION: Be clear how the board receives assurance on 7 areas from the report and map this and provide visibility to the board/assurance committees.**	**RJ**
2.0 STRATEGY		
2.1	**Strategic objectives delivery plan – progress report**	
	The Chief Executive (EC) confirmed that the priorities were agreed at the July Board. 'SMART' objectives were agreed under the Trusts' 3 strategy ambitions; First for Patients, First for Staff and First for the future, with priorities relating to;	

	• Delivery of **service pathway changes**, as laid out in the Clinical and Care Strategy • A strong priority on **Equality, Diversity and Inclusion** to address the disparity between different groups where the evidence shows that staff are disadvantaged or feel discriminated against • A large focus on **line management development** given the feedback from What Matters To You 2, the National Staff Survey and the Freedom to Speak Up Champions alongside the impact this would have on a large portion of the organisation • A step change in delivery on **prevention and proactive care** given the modelled demand projections and the explicit need for this to support the Future Systems Programme • Development of **transformation capacity and capability** given the scale of change required for both business-as-usual challenges and to support the Future Systems Programme **ACTION: Consider how to give visibility to trajectory delivery for the SMART objectives (dated and as part of a longer-term delivery plan). Make explicit where delivery is currently monitored and escalated.** **ACTION: Look to include discussion on 2024/25 priorities in the programme for the November development day**	**RJ** **RJ**
2.2	**Future system board report**	
	The Executive Director of Resources (CB) presented the report regarding Future System. More recent developments have seen the announcement that seven new schemes, predominantly those hospitals constructed from reinforced aerated autoclaved concrete (RAAC), have been included in the New Hospital Programme (NHP) and will be 'prioritised' to ensure they are completed in the most efficient way. New Hospitals Programme team visited recently. The assumptions and suggestions were consistent with expectations. 40 schemes and £20 billion doesn't work. There was, however, movement of the national team towards our number this week. A placeholder of a report review to come, but there is nothing at present. The strategic case for the new hospital is now widely agreed and work is underway to optimise and agree the designs that will form	

	the basis of an Outline Business Case. Work to satisfy our pre-commencement planning conditions is underway. The team is undertaking an internal exercise relating to our schedule of accommodation, to move it down to the national range. A scheme will be agreed with the national team at the same time as agreeing the budget with the construction partners. Inflation is not a main concern for Trust, rather the builders contracted. A query was sought that how assurance can be gained that with the increasing demand and with an aging population and increase in housing, the hospital will be fit for purpose. The Trust is applying the NHP commissioned demand and capacity model to the Trust's modelled assumptions to ensure a common view of how increased demand will impact the dimensions of future services.	
2.3	**West Suffolk Alliance and SNEE Integrated Care Board**	
	The West Suffolk Alliance (WSA) Director (PW) gave an update from the Alliance and ICB. <u>Report from WSA</u> Latest version of WSA strategy to come to next board meeting. Additional funds have come into the WSA which will be considered with input from community colleagues. Evaluation of the use of funding is important. If more funding is available for winter, this could be used to increased capacity. WSA to look at key targets in the next quarter. **ACTION: Information about the utilisation of any WSA winter funding to also be considered at urgent and emergency governance group, which reports into Insight committee** <u>Updates</u> The ICB commissioned a review of the community contract. The Alliance Committee received an independent report reviewing the service provision following interviews with stakeholders. The report identified many areas of good progress and made recommendations for focus for future improvement. The Committee gave its strong support that this is has been a very positive strategic decision which has greatly supported integration for patients. The Committee supported the improvement recommendations made and agreed to manage these through the relevant Live Well domain structure. **Action: Consider communication of the community contract position to staff**	**CM** **NC / CM**
2.3.1	**Stay Well Domain: Overview**	
	The Chief Operating Officer (NC) and Senior Transformation Lead (RM) provided to the Board an overview of the key areas of focus of the Stay Well domain. The overarching goal of the domain is for	

	all stakeholders within health, local government and the voluntary, community and faith sectors to work in partnership to support adults with health or care issues to access support and maintain healthy, productive, and fulfilling lives. It is an Alliance vehicle that will deal with the long term conditions and health needs, from primary and community care partners. It's an end-to-end approach, including urgent and emergency care and elective work, developing and partnership working. A clarification was sought on how the milestones are going to be monitored, as they cover different partners within the ICB and it was informed that key performance indicators (KPI's) are being developed. There are SNEE ICB discussions taking place to design and develop an Integrated Diabetes model in west Suffolk. The ICB has set up a Steering Group. The Steering Group is using the national best practice framework for integration and best practice models to scope the design of the integrated service. The Stay Well model of care is being developed alongside with the Age Well domain with the aim to strengthen the integration of the various individual community services and support people to stay at home through admission prevention and discharge pathways. The development of the direct access pathway for breast is on hold due to capacity issues.	
3.0 PEOPLE AND CULTURE		
3.1	**Involvement Committee report** Chair's key issues from meeting	
	The Non-Executive Director and Chair of the Involvement Committee (TD) reported on the August meeting CKIs and highlighting the following: - under Equality, Diversity and Inclusion plan, good progress has been made under the 'Board Responsibilities' workstream by developing a stock take of actions grouping these into seven workstreams with accountable owners. - The new Freedom Speak Up Guardian will attend the next board meeting - There is now a new suite of leadership and development programmes that have been introduced, to help with culture within the Trust. **ACTION: Develop workforce KPIs to be received by the involvement committee.**	**JMO**
3.2	**Putting You First Awards**	
	The Board noted the report.	

4.0 ASSURANCE		
4.1	**Insight committee report** – Chair's key issues from the meetings	
	The Non-Executive Director and Chair of the Insight Committee (AJ) presented the report from July's meeting and highlighted the following: - Community paediatrics review is continuing at pace and some improvements are already being implemented. Deep dive is planned to explore in more detail some of the system wide issues and options being discussed within the SNEE ICB - The total waiting list is an emerging area of concern and there is a need to focus on outpatients with the aim of protecting and expanding elective capacity. There is a renewed focus on improving productivity. The Trust is participating in an ICB-wide outpatient transformation programme - Assurance on the processes of the CIP programme and recovery were given, but in terms of delivering the plan, there is an underlying deficit for 2023/24 - The performance in the Breast service for two week wait and 28 day faster diagnostic standard will impact on WSFT's overall performance and there is a risk The Trust will not stay on trajectory to meet the standard - Due to lack of data Glemsford Surgery was still not possible to report against the 2-week access to a GP standard - The UEC service was visited by a peer review team It was recognised by the peer review that several of the areas of focus had already been included in the internal UEC recovery plan.	
4.2	**Finance report**	
	The Executive Director of Resources (CB) presented the report and the following was highlighted: - reported position as at the end of August was a deficit of £5.5m against a planned deficit of £2.3m. This has resulted in an adverse variance of £3.2m - In order to improve financial position, the two most significant areas of focus should be on temporary staffing costs and delivering CIP programme. There is also the possibility of funding from the Elective Recovery Fund (ERF). The Trust has submitted a Financial Recovery Plan that improves forecast deficit to £6.7m	

	- revised forecast is contingent on ERF income at £5m, delivering CIP at £5m and improving run rate at £3.4m - Key risks associated among various are delivering challenging CIP, unanticipated costs of industrial action and improvement in run-rate - deficit has impacted on cash position which has resulted in an application for revenue support of £10m from Department of Health CB said that a plan is in place to look at the use of temp staff and have a better focus on nursing rosters. A group has been created to look at clinical and admin and temporary staff use and opportunities to reduce temporary staffing costs. The group would need to find appropriate targets to each department and their priorities will be linked to the Trust priorities. Project Initiation Documents (PIDs) across the Trust are due for completion by various departments. Some departments have a better opportunity to increase productivity and control costs as compared to other. There is a need to look at what support is needed going forward which is capacity, rather than a culture issue. The Board needs to look at broader policy choices, and more transparency is needed in an open forum. The Board noted the revised capital plan of £35.527m for 2023-24. There was an overspend on medicine equipment which is an aging infrastructure and getting closer to moving into a new hospital, against needing to immediately replace equipment which caused the overspend. **ACTION: Provide greater detail of recovery schemes for discussion and transparency** **ACTION: Reflect on level of information provided to understand movements in capital spend**	**CB** **CB**
4.3	**Improvement committee report** – Chair's key issues from the meetings	
	The Non-Executive Director and Chair of the Improvement Committee, Louisa Pepper (LP) highlighted the following: - The Committee received a very informative presentation on nutrition - Good progress is made around Glemsford CQC inspection progress report to achieve all elements of the Improvement plan following inspection. There were concerns around Clinical Pharmacist departure however post has now been successfully recruited to. Some IPC concerns, mainly	

	related to buildings/estate will be addressed through current/planned building work. - Ockenden Improvement programme has moved forward. Structured plan with divisional links required. Allocation of individual elements of the plan to exec lead and assurance committee would be helpful - Clinical Effectiveness governance group –There are risks around Pathology accreditation, Pharmacy staffing and its impact on R&D activity and lack of system to process and upload clinical guidelines. -	
4.4	**Quality and nurse staffing report**	
	The Executive Chief Nurse (SW) presented the report and drew attention of the to the following: - Nursing assistant vacancy and turnover rates are still high, but the Trust has some projects in place to reduce this number - In response to the challenging financial position of the trust, the corporate nursing division has enacted several actions and work programs to provide additional grip and control over temporary nursing spend - The Trust has achieved 'Gold' accreditation for pastoral care of support workers. To achieve the award, the Trust successfully met a set of standards, demonstrating best practice pastoral care for support workers, including recruitment, induction and support; ongoing learning and development; valuing staff and recognition. This is a positive achievement and testament to the interventions applied to address the high turnover of this staff group - Reduction in enhanced rapid response pool shifts in line with improvements in substantive recruitment The need has reduced due to permanent staff levels. Number of shifts and increase pay rate has reduced too. - International staff recruitment has a considerable cost associated to their hire. This will be offset by successful local recruitment and a reduced pipeline will be considered going forward. **ACTION: Reflect on the quality indicators used in the report and whether there are more sensitive indicators which relate to staffing levels.** **ACTION: Provide update to Board on review of the international recruitment pipeline (include retention data to**	**RJ** **SW/JO**

	support decision). Link this to the nursing associate pipeline and transition to registered status.	
4.4.1	**Maternity services report**	
	The Head of Midwifery, Karen Newbury (KN) presented the Board with highlights of the report: - Mandatory training compliance targets to be met by December but there is a risk of delay due to the industrial action - The training plan will be updated in line with the Core Competency Framework v 3 and this will be in place for compliance by August 2024 - Core competency plan. The ask has increased, now 5 mandatory days, on top of department needs. Over the 3 years, we need over 90% - There is a need for additional staff in the neonatal unit and should have a shift coordinator for every shift and a senior nurse who has no clinical commitment during the shift - There has been increases in costs, related to block contracts. A number of initiatives are funded, which comes through the ICB - Concerns around robust systems for data collection with regards to activity and appropriate admissions and a link to community services and the associated cost were raised and that the support is needed.	
4.5	**Audit committee Chair's key issues report**	
	The Non-Executive Director and Chair of the Audit Committee, Michael Parsons (MP) presented the report and drew attention to the following: - Outstanding audits from 2022-23 completed; good progress with 2023-24 audit plan. Insight and Improvement will be discussing the two recent audits with negative assurance options - The Committee was satisfied with the performance of both internal and external audit and with the thorough analysis and mitigations in place.	
5.0 GOVERNANCE		
5.1	**Governance Report**	
	The Trust Secretary and Head of Governance (RJ) highlighted the to the Board that NHS England has developed a Fit and Proper Person Test (FPPT) Framework which is effective from is effective from 30 September 2023 and should be implemented by all boards going forward from that date. NHS organisations are not expected	

	to collect historic information, but to use the Framework for all new board level appointments or promotions and for annual assessments going forward. The Board noted these amendments to the FPPT framework in relation to their roles. A new policy on engagement between the Council of Governors (CoG) and Board was presented with a request to approve the same. **The Board of Directors agreed on this Policy on Engagement between Board of Directors and Council of Governors and it was approved as presented.**	
5.2	**Board assurance framework**	
	RJ highlighted the following to the Board: - Internal auditors to undertake BAF review of target risk work. - Risk appetite is the topic of the next Board workshop in November.	
5.3	**Meeting schedule for 2024**	
	ACTION: 2024 schedule of meetings to be sent out to Board members & attendees	**PS**
6.0 OTHER ITEMS		
6.1	**Any Other Business**	
	1) Balance items on the agenda via assurance committees and for information rather than decision. Time for so what question in the discussion (consider what the papers look like for wider list of committees). 2) Reflect on the content of the IQPR through the assurance committees. 3) Lack of financial implications on any papers other than the financial report – reflect on the template to support culture which considers financial impact. 4) Reflect on the use of abbreviations in papers.	
6.2	**Reflections on meeting**	

	JC, Chair thanked everyone in relation to the reduction in number of papers produced and presenters, which added to a more concise meeting overall. It was noted that the timing of assurance committees and ability to report CKIs is difficult.	
6.3	**Date of next meeting** Friday, 1 December 2023	

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

1.4. Action log and matters arising

To Review

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
3030	Open	29/9/23	1.5	**Questions from Governors and the public relating to items on the agenda -** To consider how we include total waiting list numbers in the IQPR	**The IQPR content is being reviewed through the 3I committee development. It is suggested this be picked up through the planned Insight workshop in the New Year.**	NC	01/12/23	Green	
3031	Open	29/9/23	1.6	**Patient and Staff Story** - Deep dive into 'end of life' for future board, linked to leadership/ communication within team and with relatives/carers – improvement committee		LP/SW	22/03/2024	Green	
3034	Open	29/9/23	2.1	**Strategic Priorities Delivery Plan -** Consider how to give visibility to trajectory delivery for the SMART objectives (dated and as part of a longer-term delivery plan). Make explicit where delivery is currently monitored and escalated.	**The priorities were reviewed at the Board workshop and these discussions and actions will be incorproated into the update report scheduled for January's board meeting.**	RJ	01/12/23	Green	
3039	Open	29/9/23	4.2	**Finance Report** - Provide greater detail of recovery schemes for discussion and transparency. Also reflect on level of information provided to understand movements in capital spend		CB	26/01/24	Green	

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
3005	Open	26/5/23	2.3	***CEO Report -*** Prioritise a staff story from experience of the emerging incident review meetings (EIRs)	**This has been raised with the engagement and patient safety teams. Aim to provide a suitable staff story later this year. This will include consideration of sharing the experience more widely with staff through video recording.** **AGENDA ITEM**	RJ	01/12/23	Complete	01/12/2023
3022	Open	21/7/23	2.4	**West Suffolk Alliance and SNEE Integrated Care Board -** Provide report on dementia at a future Board meeting, and provide clear reporting of the benefits achieved through BCF investment.	Verbal update to be provided at today's (29.9.23) meeting. Schedule dementia strategy for meeting in December. Need transparency on the use of the Better Care Fund and discharge funding report to the urgent and emergency care governance group and through that to Insight. **AGENDA ITEM.**	PW	29/09/23	Complete	01/12/2023
3029	Open	29/9/23	1.3	**Minutes of the previous meeting -** adding Krishna Yergol, Non-executive director, to the list of attendees**.**	**Actioned.**	RB	01/12/23	Complete	01/12/2023
3032	Open	29/9/23	1.6	**Patient and Staff Story** - Reflect on the impact of the story and how to balance hearing these stories with sharing in advance the content with board members and other in attendance.	**The importance of the Board hearing patient and staff stories is clearly recognised but it is also appropriate to support Board members and those in attendance by communicating details of the story in advance. Action has been taken to support this approach.**	JC	01/12/23	Complete	01/12/2023

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
3033	Open	29/9/23	1.8	**Reflection on the Letby Case** - Be clear how the board receives assurance on 7 areas from the report and map this and provide visibility to the board/assurance committees.	**The committee mapping is described below:** **Involvement: speaking up; grievances (staff); complaints (patients) Improvement: mortality oversight; Medical Examiner Officer; incident monitoring; results management and review (through patient safety team).** **These will be reviewed against the forward committees plans and amendments made as required.**	RJ	26/01/24	Complete	01/12/2023
3035	Open	29/9/23	2.1	**Strategic Objectives Delivery Plan -** Look to include discussion on 2024/25 priorities in the programme for the November development day.	**Considered in Board development session on 2/11/23 - update in Governance report.**	RJ	01/12/23	Complete	01/12/2023
3036	Open	29/9/23	2.3	**West Suffolk Alliance and SNEE Integrated Care Board** - Information about the utilisation of any WSA winter funding to also be considered at urgent and emergency governance group, which reports into Insight committee.	**Discharge Fund informatin shared with UEC at meeting on 13.11.23.**	CM	01/12/23	Complete	01/12/2023
3037	Open	29/9/23	2.3	**West Suffolk Alliance and SNEE Integrated Care Board** - Consider communication of the community contract position to staff.	**Actioned.**	NC/CM	01/12/23	Complete	01/12/2023
3038	Open	29/9/23	3.1	**Involvement Committee Report** - Develop workforce KPIs to be received by the involvement committee.	**Actioned.**	JMO	01/12/23	Complete	01/12/2023
3040	Open	29/9/23	4.4	**Quality and Nurse Staffing Report** - Reflect on the quality indicators used in the report and whether there are more sensitive indicators which relate to staffing levels.	**Today's report (1.12.23) refers)**	SW	01/12/23	Complete	01/12/2023
3041	Open	29/9/23	4.4	**Quality and Nurse Staffing Report** - Provide update to Board on review of the international recruitment pipeline (include retention data to support decision). Link this to the nursing associate pipeline and transition to registered status.	**Included in today's nurse staffing report (1.12.23)**	SW/JMO	01/12/23	Complete	01/12/2023
3042	Open	29/9/23	5.3	**Meeting Schedule for 2024** - 2024 schedule of meetings to be sent out to Board members & attendees	**Calendar invitations sent.**	PS	01/12/23	Complete	01/12/2023

1.5. Questions from Governors and the Public relating to items on the agenda

To Note

Presented by Jude Chin

1.6. Patient and Staff Story

Disability history month runs from 16 November and we have therefore prioritised this month’s staff story to hear from the disability network. Ceiridwen Fowles will present some examples of staff stories, including in relation to reasonable adjustments.

To Review

1.7. Chief Executive’s report

To inform

Presented by Ewen Cameron

BOARD OF DIRECTORS	
Report title:	**CEO report**
Agenda item:	1.7
Date of the meeting:	Friday, 1 December 2023
Sponsor/executive lead:	Dr Ewen Cameron
Report prepared by:	Sam Green and Helen Davies

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

Executive Summary
WHAT? *Summary of issue, including evaluation of the validity the data/information*
-
SO WHAT? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*
-
WHAT NEXT? *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*
-
Action Required
-

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

Performance

Pressures and demand

As we move into late Autumn, the pressures on our services show no signs of decreasing and our colleagues from every team continue to go above and beyond to provide excellent care for our community.

The pressures on our Trust are stark. From dealing with the ageing estate at West Suffolk Hospital (whilst we work hard on plans to build a new hospital) to coping with ever increasing demand for our services; and from working to improve our financial position to dealing with the complexities of industrial action, it would be remiss of me not to overtly state just how challenging things are at the moment.

However, as I go out and about seeing teams across the organisation, I am continually impressed by everyone's resilience and dedication to do their absolute best for our patients. I am immensely proud of the quality of the care we provide and how even in the most challenging of times, colleagues keep delivering time and time again.

The combination of increasing demand on our urgent and emergency care services and the strike action means our waiting lists are still above where we would like them to be. At the end of October, we had 56 patients waiting over 78 weeks, of which 40 were capacity breaches. We had 621 patients waiting over 65 weeks, but we remain on track to reduce this number significantly by the end of March 2024.

We know how frustrating and debilitating it can be for people to wait for the care they need, and I would like to apologise to all those who are waiting longer than we would like them to. Please be assured that we are taking many positive actions to reduce waiting times. For example, we are sourcing additional capacity in our urogynaecology and dermatology teams so we can run weekend activity. We also have a continued focus on outpatient transformation which is helping us to release capacity. We are also focused on increasing theatre productivity, so we can treat as many patients as possible, and we are utilising the independent healthcare sector to help us increase our capacity.

Finance update

Colleagues and I have spoken openly about the Trust's financial challenges. These pressures have been caused by a range of factors such as industrial action, staffing costs and having kept our winter escalation ward open for longer than anticipated earlier this year.

To help us improve our position, every team from across the organisation has worked to deliver improvements and savings under our cost improvement programme, which is being led by the finance team. Due to the efforts from everyone involved, we are seeing an improvement in our position, meaning we are making significant progress in meeting our financial goals for this year. Despite this progress however, there is still a lot we will need to do both this year and in the future to become financially sustainable. My colleague, Craig Black, will outline our current position in more detail later today, but I first wanted to thank everyone for their herculean efforts.

Additionally, I was glad to recently receive indication from NHS England that the Trust would receive a share of £800 million to deal with the financial impact of industrial action, as well as the reduction in the threshold of the Elective Recovery Fund (ERF) for the rest of the year, alongside the recognition of the recent performance pressures. This means that while we are on our way to meeting our financial goals, there is still a lot that we need to do.

Impact of industrial action

In the communication from NHS England outlined above, there was also the request to set out revised priorities in light of these unforeseen financial pressures. These revised priorities include achieving financial balance; protecting patient safety and prioritising emergency performance and

capacity; whilst also protecting urgent care, high priority elective and cancer care. Since receiving this information, we have been working on a set of actions to deliver these priorities for the remainder of the financial year.

Broadly speaking, we will be committing to the following actions and targets:

- Recommitting to our already submitted trajectories regarding achievement of the cancer 28 day faster diagnosis standard and the reduction of the 62 day backlog by March 2024
- In urgent and emergency care (UEC), we will be restating our commitment to achieving 76% for the 4-hour standard by March 2024
- We have reaffirmed our commitment to reducing the number of elective patients waiting 65 weeks or more, improving on our original plan
- Helping patients return home sooner by including discharge ready date information in our Integrated Quality and Performance Report.

Quality and Safety

The safety of the care we provide is paramount and lies at the heart of everything we do, and as such, there is a large volume of work ongoing to drive improvements.

We have recently released additional modules as part of our patient safety education programme. This helps our staff understand the importance of using systems thinking to understand why and how things do not go as we intended. We recognise that we work in a complex, dynamic environment which can be uncertain, and we need to consider all the components that go into patient care when analysing how and why things do not go to plan. We use the Systems Engineering Initiative for Patient Safety (SEIPS) Framework because this helps us understand outcomes within complex socio-technical systems. The work system is made up of tools and technologies, tasks, the internal environment, and organisation which is all centred around people. As an early adopter of the Patient Safety Incident Response Framework (PSIRF), we did not have an education programme which supported our transition, so the patient safety team have been crafting a programme for all staff to support and grow system thinking at all levels of the organisation, which will build a more positive safety culture and an overall safer system in which we can deliver care.

For those who have Human Factors experience, systems thinking is not a new concept. A Human Factors and Ergonomics specialist has been recruited in our patient safety team, who will work seamlessly to help deliver the education programme and support project implementation in areas of improvement.

There has been a significant increase in the number of projects that we are currently undertaking to ensure we continually make improvements. Currently, there are 327 active projects across the Trust, which represents a very large increase given that there were just 12 in April 2020. A lot of these projects are also in their infancy, with 41 projects having been established in the second quarter (Q2) of this financial year alone, highlighting the focus we are all placing on driving improvements.

During Q2, our quality improvement (QI) team provided support to numerous teams across the organisation. The QI team have worked to provide training they have created for colleagues across the organisation, which aims to give them the necessary tools to make positive changes that help improve the care we provide. As a result, teams have completed projects that have resulted in improvements in outcomes for our patients. For example, the team on F3 ward worked to better understand the link between the development of pressure ulcers and those who undergo significant orthopaedic surgery. By improving awareness and clinician confidence through training, the team decreased the number of patients who developed pressure ulcers following

orthopaedic surgery by 43%, which will provide our patients with a much greater level of comfort during their recovery.

Workforce

Listening to staff

We have an extensive programme of listening and engaging with our staff. This helps us understand how our staff are feeling, the concerns they have and the areas they would like us to focus on and make improvements in. One of these listening exercises is the annual NHS Staff Survey, which has recently closed for this year. I'm delighted that this year (at the time of writing ahead of the survey closing), 45% of our staff completed the survey, which is an increase from the 41% that completed this last year. This increase also comes after we grew the size of the organisation over the past year, meaning we have greatly increased the number of our staff who have chosen to provide their valuable feedback. We look forward to sharing the results with staff and developing actions on the things they tell us are important in due course.

These new actions will build on a raft of positive changes we are already making to help improve how our Trust runs and how we care for and develop our staff.

The staff survey is just one of many ways staff can speak up and raise concerns. Recently, I've heard directly from some colleagues who have been subjected to racist and homophobic abuse by patients receiving care at West Suffolk Hospital. This is completely unacceptable. As well as being morally wrong, staff receiving this sort of abuse, and their colleagues, are negatively impacted, and their wellbeing may suffer. We know it is difficult for our staff to provide the best care under these circumstances. As a Trust we are now signed up to the anti-racist charter and we've put together a 90-point inclusion action plan. We want to be a caring and inclusive organisation which welcomes people from all parts of the world and celebrates people's diversity. While we have done a lot so far, we will continue to work and develop this to ensure our Trust is the best place to work and receive care.

Celebrating colleagues

Our staff deserve to be listened to and respected because they're amazing. Over the last few weeks, we've had several causes to celebrate members of our team.

A member of our integrated clinical education team, Sandra Austin, recently received the prestigious Chief Nursing Officer award. This is a national award and was given to Sandra for her dedication and commitment to the quality of care the Trust provides.

Bridget Glynn, senior staff nurse in critical care services, won a coveted 'Cavell Star', which honours the memory of Edith Cavell, a British nurse who treated soldiers from both sides of the First World War. Bridget's colleagues nominated her for the award to recognise her long and outstanding career at the West Suffolk Hospital, which over 40 years here includes more than 37 in critical care.

In October, the Trust held a thank you event in our Time Out restaurant at the West Suffolk Hospital, to mark the arrival of the 50th cohort of international nurses who have joined us in the past five years for their OSCE journey. Successfully completing OSCE (Objective Standard Clinical Examination) is part of the registration process for nurses and midwives trained outside the UK or EU. Taking this exam is not an easy task for anyone, let alone someone arriving from another country and who may have English as a second language. Congratulations to them all and thank you for joining us here.

Looking to the Future

While there are many challenges that we are currently dealing with, it is a very exciting time as we continue our work to deliver a new healthcare facility by 2030 on the Hardwick Manor site in

Bury St Edmunds. We have continued to work collaboratively with our national New Hospital Programme team colleagues to fully utilise the benefits of their programmatic approach.

The future systems team have continued to develop the outline business case and the schedule for accommodation, upon which the business case will be based, which we anticipate being finalised by the end of the year.

Enabling works for the new hospital are underway, which has included the discharging of pre-commencement planning conditions as part of our ecology compensation strategy. This has involved moving approximately one hectare of turf containing rare fungi from its current location on the Hardwick Manor site to two new sites with identical soil DNA to conserve it. The success of this move is looking positive with early signs of the fungi thriving.

The scheme continues to co-produce its designs and has been conducting extensive engagement regarding digital technology in the new hospital, discussing the ethos “digital first not digital only” with staff, patients and members of the community to help bring the strategy to life and understand the true impact on those who will work within and use our hospital. Anyone can get involved by completing the survey, which is open until 5 December, so please take five minutes to complete this.

2. STRATEGY

2.1. Prevention, Personalised Care and Health Inequalities Strategy

To Approve

Presented by Paul Molyneux

BOARD OF DIRECTORS

Prevention, health inequalities and personalised care strategy

Report title:	Prevention, health inequalities and personalised care strategy
Executive lead:	Paul Molyneux, medical director
Report prepared by:	Helena Jopling, clinical lead for public health
Previously considered by:	Senior leadership team, 19 June 2023 Trust board, 02 November 2023

For approval ☒	For assurance ☐	For discussion ☐	For information ☐
Trust ambitions			
Please indicate ambitions relevant to this report			Make the biggest possible contribution to prevent ill-health, increase wellbeing and reduce health inequalities

Executive summary

WSFT has a history of innovation and leadership in prevention, health inequalities and personalised care (PHIPC) stretching back at least a decade. Reflecting the growing local and national recognition of these crucial levers for both population health and the long-term sustainability of the NHS and social care, PHIPC took a more prominent position in the 2021-26 trust strategy under the ambition First for the Future. The trust has committed to Make the biggest possible contribution to prevent ill health, increase wellbeing and reduce health inequalities.

This new document, the PHIPC strategy, lays out in detail the meaning of that commitment and the ways in which the trust will achieve it. The document acts as a sub-strategy to the main trust strategy and aligns with a number of other strategies and plans including the Clinical and Care Strategy, the People and Culture Plan, and the Green Plan.

The lifetime of the PHIPC strategy matches that of the clinical and care strategy, 2023-2031, and indeed work is already well underway on the 2023-25 action plan, of which this year's strategic priorities in prevention and proactive care form a part.

The strategy is presented as a trust document in order to focus the organisation on discharging its legal and contractual duties thoroughly and comprehensively, but that does not mean acting in isolation; on the contrary, most of the objectives will only be able to be achieved through joint working with Alliance partners. The trust benefits from a highly unusual resource in having its own public health team which brings the benefits of professional leadership, specialist expertise, dedicated capacity, and connection into the wider public health system. The Suffolk and North-East Essex Integrated Care System infrastructure for integrated action on prevention, health inequalities and personalised care is developing rapidly. The trust is playing an active role at both ICS and Alliance level and the PHIPC strategy is fully aligned to the system's stated goals. It is intended that over time the trust's strategy will blend with the emerging ICS- and Alliance approaches, led by Suffolk's director of public health.

On 2nd November 2023 the Trust board held a development session which provided an introduction to the PHIPC strategy and some examples of the work being done towards the 2023-5 action plan, including collaborative projects with West Suffolk Alliance partners. For example, the board learnt that smoking is the most important cause of health inequalities and the trust's tobacco control plan is crucial for improving the population's health. Board members prioritised interventions to help achieve a smoke-free site at West Suffolk Hospital by September 2024.

Recommendation: It is proposed that the smoke-free site should feature in the board's strategic prevention and proactive care objective for 2024/25.

The discussions elicited a high level of ambition amongst the board around prevention, health inequalities and personalised care. An important task will be monitoring the healthcare inequalities that the trust is creating, and hopefully reducing, with meaningful measurement.

Recommendations about how the board might like to achieve this are as follows:

- In the first instance, prioritise the Core20PLUS5 indicators, embedding their reporting into the relevant divisional performance reports so that they are monitored alongside all the other performance, access and quality indicators
- Over time, adopt a routine of scrutinising all the key organisational performance indicators for inequalities gradients. The priority KPIs should include emergency department waiting times, elective care waiting times, maternal and neonatal outcomes, and complaints. The report provides an example of analysing waiting times for elective care by deprivation.

Both these approaches lend themselves to being expanded into a cross-organisational Alliance view once the reporting streams and familiarity with this type of analysis is established.

Action required of the Board

To approve the PHIPC strategy and to note in particular the collaboration with West Suffolk Alliance partners in the 2023-5 action plan

To note the outputs of the board development session

To adopt achieving a smoke-free site at West Suffolk Hospital under the prevention and proactive care strategic objective for 2024/25

To consider the recommendations for monitoring healthcare inequalities indicators and embedding their scrutiny into the existing governance activities.

Risk and assurance:	Non-delivery of the PHIPC strategy would create a number of regulatory and contractual risks (see the box below). Assurance will be obtained through the continued allocation of resources to delivery of the PHIPC strategy and the other strategies and plans which contribute to prevention, health inequalities and personalised care.

Equality, diversity and Inclusion:	For patients: implementing the PHIPC strategy will make a direct contribution to improving equality and inclusion through action on the health inequalities faced by minority and marginalised groups. For staff: The PHIPC strategy aligns with and is informed by the trust's People and Culture plan and Inclusion work plan.
Sustainability:	The PHIPC strategy aligns with and is informed by the trust's Green Plan. Prevention and personalised care both decarbonise healthcare: • preventative interventions tend to be low-carbon in their delivery • both prevention and personalised care reduce the need for downstream services, reducing carbon consumption as well as cost and the risk of harm
Legal and regulatory context:	The trust has several contractual and regulatory duties to take action on prevention, health inequalities and personalised care, laid out in Box 2 in the strategy document. Implementing the strategy will ensure the trust discharges these duties.

Introduction

WSFT has a history of innovation and leadership in prevention, health inequalities and personalised care (PHIPC) stretching back at least a decade. In 2016, WSFT became the first acute provider in the east of England to invest in in-house public health expertise. In 2017 we published our first prevention, health inequalities and personalised care (PHIPC) strategy – *Protecting and improving your health and wellbeing, together*[1] – which codified the variety of PHIPC initiatives that were already in place and set out our aspiration to truly be part of a national health service, not just a national illness service (see page 4 in the document).

In the time since then the national attention and the NHS policy drivers for prevention, health inequalities and personalised care have grown substantially. PHIPC has become established as a core component of high-quality care, through regulation (in the Care Quality Commission assessment framework), contract (in the NHS standard contract) and statute (in the Equality Act 2010 and the Public Services (Social Value) Act 2012). The NHS Long Term Plan prioritises personalised care in its first chapter and prevention and health inequalities in its second. Integrated care systems create the conditions and mechanisms to make the plan come true.

Reflecting the local and national evolution, PHIPC took a more prominent position in the 2021-26 trust strategy under the ambition First for the Future. The trust has committed to **Make the biggest possible contribution to prevent ill health, increase wellbeing and reduce health inequalities**. The PHIPC strategy therefore acts as a sub-strategy to the main trust strategy, laying out in detail the meaning of that commitment and the ways in which the trust will achieve it. The lifetime of the PHIPC strategy matches that of the clinical and care strategy, reflecting their shared imperative for the success of the Future System Programme.

Prevention, health inequalities and personalised care are not small topics and they require coordinated action across the entire trust, and with partners, to make progress. The PHIPC strategy sets out objectives for each topic (prevention, health inequalities and personalised care) for each of the trust's three main audiences – patients, staff, and the public.

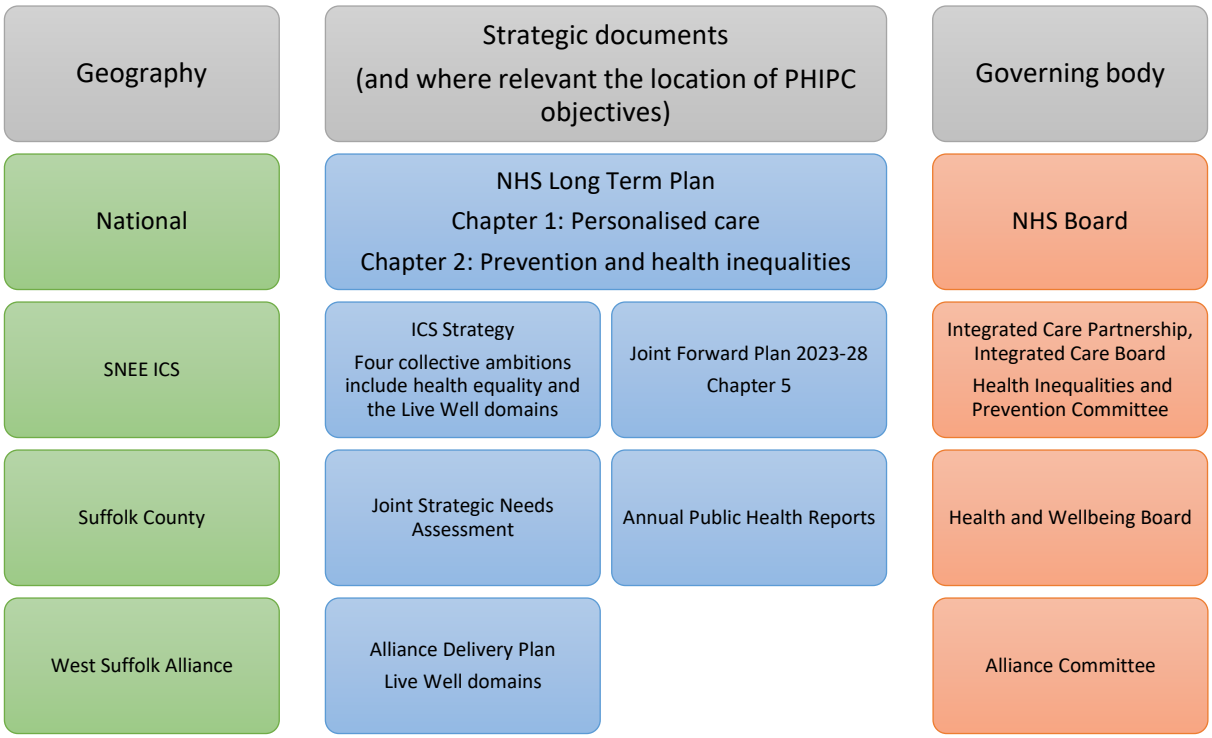
The strategy explicitly recognises and respects the links into departments such as workforce and estates & facilities management and does not seek to duplicate objectives which are already covered elsewhere and well in-hand. Rather, it identifies and celebrates the role that many other strategies and plans play in preventing ill-health, increasing wellbeing and reducing health inequalities, including the People and Culture plan, Inclusion work plan, Estates and facilities management strategy and the Green plan. The goal of the PHIPC strategy is to emphasise the full extent and the diversity of the contribution that the trust makes to improving the population's health.

Similarly, the strategy is written as a trust document but it does not imply that the trust will act in isolation on prevention, health inequalities and personalised care. On the contrary, most of the objectives will only be able to be achieved through joint working with Alliance partners. Moreover, the objectives have been devised cognisant that the trust can and should add significant value to collective activities at both ICS- and Alliance level. The Suffolk and North-East Essex Integrated Care System infrastructure for integrated action on prevention, health inequalities and personalised care is developing rapidly and the trust is playing an active role. The PHIPC strategy sits comfortably within this context (Figure 1) and

[1] https://www.wsh.nhs.uk/CMS-Documents/Trust-Publications/Health-and-wellbeing/Health-and-wellbeing-brochure.pdf

is fully aligned to the system's stated goals. It is intended that over time the trust's strategy will blend with the emerging ICS- and Alliance approaches, led by Suffolk's Director of Public Health and the Alliance director respectively.

Figure 1: The national, regional and local context for strategy and governance of prevention, health inequalities and personalised care



Board development session

On 02 November 2023 the trust board held a development session which provided an introduction to the PHIPC strategy. The session used the What? So What? Now What? framework to bring the objectives in the PHIPC strategy to life and to explore the board members' interests in PHIPC.

Level of ambition and leadership for PHIPC

In the first session the board heard some examples of health inequalities analysis in the local population and some emerging partnership work which is being done. Examples included:

- using population health intelligence to identify people with unmanaged hypertension with Forest Heath general practice
- using data and community engagement to understand and address the healthcare inequalities faced by people living in the most deprived neighbourhood in the catchment area, working with community leaders, voluntary and community organisations, primary care and West Suffolk Council

Board members each considered their opportunities to lead for reducing health inequalities through their core portfolios and highlighted a number of priorities and tools that they require. Non-exhaustively, these included:

- a clear desire to enact the principles of prevention, health inequalities and personalised care widely across the trust's business and as an Alliance
- a keen interest in the trust's ability as an employer to improve the wider determinants of health for employees and their families
- a focus on being data-driven and implementing interventions that are known to work and likely to have the biggest impact. The board recognised that this is achieved by starting with the people whose needs are greatest
- an emphasis on measuring outcomes to ensure that the intended effects are realised.

The board expressed a level of ambition highly consistent with the trust's strategy and values, and wants the trust to be known as an organisation which excels in this field.

Tobacco control

In the second session the board heard about the recent introduction of an inpatient tobacco dependence service, driven by the NHS Long Term Plan and set up in partnership with Suffolk County Council and SNEE ICB. Since its introduction in November 2022, the service has used continuous improvement principles to scale up and as of October 2023 is now successfully seeing all people who are smokers and admitted to an acute inpatient ward. Since the board development day, the service has been invited to be an NHS England case study for their integrated pathway in community pharmacy.

The board also heard that the smokefree site policy is being revised by a multidisciplinary group, including district council and patient representatives, with the benefit of human factors research which was conducted in 2022/23. The approach taken has firmly recognised that smoking is an addiction, that stopping smoking is difficult, and that stigmatising smoking is unlikely to be helpful. The human factors research identified a number of potential interventions which would help the trust achieve a smokefree site at West Suffolk Hospital, including by talking to people who smoke and/or vape on or near the site. The board members prioritised the interventions and showed a clear preference for interventions which were compassionate and supportive towards smokers:

1. nicotine replacement therapy (including vapes) being available for sale on site
2. a staff stop smoking service, including psychological support and free nicotine replacement therapy (including vapes)
3. including information about the support available to have a smokefree shift in induction and appraisal
4. a comprehensive communications package promoting a smokefree site through consistent visual queues and messaging, and support for staff to have a smokefree shift, patients to have a smokefree stay and visitors to have a smokefree visit.

The team will proceed to work these interventions up as part of the trust's holistic tobacco control plan. Given the organisation-wide cooperation that will be needed to implement them and the scale of the impact that they will create if done well, **it is recommended** that in the 2024/25 strategic board priorities, the prevention and proactive care objective should include the achievement of a smokefree site.

Monitoring healthcare inequalities

Finally, the board heard about the importance of starting to monitor healthcare inequalities indicators routinely, in order both to:

- stimulate and demonstrate improvement against NHS England's Core20PLUS5 indicators for both adults and children and young people (Figure 2 and Figure 3)
- surface and start to tackle any healthcare inequalities which the trust is inadvertently creating through implicit bias and structural inequalities

This type of reporting is in its infancy in England so the board requested some recommendations about best practice and a meaningful way to start.

Figure 2: Core20PLUS5 approach to healthcare inequalities for adults

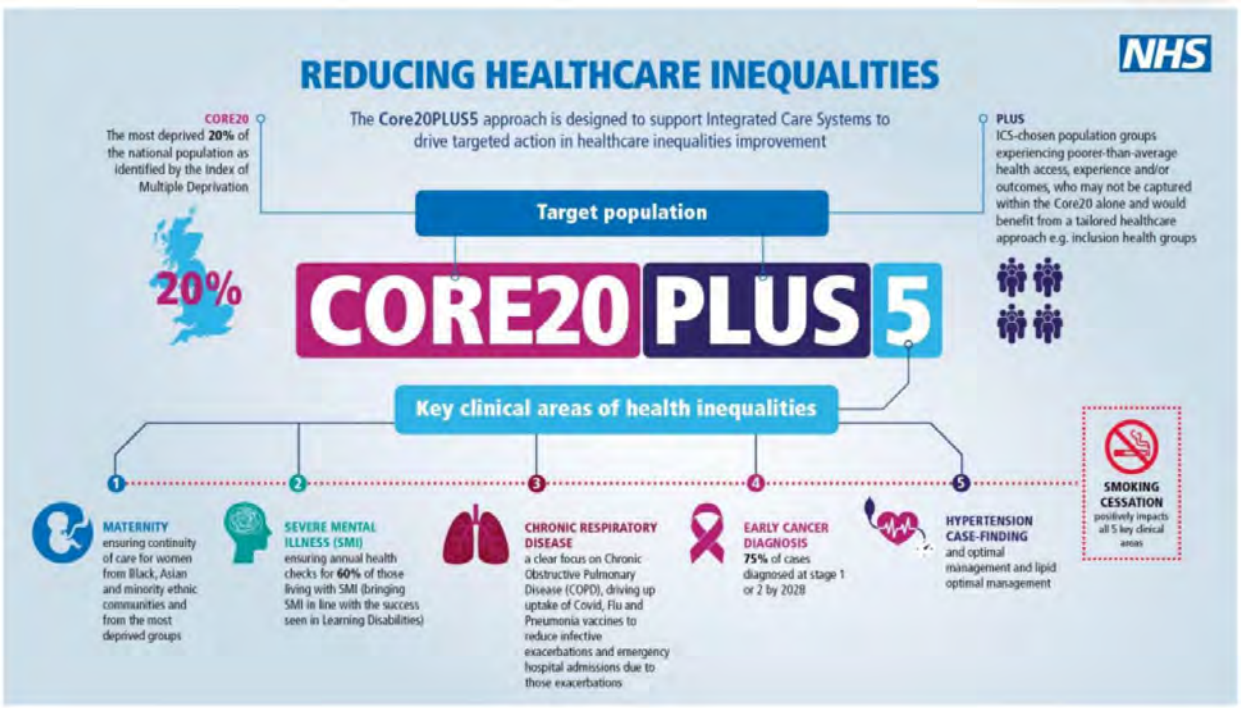


Figure 3: Core20PLUS5 approach to healthcare inequalities for children and young people

Since the development day, the results of research commissioned by NHS England to explore the ways in which boards around the country monitor health inequalities has been published by South, Central and West Commissioning Support Unit[2]. Case studies exist from 8 trusts and demonstrate a number of different approaches. Boards variously focus on strategic, tactical and/or operational indicators. The availability of suitably-skilled analyst capacity was noted as an important enabler. The top recommendation from the research team was to start something using existing processes and data, and to focus on improving data completeness and accuracy.

With this in mind, **it is recommended** that the board adopts a dual approach as follows:

1. In the first instance, prioritise the 5 clinical areas amongst each set of Core20PLUS5 indicators, embedding their reporting into the relevant divisional performance reports so that they are monitored alongside all the other performance, access and quality indicators.

   This should start with the indicators which are primarily within the trust's control:

   - For adults:
     - Continuity of care for women from Black, Asian and minority ethnic communities and from the most disadvantaged groups
     - Smoking cessation (for patients and staff)
   - For children and young people:
     - Increase access to epilepsy specialist nurses and ensure access in the first year of care for those with a learning disability or autism

   And then expand into joint reporting with partners on the indicators which require shared action across integrated pathways, e.g. early cancer diagnosis.

2. Over time, adopt a routine of scrutinising all the key organisational performance indicators for inequalities gradients. The priority KPIs should include emergency

[2] Available to download at Reporting on health inequalities to NHS Trust Boards - NHS SCW Support and Transformation for Health and Care (scwcsu.nhs.uk)

department waiting times, elective care waiting times, maternal and neonatal outcomes, and complaints.

The inequalities gradients that are scrutinised should include ethnicity, gender, disability and deprivation as a minimum. A suitable schedule of reporting might be quarterly deep dives into individual KPIs at the Insight Committee. The quality of the insights which can be provided will vary by topic and by the data which is available. The trust should aim to use both the electronic patient records (eCare and SystmOne) and the alliance- and ICS-wide population health management databases to get as comprehensive a picture as possible.

Data completeness and accuracy will certainly pose a problem at first. For example, figures 4 and 5 show the distribution of how long people who are on a trust waiting list have been waiting, divided up by deprivation quintile (figure 4 shows both admitted and non-admitted pathways, figure 5 shows admitted pathways only). It would appear to be a positive picture, because the proportion of people from the most or second most deprived groups are evenly distributed across waiting times. That is to say, there is no evidence that deprived people are waiting longer, as we might expect. However, readers will notice that for circa 13% of people there is missing data (the grey bars), i.e. their deprivation quintile is unknown. Missing data to this extent risks having an effect on the results. Being able to see and understand patterns of this kind will both establish the need to improve data quality and direct the trust's efforts to address inequalities where they are exposed. It will also give the board the opportunity to consider what appetite there might be for bolder approaches to reducing inequalities, for example by prioritising people in the most deprived communities in order that they can benefit from having their procedures sooner.

Conclusion

The trust is in a strong position to build on its existing assets and partnerships, to accelerate progress on prevention, health inequalities and personalised care between now and 2031. The PHIPC strategy sets out suitably ambitious objectives which attend to the needs of patients, staff, and the public. Through their achievement, the trust will succeed in its aim to make the biggest possible contribution to prevent illness, increase wellbeing and reduce inequalities for the population it serves.

Figure 4: Waiting time distribution of people on an WSFT waiting list, admitted and non-admitted pathways, by deprivation decile, 17 November 2023. Source: HealtheIntent elective recovery dashboard

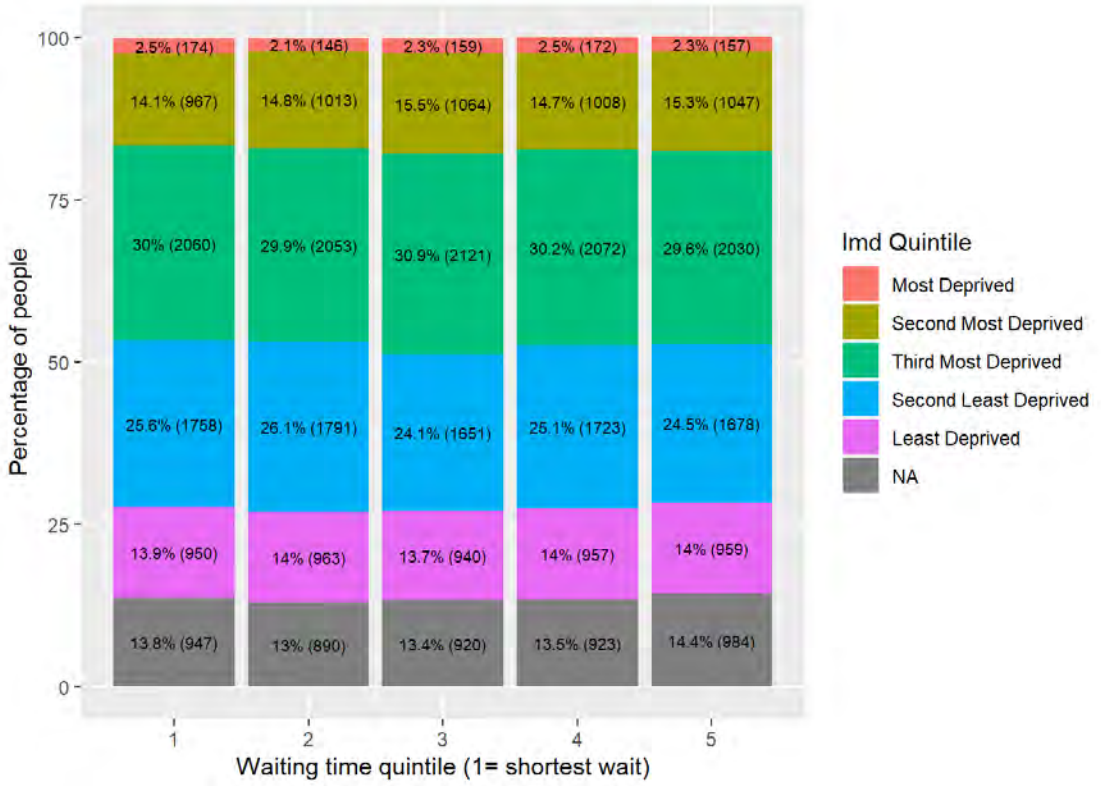
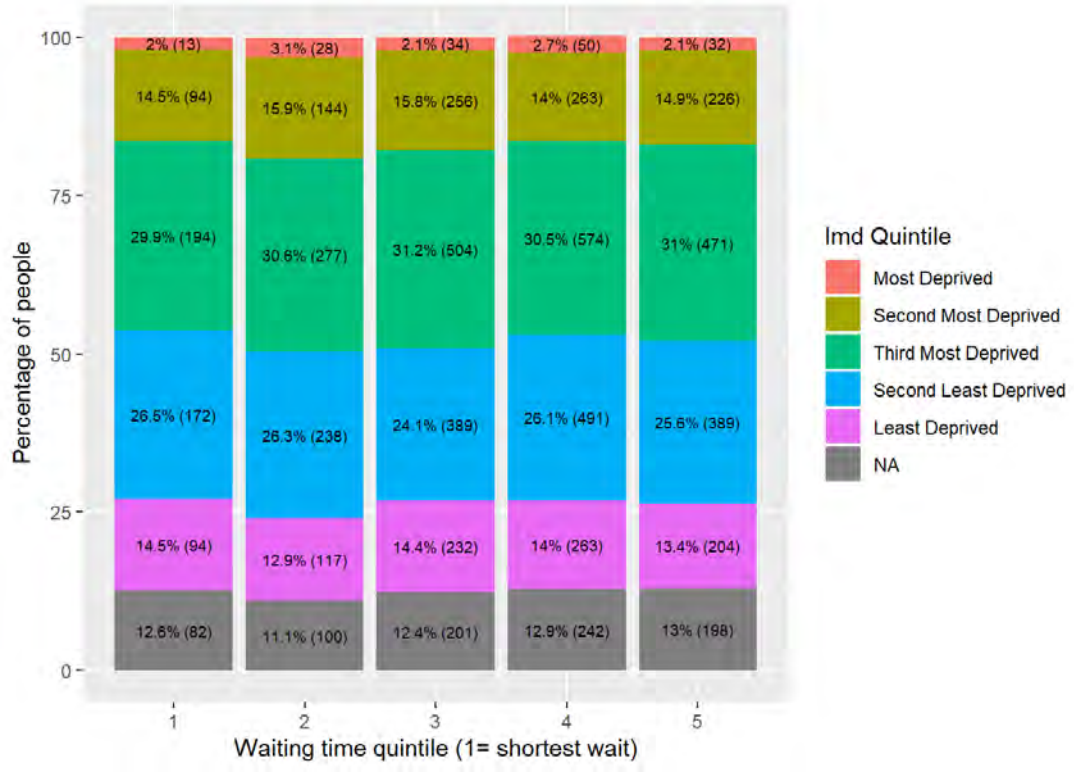


Figure 5: Waiting time distribution of people on an WSFT waiting list, admitted pathways only, by deprivation decile, 17 November 2023. Source: HealtheIntent elective recovery dashboard



WSFT Prevention, health inequalities and personalised care strategy

2023-2031

Introduction

West Suffolk NHS Foundation Trust (WSFT) provides hospital and adult community services to a largely rural geographical area with a population approaching 280,000 people. The catchment area extends beyond Thetford in the north and Sudbury in the south, to Newmarket to the west and Stowmarket to the east. The trust also provides integrated community services for children and young people who live in Ipswich and East Suffolk. Overall, the trust serves populations in the west and east of Suffolk and in parts of the neighbouring counties of Essex, Cambridgeshire and Norfolk.

The trust employs nearly 5000 staff who work from a range of different bases including hospitals, health centres, community hubs, GP surgeries, patients' homes and their own homes.

The trust is a member of a place-based partnership in the West Suffolk Alliance, within the Suffolk and North East Essex Integrated Care System.

Vision and values

Our vision

In 2021, the trust published a new five-year strategy, First for our patients, staff and the future. It lays out how the trust will deliver its vision of the best quality and safest care for our local community, in the aftermath of the Covid-19 pandemic and in an increasingly joined-up landscape, where the NHS, community services, councils and the voluntary sector are working closer together than ever before.

The First for the Future ambition includes the aim to **Make the biggest possible contribution to prevent ill health, increase wellbeing and reduce health inequalities**, which speaks directly to the population we serve:

Make the biggest possible contribution to prevent ill health, increase wellbeing and reduce health inequalities

By wellbeing we mean looking after the community's physical, mental, emotional, social, and economic needs. We're here to help make you better when you are ill, and to support you to help keep yourself well in the first place.

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

This prevention, health inequalities and personalised care strategy has been created to help achieve the first three goals on the list. The Green Plan is managed and governed separately. The Green Plan is published here.

Our values

Alongside our vision and ambitions, we share five core values which reflect the culture we are striving to create across the Trust.

Our FIRST trust values are:

- Fairness – 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
- Respect – We respect and are kind to one another and to patients. We seek to understand each other's perspectives so that we all feel able to express ourselves
- Safety – We put safety first for patients and staff. We seek to learn when things go wrong and create a culture of learning and improvement
- Teamwork – We work and communicate as a team. We support one another, collaborate and drive quality improvements across the Trust and wider local health system.

The FIRST values have been used to help create the prevention, health inequalities and personalised care strategy. Following the prevention, health inequalities and personalised care strategy will help us adhere to the values that we share.

Why do we need a prevention, health inequalities and personalised care strategy?

The needs of our local population, the nature of healthcare, the healthcare workforce and the ways in which clinical and non-clinical services are delivered have changed immeasurably over the last decade, even before the radical changes and unique challenges brought about by the Covid-19 pandemic.

The NHS Long Term Plan (NHS England, n.d.) clearly states that the NHS can and should take more action on prevention, health inequalities and personalised care to help improve the population's health and allow itself the best possible chance of meeting growing demand.

In Suffolk, we have known for some time that the growth in demand for healthcare services is unsustainable. In 2017, Suffolk County Council published analysis that showed that by 2037, another 2 hospitals the size of West Suffolk Hospital would be needed if the trend in hospital admissions didn't change (Suffolk Public Health & Communities, 2017). We are experiencing this rise in all our services, be it more district nurse visits, more children's community clinics, or more A&E attendances, for example.

WSFT is helping to tackle this crisis by joining up care within the trust and with other local organisations as a member of the West Suffolk Alliance[1] and Suffolk and North East Essex Integrated Care System[2]; through the Joint Forward Plan[3], the Alliance Live Well framework[4], our clinical and care strategy[5] and the Future System Programme[6]. It is starting to bear fruit; repeating the analysis in 2022, Suffolk County Council now estimates that only 1.5 new hospitals would be needed by 2042 (Suffolk Public Health & Communities, 2022). This is excellent progress, but it also shows that joining up care and shifting the emphasis away from a reliance on hospital specialists cannot be the whole answer.

The trust has an important and powerful role to play in helping people not to get sick in the first place, and making sure that when they do need our help, everyone gets the care they need fairly and tailored to their circumstances.

We can play this role alongside local residents, communities, councils and employers. By changing the trend, we will help our friends, families and neighbours in west Suffolk and the surrounding areas to enjoy fairer, happier, healthier lives. They will also have a better experience of our care and get more benefit from our care when they do need to visit us.

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[1] https://www.sneeics.org.uk/working-together/working-together-in-place-based-alliances/west-suffolk-alliance/
[2] www.sneeics.org.uk
[3] https://suffolkandnortheastessex.icb.nhs.uk/wp-content/uploads/2023/06/15427-SNEE-ICB-Joint-Forward-Plan-2023-2028-PROOF_20.pdf
[4] https://www.sneeics.org.uk/live-well/
[5] Please see https://www.wsh.nhs.uk/CMS-Documents/Trust-board/2023/Trust-open-board-meeting-pack-21-July-2023.pdf pages 77-104
[6] Please see www.wsh.nhs.uk/New-healthcare-facility/New-healthcare-facility.apsx for more information

We are building on strong foundations

This is not our first prevention, health inequalities and personalised care strategy. In 2017, we published our first strategy (West Suffolk NHS Foundation Trust, 2017/18) and talked about our aspiration to truly be a national health service, not just a national illness service (box 1).

Box 1: Our track record

We have been training staff in health coaching since it began being used in England in 2014. The programme has been independently evaluated by the Institute of Employment Studies (Institute for Employment Studies, 2018) and Healthwatch Suffolk (Healthwatch Suffolk, 2023).

Our catering team have held an Eat Out, Eat Well award for the fresh, healthy food it serves since 2016

WSFT's volunteer service was recognised by Helpforce in 2017 for the wide range of volunteering opportunities it offered (Helpforce, 2019). Volunteering encourages good mental health and is one of the Five Ways to Wellbeing (NHS Confederation & New Economics Foundation, 2011)

Our asset-based approach to staff health and wellbeing, with a particular focus on mental wellbeing, was shortlisted in the staff engagement category of the Health Service Journal Awards 2017

WSFT was the first acute trust in the East of England to employ a public health specialist in 2018

All healthcare support workers have been trained in Making Every Contact Count as part of their Care Certificate since 2018

We have provided free membership for staff at the local leisure centres run by Abbeycroft Leisure since 2021

We have worked with several organisations over the years to provide stop smoking advice, weight management classes, and exercise-on-referral schemes for patients and staff

Prevention, health inequalities and personalised care have also become established as core components of high-quality care (box 2). The objectives this strategy sets are not nice-to-haves; they are part of our day-to-day responsibility to the people that we serve.

Box 2: Regulatory and contractual requirements

The Care Quality Commission assesses NHS trusts with four relevant key lines of enquiry:

E5. How are people supported to live healthier lives and, where the services is responsible, how does it improve the health of its population

C2. How does the service support people to express their views and be actively involved in making decisions about their care, treatment and support as far as possible?

R1. How do people receive personalised care that is responsive to their needs?

R2. Do services take account of the particular needs and choices of different people?

The NHS standard contract 2022/23 (NHS England, 2022) has 6 relevant sections:

Service condition 8: Unmet need, Making Every Contact Count and Self-Care

Service condition 10: Personalised care Service condition 13: Equity of access, equality and non-discrimination, including the trust's duties under the Equality Act 2010 Service condition 18: Green NHS and Sustainability, including the trust's responsibility to procure for Social Value (UK Government, 2020) Service condition 19: Food standards and sugar-sweetened beverages Schedule 2M: Development plan for personalised care Schedule 2N: Health inequalities action plan

It is important that the trust focusses on its unique role in prevention, health inequalities and personalised care, working *with* partners but not duplicating other organisations' efforts. The NHS Providers Population Health Framework for Healthcare Providers (NHS Providers, 2019) is invaluable as a reference resource and a source of standards (Figure 1).

Figure 1: NHS Providers Population Health Framework for Healthcare Providers

How this strategy has been created

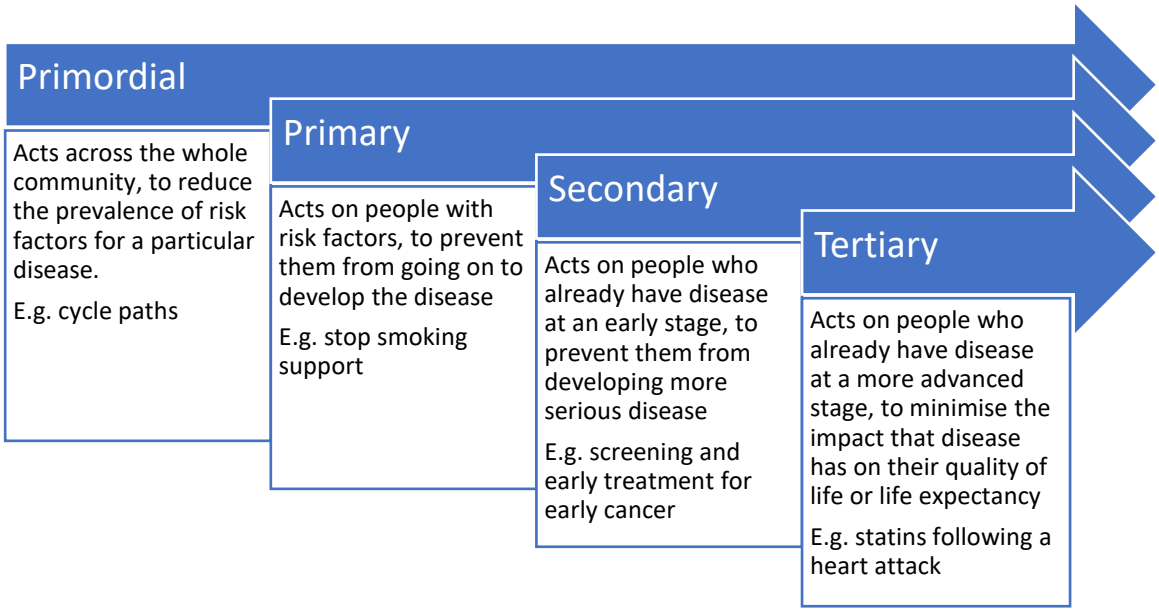
Over the next three chapters, prevention, health inequalities and personalised care will be defined as topics and set in the context of the national and local policy. For each topic, an analysis of strengths, weaknesses, opportunities and threats (SWOT) has been performed, comparing WSFT's current approaches with the evidence base for best practice (page 11, page 19, and page 26).

On the basis of the SWOT analyses, SMART objectives have been set (page 28) and an asset-based approach has been used to define an action plan for 2023-25 in the first instance (page 31).

Progress will be measured using well-designed metrics (page 33) and a continuous improvement ethos will be followed. We will review the content of the strategy on an annual basis to make sure it is up to date with best practice and we will refresh the action plan to reflect what we have achieved and what we are finding difficult.

Prevention

Prevention can be categorised into four levels:



The terms prevention and health improvement are often used interchangeably. There are several schools of thought on the prevention topics that the trust could prioritise:

- The NHS Long Term Plan focuses on smoking, obesity, alcohol, air pollution and antimicrobial resistance
- The Population Health Framework for Providers adds in workplace health and healthy premises
- The SNEE Joint Forward Plan prioritises healthy behaviours, naming tobacco, alcohol, drugs, weight, physical activity, and sleep as risk factors that need attention

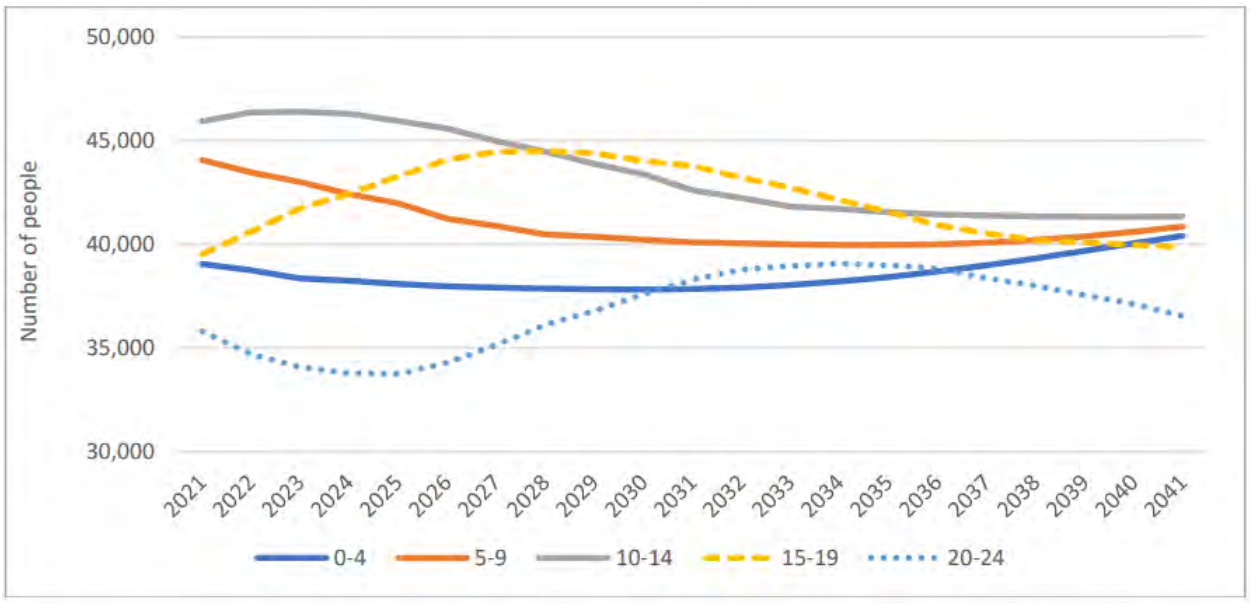
What do we know?

Our local population – population forecasts for the WSFT catchment area for district general hospital and adult community services

Age group	2021	2031	
0-14	41,025	39,689	↓ 3.3%
15-64	139,788	138,812	↓ 0.7%
65-74	27,331	30,393	↑ 11.2%
75+	26,353	33,841	↑ 28.4%
Total	234,497	242,735	↑ 3.5%

Our local population – population forecasts for the WSFT catchment area for children and young people's community services

Figure 2: Population change among children and young people aged 0-24 in Suffolk (2021 to 2041)



Source: The State of Children in Suffolk 2022 (Suffolk Public Health & Communities, 2022)

Risk factors

Obesity = 32% children and 61% of adults overweight or obese

Smoking = 16% adults smoke

Loneliness = 18% adults feel lonely

Physical activity = 29% adults physically inactive

People's experience of their health

17% people do not enjoy good health

16.5% people's day to day activities limited by a health condition or disability, including 8.5% of children and young people aged 24 or younger

Disease prevalence

People are not defined by their illnesses, but the health and care services they require are. Amongst our local population:

1 in 8 people are diagnosed with depression

1 in 126 live with a severe mental illness

1 in 6 children and young people have a probable mental health disorder

1 in 6 adults have high blood pressure

1 in 13 with asthma

1 in 44 with COPD

1 in 82 with heart failure

1 in 50 have had a stroke or transient ischaemic attack

1 in 12 have diabetes

1 in 113 have dementia

1 in 200 have a learning disability

1 in 23 have cancer

And for many people these diagnoses co-exist; increasingly people in our communities are living with multiple long-term conditions over many years.

The benefits of prevention

Healthy behaviours, social connection and healthy environments improve people's health and wellbeing.

For example:

Primordial:

Access to green and open spaces such as parks, gardens and woodlands improves mental health and happiness and reduces the risk of heart disease, obesity, cancer and musculoskeletal conditions (The King's Fund, 2023)

Primary:

Drinking less than 14 units of alcohol a week reduces a person's risk of heart disease, stroke, cancer, liver disease, injury, self-harm, and harm from risky behaviours. People who drink within the recommended limit enjoy better mood and memory and they sleep better (NHS, n.d.)

Secondary:

Recently diagnosed type 2 diabetes can be put into remission by weight loss in people who are overweight or obese (Lean, et al., 2019)

Tertiary:

Stopping smoking at or after the time of diagnosis improves survivorship from a number of different cancers (Toll, Brandon, Gritz, Warren, & Herbst, 2013). An average smoker will also save around £2000 a year by quitting (NHS, n.d.).

How are things now?

The SWOT analysis on prevention is shown in Figure 3.

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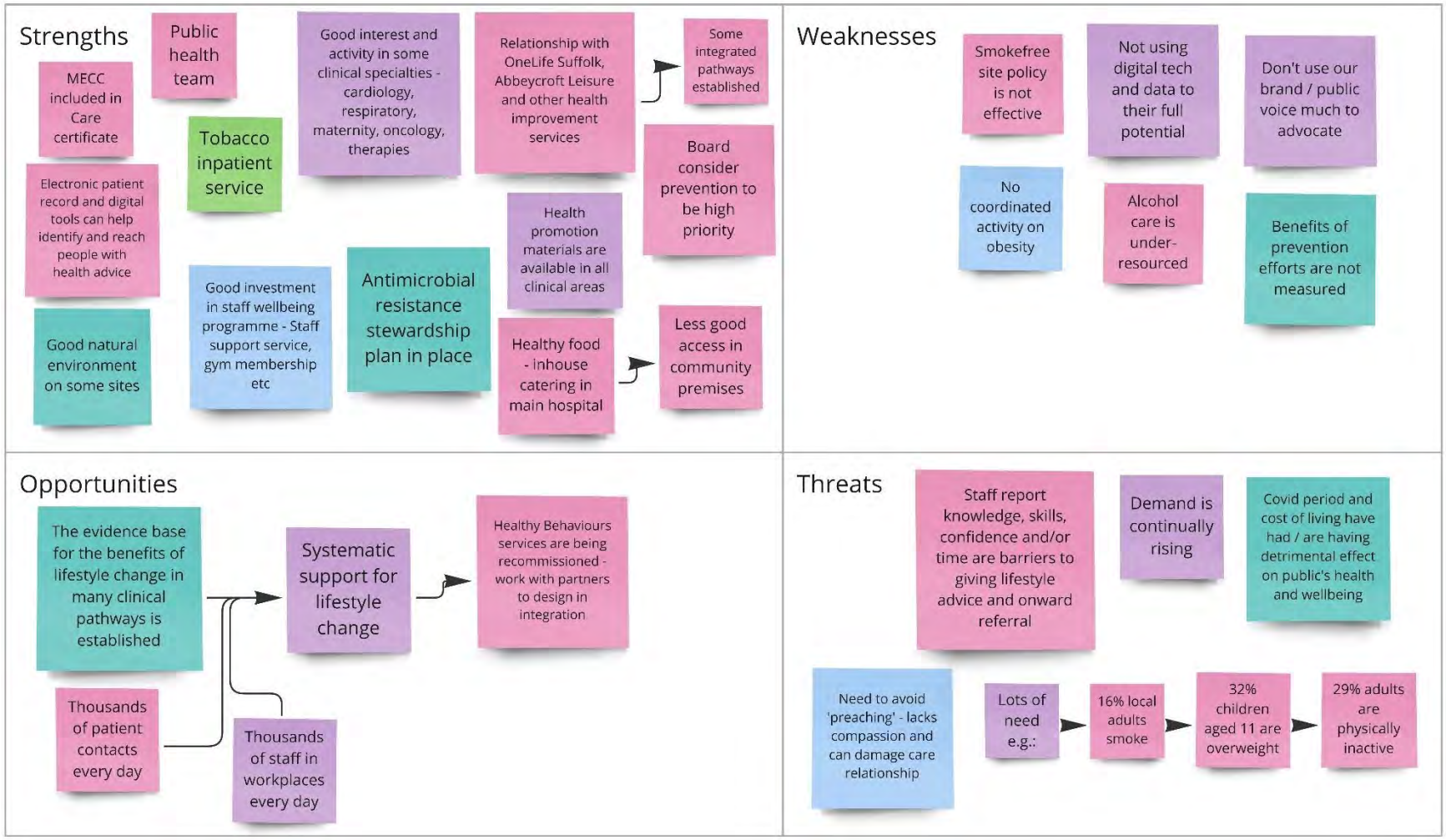
Figure 3: SWOT analysis for prevention



In summary

WSFT does some good work on prevention and there is a big opportunity to scale it up so that every service user and staff member can benefit if they wish. The challenge will be in doing so in a way that makes it realistic to achieve.

Health inequalities

Health inequalities are **unfair and avoidable** differences in health across the population, and between different groups within society.

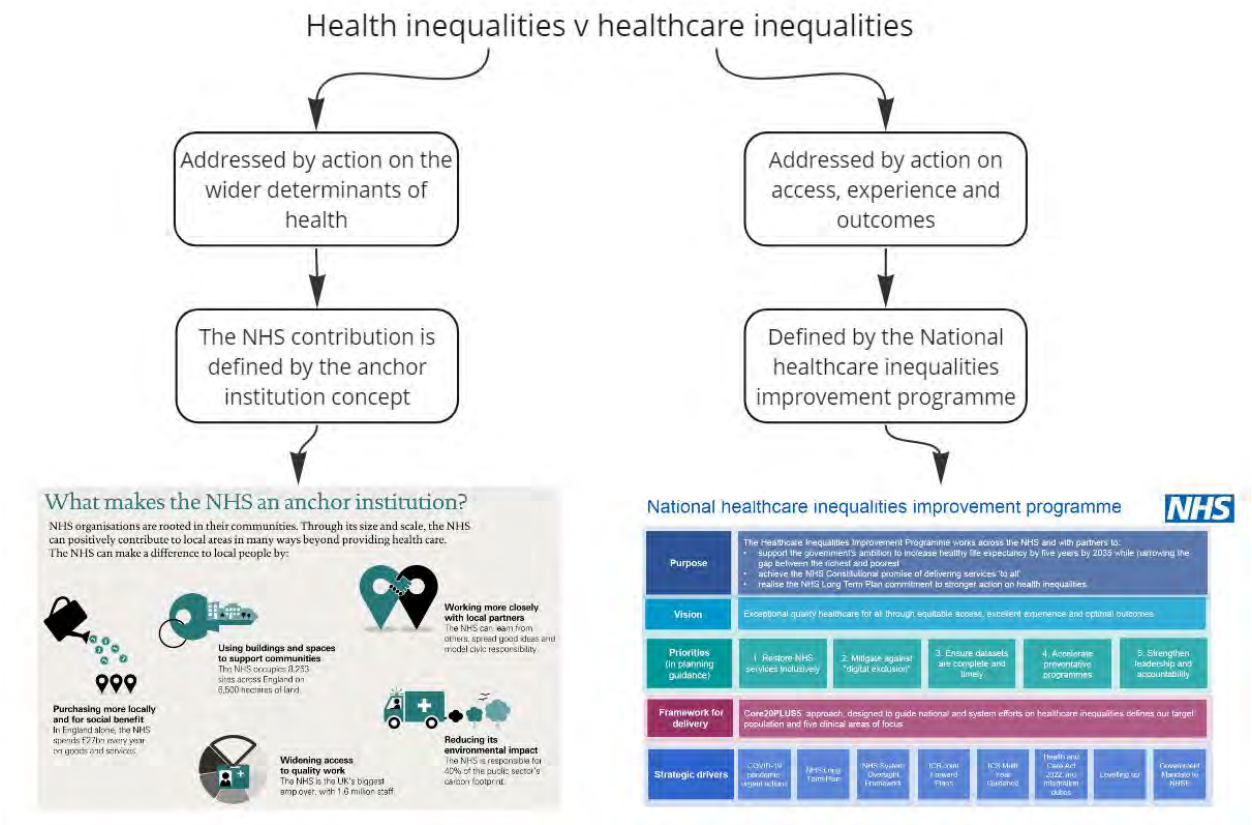
They arise because of the conditions in which we are born, grow, live, work and age. These conditions influence how we think, feel and act and can impact both our physical and mental health and wellbeing.

Within this wider context, **healthcare** inequalities are about the **access** people have to health services and their **experience** and **outcomes**.

NHS England (NHS England, n.d.)

NHS trusts have a role and responsibility to improve both health inequalities and healthcare inequalities (Figure 4).

Figure 4: Frameworks guiding the actions NHS trusts can take to improve health inequalities and healthcare inequalities (Reed, Gopfert, Wood, Allwood, & Warburton, 2019), (Future NHS, n.d.)



Health inequalities

It is widely accepted that only about 20% of health is down to healthcare (The Health Foundation, 2018). Thirty percent is achieved through healthy behaviours; and the other 50% is down to what are called the 'wider determinants of health' (Figure 5). They include economic factors like household income, social factors like high quality education and environment factors like good housing.

Not only do the wider determinants of health have a direct effect on disease and illness – such as damp housing causing respiratory illness in children – they also influence how much control

people have over their social interactions and their lifestyle 'choices' – illustrated in the famous Dahlgren and Whitehead rainbow in Figure 6.

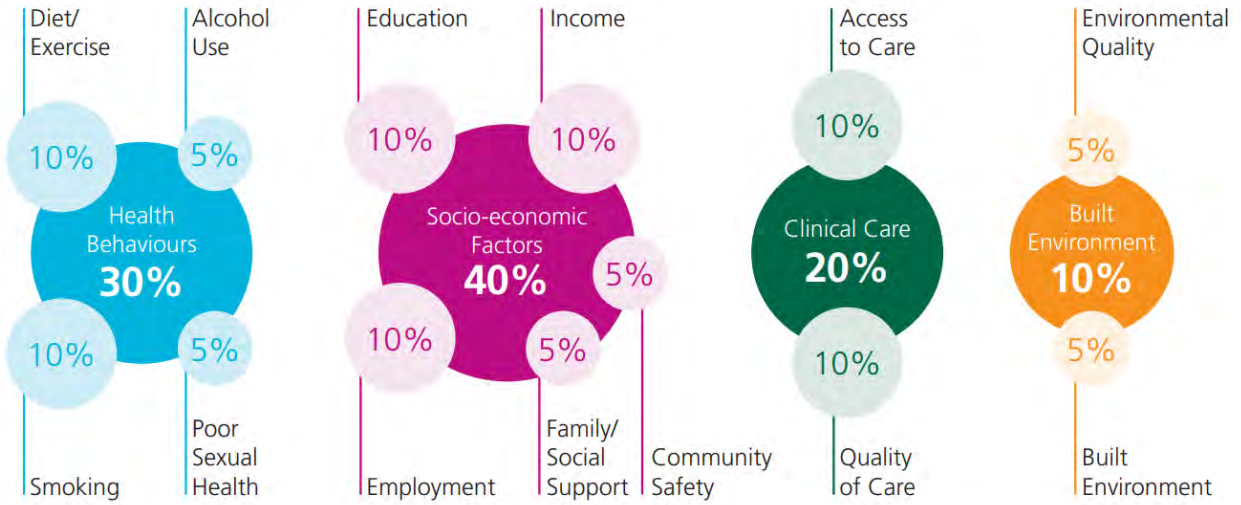


Figure 5: Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute County Health Rankings model for determining the wider determinants of population health (Suffolk and North East Essex Integrated Care Board, 2023)

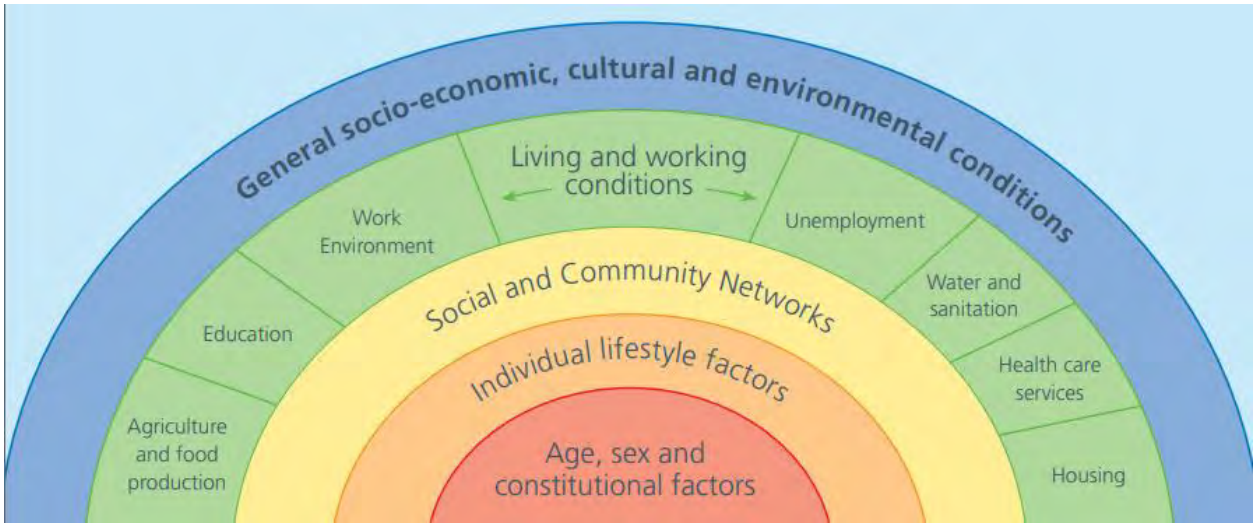


Figure 6: The factors that influence an individual's health and wellbeing – the Dahlgren-Whitehead rainbow (after (Dahlgren & Whitehead, 2006)

As Michael Marmot wrote in his landmark review of health inequalities in England in 2010 (University College London, 2010), "inequalities in health arise because of inequalities in society" (page 16). The wider determinants of health - good housing, good work, healthy food, good education, green space and clean air to name just a few - are not distributed evenly. The Marmot Review showed how this affects life expectancy, quality of life, and the national economy.

WSFT can help reduce health inequalities in the local population in a number of different ways:

- How it acts as an employer
- How it uses its purchasing power
- How it collaborates with local organisations and communities

- How seriously it takes its responsibility to help tackle the climate emergency.

Large organisations which can have a sizeable impact on the health and wellbeing of their local population, through the wider determinants of health, are referred to as ‘anchor institutions’.

It is important to make sure that the impact is had in such a way that it definitely reduces inequality, though, rather than exacerbating it.

The Health Foundation convenes a learning network to help NHS bodies increase their anchor impact. SNEE ICS has an ICS Anchor Charter to which all ICS members are signatories.

Healthcare inequalities

If health inequalities are caused by the unfair disadvantages that are created beyond the boundaries of our organisation, health**care** inequalities are caused by the unfair disadvantages that are created within it.

Not everyone finds our services equally accessible; not everyone experiences the same quality of care from us; not everyone gets the same benefit from the care we provide.

These are difficult truths to accept. No member of the NHS workforce sets out to provide care inequitably and no organisation sets out to deliver services in a way which is unfair.

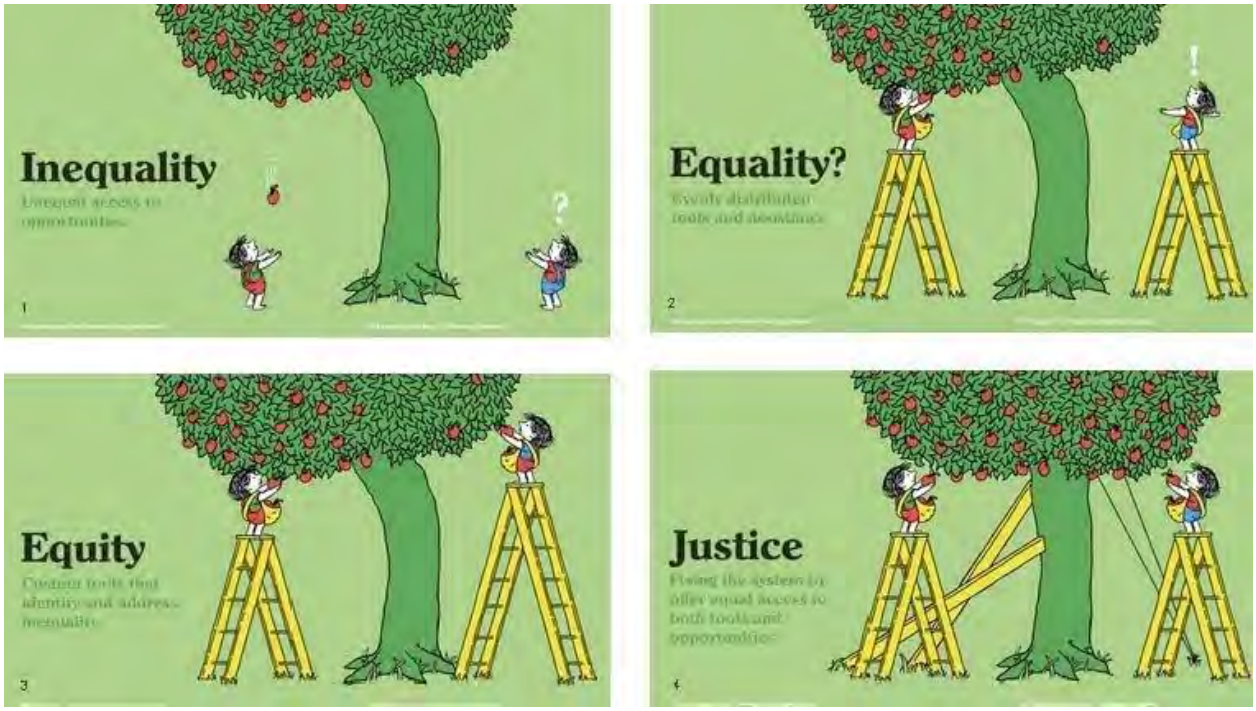


Figure 7: Equality, equity and justice (Ruth)

The problem arises from the intention to treat everyone equally, when, as Marmot explained, their needs are not equal in the first place (Figure 7). Language, literacy, culture, financial resources, and many other wider determinants of health have a heavy influence on:

1. The effectiveness of the interactions between individual patients and their healthcare professionals
2. How easily patients and their carers can navigate our buildings, our websites, the various roles and responsibilities of our services, and how we connect into rest of NHS and beyond.

The take-home point is this:

If we are not actively trying to reduce healthcare inequalities, we are almost certainly inadvertently widening them.

The national healthcare inequalities improvement programme (HIIP) has been set up specifically to help NHS organisations understand and start to address healthcare inequalities. It breaks this vast topic down into a set of focussed, manageable, impactful first steps.

The priorities that are laid out in the HIIP are:

1. Restoring NHS services inclusively (focusing on elective waiting lists)
2. Mitigating against digital exclusion
3. Ensuring datasets are complete and timely (focusing on ethnicity data first)
4. Accelerating preventative programme (including the Core20PLUS5 approach – see below)
5. Strengthening leadership and accountability

Objectives and key lines of enquiry have been developed for each priority. The objectives are provided in Appendix 1 and our position against them is summarised in the SWOT analysis in Figure 12.

The Core20PLUS5 approach is a method for identifying the population groups who are most affected by healthcare inequalities and the clinical interventions that will have the greatest impact on improving those inequalities quickly. Tailored versions of Core20PLUS5 have been created for adults (Figure 8) and for children and young people (Figure 9).

Figure 8: Core20PLUS5 approach to healthcare inequalities for adults (NHS England, n.d.)

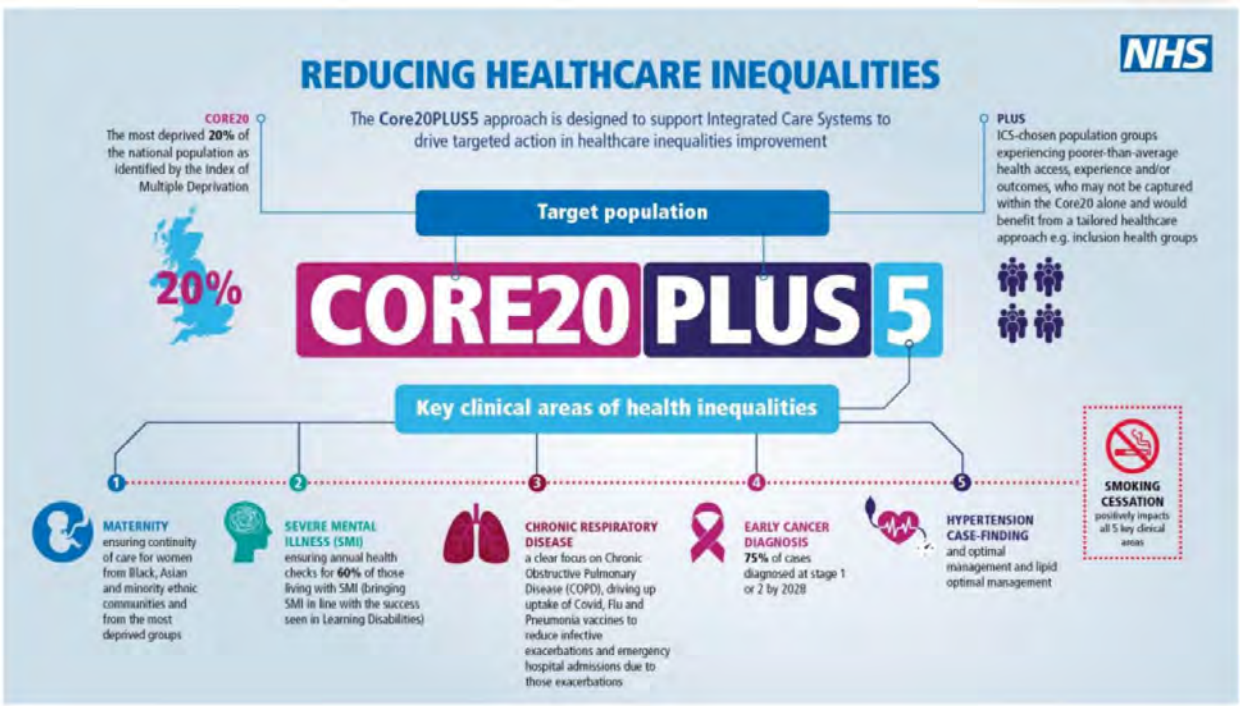


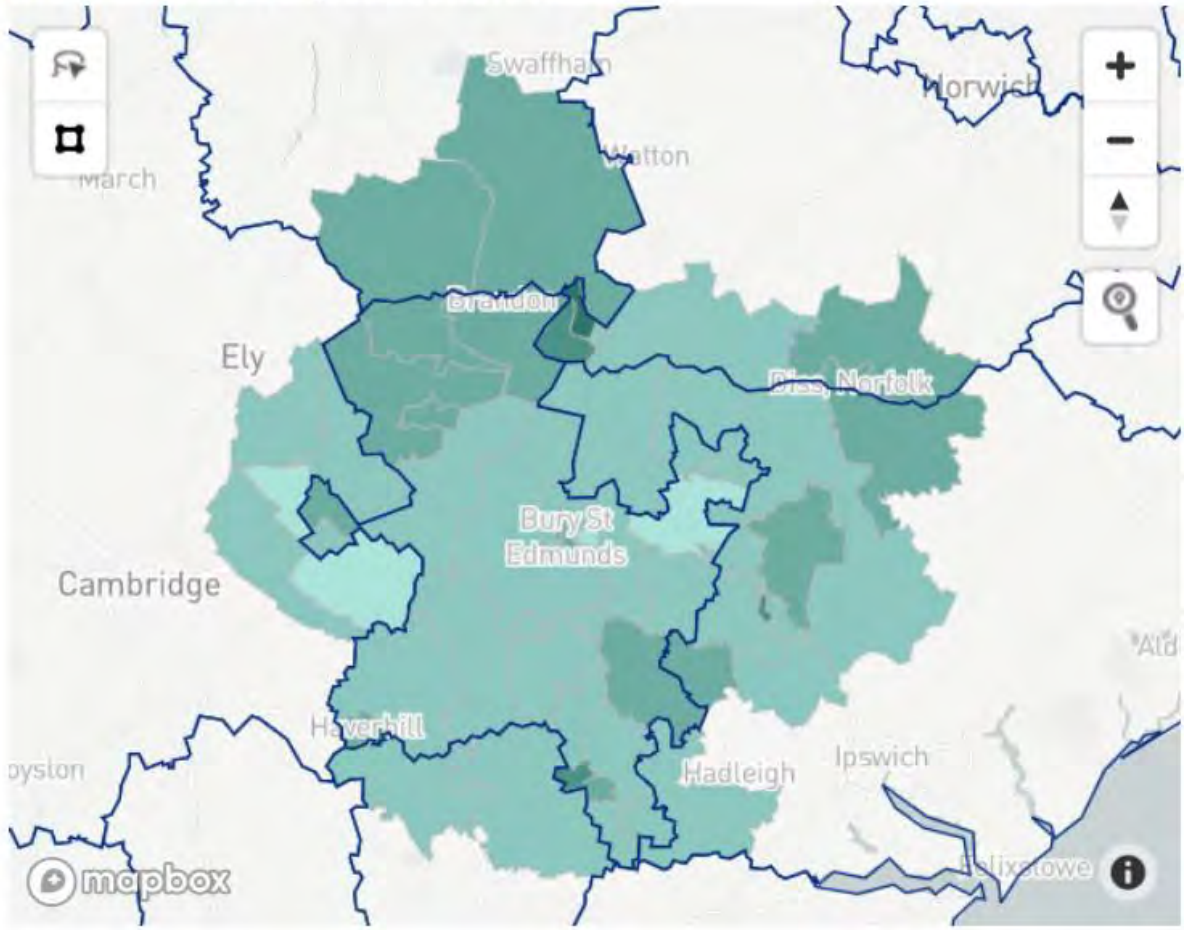
Figure 9: Core20PLUS5 approach to healthcare inequalities for children and young people (NHS England, n.d.)

What do we know?

In the WSFT catchment area, there are a lower number of people living in deprived areas than the national or regional average (Figure 10), with four neighbourhoods in the 20% most deprived nationally.

Figure 10: WSFT catchment area (defined by hospital admissions) by deprivation quintile (OHID, 2022)

IMD Quintile of Hospital Catchment



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Ordnance Survey Licence Number 100016969

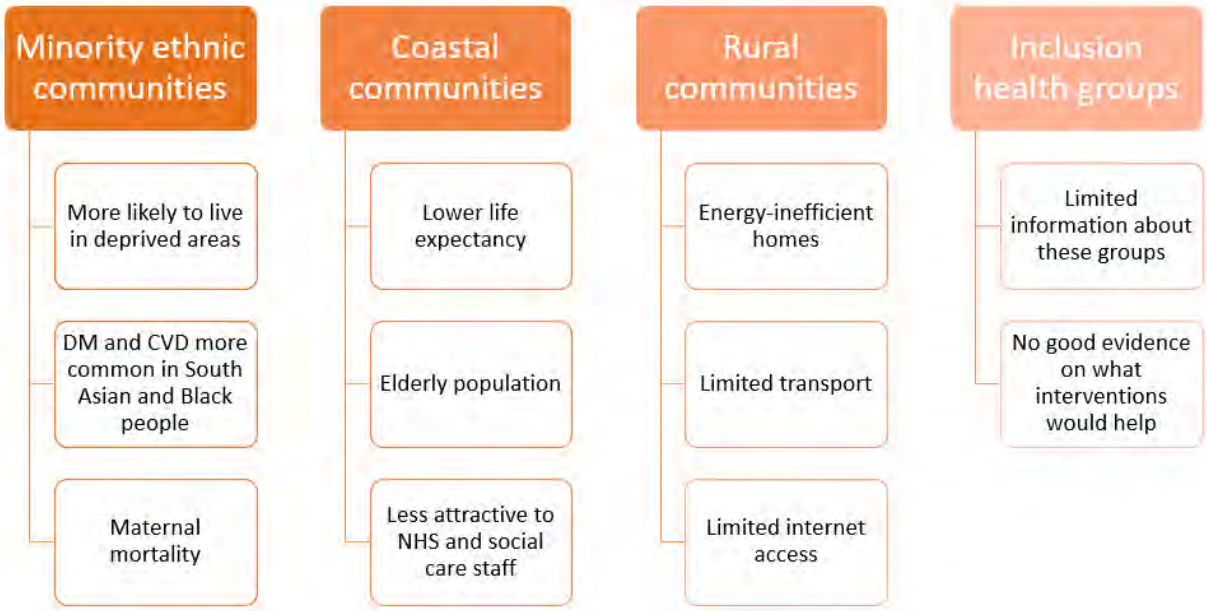
Q1 - Most Deprived
Q2
Q3
Q4
Q5 - Least Deprived

SNEE ICS has defined the PLUS populations as follows:

- People from minority ethnic groups
- Coastal communities
- Rural communities
- People and groups facing the sharpest health inequalities (groups at risk of disadvantage or “inclusion” health groups) e.g., migrants, travellers, those who are homeless, those in prison and sex workers
- People with learning disabilities and/or autism
- People with more than one health condition

West Suffolk does not have a coastline but otherwise a large proportion of our population will be covered by at least one of these categories. The nature of some of the disadvantages they face is shown in Figure 11.

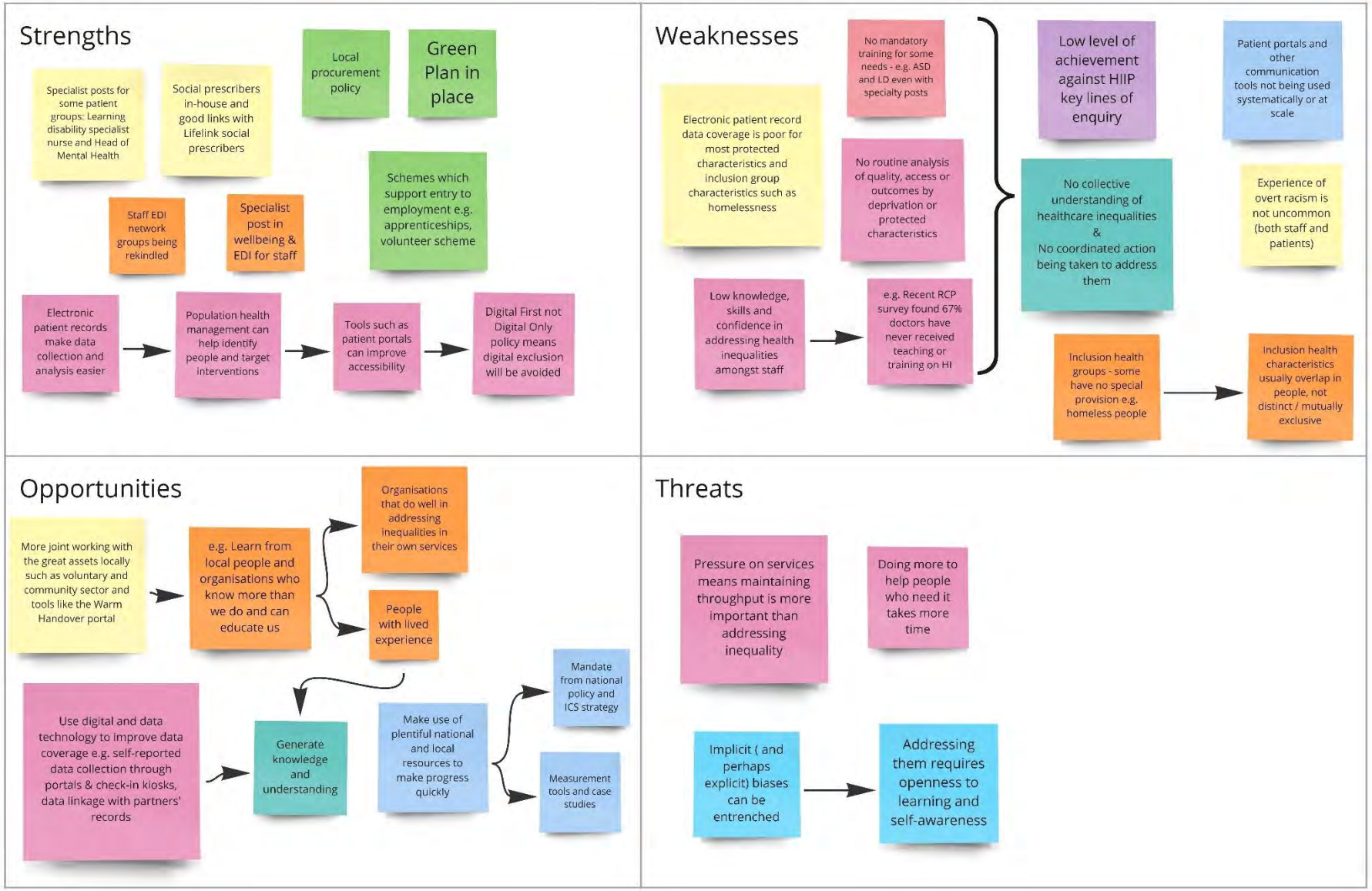
Figure 11: Characteristics that make the PLUS groups more susceptible to inequalities (courtesy of Maisie Fitzgerald, University of Cambridge)



How are things now?

The SWOT analysis on health inequalities and healthcare inequalities is shown in Figure 12.

Figure 12: SWOT analysis on health inequalities and healthcare inequalities



Whilst the electronic patient record could be a really useful tool for collecting data about people's characteristics and analysing who is subject to health inequalities, its use is impaired at the moment by the poor recording of protected characteristics and inclusion groups.

In February 2023, amongst the individual patient records:

- 100% had age, sex and ethnicity recorded

But only:

- 37% had religion recorded
- 0.33% had gender identity recorded
- 0.26% had sexual orientation recorded
- 0.07% were recorded as having a severe mental illness, compared to 0.95% in the GP register[7]
- 0.2% are recorded as having a learning disability, compared to 0.5% in the population[8]
- 0.24% are recorded as having a disability of any kind, compared to a prevalence of 16% in the population[9]

And:

- People from minority ethnic groups are under-identified – for example 2% are recorded as being in the Asian and black ethnic groups compared to 3.5% in the 2021 census
- People in inclusion health groups are difficult to identify because the information is not systematically gathered or recorded.

In summary

The trust takes its role as an anchor institution seriously and is making a good contribution to reducing health inequalities locally. There is a long way to go however on healthcare inequalities. Our ability to understand our population's different needs and characteristics and the pattern of healthcare inequalities is low. That said, there are many things that could help us, including the electronic patient record, the active voluntary, community and faith sector locally and our expanding patient engagement channels. There is the potential to make significant progress quickly.

The PLUS populations are very broad in our catchment area so we will focus first on the 20% most deprived neighbourhoods, people in minority ethnic groups and people with learning disabilities and autism, followed by inclusion health groups.

[7] Severe mental illness profile for NHS West Suffolk CCG, QOF prevalence (all ages), 2021/22 (OHID, n.d.)
[8] Learning disability profile for Suffolk, QOF prevalence (all ages), 2019/20 (OHID, n.d.)
[9] West Suffolk district, People disabled under the Equality Act: day-to-day activities limited a lot or a little (ONS, 2023)

Personalised care

Personalised care means people have choice and control over the way their care is planned and delivered. It is a change in relationship between people, professionals, and the system advocating collaboration and recognising people as active participants in their life and therefore care. It is based on ‘what matters to them’ and their individual strengths and needs as opposed to ‘what is the matter with them’.

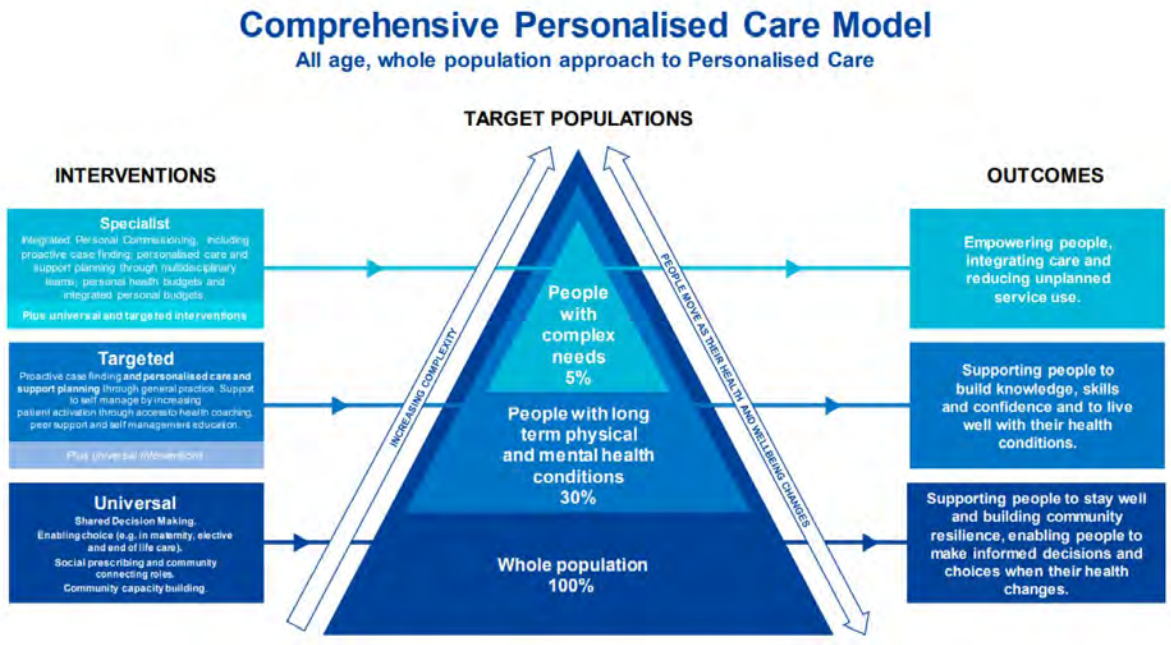
There are six pillars of personalised care. All are based on the principle of ‘what matters most’ to the individual (NHS England, 2019):

1. Patient choice – the right to make choices about health and care delivery
2. Shared decision making (SDM) – partnership between clinician and patient to ensure decisions are right for individuals
3. Patient activation and supported self-management – encourage, support, and empower living well with long-term physical and mental health conditions
4. Social prescribing and community-based support – connecting people to practical, social, and emotional support by introducing their local activities, services, and groups
5. Personalised care and support planning – joint holistic planning of treatment, management, and care with patient and/or advocate and health and care professionals
6. Personal health budgets – financial support to fulfil identified elements of the personalised care and support plan allowing more choice and control over how needs are met.

The NHS Comprehensive Personalised Care Model in Figure 13 illustrates how an all-age, whole population approach to personalised care can be achieved by using different types of interventions for different groups of people:

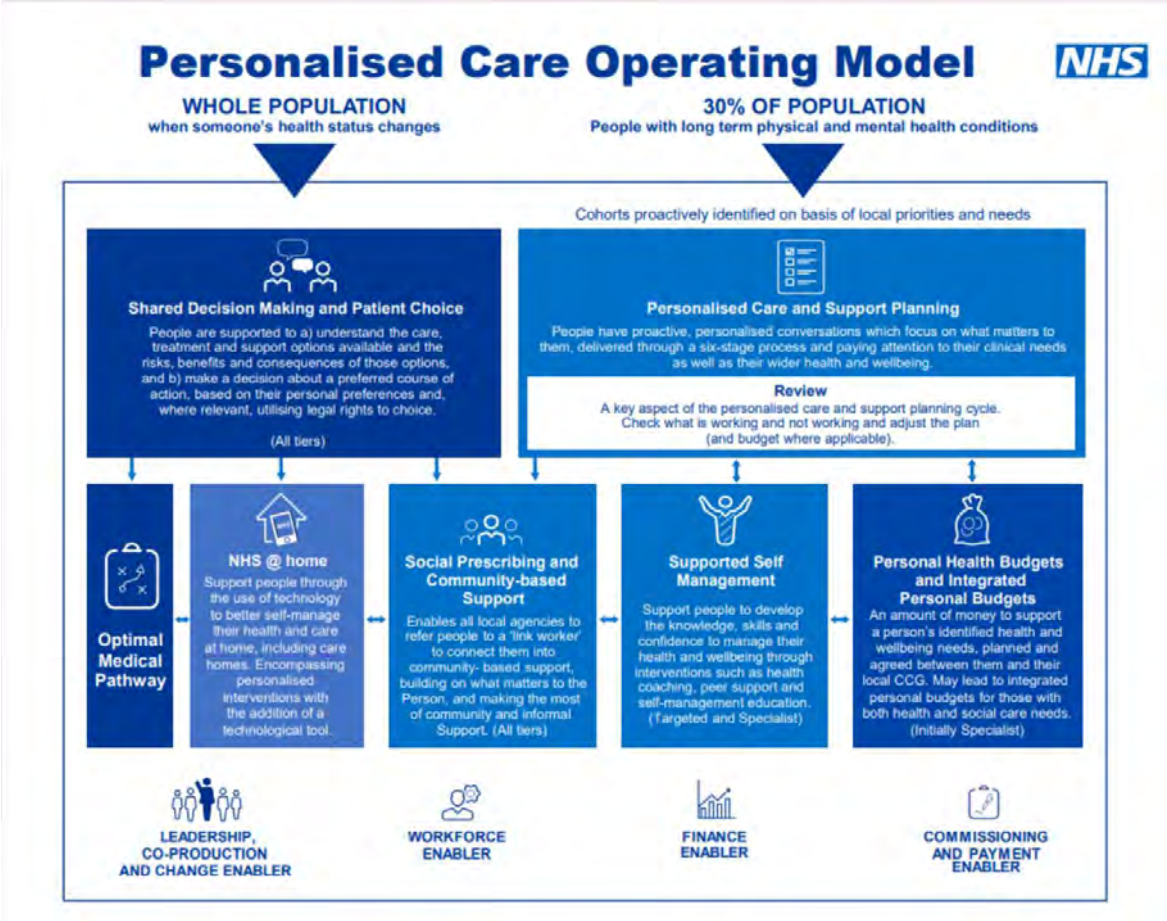
- universal interventions, such as shared decision making, which should be available to the whole population
- targeted interventions, such as health coaching, for people with long-term physical and mental health conditions
- specialist interventions, such as personal budgets, for people with the most complex needs.

Figure 13: NHS Comprehensive Personalised Care Model (NHS England, 2019)



Turning the Comprehensive Personalised Care Model into reality takes a whole-system, population approach including leadership, co-production, workforce, finance, and commissioning (Figure 14). Ultimately, personalised care will allow integration of services to be holistic around the person including health, social care, public health and wider specialist and community-based support.

Figure 14: NHS Personalised Care Operating Model (NHS England, 2018)



What do we know?

We know that individual health and care needs are becoming more complex and increasingly difficult for health and care services to manage using what can be described as 'round hole, square peg' approaches. Individuals are different, and one-size does not fit all (NHS England, 2019). Evidence tells us that by using a personalised approach to health and care, people's experience is better (round peg, round hole) and therefore their health and wellbeing outcomes improve. The NHS Long Term Plan states that 'personalised care will become business as usual across the health and care system' (NHS England, n.d.).

A briefing by The Health Foundation on the potential for 'reducing emergency admissions' through 'unlocking the potential of people to better manage their long-term conditions' highlights that people with long-term conditions spend most of their time managing treatment, medication, symptoms, and their health themselves with less than 1% of this time is spent with health professionals (Deeny, Thorlby, & Steventon, 2018). The briefing concludes that by equipping people with the knowledge, skills, and confidence to self-manage long-term conditions, it is likely to reduce demand on health and care services. It further concludes that use of health coaching to support patients more in self-management is needed, along with the Patient Activation Measure® (PAM) to assist health and care professionals in tailoring care to meet patient needs better, the impacts of which could be significant.

In addition to this, the briefing advocates social prescribing and peer support opportunities to help people more with self-management.

The evidence-base supporting personalised care continues to grow. Examples include:

- a review of over 1,000 papers concluding that peer support reduces loneliness and increases knowledge and confidence (Nesta & National Voices, 2015)
- a systematic review found that people in receipt of personal budgets prefer this to alternatives and are more satisfied, have better quality of life and fewer problems (Fleming, et al., 2019)
- of 9,000 people tracked across the health and care system, those with more confidence managing long-term conditions use their GP less and are less likely to need an emergency admission to hospital (Deeny, Thorlby, & Steventon, 2018).

There are several case-studies provided by NHS England to illustrate the impact personalised care can have on individuals. One case study describes how art, which was supported by social prescribing saved someone's life. By finding comfort, connection, and peace in art, it became a therapeutic tool allowing the person to change their perspective from being a mental health patient to an active person living a good life in society (NHS England, n.d.).

How are things now?

There is a wide range of activity underway at WSFT to increase personalised care across the six pillars. A baseline assessment of this has been completed using an NHS England maturity matrix template. The assessment rates 33 areas from starting to thriving across the six pillars and enablers specified in the operating model for personalised care delivery. The results are provided in Table 1 below and confirms that the trust is mostly in an emerging/developing position of implementation. Eight areas required a yes (n=3) or no (n=5) response, so have been excluded from the results in Table 1.

Table 1: Personalised care maturity matrix results

Key	Description	Score
Starting	Lack of leadership Not using national or local data Not considered/no emerging plans No collaboration Lack of knowledge of topic	**5**
Emerging	Leadership lacks authority Limited use of national & local data Limited thinking about how to scale up Minimal collaboration Limited knowledge of topic	**9**
Developing	Leadership in place Use of national or local data in part Teams/services/system developing clear vision Some understanding of current & future Population health needs Evidence of or plans in place towards delivering national priorities	**9**
Maturity	Strong leadership Using national or local data to inform plans Teams/services/system implementing new or redesigned care Evidence of tangible progress consistently improving delivery	**1**

Thriving	Leadership that champions at every level and project stage Demonstrating improvement in outcomes Full population health management capability Evidence of delivering national priorities Collaborative approach when issues emerge	**1**

The initiatives underway across the trust and identified through completion of the maturity matrix in March 2023 are described in Table 2. The scale of their reach is given where quantifiable.

Table 2: Current initiatives towards each of the six pillars of personalised care

Patient choice	In 2022, the trust invested in an electronic consent platform to enable better choice discussions and more accurate recording of consent processes in acute care
Shared Decision Making	Over the last six months, a shared decision making (SDM) template based on guidance from the General Medical Council has been created for the hospital electronic patient record (eCare) alongside a proposed requirement for acute and community trust colleagues to complete Personalised Care Institute SDM e-learning to encourage better quality SDM in a systematic and structured way.
Patient activation and supported self-management	In the last 12 months, 1,208 Patient Activation Measure® (PAM) surveys have been administered across 13 acute and community-based health and care services helping to tailor support to meet specific individual needs. Since the beginning of 2018, at least 640 health and care colleagues have been trained by the WSFT health coaching training service, enabling delivery of quality-assured health coaching skills[10] and enabling more opportunity for supported self-management in the population.
Social prescribing and community-based support	In September 2022, a pilot for hospital-based social prescribing began on one ward. The social prescriber contacted over 250 inpatients by March 2023 and plans to extend the service to more wards during 2023. Each integrated neighbourhood team (INT) benefits from a social prescriber being assigned to the locality to support people in the community.
Personalised care and support planning	Since 2012 people with long-term and life limiting illness have accessed a 'my care wishes' physical yellow folder. This is a personalised care and support plan to record individual wishes on treatment, admission to hospital and care options. Throughout 2023, the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) will be added to 'my care wishes', and the acute electronic patient record as an individual's personalised care and support plan. The ReSPECT plan supports an open conversation about a person's condition, priorities for future care and treatment options in an emergency.
Personal health budgets	Acute personal health budgets were introduced in 2022. These are small amounts of money to support discharges home or into the community.

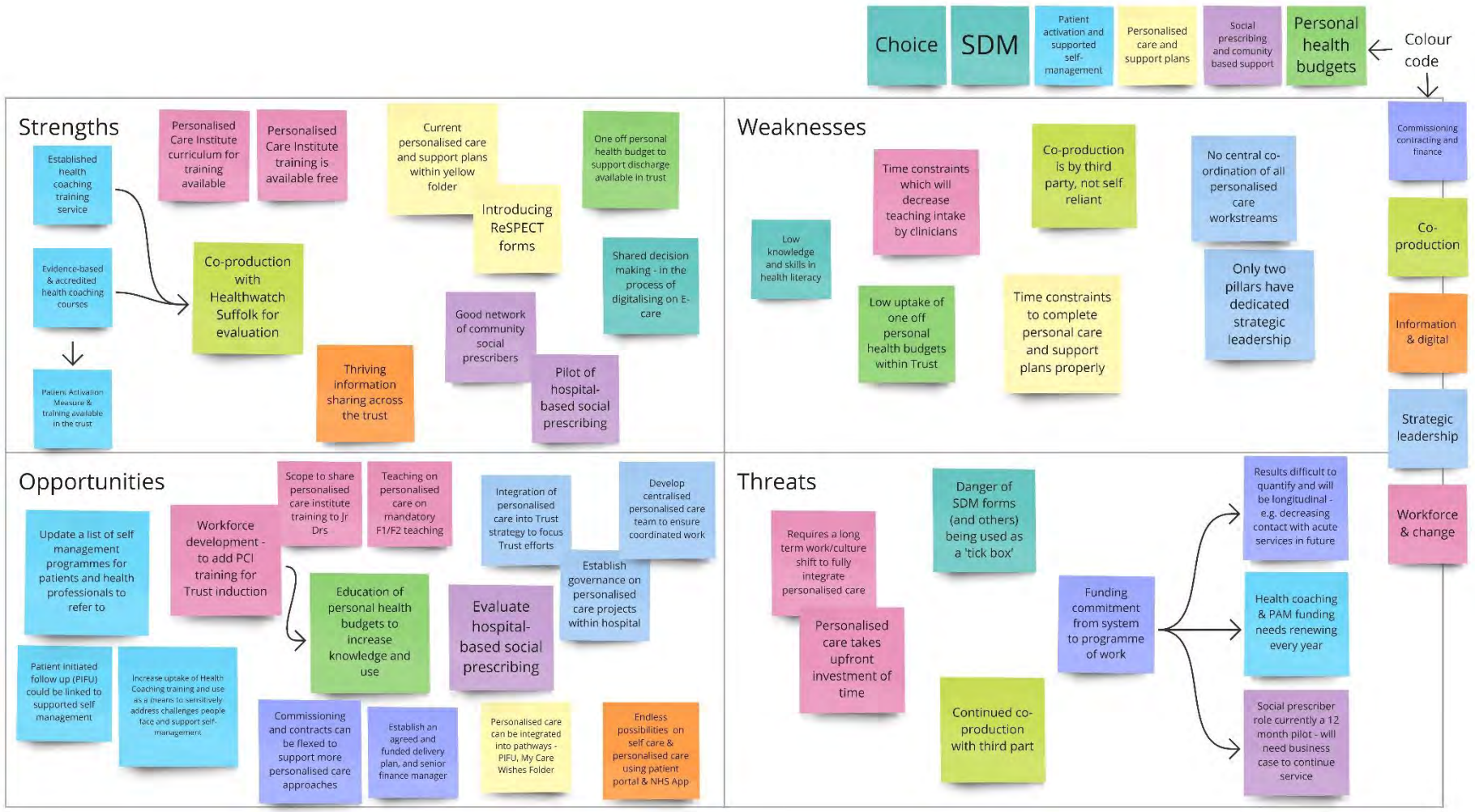
[10] The WSFT health coaching training service delivers accredited training licensed from and quality assured by TPC Health www.tpchealth.com

	Between January and March 2023, across the provision of personal health and integrated budgets, 154 people have been supported.

The SWOT analysis on personalised care is shown in Figure 15.

This highlights that the trust has existing strengths across the pillars of personalised care and therefore opportunities to build on this good work to date. Recognising our weaknesses and any threats in developing co-ordinated implementation of personalised care will allow us to plan and develop our implementation strategy taking these into account.

Figure 15: SWOT analysis on personalised care



The trust's role

The trust has an extensive role to play in the implementation of personalised care across both our acute and community services. We are uniquely placed to lead a personalised approach in all our daily contacts across the west Suffolk population. However, we must recognise that implementation of the personalised care comprehensive model is an enormous process and culture change which will take time and therefore need a phased introduction to ensure the best possible quality and outcomes for patients and staff.

There are some areas of the six pillars of personalised care, where the trust can do more than others. Already well-established programmes of work are underway for pillars two and three of personalised care: shared decision making and patient activation and supported self-management. These both have designated clinical leads identified who are responsible for driving the change needed to crystallise these elements into health and care practice across the trust. Exploratory use of acute personal health budgets to support discharge and social prescribers dedicated to meeting inpatients social needs are successfully underway. Further development of personalised care and support plans for individual wishes is planned throughout 2023.

The trust has a unique role in supporting the delivery of personalised care to our population, based on the comprehensive model. Each pillar of personalised care will need to be incorporated into core practice throughout the trust over the next few years, however, we recognise that this will need to be broken down and implemented gradually over time in a structured and systematic way to ensure alignment with the best outcomes for patients and the workforce alike.

Based on the work that the trust already successfully delivers and developments underway, over the next three years we will focus on:

1. Fully integrated consent and shared decision making in every patient contact by training colleagues in these core skills
2. Continuing to develop and grow the use of health coaching and offer PAM® across the trust in specified pathways of care, in line with the evidence-base
3. Evaluation of the effectiveness, impact, and outcomes of hospital-based social prescribing to support decisions on whether investment here should continue
4. Expanding awareness and use of acute personal health budgets to establish where they have the biggest uptake

In summary

WSFT has been a pioneer in personalised care with its early adoption and ongoing commitment to health coaching. Several other initiatives are also in place and there is a substantial investment being made overall. The initiatives are being pursued in siloes though; there is no coordinated approach to personalised care across the trust. The opportunity lies in systematising the approach and joining-up the good work underway to achieve the greatest possible impact for the population.

Objectives

To achieve our goal to **Make the biggest possible contribution to prevent ill health, increase wellbeing and reduce health inequalities**, we need to convert it into a set of objectives and SMART actions.

Prevention, health inequalities and personalised care are each big and broad topics which will require system-level effort. To make sure the Trust's contribution is effective, the objectives for this strategy have been set on the basis of two principles:

- Firstly, the Trust must do what only it can uniquely do: embed prevention, health inequalities and personalised care into its own services and employment and business practices
- Secondly, the Trust should collaborate with partner organisations where it can add significant value to the impact of collective activities.

Taking into account the national and local priorities, the evidence base and the SWOT analyses for each of the three topics, the prevention, health inequalities and personalised care strategy will pursue 12 objectives.

Prevention

For patients:

P1: We will embed prevention in all clinical and care pathways. This objective is shared with the Clinical and Care Strategy 2023-2031[11].

- We will work with partners to created integrated pathways so patients can get the help they need with tobacco, alcohol, drugs, weight management, physical activity, and sleep
- We will use our data and digital technology to its full potential to make the pathways tailored, easy and efficient to use
- Staff will have the knowledge, skills, confidence and time they need to give lifestyle advice and direct patients to the help that is available

For staff:

P2: We will maintain and improve our healthy workplaces for everyone to enjoy. This objective is shared with the Estates and Facilities Strategy 2023-2028[12], the Workplace Strategy and the Wellbeing Work Plan.

- We will use a compassionate approach to reduce smoking on all our sites
- All staff will have access to healthy food at work
- Staff who are sedentary at work will be able to be more physically active
- Staff who are active at work will be able to get good rest

[11] See Trust open board meeting pack – 21 July 2023, pages 77-104. Available at https://www.wsh.nhs.uk/CMS-Documents/Trust-board/2023/Trust-open-board-meeting-pack-21-July-2023.pdf (Accessed 22 October 2023)
[12] See Trust open board meeting pack – 31 March 2023, pages 201-284. Available at https://www.wsh.nhs.uk/CMS-Documents/Trust-board/2023/Trust-open-board-meeting-pack-31-March-2023.pdf (Accessed 20 July 2023)

- All staff will know where they can get help for themselves and their families with tobacco, alcohol, drugs, weight management, physical activity, and sleep

For the public:

P3: We will use our platform to promote healthy behaviours and the help that is available to our local population. This activity will be done in a coordinated fashion with our partners.

Health inequalities

For patients:

HI1: We will understand our population better, the inequalities they are subject to and the nature of their needs.

HI2: We will use this knowledge to reduce the healthcare inequalities we create by:

- Addressing the Core20PLUS5 priorities, jointly with local partners
- Removing the barriers that make it harder for some people to use our services than others
- Tailoring how care is provided to meet people's different needs better

HI3: We will routinely measure the inequalities in our key access and outcome metrics and demonstrate continuous improvement.

For staff:

HI4: We will perform our role as an anchor institution to the best of our ability, by:

- Being a great employer and widening access to good work, as set out in the People and Culture Plan[13]
- Promoting and celebrating the diversity of our staff and encouraging a sense of belonging, as set out in the Inclusion Work Plan[14]

For the public:

HI5: We will perform our role as an anchor institution to the best of our ability, by:

- Buying more goods and services locally and for social benefit, as set out in the Estates and facilities management strategy[15]
- Reducing our environmental impact, as set out in the Green Plan[16].

Personalised care

For patients:

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[13] See Trust open board meeting pack – 26 May 2023, pages 55-59. Available at https://www.wsh.nhs.uk/CMS-Documents/Trust-board/2023/Trust-open-board-meeting-pack-26-May.pdf (Accessed 20 July 2023)
[14] Available at https://www.wsh.nhs.uk/CMS-Documents/EqualityandDiversity/New-Docs/Inclusion-Strategy-and-Action-Plan.pdf
[15] See Trust open board meeting pack – 31 March 2023, pages 201-284. Available at https://www.wsh.nhs.uk/CMS-Documents/Trust-board/2023/Trust-open-board-meeting-pack-31-March-2023.pdf (Accessed 20 July 2023)
[16] Available at https://www.wsh.nhs.uk/CMS-Documents/Corporate-information/Green-Plan-2021-25-FINAL.pdf

PC1: We will adopt structured and systematic shared decision making across our treatment pathways

PC2: We will implement health coaching skills and offer PAM® in acute and community pathways which are evidence-based

PC3: We will use hospital-based social prescribing and acute personal health budgets to support timely discharge and reduce re-admissions

For staff:

PC4: Staff will be able to access accredited training across the spectrum of personalised care

Action plan 2023-25

The first actions that we will take are listed in the table below, numbered with reference back to the objectives they apply to. Actions which are followed by an amber **(A)** are actions which will rely on collaboration with Alliance partners. Actions which are followed by a green **(A)** mean the resources created will be shared with Alliance partners. Actions which are followed by a blue **(B)** have been adopted as Trust Board strategic objectives in 2023/24.

Number	Action
P1.1	Continue and expand the inpatient tobacco dependence service, supporting 350 people to stop smoking by March 2024, 40% of whom will live in the most deprived areas. **(B)**
P1.2	Participate in the design and delivery of the new Suffolk healthy behaviours service, led by the district, borough and county councils. The new service will go live on 01 October 2023. **(A)**
P1.3	Maintain the existing exercise referral pathways in 2023/24 and work with Abbeycroft Leisure to achieve the best impact for patients. Align them with the new health behaviours service from April 2024 onwards. **(A)**
P2.1	Revise the smokefree site policy, using co-production and human factors to devise a compassionate approach that will reduce smoking on the West Suffolk Hospital site. Demonstrate a measurable reduction in smoking on site by September 2024.
P3.1	Undertake 2 public health campaigns each year, one of which will always be a stop smoking campaign.
HI1.1	Improve the coverage and accuracy of the recording of protected characteristics in the electronic patient record: • Increase the accuracy of ethnicity data by 50% compared to Census 2021 data for people living in the West Suffolk Alliance and Breckland catchment geographies by March 2025 • Double the number of people identified as having a learning disability by April 2024
HI1.2	Conduct research and generate knowledge about health inequalities and healthcare inequalities in the WSFT catchment population. Publish the research in formats that can be understood by the trust board, all staff and all members of the community by April 2024. **(A)**
HI2.1	Using the knowledge created, collaborate with our West Suffolk Alliance partners to define the actions that WSFT will take to address the Core20PLUS5 clinical priority areas, for both adults and children & young people, by June 2024. **(A)**

PC1.1	Begin phased implementation of shared decision making in day surgery in August 2023.
PC2.1	Introduce health coaching techniques and patient activation into 4 specialist areas by March 2025.
PC3.1	Evaluate the effectiveness, impact and outcomes of hospital-based social prescribing and personal health budgets by December 2025.
Overarching.1	Expand and promote the WSFT PHIPC training curriculum, curating national and local resources so all members of staff can gain the knowledge and skills they need in order to take action on prevention, health inequalities or personalised care **(A)** • Train 1000 colleagues in prevention, health inequalities or personalised care each year **(B)** • Offer 304 training places across health coaching and patient activation for staff employed by WSFT and colleagues working in a West Suffolk integrated neighbourhood team or a VCFSE partner[17] • Offer a PHIPC fellowship for 10 fellows in 2024/25 to learn more advanced skills and apply them in their service or department
Overarching.2	Apply the PHIPC approach holistically in at least one clinical or care service each year to improve outcomes and generate learning. In 2023/24 the public health team will work with the maternity service to: • Offer expectant people and their households a smoke-free pregnancy pathway including focused sessions and treatments • Regain UNICEF Baby Friendly Stage 2 accreditation and improve families' experience and outcomes with infant feeding • Understand and start to tackle the local pattern of health inequalities in maternal and neonatal outcomes

[17] VCFSE: voluntary, community, faith and social enterprise sector

How the prevention, health inequalities and personalised care strategy will be monitored

The prevention, health inequalities and personalised care strategy acts a sub-strategy to the trust's overall strategy First for our patients, staff and the future.

The senior responsible officer for the prevention, health inequalities and personalised care strategy is the medical director.

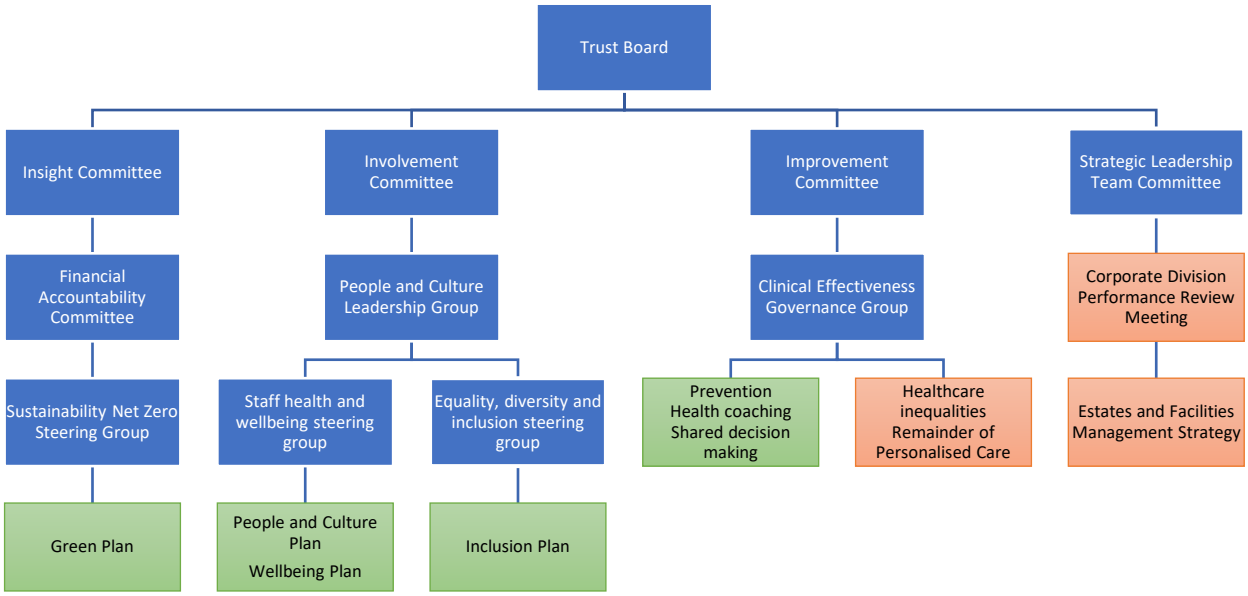
The current governance arrangements for prevention, health inequalities and personalised care are fragmented (Figure 16), however all parts of it work well for their purpose. There are three gaps currently but solutions have been identified for each:

1. There is a significant gap in that there is no existing governance for healthcare inequalities. Healthcare inequalities have a natural fit with clinical effectiveness so the Clinical Effectiveness Governance Group will extend its role to include it.

2. The Clinical Effectiveness Governance Group also provides assurance for two of the pillars of personalised care (health coaching and shared decision making) but not the other four. The governance of all six pillars will be combined and brought under CCEG's remit.

3. The Estates and Facilities Management Strategy does not have a route to board-level oversight at the moment. This will be achieved by extending the performance review approach which is used for the clinical divisions to cover the corporate division too.

Figure 16: Existing service-to-board governance of prevention, health inequalities and personalised care. Orange boxes indicate new governance which will be created. Green boxes indicate existing governance.



Each workstream is also connected into the West Suffolk Alliance Live Well framework and/or SNEE ICS governance structure, creating integrated governance with our partners and encouraging joint working.

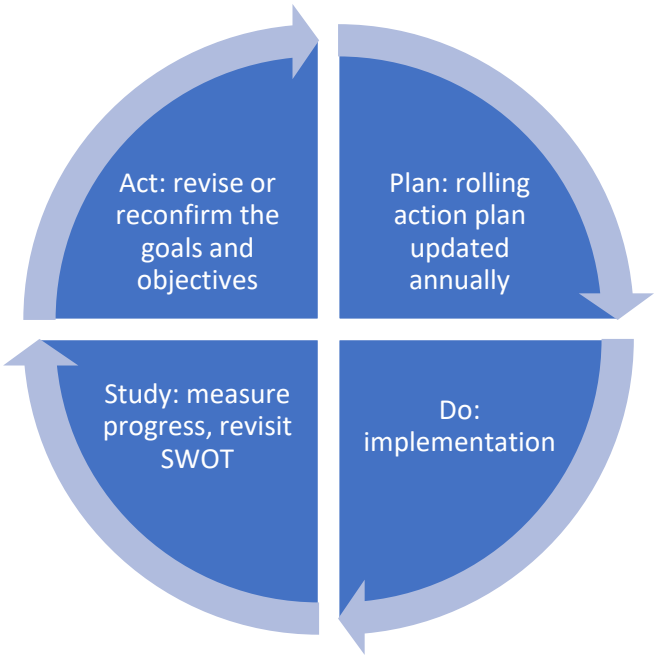
How progress will be measured

As one of the First for the Future goals, how well we **Make the biggest possible contribution to prevent ill health, increase wellbeing and reduce inequalities** will be assessed annually by our partners (please refer to page 25 of the trust strategy).

A set of outcomes and indicators have been defined which will allow our partners to make a meaningful assessment of our progress against the strategy without creating a large additional reporting burden (Appendix 2).

We will use the principles of continuous improvement to celebrate achievements, adapt to things that change and keep our ambition high (Figure 17). The objectives and the action plan will be reviewed each year, following the annual assessment, and new indicators will be added as required. The first review will be conducted in quarter 3 of 2024/25, with the action plan updated by 01 February 2025.

Figure 17: A continuous improvement approach to the prevention, health inequalities and personalised care strategy


Act: revise or reconfirm the goals and objectives
Plan: rolling action plan updated annually
Study: measure progress, revisit SWOT
Do: implementation

Appendix 1

National health inequalities improvement programme objectives of relevance to NHS trusts

Priority 1: Restoring NHS services inclusively
1.1 Systems use waiting list data to identify inequalities and ensure performance reports are broken down by patient ethnicity and IMD quintile, focusing on unwarranted variation in referral rates and waiting lists for assessment diagnostic and treatment pathways, immunisation, screening and late cancer presentations. 1.2 Systems develop and publish equality and health inequalities impact assessments (EHIAs) for elective recovery plans. 1.3 Systems' elective recovery plans give regard to the 8 elective recovery principles in fulfilment of the health inequalities criteria. 1.4 Systems use recovery data to identify inequalities and put SMART action plans in place to address identified inequalities. 1.5 Systems prioritise service delivery by taking account of the bottom 20% by IMD and Black and minority ethnic populations for patients on and not on the waiting list, including through proactive case finding. 1.6 Systems evaluate the impact of elective recovery plans on addressing pre-pandemic and pandemic-related disparities in waiting lists, including for clinically prioritised cohorts.
Priority 2: Mitigating against digital exclusion
2.1 Systems ensure that providers offer face-to-face care to patients who cannot use remote services. 2.2 Systems ensure that more complete data collection is carried out, to identify who is accessing face-to-face, telephone or video consultations, broken down by relevant protected characteristics and health inclusion groups. 2.3 Systems ensure that they take account of their assessment of the impact of digital consultation channels on patient access.
Priority 3: Ensuring datasets are complete and timely
3.1 Systems continue to improve collection and recording of ethnicity data, across primary care, outpatients, A&E, mental health, community services, and specialised commissioning.
Priority 4: Accelerating preventative programmes (including Core20PLUS5 approach)
4.1.1 Systems have clear plans for implementation of the Core20PLUS5 approach and accountability is assured through board performance reporting. 4.2.1 Systems have identified the most deprived 20% of the national population within their area. 4.2.2 Systems use this information when planning health services and interventions designed to reduce health inequalities.

4.3.1 Systems use local data, including that provided by the local joint strategic needs assessment, to identify their 'PLUS' populations.

4.3.2 Systems use this information when planning health services and interventions designed to reduce healthcare inequalities.

4.4.1 Systems ensure continuity of care for women from ethnic minority communities and from the most deprived groups in keeping with the NHSE LTP goal, taking into account the Building Blocks as communicated by the Maternity Transformation programme.

4.4.2 Systems have appropriate staffing levels to safely implement continuity of care for women from ethnic minority communities and from the most deprived groups.

4.6.1 Systems monitor uptake of covid, flu and pneumonia vaccine uptake rates in people with COPD, including those from ethnic minority, deprived and locally identified 'PLUS' groups.

4.6.2 Systems have plans in place to improve uptake of Covid, flu and pneumonia vaccines in people with COPD, particularly in the most deprived and locally identified 'PLUS' groups.

4.7.1 Systems have plans in place to improve early cancer diagnosis rates, particularly in the most deprived and the locally identified 'PLUS' groups.

4.8.1 Systems have plans in place to improve (i) hypertension case finding and optimal management, and (ii) lipid optimal management, particularly in the most deprived and locally identified 'PLUS' groups.

4.9.1 Systems have plans in place to improve smoking cessation rates, particularly in the most deprived and locally identified 'PLUS' groups.

4.10.1 Systems take a culturally competent approach to increasing covid and flu vaccination uptake in groups that have a lower uptake than the overall average (as at March 2021).

Priority 5: Strengthening leadership and accountability

Systems and providers have a named executive board-level lead for tackling health inequalities.

Systems and providers access training and the wider support offer.

The system SRO for health inequalities works with the board and partner organisations to use local population data to (a) identify the needs of communities experiencing inequalities in access, experience and outcomes (b) ensure that performance reporting allows monitoring of progress in addressing these inequalities.

Health inequalities improvement dashboard (HIID) and use of data

The system is using data and analytics to redesign care pathways and measure outcomes with a focus on improving access and health equity for underserved communities.

The system uses the HIID, and other tools where appropriate, to drive insights and interventions aimed at reducing inequalities.

Appendix 2

Specific measures for 2023-25 action plan

Number	Action	Measure	Source
P1.1	Continue and expand the inpatient tobacco dependence service, supporting 350 people to stop smoking by March 2024, 40% of whom will live in the most deprived areas. **(B)**	Number of people supported to stop smoking Percentage who live in the 40% most deprived lower super output areas Number of people who successfully quit for 4 weeks Percentage who live in the 40% most deprived lower super output areas	Tobacco dependence service
P1.2	Participate in the design and delivery of the new Suffolk healthy behaviours service, led by the district, borough and county councils. The new service will go live on 01 October 2023. **(A)**	Hours of specialist expertise contributed to the design process	Public health team
P1.3	Maintain the existing exercise referral pathways in 2023/24 and work with Abbeycroft Leisure to achieve the best impact for patients. Align them with the new health behaviours service from April 2024 onwards. **(A)**	Number of referrals into the integrated health and leisure pathways Number of successful completers Percentage who live in the 40% most deprived lower super output areas	Abbeycroft Leisure
P2.1	Revise the smokefree site policy, using co-production and human factors to devise a compassionate approach that will reduce smoking on the West Suffolk Hospital site. Demonstrate a measurable reduction in smoking on site by September 2024.	*Placeholder: Number of people smoking on the West Suffolk Hospital site (monthly spot audits)*	*To be developed*
P3.1	Undertake 2 public health campaigns each year, one of which will always be a stop smoking campaign.	Appropriate measures of campaign reach e.g. website hits, newsletter readership, social media impressions	Determined by campaign design

HI1.1	Improve the coverage and accuracy of the recording of protected characteristics in the electronic patient record: • Increase the accuracy of ethnicity data by 50% compared to Census 2021 data for people living in the West Suffolk Alliance and Breckland catchment geographies by March 2025 • Double the number of people identified as having a learning disability by April 2024	Accuracy of ethnicity data compared to Census 2021 data Number of people identified as having a learning disability For both measures, the denominator is the eCare record for the West Suffolk Alliance and Breckland registered populations	Information service (Protected characteristics report)
HI1.2	Conduct research and generate knowledge about health inequalities and healthcare inequalities in the WSFT catchment population. Publish the research in formats that can be understood by the trust board, all staff and all members of the community by April 2024. **(A)**	*Placeholder: Measure of understanding amongst the target audiences*	*To be developed*
HI2.1	Using the knowledge created, collaborate with our West Suffolk Alliance partners to define the actions that WSFT will take to address the Core20PLUS5 clinical priority areas, for both adults and children & young people, by June 2024. **(A)**	*Placeholder: Core20PLUS5 indicators*	*In development*
PC1.1	Begin phased implementation of shared decision making in day surgery in August 2023.	*Placeholder: Proportion of people admitted to the day surgery unit who have a recorded shared decision in Concentric*	*To be developed*
PC2.1	Introduce health coaching techniques and patient activation into 4 specialist areas by March 2025.	Number of new services using health coaching and patient activation in their care pathways	Health coaching team
PC3.1	Evaluate the effectiveness, impact and outcomes of hospital-based social prescribing and personal health budgets by December 2025.	*Placeholder: Appropriate measures will be identified*	*To be developed*

Overarching.1	Expand and promote the WSFT PHIPC training curriculum, curating national and local resources so all members of staff can gain the knowledge and skills they need in order to take action on prevention, health inequalities or personalised care **(A)** • Train 1000 colleagues in prevention, health inequalities or personalised care each year **(B)** • Offer 304 training places across health coaching and patient activation for staff employed by WSFT and colleagues working in a West Suffolk integrated neighbourhood team or a VCFSE partner[18] • Offer a PHIPC fellowship for 10 fellows in 2024/25 to learn more advanced skills and apply them in their service or department	Number of colleagues who have undertaken a training activity listed on the prevention, health inequalities and personalised care training curriculum	Public health team (collated from several sources)
		Number of training places offered in health coaching and patient activation Number of training places taken up Proportion of training places taken up by INTs and VCSFE organisations	Health coaching team
		Fellows' evaluation of the PHIPC fellowship scheme	Public health team
Overarching.2	Apply the PHIPC approach holistically in at least one clinical or care service each year to improve outcomes and generate learning. In 2023/24 the	Proportion of women who were smoking at the time of booking, who are smokefree at the time of delivery	Maternity team

[18] VCFSE: voluntary, community, faith and social enterprise sector

	public health team will work with the maternity service to: • Offer expectant people and their households a smoke-free pregnancy pathway including focused sessions and treatments • Regain UNICEF Baby Friendly Stage 2 accreditation and improve families' experience and outcomes with infant feeding • Understand and start to tackle the local pattern of health inequalities in maternal and neonatal outcomes	Percentage of babies whose first feed is breastmilk Percentage of babies receiving any breastmilk at time of discharge	Infant feeding team (via LifeQI)
		Placeholder: Measures of inequality in maternal and neonatal outcomes	*To be developed*

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2.2. Future System board report

To Assure

Presented by Craig Black

BOARD OF DIRECTORS	
Report title:	Future System Board Report
Agenda item:	2.2
Date of the meeting:	1st December 2023
Sponsor/executive lead:	Craig Black
Report prepared by:	Gary Norgate

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

Executive Summary

WHAT?
Summary of issue, including evaluation of the validity the data/information

This report provides an update on the Trust's plans to build a new hospital under the terms of the national New Hospital Programme.

SO WHAT?
Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk

This is a critical project as it directly addresses the risks associated with the Trusts RAAC infrastructure and provides the basis for the continuity of care and the ability of the Trust to keep pace with the needs of the community that it serves.

WHAT NEXT?
Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)

The next steps for the project are the production of an agreed definition of the size and scope of the new hospital and, therefore, the required budget and its ongoing impact on the operational cost of both the Trust and the Integrated Care System (ICS). This definition will them form the basis for the creation of an outline business case, securing full planning permission and the appointment of a build partner.

Action Required

The Board are asked to note the content of this report.

Risk and assurance:	
Equality, Diversity and Inclusion:	

Sustainability:	
Legal and regulatory context	

Future System Board Report

1.	**Introduction**
1.1	The last report to the Board stated that we aimed to have made significant progress towards achieving the following milestones in time for this meeting: • Secured sign-off of our SOC • secured the commercial agreement with our ecology partner, • finalised our schedule of accommodation and • aligned our view of scale and scope with that of NHP. The following paper provides an update on each of these areas.
2.	**Background**
2.1	As reported previously, West Suffolk Foundation Trust's plans to build a new hospital are part of the wider Governmental programme that aims to build "40 new hospitals by 2030".
2.2	More recent developments have seen the announcement that seven new schemes, predominantly those hospitals constructed from reinforced aerated autoclaved concrete (RAAC), have been included in the New Hospital Programme (NHP) and will be 'prioritised' to ensure they are completed in the most efficient way.
2.3	This announcement has caused some of the other, more complex, schemes (e.g. those representing significant service re-configuration and therefore requiring extensive public consultation) to slip beyond the previously announced 2030 deadline.
2.4	The West Suffolk scheme is one such priority and as one of the most advanced of the RAAC projects continues to be singled out as a 'pathfinder'. Consequently, WSFT are the only Trust to; have had its strategic case (SOC) formally considered; to have received funding for the development of its outline business case (the second of three mandatory cases) and to have received funding for those enabling works that support the pursuit of full planning permission and the ability to commence construction.
3.	**Detailed sections and key issues**
3.1	The West Suffolk Strategic Outline Case (SOC) has been formally heard by the New Hospital Programme (NHP) Investment Committee and passed to the Joint Investment Committee (JIC[1]) for ratification. The case for building a new hospital was widely supported, however, questions were raised with regards the affordability of the scheme in its current form. This is far from uncommon as, at this early strategic stage, cases lack detailed designs and have yet to undergo challenge and rationalisation. With this in mind, WSFT have been asked to work collaboratively with NHP, NHSE and its system partners to revisit designs and return with an agreed view on the size and scope of the new hospital
3.2	This step has always been part of our project plan and the following provides an update on progress: a. A senior-level, multi-disciplinary self-review, was completed on Friday 15th September and has resulted in the co-production of several options that refine our outline designs (a summary of the output is attached at appendix 1). b. NHP, through their partners Midlands and Lancs Commissioning Support Unit (MLCSU), have facilitated a thorough review of our demand assumptions. This work has lead us to conclude that our self-generated projections sit comfortably within the range of potential demand outcomes that the MLCSU model predicts.

[1] The Joint Investment Committee is Chaired by the Finance Directors of both NHS and Department of Health and is an advisor to HM Treasury on business cases for major capital projects.

	Given that future demand is the single most significant determinant for the future size of a hospital, this outcome provides strong assurance that our proposed design is sound. This work has allowed the production of an interim version of our schedule of accommodation (Version 12) which will be refined as we work through the other reviews (below). c. NHP transformation team have concluded a thorough review of our clinical design and layout and have supplied a detailed report highlighting opportunities to optimise space using nationally derived standards and H2.0.[2] The future system team are now methodically working through these recommendations and applying them, where applicable, to our outline designs. d. NHP's technical partners; MACE, Mott McDonald and Arcadis have now concluded their detailed review of our structural design, highlighting several opportunities to improve the "buildability" of our new hospital. Resultant recommendations will be worked through in two workshops planned for week commencing 27th November. **e.** The East of England Regional Team have commissioned a study into how to maximise the investment that the Region is receiving from the NHP programme. This work is drawing towards its conclusion and will seek to optimise the NHP investment. We do not expect the outcomes of this report to have material impact upon the plans of the Future System Team. **f.** Further to the work of our system wide programme board, a more focussed panel of stakeholders from our commissioners and neighbouring hospital trust has been established to specifically review and understand the impact that the building of a new hospital will have upon operating costs of both the Trust and the ICS. The first meeting of this panel focussed on agreeing the WSFT clinical model and subsequent meetings will seek to maximise opportunities for provider collaboration. This provider collaboration work is not exclusively related to the building of a new hospital and some options will not be deliverable within the time frame of our project, however, the new hospital is seen as a significant enabler for such discussions and as such will remain involved to ensure any eventual hospital design remains aligned and supportive of both immediate and future opportunities.
3.3	These reviews have been concluded in line with our plans and we are aiming to apply the recommendations to our designs by the end of December. In so doing we aim to have an agreed view of the optimum size, scope and cost of a new West Suffolk Hospital. Once agreed the resultant design parameters and schedule of accommodation will be used as the basis for the creation of an Outline Business Case[3], the launch of a procurement process to select our construction partner and the completion of the detailed designs required to support an application for full planning permission.
3.4	In parallel to the development of business cases. The West Suffolk Team have been working hard to progress the fulfilment of those conditions placed upon its scheme at the time it secured outline planning permission. The most significant of these "pre-commencement" conditions concerns the creation of a new and lasting habitat that will compensate our community for the inevitable disruption to Hardwick Manor caused by the construction of a new hospital.
3.5	Further to last month's report that we had secured a commercial lease for the compensatory habitat and the planning permission for its creation, I am pleased to say that the translocation of turf from Hardwick Manor to the new site is now largely complete and that there are signs that this work is "bearing fruit" (literally, as examples of healthy wax cap and other species of fungi are becoming evident on the new site). Residents continue to be engaged throughout the translocation process.
4.	**Next steps**
4.1	Outcomes of the five listed reviews will be assessed and applied to our strategic design with a view to agreeing the size, scope and cost of the hospital that our outline business case will seek authority to commence. The OBC is expected to be completed in Spring 2024, a full planning application is expected in Spring 2025 with construction commencing sometime after these two milestones have been met.

[2] H2.0 = Hospital 2.0 a set of standard designs, layouts and adjacencies that will maximise the efficiency of providing 40 new hospitals.

[3] The Outline Business Case is the second of three business cases that are mandated under the Government's process for the development of major capital projects. The OBC focusses on refining the designs that emerge from the strategic case and culminates with a an agreed option that can be used to appoint a construction partner.

4.2	Upon agreement of the size, scope and cost of the new hospital, the project team will commence market engagement with a view to identifying and, eventually, appointing a construction partner with whom the next level of detailed designs will be produced.
5.	**Conclusion**
5.1	The building of a new West Suffolk Hospital remains a priority within the New Hospital Programme.
5.2	The strategic case for the new hospital is now widely agreed and work is underway to optimise and agree the designs that will form the basis of an Outline Business Case.
5.3	Work to satisfy our pre-commencement planning conditions is physically underway.
5.4	The status of the project to build a new West Suffolk project remains Green
6.	**Recommendations**
	The Board are asked to note the content of this report.

Appendix 1 – Summary outcomes from Self Review

As described in the paper above the internal review of potential savings has been conducted simultaneously with four external reviews:

1. A regional review conducted by NHSE, looking for opportunities for collaboration and economies of scale between the 7 New Hospital Programme (NHP) sites in the East of England[1]
2. A demand and capacity review conducted by Midlands and Lancs Commissioning Support Unit (MLCSU)
3. A clinical design review conducted by the clinical team at the NHP
4. A technical review conducted by the architectural and engineering team at the NHP

The results of all 4 were expected within the same timescale as the internal review and our hope was to be able to synthesise them and present them as a whole, so their effects could be considered in the round. That hasn't proven possible as some reviews have taken longer than anticipated. Numbers 1 & 2 have generated interim results and the conclusions of numbers 3 & 4 were received in a combined document on 13th November 2023. In order to do them all justice, the completion of a final schedule of accommodation has been scheduled for the end December.

Overall, the outcomes of the internal review can be described as follows:

- It has helped us achieve modest (in relation to the overall space) savings in space throughout the scheme, which will convert into capital and revenue financial savings
- It has provided a huge bank of professional opinion and evidence against which to assess the guidance we have now received in the NHP reviews
- It has demonstrated good practice by conducting a transparent, comprehensive and inclusive review of our intended use of public funds in the NHP investment.

Method

Pre-away day

Options were collated in August 2023 from a number of different sources:

- Associate Medical Director review of the demand and capacity model and schedule of accommodation, reviving previous ideas and challenges that had been excluded through co-production
- Hospital 2.0 recommendations which had been received from the national New Hospital Programme (NHP) team
- Opportunities to stretch the principles of the workplace strategy, including benchmarking against early Hospital 2.0 standards on office space
- Early critique from the NHP clinical team on our models of care and spatial designs
- Potential derogations from the Health Building Note standards, devised by our architects
- The possibility of building some capacity to 'shell and core', suggested by the estates team i.e. building the walls, ceilings, corridors, lifts and staircases for space that would be required in the future but fitting it out at a later date. NB this lever wouldn't reduce space but it would reduce the upfront construction costs; fit out costs would be met later from trust capital funding when the capacity needed to come into use.

Each lever was rated as being Red, Amber or Green (RAG), upfront, by the Associate Medical Director and then put through a multidisciplinary risk-assessment by the Future System Project (FSP) team. Each lever was assessed through the lens of quality and safety, operations, strategic fit and equity, finance, commercial/legal, digital, communications and engagement, estates, and workforce. Where necessary subject matter experts kindly helped.

At this stage the RAG ratings were reviewed and revised by two independent members of the FSP team. Each lever was then assessed for size impact, cost impact and workforce impact by

our healthcare planners Adcuris, our quantity surveyors Castons and our workforce consultants Carados respectively.

The RAG ratings were reviewed again. At this point 15 levers were excluded because it turned out they had no potential to make a difference to the size of the build. Adcuris provided a final objective view on any potential consequences that we had not already identified and, as a last step, any levers that would require accommodation off-site which is not already funded / in existence were excluded. This was a pragmatic approach because we would need to define where the alternative accommodation would be (a long process) and we had established through the Western Way business case that alternative new build accommodation was unlikely to come in cheaper.
The remaining levers were written up into a pre-reading pack, themed under 8 headings:

- Diagnostics and clinical support
- Endoscopy
- Office space
- Outpatients
- Surgery and anaesthetics
- Urgent care
- Women's and children's services
- Other

Away day
Thirty members of Senior Leadership Team (SLT) (or deputies) attended the away day on 15th September. The alliance director fed in comments in advance and the levers which would require provider collaboration with ESNEFT were tested with ESNEFT's director of strategy and transformation by the chief operating officer. The away day was held off-site, facilitated by Adcuris, and discussion tables were facilitated by members of the FSP team, the medical director and the chief operating officer.
SLT members roved between topic tables and contributed professional opinion and evidence on the "doability" and palatability of each lever under the following framework:

1. Can't: things that aren't possible (in many cases only the people who work directly within a service can know this)
2. Won't: things which are incompatible with our trust values
3. Don't want to but should do: self-explanatory
4. Should do: ditto

This unusual framework was devised to allow SLT members to express their views clearly and openly, recognising the human factors at play in making these sorts of decisions and the importance of the trust values for effective and committed leadership.

The day was long and intense but feedback from many participants was good. Input was gathered after the day from the head of midwifery and clinical director for women's and children's services, as neither could attend on the day and their expertise was critical for the women's and children's topic.

Post-away day
The scoring framework provided a large quantity of qualitative data which was analysed and summarised either by the topic facilitators or by the AMD. Overall, 44 levers emerged as either definitely doable or possible but requiring more work-up. Levers which were excluded either before or after the away day included:

- Remove surge capacity in critical care model (risk to patient safety too high)
- Adopt 90% occupancy for critical care beds (risk to patient safety too high)
- Double number of virtual beds (Unlikely to be achievable - we are already including an optimistic forecast)

Levers which were included and have gone forward into the next stage have three strong themes:

- Office space – optimisation of space usage and the adaption of workplace strategies to suit.
- Potential to make more use of Newmarket Hospital
- Outpatients (e.g. adaptations to our ambitions for how we make more use of remote consultations and community settings).
-

Along with:

- a handful that could be taken forward straight away, e.g. combining the separate therapies room and treatment room which were planned for each inpatient ward
- a handful that we needed to wait for the outcome of the NHP reviews
- a handful that needed more staff engagement with the help of the architects and our human factors specialist, e.g. reducing the number of facilities management hubs by improving the flows of supplies and waste around and between the buildings
- a handful that needed some further information gathering, e.g. the potential for the regional radiology network to reduce space further than the efficiencies we had already assumed.

What happens next

- Conclude reviews of demand and capacity modelling
- Conclude East of England Review
- Conclude NHP Review
- Consider all options and levers in the round and reflect all agreed changes into a 'final' schedule of accommodation upon which business cases and designs will be based.
- Embed any changes into working practice so that the designed accommodation effectively supports the resultant operational model.

2.3. West Suffolk Alliance and SNEE Integrated Care Board

Gail Cardy & Jason Joseph in attendance

To Assure

Presented by Peter Wightman

West Suffolk Alliance Director Update 20 November 2023

Headlines from Committee Meetings held 10 October and 14 November 2023

1. Health Inequalities

At the Alliance Committee on 10 October, Public Health and Communities presented to members on the ICB HPIC fund and the west Suffolk inequalities agenda. Non-recurrent funding of £527,754 over 2 years has been identified to reduce health inequalities in west Suffolk. The priorities for use of this funding are:

- **Maternal health & children:** Improving health equity across the perinatal continuum (to be defined) and/or tackling variation in emergency asthma admission amongst children (25%).
- **Supporting people with COPD** to stay well including optimising management of COPD, increasing vaccine uptake (flu, pneumococcal and covid) and supporting people to be smoke free.
- **Supporting people with high blood pressure (hypertension) and Atrial Fibrillation (AF)** to optimise their health outcomes and proactively identify those a risk of a cardiac event (undiagnosed hypertension).
- **Work with cancer programmes** to support targeted work on screening and early diagnosis.

The Committee requested that alliance partners set up a project as soon as possible in the most deprived ward in west Suffolk – Howard Estate Bury – to learning through action, before progressing to other populations (see appendix). An implementation group has been set up working across local professionals and community leaders. Initial focus will be on case finding and maximising assets with fast mobilisation. Our aim is that the first extra health checks will take place in January 2024 with the next area identified and rolled out by April 2024. The Committee has asked for clarity on the key data to be used to track successful impact.

2. WSH Ride (Haverhill)

The service is a “dial-a-ride” style bus service transporting patients and staff from Haverhill and surrounding villages to WSFT. In the first 12 months of operation (pilot) the bus undertook 956 single journeys. From June 2022 – May 2023, the bus undertook 2160 single journeys (over 200% increase in journeys). The service allows people living along the A143 corridor, south of Bury, to request pick up from their local bus stop and has been provided by The Voluntary Network (Suffolk County Council’s Connecting Communities operator in west Suffolk).

WSFT and SNEE ICB have commissioned the service since 2019 following a pilot by Suffolk County Council. SNEE ICB and WSFT funds end March 2024. Haverhill residents identify transport as their top priority. The ICB alliance team and Suffolk County Council are conducting a holistic review of transport services, working and stakeholders from Haverhill locality to establish the best way forward.

The review is considering the following:

- The relative deprivation across Haverhill
- Local transport links from Haverhill to WSFT have been an issue for many years.
- For people who do not own or have access to their own transport, bus journeys to WSFT are difficult and taxi’s cost around £80 return.
- Mitigating travel options that might be able to be put in place.

Next report will be presented at Alliance Committee in January 2024.

3. Social Prescribing

The current service includes:

a) **Circa. 16 PCN based social prescribers** directly employed by PCNs on permanent contracts under the Additional Role Reimbursement Scheme (ARRS). NHS England has confirmed that PCNs can assume this funding will continue from March 2024.
b) **6 LifeLink social prescribing** in operation since 2017, currently hosted by the ICB aligned to the Integrated Neighbourhood Teams (INTs). Jointly funded by West Suffolk Council, the ICB and PCNs but funding ceases in March 2024. Each social prescriber has an average caseload of approximately 195 people per annum (c.1,170 people per annum).
c) **One social prescriber within the acute trust** funded non-recurrently from the NHSE personalised care fund to March 2024. Supports c.400 people per annum.

This follows the core principles of personalised care, focusing on tailored steps to improve wellbeing and connects people to the most appropriate VCSFE or statutory resource in their community.

This model as evolved over the last 2 years. The conclusions are:

- There is benefit of a network of social prescribers across the 3 settings;
- The largest reason for referral is social isolation;
- There are benefits to flow and hospital discharge;
- This is a key resource for prevention and reducing health inequalities.

The Alliance Committee agreed to support the model in principle and to explore multi-agency routes for the funding, recognising the urgency. It was recommended that the Be Well domain works with statutory partners to discuss any possibilities of financial support for this model from across the system.

4. Health Coaching

Health coaching is a specific approach used by WSFT health and care professionals to support people to take more control of their own heath and wellbeing. Healthwatch Suffolk provided the Committee with an evaluation of qualitative evidence supporting the continuation of the service and made recommendations for its future development. The Committee:

- Noted other health coaching models in place (Making Every Contact Count and Signs of Safety) and their different contributions.
- Recommended exploring introducing the health coaching model to care providers, as this is likely the most appropriate.

5. Other points of note

- **Safeguarding:**
  Priorities for 2023/24 identified as domestic abuse, Liberty Protection Safeguards, Mental Capacity Act, Looked After Children, learning from case reviews, serious violence duty.

- **Public Involvement:**
  The ICB and wider health partners have a set of legal duties to engage and consult with people and communities with new statutory guidance introduced in 2022, which are regulatory and coupled with assessment frameworks to review both at organisation and system level.

- **Quarterly Highlight Reports – Finance, Primary Care and Medicines Optimisation:**
  The ICB (west Suffolk) year to date position at M06 is £0.3m overspent with a forecast annual overspend of £2.8m. This is primarily caused by spend above budget for primary care medicines (7.6% at month 5). This follows a national trend and the Alliance medicines optimisation team is working with practices to support medicines optimisation. A research project has been launched to review the benefit of practices with higher spending on medicines with regards to patient outcomes and spending in secondar care.

PCNs were asked to produce a Capacity and Access Improvement plan in 3 key areas: patient experience of contact, ease of access and demand management, and accuracy of recording in appointment books. These plans have been approved by the Alliance team to enable PCNs to access funds to deliver improvement. PCN GP Practices have seen improvement in patient experience including ease of access/overall patient experience.

- **Air Quality:**
  The Committee received an update from Public Health and the ICB's Sustainability Lead on air quality and its impact on health in Suffolk. There is no safe level of air pollution, as evidence shows it can lead to numerous health complications including asthma, coronary heart disease, diabetes and stroke. In west Suffolk there are 3 areas where air pollution is high, which aligns with high traffic areas. The report asks organisations to encourage active or sustainable travel and other preventative measures, such as encouraging a digital first approach or hybrid working (where possible).

APPENDIX – FOCUS ON TACKLING HEALTH INEQUALITIES IN WEST SUFFOLK

West Suffolk data at integrated neighbourhood team level

The data below shows performance against the priority health indicators identified by the ICB Health Inequalities and Prevention Committee at an alliance and neighbourhood team level.

	Bury Rural	Bury Town	Haverhill	Mildenhall & Brandon	Newmarket	Sudbury	Alliance Total
Population (GP registrations for West Suffolk Alliance residents, as per PHM Reporting Suite)	41,231	52,633	38,012	24,611	19,288	42,298	218,073
Average Age	45	44	41	41	42	45	43
Average Index of Multiple Deprivation Decile	7.2	6.9	5.6	5.6	6.2	5.9	6.3
% Ethnic Minority (if recorded)	3%	6%	6%	5%	10%	3%	5%
Multimorbidity (avg no. of acute & chronic conditions)	1.1	1.1	1.0	1.0	0.8	1.2	1.1
Asthma							
Asthma prevalence (under 19s)	11.6%	11.0%	7.9%	9.8%	7.7%	10.7%	10.0%
Asthma admissions (rate per 100,000; children under 19 yrs)	144.5	119.1	114.7	96.8	*	118.0	109.2
COPD							
COPD prevalence	2.7%	2.8%	2.6%	3.0%	2.4%	3.0%	2.8%
Individuals with COPD who have smoked in the last year	22.9%	28.5%	29.7%	38.1%	35.1%	24.9%	28.6%
COPD Admissions (rate per 100,000; all ages)	102.1	140.6	169.8	152.6	117.3	192.2	146.5
Hypertension and Atrial Fibrillation							
Hypertension prevalence (16+ yrs)	22.2%	21.0%	19.6%	19.3%	15.3%	21.7%	20.5%
Hypertension patients who are Blood pressure managed (<80yrs)	63.0%	65.0%	66.5%	61.9%	70.4%	61.6%	64.2%
Count of individuals aged 45+ who are not diagnosed with hypertension, have a history of smoking, are obese and no BP check in 12 mths	267	271	224	160	88	337	1,347
Atrial Fibrilliation prevalence (65+ yrs)	11.7%	13.0%	11.6%	11.4%	11.5%	11.7%	12.0%
Smoking & Obesity							
History of smoking prevalence (coded in last 15 years)	20.4%	22.8%	27.8%	26.2%	28.0%	26.4%	24.8%
History of smoking in last year (coded in last 12 mths)	5.4%	7.9%	10.1%	10.9%	9.2%	7.0%	8.1%
Smoking cessation offered to current smokers (last 12 mths)	62.5%	73.1%	82.1%	76.9%	70.3%	77.6%	74.8%
Obesity prevalence	17.7%	15.5%	16.7%	17.6%	10.5%	17.0%	16.2%

This shows the following opportunities:

- 1347 people 45+ who are not diagnosed with hypertension but have a history of smoking, are obese and no BP check in last 12 months.
- 36% of people diagnosed with hypertension <80 are not blood pressure managed.
- Relatively high admissions in Sudbury and Haverhill for COPD

Deprived populations:

The more deprived populations are expected to show higher proportions of these opportunities therefore a good starting point. Multiple Indicators of Deprivation at “ward” level shows the following populations in wards with highest 20% deprivation in SNEE:

- Bury (3,943)
- Sudbury (7,496)
- Haverhill (7,473)
- Mildenhall (2,743)
- Newmarket (2,451)

West Suffolk Alliance Committee steer is:

- Take action together ASAP in our most deprived community (Howard Estate, Bury) and thereby inform action in Sudbury, Haverhill, Newmarket and Mildenhall.
- Focus on hypertension, but take a broader person centred approach including healthy lifestyles to benefit all health aspects where sensible.

The Howard Estate: Key points compared to general Suffolk population:

- 1,608 residents;
- 2% of the population are Asian, Asian British, Asian Welsh;
- 0.7% are Black, Black British, Black Welsh, Caribbean or African;
- 2.3% are Mixed or Multiple Ethnic groups;
- 94.2% are White British. 0.7% are classified as other;
- 93.4% main language is English.
- 22.1% disabled under the Equality Act (this is significantly higher than the Suffolk figure);
- Higher proportion live in a flat, maisonette or apartment compared to the rest of Suffolk;
- Higher number of households with no cars or vans;
- Higher number of individuals social rented properties;
- Higher number in both economically active and economically inactive status;
- Higher number in caring, leisure, other service occupations, sales and customer service, process, plant and machine operatives and elementary occupations;
- Residents from the wider MSOA area, which includes Northgate had significantly higher rates of hospital admissions compared to the England average in 2016-20, with COPD, self harm and alcohol related conditions being some key areas.

What is the focus of the Bury St Edmunds Project?

GOAL: increase in the number of people who pro-actively manage their health and wellbeing.

Engaging in healthy behaviours:

- Increase in physical activity levels;
- Increase in people living at a healthy weight;
- Decrease in number of people smoking.

Actively managing their own health:

- Increase in number of people measuring their blood pressure, in particular those who are at higher risk of a CVD event;
- Increase in the number of people diagnosed with hypertension who are “managing” their blood pressure effectively through healthy behaviours and prescribed medications.

Suffolk Dementia Partnership

Suffolk Dementia Strategy

2024 - 2029

Contents

Foreword

Joint comms from Cllr Hopfensperger / Georgia Chimbani & Dr Roz Tandy (who do we need to speak to for Norfolk & Waveney clinical lead?)

Once strategy final draft agreed look for a quote from SCC Comms (Matt Woor) and ICB comms

Healthwatch Suffolk have also agreed to write a statement for the foreword

Acknowledgement

This strategy could not have been produced without the support of so many people, networks and organisations working across Suffolk who strive to improve dementia support. That includes members of the Suffolk Dementia Action Partnership, Dementia Forum, and professionals working within Suffolk and Norfolk County Councils, the Suffolk and North East Essex and Norfolk and Waveney Integrated Care Boards. We would particularly like to thank Healthwatch Suffolk for their extensive research and capturing the voice of the personal experiences of living, or supporting someone, with dementia in Suffolk.

“Dementia has taken so much from me” “my income, my self-esteem, my future,” “But here’s a thing: I have taken so much from dementia. I live every day; I enjoy every day. I might forget it moments later, but I have learned to live in the moment and that’s a wonderful, precious thing to do. How lucky am I? They say you only live once, but that’s rubbish: you only die once. You live every day. And that’s what I fully intend to do.”

Quote taken from Peter, Slow Puncture Living Well with Dementia Peter Berry, and Deb Bunt

1.Introduction

This is the first dementia strategy across Suffolk that has been truly co-produced and responds to shared experiences through extensive engagement. It re-enforces the commitment across the Suffolk system to provide high quality care, information and support, at the right time, in the right place for people with dementia, their carers and families.

We recognise that dementia is a significant health and social care issue which impacts not only those living with dementia, but also their carers, families, and friends. 2021/22 GP data indicates there are around 7,500 people living in Suffolk with a diagnosis of dementia[1]. However, this is likely to be an underestimate, as it does not include those without a formal diagnosis. Using research data, we can estimate that there are likely to be14,200 people aged 65 and overliving with dementia in 2023, which is expected to increase to 19,200 by 2035 (a 35% increase)[2].

The strategy highlights the need for more joined up working across the system to reduce gaps and improve the experiences of people with dementia, their carers, families and friends. This means reflecting on our strengths, as well as our weaknesses across the dementia pathway and services, and by raising the profile of dementia to help reduce the stigma that is associated with dementia. We need to embed the importance of prevention and early support to reduce potential crisis and ensure that the person with dementia, carer and family is supported throughout their journey so they can continue to live well within the wider community.

This strategy will inform the planning, development, and commissioning of current dementia related services across Suffolk as well as informing thinking about how the health and care systems in Suffolk respond to the challenges presented by dementia and the need for future provision for dementia support and services. An action plan for implementation of this strategy will be co-produced by those who helped to write and shape the strategy, reflecting the needs of those affected by dementia and work already being undertaken across Suffolk.

Vision

We want to create a society without stigma where people with dementia feel safe and empowered in the knowledge that responsive services are based on an understanding of their needs and access to information, advice, guidance and support is readily available whenever they or their families need it.

To ensure that this vision, the priorities and outcomes from the strategy and associated action plan are delivered, we will need commitment from all lead health and adult social care sectors across Suffolk and Waveney including Suffolk Public Health, Suffolk & Northeast Essex Integrated Care Board, Norfolk & Waveney Integrated Care Board, Suffolk County Council, local District and Boroughs Councils, Alliances, third sector and other key organisations, including the voluntary and private care market that support people with characteristics protected under Equalities legislation[3].

[1] https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data/2022-23/main-findings

[2] https://www.poppi.org.uk/

[3] https://www.local.gov.uk/our-support/workforce-and-hr-support/equality-diversity-and-inclusion-workforce/equality-act-and#:~:text=The%20Equality%20Act%20of%202010,this%20area%20of%20employment%20law.

2 Context

Dementia: The reality

The word 'dementia' describes a set of symptoms caused by different diseases that damage the nerve cells in the brain. Over time these can affect the memory, impacting on the way a person is able to communicate, solve problems and complete tasks.

Dementia is progressive. This means signs and symptoms may be relatively mild at first, but they progress over time, impacting on how a person is able to undertake and complete daily task, which may result in changes in mood including becoming more anxious, depressed and distressed. In its final stages dementia significantly and detrimentally impacts on people's ability to cope with life.

There are many forms of dementia but around 19 out of 20 people with dementia have one of four main types:[4],[5]:

- Alzheimer's disease (50–75%), often co-exists with other forms of dementia such as vascular dementia.
- Vascular dementia (up to 20%).
- Dementia with Lewy bodies (10–15%).
- Frontotemporal dementia (2%).
- Some people develop multiple types of dementia; this is known as mixed dementia[6].

National context

According to the Alzheimer's Society[7] in 2023 there are currently around 900,000 people with dementia in the UK, although this is projected to rise to 1.6 million people by 2050.The prevalence of dementia in older people (age 65 and over) in the UK is estimated to be 7.1% -or around 1 in 14 older people[8]. Despite this, dementia diagnosis rates are too low for those aged 65 and above (and declined both nationally and locally during the pandemic).

Whilst dementia is more common in older populations, it is not a natural part of ageing. Additionally, new figures show a 'hidden population'[9] of 70,800 people in the UK who are currently living with young onset dementia. It is important to consider dementia across all ages, in order to give a more robust reflection of impact of dementia in the population.

The strategy supports the vision and outcomes within the National Dementia Strategy 2009[10]. In May 2022, the Health Secretary announced that there would be a 10-year plan for dementia. This was replaced in 2023 by the Major condition's strategy: case for change and our strategic framework[11]. The strategy also considers the legislation and guidance included in the Care Act 2014[12], the NHS Long Term Plan and National Institute for Health and Care Excellence (NICE)

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4 https://cks.nice.org.uk/topics/dementia/

5 https://www.alzheimers.org.uk/about-dementia/types-dementia/what-is-dementia

6 https://www.alzheimers.org.uk/blog/what-is-mixed-dementia

7 https://www.alzheimers.org.uk/about-us/news-and-media/facts-media

8 https://www.alzheimers.org.uk/sites/default/files/2019-11/cpec_report_november_2019.pdf

9 https://www.dementiauk.org/news/new-figures-show-70800-uk-adults-are-affected-by-young-onset-dementia/

10 https://www.gov.uk/government/publications/living-well-with-dementia-a-national-dementia-strategy

11 https://www.gov.uk/government/publications/major-conditions-strategy-case-for-change-and-our-strategic-framework

12 https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

guidance, Dementia: assessment, management and support for people living with dementia and their carers 2018[13].

These strategic governmental documents recognise the increase in prevalence and need to focus on dementia diagnosis for all ages, highlighting the importance of ensuring that people who have dementia, their carers, families and friends receive the highest quality of care. This including the importance of early identification, support, advice and information. However, dementia remains a terminal condition with no current cure. Until there is a significant shift in the way that dementia is diagnosed, viewed and resourced, it will continue to significantly impact services, people, carers and families.

Local context

Suffolk is predominantly a rural county and has a population of 760,700, (reported at the time of the 2021 Census) with approximately 305,020 people living in areas classed as rural. People living in more rural areas often find transport options more limited (such as infrequent public transport, or having to rely on expensive private transport), meaning access to key services is more difficult.

Children and young people (aged between 0 and 15 years) account for 17.1% of Suffolk residents, lower than England estimates (18.5%).

Adult population (aged between 16 and 64 years) account for 59.3%, lower than England estimates (63.2%). 23.6% of Suffolk residents are 65 years or over, higher than the England average (18.6%)[14].

In Suffolk:

- 2021/22 aggregated GP level data indicates 7,450 people of all ages and registered with a GP were recorded as having dementia: 0.9% of the population, statistically significantly higher than England (0.7%)[15].
- October 2023 data is available for dementia estimates in those aged 65 and over. This indicated that 7,427 people aged 65 and over were recorded as having dementia, but that 13,016 people were estimated to have dementia in this age group. A diagnosis gap of 5,589 people[16].
- 'Young' onset dementia data is currently only published at sub-ICB level, making it difficult to understand the true number of people with a diagnosis of 65 and below as there continues to be a focus nationally on those with a dementia diagnosis over 65 and above.

Dementia diagnosis rates are calculated by comparing recorded diagnoses of those over 65 in general practice against the practice prevalence. This will then give an estimated dementia prevalence for that practice area. This diagnosis does not take into consideration anyone diagnosed under 65 or who has mild cognitive impairment, so the true picture of what dementia looks like in Suffolk now and in the future is unknown. The 2023 dementia diagnosis rate for people in Suffolk over 65 is 56.9% The diagnosis rate has been statistically significantly below the target rate since the pandemic. This suggests further work is needed to improve local pathways and processes to ensure access and opportunities are available to everyone for early diagnosis and support, including carers, families and friends.

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[13] https://www.nice.org.uk/guidance/ng97

[14] https://www.suffolkobservatory.info/

[15] QOF data via Fingertips (17 Nov 23)

[16] https://digital.nhs.uk/data-and-information/publications/statistical/primary-care-dementia-data/october-2023

3. Engagement and Co-production

Between September 2022 and February 2023 Healthwatch Suffolk undertook extensive stakeholder engagement with people with dementia, their carers and families across Suffolk,

In total Healthwatch Suffolk collected 156 people's experiences in three ways, including 19 in-depth interviews with carers, families, and the person with dementia, 100 feedback forms and 28 comments from the feedback centre.

People were asked to share:

- Their experiences of accessing health and care services, including getting a diagnosis, and care received in hospital, at home or in a care home
- What sources of information and support they had found useful and what was missing
- What they would like people to know about living with dementia or caring for someone with dementia
- Their understanding of 'dementia friendly communities' and what is needed to make a community dementia friendly
- Carers were asked about the support they had received in their role as a carer

Between November 2022 and June 2023 further engagement and co-production sessions were held across Suffolk involving people with dementia, their carers and families, health, social care professionals, stakeholders and the voluntary community and faith sector.

This included

- **Dementia Marketplace event:** co-produced with people with lived experiences and the voluntary, community and faith sector, providing resources, information, and advice for those with dementia and their families across Suffolk
- **8 Dementia roadshows across Suffolk:** to ensure that people in rural locations could access resources and information, as well as sharing their experiences of dementia.
- **16 Dementia groups and 8 awareness sessions across Suffolk:** to ensure that those living with dementia and their families who are currently accessing services and support were able to share their experiences.
- **Spoke to over 152 people from 48 organisations either in person or virtually:** to ensure that people of Suffolk had the opportunity to share their experiences and have them included in the strategy

From these co-production sessions, consistent themes emerged around:

- Communication
- Information and advice
- Support
- Training and education
- Carers

The quotes within the strategy have been taken directly from the Healthwatch Suffolk dementia report 'A roundabout without signposts': People's experiences of dementia in Suffolk'[17] and from further engagement and co-production sessions co-ordinated by the Dementia Strategy Development & Implementation Lead. There are also quotes from professionals and those from the third sector, either on behalf of their service, or the voice of the person with dementia, carers, and

[17] https://healthwatchsuffolk.co.uk/news/dementiaresearch-2023/

families. Healthwatch Suffolk highlighted key learning points for the system which have been incorporated into the strategy, to ensure that the voice of those with lived experience is embedded throughout.

As a result of the views expressed, the strategy follows the NHS England 'Well Pathway for Dementia'[18]

4. Preventing Well

[18] https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/03/dementia-well-pathway.pdf

Limiting risk and delaying onset dementia

There is growing evidence that people can reduce their risk of developing certain types of dementia, or delay onset by 40%, just by making simple changes to their lifestyle. Evidence shows the benefits of addressing the twelve modifiable risks[19] and how this can reduce the risks of getting dementia as below:

- Having regular **hearing** and **sight tests**
- Maintaining a **healthy weight** by **eating a balanced diet** and **exercising** regularly, which also **reduces the risk of falls**
- Keeping **alcohol** within recommended limits
- Reduce or **stop smoking**
- Monitoring your **blood pressure, cholesterol, and blood sugar** to ensure it is within recommended limits
- Given the ability to **stay socially connected** in the community to **improve wellbeing** and **reducing stress**
- **Reducing intake of air pollution** by not exposing yourself to areas of heavy traffic
- Having the support and opportunity to **remain in education**

Making changes to your lifestyle is beneficial no matter when you decide to make them, even after diagnosis.

Priority 1. Improve awareness by ensuring that risk reduction messages are included in relevant public health campaigns, policies and programmes. This must include a culturally sensitive approach.

Outcome 1. Limiting risk and delaying onset dementia
People understand how to make changes to their own lifestyle where possible, to limit the risk or delay the onset of certain types of dementia

Increasing awareness and understanding of dementia

The Healthwatch Suffolk dementia report[20] and engagement with the wider statutory and voluntary sector found that there was a reluctance for people to seek help and advice when they started to experience early signs of dementia, due to fear, stigma and discrimination that can come with that diagnosis.

209,600 people will develop dementia this year in the UK, that's one every three minutes. It is estimated that 70 per cent of people in care homes have dementia or severe memory problems[21].

'I can't believe I've got that disease.'

People with dementia said that having a diagnosis can make them feel excluded and less welcome in the activities they used to enjoy, leading to feelings of loneliness and isolation.

Some carers and families also felt that as the dementia progressed there was less tolerance from the wider community, and they were left feeling there was nowhere to go for support.

"How hard and alone you are - there is no support, and no one cares. There is no treatment and there is little hope."

For some people there was also a lack of understanding from family, friends, their community and even among health and adult social care professionals including their own GPs.

[19] https://www.thelancet.com/infographics-do/dementia-risk

[20] https://healthwatchsuffolk.co.uk/wp-content/uploads/2023/05/Healthwatch-Suffolk_Dementia-report-2023.pdf

[21] https://www.alzheimers.org.uk/about-us/news-and-media/facts-media#:~:text=The%20report%20found%20there%20are,dementia%20or%20severe%20memory%20problems.s

"Nobody else in the family could see what I was seeing... that was the worst part..."

In Suffolk we know from feedback from those with lived experiences, that there can be further challenges for those with protected *'In our society, there isn't a diagnosis of dementia.*

characteristics including some groups from ethnic minority backgrounds.

"She used to get confused. We just thought it was because of the language barrier."

Priority 2. Preventing Well: Improve training and education by ensuring that people have the right skills to identify and support people earlier to ensure that a timely diagnosis is offered, reducing stigma through raising awareness of dementia.

Outcome 2. Increasing awareness and understanding of dementia
Everyone in Suffolk has the same opportunities for early intervention and support.

Pre-diagnosis acknowledgement and identification of dementia

We know that having initial conversations about dementia can make some people feel anxious, which can often delay the diagnosis process and the benefits that an early diagnosis can bring.

We need to ensure that people understand the benefits of an early diagnosis and have the confidence to begin conversations with their doctor or other professionals.

one in two of the population will be affected by dementia in our lifetime, either by caring for someone with the condition, developing it or both[22]

We want professionals, voluntary and the wider statutory sector to know how to recognise the signs of dementia earlier and have the knowledge of the options available to support and treatment if they refer someone for a formal diagnosis.

Key learning from the Healthwatch Suffolk dementia report from conversations with people with dementia and carers

Find ways to make dementia less hidden

Break down the fear and stigma people experience so there can be open and honest discussion about dementia.

Make it easier to find early help
People need to know what support is available if they think they or a relative has a problem with their memory, and they need to know how to access that support.

Information and awareness
Early signs and symptoms are not widely known. People need help to find information about dementia, so they know what to look for.

Include people without a diagnosis
Difficulties with obtaining a formal diagnosis mean people can miss out on support. People should have the same access to help whether they have a formal diagnosis or not.

"It was hard to get help. Nobody would listen to me."

We know that the early signs of dementia can be difficult to identify, often mistaking symptoms for getting older, even though dementia is not a normal part of ageing,[23] further delaying the diagnosis process. Some symptoms can occur for other reasons; stress,

[22] https://www.alzheimers.org.uk/about-us/news-and-media/facts-media#:~:text=The%20report%20found%20there%20are,dementia%20or%20severe%20memory%20problems.s

[23] https://www.alzheimers.org.uk/about-dementia/symptoms-and-diagnosis/how-dementia-progresses/is-it-getting-older-or-dementia

thyroid problems, menopause, head injuries or vitamin deficiencies, such as vitamin B12.[24] An early assessment is important to identify the cause of the symptoms in order to provide the right treatment and support, along with regular reviews.

'What's the point? There's no support, it's just a label.'

We also recognise that not everyone wants a formal diagnosis of dementia. We need to ensure that people and professionals know how to access advice, support and information, to help individuals to make informed decisions about their memory. If they do have concerns and wish to have a formal diagnosis, they are supported throughout their journey.

Priority 3. Improve information and advice: by ensuring that people (with memory concerns, pre diagnosis, diagnosis, and post diagnosis) can access the right information and advice, when it is right for them, so they are able to make informed decisions about their own health and wellbeing

Outcome 3. Pre-diagnosis acknowledgement and identification of dementia
People have increased awareness and understanding of dementia and the challenges it brings and know how to address them, including reducing stigma.

5. Diagnosing Well

[24] https://cks.nice.org.uk/topics/dementia/diagnosis/differential-diagnosis/

Assessment and diagnosis

We know that the longer people wait to be diagnosed the less choice they have about their future care and support. The impact this can have on them, and their families can be catastrophic, resulting in carer breakdown and crisis hospital admissions.

Getting the right information, support and guidance early can have a significant impact on someone's emotional health, wellbeing, and ability to manage their own condition and live independently in their local community.

The national target rate for dementia diagnosis in those aged 65 and over in England is 66.7%. In comparison, in August 2023 in Suffolk, the rates were 57.6% in Ipswich & East Suffolk, 55.3% in West Suffolk and 58.3% in Waveney. It is important that we continue to work together as one system to improve this.

Although dementia diagnosis rates are below the 66.7% target, since the COVID-19 pandemic the number of people referred to the memory services with concerns about their cognition has significantly increased. However, this has resulted in longer waits for people, which can be detrimental to health and wellbeing for them and their families. Evidence shows there are a number of challenges for people being able to attend a clinic in central Ipswich, Bury St Edmunds, and Lowestoft, including access to public transport, and the cost of private transport. Dementia diagnostic services continue to work with partners across the system to offer appointments elsewhere, including those in more rural parts of the county, but are challenged by the availability of clinical space and the associated costs.

"Dementia was not just a diagnosis for me but for the whole family"

For many people, including carers and families, receiving a diagnosis of dementia can be hard to accept. However, there are others who feel that having a diagnosis has helped them to understand the changes they have been experiencing and this has contributed to improvements in their wellbeing. Knowing their diagnosis enables people to research more about the condition and can motivate them to participate in research studies with other national organisations[25]. How a person, family member or carer feels when they receive a diagnosis of dementia is very personal. Feedback from engagement suggests people want someone to talk to about the diagnosis at a time that is right for them; this may be at the point of diagnosis or a time when it is more suitable to them.

Not all diagnoses are given at memory assessment services. In Suffolk, work has begun on "delivering a diagnosis well," working with people with dementia and carers, to improve the experience of receiving a dementia diagnosis from any professional.

We know from talking to people with dementia and professionals in health and adult social care, that inconsistencies in the dementia pathway across Suffolk are impacting on people getting a timely assessment and diagnosis. This then delays access to the support, advice and care they and their families may need. Closer working relationships are needed with professionals across health, adult social care, community services, voluntary sector, and the wider system, for earlier identification of people who are most at risk of developing dementia.

"I'm afraid I'm going to forget who I am and the things that I can do"

Following a diagnosis, many people and families described a lack of support available and how alone they felt as a result. Key findings from the Healthwatch Suffolk dementia report identified a lack of post-diagnostic and follow-up support, including annual reviews from their GP or health professional. Where people had received a

[25] https://www.joindementiaresearch.nihr.ac.uk/

review, the outcome was inconsistent, ranging from feeling reassured and more confident to continue with their everyday lives, to feeling let down by lack of support and empathy.

Key learning from the Healthwatch Suffolk dementia report and further conversations had by the Dementia Strategy Development Lead with people with dementia and carers

Listen to carers
Family carers want to be listened to and taken seriously when they ask for help– this includes health professionals doing things differently to support them or their relative in getting a diagnosis.

This included addressing any sensory loss, learning disabilities, language, or cultural issues.

Improve cross-service communication
Families want services that talk and communicate with each other and with them.

Compassionate diagnosis delivery
A dementia diagnosis can be unexpected, alarming, and life changing. Professionals must make sure that any diagnosis is communicated in a compassionate and supportive way.

Transport
Limited options in areas across Suffolk can have barriers to getting a diagnosis. People want to attend clinics in their community where they can be supported locally whether this is rural or urban.

"I cannot believe that with what is a terminal condition patients are not routinely offered a review with a doctor."

"I have finally booked one for Mum this month, but not without a fight."

It is important that health and adult social care professionals know what support and advice there is across Suffolk, both pre- and post-diagnostic. This would give confidence to those they care for, and their families; that they can have access to the right support, at the right time and in the right place throughout their dementia journey. Health and adult social care professionals need to be supported to ensure they have the right levels of knowledge, skills, and training to be able to make an appropriate diagnosis or referral to specialist services for assessment of cognitive changes.

Priority 4. Improve communication: by ensuring that services listen and don't ask people with dementia, carers and their families to tell their story more than once.

Outcome 4. Assessment and Diagnosis
People receive a compassionate assessment and diagnosis, including the benefits of assistive technology to help them live well.

6. Living Well

Keeping independent for longer

Lived experiences of those with dementia, including their carers and families are key to changing the way we think about dementia in Suffolk. Through comprehensive engagement with the wider statutory and voluntary sector we have listened carefully to what people with dementia are experiencing and heard how individuals, families and carers manage the changes that they encountered and the diverse ways they cope.

Key learning about from the Healthwatch Suffolk dementia report from conversations with people with dementia and carers

Improve integrated care
Services need to work well together to support people when they have health and care needs.

Coordinate resources
Services should draw upon the expertise, knowledge and skills that other teams/professionals offer in order to provide person-centred care and support.

Support families to participate
Families should be invited and supported to participate in multi-disciplinary meetings. They should also be informed about how they can initiate a multi-disciplinary meeting.

Improve communication between services
There needs to be better basic communication between services to ensure key information is made available to everyone involved in the care and support of someone with dementia.

"You're still the same person you were before you got the diagnosis of dementia."

To enable people to live well with dementia we need to meet the needs of the individual and create a support system around them, delivered in their own community that:

- enables them to remain at home and live independently for as long as possible
- enables them to access services in person which are visible, delivered locally, and at a place that is familiar
- responds to the individual needs of the carers and families
- responds to the language, cultural beliefs, or specific needs such as those with young onset dementia, learning disabilities or sensory issues.
-

"Make life about the 'I can do's, not the can't do's."

We know that everyone's needs are different, and how we support one person to live with dementia will be very different to another. We need to continue to work with, and listen to, the dementia advisors from our pre and post diagnostic service[26] who already provide support in the community, along with our third sector organisations who support people on a day to day basis.

Key learning about from the Healthwatch Suffolk dementia report from conversations with people with dementia and carers

Communicate about the service consistently
People need to be consistently referred to the dementia support service at the earliest opportunity – at time of diagnosis, if not before.

Help people to know how to access support
People need to know that they can self-refer for help and support. Many people were unclear about how to access the service.

Be clear with people about the service offer

[26] https://www.alzheimers.org.uk/support-services/Suffolk%20Local%20Services/Dementia%20Connect%20-%20Suffolk/regional norfolk@alzheimers.org.uk

People need to be consistently informed about what the service provides, and that it is not only available to those with a diagnosis.

Aim for services to be a guide
People want individualised support, that is proactive in contacting families and offers emotional and practical support.

Support people to find digital solutions that help
People want advice on technological solutions that can help them live independently with dementia.

Clarify and differentiate support for those with early onset dementia
There needs to be a different approach to providing support for people with Early onset dementia. The issues or challenges they face are very different to those for older people.

The pre and post diagnostic service should continue to work flexibly with the community and wider system to provide a multi-disciplinary approach, contributing to the individual needs of the person with dementia, their carers and families to ensure:

- that people have the right information to identify the signs and symptoms[27] of dementia and what steps they need to take should they wish to have a diagnosis.
- that the person with dementia is able to express who they are and their needs to the people who care and support them, using documents such as "This is Me"[28]
- that the needs of the carer and other family members or friends are included in a carers assessment[29].
- that support is available for healthy behaviours, including exercises to reduce falls, advice on healthy eating, reducing smoking and drinking.
- that memory is also supported, realising the benefits of cognitive stimulation.
- that people are aware of the benefits of making decisions earlier in their diagnosis so they can choose how they are supported in the future, including lasting power of attorney, My Care Wishes (Yellow Folder) or My

[27] https://www.alzheimers.org.uk/about-dementia/five-things-you-should-know-about-dementia

[28] https://www.suffolkuserforum.co.uk/this-is-me-a-support-tool-to-enable-person-centred-care/ https://carersmatternorfolk.org.uk/this-is-me/

[29] https://www.suffolk.gov.uk/care-and-support-for-adults/caring-for-someone/carers-assessments https://suffolkfamilycarers.org/carers-resources/carers-assessments/

Care Record[30] ReSPECT[31] and Advance Care Plans (ACP)[32]

- that people are connecting with their local community by accessing Suffolk Infolink[33] and Alzheimer's Dementia Voice[34] to find local peer to peer support networks, groups and activities that promote inclusive communities
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Priority 5. Improve lifestyles: by ensuring that people are provided with person centred, holistic support that empowers independence and healthy behaviours

Outcome 5. Keeping independent for longer
People with dementia, carers and families will know where to get support which will enable them to remain part of their community for longer by accessing inclusive groups and activities

Support to stay well: with dementia

For people to live well and independently with a diagnosis of dementia we need to ensure that they are listened to and that their voice is heard, by offering the right support and advice to keep them safe. This should include:

Staying Safe in the home
Housing agencies and the Independent Living Suffolk service[35] should support people with dementia to continue to live independently, by providing a range of housing or extra care facilities and access to physical adaptations along with digital solutions in existing home utilising the care technology offer from Cassius[36].

Supporting people with dementia experiencing distress
People with a diagnosis of dementia may experience times when they are fearful, frustrated, or distressed, often when they are unable to communicate an unmet need. This can also have an impact on carers and family members if they are unable to help that person at their most vulnerable.

An understanding of the changes in a person's behaviour needs to be developed by taking into consideration their environment, physical and mental health, underlying medical issues such as pain or infection, and reviewing any medication they are on.
Having this information will help health and adult social care providers develop a plan to support a person's needs. This will help others understand why they are experiencing distress and how to respond to them, to improve the quality of their life and help them to live independently.
At times, if a person's level of distress impacts on their own safety and is a risk to themselves and others, it may be appropriate, after all other psychosocial interventions have been utilised, to use medication such as 'anti-psychotics.' This should be seen as a last option and only as a short-term intervention, audited and monitored carefully by health professionals to ensure that it meets published guidelines by NICE (National Institute for Excellence)[37] and recommendations from NHS England[38]. Anti-psychotics should not be overused and seen as a long-term solution to manage any person's distress.

[30] https://suffolkandnortheastessex.icb.nhs.uk/health-and-care-professionals-area/care-home-support/my-care-wishes-yellow-folders/ https://www.nnuh.nhs.uk/publicatioriorityPn/norfolk-and-waveney-my-care-record/
[31] https://suffolkandnortheastessex.icb.nhs.uk/health-and-care-professionals-area/support-for-primary-care/respect/ https://wearenchc.nhs.uk/news/respect/
[32] https://www.health-ni.gov.uk/advance-care-planning-now-and-future
[33] https://infolink.suffolk.gov.uk/kb5/suffolk/infolink/home.page
[34] https://www.alzheimers.org.uk/get-involved/dementia-voice
[35] https://www.suffolk.gov.uk/care-and-support-for-adults/how-social-care-can-help/independent-living-suffolk
[36] https://www.suffolk.gov.uk/care-and-support-for-adults/help-to-stay-at-home/technology-to-help-you-live-independently
[37] https://cks.nice.org.uk/topics/dementia/prescribing-information/antipsychotics/
[38] https://www.england.nhs.uk/london/wp-content/uploads/sites/8/2022/10/Antipsychotic-Prescribing-Toolkit-for-Dementia.pdf

Herbert Protocol

The 'Herbert Protocol'[39] can be used should an adult go missing.

A form can be completed to provide pertinent information about the person with dementia, such as any health issues, and include a recent picture of them.

The form can then be handed to the police to help the investigation to locate them more quickly, safeguard them more effectively, and return them to safety.

The Herbert Protocol has been used many times to trace missing people with a diagnosis of dementia and return them home. It is another example of how emergency and care services are working together to keep those with dementia safe.

Advocacy

Advocacy and advocate can mean something different to different people. Friends and family may see themselves as an "advocate" for the person with a diagnosis of dementia to ensure that their wishes are met and professionals in health and adult social care may need to advocate for people they support. However in some situations the need for a professional independent advocate is necessary to help understand the rights they have and support them to communicate their own choices and challenge a decision.

Suffolk Advocacy Service is delivered by a partnership which includes POhWER[40], Suffolk Family Carers[41], ACE Anglia[42] and Suffolk User Forum[43] who provide professional independent advocates to work with individuals across Suffolk.

Capacity

The purpose of the Mental Capacity (Amendment) Act 2019[44] is to reform the process under the Mental Capacity Act 2005 ("MCA")[45] which protects individuals who lack capacity to make specific decisions. It also ensures that they can still participate as much as possible in any decisions made on their behalf and in their best interests. The MCA also allows people to express their preferences for care and treatment, and to appoint a trusted person to decide on their behalf should they lack capacity in the future.

Safeguarding

It is important to recognise that people with dementia and protected characteristics, including learning, sensory and communication difficulties are often at a higher risk of abuse or neglect.

Dementia UK is projecting that it will receive **9 times** more safeguarding calls in **2023** that it did in **2021**.

It is also important that we continue to engage with services that support and work with vulnerable people about dementia. Including probation, homeless, traveller communities, refugee / asylum seekers (where English may not be their first language), substance misuse, mental health and those people who live on their own and are isolated. Giving choice and control is at the heart of planning, commissioning, and delivery of health and adult social care support in Suffolk. The Care Act 2014[46] and the White Paper, People at the Heart of Care[47] strengthen and support existing safeguarding arrangements and are embedded in all work and training across the workforce.

Key learning about from the Healthwatch Suffolk dementia report from conversations with people with dementia

[39] https://www.suffolk.gov.uk/care-and-support-for-adults/caring-for-someone/family-carers-emergency-plan

[40] https://www.pohwer.net/suffolk-advocacy-service

[41] https://suffolkfamilycarers.org/

[42] https://www.aceanglia.com/

[43] https://www.suffolkuserforum.co.uk/

[44] https://www.legislation.gov.uk/ukpga/2019/18/enacted

[45] https://www.legislation.gov.uk/ukpga/2005/9/contents

[46] https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

[47] https://www.gov.uk/government/publications/people-at-the-heart-of-care-adult-social-care-reform-white-paper/people-at-the-heart-of-care-adult-social-care-reform

and carers regarding support from healthcare professionals

Make sure people receive an annual review
People need to be able to access their annual review after a diagnosis of dementia.
Compassion and empathic responses are important
People need and should expect compassionate responses from their health and care professionals.
Make reasonable adjustments
People want health professionals to make reasonable adjustments to accommodate the needs of the person with dementia and their family carers.
Help people to access support
People need GPs, practice staff and other professionals to help them to access other support by proactively referring, as appropriate.

Support to stay well: as an unpaid carer

We know from the Suffolk All Age Carers Strategy[48] that caring looks different from carer to carer and circumstances. The definition of carer can also be very different it could mean someone who is a paid to care for someone paid carer[49] or unpaid carer[50] usually a family member. Unpaid carers are all ages from young carer, sibling carers, young adult carers, adult carers, sandwich carers, working carers, older adults, carers over 75 and those after caring/between caring. It is important that the wellbeing of the unpaid carer should not be forgotten when caring for a person with dementia, there is often an assumption that the family will automatically be responsible for the continued care of an individual and feel that they have no choice but to care, but in reality for example they may have to work or have their own health concerns. It is therefore important to for professionals to acknowledge the support unpaid carers and families undertake and identify when there is a need for there unpaid carer to manage their own physical health and emotional wellbeing, as well as the person they care for, or when there is a need for additional care and support to be put in place.

"It is unrelenting. A day will arrive when I cannot cope. I cannot make plans for future events. I am not equipped or educated to deal with his decline, but I am doing my best on a daily basis."

Some carers feel that they have no choi

This includes:

Family Carer Emergency Plan

Carers are encouraged to complete a Family Carer Emergency Plan[51] in advance, identifying contingency plans for what needs to happen to the person cared for in the case of an emergency. This includes identification of an alternative emergency contact if the main carer for someone is unable to provide care for whatever reason. Once completed, the plan is held on Suffolk County Council's case management system within the records of the person being cared for.

Some choice to care, I think sometimes there is an assumption that the family at home will automatically take this responsibility but in reality, unable to due to work,

[48] https://www.suffolk.gov.uk/asset-library/imported/digital-version-aacs-2022-2027-1.pdf

[49] https://www.nhs.uk/conditions/social-care-and-support-guide/care-services-equipment-and-care-homes/homecare

[50] https://www.england.nhs.uk/commissioning/comm-carers/carers/

[51] https://www.suffolk.gov.uk/care-and-support-for-adults/caring-for-someone/family-carers-emergency-plan

7. Supporting Well

Increased need as dementia develops

We understand that many people with a diagnosis of dementia have a strong desire to remain in their own home for as long as possible. Hospital admissions, particularly lengthy ones, increase the risk of a person with dementia losing independent living skills and not returning home. To reduce the risk of this happening, organisations and services, including dementia intensive support teams/mental health/learning disabilities/hospices, homecare services and Integrated Neighbourhood Team practitioners, will need to work closely, in a timely way, to manage and de-escalate complex and / or crisis situations. This could be via community assessments, home treatments, virtual wards or a planned hospital admission.

"It always feels like health blame social care, social care want health to take it up, and there's no accountability"

Support for families and carers including home care, extra care, and personalised breaks

Carers and families have a key role when it comes to supporting and enabling a person with dementia to remain living at home for as long as possible. The support carers provide typically includes managing daily activities including medication, supervision, night time support as required, as well as supporting the person with dementia's overall physical and emotional wellbeing. In Suffolk, we should value the role of unpaid carers. The Suffolk All Age Carers' Strategy commits to ensuring that carers of all ages are heard and supported.

Unpaid carers supporting someone with dementia save the UK economy **£14.6 billion** a year.
By 2040 this will rise to **£35.7 billion**[52]

As dementia progresses, many carers fed back through the engagement that they became more isolated and did not know who to turn to or what support they were eligible for. We recognise too that the desire to retain independence for as long as possible places enormous pressure on family carers and that this strain may lead to conflicting desires between the cared-for and the carer.

Under the Care Act 2014, all carers are entitled to a statutory carer's assessment which considers the impact of their caring role on their own health and wellbeing. Caring for anyone can be difficult at times, carers should therefore be offered additional support through home care, extra care, and breaks[53] from their role as a carer. This enables them to remain independent and keep their own identity, to allow them to continue in their caring role for as long as possible.

It is estimated that **60%** of people who draw on support from homecare are people living with dementia.[54]

52 https://www.alzheimers.org.uk/about-us/news-and-media/facts-media#:~:text=The%20report%20found%20there%20are,dementia%20or%20severe%20memory%20problems.s

53 https://www.suffolk.gov.uk/care-and-support-for-adults

54 https://www.alzheimers.org.uk/about-us/news-and-media/facts-media#:~:text=The%20report%20found%20there%20are,dementia%20or%20severe%20memory%20problems.s

A longer break for a carer can be facilitated by the person with dementia receiving support elsewhere, either through a day centre, or by a temporary stay in residential care. It is important to balance the needs and wishes of the carer with those of the person with dementia. At times these can be different, and so need careful discussion and consideration. Any support provided needs to be person centred and flexible to meet the individual needs of the person with dementia, their family and carers, who will all have different expectations and needs.

'You've got funding yourself, you just need to get care.'

We know from the Healthwatch Suffolk dementia report that many carers felt like they were unable to cope. Despite local authorities being able to access and offer guidance and advice to people who are self-funding, there was a perception from some carers that they did not feel listened to and dismissed by health and adult social care.

There needs to be better awareness of when continuing health care[55] need to be involved if the cost of care does need to be funded.

'The carers chop and change constantly.'

Carers reported that the provision of home care can also create challenges, not least because having different carers everyday can cause more confusion for those with dementia, who may already be unwilling to accept additional help. Where possible, this can be assisted by having a consistent carer(s), who are able to get to know that individual and family, and hence provide more personalised care. Consistency of care also means the carer(s) are more likely to notice any changes in the person with dementia, and work with the family and other professionals to manage any physical, health or emotional wellbeing before it escalates.

Key learning about from the Healthwatch Suffolk dementia report from conversations with people with dementia and carers

Help people to know how social care can help
People need better information about how social care can help them, what support they might be eligible for and how to access social care - they also need this information earlier.

People who can fund care still need help to find social care support
Self-funders need as much support in finding social care support as those who are funded through the local authority.

Trust and continuity really matters
Homecare providers need to work with families to build trusted relationships. Continuity of care is crucial to the success of homecare for people with dementia. People need to understand what they can do if they have concerns about the care being provided to their relative (either homecare or care home), and how to raise concerns. Providers must make this information clear and be prepared to engage and work with people to resolve any issues.

Help people with the transition to care
There needs to be more support for people with dementia and their families to manage the transition into care homes, including support for the carers to adjust to their new roles.

Make sure staff are trained to care for people with dementia
Care quality issues could be addressed by ensuring that homecare and care home staff are adequately trained in understanding the needs of people with dementia and most importantly in how to communicate.

Improve support for long-distance carers
There needs to be better identification of and support for people who are long distance carers

[55] https://www.gov.uk/government/publications/national-framework-for-nhs-continuing-healthcare-and-nhs-funded-nursing-care

Improved coordination of care when people move between areas
There needs to be more co-ordinated support for families who are moving their relative into Suffolk and improved information what people should expect could help people to know how to find care and support if they need it.

Priority 6. Improve support for carers, families and friends: by ensuring that people have the right information and advice, provided when they want it, so they are able to make informed decisions about their own health and wellbeing as well as the person they care for.

Outcome 6. Increased need as dementia develops
Families are supported by professionals in health and adult social care to provide care to the person with dementia in a place of their choice

Care home setting

Not all care can be provided in a person's own home and there may be a time when, even with additional support, a person with dementia can no longer remain in their own home. Going into a different environment can be overwhelming for a person with dementia. Where possible, provision for transition from home to care home should be gradual and sensitively approached for all involved, including the person with dementia, their carer, and their family. In some cases, if the person has had day care, or a temporary break in the same setting, the transition from home to care home can be much easier. There is also potential in the future to use virtual reality to show a person around the home before their stay.

Sometimes the decision to move to a care home will be triggered by a hospital admission for the person with dementia. At this point (if the person is deemed to have lost capacity to decide how their care and support needs will be met), a best interest's decision will be made under the Mental Capacity Action legislation[56] assessing if a care setting would be in the best interest for the person with dementia and their carer.

From the Healthwatch Suffolk dementia report, we know that families sometimes felt pressured to find and accept a home placement quickly and for many carers they found the transition of moving their relative into a care home difficult to manage, not just for them but for the person with dementia. It is therefore vital that health and adult social care colleagues work closely with care homes and families to support the transition for everyone involved.

The cost of adult social care for people with dementia is set to nearly treble by **2040**, increasing from **£16.9 billion** to **£45.4 billion**[57]

Placements in care homes can often be more complex if a person with dementia has been in hospital for an extended period. This may have an impact on the way that they present, which could be through distress or lack of engagement, both needing more care and

[56] https://www.legislation.gov.uk/ukpga/1983/20/contents

[57] https://www.alzheimers.org.uk/about-us/news-and-media/facts-media#:~:text=The%20report%20found%20there%20are,dementia%20or%20severe%20memory%20problems.s

support than when they first came into hospital.

To understand the individual, potentially complex, needs of the person with dementia, health and adult social care professionals need to have open, honest, and transparent conversations with carers and care homes to ensure that the right level of care and support can be made available for that person. We know from conversations with care homes, that they feel there is limited support offered once a person with a diagnosis of dementia is placed in their care home. There can often be limited information about the person's needs, which means that care home staff are not equipped or trained to best support that person. This can result in escalation to the point where emergency services are involved, and a return to acute care which will increase the anxiety and distress for that person with dementia.

'We are not a crisis intervention we are a care home, we need the right levels of training, care and support'

It is vital that managers and staff have the right training to understand and manage more complex situations, as well as having robust and accessible links with specialist services within health, mental health and adult social care. This should include the availability of specialist training and face to face support for care homes, including oversight from GP practices as part of the Enhanced Health in Care Homes (EHCH)[58] model. Enhanced Health in Care Homes ensures that the best quality care is offered by all residential and nursing homes. This includes supporting the physical and mental health of people living in a care home, reviewing medication, including anti-psychotics, and ensuring that advance care plans[59] are already in place. In Suffolk there are also GP Care Home Leads who support care homes to diagnose people living with advanced dementia in a care home setting using the DiADeM (Diagnosing Advanced Dementia Mandate) tool,[60] to ensure that they get the right care and support they need without having to attend a memory assessment clinic.

'She is a different person, she's happy, she's settled, she's cared for and blessed. There are still things that are not perfect but just the level of care and it's like they really treat her like they want her there and she's cherished'

When there is a need for a hospital admission

We recognise that not all care can be provided in the community and there may be a time when a person with dementia needs to access urgent and emergency care in an acute hospital bed.

Health and adult social care providers need to work together swiftly and cohesively to support the person with dementia who will often be at their most vulnerable. This will include ensuring that their individual needs and care plans are reviewed to prevent unnecessary admissions. If an admission is unavoidable, then health and social care professionals should work together to look at ways to reduce the length of stay for that person. If there is a possibility to use a virtual ward[61] to support that person in their own environment with regular contact from health professionals, then this should be considered.

'She was on a trolley in the corridor in A&E for ages'

Evidence from NICE guidance hospital care[62] states that people with dementia will often

[58] https://suffolkandnortheastessex.icb.nhs.uk/health-and-care-professionals-area/care-home-support/ehch/

[59] https://www.dementiauk.org/information-and-support/financial-and-legal-support/advance-care-planning

[60] https://www.alzheimers.org.uk/dementia-professionals/resources-gps/diadem-diagnosing-advanced-dementia-mandate

[61] https://www.england.nhs.uk/virtual-wards/

[62] https://www.nice.org.uk/about/what-we-do/into-practice/measuring-the-use-of-nice-guidance/impact-of-our-guidance/niceimpact-dementia/ch3-hospital-care

experience longer hospital stays, delays in leaving hospital and reduced independent living. Hospital admission can trigger distress, contributing to a decline in functioning and a reduced ability to return home to independent living.

'I found the lack of knowledge of dementia from the doctors and nurses amazing'

From the Healthwatch Suffolk dementia report we heard of experiences from carers that included issues in hospital due to limited resources including beds, equipment, staffing and lack of dementia knowledge and training.

'Staff do not always have the time, skills or knowledge to deal with the specific issues of patients with dementia'

Key learning from the Healthwatch Suffolk dementia report from conversations with people with dementia and carers

Admission avoidance and step-down support
Hospitals are a difficult environment for people with dementia. There needs to be more access to admission prevention (to prevent people going into hospital in the first place) and step-down services (to help patients transition back home).

Improve dementia knowledge in hospitals
Care quality issues could be addressed by ensuring that hospital staff are adequately trained in understanding the needs of people with dementia, and most importantly in how to communicate with patients and families.

Prevent rapid deterioration by providing the right care environment
There needs to be more help to prevent people losing vital skills whilst they are in hospital.

Improve discharge planning with families
Families need to be engaged in hospital discharge planning. Poorly planned hospital discharges result innegative consequences for both people living with dementia , and their carers.

Listen to carers
Family carers experience and knowledge about the person with dementia should be recognised and valued by health professionals. People sometimes felt dismissed by staff, and that this had affected the quality of care provided to the person with dementia.

'I had to tell them my wife had dementia.'

Hospital staff also fed back that they were sometimes unable to provide the support that they wanted to due to time pressures and lack of training to support people with dementia and their carers. This often led to an escalation in distress for the person with dementia, particularly when confined to a bed for too long or when they received a lack of attention to manage their daily needs.

"I had to fight my case to stay with my mum, but then, after trying to communicate with my Mum, they realised that I did need to be there."

Family members and carers also told us that hospitals should listen to them more and allow them to support a person whilst in hospital should they wish to. There should also be more flexibility for a person with dementia. This includes:

- when meals are provided and choice around finger foods over a main meal
- allowing people to sleep and wake when they want to
- varied visiting times for carers and families
- providing activities that are meaningful to the person and support their emotional wellbeing whilst staying in hospital
- support for families and carers to remain engaged and continue to support that person whilst in hospital
- looking at how to improve the "dementia friendliness" of the hospital environment, and any tools which

would help better communicate a person's needs
- reviewing all aspects of a person especially if they display distress, including physical health and medication together with the symptoms of their dementia diagnosis. This should include ensuring people are screened to identify delirium, which is common for people with dementia so that can be appropriately treated.

"...in the end, I took my own whiteboard marker and filled it in, so that they knew... because it sounds simple, but some of those things (people's preferences in hospital) are so vital."

It is important to ensure that staff have the right level of training throughout the trusts, so that they have the confidence to support and communicate with people with dementia, allowing them to remain physically and emotionally independent during their stay in hospital, reducing the risk of physical and cognitive decline.

'Still having professional only meetings.'

Staff also need to be able communicate and work with carers and families to ensure that the person with dementia's needs are met whilst staying in hospital. Where there are decisions to be made about a person's future care needs, everyone should be part of these discussions including the person with dementia.

We also heard from the Healthwatch Suffolk dementia report that carers and families are not always involved in discharge planning, often resulting in a poor experience and negative impact on both the person with dementia and their family. It is important that professionals involved in discharge planning take into consideration factors such as the potential impact of what time of day a person is being discharged, whether they have the right equipment available before leaving the hospital and, if they are going back to familiar, or new, surroundings. We recognise that health and adult social care professionals are frequently under pressure, and it is important that we listen to them to ensure they have the right support and training to enable them to deliver the best quality care to people with dementia and their families.

Being passed between services "DIST (Dementia Intensive Support Teams) actually said '[It's the mental health hospital's] problem' and [The hospital] were of course 'it's not our problem. She's in the community now.' I said, 'I know that but we're now getting desperate again.' So, they both blamed each other, and they all wanted to blame health and I started on the social worker saying 'Come on, this is looking like we're going to need urgent respite or something. This is not going to be manageable'.... And so, we kept going. "

When there is a need for inpatient care for older people with mental health services

Sometime people with a diagnosis of dementia will require additional specialist care necessitating admission to an older person's mental health inpatient unit or dementia assessment bed in hospital. As with any healthcare setting, care should be delivered in a person-centred, holistic, and respectful way. The Healthwatch Suffolk report identifies that carers often experience challenges in transfers of responsibility of care, and many carers felt they were being passed from service to service without any real progress.

8. Dying Well

End of Life and Palliative care

The Office of National Statistics reported that dementia and Alzheimer's disease had been the leading cause of death in England for 24 consecutive months since June 2021. In July 2023, dementia and Alzheimer's disease was the second leading cause of death, (coronary heart disease (CHD) being the first) with 75.5 deaths per 100,000 in England (3,782 deaths)[63].

The Cicely Saunders International Centre paper "A right to be heard"[64], reported that 'Dementia is frequently not recognised as a life-limiting condition nor considered suitable for palliative care. Too often people affected by dementia have limited access to support in the community and experience high hospital use and a high burden of suffering. They deserve better.'

"I didn't just lose my wife, I lost her along time ago when she forgot who I was"

Due to the complexities of dementia, it can be difficult to know when a person is nearing the end of their life as dementia can be slow to progress, sometimes over a number of years. Many carers, families and friends told us that they experienced prolonged grief with multiple losses, including the progression of dementia, the person not being able to recognise or remember who they were, and then finally when the person with dementia passed away.

"I'm not gonna be a carer for the last few days of my dad's life. I want to be his daughter."

From the Healthwatch Suffolk dementia report and engagement, carers and families shared that they felt that there could have been more done to support them and the person they were caring for, throughout their dementia journey and at the end of their lives. Many carers reported feeling alone when delivering care at the end of life with fragmented support from the system. These findings were also reflected in the Suffolk Healthwatch End of Life care report[65]

'I don't care who's role it is, I just need help.'

Key learning from the Healthwatch Suffolk dementia report from conversations with people with dementia and carers and recommendations from the Healthwatch Suffolk End of Life care report

Prevent people from being passed between services at the end of life
There needs to be better co-ordinated support for people with dementia and their families at end of life

Ensuring people have access to the information and tools they need to prepare for death.

Exploring the opportunities that digital offers bring to helping people to access information about services and support.

Helping people to understand more about what to expect when a person is at the end

[63] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/monthlymortalityanalysisenglandandwales/july2023#:~:text=Dementia%20and%20Alzheimers%20disease%20had,in%20Wales%20(250%20deaths)

[64] https://www.kcl.ac.uk/nmpc/assets/a-right-to-be-heard-policy-brief.pdf

[65] https://healthwatchsuffolk.co.uk/eolsummary/

of their life (signs, symptoms and support).

Improving communication and integration between the services providing support, and ensuring people know what to expect from each of them.

Making sure people understand what they have been told about their prognosis. Ensuring that all conversations with professionals (at all levels within organisations), are compassionate.

Ensuring people have the option of support from someone they know, or a professional, at key moments.

Priority 7. Dying Well: Improve end of life care by ensuring that people with dementia, and their families, receive person centred care and support that adapts as the needs of an individual increases

Outcome 7. End of Life and Palliative Care
A pathway will be in place that is meaningful to people with a diagnosis of dementia and their families

9. How we will achieve this

An action plan will be co-produced with those with lived experiences of dementia and the wider statutory and voluntary sector to ensure that all aspects of the strategy are considered. We will continue to build on established relationships in the community, learning from existing local approaches to dementia to ensure that people with dementia, their carers, families, and friends are at the centre of everything we do.

We need to review the current lines of communication, awareness, and accessibility to make it easier for people to access all forms of information, advice and support. Other feedback has clearly identified gaps in our system which differ locally; we will aim to address these by working together to offer consistency of service across county boundaries.

By reviewing population health management data and integrated care management[66] we will ensure we understand the challenges across Suffolk now and in the future and are monitoring our progress in addressing them.

Implementation of the strategy via the action plan will focus on priorities over the next five years and will be overseen by the Dementia Action Partnership. Progress will be reported to the Suffolk Health and Wellbeing Board and other boards and committees across health and social care as required. After two years a review will be undertaken by Healthwatch Suffolk to engage with both services and people with lived experience to understand the progress made.

Priorities

The coproduced outcomes of this strategy are:

Priority 1. Preventing Well: Improve awareness by ensuring that risk reduction messages are included in relevant public health campaigns, policies and programmes.

Priority 2. Preventing Well: Improve training and education by ensuring that people have the right skills to identify and support people earlier to ensure that a timely diagnosis is offered, reducing stigma through raising awareness of dementia.

Priority3. Preventing Well: Improve information and advice by ensuring that people (with memory concerns, pre diagnosis, diagnosis, and post diagnosis) can access the right information and advice, when it is right for them, so they are able to make informed decisions about their own health and wellbeing

Priority 4. Diagnosing Well: Improve communication by ensuring that services listen and don't ask people with dementia, carers and their families to tell their story more than once

[66] https://www.england.nhs.uk/integratedcare/what-is-integrated-care/phm

Priority 5. Living Well: Improve lifestyles: by **e**nsuring that people are provided with person centred, holistic support that empowers independence and healthy behaviours

Priority 6. Supporting Well: Improve support for carers, families and friends by ensuring that people have the right information and advice, provided when they want it, so they are able to make informed decisions about their own health and wellbeing as well as the person they care for.

Priority 7. Dying Well: Improve end of life care by ensuring that people with dementia, and their families, receive person centred care and support that adapts as the needs of an individual increases

Outcomes

The coproduced outcomes of this strategy are:

Outcome 1. Preventing Well: Limiting risk and delaying onset dementia
People understand how to make changes to their own lifestyle where possible, to limit the risk or delay the onset of certain types of dementia**.**

Outcome 2. Preventing Well: Increasing awareness and understanding of dementia
Everyone in Suffolk has the same opportunities for early intervention and support.

Outcome 3. Preventing Well: Pre-diagnosis acknowledgement and identification of dementia
People have increased awareness and understanding of dementia and the challenges it brings and know how to address them, including reducing stigma.

Outcome 4. Diagnosing Well: Assessment and diagnosis
People receive a compassionate assessment and diagnosis, including the benefits of assistive technology to help them live well.

Outcome 5. Living Well: Keeping independent for longer
People with dementia, carers and families will know where to get support which will enable them to remain part of their community for longer by accessing inclusive groups and activities

Outcome 6. Supporting Well: Increased need as dementia develops
Families are supported by professionals in health and adult social care to provide care to the person with dementia in a place of their choice

Outcome 7. Dying Well: Palliative and end of life care: a pathway will be in place that is meaningful to people with a diagnosis of dementia and their families

Appendix 1. Protected characteristics and dementia

Everyone is different and to ensure that Suffolk meets the needs of the whole population, the following themes and actions have been identified as areas warranting particular attention across the dementia pathway. All areas of service development arising from this strategy must acknowledge, accommodate and address these.,

Young onset dementia
People who are diagnosed with dementia at a younger age will often have different needs to those diagnosed later in their lives. Many may:

- be carers for children, parents, or their partner
- working full time and have financial commitments, some may be the main or sole provider of income
- be more physically active, fitter, and stronger than those who are much older

There are over 42,000 people under 65 with dementia in the UK. This is known as young on-set dementia[67]. However new figures show a 'hidden population' of 70,800 people in the UK who are currently living with young onset dementia — a rise of 28,800 (69 per cent) since 2014[68].

Learning disabilities and dementia
People with learning disabilities[69] have a higher risk of getting dementia compared to the rest of the population. The Alzheimer's Society reported that people with a learning disability are more likely to get dementia at a younger age. About 1 in 5 people with learning disabilities who are over the age of 65 will develop dementia. People with Down's Syndrome have an even higher risk, with about 2 in 3 people over the age of 60 developing dementia, usually Alzheimer's disease[70].

Making a diagnosis of dementia can be more difficult for people who have a condition that may limit the way they communicate the symptoms they are experiencing, and have difficulties with short term memory, or clarifying information.

Sensory and physical impairment and dementia
People with dementia may have a form of sensory impairment (such as Deafness, blindness, visual impairment, hearing impairment and Deaf blindness) or physical impairment (such as physical functioning, mobility, dexterity, or stamina). Services need to ensure that reasonable adjustment is made to ensure people have time to communicate their individual needs and how they wish to be supported.

Gender
65% of the 944,000 people living with dementia in the UK are women. Two-thirds of unpaid carers for those with dementia are women. By the age of 60, 1 in 5 women will have provided unpaid care to an elderly friend or relative[71].

Lesbian, Gay Bisexual, Transgender, Queer, Intersex, and Asexual (LGBTQIA+)
The Bring Dementia Out programme from the LGBT Foundation suggests that there are around 68,000 LGBTQIA+ people living with dementia in the UK.[72]people who are diagnosis with dementia will often have concerns about future personal care and how services will support them based on their individual needs. The Alzheimer's Society reports the difficulties that impact LGBTQIA+ people with a diagnosis of dementia, which includes not being able to remember they have transitioned, are in the process of transitioning or that they have shared their

67 https://www.alzheimers.org.uk/about-dementia/types-dementia/young-onset-dementia

68 https://www.dementiauk.org/news/new-figures-show-70800-uk-adults-are-affected-by-young-onset-dementia/

69 https://www.alzheimers.org.uk/about-dementia/types-dementia/learning-disabilities-dementia

70 https://www.mencap.org.uk/learning-disability-explained/learning-difficulties

71 https://dementiastatistics.org/about-dementia/prevalence-and-incidence/

72 https://lgbt.foundation/bringdementiaout

sexual orientation of gender identity. This can cause the person with the diagnosis of dementia further anxiety. It is therefore important that health and social care professionals understand the impact that memory loss can have on an individual and how they identify themselves[73].

Ethnic Minority Background (EMB) (including Gypsy, Roma, and Irish Traveller groups).

There are more than 25,000 people currently living with dementia from Black, Asian and minority ethnic groups, which includes the Travelling community in England. This is expected to exceed 172,000 people by 2051 – a seven-fold increase in comparison to a two-fold increase among the wider population.[74]

In Suffolk, census data indicates 93.1% of the population were classified as White (compared to 81.0% for England). Whilst Suffolk is less diverse than England, diversity has increased compared to the last census. There is variation within Suffolk, with Ipswich having the lowest percentage of White population at 84.3% and Mid Suffolk having the highest percentage of White population at 96.8%[75].

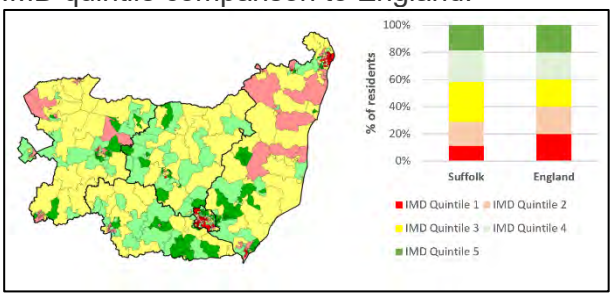
Ensuring people from an EMB background can access services when they need to easily is key to reducing the stigma and fear that may relate to a diagnosis of dementia. In some cultures, and faiths there may not be a word or meaning for dementia which can lead to a reluctancy to access services. It is therefore important that information, advice, and support is provided in a format that is culturally appropriate and meaningful when it is needed.

Socio-economic disadvantage

Alzheimer's Research links socioeconomic deprivation, including neighbourhood disadvantages and persistent low wages, to higher dementia risk, lower cognitive performance, and faster memory decline. Findings, from four separate studies, also show that people who experience high socioeconomic deprivation are significantly more likely to develop dementia compared to people who live in more affluent areas[76].

The English Index of Multiple Deprivation (IMD) was published in 2019 and provides a way of comparing relative deprivation across small areas in England. The 20% most deprived areas are shown in red in the map below. 11.3% of small areas within Suffolk fall within the most deprived areas nationally and are situated primarily within Lowestoft and Ipswich.

Figure 2: Suffolk IMD map by LSOA area and IMD quintile comparison to England.



Source: English indices of deprivation 2019

Rural and remote areas

Rural areas tend to be inhabited by more older people and thus have a higher prevalence of dementia. Combined with lower population densities and more sparse geography, rural areas pose numerous barriers and costs relating to support and resource provision.[77]

Suffolk is a predominantly rural and ageing county, where 1 in 4 people (23.6%) are aged 65 and over, compared to around 1 in 5 for England (18.6%). Furthermore, the population aged 65 and over is forecast to increase over the next 20 years – when 1 in 3 people are predicted to be aged 65 and over.

Being part of a rural / remote community can have its benefits for a person with a diagnosis of dementia, it can provide familiarity, established trusted community networks as well as green spaces which can benefit well-being.

[73] https://www.alzheimers.org.uk/get-support/help-dementia-care/lgbtq-dementia-memory-problemS

[74] https://www.dementiauk.org/dementia-care-gypsy-roma-travelling-communities/

[75] https://www.suffolkobservatory.info/

[76] https://www.alzheimersresearchuk.org/bolder-government-action-is-needed-to-address-inequalities-in-dementia-risk-says-alzheimers-research-uk/

[77] https://www.alzheimersresearchuk.org/bolder-government-action-is-needed-to-address-inequalities-in-dementia-risk-says-alzheimers-research

However, some people who live in rural / remote areas with a diagnosis of dementia, may experience further challenges such as isolation due to lack of transport and access to services which may not be local. Carers may also experience further isolation if they are unable to drive or access public transport as the persons condition progresses, due to increased anxiety or changes in mood, meaning they are restricted as to when they can leave their house, impacting on their own health and wellbeing.

Suffolk Dementia Strategy

Suffolk Board

01 December 2023

Gail Cardy

Contracts and Service Development Manager – Dementia Strategy Development & Implementation Lead

Strategic Planning and Resources Team

Adult and Community Services & Suffolk and North East Essex ICB

Co-production

There has been continued engagement and co-production across the whole development of the strategy with people with dementia, carers, families, third sector and wider health and adult social care systems. The ethos that Suffolk owns the dementia strategy is important to me. The themes from the Healthwatch report are embedded throughout the strategy

Summary of co-production

Jan – March 2023	Engagement across the system
16 May 2023	Dementia Marketplace Event
May – June 2023	Dementia Roadshows across Suffolk & Waveney
20 June 2023	Co-production session face to face
03 July 2023	Co-production session virtual
July – August 2023	Further engagement and co-production across the system
18 & 21 Sept 2023	Co-production focused session to review the draft strategy
Oct 2023	Share the draft strategy for review and comment
Oct – Nov 2023	Further co-production on the actions and implementation plan

Co-production

Between September 2022 and February 2023 Suffolk Healthwatch were commissioned to undertake extensive stakeholder engagement with people with dementia, their carers and families across Suffolk

Healthwatch Suffolk collected 156 people's experiences in three ways,

- 19 in-depth interviews with carers, families and the person with dementia,
- 100 feedback forms
- 28 comments from the feedback centre

November 2022 and June 2023 further engagement and co-production sessions were held across Suffolk involving people with dementia, their carers and families, health, social care professionals, stakeholders and the voluntary community and faith sector

We held a Dementia Marketplace event,

- 8 Dementia Roadshows,
- 16 dementia groups attended,
- 8 awareness sessions in person
- 152 people met and talked to from 48 organisations, either in person or virtually.

Communication:

- **Services working together:** Improved communication between services
- **Diagnosis:** Improve cross service communication

Information and advice:

- **Pre-diagnosis**: Make it easier to find early help and include people without a diagnosis

Support:

- **Pre and Post diagnosis:** Provide emotional and practical support
- **Post diagnosis:** Help people know how to access support
- **Post diagnosis:** Ensure that annual dementia reviews happen

Training and education:

- **Hospital care:** Train staff in hospitals so they know how to care and communicate with people with dementia
- **Post diagnostic support:** Make sure staff are trained to care for people with dementia
- **Prevention:** offer training to the community

Carers:

- **Hospital care:** Listen to carers
- **Diagnosis:** Listen when carers as for help

Admission avoidance:

- **Hospital care:** Enhanced admission avoidance and stepdown support

Priorities using the Dementia Wellbeing Pathway

- **Priority 1. Preventing Well: Improving awareness** by ensuring that risk reduction messages are included in relevant public health campaigns, policies and programmes.

- **Priority 2. Preventing Well: Improve training and education** by ensuring that people have the right skills to identify and support people earlier to ensure that a timely diagnosis is offered, reducing stigma through raising awareness of dementia.

- **Priority 3. Preventing Well: Improve information and advice** by ensuring that people (with memory concerns, pre diagnosis, diagnosis, and post diagnosis) can access the right information and advice, when it is right for them, so they are able to make informed decisions about their own health and wellbeing

- **Priority 4. Diagnosing Well: Improve communication** by ensuring that services listen and don't ask people with dementia, carers and their families to tell their story more than once

- **Priority 5. Living Well: Improve lifestyles** by ensuring that people are provided with person centred, holistic support that promotes independence and healthy behaviours

- **Priority 6. Supporting Well: Improve support for carers, families and friends** by ensuring that people have the right information and advice, provided when they want it, so they are able to make informed decisions about their own health and wellbeing as well as the person they care for.

- **Priority 7. Dying Well: Improve end of life care** by ensuring that people with dementia, and their families, receive person centred care and support that adapts as the needs of an individual increases

Outcomes

- **Outcome 1. Preventing Well: Limiting risk and delaying onset dementia** People understand how to make changes to their own lifestyle where possible, to limit the risk or delay the onset of certain types of dementia**.**
- **Outcome 2. Preventing Well: Increasing awareness and understanding of dementia** Everyone in Suffolk has the same opportunities for early intervention and support.
- **Outcome 3. Preventing Well: Pre-diagnosis acknowledgement and identification of dementia** People have increased awareness and understanding of dementia and the challenges it brings and know how to address them, including reducing stigma.
- **Outcome 4. Diagnosing Well: Assessment and diagnosis** People receive a compassionate assessment and diagnosis, including the benefits of assistive technology to help them live well.
- **Outcome 5. Living Well: Keeping independent for longer** People with dementia, carers and families will know where to get support which will enable them to remain part of their community for longer by accessing inclusive groups and activities
- **Outcome 6. Supporting Well: Increased need as dementia develops** Families are supported by professionals in health and adult social care to provide care to the person with dementia in a place of their choice
- **Outcome 7. Dying Well: Palliative and end of life care:** a pathway will be in place that is meaningful to people with a diagnosis of dementia and their families

How will we know we are making progress?

- **Implementation of the co-produced action plan:** the Dementia Strategy will be signed off by the Suffolk Health and Wellbeing Board and owned by Suffolk County Council and Suffolk and Northeast Essex Integrated Care Board

- **Regular reviews:** against the action and implementation plan by the Dementia Action Partnership and Suffolk Dementia Forum

- **Feedback from people:** regular reviews of the progress by Suffolk Healthwatch and Suffolk Dementia Forum acting as a “critical friend”

- **Performance data:** changes in trends for national reporting, i.e., increase in dementia diagnosis and contract reporting i.e., evidencing earlier contact from more people seeking advice and support

- **Less need for crisis support:** delay in people needing formal care and support, earlier preventative planning, and less reactive / crisis response

Question(s) for Public Board

Do you support the priorities and objectives of the Dementia Strategy?

Are there any gaps in what the Strategy has covered

Do you have any thoughts/ideas about how you could support this as a board for West Suffolk?

2.4. Digital Programme Board Report

To Assure

Presented by Craig Black

BOARD OF DIRECTORS	
Report title:	Digital programme board report
Agenda item:	2.4
Date of the meeting:	1st December 2023
Lead:	Craig Black
Report prepared by:	Liam McLaughlin, CIO

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

Executive Summary
WHAT? *Summary of issue, including evaluation of the validity the data/information*
The digital programme covers a wide range of projects and initiatives and the key deliverables are described.
SO WHAT? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*
The people, financial and technical resources are constrained and so it is essential to ensure that the digital initiatives support the Trust strategy, ambitions and plans, and deliver the expected benefits and organisational transformation.
WHAT NEXT? *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*
The digital programme will continue to support and closely align with the Trust strategy.
Recommendation / action required
The report provides evidence and assurance that the digital programme is in line with Trust plans

Previously considered by:	n/a
Risk and assurance:	Risks are managed through the Pillar governance and through the Trust risk register
Equality, diversity and inclusion:	The Trust approach is considered to be “digital first but not digital only”

Sustainability:	
Legal and regulatory context:	

Digital Programme report

1.	**Introduction**
1.1	The digital programme supports the Trust in providing a wide range of technical infrastructure, clinical systems and digital solutions to support the transformation of the organisation
2.	**Background**
2.1	The digital programme consists of 5 main pillars of work: • Clinical systems – primarily e-Care, the main hospital patient record • Regional initiatives including population health management and the ICS shared care record • Community digital initiatives • Digital infrastructure and foundations • Optimisation
2.2	Additionally, the Future System Programme has a digital workstream which is considering and defining work requirements to support a smart hospital and outline that can be carried out in advance of the new hospital. This also includes initiatives to assess the digital capabilities and preparedness of both of staff and patient/carer communities. Several key digital staff are seconded to work on the FSP digital workstream.
2.3	Overall, resources to deliver the programme remain
3.	**Detailed sections and key issues**
3.1	**Clinical systems - Pillar 1** There are two major projects underway to replace and extend key functionality in the main patient record, e-Care. This is improved outpatient functionality together with moving critical care onto e-Care. It includes the implementation of integrated infusion pumps and associated Medicines drug catalogue build. It is planned for implementation in autumn 2024. The initial specialities have now started to use the e-Consent solution, Concentric, which enables patients to sign electronically to consent to surgical or medical procedures. This is a significant stepping stone in the transition to Shared Decision making. We are implementing a new self check-in kiosk solution to replace the in house developed system. The same solution has been used in the last 4 new hospital builds and so gives us the chance to get familiar with the technology long before the opening of the new hospital. It includes the ability to help direct patients to different waiting areas and give directions to the specific clinic area. We have introduced a new workflow for inviting patients to join a virtual outpatient appointment. It have shown to be very straightforward for patients to use and is full integrated into e-Care. We are also exploring the potential for use in community settings and teams. We have supported an upgrade to the mortuary system to move to a cloud based solution with enhanced user interface.

	We are working as part of the East Digital Imaging Network to implement an image sharing solution that will also be able to support reporting on images across the network wherever the radiologist reporting capacity is available.
3.2	**Regional initiatives - Pillar 2** WSFT operates the Health Information Exchange (HIE) on behalf of the ICS delivering a shared care record solution for staff to support direct care. It joins up clinical information from primary care, community, secondary care, mental health and social care. Likewise it connects to neighbouring shared care record systems to give seamless clinical information especially covering patients who may move between different ICS providers. The WSFT Population Health Management (PHM) solution aggregates and normalises data for seven data sources to create a longitudinal patient record and apply four population analytics packages to create intelligence to identify, predict, attribute, act and measure health outcomes. It is based on Cerner's Healthe Intent platform. Recent initiatives include a focus on Atrial Fibrillation where, using a risk stratification approach, it has been possible to identify patients who may be at increased risk of the condition and treatment started where appropriate. Use of the NHS App continues to grow across the region and the Trust has now delivered appointment details so that they are visible in the NHS App. Further use will be made of the app to deliver an increasingly wide range of information. The patient portal provides a wide range of clinical information to registered users and works in conjunction with the Dr Doctor platform to provide appointment letters electronically where applicable. This platform also provides appointment reminders and an increasing level of patient engagement initiatives.
3.3	**Community digital initiatives – Pillar 3** The WSFT digital team that support the Community teams have been focused on a whole series of optimisations to the SystmOne platform that support their clinical and administrative processes. It includes many new and additional data capture templates for a whole range of community teams and services as well as new community units, pathways and careplans. This has been enabled as a result of having a digital resource dedicated to WSFT community optimisation.
3.4	**Digital infrastructure – Pillar 4** Significant investment has been in the network infrastructure across the acute and community locations. On the main hospital site, work is underway to upgrade the Wifi access points to support the latest protocols and frequencies. This will initially be a like for like replacement followed by a survey to identify any dead spots that might have been introduced during the remedial building work. Further work is underway to introduce additional internet capacity and upgrade to the infrastructure that specially supports the staff and public facing WiFi service and internet connections. Work to ensure the Trust cyber security continues and a cyber hygiene report is presented at the quarterly Information Governance Steering group and covers the status of our server and workstation patching, CareCERT nationally reported critical patches, threat detections and volumes of e-mail and web site activities. It includes an additional solution that can monitor medical and other Internet of Things (IoT) devices that are connected to the Trust network. The Trust storage area network (SAN) is being upgraded to deliver greater resilience and capacity following the end of the previous managed service platform.

	A number of projects are exploring ways in which we can make better use of the range of Microsoft products and solutions that we have based on the current license position. The NHS has negotiated a continued preferential rate from Microsoft for the supply of many of their license specifically to the NHS. A number of audits and accreditations are currently in progress including the Data Protection Toolkit audit in conjunction with the Information Governance team, ISO 9001 and ISO 27001 accreditations and renewal of NHS secure e-mail status.
3.5	**Optimisation – Pillar 5** Same Day Emergency care activity must be recorded and reported nationally. Revisions to the processes and workflow are being built within the Emergency Department section of e-Care. Consideration of ways in which both results management and the discharge process could be improved and enhanced are underway. These are complex processes that cut across many teams and departments across the organisation. It also includes changes to systems to address clinical safety issues arising from the use of the digital solutions together with use of systems to help mitigate or avoid clinical incidents
3.6	**Other initiatives** The Cerner (now Oracle Health) contract for e-Care has been in place for 10 years in July 2024. Working closely with the contracting and procurement teams we are looking at ways of re-contracting with Cerner. It is planned to bring the proposal to the January board meeting for discussion and approval.
4.	**Next steps**
4.1	The digital programme will continue to support and closely align with the Trust strategy.
5.	**Conclusion**
5.1	The digital programme covers a wide range of projects and initiatives, and these are managed effectively through the pillar structure.
6.	**Recommendations**
	The report provides evidence and assurance that the digital programme is in line with Trust plans

Guidance notes

The practice of scrutiny and assurance

	Questions regarding quality of evidence…	Further consideration…
What? Deepening **understanding** of the evidence and ensuring its **validity**	**Validity** – the degree to which the evidence… • measures what it says it measures • comes from a reliable source with sound/proven methodology • adds to triangulated insight	• Good data without a strong narrative is unconvincing. • A strong narrative without good data is dangerous!
So what? Increasing **appreciation** of the **value** (importance and impact) – what this means for us	**Value** – the degree to which the evidence… • provides real intelligence and clarity to board understanding • provides insight that supports good quality decision making • supports effective assurance, provides strategic options and/or deeper awareness of culture	• What is most significant to explore further? • What will take us from good to great if we focus on it? • What are we curious about? • What needs sharpening that might be slipping?
What next? Exploring what should be **done next** (or not), informing **future** tactic / strategy, agreeing follow-up and future **evidence of impact**		• Recommendations for action • What impact are we intending to have and how will we know we've achieved it? • How will we hold ourselves accountable?

3. PEOPLE AND CULTURE

3.1. Involvement Committee report - Chair's Key Issues from the meeting

To Assure

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Involvement Committee			Date of meeting: 18th October 2023		
Chaired by: Tracy Dowling- Non executive Director			Lead Executive Director: Jeremy Over and Sue Wilkinson		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
1	Attendance / apologies: scope for improvement	3. Partial	Remind all members of importance of prioritising attendance	Review over next 6 months	1. No escalation
6.	Presentation from Chair and Director of Communications at Healthwatch Suffolk with a detailed discussion about how we develop our strategic partnership with them.	2. Reasonable	It was evident that Healthwatch Suffolk are a vital independent partner and they are able to represent the opinion and experience of patients and public in West Suffolk. We wish to develop this partnership to add depth to our understanding of patient experience of our services; and use this alongside our internal intelligence to support learning and improvement for patients and staff	Cassia Nice – Head of Patient Experience and Engagement agreed to lead work to develop the partnership and its value, specifically: 1. how we streamline our interactions with Healthwatch; 2. how we promote people using Healthwatch as an independent place to give feedback; 3. how we consider inequity in healthcare access, experience and outcomes with Healthwatch. To come back to Involvement Committee in 6 months time	1. No escalation

Originating Committee: Involvement Committee			Date of meeting: 18th October 2023		
Chaired by: Tracy Dowling- Non executive Director			Lead Executive Director: Jeremy Over and Sue Wilkinson		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
7.	Staff Psychology Support Service update received from Dr Emily Baker including what the service provides, how the service has developed, and future areas for development of the service to increase the value of the service to the Trust.	2. Reasonable	It was clear from the presentation that the demand for the service is high, and the service is increasingly able to demonstrate its value in quantifiable terms. The future developments, such as taking a trauma informed approach to critical incident debriefs – shows how this service is becoming more proactive. The Committee also supported the work of the service to make it more accessible to staff groups who are currently low level users (e.g male staff).	The Committee supported the approach of the service to maintain the boundaries of the support and treatment it provides; and where it needs to refer people to more appropriate services. The Committee supported the areas of service development. The Committee did consider the need to be able to quantify the value and justification for continuing the level of investment in this service at a time of financial deficit. However there was agreement that this service is making a significant difference to staff and therefore to service delivery and quality of care, but this needs to be clearly evidenced.	1. No escalation

Originating Committee: Involvement Committee			**Date of meeting: 18th October 2023**		
Chaired by: Tracy Dowling- Non executive Director			**Lead Executive Director: Jeremy Over and Sue Wilkinson**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 4. No escalation 5. To other assurance committee / SLT **6.** Escalate to Board
8.	Involvement Committee Development Workshop The write up of the workshop was agreed; with a couple of additions	2. Reasonable	The next steps in the development include: • Review Terms of Reference • 'Frame' our meetings with an introductory slide of values and behaviours • Change our use of time to have half the meeting devoted to strategic issues that are impacted by the experience of staff, patients and partners; with half our time for assurance • Empower and support those undertaking work on behalf of the Committee; including those who attend the Committee to present work • Identify areas of the organisation who need most support in their development	Review terms of reference before the next meeting in December Undertake the agreed next steps Review progress in 6 months	1. No escalation

Originating Committee: Involvement Committee			Date of meeting: 18th October 2023		
Chaired by: Tracy Dowling- Non executive Director			Lead Executive Director: Jeremy Over and Sue Wilkinson		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 4. No escalation 5. To other assurance committee / SLT **6.** Escalate to Board
9.	Board Assurance Framework Detail of risks reviewed	3. Partial	Consideration needs to be given to whether there are BAF level strategic risks in relation to patient experience	Board members agreed to consider this at the Board Development session on risk and the BAF in the calendar for 2nd November	3.Escalation to Board Development
9.	IQPR extract	2. Reasonable	Agreement that patient experience metrics in the IQPR are not comprehensive as only cover complaints	Further work on patient experience data and evidence; including but not restricted to complaints; for inclusion in IQPR	1. No escalation

**See guidance notes for more detail*

Guidance notes

The practice of scrutiny and assurance

	Questions regarding quality of evidence…	Further consideration…
What? Deepening **understanding** of the evidence and ensuring its **validity**	**Validity** – the degree to which the evidence… • measures what it says it measures • comes from a reliable source with sound/proven methodology • adds to triangulated insight	• Good data without a strong narrative is unconvincing. • A strong narrative without good data is dangerous!
So what? Increasing **appreciation** of the **value** (importance and impact) – what this means for us	**Value** – the degree to which the evidence… • provides real intelligence and clarity to board understanding • provides insight that supports good quality decision making • supports effective assurance, provides strategic options and/or deeper awareness of culture	• What is most significant to explore further? • What will take us from good to great if we focus on it? • What are we curious about? • What needs sharpening that might be slipping?
What next? Exploring what should be **done next** (or not), informing **future** tactic / strategy, agreeing follow-up and future **evidence of impact**		• Recommendations for action • What impact are we intending to have and how will we know we've achieved it? • How will we hold ourselves accountable?

Assurance level

1. Substantial	Taking account of the issues identified, the board can take substantial assurance that this issue/risk is being controlled effectively. There is substantial confidence that any improvement actions will be delivered.
2. Reasonable	Taking account of the issues identified, the board can take reasonable assurance that this issue/risk is being controlled effectively. Improvement action has been identified and there is reasonable confidence in delivery.
3. Partial	Taking account of the issues identified, the board can take partial assurance that this issue/risk is being controlled effectively. Further improvement action is needed to strengthen the control environment and/or further evidence to provide confidence in delivery.
4. Minimal	Taking account of the issues identified, the board can take minimal assurance that this issue/risk is being controlled effectively. Urgent action is needed to strengthen the control environment and ensure confidence in delivery.

3.2. People and OD Highlight Report

For Discussion

Presented by Jeremy Over

Board of Directors

Report title:	**People & OD highlight report**
Agenda item:	3.2
Date of the meeting:	Friday 02 December 2023
Sponsor/executive lead:	Jeremy Over, executive director of workforce & communications
Report prepared by:	Members of the workforce and communications directorate Freedom to Speak Up Guardian Guardian of Safe Working Hours

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

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

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

1.	Introduction
1.1	The People & OD highlight report is a regular report to help strengthen the Board's focus on how we support our people, grow our culture and develop leadership at all levels. This approach has been further augmented by the establishment of the Involvement Committee and this report now sits alongside the CKI report from that group to provide additional background and clarity. In addition to discussing the content of the report, and related issues, continued feedback is welcomed as to the structure and content of this report and how it might be developed in future. This month the report provides updates on the following areas of focus: • Putting You First awards (October/November) • Freedom to Speak Up Guardian Report Q2 2023/24 • Guardian of Safe Working Hours (junior doctors) – annual report • Staff engagement indicators • Friends of West Suffolk grant awards We routinely measure the impact of our approach through a set of workforce key performance indicators, which are included within the integrated performance report and also monitored through the Involvement Committee.
2.	**Putting You First Awards (October/November)**
2.1	**Kristy Finnigan, speech and language therapist, and Sarah Banfield, SLT apprentice** *Nominated by Liz Asti, professional lead, SLT* Sarah and Kristy delivered personalised training to a patient and their family and friends. The SLTA suggested they would be able to attend the home to support the patient's care team and visitors in considering strategies that would help more effective communication. The home worked with the family to ensure that as many of their regular visitors as possible were able to attend the session. Over 20 of the care team and visitors, including family were able to attend the session and the patient also attended and played a part in it, by being able to set out good ground rules for their visitors to make those visits as effective and enjoyable as possible. All involved have seen significant benefits of having this combined approach to the patient's care. The patient was completely overwhelmed to have so many of their visitors coming to support and be involved. What felt most positive about the event was that the patient was a fundamental part of it – it wasn't done behind their back, but with them directing what worked best for them. They were able to feed back to the family the following week that they felt it worked well and 'really appreciated' how a friend had then been able to follow what was discussed at the session to have a more productive visit where she came and read the Bury Free Press to the patient, which they both got a lot from.
2.2	**Amanda Coltman, hospice specialist nurse, St Nicholas Hospice community team** *Nominated by Hannah Messenger, community nurse team* I would like to nominate Amanda because she is compassionate and caring, and advocates for the needs of patients. She is a huge asset to her team and has broken down barriers between the district nurses and the hospice team. Amanda frequently goes above and beyond with her patients to ensure that they are comfortable and settled at the end of life. Amanda ensures the wellbeing of not only her patients, and the hospice team, but also the wellbeing of other community teams in challenging circumstances.
2.3	**Pippa Sharp, team manager for integrated neighbourhood teams, Mildenhall and Brandon** *Nominated by Karen Line, clinical lead, quality and safety, community and integrated therapies* Pippa showed great courage, skill and leadership when a very vulnerable person was referred to community nursing. The patient didn't meet the criteria for our services, however was very vulnerable as having (*detail redacted*). The circumstances of the patient immediately prior to the referral (*detail redacted*) meant that it was a very challenging situation for her and colleagues, involving the management of significant risk.

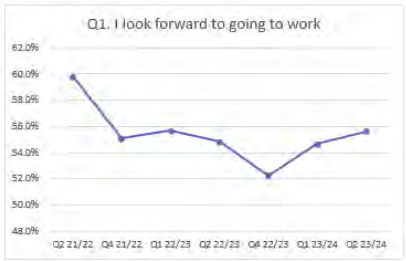
	Pippa involved a wide variety of professionals to improve the support to this person and visited them at home to ensure they had medications and could take them. Pippa went above and beyond to ensure this patient was as safe as possible until other professionals took on the responsibilities.
2.4	**Ceirdwen Fowles, public health coordinator** *Nominated by Apryl Almont, Datix admin assistant* Ceiridwen has made a huge difference and large improvement to the Disability Staff Network. Every single meeting she puts all her time and effort into making a change and making all staff feel included and their voices heard. If Ceiridwen says she will do something she will do it to 110% of her effort. I really cannot credit and praise her enough for how much her passion and drive is making a difference for staff and then in turn patient care.
3.	**Freedom to Speak Up Guardian report – Q2 2023/24**
	Jane Sharland, Freedom to Speak Up Guardian will present her Q2 report at the Board meeting on 02 December, which is included as appendix 1 to this item. The Board will wish to reflect carefully on the themes in the report that are particularly pertinent for our leadership role, that we have already identified as priorities for us. This includes relationships in the workplace and the impact that incivility can have on individuals and teams.
4.	**Guardian of Safe Working Hours annual report**
	Dr Francesca Crawley, Guardian of Safe Working Hours will present her annual report at the Board meeting on 02 December, which is included as appendix 2 to this item. Key issues for the Board to note include the assessment of the impact that industrial action has had on wellbeing and training opportunities, the need to reinforce the practice of exception reporting in two specific medical wards, and the positive overall conclusions for WSFT from the GMC survey of junior doctor experience.
5.	**Staff engagement indicators (quarterly staff survey and national staff survey response rate)**
	In addition to a full, annual survey of all staff working in the NHS in England, additional quarterly 'pulse' surveys are undertaken at three other points in the year. We have recently received the analysis for quarter 2, the fieldwork for which was undertaken in July. The quarterly survey provides an overall 'staff engagement' score, based on the average of three specific indicators: advocacy, involvement and motivation. Amongst acute and acute & community combined trusts in the east of England, WSFT had the best scores for involvement and motivation, and the second best for advocacy, leading to an overall engagement score of 7.01 / 10.00 – the highest in the region (range was 5.66 to 7.01).

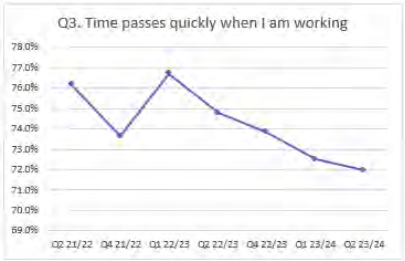
West Suffolk NHS Foundation Trust Rank: Acute & Community Trusts

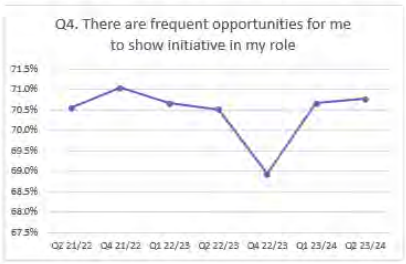
Engagement	Advocacy	Involvement	Motivation
1	2	1	1

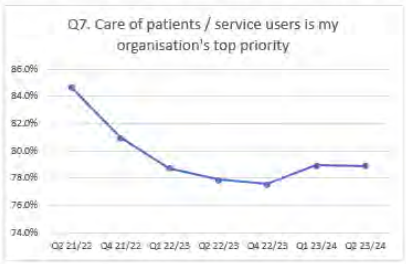
This is encouraging to read, however what matters most is our overall score rather than our position relevant to others. The score of 7.01 underlines the scope for further improvement and to that end there will be continued focus on delivery of our people and culture plan.

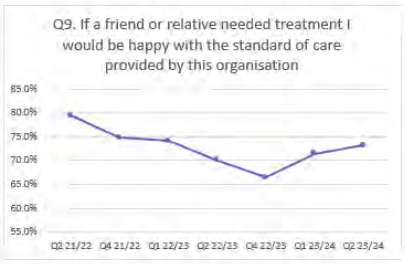
Each of the three domains of advocacy, involvement and motivation are informed by three separate questions. The following graphs highlight the nature of these questions and the WSFT trends over the last two years. For most (not all) of the nine questions, there has been an improvement in scores over the most recent two quarters. This follows a deterioration in staff survey scores (both here and nationally), in the immediate post-pandemic period.











At the time of writing, the fieldwork for the full annual staff survey is being completed. The latest information around response rate for WSFT is as follows: 45.5% response rate (national average 44.2%). This equates to just over 2,400 responses. We anticipate receiving the results from the survey in the first quarter of 2024.

6. Friends of West Suffolk Hospital – grant awards 2023

The Friends of West Suffolk Hospital (WSH) are a registered charity who have supported the work of WSFT over the last 30 years. As well as fundraising through subscriptions, donations and legacies, the Friends also run the hospital shop, the trolley service around the hospital, and more recently an online shop through which relatives can order gifts and goodies to be delivered directly to patients. The Friends also spend an annual sum of around £1000 on courtesy packs for patients having to stay the night unexpectedly (soap, toothpaste, comb etc.), as well as funding the purchase of Christmas trees for different locations throughout the hospital.

Over the last 8 years the Friends have donated over £940,000 to the hospital, providing grants that focus primarily on the enhancement of the patient experience. Previous awards have included a full treatment unit in the ENT room; a birthing unit; refurbishment of waiting areas; stroke rehabilitation equipment; garden equipment and shed for community outpatients; and new chairs for the outpatient waiting area.

In 2023 the Friends have made a further £100,000 available and a bid process was launched for projects in September. 50 bids were received totalling almost £310,000. At a recent Friends meeting, a number of projects have been awarded, with a few projects being explored further. Communications are now planned to notify successful and unsuccessful applicants.

The Trust is very grateful for the work that the Friends undertake, and the funding for projects across the hospital that support our patients, and often also our staff.

7. Recommendation

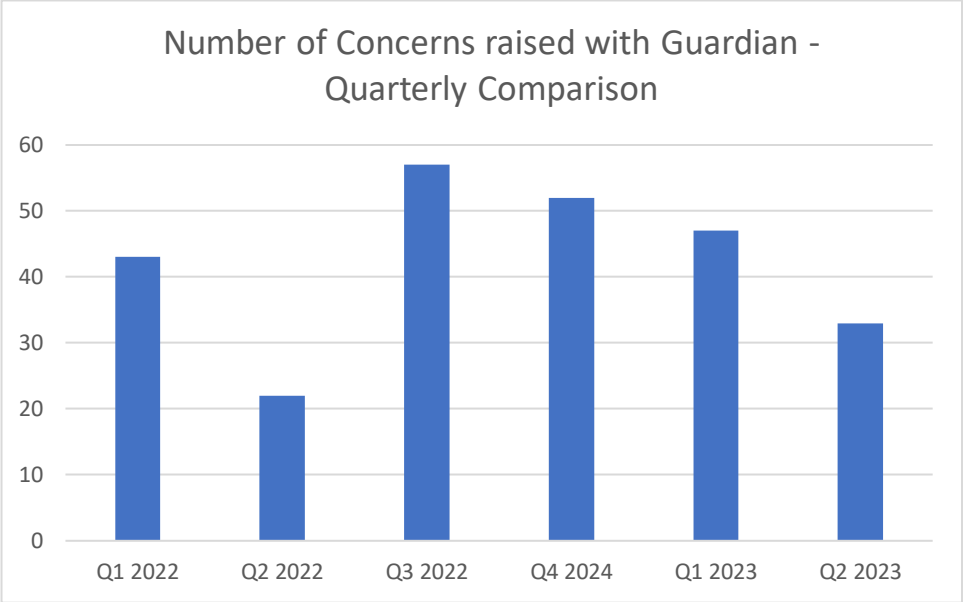
To note and provide comment and/or feedback on the report.

Appendix 1: Freedom to Speak Up: Guardian's Report Q2 (July-September) 2023-24

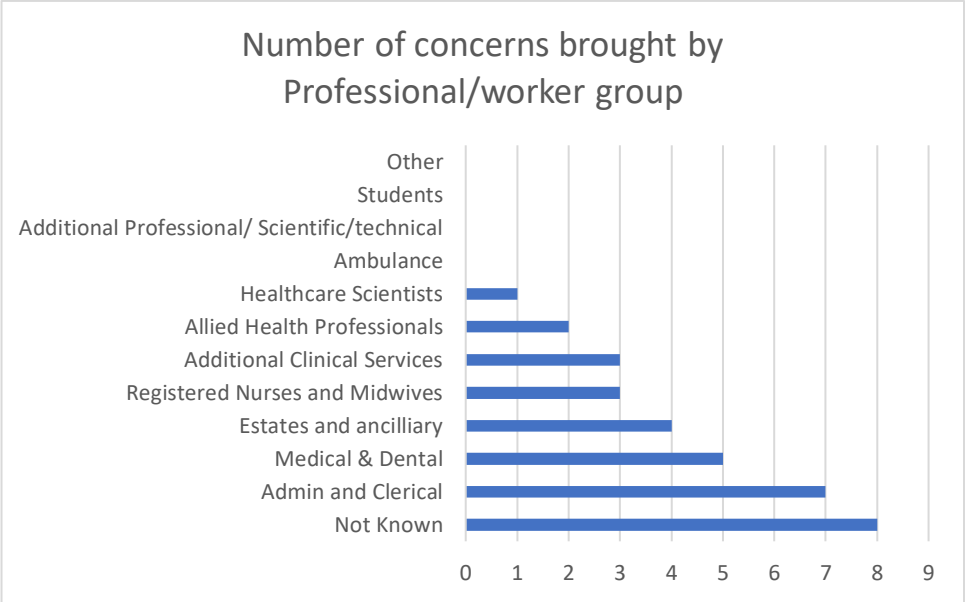
Introduction

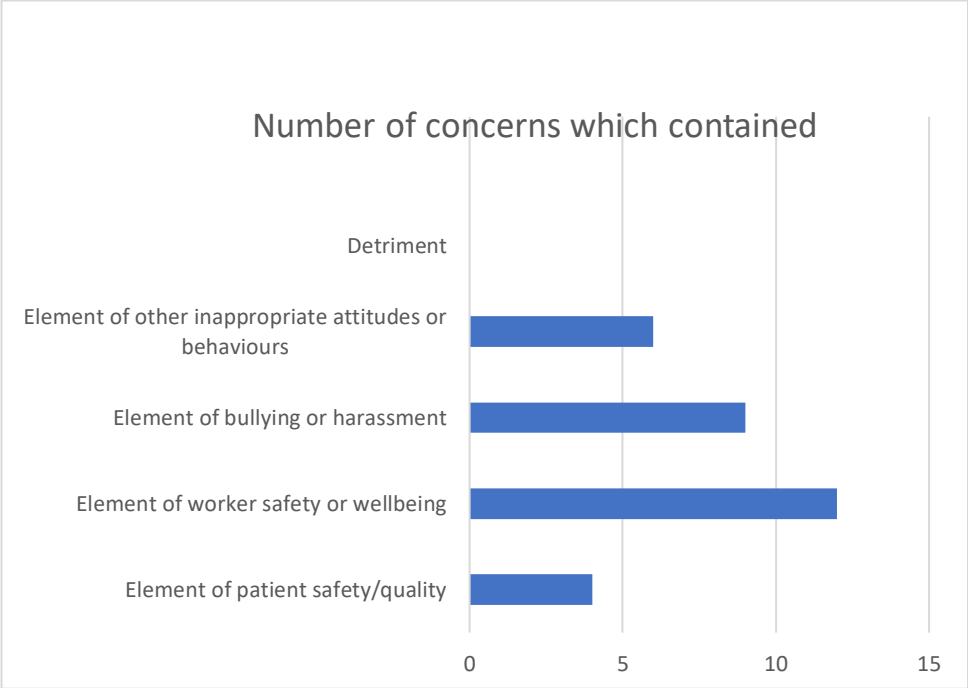
The previous Guardian left on 10th September 2023 and the new Guardian was appointed on 25th September 2023. There has been considerable communication to all staff, including via Green Sheet, Staff briefing and Intranet, around the change of Guardian, and telephone and mailbox contacts have remained the same, to allow as smooth a transition as possible.

The number of concerns raised with the Guardian has decreased from the previous quarter to 33; 8 of these were raised anonymously.



Data Sent to National Guardian's Office





What were people speaking up about?

Themes for Q2

An element of many concerns has been strained relationships between staff and incivility which have continued to be themes in this quarter.

- Dissatisfaction with management, with some staff feeling unable to raise issues with their own manager.
- Some staff reported feeling undervalued and not listened to.
- An instance of junior medical staff feeling not listened to by a senior staff member

Each concern is dealt with on an individual basis and raised with the appropriate senior leader**.** However, the Trust continues to address themes encountered by FTSU, and accepts the information gained as a gift to support future learning and development.

- The Learning and Development team have launched three leadership programmes, for all levels of leaders, which incorporate coaching and reflection to support managers to listen well and deal with uncivil behaviours. A fourth programme will be launching in 2024 along with a series of 'management essentials' bite-sized learning events which aim to tackle specific conversation and behavioural based development areas.
- Ongoing encouragement of the Freedom to Speak Up culture, and management training on how to receive a concern raised, including understanding the barriers to speaking up and the importance e of psychological safety.
- The Trust has enlisted support from the King's Fund to explore and support cultural improvement in emergency services.

Feedback on the Freedom to Speak Up Process

Following closure of each FTSU case, the person speaking up is sent an evaluation form to report their experience of the process. The figures below show a summary of evaluations received in Q3.

- 7 responses were received. Of these, 6 said they would speak up again, one said they may speak up again.

Free text comments and other feedback received verbally and via email was positive, with the theme of having the opportunity to talk through the concern without judgement had been helpful in itself.

"I was listened to and felt the matter was dealt with in a timely way."

Summary of learning points

A focus needs to be maintained on building and maintaining professional relationships and civility especially during very busy and pressured times.

Importance of listening to junior colleagues as lessons can be learnt from all colleagues.

The Guardian and FTSU champions are working to improve the culture of speaking up throughout the WSFT. Our actions are categorised under 8 key areas aligned with the National Guardian's Office guidance.

Our aim is that workers throughout the organisation have the capability, knowledge, and skills they need to speak up themselves and to support others to speak up.

What's going well:

- FTSU continues to be promoted throughout the Trust. Training sessions by FTSU Guardian for preceptorship, new starter welcome and student training programmes.
- 'Speak Up' and Listen Up' mandatory training is promoted and we have high numbers of staff completing this (82% and 90% respectively)

Plan:

- All staff to meet FTSU Guardian face to face at New Starter Welcome, beginning November 2023
- New FTSU champion to visit wards and departments including community site to further increase visibility and awareness of Speaking Up at WSFT

Speaking up policies and processes are effective and constantly improved

What's going well:

- New FTSU policy adopted and adapted to suit WSFT easily available online
- FTSUG working closely with NGO and local area FTSUG network to ensure adherence with national policies and processes.

Plan:

- New FTSU Guardian to undertake FTSU Reflection and Planning Tool to ensure ongoing adherence with National policies and processes.

Senior leaders are role models of effective speaking up

What's going well:

- FTSU non-executive director appointed.
- CEO supporting the role of FTSU Guardian and promoting Speaking Up culture in staff briefing and public comms.
- FTSU pledge established for board.

Plan:

- New FTSU Guardian to work closely with and have regular meetings with FTSU NED.

All workers are encouraged to speak up

What's going well:

- Speak Up month (October 2023) used as an opportunity to promote speaking up to all with weekly articles in the Green Sheet.
- Focus on inclusion and reaching those who may be less likely to speak up e.g., students
- Increasing number of concerns raised by champions supporting team members
- International nurses have strong representation on champion's network, and support via preceptorship programme
- Over 40 FTSU champions in place

Plan:

- Culture continues to improve to enable psychological safety in all teams. It is hoped this will be achieved through continued FTSU training and promotion, and work undertaken around values and behaviours
- Gap analysis to be undertaken by Guardian re distribution of champions throughout the Trust and to promote recruitment in areas as needed.
- FTSU Guardian to support champions by re-starting lunch and learn sessions, working with wellbeing champion lead to establish peer support sessions for champions, and put training in place for new champions, January 2024

Individuals are supported when they speak up

What's going well:

- Individuals are thanked for speaking up, and told that they are they are helping to identify areas of learning and improvement.
- Champions offer valuable support by listening to colleagues, especially during times of pressure
- Individuals report feeling listened to and supported by the Guardian when raising concerns, as evidenced from feedback survey.
- All leaders complete 'Listen Up' mandatory training
- Leadership programmes now in place which will support listening skills and promotion of Speaking Up culture as business as usual.

Plan:

- Increased promotion regarding Trust's stance on protecting staff who speak up and a zero-tolerance approach to detriment. Focus on psychological safety in welcome session.

Barriers to speaking up are identified and tackled

What's going well:

- Regular and ongoing face to face sessions for speak up training and opportunities to raise concerns for porters.
- Inclusion training session offered for FTSU champions.

Plan:

- FTSU champion to work closely with newly appointed EDI lead to ensure barriers to speaking up are identified and overcome.
- FTSU guardian face to face sessions with students and new starters
- FTSU Guardian to cover regular Out of Hours shifts to ensure equal visibility to OOH staff.

Information provided by speaking up is used to learn and improve

What's going well:

- Where possible and obvious, swift action is taken to address concerns, to learn and improve.
- Concerns have been shared with Future System team to enable improvements at new site, for example to ensure there are appropriate private rooms available for private conversations and quiet spaces for wellbeing.
- Regular meetings set up to share and explore themes identified with patient safety team and PALS to support organisational learning.

Plan:

- Continue to work closely with HRBP, department leads and executive to ensure concerns are shared and used for learning and improvement

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

What's going well:

- Guardian attending community of practice events for East of England FTSU Guardian Network
- Trust working in line with NHS and NGO guidance on speaking up

Plan:

- Work with ICS partners to improve FTSU
- As a culture of Speaking Up grows within the Trust, with staff feeling psychologically safe to raise concerns, and leaders accepting the information brought to them as a gift to allow learning and improvement, more concerns may be raised without the involvement of the FTSU Guardian.
- To gather data via staff survey to capture speaking up which is dealt with successfully through other channels.

Jane Sharland
Freedom to Speak Up Guardian

Appendix 2: Annual Guardian of Safe Working Hours report

This report covers the twelve month period (1st August 2022 – 31st July 2023 inclusive). During that time there have been periodic (4 monthly) reports from which this summary is drawn.

Introduction

This is the seventh annual report produced since the introduction of the 2016 Terms and Conditions of Service (TCS) for Doctor and Dentists in Training by NHS Employers. Full details of this contract are to be found here: http://www.nhsemployers.org/your-workforce/need-to-know/junior-doctors-2016-contract

The report is compiled by the Guardian of Safe Working Hours (GOSW), a role appointed as part of the new contract. The purpose of the report is to provide evidence of safe rostering and compliance with the TCS, to highlight any difficulties which have arisen, and to explain how they are being addressed. A system of Exception Reporting is in place, which replaced monitoring of working hours.

The report is also informed by the monthly Junior Doctors' Forum. This meeting is held in two parts: The first is an open (unminuted) forum for all junior doctors; the second is chaired by the GOSW and includes Junior Doctor representatives, including the mess president, and BMA representatives, and also the Director of Education, the Foundation Programme Director, Medical Staff Manager, rota co-ordinators, and BMA advisors. This meeting is minuted.

All trainees taking up appointments are on the new contract. It should be noted that a further 63 doctors are currently working in Trust grade positions are on contracts that mirror the new contract due to filling either Trust posts, or vacant training posts. They also have the ability to exception report to ensure that all issues within departments are highlighted.

Summary data

Number of doctors / dentists in training (total):	148
Number of doctors / dentists in training on 2016 TCS (total):	148(includes p/t trainees)
Amount of time available in job plan for guardian to do the role:	1 PAs / 4 hours per week
Admin support provided to the guardian (if any):	0.5WTE
Amount of job-planned time for educational supervisors:	0.125 PAs per trainee[1]
Amount of job-planned time for Clinical Supervisors:	0, included in 1.5 SPA time[1]

Exception Reporting

A process is in place on Allocate for the Junior Doctors to fill in an exception report (ER). Doctors are expected to discuss any ER's logged with either their clinical or educational supervisor. Details of the exception report are sent to the Guardian and Clinical /Educational Supervisor.

EXCEPTION REPORTS BY DEPARTMENT (August 2022 – July 2023)			
Period (inclusive) **Specialty**	August 2022 – November 2022	December 2022 – March 2023	April 2023 – July 2023
Surgery	47	20	25
Medicine	219	147	99
Woman & Children	3	5	2
TOTAL	**269**	**172**	**126**

Exception Reporting: accuracy

It is clear that not all doctors' exception report.

Patterns of Exception Reporting

Various reasons for exception reporting are detailed using the Allocate system and these are generally about workload or particularly sick patients. There are some ER around missed educational opportunities, normally due to the ward being too busy for the doctor to attend local teaching and a few around lack of support (mainly out of hours).

Work Schedule Reviews.

There have been no formal Work Schedule Reviews reported as difficulties have been handled promptly by service managers.

Fines

Total breach fines paid by the Trust from August 2017 to date are £13,137.75 and the Guardian Fund currently stands at £3708.84.

Vacancies by quarters:

VACANCIES BY QUARTERS – AUGST 2022 – JULY 2023					
Department	**Grade**	August – November 2022	December 2022 – March 2023	April – July 2023	Average gaps
Emergency	SpR	2.5	3	4.75	3.4
General Surgery	SpR		0.1	0.25	0.1
Anaesthetics	SpR/SAS	3	3.5	2	2.8
	IMT / ACCS 1			1.25	0.4
	CT1	1			0.3
Medicine	F1			0.2	0.06
	F2/GP/IMT1-2		1	0.2	0.4
	IMT/SpR	1.75	2.25	0.65	1.55
Obs & Gynae	F2	0.55			0.18
	ST1		0.6		0.2
	ST3+		0.2	0.2	0.13
T&O	ST3+			0.2	0.06
Paediatrics	F2/GP/ST1-2	0.25	0.1		0.1
	ST3+			0.2	0.06
Opthalmology	Specialty Doctor			1	0.33
Total		9.05	10.75	10.9	10.23

Key issues from host organisations and actions taken

2023 has been dominated by industrial action (IA). This has impacted on wellbeing and on training opportunities. The morale of junior doctors is low and, at the time of this report, the DHSC and BMA do not seem to be close to a resolution. Many doctors are already burnout post pandemic and the IA is perpetuating this.

There remain issues with exception reporting from two medical wards. This has been escalated to the clinical director for medicine, the Trust Negotiating Committee, and the Medical Director. Sarah Watson, senior manager for medicine, is working with the transformation team to unpick and resolve this as currently doctors on these two wards are stressed and feel relatively unsupported. Unfortunately, the IA has impacted on this project.

On a positive note, in 2023 West Suffolk FT received the best feedback via the GMC survey of all acute trusts in the East of England. This reflects many teams- including the smooth onboarding from medical staffing, supportive junior doctor WhatsApp group, rotas being issued on time, provision of a mess and food out of hours, the medical education team, the support of the service managers who attend the GOSW meeting and try to resolve juniors concerns and the largely excellent support for training from the consultant body and wider workforce.

Summary

This year has been dominated by IA and with the prospect for resolution looking unlikely, this is likely to impact 2024.

Finally, I would again like to thank Helen Kroon as medical staffing manager who has provided considerable support (much of it out of hours) for all juniors via the WhatsApp group and personal conversations throughout this year. Many of them have commented how helpful this has been.

Dr Francesa Crawley
Guardian of Safe Working Hours

COMFORT BREAK

4. ASSURANCE

4.1. Insight Committee Report - Chair's Key Issues from the meeting

To Assure

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Insight Committee			**Date of meeting: 20 September 2023**		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Craig Black**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
Outpatients deep dive	The Committee had a presentation on Outpatients transformation work programme. Improved outpatient performance is key to elective recovery trajectories.	**2 Reasonable**	The work programme includes activity at all stages of a patient's journey from pre-referral to follow up and reporting outcomes. It encompasses technological enhancements and changes to culture and practice with a move to a system of Patient Initiated Follow up.	There is a detailed work plan for the programme. Outcome indicators to be developed to measure success – desired outcomes would be a better experience for patients, and more efficient and cost effective services which also provide a better working environment for staff.	3 Escalate positive progress to Board

Originating Committee: Insight Committee			Date of meeting: 20 September 2023		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Craig Black**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data** **Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal		**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
Patient Access Governance Group /IQPR data	**Elective Recovery** WSFT remains in Tier 2 for elective performance. the specialities most at risk in terms of achieving 65 weeks remain Urogynae and Dermatology	3.Partial	The wait time for a first routine appointment in dermatology is 52+ weeks. Theatre staffing and bed constraints due to an increase in emergency demand have contributed to an increase in cancellations and this could impact on delivery of the 65 weeks trajectory if it continues. Not achieving activity level targets may impact future achievement of the Elective Recovery Fund activity thresholds.	There is a focus on clearing first outpatient waits by the end of October 2023, in line with NHSE ambitions. A paper being prepared for Executives on insourcing for Dermatology.	3 Escalate to Board
	Cancer standards These are currently out of line with trajectories for both 62-day backlog and the Faster Diagnosis Standard (FDS),.	**3 Partial**	Breast FDS performance significantly reduced due to unforeseen absences within the radiologist workforce. As breast is a high-volume pathway any change in performance here will have a noticeable impact on overall FDS compliance. The	A revised trajectory for breast has been produced based on additional sessions in September and October to reset waiting times for breast one-stop clinics to below 28 days. Longer term plans are in discussion for doubling up clinics when possible.	3 Escalate to Board

Originating Committee: Insight Committee			Date of meeting: 20 September 2023		
Chaired by: Antoinette Jackson			Lead Executive Director: Nicola Cottington/Craig Black		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
			service is not resilient to changes in demand. The 62-day backlog is highest for skin cancers. Many of which have been treated but are awaiting post-operative histopathology to close the pathway record. A number of non-cancers in all tumour sites are awaiting formal clinical decisions to close pathways and record FDS end dates.	Implementation of head and neck one stop clinic to commence 6th October. Implementation of new gynaecology pathway to commence 9th October. Nurse led prostate biopsy project to recommence in September.	
	Diagnostic performance Performance is in line with trajectories, with a continued the continued risk around MRI performance. Ultrasound is beginning to show some concern within some sub-specialities where there has been an impact due to industrial action.	**3 Partial**	MRI is running at full capacity across the seven days but current capacity insufficient.	MRI mutual aid options within the ICB being explored. Plan to up skill Sonographers from the main department to be trained in Musculoskeletal procedures which will help with capacity, reducing waiting times and agency spend.	3 Escalate to Board

Originating Committee: Insight Committee			Date of meeting: 20 September 2023		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Craig Black**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
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	Urgent and Emergency Care. Performance is still above trajectory but there is concern that the service is very fragile 12-hour length of stay is over the 2% threshold, mostly due to bed delays.	**3 Partial**	There has been a sustained reduction in numbers of patients not meeting the Criteria to Reside in the acute hospital, which will have a positive impact on patient flow. Bed occupancy will need to reduce towards or below 92% to ensure patient flow is effective and patients are not left waiting for admission.	UEC recovery plan continues to be developed . The Focus on Flow programme has been revised in order to focus on actions that will demonstrably increase flow and reduce bed occupancy.	3 Escalate to Board
Finance - Month 6	Finance – Month 6 The reported I&E for September is an adverse variance of £0.9m to budget	**3 Partial**	The September actuals (£0.6m deficit) reported an improvement against the M1-5 trend (£1.1m deficit per month) The YTD position reports an adverse variance of £4.2m which is largely due to: Underachieved CIP £2.8m Unfunded industrial action £0.9m	Although the position is in line with the recovery plan trajectory this represents a challenge for 24/25. CIP performance will continue to be a focus as will the planning process for 24/25.	3 Escalate to Board

Guidance notes

The practice of scrutiny and assurance

	Questions regarding quality of evidence…	Further consideration…
What? Deepening **understanding** of the evidence and ensuring its **validity**	**Validity** – the degree to which the evidence… • measures what it says it measures • comes from a reliable source with sound/proven methodology • adds to triangulated insight	• Good data without a strong narrative is unconvincing. • A strong narrative without good data is dangerous!
So what? Increasing **appreciation** of the **value** (importance and impact) – what this means for us	**Value** – the degree to which the evidence… • provides real intelligence and clarity to board understanding • provides insight that supports good quality decision making • supports effective assurance, provides strategic options and/or deeper awareness of culture	• What is most significant to explore further? • What will take us from good to great if we focus on it? • What are we curious about? • What needs sharpening that might be slipping?
What next? Exploring what should be **done next** (or not), informing **future** tactic / strategy, agreeing follow-up and future **evidence of impact**		• Recommendations for action • What impact are we intending to have and how will we know we've achieved it? • How will we hold ourselves accountable?

Assurance level

1. Substantial	Taking account of the issues identified, the board can take substantial assurance that this issue/risk is being controlled effectively. There is substantial confidence that any improvement actions will be delivered.
2. Reasonable	Taking account of the issues identified, the board can take reasonable assurance that this issue/risk is being controlled effectively. Improvement action has been identified and there is reasonable confidence in delivery.
3. Partial	Taking account of the issues identified, the board can take partial assurance that this issue/risk is being controlled effectively. Further improvement action is needed to strengthen the control environment and/or further evidence to provide confidence in delivery.
4. Minimal	Taking account of the issues identified, the board can take minimal assurance that this issue/risk is being controlled effectively. Urgent action is needed to strengthen the control environment and ensure confidence in delivery.

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Insight Committee			**Date of meeting: 15 November 2023**		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Craig Black**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:** **SO WHAT?** *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
Community Paediatrics deep dive	The Committee had a presentation on the work being undertaken in community paediatrics by the Children's Community medical team to improve performance. This is a Suffolk wide service.	**2 Reasonable**	The presentation included detailed analysis of the demands on the service and the clinical hours available to address that demand. Demand has risen significantly and the Referral to Treatment target of 18 weeks is not being met. Before Covid 75% met target but this is now only 25%. There is a growing backlog of c.1220 in the NNDP (neurodevelopmental disorder pathway) which is a multi-agency pathway, co-ordinated by a different organisation. There are system wide issues that need addressing to tackle the root cause of referrals and seasonal spikes and there is an underlying deficit in clinical hours.	There is a detailed work plan for the service which includes: Learning from other services elsewhere about approaches to service specifications and stratifying demand. Stopping non-essential work to free up clinical hours. Discussing system issues within the ICB Considering bids for more resources.	3 Escalate to Board

Originating Committee: Insight Committee			Date of meeting: 15 November 2023		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Craig Black**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
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Finance Accountability Committee	**Financial Recovery Plan and CIP programme** The Committee were advised that the Capital and CIP programme were both on track. The FRP was broadly on track overall aided by funding received of £3.2m for costs of Industrial action and estimated £1.9m for ERF. A bid had been made for cashflow support but the Trust received £3.3m less than asked for. For 24/25 the Trust was assuming a deficit of £30m (£22.9m if you assumed a CIP programme delivered 2.5%)	**2. Reasonable**	Performance is in line with trajectory which is promising. This is in line with the £5m assumed in the Financial Recovery Plan We will need to make a further bid for more cash support Before Christmas. This remains a challenging target	The FRP will continue to be monitored. The board will have an update at its December meeting See below on business planning process	1. No escalation

Originating Committee: Insight Committee			Date of meeting: 15 November 2023		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Craig Black**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
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Business Planning process	The Committee were updated on the proposed business planning process for 24/25 and the links to the budget setting process.	3 Partial	The budget planning process included detailed guidance for budget holders and a detailed timetable. The Committee noted that the Board were due to see the outcomes of this quite late in the process.	Give the scale of the gap to be addressed in 24/25 the committee agreed there needs to be early discussion at Board about the priorities and policy choices and the planned speed of tackling the deficit given the underlying pressures. This needs to be linked to the corporate business planning process but can't wait until the outcome of this.	3 Escalate to Board
Patient Access Governance Group /IQPR data	**Cancer standards** Good performance continues against the 62-day and 31-day standards, delivery of the 28-day Faster Diagnosis Standard in breast and dermatology remains challenging. The challenging Faster diagnosis standards are attributed to staffing shortfalls	2 Reasonable	For patients, longer waiting times can lead to poorer outcomes, potential physical and psychological harm, worsened experience and possible increased demands on primary and urgent/emergency care as patients seek alternative help in manging their condition.	The uro-gynae insourcing project should commence in November and approval has been sought for a similar approach for dermatology, which should see the 65ww trajectory over-achieved. Additional breast cancer one-stop clinics have been running throughout September and	1 no Escalation

Originating Committee: Insight Committee			Date of meeting: 15 November 2023		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Craig Black**		
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	Progress continues in delivering the trajectory for reducing elective patients over 65 weeks.		Continuing to meet this trajectory is dependent on insourcing solutions for uro-gynaecology and dermatology being deployed	October which should see performance against the FDS return to previous levels. With the skin cancer pathway also 'catching up' with referrals, FDS performance should return to 70%.	
	Diagnostics CT and echocardiography continue to deliver good performance against the DM01 6-week standard, with MRI and endoscopy recovering ahead of trajectory	**2 Reasonable**			1 no Escalation
	Urgent and Emergency Care Delivery of the 4-hour standard is slipping below trajectory and plateauing. 12% of patients have a length of stay over 12 hours in	**3 Partial**	Impact on patient care and operational plan targets	Process efficiencies from the UEC Phase 2 recovery plan, Focus on Flow (winter planning) and social care/better care discharge funding workstreams must be delivered to reduce bed occupancy and ensure that	1 no Escalation

Originating Committee: Insight Committee			Date of meeting: 15 November 2023		
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	the Emergency Department against a target of less than 2% A recent audit of community beds at Newmarket Community Hospital showed 50% of admissions taking place outside core hours, and it is important to maintain safety across acute and community services		High bed occupancy impacts on patient flow.	performance against the 4-hour, 12-hour and 30-minute ambulance handover UEC access standards can be delivered alongside optimal quality care.	
	Inequalities data Data on elective waiting list times split by ethnicity and deprivation quintile has been reviewed. No statistically significantly increased waiting times were seen between ethnicities and no statistically significantly different waiting times are seen between deprivation quintiles.	**1 Substantial**	It is important to review health inequalities data to ensure that disparities in access are not introduced as a result of how services are run. Equally, should any inequalities be observed it is important that actions are undertaken to ensure equity of access across a population.	The data will be kept under review by PAGG	1. No Escalation

Guidance notes

The practice of scrutiny and assurance

	Questions regarding quality of evidence…	Further consideration…
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What next? Exploring what should be **done next** (or not), informing **future** tactic / strategy, agreeing follow-up and future **evidence of impact**		• Recommendations for action • What impact are we intending to have and how will we know we've achieved it? • How will we hold ourselves accountable?

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4.2. Finance Report

To Assure

Presented by Craig Black

Board of Directors	
Report title:	Finance Board Report – October 2023
Agenda item:	4.2
Date of the meeting:	1st December 2023
Lead:	Craig Black, Executive Director of Resources
Report prepared by:	Nick Macdonald, Deputy Director of Finance

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

Executive Summary

WHAT?
Summary of issue, including evaluation of the validity the data/information

Income and Expenditure and forecast for 2023-24

The revised forecast deficit of £6.7m was agreed by the Board in September 2023. This included funding in relation Industrial Action via the Elective Recovery Fund. Early in November additional funding has been announced to support costs relating to Industrial Action, but with an expectation that we are able to improve our deficit to £6.27m. Therefore, our forecast now reflects this.

The reported I&E for October is a deficit of £0.7m with an adverse variance of £0.6m. The YTD position reports a deficit of £6.8m against a planned deficit of £2.0m (an adverse variance of £4.8m). However, this does not include the recently announced funding in relation to our costs of Industrial Action (£3.7m)

Whilst we are awaiting national guidance for 24-25 planning, our first draft plan for 24-25 suggests we would plan for a deficit of £22.9m (after delivering £10m CIP). This is subject to assumptions made and planning guidance.

Cash

The 23-24 deficit has impacted on our cash position which resulted in an application for revenue support of £10m. This was not fully funded and as a result we require further cash support and the Board is asked to approve the Trust applying for £6m in revenue support from DHSC.

SO WHAT?
Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk

As a result of our financial performance the ICS have developed plans to compensate for the WSFT position by slipping investments elsewhere within the ICS

WHAT NEXT?
Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)

Continue to monitor financial performance through Insight and the Board and take corrective action where necessary

Recommendation / action required
Review and approve this report Approve application for a further £6m of revenue support

Previously considered by:	Parts of this report were discussed at November Insight Committee
Risk and assurance:	Financial risk
Equality, diversity and inclusion:	n'a
Sustainability:	Financial sustainability
Legal and regulatory context:	Financial reporting

Guidance notes

The practice of scrutiny and assurance

	Questions regarding quality of evidence…	Further consideration…
What? Deepening **understanding** of the evidence and ensuring its **validity**	**Validity** – the degree to which the evidence… • measures what it says it measures • comes from a reliable source with sound/proven methodology • adds to triangulated insight	• Good data without a strong narrative is unconvincing. • A strong narrative without good data is dangerous!
So what? Increasing **appreciation** of the **value** (importance and impact) – what this means for us	**Value** – the degree to which the evidence… • provides real intelligence and clarity to board understanding • provides insight that supports good quality decision making • supports effective assurance, provides strategic options and/or deeper awareness of culture	• What is most significant to explore further? • What will take us from good to great if we focus on it? • What are we curious about? • What needs sharpening that might be slipping?
What next? Exploring what should be **done next** (or not), informing **future** tactic / strategy, agreeing follow-up and future **evidence of impact**		• Recommendations for action • What impact are we intending to have and how will we know we've achieved it? • How will we hold ourselves accountable?

FINANCE REPORT
October 2023 (Month 7)

Executive Sponsor: Craig Black, Director of Resources
Author: Nick Macdonald, Deputy Director of Finance

Executive Summary

This report focusses on the YTD adverse variance and the actions required in order to meet our revised planned deficit (£6.7m) by 31st March 2024, as well as improve our trajectory for 24-25 when we will no longer benefit from non-recurring support (£15m).

- The revised forecast deficit of £6.7m was agreed by the Board in September 2023. However, early in November additional funding has been announced to support costs relating to industrial action, but with an expectation that we are able to improve our deficit to £6.27m. Therefore, our forecast now reflects this.
- This revised forecast is contingent on:
  - Funding associated with Industrial Action - £3.7m
  - ERF related income - £1.7m
  - Delivering CIP - £5m
  - Improving our run rate - £3.4m
- This forecast includes the benefits resulting from £15m of non-recurring support.
- The reported I&E for October is a deficit of £0.7m with an adverse variance of £0.6m
- The YTD position reports an adverse variance of £4.8m which is largely due to:
  - Underachieved CIP £2.8m
  - Unfunded costs relating to industrial action £2.0m
- **The Board is asked to approve the Trust applying for £6m in revenue support from DHSC.**

Key Risks in 2023-24

- Delivering challenging CIP
- Delivering improvement in run-rate
- Depreciation funding
- Unanticipated costs of further industrial action (if unfunded).

Financial Summary

SUMMARY INCOME AND EXPENDITURE ACCOUNT - October 2023	October 2023			Year to date			Year end forecast		
	Budget	Actual	Variance F/(A)	Budget	Actual	Variance F/(A)	Budget	Actual	Variance F/(A)
	£m	£m	£m	£m	£m	£m	£m	£m	£m
NHS Contract Income	27.9	27.9	0.0	196.7	198.6	1.9	336.7	339.7	3.0
Other Income	5.4	4.5	(0.9)	24.6	24.4	(0.2)	40.1	47.0	6.9
Total Income	**33.3**	**32.4**	**(0.9)**	**221.3**	**223.0**	**1.7**	**376.8**	**386.7**	**9.9**
Pay Costs	21.5	22.1	(0.6)	150.4	153.0	(2.6)	256.9	258.6	(1.7)
Non-pay Costs	10.5	9.6	0.9	61.6	65.7	(4.1)	103.2	114.1	(10.9)
Operating Expenditure	**32.0**	**31.7**	**0.3**	**212.0**	**218.7**	**(6.7)**	**360.0**	**372.7**	**12.7**
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
EBITDA	**1.3**	**0.7**	**(0.6)**	**9.3**	**4.3**	**(5.0)**	**16.7**	**14.0**	**(2.8)**
Depreciation	1.0	0.9	0.2	7.5	7.4	0.2	12.9	13.8	0.9
Finance costs	0.4	0.5	(0.2)	3.8	3.7	0.1	6.5	6.5	0.0
SURPLUS/(DEFICIT)	**(0.1)**	**(0.7)**	**(0.6)**	**(2.0)**	**(6.8)**	**(4.8)**	**(2.7)**	**(6.3)**	**(3.7)**

I&E Position YTD	**£6.8m**	**adverse**
Variance against Plan YTD	**£4.8m**	**adverse**
Movement in month against plan	**£0.6m**	**adverse**
EBITDA position YTD	**£4.3m**	**favourable**
EBITDA margin YTD	**2%**	**favourable**
Cash at bank	**£14.3m**	

Contents:

Key:

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

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

FINANCE REPORT – October 2023

Income and Expenditure Summary - October 2023

Summary of I&E indicators

Income and Expenditure	Original Plan/ Target £000'	Actual/ Forecast £000'	Variance to plan (adv)/ fav £000'	Direction of travel (variance)	RAG (report on red)
In month surplus/ (deficit)	(143)	(710)	(567)	↑	Amber
YTD surplus/ (deficit)	(1,994)	(6,794)	(4,800)	↓	Red
EBITDA YTD	9,297	4,251	(5,046)	↓	Red
EBITDA %	4.2%	1.9%	(2.3%)	↓	Red
Clinical Income YTD	(198,937)	(202,033)	3,096	↑	Green
Non-Clinical Income YTD	(20,242)	(20,944)	702	↓	Green
Pay YTD	150,388	153,004	(2,616)	↑	Red
Non-Pay YTD	72,804	76,774	(3,970)	↑	Red
CIP Target YTD	5,516	2,732	(2,784)	↑	Red

Income and Expenditure Plan for 2023-24

The Income and Expenditure (I&E) budget is for the Trust to record a deficit of £2.7m in 2023-24, which includes achieving Cost Improvements (CIP) of 3% (£10.6m).

Our reported position as at the end of October was a deficit of £6.8m against a planned deficit of £2.0m. This has resulted in an adverse variance of £4.8m. The most significant causes of this adverse variance are:

- Underachieved CIP £2.8m
- Unfunded costs relating to industrial action £2.0m

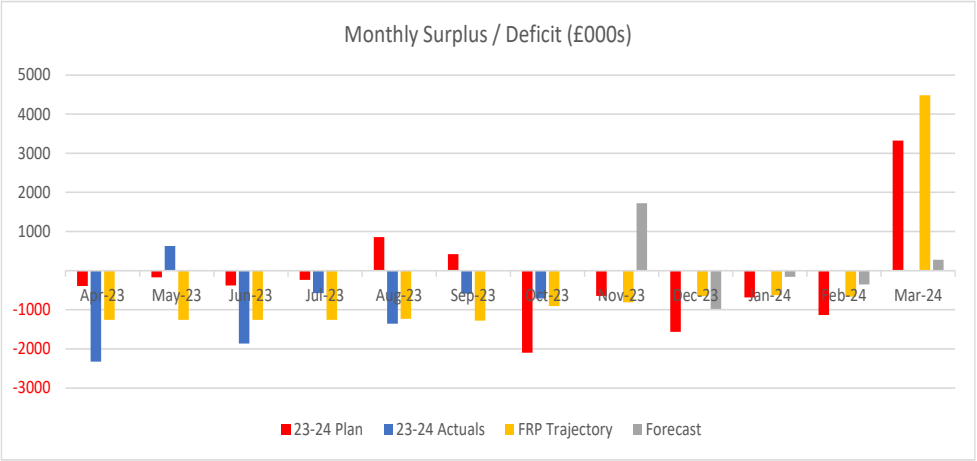
The October position reported an improvement against the M1-6 trend.

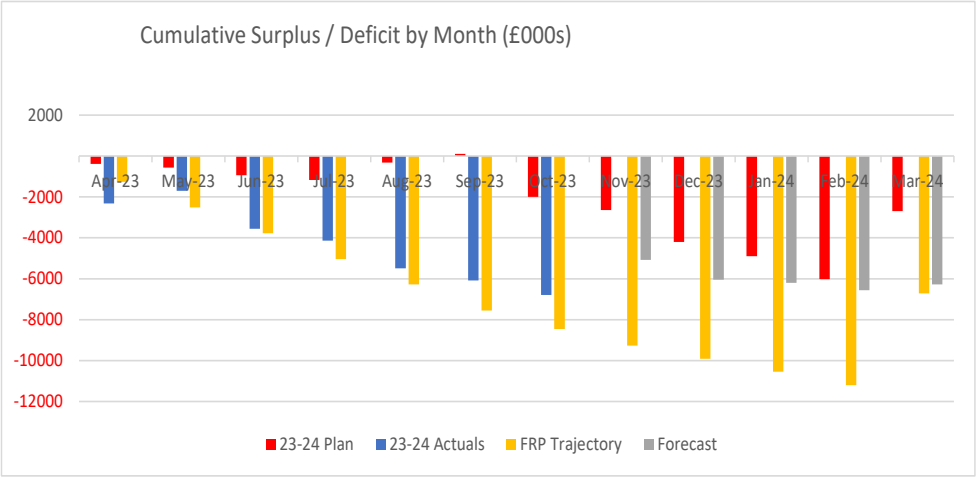
Forecast 2023-24

The M7 position does not include the £3.7m support for our costs in relation to Industrial Action (announced at the beginning of November) which would have improved our deficit to £3.1m. This funding will be included within the M8 position rather than in M12 (as can be seen in the charts below).

Whilst this funding requires us to improve our forecast to £6.3m deficit a straight line forecast based on the adjusted M7 position would align with this forecast (after including seasonal costs during the winter).

Therefore, our forecast trajectory for the remainder of 2023-24 is as below





Financial Planning and Budget Setting for 2024-25

Depending on the extent to which we improve our trajectory in 2023-24, the deficit for 2024-25 is currently forecast to be £22.9m after delivering a Cost Improvement Programme of £10m (2.5%), subject to assumptions made and planning guidance. This is largely as a result of losing £15m of non-recurring support, shortfalls in external funding and any shortfall in recurrent CIPs which are included within the 2023-24 plan and forecasts.

FINANCE REPORT – October 2023

Cost Improvement Programme (CIP)

A summary of progress on the CIP plan is included below (£5m), as well as our planned run rate improvements (£3.4m). This £8.4m improvement was approved as part of our Finance Recovery Plan (FRP).

CIP Achievement

As at the end of October WSFT had achieved £2.7m CIP towards the £5m CIP target included within the FRP. There are plans with a value of £8.2m which are forecast to achieve a minimum of £6.3m by March 2024 (table 1).

Run -Rate

Note that the CIP table does not include savings identified through run-rate savings. The FRP includes £3.4m of run-rate improvements, and we have identified £2.3m broken down between:

- Workforce Resource Group (inc Nurse Deployment Group) - £1,550k
- Procurement, Pharmacy and Discretionary Spend - £750k

We therefore have plans in place that total £10.5m against the target of £8.4m. We forecast to deliver a minimum of £6.3m from CIP and together with the forecast run rate reductions we expect to achieve the £8.4m target in line with the FRP.

Table 1 – CIP achievement to date, with current forecast

	Target vs Plan			YTD Target vs YTD Actuals			Target vs Actuals + Forecast		
Division	Annual Target (£k)	Plan In-Year 2023/24 (£k)	Variance (£k)	Target YTD (£k)	Actuals YTD (£k)	Variance (£k)	Annual Target (£k)	Actuals & Forecast In-year 2023/24 (£k)	Variance (£k)
Medicine	2,610	1,329	(1,281)	1,508	290	(1,217)	2,610	406	(2,204)
Surgery	1,978	1,754	(224)	942	644	(297)	1,978	1,441	(537)
Women & Children	671	688	17	299	458	159	671	686	15
CSS	1,260	684	(576)	612	88	(523)	1,260	305	(955)
Community	1,588	2,076	488	793	674	(119)	1,588	1,768	180
Estates & Facilities	677	694	18	303	378	74	677	746	70
Corporate	1,817	970	(847)	1,060	198	(861)	1,817	951	(866)
Trustwide	-	24	24	-	-	-	-	24	24
TOTAL	10,601	8,220	(2,381)	5,516	2,732	(2,784)	10,601	6,328	(4,272)

In month progress (October)

- Total value of identified schemes has increased by £1.7m (£6.5m at M6)
- All divisions have reduced the unidentified gap assigned to them
- Pipeline PIDs have increased by 52 (101 at M6)

Table 2 – CIP Identification Progress - Non-risk Adjusted – CIP

Division	Target £k	Identified 23/24 £k	Gateway 1 £k	Gateway 2 £k	Gateway 3 £k	Total £k	Gap £k	Pipeline PIDs
Medicine	2,610	1,329	535	499	295	1,329	1,281	10
Surgery	1,978	1,754	45	80	1,629	1,754	224	46
Women & Children	671	688	3	147	539	688	-17	14
Clinical Support Services	1,260	684	446	30	207	684	576	18
Community	1,588	2,076	1,307	0	769	2,076	-488	26
E&F	677	694	0	0	694	694	-18	12
Corporate	1,817	994	625	41	329	994	823	2
Total	**10,601**	**8,220**	**2,962**	**796**	**4,462**	**8,220**	**2,381**	**153**

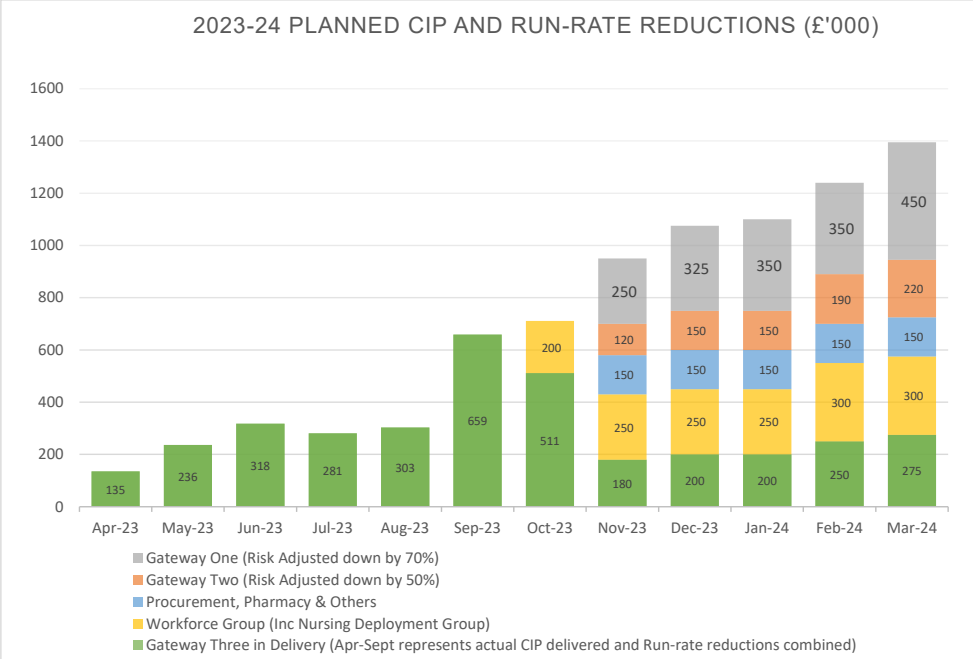
A Risk Framework for CIP Progress has been applied according to the stages of the Trust PMO gateways – see table 3. The Risk framework will be reviewed periodically to adjust reduction criteria as the Trust processes around PMO and CIP programme mature further.

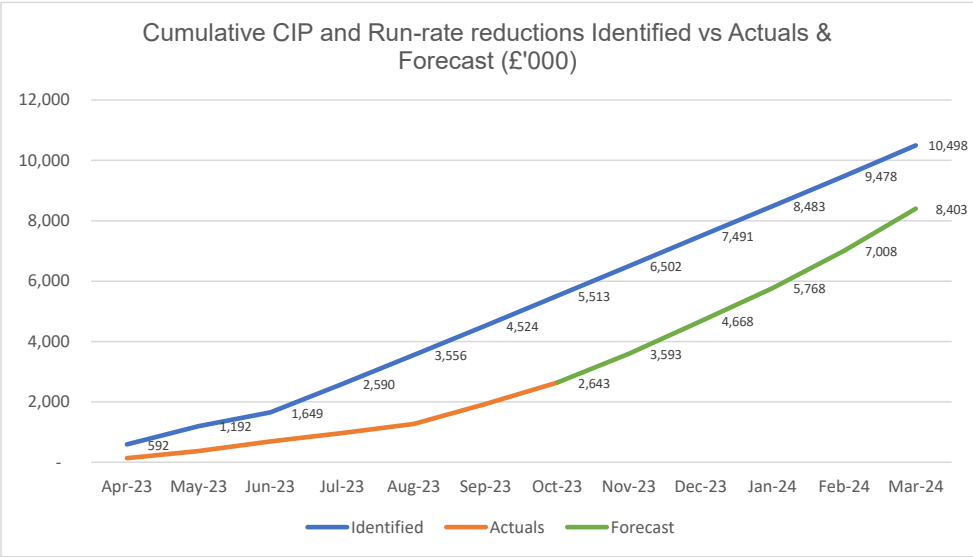
The PIDs that are in pipeline continues to grow. This is encouraging as we move towards building our CIP programme for 24-25. Since we need to identify schemes that will deliver at least £10m in 24-25 the sooner these schemes can be in place the more confidence we will have in achieving that.

Table 3 - Risk Framework

CIP Progress Stages	Definition/Requirement	Risk framework - cost reduction %	Rationale for Risk framework cost reduction %
Ideas/Pipeline	1.Scheme idea with no/initial planned financials 2.A pipeline scheme is still at concept stage.	100%	No financial values are required at this stage, therefore no cost reduction % is required.
PMO Gateway One	1.Scheme with a indicative financials associated with it. Phasing is not required. 2.There has been divisional/clinical input at this stage. Figures/project scope is not finalised.	70%	At this stage, the cost attached to the scheme is only indicative and there is a risk that it will change materially, partly because the scope is likely to change. All of these imponderables mean that a significant risk adjustment is essential.
PMO Gateway Two	1.The scheme has a benefits realisation plan, project brief is complete and financial phasing is provided 2.Impact assessment is to be completed/in progress. 3.Clinical/Finance/Corporate level approvals are in place. Only at this point is the scheme a CIP in progress.	50%	Notwithstanding the fact that there are clinical, finance and corporate level approvals in place by Gateway Two, there is still a significant risk to the Trust of under-delivery. This results in a material risk adjustment of 50%.
PMO Gateway Three	1.Project brief, BRP, Impact assessment and financial phasing completed 2.Schemes has gone through QIA approval process 3.This is the final stage and schemes will be considered as in implementation phase for delivery	30%	Notwithstanding the fact that there are clinical, finance, corporate level and QIA approvals in place by Gateway Three, there is local, current empirical evidence that schemes at this stage are only delivering, on average, 70% of the forecast cost saving. Hence, the risk adjustment must be 30%.

FINANCE REPORT – October 2023





Financial Recovery Group (FRG) Progress

FRG meets 3 weeks out of 4 and oversees progress against the delivery of the agreed Financial Recovery Plan (FRP). In summary, FRG:

- receives assurance on progress against the Financial Recovery Plan (FRP)
- makes appropriate decisions on priorities and
- ensures any blockages are removed that could impede delivery of efficiencies.

For example FRG have recently:

- agreed to delay the opening of the winter escalation ward by a month and aim to close by the end of February 2024.
- agreed to reinstate the mileage cap for travel expenses at 3,500 miles and
- agreed to continue to deliver the 5pm to 9pm shift on AAU through Extra Contractual Work. However, we agreed to continue to work towards a more sustainable solution.

FINANCE REPORT – October 2023

Divisional Financial Performance

	Current Month			Year to date		
	Budget	Actual	Variance F/(A)	Budget	Actual	Variance F/(A)
MEDICINE	£k	£k	£k	£k	£k	£k
Total Income	(339)	(753)	414	(2,371)	(3,175)	804
Pay Costs	5,625	5,903	(278)	39,377	41,606	(2,229)
Non-pay Costs	2,701	2,122	579	13,937	15,209	(1,272)
Operating Expenditure	8,326	8,026	300	53,314	56,815	(3,501)
SURPLUS / (DEFICIT)	(7,987)	(7,273)	715	(50,943)	(53,640)	(2,697)
SURGERY						
Total Income	(262)	(334)	72	(1,616)	(1,988)	372
Pay Costs	4,420	4,610	(190)	30,721	31,054	(333)
Non-pay Costs	1,373	1,499	(125)	9,980	10,551	(570)
Operating Expenditure	5,793	6,108	(316)	40,702	41,605	(903)
SURPLUS / (DEFICIT)	(5,531)	(5,775)	(244)	(39,086)	(39,617)	(531)
WOMENS AND CHILDRENS						
Total Income	(154)	(481)	327	(1,089)	(1,766)	677
Pay Costs	1,971	2,026	(55)	13,751	13,962	(211)
Non-pay Costs	92	135	(44)	852	996	(144)
Operating Expenditure	2,062	2,161	(99)	14,603	14,958	(355)
SURPLUS / (DEFICIT)	(1,908)	(1,681)	227	(13,514)	(13,193)	321
CLINICAL SUPPORT						
Total Income	(223)	(180)	(42)	(1,537)	(1,299)	(238)
Pay Costs	2,631	2,778	(147)	18,354	19,143	(789)
Non-pay Costs	1,367	1,322	45	8,412	9,133	(721)
Operating Expenditure	3,998	4,100	(102)	26,766	28,277	(1,511)
SURPLUS / (DEFICIT)	(3,776)	(3,919)	(144)	(25,229)	(26,978)	(1,749)
COMMUNITY SERVICES						
Total Income	(544)	(645)	100	(3,981)	(4,244)	263
Pay Costs	3,484	3,594	(110)	24,406	24,654	(248)
Non-pay Costs	1,367	1,428	(61)	10,157	10,866	(710)
Operating Expenditure	4,851	5,022	(171)	34,563	35,521	(958)
SURPLUS / (DEFICIT)	(4,307)	(4,378)	(71)	(30,582)	(31,277)	(695)
ESTATES AND FACILITIES						
Total Income	(346)	(366)	19	(2,268)	(2,406)	138
Pay Costs	1,219	1,229	(10)	8,539	8,752	(212)
Non-pay Costs	1,000	954	45	6,387	7,068	(680)
Operating Expenditure	2,218	2,183	35	14,927	15,819	(893)
SURPLUS / (DEFICIT)	(1,872)	(1,818)	54	(12,659)	(13,413)	(754)
CORPORATE						
Total Income	(30,353)	(29,744)	(610)	(208,259)	(208,452)	193
Pay Costs	2,139	2,051	88	15,240	13,832	1,409
Non-pay Costs	1,518	2,060	(542)	11,650	11,675	(24)
Capital Charges and Financing Costs	1,411	1,499	(88)	11,354	11,622	(268)
Operating Expenditure	5,068	5,611	(542)	38,245	37,129	1,116
SURPLUS / (DEFICIT)	25,285	24,133	(1,152)	170,015	171,324	1,309
TOTAL						
Total Income	(32,221)	(32,501)	280	(221,121)	(223,330)	2,209
Pay Costs	21,488	22,191	(703)	150,388	153,004	(2,616)
Non-pay Costs	9,418	9,521	(104)	61,377	65,498	(4,121)
Capital Charges and Financing Costs	1,411	1,499	(88)	11,354	11,622	(268)
Operating Expenditure	32,317	33,211	(894)	223,119	230,124	(7,005)
SURPLUS / (DEFICIT)	(96)	(710)	(614)	(1,998)	(6,793)	(4,796)

Medicine (Sarah Watson)

The Medicine division reported an adverse variance of £2.9m YTD as at M7. For the month of October, the division was ahead of plan by £0.7m
Non-clinical income is ahead of plan by £0.6m, due to significant unplanned private patient income received from overseas nationals.
Pay budgets reported a year-to-date adverse variance of £2.2m (5.6%). The key drivers behind the pay variances are;

- £2m overspend on medical staffing driven by temporary staffing to cover consultant sick leave, industrial action cover, vacancy cover and higher than budgeted establishments for junior doctors. Temporary medical pay spend is expected to reduce if no further IA and the division is considering further plans to reduce temporary spend.
- £0.7m overspend in unregistered nursing pay costs, which is offset by £0.6m underspend in registered nursing vacancies
- £0.3m unmet Pay CIP target, after identification of £56k CIP.

Non-pay budgets reported an adverse variance of £1.3m (9%). The key drivers behind the non-pay variance for the year-to-date are;

- £1.1m for undelivered CIP. The Division has not been able to identify any significant improvements in their non-pay cost base to meet this target but is continuously reviewing ideas for further efficiencies.
- £0.1m in clinical supplies, which is largely due to inflation and a slight increase in volume.

The Division has delivered CIP of £0.3m YTD and continues to review and implement plans to reduce run rate, going forward.

Surgery (Moira Welham)

The Surgical division reported an adverse variance of £244k for October with a year-to-date adverse variance of £531k. This aligns with the expected performance for October.

Pay reported an adverse variance of £190k in October (£333k YTD). Main drivers for the overspend in pay is the use of high-cost temporary resources being used to support the hard to fill vacancies, particularly within Anaesthetics, Urology and Theatres. This is in addition to costs associated with supporting UEC and elective recovery. Overall temporary staffing accounts for 13.3% of pay costs in the month.

Non-pay reported an adverse variance of £125k in month (£570k YTD). Main drivers behind the adverse variance in month are:

- Theatres equipment repairs
- Procurement of new theatre equipment
- Billing tariff uplifts and corrections from suppliers being applied in month.

Women and Children's (Simon Taylor)

In October, the Division reported a favourable variance of £227k (£321k YTD). Paediatric income was ahead of plan both in month (£276k) and YTD (£656k) relating to Tricare income in neonatal inpatients and outpatients predominantly. The YTD income for Women's services is £21k ahead of plan.

Pay reported a £55k overspend in-month (£211k overspend YTD). This is due to a few main factors:

- temporary staff spend to support safe staffing levels during periods of sickness, industrial action and to cover rota gaps.
- the increase in demand for gynaecological services.
- Successful recruitment in maternity teams whose vacancies have previously offset overspends in other cost centres.
- Known over-establishment in paediatric ED.

Non-pay reported a £44k overspend in month (YTD £144k overspend) driven various factors including: clinical supplies (high value purchase of jaundice meters); premises (increase in rent charges for community midwifery bases); and other costs (including unbudgeted annual licences for Infoflex; and injury benefit scheme charges). Drugs are also overspent YTD and this is expected to increase over the coming months with winter pressures.

Clinical Support (Simon Taylor)

In October, the Division reported an adverse variance of £144k (YTD adverse variance of £1.7m).
Income was behind plan in month (£42k) and YTD (£238k). A large component of this is legacy income targets for utilities income within expired managed service contracts in diagnostics which we no longer have. This is offset by underspends in non-pay for these contracts and higher than anticipated income in private patient income and backdated inflationary increases.

Pay reported a £147k overspend in-month (£789k overspend YTD). This is due to an increase in agency usage in Health records and microbiology predominantly, alongside diagnostics overspends in relation to increased activity.

Non-pay reported a £45k underspend in month (YTD £721k overspend). As well the underspend on expired managed service contracts, there are cost pressures in histopathology for the Leica contract (£141k YTD) and chemistry send-away tests continue to overspend. The latter is due to higher than anticipated costs from CUH. The department have identified alternative providers and are moving services away from CUH. However, some of these Trusts have been slow to come online and therefore the costs continue above the previously contracted price. From month 5, this cost has started to reduce but there are 2 centres still not fully implemented.

Community Services (Clement Mawoyo)

The Community Division reported an adverse variance of £71k in M7 (£694k adverse YTD).

Income reported a £100k over recovery in October (£263k favourable YTD). The YTD favourable variance was due to additional income recovery for COVID and flu vaccination programmes and the recovery of some of the additional costs incurred through the Community Equipment Service contract on behalf of Suffolk County Council, ESNEFT and the ICB. Additional IT Hardware costs incurred by the Suffolk Communication Aids Resource Centre (SCARC) were recharged to Suffolk County Council.

Pay reported an adverse variance of £110k in October (£248k YTD), net of a £200k non-recurrent vacancy saving CIP, owing to attrition and recruitment gaps. At M7, the pay run-rate has increased above budget. This is because the division is delivering capacity to support the Urgent Emergency Response services, including enhanced overnight care in the Early Intervention Team, 7-day therapy cover for acute medicine wards, and therapist provision in ED.

Due to the division's turnover and vacancies, bank and agency temporary staff were used to cover some vacant roles across services. This is limited to cover budgeted vacancies only, and/or to fund externally funded posts where that funding is time limited. With HEE funding support, the division has invested in an upskilling programme for community bank nurses and now has a larger pool of bank staff. This means agency staff are used by exception, to ensure continuity of safe care within services facing recruitment challenges and where services have multiple

vacancies, particularly those focused on admission avoidance and our urgent care response.

Non-pay reported a £61k adverse variance in M7 (£710k adverse YTD). Drivers for the YTD adverse variance are:

- £153K unmet non-pay CIP/slippage in the first half of the year due to scheme delay – the division expect to recover this position in the second half of the year.
- Significantly increased referrals into wheelchair services in the first half of the year, despite increased use of recycled equipment, and increased demand for community equipment as incurred a £303k YTD overspend. However, some of this is offset by the increase in income noted above.
- £80K of additional IT hardware and software costs were incurred, primarily for use by the SCARC,
- Inflationary cost pressures of £97K were incurred for service contracts and staff travel costs are £77K over budget YTD.

Estates and Facilities (Chris Todd)

In February, the division recorded a positive variance of £54k, (YTD adverse variance of £754k). An increase in income following the reinstatement of staff parking charges has led to £121k surplus YTD in the Car Park management unit. An increase in catering income of £127k YTD is the result of customer numbers returning to pre-covid levels and a small increase in prices charged. This increase in income has been offset by the use of temporary staff to meet demand.

There are cost pressure in the following areas:

- Medical Physics (£196k YTD) – the cost of spare parts, plus third-party repairs and maintenance contracts are putting pressure on this budget.
- Estates (£284k) – This overspend is the result of redecorating costs and third party servicing and maintenance costs exceeding the budget by £95k and £175k respectively.
- Estate Management (£308k) - There has been significant downtime in the Trust's combined heat and power unit this year. This has led to an increase in the volume of electricity used, YTD cost pressure £405k, and a corresponding reduction in the amount of gas burned to generate electricity, saving YTD £131k.

FINANCE REPORT – October 2023

Workforce

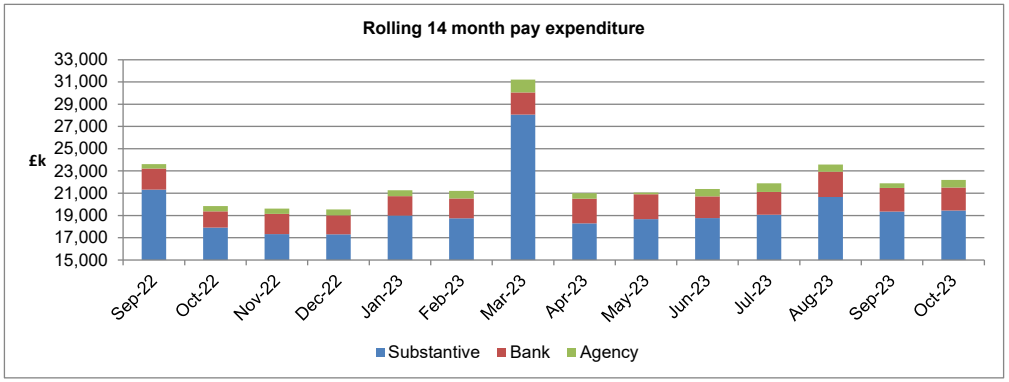
During October the Trust overspent by £0.7m on pay

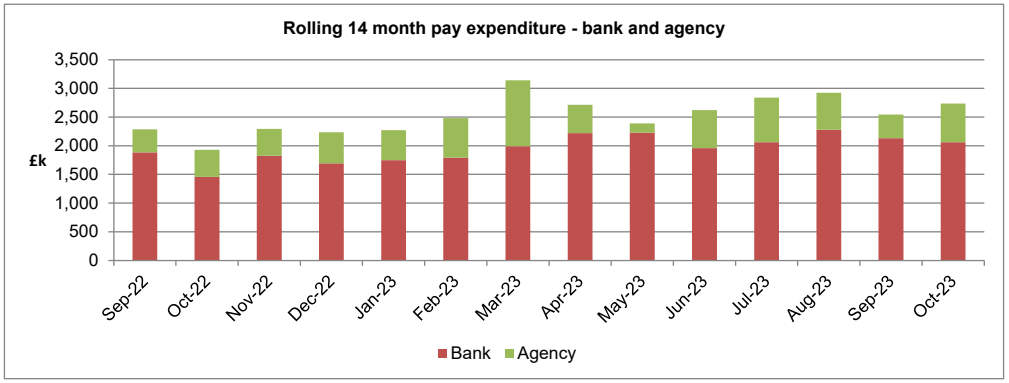
Compared to October 2023 we now employ 388 more WTEs (8.4%), of which 374 are substantive and 14 are temporary

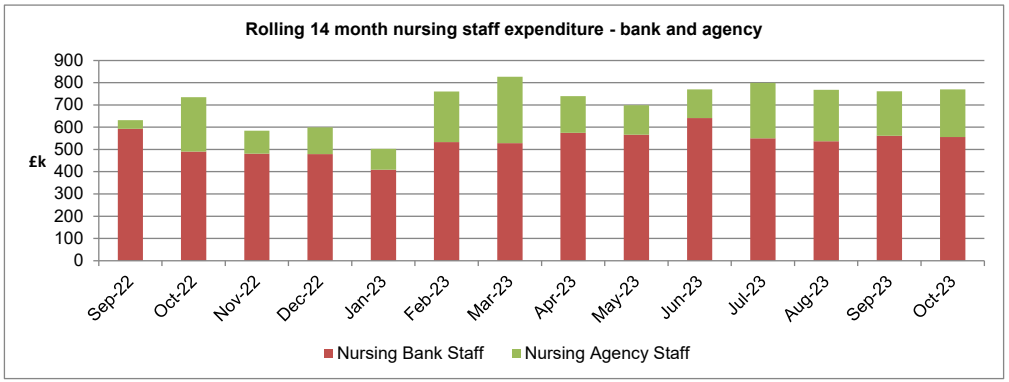
Monthly Expenditure (£)				
As at October 2023	Oct-23	Sep-23	Oct-22	YTD
	£000's	£000's	£000's	£000's
Budgeted Costs in-month	21,488	21,435	20,172	150,388
Substantive Staff	19,454	19,343	17,917	134,228
Medical Agency Staff	278	43	144	837
Medical Locum Staff	570	547	388	3,857
Additional Medical Sessions	410	493	(47)	2,797
Nursing Agency Staff	214	200	245	1,321
Nursing Bank Staff	556	561	490	3,985
Other Agency Staff	184	171	86	1,678
Other Bank Staff	209	227	246	1,656
Overtime	101	112	192	1,222
On Call	215	190	186	1,424
Total Temporary Expenditure	2,737	2,545	1,931	18,776
Total Expenditure on Pay	22,191	21,888	19,847	153,004
Variance (F/(A))	(703)	(453)	325	(2,616)
Temp. Staff Costs as % of Total Pay	12.3%	11.6%	9.7%	12.3%
memo: Total Agency Spend in-month	676	414	475	3,836

Monthly WTE			
As at October 2023	Oct-23	Sep-23	Oct-22
Budgeted WTE in-month	5,001.8	4,992.7	4,818.2
Substantive Staff	4,645.4	4,615.5	4,271.4
Medical Agency Staff	14.5	12.5	8.7
Medical Locum Staff	32.8	44.1	32.5
Additional Medical Sessions	13.1	9.7	7.5
Nursing Agency Staff	28.0	26.5	28.9
Nursing Bank Staff	141.8	145.2	120.6
Other Agency Staff	40.0	33.9	17.4
Other Bank Staff	67.0	74.5	82.4
Overtime	24.9	28.0	48.0
On Call	5.7	5.9	7.7
Total Temporary WTE	367.8	380.2	353.5
Total WTE	5,013.2	4,995.6	4,624.9
Variance (F/(A))	(11.4)	(2.9)	193.3
Temp. Staff WTE as % of Total WTE	7.3%	7.6%	7.6%
memo: Total Agency WTE in-month	82.5	72.8	54.9

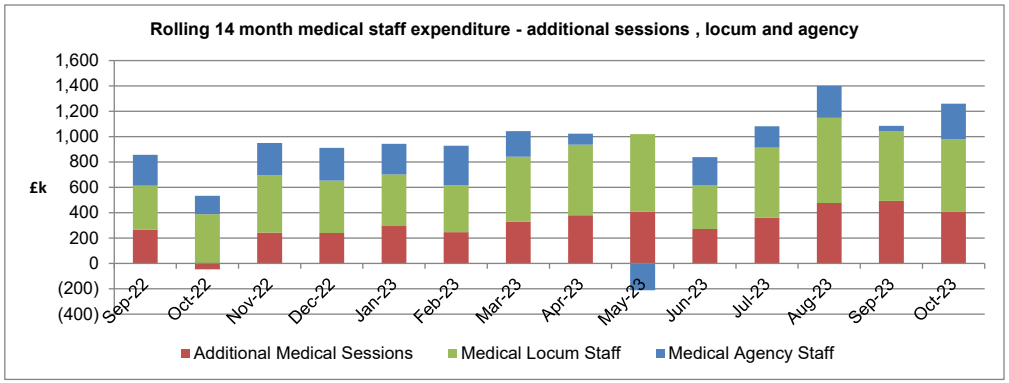
Pay Costs

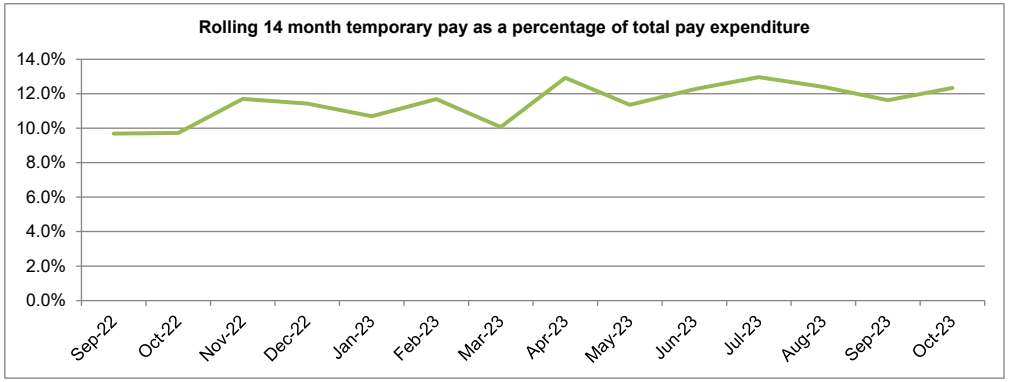


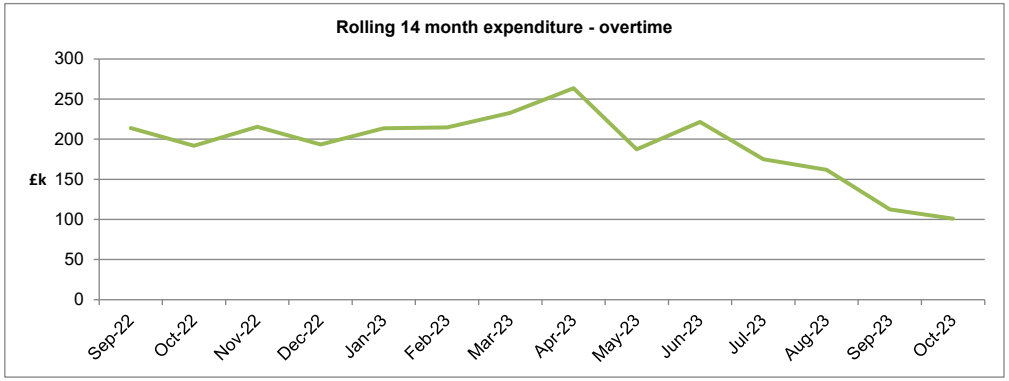




FINANCE REPORT – October 2023







FINANCE REPORT – October 2023

Statement of Financial Position – 31 October 2023

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2023	Plan 31 March 2024	Plan YTD 31 October 2023	Actual at 31 October 2023	Variance YTD 31 October 2023
	£000	£000	£000	£000	£000
Intangible assets	61,869	57,425	57,245	68,329	11,084
Property, plant and equipment	193,976	227,589	199,384	199,833	449
Right of use assets	9,817	9,929	10,969	9,169	(1,800)
Trade and other receivables	6,001	6,341	6,341	6,001	(340)
Total non-current assets	**271,663**	**301,284**	**273,939**	**283,332**	**9,393**
Inventories	4,365	3,800	3,800	4,687	887
Trade and other receivables	41,871	14,991	15,457	16,764	1,307
Non-current assets for sale	520	0	0	520	520
Cash and cash equivalents	7,895	14,298	7,838	14,253	6,415
Total current assets	**54,651**	**33,089**	**27,095**	**36,224**	**9,129**
Trade and other payables	(73,503)	(45,862)	(39,397)	(47,368)	(7,971)
Borrowing repayable within 1 year	(4,801)	(3,724)	(3,724)	(4,748)	(1,024)
Current Provisions	(64)	(46)	(46)	(64)	(18)
Other liabilities	(1,336)	(5,185)	(4,685)	(10,713)	(6,028)
Total current liabilities	**(79,704)**	**(54,817)**	**(47,852)**	**(62,893)**	**(15,041)**
Total assets less current liabilities	**246,610**	**279,556**	**253,182**	**256,663**	**3,481**
Borrowings	(48,038)	(41,265)	(43,663)	(45,661)	(1,998)
Provisions	(507)	(852)	(852)	(502)	350
Total non-current liabilities	**(48,545)**	**(42,117)**	**(44,515)**	**(46,163)**	**(1,648)**
Total assets employed	**198,065**	**237,439**	**208,667**	**210,500**	**1,833**
Financed by					
Public dividend capital	230,215	271,107	241,923	249,442	7,519
Revaluation reserve	12,054	12,640	12,640	12,055	(585)
Income and expenditure reserve	(44,204)	(46,307)	(45,896)	(50,997)	(5,101)
Total taxpayers' and others' equity	**198,065**	**237,440**	**208,667**	**210,500**	**1,833**

The above table shows the year to date position as at 31 October 2023.

Total reserves are ahead of plan and this is due to a couple of factors. Firstly, we have received more PDC that we had originally planned, relating to revenue support to help our cash position and capital PDC for the New Hospital Project. Secondly, we are reporting a deficit higher than plan.

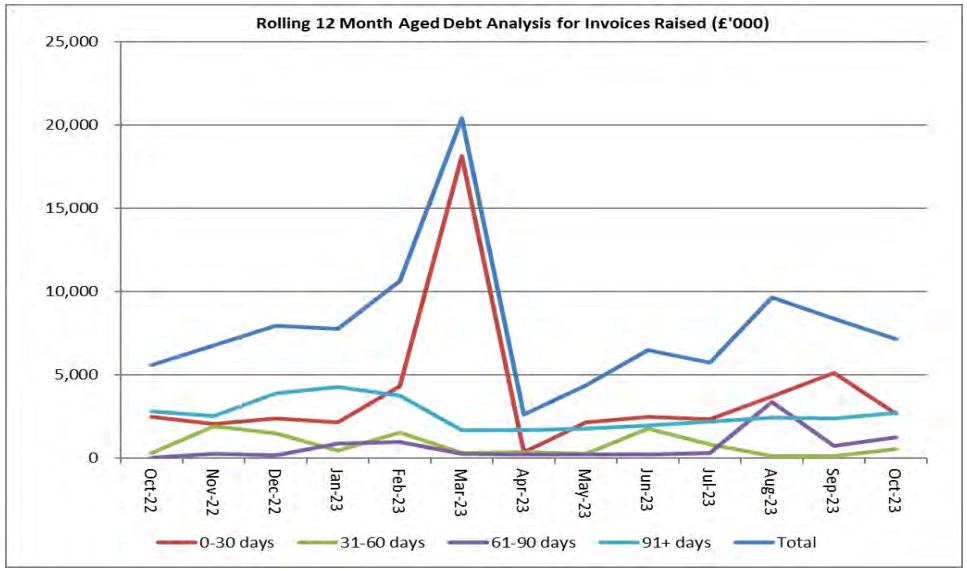
Our cash position appears higher than plan, this all relates to capital PDC received as cash and is offset by the increase in capital payables.

Although the asset base is growing, the phasing of the plan is not in line with actual spend.

Other liabilities are higher than plan due to £5m received from the ICB that is being treated as deferred income as it is contract income received in advance.

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 maintain an adequate cash balance.

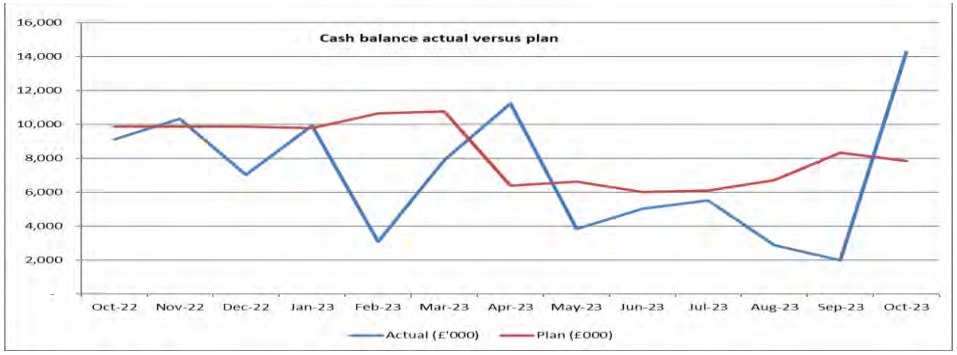
The overall level of sales invoices raised but not paid continues to remain stable and we have been working hard to reach resolution on some of the older debts in order to help the Trust's cash position. We have made significant progress with the debt held with Suffolk County Council with a large amount being settled in month 8.

Over 65% of the outstanding debts relate to NHS/WGA Organisations, with 30% of these types of debts being greater than 90 days old.

FINANCE REPORT – October 2023

Cash Balance for the year

The graph illustrates the cash trajectory since October 2022. The Trust is required to keep a minimum balance of £1.1m.



During month 7 we received £6.7m of revenue support funding from DHSC along with £8.7m of PDC capital funding. As at 31 October 2023, £6.8m of the Trust's cash balance related to capital funding received (to be spent on capital), with the remaining £7.4m balance being for revenue spend. The large cash balance at the end of the month is due to timing, particularly of some large capital invoices for which the PDC relates.

Our cash is being rigorously monitored to ensure that we have adequate cash reserves to match our expenditure. However, as the Trust continues to report a deficit, our cash position continues to deteriorate. The Trust applied for £10m in revenue support in September 2023. Or application was originally rejected and we received a reduced amount of £6.7m as noted above. However, further discussions have been held with NHSE and we have provided further evidence to support the fact that the Trust requires the additional £3.3m (to make up the £10m) in December. This is currently being discussed between NHSE and DHSC.

In order to ensure that the Trust has adequate cash support through to the end of March 2024, the Trust is required to request further revenue support from DHSC (through NHSE) for the final quarter for the year. Based on internal cash flow forecasts, the Trust will require a further £6m in revenue support to ensure that we remain within the minimum cash balance of £1.1m. The cash flow forecast takes in to account the expectation that funding for industrial action will be received before the end of March.

The support will be requested as working capital support and an application is required by 1 December 2023. Therefore, documentation will be submitted as soon as Board approval is obtained.

The Board is asked to approve the request of £6m revenue support for the final quarter of 2023-24.

Capital Progress Report

The previously revised Capital Plan for 2023/24 of £35.527m has now been further increased by £14.308m due to additional PDC funding received for the New Hospital. This results in a further revised capital plan of £49.835m for 2023/24. There continues to be discussions around the phasing of the capital funding for the New Hospital Project and the Newmarket CDC and therefore we may see a reduction in the programme, with expenditure and associated funding being moved to 2024/25.

The year to date capital spend at month 7 capital spend is £19.691m. The table below shows the breakdown:

Capital Spend - 31st Oct 2023		Year to Date (M5)				
Capital Scheme	Full year Plan	YTD Original Plan (M5)	YTD Actual (M5)	Variance	Funding Split: Internal	Funding Split: PDC Available
	£000's	£000's	£000's		£000's	£000's
New Hospital (Future Systems)	15,450	753	6,474	- 5,721	200	15,250
Newmarket CDC	12,549	7,280	931	6,349		12,549
RAAC	10,900	4,900	4,443	457		10,900
Estates	1,966	1,400	885	515	1,966	
IM&T	5,989	3,731	3,423	308	5,989	
Medical Equipment	826	287	1,060	- 773	495	331
Imaging Equipment	1,830	1,064	2,476	- 1,412	1,830	
Other Schemes	325	189	-	189	325	
Total Capital Schemes	49,835	19,604	19,691	- 87	10,805	39,030
Overspent vs Original Plan					49,835	
Underspent vs Original Plan						

The Trust is on track to deliver the full year plan by 31 March 2024, subject to the phasing of some of the capital spend and associated funding for the New Hospital and Newmarket CDC

FINANCE REPORT – October 2023

4.3. Improvement Committee Report - Chair's Key Issues from the meeting

To Assure

Presented by Louisa Pepper

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Improvement	Date of meeting: 20th September 2023
Chaired by: Louisa Pepper	Lead Executive Director: Sue Wilkinson

Agenda item	WHAT? *Summary of issue, including evaluation of the validity the data**	Level of Assurance* 1. Substantial 2. Reasonable 3. Partial 4. Minimal	For 'Partial' or 'Minimal' level of assurance complete the following: SO WHAT? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*	WHAT NEXT? *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	Escalation: 1. No escalation 2. To other assurance committee / SLT 3. To Board
4.1	Presentation – '*Safeguarding our ED patients with a mental health diagnosis'*	2	This is one of the regular subject specific updates the Improvement committee receives using a locally designed quality assurance template	The MH transformation group continue to progress a programme of work which is reported via the PQASG to Improvement	1
5.1ii	PRM packs A summary of the key Q&S indicators and narrative contained within the divisional reports	2	IQPR already received, this additional report demonstrates the divisional level breakdown of the key IQPR metrics as well as those specific to individual divisions	Improvement to continue to receive a monthly highlight report with the option to receive a more detailed annual report from each division (possible future option)	1
6.1	Patient Quality & Safety (PQASG) Updates provided from August meeting: Mental Health Transformation Group, Adult Safeguarding group, Learning disability services, Duty of Candour and learning from incidents	2	Regular monthly report using the trust's 1-4 (substantial – minimal) assurance level scale. Areas of partial assurance • Recording of least restrictive practice (now in place in Datix) • Mental Health awareness training • IA report on MCAs and DOLs • LD & A Oliver McGowen training	PQASG will continue to maintain oversight of all items reported as emerging concerns through its reporting framework.	1
6.2	Clinical Effectiveness (CEGG) Updates provided from July + August meetings: Guidelines editorial group, QI, CQUIN, Radiology including accreditation, Public health programme, Cervical Screening Annual Report.	4	Regular monthly report using the trust's 1-4 (substantial – minimal) assurance level scale. Areas of partial assurance • Public health report (concerns around tobacco dependency products).	Where significant concerns have been raised (e.g. tobacco) a risk register entry has been completed. CEGG will continue to maintain oversight of all items reported as emerging concerns through its reporting framework.	1

	New national best practice publications allocated using the NBP framework		• Guideline editorial group (admin support now in place but an expected time-lag to clear the backlog of guidelines)		
7.1	Patient safety strategy progress and Patient safety specialists report Updates on all key projects provided. Also highlighted: Development of SIG – assess progress and review. Collaboration with change hub to support areas for safety improvement	2	Considerable overlap of requirements of our strategy and the key projects NHSE have assigned to the patient safety specialist role. To that end they should be considered as one list. The quarterly report to Improvement provides an update on those projects.	Go back out to advert to recruit patient safety partners. Re-establish project group to oversee the implementation of the 'Simple steps to keep you safe' initiative. Work ongoing to make the safety improvement process more effective	1
8.1	CQC update New Single assessment framework will come into place from Nov23	3	The basic principles of the SAF are based on the same concepts of quality that the NHS aspires to and so everything in the SAF should already be a focus of our organisation.	Executive-led review of the updated Well-led domain and structures in place in WSFT to support. Safe, Effective, Caring and Responsive to follow.	2. Of relevance to Insight, Involvement and SLT
8.2	Quality improvement programme Quarter 1 update provided including team resources, training uptake, projects registered and the QI teams' interrelationship with the Change hub	2	NHS IMPACT, Trust Priorities and the ICB Improving Quality Strategy serve to guide the future development of continual improvement	The QI team continue to progress a programme of work which is reported via the CEGG to Improvement	1
8.3	Ockenden update Building on the work already undertaken executive leads have been identified for the relevant areas of the Ockenden report in order to review and approve the self-assessment, assurance and improvement actions	2	A clear process to manage the Trust's self-assessment and improvement actions for the Ockenden report will mitigate risks of exposing our patients and organisation to the same vulnerabilities as were manifest in the findings of the Ockenden report.	Updates will be reported in October and subsequent months following executive-led review and challenge.	2. Shared with Involvement
9.1	Annual review of effectiveness Minor amendments made to ToR to clarify remit	2	Good practice states that the Board should develop a clear rationale for its committee(s) and regularly revisit their effectiveness and fitness for purpose.	Away ½ day session (following positive feedback from Involvement committee session)	1

9.2	Internal audit reports A new process will ensure oversight of IA recommendations is managed as part of the specialist committee reporting framework upwards to 3i, rather than as a standalone.	2	The work of internal audit provides an important source of assurance on the effectiveness of the control environment regarding key systems and processes.	Medicines management report (11.22/23) will be reviewed by D&T committee with progress reported to PQASG in their next quarterly update.	1

Acronyms: ToR (terms of reference), IA (internal audit), D&T (drugs & therapeutics), PRM (performance review meetings), ED (emergency department), MH (mental health), SAF (single assessment framework), QI (quality improvement), SLT (Senior leadership team meeting), LD&A (Learning Disabilities and Autism)

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Improvement	**Date of meeting: 18 October 2023**
Chaired by: Louisa Pepper	**Lead Executive Director: Sue Wilkinson**

Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	Level of Assurance* 1. Substantial 2. Reasonable 3. Partial 4. Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:** **SO WHAT?** *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT 3. To Board
4.1a	Quality strategy development. (*Improvement committee action 84*)	4	Improvement committee action 84. Initial proposal received.	Further work required to scope this project with specific reference to how it can be co-produced with relevant stakeholders. Update on proposed timeframes to November meeting.	1
4.1b	Reporting key quality + safety information as part of Improvement assurance process (*Improvement committee action 101)*	2	Interim progress report received. Links to wider programme of performance reporting and quality control / quality assurance pathways	Further work required to progress this action to completion. Updates to be provided as part of PQASG regular reports in future months.	1
5.1	IQPR including divisional PRM packs. Received for information	1	IQPR and PRM reports demonstrate divisional level breakdown of key trust metrics as well as those specific to individual divisions. Provides a source of insight to highlight areas benefitting of extra scrutiny by Improvement.	Future subject specific update agreed: Maternity indicators (including domestic violence). Timeframe to coincide with external review of IUDs for BAME mothers (outcome to be included in report)	1
5.2	Presentation – ' Learning Disabilities & Autism"	2	This is one of the regular subject specific updates the Improvement committee receives using a locally designed quality assurance template		1
6.1	Patient Quality & Safety (PQASG)	2	Regular monthly report using the trust's 1-4 (substantial – minimal) assurance level scale.	PQASG will continue to maintain oversight of all items reported as emerging concerns through its reporting framework.	1

Agenda item	WHAT? *Summary of issue, including evaluation of the validity the data**	Level of Assurance* 1. Substantial 2. Reasonable 3. Partial 4. Minimal	For 'Partial' or 'Minimal' level of assurance complete the following:		
			SO WHAT? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT 3. To Board
	Updates provided from September meeting: Infection Prevention, Falls, Pressure Ulcer, Trauma, Nutrition and Drugs & Therapeutics		Areas of <u>partial assurance</u> • National Patient Safety alert regarding the use of bed rails • Provision of low-rise beds • Fluid balance audit compliance • Attendance at Trauma committee • No established role for trauma unit major injury coordinator • National shortages of IV paracetamol	No actions or escalations for Improvement (will all be overseen by PQASG).	
6.2	<u>Clinical Effectiveness (CEGG)</u> Updates provided from September meeting: Pathology Quality including accreditation, National and Local clinical audits and NICE National best practice (NBP) process report reviewed prior to submission to October SLT. (*Improvement committee action 105*)	3	Regular monthly report using the trust's 1-4 (substantial – minimal) assurance level scale. No areas of <u>partial assurance</u> in this month's report For info only - three new national best practice publications allocated using the 'simple' NBP framework	CEGG will continue to maintain oversight of all items reported as emerging concerns through its reporting framework.	1
7.1	<u>Patient Safety Incident Response Plan (PSIRP) update</u> This is the Q3 update. Five suggested areas for improvement agreed with SNEE ICB Annual review of the ToR and effectiveness of the safety improvement group (SIG) has prompted a need to review its current structure and processes in line with the principles of PSIRF.	2	PSIRP updates presented quarterly: Q1 - Present new PSIRP for approval by Improvement on behalf of the board Q2 - ICB annual review of previous year's PSIRP **Q3 - Planned improvements from annual review with progress to date** Q4 - Statistics from this year's PSIRP (9 months in) and plan for developing next year's PSIRP	Implement proposed actions in main body of report over the 12 months following SNEE ICB review with a view to evaluating at the next annual review (summer 2024). Detail of SIG review to be provided to November Improvement meeting	1

Agenda item	WHAT? *Summary of issue, including evaluation of the validity the data** Level of Assurance* 1. Substantial 2. Reasonable 3. Partial 4. Minimal	For 'Partial' or 'Minimal' level of assurance complete the following:		
		SO WHAT? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT 3. To Board
7.2	NatSSIPs-2 implementation update ICB keen to adopt a SNEE-wide approach to NatSSIPs. Initial scene setting meeting in May23 attended by multidisciplinary team from WSFT + colleagues from ESNEFT, ICB safety lead, ICB patient safety partner and a national NatSSIPs lead. Follow up meeting held in Oct23 with WSFT asked to propose project membership	3	NatSSIPs2 was developed by the centre for perioperative care (CPOC) at the request of NHS Improvement following the publication of the 2021 HSIB report https://www.hssib.org.uk/patient-safety-investigations/never-events-analysis-of-hsibs-national-investigations/ . Previously reported to Improvement, Digital Board, SLT and Clinical directors meeting. Also highlighted to the Change team requesting project support.	Next steps • Agree WSFT membership of SNEE-wide project team (Nov23) • Escalate to Board specifically: o Organisation standards o Clinical staff time commitment (mainly but not exclusively medical staff) o Implication for all clinical divisions / departments (not just Surgical division)	3
9.1	BAF 1 (quality & safety) Received for information. "*If we do not have a pro-active and positive culture of safety based on openness and honesty underpinned by robust systems for reporting, structured learning and improvement we will fail to keep our patients, service users and staff safe, learn lessons and embed good practice*"	2	This risk is currently rated as RED and therefore requires a quarterly review as per the risk management framework timeframes. PQASG has oversight of the content of this risk and the actions contained within.	An initial review of content including an update of action plan to be undertaken by PQASG core membership in October Future quarterly updates will be included in PQASG reporting to Improvement. Next due Jan24.	1

Acronyms: ToR (terms of reference), PRM (performance review meetings), SLT (Senior leadership team meeting), IQPR (Integrated quality & performance report), IUD (Intrauterine deaths, also referred to as stillbirths), BAME (Black and minority ethnic), NICE (National Institute for Health and Care Excellence), NatSSIPS (National safety standards for invasive procedures), BAF (Board assurance framework)

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Improvement Committee			Date of meeting: 15th November 2023		
Chaired by: Louisa Pepper			**Lead Executive Director: Susan Wilkinson**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:** **SO WHAT?** *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
6.1	IQPR including Divisional PRM packs. Received for information	2	IQPR and PRM reports demonstrate Trust level metrics as well as those specific to each Division. Question does this document provide appropriate data/ information reflecting all elements of quality and safety	C-Diff infections were raised as a concern. Deep Dives for C-Diff improvement initiatives to be considered by IPCC and reported back to future Improvement Committee Meetings as part of the work programme. Proposal to be developed to incorporate qualitative narrative in respect of IQPR data sets relevant to Improvement Committee.	2
6.2	Internal Critical Incident Reviews and on-going process of learning.	2	Process of reporting via Datix explained as well as an example of critical incident analysis.	Future subject update to understand how outcomes and learning are embedded within the	1

Originating Committee: Improvement Committee			Date of meeting: 15th November 2023		
Chaired by: Louisa Pepper			Lead Executive Director: Susan Wilkinson		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
				Trust to improve quality and safety of care as incidents occur	
7.1	Patient Quality and Safety Group (PQASG) Updates provided from October meetings;- Deteriorating Patient Group Mortality Oversight Group End of Life HTA Mortuary Safer Discharge Group	2	Regular monthly report using the Trust's 1-4 assurance level scale. Areas of partial assurance;- Sepsis – not fully compliant with Sepsis bundle 6. Improving early sepsis recognition and treatment improves patient outcomes. Fluid Balance- NICE Guideline compliance re 24 hr patient monitoring Dementia – National Audit delirium identification question Discharge Summaries – Project with a task and finish group Discharge Waiting Area	PQASG will continue to maintain oversight of all items reported as emerging concerns through its reporting framework. No actions or escalations for Improvement Committee. Concerns and work streams relating transfer of care (discharge) to be pulled together via a workshop in January 2024 to align and progress. Update to improvement committee via workplan	1

Originating Committee: Improvement Committee			Date of meeting: 15th November 2023		
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			Support for Data Gathering.		
7.1	Mortality SHMI Data Dec 2022 – Rise in Trust SHMI data into special case for concern. Data validation exercise undertaken showing unallocated coding and data set inaccuracies. Deep dive revealed no actual or unexpected rise in deaths has occurred	2	Due to the SHMI data – Dec 2022, Improvement Committee requested a specific update to gain an understanding of the issue and to seek assurance regarding outcomes and learning.	PQASG will continue to maintain oversight of SHMI data via Mortality Oversight Group. SHMI data to be included within the IQPR. No escalations for Improvement Committee.	1
7.2	Clinical Effectiveness Governance Group (CEGG) Updates provided from October meeting. National Audit and other national best practice publications, Quality Improvement and Guideline Editorial Group	2	Regular monthly report using the Trusts 1-4 assurance level scale. One area of partial assurance – Guideline Editorial Group – initial on-boarding meeting held, pathway for guideline review using Sharepoint. Backlog to address. For info only – nine national best practice	CEGG will continue to maintain oversight of all items reported as emerging concerns through its reporting framework. CEGG and the Guideline Editorial group prioritise the guideline backlog and new guidelines to ensure that the most pressing are updated.	1

Originating Committee: Improvement Committee			Date of meeting: 15th November 2023		
Chaired by: Louisa Pepper			Lead Executive Director: Susan Wilkinson		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
			publications allocated using the NBP framework.		
7.2	Clinical Effectiveness Governance Group (CEGG) Annual Review and self-assessment and Independent Review Improvement Committee action 66	2	Annual report and self-assessment for 2022/23 and how CEGG met its TOR and priorities. CEGG acknowledged that it had evolved over the last year.	CEGG have identified areas for improvement which will be reflected in the TOR and improvement/development plan going forward. An area of work to be undertaken as part of this process is to consider areas of CEGG responsibility reported to the Improvement Committee for inclusion in the work programme.	1
8.1	Safety Improvement Group (SIG) Level of assurance relating to organisational learning	2	For the Trust to be a safe organisation, we need to ensure where areas for improvement have been identified from Patient Safety Incident Investigations (PSII) and Patient Safety Reviews (PSR) There is a process which allows quality improvement to follow.	SIG remit is under review as part of a quality improvement project (QIP) – concluding June 24.SIG aims to provide monitoring, oversight, and support to progress safety recommendations through to effective and sustained completion.	2

Originating Committee: Improvement Committee			Date of meeting: 15th November 2023		
Chaired by: Louisa Pepper			Lead Executive Director: Susan Wilkinson		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
9.1	Trust Quality Priorities Against our plan – Update	2	Improvement Committee has oversight of QP1: - Deliver measurable improvements in safe care and confidence to raise concerns through implementation of our patient safety strategy – March 2024	To continue to progress all aspects of QP1 and our patient strategy with a view to aligning the national strategy development and local safety initiatives - both WSFT and SNEE wide in the future. To develop a proposal as to how the quality outcomes and sustained improvements can be reported to provide assurance to the Improvement Committee.	1

**See guidance notes for more detail*

Guidance notes

The practice of scrutiny and assurance

	Questions regarding quality of evidence…	Further consideration…
What? Deepening **understanding** of the evidence and ensuring its **validity**	**Validity** – the degree to which the evidence… • measures what it says it measures • comes from a reliable source with sound/proven methodology • adds to triangulated insight	• Good data without a strong narrative is unconvincing. • A strong narrative without good data is dangerous!
So what? Increasing **appreciation** of the **value** (importance and impact) – what this means for us	**Value** – the degree to which the evidence… • provides real intelligence and clarity to board understanding • provides insight that supports good quality decision making • supports effective assurance, provides strategic options and/or deeper awareness of culture	• What is most significant to explore further? • What will take us from good to great if we focus on it? • What are we curious about? • What needs sharpening that might be slipping?
What next? Exploring what should be **done next** (or not), informing **future** tactic / strategy, agreeing follow-up and future **evidence of impact**		• Recommendations for action • What impact are we intending to have and how will we know we've achieved it? • How will we hold ourselves accountable?

Assurance level

1. Substantial	Taking account of the issues identified, the board can take substantial assurance that this issue/risk is being controlled effectively. There is substantial confidence that any improvement actions will be delivered.
2. Reasonable	Taking account of the issues identified, the board can take reasonable assurance that this issue/risk is being controlled effectively. Improvement action has been identified and there is reasonable confidence in delivery.
3. Partial	Taking account of the issues identified, the board can take partial assurance that this issue/risk is being controlled effectively. Further improvement action is needed to strengthen the control environment and/or further evidence to provide confidence in delivery.
4. Minimal	Taking account of the issues identified, the board can take minimal assurance that this issue/risk is being controlled effectively. Urgent action is needed to strengthen the control environment and ensure confidence in delivery.

4.4. Quality and Nurse Staffing Report

To Assure

Presented by Susan Wilkinson

BOARD OF DIRECTORS	
Report title:	Quality and Workforce Report & Dashboard – September and October 2023
Agenda item:	**4.4**
Date of the meeting:	**29th September 2023**
Sponsor/executive lead:	**Susan Wilkinson**
Report prepared by:	**Daniel Spooner: Deputy Chief Nurse**

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
WHAT? ***Summary of issue, including evaluation of the validity the data/information***
This paper reports on safe staffing fill rate, contributory factors and quality indicators for inpatient areas for September and October 2023 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 within the sphere of nursing resource management. This paper also demonstrates how nursing directorate is supporting the Trust's financial recovery ambitions, following a nursing deployment group established to provide oversight for nursing resource utilisation.
SO WHAT? ***Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk***
• Overall RN/RM vacancy rate is 6% and in special cause improvement. • Overall Nursing assistant vacancy rate is 12% and an improving picture. • Turn over for RN/RM remains under 10% • Combined nursing and NA fill rates above 90% continues this in this period. • Expected CHPPD achieved for both September and October • International recruitment on track to meet 2023 target. • Nursing temporary spend reduced in this period
WHAT NEXT? ***Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)***
To continue to monitor early Improvements in temporary staffing spend in this period following implementation of Nursing Deployment Group and associated interventions.

Action Required
For assurance around the daily mitigation of nurse staffing and oversight of nursing establishments No action from board required needed.

Risk and assurance:	Red Risk 4724 amended to reflect surge staffing and return to BAU
Equality, Diversity and Inclusion:	Ensuring a diverse and engaged workforce improves quality patient outcomes. Safe staffing levels positively impacts engagement, retention and delivery of safe care
Sustainability:	Efficient deployment of staff and reduction in temporary staffing and improving vacancy rates contributes to financial sustainability
Legal and regulatory context	Compliance with CQC regulations for provision of safe and effective care

1. Introduction

The National Quality Board (NQB 2016) recommend that monthly, actual staffing data is compared with expected staffing and reviewed alongside quality of care, patient safety, and patient and staff experience data. The trust is committed to ensuring that improvements are learned from and celebrated, and areas of emerging concern are identified and addressed promptly. This paper will identify safe staffing and actions taken in September and October 2023. The following sections identify the processes in place to demonstrate that the Trust proactively manages nurse staffing to support patient safety.

2. Nursing Fill Rate

The Trust's safer staffing submission has been submitted to NHS Digital for September and October 2023 within the data submission deadline. Table 1 shows the summary of overall fill rate percentages for these months and for comparison, the previous four months. Appendix 1a and 1b illustrates a ward-by-ward breakdown for September and October 2023.

	Day		Night	
	Registered	Care Staff	Registered	Care staff
Average fill rate May 2023	87%	83%	94%	94%
Average fill rate June 2023	89%	84%	94%	95%
Average fill rate July 2023	91%	89%	97%	100%
Average fill rate August 2023	91%	87%	96%	100%
Average fill rate Sept 2023	92%	85%	97%	97%
Average fill rate October 2023	93%	87%	98%	101%

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

An average of the fill rates for roles and shifts have been combined in chart 2 to illustrate the cumulative challenge to nurse staffing over the last year which has seen a deteriorating trend since summer 2021. September and October saw both months above 90% and the past four months have achieved the >90% aspiration.

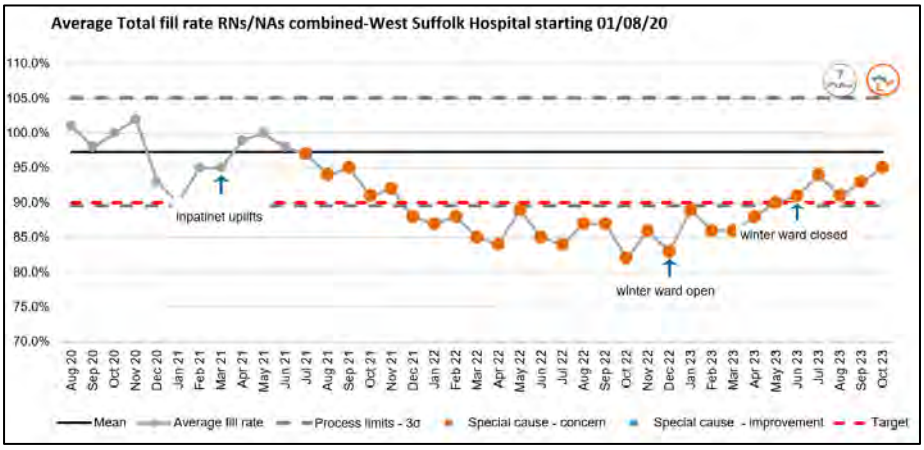


Chart 2.

2.1 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. Chart 3 (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. The past four months have achieved close to or above this ambition which is correlated with improvements in shift fill rates.

CHPPD can be affected adversely by opening additional beds either planned or emergency escalation, as the number of available nurses to occupied beds is reduced. Periods of high bed occupancy can also reduce CHPPD.

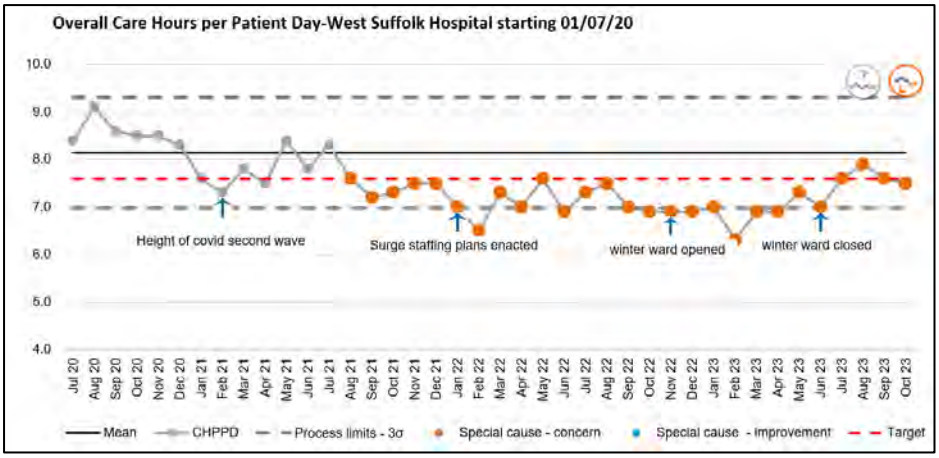


Chart 3 Adapted from model hospital/unify data.

3. Sickness

Sickness rates in both groups have reason over consecutive months. A combined rise of 1% in month 7

	Mar 23	Apr 23	May 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23
Unregistered staff (support workers)	7.27%	7.41%	6.74%	6.63%	6.09%	5.78%	6.14%	6.57%
Registered Nurse/Midwives	4.75%	4.06%	3.84%	4.45%	4.48%	4.69%	4.78%	6.04%
Combined Registered/Unregistered	**5.60%**	**5.20%**	**5.42%**	**4.92%**	**5.02%**	**5.05%**	**5.23%**	**6.21%**

Table 4

Chart 4

4. Recruitment and Retention

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

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

- Substantive Inpatient RN/RM WTE improved on last period. October 2023 has the highest number of WTE substantive staff since (April 2020)
- Inpatient RN/RM vacancy rate has reduced from 11.3% to **8.5%**

- Total RN/RM vacancy rate continues to improve and has reduced from 9.0% to **6%**
- Inpatient ward NA vacancies percentages over this period has increased slightly to **13.0%** in month 7.
- Total NA vacancy rate has increased to **12%**, the improvement trend is not as consistent as with registered staff.
- WTE for NA in both inpatient and trust total is an improving picture and is in special cause improvement.

	Inpatient	Sum of Actuals Period 2 (May)	Sum of Actuals Period 3 (June)	Sum of Actuals Period 4 (July)	Sum of Actuals Period 5 (Aug)	Sum of Actuals Period 6 (Sept)	Sum of Actuals Period 7 (Oct)	WTE VACANCY at period 7
RN/RM Substantive	Ward WTE	666.6	674.8	667.6	678.7	688.2	699.7	65.3
Nursing Unregistered Substantive	Ward WTE	407.8	405.3	394.0	390.4	401.2	390.6	58.6

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

5. New Starters and Turnover

5.1 International Nurse Recruitment (INR):

In 2023 our recruitment target was 84 nurses, and this will confidently be achieved at by December 2023 with a monthly average of 7 nurses per cohort. We anticipate another 12 arriving before the end of the financial year. At present organisations have not received any funding arrangements from NHSE for FY24/25. The international nurse recruitment program continues with positive results and maintains a 100% pass rate for supporting staff through the registration process. Over the past 18 months we have retained all but one nurse due to personal circumstances so turnover of this staff group currently is minimal.

Following a positive vacancy position of registered nurses, as described in section 4, it is anticipated that the monthly cohorts of international nurses will be reduced further. Matching experience and skills to clinical areas is becoming more challenging due to the lack of vacant posts. The international pipeline has been integral to the positive vacancy position so turning off this pipeline may leave the registered nurse cohort vulnerable, particularly considering the reduced candidates in the traditional UK preregistration training programs. In addition, this international pathway will need to be maintained to support the nursing staffing aspirations of the new hospital program where an assumed increased in registrants will be required.

5.2 New starters

	May 23	Jun 23	July 23	Aug 23	Sept 23	Oct 23
Registered Nurses	22	17	15	12	47*	18
Non-Registered	22	26	12	36*	23	24

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

- In September, 47 RNs completed induction; of these; 28 were for the acute, 5 for bank service, 8 for community and 6 for midwifery services.
- In September, 23 NAs completed induction; of these; 12 NAs are for the acute Trust, and 9 for bank services and 2 for midwifery services.

- In October, 18 RNs completed induction; of these; 12 were for the acute, 4 for Midwifery and 2 for bank services.
- In October, 24 NAs completed induction; of these; 16 NAs are for the acute Trust, 1 for midwifery and 4 for bank services and 3 for community services.

5.3 Turnover

On a retrospective review of the last rolling twelve months, turnover for RNs continues to positively be under the ambition of 10%. Turnover remains static at 9.1% for this period. NA turnover has decreased slightly to 23.4%. The high turnover of this staff group has been escalated through the finance and workforce committee and is being captured at the Trust retention group. Interventions to address high turnover included more informative onboarding process and this has been positively received by clinical teams.

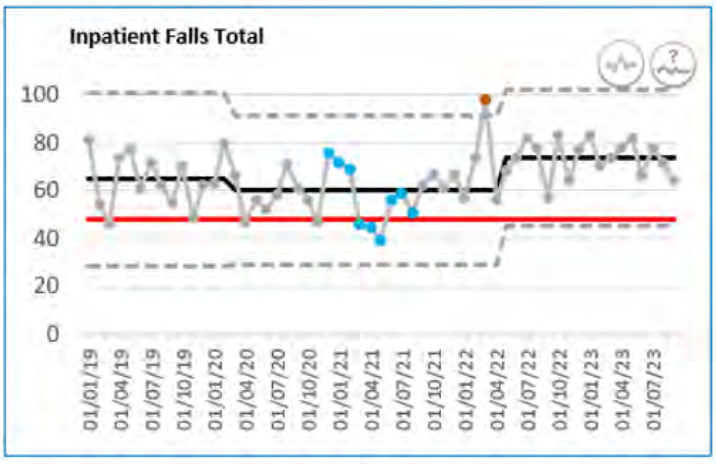
		Turnover	01/11/2022	-	31/10/2023			
Staff Group	Average Headcount	Avg FTE	Starters Headcount	Starters FTE	Leavers Headcount	Leavers FTE	LTR Headcount %	LTR FTE %
Nursing and Midwifery Registered	1,423.50	1,238.0577	88	72.3400	140	112.9467	9.8349%	9.1229%
Additional Clinical Services	603.00	505.1375	301	276.2154	149	118.1986	24.7098%	23.3993%

Table 7. (Data from workforce information)

6. Quality Indicators

Falls and acquired pressure ulcers.

Both falls and presure ulcers incidents remain in common cause variation (chart 8 & 9). Althogh falls per 1000 bed days is an improving picture. A full narrative around this quality measure interventions can be found in the IQPR. Improvement projects and overisght is completed through the patien quality and safety governance group (PQSGG).



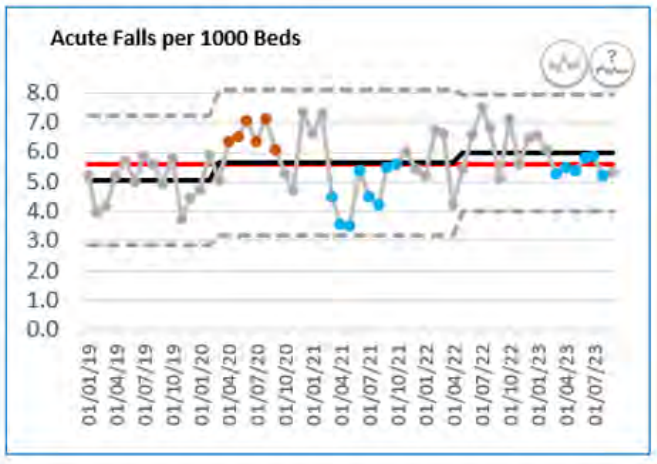
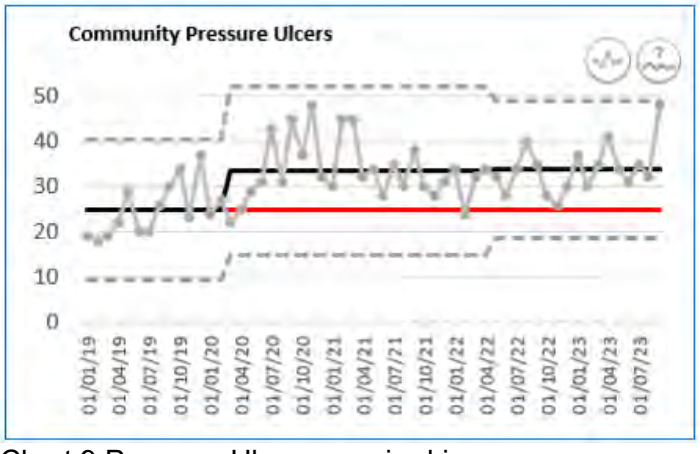


Chart 8- inpatient falls



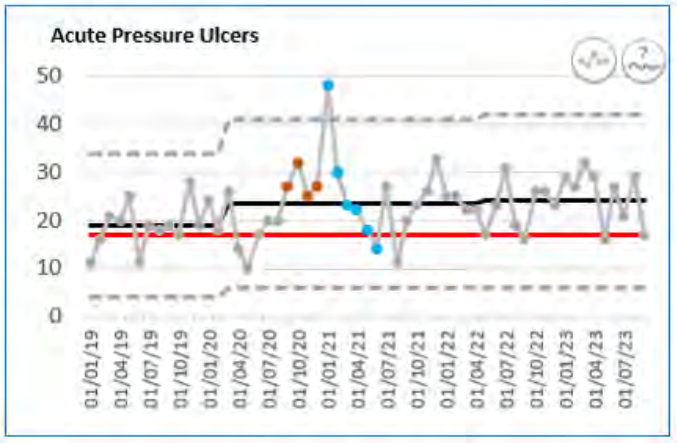


Chart 9 Pressure Ulcers acquired in care.

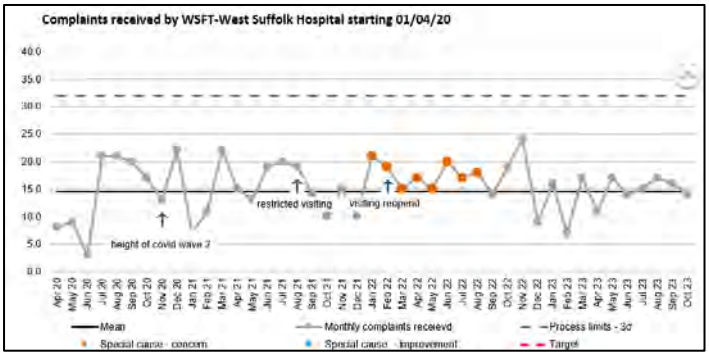
7. Compliments and Complaints

16 formal complaints were received in September. A theme for complaints this month was patient care – including nutrition/hydration with 6 formal complaints being listed under this subject. Complaints listed under this subject mainly related to care needs not being adequately met and failure to monitor pressure sores. Any patient harms will go through an after-action review (AAR) process and feed into the complaint response. An additional theme this month was 'communication' and 'values & behaviours' (staff) with 3 complaints being listed under each of these subjects.

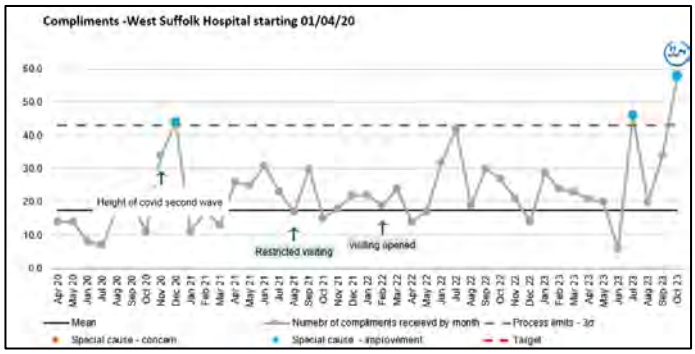
14 formal complaints were received in October. The main theme for complaints in October was Clinical Treatment with 8 formal complaints being listed under this subject (although these are separated out into areas e.g., clinical treatment – surgical group). Complaints listed under this subject mainly related to delays in treatment and diagnosis.

Chart 10a and 10b demonstrates the incidence of complaints and compliments for this period. The number of complaints is at expected levels for this period and October complaints were below monthly average. October saw another period of special cause improvement with highest number of compliments received this month.

The clinical helpline continues to take approximately 100 calls per day.



10a Complaints



10b Compliments

8. 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. For the purpose of this paper only those that meet NQB recommendations of a 'red flag' are included.

Red Flag	Apr 23	May 23	June 23	July 23	Aug 23	Sep 23	Oct 23
Registered nursing shortfall of more than 8 hours or >25% of planned nursing hours	2	1	1	-	4	2	2
>30-minute delay in providing pain relief	1	1	1	-	-	1	-
Delay or omission of intention rounding	3	-	5	2	2	1	4
<2 RNs on a shift	1	3	3	-	1	4	1
Vital signs not recorded as indicated on care plan	-	-	1	1	-	-	-
Unplanned omissions in providing medication	-	-	1	-	-	1	-
Lack of appointments (local agreed red flag)	-	1	-	-	-	-	1
Delay in routine care (locally agreed red flag)	4	1	3	3	7	2	2
Unable to make home visits locally agreed	-	1	-	-	2	2	-
GPICS standards not met (new descriptor for ITU)	-	-	-	-	-	5	1
Impact not described	-	1	2	-	-	-	-
Total	11	9	17	6	17	18	11

Table 11.

- In September 17 Datixs recorded for nurse staffing that resulted in a Red Flag event (see table 11.). One incident has been reported as moderate harm, following a readmission to hospital from virtual ward.

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

9. Maternity Services

A full maternity staffing report will be attached to the maternity paper as per CNST requirements.

	Standard	May	June	July	August	Sept	Oct
Supernumerary Status of LS Coordinator	100%	100%	100%	100%	100%	100%	100%
1-1 Care in Labour	100%	100%	100%	100%	100%	100%	100%
MW: Birth Ratio	1:27 changed to 1:21 March	1:26	1:26	1:21	1:22.5	1:20.5	1:23.5
No. Red Flags reported		4	2	2	1	6	2

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. Red Flags are captured on Datix and highlighted and mitigated as required at the daily Maternity Safety Huddle.

- There were six red flag events reported in September
- There were two red flag events in October

All red flags reported were due to delays in commencing induction of labour process as a result of high acuity in the Unit and some sickness related staff absence. No harm was recorded as in impact of these incidents.

Midwife to Birth ratio

Latest BirthRate plus review undertaken in March 2023 shows that Midwife to Birth ratio at West Suffolk NHS Foundation Trust dropped to 1:21. The ratios are based on the Birthrate Plus® dataset, national standards with the methodology and local factors, such as % uplift for annual, sick & study leave, case mix of women birthing in hospital, provision of outpatient/day unit services, total number of women having community care irrespective of place of birth and primarily the configuration of maternity services.

- September's midwife to birth rate was 1:20.5
- October slight increase in midwife to birth ratio was noted 1:23.5. This was due to increased acuity and some staffing shortages due to short notice sickness.

Supernumerary status of the labour suite co-ordinator (LSC)

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 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. 100% compliance against this standard was achieved in September and October 2023.

10. Community & Integrated services division

10.1 Demand

The SPC charts show that demand for therapy in the INT teams is consistently increasing while nursing referrals have remained static, although October data showed a significant increase in activity.

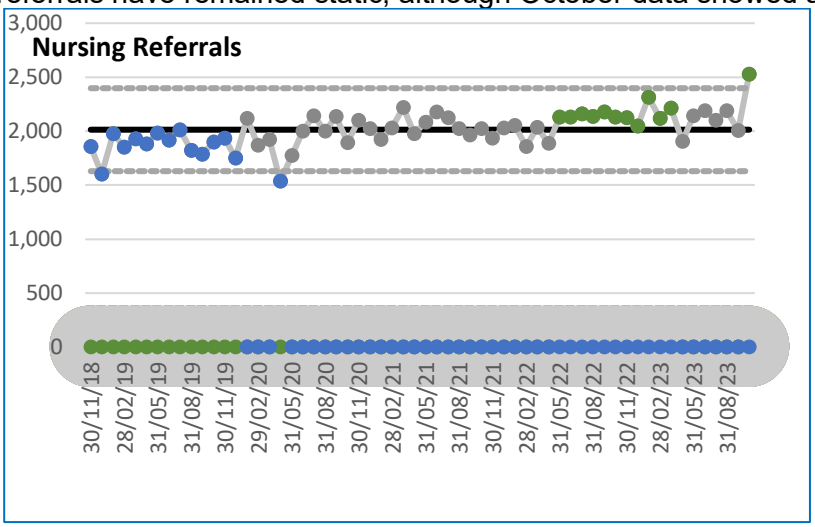


Chart 12a

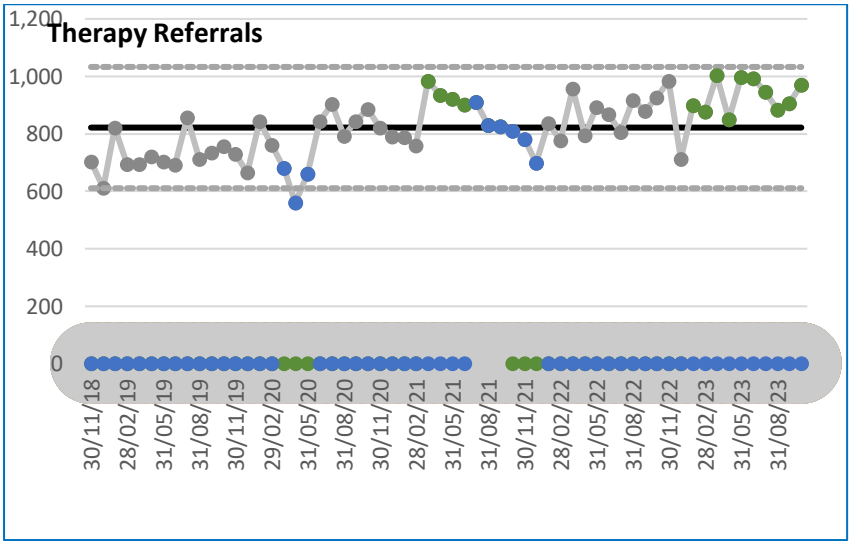


Chart 12b

10.2 Sickness & Turnover

Sickness within the community continues to be in a positive improvement. As can be seen in the SPC (chart 13) the levels of sickness are reducing but not consistently below the <5% ambition. Whilst the Turnover data (chart 14) shows that community are not meeting the Trust's target of 10%, the Division has made a significant reduction in turnover since August (2022) when the Division peaked at 16% and continues to reduce month on month with a sustained improvement.

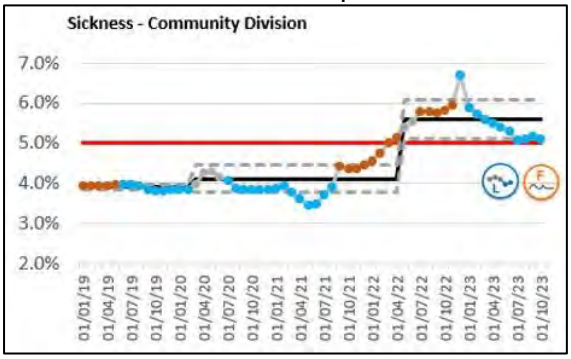


Chart 13.

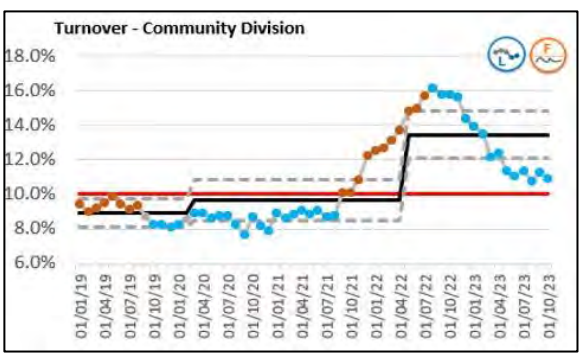


Chart 14

10.3 What next for community teams?

- Reducing Turnover is a constant theme with all managers. Areas with over 10% turnover receive special focus and HR are working with managers on exit interviews and "stay conversations".
- Healthroster templates have not been accurate for INT teams, this is an area being prioritised by team managers so that they have accurate view of staffing levels and can keep a tighter control on the use of bank and agency staffing.
- Historically INT teams did not have headroom considered. The use of the Community safer staffing is helping us to understand and better model the staffing requirements based on caseload size and dependency. A paper is being written to explain the results of the CNSST and the next steps.
- HR are using new recruitment website, which is attracting more candidates to apply for posts.

11. Nursing Resource Oversight.

At the time of writing the Nursing Deployment Group (NDG) has met three times to provide grip and assurance around temporary nursing spend and the appropriate deployment of the nursing and midwifery resource. This group will report into the Workforce Resource Group (WRG) to provide additional governance and oversight of its outputs. Trust level data regarding nursing/midwifery temporary spend can be found in appendix 4.

12. Recommendations and actions

- Note the information on the nurse and midwifery staffing and the impact on quality and patient safety.
- Note the content of the report and that mitigation is put in place where staffing levels are below planned.
- Note that the content of the report is undertaken following national guidelines using research and evidence-based tools and professional judgement to ensure staffing is linked to patient safety and quality outcomes.

Appendix 1. Fill rates for inpatient areas (September 2023): Data adapted from Unify submission.

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

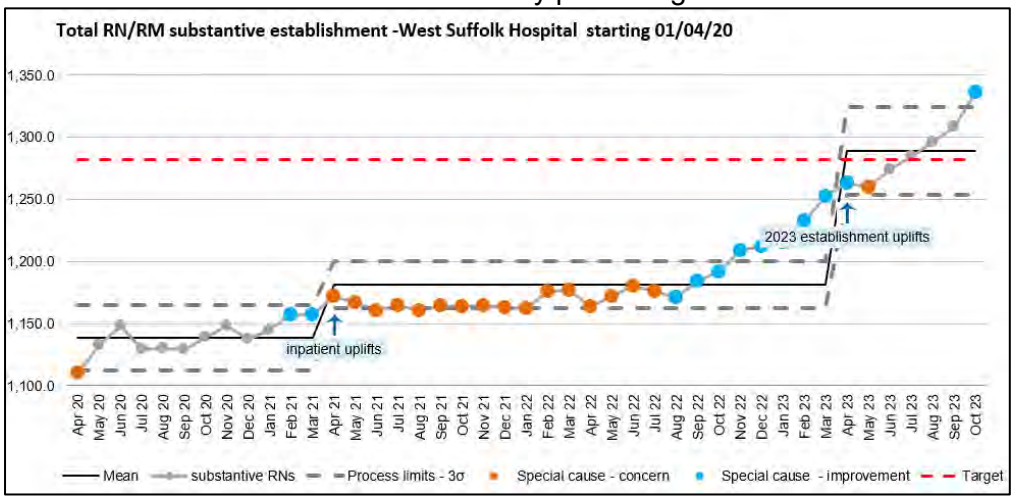
	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	RNs/RMN		Non registered (Care staff)		RNs/RMN		Non registered (Care staff)									
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned 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	1304.25	1267	1710.5	1487	1012	988.75	1380	1301	97%	87%	98%	94%	452	5.0	6.2	11.2
Glastonbury Court	685.5	687	1034	1021.5	690	690	525	519.5	100%	99%	100%	99%	384	3.6	4.0	7.6
Acute Assessment U	2041	2124.5	2379.25	1661.25	1702	1610.5	1366.5	1046.5	104%	70%	95%	77%	761	4.9	3.6	8.5
Cardiac Centre	1725	1644.5	1007.5	731.5	1725	1541	690	652.5	95%	73%	89%	95%	632	5.0	2.2	7.2
G10	1674.5	1468	1627.75	1390.25	1035	1034.25	1679	1408	88%	85%	100%	84%	707	3.5	4.0	7.5
G9	1426	1342.5	1373	1259	1368.5	1287	1035	1175.75	94%	92%	94%	114%	752	3.5	3.2	6.7
F12	552	690.5	425.5	363	650	615.5	338	389.5	125%	85%	95%	115%	240	5.4	3.1	8.6
F7	1675.5	1532	1639	1473	1380	1367.5	1712.5	1348	91%	90%	99%	79%	683	4.2	4.1	8.4
G1	1389	962.5	343.5	351.5	690	690	322	332.5	69%	102%	100%	103%	485	3.4	1.4	4.8
G3	1655.25	1434.5	1646	1617.5	1000.5	1000.5	1035	1350.5	87%	98%	100%	130%	864	2.8	3.4	6.3
G4	1695	1352.25	1721	1579	1026	873	1372	1361.5	80%	92%	85%	99%	896	2.5	3.3	5.8
G5	1345.5	1377	1630	1484.5	690	1042.333333	1380	1446.5	102%	91%	151%	105%	760	3.2	3.9	7.0
G8	2382.5	1995.5833	1498.25	1388.75	1667.5	1614.333333	1027.5	995.5	84%	93%	97%	97%	615	5.9	3.9	9.7
F8	1725	1554.3333	1721	1543.5	1023.5	967	1380	1406.75	90%	90%	94%	102%	723	3.5	4.1	7.6
Critical Care	2407.75	2279.25	330	158.75	2414	2279.5	0	9.5	95%	48%	94%	*	388	11.7	0.4	12.2
F3	1557	1428.1667	2070	1539.6667	1035	1030	1380	1333.25	92%	74%	100%	97%	732	3.4	3.9	7.3
F4	908.5	855.5	852	598	644	609.5	574	417.5	94%	70%	95%	73%	633	2.3	1.6	3.9
F5	1841	1830.1667	1390	1060.5	1012	999.5	1035	852.5	99%	76%	99%	82%	698	4.1	2.7	6.8
F6	1701	1253.6667	1677.5	1477.75	1081	1020.916667	671.1666667	990.666667	74%	88%	94%	148%	942	2.4	2.6	5.0
Neonatal Unit	1163.75	1134.25	408	432	924	948	492	480	97%	106%	103%	98%	116	18.0	7.9	25.8
F1	1703	1570.25	690	578.5	1380	1276.5	0	43	92%	84%	93%	*	115	24.8	5.4	30.2
F14	360	356.5	0	0	720	720	0	0	99%	*	100%	*	106	10.2	0.0	10.2
Total	32,918.00	30,139.92	27,173.75	23,196.42	24,870.00	24,205.58	19,394.67	18,860.42	**92%**	**85%**	**97%**	**97%**	**12684**	**4.3**	**3.3**	**7.6**
* planned hours are zero, so additional support used on ward to mitigate unfilled nursing hours																

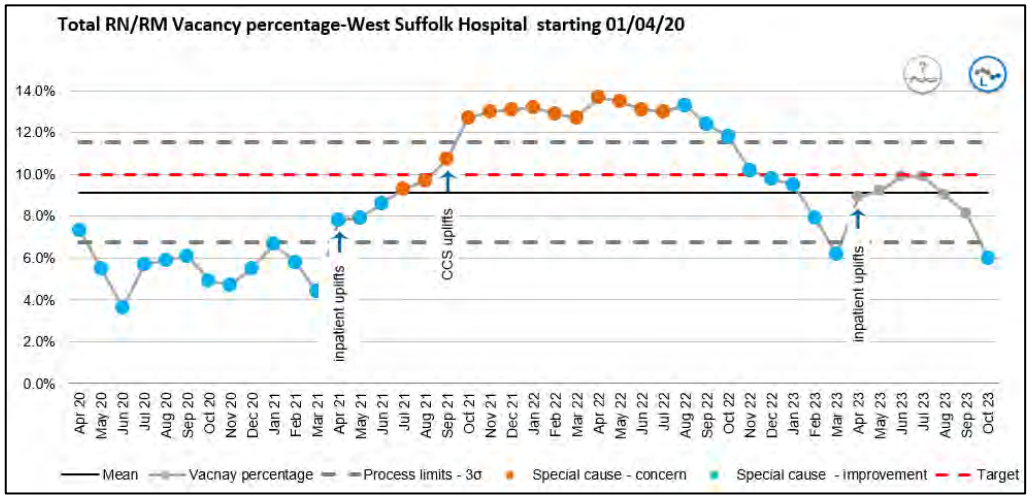
Appendix 1. Fill rates for inpatient areas (October 2023) Data adapted from Unify submission.

	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	1380.75	1244.75	1788	1634.75	1068.5	1068.5	1426	1407.41667	90%	91%	100%	99%	970	2.4	3.1	5.5
Glastonbury Court	718	728	1064.5	1057.3	713	712.25	536.5	524	101%	99%	100%	98%	552	2.6	2.9	5.5
Acute Assessment U	2092.5	2221	2358.25	1831	1782.5	1813	1377	1197	106%	78%	102%	87%	761	5.3	4.0	9.3
Cardiac Centre	1753	1585.5	1058	791	1771	1575.5	709	674.5	90%	75%	89%	95%	632	5.0	2.3	7.3
G10	1728	1526.5	1692.41667	1536.0833	1058	1036	1731.983333	1425.48333	88%	91%	98%	82%	707	3.6	4.2	7.8
G9	1669.25	1497.25	1380	1418.0833	1288	1265.5	1069.5	1262	90%	103%	98%	118%	752	3.7	3.6	7.2
F12	552	606.5	572	377.5	655.5	573	333.5	317	110%	66%	87%	95%	240	4.9	2.9	7.8
F7	1748	1684	1581.25	1482.25	1411	1337.333333	1758	1559	96%	94%	95%	89%	683	4.4	4.5	8.9
G1	1433	980.5	354.5	316.75	713	713	356.5	345	68%	89%	100%	97%	485	3.5	1.4	4.9
G3	1628	1500.25	1698.5	1617.75	1046.5	1058	1057	1505	92%	95%	101%	142%	864	3.0	3.6	6.6
G4	1778.5	1501.5	1787	1685	1058	943	1423	1483.5	84%	94%	89%	104%	896	2.7	3.5	6.3
G5	1426	1389	1775.5	1544.5333	713	1037	1426.5	1481.5	97%	87%	145%	104%	760	3.2	4.0	7.2
G8	2020	2032.1667	1407.73333	1470.5667	1592.5	1604.916667	1064.5	1150.75	101%	104%	101%	108%	615	5.9	4.3	10.2
F8	1533.5	1543.9167	1742	1622.1667	1046.5	958	1426	1459.5	101%	93%	92%	102%	723	3.5	4.3	7.7
Critical Care	2494.75	2392.75	341	154	2495.5	2403.25	0	11	96%	45%	96%	*	388	12.4	0.4	12.8
F3	1610	1463.75	2111	1604.8333	1069.5	1048.5	1403	1392.5	91%	76%	98%	99%	732	3.4	4.1	7.5
F4	860.5	802.71667	531	507.5	644	621	368	314.5	93%	96%	96%	85%	633	2.2	1.3	3.5
F5	1886.5	1734.0833	1610.5	1096.3333	1023.5	1023.5	1012	897.75	92%	68%	100%	89%	698	4.0	2.9	6.8
F6	1723.5	1390.75	1746	1355.5	1058	1079	701.5	1120	81%	78%	102%	160%	942	2.6	2.6	5.2
Neonatal Unit	1276.75	1148.75	742	608.5	1116	960	744	504	90%	82%	86%	68%	116	18.2	9.6	27.8
F1	1682.5	1837.5	713	564.75	1426	1426	0	23	109%	79%	100%	*	115	28.4	5.1	33.5
F14	372	368	120	120	744	744	0	0	99%	100%	100%	*	106	10.5	1.1	11.6
Total	33,367.00	31,179.13	28,174.15	24,396.15	25,493.50	25,000.25	19,923.48	20,054.40	**93%**	**87%**	**98%**	**101%**	**13370**	**4.2**	**3.3**	**7.5**
* planned hours are zero, so additional support used on ward to mitigate unfilled nursing hours																

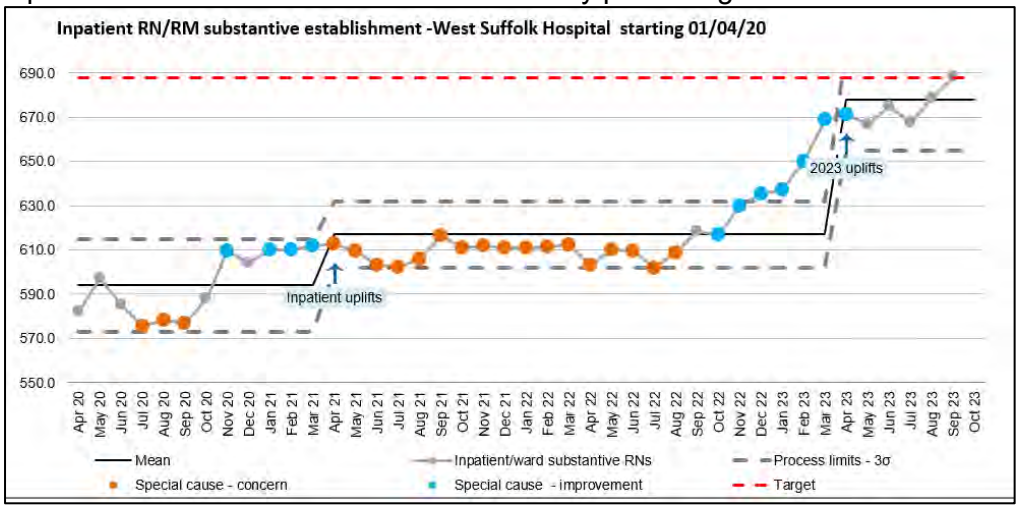
Appendix 2 SPC charts.

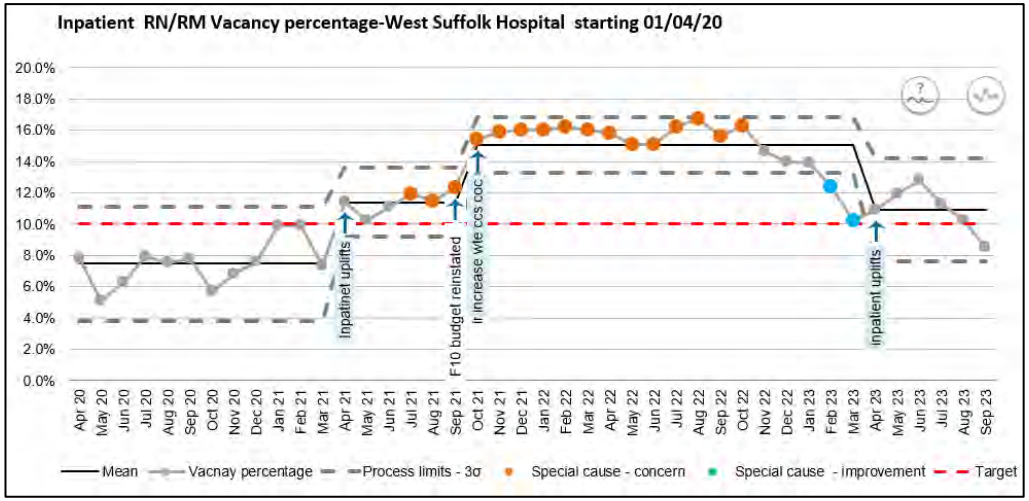
Total RN/RM establishments and vacancy percentage



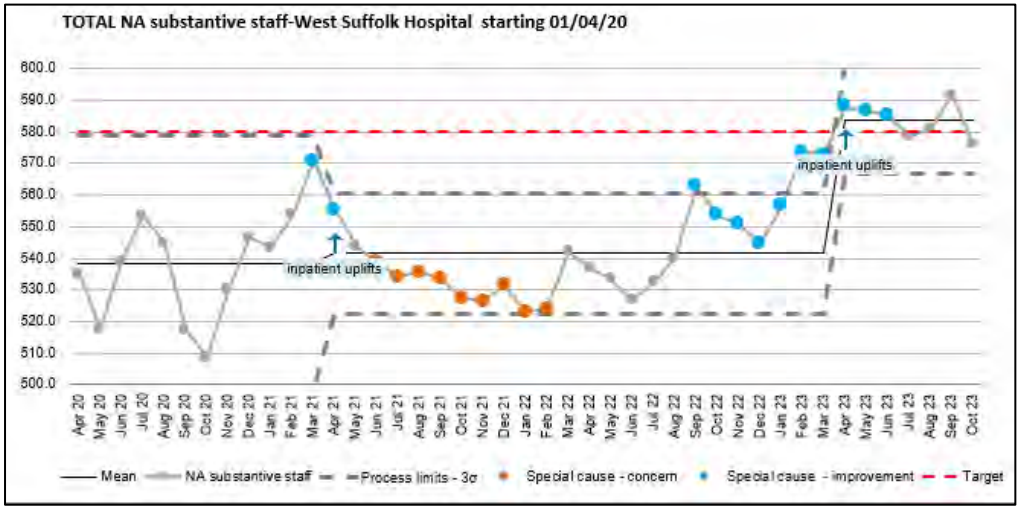


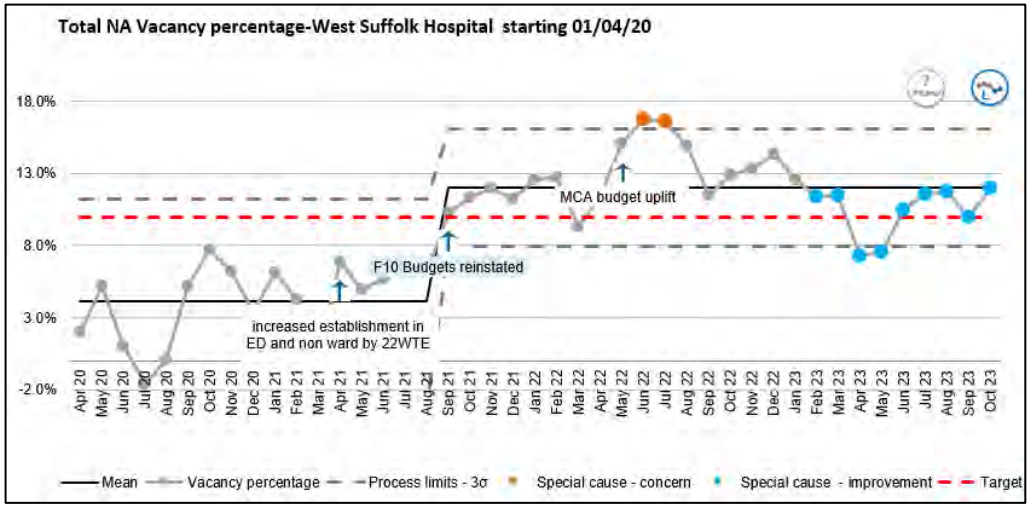
Inpatient RN/RM establishments and vacancy percentage



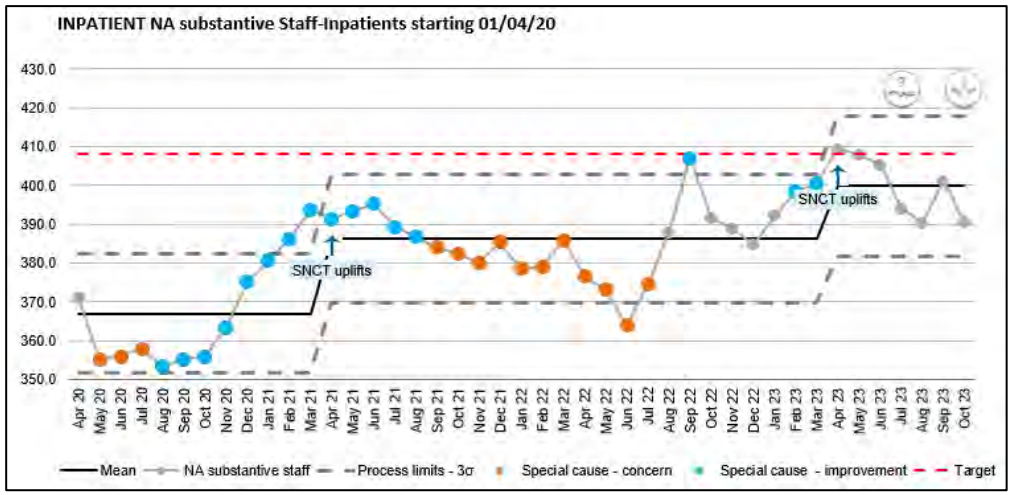


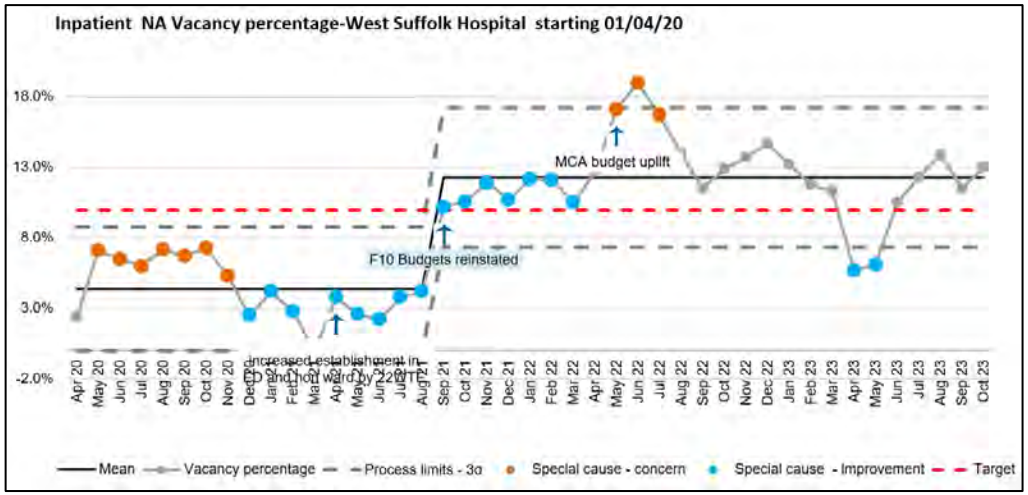
Total NA WTE numbers and vacancy percentages





Inpatient NA WTE numbers and vacancy percentage





Appendix 3: Red Flag Events

Maternity Services

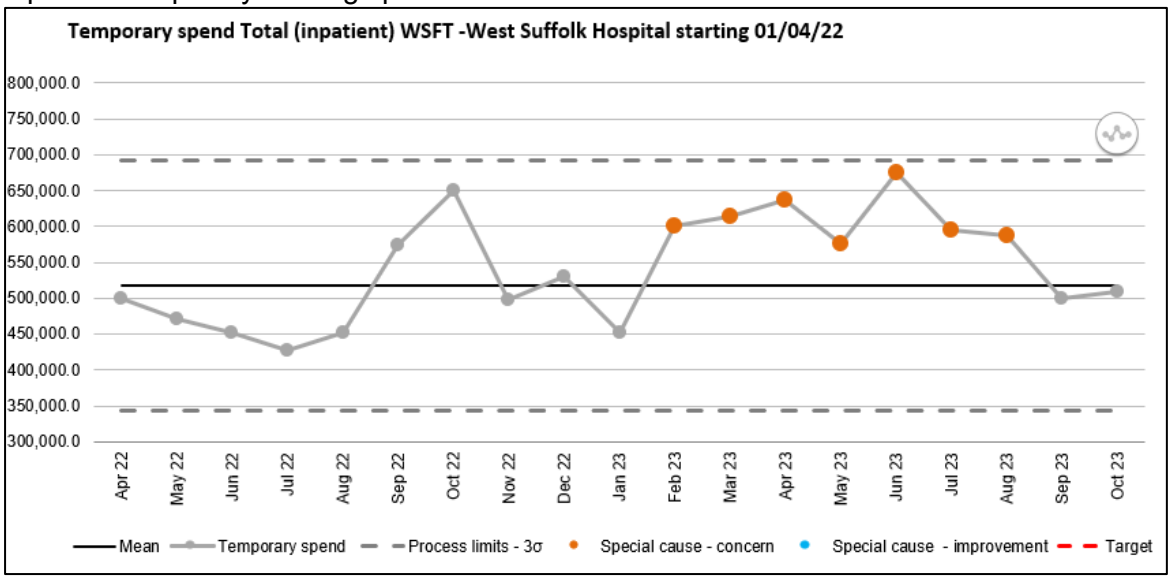
Missed medication during an admission
Delay of more than 30 minutes in providing pain relief
Delay of 30 minutes or more between presentation and triage
Delay of 60 minutes or more between delivery and commencing suturing
Full clinical examination not carried out when presenting in labour
Delay of two 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

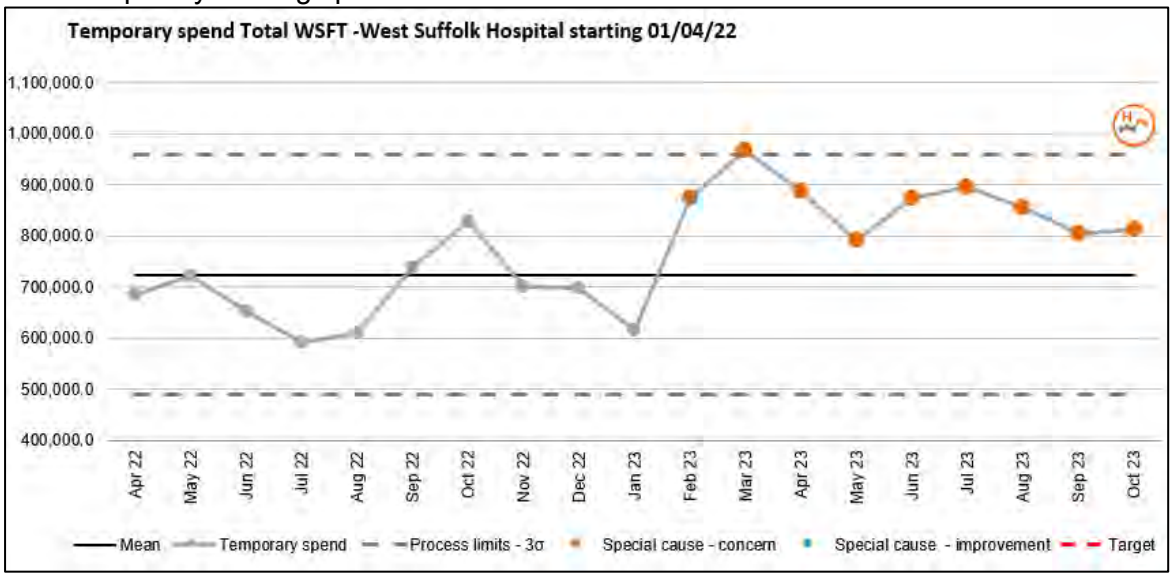
Unplanned omission in providing patient medications.
Delay of more than 30 minutes in providing pain relief
Patient vital signs not assessed or recorded as outlined in the care plan.
Delay or omission of regular checks on patients to ensure that their fundamental care needs are met as outlined in the 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.
Unable to make home visits.

Appendix 4: Trust level temporary spend

Inpateint temporary nursing spend.



Total temporary nursing spend.



4.4.1. Maternity Services

Karen Newbury, Kate Croissant & Simon Taylor in attendance

To Approve

Open Trust Board	
Report title:	Maternity quality, safety, and performance report
Agenda item:	Maternity services quality & performance report
Date of the meeting:	1st December 2023
Sponsor/executive lead:	Sue Wilkinson, Executive Chief Nurse Paul Molyneux, Medical Director & Executive MatNeo Safety Champion
Report prepared by:	Karen Newbury, Director of Midwifery

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

WHAT?

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 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 System.

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)
- Neonatal Medical Workforce Report – April to September 2023 (Annex B)
- Obstetric Workforce Report (Annex C)
- Transitional Care and Avoiding Term Admissions to the Neonatal Unit (ATAIN) Q2 2023-2024 (Annex D)
- Neonatal Nursing Staffing Assessment August 2023 (Annex E)
- Maternity Incentive Scheme Safety Action 5 Midwifery Workforce (Annex F)
- Maternity Incentive Scheme Safety Action 7 Maternity and Neonatal Voices Partnership (Annex G)
- Perinatal Mortality Report – Quarter 2, 2023- 2024 (Annex H)
- Maternity and Neonatal Safety Investigations (formerly HSIB) and Early Notification Report Quarter 2 2023-2024 (Annex I)

• Maternity Claims Scorecard, incident and complaint data Quarterly Review (Quarter 2 -July-September 2023) (Annex J)
SO WHAT?
The report meets NHSE standard of perinatal surveillance by providing the Trust board a methodical review of maternity and neonatal safety and quality.
WHAT NEXT?
Action plans will be monitored and any areas for non-completion, escalated as appropriate. Quarterly, bi-annual and annual reports will evidence the updates. Reports will be shared with external stakeholders as required.
Action Required
For assurance and information only.

Risk and assurance:	As below
Equality, Diversity and Inclusion:	This paper has been written with due consideration to equality, diversity, and inclusion.
Sustainability:	As per individual reports
Legal and regulatory context	The information contained within this report has been obtained through due diligence.

Maternity quality, safety, and performance report

1.	**Detailed sections and key issues**
1.1	**Maternity improvement plan** The Maternity and Neonatal Improvement Board (MNIB) receives the updated Maternity improvement plan monthly. 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 and continues to be reviewed by the Maternity Improvement Board monthly. It has been agreed with the exit from the Maternity Safety Support Programme (MSSP) that NHSE regional team and ICS (Integrated Care System) will be invited to attend the MNIB monthly for additional assurance and scrutiny. In addition to this, the next 60 Supportive Steps visit from NHSE and the ICS is planned for mid December 2023, to provide a systematic review of the Trust's maternity and neonatal service.
1.2	**Safety Champion 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'. Roger Petter our Non-Executive Maternity and Neonatal Safety Champion completed four walkabouts throughout September and October 2023. Due to the close working relationships between maternity and theatres, Roger visited theatres twice in September 2023. The theatre team shared some improvement ideas as well as general

comments, including; they would like to understand the rationale or underlying cause for changes in practice, so they are not perceived as a tick box exercises and the minuting of meetings so that those not in attendance can be informed of what was discussed. Improvement ideas were put forward which have been shared with the wider maternity team, regarding communication in theatre, for example theatre hats with job titles on them, patients wearing alert wristbands for specific procedures, reinstatement of monthly meetings between maternity and theatre teams. The Team have found the scenario training with maternity staff very helpful and would like to attend more human factors training.

Roger also visited the community midwifery team in Sudbury on the 25th October and the Thetford community midwifery team on the 26th October. No safety concerns were raised however discussion regarding data entry risks due to IT systems not communicating with each other in the community and Entonox cylinder provision in the community was highlighted.
Roger has utilised the walkabouts to generally emphasise Freedom to Speak (FTSU) up and to assure all that Trust Board level and the senior team take FTSU very seriously.

In addition to this, as part of the Maternity Improvement Scheme, a new requirement for the Board Safety Champions to meet with the Perinatal Quadrumvirate quarterly to identify any support that is required from them in addressing safety issues has been introduced. This has been successfully implemented by the Associate Director of Operations for Women and Children Services attending the Safety Champion meetings where the other members of the quadrumvirate are already in attendance.

1.3 **Listening to Staff**

The National Staff Satisfaction Survey results were published in April 2023 and the divisional operational managers are working on an action plan regarding areas for further development.

The maternity and neonatal service continues to promote all staff accessing the Freedom to Speak up Guardians, Safety Champions, Professional Midwifery Advocates, Unit Meetings and 'Safe Space'. In addition to this there are maternity and neonatal staff focus groups, and specific care assistant and support worker forum, which all provide an opportunity to listen to staff.

On the back of recent retention data from the national and regional teams, it is recognised that the majority of midwives are leaving the profession 2-5 years after qualification. We are committed to working with the Local Maternity /Neonatal System and regional team to address this. In response we have undertaken a flexible working survey, commenced Midwifery Band 6 forums, and are undertaking 'stay conversations' which have been received very positively. The 'Legacy Midwife' role has now commenced, and a pilot of self-rostering (as indicated by the flexible working survey results) is underway in differing teams across maternity.

1.4 **Service User feedback**

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

Ward/Dept	Sep Survey returns	Sep FFT score	Oct Survey returns	Oct FFT Score
F11	34 ↓	100	42 ↑	98 ↓
Antenatal	8 ↓	100	2 ↓	100
Postnatal Community	5 ↓	100	1 ↓	100
Labour Suite	22 ↓	100 ↑	17 ↓	100
Birthing Unit	6 ↓	100	5 ↓	100
NNU	6 ↓	100 ↑	16 ↑	100
Transitional Care	0	N/A	0	N/A

Plans to increase the number of returns for antenatal and postnatal community were relying on the introduction of a SMS survey response. Due to financial constraints, it has not been possible to pursue this, however a solution has been found via email survey and a trial of this commenced early October 2023. The number of returns has significantly dropped across all areas. The Maternity team are working with the Patient Engagement team to resolve this.

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

On review of enquiries and complaints received during September and October 2023 the main themes continue to be regarding clinical treatment and communication. The aim for 2023 was to develop meaningful personalised care plans from the antenatal period through to the intrapartum and postnatal stages to help address this. This will require an electronic solution to enable it, which is currently still being explored.

1.5 **Reporting and learning from incidents**

During September and October 2023 there were no new cases that met the referral criteria to the Healthcare Safety Investigation Branch (HSIB). From the 1st October 2023 HSIB has transitioned to the Care Quality Commission (CQC) and is now called Maternity and Newborn Safety Investigations (MNSI). The MNSI will continue to work with NHS Resolution in line with the Maternity Incentive Scheme. There are no changes to the requirement to refer cases to them. The maternity service is represented at the Local Maternity and Neonatal System (LMNS) monthly safety forum, where incidents, reports and learning are shared across all three maternity units.

1.6 **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. Please see below:

What?	So What?	What Next?
Post-partum Haemorrhages (PPH) (>1500 mls) for Lower Section Caesarean Sections (LSCS) and Vaginal Births. The LSCS PPH rate does indicate some stability in the last couple of months (excluding August 2023) with September returning to a lower limit, whereas the vaginal PPH rates, have increased above the target for three consecutive months for the first time in over 2 years.	The rate is significantly higher than the national target and therefore the Trust is viewed as an outlier. Potential increase of length of stay and additional treatment, reduced family bonding time.	Regional and Local Maternity and Neonatal System to continue to offer support. External review requested. Relaunch of the Maternity PPH QI project in November 2023 and action plan develop to monitor the progress. Themes identified so far: • Delayed recognition of overall blood loss in the immediate PN period, usually during suturing • Delay in escalation Action take: • Skills and drills • Changes to the training provided to reflect the learning identified. • Regular reviews
Compliance with Trust guidance regarding asking Domestic Abuse questions; **twice** in the antenatal period and **once** in the postnatal	Nearly one in three women who suffer from domestic abuse during their lifetime report that the first incidence of violence happened while they were pregnant. A quarter (25%) of children in high-risk domestic abuse households are under 3	Antenatal compliance has shown a marked improvement over the last 8 months. Postnatal compliance is not consistent, therefore indicating processes are not embedded. Compliance data through audit, continues to be

	period.	years old. 62% of children living in domestic abuse households are directly harmed by the perpetrator of the abuse, in addition to the harm caused by witnessing the abuse of others	reviewed weekly. QI work has commenced, and connectivity in the community has been identified as an issue inhibiting access to patient records in community settings. Awaiting purchase of dongles prior to commencing trial. Ongoing training and guidance for staff continues. Whilst undertaking the audits it has been noted that 99% of all women are asked at least once in the antenatal/postnatal period regarding domestic abuse.

2. Reports

2.1 **Neonatal Medical Workforce Report – April to September 2023 (Annex B)**

Background: Medical staffing in the Neonatal Unit (NNU) of West Suffolk Hospital is required to meet the standards set by the British Association of Perinatal Medicine (BAPM) for staffing levels at all Tiers. The Maternity Incentive Scheme (MIS) run by NHSR is in its 5th year and the requirement is that the Trust meets the BAPM standards for safe staffing of the NNU. This report outlines the review undertaken and the findings thus providing assurance or an indication of where improvements need to be made in this area of safe effective care and services.

Findings: The rotas were assessed against the standards for the period of April 1st to September 30th 2023. There were 5 occasions where the weekday session on NNU was not covered on either a Monday, Wednesday, or a Friday. The escalation for these gaps is that the Paediatrician on call (POW) will attend NNU. This did not result in any harm or adverse outcomes for the neonates.
All other shifts were covered either with planned rostering or, in cases of shortages, with locums or consultants acting down. This reduces the risk and impact on safety and the provision of effective care.
All the consultant paediatricians have attended 8 hours of neonatal specific training and updates in the last year.

Next Steps:
• Embed the neonatal training programmes and ensure the recording process is robust and is able to easily demonstrate compliance rates.
• Ensure that the recruitment and retention of staff is a key strategy for the service and the effect of vacancies minimised by forward planning.
• Short- and long-term shortages to be proactively managed using the escalation pathway.
• A review of the arrangements for NNU consultant cover on a daily basis will be undertaken to ensure that standards are consistent throughout the week and twice daily consultant ward rounds can be held.

2.2 **Obstetric Workforce Report (Annex C)**

Background
This report is part of the ongoing assurance of the Trust's compliance with Year 5 of the Maternity Incentive Scheme Safety Action 4A: Can you demonstrate an effective system of clinical workforce planning to the required standard? Obstetric Workforce.
The 4 elements of obstetric staffing that the Trust is monitoring for these safety standards are:

- Use of short-term locums
- Use of long-term locums
- Compensatory rest for Consultant Obstetricians
- The presence of Consultant Obstetricians at certain higher risk births or clinical scenarios.

	Findings • The Trust has only used locums from the existing workforce to cover short-term shortages on the rota. Consultants acting down has also been used when required. • The Royal College of Obstetricians and Gynaecologists (RCOG) checklist has been adapted for use when long-term locums are required. One long-term locum has been used during the period of review. • The Division is committed to providing compensatory rest to Consultant Obstetricians after an on-call and it is only when there is urgent clinical work that this is not adhered to. • There continues to be a high standard of compliance with the Consultants attending specific clinical scenarios where there is a higher risk of complication or harm to the mother or baby. **Next Steps** • There should continue to be daily monitoring at the safety huddle to demonstrate that the Consultant Obstetricians are called and attend the clinical scenarios where there is increased risk of adverse outcomes or harm to mothers and babies. • The multi-disciplinary team (MDT) to work together to ensure these standards are maintained and any deviations from safe standards should be reported and investigated using the incident reporting system. Learning and improvements from these incidents should be shared with the MDT. • Board reports on attendance of the Consultant Obstetricians at certain clinical scenarios to continue every 6 months to ensure that these safety standards are maintained.
2.3	**<u>Transitional Care and Avoiding Term Admissions to the Neonatal Unit (ATAIN) Q2 2023 2024</u> (Annex D)** **Background** This report will be looking at the babies that required additional monitoring and observation, which includes term babies that required an admission to the Neonatal Unit (NNU) and the late preterm (34^{+6}-36^{+6}) and term babies that were admitted to the Neonatal Transitional Care (NTC). **ATAIN** ('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 reasons 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. Twenty-one term babies (4% of the babies born) admitted to the neonatal unit in this reporting period of the 529 babies born. This is in line with last reporting period when 3.4% (18) term babies were. Therefore for 2 consecutive quarters the Trust has been well below the national target of 6%. Respiratory distress remained the predominant reason for admission, accounting for 20 term admissions (95.2%). All required oxygen and the majority received this through non- invasive techniques including Vapotherm (75%), four babies via nasal cannula (4 babies- 20%). One baby was intubated and ventilated due to the need for cooling (therapeutic hypothermia) and a transfer to a tertiary unit for escalation of care. The remaining baby was reviewed following a dusky episode while being skin- to – skin with the mother. The cause of this was not found and there was no sepsis identified. It has been recognised in a HSIB national report as a risk during poor positioning during skin to skin. Parent information posters regarding safe positioning are displayed in all birthing rooms. All babies in this reporting period were screened for sepsis and this was confirmed in 4 (19%) babies. There is a low threshold for the screening of sepsis in the neonate when considering both maternal and neonatal risk factors. Kaiser is an ongoing quality improvement project to reduce the number of babies receiving antibiotics, unfortunately not all term admissions meet the projects criteria.

The reviewing group is a multi-disciplinary team who evaluate the cases at a monthly held meeting, in line with best practice. The reviewing group concluded that all admissions to the Neonatal Unit were unavoidable.

All admissions to the neonatal unit were stepped down to transitional care at the earliest opportunity, transitional care facilitates mothers and their babies to remain together and minimises separation.

Due to the robustness of the review process, there are however learning points identified, and while not changing the outcome they offer valuable opportunities to improve the quality of care for the wider population.

Neonatal Transitional Care (NTC)
Neonatal Transitional Care (NTC) is not a place but a service and can be delivered either in a separate Neonatal Transitional Care area, or within the Neonatal Unit and /or in the postnatal ward setting. The West Suffolk NHS Foundation Trust (WSFT) maternity unit has an allocated 5-bedded bay on the postnatal ward (F11) and also NTC cots in side rooms on the Neonatal Unit.

The principals of NTC include the need for a multidisciplinary approach between maternity and neonatal teams, an appropriately skilled and trained workforce, robust systems 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. NTC supports resident mothers to be the primary care providers for their babies when they have care requirements more than normal well newborn care, but do not need continuous monitoring in a special care setting.

In this reporting period, sixty five (65) babies out of the total number of 529 babies born (12.3%) were cared for under the Neonatal Transitional Care pathway. This was a slight drop from 14.2% in the previous quarter. One case was identified where a baby was admitted whilst not meeting the criteria due to the gestation being one day less than the criteria.

There has been a reduction in the numbers of unwell babies requiring additional care on the Neonatal Unit or NTC in this reported time frame.

Findings
This report gives evidence that the ATAIN programme is embedded with monthly MDT meetings taking place where cases of term babies admitted to NNU are reviewed. The reviewing group is made up of an obstetric consultant, a paediatric senior registrar or consultant, senior midwifery and neonatal matrons, ward managers and risk midwives. The learning from these meetings is shared with maternity and neonatal staff and actions are taken to avoid or reduce future admissions if possible. The culture of avoiding term admissions to the NNU is ingrained within the maternity and the neonatal staff and in the last 2 quarters, there has not been an admission that was reviewed and deemed to be avoidable.
There were positive findings in regard to babies having timely observations. One case swiftly identified a deteriorating neonate and appropriate escalation was followed, demonstrating the crucial role routine observations play in safeguarding the wellbeing of the neonate.

There continues to be incidences where discrepancies are identified between the estimated birth centile on ultrasound scan and the actual birth centile. The importance of this lies within the increase in intervention related to anticipated birth centiles (either very small or very large babies), putting the neonate at a higher risk of needing additional support on the Neonatal Unit.

It was identified that there had been a lack of documented discussions regarding the administration of a corticosteroid course. At the review meeting, it was confirmed that a discussion did take place. Documentation was identified as an area that requires improvement.

Gestation is an important factor in assessing the eligibility of the criteria for NTC to ensure safe and appropriate care is provided to the neonate. While the case identified was within one day of meeting the criteria, it was important to identify this so criterion does not become blurred. A recent update of the NTC guidance, ratified in October 2023 reflects the British Association of Perinatal Medicine

	(BAPM) guidelines. This expanded the criteria to earlier gestation babies, a lower birthweight and those requiring nasogastric tube feeding. All staff are aware of the importance of the initial observations on the neonate through the newborn Risk Pathway using the RAPP tool. This risk assessment tool observes **R**espirations and work of breathing; **A**ctivity; **P**erfusion/temperature; **P**osition/tone. The effective use of this is evidenced through the number of babies having this carried out. Monthly audits demonstrate that a 100% of all babies have this tool completed and appropriate escalation was evident. It was however noted that the position of the baby is not a mandatory field on the RAPP tool. A key factor when trying to identify a cause of the deterioration in the colour of a baby. Local guidance suggests that women undergoing an elective Caesarean Section prior to 39 weeks' gestation need to be counselled regarding corticosteroid administration. This would need to be reflected in documentation of the discussion. Neonatal Transitional Care provision is not consistent across the country, or region. Neighbouring Trusts are still awaiting the introduction of such service; therefore, we are pleased that this is available to families choosing to birth here. The provision of NTC demonstrates a service that spans both neonates and maternity services (NTC located on the maternity postnatal ward), it requires collaborative working and a full understanding of differing perspectives. **Next Steps** The monthly ATAIN meetings will continue to be held with the multidisciplinary team. Wider attendance will be encouraged from staff across the department including infant feeding team and the fetal monitoring lead. This will further enhance the review process and add additional scrutiny. Work will continue in fostering good relationship with the sonography department. A formalised pathway is in place and collaborative working through a quarterly feedback meeting will continue to improve communication and coordinate improvements. All babies admitted to NTC are audited for the purpose of this report to ensure that criteria for admission are adhered to and the care given appropriate. Moving forward the service will be evaluated against the updated guideline. Regular weekly auditing of the completion of the RAPP tool is in place for the ward manager to use. This will continue to make up part of the ATAIN review when evaluating care for all babies. High quality documentation serves to ensure care plans and discussions are available for the wider team to review. The importance of the documentation of the corticosteroid administration has been communicated with the obstetric team and will continue to be audited during the monthly meetings.
2.4	**<u>Neonatal Nursing Staffing Assessment August 2023 (Annex E)</u>** **Background:** The Maternity Incentive Scheme (MIS) run by NHS resolution is in its fifth year and builds on the progress made in the previous 4 years. The safety action that this report relates to Safety Action 4d to ensure that the neonatal nursing staffing meets BAPM standards. The West Suffolk NHS Foundation Trust (WSFT) Neonatal Unit (NNU) is commissioned as a level one unit. The approved Neonatal nursing calculator was used. **The report shared with the board in September 2023 unfortunately had a miscalculation of vacancy rate, and therefore the paper has been rewritten with the correct calculation.** **Neonatal Nursing staff Requirements** • Minimum 70% neonatal nurses qualified in speciality (QIS) • All registered nurses trained and updated in Neonatal Life Support (NLS) • BAPM, DOH Neonatal Toolkit and NHSE state a supernumerary shift lead in addition to those providing direct clinical care is required. This person would also oversee the non-registered team on NTC • Neonatal Nurses are required to support the resuscitation of sick, or new-born babies in the Labour Suite, in Theatre, the Postnatal ward and in ED

	• Neonatal Nurses are required to support the medical team with enhanced nursing skills such as, cannulation, bloodletting, and the implementation of Patient Group Directives • Neonatal nurses are required to attend handover, ward round and the Multidisciplinary (MDT) safety huddle • NNU skill mix **Findings:** There is a shortfall of approximately 1.76 WTE between the budget and staff in post. This is due to a vacancy rate of 1.76 WTE Band 5, for which recruitment is underway. This equates to an approximate 6.8% vacancy rate. Another variance highlighted is, as there is no budget for band 5 nurses who have completed the Qualified In Speciality (QIS) course, the staff in post at this level contribute to the band 6 roster with some restrictions to their duties. This reflects as 0.8 WTE over budget for QIS staff, and 0.8 WTE under budget for non-QIS staff. As per the calculator guidance, only workforce that provide direct neonatal patient care on the neonatal unit have been included. Management and administrative roles including the Senior Matron for Neonatal Services, Unit Manager, Practice Development Nurse, and Governance Lead are not included, this equates to 3.15 WTE. Likewise, staff who cover the Neonatal Transitional Care (NTC) and Neonatal Community Services have not been included. This equates to 5.8 WTE band 4 to cover NTC, 0.32 WTE band 4 to cover the Neonatal Community Service and 0.64 WTE band 6 QIS to cover the Neonatal Community Service. Currently there is no separate budget for these staff groups/ services. BAPM states that nursery nurses working in NTC should be under the direct supervision and responsibility of a registered nurse or midwife. The Neonatal Unit shift leaders are band 6 QIS. The shift leader is not currently supernumerary, despite this being a national standard from NHSE, BAPM and the DOH Toolkit. The findings of the Neonatal Nursing Workforce Calculator indicate that cot occupancy is 45.92% in this 6-month period of audit. However, this does not consider neonates receiving NTC. With the continued aim to reduce term admissions to the Neonatal Unit, this cannot be ignored when calculating the number of nursing staff required. Neonatal Transitional Care activity equates to approximately 15% of activity for this period of audit. The calculator does not consider the Neonatal Community Service (NCS) which is also staffed by the neonatal workforce. This work equates to approximately 7% during this period. BAPM state that ideally neonatal community services will be available 7 days per week. The current service provision is approximately 4 days per week. The calculator does not consider Ward Attenders, neonatal patients who attend the Neonatal Unit by appointment following referral, usually from Community Midwives, but also on occasion from GP's, this equates to approximately 19% for this period. **Next steps** • There should be a regular review of the staffing levels and skill mix to enable this to reflect the activity and acuity going forward. • Allowance made for staffing of NTC, NCS and enabling staff to complete training such as the QIS course. • The review should be confirmed by the ODN to ensure that the findings of the toolkit have been applied appropriately (tool previously sent but 8/11/23 the full report has been sent to ODN). • The action plan should be agreed by all interested parties and submitted to the Divisional Management team for approval prior to submission to the Trust Board (Reviewed at Quality and Safety and Safety Champions meetings). • Complete the Neonatal Nursing Workforce calculator or equivalent each year and report on findings to reflect staffing needs and budget setting.
2.5	**<u>Maternity Incentive Scheme Safety Action 5 Midwifery Workforce</u> (Annex F)** **Background**

	This report is part of the ongoing assurance of the Trust's compliance with the NHS R Year 5 Maternity Incentive Scheme **Safety Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?** • National tools, LMNS collaboration and BirthRate Plus methodology have been used to determine the midwifery establishment. • The funded establishment meets the BirthRate Plus recommendations. • Robust escalation processes and team working are in place to monitor safe staffing. • One to one care of women in labour over the 6-month period of the report has been maintained at **100% compliance.** • Supernumerary status of the labour suite co-ordinator (LSC) has been consistently above **99%** between April & September 2023. The aim is for 100%. • Vacancies for experienced band 6 midwives are difficult to fill whilst recruitment of band 5 midwives and those from overseas has been successful, • Midwife vacancies at the end of September 23 was 10.31 wte which equates to an **8 % vacancy rate.** The service is currently employing approximately 5.00 wte midwives each month through the bank and staff working additional hours. • The impact of increasing student midwife numbers and return to practice courses will not be realised for at least another 2-4 years. • West Suffolk is actively participating in the regional work of midwifery apprenticeship schemes with the intention of having places on the first cohort when these are in place. • The Midwife to Birth ratio has been set locally at **1:20.5**; there were five months when this was not met. This reflects the vacancy factor for those months. • Red Flags continue to be monitored daily and collated monthly: delays in induction of labour remain the main clinical reason. **Findings** • Safe staffing levels are not just to ensure patient safety, but also to retain our existing workforce. • The evidence shows that we can demonstrate an effective system of midwifery workforce planning to the required standard and therefore currently we are meeting the maternity incentive scheme's requirements. • The report only covers the timeframe to the end of September 2023 and therefore the risk of not meeting the standards in subsequent months of the MIS timeframe is not yet known. **Next Steps** • Close monitoring of the supernumerary status of the LSC will continue, with each instance of non-compliance investigated and themes identified. • Active recruitment to vacancies will continue, with an effective preceptorship process in place to retain and develop staff. • Further MCoC teams will be on hold until safe staffing levels can be assured throughout the service. • Recurring themes from 'red fags' relating to staffing will be reviewed and where appropriate and possible further mitigations in place. • Escalation plans will be used to promote safe care.
2.6	**<u>Maternity Incentive Scheme Safety Action 7 Maternity and Neonatal Voices Partnership</u> (Annex G)** **Background** This report is part of the ongoing assurance of the Trust's compliance with Safety Action 7- Listen to women, parents and families using maternity and neonatal services and coproduce services with users. The 3 elements of Safety Action 7 that the Trust is monitoring for these safety standards are: - Ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance (due for publication in 2023).

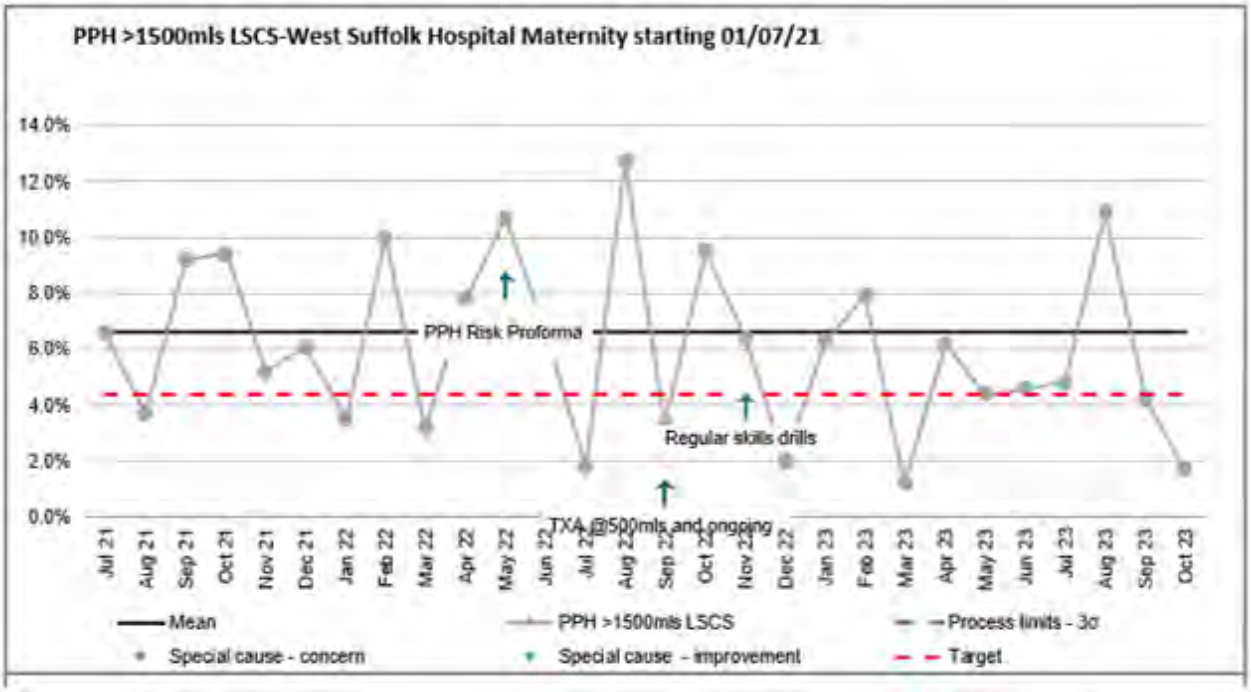
	Parents with neonatal experience may give feedback via the MNVP and Parent Advisory Group. - Ensuring an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication (due each January), including analysis of free text data, and progress monitored regularly by safety champions and LMNS Board. - Ensuring neonatal and maternity service user feedback is collated and acted upon within the neonatal and maternity service, with evidence of reviews of themes and subsequent actions monitored by local safety champions. All the documents provided as evidence of compliance for this safety action have been through internal governance process including the Maternity and Neonatal Safety Champions and will then be shared with the Local Maternity and Neonatal System. **Findings** The year 2023 has seen some changes with moving the service forward, however MNVP works continued as below: • The MNVP work plan has been updated. • Supporting the maternity unit by participating where possible in amends to videos, leaflets, and paperwork for service user consumption. • Attending the National Maternity and Neonatal Summit in Leeds, which allowed for learning and networking opportunities with other MNVP. • Reviewing content of the MNVP website, reviewing, and updating content with support of MNVP members such as the questionnaire. • Consultation and publication of the West Suffolk Maternity and Neonatal Service Strategy. • Securing funding from the ICB for last year's outstanding grant and this year's outstanding grant • Introduction of Neonatal services and service users into the West Suffolk MVP and becoming an MNVP. • Building new relationships with the ICB to obtain a stronger working relationship. • Work on coproducing maternity services will be further progressed over the next year as the West Suffolk MNVP is engaged with activities alongside the Trust employees. However, due to the depleted membership, the MNVP has not been represented at governance meetings, and some labour suite forums and guideline review meetings in 2023, although guidelines and leaflet have been sent to MNVP members for review as part of the circulation at approval stages. There has, however been attendance at the Induction of Labour Forum and the Neonatal and Maternity summit as well as involvement in co-producing of Maternity and Neonatal Service Strategy. The MNVP is actively recruiting a vice-chair and other members of the group so that they can attend governance groups and provide user input into the Trust's responses to national safety reports, complaints and updated guidelines and policies. **Next Steps** • Action plans will be monitored and any areas for non-completion, escalated as appropriate. • Annual reports will evidence the updates. • Reports will be shared with external stakeholders as required. • National MNVP Guidance that was due to be published in July 2023 has not yet been published, therefore work will need to be undertaken once this document is published to benchmark the service against the recommendation set in the guideline, this will also include recommendation for ICB regarding the remuneration of MNVP chair and key members expenses, which was difficult to established due to the lack of national guideline.
3.	**Reports for CLOSED Board** Due to the level of detail required for these reports and subsequently containing possible patient identifiable information, the full reports will be shared at Closed board only.
3.1	**Perinatal Mortality Review Tool (PMRT) Report – Q2 – 1st July to 30th September 2023 (Annex H)**

	In the period from 1st July 2023 to 30th September 2023, the Trust has reported 4 baby losses directly associated with the Maternity Services. None of the losses met the criteria for referral to HSIB. The trust collaborated with additional PMRT reviews where some care was provided by the WSFT but the baby sadly died in another NHS trust. This collaborative approach to cross boundary learning provides a valuable shared learning process and an objective assessment from the review group. Any early learning from these losses was shared with the staff and the families. 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 and completion of the surveillance information within the required time frames when required to date. The Trust was 100% **compliant** with duty of candour and informing the women that a PMRT review will be undertaken when indicated and inviting comments or questions to aid the review process. The Trust has **completed all** the PMRT reports that were due to be completed within this reporting timeframe and started the review process for all of these within 2 months of the loss. This report also includes outstanding actions from previously completed PMRT reports for the last year and recently completed actions and shared learning.
3.2	**Maternity and Neonatal Safety Investigations (formerly HSIB) and Early Notification Report Quarter 2 2023-2024 (Annex I)** **Background** All mandatory reporting for Healthcare Safety Investigation Branch (HSIB), Early Notification Scheme (ENS) and Duty of Candour (DoC) has been completed in this reporting period. Please note HSIB is now Maternity and Newborn Safety Investigations (MNSI). One case met the HSIB criteria and was appropriately referred. This case was triaged by the HSIB, declined, and referred back to the Trust for internal investigation. A delay has occurred while an external panel member could be secured. They have now been approached and a date for the formal MDT review is being negotiated. One completed HSIB report has been received in this reporting period.. The HSIB concluded there were no care issues that contributed to the outcome. However, they have reported two findings: Antenatal care was shared between the Trust and a neighbouring organisation. This mother had elected to give birth at WSH but lived across a border resulting in the majority of her antenatal care being provided elsewhere. The HSIB found that there was a lack of communication and effective sharing of information between the two providers. Furthermore, there was no communication to staff at either Trust from the social care team following the booking referral which meant that staff did not have the opportunity to take social care information into account when developing their plan of care. **Findings** Shared care is increasing in complexity as each organisation moves forward with their own digital transition. Prior to a digital patient information system woman would retain hand held care summaries that were easily accessible to each organisation. This has proved challenging to overcome and required additional resources to safeguard against reoccurrence. Action has been taken: women who wish to birth at the WSH whilst receiving antenatal care from the other organisation have a robust booking appointment undertaken by WSH midwives. This ensures all risk assessments are undertaken, safeguarding discussed and all onward referrals completed. This information is available to the neighbouring organisation's midwives with whom we share care. The patient portal serves as a failsafe that allows women to share care plans. There was a lack of understanding regarding the extent of the safeguarding concerns affecting the family. Communication was also limited due to only one person being in a specialist role.

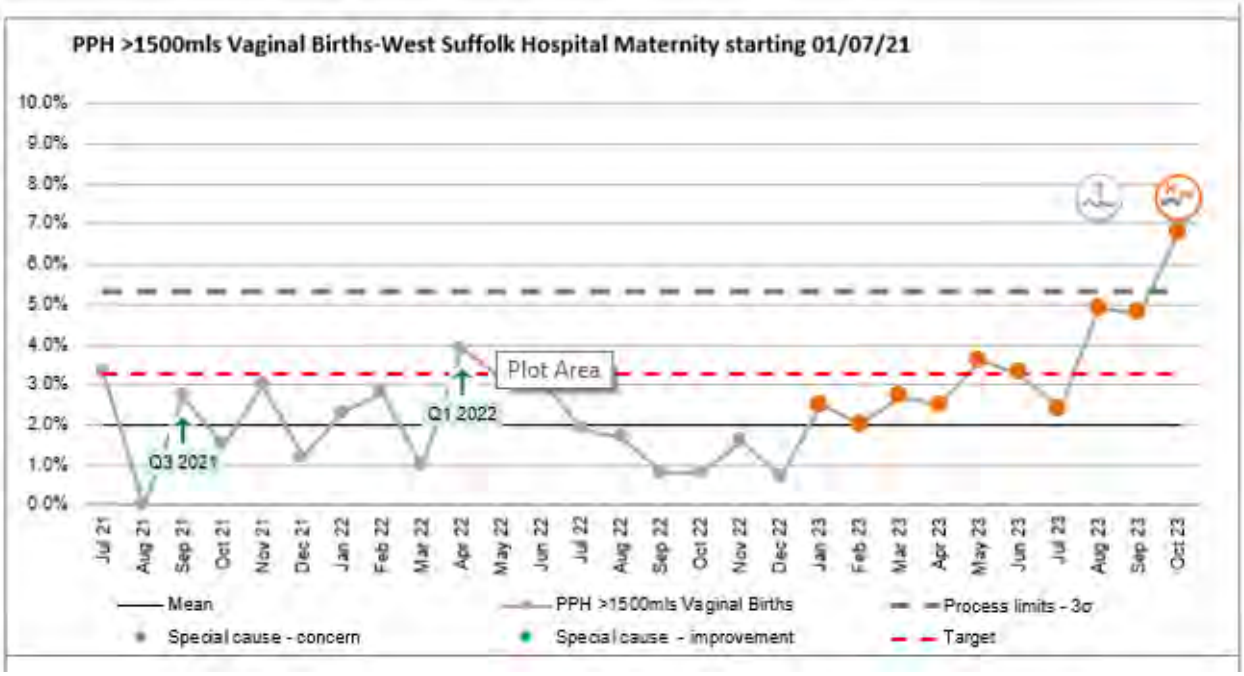
	A monthly safeguarding meeting was established to meet with our neighbouring Trust and social care providers to discuss safeguarding cases where borders are crossed. This meeting has not been maintained due to workload pressures and vacancies outside of the Trust and instead has been replaced by a shared document. This was raised at the Local Maternity Neonatal System's Safety Forum on the 22nd October 2023 and a solution is being sought. **Next Steps** A digital process or regular meeting must be established to maintain communication between care and social care providers. While the process should not have a single point of failure, the challenge remains that in a small maternity department there is often only a single specialist for key roles. However, this must be overcome by considering how the wider trust safeguarding team can support and underpin a robust process going forward.
3.3	**Maternity Claims Scorecard, incident and complaint data Quarterly Review (Quarter 2 -July-September 2023) (Annex J)** This report provides a summary of the maternity claims scorecard from 01/04/2013-31/03/2023 alongside incident and complaint data from 1st July 2023 to the 30th September 2023, identifying themes and subsequent learning. For the WSH, maternity related claims equate to 12% of the volume of claims but 48% of the value. This is in line with the national picture of 13% of the claims and 64% of the total value of those claims. In the last ten years maternity claims for our Trust is approximately £31.15 million with the average claim being about £1million. The detail of the claim's scorecard will be looked at quarterly going forward. The top claims are failure or delay in treatment, failure or delay in diagnosis, lack of assistance or care, failure of antenatal screening and unexpected death. These causes were also reflected in the safety recommendations from historical Healthcare Safety Investigation Branch (HSIB) cases. The Trust has not had any HSIB safety recommendations since mid-2021 and believes that it is quite a strong indication that we have learnt from previous incidents, and we have a more robust process in place to ensure a safe maternity unit. For Quarter 2 2023/24 three themes have been identified; management of hypertension in pregnancy, perinatal mortality in babies from ethnic diversities and management of specimens and results in pregnancy. The subsequent learning has been captured in a three-point action plan, two of which have already been completed and the third action is in progress with a target date of the end of February 2024. Action Required; • Rollout of the Equality, Diversity and Inclusion EDI community team • Appoint EDI Lead Midwife to work with the regional teams and the Local Maternity and Neonatal System to identify and implement best practices • Review of the local guidance for management of hypertensive disorders • Thematic review of the management of specimens and results in the maternity service
4.	**Next steps**
4.1	Reports will be shared with the external stakeholders as required Action plans will be monitored and updated accordingly

Annex A- Maternity Dashboard SPC Charts:

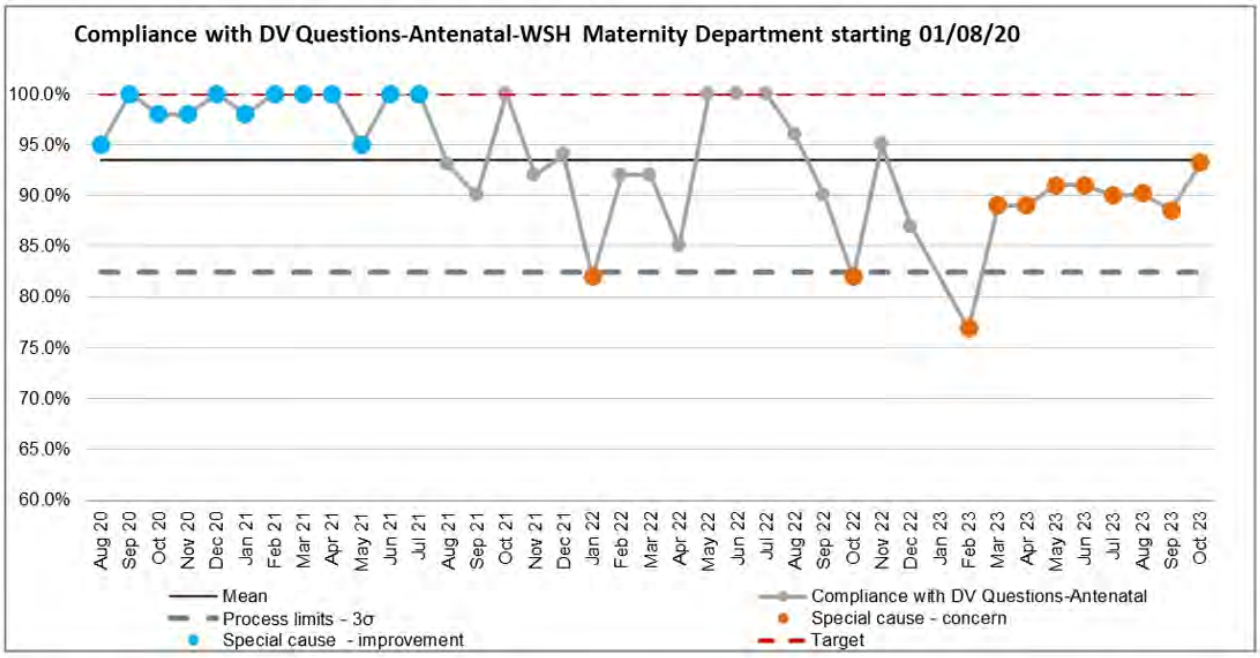
Post-Partum Haemorrhages (PPH) for Lower Section Caesarean Sections (LSCS)

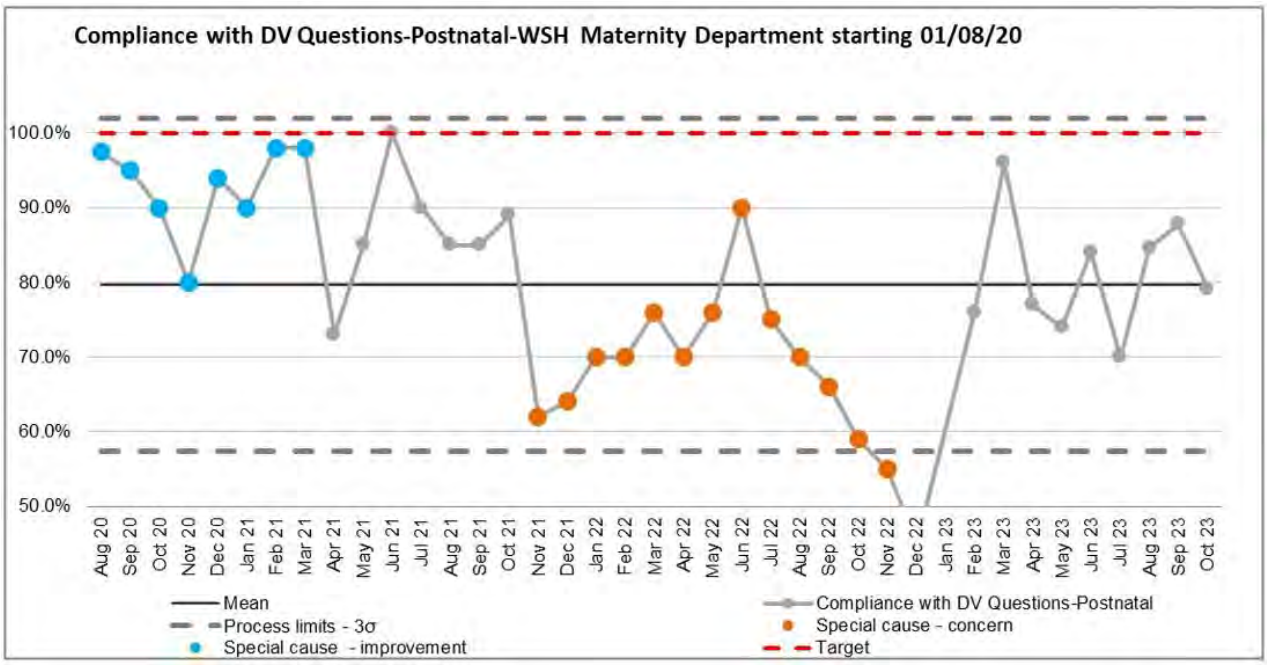


Post-Partum Haemorrhages (PPH) for Vaginal Births



Domestic Violence (DV)





5. GOVERNANCE

5.1. Governance report

To Assure

Presented by Richard Jones

Board of Directors

Report title:	**Governance report**
Agenda item:	5.1
Date of the meeting:	21 July 2023
Sponsor/executive lead:	Richard Jones, Trust Secretary
Report prepared by:	Richard Jones, Trust Secretary Pooja Sharma, Deputy Trust Secretary

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

Executive Summary

WHAT?
Summary of issue, including evaluation of the validity the data/information

This report summarises the main governance headlines for July 2023, as follows:

- Senior Leadership Team report
- Council of Governors meeting report
- Remuneration committee report
- Board workshop report
- Report urgent decision for submission
- Reference LfPSE letters and comms with ICB and CQC
- Use of Trust's seal
- Agenda items for next meeting

SO WHAT?
Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk

This report supports the Board in maintaining oversight of key activities and developments relating to organisational governance.

WHAT NEXT?
Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)

The items reported through this report will be actioned through the appropriate routes. Amendments to the terms of reference for SLT and the Executive Directors meeting will be included in the updated governance framework and reported to the Board.

.

Action Required

The Board is asked to note the report

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

Governance Report

1. Senior leadership team (SLT) report

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

At its recent meetings SLT considered a number of issues, including the pharmacy opening hours; future system programme away day results; and shaping of day of surgery admission unit (DOSA) through breakout rooms. The current financial position was also reviewed.

The meeting approved that the terms of reference for SLT and the Executive Directors meeting be updated to more clearly define their roles and extend the membership of the Executive Directors' meeting to include representation form the clinical divisions. SLT will move to play a primary role in helping to shape pieces of work where broad engagement is required prior to decision and as a forum for leadership development.

2. Council of Governors meeting report

The Council of Governors received an update on the financial position and assurance on the mechanisms in place to ensure appropriate overview and scrutiny of financial accountability.

The Council of Governors received the feedback reports from chairs of the board assurance committees and governor observers. The coversheet summarised the agenda items discussed in the meetings, with the chairs' key issues and respective governor observers' reports providing highlight updates for the council.

The Council of Governors noted the report from the nominations committee which highlighted that the feedback on NEDs appraisal process was reviewed and agreed the proposed changes to the appraisal process for 2024. FPPT annual self-attestation will also be adopted as part of the annual appraisal process. The Committee further noted that in accordance with the NHSE Code of Governance (2022) for NHS provider trusts, the governors on the council of governors for foundation trusts should meet the 'fit and proper' persons requirements. The Trust will implement FPPT for Council of Governors and the council of governors' standards committee will oversee the process for implementation. The terms of office for the NEDs were reviewed and noted. The Committee made a recommendation on NED remuneration and recommended uplift was considered and approved by the Council.

The Council also approved the recommendation from the nominations committee for non-executive director Tracy Dowling (TD) to take-up interim Chief Executive role (accounting officer) at Mid and South Essex ICB for six months.

The Council of Governors noted the report from the engagement committee and an update was received on the patient engagement and VOICE network. An overview of the engagement activity was presented related to the Future System Programme and the activity which was live. The Committee received an update on the works of MyWish Charity, how the Charity operates and how governor participation can be increased to make contributions in some of the collaborative work. The Committee noted a draft overview of content and timeline for the winter edition of the members' newsletter. The next medicine for members talk is scheduled to take place in late spring/early summer 2024 and late 2024.

The Governors noted and reviewed the governor induction programme, work programme and forward plan for 2024.

The Council of Governors approved the extension of the contract with external auditor KPMG by up to 2 years.

3. Remuneration committee report

At its meeting in October the committee considered: substantive medial director recruitment, establishing a transformation director role, flexible retirement options and learning review terms of reference.

4. Board workshop report

On 2 November the Board held a development session with a focus on: risk management; strategic priorities; and the prevention, personalised care and health inequalities strategy.

There was consensus that the session had been valuation with good contributions. Consensus on the way forward had been reached on a number of items. It was agreed that future workshops and board meetings use lower cost venues without catering for lunch. What next:

- **Risk** – update the proposed strategic risks to reflect discussion. Areas of focus and development included reporting of the board assurance framework (BAF) to provide greater tracking, including the use of charts. The risk matrix and risk appetite will also be subject to further facilitated discussion.

- **Strategic priorities** – agreed that Execs to work up the proposed priorities and report back at the board in January and further discussion at the Board workshop in February.

- **Prevention** – it was agreed to include greater prevention focus in the updated strategic priorities. The strategy document will be received by the Board in December.

It was agreed that the focus and programme for future development sessions should be collectively owned and link to the strategic priorities. Individuals will share views on topics/areas for board development.

5. Report urgent decision for submission

In accordance with the Trust's standing orders the Insight Committee was briefed on the need to make an urgent submission regarding financial and operational performance to the ICB as part of a national exercise. This related to addressing the significant financial challenges created by industrial action.

The Chair and CEO approved the return having consulted with the director of resources, chief operating officer as three NEDs: Antoinette Jackson, Michael Parson and Roger Petter.

6. Learning from patient safety events (LfPSE)

The Trust has written to the ICB in relation to our plans to achieve compliance with the new LfPSE requirements and the mitigations we have in place to ensure timely reporting of relevant incidents to the ICB and CQC during the transition period. The position has also been shared with the CQC as part of our regular engagement meetings. Implementation of the Trust's new risk management system, Radar Healthcare, is critical to delivering LfPSE compliance and we are working to achieve full compliance by the end of March 2024.

7. Use of Trust Seal

None to report

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

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

Annex A: Scheduled draft agenda items for next meeting – 26 January 2024

Description	Open		Closed	Type	Source	Director
Declaration of interests	✓		✓	Verbal	Matrix	All
General Business						
Patient/staff story - staff experience of the emerging incident review process	✓		✓	Verbal	Matrix	Exec.
Chief Executive's report	✓			Written	Matrix	EC
Culture						
Organisational development plan	✓			Written	Matrix	JMO
Strategy						
Future System Board Report	✓			Written	Matrix	CB
System update: - West Suffolk Alliance and SNEE Integrated Care Board - Wider system collaboration	✓			Written	Matrix	 PW / CM All execs
Strategic priorities – update and future monitoring	✓			Written	Action	CEO
Assurance						
Insight Committee – committee key issues (CKI) report - Finance report	✓			Written	Matrix	AJ / NC / SW
Involvement Committee – committee key issues (CKI) report - People and OD Highlight Report o Putting you First award o Staff recommender scores o appraisal performance, including consultants (quarterly) - Safe staffing guardian and FTSU reports - National patient and staff survey and recommender responses	✓			Written	Matrix	TD / JMO
Improvement Committee – committee key issues (CKI) report - Maternity services quality and performance report - Nurse staffing report - Report from Lucy Winstanley, Head of Patient Safety	✓			Written	Matrix	LP / SW / PM
Audit committee – committee key issues (CKI) report	✓			Written	Matrix	MP
Serious Incident, inquests, complaints and claims report			✓	Written	Matrix	SW

Governance						
Governance report, including - Senior Leadership Team report - Code of Governance - Annual reports from specialist areas - Use of Trust's seal - Agenda items for next meeting	✓			Written	Matrix	RJ
Confidential staffing matters			✓	Written	Matrix – by exception	JMO
Board assurance framework report	✓			Written	Matrix	RJ
Register of interests	✓			Written	Matrix	RJ
Non-executive directors responsibilities report	✓			Written	Matrix	RJ
Reflections on the meetings (open and closed meetings)	✓		✓	Verbal	Matrix	JC
Annexes to Board pack: - Integrated quality & performance report (IQPR) – annex to Board pack - Others as required						

5.2. Board Assurance Framework

To Approve

Presented by Richard Jones

Board of Directors	
Report title:	**Board Assurance Framework**
Agenda item:	5.2
Date of the meeting:	1 December 2023
Sponsor/executive lead:	Richard Jones, Trust Secretary
Report prepared by:	Mike Dixon, Head of Health, Safety and Risk

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

WHAT?

Summary of issue, including evaluation of the validity the data/information

The Board assurance framework (BAF) is a tool used to manage principal risks to the Trust's strategic objectives. The strategic risks were subject to detailed review at the Board workshop in November and the following broad themes agreed:

1. Capability and skills
2. Capacity
3. Collaboration
4. Continuous improvement and innovation
5. Digital Infrastructure
6. Estates
7. Finance
8. Governance
9. Supporting our recovery
10. Wellbeing

The existing BAF risks have been mapped to these themes which are set out in more detail in Annex A.

As part of the workshop there was a refocusing of the language used as part of the risk management process to support more engaging/inclusive language. This was focused around 'cause'; 'risk' and 'effect'. The table below sets out an example of this for one risk.

Cause	Risk	Effect
- Inability to recruit and retain key staff (Local / national) - Limited appetite for Innovation/ new ways of working - Ineffective succession planning	Fail to ensure our workforce has the capability and capacity to deliver safe, effective and efficient services	- Quality of experience / patient safety - Staff workload / Morale / Retention - Inability to meet key targets

SO WHAT?
Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk

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.

Failure to effectively identify and manage strategic risks through the BAF places the strategic objectives at risk.

It is critical that the Board is able to maintain oversight of the strategic risks through the BAF and track progress and delivery.

WHAT NEXT?
Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)

To review the BAF and the updated strategic risks we will:

- Review the updated list of strategic risks to identify any gaps and alignment
- For each strategic risk consider and document:
    - 'causes' and 'effects'
    - Existing controls (to mitigate risk)
    - Action to mitigate risk and reduce the risk rating
    - Assurance on the effectiveness of controls (internal and external)

As part of the wider update of the risk management arrangements and BAF reporting we will:

- Review the risk matrix – providing greater emphasis in the risk rating when the consequence is higher
- Develop collective understanding of risk tolerance (risk appetite) and use this to inform how risks are reported and escalated at board, assurance and corporate levels. This will be the focus of a facilitated board workshop in February 2024
- Develop reporting of BAF to the Board and assurance committee - tracking changes with summary charts/indicators and management of strategic risks against the agreed risk tolerance. The developing BAF and report will be shared with Board members and reported to Board in Jan '24
- Map sources of assurance for each of the strategic risk, internal and external and ensure that gaps in assurance are understood and managed e.g. included in internal audit programme.

Action Required

Approve the report and identified actions

Previously considered by:	The Board of Directors
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.
Equality, diversity and inclusion:	Decisions should not disadvantage individuals or groups with protected characteristics
Sustainability:	Decisions should not add environmental impact
Legal and regulatory context:	NHS Act 2006, Code of Governance. Well-led framework

Annex A: Updates strategic risks

Strategic risk (new)
1. Capability and Skills: Fail to ensure the Trust has the capability and skills to deliver the highest quality, safe and effective services that provide the best possible outcomes and experience (Inc developing our current and future staff)
2. Capacity: Fail to ensure the Trust has the capacity to deliver the best quality, safest care and respond to the changing needs in our communities
3. Collaboration: Fail to ensure the Trust can work together with our partners to provide the greatest possible contribution to prevent ill health, increase wellbeing and reduce health inequalities
4. Continuous improvement and Innovation: Fail to ensure the Trust continuously seeks to improve, learn and transform the way we work, to guarantee that Trust activities can safely and sustainably deliver for our patients, our staff and for the future
5. Digital Infrastructure: Fail to ensure the Trust implements secure, cost effective and innovative approaches that advance our digital and technological capabilities to better support the health and wellbeing of our communities
6. Estates: Fail to ensure the Trust estates are safe, fit for purpose while maintained to the best possible standard so that everyone has a comfortable environment to be cared for and work in today and for the future
7. Finance: Fail to ensure we manage the Trust finances appropriately and effectively to guarantee the long-term sustainability of the Trust and secure the delivery of our vision, ambitions and values
8. Governance, Compliance and Professionalism: Fail to ensure the Trust has the appropriate governance structures, principles and behaviours to help us safely deliver our vision and ambitions in the right way.
9. Supporting our recovery: Fail to ensure the Trust can effectively and successfully deliver recovery and repair plans to be the first choice NHS provider for our patients, our people and our community and to prepare for the future health and care needs of our local population.
10. Wellbeing: Fail to ensure the Trust can effectively support, protect and improve the health, wellbeing and safety of our staff

6. OTHER ITEMS

6.1. Any other business

To Note

6.2. Reflections on meeting

For Discussion

6.3. Date of next meeting - 26 January, 2024

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

SUPPORTING ANNEXES

4.2 IQPR Full Report

BOARD OF DIRECTORS	
Report title:	**Integrated Quality and Performance Report**
Agenda item:	4.2
Date of the meeting:	1 December, 2023
Sponsor/executive lead:	Sue Wilkinson, chief nurse and Nicola Cottington, chief operating officer
Report prepared by:	Andrew Pollard, information analyst. Narrative provided by clinical and operational leads.

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

Executive summary:	The Integrated Quality and Performance Report (IQPR) 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 what the data is demonstrating (what?), the drivers for performance, what the impact is (so what?) and the remedial actions being taken (what next?). The assurance committees are currently reviewing how they operate, including the metrics used within the IQPR. Please refer to the assurance grid for an executive summary of performance. Areas of exception to bring to the board's attention: • Paediatric Speech and Language Therapy (SLT) has a maximum waiting time of 39 weeks, with 65 children waiting over 18 weeks, impacted by the increasing complexity of the caseload. Increased investment from Suffolk County Council is expected to impact on the ongoing caseload and the forward plan for the service will be presented at the November Divisional Performance Review Meeting (PRM). • 4-hour performance is above trajectory at 61.11% (trajectory 60%). Phase 2 of the internal Urgent and Emergency Care (UEC) recovery plan is being implemented alongside collaborative work with the West Suffolk Alliance and Integrated Care Board (ICB). • Performance against the 28-day Faster Diagnosis Standard (FDS) is not on track with the agreed trajectory, largely driven by the Breast pathway. Achieving the FDS and backlog targets are the key objectives for cancer in 2023/24 planning. There is a risk that WSFT may be placed into 'Tier 2' intervention from NHSE regional colleagues. Additional short-term capacity is being provided in the breast service whilst longer terms plans for a sustainable service are being developed. • Whilst the absolute number of 65 week wait patients continues to increase, the focus remains on the total cohort of patients who need to be treated to deliver our revised trajectory of no more than 52 patients by March 2024. There were no patients waiting over 104 weeks.

Executive summary:	• SHMI suggesting special cause for concern following Dec 22 data release. A review of this case revealed a data coding back log affected reliability of result. SHMI still within expected range despite special cause for concern and triangulation. Local patient level data suggests no additional concern. Full report within PQSGG
Action required / Recommendation:	To receive and approve the report

Previously considered by:	**Component metrics are considered by Patient Safety and Quality Group and Patient Access Governance Group.**
Risk and assurance:	BAF risk 3.1: Failure to manage emergency capacity and demand in the context of Covid activity and delivery of the RAAC remediation plan BAF risk 3.2: Delivery of elective access standards based on clinical priorities, in context of Covid activity and delivery of the RAAC remediation plan (BAF 3.2) and the emergency demand
Equality, diversity and inclusion:	Monitoring of waiting times by deprivation score and ethnicity are monitored at ICB level.
Sustainability:	N/A
Legal and regulatory context:	NHS Act 2006, West Suffolk NHS Foundation Trust Constitution

Assurance Grid

September 2023	ASSURANCE: Pass (P)	ASSURANCE: Hit and Miss (?)	ASSURANCE: Fail (F) — Not Met
VARIANCE: Special Cause Improvement (H / L)		**INSIGHT** RTT 104+ Week Waits **INVOLVEMENT** Staff Sickness – Rolling 12months Staff Sickness	**INSIGHT** RTT 78+ Week Waits **INVOLVEMENT** Mandatory Training Turnover
VARIANCE: Common Cause	**INSIGHT** Urgent 2 hour Response	Please see box to right	**INSIGHT** Ambulance Handover within 15min 12 Hour Breaches Incomplete 104 Day Waits Diagnostic Performance % within 6 weeks Total **IMPROVEMENT** Nutrition – 24 hours **INVOLVEMENT** Appraisal
Deteriorating: Special Cause Concern (H / L)		**INSIGHT** Reduce Adult General & Acute Bed Occupancy 28 Day Faster Diagnosis	

Indicators for escalation as the variation demonstrated shows we will not reliably hit the target. For these metrics, the system needs to be redesigned to reduce variation and create sustainable improvement.

INSIGHT:
Pledge 2 *% Compliance
Ambulance Handover within 30min
Ambulance Handover within 60min
IMPROVEMENT:
MRSA
C-Diff
Hand Hygiene
Sepsis Screening for Emergency Patients
VTE – All Patients
Mixed Sex Breaches
Community Pressure Ulcers
Acute Pressure Ulcers
Inpatient Falls Total
Acute Falls per 1000 Beds
INVOLEMENT:
Overdue Responses

INSIGHT: Glemsford GP Practice – the following KPIs are applicable to the practice:

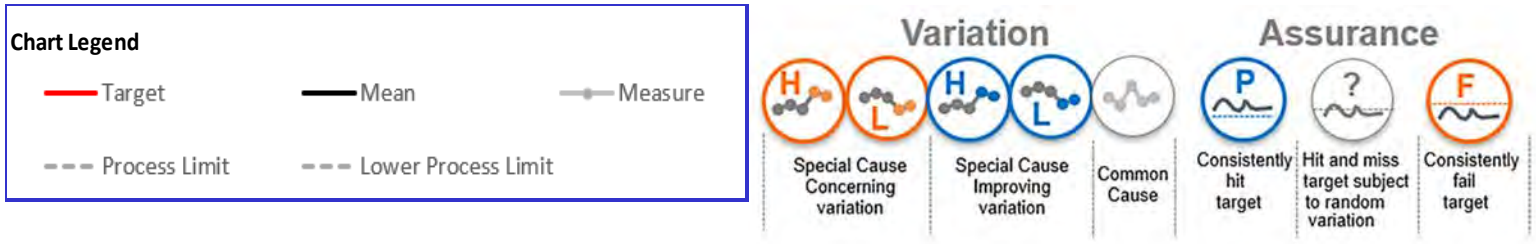
- Urgent appointments within 48 hours
- Routine appointments within 2 weeks
- Increase the % of patients with hypertension treated to NICE guidelines to 77% by March 2024
- Increase the % of patients aged 25-84 years old with a CVD risk score of >20% on lipid lowering therapies to 60%

Currently this data is not available to the Trust, however the Information Team are working to resolve this.

*Cancer data is 1 month behind

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:
INSIGHT - Urgent & Emergency Care: Ambulance Handover within 15min, 12 Hour Breaches, Reduce Adult General & Acute Bed Occupancy
Cancer: 28 Day Faster Diagnosis, Incomplete 104 Day Waits
Elective: Diagnostic Performance % within 6 weeks Total, RTT 78+ Week Waits
IMPROVEMENT - Safe: Nutrition – 24 hours
INVOLVEMENT - Well-Led: Mandatory Training, Appraisal, Turnover

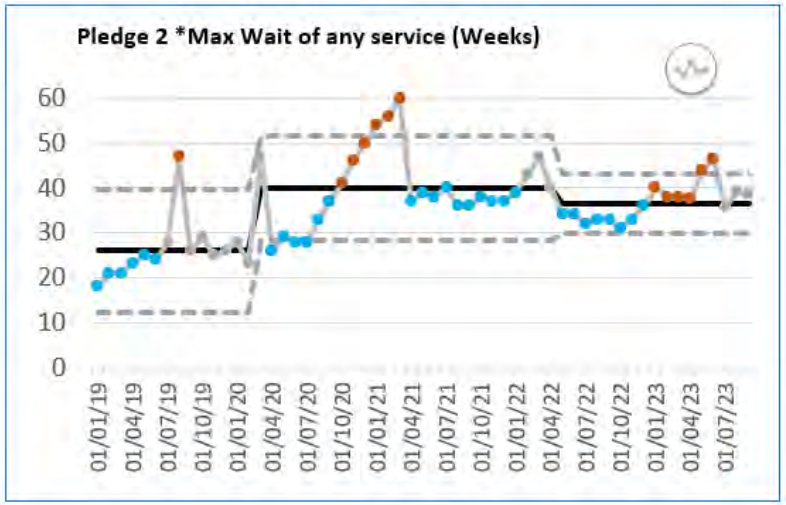
INSIGHT COMMITTEE METRICS

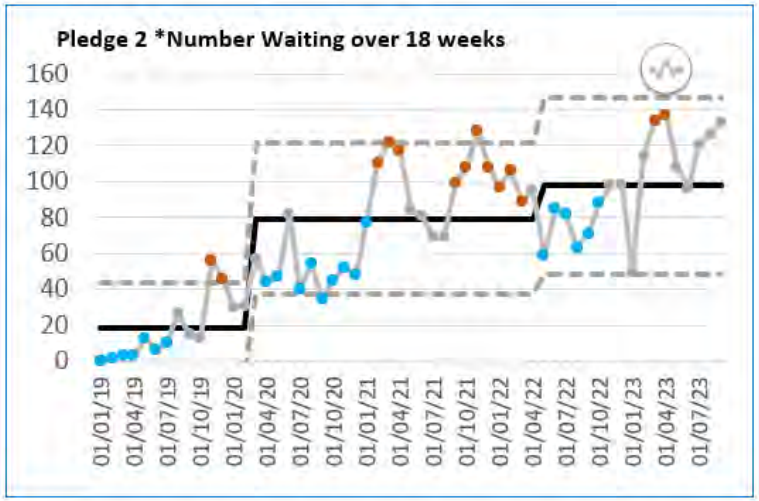


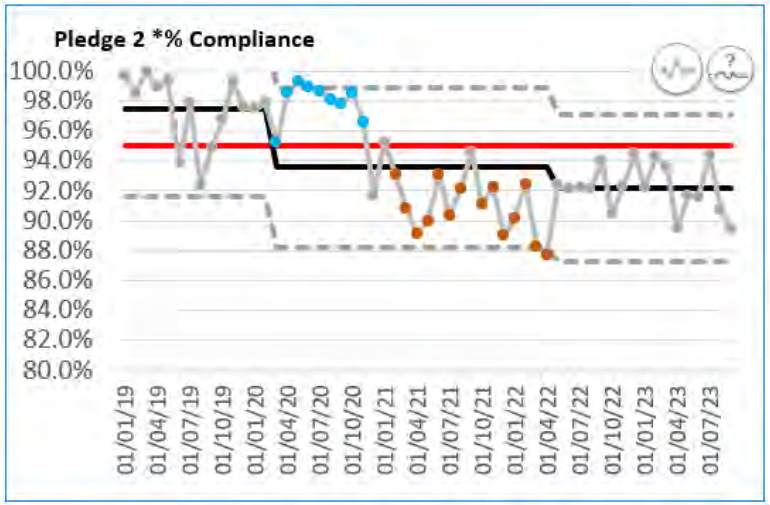
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Pledge 2 *Max Wait of any service (Weeks)	Sep 23	39	-			37	30	43
Pledge 2 *Number Waiting over 18 weeks	Sep 23	133	-			98	49	147
Pledge 2 *% Compliance	Sep 23	89.4%	95.0%			92.2%	87.3%	97.1%
Urgent 2 hour response	Sep 23	93.5%	70.0%			90.0%	81.2%	98.8%
Criteria to reside (Average without reason to reside) Acute	Sep 23	50	-			60	48	73
**Criteria to reside (Average without reason to reside) Community	Sep 23	16	-			17	13	21

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

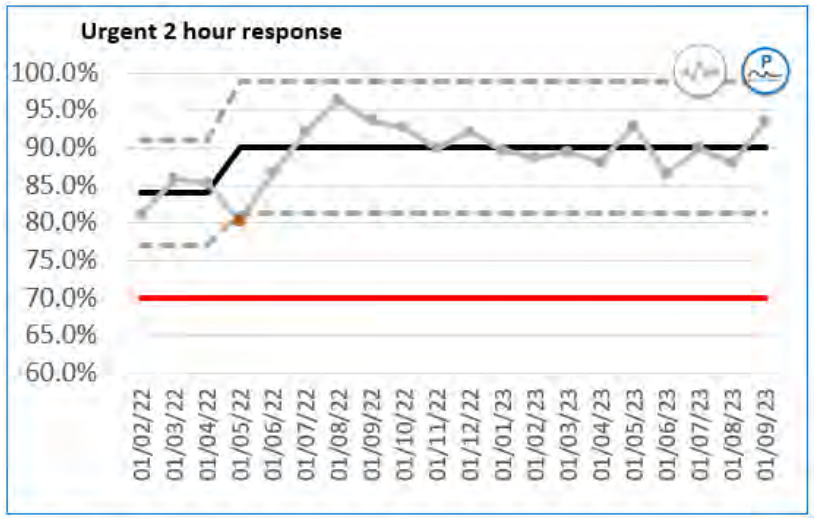
** Figures are for Glastonbury and Newmarket only, data not currently captured at Hazel Court.

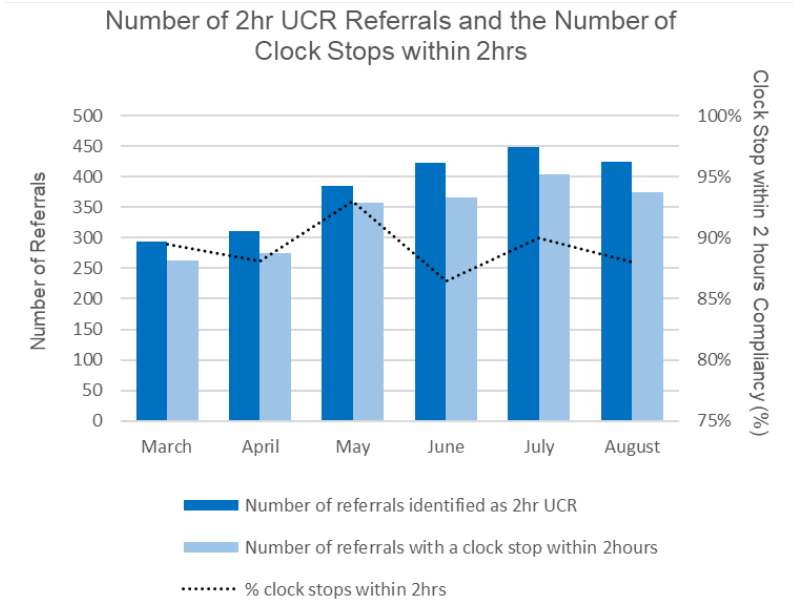






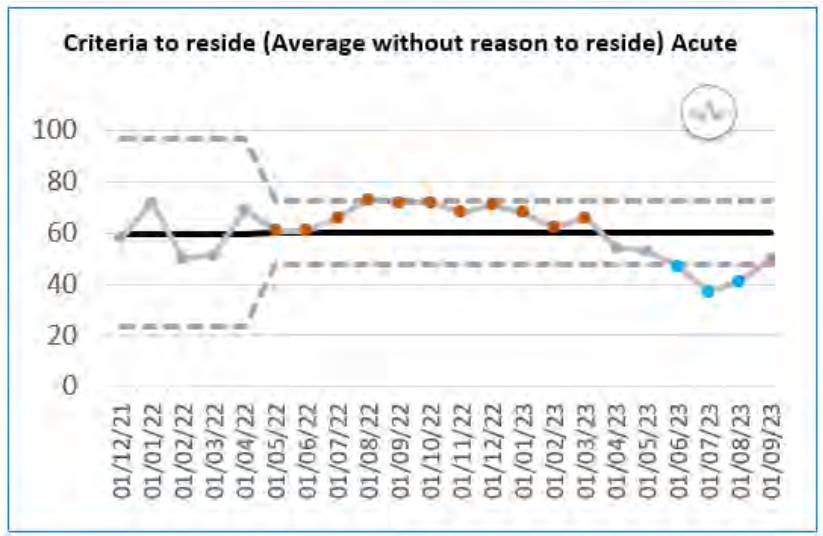
What	So What?	What Next?
Wheelchair Services: Compliance of wheelchair handovers completed within 18weeks has increased from previous month to 91.7%. **Paediatric Speech and Language Therapy (SLT):** Further reduction in 18wk compliance to 54.9% with maximum wait time being 39wks. There are 65 children waiting over 18wks.	**Wheelchair Services:** Focused work on RTT is evident, referrals remain high. All patients are triaged within 72 hours and typically receive an assessment within 14 weeks, however urgent cases are assessed quicker. Basic provision from accredited assessors are processed within 5 working days. 1 Additional session added to each clinic since May 2022 to increase capacity **Paediatric SLT:** Service caseloads are increasing further with the need to prioritise support for children with an Education Health and Care Plan (EHCP) and children within our pre-school complex needs pathway (who are not represented in this slide as on caseloads with no new clocks)	**Wheelchair Services:** B6 Physio recruited will commence Mid-Nov 23, vacant since July 23 will then begin 6-12 months of on-the-job training to commence simple clinics **Paediatric SLT:** Implementation of Suffolk County Council (SCC) investment for EHCP provision in special schools and specialist units. SCC will be added as associate commissioner to enable "joint commissioning" discussion to respond to high level of service demand. Capacity mapping of SLT in progress and early findings available but suggest detail to be shared at November Performance Review Meeting.

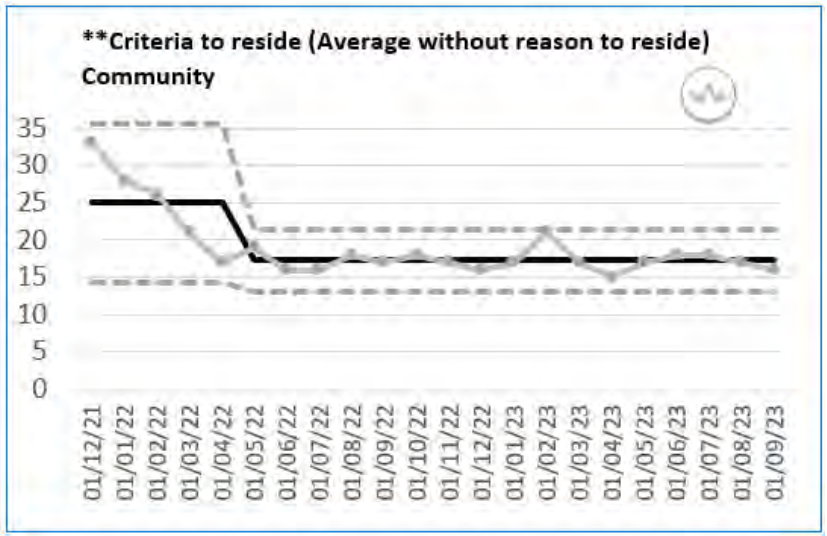




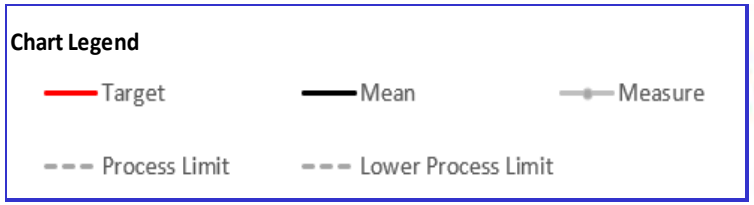
What	So What?	What Next?
Referral numbers appear to be stabilising and 2 hr response continues to exceed 70% target	Patients are seen within dedicated time frame and treated at home	Team Lead Presented new Urgent Community Response (UCR) Strategy at Senior Leadership Team Committee on 16.10.2023 and now working on bringing the strategy into operation to ensure resilience and increase capacity for future to reduce ED attendance in frail patients Integrated Neighbourhood Teams have commenced 2hr reporting with 1st data set due Nov 23. Initial ESNEFT INT data set for 2hr compliance was reported at 56%.

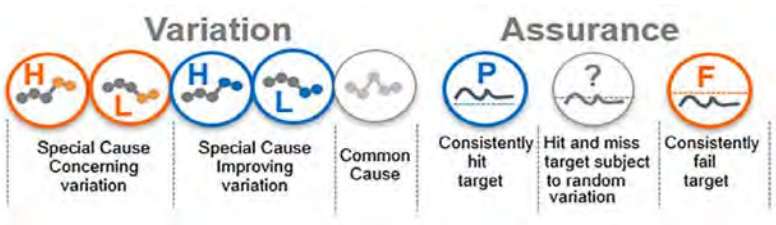
Criteria to reside





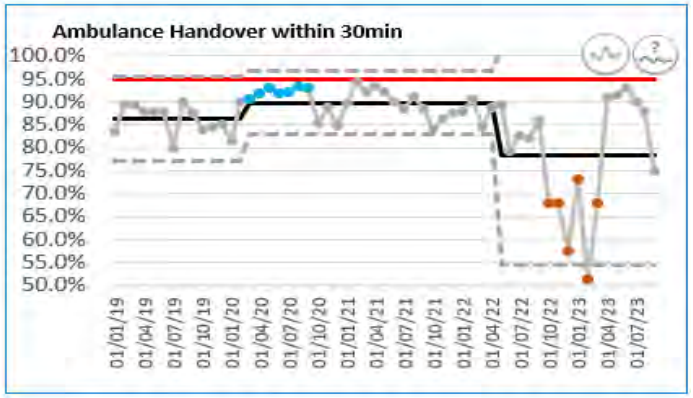
What	So What?	What Next?
For September, we can see there is normal variation both within Criteria to reside in the acute and Criteria to Reside community. The Transfer of Care Hub's referral numbers have increased in comparison to the previous months, although we continue to see lower referral numbers in comparison to the same period last year, which coincides with lower criteria to reside numbers in the same comparison.	Less number of patients without criteria to reside in the Trust can contribute towards improved patient flow throughout the whole journey, freeing up bed capacity and ensuring patients receive their treatment/recovery in the right setting. Therefore, with the slight increase in acute figures in September, although lower than the previous year, this could have a negative impact upon patient flow. Reduced amounts of patients remaining in hospital without criteria to reside correlates with patients being able to return home, or to their onward place of discharge quicker, reducing length of stay and risks associated with prolonged hospital admissions.	A number of projects are still underway to improve the speed of our discharges from the Trust, and in turn the overall no criteria to reside numbers. An external reablement pilot is being explored by Home First to increase the capacity for our Pathway 1 patients being discharged under this service, and prevent the use of the Responsive Overflow service, which can cause additional delays at times. Focus on flow work continues, specifically surrounding our community assessment pathway 2 beds, to explore how we can improve the flow throughout these settings and maximise capacity.

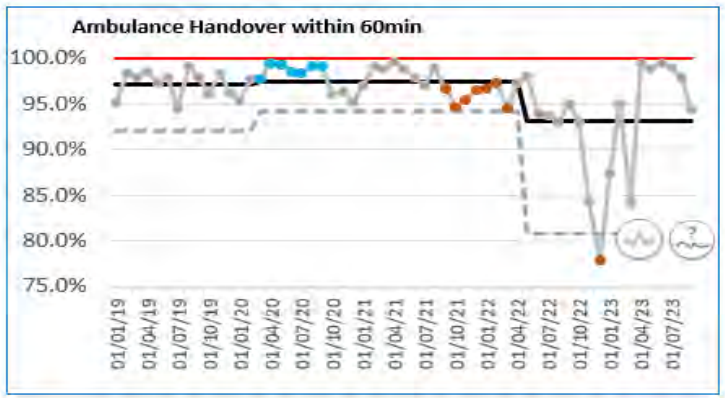


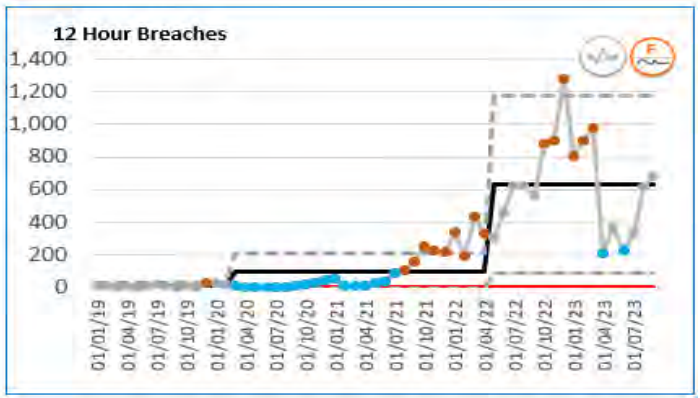


KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Ambulance Handover within 15min	Sep 23	24.7%	65.0%			30.6%	17.5%	43.8%
Ambulance Handover within 30min	Sep 23	75.0%	95.0%			78.4%	54.5%	102.3%
Ambulance Handover within 60min	Sep 23	94.3%	100.0%			93.2%	80.9%	105.5%
12 Hour Breaches	Sep 23	681	0			633	86	1179
Reduce adult general and acute (G&A) bed occupancy	Sep 23	94.4%	92.0%			92.3%	90.9%	93.8%
4 hour breaches	Sep 23	3016	0					
4 hour performance	Sep 23	61.1%	76.0%					

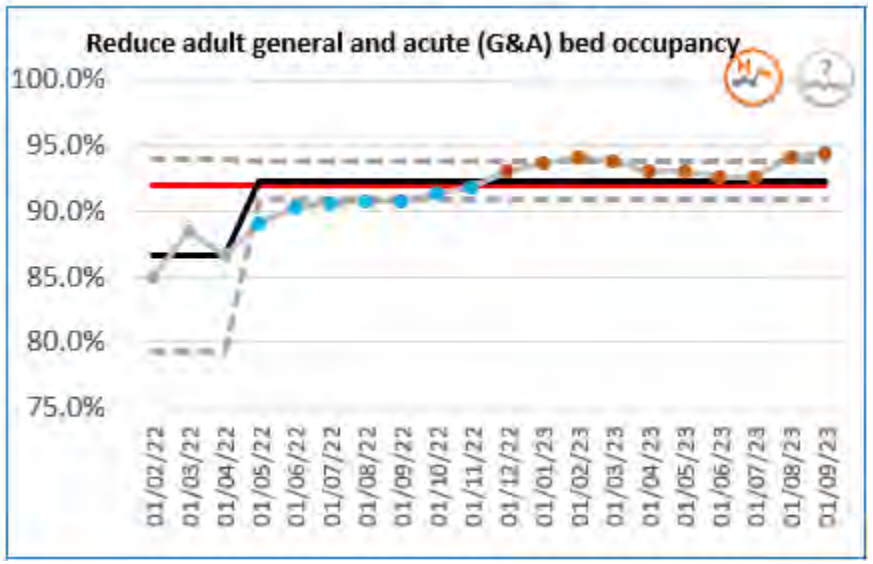
Urgent & Emergency Care (TRUST)





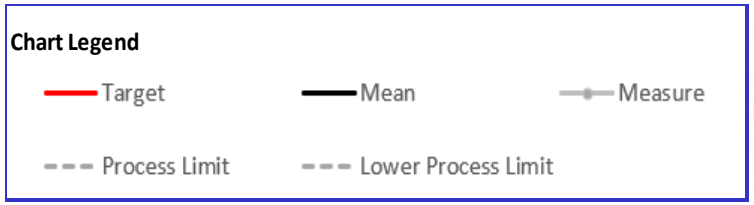


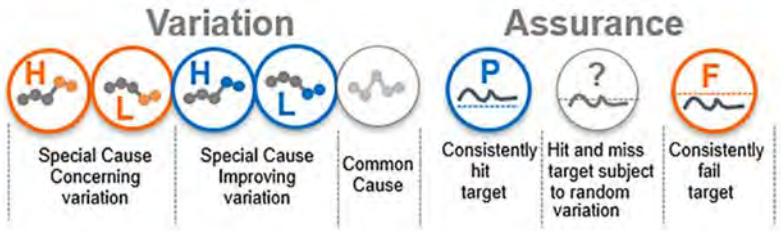
What	So What?	What Next?
There has been no significant change with overall attendances to ED. We remain above our trajectory for the 4 hour performance (*chart not included)* with performance at 61.11% Ambulance handover performance is not demonstrating an improvement and remains challenging in all 3 metrics, this is attributed to a continued increase in crowding within the emergency department and an increase in the length of stay of patients which results in reduced capacity to offload ambulances. The above factors have also impacted on the decline in performance of 12 hour length of stay breaches.	Meeting UEC performance metrics is key in ensuring that our patients are receiving timely emergency care. Achievement of ambulance handovers metrics and the 76% 4 hour ED standard will meet the national targets. The lack of flow out of the Emergency Department during the month has resulted in the opening of escalation areas to assist with this flow, including Rapid Assessment Area opened overnight, ambulance cohorts open and the use of the Same Day Emergency Care (SDEC) footprint, and AAU corridor.	We continue to work through phase two of our internal UEC recovery plan whilst working collaboratively with the alliance and the ICB on the 'One Plan' to ensure improved UEC performance. UEC performance reported via governance meeting. Work continues on embedding our processes to achieve the 4 hour standard and performance continues to be above trajectory. We plan to have a refocus on the 4 hour target in the coming weeks. Direct ambulance referrals into SDEC from paramedics and HALO's at the front door are now embedded.



What	So What?	What Next?
Bed occupancy has tracked above the 92% threshold in all months of 2023, and has demonstrated a continuous upward trend since 2022, driven by a corresponding increase in length of stay (although not yet significantly impacting on numbers of stranded patients). August and September tracking above the upper control limit has directly resulted in a higher number of patients awaiting beds in the hospital in our Emergency Department.	Increasing bed occupancy within a finite bed stock reduces timely and effective patient flow, as rates of admissions have stayed constant. This increases the likelihood of patients waiting for beds in the Emergency Department and Acute Assessment Area, in some cases for many hours. This in turn impacts on the timely delivery of care within the Emergency Department, worsening 4-hour and 12-hour performance.	Bed occupancy will need to reduce towards or below 92% to ensure patient flow is effective and patients are not left waiting for admission. The Focus on Flow programme being managed by the Operational Improvement team has 12 workstreams with the ambition of increasing flow and reducing bed occupancy. WSFT's planning trajectory to keep occupancy below 92% requires this programme, Virtual Ward, discharge funding, surgical SDEC/SAU and the national UEC funding to deliver to deliver the equivalent of 45 beds, with an additional 33 escalation beds forecast to be needed from December.

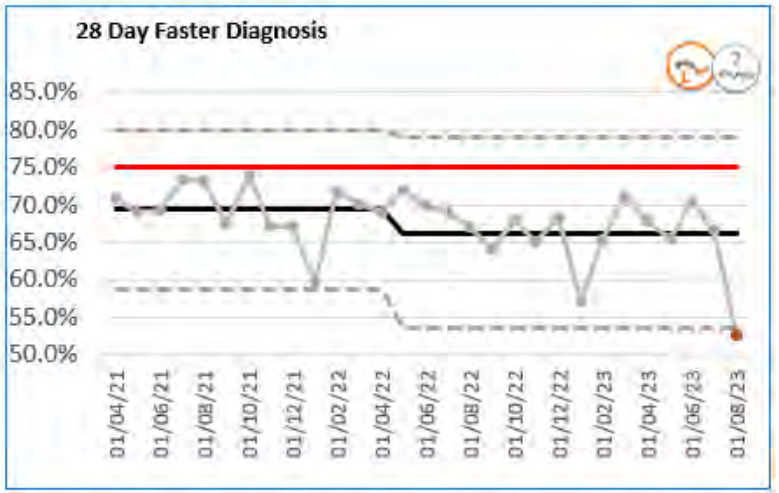
Cancer Access Summary

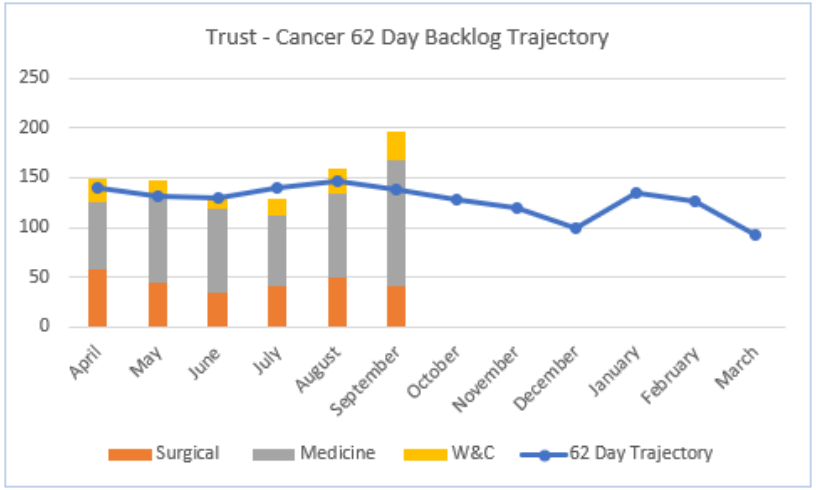


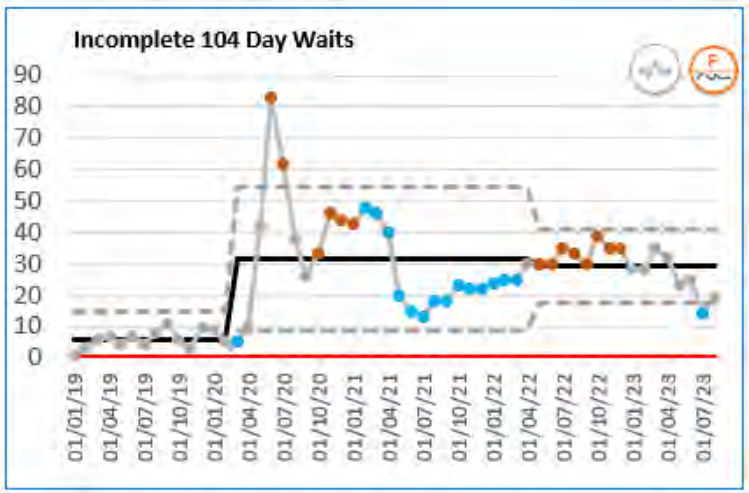


KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
28 Day Faster Diagnosis	Aug 23	52.7%	75.0%			66.2%	53.5%	79.0%
Trust Cancer 62 Day Backlog Trajectory	Aug 23	196	138					
Incomplete 104 Day Waits	Aug 23	19	0			29	18	41

Cancer Access (Month Behind)







What	So What?	What Next?
Performance against the 28-day Faster Diagnosis Standard (FDS) is not being consistently met nor demonstrating the improvement trajectory required to deliver the interim quarterly milestones and 75% target by March 2024. The downturn in August performance is largely driven by the Breast pathway, where one-stop clinics were occurring after 28 days from referral – as breast referrals make up a large proportion of the total any change in performance will have a noticeable impact on overall performance. The 62-day backlog is over trajectory with increases being most noticeably driven by the skin cancer pathway and patients awaiting post-operative histopathology results. The majority of other patients are awaiting actions to be removed from the pathway, rather than awaiting treatment dates. The number of 104-day waits has not significantly decreased.	Achieving the FDS target of 75% and a 62-day backlog of no more than 93 patients by March 2024 are the key objectives for cancer in 2023/24 planning. As we approach mid-year and are not demonstrating an improvement against these there is a possibility that WSFT may be placed into 'Tier 2' intervention from NHSE regional colleagues for which a more intensive recovery plan will be required. As well as recovering breast FDS performance to >90%, ensuring skin delivers >90% and improving performance in urology, lower GI, head & neck and gynaecology pathways will be required to meet the 75% target. Action is required to reduce the 62-day backlog, ensuring patients are not awaiting decisions to close pathways where treatment is complete or results negative for cancer are available.	Additional weekend breast cancer clinics should see the booking time return to <28days, additional baselined activity will need to continue further to improve performance. A step change in breast pathway capacity is due to go live with another room available by the end of October. The impact of actions to improve FDS performance in gynaecology, head & neck (one-stop clinics) and urology (nurse-led prostate biopsy) will need to be monitored and further actions identified if necessary. The East of England Cancer Alliance are currently running a 'Rapid Cancer Action Team' to identify and implement FDS improvements in skin, gynaecology and lower GI pathways in which WSFT is an active participant.

Elective Access – Summary: Activity

NHS England - 23/24 (Monthly - IQPR)

** Outpatient weekly data only includes e-care records (no Cardiology Diagnostics or Radiology)*

West Suffolk NHS
NHS Foundation Trust

All

All

Outpatient First

Mon	19/20	107%	23/24	Var %
Apr	6,625	7,089	6,718	101.4%
May	7,453	7,975	8,395	112.6%
Jun	8,097	8,664	8,294	102.4%
Jul	7,499	8,024	7,818	104.3%
Aug	7,637	8,172	7,584	99.3%
Sep	7,729	8,270	8,553	110.7%
Oct	8,097	8,664		
Nov	8,373	8,959		
Dec	6,717	7,187		
Jan	8,373	8,959		
Feb	7,821	8,369		
Mar	7,591	8,122		
Total (YTD)	**45,040**	**48,193**	**47,362**	**105.2%**

September 2023

19/20	7,729
107%	8,270
23/24	8,553
Var	283
Var %	110.7%

Daycase

Mon	19/20	107%	23/24	Var %
Apr	1,903	2,033	2,064	108.4%
May	2,175	2,324	2,392	110.0%
Jun	2,338	2,498	2,449	104.7%
Jul	2,189	2,338	2,309	105.5%
Aug	2,257	2,411	2,367	104.9%
Sep	2,284	2,440	2,343	102.6%
Oct	2,393	2,556		
Nov	2,556	2,731		
Dec	1,985	2,121		
Jan	2,461	2,629		
Feb	2,365	2,527		
Mar	2,284	2,440		
Total (YTD)	**13,146**	**14,045**	**13,924**	**105.9%**

September 2023

19/20	2,284
107%	2,440
23/24	2,343
Var	(97)
Var %	102.6%

Outpatient Follow Up

Mon	19/20	85%	23/24	Var %
Apr	14,014	11,912	15,188	108.4%
May	15,766	13,401	18,315	116.2%
Jun	17,128	14,559	18,528	108.2%
Jul	15,863	13,484	17,320	109.2%
Aug	16,155	13,732	17,493	108.3%
Sep	16,350	13,897	17,704	108.3%
Oct	17,128	14,559		
Nov	17,712	15,055		
Dec	14,209	12,077		
Jan	17,712	15,055		
Feb	16,544	14,063		
Mar	16,058	13,649		
Total (YTD)	**95,276**	**80,984**	**104,54**	**109.7%**

September 2023

19/20	16,350
85%	13,897
23/24	17,704
Var	3,807
Var %	108.3%

Elective

Mon	19/20	107%	23/24	Var %
May	299	319	295	98.8%
Sep	300	321	293	97.5%
Apr	257	275	239	92.8%
Jun	318	340	278	87.3%
Aug	315	337	258	82.0%
Jul	300	321	243	80.9%
Oct	318	340		
Nov	329	352		
Dec	277	296		
Jan	275	294		
Feb	300	321		
Mar	286	306		
Total (YTD)	**1,790**	**1,914**	**1,606**	**89.7%**

September 2023

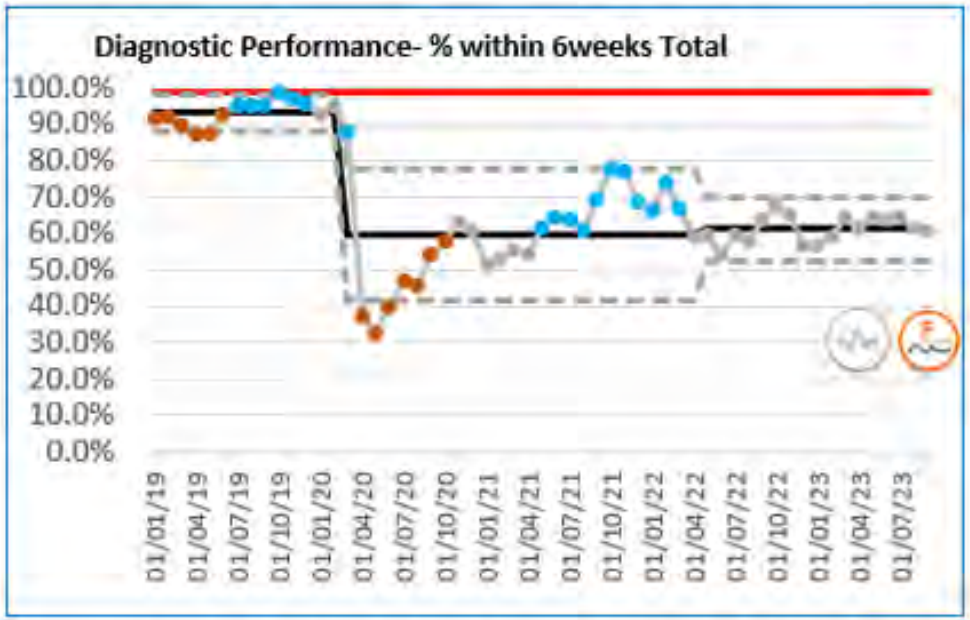
19/20	1,790
107%	321
23/24	293
Var	(28)
Var %	97.5%

What	So What?	What Next?
Year to date, day case and outpatient first totals are above 2019/20 levels however are not meeting the 107% ambition, with electives significantly behind in all months and showing a downward trend. Industrial action, with pre-emptive cancellations and increases in on the day cancellations due to bed capacity/emergency demand will have impacted on this. Outpatient follow ups are consistently and significantly adrift from the 75% target – despite reductions in activity due to industrial action.	Not achieving activity level targets impacts on our ability to deliver key requirements to reduce the number of long waiting patients, outpatient transformation ambitions and achieve the Elective Recovery Fund activity thresholds which are part of our financial modelling and overall recovery.	It is possible that the 107% Elective Recovery Fund activity threshold will be lowered to 105% in recognition of the impact from Industrial Action. Plans are in place to increase activity in surgical specialties, and a refreshed Trust and ICB-wide outpatient transformation programme will have a key priority to reduce follow ups by 25% in line with national expectations. Further work and cultural shift will be required to deliver this.

Elective Access Summary

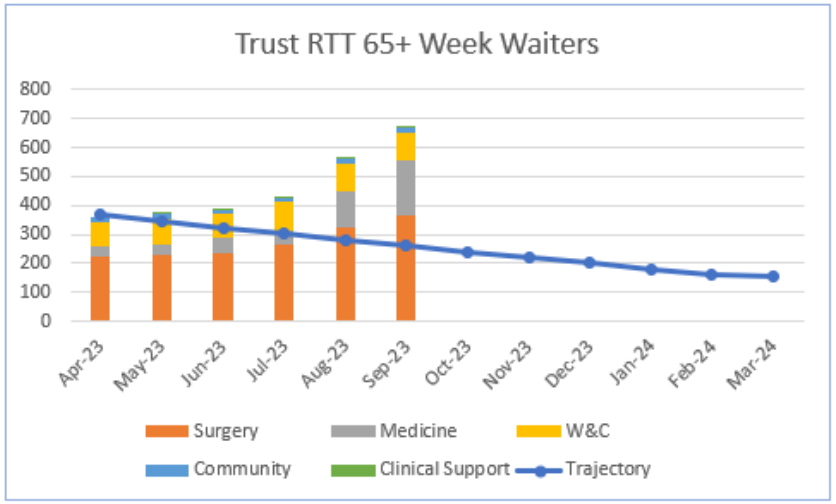
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Diagnostic Performance- % within 6weeks Total	Sep 23	61.0%	99.0%		F	61.2%	52.5%	69.9%
RTT 65+ Week Waits	Sep 23	674		H		465	287	642
RTT 78+ Week Waits	Sep 23	67	0	L	F	224	120	328
RTT 104+ Week waits	Sep 23	0	0	L	?	14	-5	34
Potential 65+ ww at end of March 2024	Sep 23	4786						

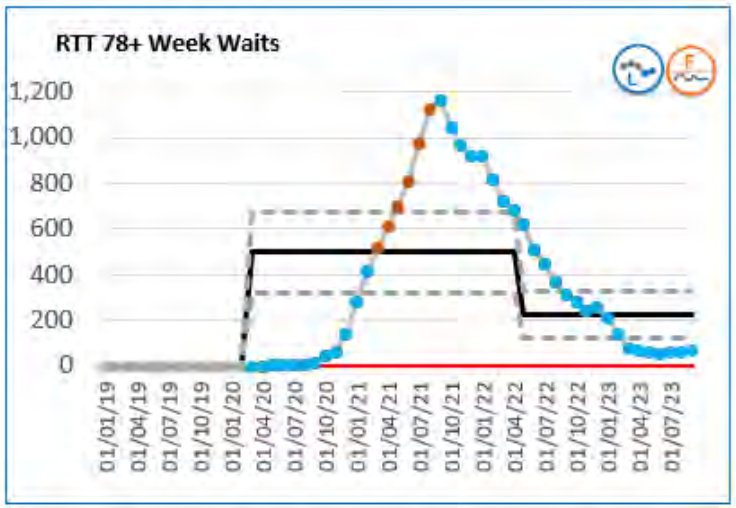
Elective Access

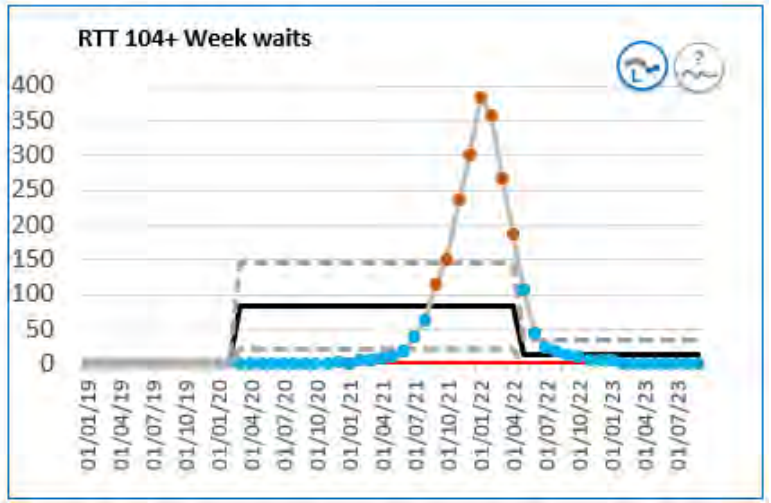


Elective Access

What	So What?	What Next?
The number of procedures undertaken is fluctuating month on month driven by capacity, clinical and non-clinical cancellations. There have also been increased sickness absence in month, primarily colds and coughs and absence within the anaesthetic team, driven by events outside of work. We have kept the insourced anaesthetist until 30th November to support the running of activity and have had some success in recruiting theatre staff, including 5 anaesthetic technology students from overseas. There have been recent skill mix issues noted in theatres and as such all emergency lists are being locked down. It is likely the division lost IRO 200 procedures due to IA in September, recognising booking ceased upon notification. **MRI** - Common cause consistently failing target. Running at full capacity across the seven days but current capacity insufficient. **CT** –Currently meeting DM01 compliance target despite replacement programme. **US** –Improving trend towards DM01 compliance but an unexpected decline in performance in August owing to staffing challenges which have continued into September an have been compounded by industrial action **Endoscopy –** Concerning variation, consistently failing to achieve target. Progress is being made against DM01, however extended waits have been noted for patients on a cancer pathway and a re-balancing of capacity is being undertaken to ensure sufficient weekly capacity is available to meet cancer pathway requirements. This may in turn slow the progress with DM01 recovery marginally. Priority is being given to longest waiting routine patients and priority RTT pathways. Total waiting list has increased reducing but DM01 performance is showing consistent improvement for endoscopy.	We continue to strive to deliver the best care for our patients, but some continue to have a poor patient experience by being cancelled on the day. In addition, some patients are not adequately prepared which is multi-factorial. This highlights the need for a day of surgery admissions unit. Longer waiting times for diagnosis and treatment	• Standby for surgery scheme • Review of Fitter for surgery programme • Liaison with ESNEFT and WSFT Pre-operative assessment • Dedicated deputy clinical director for theatre productivity • Refresh of late starts/early finish dashboard • Clinicians attending theatre scheduling • Reinforcement of cancellation policy and RCA's undertaken f=of random sample for learning **MRI** –Requests to NHSE/Networks for additional resources have been fed back including a staffed MRI and additional reporting capacity we are yet to see a result of these bids but are in close liaison with the relevant network and regional teams. Ongoing and further liaison with SNEE partners re: mutual aid opportunity to access weekend MRI capacity but this would require additional insourced staffing support. Longer term CDC will begin to address. **CT** - Potential impact from CT replacement programme. Longer term CDC will begin to address. **US** –Plan to up skill Sonographers from the main department to be trained in MSK which will help with capacity, reducing waiting times and agency spend. Staffing issues resolving and performance now expected to improve. **Endoscopy** - Current trajectory anticipates compliance in June 2024 against the DM01 target ambition of 95% by March 2025. Negotiations have secured access to externally funded underutilised InHealth capacity beyond the current plan of September 2023. Additional work in liaison with Cambridge University to explore opportunities to maximise efficiency in processes due to commenced early October.

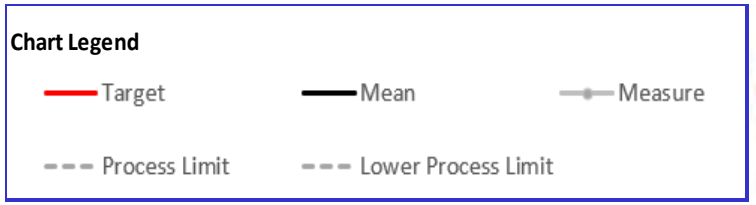


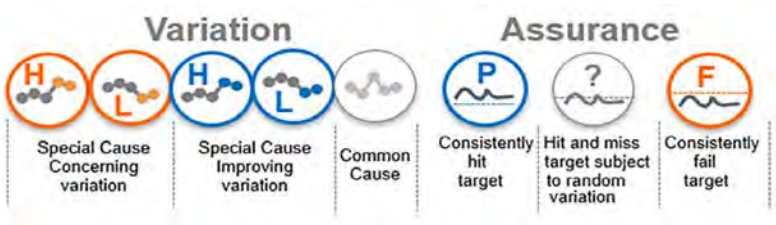




What	So What?	What Next?
Whilst the absolute number of 65ww patients continues to increase, our focus remains on the total cohort of patients who need to be treated to deliver our revised trajectory of no more than 52 patients by March 2024. The absolute number of 78ww patients remains constant in line with our forecast trajectory for capacity breaches (within the uro-gynaecology specialty). There were no 104ww patients as of the end of September.	Delivering the objective of no patients waiting over 65 weeks by March 2024 is the central focus of 2023/24 planning, delivering an improved set of outcomes and experience for our patients – as patients are at increased risk of harm and/or deteriorating the longer they wait. This increases demand on primary and urgent and emergency care services as patients seek help for their condition. WSFT's non-zero trajectory for 65ww that was submitted in 2023/24 planning resulted in us being assigned 'Tier 2' support from NHSE regional colleagues, we are expected to exit this arrangement imminently as actions to improve pour position have either been completed or have confirmed start dates.	Insourcing of additional uro-gynae activity is due to start in November, providing the main mitigation against our non-zero 65ww trajectory, aiming to deliver a revised position of no more than 52 patients by March 2024, down from 187. Insourcing is also being explored for the dermatology pathway, given a rise in the number of urgent patients needing to be seen which has increased the waiting time of routine patients and which could tip over into the 65 and 78ww cohorts. Delivery of the actions from the August 2023 NHS elective recovery letter is focussed on validation of the waiting list and clearing waits for first appointments by the end of October.

IMPROVEMENT COMMITTEE METRICS

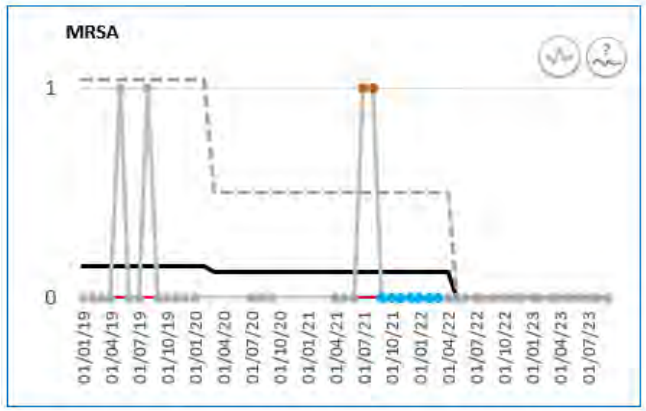


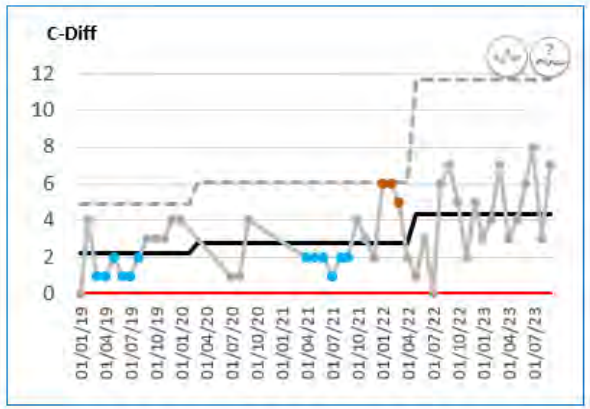


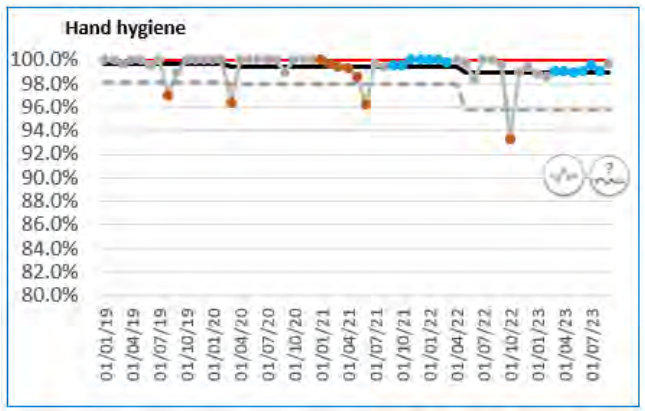
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
MRSA	Sep 23	0	0			0	0	0
C-Diff	Sep 23	7	0			4	-3	12
Hand hygiene	Sep 23	99.7%	100.0%			98.9%	95.7%	102.1%
Sepsis Screening for Emergency Patients	Sep 23	75.0%	100.0%			86.6%	62.7%	110.6%
VTE - all inpatients	Sep 23	99.4%	95.0%			97.3%	94.9%	99.6%
Mixed Sex Breaches	Sep 23	8	0			4	-6	15
Community Pressure Ulcers	Sep 23	48	25			34	19	49
Acute Pressure Ulcers	Sep 23	17	17			24	6	42
Acute Pressure Ulcers per 1000 Beds	Sep 23	2.0	-			2.2	0.5	4.0
Inpatient Falls Total	Sep 23	64	48			74	45	102
Acute Falls per 1000 Beds	Sep 23	5.3	5.6			6.0	4.0	8.0
Nutrition - 24 hours	Sep 23	90.0%	95.0%			87.4%	80.3%	94.4%
Patient Safety Incidents per 1,000 OBDs	Sep 23	68.8	-			63.6	51.9	75.2
Patient Safety Incidents Reported	Sep 23	879	-			843	686	1000
Patient Safety Incidents Resulting in Harm	Sep 23	178	-			171	127	215

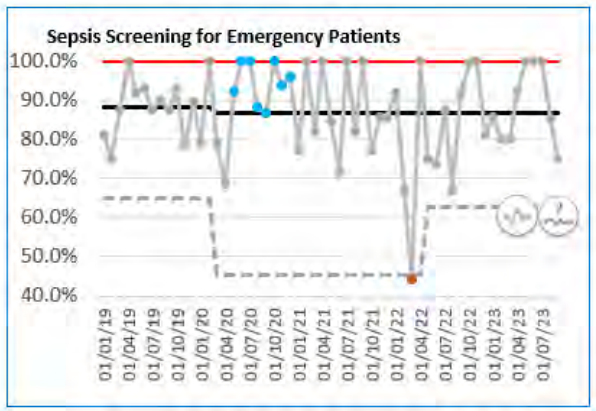
Falls are only counting Inpatients and Exclude Assisted Falls & Outpatient areas.

Safe



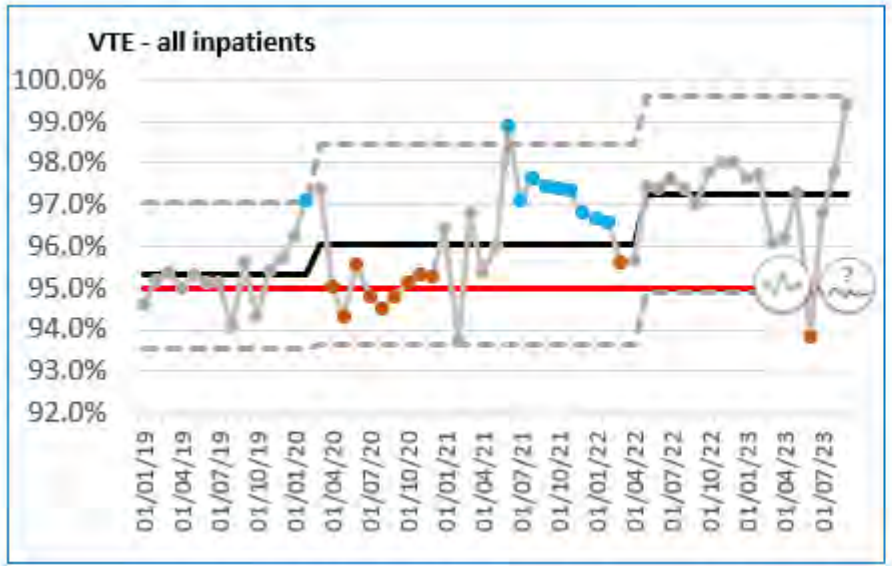


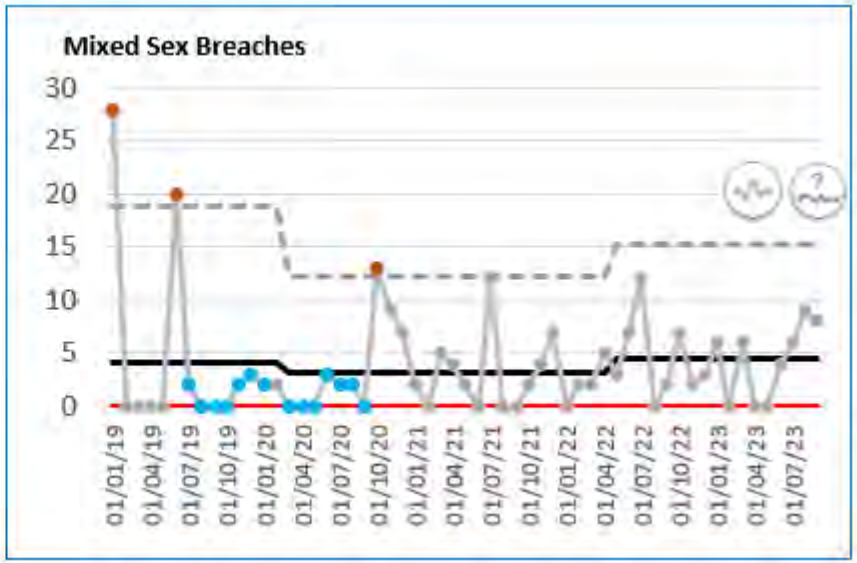




What	So What?	What Next?
There is consistent performance with MRSA Bacteraemia. <u>C-Diff</u> There are two repeat samples of known positive cases this month., these are considered ongoing infections from previous and not 'new' infections. Increase on last month with no significant change in month on month incident rate. It is recognised Nationally that the rates of *Clostridioides difficile* have increased significantly over the last two reporting years.	Healthcare-associated infections (HCAIs) can develop either as a direct result of healthcare interventions such as medical or surgical treatment, or from being in contact with a healthcare setting. HCAIs pose a serious risk to patients, staff and visitors. They can incur significant costs for the NHS and cause significant morbidity to those infected. As a result, infection prevention and control is a key priority for all NHS providers.	Individual cases, themes and periods of increase incidence will be identified and reviewed through the Trust process in a timely manner. The impact of the learning/good practices are formally discussed and taken back to the appropriate teams via the Heads of Nursing at the Infection Prevention & Control Committee/Matron and/or ward representative with a view to reducing the rates of healthcare associated infections. Proposed changes to Ecare for a hard stop to antibiotic course lengths. To promote appropriate antibiotic course length and timely switching to antibiotics according to available sensitivities. Trust *Clostridioides difficile* infection reduction plan has been submitted to NHS England In the reporting period 2022-23 the 'NHS Standard Contract 2022/243: Minimising Clostridioides difficile and Gram-negative bloodstream infections; the Trust threshold for Hospital Associated Cases (both Hospital and Community onset) was '55' with a Trust 'actual' of 52 cases.

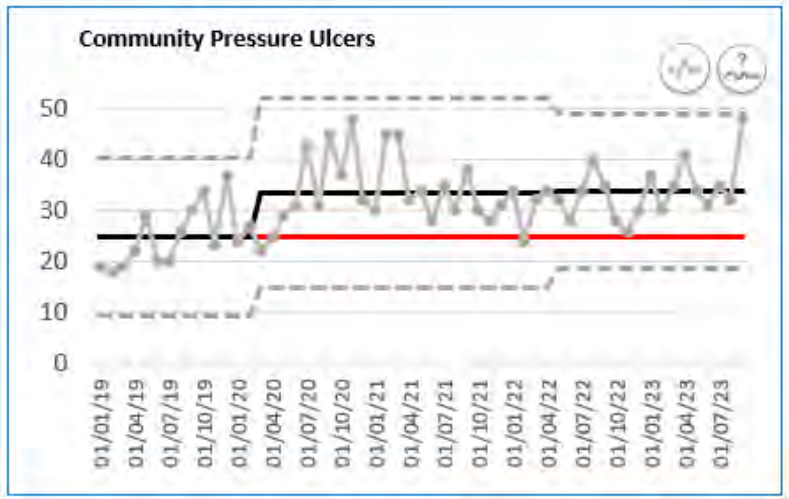
Safe

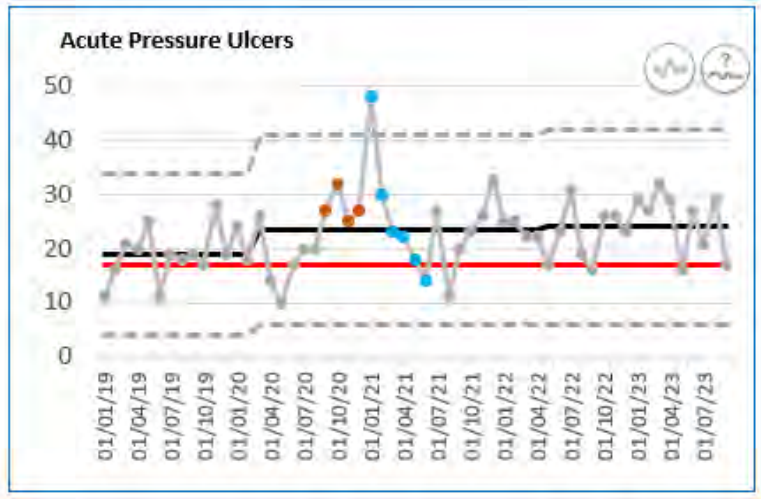


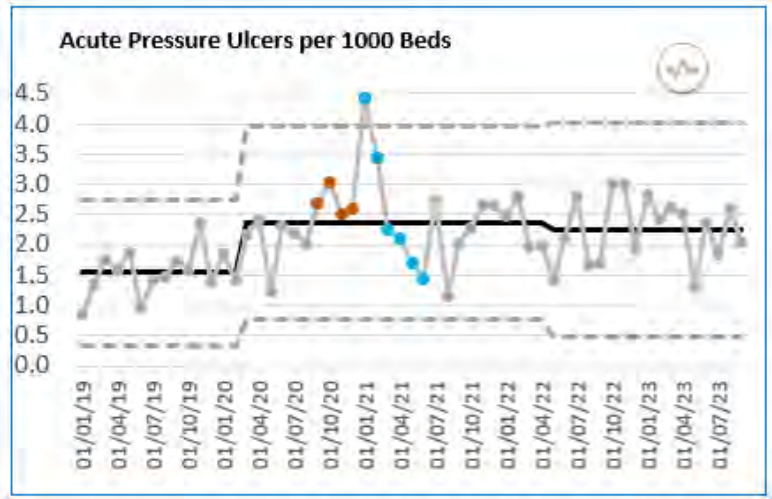


What	So What?	What Next?
There has been a marked improvement in VTE baseline assessment for 97.78% in August to 99.37% in September. This is driven by an improvement in the compliance in AAU . This normally runs at around 70- 80% but was 94.23% in September. Trust achievement has been consistently above target since January with only one data point below target <u>MSA</u> Data suggests that eliminating MSA breaches is not consistent. Again this performance is driven by challenges of stepping patients out of ITU in a timely manner, once no longer requiring critical care	This means that the compliance with baseline assessment for VTE remains above the target of 95%. Patients who have these assessments and thereby the appropriate prophylaxis are less likely to suffer an avoidable hospital acquired VTE. Avoiding MSA ensure that patient's experience is maintained to the best of our ability. No MSA has occurred outside of the high dependency area	It may be that there is a genuine improvement in practice in AAU but due to the high turnover of patients it has previously proved very difficult to get compliance over 80%. The acute medical team have been asked to explore these figures to understand the positive compliance MSA breaches and the need to step out of ITU timely is reviewed at every bed meeting and is a balance of risk, considering timely patient placement through the emergency pathway

Safe

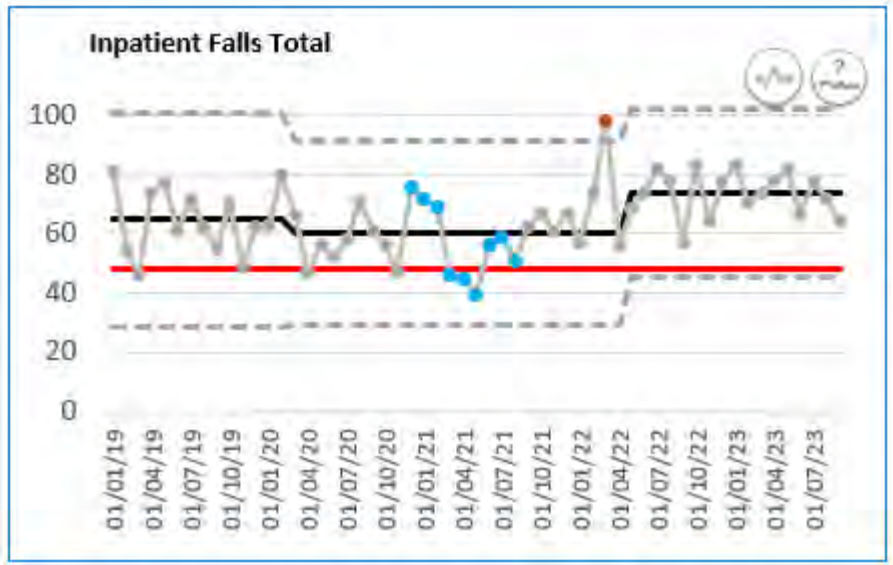


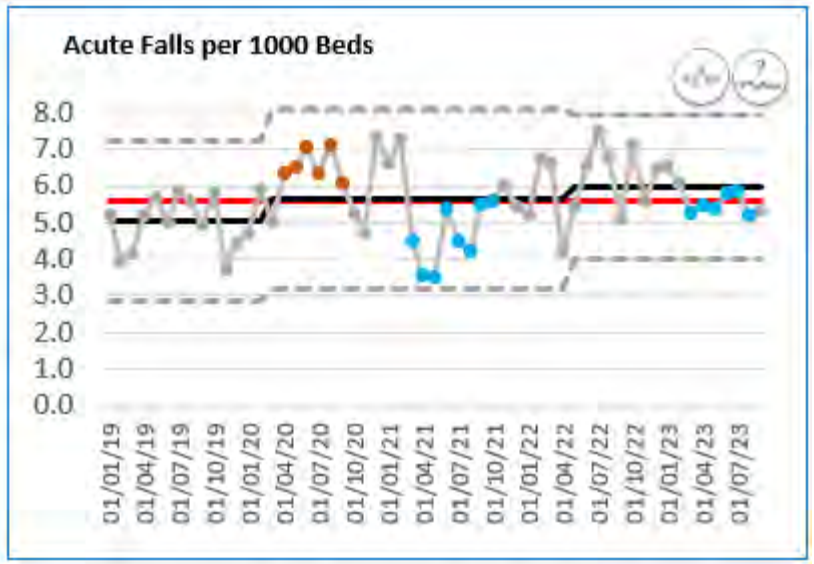




What	So What?	What Next?
The data demonstrates acute PU remains static from previous month, within the Community we have seen a more significant increase however overall incidents neither in decline or improvement trajectory For this month, all the large community teams reported higher PU particularly Bury Town. Community CAB beds Newmarket reported higher than average Pressure ulcers. Within the acute highest PU incidents remains in medicine.	Pressure ulcers remain a mainly avoidable harm associated with healthcare delivery. Developing a pressure ulcer has long term consequence to a patients health, quality of life and also the financial cost of providing ongoing care Causation of a pressure ulcer can vary significantly and is driven by co-morbidities, concordance and also factors within the control of healthcare provision including [but not limited to] staffing levels, care planning and risk identification. Community training has been driven in previous months on Pressure area care and basic wound care, these initiatives often drive a spike in reporting due to raised awareness.	Continue to monitor pressure ulcer incidents and recognise and act on themes through the Pressure Ulcer Prevention Group (PUPG). These initiatives are part of wider overarching Quality Improvement works across the trust. Full work stream oversight is monitored through PUPG Community have been rolling out awareness programs and training across the community including the inpatient community beds National Stop The Pressure the pressure week planned for November 2023 and this is an opportunity to promote Pressure ulcer awareness and this will be promoted across community and acute.

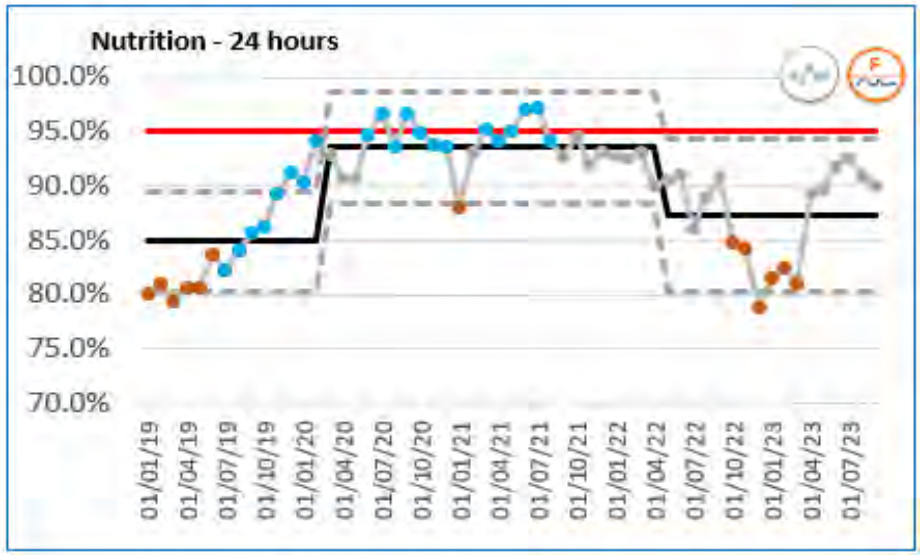
Safe





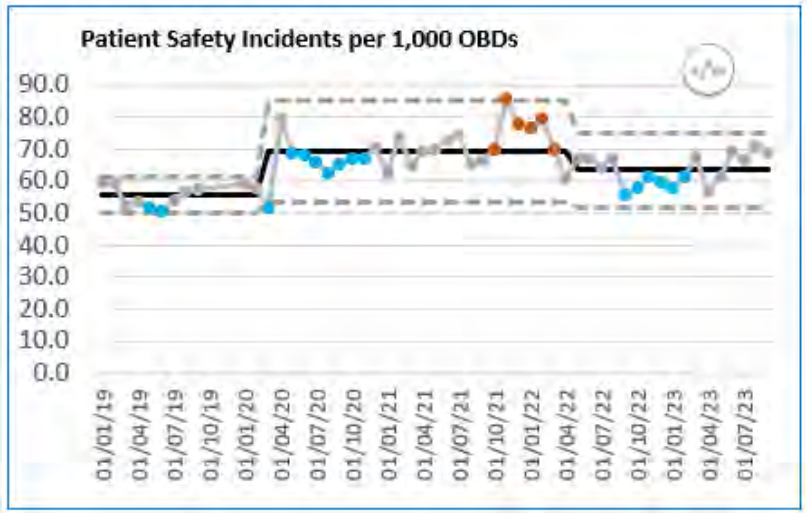
What	So What?	What Next?
There has been no significant change in the number of inpatient falls reported within the inpatient area, however there is some positive improvement in falls per 1000 bed days with sustained incident rate below the trust average This month (September) there was 1 fall reported as catastrophic harm (subdural haemorrhage) and 1 fall reported as moderate harm (fractured ankle). During the month of September there were 12 repeat fallers with one patient having three falls and another patient having four falls in the reporting month.	The effects of falls within hospital can range increase length of stay due to loss of patient confidence and deconditioning, to life changing severe harm. Its widely acknowledge that mortality of patient suffering from severe harm is greatly increased despite initial recovery. Older adults who fall more than once per year are defined as recurrent fallers and are risk for functional decline and mortality. All falls with major and moderate harm will be reviewed through PSIRF after action reviews to understand learning and actions.	Actions and quality improvement work is continuing and focusing on different aspects of falls prevention and post fall management. Learning from recent 'post fall' after action reviews has prompted an addition to eCare to highlight necessary actions to take/consider to mitigate the risk of further falls and reduce the incidence of patients falling repeatedly.

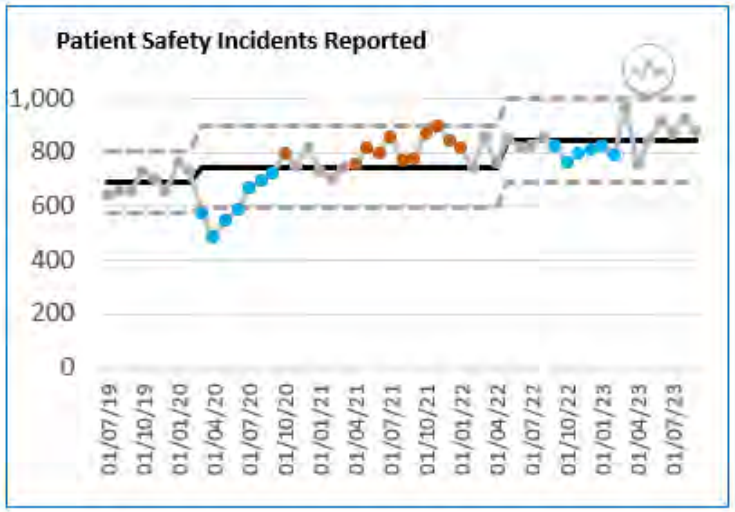
Safe

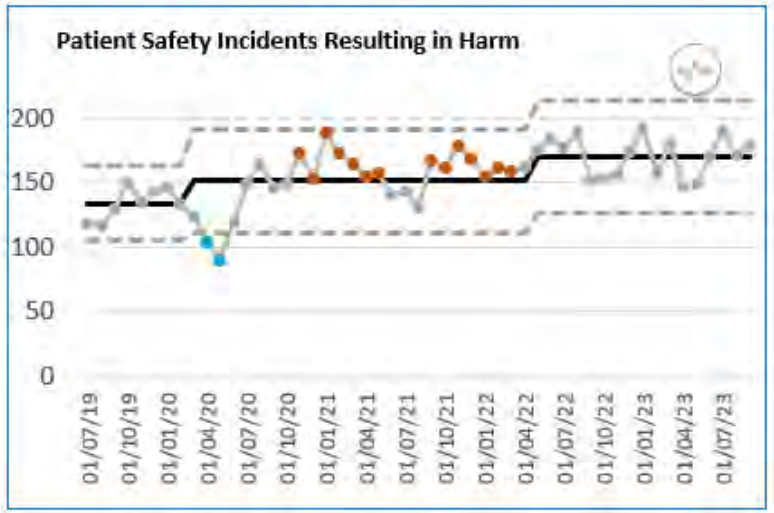


What	So What?	What Next?
Performance of this metric has been above average for the last 6 months, following significant decline over the preceding 6 months. al The patient journey time from ED to the ward has increased again due to capacity pressures and this leads to delays in completing assessments, including the nutritional assessment. The metric also continues to be reviewed at 48hrs and there is increasing improvement, providing assurance that the majority of patients are assessed on admission.	Nutrition and hydration is a fundamental element of care and continues to be an area of focus and improvement for all the teams in the Trust. There is improved awareness that this will underpin a positive experience and outcome for the patients in our care. the Trauma practitioners have commenced a QI project to provide supplement drinks pre and post operatively to those patients with fractured neck of femur to improve outcomes and healing. Early indications are demonstrating a 2-3 day reduction in length of stay for this cohort of patients	• Liaise with Dieticians to monitor impact of any delayed assessments and share learning – November Nutrition Steering Group • Review of data at performance meetings and Governance reviews monthly to inform performance • Work with Information team to improve metrics and reporting – For completion and relaunch December 2023 • Continue to share the data with teams monthly • Review of QI projects to support improvements - December 2023 • Continued focus on aspects of nutrition including protected mealtimes and the provision of supplements • QI work to improve Protected mealtimes – Review January 2023 • Review of audit data to enhance this aspect of care and work with QI team – November 2023 • There has also been increased focus from the ward teams to ensure assessments are completed and care plans activated if indicated. In addition, weighing patients on admission also continues to be a challenge, but there has also been improvement with this metric with additional focus from all areas.

Safe







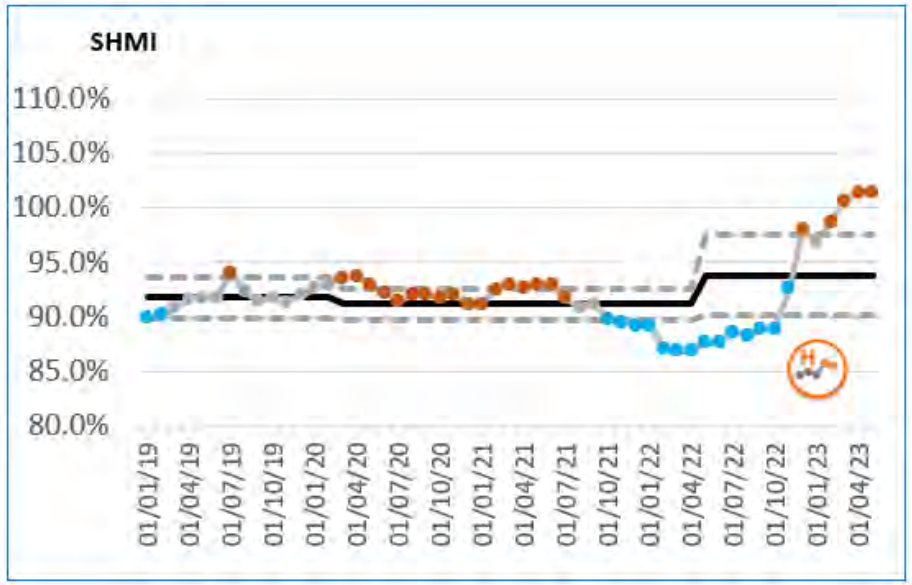
What	So What?	What Next?
The number of patient safety incidents reported remains within an expected range however incidents resulting in harm are reduced. We activity encourage reporting of patient safety events to ensure we have an open and candid culture where staff feel able to report incidents without fear of retribution. We have oversight of incidents reported as major or catastrophic at our emerging incident review meeting and ensure proportionate investigation pathway, duty of candour requirements and safety mitigation are addressed.	Reporting of patient safety incidents is a crucial factor in measuring safety however, this should not be the only metric used. Reporting patient safety incidents allows an opportunity for improvement and change and ultimately a reduction in the number of incidents which occur.	Reported patient safety incident are not a performance measure but an indication of safety and safety culture. Reporting allows us to target improvement by way of theming and analysis. The patient safety team undertake a thematic analysis of incidents on a quarterly basis to target improvement opportunities working with specialist and divisional leads.

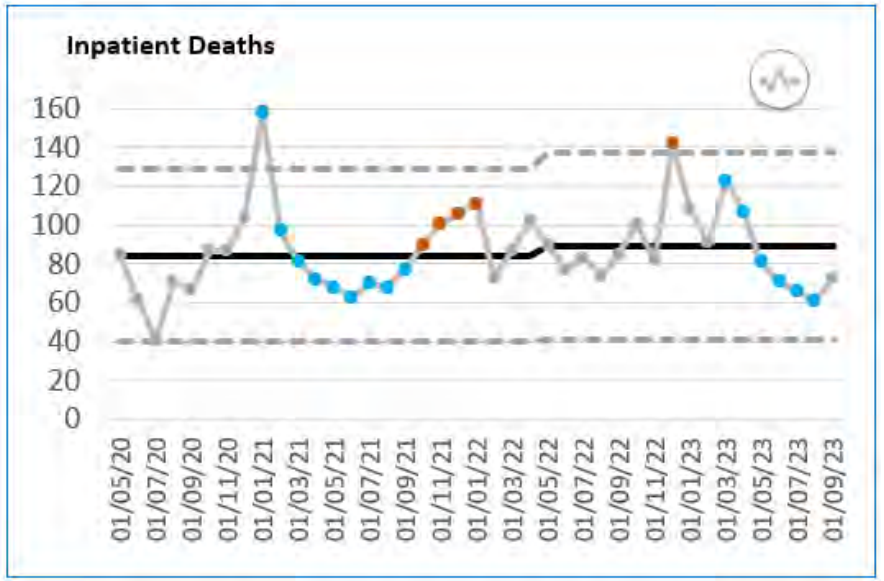
Mortality Summary

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
SHMI	May 23	101.4%				93.8%	90.1%	97.5%
Inpatient Deaths	Sep 23	73				89	41	137

These will be updated once the SHMI data has been published and the Deaths have been agreed

Mortality





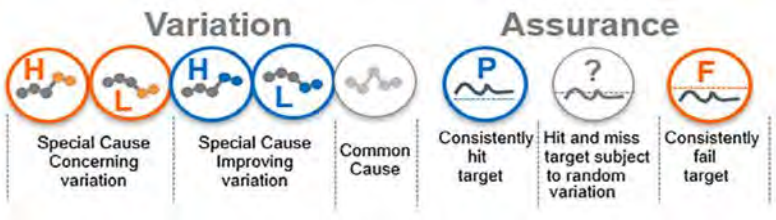
What	So What?	What Next?
SHMI chart highlights a special cause concerning variation from Dec22. Local records of Inpatient deaths show a peak in Dec22 compared to Dec21 albeit considerably lower than Dec20 (which is impacted by Covid). A review of SHMI data for Nov/Dec22 drilled down at the by diagnosis group level flagged a high peak in group 140 (which includes all uncoded records). SHMI = Summary Hospital-level Mortality Indicator	SHMI is reported several months in arrears and is expressed as a "12 months to ..". Current data (issued 12 October) reports deaths to May 2023. SHMI excludes Covid deaths and so does not exactly match local death data (reported up to September). A SHMI of 100% is graded "as expected" meaning that total number of death exactly matches expected deaths. Our SHMI (12 months to May23) is currently 101.39% but it had been 80-90% for a considerable period of time up until Nov/Dec23. The backlog of clinical coding of Nov/Dec22 records means that some patients may be without a primary diagnosis. This means that other diagnostic groups are not presenting an accurate picture so cannot be replied on to give an accurate picture. Most noticeably group 73 (Pneumonia) is currently flagged as "below expected" with a SHMI of 67.54%. Local patient level data has been obtained to cross reference against December deaths. The Mortality oversight group (MOG) reviewed the outcome of this and was confident that the increased deaths were explainable as a consequence of the higher than usual ratio of non-elective admissions in the period. Whilst coded data is not available, the Medical examiner data (cause of death) shows a high ratio of pneumonia as cause of death.	Improvement committee receiving details of review of local mortality data in November. Board awareness of Coding backlog status and its impact on diagnostic coding in SHMI. Executive team and relevant clinical and operational leads are already aware. National SMHI publication to be annotated with a data quality note to reflect the potential inaccuracies at diagnostic coding level (now in place for Oct23 issue).

INVOLVEMENT COMMITTEE METRICS

Safe- Summary

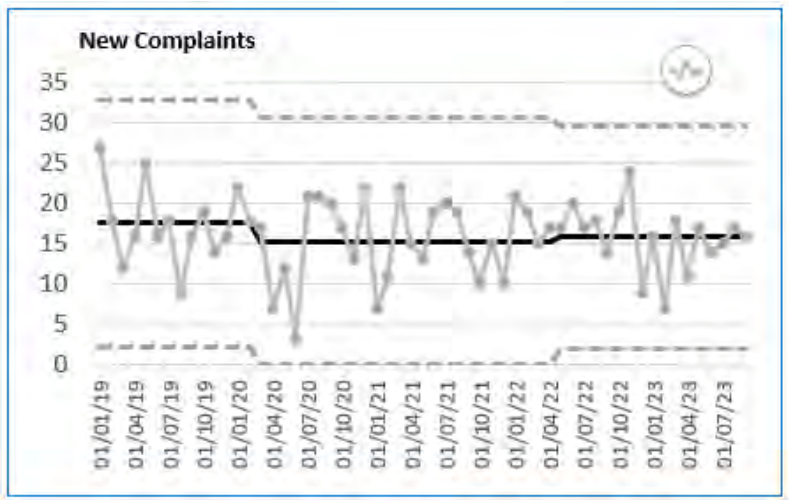
Chart Legend

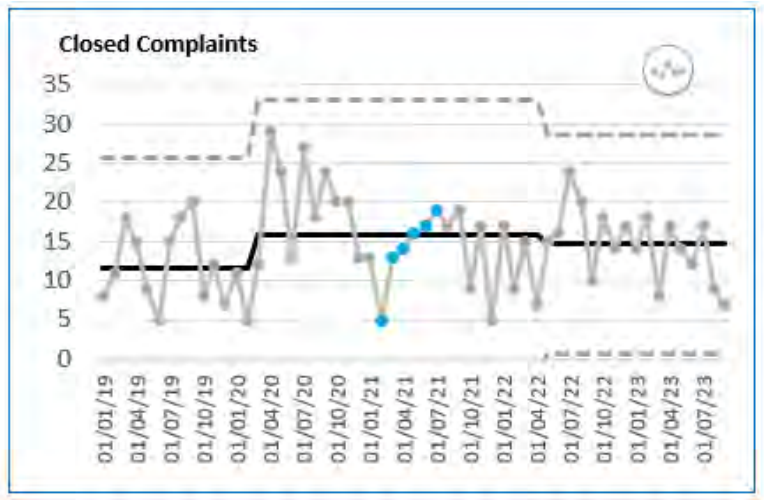
Target | Mean | Measure | Process Limit | Lower Process Limit

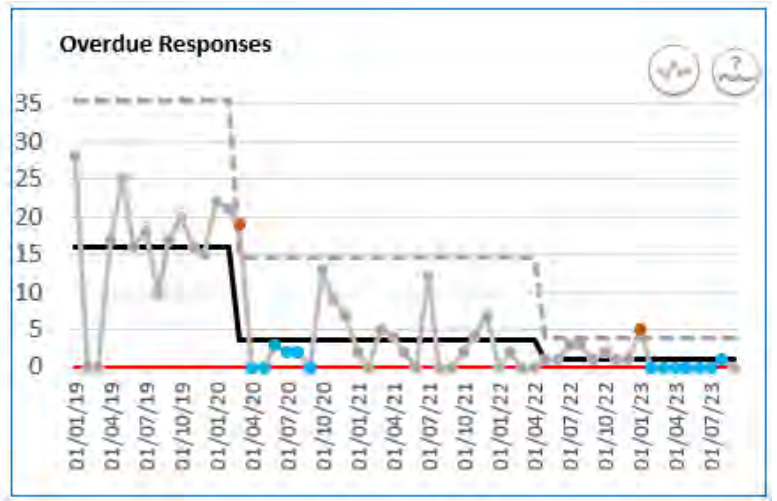


KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
New Complaints	Sep 23	16				16	2	30
Closed Complaints	Sep 23	7				15	1	29
Overdue Responses	Sep 23	0	0			1	-2	4

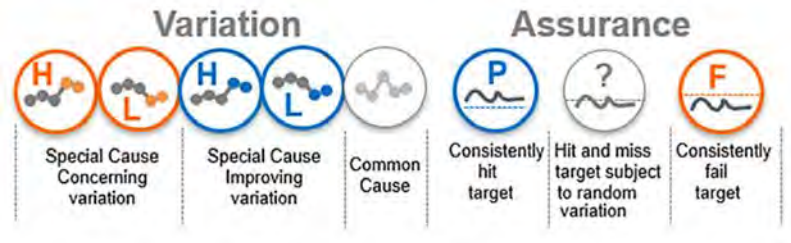
Safe





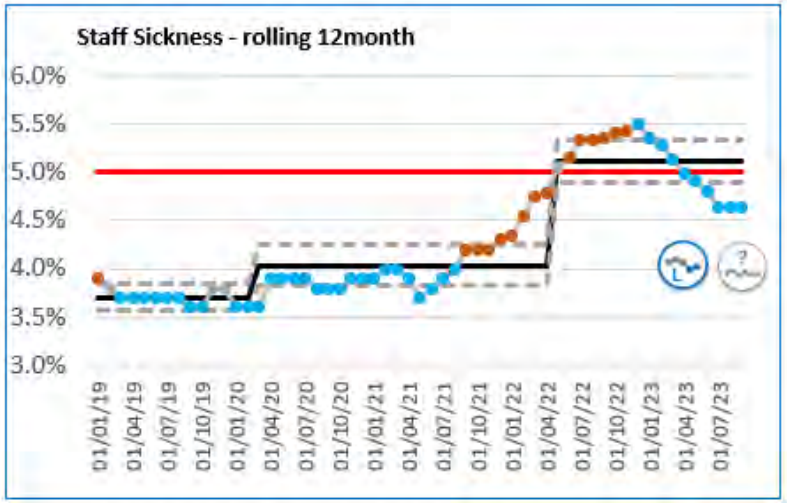


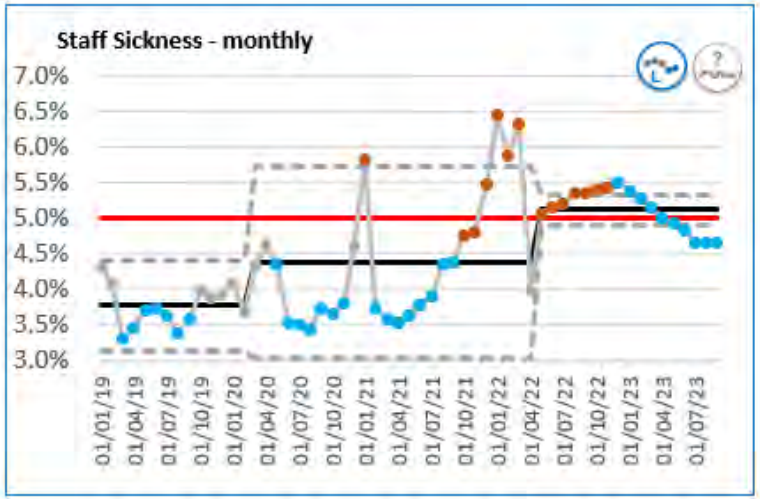
What	So What?	What Next?
September saw 16 new formal complaints logged which is average and within the controlled limits. We did see a reduction in the amount of complaints closed (7). This was due to annual leave within the patient experience team and the remaining staff focussing on more complex cases which require additional time to investigate. Again, there were no overdue responses and complainants have been kept updated throughout.	We have continued to update patients regularly which is reflected in the low number (zero) of overdue responses. Timely responses and minimal second letters provides greater experience for complainants and indicates satisfaction with investigation responses. Survey responses also acknowledge this.	We are still providing an option to meet with clinical staff to provide a more timely response and provide more capacity to staff to allow them to focus on clinical duties. The team are also meeting regularly to ensure timely responses are provided to complainants. Data will continue to remain within the controlled limits.

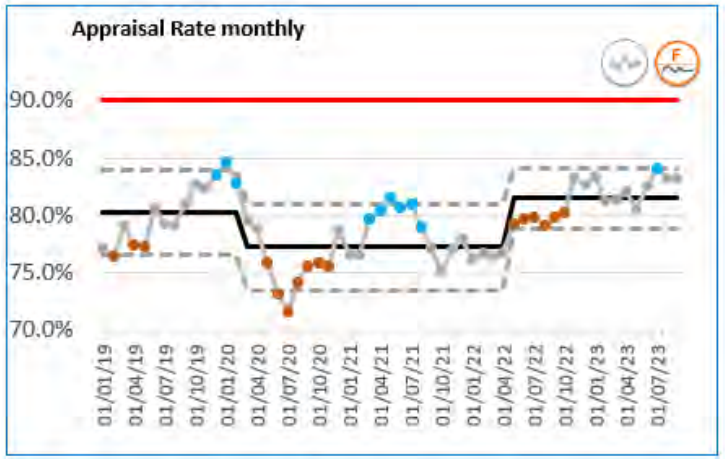


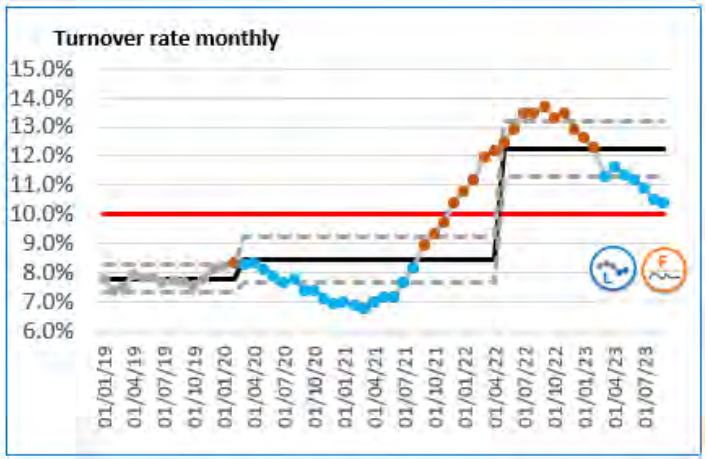
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Staff Sickness - rolling 12month	Sep 23	4.6%	5.0%	L	?	5.1%	4.9%	5.3%
Staff Sickness - monthly	Sep 23	4.6%	5.0%	L	?	5.1%	4.9%	5.3%
Mandatory Training monthly	Sep 23	90.1%	90.0%	H	F	88.4%	87.1%	89.8%
Appraisal Rate monthly	Sep 23	83.2%	90.0%		F	81.5%	78.9%	84.1%
Turnover rate monthly	Sep 23	10.4%	10.0%	L	F	12.2%	11.3%	13.2%

Well Led









What	So What?	What Next?
All key performance indicators, bar appraisal are recording an improved variation. **Sickness** – achieving target following a period of sustained improvement since December 2022. **Mandatory training** – now achieving target, which to note, we have not achieved in the last 12 months and beyond. **Appraisals** – a key performance indicator that is consistently failing target with a recorded drop in compliance in September **Turnover** – marginally below target, improvement sustained in September and a continued improved position has been sustained since November 2022.	These workforce key performance indicators directly impact on staff morale, staff retention, and therefore, patient care and safety. Additionally, improvements in these workforce key performance indicators will strengthen our ability to be the employer of choice for our community and recognised as a great place to work.	Maintain improvements in staff attendance and continue to follow up the internal audit findings of the importance of the 'return to work discussion, every employee, every time.' Sustain the target compliance of mandatory training ensuring areas or staff groups are identified where further support may be required. Continued analysis of appraisal data to target areas in need of action and improvement; continue to pilot new appraisal forms and guidance for launch in January 2024. Focus on the delivery of our people and culture plan priorities to aide recruitment and retention.

4.4.1 Maternity - Annexes

Trust Board	
Report title:	**Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard? C Neonatal Medical Workforce**
Agenda item:	Maternity and Neonatal Services
Date of the meeting:	01/12/2023
Sponsor/executive lead:	Paul Molyneux, Trust Medical Director, Maternity and Neonatal Board Safety Champion.
Report prepared by:	Beverley Gordon, Project Midwife Tayyaba Aamir, Neonatal Safety Champion Hannah Pawsey, Senior Operations Manager

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

WHAT?

Medical staffing in the Neonatal Unit (NNU) of West Suffolk Hospital is required to meet the standards set by the British Association of Perinatal Medicine (BAPM) for staffing levels at all Tiers. The Maternity Incentive Scheme (MIS) run by NHSR is in its 5th year and the requirement is that the Trust meets the BAPM standards for safe staffing of the NNU. This report outlines the review undertaken and the findings thus providing assurance or an indication of where improvements need to be made in this area of safe effective care and services.

SO WHAT?

The rotas were assessed against the standards for the period of April1st to September 30th 2023.
There were 5 occasions where the weekday session on NNU was not covered on either a Monday, Wednesday, or a Friday. The escalation for these gaps is that the Paediatrician on call (POW) will attend SCU. This did not result in any harm or adverse outcomes for the neonates.
All other shifts were covered either with planned rostering or, in cases of shortages, with locums or consultants acting down. This reduces the risk and impact on safety and the provision of effective care.
There is forward planning for known retirements and upcoming vacancies rates are proactively managed to ensure that gaps can be covered wherever possible.
All the consultant paediatricians have attended 8 hours of neonatal specific training and updates in the last year. The programme is being enhanced and recording of attendance is being monitored and recorded to ensure that maintenance of confidence and competence can be assured thus preventing safety issues and promoting effective care.

WHAT NEXT?

Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)

- Monthly monitoring and 6 monthly reports on staffing levels against BAPM requirements
- Embed the neonatal training programmes and ensure the recording process is robust and is able to be interrogated for compliance rates.

- Ensure that the recruitment and retention of staff is a key strategy for the service and the effect of vacancies minimised by forward planning.
- Short- and long-term shortages to be proactively managed using the escalation pathway.
- A review of the arrangements for NNU consultant cover on a daily basis will be undertaken to ensure that standards are consistent throughout the week and twice daily consultant ward rounds can be held.

Action Required

The Board is asked to receive the report as assurance of the medical staffing levels in the neonatal unit and services in the Trust.
The next formal staffing report will be completed in 6 months but any immediate concerns around patient safety or staff welfare will be escalated as and when required.

Previously considered by:	**Maternity Quality & Safety Group:** 16th October 2023 **Maternity & Neonatal Safety Champions:** 24th October 2023
Risk and assurance:	This report provides assurances that all tiers are covered to ensure that emergency help can be obtained when required.
Equality, Diversity and Inclusion:	This report meets standards for equality, diversity and inclusion – all staff are treated equally.
Sustainability:	The staffing levels need to be monitored monthly and any issues affecting staffing levels and patient safety are escalated as identified.
Legal and regulatory context	This report outlines the Trusts compliance with NHS Resolution Maternity Incentive Scheme.

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard? C Neonatal Medical Workforce	
1.	**Introduction**
1.1	In May 2023, Year 5 of the NHSR Maternity Incentive Scheme (MIS) was published with 10 safety actions that Trusts are required to comply with or make progress towards complying with, to improve and maintain safety in maternity and neonatal units. The guidance was republished with minor amendments to some requirements, but this safety action was unaffected. This report is part of the ongoing assurance of the Trust's compliance with Safety Action 4c. ***Can the Trust demonstrate an effective system of clinical workforce planning to the required standard for the Neonatal services?***
1.2	**Required Standards for Safety Action 4c** **c) Neonatal medical workforce** The neonatal unit meets the relevant British Association of Perinatal Medicine (BAPM) national standards of medical staffing. If the requirements have not been met in year 3 and or 4 or 5 of MIS, Trust Board should evidence progress against the action plan developed previously and include new relevant actions to address deficiencies. If the requirements had been met previously but are not met in year 5, Trust Board should develop an action plan in year 5 of MIS to address deficiencies. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).
1.3	**Minimum Evidence** The Trust is required to formally record in Trust Board minutes whether it meets the relevant BAPM recommendations of the neonatal medical workforce. If the requirements are not met, Trust Board should agree an action plan and evidence progress against any action plan developed previously to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN).

2.	Background
2.1	The staffing levels for the neonatal medical workforce were last formally reviewed and reported in a Board report for March to August 2022. In this previous report, it was assessed and concluded that the Trust met the standards expected during this period of time. This has been achieved by rota management, the use of locums and staff acting down when required to provide safe staffing levels. It is not always clear from the rotas when clinical activities or training has been restricted due to shortages. The intention had been to repeat the audit every 6 months, but this did not occur as there was reassurance that the standards were met, and the establishment had not been changed. At the time of submission of evidence for year 3 and year 4 of MIS, the standards were met, and no direct actions were required to address any shortfalls. This current report is prepared to provide ongoing reassurance that the medical staffing for the neonatal unit is maintained at safe levels consistently and actions taken to mitigate short and long-term staffing shortages. It also provides assurances against the minimum evidence requirements for Year 5 of MIS to meet the requirements for Year 5.
2.2	**Technical Guidance to support the staffing review:** *Do you meet the BAPM national standards of junior medical staffing depending on unit designation?* *If no, Trust Board should outline progress with the action plan developed in year 3 of MIS and submit this to the Neonatal ODN.* *There should also be an indication whether the standards not being met is due to insufficient funded posts or no trainee or/suitable applicant for the post (rota gap). There should also be a record of the rota tier affected by the gaps.* ***BAPM** "Optimal Arrangements for Neonatal Intensive Care Units in the UK. A BAPM Framework for Practice" 2021* *or* *"Optimal arrangements for Local Neonatal Units and Special Care Units in the UK including guidance on their staffing: A Framework for Practice" 2018* **Special Care Unit (SCU)** Tier 1 A resident tier 1 practitioner dedicated to the neonatal service in day-time hours on weekdays and a continuously immediately available resident tier 1 practitioner to the unit 24/7. This person could be shared with a co-located Paediatric Unit out of hours. Tier 2 A resident tier 2 to support the tier 1 in SCUs admitting babies requiring respiratory support or of very low admission weight <1.5kg. This Tier 2 would be expected to provide cover for co-located paediatric services but be immediately available to the neonatal unit. **Additional Guidance** In addition, BAPM (2018) indicates that the following standards apply: **3.2.3b Special Care Units** • In SCUs 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) BAPM released guidance in November 2022 outlining the service agreements for all levels of paediatric doctors. BAPM Service Quality Standards FINAL.pdf (amazonaws.com). In relation to Tier 3 (expert roles) the following standards are in place (indicative not exhaustive): • To carry out twice (or more frequent) daily neonatal ward rounds • To be accountable for overseeing patient care under their management. • To teach, train and support the Tier 2 and Tier 1 staff. • To undertake compassionate communication with families both antenatally and postnatally for cases of all levels of complexity.

	• To work within a team to provide leadership and oversee all management aspects of the neonatal department's functions. • To liaise with other consultants in other disciplines and other Trusts or Health Boards as required. • To maintain their own skills
2.3	**Reporting Period** A review has been undertaken for any 6-month period during the Maternity Incentive Scheme period – 30th May 2023 to 7th December 2023. Whilst this is a fixed period of time set by the MIS year 5 safety actions, it is expected that this process is an ongoing process of assessment and review each and every year. The Ockenden recommendations indicate that a 6 monthly reporting process is required to maintain standards and identify areas we need to escalate and manage.
2.4	**Rota Management** The Paediatric medical staff rotas are kept up to date by the Assistant Service Manager, the rota coordinator, and one of the personal assistants to the Consultant Paediatrician. The Consultant Paediatrician day-to-day rota is recorded on an Excel spreadsheet and includes detail on the consultant paediatrician's commitments for 4 key areas: • The Consultant paediatrician on call for the week (or day) (POW) • The Consultant paediatrician on call for the night • The Consultant paediatrician who is allocated/dedicated to NNU cover Monday, Wednesday and Friday mornings. The POW will cover NNU on the other days. • The Consultant allocated to Children's Assessment Unit (CAU) and the Emergency Department (ED) 9.00-13.00 and 13.00-17.00 Monday to Friday (except Public Holidays). There are 15 Consultants on the rota, and 6 of them are 'acute' consultants. The POW and acute team roster is available on allocate electronic system. All consultants leave (annual leave and study days) are recorded on allocate and are available electronically to the team on allocate me. All job plans (included non-acute activities like clinics, Admin, SPA) are recorded on allocate. There are 2 escalation policies currently – one for NNU linked to maternity and one for paediatric ward/ CAU linked to A&E. We plan to have a single escalation policy in the future for the 3 departments. It is the role of the Pow+/- clinical lead and service manager to take the decision to cancel clinics if needed depending on the escalation situation. An electronic health roster is used for the Tier 1 and Tier 2 paediatric staff. The roster gives details of the Tier 1 and Tier 2 doctors allocated to various aspects of the paediatric service. During the normal working day – Mondays to Fridays 9.00-17.00 – there is specific Tier 1 and Tier 2 cover to the Neonatal Unit, Maternity wards and attendance at births when required. From 17.00-21.00, overnight and weekends there is one Tier 1 and one Tier 2 doctor covering the paediatric services including the Paediatric ward, ED, neonatal unit, maternity wards and attendance at births. Some support for neonatal care is provided by Registered Nurses who have completed training to Advanced Paediatric Nurse Practitioner level (NB not neonatal nurse practitioner level). The nurse practitioners who cover neonatal care undertake the Neonatal Life Support (NLS) training locally and the 3 yearly external training/updates. They are included on the on-call rota as a tier 1. In addition, Physician Associates (PA's) are employed to assist the Tier 1 doctors. They are not on the on-call rota on their own but are rostered as supernumerary or as tier 1. The health roster gives details of the consultant paediatrician's leave – planned and unplanned, planned training days/courses and indicates if the consultant is covering the rota at Tier 1 and Tier 2 level. Some of this cover is planned as part of their role (the acute consultants for example) and some as part of escalation to cover staffing shortages. The electronic health roster gives the names of locums used across all grades. If the shift is not covered, this will be in red on the roster. Locum gaps are sent out by the rota coordinator for all tiers. In the situation when gaps are not covered, the acting down policy will be in place to ensure safe cover and another consultant will take over on-call duties.

	The 'acute' Consultants cover the work of the Tier 2 on a regular, planned basis. The experienced Specialist doctor (Staff, Associate Specialist and Speciality doctor - SAS) provides cover at consultant level but will also provide cover at Tier 2 when required. When the Consultant is covering the Tier 2 shifts either as step down or as part of the planned rota, another Consultant will be on call. The Consultant on call is on site from 5 pm till 9.30 pm and on call off site from 9.30 pm till 9.00 am for weekdays unless required for clinical reasons. Weekend consultant covers are split to ensure that the same consultant is not on call more than 24 hours at the time. At weekends and on public holidays, the consultant will be on site 9.00 am till 1.00 pm and 6 pm till 9.30 pm and on call off site between 1 pm and 6 pm and between 9.30 pm till 9.00 am unless required for clinical reasons. **Local Staffing and Rota Agreements** There is a local agreement that has been in place for a number of years that there is a consultant paediatrician dedicated to NNU Monday, Wednesday and Friday mornings in normal working weeks. On Tuesdays and Thursdays, the Consultant on call for the week (POW on rota) covers NNU and will have a discussion with the registrar on NNU mid-way through the day. They will attend NNU to review any new admissions or attend any emergency calls or requests for review from the NNU or Maternity staff. The CAU consultant will cover the ward and CAU if the POW is needed for NNU. All neonatal patients are discussed, and the management plan is reviewed and discussed 3 times a day during team handovers. In the light of updated 2022 guidance from BAPM, the arrangement for consultant NNU cover will be reviewed and discussed. **Consultant Training** All Consultant Paediatricians who provide neonatal care are required to have 8 hours specific neonatal training over each year. 2 hours per month is included in the Consultants job plan for these sessions. This will be provided in monthly teaching sessions with varied topics, and with external study days, training and self-directed education and training. Whilst Newborn Life Support (NLS) training – either as a participant or an instructor - is essential to the work of the paediatricians involved in neonatal care, it is expected that there will be a varied number of topics to ensure staff are updated in all aspects of neonatal practices, new equipment and updated guidance. To this end, there is a local agreement that only 1 hour of NLS instructor or training will be counted in the 8 hours and 1 hour of self-directed study so that there is a wide range of neonatal updates given. This agreement is only for the purposes of this 8-hour training requirement and the requirements for NLS training updates, training hours for instructors and other mandatory and emergency training is still required for compliance with the Core Competency Framework v 2 (2023).
3.	**Findings and analysis**
3.1	The rotas were assessed against the standards for the period of April1st to September 30th, 2023. There were 5 occasions where the weekday session on NNU was not covered on either a Monday, Wednesday or a Friday. The escalation for these gaps is that the Paediatrician on call will attend NNU. All other shifts were covered either with planned rostering or, in cases of shortages, with locums or acting down. There is a lead consultant for the neonatal service who is also the neonatal safety champion. There is a daily consultant ward round on NNU on the days when there is dedicated neonatal consultant allocated. At all other times, this will be carried out by the allocated registrar daily. There is forward planning for known retirements and upcoming vacancies rates are proactively managed to ensure that gaps can be covered wherever possible.
3.2	All the consultant paediatricians have attended 8 hours of neonatal specific training and updates in the last year. The programme is being enhanced and recording of attendance is being monitored and recorded to ensure that maintenance of confidence and competence can be assured thus preventing safety issues and promoting effective care.

3.3 The current vacancies are as follows:

	April-Sept 2023	Dec 2023 – Mar 2024
Cons	0.2 WTE	0.2 WTE
SPR	0.5 WTE	-
Jnr	0.4 WTE	-

These vacancies are covered by locums, prioritisation and rota management and if necessary, acting down.
Vacancies are monitored and the impact of vacancies is risk assessed to ensure that patient safety and staff wellbeing is preserved.

4. Next steps

4.1 The rotas are to be monitored on a monthly so that any issues can be identified at an early stage and escalated.

4.2 The consultant rota is to be transferred to the same electronic roster platform as the Tier 1 and Tier 2 doctors.

4.3 Training records are to be formalised and monitored to ensure that staff are meeting the requirements.

5. Conclusion

5.1 The NNU medical staffing meets the standards expected throughout the review period. Some of the shifts are covered by locums or by consultants acting down in order to provide safe and effective care.
The Consultant Paediatrician neonatal updates are embedded, and each consultant has met the standard of 8 hours per year.
Currently there is a specific consultant allocated to NNU 3 out of 5 weekdays and the other days, are covered by the consultant on call for the week who covers all areas of paediatric work. This means that there is not a dedicated consultant ward round twice daily on NNU.

6. Recommendations

- Monthly monitoring and 6 monthly reports on staffing levels against BAPM requirements
- Embed effective neonatal training programmes and ensure the recording process is robust and is able to demonstrate compliance rates.
- Ensure that the recruitment and retention of staff is a key strategy for the service and the effect of vacancies minimised by forward planning.
- Short- and long-term shortages to be proactively managed using the escalation plan.
- Consider what resources are required in order to introduce and embed daily consultant ward rounds on NNU and evidence Board handovers later in the day. Develop work plans and business case to identify the support required to achieve this.

Appendix 1 Summary of Compliance with Safety Action 4c

Standard	Target	Comments
The Trust is required to formally record in Trust Board minutes whether it meets the relevant BAPM recommendations of the neonatal medical workforce.	A review has been undertaken of any 6-month period between 30 May 2023 – 7 December 2023	Review completed; report to Board December 2023
If the requirements are not met, Trust Board should agree an action plan and evidence progress against any action plan developed previously to address deficiencies.	A review has been undertaken of any 6-month period between 30 May 2023 – 7 December 2023	Requirements met – see report
A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN).	A review has been undertaken of any 6-month period between 30 May 2023 – 7 December 2023	Report to be sent to ODN

Trust Board and Local Maternity and Neonatal System	
Report title:	Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard? **4a Obstetric**
Agenda item:	Maternity and Neonatal Services
Date of the meeting:	1st December 2023
Sponsor/executive lead:	Paul Molyneux, Trust Medical Director, Board level Safety Champion Sue Wilkinson, Chief Nurse
Report prepared by:	Beverley Gordon, Project Midwife Barkha Sinha, Clinical Lead, Obstetrics

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

WHAT?

In May 2023, Year 5 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, to improve and maintain safety in maternity and neonatal units. Some of the technical guidance was updated in July 2023 but this Safety Action remained unchanged.

This report is part of the ongoing assurance of the Trust's compliance with Safety Action 4A: **Can you demonstrate an effective system of clinical workforce planning to the required standard? Obstetric Workforce.**

The 4 elements of obstetric staffing that the Trust is monitoring for these safety standards are:

- Use of short-term locums
- Use of long-term locums
- Compensatory rest for Consultant Obstetricians
- The presence of Consultant Obstetricians at certain higher risk births or clinical scenarios.

SO WHAT?

The Trust has only used locums from the existing workforce to cover short-term shortages on the rota. Acting down has also been used when required.

The Royal College of Obstetricians and Gynaecologists (RCOG) checklist has been adapted for use when long-term locums are required.

The Division is committed to providing compensatory rest to Consultant Obstetricians after an on-call and it is only when there is urgent clinical work that this is not adhered to.

There continues to be a high standard of compliance with the Consultants attending specific clinical scenarios where there is a higher risk of complication or harm to the mother or baby.

WHAT NEXT?

- There should continue to be daily monitoring at the safety huddle to demonstrate that the Consultant Obstetricians are called and attend the clinical scenarios where there is increased risk of adverse outcomes or harm to mothers and babies.

- The multi-disciplinary team (MDT) to work together to ensure these standards are maintained and any deviations from safe standards should be reported and investigated using the incident reporting system. Learning and improvements from these incidents should be shared with the MDT.
- Board reports on attendance of the Consultant Obstetricians at certain clinical scenarios to continue every 6 months to ensure that these safety standards are maintained.

Action Required

The Trust Board is asked to receive this report as evidence of the Maternity Services commitment to safe obstetric staffing levels.
The next report will be prepared for April 2024.

Previously Considered by:	Maternity Quality & Safety Group: 20/11/23 Maternity & Neonatal Safety Champions: 28/11/23
Risk and assurance:	This report provides assurance of safe obstetric staffing levels and compliance with the Safety Action for the Maternity Incentive Scheme Year 5 (2023).
Equality, Diversity and Inclusion:	This report demonstrates that all staff are treated equally when it comes to staffing standards and expectations and that this allows all women and babies to be treated when required.
Sustainability:	There is a need for there to be continued support and oversight from the Board to maintain these standards and commitment from the Division to prioritise safe staffing levels.
Legal and regulatory context	This report is provided as support for the Trust to submit evidence against the required standards for the Maternity Incentive Scheme Year 5 safety requirements.

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

1.	**Introduction**
1.1	In May 2023, Year 5 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, to improve and maintain safety in maternity and neonatal units. Some of the technical guidance was updated in July 2023 but this Safety Action remained unchanged. This report is part of the ongoing assurance of the Trust's compliance with Safety Action 4A: **Can you demonstrate an effective system of clinical workforce planning to the required standard? Obstetric Workforce**
2.	**Background**
2.1	**Required Standards** **a) Obstetric medical workforce** 1) NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas: a. Currently work in their unit on the tier 2 or 3 rota or b. Have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP) or c. Hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums. 2) Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings. rcog-guidance-on-the-engagement-of-long-termlocums-in-mate.pdf

	3) Trusts/organisations should implement RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day. Services should provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings. rcog-guidance-on-compensatory-rest.pdf 4. Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations 27 listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/ when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance. Trusts' positions with the requirement should be shared with the Trust Board, the Board-level safety champions as well as LMNS.
2.2	**Minimum Evidence** 1) Trusts/organisations should audit their compliance via Medical Human Resources and if there are occasions where these standards have not been met, report to Trust Board Trust Board level safety champions and LMNS meetings that they have put in place processes and actions to address any deviation. Compliance is demonstrated by completion of the audit and action plan to address any lapses. Information on the certificate of eligibility (CEL) for short term locums is available here: www.rcog.org.uk/cel This page contains all the information about the CEL including a link to the guidance document: Guidance on the engagement of short-term locums in maternity care (rcog.org.uk) A publicly available list of those doctors who hold a certificate of eligibility of available at https://cel.rcog.org.uk 2) Trusts/organisations should use the monitoring/effectiveness tool contained within the guidance (p8) to audit their compliance and have a plan to address any shortfalls in compliance. Their action plan to address any shortfalls should be signed off by the Trust Board, Trust Board level safety champions and LMNS. 3) Trusts/organisations should provide evidence of standard operating procedures and their implementation to assure Boards that consultants/senior SAS doctors working as non-resident on-call out of hours are not undertaking clinical duties following busy night on-calls disrupting sleep, without adequate rest. This is to ensure patient safety as fatigue and tiredness following a busy night on-call can affect performance and decision-making. Evidence of compliance could also be demonstrated by obtaining feedback from consultants and SAS doctors about their ability to take appropriate compensatory rest in such situations. NB. All 3 of the documents referenced are all hosted on the RCOG Safe Staffing Hub Safe staffing | RCOG.
2.3	1. After February 2023 – Audit of 6 months activity 2. After February 2023 – Audit of 6 months activity 3. 30 May 2023 - 7 December 2023 4. 30 May 2023 - 7 December 2023
2.4	
3.	**Findings**
3.1	**Short-term Locums** Audit of 6 months activity from March – August 2023: 7 doctors who are currently working in the Trust, have undertaken locum shifts thus complying with the requirements for safe staffing. No external short-term locums or RCOG certificated locums have been used.
3.2	**Long-term Locums** One long-term locum employed from July – RCOG checklist adapted and completed.
3.3	**Compensatory Rest**

	The SOP for Roles and Responsibilities of the Obstetric Consultant on call has been updated with information on how all the aspects of safe staffing are to be met. A survey of the obstetric consultants demonstrated that out of the seven staff members who responded, only one said that due to clinical need they were unable to take compensatory rest the following day, but they accepted this as essential.
3.4	**Consultant Attendance** Results of the audit of attendance of the consultant obstetrician for specific scenarios demonstrate that this has been maintained at a high level with the only two exceptions being major obstetric haemorrhages which were brought under control very quickly by the attending senior team. This will continue to be monitored at the safety huddles each day and incident reporting will be used to identify situations where this does not occur, the reasons why it occurred and the outcome from this. Six monthly reports to conclude findings will continue as business as usual.
4.	**Next steps**
4.1	This report should be used to confirm compliance with the required safe staffing levels for obstetric staffing.
4.2	Staffing levels and escalation as outlined in Trust policies and guidance, to continue to be monitored and escalated if safe standards are not met.
5.	**Conclusion**
5.1	The Obstetric staffing policies and procedures are consistent with the standards expected and outlined in the RCOG policy documents.
5.2	The Obstetric staff are committed to providing high quality, safe care to the women and babies who are within the care of the Trust, and this is demonstrated in the results of audits and monitoring processes.
6.	**Recommendations**
	• There should continue to be daily monitoring at the safety huddle to demonstrate that the Consultant Obstetricians are called and attend the clinical scenarios where there is increased risk of adverse outcomes or harm to mothers and babies. • The multi-disciplinary team (MDT) to work together to ensure these standards are maintained and any deviations from safe standards should be reported and investigated using the incident reporting system. Learning and improvements from these incidents should be shared with the MDT. • Board reports on attendance of the Consultant Obstetricians at certain clinical scenarios to continue every 6 months to ensure that these safety standards are maintained. If there is non-compliance, these situations will be reviewed and learning shared if required.

Appendix 1 Summary of Compliance against CNST standards

Standard	Target	Comments
1) NHS Trusts/organisations should ensure that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas	1. After February 2023 – Audit of 6 months activity	Audit of 6 months activity from March – August 2023. 7 doctors who are currently working in the Trust, have undertaken locum shifts. No external short-term locums or RCOG certificated locums used.
2)Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance, or an action plan to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings. rcog-guidance-on-the-engagement-of-long-termlocums-in-mate.pdf	2. After February 2023 – Audit of 6 months activity	One long-term locum employed from July – checklist adapted and completed.  Long term locums.docx
3)Trusts/organisations should implement RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day.	3. 30 May 2023 - 7 December 2023	SOP updated with information on how all of the aspects of safe staffing is met. Survey of consultants demonstrates that 7 staff members were asked and only one said that due to clinical need they were unable to take compensatory rest the following day.
4. Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations 27 listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/ when a consultant is required to attend in person	4. 30 May 2023 - 7 December 2023	Audit results of attendance of the consultant demonstrate that there is still high compliance with this. The two exceptions in the period of audit were for major obstetric haemorrhage where the bleeding was brought under control quickly by the senior team present at the time before the consultant attended and further interventions were not required.

Trust Board	
Report title:	**Quarterly Progress Report of the ATAIN Programme and an Audit of the Operational Pathway of Care into the ATAIN Neonatal Transitional Care**
Agenda item:	**Quarter 2 Report- 1st July to 30th September 2023**
Date of the meeting:	1st December 2023
Sponsor/executive lead:	Sue Wilkinson, Chief Nurse Paul Molyneux, Medical Director & Maternity and Neonatal Safety Champion
Report prepared by:	Abigail Marquette- Quality, Assurance and Governance Lead for Neonatal Services

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

WHAT?

This report will be looking at the babies that required additional monitoring and observation, which includes term babies that required an admission to the Neonatal Unit (NNU) and the late preterm (34^{+6}-36^{+6}) and term babies that were admitted to the Neonatal Transitional Care (NTC).

ATAIN ('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 reasons 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.

Twenty-one term babies (4% of the babies born) were admitted to the neonatal unit in this reporting period of the 529 babies born. This is in line with last reporting period when 3.4% (18) term babies. Therefore for 2 consecutive quarters we have been well below the national target of 6%. Ten babies were excluded due to not meeting the criteria of the ATAIN programme.

Respiratory distress remained the predominant reason for admission, accounting for 20 term admissions (95.2%). All required oxygen and the majority received this through non- invasive techniques including Vapotherm (75%), four babies via nasal cannula (4 babies- 20%). One baby was intubated and ventilated due to the need for cooling (therapeutic hypothermia) and a transfer to a tertiary unit for escalation of care.

The remaining baby was reviewed following a dusky episode while being skin- to – skin with the mother. The cause of this was not found and there was no sepsis identified. It has been recognised in a HSIB national report as a risk during poor positioning during skin to skin. Parent information posters regarding safe positioning are displayed in all birthing rooms.

All babies in this reporting period were screened for sepsis and this was confirmed in 4 (19%) babies. There is a low threshold for the screening of sepsis in the neonate when considering both maternal and neonatal risk factors. Kaiser is an ongoing quality improvement project to reduce the number of babies receiving antibiotics, unfortunately not all term admissions meet the projects criteria.

This reviewing group is a multi-disciplinary team who evaluate the cases at a monthly held meeting, in line with best practice. The reviewing group concluded that all admissions to the Neonatal Unit were unavoidable.

All admissions to the neonatal unit were stepped down to transitional care at the earliest opportunity, transitional care facilitates mothers and their babies to remain together and minimises separation.

Due to the robustness of the review process, there are however learning points identified, and while not changing the outcome they offer valuable opportunities to improve the quality of care for the wider population.

The reviewing group found awareness needed to be raised amongst staff about the importance of educating the women receiving specific hypertensive medications (beta blockers) regarding the risk of hypoglycaemic episodes in their neonate and how this can be helped with the administration of colostrum obtained during the pregnancy.

There were positive findings in regard to babies having timely observations. One case swiftly identified a deteriorating neonate and appropriate escalation was followed, demonstrating the crucial role routine observations play in safeguarding the wellbeing of the neonate.

There continues to be incidences where discrepancies are identified between the estimated birth centile on ultrasound scan and the actual birth centile. The importance of this lies within the increase in intervention related to anticipated birth centiles (either very small or very large babies), putting the neonate at a higher risk of needing additional support on the Neonatal Unit.

It was identified that there had been a lack of documented discussions regarding the administration of a corticosteroid course. At the review meeting, it was confirmed that a discussion did take place. Documentation was identified as an area that requires improvement.

Neonatal Transitional Care (NTC)
Neonatal Transitional Care (NTC) is not a place but a service and can be delivered either in a separate Neonatal Transitional Care area, or within the Neonatal Unit and /or in the postnatal ward setting. The West Suffolk NHS Foundation Trust (WSFT) maternity unit has an allocated 5-bedded bay on the postnatal ward (F11) and also NTC cots in side rooms on the Neonatal Unit.

The principals of NTC include the need for a multidisciplinary approach between maternity and neonatal teams, an appropriately skilled and trained workforce, robust systems 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. NTC supports resident mothers to be the primary care providers for their babies when they have care requirements more than normal well newborn care, but do not need continuous monitoring in a special care setting.

In this reporting period, sixty five (65) babies out of the total number of 529 babies born (12.3%) were cared for under the Neonatal Transitional Care pathway. That was a slight drop from 76 (14.2%) in the previous quarter. One case was identified where a baby was admitted whilst not meeting the criteria due to the gestation being one day less than the criteria.

Reassuringly we have seen a reduction in the numbers of unwell babies requiring additional care on the Neonatal Unit or NTC in this reported time frame.

SO WHAT?

This report gives evidence that the ATAIN programme is embedded with monthly MDT meetings taking place where cases of term babies admitted to NNU are reviewed. The reviewing group is made up of an

obstetric consultant, a paediatric senior registrar or consultant, senior midwifery and neonatal matrons, ward managers and risk midwives. All attendees are committed to regularly attending the reviews. The learning from these meetings is shared with maternity and neonatal staff and actions are taken to avoid or reduce future admissions if possible. The culture of avoiding term admissions to the NNU is ingrained within the maternity and the neonatal staff and in the last 2 quarters, there has not been an admission that was reviewed and deemed to be avoidable.

Communication with the Superintendent sonographer is an important factor in escalating concerns identified when reviewing cases. A formalised pathway has been put in place where reviews have been requested and learning can be fed back to the reviewing group.

Gestation is an important factor in assessing the eligibility of the criteria for NTC to ensure safe and appropriate care is provided to the neonate. While the one case that was outside the criteria was within one day of meeting the criteria, it was important to identify this so criterion does not become blurred. A recent update of the NTC guidance, ratified in October 2023 reflects the British Association of Perinatal Medicine (BAPM) guidelines. This expanded the criteria to earlier gestation babies, a lower birthweight and those requiring nasogastric tube feeding.

All staff are aware of the importance of the initial observations on the neonate through the newborn Risk Pathway using the RAPP tool. This risk assessment tool observes **R**espirations and work of breathing; **A**ctivity; **P**erfusion/temperature; **P**osition/tone. The effective use of this is evidenced through the number of babies having this carried out. Monthly audits demonstrate that a 100% of all babies have this tool completed and appropriate escalation was evident. It was however noted that the position of the baby is not a mandatory field on the RAPP tool. A key factor when trying to identify a cause of the deterioration in the colour of a baby.

Local guidance suggests that women undergoing an elective Caesarean Section prior to 39 weeks' gestation need to be counselled regarding corticosteroid administration. This would need to be reflected in documentation of the discussion.

Neonatal Transitional Care provision is not consistent across the country, or region. Neighbouring Trusts are still awaiting the introduction of such service; therefore, we are pleased that this is available to families choosing to birth here. The provision of NTC demonstrates a service that spans both neonates and maternity services (NTC located on the maternity postnatal ward), it requires collaborative working and a full understanding of differing perspectives.

WHAT NEXT?

The monthly ATAIN meetings will continue to be held with the multidisciplinary team. Wider attendance will be encouraged from staff across the department including infant feeding team and the fetal monitoring lead. This will further enhance the review process and add additional scrutiny.

Work will continue in fostering good relationship with the sonography department. A formalised pathway is in place and collaborative working through a quarterly feedback meeting will continue to improve communication and coordinate improvements.

All babies admitted to NTC are audited for the purpose of this report to ensure that criteria for admission are adhered to and the care given appropriate. Moving forward the service will be evaluated against the updated guideline.

Regular weekly auditing of the completion of the RAPP tool is in place for the ward manager to use. This will continue to make up part of the ATAIN review when evaluating care for all babies.

High quality documentation serves to ensure care plans and discussions are available for the wider team to review. The importance of the documentation of the corticosteroid administration has been communicated with the obstetric team and will continue to be audited during the monthly meetings.

Actions Required

- Ongoing communication with the Superintendent Sonographer to report cases where a discrepancy of 10- 15% between the centiles reported from the USS and the actual birthweight, get feedback and action taken through potential planned teaching.
- Communicate with staff regarding the importance of completing RAPP using patient story to support continued good practice.
- Awareness amongst NTC and NNU staff of the changes in the guideline and the subsequent changes required in practice.
- Sharing of the findings of the ATAIN outcomes with staff groups

Risk and assurance:	There are patient safety risks associated with non- compliance with Avoiding Term Admissions into Neonatal Unit (ATAIN) and the insufficient use of Neonatal Transitional Care (NTC) financial risks associated with non-compliance with the Maternity Incentive Scheme Year 5 requirements.
Equality, Diversity and Inclusion:	All cases are reviewed through an equality, diversity and inclusion lens, to identify any themes and learning, which will be captured in the report
Sustainability:	This report is sustainable through regular monitoring and reviewing of the cases of term babies admitted to NNU and the monitoring of the use of NTC.
Legal and regulatory context	The information contained within this report has been obtained through due diligence and auditing clinical care and outcomes.

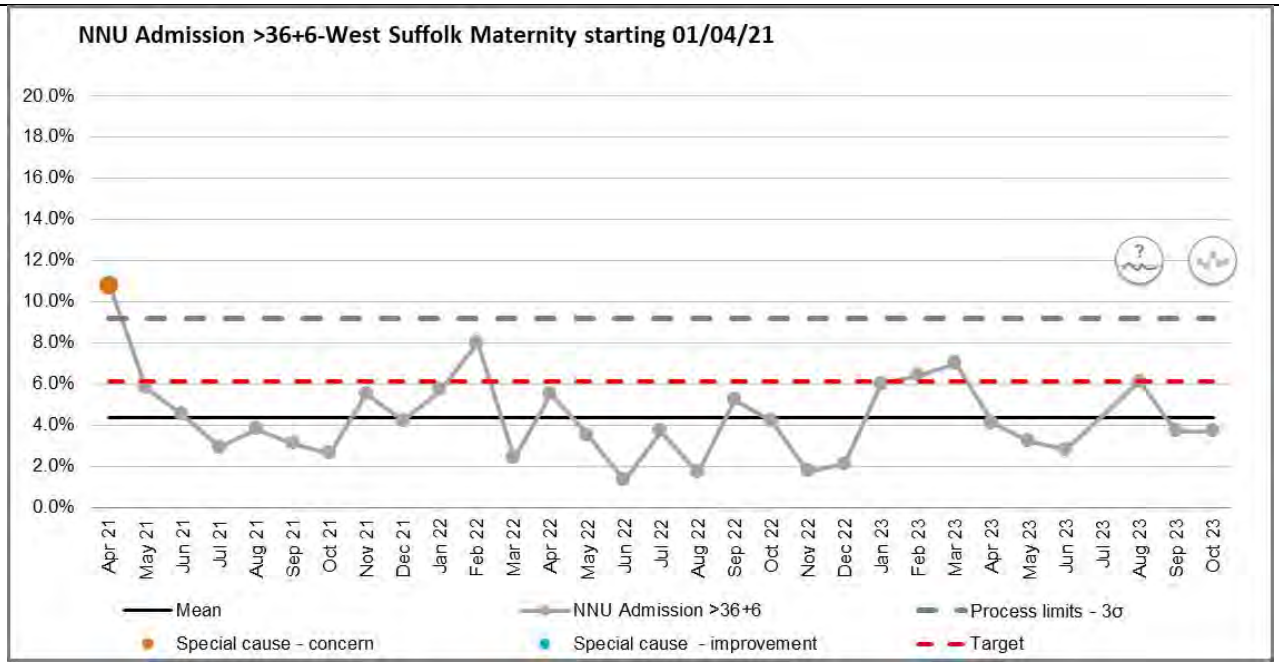
A Progress Report of the ATAIN Programme and an Audit of the Operational Pathway of Care into the Neonatal Transitional Care
(Quarter 2 Report- 1st July to 30th September 2023)

1.	Introduction
1.1	**Principles of ATAIN** This is a programme of work to reduce harm leading to avoidable admission to a Neonatal Unit (NNU) for infants born at term (over 37 weeks gestation). A central aim of the work is to prevent harm leading to the separation of mother and baby. Some term admissions are necessary even if all the appropriate care has been given. Some babies will require antibiotic treatment or treatment for their jaundice. The latter groups of babies if remain well can be cared for on the Neonatal Transitional Care (NTC) alongside their mothers. The impact of the mother and baby separation has been studied and it shows that the lack of skin- to-skin and early separation may disturb the maternal- infant bonding, reduce the mother's affective response to her baby, and have a negative effect on maternal behaviour (Bystrove et al 2009). It increases the risk of failure to establish and continue breastfeeding. **Principles of NTC** Neonatal Transitional Care (NTC) is not a place but a service and can be delivered either in a separate Neonatal Transitional Care area, or within the Neonatal Unit and /or in the postnatal ward setting. The West Suffolk Hospital NHS Foundation Trust (WSH) maternity unit has an allocated bay on the postnatal ward (F11) and also NTC cots on the Neonatal Unit. The principles of NTC include the need for a multidisciplinary approach between maternity and neonatal teams, an appropriately skilled and trained workforce, robust systems 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 neonatal care. NTC supports resident mothers to be the primary care providers for their babies when they have care requirements more than normal well newborn care, but do not need continuous monitoring in a special care setting. NTC avoids separation of the mother and baby and facilitates the establishment of breast feeding whilst enabling safe and effective management of a baby with additional care needs. NTC also has the potential to prevent admission to the neonatal unit and to provide additional support for small and/or late preterm babies and their families.

	NTC helps in the smooth transition to discharge home from the neonatal unit for recovering sick or preterm babies whilst providing specialised support away from the more intensive clinical setting. The babies admitted to NTC are cared for by midwifery and neonatal teams. Babies admitted from home requiring NTC are admitted to a side room on the Neonatal Unit. This report is represented in new format for this quarter. It is an amalgamation of two reports previously presented separately. It was felt that having the report of the progress of the ATAIN programme and the report of the Neonatal Transitional Care pathway gives more insight of the service provision and the movement of the babies that were well enough from the intensive aspect of neonatal care to transitional care next to the mother's bedside. This connection is also recognised in the CNST Maternity Incentive Scheme as highlighted in the next section. **CNST Maternity Incentive Scheme** In May 2023, NHS Resolution has published the Maternity Incentive Scheme year five and 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.*** NHS Resolution is operating year five of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to continue to support the delivery of safer maternity care. **Safety action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?** **Required standard** A. Pathways of care into transitional care (TC) have been jointly approved by maternity and neonatal teams with a 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. A robust process is in place which demonstrates a joint maternity and neonatal approach to auditing all admissions to the NNU of babies equal to or greater than 37 weeks. The focus of the review is to identify whether separation could have been avoided. An action plan to address findings is shared with the quadrumvirate (clinical directors for neonatology and obstetrics, Director or Head of Midwifery (DoM/HoM) and operational lead) as well as the Trust Board, LMNS and ICB. C. Drawing on the insights from the data recording undertaken in the Year 4 scheme, which included babies between 34+0 and 36+6, Trusts should have or be working towards implementing a transitional care pathway in alignment with the BAPM Transitional Care Framework for Practice for both late preterm and term babies. There should be a clear, agreed timescale for implementing this pathway.
2.	**Background**
2.1-	**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 • Quality and safety manager / Quality, assurance and governance lead for neonatal services • 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 who attends NNU briefly prior to transfer to transitional care (TC) has also been recorded. From July 2022 these babies, and any baby that attends NNU for care while an inpatient on the maternity unit, will be recorded. Initially these attendances were reported to the East of England Neonatal operational delivery network (ODN) along with information on reason for attendance, parental accompaniment and any emerging themes, however, this reviw is no longer required as of March 2023.
2.2-	**The Operational Pathway of Care into NTC,** a data recording process, captures transitional care activity each month by the Neonatal unit and the Maternity Quality and Safety team. This is a manual process utilising the Neonatal Unit's admission book alongside the electronic neonatal information system Badgernet® and the patient information system E-Care®. Information from the reviews and learning are shared with the Local Maternity and Neonatal System (LMNS) and Integrated Care Board (ICB) as required. Data is submitted to the Operational Delivery Network (ODN) on request or as part of data capture from Badgernet®. Quarterly audits and analysis reports are completed to identify whether the agreed standards have been met and therefore embedded. The reports are shared with the Maternity and Neonatal Safety Champions at Divisional and Board level, Local Maternity and Neonatal System (LMNS), and the Integrated Care System (ICS) quality surveillance meeting each quarter. Part of the review of term admissions to the neonatal unit includes ascertaining if a baby could have been admitted or transferred to NTC during their care pathway.
2.3- CNST	In May 2023, NHS Resolution has published the Maternity Incentive Scheme year five and 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.** NHS Resolution is operating year five of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to continue to support the delivery of safer maternity care. Minimum evidential requirement for Trust Board includes the following: **Evidence for standard A.** *Pathways of care into transitional care (TC) have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies.*

	Neonatal teams are involved in decision making and planning care for all babies in transitional care. to include: Local policy/pathway available which is based on principles of British Association of Perinatal Medicine (BAPM) transitional care where: • There is evidence of neonatal involvement in care planning. • Admission criteria meets a minimum of at least one element of HRG XA04 • There is an explicit staffing model. • The policy is signed by maternity/neonatal clinical leads and should have auditable standards. • The policy has been fully implemented and quarterly audits of compliance with the policy are conducted. **Evidence for standard B.** *A robust process is in place which demonstrates a joint maternity and neonatal approach to auditing all admissions to the NNU of babies equal to or greater than 37 weeks. The focus of the review is to identify whether separation could have been avoided. An action plan to address findings is shared with the quadrumvirate (clinical directors for neonatology and obstetrics, Director or Head of Midwifery (DoM/HoM) and operational lead) as well as the Trust Board, LMNS and ICB,* ***to*** include: • Evidence of joint maternity and neonatal reviews of all admissions to the NNU of babies equal to or greater than 37 weeks. • Evidence of an action plan agreed by both maternity and neonatal leads which addresses the findings of the reviews to minimise separation of mothers and babies born equal to or greater than 37 weeks. • Evidence that the action plan has been signed off by the DoM/HoM, Clinical Directors for both obstetrics and neonatology and the operational lead and involving oversight of progress with the action plan. • Evidence that the action plan has been signed off by the Trust Board, LMNS and ICB with oversight of progress with the plan. **Evidence for standard C.** *Drawing on the insights from the data recording undertaken in the Year 4 scheme, which included babies between 34+0 and 36+6, Trusts should have or be working towards implementing a transitional care pathway in alignment with the BAPM Transitional Care Framework for Practice for both late preterm and term babies. There should be a clear, agreed timescale for implementing this pathway,* to include: • Guideline for admission to TC to include babies 34+0 and above and data to evidence this is occurring. OR • An action plan signed off by the Trust Board for a move towards a transitional care pathway for babies from 34+0 with clear time scales for full implementation. This safety action is based on the British Association for Perinatal Medicine (BAPM) Framework for Neonatal Transitional Care (2017) and the Avoiding Term Admissions into Neonatal Units (ATAIN) programme of health improvement from the NHS.
3.	**Findings**
3.1-ATAIN	During the past quarter, Term admissions varied from one month to another. July's rate was low with 2.2% (4 babies out of 184) of all babies born at the WSH being admitted to the Neonatal Unit. However, a rise was seen in August (6.07%- 11 babies out of 181 babies born) which could not be explained because the number of births in August was lower than that in July. The rates in September have positively plummeted to 3.7% (6 babies out of 164 born).



There was a total of 21 term admissions in this quarter, with an additional 10 term babies that did not meet the criteria for review under ATAIN. The excluded babies included 4 social admissions, 2 repatriations, 2 babies admitted from home and 1 born in a different hospital and transferred to WSH for escalated care. The 2 babies born at home were reviewed during the meeting but removed from the statistics as they would be seen in a paediatric setting in other Trusts. These excluded babies are not included in the overall admission numbers but are referenced for transparency.

Cases were reviewed to identify any areas for learning and improvement in a joint monthly multidisciplinary meeting. The review proforma is populated in advance for each case to facilitate MDT review. Each case was discussed in detail at the ATAIN group meeting, and any learning points identified. Where appropriate, actions that are agreed are recorded on the ATAIN rolling action plan.

Respiratory distress remained the most common reason for admission accounting for 95.2% of admissions (20 babies). All babies admitted for respiratory support also underwent a septic screen.

The most prevalent maternal risk factor for babies admitted to the Neonatal Unit remains the prolonged time from rupture of membranes to time of birth (3 babies out of 21). Other risk factors present in this quarter included maternal Group B streptococcus (2 cases out of 21) and maternal sepsis.

There were no discrepancies in the estimated fetal weight and the actual birthweight in any of the cases reviewed in July and August, however one case was identified in September. A meeting was held with the Superintendent Sonographer and more discussions are planned to rectify a potentially identified issue (1 case).

The number of babies with a suboptimal temperature in this quarter was 4. One baby was hypothermic with a temperature of 36.1 degrees which could have been attributed to resuscitation after delivery and possibly being exposed to cold air, and maternal Gestational Diabetes, although the blood sugar remained within normal limits. A drop in blood sugar might have been prevented with a prompt action to warm the baby again. The other 3 babies had a temperature of 36.5 degrees, which remains controversial as local guidance classifies a temperature of below 36.6 degrees as low whereas BAPM guidelines consider this as the lowest limit of normal.

All infants were stepped down to transitional care in a timely manner, as soon as deemed stable enough. It was agreed that all admissions were unavoidable.

Monthly Summaries

July 2023

In July there were 4 babies that were admitted to the Neonatal Unit at term. They all required oxygen. One baby was admitted with a low blood sugar needing monitoring but did eventually need respiratory support in the form of Vapotherm due to desaturations. The remaining 3 babies were admitted from the place of birth with an oxygen requirement and were placed on respiratory support on admission.

All babies admitted had a partial septic screen carried out and received intravenous antibiotics. None of the babies required extensive periods of antibiotics as no sepsis was identified through the C-reactive protein (CRP) and the blood culture results. They all had the routine course of antibiotics.

It was noted that the baby who was admitted with low blood sugars was a baby of a mother that had Labetalol throughout the pregnancy. A question was raised during the MDT meeting regarding the information given to women with hypertension about expressing breast milk. It was suggested that a change in the question on e-care would support in prompting the discussion. This issue was discussed previously, and patient information leaflets and an expressing pack started to be handed out which will be followed up by a tabletop audit in 2-3 months after the commencing of this.

All babies admitted during this month had an unavoidable admission and no actions or inaction during the pregnancy, labour or immediate postpartum periods would have changed the outcome. All babies were also transferred to Transitional Care at the earliest opportunity which in most cases was12 hours after stopping respiratory support. There is evidence this is an embedded practice within the Neonatal Unit. This extends across disciplines with plans of care during the doctors' ward round observing the recommendations of the ATAIN and TC improvement projects.

There was a suggestion made regarding monitoring the blood sugars for large for dates babies in the absence of maternal diabetes. This would need further looking into and examination of the evidence.

August 2023

All the eleven (11) cases looked at in the ATAIN meeting were classed as unavoidable and no actions during the pregnancy, labour or immediate postpartum periods would have changed the outcome. The babies that were able to be stepped down to Transitional Care, were taken over at the earliest opportunity which is in most cases 12 hours after stopping respiratory support. It was noted that not all the babies needing a septic screen and antibiotics had risk factors for sepsis.

Ten (10) babies were admitted for respiratory support. For three (3) babies, low saturations were picked on the Newborn Risk Pathway - RAPP tool which shows the importance of this tool. A discussion was held about completion of the RAPP tool and a reminder was sent out to all midwives about the importance of discussing the position of the baby during skin- to – skin with the parents and the documentation of this.

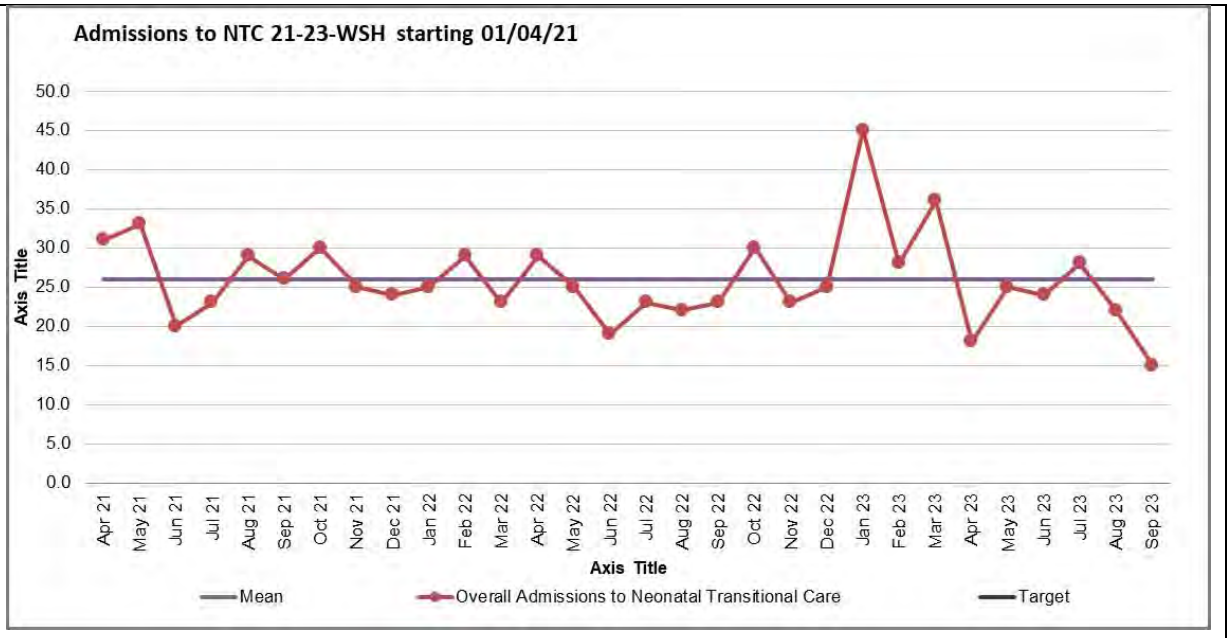
It was also added that it is important to act upon any abnormal findings from the RAPP tool while waiting for the paediatric review. A case that was reviewed this month had low saturations identified on the RAPP tool and oxygen was given as requested by the paediatric team until they arrived for the review.

Eight (8) out the ten babies requiring respiratory support received this via Vapotherm which is the method most used for non- invasive ventilation for neonates at the West Suffolk Hospital. The other baby required intubation and ventilation due to the need for cooling and consequent transferring out. The remaining baby had low flow oxygen via a nasal cannula.

One of the babies that required respiratory support was discussed in more detail with the obstetrician after the meeting. The timing of the Elective Caesarean Section was questioned during the meeting because this occurred at 37+3 weeks' gestation. The obstetrician highlighted that this was a planned admission to the Neonatal Unit due to presence of cell free DNA in the fetus that increased risk of being large for gestational age and neonatal hypoglycaemia.

	The last baby that needed admitting to the Neonatal Unit was for monitoring and observations after having had a dusky episode at 2 hours of age while in skin-to- skin with mum. This baby had PEEP and oxygen in the delivery room that was gradually weaned down and did not need any further respiratory support. A partial septic screen was carried out and IV antibiotics given. Sepsis was not confirmed, and no further dusky episodes were seen. ***September 2023*** All the babies (6) admitted to the Neonatal Unit had respiratory problems and needed oxygen. There was one (1) other baby that was excluded for not meeting the criteria for ATAIN due to having been born in a different hospital. There was one case where a discrepancy in the estimated fetal weight on ultrasound scan and the birthweight was noted. All the cases looked at in the ATAIN meeting were classed to be unavoidable and no actions during the pregnancy, labour or immediate postpartum periods would have changed the outcome. The babies that were able to be stepped down to Transitional Care, were taken over at the earliest opportunity which is in most cases 12 hours post stopping respiratory support. All babies admitted were screened for sepsis. Five (5) of the babies had oxygen via Vapotherm and one had it via nasal cannula. Only one baby was not transferred to Transitional Care due to the need for escalation of care for a surgical review in a tertiary unit this was deemed as appropriate by the reviewing group. Four (4) women were counselled for corticosteroid administration. One had a full course of steroids due to presenting with an eclamptic fit early on in the pregnancy and stratified as high risk for preterm labour. Three (3) women were counselled prior to their Elective Caesarean Section due to the timing of this being appropriately before 39 weeks. This is in line with the RCOG guidelines (2022). It was noted that one woman did not have any documentation of this, but the obstetric consultant present for the meeting had followed up this lady during the pregnancy and confirmed she had counselled her regarding the need for steroids. A reminder is to be sent out about documentation of discussions held with women. Steroid administration with diabetic women was discussed due to the risk and benefits imbalance.
3.2- NTC	In this quarter, sixty five (65) babies out of the total number of 529 babies born (12.3%) were cared for under the Neonatal Transitional Care pathway. That was a slight drop from 76 (14.2%) in the previous quarter. A downward trend can be seen throughout this quarter (refer to SPC chart below). In the absence of a rise in neonatal term admissions (requiring mother and baby separation) we deem this to be a positive result.

Timing of Admission to NTC	Number
From Birth	17
From Postnatal Ward/area	8
From Community/Home	22
Step down from Neonatal Unit	18
Total	**65**



The majority of admissions, in this quarter, were admitted to NTC from home (22 out of 65 i.e., 33.8%). This is a change from the last quarter where most admissions occurred from the place of delivery.

The provision for babies to be readmitted with their mothers to a transitional care ward within the maternity setting is a beneficial opportunity for WSFT's service users, due to the more holistic approach for both mum and baby. Most of these babies were admitted for treatment of jaundice, feeding support and weight loss. There were two (2) atypical cases, one who was admitted for grunting noises of respirations at home and the other one as a stepdown from another hospital after being transferred out for escalation of care at birth.

The next common reason for admission to NTC was babies that are stepped down from NNU to NTC next to the mother's bedside. From the ATAIN monthly meetings, it is noted that this practice is embedded, and babies are transferred in a timely manner, which is often 12 hours after stopping respiratory support or coming off continuous monitoring, to the mother's bedside. This demonstrates that the whole system is working towards the joint vision of minimising mothers and babies being separated whilst caring for babies in the most clinically appropriate setting.

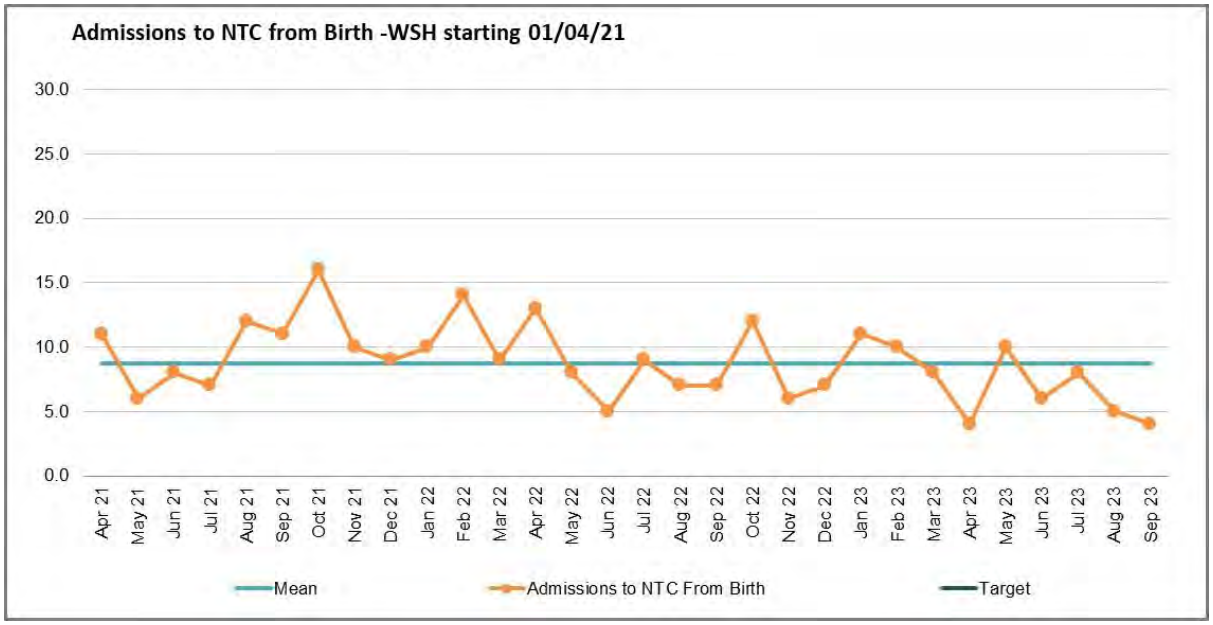
The babies who were admitted through the Kaiser calculation for observations have been included with the babies admitted from the delivery setting. Having this group of babies separately was not producing any fruitful data and this calculation has to be carried out within an hour of birth therefore it would always occur at the delivery setting.

Summary of details of babies admitted to transitional care from birth (17 babies)

Clinical Standards		Criteria met
Criteria for immediate admission		
Gestational age >34+6 weeks	16 out of 17 (94%) of the babies were above this gestational age. Only one baby did not meet this criterion because they were 34+6 exactly	No
Not requiring intensive or high dependency care	Babies did not require intensive care	Yes
Birthweight >1600g	17/17 (100%) babies had birthweights above 1600g	Yes
Maternal suspected /confirmed sepsis in labour	3 mothers had pyrexia	Yes
Maternal and Fetal symptoms of suspected sepsis.	2 babies had a combined risk of maternal and neonatal sepsis	Yes

Neonatal risks of Sepsis	1 baby had suspected sepsis	Yes
Preterm within the cohort (less than 37 weeks	5 babies were preterm	Yes
Other reasons	Babies were admitted for feeding support notably with twin babies and low birthweight	Yes

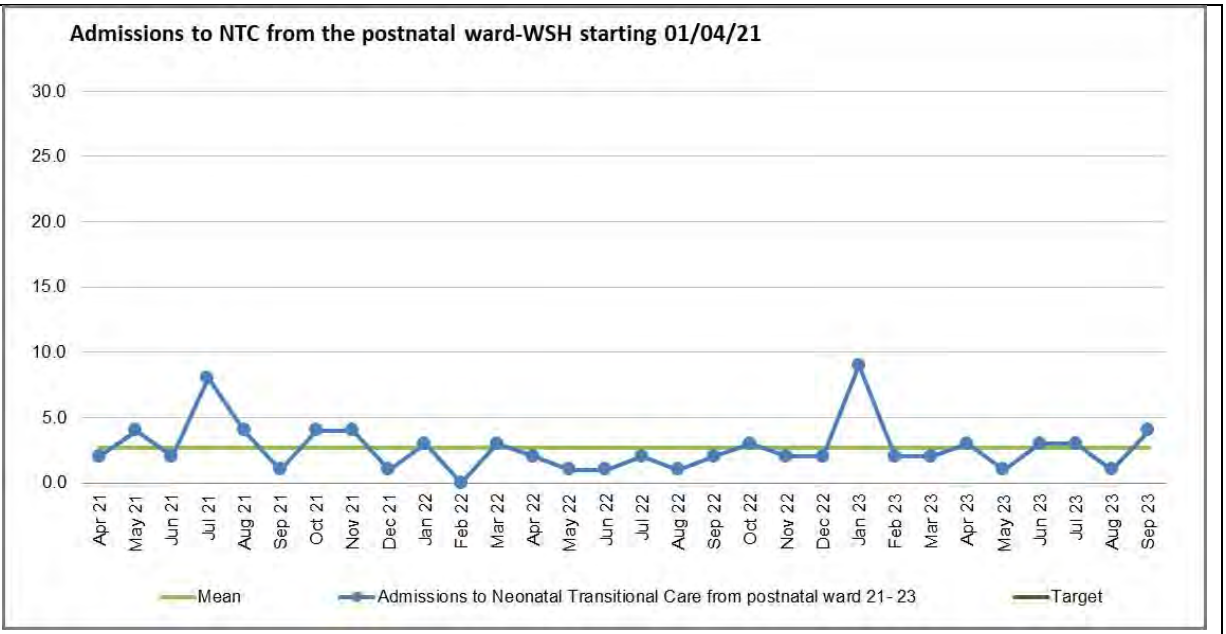
- **19/20 babies (95%) of the babies admitted to NTC met the criteria according to the local guidance. The one baby that did not meet the prescribed criteria did not need admission to the neonatal unit and therefore NTC could be considered to be appropriate in these cases.**



Summary of details of babies admitted to transitional care from the postnatal ward

Clinical Standards		**Criteria met**
Criteria for admission – developing: Risk factors		
Risk factors for sepsis requiring IV antibiotics	4/8 babies developed or had persistent respiratory symptoms or difficulties maintaining a normothermic temperature where sepsis was suspected.	Yes
Maternal risk factors for babies requiring TC	3/8 babies required IV antibiotics due to their mother developing signs of sepsis and being GBS positive.	Yes

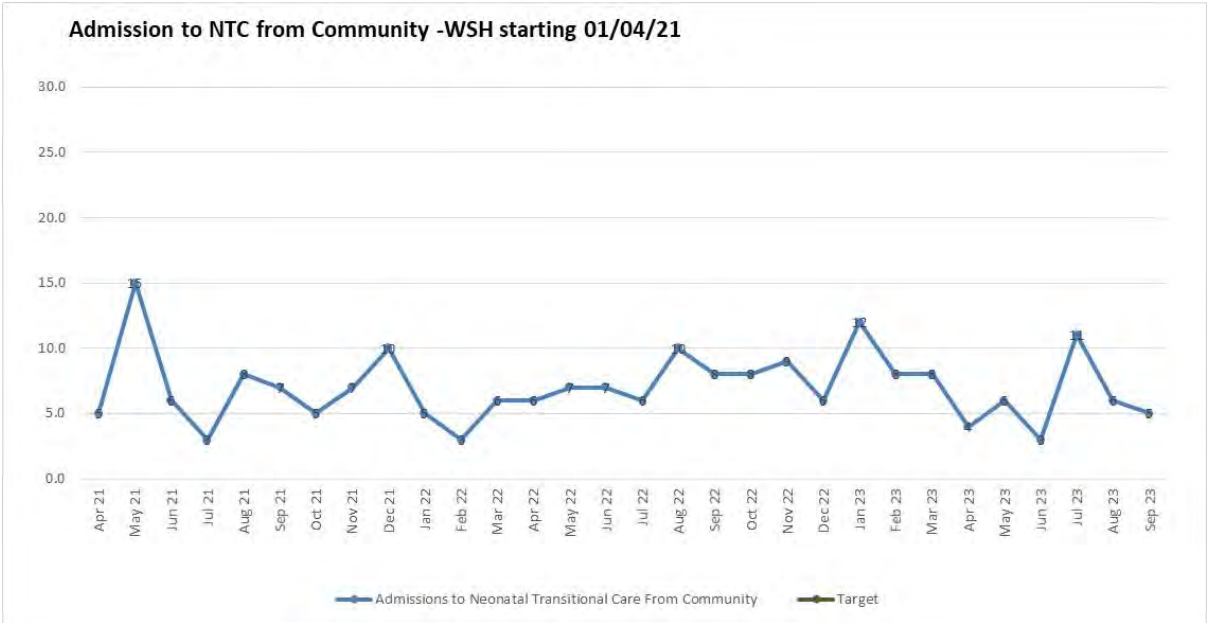
All babies admitted to NTC met the criteria. Along with the 7 babies mentioned in the table above, there was another baby that was admitted due to poor feeding. What are the numbers at the left side of the table?



Summary of details of babies admitted to transitional care from the community setting and received transitional care

Clinical Standards		Criteria met
Criteria for readmission from community met:		
Requiring phototherapy and serum bilirubin monitoring	13/22 babies were re-admitted with neonatal jaundice. Some of these babies had associated weight loss.	Yes
Weight loss /poor feeding	6/22 babies were readmitted due to problems with feeding and associated weight loss.	Yes

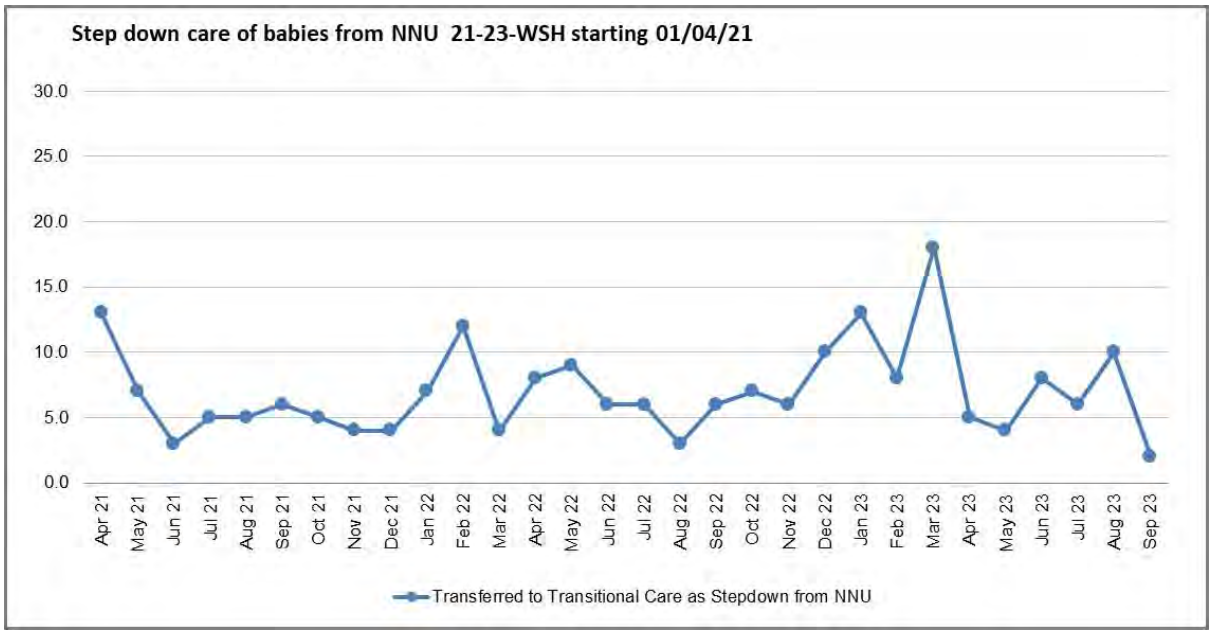
All these babies met the criteria for NTC. The three babies that are not included in the table for feeding support, grunting at home and a step down of care from a specialised hospital. It was noted that some babies had both jaundice and weight loss due to the babies being reluctant to feed due to the effects of jaundice.



Summary of details of babies admitted to transitional care following stepdown of care from the NNU

Clinical Standards		Criteria met
Criteria for step down from NNU:		
Corrected gestational age > 33+0 and clinically stable.	18/18 babies were preterm and within the agreed criteria for gestational age when they were stepped down from the NNU.	Yes
Observations required no more than 3 hourly	18/18 babies were all on an observation frequency of at least 3 hourly intervals	Yes
Stable baby with sepsis requiring antibiotics	18/18 babies were continuing IV antibiotic treatment.	Yes

All babies met the criteria for step down of their care to NTC from NNU. Continuing a course of antibiotics and being monitored for a longer period of time in NTC allowed mother and baby to be together.



Operational Standards

Audit of Operational Standards for staffing		
Operational Standards – Midwifery staffing of NTC		**Criteria met**
Midwife from F11 is allocated to care for women whose baby is in NTC 24/7	A midwife is allocated to oversee postnatal care of women in the NTC bay and works alongside the NNU to undertake joint care	Yes
Operational Standards – NNU staffing of NTC		
A NNU nurse or nursery nurse is allocated to care for the babies in NTC 24/7	A NNU nursery nurse is allocated to provide the care to babies having NTC on F11 and on the NNU's side rooms working alongside the midwife and the shift leader for NNU.	Yes
Operational Standards – Neonatal medical staffing		
A daily review of all babies having NTC is conducted by the consultant paediatrician, or the paediatric registrar allocated to NNU	A paediatric ward round led by a consultant paediatrician, or a paediatric registrar is undertaken daily for all babies having NTC care on the postnatal ward or NNU. This is recorded on the baby's records on e-care.	Yes

	Required Standard		
	Pathways of care into TC have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in TC	There is evidence of neonatal involvement in care planning	Yes
		Admission criteria meets a minimum of at least one element of HRG XA04 There is an explicit staffing model.	Yes
		The policy is signed by maternity/ neonatal clinical leads and should have auditable standards.	Yes
		The policy has been fully implemented and quarterly audits of compliance with the policy are conducted.	In progress
	A robust process is in place which demonstrates a joint maternity and neonatal approach to auditing all admissions to NNU of babies ≥ 37 weeks. The focus of the review is to identify whether separation could have been avoided. An action plan to address findings is shared with the quadrumvirate as well as the Trust Board, LMNS and ICB	Evidence of joint maternity and neonatal reviews of all admissions to the NNU of babies equal to or greater than 37 weeks.	Yes
		Evidence of an action plan agreed by both maternity and neonatal leads which addresses the findings of the reviews to minimise separation of mothers and babies born equal to or greater than 37 weeks	Yes
		Evidence that the action plan has been signed off by the DoM/HoM, Clinical Directors for both obstetrics and neonatology and the operational lead and involving oversight of progress with the action plan.	Yes
		Evidence that the action plan has been signed off by the Trust Board, LMNS and ICB with oversight of progress with the plan	Yes
	Drawing on the insights from the data recording undertaken in the Year 4 scheme, which included babies between 34 and 36+6, Trusts should have or be working towards implementing a TC pathway in alignment with the BAPM Transitional Care Framework for Practice for both late preterm and term babies. There should be a clear, agreed timescale for implementing this pathway	Guideline for admission to TC to include babies 34+0 and above and data to evidence this is occurring	**In progress- approved by Governance and awaiting guideline to be updated online**
4.	**Next steps**		
4.1- ATAIN	Some actions and learning opportunities were identified in this quarter. They were: • Discrepancy of more than 10- 15% between the centiles reported from the USS and the actual birthweight was identified in one case. • Duplication of the breastfeeding questions from the diabetes section to general outpatient questions to prompt clinic staff. • Reminder for staff to complete RAPP tool for all babies and to comment on position? • Reminder for staff to action findings on RAPP tool while awaiting paediatric review.		

	• Importance of booking a glucose tolerance test (GTT) if there has been GDM in a previous pregnancy. • Uploading of NTC guideline and awareness amongst staff of the changes required in practice.
4.2	There is evidence that NTC is being utilised to achieve a minimum disruption to the separation of the mother and baby. This can be seen through the admission of neonates to NTC if minimal observations are required as well as the step down of those babies on NNU as soon as they require less monitoring but are not ready to be discharged to the community yet. This is assessed during the ATAIN meeting for every term baby that is reviewed. An operational Policy for Neonatal Transitional Care has been updated and approved in the June Quality and Safety meeting. It is at present being editing for uploading to conform with the BAPM guidelines. The operational Policy for Neonatal Transitional Care is in the final stages of being uploaded to the intranet and the subsequent implementation of the changes and the awareness of the staff regarding this will follow. The Work on introducing NEWTT 2 assessment and wellbeing observations into practice is being planned for when the electronic versions of observation charts are available on the information system in the Trust. There have not been any updates from the last quarter report. A gap analysis has been carried out and changes to the current system will be discussed with the IT team.
5.	**Conclusions**
5.1-ATAIN	Communication with the Superintendent Sonographer occurs around the time of the ATAIN meeting and actions taken if required. At present work is being done around planning teaching sessions. E-care will continue to be adapted and amended to improve the care provided to the women by prompting the caregiver accordingly. A reminder to all staff was sent around the importance of the RAPP tool and the need for the description of the position of the neonate, through Take 5, Quality and Safety Newsletter (previously known as Risky Business) and an email to the senior team of midwives. A reminder was sent to the Lead Midwives of all areas about the importance of booking a GTT for women who had a previous pregnancy affected by GDM. Communications with the Diabetes Specialist Midwife have resulted in the fact that it was through no midwives' fault that the GTT was not booked but simply a miss in ticking a box from the woman's side.
5.2-NTC	The number of babies receiving care under the NTC pathway has decreased in this quarter compared to the last quarter. This did not result in more babies being admitted to the NNU therefore it can be seen that NTC is still being utilised to achieve its aim. All babies but one met the criteria because of the gestational age. The baby was born at 34+6 and the current admission criteria states more than 34+6. This is however changing when the updated guideline comes into place to 34 weeks of gestation, and this is in accordance with the BAPM framework for Transitional Care. Upon the implementation of the updated guideline, more neonates will be able to be cared for on NTC and an increase in numbers might be seen in the next quarter.
6.	**Recommendations**

6.1-ATAIN	Action	Plan	Comments	Date to be Achieved
	Duplicate the breastfeeding questions from the diabetes section	• Update of E-care	This would be a prompt to clinic staff when seeing women including women	October 16th 2023

	to general outpatient questions		who are on antihypertensive medication	
	Reminder for staff to complete RAPP tool for all babies and to comment on position	• Email to senior team • Take 5 • Risky Business		**Action completed**
	Reminder for staff to action findings on RAPP tool while awaiting paediatric review	• Email to senior team • Take 5 • Risky Business		**Action completed**
	Importance of booking GTT if there has been GDM in a previous pregnancy	• Communication for information dissemination to ANC manager, Community lead midwives and MDAU manager	to note: it was found that the woman concerned did not communicate the presence of GDM in the previous pregnancy and ticked the wrong box online.	**Action completed**
	Raising awareness among the maternity team of thermoregulation and the prevention of sub optimal temperatures in the neonate	• Educational piece in Risky Business • Message in Take 5	Monthly updates from ATAIN and learning in Risky Business –	End of November 2023
	Explore introducing AID (RCOG tool to help in communication between the MDT)	• Present in the Audit and Education meeting and the Quality and Safety meeting	Collaboration with LMNS Maternity Safety and Quality lead (who was part of the development team)	November 8th 2023 In progress
	Neonatal medical and nursing teams to have more awareness around the babies' weight at discharge -	• Weekly communication Wise Words to remind Nurses to communicsate weights and esacalte if any concerns prior to discharge • Email to all paediatric team outlining the importance of feeding plans for family and safety netting prior to discharge	Cases will be continued to be viewed through ATAIN and patient safety incidents to be raised where care or service delivery problems are identified.	Ongoing form last quarter report until reviews suggest feeding plans are present prior to discharge (where applicable)
	Information videos for Staff facebook page	• Informational video "Thermoregulation of the Newborn" on staff facebook page.	Video awaiting sign off.	**Action completed**
	Instructions added to Warming Cots on F11	• Add instructions to all warming cots to ensure	Updated warming cot instructions added to warming cots on unit.	**Action completed.**

		correct usage of equipment		
	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.	**Action completed**
	Handover “Hot Topic”	• Remind staff at handover about importance of keeping babies warm (in Theatre, LS and F11)	Facilitated by inpatient matron in communications to Band 7 area leads.	**Action Completed**
	Parental Education Poster/Leaflet	• Poster/Leaflet to display in LS rooms/F11 bays to increase awareness in parents	In development.	**Action completed**
	Parental Education – Cot Cards “Keep me Warm”	• Cot cards for all cots on LS, MLBU and F11		**Action completed**
	Signs for Resuscitaires demonstrating how to keep babies warm	• Posters made with visual aid for resuscitaires in Theatre, LS and MLBU		**Action Completed**

West Suffolk NHS
NHS Foundation Trust

Maternity Incentive Scheme – Year 5

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	Senior Matron Neonatal Services
Report Author	Maija Blagg, Senior Matron Neonatal Services 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 5 reporting period. Reporting periods: **1st March 2023 to 31 August 2023**
Date of this report:	12st September 2023
Presented at:	Maternity, Neonatal and Gynaecology Quality & Safety Meeting 18th September 2023 Maternity & Neonatal Safety Champions 26th September 2023 Trust Board 29th September 2023 Resubmitted 1st December 2023

Executive summary:

The purpose of this report is to provide evidence and give the Board assurance that work continues to be undertaken within neonatal services at West Suffolk NHS Foundation Trust, to demonstrate progress towards meeting safe staffing standards within the neonatal nursing workforce. These standards are outlined in the British Association of Perinatal Medicine (BAPM) guidance and are assessed using the agreed Neonatal Clinical Review Group (CRG) nursing workforce calculator (2020).
The report shared with the board in September 2023 unfortunately had a miscalculation of vacancy rate, and therefore the paper has been rewritten with the correct calculation.

This report indicates there is a **shortfall of approximately 1.76 WTE** between the budget and staff in post. This is due to a vacancy rate of 1.76 WTE Band 5, for which recruitment is underway. This equates to approximately **6.8% vacancy rate**.

Another variance highlighted is, as there is no budget for band 5 nurses who have completed the Qualified In Speciality (QIS) course, the staff in post at this level contribute to the band 6 roster with some restrictions to their duties. This reflects as 0.8 WTE over budget for QIS staff, and 0.8 WTE under budget for non-QIS staff.
As per the calculator guidance, only workforce that provide direct neonatal patient care on the neonatal unit have been included. Management and administrative roles including the Senior Matron for Neonatal Services, Unit Manager, Practice Development Nurse, and Governance Lead are not included, this equates to 3.15 WTE.
Likewise, staff who cover the Neonatal Transitional Care (NTC) and Neonatal Community Services have not been included. This equates to 5.8 WTE band 4 to cover NTC, 0.32 WTE band 4 to cover the Neonatal Community Service and 0.64 WTE band 6 QIS to cover the Neonatal Community Service. Currently there is no separate budget for these staff groups/ services.

BAPM states that nursery nurses working in NTC should be under the direct supervision and responsibility of a registered nurse or midwife. The Neonatal Unit shift leaders are band 6 QIS. The shift leader is not currently supernumerary, despite this being a national standard from NHSE, BAPM and the DOH Toolkit.
BAPM also state that neonatal workforce planning should include a 25% uplift for nursing time over and above direct clinical care for education, training, professional development, annual leave, sickness, maternity leave, and non-clinical commitments including (but not inclusive of), QI and safeguarding. In addition to this, there should be a shift coordinator for every shift. This should be a senior nurse (generally band 7) who has no clinical commitment during the shift.

The findings of the Neonatal Nursing Workforce Calculator indicate that **cot occupancy is 45.92%** in this 6-month period of audit. However, this does not consider neonates receiving NTC. With the continued aim to reduce term admissions to the Neonatal Unit, this cannot be ignored when calculating the number of nursing staff required. **Neonatal Transitional Care activity equates to approximately 15%** of activity for this period of audit.
The calculator does not consider the **Neonatal Community Service** (NCS) which is also staffed by the neonatal workforce. This work equates to approximately **7%** during this period. BAPM state that ideally neonatal community services will be available 7 days per week. The current service provision is approximately 4 days per week.
The calculator does not consider **Ward Attenders**, neonatal patients who attend the Neonatal Unit by appointment following referral, usually from Community Midwives, but also on occasion from GP's, this equates to approximately **19%** for this period.

Recommendation:
This report is submitted for review and approval at the Maternity, Neonatal & Gynaecology Quality and Safety Group and 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 and finally with the East of England Neonatal Operational Delivery Network (ODN).

The Trust board is asked to receive this report as evidence of progress towards safe nursing staff standards in the Neonatal Unit and provide support to address the shortfalls.

1. Background

The Maternity Incentive Scheme (MIS) run by NHS resolution is in its fifth year and builds on the progress made in the previous 4 years. The safety action that this report relates to Safety Action 4d to ensure that the neonatal nursing staffing meets BAPM standards. The year 5 safety actions were released in May 2023 and updated with small amendments in July 2023. This safety action – 4d – is relatively unchanged for year 5.

The West Suffolk NHS Foundation Trust (WSFT) Neonatal Unit (NNU) is commissioned as a level one unit equipped to care for babies ranging from 30 weeks gestation for singletons, 32 weeks gestation for multiples, 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 at WSFT 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 repatriation and on-going care. Neonatal services at WSFT will follow agreed strategies and guidance as part of the wider East of England Neonatal Network (ODN), 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 considers the level of care provided in the unit. Capacity should be planned on an average 80% occupancy where possible- this provides 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 Trust and recommendations 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 because of the audit.
- Provide assurance to the Board that the care delivered on the 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 WSFT to demonstrate progress towards meeting safe staffing standards within the midwifery and neonatal nursing workforce.

2. Methodology

The Neonatal CRG Nursing Workforce Tool (2020) has been adapted from the Neonatal Nursing Workforce Calculator (2013) approved by the Neonatal Improvement Board 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) BAPM (2022).

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 Senior Matron Neonatal Services, Unit Ward Manager, Practice Development Nurse, Neonatal Community Service, Neonatal Intensive Care trained Nurses (Qualified in Speciality - QIS), supported by Staff Nurses, Nursery Nurses, Ward Clerks, and a Neonatal Information Administrator. There is a lead neonatologist 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, occupational therapist, and clinical psychology support. Many of these roles have been allocated additional hours to support the Neonatal Service due to Ockenden funding.

3. Neonatal service requirements:

- Minimum 70% neonatal nurses qualified in speciality (QIS)
- All registered nurses trained and updated in Neonatal Life Support (NLS)
- BAPM, DOH Neonatal Toolkit and NHSE state a supernumerary shift lead in addition to those providing direct clinical care is required. This person would also oversee the non-registered team on NTC
- Neonatal Nurses are required to support the resuscitation of sick, or new-born babies in the Labour Suite, in Theatre, the Postnatal ward and in ED
- Neonatal Nurses are required to support the medical team with enhanced nursing skills such as, cannulation, bloodletting, and the implementation of Patient Group Directives
- Neonatal nurses are required to attend handover, ward round and Multidisciplinary (MDT) safety huddle
- NNU skill mix

4. Neonatal service recommendations:

- BAPM state all NNU's should have a neonatal community service. Ideally this should be available 7 days per week.
- BAPM recommends link roles with protected time and responsibility for the following areas:
  - Infant feeding
  - Family care
  - Developmental care
  - QI in perinatal optimisation
  - Safeguarding
  - Bereavement support and palliative care
  - Discharge planning and community outreach
  - Risk, governance, and patient safety
  - Infection prevention
  - Education and practice development

Clinical Area	Day	Evening	Night
Currently in place:			
Neonatal Unit (including NTC)	2 Neonatal trained nurses/ midwives (QIS) 2 Staff nurses (non-QIS) or Nursery nurses (1 nursery nurse/ nurse allocated to TC) Ward manager (weekdays only) and Practice development nurse (4 weekdays only) 1 Ward clerk (weekdays only) 1 Neonatal Information Administrator (2 weekdays only) 1 Neonatal Community Service staff member (4 weekdays only)	2 Neonatal trained nurses/ midwives (QIS) 2 Staff nurses (non-QIS) or Nursery nurses (1 nursery nurse/ nurse allocated to TC)	2 Neonatal trained nurses/ midwives (QIS) 2 Staff nurses (non-QIS) or Nursery nurses (1 nursery nurse/ nurse allocated to TC)
Service requirements:			
Clinical Area	Day	Evening	Night
Neonatal Unit (including NTC)	1 Supernumerary QIS shift lead 2.5 Neonatal trained nurses/ midwives (QIS) 2 Staff nurses (non-QIS) or Nursery nurses (1 nursery nurse/ nurse allocated to TC) Ward manager (weekdays only) and Practice development nurse (4 weekdays only) 1 Ward clerk (weekdays only)	1 Supernumerary QIS shift lead 2.5 Neonatal trained nurses/ midwives (QIS) 2 Staff nurses (non-QIS) or Nursery nurses (1 nursery nurse/ nurse allocated to TC)	1 Supernumerary QIS shift lead 2.5 Neonatal trained nurses/ midwives (QIS) 2 Staff nurses (non-QIS) or Nursery nurses (1 nursery nurse/ nurse allocated to TC)

	1 Neonatal information administrator (2 weekdays only) 1 Neonatal Community Service staff member		

Nurse/Patient Ratios for the Neonatal Unit:

- **Transitional Care:** The ratio of nurses looking after TC babies is at least 1:4**.** Registered nurses and non-registered clinical staff may care for these babies under the direct supervision and responsibility of a QIS neonatal nurse. Staffing in TC must be sufficient to ensure that discharge is properly planned and organised, including adequate support for parents.
- **Special Care:** The ratio of nurses looking after SC babies is at least 1:4**.** Registered nurses and non-registered clinical staff may care for these babies under the direct supervision and responsibility of a QIS neonatal nurse. Staffing in SC must be sufficient to ensure that discharge is properly planned and organised, including adequate support for parents.
- **High Dependency Care:** The ratio of QIS neonatal nurses responsible for the care of babies requiring HD care is 1:2. More stable and less dependent babies may be cared for by registered non-QIS nurses, who are under the direct supervision and responsibility of a QIS neonatal nurse.
- **Intensive Care:** Due to the complex needs of both baby and their family the ratio of QIS neonatal nurse to baby is 1:1. This nurse should have no other managerial responsibilities during the time of clinical care but may be involved in the support of a less experienced nurse working alongside them in caring for the same baby.

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 Ward Manager or PDN, to undertake clinical duties to support the team. The Maternity Bleep Holder should be informed and asked to provide advice and assistance, the Emergency Bed Service (EBS), and the ODN should also be informed and DATIX should be completed.

The nursing establishment in the budget is historically set and based on actual activity of the unit, rather than at the recommended 80% capacity. The budget for this year was set on the number of posts in each band and has increased slightly since last year. This budget covers the NNU, NCS and NTC services. It is a work in progress to separate these budgets.

All band 6 senior staff nurses are Qualified in Specialty (QIS), 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 approximately 1 year and requires a placement in a level 3 unit. The Unit used for this is the Tertiary Unit in the cluster group - Cambridge. There is a rolling programme to give all band 5 nurses the opportunity to undertake the course which runs each year. In previous years an average of 2 nurses per year (dependant on staff having the relevant pre-course experience) have received funding, either from the Trust, charitable donations or from Health Education England (HEE) Continued Professional Development (CPD) funding.
All band 4 Nursery Nurses are required to complete a Transitional (or Special) Care Module to provide the highest level of care within NTC.

The Unit has a band 6 shift leader. This is a QIS neonatal nurse. The shift leader is not supernumerary despite this being a national standard i.e. NHSE, BAPM and the DOH Neonatal Toolkit.

The number of cots and the breakdown of levels of care has not changed since changing from level 2 to level 1 unit many years ago.

4. MIS Safety action 4: Can you demonstrate an effective system of clinical* workforce planning to the required standard? – year 5

4d) Neonatal nursing workforce

The neonatal unit does not meet the service specification for neonatal nursing standards, as we do not currently have a supernumerary shift leader. If the requirements had not been met in both year 4 and year 5 of MIS, Trust Board should evidence progress against the action plan developed in year 4 of MIS as well include new relevant actions to address deficiencies. If the requirements had been met in year 4 without the need of developing an action plan to address deficiencies, however they are not met in year 5, Trust Board should develop an action plan in year 5 of MIS to address deficiencies and share this with the LMNS 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 4 of MIS to address deficiencies.
A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN) Lead.

Time Frames

d) Neonatal nursing workforce
Nursing workforce review has been undertaken at least once during year 5 reporting period.

5. Findings

The audit was undertaken in September 2023 based on the unit activity and staffing levels for the period 1st March 2023 to 31st August 2023. The audit was undertaken by the Senior Matron Neonatal Services. The results were generated electronically based on the data submitted. The East of England Neonatal Operational Delivery Network request that the tool is submitted to themselves for confirmation and verification of the data presented. The tool will also be shared with the Local Maternity & Neonatal System.

Input activity (HRG 2016)			Input staffing numbers (WTE) DIRECT PATIENT CARE ONLY		
	Activity	Declared cots		Budget	In post
HRG 1 (IC)	26	1	Total QIS	15.44	16.24
HRG 2 (HD)	251	3	Total Non QIS	7.16	4.60
HRG 3 (SC)	737	8	Total Non Reg	3.13	3.13
Total	**1,014**	**12**	**Total**	**25.73**	**23.97**

This report indicates there is a shortfall of approximately 1.76 WTE between the budget and staff in post. This is due to a vacancy rate of 1.76 WTE Band 5, for which recruitment is underway. This equates to approximately 6.8% vacancy rate.
Other variance is due to there being no budget for band 5 nurses who have completed the QIS course, the staff in post at this level contribute to the band 6 roster with some restrictions to their duties, specifically taking charge of the shift. This reflects as 0.8 WTE over budget for QIS staff, and 0.8 WTE under budget for non-QIS staff.

As per the calculator guidance, only workforce that provide direct neonatal patient care on the neonatal unit have been included. Management and administrative roles including the Senior Matron for Neonatal Services, Unit Manager, Practice Development Nurse, and Governance Lead are not included, this equates to 3.15 WTE.
Likewise, staff who cover the Neonatal Transitional Care (NTC) and Neonatal Community Services have not been included. This equates to 5.8 WTE band 4 to cover NTC, 0.32 WTE band 4 to cover the Neonatal Community Service and 0.64 WTE band 6 QIS to cover the Neonatal Community Service.

We do not currently have a supernumerary shift lead to cover and supervise the Neonatal Unit nor Transitional Care.

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	26	*0.2*	*6.07*	1	14.13%	1	0
HRG 2	251	*1.7*	*3.04*	3	45.47%	1	2
HRG 3	737	*5.0*	*1.52*	8	50.07%	5	3
Total	**1,014**			**12**	**45.92%**	**7**	**5**

The findings of the Neonatal Nursing Workforce Calculator (2020) indicate that cot occupancy is 45.92% in this 6-month period of audit. This does not consider neonates receiving Neonatal Transitional Care (NTC). With the continued aim to reduce Term admissions to the Neonatal Unit, this cannot be ignored when calculating the number of nursing staff required. Neonatal Transitional Care activity equates to approximately 15% of activity for this period.
Neither does the calculator consider the Neonatal Community Service (NCS) which is also staffed by the Neonatal workforce. This work equates to approximately 7% during this period.
Nor does the calculator consider Ward Attenders, neonatal patients who attend the Neonatal Unit by appointment following referral, usually from Community Midwives, but also on occasion from GP's, this equates to approximately 19% for this period.

The following table breaks down the figures for TC including bed days.

Number of babies:	March 2023	April 2023	May 2023	June 2023	July 2023	Aug 2023
In TC	36	18	29	25	20	22
Bed days	92	54	79	68	76	95
Admitted from home	7	4	5	2	12	7

Ward attender	46	15	25	27	32	44
Bed days	93	47	85	83	36	49
Stepdown (NNU to TC)	18	5	4	8	3	10
TOTAL Bed days	185	101	164	151	112	144

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	25.73	23.97	19.92	5.81	4.05
Total reg nurses	22.60	20.84	17.64	4.96	3.20
Total QIS	15.44	16.24	12.35	3.09	3.89
Total non-QIS	7.16	4.60	5.29	1.87	-0.69
Total non-reg	3.13	3.13	2.28	0.85	0.85
Reg nurses as % nursing staff	87.8%	86.9%	88.6%		
QIS as % reg nurses	68.3%	77.9%	70.0%		

The results show that 77.9% of staff have completed the QIS course which is above national target of 70%. These figures do not include QIS staff who do not routinely provide direct neonatal care, such as the Ward Manager, PDN, Governance Lead or Senior Matron Neonatal Services, this takes the QIS percentage to 89%.

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 support and education required for new parents/carers. Acuity and dependency vary according to the individual needs of the neonate. Periods of relatively less intensive activity should be seen as an opportunity for neonatal nursing staff to undertake self-directed learning, unit-based teaching, e.g., simulation sessions, or focus on BAPM recommended link roles.

This report indicates there is a **shortfall of approximately 1.76 WTE** between the budget and staff in post. This is due to a vacancy rate of 1.76 WTE Band 5, for which recruitment is underway. This equates to approximately **6.8% vacancy rate.**

Other variance is due to there being no budget for band 5 nurses who have completed the QIS course, the staff in post at this level contribute to the band 6 roster with some restrictions to their duties, specifically taking charge of the shift. This reflects as 0.8 WTE over budget for QIS staff, and 0.8 WTE under budget for non-QIS staff.

The Neonatal Unit has a band 6 QIS neonatal nurse shift leader. They are required to cover and supervise the NNU and NTC, attend handover, ward round, MDT safety huddle, crash calls, deliveries of anticipated admissions to the NNU, they have extended nursing skills to support the medical team, such as cannulation, bloodletting and are trained to implement patient group directives (PGDs), they are required to support and supervise the junior team, assess ward attenders from home, oversee admissions, deal with any issues or concerns from parents/ carers and facilitate transfers in and out of the Unit, this is usually done with the addition of a patient allocation as the shift leader is not supernumerary, despite this being a national standard i.e. NHSE, BAPM and the DOH Toolkit.

The findings of the Neonatal Nursing Workforce Calculator indicate that **cot occupancy is 45.92% in this 6-month period of audit**. This does not consider neonates receiving Neonatal Transitional Care (NTC). With the continued aim to reduce Term admissions to the Neonatal Unit, this cannot be ignored when calculating the number of nursing staff required**. Neonatal Transitional Care** activity equates to approximately **15%** of activity for this period.
Neither does the calculator consider the **Neonatal Community Service (NCS)** which is also staffed by the Neonatal workforce. This work equates to approximately **7%** during this period.
Nor does the calculator consider **Ward Attenders,** neonatal patients who attend the Neonatal Unit by appointment following referral, usually from Community Midwives, but also on occasion from GP's, this equates to approximately **19%** for this period.

8. Recommendations

There should be a regular review of the staffing levels and skill mix to enable this to reflect the activity and acuity going forward.

Allowance made for staffing of NTC, NCS and enabling staff to complete training such as the QIS course.

The review should be confirmed by the ODN to ensure that the findings of the toolkit have been applied appropriately.

The action plan (Appendix 4) should be agreed by all interested parties and submitted to the Divisional Management team for approval prior to submission to the Trust Board.

Complete the Neonatal 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

The Trust is required to formally record to the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020). Neonatal Nursing workforce review has been undertaken at least once during year 5 reporting period 30 May 2023 – 7 December 2023.

Technical guidance	
Neonatal nursing workforce standards and action	
Where can we find more information about the requirements for neonatal nursing workforce?	Neonatal nurse staffing standards are set out in the BAPM Service and Quality Standards (2022) https://www.bapm.org/resources/service-and-quality-standards-for-provision-of-neonatal-care-in-the-uk The Neonatal Nursing Workforce Calculator (2020) should be used to calculate cot side care and guidance for this tool is available here: https://www.neonatalnetwork.co.uk/nwnodn/wp-content/uploads/2021/08/Guidance-for-Neonatal-Nursing-Workforce-Tool.pdf Access to the tool and more information will be available through your Neonatal ODN Education and Workforce lead nurse.
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?	There also needs to be evidence of progress against any previously agreed action plans. 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 have not been met in year 3 and or year 4 and 5 of MIS, Trust Board should evidence progress against the action plan previously developed and include new relevant actions to address deficiencies. If the requirements had been met previously without the need of developing an action plan to address deficiencies, however they are not met in year 5 Trust Board should develop an action plan in year 5 of MIS to address deficiencies. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).	**Green – staffing assessment completed** **Amber- vacancies staff recruitment is taking place** **Red- Currently no supernumerary shift lead**	Between 30 May 2023 – 7 December 2023 each neonatal unit should perform a nursing workforce calculation using the agreed workforce staffing tool.	The Trust is required to formally record to the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020). For units that do not meet the standard, the Trust Board should agree an action plan and evidence progress against any action plan previously developed to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN). **Board Report September & December 2023**

Appendix 3 Copy of the Neonatal CRG Nursing Workforce Calculator (2020): West Suffolk

Input unit details			
Trust	West Suffolk NHS Foundation Trust		
Unit	West Suffolk		
Designation	SCU		
Completed by	Maija Blagg		
Date completed	08/09/23		
Activity period	01 March 2023 - 31 Aug 2023	Days in period	184

Input activity (HRG 2016)		
	Activity	Declared cots
HRG 1 (IC)	26	1
HRG 2 (HD)	251	3
HRG 3 (SC)	737	8
Total	**1,014**	**12**

Input staffing numbers (WTE) DIRECT PATIENT CARE ONLY		
	Budget	In post
Total QIS	15.44	16.24
Total Non QIS	7.16	4.60
Total Non Reg	3.13	3.13
Total	**25.73**	**23.97**

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	26	*0.2*	*6.07*	1	14.13%	1	0
HRG 2	251	*1.7*	*3.04*	3	45.47%	1	2
HRG 3	737	*5.0*	*1.52*	8	50.07%	5	3
Total	**1,014**			**12**	**45.92%**	**7**	**5**

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	25.73	23.97	19.92	5.81	4.05
Total reg nurses	22.60	20.84	17.64	4.96	3.20
Total QIS	15.44	16.24	12.35	3.09	3.89
Total non-QIS	7.16	4.60	5.29	1.87	-0.69
Total non-reg	3.13	3.13	2.28	0.85	0.85
Reg nurses as % nursing staff	87.8%	86.9%	88.6%		
QIS as % reg nurses	68.3%	77.9%	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: Maija Blagg	Title: Senior Matron Neonatal Services	Contact: Maija.Blagg@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	Ongoing review	Neonatal Unit Ward Manager	Monthly review completed and ongoing
Complete Neonatal Nursing Workforce calculator 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	July 2024	Senior Matron Neonatal Services/ Neonatal Unit Ward Manager	Completed for 2023
Allowance made for staffing of NTC, NCS and enabling staff to complete QIS.	Ongoing training	Ongoing	Senior Matron Neonatal Services/ Neonatal Unit Ward Manager/ Neonatal Unit Practice Development Nurse	On track
The review should be confirmed by the ODN to ensure that the findings of the	Nursing workforce calculator submitted to ODN for review and confirmation of findings	December 2023	Senior Matron Neonatal Services	Awaiting board receipt

calculator 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.	Report and action plan to be submitted to Quality and Safety meeting and Safety Champion prior to submission to the Board	Sept 2023	Senior Matron Neonatal Services	Due Sep 23 – Trust Board
There should be a shift leader for every shift. This should be a senior nurse (generally band 7) who has no clinical commitment during the shift i.e. supernumerary	Business case to be developed and presented for additional funding to support supernumerary shift lead	31/3/24 – 30/6/24	Senior Matron Neonatal Services/ Deputy Head of Maternity /Operational Manager	Requires action
The NCS provision should look to extending to a 7 day per week service.	This will require careful consideration, audit of service gaps, patient workload, and possible business case developed and presented to expand the service and secure appropriate funding	31/3/24 – 30/6/24	Senior Matron Neonatal Services/ Deputy Head of Maternity/ Operational Manager	Requires action

BOARD OF DIRECTORS	
Report title:	Bi-Annual Report on Midwifery Workforce – October 2023 for period 1st April 2023 to 30th September 2023
Agenda item:	**Maternity and Neonatal services**
Date of the meeting:	1st December 2023
Sponsor/executive lead:	Sue Wilkinson, Executive Chief Nurse
Report prepared by:	Karen Newbury, Head of Midwifery

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

Executive Summary

WHAT?

In May 2023, Year 5 of the NHSR Maternity Incentive Scheme (MIS) was published with 10 safety actions that Trusts are required to comply with or make progress towards complying with, to improve and maintain safety in maternity and neonatal units. The guidance was republished with minor amendments to some requirements, but this safety action was unaffected.
This report is part of the ongoing assurance of the Trust's compliance with **Safety Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?**

- National tools, LMNS collaboration and BirthRate Plus methodology have been used to determine the midwifery establishment.
- The funded establishment meets the BirthRate Plus recommendations.
- Robust escalation processes and team working are in place to monitor safe staffing.
- One to one care of women in labour over the 6-month period of the report has been maintained at **100% compliance.**
- Supernumerary status of the labour suite co-ordinator (LSC) has been consistently above **99%** between April & September 2023. The aim is for 100%.
- Vacancies for experienced band 6 midwives are difficult to fill whilst recruitment of band 5 midwives and those from overseas has been successful,

- Midwife vacancies at the end of September 23 was 10.31 wte which equates to an **8 % vacancy rate.** The service is currently employing approximately 5.00 wte midwives each month through the bank and staff working additional hours.
- The impact of increasing student midwife numbers and return to practice courses will not be realised for at least another 2-4 years.
- West Suffolk is actively participating in the regional work of midwifery apprenticeship schemes with the intention of having places on the first cohort when these are in place.
- The Midwife to Birth ratio has been set locally at **1:20.5**; there were five months when this was not met. This reflects the vacancy factor for those months.
- Red Flags continue to be monitored daily and collated monthly: delays in induction of labour remain the main clinical reason.

SO WHAT?

- Safe staffing levels are not just to ensure patient safety, but also to retain our existing workforce.
- The evidence shows that we can demonstrate an effective system of midwifery workforce planning to the required standard and therefore currently we are meeting the maternity incentive scheme's requirements.
- The report only covers the timeframe to the end of September 2023 and therefore the risk of not meeting the standards in subsequent months of the MIS timeframe is not yet known.

WHAT NEXT?

- Close monitoring of the supernumerary status of the LSC will continue, with each instance of non-compliance investigated and themes identified.
- Active recruitment to vacancies will continue, with an effective preceptorship process in place to retain and develop staff.
- Further MCoC teams will be on hold until safe staffing levels can be assured throughout the service.
- Recurring themes from 'red fags' relating to staffing will be reviewed and where appropriate and possible further mitigations in place.
- Escalation plans will be used to promote safe care.

Actions Required

- Ongoing recruitment and retention of workforce as per plan
- Staffing templates and recruitment to be complete to enable supernumerary status of the LSC to be 100%
- Trust Board to evidence midwifery staffing budget reflects calculated staffing establishment.
- Enable accurate electronic recording of planned versus actual staffing on E-Roster

Risk and assurance:	There are financial risks associated with non-compliance with the Maternity Incentive Scheme Year 5 requirements. This report outlines the Trust's position against safe midwifery staffing
Equality, Diversity and Inclusion:	The information contained within this report has been obtained through due diligence.
Sustainability:	The Maternity and Neonatal Services will sustain these processes by having appropriate governance pathways and escalations in place.

Legal and regulatory context	This report outlines evidence of the Trust's compliance with NHSR Maternity Incentive Scheme. This evidence will be verified in order that the claim for funding from the scheme is legitimate.

Bi-Annual Report on Midwifery Workforce – October 2023 for period 1st April 2023 to 30th September 2023	
1.	**Introduction**
1.1	In May 2023, Year 5 of the NHSR Maternity Incentive Scheme (MIS) was published with 10 safety actions that Trusts are required to comply with or make progress towards complying with, to improve and maintain safety in maternity and neonatal units. The guidance was republished with minor amendments to some requirements, but this safety action was unaffected. This report is part of the ongoing assurance of the Trust's compliance with **Safety Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?**
1.2	**Required standard for Safety Action 5:** a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed. b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above. c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service. d) All women in active labour receive one-to-one midwifery care. e) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year five reporting period
1.3	**Minimum evidence:** A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated. • In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations. • Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls. • The plan to address the findings from the full audit or tabletop exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners. 38 • Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing. o The midwife to birth ratio o The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives. • Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward coordinator status and the provision of one-to-one care in active labour. Must include plan for mitigation/escalation to cover any shortfalls.

	Whilst no longer an essential requirement, it is recommended that this report continues to include information on the monitoring of red flag events associated with midwifery staffing.
1.4	**Relevant time period for MIS** 30th May 2023- 7th December 2023
2.	**Background**
2.1	**Assessment of required midwifery staff** A full BirthRate Plus (BR+) assessment was completed in March 2023. The assessment calculates the number of midwives required to provide care in the antenatal, intrapartum and postnatal period for a unit of our size, taking into account, acuity, complexity, geographical area and cross border activity. The March 2023 assessment demonstrated the actual funded establishment of clinical midwives was in line with their recommendations. BR+ calculations **with no** Continuity of Carer, March 2023: Clinical midwives: 106.76 wte Specialist midwives: 15.72 wte **Total number of midwives: 122.48 (wte) whole time equivalent** To note; the above calculation excludes roles that have been introduced to support our recruitment and retention, including legacy midwifery role and practice facilitators for international recruitment. BR+ does not capture the total amount of non-clinical time ward managers and community team leads require to fulfil their management roles. Our remaining continuity of Carer team were also excluded from the above calculation. Due to the increasing demand for maternity and neonatal services to work closely together for the safety of mothers and babies, it was decided to merge the neonatal unit and maternity service. This has enabled closer working relationships including, daily attendance at the safety huddle, multidisciplinary working, multidisciplinary training and shared goals regarding safety standards. Therefore, there are some roles in maternity that also oversee neonatal services. In addition to this, gynaecology sits alongside maternity and from a quality and safety perspective is also merged. The additional services that sit under maternity are not recognised or captured within the BR+ assessment. This in addition to the excluded midwifery roles, result in a difference between the funded establishment and the BR+ calculation. These roles could be removed for reporting purposes to demonstrate that the BR+ recommendation meets the funded establishment, however due to the cross department working it would be extremely difficult to do so.
2.2	**Agreement of midwifery staffing establishment and budgets** The agreement of midwifery staffing establishment and associated budgets were endorsed by the Trust Board along with the proposal to suspend the introduction of further MCoC teams in May 2022.

The agreed funded midwifery establishment for 2023/24is as follows:

Band	Budget wte
8	5.0
7	34.05
6	92.32
TOTAL MIDWIVES	**131.37**

In line with the Royal College of Anaesthetists standards the service has commenced recruitment of registered nurses to enhance the team in supporting the management of women with complex medical conditions and to undertake immediate post-operative recovery for non-general anaesthetic cases. The team are aiming to recruit more substantive nurses to ensure 24 hours a day/ 7days a week cover. The funding for the registered nurses is separate to the midwifery budget as per the guidance.

2.3 **Continuity of Carer (CoC)**

The full Ockenden report was published in March 2022 with one of the essential actions being for services to *'review and suspend, if necessary, the existing provision and further roll out of midwifery continuity of carer unless they can demonstrate staffing meets safe minimum requirements*'.

As part of the BR+ assessment the number of midwives required to roll out continuity of carer was calculated as follows:

BR+ calculations **with** Continuity of Carer, March 2023:

Clinical midwives	135.01 wte
Specialist midwives	15.72 wte
Total	**150.73 wte**

We would therefore require 28.25 wte additional midwives to roll out CoC. This would require significant further investment to enable this as well as sustainable workforce provision. In the short-term the emphasis is to work towards CoC for the most vulnerable pregnancies.

2.3 **Recruitment and retention of midwifery staff and strategies employed to mitigate shortages**

The number of midwife vacancies at the end of September 23 was 10.31 wte which equates to 8% vacancy rate. The service is currently employing approximately 5.0 wte midwives each month through the bank and staff working additional hours. This demonstrates an improving picture regarding midwifery recruitment.

	Vacancy wte	Vacancy rate	Bank/additional shifts
September 2023	10.31	8%	5 wte
May 2023	29.9 wte	22%	10 wte

There continues to be a concentrated effort for the retention and sustainable recruitment of midwives including:

- An increase in midwifery students to enable a larger pool of newly qualified midwives to recruit from in future years.

	• Focussed work with HR partners to look at improved ways of retaining staff. This includes work exploring themes around why staff are leaving the Trust following exit interviews.
	• 'Growing our own' future midwifery workforce, through:
	  o Collaborative working with local HEI's leading to an increase in student midwife places each cohort.
	  o Accessing the 18-month course to encourage nurses to train as midwives.
	  o Offering Return to Practice course for midwives whose registration has lapsed.
	  o A programme to develop Midwifery Apprenticeships is being developed across the East of England region. West Suffolk midwifery service are actively participating in this, with a view to having students on the first cohort.
	
	Work on retention of midwives continues to be undertaken at local, regional and national levels. The service has not had a significant increase in the number of 'leavers' in the last 4 years with an average of 8-10 staff leaving each year. This remains static however 5 out of the 8 midwives who have left in the last year was due to geographical relocation. The recruitment of staff to replace these has been positive with a similar number of staff joining the Trust each year. However, often experienced band 6 midwives are being replaced by newly qualified band 5 midwives who need to complete their preceptorship programme.
	
	To address this, a recruitment and retention role has been introduced to undertake 'stay conversations', pre-exit interviews, staff forums and to represent the Trust at regional forums regarding recruitment and retention.
	
	The service also notes an increase of substantive staff requesting a reduction in hours to enable a better work/life balance. Work is underway to review the current on call arrangements and introduce more flexible working. The current exit interview process will be made more robust and thematic analysis improved.

3.	**Findings**
3.1	**Midwifery Staffing Levels** Maintaining safe staffing levels, continues to provide significant challenges to the service. To mitigate against this the service has a robust escalation policy and at times of heightened activity the following actions are deployed: • The service employs midwives from the established in-house bank plus some staff have also been willing to undertake hours in addition to contract. • The midwifery service has the support and flexibility to offer an uplift in pay at times when safe staffing levels cannot be achieved. When initiated this does assist the service in filling shifts that are proving difficult to cover. • Midwives working in specialist roles also work clinically to support safe staffing levels and ensure women receive safe care. • The community midwifery service in times of escalation has been utilised on the acute site on several occasions. Whilst this can impact on the availability of a midwife for a home birth and routine community duties, maintaining safe care and staffing levels in the hospital service remains a priority.

3.2 **Monitoring staffing levels**

- There is regular liaison with the matrons, deputy HOM and HOM to discuss strategies and actions needed to balance acuity against staffing levels across the day and planning for the next 48 hours.
- The BR+ app was discontinued as part of our Cost Improvement Programme and the OPEL (Operational Pressures Escalation Levels) tool is now completed 3 times a day with information informing decision making by the senior team.
- Staffing levels are discussed and recorded at the daily safety huddle and actions shared with the MDT.
- There is a midwifery manager on call for each 24-hr period and a unit bleep holder (band 7 Midwife) on site for both day and night shifts 7 days a week.
- Weekly staffing meetings with ward managers and matrons take place to plan ahead and discuss gaps in the rosters and options for maximising staff deployment.

The Head of Midwifery provides information on midwifery staffing that is included in Trust Board papers on a bi-annual basis. Key elements of this report include the number of shifts not filled, 1-1 care in labour and the MW to birth ratio.

NUMBER OF RM SHIFTS NOT FILLED: 2023		
Month	**WTE**	**Shifts per month**
April	11.8	91
May	10.9	75
June	11	66
July	10.2	64
August	9.7	47
September	10.15	56

To note: the unfilled shifts per month are a mixture of six, seven and a half and 12-hour shifts.

The service currently publishes the number of staff on duty against the minimum staffing levels expected in each clinical area. E-Roster gives more detailed information on the numbers of staff on duty, absences, unfilled shifts and bank shifts utilised. Until the E-roster templates have been built, it has not been possible for the system to deliver bespoke staffing reports.

3.3 **Midwife to birth ratio**

The monthly midwife to birth ratio is calculated using information from both e-roster for staffing and E-Care for activity. The Head of Midwifery takes responsibility for this, with the calculations being based on the actual number of midwives in post and working rather than the funded establishment. This is the most accurate way of calculating the true midwife to birth ratio as it enables adjustments to be made for vacant posts, staff on long term sickness and maternity leave. Likewise, midwives employed for additional hours or on a bank contract are included to formulate a true measure of the number of available midwives. This figure is measured against the actual number of births each month and reported on the service dashboard. The figure will fluctuate month on month, due to activity and availability of midwives.

	The BR+ funded establishment gives an overall achievable ratio of 1 Midwife (MW) to 20.5 births which is in line with current national BR+ recommendations. There were five months when this was not met, which reflects the vacancy factor and number of births that month. September was the only month the ratio was achieved which is arguably due to the vacancy rate and unfilled shifts being low.

MW TO BIRTH RATIO Standard = 1:20.5	
Date	**Ratio**
April	1:24
May	1:26
June	1:26
July	1:28
August	1:22.5
September	1:20.5

3.4	**Specialist Midwives (SpMW) in post** The service employs a variety of specialist midwives at Band 6 and 7 to support the service. All specialist midwives have a clinical component to their role contributing to the care of women. How this is attributed, depends on the role function, and contracted hours the SpMW works and is discussed and agreed between the SpMW and their line manager. This is managed fairly and equitably, to ensure the specialist function of the midwife's role is not eroded. Specialist MWs also contribute to the service escalation plan at times of heightened activity and acuity. Due to the national shortage of midwives where a role does not require clinical midwifery practice other professions have been considered. Currently this only applicable to the recruitment and retention lead and therefore they cannot be called upon for escalation. The service also has one band 7 MW and two band 6 posts that are externally funded to support the clinical practice facilitator function and Smoking cessation midwife. The total establishment of specialist MW and clinical managers needed to lead the service, constitutes approximately 11.5% of the total midwifery workforce. The target is 8-10% of the overall midwifery establishment being in a specialist role. For smaller units this is unachievable, as there is the requirement to have the same key specialist roles as larger maternity units with higher overall establishments. In addition to this there are mandated roles that have very little or nonclinical components and therefore are in addition to the above.
3.5	**Status of the labour suite co-ordinator (LSC) in relation to being supernumerary** Safer Childbirth (RCOG 2007) states that 'each labour ward must have a rota of experienced senior midwives as labour ward shift co-ordinators, supernumerary to the staffing numbers required for one-to-one care to ensure 24-hour managerial cover'. The lack of a supernumerary LSC has been identified as a contributory factor in many cases of maternal and perinatal morbidity and mortality reported at national forums. The LSC role is nationally recognised as being at Band 7. The technical guidance for Safety Action 5 in the CNST standards was published in May 2023 adding clarity to the assessment of supernumerary status:

	The Trust can report compliance with this standard if this is a one-off event and the coordinator is not required to provide 1:1 care or care for a woman in established labour during this time. If this is a recurrent event (i.e. occurs on a regular basis and more than once a week), the Trust should declare non-compliance with the standard and include actions to address this specific requirement going forward in their action plan mentioned in the section above. The role of the co-ordinator includes providing oversight of the labour ward and support and assistance to other midwives. For example: providing CTG 'fresh eyes', giving second opinion and reviews, providing assistance to midwives at birth when required, supporting junior midwives undertaking suturing etc. This should not be counted as losing supernumerary status. Following review, the service is confident that the methodology deployed meet the standard and no changes are needed in the way supernumerary status is assessed. Robust monitoring of the supernumerary status of the LSC takes place on a daily and monthly basis: • At the daily Safety Huddle the status of the LSC in last 24-hour period is checked and documented. • When the LSC is not supernumerary, this is reported as a 'Red flag' event. • Monthly compliance is collated, calculated, and published on the Quality and Safety dashboard. • Monthly analysis of the reasons why compliance has not been achieved is undertaken and any identified themes highlighted. Two band 7 MWs are deployed on both day and night shifts to ensure the presence of senior midwifery staff on a 24/7 basis. One of these will be the unit bleep holder who can support the labour suite at times of heightened activity and acuity. **Date** / **% Compliance:** **April** 99%* **May** 100% **June** 100% **July** 100% **August** 100% **September** 100% There was one unavoidable instance* where a woman arrived in advanced labour and gave birth rapidly and the LSC needed to prevent harm to the mother and baby by managing the birth themselves. Whilst the service aspires to achieve 100%, the safety of mothers and babies has to be the priority and these figures show great improvement and will continue to be monitored on a daily and weekly basis and actions taken when required. To note, the above * does not affect Year 5 s CNST submission due to this occurring prior to the relevant time period; 30th May 2023- 7th December 2023.
3.6	**Provision of 1-1 care in labour** Monitoring of compliance to this standard is provided monthly using the maternity information system e-Care. Midwives enter the information as part of their delivery records and this information is collated monthly and reported on the service quality dashboard.

The provision of 1-1 care is prioritised by the senior management team with staff movement and escalation processes being deployed to ensure women are provided with safe care. The service has been able to maintain 100% compliance to this standard in this six-month period.

1-1 Care in Labour	
Date	% Compliance
April	100%
May	100%
June	100%
July	100%
August	100%
September	100%

3.7 **Monitoring of Red Flags in relation to midwifery staffing**

Red flags in maternity services are defined as 'warning signs that something may be wrong with midwifery staffing'. The Red Flag incidents/events currently monitored in relation to midwifery staffing are as follows:

RED FLAGS RELATING TO MIDWIFERY STAFFING:
Redeployment of staff to other services/sites/wards based on acuity
Delayed or cancelled time critical activity
Missed or delayed care (for example, delay of 60 minutes or more in washing or suturing)
Missed medication during admission to hospital or MLBU
Delay of more than 30 minutes in providing pain relief
Delay of 30 minutes or more between presentation and triage
Full clinical examination not carried out when presenting in labour
Delay of two hours or more between admission for induction and beginning process and/or delay of more than 2 hours during the process.
Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)
Any occasion when one midwife is not able to provide continuous 1-1 care in established labour
Unable to facilitate women's choice of birthplace
Labour suite co-ordinator not supernumerary

Red flags are discussed and recorded at the daily safety huddle which is attended by medical, midwifery and nursing staff. These are reported on the Datix incident system. The number of red flags each month is recorded on the quality dashboard and monitored at the Maternity Quality and Safety Group meeting. Actions taken to mitigate and escalate issues and themes are documented and when a red flag Datix is submitted, care is reviewed by the senior team to assess impact and identify trends.

The number of Red Flags submitted each month is as follows:

RED FLAGS Apr-Sep 2023	
Month	**Number**
April	4
May	4
June	2

	July 2 **August** 1 **September** 4 **TOTAL** **17** This is a reduction from the last biannual report (49in total). To note the majority of Red Flags submitted during this period were in relation to delays in commencing induction of labour and continuing the process once started. Continued work regarding workflow has commenced to reduce the delay for induction of labours in addition to further recruitment.
4.	**Next steps**
4.1	The maternity service continues to strive to achieve safe and effective care for women through the provision of a midwifery workforce that is competent, skilled and trained to meet the needs of the local population. The service has been supported by the Trust with a significant increase in funding to achieve an establishment of midwives that will meet: • maintaining safe staffing levels for both in-patient and outpatients' areas in the hospital/community • provide enough specialist MW and managers currently needed to safely run the service. • deliver a community service for out of area women. In the last 6-months successfully recruiting midwives who have trained overseas has improved the vacancy rate considerably. The extensive midwifery experience and skills they bring with them is a real asset for our workforce. Maintaining safe levels of staffing is a priority and a recruitment and retention plan is in place, including: future staff availability with the increase in students, midwifery apprenticeships, and return to practice courses but the benefits of these may not be realised for at least another 2-4 years. All adopted practices around improving staff recruitment will be continued until the vacant posts are filled. The service has been proactive in maintaining a safe level of staff in the hospital service, particularly for women in labour. This has been achieved by having a robust escalation plan and good multi-disciplinary team working to ensure available staff are accessed and moved to areas where needed. This has disrupted normal working for some staff especially those in the community, management, and specialist roles. The positive outcome of the day-to-day operational scrutiny, decision making and action by all members of the midwifery team has enabled the service to achieve high compliance with supernumerary status of the LSC and all women in labour received 1-1 care. An action plan has been developed and attached as Appendix 1 to highlight where (and how) the service needs to improve compliance. Some actions from the previous report have been carried over for continued monitoring and completed actions have been highlighted. This action plan will be monitored quarterly at the Maternity Quality and Safety meeting and will be updated for the next Board Report due in the summer 2024.

5.	Recommendations
	• Close monitoring of the supernumerary status of the LSC will continue, with each instance of non-compliance investigated and themes identified. • There will continue to be monitoring of safe staffing levels, 1-1 care in labour, staff to birth ratios and red flags as part of the processes in place. • Active recruitment to vacancies will continue, with an effective preceptorship process in place to retain and develop staff. • Further MCoC teams will be on hold until safe staffing levels can be assured throughout the service. • Recurring themes from 'red flags' relating to staffing will be reviewed and where appropriate and possible further mitigations in place. • Escalation plans will be used to promote safe care. • The discussions on further roles within maternity services such as a Director of Midwifery and Consultant Midwife are continuing with the Trust Executive team.

Appendix 1 Action Plan

Action Plan Owner:	Karen Newbury	**Role Title:** Head of Midwifery	**Contact:** Karen.newbury@wsh.nhs.uk

RECOMMENDATION		**ACTIONS REQUIRED**	**TARGET DATE**	**PERSON RESPONSIBLE**	**COMPLIANCE / PROGRESS October 2023**
1.	Recruitment and retention of workforce	NHS Recruitment and Retention NHS Self-assessment to be completed.	Completed	HOM Matrons HR	Self-assessment completed October. To be shared at Governance forums and Trust Board
		Review on-call requirements and introduce more flexible working.	End Jan 2024	HOM Matrons HR	Staff focus group now in place. Flexible working survey complete and results shared with staff. Pilot for self-rostering due to commence. On-call requirement still under review.
		Improve quality of exit interviews including thematic reviews annually	End March 2023	HOM Matrons HR	Complete and ongoing
		Ongoing recruitment plans and commitment to exploring apprenticeships with NHS England	Review progress Early 2024	NHS England with local Trusts	Ongoing work – to be evaluated by the end of Jan 2024
		Staff surveys regarding staff satisfaction and areas for further development	Early 2024	PDM's CPF's Deputy HOM	Await results of National Staff survey. Feedback from staff forum and Safety Champion walkabouts does not raise any immediate concerns.
2.	Aim for supernumerary status of the LSC to be 100%	Communication to LSC team clarifying supernumerary status	On-going monitoring End Jan 2024	Head of Midwifery	Complete regarding communication with LSC. At risk due to staffing vacancies. Once staffed to establishment and roster template has been changed this should be complete
		Review escalation policy	July 2023		Completed
		Review of staffing template/establishment	July 2023		Complete

3.	Trust Board to evidence midwifery staffing budget reflects calculated staffing establishment.	Full BR + assessment using the agreed tool to be completed	1st December 2023	Trust Secretary and Head of Governance	On track
		Annual budget setting to be approved	March 31st 2023	Finance and Maternity leads	Completed July 2023
		Trust Board to provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations.	1st December 2023	Finance and Maternity leads Trust Board Secretary and Head of Governance	On track
4.	Enable accurate electronic recording of planned versus actual staffing on E-Roster	Review rules and templates on E-Roster to enable the system to generate accurate reports on planned versus actual staffing levels.	March 2024	Matron IP services. Ward Managers	Inpatient and outpatient midwifery cost code to be merged to reflect the cross-unit working/hybrid model. New templates to be up-loaded.
5.	Review the implementation of Must Do's arising from the Ockenden Report	Full Ockenden recommendations are currently under assessment by the MDT and executive. Particular actions in relation to midwifery staffing will be monitored and reported on in this bi-annual report.	On going	HOM Matrons LMNS CCG	Review completed – included in other aspects of staffing reports and developments

BOARD OF DIRECTORS	
Report title:	**Safety action 7: Listen to women, parents and families using maternity and neonatal services and coproduce services with users**
Agenda item:	Maternity and Neonatal services
Date of the meeting:	1st December 2023
Sponsor/executive lead:	Paul Molyneux, Trust Medical Director, Board level Maternity & Neonatal Safety Champion Sue Wilkinson, Chief Nurse
Report prepared by:	Justyna Skonieczny, Deputy Head of Midwifery

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

WHAT?

This report is part of the ongoing assurance of the Trust's compliance with The NHSR Maternity Incentive Scheme Safety Action 7- Listen to women, parents and families using maternity and neonatal services and coproduce services with users.

The 3 elements of Safety Action 7 that the Trust is monitoring for these safety standards are:

- Ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance (due for publication in 2023). Parents with neonatal experience may give feedback via the MNVP and Parent Advisory Group.
- Ensuring an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication (due each January), including analysis of free text data, and progress monitored regularly by safety champions and LMNS Board.
- Ensuring neonatal and maternity service user feedback is collated and acted upon within the neonatal and maternity service, with evidence of reviews of themes and subsequent actions monitored by local safety champions.

All the documents providing evidence of compliance have been through internal governance process including the Maternity and Neonatal Safety Champions and will then be shared with the Local Maternity and Neonatal System.

SO WHAT?

The year 2023 has seen some changes with moving the service forward, however MNVP works continued as below:

- The MNVP work plan has been updated.
- Supporting the maternity unit by participating where possible in amends to videos, leaflets, and paperwork for service user consumption.
- Attending the National Maternity and Neonatal Summit in Leeds, which allowed for learning and networking opportunities with other MNVP.

- Reviewing content of the MNVP website, reviewing, and updating content with support of MNVP members such as the questionnaire.
- Consultation and publication of the West Suffolk Maternity and Neonatal Service Strategy.
- Securing funding from the ICB for last year's outstanding grant and this year's outstanding grant
- Introduction of Neonatal services and service users into the West Suffolk MVP and becoming an MNVP.
- Building new relationships with the ICB to obtain a stronger working relationship.
- Work on coproducing maternity services will be further progressed over the next year as the West Suffolk MNVP is engaged with activities alongside the Trust employees.

However, due to the depleted membership, the MNVP has not been represented at governance meetings, and some labour suite forums and guideline review meetings in 2023 although guidelines and leaflets have been sent to MNVP members for review as part of the circulation at approval stages. There has, however been attendance at the Induction of Labour Forum and the Neonatal and Maternity summit as well as involvement in co-producing of Maternity and Neonatal Service Strategy.

The MNVP is actively recruiting a vice-chair and other members of the group so that they can attend governance groups and provide user input into the Trust's responses to national safety reports, complaints and updated guidelines and policies.

WHAT NEXT?

- Action plans will be monitored and any areas for non-completion, escalated as appropriate.
- Annual reports will evidence the updates.
- Reports will be shared with external stakeholders as required.
- National MNVP Guidance that was due to be published in July 2023 has not yet been published, therefore work will need to be undertaken once this document is published to benchmark the service against the recommendation set in the guideline, this will also include recommendation for ICB regarding the remuneration of MNVP chair and key members expenses, which was difficult to established due to the lack of national guideline.
-

Action Required

The Trust Board is asked to receive this report as evidence of the Maternity Services commitment to meeting the requirement of NHSR Maternity Incentive Scheme Safety Action 7

Previously considered by:	Maternity Quality & Safety Group 20/11/2023 Maternity & Neonatal Safety Champions 28/11/2023
Risk and assurance:	This report contains information that has previously been made known to the Trust Board through Board Reports and Dashboards. There is a risk to patient safety if these processes are not embedded and the maternity and neonatal services do not respond to safety intelligence.
Equality, Diversity and Inclusion:	All maternity and neonatal services are committed to provide equality of care and treatment to all.
Sustainability:	The Maternity and Neonatal Services will sustain these processes by having appropriate governance pathways and escalations in place.
Legal and regulatory context	This report outlines evidence of the Trust's compliance with NHSR Maternity Incentive Scheme. This evidence will be verified in order that the claim for funding from the scheme is legitimate.

Safety action 7: Listen to women, parents and families using maternity and neonatal services and co-produce services with users.

1.	Introduction
1.1	In May 2023, Year 5 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 to improve and maintain safety in maternity and neonatal units. This report is part of the ongoing assurance of the Trust's compliance with Safety Action 7:

	Listen to women, parents and families using maternity and neonatal services and co-produce services with users.
2.	**Background**
2.1	**Required Standards** 1. Ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and national MNVP Guidance (updated guidance due for publication in late 2023). Parents with neonatal experience may give feedback via the MNVP and Parent Advisory Group. Responsibility of funding MNVPs lies with ICBs. 2. Ensuring an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication (due each January), including analysis of free text data, and progress monitored regularly by safety champions and LMNS Board. 3. Ensuring neonatal and maternity service user feedback is collated and acted upon within the neonatal and maternity service, with evidence of reviews of themes and subsequent actions monitored by local safety champions.
2.2	**Minimum Evidence** **Evidence should include:** • Minutes of meetings demonstrating how feedback is obtained and evidence of service developments resulting from coproduction between service users and staff. • Evidence that MNVPs have the infrastructure they need to be successful. Workplans are funded. MNVP leads, formerly MVP chairs, are appropriately employed or remunerated and receive appropriate training, administrative and IT support. • The MNVP's work plan. Evidence that it is fully funded, minutes of the meetings which developed it and minutes of the LMNS Board that ratified it. • Evidence that service users receive out of pocket expenses, including childcare costs and receive timely payment for these expenses. • Evidence that the MNVP is prioritising hearing the voices of neonatal and bereaved families as well as women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, given the findings in the MBRRACE-UK reports about maternal death and morbidity and perinatal mortality.
2.3	**Validation Process** Self-certification to NHSR using the Board declaration document.
2.4	**Timeframe** Trusts should be evidencing their position at 7th December 2023 for submission of their declaration by 1st February 2024.
3.	**Compliance with standards**
3.1	**Ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance (due for publication in 2023). Parents with neonatal experience may give feedback via the MNVP and Parent Advisory Group.** West Suffolk Maternity and Neonatal Voices Partnership (MNVP) is an independent multi-disciplinary advisory and action forum with service users at the centre. It both uses a formal committee structure, with written agendas and formal minutes of discussions and decisions and incorporates the principles and practice of participatory co-design and co-production through regular break-out sessions and small group work to ensure that the five principles of MNVPs are at the core of the commissioning, monitoring and continuous improvement of maternity and neonatal services. The year 2023 has seen some changes with moving the service forward, however MNVP works continued as below: • MNVP work plan has been updated.

	• Supporting the maternity unit by participating where possible in amends to videos, leaflets, and paperwork for service user consumption. • Attending the National Maternity and Neonatal Summit in Leeds, which allowed for learning and networking opportunities with other MNVP. • Reviewing content of the MNVP website, reviewing, and updating content with support of MNVP members such as the questionnaire. • Consultation and publication of the West Suffolk Maternity and Neonatal Service Strategy. • Securing funding from the ICB for last year's outstanding grant and this year's outstanding grant • Introduction of Neonatal services and service users into the West Suffolk MVP and becoming MNVP. • Building new relationships with the ICB to obtain a stronger working relationship. • Work on coproducing maternity services will be further progressed over the next year as the West Suffolk MNVP is engaged with activities alongside the Trust employees. However, due to the depleted membership, the MNVP has not been represented at governance meetings, and some labour suite forums and guideline review meetings in 2023 although guidelines and leaflets have been sent to MNVP members for review as part of the circulation at approval stages. There has, however been attendance at the Induction of Labour Forum and the Neonatal and Maternity summit as well as involvement in co-producing of Maternity and Neonatal Service Strategy. The MNVP is actively recruiting a vice-chair and other members of the group so that they can attend governance groups and provide user input into the Trust's responses to national safety reports, complaints and updated guidelines and policies. National MNVP Guidance that was due to be published in July 2023 has not yet been published, therefore work will need to be undertaken once this document is published to benchmark the service against the recommendation set in the guideline, this will also include recommendation for ICB regarding the remuneration of MNVP chair and key members expenses, which was difficult to established due to the lack of national guideline.
3.2	**Ensuring an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication (due each January), including analysis of free text data, and progress monitored regularly by safety champions and LMNS Board.** National CQC Maternity Survey 2022 was sent out to women who gave birth in February 2022. As there were less than 300 births in February, women who gave birth in January were also invited to participate. The Trust had a 55% response rate. Whilst this was lower than the 2021 response, it was higher than the Trust average nationally. Areas of higher-than-average feedback include being given appropriate information around the risks and the processes before induction of labour, having a partner with them when they needed this, being treated with kindness and consideration after the birth of their baby whilst in hospital, and being involved in decisions about their care during labour and birth. Areas where the feedback was at the national average included being involved in the decision for induction of labour, delays in discharge home, being left alone at a time when it worried them in labour, being able to obtain help when this was needed in labour and staff introducing themselves before treating or examining them. To note; personalised care plans are being developed and the unit now has discharge coordinators in place to improve discharge processes and to avoid delays. Ongoing training and development of good communication skills amongst staff is part of the core training in all areas. Unfortunately, there were no responses for the antenatal or postnatal questions due to the current patient information system being unable to collate the data required. The digital team and maternity services continue to work to identify how improvements in data retrieval can be achieved to avoid manual processes being required. An action plan developed was shared with the service users and this has been attached in Appendix 1.
3.3	**Ensuring neonatal and maternity service user feedback is collated and acted upon within the neonatal and maternity service, with evidence of reviews of themes and subsequent actions monitored by local safety champions.**

	Feedback from users has a key role to play in tracking quality of care and shaping service improvements. Patient feedback consists of the views and opinions of patients and service users on the care they have experienced. At West Suffolk NHS Foundation service users' feedback are collected in a variety of ways including surveys (Friends and Family Test (FFT), CQC Maternity Survey), compliments, comments, and concerns raised via Patient Advice and Liaison Service, formal complaints, MNVP group and social media. The feedback is also gathered through the Neonatal Parent Advisory Group, Parents Evening Groups, external visit with service users' involvements (Maternity 60 Supportive steps, Neonatal Unit Gold BLISS Accreditation, Neonatal Unit PEER review) Information gathers are analysed, and shared in numbers of ways, via Quality and Safety meetings, 'Risky Business', monthly staff meetings, 'Take 5' newsletter. Feedback is also shared with the quadrumvirate and Safety Champions and learning shared across the Local Maternity and Neonatal System (LMNS), Integrated Care Board (ICB) and the Regional Maternity Quality and Safety Forum through the RPQOG and Score card and evidence of this has been attached in Appendix 1.
4.	**Recommendation and Next steps**
4.1	• The MNVP is actively recruiting a vice-chair and other members of the group so that they can attend governance groups and provide user input into the Trust's responses to national safety reports, complaints and updated guidelines and policies. • Benchmarking against MNVP Guidance once published. • 15 Steps to Maternity visit from MNVP • Reports will be shared with the external stakeholders as required. • Action plans will be monitored and updated accordingly.
5.	**Conclusion**
5.1	The year 2023 has seen some challenges as well as changes with moving the service forward. The MNVP work plan has been updated and MNVP Chair supported the maternity unit by participating where possible in amends to videos, leaflets, and paperwork for service user consumption as well as West Suffolk Maternity and Neonatal Strategy. The Chair has attended the National Neonatal and Maternity summit in Leeds, which allowed for learning and networking opportunities with other MNVP. The content of the MNVP website was reviewed and updated. The funding for the MNVP has been secured from the ICB. The MNVP guideline was due to published in July 2023 to streamline the service, however this has been delayed and we are awaiting the confirmation of the new date for this document to be release. The result from the National NHS Maternity Survey 2022 was published and the Trust had a 55% response rate. Whilst this was lower than the 2021 response, it was higher than the Trust average nationally. Areas of higher-than-average feedback were identified, and this shows the ongoing improvement in the service provision. Areas where the feedback was at the national or below the average allowed the service to look at future improvements. Unfortunately, there were no responses for the antenatal or postnatal questions due to the current patient information system being unable to collate the data required. Feedback from users has a key role to play in tracking quality of care and shaping service improvements. At West Suffolk NHS Foundation service users' feedback are collected, analysed, and shared in numbers of way described in the main body of this report.

Action Plan

Recommendation	Action	Date Due	Lead	Status
The MVP is actively recruiting a vice-chair and other members of the group to provide input into the future service provision.	Recruiting a vice-chair and other service users	December 2023	MNVP Chair	
Awaiting publication of the MNVP Guidelines.	Benchmarking against MNVP Guidance once published	Awaiting national guideline	MNVP Chair	

Report and action plan will be shared with the external stakeholders as required.	Presentation of the report/ action plan via internal governance process and share with external stakeholders	December 2023	JS	

Appendix 1 Summary of Compliance

Requirements	Target	Comments	Status
Funded user-led MNVP in place – in accordance with Delivery plan and MNVP guidance: Minutes/workplan/infrastructure/ user group expenses/prioritising neonatal and bereaved/BAME/ women from high areas of deprivation (MBRRACE report)	Position at 7th December 2023	Minutes of meetings MNVP workplan Remuneration of MNVP chair and key members expenses	
Action plan from CQC maternity survey co-produced by MNVP, including free text, shared and reviewed at Safety Champions and LMNS	Position at 7th December 2023	Minutes of meetings where the action plan has been developed and agreed. Evidence of completion or progress of actions	
Collecting and acting upon feedback including thematic review and review by Safety Champions.	Position at 7th December 2023	Minutes from meetings and other evidence where user feedback has been discussed and used to enhance care and services. User surveys and claims and actions taken as a result. Shared learning	

Appendix 2 Technical Guidance

Technical guidance	
What is the Maternity and Neonatal Voices Partnership?	An MNVP listens to the experiences of women, birthing people, and families, and brings together service users, staff and other stakeholders to plan, review and improve maternity and neonatal care. MNVPs ensure that service user voice is at the heart of decision-making in maternity and neonatal services by being embedded within the leadership of provider Trusts and feeding into the local maternity and neonatal system (LMNS). MNVPs ensure service user voice influences improvements in the safety, quality, and experience of maternity and neonatal care.
We are unsure about the funding for Maternity and Neonatal Voices Partnerships	It is the responsibility of ICBs to: Commission and fund MNVPs, to cover each Trust within their footprint, reflecting the diversity of the local population in line with the ambition above.
What advice is there for Maternity and Neonatal Voices Partnership (MNVP) leads when engaging and prioritising hearing the voices of neonatal and bereaved service users, and	MNVPs should work in partnership with local specialist voluntary, community, and social enterprise (VCSEs) with lived experience to gather feedback. Engagement needs to be accessible and appropriate, particularly for neonatal and bereaved families. It is essential that you consider how you will protect people from being retraumatised through giving feedback on their experience. Training for MNVPs to engage with

what support or training is in place to support MNVP's?	seldom heard or vulnerable communities may be required to ensure unintentional harm is avoided. MNVPs can also work in collaboration with their trust bereavement leads to ensure adequate support is in place for themselves and the families they may engage with. Attendance at the trust training could be beneficial.
When will the MNVP guidance be published?	We are working with our stakeholders to publish the MNVP guidance as soon as possible. As it is not yet published, it is acknowledged that there may not be enough time ahead of the reporting period for full implementation of all the requirements of the MNVP guidance. Where an element of the guidance is not yet fully implemented, evidence must be presented that demonstrates progress towards full implementation within 12 months.