Board of Directors (In Public)

Schedule	Thursday 2 February 2023, 9:15 AM — 1:30 PM GMT
Venue	Conference Room, Mildenhall Hub, Sheldrick Way, Mildenhall. IP28 7JX
Description	A meeting of the Board of Directors will take place on Thursday 2 February 2022 at 9:15am.
Organiser	Ruth Williamson

Agenda

AGENDA

- _WSFT Public Board Agenda - 2 Feb 2023 - Final.docx

1. 9:15 - GENERAL BUSINESS

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

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

1.3. Minutes of the previous meeting - 25 November 2022
To Approve - Presented by Jude Chin

- Item 1.3 - WSFT Minutes Open Board 25 Nov 2022 final draft.docx

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

- Item 1.4 - Matters Arising - Active.pdf
- Item 1.4 - Matters Arising - Complete.pdf

2. 9: 20 - PEOPLE AND CULTURE

2.1. Questions from Governors and the Public relating to items on the agenda
To Note - Presented by Jude Chin

2.2. Patient / staff story
To Review - Presented by Susan Wilkinson

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

Item 2.3 - CEO board report.docx

2.4. People & Organisational Development highlight report
Amanda Bennett in attendance
To Assure - Presented by Jeremy Over

Item 2.4 - People OD highlight jan2022.docx

2.5. Involvement Committee Report - 19 December, 2022 Chair's key issues
To Assure - Presented by Alan Rose

Item 2.5 - CKI Involvement Dec '22 - draft.docx

3. 11:00 - STRATEGY

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

Item 3.1 - WSFT FS public board January 2023.docx

3.2. System update - ICS and West Suffolk Alliance
Richard Watson in attendance (10.30 am)
To Assure - Presented by Peter Wightman and Clement Mawoyo

Item 3.2 - ICB JFP Update 240123.doc

3.2.1. Presentation on example from domains - Die Well
To Assure - Presented by Susan Wilkinson

Item 3.2.1 - WSA Committee Die Well Domain Dec 22 FINAL.pptx

3.3. Digital Board Report - Digital Prioritisation
To Assure - Presented by Nick Macdonald

Item 3.3 - Digital Board Report.docx

11.50 - COMFORT BREAK

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4. 12 Noon - ASSURANCE

4.1. Insight Committee Report - 5 December, 2022 and 9 January, 2023 - Chair's Key Issues from the meeting
To Assure - Presented by Richard Davies

Item 4.1 - Chair's Key Issues December 2022 final - Insight.docx

Item 4.1 - Chair's Key Issues Jan 2023 - Insight.docx

4.2. Finance Report
To Assure - Presented by Nick Macdonald

Item 4.2 - Finance Cover - December_2022_FINAL.docx

Item 4.2 - Finance Report- December_2022_FINAL.docx

4.3. Operational Response:
To Assure - Presented by Nicola Cottington and Clement Mawoyo

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4.3.1. West Alliance Seasonal Plan
To inform - Presented by Nicola Cottington and Clement Mawoyo

Item 4.3.1 - West Alliance Seasonal Plan update.docx

Item 4.3.1 - West Seasonal Plan January update (003) (002).pptx

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4.3.2. Operational Planning Guidance
To inform - Presented by Nicola Cottington

Item 4.3.2 - 202324 NHS priorities and operational planning guidance NC.docx

Item 4.3.2 - 202324 NHS priorities and operational planning guidance NC.pdf

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4.3.3. Change and Transformation Function
To inform - Presented by Nicola Cottington

Item 4.3.3 - Change and transformation update for board final NC.docx

4.4. Improvement Committee Report - 12 December, 2022 & 16 January, 2023 - Chair's Key Issues from the meeting
To Assure - Presented by Louisa Pepper

Item 4.4 - 22-12 Chairs key issues - Improvement Committee.docx

Item 4.4 - 23-01 Chairs key issues - Improvement Committee.docx

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

Item 4.5 - Safe Staffing Nov Dec Final.docx

4.5.1. Maternity Services Quality & Performance Report
Karen Newbury, Simon Taylor & Kate Croissant in attendance
For Approval - Presented by Susan Wilkinson

Item 4.5.1 - February 2023 Maternity Quality Safety and Performance Board Reportv2.docx

5. 12.55 - GOVERNANCE

5.1. Audit Committee Report - 11 January, 2023 - Chair's Key Issues
To inform - Presented by Alan Rose

Item 5.1 - CKI Audit committee 110123.docx

5.2. Remuneration Committee Report - 16 December, 2022 - Chair's Key Issues
To inform - Presented by Alan Rose

Item 5.2 - CKI RemCom 161222 - draft.docx

5.3. Governance report
To inform - Presented by Richard Jones

Item 5.3 Governance Report.docx

Item 5.3 Annex Draft agenda items.docx

6. 13:15 - OTHER ITEMS

6.1. Any other business
To Note

6.2. Reflections on meeting
For Discussion

6.3. Date of next meeting - 31 March, 2023
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

1.4 - CQC New Inspection Framework

- Annex - Item 1.4 - CQC new framework.docx

4.2 IQPR Full report November 2022

- Annex - Item 4.2 - Board report November 2022.pptx

4.5.1 Maternity Papers - Annexes B-K

- Annex B - 2022 ATAIN Quarter 3 Oct-Dec 2022 progress report.pdf
- Annex B - ATAIN ROLLING ACTION PLAN - 2022.pdf
- Annex C - Safety Action 8 MDT training Updated January after Board meeting.docx
- Annex D - Version 3 Element 4 SBL Compliance fetal monitoing November_December 2022 (003).docx
- Annex E - Audit report for Compliance with UAD at USS.docx

Annex F - Safety Action 6 SBL overall report November_December 2022 (004).docx

Annex G - Safety Action 4b Anaestheitc staffing report November 2022.docx

Annex H - Updated Safety Action 4 NN nursing Board Report after ODN 4_1_23 for noting.docx

Annex I - Compliance with NHSR Maternity incentive scheme Year 4.docx

Annex J - Trust Review of East Kent Kirkup Report.docx

Annex K - reading-the-signals-maternity-and-neonatal-services-in-east-kent_the-report-of-the-independent-investigation_print-ready.pdf

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5.1 - MyWish Annual Report and Accounts

Annex - Item 5.1 - Audit Report 2122.pdf

Annex - Item 5.1 - My Wish.pdf

5.3 - Governance

Annex - Item 5.3 Charitable Funds Terms of Reference Jan 2023- approved by chair's action.docx

Annex - Item 5.3 Code-of-governance-for-nhs-provider-trusts-october 2022.pdf

Annex - Item 5.3 Future System Programme Board TOR - 17.1.2023 - final clean.docx

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AGENDA

WSFT Board of Directors – Public Meeting

Date and Time	Thursday, 2 February 2023 9:15 – 13:30
Venue	Conference Room, Mildenhall Hub, Sheldrick Way, Mildenhall. IP28 7JX

Time	Item	Subject	Lead	Purpose	Format
1.0 GENERAL BUSINESS					
09.15	1.1	**Apologies for absence**	Chair	Note	Verbal
	1.2	**Declarations of Interests**	All	Assure	Verbal
	1.3	**Minutes of meeting – 25 November 2022**	Chair	Approve	Report
	1.4	**Action log and matters arising**	All	Review	Report
2.0 PEOPLE AND CULTURE					
09:20	2.1	**Questions from Governors and the public relating to items on the agenda**	Chair	Note	Verbal
09:45	2.2	**Patient / staff story**	Chief Nurse	Review	Verbal
10:10	2.3	**CEO report**	Chief Executive	Inform	Report
10.30	2.4	**People and organisational development highlight report** including: FTSU Guardian report	Director of Workforce Amanda Bennett	Assure	Report
	2.5	**Involvement committee report** - Chair's key issues from meetings	NED Chair	Assure	Report
3.0 STRATEGY					
11:00	3.1	**Future system board report**	Chief Executive	Assure	Report
	3.2	**System update – ICS and West Suffolk Alliance Richard Watson to join (10.30)**	Peter Wightman / Clement Mawoyo	Assure	Report
	3.2.1	**Presentation on example from domains – die well**	Chief Nurse	Assure	Report
	3.3	**Digital Board Report - digital prioritisation**	Director of Resources	Assure	Report

Time	Item	Subject	Lead	Purpose	Format
11:50 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
	4.3	**Operational Response:** 4.3.1 **West Alliance Seasonal Plan** 4.3.2 **Operational Planning Guidance** 4.3.3 **Change and Transformation Function**	COO & Clement Mawoyo	Assure	Report
12:15	4.4	**Improvement committee report** – Chair's key issues from the meetings	NED Chair	Assure	Report
	4.5	**Quality and nurse staffing report**	Chief Nurse	Assure	Report
	4.5.1	**Maternity services:** - Quality Safety & Performance Report - Clinical negligence scheme for trusts (CNST) submission - Maternity and neonatal services in East Kent – report of the Independent Investigation	Chief Nurse Karen Newbury, HOM and wider team	Approval	Report
5.0 GOVERNANCE					
12:55	5.1	**Audit committee report** – Chair's key issues from the meetings	NED Chair	Inform	Report
	5.2	**Remuneration committee report** – Chair's key issues from the meetings	NED Chair	Inform	Report
	5.3	**Governance Report**	Trust Secretary	Inform	Report
6.0 OTHER ITEMS					
13.15	6.1	**Any Other Business**	All	Note	Verbal
	6.2	**Reflections on meeting**	All	Discuss	Verbal
	6.3	**Date of next meeting** • **31 March 2023**	Chair	Note	Report

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

Supporting Annexes

Agenda item	Description
1.4	CQC New Inspection Framework
4.2	IQPR full report – November, 2022
4.5.1	Maternity papers – Annexes B-K
5.1	MyWish annual report and accounts
5.3	Governance

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. 9:15 - GENERAL BUSINESS

1.1. Apologies for absence

To Note

Presented by Jude Chin

1.2. Declaration of interests for items on the agenda

To Assure

Presented by Jude Chin

1.3. Minutes of the previous meeting - 25 November 2022

To Approve

Presented by Jude Chin

WEST SUFFOLK NHS FOUNDATION TRUST

DRAFT MINUTES OF THE
BOARD OF DIRECTORS MEETING OPEN

Held on 25 November 2022 9.15 – 12.45
At Denny Bros Conference Room, Bury St Edmunds

Members:		
Name	**Job Title**	**Initials**
Jude Chin	Chair	JC
Alan Rose	Deputy Chair/Non-Executive Director	AR
Louisa Pepper	Non-Executive Director	LP
Richard Davies	Non-Executive Director/Senior Independent Director	RD
Antoinette Jackson	Non-Executive Director	AJ
Geraldine O'Sullivan	Non-Executive Director	GO'S
Krishna Yergol	Non-Executive Director	KY
Tracy Dowling	Non-Executive Director	TD
Nicola Cottington	Chief Operating Officer	NC
Sue Wilkinson	Executive Chief Nurse	SW
Nick Macdonald	Interim Executive Director of Finance	NMD
Ravi Ayyamuthu	Deputy Medical Director	RA
Jeremy Over	Executive Director of Workforce and Communications	JO
In attendance:		
Richard Jones	Trust Secretary & Head of Governance	RJ
Pooja Sharma	Deputy Trust Secretary	PS
Clement Mawoyo	Director of Integrated Adult and Social Care Services	CM
Peter Wightman	West Suffolk Alliance Director	PW
Helen Davies	Head of Communications	HD
Vivian Yiu	Clinical Lead, Virtual Ward (item 1.5.2 only)	VY
Ehab Georgy	Service Manager, Suffolk Early Supported Discharge Service (item 1.5.1 only)	SC
Dan Spooner	Deputy Chief Nurse (items 4.5 and 4.5.1 only)	DS
Karen Newbury	Head of Midwifery (item 4.5.1 only)	JS
Simon Taylor	Associate Director of Operations (for item 4.5.1 only)	ST
Wendy Matthews	Regional Chief Midwife (for item 4.5.1 only)	WM
Lisa Nobes	Director of Nursing, Suffolk and NE Essex ICS (for item 4.5.1 only)	LN
Amanda Bennett	Freedom to Speak Up Guardian (item 2.1 only)	AB
Louise Kendall	Executive Assistant to Associate Medical Director (minute taking)	LK

Apologies:
Hilary McCallion, Non-Executive Director
Paul Molyneux, Medical Director
Craig Black, Interim Chief Executive

Governors:		
Clive Wilson	Public Governor	CW
Liz Steele	Public Governor - Lead	LS
Florence Bevan	Public Governor	FB
Jane Skinner	Public Governor	JS
Staff:		
Heidi Rolfe-Hill	Staff side representative	HRH
Paul Pearson	Unison	PP
Jon Hemsley	Unison	JH
Kirsty White	RCN representative	KW
Members of the public:		
Charlie Masters	Journalist from Suffolk News	CM

1.0 GENERAL BUSINESS		
1.1	**Apologies for absence**	**Action**
	The Chair (JC) welcomed all to the meeting, including the new Non-Executive Directors, and noted apologies for absence. JC expressed thanks to the Emergency Department and all the staff for their work in keeping patients safe in this very busy period.	
1.2	**Declarations of interest**	
	No declarations of interest were received.	
1.3	**Minutes of the previous meeting**	
	The minutes of the previous meeting held on 30 September 2022 were approved as a true and accurate record.	
1.4	**Action log and matters arising**	
	• **2057** Communicating waiting list challenges to the public and patients. Action has been taken but work is ongoing. In answer to a question, NC said that preparedness for industrial action includes patients on waiting lists, and further work with union reps and staff will take place to ensure emergency care continues, in the same way as planning for bank holidays. Action to be monitored in Improvement Committee – **action closed.** • **2066 Patient** transport. SW attends the quality and contract meetings with E-Zec and a plan is in place to support improvements both within the trust and with E-Zec. Progress to be monitored in Involvement Committee – **action closed.** Three further open action items are to be carried forward.	

1.5	Patient Story	
1.5.1	**Early Supported Discharge** Dr Ehab Georgy (Service Manager, Stroke Early Supported Discharge Service) gave a presentation on the ESD service, which allows the care of some stroke patients to be transferred from the acute setting into the community as soon as they are medically fit. It enables rehabilitation to continue at home with the same expertise as is available in hospital. It is a county-wide service between WSFT and ESNEFT and is unique as it is fully aligned between the two organisations. The service provides a 6-week tailored rehabilitation programme, from hospital discharge to ESD discharge. The aim is to reduce the average hospital stay for a stroke patient from 25 days to 17 days. In WSH, the average length of stay is now 8.4 days. Added benefits include increased patient satisfaction, and improved clinical outcomes. The service offers intensive programmes in the patient's home with a specialist team, which is designed to meet individual needs. A patient may receive up to 5 visits a week with up to 135 minutes per visit. EG explained a case study which demonstrates how health and social care come together. ESD, as part of the Integrated Therapies Team, is working on integrating health and social care together with Suffolk Family Carers and has a joint project with Home First to maximise stroke rehab input by involving reablement support workers. The case study was an 87-year-old patient who was previously independent and presented with stroke-related symptoms. He was at high risk of falls, required assistance with personal care and had some cognisant deficit. A new package of care was introduced which included occupational therapy, speech and language therapy, and physiotherapy. Home First reablement support workers also designed a simple care plan listing the input required and goals to work on, including to make breakfast and lunch, to hoover safely, to hang out washing, and to be independent with showering and dressing within 4 weeks. All goals were met or exceeded, which demonstrated excellent patient outcome. Up to 35 sessions were delivered within 28 days which showed excellent alliance work and meant that daily practice was possible. At the end of 6 weeks, no further care was required. The patient's independence improved and reduced care was required from his family. He did not need any ongoing referral. Patient and carer feedback was very positive, which stressed the impact of input in order to achieve goals. Questions and Answers: <u>Q - How many patients is ESD able to take through the process?</u> Input has to start from Home First in order to support people who require care at home. The number of patients using Home First is being	

	monitored, but the figures suggest that the work is part of what they normally do and is not putting a strain on other services. Q – Is there an opportunity to extend the service to other patient groups? The service is linked to occupational therapy services and the hope is to train reablement support workers to be able to extend to other patients. The training required is minimal. Q – How much emotional or communication therapy do reablement support workers have to provide and how much credit do we give them? Any psychology support is provided by ESD, which includes a clinical psychologist. It was noted that acute therapy input is also very important. There are many different kinds of strokes which require more input - 50% of patients are not suitable for this service because of their strokes and there is currently no team outside of the hospital which can take on cases of severe stroke. Q – What support is available to patients after the service ends? A new national model should bring in equity with other counties, whereby a specialist stroke service would take over. At present there is one physio and one occupational therapist, as well as ICANHO (a brain injury organisation) but the waiting list for that service is currently 4 months. A 6-month review system is being introduced to review patients in 6 months' time and will address any outstanding needs. CM reported that with regard to reablement support workers, Home First will extend their service beyond 6 weeks, depending on need. Outcomes from interventions are very positive and feedback received from carers is remarkable. The service has alleviated considerable pressure. Q – Is the service available in care homes? Yes, as long as the patient has rehab goals. 10% of patients can be extended by another 6 weeks in order to achieve goals and prevent onward referral. Q - Are Primary Care involved? GPs are part of the support network but not an integral part of the service. Discharge summaries and actions are sent to GPs. Not every patient needs GP input. Q – What is the major constraint for growing the service? The challenge is with regard to the capacity for the reablement service. Services need to grow to provide improved outcomes for the population	

	in general. This workforce group is one of our priority target areas to increase and improve. The service has no cap so the current forecast is around 540 referrals per year, but last year there were 635 referrals. Fortunately, the service is fully staffed and resourced and has all the equipment needed, but the pressure is still quite high. Q – How possible is it to know the cause of stroke and is there anything within the package to prevent stroke? It is unclear whether Covid may contribute. Prevention is very important, but there has been an increase in patients admitted with a second stroke, although this is not fully understood. This has been noticed across the country. The Board thanked Dr Georgy for his presentation.	
1.5.2	**Virtual Ward** Vivian Yiu, consultant nephrologist and clinical lead for the virtual ward, gave a presentation on the virtual ward which will be launched within WSFT on 28 November 2022. VY explained the background. The NHS long term plan includes digital technologies and their increasing role in patient care. This provides the opportunity for patients to be cared for in their chosen place. In the longer term, they can manage their own health by monitoring themselves to enable them to stay well. The plan for virtual wards has been accelerated by covid. They are a safe and efficient way of providing care, are clinically led but enabled by exciting digital technology. The feedback from patients already using virtual wards is very positive. Staff also feel this is a much better way of providing holistic care, so it has a positive impact on staff too. It is also a cost-effective solution for addressing the increased demand on acute services. VY explained a patient story, based on a patient on ward F8. The patient is a 72-year-old man with a history of high blood pressure and enlarged prostate. He visited AAU with acute kidney injury and stayed in hospital over a weekend. With the virtual ward, he could have had scans and be admitted for just one night, before moving to the virtual ward where he could have been remotely monitored, without the need for an inpatient stay. He could have had daily video calls, a pharmacist review of medications, and it would have reduced his length of stay and potential complications from e.g., infection. The pathways chosen for the virtual ward were falls, Chronic Obstructive Pulmonary Disease COPD, heart failure, acute kidney injury and IV antibiotics. The ward will have 47 beds by December, and will be operational 12 hours, 7 days a week with plans for out of hours cover.	

	There will be daily multi-disciplinary team MDT and ward rounds to review patient care. At present the ward will only take adults, but consideration is being given to including paediatric care. Admission criteria include living locally, and not being at risk of acute deterioration. Current Health technology is being used, as it requires very little patient input and has good reviews. The only input required by patients is blood pressure readings. Video calls can be conducted, and it includes a dashboard with RAG rating and the ability to schedule tasks for the patient on their tablet. The virtual ward team is similar to a physical ward team, including Band 6 and Band 5 nurses, with some going out to visit patients at home. It also includes a new innovative post for a specialist nurse, a pharmacist, occupational therapist, generic workers and a discharge coordinator. An out of hours support hub will be staffed by nurses overnight in case of any problems. There will be a handover from the overnight hub to the virtual ward each morning. Suitable patients will be referred from front door services and assessed by the virtual ward. Challenges have included staff recruitment, the line of accountability for staff working across ICS, the communications strategy, out of hours cover and the integration of the digital solution within existing electronic health records. Questions and Answers: <u>Q – How confident are you of reaching 47 beds?</u> There may be some snagging issues, but the aim is to do things slowly and surely and get things right. The plan is to open all pathways at the beginning. WSFT is starting earlier than most Trusts in the country, but the numbers remain to be seen. <u>Q – Does the virtual ward have the same level of staffing as static wards and are there risks associated with bringing patients back in through the ED if they are deteriorating?</u> There are staffing efficiencies, as fewer nurses are required. Patient readmissions is a risk and during the day, observations are monitored continuously. Out of hours, other Trusts across the country have had 10 or 15% readmissions, but it does take away pressure from the front door. Admin time would also be saved if a patient is readmitted. <u>Q – Is there anything you would have done differently?</u> Clinically led and digitally enabled is the right way forward. It would have been good to have had a digital solution in the ICS which was clinically appropriate. Constructive discussions on this have taken place, but it is important to have clinical input every step of the way. It is important to work with a team from across disciplines. All meetings were recorded and a deep level of accountability has been vital.	

	Q – Is it changing the nature of the relationship between healthcare professionals and patients, and are there any ethical concerns which could influence the future direction of travel? There has been a lot of virtual care in the last couple of years. Patients have become surprisingly used to this model and it is driven by patients' needs and wants. Care home providers also feel much more reassured as they can dial in to MDTs and express concerns and do not feel so detached from patient care in hospital. Accessibility has been enabled as much as possible, e.g., telephones can be used if a patient does not want to use a tablet. There are many possibilities to expand virtual wards across the hospital. Q – Have you anticipated any unexpected pressures across other areas of the system e.g., in the community? The community team has been involved to gain an insight into their working and the number of risks they manage. Additional nurses are being resourced to carry out work in the community. Do not anticipate putting an additional burden on Primary Care and in the longer term, hopeful to reduce the burden by referring directly from GPs to the virtual ward and avoid the hospital altogether. Q – Is there a burden on carers or families? The digital technology is self-explanatory and training will be given to patients. Families are not being asked to provide an increase in care, although they can engage if they wish to. Q – What is in place in terms of evaluation and audit to inform future potential? Data will be collected for NHS England and a patient evaluation survey will collect feedback immediately. KPIs are also being developed across the ICS. Evaluation of the out of hours service will also be collected. The Board thanked Dr Yiu for the presentation.	
1.6	**Questions from Governors and the public**	
	Staffing during industrial action: Liz Steele, Lead Governor LS asked for definitive information to be shared when available about how the hospital will be staffed during strike activity. This will be covered under the people and OD update. Flu vaccinations: Liz Steele, Lead Governor In proportion to the number of staff, there is still a long way to go to vaccinate staff. Assurance was given that this is being pursued and the Trust is heading for higher numbers. A dedicated vaccination team is	

	proactively walking around clinical areas to maximise opportunities, and vaccinations continue to be advertised through all communication channels. Vaccinations cannot be mandated, but staff are encouraged at every opportunity. The vaccination team is also going out to community staff. LS thanked the Board for supporting her and Florence Bevan during their time as lead governor and deputy lead governor. Training in foetal monitoring: Jane Skinner, Public Governor JS asked for assurance that there will always be a midwife available who is competent in foetal monitoring. Karen Newbury, Head of Midwifery, confirmed that all midwives are competent in those skills. Agency midwives: Jane Skinner, Public Governor Shifts are filled by bank staff and by midwives working extra hours. Agency midwives are as short in supply as substantive midwives, so we use mostly our own staff. Copies of slide presentations for governors: Florence Bevan, Public Governor **Action: To circulate presentation slides to Governors**	**R Jones**
1.7	**CEO report incorporating SNEE ICB**	
	The Board noted the report. Most areas will be covered in the meeting.	
2.0 CULTURE		
2.1	**People And OD Highlight Report** JO presented the report and highlighted the following: • The Putting You First awards, awarded to Clair Bacon, John Songkip, Gill Cooksey, Mireille Connolly and Te-Ahna Hanns. • Autumn of active listening, including the national staff survey, Speak Up month in October, and the local programme of staff listening and feedback (What Matters To You) which has been extended into December. The programme is reaching out to staff at their place of work, with priority given to staff who work outside of the hospital base. All locations have been visited. Emerging themes are detailed in the report. • Improvements to the library service. These have focussed on recognising the links between what we do, and our wellbeing. The library has been redesigned with that in mind. • Industrial action. The RCN has completed the balloting process which met the threshold for industrial action. The RCN will now formally write to confirm industrial action, but the Trust is proceeding on the basis that it will go ahead on 15th and 20th December. The Trust will be in dialogue with the RCN to understand how to work together and agree which areas will be	

exempted because of their work. Patient safety must be prioritised.
- Focus on building HR capacity to support and lead in the organisation, detailed in the report.

Question and Answers:

Q. Has there been an increase in requests for health and wellbeing support for staff?

In terms of accessing financial advice, Wagestream has been introduced this month, which enables staff to draw down pay in advance of payday. There has been a strong uptake of use of the app. West Suffolk Council's resources have also been shared, and we are raising the profile of what is available and considering what else can be done to support staff.

Q. How is the information gathered in the What Matters To You exercise being used, and how is that fed back to staff?

Action must be taken at an organisational level according to the themes. HR business partners are advocates at divisional level. Themes are linked to the Trust strategy and that has been used in communications to staff. It is important to reach everybody with updates.

The Freedom to Speak Up Guardian (AB) presented report for Q2 and highlighted the following:

- There were 62 cases in total, which indicated a steady increase. Most concerns were related to staffing and excessive workload, particularly in the community
- Feedback received included help for bank shifts by introducing weekly pay, which the introduction of Wagestream will help with. However, there is still a feeling that there is no point in speaking up if no one is listening
- There is a continuing fear of losing jobs by speaking up. Speak Up month took place in October, which included additional speak up training.
- The reflection tool for the Board to give their thoughts has provided some good feedback. Executives have also completed training, which can now be accessed on ESR.

It was agreed that the fear of speaking up needs to be tackled, with appropriate messaging to staff. This is linked to organisational development and good line management. Managers need to be supported in order to feel comfortable to receive feedback. About 70% of how staff feel is about their direct line manager.

	It was noted that the problem of staffing is huge. The Trust needs to be open and transparent and make clear the reality of the situation, explaining what is being done, notwithstanding the staffing levels. Q. Are the issues raised just wishes, or do staff really hope that things will happen? Requests are realistic and should be achievable. However, it is important that everyone recognises their respective roles and responsibilities. It is the Board's role to act on concerns. The reflection tool synopsis makes appropriate challenges and should be made available to the Board. Q. Have there been incidences of whistleblowing in the last year? There have been two or three concerns raised externally to the CQC in the last two-and-a-half years. These are often anonymous, so feedback is difficult. They provide a learning curve for the organisation which is taken very seriously and are a good opportunity to communicate with staff and make improvements. Q. Does the Trust have the capacity to ensure that everyone who wants to speak up, can do so? The Trust has capacity although there is a lot to do. AB said that she feels very well supported.	
3.0 STRATEGY		
3.1	**Future System Board Report** The Board noted the report.	
3.2	**System Update** The Chief Operating Officer presented the report, jointly produced with ESNEFT, which summarises the collaborative working between WSFT and ESNEFT, including the two Board-to-Board meetings which have taken place. The following points were highlighted: • Both Trusts have different strengths and values which enables learning from each other and seeing value in the difference • Both are integrated acute and community Trusts. Collectively, the ability to influence the wider system is really strong • Digital collaboration is a priority. WSFT has shared its journey as a digital exemplar • Collaboration so far has included the important mutual aid in relation to orthopaedic surgery. This was ground-breaking and welcomed in Ipswich and Colchester. The reduction in waiting times was partly due to this collaboration. There were some very positive experiences as well as some challenges	

	• Actions and recommendations are listed in the report, which has been presented to both Boards. It was agreed that both Trusts should publicise the collaboration in terms of vision and rationale. **Action: To publicise the vision and principles for the collaboration internally and externally.** Q. How tightly are we controlling this collaboration? Should we be encouraging all our teams to seek out collaboration with ESNEFT? There is already much collaboration happening between teams that are closer to patient care. We have a responsibility to create the culture that supports and encourages more collaboration. Q. Are there opportunities for R & D, improvement and audit? Discussion has taken place and there are many opportunities which should be explored further. One of the barriers to clinical collaboration was that WSFT use an electronic patient record and ESNEFT currently do not have an electronic patient record but are addressing this. Discussions are taking place about the advantages of being on the same platform. **The Board noted the progress of collaboration to date and the themes for future work; agreed the vision, principles and ways of working; agreed the establishment of a collaborative oversight mechanism; and supported the development of shared programme support for the priorities identified at the October Board-to-Board and provide regular reporting on collaborative activity to both Boards.**	**N Cottington**
3.2.1	**Alliance** The West Suffolk Alliance Director (PW) presented the report with the Director of Integrated Adult and Social Care Services (CM), and drew attention to the following: • A strategy on dementia is being created and is in the business case process. As a system it is a challenge to consider how to take on the extra demand • Suffolk County Council are considering Healthy Behaviours and Lifestyle Change services, including adult weight management and smoking cessation • Diabetes recovery is a challenge in West Suffolk. It is not clear whether this is a data issue or a service issue. NE Essex has a good model and that is being examined	

	• The six Live Well Domains now each have a leader to help proceed with those and there is a plan to bring topics to Alliance committee meetings. Q. How do we balance work with barriers e.g., reablement of community care? There is a risk that we could gain assurance, but what is the alliance's role in that? Alliance partners are part of a forum which looks at the long-term approach to reablement. It needs to grow across health and social care. Lower-level health interventions are also being examined, to ensure provision in the care market. Training will be required. It was noted that diabetes constitutes a significant part of the work for community teams, and relevant clinicians must be on board to ensure that community workers are not overloaded. There is an opportunity to do more, and an increase in personal care budgets would help in managing that. Q. Are the problems reflective of problems in the mental health Trust? There are delays in diagnosis compared to NE Essex and work is ongoing to improve that. Diabetes and dementia are two areas which the Alliance is working on to improve. The Cassius plus service is doing fantastic work and was praised by the ICB Board. The dental, ophthalmology and pharmacy commissioning will be considered by the ICB next year and the aim is to have more NHS capacity in the community from April 2023. There is also a process in place to refresh the ICB strategy. National benchmarks should be aspired to, along with setting goals over the next few months. Q. What is happening in other areas e.g., reducing obesity? This sits within one of the Live Well Domains (Be Well). It was agreed that a deep dive into some of the Live Well Domains would be helpful in order to understand them better. **Action: To bring the Live Well Domains to a future Board meeting**	**P Wightman/ C Mawoyo**
3.3	**Digital Board Report** The Board noted the report. A question was raised about the communication of the closure of Pillar 3. This is being stood down – it is now an Alliance wide issue rather than just a Trust focus. It was noted that digital concerns had been brought to the Improvement Committee. It is important to link these in with the Digital Board. Many change requests had been processed and there was a	

	question around whether these are being prioritised adequately. It was agreed that a report to the next Board meeting would be helpful. **Action: To report to the next Board meeting on digital prioritisation.**	**C Black**
4.0 ASSURANCE		
4.1	**Insight Committee Report** The Insight Committee Chair presented the report. The reduction in waiting times was highlighted, but concerns remain in endoscopy, the ED, and MRI. MRI has a potential solution, with a business case being prepared for a new scanner. With regard to the cancer services deep dive, it is clear that the problems with some targets are well understood and good plans are in place to address the issues. Community paediatrics remains a significant concern. Staff are prioritising those patients with complex needs. There is a growing number of children referred with possible neurodiversity which is very complex and involves several areas of the system. There is a need to understand what the service can and should provide. Concern was expressed about the high number of 12-hour trolley waits. The reasons for this are complex and there is a plan in place going forward, but the same assurance cannot be given to that, as to some of the other areas.	
4.1.1	**Self-certification** The Chief Operating Officer explained that WSFT is required by NHSE Eastern Region to complete a self-assessment in relation to our recovery of elective performance. The self-assessment has been signed off by the Executive team because of the timescales involved and submitted to region. This will be considered in the Insight Committee to make further improvements, recognising some of the constraints involved. **Action: Insight Committee to bring back assurance to the Board and identify how to reach better compliance.**	**R Davies**
4.1.2	**Cancer Performance Standards** The Chief Operating Officer (NC) presented the report and stated that the plans are monitored through the Insight Committee and at the ICB. The Trust has not met most of the cancer performance standards for some time. The priority now is around an audit of best practice timed pathways – if patients receive diagnostics within 28 days, they will	

	receive treatment within 62 days. We are successful in the 31-day target from diagnosis to treatment. Delays are generally within the diagnostic pathway and there is a plan to address those areas which require improvement. Q. What are the challenges in terms of achieving next steps? Diagnostics are a challenge, including ageing equipment. There are also clinical capacity and workforce challenges. There are risks around the plan and these should be clearly articulated. Some clinics have dedicated resource for those on an expected cancer pathway. Peaks in demand can be difficult to deal with but clinics have more flexibility to be more resilient - more presentations have been seen following media campaigns and high-profile cases. Plastics will be increasing their workforce with two more fixed term consultants joining, and interviews next year for two more permanent consultants.	
4.2	**Finance and Workforce Report** The interim Executive Director of Resources (NM) presented the report and highlighted the following: • A small overspend to date of £200,000 • Concerns over the coming months about depreciation and pay awards. The Trust is still forecasting break-even but there are some risks associated with funding, and other mitigations • Planning for the next FY will begin soon, and by the next meeting the position for next year should be clear. Business plans are being prepared which should help inform the position. Q. With regard to the 10 risks to performance listed on page 3 of the report, which ones are most worrying and if we have a deficit, are there any implications for the Trust? No central penalties have been made clear. Should there be an overspend across the system, another organisation may underspend to compensate. There are specific issues around depreciation associated with RAAC, pay awards are a risk, as well as an increase in consultants' additional payments. There are risks, but also mitigations. Some may be funded but the position is still unclear at this point. NM confirmed that the system budget includes WSFT, ESNEFT and the Ambulance Service. All three are broadly on track at present. A regular update on this will be provided in the finance report. NM also confirmed that with regard to capital, brokerage is still the intention, but it is likely that diagnostic equipment will be funded centrally rather than through brokerage. **Action: To provide regular updates on the system budget in the Finance Report.**	**N Macdonald**

4.3	**Seasonal Planning** The Chief Operating Officer (NC) and Director of Integrated Adult and Social Care Services (CM) gave a presentation on the Alliance seasonal plan for West Suffolk, in which WSFT plays a part. CM drew attention to the following points: • The plan does not reflect business as usual work, which is ongoing. It covers various elements within elective and emergency care. Schemes are prioritised based on impact and ease of implementation • Activity includes the ageing well programme, virtual ward delivery and providing adequate support in care homes. Some of the schemes in West Suffolk include working with care homes, the hospice and the wider care market in order to support pathway 1 discharges • Additional schemes being considered include a discharge vehicle to support urgent and emergency care, and how integrated neighbourhood teams can relieve some of the pressures • Expansion of the GP steaming provision in the ED is being considered. • The bulk of the schemes have commenced and are live and supporting flow in the system. Some require more strengthening and we have seen good progress with delivery. Live in are (red rated) is an opportunity to work with adults to discharge them to their own accommodation with support during the day. The team is working with the care sector to bridge the gap. NC explained the risks and mitigations. At present there are extreme pressures despite increased support in the community. Turnover within the workforce (reablement support workers and care staff) is also being seen. The bed model takes into consideration predicted activity with particular challenges around the RAAC programme. Elective activity has been set at 104% of 19/20 activity in order to reduce waits. There is likely to be future fluctuations in Covid demand which has also been factored in. A decision was made to reduce the RAAC programme to only one ward being available, however the programme is still on schedule. Mitigations from all of the schemes have been included, but not necessarily factored into business as usual, some of which has changed the model of care. The good news is that the elective bed base has a surplus, but not in non-elective. <u>Q. Where does Newmarket capacity fit into the bed base?</u> Newmarket has been taken out of the acute bed base but is part of the wider bed base capacity.	

	Q. Could we pause some of our RAAC work? The challenge is to balance the RAAC programme with the plan, which is why the RAAC programme has been reduced to one ward. In any case staffing two wards would not be possible, and the RAAC risk represents a health and safety risk and therefore cannot be paused. Q. Some patients stay much longer than they should in Norfolk and Waveney – how are we supporting that? There has been an improvement in discharges and we are now working on improvements for those who require step down support. Q. What is the variation in terms of day of week and time of day seeing patients, and the time they leave? Patients are not being discharged early enough in the day. We are trying to even out the variation over the week including weekends, which has not made as many improvements as we would like. A deeper evaluation of areas to be worked on is taking place. Q. How can inappropriate presentations to ED be prevented? This forms part of the Ageing Well initiative in terms of urgent community response. The early intervention team has strong links to primary care and the ambulance service and provides effective response within the community.	
4.4	**Improvement Committee Report** The Improvement Committee Chair (LP) presented the report. Key headlines were an increase in concerns over patient safety issues and duty of candour; frailty and medication safety; and the patient safety strategy. Also mentioned was the quality & learning report dated 10 October 2022 (previously reported to the Board), which included learning points and improvements that had arisen from activities including investigations in our PSIRP, thematic review of incidents and patient feedback. At the November meeting the key theme was the change process and assurance around how that is delivered. With regard to the Ockendon and organisation recommendations, the Committee can provide partial assurance but some traction is required. The difficulty is that staff are busy in clinical activity, and consideration needs to be given to how we can achieve assurance without making additional work. Lessons can be learned from the maternity service, which has achieved improvements and could be replicated elsewhere. The transformation structure needs to be better understood. This is under discussion and will be brought to the Board for scrutiny. NC	

	reported that this was discussed at a Senior Leadership Team meeting this week and a proposal will be submitted to the next SLT meeting in December. ESNEFT has resources which could be tapped into.	
4.5	**Quality and Nurse Staffing Report** The Deputy Chief Nurse (DS) presented the report and highlighted the following points: • A decline in fill rates due to an increase in demand in some areas • The total Trust WTE RNs is the largest number seen for a long time • The SNCT review was completed and the process for how this was completed had been presented to improvement committee for assurance that the process is evidence based and uses validated methodologies. Recommendations for any suggested changes in establishments will be presented to the Investment Panel • The rise in sickness rates is noted. However, there has been improvement anecdotally in November • The Nursing Times Workforce Awards, in which WSH was nominated in 6 categories. The Trust was not successful in winning any, but this was very positive recognition for the organisation. <u>Q. What can be done to retain nursing assistants?</u> Locally we can cast the net wide to fill vacancies, but this sometimes attracts staff who do not understand what the role involves. Attrition has been reduced but nursing assistants do leave, sometimes attributed to pay. Role descriptions are being examined within the system, and lessons can be learned from other regions about their experiences and processes to retain staff. Open days are being considered to market the hospital for a variety of roles, and demonstrating what care actually is. It is not clear why staff are leaving or where they are going to. Research is needed to understand what is driving the turnover, and this has been requested from the system. Concern was expressed about the interpretation the making data count narratives relating to common/special cause variation. DS explained that common cause variation means that it is not changing but this is not necessarily reassuring and needs to be monitored. <u>Q – Could we build a narrative about what we need to do to make changes?</u> There are some areas which are constantly hitting the target and there is a question about whether we should aim higher. There is more work	

	to be done on how we use the narrative to give explanations. This also needs to be socialised publicly. It would be helpful to have a Board session on the Making Data Count charts to get a better understanding of the data. **Action: To schedule a Board session on Making Data Count and IQPR.** <u>Q. Do fill rates in AAU exacerbate the issues in ED? Why are the day fill rates affecting that area more than others?</u> Fill rates in AAU do affect the ED. The ED is a difficult area to work in with significant pressures. We have effective processes to mitigate risks, but this comes with its own risks and consequences. Nurses choose to work in ED and AAU because they like the clinical speciality. ED nurses work in a different way to those choosing to work in inpatient areas, however, with long waits in ED such as the work is changing and they are required to carry out tasks other than those which they would normally do within the ED footprint. An update on international recruitment would be welcome. Recruitment for AHPs and midwives has not been as successful as other professionals. **Action: To update the Board on international recruitment and support for AHPs.**	**R Jones** **D Spooner**
4.5.1	**Maternity Services Quality and Performance Report** The Head of Midwifery (KN) presented the report and drew attention to the fact that the service has now officially exited the Maternity Safety Support Programme. The ongoing plan is to continue to meet all of the standards. KN highlighted two issues related to reporting to the perinatal mortality review and ensuring that the labour suite coordinator is supernumerary. However, neither of these impacted on patient safety. With regard to training, a lead multidisciplinary trainer has been employed to ensure that all staff have received all the training they require. NHS England are looking to introduce a single delivery plan which may identify that we will need 5-7 mandatory training days and which will require an uplift in staffing. Training is required in foetal monitoring although labour suite coordinators have full sight of monitoring and are assured that all patients are receiving safe care. <u>Q – Are there any processes for collaborating with other hospitals in the area?</u>	

	A safety forum exists to meet and share QI projects and experiences regarding triage, there is a structured approach to ensure that care is same across the region. It was noted that the new NEDs had much to learn about the maternity service and would welcome time with experts to understand more. Referring to the earlier question from a Governor about the use of agency midwives, KN said that it had been tried, but they are in short supply. If agency midwives had been employed, they would have received mandatory training first. It was noted that despite a considerable move of services during remedial building work, fantastic care had continued through all the complexities. It was also noted that WSFT continues to ensure that we are transparent and honest in terms of incident reporting and actions. The Regional Chief Midwife (WM) commented that the organisation has grown tremendously over the last two years, which could be attributed to transparency, as well as Executive and Board engagement and recognising the importance of maternity services.	
4.6	**Involvement Committee Report** The Involvement Committee Chair (AR) presented the report and noted that it was only possible to give partial assurance on the issues discussed in this committee. The Equality, Diversity and Inclusion report was considered at the last meeting. This is an ongoing challenge, but much work is being done in this area. Several issues will be on the agenda next month.	
5.0 GOVERNANCE		
5.1	**Audit Committee Report** The Audit Committee Chair (AR) presented the report and noted that there had been considerable discussion about data security and protection following an unsatisfactory internal audit. This is a permanent risk on the whole NHS.	
5.2	**Remuneration Committee Report** The Remuneration Committee Chair (AR) presented the report and noted that there is more transparency which can be seen in the report.	
5.3	**Governance Report** The Trust Secretary (RJ) highlighted that the GGI report was received at the last Council of Governors' meeting, and a plan is in place to	

	implement the recommendations. The Board assurance framework and risk management process will be started with agreement from the Board. The NEDs' responsibilities have been updated, and committee terms of reference are being revised. Five terms of reference are presented for approval. **The Board approved:** • **a board assurance review with a focus on the BAF.** • **terms of reference of Insight Committee; Improvement Committee; Involvement Committee; Board Remuneration and Nomination Committee; and Audit Committee.**	
5.4	**West Suffolk NHS Foundation Trust Annual Report and Accounts 2021-22** The Board noted that the Annual Report and Accounts 2021/22 have been laid before the Parliament and are publicly available on the Trust website.	
6.0 OTHER ITEMS		
6.1	**Any Other Business** The Board and sub-committee meeting dates for 2023 were approved. **Action: To circulate the Board and sub-committee dates as an email and send out diary invitations.**	**R Jones**
6.2	**Reflections on meeting** • The venue acoustics were slightly better, but the noise of the A/C was a little problematic. • Good to have natural light. • A microphone for presentations might be useful, and/or a roving microphone for speakers. • It would be good to receive feedback from newcomers in particular.	
6.3	**Date Of Next Meeting** Trust Board Open**:** Thursday 2 February 2023	
RESOLUTION The Trust board agreed to adopt the following resolution: - "That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" Section 1 (2), Public Bodies (Admission to Meetings) Act 1960		

1.4. Action log and matters arising

To Review

Presented by Jude Chin

Board meeting - action points

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
2070	Open	30/9/22	10.3	Involvement committee to consider the issue of staff shifts and rota patterns (inc in radiology)	**Matter referred to Involvement Committee in February.**	JMO	~~31/01/2023~~ 28/02/2023	Green	
2077	Open	25/11/2022	3.2	***System Update - ESNEFT -*** It was agreed that both trusts should publicise the vision and principles for the collaboration internally and externally.	**Meeting planned with Comms to progress in mid-January.**	NC	02/02/2023	Green	

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

Board meeting - action points

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
2058	Open	22/7/22	4.4	For the new CQC model assessment to be discussed at a future board meeting	New model is now published and engaging with national programme for delivery. Review scheduled for Improvement committee in January '23. **Annex attached to today's (2.2.23) papers refer.**	NC/SW	30/01/23	Complete	02/02/2023
2075	Open	25/11/2022	1.6	***Questions from Governors & the*** *Public* - Copies of slide presentations for governors	**The presentations have been added to the Board pack on Convene.**	RJ	02/02/2023	Complete	02/02/23
2078	Open	25/11/2022	3.2.1	***Alliance -*** To bring the Live Well Domains to a future Board meeting.	**Today's agenda item (2.2.23) refers.**	PW/CM	02/02/2023	Complete	02/02/23
2079	Open	25/11/2022	3.3	***Digital Board Report -*** To report to the next Board meeting on digital prioritisation.	**Today's agenda item (2.2.23) refers.**	CB	02/02/2023	Complete	02/02/23
2080	Open	25/11/2022	4.1.1.	***Self-Certification*** - Insight Committee to bring back assurance to the Board and identify how to reach better compliance.	**This was discussed at Insight on 9 January, 2023 with an update on progress on compliance (RAG rated). This will continue to be monitored through PAGG and reported to Insight.**	RG	02/02/2023	Complete	02/02/23
2081	Open	25/11/2022	4.2	***Finance & Workforce Report*** - To provide regular updates on the system budget in the Finance Report.	**Today's report (2.2.23) refers.**	NM	02/02/2023	Complete	02/02/23
2082	Open	25/11/2022	4.5	***Quality & Nurse Staffing Report*** - To schedule a Board session on Making Data Count and IQPR.	**Link to previous presentation shared with Board members.**	RJ	02/02/2023	Complete	02/02/23
2083	Open	25/11/2022	4.5	***Quality & Nurse Staffing Report*** - To update the Board on international recruitment and support for AHPs.	**Today's report (2.2.23) refers.**	Dan Spooner	02/02/2023	Complete	02/02/23

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

2. 9: 20 - PEOPLE AND CULTURE

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

To Note

Presented by Jude Chin

2.2. Patient / staff story

To Review

Presented by Susan Wilkinson

2.3. Chief Executive’s report

To inform

Presented by Craig Black

Board of Directors - Public

Report title:	**CEO Report**
Agenda item:	2.3
Date of the meeting:	2 February, 2023
Sponsor/executive lead:	Craig Black, Interim CEO
Report prepared by:	Daniel Charman, Communications 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
A round up of key issues and projects across the Trust
Action Required of the Board
For information

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

You'll be aware that the Trust has undergone a uniquely challenging period. We have experienced higher levels of demand for our services which has been affected by the increased prevalence of Covid-19 and flu, as well as other operational challenges.

I am very proud of the work all my colleagues have produced during this time, rising again to deliver the level of service we strive to provide to our communities. However, this is another time when ~~my~~ colleagues have had to step up to even higher expectations and has involved significant planning across the organisation, the alliance and our system partners who worked together to ensure we provide safe and high-quality care. I am sure you will join me in sending the warmest of thanks to everyone, as they have worked tirelessly to ensure we continue delivering our services.

Right Care, Right Time, Right Place review

Our initial modelling suggested that we would be under significant pressure over the Christmas and New Year period, which was shown to be correct. Pre-empting this, the Trust undertook the 'right care, right time, right place review' to ensure that the processes in place which supported the flow of patients through the Trust were as effective as possible.

From this, there has been a sustained focus on ensuring we are utilising the mechanisms we have at our disposal so that those who are ready to leave hospital can go home at the earliest opportunity, and that those who come through our doors requiring our care are able to access this at the right time and in the right place. I am pleased to say that these preparations helped us protect our services so we could be there for those who need us.

RCN industrial action

We have also been very busy preparing for the Royal College of Nursing (RCN) industrial action which took place on Wednesday, 18 and Thursday, 19 January. We worked closely and productively with the strike committee to put processes in place to support patients and colleagues during this time. I would like to thank all those who took part in these honest and collaborative discussions which have laid the foundations of a strong relationship as we get ready for the next round of industrial action which takes place on Monday, 6 and Tuesday, 7 February.

NHS Patient Survey Programme maternity results

In January, we received the maternity results from the 2022 NHS Patient Survey Programme which is commissioned by the Care Quality Commission (CQC). I am proud to say that this year's results show an improvement in the quality of the service we provide where the majority of areas ranked at or above the national average when compared to other Trusts. I am pleased to say that in no part of the survey did we perform 'Much worse than expected', 'Worse than expected' or 'Somewhat worse than expected'. In fact, we performed 'Somewhat better than expected' in three areas and 'Better than expected' in two areas, which can be attributed to a significant effort from all of those in our maternity services. While there are areas that we will continue to improve, these results demonstrate how as a Trust we continue to work to deliver the highest quality services we possibly can.

Notable projects for 2023

Going forward into this New Year, we have exciting projects that we all look forward to making progress on, which will help us provide an even better of standard of care for those in our communities. The work to deliver a new healthcare facility on Hardwick Manor in Bury St Edmunds made significant progress in 2022 with the successful application for outline planning permission. This year, we will continue to work closely with the Government and

the local planning authority to further develop these plans so we achieve our ambition of delivering this facility by 2030.

We will also be making progress on the new community diagnostic centre on the Newmarket Community Hospital site. This facility, which has received backing from our partners at the Suffolk and North East Essex Integrated Care System, will help us deliver almost 100,000 tests to those in local communities. This will help provide quicker access to tests and reduce health inequalities across the region.

Update from the Suffolk and North East Essex Integrated Care System

As detailed in the last updated, the integrated care system (ICS) has launched a programme encouraging students searching for employment, recently retired health workers and people interested in healthcare careers to become NHS Reservists. As of January 2023, more than 700 applications have been received for the programme, with screening of applicants now underway. Reservist model options are currently being developed and a revised recruitment campaign also designed.

The system has undertaken extensive consultation with those living and working in Suffolk and North East Essex, asking them what is important to them in health and care, and how we should be thinking differently. We offered a range of ways for people to share their views, which included completing an online survey, conversations with community groups and recording their views in our pop-up video booth. From this, we learned that ‘timely and convenient access to health and care’ was important for many respondents, and that ‘access to, and quality of GP services’ was the single biggest issue highlighted.

The result of this is the system’s integrated care strategy, which aims to build on and bring together earlier work and thinking with our system partners to deliver a strategy that aims to deliver on our collective ambitions of the system by focusing on what matters to those in the region. We are glad to say that this has now been app

2.4. People & Organisational Development highlight report

Amanda Bennett in attendance

To Assure

Presented by Jeremy Over

Board of Directors - Public

Report title:	**People & OD Highlight Report**
Agenda item:	2.4
Date of the meeting:	Thursday 02 February 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

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

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

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

People and OD highlight report

1.	**Introduction**
1.1	The People & OD highlight report was established during 2020-21 as a regular report to strengthen the Board's focus on how we support our people, grow our culture and develop leadership at all levels. This format will continue to be developed, alongside the CKI report from Involvement Committee, to reflect the work that is ongoing, bringing together various reports that the Board has routinely received into one place. In addition to discussing the content of the report, and related issues, continued feedback is welcomed as to the structure and content of this report and how it might be developed in future. This month the report provides updates on the following areas of focus: • Putting You First awards (December/January) • Freedom to Speak Up Guardian Report Q3 2022/23 • Responding to industrial action at WSFT • Improving and strengthening our recruitment practice • What matters to you 2 – update / progress • Strengthening our OD capacity & capability • Physiotherapy support for staff and WSFT • Relaunching our staff networks • Cost of living support for colleagues 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 (December / January)**
2.1	Kathy Hammond – specialist physiotherapist, *nominated by Helen Stewart Physiotherapy Professional Lead* We had a lovely letter from a very happy family with regards to the treatment and service that one of our Specialist Physiotherapists, Kathy Hammond, gave to their son. It finishes with the below statement: *"I have no doubt in my mind that had we not had Kathy through all of this then the outcome would not be the same. There is so much to thank her for, for myself, the family generally and for "son". We are just so grateful. I felt it was important to let you know how important Kathy and the service has been to us and to thank you all for your care, especially in difficult times."* I would like to nominate Kathy for a putting you first award. Kathy has been in our team for more than 20 years, and this email is not the first that we have received.
2.2	Rose Hazell-Evans – radiographer and Leah Alexander – radiographer, *nominated by Kelly Fuller, Head of Radiography* Rose trained as a radiographer at WSH and after working in general x-ray she then specialised in nuclear medicine scanning, gaining a Masters degree. A short while after this she started training to report some of the scans (reporting would otherwise be carried out by a radiologist so this frees them up to report other examinations) and gained a PgCert in reporting. Rose is now starting to report independently. This is a very rare role in radiography and I am not aware of any other radiographers reporting nuclear medicine scans, certainly not within the region at least.

	Leah trained as a radiographer at WSH and then worked elsewhere as a general radiographer before returning to WSH. After a bit more time in general x-ray here she then specialised in CT scanning. After a few years Leah then started training to report CT head scans and gained a PgCert. Leah is now starting to report independently. This role is not carried out in all NHS Trusts and is still relatively rare in radiography. Both Rose and Leah were supported by the radiology department to complete this training which was funded from the Trust's education/CPD fund. They have both worked incredibly hard to gain these extra qualifications and both roles are new to the WSH Radiology department. Rose and Leah are now part of a large group of reporting radiographers at WSH who report plain film (x-ray) images, MRI scans, fluoroscopy cases and CT Colonography. As a department we are very proud of the wide range of knowledge and skills the team have developed. These skills allow us to provide an excellent service for our patients while supporting the radiologists to focus on reporting other imaging exams. This goes a long way in bridging the radiologist workforce gap while promoting career progression and professional development for radiographers.
3.	**Freedom to Speak Up Guardian report – Q3 2022/23**
	Amanda Bennett, Freedom to Speak Up Guardian will present her Q3 report at the Board meeting on 25 November, which is included as an appendix to this item.
4.	**Responding to industrial action at WSFT**
4.1	Last year, the Royal College of Nursing (RCN), the trade union for nursing staff, balloted on whether to carry out industrial action as part of a national campaign related to pay and wider national workforce concerns. They gained support from their members, and in December 2022, 44 Trusts saw strike action taking place, albeit WSFT was unaffected. With new strike dates of 18 and 19 January 2023 having been announced, and the number of sites expanding from 44 to 55 NHS employers, we saw industrial action taking place at WSFT on these dates. Without a resolution to the pay dispute, further strike dates will be announced in the future and we have been confirmed as a strike site on 6 and 7 February 2023. We understand the issues that underlie this campaign and are aware that for many colleagues who took part in the vote they did so reluctantly and with a heavy heart. We recognise the dispute isn't between the Trust and the Trust is supportive of colleagues' rights to take legal action. Other trade unions of NHS staff including Unite, GMB and Unison have also balloted their NHS members to take part in industrial action with strikes already having taken place before Christmas and others planned for the coming months. Other medical unions such as the British Medical Association are also balloting their junior doctor membership.
4.2	Our priorities in relation to this action were: • To maintain safe patient care • To support our staff who wish to exercise their rights to take legitimate and legal action We undertook robust planning for those days affected by industrial action and worked to support patients and colleagues alike. Strike action undertaken by RCN members followed the 'life preserving care model'. In that regard, the RCN agreed national level derogations. A derogation is an exemption, either of an individual or a whole service, from taking part in strike action so that we can safeguard crucial services. The national service level derogations agreed with the RCN were: • Critical Care Units e.g., ITU/HDU • Dialysis and chemotherapy services • Neonatal and paediatric ICU

	• Paediatric A&E The following national staffing level derogations were also agreed by the RCN: • In-patient areas to be on night-duty staffing levels • 'Front-door' urgent care assessment and admission units (including adult emergency departments) to be based on Christmas Day staffing levels • 'Front door' urgent care assessment and for paediatric standalone emergency departments to be run as Christmas day rotas. Where paediatric urgent care assessments occur in a general emergency department, these were derogated to Christmas Day rotas • Specific derogations were also agreed for mental health and learning disability & autism services as part of an emergency crisis response • Community services were derogated to Christmas Day staffing, allowing community teams to provide clinically urgent interventions and palliative care There was also the opportunity for us to apply for additional derogations, directly to our RCN Strike Committee, which we did and a number of which were supported. As part of our response to the strike action we provided regular supportive briefings for colleagues and ran specific sessions for both staff and managers to attend. We also provided a conduit for questions to be asked, anonymously if preferred, which the HR team then responded to. On the two days of strike action a team of 'incident responders' were based in the Northgate meeting room, led by our chief and deputy chief nurse, supported by senior nurses as co-ordinators, redeployment leads and members of the workforce and communications team, who managed the days, mitigating the risk of areas that were under derogated levels, redeploying colleagues where appropriate to ensure all relevant areas were safe for our patients and colleagues. Relationships with our RCN partners were really collaborative and co-operative, mutually respecting each other's position and feedback from the RCN was how inclusive we had been in dealing with the strike action. An After Action Review took place on 24 January 2023 to ensure that any learnings were captured as we move forward into further strike action.
4.3	Whilst through detailed and robust planning we were able to safeguard clinical activity deemed a priority, through the use of derogations described above, there was nonetheless an impact with certain work postponed to a later date. In summary, this was as follows: • Most routine elective and diagnostic activity which required nursing staff was postponed with a plan to reschedule within 4 weeks • Within the Medicine Division most clinics were converted to doctor-led telephone appointments and some face-to-face clinics that did not require nursing support • Within the surgical division 118 procedures were impacted, the majority being day case • Outpatient planning within the surgical division is more complex, with 660 appointments affected over the two days • The aim is to align recovery from the industrial action with the 78-week recovery trajectory, with no anticipated impact on delivering zero patients over 78 weeks by the end of March (excluding uro-gynae) • Routine community activity was postponed, delaying up to 600 patient interventions each day of the strike, with a plan to reschedule within 1 week
5.	**Improving / strengthening our recruitment practice**
5.1	Various areas for improvement have been identified and plans made to strengthen recruitment practices and processes in our general recruitment team and West Suffolk Professionals (Staff Bank).

	Within the general recruitment team we have restructured the work processes so they are now allocated by division as opposed to tasks. Each recruitment assistant has a particular area of responsibility and they cover all recruitment matters for their area. They are backed up by a deputy so there is no drop in service during periods of absence. The new structure has received a lot of positive feedback from the divisions, and also from within the team itself as the staff feel they have more ownership and responsibility. Our paperwork and written correspondence has also been reviewed to reduce the bureaucracy but also make our messages to managers and candidates clearer and easy to follow. A review undertaken within West Suffolk Professionals (our temporary staffing team) has shown that the recruitment process requires some improvements and these are planned to begin in February. There will be joint nursing assistant interviews with the general team to speed up interviewing and onboarding and reduced bureaucracy in the registration process for existing substantive staff. A business case for a new recruitment system has been prepared and, if accepted, this new software will dramatically improve the recruitment processes for all teams by reducing the administrative burden and improvements will be made in the communication and transparency for candidates and managers. NHS Jobs training for managers continues. To date over 120 managers have been trained on how to use the system to ensure effective shortlisting of candidates. Various recruitment events have already taken place and our first WSFT recruitment event in many years took place on 24 January at our Newmarket Community Hospital. We have been working with the DWP to arrange some interviewing days at their job centre sites and these will begin from 27 February. A resourcing strategy is being written in stages, with the international recruitment element now out for consultation. Once complete, the strategy will provide guidance to all in the Trust on our objectives and action plans for each element. These plans will also then allow for an evaluation at agreed points.
6.	**What Matters to You 2**
6.1	Further to the update provided to the Board in November 2022, the 'What Matters to You 2022' campaign continued to run throughout December. Building on the listening sessions that had been completed across 19 community locations, listening sessions were also held across 19 different teams/areas of the hospital. Over 300 staff in total attended a listening session and spoke openly about their experiences at the Trust. In addition, 290 staff completed the online feedback form providing additional insight and information. The data gathered is currently being analysed in full, including being triangulated with the early outcomes of the NHS staff survey. A report and action plan will follow shortly. Early indications suggest key themes emerging include: 1. The **basic human needs** of rest, recovery, hot food and drink 24/7, and safe access to work across multiple locations because of the challenges of car parking, are not being met. Staff feel "broken" as a result, struggling to operate without these basic essentials in place. 2. Multiple issues related to **staffing** are being reported, including staffing levels; retention; reward and recognition; skills gaps and variation in skills; recruitment; and having time and space to rest, recover, learn and function well with one-another. 3. There is a significant deficit in **leadership and management capabilities and skills**, including high levels of variation in terms of support provided to staff. Whilst there are examples of excellent practice in some areas, staff reported experiencing that leaders / line managers do

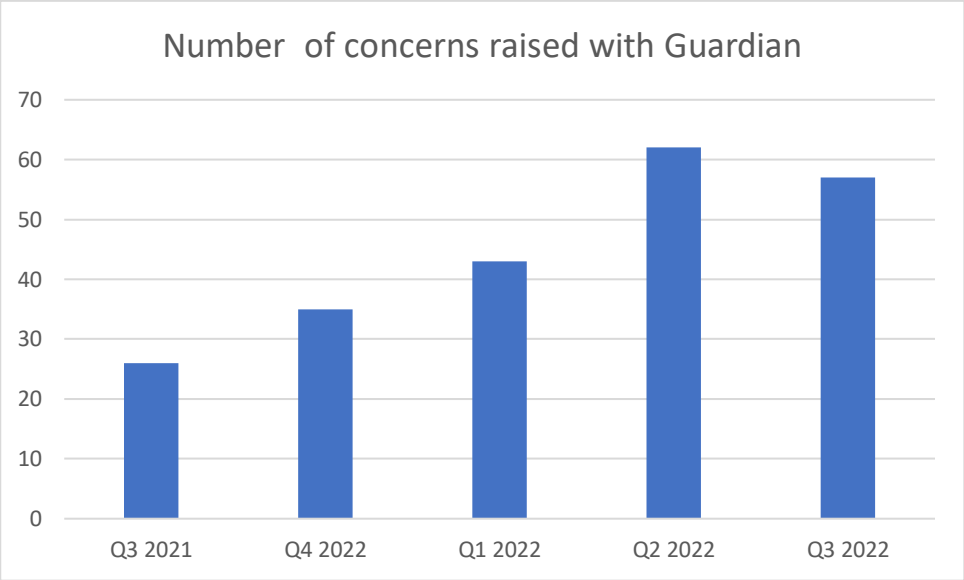
	not always communicate with teams or support the career development of staff. The enhancement of leadership practice is therefore essential at all levels. 4. Staff welcomed being heard as part of this listening process, although cited **communication** as remaining a key challenge for the Trust. This included staff not feeling listened to as well as a lack of clarity and understanding about Trust wide and local matters. This reiinforced the current skills gap in line manger two-way communication, and the need for giving time for *effective* communication as part of everyday interactions. 5. Continued work on the **culture** at the Trust is evident, including reducing fear, bullying, and hierarchy. There is a need to improve safety to speak-up with visible action taken, respectfulness, confidence to check and challenge, appreciation of colleagues, and unifying acute and community areas. Some staff groups still need to feel more supported by their line manager, colleagues, and the Trust as an organisation. 6. A wide range of clinical and non-clinical **process inconsistencies** were highlighted, with teams operating differently or having differing equipment/tools and levels of support to do their job. This was most apparent as people moved between wards or across community locations, with staff seeing good practice and feeling dis-empowered to make changes. This was also cited in corporate and non-clinical areas. The next stage of the What Matters to You 2022 campaign will involve the roll out of a 'Living our Values' one hour workshop, run online and face-to-face multiple times and in multiple locations. These sessions will invite staff to explore the Trusts FIRST values and define the behaviours associated with these. The culmination of this work will result in a co-created behavioural framework for the Trust which will be integrated into HR and other processes. This work has already started in some areas, including across integrated community teams where values from separate organisations have been combined and reviewed to enable shared team working.
7.	**Strengthening our OD capacity and capability**
7.1	Further to the update provided in November's board report, a range of new roles covering OD and L&D have been evaluated, approved, and will be advertised shortly. This will significantly enhance the Trust's capacity and capability to support leadership, management and staff development, as well as support coaching and mentoring; online learning; career development and succession planning; reward and recognition and health, wellbeing and inclusion. The Learning Hub, a new online learning environment for all staff is in the process of being launched with plans to grow and develop this significantly over time. Work across the system to identify mutual challenges, opportunities and areas of best practice that can be shared is also progressing, with the OD and L&D leads working together to develop a plan for consideration by the ICS People Board.
8.	**Physiotherapy support for staff and WSFT**
8.1	The WSFT physiotherapy service, run and delivered by Mike Chatten, continues to meet all KPI's with staff being seeing in a timely manner. In a recent patient satisfaction survey: • 97% of respondents rated their experience of the service as very good, which was the highest rating • 93% were satisfied with the assessment and subsequent treatment provided • 100% of staff reported they were treated with dignity and respect Typical feedback from the survey included: *"I was treated quickly and effectively and with respect. All staff were friendly, polite and professional, I have nothing but praise and thanks for my treatment."* *"Regular appointments at a time convenient for me. There was flexibility about frequency of appointments. I found the treatment advice realistic and tailored to my lifestyle."*

	"Mike always explained what he would be doing in each session, always asked for consent before starting treatment, really approachable and friendly person which made the overall experience much more comfortable. Was extremely helpful with pointing me in the right direction regarding my referral." Analysis has also been undertaken of MSK rates over the last 5 years, including investigating the sharp increase in sickness days reported lost in 2022 due to MSK injuries. A range of potential explanations have been explored and work is progressing to mitigate risk and reduce reported sickness rates in this area. In addition to this service, recent developments across SNEE has seen the appointment of Connect for Health on a 12 month contract. Whilst primarily providing a service to ESNEFT and other SNEE partners who do not have access to physio services for staff, this partnership will augment our service by providing cover for annual leave and sickness, as well as enabling extra capacity for the service, and additional options in terms of choice of physiotherapist. We are currently working with Connect for Health to enable a smooth launch.
9.	**Relaunching our staff networks**
9.1	Three staff networks have been in existence at WSFT previously although have waned over the past 12-18 months: 1. BAME staff network, for Black, Asian and other ethnic minority staff and allies 2. Disability network, for colleagues with a disability, health condition or neurodifference and allies 3. LGBT+ network, for colleagues who are lesbian, gay, bisexual A new governance framework has been agreed by the Trust Executive which sets out clearer parameters within which these networks will operate in the future, and the important role they will play for individuals and the Trust as a whole. As a result, the networks have met recently and are in the process of appointing chairs and co-chairs, as well as determining terms of reference and priorities. Executive board sponsors are also being identified for each network group. Work is continuing on communicating these networks more widely, embedding their role and purpose, and enabling them to become vibrant and supportive spaces.
10.	**Cost of living support**
10.1	In recognition of the challenging cost of living conditions staff are facing, the Trust has conducted a review of impact, need and potential options for support. A range of staff were interviewed as part of the data gathering process, and recommendations were made relating to low, medium and high cost/effort options. All of the low cost/effort options have been progressed, including the introduction of Wagestream – a new financial tool to enable staff to access their wages as they are earned, and to establish saving pots. This initiative has been very successful, with the initial rollout exceeding the 10% threshold meaning a higher rate of interest is now being applied to all savings pots opened. Work to progress other options is continuing, including the recently announced funding from HEE to provide all staff with a Blue Light Card. A detailed evaluation of all activities implemented will be undertaken to measure success and impact.
11.	**Recommendation**
11.1	To note and provide comment and/or feedback on the report.

Appendix: Freedom to Speak Up: Guardian's Report Q3 2022: Oct-Dec 2022

Introduction

The number of concerns raised with the Guardian has decreased slightly from the previous quarter to 57



Data

Data submitted to the NGO for Q3 is shown below:

Total number of cases	**57**

Raised by professional group:

Allied Health professionals	6
Medical and Dental	2
Ambulance	0
Registered Nurse and Midwife	14
Administrative and Clerical	7
Additional professional and scientific and technical	1
Additional clinical services	3
Estates and Ancillary	5
Healthcare Scientists	4
Students	0
Not known	14
Other	1

Number raised anonymously	14
Number with an element of patient safety / quality	12
Number with an element of worker safety or wellbeing	44
Number with an element of bullying and harassment	7
Number with an element of inappropriate attitudes and behaviours	17

What were people speaking up about?

5 people spoke up about staffing, this is a decrease from 15 recorded in the last quarter and 2 spoke up about unmanageable caseloads. 5 concerns were raised regarding facilities: 2 of these included concerns with lighting and security in the staff car parks (resolutions to which have been identified,) and 3 were regarding insufficient rest and refreshment facilities for staff (particularly at night-time). This has led to a review of the situation, changes made where practicable and recommendations passed to the future systems regarding the new hospital build.

Themes from Q3

Key themes of staffing and unmanageable caseloads seen in previous quarters remain, however no longer continue to dominate. Feedback given via staff briefings and by managers regarding current recruitment drives (e.g., international recruitment,) has been welcomed.

An element of many concerns has been strained relationships and incivility.

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.

- 8 responses were received.
- 8 people said they would not like any further action
- 1 person said they suffered detriment, and this is currently being looked in to.
- 7 said they would speak up again, one said maybe.

The themes emerging from the FTSU process evaluation indicated once again that it was a positive experience being able to talk to an independent and impartial person

"Just allowing myself to talk through my problem…made me able to move forward."

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. FTSUG to continue to liaise with WMTY2 and staff psychological support team to promote WSFT values and desired behaviours.

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

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 promoted in community; examples include:
  - Rosemary Ward Newmarket where HRBP, community matron, manager, community leads and chief and deputy chief nurse working together to make speaking up become business as usual by providing enhanced listening opportunities leading to practical actions.
- Community service lead offering listening clinics.
- New FTSU champion in community paediatric team and estates department
- Champion's network continues to grow and attract new champions

- ‘Speak up and Listen up’ training promoted Trust wide during Speak Up month and numbers of staff who have completed training is increasing

Even better if:

- Scope remains to increase champion numbers especially in community teams
- An increase in mandatory FTSU training compliance

Speaking up policies and processes are effective and constantly improved

What’s going well:

- New FTSU policy adopted and adapted to suit WSFT ratified by Trust Council Dec 2022
- FTSUG working closely with NGO and local area FTSUG network to ensure adherence with national policies and processes.

Even better if:

- Increased scrutiny from self-assessment and internal audit by creation of associate guardian role

Senior leaders are role models of effective speaking up

What’s going well:

- Questionnaire developed from the recent NHS FTSU reflection tool completed by 5 directors and results shared with executive director responsible for speaking up
- Senior leaders promoted and participated in Speak Up Month in October 2022
- Medical consultants working positively to promote and role model speaking up
- Associate director of estates and facilities actively promotes listening, psychological safety and anti-bullying throughout division

Even better if:

- Senior leaders continue to be aware of FTSU guidance and resources available from NHS England and the National Guardian’s Office
- FTSU pledge to be established for board

All workers are encouraged to speak up

What’s going well:

- Speak Up month (October 2022) 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

Even better if:

- 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

Individuals are supported when they speak up

What’s going well:

- 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
- Face to face listening training for managers offered
- HRBP active in supporting colleagues when speaking up
- Supervisors and managers in portering team actively encouraging and supporting speaking up

Even better if:

- Increased promotion regarding Trust's stance on protecting staff who speak up and a zero-tolerance approach to detriment following speaking up by issuing supporting statement

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
- Guardian completed NGO training to support an inclusive speak up culture

Even better if:

- A "you said; we did" staff communications campaign across the Trust to promote continued actions taken as a result of speaking up

Information provided by speaking up is used to learn and improve

What's going well:

- Where possible and obvious, swift action is taken to address concerns, to learn and improve.
- Concerns shared with Future System team (e.g. regarding staff facilities) to enable improvements at new site.
- Trust work and initiatives to increase and support staffing has been shared via staff briefing and the Green Sheet
- Patient transport concerns fed into Trust future commissioning / procurement planning

Even better if:

- 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 co-leading community of practice events for East of England FTSU Guardian Network
- Trust working in line with NHS and NGO guidance on speaking up
- FTSUG liaising with ICB lead for international nurses

Even better if:

- Work with ICS partners to improve FTSU

2.5. Involvement Committee Report - 19 December, 2022 Chair's key issues

To Assure

Presented by Alan Rose

Chair's Key Issues

Originating Committee:	Involvement Committee	Date of Meeting:	19 December 2022
Chaired by:	Alan Rose	Lead Executive Director:	Jeremy Over

Item	Details of Issue	For: Approval/ Escalation/Assurance	BAF/ Risk Register ref.	Paper attached?
Junior Medical Workforce GMC Survey & Safe Working Report (FIRST for Staff)	- Presentations given on the latest annual GMC survey and the latest quarterly report from our Guardian of Safe Working (a paper prepared by Dr Francesca Crawley) - Detail is available at Divisional level or similar; the picture varies across the Trust. - ITU praised as a really strong area in the GMC survey - Good general satisfaction and feedback on the Trust being a supportive environment with the following challenges noted: ■ The need to strengthen junior medical rotas in medicine (AAU), surgery and anaesthetics, through the contribution of ACPs and/or recruitment of additional medics and/or rota redesign ■ Poor flexibility/funding for study leave/regional training ■ Food availability at night (which has been resolved) ■ Concern as to the potential impact of loss of ECW work should agreement not be reached over rates	**Partial Assurance** for the Board, with specific actions via the Medical Director, especially on the rota sustainability concerns.	BAF Risk 6 (Workforce wellbeing)	

Originating Committee:	Involvement Committee	Date of Meeting:	19 December 2022
Chaired by:	Alan Rose	Lead Executive Director:	Jeremy Over

Item	Details of Issue	For: Approval/ Escalation/Assurance	BAF/ Risk Register ref.	Paper attached?
What Matters to You-2 (WMTY) & related initiatives to strengthen our Workforce Governance (FIRST for Staff)	- Jeremy Over updated the group on the early and emerging feedback from the listening process, which was still ongoing. - There is a range of views as to the impact of WMTY1, with some themes progressing more than others - Main messages currently are on the need for rest, for recovery, and a range of "staffing" themes (nothing new, but lots of strong concerns). - Jeremy reported on the plan to initiate a new "People & Culture" management committee. This will be action-orientated and the Involvement Committee will look to its output for some of our assurance.	**Partial Assurance** for the Board, but considerable efforts to extend the listening and awareness to the widest range of staff to reinforce our gradual cultural shift **Strong Support** for the setting up of the new management committee	BAF Risk 6 (Workforce wellbeing)	
Patient Experience (FIRST for Patients)	- Cassia Nice presented the 5 initiatives designed to deliver improvements through the "Experience of Care" strategy. ■ Sharing good practice ■ Improving equality of access ■ Extend feedback opportunities for patients, carers and families ■ Improve opportunities for patients to influence a range of decisions ■ Achieve a higher proportion of patients recommending WSFT - Patient Experience team now represented on WSFT Investment Panel - Team represented on ICB "Engagement Practitioners Network"	**Good Assurance** for the Board, but Cassia requested to develop clearer measures for these initiatives.	BAF Risk 1 (Quality and Safety)	
OD plan	- Jeremy Over presented an update on the OD plan that was put in place following the West Suffolk Review. He also described how the governor working group was satisfied with progress and had agreed to recommend to the full Council of Governors that the group's work is now complete, and the cultural and OD issues returned to normal oversight and governance.	**Good assurance** regarding progress with the plan, whilst noting that the issues require constant and ongoing	BAF Risk 1 (Workforce wellbeing)	

Originating Committee:	Involvement Committee	Date of Meeting:	19 December 2022
Chaired by:	Alan Rose	Lead Executive Director:	Jeremy Over

Item	Details of Issue	For: Approval/ Escalation/Assurance	BAF/ Risk Register ref.	Paper attached?
		focus to improve and develop		
ICS focus on Workforce (FIRST for Staff)	- Jeremy Over shared how we are working with ICS colleagues on workforce issues and the potential for this to be more effective.	**Limited Assurance** for the Board; Jeremy can elaborate at Board	BAF Risk 6 (Workforce wellbeing)	
Turnover & Sickness (FIRST for Staff)	- A discussion took place as to whether the higher than historic levels of sickness and turnover of staff at the Trust which, although plateauing somewhat, are now at a "new normal" level – both for WSFT and the wider NHS. Is this so and what are the implications for staffing levels and potential new workforce-related initiatives?	**Partial Assurance** for the Board; What new initiatives are we/should be considering to address this?	BAF Risk 6 (Workforce wellbeing)	
Next time: (20/02/23)	- Patient Profile project update - National staff survey - What matters to you – next steps			
Date Completed and Forwarded to Trust Secretary		**23 January 2023**		

3. 11:00 - STRATEGY

3.1. Future System board report

To Assure

Presented by Craig Black

Board of Directors - Public

Report title:	**Future System Board Report**
Agenda item:	3.1
Date of the meeting:	Thursday 02 February 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

Executive Summary

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

1. Planning permission – It is with great pleasure (and some significant relief!) that I can confirm the approval of our outline application to build our new hospital on the Hardwick Manor site that the Trust acquired in October 2020.
2. An extensive communications plan ensured the widest possible range of stakeholders were informed of this outcome.
3. There are several conditions attached to the permission that will need to be fulfilled prior to building work commencing, however, all are seen as deliverable and advanced funding for these "enabling works" has been requested.
4. One such condition is the conclusion of a "section 106[1]" agreement, the content of which has been agreed with the local planning authority and the detail of which has been submitted to the WSFT Board for signature.

[1] Section 106 of the Town and Country Planning Act 1990 allows local planning authorities and developers to enter into legally binding agreements and obligations that aim to mitigate the impact that a development may have upon its environment.

5. As reported last month, the New Hospital Programme went before the Major Projects Review Group[2] (MPRG) on 6th December. We are awaiting confirmation of the outcome of this meeting and what this will mean for our scheme.
6. The New Hospital Programme held its flagship industry day in December. Aimed at engaging those partners that will be essential to the successful execution of the programme, the event covered a wide range of subjects (modern methods of construction, commercial frameworks etc) but will probably be remembered for the announcement that all new hospitals will have single patient rooms.
7. Further to discussions on the **potential** use of Western Way as a location from which non acute services currently delivered within the Hospital could be co-located, a broader options appraisal will now be undertaken and progressed as a sub-section of our overall Outline Business Case.
8. I was delighted to welcome Jo Churchill MP, WSFT's non executive team and members of the Integrated Care Board to Hardwick Manor and to update them on the progress being made to build our new hospital. The positives of the site are clear to see, however, its challenges were also recognised and I was pleased to be able to assure visitors that we have comprehensive plans to mitigate these challenges as far as is possible and practical.
9. The initial version of the Future System Programme Digital Strategy has now been completed and will be discussed later in this paper.
10. In the next 6 weeks we expect to; sign a Section 106 agreement, learn the outcome of our application for enabling works funding, receive the first of the co-produced national standards / designs and understand the consequences of MPRG discussions

Estates Workstream

Key activities and milestones:

In last month's paper I reported "Securing a positive determination for our planning application remains the most critical risk in our programme." I am therefore delighted to report that our application has been successful. Contained within our permission are:

- Construction of a new hospital comprising up to 100,000m2,
- Surface and multistorey car park with associated infrastructure,
- Structural landscape buffer,
- Temporary construction compound,
- Demolition of existing hospital buildings,
- The change of use of Hardwick Manor from residential to health care related use.

The application was not without challenge and we retain a significant responsibility (some of which will be prescribed within the obligations of a Section 106 agreement) to ensure these challenges and mitigated.

To this end a Section 106 agreement has been agreed and contains a number of commitments that the Trust will need to honour before commencing its build. These include construction of sustainable pedestrian / cycle routes, the posting of a bond for future traffic mitigations (should they prove necessary) and the provision of funds to cover the costs of the development and implementation of various traffic regulation orders. The signing of this document will trigger the formal notice of planning and from this point anyone wishing to undertake a judicial review of the planning process has 6 weeks in which to flag their intent.

In order to progress solutions to these conditions, as well as the early planting of buffer screens and the provision of utilities to site, the Trust has submitted an application for enabling works funding. We expect to hear the outcome of our application in time for the next Board.

[2] Major Projects Review Group scrutinise major projects and advise HM Treasury

Our planning journey will now progress to the "reserved matters" phase during which the absolute size and positioning of the new hospital (along with detailed access plans etc.) will all be concluded. This activity is a major undertaking and we plan to secure full planning consent by a date that compliments the position of our project within the wider New Hospitals Programme (NHP) schedule.

New Hospitals Programme Update

As mentioned last month, our West Suffolk project had been identified as one of five 'architypes' that would be analysed with a view to establishing the costs of building new hospitals. This "sprint" has now been completed and will be utilised by the New Hospital Programme team in future modelling. We are still awaiting details on the outcome of the MPRG discussions and what this will mean for our scheme, particularly in terms of funding (in any event funding will not be available until the next Spending Review scheduled for 2025).

NHP expect to deliver the first drop of their "Hospital 1.0" (now termed Hospital 2.0) model hospital design in January 2023.

This will enable our clinical team to progress with phase 5 of its coproduction process aimed at aligning our plans with the standards and capital budget emerging from the NHP and we will be able finalise our own project plan.

Clinical / Digital Workstream

Members will recall previous discussions concerning the clinically optimum positioning of a number of outpatient services in relation to the new hospital building. The new Western Way building has previously been stated as the preferred location for these services, however, the financial sums associated with such a move necessitate that any such recommendation be tested with a formal outline business case, ensuring that all the options for alternative sites have been identified and thoroughly considered. To this end a process for the production and governance of a case for a "Bury St Edmunds Community Health Hub" has been agreed. A very brief overview of the decision making gateways follows and members should be assured that this process will ensure transparency, objectivity, alignment and compliance with established commercial rules:

Gateway 1 – Having fully appraised a long and short list of options we collectively agree the preferred way forward. This decision will require sign off from Senior Responsible Officer (SRO- Peter Wightman – representing WSFT Board and Integrated Care Board - ICB), NHP (agreement in principle) and NHSE (agreement in principle)

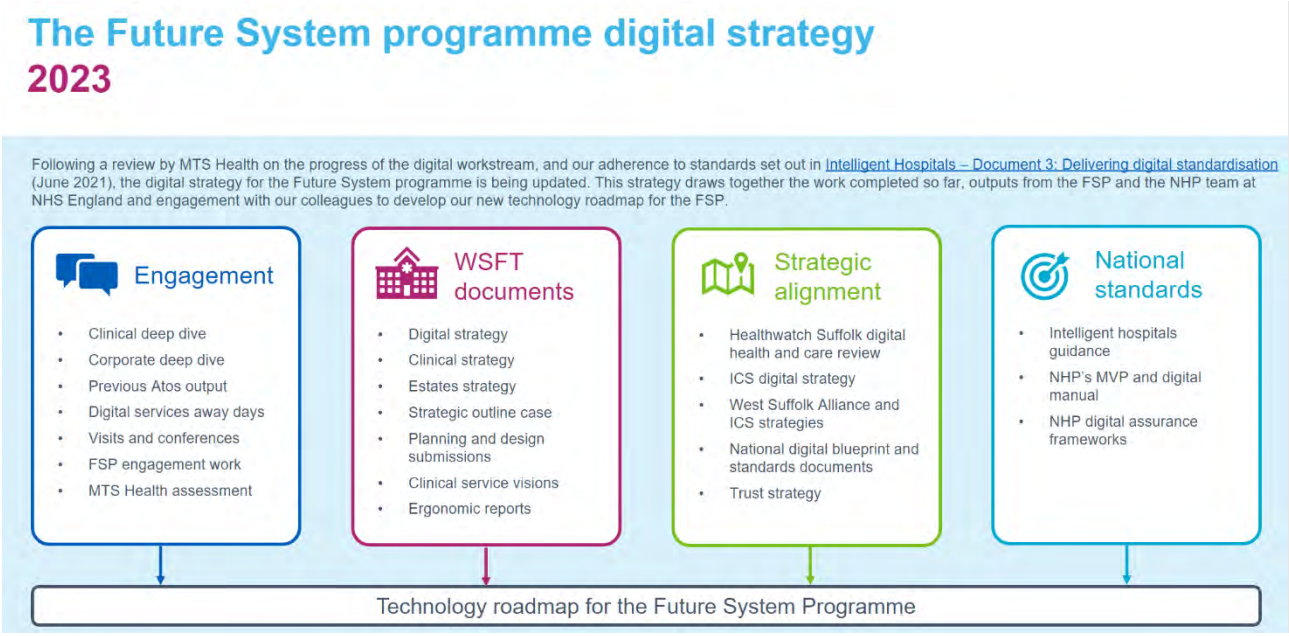
Gateway 2 - Having established value for money, established affordability and planned for benefits realisation, the outline business case containing the preferred option will be agreed by SRO and WSFT / IC Boards and signed off by NHP and NHSE.

Gateway 3 – Investment decision –Having set out the negotiated deal, its financial implications and the plans for managing risks and realising benefits, the full business case will be agreed by SRO and WSFT / IC Boards and signed off by NHP and NHSE.

We're also pleased to announce that an ergonomics supplier has been engaged to provide the human factors and ergonomics expertise required for phase 5 of the clinical co-production. Morgan Human Systems (MHS), who conducted the previous work for us on the emergency department and operating departments, were successful in winning the contract. David Higgins, one of the FSP co-production leads and a member of the trust's own human factors training faculty, will work alongside MHS to make sure we achieve as much knowledge transfer as possible from the project, to increase our in-house capabilities in human factors and ergonomics.

Digital – following an immense amount of work, Sarah Judge has now completed the first version of the Future System Programme Digital Strategy. The graphic below illustrates how numerous data sources

have been consulted and considered to arrive at a truly integrated and aligned strategy for how we ensure our new hospital leverages digital technologies and techniques.



The strategy is based around 5 digital themes (below) for each of which there are a number of "digital requirements" a definition of "what good looks like" and a roadmap for how we realise this future state. This structured approach will ensure the benefits of our co-produced clinical innovations (e.g. single rooms) are fully supported and digitally enabled.

Communications and Engagement

Following the positive outcome of our planning application, the communications team launched a comprehensive plan of communications that sought to; re-iterate the need for a new hospital, communicate the positive outcome, thank contributors (staff, public and partners), outline next steps and state how to remain involved. Feedback has been very positive although small numbers continue to voice concerns relating to traffic and environmental impact. A programme of site visits continues to create excitement and remains a key means of conveying the steps being taken to mitigate the inevitable impact of building a new hospital. In recent weeks we have hosted our local MP, our new non executive Board members and our ICB. In the coming weeks visits from NHS England and the New Hospitals Programme (workforce team) are planned.

Workforce

Work continues towards defining a plan for understanding the future staff and skills needs of the future system. Any such plan needs to reflect all of the changes to working practice (e.g.virtual wards), demand and capacity, digital enablement, service adjacencies, new infrastructure etc. that stem from moving to a new hospital / future system. Consequently, we have started by engaging our service managers and co-production leads in the definition of their foreseen needs.
With an overarching clinical strategy now agreed, I am delighted to announce the successful recruitment of a new Workforce lead who will engage the whole Trust and its partners in a formal business planning cycle aimed at producing a congruent view of future workforce, the associated implications and a plan for transitioning to this future state.

Finance

Our project continues to progress in line with its defined budget and is expected to outturn the year on target.
Having received additional funding of £300k from NHP to cover imminent survey work, we await confirmation of enabling works funds and money to cover the development of our outline business case in 2023.

All in all, this has been a period in which we have taken a huge stride forward in terms of planning consent and defining a digital roadmap that supports our clinical strategy. The next period should see the culmination of several key activities:

- The results of MPRG discussions should be known
- The first national workstreams will start to produce outcomes.
- We should have a view of team funding and enabling works
- We may have a view of our capital budget

Action Required of the Board

To note the contents of this report.

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

3.2. System update - ICS and West Suffolk Alliance

Richard Watson in attendance (10.30 am)

To Assure

Presented by Peter Wightman and Clement Mawoyo

NHS
Suffolk and North East Essex Integrated Care Board

Title	SNEE Joint Forward Plan Update
Lead Director	Richard Watson, Deputy Chief Executive and Director of Strategy and Transformation
Author(s)	Richard Watson, Deputy Chief Executive and Director of Strategy and Transformation Ruth Kelly, Archus
Purpose	To provide an update on the development of the Joint Forward Plan (JFP) from 2023 to 2028 for SNEE ICB.
Recommendation: To continue at pace, progressing delivery of a robust five-year JFP for SNEE ICB and bringing back to final version for agreement to the March meeting of the ICB.	

1. Background

As mandated by the Health and Care Act 2022, ICBs and partner NHS Trusts / Foundation Trusts must prepare a five-year Joint Forward Plan (JFP) in collaboration with local Health and Wellbeing Boards (HWBs). The JFP describes how SNEE ICB and its partner trusts intend to arrange and provide NHS services to meet its population's physical and mental health needs. This includes consideration for the delivery of universal NHS commitments and addressing the ICSs' four core purposes.

Archus has been supporting SNEE ICB since October 2022 in the preparation of its JFP which sets out key ambitions for the ICB over the period 2023 to 2028. JFPs must be reviewed and updated or confirmed annually before the start of each financial year. NHSE shared guidance on the development of JFPs with ICBs on 24 December 2022. Key components noted by the guidance for inclusion in the Plan are:

- Purpose of the JFP
- NHS mandate
- Alignment to the Integrated Care Strategy
- System capital plans
- Summary of views expressed by anyone the ICB/partner trusts have a duty to consult
- Describe the health services for which the ICB proposes to make arrangements
- Duty to promote integration
- Duty to have regard to wider effect of decisions
- Financial duties
- Implementing Joint Local Health and Wellbeing Strategies (JLHWSs)
- Duty to improve quality of services
- Duty to reduce inequalities
- Duty to promote patient involvement
- Duty to promote public involvement
- Duty to patient choice
- Duty to obtain appropriate advice
- Duty to promote innovation
- Duty in respect of research
- Duty to promote education and training
- Duty as to climate change
- Addressing the particular needs of Children and Young People (CYP)
- Addressing the particular needs of victims of abuse

The JFP that SNEE ICB is producing encompasses these areas as well as much of the additional content recommended by NHSE in its guidance. These supplementary items are noted below:

- Workforce
- Performance
- Digital/data
- Estates
- Procurement/supply chain
- Population Health Management (PHM)
- System development
- Supporting wider social and economic development

2. Overview of JFP and Key Activities

The JFP proposed vision is for everyone at all stages of their life to be able to **Live Well** across SNEE.

We have therefore adopted, organise ourselves and define the outcomes we wish to achieve using the six domains of the Live Well model:

- **Start Well** – Giving children and young people the best start in life
- **Feel Well** – Supporting the mental wellbeing of our local population
- **Be Well** – Empowering adults to make healthy lifestyle choices
- **Age Well** – Supporting people to live safely and independently as they grow older
- **Stay Well** – Supporting adults with health or care concerns to access support and maintain healthy, productive and fulfilling lives
- **Die Well** – Giving individuals nearing end of life choice around their care

Our six Live Well Domains and the outcomes there within are underpinned by a focus upon reducing health inequalities for our local population. To support our vision and achievement of our outcomes we are committed to collaborating with the people and comminates of SNEE at every stage of our work, and this is a fundamental part of the successful delivery of the Plan.

The Live Well priorities have been developed by partners across a wide range of established arrangements and will contribute to the ICB's delivery against the domains. Key components of each of the domains are shown below:

Table 1: Joint Forward Plan Live Well Domains

Start Well	*Feel Well*	*Be Well*	*Stay Well*	*Age Well*	*Die Well*
• Maternity & Neonatal Care • Children & Young People incl. CAMHS, Neuro Developmental, SEND, Community and LTCs	• Mental Health & Wellbeing • Suicide Prevention • Addictions • Trauma and Abuse	• Healthy Behaviours • Personalised Care • Women's Health • Dental / Oral Health • Eye Health	• Primary Care • Elective Care & Diagnostics • Urgent & Emergency Care incl. community • Cancer • Diabetes • Respiratory • Cardiovascular Disease • Stroke & Stroke Rehab • ME and CFS • Neuro Rehab • Learning Disabilities & Autism	• Ageing Well Programme • Dementia • Carers	• End of Life

Each of the areas identified above will follow a common methodology through setting out:

- Why is it important for the people of SNEE
- What do we know about people's local experiences
- How do we plan to make a difference
- How we will know we are making a difference
- Case study for the area

Alongside the six Live Well Domains, the JFP will also have key sections covering:

- Why do we need a JFP?
- How we will work differently to achieve our priorities including:
    - ICB Governance
    - Alliances and Localities
    - Collaboratives
    - Population Health Management
    - Demand and Capacity Planning
    - Medium Term Financial Planning
    - Quality and Safety
    - Clinical and Professional Leadership
- Our enablers to success
    - Working in partnership with people and communities – co production
    - Workforce
    - Estates
    - Digital
    - Intelligence
    - Communication and Engagement
    - Research and Innovation
    - Sustainability

- Our partners aligned plans including primary care, community, acute, mental health, local government, voluntary care and social enterprise, care homes, Healthwatch and hospices
- Managing the JFP including how we report progress and our performance

Our Plan will be delivered through our three place-based Alliances, Ipswich and East Suffolk, North East Essex and West Suffolk, and each is commencing work on their own localised delivery plan.

We now have a strong first draft of the JFP and are planning to engage more widely with our local population and partners.

3. Patient and Public Engagement

As part of this work, ICBs and their partner trusts must consult with those for whom the ICB has core responsibility. SNEE ICB has therefore started to engage a range of partners and stakeholders from across the ICS to both draft and review the JFP. Leads from the ICB, ICP, Healthwatch, primary care, community and acute trusts, mental health trusts, Suffolk County Council, Essex County Council, collaboratives, networks, alliances and the VCSE sector have been involved in the drafting of key sections to date to ensure a robust and complete JFP is produced for the ICB.

A JFP Communications and Engagement Sub-Group has been established to plan out key activities for 2023. The ICB People and Communities Team have developed an approach that enables the ICB to share the draft JFP with the wider public as well as key partners throughout January and February 2023 via meetings, an engagement event in each Alliance and using the letstalksnee.co.uk/ platform for wider engagement and comment on the content of the JFP.

The JFP pages on the LetsTalkSNEE platform went live on 16 January 2023. On 30 January, a full, revised JFP draft and executive summary was published online on letstalksnee.co.uk/, a platform which over 1,000 local people are signed up to. The platform enables the opportunity to consider the content of the Live Well Domains and suggest any changes whilst also commenting more broadly on the one to two top priorities each person feels the ICB should commit to over the next five years.

All feedback will be analysed and a revised version of the JFP developed by 27 February 2023 for consideration and agreement which will include a suggested top set of commitments the ICB will make over the next five year as part of the document.

As JFPs do not require full formal public consultation unless a significant reconfiguration or service change is proposed, previous local patient and public engagement exercises have informed this work for SNEE ICB. An engagement tracker has been developed to minimise duplication across teams on where the JFP content has been shared for development. This tracker also supports the team in identifying key groups that are yet to be engaged and/or consulted as part of the work to ensure a thorough JFP is produced by 31 March 2023.

4. Next Steps

Key timelines for the JFP as detailed within the NHSE guidance documents are noted below:

- NHSE expects ICBs to have commenced the process of consulting on a draft of their plans. A first draft of the JFP should be prepared by 31 March 2023. This aligns to the work underway by the JFP development team since October 2022.
- Consultation on further iterations will continue from April to June 2023, prior to the plan being finalised in time for publication by 30 June 2023
- The JFP development team at SNEE ICB had previously anticipated a final deadline of 31 March 2023 for completion of the document. Therefore, key timelines for the SNEE ICB JFP are proposed to still aim to finalise the JFP for approval at the 21 March ICB Board. Key next steps are:

Action	Date
Launch public and system partner engagement on the JFP via pages on [redacted] with a summary of the Live Well domain sections	16 January
Final iterations of JFP sections received from all leads	25 January
Share full draft of the JFP on the LetsTalkSNEE platform	30 January
Public and system partners engagement on the JFP	16 January – 22 February
North and East Essex Health and Wellbeing Alliance Committee	7 February
West Suffolk Alliance Committee	14 February
Ipswich and East Suffolk Health and Wellbeing Alliance Committee	21 February
Share JFP update at ICB Board Development Session with focus upon key commitments	21 February
Alliance based engagement events (x3) on the JFP	13, 15, and 16 February
Weekly summary of comments received shared with section leads as appropriate for further updating of the JFP sections	23 January – 22 February
Final version of the JFP completed	27 February
SNEE ICB Executive consideration of the JFP	6 March
ICP consideration of draft JFP	10 March
ICB approval of the JFP	21 March
ICP consideration of the final JFP	April meeting (14th?)
Essex Health and Wellbeing Board consideration of the final JFP	17 May
Suffolk Health and Wellbeing Board consideration of the final JFP	18 May
Publication of JFP	*

**Clarity being sought on whether the JFP must go to the Health and Wellbeing Boards before formal publication.*

5. Recommendation

To continue at pace, progressing delivery of a robust five-year JFP for SNEE ICB and bringing back to final version for agreement to the March meeting of the ICB.

3.2.1. Presentation on example from domains - Die Well

To Assure

Presented by Susan Wilkinson

Die Well Domain

West Suffolk Alliance Committee
13th December 2022

Die Well Domain

Is the Committee well informed on the programme of work?

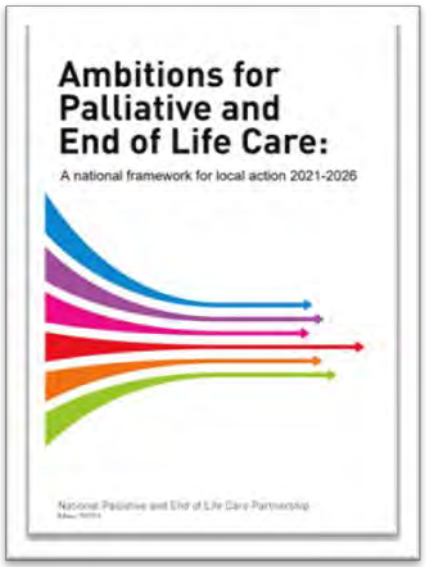
Sponsor - Sue Wilkinson, Chief Nurse, WSFT
Strategic Lead - Sharon Basson, Clinical Services Director, St Nicholas Hospice
Change Coordinator - Cara Twinch, Transformation Lead

Contents

1. What is the national/ ICS/ Local direction for End of Life Care?
2. What are the delivery priorities for the alliance in relation to Palliative and End of life care and how are these priorities currently being delivered?
3. To what extent are the identified outcome measures being achieved?
4. What is working well and what needs to be improved?
5. How is the Alliance ensuring work is co-produced?
6. Key Priorities for Action

1. What is the national/ ICS/ local direction for End of Life Care?

What is the national direction for End of Life Care?



‘all integrated care boards to commission services or facilities for palliative care, including specialist palliative care, as they consider appropriate for meeting the reasonable requirements of the people in their area’

01 Each person is seen as an individual
I, and the people important to me, have opportunities to have honest, informed and timely conversations and to know that I might die soon. I am asked what matters most to me. Those who care for me know that and work with me to do what's possible.

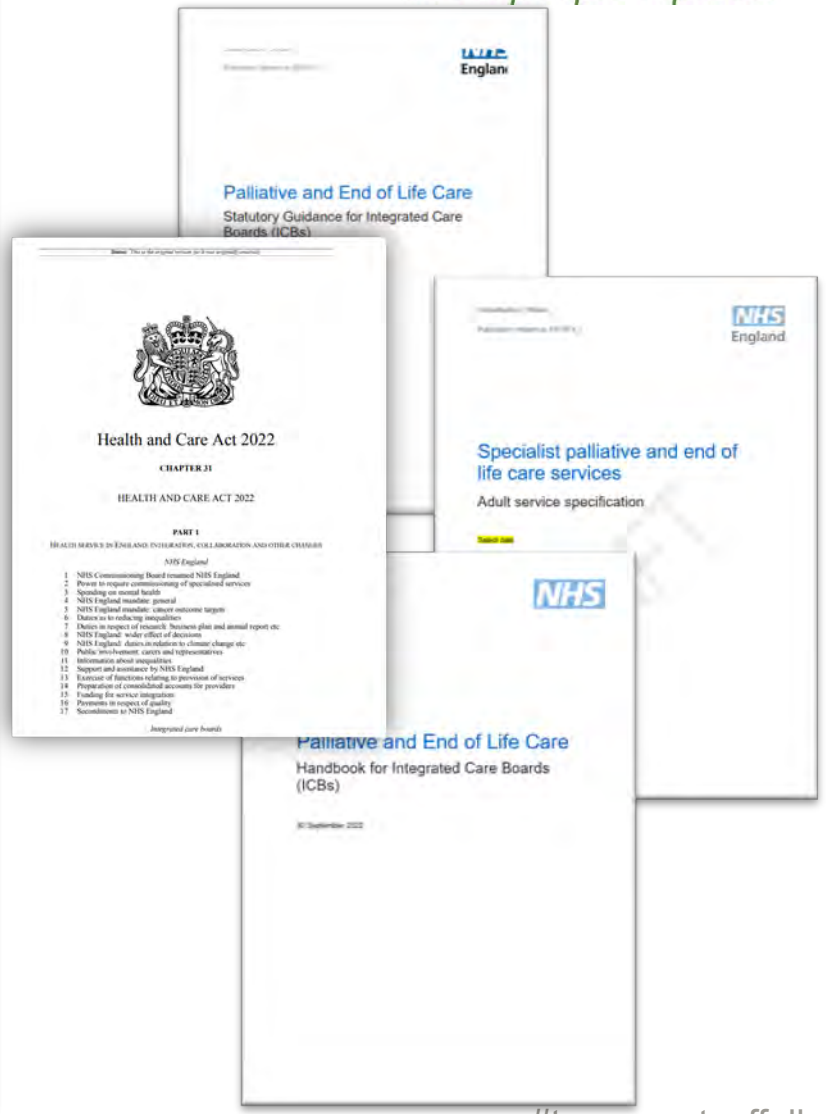
02 Each person gets fair access to care
I live in a society where I get good end of life care regardless of who I am, where I live or the circumstances of my life.

03 Maximising comfort and wellbeing
My care is regularly reviewed and every effort is made for me to have the support, care and treatment that might be needed to help me to be as comfortable and as free from distress as possible.

04 Care is coordinated
I get the right help at the right time from the right people. I have a team around me who know my needs and my plans and work together to help me achieve them. I can always reach someone who will listen and respond at any time of the day or night.

05 All staff are prepared to care
Wherever I am, health and care staff bring empathy, skills and expertise and give me competent, confident and compassionate care.

06 Each community is prepared to help
I live in a community where everybody recognises that we all have a role to play in supporting each other in times of crisis and loss. People are ready, willing and confident to have conversations about living and dying well and to support each other in emotional and practical ways.



What is the national direction for End of Life Care?

“ I can make the last stage of my life as good as possible because everyone works together confidently, honestly and consistently to help me and the people who are important to me, including my carer(s)”

2. What are the priorities for the alliance in relation to Palliative and End of life care and how are these priorities currently being delivered?

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about people & places

WS EOL Programme Group Programme of Work

Aligning with the ICS strategy for End of Life care the group seeks to ensure that patients, families and carers across the ICS have equality in their end of life care and experience and that people approaching end of life and their support networks / carers are prepared and informed to help make timely choices about their care and treatment; receiving the best quality care and support.

The group is chaired by **Sponsor** -Susan Wilkinson, Chief Nurse WSFT and **Strategic Lead** -Sharon Basson, Clinical Director of St Nicholas Hospice.

The 5yr Programme Plan, coproduced with system partners outlines our aims and programme of work supporting:

- Our wider ambitions for EOL care in WS
- Best practice
- Recommendations from the Care at End of Life Healthwatch Survey (Dec 2021)
- WSFT 2022 National Audit of Care at End of Life (NACEL) report Parameter agreed for the Futures Systems programme of at least 70% of individuals dying outside of the acute hospital setting in 10 years.

PRIORITY ACTIONS AND MEASURING OUR IMPACT
How will the West Suffolk Alliance make a difference in supporting people to Die Well?

Ambition One - Each person is seen as an individual

Ambition Lead - to be confirmed

Link to LTP / High Ambition

Everyone in Suffolk and North East Essex has flexibility, choice and control over their care, and support for those closest to them, at the end of their life

Story behind the baseline – Why is this important?

I, and the people important to me, have opportunities to have honest, informed and timely conversations and to know that I might die soon. I am asked what matters most to me. Those who care for me know that and work with me to do what is possible.

Healthwatch recommendations:

- Communicate clearly – Make sure people have understood what they have been told.
- Make sure all professionals can access the information they need about patients with specific long-term conditions.
- Consider how information sharing and communication between professionals can be improved at all levels
- Explore the opportunities that digital offers to bring to help people access information about services and support.
- Make it easier for people to share and access end of life choices

How will this be achieved? Actions & Milestones

2022/23	Project lead	Outcome
We will develop and pilot ROSI (Record Once Share Insight) solution to support proactive planning, information sharing and care co-ordination for professionals.	**Roland Appel/ Cara Twinch**	Access to EOL care plan and choices for the individual their carers and professionals
Initial scope and benchmarking required to roll out ReSPECT across ICS (link with ROSI)	**Juliet Estall**	Implementation plan produced
Complete the roll-out of community medical examiner and evaluate (ICS wide)	**Marcia Schofield**	Medical Examiners operating in Community
Focus on wellbeing in death and bereavement (personalised care) – St Nicholas hospice and care homes testing approach and to extend and build on compassionate communities model (12 month project)	**Sharon Basson / Charlotte Harkness**	Methodology / approach becomes BAU in Care Homes
Roll out To Live with Dying website across West Suffolk	**Trisha Stevens**	Accessible clear information available for individuals
QI EOL programme in West Suffolk Hospital to aid recognition of need for advance planning discussions (SPICT tool)	**Mary McGregor**	SPICT Tool BAU – earlier identification of individuals at EOL

What success looks like

Individuals feel better in control and consulted, that their information is shared effectively and that they don't have to keep repeating themselves.

Practitioners have improved access to the EoL care record and so better understand the individuals health and care needs and what is important to them.

Individuals at EOL are identified earlier and appropriate information and support is provided

West Suffolk End of Life Programme Group

The programme plan is far reaching with the following key priorities:

- **Identifying patients in their last year of life**, recording their wishes to support patients dying in their preferred place of choice and to share and make accessible their digital record.
- **Coordinated services** to ensure that the patient and their family receive 24/7 coordinated care and support through a collaborative, cohesive appropriately trained workforce through end of life and bereavement through their journey.
- **A compassionate community** where people are empowered to talk about death and are equipped and able to support each other as they face dying, death, caring and grief

Key priorities for 22/23

ROSI (Record Once Share Insight)

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about people & places

New Advance Care Plan Solution Co-designed by Citizens

COHESION
Connected Citizen Health

freshEHR

valida

better

PRSB Professional Record Standards Body

ROSI and Me App
Patients and informal carers

Professional Application

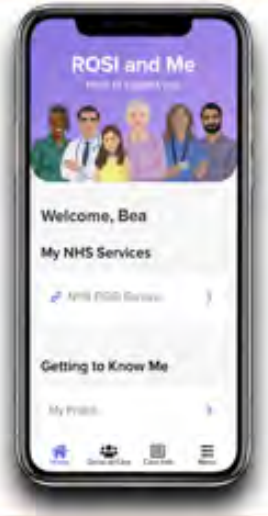
Advance Care Plan

End of Life Key Information (Summary)
Sections / forms

1. Getting to Know Me (Circle of Care)
2. Advance Care Information
3. End of Life Care Plan
4. Emergency Care Plan & Resuscitation Decision

Open Platform Data Repository (Cloud)
Integrated with GP and Hospital EPRs

Similar solution in place across London to replace Coordinate My Care, but without Patient App.



People and their families will be able to use the **ROSI and Me** App:

- To view their Clinical Care Plan
- Share information about what and who is important to them, including past and future events.
- List people and organisations involved in supporting them.

- New electronic shared care plan
- Can be edited by patients, families and professionals
- Accessible via Android, IOS and web browser
- Integrated with organisations' Patient Record Systems
- CPR decision compatible with ReSPECT
- Ability to print DNACPR and care plans.

Key Priority for 22/23

ReSPECT (Recommended Summary Plan for Emergency Care and Treatment)

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about people & places

Aims

ReSPECT Recommended Summary Plan for Emergency Care and Treatment

- Increase the **quality of conversations** and documentation in relation to emergency treatment and care.
- Enable conversations to take place and be recorded **earlier**, when a **patient has the capacity and time** to make an **informed decision**.
- Replace multiple forms of CPR documentation. This will **standardise documentation** to ensure it will be recognised, and can be used, wherever an emergency occurs across the region.

Resuscitation Council UK

Key Priority for 22/23

Enhancing EOL Out Of Hours Support

- Hospice Extra Support Team (HEST) 6 month evaluation underway with aims to seek recurrent funding to continue to support patients to remain in their preferred place of care as they receive end of life support, and with access to additional care during times of intense clinical need, including the provision of short term carer/family support and symptom management.

- Outline proposal under development with system partners to build on HEST model to provide out of hours support with the ability to link across the West Suffolk Alliance, working closely with the WSFT Early Intervention Team and Marie Curie Service.

- This service would provide both telephone, virtual and face to face support out of hours for patients receiving palliative and end of life care and their families, as well as the wider health and care system. It would be staffed by Senior Hospice Nurses, seeking clinical support when needed from existing on call medical colleagues.

- Education and training key to mitigate workforce challenges with proactive support and cross system working.

Ambition 4 - Care is Coordinated
"I get the right help at the right time from the right people. I have a team around me who know my needs and my plans and work together to help me achieve them. I can always reach someone who will listen and respond at any time of the day or night"

West Suffolk Palliative and End of Life Care Model

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about people & places

Overarching Principles

Supporting the people in West Suffolk to live well before dying with peace and dignity in the place of their choice

End of Life Care

In West Suffolk, we seek to ensure that patients, families and their carers across the ICS have equality in their end of life care and experience and that people approaching end of life and their support networks/ carers are prepared and informed to help them make timely choices about their care and treatment, receiving the best quality individualised care and support.

Adapted from The Pennine Lancashire End of Life Care Model

What does our future EOL service offer look like?

- Identifying patients in their last year of life, recording their wishes to support patients dying in their preferred place of choice and to share and make accessible their digital record.
- Coordinated services to ensure that the patient and their family receive 24/7 coordinated care and support through a collaborative, cohesive appropriately trained workforce through end of life and bereavement through their journey
- A compassionate community where people are empowered to talk about death and are equipped and able to support each other as they face dying, death, caring and grief.

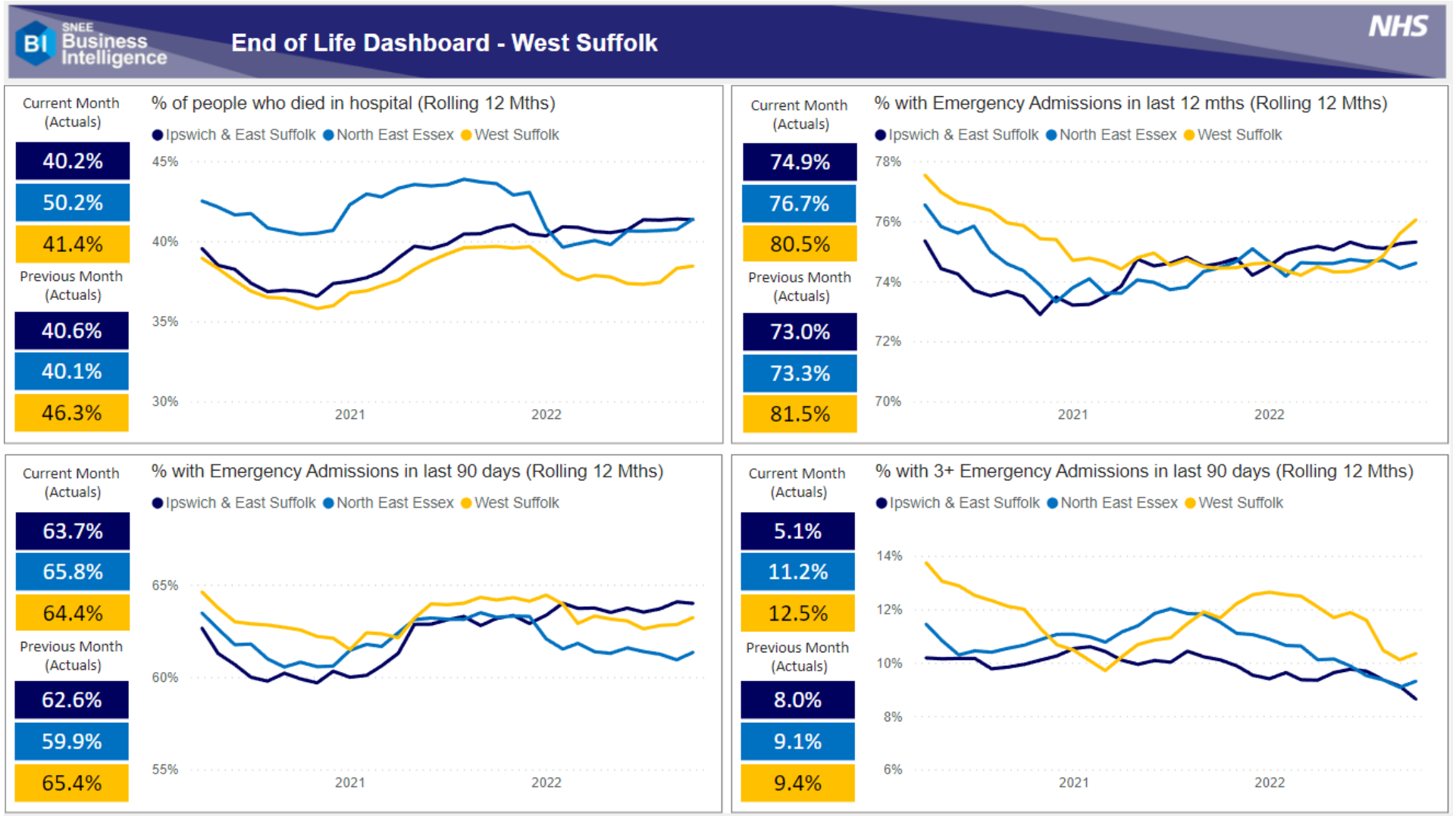
The 'Elements of Dedicated Palliative Care' model applies throughout the stages of the 'West Suffolk End of Life Care' Model

Elements of Dedicated Palliative Care

The West Suffolk End of Life Care Model

To what extent are the identified outcome measures being achieved?

- National guidance to inform outcomes with ICS wide outcome measures under consultation currently for agreement
- Dashboard extract from WS Alliance emergency admissions and deaths in Hospital
- Benchmarking to take place against the national ambitions using the **Ambitions Self - Assessment Tool**



What is working well?

Collaboration

- Established Programme Groups
- System relationships
- Hospice peer support
- CYP EOL Strategy under development
- EOL dashboard created through Power BI platform
- Care around the patient

Covid response

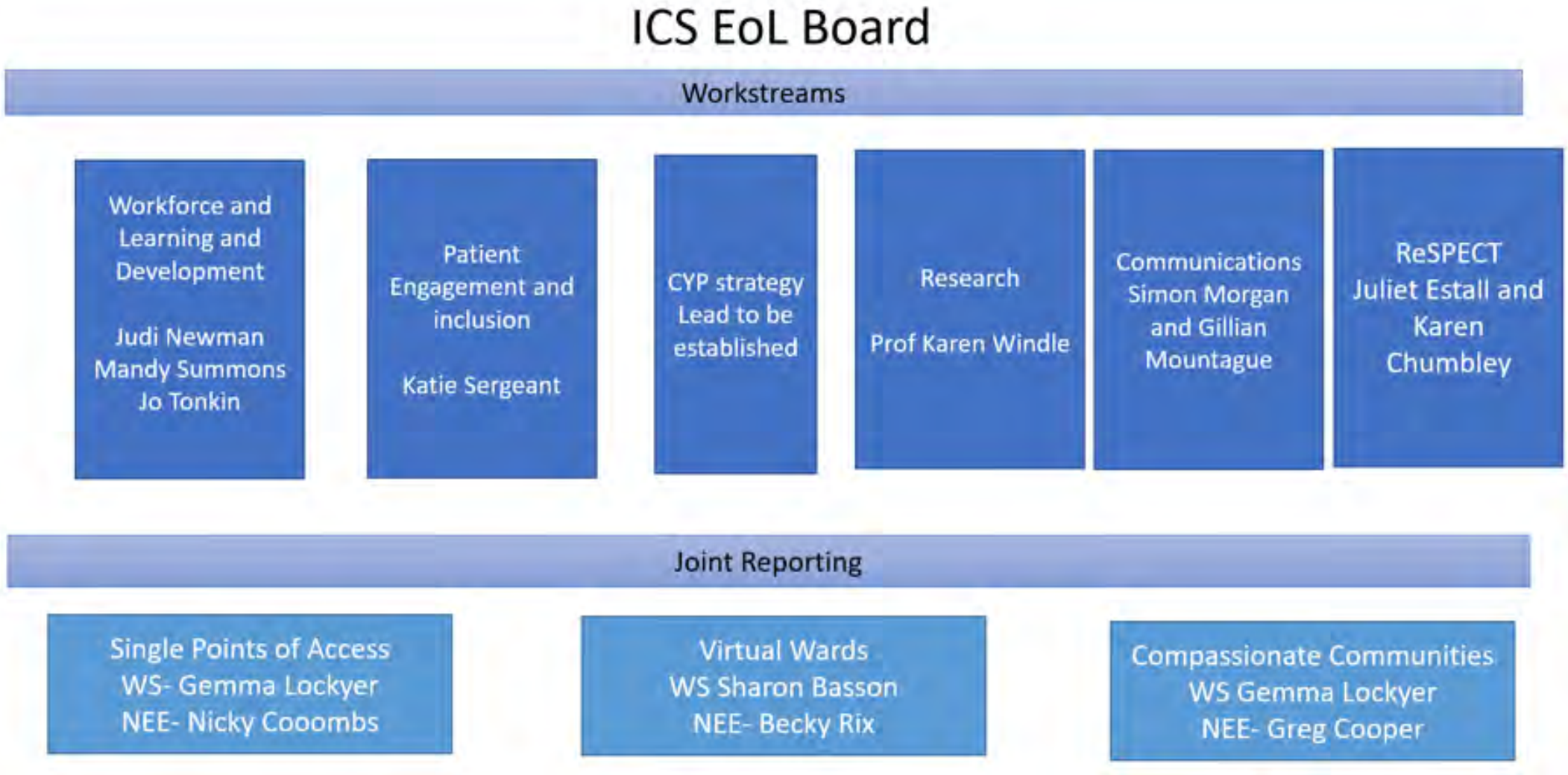
- Legacy of relationships built
- Willingness to find solutions

Doing things differently:

- Family administered Anticipatory medicines policy
- Opening up referral pathways
- Coordination of services
- Palliative Care MDTs continuing in 92% of GP practices

Wider ICS EOL Workstreams

WEST SUFFOLK ALLIANCE
about people & places



Wellbeing strategy: a programme of supporting for well being in death and bereavement which links the work of wellbeing and the volunteer strategy to the work in care homes and at end of life through an integrated project with St Nicholas Hospice.

Case of Need: The Healthwatch Suffolk publication '*End of Life Care in Suffolk and Northeast Essex*' indicated the significant increase in the numbers of deaths within SNEE in 2020 as a result of the coronavirus pandemic. It provided evidence of the :
Unequal Impacts of Covid Related Deaths and Bereavement
Complexity of Covid Related Bereavement
The need for targeted support – care homes is an area of high stress, grief related trauma, unresolved grief and staff reporting utter exhaustion and struggling to cope, with of understanding about palliative care amongst all staff.

Aim of the project:
To provide all care home staff, residents, and the families of residents, with bereavement support
To train volunteers with the requisite knowledge to support bereaved people in care homes
Volunteers to deliver interventions to care homes: bereavement cafes, reflective practice, St Nic's chat, memorial events
To facilitate healthy bereavement outcomes and improved well being
To report on outcomes and develop an effective and sustainable model for bereavement support in care homes and extend to other settings

The project plan:
One year project with St Nicholas's Hospice to support adjustment to loss and improve wellbeing following bereavement. The project has started in 3 care homes and will roll out to 3 more every quarter over one year. Volunteers have been trained to provide reflective practice, bereavement cafes, St Nick's chat and memorialisation. The support is given to residents, recently bereaved families of residents, families of residents at end of life and care home staff. The volunteers will work with the care homes for 8 weeks which is followed by a period of evaluation.

Project to be presented at the Hospice UK Conference next week!

WEST SUFFOLK ALLIANCE
about people & places

Family-administered 'Just in Case' medications –

Background

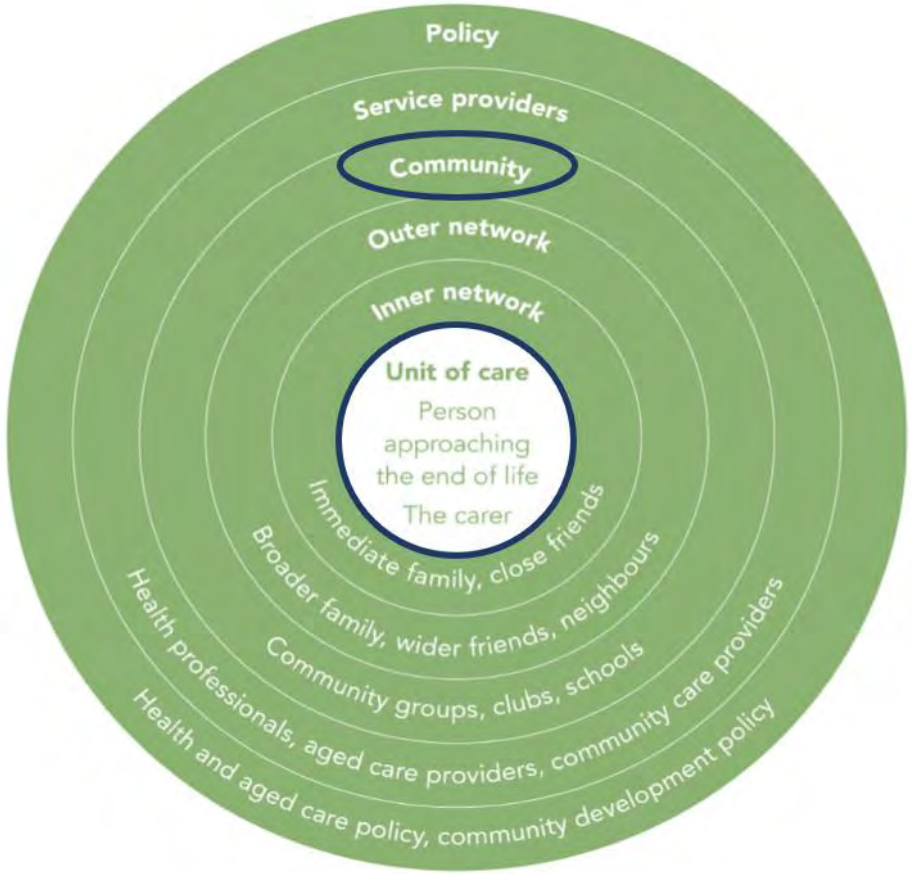
- Developed by Dr Sarah Mollart, Palliative Medicine Consultant, St Nicholas Hospice and West Suffolk Hospital and Amanda Keighley, Senior Matron, WSFT Community health team
- In other parts of the UK, and other countries (e.g. Australia), it is common practice for family members to be trained to administer PRN subcut end of life injections
- This can provide more rapid symptom control than when this task is solely delegated to community nursing teams
- This is not suitable for every family – by no means
- But when chosen appropriately, carers value the role and can feel empowerment, pride, achievement – rather than helplessness
- The Suffolk policy is for injections given via a SC cannula

Process:

- The idea originates (pt / family led)
- Eligibility screening
- MDT discussion
- Information shared with family and informal carers
- Consent
- Ensure drugs are in place
- Training takes place with completion of competencies
- Administration charts in place
- Ongoing communication and follow up
- Evaluation process in place

What needs to be improved?

- Cultural shift required to improve death literacy
- Earlier identification of dying phase
- Difficult conversations
- Accessibility and completion of advance care plans
- Coordination of Care
- Transition from children's services
- Finance – dying in poverty
- Social isolation
- 24/7 palliative/ EOL support
- Equality in access to services and experience
- Access to specialist palliative education and training
- Resource to deliver WS EOL Programme
- Primary care representation at WS EOL PG
- ICT System interoperability



"A person living at home with a life limiting illness may only come into contact with statutory services for up to 5% of their day, as a community, what can we do to occupy that 95%?"

Professor Allan Kellehear

How is the Alliance ensuring work is co-produced?

- End of Life Care is something that all communities in WS will access
- Palliative and End of Life Care Programme Board was re established for co-production with clinicians and experts-by-experience
- Across the alliance People and Community Partnerships Teams are working with partner organisations and individuals to seek their thoughts to inform commissioning
- The People and Community Partnerships Teams will review 12 patient stories a year with the wider system bringing the diversity of End of Life experience to life for discussion and reflection.
- Patient and Public Involvement and Experience will continue to focus its attention on:
    - Religion
    - Ethnicity and culture
    - Age
    - Sexuality
    - Learning disability, mental health and autism
    - Marital status and family
    - Low income households

Key priorities for Action

WEST SUFFOLK ALLIANCE
about people & places

Phase 1

- Six month evaluation of HEST underway, to be presented to WS EOL PG 13th Dec for discussion and decision on continuation of service.
- Proposal being finalised to enhance OOH support to ensure 24/7 access to specialist advice and care for patients, carers and professionals– with agreement to be sought at January WS EOL PG and funding streams to be identified.
- Continue to progress RoSI pilot conversations to aid proactive planning, information sharing and access to patients wishes.
- Benchmark palliative and EOL services using the Ambitions Assessment to ensure equality in access to services and patient experience across the ICS
- Compassionate Communities community of practice group established to support the aim of building a compassionate community which includes families, neighbours, local organisations, spiritual support as well as health and care professionals.

Phase 2

- ReSPECT to be launched in March 2023 with steering group set up and implementation plan in place.
- Hospice MDT Review currently underway to review commissioning arrangements across ICS and any variations in service. Common commissioning principles to be developed as well as implications of statutory legislation for ICBs to commission specialist palliative and EOL care to be further understood.
- The development of the Future Systems Programme Outline Business case for the Community Workstream continues– resource and investment requirements to be scoped as part of growth mitigation, demand mgmt. modelling and risk stratification for the new EOL model of care. Whole system mapping currently underway will support this work
- Complete the roll-out of community medical examiner (ICS wide)

Phase 3

- Future EOL model of care case for change developed for all additional elements to support the FSP outcomes and target of 70% of all deaths to take place outside the acute within 10 years and investment requirements.
- Palliative care needs assessment underway with Public Health Suffolk to help determine the longer term needs to support future capacity planning and identify potential areas of health inequality and consideration of hard to reach communities
- Future EOL Model of Care case for change finalised and agreed with WS Alliance with implementation plan developed to support all elements of best practice pathway

3.3. Digital Board Report - Digital Prioritisation

To Assure

Presented by Nick Macdonald

Board of Directors – Public

Report title:	Digital Board Report - digital prioritisation
Agenda item:	3.3
Date of the meeting:	2 February, 2023
Sponsor/executive lead:	Nick Macdonald
Report prepared by:	Liam McLaughlin

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 prioritisation of digital initiatives is part of a wider review of the digital governance framework that is currently being developed. A first draft is being consider initially at the Digital Board on 26th January. A further update will be provided to the Trust Board following this and any subsequent wider consultation.

Previously considered by:	N/A
Risk and assurance:	Ensure that digital supports the wider Trust strategic objectives
Legislation, regulatory, equality, diversity and dignity implications	-

The governance framework for digital projects is being reviewed and is considering two key aspects of governance:

- Are we doing things right?
- Are we doing the right things?

The former is typically at the forefront of our governance approach. However, we do want to use the opportunity to reframe our approach to governance and dispel some common myths whilst at the same time ensuring that the latter prioritisation of digital work is enabled in line with wider Trust strategic objectives and supports the digital strategy.

Myth #1
Today's myth: "Let's find the perfect model"

Myth reimagined: "Start with the context and build from there"

Myth #2
Today's myth: "Governance is static"…

Myth reimagined: "Governance is an evolving journey"

Myth #3
Today's myth: "Governance is simple and done by a few"

Myth reimagined: "Governance is a complex process of collaborating with others"

Myth #4
Today's myth: "Governance is restrictive and dominated by top down power"

Myth reimagined: "Governance is about enabling flows of healthy power"

Myth #5
Today's myth: "Governance is tedious and stressful"

Myth reimagined: "Governance is life giving"

Source: Reimagining governance myths - The Futures Centre

A draft of a proposed digital governance framework is first being considered at the Digital Board on 26th Jan so the outcome is not available at the time of writing to report back to the Trust Board.

However, in summary, a key element of the proposal is to establish a new digital priorities group who have a broad perspective on how proposed projects and programmes align to the Trust priorities. This in turn would link in with the wider work that is currently underway on Change Management.

We are investigating a number of different prioritisation methods that could give structure to the discussions by identifying objective measures of the extent to which the work aligns and whether it can realistically be delivered.

The challenge is to define the level at which this group would operate (ie Board level, SLT, ADO, cross functional team etc) in order to provide sufficient breadth of understanding of priorities but at the same time be able to comment on the realistic availability of all the resource requirements (eg people, financial, subject matter experts, solutions etc). The group and the process should be sufficiently agile and meet with appropriate frequency as to be able to respond to changing demands in priorities but also recognise existing commitments that may not be so easily altered.

A further update will be presented to the board following further development of the proposal and wider consultation

11.50 - COMFORT BREAK

4. 12 Noon - ASSURANCE

4.1. Insight Committee Report - 5 December, 2022 and 9 January, 2023 - Chair's Key Issues from the meeting

To Assure

Presented by Richard Davies

Chair's Key Issues

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

Item	Details of Issue	For: Approval/ Escalation/Assurance	BAF/ Risk Register ref	Paper attached? ✓
Finance and Workforce Governance Group Report **High-cost procurement and tender summaries**	F&WGG reported issues in relation to the managed service contract for radiology and endoscopy, and the pacemaker tender. Both were considered by the committee and both were felt to require further clarification. The former will be brought back to Insight in January in time for implementation in April 2023 and the latter will go back out to tender. Despite the inevitable delays Insight received assurance from this that F&WGG has effective processes in place to scrutinise and challenge high-cost procurements and tenders and to require appropriate clarification. The MultiQuote system will now allow for early identification of high-cost contracts with renewals due in the next six months – and these will be presented to Insight, providing helpful oversight and significantly reducing the risk of 'urgent' renewal of tenders.	**Assurance**	**BAF 5**	
Finance and Workforce Governance Group Report **Business Case Register**	This will now be presented to Insight on a regular basis. There is an assumption (as yet unconfirmed as the 23-24 budget has not been formally approved) of a recurring £3m available for investment board allocation. Of this there is currently £1.15m still available for next year – and this will be allocated through the business planning process. The process for prioritisation of business cases will require some further work.	**Assurance**	**BAF 5**	
Patient Access Governance Group Report **Pathway One Discharges**	Capacity within the community care market remains a significant challenge to timely patient discharge. Plans are in place to enhance pathway one capacity in some areas and significant improvement has been achieved by health and social care colleagues in Norfolk. Nevertheless this remains a major challenge throughout the system.	**Limited Assurance**	**BAF 3**	

Patient Access Governance Group Report **Gynaecology U/S**	A data quality check has revealed that some patients awaiting Gynae U/S have been incorrectly recorded under the Obstetric list. This has now been corrected but will significantly increase the size of the Gynae U/S waiting list in future data	**For Information**	**BAF 3**	
Patient Access Governance Group Report **ICS overview RTT performance**	RTT waiting times are monitored weekly across the ICS. For the first time the WSFT and ESNEFT overall waiting times are the same (compared to a 19 week difference this time last year). This is testament to effective system working which has helped to reduce backlogs at both Trusts. There are still significant waiting time differences within particular specialties and there is ongoing work between the two Trusts to consider opportunities for further collaboration within these areas.	**Assurance**	**BAF 3**	
Patient Access Governance Group Report **Long wait elective patients**	Progress on 104 week waits has been maintained and work is ongoing on the 78 week waits Whilst this numerical data is encouraging, the importance of factoring in data relating to possible patient harm from prolonged waits was acknowledged	**Partial Assurance**	**BAF 3**	
Patient Access Governance Group Report **Cancer Performance**	Cancer performance remains challenged in most areas. However, following the detailed presentation of cancer performance standards and plans at last month's Insight meeting and at Board, it was noted that the 62 day Treatment backlog is starting to improve. The Trust aims to achieve the key 28 day Faster Diagnosis standard by April 2023. Performance will continue to be monitored at Insight	**Partial Assurance**	**BAF 3**	
Patient Access Governance Group Report **Diagnostic performance**	Improvement was noted in CT and Echo performance. Challenges remain in Endoscopy and Ultrasound Plans are in place to improve performance in both areas. A deep-dive into Trust Endoscopy performance and plans is scheduled to come to Insight in May	**Partial Assurance**	**BAF 3**	

	A SNEE deep-dive into diagnostic performance and system-wide action plan is anticipated in January			
Patient Access Governance Group Report **12 Hour LOS Waits**	A detailed recovery plan was presented. 12 hour performance in ED remains a significant concern. This is a complex problem with multiple system-wide components. Positives include: • Focus on care of patients within ED (e.g. – Consultant risk assessment of patients waiting in ambulances – and initiation of required investigations, provision of hot meals, 'ward' and 'medication' rounds within ED) • Ambulance handover times – whilst not achieving targets, performance is good in comparison to other regional Trusts Key Challenges include: • Pressure on ED staff – and the 'moral' injury of not being able to provide the best care • Flow out of ED (and of course out of hospital) • High levels of patient frailty The recovery plan provides assurance that the Trust understands the challenges and has appropriate plans in place in relation to the issues that the Trust has direct control over. Ultimately solutions to the emergency care challenges depend on changes to the ways that care is managed across the health and social care system. The Trust has responsibilities both in terms of taking ownership of those elements within its control, and also in terms of its collaboration with system partners to enact change. There is an acknowledgment that solutions are not simple and that pressures are likely to remain high during the winter. It is important to recognise that staff across the Trust continue to go 'above and beyond' in the care of patients despite the enormous pressures they are facing – and that it is this commitment to patient care that ultimately provides the most compelling assurance	**Limited Assurance**	**BAF 2**	
Date Completed and Forwarded to Trust Secretary		**23.12.22**		

Chair's Key Issues

Originating Committee	Insight Committee	Date of Meeting	9th January 2023
Chaired by	Richard Davies	Lead Executive Director	Nicola Cottington

Item	Details of Issue	For: Approval/ Escalation/Assurance	BAF/ Risk Register ref	Paper attached? ✓
Financial Accountability Committee	Following the creation of a new Trust People and Culture Committee, assurance regarding workforce issues will now be provided through the Involvement Committee. The Finance and Workforce Governance Group has therefore developed into a new Financial Accountability Committee which will focus entirely on financial issues. Assurance for this committee will continue to be provided through the Insight Committee. The Terms of Reference for the Financial Accountability Committee were discussed and some changes suggested (particularly in relation to attendees). Since this is a new committee it was agreed that the ToR will be reviewed in 6 months	**Approval**	**BAF 5**	
Financial Accountability Committee **Management Service for Endoscopy and Radiology**	The current contract expires at the end of March 2023. A tendering process has been enacted and there are a number of possible options for the replacement of this contract. It was agreed that some further clarification was required prior to making a final decision and in view of the short timeline, a final decision would be discussed at the next Insight meeting in February, which will allow adequate time to ensure that an appropriate contract is in place from the beginning of April	**Information**	**BAF 5**	
Financial Accountability Committee **Better Payment Practice Code (BPPC)**	This national standard requires NHS organisations to pay 95% of all invoices in line with contract terms. The Trust is the worst performing in the region (performance as at 30th November 2022 was 82.3%). The key issues for the Trust are the complexities of the standalone Procurement System and staff training. A fully integrated purchase to pay system has been ordered and it is anticipated that this development, with the associated staff training, will have	**Assurance**	**BAF 5**	

	a very significant impact on Trust performance. Assurance was received that the current action plan will enable the Trust to achieve the BPPC standard			
Patient Access Governance Group Report **Community Paediatrics**	The committee received an update in relation to the challenges faced by Community Paediatric Services. Service provision in relation to neurodiversity diagnosis and support is complex and involves a number of system partners. An independent consultant has been recruited to undertake a review, starting with a fact-finding process. An update will be provided at the next Insight meeting with a clearer timeline for a detailed review and action plan A separate issue of concern is the ongoing pressure on paediatric SLT services, with high referral rates, and significant capacity issues across the region. National mutual aid has been requested and it is not yet possible to provide a clear recovery forecast	**Limited Assurance**	**BAF 3**	
Patient Access Governance Group Report **Access Standards**	Long Waits Performance for 104 week waits has been maintained, and focus remains on 78 week waits, with a forecast in place for continued improvement. Urogynaecology remains a particular challenge Cancer performance KPIs are not currently showing signs of improvement, with Lower GI, Breast, and Urology showing particular challenges. As detailed in previous meetings an action plan is in place and this will continue to be monitored. One positive is the effective uptake of FIT testing in primary care Emergency performance All performance indicators have deteriorated and as previously discussed emergency care remains under enormous pressure despite ongoing work throughout the Trust and the System	**Limited Assurance**	**BAF 2 and 3**	
Patient Access Governance Group Report	The committee received an excellent deep dive presentation into the regional Stroke Early Supported Discharge service. The service has very significantly	**Celebration**		

Stroke Early Supported Discharge	reduced the average length of stay for stroke patients, with excellent patient satisfaction and clinical outcome data. Further potential developments such as the possibility of extending the service to 6 or 7 days a week and enhancing the provision of clinical psychology were discussed, as well as the potential for dissemination of learning to other rehabilitation services.			
Patient Access Governance Group **Theatre Efficiency**	The committee received a paper providing assurance in relation to the mechanisms in place to ensure appropriate overview of theatre efficiency and plans to support improvement. Whilst WSFT is currently in the lowest performing quartile for theatre utilisation, there has been significant improvement over time and there are effective assurance mechanisms in place to provide appropriate oversight of progress against objectives	**Partial Assurance**	**BAF 3**	
Corporate Risk Governance Group	There is ongoing work in relation to the BAF and the Board Risk Register to ensure that they are used most effectively to support improvement. This work will be presented at future Board and Insight Committee meetings.	**Information**		
Date Completed and Forwarded to Trust Secretary		**11.1.23**		

4.2. Finance Report

To Assure

Presented by Nick Macdonald

Board of Directors - Public

Report title:	**Finance and Workforce Board Report – December, 2022**
Agenda item:	4.2
Date of the meeting:	2 February, 2023
Sponsor/executive lead:	Nick Macdonald, Executive Director of Resources (Interim)
Report prepared by:	Charlie Davies, Deputy Director of Finance (Interim)

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

Executive summary

Income and Expenditure Summary as at December 2022

The reported I&E for December is breakeven (YTD £0.2m deficit). At present, it is still appropriate to anticipate a break-even position for 22/23 in line with our budget.

Over the course of the last 3 financial years, the Trust has received significant non-recurrent funding to support our response to the COVID 19 pandemic (20/21 £14m, 21/22 £14m, 22/23 £5.9m). During this period the Trust has not needed to utilise all this funding on Covid related expenditure and has therefore been able to retain a proportion of it to be able to use non-recurrently.

In 22/23, a number of factors lead us to estimate that the Trust has an underlying recurring deficit of £15m, including: the recurrent nature of some services initially introduced during the pandemic, an underlying deficit entering into the pandemic, reduced CIP achievement over the period and cost pressures relating to inflationary funding that have arisen during 22-23.

As such, in 22/23 we are planning to utilise the retained non-recurrent support to offset this deficit and achieve the mandated breakeven position. However we do not anticipate there being similar support available in 23/24.

With planning guidance released in late December ’22, we now understand a number of assumptions included within our allocation (i.e. level of funding) for 23/24 around pay awards, non-pay inflation and CIP requirements. In addition, for planning purposes we are assuming that there will be sufficient growth funding to enable a £3m investment fund in 23/24 and that the Trust meets the elective activity target and therefore does not incur any funding shortfall.

With the underlying deficit brought forward, it is prudent to plan for a deficit of £15m in 23/24. This however is dependent on the full achievement of a £10m CIP in 23/24.

Capital Forecast
The forecast capital spend as at month 9 is £39.27m. However, this is expected to increase as the Trust is awarded further funding for specific projects, all of which must be spent by the 31 March. Further details can be seen on page 9.

Action required of the Board
The Board is asked to review this report.
Recommendation
N/A

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

FINANCE REPORT
December 2022 (Month 9)

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

Financial Summary

I&E Position YTD	£0.2m	adverse
Variance against Plan YTD	£0.2m	adverse
Movement in month against plan	£0m	on-plan
EBITDA position YTD	£13.7m	favourable
EBITDA margin YTD	5%	favourable
Cash at bank	£7m	

Executive Summary

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

Key Risks in 2022-23

- Any unanticipated costs of potential industrial action.
- Unanticipated costs of winter pressures
- Impact of unfunded inflationary pressures. In the planning round the Trust was funded for inflation at broadly 6%, whilst however we have seen inflation significantly above
- Inability to earn ERF for performance.
- Risks around the costs of additional sessions

SUMMARY INCOME AND EXPENDITURE ACCOUNT - December 2022	December 2022			Year to date			Year end forecast		
	Budget	Actual	Variance F/(A)	Budget	Actual	Variance F/(A)	Budget	Actual	Variance F/(A)
	£m	£m	£m	£m	£m	£m	£m	£m	£m
NHS Contract Income	26.7	26.7	0.0	240.3	240.3	(0.0)	310.9	315.3	4.4
Other Income	3.3	3.4	0.1	28.8	28.4	(0.4)	38.8	37.9	(0.9)
Total Income	**30.0**	**30.0**	**0.1**	**269.1**	**268.7**	**(0.4)**	**349.8**	**353.1**	**3.5**
Pay Costs	19.6	19.5	0.1	180.4	176.4	3.9	240.6	238.4	2.2
Non-pay Costs	9.2	9.0	0.2	77.2	78.5	(1.4)	93.9	96.8	(2.8)
Operating Expenditure	**28.8**	**28.5**	**0.3**	**257.5**	**255.0**	**2.6**	**334.6**	**335.2**	**(0.5)**
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
EBITDA	**1.2**	**1.5**	**0.3**	**11.5**	**13.7**	**2.2**	**15.2**	**17.9**	**3.0**
Depreciation	0.8	0.9	(0.1)	7.6	8.6	(1.0)	9.8	11.7	(1.9)
Finance costs	0.4	0.6	(0.2)	4.0	5.3	(1.3)	5.3	6.3	(1.0)
SURPLUS/(DEFICIT)	**(0.0)**	**0.0**	**0.0**	**(0.0)**	**(0.2)**	**(0.2)**	**0.0**	**(0.0)**	**0.0**

FINANCE REPORT – December 2022

Contents:

- Income and Expenditure Summary Page 3
- Cost Improvement Programme Page 3
- Trends and Analysis Page 4
- Income and Expenditure by Division Page 5
- Balance Sheet Page 8
- Cash Page 8
- Debt Management Page 9
- Capital Page 9
- Annex 1 – Benchmarking Page 10

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 – December 2022

Income and Expenditure Summary as at December 2022

The reported I&E for December is breakeven (YTD £0.2m deficit). At present, it is still appropriate to anticipate a break-even position for 22/23 in line with our budget. Over the course of the last 3 financial years, the Trust has received significant non-recurrent funding to support our response to the COVID 19 pandemic (20/21 £14m, 21/22 £14m, 22/23 £5.9m). During this period the Trust has not needed to utilise all this funding on Covid related expenditure and has therefore been able to retain a proportion of it to be able to use non-recurrently.

In 22/23, a number of factors lead us to estimate that the Trust has an underlying recurring deficit of £15m. These factors include

- the recurrent nature of some services initially introduced during the pandemic that are over and above the remaining Covid funding (including MAU and the staff psychology service),
- an underlying deficit entering into the pandemic
- reduced recurrent CIP achievement over the period and
- cost pressures relating to inflationary funding that have arisen during 22-23

As such, in 22/23 we are planning to utilise the retained non-recurrent support to offset this deficit and achieve the mandated breakeven position. However we do not anticipate there being similar support available in 23/24.

Summary of I&E indicators

Income and Expenditure	Plan/ Target £000'	Actual/ Forecast £000'	Variance to plan (adv)/ fav £000'	Direction of travel (variance)	RAG (report on red)
In month surplus/ (deficit)	(0)	0	(0)	⟷	Green
YTD surplus/ (deficit)	0	(170)	(171)	⟷	Amber
EBITDA YTD	11,537	13,725	2,188	↑	Green
EBITDA %	4.3%	5.1%	0.8%	↓	Green
Clinical Income YTD	(250,145)	(249,038)	(1,107)	↓	Red
Non-Clinical Income YTD	(18,913)	(19,657)	744	↑	Green
Pay YTD	180,361	176,426	3,935	↑	Green
Non-Pay YTD	88,705	92,457	(3,751)	↓	Red

Budget setting and planning for 23/24

With planning guidance released in late December '22, we understand that the following are included within our allocation (i.e. level of funding) for 23/24:

- Pay awards will be funded at 2%. Any agreed award above 2% will be funded separately.
- Non-pay inflation is funded at 5.5%.
- The system will receive PbR for elective activity beyond ICB elective activity target. This target itself will be based on adjusted 22-23 performance relative to 19-20 levels.
- The block contract will exist for non-elective activity.
- There is a requirement of cost improvements of 3%. This equates to £10m for WSFT.

In addition to this, we are assuming:

- Depreciation charges are funded in relation to any COVID related capital or RAAC expenditure
- There will be sufficient growth funding to enable a £3m investment fund in 23/24. Through the work of the Investment Panel, this £3m has already been allocated to schemes in 23/24. Therefore if growth funding isn't available, these schemes will represent cost pressures to the Trust.
- The Trust meets the elective activity target and therefore does not incur any funding shortfall

With the underlying deficit brought forward, it is prudent at this initial stage to plan for a deficit of £15m in 23/24. This however is dependent on the full achievement of the £10m CIP in 23/24.

Capital Forecast

The forecast capital spend as at month 9 is £39.27m. However, this is expected to increase as the Trust is awarded further funding for specific projects, all of which must be spent by the 31 March. Further details can be seen on page 9.

FINANCE REPORT – December 2022

Trends and Analysis

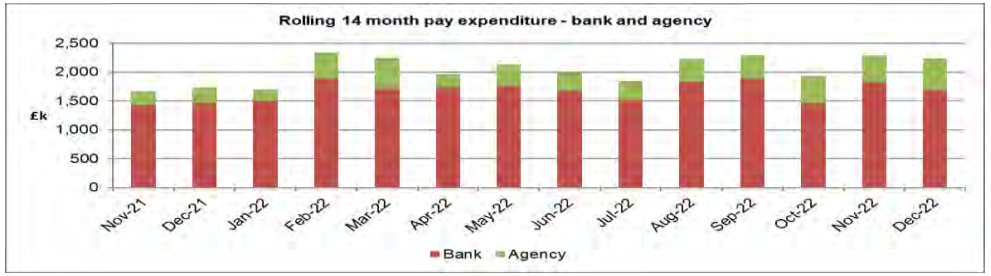
Workforce

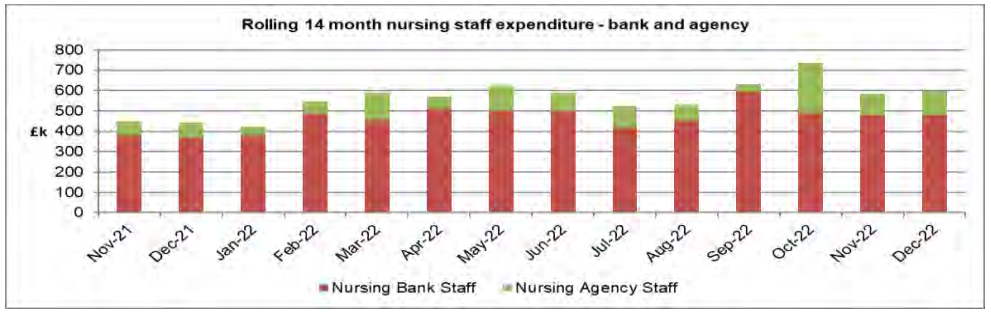
During December the Trust underspent by £0.1m on pay

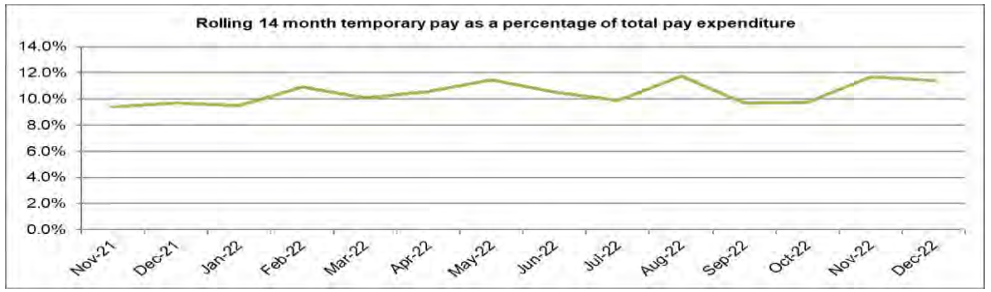
Monthly Expenditure (£)				
As at December 2022	Dec-22	Nov-22	Dec-21	YTD
	£000's	£000's	£000's	£000's
Budgeted Costs in-month	19,615	20,308	17,938	180,361
Substantive Staff	17,305	17,330	16,092	157,520
Medical Agency Staff	259	255	113	1,485
Medical Locum Staff	413	451	341	3,534
Additional Medical Sessions	239	243	302	2,197
Nursing Agency Staff	120	103	74	964
Nursing Bank Staff	479	481	369	4,420
Other Agency Staff	160	109	88	1,082
Other Bank Staff	241	247	183	2,159
Overtime	193	216	139	1,664
On Call	137	180	121	1,402
Total Temporary Expenditure	2,242	2,285	1,730	18,907
Total Expenditure on Pay	19,547	19,615	17,822	176,426
Variance (F/(A))	68	693	116	3,935
Temp. Staff Costs as % of Total Pay	11.5%	11.6%	9.7%	10.7%
memo: Total Agency Spend in-month	539	467	275	3,531

Monthly WTE				
As at December 2022	Dec-22	Nov-22	Dec-21	YTD
Budgeted WTE in-month	4,823.0	4,823.0	4,533.2	55,020.5
Substantive Staff	4,308.6	4,300.8	4,066.9	38,100.4
Medical Agency Staff	11.3	12.7	4.9	89.2
Medical Locum Staff	42.6	39.1	28.3	346.9
Additional Medical Sessions	8.3	5.6	11.7	43.9
Nursing Agency Staff	13.3	14.9	11.2	133.6
Nursing Bank Staff	123.1	125.6	112.0	1,115.2
Other Agency Staff	29.4	21.8	15.8	215.0
Other Bank Staff	82.6	84.7	68.3	721.9
Overtime	50.1	54.4	36.7	419.2
On Call	6.3	7.4	6.8	74.1
Total Temporary WTE	367.0	366.1	295.7	3,158.9
Total WTE	4,675.6	4,666.9	4,362.5	41,259.3
Variance (F/(A))	147.4	156.1	170.7	13,761.2
Temp. Staff WTE as % of Total WTE	7.8%	7.8%	6.8%	7.7%
memo: Total Agency WTE in-month	54.0	49.3	31.9	437.8

Pay Costs







FINANCE REPORT – December 2022

Income and Expenditure Summary by Division

Position by Income, Pay and Non Pay	Income		Pay		Non Pay		Capital Charges and Financing Costs		Total	
Division (groups)	In-Month Variance £	YTD Variance £	In-Month Variance £	YTD Variance £	In-Month Variance £	YTD Variance £	In-Month Variance £	YTD Variance £	In-Month Variance £	YTD Variance £
Facilities	-257K	-1,757K	21K	131K	-67K	-314K			-302K	-1,940K
Medical Services	8K	78K	-166K	-776K	-453K	-757K			-611K	-1,454K
Clinical Support	17K	309K	65K	255K	95K	-392K			178K	172K
Contract Income & Corporate	-159K	-421K	143K	1,920K	1,364K	1,300K	-320K	-2,358K	1,028K	440K
Woman & Children Services	177K	793K	-8K	174K	-38K	-384K			130K	584K
Community Services	207K	-34K	83K	557K	-159K	92K	0K	1K	131K	616K
Surgical Services	70K	669K	-71K	1,673K	-552K	-929K			-553K	1,414K
Total	**63K**	**-363K**	**68K**	**3,935K**	**190K**	**-1,384K**	**-320K**	**-2,357K**	**1K**	**-169K**

Medicine (Sarah Watson)

The Medicine division reported an adverse variance of £611k for December (YTD £1.45m).

Pay expenditure reported a deficit of £166k in December (YTD £776k), however, there were large compensating variances between different staff groups. The key year to date variances are:

- Registered Nurses - The division is reporting a surplus of £1.9m for Registered Nurses as the division continues to struggle to recruit to registered nurse vacancies.
- Unregistered Nurses- There is a £570k deficit to partially compensate for Registered Nurses vacancies (including the use of temporary staffing solutions).
- Medical Doctors - £1.750m deficit on Medical staffing. Key drivers are the use of locums and additional sessions to cover for sickness and leave; difficulties in recruiting substantively to mid-grades within ED and a higher than anticipated the number of junior doctors.

The key drivers behind the non-pay budget variance for the year-to-date are;

- Drugs- There is an overspend of £550k (4%) in the division. Set against a national benchmark for NHS drug inflation of 9%, the division has is managing to contain the overall drugs costs thus far.
- Operating leases- There is a YTD overspend of (£0.1m) for equipment leases within Cardiology. Work is in progress to capitalise these expenses in line with IFRS 16 guidelines
- Med & Surgery equipment- Disposable and non-disposable equipment spend is 30% over budget YTD, this could be attributed to the volumes used.

Surgery (Moira Welham)

In December, the division reported a deficit of £553k (YTD £1.41m underspend).

Pay expenditure reported an overspend of £71k in month (underspend of £1.67m YTD). Overspends in month are driven by an increased usage in temporary staffing to cover vacant posts and sickness, predominantly within Plastic Surgery, Urology and Theatres.

Non-pay expenditure reported an overspend of £552k in month (£929k YTD). The overspend is driven by the continued use of external providers to support the recovery work in addition to the increased expenditure on clinical supplies within our theatres.

Women and Children's (Simon Taylor)

In December, the Division reported a favourable variance of £130k (YTD favourable variance of £583k).

Paediatric income was ahead of plan both in month (£21k) and YTD (£196k) relating to Tricare income for one patient. Women's income is ahead of plan YTD (£570k) due to doctor and other training income being higher than anticipated, plus funding received towards midwifery retention support. There was also significant income in the current month relating to maternity workforce income for 22/23 from NHS England totalling £67.7k for the year, with most of this being recognised in M9.

Pay reported a £8k overspend in-month (£174k underspend YTD), as there was a significant overspend in paediatrics and obstetrics pay costs largely netted off by an underspend in Maternity Services. In obstetrics, there is a known cost pressure of 0.8WTE unfunded consultant post and in paediatrics the overspend is largely due to sickness and resource gaps within Medical staffing. Meanwhile, the continued struggle to fill vacancies within Maternity (due to the national shortage of midwives) is driving the YTD underspend.

Non-pay costs are overspent in month by £38k (YTD £383k overspend) predominantly due to drugs overspends. There is an increase of women on the obs & gynae waiting lists and therefore drugs spend increase whilst they wait for treatment. In addition, the drug treatments in paediatrics for respiratory illnesses started much earlier, with this trend expected to continue.

Clinical Support (Simon Taylor)

In December, the Division reported a favourable variance of £178k (YTD £172k favourable variance).

Income was £17k ahead of plan in-month, which predominantly due to histopathology income which has been higher than budgeted throughout the year. The YTD shows income at £309k ahead of plan.

Pay reported an in-month underspend of £65k (YTD £254k underspend) with Pathology and Diagnostics both incurring additional costs, offset by vacancies in Pharmacy, Outpatients and Support. The division continues to carry significant vacancies in both pharmacy and outpatients.

Non-pay reported £94k underspend in-month (YTD £392k overspend), largely a result of re-estimating YTD outsourcing costs which had been over-accrued (£208k). Offsetting this, the division continues to overspend on recovery measures for CT and endoscopy, as well as increased activity in pathology (including Roche and Leica ongoing contracts which are unbudgeted). The division continues to progress replacement of CT2 and the installation of the third CT scanner.

Community Services (Clement Mawoyo)

The Community Division reported a favourable variance of £131k in M9 of 2022/23 (YTD £615k favourable).

Income reported a £207k over recovery in December (£34k adverse YTD), due to higher than budgeted growth and inflation funding recognised in the Division. Following the transfer of the Covid vaccination service to the Community Division, additional income from this service is now reflected in the monthly position too.

Pay reported a favourable variance of £83k in December (YTD £557k favourable). Pay expenditure has continued to increase in line with budget, to reflect recruitment to externally funded urgent community (responsive) additional roles as well as new roles funded via external business cases (such as roles supporting Autism Spectrum Disorder service recovery) or other external grants (such as MacMillan).

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

Non-pay reported a £159k adverse variance in December (£92k favourable YTD). Pressures noted under community equipment costs, driven by increased demand which were partially offset by additional collection credits for returned core stock items of equipment. Additional external funding has been ringfenced for Community

Equipment as a key enabler to supporting hospital discharge and will be reflected in January's position (and ongoing until March) and should therefore not create an in-year cost pressure.

Additional non-pay cost pressures were from additional costs incurred by wheelchair services, in line with the recovery trajectory for the service. Prior to this we had a year to date underspend on wheelchair services so the year to date position remains favourable. This position is also reflective of the good work we have done to increase recycling of equipment, to ensure sustainability. Other cost pressures were from dressings and disposables, reflecting increased activity and the higher acuity of patients supported in the Community.

Estates and Facilities

In December, the division recorded an adverse variance of £302k, (YTD adverse variance of £1.94m). The financial year shortfall in income stands at £1.76m with non-pay costs overspent by £314k, pay costs are broadly in line with budgeted values.

Car parking income improved to £102k, but was still below budgeted levels (£67k). Should the monthly figure achieved be consistent the £350k transfer from the investment panel will cover shortfalls for the year leaving the variance to budget as (£595k) for the financial year. Catering incomes continue to record monthly adverse variances to budget (£79k) as the Time Out Restaurant remains closed to patients and visitor. Pay costs both in month (£15k) and for the year (£107k) were favourable to budget owing to the current vacancy factor within the directorate.

Non-Pay costs have an adverse variance to monthly budget of £134k driven by Utilities expenditure (£337k overbudget). A request from reserves will be made address this in M10 and the increased energy expenditure will be budgeted based on anticipated inflated levels.

FINANCE REPORT – December 2022

Statement of Financial Position at 31 December 2022

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2022	Plan 31 March 2023	Plan YTD 31 December 2022	Actual at 31 December 2022	Variance YTD 31 December 2022
	£000	£000	£000	£000	£000
Intangible assets	52,039	56,905	56,911	54,163	(2,748)
Property, plant and equipment	170,887	188,990	182,189	176,917	(5,272)
Right of use assets		12,425	13,484	13,925	441
Trade and other receivables	5,807	6,341	6,341	5,807	(534)
Total non-current assets	**228,733**	**264,661**	**258,925**	**250,812**	**(8,113)**
Inventories	3,574	3,689	3,689	3,887	198
Trade and other receivables	15,069	18,362	18,362	25,916	7,554
Cash and cash equivalents	33,323	10,767	9,849	7,025	(2,824)
Total current assets	**51,966**	**32,818**	**31,900**	**36,828**	**4,928**
Trade and other payables	(60,164)	(38,925)	(37,675)	(46,417)	(8,742)
Borrowing repayable within 1 year	(5,858)	(9,684)	(10,743)	(7,203)	3,540
Current Provisions	(38)	(46)	(46)	(8)	38
Other liabilities	(2,888)	(5,685)	(5,685)	(1,966)	3,719
Total current liabilities	**(68,948)**	**(54,340)**	**(54,149)**	**(55,594)**	**(1,445)**
Total assets less current liabilities	**211,751**	**243,139**	**236,676**	**232,046**	**(4,630)**
Borrowings	(44,002)	(47,927)	(49,209)	(51,157)	(1,948)
Provisions	(415)	(852)	(852)	(415)	437
Total non-current liabilities	**(44,417)**	**(48,779)**	**(50,061)**	**(51,572)**	**(1,511)**
Total assets employed	**167,334**	**194,360**	**186,615**	**180,474**	**(6,141)**
Financed by					
Public dividend capital	200,285	227,311	219,566	213,595	(5,971)
Revaluation reserve	11,704	11,704	11,704	11,704	0
Income and expenditure reserve	(44,655)	(44,655)	(44,655)	(44,825)	(170)
Total taxpayers' and others' equity	**167,334**	**194,360**	**186,615**	**180,474**	**(6,141)**

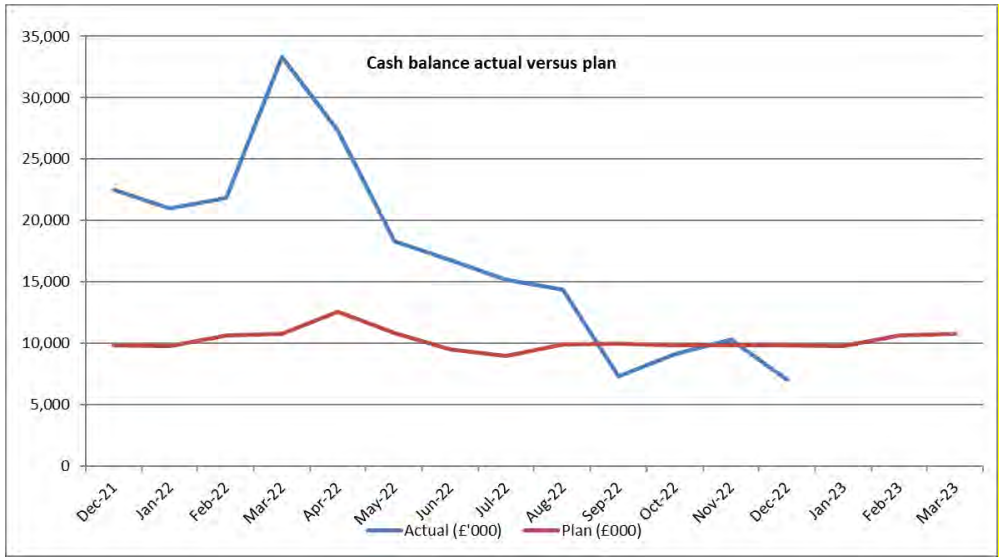
The impact of IFRS16 (right of use assets) is now reflected in the actual figures in the balance sheet above. The split in the actuals between property, plant and equipment and borrowing (current and non-current) to reflect the lease liability is now more accurate and therefore slightly different to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

The phasing of the PDC is not in line with the plan, which is showing a significant movement in month 9. The same applies for trade payables and other liabilities. However, if the plan was corrected, these movements would net off to a minimal movement.

A better comparison of trade payables is to the prior year outturn and the prior month. The movement since the year end is in line with expectations as a number of aged creditors have been paid. The movement in creditors and accruals is in line with the previous month (£46m at month 8).

Cash Balance Forecast for the year

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



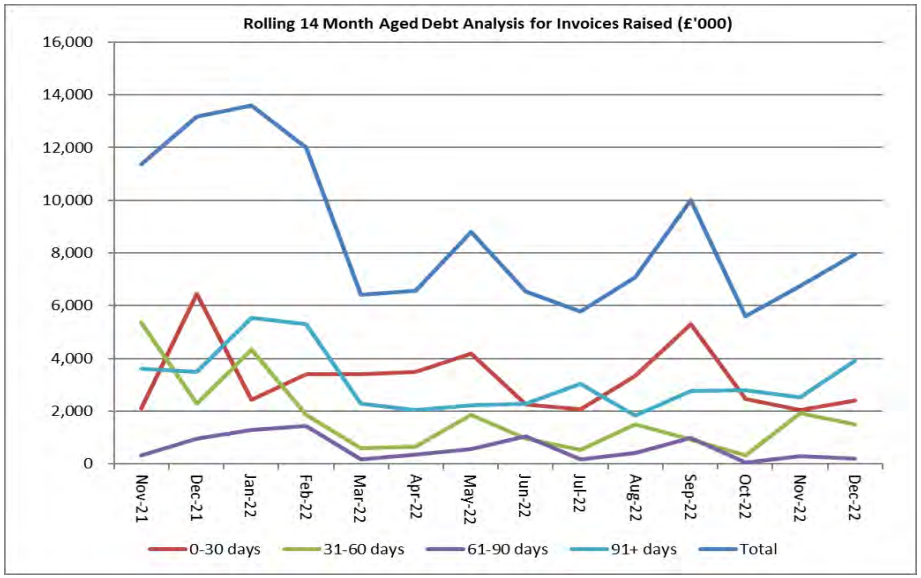
The cash position is slightly below plan at month 9, however we will closely monitor the position to ensure that it remains in line with the year-end forecast of £10.7m. One reason is due to the number of receivables outstanding at the end of month 9, when it was anticipated that more income would have been received.

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

FINANCE REPORT – December 2022

Debt Management

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



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

The overall level of sales invoices raised but not paid has increased slightly as at month 9 and this is mainly in relation to debts with other NHS Organisations that have become overdue. A large proportion of the debts outstanding are historic debts, although these are reducing. Over 86% of these outstanding debts relate to NHS Organisations, with 49% of these NHS debts being greater than 90 days old. We are actively trying to agree a position with the remaining corresponding NHS Organisations for these historic debtor balances and a significant amount of work has been completed in this area to help reduce these historic balances.

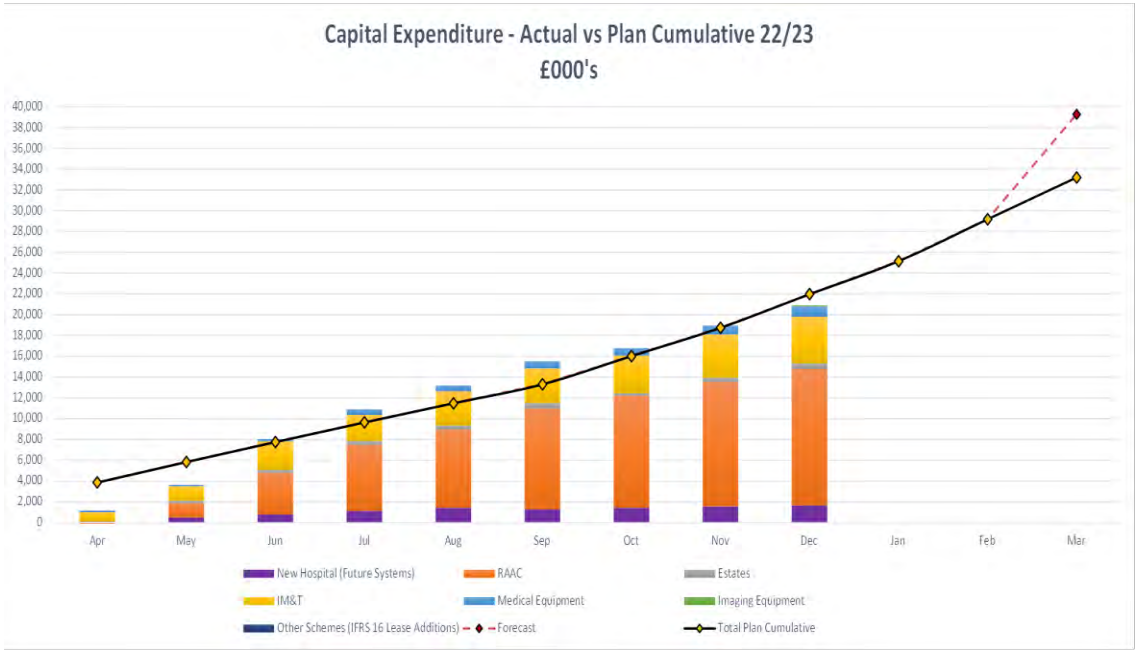
Capital Progress Report

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

The forecast of capital spend is being rigorously monitored and is under constant review. Since the Capital Plan was set, the Trust has been awarded additional PDC funding for specific capital items. These are noted in the table below. It is anticipated that further additional funding will be received during the financial year, particularly for IT projects, which will need to be spent by 31 March 2023.

The year to date capital spend for month 9 was £20.9m. The table below shows the capital forecast as per the original plan, plus the additional PDC funding for which the final approved documentation has been received in month 9.

Capital Spend - 31st December 2022	Year to Date					Forecast				
Capital Scheme	YTD Original Plan	YTD Actual	Variance	PO's Outstanding / Commitments	Total YTD Inc Commitments	Full year Original Plan	Funding Split		Full Year Forecast to 31st Mar 2023	Total Full Year Variance Forecast vs Available Funds
							Internal	PDC Available		
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
New Hospital (Future Systems)	796	1,656	(860)	402	2,058	1,060	1,000	1,332	2,332	(1,000)
RAAC	13,247	13,121	126	9,379	22,500	21,000		22,500	22,500	-
Estates	1,424	534	890	480	1,014	1,435	1,435	2,318	3,753	-
IM&T	4,262	4,479	(217)	1,094	5,572	5,675	5,675	88	5,763	-
Medical Equipment	350	860	(510)	2,331	3,191	400	400	1,424	1,824	-
Imaging Equipment	-	242	(242)	2,066	2,307	1,740	740	467	1,207	-
Other Schemes (incl. IFRS 16 Lease Additions)	1,891	-	1,891	-	-	1,891	-	1,891	1,891	-
Total Capital Schemes	21,970	20,891	1,079	15,752	36,643	33,201	9,250	30,020	39,270	(1,000)
Overspent vs Plan										
Underspent vs Plan										


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

4.3. Operational Response:

To Assure

Presented by Nicola Cottington and Clement Mawoyo

4.3.1. West Alliance Seasonal Plan

To inform

Presented by Nicola Cottington and Clement Mawoyo

Board of Directors - Public

Report title:	**West Alliance Seasonal Plan (update)**
Agenda item:	**4.3.1**
Executive lead:	Nicola Cottington – executive chief operating officer Clement Mawoyo- director of integrated adult health and social care
Report prepared by:	Lesley Standring - head of operational improvement Lucy Webb – transformation lead West Suffolk Alliance

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

Trust strategy	FIRST FOR PATIENTS	FIRST FOR STAFF	FIRST FOR THE FUTURE
Please indicate ambitions relevant to this report	☒	☒	☒

Executive summary
The following slides provide an update on the alliance seasonal plan presented to board in November 2022. The slides set out the funding committed from 1st October 22 to 31st March 2023 for schemes to support patient flow. We also identify slippages, risks and mitigation for individual schemes. The seasonal plan is sponsored by the Alliance director and has been co-produced by partners through a dedicated seasonal planning working group reporting into the West Suffolk Alliance Operational Resilience Group. The plan integrates where appropriate with organisational plans of WSFT, NSFT, and SCC. The plan has been shared with Urgent and Emergency Care Committee and forms part of the wider SNEE Seasonal Plan.
Action required/recommendation
The Board are asked to note the update

Previously considered by:	Suffolk Alliance Operational Resilience 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: If we do not deliver elective access standards based on clinical priorities in the context of Covid activity, this will affect our ability to deliver safe, effective and efficient services and care to patients. ***Note the description of these risks currently under review***

Equality, Diversity and Inclusion:	The Equitable access to services and reducing health inequalities underpin the Alliance strategy and the Live Well domains.
Sustainability:	Plans should be undertaken in line with best practice for sustainability and make the best use of resources.
Legal and regulatory context:	Utilisation of funding must be in line with the guidance set out by NHS England. Providers of care must be CQC registered.

West Suffolk Seasonal Plan

Presented by Nicola Cottington & Clement Mawoyo

Purpose – Update

Oversight, Governance and Principles

The Seasonal Plan is sponsored by the Alliance Director and has been co-produced by partners through a dedicated Seasonal Planning Working Group reporting into the West Suffolk Alliance Operational Resilience Group. The plan integrates where appropriate with the organisational plans of WSFT, NFST and SCC.

The plan has been shared with the Urgent and Emergency Care Committee and forms part of the wider SNEE Seasonal Plan.

The Seasonal Planning Working Group has agreed the following set of shared working principles to delivery of our plan:

- The seasonal period for the purpose of this plan starts from 1 October 22 to 31 March 23
- Schemes will support delivery of the ambitions set out in the west Suffolk Alliance Seasonal Plan and make progress on the key enablers of integration
- All schemes are signed off and overseen by the Alliance partners through the Operational Resilience Group which has delegated authority for decision making from the Alliance Committee

Oversight, Governance and Principles cont.

- Schemes were prioritised based on impact and ease of implementation
- Schemes have a named owner who is ensuring the proposed outcome/impact, start and finish dates and associated risks are recorded on the seasonal planning document
- The seasonal planner will maintain a planned v actual trajectory of impact against all schemes.
- All funding slippage will be pooled for the Alliance to allocate to other areas of need
- An evaluation of the schemes will be conducted at the end of the season.
- The coordinator for seasonal planning in west Suffolk is lucy.webb@wsh.nhs.uk

West Alliance Seasonal Plan

Scheme	Start date	Revised Start Date	Cost	Slippage/under/ over spend	Funding Source	Lead	Comments	Governance/approval	RAG mobilisation
Hybrid CAB model Operate a hybrid of Community Assessment Beds and spot purchased with significant 'wrap round' reablement support to manage length of stay. Convert 15 block purchased bed to the CAB model and spot purchase up to 10 beds as necessary	Oct-22	N/A	£419,110.71	Monitored by WDF reporting	Winter Discharge Fund	Lesley Standring/ Georgie Stevens/Gylda Nunn	**Discharge Risks associated** – Dependant on care home capacity and workforce for wrap around support.	West Suffolk Alliance Operational Group	
Additional beds at SNHC SNHC will increase their bed capacity from 8 to 12 until 31-3-23 including staffing, pharmacy, catering and domestic cost	Oct-22	N/A	£200k	N/A	Demand & Capacity	Cara Twinch/ Sharon Basson	**Discharge Risk associated** - Workforce dependent and service variation agreements	West Suffolk Alliance Operational Group	
Increase interim care home beds Block purchase and/or spot purchase care home beds	Oct-22	N/A	£334,500	Awaiting reconfiguration of figures	Demand & Capacity	Michelle Glass / Georgie Stevens	**Discharge Risk associated** – Dependant on care home capacity.	West Suffolk Alliance Operational Group & Suffolk Healthcare & education strategic planning group	
Reduce P1 discharge delays Use of external care provider 'Airmid', to provide bridging service to support Home First to enable better system Flow. Support of HomeFirst will allow Support to Go Home to reduce support to Home First and concentrate on Pathway 1 discharges. HomeFirst agency in addition to Airmid is included in the cost provided.	Dec-22	N/A	£532k	Current invoice until mid December. Awaiting. Monitored by WDF reporting	Winter Discharge Fund	Georgie Stevens	**Discharge Risk associated –** Work force dependant	West Suffolk Alliance Operational Group	
Virtual Ward A safe and efficient alternative to NHS bedded care, enabled by technology. Supporting patients who would otherwise be in an acute hospital bed. Virtual Ward supports early discharge and preventing avoidable admissions.	Nov-22	N/A	£845,264	Slippage – TBC with finance	Virtual Ward Business Case	Lucy Webb/ Kevin McGinness	**Discharge and Admission prevention**	West Suffolk Alliance Operational Group, West Suffolk Alliance Committee & SDAB	
Additional patient Discharge vehicle Additional discharge patient vehicle to support patient discharge via a private ambulance, allowing flexibility between stretcher and wheelchair bound patients. 10hr shifts (8:00 - 18:00) 7 days per week. Ability of immediate start	Nov- 22	N/A	£100k	Monitored by WDF reporting	Winter Discharge Fund	Lesley Standring/Gary Ingalla	**Discharge**	West Suffolk Alliance Operational Group	

Scheme	Start date	Revised start date	Cost	Slippage/under/ over spend	Funding Source	Lead	Comments	Governance/approval	RAG mobilisation
Improve discharges – Criteria Led discharge CLD is a process that empowers a competent member of the multidisciplinary team to discharge a patient when they meet pre-agreed clinical criteria for discharge	Oct-22	N/A	£0	N/A	Health & Care Interface Fund - WS £996k	Lesley Standring	**Discharge Risks associated** – Dependant on medical staffing cooperation. Implementation mid – October 2022.		
Delirium Nurse specialist The specialist nurse supports patients with a delirium who have transferred from an acute hospital bed to an interim Care Home bed– monitoring their recovery and liaising with family, social care, and other stakeholders	Jan-23	March-23	£60k	Delay in recruitment FYE	Health & Care Interface Fund - WS £996k	Lesley Standring/ Lois Bull	**Discharge Risk associated** – Recruitment dependant. Position appointed start date March. Links with spot purchased delirium beds.		
Live in care Expansion of enhanced live –in provision, additional to current provision	Oct-22	N/A	£55k	Likely slippage due to patient need and patient home capacity.	Virtual Ward Double Count	Michelle Glass/ Georgie Stevens	**Discharge Risk associated** - Dependent on live-in provider capacity, patient home capacity. Risk of how to remove live in provider once discharged	West Suffolk Alliance Operational Group	
INT Phlebotomy Phlebotomy provision is a system pressure due to increasing levels of demand in an attempt to manage the backlog of LTC checks following the pandemic and the rise in requests for urgent diagnostics. Primary care is seeking additional resource is considered for each PCN area to mitigate the demand on practices and acute hospital. This is currently in the scoping stage and is being worked up in preparation for any winter contingency funding. Approximate costs would be £200k for 1 year.	Jan-23	Feb-23	£200k		WS ICB Resilience	Sarah Portway/ Sandie Robinson		West Suffolk Alliance Operational Group	
Falls support in care homes Falls Prevention Exercise sessions will be offered to care homes for their residents who have experienced falls or who are considered to be at risk of falling. The aim of the sessions will be to help prevent or reduce falls by improving balance, co-ordination, strength and flexibility. The funding will allow for the sessions to be run over a 6 month period across the 39 care homes in west Suffolk.	Nov-22	N/A	£60k	N/A	Virtual Ward Double Count	Michelle Glass/ Cara Twinch	**Admission Prevention** Risk associated – GP staffing	West Suffolk Alliance Operational Group	
GP Streaming WSFT ED Re-direction & admission avoidance of ED patients	Dec-22	N/A	£85k	N/A	Virtual Ward Double Count	Jane Allen/ Lesley Standring	**Admission Prevention**	West Suffolk Alliance Operational Group	

Scheme	Start date	Revised start	Cost	Slippage/under/over spend	Funding Source	Lead	Comments	Governance/approval	mobilisation
Pathway1 care support Additional HomeFirst agency staff x6 to support discharge from hospital.	Dec-22	N/A	£267,429	Slippage expected due capacity of agency staff for the full period.	Demand & Capacity	Georgie Stevens	**Discharge** **Risks associated** recruitment of agency staff.	West Suffolk Alliance Operational Group	
GP in hours home visiting car Service provided by GPFed for two cars/GPs to operate across the West on the in hours patients home visits. GP practices will refer to SGPF to carry out the home visit on behalf of the practice.	Jan-23	N/A	£100,000	N/A	Virtual Ward Double Count	Sarah Portway	**Admission Prevention Risk associated –** Dependant on GP staffing	West Suffolk Alliance Operational Group	
Additional 10 beds Additional 10 beds across Stowhealth until end of January 2023 x6 Stowlangtoft x2 Brandon Park x2 Long Melford	Dec-22	N/A	£68,700	N/A	Virtual Ward Double Count	Georgie Stevens	**Discharge**	West Suffolk Alliance Operational Group	
Primary Care Cover Primary Care cover for practices with additional step down beds across West Suffolk since October 2022 – end of Jan 2023	Oct-22	N/A	TBC	N/A	Virtual Ward Double Count	Sarah Portway/Lucy Webb	**Discharge**	West Suffolk Alliance Operational Group	
PPG Support for Primary Care over Christmas/New Year period.	Dec-22	N/A	£10,000	N/A	Virtual Ward Double Count	Peter	Support – £10,000		
Additional CAB 10 additional CAB beds for a 4 month period, inclusive of wrap around care. Commissioned as CAB for allowance of bed access in line with need.	Dec-22	N/A	£255,000	Awaiting reconfiguration of figures. Monitored by WDF reporting	Winter Discharge Fund	Georgie Stevens	**Discharge**	West Suffolk Alliance Operational Group	
Mental Health D2A beds 2 x beds specifically for patients requiring mental health support to facilitate discharge from WSFT.	Dec-22		£43,000	Awaiting information	Winter Discharge Fund		**Discharge**	West Suffolk Alliance Operational Group	
Medequip Additional resource to help with capacity to support seasonal schemes	Dec-22	N/A	£160,000	Monitored by WDF reporting	Winter Discharge Fund	Rob Stephens	**Discharge**	West Suffolk Alliance Operational Group	
Minor Prescription equipment Minor equipment prescription for items that on occasion can delay discharge when needing to be externally sourced by family. Individual approach to be given to each potential prescription and impact on discharge delay.	Dec-22	N/A	£4,912	Likely slippage if equipment not required for D/C. Monitored by WDF reporting	Winter Discharge Funding	Lois Bull		West Suffolk Alliance Operational Group	
West Risk Share for Ageing Well	Oct-22	N/A	£200,000		ICB Resilience			West Suffolk Alliance Operational Group	

West Alliance Seasonal Schemes at Risk

Scheme	Start date	Revised start	Cost	Slippage/under/ over spend	Funding Source	Lead	Comments	Governance/approval	RAG
WSFT DWA Increase operating hours of discharge waiting area to 24/7	Oct-22	March-23	£50,000	Slippage £50k	Demand & Capacity	Lesley Standring/ Gary Ingalla	**Discharge** **Risk associated** – Recruitment of staff to cover 24/7	West Suffolk Alliance Operational Group	
Sport Purchase delirium beds Linked to delirium nurse specialist to support discharge of delirium patients.	Oct-22	N/A	£112,500	X11 beds in block used.	Virtual Ward Double Count	Georgie Stevens/ Lois Bull	**Discharge** **Risk associated** – Dependant on care home capacity.	West Suffolk Alliance Operational Group Suffolk Healthcare & education strategic planning group	
Pathway1 wrap around care	Sept 22		£280,121	N/A	Health & Care Interface Fund	Gylda Nunn	**Discharge**		
UCR All Additional ACP's as well as extended weekend and core hours EIT	Dec -22		£240,000	Recruited to 2 x LD advanced paramedic	Health & Care Interface Fund	Gylda Nunn			
Community Diabetic Specialist Nurse Reducing active INT diabetic caseloads. Enhance team capacities at peak times to effect admission avoidance and enable discharge through reducing the diabetic caseload workload.	Dec-22	Feb-23	£60,000	N/A	Virtual Ward Double Count	Kevin McGuinness	**Admission Prevention & Discharge** **Risk Associated** – Recruitment Interviews w/b 23/01/23	West Suffolk Alliance Operational Group	
SDEC Clinical Navigator Optimisation of the SDEC by recruiting a Clinical Navigator to answer the GP phone for both surgical and medical patient referrals and provide a timely response, including advice, navigation thus creating a reliable robust service which does not rely on people with other clinical responsibilities	Dec-22		£60,000	N/A	Health & Care Interface Fund - WS £996k	Andrea Ballentine/ Jane Allen	**Admission prevention** **Risk associated** - Workforce dependent.		
Age Well domain discharge leadership support	Jan-22		£35,000		Virtual Ward Double Count	Sandie Robinson		West Suffolk Alliance Operational Group	
Suffolk Family Carers As we continue to innovate to ensure individuals are able to be discharged from hospital in an optimal manner we need to ensure that their families / carers are adequately supported so that they have access to a range of advice including: benefits, carers assessment, personal health budget, appropriate equipment, local community / voluntary group support (social prescribing). The proposal is for a hybrid Carers Support role based in the hospital focussed on discharge advice / support, including a Social Prescribing and Personalised Care approach.	Dec-22	N/A	£84,000	Slippage £84,000	Winter Discharge Funding	Trisha Stevens	Unable to mobilise prior to 31st March 2023. Consideration for recurrent funding 23/24	West Suffolk Alliance Operational Group	
Lofty Heights House clearance service to support where space is needed within a patients home to facilitate discharge. Increase in working hours to 7 day working to support weekend discharge	Dec-22	N/A	£75,000	Slippage £75,000	Winter Discharge Fund	Allan Petchey	**Discharge** Unable to mobilise prior to 31st March 2023. Consideration for recurrent Funding 23/24	West Suffolk Alliance Operational Group	

Next steps for at risk schemes

Scheme name	Risk	Mitigation	New mobilisation rating
WSFT DWA Increase operating hours of discharge waiting area to 24/7	Recruitment of workforce within timeframe of funding. Start date post March 2023.	Plan to extend/rollover funding to facilitate post	
Spot Purchase delirium beds Linked to delirium nurse specialist to support discharge of delirium patients.	Wrap around care for spot beds	Due to governance issues now part of block process.	
Pathway1 wrap around care	Recruitment of workforce	Working with WSFT QI team, carrying out PDSA on impact of care on care package length	
UCR All Additional ACP's as well as extended weekend and core hours EIT	ACP recruitment risk	Extended weekend working and core hours EIT	
Community Diabetic Specialist Nurse Reducing active INT diabetic caseloads. Enhance team capacities at peak times to effect admission avoidance and enable discharge through reducing the diabetic caseload workload.	Recruitment of workforce within timeframe of funding. Start date post March 2023.	Plan to extend/rollover funding to facilitate post.	
SDEC Clinical Navigator Optimisation of the SDEC by recruiting a Clinical Navigator to answer the GP phone for both surgical and medical patient referrals and provide a timely response, including advice, navigation thus creating a reliable robust service which does not rely on people with other clinical responsibilities	Recruitment challenge for navigator	Funding move to ACP trainee post, incorporating role of navigator within post. Ongoing review of optimisation of role with navigating & ACP.	
Age Well domain discharge leadership support	Recruitment challenge within timeframe of funding	Plan to extend/rollover funding to facilitate post	
Suffolk Family Carers As we continue to innovate to ensure individuals are able to be discharged from hospital in an optimal manner we need to ensure that their families / carers are adequately supported so that they have access to a range of advice including: benefits, carers assessment, personal health budget, appropriate equipment, local community / voluntary group support (social prescribing). The proposal is for a hybrid Carers Support role based in the hospital focussed on discharge advice / support, including a Social Prescribing and Personalised Care approach. The role would include a budget for Personal Health Budgets to support the carer to enable an effective maintained discharge.	Unable to progress due to recruitment challenges within funding timeframe	Consideration for recurrent Funding 23/24	
Lofty Heights House clearance service to support where space is needed within a patients home to facilitate discharge. Increase in working hours to 7 day working to support weekend discharge	Unable to progress due to recruitment challenges within funding timeframe	Consideration for recurrent Funding 23/24	

Additional hospital discharge funding January 2023 – 31st March 2023

To purchase bedded step down capacity plus associated clinical support for patients for those who cannot be discharged with capacity available through existing finding routes. Daily sitreps required. Funding for a 4 week period per patient.

Scheme	Start date	Revised start	Cost	Slippage/under/over spend	Funding Source	Lead	Comments	RAG mobilisation
Additional beds Eastcotts x3 beds for a 4 week period starting 02/01/2023	Jan-23	N/A	£13,200	N/A	Hospital D/C Funding £200 m	Georgie Stevens		
Additional beds at Catchpole x4 beds for a 4 week period starting 10/01/2023	Jan-23	N/A	£18,172	N/A	Hospital D/C Funding £200 m	Georgie Stevens		
Additional beds Eastcotts **5** Beds for a 4 or 8 week period starting 01/02/23	Feb-23	N/A	4 week - £22,000 8 week - £44,000		Hospital D/C Funding £200 m	Georgie Stevens		
Additional beds at Catchpole **5** Beds for a 4 or 8 week period starting 01/02/23	Feb-23	N/A	4 week - £24,000 8 week – £48,000		Hospital D/C Funding £200 m	Georgie Stevens		
Extension of Stowhealth beds Brandon Park x2 beds Long Melford x 2 beds Stowlangtoft x3 beds	Feb -23	N/A	4 weeks - £32,060 8 weeks - £64,120		Hospital D/C Funding £200 m	Georgie Stevens		
Social Care wrap around care X3 social workers to cover additional beds. Feb 23-end of March 23.	Feb-23	N/A	£32,400		Hospital D/C Funding £200 m	Tracey Rowe	Risk of recruitment with agency	
Therapy wrap around care	Feb-23	N/A	TBC		Hospital D/C Funding £200 m	Gylda Nunn	Risk of recruitment with agency	
Primary Care cover Primary Care cover for practices with additional step down beds across West Suffolk Jan23 – end of March 23.	Feb-23	N/A	£300 per bed per month		Hospital D/C Funding £200 m	Sarah Portway		
Reduce P1 discharge delays Use of external care provider 'Airmid', to provide bridging service to support Home First to enable better system Flow. Support of HomeFirst will allow Support to Go Home to reduce support to Home First and concentrate on Pathway 1 discharges. HomeFirst agency in addition to Airmid is included in the cost provided.	Feb-23	N/A	TBC – Utilisation of current capacity being explored prior to contract being extended.		Hospital D/C Funding £200 m	Georgie Stevens	Risk of recruitment with agency	
Spot purchase beds	Jan-23	N/A	N/A		Hospital D/C Funding £200 m	Georgie Stevens	Risk of bed availability	
Total			Awaiting information					

Next Steps

- Focus on schemes with delayed start, identify if mobilisation possible or reallocate money to other schemes.
- Identification of current schemes that could utilise slippage/underspend or new initiatives that could mobilise and impact within the funding period.
- Lessons learned exercise via CRT – ‘Right patient, right place’, and ICB transformation team with linking into wider partners to help with preparation for future peaks in demand.
- Scheme impact at end of contracts, linking into lessons learned for the value of the schemes in terms of effectiveness, ease of mobilisation & monetary value.
- Identify schemes/new initiatives for recurring funding 23/24.
- Delegated accountability & responsibility for recurrent planning and oversight to sit with Age Well domain on behalf of the Alliance Committee.
- CRT at WSFT which is inclusive of ACS & ICB members to continue with workstreams identified as needing longer term support.

4.3.2. Operational Planning Guidance

To inform

Presented by Nicola Cottington

Board of Directors - Public

Report title:	**2023/24 NHS priorities and operational planning guidance**
Agenda item:	4.3.2
Date of the meeting:	2 February 2023
Sponsor/executive lead:	Nicola Cottington, chief operating officer
Report prepared by:	Nicola Cottington, chief operating officer Richard Jones, 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:	On 23 December 2022 the NHS published the priorities and operational planning guidance for 2023/24. This paper summarises the guidance, the Trust's current position in relation to the operational requirements, and the process for the development of a West Suffolk Alliance and Suffolk and North East Essex (SNEE) Integrated Care Board (ICB) response.
Action required/ recommendation:	The board are asked to note the guidance and support the approach being taken to meet the priorities set out.

Previously considered by:	N/A
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: If we do not deliver elective access standards based on clinical priorities in the context of Covid activity, this will affect our ability to deliver safe, effective and efficient services and care to patients. *Note the description of these risks currently under review.*

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:	Failure to meet the standards set out in the NHS priorities and operational planning guidance may result in targeted support from NHS England.

2023/24 NHS priorities and operational planning guidance

1.	**Introduction**
	As part of the annual NHS planning cycle, and in the context of recovery from the pandemic, the NHS published the 2023/24 NHS priorities and operational planning guidance on 23 December 2022. The full guidance is attached as an appendix. There is recognition in the guidance of the progress made nationally in reducing long waits for elective care. There is also acknowledgement of the ongoing impact of Covid-19 infections, capacity constraints in social care, increased costs, and reduced productivity within the NHS. Access to emergency and primary care has been particularly challenging over the past year. The immediate priorities in responding to the current situation are to: • Recover our core services and productivity • Make progress in delivering the key ambitions in the NHS Long Term Plan (LTP) • Continue transforming the NHS for the future The NHS objectives in relation to these priorities are set out in the guidance appended.
2.	**Recovering core services and productivity**
	The key areas identified for recovery and improving productivity are set out below: 1. Improve ambulance responses and **A&E waiting times** 2. Reduce elective **long waits and cancer backlogs** and improve core **diagnostic performance** 3. Ensure easier access to **Primary Care services** especially General Practice Emergency care performance has been extremely challenging for WSFT over the last year with a steady deterioration of all performance metrics. A review of the access and programme governance to support improvement is currently underway. The Trust consistently achieves the 2-hour urgent community response standard. Further work is taking place to broaden the response and redirect even more 999 calls to community services and thus avoid unnecessary emergency department attendances and admissions. Significant transformation is required locally to respond to the ambitions in the operational planning guidance relating to urgent and emergency care. The Trust has been successful in reducing the longest elective waiting times and is focussed on achieving the 28-day faster diagnosis standard for cancer, supported by improvement plans. Diagnostic recovery has been more challenging. A capital replacement programme is in progress and enhanced monitoring of recovery plans is in place.

	It has been difficult to establish primary care access data flows to enable monitoring of the operational performance of Glemsford practice and further work is needed to incorporate this into Trust assurance processes.
3.	**Delivering the key NHS LTP ambitions and transforming the NHS**
	The ambitions include NHS England's core commitments to: • Improve mental health services and services for people with a **learning disability and autistic people** • Prevention and the effective management of **long-term conditions** • Support delivery of the primary and secondary **prevention priorities** • Development of an NHS Long Term Workforce Plan to be published in the spring • Level up **digital infrastructure** and drive greater connectivity • Develop the **national improvement offer** to complement local work The delivery of these ambitions locally will link to the Joint Forward Plan (JFP) being developed by the ICB, the Live Well domains, the West Suffolk Alliance strategy and the WSFT strategy. The aligned change management function within West Suffolk will facilitate the local changes required and complement the national improvement offer.
4.	**Local empowerment and accountability**
	There is an emphasis on Integrated Care System (ICS) and ICB accountability within the guidance: • ICSs to agree specific **local objectives** that complement the national NHS objectives • Ensure oversight and performance management arrangements within ICSs are **proportionate and streamlined** The government have also commissioned the Hewitt review to evaluate mechanisms for accountability, targets, and performance within the NHS and to consider the relationships and roles between NHS England and ICBs.
5.	**Funding assumptions**
	The planning guidance is underpinned by financial assumptions: • The Autumn Statement 2022 announced an extra £3.3 bn in both 2023/24 and 2024/25 • NHS England is issuing two-year revenue allocations for 2023/24 and 2024/25. At national level, total ICB allocations are flat in real terms with additional funding available to expand capacity • Core ICB capital allocations for 2022/23 to 2024/25 have already been published and remain the foundation of capital planning for future years. Capital allocations will be topped-up by £300 million nationally • ICBs and NHS primary and secondary care providers are expected to work together to plan and deliver a balanced net system financial position in collaboration with other ICS partners.
6.	**Next steps**
	WSFT is working collaboratively with Alliance and ICB partners to create a system response in line with the timeline below. This includes mapping against existing priorities and strategies, assessing the level of risk of delivery and identifying the resources required to achieve the ambitions. • w/c 19th December – the release of the 23/24 guidance • w/c 9th January – release of all supporting documents (technical guidance, lookup tool, FAQs) • w/c 9th January – release of the non-functional template • w/c 16th January – eCollection portal opens for interim submissions • **23rd February – interim submission deadline** • 2nd March – eCollection portal opens for final submissions • 30th March – final submission deadline

Classification: Official

Publication approval reference: PRN00021

2023/24 priorities and operational planning guidance

23 December 2022

Foreword from the NHS CEO

Thank you to you, and to your teams, for your continued extraordinary efforts on behalf of our patients – particularly over the past weeks as we have prepared for and managed periods of industrial action. There is no denying it has been an incredibly challenging year for everyone working in the NHS, and arguably tougher than the first years of the pandemic.

We have already made real progress towards many of our goals for 2022/23 – in particular in all but eradicating two year waits for elective care and delivering record numbers of urgent cancer checks. This was achieved alongside continuing to respond to the build-up of health needs during the pandemic, an ongoing high level of COVID-19 infection and capacity constraints in social care, increased costs due to inflation and reduced productivity due to the inevitable disruption caused by COVID-19.

2023/24 will also be challenging. Our planning approach therefore reflects both our new ways of working, as recently articulated in the NHS Operating Framework, and an acknowledgement of the continuing complexity and pressure you face.

We will support local decision making, empowering local leaders to make the best decisions for their local populations and have set out fewer, more focused national objectives. These align with our three tasks over the coming year:

- recover our core services and productivity;
- as we recover, make progress in delivering the key ambitions in the Long Term Plan (LTP), and;
- continue transforming the NHS for the future.

To assist you in meeting these objectives, we have set out the most critical, evidence-based actions that will support delivery - based on what systems and providers have already demonstrated makes the most difference to patient outcomes, experience, access and safety.

I look forward to continuing to work with and support you over the year ahead to deliver the highest possible quality of care for patients and the best possible value for taxpayers.

Amanda Pritchard

Our priorities for 2023/24

In 2023/24 we have three key tasks. Our immediate priority is to recover our core services and productivity. Second, as we recover, we need to make progress in delivering the key ambitions in the NHS Long Term Plan. Third, we need to continue transforming the NHS for the future.

The table below sets out our national objectives for 2023/24. They will form the basis for how we assess the performance of the NHS alongside the local priorities set by systems.

Recovering our core services and productivity

To improve patient safety, outcomes and experience it is imperative that we:

- improve ambulance response and A&E waiting times
- reduce elective long waits and cancer backlogs, and improve performance against the core diagnostic standard
- make it easier for people to access primary care services, particularly general practice.

Recovering productivity and improving whole system flow are critical to achieving these objectives. Essential actions include: reducing ambulance handovers, bed occupancy and outpatient follow-ups relative to first appointments; increasing day case rates and theatre utilisation; moving to self-referral for many community services where GP intervention is not clinically necessary and increasing use of community pharmacies. We must also increase capacity in beds, intermediate care, diagnostics, ambulance services and the permanent workforce. These actions are supported by specific investments, including those jointly with local authorities to improve discharge.

Our people are the key to delivering these objectives and our immediate collective challenge is to improve staff retention and attendance through a systematic focus on all elements of the NHS People Promise.

As we deliver on these objectives we must continue to narrow health inequalities in access, outcomes and experience, including across services for children and young people. And we must maintain quality and safety in our services, particularly in maternity services.

The NHS has an important role in supporting the wider economy and our actions to support the physical and mental wellbeing of people will support more people return to work.

Delivering the key NHS Long Term Plan ambitions and transforming the NHS

We need to create stronger foundations for the future, with the goals of the NHS Long Term Plan our 'north star'. These include our core commitments to improve mental health services and services for people with a learning disability and autistic people.

Prevention and the effective management of long-term conditions are key to improving population health and curbing the ever increasing demand for healthcare services. NHS England will work with integrated care systems (ICSs) to support delivery of the primary and secondary prevention priorities set out in the NHS Long Term Plan.

We need to put the workforce on a sustainable footing for the long term. NHS England is leading the development of a NHS Long Term Workforce Plan and government has committed to its publication next spring.

The long-term sustainability of health and social care also depends on having the right digital foundations. NHS England will continue to work with systems to level up digital infrastructure and drive greater connectivity- this includes development of a 'digital first' option for the public and further development of and integration with the NHS App to help patients identify their needs, manage their health and get the right care in the right setting.

Transformation needs to be accompanied by continuous improvement. Successful improvement approaches are abundant across the NHS but they are far from universal. NHS England will develop the national improvement offer to complement local work, using what we have learned from engaging with over 1,000 clinical and operational leaders in the summer.

Local empowerment and accountability

ICSs are best placed to understand population needs and are expected to agree specific local objectives that complement the national NHS objectives set out below. They should continue to pay due regard to wider NHS ambitions in determining

their local objectives – alongside place-based collaboratives. As set out in the recently published Operating Framework, NHS England will continue to support the local NHS [integrated care boards (ICBs) and providers] to deliver their objectives and publish information on progress against the key objectives set out in the NHS Long Term Plan.

Alongside this greater local determination, greater transparency and assurance will strengthen accountability, drawing on the review of ICS oversight and governance that the Rt Hon Patricia Hewitt is leading. We welcome the review which NHS England has been supporting closely, and we look forward to the next stage of the discussions as well as the final report. NHS England will update the NHS Oversight Framework and work with ICBs to ensure oversight and performance management arrangements within their ICS area are proportionate and streamlined.

Funding and planning assumptions

The Autumn Statement 2022 announced an extra £3.3 bn in both 2023/24 and 2024/25 for the NHS to respond to the significant pressures we are facing.

NHS England is issuing two-year revenue allocations for 2023/24 and 2024/25. At national level, total ICB allocations [including COVID-19 and Elective Recovery Funding (ERF)] are flat in real terms with additional funding available to expand capacity.

Core ICB capital allocations for 2022/23 to 2024/25 have already been published and remain the foundation of capital planning for future years. Capital allocations will be topped-up by £300 million nationally, with this funding prioritised for systems that deliver agreed budgets in 2022/23.

The contract default between ICBs and providers for most planned elective care (ordinary, day and outpatient procedures and first appointments but not follow-ups) will be to pay unit prices for activity delivered. System and provider activity targets will be agreed through planning as part of allocating ERF on a fair shares basis to systems. NHS England will cover additional costs where systems exceed agreed activity levels.

ICBs and NHS primary and secondary care providers are expected to work together to plan and deliver a balanced net system financial position in collaboration with other ICS partners. Further details will be set out in the revenue finance and contracting guidance for 2023/24.

Next steps

ICBs are asked to work with their system partners to develop plans to meet the national objectives set out in this guidance and the local priorities set by systems. To assist them in this, the annex identifies the most critical, evidence based actions that systems and NHS providers are asked to take to deliver these objectives. These are based on what systems and providers have already demonstrated makes the most difference to patient outcomes, experience, access and safety.

System plans should be triangulated across activity, workforce and finance, and signed off by ICB and partner trust and foundation trust boards before the end of March 2023. NHS England will separately set out the requirements for plan submission.

National NHS objectives 2023/24

	Area	Objective
Recovering our core services and improving productivity	**Urgent and emergency care***	Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25
		Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25
		Reduce adult general and acute (G&A) bed occupancy to 92% or below
	Community health services	Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard
		Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals
	Primary care*	Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need
		Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024
		Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024
		Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels
	Elective care	Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)
		Deliver the system- specific activity target (agreed through the operational planning process)
	Cancer	Continue to reduce the number of patients waiting over 62 days
		Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days
		Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028
	Diagnostics	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%
		Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition
	Maternity*	Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury
		Increase fill rates against funded establishment for maternity staff
	Use of resources	Deliver a balanced net system financial position for 2023/24
	Workforce	Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise
	Mental health	Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019)
		Increase the number of adults and older adults accessing IAPT treatment
		Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services
		Work towards eliminating inappropriate adult acute out of area placements
		Recover the dementia diagnosis rate to 66.7%
		Improve access to perinatal mental health services
	People with a learning disability and autistic people	Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024
		Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit
	Prevention and health inequalities	Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024
		Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%
		Continue to address health inequalities and deliver on the Core20PLUS5 approach

**ICBs and providers should review the UEC and general practice access recovery plans, and the single maternity delivery plan for further detail when published;*

Annex

This annex sets out the key evidence based actions that will help deliver the objectives set out above and the resources being made available to support this. All systems are asked to develop plans to implement these. To assist systems in developing their plans a summary of other guidance, best practice, toolkits and support available from NHS England is available on the planning pages of FutureNHS.

1. Recovering our core services and productivity

1A. Urgent and emergency care (UEC)

Key actions:

- Increase physical capacity and permanently sustain the equivalent of the 7,000 beds of capacity that was funded through winter 2022/23
- Reduce the number of medically fit to discharge patients in our hospitals, addressing NHS causes as well as working in partnership with Local Authorities.
- Increase ambulance capacity.
- Reduce handover delays to support the management of clinical risk across the system in line with the November 2022 letter.
- Maintain clinically led System Control Centres (SCCs) to effectively manage risk.

In order to improve patient flow, we all agree we need to reduce bed occupancy to at least 92% (NHS review of winter), increase physical capacity in inpatient settlings to reflect changes in demographics and health demand [Projections: General and acute hospital beds in England (2018–2030)], as well as improve support for patients in the community. NHS England [working with the Department of Health and Social Care (DHSC) and the Department for Levelling Up, Housing and Communities (DLHUC)] will develop a UEC recovery plan with further detail and this will be published in the new year. Delivery of this plan and the objectives set out in this guidance are supported by:

- £1bn of funding through system allocations to increase capacity based on agreed system plans. NHS England anticipates that capacity will be focused on increasing G&A capacity, intermediate and step-down care, and community beds with an expectation that utilisation of virtual wards is

increased towards 80% by the end of September 2023. NHS England will continue share best practice across a range of conditions to support this.

- £600m provided equally through NHS England and Local Authorities and made available through the Better Care Fund in 2023/34 (and £1bn in 2024/25) to support timely discharge. In addition, a £400m ring-fenced local authority grant for adult social care will support discharge among other goals. Further detail will be set out in the revenue finance and contracting guidance for 2023/24.
- An increase in allocations for systems that host ambulance services to increase ambulance capacity.

1B. Community health services

Key actions:

- Increase referrals into urgent community response (UCR) from all key routes, with a focus on maximising referrals from 111 and 999, and creating a single point of access where not already in place
- Expand direct access and self-referral where GP involvement is not clinically necessary. By September 2023, systems are asked to put in place:
    - direct referral pathways from community optometrists to ophthalmology services for all urgent and elective eye consultations
    - self-referral routes to falls response services, musculo-skeletal physiotherapy services, audiology-including hearing aid provision, weight management services, community podiatry, and wheelchair and community equipment services.

Expanding direct access and self-referrals empowers patients to take control of their healthcare, streamlines access to services and reduces unnecessary burden on GP appointments.

NHS England will allocate core funding growth for community health services as part of the overall ICB allocation growth, with £77m of Service Development Funding maintained in 2023/24.

1C. Primary care

Key actions:

- Ensure people can more easily contact their GP practice (by phone, NHS App, NHS111 or online).

- Transfer lower acuity care away from both general practice and NHS 111 by increasing pharmacy participation in the Community Pharmacist Consultation Service.

NHS England will publish the General Practice Access Recovery Plan in the new year which will provide details of the actions needed to achieve the goals above. In addition, once the 2023/24 contract negotiations have concluded, we will also publish the themes we are looking to engage with the profession on that could take a significant step towards making general practice more attractive and sustainable and able to deliver the vision outlined in the Fuller Stocktake, including continuity of care for those who need it. The output from this engagement will then inform the negotiations for the 2024/25 contract.

Delivery of this plan and the objectives set out in this guidance is supported by funding for general practice as part of the five year GP contract, including funding for 26,000 additional primary care staff through the Additional Roles Reimbursement Scheme (ARRS). ICB primary medical allocations are being uplifted by 5.6% to reflect the increases in GP contractual entitlements agreed in the five-year deal, and the increased ARRS entitlements. Data on general practice appointments is being published, including at practice-level, and work is ongoing to improve the quality and use of the data.

1D. Elective care

Key actions:

- Deliver an appropriate reduction in outpatient follow-up (OPFU) in line with the national ambition to reduce OPFU activity by 25% against the 2019/20 baseline by March 2024
- Increase productivity and meet the 85% day case and 85% theatre utilisation expectations, using GIRFT and moving procedures to the most appropriate settings
- Offer meaningful choice at point of referral and at subsequent points in the pathway, and use alternative providers if people have been waiting a long time for treatment including through the Digital Mutual Aid System (DMAS)

The goals for elective recovery are set out in the 'Delivery plan for tackling the COVID-19 backlog of elective care'. These include delivery of around 30% more elective activity by 2024/25 than before the pandemic, after accounting for the impact of an improved care offer through system transformation, and advice and

guidance. Meeting this goal of course still depends on returning to and maintaining low levels of COVID-19, enabling the NHS to restore normalised operating conditions and reduce high levels of staff absence. We will agree targets with systems for 2023/24 through the planning round towards that goal on the basis that COVID-19 demand will be similar to that in the last 12 months. The contract default will be to pay for most elective activity (including ordinary, day and outpatient procedures and first appointments but excluding follow-ups) at unit prices for activity delivered.

ICBs and trusts are asked to update their local system plans, actively including independent sector providers, setting out the activity, workforce, financial plans and transformation goals that will support delivery of these objectives.

NHS England will allocate £3bn of ERF to ICBs and regional commissioners on a fair shares basis and continue to work with systems and providers to maximise the impact of the three-year capital Targeted Investment Fund put in place in 2022. Further details will be set out in the *Revenue finance and contracting guidance for 2023/24* and *Capital guidance update 2023/24.*

1E. Cancer

Key actions:

- Implement and maintain priority pathway changes for lower GI (at least 80% of FDS lower GI referrals are accompanied by a FIT result), skin (teledermatology) and prostate cancer (best practice timed pathway)
- Increase and prioritise diagnostic and treatment capacity, including ensuring that new diagnostic capacity, particularly via community diagnostic centres (CDCs), is prioritised for urgent suspected cancer. Nationally, we expect current growth levels to translate into a requirement for a 25% increase in diagnostic capacity required for cancer and a 13% increase in treatment capacity.
- Expand the Targeted Lung Health Checks (TLHC) programme and ensure sufficient diagnostic and treatment service capacity to meet this new demand.
- Commission key services which will underpin progress on early diagnosis, including non-specific symptoms pathways (to provide 100% population coverage by March 2024), surveillance services for Lynch syndrome, BRCA and liver; and work with regional public health commissioners to increase

colonoscopy capacity to accommodate the extension of the NHS bowel screening programme to 54 year olds.

The NHS is implementing one of the most comprehensive strategies on early diagnosis anywhere in the world. Cancer Alliances and the ICBs they serve will lead the local delivery of this NHS-wide strategy. NHS England is providing over £390m in cancer service development funding to Cancer Alliances in each of the next two years to support delivery of this strategy and the operational priorities for cancer set out above. As in previous years, the Cancer Alliance planning pack will provide further information to support the development of cancer plans by alliances and these, subject to ICB agreement, are expected to form part of wider local system plans.

1F. Diagnostics

Key actions:

- Maximise the pace of roll-out of additional diagnostic capacity, delivering the second year of the three-year investment plan for establishing Community Diagnostic Centres (CDCs) and ensuring timely implementation of new CDC locations and upgrades to existing CDCs
- Deliver a minimum 10% improvement in pathology and imaging networks productivity by 2024/25 through digital diagnostic investments and meeting optimal rates for test throughput
- Increase GP direct access in line with the national rollout ambition and develop plans for further expansion in 2023/24 (NHS England will publish separate guidance to support the increase GP direct access)

Timely access to diagnostics is critical to providing responsive, high quality services and supporting elective recovery and early cancer diagnosis. NHS England has provided funding to support the development of pathology and imaging networks and the development and rollout of CDCs. £2.3bn of capital funding to 2025 has also been allocated to support diagnostic service transformation, including to implement CDCs, endoscopy, imaging equipment and digital diagnostics.

1G. Maternity and neonatal services

Key actions:

- Continue to deliver the actions from the final Ockenden report as set out in the April 2022 letter as well as those that will be set out in the single delivery plan for maternity and neonatal services .
- Ensure all women have personalised and safe care through every woman receiving a personalised care plan and being supported to make informed choices
- Implement the local equity action plans that every local maternity and neonatal system (LMNS)/ICB has in place to reduce inequalities in access and outcomes for the groups that experience the greatest inequalities (Black, Asian and Mixed ethnic groups and those living in the most deprived areas).

NHS England will publish a single delivery plan for maternity and neonatal services in early 2023. This will consolidate the improvement actions committed to in Better Births, the NHS Long Term Plan, the Neonatal Critical Care Review, and reports of the independent investigation at Shrewsbury and Telford Hospital NHS Trust and the independent investigation into maternity and neonatal services in East Kent.

To support delivery including addressing the actions highlighted in the Ockenden report NHS England has invested a further £165m through the maternity programme for 2023/24. This is £72m above the £93m baselined in system allocations to support the maternity and neonatal workforce. That investment has increased the number of established midwifery posts by more than 1;500 compared to 2021.

1H. Use of resources

To deliver a balanced net system financial position for 2023/24 and achieve our core service recovery objectives, we must meet the 2.2% efficiency target agreed with government and improve levels of productivity.

ICBs and providers should work together to:

- Develop robust plans that deliver specific efficiency savings and raise productivity consistent with the goals set out in this guidance to increase activity and improve outcomes within allocated resources.
- Put in place strong oversight and governance arrangements to drive delivery, supported by clear financial control and monitoring processes.

Plans should include systematic approaches to understand where productivity has been lost and the actions needed to restore underlying productivity, including, but not be limited to, measures to:

- **Support a productive workforce** taking advantage of opportunities to deploy staff more flexibly. Systems should review workforce growth by staff group and identify expected productivity increases in line with the growth seen.
- **Increase theatre productivity** using the Model Hospital System theatre dashboard and associated GIRFT training and guidance, and other pathway and service specific opportunities.

Plans should also set out measures to release efficiency savings, including actions to:

- **Reduce agency spending** across the NHS to 3.7% of the total pay bill in 2023/24 which is consistent with the system agency expenditure limits for 2023/24 that are set out separately. NHS England has published toolkits to support this.
- **Reduce corporate running costs** with a focus on consolidation, standardisation and automation to deliver services at scale across ICS footprints. NHS England has published annual cost data benchmarking and a corporate service improvement toolkit .
- **Reduce procurement and supply chain costs** by realising the opportunities for specific products and services. Systems should work to the operating model and commercial standards and the consolidated supplier frameworks agreed with suppliers through Supply Chain Coordination Limited (SCCL). Systems should engage with the Specialised Services Devices Programme to leverage the benefits across all device areas.
- **Improve inventory management**. NHS Supply Chain will lead the implementation of an inventory management and point of care solution. National funding will support providers that do not have effective inventory management systems.
- *Purchase medicines at the most effective price point* by realising the opportunities for price efficiency identified by the Commercial Medicines Unit, and ensure we get the best value from the NHS medicines bill. National support to deliver efficiencies will continue to be available for systems through the National Medicines Value Programme.

2. Delivering the key NHS Long Term Plan ambitions and transforming the NHS

2A. Mental health

Key actions:

- Continue to achieve the Mental Health Investment Standard by increasing expenditure on mental health services by more than allocations growth.
- Develop a workforce plan that supports delivery of the system's mental health delivery ambition, working closely with ICS partners including provider collaboratives and the voluntary, community and social enterprise (VCSE) sectors.
- Improve mental health data to evidence the expansion and transformation of mental health services, and the impact on population health, with a focus on activity, timeliness of access, equality, quality and outcomes data.

As systems update their local plans, they are also asked to set out how the wider commitments in the NHS Mental Health Implementation Plan 2019/20–2023/24 will be taken forward to improve the quality of local mental healthcare across all ages in line with population need.

NHS England has allocated funding to grow the workforce and expand services to support delivery of the mental health NHS Long Term Plan commitments. In particular, NHS England will continue to support the growth in IAPT workforce by providing 60% salary support for new trainees in 2023/24. We will also support ICBs to co-produce a plan by 31 March 2024 to localise and realign mental health and learning disability inpatient services over a three year period as part of a new quality transformation programme.

2B. People with a learning disability and autistic people

Key actions:

- Continue to improve the accuracy and increase size of GP Learning Disability registers.
- Develop integrated, workforce plans for the learning disability and autism workforce to support delivery of the objectives set out in this guidance. (The workforce baselining exercise completed during 2022/23 will assist in the development of local, integrated, workforce plans to support delivery.)

- Test and implement improvement in autism diagnostic assessment pathways including actions to reduce waiting times.

NHS England has allocated funding of £120m to support system delivery against the objectives and will publish guidance on models of mental health inpatient care to support a continued focus on admission avoidance and improving quality.

2C. Embedding measures to improve health and reduce inequalities

Key actions:

- Update plans for the prevention of ill-health and incorporate them in joint forward plans, paying due regard to the NHS Long Term Plan primary and secondary prevention priorities, including a continued focus on CVD prevention, diabetes and smoking cessation. Plans should:
    - build on the successful innovation and partnership working that characterised the COVID vaccination programme and consider how best to utilise new technology such as home testing. NHS England will publish a tool summarising the highest impact interventions that can be – and are already being – implemented by the NHS.
    - have due regard to the government's Women's Health Strategy.
- Continue to deliver against the five strategic priorities for tackling health inequalities and:
    - take a quality improvement approach to addressing health inequalities and reflect the Core20PLUS5 approach in plans
    - consider the specific needs of children and young people and reflect the Core20PLUS5 – An approach to reducing health inequalities for children and young people in plans
    - establish High Intensity Use services to support demand management in UEC.

Funding is provided through core ICB allocations to support the delivery of system plans developed with public health, local authority, VCSE and other partners. The formula includes an adjustment to weight resources to areas with higher avoidable mortality and the £200m of additional funding allocated for health inequalities in 2022/23 is also being made recurrent in 2023/24.

2D. Investing in our workforce

In 2022/23 systems were asked to develop whole system workforce plans. These should be refreshed to support:

- Improved staff experience and retention through systematic focus on all elements of the NHS People Promise and implementation of the Growing Occupational Health Strategy, improving attendance toolkit and Stay and Thrive Programme.
- Increased productivity by fully using existing skills, adapting skills mix and accelerating the introduction of new roles (e.g. anaesthesia associates, AHP support workers, pharmacy technicians and assistants, first contact practitioners, and advanced clinical practitioners).
- Flexible working practices and flexible deployment of staff across organisational boundaries using digital solutions (e-rostering, e-job planning, Digital Staff Passport).
- Regional multi professional education and training investment plans (METIP) and ensure sufficient clinical placement capacity, including educator/trainer capacity, to enable all NHS England- funded trainees and students to maintain education and training pipelines.
- implementation of the Kark recommendations and Fit and Proper Persons (FPP) test.

NHS England is increasing investment in workforce education and training in real terms in each of the next two years.

2E. Digital

Key actions:

- Use forthcoming digital maturity assessments to measure progress towards the core capabilities set out in What Good Looks Like (WGLL) and identify the areas that need to be prioritised in the development of plans. Specific expectations will be set out in the refreshed WGLL in early 2023.
- Put the right data architecture in place for population health management (PHM).
- Put digital tools in place so patients can be supported with high quality information that equips them to take greater control over their health and care.

DHSC recently published strategic plans for digital, data and technology. Data saves lives and A plan for digital health and social care set out how digitised services can support integration and service transformation. NHS England will:

- Provide funding to help ICSs meet minimum digital foundations, especially electronic records in accordance with WGLL.
- Procure a Federated Data Platform, available to all ICSs, with nationally developed functionality including tools to help maximise capacity, reduce waiting lists and co-ordinate care.
- Roll out new functionality for the NHS App, to help people take greater control over their health and their interactions with the NHS, including better support to get to the right in-person or digital service more quickly, access to their patient records, improved functionality for prescriptions and improved support for hospital appointments and choice ahead of next winter.
- Accelerate the ambition of reducing the reporting burden on providers and addressing the need for more timely automated data through the Faster Data Flows (FDF) Programme.

Funding is allocated to meet minimum digital foundations (especially electronic patient records) and scale up use of digital social care records in accordance with WGLL.

2F. System working

2023/24 is the first full year for ICSs in their new form with the establishment of statutory ICBs and integrated care partnerships (ICPs). Key priorities for their development in 2023/24 include:

- Developing ICP integrated care strategies and ICB joint forward plans.
- Maturing ways of working across the system including provider collaboratives and place-based partnership arrangements.

Improving NHS patient care, outcomes and experience can only be achieved by embedding innovation and research in everyday practice. ICBs have a statutory duty to facilitate or otherwise promote research and the use of evidence obtained from research and to promote innovation, for example AI and machine learning which is driving efficiency and enabling earlier diagnosis.

NHS England will continue to support ICSs to draw on national best practice and peer insight to inform future development.

Joint forward plans

The National Health Service Act 2006 (as amended by the Health and Care Act 2022) requires ICBs and their partner trusts (the ICB's partner NHS trusts and foundation trusts are named in its constitution) to prepare five-year JFPs before the start of each financial year.

NHS England has developed guidance to support the development of JFPs with input from all 42 ICBs, trusts and national organisations representing local authorities and other system partners, including VCSE sector leaders.

Systems have significant flexibility to determine their JFP's scope as well as how it is developed and structured. Legal responsibility for developing the JFP lies with the ICB and its partner trusts. However, we encourage systems to use the JFP to develop a shared delivery plan for the integrated care strategy (developed by the ICP) and the joint local health and wellbeing strategy (JLHWS) (developed by local authorities and their partner ICBs, which may be through health and wellbeing boards) that is supported by the whole system, including local authorities and VCSE partners.

Delegated budgets

We are moving towards ICBs taking on population healthcare budgets, with pharmacy, ophthalmology and dentistry (POD) services fully delegated by April 2023 and appropriate specialised services delegated from April 2024. This will enable local systems to design and deliver more joined-up care for their patients and communities. NHS England will support ICBs as they take on commissioning responsibility across POD services from April 2023, supporting the integration of services.

Subject to NHS England Board approval, statutory joint committees of ICBs and NHS England will oversee commissioning of appropriate specialised services across multi-ICB populations from April 2023, ahead of ICBs taking on this delegated responsibility in April 2024.

ICBs are expected to work with NHS England through their joint commissioning arrangements to develop delivery plans. These should identify at least three key priority pathways for transformation, where integrated commissioning can support the triple aim of improving quality of care, reducing inequalities across communities and delivering best value. NHS England will provide ICBs with tools and resources to support transformation, and to further develop their understanding of specialised services and enable them to realise the benefits of integration.

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4.3.3. Change and Transformation Function

To inform

Presented by Nicola Cottington

Board of Directors - Public

Report title:	**Change and Transformation Function update**
Agenda item:	4.3.3
Date of the meeting:	2 February 2023
Sponsor/executive lead:	Nicola Cottington, executive chief operating officer
Report prepared by:	Nicola Cottington, executive chief operating officer

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 First for the Future ambition of the Trust strategy requires an extensive programme of work to meet the demands of the population in a sustainable way. Delivery of the Trust objectives, including the clinical and care strategy will require a transformative approach to change. An action was agreed through board development workshops to: **Make better use of the large amount of capability and capacity we already have in the people with expertise in change and improvement.** A paper was considered by the Senior Leadership Team (SLT) on 19th December and the following option supported: **Scope a unified process for transformative change management to support delivery of the clinical strategy. This will be an integrated approach with West Suffolk Alliance colleagues.** The teams who lead change and transformation within the Trust are currently co-producing a unified transformative change management function, the scope of which will be presented to SLT on 20th February 2023. The new processes will go live on 1st April 2023.
Action required/ recommendation:	**For the board to note the update**

Previously considered by:	**N/A**
Risk and assurance:	**Strategic risk on the Future System programme risk register:** **Amber: Trust responsibility and delivery of cultural change and strategy** **The organisation needs to accept responsibility for delivery and ownership of the cultural change and strategy to move to transition to enable the new hospital to function. This includes new ways of working that needs to commence as soon as possible to support a cultural change and smooth transition and mobilisation for the new build. A metamorphosis of the old into the new.**
Equality, diversity and inclusion:	**Reducing inequalities in access and outcomes is critical to the future delivery of services.**
Sustainability:	**Service improvement and transformation will also contribute to the delivery of the Trust Green Plan.**
Legal and regulatory context:	**N/A**

1. Background

1.1 The Trust has launched its new strategy First for our patients, staff and the future which sets out the ambitions and values that the trust will work to over the next five years and how success will be measured.

The First for the Future ambition requires an extensive programme of change, to meet the demands of the population in a sustainable way. Within the Future System Programme (FSP) this is summarised as:

1. New ways of working within the acute hospital
2. The hospital only doing what only the hospital can do, with more care provided at home by the community services and grasping the full potential for a left shift in the locus of care
3. Working across multiple sites
4. A world-leading digital strategy
5. Workforce planning and development for the expansion in the workforce that will be required, along with new roles, new working patterns and new responsibilities in existing roles
6. A workplace strategy supporting flexible and routine working from home
7. Mobilisation into the new facilities

Implicit in these objectives are also the requirements to continuously improve the quality of care, reduce environmental impact and deliver services within budgetary constraints.

Effective change management, therefore, is now more important than ever. Both the cultural approach to change within the organisation and the structure and processes that facilitate change are critical.

1.2 This topic has been previously discussed at board development days on 8th and 29th April 2022 and the following actions were agreed:

An explicit cultural programme to heal and re-form as Team WSFT after the stress and distress of the last 2 years (pandemic, RAAC, West Suffolk Review, board turnover, new governance structure).

Adopting the future models of care and business that have been created by the Future System programme as policy and combining and/or harmonising other strategic objectives and existing plans with them.

Make better use of the large amount of capability and capacity we already have in the people with expertise in change and improvement.

Identify and increase strategic thinking and planning ability within multi-professional teams.

Understand that most of the solutions for the future lie in the Alliance and the ICS working.

Use co-production to determine how to deliver the change

Set and use schemes of delegation much more effectively and lift senior leaders out of operational decision making.

This paper provides an update on progress against action 3 identified above: **Make better use of the large amount of capability and capacity we already have in the people with expertise in change and improvement.**

2 Current change management teams

2.1

2.2 As set out above, there are currently various teams/functions that support change and improvement across the Trust including:

- Operational Improvement (works in an integrated way with Alliance transformation team)
- Performance and Efficiency
- Project Management Office (PMO)
- Quality Improvement
- Elective Care Recovery and Improvement including Cancer Transformation
- Digital Transformation
- Human Factors

In appraising the current situation and thinking about options going forwards, the work has focussed to date on the teams in the blue section of figure 1. Through discussion with those teams, it has been proposed that future phases of this work could include other functions engaged with change management.

There are commonalities and differences between the functions described above. All of the teams are passionate about supporting clinical and operational teams to deliver improvements for patients. Diversity in approach can be very helpful, as different projects can be assigned the most appropriate support. However, until now there has not been a systematic method of assigning support. Not all projects and programmes of work have clear senior responsible officers (SROs), operational leads or clinical leads. There is also a lack of an overarching plan for visibility of all change programmes and projects within the Trust. Given the extensive programme of change that is required to deliver the First for the Future ambition of the Trust strategy, it is vital that resources are deployed in the most effective way.

In reviewing the options, the transformation structure at ESNEFT was considered as a comparator. It is worth noting that the teams there are managed as distinct functions: Quality Improvement (managed by the Medical Director), Transformation (managed by the Managing

Director) and Strategy/growth/business opportunities (managed by the Director of Strategy, Research, and Innovation). However, the various projects are co-ordinated through one overarching programme plan.

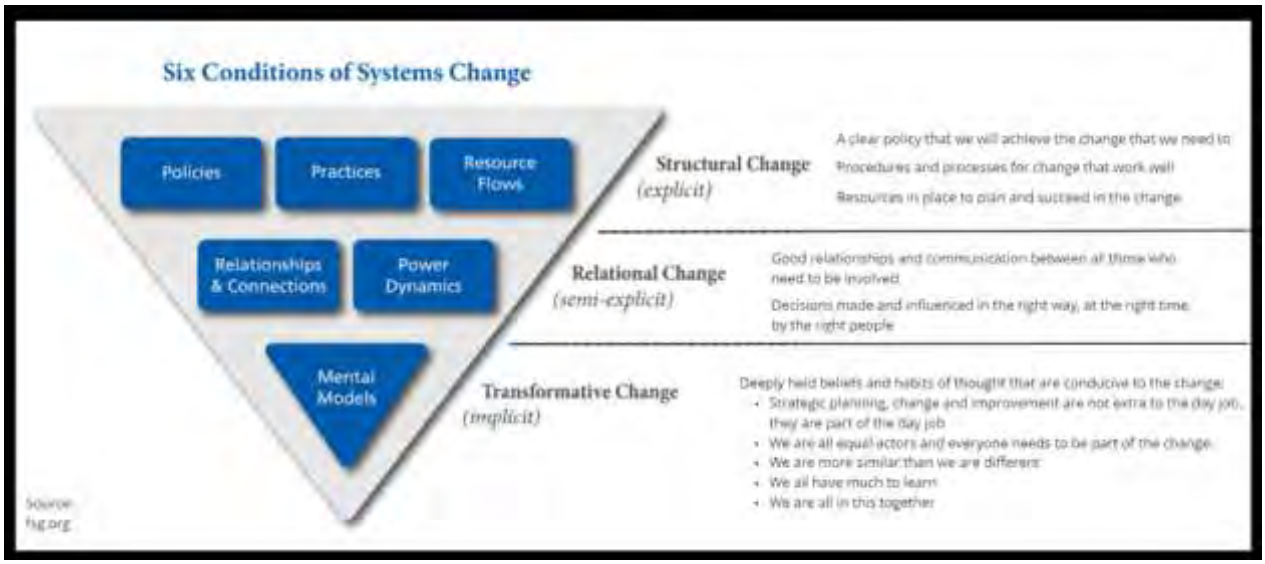
It is worth highlighting that the operational improvement team at WSFT are already integrated with the West Suffolk Alliance transformation team in the way they work. The ambitions of the Future System Programme, including the clinical strategy, will be delivered not only by the Trust but by the Alliance as a whole and therefore there is value to an Alliance approach to leading and supporting the transformative change required.

3. Developing a unified function for transformative change management

3.1 The current internal change management functions provide expertise and capacity in relation to incremental change and project management, leading to tangible improvements in performance, quality and cost. It is recognised that the delivery of the clinical strategy for the Future System programme requires a different approach, that of transformative change:

"Transformative change requires a coalition of visionary leaders willing to understand the possibilities in the future operating environment and then operate in ambiguity and take risks to design a future state that is based on an uncertain future context. These leaders define a vision of the future that is completely new and unconstrained by today's policies, structures, or authorities of the past or present." (Distinguishing between Transformative and Incremental Change Initiatives, Patricia Koopersmith, Rockwood Company Founder and CEO 2021)

3.2



3.3 A workshop was held on 3rd September 2022 to enable the leads of the change management teams to explore how to maximise the existing capacity and capability of their teams and to align change management processes. A more structured approach was proposed, which could include the following components:

- A single "front door", through which change projects would be appraised for their strategic fit and accepted or declined
- Appropriate change management support would be assigned to the project
- All projects would fit within programmes of change, supported by Executive Senior Responsible Officers (SROs)

- Programmes of change would form an overarching change plan, signed off by SLT
- Progress within projects and programmes would be monitored and benefits tracked
- The process would be managed by a multidisciplinary team, including the leads for the various change teams, similar to the Core Resilience Team (CRT)

A draft model is included at appendix 1

3.4 A range of options was presented to SLT on 19th December 2022 including more formal restructuring of the teams involved in change management. The leads of these teams have developed an alternative approach, of developing a collaborative change management faculty to address the challenges set out in this paper. The results of their initial evaluation have been summarised using a Situation, Target, Proposal (STP) approach, included at Appendix 2.

This collegiate approach was supported by SLT who endorsed the option below:

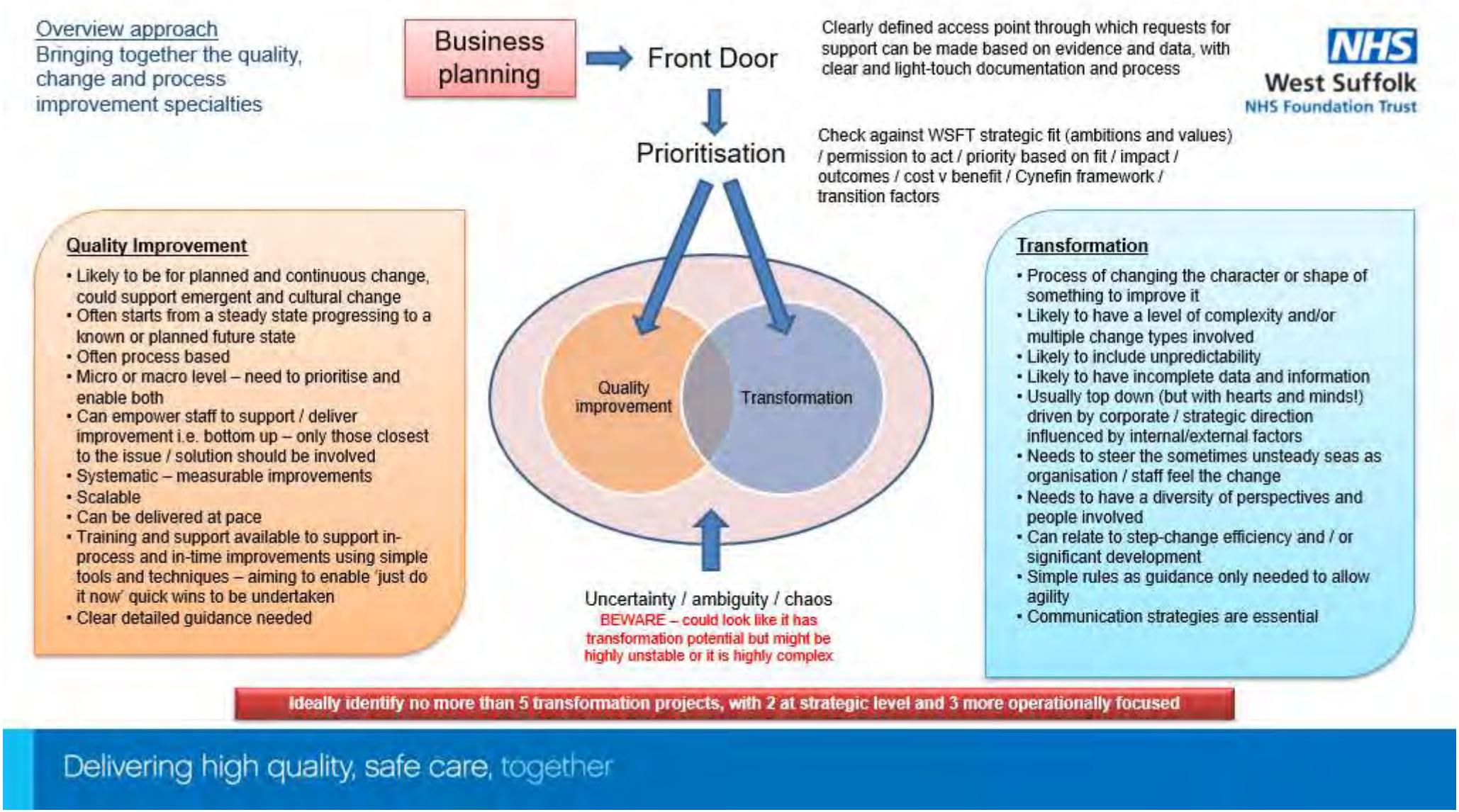
Scope a unified process for transformative change management to support delivery of the clinical strategy. This will be an integrated approach with West Suffolk Alliance colleagues.

4. Next steps

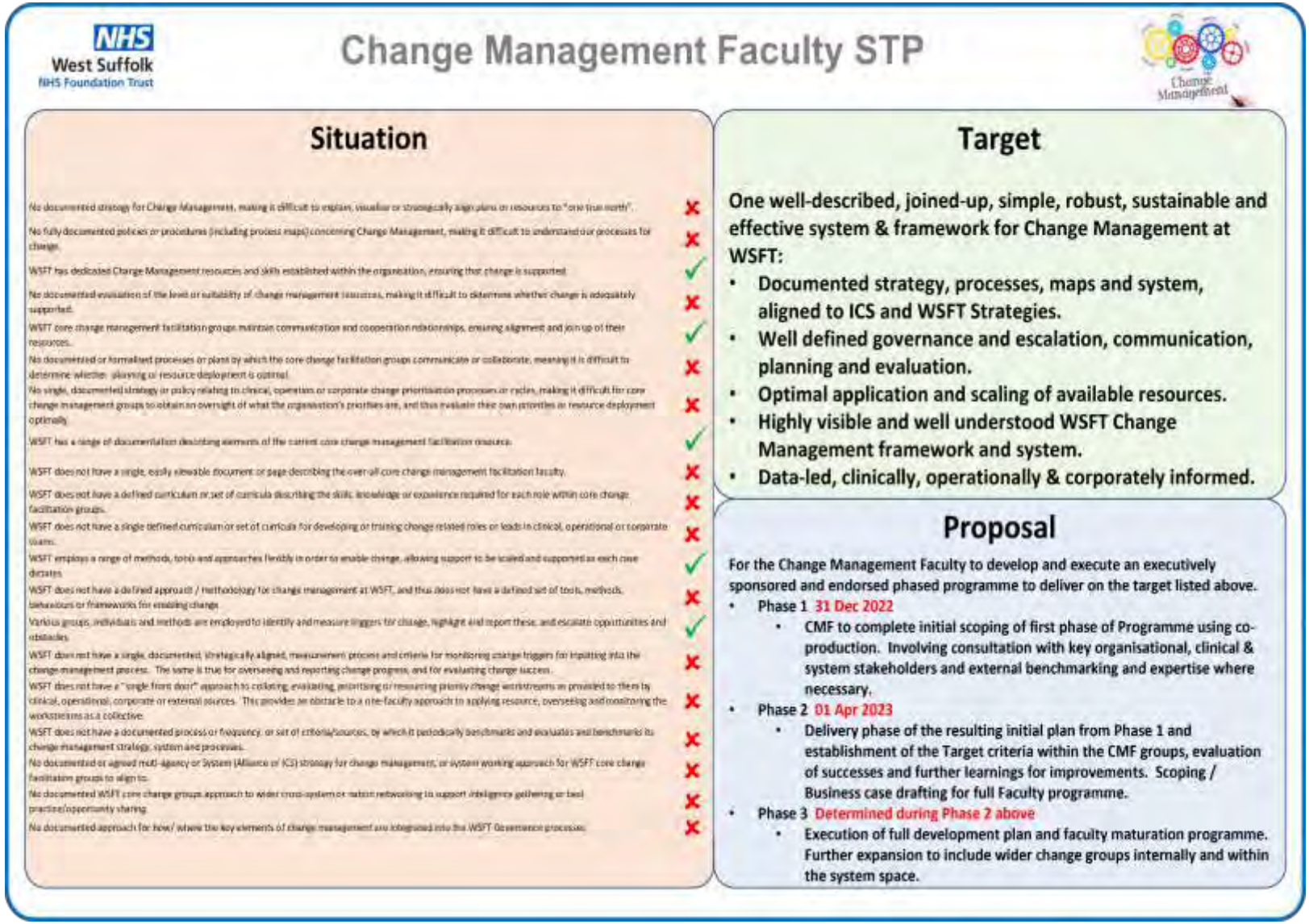
Following the discussion at SLT, the planned outputs include:

- Presenting the scope and proposed process to SLT on 20th February 2023
- The scope will refer not only to delivery of the clinical strategy but delivery of the Trust strategy, and will also align with the six Live Well domains as part of the Alliance strategy
- An integrated approach with Alliance colleagues and Future System team
- Identified programmes of work, including 2/3 transformation programmes
- Benefits tracking for quality, financial and environmental sustainability benefits
- A single overarching plan which visualises all change programmes within the Trust by 1st April 2023
- A unified process of prioritising change projects and programmes, identifying the most appropriate resource to support, tracking delivery and evaluation, live from 1st April 2023

Appendix 1: Proposed model for aligned change management process



Appendix 2: Change Management Faculty Situation, Target, Proposal



4.4. Improvement Committee Report - 12 December, 2022 & 16 January, 2023 - Chair's Key Issues from the meeting

To Assure

Presented by Louisa Pepper

Chair's Key Issues

Originating Committee	Improvement Committee	**Date of meeting**	12 December 2022
Chaired by	Geraldine O'Sullivan	**Lead Executive Director**	Sue Wilkinson

Agenda item	Details of issue	For: Approval/ Escalation/ Assurance	BAF/ Risk Register ref	Paper attached? ✓
3.1	<u>IQPR – level of reporting / inclusion of IQPR data-pack in committee papers</u> IQPR data pack to be included in Improvement papers, ideally with relevant metrics. NED members of Improvement to consider what if any further level of reporting / narrative is required.	**Approval** To increase NED oversight of Q&S	Failure to maintain and further strengthen effective governance structures (BAF 1)	
3.2	<u>Change management</u> Paper going to SLT in December describes how to make optimal use of existing capability and capacity expertise in change and improvement. SLT paper sets out options for aligning the expertise with the delivery of change. An update on the outcome of this will be provided to a future Improvement meeting for assurance.	**Approval and Assurance** To ensure appropriate and optimal use of expertise to enable change management	BAF 1	
4.1	<u>Prioritisation framework Process for Change Management</u> Links to 3.2 above. Response to November meeting request "*committee seeks assurance of how a prioritisation framework might be developed, applied and maintained to focus the change management approach. To include how/from where to receive intelligence to maintain that framework*" Improvement committee assured that this will be incorporated into wider change management strategy under the direction of SLT and therefore no further separate action required at this time by Improvement committee.	**Assurance** See 3.2	BAF 1	

Agenda item	Details of issue	For: Approval/ Escalation/ Assurance	BAF/ Risk Register ref	Paper attached? ✓
4.2	<u>Deep dive – Reducing the elective orthopaedic length of stay</u> Informative presentation from orthopaedic therapist on effective improvement project to reduce Length of Stay. Congratulations were offered to the team for a demonstrable improvement journey. Request made to consider how such project/learning would be shared across the organisation and especially with General Surgery colleagues so that such initiatives can be promoted.	**Assurance** gained on an excellent improvement project	Delivery of elective access standards based on clinical priorities (BAF 3)	
5.1	<u>PQAS</u> November report provided. Updates provided for: • Mortuary: Positive assurance - HTA[1] inspection in Feb22. All actions now completed and HTA confirmed required improvements met; Concern re lack of relatives' room/waiting area and still awaiting engagement from estates regarding time frame for completed works. • Deteriorating patient group: ReSPECT[2] being rolled out in 2023 to replace EPARS. Concern that Sepsis 6 audit data suggests compliance with KPIs within sepsis bundle is poor. Further work is required to provide assurance and the Committee to be updated. • Dementia/Frailty group: Recruitment of established dementia CNS following retirement of current lead. Participation in national dementia audit on track. • End of Life group: Palliative Care CNS is now a full onsite 7-day service • Learning from Deaths: Future reports will be from Mortality oversight group. Query if rise in LD deaths seen; definition updated in 2022 to incorporate Autism may explain perceived rise. Will continue to monitor and report back to committee. • Inquests and claims: No cause for concern or escalation noted.	**Assurance** Gained that improvements being made in most areas (see details). **Escalation to Executive Team/SLT** Estates prioritisation framework required to enable important estates work to be scheduled In a prioritised and timely manner.	BAF 1 And Implementation of Estates Strategy to provide a building environment suitable for patient care and adequately maintained (BAF 7)	

[1] HTA - Human Tissue Authority
[2] ReSPECT | Resuscitation Council UK https://www.resus.org.uk/respect

Agenda item	Details of issue	For: Approval/ Escalation/ Assurance	BAF/ Risk Register ref	Paper attached? ✓
5.2	<u>CEGG</u> December report provided. Updates provided for: • GIRFT: Recent T&O / General Surgery session provided positive feedback on WSFT services; Recent Pathology visit outcomes and actions being recorded through an improvement programme on LifeQI. • Clinical audit : Positive assurance on participation in national and local audits; audit intranet microsite including new electronic registration form; established links between clinical audit and QI. Specialist committees (reporting into PQAS) now include requirement for audit programme within ToR. • Research and Development: report received for information only. No cause for concern or escalation required. Improvement committee to receive an assurance report on R&D in 2023. It was noted for escalation that the ability of CEGG to oversee improvements is limited as it is focused on assurance and doesn't have the mechanisms/connections to enact improvements to address deficits identified through gap analysis, particularly where multidisciplinary actions are required. Item 6.1 has thrown up the challenge.	**Partial Assurance/ Escalation** It was noted for escalation to Executive Team/SLT that the ability of CEGG to oversee improvements is limited as it is focused on assurance and doesn't have the mechanisms/connections to enact improvements to address deficits identified through gap analysis	BAF 1 .	
6.1	<u>Ockenden gap analysis and improvement plan</u> Report considers trust-wide implications (Maternity reported separately to Board). Gap analysis has been undertaken on the main themes (staffing, training, patient engagement, learning from incidents and complaints, partnerships, psychological issues and anaesthetics) and categorised into levels of compliance. SMART action plans and /or improvement plans required (see escalation note in 5.2). Potential for future quality assurance of reported compliance. Stakeholder meeting scheduled for early January to consider the product and next steps including ongoing reporting of an improvement plan.	**Partial Assurance** Lack of assurance about the existence of a robust framework for addressing the wider implications of Ockenden beyond the Maternity service – this is linked to 5.2 and for escalation.	BAF 1	

Agenda item	Details of issue	For: Approval/ Escalation/ Assurance	BAF/ Risk Register ref	Paper attached? ✓
7.1	<u>Quality improvement priorities – interim update for period Q1 - Q2 (2022/23)</u> Addresses five QIPs (other eight reported via Involvement committee) Provided in format - *What we've done in 2022/23 to date* / *Even better if* • Deliver improvements through our patient safety incident response framework • Deliver improvements as measured by the CQUIN indicators for 2022-23 • Through shared learning deliver improvements to reduce patient harm • Effectively respond to national reports to support quality improvements • Develop our quality assurance framework to support systematic quality improvement	**Partial Assurance** Ongoing work to do these better.	BAF 1	
8.1	<u>Quality assurance (QA) framework</u> Development of a QA framework with co-production by the key organisational stakeholders (corporate quality, safety and effectiveness teams with divisional triumvirate representation and other relevant parties as identified). The Improvement committee to maintain oversight of the development of this framework and provide assurance to the Board of its progress with an intention to enable Board approval of the final framework in early 2023	**Full Assurance about the proposed framework.**	BAF 1	

Chair's Key Issues

Originating Committee	Improvement Committee	**Date of meeting**	16 January 2023
Chaired by	Louisa Pepper	**Lead Executive Director**	Sue Wilkinson

Agenda item	Details of issue	For: Approval/ Escalation/ Assurance	BAF/ Risk Register ref	Paper attached? ✓
4.1	Estates Follows a request for further clarification re Estates prioritisation framework (see December's CKIs). Outline of process provided however assurance not available re specific item (refurbishment of bereavement room). Specific action agreed for this clarification. Wider discussion of estates requests programme, referral to Audit committee to consider adding to next year's IA programme (on long list).	**Partial assurance**	Implementation of Estates Strategy to provide a building environment suitable for patient care and adequately maintained (BAF 7)	
5.1	IQPR Received for information. Discussion re urgent & emergency care indicators (ambulance handover and 12-hour breaches). Request for deep dive into the impact of these operational pressures on patient safety and quality. To be brought to February meeting.	**Assurance**	Failure to maintain and further strengthen effective governance structures (BAF 1)	✓ IQPR in Board appendices
5.2	Being open and the Duty of candour (DoC) Presentation for information. Focus has expanded from a simple focus on timeliness to a more comprehensive framework including a QI project and a clinical audit of qualitative indicators. Recognising this is an ongoing improvement journey, an update will be brought back to the committee in six months.	**Assurance**	BAF 1	

Agenda item	Details of issue	For: Approval/ Escalation/ Assurance	BAF/ Risk Register ref	Paper attached? ✓
5.3	Patient communication and harm reviews Presentation for information. Actions being taken include: • Significant effort to reduce time patients waiting (104 / 78 / 52 week waits) • Validation of waiting list to ensure patients still require appointment/surgery • Focus on communication initiatives with next steps including methods for patients to escalate where conditions have worsened. Harm reviews for >52 week waits routinely undertaken pre-covid and continued during covid in Aug20 and Apr21 however there is limited assurance that this is still a robust process and new processes have been proposed but there are challenges encompassed within including clinical input into harm review process. Assurance not provided to Improvement that this will achieve its desired impact and concerns around the timeliness of implementing proposals. To be escalated to Strategic leadership team (SLT) for consideration / action. Subject detail better meets the remit of Insight committee therefore Improvement refers to Insight for future assurance and oversight.	**Lack of assurance**	Delivery of elective access standards based on clinical priorities (BAF 3)	
5.4	Frailty quality assurance (QA) visit report and next steps Received for information. Positive feedback from ICS-led external reviewers with only minor areas of concern and many positives to be highlighted. Next steps include a visit to one of our community teams to complete the QA process and development of an improvement plan. Of particular positive note is an ambition for a shared community of practice with Newmarket Hospital and Kings Suite, Glastonbury Court joining the three CAB units in East Suffolk and one in North-East Essex. This forum would encompass more than just frailty and enable our teams to discuss challenges, share learning, work together to implement national initiatives and provide a space and platform for peer-to-peer support.	**Assurance**	BAF 1	

Agenda item	Details of issue	For: Approval/ Escalation/ Assurance	BAF/ Risk Register ref	Paper attached? ✓
6.0	Reporting from Governance sub-groups Verbal update from PQAS (no CEGG meeting since last report). No immediate safety concerns raised.	**Assurance**	BAF 1	
7.1	Patient safety oversight reports Updates of strategy implementation and patient safety specialist programmes of work received for information. Clarification requested on the pathways for reporting (assurance and escalation) on the major projects contained within, some of which have organisation-wide impact. Further exploring of this topic to be undertaken at the February meeting when more time available.	**Assurance**	BAF 1	
7.2	Peer support network Received for information. An excellent new initiative introduced following the 'supporting staff in difficult situations' consultation. This seeks to introduce a peer-to-peer support for doctors involved in emotionally difficult situations such as inquests, serious incidents, claims etc. The first cohort of trained staff are now in place and a six-month review of the initiative will be brought to a meeting of Improvement in the summer.	**Assurance**	Value our workforce and look after their well-being (BAF 4)	
8.1	QI programme Received for information.	**Assurance**	BAF 1	
8.2	Glemsford CQC Improvement plan update Received for information. The content of the CQC plan will be incorporated into the wider Glemsford improvement programme and an update on progress will be provided in six months.	**Assurance**	BAF 1	

Agenda item	Details of issue	For: Approval/ Escalation/ Assurance	BAF/ Risk Register ref	Paper attached? ✓
8.3	<u>CQC new inspection framework</u> Received for information. SLT will receive a paper setting out proposals for organisation wide response and review as part of a wider quality assurance framework. This recognises that the subjects contained within the CQC documents are key constituents of an organisation's focus quality rather than purely compliance with a regulatory body.	**Assurance**		
10.1	<u>Sign-off Maternity Incentive scheme (Year 4) submission on behalf of Board</u> The Improvement committee has delegated authority to receive and approve this submission on behalf of the Trust Board. To this end the committee members have undertaken the following: 1. Received the report and appendices as evidence for the Maternity incentive scheme year four submission. 2. Acknowledged the two areas of reported non-compliance and the explanations thereof. 3. Considered the one area of reported compliance where the Maternity service have requested scrutiny to support the declaration of full compliance. The assumptions made have been agreed as suitable to allow for a declaration of compliance with that element. 4. Accepted the seven other areas of reported compliance where oversight and review have already provided sufficient evidence to support a declaration of full compliance. On behalf of the Board, the Improvement committee recommends to the WSFT Chief Executive that he co-signs sign the Board declaration form (together with Accountable Officer for our Integrated Care Board) as evidence that they are both fully assured and in agreement with the compliance submission to NHS Resolution.	**Approval**		

4.5. Quality and Nurse Staffing Report

To Assure

Presented by Susan Wilkinson

Board of Directors – Public

Report title:	Quality and Workforce Report & Dashboard –November and December 2022
Agenda item:	4.5
Date of the meeting:	2 February, 2023
Sponsor/executive lead:	Sue Wilkinson
Report prepared by:	Dan Spooner

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

Executive Summary

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

Highlights

- Improved total fill rates and CHPPD in all shifts in November, but declining in all shifts during December driven by increased sickness and opening of an additional ward mid-month
- Inpatient substantive RN/RM numbers achieved special cause improvement in November and December
- Inpatient RN/RM vacancy percentage achieved special cause improvement in December at 14%
- Total RN/RM vacancy rate achieved special cause improvement in December at 10.3%
- Turnover in NA roles continues to be high
- Nurse sensitive indicator increasing in December (falls)

Action Required of the Board

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

Risk and assurance:	Red Risk 4724 amended to reflect surge staffing and return to BAU
Equality, Diversity and Inclusion:	*N/A*
Sustainability:	*N/A*
Legal and regulatory context	*Compliance with CQC regulations for provision of safe care*

1. Introduction

Whilst there is no single definition of 'safe staffing', the NHS constitution, NHS England, CQC regulations, NICE guidelines, NQB expectations, and NHS Improvement resources all refer to the need for NHS services to be provided with sufficient staff to provide patient care safely. NHS England cites the provision of an *"appropriate number and mix of clinical professionals"* as being vital to the delivery of quality care and in keeping patients safe from avoidable harm. (NHS England 2015).

West Suffolk NHS Trust is committed to ensuring that levels of nursing staff, which includes Registered Nurses, Midwives and Nursing Associates and Assistant Practitioners, match the acuity and dependency needs of patients within clinical ward areas in the Trust. This includes ensuring there is an appropriate level and skill mix of nursing staff to provide safe and effective care using evidence-based tools and professional judgement to support decisions. The National Quality Board (NQB 2016) recommend that monthly, actual staffing data is compared with expected staffing and reviewed alongside quality of care, patient safety, and patient and staff experience data. The trust is committed to ensuring that improvements are learned from and celebrated, and areas of emerging concern are identified and addressed promptly.

This paper will identify safe staffing and actions taken in November and December 2022. The following sections identify the processes in place to demonstrate that the Trust proactively manages nurse staffing to support patient safety.

2. Nursing Fill Rate

The Trust's safer staffing submission has been submitted to NHS Digital for November and December 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 November and December.

	Day		Night	
	Registered	Care Staff	Registered	Care staff
Average fill rate July 2022	87%	70%	89%	91%
Average fill rate August 2022	87%	78%	87%	95%
Average fill rate Sept. 2022	87%	76%	88%	95%
Average fill rate October 2022	83%	70%	87%	88%
Average fill rate November 2022	87%	74%	89%	94%
Average fill rate December 2022	84%	72%	85%	86%

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

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

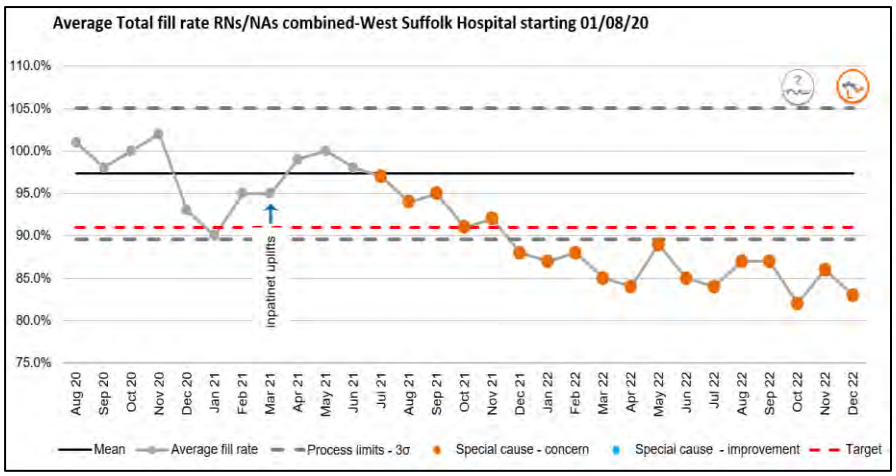


Chart 2.

Highlights

- RN fill rates improved on month in November but declined in all shifts in December. This is likely to be driven by the opening of an additional ward in December 2022 and increased sickness levels that is illustrated in chart 4a.

Care Hours per Patient Day (CHPPD)

CHPPD is a measure of workforce deployment and is reportable to NHS Digital as part of the monthly returns for safe staffing (Appendix 1). CHPPD is the total number of hours worked on the roster by both Registered Nurses & Midwives and Nursing Support Staff divided by the total number of patients on the ward at 23:59 aggregated for the month (lower CHPPD equates to lower staffing numbers available to provide clinical care). Using model hospital, the average Recommended CHPPD for an organisation of our size is 7.6. The chart below demonstrates our achievement of this. Since August 2021 we are not achieving this consistently and further demonstrates the staffing challenges over the last year.

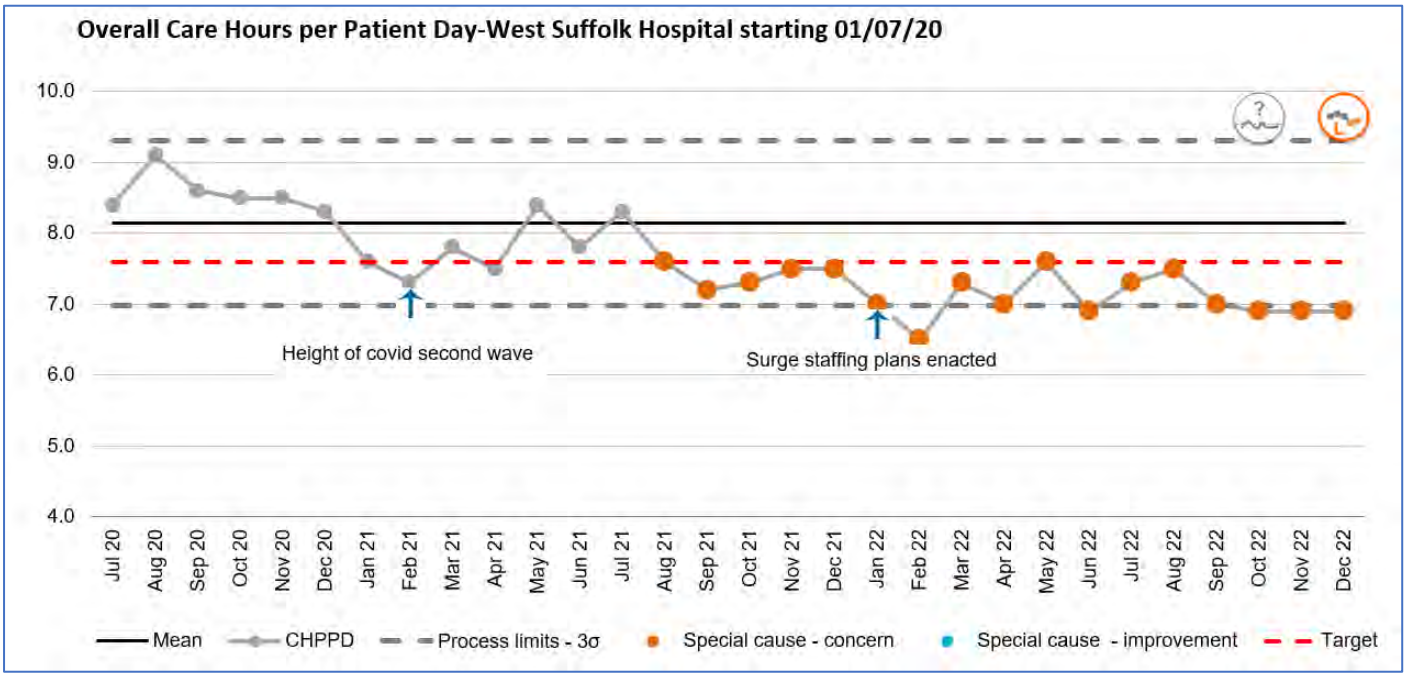


Chart 3 Adapted from model hospital/unify data

3. Sickness

Sickness rates peaked in December 2022, potentially driven by increased community prevalence of both covid and influenza.

	May-22	Jun-22	Jul-22	Aug-22	Sep 22	Oct 22	Nov 22	Dec 22
Unregistered staff (support workers)	7.30%	9.45%	9.64%	7.39%	6.85%	7.95%	6.33%	8.71%
Registered Nurse/Midwives	5.56%	5.45%	6.09%	4.42%	4.61%	5.54%	4.96%	6.63%
Combined Registered/Unregistered	**6.15%**	**6.79%**	**7.31%**	**5.44%**	**5.38%**	**6.36%**	**5.42%**	**7.33%**

Table 4

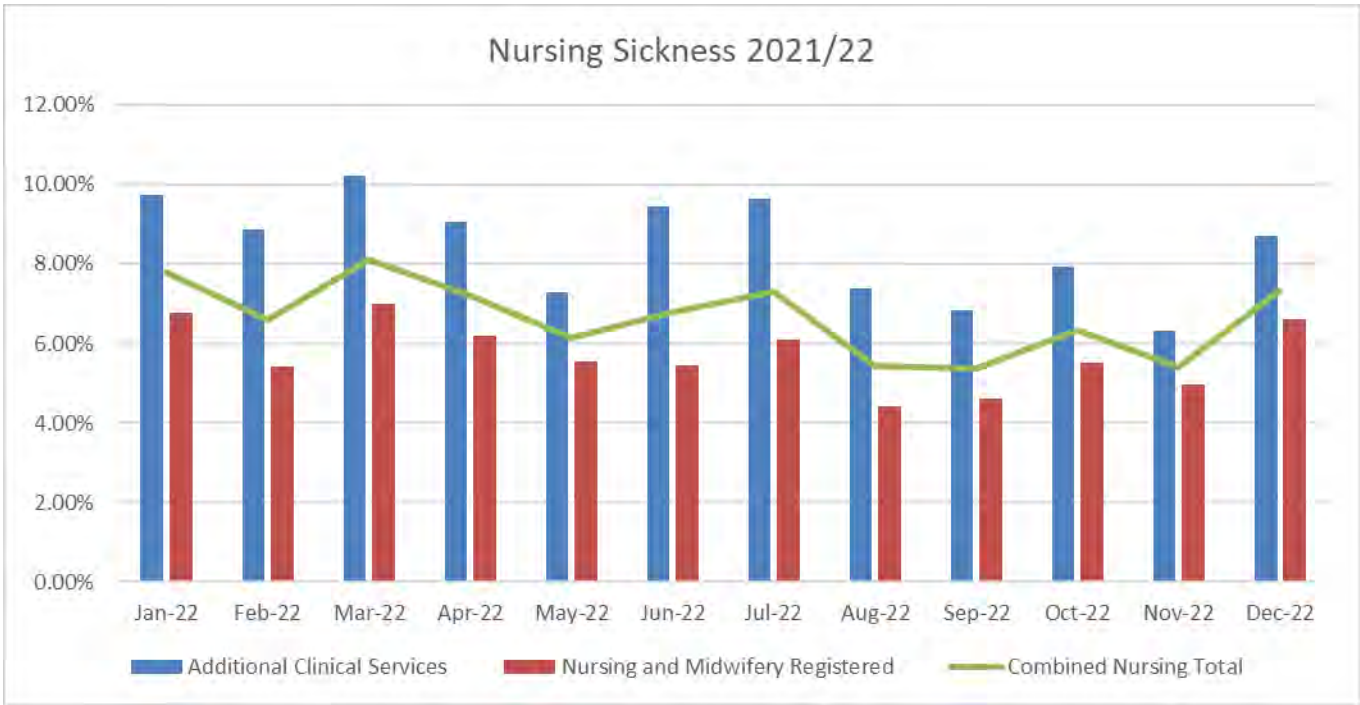


Chart 4a

4. Patient Flow and Escalation

Good patient flow is central to patient experience, clinical safety and reducing the pressure on staff. It is also essential to the delivery of national emergency care access standards (NHSI 2017). Ward closures and moves can add additional staffing challenges and opportunities. In recent months ward relocations and structural repair have challenged flow and staffing.

In December following consistent challenges to patient safety and flow through the emergency pathway, an additional ward was opened. This was planned to open mid-January, however, consistent pressures in early December required this to be opened earlier than anticipated. Ward F10 was opened, and staff were sourced from within the current nursing establishment. Senior oversight has been provided by an established matron and ward sister to provide consistency. This ward remains open at the time of writing. But has now moved to F9 which has further increased the bed base?

5. Recruitment and Retention

Vacancies: Registered nursing (RN/RM):

- Substantive Inpatient RN/RM WTE and vacancy rate is special cause improvement.
- Inpatient vacancy rate is 14% and 13.1% (excluding Registered Midwives (RMs), this is a 3% improvement from last reporting period
- Total RN/RM establishment and vacancy rate continues special cause improvement in this reporting period and is at 10.3%
- Inpatient ward NA vacancies have increased over this period from 12.9% to 14.3%
- Total NA vacancy rate is 14.7% and is common cause variation.

Table 5 demonstrates the total RN/RM establishment for the inpatient areas (WTE). The total number of substantive RNs has seen an improving trend until March this year. Full list of SPC related to vacancies and WTE can be found in appendix 2. Areas of concern remain within the non-registered staff group. While recruitment for RNs is in a positive position this is yet to be reflected in fill rates. This is in part due to staffing additional escalation areas and the addition ward mentioned in section 4 which require moving staff from other wards and adversely affecting their planned fill rate.

	Inpatient	Sum of Actuals Period 04 (July)	Sum of Actuals Period 05 (Aug)	Sum of Actuals Period 06 (Sept)	Sum of Actuals Period 07 (Oct)	Sum of Actuals Period 08 (Nov)	Sum of Actuals Period 09 (Dec)	WTE VACANCY at period 9
RN/RM Substantive	Ward WTE	601.8	608.7	617.5	612.8	624.8	629	102.4
Nursing Unregistered Substantive	Ward WTE	374.4	387.9	407	391.6	389	384.7	66.2

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

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

6. New Starters and Turnover

International Nurse Recruitment:

Following some significant problems with nurses arriving in the December cohort due to flight availability, we were 12 under target for 2022 recruitment. The delayed cohort have arrived in January and equates to 2 under target for 2022.

The January to March 2023 recruitment target for international nurses is 26 and we are on track to achieving this. We have successfully supported recruitment of nurses for our community inpatient beds and are providing bespoke support to ensure adequate education provision and integration into this team.

In December NHSE formally presented the trust with our accreditation for the pastoral support we provide to our international nurse colleagues. A celebration ceremony was well attended in the education centre.

Allied health professional (AHP) recruitment

In November a new role with HR recruitment team was established to focus on AHP recruitment. The biggest area of challenge for this role is vacancies within the pharmacy department. A procurement exercise is being completed to engage a recruitment agency to help source candidates from overseas, with the ambition of similar successes of the international nursing program. In the interim, the recruitment lead is engaging with 'Indeed' to increase the reach of our current recruitment process and improve engagement with online enquires and countries that can efficiently supply workers. The cost of this program is being scoped including understanding where best to target and what has worked with previous Trust's.

International recruitment for AHPs is new territory for the trust and the offer for international recruits is not as well defined or as mature as the nursing pathway. This is being scoped within the international recruitment strategy.

New starters

	July 22	August 22	Sept 22*	Oct 22	Nov 22	Dec 22
Registered Nurses*	18	18	43	21	24	25
Non-Registered	16	9	31	22	40	9

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

- In November, twenty-four RNs completed induction; of these; 17 were for acute services, 3 for bank, 2 for maternity and 2 for community services joined this cohort
- In November, forty NAs completed induction; of these 31 NAs are for the acute Trust, 5 for bank services, 1 for midwifery and 3 for community.

- In December twenty-five RNs completed induction; of these 22 were for the acute, 1 midwifery and 1 for community and 1 for bank staff
- In December nine NAs completed induction; of these, six NAs are for the acute Trust,1 for bank services and 2 for community services

Turnover

On a retrospective review of the last rolling twelve months, turnover for RNs has improved marginally to 10.26% just above the trust ambition of <10%. NA turnover has increased again from 22.96% to 24.71%. The increasing turnover has been escalated through the finance and workforce committee and is being captured at the Trust retention group. In addition, the DCN is working collaboratively with other trusts within our ICB to review the terms and conditions of the NA role following publications of national job profiles. An open day recruitment event is planned for January which will showcase the role and indicate the reality of the role for potential candidates to reduce attrition once starting in role.

Turn Over 01/01/2022 - 31/12/2022								
Staff Group	Average Headcount	Avg FTE	Starters Headcount	Starters FTE	Leavers Headcount	Leavers FTE	LTR Headcount %	LTR FTE %
Nursing and Midwifery Registered	1,337.00	1,158.6029	109	85.39	147	118.84	10.99%	10.26%
Additional Clinical Services	582.00	485.55	268	243.29	149	119.97	25.60%	24.71%

Table 7. (Data from workforce information)

7. Quality Indicators

Falls

Fall incidents remain in common cause variation. With December seeing a higher number of incidents than November.

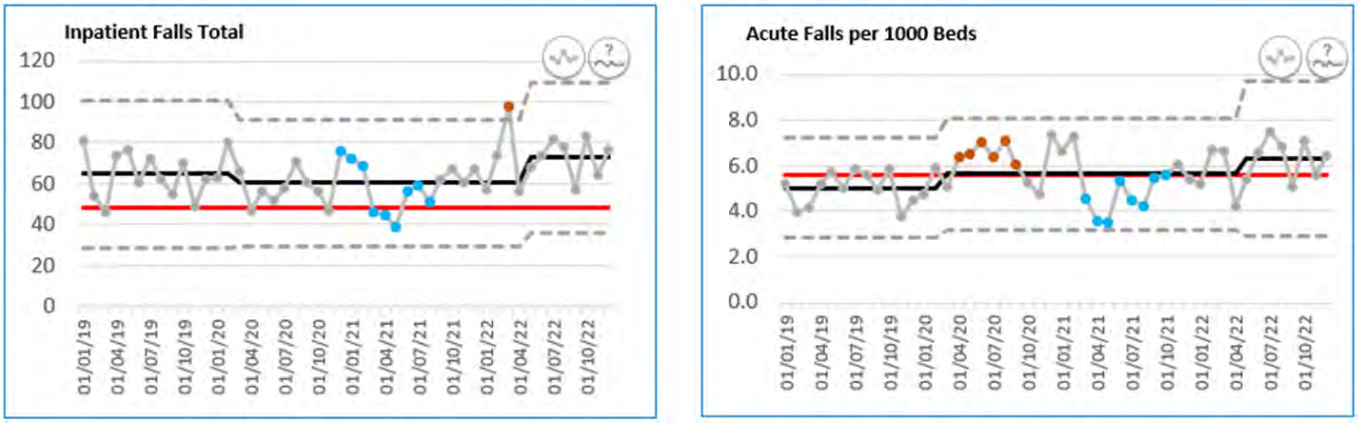
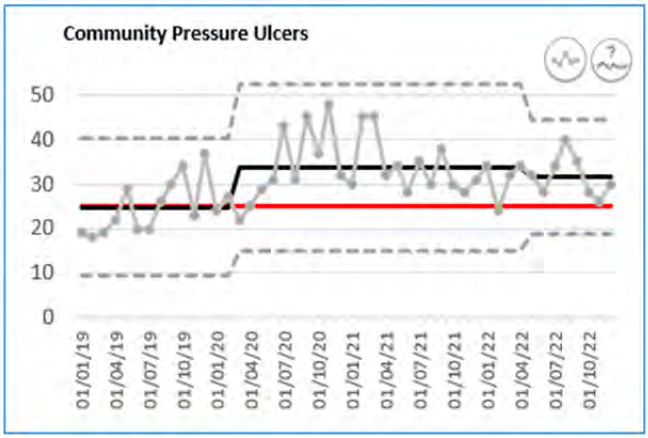


Chart 8

Pressure Ulcers

Within the inpatient areas (inclusive of CAB), the increasing trend above average expectation returned to common cause variation in May 2022. This variation continues. This is possibly driven by challenges with high NA absences and an increasing turn over for this group. Areas where high incidence have occurred have been supported with bespoke training and study days over the summer months. Targeted interventions for wards with high incidents are reviewed and monitored through PQSGG. Trust wide interventions have included the procurement of toto turning systems to aid vulnerable patients and purchasing of pocket mirrors for staff to promote the checking of heels.

Community prevalence has maintained common cause variation for over a year. The senior nursing team have been working with the national wound care collaborative on improvement methods within the community. After three months reduction the community team are cross referencing with active care plans to ensure that this is not due to under reporting



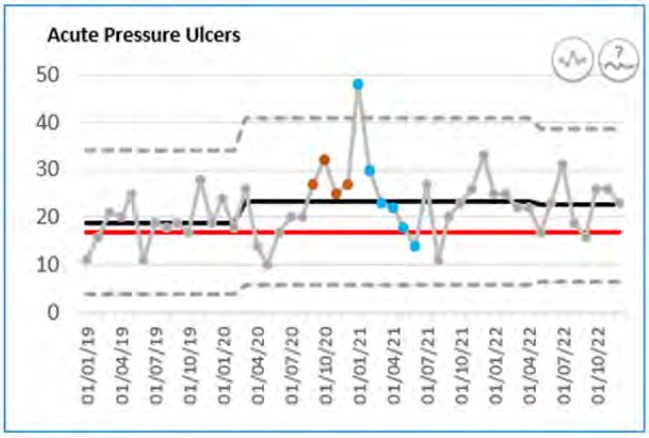


Chart 9

8. Compliments and Complaints

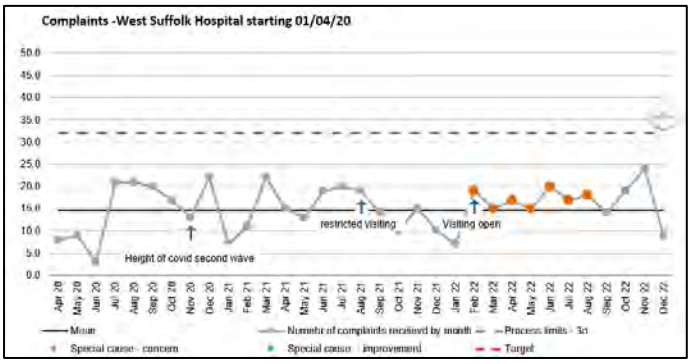
In November the average number of calls to the clinical helpline was 104 and 105 per day in December. This activity is well sustained since the relaxing of visiting restrictions in May 2022.

Twenty-four new complaints were received in November. 8 of the complaints received were for the medical division, 6 were for the surgical division, 5 were for women & children's division, 2 were for integrated community services and 1 complaint was for estates and facilities. The overall theme of complaints received in November was Patient Care – including nutrition/hydration with 5 formal complaints being listed under this subject. Admissions, discharge & transfers were a secondary theme with 4 formal complaints being listed under this subject.

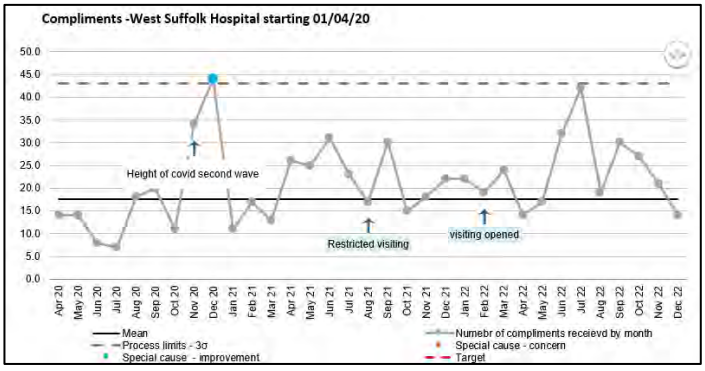
Nine new complaints were received in December. Of those received in December, 6 of these complaints were for the medical division, 2 for the surgical division and 1 complaint was for the women & children's division.

The overall theme of complaints received in December 2022 was clinical treatment with 6 formal complaints being listed under this subject. On reviewing the sub-subjects of these complaints, the main themes were, delay or failure to undertake scan/x-ray etc. and disputes over diagnosis.

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



10a Complaints



10b Compliments

9. Adverse Staffing Incidences

Staffing incidences are captured on Datix with recognition of any red flag events that have occurred as per National Quality Board (NQB) definition (Appendix 5). Nursing staff are encouraged to complete a Datix as required, so any resulting patient harm can be identified and if necessary, reviewed retrospectively.

Red Flag	June 22	July 22	Aug 22	Sept 22	Oct 22	Nov 22	Dec 22
Registered nursing shortfall of more than 8 hours or >25% of planned nursing hours	7	12	7	3	2	5	7
>30-minute delay in providing pain relief	-	2	2	3	2	2	7
Delay or omission of intention rounding	5	3	3	2	12	4	8
<2 RNs on a shift	5	1	5	8	7	5	7
Vital signs not recorded as indicated on care plan	-	1	2	1	2	3	7
Unplanned omissions in providing medication	-	-	-	-	-	1	1
Lack of appointments (local agreed red flag)	3	1	-	-	1	1	
Delay in routine care (new descriptor)	18	14	18	10	17	19	20
Impact not described	-	-	-	-	1	-	
Total	38	34	37	27	44	40	57

Table 11.

- In November there were 40 Datixs recorded for nurse staffing that resulted in a Red Flag event (see table 11.). No harm is recorded for these incidents at the time

- In December there were 57 Datixs recorded for inpatient nurse staffing that resulted in a Red Flag event (see table 11). 3 Datixs where recorded as moderate harm. On review of these Datix the actual harm is not indicative of actual harm however the narrative suggests very challenging shifts in ED, G4 and DWA and the potential for harm. These Datixs are linked to the organisation risks ID4074 and ID5703

10. Maternity Services

A full maternity staffing report will be attached to the maternity paper as per CNST requirements.

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

Red Flag events

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

- There were nine red flag events in November. No harm was recorded as in impact of these incidents
- There were eleven red flag events in December. No harm was recorded as in impact of these incidents.

Midwife to Birth ratio

Midwife to Birth ratio was 1:27 in November and 1:29 in December, December ratio was above the national average of 1:28 or Birthrate Plus recommendation of 1:27.7 and was due to increase staffing sickness.

1:1 care was achieved 100% in both November and December

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 any

women. This is to enable the co-ordinator to have situational awareness of what is occurring on the unit and is recognised not only as best but safest practice. In November and December 99% compliance against this standard was achieved. This was due to staff shortages and increased acuity in the Unit and a woman who arrived unannounced and successfully gave birth immediately. No adverse outcome resulted from the occurrence. This is clarified and explained in the full Midwifery staffing report.

11. Community & Integrated services division

12.1 Demand

Demand within the community setting can be illustrated by the number of referrals each service receives. Chart 12a and 12b are examples of the rise in demand for both community nursing and community therapy experienced in the last year. The demand on community healthcare teams, and community and integrated therapies in general remain high and above pre -pandemic averages and is special cause for concern. Referrals to therapy in the INTs had been reducing, although levels are still above our average (x1 data point of reduced referrals for Therapies in last data set).

These increases reflect our growing older, frailer population and the required healthcare at home to maintain their health. The CHT therapists have QI projects in progress to ensure referrals are appropriate, and where we can signpost to alternative options at the point of referral, for example the care homes team or Abbeycroft leisure for exercise programmes.

B7 therapy recruitment has now been completed which will allow a greater inspection and QI focus within future planning and project management

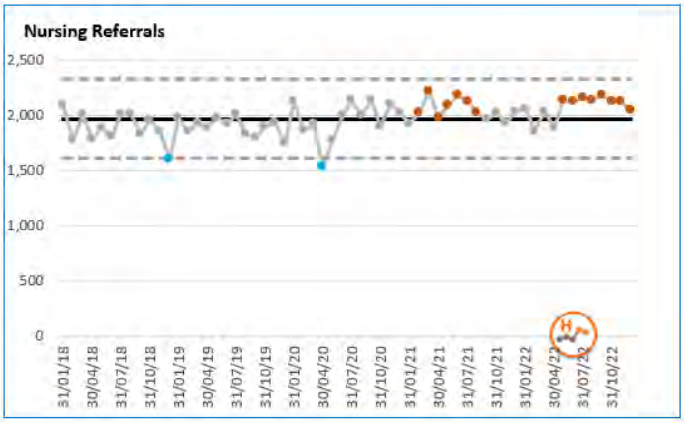


Chart 12a

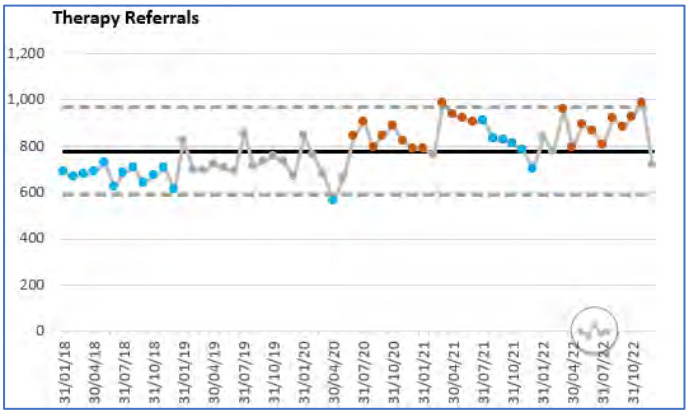


Chart 12b

12.2 Prioritisation of nursing patients

All patients are prioritised using rag rated care plans. This allows the senior team to identify, which are most urgent and require prioritisation. This allows the team to have flexibility when managing nursing/therapy

resource and can defer low urgency visits to the following day. There is currently no automated method to calculate the care hours. Care plan hours are calculated manually and balanced against WTE staffing levels. Escalation is provided via an OPEL agreed framework and surge plan enacted if required.

12.3 Sickness

The data is showing a higher value of variation and indicates that we are consistently passing the target of 5%, as we currently stand at 6.7% for December 2022 (chart 13).

In December 13 out of 56 departments across the Division were >5% target. A focused review into the areas over the 5% target to look at reasons for sickness and to provide support to managers and staff, ensuring attendance is being managed appropriately.

Additional training with the staff psychology team is being provided to managers on how to support staff's emotional wellbeing as this is a common cause and reason for absences currently

Chart 13.

12.4 Vacancies in CHTS

Role	Vacancy percentage	
	Last reported	October
RNs	16%	17%
Physiotherapists	31%	23%
Occupational therapists	9%	6%
Generic workers /unregistered	13%	12%

Actions regarding AHP recruitment are illustrated in section 6

12.5 Ongoing actions being taken by division

- Vacancies that attract no applicants are always reviewed to see if a change in the skill mix might attract new applicants.
- Video being used to promote recruitment for nurses in CHTs.
- Senior matron dedicated to CAB beds in post from October. Focus on recruiting to vacancies, recruiting from overseas
- Community Nursing Safe Staffing Tool (CNSST) licence has been acquired and training for key staff members of the audit process is being rolled out. This is a significant step forward in being able to assess the establishment of our community nursing teams. Data run anticipated in February.
- Recruitment event scheduled for January 2023 to promote roles within Newmarket Community Hospital
- Workforce Workshop being run in February in conjunction with ICB utilising STAR methodology

12. Activity of note

During the month of December, following a ballot of its members, members of the RCN voted to take industrial action. WSFT was not part of the first tranche of strikes in late December but were nominated to take part in early January. A full description of this activity and impact is set out in the People and OD report. Further industrial action is currently planned 6th and 7th February 2023.

13. 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 (November 2022): Data adapted from Unify submission

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

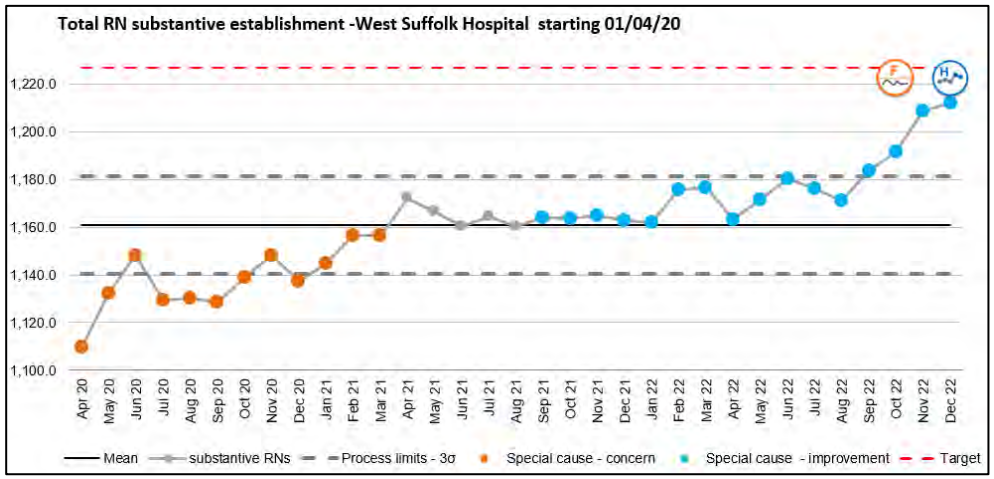
	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	RNs/RMN		Non registered (Care staff)		RNs/RMN		Non registered (Care staff)									
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average Fill rate RNs/RM %	Average fill rate Care staff %	Average Fill rate RNs/RM %	Average fill rate Care staff %	Cumulative count over the month of patients at 23:59 each day	RNS/RMs	Non registered (care staff)	Overall
Rosemary Ward	1263	1070	1818.48	1403.73	1000.5	941.5	1380	1311.5	85%	77%	94%	95%	953	2.1	2.8	5.0
Glastonbury Cour	692.5	709.5	1028	918.5	690	690	525	526	102%	89%	100%	100%	548	2.6	2.6	5.2
Acute Assessmen	2051	1780.42	2403.5	1163.88	1725	1455	1380	1046.5	87%	48%	84%	76%	761	4.3	2.9	7.2
Cardiac Centre	2397.5	2062.5	1230.5	974	1725	1472	690	678.5	86%	79%	85%	98%	632	5.6	2.6	8.2
G10	1571	1286	1572.75	1115.75	1035	946.5	1380	1284	82%	71%	91%	93%	707	3.2	3.4	6.6
G9	1380	1231	1380	1118.25	1380	1204.5	1033.5	1146	89%	81%	87%	111%	752	3.2	3.0	6.2
F12	552	677	345	244.75	690	557.5	345	428.5	123%	71%	81%	124%	240	5.1	2.8	7.9
F7	1725	1397	1723	1209.5	1380	1148.33	1715.5	1099	81%	70%	83%	64%	683	3.7	3.4	7.1
G1	1546.5	1073.92	345	310.5	690	681.5	345	218.5	69%	90%	99%	63%	485	3.6	1.1	4.7
G3	1675	1350.75	1725	1441.75	1000.5	934.25	1019.25	1232.75	81%	84%	93%	121%	864	2.6	3.1	5.7
G4	1725	1419.5	1765	1470.5	1035	810	1406	1292.75	82%	83%	78%	92%	896	2.5	3.1	5.6
G5	1380	1336.5	1718.5	1280.75	690	904	1380	1320.75	97%	75%	131%	96%	760	2.9	3.4	6.4
G8	2405.5	1807.08	1727.75	1380.42	1725	1480.72	1012	989.42	75%	80%	86%	98%	615	5.3	3.9	9.2
F8	1379.5	1387.5	2041	1406.67	1023.5	760	1376	1306	101%	69%	74%	95%	723	3.0	3.8	6.7
Critical Care	2720.5	2326.17	324	210	2748.5	2330.25	0	0	86%	65%	85%	*	388	12.0	0.5	12.5
F3	1725	1484.4	2063.25	1291	1035	1034.5	1368.5	1357.75	86%	63%	100%	99%	732	3.4	3.6	7.1
F4	1196	864.5	943	555	690	632.5	598	400.5	72%	59%	92%	67%	633	2.4	1.5	3.9
F5	1720.5	1554	1376	1015.92	1035	982.5	1035	856	90%	74%	95%	83%	698	3.6	2.7	6.3
F6	1964	1730.75	1601.25	1055.33	1380	1021.25	689	821.75	88%	66%	74%	119%	942	2.9	2.0	4.9
Neonatal Unit	1209	1245.75	600	574	1008	984	408	409.75	103%	96%	98%	100%	116	19.2	8.5	27.7
F1	1821.5	1618.92	688.25	669.25	1380	1285.25	0	43	89%	97%	93%	*	115	25.3	6.2	31.4
F14	746	770.7	312	353	720	732	0	137.5	103%	113%	102%	*	106	14.2	4.6	18.8
Total	34,846.00	30,183.86	28,731.23	21,162.45	25,786.00	22,988.05	19,085.75	17,906.42	**87%**	**74%**	**89%**	**94%**	**13349**	**4.0**	**2.9**	**6.9**

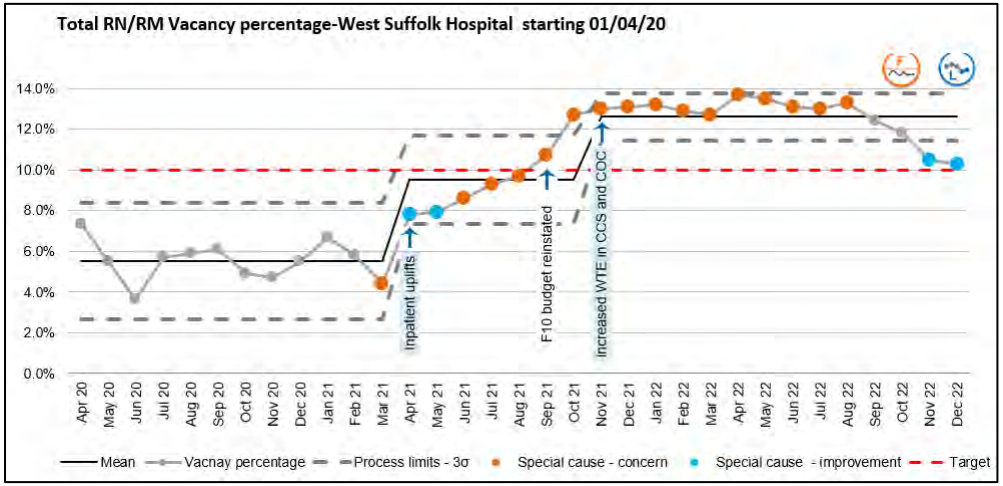
Appendix 1. Fill rates for inpatient areas (December): Data adapted from Unify submission

	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	1305	954.75	1767.75	1315	1069.5	914.5	1415	1183	73%	74%	86%	84%	452	4.1	5.5	9.7
Glastonbury Cour	716.25	719	1068.75	860	713	714.5	540	488.5	100%	80%	100%	90%	384	3.7	3.5	7.2
Acute Assessmen	2112	1771.5833	2489	1319.25	1776	1408	1426	992	84%	53%	79%	70%	761	4.2	3.0	7.2
Cardiac Centre	1778.5	1505	1069.5	777	1782.5	1483.5	709	572.5	85%	73%	83%	81%	632	4.7	2.1	6.9
G10	1624	1204	1568.5	1259.5	1069.5	884.5	1397.5	1139.5	74%	80%	83%	82%	707	3.0	3.4	6.3
G9	1431.5	1214.4833	1421.5	1181.7	1426	1225.5	1069.5	1047	85%	83%	86%	98%	752	3.2	3.0	6.2
F12	563.5	626.5	356.5	320.5	704	553.5	356.5	264.5	111%	90%	79%	74%	240	4.9	2.4	7.4
F7	1782.5	1341.75	1780	1185.75	1420.5	1019	1783	1099	75%	67%	72%	62%	683	3.5	3.3	6.8
G1	1520	1027.5	350.5	396.5	712	712	333.5	256.5	68%	113%	100%	77%	485	3.6	1.3	4.9
G3	1651	1363.25	1772.5	1396	1069.5	947.5	1065.5	1250.25	83%	79%	89%	117%	864	2.7	3.1	5.7
G4	1808	1458	1823.5	1430.5	1069	786.5	1425.5	1245.5	81%	78%	74%	87%	896	2.5	3.0	5.5
G5	1426	1372	1778.5	1291.5	712	917	1421	1278	96%	73%	129%	90%	760	3.0	3.4	6.4
G8	2487.5	1943.3667	1796.25	1229.5	1782.5	1412.166667	1069.5	1016.66667	78%	68%	79%	95%	615	5.5	3.7	9.1
F8	1426	1349.3333	2134	1349.75	1069.5	779	1426	1235.5	95%	63%	73%	87%	723	2.9	3.6	6.5
Critical Care	2839.5	2554	341	223.16667	2852	2550.583333	0	0	90%	65%	89%	*	388	13.2	0.6	13.7
F3	1782.5	1571.75	2140	1294.75	1069.5	991	1426	1290	88%	61%	93%	90%	732	3.5	3.5	7.0
F4	1219	750.5	971	655.91667	713	634.5	609.5	372	62%	68%	89%	61%	633	2.2	1.6	3.8
F5	1782.5	1421.75	1416	984.75	1069.5	921.5	1065.5	892.666667	80%	70%	86%	84%	698	3.4	2.7	6.0
F6	2007.5	1689.25	1654.5	954.58333	1426	1034.5	710.5	822	84%	58%	73%	116%	942	2.9	1.9	4.8
Neonatal Unit	1257	1389.5833	552	570.5	1068	1113.5	456	420	111%	103%	104%	92%	116	21.6	8.5	30.1
F1	1862.5	1569.5	707.5	720.65	1426	1288	0	68.25	84%	102%	90%	*	115	24.8	6.9	31.7
F14	776	812	312	345	744	697	0	72	105%	111%	94%	*	106	14.2	3.9	18.2
F9 (winter esc)	690	427.75	760.75	529.25	586.5	376.5	609.5	393	62%	70%	64%	74%	744	1.1	1.2	2.3
Total	35,848.25	30,036.60	30,031.50	21,591.02	27,330.00	23,364.25	20,314.50	17,398.33	**84%**	**72%**	**85%**	**86%**	**13428**	**4.0**	**2.9**	**6.9**

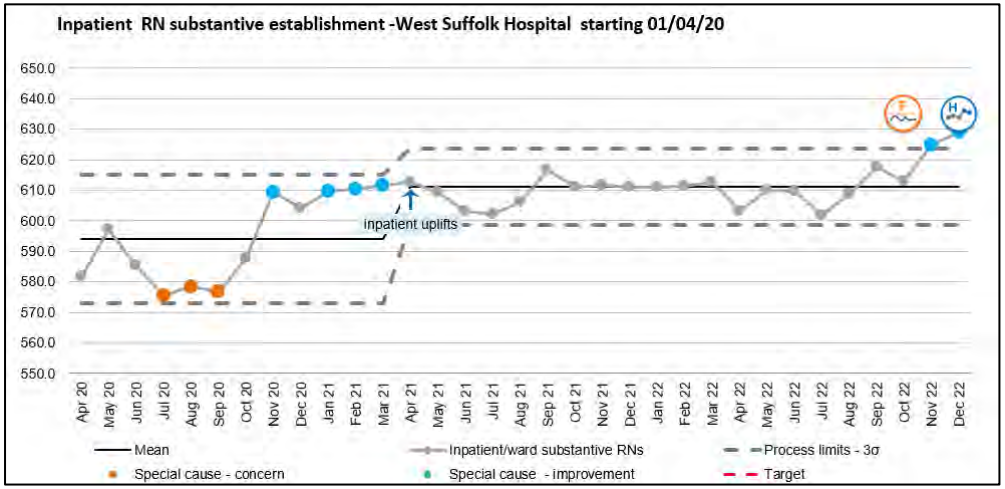
Appendix 2 SPC charts

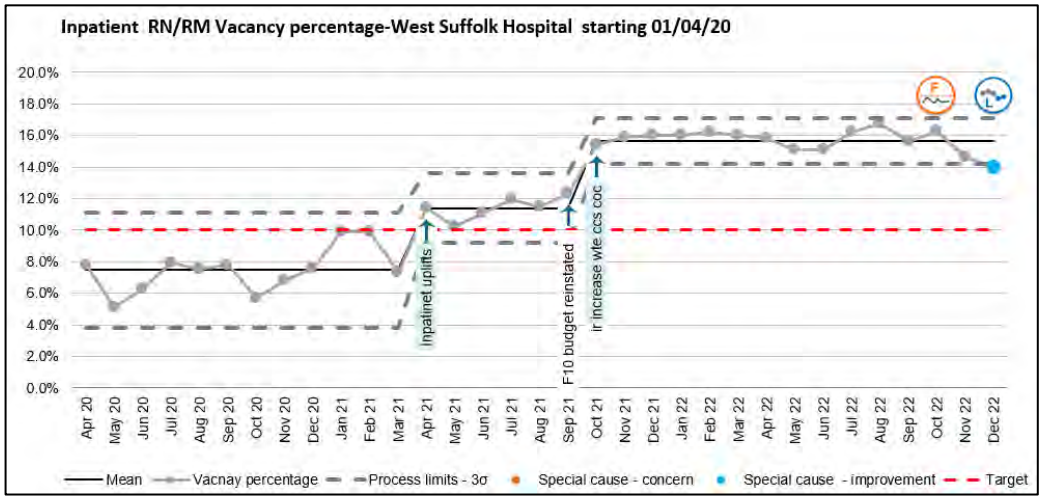
Total RN/RM establishments and vacancy percentage



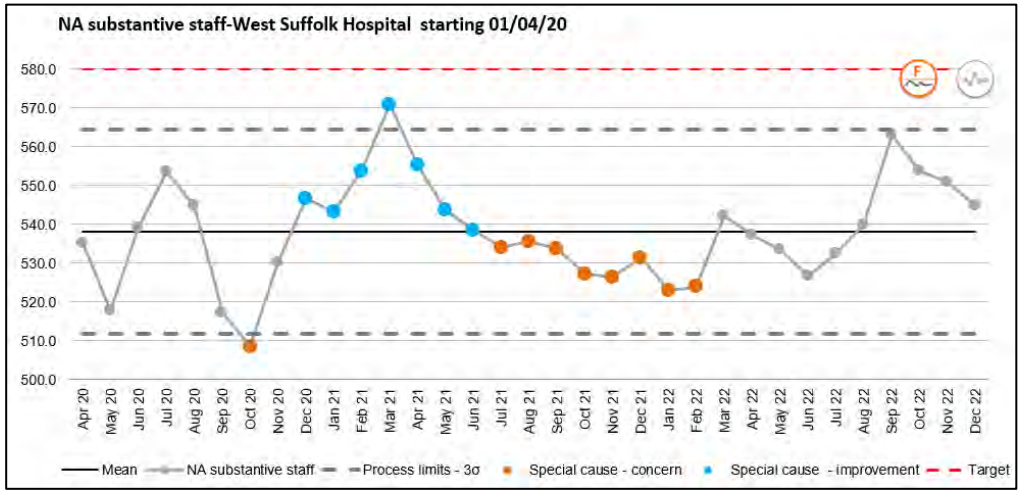


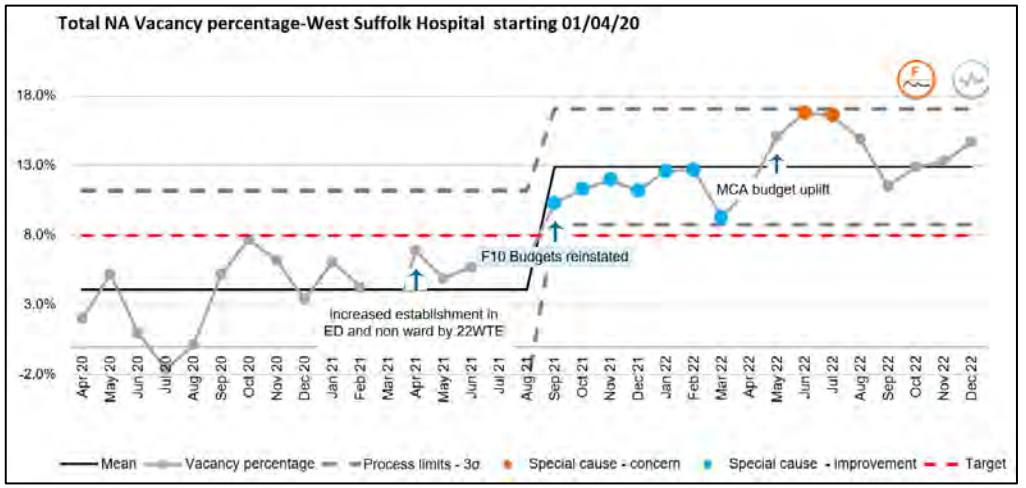
Inpatient RN/RM establishments and vacancy percentage



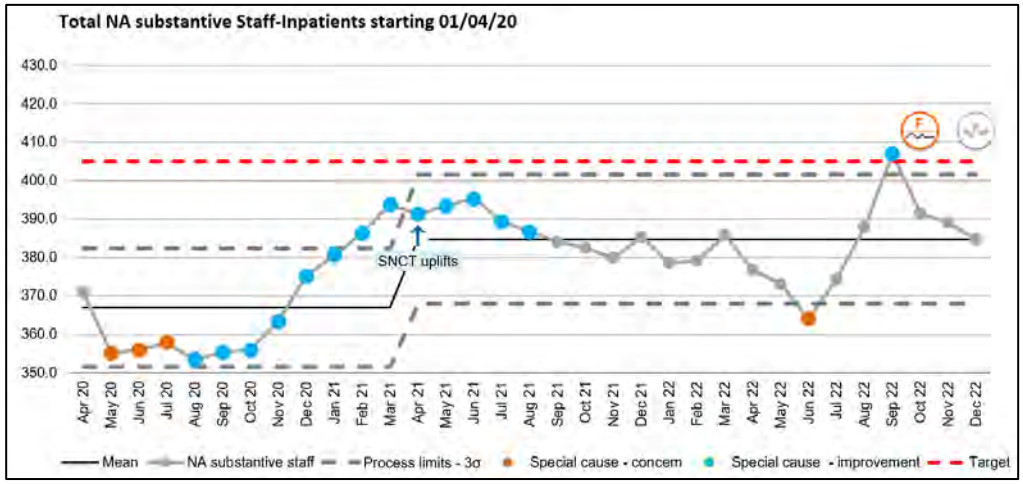


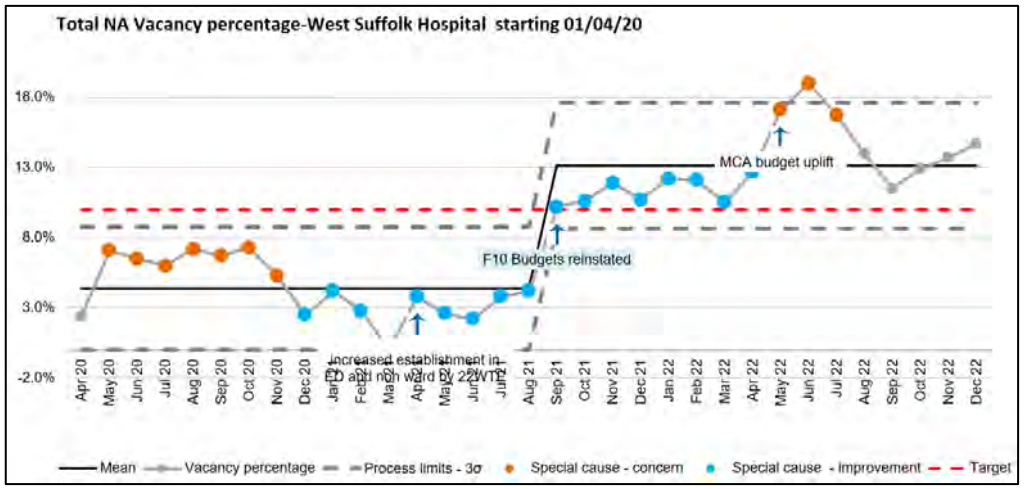
Total NA WTE numbers and vacancy percentages





Inpatient WTE numbers and vacancy percentage





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

Dec-22										
Ward/Department	Register Nurses/Midwives				Ward/Department	NA/MCA				Combined RN/NA
	Actual establishmet	Budgetted establishment	Vacancy rate (WTE)	Vacancy percentage %		Actual Establishment	Budgeted Establishment	Vacancy rate (WTE)	Percentage Vacancy %	Total Vacancy %
AAU	29.6	30.1	0.5	1.8	AAU	18.0	28.3	10.3	36.3	18.5
Accident & Emergency	53.7	69.5	15.8	22.7	Accident & Emergency	33.6	34.5	0.9	2.6	16.1
Cardiac Centre	35.6	40.7	5.1	12.4	Cardiac Centre	15.6	15.7	0.1	0.8	9.2
Glastonbury Court	11.5	11.7	0.2	1.4	Glastonbury Court	11.9	12.6	0.7	5.9	3.7
Critical Care Services*	43.8	50.0	6.2	12.5	Critical Care Services	1.6	1.9	0.3	14.9	12.6
Day Surgery Wards	11.1	11.0	-0.1	-0.6	Day Surgery Wards	2.9	3.9	1.0	26.0	6.3
Gynae Ward (On F14)	12.8	14.1	1.3	9.3	Gynae Ward (On F14)	2.0	2.0	0.0	0.0	8.2
Neonatal Unit	20.4	20.6	0.2	0.8	Neonatal Unit	8.6	10.1	1.5	14.9	5.4
Rosemary ward	13.7	18.4	4.7	25.4	Rosemary ward	20.1	24.8	4.7	19.0	21.7
Recovery Unit	25.0	27.3	2.3	8.5	Recovery Unit	0.9	0.9	0.0	1.2	8.3
Ward F1 Paediatrics	22.9	25.1	2.2	8.9	Ward F1 Paediatrics	6.4	7.7	1.3	16.9	10.8
Ward F12	8.1	11.9	3.9	32.3	Ward F12	6.2	5.9	-0.4	-6.3	19.6
Ward F3	21.1	22.2	1.0	4.6	Ward F3	21.4	25.8	4.4	17.1	11.4
Ward F4	14.7	15.0	0.3	2.3	Ward F4	9.6	12.4	2.8	22.4	11.4
Ward F5	20.8	22.2	1.4	6.1	Ward F5	13.3	18.1	4.8	26.5	15.3
Ward F6	23.1	26.6	3.4	12.9	Ward F6	12.0	17.4	5.4	31.1	20.1
Ward F7 Short Stay	21.6	24.9	3.3	13.2	Ward F7 Short Stay	15.1	25.8	10.6	41.3	27.5
Ward G5	17.4	21.8	4.4	20.1	Ward G5	19.8	23.2	3.4	14.6	17.3
Ward G1 Hardwick Unit	23.4	29.6	6.2	20.9	Ward G1 Hardwick Unit	10.3	10.5	0.2	2.2	16.0
Ward G3	20.8	22.1	1.3	5.9	Ward G3	23.1	23.0	-0.1	-0.5	2.6
Ward G4	17.3	22.1	4.8	21.7	Ward G4	24.6	23.5	-1.1	-4.7	8.1
Ward G8	24.0	32.7	8.7	26.7	Ward G8	20.0	20.6	0.6	3.0	17.5
Renal Ward - F8	17.8	19.5	1.7	8.6	Renal Ward - F8	20.0	25.8	5.8	22.4	16.4
Ward G10	18.4	19.0	0.6	3.2	Ward G10	20.2	24.1	3.9	16.2	10.4
Respiratory Ward - G9	18.8	23.7	4.9	20.6	Respiratory Ward - G9	15.2	18.0	2.8	15.7	18.5
Total	547.3	631.6	84.3	**13.3**	Total	352.3	416.3	64.0	**15.4**	**14.2**
Hospital Midwifery	44.8	57.8	13.0	22.5	Hospital Midwifery	25.7	28.5	2.8	9.8	18.3
Midwifery management	18.1	17.4	-0.7	-4.0						
Continuity of Carer Midwifery	35.8	39.1	3.3	8.4						
Total	98.7	114.3	15.6	**13.6**	Total	25.7	28.5	2.8	**9.8**	**12.9**
*not including clinic/OP staff										

Appendix 4:

Ward by Ward breakdown of Falls and Pressure ulcers November and December 2022

HAPU

Nov-22	Cat 2	Unstageable	Total
F3 - ward	1	0	1
G1 - ward	1	0	1
G10	1	0	1
G3 - Endocrine and General Medicine	1	0	1
Rosemary Ward	1	0	1
Acute Assessment unit (AAU)	1	0	1
F5 - ward	1	0	1
G8 - Stroke Ward	1	1	2
F7	1	1	2
Cardiac Centre - Ward	3	0	3
Critical Care Unit	3	0	3
Respiratory Ward	3	1	4
Renal Ward	6	1	7
Total	24	4	28

Dec 22	Cat 2	Cat 3	Unstageable	Cat 4	Total
F12 Isolation Ward	1	0	0	0	1
G3 - Endocrine and General Medicine	1	0	0	0	1
G8 - Stroke Ward	1	0	0	0	1
Respiratory Ward	1	0	0	0	1
F5 - ward	1	0	0	0	1
F6 - ward	1	0	0	0	1
F3 - ward	1	0	1	0	2
G1 - ward	2	0	0	0	2
G4 - ward	2	0	1	0	3
Renal Ward	1	1	1	0	3
F7	3	0	0	0	3
Acute Assessment unit (AAU)	2	0	0	1	3
Critical Care Unit	4	0	0	0	4
Total	21	1	3	1	26

Falls

Nov 22	None	Negligible	Minor	Moderate	Major	Total
Day Surgery Unit -	0	0	0	1	0	1
F12 Isolation Ward	1	0	0	0	0	1
G1 - ward	1	0	0	0	0	1
Rapid Access and Treatment	0	0	1	0	0	1
Support to go home	0	0	2	0	0	2
F14 (Gynae - EPAU)	3	0	0	0	0	3
Gastroenterology Ward	1	0	1	1	0	3
Emergency Department	2	0	0	0	1	3
F3 - ward	4	0	0	0	0	4
Major Assessment Area (MAA)	4	0	0	0	0	4
F6 - ward	4	0	0	0	0	4
Cardiac Centre - Ward	3	0	1	0	1	5
G3 -	3	0	2	0	0	5
Respiratory Ward	3	0	2	0	1	6
Acute Assessment unit (AAU)	6	0	0	0	0	6
G10	6	0	1	0	0	7
G4 - ward	5	0	2	0	0	7
Glastonbury Court	7	0	0	0	0	7
G8 - Stroke Ward	6	0	2	0	0	8
F7	7	1	0	0	0	8
Rosemary Ward	6	1	2	1	0	10
Renal Ward	8	2	1	0	0	11
Total	80	4	17	3	3	107

Dec-22	None	Negligible	Minor	Moderate	Major	Total
Discharge Waiting Area (DWA)	0	0	1	0	0	1
F12 Isolation Ward	1	0	0	0	0	1
F4 - ward	0	0	1	0	0	1
Macmillan Unit	1	0	0	0	0	1
West Suffolk Physio	1	0	0	0	0	1
Early Intervention Team	0	0	1	0	0	1
Rapid Access and Treatment	1	0	0	0	0	1
Major Assessment Area (MAA)	1	0	0	0	0	1
F5 - ward	1	0	0	0	0	1
Renal Ward	2	0	0	0	0	2
Respiratory Ward	1	0	0	2	0	3
F6 - ward	2	1	0	0	0	3
Cardiac Centre - Ward	4	0	0	0	0	4
F10 - Ward	3	0	1	0	0	4
F3 - ward	4	0	0	0	0	4

Glastonbury Court	4	0	0	0	0	4
G3 -	5	0	0	0	0	5
Gastroenterology Ward	4	1	0	0	0	5
Acute Assessment unit (AAU)	4	0	2	0	0	6
G4 - ward	7	0	0	0	0	7
G8 - Stroke Ward	6	0	1	0	0	7
Rosemary Ward	5	0	2	0	0	7
Emergency Department	4	0	3	1	0	8
G1 - ward	6	0	3	0	0	9
F7	9	0	1	0	0	10
G10	14	1	0	0	1	16
Total	90	3	16	3	1	113

Appendix 5: Red Flag Events

Maternity Services

Missed medication during an admission
Delay of more than 30 minutes in providing pain relief
Delay of 30 minutes or more between presentation and triage
Delay of 60 minutes or more between delivery and commencing suturing
Full clinical examination not carried out when presenting in labour
Delay of two hours or more between admission for IOL and commencing the IOL process
Delayed recognition/ action of abnormal observations as per MEOWS
1:1 care in established labour not provided to a woman

Acute Inpatient Services

Unplanned omission in providing patient medications.
Delay of more than 30 minutes in providing pain relief
Patient vital signs not assessed or recorded as outlined in the care plan.
Delay or omission of regular checks on patients to ensure that their fundamental care needs are met as outlined in the care plan. Carrying out these checks is often referred to as 'intentional rounding' and covers aspects of care such as: • pain: asking patients to describe their level of pain level using the local pain assessment tool • personal needs: such as scheduling patient visits to the toilet or bathroom to avoid risk of falls and providing hydration • placement: making sure that the items a patient needs are within easy reach • positioning: making sure that the patient is comfortable, and the risk of pressure ulcers is assessed and minimised.
A shortfall of more than eight hours or 25% (whichever is reached first) of registered nurse time available compared with the actual requirement for the shift
Fewer than two registered nurses present on a ward during any shift.

4.5.1. Maternity Services Quality & Performance Report

Karen Newbury, Simon Taylor & Kate Croissant in attendance

For Approval

Presented by Susan Wilkinson

Board of Directors - Public	
Report title:	Maternity quality, safety and performance report
Agenda item:	4.5.1
Date of the meeting:	2nd February 2023
Sponsor/executive lead:	Sue Wilkinson, Executive Chief Nurse Paul Molyneux, Interim Medical Director & Executive MatNeo Safety Champion Karen Newbury, Head of Midwifery Simon Taylor Associate Director of Operations, Women & Children and Clinical Support Services Kate Croissant, Deputy Clinical Director
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:	This report presents a document to enable board scrutiny of Maternity services and receive assurance of ongoing compliance against key quality and safety indicators and provide an update on Maternity quality & safety initiatives. The papers presented are for information only and issues to note are captured in this summary report. All of the attached papers have been through internal governance process including the Maternity and Neonatal Safety Champions and will then be shared with the Local Maternity and Neonatal System. In addition, this report contains the formal declaration papers for the NHS Resolution Maternity Incentive Scheme, Year 4. All papers were presented to the Improvement Committee on the 16th January 2023 and agreed as an assurance sub-committee of the Board with delegated authority to receive and recommend the approval of this submission. **This report contains;** • Maternity improvement plan • NHSE Regional team - Maternity Assurance Visit 25th November 2022 • Safety champion feedback from walkabout • Listening to staff

	• Service user feedback • CQC Survey results • Reporting and learning from incidents • HSIB/EN reporting Q3 22/23 **Full report to CLOSED BOARD** • Perinatal Mortality Report Q3 22/23 **Full report to CLOSED BOARD** • Maternity Dashboards (Annex A) • ATAIN Q3 22/23– avoiding term admissions to NNU (Annex B) • MDT Training compliance (Annex C) • Element 4 Saving Babies Lives – Effective Fetal Monitoring (Annex D) • Uterine Artery Doppler – audit of compliance (Annex E) • Maternity Incentive Scheme Year 4 Safety Action 6 Saving Babies Lives – overarching report on compliance with elements 1, 2,3 and 5 (Annex F) • Compliance with Obstetric Anaesthetic Staffing (Annex G) • Neonatal Nursing workforce assessment (Annex H) • Compliance with NHSR Maternity Incentive Scheme Year 4 (Annex I) • Trust Review of; 'Reading the Signals – Maternity and neonatal services in East Kent – the report of the Independent Investigation' (Annex J) • 'Reading the Signals – Maternity and neonatal services in East Kent – the report of the Independent Investigation' Full Report (Annex K)
Action required/ recommendation:	**For information, Annex H & I for approval**

Previously considered by:	Maternity Quality and Safety Group Maternity and Neonatal Safety Champions Trust Board LMNS ICB Improvement Committee
Risk and assurance:	
Equality, diversity and inclusion:	This paper has been written with due consideration to equality, diversity and inclusion.
Sustainability:	There are no sustainability issues related to this report
Legal and regulatory context:	The information contained within this report has been obtained through due diligence.

Maternity quality, safety and performance report

1.	**Introduction**
1.1	**Maternity improvement plan** The Maternity Improvement Board (MIB) receives the updated Maternity improvement plan on a monthly basis. This has been created through an amalgamation of the original CQC improvement plan with the wider requirements of Ockenden, HSIB, external site visits and self-assessment against other national best practice (e.g. MBRRACE, SBLCBv2, UKOSS). In addition, the plan has captured the actions needing completion from the 60 Supportive Steps visit from NHSE/I and continues to be reviewed by the Maternity Improvement Board every two weeks. It has been agreed with the exit from the Maternity Safety Support Programme (MSSP) that NHSE regional team and ICS will be invited to attend the MIB monthly for additional assurance and scrutiny.
2.	**Background**
2.1	**NHSE Regional team - Maternity Assurance Visit 25th November 2022** Following the exit from the MSSP, NHSE regional team, LMNS and the Chair of our Maternity Voice Partnership, visited the unit to review our progress and offer additional support if required. The feedback received was extremely positive and improvements across all areas of maternity had been noted. The team also identified many areas of positive practice. The following areas were identified as requiring continued improvement**:** • Recruit a Consultant Midwife in line with the RCM manifesto • Review having a Director of Midwifery in line with the RCM manifesto • Ensure all once only use products are sealed to ensure the product remains sterile • Review upskilling of Maternity Care Assistants at band 2 to band 3 • Continue cultural work • Need a maternity service general manager • Discontinue reliance on dedicated external support • Separate Day Assessment unit from Triage These actions have been added to the Maternity Improvement plan and it was agreed that there would be another quality visit by NHSE in May 2023 to gain assurance with our improvement journey.
2.2	**Safety Champion Walkabout feedback** The Board-level champion undertakes a monthly walkabout in the maternity and neonatal unit. Staff have the opportunity to raise any safety issues with the Board level champion and if there are any immediate actions that are required, the Board level champion will address these with the relevant person at the time. Individuals or groups of staff can raise the issues with the Board champion. An overview of the Walkabout content and responses is shared with all staff in the monthly governance newsletter 'Risky Business'.

Richard Davies (our non-executive Board Safety Champion) visited ward F11 on 20/12/22 and was able to speak to a number of clinical and support staff.

- The overall feel was of a ward providing professional care in a calm and generally happy environment.
- It was noted that there have been a lot of positive changes and that 'things are getting better'.
- Staff reported good mutual support, good senior support and good interprofessional relationships – and felt able to speak up when they had any concerns.
- The key issue raised was staffing levels, exacerbated by staff sickness, but there was also a recognition that this is a national problem and a feeling that the Trust was doing all it could to recruit more staff and mitigate staff vacancies.
- One staffing issue that was causing some frustration was the delay in getting support staff fully trained.
- The recent move back to F11 has not been without problems – there are some space issues (the MDAU office was noted to be small and airless) – and staff are sometimes struggling to 'find things' – however, it was recognised that some of this was just teething problems.
- A member of staff did raise a Trust wide issue of how lower band roles are perceived less favourably by others in some areas.

In response to the issues mentioned, Richard has raised with the executive team that further work regarding respect and being valued is required, especially in regards to lower banding staff. In response to new staff completing their training, this is in relation to the Care Certificate, which is a national initiative that all support staff have to complete. Maternity does have a dedicated person to support staff with this, however they have had to ensure that all support staff have completed the Care Certificate which does take time. Continued recruitment and work around retention of staff is in progress as staffing deficits are still acknowledged.

2.3 **Listening to Staff**

The National Staff Satisfaction Survey results were published in April 2022 and the triumvirate team have collated an action plan in response to this. A very short temperature check survey was sent to all staff in October 2022. 61 people completed the survey asking six questions relating to work life balance, sickness, meaningful appraisals and freedom to speak up. The results will be shared with the Board once the action required has been agreed by the maternity staff focus group.

In addition to the Freedom to Speak up Guardians, Safety Champions, Professional Midwifery Advocates, Unit Meetings and 'Safe Space' and maternity staff focus group are all forums to listen to staff.

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

Ward/Dept	Nov Survey returns	Nov FFT score	Dec Survey returns	Dec FFT Score
F11	32	91	5	100
Antenatal	12	92	6	83
Postnatal Community	10	100	4	100
Labour Suite	37	100	24	96
Birthing Unit	9	100	8	100
NNU	nil	n/a	5	100

	In addition to the FFT, feedback is gained via our and the Maternity Voice Partnership (MVP) social media, MVP, CQC and Healthwatch surveys. 3 compliments were shared with the patient experience team for women & children's division for logging in November & December 2022. In November and December 2022, a total of 8 PALS enquiries and 2 complaints were received for maternity and Neonatal Unit (NNU). The main themes are around communication and plans of care. The aim for 2023 is to develop meaningful personalised care plans from the antenatal period through to the intrapartum and postnatal stages.
2.5	**CQC Survey results** The Care Quality Commission (CQC) have assigned the NHS Patient Survey Programme (NPSP) to annually collect feedback on maternity care since 2007.The CQC use the results from the survey in the regulation, monitoring and inspection of NHS trusts in England. Due to there being less than 300 births at the West Suffolk Hospital in February 2022, births from January 2022 were also included in this year's survey. The overall results were very positive and a full report and actions taken will be shared in forthcoming papers.
2.6	**Reporting and learning from incidents** During November and December 2022 there were no new cases referred to the Healthcare Safety Investigation Branch (HSIB). The trust has received draft reports from cases earlier in 2022 and once reports are available these will be shared with the Board as per Ockenden instructions.
3.	**Detailed sections and key issues**
3.1	**HSIB and Early Notification Reporting and Duty of Candour Q3 22/23: Maternity Incentive Scheme Year 4 Safety Action 10 quarterly reporting Closed Board** This report provides details of the Trust compliance for quarter 3 2022/2023 with reporting of maternity incidents that meet the criteria to HSIB Maternity Investigations and the NHS Resolution Early Notification Scheme and duty of candour related to these unexpected events. In this quarter 3 – October 1st 2022 to December 31st 2022 – there was a referral to HSIB for investigation. There have been no cases reported to Early Notification in this period of time. Duty of candour has been completed in accordance with statutory requirements and Trust guidance. Information is recorded on the Claims Management Wizard and the Maternity Services work closely with the legal services department to ensure that reporting and recording is accurate and timely. The Trust is assured that the processes are being followed for referral to HSIB and the ENS. The agreed reports from HSIB will be shared once completed.
3.2	**Perinatal Mortality Reports (PMRT) Q3 22/23 – Maternity Incentive Scheme Year 4 Safety Action 1 – quarterly reporting Closed Board** The report outlines the details of Perinatal deaths occurring within the Trust and the reviews and actions from these. The report includes completed investigations and actions from Quarter 3 - 1st October 2022 to 31st December 2022 for West Suffolk NHSFT (WSH). In this period the Trust has reported baby losses directly associated with the Trust. Due to the small number no identifiable information can be shared in this Open Board Report. Where appropriate to do so referrals have been made to HSIB and the Sudden Unexpected Death in Childhood (SUDIC) panel. Following immediate internal investigations there were no safety actions identified but some learning has been recognised which is being shared with the staff.

The Trust has met all of the standards for reporting all incidents of perinatal mortality that met the relevant criteria to the appropriate national platforms within the required time frames. With regard to compliance with reporting to MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) and completion of the surveillance information within the required time frames This standard was also met.

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. These actions are recorded and managed on an overarching action plan and as part of the individual datix incident report. Learning is shared via the Risky Business Newsletter and at perinatal mortality and morbidity meetings and educational forums.

3.3 **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:

Indicators	Narrative
Decision to delivery times for grade 2 sections	Ongoing improvement, however not fully sustained. To be monitored monthly via maternity quality and safety meetings.
Post-partum Haemorrhages for LSCS >1500 mls	In line with increase of caesarean section and induction of labour, however QI project continues locally and across the Local Maternity and Neonate System.
Compliance with DV questions	Remains a significant drop-in compliance rate. Safeguarding Lead Midwife, Community Team Leads, Ward managers and Digital Midwife all working in collaboration to address this. Compliance data reviewed weekly to enable scrupulous oversight.

3.4 **ATAIN report and rolling action plan Q3 22/23: Maternity Incentive Scheme Year 4 Safety Action 3 – Avoiding Term Admissions into the Neonatal Unit (ATAIN), quarterly reporting and rolling actions (Annex B)**

There were 15 term babies admitted to the neonatal unit in this quarter (October 2022- December 2022). Babies that did not meet the referral criteria have not been included for review under ATAIN. Respiratory distress remained the predominant reason for admission, with no overarching themes or common denominators identified amongst those admissions. Thirteen babies were admitted with signs of respiratory distress and required oxygen support, and underwent a partial septic screen, treated with prophylactic antibiotics. Risk factors for sepsis were present in >50% of the cases. Other potentially contributing factors, including mode of delivery and gestation, varied and provided limited evidence to draw conclusions. Twelve of the 15 babies had optimal APGARs, scoring 8 or more at 1 minute. The majority of term babies admitted were stepped down to transitional care at the earliest opportunity

	unless they were not medically appropriate to do so. No admissions this quarter were deemed avoidable. **Recommendations and Next Steps** Some minor opportunities for learning were identified this quarter, none of which were thought to have impacted the admission. All opportunities for learning are discussed and a relevant action or pathway for shared learning agreed upon. The rolling action plan is updated and actions completed or progressed towards completion.
3.5	**MDT Training compliance – Maternity Incentive Scheme Year 4 Safety Action 8 and Saving Babies Lives element 4 Effective Fetal Monitoring Safety Action 6 (Annex C)** The local training programme has been approved and embedded to provide the training programmes required for the next 3 years to cover the 6 core modules. This was updated in August 2022 to extend the multiprofessional day to include fetal monitoring training as part of the day. The attendances at the parts of the training day which include obstetric emergencies and neonatal life support are compliant with 90% or more of each of the relevant staff groups for each element of training. The Trust has not had the fetal monitoring training as part of the one-day in-house multiprofessional training day for the whole of 2022 as this required a major change to the schedules and there were changes to the staff in post for specific lead roles. Following review of attendance at training sessions and completion of modules, that have taken place across the 3 mediums - cases reviews, K2 (bespoke on-line) training and the sessions introduced on the training day since August, it is considered that these constitute equivalent compatibility with the overall philosophy and training programmes required to maintain safety. Using all these training elements and formats, more than 90% of each staff group have attended the equivalent fetal monitoring over the 12-month period and therefore it is assumed that the Trust can provide sufficient assurance to demonstrate compliance with this element of Saving Babies Lives Element 4 and Safety Action 8 of the Maternity Incentive Scheme. For all faculty members it is assumed that while leading the training days they will participate in various scenarios and simulations as part of the MDT and therefore meet the individual and course requirements for compliance. **Next Steps** The maternity service is progressing against the 3-year training plan and will continue to plan for all staff to be compliant with this essential training against the trajectory. The processes for escalation of non-compliance or non-attendance and having a consistent recording process for all training is being enhanced to ensure that there is early recognition and management of situations that may impinge on safe practice.
3.6	**Element 4 Saving Babies Lives – Effective Fetal Monitoring (Maternity Incentive Scheme Year 4 Safety Actions 6 and 8) (Annex D)** The Trust has not had the fetal monitoring training as part of the one-day in-house multiprofessional training day for the whole of 2022 as this required a major change to the schedules and there were changes to the staff in post for specific roles. However, given that the training and competency assessments that have taken place across the 3 mediums of cases reviews, K2 training and the sessions introduced on the training day since August, it is considered that these constitute equivalent compatibility with the overall philosophy and training programmes required to maintain safety. Using all 3 aspects of training, the compliance levels, are equal to or more than 90% for all relevant staff groups.

	The Trust is fully compliant with the other 3 interventions of these safety measures. Risk assessments for fetal monitoring at the start and during labour are embedded in practice, the buddying arrangement for assessment of fetal wellbeing in labour is also embedded and all of these aspects are monitored on a regular basis in order to maintain these high standards. The fetal monitoring leads are in post and committed to further enhancing their roles in maintaining safe practices and competencies. The training and education programmes have been updated this year and will be fully embedded for all relevant staff from January 2023. The effectiveness of the changes will be monitored through review of cases and outcomes. **Recommendations**: • Training compliance to be reported on the Quality and Safety dashboard on a monthly basis. • Consideration to be given to included attendance at the fetal monitoring study day to be linked to ESR (Electronic Staff Record). • Adapt the current process for managing non-attendance at fetal monitoring case reviews to include the responsibilities of line managers as a key role in continuing professional development. • Develop and embed a training package to introduce Intelligent Intermittent Auscultation for low risk intrapartum care and update the guideline when this is implemented.
3.7	**<u>Uterine Artery Doppler– audit of compliance</u>: Safety Action 6, Saving Babies Lives, Element 2 – high risk pregnancies (Annex E)** A prospective audit was completed for women and pregnant people who were attending the West Suffolk Hospital for their fetal anomaly ultrasounds during the time period of the 5th December 2022 to the 15th December 2022. This totalled 68 patients. In order to collect the data, the previous days ultrasounds attendance list was reviewed to identify eligible patients. Their records were then reviewed to assess for any risk factors identified in the standards listed above. The auditor assessed whether the Uterine Artery Doppler (UAD) was then: Required and completed/required and not completed/not required. **Results:** The vast majority of cases that were audited were low risk pregnancies that did not fit the criteria set within the SOP029- Uterine Artery Dopplers. June 2022 for UAD's to be completed at the time of the anomaly. There was one missed opportunity for a referral for UAD to be completed as part of anomaly USS, however this was later identified and performed within the correct timeframe. **Recommendations:** As this is still a fairly new recommendation into practice it is recommended maternity staff are reminded of the referral criteria for UAD to ensure that all eligible patients are captured. A subsequent audit it recommended to assess future compliance.
3.8	**<u>Maternity Incentive Scheme Year 4 Safety Action 6 Saving Babies Lives – overarching report on compliance with elements 1, 2,3 and 5</u> (Annex F)** The Trust has embedded all 5 elements of the version 2 of Saving Babies Lives. Progress has been made in achieving a high standard or compliance with the standards beyond 80% in most cases. This report encompasses all the elements of saving babies lives except Element 4 – effective fetal monitoring – in the Effective Fetal Monitoring Report Annex It has not been possible to achieve more than 80% compliance with the administration of a course of steroids to women who give birth under 34 weeks gestation during this period of time. The criteria for

	administration of steroids to women from the Royal College of Obstetricians (RCOG) guidance issued in 2022 has been applied but despite the use of diagnostic aids to help to predict preterm birth, labour does not always commence within the first 7 days. As it takes up to 24 hours to administer a full course, getting the timing of the doses correct is a clinical challenge. Women who gave birth on route to the maternity unit or who delivered rapidly after admission have been omitted from the compliance as these situations were unavoidable. **Recommendations and Next Steps** Continue to review and monitor all births where there is perinatal mortality or morbidity associated with these elements and where the outcome is unexpected such as small babies, preterm labour and preterm birth to ensure that risk factors are managed appropriately at booking and during pregnancy care. Complete audit and surveys as required to evidence sustained improvements.
3.9	**Compliance with Obstetric Anaesthetic Staffing: Maternity Incentive Scheme Safety Action 4b (Annex G)** This report has been written to confirm compliance with safe staffing requirements for obstetric anaesthesia within the Maternity Unit of West Suffolk NHS FT (WSNHSFT). The previous reports provided evidence of ongoing compliance with safety standards for obstetric anaesthetic staffing levels in Quarter 3 and 4 of 2021/2022. This new report covers the period April 1st to September 30th 2022. **Findings** The rotas for anaesthetic staff have been independently reviewed to ensure that there is a named staff member covering the on call obstetric rota for each 24-hour period. The findings confirm that there is allocation and identification of a dedicated anaesthetist on the rota for obstetric cases throughout this 6-month period. **Next steps** The next review and report will be completed in 6 months.
3.10	**Neonatal Nursing workforce assessment: Safety Action 4d - For information only (Annex H)** This report was updated January 2023 with removal of reference to 'Dinning tool' and CRG (Clinical Reference Group) from the tools used for neonatal nursing workforce assessment. As CRG was in the heading of the tool used at the time, we have left this as it is. The content and findings in the report have not been changed.
3.11	**Compliance with NHSR Maternity Incentive Scheme Year 4 – presented to Improvement Committee 16th January 2023 (Annex I)** The Maternity Incentive Scheme (MIS) run by NHS resolution is in its fourth year and builds on the progress made in the previous 3 years. Year 4 safety actions were published in May 2022 (following a period on hold during the pandemic response) with updated timeframes and requirements. This report provides the formal declaration of (partial) compliance which requires Board sign-off prior to submission on 2nd February 2023. The Improvement committee as an assurance sub-committee of the Board has delegated authority to receive and recommend the approval of this submission to the Trust Board. To note: the paper submitted to the Improvement Committee on the 16th January 2023 stated that an Accountable Officer for the ICB should countersign the declaration from, however NHSR have now instructed that it needs to be the CEO for the ICB. Therefore, this paper has be amended to confirm this.

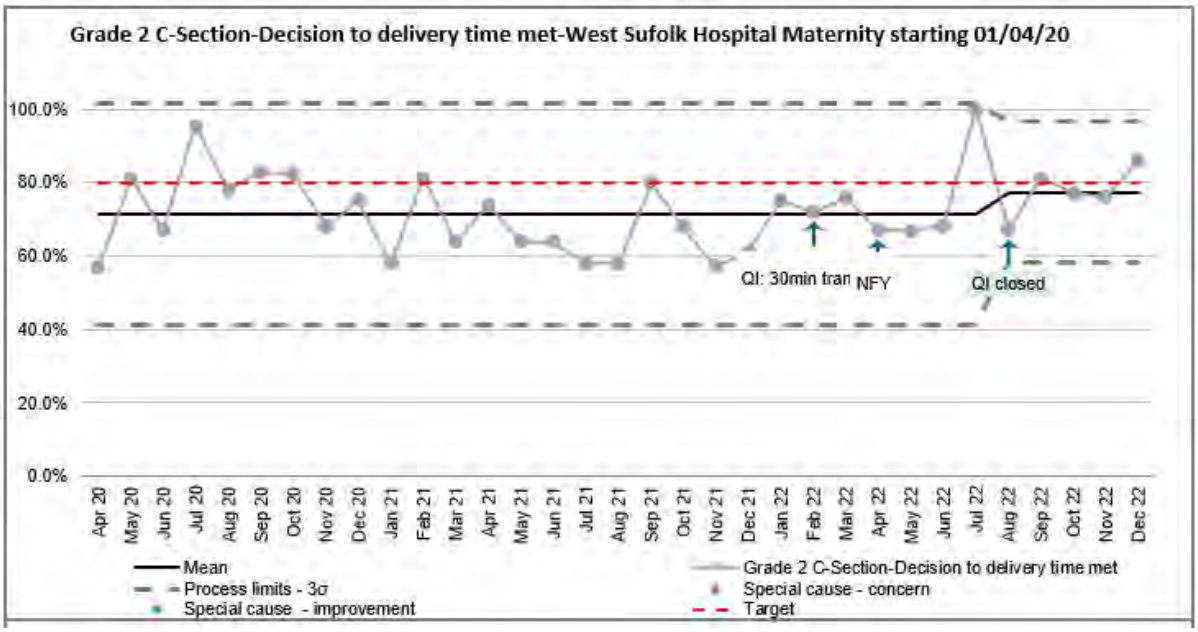
	The CEO for our Integrated Care Board (ICB) has been appraised of the MIS safety actions' evidence and declaration form. The CEO for the ICB has arranged for a panel to review all evidence to ensure this is robust. The outcome of this review will be verbally conveyed to this committee and provided in writing as part of the Improvement committee recommendation to the Board. The WSFT and ICB Chief Executive must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHS Resolution. There are ten safety actions for the Trust to provide evidence of compliance. This report provides the WSFT response to those requirements with a statement of compliance against the ten safety actions. The Trust is declaring compliance with eight of the ten as per table 1 below. The evidence for compliance (and partial non-compliance) has been reviewed within the organisation through the divisional internal governance process and by external stakeholders and has been reported through the year in the regular Maternity report to the Open Trust Board. More detail on this oversight is provided in the main body of the report. • For seven of the actions, internal and external scrutiny has been sufficient to declare full compliance (evidence provided in appendix). Two safety actions have one area of non-compliance but the Trust has achieved overall compliance for these Safety Actions. • For two actions (1 and 5), the trust is not able to declare compliance – previously presented in Board reports and explanation in the main body of report and compliance evidence provided in separate reports • For one action (8), evidence exists to declare full compliance (evidence provided in separate report) however the external scrutiny (from project midwife) has recommended that an explanation of that was considered by this committee prior to sign-off. The Improvement Committee and LMNS have agreed that given the interpretation of the guidance and using clinical discretion, we can confirm compliance with the expected safety actions. **Next steps** Actions to address non-compliance with safety actions have been included in the Trust's declaration form and progress will be monitored through the internal and external governance processes.
3.12	**'Reading the Signals – Maternity and neonatal services in East Kent – the report of the Independent Investigation' (Annex J)** NHS England has written to all Trust Boards asking them to review the findings of 'Reading the Signals: Maternity and Neonatal Services in East Kent – the Report of the Independent Investigation. This report provides a brief overview of the Independent Investigation into East Kent Maternity Services by Dr Kirkup, which highlights that the repeated problems were systemic, particularly reflecting problems of attitude, behaviour and team working, and they reflected a persistent failure to look and learn. Board members are asked to reflect on the report and share their insights to inform our next steps. Next steps; The Board will develop a response through meaningful discussion at the next Board Development Day and share the outcomes at the next Open Board.

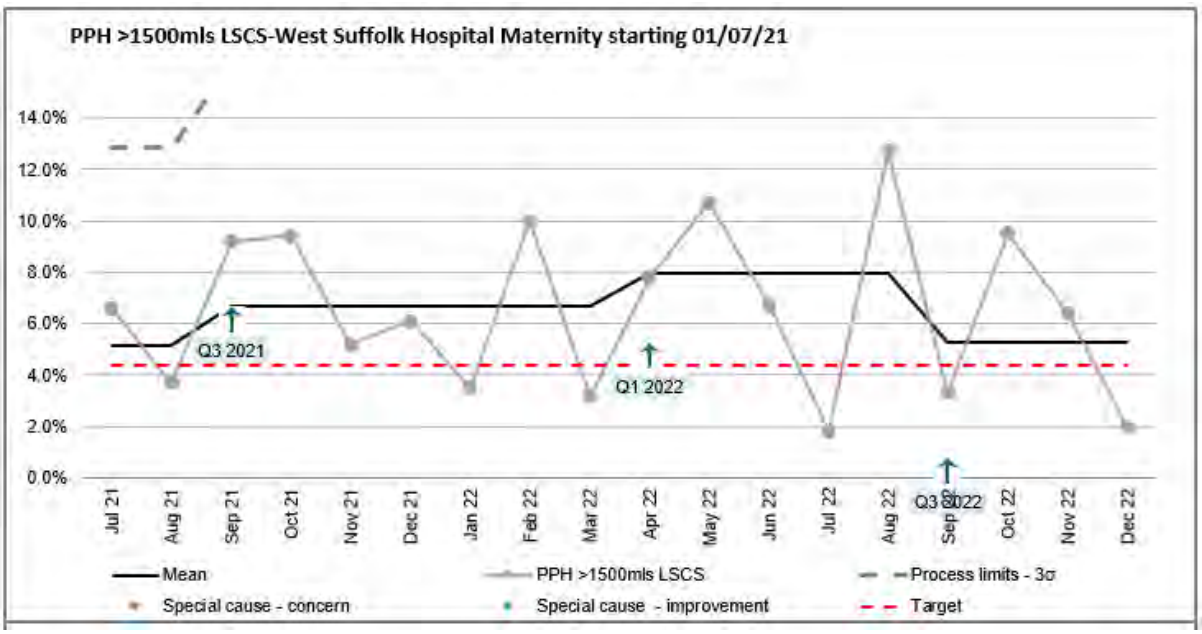
Trust priorities	**Deliver for today**		**Invest in quality, staff and clinical leadership**			**Build a joined-up future**	
Trust ambitions	*Deliver personal*	*Deliver safe care*	*Deliver joined-up*	*Support a healthy*	*Support a healthy*	*Support ageing well*	*Support all our*
Previously considered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

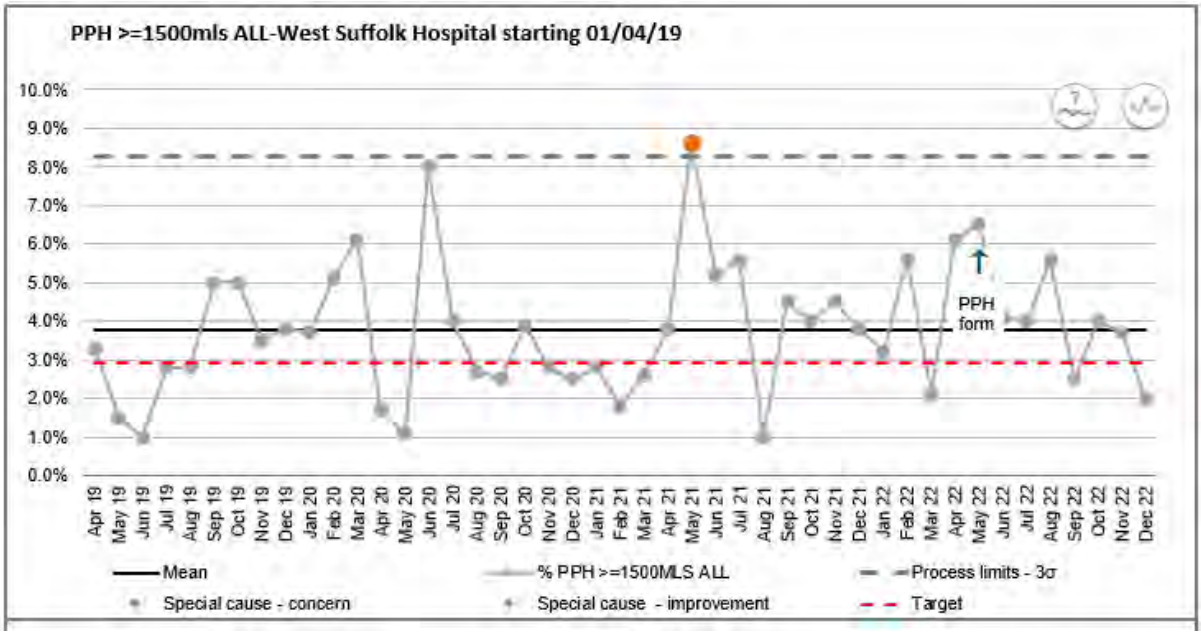
4.	**Recommendations and Next Steps**
4.1	
4.2	
5.	**Conclusion**
5.1	
6.	**Recommendations**
	[Insert same wording you have on your cover sheet]

Annex A

Maternity Dashboard SPC Charts;




PPH >1500mls LSCS-West Suffolk Hospital Maternity starting 01/07/21
14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
Q3 2021
Q1 2022
Q3 2022
Jul 21
Aug 21
Sep 21
Oct 21
Nov 21
Dec 21
Jan 22
Feb 22
Mar 22
Apr 22
May 22
Jun 22
Jul 22
Aug 22
Sep 22
Oct 22
Nov 22
Dec 22
Mean
PPH >1500mls LSCS
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target


PPH >=1500mls ALL-West Suffolk Hospital starting 01/04/19
10.0%
9.0%
8.0%
7.0%
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
PPH form
Apr 19
May 19
Jun 19
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Apr 22
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Jun 22
Jul 22
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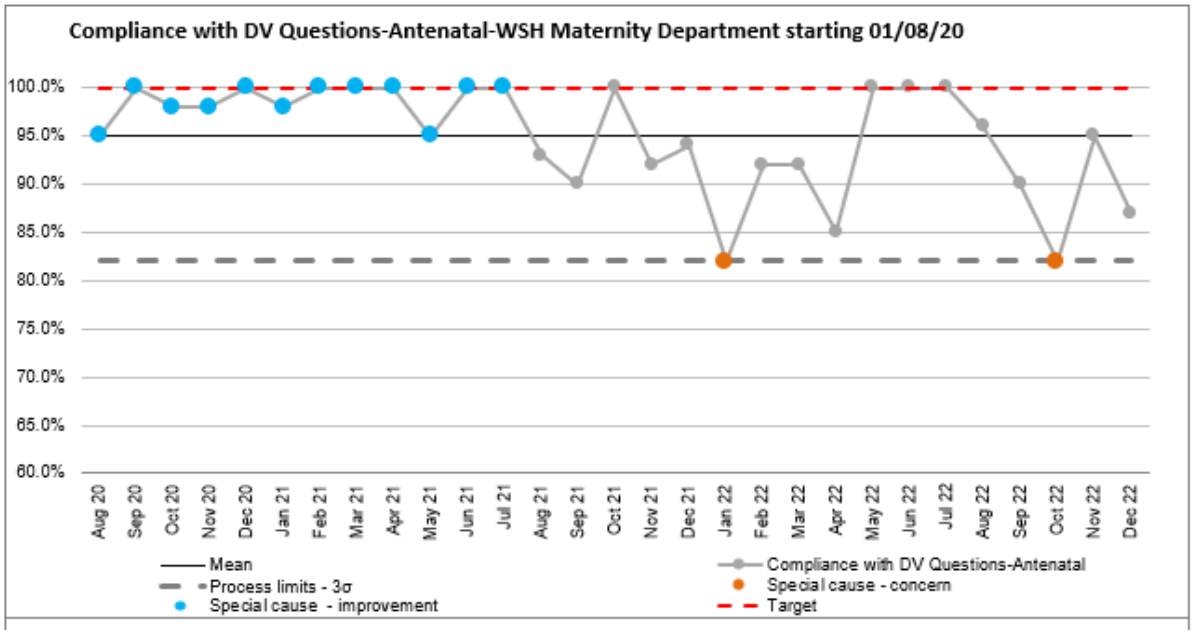
Nov 22
Dec 22
Mean
% PPH >=1500MLS ALL
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target


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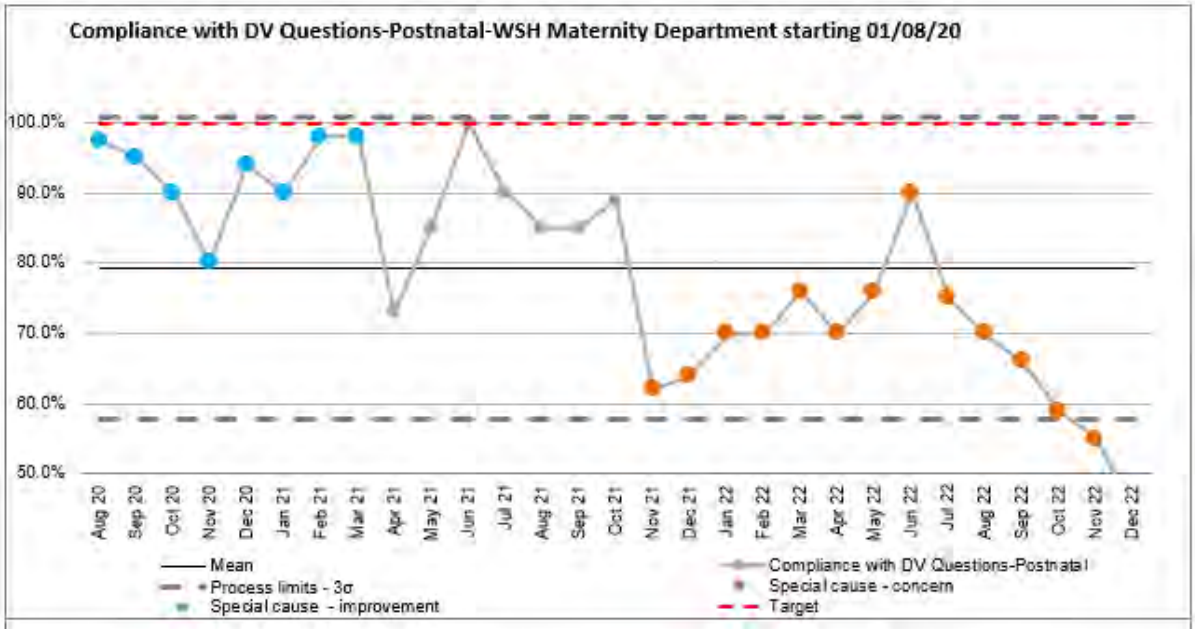
Nov 21
Dec 21
Jan 22
Feb 22
Mar 22
Apr 22
May 22
Jun 22
Jul 22
Aug 22
Sep 22
Oct 22
Nov 22
Dec 22
Mean
Process limits - 3σ
Special cause - improvement
Compliance with DV Questions-Antenatal
Special cause - concern
Target


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

5. 12.55 - GOVERNANCE

5.1. Audit Committee Report - 11 January, 2023 - Chair's Key Issues

To inform

Presented by Alan Rose

Chair's Key Issues

Originating Committee:	Audit Committee	Date of Meeting:	11 January 2023
Chaired by:	Alan Rose	Lead Executive Director:	Nick Macdonald

Item	Details of Issue	For: Information	BAF/ Risk Register ref.	Paper attached?
MyWiSH Annual Report and Accounts	- The annual report and accounts of the MyWish charity were reviewed, including the consideration of the audit findings report and Letter of representation from Lovewell Blake Audit. - The annual report and accounts were approved by the Audit Committee.	For: Information	N/A	**N/A**
Urgent Board decision	- As a result of a change to meeting timings based on the committee's approval subsequent to the meeting an urgent decision was taken by the Board to approve the MyWish report and accounts for submission to the Charities Commission. This decision was taken on 11 January 2023 and included Jude Chin, Alan Rose, Richard Davies, Louisa Pepper, Craig Black and Nick Macdonald.	For: Noting	N/A	MyWish report and accounts appended to meeting pack
Delegated authority	- It was agreed that as part of the ongoing review of the Board's scheme of reservation and delegation authority should be delegated to the audit committee to approve the MyWish annual report and accounts. This will be included in this review for approval by the Board later in the year.	For: Information	N/A	**N/A**
Date Completed and Forwarded to Trust Secretary		**24 January 2023**		

5.2. Remuneration Committee Report - 16 December, 2022 - Chair's Key Issues

To inform

Presented by Alan Rose

Chair's Key Issues

Originating Committee:	Remuneration Committee	Date of Meeting:	16 December 2022
Chaired by:	Alan Rose	Lead Executive Director:	Jeremy Over

Item	Details of Issue	For: Information	BAF/ Risk Register ref.	Paper attached?
(Substantive) Chief Executive Remuneration	- Discussion to agree the appropriate level of remuneration for the incoming Chief Executive.	For: Information	N/A	**N/A**
Clinical Excellence Awards ('22-'23)	- Confirmation that in view of the workload involved in the application and evaluation process, the national decision is for the centrally-determined funds to be shared equally across all eligible consultants.	For: Information	N/A	**N/A**
Trust Board Composition	- Agreement that the role of the Executive Workforce Director be added to the voting members of the Board. The required voting majority of the Non-Executive Directors is maintained, due to the earlier addition of Non-Executive Directors to the Board, as agreed with the Governors.	For: Information	N/A	N/A
Medical director	- Discussion took place on options for appointing a permanent Medical Director. Following the meeting agreement was reached to extend the existing arrangements until December 2023.	For: Information	N/A	N/A
Date Completed and Forwarded to Trust Secretary		**23 January 2023**		

5.3. Governance report

To inform

Presented by Richard Jones

Board of Directors - Public	
Report title:	**Governance Report**
Agenda item:	5.3
Date of the meeting:	2 February 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

This report summarises the main governance headlines for Feb 2023, as follows:

1. Urgent Board decisions and delegated authority
2. Council of Governors meeting report
3. Senior Leadership Team report
4. Code of Governance for NHS Provider trusts
5. Annual review of governance
6. Revised committee terms of reference (ToR)
7. Board assurance framework (BAF) summary and risk report
8. Use of Trust's seal
9. Register of interests
10. Draft agenda items for the next Board meeting

Annex A: Draft agenda items for the next Board meeting

Action Required of the Board

The board is asked to:

- **Minute** receipt of the report contents are summarised above, including the urgent Board decisions and delegated authority matters relating to MyWiSH Annual Report and Accounts and NHS resolution - maternity incentive scheme year 4 declaration
- **Approve** the terms of reference of the charitable funds committee and future system programme board.

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

Governance Report

1. Urgenct Board decisions and delegated authority

a. MyWiSH Annual Report and Accounts

This decision is documented in the CKI report from the audit committee meeting on 11 January 2023 but is repeated here for ease of access.

The annual report and accounts of the MyWish charity were reviewed by the audit committee, including the consideration of the audit findings report and Letter of representation from Lovewell Blake Audit. Based on this review the annual report and accounts were approved by the Audit Committee. As a result of a change to meeting timings based on the committee's approval subsequent to the meeting an urgent decision was taken by the Board to approve the MyWish report and accounts for submission to the Charities Commission. This decision was taken on 11 January 2023 and included Jude Chin, Alan Rose, Richard Davies, Louisa Pepper, Craig Black and Nick Macdonald.

b. NHS resolution - maternity incentive scheme year 4 declaration

Detailed information is provided within the maternity section of the agenda under the improvement committee's assurances. A summary is provided below for ease of access.

The Maternity Incentive Scheme (MIS) is run by NHS resolution and the report provides the formal declaration of (partial) compliance which requires Board sign-off prior to submission on 2 February 2023. As a result of a change to meeting timings and to avoid any risk to meeting the submission deadline the delegated authority of the improvement committee was used to support the detailed review of the submission and Board approval of the submission.

This decision was taken on 16 January 2023 and included the following Board members: Louisa Pepper (meeting chair), Tracy Dowling, Geraldine O'Sullivan, Nicola Cottington and Sue Wilkinson.

2. Council of Governors meeting held on 12 January 2023

The Council of Governors approved the appointment of Roger Petter as the new University of Cambridge nominated non-executive director (NED). Roger will take-up this role in March, replacing Richard Davies who has made an enormous contribution in this role for the last six years.

3. 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.

SLT considered a number of strategic issues in its recent meetings, which has included discussion of: digital change within the Trust and Alliance; operational planning priorities for 2023-24, including prioritisation and budget setting; the business planning cycle and process for 2023-24; development of the workplace strategy; and development of the patient led assessment of the care environment (PLACE) and associated improvements.

4. Code of Governance for NHS Provider trusts

An updated code of governance for NHS provider trusts was published at the end of 2022 (a full copy is provided as an addendum to the Board pack). The code will come into effect from 1 April 2023, replacing the version published in 2014. The document sets out an overarching framework

for the corporate governance of trusts, supporting delivery of effective corporate governance, understanding of statutory requirements where compliance is mandatory and provisions with which trusts must comply, or explain how the principles have been met in other ways.

We are undertaking a review of compliance with the new code and will report any areas for development to both the Council of Governors and the Board of Directors. This will include any updates required to the Trust's Constitution.

The assessment of compliance with the new code will be linked to the ongoing governance review detailed in item, 5 of this report.

5. Annual review of governance

At the last Board meeting it was agreed to use the toolkit for health sector organisations developed by NHS Providers and Baker Tilly to structure our self-assessment with regards to board assurance arrangements. The feedback is being collated and the results will be reported to the corporate risk governance group to consider and develop an improvement plan. This output of which will be considered by the Board.

6. Revised committee terms of reference (ToR)

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

- Charitable Funds Committee
- Future System Programme Board

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

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

The Board assurance framework is a tool used by the Board to manage its principal strategic risks. Focusing on each risk individually, the BAF documents the key controls in place to manage the risk, the assurances received both from within the organisation and independently as to the effectiveness of those controls and highlights for the board's attention the gaps in control and gaps in assurance that it needs to address in order to reduce the risk to the lowest achievable risk rating. The Board has an approved risk appetite statement which supports the organisation's approach to risk mitigation.

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

A full executive-led review of the BAF is currently being undertaken. This will identify potential risks to delivery of the objectives set out in the revised Trust strategy. The updated BAF will be reported to the open Board meeting in March 2023.

8. Register of interests

Following review of the external audit requirements this item has been deferred to the March meeting of the Board to align with the schedule of the Trust annual reporting requirements.

The requirement for individuals to maintain and declare any interests for matters under consideration remains in place and is not impacted by this change to the reporting cycle.

9. Use of Trust Seal

None since last meeting.

10. Agenda Items for the Next Meeting (Annex)

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 – March 2023

Description	Open		Closed	Type	Source	Director
Declaration of interests	✓		✓	Verbal	Matrix	All
General Business						
Patient/staff story	✓		✓	Verbal	Matrix	Exec.
Chief Executive's report	✓			Written	Matrix	CB
Culture						
Organisational development plan, including: safe staffing guardian, FTSU guardian reports	✓			Written	Matrix	JMO
Strategy						
Future System Board Report	✓			Written	Matrix	CB
System update: West Suffolk Alliance and SNEE Integrated Care Board	✓			Written	Matrix	CB
Digital programme board report (qrtly)	✓			Written	Matrix	NM
Operational planning priorities report	✓		✓	Written	Matrix	NC
Establishment of the Suffolk Mental Health Collaborative			✓	Written	Matrix	CB
Assurance						
Report from 3i Committees: Insight, Improvement & Involvement	✓			Written	Matrix	RD / AR / JC
Insight Committee Report - Finance and workforce report - Operational report – winter preparedness and self-certification - Budget setting and capital programme	✓			Written	Matrix	NM/NC/RD
Involvement Committee Report - People and OD Highlight Report o Putting you First award o Staff recommender scores - National patient and staff survey and recommender responses - Education report - including undergraduate training	✓			Written	Matrix	JMO/AR
Improvement Committee Report - New CQC model of assessment *(action 2058)* - Maternity services quality and performance report (inc. Ockenden) - Nurse staffing report - Quality and learning report, including learning from deaths	✓			Written	Matrix	SW / PM
Integrated quality & performance report (IQPR) – annex to Board pack	✓			Written	Matrix	NM/NC/SW/PM
Serious Incident, inquests, complaints and claims report			✓	Written	Matrix	SW
Governance						
Governance report, including	✓			Written	Matrix	RJ

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

6. 13:15 - OTHER ITEMS

6.1. Any other business

To Note

6.2. Reflections on meeting

For Discussion

6.3. Date of next meeting - 31 March, 2023

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

1.4 - CQC New Inspection Framework

Board of Directors - Public	
Report title:	CQC new inspection framework
Agenda item:	1.4
Date of the meeting:	2 February, 2023
Sponsor/executive lead:	Sue Wilkinson – Executive Chief nurse
Report prepared by:	Rebecca Gibson - Head of Compliance & Effectiveness

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

Executive summary:	This report seeks to raise organisational awareness of the new CQC assessment framework, provide an overview of the model (see Annex 1 and 2), understand the key changes and enable planning of the next steps for the organisation.
Action required/ recommendation:	Consider the next steps proposed

Previously considered by:	Improvement committee
Risk and assurance:	BAF 1 - Failure to maintain and further strengthen effective governance structures BAF 6 - Value our workforce and look after their wellbeing and development
Equality, diversity and inclusion:	CQC Quality statement • (Caring) *Treating people as individuals* • (Responsive) *Equity in access* and *Equity in experiences and outcomes* • (Well led) *Workforce equality, diversity and inclusion*
Sustainability:	CQC Quality statement • (Well led) - *Environmental sustainability – sustainable development*
Legal and regulatory context:	The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Care Quality Commission (Registration) Regulations 2009

CQC new inspection framework

1.	**Introduction**
1.1	This report seeks to raise organisational awareness of the new CQC assessment framework, provide an overview of the model (see Annex 1 and 2), understand the key changes and enable planning of the next steps for the organisation. NOTE – In December the CQC announced a delay in their new framework (originally due to be launched in January 2023) for 9-12 months.
2.	**Background**
2.1	The new CQC framework is for providers, local authorities and systems. It focuses on what matters to people who use health and social care services and their families. It will let us provide an up-to-date view of quality. It covers all sectors, service types and levels – from registration, to how we look at local authorities and integrated care systems. Ratings (outstanding / good / requires improvement / inadequate) and the five key questions (safe / effective / caring / responsive / well led) remain. Quality statements focus on specific topic areas under key question. They set clear expectations of providers, based on people's experiences and the standards of care they expect. They replace the key lines of enquiry (KLOEs), prompts and ratings characteristics. See Annex 1 The framework introduces six new evidence categories to organise information under the new quality statements: people's experiences; feedback from staff and leaders; observations of care; feedback from partners; processes and outcomes of care. See Annex 2 The CQC will use a range of information to assess providers flexibly and frequently. Assessment will not be tied to set dates or driven by a previous rating as there will be a process to collect evidence on an ongoing basis and respond more flexibly to changes in risk. This means that the CQC can update ratings at any time Whilst they can and will use inspections (site visits) as a tool to gather evidence to assess quality, the use of data and insight will prompt which services to visit and the output of inspections will result in shorter and simpler reports, showing the most up-to-date assessment. The subjects covered by Quality statements have considerable overlap with the previous inspection regime (e.g. safeguarding, IPC and medicines management are still key components in Safe) but there are also some additions including a more focus on systems (e.g. at ICS level not just provider level), workforce wellbeing and enablement added in Caring and the Well-led domain has been substantially updated to reflect wider priorities such as Environmental sustainability, equality diversity & inclusion and freedom to speak up.
3.	**Timeframes** (last updated by CQC in December 2022)
3.1	**2021** - Strategy launched. **August 2022** - Started to roll out new elements of approach in a phased way with small groups of 'early adopters' including a small number of prospective home care providers who are registering with CQC for the first time and a small number of hospice providers. **2023 onwards** Share further updates on new approach to local authority and integrated care systems in early 2023 From spring focus on: • making sure the technology needed is in place and able to be tested with providers • being confident that new regulatory approach is ready to launch. • new Regulatory Leadership team will set out priorities across the sectors, including thematic reviews. • regulating as normal using current sector-based approaches, strengthened by priorities listed.

	In summer: • launch of new online provider portal in stages (with support and guidance provided): • providers will be able to submit statutory notifications • CQC will improve how the enforcement process works. Towards the end of 2023 start to carry out assessments in the new way using the new assessment framework with new integrated assessment teams and supported by new technology
4.	**Next steps**
4.1	1. Ensure Board awareness of new assessment framework 2. Ensure divisional / specialist awareness of new assessment framework 3. Consider the option of undertaking a self-assessment of the new Well-led framework 4. Consider the need for a gap analysis at organisational and core service level
5.	**Conclusion**
5.1	Whilst the implementation of the new framework has been delayed there is still a need to undertake a review of the updated framework, and this should be incorporated into the wider project to describe and report on our quality assurance frameworks.
6.	**Recommendations**
	Consider the next steps proposed

Annex 1 - Quality statements

SAFE	
Learning culture	We have a proactive and positive culture of safety based on openness and honesty, in which concerns about safety are listened to, safety events are investigated and reported thoroughly, and lessons are learned to continually identify and embed good practices.
Safe systems, pathways and transitions	We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services.)
Safeguarding	We work with people to understand what being safe means to them as well as with our partners on the best way to achieve this. We concentrate on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. We make sure we share concerns quickly and appropriately.
Involving people to manage risks	We work with people to understand and manage risks by thinking holistically so that care meets their needs in a way that is safe and supportive and enables them to do the things that matter to them.
Safe environments	We detect and control potential risks in the care environment. We make sure that the equipment, facilities and technology support the delivery of safe care.
Safe and effective staffing	We make sure there are enough qualified, skilled and experienced people, who receive effective support, supervision and development. They work together effectively to provide safe care that meets people's individual needs.
Infection prevention and control	We assess and manage the risk of infection. We detect and control the risk of it spreading and share any concerns with appropriate agencies promptly.
Medicines optimisation	We make sure that medicines and treatments are safe and meet people's needs, capacities and preferences by enabling them to be involved in planning, including when changes happen
EFFECTIVE	
Assessing needs	We maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.
Delivering evidence-based care and treatment	We plan and deliver people's care and treatment with them, including what is important and matters to them. We do this in line with legislation and current evidence-based good practice and standards.
How staff, teams and services work together	We work effectively across teams and services to support people. We make sure they only need to tell their story once by sharing their assessment of needs when they move between different services.)
Supporting people to live healthier lives	We support people to manage their health and wellbeing so they can maximise their independence, choice and control. We support them to live healthier lives and where possible, reduce their future needs for care and support.)
Monitoring and improving outcomes	We routinely monitor people's care and treatment to continuously improve it. We ensure that outcomes are positive and consistent, and that they meet both clinical expectations and the expectations of people themselves.
Consent to care and treatment	We tell people about their rights around consent and respect these when we deliver person-centred care and treatment.
CARING	
Kindness, compassion and dignity	We always treat people with kindness, empathy and compassion and we respect their privacy and dignity. We treat colleagues from other organisations with kindness and respect.
Treating people as individuals	We treat people as individuals and make sure their care, support and treatment meets their needs and preferences. We take account of their strengths, abilities, aspirations, culture and unique backgrounds and protected characteristics.
Independence, choice and control	We promote people's independence, so they know their rights and have choice and control over their own care, treatment and wellbeing.

Responding to people's immediate needs	We listen to and understand people's needs, views and wishes. We respond to these in that moment and will act to minimise any discomfort, concern or distress.
Workforce wellbeing and enablement	We care about and promote the wellbeing of our staff, and we support and enable them to always deliver person centred care.
RESPONSIVE	
Person-centred care	We make sure people are at the centre of their care and treatment choices and we decide, in partnership with them, how to respond to any relevant changes in their needs.
Care provision, integration, and continuity	We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity.
Providing information	We provide appropriate, accurate and up-to-date information in formats that we tailor to individual needs.
Listening to and involving people	We make it easy for people to share feedback and ideas or raise complaints about their care, treatment and support. We involve them in decisions about their care and tell them what's changed as a result.
Equity in access	We make sure that everyone can access the care, support and treatment they need when they need it.
Equity in experiences and outcomes	We actively seek out and listen to information about people who are most likely to experience inequality in experience or outcomes. We tailor the care, support and treatment in response to this.
Planning for the future	We support people to plan for important life changes, so they can have enough time to make informed decisions about their future, including at the end of their life.
WELL LED	
Shared direction and culture	We have a shared vision, strategy and culture. This is based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of people and our communities in order to meet these.
Capable, compassionate and inclusive leaders	We have inclusive leaders at all levels who understand the context in which we deliver care, treatment and support and embody the culture and values of their workforce and organisation. They have the skills, knowledge, experience and credibility to lead effectively. They do so with integrity, openness and honesty.
Freedom to speak up	We foster a positive culture where people feel that they can speak up and that their voice will be heard.
Workforce equality, diversity and inclusion	We value diversity in our workforce. We work towards an inclusive and fair culture by improving equality and equity for people who work for us.
Governance, management and sustainability	We have clear responsibilities, roles, systems of accountability and good governance. We use these to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate.
Partnerships and communities	We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.
Learning, improvement and innovation	We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research
Environmental sustainability – sustainable development	We understand any negative impact of our activities on the environment, and we strive to make a positive contribution in reducing it and support people to do the same.

Annex 2 - Evidence categories

People's experience of health and care services

"*a person's needs, expectations, lived experience and satisfaction with their care, support and treatment. This includes access to and transfers between services*".

Key points:

- People using services, families, friends and advocates are the best sources of evidence about lived experiences of care. This includes their perspective of how good their care is.
- We value people's experiences as highly as other sources of evidence and weight them equally with other required evidence categories.
- We consider the context and impact of people's experiences in our analysis.
- If we receive feedback that people have poor experiences of care, we will always identify it as a concern. We will review further and gather more evidence. This is even if other evidence sources have not indicated any issues.
- We increase our scrutiny of, and support for, how providers and systems encourage, enable and act on feedback. This includes feedback from people who face communication barriers. We look at how they work together to improve services.
- People's experiences are a diverse and complex source of evidence. We analyse a range of sources, such as data on demographics, inequalities and frequency of use for care services.

Outcomes

"*focused on the impact of care processes on individuals. They cover how care has affected people's physical, functional or psychological status.*"

The CQC considers outcomes measures in context of the service and the specifics of the measure. Examples of outcome measures are:

- mortality rates
- readmission rates
- emergency admission rates
- patient reported outcome measures following hip surgery
- infection control rates
- quality of life assessments.

Information is sourced from:

- patient level data sets
- national clinical audits
- initiatives such as the patient reported outcome measures (PROMs) programme.

Feedback from partners

"*evidence from people representing organisations that interact with the service that is being assessed."*

The CQC may gather evidence through interviews and engagement events. Organisations include, for example:

- commissioners
- other local providers
- professional regulators
- accreditation bodies
- royal colleges
- multi-agency bodies.

Observation

"We can observe the quality of care either off-site, on-site, or a combination of both."

Off-site observations

- interviews with staff and professionals who work in the service
- Healthwatch and other partners
- Experts by Experience support:
- telephone and video calls with people using services, families and carers
- engaging with communities whose voices are seldom heard.

On-site observations (inspections)

- observing care
- observing the care environment, including equipment and premises
- speaking to people using services and staff
- understanding the culture and how staff interact with each other.

Processes	Feedback from staff and leaders
"*the series of steps, or activities that are carried out to deliver care that is safe and meets people's needs. Assessment focuses on how effective policies and procedures are.*" The CQC will look at information from the provider and data sources that measure processes. For example: • data from national clinical audits • indicators from patient level data sets • waiting times • infection prevention control • reported incidents / notifications • reviews of care records.	"*evidence from people who work in a service, and staff groups who provide care to people. It also includes evidence from leaders of services*." This includes, for example: • results from staff surveys • trainee surveys • interviews with individual or groups of staff • staff focus groups • interviews with leadership of a service • evidence from provider's self-assessments • compliments and concerns raised with the CQC.

4.2 IQPR Full report November 2022

Insight Committee	
Report title:	**Integrated Quality and Performance Report**
Agenda item:	
Date of the meeting:	
Sponsor/executive lead:	Sue Wilkinson, chief nurse and Nicola Cottington, chief operating officer
Report prepared by:	Brain Addis, 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 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, the drivers for performance, actions being taken and assurance mechanisms. Please refer to the assurance grid for an executive summary of performance.
Action required / Recommendation:	To receive and approve the report

Previously considered by:	**Component metrics are considered by Patient Safety and Quality Group ad 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

Not Met

November 2022		ASSURANCE: Pass	Hit and Miss	Fail
VARIANCE	Special Cause Improvement		RTT 104 Week waits	Appraisal Rate monthly
	Common Cause	Cancelled Operations VTE - all inpatients		Ambulance Handover within 15min Staff Sickness - rolling 12month Turnover rate monthly Diagnostic Performance- % within 6weeks Total 12 Hour Breaches 28 Day Faster Diagnosis Cancer 62 Day GP Referrals Total Incomplete 104 Day Waits
	Special Cause Concern		Ambulance Handover within 30min Ambulance Handover within 60min	Staff Sickness – monthly

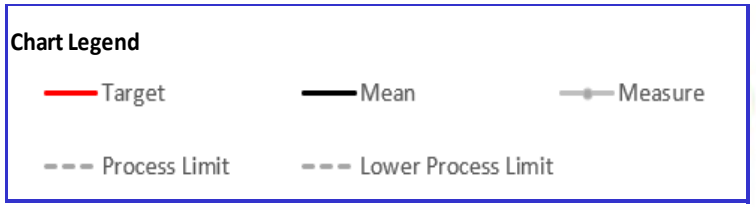
Deteriorating

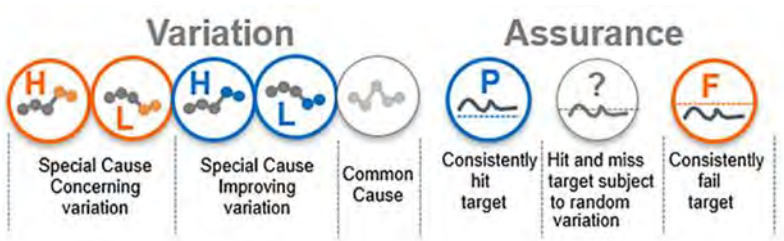
This shows us these indicators will not reliably hit the target:

% Compliance
Cancer 2 Week Wait for Urgent GP Referrals Total
Cancer 2 Week Wait Breast Symptoms Total
Cancer 62 Day Screening
2 week wait rapid chest pain
MRSA
C-Diff
Hand hygiene
Sepsis Screening for Emergency Patients
Mixed Sex Breaches
Community Pressure Ulcers
Acute Pressure Ulcers
Inpatient Falls Total
Acute Falls per 1000 Beds
Nutrition - 24 hours
Overdue Responses
Mandatory Training monthly

*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:
Urgent & Emergency Care: Ambulance Handover within 15min, Ambulance Handover within 30min,Ambulance Handover within 60min, 12 Hour Breaches
Cancer: 28 Day Faster Diagnosis, Cancer 62 Day GP Referrals Total, Incomplete 104 Day Waits
Elective: Diagnostic Performance- % within 6weeks Total
Well-Led: Staff Sickness- Rolling 12 month, Staff Sickness monthly, Turnover Rate, Appraisal Rate

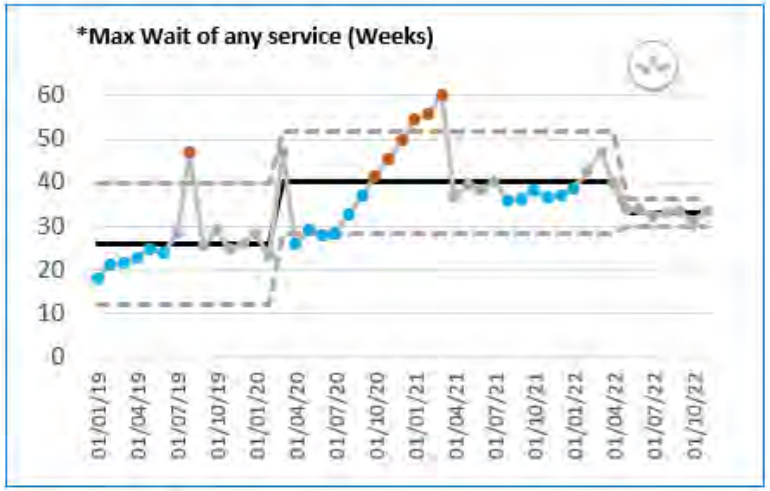


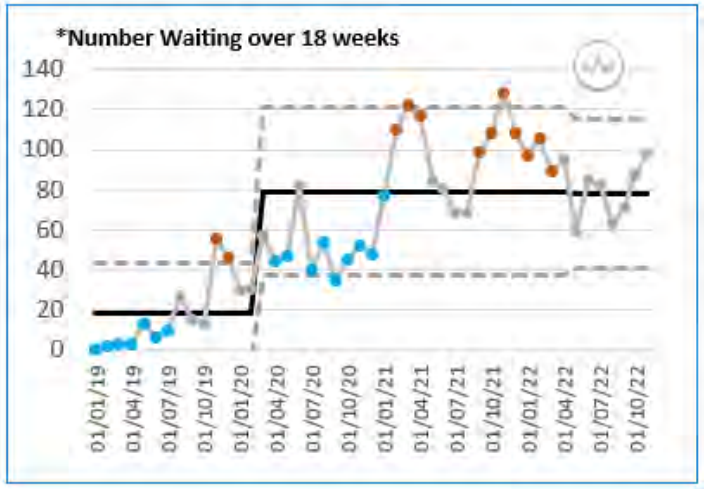


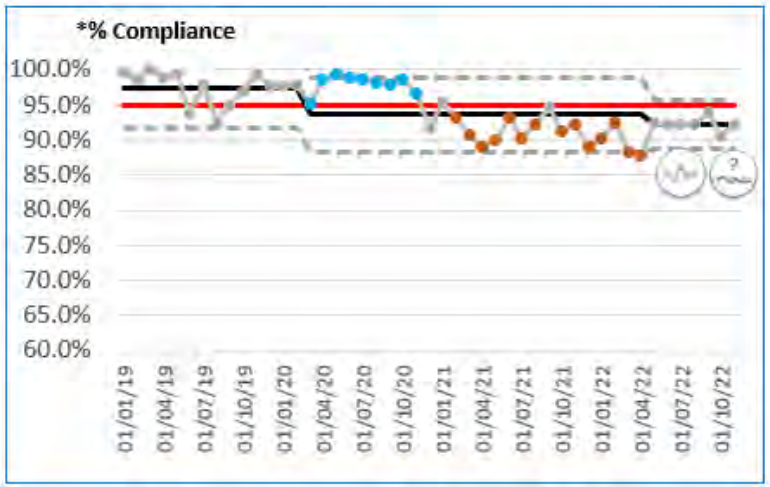
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
*Max Wait of any service (Weeks)	Nov 22	33	-			33	30	36
*Number Waiting over 18 weeks	Nov 22	98	-			78	41	115
*% Compliance	Nov 22	92.3%	95.0%			92.2%	88.8%	95.7%
Urgent 2 hour response	Nov 22	89.9%	70.0%					
Criteria to reside (Average without reason to reside)	Nov 22	68	-			64	45	84
Criteria to reside (Average without reason to reside)	Nov 22	17	-			20	14	27

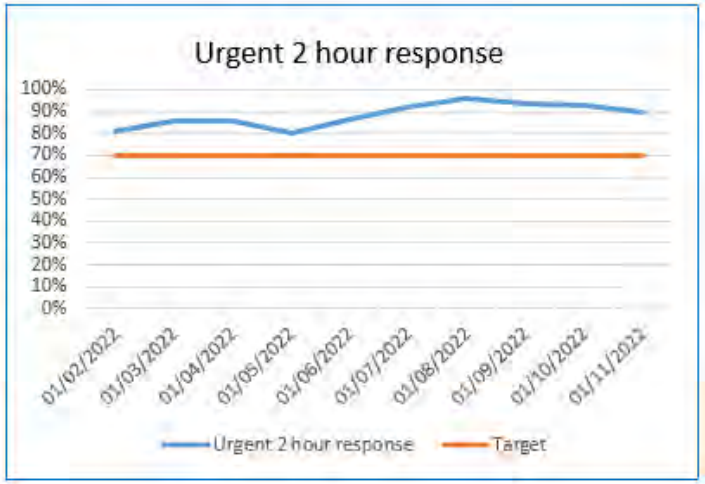
*The first 3 indicators cover all the non-consultant led community services of: Adult SLT, Heart Failure, Neurology Service, Parkinson's Nursing, Wheelchairs, Paediatric OT, Paediatric Physio and Paediatric SLT.

Community Access

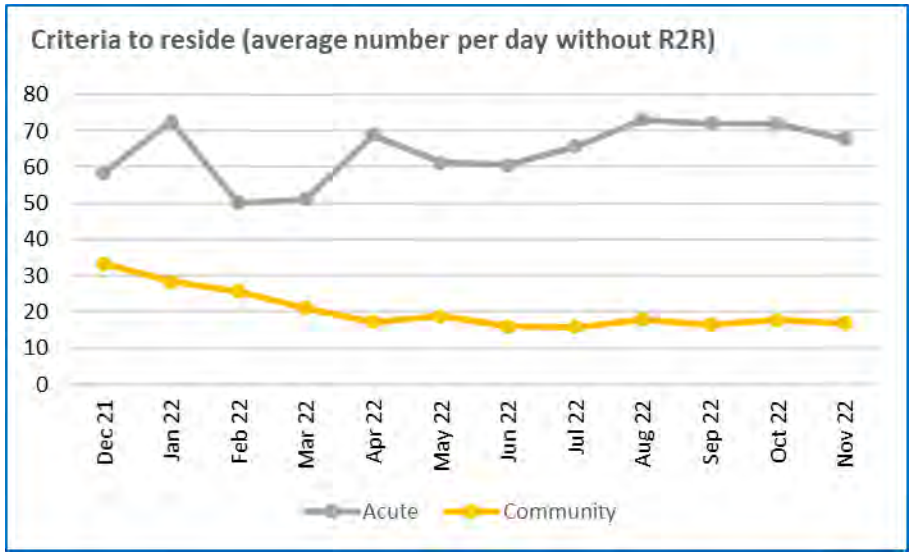




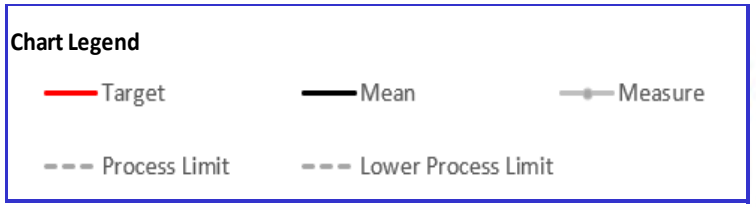


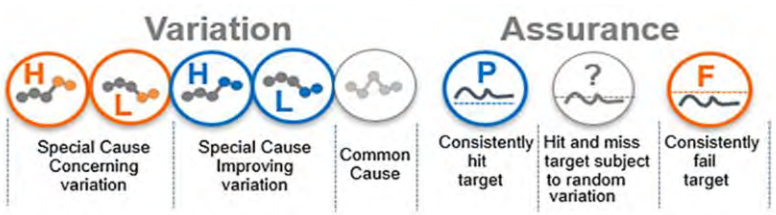


Summary	Action	Assurance
Paediatric Services: There continues to be challenges to meet compliance within the following services - Speech and language therapy, Paediatric medical and Audiology. This links to higher demand post pandemic for paediatric services. SLT service is further exacerbated by vacancies in the team.	**Paediatric Services:** Continued prioritisation according to clinical need. Use of locum (paeds) and continued focus on recruitment.	**Paediatric Services:** PAGG/Insight, Service operational oversight.



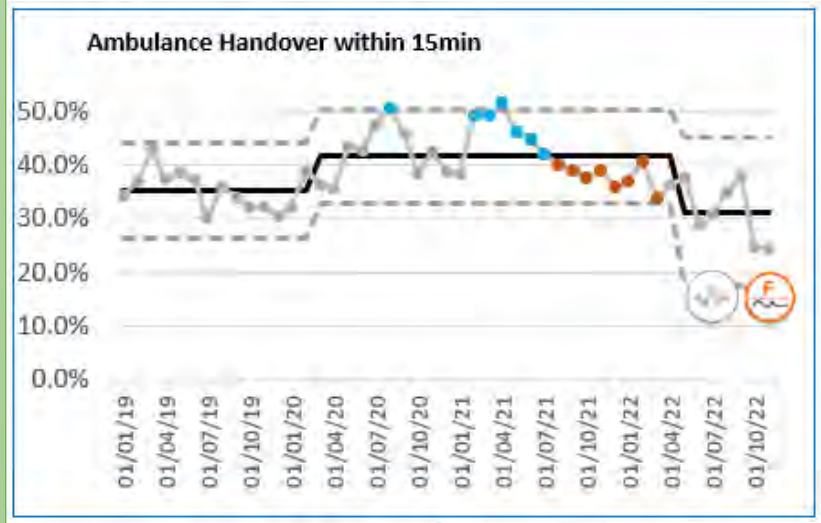
Summary	Action	Assurance
Similar issues to previous months continue with significant challenges in both home care capacity coupled with complexity of patients requiring large double handed packages of care. Additional agency support via Airmid was introduced to providing bridging support and take over Provider of Last Resort cases from STCH and Home First. Complexity of patients remains a challenge requiring complex plans and often higher needs placements which are difficult to source.	Significant work to increase pathway 1 capacity has been undertaken by the transfer of care hub, determining whether care to be requested by ACS or discharge supported by Responsive team/Support To Go Home in order to minimise delays. Further capacity from Airmid is being reviewed in order to provide continued support for pathway 1 discharges. Additional pathway 2 beds are being utilised to minimise delays.	System and Alliance focus on building capacity to enhance transfer of care arrangements through the Alliance Operational Delivery Group and the SNEE Urgent and Emergency Care group. Daily monitoring through Transfer of Care Hub meetings of both acute and community delays.

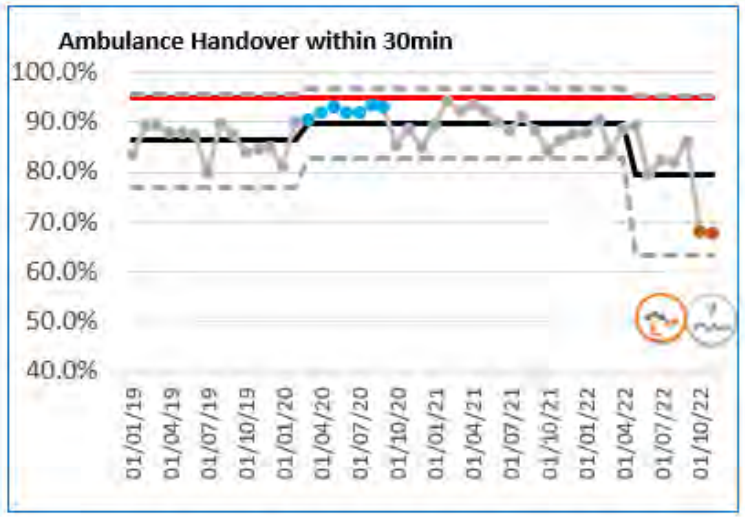


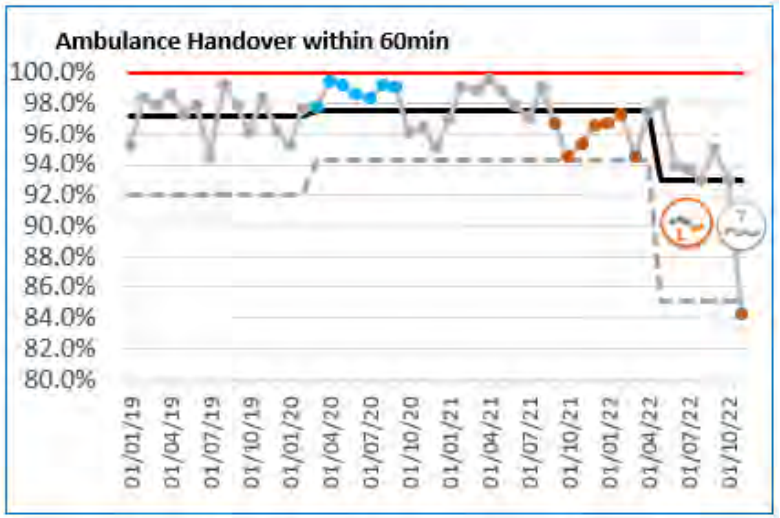


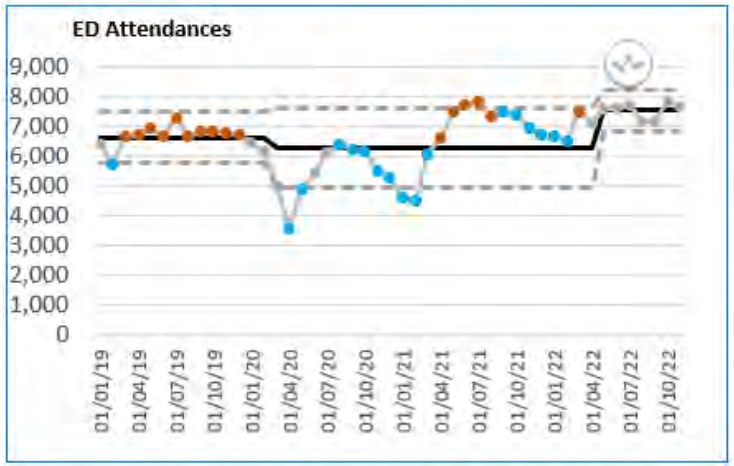
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Ambulance Handover within 15min	Nov 22	24.3%	65.0%			31.3%	17.4%	45.2%
Ambulance Handover within 30min	Nov 22	67.8%	95.0%			79.3%	63.3%	95.3%
Ambulance Handover within 60min	Nov 22	84.3%	100.0%			93.0%	85.2%	100.9%
ED Attendances	Nov 22	7654	-			7538	6862	8214
12 Hour Breaches	Nov 22	945	0			638	290	987
Stroke Quartely SNNAP Score	July 22 - Sept 22	A						

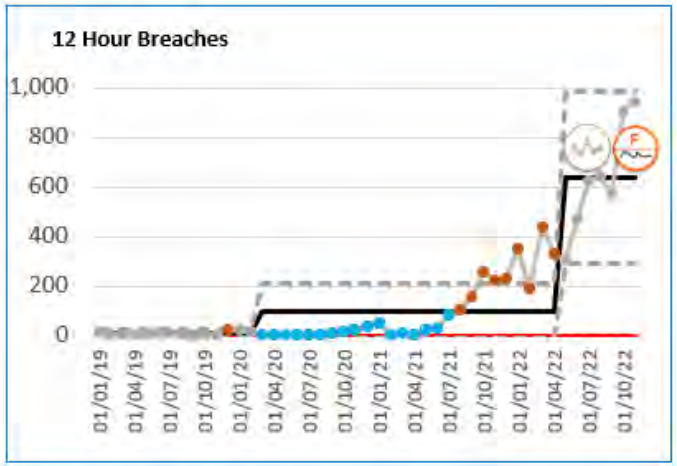
Urgent & Emergency Care







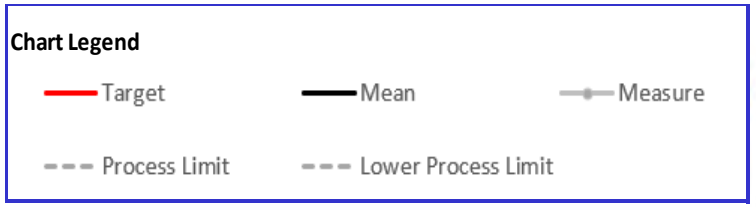


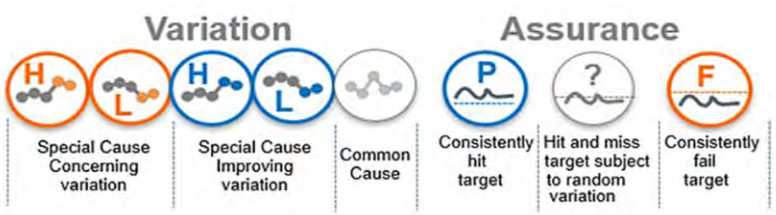


Urgent & Emergency Care

Summary	Action	Assurance
November has seen a further decline in all performance indicators within emergency care. Ambulance handover times remain a challenging picture and we continue to fail to meet the required standard. Instigating regular cohorting of patients to reduce offload times. November has seen the greatest number of 12 hour breaches within ED at 945.	GP streaming to cover 12 hours, 7 days a week to assist with increase of walk in attendances with good utilisation of slots. To ensure patients are seen by the appropriate clinician. Review of need for second GP room to manage increase activity within this steam of patients Medical SDEC activity continues with a focus on improving weekend activity Daily discussions with other divisions to free up space to allow ED activity – such as utilisation of fracture clinic rooms To ensure patient safety ED Consultants are reviewing and initiating investigations for patients in any queuing ambulance if cohorting area is full. Ongoing planning for additional trust escalation capacity. Working in collaboration with EEAST management colleagues to review our ambulance handover and cohorting process.	Continue to monitor GP utilisation which has significantly increased. SDEC activity is now monitored via new reporting metrics Harm reviews ongoing for a % of all 12 hour length of stays and patient waiting on ambulances greater than 1 hour. UEC metrics monitored via Patient Access Governance group feeding into WSFT Insight group and West Suffolk Alliance Operational Resilience Group

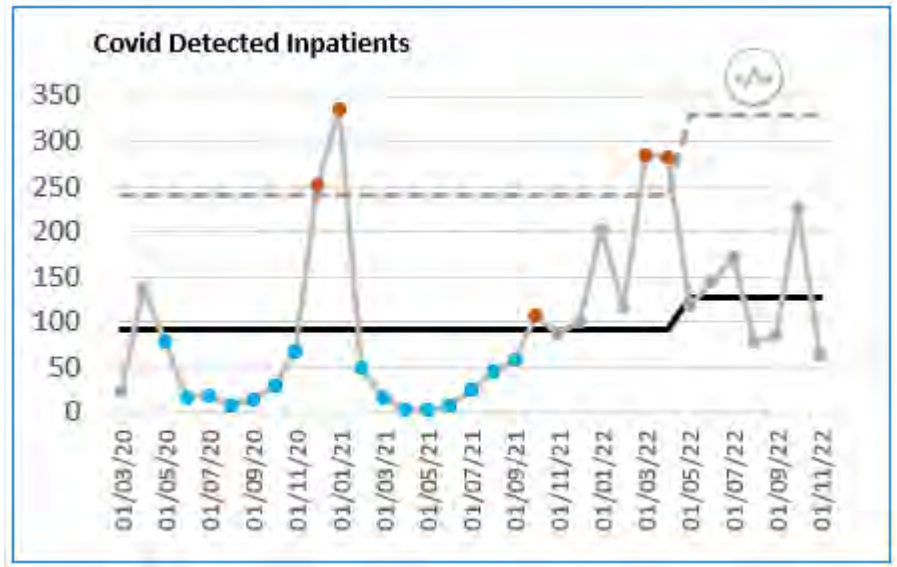
Covid Summary

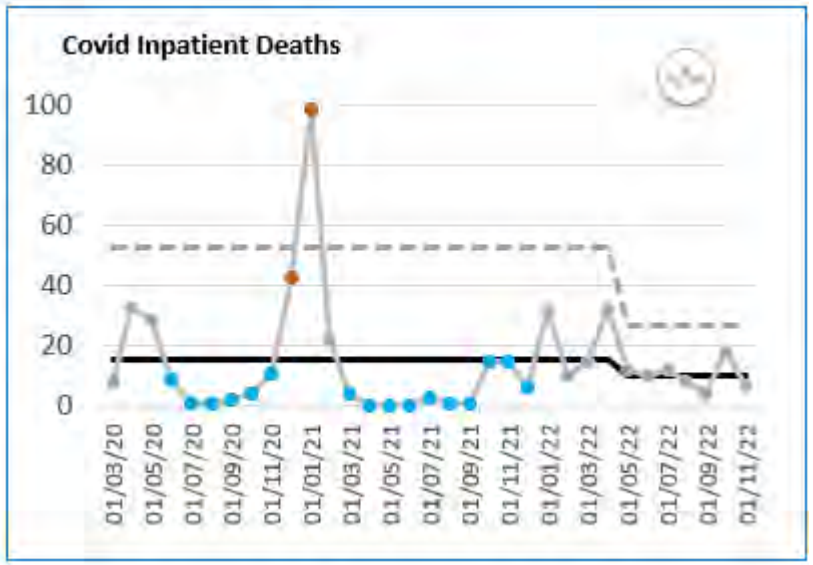




KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Covid Detected Inpatients	Nov 22	63	-			127	-76	330
Covid Inpatient Deaths	Nov 22	7	-			10	-6	27

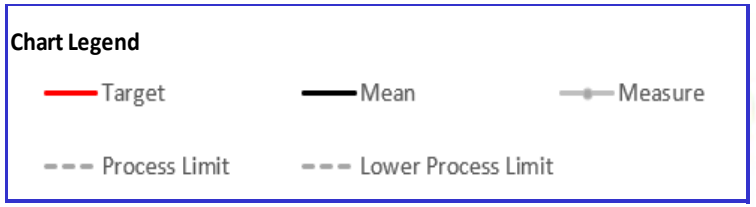
Covid

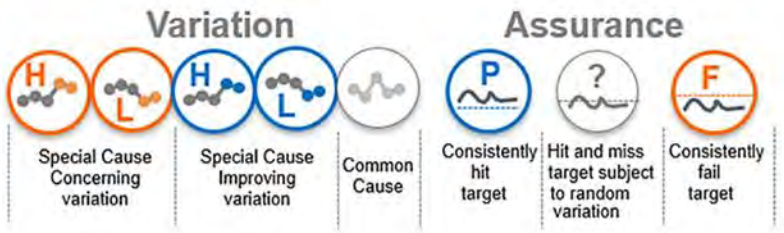




Summary	Action	Assurance
Lowest number of inpatient seen September 2021, in keeping with community prevalence. Covid patients contained in one single area G10 Anticipated rise both in covid and flu infections end of December/January as UKSHA modelling informs.	No further actions taken No change in current guidance or pathway plans	Nosocomial infections monitored by IPC team IMT stood up if cases meeting threshold of outbreak reached.

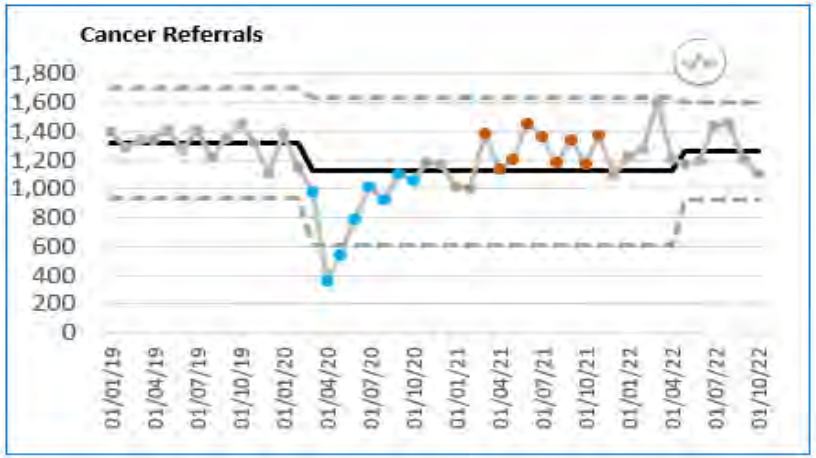
Cancer Access (Month Behind) Summary

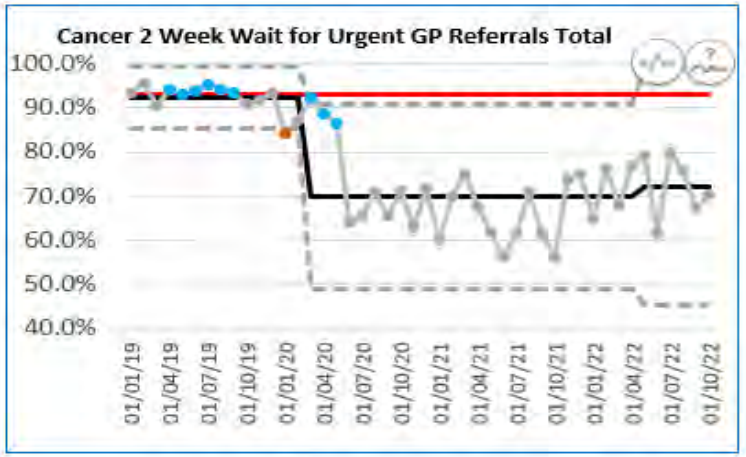


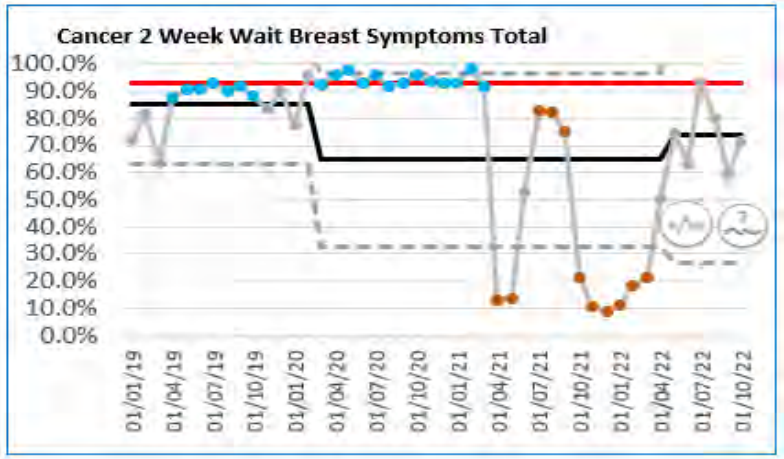


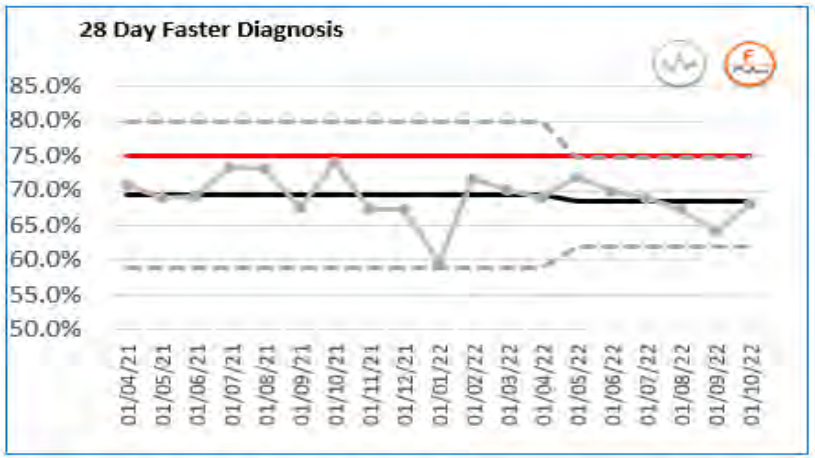
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Cancer Referrals	Oct 22	1105	-			1263	923	1603
Cancer 2 Week Wait for Urgent GP Referrals Total	Oct 22	70.1%	93.0%		?	72.3%	45.2%	99.3%
Cancer 2 Week Wait Breast Symptoms Total	Oct 22	71.8%	93.0%		?	73.7%	26.5%	120.9%
28 Day Faster Diagnosis	Oct 22	68.0%	75.0%		F	68.4%	62.0%	74.8%
Cancer 62 Day GP Referrals Total	Oct 22	65.1%	85.0%		F	66.4%	56.6%	76.2%
Cancer 62 Day Screening	Oct 22	100.0%	90.0%		?	89.5%	61.0%	118.0%
Incomplete 104 Day Waits	Oct 22	39	0		F	33	23	43

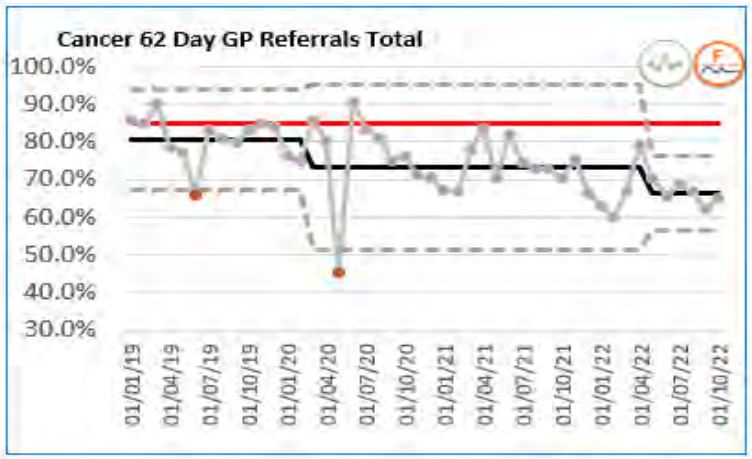
Cancer Access (Month Behind)

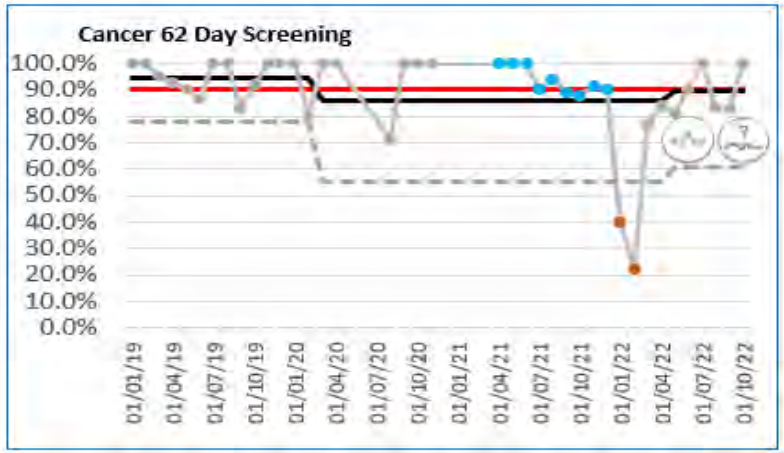


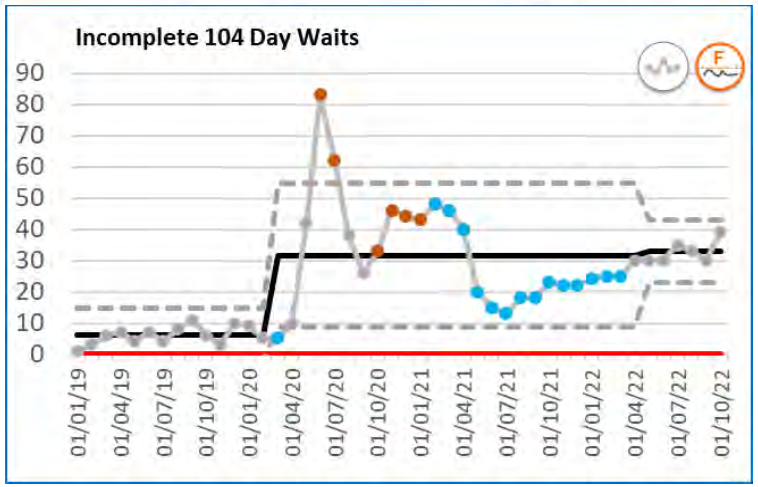








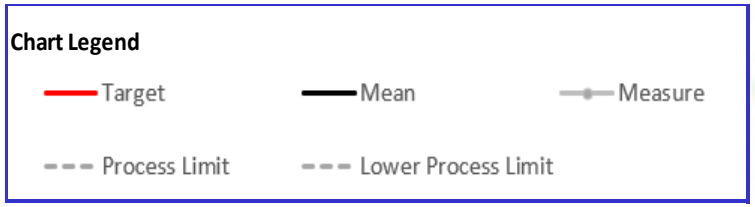


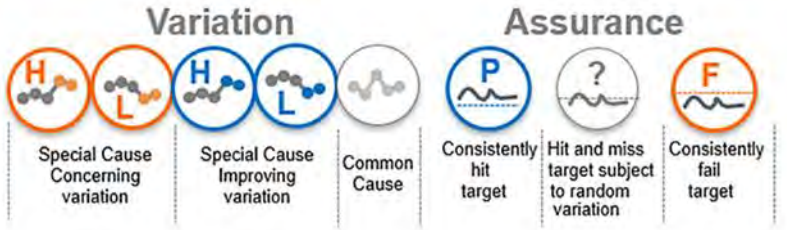


Cancer Access (Month Behind)

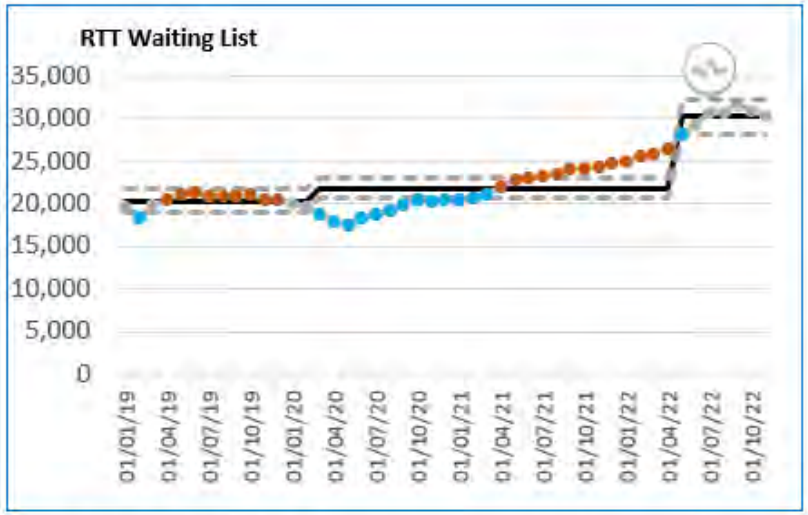
Summary	Action	Assurance
All of the cancer standards demonstrate a variation in compliance, with none of the KPI's demonstrating an improving trend with 28 and 62 day performance consistently failing the standard. For the 2ww standard Lower GI continues to be the driver with performance at 28%, Breast performance is also at 57%, however Skin had improved to 83%. For 28 day performance, Lower GI (46%), Skin (56.5%) and Urology (52.9%) continue to be driving the under performance. For 62 day performance, Skin (71%) and Urology(61%) are again the main drivers for the under performance due to delay at the front end of the pathway. The 104 day position is not yet demonstrating improving variation.	A full recovery action plan is in place. Some of the key actions within this include: • Monitor the newly adopted FIT pathway and adapt as required. • Commence the nurse led template biopsies in Urology Recruitment within Breast team for longer term sustained performance • Audit against best practice timed pathways – now complete for Prostate and Skin to be presented to teams W/C 19th December, action plan for improvements will follow. • Lower GI actions following audit are being undertaken, with a number of short and long term solutions to improve performance in place.	Recovery is monitored through local Cancer PTL meeting as well as SNEE wide Cancer Board and Cancer alliance level forums. Performance against trajectory for 62 day backlog is monitored via Insight committee.

Elective Access Summary





KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
RTT Waiting List	Nov 22	30225	-			30211	28180	32243
RTT 52Week Waits	Nov 22	1528	-			1647	1536	1759
RTT 78 Week Waits	Nov 22	238	-			395	227	563
RTT 104 Week waits	Nov 22	5	0			32	-14	77
2 week wait rapid chest pain	Nov 22	100.0%	95.0%			98.6%	93.8%	103.5%
Diagnostic Performance- % within 6weeks Total	Nov 22	64.8%	99.0%			61.1%	50.1%	72.0%
Elective Operations (Excluding Private Patients & Community)	Nov 22	1016	-			917	786	1049
Cancelled Operations	Nov 22	28	0			24	15	34
Cancelled Operations 2nd time	Nov 22	0	-			0	0	0


RTT Waiting List
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
01/01/19
01/04/19
01/07/19
01/10/19
01/01/20
01/04/20
01/07/20
01/10/20
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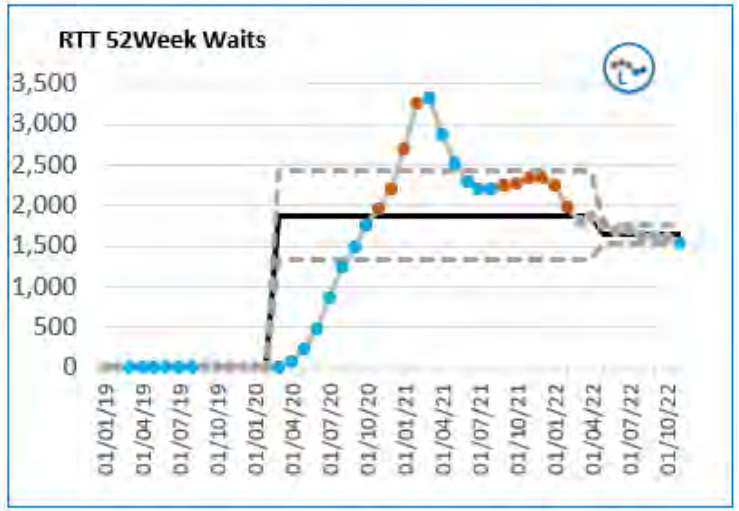
01/04/22
01/07/22
01/10/22


RTT 52Week Waits
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3,000
2,500
2,000
1,500
1,000
500
0
01/01/19
01/04/19
01/07/19
01/10/19
01/01/20
01/04/20
01/07/20
01/10/20
01/01/21
01/04/21
01/07/21
01/10/21
01/01/22
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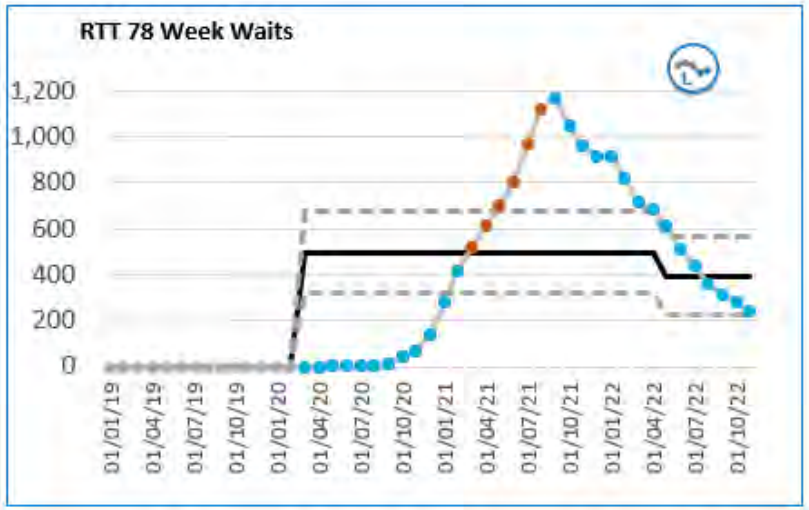
01/07/22
01/10/22


RTT 78 Week Waits
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1,000
800
600
400
200
0
01/01/19
01/04/19
01/07/19
01/10/19
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01/07/20
01/10/20
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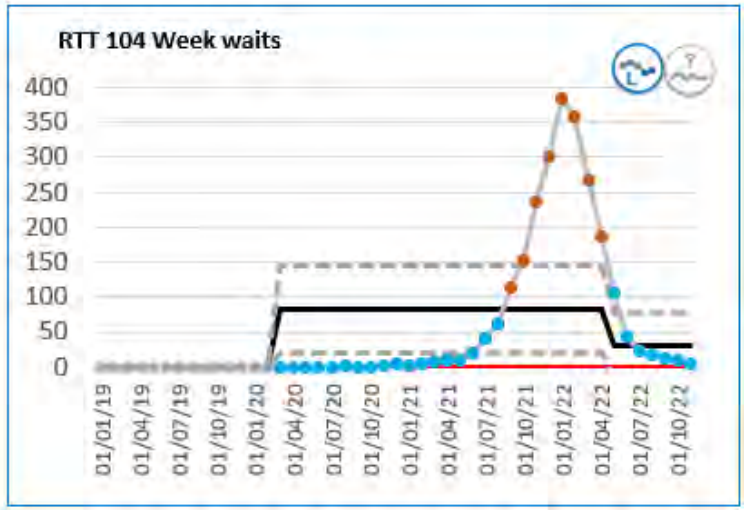
RTT 104 Week waits
400
350
300
250
200
150
100
50
0
01/01/19
01/04/19
01/07/19
01/10/19
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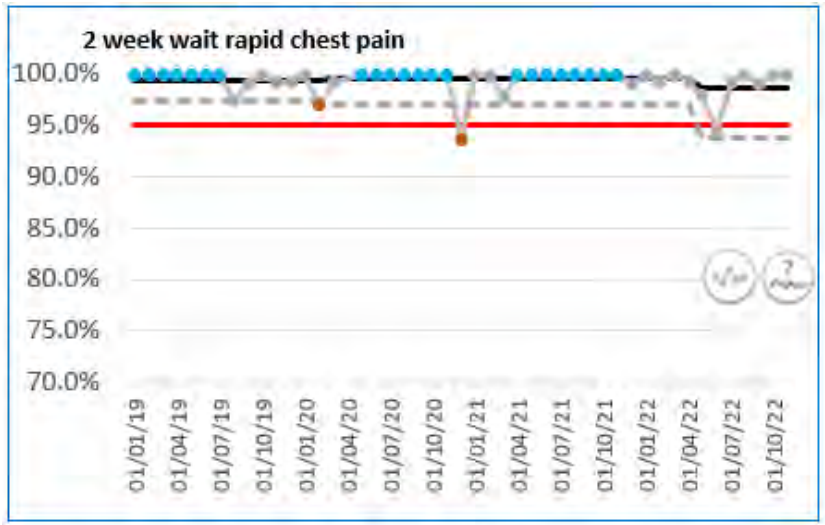
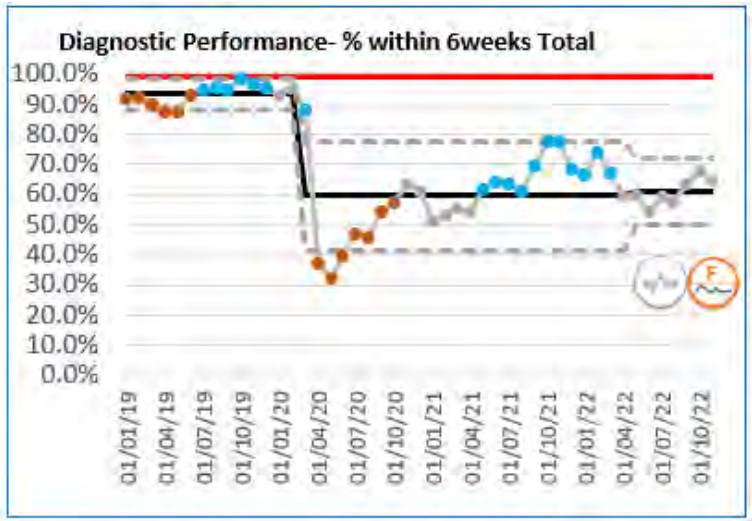
01/04/20
01/07/20
01/10/20
01/01/21
01/04/21
01/07/21
01/10/21
01/01/22
01/04/22
01/07/22
01/10/22

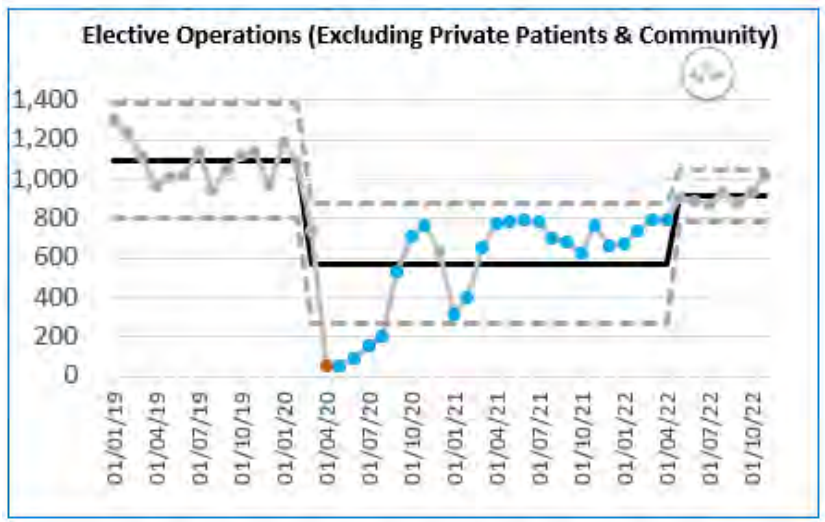
Elective Access

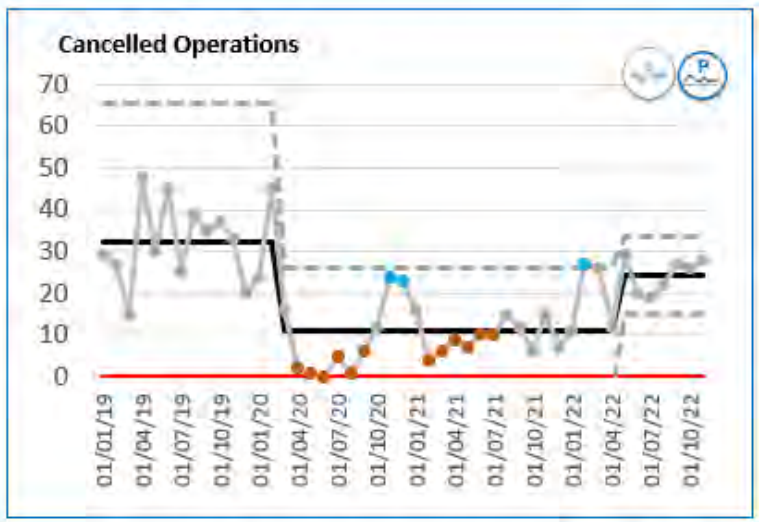
Summary	Action	Assurance
52, 78 and 104 week waits are all demonstrating improving variation. The total waiting list size continues to be of concern, although this is no longer demonstrating a continual increasing trend. The number of patients over 104 weeks continues to show a reducing position, whilst not at the 0 target quite yet due to patient complexities and patient choice. The 78 week wait position continues to show an improving variation with the end of November number at 259 against the forecast of 277.	The focus continues to be clearing the 104 week waits and achieving the 78 week wait standard by March 2023. The actions to achieve this include: • Continued focus on theatre productivity • Increased operational validation • Insourcing of pain management, urology diagnostics, endoscopy • Locum/fixed term recruitment in Plastics • SNEE wide deep dive for Orthopaedics, with General surgery next, followed by Gynaecology reporting into the elective care programme board	Progress against trajectory and action plans are monitored at the weekly access meetings, which feed into the insight committee. The position is also monitored across the ICS via the operational hub meetings feeding into the SNEE recovery and restoration board.

Elective Access





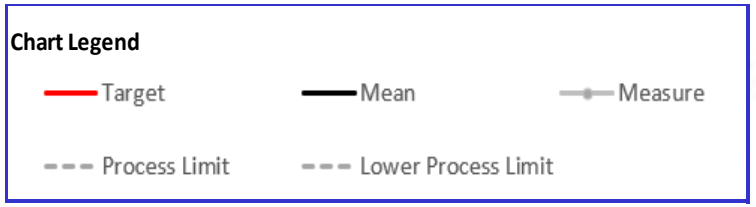


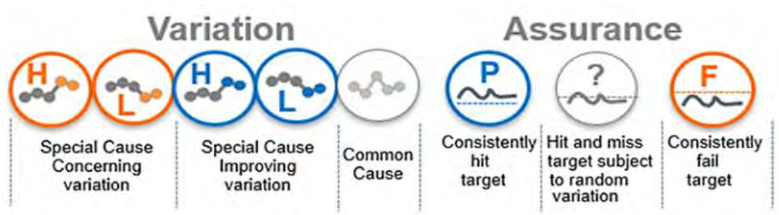


Elective Access

Summary	Action	Assurance
Common cause variation, no significant change. The system is not capable and will fail to consistently meet target without significant change. **MRI** - Running at full capacity across the seven days but current capacity insufficient. **CT** – compliant with DM01 at 99.21% **US** –The full impact of recruitment in November has yet to be seen. Correction of a data quality issue has also had a negative impact on the DM01 performance resulting in a lesser gain in performance than anticipated from actions already in place. **Endoscopy –** 2WW pressures have increased as a result of CT downtime impacting on routine waiting times. Priority is being given to longest waiting routine patients and priority RTT pathways. Trust delivered the highest number of elective procedures (1016) since February 2020. Theatre 1 remains closed and this will continue until 31 March 2023. 6-4-2 process successfully implemented in November 2022 and this is resulting in fewer dropped lists and cancellations. Biggest challenge going forward is the loss of F4 due to UEC pressures. The Division aims to recommence elective orthopaedic (major joint) work from 9th January 2023. Trust 3 patients behind 78 week trajectory desired position. However, this includes April buffer of 175 patients so we are still on course although orthopaedics and general surgery will be at risk if bed base cannot be protected. Scheduling is ensuring those who need capacity are prioritised and lists are being flipped within specialty Tri's. Cancellation protocol reinforced. Daily booking report sent to ADO/SOM's to ensure numbers are maintained.	**MRI** – options for temporary scanner being reviewed, case reviewed at insight and will require further consideration, further temporary MRI likely to be cost prohibitive in the short term. Requests to NHSE/Networks for additional resources have been feedback including a staffed MRI and additional reporting capacity. Longer term Community Diagnostic Centre will begin to address. **CT** - performance continues to recover but will be further impacted by CT2 and CT3 replacement programmes. Longer term Community Diagnostic Centre will begin to address. **US** – additional sonographers have been recruited and also two further imaging assistants to maximise capacity. The impact of the sonographers on performance should be seen going forward. **Endoscopy** - A recovery trajectory for endoscopy has been formulated to meet the national target but this has been impacted by a number of issues including medical recruitment. A review group will be meeting in January to focus on actions to improve current DM01 performance. Additional IS capacity is available which is underutilised for GP direct access. The division are looking at how WSFT can best utilise this capacity as soon as possible. • Monitoring of utilisation through Theatre utilisation review meeting (TURM) • Instatement of theatre amendment process • Weekly 28 day breach report • Pre-PTL meeting for theatres Tri • Reinforcement of theatre etiquette • Delivery of theatre plan	• Ongoing performance will be monitored at the weekly CSS access meeting, Divisional PRM and the Elective Access Insight Meeting. • PTL meetings • Weekly Access Group • Weekly tracker

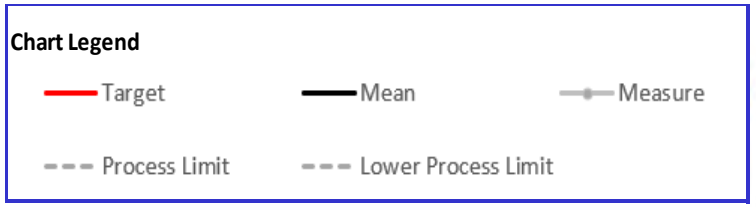
Safe- Summary

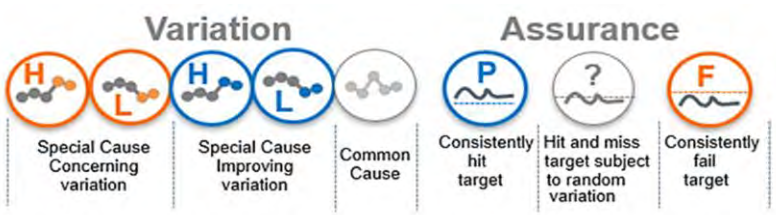




KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
MRSA	Nov 22	0	0			0	0	0
C-Diff	Nov 22	2	0			3	-4	11
Hand hygiene	Nov 22	98.9%	100.0%			98.6%	91.7%	105.4%
Sepsis Screening for Emergency Patients	Nov 22	100.0%	100.0%			84.8%	53.8%	115.8%
VTE - all inpatients	Nov 22	98.0%	95.0%		P	97.5%	96.7%	98.4%
Mixed Sex Breaches	Nov 22	2	0			5	-10	19
Community Pressure Ulcers	Nov 22	26	25			32	19	45
Acute Pressure Ulcers	Nov 22	26	17			23	5	40
Acute Pressure Ulcers per 1000 Beds	Nov 22	3.0	-			2.2	0.5	4.0
Inpatient Falls Total	Nov 22	64	48			72	35	110
Acute Falls per 1000 Beds	Nov 22	5.6	5.6			6.3	2.7	9.9

Safe- Summary





KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Nutrition - 24 hours	Nov 22	84.2%	95.0%			88.1%	80.4%	95.8%
Patient Safety Incidents per 1,000 OBDs	Nov 22	61.6	-			63.0	53.1	72.8
Patient Safety Incidents Reported	Nov 22	497	-			776	587	965
Patient Safety Incidents Resulting in Harm	Nov 22	156	-			170	139	201
Within 10 Days Duty of Candour	Nov 22	77.0%	-			54.3%	22.8%	85.8%
New Complaints	Nov 22	24	-			18	9	28
Closed Complaints	Nov 22	14	-			17	1	32
Overdue Responses	Nov 22	1	-			2	-1	4

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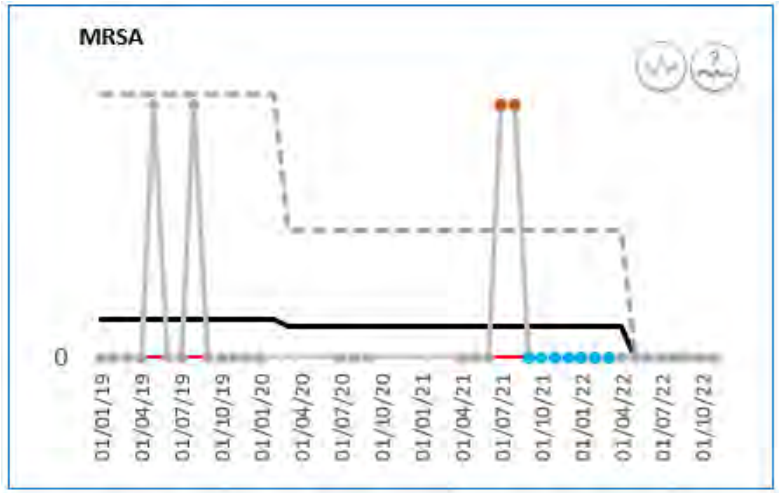

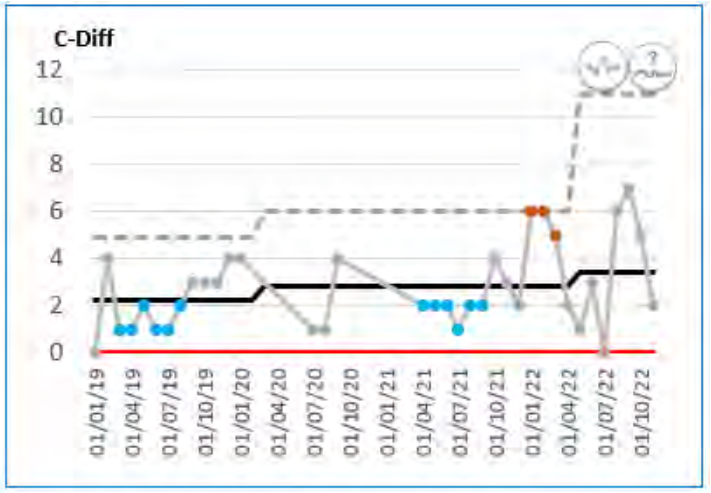

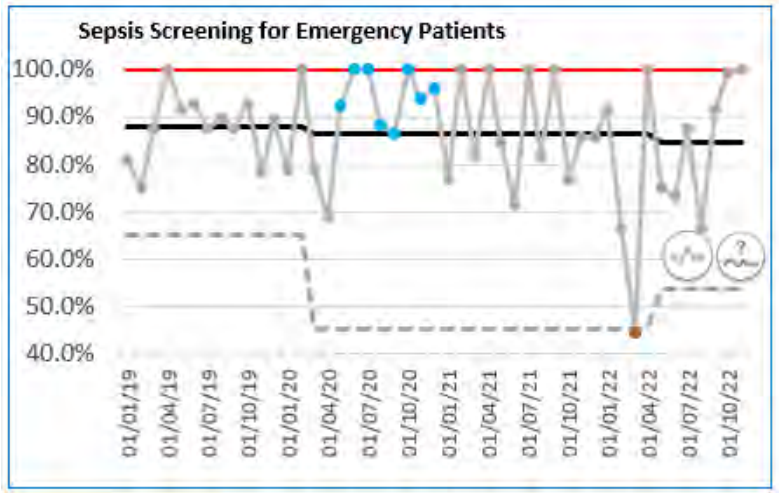

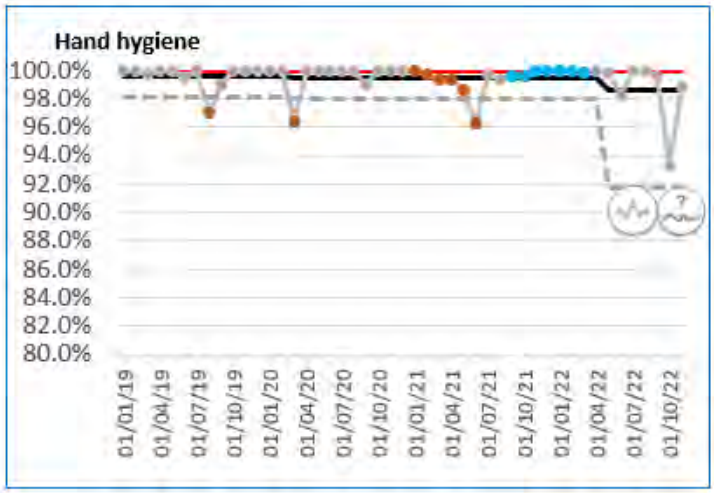

Summary	Action	Assurance
Consistent performance with MRSA Bacteraemia with no incidents over past 2 quarters 2 cases of C.diff, no links identified.	Surveillance continues to identify any potential links in a timely manner. Cdiff: PIR/RCA's planned however 1 case was a re-lapse/repeat specimen, but was treated with antibiotics appropriately.	Monitored through audit and reporting into the IPC committee.

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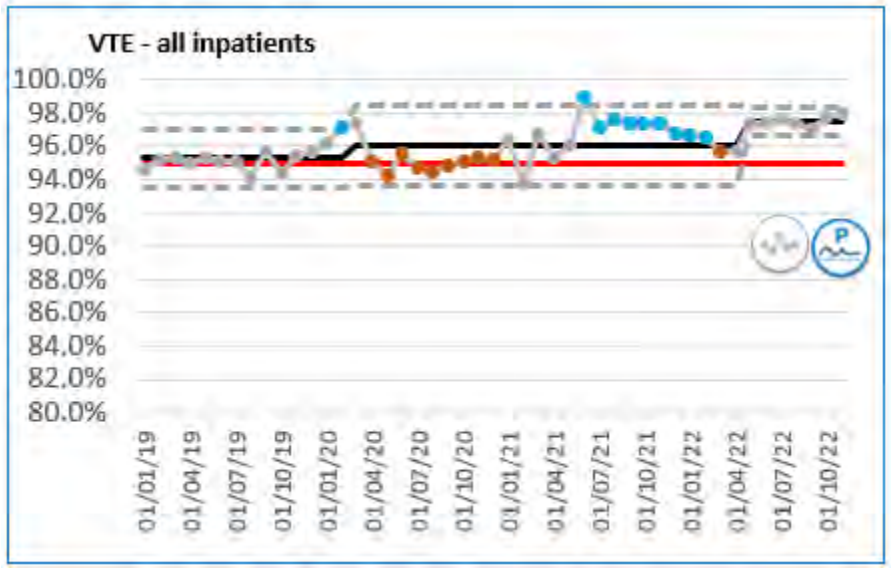

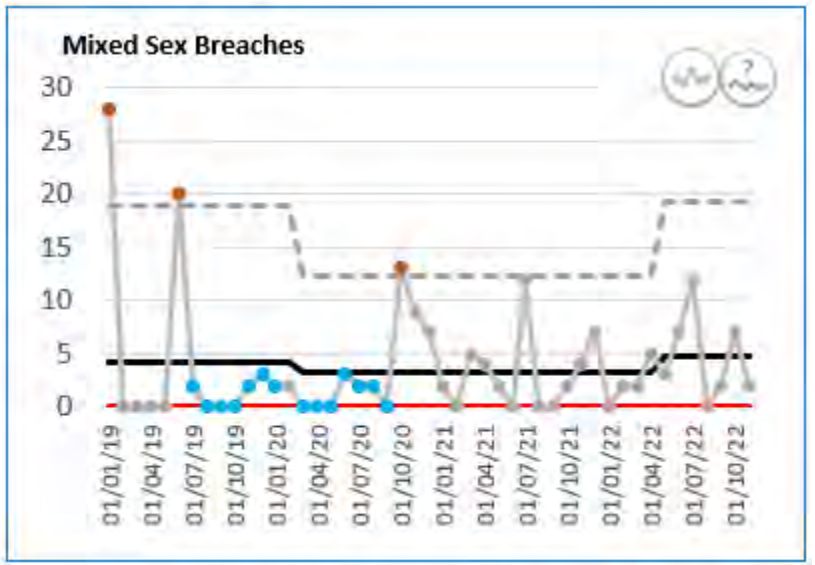

Summary	Action	Assurance
No significant change from last month. Performance has been maintained. AAU performance remains below other areas at 76.4%	The numbers are shared at divisional meetings. No further action currently	The monthly reports contain ward level data and the information can provide patient level data if required for areas of concern.

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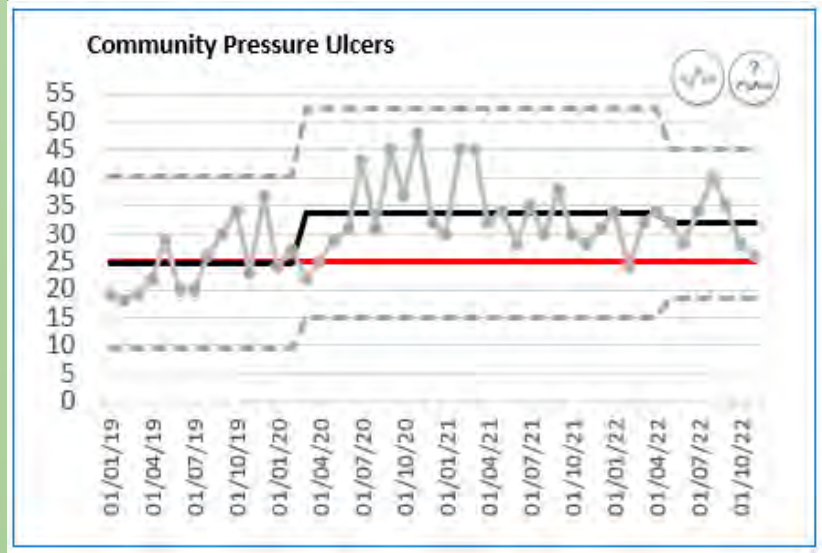

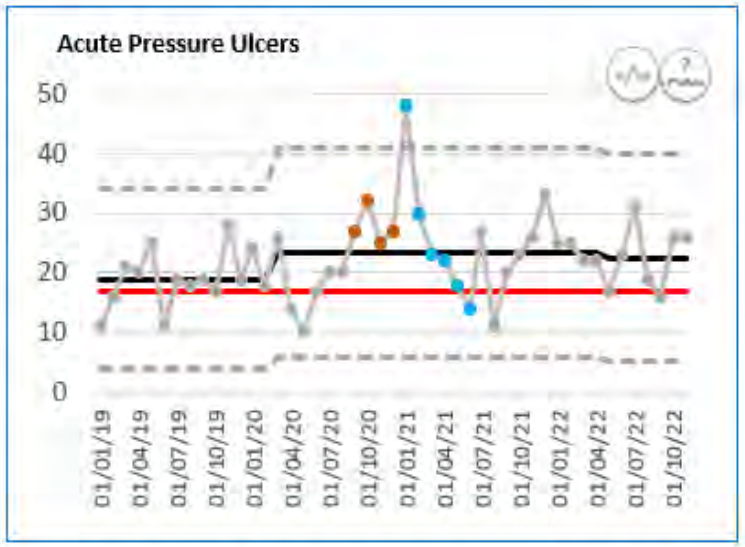

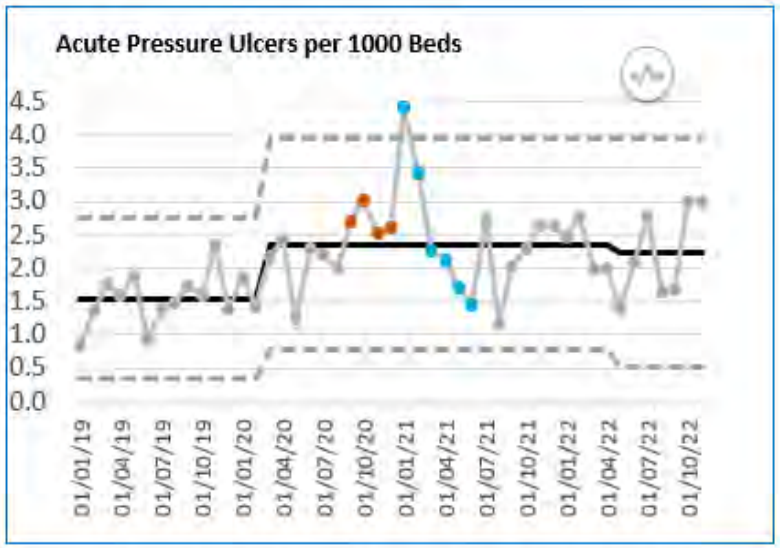

Summary	Action	Assurance
Acute pressure ulcers continue to report as a common cause concern. Following an initial spike in early summer incidence have been around trust average Community Pressure ulcers remain as common cause and assurance remains an inconsistent target due to random variation. Downward trend in last quarter may be driven by the adoption of the NWCSP framework	Continued provision of generalised training through development days and targeted training, although this has been difficult due to recent trust pressures. QI projects continue such as provision of pocket mirrors for HCA staff and support skin inspection and engagement. Rental of TOTO turning beds to support turning on our most vulnerable patients Alignment of Pressure Ulcer prevention group (PUPG) with QI methodology to provide more consistent structure and measurable targets.	Incident rates and thematic learning are explored through PUPG and Patient Quality and Safety group. Individual ward progress is monitored through PUPG QI team currently supporting the PUPG to monitor improvements and relevant data both trust wide and departmentally to support greater oversight of pressure ulcer incidence and areas area of need to monitor continuous quality improvement

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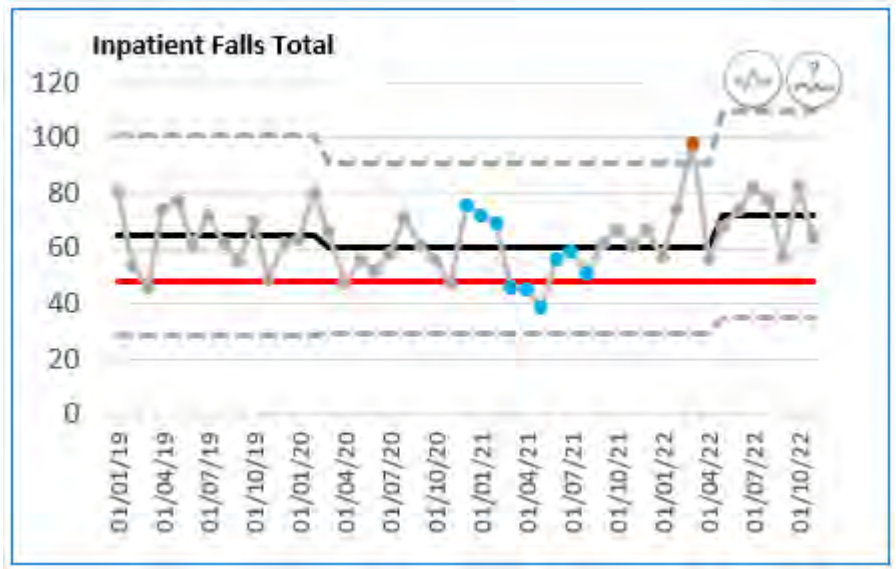

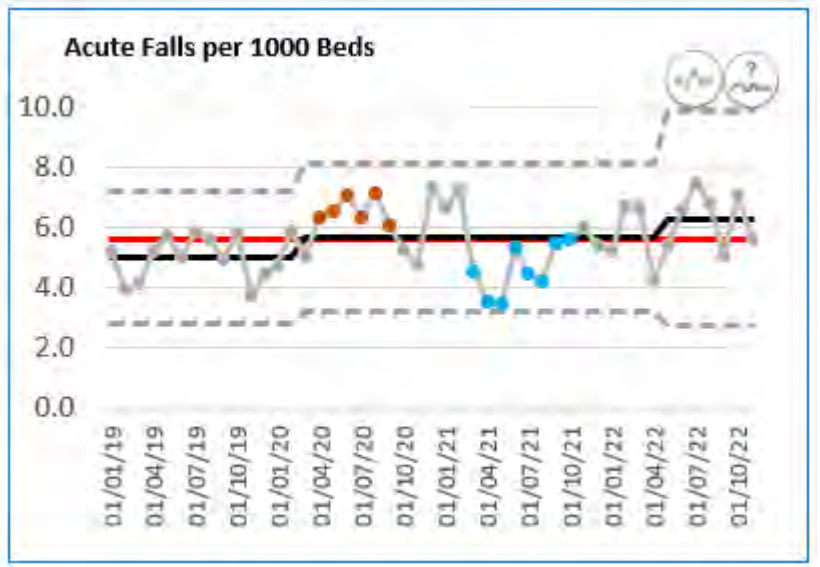

Summary	Action	Assurance
Month on month decrease seen in November and data remains in common cause variation. This month • 3 falls reported as major harm, • 3 falls as moderate harm	Feedback is being gained from wards regarding a new post fall form that has been piloted on F7 and plan to roll out across all the wards. This will better understand actions post fall, a common theme of learning from after action reviews (AARs) AARs have been completed for the falls with moderate and severe harm and from these action plans and areas for improvement identified. Improvement will be monitored through falls group and patient safety review panel	The falls group meets bimonthly and receives multiple measures related to falls including the above data. The falls improvement plan is reviewed and updated. The falls group report quarterly to the patient quality and safety governance group and is next scheduled to present in December 2022

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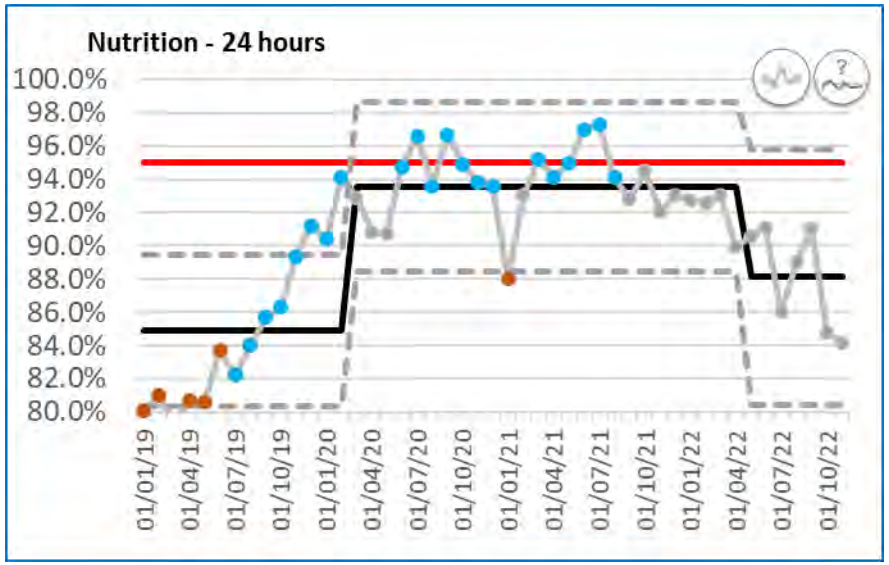

Summary	Action	Assurance
In November, there was further decline in compliance with completing the nutrition risk assessments within 24hrs of admission, with the Trust achieving **84.2%** overall. However, compliance during the admission does remain overall positive beyond the 24hr target. On review, it is becoming increasingly difficult to achieve the 24hr target, as patients are spending an increasing amount of time in the Emergency Department awaiting a ward bed, thus decreasing the time to achieve the expected target. Staffing challenges also continue to impact on this aspect of care and assessment and the Matrons continue to work with the teams to review how we can improve the position.	• Continue to share the data with teams • Audit of times weights and assessments are achieved • Promote the importance of timely and accurate assessments • Matron to focus on this aspect of care , engaging with ward teams • Encourage teaching sessions on the wards from the dietician • To commence a QI project in association with the Dietetic team to improve accurate assessing • Engage team to discover solutions to improve • Continued review of equipment to ensure it is working and effective. • Work with Patient flow team to support improved patient flow through the organisation	• Daily spot checks of compliance by Matron and WM • Monitor data and continue to share with teams • Liaise with Dieticians to monitor impact of delayed assessments and share learning. • Review of data at performance meetings and Governance reviews.

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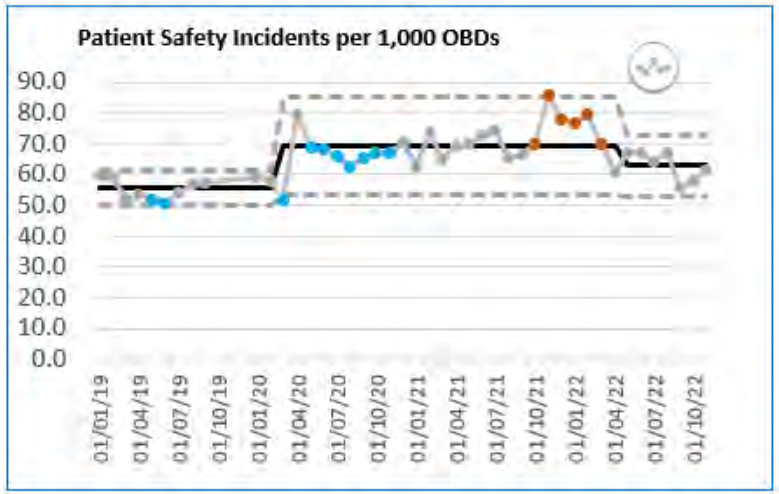

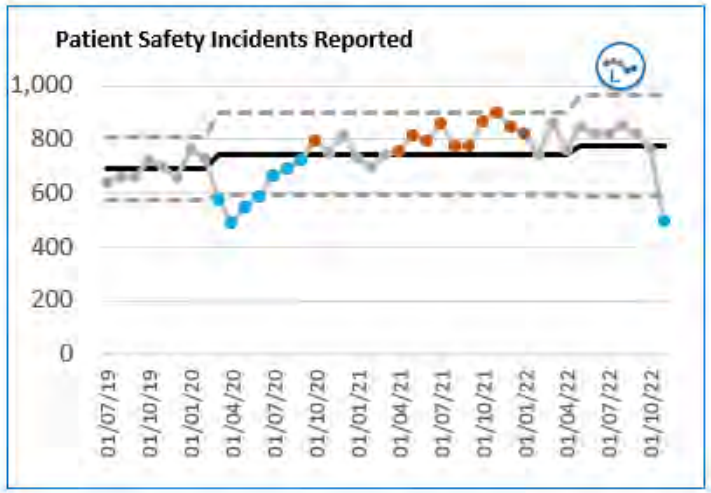

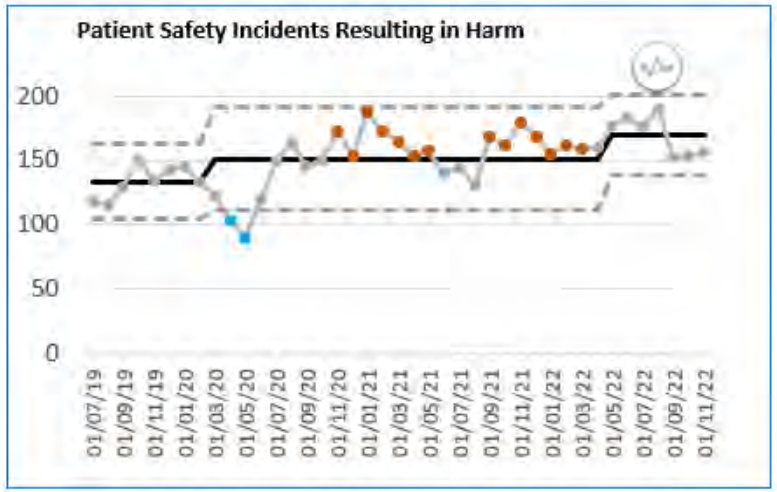

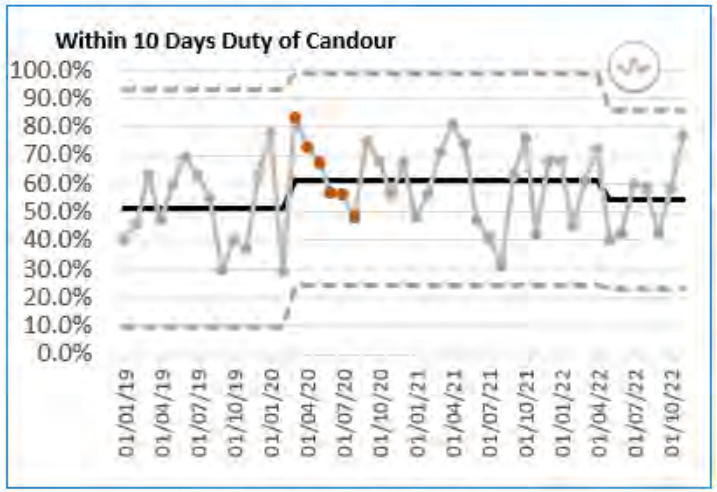

Summary	Action	Assurance
No variation in reporting of PSI's noted. This is an expected level of incidents for our organisation. Improvement in compliance of delivery of Duty of Candour within 10 working days due to robust administration by the patient safety administrators and managers and the associated QIP.	Continue to support reporting of incidents and review of incidents on a daily basis through the safety huddle.	Trends and themes of incidents monitored through quarterly analysis undertaken by the patient safety team and shared with specialist committees for action. Reported through the PQSGG. Results of DoC QIP to be shared at the next Improvement committee.

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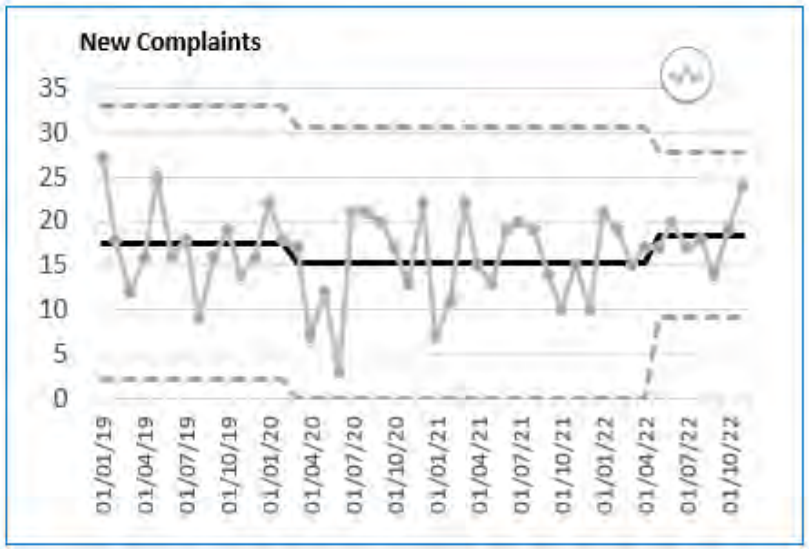
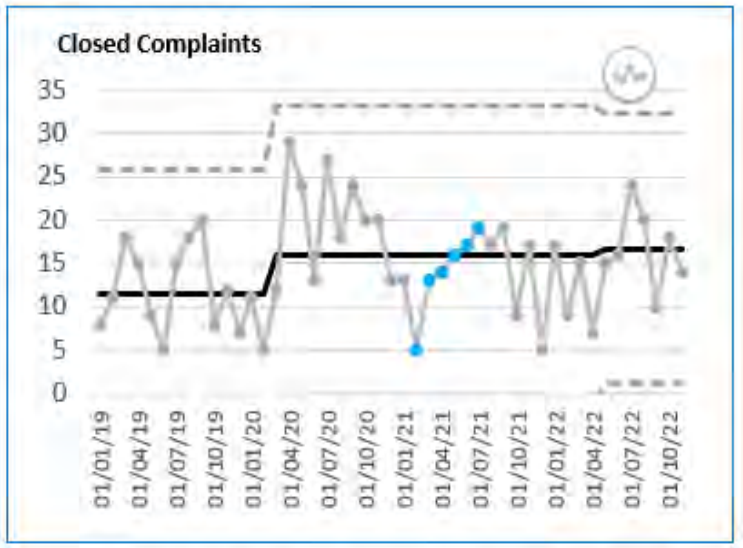
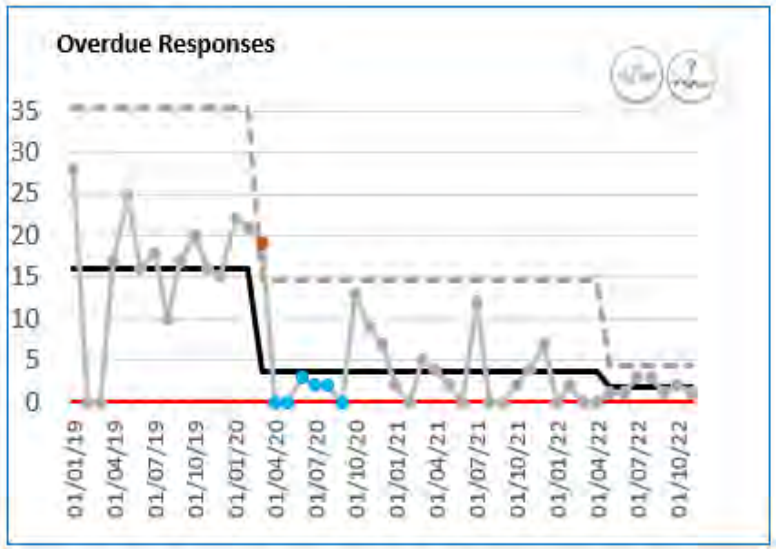
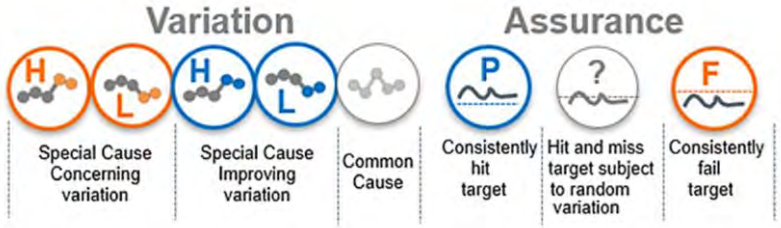






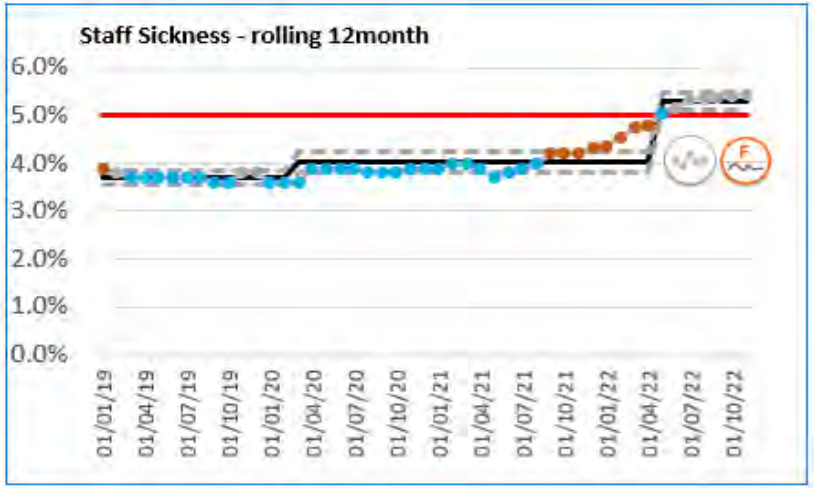
Summary	Action	Assurance
A high volume of new complaints received in November however remain within the upper control limits. At this stage, there has been no themes or trends identified. Due to the influx of new complaints, more administration has had to be completed and therefore a slight reduction in complaints closed. Overdue responses remain low.	Historic December trend reflects a reduction in complaints and will allow to catch up with open cases. Continue to maintain performance within the controlled limits	Overdue responses will continue to remain low.

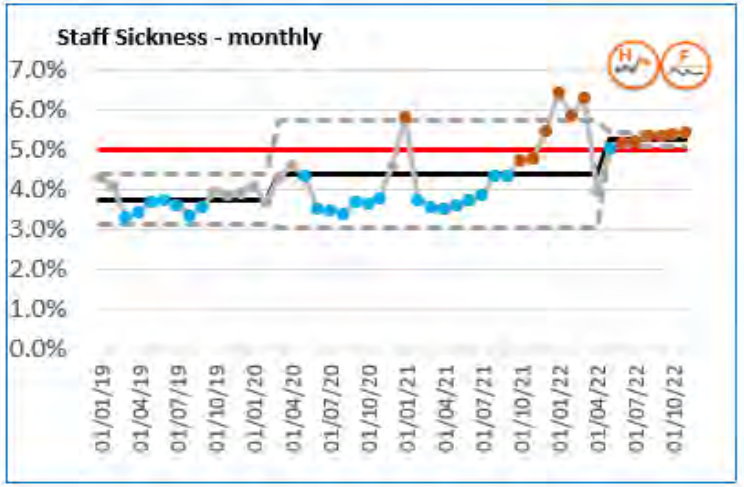
Well Led Summary

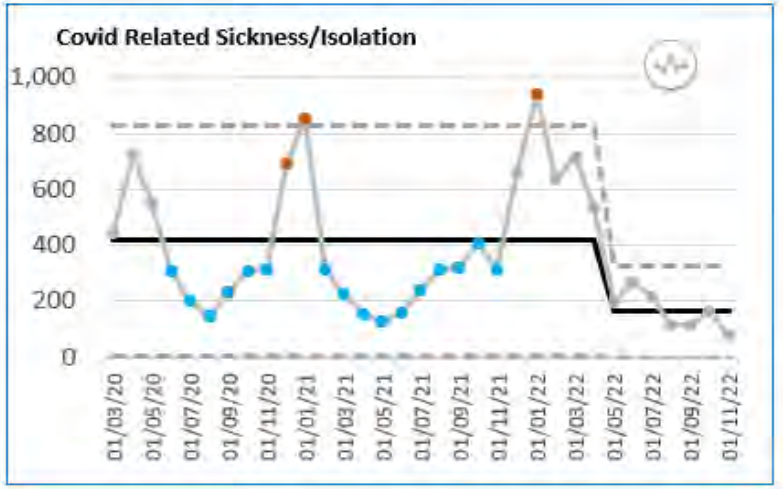


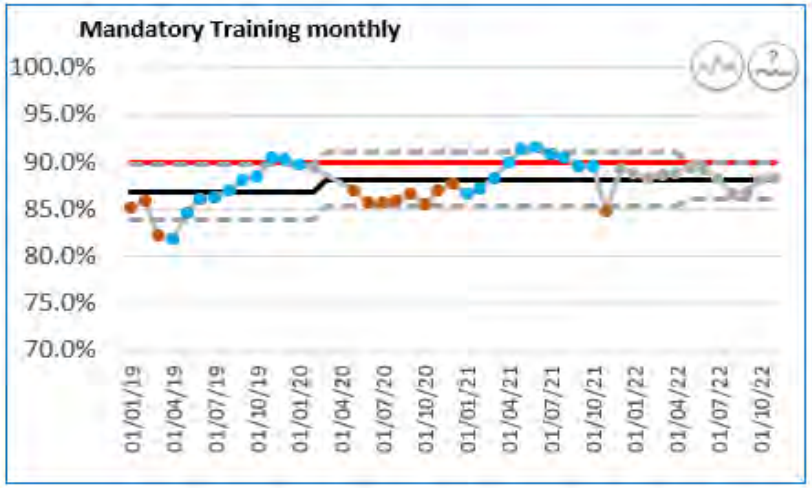
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Staff Sickness - rolling 12month	Nov 22	5.4%	5.0%		F	5.3%	5.1%	5.5%
Staff Sickness - monthly	Nov 22	5.4%	5.0%	H	F	5.3%	5.1%	5.4%
Covid Related Sickness/Isolation	Nov 22	76	-			165	2	328
Mandatory Training monthly	Nov 22	88.3%	90.0%		?	88.1%	86.1%	90.0%
Appraisal Rate monthly	Nov 22	83.2%	90.0%	H	F	80.2%	77.8%	82.6%
Turnover rate monthly	Nov 22	13.5%	10.0%		F	13.3%	12.5%	14.1%

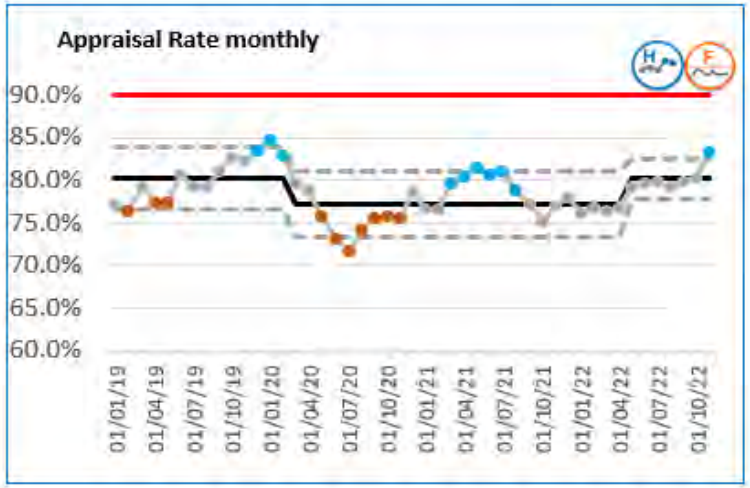
Well Led

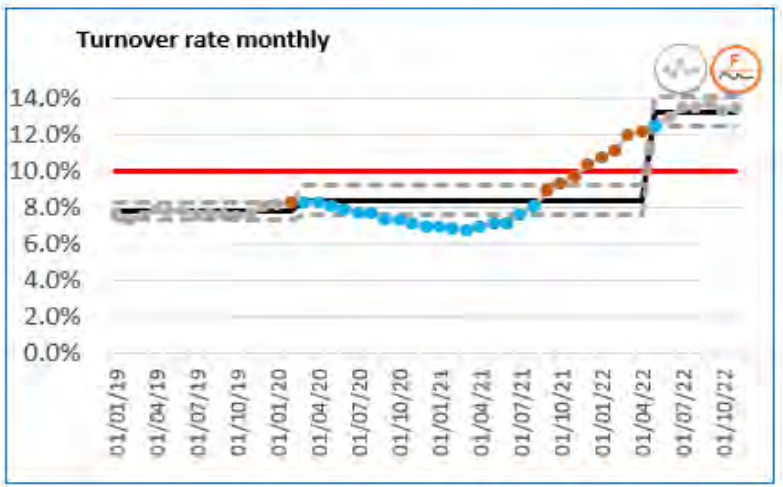












Summary

Sickness – The data is showing a common cause with no significant change variation. Further focus is needed in the coming months around managing attendance to ensure it continues to move towards achieving target for assurance.

Appraisal – The data shows a special cause of an improving nature with appraisal compliance. However, focus needs to continue to ensure future assurance moves from failing to passing Trust target.

Turnover – No significant change compared with last months data, turnover continues to fall short of the target.

Action

Sickness – Further focus on action plans within each division and corporate area.

Appraisal – Continued focus in all areas with regards to action plans and escalation by HRBP's to areas not hitting target.

Turnover – Divisional and corporate action plans to focus on recruitment and retention initiatives.

Assurance

This will continue to be monitored through PRM, and escalation to the involvement committee.

HRBP's to continue to push action plan and escalation within their Divisions where appropriate – monitoring progress and escalating blockers.

4.5.1 Maternity Papers - Annexes B-K

ATAIN Programme

Avoiding Term Admissions to the Neonatal Unit

Progress Report Quarter 3 October to December 2022

January 2023

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

Report presented for information and approval	**Maternity Quality and Safety Group – 16/1/23**
	Maternity and Neonatal Safety Champions – 26/1/23
	Trust Board – 02/02/23
Date of Report	**January 2023**

Executive Summary
There were 15 term babies admitted to the neonatal unit in this quarter (October 2022-December 2022). This figure does not include an additional 5 babies who were admitted but did not meet the criteria for review under ATAIN.

Respiratory distress remained the predominant reason for admission, with no overarching themes or common denominators identified amongst those admissions.

Thirteen babies were admitted with signs of respiratory distress and required oxygen support, and underwent a partial septic screen, treated with prophylactic antibiotics. Risk factors for sepsis were present in >50% of the cases. Other potentially contributing factors, including mode of delivery and gestation, varied and provided limited evidence to draw conclusions. Twelve of the 15 babies had optimal APGARs, scoring 8 or more at 1 minute.

One baby was admitted with suspected sepsis and was treated with intravenous antibiotics. This baby had originally been allocated to transitional care and screened for sepsis due to maternal risk factors, and was admitted to NNU for closer observation following an unexpectedly elevated CRP.

The final baby was admitted with hypoglycaemia and had the concurrent maternal risk factor of suspected hypoglycaemia. This baby required intravenous dextrose and feeding was supported with a nasogastric tube which delayed step down to transitional care.

All other admissions were stepped down to transitional care at the earliest opportunity.
No admissions this quarter were deemed avoidable.

Recommendations and Next Steps
Some minor opportunities for learning were identified this quarter, none of which were thought to have impacted the admission. They were:

- Omission of placental histology
- Incorrect antenatal care pathway for mother
- Deviation from sepsis guideline
- Incomplete CTG assessment
- Conflicting APGAR scores between clinicians

All opportunities for learning are discussed and a relevant action or pathway for shared learning agreed upon.

1. Background to project

ATAIN (an acronym for 'avoiding term admissions into neonatal units') is a programme of work to reduce harm leading to avoidable admission to a neonatal unit for infants born at term, i.e. ≥ 37+0 weeks gestation.
The programme focuses on 4 key clinical areas which make up the majority of admissions to neonatal units, however it is expected that shared learning from local reviews will identify other reasons for admission.
The ATAIN programme uses tools developed by NHS improvement for the 4 areas under focus:

- Respiratory conditions
- Hypoglycaemia

- Jaundice
- Asphyxia (perinatal hypoxia – ischaemia)

2. Local reviews

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

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

Process for review

The neonatal and midwifery team review the maternal and neonatal records prior to the ATAIN meeting using the approved NHS improvement tools.
Updated safety actions for CNST state that the care of all babies transferred or admitted to the NNU for *any period of time* should be reviewed, in some capacity, and reported under the ATAIN project. This is a change from previous guidance which required review only for babies admitted to NNU. Therefore, since May 2022 any baby that attends NNU briefly prior to transfer to transitional care (TC) has also been recorded. From July 2022 these babies, and any baby that attends NNU for care while an inpatient on the maternity unit, will be recorded and reported to the East of England Neonatal operational delivery network along with information on reason for attendance, parental accompaniment and any emerging themes.

3. Findings

During the past quarter, monthly Term admissions have remained below the target level of < 5%. There were 15 admissions in total, with 5 additional term babies admitted to NNU this quarter that did not meet the criteria for review under ATAIN; they included 3 transfers in from other hospitals, one admission for a place of safety and one due to a known congenital abnormality. They are not included in the overall admission numbers but are referenced for transparency.

Cases were reviewed carefully to identify any areas for learning and improvement.
Respiratory distress remained the predominant reason for admission, with no overarching themes or common denominators identified amongst those admissions. All babies admitted for respiratory support also underwent a septic screen; the majority of whom had risk factors for sepsis (risk factors varied with no dominating themes apparent). None of the admissions this quarter were deemed as avoidable.

Monthly Summaries

October 2022

In October there were 8 term admissions; all of whom were admitted with signs of respiratory distress. All received oxygen therapy and a partial septic screen including intravenous antibiotics. The predominant presenting symptom was low oxygen saturations which affected 6 out of the 8 babies. Five of the 8 babies had known risk factors for sepsis. None of the admissions were classified as avoidable and all babies

were stepped down to TC when clinically suitable, with the exception of one who remained on NNU due to the presence of a nasogastric tube.

November 2022

In November there were 3 term admissions; 2 of whom were admitted with signs of respiratory distress and were treated with both oxygen and IV antibiotics. Neither had any known risk factors for sepsis.

The third was admitted due to an unusually elevated CRP and had a known risk factor for sepsis; they were stepped back down to TC within 36 hours when the CRP level reduced to an acceptable level.

None of the three admissions were thought to have been avoidable and all were stepped down to TC at the earliest safe opportunity.

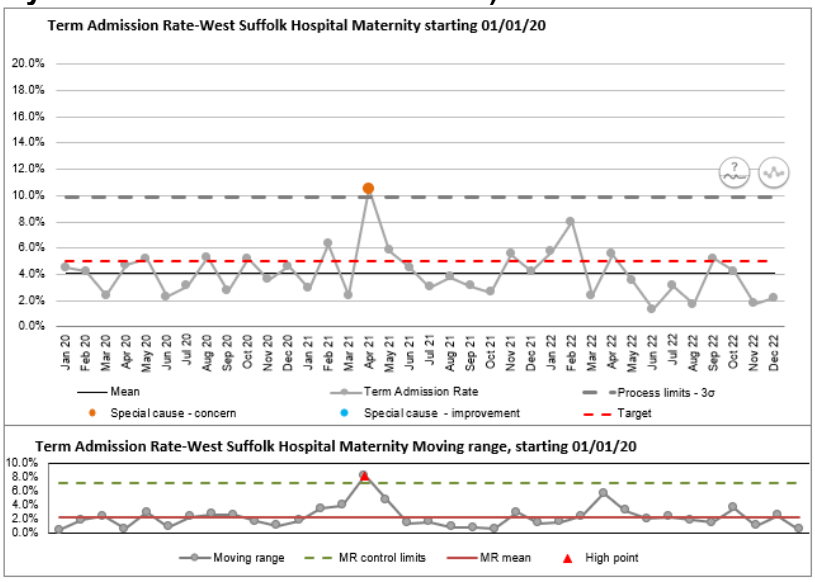
December 2022

In December there were 4 term admission; 3 admitted with signs of respiratory distress. All exhibited low saturations at birth and were admitted directly from Theatre and were treated with oxygen and underwent a septic screen with intravenous antibiotics. Two of the babies have subsequently been investigated for a suspected cardiac issue that was not known antenatally.

The fourth was admitted with hypoglycaemia and treated with intravenous dextrose; and had been monitored due to the maternal risk factor of gestational diabetes. Feeding was supported via nasogastric tube which subsequently delayed step down to TC.

4. Progress

(Monthly admission rates since Jan 2020)



5. Opportunities for learning and improvement

There were no significant opportunities for learning identified this quarter but some smaller issues were noted during the review of the antenatal, intrapartum and postnatal care. None of which are thought to have impacted on the admissions.

October

- Placenta not being sent for histology – shared in Risky Business
- A mother allocated to an incorrect care pathway due to inaccurate BMI calculation resulting in unnecessary serial scan pathway (error was picked up in Pregnancy)
- A deviation from the Sepsis guideline – feedback to Obstetric Team by Lead Labour Suite Consultant

November

- Incomplete CTG – shared in Risky Business

December

- Documentation of conflicting APGARs by Midwifery and Neonatal Team – shared in Risky Business.

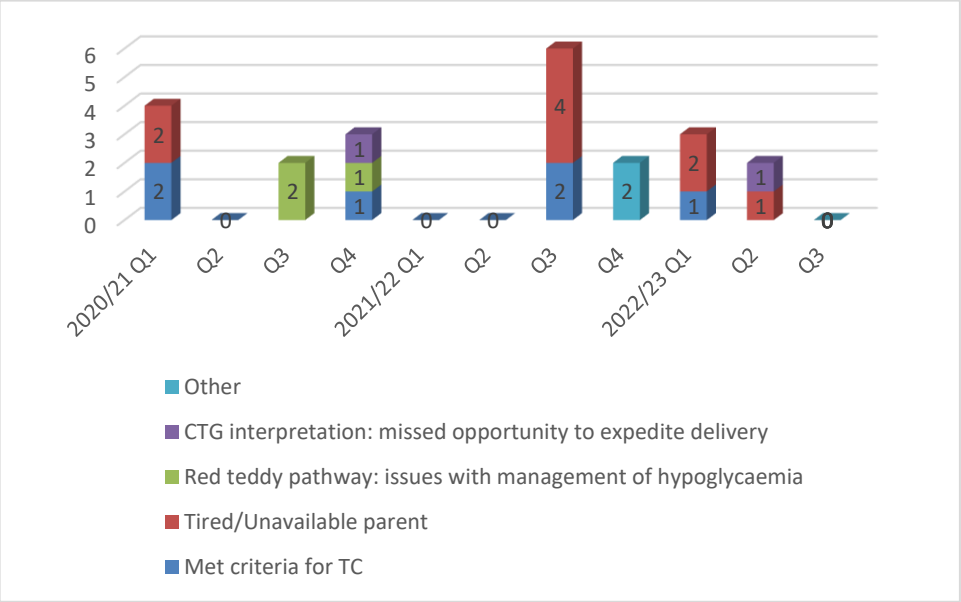
6. Action Plans

All opportunities for learning are discussed and a relevant action or pathway for shared learning agreed upon.

Any actions are added to the rolling action plan. Please refer to the rolling action plan for details of work undertaken.

7. Potentially Avoidable admissions

No avoidable admissions were identified this quarter.



8. Progress and learning with the key reasons for admission

Symptoms of respiratory distress remained the primary reason for admission in quarter 3, accounting for 87% of admissions (13 out of 15 babies). All were treated with vapotherm and intravenous antibiotics due to their clinical presentation, with 54% (7 of 13) having known risk factors for sepsis.

There were no common themes identified in the quarter overall with presenting symptoms continuing to vary. Mode of delivery was also inconsistent with gestations ranging from 37+0 to 41+5 and the majority born with good APGARs. There was no common overarching risk factor for sepsis or respiratory distress. As such the conclusions that can be drawn are limited.

October 22

- 8 of 8 babies were admitted to NNU with signs of respiratory distress
- All 8 treated with oxygen (vapotherm or nasal cannula oxygen) and IV antibiotics
- 6 of the 8 presented with low oxygen saturations
- 5 of 8 had known risk factors for sepsis
- 4 were delivered by caesarean section and 4 vaginally (one requiring forceps)

November 22

- 2 of 3 babies were admitted to NNU with signs of respiratory distress
- Both treated with oxygen and IV antibiotics
- Neither had known risk factors for sepsis
- All were born vaginally

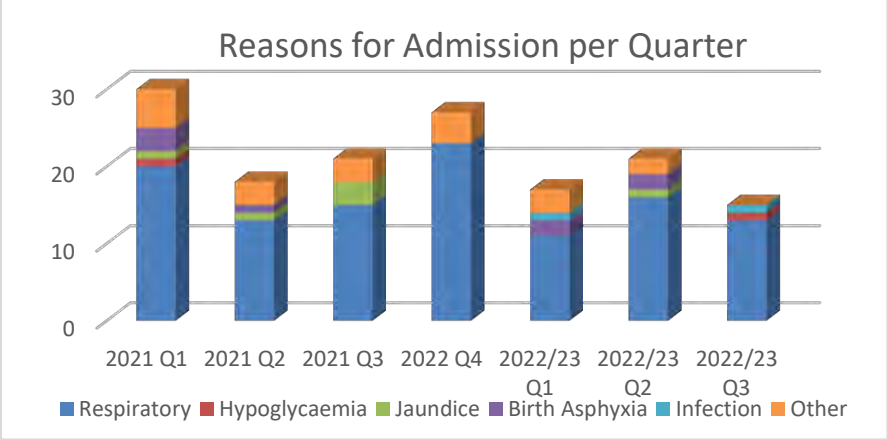
December 22

- 3 of 4 babies were admitted to NNU with signs of respiratory distress
- All 3 treated with oxygen and IV antibiotics
- 2 of the 3 babies on IV antibiotics had known risk factors for sepsis
- 2 were born by caesarean section and 2 were born vaginally (one requiring forceps)

9. Quarterly Comparison

The chart below shows the reasons for admission per quarter in the 2021-2022 and 2022-23 year; demonstrating respiratory issues as the predominant reason for admission each quarter. No underlying common theme has been identified to date though it was noted that over 50% of babies admitted with respiratory concerns had recognised risk factors.

Figure 3: Reasons for Admission - Quarter by Quarter comparison



10. Transitional Care admissions via NNU

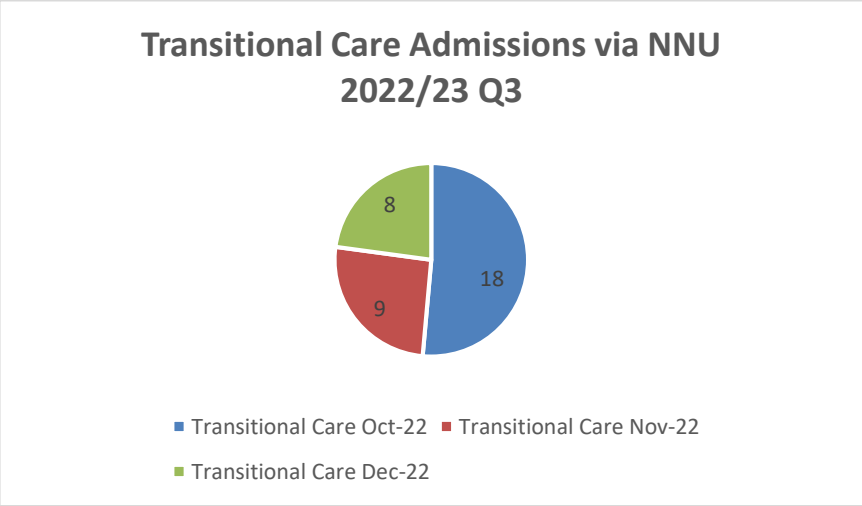
Since May 2022; new national guidance recommends that all babies attending or admitted to the NNU for any period of time should be reviewed, in some form, as part of the ATAIN project. This includes any baby who visits the NNU prior to being admitted to transitional care, and any baby who attends NNU for care while an inpatient on the unit.

Further guidance from the regional clinical oversight group has clarified that any baby who attends NNU for care, without being admitted, (e.g. IV cannulation, repeat blood test) should have the following information recorded: parental accompaniment, reason for attendance and any themes or learning identified. Only babies who are admitted to NNU should be reviewed under the ATAIN framework which continues to involve a detailed review of antenatal, intrapartum and postnatal care using a new national proforma.

The Neonatal Unit are currently recording any short term NNU attendances from babies undergoing inpatient care on the maternity unit (under TC or Midwifery care) along with parental accompaniment data that is being reported to the East of England Neonatal operational delivery network on a monthly basic (commenced July 2022).
Since December 2022 transitional care is now able to run 24/7 on the postnatal ward. This is expected to reduce the number of infant/parent separation episodes, with the majority of medications and blood tests now able to be undertaken on the ward, reducing the need for babies to physically attend the NNU and thus reducing separation from the mother.

A number still require brief admission to NNU (<4 hours) prior to admission to TC; in the majority of cases for initial cannulation for septic screen or short-term observation.

The charts below detail the infants who attended NNU this quarter prior to transfer to Transitional Care.



11. Quality improvement in this quarter

Thermoregulation QI Project
There is a continued drive raise awareness and to improve admission temperatures of babies admitted to NNU at term, with a QI project ongoing.
This quarter has resulted in 0% of admissions with a sub-optimal body temperature which is a substantial improvement compared to previous quarters. The QI project will continue with further actions developed to help maintain awareness around the unit with the aim of sustaining optimal body temperatures for all infants.

Quarter 4 (2021/22)	**No. of babies with sub-optimal temp (≤36.5)**	**%**
January 2022	2/10	20%
February 2022	5/13	38%
March 2022	1 /4	25%
Quarter 1 (2022/23)		
April 2022	2/9	22%
May 2022	2/6	33%
June 2022	1/2	50%
Quarter 2 (2022/23)		
July 2022	2/6	33.3%
August 2022	1/3 (2 additional admissions for cooling not inc)	33.3%
September 2022	3/10	30%
Quarter 3 (2022/23)		
October 2022	0/8	0%
November 2022	0/3	0%
December 2022	0/4	0%

12. Current/On-going Actions

Action	Plan	Comments
Raising awareness among the maternity team	• Educational piece in Risky Business • Message in Take 5	Monthly updates from ATAIN and learning in Risky Business – **Monthly Action**
Instructions added to Warming Cots on F11	• Add instructions to all warming cots to ensure correct usage of equipment	Updated warming cot instructions added to warming cots on unit. **Action completed.**
Explore possibility of procurement of Towel Warmer for Theatre	• Towel warmer for Theatre/LS	For Theatres/LS. Promote maintainance of appropriate temperature at delivery and in early newborn period. **In-progress**
Information videos for Staff facebook page	• Informational video "Thermoregulation of the Newborn" on staff facebook page.	Video awaiting sign off. **In-progress**
Handover "Hot Topic"	• Remind staff at handover about importance of keeping babies warm (in Theatre, LS and F11)	Facilitated by inpatient matron in communications to Band 7 area leads. **Action Completed.**

Parental Education Poster/Leaflet	• Poster/Leaflet to display in LS rooms/F11 bays to increase awareness in parents	In development. **In-progress**
Parental Education – Cot Cards "Keep me Warm"	• Cot cards for all cots on LS, MLBU and F11	**Action completed**
Signs for Resuscitaires demonstrating how to keep babies warm	• Posters made with visual aid for resuscitaires in Theatre, LS and MLBU	**Action Completed**

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

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ATAIN Programme

Avoiding Term Admissions to the Neonatal Unit

Project commencement date: September 2018

ROLLING ACTION PLAN from January 2022

Background to project

Trends and admission rates
Between 2011 and 2014, the number of term (at or over 37 weeks gestation) live births in England declined by 3.6%, but the number of admissions of term babies to neonatal units increased to 24% with a further increase of 6% in 2015.

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.

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

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

Local reviews
For all unplanned admissions to the neonatal unit for medical care at term, a joint clinical review by maternity and neonatal services takes place each month to identify learning points to improve care provision, and considers the impact that transitional care service has on reducing admissions and identifies avoidable harm.

Learning is identified and included on a rolling action plan.

The review group includes:
Neonatal ward manager / neonatal practice development nurse
Clinical risk manager / clinical risk midwife
Consultant paediatrician
Consultant obstetrician (may review records outside of the ATAIN meeting)

The review meetings commenced September 2018.

Process for review
The neonatal and midwifery team reviews the mothers and neonates notes prior to the ATAIN meeting using the approved NHS improvement tools. Notes identified which require in depth obstetric review are taken to the weekly Maternity Case Management meeting for multi-professional review to determine if different care in labour may have prevented admission.

Learning and improving
Learning identified at each ATAIN meeting is shared according to the nature of the learning. The NNU manager shares learning with the NNU nursing team via weekly 'Wise Words' read out at handover times, and via a Whatsapp group that all of the nursing team subscribe to.

Midwives receive key messages via 'Take 5' and in the monthly maternity publication 'Risky Business' which is circulated among the whole maternity team, as well as the consultant paediatricians.

A monthly report is produced following each meeting, and the rolling action plan is updated as actions are agreed. The monthly reports are shared with the Paediatric Service Manager, the Paediatric Safety Champion, the Clinical Risk Manager and other members of the maternity quality and safety team.

From December 2020, a quarterly progress report will be shared with the board level Safety Champion.

CURRENT ACTION LOG ATAIN Project January 2022-December 2022					
Date	**Issue**	**Action**	**Due**	**Status**	**Evidence of completion**
January 2022	Insertion of UVC	Highlight issue to individual practitioners and familiarise with guidelines	Within 3 months	**Completed**	Feedback and training by Dr Mohammed.
February 2022	Learning: GBS status not updated on eCare and buff notes	Issue highlighted in Take 5 and Risky Business	Within 3 months	**Completed**	Take 5 - 18/03/22 Risky Business  03 Risky Business MARCH 2022 .pdf 15/03/22
	Learning: Low birth weight centile not recognised as requiring admission to NNU	Issue highlighted in Take 5 and Risky Business Feedback to Paediatric Team	Within 3 months	**Completed**	Take 5 – 18/03/22  04 Risky Business APRIL 2022.pdf Risky Business – April (pages 1-2) NNU comms
March 2022	Sub optimal body temperatures on admission to NNU	Procurement of Towel Warmer for Theatre/LS	31/03/23	**Partially completed** **(purchase pending)**	Costing for towel warmer completed. Funding approved.

					Purchase now with Procurement and Friends of West Suffolk
		Instructions attached to warming cots.	30/04/22	**Completed**	Instructions for warming cots in situ.
		Educational piece in Risky Business	30/04/22	**Completed 30/04/22**	04 Risky Business APRIL 2022.pdf Risky Business – April (pages 1-3)
		Message on Take 5	30/04/22	**Completed 14/04/22**	Take 5 April 14/04/22
	Consistent information regarding antenatal steroids.	Information sheet in line with RCOG guidance to be produced for clinicians.	31/12/22	**Completed**	Steroids Leaflet.pdf

April 2022	Multiple cannulation attempts before switching to IM administration of Antibiotics.	Issue highlighted in Risky Business Feedback to be given to team by Neonatal Lead	30/06/22	**Completed 30/06/22**	Risky Business 06 Risky Business JUNE 2022.pdf
	Vapotherm commenced at 6 litres/min (Vapotherm guidance recommends between 6-8 litres/min) but local preference is to commence at 8 litres.	Issue highlighted in Risky Business Feedback to be given to team by Neonatal Lead	30/06/22	**Completed 30/06/22**	06 Risky Business JUNE 2022.pdf
May 2022	Increase awareness around thermoregulation (ongoing drive)	Risky Business	30/06/22	**Completed**	06 Risky Business JUNE 2022.pdf
June 2022	Thermoregulation of the newborn	Information video for staff facebook page	31/12/22	**In-Progress**	

		Parental education poster/leaflet	31/12/22	**In-Progress**	
		Handover “Hot Topic”	30/06/22	**Completed**	Not evidenced.
	Syringe/Cup Feeding in the Community	New infant feeding guideline to contain guidance around syringe and cup feeding outside of the immediate postnatal period	30/09/22	**Completed July 2022**	Completed July 2022 Infant feeding - West Suffolk NHS.p
August 2022	Throat swab omitted from septic screen (no impact on outcome but point of learning)	Septic Screen Audit	31/12/22	**No longer Applicable**	After further discussion with the labour suite lead consultant and taking advice e from the Trust sepsis specialist nurse it was decided that throat swabs are only necessary as part of a septic screen where the woman is symptomatic (sore throat) or

					has had known contact with someone with step A infection. This has been communicated in Risky Business – September 2022 issue.
Sept 2022	Opportunities for learning noted during review (which did not impact on need for admission). • Need to prioritise cord gasses where indicated • Correct use of Oxygen Sats monitor • Utilisation of CFM monitoring • Improved detail in documentation	"Learning from ATAIN" in Risky Business	31/11/22	**Completed**	November 2022 Risky Business

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ARCHIVED ACTION LOG ATAIN PROJECT December 2018 –

ATAIN Meeting	Issue	Action	Due	Status	Evidence of completion
December 2018	Raise awareness among staff about the ATAIN project	Informative article in Risky Business	**Completed**		Risky Business December 2018.pdf
December 2018	Immediate action for the management of hypoglycaemia is immediately accessible in relevant areas	Laminated pathway visible on Labour Suite and F11	**Completed**		Pathway printed, laminated and displayed in clinical areas (see page 12 of embedded document) Hypoglycaemiainthe NewbornBabyJuly 20.
December 2018	Highlighted at the ATAIN meeting that input by medical staff onto BadgerNet is not accurate with regards to whether a baby is a TC or NNU admission.	Consultant paediatrician to email Paediatric staff to ensure this is correct.	**25/02/19**	**Completed**	admissions to transitional care.msg
February 26th 2019	ATAIN action plan to be signed off by the Trust board. CNST requirement	Rolling Action Plan sent to Trust board for sign off.	**01/03/19**	**Completed**	Sign of action plan Trust board.docx

February 27th 2019	Meeting with Liz Langham Neonatal Network Director CNST requirement	Action plan verbally signed off by ODN at meeting.	**27/02/19**	**Completed**	No minutes available
ATAIN Meeting	**Issue**	**Action**	**Due**	**Status**	**Evidence of completion**
February 27th 2019	Compliance with the British Association of Perinatal Medicine BAPM Transitional care.	Changes made to current operational policy for Transitional care. Agreed changes to criteria with Neonatal Network Director.		**Completed**	 Transitional Care Operational Policy for
	Improve communication in relation to plans of care for Neonates in TC between Neonatal nurses and Midwives.	08.30 Huddle between Midwife care of Mother and NNU care of baby. Repeat huddle following morning paediatric consultant round. Discussion and following paediatric ward round. • Included on Take 5 Maternity. • Wise Words neonatal publication	04/3/19	**Completed**	 Wise Words Feedback.pdf  Take 5.docx
March 7th 2019	Action to be signed off by the Local Maternity System. CNST requirement	Signed off by LMB (Local Maternity Board)	07/03/19	**Completed**	No minutes available

2nd April 2019	Emerging theme identified as a result of monthly ATAIN meetings: low admission temperatures to NNU, indicating a potentially avoidable factor.	Raise awareness among midwives of the importance of keeping babies warm. Risky Business and Take 5	04/04/19	**Completed**	Take 5.docx Informative article published in RB (see page 2) Risky Business 04 APRIL.pdf
ATAIN Meeting	**Issue**	**Action**	**Due**	**Status**	**Evidence of completion**
1st May 2019	ATAIN action plan to be signed off by the Trust board. CNST requirement.	Action plan sent to the Scrutiny Committee meeting	19/05/19	**Completed**	Minutes of inclusion in the scrutiny committee.
24th May 2019 (review of cases for March and April)	Where there are concerns about persistent abnormal observations (in this case elevated respiratory rate) on the postnatal ward, it is appropriate for the baby to be reviewed by a senior paediatrician (SpR) to consider admission to TC or NNU as appropriate.	Consultant Paed to meet with SHO to discuss case to facilitate reflection and learning	28/6/19	**Completed**	Verbal confirmation of feedback / supported reflection with SHO.
	NNU Manager to provide feedback to nurse responsible for lack of contemporaneous record keeping during episode of care. This made it very difficult to assess the reason	NNU Manager to provide individual feedback	30/6/19	**Completed**	Verbal confirmation of completion at ATAIN meeting

	why the baby could not have been transferred to TC.				
	Because midwives may seldom use warming cots, ensure that the appropriate instructions are attached to each unit.	Clinical Risk Midwife to ensure that clear instructions are attached to each unit	30/6/19	**Completed**	Clear instructions about the correct procedure and process for weaning from the warming cot are included in the Neonatal Guideline 002 'Warming Cot Use'. This has been laminated and attached to each warming cot that is used on F11.
	ATAIN monthly meetings have highlighted that further work is required to reduce admissions related to hypothermia and hypoglycaemia.	Implement a task and finish working group to identify and co-ordinate any changes to guidelines, documentation or approaches to reduce term neonatal admissions		**Completed**	First month's minutes, June 2019. This document details the plans agreed (see specific actions in September 2019)  Minutes T&F group June 2019.doc
ATAIN Meeting	**Issue**	**Action**	**Due**	**Status**	**Evidence of completion**
19th September 2019	Actions agreed at task and finish group (Reducing term admissions). All to be completed by the next meeting on 29.10.19	Present the proposed new infant risk pathway and NEWTT chart at the next Paediatric Governance Meeting	29/10/19	**Completed**	 Minutes T&F group SEPTEMBER 2019.doc

		Complete audit of newborn temperatures Labour Suite / F11	29/10/19	**Removed**	**September 2020** This was not completed as agreed, but when the Newborn Risk Pathway was implemented in December 2019 the need for this audit was reduced because all babies now have their temperature recorded at 1 hour and 2 hours of age. NEWTT charts are currently being regularly audited. Therefore this action has been closed.
		Investigate whether oxygen saturations can / should be included in routine observations	29/10/19	**Completed**	BAPM guidelines were consulted and as a result, it was subsequently agreed that they must form part of the NEWTT system, and SaO2 monitors would be purchased for F11 and Labour Suite.
		The hypoglycaemia management guideline is overdue for review. Currently our management is not in accordance with BAPM guidelines, but there are several reasons for this	29/10/19	**Completed**	No Paediatrician came forward to lead on this and therefore the T&F group agreed that the guideline should be updated in line with BAPM guidelines, and circulated for comments in

		(including resources). **It was felt that the review of this guideline must take place at the earliest opportunity, but this needs to be led by a senior paediatrician.** It was agreed that this will be raised this at the next quality meeting in order for a lead to be allocated. *Update to be given at next meeting.*			accordance with usual procedure. This guideline was approved in February 2020. A significant amount of work was required before the guideline could be implemented – for example, development and ratification of a PGD for glucose gel, education and training of staff, etc. MAT0077 Prevention, detectior
29th October 2019	Actions agreed at Task and Finish Group	Develop PDSA to trial the Newborn Risk Pathway	30/11/19	**Completed**	Version 1 of the newborn risk pathway developed in October 2020. Ratified at paediatric and obstetric governance meetings November 2020. Implemented in December 2019, and feedback collected, table-top audit completed to assess if the pathway was being completed correctly.

					PDSA Cycle 1 Newborn Risk Pathwa As a result of the PDSA cycle, version 2 was agreed and implemented Newborn Risk Pathway, Version 2, I
		Update 'Prevention, Detection and Management of Hypothermia in the Newborn Baby' MAT0078 to include guidance about the use of warming cots and to reflect the changes that will be made by the implementation of the Newborn Risk Pathway (in progress since last meeting and almost complete). Submit the updated guideline for circulation at the earliest opportunity.	30/11/19	**Completed**	MAT0078 Prevention, detectior
10th December	Hypothermia and Hypoglycaemia to be added to the midwifery mandatory training programme for	Hypothermia and Hypoglycaemia to be added to the midwifery mandatory	31/12/19	**Completed**	It has been agreed and arranged that this training will be delivered by the

	the coming year in order to raise awareness and improve midwives' and understanding and management.	training programme for the coming year (2020).			NNU Manager and the NNU Practice Development Nurse. This training is once monthly and all midwives attend during the course of a year (commenced December 2019) The most effective way to assess if this training is embedded will be to look at the impact on the rate of term admissions subsequently.
March 2020	Ongoing challenge with identifying accurate data for NNU admissions / TC admissions. This is because it relies on the data being entered manually by the doctor at the time of admission, and their understanding of the 4 hour threshold. This does not affect the figures, but wastes time because the NNU manager has to go through the notes to each case and correct the data prior to each meeting.	Begin providing feedback to *individuals* about clearly recording the time that a baby is transferred to TC until the practice is embedded.	30/4/2020	**Completed**	Verbal confirmation from NNU manager that feedback is directed at individuals to support learning and improve the use of the systems in place. Due for re-assessment after at least 3 months to assess if this has improved. October 2020: No ongoing improvement, especially since doctors have rotated since this initial action.

					Posters displayed on NNU to raise awareness and improve correct documentation.
		Remind staff about the importance of using the Obstetric Sepsis Screening Tool to identify women and babies at risk of sepsis at the earliest opportunity.	30/4/2020	**Completed**	ATAIN monthly report MARCH 2020.p The sepsis guideline was updated and ratified in May 2020. This gives clear guidance on how to use the obstetric sepsis screening tool. MAT0113 Maternal Sepsis Prevention Re
		A summary of the guidance about paediatric attendance at deliveries to be circulated to Paediatricians as a reminder.	30/4/2020	**Completed**	**Paediatric attendance at deliver** This is also detailed within the following guidelines: • MAT0073 Newborn Basic Life Support • MAT0060 Meconium Stained Liquor
April 2020			30/6/2020	**Completed**	

	Key learning message identified during review of ATAIN cases: When neonatal oxygen saturations are low, the first action should be to take a baby to a resuscitaire and administer oxygen whilst an emergency call is put out to the paediatrician.	Add to midwives mandatory training update (given by NNU Practice development Nurse)			PDN informed via email and agreed to include oxygen saturations and when to commence oxygen therapy in the mandatory training programme for midwives. No adverse outcome was associated with this learning, therefore the aim is to raise awareness to reduce the risk of adverse outcome.
		Inform Practice Development Midwife about this issue.	30/6/2020	**Completed**	PDM informed and agreed to email all midwives to raise awareness of this practice issue to reduce the risk of repeat occurrences that could result in adverse outcomes  RE Practice issue identified as part of A
May 2020	Share feedback from the review of April and May cases via Risky Business.	Risky Business	10/7/2020	**Completed**	 06 Risky Business JUNE 2020.pdf

					(page 5)
	Feedback learning from ATAIN to NNU nursing staff via 'Wise Words'. • A reminder about the aims and objectives of the ATAIN project – i.e. keeping mothers and babies together. Although offering to keep babies on NNU to let Mum rest is done out of kindness, it works against the overall benefits of reducing separation, and can have a negative impact on breastfeeding. • Formula should only be offered to breastfeeding babies when it is clinically indicated. Please avoid calculating the amount of formula the baby should have per feed based on fully formula fed babies when the mother intends to breastfeed. This will have a negative impact on her attempts to breastfeed. • In one case a breastfeeding baby was commenced on phototherapy. The records indicate that the baby was placed on 'full bottle top-ups'. There was further discussion about whether this was clinically indicated or appropriate for a breastfeeding baby, and it	Wise Words (NNU)	30/6/2020	**Completed**	The NNU manager usually shares information with the nursing team via a system called 'Wise Words' key messages each week, shared at handovers. During the pandemic, many staff are shielding or working from home. Therefore, a private Whatsapp group for all NNU nursing staff has been set up so that key messages can be disseminated regardless of where members of the team are working. These messages were shared via the Whatsapp NNU nursing group in June.

	was agreed that it was not. More could have been done to facilitate an infant feeding plan that supported the establishment of breastfeeding, whilst also treating the jaundice. • In another case HiFlow was commenced based on a blood gas result. It was documented that the baby's foot was cold. On reflection, it was discussed that taking the full clinical picture into account, it would have been appropriate to have warmed the baby's foot and repeated the test. There was no harm caused by commencing the oxygen, but there are implications for parental anxiety and the experience for the baby.				
	Discussion about infant feeding training for Paediatricians has highlighted that the current set of trainee Paediatricians have not been registered onto the e-learning system used, but they need to complete this training at the earliest opportunity. Responsibility for keeping the system updated and for monitoring compliance needs to be clearly defined.	Liaise with the Paediatric department to ensure that all doctors are able to access the e-learning, and are informed of the requirement for them to complete it.	31/7/2020	**Completed**	Escalated at Paediatric Governance Meeting

	Other Paediatric learning points: • One of the potentially avoidable admissions was over-medicalised. On reflection, the Consultant Paediatrician present felt that alternative courses of actions could have been considered. The risk of a baby becoming unwell with sepsis is greatest within the first 24 hours, and this baby was commenced on the sepsis care pathway at around 48 hours. It may have been appropriate to have involved a more senior Paediatrician in the care plan for this baby.	Supportive discussion with the Paediatrician involved	24/7/2020	**Completed**	Verbal confirmation of completion received from Consultant Paediatrician
September 2020	Produce a report that summarises the progress, successes and challenges of the ATAIN project so far.	Present information at Clinical Governance Steering Group meeting, and add as an item on the agenda at the next Safety Champions meeting	31/10/20	**Completed**	Presentation scheduled for Nov CGSG meeting Added to the agenda for the Nov safety champions meeting
October 2020	Explore the possibility of providing all women who have risk factors for neonatal hypoglycaemia with information about the benefits of hand expressing during pregnancy and freezing colostrum for their	QI project to offer women with pre-existing risk factors for neonatal hypoglycaemia information about colostrum harvesting requires: • PDSA	30/11/20 Agreed project	**Completed**	It has been agreed that this will form the basis for a quality improvement project with a lot of potential:

	baby at birth. Currently this information is given to women with Diabetes only (at the Med Obs clinic)	• SOP • Written information for parents • Milk freezer to be installed on the postnatal ward • Education and training for midwives • Audit process	For implemetation ASAP		• Improving breastfeeding rates • Reducing supplementation rates • Reducing term neonatal admissions (and separation of mothers and babies) The Clinical Quality Assurance Midwife will be supporting the Infant Feeding Co-ordinators with this project. Antenatal expression kits now available for women with risk factors e.g. Diabetic
	Address increase in number of babies admitted to NNU associated with hypothermia.	Share learning with the wider team Risky Business	20/11/20	**Completed**	10 Risky Business OCTOBER 2020.pdf Page 2
November 2020	Two potentially avoidable admissions identified (both babies on Red Teddy care pathway). Learning identified for these specific cases, but it was agreed that it would be useful to evaluate if	Tabletop audit to evaluate the care provided to babies with risk factors for hypoglycaemia.	12/01/21	**Completed**	Tabletop audit held 1st January. Red teddy pathway Tabletop audit SP.doc

	there are recurring themes, etc. in babies who avoid admission.				Report shared with ANC team lead, Inpatient Service Manager, LS Manager, F11 ward manager on 15/01/21 to implement improvements and share learning with their teams.
	Share learning with the wider team	Risky Business	31.12.21	**Completed**	11 Risky Business NOVEMBER 2020.pdf Page 2
January 2021	Learning identified: Opportunities missed by midwives to treat hypoglycaemia with Glucose gel. This has been part of local guidance since February 2020. There appears to be tendency for midwives to feel more confident to escalate to the paediatrician first and see what they advise, but this delays administration and treatment.	Publish a clear, step by step guide with photos of how to administer Glucose gel (with a reminder about the indications). Also display as posters in clinical areas.	15.1.21	**Completed**	12 Risky Business DECEMBER 2020.pdf Page 2
		Risky Business	12.3.21	**Completed**	

	Following publication of the quarterly ATAIN report (shared with Safety Champions), publish a general progress update for the wider team.				01 Risky Business JANUARY 2021.pdf (Page 2)
	Publish case study with significant learning for midwives.	Risky Business	12.3.21	**Completed**	See link above (page 3)
February 2021	Learning identified: Opportunities missed by junior paediatricians to admit a baby with persistent hypoglycaemia to NNU for urgent treatment	Email to Paediatric team to highlight this learning	10.4.21	**Completed**	Also reported to Clinical Risk Manager for inclusion in March Paediatric Governance meeting agenda.
March 2021	Learning identified: a term baby was identified to have an imperforate anus, and needed to be transferred for specialist care and surgery. It would be expected that this congenital abnormality would be detected on routine examination by the midwife at birth, or by the paediatrician who performed the NIPE examination. The baby had a small fistula which resulted in meconium staining in the nappy – this may have led to false reassurance that the anus was patent, and therefore the importance of careful visual	Email to paediatric team to highlight learning message Inform NIPE lead midwife of this important learning, so that it can be disseminated among NIPE trained midwives.	30.4.21	**Completed**	**ATAIN monthly report - March term a** **Dissemination of learning for NIPE trair**

	examination, regardless of the presence of meconium.				
April 2021	Raise awareness among the maternity team about the role of the Physician's Associates who work within the paediatric team.	Risky Business	30.5.21	**Completed**	04 Risky Business APRIL 2021.pdf (page 3)
May 2021	Theme identified: 40% of the babies admitted this month had low admission temperatures. Two of the babies were born in theatre at a time when it had been recorded that the theatre temp was only 21 degrees.	• Wise words • Take 5 – urgent message • Share learning about theatre temperature with Theatre Team Lead, Labour Suite team, and Obstetricians. • Display poster next to air condition control unit in theatre (displaying correct temp range) • Share learning with senior midwives on Labour Suite (air conditioning in birth rooms). • Continue to record admission temperatures for term admissions as part of ongoing monthly reviews in order to monitor this closely.	30.6.21	**Completed**	**Take 5 for the Week beginning 28** **Sharing learning between maternity a** **Important problem - help please.msg** THEATRE POSTER.docx **Important problem - help please MW.m** **RE Success! Thank you.msg**

June 2021	Improve accuracy of electronic data for NNU admissions	Assign responsibility to check that every baby has been correctly admitted to either NNU or TC on a daily basis (Mon-Fri) to ward clerk on NNU. Correct errors on a daily basis so that the data is accurate by the end of each month. Ensure that the time of transfer to TC is accurately recorded on e-care.	31.12.21	**Completed**	Confirmation of action closure.msg Continued monitoring of data accuracy at monthly ATAIN meetings.
	Key message from review of one case: grunting that persists beyond the first hour, and especially beyond 4 hours should be immediately actioned by admission and assessment, and close observation.	• Support reflection and learning with the individual • Highlight this learning to the whole team (email)	31.7.21	**Completed**	Confirmation from Dr. Evans
	Use the same case as a case study to support learning and improvement	Risky Business	6.8.21 (S. Paxman)	**Completed**	07 Risky Business JULY 2021.pdf
	Audit birth room temperatures on Labour Suite (snap shot audit over period of one week	Audit to be conducted by senior midwives on Labour Suite	31.8.21 (SP)		This was attempted in the last week of July, but unfortunately not well completed due to understaffing on Labour Suite. The data was not of sufficient quality to draw any significant conclusions.

					However, the exercise did raise awareness about the importance of maintaining warm rooms when mothers are labouring. Since then, there has been a significant improvement and not one baby hat has been admitted to the NNU has had a low body temperature.
September 2021	Positive feedback provided to midwives, theatre staff, NNU teams and anaesthetists regarding the dramatic improvement in body temperatures for babies admitted to NNU. (Previously identified as a theme for improvement in May 2021)	Share improvement and thanks at Labour Ward Forum	08/10/21 (SP)	**Completed**	Very well attended meeting. The theatre manager agreed to share thanks and feedback with the theatre team, who have played a key role in this success. The NNU manager will thank and update the NNU nurses who have been really key to this improvement.  RE Success! Thank you.msg
			27/09/21 (SP)	**Completed**	

	Learning identified from review of term admissions during September. • Very difficult to piece together events as midwives recording neonatal records on mother's record. • This has resulted in inadequate information in the neonatal records	Highlight this documentation issue to midwives via Take 5			Take 5 27th Sep.docx
	Learning: It is documented that a mother was given the standard postnatal leaflet on discharge, but not the one specifically about jaundice. The postnatal leaflet does have information about jaundice, but the other one makes a bigger impact because it has colour photos of jaundice. This should be given to all parents on discharge – and is especially important when a baby has risk factors for jaundice.	Feedback this learning to F11 ward manager and Digital Midwife	10/10/21	**Completed**	**F11 ward manager feedback.msg**
October 2021	Addition of terminology 'Unavoidable admission' into questions relevant to the case as it was felt that appropriate admission did not reflect whether the admission could have been avoided	Update of questions to reflect change in terminology	10/11/21	**Completed**	Well turned out meeting with good representation from MDT team for shared learning and development

	Some discrepancies highlighted in frequency of some observations/BG etc and the use of the RED/AMBER/GREEN teddy pathway between services	Review of guidelines to ensure that care specific standards (frequency of obs, BG etc) are consistent throughout both NNU and maternity services taking into account individualised care plans	Aim initial review within 3 months	**Completed**	No subsequent issues identified. Green/Amber or Red Teddy pathways of care consistent between services.
December 2021	No clarity on Decision to Delivery time if emergency is downgraded.	Guideline amendment to include consideration of decision to delivery time when a case is downgraded/upgraded.	Within 3 months	**Completed**	CG10532-1 Assisted Vaginal Birth.pdf
	No clarity on when to start IV abx for known GBS women at term once SROM is confirmed and prior to IOL	Review local guideline to ensure clarity in line with RCOG recommendations.	Within 4 months	**Completed**	CG10620-2Prevention ofearlyonsetGBSc

Requirements number	Safety action requirements	Yes/ No /Not applicable
Can you evidence that:		
1	A local training plan is in place to ensure that all six core modules of the Core Competency Framework, will be included in your unit training programme over 3 years, starting from the launch of MIS year 4 in August 2021. should include the following 6 core modules: • Saving Babies Lives Care Bundle • Fetal surveillance in labour • Maternity emergencies and multi-professional training • Personalised care • Care during labour and the immediate postnatal period • Neonatal life support	**Yes**
Can you demonstrate at the end of 12 consecutive months within the period of 1st August 2021 until 5th December 2022, 90% of each relevant maternity unit staff group has attended an 'in house' one day multi-professional training day, that includes maternity emergencies?		
2	90% of Obstetric consultants?	**Yes**
3	90% All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota, including GP trainees?	**Yes**
4	90% Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives)?	**Yes**
5	90% of Maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum)?	**Yes**
6	90% of Obstetric anaesthetic consultants?	**Yes**
7	90% of all other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) contributing to the obstetric rota?	**Yes**

Can you demonstrate at the end of 12 consecutive months within the period of 1st August 2021 until 5th December 2022, 90% of each relevant maternity unit staff group attended an 'in-house' one day multi-professional training day that includes antenatal and intrapartum fetal monitoring?		
8	90% of Obstetric consultants?	**Yes**
9	90% of all other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota?	**Yes**
10	90% of GP trainees who have any obstetric commitment to intrapartum care?	**Yes**
11	90% of midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives). Maternity theatre midwives who also work outside of theatres (if applicable)?	**Yes**
12	Are fetal monitoring sessions consistent with the Ockenden Report recommendations, and include: intermittent auscultation, electronic fetal monitoring with system level issues e.g. human factors, escalation and situational awareness?	**Yes**
13	Has the Trust board specifically confirmed that within their organisation 90% of eligible staff have attended local multi-professional fetal monitoring training annually as above?	**Yes**
Can you demonstrate at the end of 12 consecutive months within the period of 1st August 2021 until 5th December 2022, 90% of the team required to be involved in immediate resuscitation of the newborn and management of the deteriorating newborn infant have attended in-house neonatal life support training or a Newborn Life Support (NLS) course?		
14	90% of neonatal Consultants or Paediatric consultants covering neonatal units	**Yes**
15	90% Neonatal junior doctors (who attend any births)	**Yes**
16	90% of Neonatal nurses (Band 5 and above)	**Yes**
17	90% of advanced Neonatal Nurse Practitioner (ANNP)	N/A
18	90% of midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) and Maternity theatre midwives who also work outside of theatres.	**Yes**

Maternity Incentive Scheme

Safety action 8: Multi-professional maternity training

Report Title	**Safety action 8: Multi-professional maternity training**	
Report for	Approval and Information	
Report from	Maternity Services	
Lead for Safety Action	Training leads	
Report Author	Beverley Gordon, Project Midwife Georgie Brown, Training Lead, Women's and Children	
Report submitted for approval	Maternity & Gynaecology Quality & Safety	19/12/22
	Maternity & Neonatal Safety Champions	22/12/22
	Trust Board	16/1/23 (Improvement Committee) and 2/2/23 (Trust Board)

Executive Summary

The local training programme has been approved and embedded to provide the training programmes required for the next 3 years to cover the 6 core modules. This was updated in August 2022 to extend the multiprofessional day to include fetal monitoring training as part of the day.

The attendances at the parts of the training day which include obstetric emergencies and neonatal life support are compliant with 90% or more of each of the relevant staff groups for each element of training.

The Trust has not had the fetal monitoring training as part of the one-day in-house multiprofessional training day for the whole of 2022 as this required a major change to the schedules and there were changes to the staff in post for specific lead roles. Following review of attendance at training sessions and completion of modules, that have taken place across the 3 mediums - cases reviews, K2 training and the sessions introduced on the training day since August, it is considered that these constitute equivalent compatibility with the overall philosophy and training programmes required to maintain safety. Using all these training elements and formats, more than 90% of each staff group have attended the equivalent fetal monitoring over the 12-month period and therefore it is assumed that the Trust can provide sufficient assurance to demonstrate compliance with this element of Saving Babies Lives Element 4 and Safety Action 8 of the Maternity Incentive Scheme.

In the absence of obstetricians and anaesthetists being candidates, it is our assumption that the obstetrician and obstetric anaesthetist who are part of the faculty for the multidisciplinary (MDT) training, will provide assurance that the sessions are compliant with the MDT element of the training days.

Next Steps

The maternity services are progressing against the 3 year training plan and will continue to plan for all staff to be compliant with this essential training against the trajectory.

The processes for escalation of non-compliance of non-compliance or non-attendance and having a consistent recording process for all training is being enhanced to ensure that there is early recognition and management of situations that may impinge on safe practice.

Multi-professional Maternity Emergencies Training

1. Introduction

The Maternity Incentive Scheme run by NHS resolution is in its fourth year and builds on the progress made in the previous 3 years. The safety action that this report relates to - Safety Action 8 - to ensure that the Trust has processes in place to train and maintain competence of all staff who are involved in providing clinical care to women and neonates within the maternity and neonatal services provided by the Trust.
Year 4 safety actions were published in August 2021 but in December 2021, the requirements for evidence and submission were put on hold due to the effects of the pandemic on maternity services across the country. In May 2022, the safety actions were republished with updated timeframes and requirements where required and then further updated in October 2022. This report outlines the compliance with required standards for training programmes and attendance at key multidisciplinary training sessions.

2. Standards for Safety Action 8

Safety action 8: Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4?
In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?

3. Required standards and minimum evidential requirement

Can you evidence that:

a) **A local training plan** is in place to ensure that all six core modules of the Core Competency Framework, will be included in your unit training programme over the next 3 years

Six Core Modules:

- *Saving Babies Lives Care Bundle*
- *Fetal surveillance in labour*
- *Maternity emergencies and multi-professional training.*
- *Personalised care*
- *Care during labour and the immediate postnatal period*
- *Neonatal life support*

b) 90% of each relevant maternity unit staff group have attended an annual 'in-house' one day multi-professional training day, to include maternity emergencies starting from the launch of MIS year four

The one-day training programme should include training on:

- *Fetal monitoring and surveillance (in the antenatal and intrapartum period) (see c for detail)*
- *Maternity emergencies training scenarios*
- *Neonatal life support (see d for detail)*

There should be sharing of local maternal and neonatal outcomes, ideally benchmarked against other organisations with a similar profile. These data may be local, drawing on learning from case studies, incidents, exemplars or from National

programmes e.g. National Maternity Perinatal Audit (NMPA), Getting It Right First Time (GIRFT) and others.

Multi-professional maternity emergencies training

- *The training day should include 4 of the minimum requirements for multi-professional maternity emergency scenarios, as set out in the Core Competency Framework, with the aim that all scenarios will be covered over a 3-year period.*
- *The 4 scenarios will be based on locally identified training needs relating to emergency scenarios, drawing on learning from local serious incidents, near misses, audits and thematic reviews.*
- *At least one scenario should include a learning from excellence case study.*
- *At least one of the four emergency scenarios should be conducted in the clinical area, ensuring full attendance from the relevant wider multi-professional team. This will enable local system and environmental factors within the clinical setting to be considered, any risks and issues identified and an action plan developed to address these.*

c) 90% of each relevant maternity unit staff group have attended an annual 'in-house' one day multi-professional training day, to include antenatal and intrapartum fetal monitoring and surveillance, starting from the launch of MIS year four

Fetal monitoring and surveillance (in the antenatal and intrapartum period)
Should be consistent with the Ockenden Report (2021) recommendations, and include as a minimum:

- *Risk assessment*
- *Intermittent auscultation*
- *Electronic fetal monitoring*
- *System level issues e.g. human factors, classification, escalation and situational awareness*
- *Use of local case histories*
- *Using their local CTG machines*

d) Can you evidence that 90% of the team required to be involved in immediate resuscitation of the newborn and management of the deteriorating newborn infant have attended your annual in-house neonatal life support training or Newborn Life Support (NLS) course starting from the launch of MIS year four

Neonatal life support

- *All staff in attendance at births should attend local neonatal life support training every year.*
- *Attendance on separate certified NLS training for maternity staff should be locally decided but this would be the gold standard.*
- *Those attending a NLS programme every 4 years will attend annual local neonatal life support training in between.*
  Training should include as a minimum:

- *Preparing for neonatal resuscitation, including suitability of the clinical environment and preparing the resuscitation device(s)*
- *Identification of a baby requiring resuscitation after birth*
- *Knowledge and understanding of the NLS algorithm, annual updates should be following the latest NLS edition.*
- *The timing and how to call for help within the organisation*

- *Situation, Background, Assessment Recommendation (SBAR) or equivalent communication tool handover on arrival of help.*

Time frames

Compliance for 12 consecutive months from the launch of the Maternity Incentive Scheme (MIS) year 4 (August 2021) up until 5th December 2022.

4. Maternity and Neonatal Training Days at West Suffolk Hospital

There is a multidisciplinary obstetric emergency training day (PROMPT) which also includes the local neonatal life support training. The training is facilitated by members of the faculty and specialist leads. Up until August 2022, the **fetal monitoring training was not part of the training day** but was delivered by multidisciplinary case review/educational sessions and completion of the modules on the K2 training package – all of which met the requirements. From August 2022, the K2 training has been replaced with a 4-hour session on the emergency training day which meets the requirements. It was not possible to introduce this at an earlier stage due to staffing issues and staff being introduced into new roles.

The Trust has not had the fetal monitoring training as part of the one-day in-house multiprofessional training day for the whole of 2022 as this required a major change to the schedules and there were changes to the staff in post for specific roles. However, given that the training and competency assessments that have taken place across the 3 mediums of cases reviews, K2 training and the sessions introduced on the training day since August, it is considered that these constitute equivalent compatibility with the overall philosophy and training programmes required to maintain safety.

From January 2023, the K2 training modules will cease so that all the relevant staff will have 4 hours of case review/educational sessions and 4 hours training on the PROMPT day. For this part of the training report, we have provided a separate report on fetal monitoring requirements for element 4 of Saving Babies Lives.

Other core training sessions for Saving Babies Lives and other core topics are incorporated into the mandatory training at face to face sessions and as part of on-line training modules.

Attendance is recorded on training databases and processes are in place for escalation of non-attendance and non-compliance.

The neonatal life support sessions held locally are mandatory for all staff annually unless they are an NLS trainer or have updated their NLS certificate in that year. The training compliance has taken into consideration all these aspects of compliance.

5. Compliance with standards

Evidence Required	WSH compliance	Progress Report	Evidence Source
a) A local training plan is in place to ensure that all six core modules of the Core Competency Framework, will be included in your unit training programme over the next 3 years • Saving Babies Lives Care Bundle • Fetal surveillance in labour • Maternity emergencies and multi-professional training. • Personalised care • Care during labour and the immediate postnatal period • Neonatal life support	**GREEN**		Original training plan approved February 2022. Updated training plan from August 2022, formally approved November 2022
b) 90% of each relevant maternity unit staff group have attended an annual 'in-house' one day multi-professional training day, to include maternity emergencies starting from the launch of MIS year four			
Staff Group	**WSH compliance**	**Actions needed to address shortfall**	**Evidence Source**
➢ Midwives	**97.28%**		Training Database and quarterly reports with compliance submitted to MNSC/TB and LMNS The training programme includes the core elements required.
➢ Obstetric trainees	**92.86%**	Not Neonatal resuscitation	
➢ Obstetric Consultants	**100%**	Not Neonatal resuscitation	
➢ Obstetric Anaesthetic Trainees	**93.2%**	Not fetal surveillance or neonatal resuscitation	

➢ Obstetric Anaesthetic Consultants	**100%**	Not fetal surveillance or neonatal resuscitation	
➢ Maternity Support Workers and Health Care Assistants	**96.97%**	Not fetal surveillance or neonatal resuscitation	

c) 90% of each relevant maternity unit staff group have attended an annual 'in-house' one day multi-professional training day, to include antenatal and intrapartum fetal monitoring and surveillance, starting from the launch of MIS year four – see separate report for details

Staff Group	WSH compliance	Actions needed to address shortfall	Evidence Source
Midwives	**90.3%**	The training has been delivered across 3 methods of training this year. From 2023, the training will be 4 hours MDT case review sessions and 4 hours at the MDT training day. **Not all of the training has been part of the one-day training day.**	Training report
Obstetric staff – trainees	**93%**		
Obstetric staff – Consultants	**100%**		

d) Can you evidence that 90% of the team required to be involved in immediate resuscitation of the newborn and management of the deteriorating newborn infant have attended your annual in-house neonatal life support training or Newborn Life Support (NLS) course starting from the launch of MIS year four

Midwives	**97.28%**		Training Database and/or reports with compliance including NLS courses
Paediatric staff – trainees	**100%**		
Paediatric Consultants on NN rota	**100%**		
Neonatal Unit Nursing staff	**96%**		

Multi-professional attendance

In the absence of obstetricians and anaesthetists being candidates on the obstetric emergency training day, it is our assumption that the obstetrician and obstetric anaesthetist who are part of the faculty, will provide assurance that the sessions are multiprofessional and therefore the compliance with the MDT element of the training is met.

6. Conclusions

Much progress has been made in providing a training programme which meets the needs of the staff and the organisation. Attendance and compliance has shown significant progress over the last year and plans are in place to sustain this progress over the years to come.

The local training programme has been approved and embedded to provide the training programmes required for the next 3 years to cover the 6 core modules. This was updated in August 2022 to extend the multiprofessional day to include fetal monitoring training as part of the day.

The attendances at the parts of the training day which include obstetric emergencies and neonatal life support are compliant with 90% or more of each of the relevant staff groups for each element of training.

The Trust has not had the fetal monitoring training as part of the one-day in-house multiprofessional training day for the whole of 2022 as this required a major change to the schedules and there were changes to the staff in post for specific lead roles. Following review of attendance at training sessions and completion of modules, that have taken place across the 3 mediums - cases reviews, K2 training and the sessions introduced on the training day since August, it is considered that these constitute equivalent compatibility with the overall philosophy and training programmes required to maintain safety. Using all these training elements and formats, more than 90% of each staff group have attended the equivalent fetal monitoring over the 12-month period and therefore it is assumed that the Trust can provide sufficient assurance to demonstrate compliance with this element of Saving Babies Lives Element 4 and Safety Action 8 of the Maternity Incentive Scheme.

In the absence of obstetricians and anaesthetists being candidates, it is our assumption that the obstetrician and obstetric anaesthetist who are part of the faculty for the multidisciplinary (MDT) training, will provide assurance that the sessions are compliant with the MDT element of the training days.

7. Recommendations

Monthly monitoring of compliance with training as an overall, and highlighting individual requirements.

Confirm updated training and education SOP.

Enhance process for highlighting non-compliance with line managers and training leads.

Embed faculty meetings and forums to oversee training programmes and progress.

Explore recording of medical training requirements on ESR.

Improve compliance with the multi-professional aspect of the training days.

Appendix 1 Technical Guidance

Technical guidance	
What training should be covered in the local training plan to cover the six modules of the Core Competency Framework?	A training plan should be in place to cover all six core modules of the Core Competency Framework. The training plan will span a 3-year time period and should include the following 6 core modules: • Saving Babies Lives Care Bundle • Fetal surveillance in labour • Maternity emergencies and multi-professional training. • Personalised care • Care during labour and the immediate postnatal period • Neonatal life support
Core competency framework-maternal critical care What is the expectation of those unit that don't provide enhanced maternal critical care in the maternity setting?	This should relate to recognition of deterioration, escalation, stabilisation and monitoring of the woman until transfer takes place
Core competency framework – which modules should our unit focus on?	For MIS year 4, Trusts only need to focus on the 6 core elements – and do not require the 2 modules relating to directly to COVID care (core modules 7 and 8).
Covid-19 impact on training. Does 'in-house' training have to be face to face?	We encourage the reinstatement of face to face training wherever possible, however where this is not possible hybrid and/or remote training formats that meet the requirements of the safety actions, can all be counted to meet the proportion of staff attending training.

What training should be covered for the one-day multi-professional training?	The one-day training programme should include: • Antenatal and Intrapartum Fetal monitoring • 4 Maternity emergencies • Neonatal life support Local maternal and neonatal outcomes should be provided on the training days, ideally benchmarked against other organisations with a similar clinical profile. These data may be local, drawing on learning from case studies, local incidents and/or exemplars or from National programmes e.g. National Maternity Perinatal Audit (NMPA), Getting It Right First Time (GIRFT) and others.
What should be covered in the training programme?	**Fetal monitoring and surveillance (in the antenatal and intrapartum period)** Should be consistent with the Ockenden Report (2021) recommendations, and include as a minimum: • Risk assessment • Intermittent auscultation • Electronic fetal monitoring • System level issues e.g. human factors, classification, escalation and situational awareness • Use of local case histories • Using their local CTG machines **Multi-professional maternity emergencies training** • The training day should include 4 of the minimum requirements for multi-professional maternity emergency scenarios, as set out in the Core Competency Framework, with the aim that all scenarios will be covered over a 3-year period. • The 4 scenarios will be based on locally identified training needs, drawing on learning from local serious incidents, near misses and local reviews. • At least one scenario should include a *'learning from excellence'* case study where care was excellent. • Ideally, at least one of the four emergency scenarios should be conducted in a clinical area, ensuring full attendance from the relevant wider multi-professional team. This will enable local system and environmental factors within the clinical setting to be identified with an action plan developed to address issues identified. **Neonatal life support** • All staff in attendance at births should attend local neonatal life support training every year. • Attendance on separate certified NLS training for maternity staff should be locally decided but this would be the gold standard.

	• Those attending a NLS programme every 4 years will attend annual local neonatal life support training in between. Training should include as a minimum: • Preparing for neonatal resuscitation, including suitability of the clinical environment, and preparing the resuscitation device(s) • Identification of a baby requiring resuscitation after birth • Knowledge and understanding of the NLS algorithm, annual updates should be following the latest NLS edition. • The timing and how to call for help within the organisation • Situation, Background, Assessment Recommendation (SBAR) or equivalent communication tool handover on arrival of help.
How do maternity units include the remaining components of the Core Competencies Framework that are not listed above? **The remaining 2 components are:** • **Personalised care** • **Care during labour and the immediate postnatal period**	For the remaining 2 components of the Core Competencies Framework, maternity teams should choose 2 subjects per year from those listed in each of these core competencies, and these should be based on identified unit priorities, audit report findings and locally identified learning (e.g. ATAIN reviews) involving aspects of care which require reinforcing and national guidance. The aim is that all subjects within the Core Competencies Framework will be covered over the three-year period.
Which maternity staff attendees should be included for the 'in house' maternity emergencies multi-professional training day?	Maternity staff attendees should include 90% of each of the following groups: • Obstetric consultants • All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota • Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) • Maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum) • Obstetric anaesthetic consultants • All other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) contributing to the obstetric rota

Training timeframe - What if we had a large number of staff trained in July/ and August 2021– do we then have to have these staff do their training again before 12 months are up?	The MIS year 4 reporting timeframe referred in safety action 8 is between the launch of MIS year 4 in August 2021 and 5th December 2022 with a submission deadline of 2nd February 2023. Trusts should assess their compliance based on the proportion of staff trained in 12 consecutive months within the reporting period. 90% compliance should be demonstrated by the end of the 12 month period.
Should the anaesthetic and maternity support workers (MSWs) attend fetal surveillance in labour and neonatal life support training?	Anaesthetic staff and MSWs are not required to attend fetal monitoring. The staff groups below are not required to attend neonatal resuscitation training: • All obstetric anaesthetic doctors (consultants, staff grades and anaesthetic trainees) contributing to the obstetric rota and • Maternity critical care staff (including operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit)
What compliance is required for maternity theatre staff?	Maternity theatre staff are a vital part of the multidisciplinary team and are encouraged to attend the one-day maternity emergencies and multi-professional training, however they will not be required to meet MIS year four compliance assessment.
Which staff should be included for immediate neonatal life support training?	Staff in attendance at births should be included for immediate neonatal life support training - listed below: • Neonatal Consultants or Paediatric consultants covering neonatal units • Neonatal junior doctors (who attend any births) • Neonatal nurses (Band 5 and above) • Advanced Neonatal Nurse Practitioner (ANNP) • Midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) and Maternity theatre midwives who also work outside of theatres.
Which maternity staff attendees should be included for the local intrapartum fetal surveillance in line with Saving Babies Lives Care Bundle (SBLCBv2)?	Maternity staff attendees should be 90% of each of the following groups: • Obstetric consultants • All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota • Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and

	bank/agency midwives). Maternity theatre midwives who also work outside of theatres.
Fetal monitoring training- Should GP trainees attend fetal monitoring training as stated in safety action 6/8 even though our unit has a protocol that GP rotational doctors do not undertake CTG reviews in <u>any</u> circumstances?	GP trainees should also attend the fetal monitoring training session if they have any obstetric commitment to intrapartum care.
What if staff have been booked to attend training after (add in date) for the 'in-house' multi-professional training day?	Only staff who have attended the training will be counted toward overall percentage. If staff are only booked onto future training sessions and/or have not attended training, they cannot be counted towards the overall percentage.
Will we meet the action if one of our staff group is below the 90% threshold for the 'in-house' maternity emergencies and multi-professional training day?	No, you will need to evidence to your Trust Board that you have met the threshold of 90% for each of the staff groups by 5th December 2022.
Training compliance - breakdown by staff groups	Compliance should be presented by staff group mentioned e.g. obstetric consultants 90%, obstetric trainees 89%, anaesthetic consultants 92% etc.
What if Covid-19 restrictions are still in place for in house training?	If social distancing guidelines preclude face to face training then remote or hybrid formats will be acceptable.
I am a NLS instructor, do I still need to attend neonatal resuscitation annual training?	If you have taught on a NLS course at least once during that year, you do not need to attend local neonatal resuscitation training as well
I am a Medical Obstetric Emergencies and Trauma (MOET) instructor, do I still need to attend the emergency training session?	MOET instructors do not need to attend annual training if their NLS instructor status is still valid.
I have attended my NLS training, do I still need to attend neonatal resuscitation annual training?	For MIS purposes, not during the same year that you completed NLS training, but you will need to attend neonatal resuscitation training annually for the 3 years in-between each NLS course.
Which members of the team can teach in house neonatal resuscitation training?	Best practice would be for this training to be delivered by a trained NLS instructor. The minimum standard would be for training to be provided by staff who hold an in-date NLS provider certificate and have a teaching role such as a clinical skills facilitator.

Who should attend certified NLS training in maternity?	Attendance on separate certified NLS training for maternity staff should be locally decided but this would be the gold standard.
What is the required timeframe?	One day training on multi-professional, maternity emergencies, including a learning from excellence case study and intrapartum fetal surveillance should be undertaken by each staff group within the MIS reporting period.
Where can I find the Core Competencies Framework and other additional resources?	• NHS England and NHS Improvements Core Competency Framework (December 2020) https://www.england.nhs.uk/publication/core-competency-framework/ • https://www.resus.org.uk/library/2021-resuscitation-guidelines/newborn-resuscitation-and-support-transition-infants-birth • All link to forthcoming national intrapartum fetal surveillance programme • Toolkit for high quality neonatal services (October 2009) http://www.londonneonatalnetwork.org.uk/wp-content/uploads/2015/09/Toolkit-2009.pdf

Report Title	**Report for compliance with Saving Babies Lives - Element 4 Effective Fetal Monitoring in Labour**
Report for	Approval and Information
Report from	Maternity Services
Lead for Safety Action	Emma Butcher, Fetal Monitoring Lead Midwife Laura Minns, Fetal Monitoring Lead Consultant Obstetrician
Report Authors	Emma Butcher Beverley Gordon, Project Midwife In collaboration with the Maternity Training faculty and administrative support and Quality, Risk and Governance Team
Report presented for information and approval	Maternity Quality and Safety Group – 19/12/22 Maternity and Neonatal Safety Champions – 22/12/22 Trust Board – February 2023
Date of Report	5th December 2022
Risk and assurance:	There are no financial or healthcare risks associated with this report which outlines the Trust's position against National reporting frameworks for the review of Perinatal losses. The details contained within this may contain sensitive information regarding aspects of care with regard to perinatal losses within the Trust which may cause concern for the Trust and individuals involved in that care. Assurance is given that these details have been shared with individual mothers and families as part of our duty of candour and with staff as part of individual and team learning.
Legislation, regulatory, equality, diversity and dignity implications	The information contained within this report has been obtained from the use of regulated National and local reporting platforms. There are no equality and diversity issues related to this report and confidentiality has been maintained by removing patient identifiable information from the report.

Executive summary:

The report outlines the details of the Trust's Maternity Services compliance with the Saving Babies Lives element 4 Effective Fetal Monitoring in labour and compliance with the year 4 Maternity Incentive Scheme Safety Action 6 and Safety Action 8 in respect of fetal monitoring training.

The Trust has not had the fetal monitoring training as part of the one-day in-house multiprofessional training day for the whole of 2022 as this required a major change to the schedules and there were changes to the staff in post for specific roles. However, given that the training and competency assessments that have taken place across the 3 mediums of cases reviews, K2 training and the sessions introduced on the training day since August, it is considered that these constitute equivalent compatibility with the overall philosophy and training programmes required to maintain safety.
Using all 3 aspects of training, the compliance levels, are equal to or more than 90% for all relevant staff groups.

The Trust is fully compliant with the other 3 interventions of these safety measures. Risk assessments for fetal monitoring at the start and during labour are embedded in practice, the buddying arrangement for assessment of fetal wellbeing in labour is also embedded and all of these aspects are monitored on a regular basis in order to maintain these high standards.
The fetal monitoring leads are in post and committed to further enhancing their roles in maintaining safe practices and competencies.
The training and education programmes have been updated this year and will be fully embedded for all relevant staff from January 2023. The effectiveness of the changes will be monitored through review of cases and outcomes.

Recommendations:

- Training compliance to be reported on the Quality and Safety dashboard on a monthly basis.
- Consideration to be given to included attendance at the fetal monitoring study day to be linked to ESR.
- Adapt the current process for managing non-attendance at fetal monitoring case reviews to include the responsibilities of line managers as a key role in continuing professional development.
- Develop and imbed a training package to introduce Intelligent Intermittent Auscultation for low risk intrapartum care and update the guideline when this is implemented.

Next steps

The Trust Safety Champions are asked to consider and advise if the Maternity Services are able to submit a compliance with Safety Action 8 for the Maternity Incentive Scheme Year 4 in relation to the fetal monitoring standards given that this has not been part of the one-day training day for the whole of the compliance period.

This report is submitted for review and approval at the Maternity & Gynaecology Quality and Safety Group and then the Maternity and Neonatal Safety Champions Group and presented for information to the Divisional Board. Following this, the report will be presented at the Trust Board meeting and the Local Maternity and Neonatal Service (LMNS) Board.

1. Introduction

The importance of working and training together as a multidisciplinary team (MDT) has never been more important. In this report, we outline the progress made by the Maternity Services to address competency and confidence in effectively monitoring fetal wellbeing in pregnancy and labour. This report provides evidence with the specific aspects of the Saving Babies Lives Care Bundle v2 (2019) Element 4 Effective fetal Monitoring during labour. The full details of these requirements are included in Appendix 1.
By embedding these interventions, the Trust will also provide evidence for meeting the requirements of Year 4 of the Maternity Incentive Scheme Safety Actions 6 and Safety Action 8 (October 2022). These requirements are outlined in Appendix 2. Safety issues around fetal monitoring in labour has also been highlighted by national reports such as Ockenden (2020 &2022) and any recommendations from these reports has also been included in the overall quality and safety plans within the Trust.

2. Standards to be met:
2a Saving Babies Lives Care Bundle v2 (2019): Element 4. Effective fetal monitoring during labour

Interventions

4.1 All staff who care for women in labour are required to undertake annual training and competency assessment on cardiotocograph (CTG) interpretation and use of auscultation. Training should be multidisciplinary and include training in situational awareness and human factors. The training and competency assessment should be agreed with local commissioners (CCG) based on the advice of the Clinical Network. No member of staff should care for women in a birth setting without evidence of training and competence within the last year.

4.2 There is a system agreed with local commissioners (CCG) based on the advice of the Clinical Network to assess risk at the onset of labour which complies with NICE guidance47, irrespective of place of birth. The assessment should be used to determine the most appropriate fetal monitoring method.

4.3 Regular (at least hourly) review of fetal wellbeing to include: CTG (or intermittent auscultation (IA)), reassessment of fetal risk factors, use of a Buddy system to help provide objective review for example ‘Fresh Eyes’, a clear guideline for escalation if concerns are raised through the use of a structured process. All staff to be trained in the review system and escalation protocol.

4.4 Identify a Fetal Monitoring Lead for a minimum of 0.4 WTE per consultant led unit during which time their responsibility is to improve the standard of intrapartum risk assessment and fetal monitoring.

Continuous Learning

4.5 Maternity care providers must examine their outcomes in relation to the interventions, trends and themes within their own incidents where fetal monitoring was likely to have been a contributory factor.

4.6 Individual Trusts must examine their outcomes in relation to similar Trusts to understand variation and inform potential improvements.

4.7 Maternity providers are encouraged to focus improvement in the following areas: a. Risk assessment of the mother/fetus at the beginning and during labour. b. Interpretation and escalation of concerns over fetal wellbeing in labour.

Process Indicators

i. Percentage of staff who have received training on CTG interpretation and auscultation, human factors and situational awareness

ii. Percentage of staff who have successfully completed mandatory annual competency assessment

Outcome Indicators

i. The percentage of intrapartum stillbirths, early neonatal deaths and cases of severe brain injury* where failures of intrapartum monitoring are identified as a contributory factor.

*Using the severe brain injury definition as used in Gale et al. 2018

Implementation

Trusts must be able to demonstrate that all qualified staff who care for women in labour are competent to interpret CTG, use the Buddy system at all times and escalate accordingly when concerns arise or risks develop. This includes staff that are brought in to support a busy service from other clinical areas such as the postnatal ward and the community, as well as locum, agency or bank staff (medical or midwifery).

Additional information on this element can be found in Appendix 1.

Local Interventions in place at West Suffolk NHSFT

4.1 Training and Education:

Annual training and competency assessment

Local Intervention

a) MDT case reviews and learning from experience

Midwives and doctors should attend 4 hours of training and education sessions either face to face or on Teams, per year. Two 30-minute sessions are facilitated by the obstetric and midwifery leads each week. These sessions have been in place since September 2020. It is recommended that staff need to attend at least one hour per quarter but some staff, due to leave and rotas will do more in some months than others so the compliance will be worked out over the whole year with a sense check every quarter. Some staff will have joined and some will have left within each period so it is important that this is taken into consideration. Student midwives and student doctors also attend the training sessions but are not included in the compliance reports.

b) K2 online training and assessment

In addition, all midwives and obstetricians providing intrapartum care must complete the K2 modules and assessment programmes each year. Staff providing intrapartum care need to complete all of the intrapartum modules and pass the assessment module.

c) Fetal monitoring face to face study day

From August 2022 all midwives, obstetric consultants and obstetric trainees must complete a face to face study day on fetal monitoring which covers risk assessment, multidisciplinary working, system level issues, local case histories and use of local equipment. All staff must

pass a competency assessment. These sessions are delivered by the fetal monitoring lead midwife and obstetrician.

4.2 Risk Assessment in labour

The MBRRACE-UK Perinatal Confidential Enquiry report recommended the national development of a standardised risk assessment tool. As this has not yet been developed the procedure should comply with NICE guidance. A case example based upon NICE guidance has been provided in the Saving Babies Lives guidance, Appendix E, however further assessment tools may be developed in the future.

Local Intervention

All women in labour will have a risk assessment at the start of labour to determine the type of fetal monitoring that is required from the start of labour. The risk assessment is completed electronically on E-care and will be updated and the method of monitoring reviewed at each hourly assessment – either fresh eyes or fresh ears.

4.3 Review and assessment in labour

Fetal wellbeing is assessed regularly (at least hourly) during labour through discussion between the midwife caring for the fetus and another midwife or doctor. Use of a buddy system.

Local Intervention

If intermittent auscultation is the chosen and correct method of monitoring fetal wellbeing in labour, a fresh ears assessment will be undertaken every hour. If electronic fetal monitoring is indicated, an hourly fresh eyes assessment is undertaken. Fresh Ears and Fresh Eyes are conducted hourly in the first stage of labour and every 30 minutes during the second stage of labour. Fresh Eyes and Fresh Ears can be completed by a Core Band 6 Midwife, Labour Suite Coordinator, Maternity Bleep Holder or Obstetrician. Concerns are escalated to the Labour Suite Coordinator or Obstetrician. Difference of opinions are discussed and a third person's opinion is sought. The Trust uses the FIGO assessment rather than the NICE guidance.

4.4 Fetal Monitoring Leads

Some Trusts may choose to extend the remit of the Practice Development Midwife to fulfil the role of Fetal Monitoring Lead, whereas others may wish to appoint a separate clinician. The critical principle is that the Fetal Monitoring Lead has dedicated time when their remit is to support staff working on the labour ward to provide high quality intrapartum risk assessments and accurate CTG interpretation. The role should contribute to building and sustaining a safety culture on the labour ward with all staff committed to continuous improvement.

Local Intervention

Obstetric and midwifery leads are in place fulfilling the lead fetal monitoring roles. The Midwife is allocated 15 hours per week and the consultant is allocated 2 hours per week.
Job descriptions are available for both roles.

2b Maternity Incentive Scheme Year 4 Safety Action 8

Safety action 8: Can you evidence that a local training plan is in place to ensure that all six core modules of the Core Competency Framework will be included in your unit training programme over the next 3 years, starting from the launch of MIS year 4?
In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day which includes a selection of maternity emergencies, antenatal and intrapartum fetal surveillance and newborn life support, starting from the launch of MIS year 4?

b) 90% of each relevant maternity unit staff group have attended an annual 'in-house' one day multi-professional training day, to include maternity emergencies starting from the launch of MIS year four

The one-day training programme should include training on:

- *Fetal monitoring and surveillance (in the antenatal and intrapartum period) (see c for detail)*
- *Maternity emergencies training scenarios*
- *Neonatal life support (see d for detail)*

There should be sharing of local maternal and neonatal outcomes, ideally benchmarked against other organisations with a similar profile. These data may be local, drawing on learning from case studies, incidents, exemplars or from National programmes e.g. National Maternity Perinatal Audit (NMPA), Getting It Right First Time (GIRFT) and others.

Fetal monitoring and surveillance (in the antenatal and intrapartum period)
Should be consistent with the Ockenden Report (2021) recommendations, and include as a minimum:

- *Risk assessment*
- *Intermittent auscultation*
- *Electronic fetal monitoring*
- *System level issues e.g. human factors, classification, escalation and situational awareness*
- *Use of local case histories*
- *Using their local CTG machines*

The Trust has not had the fetal monitoring training as part of the one-day in-house multiprofessional training day for the whole of 2022 in accordance with Safety Action 8 for year 4 of the Maternity Incentive Scheme. This was because this required a major change to the schedules and there were changes to the staff in post for specific roles. However, given that the training and competency assessments that have taken place across the 3 mediums of cases reviews, K2 training and the sessions introduced on the training day since August, it is considered that these constitute equivalent compatibility with the overall philosophy and training programmes required to maintain safety.

Monitoring of interventions – Saving Babies Lives

A. Percentage of staff who have received training on intrapartum fetal monitoring in line with the requirements of Safety Action eight, including: intermittent auscultation, electronic fetal monitoring, human factors and situational awareness.

B. Percentage of staff who have successfully completed mandatory annual competency assessment.

Note: An in-house audit should have been undertaken to assess compliance with these indicators. Each of the following groups should be attending the training: The compliance required is the same as safety action eight i.e. 90% of maternity staff which includes 90% of each of the following groups:

 Obstetric consultants

 All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota

 Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives). Maternity theatre midwives who also work outside of theatres.

The Trust to identify any shortfall in reaching the 90% threshold and commit to addressing this as soon as possible.
The Trust Board should minute in their meeting records a written commitment to facilitate local, in-person, fetal monitoring training when this is permitted.

WSH Guidelines:
Antenatal Observations
Fetal Monitoring
Maternity Training and Education
Reduced Fetal Movements
Risk Assessment in Labour

3. Results

The results on compliance with each intervention are recorded below:

Intervention 1 Fetal Monitoring Training

Due to the transitional period from using K2 to the inclusion of fetal monitoring training on the MDT training day, the training compliance has been recorded using both aspects for this year only. From January 2023, K2 training will stop as a routine.

a) Training and Education Sessions – Case Review MDT forums – 4 hours per year

Professional Group	% Attendance at 4 hours of training 6th December 2021 - 5th December 2022
All Midwives	90.3%
Obstetric Consultants	93%
Obstetric Registrars and other obstetric trainees	100%

b) K2 online training and assessment or attendance at MDT training day – 4 hours training

In addition, all midwives and obstetricians providing intrapartum care must complete the K2 modules and assessment programmes each year. Staff providing intrapartum care need to complete all of the intrapartum modules and pass the assessment module.

Professional Group	6th December 2021 – 5th December 2022
All Midwives	92.1%
Obstetric Consultants	100%
Obstetric trainees	100%

The training compliance has been achieved for at least 90% of all the staff groups.

Intervention 2 Risk Assessment at the start and during labour

Month	Compliance
September 2022	100%
October 2022	100%
November 2022	100%

There is maximum compliance with this safety action.

Intervention 3 Compliance with Fresh Ears and Fresh Eyes

No.	Standard	Target	Findings	Comments
1.	Fresh ears performed every hour by two registered professionals in the first stage of labour.	100%	100%	Fully compliant
2.	Fresh ears performed every 30 mins by two registered professionals in the second stage of labour.	100%	100%	Fully compliant
3.	Escalated if concerned with IA	100%	100%	Fully compliant
4.	Fresh eyes review completed every hour by two registered professionals in the first stage of labour.	100%	100%	Fully compliant
5.	Fresh eyes review completed every 30 mins by two registered professionals in the second stage of labour.	100%	100%	Fully compliant
6.	Concerns escalated if appropriate.	100%	100%	Fully compliant
7.	Hourly classification stickers applied & completed in full.	80%	100%	Fully compliant
8.	Intrapartum care review completed hourly in the first stage of labour	100%	100%	Fully compliant
9.	Intrapartum care review completed every 30 mins in the second stage of labour	100%	100%	Fully compliant
10.	Any concerns with fresh care elements escalated for review	100%	100%	Fully compliant

The audit of compliance with assessment of fetal wellbeing demonstrates that the Trust is fully in line with this safety action.

Intervention 4 Fetal Monitoring Leads

The fetal monitoring lead midwife has been a specified role since July 2020 and has 15 hours allocated to this. These are indicated as 'management' days on the roster. The job description was updated and approved 2021. The post holder has changed in February 2022 and additional responsibilities have resulted in an increased emphasis on fetal monitoring at MDT meetings.

The fetal monitoring lead consultant has been in place since January 2021 but the sessions have not been allocated as a PA until April 2021. The post holder changed in August 2022 when the new consultant also became the labour ward lead as well. Four hours per week are allocated to the combined role. The work undertaken in this role is not currently specified on the roster but is indicated as attendance at the training sessions. The job description has been approved.

The Training leads are in place and are actively involved in all aspects of training and reviews of cases as part of their roles.

Process indicators

Adverse Events

For the period between December 2021-December 2022 there have been 2 adverse outcomes where fetal monitoring may have been a contributory factor in the outcome. In these cases, both babies were transferred to tertiary units for therapeutic cooling, both were reported to HSIB for investigation. One of these cases did not meet the requirements for HSIB and was investigated internally.

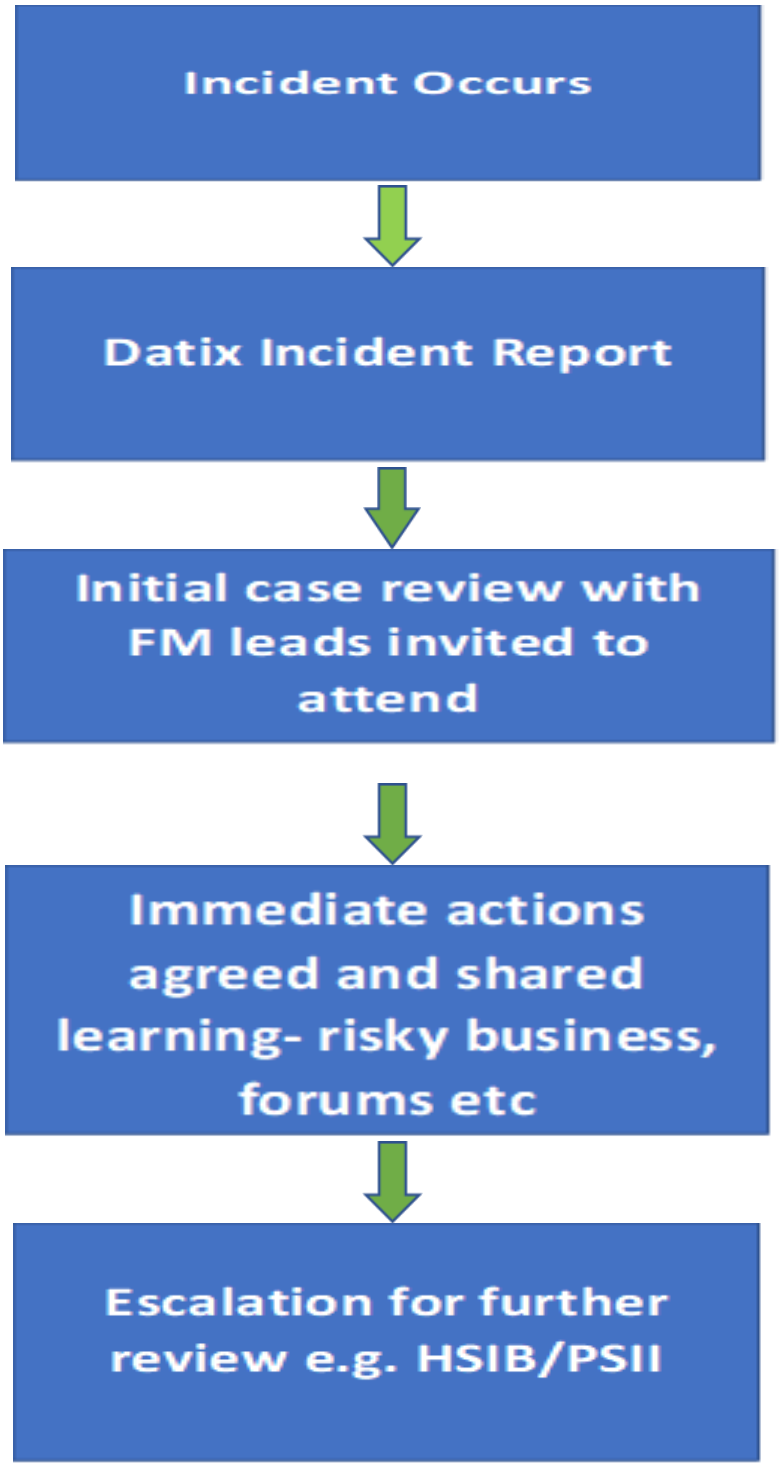
The case currently under HSIB investigation was discussed at multidisciplinary case review and fetal monitoring was reviewed. There were no immediate recommendations raised by the team and there were no recommendations made at that meeting around fetal monitoring. The Trust awaits the recommendations from HSIB.

The case investigated internally found that concerns with fetal monitoring were acted on appropriately at the time and that the timing for intervention with instrumental delivery was appropriate. This case involved a shoulder dystocia and the cord gas results at delivery indicate an acute hypoxic event in line with a shoulder dystocia. The Trust internal investigation did not raise concerns with fetal monitoring and no learning around fetal monitoring was identified.

Update of processes

The review by FM leads for immediate actions and lessons learned is being embedded and a SOP is being written for this and will be finalised in January 2023. Current informal process is as follows:

Process for Escalation



5. Monitoring of compliance

Training compliance is recorded on the Maternity Quality Dashboard each month. The Leads for fetal monitoring are identifying staff who are not completing the required attendance at sessions and escalating these to the line managers of the staff members to facilitate an improvement in performance.
Training compliance is discussed as part of the Head of Midwifery Quality and Performance Board report and as part of the reporting to the LMNS on a quarterly basis.

From January 2023 attendance at fetal monitoring case review sessions will be reported on the Maternity Quality Dashboard on a monthly basis which will be a 12 month rolling attendance.

6. Conclusions

Intervention 1: The Trust has 2 elements to fetal monitoring training - case reviews and training programmes which include competency assessment. In January 2023 the Trust will not be renewing the contract for K2 and annual face to face training for fetal monitoring will replace this. This face to face training will run alongside obstetric emergencies and neonatal resuscitation and will include competency assessments with all elements of fetal monitoring and the use of local equipment. This study day was implemented in August 2022.
Local CTG Case Reviews occur twice weekly and include situational awareness and human factors. They provide further teaching on fetal physiology, risk assessment, multidisciplinary working and further channels of communication to follow in response to changes or concerns with fetal monitoring.
In this interim period of change, at least 90% of the relevant staff groups have attended the required training in both aspects.
From January 2023, there will be enhanced monitoring of the training compliance and there will be an early identification and escalation if staff are not compliant.

Intervention 2: The Trust demonstrates full compliance with intrapartum risk assessments and has a system in place to ensure this is reviewed hourly in the first stage of labour and every 30 minutes in the second stage of labour. Compliance for intrapartum risk assessment is monitored and reported on a weekly basis via Tendable, a platform used by the Trust to ensure safety standards are met across the Trust. This information is also included in the monthly fetal monitoring audits.

Intervention 3: The Trust has a system in place for fetal monitoring care reviews and is currently fully compliant. Intrapartum fetal monitoring is reviewed by another professional hourly in the first stage of labour and every 30 minutes in the second stage of labour. Compliance is audited on a monthly basis and a rolling action plan is in place to improve compliance. Audit findings are included on the Quality Dashboard and presented at the Quality and Safety Meeting. Findings are also discussed at the Maternity Improvement Board.

Intervention 4: The Trust has a fetal monitoring midwife and consultant obstetric lead in place who lead and have oversight of all training, education and learning related to fetal monitoring training.

Adverse events and outcomes
There have been no adverse outcomes as a result of issues directly related to fetal monitoring. Individual cases of perinatal mortality and morbidity have an immediate case review and urgent actions are addressed. Information is shared with the staff through ‘Take Five’ communications and Risky Business Newsletters.

External review is implemented for all serious incidents where HSIB are not involved. Reports from PMRT and HSIB have actions in place to address issues arising that relate to fetal monitoring and these are monitored through the Maternity Risk and Governance staff in order that assurance of improvement can be demonstrated.

Content:
The content of the training sessions now fully meets the requirements and the output from the training sessions are shared in the Maternity Risky Business Newsletters.

Attendance:
MDT attendance at the training and education sessions have met the 90% target for all professionals involved in intrapartum care.

6. Recommendations

- Training compliance to be reported on the Quality and Safety dashboard on a monthly basis.
- Consideration to be given to included attendance at the fetal monitoring study day to be linked to ESR.
- Adapt the current process for managing non-attendance at fetal monitoring case reviews to include the responsibilities of line managers as a key role in continuing professional development.
- Develop and imbed a training package to introduce Intelligent Intermittent Auscultation for low risk intrapartum care and update the guideline when this is implemented.

7. Actions

ACTION	LEAD	DATE FOR COMPLETION	EVIDENCE OF COMPLETION
Create a SOP for cases where fetal monitoring may be a contributory factor in poor outcomes	Emma Butcher Laura Minns	January 2023	
Intelligent Intermittent Auscultation training and imbed into practice	Emma Butcher	June 2023	
Update Fetal Monitoring Guideline.	Laura Minns Emma Butcher	August 2023	
Report training compliance monthly	Emma Butcher	Ongoing from January 2023	
Enhance the process for managing non-attendance at mandatory training sessions.	Training leads	February 2023	

Appendix 1 Saving Babies Lives v2 (2019)

Element 4. Effective fetal monitoring during labour

Interventions

4.1 All staff who care for women in labour are required to undertake annual training and competency assessment on cardiotocograph (CTG) interpretation and use of auscultation. Training should be multidisciplinary and include training in situational awareness and human factors. The training and competency assessment should be agreed with local commissioners (CCG) based on the advice of the Clinical Network. No member of staff should care for women in a birth setting without evidence of training and competence within the last year.

4.2 There is a system agreed with local commissioners (CCG) based on the advice of the Clinical Network to assess risk at the onset of labour which complies with NICE guidance47, irrespective of place of birth. The assessment should be used to determine the most appropriate fetal monitoring method.

4.3 Regular (at least hourly) review of fetal wellbeing to include: CTG (or intermittent auscultation (IA)), reassessment of fetal risk factors, use of a Buddy system to help provide objective review for example 'Fresh Eyes', a clear guideline for escalation if concerns are raised through the use of a structured process. All staff to be trained in the review system and escalation protocol.

4.4 Identify a Fetal Monitoring Lead for a minimum of 0.4 WTE per consultant led unit during which time their responsibility is to improve the standard of intrapartum risk assessment and fetal monitoring.

Continuous Learning

4.5 Maternity care providers must examine their outcomes in relation to the interventions, trends and themes within their own incidents where fetal monitoring was likely to have been a contributory factor.

4.6 Individual Trusts must examine their outcomes in relation to similar Trusts to understand variation and inform potential improvements.

4.7 Maternity providers are encouraged to focus improvement in the following areas: a. Risk assessment of the mother/fetus at the beginning and during labour. b. Interpretation and escalation of concerns over fetal wellbeing in labour.

Process Indicators

a) Percentage of staff who have received training on CTG interpretation and auscultation, human factors and situational awareness

b) Percentage of staff who have successfully completed mandatory annual competency assessment

Outcome Indicators

ii. The percentage of intrapartum stillbirths, early neonatal deaths and cases of severe brain injury* where failures of intrapartum monitoring are identified as a contributory factor.

*Using the severe brain injury definition as used in Gale et al. 2018

Implementation

Trusts must be able to demonstrate that all qualified staff who care for women in labour are competent to interpret CTG, use the Buddy system at all times and escalate accordingly when concerns arise or risks develop. This includes staff that are brought in to support a busy service from other clinical areas such as the postnatal ward and the community, as well as locum, agency or bank staff (medical or midwifery).

Additional information on this element can be found in Appendix 1.
Intervention 1: Owing to a lack of formal assessment it is not possible to be prescriptive about the exact nature of either training packages or indeed competency assessment. However, training packages should adhere to the following principles:

• Include multidisciplinary and scenario-based training – this should involve all medical and midwifery staff who care for women in birth settings.
• Teaching about fetal physiological responses to hypoxaemia, the pathophysiology of fetal brain injury, and the physiology underlying changes in fetal heart rate (FHR). In addition, the impact of factors such as fetal growth restriction and maternal pyrexia.
• Effective fetal monitoring in low risk pregnancies, including the role of IA in initial assessment, in established labour and indications for changing from IA to CTG.
• Interpretation of CTG including:
  - normal CTG o impact of intrapartum fetal hypoxia on the FHR
  - Significance of abnormal CTG patterns o interpretation in specific clinical circumstances (such as previous caesarean sections, breech and multiple pregnancy).
• Interventions that can affect the FHR (such as medication) and those that are intended to improve the FHR (such as oxygen).
• Additional tests of fetal wellbeing that help clarify fetal status and reduce the false positive rate of CTG.
• Channels of communication to follow in response to a suspicious or pathological trace, risk management strategies including governance and audit.
• Application of NICE fetal monitoring recommendations for low risk women. The Trust uses FIGO for intrapartum CTG interpretation.
• Training in situational awareness and human factors to enable staff to respond appropriately to evolving, complex situations.
• Provision of adequate training is a Trust priority – as a minimum all staff should receive a full day of multidisciplinary training (following the principles outlined above) each year with reinforcement from regular attendance at fetal monitoring review events. Competency assessment: all staff will have to pass a formal annual competency assessment that has been agreed by the local commissioner (CCG) based on the advice of the Clinical Network. The assessment should include demonstrating a clear understanding of the areas covered in training (see principles above), for example, fetal physiology, recognition of abnormal CTGs and use of IA and situational awareness. Trusts should agree a procedure with their CCG for how to manage staff who fail this assessment.

Appendix 2 Maternity Incentive Scheme Year 4 Safety Action 6 and Safety Action 8

Safety Action 6 Saving Babies Lives

The Trust to demonstrate embedding of all elements.

Safety Action 8 Multidisciplinary Training

The Year 4 requirements for MIS include having a planned annual training day which will include
Fetal monitoring and surveillance (in the antenatal and intrapartum period)
Maternity Obstetric Emergencies
Neonatal life support

Fetal monitoring and surveillance (in the antenatal and intrapartum period)
Should be consistent with the Ockenden Report (2021) recommendations, and include as a minimum:

- Risk assessment
- Intermittent auscultation
- Electronic fetal monitoring
- System level issues e.g. human factors, classification, escalation and situational awareness
- Use of local case histories
- Using their local CTG machines

More than 90% of each of the relevant staff groups who provide intrapartum care should attend the annual training session and be assessed as competent.

West Suffolk NHS
NHS Foundation Trust

Audit of Compliance with Uterine Artery Dopplers at Anomaly Ultrasound

Woman and Children Health Division

Victoria McEwen-Smith

Clinical Quality and Assurance Midwife

Project Team

Name: Antenatal Clinic Midwives	Title/grade:

16.12.2022

Report status – draft

Background/Rationale

Saving Babies Lives Care Bundle 2 (SBLCBv2) recommends that alongside the routine fetal anomaly scan that Uterine Artery Dopplers (UAD) can be undertaken in the second trimester 18 - 24 weeks. Following consultation, the decision was taken that West Suffolk Hospital would complete this, however due to scanning capacity it would be offered to only those with high risk pregnancies.
This SOP was approved for use via the Quality and safety meeting in June 2022.

UAD is used within high-risk pregnancies, to determine the risk of placental dysfunction and associated risk of hypertensive disorders or early onset fetal growth restriction.

There is strong evidence to suggest that fetal growth restriction (FGR) is the biggest risk factor for stillbirth. Therefore, antenatal detection of growth restricted babies is vital and has been shown to reduce stillbirth risk significantly because it gives the option to consider timely delivery of the baby at risk. However, by seeking to capture all babies at risk, it has the potential to increase interventions in women and pregnant people who are only marginally at increased risk of FGR related stillbirth. Uterine artery Doppler measurement in high risk pregnancies can improve efficiency by targeting scan resources focussing more attention on those at highest risk. An abnormal uterine artery doppler in the late second trimester increases the risk of fetal growth restriction and the development of pre-eclampsia.

Alongside the dating scan or on receipt of booking paperwork from Community teams, a risk assessment will be performed by the antenatal clinic midwives and those identified as high risk will be referred on for uterine artery dopplers.

Aim

To ascertain percentage of patients whereby a UAD was warranted following completion of risk assessment and assurance that UAD was completed when requested

Objectives

To ensure adherence to West Suffolk Hospitals SOP029- Uterine Artery Dopplers. June 2022

Standards

No.	Standard	Target %	Exceptions
1.	**Previous pregnancy Risk Factors**	100%	If UAD are declined by parents
	Previous FGR (birthweight <3rd centile or abnormal dopplers)		
	Previous Stillbirth		
	Previous PET(Pre-eclamptic toxaemia) (Severe/evidence of placental disease or <34/40)		
	Previous Placental abruption		
	Maternal medical history	100%	If UAD are declined by parents
	Chronic Hypertension		
	Renal Impairment		
	Antiphospholipid Syndrome		

	Current Pregnancy complications	100%	If UAD are declined by parents
	Low PappA <0.42 MoM		
	Fetal echogenic bowel		
	Significant/recurrent antepartum haemorrhage		

Methodology

A prospective audit was completed for women and pregnant people who were attending the West Suffolk Hospital for their fetal anomaly ultrasounds during the time period of the 5th December 2022 to the 15th December 2022. This totalled 68 patients.
In order to collect the data, the previous days ultrasounds attendance list was reviewed to identify eligible patients. Their records were then reviewed to assess for any risk factors identified in the standards listed above.
The auditor assessed whether the Uterine Artery Doppler was then

- Required and completed
- Required and not completed
- Not required.

Results

Of the 68 patients who attended for Anomaly ultrasounds, 6 were identified either at booking, or as part of the ongoing pregnancy, as having risk factors which required them to have UAD performed alongside the anomaly USS

No.	Standard	Target %			Findings		Comments
			Required + Completed	Required & not completed	Not required	%	
1.	Previous FGR (birthweight <3rd centile or abnormal dopplers)	100%	-	1	67/68		1 patient required UAD for this risk factor however this was not identified at booking and therefore not completed until 23/40
2.	Previous Stillbirth	100%	1	-	67/68	100%	
3.	Previous PET (Severe/evidence of placental disease or <34/40)	100%	-	-	68/68	-	

4	Previous Placental abruption	100%	-	-	68/68		
5.	Chronic Hypertension	100%	1	-	67/68	100%	
6.	Renal Impairment	100%	-	-	68/68		
7	Antiphospholipid Syndrome	100%	-	-	68/68		
8	Low PappA <0.42 MoM	100%	3	-	65/68	100%	
9.	Fetal echogenic bowel	100%	1	-	67/68	100%	
10.	Significant/recurrent antepartum haemorrhage	100%	1	-	67/68	100%	

Conclusions

The vast majority of cases that were audited were low risk pregnancies that did not fit the criteria set within the SOP029- Uterine Artery Dopplers. June 2022 for UAD's to be completed at the time of the anomaly.

There was one missed opportunity for a referral for UAD to be completed as part of anomaly USS. This patient had a history of FGR SGA (Small for Gestational Age) and should have been referred following completion of the customised growth chart at booking.

The remaining 5 patients were identified and referred for UAD appropriately at USS. Of these 5, one patient developed risk factors for Low Papp-A, Fetal echogenic bowel and significant / recurrent APH (Ante-partum haemorrhage) during the pregnancy

Recommendations

As this is still a fairly new recommendation into practice it is recommended maternity staff are reminded of the referral criteria for UAD to ensure that all eligible patients are captured.

A subsequent audit it recommended to assess future compliance

Learning Points

All maternity staff to ensure that they are familiar with the referral criteria for UAD and refer accordingly

References

Saving Babies Lives Care Bundle version 2. Available at https://www.staff.wsh.nhs.uk/pdfs/matsop029-uterine-artery-dopplers.pdf

West Suffolk Hospitals SOP029- Uterine Artery Dopplers. June 2022

Action Plan

Project title	Audit of compliance with Uterine Artery Dopplers at USS

Action plan lead	Name: Karen Bassingthwaighte	Title: Outpatient Community Matron	Contact:2995

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

Recommendation	**Actions required** *(specify “None”, if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Comments/action status** *(Provide examples of action in progress, changes in practices, problems encountered in facilitating change, reasons why recommendation has not been actioned etc)*
Communication to all staff regarding the criteria for UAD and ensure completed	Email	Immediate	Karen Bassingthwaighte	Complete – email and face to face discussion with team leads
Repeat Audit to assess compliance	Audit	6 months	Karen Bassingthwaighte	

Requirements number	Safety action 6 requirements	Requirements Met
1	Do you have evidence that Trust Board level consideration of your organisation is complying with the Saving Babies' Lives care bundle version two (SBLCBv2), published in April 2019? Note: Full implementation of the SBLCBv2 is included in the 2020/21 standard contract.	**Yes**
2	Has each element of the SBLCBv2 been implemented? Trusts can implement an alternative intervention to deliver an element of the care bundle if it has been agreed with their commissioner (ICB). It is important that specific variations from the pathways described within SBLCBv2 are also agreed as acceptable clinical practice by their Clinical Network.	**Yes**
3	The quarterly care bundle survey should be completed until the provider Trust has fully implemented the SBLCBv2 including the data submission requirements. Have you completed and submitted this?	**Yes**
Element 1 - Reducing smoking in pregnancy Standard a*) Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded.* *Standard b) Percentage of women where CO measurement at 36 weeks is recorded.*		
4	Has the Trust Board received data for standard a) from the organisation's Maternity Information System (MIS) evidencing an average of 80% compliance over a four month period (i.e. four consecutive months in during the MIS year 4 reporting timeframe)?	**Yes**
5	Has the Trust Board received data for standard b) from organisation's Maternity Information System or has an audit of 60 consecutive cases been provided to demonstrate >80% of women having a CO measurement recorded at 36 weeks?	**Yes**
6	Is the audit accompanied by a brief description of the stop smoking strategy within the Trust and any plans for improvement?	**Yes**
7	If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%. Has this been completed?	**Yes**

Do you have evidence that the Trust Board has specifically confirmed that within their organisation they:		
8	Pass the data quality rating on the National Maternity Dashboard for the 'women who currently smoke at booking appointment' Clinical Quality Improvement Metric.	**Yes**
9	Have a referral pathway to smoking cessation services (in house or external)?	**Yes**
10	Have evidence of an audit of 20 consecutive cases of women with a CO measurement ≥4ppm at booking, to determine the proportion of women who were referred to a smoking cessation service?	**Yes**
4) Have you generated and reviewed the following outcome indicators within the Trust for four consecutive months within the MIS year 4 reporting period:		
11	Percentage of women with a CO measurement ≥4ppm at booking?	**Yes**
12	Percentage of women with a CO measurement ≥4ppm at 36 weeks?	**Yes**
13	Percentage of women who have a CO level ≥4ppm at booking who subsequently have a CO level <4ppm at the 36 week appointment?	**Yes**
Element 2 - *Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR)* *If a Trust has implemented the Tommy's Centre Risk Assessment and Clinical Decision Tool within a research programme then confirmation of the latter by the Trust Board will meet the requirement that Standards 1, 2 and 3 of Element 2 have been implemented* A Trust will fail Safety Action 6 if the process indicator metric compliance is less than 80%.		
14	Standard 1) Have you provided evidence showing the percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded using a risk assessment pathway at booking and at the 20 week scan? The relevant data items for these process indicators should be recorded on the provider's Maternity Information System and included in the MSDS submissions to NHS Digital If your Trust has implemented the Tommy's Centre Risk Assessment and Clinical Decision Tool within a research programme then confirmation of the latter by the Trust Board will meet the requirement that Standards 1, 2 and 3 of Element 2 have been implemented	**Yes**

15	Has the Trust board received data from the organisation's MIS evidencing 80% compliance or has an in house audit of 40 consecutive cases of women at 20 weeks scan using locally available data or case records been undertaken and submitted to Board to assess compliance with this indicator?	**Yes**
Do you have evidence that the Trust Board has specifically confirmed within their organisation?		
16	Standard 2) Women with a BMI>35 kg/m^2 are offered ultrasound assessment of growth from 32 weeks' gestation onwards? If a Trust has implemented the Tommy's Centre Risk Assessment and Clinical Decision Tool within a research programme then confirmation of the latter by the Trust Board will meet the requirement that Standards 1, 2 and 3 of Element 2 have been implemented	**Yes**
17	Standard 3) In pregnancies identified as high risk at booking uterine artery Doppler flow velocimetry is performed by 24 completed weeks gestation? If a Trust has implemented the Tommy's Centre Risk Assessment and Clinical Decision Tool within a research programme then confirmation of the latter by the Trust Board will meet the requirement that Standards 1, 2 and 3 of Element 2 have been implemented	**Yes**
18	Standard 4) There is a quarterly audit of the percentage of babies born <3rd centile >37+6 weeks' gestation?	**Yes**
19	Standard 5) They have generated and reviewed the percentage of perinatal mortality cases for 2021 where the identification and management of FGR was a relevant issue (using the PMRT)?	**Yes**
20	Standard 6) Their risk assessment and management of growth disorders in multiple pregnancy complies with NICE guidance or a variant has been agreed with local commissioners (ICBs) following advice from the Clinical Network?	**Yes**

21	Standard 7) You have undertaken a quarterly review of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks' gestation. The review should seek to identify themes that can contribute to FGR not being detected (e.g. components of element 2 pathway and/or scanning related issues). The Trust board should be provided with evidence of quality improvement initiatives to address any identified problems. Trusts can omit the above mentioned quarterly review of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks' gestation for quarter 3 of this financial year (2021/22) if staffing is critical and this directly frees up staff for the provision of clinical care.	**Yes**
Element 3 *Raising awareness of reduced fetal movement.* A. Percentage of women booked for antenatal care who had received reduced fetal movements leaflet/information by 28+0 weeks of pregnancy. B. Percentage of women who attend with RFM who have a computerised CTG (a computerised system that as a minimum provides assessment of short term variation). The SNOMED CT code is still under development for RFM and therefore an in-house audit of two weeks' worth of cases or 20 cases of women attending with RFM whichever is the smaller to assess compliance with the element three process indicators. If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%. A Trust will fail Safety Action 6 if the process indicator metric compliance is less than 80%.		
	Q22 and Q23 are linked	
22	Have you completed an in-house audit of two weeks' worth of cases or 20 cases of women attending with RFM (whichever is the smaller) demonstrating 95% compliance with the element three process indicators?	**Yes**
23	If the process indicator scores are less than 95% , have you submitted an action plan for achieving >95%?	**N/A**
Element 4 *Effective fetal monitoring during labour* *(Please see safety action 8 for fetal monitoring training)*		
You do not need to submit evidence within element 4, as it is included within safety action 8		
Element 5 *Reducing preterm births* *The relevant data items for these process indicators should be recorded on the provider's Maternity Information System and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding.* *If there is a delay in the provider Trust MIS's ability to record these data then an audit of 40 cases consisting of 20 consecutive cases of*		

women presenting with threatened preterm labour before 34 weeks and 20 consecutive cases of women who have given birth before 34 weeks using locally available data or case records should have been undertaken to assess compliance with each of the process indicators. *The Trust board should receive data from the organisation's Maternity Information System evidencing 80% compliance with process indicators A, C and D. The percentage for process indicator B should be as low as possible and can be reported as the proportion.* *A Trust will not fail Safety Action 6 if the process indicator scores for standards a,b,c & d are less than 80%. However, Trusts must have an action plan for achieving >80%.*		
	Q24, Q26, Q27 and Q28 are linked	
24	a) Has the Trust Board received data from the organisation's MIS evidencing 80% compliance or an in house audit demonstrating that 80% of singleton live births (less than 34+0 weeks) received a full course of antenatal corticosteroids, within seven days of birth?	**No**
25	b) Has the percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids been recorded on the provider's Maternity Information System and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding?	**Yes**
26	c) Has the Trust Board received data from the organisation's MIS evidencing 80% compliance or an in-house audit demonstrating that 80% of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth?	**Yes**
27	d) Has the Trust Board received data from the organisation's MIS evidencing 80% compliance or an in-house audit demonstrating that 80% of women have given birth in an appropriate care setting for their gestation (in accordance with local ODN guidance)?	**Yes**
28	If your process indicator scores for standards a,c or d are less than 80%, do you have an action plan for achieving >80%?	**Yes**
29	Do you have a dedicated Lead Consultant Obstetrician with demonstrated experience to focus on and champion best practice in preterm birth prevention?	**Yes**
	Q30 and Q31 are linked	
30	Do women at high risk of preterm birth have access to a specialist preterm birth clinic where transvaginal ultrasound to assess cervical length is provided?	**Yes**
31	If this is not the case, has the board described the alternative intervention that has been agreed with their commissioner (ICB) and that their Clinical Network and has agreed this is acceptable clinical practice?	**N/A**

32	Has an audit of 40 consecutive cases of women booking for antenatal care been completed to measure the percentage of women that are assessed at booking for the risk of preterm birth and stratified to low, intermediate and high risk pathways, and the percentage of those assessed to be at increased risk that are referred to the appropriate preterm birth clinic and pathway? The assessment should use the criteria in Appendix F of SBLCBv2 or an alternative which has been agreed with local ICBs following advice from the Clinical Network.	**Yes**
33	Does the risk assessment and management in multiple pregnancy comply with NICE guidance or a variant that has been agreed with local commissioners (ICBs) following advice from the provider's clinical network?	**Yes**

West Suffolk NHS
NHS Foundation Trust

Maternity Incentive Scheme

Safety Action 6 - Saving Babies Lives

Report Title	**Safety action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?**
Report for	Approval and Information
Report from	Maternity and Neonatal Services
Leads for Report	Karen Newbury, Head of Midwifery, Midwifery Safety Champion Kate Croissant, Obstetric Safety Champion & Deputy Clinical Director for Women's and Children's Services
Report Authors	Beverley Gordon, Project Midwife Karen Green, Clinical Quality and Governance Matron
Report presented for information and approval	Maternity Quality and Safety Group – 16th January 2023
	Maternity and Neonatal Safety Champions – 26th January 2023
	Trust Board – February 2023
Date of Report	December 2022
Risk and assurance:	There are financial risks associated with non-compliance with the Maternity Incentive Scheme Year 4 requirements as this report outlines the Trust's position
Legislation, regulatory, equality, diversity and dignity implications	The information contained within this report has been obtained through due diligence

Executive Summary

The Trust has embedded all 5 elements of the version 2 of Saving Babies Lives. Progress has been made in achieving a high standard or compliance with the standards.

It has not been possible to achieve more than 80% compliance with administration of a course of steroids to women who give birth under 34 weeks gestation during this period of time. The criteria for administration of steroids to women from the Royal College of Obstetricians (RCOG) guidance issued in 2022 has been applied but despite the use of diagnostic aids to help to predict preterm birth, labour does not always commence within the first 7 days. As it takes up to 24 hours to administer a full course, getting the timing of the doses correct is a clinical challenge.

Women who gave birth on route to the maternity unit or who delivered rapidly after admission have been omitted from the compliance as these situations were unavoidable.

Element 5: A Trust will not fail Safety Action 6 if the process indicator scores are less than 80%. However, Trusts must have an action plan for achieving >80%

Recommendations and Next Steps

Continue to review and monitor all births where there is perinatal mortality or morbidity associated with these elements and where the outcome is unexpected such as small babies, preterm labour and preterm birth to ensure that risk factors are managed appropriately at booking and during pregnancy care.

Report Title -Compliance with Maternity Safety Action 6 – Saving Babies Lives

1. Purpose of the Report

To provide assurance on the Trust's commitment to implementing and embedding of processes and practices to comply with Saving Babies' Lives Care Bundle version 2

2. Background

The Maternity Incentive Scheme run by NHS resolution is in its fourth year and builds on the progress made in the previous 3 years. The safety action that this report relates to Safety Action 4 to ensure that all of the elements of the Saving Babies Lives Care Bundle version 2.0 are implemented.
Year 4 safety actions were published in August 2021. In December 2021, the requirements for evidence and submission were put on hold due to the effects of the pandemic on maternity services across the country. In May 2022, the safety actions were republished with updated timeframes and requirements where required.

3. Standards Required – October 2022

1. Trust Board level consideration of how its organisation is complying with the Saving Babies' Lives care bundle version two (SBLCBv2), published in April 2019.
   Note: Full implementation of the SBLCBv2 is included in the 2020/21 standard contract.
2. Each element of the SBLCBv2 should have been implemented. Trusts can implement an alternative intervention to deliver an element of the care bundle if it has been agreed with their commissioner (CCG). It is important that specific variations from the pathways described within SBLCBv2 are also agreed as acceptable clinical practice by their Clinical Network – see Appendix 1.
3. The quarterly care bundle survey should be completed until the provider Trust has fully implemented the SBLCBv2 including the data submission requirements.

   The survey will be distributed by the Clinical Networks and should be completed and returned to the Clinical Network or directly to *England.maternitytransformation@nhs.net* from May 2022 onwards.
   Evidence of the completed quarterly care bundle surveys should be submitted to the Trust board.

4. Compliance with Safety Actions

SBL Element	Standard	WSH Compliance	Evidence Source
1. Trust Board level consideration of how its organisation is complying with the Saving Babies' Lives care bundle version two (SBLCBv2), published in April 2019. Note: Full implementation of the SBLCBv2 is included in the 2020/21 standard contract.		**GREEN**	Audit reports and survey
2. Each element of the SBLCBv2 should have been implemented. Trusts can implement an alternative intervention to deliver an element of the care bundle if it has been agreed with their commissioner (CCG). It is important that specific variations from the pathways described within SBLCBv2 are also agreed as acceptable clinical practice by their Clinical Network.	**Element 1 – Smoking in pregnancy** **80%**	A. 90.5%	**Audit Report December 2022** CO monitoring at booking 4 consecutive months or 60 consecutive cases
		B. 98%	CO monitoring at 36 weeks 4 consecutive months or 60 consecutive cases
		1.	Data quality rating for July 2022
		2. Yes	Referral pathway in place in Trust
		3. Yes	Audit 20 consecutive cases ≥4ppm at booking – referral
		4. a 5.3% b 5.2% c 2.7% or 51.2%	a) % women with ≥4ppm at booking b) % women with ≥ 4ppm at 36 weeks c) % women with ≥ 4ppm at booking but <4ppm at 36 weeks Over 4 consecutive months
	Element 2 – Fetal Growth	1 100%	
		2 100%	
		3 100%	

		4 Completed Q1 & Q2 audits	
		5 - 2 cases but not considered to be directly related to FGR assessment or poor care	Cases of PMM from 2021 where fetal growth was identified as an issue
		6 Agreed as compliant	
		7 Completed	10 cases every quarter FGR – number of cases each quarter is <10.
	Element 3 – Fetal Movements	A 100%	
		B 100%	
	Element 4 – Fetal Monitoring in Labour		See Training compliance report for Safety Action 8
	Element 5 – Preterm Labour and Birth	A 45% of all babies born <34 weeks	Draft overarching report
		A 75% of babies where it was possible to give 2x steroids	Steroids within 7 days of birth under 34 weeks **A Trust will not fail Safety Action 6 if the process indicator scores are less than 80%. However,**

			Trusts must have an action plan for achieving >80%.
		B Yes	Steroids >7 days of birth on MIS (15%)
		C 75% of all babies delivering under 30 weeks	Magnesium sulfate administered within the last 24 hours before birth <30 weeks. One baby was born on route to the hospital so this was unavoidable so birth in the unit compliance is 100%.
		C 100% of all babies where it was possible to give mag sulfate	
		D 80%	Suitable birth setting – 2 babies born in transit to the unit – one was < threshold for the Trust.
		E i see report Ii see above	20 cases threatened PTL 20 cases PT birth
		a Yes	Lead for PT prevention
		b Yes	Access to PTB clinic and cervical screening – see guidance
		C 100%	40 consecutive cases risk assessment and referral to PTP clinic
		D Yes	Multiple pregnancy guidance compliant with NICE

3. The quarterly care bundle survey should be completed until the provider Trust has fully implemented the SBLCBv2 including the data submission requirements. The survey will be distributed by the Clinical Networks and should be completed and returned to the Clinical Network or directly to *England.maternitytransformation@nhs.net* from May 2022 onwards.	Evidence of the completed quarterly care bundle surveys should be submitted to the Trust board.	**GREEN**	

5. Conclusions

The Trust has embedded all 5 elements of the version 2 of Saving Babies Lives. Progress has been made in achieving a high standard or compliance with the standards.

It has not been possible to achieve more than 80% compliance with administration of a course of steroids to women who give birth under 34 weeks gestation during this period of time. The criteria for administration of steroids to women from the Royal College of Obstetricians (RCOG) guidance issued in 2022 has been applied but despite the use of diagnostic aids to help to predict preterm birth, labour does not always commence within the first 7 days. As it takes up to 24 hours to administer a full course, getting the timing of the doses correct is a clinical challenge.

Women who gave birth on route to the maternity unit or who delivered rapidly after admission have been omitted from the compliance as these situations were unavoidable.

Element 5: A Trust will not fail Safety Action 6 if the process indicator scores are less than 80%. However, Trusts must have an action plan for achieving >80%.

6. Recommendations

Identify ways in which the level of administration of steroids for women with suspected PROM and Pre-term labour within 7 days of a preterm birth can be improved where time allows.

Continue to review and monitor all births where there is perinatal mortality or morbidity associated with these elements and where the outcome is unexpected such as small babies, preterm labour and preterm birth to ensure that risk factors are managed appropriately at booking and during pregnancy care.

7. Action Plan

Action plan lead	Name: Kate Croissant	Title: Clinical Lead	Contact:

Recommendation	Actions required	Action by date	Person responsible	Comments/action status
Identify ways in which the level of administration of steroids for women with suspected PROM and Pre-term labour within 7 days of a preterm birth can be improved, where possible	Monitor compliance with the risk assessment for preterm birth at booking as part of the audit schedule Review of the risk assessment and documentation for women attending the unit with suspected preterm labour or pre-labour, preterm SRM against the RCOG guideline for steroid administration to ensure that, where possible steroids are given within 7 days of birth <34 weeks. Exception reporting when it is deemed that steroid administration has not followed best practice and/or non-compliance is avoidable	Ongoing quarterly audits	Victoria Mc Ewen-Smith	
Monitor compliance with all elements through audit and data submitted from the Maternity Information System	Audit plan and completion of SBL surveys. Monitoring on the Quality Dashboard	Ongoing quarterly audits	Victoria Mc Ewen-Smith Karen Green	

Appendix 1 Specific standards for each element

Element one

Process indicators:

A. Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded.

B. Percentage of women where CO measurement at 36 weeks is recorded.

Note: The relevant data items for these process indicators should be recorded on the provider's Maternity Information System (MIS) and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding. The Trust board should receive data from the organisation's MIS evidencing an average of 80% compliance over a four month period (i.e. four consecutive months in during the MIS year 4 reporting timeframe).

If there is a delay in the provider Trust's ability to submit these data to MSDS then compliance can be determined using their interim data recording method. The denominator should still be the total number of women at booking or 36 weeks gestation, as appropriate for each process indicator.

If the provider Trust is unable to record these data on their maternity information system an audit of 60 consecutive cases would be acceptable evidence to demonstrate >80% of women having a CO measurement recorded at 36 weeks. The denominator for the audit should be 60 consecutive women at 36 weeks gestation, whereas the denominator for the electronic audit would be the total number of women at 36 weeks gestation. In addition to this, the audit should be accompanied by a brief description of the stop smoking strategy within the Trust and any plans for improvement.

A Trust will fail Safety Action 6 if the process indicator metric compliance is less than 80%.

If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%.

In addition, the Trust board should specifically confirm that within their organisation they:

1) Pass the data quality rating on the National Maternity Dashboard for the 'women who currently smoke at booking appointment' Clinical Quality Improvement Metric.
2) Have a referral pathway to smoking cessation services (in house or external).
3) Audit of 20 consecutive cases of women with a CO measurement ≥4ppm at booking, to determine the proportion of women who were referred to a smoking cessation service.
4) Have generated and reviewed the following outcome indicators within the Trust for four consecutive months within the MIS year 4 reporting period:
   - Percentage of women with a CO measurement ≥4ppm at booking.
   - Percentage of women with a CO measurement ≥4ppm at 36 weeks.
   - Percentage of women who have a CO level ≥4ppm at booking who subsequently have a CO level <4ppm at the 36 week appointment.

Additional information

If your Trust is planning on using the maternity dashboard to evidence an average of 80% compliance over four months, please be advised that there is a three month delay with MSDSv2 data, for example data submitted at the end of August 2022 will be published on the dashboard at the end of November 2022.

If your Trust does not have an in house stop smoking service or a pathway to an external service, please contact your local authority stop smoking service or escalate to your local maternity system to enable the Trust to ensure provision is in place.

***Percentage of women where Carbon Monoxide (CO) measurement at booking is recorded*.**

Women declining CO testing at booking / 36 weeks appointment

Standard A and B of element 1 require Trusts to demonstrate that 80% of women had CO testing at booking and at 36 weeks respectively and that this is recorded in the Trusts' information system.
In the event of a high number of women declining CO testing a Trust would be at risk of failing standard A and B by not reaching the 80% testing rate. We suggest Trusts proactively monitor their testing rate and consider interventions to maintain adequate compliance.

Element two

Process indicator:

1) Percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded using a risk assessment pathway at booking and at the 20 week scan (e.g. Appendix D).

Note: The relevant data items for these indicators should be recorded on the provider's Maternity Information System and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding. The Trust board should receive data from the organisation's MIS evidencing 80% compliance.

If there is a delay in the provider Trust Maternity Information System's ability to record these data at the time of submission an in house audit of 40 consecutive cases of women at 20 weeks scan using locally available data or case records should have been undertaken to assess compliance with this indicator.

A Trust will fail Safety Action 6 if the process indicator metric compliance is less than 80%.

If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%.

In addition the Trust board should specifically confirm that within their organisation:

2) Women with a BMI>35 kg/m^2 are offered ultrasound assessment of growth from 32 weeks' gestation onwards
3) In pregnancies identified as high risk at booking uterine artery Doppler flow velocimetry is performed by 24 completed weeks gestation
4) There is a quarterly audit of the percentage of babies born <3rd centile >37+6 weeks' gestation.
5) They have generated and reviewed the percentage of perinatal mortality cases for 2021 where the identification and management of FGR was a relevant issue (using the PMRT).
6) Their risk assessment and management of growth disorders in multiple pregnancy complies with NICE guidance or a variant has been agreed with local commissioners (CCGs) following advice from the Clinical Network.
7) They undertake a quarterly review of a minimum of 10 cases of babies that were born <3rd centile >37+6 weeks' gestation. The review should seek to identify themes that can contribute to FGR not being detected (e.g. components of element 2 pathway and/or scanning related issues). The Trust board should be provided with evidence of quality improvement initiatives to address any identified problems. Trusts can omit the above mentioned quarterly review of a minimum of 10 cases of babies that were

born <3rd centile >37+6 weeks' gestation for quarter 3 of this financial year (2021/22) if staffing is critical and this directly frees up staff for the provision of clinical care.

Element three

Process indicators:

A. Percentage of women booked for antenatal care who had received reduced fetal movements leaflet/information by 28+0 weeks of pregnancy.

B. Percentage of women who attend with RFM who have a computerised CTG (a computerised system that as a minimum provides assessment of short term variation).

Note: The SNOMED CT code is still under development for RFM and therefore an in-house audit of two weeks' worth of cases or 20 cases of women attending with RFM whichever is the smaller to assess compliance with the element three process indicators.

A Trust will fail Safety Action 6 if the process indicator metric compliance is less than 80%.

If the process indicator scores are less than 95% Trusts must also have an action plan for achieving >95%.

Element four

There should be Trust board sign off that staff training on using their local CTG machines, as well as fetal monitoring in labour are conducted annually. The fetal monitoring sessions should be consistent with the Ockenden Report recommendations, and include: intermittent auscultation, electronic fetal monitoring with system level issues e.g. human factors, escalation and situational awareness.

The Trust board should specifically confirm that within their organization 90% of eligible staff (see Safety Action 8) have attended local multi-professional fetal monitoring training annually as above.

Please refer to safety action 8 for more information re training.

Element five

Process indicators:

A. Percentage of singleton live births (less than 34+0 weeks) receiving a full course of antenatal corticosteroids, within seven days of birth.

B. Percentage of singleton live births occurring more than seven days after completion of their first course of antenatal corticosteroids.

C. Percentage of singleton live births (less than 30+0 weeks) receiving magnesium sulphate within 24 hours prior birth.

D. Percentage of women who give birth in an appropriate care setting for gestation (in accordance with local ODN guidance).

Note: The relevant data items for these process indicators should be recorded on the provider's Maternity Information System and included in the MSDS submissions to NHS Digital in an MSDSv2 Information Standard Notice compatible format, including SNOMED-CT coding.

If there is a delay in the provider Trust MIS's ability to record these data then an audit of 40 cases consisting of 20 consecutive cases of women presenting with threatened preterm labour before 34 weeks and 20 consecutive cases of women who have given birth before 34 weeks using locally available data or case records should have been undertaken to assess compliance with each of the process indicators.

The Trust board should receive data from the organisation's Maternity Information System evidencing 80% compliance with process indicators A, C and D. The percentage for process indicator B should be as low as possible and can be reported as the proportion.

A Trust will not fail Safety Action 6 if the process indicator scores are less than 80%. However, Trusts must have an action plan for achieving >80%.

In addition, the Trust board should specifically confirm that within their organisation:

- They have a dedicated Lead Consultant Obstetrician with demonstrated experience to focus on and champion best practice in preterm birth prevention. (Best practice would be to also appoint a dedicated Lead Midwife. Further guidance/information on preterm birth clinics can be found on https://www.tommys.org/sites/default/files/2021-03/reducing%20preterm%20birth%20guidance%2019.pdf
- Women at high risk of preterm birth have access to a specialist preterm birth clinic where transvaginal ultrasound to assess cervical length is provided. If this is not the case the board should describe the alternative intervention that has been agreed with their commissioner (CCG) and that their Clinical Network has agreed is acceptable clinical practice.
- An audit of 40 consecutive cases of women booking for antenatal care has been completed to measure the percentage of women that are assessed at booking for the risk of preterm birth and stratified to low, intermediate and high risk pathways, and the percentage of those assessed to be at increased risk that are referred to the appropriate preterm birth clinic and pathway. The assessment should use the criteria in Appendix F of SBLCBv2 or an alternative which has been agreed with local CCGs following advice from the Clinical Network.
- Their risk assessment and management in multiple pregnancy complies with NICE guidance or a variant that has been agreed with local commissioners (CCGs) following advice from the provider's clinical network.

Appendix 2 Technical Guidance

Technical guidance	
Where can we find guidance regarding this safety action?	SBL care bundle: https://www.england.nhs.uk/publication/saving-babies-lives-version-two-a-care-bundle-for-reducing-perinatal-mortality/ The SBLCB v2 Technical Glossary which includes the numerators and denominators for all of the process indicators can be found on the NHS Digital webpages here: https://digital.nhs.uk/binaries/content/assets/website-assets/data-and-information/data-sets/maternity-services/sblcbv2-msds-v2.0-technical-glossary-for-publication.xlsx Any queries related to the **digital aspects** of this safety action can be sent to NHS Digital mailbox maternity.dq@nhs.net For any other queries, please email nhsr.mis@nhs.net
Further guidance regarding element 2 of the SBL care bundle V2	Compliance with the intervention for surveillance of low-risk women does not mandate participation in the Perinatal Institute's Growth Assessment Protocol (GAP) or the use of customised fundal charts. Providers should however ensure that for low risk women, fetal growth is assessed using antenatal symphysis fundal height charts by clinicians trained in their use. All staff must be competent in measuring fundal height with a tape measure, plotting measurements on charts, interpreting appropriately and referring when indicated. All women should have a risk assessment for FGR at booking. It should be appreciated that some women will develop additional risk factors after the booking appointment such as significant bleeding or risk factors that will only be evident after the mid-trimester anomaly scan, such as echogenic bowel or EFW <10th centile. When these risk factors are identified their clinical pathway will change as per SBLCBv2 Figure 6 in Appendix D. If a Trust chooses to meet this standard using an electronic audit which is unable to capture risk factors after booking then the Trust should include a brief description of how women with significant bleeding after booking, echogenic bowel or EFW <10th centile are triaged to the appropriate pathway described in fig. 6 of appendix D in SBLCBv2. There will be a variety of ways Trusts choose to do this, but what is important is that women with these risk factors receive the appropriate care. An example might be that when a risk factor is identified at the mid-trimester scan the ultrasonographer alerts the antenatal clinic midwife who then arranges obstetric review and the additional scans indicated. A similar process of escalation should be described for significant bleeding after booking. Confirmation by the Trust Board that the Trust has implemented the Tommy's Centre Clinical Decision Tool within a research programme will

	meet the requirement that standard 1-2 above have been implemented.
What is the deadline for reporting to NHS Resolution?	2 February 2023 at 12noon

West Suffolk NHS
NHS Foundation Trust

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

Report Title	**Report on compliance with Safe Obstetric Anaesthetic staffing from January to March 2022**
Report for	**Information and Approval of Actions**
Report from	Women's & Children's Services in collaboration with Theatres & Anaesthetics
Report Author	Beverley Gordon, Project Midwife, WSH
Dates and groups for approval	1. Maternity Quality and Safety 19th December 2022 2. Maternity and Neonatal Safety Champions 22nd December 2022 3. Trust Board 2nd February 2023

Executive Summary

This report has been written to confirm compliance with safe staffing requirements for obstetric anaesthesia within the Maternity Unit of West Suffolk NHS FT (WSNHSFT).
The previous reports provided evidence of ongoing compliance with safety standards for obstetric anaesthetic staffing levels in Quarter 3 and 4 of 2021/2022. This new report covers the period April 1st to September 30th 2022.

Findings
The rotas for anaesthetic staff have been independently reviewed to ensure that there is a named staff member covering the on call obstetric rota for each 24-hour period.
The findings confirm that there is allocation and identification of a dedicated anaesthetist on the rota for obstetric cases throughout this 6-month period.

Next steps
The next review and report will be completed in 6 months.

1. Background

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

2. Standards to be met

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

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

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

Anaesthesia Clinical Services Accreditation (ACSA) standards and action

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

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

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

There is no fixed period of time that the rotas need to be reviewed so the Trust has taken the decision to review the rotas at 6 monthly intervals to ensure there is sustainability within the rota management.

3. Methodology

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

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

4. Results

All the rotas demonstrated that a staff member was allocated to hold the on-call bleep 770 during this period of time from April 1st to September 30th 2022. The rotas show that where the bleep holder is allocated to other duties – e.g. the elective caesarean section list – the bleep holder is working with other anaesthetists who can either continue with the planned activity or attend to provide obstetric anaesthetic services.

5. Current Compliance with Standards

Clinical Workforce Group	Standard to be met	WSH compliance	Progress Report	Evidence Source
Anaesthetic medical workforce	**Anaesthetic medical workforce** A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (ACSA standard 1.7.2.1)			
	1.7.2.1 A duty anaesthetist is available for the obstetric unit 24 hours a day, where there is a 24 hour epidural service the anaesthetist is resident If this service is offered, rotas should be provided as evidence. If this service is not provided, patient information should be seen which relays exactly what services can be offered	**Yes**	**April 1st to September 30th 2022**	Rotas demonstrate 100% compliance for this period of time.

6. Conclusions

The obstetric anaesthetic rotas reflect the 24/7 cover of the obstetric services and therefore the Trust is assured that the standards are met for Anaesthesia Clinical Services Accreditation (ACSA) standard **1.7.2.1.**
The relevant rotas are stored electronically if required for confirmatory evidence.

7. Recommendations

Continue to monitor the standard to provide assurance that the maternity patients are receiving obstetric anaesthetic services when required.
Any delays in care and/or adverse outcomes due to shortages or lack of/delay in providing obstetric anaesthetic services will be highlighted as an incident using the Trusts incident recording system and investigated by the multidisciplinary Quality and Safety team alongside clinical leads in order to identify learning and remedial actions required to improve practice/services.
A further review and report will be presented in May 2023.
No actions have been identified directly as a result of this report.

West Suffolk NHS
NHS Foundation Trust

Maternity Incentive Scheme – Year 4

Report Title	Report for Safety Action 4d - **Can you demonstrate an effective system of clinical* workforce planning to the required standard? Neonatal Nursing Staff**
Report for	Approval and Information
Report from	Maternity and Neonatal Services
Lead for Safety Action	Deputy Head of Midwifery
Report Author	Justyna Skonieczny, Deputy Head of Midwifery Karen Ranson, NNU Ward Manager Beverley Gordon, Project Midwife
Frequency of report:	The Trust is required to formally record to the Trust Board minutes the compliance to the service specification standards annually using the neonatal clinical reference group nursing workforce calculator. Neonatal nursing workforce review should be undertaken at least once during year 4 reporting period Reporting period: **October 2021-March 2022**
Date of this report:	1st May 2022
Presented at:	May 2022 Operational Delivery Group for information 18th July 2022 Maternity and Gynaecology Quality & Safety 18th August 2022 Maternity & Neonatal Safety Champions 30th September 2022 Trust Board Update for information only 2nd February 2023

Executive summary:

The purpose of this report is to provide evidence and give the Board assurance that work continues to be undertaken within maternity and neonatal services at West Suffolk, to demonstrate progress towards meeting safe staffing standards within the midwifery and neonatal nursing workforce. These standards are outlined in the British Association of Perinatal Medicine (BAPM) guidance and are assessed using the agreed neonatal nursing workforce calculator.

The report indicates that there is a shortfall of 1.40 WTE (6%) between the budget and staff in post. Whilst there is no budget for band 5 nurses who have completed the QIS course, the staff in post at this level contribute to the shortfall in band 6 nurses. This vacancy has been advertised and going through the recruitment process.

The Unit has either a band 6 or band 7 shift leader. All of these staff are QIS. The shift leader is not routinely supernumerary but this is considered Gold Standard, and we aim to hopefully achieve this by the end of the year once the vacant posts have been appointed to.

The findings of the toolkit indicate that the cot occupancy is 70.47% in this period of audit although the number of babies does not consider the neonates having Transitional Care who are still under the care of the neonatal nurses. With the continued aim to reduce Term admissions to the Neonatal Unit, this should not be ignored when calculating the number of staff who are required to deliver direct care.

Following successful approval of a business case to support further development of Transitional Care - 5.8 wte band 4 Nursery Nurses (or equivalent) have been appointed to provide 24-hour support on TC and have been enrolled onto the Transitional Care course starting in September 2022. On completion of this training and passing the competencies for TC, the aim is for TC to be independently staffed 24hrs per day to offer optimal support for Mothers, and further reduce separation of Mother and her baby.

Recommendation:
This report is submitted for review and approval at the Maternity & Gynaecology Quality and Safety Group and then the Maternity and Neonatal Safety Champions Group and presented for information to the Divisional Board. Following this, the report will be presented at the Trust Board meeting and the Local Maternity and Neonatal Service (LMNS) Board.

The Trust board is asked to receive this report as evidence of progress towards safe nursing staff standards in the Neonatal Unit.

1. Background

The Maternity Incentive Scheme (MIS) run by NHS resolution is in its fourth year and builds on the progress made in the previous 3 years. The safety action that this report relates to Safety Action 4d to ensure that the neonatal nursing staffing meets BAPM standards. Year 4 safety actions were published in August 2021. In December 2021, the requirements for evidence and submission were put on hold due to the effects of the pandemic on maternity services across the country. In May 2022, the safety actions were republished with updated timeframes and requirements where required.

The West Suffolk Hospital Neonatal Unit is commissioned as a level one unit equipped to care for babies ranging from 30 weeks gestation to full term, according to their clinical conditions and needs. There are 12 cots: 1 Intensive care, 3 High Dependency Care and 8 Special Care. The designated Level Three Unit is Addenbrookes in Cambridge, a baby needing more intensive care is stabilised within the Unit, and transferred to the nearest Level Two or Three Unit via a designated transport service- PANDR (Paediatric and Neonatal Decision Support and Retrieval Service) once stable, the baby is transferred back for on-going care. Neonatal services at WSFT will follow agreed strategies and guidance as part of the wider East of England Neonatal Network, which encompasses the 17 Neonatal Units in the region of all levels.

Neonatal Unit capacity is planned in co-ordination with the local maternity service and the neonatal operational delivery network (ODN). This takes into account the level of care provided in the unit. Capacity should be planned on an average 80% occupancy where possible- this 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 and recommendation following completion of the audit.

The review was undertaken to:

- To provide evidence of safe neonatal nursing staffing levels against BAPM standards and action required as a result of the audit.
- Provide assurance to the Board that the care delivered on NNU at WSFT is safe and meets the national standards and recommendations.

The purpose of this report is to provide evidence and give the Board assurance that work continues to be undertaken within maternity and neonatal services at West Suffolk, to demonstrate progress towards meeting safe staffing standards within the midwifery and neonatal nursing workforce.

2. Methodology

The Neonatal Nursing Workforce Tool (2020) has been adapted from the 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).

The safety element of this is to ensure that the neonatal unit has the required numbers and experience of staff in post to safely provide care for babies to the required standard. The Trust is required to ensure that there are safe staffing levels on the Neonatal Unit to manage the care of babies who require additional support after birth and to stabilise and

transfer in-utero or ex-utero babies who may need care and treatment outside the limitations of the unit.

Staffing on the Neonatal Unit consists of the Unit Manager, a Practice Development Nurse, a Neonatal Community Sister; Neonatal Intensive Care trained Nurses (Qualified in Speciality - QIS), supported by Staff Nurses, Nursery Nurses and a Ward Clerk. There are two lead neonatologists and designated middle grade doctors within the medical team to support the clinical elements.

Other health care professionals attend the unit to input into neonatal care and these include a physiotherapist; dietician; radiologist; ophthalmology specialist; pharmacist; speech & language therapist, and Clinical Psychology support.

3. Neonatal service requirements:

- Minimum 70% neonatal nurses qualified in speciality (QIS);
- All registered nurses are trained and up-dated in neonatal life support- NLS;
- There should be a supernumerary team leader on an early shift in addition to those providing direct clinical care;
- The Neonatal Nurses are required to support the resuscitation of sick new-born babies in the Labour Suite;
- NNU Skill mix:

Clinical Area	Day	Evening	Night
Neonatal Unit	2 Neonatal trained nurses (QIS) 1-2 Staff nurses (non-QIS) or Nursery Nurses 1 Ward clerk	2 Neonatal trained nurses (QIS) 1-2 Staff nurses (non-QIS) or Nursery Nurses	2 Neonatal trained nurses (QIS) 1-2 Staff nurses (non-QIS) or Nursery Nurses

Nurse/Patient Ratios for the Neonatal Unit:

- **Special Care** 1:4 (registered nurse: infant requiring special care)
- **High Dependency care** 1:1 (registered nurse: infant requiring high dependency care)
- **Intensive care** 1:1 (registered nurse: infant requiring intensive care)

A clear pathway of escalation to support safe, proactive management in times of increased activity, neonatal emergency, insufficient staffing and/or over capacity is set out in the Maternity Escalation Policy (CG10635) in a section specific to NNU. During working hours, it may be necessary for off-rota nursing staff such as the Lead Nurse, PDN, and Ward Manager to undertake clinical duties to support. The Maternity Bleep Holder should also be informed and asked to provide advice and assistance and DATIX should be completed.

The nursing establishment in the budget is usually set historically and based on the activity of the unit. The budget for this year was set on the number of posts in each band.

All band 6 senior nurses are Qualified in Specialty (QIS) trained and the band 5 nurses are given the opportunity to undertake the Qualified in Specialty (QIS) course after approximately 2 years of experience in a neonatal unit. The course takes about 1 year and requires a 12-week placement in a level 3 unit. The Unit used for this is the Tertiary Unit in the cluster group

where the QIS Course is being provided - Cambridge. There is a rolling programme to give all band 5 nurses the opportunity to undertake the course which runs each year. The Trust supports on average 2 nurses per year dependant on staff having the relevant pre-course experience. Due to the Covid crisis, the course for staff for the 19/20 year was suspended however this was re-commenced in January 2022 and 3 staff members are currently undertaking the course.
In addition, all band 4 Nursery Nurses are required to complete the Transitional or Special Care Module in order to provide a higher level of care within transitional care. Following successful approval of a business case to support further development of Transitional Care - 5.8 wte band 4 Nursery Nurses (or equivalent) have been appointed to provide 24 hours support on TC and have been enrolled on to the Transitional Care course starting in September 2022. On completion, and once all staff have completed the TC training and competencies for TC, the aim is for TC to be independently staffed 24hrs per day to offer optimal support for Mothers, and further reduce separation of Mothers and her baby, with a support from Neonatal Nurse.

The Unit has either a band 6 or band 7 shift leader. All of these staff are QIS. The shift leader is not routinely supernumerary but this is considered Gold Standard, and the Trust has an aim to hopefully achieve this by the end of the year as this can be achieved once current vacancies will be filled.

The number of cots and the breakdown of levels of care has not changed since changing from level 2 to level 1 unit.

4. MIS Safety action 4: Can you demonstrate an effective system of clinical* workforce planning to the required standard? – year 4

4d) Neonatal nursing workforce
The neonatal unit meets the service specification for neonatal nursing standards. If the requirements had not been met in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies. If the requirements had been met in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies and share this with the Royal College of Nursing, LMS and Neonatal Operational Delivery Network (ODN) Lead.

Minimum Evidence
The Trust is required to formally record to the Trust Board minutes, the compliance to the service specification standards, annually, using the neonatal clinical reference group nursing workforce calculator (see above). For units that do not meet the standard, the Trust Board should evidence progress against the action plan developed in year 3 of MIS to address deficiencies.
A copy of the action plan, outlining progress against each of the actions, should be submitted to the Royal College of Nursing (doreen@crawfordmckenzie.co.uk), LMS and Neonatal Operational Delivery Network (ODN) Lead.

Time Frames
d) Neonatal nursing workforce
Nursing workforce review has been undertaken at least once during year 4 reporting period.

5. Findings
The audit was originally undertaken in May 2022 and based on the unit activity and staffing levels for the period 1st October 2021 to 31st March 2022. The audit was undertaken by the

Ward Manager & Deputy Head of Midwifery. The results were generated electronically on the basis of the data submitted. The ODN requested that the tool was submitted to themselves for confirmation and verification of the data presented.

Input activity (HRG 2016)		
	Activity	Declared cots
HRG 1 (IC)	28	1
HRG 2 (HD)	134	3
HRG 3 (SC)	1,377	8
Total	**1,539**	**12**

Input staffing numbers (WTE) DIRECT PATIENT CARE ONLY		
	Budget	In post
Total QIS	15.16	12.76
Total Non QIS	3.44	4.44
Total Non Reg	3.28	3.28
Total	**21.88**	**20.48**

These results indicate that there is a shortfall of 1.40 WTE between the budget and staff in post. Whilst there is no budget for band 5 nurses who have completed the QIS course, the staff in post at this level contribute to the shortfall in band 6 nurses. However, the band 5 QIS will not be a shift leader so the requirement is for the band 6 posts to be filled to ensure that there is adequate shift leader cover. This vacancy has been advertised and is going through the recruitment process.
This calculation includes the shift coordinator who is not currently supernumerary but does not include management and education hours for the ward manager and the PDN.

Activity (HRG 2016)							
	Activity	*For calculations*		Declared cots	Occupancy for period	Cots required to meet activity at average 80% occupancy	Variance: declared cots against required
		80% of daily activity	*WTE (6.07 / BAPM)*				
HRG 1	28	*0.2*	*6.07*	1	15.38%	1	0
HRG 2	134	*0.9*	*3.04*	3	24.54%	1	2
HRG 3	1,377	*9.5*	*1.52*	8	94.57%	9	-1
Total	**1,539**			**12**	**70.47%**	**11**	**1**

The data presented above suggests that the cot occupancy is 70.47% which is below the expected standard of 80%. However, this data does not consider any babies having transitional care either in the unit or on the wards which accounts for approximately 16% of babies born each year.

The occupancy in the neonatal unit does not reflect any transitional care (TC) activity either on the ward or in the Special Care unit and admissions from home to TC, therefore this is an additional group of babies requiring oversight and care delivered by the NNU nursing staff. This has been included in the staffing model with a ratio of 1:4 (nurses to babies). Care of the baby should be overseen by a registered nurse whilst the mother is cared for by the midwife and maternity support staff. Joint working is in place to ensure care is delivered according to guidelines. The following table breaks down the figures for TC and the bed days.

Number of babies:	October 2021	November 2021	December 2021	January 2022	February 2022	March 2022
In TC	22	14	9	13	15	12
Bed days	73	57	27	52	60	74
Admitted from home	5	7	7	3	4	6
Bed days	21	51	34	14	15	8
Stepdown (NNU to TC)	6	5	7	10	12	3
Bed days	12	6	8	18	18	8
TOTAL	33	26	23	26	31	21
TOTAL Bed days	106	114	69	84	93	90

6. Nursing Staff against toolkit

Nursing workforce (WTE) DIRECT PATIENT CARE ONLY					
NB total nurse staffing required to staff declared cots = 33.39, of which 23.37 (70%) should be QIS					
	Current position		Required to meet activity at average 80% occ	Variance: budget against required	Variance: in post against required
	Budget	In post			
Total nursing staff	21.88	20.48	24.38	-2.50	-3.90
Total reg nurses	18.60	17.20	20.08	-1.48	-2.88
Total QIS	15.16	12.76	14.05	1.11	-1.29
Total non-QIS	3.44	4.44	6.02	-2.58	-1.58
Total non-reg	3.28	3.28	4.31	-1.03	-1.03
Reg nurses as % nursing staff	85.0%	84.0%	82.3%		
QIS as % reg nurses	81.5%	74.2%	70.0%		

The results show that 74.2% of staff have completed the QIS course which is above national target of 70% and the overall number of registered or trained staff is 84%.

The shift coordinators are either band 6 or band 7 nurses and are currently not supernumerary. Additional band 6 hours have been recruited to in order to work towards this being possible at least some of the time. This should lead to increased assurance of safe staffing levels when staff need to attend high risk births, allow the ward manager to participate in governance forums such as meetings, audits, case reviews, responding to urgent requests for updates and service developments and needs and to ensure that mandatory training and competencies are being met by all the relevant staff. This would also provide some additional support during escalation of activity or acuity when required.

7. Summary

Neonatal care is a high cost speciality commissioned by specialised services. It covers all levels of care from intensive through to care in the community. It should also include the support and education required for new parents/carers. Acuity and dependency vary according to the individual needs of the neonate.

The report indicates that there is a shortfall of 1.40 WTE (6%) between the budget and staff in post. Whilst there is no budget for band 5 nurses who have completed the QIS course, the staff in post at this level contribute to the shortfall in band 6 nurses. This vacancy has been advertised and going through the recruitment process.

The Unit has either a band 6 or band 7 shift leader. All of these staff are QIS. The shift leader is not routinely supernumerary but this is considered Gold Standard, and we aim to hopefully achieve this by the end of the year ones the vacancies post has been appointed to.

The findings of the toolkit indicate that the cot occupancy is 70.47% in this period of audit although the number of babies does not consider the neonates having Transitional Care who are still under the care of the neonatal nurses. With the continued aim to reduce Term admissions to the Neonatal Unit, this should not be ignored when calculating the number of staff who are required to deliver direct care.

Following successful approval of a business case to support further development of Transitional Care - 5.8 wte band 4 Nursery Nurses (or equivalent) have been appointed to provide 24-hour support on TC and have been enrolled onto the Transitional Care course starting in September 2022. On completion of this training and passing the competencies for

TC, the aim is for TC to be independently staffed 24hrs per day to offer optimal support for Mothers, and further reduce separation of Mother and her baby.

8. Recommendation

There should be a regular review of the staffing levels and skill mix to enable this to reflect the activity and acuity going forward.

Allowance made for staffing of TC and enabling staff to complete QIS.

The review should be confirmed by the ODN to ensure that the findings of the toolkit have been applied appropriately

An action plan should be formulated and agreed by all interested parties and submitted to the Divisional Management team for approval prior to submission to the Trust Board.

Complete 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

Technical guidance	
Neonatal nursing workforce	
Where can we find more information about the requirements for neonatal nursing workforce?	Between 8 August 2021 until 5 January 2023, each neonatal unit should perform a nursing workforce calculation using the CRG work force staffing tool. Units that do not meet the service specification requirement for nursing workforce should have an action plan signed off by their Trust board, as per MIS year 3 requirements. Trust Board should evidence progress against the action plan and share those with the RCN, LMNS and Neonatal ODN.
Our Trust does not meet the relevant nursing standards and in view of this an action plan, ratified by the Board has been developed. Can we declare compliance with this sub-requirement?	If the requirements are not met, Trust Board should evidence progress against the action plan developed in year 3 of MIS to meet the recommendations. The action plan and related progress, signed off by the Trust Board, should be shared with the Royal College of Nursing (doreen@crawfordmckenzie.co.uk) and Neonatal ODN Lead. This will enable Trusts to declare compliance with this sub-requirement.

Appendix 2 Summary of Safety Action 4d - Compliance with Standards				
Clinical Workforce Group	**Standard to be met**	**WSH compliance**	**Progress Report**	**Evidence Source**
Neonatal nursing workforce	The neonatal unit meets the service specification for neonatal nursing standards. If the requirements had not been met in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies. If the requirements had been met in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies and share this with the Royal College of Nursing, LMS and Neonatal Operational Delivery Network (ODN) Lead.	**GREEN – staffing assessment completed** **Amber- vacancies as staff recruited to posts have not yet commenced their employment**	Between 8 August 2021 until 5 January 2023, each neonatal unit should perform a nursing workforce calculation using the agreed workforce staffing tool.	Units that do not meet the service specification requirement for nursing workforce should have an action plan signed off by their Trust board, as per MIS year 3 requirements. Trust Board should evidence progress against the action plan and share those with the RCN, LMNS and Neonatal ODN. If the requirements are not met, Trust Board should evidence progress against the action plan developed in year 3 of MIS to meet the recommendations. The action plan and related progress, signed off by the Trust Board, should be shared with the Royal College of Nursing (doreen@crawfordmckenzie.co.uk) and Neonatal ODN Lead. This will enable Trusts to declare compliance with this sub-requirement.

Appendix 3 Copy of the Neonatal Nursing Workforce Calculator

Neonatal CRG Nursing Workforce Calculator (2020): West Suffolk

Input unit details			
Trust	West Suffolk NHS Foundation Trust		
Unit	West Suffolk		
Designation	SCU		
Completed by	J Skonieczny, K. Ranson,		
Date completed	12/05/22		
Activity period	1 October 2021- 31 March 2022	Days in period	182

Input activity (HRG 2016)			Input staffing numbers (WTE) DIRECT PATIENT CARE ONLY		
	Activity	Declared cots		Budget	In post
HRG 1 (IC)	28	1	Total QIS	15.16	12.76
HRG 2 (HD)	134	3	Total Non QIS	3.44	4.44
HRG 3 (SC)	1,377	8	Total Non Reg	3.28	3.28
Total	**1,539**	**12**	**Total**	**21.88**	**20.48**

Activity (HRG 2016)							
	Activity	*For calculations*		Declared cots	Occupancy for period	Cots required to meet activity at average 80% occupancy	Variance: declared cots against required
		80% of daily activity	*WTE (6.07 / BAPM)*				
HRG 1	28	*0.2*	*6.07*	1	15.38%	1	0
HRG 2	134	*0.9*	*3.04*	3	24.54%	1	2
HRG 3	1,377	*9.5*	*1.52*	8	94.57%	9	-1
Total	**1,539**			**12**	**70.47%**	**11**	**1**

Nursing workforce (WTE) DIRECT PATIENT CARE ONLY					
NB total nurse staffing required to staff declared cots = 33.39, of which 23.37 (70%) should be QIS					
	Current position		Required to meet activity at average 80% occ	Variance: budget against required	Variance: in post against required
	Budget	In post			
Total nursing staff	21.88	20.48	24.38	-2.50	-3.90
Total reg nurses	18.60	17.20	20.08	-1.48	-2.88
Total QIS	15.16	12.76	14.05	1.11	-1.29
Total non-QIS	3.44	4.44	6.02	-2.58	-1.58
Total non-reg	3.28	3.28	4.31	-1.03	-1.03
Reg nurses as % nursing staff	85.0%	84.0%	82.3%		
QIS as % reg nurses	81.5%	74.2%	70.0%		

Assumptions For further detail please refer to the narrative sheet.

- Calculations are valid for neonatal unit only - transitional care staffing and activity should be excluded.
- 6.07 WTE is required for 1 nurse per shift. The detail of how this multiplier was calculated is on a separate sheet.
- Staffing requirements are based on activity, and BAPM nurse to baby ratios are used, ie IC 1:1; HD 1:2; SC 1:4.
- Numbers are for nurses providing direct patient care only. Exclude additional roles e.g. management, outreach, education.
- A supernumerary nurse in charge is included for all units on all shifts.
- At least 70% of registered nurses should be Qualified In Specialty (QIS).
- All intensive and high dependancy care should be undertaken by registered nurses with QIS training.
- For special care, registered to non-registered staff ratios are calculated at 70:30.
- Cot calculations assume that cots can be flexed up but not down, so round up to the higher level cots. See narrative for more detail.

Appendix 4 Action plan:

Action plan lead	Name: Justyna Skonieczny	Title: Deputy Head of Midwifery	Contact: Justyna.skonieczny@wsh.nhs.uk

Recommendation	Actions required	Action by date	Person responsible	Comments/action status
There should be a regular review of the staffing levels and skill mix to enable this to reflect the activity and acuity going forward.	Regular staffing review to be undertaken including succession planning	Ongoing review	Karen Ranson	
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	June 2023	Justyna Skonieczny/ Karen Ranson	
Allowance made for staffing of TC and enabling staff to complete QIS.	Ongoing training	June 2023	Karen Ranson/ Maija Blagg	
The review should be confirmed by the ODN to ensure that the findings of the toolkit have been applied appropriately	Report to be submitted to ODN for review and confirmation of findings	July 2022	Justyna Skonieczny	Report approved by ODN on the 7th July 2022
An action plan should be formulated and agreed by all interested parties and submitted to the Divisional Management team for approval prior to submission to the Trust Board.	Report and action plan to be submitted to Quality and safety meeting, Safety Champion prior to submission to the Board	July 2022	Justyna Skonieczny	MNSC meeting August 2022

Trust Open Board	
Report title:	Board approval for Maternity Incentive Scheme – Year 4 - declaration
Agenda item:	
Date of the meeting:	2nd February 2023
Sponsor/executive lead:	Dr Paul Molyneux – Executive Medical Director / Lead Executive for Maternity services Dr Richard Davies – Non-Executive Director lead for Maternity services
Report prepared by:	Karen Newbury, Head of Midwifery Beverley Gordon, Project Midwife

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 Maternity Incentive Scheme (MIS) run by NHS resolution is in its fourth year and builds on the progress made in the previous 3 years. Year 4 safety actions were published in May 2022 (following a period on hold during the pandemic response) with updated timeframes and requirements. This report provides the formal declaration of (partial) compliance which requires Board sign-off prior to submission on 2nd February 2023. The Improvement committee as an assurance sub-committee of the Board has delegated authority to receive and recommend the approval of this submission to the Trust Board. The Chief Executive Officer (CEO) for our Integrated Care Board has been apprised of the MIS safety actions' evidence and declaration form. The CEO has arranged for a panel to review all evidence to ensure this is robust. The outcome of this review will be verbally conveyed to this committee and provided in writing as part of the Improvement committee recommendation to the Board. The WSFT and ICB Chief Executive must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHS Resolution. There are ten safety actions for the Trust to provide evidence of compliance. This report provides the WSFT response to those requirements with a statement of compliance against the ten safety actions. The Trust is declaring compliance with eight of the ten as per table 1 below.

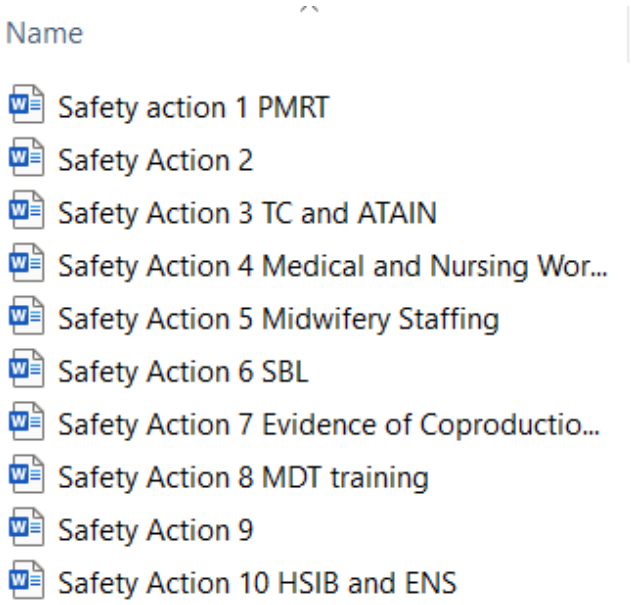
	The evidence for compliance (and partial non-compliance) has been reviewed within the organisation through the divisional internal governance process and by external stakeholders and has been reported through the year in the regular Maternity report to the Open Trust Board. More detail on this oversight is provided in the main body of the report • For seven of the actions, internal and external scrutiny has been sufficient to declare full compliance (evidence provided in appendix) • For two actions (1 and 5), the trust is not able to declare compliance (explanation in main body of report and compliance evidence provided in appendix) • For one action (8), evidence exists to declare full compliance (evidence provided in appendix) however the external scrutiny (from project midwife) has recommended that an explanation of that be considered by this committee prior to sign-off. This is provided in two parts in the main body of report and sets out the assumptions that have been made to arrive at that statement of compliance. To this end, the report and its associated appendices are attached. Table 1 – Safety action compliance

Safety action		**Supporting narrative**
1 Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard	NO	See main report for more details and appendix
2 Maternity Services Data Set (MSDS)	YES	Evidence provided for full compliance in appendix
3 Avoiding Term Admissions into Neonatal Units	YES	Evidence provided for full compliance in appendix
4 Clinical Workforce	YES	Evidence provided for full compliance in appendix
5 Midwifery Staffing	NO	See main report for more details and appendix
6 Saving Babies Lives	YES	Evidence provided for full compliance in appendix
7 Service User feedback and coproduction	YES	Evidence provided for full compliance in appendix
8 Multi-professional maternity training (**for scrutiny**)	YES*	See main report for more details and appendix
9 Safety champions	YES	Evidence provided for full compliance in appendix
10 Reporting to Healthcare Safety Investigation Board (HSIB) and NHS Resolution	YES	Evidence provided for full compliance in appendix

Action required / recommendation:	The Improvement committee has delegated authority to receive and approve this submission on behalf of the Trust Board. To this end the committee members are requested to: 1. Receive the report and appendices as evidence for the Maternity incentive scheme year four submission 2. Acknowledge the **two** areas of reported non-compliance and the explanations thereof 3. Consider the **one** area of reported compliance where the Maternity service have requested scrutiny to support the declaration of full compliance 4. Accept the **seven** other areas of reported compliance where oversight and review have already provided sufficient evidence to support a declaration of full compliance

Previously considered by:	Maternity Quality and Safety Group Maternity and Neonatal Safety Champions Trust Board LMNS ICB Improvement Committee
Risk and assurance:	There are financial risks associated with non-compliance with the Maternity Incentive Scheme Year 4 requirements
Equality, diversity and inclusion:	There are no equality and diversity issues related to this report
Sustainability:	There are no sustainability issues related to this report
Legal and regulatory context:	The information contained within this report has been obtained through due diligence.

The following appendices were provided to the Improvement Committee – the embedded files within these appendices have previously been available through reporting to Trust Board meeting.



1.	**Introduction**
	This report provides the formal declaration of (partial) compliance which requires Board sign-off prior to submission on 2nd February 2023. The Improvement committee as an assurance sub-committee of the Board has delegated authority to receive and recommend the approval of this submission to the Trust Board.
2.	**Background**
	The Maternity Incentive Scheme (MIS) run by NHS resolution is in its fourth year and builds on the progress made in the previous 3 years. Year 4 safety actions were published in August 2021. In December 2021, the requirements for evidence and submission were put on hold due to the effects of the pandemic on maternity services across the country. In May 2022, the ten safety actions were republished with updated timeframes and requirements where required.
3.	**Previous review and oversight of the evidence**
	All evidence has gone through the divisional internal governance process prior to being reviewed by the Maternity Safety Champions, Trust Board and the Local Maternity and Neonatal System. The Trust Board meetings have received all the evidence presented today through the Open Board Maternity report. The non-Executive Director with responsibility for Maternity services (Dr Richard Davies) has provided the following assurance to the committee today *"I have already had visibility of the details of the CNST submission through the maternity and neonatal safety champions meetings – so am happy to support the signing of the declaration without attending Improvement Committee*" The Accountable Officer (AO) for our Integrated Care Board (Lisa Nobes – SNEE ICB Chief Nurse) has been apprised of the MIS safety actions' evidence and declaration form. The AO has arranged for a panel to review all evidence to ensure this is robust. The outcome of this review will be verbally conveyed to this committee and provided in writing as part of the Improvement committee recommendation to the Board.
4.	**Compliance**
4.1	Full compliance (seven safety actions) 2. Maternity Services Data Set (MSDS) 3. Avoiding Term Admissions into Neonatal Units 4. Clinical Workforce 6. Saving Babies Lives 7. Service User feedback and coproduction 9. Safety champions 10. Reporting to Healthcare Safety Investigation Board (HSIB) and NHS Resolution Notes • Safety action four: Whilst the neonatal nursing workforce calculator indicates we are not compliant with the numbers of band 6 nurses in the neonatal unit, the Trust has mitigated this by having more band 5 nurses who are qualified in specialty. This is sufficient to allow a declaration of compliance. • Safety action six: We are not compliant with one element of this action but that still provides an overall scoring of compliance for this action.
4.2	Non compliance (two safety actions) 1. Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard

	5. Midwifery Staffing Notes • Safety action 1: The date for submitting surveillance information on a baby loss was outside the timeframe of one month (by one working day). This was an administrative error and safeguards have been put in place in order to mitigate any future issues. There was no patient safety incident as a result of this delayed submission and a multidisciplinary review had taken place and any immediate actions were taken at the time. • Safety action five: The requirements for midwifery staffing include that the Labour suite coordinator be supernumerary at all times. Whilst this can be challenging with current staffing establishments, the maternity unit make every effort to maintain this standard. The standard notes that "*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 for a woman in established labour during this time*." On one occasion a woman in advanced labour presented to the unit and the baby was born before additional support from other staff could be organised as the labour proceeded swiftly. In order to ensure the woman was supported during the birthing episode, the labour suite coordinator attended the delivery for a short period of one-to-one care in labour thus not adhering to her supernumerary status. The service considers that this was the most appropriate action to take at the time from a caring and safe perspective but acknowledges that this results in a declaration of non-compliance.
4.3	Compliance statement for discussion – Assumptions made(one safety action) 8. Multi-professional maternity training The local training programme has been approved and embedded to provide the training programmes required for the next 3 years to cover the 6 core modules. This was updated in August 2022 to extend the multiprofessional day to include fetal monitoring training as part of the day. The attendances at the parts of the training day which include obstetric emergencies and neonatal life support are compliant with 90% or more of each of the relevant staff groups for each element of training. The Trust has not had the fetal monitoring training as part of the one-day in-house multiprofessional training day for the whole of 2022 as this required a major change to the schedules and there were changes to the staff in post for specific roles. <u>Assumption one</u> - Following review of attendance at training sessions and completion of modules, that have taken place across the 3 mediums - cases reviews, K2 training and the sessions introduced on the training day since August, it is considered that these constitute equivalent compatibility with the overall philosophy and training programmes required to maintain safety and therefore assumed that the Trust is compliant. <u>Assumption two</u> - In the absence of obstetricians and anaesthetists being candidates, it is our assumption that the obstetrician and obstetric anaesthetist who are part of the faculty, will provide assurance that the sessions are multi-professional and therefore the compliance with the MDT element of the training is met. Note – This action was previously reported as non-compliant to the trust board meetings because the total number of staff trained had not met the required target. This has now been met and therefore that part of the compliance statement is fully supported by the evidence provided.

5.	**Formal sign-off**
	The WSFT Chief Executive and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHS Resolution. This will be undertaken once the following events have occurred: • Improvement committee receive this report and agree with the declaration of 8 / 10 safety actions compliance (16th January 2023) • Accountable Officer panel complete review all evidence to ensure this is robust. 5/10 review already complete at date of this report (13th January 2023), remaining 5/10 review being completed 17th January 2023. The Board meeting on the 2nd February will formally minute the submission which is required to be uploaded by midday on that same day.
6.	**Recommendations**
	The Improvement committee has delegated authority to receive and approve this submission on behalf of the Trust Board. To this end the committee members are requested to: 1. Receive the report and appendices as evidence for the Maternity incentive scheme year four submission 2. Acknowledge the **two** areas of reported non-compliance and the explanations thereof 3. Consider the **one** area of reported compliance where the Maternity service have requested scrutiny to support the declaration of full compliance 4. Accept the **seven** other areas of reported compliance where oversight and review have already provided sufficient evidence to support a declaration of full compliance

Trust Open Board – 2nd February 2023

Report title:	Trust Review of; 'Reading the Signals – Maternity and neonatal services in East Kent – the report of the Independent Investigation'
Agenda item:	
Executive lead:	Sue Wilkinson - Chief Nurse
Report prepared by:	Karen Newbury, Head of Midwifery

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

Trust strategy	FIRST FOR PATIENTS	FIRST FOR STAFF	FIRST FOR THE FUTURE
Please indicate ambitions relevant to this report	☒	☐	☒

Executive summary

NHS England has written to all Trust Boards asking them to review the findings of 'Reading the Signals: Maternity and Neonatal Services in East Kent – the Report of the Independent Investigation.

This report provides a brief overview of the Independent Investigation into East Kent Maternity Services by Dr Kirkup, which highlights that the repeated problems were systemic, particularly reflecting problems of attitude, behaviour and team working, and they reflected a persistent failure to look and learn.

The letter from NHS England continues to state:

- That all Trust Boards should remain focused on delivering personalised and safe maternity and neonatal care. 'You must ensure that the experience of women, babies and families who use your services are listened to, understood and responded to with respect, compassion and kindness. The experiences bravely shared by families with the investigation team must be a catalyst for change.
- Every board member must examine the culture within their organisation and how they listen and respond to staff. You must take steps to assure yourselves, and the communities you serve, that the leadership and culture across your organisation(s) positively supports the care and experience you provide.
- We expect every Trust and ICB to review the findings of this report at its next public board meeting, and for boards to be clear about the action they will take, and how effective assurance mechanisms are at 'reading the signals'.

In 2023 NHSE will publish a single delivery plan for maternity and neonatal care which will bring together actions required following this report, the report into maternity services at Shrewsbury and Telford NHS Foundation Trust (Ockendon), and NHS Long-Term Plan and Maternity Transformation Programme deliverables.

The maternity services leadership team and Trust Board Level Maternity Safety Champions will work with staff, user representatives and partners for the Local maternity and neonate system (LMNS) to respond to the requirements of national standards in providing assurance to address the 4 key areas of action. This will support and ensure that our overall practices, culture and leadership in the Maternity Unit and trust wide are safe, open and accountable for our families and our staff. This will also safeguard the Trust to meet the standards and outcomes expected nationally.
Action required of the Board
To receive findings To respond to the actions for the Trust; approach to reputation management and to ensure there is proper representation of maternity care on their boards.
Recommendation
The Board agrees to commit to discuss and review the report implications and actions fully at the next Board development day to develop a Board response that will be shared at the next open board.

Previously considered by:	Maternity Quality and Safety forum, Maternity and Neonatal Safety Champion meeting, Local Maternity and Neonatal System forums/Committees
Risk and assurance:	
Equality, Diversity and Inclusion:	This paper has been written with due consideration to equality, diversity and inclusion.
Sustainability:	There are no sustainability issues related to this report
Legal and regulatory context:	The information contained within this report has been obtained through due diligence.

1.	**Introduction**
	NHS England have requested that all Trust Boards review the findings of the Independent Investigation into East Kent Maternity and Neonatal Services and to be clear about the action they will take and how effective assurance mechanisms are at 'reading the signals'
2.	**Background**
	The independent investigation team led by Dr Bill Kirkup, into East Kent Hospitals University NHS Foundation Trust, published a report setting out its findings and key areas where action is needed to improve patient safety in maternity and neonatal services on 19th October 2022. **Reading the signals: maternity and neonatal services in East Kent, the report of the independent investigation – Full Report (Annex K)** The investigation was formally commissioned by the Secretary of State in February 2020. Its aim was to assess the systems and processes used by the Trust to monitor compliance and improve quality within the maternity and neonatal care pathway, evaluate their approach to risk management and implementing lessons learnt, and to assess the governance arrangements that oversee the delivery of these services.
3.	**Investigation findings**
	<u>A. Assessment of Clinical Care Provided</u> The investigation identified the following clinical outcomes: • Had care been given to the nationally recognised standards, the outcome could have been different in 97, or 48%, of the 202 cases assessed by the Panel, and the outcome could have been different in 45 of the 65 baby deaths, or 69% of these cases. • In the 25 cases involving injury to babies, 17 involved brain damage (HIE and/or cerebral palsy) had care been given to nationally recognised standards, the outcome could have been different in 12 of these 17 cases (70.6%). • In the 32 cases involving maternal injuries or deaths, the Panel's findings are that in 23 (71.9%) had care been given to nationally recognised standards, the outcome could have been different. • The Panel has not been able to detect any discernible improvement in outcomes or suboptimal care, as evidenced by the cases assessed over the period from 2009 to 2020. <u>B. Experience of Families</u> The wider experiences of the families identified 6 common themes which have been further elaborated by their indicative behaviour: 1. Not being listened to or consulted with • Not listening to women's concerns or not taking them seriously, resulting in a failure to recognise warning signs or a deteriorating situation • Not taking the time to explain to women or their families what was happening or involving them fully in decisions about their care • Failing to keep accurate notes about what women themselves were saying and how they were feeling 2. Encountering a lack of kindness and compassion • Showing a basic lack of kindness, care and understanding to women and their families • Making unkind or insensitive comments to women and their partners

	• Showing an indifference to women's pain • Failing to ensure or preserve women's dignity or provide for their basic needs • Placing women with other mothers and their newborn babies following the loss of their own baby or after a serious event • Putting pressure on families to consent to a post-mortem examination 3. Being conscious of unprofessional conduct or poor working relationships compromising their care • Making rude, inappropriate or offensive comments to women and their partners • Behaviours or comments that undermined colleagues, including public disagreements and raising concerns directly with women about their care • Disagreements between individuals in the same or different professional groups about women's care, including giving mixed messages • Failing to pass on or act on information, including failing to hand over effectively at shift change or to communicate effectively between services • Shifting the blame for a poor outcome onto colleagues 4. Feeling excluded during and immediately after a serious event • Not being told what was happening, or what had happened, when things went wrong • Leaving family members waiting and anxious for news 5. Feeling ignored, marginalised or disparaged after a serious event • A collective failure to be open and honest or to comply with the duty of candour • A collective failure to act on or respond to concerns, including a poor or inadequate response to complaints • A tendency for the Trust to fail to take responsibility for errors or to show accountability • A failure to provide adequate follow-up support, including appropriate counselling 6. Being forced to live with an incomplete or inaccurate narrative. • Blaming women and families, or making them feel to blame for what had happened to their baby • Not giving women and their families answers or reasons for why things had gone wrong <u>C. Experience of Staff</u> - This helped to shape the investigation findings.
4.	**Key Actions Identified**
	The Four Key Areas for Action identified to be addressed: **Key Action Area 1: Monitoring safe performance – finding signals among noise** A reliable nationally standardised mechanism to give early warning of problems before they cause significant harm. This will monitor the safety and performance of its maternity and neonatal services in real time and will be based on: **I. Better outcome measures that are meaningful, reliable, risk adjusted and timely.** **II. Trends and comparators, both for individual units and for national overview.** **III. Identification of significant signals among random noise, using techniques that account properly for variation while avoiding spurious ranking into "league tables".**

	Key Action Area 2: Standards of clinical behaviour – technical care is not enough Technical competence is not enough, there is an equal need for staff to behave professionally and to show empathy. There were frequent instances of a distressing and harmful lack of professionalism and compassion and evidence of staff not showing kindness or compassion and not listening or being honest. Staff response had been based on personal and institutional defensiveness on blame shifting and punishment. The well-founded views and concerns of women and other family members were dismissed or ignored altogether they were simply not listened to. This key action area highlights the need to address the balance between the technical aspects and the human kindness needed to care for people compassionately, effectively and safely. **Key Action Area 3: Flawed team working – pulling in different directions** A team that does not share a common purpose is not a team. The East Kent maternity services was dysfunctional and described as "toxic", "stressful" working environments. The failure of obstetric staff and midwives to trust and, in some cases, respect each other added a further significant threat to patient safety. There is a need for a better concept of teamwork for maternity services; one that establishes a common purpose across, as well as within, each professional discipline. **Key Action Area 4: Organisational behaviour – looking good while doing badly** The East Kent Trust prioritised reputation management to the detriment of being open and straightforward with families, with regulators and with others. The problems of organisational behaviour that place reputation management above honesty and openness are both pervasive and extremely damaging to public confidence in health services.
5.	**Recommendations from the report**
	<u>Recommendation 1</u> • The prompt establishment of a Task Force with appropriate membership to drive the introduction of valid maternity and neonatal outcome measures capable of differentiating signals among noise to display significant trends and outliers, for mandatory national use. <u>Recommendation 2</u> • Those responsible for undergraduate, postgraduate and continuing clinical education be commissioned to report on how compassionate care can best be embedded into practice and sustained through lifelong learning. • Relevant bodies, including Royal Colleges, professional regulators and employers, be commissioned to report on how the oversight and direction of clinicians can be improved, with nationally agreed standards of professional behaviour and appropriate sanctions for non-compliance. <u>Recommendation 3</u> • Relevant bodies, including the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives and the Royal College of Paediatrics and Child Health, be charged with reporting on how team working in maternity and neonatal care can be improved, with particular reference to establishing common purpose, objectives and training from the outset.

	• Relevant bodies, including Health Education England, Royal Colleges and employers, be commissioned to report on the employment and training of junior doctors to improve support, team working and development. <u>Recommendation 4</u> • The Government reconsider bringing forward a bill placing a duty on public bodies not to deny, deflect and conceal information from families and other bodies. • **Trusts be required to review their approach to reputation management and to ensuring there is proper representation of maternity care on their boards**. • NHSE reconsider its approach to poorly performing trusts, with particular reference to leadership <u>Recommendation 5</u> • The Trust accept the reality of these findings; acknowledge in full the unnecessary harm that has been caused; and embark on a restorative process addressing the problems identified, in partnership with families, publicly and with external input.
6.	**Conclusion**
	The origins of the harm identified and set out in this report lie in failures of team working, professionalism, compassion and listening. The report further highlights failures after safety incidents, failure in the Trust's response including at Trust Board level and the actions of the regulator including numerous missed opportunities to rectify the situation that had developed relating to attitudes and behaviour, and dysfunctional team working. Furthermore, it identifies a clear pattern that those responsible for the services too often provided clinical care that was suboptimal and led to significant harm, failed to listen to the families involved, and acted in ways which made the experience of families unacceptably and distressingly poor. Overall the investigation report importantly highlights that the repeated problems were systemic, particularly reflecting problems of attitude, behaviour and team working, and how they reflect a persistent failure to look and learn. This included poor professional behaviour among clinicians, particularly a failure to work as a cohesive team with a common purpose. True transformation of maternity services can only happen by demonstrating compassion, listening to women and families and responding to their needs and individual experiences. The report details a need to establish a transparent and trusted system that can monitor performance, investigate incidents and promptly identify and improve services. This will be enhanced by the single delivery plan for maternity and neonatal care which will bring together actions required following this report and recent other reports into maternity and neonatal care. West Suffolk NHS Foundation Trust Maternity Unit Actions and Progress;

	The maternity services leadership triumvirate and Trust Board Level Maternity Safety Champions, will work with staff, user representatives and the Local Maternity and Neonatal System to continue to provide assurance to address the four key areas of actions. This will continue to ensure that our overall practices, culture and leadership in the Maternity Unit are safe, open and accountable for our families and our staff. This will also safeguard the Trust to meet the standards and outcomes expected nationally.
7.	**Recommendations and next steps**
	The Board is asked to receive this overview for discussion. NHS England have asked all Trust Boards to review the findings of this Report at their next public Board meeting, and for boards to be clear about the action they will take, and how effective assurance mechanisms are at 'reading the signals'

Reading the signals

Maternity and neonatal services in East Kent – the Report of the Independent Investigation

October 2022

Dr Bill Kirkup CBE

HC 681

Return to an Address of the Honourable the House of Commons
dated 19 October 2022 for

Reading the signals

Maternity and neonatal services in East Kent – the Report of the Independent Investigation

Ordered by the House of Commons to be printed on 19 October 2022

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Open letter to the Secretary of State for Health and Social Care and Deputy Prime Minister and to the Chief Executive of the NHS

The death of a baby is a devastating loss for any family. As one bereaved mother put it, *"When your baby dies, it's like someone has shut the curtains on life, and everything moves from colour to darkness."* How much more difficult must it be if the death need not have happened? If similar deaths had occurred previously but had been ignored? If the circumstances of your baby's death were not examined openly and honestly, leaving the inevitability of future recurrence hanging in the air?

The Panel investigating East Kent maternity services heard the harrowing accounts of far too many families to whom all of this had happened, and more. If it was hard for us to listen to, we could not imagine how much harder it was for those families to relive, although the effects on those who were giving us their accounts were often all too clear. The primary reason for this Report is to set out the truth of what happened, for their sake, and so that maternity services in East Kent can begin to meet the standards expected nationally, for the sake of those to come.

But this alone is not enough. It is too late to pretend that this is just another one-off, isolated failure, a freak event that *"will never happen again"*. Since the report of the Morecambe Bay Investigation in 2015, maternity services have been the subject of more significant policy initiatives than any other service. Yet, since then, there have been major service failures in Shrewsbury and Telford, in East Kent, and (it seems) in Nottingham. If we do not begin to tackle this differently, there will be more.

For that reason, this Report is somewhat different to the usual when it comes to recommendations. I have not sought to identify detailed changes of policy directed at specific areas of either practice or management. I do not think that making policy on the basis of extreme examples is necessarily the best approach; nor are those who carry out investigations necessarily the best to do it. More significantly, this approach has been tried by almost every investigation in the five decades since the Inquiry into Ely Hospital, Cardiff, in 1967–69, and it does not work. At least, it does not work in preventing the recurrence of remarkably similar sets of problems in other places.

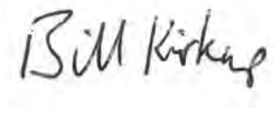
This Report identifies four areas for action. The NHS could be much better at identifying poorly performing units, at giving care with compassion and kindness, at teamworking with a common purpose, and at responding to challenge with honesty. None of these are easy or necessarily straightforward, because longstanding issues become deeply embedded and difficult to change. Nor do I pretend to have the answers to how best they should be tackled: they require a broader-based approach by a wide range of experienced experts. But unless these difficult

areas are tackled, we will surely see the same failures arise somewhere else, sooner rather than later. This Report must be a catalyst for tackling these embedded, deep-rooted problems.

Above all, we must become serious about measuring outcomes in maternity services. There are obvious difficulties, given that pregnancy and childbirth are physiological in most cases and poor outcomes less common, but this must not become an excuse. Meaningful, risk-sensitive outcome measures can be found, as they have been in other specialties. They can be used, not to generate meaningless league tables, but to identify results that are genuine outliers. Only in this way can we hope to detect the next unit that begins to veer off the rails before widespread harm has been caused, and before it has had to be identified by families who have suffered unnecessarily. There is work under way in the NHS but it needs further support and direction and the approach must be mandatory, not optional. I am ready to discuss and explain further how this can best be done.

But if we are to break the cycle of endlessly repeating supposedly one-off catastrophic failures, all four areas must be addressed. There are very difficult and uncomfortable issues here, but we cannot in all conscience pretend that “it will not happen again” unless we are serious about tackling them.

My thanks are due to everyone who assisted with this Investigation, including NHS and Trust staff, and it would not have been possible without an incomparable Panel, Advisers and Secretariat. Most of all, however, thanks are due to the families, some of whom made the Investigation happen in the first place and all of whom helped us understand the reality, often at great personal cost to themselves. We owe it to them to listen and learn, not only for East Kent but for NHS services elsewhere.



Dr Bill Kirkup CBE

October 2022

Chapter 1: Missed opportunities at East Kent – our Investigation findings

Introduction

1.1 The Panel has examined the maternity services in two hospitals, the Queen Elizabeth The Queen Mother Hospital (QEQM) at Margate and the William Harvey Hospital (WHH) in Ashford, between 2009 and 2020, in accordance with our Terms of Reference. Responsibility for these services lay with East Kent Hospitals University NHS Foundation Trust (the Trust).

1.2 We have found a clear pattern. Over that period, those responsible for the services too often provided clinical care that was suboptimal and led to significant harm, failed to listen to the families involved, and acted in ways which made the experience of families unacceptably and distressingly poor.

1.3 The individual and collective behaviours of those providing the services were visible to senior managers and the Trust Board in a series of reports right through the period from 2009 to 2020, and lay at the root of the pattern of recurring harm. At any time during this period, these problems could have been acknowledged and tackled effectively. We identify here eight clear separate opportunities when that could and should have happened.

1.4 It is therefore only right that in our Report we indicate where, in our judgement, accountability lies for missing the opportunities to bring about real improvement in the clinical outcomes and in the wider experience of families in East Kent.

1.5 The consequences of not grasping these opportunities are stark. Our assessment of the clinical outcomes, set out in Chapter 2, shows that:

- Had care been given to the nationally recognised standards, the outcome could have been different in 97, or 48%, of the 202 cases assessed by the Panel, and the outcome could have been different in 45 of the 65 baby deaths, or 69% of these cases.
- The Panel has not been able to detect any discernible improvement in outcomes or suboptimal care, as evidenced by the cases assessed over the period from 2009 to 2020.

1.6 We have no doubt that these numbers are minimum estimates of the frequency of harm over the period. We made no attempt to review other records or to contact families who did not volunteer themselves. It was our judgement that we had enough evidence based on the existing 202 cases to identify the problems and their causes, and we did not wish to delay publication of our findings.

1.7 Nor was the harm restricted to physical damage. Chapter 3 sets out the equally disturbing effects of the repeated lack of kindness and compassion on the wider experience of families, both as care was given and later in the aftermath of injuries and deaths.

1.8 This chapter sets out what we have found in East Kent maternity services, and how the Trust failed to read the signals and missed the opportunities to put things right. We know that this will make for painful reading for families affected but also for the Trust, for regulators and for the wider NHS. But unless this is stated and acknowledged, history in East Kent and nationally suggests that there is a real danger that our Investigation will become yet another missed opportunity, not only in East Kent but elsewhere.

1.9 As well as setting out what happened, we identify here the underlying failures that led to the harm we found, as well as some key themes that must be addressed in the response to the failures in East Kent. This chapter also explains the missed signals and where accountability lies. The evidence behind our findings is laid out in Chapters 2 to 5; in Chapter 6, we draw out the lessons with recommendations both for East Kent and for national application.

Our findings

1.10 There is a crucial truth about maternity and neonatal services which distinguishes them from other services provided at hospitals. It is in the nature of childbirth that most mothers are healthy, and, thankfully, their babies will be too. But so much hangs on what happens in the minority of cases where things start to go wrong, because problems can very rapidly escalate to a devastatingly bad outcome.

1.11 We listened carefully to the families who have participated in our Investigation, and we listened equally carefully to staff at the Trust and in other relevant organisations. As a result, we identified problems at every level within the services:

- What happened to women and babies under the care of the maternity units within the two hospitals
- The Trust's response, including at Trust Board level, and whether the Trust sought to learn lessons
- The Trust's engagement with regulators, including the Care Quality Commission (CQC), and the actions and responses of the regulators, commissioners and the NHS, regionally and nationally.

Running through each one of these layers has been a failure to recognise and acknowledge the scale and nature of the problem.

1.12 We have found that the Trust wrongly took comfort from the fact that the great majority of births in East Kent ended with no damage to either mother or baby.

1.13 This failure reflects badly, not only on practice within East Kent maternity services, but on how statistics are used to manage maternity services across the country as a whole. We believe that it should be possible for individual trusts to monitor and assess whether they have a problem; that it should be possible for the NHS regionally and nationally to identify trusts whose safety performance makes them outliers; and that it should be possible for the regulators to differentiate the services provided more quickly and reliably. We set this out in our first key area for action, to be addressed below and in Chapter 6.

1.14 More immediately, the Trust should acknowledge the full extent and nature of the problems which have endured over the period. It has not yet done this in full. We have found that its failure to do so explains why the action that has been taken has not been sustained and has not had the impact needed.

What happened to women and babies

1.15 Chapter 2 gives details of our assessment as to whether the cases within our Investigation involved suboptimal care. We used the approach of the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI), now commonly referred to as CESDI scores.

1.16 In these cases, we have not found that a single clinical shortcoming explains the outcomes. Nor should the pattern of repeated poor outcomes be attributed to individual clinical error, although clearly a failure to learn in the aftermath of obvious safety incidents has contributed to this repetition.

1.17 Although there are shortcomings in the physical infrastructure at both hospitals, and there have been periods of staffing and resource shortages, we have not found that these played a causative role in what happened. While these factors require attention, and are rightly the subject of national consideration, they do not justify, explain or excuse the experience of the families using East Kent maternity services as revealed by our Investigation.

1.18 Similarly, the geography of East Kent, its coastal location, the demographics of its population and the distance between the two hospitals are factors, but they should not have been regarded as explaining or justifying the service provided. We have found evidence of these factors fuelling what is sometimes referred to as a "victim mentality". Those who should have provided leadership have been tempted to regard themselves as victims of geography, recruitment difficulties and a neglected estate.

1.19 Rather, we have found that the origins of the harm we have identified and set out in this Report lie in failures of teamworking, professionalism, compassion and listening.

Failures of teamworking

1.20 Teamworking is crucial to modern healthcare. Poor teamworking may result from a lack of respect for other staff and a lack of mutual trust, with insufficient credence given to the views of others. Failure to work effectively together leads directly to poor care and jeopardises patient safety. In maternity services, it leads to staff failing to escalate clinical concerns promptly or appropriately. As a result, necessary assessments and interventions are either done by the wrong people with the wrong skillsets or are not done at all. In both cases, the risks to safety are obvious.

1.21 We found gross failures of teamworking across the Trust's maternity services. There has been a series of problems between the midwives, obstetricians, paediatricians and other professionals involved in maternity and neonatal services in East Kent. Some staff have acted as if they were responsible for separate fiefdoms, cultivating a culture of tribalism. There have also been problems within obstetrics and within midwifery, with factionalism, lack of mutual trust, and disregard for other points of view.

1.22 We found clear instances where poor teamwork hindered the ability to recognise developing problems, and escalation and intervention were delayed. The dysfunctional working we have found between and within professional groups has been fundamental to the suboptimal care provided in both hospitals.

1.23 Poor teamworking was raised as a prominent feature by many of those we interviewed. Some obstetricians had *"challenging personalities … big egos … huge egos"*. Midwives showed *"cliquey behaviour"* and there was an in-group, *"the A-team"*. This behaviour was displayed *"in front of women"*. One clinician told us that *"many times we could have done better … the culture in obstetrics and the relationship with midwifery were poor"*. An external assessor with wide experience of the NHS said that the Trust had *"the worst culture I've ever seen"*. Another, from a different organisation, had *"not encountered such behaviour anywhere else"*.

1.24 We have found divisions among the midwives which at times included bullying to such an extent that the maternity services were not safe. We also found that some obstetric consultants expected junior staff and locum doctors to manage clinical problems themselves, discouraged escalation, and on occasion refused to attend out of hours. This, too, put patient safety at significant risk. We have found that midwives and obstetricians did not always share common goals, and that this damaged the safety of patient care. One mother, who asked a paediatrician why her baby had died, was told that *"if you want to look for blame, you should be looking at the obstetricians not me".*

Failures of professionalism

1.25 Professionalism means putting the needs of mothers and babies first, not the needs of staff. It means not being disrespectful and not disparaging other staff in front of women, who lose confidence in services as a result and may make poorly informed decisions about their care. It means not blaming women when something has gone wrong, and it means making decisions on who is best placed to care for an individual based on their clinical need, not on who belongs to which staff clique.

1.26 We found clear and repeated failures to uphold these principles. Staff were disrespectful to women and disparaging about the capabilities of colleagues in front of women and families. A family member heard a consultant describe the unit they were in as *"unsafe"* to a colleague in the corridor, which was hardly the way to raise any legitimate concerns they may have had.

1.27 Others sought to deflect responsibility when something had gone wrong. A staff member visited a mother the day after a significant problem with her baby had been missed at birth. The mother remembers that the staff member did not ask how her baby was, but said: *"[Y]ou do remember I was handing over, don't you?"* Another woman, whose baby had died, was told: *"It's God's will; God only takes the babies that he wants to take."*

1.28 In other cases, women themselves were blamed for their own misfortune. A woman admitted to hospital to stabilise her type 1 diabetes pointed out to antenatal ward staff that they were not adjusting her insulin correctly. She was told that *"we're midwives not nurses and we don't deal with diabetes … it's not our issue and you don't fit in our box"*.

1.29 We heard that midwives who were not part of the favoured in-group at WHH were sometimes assigned to the highest-risk mothers and challenged to achieve delivery with no intervention. This was a downright dangerous practice.

Failures of compassion

1.30 Technical competence alone is not sufficient for good care, if it is delivered without compassion and kindness. Uncompassionate care can be devastating for the wellbeing and mental health of the recipients. It can cost women the care that they need and it can affect their peace of mind, sometimes in extremely fraught situations that involve the loss, or potential loss, of their baby's or their own life or health.

1.31 We heard many examples of uncompassionate care that shocked us. A woman who asked for additional information on her condition during an antenatal check was dismissively told to look on Google. A mother who was anxious about her baby's clavicle, fractured during a difficult delivery, was told that *"collar bones break all the time because they are built to do that to get them out easier"*. Another, who asked why an additional attempt at forceps delivery was to be made, was brusquely told that it was *"in case of death"*. Women who pointed out that their spinal or epidural analgesia was not effective and they were in pain were ignored or disbelieved; one told us that *"they didn't listen … they carried on, obviously, to cut me open. I could feel it all."*

1.32 The effects of many further examples of lack of compassion are considered in detail in Chapter 3.

Failures to listen

1.33 Good care must involve listening and responding appropriately. Women know what they are experiencing at that moment in a way that a clinical attendant cannot. Failing to listen – or, worse, telling someone that they must be wrong – is disrespectful and dangerous. A wise physician, William Osler, encouraged clinicians over 100 years ago to *"listen to the patient,* [they are] *telling you the diagnosis"*. Ignoring or discounting what a patient says means discarding clinical information that may make the difference between a good outcome and a disaster.

1.34 We have found that there have been repeated failures to listen to the families involved, as exemplified in Illustrative Case A.

Illustrative Case A

A's second pregnancy progressed normally to term, when she reported a loss of clear fluid and suspected that her waters had broken spontaneously. No fluid could be seen on examination, and she was sent home with a view to inducing labour a week later. After four days, however, she telephoned the hospital to say that she was experiencing contractions and her baby's movements had reduced markedly over the previous day. As her contractions were deemed not yet frequent enough to indicate established labour, she was asked to wait at home despite her concern over her baby's movements. When she attended the following day with more frequent contractions, her baby's heartbeat could not be found, and she gave birth to a stillborn baby.

1.35 In some cases, we have found that this failure to listen contributed to the clinical outcome. In others, it was part of a pattern of dismissing what was being said, which contributed significantly to the poor experience of the families within our Investigation, as Chapter 3 sets out. Aspects of the families' experiences have been extremely damaging and have had a significant effect on the outcome for them.

Failures after safety incidents

1.36 We found that the same patterns of dysfunctional teamworking and poor behaviour marred the response by staff after safety incidents, including those incidents that led to death or serious damage. Although some staff were caring and sympathetic, and this was recognised and welcomed by families, others were not. Sadly, but naturally, the poor responses are the ones that remain in families' memories. In a number of cases, the dysfunctional relationships between

the staff involved were all too visible to the families themselves. This was such a common feature that we have concluded that it was part of the culture at QEQM and WHH.

1.37 Time after time, we heard that staff not only failed to show compassion, they also denied responsibility for what had happened, or even that anything untoward had occurred. Similarly, we have found instances where the mother was blamed for what had happened.

1.38 Where things went wrong, clinical staff, managers and senior managers often failed to communicate openly with families about what had happened. Safety investigations were often conducted narrowly and defensively, if at all, and not in a way designed to achieve learning. The instinct was to minimise what had happened and to provide false reassurance, rather than to acknowledge errors openly and to learn from them. Where the nature of the safety incident made this impossible, a junior obstetrician or midwife was often found who could be blamed.

1.39 The following example (Illustrative Case B) illustrates a number of features we have found repeated many times, and the harm to wellbeing that can result from a failure to listen and to respond compassionately. It also shows that multiple failures may coexist in the same case.

Illustrative Case B

"We feel lucky that we have our daughter and grandson; other people weren't as lucky as us. But we are where we are by a whole string of luck rather than by good planning and good care." (B's mother)

B was pregnant for the first time and chose care in her local Midwifery-Led Unit (MLU). She had a good relationship with the midwife she saw. The midwife told B how lucky she was to be fit and healthy, and B trusted her advice, although she had scans which showed excessive growth of her baby that was not investigated or followed up. At 39 weeks pregnant, B developed two significant complications of pregnancy: pre-eclampsia and obstetric cholestasis (a liver condition). A doctor recommended induction of labour and noted the risk of a postpartum haemorrhage and the need for tests of her disordered liver function and blood clotting. The blood-clotting results were lost until after her baby was born.

Despite the risk factors, B was monitored only intermittently in labour, and she received varying advice from different professionals about the likelihood of requiring a caesarean section, which unsettled her. Progress was slow, and the next day her cervix stopped dilating at 7cm. B's baby was born by caesarean section, apparently uneventfully, although the need for extra stitching to control blood loss from the uterine incision was recorded.

Afterwards, B and her family were placed in a recovery room, where they remained alone for over two hours, undisturbed by staff who should have carried out postoperative checks. After this time, B's family were alarmed by blood emerging from under the blanket and realised to their great distress that she was bleeding very heavily. They raised the alarm, and staff implemented the hospital's protocol for massive postpartum haemorrhage.

B was taken to theatre while her mother and other family members were left with the new baby, waiting anxiously and tearfully for news in a four-bedded bay, separated from other mothers and babies only by curtains. After some time, their request to be moved to a side room was granted. In theatre, B was thought to be bleeding because of an atonic uterus – this is when the uterus has not contracted effectively after the birth –

and a device called a Bakri balloon was placed in the uterus and inflated to reduce the bleeding by compression. B was then transferred to the intensive care unit.

Meanwhile, the family remained with the baby, who now needed feeding. B's mother asked for assistance: *"I asked for milk, and this was the thing that was really quite upsetting at the time, the baby needing feeding, and I was told that 'we encourage breastfeeding here and if you want milk you have to go to ASDA, it's up the road'."* After she insisted, some milk was brought, but the irritation of staff was obvious, she said, and no advice was given on feeding under the circumstances. Some staff were subsequently helpful, but others made the family feel that they were being a nuisance.

During the night, family members saw the consultant obstetrician again, who explained that B was still bleeding and would need to return once again to theatre. The family recall the consultant saying, *"'you're really lucky because I've phoned a friend' and this rings a bell, because I thought, oh no, we're going 50/50 next and then we're going to ask the audience. I couldn't believe* [they were] *saying it."*

The "friend" was a consultant gynaecological oncologist who carried out an exploratory operation. They found that there was an extensive collection of blood in the broad ligament (alongside the uterus). The bleeding was from a tear in the cervix extending into the upper vagina, which must have occurred at the time of either the caesarean section or the insertion of the Bakri balloon. The consultant tied off blood vessels in the pelvis, including the internal iliac artery, a major artery, and evacuated the blood. This stopped the bleeding, but B required extensive blood transfusion.

B's subsequent recovery was steady, but her mother remembers being severely reprimanded by midwives for taking the baby to the intensive care unit to bond with B, and the lack of contact and monitoring when B returned to the ward after several days. B felt that she would be just as well off at home, but was told that she shouldn't leave, because she was *"like a broken car that we've fixed up and if you leave you might just break down again*". B realises that it was the doctor's way of trying to explain things, but she found it very insensitive and has not been able to forget what they said. *"In that moment, when I wasn't really being looked after, was I just going to break down, was I just going to die?"*

After they sent a letter of complaint, B and her mother were told that the unit was safe, with mortality rates below the national average, and that B's care would be reviewed because there was a good governance system for reviewing cases. B's family asked for the review to be shared with them but were told: *"It doesn't happen like that; the team sit round and read through the notes to check that the haemorrhage was managed correctly."* They also asked if the review would consider whether the haemorrhage could have been avoided and were told that it would not. Later, they found out that the case had not been recorded as a serious incident because the haemorrhage had been managed correctly and it was not an unexpected admission to intensive care. *"Nothing seemed to ring true"* to B and her mother.

B and her family found the lack of care and compassion to be the most distressing feature. *"The whole thing was 'you're lucky, you've got a baby, you're alive, you didn't die, your baby didn't die; you need to brush yourself down, get on with it and go on and have another baby'; it was really insensitive to the problems."*

B was advised to go and see the midwife to talk through her birthing story. She understood that this would be a therapeutic exercise that would help her understand what had happened. However, the midwife read her notes and said: *"I don't know why you're here, you're really lucky, you're alive, your baby's alive."* There was no recognition

of B's obvious guilt over feeling upset about what had happened when her baby had survived. She received only reinforcement that she should feel lucky to be alive. The impact on her mental wellbeing was not considered.

B had another appointment with her consultant. They told her that they fully expected to see her in a few months, because *"you've still got everything, you can still have a baby, we'll look after you".* But the experience has left B terrified about becoming pregnant again. It appears that at no point was any explanation given that her continued bleeding had been due to surgical injury to her cervix and vagina.

"It just seemed that people would think that everything would be fine because I was alive and I would just move on and I shouldn't be sad or upset or mentally scarred from it, from a traumatic experience, and for me I was robbed from having my second baby. I've always wanted a second baby and I will never do that, ever, and no one appreciates that side to it."

This case illustrates clear problems of teamworking, professionalism, lack of compassion and failure to listen. B was made to feel ignored, marginalised and disparaged after the event. Also striking are the lack of frankness about what had happened and the failure to report and investigate a serious incident.

Failure in the Trust's response, including at Trust Board level

1.40 In specific instances where things have gone wrong, the Trust has found it easier to attribute the causes to individual clinical error, usually on the part of more junior staff, or to difficulties with locum medical staff. But we have found that these are symptoms of the problems, not the root causes. This has been combined with the disposition to minimise problems, so it is unsurprising that the Trust has given the appearance of covering up the scale and systematic nature of those problems.

1.41 The problems among the midwifery staff and the obstetric staff were known but not successfully addressed. The failure to confront these issues further damaged efforts to improve maternity services and exposed critical weaknesses in the Human Resources (HR) function. When bullying and divisive behaviours among midwives were challenged, the staff involved began a grievance procedure, following which, it appears to us, the Head of Midwifery was obliged to leave and not speak out. The bullying and divisive behaviours were not addressed.

1.42 One critical weakness was the lack of control that could be exercised in relation to consultants. We have found that experience in East Kent demonstrates the problems that occur when some consultants stubbornly refuse to change unacceptable behaviour. In these circumstances, the mechanisms that trusts are able to deploy to address such behaviour, either through professional regulation or HR processes, may prove frustratingly ineffective.

1.43 It seems to us that the Trust was disposed to replace staff in key managerial roles who identified and challenged poor behaviour. The staff who remained were those who either personified the poor culture or were prepared to live with it rather than question it.

1.44 We have found that the Trust Board itself missed several opportunities to properly identify the scale and nature of the problems and to put them right. These opportunities are described later in this chapter.

1.45 The Trust Board was faced with other challenges. Some of these concerned other hospital services, particularly the Accident and Emergency department, and the failure to meet targets. But those other challenges, though considerable, do not constitute a good enough reason for failing to put right the way in which maternity and neonatal services were operating.

1.46 The Trust Board did endorse a succession of action plans. It was said to us that *"if there is one thing East Kent can do it's write an action plan"*. But these plans and the way in which the Trust Board engaged with them masked the true scale and nature of the problems. Instead, the plans supported an imagined world where there were fewer problems, and where the plans associated with newly appointed staff were deemed to be sufficient despite the previous recurring pattern of failure. Individuals were lauded only to fall out of favour, sometimes quite quickly.

1.47 The repeated turnover of staff at many levels, including Chief Executive, served to encourage this cycle; each time it was believed that this time things really would get better. Looking at cases to the end of 2020, we have not seen evidence to convince us that this cycle has ended.

1.48 Treating problems as limited one-off issues susceptible to being picked off by the latest action plan or new manager, rather than acknowledging their full extent and nature, has got in the way of confronting the issues head-on. Where issues have been brought into public focus by the efforts of families or through the media, too often the Trust has focused on reputation management, reducing liability through litigation and a "them and us" approach. Again, this has got in the way of patient safety and learning.

The actions of the regulators

1.49 We have reviewed how the Trust engaged with the regulators and others and how those organisations handled the signs of problems with maternity services in East Kent.

1.50 We have found that the Trust was faced with a bewildering array of regulatory and supervisory bodies, but the system as a whole failed to identify the shortcomings early enough and clearly enough to ensure that real improvement followed.

1.51 In practice, there was no shortage of regulatory and other bodies holding relevant information. The list includes:

- General Medical Council (GMC)
- Nursing and Midwifery Council (NMC)
- Local Supervising Authority (LSA; previously performing the role of supervision of midwives)
- Royal College of Obstetricians and Gynaecologists (RCOG)
- Royal College of Midwives (RCM)
- NHS England (NHSE)/NHS Improvement (NHSI) (merged from April 2019 as NHSE&I; NHSE again from July 2022)
- Care Quality Commission (CQC)
- Healthcare Safety Investigation Branch (HSIB)
- Clinical Commissioning Groups (CCGs)
- Local Maternity System/Local Maternity and Neonatal System (LMS/LMNS)

1.52 Looked at individually, a case can be made that the distinctive role of each organisation should have added positively to identifying and addressing the problems. However, standing back from that detail, it is hard to avoid the impression that, in practice, the plethora of regulators and others served to deflect the Trust into managing those relationships and away from its own responsibility.

1.53 The task of regulators was made more difficult by the extent to which problems were denied; this denial ran right through the Trust, from clinical staff to Trust Board level. Even five years on, the Panel has been told that *"we were not as bad as people were saying we were* [in 2015/16]*"* and that *"it only takes one case* [baby Harry Richford] *to trigger an investigation"*. A critical RCOG report in 2016 (see paragraphs 1.97–1.102) was based on *"hearsay and uncorroborated comments"*. Legitimate challenge by the CQC was *"always met with anger and defensiveness"*.

1.54 There are inherent tensions in the roles of regulators and professional bodies, both individually and collectively. The RCM, for example, combines three functions: that of promoting quality maternity services and professional standards; that of advising and commissioning legal representation for individual members subject to disciplinary and professional processes; and that of a representative body for its membership. We found that these functions became entangled when the RCM was involved in problems relating to midwife behaviour in East Kent, and it was not possible to tell in what capacity it was operating at any one time, fuelling the perception that these problems were too difficult for the Trust to resolve.

1.55 The actions of the regulators and others are set out in Chapter 5.

1.56 We have found that NHSE&I did seek to help bring about improvements in the Trust. We have heard that a Quality Surveillance Group was established at least as early as April 2014. This followed identification of concerns by the CCGs (see paragraphs 1.75–1.81). As with the other regulators, we have found that the intervention of NHSE&I and its predecessors failed to secure the necessary improvements in the services provided.

Missed opportunities

Illustrative Case C

1.57 A young mother (C) arrived at the hospital having had a healthy pregnancy. She had been told by a community midwife that the slowing down of her baby's movements was not a reason for concern. Following a scan late on in the pregnancy, C was further reassured that there were no underlying problems with her baby.

1.58 When C went into labour late in the evening, she was told to wait until her contractions were stronger and more frequent before travelling to the hospital. She felt discouraged and waited until the following afternoon, despite the altered movements of her baby. On arrival, she vomited in the corridor, often a sign of a rapidly progressing labour. The first midwife on the scene could not tell how dilated C's cervix was and brought in another midwife.

1.59 The standard method for checking a baby's heartbeat is by using what is known as a doppler. The staff present followed this practice but detected C's heartbeat instead. The midwife left for a break and another one was brought in from the labour ward. The new midwife spotted that the baby's own heartbeat was not recovering quickly enough after the contractions. The first midwife was called back and, following discussions, C was taken to the labour ward.

1.60 C wanted to push but had been told not to do so. But now she was told to push and the baby was delivered with forceps without additional pain relief. C remembers seeing her baby in the resuscitation cot in the corner of the room. She felt euphoric at having given birth but also concerned by what she saw. She assumed that her baby would be resuscitated and that she would be able to hold the baby at any moment. She remembers being told that her baby was breathing before then seeing her baby being taken away to the neonatal intensive care unit.

1.61 C was left in the room with her family – her parents and partner. No member of staff stayed with them or joined them, and they were not told what was happening. C remembers that she was bleeding profusely and that her father left the room in order to ask whether somebody could attend, only to be told that *"they are all in the staffroom having a cup of tea to recover from the shock".*

1.62 When the consultant obstetrician arrived, C remembers being told that her baby was being cooled on a life support machine, because of the effects of a lack of oxygen. She was also told that the baby had too much acid in her blood as a result of distress in labour. And then the awful news. Her baby might not survive, or might survive with brain damage.

1.63 For a time, as any parent would, C and her partner were hopeful that their baby would indeed recover. C was expressing milk for her newborn child, who was well grown and had appeared healthy.

1.64 In the coming days, C and her partner would see the effects of their baby's organs shutting down. They stayed up all night with their baby not knowing when the baby's last breath would be. The baby passed away in C's arms the following afternoon.

1.65 Some months later the family had a meeting with the Head of Midwifery and with the head of the MLU. They remembered being told that *"many many mistakes had been made"*; their baby's death could have been prevented had delivery been only a matter of hours earlier. In response to a question, C was told that ten babies had died since her baby.

1.66 As well as the Trust admitting negligence, C recalls being told that if the family wanted to take any legal action the hospital would be supportive. C and her partner considered carefully what to do and came to their decision. They would pursue the case in order to highlight the issue higher up in the NHS, with the aim of preventing similar outcomes in the future.

1.67 Concern about the death of baby Harry Richford in November 2017 precipitated our Independent Investigation. But this is not Harry Richford; it is baby Amber Bennington, who was born seven years earlier, in August 2010, and who died nine days later.

1.68 There are similarities between the two cases. One is that the Panel has found that in both cases different clinical management would have been expected to have made a difference to the outcome.

1.69 Another similarity is that both families have wanted their experience to be considered in order that the services be improved. The fact that it took the experience of Sarah and Tom Richford, seven years after the experience of Lucy and David Bennington, to bring East Kent maternity services into national focus suggests that the issues are deep and entrenched, and that the Trust has not been ready to look for signs of problems.

1.70 It is clear that concerns have arisen throughout the period since 2009 when the Trust was constituted, and that numerous opportunities have been missed to rectify the situation that had developed. It is likely that the sooner this was tackled, the more straightforward it

would have been, before problematic attitudes and behaviour, and dysfunctional teamworking, became embedded. Yet each of these opportunities was missed in one way or another, and the consequences continued. The most significant are set out here.

Missed Opportunity 1: Internal review and report, 2010

1.71 On 24 September 2010, Dr Neil Martin, the Trust's Medical Director, gave a presentation to the Board on a recent serious untoward incident within maternity services. He also reported that the Trust's internal monitoring process had highlighted an increase in the number of babies showing symptoms of hypoxic ischaemic encephalopathy (HIE), a type of brain damage that occurs when babies do not receive enough oxygen and/or blood circulation to the brain. An internal review was being undertaken and external midwifery support had immediately been put in place at WHH due to a concern about a decrease in the skill mix at the unit.

1.72 The review examined the antepartum management of 91 babies who had an unexplained admission to the neonatal intensive care and special care baby units within East Kent between January and September 2010. In 40% of the cases examined, the review highlighted the presence of suboptimal care, and in a third of those cases the suboptimal care was considered possibly, probably or likely to be a factor that was relevant to the outcome. Of the 91 cases reviewed, there were 16 perinatal deaths; significant or major suboptimal care was noted in 4 of those cases. Six babies were identified as likely to have what the report described as "long-term handicap"; significant suboptimal care was identified in three of those cases.

1.73 More broadly, the review report raised significant concerns about midwifery and obstetric management, midwifery staffing and skill mix, and resuscitation of babies showing signs of a shortage of oxygen. The review identified a number of themes, many of which are recurring issues in the inspections that took place and in the reports and findings published between 2010 and 2020. The main themes were poor identification of fetal growth restriction, failure to diagnose labour leading to inadequate fetal monitoring, incorrect intermittent fetal monitoring, poor practice of continuous fetal monitoring with failure to correctly identify pathological traces and escalate concerns, and failure to follow guidelines.

1.74 The outcome of the review was to move the standalone midwifery units at Canterbury and Dover and to locate them alongside the obstetric units at Margate and Ashford. Recommendations were made to remind staff to practise within guidelines, to improve diagnosis of labour in low-risk settings, to improve standards in fetal monitoring, to review clinical guidance and resuscitation arrangements where meconium is present, to review the process by which medical staff of all grades learn from adverse events, and to review the process of escalating concerns about the progress of labour to more senior staff on call. We could find no evidence that these recommendations were followed up.

Missed Opportunity 2: Clinical Commissioning Group reporting to NHS England from spring 2013

1.75 The CCGs were created and commenced oversight from 1 April 2013. From the very outset, East Kent CCGs raised concerns about the Trust, including concerns about maternity services; they included these concerns in monthly written reports to NHSE. For example, in the June 2013 Quality Report to NHSE, the CCGs noted:

> *There is concern about the number of Serious Incidents (SIs) relating to maternity services at the Trust. Prior to April 2013 there were five SIs relating to maternity still open and in April 2013, two more were logged.*[1]

1.76 These concerns were repeated in the August 2013 Quality Report to NHSE:

> *The quality group and the Kent and Medway Quality Surveillance Group have both expressed concerns in relation to the number of serious incidents and the severity and trends within serious incidents related to maternity services within East Kent. Site visits have already taken place to both maternity units and further work with the trust and members of the quality surveillance group will now be taking place to further explore these issues.*[2]

1.77 The Panel heard that the CCGs were *"met with anger and defensiveness by the Trust, always, no matter whether it was a financial challenge or clinical challenge" – "you took a deep breath to have the conversations before you picked up the phone or you met with them"*.

1.78 Another interviewee said:

> *The Trust thought they were exemplars of best practice and there was a real arrogance back in 2013 … they would say it in public meetings, "we are the best acute trust in the country, we are innovative, we are clinically excellent, we are the safest place to be" … they would narrate it … over and over to try and make it become fact … you then had NHSE saying, "yeah we haven't really got any specific issue" … and then you had us* [CCGs] *… shouting, "… they're not financially stable, their leadership is falling apart … they're not a cohesive leadership team … they're not safe from a clinical and patient safety perspective … there are many gaps, and then they've got big cultural issues, huge cultural issues …"*

1.79 These differences between the Trust and the CCGs were recognised by a member of the Trust Board and the Executive, who spoke of their astonishment at the level of antagonism in the room when attending their first Quality Surveillance Meeting with the CCGs.

1.80 The CCGs found it difficult to gain recognition of their concerns within NHSE. It is not clear whether this was because the CCGs were able to bring fresh eyes to bear on the situation, or whether there had been rapid deterioration, but the existence of problems identified in 2010 makes rapid deterioration an unlikely explanation.

1.81 Having failed to gain traction with NHSE, the CCGs approached the CQC, and the Panel heard that it was this engagement that contributed to the CQC inspection in 2014. In the meantime, however, both the Trust and NHSE failed to accept that the CCGs had grounds for concern – another missed opportunity to recognise and address what was happening.

Missed Opportunity 3: Care Quality Commission report and governance issues, 2014

1.82 The CQC inspected the Trust over six visits in March 2014 and published its findings on 13 August 2014. The overall rating for the Trust was "Inadequate", with findings that the Trust was "Inadequate" in the domains of providing safe care and being well led, and a finding of "Requires Improvement" for effective and responsive services. Again, there are significant similarities between some of the CQC findings and those in previous and subsequent reviews.

1.83 Key findings from the CQC included the divide between senior management and frontline staff, governance and assurance processes that did not reflect reality, very poor staff engagement, poor reporting and investigation of safety incidents, and limited use of clinical audit. The CQC noted an unusually high number of staff raising concerns about safety directly with its inspectors.

1.84 Maternity services were given a less stringent rating: "Requires Improvement". Unfortunately, this implied that problems in maternity care were not as bad as elsewhere, not only downplaying the very significant problems that had existed for several years, but also deflecting attention to those areas seen as higher priorities.

1.85 The reaction of the Trust was again one of defensiveness and disbelief, and we found that there was a very tense and difficult relationship between the Trust and regulators throughout. One former member of the Board and Executive told us that a decision had been taken by the Trust to *"fight the regulators"*. We heard that the Trust reacted very badly to the CQC report, sending back hundreds of minor challenges, including grammatical and spelling issues, rather than addressing its substance. Despite issues being flagged as poor by the CQC during its inspections and reported back to the Trust each day, there was still disbelief when the report came in. Six months were spent quibbling over it, and when action plans were drawn up, they were of poor quality and not effectively followed up. This was another significant missed opportunity.

Missed Opportunity 4: Bullying and inappropriate behaviour within the Trust and maternity services, 2014/15

1.86 Bullying and harassment have been prevalent features in the Trust's maternity services over a prolonged period, as reported by many staff with whom we spoke. Staff surveys confirmed that staff felt disengaged, and reports of bullying and harassment were numerous. Some interviewees were explicit that the effects of this behaviour put the safety of care at risk.

1.87 This issue came to a head in 2014/15, initially when the Trust's Chief Nurse received an anonymous letter:

> *I work on maternity at the William Harvey. I'm ashamed to say that I feel intimidated at work. I have been made to look stupid in front of patients and other staff at work. I feel completely unsupported by our most senior staff. At times I dread going to work with certain people … Management and those with authority are not approachable, there is a blame culture, a just get on with it and shut up attitude, slog your guts out and still get grief. It's ok if your face fits, we operate a one rule for one, and another rule for everyone else on maternity … you need to know that at times the unit is* [an] *awful place to be.*

1.88 In response to this and to other evidence of staff unhappiness, the new Head of Midwifery undertook a review, working alongside the Trust's HR department. In all, 110 staff were interviewed. There were consistent reports from over half of these staff of abrupt and sarcastic senior staff, junior staff being shouted at and humiliated in front of others, staff feeling intimidated and undermined in front of patients, alleged racism, and a daunting and frightening work environment.

1.89 The Head of Midwifery decided, with HR, that some senior midwives who were repeatedly identified as central to the issues should be relocated or suspended pending further action. A collective letter of grievance with 49 signatories was subsequently submitted via the RCM, alleging failures of process in the review. It is notable that this letter admitted that the unit was *"dysfunctional"*.

1.90 We heard that, as a result, the Trust withdrew support from the review process and from the Head of Midwifery. Consequently, she resigned from her post in August 2015. She requested advice from the RCM on whistleblowing about the culture of bullying and intimidation prevalent in the unit and was advised against disclosure in the interests of patient safety because of the

risk this posed to her future career prospects. It is notable that the RCM was already aware of the dysfunctional behaviours at the Trust.

1.91 The Panel heard of no further efforts to address the bullying behaviour, which, we heard, persisted. This was another significant missed opportunity.

Missed Opportunity 5: *The Report of the Morecambe Bay Investigation*, 2015

1.92 The report into the serious failings in Morecambe Bay maternity services was published in early 2015. It identified, among other issues, failings of poor working relationships and dysfunctional teamworking, failures of risk assessment and planning, and failure to investigate properly and learn from safety incidents. All of these features were already evident in East Kent maternity services.

1.93 In May 2015, the Head of Midwifery at the East Kent Trust had already noted the similarity of issues and lessons identified within the Morecambe Bay report and sought to raise similar issues of concern with the Trust leadership. She was not heeded.

1.94 When we interviewed staff in 2021/22, some told us that they still believed the comparison to be misplaced. The Trust had commissioned a report later in 2015 specifically addressing this question; it found that the East Kent Trust *"was not another Morecambe Bay"*.

1.95 Given what the Trust knew about its own services at this point, this is an extraordinary conclusion; we can only suppose that it reflects the pattern of false assurance and defensiveness that characterised much of the Trust's behaviour.

1.96 The Morecambe Bay report included a message for other trusts in 2015:

> *It is vital that the lessons, now plain to see, are learnt and acted upon, not least by other Trusts, which must not believe that "it could not happen here". If those lessons are not acted upon, we are destined sooner or later to add again to the roll of names* [of dishonoured trusts].[3]

Missed Opportunity 6: Report of the Royal College of Obstetricians and Gynaecologists, 2016

1.97 In 2015, concerned about accumulated evidence on the working culture in maternity services, the Medical Director, Dr Paul Stevens, commissioned a review by the RCOG. He specifically identified for review the poor relationship between obstetricians and midwives, compliance with clinical standards, poor governance and response to safety incidents, supervision of trainees, consultant accessibility and responsiveness, and consultant presence on the delivery suite.

1.98 The RCOG review reported in February 2016 and made serious criticisms of the maternity services in East Kent. Among other things, the report was critical of the lack of engagement of obstetricians in drawing up guidelines, which were of poor quality as a result. Safety incident investigations were inadequate and failed to identify areas where obstetric practice could be improved. Some consultant obstetricians at QEQM consistently failed to attend labour ward rounds, review women in labour, or draw up care plans; they also refused to attend when asked to when on call out of hours. Although these consultants were clearly contravening their duties to the Trust and to their profession, the RCOG review found that *"this unacceptable practice has continued not to be addressed despite repeated incident reporting with the result that this unit has developed a culture of failing to challenge these poorly performing consultants"*.[4]

1.99 As a result of these appalling patterns of behaviour, trainees were under pressure to cope with clinical issues they were not competent to deal with unsupported, and midwives felt that there was no point in escalating emerging urgent clinical concerns. In addition, both groups of staff had given up reporting concerns about unacceptable behaviour, as no action was taken. Educational supervision of trainees was inconsistent, posts were often filled by locums, and morale was poor.

1.100 In keeping with the familiar pattern of defensiveness, the Trust told the RCOG that it would not respond to the report in light of an anticipated CQC inspection. When this occurred, the RCOG report was not shared with the CQC. Within the Trust, the RCOG review report was not widely distributed and was dismissively described as *"a load of rubbish"* by some senior obstetricians. A meeting of the Trust Quality Committee heard that *"initial information from the recent* [RCOG] *Maternity Review report is clear – the Trust does not have an unsafe maternity service but there is improvement work to do around how the service is run in some areas"*.

1.101 There was, however, sufficient pressure that maternity services were recognised as presenting an "extreme" risk, with potential harm to both pregnant women and neonates, in the Corporate Risk Register in June 2016. The resulting action plan, heavily process-oriented, was subsequently merged with a general improvement plan in response to the national Maternity Transformation Programme, diluting it and losing some of the specific elements prompted by the RCOG report. Fewer than a quarter of the action points had been completed when the risk was removed from the Register in 2019.

1.102 Most obviously, at no time was there an explicit plan documented or actioned to address the identified failure of some consultants to fulfil their professional duties. We heard that it was a *"difficult area"*, that *"quiet words"* were had, that two consultants had moved on or retired, and that another had a modified job plan that excluded overnight labour ward cover. While we recognise the constraints, and will comment elsewhere on them, the failure to tackle this explicitly or visibly has left echoes in the unit that still persist. This was another significant missed opportunity.

Missed Opportunity 7: The death of baby Harry Richford

1.103 Baby Harry Richford died on 9 November 2017 in the neonatal unit at WHH in Ashford, seven days after he was delivered at QEQM in Margate. The cause of death was recorded as hypoxic ischaemic encephalopathy (HIE).

1.104 Many of the same red flags that had shown themselves in the litany of previous inspections, reviews and reports appear again in baby Harry's case. Not only does this apply to the clinical care given to his mother, Sarah Richford, it is also evident in the way that the whole family were treated after his death. The patient safety issues echoed the problems that had been highlighted first in the Trust's internal review of 2010 and most recently again in the RCOG report, published 18 months before Sarah attended QEQM.

1.105 Sarah witnessed conflict and disagreement between the obstetric and midwifery teams about the way that oxytocin was being used to augment her labour. Midwives were concerned about changes to the continuous heart trace of the baby, but the obstetric team disagreed.

1.106 Obstetric cover on the labour ward was provided by a locum specialist registrar, whose knowledge and experience had not been assessed by a Trust consultant. When there was disagreement over Sarah's care plan, neither the locum registrar nor the midwifery team escalated this to the consultant on call, contrary to guidelines. Sarah was not reviewed by an obstetric consultant during either the 1pm or 6pm assessment rounds, contrary to unit protocols.

1.107 There were further features of concern over the baby's condition coming up to delivery, and the locum registrar undertook to expedite delivery, either by forceps delivery or, if this was not possible, by a caesarean section. It appears that the locum registrar discussed this by telephone with the consultant on call, who agreed with the plan but did not attend, although it was likely to present challenges to an inexperienced obstetrician.

1.108 After an unsuccessful attempted forceps delivery, a caesarean section was undertaken. Unsurprisingly, in view of the descent of the baby's head, this proved very difficult; several attempts were made to dislodge the head from the pelvis, including by applying pressure vaginally. The consultant on call was contacted by telephone and offered advice but was still not in attendance.

1.109 There were major difficulties in resuscitating baby Harry after delivery, including delay in establishing an airway, together with delay in escalating concerns to a consultant paediatrician on call.

1.110 In keeping with the familiar pattern of downplaying problems and seeking to avoid external scrutiny, the Trust classified baby Harry's death as "expected" on the basis that he was admitted to the neonatal unit at WHH with severe HIE, and therefore death was not an unexpected outcome. For that reason, the Trust initially refused to refer baby Harry's death to the coroner for investigation. There were errors in the data sent to the national audit, Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK).

1.111 Baby Harry's family faced great difficulty in finding out what had gone wrong, although they were sure that something had, and they began to distrust any information they received from the Trust. The weeks, months and years that followed baby Harry's death involved sustained efforts by his family to seek understanding and truth about what had happened during his delivery. Their efforts included referring the case to HSIB and to the CQC for investigation and pressing to have a full inquest into the circumstances of his death.

1.112 This pattern of behaviour by the Trust, clearly evident in this case, recurred in many others that we examined. It included denying that anything had gone amiss, minimising adverse features, finding reasons to treat deaths and other catastrophic outcomes as expected, and omitting key details in accounts given to families as well as to official bodies. Although we did not find evidence that there was a conscious conspiracy, the effect of these behaviours was to cover up the truth.

1.113 Even had none of the previous failings been known – and they were – baby Harry's death should surely have been a catalyst for immediate change. In fact, it required public remonstration by a coroner over two years later, precipitated by the persistence, diligence and courage of baby Harry's family, to reveal an organisation that did not accept its own failings, considered itself above scrutiny or accountability, and consistently rejected the opportunity to learn when things went wrong.

Missed Opportunity 8: Engagement with the Healthcare Safety Investigation Branch from 2018

1.114 HSIB was established in 2017 in response to widespread concern that the NHS was not learning consistently from safety incidents. Its brief is to carry out independent investigations into safety incidents, focusing on systems and processes, to identify learning. In light of previous issues, most obviously at Morecambe Bay, HSIB was given a special brief to look at all maternity incidents that fulfilled certain harm criteria. In 2018, it became evident that East Kent

maternity services were an outlier because of the rate of occurrence of safety incidents resulting in serious harm.

1.115 From the outset, HSIB experienced difficulties in its dealings with the Trust, including problems obtaining information, staff attendance at interviews, and support for the process from the Trust's senior leadership team. HSIB found this to contrast sharply with the response of other trusts in the region, which generally welcomed the opportunity to have "fresh eyes" on any problems. The East Kent Trust, on the other hand, challenged HSIB's right to carry out investigations and its credentials to act as what the Trust saw as another regulator.

1.116 HSIB's concerns increased over the course of 2018, particularly over failures to escalate clinical concerns, unsupported junior obstetric staff, the use and supervision of locum doctors, management of reduced fetal movement, neonatal resuscitation, and fetal monitoring and its interpretation. In light of its *"grave concerns"*, HSIB sought a meeting with the Trust's senior leadership team, which took place in June 2019.

1.117 The accounts of that meeting that we heard from more than one source left us shocked, given the extent of the problems at the Trust that by then had been evident for almost ten years. The HSIB team was not made welcome but was left waiting in a corridor for an extended period. Senior executives greeted them in an *"incredibly aggressive"* manner, saying *"I don't know why you are here"* and telling HSIB that its recommendations were *"not needed"*. The tone of the meeting was one of defensiveness and aggression, and there was a *"heated discussion"* about a maternal death.

1.118 Although relationships between the Trust and HSIB became more cordial, we heard that the Trust did not achieve the same level of acceptance and learning evident in other trusts that HSIB deals with. This is the most recent in this long series of missed opportunities.

Where accountability lies

1.119 This section has highlighted our findings and set out the series of missed opportunities that has characterised the whole period since the establishment of the Trust in 2009. Any one of these was a chance to rectify a situation that had clearly gone very wrong and was continuing to deteriorate. Had any of these opportunities been grasped, there would undoubtedly have been benefits in terms of death, disability and other harm avoided, and in terms of the mental wellbeing of many families who were disregarded, belittled and blamed.

1.120 We do not blame, or identify, those who have made honest clinical errors. Clinicians should not have to live in fear of clinical error and its aftermath; it is an inescapable accompaniment to practice everywhere. The fundamental point is to recognise and report error, so that it can be investigated and learned from. The route to improved maternity services would be fatally undermined if individuals, be they midwives or consultants, were deterred from reporting, or from entering practice, by the fear that honest clinical errors would result in public or professional vilification.

1.121 We have found that repeated problems were systemic, particularly reflecting problems of attitude, behaviour and teamworking, and they reflect a persistent failure to look and learn. They concerned both hospitals and continued throughout the period we have investigated. They included poor professional behaviour among clinicians, particularly a failure to work as a cohesive team with a common purpose.

1.122 Each of these problems has been visible to the senior management of the Trust. In these circumstances, while it is right that this report should be clear about those systemic issues and how they have been evident through the organisation, we have concluded that accountability lies with the successive Trust Boards and the successive Chief Executives and Chairs. They had the information that there were serious failings, and they were in a position to act; but they ignored the warning signs and strenuously challenged repeated attempts to point out problems. This encouraged the belief that all was well, or at least near enough to be acceptable. They were wrong.

Key areas for action

1.123 It is a privilege to have been asked to investigate maternity and neonatal services in East Kent. But, in doing so, we are faced with a reality of national as well as local significance.

1.124 This Investigation is simply the latest to focus on failings in an individual NHS trust. The list is now a long one, going back at least as far as the 1960s. As the Health Foundation has pointed out, most people think of the inquiry into failures of care at Ely Hospital in Cardiff in 1967 as the first NHS inquiry.

1.125 The period since then has been punctuated by reviews into local circumstances: for example, the *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, published in 2013. With maternity services alone, the spotlight has been shone on Morecambe Bay in 2015, on Shrewsbury and Telford in 2021/22, East Kent, with this Investigation commissioned in 2020, and now Nottingham.

1.126 The pattern is now sadly familiar: detailed investigation, lengthy reports, earnest and well-intentioned recommendations – all part of a collective conviction that this must be the last such moment of failure, with the lessons leading to improvement, not just locally but nationally. Experience shows that the aspirations are not matched by sustained improvement. Significant harm then follows, with almost always patients and families the first to raise the alarm.

1.127 In investigating East Kent maternity services and their missed opportunities, we have become all too aware that a conventional report, with multiple recommendations, overlapping with recommendations from other inquiries, other periods and other sources, is unlikely to break free of this pattern.

1.128 For this reason, we have set ourselves the objective of identifying a more limited number of key themes and recommendations, and of not confusing the already difficult – if not impossible – task of making sense of those that already exist.

1.129 Within this approach, we want to tackle head-on the fundamental issue affecting maternity services that this succession of reviews creates. The frequency with which supposedly one-off outliers keep cropping up despite previous investigations and reports makes it, in our view, unsafe to suppose that East Kent is the last one that will be identified. The answer cannot be to hope that individual reviews and multiple recommendations prevent recurrences elsewhere. If that approach were the right one, it would have worked by now. It hasn't.

1.130 We have identified four key areas for action that we believe must be addressed.

Key Action Area 1: Monitoring safety performance – finding signals among noise

1.131 We have come to the view that something more reliable needs to be put in place, not only in East Kent but also elsewhere and nationally, to give early warning of problems before they cause significant harm. The aim must be for every trust to have the right mechanism in place to monitor the safety of its maternity and neonatal services, in real time; for the NHS to monitor the safety performance of every trust; and for neither the NHS nor trusts to be dependent on families themselves identifying the problems only after significant harm has been done over a period of years.

1.132 We are clear that such a mechanism can be developed in order to spot the relevant signals. In Chapter 6, we recommend how this should be done. This is not a toolkit, because it must be nationally standardised, and it is not optional. It will be based on:

- Better outcome measures that are meaningful, reliable, risk adjusted and timely
- Trends and comparators, both for individual units and for national overview
- Identification of significant signals among random noise, using techniques that account properly for variation while avoiding spurious ranking into "league tables".

1.133 In essence, it is clear that in East Kent the Trust too often treated the concerns expressed by families as "noise" when they were in fact an accurate signal of real problems. One example is how the family of baby Harry Richford was treated, particularly when they sought answers to legitimate questions. But that is not the only such example. The accounts we have heard from families show persuasively that the Trust's mindset was too often to be defensive and to minimise problems; and that this mindset was itself a barrier to learning.

1.134 The Trust also took false reassurance from national statistics that appeared to suggest that the number of baby deaths was no higher than in other trusts, underlining the shortcomings of available information. This was very clear from the accounts we have heard from the Trust's staff. For example, a senior clinician accepted that the Richford case was tragic and avoidable but added that, *"however, when you look at the figures it was only in 2017 that* [East Kent] *were slightly outside average Trust behaviour"*.

1.135 Chapter 5 describes how the Trust sought to monitor its performance. By contrast, we have identified a more reliable approach that would utilise the available statistics in the way suggested in Chapter 6, for the use of clinical teams, trusts, regulators and the public, as well as listening to what women and their families say – treating that too as a likely signal, not as noise.

Key Action Area 2: Standards of clinical behaviour – technical care is not enough

1.136 The frequent instances we have found of a distressing and harmful lack of professionalism and compassion are of great concern to us. Of course, we are aware that the majority of clinical staff do not behave like this; but, equally, it would be wrong to imagine that these behaviours are confined to East Kent's maternity services.

1.137 This is not a finding of technical incompetence. But the experience shared vividly with us by families and often confirmed by staff accounts has demonstrated that technical competence is not enough. In any clinical situation, not least the stressful circumstances of giving birth, there is an equal need for staff to behave professionally and to show empathy. The evidence of staff

not showing kindness or compassion and not listening or being honest has been both harrowing and compelling.

1.138 Part of a professional approach is explaining what is happening or has happened honestly and openly – at the time, whenever possible, and certainly afterwards. But what we have found is that, too often, the response has been based on personal and institutional defensiveness, on blame shifting and punishment.

1.139 We have found a worrying recurring tendency among midwives and doctors to disregard the views of women and other family members. In fact, in a significant number of cases, the Panel has found compelling evidence that women and their partners were simply not listened to when they expressed concern about their treatment in the days and hours leading up to the birth of their babies, when they questioned their care, and when they challenged the decisions that were made. Too often, their well-founded concerns were dismissed or ignored altogether.

1.140 A particular area of concern was the telephone advice given to mothers to stay at home if they were not adjudged to be in established labour. It is foolhardy to disregard the woman's voice, especially if she has experience of previous labour, and we saw evidence of distressing births before the mother's arrival in the maternity unit as a result. But it is dangerous when the caller has also reported other problems such as altered movements by the baby, and we saw examples of babies lost as a consequence of such advice.

1.141 We have also found a pattern of particularly stubborn and entrenched poor behaviours by some obstetric consultants, particularly at QEQM. We are clear that this has been damaging, not just to team relationships but also to the safety of women and their babies.

1.142 Some consultants did not attend when requested, although they were on call, and they did not attend scheduled labour ward rounds. They discouraged both junior staff and midwives from calling them at night, leading most staff to conclude that they just had to get on with it without the advice or presence of consultants when those consultants were on call. These concerns were known to the Trust, having been clearly identified in the RCOG report of 2016 and confirmed subsequently by the Trust itself in an audit conducted in April and May 2016. The RCOG did not immediately offer to be involved in how these problems might be resolved, and was rebuffed by the Trust on offering to revisit six months later.

1.143 We note that, in seeking to overcome the reluctance of some consultants to attend when on call, the Trust's actions were weaker than when dealing with midwives. This difference was evident to staff, who put it to us in these terms: *"Nurses would potentially be disciplined … doctors would be asked to reflect on what happened."*

1.144 It is apparent to us that this reflects a much wider difficulty. Any trust seeking to address problematic behaviour by consultants will face significant constraints. Employers effectively have no sanctions short of dismissal against a consultant who defies them, and experience suggests that if employers do act, or if a consultant claims constructive dismissal, the employers are very likely to lose at an employment tribunal. In such situations, external support for trusts is often unhelpful, while defence organisations mobilise their full resources in support of their member. When the GMC was belatedly informed of the unacceptable consultant behaviour in East Kent, it decided that no fitness to practise proceedings were required, and confirmed to us later that it was not able to address *"lower-level behavioural issues, or cultural issues, or attitudinal issues"*. Without wishing to detract from the importance of employment protection, it cannot be right that behaviour which seriously threatens patient safety cannot be robustly addressed.

1.145 There is a pressing need to understand better the gross lapses of professionalism, compassion and willingness to listen that these events illustrate, including their prevalence, the underlying causes, and – most importantly – how they can be changed. Unless we address the balance between the technical aspects and the human kindness needed to care for people compassionately, effectively and safely, the problems evident in East Kent will recur elsewhere.

Key Action Area 3: Flawed teamworking – pulling in different directions

1.146 We have found that teamworking in East Kent maternity services was dysfunctional. This was clear in the accounts we have heard from families and was consistently supported by the evidence of the staff interviews and available records. Many staff described *"toxic"*, *"stressful"* working environments. Arguments between staff were played out in front of families just at the time when truly effective teamwork was required and just when families needed to see that teamwork at work.

1.147 Fundamentally, there were poor relationships both within and between professional groups. There were factions and divisions within midwifery. There was poor working in obstetrics, with a division between consultants and junior staff that left unsupported staff to deal with complex situations beyond their experience. The failure of obstetric staff and midwives to trust and, in some cases, respect each other added a further significant threat to patient safety.

1.148 In sometimes suggesting that the relationships between midwives and obstetricians and neonatologists were satisfactory, staff revealed the limitations in their concept of teamworking. This was, at most, a concept of each discipline doing its own job to an acceptable standard, but within rigidly demarcated and sometimes conflicting roles. In part, this resulted from an inflexible interpretation of a wider maternity debate, positioning midwives as the defenders of women against intervention and obstetricians as the inflictors of over-medicalised models of care.

1.149 This is no basis for effective teamworking in maternity services. Midwives and obstetricians each bring a unique set of skills and experience to maternity care. They should contribute to maternity care as equal and valued partners. But it is inconceivable that they might have objectives that differ. There is not a separate role to promote "normal" birth or to reduce caesarean sections, or to be the "guardians of normality", any more than there is a separate role to promote safety. A team that does not share a common purpose is not a team.

1.150 We have not found any systematic policy in East Kent maternity services of inappropriately favouring either unassisted birth or assisted vaginal birth in circumstances where this would place women and babies at risk. Those we interviewed were careful to say that there was no such policy. We have found, however, that the way in which "normal birth" was spoken about and set out in material for mothers created an expectation that it was an ideal that staff and women should strive to achieve. On some occasions, this pressure of expectation seemed to contribute to staff decisions not to escalate concerns or to intervene, decisions that were otherwise inexplicable.

1.151 One particular example is the Vaginal Birth After Caesarean (VBAC) Clinic, which started at QEQM in 2005 and was operational across the Trust by 2007. The inherent expectation of the clinic was clearly the promotion of VBAC, and it certainly operated in that way. While VBAC is a welcome and appropriate plan for some women, the benefits must be weighed against the risks, particularly of uterine rupture, taking into account any adverse factors. There were clear examples of women who were at high risk from VBAC where we could find no evidence that these risks were discussed, or that a decision which placed a woman at high risk was communicated to her or flagged to inform her future care. Such decisions need to be taken carefully, free from inherent prejudice about the "best" method of delivery.

1.152 We believe that insufficient attention has been given nationally to the language that is used around "normality" and to the presentation of information, or to the expectations that both can create among both maternity staff and mothers. Language and information that are helpful in the majority of cases can have disastrous consequences when labour does not progress physiologically. We are aware that some recent steps have been taken to improve this, but these are insufficient in our view to remove the risk of misunderstanding and misinterpretation.

1.153 Trainees in all disciplines contribute significantly to the work of maternity teams, providing care while gaining experience. For this to be effective, they need to feel supported, both by their peers and by senior staff, and they also need to take part in supervised learning. We found that clinicians in training did not feel supported; they felt isolated, exposed and vulnerable, and they sometimes worked unsupervised in complex situations beyond their experience. This applied equally to midwives and obstetricians, as well as to paediatricians in some cases.

1.154 We found that bullying and harassment were frequently reported, working relationships with other disciplines did not feel comfortable, and more senior staff could be undermining and unhelpful. There were shortages of junior medical staff and posts often had to be filled by locums, further impeding the development of teamworking. New staff were made to feel unwelcome, were excluded from cliques, and were given challenging cases and expected to manage them without support.

1.155 In part, this can be related to national changes in the training of junior medical staff brought about by the need to reduce working hours and compress training. While both of these have welcome consequences, principally in reducing fatigue and unjustifiably extended training, they also have unwelcome consequences. Shift working reduces continuity of care and increases the likelihood of information loss or error at handovers. The loss of the former "firm" system, in which junior medical staff were part of a stable clinical unit headed by one or more consultants, has reduced the feeling of belonging for staff, as well as the opportunity for staff to develop trust and knowledge of colleagues' capabilities. It is important that we find ways to counter these unwelcome features and improve the sense of belonging among staff.

1.156 A more longstanding difficulty is the separation of early training into different clinical disciplines, when staff's future ability to work in teams in a mutually supportive way will be crucial. Staff who work together should train together from the outset, at least in part, and not just in rehearsing emergency drills (which is the most common form of joint training claimed).

1.157 We believe that there is a pressing need to understand the effects of the dynamics of training and education, and how changes made for good reasons have had unintended consequences. More generally, we believe that it is time to think about a better concept of teamwork for maternity services – one that establishes a common purpose across, as well as within, each professional discipline.

Key Action Area 4: Organisational behaviour – looking good while doing badly

1.158 Throughout the period we have investigated, it was clear that the Trust prioritised reputation management to the detriment of being open and straightforward with families, with regulators and with others.

1.159 With families, this was evident in the way in which their concerns were dismissed. Where there were complaints, too often the Trust's instinct was to manage those complaints rather than to consider what was being said as feedback and learning.

1.160 With regulators and others, we have found that too much effort was consumed in seeking to challenge and undermine any scrutiny. For example, it is revealing that when the CQC report became available in 2014, the Trust *"went through every line, every word of* [it] *and came up with hundreds of challenges to the report, grammatical, spelling … rather than actually going to the essence of the report and seeing 'what do we do'"*, as a member of staff put it to us.

1.161 Unfortunately, these problems are far from restricted to East Kent. Indeed, reputation management could be said to be the default response of any organisation that is challenged publicly. When the end result is that patient safety is being damaged, unrecognised and uncorrected, however, it is especially problematic. At present, the benefits of inappropriate and aggressive reputation management outweigh the meagre risks to an organisation of behaving in this way. This balance must be addressed.

1.162 We have found at Chief Executive, Chair and other levels a pattern of hiring and firing, initiated by NHSE. The practice may never have been an explicit policy, but it has become institutionalised. In response to difficult problems, pressure is placed on a trust's Chair to replace the Chief Executive, and/or to stand down themself.

1.163 There may be organisations in which the frequent and short-term appointment of key staff proves effective. It is clear that this approach was not just ineffective in East Kent, but wholly counterproductive. These decisions appear to us to have been made separately from any question of accountability: the effect was simply to rotate in a new face and rotate out the previous incumbent elsewhere.

1.164 In practice, the appointments that were made led the Trust, and NHSE, to believe that things were changing when in fact the underlying shortcomings remained. This approach also led to the term of the then Chief Executive being cut short in 2017, when some of our interviewees suggested that improvements were beginning to be made.

1.165 We are conscious of the damage caused by the succession of appointments as Chief Executive, Chair and Head of Midwifery, but also in other posts. Enthusiasm for the newly appointed individuals created unrealistic expectations that only fuelled criticism when those expectations were not met; this was described to us as a flawed model based on *"heroic leadership"*. NHSE and the Trust have not yet been able to break free of this unproductive cycle.

1.166 The problems of organisational behaviour that place reputation management above honesty and openness are both pervasive and extremely damaging to public confidence in health services. A legal duty of truthfulness placed on public bodies has been proposed as one of the responses to the Hillsborough disaster. It seems that NHS regulation alone is unable to curtail the denial, deflection and concealment that all too often become subsequently clear, and more stringent measures are overdue.

Conclusion

1.167 The Independent Investigation into East Kent Maternity Services has been a challenge to carry out, and at times difficult, but the Panel has never once doubted that it has been so very much more challenging, difficult and personally demanding for the families without whom it would not have been possible.

1.168 We have set out in this chapter the stark findings of deep problems at every level in the Trust, from labour ward clinicians to the Board and external relationships. We have summarised the shocking consequences for the lives of women, babies and families, their health and their wellbeing. We have identified the significant missed opportunities stretching back to 2010 to prevent the continuing toll. We have introduced the four areas for action that we believe are essential to correct the underlying problems in East Kent and elsewhere, and to prevent recurrence. These are considered further in Chapter 6, with a route to taking action in each area.

1.169 Our lasting gratitude goes to the families who put aside for a while the cares they should not have had to bear, to help us to understand the events, and to make the Investigation happen in the first place. We all owe them our undertaking to make things better. It is essential that the findings of this Report are heard, and the necessary actions heeded, around the NHS as in East Kent.

Chapter 2: The Panel's assessment of the clinical care provided

This chapter explains that, had care been given to nationally recognised standards, the outcome could have been different in 97 of the 202 cases the Panel assessed (48%), and it could have been different in 45 of the 65 cases of baby deaths (69.2%).

In the 25 cases involving injury to babies, 17 involved brain damage. This included hypoxic ischaemic encephalopathy (HIE, a type of brain damage that occurs when babies do not receive enough oxygen and/or blood circulation to the brain) and/or cerebral palsy attributable to perinatal hypoxia (insufficient oxygen). Had care been given to nationally recognised standards, the outcome could have been different in 12 of these 17 cases (70.6%).

In the 32 cases involving maternal injuries or deaths, the Panel's findings are that in 23 (71.9%), had care been given to nationally recognised standards, the outcome could have been different.

The Panel has not been able to detect any discernible improvement in outcomes as evidenced by cases over the period within our assessment (2009 to 2020). Our assessment has also indicated that the outcomes and patterns of suboptimal care concerned both the Queen Elizabeth The Queen Mother Hospital at Margate (QEQM) and the William Harvey Hospital in Ashford (WHH).

Introduction

2.1 We have conducted a review of each of the 202 cases where the families involved asked to participate in this Independent Investigation, and where their care by the maternity and neonatal services of East Kent Hospitals University NHS Foundation Trust (the Trust) fell within the scope of the Investigation's Terms of Reference. This chapter describes the review undertaken, our sources of evidence and its results.

2.2 We have reviewed 202 cases, identified using our Terms of Reference and via families who had approached us to participate in the Investigation. In focusing on reviewing what happened in these participating cases, we have had the benefit of richer sources of evidence than we would have had by looking at, for example, clinical records in isolation. Specifically, our review draws upon the following three sources of evidence:

- **Family listening sessions:** In the great majority of the participating cases (189 out of 202), the family was prepared to relive their often traumatic experience for the benefit of this Investigation. In a minority of cases (13), the family wanted their experience to be heard without going through the distressing process of retelling what had happened. In these cases, the Panel focused on the information available in the clinical notes. We wish to place on record our thanks to each and every family, regardless of the decision they took on this point. The family listening sessions have provided a wealth

of evidence, expressed in a compelling way and creating a clear and vivid picture of what happened. In many cases the family listening sessions have included the husband or partner. Where they were present for the birth, their account as witnesses to what happened has proved to be invaluable, often including details which go beyond those available from other sources. In addition, the accounts of husbands and partners are testament to their own personal experiences as events unfolded; they are considered further in Chapter 3.

- **The clinical records:** We have had full access to the records we needed to conduct our review of the 202 cases. We would like to thank the team in the Trust who have made this possible in a full and timely fashion. In every case where the participating families have themselves been given documents, they have been ready and generous in making these available to the Investigation.
- **Interviews with clinical staff and others:** Chapter 4 sets out what we heard more generally from the staff at the Trust, past and present, and from others whose role has shed light on the maternity and neonatal services provided. In conducting our clinical review, we were able to invite to case-specific interviews the staff involved, including midwives, doctors and managers, where we judged that it would be helpful to do so. We are pleased to report that in every such case the person involved agreed to participate. This too has provided a very rich vein of evidence, largely confirming what the families witnessed and were able to recall in their accounts. Some of those interviewed provided additional documents which have helped to complete the picture.

2.3 Drawing upon these sources of evidence, this chapter explains how the clinical review was conducted. It also sets out its results, both in terms of the grading of suboptimal care (using the standardised scoring system developed for the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI)) and the associated harm in each case (adapted from the NHS National Reporting and Learning System (NRLS) definitions of degrees of harm). A fuller description of our process of clinical assessment is given in Appendix B.

2.4 Alongside the clinical review, the Investigation has witnessed the wider range of harm which followed from the experience of the participating families. That wider experience, described in Chapter 3, is no less significant than the clinical outcomes.

Clinical review and grading of cases

2.5 The Investigation spans the period from 2009 – when the Trust achieved foundation status, so acquiring a new degree of autonomy and financial independence – to the end of 2020. A number of women came forward whose pregnancies fell outside the timeline set out in the Terms of Reference or whose approach to the Investigation came after we had completed this phase of our work. The Panel considered information about these cases, for background, but they do not feature within the grading of cases.

2.6 Figure 1 does not show the total number of births in the Trust or indicate where the births relate to suboptimal care or a poor outcome. It does show how the participating cases span the period covered by the Investigation.

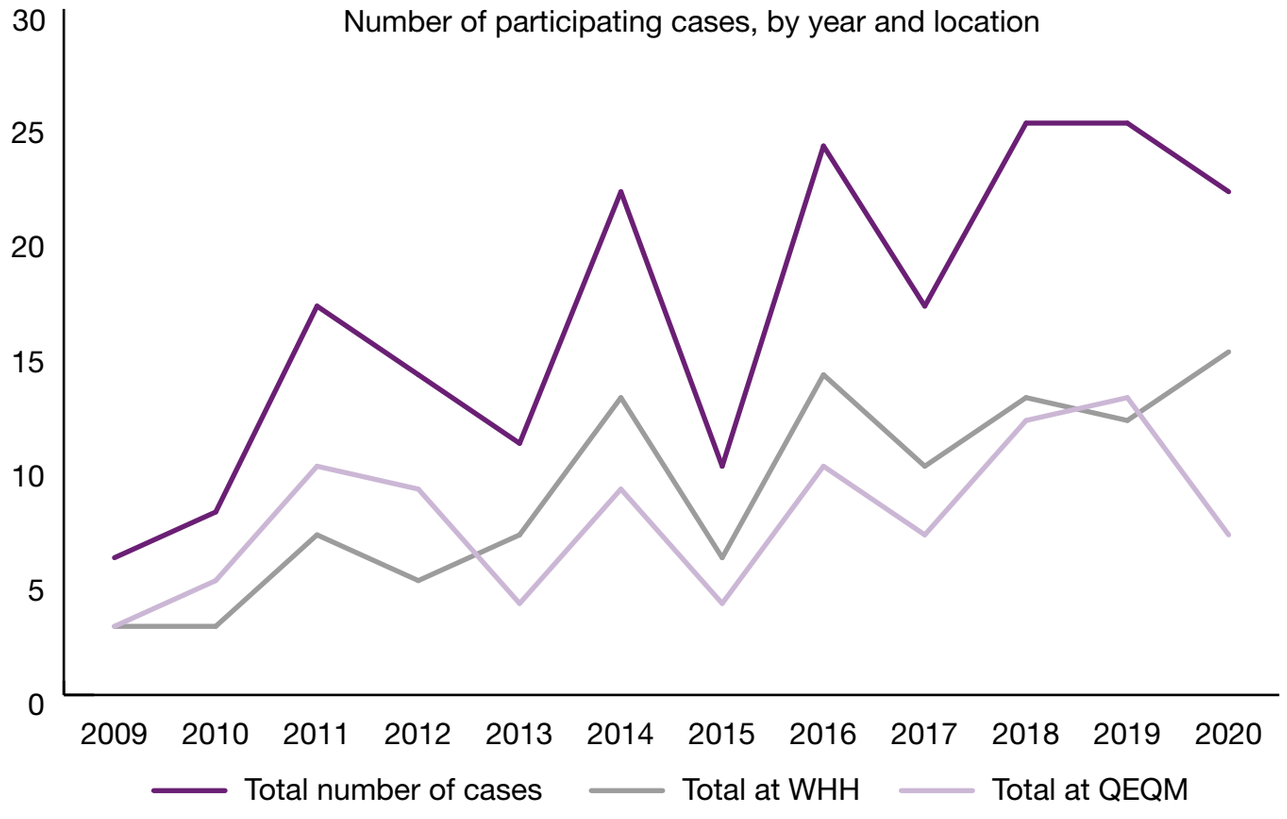


Figure 1: Cases reported to the Investigation by year and location

2.7 With the consent of the families involved, we carried out a thorough review of the clinical records of each woman and baby's care by the Trust's maternity services, adopting a systematic approach (as described in Appendix B). In addition to the clinical records, the Trust provided other documentation such as complaints correspondence, investigation reports and exchanges with GPs.

2.8 The Panel reviewed the records primarily to identify the presence of suboptimal care that might have led to a poor outcome in the period of pregnancy up to labour (antenatal), from the onset of labour through to delivery of the placenta (intrapartum) and in the hours and days after delivery (postnatal for mother; neonatal for baby).

2.9 The Panel came together to consider the evidence contained in the clinical records, with our understanding enhanced by what we had learned from the other sources of evidence. As a result, the assessment of each case reflects the judgement of the Panel collectively.

2.10 All the cases were graded using the CESDI scoring system previously used in *The Report of the Morecambe Bay Investigation*, published in March 2015. This defines four levels of suboptimal care based on their relevance to the outcome (see Table 1).

Table 1: CESDI scoring system

Level of suboptimal care	Relevance to the outcome
Level 0	No suboptimal care
Level 1	Suboptimal care, but different management would have made no difference to the outcome
Level 2	Suboptimal care, in which different management might have made a difference to the outcome
Level 3	Suboptimal care, in which different management would reasonably be expected to have made a difference to the outcome

2.11 In addition to grading the level of suboptimal care, the Panel determined the degree of harm in each case, using a classification adapted from the NHS NRLS definitions of degrees of harm (see Table 2).*

Table 2: Degrees of harm

Degree of harm	Outcomes	Impact on woman and/or baby
None	No harm	There was no impact on the woman or her baby
Minimum	Maternal injury; baby birth injury	The woman or her baby required extra observation or minor treatment
Moderate	Maternal injury; baby birth injury	There was short-term harm and the woman or her baby required further treatment or procedures
Severe	Maternal injury; brain damage, including HIE and/or cerebral palsy attributable to perinatal hypoxia	The woman or her baby suffered permanent or long-term harm
Death	Stillbirth; neonatal death; late neonatal death; maternal death	The woman or her baby died

* Although there are plans to replace the NRLS with the Learn from Patient Safety Events (LFPSE) service, which does not define degrees of harm in the way the NRLS does, the Panel found it helpful to use a form of assessment of harm that is recognisable and understood when reviewing the cases subject to our Investigation.

What the numbers tell us

Suboptimal care and associated outcomes: summary of the Panel's findings

Table 3: Degree of suboptimal care, Trust-wide

Suboptimal care	Relevance to the outcome	No. of cases Trust-wide	No. as a percentage
Level 3	Suboptimal care, in which different management would reasonably be expected to have made a difference to the outcome	69	34.2%
Level 2	Suboptimal care, in which different management might have made a difference to the outcome	28	13.9%
Level 1	Suboptimal care, but different management would have made no difference to the outcome	54	26.7%
Level 0	No suboptimal care	51	25.2%
Total		202	100%

2.12 The Panel's findings, set out in Table 3, mean that:

- **Had care been given to nationally recognised standards, the outcome could have been different in 97 of the 202 cases reviewed (48%).**
- **In 69 of these 97 cases, the outcome would have reasonably been expected to be different.**
- **In 28 of these 97 cases, it might have been different.**

2.13 The Panel found no differences to the outcomes or occurrence of suboptimal care over the time period covered by the Investigation (2009 to 2020). That is to say, we have not been able to detect any discernible reduction in suboptimal care or adverse outcomes over time, as evidenced by the cases we have assessed. Our assessment has also indicated that the outcomes found and patterns of suboptimal care concerned both QEQM and WHH.

2.14 Table 4 gives a breakdown of the range of outcomes in the assessed cases.

Table 4: Outcomes as reviewed by the Panel

Outcome	Total number of cases
Baby death (stillbirth or neonatal death)	65
Baby sustaining hypoxic or other injury during labour or birth	25
Maternal death	4
Injury to mother	28
Other physical harm (psychological harm is considered separately in Chapter 3)	32
No death or injury	48
Total	202

2.15 In relation to baby deaths, drawing upon our assessment of suboptimal care and the breakdown of outcomes, the Panel's findings mean that:

- **Had care been given to nationally recognised standards, the outcome could have been different in 45 of the 65 cases of baby deaths (69.2%).**
- **In 33 of these 45 cases, the outcome would have reasonably been expected to be different.**
- **In 12 of these 45 cases, it might have been different.**

2.16 In relation to cases of injury to babies, drawing upon its assessment of suboptimal care and the breakdown of outcomes, the Panel's findings mean that:

- **Had care been given to nationally recognised standards, the outcome could have been different in 12 of the 17 cases of brain damage (70.6%), including HIE and/or cerebral palsy attributable to perinatal hypoxia.**
- **In 9 of these 12 cases, the outcome would have reasonably been expected to be different.**
  - **In three cases, it might have been different.**

2.17 In respect of cases involving maternal injuries and deaths, drawing upon its assessment of suboptimal care and the breakdown of outcomes, the Panel's findings mean that:

- **Had care been given to nationally recognised standards, the outcome could have been different in 23 of 32 such cases (71.9%).**
- **In 15 of these 23 cases, the outcome would have reasonably been expected to be different.**
- **In eight cases, it might have been different.**

Illustrative cases of suboptimal care

2.18 The findings set out above are stark. But the impact of suboptimal care, while suggested by these findings, goes beyond mere numbers and can best be conveyed through a series of illustrative cases. These are just a few of the examples the Panel has studied, but serve to highlight some of the points that arose in many further cases. The first set comprises three examples of neonatal death (Illustrative Cases D, E and F) and one of antepartum stillbirth (Illustrative Case G).

Illustrative Case D

D's pregnancy was uneventful and she went into spontaneous labour around her due date. Progress was slow, and her baby developed signs of oxygen shortage. After significant delay in recognising the need for urgent delivery, an inexperienced locum doctor attempted an instrumental delivery, which was difficult and hazardous as the baby's head remained high. When this failed, D's baby was delivered by emergency caesarean section, with considerable damage and bleeding. The baby was in poor condition at birth. Resuscitation was inexpertly carried out, with significant delay in establishing an airway, and he died after a few days due to severe hypoxic brain damage.

Illustrative Case E

E gave birth to twins after an uncomplicated pregnancy and induced labour. After a few hours, she reported that the first twin's breathing was laboured and noisy, only to be told by a midwife that *"he's not grunting, he's singing".* His temperature later dropped, suggestive of infection, and a medical assessment was requested. A middle-grade paediatric trainee attended two hours later but saw no grounds for concern, and significant further delay ensued before a consultant neonatologist initiated investigation and treatment for neonatal sepsis. The delay proved too much, however, and despite transfer to a specialist centre, the baby died of overwhelming streptococcal infection.

Illustrative Case F

F's first child was born by caesarean section following lack of progress after full dilation of her cervix. When she became pregnant again, F was keen to have a vaginal birth with as little intervention as possible. At her first meeting with her consultant, F and her partner were deeply disappointed to be advised that she should give birth in an obstetric unit, where she could be monitored effectively in view of the risk of uterine rupture.

The couple deferred their decision, but as F's due date approached, they decided they wanted their baby to be born in a midwifery-led unit alongside an obstetric unit, with a doula present. They were aware that this was against recommendations because of F's high-risk status. The couple met with the consultant midwife at the Vaginal Birth After Caesarean (VBAC) Clinic, who refused to book F for delivery in the midwife-led unit on the grounds of safety. When the couple resisted the recommendation of delivery in the hospital's obstetric unit, the midwife suggested that in that case they should consider a home birth.

The couple remained very averse to the obstetric unit, and a plan was drawn up with midwifery staff for a home birth. Despite the obvious risks, which had already been regarded as sufficient to close off the option of birth in a midwifery-led unit, no formal assessment of the risk to mother and baby of a home birth was made. Neither was any consideration given to allowing F to give birth in a midwifery-led unit as an exception to protocol.

F went into labour a few days after her due date and her contractions soon became strong. After some time, progress in labour slowed and F was transferred by ambulance to the nearest hospital obstetric unit. Once there, concerns about the baby's heart rate resulted in F being taken to theatre for an emergency caesarean section. Baby F was born with signs of brain damage and required specialist care. She died soon after.

Illustrative Case G

G progressed fairly uneventfully in her second pregnancy up to 36 weeks, when an ultrasound scan showed an excess of amniotic fluid around her baby. At 38 weeks, she reported reduced fetal movements, and although the baby's heart rate record (cardiotocography or CTG) showed no adverse features, she had a second episode of reduced movements two days later. A repeat ultrasound scan showed marked levelling off of the baby's growth. G recalls induction of labour being discussed in general terms, but felt concerned about the risk of cord prolapse, which she had been told was raised because of the excess amniotic fluid. There is no record of discussion of the risk of continuing with the pregnancy in light of the adverse findings of reduced growth, reduced fetal movements and excess amniotic fluid. Despite these obvious adverse factors putting her baby at risk, G was sent home with an appointment to return at 41 weeks. Two days before term, she attended again, having felt no fetal movements for a period of six hours. No heartbeat could be found.

2.19 The second set of illustrative cases comprises examples of HIE (Illustrative Case H) and maternal injury (Illustrative Case J).

Illustrative Case H

H experienced reduced fetal movements and attended QEQM. The CTG showed very abnormal features from the start and was seen by an obstetrician who recognised its nature but who was about to start another caesarean section. This situation should have been escalated immediately to the consultant on call but was not. In all, it took 70 minutes before the decision that an emergency caesarean section would be necessary was confirmed, the need for which should have been obvious to clinicians from the outset. Meanwhile, the baby's heartbeat had slowed significantly, and was undetectable as the caesarean section was about to commence. The baby was in very poor condition at birth, with profound hypoxia. There was delay in establishing an airway because the correct tube for intubation was not immediately available, but after eight minutes pulse and respiration had become established. The baby was cooled and transferred to WHH for neonatal intensive care. He suffered further problems related to severe HIE and has been left with significant brain damage.

Illustrative Case J

At 41 weeks, J attended for a booked induction of labour. Progress was slow in labour, and a caesarean section was undertaken. The baby was delivered in good condition, but there was significant bleeding from J's uterus because the incision had extended into the uterine artery on one side. The surgeon was inexperienced, and did not recognise the dangerous nature of the situation at first or the need to escalate to consultant level immediately. In trying to control the bleeding, a stitch was wrongly placed around the ureter on that side, jeopardising kidney function. J required emergency intervention by a urologist to conserve kidney function and by an interventional radiologist to embolise (create a blood clot in) the uterine artery to control bleeding. She recovered after a difficult postoperative course, including the need later to remove part of the placenta from her uterus, but was left with prolonged pain.

2.20 The final set of illustrative cases in this section comprises examples of maternal death (Illustrative Case K) and intrapartum stillbirth (Illustrative Case L).

Illustrative Case K

K was booked for an elective caesarean section. She had previously had an emergency caesarean section following a complicated pregnancy, and was at raised risk of venous thromboembolism, blood clots that may travel to the lungs and cause pulmonary embolism (a serious emergency). K's raised risk was not identified before the elective caesarean section, but it was noted on medical assessment on the first postoperative day, with an instruction that she should have ten days of preventive treatment with an anticoagulant. This was not acted upon, and K had no preventive treatment after the first postoperative day. Her discharge notification incorrectly stated that thromboembolism prevention was not required. Three weeks after the caesarean section, K collapsed at home and subsequently died from extensive pulmonary embolism.

Illustrative Case L

L, an older mother with a raised body mass index (BMI), was in her sixth pregnancy. Her last pregnancy had ended with an emergency caesarean section after prolonged spontaneous rupture of the membranes, with sepsis. As was routine, she was referred to the VBAC Clinic to discuss having a vaginal birth. There is no record that any of the additional risk factors particular to L were recognised or discussed with her, and she chose to follow the VBAC pathway. At two days post term, she had an induction of labour with a prostaglandin pessary. L reported excessive pain from the outset, which was unresponsive to tramadol and pethidine administered without an obstetric assessment. After four hours, labour was not progressing and she was still reporting excessive pain. She asked for a caesarean section, but her request was denied. After another four hours, a trace of the baby's heart was attempted (monitoring had been only intermittent despite the risk factors), but no heartbeat could be detected, and the death of her baby was confirmed. A consultant discussed the intended mode of delivery and offered a caesarean section, without apparently recognising the implications of the intrapartum death and L's severe pain. At caesarean section, three hours later, her uterus was found to be ruptured and her abdomen full of blood. L recovered after a difficult postoperative course.

Narrow escapes

2.21 The Panel found that, in a few cases, there was suboptimal care that did not lead to a poor outcome or which led to an outcome that could have been much worse. We do not consider these to be "near misses", things that were prevented from happening because they were identified in time and action taken; rather, they are examples of suboptimal care that went unnoticed, which purely by chance did not result in a poor or even grave outcome for the woman concerned. They are "narrow escapes". As such, they too have informed our view about the Trust's failure to ensure the provision of safe care to families. This point is exemplified by the following illustrative case, an example of a maternal injury considered by the Panel to be a narrow escape.

Illustrative Case M

When M's labour began, at 41 weeks in her first pregnancy, she went to hospital where her cervix was found to be almost fully dilated. She was pleased to be able to use the birthing pool, and soon began pushing. After about two and a half hours, her cervix was confirmed as fully dilated. However, there was no progress apparent and she began to become exhausted. She was transferred to obstetric care. Three hours after confirmation of the second stage of labour – which should not normally last for more than two hours in a first pregnancy – a plan was made to allow a further hour for the baby's head to descend. An epidural was then set up, and a further hour *"allowed for descent"*. After five hours of confirmed second stage labour, with the baby's head in a transverse position and still not descended into the pelvis, a trial of instrumental delivery was undertaken. There was no descent of the baby's head with four pulls on the forceps, and a caesarean section was undertaken after six hours of confirmed second stage labour. The mother suffered perineal damage from the attempted instrumental delivery, but fortunately her baby remained in good condition.

Failure to listen to parents

2.22 In assessing cases, it has been striking how the avoidable factors we identified match many of the issues of concern that families themselves brought to our attention in the listening sessions we held with them. It is clear to the Panel that women had raised many of these concerns with their doctors and midwives while they were receiving their care. This is an important point, not least because it emphasises the role of women themselves in achieving a good outcome.

2.23 An overriding theme to have come from the listening sessions is the tendency of midwives and doctors to disregard the views of women. In fact, in a significant number of cases, the Panel found compelling evidence that women and their partners were simply not listened to when they expressed concern about their treatment in the days and hours leading up to the birth of their babies, their concerns often dismissed or ignored altogether. In at least some of these cases, the Panel was able to draw a connection between that failure to listen and an adverse outcome.

2.24 The illustrative cases below provide examples of this theme. They describe the circumstances surrounding an antepartum stillbirth (Illustrative Case N) and a failure of neonatal diagnosis (Illustrative Case O). These are further examples of what the Panel found to be a failure to listen to women or other family members that contributed to an adverse clinical outcome.

Illustrative Case N

N's first pregnancy progressed normally until 37 weeks, when she reported abdominal pain and altered movements by her baby. She was admitted to hospital for observation. She was not in labour, and intermittent CTG recordings of her baby's heart were within normal limits. A blood test indicative of infection was noted in her records but was not followed up, and she was allowed home the following day with no further arrangements or follow-up scheduled other than a routine appointment in two weeks. When she attended at 39 weeks, N reported reduced movements again, and her baby's heart was not heard. A stillborn baby was delivered the following day. Subsequent post-mortem examination confirmed the presence of an acute infection of the membranes inside the uterus.

Illustrative Case O

Baby O was very quiet and lethargic, and hadn't fed since he was born. Just after 11pm, about three hours after delivery, he started to vomit and O called for help and asked for clean bedding. By 1am, he still hadn't fed and vomited again. O called for help again and told the midwives that something was wrong, that her baby hadn't fed and was vomiting green bile. She was told this was normal, and no checks were done or further enquiries made. In the morning, O told the nurse that she was really concerned, that her baby had been sick all night and still hadn't fed. This was at the change of shift and the sister who came on duty raised the alarm. Doctors attended immediately and inspected the sheets, removed the baby's nappy and asked whether he had passed a stool, which he had not. He was then transferred to the Intensive Therapy Unit. Baby O had been born with no anorectal canal and complete intestinal obstruction. It had taken 14 hours from his birth to identify this condition, rather than it being picked up by the midwife at the newborn check or later in response to the mother's concerns about his bilious vomiting. During this time, baby O's condition had deteriorated significantly because his developing electrolyte imbalance had not been corrected with intravenous fluids and attempted feeding had continued. He required specialist surgery at another hospital and prolonged follow-up.

Conclusion

2.25 This chapter has set out the Panel's assessment of the clinical outcomes experienced by the women and their families who contributed to our Investigation, and the extent to which these outcomes could have been different in the absence of suboptimal care. It shows that, in nearly half of the cases assessed by the Panel, the outcome could have been different had care been given to the standards expected nationally.

2.26 The findings on clinical outcomes are stark. But the issues go wider and deeper than the clinical practice evident in the cases we have assessed. In other cases, including the 54 where the assessment of suboptimal care was at Level 1 and different management would have made no difference to the clinical outcome (see Table 3), or in the 48 cases where the Panel found that there had been no injury to the mother or baby (see Table 4), the care provided fell short of expected standards of service. We repeatedly heard that women's confidence in their care, and in the Trust more widely, was lost because of poor communication, a failure to engage and an unwillingness to involve women in decisions about their care.

2.27 In particular, an overriding theme, raised with us time and time again, is the failure of the Trust's staff to take notice of women when they raised concerns, when they questioned their care, and when they challenged the decisions that were made about their care. This is considered in more detail in Chapter 3, along with other aspects of the families' experience.

Chapter 3: The wider experience of the families

"You go to hospital to trust people, because your life is in their hands, and you never expect one of your family members or you to be let down by the system like that; it's really scary."

"The experience has affected all of our family but particularly myself and [my daughter] *… she is my baby and I cannot do anything to take her pain* [of her lost baby] *away."*

"We want to move forward and actually live our lives a little bit. We don't want this to be our lives … we want to move on. It's difficult; you're stuck. You lose whatever you do. We feel like we're not doing H justice or we're not doing ourselves justice. Whatever you do, you can't win."

This chapter describes the wider experiences of the families beyond the clinical outcomes described in Chapter 2. It identifies six common themes:

1. Not being listened to or consulted with

2. Encountering a lack of kindness and compassion

3. Being conscious of unprofessional conduct or poor working relationships compromising their care

4. Feeling excluded during and immediately after a serious event

5. Feeling ignored, marginalised or disparaged after a serious event

6. Being forced to live with an incomplete or inaccurate narrative.

Illustrative cases show how these themes featured in individual situations. These are just a few of the many accounts that we heard. The Panel has been struck by the extent to which there has been a deep impact on the wellbeing of families that continues to this day, sometimes many years after the birth. This is described towards the end of the chapter.

Introduction

3.1 In this chapter, we set out what we learned from the families we spoke to about what was important to them while they were under the care of East Kent Hospitals University NHS Foundation Trust (the Trust); how they felt they were treated by the midwives, doctors and others who looked after them; and in what ways they felt let down. It should be said that, among the stories of individual and systemic failures, there were also examples of good care by individuals, as well as compassion and kindness.

3.2 Our starting point for the Investigation, and a core principle underpinning our work, was an acknowledgement that the experiences of women and their families were key to our gaining an understanding of what was happening in the Trust's maternity services during the period under scrutiny.

3.3 Equally important was the Panel's undertaking to carry out an expert clinical review of what had happened in each case, including selected interviews with staff. The Panel's meetings with families, referred to as family listening sessions and described below, provided the contextual information and a sense of families' own experiences. Both these were invaluable to the Panel in its later review of individual clinical notes and its ability to make broader judgements about women's clinical care and any consequences.

How we engaged

Family listening sessions

3.4 The women and their families were a primary source of evidence. In family listening sessions with Panel members, they shared their knowledge, experience and perceptions of the care they received, often providing poignant and moving descriptions of their treatment by those responsible for their care, in whom they had placed their trust. This process was sometimes difficult and painful and we are indebted to them for their courage and willingness to engage fully with the Investigation. Their accounts tell us much about the Trust's culture and organisational values throughout the period under scrutiny, as practised rather than espoused: in other words, the gap between what the Trust said it did and what it actually did. We believe that this gap itself contributed to the poor outcomes experienced by the women and their families who participated in our Investigation.

3.5 It is important to acknowledge the experiences of the husbands and partners whose contributions, in themselves, have been invaluable. Not only have they had to deal with their own sense of pain and personal loss, but they have also had to provide ongoing care and support to their wives and partners, many of whom continue to have difficulties. In addition, some of our couples have experienced relationship difficulties – particularly around intimacy – greater than those that might be expected following a normal pregnancy and birth, and continue to do so.

3.6 Every family was given the opportunity to meet members of the Panel in a family listening session, either by video (an imperative in the early months of the Investigation because of the Covid-19 pandemic) or, if they wished and it was possible, in person. Our early reservations about using video for such sensitive encounters were soon allayed, as the benefits of allowing people to contribute from the safety and security of their own homes became apparent and, without exception, they spoke freely and candidly about what had happened to them.

3.7 We were also careful to correlate what we heard in family listening sessions with what was recorded in the clinical notes in each case and, where necessary, to interview relevant staff about the events.

Trauma-informed counselling

3.8 Mindful of the additional anxiety and distress that might be caused to them by having to recount and possibly relive their experiences, we offered each family the opportunity to attend a session with an expert counsellor.

3.9 Like many who have experienced trauma, our women and families frequently described a sense of not being able to cope or to live their lives as they had before because of what had happened to them. The aim of our counselling was to support families as well as possible after they had relived their experiences with the Panel, seeking to increase their personal confidence in making decisions about how to manage the impact of the harm done to them. The counselling was the start of this process for some, while others were further on in their journey. For all, it was an opportunity to reflect and take stock.

3.10 We were struck by how many families took up the offer of counselling as a result of participating in a family listening session. We believe this, in itself, is a sign that these families had experienced a significant effect on their wellbeing. In total, 54 families (more than a quarter) attended counselling sessions, some more than once. In some cases, families were signposted to other counselling services for further suitable support.

Themes and behaviours

3.11 Putting aside issues relating to the technical aspects of clinical care, which are covered in Chapter 2, there are a number of overarching themes that characterise the experience of the participating families. This is particularly concerning, given that the cases span an 11-year period up to as recently as 2020. It suggests that the themes are symptomatic of deep-rooted and endemic cultural problems across the Trust, which continue to hamper staff and compromise the safety of maternity services.

3.12 Although there are overlaps across the range of themes in this context, they can be grouped into those that feature in the period up to and immediately after birth, and those that relate to families' experiences after a poor outcome.

3.13 From our analysis, each theme can be characterised by particular indicative behaviours. We believe these have been detrimental to the quality and safety of the care given to women, and to the overall experience of them and their families (see Table 5).

Table 5: Themes arising from family listening sessions

Theme: experience of women and their families	Indicative behaviours of staff
1. Not being listened to or consulted with	• Not listening to women's concerns or not taking them seriously, resulting in a failure to recognise warning signs or a deteriorating situation • Not taking the time to explain to women or their families what was happening or involving them fully in decisions about their care • Failing to keep accurate notes about what women themselves were saying and how they were feeling
2. Encountering a lack of kindness and compassion	• Showing a basic lack of kindness, care and understanding to women and their families • Making unkind or insensitive comments to women and their partners • Showing an indifference to women's pain • Failing to ensure or preserve women's dignity or provide for their basic needs • Placing women with other mothers and their newborn babies following the loss of their own baby or after a serious event • Putting pressure on families to consent to a post-mortem examination
3. Being conscious of unprofessional conduct or poor working relationships compromising their care	• Making rude, inappropriate or offensive comments to women and their partners • Behaviours or comments that undermined colleagues, including public disagreements and raising concerns directly with women about their care • Disagreements between individuals in the same or different professional groups about women's care, including giving mixed messages • Failing to pass on or act on information, including failing to hand over effectively at shift change or to communicate effectively between services • Shifting the blame for a poor outcome onto colleagues
4. Feeling excluded during and immediately after a serious event	• Not being told what was happening, or what had happened, when things went wrong • Leaving family members waiting and anxious for news

Theme: experience of women and their families	Indicative behaviours of staff
5. Feeling ignored, marginalised or disparaged after a serious event	• A collective failure to be open and honest or to comply with the duty of candour • A collective failure to act on or respond to concerns, including a poor or inadequate response to complaints • A tendency for the Trust to fail to take responsibility for errors or to show accountability • A failure to provide adequate follow-up support, including appropriate counselling
6. Being forced to live with an incomplete or inaccurate narrative	• Blaming women and families, or making them feel to blame, for what had happened to their baby • Not giving women and their families answers or reasons for why things had gone wrong

3.14 Each of these themes is considered in turn in the following pages. We have included a selection of illustrative cases and direct quotations from families relating to each theme, to add weight to our findings and because they speak for themselves.

3.15 It was common for families to experience behaviours spanning the range of the themes we identified, which had an additional and cumulative impact on them. A more in-depth illustrative case is included later in the chapter to demonstrate this.

Theme 1: Not being listened to or consulted with

3.16 As in previous investigations into maternity services, we have found strong evidence at East Kent maternity services of a failure to listen to women and their families.

3.17 We saw in Chapter 2 that not listening to women and their partners risks there being a poor clinical outcome, with the Panel finding examples of a clear link between a failure by clinical staff to take notice of women's concerns and the poor outcome they experienced. However, this recurring theme emerged from our review not just as one that had potential clinical consequences, but as one that had a broader and deeper impact on the families concerned.

3.18 Not being listened to or not feeling that they were involved in decisions about their care undermined women's confidence in those providing that care and caused them to feel uncared for and, in some cases, unsafe. This was particularly the case when the woman was aware that she was high risk or had been told by a doctor that her pregnancy was considered to be high risk.

3.19 This "not being listened to" took several forms. We saw a pattern of women, particularly first-time mothers, being made to feel patronised and demeaned when their concerns were dismissed as overreactions and unnecessary anxieties based on "first-time nerves". There were women whose concerns about the wellbeing of their unborn babies were ignored; and women on their second or later pregnancies whose personal knowledge, experience and understanding of their own bodies informed their convictions that something was wrong, but whose concerns were either ignored or dismissed. There were also women whose legitimate concerns about their newborn babies were not taken seriously.

Indicative behaviour: Not listening to women's concerns or not taking them seriously, resulting in a failure to recognise warning signs or a deteriorating situation

3.20 We heard about:

- Women's feelings or concerns about their symptoms being dismissed:
  - *"A lot of it was that no one listened, every time I went to hospital. If they had, it might have been a very different outcome."*
  - *"I know I haven't had a baby before but this is my body and I know what's going on, and this doesn't feel right, this doesn't feel safe. I was expecting to be in pain, I'm not stupid, but this feels unsafe, this amount of pain; and being told, 'you've never had a baby before, I don't know what you expected'."*
  - *"I was saying 'look, I'm really swollen', but they didn't listen, they didn't take on board the things I was pointing out."*
- Women's concerns about reduced fetal movements being ignored:
  - *"I just wish so hard that when I went and said she was not moving the way she should be, that if they'd listened to me seriously …"*
  - *"I had gone into day care with reduced movements; having had babies before, I knew that was a big no-no and I was shocked really, the whole approach was very dismissive, I felt like I was wasting their time for being there."*
  - *"The last thing I wanted was to be sat at the hospital, when I already had a three-year-old at home. I wasn't there to waste their time. I was there because I thought something was genuinely wrong. Even if there was nothing wrong, and I was just being neurotic, they still could have done things to support you rather than just be completely dismissive … There were so many things that could have been different, that would have helped me feel like I wasn't going completely mad and maybe prevented the outcome."*
- Women's assertions that they were in labour or that their waters had broken being dismissed:
  - *"My waters went at 18 weeks and I went to* [the hospital] *and told them and the whole time I was there, they just told me that they hadn't gone and I was like 'I think they have' but they didn't believe me at all; I think it was that night that they did a scan, and it came back that my waters had gone, so quite a distressing time, and all I was told was 'it's not too late to have an abortion if you want to'; the whole day, the whole night, that's all they kept offering me."*
  - *"My waters broke when I came out of the shower and I mentioned it to the nurse, and she was quite dismissive of it, thinking it was just water from the shower dripping off my body … and I don't feel that anything was picked up then; obviously now, looking back, that was really key, for me to be monitored after that particular time."*
  - *"I was in a side room on a bed waiting for obs, but as I stood up, there was this big gush, you know, like water, and they told me I'd weed myself; and I said, look, I have not weed myself, I'm so sure this is my waters gone, I would know if I'd weed myself … again, I'm still being dismissed."*

- Women's concerns about the progress of their labour or the delivery of their baby being dismissed:
  - *"No one was trying to make the situation any better, apart from telling me that I was doing it wrong, and I wasn't doing enough to get the baby out … I didn't feel supported by anyone in the room or that anyone really cared when I was telling them 'my body is telling me this isn't going to happen'."*

- Women's concerns about their newborn babies being disregarded:
  - *"I felt everyone was quite patronising and playing it down and we were trying to tell them that something was wrong … We could see the deterioration. We never saw the same midwife. When he didn't open his eyes, I spoke to two midwives, one said to the other 'first-time parents'."*

Indicative behaviour: Not taking the time to explain to women or their families what was happening or involving them fully in decisions about their care

3.21 We heard about:

- Women being left frightened or uncertain because of a failure to communicate with them effectively:
  - *"We weren't really told much but I was told that sepsis is the main killer of babies and as a new mum I was petrified."*
  - *"No-one was telling me what was actually going on, they were just telling me what they were doing. They weren't explaining things. I was clueless."*
  - *"Although they tell you things, they don't tell you things how you need to hear them."*
  - *"Every time I tried to sit up, I was physically forced back, to lie back down. I was having flashes in my brain of old films about mental hospitals and things where people are forced to lie down and strapped in, and that's what it felt like especially with all the wires."*

- A failure by doctors and midwives to explain risks and ensure that women were fully informed, including when seeking consent:
  - *"Nobody talked through the risks of a VBAC* [vaginal birth after caesarean]*. Had I known, I would not have put my baby at risk and would have elected for a C-section … there was no discussion about any risks associated with VBAC induced pregnancies, or the fact that I was an older mum and overweight."*

- Women feeling patronised and that they were not getting answers to their questions:
  - *"Because of my age, I was 19, I think that made her feel she could get away with not explaining things to me; it was like she thought I was stupid and she knew better."*
  - *"She didn't give me any answers, which I think is a massive thing. If she had just explained her thought process, it would have helped so much."*
  - *"Above all, no matter how old you are, you should be listened to."*
  - *"My midwife wasn't interested in talking to me … she would just say just speak to your doctor or have you had a look on Google; but you want reassurance."*

- A reluctance of staff to discuss women's birth plans or to try to comply with their wishes:
  - *"I got the impression that the decision was made there and then, anything I thought was pretty silly because she's the nurse and she knows better than me, because I'm just the mother; I came out thinking that I was banging my head against a brick wall, she just wasn't listening."*
  - *"It was a battle to be heard from day one, it was 'I'm the clinician, I'll make the clinical decision'."*
  - *"I didn't think they could do things to you after you said 'no', but they did. It makes me scared to give birth in future; it makes me feel like I would end up giving birth at home with no one there because I'm so scared of midwives just doing what they want and not having my best interests and not listening."*
  - *"When I asked about alternatives to induction, I was met with 'if you don't get induced and if anything happens, it'll be your fault'."*
  - *"It very much felt like it was something being done to you, and not something we were involved with. 'This is what has to happen, and because it has to happen it doesn't matter what you think. This is what the list says we need to do.'"*

- Women feeling pressured about the mode of delivery:
  - *"The sister just looked at her and she said 'that's a swear word in my ward; we don't talk about C-sections in this ward, you'll be alright, you will be able to push this baby out'."*
  - *"It felt a little bit like the choices were out of my hands; as a patient, you know nothing and they know everything."*
  - *"I can't explain it, but I had this feeling that I wanted the babies to be delivered and I wanted a C-section; I asked the staff and was told we don't do C-sections because the mother is uncomfortable, it's not about the mother."*
  - *"They threatened me, it felt like, with a caesarean. 'If you can't be bothered to deliver this baby on your own, we'll have to do a caesarean. Is that really what you want out of this situation?' As if I was somehow being lazy, or just not doing what I needed to do."*
  - *"At one point, X said to her, 'hang on, why are you going to try forceps now when we've just agreed to a C-section? My wife has said she doesn't want forceps, she would much prefer a C-section.' Maybe we were being naïve that we had some sort of a say in this. She turned around and really snapped back and told* [him] *off saying, 'I'm the clinician, I'll make the clinical decision', and then stormed out."*

- Women being poorly communicated with and browbeaten to give consent in emergency situations:
  - *"That ultimatum on the operating table with someone stood over you with a scalpel in one hand was just like something from a horror film. It was so scary. These women who had been treating me, by this point I thought that they would do anything to me without consent."*
  - *"The doctors were rushing around, using words that made X anxious and she couldn't understand what they were saying. They wanted her to sign papers to say that she was happy to go to theatre, but she didn't understand what was happening or what she was signing. She was crying and shaking."*

- *"The doctor turned around to me and went 'you need to start thinking about your baby'. I wanted to know what was going to happen. I didn't know if they were planning for me to have a caesarean. I didn't know what I was signing for. I signed the form because I didn't want them to think I wasn't thinking about my baby."*
- *"I remember one of the midwives saying do you understand what's going on? And I just said, C-section … they didn't ask if it was ok to use forceps … and that's what they did. I didn't understand why they did it without asking … I felt violated."*

Indicative behaviour: Failing to keep accurate notes about what women themselves were saying and how they were feeling

3.22 We heard about:

- Women's concerns that their notes were inaccurate, with important aspects of their care missed out or incorrectly recorded:
  - *"So many times throughout the pregnancy I said I'm worried about this, I'm concerned about that, I'm not feeling great, but my notes just seem to say 'mother was happy'."*
  - *"They haven't written any epidural request, any caesarean request, any help request. Nothing. They just did their own thing."*
  - *"He* [the consultant] *went through my notes and said there is nothing in here that tells me about that* [dysphasia]*; and there was nothing in there that told him that her collarbone had broken and that we'd had an x ray – in her maternity notes – the slightly alarming thing for me is that, whatever happened, it hasn't been recorded in the notes. To me, that's alarming and it means that something's wrong."*

3.23 It is the Panel's estimation that, in a significant proportion of cases, this failure by midwives and doctors to listen to what women were telling them was a feature of the care experienced.

3.24 Overall, we found "not being listened to" to be part of a broader tendency of clinical staff to fail to engage women in the management of their care.

Theme 2: Encountering a lack of kindness and compassion

3.25 The Nursing and Midwifery Council publishes professional standards which govern the activities and behaviours of nurses and midwives. Its first standard is *"treat people with kindness, respect and compassion"*.[1] Similarly, the General Medical Council publishes professional standards that govern the activities and behaviours of doctors. It states: *"You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession."*[2]

3.26 The public might expect that kindness and empathy would characterise maternity and neonatal services anyway, without reliance upon a professional standard. Given the long-standing existence of professional standards set by regulatory bodies and the legitimate expectations of patients and their families, it is all the more concerning that lack of kindness and empathy features so heavily in our families' accounts. We heard about behaviours of both midwives and doctors that fell some way short of those expected standards and legitimate expectations. In fact, in a majority of cases, families described aspects of their care that they felt were the result of unkindness and a lack of compassion and empathy.

Indicative behaviour: Showing a basic lack of kindness, care and understanding to women and their families

3.27 We heard about:

- Women and families who felt uncared for and unwanted by doctors and midwives:
  - *"They are meant to be there for you … I was a first-time mum; I was worried and I didn't know how it all worked. It was unbelievable how I was treated."*
  - *"There were so many failures that it's hard to sum up … It wasn't even the physical medical things that happened … it was the treatment from the people, the way we were treated, the way we were spoken to, with no human decency whatsoever, no bedside manner, no consistency, no continuity of care, the list goes on and on. And I think that is the culture, that is the culture there. It is this conveyor belt, where they are so immune to it, they forget that the women are even there."*
  - *"If they had just cared, it would have made the blow a little less; a bit of support, a hug, just something, but there was nothing. It was really hard."*
  - *"I came away from the experience very scared and humiliated. That's what I took away from the experience of childbirth."*
  - *"The care for my son was second to none. The care for me was diabolical."*
  - *"I'm a carer and if I had acted like some of the midwives I would have been taken into the office and disciplined."*
  - *"It just felt like a really lonely and traumatic experience, which I feel like maybe if it had been a more experienced midwife or someone else there, that I would have got that reassurance and encouragement that is really important when you're having a baby, let alone in traumatic circumstances."*
  - *"I felt like I was a nuisance."*

- An apparent lack of awareness or a failure to take account of pre-existing mental health conditions or personal histories which made women particularly vulnerable to feelings of fear or anxiety:
  - *"The feelings are so similar to the sexual abuse but this time I'm left with a physical disfigurement as well as the mental side of it."*
  - *"They were going to do an internal; I am a survivor of childhood sexual abuse and it was a male midwife and a male doctor; it's making me sweat just thinking about it … it was horrible."*
  - *"I used to suffer with mental health issues … that was in my notes with my first pregnancy and it went on my notes for my second but my community midwife, who I have to say has been amazing afterwards, she did take it off my notes at one of my appointments and that's concerning for me actually now, looking back … I did bring it up with* [name]*, one of the midwives at the hospital, she did go away and speak to a doctor, who she said said to her, just put her on Sertraline … and I don't want to go back on tablets, I spent a long time coming off tablets."*

- The needs of family members not being met, and in particular a tendency to leave people waiting, knowing that something has gone wrong but not being given any information:
  - *"X was taken back to theatre and I went to the ward to find the rest of the family and the new baby. They had been told to wait in a four-bedded bay; they were standing*

in the space where X's bed would have been, huddled together and crying behind the curtains, surrounded by the three other women in that ward and their babies."

- *"No one said anything to me … I think at that point it probably would have been better if I had been told, look, there is something serious, given I could have probably switched into a more supportive role … I always look back and feel quite guilty that at that time I wasn't supportive enough and actually I was sitting there and I was just questioning everything and thinking well maybe I'm just being overly worried here and there is nothing. I would probably have preferred to have known at that point"* [the reflections of a woman's partner recalling the moment he realised that their baby was ill; it was several hours later that they were told the gravity of the situation].

- Women or their partners calling for help and feeling ignored when no one came:
  - *"Within minutes, I began to feel very unwell and began shaking violently and vomiting. We pressed the emergency buzzer, but no one came. X* [her partner] *then went out into the corridor to try to find someone to help, but could not find anyone, so was left to deal with the situation alone."*

Indicative behaviour: Making unkind or insensitive comments to women and their partners

3.28 We heard about:

- Women and family members feeling patronised, being ignored or "told off", or being subject to hurtful remarks:
  - *"Some parents just aren't supposed to have children"* [a woman recalling the comments of a doctor].
  - *"I was told at one point it was because I was fat. It wasn't even beating around the bush, saying 'because of your weight' or anything like that: it was 'well, because you're fat, that's how it is and we have to do different things'."*

- Women feeling that they were unimportant and too much trouble:
  - *"She said sorry for your loss, but our baby was dead and there were other babies who were still living that she needed to attend to."*
  - *"We have more important people on this ward, you are not the only one who is in need at this point"* [a woman recalling the comments of a midwife made to her while she was waiting for a blood transfusion].
  - *"They would make me feel terrible … every time I went, they would make me feel like I shouldn't be there."*

Indicative behaviour: Showing an indifference to women's pain

3.29 We heard about:

- Women in acute pain feeling ignored and being left without appropriate pain relief, their pain sometimes being dismissed:
  - *"I wanted to die, I was in so much pain."*

  - *"The pain was horrific pain but the midwives who examined me said I was fine. I was in so much pain that I couldn't place my feet flat on the floor, but they just told me I was doing well. I felt like nobody was listening to me and they couldn't be bothered."*
  - *"She said 'you'll have to wait, I'm busy, I've got other things to do'; and I waited two hours, I spent two hours crying in pain before I rang the bell again because I was too scared, in case she started having a go at me again."*
  - *"People give birth in Africa in mud huts without pain relief"* [a woman recalling the comments of a midwife made to her during her labour].
  - *"I still have nightmares to this day, of feeling that pain so vividly."*

- Women feeling pain because of a failed epidural or spinal,* or one that was wearing off:
  - *"He came and did these manual evacuations; my spinal had started to wear off a bit and he was going up with his hand right into my uterus and pulling out all the clots it was the most painful thing I've ever experienced in my whole life … he was looking at me and said to me, Oh, is that painful? And I was like, yeah, your hand's right up there, my spinal's wearing off and I've just had surgery ... He didn't seem to have any feeling … The midwife said to me oh my God, they were looking horrified; they couldn't hide their looks"* [a woman describing how a registrar proceeded with manual evacuation of placental tissue as her spinal was starting to wear off].
  - *"I lay down on the table and they started to do the cold spray, straight away I could feel it … I kept saying I can feel this … they didn't listen to me, I said this about four or five times to the team, I can feel this, it's not right. They didn't listen … They carried on, obviously, to cut me open. I could feel it all. My left side was slightly numb, I could feel everything on my right side. I felt the knife going in; I started to get hot and I could feel the blood draining from my face. I started to really panic and remember trying to push them off me … I felt everything from there on, it was just an absolute nightmare."*

Indicative behaviour: Failing to ensure or preserve women's dignity or provide for their basic needs

3.30 We heard about:

- Women not being able to be accommodated in the labour ward:
  - *"I was told we have no beds and you'll need to wait in the day care waiting area; I had a really bad feeling at that point and burst into tears … nobody reassured me, I felt like there was no sympathy or empathy expressed by anyone. I was told sorry, that's the only place we've got for you, so I sat out there all day. That's basically where I sat for the rest of my time, until I had my daughter at about 4.00 in the afternoon … from 7.00 in the morning, I had been looked at, assessed once … they asked my partner to hold her so she didn't fall to the floor, because I was standing up. There were no midwives around, they had to go and find somebody … I had to ask for blankets … there was no dignity, I had to ask somebody to cover me up."*

* "Epidural" and "spinal" refer to forms of pain relief often used in labour or for obstetric procedures, involving an injection of anaesthetic around the nerve roots.

- Women's distress at their dignity not being preserved, for example by them being left for long periods in soiled bedding or in ward areas which did not provide for their privacy:
  - *"My blood was up the walls, on the ceiling; my sheets weren't changed."*
  - *"I know that doctors and midwives need to come and go, but the door was left open quite a few times, which was not very nice; there was no privacy – I think everyone in that hospital saw me in that bed. That was awful."*

Indicative behaviour: Placing women with other mothers and their newborn babies following the loss of their own baby or after a serious event

3.31 We heard about:

- The impact of the limitations of the two hospitals' premises on women who had just lost their babies, which meant they were placed in wards among other mothers with their newborns or had to carry their babies' bodies to other areas:
  - *"It is soul destroying to hear the cries of healthy babies being born knowing that your baby will be born silent."*
  - *"Spending about 24 hours on the labour ward listening to other babies crying was hell on earth."*
  - *"It didn't make it easy for us; having to come out and see lots of happiness and we were going through the worst point ever."*
  - *"As I stepped outside, one of the mums from the nursery next door came up to me and said 'oh, how's he doing', and I looked at her and said 'he's dead'. That should never have happened, for her."*
  - *"They were walking the same way we were going, turning around, staring. That will haunt me for the rest of my life because they knew I was carrying a baby that was not here. They were just watching me the entire time, walk through the corridor. She said to her husband, as I passed them, 'she's carrying a dead baby'. It was awful."*

Indicative behaviour: Putting pressure on families to consent to a post-mortem examination

3.32 We heard about:

- Newly bereaved parents feeling under pressure to consent to a post-mortem examination of their infant:
  - *"The pressure is unreal, for everything. Hours after we delivered him, they're there, 'do you want a post-mortem?'. This is stuff that I have never even thought to have done, and you're bombarding me with these questions."*
  - *"They wanted to know if we were happy for them to do a post-mortem and we were like, no, we don't want to have one, we don't want it to happen … but they were like, ok, but it will really help other parents if you have one, and we were like, please do not ask, we do not want one … and the next day, they asked us again, and we said we've already decided, do not ask us again, we do not want one, and we had to be quite firm … that was quite hard because we felt they were pushing us into it."*

Illustrative Case P

At 29 weeks pregnant, P began to feel unwell with abdominal pains. She called maternity day care and was told to attend for observation and cardiotocography (monitoring of the baby's heartbeat). She told the midwife it felt like she was having contractions but the midwife was dismissive, saying it would be a urine infection and the doctor would give her antibiotics and send her home. P believed the midwife, despite her concerns.

Two hours later, P noticed that she was bleeding and, on examination, was found to be in labour. Baby P was delivered by caesarean section. After initially making good progress, the baby developed a severe infection and his condition worsened.

After ten days, a doctor informed P and her partner that treatment had failed and nothing further could be done.

"[They were] *so blasé,* [they] *got the ultrasound scan and literally just said yes, that's infected, that's infected, his brain's covered in this, his heart's covered in that; I'll come back at ten o'clock when I've done my rounds and take the tubes out."*

Afterwards, P sat with her dead baby in her arms with the other parents in the room listening to her *"howl from her soul"*.

Illustrative Case Q

At 17 weeks pregnant and bleeding heavily, Q was told to attend the maternity department. The person on reception was busy making arrangements to deliver a cake and made her wait. Placenta praevia was diagnosed and Q required an overnight stay.

Afterwards, at home, the bleeding resumed and Q found herself back in hospital. Suffering from a headache and feeling extremely thirsty, she called the midwife, who – in front of all those in the ward – said, *"Aren't you the woman who's going to have an abortion?"* Q was distraught: she had been told when she was first admitted that the viability of her pregnancy might be in question because of the heavy bleeding, but nobody had told her that she was at that stage.

A few hours later a consultant attended, who told her there had been a mistake, the midwife should not have spoken to her in that way and she had no need to worry. On her fifth day in hospital, Q was discharged and told to reschedule her 20-week scan, due in two weeks, because she was high priority. However, when she tried to bring the appointment forward, she was told this could not be done.

For the next three weeks, Q stayed at home, bleeding and suffering from headaches, scared of being a nuisance. She finally returned to the hospital and a scan revealed the presence of two large haematomas. After a week in hospital, she haemorrhaged and woke in theatre to confusion and panic. A consultant was present but there was no anaesthetist and there was a delay in obtaining the blood necessary for a transfusion.

Q's baby had not survived and she required a hysterectomy to control the bleeding; the consultant told her that, in their 30-year career, they had never had to perform one in such circumstances. The midwives told Q's husband: *"We're not set up for this, we haven't got the procedures."*

3.33 What the Panel has learned from its interviews with Trust staff is described in Chapter 4, so will not be covered here. However, we found evidence that the prevalent culture in the Trust has tolerated and fostered the unkind, uncompassionate and intolerant behaviours sometimes experienced by women and their families.

Theme 3: Being conscious of unprofessional conduct or poor working relationships compromising their care

3.34 Team conflicts pose a potential threat to the quality of relationships and communication between patients and staff, as well as to the quality of care. They can also make patients feel unsafe when they perceive that staff are not communicating with each other or working as a team. It is therefore unsurprising that a lack of teamwork and a failure to share information featured in the family listening sessions as matters of concern to the women and families who spoke to us.

3.35 We heard accounts of unprofessional conduct that were alarming to women and their families because they undermined their confidence in the doctors and midwives looking after them and, in some cases, made them question the safety of their care. For one family, these concerns were compounded by the comments of a consultant, overheard in a patient area, who was discussing with a colleague how unsafe the unit was and how they had reported it to senior management but had given up trying to raise it.

Indicative behaviour: Making rude, inappropriate or offensive comments to women and their partners

3.36 We heard about:

- Women or their partners being on the receiving end of inappropriate and unprofessional comments, which they found hurtful or offensive:
  - *"She's making the wrong call here, and it's going to be your wife's fault when it all goes wrong"* [a woman's husband recalling the comments of a midwife].
  - "[They're] *all over the place because* [they've] *just come back from a cruise"* [a woman recalling the comments of a consultant about a colleague].
  - *"Is she normally this dramatic with pain?"* [a woman's husband recalling the comments of a consultant].
  - *"I don't have time for this. I have to get to Canterbury and the parking is bad"* [a woman recalling the comments of a consultant made during a consultation].
  - *"Under no circumstances can you leave this room. If you do, you are putting your unborn child at risk … on your head be it"* [a woman recalling the comments of a consultant].

Indicative behaviour: Behaviours or comments that undermined colleagues, including public disagreements and raising concerns directly with women about their care

3.37 We heard about:

- Midwives complaining about doctors and other midwives behind their backs:
  - In one case, midwives referred to a consultant as having a *"God complex"*.

- Midwives ignoring the advice of doctors and taking contrary action:
  - *"I don't agree with that, this is what we're going to do"* [a woman recalling the comments of a midwife made after a consultant had explained their plan for her care and left the room].

- Doctors showing disregard for their midwife colleagues:
  - *"*[They] *told the midwives off in front of me."*

- Doctors disagreeing within earshot of women and their families:
  - *"Don't you dare argue this with a patient, this isn't appropriate or professional"* [a woman recalling comments made by a consultant to a colleague, disagreeing about a baby's transfer to the bereavement suite].

- Women being told "on the quiet" that their care had been substandard and they shouldn't accept it:
  - *"There are things that should have been done differently. If you were a member of my family, I would not be happy with the care that you've had"* [a woman recalling the comments of a midwife after a bladder injury during a caesarean section].

3.38 In some cases, these behaviours reflected poor working relationships within and across professional groups. This theme is picked up below in reference to teamworking and information sharing, and in Chapter 4 on what we heard from staff. In any event, the impact of such behaviours on the women who witnessed them was such that they featured heavily in their accounts of what they experienced at the Trust. This laid bare for the Panel the extent and pervasive nature of the poor behaviours and teamworking in both maternity units, which the senior team failed to address with any degree of success.

Indicative behaviour: Disagreements between individuals in the same or different professional groups about women's care, including giving mixed messages

3.39 We heard about:

- Doctors and midwives contradicting each other or disagreeing in the presence of women, which caused the women anxiety and made them lose confidence in their care:
  - *"I'm not dealing with this, I'm not going to be here while you do this"* [a woman recalling the comments of a midwife made to two consultants who were about to break her waters].
  - *"Women and their families are set up for misunderstanding. You're on the back foot and need to reinterpret what you've been told."*
  - *"In hindsight, it's easy to see there was a bit of a tug-of-war between the midwives and the registrar."*
  - *"The consultant came to see me and said that they wanted to keep me in overnight, and the midwife sent me home about an hour later. And the consultant had written in my notes that they wanted to keep me in overnight and the midwife sent me home, and there were no notes after that to say why. I had no explanation. They just sent me home."*

Indicative behaviour: Failing to pass on or act on information, including failing to hand over effectively at shift change or to communicate effectively between services

3.40 We heard about:

- Failures to provide sufficient information at handover, or to document information in the notes at shift change alerting staff to a possible risk to mother or baby, resulting in poor continuity of care and compromising safety:
  - *"The shift changes were shocking, there was no communication between teams; the new team didn't have a clue what we had been through during the previous three days."*
  - *"Communication seemed to be the biggest issue on that day … the night shift didn't hand over all the details … there was the potential there to record some things that would have made it an amber alert but it was ten hours before we finally got those antibiotics, which in my opinion was too late."*
- A failure to pass on information to colleagues and teams, including to the delivery ward or community midwives, resulting in upsetting interventions by staff following the death of an infant:
  - *"Calm down everyone, you're going to have a baby today"* [a woman recalling the comments of a midwife made in the delivery suite prior to the planned delivery of her stillborn baby].
  - *"There's no loop, no one communicated properly … they didn't even think to tell my midwife that my baby had died, it took me to do everything …* [they] *signed me up for groups for after I'd had R, being a young mum, and I got letters in the post from them inviting me to mums' groups, because nobody told them that my son had died."*

Indicative behaviour: Shifting the blame for a poor outcome onto colleagues

3.41 We heard about:

- Doctors and midwives trying to abdicate responsibility to others or shift the blame when things had gone wrong:
  - *"You could feel this cultural thing going on, where the consultants were saying 'no, no, no, it's the midwives' and the midwives were saying 'no, it's not us'; and immediately, we got this little window into what was actually going on there."*
  - *"We got taken to this tiny little box room and she just kept saying the whole time, 'as long as you know, it is not our fault. It is no-one's fault. It is just one of those things.'"*

Illustrative Case R

R was pregnant with twins. At her 20-week scan, slight ventriculomegaly (enlargement of the ventricles of the brain) was apparent in twin one, and this had become severe by her 24-week scan.

The consultant told R and her partner there was a 95% chance that twin one would be severely disabled, and it was likely that the other baby would be as well. The consultant also told the couple that they were being unfair on their older children by continuing the pregnancy and that termination of the entire pregnancy was recommended, as it was not viable.

Even though they believed it was no one's decision but their own, the couple felt they would be going against medical advice if they chose to continue with the pregnancy. They were referred to King's College Hospital in London where the range of possible outcomes was discussed, including a positive outcome. They were also told that selective termination of just one twin was an option; this had not been communicated to them before.

The couple moved areas and within a few weeks R had her first appointment at the local hospital. The perinatal and obstetrics and gynaecology consultants advised her that there was a possibility of complications, but that this wasn't guaranteed and every baby should be given a chance. The couple felt that they were being treated as intelligent people who were competent to make their own decisions.

The following week, R had a bleed and was admitted. After a month as an inpatient, she delivered two baby girls by caesarean section. Although one required resuscitation, the twins were both well and continue to thrive.

Illustrative Case S

Towards the end of an uneventful pregnancy, S developed a rash on her body, the cause of which could not be determined, and a decision was made for labour to be induced. The date was set and, early that morning, she called the hospital to check that she should come in. She was told that there were no beds available and to call back later.

Around 20 minutes later, S's waters broke; she called the hospital again and was advised to go to a neighbouring clinic to be checked. From the clinic, she was sent to hospital for additional monitoring, where it was confirmed that the baby's heart rate was slow, but she was wrongly told this was not a cause for concern.

S was sent home to allow labour to develop. That evening, having not felt her baby move for a while, she called the hospital again and was told to attend. She arrived as the night shift changeover was taking place. She was checked and found to be having contractions, but her labour was not progressing. S was attended by a student midwife, who applied Prostin gel to speed up her labour, and arranged for a birthing pool. The student midwife told S that it was likely she would end up having a caesarean section as her waters had broken more than 24 hours previously and her labour was not progressing.

Soon after, S was attended by a different midwife, who disagreed that a caesarean section would be necessary. S was given an epidural and labour augmented with Syntocinon; however, she felt very unwell as a result, and was shaking and vomiting.

The day shift ended, and S's care was handed over to a senior midwife, who told her that she had been left in a *"ridiculous"* situation and that she shouldn't have been kept on a drip, which clearly wasn't working as she was still in the same state of labour as she had been that morning, but was now exhausted and unwell.

Because labour was not progressing, a decision was made that delivery should be by caesarean section. S's epidural was topped up in preparation, but she felt very unwell again. No one seemed concerned or acknowledged that this was the second episode of these symptoms. One of the surgical team said: *"It happens, sometimes people are sick."*

Theme 4: Feeling excluded during and immediately after a serious event

3.42 In several cases, women became aware that something was going wrong in the course of their care, either as it was happening or shortly afterwards. They described a lack of compassion and a sense of being excluded as events unfolded or in the immediate aftermath. Sometimes, this failure to inform and consult them about a deteriorating situation extended to the woman's partner and other family members, who were left waiting for long periods in a state of ignorance and growing anxiety and fear.

Indicative behaviour: Not being told what was happening, or what had happened, when things went wrong

3.43 We heard about:

- Women and their partners or family members not being informed what was happening as events were unfolding:
  - *"No one talked to me at all through the operation … I had the spinal block and no one told me what was happening. I was asking questions constantly … I was trying to make sure that I stayed conscious so I could remember everything, and no one told me what was going on. I kept on peeking up and they kept on telling me to lie down. I just saw them covered in blood, up to their elbows covered in blood, having conversations about me saying, 'oh that's bad, that's bad, that's bad', but not telling me what was going on … I was 100% sure I was going to die."*
  - *"My daughter went one way, my wife went the other, and I was left on my own, not knowing if my wife was alive or my daughter was going to be alive at the end of the day."*
  - *"I was just left for so long to my own devices. When the doctor came in, it was like no one wanted to tell me that he had died. They waited for me to go down to ultrasound, but by this point I knew something was up. I used to find* [his heartbeat] *at home on my own so I knew something wasn't right, but nobody was telling me."*

Indicative behaviour: Leaving family members waiting and anxious for news

3.44 We heard about:

- Women and their partners or family members not being informed after a serious event about what had happened:

- *"When I came around in recovery, I kept saying to them, 'where is he, where's my baby'. Nobody would look at me, nobody would tell me anything. It was only when X came in and I saw his face that I knew he was gone. They knew there and then that things had been done badly, because they wouldn't even look at me."*
- *"What was really strange, and what I really didn't understand, is that no one was really willing to tell me anything, to explain to me what happened. They were really vague, and you would get different versions depending on what doctor you spoke to."*

Illustrative Case T

T had had three previous caesarean sections and knew what to expect, but her reception at the hospital unsettled her. She and her partner found the surgeon arrogant, rude and unreceptive to questions, though the anaesthetist was more reassuring.

T was given pain relief and a screen was put up, but no one provided any explanation about the procedure and T wasn't even aware when it had started. Then, as the baby was delivered, a midwife leaned over and said: *"I'm really sorry the paediatrician is not here yet, but he will be here."* T didn't know what to make of that.

The infant was born translucent, pale and white. He was taken away and T knew that something was wrong. She asked what was going on and what had happened, but was not given any information other than that it was a *"freak of nature"*, an *"accident"*.

It was nearly an hour before T was able to hold her baby. When he was put into her arms, she was shocked at his pallor. He was then taken for a blood transfusion. T asked for information and was told that the clinicians had cut through the placenta; she knew there had been a ten-minute gap between knife to skin and the baby being delivered, and felt panic at the thought that he had been without oxygen for ten minutes.

The hospital staff said they had performed a computerised tomography (CT) scan and the baby's brain was fine, but T was worried about the possibility of brain damage. She kept asking if he was OK and was told that he had been given a CT scan which had come back clear. She later found out from her notes that he had received a cranial ultrasound, not a CT scan. After discharge, T contacted the hospital to inform them that her baby was *"juddery"* and his eyes weren't right; she was told *"boys are lazy"*.

At the two-month check-up, T asked whether the ultrasound would definitely have detected damage and was told by the sonographer that this was not necessarily so. With a great deal of effort, T managed to secure a magnetic resonance imaging scan for her baby. The couple were informed on the telephone that their baby had suffered a cerebral infarction. They attended the William Harvey Hospital in Ashford (WHH) to see the scan and were shocked at the very large area of baby T's brain that had been affected. They asked how extensive the damage was and were told *"work it out yourself"*. The hospital has never provided an account of what happened.

Theme 5: Feeling ignored, marginalised or disparaged after a serious event

3.45 As well as their frustration and anger about not being informed as events unfolded, families described a range of experiences of the Trust's investigations process that followed. Some felt that the process had been reasonably open and fair, while others felt deeply distressed and aggrieved by it. Sometimes, where there had been a very serious adverse outcome, families lacked information about what to expect and what processes should and would be

followed, including how they would be involved. In general, there appears to have been a collective unwillingness to engage with families and a reluctance to invite them to contribute to investigations; some families were not even made aware that an investigation was taking place.

3.46 We also heard about the downgrading of incidents without proper explanation, and families' concerns about deaths that should have been reported to the coroner but were not.

3.47 It is clear to the Panel that this failure to engage with women and their families after a serious event – or to do so in a manner that did not take into account either their distress or their concerns about their care, or to provide appropriate and timely support – caused them additional harm. These types of responses, illustrated by the indicative behaviours for this theme, made it harder for women and their families to work towards regaining a sense of being able to cope or to return to the kind of lives they had prior to what happened to them.

Indicative behaviour: A collective failure to be open and honest or to comply with the duty of candour

3.48 At the time of writing this Report, it has been confirmed that, for some women, the Trust's failings have contributed to or caused the poor outcome experienced by them or their baby. In a few cases, this has been as a result of the Trust's own investigation; in others, it has followed a coroner's inquest or the interventions of a third party such as the Healthcare Safety Investigation Branch. However, there are many families who remain in the dark and who seek long overdue answers to their questions, as well as confirmation that any lessons learned have resulted in improvements.

3.49 We heard about:

- Failures to explain to women or their families what had happened or to apologise, and families being "fobbed off" when they sought answers to their questions:
  - *"When things go wrong, people should talk about it and learn. Nobody thought I was in labour, nobody said they had made a mistake, and these are the consequences."*
  - *"Although it was seven years ago for us, it is still burning in our hearts because we haven't had answers."*
  - *"WHH shut down to us, they were more concerned about us taking legal action than actually wanting to learn from A's death."*
  - *"We've heard lots of people say they knew the hospital was an unsafe place and the culture was wrong. When we complained about the basic things, like the cleaning of condemned mattresses,* [senior nurse] *said she was surprised, because the CQC* [Care Quality Commission] *were due and everywhere had been painted. It was like, we've done the painting, and it's all ok; like the Queen's coming to visit so we've done a bit of decorating."*
  - *"People think that we are on a witch hunt for the surgeon, but we are not that sort of family. We understand that things go wrong, but we are having a problem because they could have seen it from a different view."*

Indicative behaviour: A collective failure to act on or respond to concerns, including a poor or inadequate response to complaints

3.50 We heard about:

- A poor complaints process, with responses to complaints sometimes not being received, defensiveness and a "pick and choose" approach to what was covered in complaint responses:
  - *"If it's a small company, you can go to the boss to complain that this has been terrible … With something as big as the NHS, you're fighting a losing battle."*
  - *"I had made suggestions in my complaint, and I had made it clear how wonderful the people were that had helped me. My complaint wasn't about the fact that this was maybe an error or a faulty device, my complaint was about the lying and blaming me and covering it up. That's what's really upset me about it."*
  - *"We wrote a measured complaint after some time, we didn't do it in raw emotion, we waited, and I think it was quite clear what we wanted out of it in terms of an apology and to know that things were going to improve and not just ignored or brushed under the carpet … it took three attempts to send that letter in before someone replied to us and in the end it took me writing to the CEO of the hospital Trust, just to get a reaction and acknowledge that we'd written the complaint … they went on to investigate it … and it took another six months before we had our meeting."*

Indicative behaviour: A tendency for the Trust to fail to take responsibility for errors or to show accountability

3.51 We heard about:

- A failure by the Trust to undertake robust investigations or to involve families:
  - *"People are investigating things by looking at the notes and we're the ones who were with her, who could hear what she was saying and all the texts on her phone saying no one's listening to me, everyone's acting like it's normal to feel like this."*
- Delays in completing internal investigations, a defensive approach, and a reluctance to involve families, keep them informed of progress or report back to them, sometimes resulting in them fearing a cover-up:
  - *"It was literally like cloak and daggers, going round, trying to find out information and getting stuff from nurses who had put it by for us, who had photocopied things to try and give us the information we needed. We were getting no support from the management about anything at all."*
  - *"Every time at the hospital, it always seems like one person is covering up for the next; they are a team and they work together, but they shouldn't cover up when children are dying."*
  - *"Their attitude was 'we made a mistake, but it wasn't that bad, and it won't happen again'."*
- The ongoing concerns and experiences of women being consistently ignored and invalidated after the event:

- *"They did their investigation … I don't know whether it's ironic, but we got their response back, it was not good enough, I mean the response took over three months, but we got a response back the day before the Coroner's court, but it was very very short, it was almost like bullet points, and we were like this is not good enough, straight away. So then we did a timeline, we did every question possible and the potential answers and we sent it to them … so we are now waiting to see the response from that."*

- A failure to demonstrate that the Trust has learned from serious incidents:
  - *"I just want to put things right for mums and babies. I just want to see things get better. Without accountability you can't hold them to their promises and that's why we're here. I know people will promise you anything to get rid of you, but we really do need to get the accountability in order to get improvements – I don't want differences, I don't want changes, we want improvements."*
  - *"What I can't accept is that you refuse – you actively go out of your way to try and avoid learning from the situation, you actively try to cover it up, and that ultimately means it will happen again. That is something that I find unacceptable."*

Indicative behaviour: A failure to provide adequate follow-up support, including appropriate counselling

3.52 We heard about:

- Inconsistencies in the referral process to the Birth Afterthoughts service; when families were referred, they often found it unhelpful or even detrimental to their recovery:
  - *"That appointment was more hurtful than anything else. The lady was trying her best but she didn't have all the notes, some of the notes were in the wrong order. There were notes that contradicted each other … we just came out and cried."*
  - *"I asked for Birth Afterthoughts and was told that wasn't suitable because I had a complaint in process."*

- Poor and sporadic access to and quality of counselling for the mother, with non-existent provision for fathers; many families have resorted to sourcing counselling themselves:
  - *"There was no care, no support, it was very lonely."*
  - *"I just left there and thought this was the biggest waste of time ever. Because you don't really want to go back to that hospital anyway when something like that has recently happened, and to go there and they can't even get your name right or the baby's name right, or how far along you were in your pregnancy, it was insulting."*
  - *"It* [the follow-up] *was really, really bad. It was terrible. When they answered the phone, they didn't want to help, they didn't want to know anything about it."*
  - *"For my counselling after it, I put myself forward for the doctor … I didn't even really know I needed anything, and then I got myself in a really bad state one day and thought about harming myself and then I realised I needed help."*

- Failures of the bereavement service to provide an adequate and supportive response:
  - *"We asked to see the bereavement counsellor, and she refused to see us because we weren't having a funeral, she was like, well, there's nothing I can do for you."*

- *"I wanted to get some counselling, but the waiting times were months and months for those … I had a bereavement counsellor but because it was covid times, it was all over the phone and it was quite distanced and it was a very lonely time. I didn't really find the bereavement* [counselling] *terribly helpful … in the end it felt I was left to my own devices."*

3.53 Not being listened to, not being extended kindness and compassion, and feeling ignored or marginalised when accessing healthcare may leave patients who have uneventful care feeling insignificant and invisible. In those circumstances, it is not uncommon for patients to rationalise their responses as being the result of service pressures and to accept and normalise them.

3.54 However, when these responses occur after events that are traumatic, frightening or have a poor outcome, as was the case for families in our Investigation, there is an expectation that staff will do all they can to minimise any impact and will act with compassion and insight. When this does not happen, the impact is greater. We heard this in the accounts given by the women and their families, and saw it in their visible distress months and years after their experiences. They were left questioning why they were treated in such a manner and feeling diminished, powerless and even worthless, adding a layer of harm to what was already for many an almost unbearable event.

3.55 In common with other investigations, the trigger for regulatory scrutiny and the commissioning of this Independent Investigation came from individual families who had been failed by the Trust. It was their persistence and determination to get to the truth that has led us to where we are now. It is disappointing that families continue to have to do this to substitute for ineffective safety monitoring by trusts and regulators.

Theme 6: Being forced to live with an incomplete or inaccurate narrative

3.56 Many women were not party to the whole of their own or their baby's experience, due to being sedated, not being in the same room as their baby or simply being too unwell to remember parts of what happened. In the absence of full and frank information from Trust staff, this left a space that was filled by women and families trying to make sense of what had happened and how and why it had happened.

3.57 Being left with so many questions about events that they were unable to answer naturally led women and families to seek answers from the Trust. These answers were not always forthcoming, were only partial, or in some cases were misleading. We heard of internal investigations failing to get to grips with what had happened, so that no meaningful explanation could be provided. This led to families resorting to working through and trying to make sense of clinical notes in order to piece together what had happened, or to get answers to their questions. In doing so, they often found that how they had felt at the time and what they had been telling the doctors and midwives were not reflected in their notes, adding to their frustration and anxiety.

3.58 In addition, being blamed by individual doctors or midwives for aspects of events, or being made to feel to blame for what had happened to their baby and being unable to challenge hierarchical systems and individuals with professional knowledge, left our families living with "what ifs". This inevitably meant that they were forced to construct an uncertain or incomplete narrative about what had happened, due to the lack of facts, their sense of responsibility for events or simply the uncertainty with which they were left.

Indicative behaviour: Blaming women and families, or making them feel to blame, for what had happened to their baby

3.59 We heard about:

- Women and their partners being made to feel to blame and living with the guilt of believing that they were in some way responsible for the outcome or should have done more:
  - *"A member of staff said to me 'is there anything that you think you could have done better?', which stuck with me for months and months afterwards, I felt so guilty."*
  - *"As I'm sitting here talking about what other humans could have done more, I still also feel myself that I could have done more as his mother, and I'm sure his dad feels the same, but this is what you're left with."*
  - *"To cover it up, to cover herself rather than try to stop it happening again, by blaming mums, I think this is something that happens. I think this is an ingrained thing, and that does cause damage, psychological damage. I am still upset now talking about it, but my son is okay."*
  - *"The problems are ingrained, not listening to anyone and blaming the most vulnerable people at the most vulnerable time. They need to be doing the opposite of that. They need to be listening to the mums. They need to take accountability even if it's human error. I would forgive anyone for a mistake, but lying and blaming is unforgiveable."*

Indicative behaviour: Not giving women and their families answers or reasons for why things had gone wrong

3.60 We heard about:

- Families being left convinced that their baby's death or injury was the result of failures in care because of the lack of information and attention provided by the Trust in the days, weeks and months after the death:
  - *"My opinion will always be that F died because somebody didn't do their job properly; and that's fine if you work in Sainsbury's but when it comes to a family's life; it has affected me, my husband, our son … it's devastating and it can't be undone, it's what we just have to live with."*
  - *"What's caused the suffering, and what is dangerous, is the lies and the falsifying the notes and blaming me to cover up for the human error or the device, and that being seen, when you make a complaint, as acceptable. I think that covering up and that blaming is really dangerous because we do not know what really happened."*

3.61 The consequences for the families are profound. Living with a narrative that they know to be untrue or partially untrue, or never knowing for certain if things might have been different, has fractured their trust in healthcare professionals, often challenging previously held beliefs about who is trustworthy and who is not. Having these previous beliefs challenged, as well as feeling unable to construct a true explanation about a major event in their own lives – even when they may have been present – has undermined their confidence in their abilities, strengths and decision making.

3.62 We saw that this has often led to major changes in how families viewed themselves and others, and their ability to manage their lives. They were generally less trusting and confident in the ability of others to have their best interests at heart, even those closest to them. This additional harm has added to their grief, loss, physical disability or change in circumstances, with some families also experiencing major financial difficulties. In these circumstances, their ability to regain their capacity to cope has been severely hindered.

Illustrative Case U

Two weeks after her due date, U was booked in for an induction. Despite a sweep and two doses of Prostin, progress was slow, and U and her partner felt neglected as staff were busy with other patients. One midwife refused to carry out an internal examination of U that evening, even though one was overdue, and no examination took place before a second dose of Prostin was administered.

During the night, U woke in intense pain and experiencing contractions. As her contractions became more frequent and stronger, she asked again whether she would be examined but was made to feel like she was making a fuss. In the morning, U mentioned the pain she was experiencing and that her contractions were getting shorter. Then the contractions suddenly stopped and she experienced reduced fetal movement. The midwives said that her baby would be sleeping.

On the induction ward, U was monitored and there was still very little fetal activity. A midwife said she should stay on the trace for another ten minutes for a “sleep trace”. The monitor started to sound an alarm, and within minutes an emergency caesarean section was performed and baby U was delivered covered in meconium and requiring resuscitation. She was cooled straight away and had several seizures. Fortunately, she did not sustain any long-term damage.

U and her partner were informed that there had been a meeting about the event, but they were denied any details. Subsequently, they requested the minutes of the meeting but were told that these could not be found. They believe there was an investigation but the outcome was not shared with them. They queried the care provided on the evening prior to baby U’s delivery when the midwife refused to examine U, and the failure to properly monitor her to identify that the infant was in distress. However, they received no answers and no explanation of why the baby was born in such poor condition.

The couple indicated their intention to complain and asked to be put in touch with the Head of Midwifery; however, the hospital failed to contact them. Then, feeling that they had done all they could to obtain answers to their questions, they instructed a solicitor. The Trust called into question U’s account of events because it did not correlate with what was recorded in her notes. The couple were told that their legal claim could not succeed because their baby had survived without lasting damage. They agreed to mediation at the request of the Trust. However, on the day before the mediation, the Trust submitted additional paperwork and refused to be bound by the mediation’s outcome, leaving the couple without any determination and a hefty fee. They are left not knowing what happened and believing that the hospital is hiding something from them.

Many of the cases included all the above themes

3.63 Illustrative Case V is representative of many accounts we heard, in that it describes how one family experienced failures in care and poor behaviours of staff that cut across the range of themes we have identified. It is necessarily more detailed than the others in this chapter and, for that reason, all the more powerful.

Illustrative Case V

When V became pregnant, she was told that she was at high risk, so she was surprised that each time she attended for an appointment, she saw a different doctor. She experienced swelling in her face, feet and fingers, and breathlessness, headaches and tiredness. All of these symptoms and the extent to which she was struggling were dismissed as due to her weight.

"I felt like I was going to these appointments and was just being churned through a mill. I would sometimes sit for way past an hour past my slot time, to be measured and weighed and just told yes, just carry on, we'll see you in four weeks. And I thought, you've not asked anything about what went on since the last appointment; I was saying things like 'I'm really swollen', but they didn't listen, they didn't take on board the things I was pointing out … I was just told, no, you're just fat."

Near to her due date, V had an appointment with a new junior doctor, who told her that she had too much fluid, and that if she were to go into labour she was at risk of the fluid *"gushing out of her"*, possibly resulting in an accident to the umbilical cord. This alarmed her, and she worried that all she could do was ring for an ambulance if her waters broke.

By the time of her final consultant appointment, V was suffering from symphysis pubis dysfunction; her pelvis was extremely painful and she had difficulty walking. She told the consultant that she felt sure she would need a caesarean section, particularly given that her scans were showing her baby to be large. She was told that she should have no concerns about a natural birth and all would be fine.

"And again, I felt like, in that appointment, I was churned out, they didn't have any time for my questions. That was my very last appointment with a consultant, and I was just totally disregarded. I really don't even know why we bothered going, because everything that I was worried about, it was just 'you'll be fine, mother nature will take care of you'."

V's anxiety was compounded by her midwife, who told her that *"it was not midwife territory"* and *"they're not interested in having you under consultant care"*. She told V that she too had raised concerns with the consultant, which were dismissed.

At 41 weeks pregnant, V was very unwell. Feeling *"fobbed off"* by the hospital, she went to see her GP, who sent her straight there, giving her a letter to take with her stressing the urgency of the situation due to her evident pre-eclampsia.

"I got there, and it was just the same as usual; it was the same 'well, this is how it is at the end of your pregnancy, you're not going to feel your best'. And I thought, there's not feeling your best, and there's feeling horrendous. One of the things that I really want to be highlighted is that there were so many times throughout the pregnancy when I said I'm worried about this, I'm concerned about that, I'm not feeling great, but my notes just seem to say 'mother was happy'. And I wasn't happy."

The hospital consultant confirmed that V's baby needed to be delivered in light of her pre-eclampsia. However, there was no room for her that day, nor the next, which was a Friday, so she would have to come back on Monday because they did not induce women over the weekend. The consultant organised for her to have a sweep and she was told that, if that brought on labour, she should go straight back to the hospital because a woman in labour could not be turned away. Her labour began that weekend.

"I had to go with 'there's no room at the inn' and go home after the sweep, and I felt again that they were just not taking it seriously. I went home and I did go into labour

over the weekend. We went in on the Sunday morning, I think at a time that wasn't ideal, it was the changeover of the shift, and they actually said when we got there, 'oh, we've had such a long night'; and we were a bit apologetic. And I said, 'well I've had a long night too, we've not really had any sleep'. My contractions had started on and off and then really picked up in the early hours of Sunday morning, and they were like 'well, they're not that strong' and started to play it down immediately."

V was told by a midwife that she was not in labour because her contractions were mild and subsiding, and that she should go home and come back the next day, Monday, for her booked induction. The midwife asserted that, in her excitement to give birth, she was reading too much into the pains, which were not the real thing. V asked if she was going to be examined by the consultant, whom she had seen at the desk when she arrived and who had said she could stay if her cervix was dilated, but was told by the midwife that she did not need to be subjected to *"unnecessary poking and prodding"*. The midwife said: *"I can 100% guarantee that you're not dilated."*

"We were leaving, even though I was in pain, because we were not wanted there."

V went to bed. Later that day, she noticed that her abdomen had softened and dropped and there was no resistance or kicking back when she pressed it. She rang the hospital and explained that she hadn't felt her baby move for around six hours. The person on the telephone told her to come in and then hung up. On arrival, V, her partner and her mother were put in a room with other people. Looking back, she wonders whether it might have been better to place them in an empty room, given that she had told the hospital that her baby wasn't moving.

All the curtains were open as staff tried to find a heartbeat. Everyone was staring at them. When no heartbeat could be found, V became upset and the family were moved to another room for a scan. After what seemed like a long wait, a junior doctor arrived; the doctor wouldn't talk to them, look at them or give them any information, merely saying, *"well, give us a chance"* when they asked what was happening. Even though no heartbeat had been found, V was in a state of disbelief that something could be wrong.

"After a really long time, I'm guessing close to an hour, an obstetrician turned up and [they] *scanned me. Again, there was no conversation. And then* [they] *said, 'you have to be very brave, because your baby has passed away, there's no heartbeat, your baby has died'. Everyone was crying but I said to* [them] *straight away, 'how did this happen, I was here this morning and you said everything was fine and I should go home'. And then* [they] *left the room, and I didn't see* [them] *again for six years until I was in a courtroom with* [them]*."*

Having been told that there was no heartbeat, V was given a pessary to commence labour. She was told that as her cervix was already 5cm dilated, it would probably happen quite quickly.

"It's not really one of those things that you can measure because I know that people can go from zero to five centimetres in no time at all, but it plays on my mind that maybe if [the consultant] *had just examined me in the morning, I would have been enough dilated to have stayed. And even if the outcome had been the same, that I'd have been left in that room all day on a monitor and he still died, I'd have felt that I was in the right place. Instead, we have all these 'what if' questions, which now we just have to live with and it's difficult to move past that."*

V's labour was traumatic and began with a failure in communication that was most distressing for the family.

"When they came in, one of them said, 'calm down everyone, you're going to have a baby today' and they hadn't been told. Then she had a bit of her own meltdown because she felt so silly, and we ended up feeling sorry for her. It was such a mess. Sometimes, I think I don't know what difference it would have made, for her coming and saying sorry for your loss, let's help you, but at the same time, the two of them came in like a parade, like happy, happy, it was just awful."

V spent 18 hours trying to deliver her infant because the hospital did not initially agree to a caesarean section. At one point, she lost consciousness – a terrifying experience for her partner. Finally, a caesarean section was carried out to deliver the stillborn baby. The surgeon told them that the baby shouldn't have died, that he was a good size and healthy and they should take matters further.

"I had just delivered a stillborn baby and I was already being told, this isn't right, something has gone wrong here. But we knew it, we knew it anyway, because we'd been to all these appointments, but nothing was put in place."

Afterwards, V had to stay in hospital for a while. Being on the ward with no baby was particularly difficult, but it was during those few days that the couple experienced a growing awareness that things had gone wrong. The comments of one particular doctor stand out for them.

"[They] *said to us 'we can manage this in other pregnancies, we can give you a small dose of aspirin every single day and your pre-eclampsia will be managed; this won't happen to you again, and I'm sorry it happened to you this time'. And then* [they were] *swept out of the room so quickly, as if we shouldn't have been told that, because until then, pre-eclampsia just hadn't been mentioned."*

Then, when V had returned home, she was telephoned by her midwife; her recollection of what the midwife said is as follows:

"I shouldn't say this to you, but I think we're friends now, you need to get a lawyer … they're covering things up and I shouldn't tell you this and I don't really want to talk about it anymore."

The couple pursued a legal claim, but no fault in V's care could be proved – not least because of the emphasis placed on her clinical notes, which the couple believe do not give an accurate picture of her condition or care. They are left with the belief that the management of V's pregnancy was *"a mess from start to finish"*. They remain particularly upset that the hospital made an error regarding the gestation of their baby, whose post-mortem examination confirmed that he was far more advanced than had been recorded. Despite telling the hospital that her dates did not match theirs, V was left to go overdue, her baby *"fighting on for an extra two weeks"* before he died.

Over the last eight years, V and her partner have asked hundreds of questions about what went wrong and have still not had answers. They were told that nothing went wrong; it was one of those things. They have never received an apology.

Conclusions, including consequences and impact on wellbeing

3.64 The Panel has considered carefully the evidence provided through the family listening sessions, alongside the information obtained from reviewing clinical notes and other documentary sources. In doing so, it has identified a range of repercussions for women and their families. These families attribute the following consequences to the events they experienced and the actions of clinicians and other Trust staff:

- Not knowing if things might have been different; living with "what ifs"
- Feelings of guilt and responsibility for what happened
- Changes in personal beliefs about healthcare
- Mistrust of clinicians, institutions and the wider health system
- Feeling forced into a position where they sought legal advice to find out what had happened
- Loss of personal confidence
- Heightened emotions, including anger, rage and shame
- Self-blame for not raising concerns more forcefully or speaking up enough
- Panic attacks
- Not wanting more children or being frightened at the prospect of having another baby
- Needing to move away from the area or avoid being in proximity to the hospital
- Relationship difficulties, including some that have ended in separation, and difficulties with intimacy.

3.65 We would also like to highlight the additional guilt that many families have come to feel for not speaking up, when they have seen more recent cases come to light. We are absolutely clear that no family should feel that way: it is not up to families to correct the deficiencies of a Trust that has shown itself consistently incapable of learning.

3.66 Losing a baby or sustaining a life-changing injury during childbirth as a result of failures in clinical care has an emotional and psychological effect that most people would find hard to contemplate. However, the Panel is in no doubt that, on top of this, these women and their families experienced behaviours from clinical staff which failed to meet the standards required of them and rightly expected by the families.

3.67 We found that the impact on the wellbeing of women and their families was often compounded by the additional harm caused by the behaviours and attitudes of those responsible for communicating with and supporting them after the event. This included the doctors and midwives who had been directly involved in their care, as well as others who were acting on behalf of the Trust in a different capacity, such as those responsible for leading internal safety investigations or managing complaints.

3.68 This additional harm served only to worsen and magnify the families' sense of pain, anger and injustice and hinder their ability to come to terms with what had happened to them and begin to live their lives fully again. The Panel is in no doubt that this could have been avoided had the initial response of the Trust and its staff been open and compassionate, with a focus on including and supporting women and their families.

Illustrative Case W

W sustained a life-threatening surgical injury, either during a caesarean section or afterwards during a procedure to stem heavy bleeding. After her discharge from hospital, she met with her consultant. They told her that they fully expected to see her in a few months, because *"you've still got everything, you can still have a baby, we'll look after you"*. But the experience has left W terrified about becoming pregnant again. It appears that at no point was any explanation given that her continued bleeding had been due to surgical injury to her cervix and vagina.

"It just seemed that people would think that everything would be fine because I was alive and I would just move on and I shouldn't be sad or upset or mentally scarred from it, from a traumatic experience, and for me I was robbed from having my second baby. I've always wanted a second baby and I will never do that, ever, and no one appreciates that side to it."

3.69 In this chapter we have described the wider experiences of the families, setting out and providing evidence for the themes we have identified and the behaviours that are indicative of those themes. These experiences provide further evidence of care and treatment that fell short of what might reasonably be expected, and that in some cases contributed to the poor outcomes many families suffered.

3.70 In addition, we have made clear our finding that women and their families have suffered additional harm as a result of the behaviours and attitudes of the health professionals who were responsible for their care, as well as others at the Trust with whom they had interactions after the events. For some, this has had an impact on their wellbeing which continues to affect their lives today. It is the Panel's view that aspects of the families' experiences have been so damaging as to have had a profound and lasting effect on their health and wellbeing.

Chapter 4: What we have heard from staff and others

Alongside listening to families, the Investigation has conducted interviews with 112 current and former staff at East Kent Hospitals University NHS Foundation Trust (the Trust) and with others whose work brought them into contact with the Trust's maternity and neonatal services. This has been a key part of the Investigation. It is important to note that these interviews helped shape our findings as set out in Chapter 1 and that this chapter describes what we heard. This chapter should be read as performing that function, not as an indication of the Panel's own thinking and conclusions.

Introduction

4.1 Between October 2021 and June 2022, the Investigation Panel met with 90 different members of Trust staff, including midwives, neonatal nurses, obstetricians, neonatologists, paediatricians and other clinicians, as well as members of the Board, the Executive and other managers. The Panel met five of those people twice.

4.2 In addition, the Investigation interviewed 22 individuals who did not work at the Trust but whose role brought them into contact with the Trust in connection with the provision of maternity care, such as representatives from the Care Quality Commission (CQC), the Healthcare Safety Investigation Branch (HSIB), Clinical Commissioning Groups (CCGs) and NHS England/NHS Improvement (NHSE&I).

4.3 This chapter reflects what the Panel was told by those it interviewed. It does not contain the Panel's commentary or assessment of any of the information provided by staff and others except where explicitly stated, but it does focus on what the Panel heard about the problems and challenges facing the Trust. That is not to say that the Panel did not hear about positive aspects – the efforts made to improve the culture and service, the initiatives to support better performance and outcomes, and the commitment of the majority of staff to do their best for their patients.

4.4 In particular, the Panel was conscious that many interviewees understandably wished to put a positive light on subsequent improvements in services, but we found that this view was not generally borne out by other evidence.

History and structure

4.5 Many staff with whom the Panel met raised the fact that the Trust was previously three separate trusts: the Kent and Canterbury Hospital Trust, Thanet Healthcare Trust and South Kent Hospitals Trust. The three trusts merged in 1999 following a local review of services, "Tomorrow's Healthcare", and the resulting trust became one of the largest hospital trusts in the country at that time. The long-term outcome of the Tomorrow's Healthcare review on maternity

services was to focus obstetrics at Ashford's William Harvey Hospital (WHH) and Margate's Queen Elizabeth The Queen Mother Hospital (QEQM).

4.6 Each hospital had an obstetric unit. WHH had a Level 3 neonatal intensive care unit, which is suitable for all babies who do not require very specialised regional or national specialist care. QEQM had a Level 1 special care unit, suitable for low dependency care of babies born after 32 weeks of pregnancy. Dover and Canterbury hospitals operated standalone Midwifery-Led Units (MLUs) in the former obstetric units (later relocated alongside the obstetric units in WHH and QEQM).

What we heard from staff

4.7 The Tomorrow's Healthcare review was described by one clinician as *"a bruising period"* and by another as *"a very traumatic process, as it basically pitched all three Trusts against each other"*. The clinician told us:

> [It was a] *challenge to integrate the whole of the maternity services which were so divided before, and especially during, the Tomorrow's Healthcare consultations, and to bring some order to the whole Trust. It took years, not months, to bring understanding that they would have two units and it was no longer possible to have three.*

4.8 The Panel heard about the challenges that merging the trusts brought. One member of the medical leadership team said: *"Moving from three relatively small organisations to one large organisation meant there was a lot to do in terms of healing rivalries, managing the communities and to some extent the staff."* Although effort was put in to build an *"East Kent focus"* across the Trust, many people reported that the hospitals remained quite separate, and in 2014 a CQC inspection report noted that the Trust still behaved like three separate organisations.

4.9 The Panel was told that the Trust *"had never really coped with the merger"* and that *"the merger is highly relevant to what goes on in the Trust day-to-day"*:

> *They were supposed to be one team but in reality that wasn't the case. Even the guidelines were different for each site until recently.*

4.10 When the Trust became a Foundation Trust, the internal structure was relatively flat and involved clinical directorates; this, it was said, allowed people to participate in decision making. The application for foundation status resulted in Monitor* insisting on fewer management groups, which, the Panel heard, left senior staff (especially clinicians) feeling that they did not have a voice and were excluded from Trust business. The Trust moved the individual directorates into four (*"massive"*) divisions in 2011 as part of a reorganisation. The Women's Health directorate was rolled up in the Specialist Services division with renal, dermatology, cancer services and paediatrics – *"specialities that had nothing to do with each other, but that was the structure of the Trust at the time"*. The Panel heard:

- *"It felt like* [women's services] *were being put with other odds and ends – the elsewhere 'unfileable'."*
- *"… the voice of maternity services was diluted within that Division."*

* Monitor was an executive non-departmental public body of the Department of Health, responsible between 2004 and 2016 for ensuring that healthcare provision in NHS England was financially effective.

4.11 One Trust Board member commented that *"staff in maternity felt they were always the poor neighbour to cancer"*, and an obstetric consultant told the Panel that the Specialist Services division had far too wide a remit and resulted in people at divisional level taking their eyes off the ball in terms of maternity services. The Panel heard that the new director leads had little understanding of midwifery and maternity services, and *"the maternity unit was in disarray with few plans for the future"*.

4.12 In 2018, soon after the arrival of a new Chief Executive Officer (CEO), the Trust changed from directorates to clinically led care groups. This was intended as a move from a management-driven structure, in which clinicians supported managers, to one in which the clinicians delivering the services would be supported by their managers. There were initially seven care groups, but the Women's and Children's Health group was later split in two and there became eight. This was considered a positive development.

4.13 The Trust was described to the Panel as a *"challenged"* organisation typical of a cohort of trusts where there were significant performance and operational challenges, but where the underlying problem was really one of culture.

Poor staff morale

4.14 A member of staff who had been with the Trust for 20 years described the first ten years as *"generally good"*, but they resigned more recently due to a *"toxic culture"*. Working at the Trust during the reference period of the Investigation was said to be *"challenging"*.

4.15 One band 7 midwife[†] who had been at the Trust during the same period described the peaks and troughs: *"times when I felt positive and times when I felt rock bottom. It has always been that way at East Kent, good times and bad times."* When they were going through a trough, when morale was low, people might not work as well as a team or they might be short-tempered. Those were the times when this midwife felt that teamworking was not good.

4.16 In 2014, following the CQC report, the executive team was described as *"demoralised and not working as a team"*. In the year that followed:

> *An awful lot of work took place to try and engage and improve the morale of staff, trying to bring together management and clinical staff. That was probably the biggest problem the organisation had, that there was this disconnect between the hierarchy of management and clinicians.*

4.17 The Panel heard about a *"really bad period of time"* when there was a big change in managers and people didn't have the experience to manage correctly or appropriately. This resulted in lots of disciplinary issues, and it affected morale because people were nervous and they weren't *"nice"* to each other: *"It had a knock-on effect, like dropping a pebble in the water."* We were told:

> *Everybody wants to get it right and everybody wants to give quality care. Nobody wants to cause any harm to people. When it does go wrong it has a massive effect on people's wellbeing and morale. There was definitely a lack of understanding between divisional and Trust levels of management and what goes on on the shop floor. That lack of understanding would sometimes have a negative effect on things.*

[†] Band 7 is a senior grade of midwife or nurse, still generally with clinical responsibilities.

4.18 One director attributed the causes of staff disenchantment across all sites to the Foundation Trust status requiring financial savings and the close scrutiny under which the Trust operated. Decisions taken by the Trust to improve efficiency and clinical systems were aimed at improving patient safety and clinical services but resulted in staff earning less money. Some staff expressed that they were unhappy with the new arrangements.

4.19 A member of staff decided to leave the Trust because it was *"trying to do too many things in too many places"*, not only from a workforce perspective but also from a financial perspective. Their view was that the models of care that were operating were not sustainable, and the cultural difficulties persisted:

> *[S]ome people were trying to deliver services that were really hard for them to deliver, and consequently, their behaviours and interpersonal relationships struggled and were damaged by that.*

4.20 The Panel was told how perceived poor performance by people in senior positions negatively impacted staff morale, but that there had been more recent initiatives such as regular safety huddles that aimed to help develop and strengthen relationships between different disciplines and in all areas of maternity services.

4.21 One midwife, who had often raised concerns around consultant decision making, was told in relation to a poorly performing doctor that having *"someone was better than no-one"*. Those aspects were described as *"very challenging and demoralising"*.

4.22 This same point was echoed by a member of the medical team, who commented that, for the Trust, *"having bad clinicians is better than having no clinicians"*. They remembered a clinical member of the Trust Executive saying that a clinician who had been investigated by the General Medical Council (GMC) was *"just about good enough and that was all that could be expected at East Kent".* The message given was that mediocre was acceptable, which was a depressing standard for clinicians to aspire to.

4.23 A senior obstetrician told the Panel that the staff were fundamentally good people who were placed in an impossible position because of the pressures of the roles they were asked to perform.

4.24 A member of staff told the Panel that the Trust and maternity services had a bad reputation and that there was a bad news story every week, which had a profound impact on morale:

> *It was hard to watch the media reports and see the Trust criticised. Staff morale was low and there were shockwaves among the staff. It was difficult for pregnant women to come into the hospital having seen the media reports. They would ask if they would be safe delivering there … There was support, but the shockwaves that affected the shop floor weren't noticed.*

4.25 One midwife working at the Trust throughout the Covid-19 pandemic noted that morale seemed worse at the time because of bullying and the questioning of practice in a *"personal and aggressive way that wasn't justified".*

4.26 Another midwife, in commenting on the behaviour of senior midwives, told the Panel:

> *[S]enior midwives often came across as lazy, or they were just attending the ward to complete their hours.*

4.27 Band 7 midwives told the Panel that they were held accountable for what other midwives were doing, when there should have been a level of individual accountability (they were *"getting the blame from everywhere"*). The band 7 group of midwives also felt very demoralised due to the scrutiny of maternity services.

4.28 Concerns about accountability were raised by another midwife in connection with the lack of personal professional responsibility on the part of some members of the midwifery team. This was attributed to low morale and poor management:

> *There has to be some accountability. Since the loss of supervision, there are no consequences for people not acting correctly.*

Engagement and leadership

4.29 The biggest obstacle to implementing change – in particular the improvement plans in response to the 2014 CQC report and the Royal College of Obstetricians and Gynaecologists (RCOG) report in 2016 (see Chapter 1) – was the lack of staff engagement with the process. The Trust was described as reactive and not *"terribly forward-looking"* in changing the culture around staff engagement.

4.30 One Board and Executive member, commenting on the change to a managerially led divisional structure in 2011, told the Panel:

> *It would be unfair to say that was responsible for poor medical engagement because the poor medical engagement was there already, but it didn't help.*

4.31 The Trust had poor medical engagement, the obstetrics and gynaecology department was described as *"dysfunctional"*, and poor behaviour and leadership by consultants adversely impacted patient care and safety. However, the Panel was told that, since 2018, there has been a change of emphasis within the Trust, with more clinicians prepared to step into clinical lead roles.

4.32 Another Board and Executive member found the Trust a very despondent place for all staff. Consultant engagement scores were very low and the culture came across as very negative. There was a historical lack of clinical leadership and of clinicians feeling accountable for what they did. The same Board and Executive member identified several dangers around the way in which clinical effort was focused, including the divisional structure and the need to turn the Trust from a managerial approach to a clinically led culture. This was described as a *"colossal"* piece of work, which lasted from 2018 well into 2019 and required the appointment of new clinical leaders, particularly in maternity services.

4.33 The Panel was told that consultants did not engage in clinical audit or clinical guideline development because there was no time written into their job plans for it. For the same reason, we were told, areas where one would expect consultants to lead – the development of clinical guidelines, conducting maternal death and perinatal investigations, and leading on perinatal meetings – were all led by midwives.

4.34 A lot of time was spent on incidents and complaints, with governance midwives being recruited to manage these alongside the consultant with responsibility for risk management and clinical governance. There was a lack of engagement from obstetricians on clinical governance and updating guidelines, *"leaving* [the consultant] *to do a lot of the work"*.

4.35 One consultant noted a difficulty in getting clinicians at QEQM to be part of an investigation into a neonatal incident, and told the Panel that this remains a challenge. The Panel heard that there was a greater focus on midwifery than on obstetrics, and that there was an expectation that engagement in serious incidents was the responsibility of midwifery rather than obstetrics.

4.36 The Panel heard that Women's and Children's Health, as part of the Specialist Services division, had two and a half days a year devoted to learning and considering incidents, complaints and feedback, including positive news. However, the Panel also heard that doctors never attended the meetings; only nurses and healthcare professionals attended (although this began to change later).

4.37 The Panel was told that there were *"about three"* cultural change programmes at the Trust that failed because of a lack of direction and leadership, and that the Trust paid lip service to cultural change but this was not sufficient. There was not enough commitment or engagement from leaders of the organisation.

4.38 Professor James Walker, the Clinical Director of Maternity Investigation at HSIB, commented:

> *They don't really have consultant supervision to try and support the service. Now whether that is because they haven't enough, or they don't have enough people interested or whatever, I don't know, but it took us a long time to get the obstetricians involved* [with HSIB investigations]. *Even now, we get the lead obstetrician there or the lead paediatrician comes in – I am not sure how much our messages are getting down into the shop floor. In other hospitals we present back, and we've got consultants, students, registrars, and student midwives in the room, and that is where these hospitals really take ownership of problems. It's interesting because people will then talk about the cases and the obstetricians and midwives will then realise the problems the others have, and that helps to move forward for solutions.*

Staff behaviour and bullying

Relationships between professions

4.39 A senior clinician with a regulatory and oversight organisation told the Panel that East Kent maternity services had the worst culture they had seen in their long experience of working in hospitals with inappropriate cultures, and a *"terrible culture between the medics and the midwives"*. Staff were not supportive or encouraging to each other and there was *"a bullying culture"*; *"freedom to speak up at the Trust was not good"*. They said:

> *People's standards weren't what they should have been, and they didn't know what good looked like.*

4.40 The relationship between midwives and doctors was described by one senior midwife as *"cordial"*, and concern about difficulties with working relationships at the Trust featured prominently during staff interviews and was an issue raised across different levels of seniority.

4.41 The Chief Executive of the Nursing and Midwifery Council (NMC), Andrea Sutcliffe, told the Panel that *"the relationship between midwives and obstetricians is absolutely critical"*.

4.42 Contrasting views were expressed about teamworking. Some said that teamworking between obstetricians and midwives had always been good. Nevertheless, the Panel was

repeatedly told of poor teamwork, particularly between different professions. The senior consultant obstetricians were described by one senior manager as *"extraordinarily challenging in their behaviours, lack of communication and teamwork"*:

> *Their behaviour was appalling, and they had no respect for their colleagues. Consultants did and do still refer to midwifery staff as "lazy fucking cunts".‡ They take no responsibility for their actions and blame colleagues for any challenges and failings … such a rancorous, hostile environment creates a service ripe for error, risk and lapses in safety.*

4.43 A senior member of the Executive noted the *"dysfunctional relationships within specialities"* and that, within maternity services, there were issues with obstetricians and midwives working together. A senior manager observed that *"doctors and midwives sat apart in meetings … and clearly did not respect one another"*.

4.44 Doctors were said to have been overpowering in a lot of situations and women's voices were discounted as a result. It took one midwife a very long time to feel confident enough to speak up to doctors because they came across as quite intimidating. The same midwife felt that the situation later improved, although women were still not always empowered by doctors. This point was echoed by another midwife to whom the Panel spoke. They described ineffective communication and discussions that were *"quite hierarchical … Ultimately, decisions come from the top, rather than because staff communicate well and listen to each other."*

4.45 A senior midwife spoke about the fact that many of the consultants working at QEQM are longstanding members of staff and have a more *"traditional"* model of working when they are on call overnight, and that because there are a few layers between midwives and the consultant (mostly filled by junior doctors), midwives can find it hard to reach a consultant at times. In contrast, the obstetric team had a greater opportunity for contact with consultants.

4.46 The Panel heard that there were set patterns for doing things and that it was difficult to introduce new ideas from elsewhere. A midwife at QEQM who had worked at the Trust for over 20 years told the Panel that they felt like *"an outsider"* for quite a few years. Students who came through the unit would be the trained midwives of the future; similarly, trainee doctors would often return as consultants once they had completed their training. The team was considered to be *"like a family"* and their strengths and weaknesses were well known.

4.47 The dynamics of the team affected decision making; this was recognised as *"not a safe way to practise"*. There was no multi-disciplinary team learning and there was very much a *"divide between disciplines"*. The Panel was told that the obstetricians had *"huddles"*, but these were a *"tick box exercise with no real value".* One midwife commented that the relationship with the obstetricians could be challenging and it had a big impact on how midwives felt about their work. Some of the consultants were very unhappy about being questioned and would become stubborn and unwilling to back down. Another midwife mentioned that junior doctors felt *"bullied"* by the midwives, and the relationship with the obstetricians wasn't very good.

4.48 A midwife who had been with the Trust for a lengthy period told the Panel that the lead clinician for obstetrics faced *"massive challenges"* with relatively little support, that there were some *"big egos"* among the obstetric consultants, and that to try to bring about change with these strong personalities present was very challenging. They also said that poor communication was a significant theme and spoke about how everyone knew that it would be a difficult day if a particular clinician was on duty.

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‡ The Panel deprecates the use of language that is disrespectful to other staff and demeaning to women; it is included here only to underline the extreme lack of respect and professionalism among some Trust staff.

4.49 Some consultant obstetricians were described as *"a bit dictatorial",* and, while a lot of the team had gone on the "Human Factors" course to try to improve things, there was a cultural expectation of hierarchy. The hierarchy disempowered staff from speaking up and the Panel heard that it was hard to voice opinions without them being taken the wrong way.

4.50 A midwife said:

- *"… the culture just continued. A lot of work with human factors was done but it never really seemed to translate into the management team."*
- *"Years ago, the matrons used to go round and talked to all the staff first thing in the morning when they came on duty. They used to go and speak to the women to see if they've got any problems. A lot of complaints could also be addressed at that level before they got bigger. The management team now go to their office and don't speak to anyone."*

4.51 One midwife commented that the Trust seemed to have forgotten the Human Factors principles in the past few years and that professional challenge was perceived as criticism. A consultant told the Panel: *"The Trust thinks if you send someone on a three-day training course in human factors, that their personality will change forever but that's not going to happen."* Another clinician expressed having limited confidence in the behaviour and competence of certain obstetricians.

4.52 A midwife spoke of the *"fear of speaking up"*. Instead of consulting staff and discussing how issues could be improved, staff were told what to do and viewed as *"negative"* if they proposed any alternatives:

> *Staff feel they don't have a voice, that nothing will change and that if they don't agree with instructions from above, they will be ostracised. Staff are desperate to get on with everybody at work which means that they say and do things that they don't agree with. It hinders their ability to speak up when things aren't as they should be.*

4.53 The Panel heard examples of this behaviour, such as a staff member feeling as though they weren't very good if they asked for a short break after ten hours of work instead of carrying on like the rest of the team, or a midwife admitting that they didn't feel confident suturing a woman and facing a response like *"she's been a midwife for years. What's her problem?"*

4.54 The Panel was told of an occasion when a midwife had sought to explain to a consultant the adverse impact of the consultant's late arrival on the operation of the clinic and associated services, in response to which the consultant wagged a finger in the midwife's face and said: *"I am a consultant, and you can't tell me what to do."* The midwife was astounded that colleagues could speak and act in this way, but this kind of behaviour was described as *"relentless".*

4.55 The Panel heard about conflict over patient management plans and midwives *"bracing"* themselves to discuss these cases. There were suggestions of pressure put on midwives to accept women into the low-risk pathway when they had not been risk assessed or they were outside the guidelines, and consultants challenging any resistance to this approach.

4.56 One member of staff told the Panel that many families had complained about staff arguing among themselves in front of women over whether to call for support and assistance from a more senior clinician, including in life-threatening situations.

4.57 Another midwife commented that, in the past, although members of the multi-disciplinary team were supposedly working towards the same goal, it felt as though they were on *"parallel tracks"* rather than on the same path. However, they thought that this was less the case more recently. The introduction of a preventive measure for rhesus disease was cited as an example of good collaborative working between midwives and obstetricians. The Panel was told that, in the recent past, *"it was definitely not a case of them and us"* and that things had improved, but there was still some way to go. The Panel was told that the change process had been aided by new staff thinking differently, having more enthusiasm and providing a lead for others to follow. A more recently appointed obstetrician had been particularly interested in leading on multi-disciplinary working.

4.58 The Panel heard contrasting views about multi-disciplinary working. On the one hand, we were told that the relationship between multi-disciplinary teams was positive; relationships with the neonatal team had *"always been good"* and anaesthetists were *"a great support to the labour ward"*. One senior member of staff suggested that the relationship between neonatology and obstetrics had always been good at QEQM, with communication between the teams if there were problems. The Panel was told of the recent appointment of obstetricians who had trained at East Kent maternity services and knew the units.

4.59 However, the Panel also heard numerous contrary accounts. It was said that there had always been friction between anaesthetists and other specialties: on one occasion a *"massive argument"* took place between an anaesthetist and a doctor in the middle of the corridor on the labour ward. We heard accounts of problems between midwives, obstetricians and neonatologists; neonatal provision at QEQM was not as *"supportive, available or accessible"* as it was at WHH. The obstetricians were described as *"challenging"* but nothing was done to address challenging behaviour.

4.60 The Panel heard that one perinatal meeting ended with a dreadful conversation and arguments with a senior midwife, who became very upset and went on sick leave. The issue was never addressed. We were also told that there were ongoing issues with communication between paediatricians and maternity services on the Kingsgate Ward; midwives were not listened to and were not taken seriously when concerns were raised. Paediatricians were also said to be slow to attend.

Challenging poor consultant behaviour

4.61 The Panel heard from a number of people about poor consultant behaviour and the difficulties in challenging consultants and addressing their behaviour. It was felt that the poor behaviour of consultants was dealt with very differently compared with the poor behaviour of midwives.

4.62 The Trust was said to have done little to change the poor working culture; instead, it tolerated bad behaviour, especially in relation to those who had been with the Trust for a long time or held a senior position. In 2019, a formal complaint was made about bullying at WHH; at that time, one consultant was known for making midwives cry in front of others, often at handovers. However, the Panel heard that nothing really happened when bad behaviour was reported. Some staff did not have faith in the Trust to make improvements.

4.63 Staff observed that the consultants who had worked there longer had a louder voice than the newer consultants, who struggled to find their way. When efforts were made to tackle poor behaviour, people backed away from the situation, or didn't report it in the first place. Consultants' poor behaviour was dismissed as *"just the way they were"*. Staff reported being

heckled, shouted at and having things thrown at them: *"it was accepted and allowed to happen, that was the way we worked"*.

4.64 The Panel heard that staff were not empowered to challenge consultants' bad behaviour. The Panel heard instances of extremely poor behaviour from consultant obstetricians; one became rude and very personal with another member of staff who had tried to generate discussion in a large meeting around the findings of the Morecambe Bay report. No one intervened, although it became evident afterwards that there were people in the room who recognised that the behaviour had been unacceptable. This incident was one of the issues that prompted the Medical Director to invite the RCOG to conduct a review.

4.65 The Panel was told about clinical and behavioural concerns raised by one consultant about another, which they thought would be investigated by the Trust. The only feedback provided was that there was a communication issue and there would be training:

- *"After this there was reluctance for people to raise issues or make comments if they were asked further because of the way the process was done."*
- *"If people get away with bad behaviour, they're going to keep doing it."*

4.66 Some midwives told the Panel that when they raised issues with their line manager, they would not hear about the outcome. The Panel heard that midwives often talked to each other about raising issues but questioned whether anything really changed. The person involved might be told off and improve for a few weeks, but then they would slip back into old habits. Behaviour was also explained away as *"it's the way they are"*.

4.67 The lead CCG for maternity services pointed out that Medical Directors generally lacked the tools to be able to handle intransigent consultants. As an example, in 2020, there was a discussion with the Trust's new Chief Medical Officer about an anonymous survey to identify problem consultants (whom people did not feel able to challenge and with whom they could not escalate issues). Although the problem consultants were known, no one was willing to raise a concern formally. The CCG also noticed a difference in the way in which nurses and doctors were treated in connection with serious incidents – nurses would potentially be disciplined, while doctors were merely asked to reflect (see "Culture of blame and handling complaints", paragraphs 4.154–4.168).

Midwifery culture

4.68 The Panel heard about a lack of professional respect for midwives from the MLU and the community, and that their professional judgement was disregarded and dismissed in front of women.

4.69 The Panel was informed that there were several "freedom to speak up" issues raised from the maternity department at WHH. The issues related to bullying and behaviour. The Panel heard from one midwife that *"once that individual had the impact of their behaviour pointed out, they reflected and modified it. It just needed someone to point it out to them. There haven't been any further concerns raised about the individuals' behaviour."* However, other midwives told us that bullying persisted and remained prevalent. There were also issues raised around rostering and equipment.

4.70 The Panel heard that, since 2012, the Trust had had a Medical Director for Governance and Patient Safety and two band 7 nurses as Freedom to Speak Up Guardians, although the latter had not had protected time to fulfil these roles. Only recently had the Trust appointed its

first full-time Freedom to Speak Up Guardian. A predominant theme at patient safety speak-ups was behaviour – not so much bullying as poor leadership and a reluctance or lack of skills to actively listen to what staff were saying. Poor behaviours existed *"at all levels of the organisation from top to bottom"* and the Panel heard that it was *"challenging when it is senior people who are bullying"*.

4.71 The Panel heard that there was discussion within the Trust on whether there was enough documented information to take people through a disciplinary process. However, although the Trust received a lot of information, staff were rarely prepared to put it in writing. We were told: *"The Trust sometimes moves the problem around but actually it's about six months later and there are reports from the other site around the same issue."*

4.72 The origin of different cliques of maternity staff was said to have dated back to the closure of the Canterbury site, when staff were moved to WHH and QEQM: *"In both hospitals, there were two circles of core staff that had been at William Harvey/QEQM and then the Canterbury staff. They didn't get on well together."*

4.73 A midwife who had worked at various sites and in various roles across the Trust told the Panel that the staff working at WHH had a reputation for being outspoken, and that allegations of bullying – in particular, more senior nurses treating junior staff with little respect – had circled the site for many years and had not been dealt with effectively. QEQM was considered to be friendlier, with less staff turnover and better working relationships, and new staff found it easier to settle in; it was suggested that this might be due to QEQM being a quieter site.

4.74 Staff told the Panel that *"senior midwives"* at WHH had a tendency to form *"cliques"* and that this could come across as threatening to more junior members of staff. They also told us that support workers had raised complaints about being treated unfairly compared with other groups of employees within the maternity unit. They indicated that, while there had been an improvement latterly at WHH in the way in which staff communicated with each other and mothers, it remained a concern. The Panel also heard that management *"cover themselves"* so that action would not be taken if the friend of a band 7 midwife did something wrong. One midwife was told expressly not to enter details of an incident on Datix (patient safety incident reporting software) as the band 7 midwife involved *"just forgot"* to take the required action.

4.75 One midwife described difficulties with the coordinator culture at WHH, with coordinators not listening to other team members or doing things in a set way. They were described as *"unhelpful and not hands-on"*, and they did not have the confidence of certain members of staff.

4.76 The Panel was told about midwives shouting and screaming at each other. A band 7 midwife spoke about witnessing a loud argument between a unit coordinator and a ward clerk, which prompted the band 7 midwife to close the doors around the ward to prevent women and families from hearing the argument. Afterwards, the band 7 midwife felt *"terrified by the way the coordinator spoke to* [them] *about having done this"*.

4.77 The Panel heard that a supervisory session for midwives was carried out at WHH and one of the questions asked was *"what is a good day for you"*. The response from one midwife was *"getting to the car, across the car park, at the end of the day without bursting into tears"*.

4.78 The Panel heard that student midwives did not feel valued by more senior staff members. Many student midwives did not feel welcomed and heard more senior members of the midwifery team gossiping about them. Another member of staff observed *"quite sharp questioning"* at WHH during handovers, which left staff feeling uncomfortable and feeling that they were being

judged rather than supported. The handover was described as a *"blood bath"*, with one member of staff telling the Panel that it was *"terrifying as* [a] *student"* and reporting being told off for showing a baby to the grandparents in the corridor, or for using someone else's cup. The band 7 midwives were described as *"quite fierce"*:

> *As someone who was quite new to the profession, you would second guess yourself quite often to make sure you weren't using someone's cup or sitting in someone's seat.*

4.79 The culture of the Trust was also described as follows:

> [There was] *favouritism and some people are not treated fairly within midwifery … there were* [senior midwives] *put in place who were bullies and they reported people who perhaps shouldn't have been and others perhaps who shouldn't be in the job.*

4.80 More than one midwife identified challenges with internal recruitment: namely, that promotions were predictable and the same people would always be promoted. People with friends higher up in the maternity unit were said to get jobs before they had even been interviewed. Regarding senior management culture, we were told:

> *[I]f you're friends with someone, you'll get the job. It has been the case for quite a while that preferred candidates are coached for job interviews.*

4.81 One midwife said that they did not apply for positions as they knew they would not be chosen. Another staff member had withdrawn from an application as their face didn't fit:

> *At East Kent, if your face fits, you'll get the job.*

Bullying

4.82 The Panel was told that there were large numbers of staff who complained of bullying, harassment or discrimination. A member of the HR team commented on the high levels of bullying and harassment:

> *There were other issues but that was the most troubling because of the duty of care to the workforce and their perception of what it was like to work in that environment.*

The same person told us that nobody got to grips with the situation or wanted to tackle it.

4.83 A member of the Executive told the Panel that the problem of bullying was *"well distributed"* across the organisation, and that it was not any worse in maternity than elsewhere. However, the Panel also heard:

> *[P]eople outside maternity would probably not have been aware of the bullying culture within midwifery and* [the] *difficulty with performance of obstetricians. There was a cloud of secrecy as staff members were involved in the disciplinary processes. It wasn't openly discussed. They had to deal with individuals confidentially and professionally.*

4.84 The Trust was said to be occupied with firefighting visible issues, such as the difficulties with the Accident and Emergency department (A&E), but did not address the underlying problem of the culture of the organisation, including bullying, harassment and discrimination. One midwife commented that the focus was on the little things to make it look good from the outside.

4.85 While complaints of bullying were often made by midwives, it should be noted that staff also spoke of bullying behaviours towards consultants and among members of the Executive. One consultant told the Panel that they were bullied by a senior midwife in the special care baby unit and by senior nurses. The Panel further heard of poor behaviours of non-executive directors at the Trust Quality and Safety Committee: *"The behaviour of the non-executive directors was appalling, rude, bullying. It was shameful."* Sessions with registrars had been introduced to enable junior doctors to report concerns; these were then fed back to consultants to determine what needed to be done.

4.86 A CCG staff member told the Panel that, through quality visits, they had picked up on *"quite unpleasant"* bullying. One senior member of Trust staff described maternity services as *"a vipers' nest"*, and another expressed the belief that the deaths of some babies could have been prevented had there not been a bullying culture within maternity services.

4.87 A midwife told the Panel that staff were not given any individual or constructive feedback to improve the results of the staff surveys. Band 7 midwives had occasional study days, annual supervisory reviews and either irregular appraisals or no appraisals at all. However, nothing was mentioned to identify that any improvement was needed in this area and the Panel heard that issues of bullying had not been raised as part of the appraisal process. In 2010, approximately 80% of staff had no appraisal at all.

4.88 The bullying culture at WHH was described as *"horrible"* and *"sickening"* and as persisting indefinitely. Between 2010 and 2012, an anonymous complaint was made to the Chief Nurse by junior midwives at WHH stating that the band 7 midwives were bullying them, forming cliques, excluding the junior midwives and creating a hostile "in or out" group dynamic. No one was named in the complaint. The Head of Midwifery wrote to all midwives across the Trust, urging them to speak to the Head of Midwifery directly. The Panel heard that one midwife left the Trust because of bullying.

4.89 The Panel heard that repeated concerns were raised about some staff members' behaviour, but no action was taken in response. The Panel also heard that, in some cases, allegations of racial abuse were made against individuals, but there was no resolution and there was no structured way of dealing with allegations. Bullying and harassment policies required that an opportunity be provided for people to speak to each other in an informal way, to try to encourage them to understand the other person's position. However, the inability of certain staff to communicate respectfully with each other was such an issue that they could not safely work on the same shift.

4.90 One midwife commented that bullying was a mindset. They told the Panel:

> *[I]f people bully you, you're part of that relationship … there were people that I dreaded to work with, and I knew they would be short or cross … but I just had to carry on doing the work … you have to focus on the people that you're caring for – sometimes, the management or whatever is happening in our sort of profession may be harrowing – there's no staff, it's difficult, there's … problems between managers and things that you have to really put into the background and try and focus on the care.*

4.91 In 2014, an internal investigation into bullying began, carried out jointly by the then Head of Midwifery and the HR department. As a result of information obtained from the investigation, the Head of Midwifery was sufficiently concerned to recommend that the unit at WHH should be closed because of the risk to women.

4.92 The bullying was described as occurring more at WHH, where *"there were a lot of cliques"*, and where, *"as a junior midwife, you would hand over and you'd be berated … and put down. I remember … one time saying this lady's been in second stage for two hours and the band 7 said, 'she'll end up in ITU and it'll all be due to you'."* The environment was described as *"toxic"*, and it was commented that *"Labour Ward and Post-Natal are high risk and high pressured enough without feeling scared to hand over"*. Cliques were prevalent in management and on the shop floor within midwifery. The Panel heard that, if a friendship group of midwives was on the same shift, the most difficult cases were delegated and shorter breaks given to the midwives outside the group. The Panel was told: *"It would depend on what mood the co-ordinators or some of the midwives were in on that day as to what you got … If your face fitted you did really well."* The existence of cliques was also an issue at QEQM, where one junior midwife noted that the culture in maternity services was *"hostile at times"*.

4.93 The Panel heard that the repercussion of making a complaint at WHH was to be given extra work. One midwife described feeling unable to tell the truth around the time of the 2014/15 investigation because, if they did, they would be bullied themself. The midwife felt that they had no choice but to give a character reference to a band 7 midwife accused of bullying, although, really, they were *"dying to tell the truth".*

4.94 The Panel was told that a number of anonymous letters were sent prior to the 2014/15 investigation but that the response from leadership at the time was that they would not do anything about it *"if no one is brave enough to put their name on these letters"*. Another senior midwife told the Panel that there was no recognition of, insight into or acknowledgement of the issue of bullying from obstetricians or midwives, and that people in senior positions did not respond appropriately to the situation.

4.95 A midwife at QEQM described a culture of *"playing the bullying card"*, and *"if you say something that I don't like then I will accuse you of bullying me"*. In their view, this tactic put a halt to managing challenging situations, while attempts to introduce positive change were met with the response that *"you are picking on me"*.

4.96 In 2015, a collective grievance was raised by staff about the manner in which the 2014 internal investigation into bullying had been conducted. However, the grievance about the investigation process accepted the existence of serious bullying and dysfunctional behaviour within maternity services at WHH. The grievance also referred to the fact that:

> *An absence of senior support for staff at this present time has exacerbated an already difficult situation, as a result of which we believe there is a significant risk to our health and wellbeing, the patients we care for and the service as a whole.*

4.97 The Panel was told that the Royal College of Midwives (RCM) represented some of the midwives who were subject to the investigation into bullying and that the RCM assisted with lodging a collective grievance.

4.98 A representative of the RCM told the Panel that the RCM had known before the collective grievance that there were challenging issues around midwifery leadership in the Trust at both WHH and QEQM. There were two big units operating without sufficient overall strategic leadership or strong management on either site. Cultural issues of bullying, harassment and poor staff engagement had been identified by RCM members, as well as being raised with the CQC.

4.99 The Head of Midwifery in 2014/15 told the Panel that they regretted going to the RCM for support with whistleblowing because the RCM advised them to resign and move on; if not, the RCM said that they would be unemployable in a senior position, and they should protect themself. They told the Panel that it was really hard making the decision as they did not want to leave women vulnerable. However, they had been told by the RCM that whistleblowing was not in the public interest and they had to think of their career.

4.100 The Panel heard from Robert Eames, who worked as Associate Director of HR between 2014 and 2015, that *"*[the Head of Midwifery] *wasn't part of the problem. I think* [they] *had a good go at trying to fix the cultural piece and the behaviours, but the team lashed out at* [them]*."*

4.101 A number of midwives told the Panel that 2014/15 was a very difficult and strange time in midwifery. One midwife thought that the bullying stopped when certain midwives were suspended. However, the Panel also heard that some obstetricians and some neonatologists did not think the correct midwives were suspended. Other midwives told us that the bullying persisted after 2016.

4.102 Some staff did not perceive the behaviours as bullying; the band 7 midwives were *"good at their jobs; they were just a bit fierce and a bit scary. If you had a problem, you could take one aside and talk to them … they were strong, dominant women, commanding a unit."* A midwife at WHH considered that band 7 midwives were often a target for accusations of bullying, because the nature of the role meant that they often had to tell staff to do things differently.

Lack of diversity and racial discrimination

4.103 The Panel was told that the Trust had been rated one of the worst in the country for workplace diversity and attitudes towards cultural difference. The QEQM midwifery unit was described by one member of staff as being *"often seen as a white-led midwifery unit"* that would benefit from having more people from different cultural backgrounds.

4.104 Complaints of discrimination were sometimes based on race. A member of the Executive recognised racial inequality in East Kent and the existence of racial tensions, which probably contributed to bullying in parts of the Trust. One midwife from an ethnic minority background had been to HR three times; however, on each occasion the complaint was reduced to an overreaction. On one occasion, a midwife was discriminated against when a coordinator, at a woman's request, would not permit the woman to be looked after *"by anybody except an 'English' midwife".* Concerns were also raised about management making offensive comments or jokes connected to race; however, these concerns were minimised and put down to staff just trying to be humorous. The Panel heard more than once that instances of personally offensive behaviour by consultants and midwives were not treated seriously.

4.105 Concern was expressed that the Trust's attitude and lack of diversity were having an impact on patients as well as on staff. It was said that, at WHH, women who could not speak English or who were from different ethnic backgrounds were treated differently, as though they were at fault.

4.106 However, contrasting views were also expressed to the Panel. One senior member of staff from an ethnic minority background described not only being made to feel welcome but being positively favoured due to their heritage. Another member of staff told the Panel that they had not experienced any prejudice as a person from an ethnic minority background and felt happy when called to work at QEQM.

Consultant rotas and availability

4.107 Consultants identified challenges arising from the on-call rota. Prior to 2020, consultants would arrive around 8am and stay until 5pm or 6pm and then be on call from home. They covered other duties including gynaecology as well, limiting their presence on the labour ward.

4.108 One midwife told the Panel that the process for escalating a clinical issue was very clearly to the Senior House Officer (SHO; a junior doctor), then to the registrar, and then to the consultant, in that order:

> *I didn't escalate directly to the consultant because that wasn't the culture … the issue was that consultants were at home in the night and so it was difficult to call them about a pathological CTG* [cardiotocograph; a trace of fetal heart rate] *if the registrar was busy with a case in theatre.*

4.109 One consultant told the Panel that they escalated issues around lack of consultant availability, but that the process of trying to get these resolved took a long time because of the way in which consultants were treated (or needed to be treated). There was a lack of support provided to the junior doctors, and the Panel heard that *"East Kent did not feel like a consultant-led service".*

4.110 A midwife told the Panel that, in 2016, after the RCOG report had been submitted, the consultants at WHH made a noticeable effort to be more visible and accessible while on call.

4.111 A junior doctor recalled that *"consultants would point-blank refuse to come into the hospital after hours and would put other staff under intense pressure as a result"*.

4.112 The Panel was told about one occasion when a woman who was 35 weeks pregnant and thought her waters had broken attended QEQM. The woman needed a speculum examination; however, the SHO hadn't been trained on how to do it. Although the consultant was called, they did not attend and the SHO sought advice from YouTube on how to do the procedure.

4.113 There was a reluctance among junior doctors and midwives to raise the issue – people did not want to complain about a consultant or be named as the person who had brought up the issue. A Trust Board member supported this view and told the Panel that it was very hard for their clinical leaders to call out bad behaviour in a way that was effective.

4.114 However, the Panel was also told by an obstetric consultant that, more recently, adverse publicity had resulted in consultants either being contacted more frequently, perhaps in circumstances where trainees could do what was necessary, or themselves being too cautious.

The separate operation of the WHH and QEQM sites

4.115 The Panel was told by a number of staff that, although the merger of the three different trusts to create the East Kent Trust occurred over 20 years ago, the Trust continued to operate as if there were three separate hospitals that ran independently of each other.

4.116 The Panel heard that staff in the Trust had never come to terms with the merger:

> *Ashford is still taking it hard, and Canterbury doesn't understand why they aren't the centre of the world. It is deep rooted.*

4.117 More than one member of staff spoke about the Canterbury-centred nature of the Trust, which was an issue that needed addressing:

> [The Trust] *was run like three completely separate units, and nobody had really tried to merge it in any way. Canterbury was full of the great and the good consultant-wise, and they sort of looked down at Margate and Ashford and everybody knew that as well. The inter relationships were really difficult.*

4.118 The Panel heard that there was no cross-site teamworking or shared learning. The sites *"always ran distinctly, even down to different working policies"*.

4.119 There was also a perceived inequality and an "us and them" culture between the two sites at Ashford (WHH) and Margate (QEQM). One member of staff told the Panel that, although QEQM was quite big, *"it always felt like it was a bit of an afterthought"*.

4.120 One member of the Executive commented:

> *[P]eople working in Margate don't feel massively connected on a day-to-day basis with what's happening in the William Harvey maternity and neonatal service. This should not be underestimated. It's not an excuse for people not engaging and not following national guidance but it is a factor that cannot be ignored … There is an element of clinical isolation at Margate whereby you don't get an opportunity to see how things are done elsewhere and there isn't much interchange … However, you can also flip this round, and Margate has been able to find their own solutions to problems, and they are committed to their population who they live with and understand (whereas at William Harvey the atmosphere is not quite so embedded in the locale as Margate). When this works well it can be very powerful and a force of great good. But by the same token when it's not quite right you can get quite a long way from what is best practice.*

4.121 One experienced midwife told the Panel that there had always been a very different working pattern at the two sites, and this impacted on the midwives and on patient care. At QEQM, the consultants were not on the labour ward after handover; this also had an impact on the junior doctors, on their teaching and on the support available. Further, at WHH, regular ward rounds were conducted with the obstetricians; however, this was not the case at QEQM. Some staff at QEQM did not do ward rounds at all, although one midwife suggested that this had subsequently improved.

4.122 Another difference relates to the treatment of families following the loss of a baby. We heard that, for a number of years, the consultants at WHH have been speaking with families at around 6 to 8 weeks following the loss of a baby of 12 weeks' or more gestation, so that the family could understand what happened and to discuss how the family would be looked after in their next pregnancy. However, the Panel heard that the doctors at QEQM have resisted this practice.

Training

4.123 A member of the Executive spoke of their concern that an organisational development programme was not introduced when the Trust was going through restructuring; instead, the restructure focused on moving people without developing them.

4.124 A senior clinician recognised that there were challenges in gaining experience and competence in neonatal intubation and in maintaining neonatal resuscitation skills as a general paediatrician at QEQM. Each consultant performed intubation of extreme premature babies approximately once a year, and there were not many other intubations during the year. This posed a risk of consultants gradually becoming deskilled over time, and there was a need to ensure that all staff were up to date with neonatal life support training.

4.125 The Panel was told that a simulation training programme to teach resuscitation techniques was introduced following the inquest into the death of baby Harry Richford. Consultants across the whole team participated in the simulation and the Panel was told there was a neonatal simulation held jointly with midwifery every other week.

4.126 The Panel also heard that there had been a robust in-house teaching programme for neonatology and paediatrics for some time. Other basic skills taught include airway skills on mannequins, resuscitation, non-labour emergencies in neonates and communication with midwives.

4.127 The Panel heard that, more recently, staff grade doctors who came from abroad, or trainees without experience working in the UK, were trained and rotated to the neonatal unit at WHH for experience; this also applied to non-trainee grades who lacked confidence in their skills.

4.128 Many midwives spoke about a lack of support during their training or when they first started in their roles and a lack of mentorship. One midwife who was appointed into a coordinator role had to teach themself the leadership skills needed to maintain a safe service:

> *[S]ome band 5 midwives don't have professional resilience because they've not been taught how to develop it. It's a big jump from being a student to becoming a band 5 midwife.*

Organisational issues

Culture of denial and resistance to change

4.129 The Panel heard about the *"sense of optimism"* in the Trust as it achieved Foundation Trust status in 2009. The Dr Foster Hospital Guide named the Trust as Overall Trust of the Year and Foundation Trust of the Year in England in 2010; however, this appeared to be a double-edged sword. One member of staff said that the Dr Foster recognition was:

> *… a bad thing and a major error. Complacency started to come in … There were things the Board believed that were not true … [P]eople had got into the wrong frame of mind. It was great to get awards if you were doing well, but not if it gave false assurance, and things were melting down behind the scenes.*

4.130 One consultant felt that senior managers became arrogant as a result of the 2010 award and *"shot down other people's suggestions for further improvement as a result"*. A senior member of the management team described the Trust as:

> *… riding on the Dr Foster's award and felt itself to be quite above everything else … the Dr Foster's award was held up to every criticism.*

4.131 Many staff, and others, spoke about a culture of denial at the Trust and a resistance to change. The Panel was told that, following the 2014 CQC inspection and report (which resulted in the imposition of Quality Special Measures), the reaction of the Trust was one of real defensiveness.

4.132 A member of the Executive who joined the Trust after the CQC report commented that the Board was *"potentially in denial about the organisation"*, which served to reinforce the disconnect between the Board and the wards. One manager told the Panel:

> *[T]he organisation was utterly floored and did not recognise the report. People were traumatised.*

4.133 There was quite a strong feeling from Board members that the Trust was a victim, that *"everyone was against them"*, and that *"things weren't as bad as this"*. Another senior manager commented:

> *[T]he Trust board were in complete denial and were shocked, angry and hurt. They disagreed with just about every point in the report.*

4.134 The Trust went through the CQC reports:

- The Trust came up with *"hundreds of challenges to the report, including grammatical/spelling issues … rather than getting to the essence of the report or discussing what to do".*
- *"It was not for nothing that the Trust was rated inadequate, yet they responded by sending back comments about commas and semi-colons, losing sight of the problem."*

4.135 We heard that the Trust did not use its staff surveys to identify issues, and that there were some very bad staff surveys that fed into the CQC report. The staff survey results in 2014 gave an indication of bullying; however, these results were not a one-off and bullying had been a common theme in previous surveys. We heard that *"the trust central teams were in denial"* and it seemed that they were not *"systematically reviewing anything on a regular basis"*.

4.136 Interviewees confirmed that staff survey results at the Trust were never very good. A member of the HR team told the Panel that, whenever they tried to discuss the results, *"they weren't necessarily what people wanted to see and hear. We were told there were lots of reasons why the results were invalid."* They told us that there was no desire on the part of the Board or the executives to think about the survey results and what they were telling the Trust:

> *This desire to give a rosy view was unhelpful … it was unhelpful to patients too because it doesn't provide a full picture of what is really going on in an organisation and the potential risks and issues.*

4.137 In 2014/15, the then new Head of Midwifery identified cultural issues within maternity services; they described their reaction to East Kent maternity services to the Panel as being *"the next Morecambe Bay"*. One senior midwife told the Panel that staff were really shocked by this as they did not see the similarity: *"things were being said that were very untrue"*. The Panel also heard that East Kent was *"equal to or worse than Morecambe Bay"*, but:

> *[T]here was no recognition, insight or acknowledgment from the obstetricians or the midwives into any of the issues identified in the 2014* [CQC] *report.*

4.138 One clinician told the Panel that they did not recognise some of the issues that were highlighted in either the CQC or the RCOG report. A senior midwife remembered the RCOG report being dismissed by a senior consultant obstetrician as a *"load of rubbish"*. The midwife commented to the Panel that Trust obstetricians did not like the light being shone on them in that way.

4.139 Another clinician couldn't recall the RCOG report being widely discussed, and they were not made aware of the report's key findings or recommendations. Similarly, a junior doctor told the Panel that the report was not formally discussed with junior doctors. Another consultant told

the Panel that they believed the issue raised by the RCOG report around consultant availability was limited to just two consultants, one of whom left the Trust.

4.140 In 2018, the Trust's maternity services were rated by the CQC as "Requires Improvement", although reference was made to the introduction of multi-disciplinary training as a step in the right direction. We heard that the Board took reassurance from that, notwithstanding the lack of effective audit and quality assurance systems that was identified by the CQC.

4.141 Professor Walker, the Clinical Director of Maternity Investigation at HSIB, spoke of the initial defensiveness of the Trust in 2018 and of a lack of opportunity to engage with staff outside a small number of senior Trust staff. There was a meeting in the summer of 2019 between HSIB and members of the Trust's Executive, at which there was a lot of aggression and pushback by the Trust. Professor Walker told those present in the meeting: *"[L]ook, you've got a major problem at this hospital, which is going to escalate, and you'll hit the press by the end of 2019."*

4.142 Another HSIB officer told the Panel: *"There was denial in the Trust about the enormity of the underlying problems."*

4.143 The relationship with HSIB was described by a member of the Board and Executive as difficult. So too was the transition from a process whereby the Trust conducted investigations itself, with the benefit of having a relationship with the family involved, to outsourcing the process to HSIB. They commented that the HSIB process felt very impersonal, and people were defensive.

4.144 This defensiveness was echoed by another member of the Board, who described being *"blind-sided"* by HSIB's serious concerns in about 2019 that East Kent maternity services were at the top of the list for total body cooling (therapeutic hypothermia) and feeling disappointed that the Trust had not engaged appropriately with HSIB on the issue. There was an internal report to the Board in December 2019 addressing HSIB's concerns and citing improvements in certain areas (such as staff recognition of clinical deterioration or changes in the escalation process), although no evidence was provided and *"frankly the Board was not assured that what they were doing was enough"*.

4.145 A non-clinical member of the Board felt that the relationship with HSIB was not proactive and detected a reluctance within the Trust's clinical team to accept what HSIB was saying.

4.146 The Panel heard from Nick Hulme, a Trust Governor, that, even as recently as 2020, at Council of Governors meetings it was regularly highlighted that it was *"not fair"* that East Kent scored lower down the lists of trusts, given the large size of the Trust and that it had *"a lot of comorbidities"*. Mr Hulme told the Panel that governors were told to *"ignore the press"* because they had *"an agenda"*. Mr Hulme also told the Panel that he had been actively dissuaded from speaking to the Panel by a member of the Board, who told him that he *"would not add value"*.

4.147 Mr Hulme also told the Panel about an attitude within the Trust of *"well, as long as we're not bottom, that's alright"*. There was no ambition to be anything other than *"bang average"*, and the focus was on *"get to good"*. The Panel also heard from a Board member of a *"culture of failure for five or six years"*, with the Board being described in around 2017/18 as *"very fragile and brittle"*:

> *There were few people left in the Trust who knew what success looked like or who had experienced working in an organisation that was functioning effectively. It wouldn't be straightforward to change that.*

4.148 The Panel heard of clinical leads who were resistant to change and reluctant to look outside the organisation or to be open to other ways of working. One manager was used to organisations seeking fresh eyes on incidents or complaints, but this was always resisted at the Trust.

4.149 The Panel was told that concerns about maternity services were raised with the executive team by the divisional management and by other functions within the Trust, such as clinical governance and patient safety, legal and HR, but nothing happened.

4.150 The Panel heard that the practice of the Trust was to discourage the reporting of screening issues to Public Health England, despite it being national policy to do so, and that a screening coordinator was reprimanded for involving Public Health England in a serious incident and was told not to report issues externally. The Panel heard that the culture in the past was to keep things in-house, but that this had improved more recently.

4.151 One consultant midwife sometimes found East Kent maternity services slow to adopt new national recommendations, for example about identifying women at risk of restricted fetal growth. They told the Panel that they would approach the governance team, maternity leadership and the obstetricians about making the recommended changes, but those approached would often produce counterarguments relating to equipment or resources for why the recommendations could not be implemented.

4.152 A member of staff who had rejoined the Trust in 2019 recognised positive changes that had occurred and noted that morale and staffing had improved. However, there was still a reluctance within the Trust to adopt new research and guidelines.

4.153 The Panel was told that, even in 2020, obstetricians and paediatricians had a focus on process rather than on outcomes. That included some of the work of the Birthing Excellence: Success Through Teamwork (BESTT) programme:

> *For example, they would try to decide whether a day or a day and a half of training per month was needed, instead of identifying the outcomes they needed to achieve and then basing the training requirement on those.*

Culture of blame and handling complaints

4.154 The Panel heard from a number of people about a "blame culture" when things went wrong:

- *"Feedback was almost like a blame game where someone was at fault and had done something wrong, rather than giving feedback on how to improve when something happens."*
- *"Raising complaints at the William Harvey was difficult as individual staff would feel blamed for mistakes."*
- *"Ashford* [WHH] *is odd and the culture there is weird. They are less likely to support each other, and more likely to blame."*
- *"Staff are less supported now by senior management than they have ever been, and there is a culture of blame and recrimination."*
- *"There was often feedback, but it was not given in as supportive a manner as it could have been … You were only called to see your supervisor if you had done something wrong … I am open to scrutiny if there are lessons to be learnt but that doesn't mean you're a bad midwife or that you did it on purpose."*

- *"*[Consultants] *take no responsibility for their actions and blame colleagues for any challenges and failings."*
- *"One particular paediatrician would often blame obstetricians for any deaths or serious incidents that arose."*
- *"Historically there was a lot of jumping to conclusions and finger-pointing, whereas* [more recently] *there's recognition that things aren't black and white – that they can be complex, and you shouldn't jump to conclusions."*

4.155 A midwife told the Panel of an incident when they were called before an obstetrician after a baby had become grey and floppy in recovery, and the obstetrician seemingly accused the midwife of doing something wrong (*"that baby was screaming and fine in theatre, what happened?"*). There was a similar account from another midwife where there was a poor outcome:

> *[T]he consultant stormed onto the ward the next day and demanded to know what I had done to produce this outcome.*

4.156 A band 7 midwife told the Panel of the *"punitive approach"* to dealing with issues:

> *[T]here's a lot of fear among staff about making mistakes and being told off, and this hinders their ability to learn.*

4.157 The same member of staff told the Panel that there was *"no celebration"* of anything that was done well, and communication was not transparent. When a learning opportunity was identified, it felt like a punishment; the approach at the Trust's maternity services was *"not healthy"*.

4.158 The Panel heard from a senior midwife about the difference in the treatment of midwives and doctors. Whenever there was a root cause analysis investigation, there were often outcomes for midwives such as referrals for supervision or reflection, or formal HR processes. However, for doctors, there would simply be an informal conversation:

> *This was why the midwives felt that there was a blame culture and that things were inequitable.*

4.159 A separate senior midwife made the same point and described how issues raised with doctors wouldn't go any further and there wasn't any challenge to difficult obstetricians, whereas with midwives the outcomes were very structured, with a pathway and supervision.

4.160 We heard that a lot of disciplinary action was taken and that, at one disciplinary hearing, the Chair said: *"I don't know why this has got this far. How did it get to this?"* When a midwife was referred to the NMC, the case manager came back and said: *"I've looked at everything and I don't know why she was referred."* We were told:

> *There was a knee-jerk reaction to punish people and it created a very unpleasant environment.*

4.161 Others commented that, when things went wrong, there was no opportunity to debrief; the response was reactive rather than proactive. The Panel was told of a culture of blaming junior staff or locum doctors for whatever problems occurred within the Trust.

4.162 The Panel heard that some issues could escalate quite quickly, and that staff seemed to act on rumours rather than facts. A midwife could quickly be on an action plan after raising a

simple issue that they were not sure about, when "[it] *didn't need to go that far".* The Panel was told that midwives were hindered by fear: they worried about what people thought and said about them, and about things being done in the background that they were not aware of.

4.163 The Panel was told about a focus on documentation, and that this could distract from giving actual care, noticing when things deviated from the norm, or recognising when issues needed to be escalated. The Panel heard that midwives were sometimes too scared to press the emergency buzzer in case they were wrong, or to tell a more senior staff member on duty that they were unsure about a situation. This fear related to delivery suite coordinators and obstetricians as well as band 6 and 7 midwives.

4.164 There were approximately five to ten complaints each month about maternity services, mainly about communication and relationships. They covered:

> *… things like the fact that people didn't feel involved in the decisions that were being made and hadn't been provided with sufficient information.*

4.165 We heard that a high proportion of complaints about maternity services concerned the midwives' attitude towards and communication with younger women, who felt that things weren't always explained well or that they weren't listened to, helped with breastfeeding or given information about their baby. Other common themes reported to the Panel included pain relief and whether or not a caesarean section should have taken place.

4.166 A senior midwife commented that inappropriate staff behaviour was the most prevalent *"human factor"* at the Trust, and that it was not limited to midwives; complaints were also made against healthcare assistants, obstetricians and ultrasound staff. They commented that *"complaints as a result of poor behaviour impacted staff across the board"*.

4.167 The Panel was told that the obstetrics and gynaecology department had a "fix it" clinic every other Friday morning, where a consultant and specialist nurse would meet with women who were unhappy with their treatment and care. There was a six-month waiting list for the clinic, but the women *"had the opportunity to get stuff off their chest and try to sort something out".*

4.168 The Panel was told that Trust staff had later come to see the importance of standing back and thinking about what the family's needs were in situations where complaints were made, and the need for staff to take time to talk things through with the family, to listen to them, to understand what was important to them and how they were feeling, and then to respond to that, rather than assuming that they knew what was important.

External factors or problems as the staff saw them

Facilities and infrastructure

4.169 Infrastructure was cited as an issue for many services in the Trust. One member of the Board and the executive team talked about the estate:

> [It is] *profoundly challenging – it is difficult to attract clinicians and to provide good modern services.*

4.170 Another Board member commented:

> *The maternity estate is tired, poor, and needs replacing and totally modernising. But it's not just maternity – the entire estate needs this.*

4.171 Some members of staff talked about QEQM as *"falling apart"* and not *"fit for use"*. The Panel heard about the challenges presented by the size of the rooms and the lack of resuscitation trolleys on the ward.

4.172 We heard that theatre access was identified as a problem at QEQM: there is only a single theatre in the labour ward and, if there were a second emergency, it could take up to 30 minutes to organise and start operating in the main theatre.

4.173 One midwife referred to the *"struggle with the footprint of both the acute labour wards"*. The MLUs were new, but the majority of women were giving birth in environments that were not fit for purpose. Another senior midwife described the dated estate as a *"big problem"*.

4.174 A member of staff who worked in the MLU at WHH commented on the difficulty presented by having the MLU on a different floor of the hospital from the labour and postnatal wards:

> *The team felt disjointed … The perception was that you didn't matter. It was difficult to keep the woman at the centre when you're juggling politics between two areas.*

4.175 One consultant commented:

> [A] *lot of the labour beds have only 30% of space recommended by national guidance. This meant that if a baby was born in poor condition, midwives would have to run down the corridor to consultants as there was no space to treat the baby by the bedside.*

4.176 The Panel heard that WHH would struggle to meet guidance recommendations that each labour bed should have a bath available.

4.177 We heard that there was only one toilet for staff across the whole unit at WHH, so if someone was working on the Folkestone Ward (which provided care for antenatal and postnatal admissions), they had to tell the other midwives that they were leaving the ward to go to the toilet. One midwife told the Panel: *"I feel like we're not well looked after as midwives."*

4.178 The Panel heard that requests for a second obstetric theatre at WHH were declined because maternity services did not generate as much money as other departments.

4.179 The Panel was told by many interviewees that one of the problems at QEQM was that the resuscitation trolleys were outside the delivery rooms, and there were several cases where a baby was taken out of the room but their mother would hear things going on in the corridor that related to their baby, which was very distressing. The response of the Trust was that it couldn't do anything about it because, in its view, it was the nature of the Trust estate.

4.180 The Panel also heard from Mr Hulme, a Trust Governor, who commented:

> *[Y]es, the estate is in a mess and absolutely needs to be improved; they are awful but … it is not impossible to do really good care just because the buildings are rubbish.*

Geography

4.181 Some people who spoke to the Panel mentioned the challenges presented by East Kent's geography:

- *"The geographical location of the hospitals on two different sites is also a difficulty, as staffing levels and service quality need to be maintained across both sites."*
- *"You can't change the geography of the organisation. The challenge is how to ensure the right support is in there, given the geography."*

4.182 A director observed:

> *[O]ne of the challenges for East Kent staff is that there are few alternative employment opportunities. A nurse working in Margate would have to commute eighty miles, e.g., to Medway* [and back]*, if they wanted to work at another NHS trust. Professionals who train at Canterbury Christchurch University, e.g., radiographers and nurses, gain their practical experience in the Trust and then* [are] *likely* [to] *come to work for the organisation too … staff tended to be inward-looking in their view as a result.*

4.183 The Panel also heard comments that it is difficult to build strong organisational connections and shared values across separate sites. Some staff expressed doubt as to whether the Trust would be viable over the long term with two or three sites.

4.184 An experienced consultant told the Panel that the geography made the Trust difficult to work at:

> *[W]hen an incident does occur, managers become torn between multiple sites and must choose carefully where they spend their time.*

4.185 The Panel was told by an experienced midwife of occasions when the labour ward at QEQM was closed due to safety reasons, requiring attendance at other sites. As the nearest labour ward is 30 miles away and women are often reluctant to travel to other sites, unplanned home births could result. Women were not routinely told that there was a risk of the labour ward being full before they entered the hospital or that being transferred to a different trust was a possibility. This was particularly a problem at Thanet, where many people do not have their own transport and therefore there was little possibility of reaching another trust in time to give birth safely.

4.186 A member of the Board and Executive described how the maternity case mix at the Trust changed between 2007 and 2015:

> *[T]here was more complexity, higher teenage pregnancies, higher than usual problems with smoking, obesity, and diabetes – all the social determinants of health. East Kent has both affluent areas and also a lot of deprived areas, particularly coastal areas. From a midwifery point of view there was a lot of complexity that people were managing. The Trust was tracking c-section* [caesarean section] *rates and intervention rates and they were tracking slightly higher than the national norm.*

Staffing

4.187 A number of people to whom the Panel spoke commented on the difficulty of recruiting staff to the Trust, particularly at Margate:

- *"QEQM was always a difficult site to recruit to, on the extreme southeast of the country and a coastal community."*
- *"Margate is the furthest place from London where people want to go and settle, and finding staff is not easy."*

- *"One thing about the geography was that it was almost impossible to recruit staff to go to Margate, so the only staff they had were people who lived there, and they had been there a very long time. If you don't get any turnover, then that brings about an issue."*
- *"The biggest issue was staffing. Just prior to 2009 there was a large investment (almost £4M) into nursing and midwifery because the staffing levels were not safe. However, recruitment was a challenge given the geography of East Kent (coastal areas at one end of the country), and there was difficulty in recruiting both midwives and obstetricians, and the Trust was more reliant than it wanted to be on locums."*

4.188 One senior consultant described QEQM's middle grade medical staffing situation in 2012 as *"dire".* However, we heard that, by the end of 2013, QEQM had a full set of middle grades and there was active recruitment of staff from abroad.

4.189 The picture presented to the Panel in some interviews was that, up to 2015/16, there were quite a few experienced middle grade doctors who had been at the Trust for a long time; and that from 2015/16 to 2019, there were a lot of rota gaps and there was a time when more than 50% of the rota was covered by locum doctors. Some consultant obstetricians told us that they were always worried when working with someone they had not met before and that they gave careful consideration to whether locums could be left unsupervised. These issues were escalated to the divisional Medical Director, but it was not felt that they were taken seriously enough by the Trust. We were told:

> *It was difficult to maintain quality with locums. This is not a problem unique to East Kent but the thing that set them apart was the scale of it – 40-50% of the shifts … Trying to secure locums at short notice was an endless task.*

4.190 A senior midwife described how the CQC's intervention in 2014 and the adverse publicity facing the Trust caused difficulties in recruiting staff. They described the workforce as stable and structured prior to 2016, but after this there was a need to use significant numbers of locum doctors, which had a negative impact. The quality of some of the locums was described as *"troubling"* but it was *"a case of having that locum or nobody"*.

4.191 We heard that the Trust was spending about £17 million per annum in 2018 on locum doctors and agency staff, which was, according to one Board member, *"bad for patient safety and continuity"*. The Panel heard that there were constant challenges in keeping staff up to date.

4.192 The Trust was described by a regulator as *"not a Trust that attracts quality staff from elsewhere"*, and a midwife told the Panel that trainees did not want to come to East Kent as it is too far out of London.

4.193 The Panel was told that a benchmarking exercise within midwifery in 2020 had established that numbers of staff within the Trust's midwifery unit were too low. A review of resources in the same period had established a need for specialists in mental health and heart monitoring, more core midwives, an additional community midwife, a Deputy Director of Midwifery, and two senior band 7 nurses to focus on patient experience and digitisation.

Leadership

4.194 The Panel was told that, following the achievement of Foundation Trust status in 2009, the period from then until 2014 was one of relative stability, and that at Board level things felt strong. However, one Board and Executive member reflected that staff morale was adversely affected by the impact of 5–6% efficiency savings year on year; the Board failed to recognise

this development, even though the signs were there in the staff survey results, which showed that stress and bullying increased during this period.

4.195 A non-executive director told the Panel that the Trust was *"too large, complex and diverse for the ability of the executive team"*:

> *It was just out of their league. It was just too big. The span and complexity was too large for them … They weren't even firefighting. They were just on the ropes being punched the whole time.*

4.196 It was said that individuals were doing the best they could; however, the system was letting them down. The lack of senior leadership training and senior leadership models was an issue. Also, we were told that the problems in maternity were:

> *… symptomatic of an organisation that is outwith the competence of the executive team.*

4.197 One director during the period described the Board as:

> *… very dysfunctional; it was not united. They did not work well together, and they were very separate … The chairman and the chief exec were pretty much not talking to each other.*

4.198 It was commented that the quality of non-executive directors on the Board was variable and that they did not always provide the right kind of challenge. One member of staff described the non-executive directors as *"weak"*:

> *[T]hey didn't know what they were doing and didn't have enough challenge. They didn't know the data. Your non-execs are there to hold the executive to account in the right way and I didn't think that was happening enough.*

4.199 The Panel heard about *"really awful reporting to the board"*:

> *There was no challenge or testing at executive level, and that's partly what got them into the mess that they got into … Nobody really knew what the truth was about a problem.*

4.200 A non-executive director with experience of both public and private sector boards commented that the Trust was just going through the motions.

4.201 The Panel also heard about communication breakdown between non-executive directors and the Executive Board. One non-executive director first became aware of issues in maternity services the day before a news story was about to break on the BBC website. On another occasion, the same person first learned of an issue after seeing the front page of a newspaper. It transpired that the Executive had known about this for a month but had not thought it appropriate to tell the non-executive directors.

4.202 Senior management were described as lacking people skills. One member of the Executive was described as a *"threatening"* presence throughout the Trust; the Panel heard that *"staff did not feel supported by* [them]*"*. Another member of the Trust Executive was described as *"overwhelmed"*, with a tendency to talk at people rather than engaging fully.

4.203 The Panel was told of a toxic culture and unhealthy tension between managers and clinicians, who had different priorities. The managers were quite wary of powerful clinicians:

> *[I]t led to a really unhealthy tension where people just tiptoed around the issues.*

4.204 Of the culture, it was said:

> *[T]hey're* [senior managers] *really frightened of these people* [consultants].

Changes at Board and senior management level

4.205 After the 2014 CQC report, the Trust lost its Chair, the Chief Executive, one of the joint Chief Operating Officers, the Director of Nursing and the Director of Finance. This heralded the start of a long period of instability at Board and senior management level which had:

> … [a] *tremendous impact … Everything got put on hold because key people were not in post.*

4.206 Since 2014, there have been three Chief Executives of the Trust, four Chairs of the Board, three Chief Nurses and four Heads of Midwifery (referred to since 2018 as Directors of Midwifery). A number of members of Trust staff identified that the level of turnover in key senior positions had had a detrimental impact on the effectiveness of the Board and Executive during this period. It was also said to comprise a disproportionate amount of the Council of Governors' work.

4.207 One member of the Board and Executive described the Chief Executive post as *"undoable"* and a case of *"how long is the next one going to last"*. One Head of Midwifery was asked by a senior colleague on taking up their post, *"how long are you going to stay?"*.

4.208 The result of so many changes within the management structure was that *"people didn't have much confidence in the management team".*

4.209 The Panel was told how tough it was to maintain momentum while losing people and continually having to develop new relationships; of the damaging impact of the constant changes of senior leaders; and how initiatives were regularly implemented and then abandoned with the next change of leader.

4.210 The Panel was told that the departure of the Chief Executive in 2017 was *"catastrophic"* and that *"the visible loss of leadership had major consequences for the Trust"*: *"conflict and difficult relationships"* abounded and remained a problem for two years.

4.211 One senior midwife described how, every time someone new came in, the journey would start again, with new leaders wanting to know everything that had happened and changing priorities. It was a case of *"that's not important, this is now important"*. The BESTT Maternity Transformation Programme that was launched in 2017 was cited as an example of a programme that had been owned by the staff but was now *"shelved"* and *"just another example of not seeing something through"*.

4.212 Another senior midwife said:

> *[T]he goalposts were being moved quite a lot because there were new Heads of Midwifery coming in.*

4.213 And another member of staff said, in reference to the six different Heads of Midwifery throughout the period of the Investigation:

> [A] *new incumbent would bring new ideas and then things would change again with the next person. It felt as though we were always trying to catch up.*

4.214 The Panel heard that, both in the immediate aftermath of the 2014 CQC report and since, there had been a high turnover of non-executive directors, with some leaving because they had come to the end of their tenure but others leaving due to frustration or because the pressure of reputational issues was too much. Some non-executive directors chose to move on before the end of their term because they did not want to be associated with what was happening at the Trust.

4.215 We heard about the dangers of "hero leaders" who were expected to single-handedly reverse the fortunes of an organisation, only to be quickly and repeatedly replaced when they inevitably failed. We also heard of the need for a strong leadership team with a long-term strategic vision beyond the next two to three years.

4.216 Commenting on a whole series of changes of leadership, Professor Ted Baker, former Chief Inspector of Hospitals at the CQC, observed that stability and support from external parts of the system such as NHSE&I and the CCGs are required in order to turn a trust round from special measures:

> *If you look at East Kent … there has been a whole series of changes of leadership and none of the leaders have stayed very long. That kind of chopping and changing leadership and people who go in to lead an organisation like that and have a two-year horizon in terms of what they want to achieve, are never going to drive the change you want. There's a history in some of these trusts that don't make progress, that when we find real problems – put them in special measures – the leadership changes and a new hero leader is brought in, whoever they may be, and they are going to sort it out. And two years later they have failed, and they move on quietly and someone else comes in. The misconception is: one, it's not one person, it has to be a team; two, it's not a hero leader, it's someone who is thoughtful and who is going to drive cultural change; and three, they need support, however good they are, from the external part of the system – NHSE&I, CCGs or ICSs* [integrated care systems] *now. They need to support them because taking a trust that is in special measures, that is inadequate and has really serious issues and turning it into a really good trust, is a huge job and a formidable challenge. It's not one person's job, and it's not something anyone can achieve easily.*

4.217 Professor Walker, who had significant experience of investigating maternity incidents at the Trust with HSIB, offered this insight:

> *There were continued problems and with continued themes, which in fact have continued to this day … A lot of big hitters come into East Kent to try and solve a problem, and in fact they make the problems worse because they obligate the Trust to spend a lot of money and time building structure, while not necessarily solving the problem on the shop floor. And so, the same problems on the shop floor, lack of support, lack of escalation, are still going on … The appointment of a CTG midwife or a lead person in this, or having a committee in that, doesn't solve these problems … A lot of the oversight groups spend their time trying to be reassured by what's going on, rather than finding out whether something is improving. They want people to say, "we've got this committee, we're looking at that, this is our report, this was our graph", and everyone nods and says, "well, that's really good" and "let's move on" without looking to see whether things have changed … What East Kent told us is that although there was leadership there, they weren't in touch with what was going on … and they tended to believe what they were told.*

4.218 The Panel was also told of a lack of stability within key clinical roles and that members of the Executive did not act as a single cohesive team providing a tier of support below the Chief

Executive. The size of the Trust, the portfolios of those working there and the expectations were said to be huge and potentially unworkable.

4.219 One experienced midwife told the Panel that they saw the situation deteriorate around 2015/16:

> *[T]here seemed to be a flurry of appointments made of people who had very little experience and it appeared almost as if they were trying to eradicate all previous managers and senior people from the team … They were appointing people with no background experience and their lack of experience was reflected in what was happening on the shop floor unfortunately.*

4.220 The Panel heard:

> *[T]he long history of reports of deep cultural issues in East Kent maternity services was related to instability in the leadership team. Other contributory factors were the fact that the two sites worked separately rather than together as one trust, and the large geographical spread of the trust. In 2018 there was more stability in the leadership, and it felt as though a shift in culture led to people working well together … staff took more ownership of what was happening. There were obstetrics and midwifery leads for all pieces of work and if the focus of a project was on one site, then the other site had shadow leads for obstetrics and midwifery.*

Clinical leadership

4.221 The Panel heard that doctors were not engaged in the management of the Trust, and a senior member of the Executive spoke of the difficulty in attracting good leaders as well as in having a body of consultants who were unwilling to be led.

4.222 Another member of the Executive highlighted several dangers related to the way in which the clinical effort was focused at East Kent maternity services – there was a historical lack of clinical leadership and *"it was much more controlling and quite negative"*:

> *There is a culture of politically aware bureaucrats versus clinicians who don't have the leadership skills.*

4.223 The Panel was told of a reluctance on the part of staff within obstetrics to take on leadership roles, and that the midwives and obstetricians held their meetings in silos with very few multi-disciplinary meetings. One midwife described a Clinical Director within the obstetric team as like a *"lone ranger"*.

4.224 The Panel was told that consultants' views were not included in decision making, and without good clinical leadership in women's services, it was hard to get voices heard. It was noted that clinicians did not feel accountable for what they did, which led to consultants not being there when they were supposed to be.

4.225 One consultant told the Panel that they had told the RCOG that three colleagues should be sacked because *"they didn't have the same work ethic and responsibility"*.

4.226 Leadership within midwifery was described at times as resistant to challenge and favouring the status quo, which was a source of frustration. The Panel heard from senior midwives that there was a perception that the views of midwives were blocked and not

escalated appropriately due to *"gatekeeping"*. It was frustrating that midwifery did not have a voice at Board level.

4.227 The Panel heard positive comments about the leadership of midwifery more recently, with improvement in effective leadership, visibility and openness to challenge.

Financial Special Measures

4.228 The Panel heard that, immediately after exiting CQC special measures, and perhaps as a result of spending on the improvements required, the Trust was placed in Financial Special Measures by Monitor.

4.229 A Board member described the impact of being placed in Financial Special Measures in 2017 as like coming out of Quality Special Measures on a Tuesday and going into Financial Special Measures on a Wednesday. A number of Board and Executive members told the Panel that going straight into Financial Special Measures was not helpful. One said:

> *The organisation came out of special measures, and the next day they went into financial special measures, which was massively unhelpful and not necessary. It gave the organisation no time to take its breath … This didn't directly lead to the problems within maternity services, but it is part of the context and the people who would have been doing work on maternity services were responding to financial special measures and all of the effort that required. Had the organisation been given time to breathe it may be that there would have been more focus on maternity issues.*

4.230 The Panel was told about the significant impact that Financial Special Measures had on the transformation and improvement agenda, and on innovation; the Trust became very financially focused and operationally led. One member of the Board and Executive described the organisation as *"controlling"* and stated that, because of the problems with the finances and the buildings:

> *[P]eople couldn't see a way out. It felt very negative. Staff were not utterly disengaged but they were very despondent.*

4.231 A member of the Board and Executive made the following points:

- The Trust has been in deficit since at least 2016 and the deficit target has been missed every year since 2017.
- The Trust has been aiming to make 4–5% efficiency savings each year (£30 million) and has sought to do this in a way that does not affect clinical services, for example by making structural changes that produce a saving on VAT.
- However, there have also been some cost efficiencies in clinical areas.

Governance

4.232 Members of the Executive spoke of the disconnect between ward and Board and of communication issues. One told the Panel:

> *It didn't help to have a disparate multi-site Trust. It didn't help that there were issues with medical engagement and a lot of turnover in the Board. It didn't help to have a bunch of people who, when the divisional structure came in, got put into roles without any development. One of the recurring themes in CQC inspections around the country is the*

middleman, through whom nothing filters down or goes back up. Where organisations work well, the communication is great from ward to Board and Board to ward. It comes back to the multi-site structure – people need to walk around to see what's going on. It is not enough to be in an office and do it by video link.

4.233 One member of the Board and Executive was aware, even before they joined the Trust, of the fact that the views of management were not shared by the staff. Another described sitting aghast as they listened to feedback provided by ward colleagues and feeling like they were not part of the same organisation. The executive team did not listen enough to what people were saying, and they did not talk to those on the ground. One senior executive observed:

[There was a] *significantly different view between the board and the staff about the purpose of the organisation.*

4.234 One clinician felt that certain sites were underrepresented within the Trust's governance structure, with QEQM being under greater pressure because of recruitment issues and a lack of capacity for staff to participate in governance. Well-staffed sites, by comparison, had more time to focus on non-clinical issues.

4.235 The Panel was told by a Board member that the governance structures within the Trust were not sufficiently robust to allow assurance from ward to Board, and that the Board did not give consideration to this issue or to what it could do differently. Another member of the Board described the governance arrangements in 2018 as:

… like being in a car, when you move the gear lever, and nothing happens. The governance from board to trust and from ward to board had broken down and needed to be fixed.

4.236 Consistent with this observation, the Trust was described by regulators as an organisation that did not actively look for problems and issues to solve; rather, it waited for them to be pointed out. They suggested that the Trust needed to be problem sensing rather than comfort seeking in its approach.

4.237 A senior midwife told the Panel that maintaining compliance, receiving feedback and implementing lessons learned were some of the key priorities that were not always addressed. It appeared to them that sometimes the Trust was waiting for an incident to happen, rather than utilising the vast amount of patient safety incident data available to predict incidents.

4.238 A senior manager described governance within maternity services as:

… frightening, but they had normalised it and couldn't see there were issues … The leadership within maternity did not mix at all. Staff days and learning within the nursing teams was not embedded. It was very narrow in the way that it operated and didn't invite people in.

4.239 A senior manager told the Panel that the Board *"tended to deny there were problems and suppress discussions"*. After the 2014 CQC report, Board committees were split so that the Quality and Safety Committee included nursing and medical staff but did not include divisional directors; this impacted the quality of the conversation and the decision making.

4.240 The Panel was told that the Executive had difficulty accepting the findings of the initial CQC review and *"spent about six months quibbling over what was in the report"*. It was said at the time of the report that *"there was nothing of significance coming out of women's services"*.

One senior member of staff thought the Trust did not understand how much time was needed to take the actions forward.

4.241 Former Board members told the Panel that, between 2016 and 2018, maternity services featured very little in Board discussions and should have had a higher priority. The priority issues for the Trust in 2018 were described by a member of the Board as: safety, governance and finance – *"the core business of a hospital"* – but with specific focus on A&E (which was the worst in the country); cancer services (which were the fifth worst); and the response to treatment time (the Trust had the second longest waiting list in the country). It was accepted that maternity services did not consistently appear in governance sessions and that issues became diluted; their significance was not recognised as they were reported up through the chain and repeatedly summarised.

4.242 The Panel was told that the Board was looking for patterns and themes, but the mechanisms were not in place to identify them. It was recognised that clinical governance required improvement because the Trust did not have information flowing up and down the organisation between the point of care and the Board.

4.243 In terms of the Trust's recognition of the wider significance of individual events, Professor Walker told the Panel:

> *They didn't link* [two maternal deaths] *together … They just saw them both as really unusual things that happened out of the blue …* [HSIB] *tried to get across, yes there is a reason for it. It's the systemic failure … These were all, what used to be termed under old parlance, "latent errors" – errors waiting* [to happen] *… It was almost like a journey of realisation for them that these things were repeated in the same way. The problem they tended to do was they blamed individuals. They blamed the locum, for instance, for the problems, instead of saying, "well, the locum only has a limitation in their ability and knowledge of the hospital". What supervision or assessment did you make of that individual? Or did they just turn up on the night of their on call, without any orientation or anything like that? … The Trust had to think about the systems approach and the preparation and making sure everything is in the right place. So that took quite a long time, really, for them to be convinced of that. Initially they kept on seeing them all as one-off events.*

4.244 A Board and Executive member commented that the information flow seemed to be there but noted that the relative performance of the Trust was not known by the Board and that they were not aware that it was *"the worst performing"* trust in the country. They also told the Panel that the Board was concerned about whether it had sufficient information, which led to overcompensation by diving too much into the detail on issues, rather than standing back to understand what the information was telling them.

4.245 One Board member was aware before joining the Trust that it was one of the – if not the – *"most challenged trusts in the United Kingdom"*:

> *My initial impression was that there was a very severe problem with governance throughout the trust, throughout the three hospitals, and that was split into two groups. There was a structural problem and there was a deep-seated cultural problem. The structural problem was that the Board only met every two months, and this is a Board with five hospital sites with some of the most challenging performances in the country and quite clearly that was nowhere near enough … But there appeared to be no recognition of what was needed*

> *for a Board. There was no ownership of* [Board] *papers. The papers were often late. To be honest with you on closer questioning they could be inaccurate. They could be incomplete.*

4.246 A different Board and Executive member expressed the belief that there remained issues around serious incident reporting and the level of visibility the system provided. They told the Panel that they became aware of baby Harry Richford's death only when they saw the first draft of the root cause analysis report in March 2018 and read it *"with mounting horror"*. They told the Panel:

> *[O]ne of the reasons it was so difficult was that obstetrics is largely a well-specialty. They were dealing with people who were well, and it can take time to pick up where things were not quite right. If activity or behaviour starts to become normalised, it needs someone to forcibly point it out, and that was part of the problem.*

4.247 The Harry Richford case was not formally considered by the Board until late 2019, prior to the inquest into his death. In response to the inquest, the Panel was told that different workstreams were set up, including a prevention of future deaths workstream, to which the action plan relating to what happened in Harry's case was added. The neonatal resuscitation process was reviewed, as was the 21-point Prevention of Future Deaths report and the 2016 RCOG report (which included the issue of consultant presence on the labour ward).

4.248 Mr Hulme, a Trust Governor, was struck by the fact that there was no external benchmarking of serious incidents; the only information provided was the number and type of serious incidents. He found it was very difficult to unpick whether the Trust was improving over time or not. There was no focus on repeated serious incidents. Mr Hulme said:

> *That does not show a learning organisation if you're not tracking the number of times that a serious incident has happened … Apparently there was no way … of looking at SIs* [serious incidents] *adjusted for comorbidities, for the size of the Trust and see whether, as a trust, we're not just resting on our laurels and assuming that we've always got to have 50 SIs per quarter, and that's just what it is.*

4.249 It was suggested that the Trust invest in a different methodology for looking at serious incidents, but *"that did not land well"* and an invitation to consider alternatives at a different trust was never taken up.

4.250 The Panel heard of concerns from midwives about how the organisation learned. Although HSIB reports were emailed, they were often not looked at or read. Although there had been improvements with the current risk team, there was no strong pathway for feeding back the learning from incidents. One midwife spoke of new guidelines being introduced in response to incidents but no one explaining why:

> *Staff aren't involved in improvement plans and yet they know what went wrong. They know how it could be fixed but they weren't invited to comment.*

4.251 One member of staff described the Trust's learning from incidents as *"formulaic"*, a *"pray and spray"* approach with *"fingers being crossed, and a policy updated"*.

4.252 There was criticism of the divisional structure, which created an extra tier of management. The structure of the divisions was described to the Panel as follows:

> *Each* [division] *was led by a divisional director. They had a doctor as a clinical lead as well, and the relationships almost without exception, between the doctor and the manager,*

were not good … The divisional directors and doctors just didn't understand about working together.

4.253 An experienced midwife recalled when a divisional leader came to a supervisors' meeting and said: *"I'll be perfectly honest with you, I don't actually know what you do."* A senior midwife told the Panel the same thing: that the appointed divisional leaders had very little understanding of maternity services and the difficulties midwives face.

4.254 Another senior midwife reported that a divisional leader did not assist the midwifery team in implementing new recommendations following the public consultation on maternity services in 2011, and that the *"potential for improvement had been lost"*.

4.255 The Panel heard similar comments from Board members and managers:

- *"[O]ne of the challenges that East Kent has had with its divisional structure and then its care group structure, is that a lot of responsibility has been delegated to those divisions/groups but the Trust has not always had the process in place to provide central oversight of their effectiveness."*
- *"There was this centralised but non-integrated board approach, and then below them they had what they called autonomous divisions and these divisions genuinely believed that they didn't have any accountability, so this wasn't just maternity. There were issues with each of the divisions."*

4.256 Midwives informed the Panel of concerns around clinical governance and said that they had written to divisional management to highlight that there was only one midwife within governance, while the number of reportable incidents in maternity services was higher than in many other specialties. They told the Panel that the governance role was much too big for just one person, that complaints were not dealt with well, and that there was a lot of pushback from consultants.

4.257 Senior midwives told the Panel that governance had not been an integral part of maternity services and that it had not been a golden thread running through the division, as it should have been. They indicated that, because governance was performed for the whole of the specialist division (of which maternity services were just a part), the ownership of governance was not felt strongly within maternity services; there were a lot of gaps and not a lot of reporting. The Panel heard that Women's and Children's Health *"didn't have a fair place at the table"*. More recently, the placement of governance within maternity services was an improvement.

4.258 The same point was made by a director:

[T]he golden thread lacked breadth and depth. It was obvious that there was no way that a good or a bad point would be taken from the top and worked down through the trust and spread across so that there could be learning or replication of good practice. The Women's and Children's Division was the same as the others, urgent care was the same, it wasn't specifically a maternity issue.

4.259 Maternity services were described as more insular than other services within the Trust, and the reporting culture was not as strong or as open as it was in other services. One midwife commented that debriefing and governance were not things that East Kent maternity services did very well. One anaesthetist commented that obstetricians and midwives often had to be requested for the debriefing process; for some, the debriefing was not very important and could

wait. A difference in approach between midwives and doctors was also noted, with midwives reporting more incidents and very little incident reporting from doctors.

4.260 One Executive member expressed concern about risk-rating issues with Datix; however, the Board was not receptive to the suggestion that the Head of Midwifery should report directly to the Board as an additional route of escalation. The Board was also dismissive of introducing a non-executive director for women's health to whom people could speak if they weren't being heard. It was therefore felt that there were issues incapable of resolution or of being escalated upwards.

4.261 A midwife told the Panel that one of the barriers to reporting was the time needed to complete the details required in Datix, and that if someone were an hour late leaving their shift then it would be quite likely that they wouldn't report an incident, even though it should be recorded. It was also said that it remained common not to escalate issues through reporting, including through Datix reports.

4.262 The Panel was also told that governance was compromised by recruitment problems and constantly changing leadership.

Response to the Royal College of Obstetricians and Gynaecologists report

4.263 The RCOG review was commissioned in 2015 because of concerns about the culture of maternity services, clinical standards and quality, particularly at QEQM. A senior manager told the Panel that they knew there were issues: *"[W]e needed something brutal to help them to change."*

4.264 A senior representative of the CCGs at the time told the Panel that the momentum for bringing in the RCOG came internally from the Medical Director within the Trust, who felt that it would be more credible to the obstetricians, particularly in QEQM, if they heard from their own professional group.

4.265 A senior midwife told us that the description of the behaviour of obstetricians within the RCOG report was accurate and said that the response to the report was not appropriate and that obstetricians did not engage with it. An Executive member similarly described the themes in the report as accurate and recalled a meeting being called with the whole executive team because the feeling was that the report was not being accepted:

> *The report's findings never resulted in an organisational approach to tackling the problem … Efforts to improve the O&G* [obstetrics and gynaecology] *service were confounded by poor and unstable midwifery leadership and disengaged clinicians.*

4.266 The Executive was asked to help get consultants to engage with the report. The Panel was told by a Board member that the main focus of the Board in relation to maternity services and its response to the 2016 RCOG report was the implementation of the BESTT programme in 2017 (which was described by one midwife as simply *"papering over cracks"*) and Human Factors training. Although the programme was considered a response to the RCOG report, it was built around the national agenda with specific areas of focus, and those involved in developing the BESTT programme were not provided with a copy of the RCOG report as it was considered *"outside of the scope of the project"*. RCOG recommendations were incorporated into a later phase of the BESTT programme in 2020 following the Harry Richford inquest.

4.267 The Panel was told that the RCOG report was never shared with the Trust Quality and Safety Committee, and that programmes such as the BESTT programme:

… seemed to indicate that matters were improving but it only involved recently appointed obstetricians and not the long-standing recidivists who were not going to change.

4.268 Other Board and Executive members told the Panel that the response to the RCOG report was merged into one improvement plan together with the actions in response to the CQC report and the Local Supervising Authority (LSA). They told us that, with hindsight, this might have meant that there was insufficient focus on maternity and neonatal services. The improvement plan was signed off by the Executive, scrutinised by the Improvement Board, and reviewed monthly by the CCGs (with respect to maternity services and obstetrics). However, it was felt that maternity services were never given any financial support and had to work within existing budgets. One Executive member considered the action plans in response to the RCOG report to be more a "tick box" exercise compared with the response to the CQC investigation. People only began taking it seriously with the triangulation of other reports.

4.269 Nobody in the Trust had been able to produce evidence of how the RCOG recommendations had been implemented and completed, and there had been no action plan endorsed at Board level to rectify the situation.

4.270 The response to the RCOG report was described by one non-executive director as follows:

At that point, the hairs were going up on the back of my neck really quickly now. I'm just thinking, "oh my word".

4.271 The culture of the obstetrics and gynaecology service was put on the risk register by the governance and patient safety team, in response to what they believed was contained within the RCOG report, although the Panel heard that they were not permitted to read the report and were later asked to remove the obstetrics and gynaecology service from the risk register.

4.272 A consultant who was involved in a review of the RCOG report in 2019 found that the action plan drawn up in response was incomplete and that fewer than 25% of the actions were robust and signed off. The consultant did not know why this was the case and could only speculate that either it was not considered important or there was no time to carry out the work properly.

4.273 A Board and Executive member spoke about how they had more recently sought to identify the actions taken by the Trust in response to the RCOG report but could not find a comprehensive response, or evidence for decisions that had been taken, or evidence of the monitoring of those decisions. They suggested that, because of this failure, the absence of a central repository for recording information and the numerous changes of personnel, a lot of the work done at the time the RCOG report was provided had been lost. They told the Panel that it was not until five years after the RCOG report that there was an action plan in place to cover the recommendations it made.

4.274 The Panel heard that the RCOG had no further involvement after the report had been written. It was believed that the Trust did not contact the RCOG after 2016.

4.275 Despite the RCOG report having been provided in early 2016 and containing a number of complaints about consultants failing to respond to requests for assistance from junior colleagues, the Panel was told that the report was not provided to the GMC until 2020, some four years later. The Panel was also told that the GMC decided, following review, that the complaints did not require "fitness to practise" proceedings.

4.276 In addition, the Panel was told that the RCOG report was not provided to the CQC until it was presented as part of information supplied prior to the May 2018 inspection.

4.277 Following the RCOG report, it was recognised by a member of the Board and Executive that it was significant that the Chief Nurse at the CCGs had written to the Trust to say that they were concerned about the quality of the serious incident investigations.

Risk management

4.278 The Panel was told that part of the risk management strategy around 2012 involved making divisions responsible for their risks:

> *This gave management teams a broader range of responsibility, though clinicians saw risk as remaining the responsibility of trust management.*

4.279 One midwife felt that people within the Trust didn't understand risk when the midwife joined in 2013, although this improved subsequently because the governance and risk obstetrician and midwife brought risk to the fore.

4.280 The Panel heard that there was one risk register for QEQM and another for WHH, and that issues on the risk registers did not necessarily come to the attention of the Risk Management Committee. The Panel heard that there was a monthly risk group meeting that lasted two hours. Corporate risks were reviewed at each meeting. Each care group had a risk register, but, depending on how many risks were on the register for each care group, it wasn't always possible to review every risk without extra time being allocated. Some maternity issues raised at the risk group – such as reading CTGs and resourcing – *"did not get the air time they needed to provide assurance for the board"*. However, there was acknowledgement from the Board about the importance of managing risk.

4.281 The risk register was sometimes updated to reflect the barriers to making changes, but it was *"underutilised and a bit hidden*. *It was all a bit of a mystery."* One senior member of staff thought that the care groups did not understand what the risk register was for, how it could be used or how it could help. The Panel heard that some staff were unfamiliar with the risk register or completely unaware of it.

4.282 A number of safety management concerns were identified to the Panel, including:

- A lack of progress with the CQC recommendations
- The risk register being frequently out of date
- Out-of-date policy documents
- An insufficient budget
- A lack of action relating to the quality improvement programme.

4.283 One member of staff was shocked by the things band 7 midwives at WHH had to say about patient safety, such as *"what's that got to do with us?"*, and that one patient safety lead was not open to challenge.

4.284 The Panel heard that perinatal morbidity and mortality meetings had always taken place at the Trust and provided an opportunity for reflection and learning. The meetings were Trust-wide until around 2006/07, when they became local. We heard that QEQM had monthly meetings to discuss patients and that these meetings were attended by middle grade doctors,

neonatology consultants, midwives and obstetricians. The obstetricians also held their own discussions that did not necessarily involve paediatricians.

4.285 Staff perceived the discussions at these meetings differently. Some considered the meetings at QEQM to be open, with challenges to practice on both sides. However, others spoke of clashes between members of staff, with one particular paediatrician often blaming obstetricians for any deaths or serious incidents.

4.286 The Panel was told that handovers (between off-going shifts and on-coming shifts) were identified as an area of risk, as were delays in communication and issues with communication between disciplines. A consultant expressed frustration at the absence at either site of a multi-disciplinary team for high-risk pregnancies.

4.287 One staff member who had experience of working in another trust commented on the communication issues in East Kent maternity services. Their experience elsewhere was that communication was open and transparent and staff were kept in the loop about investigations and learning from them; however, it was not like that at East Kent maternity services, where the staff member knew only what happened during their shift and was not kept informed about the wider picture.

4.288 One midwife told the Panel that, although there were systems in place for midwives to learn from adverse outcomes (risk meetings and perinatal meetings), in reality they did not go to them. However, midwives had statutory study days, and these were well attended.

4.289 A consultant told the Panel that there had been improvement more recently:

> *Historically there was a lot of jumping to conclusions and finger-pointing, whereas now, there's recognition that things aren't black and white – that they can be complex, and you shouldn't jump to conclusions … Before, people were told what to do rather than why things should be done. They came up with "quick reflex action points", rather than reflecting and agreeing a collaborative approach about how to address the issue … Some changes didn't work as they were just reflex responses at the time. For example, following a case of uterine rupture during induction, one action was that all inductions should have 3 hourly CTGs in the lead-up to labour. However, in this case, there were lots of signs that other things were going on with the woman, such as poor pain control. The introduction of 3-hourly CTGs was more like a tick box exercise instead of doing holistic risk assessment continuously during the woman's induction and labour. In high risk cases of induction of labour, pain or uterine activity should immediately trigger the application of the CTG to monitor foetal wellbeing. By doing 3-hourly CTGs on everyone, they are taking their eye off the ball, instead of risk assessing the woman holistically every time they look at her. They need to unravel things and reflect on what the thought process was behind the action. They need to risk assess each woman.*

Regulators and commissioners

4.290 A large number of organisations have been involved in supervision and regulation of NHS services: the GMC, the RCM, the RCOG, the NMC, the LSA, the CQC, HSIB, NHSE&I, CCGs and the Local Maternity System/Local Maternity and Neonatal System (LMS/LMNS). The Panel heard about the potential for confusion that this has caused, as well as the inability of the supervisory and regulatory bodies to bring about significant change over prolonged periods. We were told:

It isn't always helpful for individuals to have to deal with different organisations and the landscape is so confusing when you have a complaint about something significant that happened in your life. It is very difficult to pursue that.

4.291 Members of the Board and Executive described a very challenging relationship between the Trust and its regulators and commissioners. One told us that a decision had been taken by the Trust to *"fight the regulators"*, although this was a fight that could not be won and was a waste of resource and energy. The Panel was told separately that the Trust had considered taking legal action in response to the 2014 CQC report.

4.292 One member of staff expressed the following perception:

[T]he priorities of the regulators might not always be aligned with what is best for the patients. The regulators have their own set of challenges. They are balancing the politics and the requirements that are placed on them, along with the need to regulate organisations.

4.293 Managers within the Trust talked about how it was impossible to meet all of the regulators' expectations, but they said that nobody discussed whether this situation should be exposed:

[It] *might not be the regulators' intention that they are not aligned, but they don't get to hear the things that they need to hear. People don't always get rewarded by being honest.*

Clinical Commissioning Groups

4.294 A member of the Trust's Board and Executive commented that the four CCGs there had been in Kent all did things differently, making it hard to respond. The relationships were difficult:

[T]hey weren't all pulling in the same direction, and they were very focussed around money.

4.295 The Panel was told that, from the very beginning of the work of the CCGs (April 2013), the CCGs raised and escalated significant concerns about the Trust to NHS England (NHSE). Maternity cases were raised as an issue at every Quality and Compliance Steering Group, from the very first one in 2013, and within the CCGs' written escalatory reports to NHSE every single month. However:

- The CCGs' professional challenge *"was met with anger and defensiveness by the Trust, always, no matter whether it was a financial challenge or clinical challenge"*.
- *"[Y]ou took a deep breath to have the conversations before you picked up the phone or you met with them."*

4.296 A then newly appointed member of the Executive told the Panel of their astonishment at the level of antagonism in the room when attending their first Quality Surveillance Meeting with the CCGs.

4.297 The CCGs were escalating issues long before the CQC report in 2014; however, they found it difficult to gain recognition of their concerns. It was suggested to the Panel that the very people to whom the CCGs were escalating their concerns, particularly around maternity services, were the individuals who had previously commissioned those services. This meant that they didn't have fresh eyes, nor the same sense of the need for action. We were told:

[W]e were escalating to people who had obviously done the same role as us, and had worked with the provider, and accepted that practice … accepted that that was safe and hadn't escalated it, and now we were coming in saying that the same thing wasn't acceptable, so it was quite difficult politically to manage that situation … we weren't getting anywhere through repeated escalation … the lady who led the bomb-shell CQC inspection … was instrumental in getting everybody on the same page.

4.298 Another CCG officer told the Panel that the key issue in 2013 was trying to get people to believe the CCGs' concerns. They couldn't be sure whether the problems at the Trust had been there for some time but had not been picked up (and the CCGs were able to identify them because they had the benefit of fresh eyes), or whether there had been a rapid deterioration just before the CCGs took over commissioning. They commented:

[S]ome days you almost felt like you were going mad because … it just felt like people would not listen … we continually raised concerns at meetings like the Quality Surveillance Group.

4.299 The Panel was told that *"getting everyone on the same page"* was crucial because, prior to the CQC inspection and report in 2014, some people were saying that the Trust wasn't as bad as the CCGs were saying, and it was crucial for the commissioning of recovery plans for there to be a common understanding. We were told:

[T]he Trust thought they were exemplars of best practice and there was a real arrogance back in 2013 … they would say it in public meetings, "we are the best acute trust in the country, we are innovative, we are clinically excellent, we are the safest place to be" … they would narrate it … over and over to try and make it become fact … you then had NHSE saying, "yeah we haven't really got any specific issue" … and then you had us … shouting, "… they're not financially stable, their leadership is falling apart … they're not a cohesive leadership team … they're not safe from a clinical and patient safety perspective … there are many gaps, and then they've got big cultural issues, huge cultural issues around their geographical base".

4.300 However, the Panel was told that, even after the 2014 CQC report was published, there was no acceptance at Board level that it was accurate until there were major changes at Executive level in the Trust. The appointments of new members of the Executive contributed to a more collaborative relationship.

4.301 We heard that one of the things that the CCGs identified from the start in 2013 was that the Trust had a very high turnover of senior leaders in midwifery and lacked a Board lead for paediatrics. The Board lead for midwifery (the Chief Nurse) didn't have midwifery experience. The CCGs tried to work on these issues with NHSE.

4.302 Another Trust-wide issue that the CCGs identified through maternity services was the Trust's approach to serious incidents and learning: how it learned from incidents, near misses and when things went wrong. The Trust's approach was described to us as very tokenistic and it did not use nationally recognised practice or national templates. The CCGs had a battle with the Trust over everything surrounding this issue; the Trust did not identify learning, root causes or relevant systemic contributory factors. There was also evidence of a blame culture that focused much more on midwifery than on obstetrics, and there was an expectation that engagement in serious incidents was more the responsibility of midwifery than obstetrics. However, we also heard that the CCGs believed that, although early reports were not very good

and poor recommendations were made, progress was made later and the quality of reports started to improve.

4.303 A senior member of staff from the East Kent CCGs in 2018 told the Panel that their wider concerns about the Trust were in connection with:

- A large number of Never Events (safety incidents defined nationally as those that should never occur)
- A lack of learning from incidents and a failure to implement actions identified
- Cultural aspects such as a lack of challenge around serious incidents
- Long waits in A&E and poor-quality care
- Failures to follow up patients
- Concerns around medication doses
- Safeguarding and issues around security
- Infection control
- Poor communication with GPs
- A lack of proper processes for the supervision of staff
- Poor Friends and Family Test (patient experience) results
- Concern about the ability of the Trust to sustain a safe Intensive Therapy Unit service.

4.304 The Panel heard that there were also overarching issues around leadership and the ability of leadership to get to grips with the concerns, culture (particularly in relation to staff not feeling able to challenge) and learning (much of what was happening had occurred previously and there was a failure to learn and to implement actions to prevent the same mistakes from happening again).

4.305 A senior member of the CCG told the Panel that the CCG was concerned, as a commissioner, that the Board wasn't as informed as it could have been on some of the quality issues; there was awareness at committee level, but not once issues were escalated to Board level. This did seem to improve a bit as time went on; this appeared to be partly as a result of changes in leadership. There was also a worry about the number of issues that the leadership team was dealing with and its ability to get a grip on all the concerns: for example, the Medical Director, who had to contend with a challenged organisation across three sites, was also the Director of Infection Prevention and Control, and the CCGs had significant concerns about infection control.

4.306 The Panel was told that, at the end of 2019, the CCGs reported that the Board's oversight of maternity services had been poor, but that the situation had started to change; however, there was more external scrutiny happening at this time, so this may have been a factor in the improvement. The new Chief Nurse and a new Head of Governance, both of whom started around June 2019, seemed to make concerns more visible. Within maternity services there was an increase in serious incident reporting, which the CCGs believed was evidence of an improved safety culture (people were more willing to report incidents), there were better systems and training around CTG monitoring, and there were better induction processes for locum doctors. These actions, together with the work of the new Director of Midwifery, provided the CCG with assurance that things were progressing.

4.307 The CCGs raised concerns about leadership (including leadership capacity) with the Trust through discussions with the Medical Director and the Chief Nurse, in system oversight meetings and in the Quality Surveillance Group (QSG).

4.308 CCG officers observed that WHH was hampered by recruitment difficulties and that the midwives and consultants were committed to doing their best for the women using maternity services (*"they're good people, they've got good intentions"*), but the system did not support them – the scale of the challenges at the Trust was so big, and the churn in leadership didn't help. The CCGs' view was that there was also a tendency to seek to resolve problems by appointing new leaders and, when they failed, to see those leaders as the problem rather than the underlying issues.

Care Quality Commission

4.309 The Panel heard:

> *[T]he relationship with CQC and the Trust was absolutely dreadful.*

4.310 The 2014 CQC report identified a significant difference between the Board's perception of how well the Trust was doing and what the CQC found on the ground, including the frustration of staff who described bullying behaviours and a fear of speaking out about things that were problematic. A senior CQC staff member who met with the Panel spoke of the importance of the freedom to speak up as part of a strong, positive safety culture that needed to be embraced more.

4.311 A senior CQC staff member also commented that maternity services and the Trust in general had been stuck at "Requires Improvement" since 2014/15 and that the basic underpinning drivers of quality were not being addressed sufficiently to move the Trust forward to what would be regarded as "Good". It was suggested that this was partly due to the failure to develop a model of care for the large geographical area of East Kent, which is relatively remote from major population centres, and the absence of a long-term strategic plan.

4.312 We heard that, following the CQC report in 2014, the Trust Chief Executive had monthly meetings with Monitor that focused on Trust finances, the performance of A&E and the improvement plan. An Improvement Director was appointed.

4.313 There was a CQC inspection of children's and young people's services at the end of 2018. This raised significant concerns, and the Trust was rated "Inadequate" overall. The CQC issued a Section 64 letter (under the Health and Social Care Act 2008, this requires trusts to provide specific documents and information) as the information provided by the Trust didn't answer the CQC's questions. The CQC was not assured and issued urgent conditions.

Healthcare Safety Investigation Branch

4.314 The first HSIB maternity investigation involving the Trust was in April 2018. We were told:

> *The Trust was quickly branded an outlier as its referral rates were markedly higher than the trusts in the rest of the region.*

4.315 We heard that HSIB had difficulties with its day-to-day operational relationship with the Trust. These included issues such as information requests, staff attending for interview, staff giving their consent to attend for interview and difficulty in getting support with this from the Trust's senior leadership team. The Panel heard that the HSIB team had a *"very difficult reception from East Kent"*, despite its efforts to build good relationships: *"engaging with the governance team at East Kent would be difficult"*. This contrasted with other trusts. Consequently, HSIB investigations were delayed because the relationship wasn't good from the outset. However, an HSIB investigator said that, when they were able to engage with more junior staff, these staff were open and honest.

4.316 In 2018, engagement between HSIB and the Trust included preliminary recommendations from an HSIB review of ten ongoing HSIB investigations, visits to the Trust in October and November (including a presentation on HSIB's work) and a round-table meeting with the Trust in December. The meeting in December identified emerging patient safety themes, including neonatal resuscitation, documentation processes and escalation during care; these were followed up in a letter to the Trust. However, it was clear that the Trust *"did not want to engage with HSIB at all"*.

4.317 The Panel heard that obstetricians did not attend any meetings with HSIB, although they were invited to do so. One HSIB investigator's assessment was that the obstetricians didn't want to engage in such discussions, rather than that they were excluded from doing so:

> *In 2018, obstetricians didn't see incidents – especially those involving midwifery – as anything to do with them.*

4.318 The Panel was told by officers within HSIB that, by the end of 2018 (following seven or eight months of input), HSIB was identifying themes associated with maternity incidents and it had concerns about East Kent maternity services. Its concerns included: failures of escalation; unsupported junior staff; problems with locum doctors and a lack of proper supervision and assessment; the level of neonatal deaths at QEQM; neonatal resuscitation; CTG interpretation; triage, management of reduced fetal movement and ultrasonography; and the home birth and midwifery-led care environment, including fetal monitoring. We heard that HSIB was confident that it had identified the right themes:

> *[B]ut* [HSIB] *knew that they weren't being received very well at the Trust. The Trust was irritated with HSIB. It was as though the Trust thought that HSIB wasn't a regulator and what right did it have to be in the organisation, doing investigations and asking questions? East Kent wouldn't engage. By contrast, in other trusts, HSIB were being received openly, with a view to having a fresh set of eyes on the challenges.*

4.319 There were several recurring themes in the cases that HSIB saw:

- **Escalation:** Recognising women and babies who were deteriorating, reporting this to more senior staff, and those more senior staff responding appropriately; there were also frequent problems with locum staff and how they were recruited.
- **Triage:** Particularly in relation to documentation. At times there was no record that calls from patients were made, who was taking the calls or what advice was being given to patients.
- **Neonatal resuscitation:** Concerns around the geography of the work (e.g. the location of resuscitation trolleys) and the impact on families (rather than concerns about the particular skills of individuals). There was no resuscitation trolley in A&E.

4.320 These issues kept appearing, which indicated to HSIB that sustained change was not happening in response to issues being raised. As time passed, HSIB formed the view that these were longstanding issues. HSIB had three main concerns with East Kent maternity services:

- A high number of referrals in comparison with other trusts – the numbers dropped after the first year and the Trust saw this as an improvement, but when HSIB triangulated this with other information, it was clear that cases just weren't being referred
- Recurring themes – indicating that lessons were not being learned
- Patient safety concerns.

4.321 By early 2019, there was still no improvement in the Trust's engagement with HSIB, so matters were escalated to HSIB's senior maternity team and the CQC. The Panel heard:

> *[N]o changes were being made at East Kent. The Trust had still not returned HSIB's initial roundtable letter, and the same patient safety themes were continuing to harm patients.*

4.322 There was a meeting between HSIB and the Trust's senior leadership team, including clinical leadership, in June 2019; the meeting was described as *"very difficult"*. By this time, the HSIB team had *"grave concerns".* The HSIB team were not made to feel welcome by the Trust (they were kept waiting for 45 minutes in a corridor) and were greeted in an *"incredibly aggressive"* manner by the Trust representatives, with one commenting that *"I don't know why you are here"* and that HSIB's recommendations were *"not needed"*.

4.323 There was a *"heated discussion"* about one of the maternal death cases. There was denial in the Trust about the enormity of the underlying problems and HSIB was not seeing evidence that actions were being taken to change things. An HSIB investigator noted: *"It felt like the issues were being given lip service."*

4.324 As a reflection of the level of concern within HSIB about the performance of East Kent maternity services, a letter was issued to the Trust CEO in August 2019 by Sandy Lewis, Associate Director of the Maternity Programme at HSIB. This was considered a highly unusual step. The letter stated:

> *Given the gravity of the concerns raised and the lack of response to the issues raised, I consider that there may be a serious continuing risk to safety within your Trust.*

4.325 The Panel heard that the Trust's referral rate was 50% higher than that of other trusts with which HSIB was engaged at that time and HSIB was concerned about the recurrence of issues about which it had already made recommendations. HSIB thought that Trust staff *"weren't hearing them when they made recommendations"*.

4.326 HSIB set up quarterly meetings with the Trust from October 2019 for the purpose of monitoring improvements. At these meetings, overviews of national figures were provided together with common investigation themes. An HSIB investigator said:

> *Sadly, these meetings once again highlighted that the patient safety themes at East Kent were not changing.*

4.327 The approach to maternal and neonatal safety was described as *"tick-box"*: for example, following the introduction of safety huddles, poor escalation issues continued to arise, and the Trust's reaction was that it had *"already implemented a solution, so nothing more could be done to improve the situation"*. However, several Trust staff stressed in their interviews with HSIB that the safety huddles were ineffective, as they were developed by senior leadership who did not understand experiences on the shop floor.

4.328 The Panel was told that the Trust also struggled with having a safe space where people could discuss concerns.

4.329 HSIB's clinical oversight concerns revolved around the lack of engagement between midwives and obstetricians and junior staff:

> *The two professional groups don't function as one team. They are separate. There are, of course, individuals who work well together. The result of this is that the two groups don't*

> *provide effective safety for one another and mothers and babies. The communication between teams often leads to confrontation rather than reasoned discussion. They don't respect one another or have the confidence to challenge one another in a helpful and respectful way.*

4.330 In addition, a senior HSIB investigator commented:

> *The Trust board saw patient safety issues as problems with individual staff, rather than as part of their role to improve systems and learning. Patient harm was seen as the shortcoming of staff on the shop floor. There seems to be a great disconnect between the senior team and general staff.*

4.331 An HSIB investigator told the Panel that there was a strong culture of *"pushing things under the carpet"* and not listening to staff who raised concerns. We were also told of a striking disconnect between staff on the ground and the management team.

4.332 The investigator also commented that staff were not good at identifying their own problems. They stated that *"when they do look back they don't seem to be able to see what is glaringly obvious to others"*, and that the Trust had not maintained *"good, open, communicative"* relationships with families who had had bad outcomes, but that more recently this had improved.

4.333 Reflecting on how investigation reports were communicated to the staff who were required to implement them, a midwife cited the example of HSIB reports; the reports were available in hard copy, on a shared drive and circulated by email, but it was demanding for staff to absorb this information while delivering their roles, and quite a challenge to become aware of all the recommendations. It was difficult for staff to understand the detail and significance of the information without making further enquiries, and there was so much going on that information was not always properly digested. In general, recommendations were not conveyed simply and there were no bite-sized chunks of information for staff to digest.

4.334 While the number of referrals from East Kent maternity services had begun to decline and HSIB's relationship with the Trust to improve, Professor Walker explained that HSIB was still seeing *"some of the same problems coming through, particularly about support and staffing, their midwife led care services etc".*

4.335 The Panel heard that the Trust's 72 hour reports were *"very poor"*; they didn't go into detail and HSIB provided training to help improve the quality. However, the reports remained poor. Initially, the Trust would not share these reports with HSIB. The Trust challenged why HSIB would need them and said that *"they aren't there to help you with your investigation".*

4.336 HSIB still saw cases where women presented with symptoms that appeared to be an infection but were sent home without being seen by a senior person, only to return in a more serious state. Professor Walker commented that *"it is about proper assessment, risk assessment, escalation, and things like that … but to be fair the numbers* [became] *less than they were".*

4.337 The most prominent HSIB themes in 2018/19 were guidance, escalation, fetal monitoring, documentation and birth environments. The themes in 2019/20 were guidance, escalation, fetal monitoring, staffing and general clinical oversight.

4.338 Professor Walker told the Panel that, in the early years of HSIB (2018/19), it didn't know how to talk to other organisations. For example, HSIB was contacted by the CQC, which

enquired whether HSIB shared the CQC's concerns about the neonatal and paediatric services at the Trust. HSIB didn't know what information it was able to share and was anxious to maintain its independence. However, HSIB recognised that it had a duty to escalate concerns and found a way to do so without sharing case-specific facts.

Nursing and Midwifery Council

4.339 The Panel was told by Andrea Sutcliffe, the NMC's Chief Executive, that the NMC's involvement in either an individual case or a cluster of cases was dependent on the referrals that came through, which might be determined by lots of local factors. She told the Panel that, while many referrals might indicate a problem, it could be just as problematic if people weren't making referrals, because they weren't recognising problems and dealing with them. She added that, given the relatively small number of fitness to practise referrals made to the NMC, it was difficult to identify organisations with recurring problems. Referrals were affected by the leadership of organisations, and she thought that one of the issues with East Kent was the high turnover of Chief Nurses throughout the period.

4.340 Ms Sutcliffe told the Panel that the NMC received some referrals around maternity incidents at East Kent: *"[I]t was very much on an individual basis, and our analysis shows that quite a lot of these referrals were coming through from families."* In the case of baby Harry Richford, the family referral included four midwives and the NMC opened cases on a further three midwives as a consequence of that family referral. No referral was made by the Trust. Ms Sutcliffe commented:

> *Perhaps we should regard the referral of a practitioner to a regulator by a family as failure of the system. If something has gone wrong, the organisation itself should be dealing with that and doing so in a way that gives confidence to the family that the issues are being addressed appropriately and if there are issues that are to do with fitness to practise of an individual, they should be confident that that individual will get that referral. Whereas what often happens is that we get referrals from families when they've already been let down locally and so we're all compounding loss and distress as a consequence of that.*

4.341 Ms Sutcliffe told the Panel that:

> *If people are scared of the regulator then they're not going to speak up when they should. They're not going to engage with our processes in a meaningful way when they should. One of the things we've been absolutely clear about is making sure that we are improving the fairness of those processes, looking at the context of what is happening and making sure that is fully and properly taken into account.*

4.342 Ms Sutcliffe stressed the importance of regulators such as the NMC, GMC and CQC working together with trust organisations, to collaborate and share information, and to identify the indicators that might show that there is a problem. She told the Panel that the NMC set up its Employer Liaison Service in 2016 to feed back information to trusts, and to provide insight and support as well as helping in some of the training that they might need.

4.343 While continuing to stress the difficulties for a regulator of individuals to identify systemic issues (red flags) based on individual referrals, and the difficulties in taking action, Ms Sutcliffe told the Panel:

> *[I]t is probably fair to say that all of us, and the NMC is in and amongst that, could undoubtedly have done better in joining the dots earlier … If I look back and think "what would we want to do differently now" we would want to have better collaboration.*

General Medical Council

4.344 A senior GMC interviewee confirmed to the Panel that its focus is on the fitness of individual clinicians to practise. However, it receives significant and comprehensive feedback from approximately 60,000 trainees each year, and there had been no mention within that feedback of any issues with maternity services at the Trust. The fitness to practise data did not point to there being an issue either.

4.345 The Panel was told that the GMC gains information from its outreach function and the meetings with the Responsible Officer (RO) and Medical Director at trusts; these have been taking place since 2011/12. There are regular meetings to support ROs with fitness to practise issues and revalidation issues. As part of this work, the GMC has sought to address clinical leadership, which, it acknowledges, can be a difficult area for doctors.

4.346 There are other sources of information, such as revalidation data and surveys of trainee doctors (national training survey data). The GMC established an internal mechanism called the Patient Safety Intelligence Forum that gathers information on organisations and can lead to action such as talking to other organisations, or to instigating enhanced monitoring within the GMC's education functions.

4.347 We were told that the Trust was regarded within the GMC as a concern in general terms from around 2015, but not maternity services at that time. The longstanding challenges at East Kent were with recruitment and retention, the geography of the sites, and the use of locum doctors. However, the specific concerns about obstetrics and gynaecology were more recent. One GMC interviewee thought that they were not raised until early 2020, when the RO told the GMC about the CQC's and HSIB's involvement.

4.348 We were told by GMC staff that the fitness to practise data have not been informative because they involve such a small number of referrals. Making better use of the data would depend on linking them with other sources, and the GMC told us that it had put a lot of effort into working more closely with other regulators in terms of data sharing. The interviewee also made the point that the GMC is aware that teamworking issues can have a significant impact on patient care.

4.349 The Panel heard that information sharing has been challenging for the GMC, and is constrained by its precise legal powers.

4.350 The Panel also heard of the difficulties in dealing with behavioural issues among doctors, as follows:

> [Within] *healthcare regulation and oversight there are a myriad of organisations, and it can lack clarity as to who is doing what, and who is responsible for what … it can be quite confusing, I think it is confusing for patients, and it can be confusing even amongst regulators – who precisely is doing what, and who is responsible for what?* [The GMC is] *responsible for individual doctors in terms of their fitness to practise and their revalidation etc., but where you are talking about lower-level behavioural issues, or cultural issues, or attitudinal issues that are not ideal, but you are not going to strike someone off, that can be a little bit tricky as to who is responsible for dealing with that.*

Local Supervising Authority

4.351 The Panel heard that when the first Morecambe Bay recommendations were starting to be known, the LSA Midwifery Officer (LSAMO) began a gap analysis against the emerging findings.

This continued throughout the year and included the need to make sure that supervision was clear and complemented the clinical governance processes of trusts.

4.352 The first audit of the Trust carried out by the LSAMO was in 2012, and yearly thereafter. The Panel was told that the findings and recommendations of each audit were as follows:

- **2012:** The recommendations made by the LSA included better engagement with feedback from women (the Trust was not particularly strong on this at the time), ensuring one-to-one care in labour, and ensuring that meetings were held with individual midwives on an annual basis.
- **2013:** The LSA revised the supervisory audit to make it more specific to the standards and rules. The LSA also sought evidence prior to the audit – moving from a reassurance model to an assurance model. In looking at compliance with Birthrate Plus,[§] and at learning from incidents, there was a theme around disjointed supervision and clinical governance.
- **2014:** There was improved interface between governance and the supervisors of midwives, but there was still a need for more evidence. The LSAMO arranged an away day for the supervisors of midwives that was facilitated by the Trust and was centred on leadership and working towards improvements as a group. Around this time there was a lack of transparency within supervision generally (not limited to East Kent maternity services) and it was difficult to get people to say who had a problem and where the problem was. It was also a challenge to embed openness and transparency, and to share problems and issues so that improvements could be implemented and midwives could be supported in practice – this was what the teamwork was designed to address.
- **2015:** The audit showed that there was improved governance and that the Trust had a clear policy around governance – supervisors were reviewing all serious incidents. They still needed a little more evidence around this, but the situation was starting to improve. The LSA escalated to the lead CCG the need for a much clearer link between supervision and incidents; this escalation became part of the CQC action plan.
- **2016:** This was the final audit. The Trust was partially meeting most of the standards, but there was still work to be done to ensure that every midwife had an annual review and there were still some issues around making sure that governance was strengthened.

4.353 The Panel was informed that, in 2017, when the LSA ceased supervision, the action plan was handed over to the Trust; the final recommendations and action plan were also shared with the lead CCG.

4.354 The LSAMO told the Panel that they also provided education for supervisors of midwives and held monthly meetings so that good practice from the LSA's audits could be shared. Representatives of service users attended the meetings to provide information about the experiences of women who had used maternity services; this feedback looked positive for the Trust. However, the Panel heard that the supervisors of midwives would always comment about the birth environment, which was a longstanding issue for East Kent maternity services.

4.355 In the LSA's view, governance was also an issue. During this period, the Trust failed to achieve Clinical Negligence Scheme for Trusts (CNST) Level 3 (the best level of rating of risk management in a trust). Governance is at the core of a safe service, and a governance review

[§] A tool to estimate the desirable level of midwifery staffing, taking into account the size and complexity of a maternity service.

had recently been completed by the Maternity Improvement Advisor (MIA), although this could have happened earlier, had it been possible to put feet on the ground.

4.356 The Panel was also informed that a challenge of the LSAMO role was that they supervised a team of people within a trust but they had no formal management control, and the midwives only reported to the LSAMO through the statutory process. Other challenges included the length of time that investigations took and the fact that, although the outcome of any supervision investigation was shared with the trust involved, there was no reciprocal sharing of investigations by that trust, which would have provided greater context.

NHS England/NHS Improvement

4.357 A Trust Board and Executive member told the Panel that the Trust did not receive a great deal of support from NHSE&I.

4.358 Another member of the Trust Board and Executive told the Panel:

> *[T]rying to get the commissioners and NHSE&I to understand, as part of the clinical strategy, that the Trust could not continue to do loads of things in three places was a really long road.*

4.359 We heard from a member of staff of a regulator that, as late as 2018/19, the safety structures within NHSE and NHSI (at that time two separate organisations) did not see the Trust as being a problem.

4.360 The remainder of this section of the chapter (to paragraph 4.385) records the observations of NHSE&I representatives, including an account of actions undertaken by NHSE and NHSI.

4.361 NHSE was alerted by HSIB about the lack of senior engagement in 2019. In response, an intelligence-sharing call was convened with NHS Resolution (NHSR), the CQC, HSIB and the CCGs, which identified the following issues:

- NHSR raised concerns about the Trust being an outlier for claims.
- The Richford family were concerned that the Trust wasn't meeting the requirements of NHSR and CNST. A whistle-blower had also raised concerns about adherence to CNST requirements.
- The CQC expressed frustration about the lack of information coming back to them.
- HSIB raised concerns about the number of cases being higher than the national average and about the "scattergun" nature of the response from the Trust, particularly in relation to the Harry Richford case. There was no evidence of lessons being learned and there were issues with the way in which the Trust was managing the relationship with the family.
- NHSE had concerns about reports from HSIB.
- The CCGs had concerns about how difficult it was to get information from the Trust, CTG monitoring, the multiple action plans, changes in Heads of Midwifery, and the Board not being sufficiently focused on maternity services. The lack of Board to ward oversight and the lack of escalation to the Trust Quality and Safety Committee and the Board were continuous themes.

4.362 A single-item Quality Surveillance Meeting was subsequently held on 10 December 2019 at WHH. HSIB, the CCGs, the CQC, members of the Trust Executive and clinicians from

maternity and paediatrics services attended. HSIB presented its concerns and there was a long presentation from the Trust. We were told by a senior NHSE&I representative that:

> *The trust seemed slightly defensive, as though they were trying to pretend there wasn't a problem. It also felt as though they were trying to do so much that they couldn't see the wood for the trees. They seemed to have difficulty honing-in on the issues highlighted by HSIB and on the cases and the learning from them.*

4.363 After the meeting, there was further discussion among the partners. A senior NHSE&I representative told the Panel:

> *They were concerned about the pace of change, given the long history of problems in the Trust. For example, there had been a lack of action following the RCOG report of 2015. There was a lack of assurance about the changes that were needed. They felt concerned about relationships in the leadership, particularly in relation to the medical director and clinical director roles. HSIB indicated that the head of midwifery had engaged well with them but that she was probably the only one. There was no senior involvement in oversight.*

4.364 There was a concern about reporting lines between the Director of Midwifery and the Chief Nurse:

> *There seemed to be a direct relationship between the director of midwifery and the chief executive, but where was the voice of nursing in that?*

4.365 There were also concerns about whether the Trust was sufficiently focused on the issues that arose from the cases discussed at the meeting, such as escalation, CTG monitoring and fetal distress. It needed to step back and refocus on the key issues. The inquest into the death of baby Harry Richford was due in January 2020 and, as NHSE&I did not feel assured that the Trust had learned from the case, which had happened several years earlier, NHSE&I put some measures in place.

4.366 NHSE&I instigated the Maternity Safety Support Programme (MSSP) and arranged support from the regional team for the Trust Medical Director, the Chief Nurse and the Head of Midwifery to help them with the governance challenges. Actions and events included the following:

- The inquest took place in January 2020.
- The independent review of maternity services was announced in February.
- NHSR sought to recoup funding it had provided for CNST.
- The CQC did an unannounced inspection and produced findings.
- There was a joint relationship visit with the CQC.
- The Chief Midwifery Officer for NHSE&I and the Regional Chief Midwife visited the Trust at the end of January.
- There were meetings with the executive team.
- Additional external support was provided to the Trust, in the form of a former Head of Midwifery, a paediatrician, a neonatologist and an obstetrician.

4.367 A QSG review meeting was held in February 2020; by that stage, the Trust was *"feeling under siege"*. There was also increasing press attention. NHSE&I set up weekly East Kent huddles involving the GMC, the NMC, Health Education England, NHSI, the CQC and HSIB to share intelligence, help coordinate the number of requests being made of the Trust and allow the

Trust to remain focused on improvement. It specifically asked for an overarching plan that would bring together in one place responses to the RCOG report, work on coroners' cases, the BESTT programme and other relevant issues. It also requested a review of the medical workload, especially in relation to the balance between obstetrics and gynaecology. The Trust was working on an improvement model, but maternity services were just one of the Trust's challenges. It was also dealing with the pandemic and several other issues that had escalated.

4.368 The Panel heard from NHSE&I that trusts are often defensive under such circumstances, but that East Kent was particularly so. NHSE&I could see the lack of openness around the cases, and the Panel was told that the Board did not seem to be fully aware of the concerns about maternity services. The Trust wasn't open with stakeholders and providers either. We were told:

> *It felt like that at all levels. There was a lack of openness with families, through to lack of openness with stakeholders such as the CCG. It felt as though they didn't always get the information they should have done from the Trust.*

4.369 The Panel was told that the Trust didn't identify problems partly because it didn't know about them and partly because it didn't want to declare them. For example, the Harry Richford case caught the Executive off guard, until it reached escalation point in October 2019. The Panel heard that:

> *Initially, when support was offered to the Trust, they were reluctant to accept it and it was as though they were trying to prove that there wasn't a problem. There was an acceptance issue. The region had to check regularly that the support was being used continuously.*

4.370 In relation to dealing with inappropriate clinician behaviour, NHSE&I supported action in various ways:

> *The new medical director was doing a good job and making an impact, but this was* [their] *first medical director role and* [they] *needed their help with it. One of the planks of the maternity safety support programme was to help with the relationship issues between midwives and obstetricians.*

4.371 We heard that NHSE&I also provided support to paediatrics. NHSE&I split the paediatric and maternity leadership to enable maternity services to have enough bandwidth to deal with their issues.

4.372 Throughout 2020, NHSE&I was concerned about how the Board was obtaining assurance about the experience of families and patients. It also had concerns about the governance of the organisation and some of the approaches to governance during the pandemic. NHSE&I's view was that the Trust had made some improvements, but the pace of change and oversight by non-executive directors were still concerns. Improvement directors were assigned to the organisation, to help with coordination of the various improvement activities, and Board advisers were provided. NHSE&I requested a rapid governance and leadership review of the organisation, which was done in the autumn. A regional director had fortnightly meetings with the organisation to provide enhanced oversight and to keep traction on the improvement programmes.

4.373 In response to these measures, NHSE&I began to see some improvement in maternity and infection prevention and control issues. The Trust became more open, and we were told that the Medical Director began to contact the regional NHSE&I if there were any issues. The Trust became more receptive to help and support when things went wrong. However, NHSE&I remained concerned about the pace of change. For example, there was a case of maternal

death on New Year's Eve in 2020, and although the Trust reported it immediately, it didn't think that there were any issues of concern. Yet a few days later, NHSE&I received a letter from HSIB that identified several issues of concern:

> *It seemed that depth of understanding and the ability to identify issues hadn't embedded yet. They had made a few steps forward, but it was not enough, and the pace of change remained a significant concern.*

4.374 NHSE&I was concerned about the effectiveness of Board scrutiny, particularly via the Trust Quality and Safety Committee. Ward to Board escalation wasn't really happening:

> *On paper, the governance structure looked fit for purpose but under the surface, there were issues with people's understanding of the governance system and escalation. There was no common approach to safety across the organisation and there were issues around clarity of roles – especially between clinical roles at executive level.*

4.375 The lack of escalation of these issues was attributed by NHSE&I to an ineffective governance mechanism and a lack of openness, which was apparent in incident reports. The culture of openness and learning had not fully embedded in the Trust and a fear of blame partly accounted for that, although NHSE&I had not seen any actual evidence of this.

4.376 In relation to governance structures and escalation in the Trust, there was concern about the strength of Board papers and the depth of information that went to Board committees:

> *Things might have been reported but may not have been in enough depth for oversight and scrutiny.*

4.377 There was also concern about non-executive directors' scrutiny of papers in the Trust:

> *They asked lots of questions but that might have made it difficult to be open when things went wrong.*

4.378 The Trust had gone through a restructure of care groups and NHSE&I had concerns about the strength of leadership in the maternity care group and concerns about what the different committees did:

> *There were a lot of sub-groups in maternity and* [we] *questioned their effectiveness as an eye into the organisation. Also, the fact that the same people were on different groups didn't necessarily make for a robust process.*

4.379 A maternity improvement group was set up; NHSE&I told us it had made sure that it included someone from the CCGs and two representatives from NHSE&I to help them gain assurance and to act as critical friends.

4.380 NHSE&I had several concerns about nursing and midwifery in the Trust, including about nursing leadership on matters such as safeguarding and the Trust's ability to make progress on some of the issues in nursing and midwifery. NHSE&I was also concerned about:

> *… the relationship with the director of midwifery and where the executive clinical nursing role fed into that.*

4.381 Based on many interactions with the Trust, there was a concern about some of the responses of the nursing leadership and its presence in the organisation. NHSE&I provided

support to the leadership, particularly to the Head of Midwifery. The NMC conducted a review to check if nurses and midwives were being referred from East Kent maternity services, and the CQC expressed concerns about midwives.

4.382 One thing that was heard from staff was the following point:

> *[D]espite the challenges, everybody was coming to work every day to do a really good job. There was something about how you balance what are really difficult stories for women, for their families, really difficult incidents, some of them quite historical, with the ability to celebrate the small success and incremental change. It didn't feel as though the Trust had that balance quite right. There was also a need to ensure that staff were briefed in order to support them with tricky conversations or queries from women who may be concerned at the quality of care from adverse media coverage.*

4.383 The role of the NHSE&I Regional Chief Midwife for the South East was created in April 2020 to offer informal support to the Trust's Head of Midwifery on an ad hoc basis, mainly through the MSSP and meetings with the MIA on a weekly basis. The MIA relationship was key – they were there to support the Head of Midwifery, be a critical friend, and help them develop and work through the improvement plans.

4.384 The MSSP first went into the Trust as an action arising from the "Single Item" QSG in December 2019. A team went in to carry out a diagnostic assessment and the midwife lead for that team, along with an obstetrician, provided a report. There was also ongoing feedback and support. However, the pandemic hit and the MIA who carried out the diagnostic assessment was called back to their own organisation. Another MIA was sourced, commencing work in April 2020.

4.385 The feedback to the Regional Chief Midwife about the Trust at that time was that there was improvement although the pace was slow. The principal output from the "Single Item" QSG concerned consultant cover; in response, the Trust was introducing 24-hour support at WHH and improving how cover was provided at QEQM. There was also work around CTG monitoring, and around the aggregated action plan (linking to the Trust's Improvement Director).

Improvement initiatives and programmes

4.386 The Panel was told of improvements beginning in 2018 through the BESTT programme, including strengthened governance (midwife governance leads), the appointment of bereavement midwives, improved fetal monitoring, an improved dashboard, and the achievement of 100% one-to-one care.

4.387 Referring to the BESTT programme, the Panel was told:

> *[S]taff really engaged in it and were keen to be part of the change. By 2018, there were improvements in recruitment. People wanted to work at the trust and at interview, applicants were citing BESTT as a reason why they wanted to work in the trust's maternity services. They noted a big improvement in the trust's reputation on the recruitment front, and students who had trained elsewhere wanted to work there. There were significant improvements in staff survey results and staff felt more supported in engaging in improvement activities.*

4.388 Professor Walker from HSIB told the Panel that one of the problems for trusts is the multiplicity of recommendations that have originated from all over the place, and some of the recommendations disagree with each other:

> *They're getting big hammers coming in and there are too many cooks … The problem is that I'm not sure that their structures and their management structures are in place to encompass that and help the staff achieve that. I'm not sure if some of the changes they've brought in are achieving it … I wasn't convinced that they were on the right track. There're lots of people doing things and committees doing things and people with oversight of things, but I'm not sure that the people on the ground floor are being encouraged to say, "yes you are good, you can be better, let's see how we can do this" … I don't think the solutions are difficult. I think they're just fundamental and at grassroots level, like "let's build this up, let's build the teams, let's build their confidence, let's build the team working, the support". It's really from the bottom up that you want it, not from the top down.*

4.389 An experienced midwife told the Panel:

> *You have to ask yourself, why is it that despite feedback after incidents, complaints, legal claims, despite the robust training programmes that you have in place, do behaviours not change? Why are we still seeing the same themes coming up, not just in one Trust but across the country?*

4.390 The Panel was told by Professor Walker of his reaction to the focus on specific hospital trusts:

> *We've got to stop mentioning hospital names … this is a maternity problem and we've got to take ownership of it throughout the maternity system. That doesn't mean every hospital is bad, but … I think every hospital has got problems and I think we should be looking at that in a global way … But I think we need to rethink how we disseminate information, and particularly how we train and implement change.*

This chapter has explained that, alongside listening to families, the Investigation has conducted interviews with 112 current and former staff at the Trust and with others whose work brought them into contact with the Trust's maternity and neonatal services; and that this was a key part of the Investigation. We would like to thank everyone who was interviewed for their willingness to share their experience with the Panel for the purpose of this Investigation.

It is important to note that these interviews helped shape our findings as set out in Chapter 1 and that this chapter describes what we heard. This chapter should be read as performing that function, not as an indication of the Panel's own thinking or conclusions.

Chapter 5: How the Trust acted and the engagement of regulators

This chapter gives an account of how East Kent Hospitals University NHS Foundation Trust (the Trust) considered maternity and neonatal services and engaged with regulators and others. It draws upon documents and other information that the Investigation has received from the Trust and from organisations and individuals with whom it has engaged.

We refer throughout to the Board of Directors as "the Trust Board" or "the Board".

This chapter sets out how the Trust conducted itself as reflected in its own documents. Nothing included in this chapter should be taken as expressing the Investigation's own findings, except where explicitly stated: its findings are set out in Chapter 1 of this Report.

How the Trust managed maternity and neonatal services

5.1 The Board of the newly constituted East Kent Hospitals University NHS Foundation Trust met for the first time on 2 March 2009. This was the day it received its authorisation as a Foundation Trust.

5.2 As a Foundation Trust, the Trust enjoyed greater freedoms than a non-Foundation Trust, including more financial autonomy. The Trust's Chair and Chief Executive, in their foreword to the 2008/09 Annual Report, said:

> *[W]e now have much greater involvement in our decision-making from local people, including patients and staff, through a new 32-strong Council of Governors, mostly elected by a membership that now exceeds 13,000. Being granted Foundation Trust status is recognition of the standards that have been achieved by the organisation through the expertise, hard work and dedication of our staff. We are now awarded greater freedom to govern ourselves in a way that is responsive and flexible to the changing needs of the people we serve, while continuing to ensure that healthcare is provided in a safe, effective and efficient manner.*[1]

5.3 The Trust Board met for a second time on 27 March 2009. In neither of these inaugural meetings did the Board agenda include consideration of maternity or neonatal services, nor have we seen any reference to them in the papers circulated for those meetings. It is clear from the Annual Report that the Trust was focusing its attention on national priorities, which at that time included waiting times, coronary heart disease and cancer, but not maternity services.

5.4 From the material seen by the Investigation, the first substantive reference to maternity services at the Trust was at the Board meeting on 28 August 2009. At that meeting, the Deputy Director of Nursing introduced a Serious Untoward Incident (SUI) report. Particular reference was made to the changes in reporting maternity cases to the Strategic Executive Information System (StEIS), which is supposed to capture all serious incidents; this had resulted in an

increase in the number of maternity cases on the system. As a result, it had been agreed with the Eastern and Coastal Kent Primary Care Trust (PCT) that from July 2009 only cases where concerns with practice had been raised would be recorded on StEIS. The meeting also noted that neonatal deaths were being monitored by the Trust's Audit Committee and that no formal report was required by the Board.

Internal review and report, 2010

5.5 The first indication of awareness of concerns about maternity services within the Trust came at the Board meeting on 24 September 2010, where the Medical Director gave an overview of a recent SUI within maternity. They reported that the Trust's internal monitoring process had highlighted an increase between April and August 2010 in the number of babies showing symptoms of hypoxic ischaemic encephalopathy (HIE), a type of brain damage that occurs when babies do not receive enough oxygen and/or blood circulation to the brain. They reported that an internal investigation involving a review of medical notes had commenced to establish the facts, and a formal report of findings would be brought to the Board in October 2010. They added that the PCT would be involved throughout the investigation and external midwifery support was also being sought. The Medical Director went on to report that external midwifery support had immediately been put in place at the William Harvey Hospital in Ashford (WHH) due to a concern regarding a potential decrease in skill mix at this unit, which would unfortunately have an adverse effect on other units. This was intended to be a temporary measure and would be reviewed once the internal investigation had ended. Monitor and the Care Quality Commission (CQC) had also been informed.

5.6 At its meeting on 27 October 2010, the Trust Board received a confidential interim report. The report stated that *"during Q1 a higher than expected term admission rate to NICU/SCBU* [neonatal intensive care unit/special care baby unit] *was noted and discussed at the perinatal mortality and morbidity meeting in July. No themes or common factors were identified."* It went on to state that *"concern was raised about midwifery staffing levels at WHH and a 'risk alert' was circulated to midwifery staff"*, and that:

> *… a decision was made to enhance midwifery levels at WHH pending the outcome of an internal review and to do so to close the Buckland Hospital* [Dover] *birthing unit to births to increase staffing levels at WHH. This was communicated as a SUI and both CQC and Monitor informed.*

5.7 The interim report also stated that it *"does not enable any final conclusions as to the standard of care offered at this stage although a number of trends have emerged which largely reflect recognized risk factors for HIE"*. These were that *"46% of babies were born 'through' meconium stained liquor; 53% of mothers were either overweight or obese; 26% of babies showed signs of growth restriction (birth weight < 10th centile)"* and that *"to date 'no suboptimal' or 'minor suboptimal' care has been recorded in over 85% of cases"*.

5.8 The 2010 internal review examined the antepartum management of 91 babies who had an unexplained admission to the NICU or SCBU within the Trust between January and September 2010. In 40% of the cases reviewed, the review highlighted the presence of suboptimal care, and in a third of those cases the suboptimal care was considered possibly, probably or likely to have been a relevant factor in the outcome. Of the 91 babies reviewed, there were 16 perinatal deaths, and significant or major suboptimal care was noted in 4 of those cases. Six babies were identified as likely to have what the review describes as *"long-term handicap"*, and significant suboptimal care was identified in three of those cases.

5.9 More broadly, the review report raised significant concerns about midwifery and obstetric management, midwifery staffing and skill mix, and resuscitation of babies showing signs of shortage of oxygen. The report identified a number of themes, many of which are recurring issues in the reports, inspections and findings that took place between 2010 and 2020.

5.10 The report noted areas of commendable practice, including the prompt and effective response to potential or actual obstetric emergency situations.

5.11 In summarising its findings, the report addressed staffing issues and recommended an urgent review of midwifery staffing at the WHH site. It noted that midwives faced *"the challenge of caring for more than one high risk labouring woman at any one time"*, and that *"an informal poll of trusts in the South Thames region has revealed that staffing/patient ratios in EKHUFT* [the Trust] *are amongst the lowest in the region"*.

5.12 The report also noted that, where the review team identified areas of suboptimal practice, the staff involved received a letter advising them to address that area of their practice, which was copied to their supervisor. While there was a robust arrangement in place within the midwifery profession to learn from incidents and address areas of practice, the report noted that *"arrangements for medical staff are less robust and this will be reviewed"*.

5.13 The report included recommendations such as reminding staff to practise within guidelines, improving diagnosis of labour in low-risk settings, improving standards in fetal monitoring, reviewing clinical guidance and resuscitation arrangements where meconium is present, reviewing the process by which medical staff of all grades learn from adverse events, and reviewing the process of escalating concerns about the progress of labour to more senior staff on call.

5.14 The Medical Director introduced the final report of the neonatal admissions review at the Board meeting on 22 December 2010. They highlighted that there were concerns about midwifery and obstetric management and that *"midwifery staffing levels may limit the provision of safe care across obstetric birthing sites in East Kent"*. It should be noted that at this point in time there were four geographically separate maternity units: WHH, the Queen Elizabeth The Queen Mother Hospital at Margate (QEQM), Canterbury and Dover. This is what was deemed unsustainable, hence the relocation of the two standalone Midwifery-Led Units (MLUs) to be located alongside the obstetric units at WHH and QEQM. In response to a question from a non-executive director raising concerns about 40% of cases having suboptimal care, the Medical Director stated that *"this represented 1.9% of total births"* and that the Trust had not been identified as an outlier in national perinatal statistics.

5.15 The Trust Board was asked to note the recommendation that one standalone MLU remain closed until May 2011 while an urgent review of minimum midwifery staffing levels was carried out. An action plan resulting from this review would be presented to the Board.

5.16 The Assistant Head of Midwifery and the Clinical Director for Women's Health presented the action plan at the Trust Board meeting on 28 January 2011. The Clinical Director for Women's Health emphasised that *"the Trust was operating a safe staff to patient ratio"*. The Board formally noted the action plan.

Report to Monitor and review of maternity services

5.17 Monitor was responsible between 2004 and 2016 (when it became part of NHS Improvement (NHSI)) for authorising, monitoring and regulating NHS Foundation Trusts.

In January 2011, Monitor received an update on the maternity serious incident report described above. This stated that, in response to the findings of the report, the Trust was implementing changes to midwifery and obstetric practice. The Trust also recognised potential concerns with activity and midwifery staffing levels at the high-risk obstetric units.

5.18 The report to Monitor noted that, in view of these concerns, the Trust was carrying out further analysis of midwifery staffing levels at WHH and had embarked upon a review of maternity services across East Kent with the PCT, to be completed by May 2011. Until the outcome of this review was known, the Board had agreed to the closure to births of the MLU in Canterbury, while maintaining daytime services. The Board had also agreed to the reopening to births of the MLU in Dover, which had been closed in September 2010. The Trust maintained that these restrictions enabled the maintenance of enhanced midwifery staffing levels at the high-risk obstetric unit at WHH.

5.19 At the Trust Board meeting on 28 January 2011, the Medical Director reported that they had recently met with staff from the PCT who were carrying out the review of midwifery staffing levels. They referred to the need to inform the local authority's Health Overview and Scrutiny Committee of progress.

5.20 There was no further discussion of maternity services at the Trust Board until 24 June 2011, when a review of the configuration of maternity services was discussed. The review stated that it was the Trust's ambition to *"provide 1:1 midwifery care in active labour corresponding to a midwife to birth ratio of 1:28 at all birth units in line with 'Safer Childbirth' recommendations"*.[2] The average ratio at WHH was 1:40, while at QEQM it was 1:35.

5.21 The options for consultation were discussed at the Board's meeting on 26 August 2011, where the recommendation was made to the Trust Board that:

> *[T]he most sustainable option would be to maintain all services except births and step-down postnatal care at both Dover and Canterbury. This will enable a midwife to birth ratio at Queen Elizabeth the Queen Mother hospital (QEQM) and WHH of 1:28 and will enable the QEQM co-located Midwifery Led Unit (MLU) to be opened.*

This was recorded on the leaflet circulated for consultation as *"Stop births at Dover and Canterbury centres but retain midwife-led antenatal care, day clinics and postnatal support. Open the new midwife-led service at Margate. Increase staffing levels to provide one-to-one care for all mothers."* The Board agreed and consultation commenced on 14 October 2011.

5.22 After consultation, the preferred option was discussed and agreed at the Trust Board meeting on 27 April 2012. In discussion, the Assistant Head of Midwifery stressed that current services were not unsafe. They said that the driver behind the review was to ensure that services were equitable across the Trust, with all women receiving one-to-one care during labour. The Board agreed to the implementation of the preferred option. Although the issue of equitable provision across the Trust was reasonable and clearly dominated the Trust's response, it overlooked the accumulating evidence that there was more to the safety issues than that – in particular, the longstanding cultural problems subsequently described.

5.23 The Trust Board returned to the issue of maternity services on 26 October 2012, when they were featured in its regular "Patient Story" item. This focused on a positive story within maternity services at WHH: 24-hour visiting for patients and more male toilets. It was noted that the Trust had successfully recruited all the midwives who had completed their training at WHH.

5.24 There was no further reference to maternity services until the Trust Board meeting on 30 January 2014, when (under the "Questions from the Public" item) a Trust Governor referred to the Clinical Quality and Patient Safety Report (a Board paper) and the increase in incidents reported to be related to staffing levels. The Governor referred in particular to the Singleton Unit, an MLU at WHH which was fully staffed but reported 18 incidents related to staffing levels. The Chief Nurse agreed to find out the detail behind these incidents and to contact the Governor outside of the Board meeting.

5.25 The Trust Board returned to this theme at its meeting on 28 February 2014, when (again in the "Questions from the Public" item) it was reported that the trend of an increase in staffing incidents recorded had continued since January; this was due to a combination of sickness levels and maternity leave. The recruitment of 14 midwives was under way and the Trust was working through Human Resources (HR) to understand and address the underlying causes of the sickness levels.

5.26 The Canterbury and Coastal Clinical Commissioning Group (CCG) noted at its March 2014 Quality Performance Meeting that it was concerned about maternity services at the Trust. The CQC visited the Trust in the same month and rated it "Inadequate", with maternity services rated as "Requires Improvement", although the CQC report was not published until 13 August 2014.

5.27 In April 2014, the Local Supervising Authority (LSA),* then a designated function of NHS England (NHSE), commissioned a maternal death review, with a panel of clinicians responsible for the care of women during pregnancy and childbirth. The review considered six maternal deaths that occurred in Kent and Medway during the year from April 2012 to March 2013, *"in order to determine whether learning from these tragedies could help improve the future delivery of care"*.[3]

5.28 Quality Surveillance Groups (QSGs) were established by the NHS Commissioning Board (the predecessor to NHSE) in 2013. The intention was for local QSGs to be engaged in surveillance of quality at a local level, with the help of those closest to the detail and most aware of concerns. The members considered information and intelligence but also took coordinated action to mitigate quality failure. The meetings were chaired by the NHS Commissioning Board Area Director, Nursing Director and Medical Director.

Care Quality Commission report, 2014

5.29 The CQC published its findings on 13 August 2014. The overall rating for the Trust was "Inadequate", with findings that it was inadequate in providing safe care and being well led, and that it required improvement to deliver effective and responsive services. Some of the key findings from the CQC were the following:

- There was a concerning divide between senior management and frontline staff.
- The governance assurance process and the papers received by the Board did not reflect the CQC's findings on the ground.
- The staff survey illustrated cultural issues within the organisation that had been inherent for a number of years, reflecting behaviours such as bullying and harassment (staff engagement was among the worst 20% when compared with other similar trusts).

* LSAs were accountable to the Nursing and Midwifery Council (NMC), though their midwifery officers were employed elsewhere, latterly by NHSE. LSAs were responsible for producing supervisory audits of maternity services to ensure the provision of safe and high-quality midwifery care. They ceased to perform this function in 2017.

- Staff had contacted the CQC directly on numerous occasions prior to, during and since their inspections to raise serious concerns about the care being delivered and the culture of the organisation.
- Patient safety incidents were not always identified and reported, and staff use of the incident reporting system varied considerably across the Trust.
- The CQC saw limited evidence of how clinical audit was used to provide and improve patient care and saw examples of where audits had not been undertaken effectively and provided false assurance.
- The CQC found examples of poorly maintained buildings and equipment, and in some cases equipment that was not adequately maintained and was out of date and unsafe.

5.30 Maternity services were given the rating "Requires Improvement".

5.31 The findings of the 2014 CQC report identified a significant difference between the Board's perception of how well the Trust was doing and the experiences of the staff, who described bullying behaviours and a fear of speaking out about things that were problematic. In response to the report, the reaction of the Trust was one of real defensiveness and disbelief.

5.32 The improvement plan for the CQC (which embedded maternity services within it) was reported and discussed at Board level. However, the Board rarely dived into the detail of maternity and neonatal services, and its response was more about monitoring progress against the overall improvement plan (of which maternity and neonatal services were just a part).

5.33 There was a clear disconnect between ward and Board and a perception among midwives that their views were blocked and not escalated appropriately due to "gatekeeping". Governance structures within the Trust were not sufficiently robust to allow ward to Board assurance, and the Trust was not willing or able to actively look for problems and issues to solve, but rather waited for them to be pointed out. The Trust needed to be problem sensing rather than comfort seeking in its approach.

5.34 Maternity services featured very little in Board discussions, despite the concerns that had been raised. Maternity services also did not feature consistently within governance sessions, and there was rarely detailed discussion about maternity and neonatal services at Board level. Issues became diluted, and their significance was not recognised as they were reported up through the chain and repeatedly summarised.

5.35 It remains a concern that a number of themes identified in the 2014 CQC report and in reviews since then have appeared during this Investigation. By way of example:

- At the time of the CQC's initial investigations, staff commented that they were still unable to raise concerns due to the culture at the Trust. The Investigation has heard repeatedly that there was little or insufficient response when concerns were raised by staff.
- Policies were reported as being out of date long after the CQC's initial inspection.
- Lack of support with training has been an ongoing issue (for example, staff being told off for asking questions), and some departments have only recently been requested to participate in formalised training.
- Bullying and harassment remain a significant concern of staff, with some stating that they continue to be negatively impacted as a result of raising a complaint. The suppression of dissent or complaints appears to be an ongoing issue.

- The CQC report identified staffing as an issue across all three sites (Ashford, Margate and Canterbury).

Follow-up to Care Quality Commission inspection, 2014

5.36 Maternity services were discussed again at the 26 September 2014 Trust Board meeting under the "Patient Story" item. The Chief Nurse presented a report which described the experience of a couple during the birth of their first child. The report highlighted the following issues: privacy and dignity not being maintained; a lack of information provided; unprofessional behaviour of some staff; and poor pain control. Since the concerns had been raised with the Trust, the couple had met with the matron and specific actions had been put in place. The Chief Nurse reported that this was not an isolated incident. Matrons and the Head of Midwifery would undertake improvements across all teams.

5.37 In discussion, one of the non-executive directors asked for assurance that there was sufficient resource available to embed the actions and learning highlighted in the "Patient Story". The Chief Nurse stated that staff listening events held following a CQC inspection had enabled staff to discuss their experiences positively. The Chief Nurse added that there were historic cultural and leadership issues which needed to be addressed.

5.38 In October 2014, the regional QSG received a report on the maternal death review and current maternity risks from the LSA. The report identified the following causes for concern: no regional maternity lead in place, which was impacting on the Trust's ability to focus on improvement, and a shortage in midwifery leadership.

5.39 The CCG reported in November 2014 that it was taking action following the CQC inspection. The local CCGs had been meeting with the Trust to gain assurance around both its progress in recruitment and its current birth to midwife ratios. The CCGs were working with the Trust to agree a new approach for holding the Trust to account for the quality of its maternity services, and would be implementing a revised maternity dashboard (a summary of maternity statistics) from the Clinical Network once published.

5.40 In January 2015, an East Kent Maternity Patient Safety Forum was established, following recommendations from the maternal death review.

Bullying and inappropriate behaviour within the Trust and maternity services

5.41 The very significant adverse impact of bullying and harassment, particularly at WHH, was referred to by many staff with whom the Investigation has spoken.

5.42 The 2013 national NHS staff survey recorded that staff engagement at the Trust was in the lowest 20% nationally. The percentage of Trust staff who had experienced harassment, bullying or abuse from other staff in the preceding 12 months (at 31% against a national average of 24%) was one of the Trust's bottom five ranking scores, and it was identified within the survey report as a starting point for local action.

5.43 The position markedly deteriorated the following year (2014), when the national NHS staff survey recorded that the percentage of Trust staff who had experienced harassment, bullying or abuse from other staff in the preceding 12 months had increased to 42% (against

a national average of 23%). Overall staff engagement also deteriorated in 2014 and was again in the lowest 20% nationally. The percentage for staff harassment, bullying and abuse was identified again as one of the Trust's bottom five ranking scores, and again the survey report recommended action.

5.44 The 2014 CQC report published on 13 August 2014 (reflecting CQC inspection visits in March 2014) also identified bullying and harassment within the Trust as a key finding.

5.45 This Report has already referred (in paragraph 1.87) to an anonymous letter sent to the Chief Nurse on 27 October 2014 from a member of staff within maternity services at WHH, which said:

> *I work on maternity at the William Harvey. I'm ashamed to say that I feel intimidated at work. I have been made to look stupid in front of patients and other staff at work. I feel completely unsupported by our most senior staff. At times I dread going to work with certain people … Management and those with authority are not approachable, there is a blame culture, a just get on with it and shut up attitude, slog your guts out and still get grief. It's ok if your face fits, we operate a one rule for one, and another rule for everyone else on maternity … you need to know that at times the unit is an awful place to be.*

5.46 In response to the issues of bullying and harassment raised within the national NHS staff surveys, the 2014 CQC report, the anonymous letter to the Chief Nurse and the concerns of the newly appointed Head of Midwifery (appointed on 1 July 2014), an investigation, led by the new Head of Midwifery and supported by HR, was opened to find out how it felt to work within the Trust's maternity services.

5.47 On 19 November 2014, following interviews with 30 staff, an interim report was provided to the Chief Nurse and Director of HR by a member of staff from the HR Business Partner (Specialist Services Division). The interim report included an account of the following behaviours and issues:

- Prickly, sharp, abrupt and sarcastic senior staff
- Instances of staff being shouted at, criticised and humiliated in front of others
- A daunting and unsupportive environment, with one person describing how they were frightened to attend work
- Staff feeling intimidated and undermined in front of patients, resulting in a loss of confidence and time off work with depression
- Allegations of racism.

5.48 The delivery of the report on 19 November 2014 prompted a meeting later that day between the Head of Midwifery, the Chief Nurse and others, in the course of which the Head of Midwifery was sufficiently concerned to express the view that maternity services at WHH were not safe for patients and should be closed.

5.49 In the event, maternity services were not closed, and the investigation continued. Some 110 members of staff were interviewed in November and December 2014, and just over half reported that they had experienced unsupportive behaviour while working in the Trust's maternity services.

5.50 On 6 February 2015, a consultant obstetrician and gynaecologist wrote to the CQC raising concerns. They had previously worked for the Trust but left because of *"a downward spiral of staff morale following poor leadership"*.

5.51 Following this, the Trust management team received a letter dated 9 February 2015. The Trust has redacted the name of the writer, who stated:

> *I am writing to you on behalf of the midwives and their support staff at the William Harvey Hospital. Following a recent Supervisors Surgery staff have expressed their concerns and distress at the current working environment. I felt this needed to be brought to your attention before the situation deteriorates. The unanimous recommendations from the discussion at the supervisory surgery were: that the concerns stated needed to be escalated; that we should ask for a management meeting with the* [names redacted] *and Human Resources.*

5.52 The writer made a number of requests in the letter, including: *"Improved communication, where staff are listened to and heard with democratic decisions being made for the greater good rather than being dictated to."* The Trust responded on 16 February: *"It has been decided to accept your letter as a raising concern and take forward in accordance with the Raising Concerns Policy and Procedure, a copy of which is provided for your information."*

5.53 On 29 December 2015, a Report Into Raising Concerns was sent to the relevant maternity staff identified in the letter of 9 February.

5.54 Further concerns were raised with the CQC on 23 March 2015, when a midwife rang to say that, following an incident at the hospital, which they described as an *"error of judgement"* on their part, they felt that they had been bullied and victimised as a consequence, in contrast to the Trust's response to more serious incidents involving other staff. They said that they and their colleagues felt there was a culture of bullying at the Trust, that staff were afraid to raise concerns for fear of reprisal, and that such pressures were putting their ability to provide quality care in jeopardy.

5.55 The midwife said that, following the incident involving themself, they had been redeployed in a similar role at QEQM; however, they said this was clearly a *"punishment"* for what they had done, even though their actions had not resulted in an SUI. The midwife added that they were in communication with the NMC in relation to their current issues and stated that it had told them that, based on their evidence, the hospital management did not appear to know what it was doing. The NMC can find no communication relating to this matter.

5.56 In March 2015, the Royal College of Midwives' Regional Officer lodged a collective grievance on behalf of midwives at the Trust. The Trust has informed us that 51 staff signed this letter on 11 March 2015.

5.57 While the 2014 CQC inspection mainly focused on bullying and inappropriate behaviours within midwifery, these problems were not limited to that professional group. In 2015, the Trust commissioned the Royal College of Obstetricians and Gynaecologists (RCOG) to carry out a review and to report on a number of behavioural and performance issues, which included concerns about relationships between midwives and obstetricians (see paragraphs 5.77–5.98).

The Report of the Morecambe Bay Investigation, 2015

5.58 *The Report of the Morecambe Bay Investigation* into serious incidents in the maternity department at the University Hospitals of Morecambe Bay NHS Foundation Trust was published in early 2015. It found that the origin of the problems at the Trust lay in the seriously dysfunctional nature of its maternity service, where the following issues were identified:

- Clinical competence was substandard, with deficient skills and knowledge.
- Working relationships were extremely poor, particularly between different staff groups such as obstetricians, paediatricians and midwives.
- There was a growing move among midwives to pursue normal childbirth *"at any cost"*.[4]
- There were failures of risk assessment and care planning that resulted in inappropriate and unsafe care.
- The response to adverse incidents was grossly deficient, with repeated failure to investigate properly and learn lessons.

5.59 Of particular concern is the fact that, through the spring of 2015, the Head of Midwifery at the Trust had noted the issues and lessons identified within the Morecambe Bay report and sought to raise similar issues of concern with the Trust leadership, but they were not listened to.

5.60 The Head of Midwifery produced a risk assessment dated 11 May 2015 which stated that *"similarities exist between the dysfunctional elements of the Morecombe Bay O&G* [obstetrics and gynaecology] / *Maternity Services MDT* [multi-disciplinary team] *and those within the same department at East Kent Hospitals"*.[5] The risk assessment went on to identify the following areas of risk:

- Poor clinical competence
- Insufficient recognition of risk
- Poor teamworking
- Inadequate clinical governance systems
- Poor-quality investigations – both internal investigations and those undertaken by supervisors of midwives
- Denial of problems
- Rejection of criticism
- Strong group mentality – "musketeers"
- Distortion of truth
- Model answers
- Disappearance of records
- Conflict of roles.[6]

5.61 The risk assessment also noted that *"there were several missed opportunities in dealing with the issues at MB* [Morecambe Bay] *and it is questionable if a similar external review occurred here in EKHUFT* [the Trust] *Maternity Services whether similar missed opportunities would be uncovered"*.

5.62 The risk assessment produced by the Head of Midwifery scored the risk at the Trust as "Extreme Risk – immediate action required".

5.63 The risk assessment was presented at a governance meeting on 12 May 2015, and the Head of Midwifery was due to present their assessment to a wider audience at an away day on 21 May 2015. However, this presentation did not take place.

Further concerns, 2015

5.64 Meanwhile, following the April 2015 regional QSG meeting, a conference call was held on 1 May 2015 between relevant stakeholders to discuss a paper that had been presented by the LSA Midwifery Officer (NHSE South). This identified the Trust as an outlier for maternity-related SUIs in 2014/15 and detailed concerns regarding the Trust's maternity performance: namely eight unexpected admissions to the NICU, two unplanned admissions to the Intensive Therapy Unit (ITU), two neonatal deaths and suboptimal care.

5.65 The intelligence-sharing call agreed that a "deep dive" into maternity services relating to these SUIs should be undertaken by external reviewers. NHSE helped to draw up the Terms of Reference (ToR) for this, and also identified the external clinical reviewers. The Canterbury and Coastal CCG agreed to take the lead. The review was planned to take place before the August CQC visit and the ToR constructed so live learning could take place. A letter from the CCGs to the Trust dated 3 June 2015 confirmed the ToR for an investigation into the management of serious incidents at the Trust.

5.66 The CCGs informed the June 2015 Kent and Medway QSG that the review was planned to take place during July. However, at the end of July the Trust advised NHSE that the "deep dive" was to be incorporated into a wider review of maternity services by the RCOG.

5.67 The meeting also heard that there had been seven serious incidents reported in 2015 involving maternity provision at the Trust.

5.68 On 21 May 2015, at a Closed Board[†] meeting, the Medical Director and the Acting Chief Nurse alerted the Board to cultural issues within obstetrics and gynaecology. A full investigation was taking place. In addition, the Trust was looking formally at serious incidents on StEIS. Early indications were that the situation had not changed.

5.69 The Thanet and South Kent Coast CCGs produced a report on 10 June 2015 which stated that maternity lessons from serious incident investigations were not being embedded. They also reported that the Deputy Head of Midwifery was currently acting as Head of Midwifery, with external support.

5.70 On 26 June 2015, at the Trust's Closed Board meeting, the Medical Director (under "Confidential Items") updated the Board on *"longstanding cultural issues"* in maternity services following concerns raised by staff to the CQC and the subsequent collective grievance (see paragraph 5.56). The situation had improved within maternity services, but further work was required.

5.71 The Trust had commissioned an external review of obstetrics, as, according to the Closed Board papers, *"mortality rates were above the national average"*. This refers to the work of the RCOG, mentioned above.

5.72 In addition, a complaint had been received from a patient who had overheard a conversation between obstetricians about the safety of the service. Obstetricians were invited to discuss their concerns and a review of job plans was being undertaken.

5.73 One of the non-executive directors asked if the issues reported should have been visible through internal governance systems. The Medical Director explained that there had been a

[†] Trusts can hold part of their Board meetings in private. This has generally been referred to as the "Closed" part of the meeting or "Part 2" of the meeting.

long history of cultural issues and leadership gaps within the service, which unfortunately had become normalised. This had been evidenced by the CQC during its visit in 2014.

5.74 The CQC inspected the Trust in July 2015 and rated it as "Requires Improvement". In August, the South Kent Coast and Thanet CCGs stated that they were undertaking further scrutiny following the receipt of a 72 hour report in relation to a maternity death SUI.

5.75 In September 2015, NHSE and NHSI noted that they were following up a perceived lack of pace between the Trust and the four local CCGs in jointly commissioning the RCOG clinical review into maternity services, particularly in agreeing the ToR and initiating a start date.

5.76 A regional QSG report in October 2015 stated that the Trust had reported a number of maternity serious incidents relating to cardiotocography (CTG) misinterpretations that had resulted in significant harm or death of a baby. The CCGs were not confident that training was effective and were seeking additional assurance.

Report of the Royal College of Obstetricians and Gynaecologists, 2016

5.77 The RCOG review was undertaken between 24 and 26 November 2015.

5.78 It was commissioned in response to concerns about the working culture within women's services (including relationships between midwives and obstetricians), inconsistent compliance with national standards among obstetricians, poor governance in relation to serious incidents, staffing, education, supervision of obstetric middle grades and trainees, consultant accessibility and responsiveness, and consultant presence on the delivery suite. The RCOG reported in February 2016 and made 23 recommendations.

5.79 The RCOG report included the following findings:

- Major clinical guidelines for maternity did not reflect current evidence-based best practice. The majority of obstetric guidelines were written by midwives with a lack of obstetric engagement in guideline development. Despite the CQC's recommendation in 2014 that clinical guidelines be updated, the RCOG found that some guidelines had long expired or were inaccurate. The RCOG emphasised that the successful implementation of guidelines required the consultants to take ownership.
- The LSA had in place measures to address the fact that the Trust was the second highest reporter of serious incidents in the area. Recommendations were made for the Trust to provide assurance of safe and effective maternity care services through identification, investigation and learning from the management of serious incidents and effective links with supervisory processes, with evidence of an active learning culture.
- In respect of root cause analysis (RCA) investigations, there was an apparent failure both to address medical practice issues and to make recommendations on issues perceived as not contributing to the outcome. If poor consultant performance was identified during an RCA investigation, the issue would not be reflected in the report's action plans. There was also a perception by the RCOG assessors that only staff involved in an incident got a copy of the RCA report findings, and there was little evidence of wider learning across the two maternity units.
- At WHH, all obstetric consultants participated actively on the labour ward and consultant attendance for labour ward rounds was in accordance with Trust guidelines,

with consultants staying on site beyond their shift if necessary and attending the unit when requested out of hours. At QEQM, however, there were three to four consultants who consistently failed to follow Trust guidelines. The RCOG found that *"this unacceptable practice has continued not to be addressed despite repeated incident reporting with the result that this unit has developed a culture of failing to challenge these poorly performing consultants"*.[7] The interviews conducted by the RCOG assessors revealed significant concerns about the failure of these three to four consultants at QEQM to conduct daily labour ward rounds, review women, make plans of care and attend when requested out of hours.

- Obstetric trainees on both sites reported problems with clinical supervision at weekends, while the absence of consultant input at QEQM during weekends caused increased pressure on trainees.
- While there was some evidence of good multi-disciplinary working, there was no evidence of escalation by either doctors or midwives to the consultant in cases of conflicting emergencies, and there was little evidence of the "fresh eyes" approach to managing complex cases.
- The assessors heard that consultant behaviour at meetings was perceived as disrespectful, but it was behaviour that was tolerated by the consultant workforce and not recognised as a problem. Consultants worked in silos and not between sites; consultants did not interact. The assessors felt that the consultant body should be more respectful and supportive of each other as individuals, and that consultants should aspire to work together between the two sites.
- Assessors repeatedly heard that medical and midwifery staff at both sites considered there was no point in reporting safety issues as no action would be taken by the Trust. In addition, "whistle-blowers" were made to feel unsupported by managers and got minimal or no feedback on the concerns raised. The assessors expressed concerns that staff on both sites were no longer raising concerns about unsafe practices, conduct or performance of colleagues that was affecting patient safety or care, because this had been done in the past without satisfactory resolution and had involved the harassment of staff.
- Other weaknesses identified by the RCOG assessors included a lack of engagement in national audits, poor labour ward facilities and environment on both sites, and high midwifery sickness rates across both sites.

5.80 In addition to a lack of consultant supervision, the RCOG report raised specific concerns about the use of locum registrars. Notably, even as early as around 2009, the Trust was said to be more reliant than it wanted to be on locums. At the time of the RCOG report:

- QEQM was found to be reliant on middle grade locum cover.
- The RCOG found inconsistency in consultant ward rounds on labour wards at both sites, though this was more apparent at QEQM. It also noted vulnerability of the QEQM unit out of hours due to non-attendance and/or reluctance to attend by on-call consultants when requested.
- Obstetric trainees on both sites reported problems with clinical supervision at weekends, including in the daytime, as they covered both obstetrics and gynaecology.
- Only consultants committed to teaching and supervision became educational trainee supervisors, and the RCOG assessors were concerned that this would result in consultants who were not committed to teaching and supervision being on call with middle grade locum doctors, potentially of unknown competence. This in turn would impact on the safety of care in the maternity unit.

5.81 The Investigation heard that, following submission of the report, the Trust had no further involvement with the RCOG despite the RCOG's attempted follow-ups. The Trust told the RCOG that it was unable to communicate how the recommendations were being taken forward because of an upcoming inspection by the CQC, and it did not respond to the RCOG's subsequent request for follow-up information. The Trust also failed to share the RCOG's report with the CQC.

5.82 Upon publication of the RCOG report, the Chief Nurse of the CCGs wrote to the Trust to express concern about the quality of the serious incident investigations. Ahead of a QSG intelligence-sharing call on 22 February 2016, it was made clear that the issues were longstanding and that there was a need for positive action. The CCG sent an email to the Acting Chief Nurse at the Trust.

5.83 A QSG intelligence-sharing call about maternity services took place on 22 February 2016. Following it, the Accountable Officer at South Kent Coast CCG emailed the Chief Nurse at the Trust, stating:

> *Having read the report my only non-clinical comment is that it is a really sad read. This is nothing that we didn't already know and were raising through other routes. The issues around consultant behaviour were visible to me when I was commissioning Maternity services. Whatever the outcome, I think there needs to be an understanding that this is very long standing and therefore the necessary change needs to be beyond what has previously been achieved. Obviously this was a theme through CQC and is being tackled in terms of midwifery culture already – but we would need positive assurance that the changes in train are having an impact and further work to capture the issues around consultants.*

5.84 On 31 March 2016, in internal emails sent between the Medical Director, the Head of Midwifery and the Clinical Lead for Obstetrics, it was suggested that consultant cover on the labour wards exceeded RCOG guidelines at that time. From the Trust's perspective, *"safety regarding the Consultant cover is not an issue"*. Rather, the issue was *"engagement of Consultants with ward rounds and also about them being proactive, in a woman's management of care, rather than reactive – this was seen to be more of an issue on the QEQM labour ward site"*. In what might be perceived as a lacklustre response, the Trust reminded consultants in writing of Trust policy regarding on-call duties on labour wards. The Trust also committed to a two-week audit of consultants on both labour wards; the results identified no significant concerns with regard to consultant attendance or behaviour at WHH, but several concerns at QEQM in relation to consultant non-attendance. The Trust committed to a re-audit within six months.

5.85 The Investigation heard that findings around a culture of consultants being unwilling to attend were challenged by Trust staff. On publication, the report was dismissed and described as *"a load of rubbish"* by some senior obstetricians. A number of staff were also unaware of the report altogether.

5.86 The RCOG report was discussed at a Women's Health Business and Governance meeting on 5 April 2016. However, despite it having been commissioned by the Trust in the first instance, the report was met with resistance, as the following actions demonstrate:

- The Trust informed the RCOG report reviewers of 20 areas of perceived factual inaccuracies, and submitted a narrative pointing out the lack of benchmarking around safety issues and a lack of comment about the workforce.

- Those attending the meeting considered the RCOG's concerns regarding the length of the RCA process but felt the reviewers had not looked at all the medical notes and did not have a full picture.
- One recommendation was dismissed and surprise was expressed that the RCOG had not identified another issue as a strength.
- The draft action plan included circulation of the RCOG e-learning resources to be accessed by all consultants. However, it appears that these resources were only circulated in August 2016, approximately four months after the meeting.

5.87 On 6 April 2016, the Trust Quality Committee reported that initial information from the recent RCOG report showed that, in the Committee's view, the Trust did not have an unsafe maternity service, but there was improvement work to do around how the service was run in some areas. The Closed part of the Board meeting heard that the Trust was developing an action plan in response to the RCOG recommendations.

5.88 The view that the unit was not unsafe was restated by the Head of Midwifery at a Quality Committee meeting on 4 May 2016. They advised that when they had joined the Trust there had been leadership concerns; many staff in post were acting rather than substantive; there were many vacant substantive posts; there was poor compliance with audit findings and guidelines; there was a lack of equipment; and there was no progression of maternity services in line with national standards. They set out a list of achievements in the previous year, and a non-executive director congratulated them on leading a transformation from poorly led to well-led midwifery services. The agenda item concluded with the Chair recalling that there had been questions raised at the last meeting about whether this was a safe unit. The Head of Midwifery advised that it was. The meeting was told that, compared with national figures, there were low mortality rates for babies at the Trust.

5.89 While the Trust challenged the RCOG report and deemed itself not unsafe, it was felt by Thanet CCG in April 2016 that concerns about maternity services met the threshold for NHSE to call a risk summit.

5.90 An action plan specific to the RCOG report was created in May 2016, with actions to be implemented by the end of October 2016. However, the Panel heard that the RCOG action plan was *"more of a tick box"* in comparison with the CQC investigation. Subsequently, the decision was taken to address the RCOG report within the Trust's general improvement plan. The Panel was told that this meant the response to the RCOG report became diluted and there was insufficient focus on maternity issues.

5.91 The improvement plan was not implemented completely as there were difficulties in securing the full engagement of those at the Trust. The Panel heard that, had the plan been fully implemented on time, it would have *"done the job"*. The improvement plan was then subsumed into the Birthing Excellence: Success Through Teamwork (BESTT) Maternity Transformation Programme in 2017. While it was considered a response to the RCOG report, the BESTT programme was built around a national agenda and some themes from the RCOG review were not included, such as halving the rate of stillbirths.

5.92 The risk arising from regulatory non-compliance in maternity was recognised as presenting an "extreme" risk, with potential harm to both pregnant women and neonates, and was approved as a risk for the Corporate Risk Register (CRR 26) in June 2016. This risk assessment was based on the report from the RCOG and gaps identified by the LSA. The challenges in embedding a *"mature and developed patient safety culture"* were approved as a separate "moderate" risk for the Corporate Risk Register in February 2017 (CRR 48), for reasons

including that the RCOG improvement plan was not being delivered on time and there was difficulty in gaining engagement among some teams, resulting in delays in prioritising quality transformation and education workstreams. The minutes from the March 2019 Board meeting record that the maternity residual risk score (under CRR 48) had been modified to a lower value following a positive visit from the CQC, and by April 2019 the risks relating to maternity services had been removed completely from the Corporate Risk Register.

5.93 In 2019, a review of the actions in response to the 2016 RCOG report found that these were incomplete and that fewer than 25% of the actions were robust and signed off. It was not until 2020, following the coroner's findings in respect of the death of baby Harry Richford, that every recommendation had a corresponding action. The RCOG recommendations were then incorporated into the next phase of the BESTT programme, which began in 2020. It was only in January 2020 that the RCOG report was shared with the General Medical Council (GMC).

5.94 Between publication of the RCOG report in February 2016 and July 2020, just 2 of the 23 recommendations could be evidenced as having been fully met, and only 11 were partially met. The Trust failed to successfully address the issues identified by the report, and any changes that were made were not sufficiently embedded to have any significant impact.

5.95 In a report produced by the Thanet and South Kent Coast CCGs on 10 August 2016, it is stated that a Trust maternity integrated action plan had been agreed in response to quality and safety issues highlighted in RCOG, LSA, CQC and Public Health England external reports and through performance monitoring. The Trust had also recently reported three SUIs in relation to births of twins and had identified some initial learning. The CCGs were seeking assurance through the Heads of Quality and Maternity meeting that learning and mitigating actions were in place during the investigations into the three SUIs.

5.96 Staff continued to raise concerns with the CQC. One example is a letter dated 4 August 2016 from a midwife who worked at the Trust from February 2010 until 2016. It is a long letter but highlighted concerns about the way the midwifery unit operated, including roster rules being broken, skill mix, staff not being consulted, requests for training being refused, a lack of equal opportunities in applying for jobs, high turnover of staff and some staff appearing to be uncaring. The writer acknowledged that these issues may appear trivial when viewed individually, but argued that one should take account of the bigger picture.

5.97 The CQC reinspected some of the Trust's services in September 2016, including maternity services, which it rated as "Requires Improvement" in a report published on 21 December 2016.

5.98 The Trust discussed the RCOG report at its meeting on 9 December 2016, when the Medical Director noted that the issues identified during that review were being addressed. The Chief Executive Officer (CEO) at the time acknowledged the work that was already under way to address the issues highlighted by the RCOG and proposed that concerns raised about engagement could be addressed outside of the Board meeting (via the Trust Quality Committee). NHSE reported in February 2017 that the Trust had stated that its RCOG action plan was being overseen by the clinical lead.

The death of baby Harry Richford

5.99 Harry Richford was born on 2 November 2017 at QEQM. He was the son of Sarah and Tom Richford.

Harry's delivery

5.100 Sarah had an uneventful pregnancy and was considered at low risk. She attended hospital two days before her due date when her contractions started but, following an examination, she was told that she could go home. She returned to the hospital later that evening as her contractions were becoming more painful, and she was admitted to the MLU at QEQM.

5.101 The following morning, 1 November, Sarah was moved to the labour ward for assessment due to lack of progress in labour. She was seen by a registrar, but she did not see a consultant obstetrician while on the labour ward. The CTG, which records fetal heartbeat and contractions, showed decelerations of the baby's heart rate and very frequent contractions suggestive of hyperstimulation of the uterus with Syntocinon, used to accelerate labour. A disagreement took place between the registrar and midwives – in front of Sarah and her family – regarding the appropriate rate of administration of Syntocinon for Sarah.

5.102 Sarah's care was handed over to a locum registrar who commenced a shift at 8pm on 1 November. Sometime around 2.15am, the locum registrar called the on-call consultant to report on Sarah's case – the cervix was fully dilated just before midnight, and she had started pushing just after 1am. The registrar's intention was to bring Sarah to theatre to attempt instrumental delivery for failure to progress and an atypical CTG. The consultant had not met or examined Sarah and was at home as usual when on call. The consultant said that they had offered to come into the hospital, but the registrar declined; it should be noted, however, that a registrar is not in a position to accept or decline a consultant's decision. The registrar was on their third night of providing locum cover at QEQM. The consultant had not worked with or supervised them previously.

5.103 Sarah was taken to theatre at about 3am, and the registrar attempted a forceps delivery, but was unable to lock the forceps blades. Sarah had signed a consent form for a caesarean section, and the locum registrar proceeded to a caesarean section. Up until this point, the atmosphere in theatre was *"not calm but being managed"*. The Panel heard that the tension in the room increased, and the atmosphere became panicked and uncomfortable. A more junior trainee doctor was instructed by the registrar to increase the size of the incision in Sarah's uterus but, having never done this before, they were not confident in doing so. The midwife who had been with Sarah since 8.30 the previous evening was instructed to push Harry's head back up the birth canal, something they had done only twice in their midwifery career.

5.104 Harry was delivered at 3.32am. The Panel heard that the scene in theatre was chaotic and had descended into people shouting at each other. At one stage there were between 20 and 25 people in theatre, but the consultant obstetrician was not yet in attendance. Harry was taken immediately to be resuscitated. The paediatric registrar who attended Harry was a relatively junior doctor and was unable to secure an airway. Harry's father, Tom, was escorted out of theatre, and Sarah asked to be anaesthetised, rather than stay conscious (*"I would rather not be in that room … because I didn't feel safe"*). There was considerable delay in resuscitating Harry and intubation was not achieved for 28 minutes, when the anaesthetist, after administering a general anaesthetic to Sarah, left her side to assist with the resuscitation. The anaesthetist successfully intubated Harry and he was taken to the SCBU for cooling treatment.

The days following Harry's birth

5.105 The consultant obstetrician and the consultant paediatrician on call both spoke to the family after the delivery and told them that Harry was very unwell, and it was likely that he would have cerebral palsy. The consultant obstetrician assured the family that there was going

to be an investigation and told them that they were unhappy with what had happened. The consultant paediatrician told the family that they had looked at the team who had carried out the resuscitation and they had followed protocol. The family recall being told that the paediatric team *"did everything they could".*

5.106 Harry was transferred by specialist ambulance to the NICU at WHH. Sarah and Tom followed later that day. They told the Panel that the week that followed was the worst of their lives. It was unclear whether Harry would survive, and he had seizures over the days that followed. Following an MRI scan showing the extent of damage caused to Harry's brain, Harry died seven days later on 9 November 2017, being held in his parents' arms for the first time since his birth. The cause of death was recorded as HIE.

Investigations following Harry's death

5.107 The weeks, months and years that followed Harry's death involved sustained efforts by his family to seek understanding and truth about what happened during his delivery.

5.108 Harry's death was recorded as a serious incident, and the Trust conducted an RCA. The family had a number of queries which they addressed to the Trust following Harry's death, and they believed that the RCA report would answer all their questions. When, after some delays, the report was made available to the family on 8 March 2018, it raised more questions for them than it answered.

5.109 The Panel heard that the RCA was complex, and more and more issues emerged which required resolution. The magnitude of the investigation was not appreciated by the Trust at the outset, and extensions to the deadline were required.

5.110 The RCA identified problems relating to Sarah's and Harry's care which echoed issues highlighted in the Trust's internal neonatal admissions review in 2010 and the RCOG report in 2016. These included:

- Delay in diagnosing the onset of labour
- Failure to escalate issues to the obstetric team
- Disagreement and communication issues among midwifery and medical staff
- Escalation issues to obstetric consultant and paediatric consultant
- Incorrect CTG interpretation and classification
- Locum registrar on their third night at the Trust whose level of competency had not been assessed
- Difficulties in resuscitation
- Lack of consultant presence in theatre.

5.111 The sense from the family was that the RCA investigation and report were inadequate and did not tell the full truth about what happened to Harry or to Sarah. The family identified a number of errors within the RCA report, such as the level of qualification of the locum registrar, a statement that resuscitation had been carried out in accordance with national guidance, and the complete absence of any critical comment about the lack of consultant attendance. The placenta was not sent for pathological examination as it should have been, and it was acknowledged in the RCA report that it should have been sent for histology at delivery (*"especially when there is a poor and unexpected outcome at delivery of a baby"*).[8] Notwithstanding this failing, the RCA included a comment that *"there is no suggestion that a detailed examination of the placenta would have provided any extra information"*.[9]

5.112 A meeting took place a few days later, on 14 March, between the family and the Trust to discuss the RCA's findings. This meeting appears to have been challenging for all involved (it was described to the Investigation by one member of staff as *"a complete car crash"* for the Trust). The meeting room furniture was disorganised, requiring the family to rearrange it when they arrived; one of the consultants arrived ten minutes late; and another consultant had to be called to attend from Ashford. There were disagreements among the clinicians within the meeting, and inaccuracies and inconsistencies in the report emerged throughout the meeting (for example, whether there were problems relating to CTGs within the unit). The family's impression was that they were treated poorly by the Trust, spoken to like children, and dismissed when they raised concerns.

5.113 A critical issue for the family was the Trust's failure to refer Harry's death to the coroner, a concern which was raised by Tom Richford shortly after Harry died. The RCA report addresses this question as follows:

> *The coroner was not informed as the cause of death was known to be hypoxia and death occurred later than 24 hours from birth. There was a clear sentinel event coupled with difficulty in resuscitation, this fits clearly with HIE. Again coupled with the MRI findings and the MRI report, there was no uncertainty with regards to causation and the death certificate.*[10]

It should be clear that this is a wholly inadequate reason to evade referral to the coroner, when both mother and baby had been healthy at the onset of labour.

5.114 During the RCA meeting on 14 March 2018, the family raised their concerns again, and were told that Harry's case did not need to be reported to the coroner because the Trust knew the cause of death was HIE and death was, therefore, considered *"expected"* because he had been admitted to hospital with severe HIE. The family's natural concern was that the reason for the HIE, and the circumstances that caused it, were not fully understood and required close examination by a coroner. Indeed, the Trust's own internal documents following Harry's delivery identified the outcome as *"unexpected"*; however, his death was recorded on the death certificate as *"expected"*.

5.115 It was only following lengthy discussion at the RCA meeting, during which the Trust representatives finally accepted that Harry's death had been avoidable, that the Trust agreed to speak to the coroner. This action was noted within the RCA report as a recommendation, but it nevertheless took over five weeks, and much contact and follow-up from the family, before the case was referred.

5.116 This practice of delay and avoiding external scrutiny presented itself again in connection with the Trust's obligation to notify NHS Resolution (NHSR) about Harry's death. Under the early notification scheme, the Trust was required to notify NHSR of the death within 30 days. Following enquiries by the Richford family in 2019, it transpired that the notification was only sent to NHSR on 22 March 2018, one week after the RCA meeting with the family and 123 days after Harry had died.

5.117 In June and July 2018, the Trust commissioned independent medical reports into the care received by Sarah Richford and the neonatal resuscitation of Harry Richford. Both reports were critical of the treatment provided by the Trust, yet neither report was shared with NHSE or NHSI at the time. Derek Richford, one of Harry's grandfathers, made a complaint to NHSI in December 2018, raising concerns that the Trust was not learning from incidents. The response from the Medical Director was that lessons had been learned by the Trust, and that on receipt

of the report from the Healthcare Safety Investigation Branch (HSIB), which was due in January 2019, the Trust would put in place a further action plan.

5.118 HSIB is an organisation which acts independently to investigate incidents and develop recommendations to improve patient safety. The Richford family had referred Harry's case to HSIB in April 2018. When HSIB published its report into the care received by Harry and Sarah in January 2019, its findings included:

- The lack of review by a consultant obstetrician during labour
- The use of a CTG interpretation method that was not recommended by the National Institute for Health and Care Excellence
- A failure to meet the requirements of Trust guidance
- Use of a locum registrar without assessing competence or providing appropriate supervision
- The failure of the consultant obstetrician to be present in theatre in accordance with RCOG guidelines and Trust guidelines
- The failure to send the placenta for pathological examination in accordance with Trust policy
- Communication failings between consultants and registrars
- Issues around resuscitation.

5.119 The Richford family also contacted the CQC regarding Harry's case. The CQC's initial assessment was that the issues related to one doctor who had made a mistake, but there were no systemic issues to investigate. Again through the persistence of the Richford family, the issue was escalated to the CQC's Chief Inspector of Hospitals, and in October 2020 the CQC announced that it was prosecuting the Trust in connection with the care provided to Harry and Sarah Richford. In March 2021, the Trust pleaded guilty to an offence of failing to provide safe care and treatment, resulting in avoidable harm to Harry and Sarah. The Trust was fined £761,170.

5.120 Overall, the Richford family felt that the information they received from the Trust was not always truthful, and they had to press and fight to be provided with the information they were looking for about what had happened to Harry. An example relates to the incorrect information submitted by the Trust to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK), which produces annual perinatal mortality surveillance reports. The MBRRACE-UK form for Harry dated February 2019 confirmed (among other inaccuracies) that the placenta had been sent for histology, that the case had been discussed with a coroner (although this was only done following pressure from the family) and that there was a final, agreed cause of death following the results of the inquest and all investigations. This was incorrect as the inquest did not take place until the following year.

The inquest

5.121 The inquest into the death of Harry Richford was held over three weeks in January 2020 before an assistant coroner. In their conclusion, the coroner found that *"Harry Richford's death was contributed to by neglect"*. The coroner's report identified the following failures in Harry's care:

- *Harry was hyperstimulated by an excessive use of Syntocinon over a period of approximately ten hours.*[‡]
- *The CTG reading became pathological by 2am and Harry should have been delivered within 30 minutes, not 92 minutes later.*
- *The delivery itself was a difficult one. It should have been carried out by the consultant who should have attended considerably earlier than* [they] *did.*
- *The locum on duty that night was relatively inexperienced.* [They] *were not properly assessed, if at all and should not have been put in the position of being in charge unsupervised.*
- *There was a failure to secure an airway and achieve effective ventilation during the resuscitation attempts after birth leading to a prolonged period of postnatal hypoxia. The resuscitation afforded to Harry Richford failed to be of an appropriate standard.*
- *There was a failure in not requesting consultant* [paediatrician] *support earlier enough during the resuscitation attempts.*
- *There was a failure to keep proper account of the time elapsing during the resuscitation attempts with the result that control was lost.*

5.122 The coroner also issued a regulation 28 report – a report requiring action to prevent future deaths. This detailed 19 concerns identified during the inquest and the coroner's recommendations as to how they could be addressed to prevent future deaths. The recommendations included:

- Action to ensure proper review and assessment of locums and a reminder that it is the supervising consultant's responsibility to ensure the locum under their supervision is competent and experienced
- A review of Trust processes to ensure clarity around the actions required in the event of an obstetric concern or emergency developing
- A review of procedures to ensure staff understand the circumstances where consultant attendance is required
- Training and learning, including simulation training, covering neonatal resuscitation
- Cross-site paediatric working between QEQM and WHH
- Addressing confusion among staff regarding the guidelines and policies that apply to them, by reviewing staff awareness of governing clinical and operational guidance
- An audit of the quality of record keeping and documentation, as the record keeping on the obstetric unit was substantially substandard
- A review of Trust policies to ensure that the outcomes of independent reports are shared with Trust staff so that important learning takes place to prevent any future deaths.

The Trust's response

5.123 The Investigation was told that Harry's death *"caught the Executive off-guard"*. It was not raised in any detail with the Trust Board until late 2019, months before the inquest began and almost two years after Harry died. This was a significant failure of governance.

5.124 It was only in the aftermath of the coroner's findings and the regulation 28 report that the Trust took meaningful action in response to the failings identified in the Richford case. The Trust

[‡] This was the terminology used, although it should be noted that the hyperstimulation is of the uterus not the baby, leading to hypoxia of the baby.

established a Learning and Review Committee (LRC) with separate workstreams to look at the myriad issues emerging from the Harry Richford inquest, as well as previous investigations such as the RCOG report, the Richford RCA and the HSIB report. The LRC reported to the Board on its implementation of recommendations and actions, and all actions were completed by June 2020, when the LRC became the Maternity Improvement Committee.

Subsequent internal and external scrutiny

5.125 At a QSG meeting on 13 December 2017, the CCG Governing Body's Integrated Quality and Performance Report reported that concerns about maternity safety at the Trust in relation to reporting and escalating incidents had been escalated to the Maternity Performance meeting. The Trust had confirmed that it was providing training and support for staff to change the reporting culture. The Trust had also reported a Never Event within maternity services. This related to an obstetric registrar stitching a vaginal tear using a vaginal tampon, which was then unintentionally left in place after the procedure.

5.126 On 8 December 2017, the Board reported that, to celebrate the BESTT Maternity Transformation Programme, the Chair of the Maternity National Transformation Board had visited the Trust to discuss its transformation work and achievements. The Board recognised the significant progress made by the maternity team as part of BESTT. It noted key achievements so far: 100% of staff had signed up to attend essential life support in obstetrics training; the number of quality assured trainers had increased from 9 in 2016 to 76; and £33,000 had been put towards ultrasound training so that every woman could have a 36-week scan.

5.127 The 6 April 2018 Trust Board meeting discussed an item called "Patient Experience Story". The Chief Nurse asked the Board to note that the learning from this experience had resulted in improvements in teamwork and communication. The patient reported a good experience during the birth of her daughter, but she had become unwell afterwards due to a retained placenta and postpartum haemorrhage. The patient observed a lack of communication between the team and herself. There was no leadership in the room and no clear decision making around the bed, with the main issue not being addressed quickly enough. The patient highlighted that her bed covered in her blood being wheeled into the room had been traumatic for her husband.

5.128 The Trust Chair noted that the story was of a classic postpartum haemorrhage that had been poorly managed. It had changed the way the team shared, learned and addressed mistakes. The learning from the case was that the patient had not felt safe, because the staff were not working together or communicating. It was important for the team to be aware of the finer details. The Head of Midwifery noted that "Human Factors" training (training in human interactions, such as communication and teamwork) was bringing together a cohesive and holistic training approach.

5.129 The BESTT Maternity Transformation Programme had started in 2017 and had brought about a cultural shift, which the Head of Midwifery hoped would continue as more simulation training took place. One of the non-executive directors asked whether any competency issues were being addressed with staff. The Head of Midwifery noted that individual competency elements were included in the action plan, as well as whole team learning.

5.130 The Trust Chair highlighted that the patient's story had shown clearly that the clinical team had not worked well together. The Medical Director noted that perinatal blood loss was a key

measure in the National Maternity and Perinatal Audit, and it was an area on which the Trust now performed particularly well.

5.131 At the Board meeting on 10 August, it was reported that the MBRRACE-UK report on perinatal mortality indicated that the Trust's stillbirth and neonatal mortality rate was above the national average. Investigation had revealed that most of this local variation related to congenital non-survivable conditions.

5.132 In August 2018, the QSG report stated that, following nine serious incidents being reported in the maternity service, the CCG did not have assurance regarding the safety and quality of maternity services at the Trust.

5.133 On 6 September, the Board reported that the CQC had identified maternity as "Requires Improvement". The Closed Board meeting noted that an improvement in maternity services had been recognised at WHH due to the transformational work that had taken place.

5.134 On 4 December 2018, Derek Richford submitted a complaint to the NHSI National Medical Director stating that the Trust was not learning from incidents. NHSI contacted the Trust's Medical Director, who reported that, following the RCA, two independent reviews had been undertaken, by an obstetrician from the Maidstone and Tunbridge Wells Trust and by a paediatrician from the Dartford and Gravesham Trust. They stated that lessons had been learned by the Trust and changes had been made to practice. The HSIB report was due in January 2019 and would contain an assessment, conclusion and recommendations regarding the standard of care received by Sarah and Harry Richford. Following this, the Trust would put in place an action plan. The Trust reported to NHSI that they had told the CCG of this. However, the CCG reported that they only became aware when they declined closure of the RCA due to a number of queries.

5.135 At the Closed Board meeting on 6 December, it was reported that, further to an outbreak of pseudomonas infection in the NICU, no new cases had been reported but the incident remained open until the origin of the infection had been identified. Further to two maternal deaths, the Medical Director explained that there would be a meeting with HSIB in the coming week to compare the Trust's investigation with the HSIB investigation.

5.136 In February 2019, NHSI received an email from the Trust's Quality Improvement Director highlighting current key quality concerns. Maternity was not highlighted as a concern. In March, the CCG reported that maternity services were improving under the new leadership model. However, in May 2019, a letter sent to the Accountable Officer for East Kent CCGs by the NHS England and Improvement (NHSE&I) Director of Commissioning Operations following a formal assurance meeting stated:

> *There remain some significant and persistent quality failures at EKHUFT, which whilst raised appropriately by the CCGs, you have not managed to get action to achieve sustained improvements in the provider. The performance indicators are poor across EKHUFT across a range of areas including; Cancer Waits, Delayed Cancer Diagnosis, Maternity Services, Mixed Sex Accommodation, Never Events and A&E. The CCG will need to ensure that it is taking clear oversight and leadership in these areas.*

5.137 The Divisional Director for Women's and Children's Services returned to this theme at the Closed Board meeting on 4 July 2019. They confirmed that, following their report at the last meeting, they would be reviewing all the current referrals to the NMC, currently a total of ten.

5.138 The Chief Executive commented that, following the discussion at the Board meeting held that morning regarding staff who were under investigation, it was critical the Trust remained resilient as an organisation in supporting those staff and ensuring that the process was undertaken and completed promptly. The Trust needed to be robust in working with external agencies to ensure cases were investigated and closed as promptly as possible.

5.139 On 13 August 2019, the CEO of HSIB wrote to the CQC to say that HSIB had ongoing concerns around clinical safety for mothers and babies in the Trust and the Trust's response to these concerns, which they felt the CQC needed to be aware of.

5.140 On 27 August 2019, NHSE&I wrote to the Trust asking for an update on *"The impact of planned changes to improve labour ward senior medical cover"*. The Chief Nurse responded on 9 September that the Trust was considering extended consultant presence on the labour ward and a second registrar on shift. It was also reviewing guidelines on consultant out of hours cover or presence, and was sharing guidelines from neighbouring trusts for the clinical team to consider, which included examples of rotas.

5.141 The CQC wrote to the Trust on 1 October 2019 stating that it was opening a criminal investigation. The Regional NHSE&I Director referred to the letter as *"pretty unusual"*. In the same month, in a quality report to the NHSE&I Executive Quality Group, HSIB expressed concerns about senior medical cover on the Trust's labour wards.

5.142 At the Closed Board meeting on 10 October 2019, the Chief Nurse noted the current position with regard to the NMC and the 12 open cases for Trust staff, only two of whom remained employed with the Trust. There were five additional cases where the Trust was in liaison with the NMC.

5.143 HSIB returned to its concerns on 12 November, when it reported that the Trust was an outlier for referrals. It raised specific concerns about senior out of hours obstetric cover for the labour wards, escalation and CTG interpretation.

5.144 This culminated in a round-table discussion on 28 November 2019 about the Trust, where it was noted that there continued to be significant concerns with the lack of evidence that the Trust was learning from incidents in order to improve care. Following this, a report was commissioned by the Clinical Regional Quality Manager at NHSE&I. This was completed on 3 December 2019 and, in its introduction, the report said there was concern that there might be a risk to patient safety because the Trust's maternity services had not provided evidence that they were learning from serious incidents. It said that this related to a number of cases investigated by HSIB.

5.145 On 28 November, the Secretary of State for Health's Private Office contacted a Director in the Department of Health and Social Care (DHSC), to report that the Secretary of State:

> *… has asked about an operational incident at a maternity ward at William Harvey hospital in East Kent and whether we have any background. I'm afraid I don't have any further information but if this rings any bells and you are able to provide a factual briefing to share with the SoS I would be most grateful. We also have the option of putting this on the operational Quad agenda if you think it would be worth raising with Simon Stevens.*

A colleague of the Director replied to say that DHSC was unaware of the incident.

5.146 On 29 November, the Private Office official shared a briefing from NHSE&I on the issue. They said:

> *[T]he SE region have taken the decision this week (Thursday 28 Nov) to convene a single-item QSG looking at maternity services at East Kent University Hospitals. This is because they were made aware by the HSIB that the trust's referral rate of cases for investigation was notably higher per 1000 births than the national average.*

5.147 NHSE&I also referred to other actions that had been taken. First, HSIB had written to the CQC expressing its concern, which was the first time it had taken this step. In line with the general trend observed at the Trust, HSIB had referenced a specific death in November 2017, which would be subject to an inquest in January 2020. Second, the NHSE&I regional nursing team had led an intelligence-sharing call with system partners (HSIB, the CQC, NHSR and the CCG) to discuss their respective experiences and concerns, which informed the decision to refer the Trust to the QSG. The DHSC Director responded that *"NHS should do QSG asap"*, and this was relayed by the Private Office to the Secretary of State, who asked whether the QSG meeting was private. A member of the DHSC Director's team responded on 2 December: *"The guidance is clear that the QSG meeting should be conducted in an environment of confidentiality and trust, where members feel able to speak frankly and openly about concerns."* They later confirmed that the meeting had taken place on 10 December.

5.148 On 7 December 2019, the Trust's Chief Executive wrote to the Director of Nursing Professional and System Development at NHSE&I:

> *Having so many regulators involved is difficult re coordination and perspective. Particularly HSIB who as a new organisation (and not a regulator as such) are confusing regarding their role. They also work more slowly as they are building their staffing and competence. In similar circumstances in the past, one of the regulators taking the lead, setting the tone and coordinating the information requests, has been helpful. (NHSR have also been involved in this one too). I think with Shrewsbury going on and the tragic case of the Richford family, one of who is making contact with all regulators, MPs, the press etc, it would be easy for this current set of concerns, to be inappropriately calibrated. East Kent has recent history of a negative kind, of that there is no doubt. It is after all why I ended up here in the first place. However, I can see that the improvement programme is biting and the new leadership, particularly since* [the new Head of Midwifery] *arrived, has been having a great effect in maternity. The consultant leadership has also been changed too.*

5.149 On 12 December 2019, for the "Patient Story" item at the Board meeting, the Chief Nurse introduced Mrs X, who presented her daughter's experience in maternity services. Her daughter had been admitted for a planned induction and had also been diagnosed with pre-eclampsia, but did not receive the level of attention or pain relief she needed. Staff on the ward did not seem to have considered her additional needs and support requirements.

5.150 Mrs X stated that she had contacted the Maternity Matron to raise her concerns. The Maternity Matron had taken the time to listen to what she had to say. The Chief Nurse presented feedback to the ward staff in relation to lessons to be learned from this case, while keeping the patient and her family updated on the actions put in place. Mrs X emphasised the importance of staff considering the patient's perspective and taking into account any pre-existing mental health conditions when delivering care. The Chief Nurse also highlighted that it was vital that staff listened to patients, and drew attention to the importance of having robust handover procedures in place. Patients should have positive experiences while in hospital, and the Chief Nurse was always visible on the wards to allow poor experiences to be raised with them directly.

5.151 In December 2019, the Medical Director presented a report to the Closed Board meeting to inform the Board, following concerns raised by regulators, about trends in perinatal mortality,

external scrutiny and the actions being taken to mitigate risks to patient safety. Key specific issues included CTG interpretation, medical staffing cover and escalation. The Medical Director reported that actions to address these issues included adoption and rollout of physiology-based CTG interpretation, identification of gaps in medical staff cover and actions to address these, identification of additional support requirements, and provision of daily labour ward safety huddles during the day and out of hours.

5.152 The Medical Director referred to the RCOG report, which they said had resulted in the Trust adopting the BESTT improvement and transformation programme. The Chief Executive commented that it would be beneficial to review the BESTT programme and whether it had too large a focus and needed to be revised, defining a few specific key areas going forward. The Chief Executive emphasised the need to increase consultant presence on the labour wards, with a minimum requirement to recruit an additional two consultants. There was also a requirement for additional middle grade clinical support. This would, it was claimed, provide additional support for the oversight of locums.

5.153 On 17 December 2019, the Regional Chief Nurse of NHSE&I wrote to the Trust's Chief Executive, the Medical Director and the Head of Midwifery to follow up the "Single Item" QSG meeting on 10 December. The meeting acknowledged good progress made by the Trust on maternity services but outlined the following areas of concern: medical staffing, leadership, management of care, and learning from a recent coroner's case. NHSE&I listed the support it would like to offer.

5.154 An Extraordinary Trust Board meeting took place on 30 January 2020, with the single agenda item of maternity. The Trust has told us that it can locate no notes of this meeting, and that it was an informal meeting held to consider and discuss the next steps following the inquest into Harry Richford's death and to consider the setting up of an oversight group, with an external Chair reporting to the Board. This oversight group was subsequently established as the Trust's LRC.

5.155 The Board met again on 13 February 2020. The Chair reported that the format of this Board meeting would be amended, as the Board recognised and understood that recent media reports on the Trust's maternity services would have raised concerns with East Kent families who were either currently expecting a baby or who had been under the Trust's maternity care in the past. Acknowledging the importance of this issue, half of the Board meeting would be allocated to discussion and questions regarding maternity services. The Chair explained that the Chief Executive and Medical Director would present their respective reports, and time would be allocated to allow them to receive questions from members of the public. The remaining half of the Board meeting would be used to discuss the other agenda items.

5.156 The Chair extended apologies on behalf of the Board and the Trust to the family of baby Harry Richford for his tragic death and for their heartbreak. Recognising that the Trust had not always provided the right standard of care for every woman and baby in its hospitals, the Trust extended apologies wholeheartedly to those families for whom it could have done things differently. The Chair provided assurance that the Trust had made significant changes to its maternity services in recent years to improve the care of women and their families. The Trust would continue to work to improve its services, ensuring the provision of a high standard of care. It was working with the NHS Maternity Safety Support Programme, which was providing support to the Trust to make rapid and sustainable improvements to its services.

5.157 In the item "Chief Executive's Report", the Chief Executive expressed heartfelt condolences on behalf of the Trust, themself and their colleagues to the family of Harry

Richford and to every family that had not received the level of maternity care they deserved. The Chief Executive acknowledged that any death, and particularly that of a baby, was tragic and touched everyone. They assured the public and the Board of the Trust's commitment to listening to feedback from patients and their families regarding any poor care received and their suggestions for improvement. As well as taking into consideration recommendations regarding areas of suggested improvements, the Chief Executive acknowledged the work required with regard to improving the Trust's culture and listening to patients and their families. They would be extending an invitation to the families who had lost a baby to meet them.

5.158 The Chief Executive reported serious concerns raised in 2014 about inadequate staffing, poor teamwork and inadequate equipment in the Trust's maternity services. This had resulted in the Trust being put into Quality Special Measures. They stated that, since they had been in post as the Trust's Chief Executive, a new maternity senior team had been introduced, with the appointment of a Head of Midwifery and a new leadership team. These changes had resulted in successful improvements to maternity services, as detailed in the Chief Executive's report. The Trust was recruiting six additional consultants as well as middle grade doctors to support the consultants and senior clinicians already in place.

5.159 The Chief Executive confirmed that the CQC was continuing to monitor and review the Trust's maternity services. The Trust was working closely with NHSE&I to support these ongoing reviews. The Trust was also working closely with HSIB, with quarterly meetings taking place.

5.160 The Chief Executive stated that an internal review had been put in place. Its aim was to review and confirm the steps implemented to ensure that the Trust moved in the right direction to achieve the necessary improvements in providing excellent standards of care to every mother and baby who used its services.

5.161 The Medical Director reported that they would be working with external support and would be reviewing all perinatal deaths to identify those that were preventable. The Chief Executive commented that the Trust's staff wished to be associated with a "Trust of excellence", and that all staff were focused and energetic in supporting this improvement programme and would not rest until the Trust, the public and regulators were confident that an excellent standard of care was being provided. The Panel was surprised that the Trust had not been doing all of this before, given how long it had been since very similar problems were first identified.

5.162 The Medical Director highlighted areas of improvement, which included medical engagement, incident reporting, availability and presence of consultants on the labour wards and escalation. They reported the actions recommended by the family at the inquest into the tragic death of Harry Richford and indicated that there had not been sustained and embedded learning within maternity services. The Trust recognised the importance of embedding learning and the need to make changes. The Medical Director also stated that the independent HSIB review of the Trust's maternity incidents reflected themes evident nationally.

5.163 Quarterly meetings were being held with HSIB and key recommendations included medical staff engagement, which, according to the Medical Director, had significantly improved. Other key elements included escalation and communication between staff and the two sites. The Medical Director confirmed that the coroner's conclusion had been received; this included 19 recommendations, of which 2 were national recommendations. The Richford family had also submitted 42 recommendations for the coroner to consider, covering six broad areas as detailed in the coroner's report. They also submitted for consideration support for bereaved mothers with regard to accommodation, a dedicated support worker and counselling. The Medical Director highlighted the changes that had been implemented to date in addressing these

recommendations, and concluded by stating that a programme of improvement work had been put in place around learning and support in midwifery, paediatrics and obstetrics. This would be overseen by the internal overview panel, chaired by an external obstetrician.

5.164 At the Closed Board meeting on the same day, the Medical Director confirmed the completion of the review of all RCAs between 2012 and 2019 in relation to perinatal deaths and identification of any potential avoidable deaths. They reported that 11 deaths had been identified as preventable, with a further 4 potentially preventable. The Chief Executive confirmed that 25 cases had been referred to HSIB, including cases of baby deaths and babies who had recovered after receiving neonatal therapeutic cooling. The Medical Director reported that quarterly meetings continued to be held with HSIB and that update reports from these meetings would be presented to the Trust Quality Committee.

5.165 The Chief Executive confirmed that an independent review into East Kent maternity services would be undertaken by Dr Bill Kirkup. This would include a review of perinatal deaths to identify any potential avoidable deaths.

5.166 On 5 March 2020, East Kent maternity services were discussed at a Health Overview and Scrutiny Committee (HOSC) meeting. The Trust's Deputy CEO introduced the item by saying that the Trust had recognised in 2015 that the position in maternity services needed to improve and had commissioned the RCOG to undertake a review. A HOSC member asked why things had gone so wrong despite the RCOG review taking place in 2015. The Medical Director explained that themes from that review had been repeated in subsequent reports, which suggested that any changes made had failed to be embedded.

5.167 Asked how East Kent residents could be assured that the Trust's Board was adequately monitoring the implementation of best practice, when it had failed to do so in 2015, the Deputy CEO explained that, following the coroner's report, the Trust had established an externally chaired Board (a sub-committee of the main Board) which in turn had seven "task and finish groups", each with their own area of focus. The Chair of the new Board was independent, in order to provide external opinion as well as assurance. The seven workstreams were being overseen by clinicians, which the Trust felt demonstrated a real shift. The Deputy CEO also felt it was important that the Trust accepted the additional clinical support on offer. The Medical Director pointed out that each of those present at the meeting was an East Kent resident and therefore had a vested interest in making the services the best they could be. A consultant said that, as a relatively new employee of the Trust, they felt that the employer was recruiting people with different skillsets in order to build its workforce and that it was being open about the challenges it was facing.

5.168 A consultant acknowledged that there were lots of things to be done, and they were having to be prioritised. Examples of actions that had been, or were being, taken included:

- Remote fetal monitoring (where consultants could monitor a fetus from any location)
- Further investment in training and development for both technical and non-technical skills
- Implementing controls to ensure increased consultant presence on the wards
- Appointment of three specialist midwives (one specialising in the Better Births agenda and two in fetal wellbeing)
- A piece of work to scope out continuing care and what that meant for women and families in East Kent

- Out of hours safety huddles to ensure ward leads had a strategic view of the service at that time
- Investing in and expanding the Getting It Right First Time programme
- The Chief Nurse holding "floor to Board" meetings to gather intelligence and ensure staff felt listened to.

5.169 Meanwhile, the RCOG had offered earlier in the year to provide support to the Trust. This culminated in a site visit to the Trust from 11 to 13 March 2020. The proposed output from this was a service development action plan, a governance action plan and a workforce action plan.

5.170 The Trust Board met again on 12 March 2020, when it received a report from the LRC. The Chief Executive asserted that this provided the Board and the regulators with assurance around transparency and openness, given that the internal review was being externally chaired and led by an independent community representative. The Chair of the LRC reported that they had met with the individual workstream leads and were confident that actions were being taken seriously and implemented. They explained the aim of the LRC in relation to reviewing the Trust's response to the internal review and whether it had implemented the recommendations from previous historical reports. The LRC would also assess whether the BESTT improvement programme addressed these past and current action plans. The LRC would identify the information needed to assure the Board that the Trust's maternity and neonatal services were safe, well led and sustainable. It was noted that the actions in relation to how the Trust employed locums were not yet complete, but the LRC was assured that these were being taken forward and were being appropriately prioritised.

5.171 A non-executive director asked whether there was sufficient engagement, openness, determination and commitment from the Trust's clinicians to support and embed the improvement programme. The Chair of the LRC assured the Board of this commitment from the workstream clinical leads, who were fully engaged and appreciative of being given protected time to undertake this work.

5.172 There was further activity in DHSC relating to the publication of an HSIB report, including briefing to ministers on 24 March. The briefing stated that *"the summary report was produced by HSIB at the request of DHSC. It is not a routine report that HSIB would produce or publish under their maternity investigation programme as maternity reports are only shared with the family and trust. The report has been shared with the Trust."* The briefing continued:

> *We have reviewed the contents of the report and do not think there is anything contentious in it or that it highlights issues that have not already been addressed with the Trust that would prevent it from publication. CQC have shared its report with the Trust and the Trust have published the letter from CQC on their website therefore publication of this report, would be consistent with their approach. The terms of reference for the independent review commissioned by NHS England are in the process of being agreed and this report is not dependent on the outcome of the review.*

5.173 However, in light of the Covid-19 pandemic, DHSC officials advised that publication should be delayed, as it *"may detract media and public scrutiny from the vital work the Trust is doing to respond to the pandemic"*.

5.174 Ministers were again briefed on 25 March, with a draft response to a Prevention of Future Deaths report from the coroner in relation to Harry Richford. The briefing advised that the ministers' response:

> *… highlights the NHSEI and RCOG work on guidelines in relation to locum doctors in maternity services. In addition, the suggested response acknowledges the work undertaken by regulators and other national bodies to scrutinise and support the safety of maternity services at the East Kent Trust; as well as the commissioning by NHSEI of the independent investigation of East Kent maternity services led by Dr Bill Kirkup.*

Chapter 6: Areas for action

Introduction

6.1 Chapter 1 of this Report sets out the findings of the Panel's Investigation of maternity services at East Kent Hospitals University NHS Foundation Trust (the Trust). It describes how those responsible for the provision of maternity services failed to ensure the safety of women and babies, leading to repeated suboptimal care and poor outcomes – in many cases disastrous. It highlights an unacceptable lack of compassion and kindness, impacting heavily on women and families both as part of their care and afterwards, when they sought answers to understand what had gone wrong. It delineates grossly flawed teamworking among and between midwifery and medical staff, and an organisational response characterised by internal and external denial with many missed opportunities to investigate and correct devastating failings.

6.2 Chapters 2 to 5 provide the evidence to support these findings, gathered through family listening sessions, reviews of clinical records and interviews with managers, staff and others. We have reviewed the emerging findings against a large body of documentation provided to us by organisations with an interest in the Trust during the period under scrutiny.

6.3 As indicated in Chapter 1, this chapter puts forward an approach that is different from the norm: in particular, we have not sought to identify multiple detailed recommendations. NHS trusts already have many recommendations and action plans resulting from previous initiatives and investigations, and we have no desire to add to their burden with further detailed recommendations that would inevitably repeat those made previously, or conflict with them, or both. We take those previous recommendations and the resulting policy initiatives as a given.

6.4 Instead, we identify four broad areas for action based firmly on our findings but with much wider applicability. None is susceptible to easy analysis or a "quick fix", but we believe that they must be addressed, because the simple fact is that the traditional approach has not worked: supposedly one-off catastrophic failures have continued to happen, despite assurances that each would be the last. The approach here aims to identify the fundamental problems that underlie these recurrences, however difficult.

Key Action Area 1: Monitoring safe performance – finding signals among noise

The problem

6.5 There is a dearth of useful information on the outcome of maternity services. This may be a surprising statement, because plenty of data are certainly collected; however, a large majority are process measures of dubious significance, such as caesarean section rates. The minority that are related to outcomes are high level and conceal events susceptible to clinical intervention among a larger, unrelated group, such as perinatal mortality.

6.6 The unit-level information that is available tends to be presented in the form of "league tables", based on rankings in some form. These merely serve to conceal the variation between different units, with no indication of whether one or more units at the top or bottom of the rankings are there because they are outliers, or merely through chance. If units are presented only as part of a group, such as the top or bottom ranked 5%, interpretation is even more problematic for an individual unit.

6.7 The Trust exemplifies all these difficulties. It has used high-level information inappropriately as reassurance, taking comfort from the grouping that at least there were other trusts in the same boat. At times, it has used this false reassurance as a bolster against the plethora of evidence from other sources that there were very significant problems in its maternity services.

The future

6.8 There are huge benefits to the effective monitoring of outcomes. Clinicians can see where there is scope to improve effectiveness and address problems of service safety, and evidence from other specialties shows that – perhaps after a little early reluctance – they embrace this enthusiastically, with demonstrable improvement in outcomes and patient safety. Trusts can identify warning signs and take action where necessary, before problems and behaviour become embedded and perhaps intractable. Regulators, including NHS England (NHSE) and the Care Quality Commission (CQC), can identify units that are outliers and investigate appropriately before a trust descends into catastrophic failure. All parties can have a conversation based on relevant shared information about safety performance, rather than what otherwise might become a stand-off based on prejudice and refutation.

6.9 There are two overall requirements. The first is the generation of measures that are meaningful (that is, related clearly and straightforwardly to outcomes); risk adjustable (that is, they take into account the complexity of work in a unit and its effect on outcomes); and available (that is, they can be garnered from among the array of data already routinely collected, as we have no desire to suggest any data returns additional to the large array currently required). They must also be timely.

6.10 The second requirement is that the measures are analysed and presented in a way that shows both the effects of the random variation inherent in all measures, and those occurrences and trends that are not attributable to random variation. The random variation is often referred to as "noise", and the outlying event as the "signal". There are sound, statistically based approaches to detecting the signal among the noise, and presenting this graphically to show not only the level of variation but also the significant trends and outliers in the form of statistical process control charts and funnel plots. Useful work on these techniques is already being carried out by NHSE, but it is important that this is extended to clinically relevant outcome measures.

6.11 Deriving valid measures that meet these requirements is a little more problematic in maternity care than in some specialties because pregnancy and childbirth are physiological in most cases, and poor outcomes are less common. Perhaps this has underlain the lack of progress so far. It is, however, perfectly possible to overcome these problems and generate a suite of outcome measures available for the use of clinicians, units, trusts, regulators and the public. We have resisted the temptation to describe this as a "toolkit" because it is not something optional from which to pick and choose: the approach must be national, and it must be mandatory.

Recommendation 1

The prompt establishment of a Task Force with appropriate membership to drive the introduction of valid maternity and neonatal outcome measures capable of differentiating signals among noise to display significant trends and outliers, for mandatory national use.

Key Action Area 2: Standards of clinical behaviour – technical care is not enough

The problem

6.12 Caring for patients in any setting requires not only technical skills but also kindness and compassion. This is no less true for mothers and babies in maternity care. Yet we heard many graphic accounts, from staff as well as families, that showed just how far from the required standards behaviour had fallen at the Trust. Previous experience has shown the danger in assuming that such serious lapses of such a distressing nature are restricted to one trust alone.

6.13 Failing to meet basic standards of clinical behaviour has obvious effects on colleagues and those receiving care. Unprofessional conduct is disrespectful to colleagues and endangers effective and safe working; it undermines the trust of women. Lack of compassion significantly affects the wellbeing of women, often leading to unnecessary long-term harm. When families are treated unkindly in the aftermath of a safety incident, as is often evident, it compounds and prolongs the harm caused by the event itself. Failure to listen directly affects patient safety, as we found repeatedly in the Trust's maternity services, because vital information is ignored.

6.14 Because compassion is such an integral part of belonging to any caring profession, it is particularly difficult to comprehend how such failures can come about. Whether or not traits of empathy and compassion form part of the selection or assessment of new entrants, the need to be professional and to listen will surely be emphasised as part of initial education and training. What we saw and heard was that it was when clinicians were exposed to the behaviour of senior colleagues that their standards began to slip. The influence of role models, those whose positions more junior staff would aspire to fill one day, can be significantly greater than classroom teaching. If those role models themselves display poor behaviours, the potential is there for a negative cycle of declining standards.

6.15 Once such a negative cycle is established, it can prove remarkably persistent because of another feature evident in the Trust's maternity services: normalisation. Behaviour that would otherwise be challenged becomes tolerated, because "that's the way we do things here". In this way, inexorably, patterns of unprofessional behaviour, lack of compassion and failure to listen become accepted and embedded, to an extent that is genuinely shocking when seen through fresh eyes.

6.16 When such problems are brought to light, perhaps through whistleblowing or external review, they remain difficult to correct. We saw this exemplified in the Trust in the form of the grievance which stopped the investigation of bullying and harassment by midwives in its tracks, and in the failure to address grossly unprofessional conduct on the part of some consultant obstetricians who were refusing to fulfil labour ward responsibilities including attending when on call.

6.17 The Trust is far from alone in finding great difficulty in addressing unprofessional consultant behaviour. Consultants have, or perceive themselves to have, considerable freedom to act on their own responsibility without taking direction from others. The majority, of course, use this freedom wisely in line with their senior and highly qualified status; but in the minority who act unprofessionally, it serves as a shield to deflect any attempt to correct aberrant behaviour. A trust or its medical director who attempts to intervene has few sanctions available other than dismissal, with the prospect of facing lengthy processes and a likely loss at an employment tribunal against a strong legal defence funded by a protection society. This is such an unequal battle that a consultant subject to challenge is often advised to resign and claim constructive dismissal.

6.18 This is not to deny that consultants have sometimes been victimised by trusts, or that their employment rights must be protected fairly; nor is this a question of clinical competence. But it remains the case that a stubborn, poorly behaved consultant can cause havoc in a clinical unit that imperils its performance, as well as the wellbeing of staff and patients over a prolonged period. This cannot be right.

The future

6.19 Compassionate care lies at the heart of clinical practice for all healthcare staff. If some are able to lose sight of that, then it needs to be re-established and re-emphasised. Every interaction with a patient, mother and family must be based on kindness and respect. This will not be achieved through well-meaning exhortation in classrooms or by professional leaders, but through the attitudes and daily behaviour of clinicians themselves, at every level but most particularly those in more senior positions who are role models for less experienced staff.

6.20 Professional behaviour and compassionate care must be embedded as part of continuous professional development, at all levels. It must not be something learned during the earlier academic stages of training, only to be forgotten later.

6.21 There is a need for all staff to acknowledge and accept the authority of those in clinical leadership roles. These are not sinecures to be done for a couple of years on a rotating basis: they are integral to the effective and safe functioning of services. While some clinicians accept this, it is clear that many do not. Those in clinical leadership roles need to have the skills and time to carry them out effectively.

6.22 Reasonable and proportionate sanctions are required for employers and professional regulators so that poor behaviour can be addressed before it becomes embedded and intractable. The existence of such sanctions would itself act as a deterrent to the defiant reactions to challenge exhibited by an unreasonable minority.

6.23 The importance of listening to patients must be re-established as a vital part of clinical practice. This will require it to be embedded not only in continuous professional development, but also in the academic components of early training. The rapid rise in technical and diagnostic possibilities understandably puts pressure on academic curricula, but this must not be to the detriment of skills such as listening.

Recommendation 2

- **Those responsible for undergraduate, postgraduate and continuing clinical education be commissioned to report on how compassionate care can best be embedded into practice and sustained through lifelong learning.**
- **Relevant bodies, including Royal Colleges, professional regulators and employers, be commissioned to report on how the oversight and direction of clinicians can be improved, with nationally agreed standards of professional behaviour and appropriate sanctions for non-compliance.**

Key Action Area 3: Flawed teamworking – pulling in different directions

The problem

6.24 Clinical care increasingly depends on effective teamworking by groups of different professionals who bring their own skills and experience to bear in coordination. Nowhere is this more important than in maternity and neonatal services, but nowhere has it proved more problematic. Where it works well, care can be outstanding, but in almost every failed maternity service to date, flawed teamworking has been a significant finding, often at the heart of the problems.

6.25 Maternity services at the Trust were no exception. The Panel found that there was dysfunctional teamworking both within and across professional groups. The lack of trust and respect between midwives and obstetric staff, and between paediatric and obstetric staff, posed a significant threat to the safety of mothers and their babies. We found many examples of how this caused conflict, made staff feel vulnerable, prevented information from being shared, and encouraged complacency and a lack of accountability. After a safety incident, the most common response was to find somebody to blame for it – often the most junior midwife or doctor involved – preventing important lessons from being learned. The consequences for mothers and their babies were stark.

6.26 There is one feature of flawed teamworking that is particularly striking in maternity care: the divergence of objectives of different groups. A team that lacks a common purpose will struggle, working in an environment of competing interests which may rapidly descend into conflict, inappropriate hierarchies and power plays. It is evident that there was a struggle for "ownership" of maternity care in the Trust, and it is clear that this also applies elsewhere. Rather than contributing as equal partners, midwives may be encouraged to see themselves as being "there for women", defending them from the "medicalisation" of maternity care. This polarisation of approach and objectives cannot help but put them in conflict with obstetricians.

6.27 In this context, the language used around "normal birth" may have significant unintended consequences, raising expectations among women and maternity staff that this is an ideal to be aspired to by all. But it is far from ideal for all, and promoting it unselectively can leave women feeling unfairly that they have failed in some way; in some cases it can expose them to additional risk.

6.28 Poor morale among obstetric trainees is a common feature and contributed significantly to the problems in the Trust's maternity services. Trainees felt pressurised, unsupported and

obliged to carry out clinical tasks they were not ready for; unsurprisingly, there were recruitment difficulties and overuse of locum doctors who were not always properly assessed. Necessary changes to doctors' hours and training have had unintended consequences, including fragmenting care and increasing handovers. They have also removed the "firm" system previously in widespread use, which saw teams of staff with one or several consultants who would work together both in routine practice and while providing on-call services, offering support and increasing knowledge of capabilities and ways of working.

The future

6.29 We need to find a stronger basis for teamworking in maternity and neonatal services, based on an integrated service and workforce with common goals, and a shared understanding of the individual and unique contribution of each team member in achieving them. Crucially, this must be based on an explicit understanding of the contribution of different care pathways and when and how they are best offered. National guidance on this must be the same for all staff involved, and not suggest that there are different objectives for obstetricians and midwives.

6.30 Teams who train together work better together. The most frequent claim of joint training is that it is used in emergency drill training. This is very valuable, but it is not enough. There are opportunities at every stage of training – from undergraduate education onwards – not only to increase understanding of others' roles and responsibilities, but also to become used to working with other disciplines and the contributions they make.

6.31 We need to re-evaluate the changed patterns of working and training for junior doctors, and in particular how the unintended consequences of fragmentation of work and lack of support can be avoided or mitigated.

Recommendation 3

- **Relevant bodies, including the Royal College of Obstetricians and Gynaecologists, the Royal College of Midwives and the Royal College of Paediatrics and Child Health, be charged with reporting on how teamworking in maternity and neonatal care can be improved, with particular reference to establishing common purpose, objectives and training from the outset.**
- **Relevant bodies, including Health Education England, Royal Colleges and employers, be commissioned to report on the employment and training of junior doctors to improve support, teamworking and development.**

Key Action Area 4: Organisational behaviour – looking good while doing badly

The problem

6.32 The default response of almost every organisation subject to public scrutiny or criticism is to think first of managing its reputation, as is evident from a great many instances within the NHS and much more widely. Many risk registers will identify reputational damage in several contexts as something to be mitigated. If this were only a single part of a more complete response that was based on identifying failure and learning from it then it might be considered reasonable. But repeated experience says that it is not.

6.33 On the contrary, the experience of many NHS organisational failures shows that it is the whole basis of the response in many cases. Further, it has clearly led to denial, deflection, concealment and aggressive responses to challenge, in the Trust as elsewhere. Not only does this prevent learning and improvement, it is no way to treat families, who are heartlessly denied the truth about what has happened when something has obviously gone wrong, compounding the harm that they have already suffered. Refusal of scrutiny may extend to the manipulation of information for the CQC, and misrepresenting deaths (for example, as "expected") to avoid inquests.

6.34 In the case of NHSE, there is a particular issue evident when a trust is in difficulties with clinical services: naturally, NHSE wishes to take decisive action and to be seen to do so, but its scope for intervention is limited when problems relate to clinical dysfunction. One of the few levers available is the replacement of chief executives and chairs, and we have seen evidence of a pattern of reaching for this lever repeatedly, with questionable consequences. Of course, there are questions of accountability for failing to act, as we have pointed out, and perhaps of competence; however, much more often it seems that neither is the reason, as individuals were simply moved to equivalent posts elsewhere. The only reasonable conclusion is that NHSE is espousing the idea that a fresh face, or faces, will solve the problems that others could not, described to us as the "heroic leadership" model.

6.35 There are two consequences evident. First, any steps towards recovery will be halted, as staff have to adapt to new ideas and new ways of working. Second, the incentive to be less than frank about emerging problems is intensified, as individuals naturally prefer stability, and having choice over their circumstances of departure.

The future

6.36 The balance of incentives for organisations needs to be changed. The need for openness, honesty, disclosure and learning must outweigh any perceived benefit of denial, deflection and concealment. The current small risk to an organisation does not match the risk of loss of public confidence in one of its vital services.

6.37 It seems that previous attempts to encourage organisations to change this behaviour by identifying the pernicious, damaging consequences for those harmed have not worked – even when taking into account the duty of candour in relation to individual clinical incidents, typically regarded as satisfied by a single conversation. It is time to introduce legislation to oblige public bodies and officials to make all of their dealings, with families and with official bodies, honest and open. This has previously been outlined in a Public Authority (Accountability) Bill, known colloquially as the "Hillsborough Law".

6.38 When families experience harm, the response must be based on compassion and kindness as well as openness and honesty. Healthcare organisations have a lasting duty of care to those affected.

6.39 A review of the regulatory approach to failing organisations by NHSE would identify alternatives to the "heroic leadership" model, including the provision of support to trusts in difficulties and incentives for organisations to ask for help rather than conceal problems. The identification of problems should not be seen as a sign of individual or collective failure, but as a sign of readiness to learn.

Recommendation 4

- **The Government reconsider bringing forward a bill placing a duty on public bodies not to deny, deflect and conceal information from families and other bodies.**
- **Trusts be required to review their approach to reputation management and to ensuring there is proper representation of maternity care on their boards.**
- **NHSE reconsider its approach to poorly performing trusts, with particular reference to leadership.**

East Kent Hospitals University NHS Foundation Trust

6.40 For essentially the same reasons, we have not sought to set out a detailed list of things that the Trust must do – and the Trust has had numerous previous action plans that have not worked. Its problems are not susceptible to top-down point by point guidance: they are at once straightforward and deep-rooted. The new leadership of the Trust will read this Report and can see exactly what has gone wrong and what needs to be put right.

6.41 They are already aware that there are deep-seated and longstanding problems of organisational culture in their maternity units, and they can see spelled out in the words of families and their own staff the nature of the disgraceful behaviour and flawed teamworking that were previously left to fester. They will know what assistance they can commission from external bodies, including NHSE, and must receive full support. They must work in partnership with families who wish to contribute, and report publicly on their approach and its progress. We expect that staff will want to give their full engagement and cooperation, having seen the harm that resulted from previous behaviour that had become normalised.

6.42 The first step in the process of restoration is for all those concerned to accept the reality of what has happened. The time is past to look for missing commas in a mistaken attempt to deflect from findings. The damage caused to families is incalculable, and their courage in coming forward to ensure this came to light is exemplary, but it should not have been necessary. This must be acknowledged without further delay. Only then can the Trust embark on trying to make amends.

Recommendation 5

The Trust accept the reality of these findings; acknowledge in full the unnecessary harm that has been caused; and embark on a restorative process addressing the problems identified, in partnership with families, publicly and with external input.

Appendix A: Terms of Reference

Written Ministerial Statement

Written statement by Nadine Dorries, former Minister of State, Department of Health and Social Care, 11 March 2021

On the 13 February 2020 I confirmed in Parliament that, following concerns raised about the quality and outcomes of maternity and neonatal care, NHS England and NHS Improvement (NHSEI) have commissioned Dr Bill Kirkup CBE to undertake an independent review into maternity and neonatal services at East Kent Hospitals University NHS Foundation Trust (the Trust).

The Review will be known as the 'Independent Investigation into East Kent Maternity Services' (the Independent Investigation).

We take the patient safety concerns at East Kent maternity services very seriously. The Independent Investigation will provide an independent assessment of what has happened with East Kent Maternity and Neonatal Services and identify lessons and conclusions.

The Terms of Reference have been finalised now the views of the families affected have been taken into account and are published today on the Independent Investigation (Independent Investigation into East Kent Maternity Services: https://iiekms.org.uk/) and NHSE website (https://www.england.nhs.uk/publication/independent-investigation-into-east-kent-maternity-services-terms-of-reference). The Terms of Reference include the scope and arrangements that are to be put in place to support its functions and confirm the Independent Investigation will examine maternity and neonatal services in East Kent, in the period since 2009, when the Trust came into being, until 2020. The terms of reference include the scope and arrangements that are to be put in place and confirm the independent investigation will examine maternity and neonatal services in East Kent, in the period since 2009, when the Trust came into being, until 2020.

The Independent Investigation will draw conclusions as to the adequacy of the actions taken at the time by the Trust and the wider system and will produce a report to be disclosed first to the affected families and then to NHSEI as the commissioning organisation and then to the Department of Health and Social Care prior to publication.

The work of the Independent Investigation is expected to complete by the Autumn of 2022 and arrangements will be made for the final report to be presented to the Secretary of State; Ministers will subsequently publish the report to Parliament, and a response will be provided in due course.

A copy of the Terms of Reference will be deposited in the Libraries of both Houses.

Independent Investigation into East Kent Maternity Services Terms of Reference

Introduction

1. Following concerns raised about the quality and outcomes of maternity and neonatal care, NHS England and NHS Improvement (NHS E/I) have commissioned Dr Bill Kirkup CBE to undertake an independent review into maternity and neonatal services at East Kent Hospitals University NHS Foundation Trust (the Trust). The Review will be known as the 'Independent Investigation into East Kent Maternity Services' (the Independent Investigation).

2. This is to set out the Terms of Reference for the Independent Investigation, including its scope and the arrangements that are to be put in place to support its functions, detailed in an accompanying Protocol.

3. Dr Bill Kirkup is appointed by NHS E/I to chair the Independent Investigation into the management, delivery and outcomes of care provided by the maternity and neonatal services at East Kent University Hospitals NHS Foundation Trust during the period since 2009 (when the Trust came into being) drawing upon the methodology followed in the Morecambe Bay investigation.

4. The Independent Investigation was also confirmed in Parliament on 13 February 2020 by Nadine Dorries, Minister of State for Patient Safety, Mental Health and Suicide Prevention. At the same time the Minister announced that the Chief Midwifery Officer, Jacqueline Dunkley-Bent, had sent an independent clinical support team to the Trust to provide assurances that all possible measures were being taken.

Scope

5. The Independent Investigation will examine maternity and neonatal services in East Kent, in the period since 2009, by looking in particular at the following four layers:

i. What happened at the time, in individual cases, independently assessed by the investigation.

ii. In any medical setting, as elsewhere, from time to time, things do go wrong. How, in the individual cases, did the Trust respond and seek to learn lessons?

iii. How did the Trust respond to signals that there were problems with maternity services more generally, including in external reports?

iv. The Trust's engagement with regulators including the CQC. How did the Trust engage with the bodies involved and seek to apply the relevant messages? And what were the actions and responses of the regulators and commissioners?

Purpose

6. The Independent Investigation will provide an independent assessment of what has happened with East Kent Maternity and Neonatal Services and identify lessons and conclusions. This includes:

A. Determining the systems and processes adopted by the Trust to monitor compliance and deliver quality improvement within the maternity and neonatal care pathway.

B. Evaluating the Trust's approach to risk management and implementing lessons learnt.

C. Assessing the governance arrangements to oversee the delivery of these services from ward to Board.

7. The Independent Investigation will draw conclusions as to the adequacy of the actions taken at the time by the Trust and the wider system. Taking account of improvements and changes made, the Independent Investigation will aim to provide lessons helpful to East Kent but also to share nationally to improve maternity services across the country.

8. The Independent Investigation will focus on the experience of the families affected and the actions, systems and processes of the Trust, (with reference to clinical standards for maternity and neonatal care during the period). The Independent Investigation will listen to the concerns of the affected families, use their experience to shape the key lines of enquiry and provide an opportunity for them to be heard. The Investigation should also consider the processes, actions and the responses of regulators, commissioners and the wider system as they are relevant to the provision of maternity and neonatal services at the Trust.

9. The Independent Investigation will produce a report to be disclosed first to the affected families and then to NHS E/I as the commissioning organisation and to the Department of Health and Social Care prior to publication. The Report will be published and presented to Parliament.

10. The Investigation will agree with NHS E/I steps it might take at the completion of its work to help ensure that the lessons identified are understood and acted upon. These steps might include presentations to NHS groups.

Timescale

11. The Independent Investigation will aim to complete its Terms of Reference by Autumn 2022.

Protocol

Access to documents

- All relevant NHS organisations, regulators and the Department of Health and Social Care are required and expected to cooperate with the Independent Investigation as is normal, professional practice, including supplying documentation, as and when requested by the Investigation.

Contact with families and the public

- The Independent Investigation team will be responsible for managing liaison with families whose cases are relevant to the Independent Investigation

Methodology and case review

- The Independent Investigation will decide how best to deliver its Terms of Reference including by drawing upon:

  a. the experiences of families affected by maternity services in East Kent and the impact on those families looking as widely as necessary to understand the whole of that experience and impact;

  b. the medical records of patients;

  c. the corporate records showing how the Trust discharged its responsibilities for

maternity services, how it communicated and engaged with patients, their families and representatives and with regulators and others over concerns with maternity services;

d. interviews with those whose work involved maternity services;

e. interviews with regulators, NHS England and Improvement, HSIB and others;

f. its assessment of what went wrong in individual cases and lessons aimed at ensuring improvements which should be made to maternity services in East Kent and elsewhere.

- In applying its methodology, the Independent Investigation will consider individual cases where there was:
  i. a preventable or avoidable death;
  ii. concern that the death may have been preventable or avoidable;
  iii. a damaging outcome for the baby or mother;
  iv. reason to believe that the circumstances shed light on how maternity services were provided or managed or how the Trust responded when things went wrong.
- The Independent Investigation will take account of other relevant work including the following but will be responsible for reaching its own assessment, findings and conclusions:
  - HSIB Reviews
  - The invited review by the RCOG in 2015/16
  - The invited RCPCH review in 2015
  - Perinatal Mortality Review Tool data and reports
  - Intelligence from the CQC/associated reports/recommendations
  - Letters and findings from HM Coroners
  - Each Baby Counts reviews (the Royal College of Obstetricians and Gynaecologists national quality improvement programme)

Resources and governance

- Resources for the Independent Investigation will be provided by NHS England and NHS Improvement. The Independent Investigation will establish with these resources a team with sufficient expertise and capacity to carry out the work
- The Chair will appoint those with appropriate experience in order to help deliver these terms of reference, including:
  - An expert panel and specialist advisers
  - Secretariat functions
  - Clinical input
  - Legal advice
  - Communication functions
  - Engagement with and support for families
  - Engagement with relevant staff from the Trust
  - Information governance and management

- The Independent Investigation team will keep in regular contact with NHS England and NHS Improvement via the SRO and their team but will not provide a running commentary on the Investigation's findings. Through this contact, NHS England and NHS Improvement will keep in touch with progress of the Independent Investigation, ensure that sufficient resources are available and are being deployed appropriately.
- If the Independent Investigation identifies areas of concern with current patient safety in East Kent Maternity Services, it will contact the Chief Midwifery Officer, Jacqueline Dunkley-Bent in her role described by the Minister in the House of Commons on 13 February 2020.

Consent and information governance

- Specific consent will be sought from the families for their information to be shared with the Independent Investigation team, if initial contact has been via NHS England/ Improvement, or the Trust. The Independent Investigation will secure suitable consent from families for their information to be used as part of the investigation.
- The Independent Investigation will have an information handling and privacy policy that will set out the approach the Investigation takes to handling information appropriately and complying with information legislation.

Fact checking and opportunity to comment

- The Independent Investigation will notify individuals and organisations who are referred to in the investigation's conclusions and provide them with an opportunity to respond to any significant criticism proposed for inclusion in its Report.

Disclosure

- The arrangements will include disclosure first to the families and to NHS England, NHS Improvement and the DHSC so that they are aware of the content of the Report to be published.

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1 The trust was placed on the Maternity Safety Support Programme which involves improvement advisors supporting the trust with maternity improvement.

Appendix B: How the Investigation conducted its work

The importance of independence

B.1 National Health Service England/National Health Service Improvement (NHSE&I) commissioned the Independent Investigation into East Kent Maternity Services in February 2020, following concerns raised by families and others about the quality and outcome of maternity and neonatal care at East Kent Hospitals University NHS Foundation Trust (the Trust).

B.2 From the outset, the independence of the Chair and the Panel of experts was considered key to ensuring the credibility of the Investigation and the confidence of any families who would be involved. A guiding principle was that, in search of the truth, the Investigation should go in whichever direction the evidence took it, both to maximise the likelihood that families would be provided with the information they needed to address their questions and concerns, and to ensure that the knowledge and insights gained would be of benefit to the Trust and the wider NHS. In practice, this meant that we would determine the process we would follow to establish the facts, we would speak without fear or favour, and we would not shy away from difficult or contentious issues.

B.3 Our process was designed to listen to families, to understand their concerns and the reasons why they felt so aggrieved and let down. It was with the families that we first shared messages and updates during the course of the Investigation; and it was with the families that we first shared our findings and recommendations at the conclusion of the Investigation.

B.4 We did this while maintaining independence and objectivity, which is what the families affected would have wanted and what the public would have expected. We endeavoured to maintain a balanced and proportionate approach, as well as a sustained and high-quality level of engagement with those directly affected, at all times showing sensitivity and understanding.

How we worked with families

"Families first" principle

B.5 The Investigation adopted a "families first" approach. This principle is not defined in statute but forms the basis of many investigations and inquiries: for example, it was included in the Terms of Reference for the Hillsborough Independent Panel formed in 2010 in response to the Hillsborough disaster of 1989, and it was used by the Gosport Independent Panel, which reported in 2018.

B.6 Not only did the "families first" principle guide our approach to the gathering and scrutiny of evidence, it also informed how we shared our findings. In particular, our intention

from the start was to make sure that families would be the first to hear the conclusions of our Investigation and to have access to the written Report.

B.7 For the purposes of investigating and reviewing the care families received, access to personal information was needed. To ensure that the Chair and the Panel had the operational independence to determine what lines of enquiry to follow and what evidence to gather and process, Data Controller status was conferred on the investigation team.

Engagement with families

B.8 As set out in our Terms of Reference, the Investigation was tasked with looking at individual cases where there had been: a preventable or avoidable death; a concern that the death may have been preventable or avoidable; a damaging outcome for the baby or mother; or reason to believe that the circumstances shed light on how maternity services were provided or managed or how the Trust responded when things went wrong. Understanding the experiences of the families was a key part of the Investigation process.

B.9 Early on, informal conversations with families took place to answer any questions they had about the Investigation and to assure them of its independence and determination to get to the truth. We also hoped that this would help build a relationship of trust and confidence and alleviate any concerns the families might have had about participating.

B.10 On 23 April 2020, we launched the Investigation formally and invited families who wished to share their experience of the maternity and neonatal services at the Trust during the period 2009 to the end of 2020 to contact us. Then, in October 2020, the Panel Chair appealed for other families to come forward if they wished to, mindful that there needed to be a cut-off date for families to be involved. One year later, on 23 April 2021, we stopped accepting new cases to the Investigation, except in exceptional circumstances where the Panel felt that the cases added significantly to the Investigation's findings.

B.11 The Investigation received approaches from three families who wished their cases to be considered but who, on assessment, were found to be outside the scope of the Terms of Reference. In two other cases, the Panel was not able to review the woman's care because their medical notes were not available. These five cases were therefore not included in the analysis undertaken for the purposes of Chapter 2 of this Report.

Consent

B.12 In every case, we obtained the written consent of each family to:

- Access their clinical records and other documentation relating to their case
- Approach relevant organisations that may have held personal data relevant to the Investigation, and for those organisations to share that personal data with the Investigation team
- Use the information we obtained about their case to develop questions or issues for other witnesses or organisations to answer or explore on an anonymised basis
- Include in the Investigation Report personal information about the experiences they shared with us, on an anonymised basis or with their additional consent if the information may be identifiable.

Family listening sessions

B.13 Our family listening sessions provided the opportunity for families to meet the Panel and talk about their experience of care at the Trust. We encouraged them to tell us what had happened in full, including the impact on themselves. The sessions took place between January and September 2021, and the majority were conducted via video. Where families preferred to meet the Panel in person, arrangements were made at their convenience. Each session was attended by at least two members of the Panel and one of the specialist advisers to the Panel. The Investigation's family engagement lead also attended.

B.14 The family listening sessions were deliberately unstructured, with families given free rein to speak as they wished; the Panel asked questions as the need arose in order to clarify or seek further information. Each session was recorded and families were made aware that all recordings would be destroyed in line with the Investigation's Data Handling and Privacy Information policy at the conclusion of the Investigation.

B.15 All the families who contributed to the Investigation through a family listening session were provided with a summary of their spoken account to ensure that it captured the key facts and essence of their experience. The Panel Chair agreed that any comments made by a woman or a family member during their family listening session would not be attributed to them in the Investigation's final Report without their express permission.

B.16 Families who did not wish to meet with the Panel were given other options: to submit information in writing or to give consent for their records to be looked at without any active participation on their part. A small number took up these offers.

B.17 Importantly, the family listening sessions included mothers, fathers and in some cases other family members. In preparing our Report, we have referred variously to mothers, women, fathers, partners* and, on occasion, husbands. In our use of terminology, we hope that we have followed accurately the circumstances of each family and their wishes. We have kept the terms used simple in order to aid the flow of the Report, but we are mindful of the possibility of situations where the term "birthing partner" would be more apt.

Trauma-informed counselling

B.18 Mindful of the additional anxiety and distress that might be caused to them by the necessity of having to recount and possibly relive their experiences and share personal details, we offered each family the opportunity to attend a session with an expert counsellor after they had met with the Panel. We selected a professional counsellor with extensive experience of working therapeutically with people who have been harmed during healthcare, with professional knowledge and experience as an academic, and with research expertise in trauma-informed counselling for healthcare harm.

B.19 Trauma-informed counselling is based on principles intended to *"promote healing and reduce the risk of retraumatisation for vulnerable individuals"*.[1] This approach takes account of the events or series of events that contribute to a traumatic reaction and includes the principle that self-referenced trauma is as valid as that which is diagnosed clinically. In other words, despite the narrow medical definition of trauma, if people believe that they have suffered from trauma, they should be accepted as having done so. Given that so many families referred to their experience or aspects of their experience as being traumatic, this approach turned out to be wholly appropriate.

* The term 'partners' refers to married and unmarried partners, whether male or female.

B.20 Our counsellor was able to signpost families to other support, when additional or ongoing support was needed.

Individual disclosure

B.21 Because so many of the families had unanswered questions about the care they received or the outcome they experienced, the Investigation Chair undertook to meet with any family who wished to do so after publication of the Investigation Report, to answer any questions that the relevant family may wish to put to the Panel about their individual circumstances.

How we worked with the Trust

Clinical records review

B.22 With the consent of the families involved, as detailed above, and the full cooperation of the Trust, we carried out a thorough review of the clinical records of each woman's and baby's care. This included reviewing original hard copy clinical notes as well as accessing copies of them via a secure online portal.

B.23 The Panel members worked together to review individual records. They also had ongoing access to the online versions, to continue their work individually.

B.24 In addition to the clinical records, the Trust provided other documentation, such as complaints correspondence, investigation reports and exchanges with GPs, which helped the Panel build a picture of the woman's or baby's care and the events surrounding it.

Interviews with Trust Board members, senior managers and staff

B.25 Members of the Trust Board, the senior management team and staff were selected for interview with the Panel based on their period of employment with the Trust, their position (or positions) during that time, their involvement in governance and patient safety matters, and, in some cases, their involvement in particular cases reviewed by the Panel. Everyone invited was considered by the Panel to be in a position to provide information about the management, delivery and culture of the services under review, at both a service and a corporate level, during the period covered by the Investigation.

B.26 They were invited by letter to attend an interview with the Panel. The letter explained that the Investigation had conducted listening sessions with a number of affected families and now wanted to hear from past and present Trust staff, and others, who were involved in the delivery, management and/or regulation of maternity and neonatal services at the Trust during the period under scrutiny.

B.27 We recognised that individuals may wish to be accompanied by a friend, colleague or trade union official, and we offered them the option of bringing one person to support them. However, we were clear that their support person would not be able to answer questions or act in a representative capacity.

B.28 The interviews were arranged at a time convenient to the interviewee and the option was provided to attend in person or via video. Each interview was attended by at least two Panel members. In order to facilitate an open dialogue and to meet the Investigation's Terms of Reference, the Panel Chair agreed that any comments made by an individual during their interview would not be attributed to them in the Investigation's final Report without their express permission.

B.29 In advance of the interviews, individuals were provided with an outline agenda of the themes to be discussed. If they were being invited to discuss a particular case, they were provided with the details in order that they could prepare fully; they were also given access by the Trust to the relevant clinical records.

B.30 The interviews were recorded and a written summary of the interview was provided to each individual. They were made aware that all recordings would be destroyed in line with the Investigation's Data Handling and Privacy Information policy at the conclusion of the Investigation.

Review of Trust records and other material provided

B.31 Corporate records were reviewed to understand how the Trust discharged its responsibilities for maternity services and how it communicated and engaged with patients, with their families and representatives, and with regulators.

How we worked with stakeholders

B.32 An early task was to identify organisations that might have material pertinent to the matters under investigation or that could inform the work of the Investigation more broadly. These organisations were then contacted in order that the work of the Investigation and its Terms of Reference could be explained; we requested that no documents that might have a bearing on the Investigation should be destroyed.

B.33 Following on from this early contact, meetings were set up to establish with each organisation whether they had material of interest to the Investigation and to inform them that interviews might be needed with key staff to explore matters arising from our review of that material.

B.34 While documents were being provided to the Investigation for review, interviews with staff from stakeholder organisations were scheduled.

B.35 The interview process was similar to that described above. Interviews were arranged at a time convenient to the interviewee and the option was provided to attend in person or via video. Outline agendas were provided and the Panel Chair agreed that any comments made by an individual during their interview would not be attributed to them in the Investigation's final Report without their express permission.

B.36 The interviews were recorded and a written summary was provided to each individual. Participants were made aware that all recordings would be destroyed in line with the Investigation's Data Handling and Privacy Information policy at the conclusion of the Investigation.

How we assessed individual cases

B.37 Having reviewed the evidence gathered from families and Trust staff, the Panel met as a group to consider each case in turn and determine where care was suboptimal when assessed against the standards expected nationally and its relationship with the subsequent outcome. This multi-disciplinary process of assessment was key to the Investigation. The findings were structured according to the validated classification of suboptimal care adopted by the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI). Not only did this enable the

Panel to draw evidence-based conclusions about the overall quality and safety of care provided by the maternity and neonatal services at the Trust, but it also allowed us to ascertain the key facts in each case, in order that the Panel could report back to individual families about what had happened in their case.

B.38 The CESDI scoring system comprises four levels of suboptimal care based on the relationship to the outcome (see Table B1).

Table B1: CESDI scoring system

Level of suboptimal care	Relevance to the outcome
Level 0	No suboptimal care
Level 1	Suboptimal care, but different management would have made no difference to the outcome
Level 2	Suboptimal care, in which different management might have made a difference to the outcome
Level 3	Suboptimal care, in which different management would reasonably be expected to have made a difference to the outcome

B.39 In addition to grading the level of suboptimal care, the Panel determined the degree of harm in each case. For this purpose, we used a scoring system adapted from the NHS National Reporting and Learning System (NRLS) definitions of degrees of harm (see Table B2).†

Table B2: Degrees of harm

Degree of harm	Outcomes	Impact on woman and/or baby
None	No harm	There was no impact on the woman or her baby
Minimum	Maternal injury; baby birth injury	The woman or her baby required extra observation or minor treatment
Moderate	Maternal injury; baby birth injury	There was short-term harm and the woman or her baby required further treatment or procedures
Severe	Maternal injury; brain damage, including hypoxic ischaemic encephalopathy (HIE) and/or cerebral palsy attributable to perinatal hypoxia	The woman or her baby suffered permanent or long-term harm
Death	Stillbirth; neonatal death; late neonatal death; maternal death	The woman or her baby died

B.40 The Panel's conclusions drawn from its assessment of cases are set out in Chapter 2 of the Report.

† Although there are plans to replace the NRLS with the Learn from Patient Safety Events (LFPSE) service, which does not define degrees of harm in the way the NRLS does, the Panel found it helpful to use a form of assessment of harm that is recognisable and understood when reviewing the cases subject to our Investigation.

Organisations contacted by the Investigation

B.41 The organisations and stakeholders listed in Table B3 were contacted in order to provide evidence or other information in line with the Investigation's Terms of Reference. A number of these organisations have contributed information and documents to the Investigation, but a proportion of these stakeholders did not have any relevant documents to contribute.

Table B3: Organisations contacted by the Panel

Organisation name
Action against Medical Accidents (AvMA)
Birth Trauma Association
Bliss
British Medical Association
Care Quality Commission
Child Death Overview Panel
Department of Health and Social Care
Fairweather Solicitors
General Medical Council
Health and Safety Executive
Health Education England
Healthcare Safety Investigation Branch
Healthwatch
Her Majesty's Senior Coroner (Mid Kent & Medway, North East Kent, Central & South East Kent)
Kent Community Health NHS Foundation Trust
Kent County Council
Kent Police
Local Maternity System
Maternity Voices Partnership
MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK)
Medical Defence Union
Members of Parliament
National Childbirth Trust
National Guardian's Office
NHS England and NHS Improvement
NHS Kent and Medway Clinical Commissioning Group
NHS Resolution
Nursing and Midwifery Council
Parliamentary and Health Service Ombudsman

Public Health England
Royal College of Anaesthetists
Royal College of Midwives
Royal College of Nursing
Royal College of Obstetricians and Gynaecologists
Royal College of Paediatrics and Child Health
Sands (Stillbirth and Neonatal Death Charity)

Appendix C: The Investigation team

Panel members

Dr Bill Kirkup CBE (Chair)

Heather Brown (Obstetrics)

Valerie Clare (Midwifery)

Alison Fuller (Clinical Governance)

Helen MacTier (Neonatology)

Denise McDonagh (Data/Information Management)

Specialist advisers

Nicky Lyon

James Titcombe

Legal advisers

Innovo Law

Counselling support

Linda Kenward

Secretariat

Members of the Secretariat have included:

- Ken Sutton (Secretary to the Investigation)
- Altin Smajli (Deputy Secretary)
- Caroline Allen
- Annette Beckham
- Caroline Browne
- Peter Burgin
- Lynn Cabassi
- John Cairncross
- Ann Ridley

Endnotes

Chapter 1

1 Clinical Commissioning Groups. Quality Report to National Health Service England. June 2013.

2 Clinical Commissioning Groups. Quality Report to National Health Service England. August 2013.

3 *The Report of the Morecambe Bay Investigation*. 2015. www.gov.uk/government/publications/morecambe-bay-investigation-report (accessed 12 July 2022).

4 Royal College of Obstetricians and Gynaecologists. Maternity Services Review Report. 2016.

Chapter 3

1 Nursing and Midwifery Council. *The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates*. 2015, updated 2018. www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf (accessed 14 July 2022), p.6.

2 General Medical Council. *Good medical practice*. 2019. www.gmc-uk.org/-/media/documents/good-medical-practice---english-20200128_pdf-51527435.pdf (accessed 14 July 2022), p.21.

Chapter 5

1 East Kent Hospitals University NHS Foundation Trust. *Annual Report 2008/09*. 2009, p.3.

2 NHS Kent and Medway and East Kent Hospitals University NHS Foundation Trust. Maternity Services Review. 2011, p.1.

3 National Health Service England. Maternal Death Review. 2014.

4 *The Report of the Morecambe Bay Investigation*. 2015. www.gov.uk/government/publications/morecambe-bay-investigation-report (accessed 24 August 2022), p.7.

5 Head of Midwifery, East Kent Hospitals University NHS Foundation Trust. Risk Assessment. May 2015.

6 Ibid.

7 Royal College of Obstetricians and Gynaecologists. Maternity Services Review Report. 2016.

8 East Kent Hospitals University NHS Foundation Trust. Root Cause Analysis Report. 2018, p.10.

9 Ibid., p.71.

10 Ibid., p.10.

Appendix B

1 Wolf, M.R., Green, S.A., Nochajski, T.H., Mendel, W.E. and Kusmaul, N.S. “We’re civil servants”: the status of trauma-informed care in the community. *Journal of Social Service Research*, 40:1 (2014), pp.111–20.

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5.1 - MyWish Annual Report and Accounts

Independent Auditor's Report to the Trustee of My Wish Charity

Opinion

We have audited the financial statements of My Wish Charity (the 'charity') for the year ended 31 March 2022 which comprise the statement of financial activities, balance sheet, statement of cash flows and the related notes to the financial statements, including significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and United Kingdom Accounting Standards, including Financial Reporting Standard 102 *The Financial Reporting Standard applicable in the UK and Republic of Ireland* (United Kingdom Generally Accepted Accounting Practice).

In our opinion the financial statements:

- give a true and fair view of the state of the charity's affairs as at 31 March 2022, and of its incoming resources and application of resources, including its income and expenditure, for the year then ended;
- have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice; and
- have been prepared in accordance with the requirements of the Charities Act 2011.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the charity in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the trustees' use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the charity's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the trustees with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the trustees annual report, other than the financial statements and our auditor's report thereon. The trustees are responsible for the other information contained within the annual report. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the course of the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Matters on which we are required to report by exception
We have nothing to report in respect of the following matters in relation to which the Charities (Accounts and Reports) Regulations 2008 require us to report to you if, in our opinion:

- the information given in the financial statements is inconsistent in any material respect with the trustees' report; or
- the charity has not kept adequate accounting records; or
- the financial statements are not in agreement with the accounting records and returns; or
- we have not received all the information and explanations we require for our audit.

Responsibilities of trustees
As explained more fully in the trustees' responsibilities statement set out on page 34, the trustees are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the trustees determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the trustees are responsible for assessing the charity's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the trustees either intend to liquidate the charity or to cease operations, or have no realistic alternative but to do so.

Auditor's responsibilities for the audit of the financial statements
We have been appointed as auditor under section 144 of the Charities Act 2011 and report in accordance with regulations made under section 154 of that Act.

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- Enquiry of management and those charged with governance;
- Enquiry of entity staff compliance functions to identify any instances of non-compliance with laws and regulations;
- Reviewing financial statement disclosures and testing to supporting documentation to assess compliance with applicable laws and regulations.
- Performing audit work over the risk of management override of controls, including testing of journal entries and other adjustments for appropriateness, evaluating the rationale of significant transactions outside the normal course of activities and reviewing accounting estimates for bias.

Because of the inherent limitations of an audit, there is a risk that we will not detect all irregularities, including those leading to a material misstatement in the financial statements or non-compliance with regulation. This risk increases the more that compliance with a law or regulation is removed from the events and transactions reflected in the financial statements, as we will be less likely to become aware of instances of non-compliance. The risk is also greater regarding irregularities occurring due to fraud rather than error, as fraud involves intentional concealment, forgery, collusion, omission or misrepresentation.

A further description of our responsibilities is available on the Financial Reporting Council's website at: https://www.frc.org.uk/Our-Work/Audit/Audit-and-assurance/Standards-and-guidance/Standards-and-guidance-for-auditors/Auditors-responsibilities-for-audit/Description-of-auditors-responsibilities-for-audit.aspx. This description forms part of our auditor's report.

Use of our report

This report is made solely to the charity's trustees, as a body, in accordance with Part 4 of the Charities (Accounts and Reports) Regulations 2008. Our audit work has been undertaken so that we might state to the charity's trustees those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the charity and the charity's trustees as a body, for our audit work, for this report, or for the opinions we have formed.

For and on behalf of

Lovewell Blake LLP
Chartered accountants & statutory auditor
Bankside 300
Peachman Way
Broadland Business Park
Norwich
NR7 0LB

Lovewell Blake LLP is eligible to act as an auditor in terms of section 1212 of the Companies Act 2006.

My Wish Charity (Registration Number 1049223)

Annual Report 2021/22

My Wish Charity

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Foreword by the Chair of the Trustee of My Wish Charity (formerly West Suffolk Hospital Charity)

Welcome to our annual report for 2021/22. We are a Trustee body established as a separate legal identity from the West Suffolk NHS Foundation Trust ("The Trust") but work with them in partnership for the benefit of NHS patients and their families from West Suffolk and the surrounding area.

We exist to further improve the provision of high quality patient care throughout the Trust, focusing on the use of modern technology in areas not covered or fully supported by central NHS funds.

Key highlights of our year:

- **Continue to receive donations to our COVID Appeal to help support staff and patients.**
- **Offer staff extra training to enhance the service they provide.**
- **Reach our target to our 25 Appeal to support a play specialist post, and receive an extra year of funding.**
- **Upgrade the Chapel, this included a new rest room, a multifaith space, and a counselling room.**
- **Bringing a Changing Places toilet facility to the Trust, to help patients with complex needs.**

Your donations made this work possible and your future donations are key to our continued success.

This is my first report as Chair and I would like to thank the volunteers who fundraise and help us, my fellow board members, and the volunteers who work alongside the professional staff of the Trust.

I hope that like me you will be inspired by our plans. If you would like to donate, details about how to do this are set out at the end of this report. Please support us, as every pound donated counts.

Name: Jude Chin (Chair of Trustee)
Date: 11 January 2023

Who We Are

My Wish Charity is an independent registered charity (registered number 1049223). We exist to raise funds and receive donations for the benefit of the patients of West Suffolk NHS Foundation Trust. By securing donations, legacies and sponsorship, My Wish Charity can provide the 'icing on the cake' to make a real difference for the patients, their families and the staff who look after them.

Providing both acute and community care, the Trust is our key partner in fulfilling our charitable aims.

We would like you to support us in our crucial work, so please read on and let us tell you more about ourselves, what we do, what we have achieved and how we go about spending the money given to us.

Our mission

By raising new money and careful management of our existing funds, My Wish Charity is able to fund expenditure to seek to support the aims and objectives of West Suffolk NHS Foundation Trust and the organisations it works with 'To serve the patients and their families receiving services from the West Suffolk NHS Foundation Trust by funding facilities, equipment, training, education and to support associated healthcare and complimentary services for patients.'

Payments are made in accordance with charity law, our constitution and the wishes and directions of donors. In making payments, we endeavour to reflect the wishes of patients and staff by directing funds towards areas they tell us are most in need. During the year 2021/22, payments of £623k were made. Our future plans are to continue to raise our level of fundraising that will help us work with our NHS partner to transform the health prospects for patients in our community.

The directors of West Suffolk NHS Foundation Trust acting on behalf of the Corporate Trustee believe they have complied with their duty to have regard to the Charity Commission's public benefit guidance when exercising any powers or duties to which the guidance is relevant. This is demonstrated by our activities throughout the year

What we have achieved: highlights from the activities undertaken in the year

Our key aim is to serve the NHS patients of West Suffolk Hospital, Newmarket Community Hospital and the community services that West Suffolk NHS Foundation Trust provides for the public benefit. By working with the NHS we assist patients of every walk in life, irrespective of race, creed, ethnicity or personal or family financial circumstances. We put this aim into practice by helping the patients, their families and carers, and visitors to the hospital by:

- **Enhancing the care our partner hospital can offer through new equipment and building improvements to deliver better facilities**
- **Investment in people and in creating a caring environment for the patients receiving care, their families and visitors**
- **Providing direct support to patients by way of information, networking support, better facilities**.

We do this through a range of programmes funded by you, our generous donors. Highlights from the main programmes undertaken in the year are detailed below to give you a wider understanding of the difference we can make together to patients today and in the future.

During that last year, sadly we are still in the recovery period of the Covid 19 pandemic, we continue in the plight to support staff, and patients. We would like to say a huge thank you to all of our amazing donors who continue to support us.

We have been able to continue to fund the Trust to employ extra staff members; and provide items and equipment to support them and their patients.

- A psychologist for staff support
- A play specialist
- A digital communication officer
- A counsellor for our patients being treated for cancer
- Four devices to aid patients suffering from dementia, they are Reminiscence Interactive Therapy Devices (RITA) at a cost of £4,000 each

The Charity once again has been extremely well-supported by our local community, and for this we are extremely grateful.

The generosity of businesses towards an appeal to raise money for a hospital charity has resulted in £5,000 being raised for the cancer unit at West Suffolk Hospital

The money came from the Rotary Newmarket Christmas and New Year campaign with businesses and traders in the town contributing funds along with prizes for a raffle.

President of the club Colin McCarty chose the unit after four Rotarians had been treated by the department over the past six years.

Treasurer Peter Moore and Andrew Rycraft presented a cheque for £5,000 to Sally Daniels, the My WiSH fundraising manager, outside their Rotary lunch venue, the Heath Court Hotel, in Newmarket.

The Rotary club gave a huge thank you to all the local businesses who sponsored the appeal including A J Wealth Management, Anglia Fabrication, A Barker, Ben Burgess, Caps Cases, J Curtis, D J Evans, Fenway, FRS Roofing, Howdens, Jackson-Stops, Key Locks, MHHP Accountants, Mitchams Burwell, Morris Armitage, Huws Gray (Ridgeons), G Reynolds, Southgate of Newmarket, Test and Evaluation, Tops Tiles, Turners, Saint Andrew Bureau, M Skelton and UFAC UK, Zion Landscapes.

Rebecca Miller and Abbey Vinecombe, who work in the pathology department at West Suffolk Hospital, took part in the Vitality Big Half which took place in London, in August 2021 and the pair raised a whooping £1,400 for My WiSH Charity, and it was directed to the women's chosen recipients – the Macmillan Cancer Unit and the Colorectal Department at the hospital.

Both units have a special place in the women's hearts as 25-year-old Abbey, who lives in Brandon and works in the pathology department's office, had two close family members treated for cancer while Rebecca, who lives in Bury St Edmunds and is a phlebotomist, has had major bowel surgery and also had the trials and tribulations of having to deal with her son being treated for the cancer.

A catering assistant at West Suffolk Hospital linked up with her father to tackle the three highest peaks in the UK and raised a huge £1,757 for My Wish charity.

Michaela Cooper and Paul Sims scaled Ben Nevis, in Scotland, followed by Scafell, in the Lake District, and finally Snowdon, in Wales, over a 24-hour period, on Friday, June 11 2021.

The pair took on the Three Peaks challenge in a bid to raise £1,000 as part of the Beacon of Light Challenge which was being run by the Charity, which supports the West Suffolk Hospital.

And it came after three family members were treated for Covid-19 at the hospital in Bury St Edmunds.

Sadly, the pandemic claimed the lives of the grandfather and grandmother of her husband Ben while Michaela's brother-in-law Daniel Cooper, was also struck down with the illness. Thanks to the care and attention he received at the hospital was later discharged.

"The hospital cared for all three of my family members during the pandemic. Although my brother-in-law is now progressing amazingly and is back in the swing of daily life, there was a time when we were all greatly concerned about what the future held for him."

"He cannot speak highly enough of West Suffolk Hospital's critical care unit. They did their upmost to make him feel safe, reassured and cared for, during one of the scariest times of all of our lives," said the 30-year-old, who also works part time with Daniel, 34, at his outboard engine business in Soham.

"My dad has done the Three Peaks twice and I really wanted to do it to raise money for My WiSH Charity which does so much great work for the hospital."

"Daniel was very poorly but he managed to pull through and staff were amazing looking after him."

Her 32-year-old husband acted as driver for the couple assisted by family friend Will Affleck, who both play for Bury St Edmunds Rugby Club.

Michaela, who lives in Thetford, added: “They were an important part of the challenge to ensure they got us from one place to the other while we were resting.”

“I thought it would be such a nice thing for me and my father to do together to help repay the hospital in some way and was such an achievement to complete the challenge.”

We were lucky enough to have a piece of original artwork donated by fellow local charity, Geewizz. Originally donated to them by anonymous, self named artist, The Hat, the piece was called Lucky 7 and was inspired by him meeting up with his family after the lockdown of 2020.

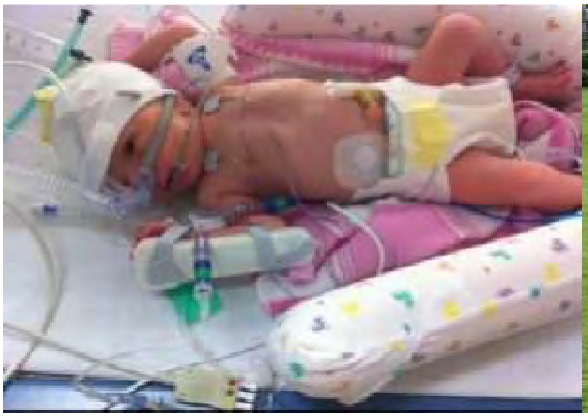
As a children’s charity, GeeWizz founder, Gina Long asked for us to donate any proceeds from Lucky 7 to our WiSH Upon a Star children’s appeal which is just what we are did. The item made a huge £1,000 which we directed to the appeal.

Our WiSH Upon a Star appeal supports young patients needing care from the West Suffolk NHS Foundation Trust which includes West Suffolk Hospital, Newmarket Community Hospital and all the community services. The appeal allows us to provide the extras including a play specialist for the emergency department, toys for children with complex care needs and enables us to support children who have lost a sibling.

An eight-year-old girl from Stowmarket has beaten a challenge to carry out 100 cartwheels in 10 minutes to raise money for charity.

Anaiya Dyer took up the Capt Tom Foundation (CTF) challenge smashing the target by doing 104 cartwheels in just three minutes ending up with £407.

The money was then split between the CTF and the My WiSH Charity, which supports the work at the West Suffolk Hospital, with the cash directed towards the neonatal unit where she was treated and who helped to save her life.



The youngster, who is a pupil at Abbots Hall Primary School, in Danescourt Avenue, Stowmarket, was inspired to carry out the stunt after seeing Capt Sir Tom Moore's charity walk. Her family and friends turned up at the town's Recreation Ground, in Park Road, to witness her challenge.

Her mother Kelly Dyer said her daughter, a member of the Bury Spectrum Gymnastics Club, was "really poorly' when she was born and was in a "bad way".

She came into the world a month early weighing 5lbs and had swallowed her meconium, meaning she needed the care of the neonatal unit.

Anaiya was even interviewed live on air on Heart radio's breakfast show with Jamie Theakston and Amanda Holden about her cartwheeling stunt.

Her 44-year-old mother said: "She was not breathing when she was born and she was really poorly and in a bad way for a week and had to be on a ventilator but the doctors and nursing staff were amazing and they effectively saved her life really and we are forever grateful."

"She has come a long way from there and it was a nice thing for her to do."

And Anaiya said that said she "enjoyed" the challenge adding: "I heard this voice in my head and I said I wanted to do this and it was really exciting and challenging."

Sally Daniels, fundraising manager, said "It was a pleasure to meet Anaiya and so kind of her to take on this challenge to raise money for both charities. Our neonatal unit are amazing and I know they are truly grateful for this donation which will go on to help other babies needing their special care".

Staff at the Tesco store in Newmarket have helped to raise over £1,000 in a day for the My WiSH Charity, who support West Suffolk NHS Foundation Trust, with the money benefitting the Macmillan Unit at the West Suffolk Hospital in memory of a former member of staff.

Staff raised money in memory of their colleague, Geoffrey Siago.

It came as a tribute to Geoffrey Siango, who worked in the fruit and veg department of the store in Fordham Road.

The 35-year-old died of cancer back in April 2021 prompting staff to help raise the money to support the charity, which enhances the care of patients at the hospital in Bury St Edmunds, with the money directed towards the unit which cared for him.

Geoffrey, an avid Chelsea supporter, joined Tesco back in 2019, and was a popular member of staff.

Zara Reynolds-Peirce, the community champion at the store, said the total amount raised for My WiSH amounted to £1,075.93 and was organised by staff members Becky Reville, Nicola Collis, Rachel Aylott and Sam Youtzy.

They dressed in the blue and white colours of Chelsea for the day with a series of in-store events taking place including a tombola, raffle and a square game where the winner gave back her £75 prize.

Zara said: “We wanted to do something for the hospital and in memory of Geoffrey and raise money for the hospital’s cancer unit. It was incredible to raise that amount of money in one day. A lot of people come into the store and everyone loved the tombola and raffle and it’s a really good way to generate the money.”

Nine-year-old Maisie Fox took to two wheels in a bid to raise money for the Rainbow Ward at the West Suffolk Hospital.

The youngster decided to take up the challenge after her mother Jordan ran 50 miles for charity.

So, Maisie followed in her mother’s footsteps and decided that she wanted to do something similar. Cycling a total of 55 miles, getting on her bike day after day to ride two to three miles around her village in Rickinghall, she spent a month completing the distance.

And at the completion of the challenge she “smashed” her target of £50 by raising a total of £586.25 for the Charity, with the money directed towards the Rainbow Ward.

Her mother, who helps run The Bell pub in the village, said: “We were in the middle of lockdown and I set a challenge to run 50 miles for Maggie’s Cancer Trust as I wanted to challenge myself and get a bit fitter during lockdown. I did some of the same routes as Maisie, in and around our village.”

“We sat down to talk about it and she said that she wanted to do something for the children’s ward at the hospital.”

“And she totally smashed her original target of £50 which was great.”

“All our family and friends helped to raise the money,” she added.

Maisie was treated at the West Suffolk when she was two-years-old and said some of her friends were also cared for at the hospital in Bury St Edmunds.

“I was thinking that I could bike 50 miles as my mum was also running 50 miles and I was really pleased with the amount of money that I raised,” she said.

By her own admission she can’t run, walk or ride a bike in a bid to raise money for charity but she can have her head shaved, and that’s just what 94-year-old Toni Gray had carried out at her home in Mildenhall.

The object of the exercise was to raise money for the My WiSH Charity with the money directed towards the Macmillan Unit, at the West Suffolk Hospital, where her son Jaimie is a patient.

The dispatch manager, who lives near his mother, is currently being treated for bowel cancer and is having chemotherapy treatment at the unit following a course of radiotherapy at Addenbrooke’s Hospital, in Cambridge.

The 61-year-old was first to get hold of the clippers to trim his mother’s locks and was closely followed by his brother Sean, 67, who travelled from his home in Basildon to make it a head shave family affair.

She raised an amazing £1,538.75 after initially setting a target of £60!

Toni, who has her hair cut by a mobile hairdresser every six weeks, said: “It’s beginning to grow back again now but having the head shave is really the only thing I could do to raise the money.”

The idea came to her after seeing the Macmillan Cancer Support's "Brave the Shave" campaign as she wanted to do something to thank the staff at the West Suffolk for caring for her son.

Toni said: "Being 94, and not as spry as I once was, I can't run a marathon or swim the Channel, but I can shave my head for the My WiSH Charity. This is in thanks for the wonderful work by all the staff, charity workers and ancillaries at the hospital."

"It was a bit of a shock when Jaimie was diagnosed with cancer and I did feel hopeless at not being able to do anything and then I saw 'Brave to Shave'."

"I suffer from arthritis and have sight issues with macular degeneration but having the head shave was quite good fun. Family and friends watched on and we demolished a couple of bottles of wine and it was a bit of an occasion."

"Jaimie said I looked better with the head shave and people that come in and see me now say that I look wonderful."

Sean said: "My mother just wanted to raise the money for the unit and decided that as she can't run a marathon or climb a mountain that she would have her head shaved."

Sally Daniels, fundraising manager, joined the family for the event and said "It was an honour to join Toni and her boys. It was actually a really fun atmosphere and they made a real occasion out of it. The total raised is just phenomenal and will help so many people in west Suffolk who are diagnosed with cancer. Huge thanks to Toni for being such a star".

Ray Coleman's work colleagues have helped to raise £250 which has funded improvements to the patient entertainment system on one of the wards at the West Suffolk Hospital.

The 56-year-old, who works at the F-35 Training School, at RAF Marham, in Norfolk, was instrumental in choosing the My WiSH Charity to receive the funds which were directed towards the Macmillan Unit, where he has been received treatment for Non-Hodgkin Lymphoma.

He said music could only be heard in half the day treatment unit and so wanted to purchase something to help.

And staff at the training school bought special polo shirts emblazoned with the school's charity emblem "One Team One Fight Against Cancer" at £20 each and wore them each Friday donating money to the fund.

Ray, who lives in Bury St Edmunds, was diagnosed with the illness back in January 2021, and has had radiotherapy and chemotherapy treatment sessions at the West Suffolk and also at Addenbrooke's Hospital, in Cambridge.

He said: "I've been a patient at the Macmillan Unit at the hospital in Bury St Edmunds since January and spent quite a of time there in the first six months of the year and I wanted to try and give something back."

"We buy the polo tops from the manufacturers and money from the sale of them goes into our charity fund."

"Once a year the bosses get together and decide who's going to have the charity money and mine was chosen."

"When I was in the Macmillan Unit there was an old radio and if you sat near it it was quite loud but the further away you could not hear it so I thought it could do with an upgrade."

Sally Daniels, fundraising manager for My WiSH Charity, met with Ray to thank him for supporting the unit, "It was great to meet Ray and say a personal thank you from the charity. Laura, the ward manager, was already thinking about buying a new radio so this donation couldn't have come at a more perfect time. Thank you to everyone who donated."

Husband and wife Ian and Pat Jenkins are linked up with four friends for a cross country cycle ride in a bid to raise money for a hospital ward which cared for a loved one up to his final days.

The couple left their home in Mildenhall, just after 7am on Saturday, August 7, along with Tracy Canham, Dean Whitehead, Dave Allen and Rob Foord and cycled the 64 miles to Southwold.

Their target was £1,000, and they smashed that to pieces by raising £4,000, with the money directed towards the Macmillan Unit at West Suffolk Hospital.

The group were supported by a back up team of Shelby Foord, Davey Friedlander, Joy Bentley and Christine Burton, while Ruth Hounsome, who had an accident coming off her bike, did the distance on the same day on her exercise bike.

Ian, who is a purchasing manager with an engineering firm in Spalding, Lincolnshire, said the cycle ride was in memory of his father Len who was treated by the team at the Macmillan Unit, after he was diagnosed with acute myeloid leukaemia in 2019.

He had regular treatment at the hospital, but died in the unit on New Year's Day after contracting sepsis and Covid aged 86. He lived in Red Lodge with his 81-year-old wife June and celebrated their diamond wedding anniversary last year.

Ian, 57, said: "My father was always complimentary of the level of care and the staff at the unit and it continued right up until the end. We were unable to get in to say our goodbyes to him because of Covid which was awful and we wanted to give something back.

Fundraising swimmer Corinne West completed 10 miles in a bid to raise money for a hospital charity campaign to thank staff for the love and care they provided for her much loved grandmother.

The 33-year-old, who lives in Thetford, completed the distance at Thetford Leisure Centre and open water swimming at a nearby lake.

She more than doubled her target of reaching £100 by raising a total of £235 for My WiSH Charity's Butterfly Fund.

Corinne's grandmother Flo West, who lived with her 87-year-old husband Roy, in Brandon, died in June 2021 after being cared for by the palliative care team at the hospital in Bury St Edmunds.

She suffered from dementia during her later years and was a treasured relative of her granddaughter.

Corinne said: "My nan was a huge part of my life and I wanted to do something to celebrate her life and my memories with her."

"She was actually the one who taught me and my sister, Claire Slattery, to swim. I remember being on holiday in the New Forest when I was about four and nan was determined that she was going to teach me to swim, more so as she could never swim herself."

She said when her 88-year-old grandmother died she wanted to do something in a way of thanking the hospital staff.

Corinne said her grandmother was an amazing lady and she lived in London and Spain before moving to Suffolk. She even spent her 80th birthday in Thailand and along with Roy they loved to travel.

"In her last days nan was taken care of by the palliative care team at West Suffolk Hospital and they treated her with such love and dignity and allowed the family to be there to say goodbye," said Corinne.

"It was just a small thing that I did to say thank you to the hospital who made her so comfortable and they made it so peaceful and dignified."

"She always said to us 'Do what you want when you want and how you want' and she was a feisty character and her and Roy were always here there and everywhere."

Corinne, who works at Center Parcs as the resource and planning manager, said how she swam two-and-a-half miles a week

During Flo's stay at the West Suffolk on the G8 ward, she was given a bear and a blanket from the palliative care team and Roy was able to sleep beside her in one of the chair beds My WiSH purchased. He also had a comfort pack so water, tissues, wipes, toothbrush and paste etc to make sure he was comfortable. And he still has the blanket and bear.

A party for family and friends of super fundraiser Heather Damsell resulted in £1,000 being raised for My Wish charity.

She invited 38 people to the Beck Row Methodist Hall for the event as part of the NHS Big Tea and described it as a “lovely” evening.

Heather, who lives in Barton Mills, has over the years raised a total of £2,825 for the My WiSH Charity which supports the work of the West Suffolk Hospital, Newmarket Community Hospital and community services in Suffolk.

Back in 2015 and 2016 she raised £1,200 for the Macmillan Unit at the hospital, and a further £625 for the Every Heart Matters cardiac appeal in 2018. Her latest effort has boosted her fundraising to near the £3,000 mark.

Music for the tea party was provided by Brian Roy and she was further helped to organise the event by her sisters Susan Adams and Jenny Darkens along with Ken Palmer and Peter Empson. Food was provided in lunch boxes to keep it all Covid safe and everyone had a wonderful time.

Heather said the money was raised from a raffle and games and she said those who attended the tea party held on Saturday, July 31, were “very generous” and thanked them for their support.

The 74-year-old said: “We just got together and had a great time doing it and we enjoyed every minute of it.”

“We love to fundraise for the hospital and every little bit helps.”

The renal ward at the West Suffolk Hospital has been gifted a set of computer tablets thanks to a donation from the Stowmarket Chorale.

A total of six Samsung tablets along with headphones and their hygiene covers have gone to the F8 ward at the hospital in Bury St Edmunds, following the donation to My WiSH charity.

The chorale wanted to help patients watch TV and, with the Trust now using a new entertainment service called WiFi Sparks, patients without a smart device cannot access it.

But the tablets mean they can now enjoy TV, radio and magazines while on the ward.

Sue Smith, head of fundraising said “The new WiFi Sparks is a brilliant addition making patient entertainment free for everyone but we wanted to ensure those without a smart device could still watch their favourite soap or quiz show while they are in hospital or enjoy the radio or just the paper. We are so grateful for the donations we receive as they allow us to be able to provide items like this to enhance a patients stay in hospital”.

Avid runner Gary Lockwood has helped to turn his life around by pounding the streets after years fighting drug and alcohol abuse.

He completed back to back marathon distances round parts of Suffolk and Cambridgeshire from his home in Burwell raising money for the childrens' ward at the West Suffolk Hospital where his son Bobby was cared for.

The 48-year-old self-employed tiler took almost nine hours running a circular course through the towns and villages of Fordham, Isleham, Freckenham, Red Lodge, Kentford, Gazeley, Dalham, Ashley, Cheveley, Newmarket, Upware and Soham for the 52.4 miles and has now ended up with a total of £1,516.74 after setting an initial target of £1,000.

The money has gone to My WiSH Charity, with it being directed towards the Rainbow Ward and used by its health play specialist Laura Nudds to buy toys and equipment to help with her role of preparing children for procedures and reducing their anxieties through play.

His challenge came after Bobby needed urgent treatment when he was just five weeks old after a bleed from his nose wouldn't stop.

Gary, who has faced a lifetime of drug and alcohol abuse since the age of 11, said he was out in the car with his son and partner Tina Basing back in May going to a local fair when Bobby stopped breathing and suffered the long term nose bleed. The youngster, who was just five-weeks-old at the time, went into shock prompting his parents to call the paramedics who took him to hospital where he was admitted to the Rainbow Ward for a couple of nights.

"But he's as healthy as you like now," said Gary. "Although it was a bit of a worrying time for me and Tina."

He said staff on the ward were so amazing he wanted to give something back and what Gary and his 35-year-old partner said was that the staff also cared for them as well as Bobby ensuring they ate, drank and slept which was "just wonderful".

The run, which took place on August 21 2021, was supported by Gary's friend Michael Hales, who lives in Fordham, and who cycled alongside and even had to bike on one wheel for 12 miles after he suffered a puncture.

Gary, who talked frankly about his life problems, said: "I only started running in April and it got my mind away from the abuse I had been suffering. When I was young I started sniffing glue and petrol and other substances then went onto drugs and into rehab. I was going through a lot of stuff and it was quite difficult for me."

But he said how running had helped him to turn his life around as he can plough his energy into pounding the streets.

"I suffer from social anxiety now and I'm not really a people person so queueing up for a run with other people is not for me but I just like to get out and run and run which I get a buzz from."

"I'm really pleased to have raised the money and to have helped the hospital out and if my running gives a bit of hope to other people with drug and alcohol addiction then that's a bit of an achievement as well," he added.

Super fundraiser Josh Wright has been at it again boosting the funds of the My WiSH hospital charity by taking part in a marathon run round Bury St Edmunds with his father Les.

The pair made a circuit of the town in four hours 30 minutes as part of the virtual London Marathon ending up through the Moreton Hall Estate, onto Rougham and crossing the “finishing line” in Thurston, where his grandfather Ron lives.The money raised is being directed towards the Macmillan Unit, at the West Suffolk Hospital, where his grandmother Christa was treated.

She suffered from cancer and the family lost the 68-year-old last October with the run taking place close to the anniversary of her death and with a total of £1,151.50 raised.

That takes the total amount of money raised by Josh to £4,213.52 for the Charity following another marathon back in 2019 along with a 24-hour gaming marathon. He then did 13 half marathons last year followed by a full marathon for the charity’s Butterfly Appeal.

The 27-year-old, who lives in Bury St Edmunds, said the latest run was in memory of his grandmother and it was poignant that they finished it in the village where she lived.

“We ran it as the same time as the London Marathon in the capital and we did a full circuit of the town before completing it in Thurston. Running for four hours was not too bad and we went over the line together.”

“Christa was in the West Suffolk Hospital and was ill for a while and took a turn for the worse in the middle of the coronavirus lockdown last year.”

“We are a very close knit family and my grandfather wanted the money we raised to go towards the ward where she was treated as the care she received was fantastic.”

Josh added: “I think this last year and more has bought forward how much we all cherish the NHS and how much we need to help it and enhance it, which is exactly what My WiSH do.”

We, My Wish Charity, would love to thank all our AMAZING fundraisers and volunteers that allow us to enhance the care, love and support of our patients, and staff!

How we funded our work, our achievements and performance

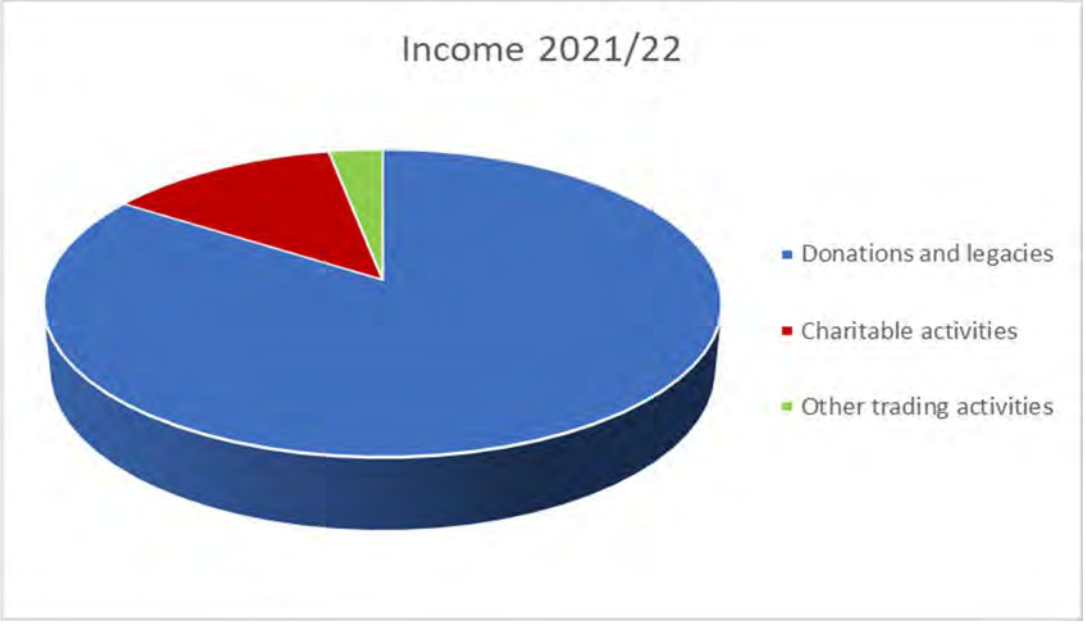
In this section we firstly explain how we raised the money and then how we spent it.

Money received: £438k ***Money spent: £640k***

My Wish Charity can only continue to support the work of the Trust for as long as we receive the money needed. Almost all of our income comes from the voluntary efforts of the general public. Overall, we ended the year with expenditure exceeding income by £202k before investment gains.

Money received: sources of funds

The pie chart shows our main sources of income. The largest is termed voluntary income and represents gifts and donations from the public.



Donations and legacies £369k – Our largest source of income is from the public and by local companies keen to support their local community:

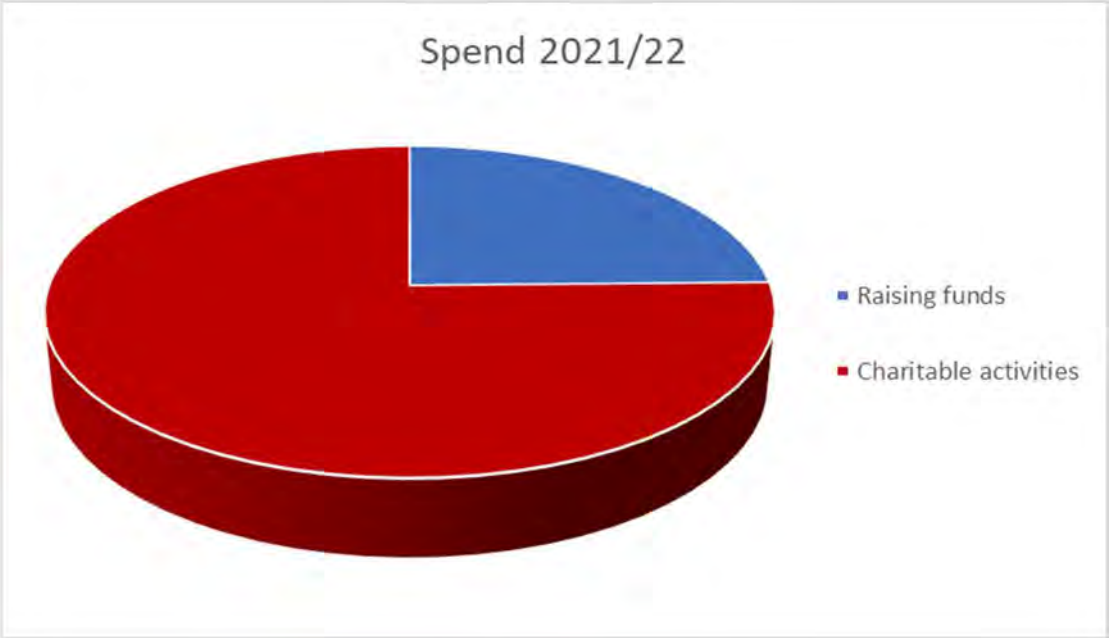
- **Gifts from the public £157k** – from a few pence in a collecting box to several hundred pounds from grateful relatives, we are fortunate to receive thousands of generous gifts each year towards our work.
- **Corporate Donations £19k** – many companies adopt charities as a way of putting something back into the community. My Wish Charity is grateful to the companies that have donated over the year and to their employees who have given their time and money to maximise the corporate support we receive.
- **Legacies £193k** – a gift in a will really is an investment in the future, and we are fortunate to be remembered by people each year.

Charitable activities £56k – £21k of this relates to grant income, whilst the remaining balance is other items of income that do not fit in to the above categories.

Other trading activities £13k – by supporting an existing event or organising one of their own with the knowledge and approval of the Trustee, thousands of people have had a good time whilst raising money for My Wish Charity. The Coronavirus pandemic has resulted in many fundraising events being cancelled and therefore the income continues to be considerably down on previous years.

- **West Suffolk Hospital other organised fundraising £5k**
- **Course fee income £1k**
- **Third party fundraising £7k**

Money spent: what we spent the money on



Our charitable work was made up of five distinct areas. The costs shown below exclude attributable support costs as set out in note 9 to the accounts:

Clinical Care & Research Posts: The funds support a counsellor and some nurses within the Macmillan Unit, a Clinical Psychologist in SCBU and a children's play specialist. The cost of these staff was **£112k** in 2021/22.

New equipment: The NHS of course buys much of its own equipment for day to day use and has its own capital programme but NHS capital funds for large items of equipment are scarce. With advances in technology we can make a real difference in purchasing items. We spent **£199k** on new equipment. Examples of equipment purchased this year are:

- **Patient monitors**
- **Clarus 700 retinal camera**
- **Optiflow nasal flow system (oxygen therapy)**
- **Infusomat infusion pump**
- **Intensive care trauma chair**

Adaptations to buildings: We spent **£46k** in 2021/22 on a number of minor capital projects including the refurbishment of the Chapel.

Staff education and welfare: We spent **£48k** on a wide variety of training and educational courses for our staff.

Patient education and welfare: We spent **£28k** supporting education and the welfare of patients.

Performance against objectives

Spending the money is only part of the story because we are concerned to achieve value for money. To ensure the money is well spent applications for General Fund funding include questions about the objectives, impact and success criteria for the proposed project.

Our fundraising performance
Members of My Wish fundraising department organise fundraising events and co-ordinate the activities of our supporters both in the hospital and in the wider community on behalf of the Charity.

During the year the total donations, legacies and income from fundraising came to £438k compared to 2020/21 of £695k.

We benchmark our fundraising activity with our peers through the Association of NHS Charities and monitor the comparative success of campaigns and overall fundraising cost to income ratios. Compared to other NHS Trusts, although we have a low cost income ratio, there is the opportunity to increase the level of donations further.

Section 162a of the Charities Act 2011 requires charities to make a statement regarding fundraising activities. Although we do not undertake widespread fundraising from the general public, the legislation defines fund raising as “soliciting or otherwise procuring money or other property for charitable purposes.” Such amounts receivable are presented in our accounts as “voluntary income” and include legacies and grants.

In relation to the above we confirm that all solicitations are managed internally, without involvement of commercial participators or professional fund-raisers, or third parties. The day-to-day management of all income generation is delegated to the fundraising team, who are accountable to the Trustee.

The charity is not bound by any undertaking to be bound by any regulatory scheme. We have received no complaints in relation to fundraising activities.

The Charity fundraises money from two main sources, the Fundraising Team at the Charity and members of the public who fundraise on behalf of the Charity. The Fundraising Team are all employed by West Suffolk NHS Foundation Trust and as such have to undergo mandatory training that includes Safeguarding Adults, Safeguarding Children, Equality and Diversity and Human Rights. The Fundraising Team is managed proactively through the management structure and their ultimate manager is the Executive Director of Workforce & Communications. It is impossible to apply the same rigour to members of public however the Head of Fundraising works closely with members of the public to ensure that relevant guidelines and legislation is complied with.

What we plan to do with your donations: our future plans

We will achieve our mission by working with the NHS to develop the facilities to treat the community of West Suffolk. We will identify ways in which we can actively assist NHS staff to treat all patients to the best of their ability. We will also actively seek guidance from those staff members to any pieces of equipment that would enhance the care of patients, and their families. Our open invitation to the reader of our annual report and accounts is to join with us in our exciting mission of compassion for the community of West Suffolk by making a gift to secure the best care.

Our detailed plans are to:

- Complete the Butterfly Appeal
- Continue to engage with our community services and Newmarket Community Hospital
- Continue to engage and develop relationships with the wider community
- Support the Hospital and community services in purchasing equipment and providing training in line with donor wishes

Your support makes these plans possible and to help us, please do consider making a donation.

How we manage the money

The Charity was entered on the Central Register of Charities on the 15 September 1995. The Charity is constituted of 89 individual funds (2020/21: 89) as at 31 March 2022 and the notes to the accounts distinguish the types of fund held and disclose separately all material funds.

Charitable funds received by the Charity are accepted, held and administered as funds and property held on trust for purposes relating to the health service in accordance with the National Health Service Act 1977 and the National Health Service & Community Care Act 1990 and these funds are held on trust by the corporate body.

Our payment making policy

All payments are normally made from the Charity – these funds comprise two elements:

- Unrestricted funds contain funds where the donor has not expressed any specific conditions for which the donation must be used.

- Restricted funds (which contain donations where a particular part of the Hospital or activity was nominated by the donor at the time their donation was made) are managed by nominated charity fund-holders who are responsible for the day to day running of the funds. Delegated powers of authority are in place. However, the ultimate responsibility for all such funds remains with the Corporate Trustee. Reviews are undertaken by the Charitable Funds Committee of the Charity's funds and actions are taken as required.

Exceptionally, transfers may be made from the reserves to finance grant supported projects which would otherwise be delayed due to a shortage of unrestricted funds. This discretion is only exercised where there is a significant on-going benefit and the projects are considered to be a high priority.

Our reserves policy

The Trustee's reserves policy is to expend unrestricted income within a reasonable period of time in furtherance of the charitable objects. Under normal circumstances, a period of one year is considered to be reasonable; therefore the Charity would be expected to hold reserves approximately equal to average annual unrestricted income. The average is determined over a three year reference period.

As at 31 March 2022 the unrestricted reserves held was £312k. This compares to an expected average annual unrestricted income of approximately £110k. The main reason for the high level of reserves is due to a combination of a high level of investment gains and a reduced level of unrestricted income. The Trustee believes that the level of reserves is sufficient.

Our financial health: a strong balance sheet

The assets and liabilities of My Wish Charity as at 31 March 2022 are stated below, compared with the position at 31 March 2021.

	31 March 2022	**31 March 2021**
	£'000	£'000
Fixed Assets	0	2
Fixed Asset investments	1,777	1,592
Total Current Assets	730	895
Creditors falling due within one year	(133)	(97)
Total Net Assets	**2,374**	**2,392**
Income Funds		
Restricted	2,062	2,076
Unrestricted Income Funds ('general fund'):	312	316
Total Funds	**2,374**	**2,392**

A few helpful definitions:

Total current assets represent the cash held on deposit and the amounts owed to the Charity.

Creditors falling due within one year represent the balance of money owed within 12 months to suppliers of goods and services. £125k of this balance is owed to West Suffolk NHS Foundation Trust.

Total net assets represent the total assets of the Charity less the value of outstanding liabilities (monies that the Charity owes).

Restricted income funds represent money which is held by the Trustee which can only be used for specified purposes.

Unrestricted income funds are funds available to be spent within the objects of the Charity which can legally be spent wholly at the discretion of the Trustee. In practice, respecting the non-binding preferences expressed by donors, for the Charity, this relates to the 'general fund'.

About investments

The Trustee continues to invest in a common investment fund - COIF Ethical Investment Fund managed by CCLA Investment Management ltd.

How we organise our affairs: reference and administrative details

The Charity

The Charitable Funds are registered with the Charity Commission under an **umbrella registration number My Wish Charity (formerly known as West Suffolk Hospital Charity)** and Other Related Charities – Register number 1049223 in accordance with the Charities Act 2011.

Related Charities:

West Suffolk Hospitals Trust Charitable Fund	1049223-1
The West Suffolk Hospital Charity	1049223-3
Sudbury Hospital Charity	1049223-2
Joyce Marno-Edwards Fund	1049223-4
West Suffolk Hospital Education Centre	1049223-5

The Trust Board devolved responsibility for the on-going management of funds to the Charitable Funds Committee which administers the funds on behalf of the Corporate Trustee.

The Committee meets at least three times a year. The Committee members are paid for their duties for the Trustee but do not receive any additional pay, emoluments or other financial benefit from the Charity. Whilst the Committee members are not paid for their time they can claim expenses, details of which are disclosed in the accounts.

The Charity's main fund has NHS wide objectives as follows: “The Trustee shall hold the trust fund upon trust to apply the income and, at their discretion, so far as may be permissible, the capital, for any charitable purpose or purposes relating to the National Health Service.”

Strategic aims are:

- To manage and govern the fundraising programme in line with best practice to ensure funds are raised effectively, efficiently, ethically and economically
- Fundraising should be in accordance with the Ethical Fundraising Policy of West Suffolk NHS Foundation Trust and follow the Institute of Fundraising’s Codes of Fundraising Practice
- To increase the charitable income – fundraising and donations - raised by My Wish Charity. This will be through a comprehensive fundraising programme which ensures fundraising income is sustainable and regular
- To promote legacies in a responsible way
- To ensure all areas of the Hospital are aware of the work of My Wish Charity and how fundraising can help each and every aspect of the trust
- To encourage the appropriate spending of charitable funds by fundholders to enhance the experience of patients, visitors and staff throughout the Trust
- To engage and build strong relationships with partners, patients, carers, staff and other stakeholders

How to contact us

The Charity office and principal address of My Wish Charity is:

The Trust Fund Office
West Suffolk NHS Foundation Trust
Hardwick Lane
Bury St Edmunds
IP33 2QZ
☎ 01284 712952

For fundraising queries please contact:

The Head of Fundraising
My Wish Fundraising Office
Hardwick Lane
Bury St Edmunds
IP33 2QZ
☎ 01284 712952

Our Trustee

The West Suffolk NHS Foundation Trust is the Corporate Trustee of the Charity, governed by the law applicable to Trusts, principally the Trustee Act 2000 and the Charities Act 2011.

The Corporate Trustee is responsible for deciding policy and ensuring that it is implemented.

During 2021/22 the Trust Board consisted of:

Non-executive Directors (NEDs)

Sheila Childerhouse (Chair)	Appointed 1 January 2018 until 31 December 2020 reappointed 1 January 2021 until 31 January 2022
Jude Chin (Chair)	Appointed 1 September 2021 as an interim NED and on 1 February 2022 was appointed the Interim Chair. Jude was appointed for a one-year term as the permanent Chair on 4 July 2022.
Alan Rose	Appointed 1 April 2017 until 31 March 2020. Reappointed 1 April 2020 until 31 March 2023
Richard Davies	Appointed 1 March 2017 until 28 February 2020 Reappointed 1 March until 28 February 2023
Angus Eaton	Appointed 1 January 2018 until 31 December 2020 Reappointed 1 January 2021 until 31 May 2021 Stood down from 31 May 2021
Louisa Pepper	Appointed 1 September 2018 until 31 August 2021 Reappointed until 31 August 2024
David Wilkes	Appointed 31 July 2020 until 11 June 2021
Rosemary Mason (Associate)	Appointed 24 August 2020 until 22 June 2021
Christopher Lawrence	Appointed 1 June 2021 until 31 October 2022

Antoinette Jackson	Appointed 1 November 2022
Dr Geraldine O'Sullivan	Appointed 1 November 2022
Tracy Dowling	Appointed 1 November 2022
Professor Hilary McCallion	Appointed 1 November 2022
Krishna Yergol	Appointed 1 November 2022

Directors

Stephen Dunn	Chief Executive – appointed 3 November 2014 left 31 August 2021
Craig Black	Executive Director of Resources – appointed April 2011 to 31 August 2021 Chief Executive (Interim) – 31 August 2021
Nick Macdonald	Executive Director of Resources (Interim) – appointed 31 August 2021
Nick Jenkins	Executive Medical Director – appointed 17 November 2016 stepped down 30 June 2021
Paul Molyneaux	Executive Medical Director (Interim) – appointed 30 June 2021
Helen Beck	Executive Chief Operating officer – appointed 1 May 2017 left 31 October 2021
Nicola Cottington	Executive Chief Operating officer – appointed 1 November 2021
Jeremy Over	Executive Director of Workforce and Communications – appointed November 2019
Susan Wilkinson	Executive Chief Nurse – appointed 1 June 2020

More details about the Trustees can be found in West Suffolk Hospital NHS Foundation Trust Annual Report.

The names of those people who served as agents for the Corporate Trustee on the Charitable Funds Committee, as permitted under regulation 16 of the NHS Trusts (membership and Procedures) regulations 1990 were as follows:

			2021/22 Attendance	**2020/21 Attendance**
Sheila Childerhouse	-	Chair	1 / 3	4 / 5
Stephen Dunn	-	Chief Executive	1 / 1	5 / 5
Angus Eaton	-	Non-Executive Director	1 / 1	3 / 3
David Wilkes	-	Non-Executive Director	1 / 1	4 / 4
Richard Davies	-	Non-Executive Director	0 / 3	0 / 3
Alan Rose	-	Non-Executive Director	1 / 3	3 / 3
Louisa Pepper	-	Non-Executive Director	2 / 3	0 / 3

Chris Lawrence	-	Non-Executive Director	3 / 3	
Jude Chin	-	Chair	1 / 2	
Rosemary Mason		Non-Executive Director	1 / 1	0 / 2
Craig Black	-	Director of Resources (until August 2021) and Interim Chief Executive (August 2021)	3 / 3	4 / 5
Jeremy Over	-	Director of Workforce and Communications	3 / 3	3 / 5
Helen Beck	-	Chief Operating Officer	2 / 2	5 / 5
Nick Jenkins	-	Executive Medical Director (until June 2021)	0 / 1	0 / 5
Paul Molyneaux	-	Interim Executive Medical Director (from June 2021)	0 / 2	
Susan Wilkinson	-	Executive Chief Nurse	0 / 3	0 / 3
Nick Macdonald	-	Interim Director of Resources (from August 2021)	2 / 2	
Nicola Cottington	-	Chief Operating Officer	1 / 1	

The Trustee is also assisted in their work by a number of professional advisors, as detailed below:

External auditors:
Lovewell Blake
Bankside 300
Peachman Way
Broadland Business Park
Norwich
NR7 0LB

Internal auditors:
RSM UK Risk Assurance Services LLP
Blenheim House
Newmarket Road
Bury St Edmunds
Suffolk
IP33 3SB

Bankers:
National Westminster Bank
7 Cornhill
Bury St Edmunds
Suffolk
IP33 1BQ

Charity governance, structure and management arrangements

The Charity was established using the Special Purposes Charity model by issuing a Declaration of Trust dated 6 March 1997. The objects clause states: “For any charitable purpose or purposes relating to the National Health Service wholly or mainly for the services provided by the West Suffolk Hospital”.

The Corporate Trustee fulfils its legal duty by ensuring that funds are spent in accordance with the objects of each fund and by designating funds the Trustee respects the wishes of our generous donors to benefit patient care and advance the good health and welfare of patients, carers and staff. Where funds have been received which have specific restrictions set by the donor, restricted funds are established.

The charitable funds available for spending are for staff and departments within the Trust’s Directorate management structure. Each fund is managed by a designated fund holder.

The Charity has adopted the Institute of Chartered Secretaries and Administrators’ guidance for an induction process for newly appointed members of the Trust Board and Charitable Funds Committee. This process currently includes information about the Charity, including the governing document, the Charitable Funds Committee Terms of Reference, Trustee’s Annual Report and Accounts and information about trusteeship. An induction to the hospital and a guided tour of the beneficiary Trust’s facilities and any other additional training that their roles may require is also available.

Acting for the Corporate Trustee, the Charitable Funds Committee is responsible for the overall management of the Charity. The Committee is required to:

- Control, manage and monitor the use of the fund’s resources
- Provide support, guidance and encouragement for all its income raising activities whilst managing and monitoring the receipt of all income
- Ensure that “best practice” is followed in the conduct of all its affairs fulfilling all of its legal responsibilities
- Ensure that any Investment Policy approved by the Trust Board as Corporate Trustee is adhered to and that performance is continually reviewed whilst being aware of ethical considerations
- Keep the Trust Board fully informed on the activity, performance and risks of the Charity.

The accounting records and the day-to-day administration of the funds are dealt with through the Charity Accounts Assistant and the Assistant Director of Finance, located in the Finance Department, West Suffolk NHS Foundation Trust, Hardwick Lane, Bury St Edmunds, Suffolk, IP33 2QZ.

Trustee recruitment, appointment and induction

Non-Executive Members of the Trust Board are appointed by the Trust’s Council of Governors and Executive members of the Board are subject to recruitment by the Trust Board. Members of the Trust Board and Charitable Funds Committee are not individual Trustees under Charity Law but act as agents on behalf of the Corporate Trustee.

Key management personnel remuneration

The Chief Executive of the Trust, under a scheme of delegated authority approved by the Corporate Trustee, has day to day responsibility for the management of the Charity. The Charity operates with agreed operating procedures. These have been reviewed and updated during the financial year. The Trust Director of Resources is employed by West Suffolk NHS Foundation Trust.

The Charity does not directly employ any management or employees. Employees associated with fundraising and in an administrative capacity have an appropriate amount of their time recharged from the Trust to the Charity depending on the amount of time undertaking charitable duties.

The board members of the Corporate Trustee are paid by West Suffolk NHS Foundation Trust and receive no direct remuneration for the work that they undertake for the Charity.

Details of expenses of board members of the Corporate Trustee incurred on behalf of the Charity are disclosed in note 11 to the accounts.

The board members of the Corporate Trustee are required to disclose all relevant interests and register them with the Charity and withdraw from decisions where a conflict of interest arises. All related party transactions are disclosed in note 2 to the accounts.

Risk analysis

As part of the business planning exercise carried out during the year, the Trustee has considered the major risks to which My Wish Charity is exposed. It has reviewed systems and identified steps to mitigate those risks. Four major risks have been identified and arrangements have been put in place to mitigate those risks set out below:

- ***Future levels of income***

  My Wish Charity is reliant on donations to allow it to make payments to its NHS partner. If income falls then the Trust would not be able to make as many payments or enter into longer term commitments with the NHS body we support.

  The Trustee mitigates the risk that income will fall by engaging with the Fundraising Department. That Department comprises dedicated fundraising experts who work with My Wish Charity to provide a co-ordinated approach to raising funds. Fundraising activity is regularly benchmarked against our peers and thorough reviews are undertaken after major campaigns and events to understand what worked well and how things could be done better.

- ***Impact of COVID19***

  The COVID19 pandemic has impacted in many ways. There is the potential for loss of income and a reduction in the value of investments.

  However fundraising events are now being held again and it is hoped that the level of income in 2022/23 will continue to rise.

  The investment performance has been volatile during the pandemic, although we are monitoring the performance closely and have still seen a gain in the investment during the year.

- ***Unforeseen changes in the operation of the NHS***

  The NHS is, by its very nature, subject to national changes in government policy as well as local politically driven decisions. The Trustee has identified this as a risk as it may mean initiatives or healthcare activities supported by My Wish Charity are no longer delivered in the local area. The Trustee regularly liaises with other NHS partners to understand the changes that they are facing at an early stage.

- ***Maintaining the reputation of the Charity***

  The Trustee is conscious of the importance of maintaining its reputation within the community.

Income and Expenditure

Income and expenditure is monitored by individual fund, on a monthly basis as part of the monthly balancing process. The Charity Accounts Assistant and the Assistant Director of Finance look for anomalies which may indicate exposure to risk and if any are detected will bring them to the attention of the Audit Committee.

Wider networks

My Wish Charity is one of over 250 NHS linked charities in England and Wales who are eligible to join the NHS Charities Together (formally known as Association of NHS Charities). As a member charity, we have the opportunity to discuss matters of common concern and exchange information and experiences, join together with others to lobby government departments and others, and to participate in conferences and seminars that offer support and education for our staff and board members.

The charity has organisational membership with the Institute of Fundraising.

Related parties

My Wish Charity works closely with, and provides all of its funding to, the West Suffolk NHS Foundation Trust (the Trust). Transactions with The Trust are considered to be related party transactions which are disclosed within the financial statements accordingly.

Our relationship with the wider community

The ability of the Charity to continue its vital support for the West Suffolk Hospital is dependent on its ability to maintain and increase donations from the general public. The charity also continues to forge strong relationships with members of staff of the hospital without whose co-operation the ability to make an effective contribution would be much diminished.

Volunteers

The Trustee would like to pay tribute to:

- Our volunteers for their time, support, and commitment
- The members of staff who give of their time out of hours in support of the work on the committees, in developing ideas for charitable fundraising and expenditure with us to identify how we can help them care for the patients
- Our fundraisers who do so much to encourage others to enrich the lives of others through donations and fundraising activities.
- The Charity has a handful of regular volunteers that help out at events; their roles vary from car park duties to serving food and drink. We are indebted and extremely grateful to our volunteers as without them the charity could not run as efficiently as it does.
- Our ambassador Frankie Dettori has been incredibly supportive, and we are extremely grateful to him.

Having read all about us, please consider supporting the work of My Wish Charity

The challenge facing My Wish charity in the future is to maintain and grow our support so that we can continue to make a difference to West Suffolk Hospital, Newmarket Community Hospital, and all the services they provide out in the community.

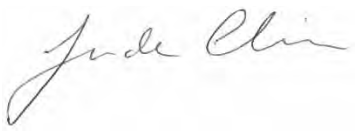
What could your gift buy?

- **£2** could buy a birthday cake for a patient spending their birthday in hospital away from their home.
- **£350** can provide 10 welcome home packs containing essentials for vulnerable patients going home to empty cupboards after a hospital stay.
- **£900** could pay for a therapist to have extra training to become competent in treating dysphagia (swallowing problems)
- **£1,000** could buy recliner chairs for patients who are having treatments
- **£2,000** could purchase an Automated External Defibrillator (AED) for a community staff.
- **£5,000** can buy a vein viewer machine, which locates veins easily taking any anxiety away from our young and vulnerable patients.
- **£8,000** could buy a chest compression system which delivers continuous compressions to a cardiac patient without the need of the care giver being hands on.
- **£20,000** can purchase a 3d scanner for our maternity patients.
- **£28,000** could buy a BK3500 ultrasound machine that can help detect cardiac arrest faster.
- **£50,000** could buy an Echo cardio machine.

If you have a larger gift in mind, please talk to us. We always have a number of major projects waiting funding.

If you would like to make a donation or support any of our fundraising activities, please give us a call on **01284 712952** or send an email to **fundraising@wsh.nhs.uk**.

Signed on behalf of the trustee:



Name: Jude Chin (Chair of Trustee)
Date: 11 January 2023

Statement of Trustee's responsibilities in respect of the Trustee's Annual Report and Accounts

Trustee responsibilities

The Trustee is responsible for preparing the Trustee Annual report and the financial statements in accordance with applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Practice).

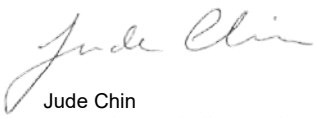
The law applicable to Charities in England and Wales requires the Trustee to prepare financial statements for each financial year which give a true and fair view of the state of affairs of the charity and of the incoming resources and application of resources of the charity for that period.

In preparing these financial statements, the Trustee is required to:

- select suitable accounting policies and then apply them consistently;
- observe the methods and principles in the Charities SORP 2019 (FRS 102);
- make judgements and estimates that are reasonable and prudent;
- state whether applicable Accounting Standards have been followed, subject to any material departures disclosed and explained in the financial statements;
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the charity will continue in operation.

The Trustee is responsible for keeping adequate accounting records that disclose with reasonable accuracy at any time the financial position of the charity and enable them to ensure that the financial statements comply with the Charities Act 2011, the Charity (Accounts and Reports) Regulations 2008 and the provisions of the Trust Deed. They are also responsible for safeguarding the assets of the charity and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

Signed on behalf of the Corporate Trustee:



Jude Chin
Chair of West Suffolk NHS Foundation Trust, Corporate Trustee
11 January 2023

Independent Auditor's Report to the Trustee of My Wish Charity

Opinion

We have audited the financial statements of My Wish Charity (the 'charity') for the year ended 31 March 2022 which comprise the statement of financial activities, balance sheet, statement of cash flows and the related notes to the financial statements, including significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and United Kingdom Accounting Standards, including Financial Reporting Standard 102 *The Financial Reporting Standard applicable in the UK and Republic of Ireland* (United Kingdom Generally Accepted Accounting Practice).

In our opinion the financial statements:

- give a true and fair view of the state of the charity's affairs as at 31 March 2022, and of its incoming resources and application of resources, including its income and expenditure, for the year then ended;
- have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice; and
- have been prepared in accordance with the requirements of the Charities Act 2011.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the charity in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the trustees' use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the charity's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the trustees with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the trustees annual report, other than the financial statements and our auditor's report thereon. The trustees are responsible for the other information contained within the annual report. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the course of the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Matters on which we are required to report by exception
We have nothing to report in respect of the following matters in relation to which the Charities (Accounts and Reports) Regulations 2008 require us to report to you if, in our opinion:

- the information given in the financial statements is inconsistent in any material respect with the trustees' report; or
- the charity has not kept adequate accounting records; or
- the financial statements are not in agreement with the accounting records and returns; or
- we have not received all the information and explanations we require for our audit.

Responsibilities of trustees
As explained more fully in the trustees' responsibilities statement set out on page 34, the trustees are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the trustees determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the trustees are responsible for assessing the charity's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the trustees either intend to liquidate the charity or to cease operations, or have no realistic alternative but to do so.

Auditor's responsibilities for the audit of the financial statements
We have been appointed as auditor under section 144 of the Charities Act 2011 and report in accordance with regulations made under section 154 of that Act.

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- Enquiry of management and those charged with governance;
- Enquiry of entity staff compliance functions to identify any instances of non-compliance with laws and regulations;
- Reviewing financial statement disclosures and testing to supporting documentation to assess compliance with applicable laws and regulations.
- Performing audit work over the risk of management override of controls, including testing of journal entries and other adjustments for appropriateness, evaluating the rationale of significant transactions outside the normal course of activities and reviewing accounting estimates for bias.

Because of the inherent limitations of an audit, there is a risk that we will not detect all irregularities, including those leading to a material misstatement in the financial statements or non-compliance with regulation. This risk increases the more that compliance with a law or regulation is removed from the events and transactions reflected in the financial statements, as we will be less likely to become aware of instances of non-compliance. The risk is also greater regarding irregularities occurring due to fraud rather than error, as fraud involves intentional concealment, forgery, collusion, omission or misrepresentation.

A further description of our responsibilities is available on the Financial Reporting Council's website at: https://www.frc.org.uk/Our-Work/Audit/Audit-and-assurance/Standards-and-guidance/Standards-and-guidance-for-auditors/Auditors-responsibilities-for-audit/Description-of-auditors-responsibilities-for-audit.aspx. This description forms part of our auditor's report.

Use of our report

This report is made solely to the charity's trustees, as a body, in accordance with Part 4 of the Charities (Accounts and Reports) Regulations 2008. Our audit work has been undertaken so that we might state to the charity's trustees those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the charity and the charity's trustees as a body, for our audit work, for this report, or for the opinions we have formed.

For and on behalf of

Lovewell Blake LLP
Chartered accountants & statutory auditor
Bankside 300
Peachman Way
Broadland Business Park
Norwich
NR7 0LB

Lovewell Blake LLP is eligible to act as an auditor in terms of section 1212 of the Companies Act 2006.

My Wish Charity Statement of Financial Activities for the year ended 31 March 2022

	Note	Unrestricted Funds 2021/22 £000	Restricted Funds 2021/22 £000	Total Funds 2021/22 £000	Unrestricted Funds 2020/21 £000	Restricted Funds 2020/21 £000	Total Funds 2020/21 £000
Income and endowments from:							
Donations and legacies	3	44	325	369	86	289	375
Charitable activities	4	2	54	56	14	275	289
Other trading activities	5	8	5	13	4	27	31
Total Income		**54**	**384**	**438**	**104**	**591**	**695**
Expenditure on:							
Raising funds	8	22	136	158	29	134	163
Charitable activities	9						
Clinical Care and Research Posts		0	125	125	0	37	37
Purchase of New Equipment		49	175	224	30	145	175
New Building and Refurbishment		(3)	52	49	20	21	41
Staff Education and Welfare		10	43	53	(3)	89	86
Patient Education and Welfare		5	26	31	1	46	47
Total Expenditure		**83**	**557**	**640**	**77**	**472**	**549**
Net gains on investments		25	159	184	39	243	282
Net income/(expenditure)		(4)	(14)	(18)	66	362	428
Net movement in funds		**(4)**	**(14)**	**(18)**	**66**	**362**	**428**
Reconciliation of Funds:							
Total funds brought forward		316	2,076	2,392	250	1,714	1,964
Total funds carried forward		**312**	**2,062**	**2,374**	**316**	**2,076**	**2,392**

All income and expenditure are derived from continuing activities.

The notes set out on pages 41 to 49 form part of these financial statements

My Wish Charity Balance Sheet
as at 31 March 2022

	Notes	Unrestricted Funds £000 31 March 2022	Restricted Funds £000 31 March 2022	Total Funds £000 31 March 2022	Unrestricted Funds £000 31 March 2021	Restricted Funds £000 31 March 2021	Total Funds £000 31 March 2021
Fixed Assets							
Intangible	14	0	0	0	0	2	2
Investments	15	359	1,418	1,777	333	1,259	1,592
Total Fixed Assets		**359**	**1,418**	**1,777**	**333**	**1,261**	**1,594**
Current Assets:							
Debtors	16	2	332	334	5	205	210
Cash at bank	17	(25)	421	396	2	683	685
Total Current (Liabilities) / Assets		**(23)**	**753**	**730**	**7**	**888**	**895**
Liabilities:							
Creditors falling due within one year	18	(24)	(109)	(133)	(24)	(73)	(97)
Net Current (Liabilities) / Assets		**(47)**	**644**	**597**	**(17)**	**815**	**798**
Total Assets less Current Liabilities		**312**	**2,062**	**2,374**	**316**	**2,076**	**2,392**
Net Assets		**312**	**2,062**	**2,374**	**316**	**2,076**	**2,392**
Charitable Funds	24						
Restricted income funds		0	2,062	2,062	0	2,076	2,076
Unrestricted income funds		312	0	312	316	0	316
Total Charitable Funds		**312**	**2,062**	**2,374**	**316**	**2,076**	**2,392**

The financial statements were approved and authorised for issue by the Corporate Trustee and were signed on its behalf on 11 January 2023

Signed:

Name: Jude Chin
Trustee

The notes set out on pages 41 to 49 form part of these financial statements

My Wish Charity Statement of Cashflows

Year Ending 31 March 2022

	Note	Total Funds 2021/22 £000	Total Funds 2020/21 £000
Cash flows from operating activities:			
Net cash provided by / (used in) operating activities	19	(289)	197
Cash flows from investing activities:			
Dividends, interest and rents from investments		0	0
Purchase of investments	15	0	(167)
Net cash provided by / (used in) investing activities		**0**	**(167)**
Change in cash and cash equivalents in the reporting period		(289)	30
Cash and cash equivalents at the beginning of the reporting period		685	655
Cash and cash equivalents at the end of the reporting period	17	**396**	**685**

The notes set out on pages 41 to 49 form part of these financial statements

1 Accounting Policies

General Information

The charity is a public benefit entity and a registered charity in England and Wales and is unincorporated. The address of the principal office is The Trust Fund Office, West Suffolk NHS Foundation Trust, Hardwick Lane, Bury St Edmunds, IP33 2QZ.

[a] Basis of Preparation

The financial statements have been prepared under the historic cost convention, subject to revaluation.

Statement of compliance

The charity constitutes a public benefit entity as defined by FRS 102. The financial statements have been prepared in accordance with Accounting and Reporting by Charities: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland issued in October 2019, the Financial Reporting Standard applicable in the United Kingdom and Republic of Ireland (FRS 102), the Charities Act 2011 and UK Generally Accepted Accounting Practice.

True and fair override

The financial statements have been prepared to give a 'true and fair' view and have departed from the Charities (Accounts and Reports) Regulations 2008 only to the extent required to provide a 'true and fair view'. This departure has involved following the Accounting and Reporting by Charities: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland issued in October 2019 rather than the Accounting and Reporting by Charities: Statement of Recommended Practice effective from 1 April 2005 which has since been withdrawn.

Going Concern

The Trustee considers that there are no material uncertainties about the My Wish Charity's ability to continue as a going concern. There are no material uncertainties affecting the current year's accounts. The Trustee has considered the following areas in its assessment of the Charity being a going concern, operational capability, market-based demand and structural finance.

Operational capability - The Charity has reviewed its structure and has increased its administration and fundraising resources to ensure that the Charity can continue to fundraise and improve its administration function. The Charity considers resourcing at the Charitable Funds Committee.

Market based demand - The Charity has considered the fundraising environment particularly now that we have returned to 'business as usual' after the coronavirus pandemic. The Committee is aware that the new post covid environment and the impact of cost of living rises may produce challenges but feel the Charity has sufficient resources to manage any downturn in income.

Structural finance - The Charity has in place a reserves policy to ensure the continued availability to fund ongoing expenditure. The Charity does not enter into significant long term expenditure commitments that would put pressure on cash balances. The most significant creditor is West Suffolk NHS Foundation Trust and this relates to reimbursement of incurred charitable funds expenditure. This means that should income reduce significantly expenditure can be cut maintaining the financial stability of the Charity.

The main risk of failure of the Charity is if income should cease for some unspecified reason. This is felt to be extremely remote as the Charity is well supported locally and any publicity around loss of income would generate local support. However, should there be a significant drop in income then the Charity has few ongoing expenses that cannot be ceased within an appropriate time period.

In future years, one of the key risks to the My Wish Charity is a fall in income from donations or investment income but the Trustee has arrangements in place to mitigate those risks (see the Risk analysis section of the Trustee Annual Report, page 28). In addition the Charity does not have ongoing contractual commitments that would impact on the going concern assumption.

[b] Funds

Restricted funds are those where the donor has provided for the donation to be spent in furtherance of a specified charitable purpose. The charity has no endowment funds.

Those funds which are neither restricted nor endowment income funds, are unrestricted income funds which are sub analysed between designated (earmarked) funds where the Trustee have set aside amounts to be used for specific purposes or which reflect the non-binding wishes of donors and unrestricted funds which are at the Trustee's discretion. The major funds held in each of these categories are disclosed in note 24.

[c] Income

All income is recognised once the Charity has entitlement to the resources, it is probable that the resources will be received and the monetary value of income can be measured with sufficient reliability.

[d] Income from legacies

Legacies are accounted for as income either upon receipt or where the receipt of the legacy is probable; this will be once confirmation has been received from the representatives of the deceased's estate that:

- probate has been granted to pay the legacy; and
- all conditions attached to the legacy have been fulfilled or are within the charity's control.

Material legacies which have been notified but not recognised as income in the Statement of Financial Activities are disclosed in a separate note to the accounts with an estimate of the amount receivable (note 20).
If there is uncertainty as to the amount of the legacy and it cannot be reliably estimated then the legacy is shown as a contingent asset until all of the conditions for income recognition are met.

[e] Expenditure and irrecoverable VAT

All expenditure is accounted for on an accruals basis and has been classified under headings that aggregate all costs related to each category of expense shown in the Statement of Financial Activities. Expenditure is recognised when the following criteria are met:

- There is a present legal or constructive obligation resulting from a past event
- It is more likely than not that a transfer of benefits (usually a cash payment) will be required in settlement
- The amount of the obligation can be measured or estimated reliably.

Irrecoverable VAT is charged against the category of expenditure for which it was incurred.

[f] Allocation of support costs

Support costs are those costs that do not relate to a single activity. These include some staff costs, internal and external audit costs and IT support. Support costs have been apportioned between fundraising costs and charitable activities on the proportion of total spend.

Income from investments is allocated to funds twice a year based upon the balance of the funds held at the time of allocation.

[g] Fundraising costs

The costs of generating funds are those costs attributable to generating income for the Charity, other than those costs incurred in undertaking charitable activities or the costs incurred in undertaking trading activities in furtherance of the Charity's objects. The costs of generating funds represent fundraising costs together with investment management fees. Fundraising costs includes expenses for fundraising activities.

[h] Charitable activities

Costs of charitable activities comprise all costs incurred in the pursuit of the charitable objects of the Charity. These costs, where not wholly attributable, are apportioned between the categories of charitable expenditure in addition to the direct costs. The total costs of each category of charitable expenditure include an apportionment of support costs as shown in note 9.

[i] Governance costs

Governance costs are classified as support costs and have therefore been apportioned between fundraising activities and charitable activities. There is no effect on the total expenditure for 2021/22 or 2020/21.

[j] Intangible fixed assets

Valuation

Intangible fixed assets are non-monetary fixed assets that do not have physical substance but are identifiable and are controlled by the Charity through custody or legal rights. Intangible fixed assets include purchased intangible assets such as software licences. Although such assets lack physical substance they provide an ongoing benefit to the Charity. FRS102 requires that intangible fixed assets must be held at their historical cost. The residual value of intangible fixed assets is nil when calculating the charge for amortisation unless evidence exists to the contrary. The carrying value of intangible assets are reviewed for impairments in periods or changes in circumstances indicate the carrying value may not be recoverable.

Amortisation

Amortisation on intangible assets are charged as an expense to the relevant Statement of Financial Activities category reflecting the use of the asset. Intangible assets are amortised at rates calculated to write them down to estimated residual value on a straight line basis. The intangible assets relate to software and this has been amortised over seven years.

[k] Realised and Unrealised Gains and Losses

All gains and losses are taken to the Statement of Financial Activities as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening market value (purchase date if later). Unrealised gains and losses are calculated quarterly based on the change in market value in the quarter. These are apportioned to the funds based on the average fund balance for the quarter. Any realised gains and losses are apportioned to funds in accordance with the fund balances at the date of sale.

[l] Debtors

Debtors are amounts owed to the Charity. They are measured based on the recoverable amount.

[m] Cash and Cash Equivalents

Cash at bank and in hand is held to meet the day to day running costs of the Charity as they fall due. Cash equivalents are short term, highly liquid investments, usually in 90 day notice interest bearing savings accounts.

[n] Creditors

Creditors are amounts owed by the Charity. They are measured at the amount that the Charity expects to have to pay to settle the debt.

[o] Pensions

My Wish Charity has no direct employees. Staff costs incurred in connection with the Charity are recharged at cost by the Corporate Trustee, West Suffolk NHS Foundation Trust and include pensions costs. Employees are able to join the NHS Pension Scheme in accordance with its rules. The Charity is not an employer that accesses the pension scheme directly therefore further disclosure is not required.

[p] Investments

Investments are recognised initially at fair value which is normally the transaction price excluding transaction costs. Subsequently, they are measured at fair value.

2 Related party transactions

West Suffolk NHS Foundation Trust acts as a sole Corporate Trustee to the Charity, and as such is both a related party and the ultimate controlling party. Members of the Charitable Funds Committee are also non-executive and executive members of West Suffolk NHS Foundation Trust. The Trust is the main beneficiary of the Charity. The Charity has provided funds to The Trust for approved expenditure made on behalf of the Charity. This funding amounted to £640k (2020/21: £549k) of which there is a net creditor of £125k (2020/21: £62k) with the Trust. The expenditure is analysed in greater detail in notes 8 and 9. The Trust also recharges the Charity for members of staff who are directly involved with the Charity, the details of which are given in note 12.

None of the members of the West Suffolk NHS Foundation Trust board or parties related to them has undertaken any transactions with the Charity or received any benefit from the Charity in payment or kind. The Trustee received no honoraria or emoluments in the year. Expenses paid to the Trustee are disclosed in note 11.

3 Income from donations and legacies

	Unrestricted Funds 2021/22 £'000	Restricted Funds 2021/22 £'000	Total 2021/22 £'000	Total 2020/21 £'000
Donations from Individuals	35	122	157	272
Corporate Donations	4	15	19	31
Legacies	5	188	193	72
Total	44	325	369	375

Donations from individuals are gifts from members of the public, relatives of patients and staff. Gift Aid is recovered from individual donations if a declaration is signed.

4 Charitable activities

	Unrestricted Funds 2021/22 £'000	Restricted Funds 2021/22 £'000	Total 2021/22 £'000	Total 2020/21 £'000
Grant Income	0	21	21	253
Other income	2	33	35	36
Total	2	54	56	289

Grant income in 2020/21 mainly relates to money received from the NHS Charities Together charity and is being spent on projects that relate to the Coronavirus pandemi

5 Other trading activities

	Unrestricted Funds 2021/22 £'000	Restricted Funds 2021/22 £'000	Total 2021/22 £'000	Total 2020/21 £'000
Course fee income	0	1	1	1
West Suffolk Hospital other organised fundraising events	5	0	5	3
Third party fundraising	3	4	7	27
Total	8	5	13	31

6 Role of Volunteers

Like all charities My Wish Charity is reliant on a team of volunteers for our smooth running. Our volunteers perform two roles:

Fund advisors:- there are 80 West Suffolk NHS Foundation Trust staff who manage how the Charity's designated funds should be spent. These funds are designated (or earmarked) by the Trustee to be spent for a particular purpose or in a particular ward or department. Each fund advisor has delegated powers to spend the designated funds that they manage in accordance with the Trustee's wishes. The Trustee determines what each fund can be spent on and the amount that can be spent in a year. Fund advisors who spend more than £5,000 are required to report to Charitable Fund Committee setting out what they spent the money on.

Fundraisers: there are about 25 local volunteers who actively fundraise for the My Wish Charity by running events and the use of collections.

In accordance with the SORP, due to the absence of any reliable measurement basis, the contribution of these volunteers is not recognised in the accounts.

7 Grants made to instutions

All grants are made to the West Suffolk NHS Foundation Trust. The charity does not make any grants to individuals. The grants received by the beneficiary for each category of charitable activity is disclosed in note 9.

8 Analysis of expenditure on raising funds

	Unrestricted Funds 2021/22 £'000	Restricted Funds 2021/22 £'000	Total 2021/22 £'000	Total 2020/21 £'000
Fundraising support costs	22	136	158	163
Total	22	136	158	163

9 Analysis of charitable expenditure

The Charity did not undertake any direct charitable activities on its own account during the year. All of the charitable expenditure was in the form of funding approved expenditure.

Expenditure was approved principally in favour by West Suffolk NHS Foundation Trust to carry out activities that will benefit patients. The Charity reimbursed expenditure incurred by West Suffolk NHS Foundation Trust or its staff.

	Funded Activity Unrestricted 2021/22 £000	Funded Activity Restricted 2021/22 £000	Funded Activity Total 2021/22 £000	Support costs 2021/22 £000	Total 2021/22 £000	Total 2020/21 £000
Clinical Care & Research Posts	0	112	112	13	125	37
Purchase of New Equipment	45	156	201	23	224	175
New Building & Refurbishment	(2)	48	46	3	49	41
Staff Education & Welfare	9	39	48	5	53	86
Patient Education & Welfare	4	24	28	3	31	47
Total	56	379	435	47	482	386

10 Allocation of support costs and overheads

All support and overhead costs are allocated between fundraising activities and charitable activities. Governance costs are support costs which relate to the strategic and day to day management of a charity. The basis of allocation is the average monthly balance of each fund.

	Raising funds £000	Charitable activities £000	2022 Total £000	2021 Total £000
External audit (2021/22 figure includes an undercharge from 2020/21)	2	7	9	7
Governance Costs	2	7	9	7
Amortisation	1	1	2	2
Computer maintenance	1	3	4	4
Salaries and related costs	12	35	47	35
Other	0	1	1	2
Total support costs and overheads	16	47	63	50

	Unrestricted funds £000	Restricted funds £000	2022 Total £000	2021 Total £000
Raising funds	2	14	16	15
Charitable activities	6	41	47	35
	8	55	63	50

11 Trustee's remuneration, benefits and expenses

The board members of the Corporate Trustee receive no direct remuneration for the work that they undertake on behalf of the Charity. However, they can claim expenses to reimburse them for costs that they incur in fulfilling their duties. No board members claimed or were entitled to claim any expenses during the year (2020/21: £nil). Board members of the Corporate Trustee receive remuneration from The Corporate Trustee, West Suffolk NHS Foundation Trust, in accordance with their contracts of employment.

12 Analysis of recharged staff costs and remuneration of key management personnel

The Charity does not directly employ any members of staff. However, the Funds are recharged by the Trust for employees providing support services to charitable activities as well as clinical members of staff supported directly by individual funds. Support employees were the Charitable Fund Accountant, Technical Accountant and members of the fundraising team. No employee had emoluments in excess of £60,000 (2020/21: £nil). My Wish Charity has no key management personnel (2020/21: £nil).

12a - Staff Costs and Employee Benefits

	2021/22 £000	2020/21 £000
Salaries and wages	237	169
Social Security Costs	23	14
Employers Pension Contribution	35	25
Total	295	208

12b - Employee numbers

Average Headcount	10.3	9.4
Average Full Time Headcount	4.5	3.9
Average Part Time Head Count	5.8	5.5
Average WTE	9.2	6.7
Number of Employees earning over £60,000 (excluding employer pension contributions)	Nil	Nil

13 Auditor's remuneration

The external auditor's remuneration of £8,220 including irrecoverable VAT (2020/21: £7,956) related solely to the audit of the financial statements with no other additional work undertaken by the external auditors (2020/21: none undertaken).

14 Intangible fixed assets

Software	2021/22	2020/21
Cost	**£000**	**£000**
At 1 April	17	17
At 31 March	17	17
Accumulated amortisation		
At 1 April	15	13
Provided during the year	2	2
At 31 March	17	15
Net book value		
Net book value at 31 March	**0**	**2**

15 Fixed asset investments

Movement in listed investment	31 March 2022	31 March 2021
	Total	**Total**
	£000	**£000**
Market value brought forward	1,592	1,143
Add purchase of investment	0	167
Less net gain / (loss) on revaluation	185	282
Market value as at 31 March	**1,777**	**1,592**

The Charity investments are in the COIF Ethical Investment fund managed by CCLA. The valuation of the investment is based on the bid price at the year end date. The original value of the investment was £1,317k.

16 Analysis of current assets

Debtors due within one year	31 March 2022 Total £000	31 March 2021 Total £000
Other debtors	334	210
Total	**334**	**210**

17 Analysis of cash and cash equivalents

	31 March 2022 Total £000	31 March 2021 Total £000
Cash in Hand	395	685
	395	**685**

18 Analysis of current liabilities

Creditors due within one year	31 March 2022 Total £000	31 March 2021 Total £000
Creditors	107	90
Other Accruals	26	7
Total	**133**	**97**

Creditors represent sums owed at the year end by the Charity. Of this amount £125k (2020/21: £62k) is owed to a related party, West Suffolk NHS Foundation Trust, for costs incurred by the Trust on behalf of the Charity in the furtherance of the Charity's objects.

19 Reconciliation of net income/(expenditure) to net cash flow from operating activities

	2022 £000	2021 £000
Net income (as per the Statement of Financial Activities)	(18)	428
Adjustments for:		
Amortisation	2	2
Gain on investments	(184)	(282)
(increase)/Decrease in debtors	(124)	54
(Decrease) / increase in creditors	35	(5)
Net cash provided by / (used in) operating activities	(289)	197

20 Material Legacies

Legacy income is only included in income where receipt is reasonably certain and the amount can be estimated with reasonable accuracy, or the legacy has been received. As at 31 March 2022 there were 4 legacies totalling £332,000 that had been notified but not received (2020/21: £202,000). These legacies have been included as income and as debtors.

21 Comparative figures

The comparative figures relate to the 12 month period between 1 April 2021 and 31 March 2022.

22 Post Balance Sheet Events

There are no post balance sheet events to report.

24 Analysis of charitable funds

Name of Fund	Source of Fund	Purpose	Fund Balance 1 April 2021 £000	Income	Expenditure	(Loss) /gain on investments in year	Fund Balance 31 March 2022 £000
Macmillan Service	Donations	Patient and Staff welfare	536	-	(146)	43	433
Every Heart Matters	Donations	Patient and Staff welfare	22	-	(2)	2	22
Scanner Appeal	Donations	Purchase of equipment	15	-	(1)	1	15
Oncology Service	Donations	Patient and Staff welfare	17	-	(2)	1	16
SCBU	Donations	Patient and Staff welfare	36	2	(3)	3	38
Paediatric and Childrens Ward	Donations	Patient and Staff welfare	28	3	(9)	2	24
Breast Cancer Fund (ex Lizzie Duncan)	Donations	Patient and Staff welfare	62	7	(7)	5	67
Microbiology	Donations	Patient and Staff welfare	22	-	(2)	2	22
Bereavement Room	Donations	Patient welfare	19	2	(3)	2	20
Mercury Dementia Appeal	Donations	Patient and Staff welfare	40	1	(15)	2	28
Ophthalmic Fund	Donations	Patient and Staff welfare	107	4	(99)	7	19
Cardiology	Donations	Patient and Staff welfare	36	7	(4)	3	42
Palliative Care	Donations	Patient and Staff welfare	325	17	(30)	26	338
Haematology research fund	Donations	Patient and Staff welfare	15	-	(2)	1	14
Stroke services	Donations	Patient and Staff welfare	16	-	8	1	25
Newmarket Radiology	Donations	Patient and Staff welfare	15	-	(1)	1	15
Newmarket Hospital	Donations	Patient and Staff welfare	91	8	(28)	7	78
Wish upon a Star	Donations	Patient and Staff welfare	34	219	(17)	5	241
Chemical Pathology	Donations	Patient and Staff welfare	43	-	(3)	3	43
Critical Care	Donations	Patient and Staff welfare	17	57	(4)	2	72
Phamacy Social Amenities	Donations	Patient and Staff welfare	15	3	(2)	2	18
Emergency Department	Donations	Patient and Staff welfare	20	(1)	(2)	1	18
Rheumatology	Donations	Patient and Staff welfare	51	-	(5)	4	50
Covid 19	Donations	Patient and Staff welfare	243	10	(108)	15	160
Other Restricted Funds			251	45	(70)	18	244
Total Restricted Funds			2,076	384	(557)	159	2,062
Unrestricted funds	Donations	Patient and Staff welfare	316	54	(83)	25	312
			2,392	438	(640)	184	2,374

These are the major funds referred to in Accounting policy note 1(b). The disclosure is based on fund previously disclosed in 2020/21 and funds with brought forward incurred during the year with balances greater than £15,000 and others where there were significant items of income and expenditure incurred during the year.

5.3 - Governance

CHARITABLE FUNDS COMMITTEE

Terms of Reference

1. Purpose of the Committee

1.1. The Trust Board hereby resolves to establish an assurance committee to be known as the Charitable Funds Committee (the committee). The committee has no executive powers other than those specifically delegated in these terms of reference. The scope of this assurance committee will focus on quality, patient safety and change management.

2. Level of Authority

2.1. The committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to request any information from any employee and all employees are directed to cooperate with any request made by the committee. The committee is authorised by the Trust Board to obtain legal advice and to secure the attendance of experts and external representatives or persons with relevant experience/expertise if it considers it necessary.

2.2. The committee has authority to make decisions on behalf of the Board but in compliance with the Trust's Standing Financial Instructions and Scheme of Delegation.

2.3. The Committee may establish sub-groups/committees reporting to it. It shall remain accountable to the Board for the work of any group reporting to it.

3. Duties and responsibilities

3.1. The key responsibilities of the committee shall be:

- To determine the organisations strategy for Charitable Funds however this is subject to the approval of the Trust Board.
- Responsibility for Charitable Funds rests entirely with the Board of Directors of West Suffolk NHS Foundation Trust, which is the sole Trustee of the charitable funds.
- The Charitable Funds Committee is a formal sub-committee of the Board and minutes of the meetings will be considered by the Board.
- The Committee as part of the strategy, will consider the approach to fundraising, the investment of funds, the approach to expenditure and the approval of procedures associated with the use of Charitable Funds.
- The Trust Board authorises the Committee to obtain expert professional advice.
- The members of the Committee are all Trustees of the Charitable Fund and must exercise the powers granted by the Trust Deed that established the Funds.
- The Committee acts with the delegated responsibility from the Trust Board of West Suffolk NHS Foundation Trust (the corporate trustee)
- To ensure the information held by the Charity Commission is kept up to date and reviewed by the committee on a regular basis
- The powers of the Trustees are set out in the Trust Deed
- In exercising these powers the following duties are relevant:

Investment

- Consider any changes in investment strategy and policy, making recommendations to the Board of Directors.
- Review performance of current investments in respect of both income and capital appreciation.

Fundraising

- The Committee will determine the strategy and policies for fundraising.
- Review the fundraising methods used and ensure that they are acceptable in terms of a health / public body context.
- To monitor the fundraising performance
- To ensure that there are procedures in place to co-ordinate the fundraising activities of the Trust
- To consider whether the Trust should undertake major fundraising appeals and establish the appropriate framework to ensure that any appeal is properly managed.

Expenditure

- To agree the expenditure strategy and policies of the Funds within the framework of the Governing Document which defines the purposes for which the charity has been established.
- To monitor compliance with the strategy and policies and ensure that the wishes of the donors are met.
- To consider and as appropriate approve Charitable Fund bids in accordance with the relevant procedures.

Reporting

- To determine the format of the performance information it requires in managing the Charitable Fund in the most effective manner. This will include information on fundraising, expenditure and investment.

Audit and Accounts

- To oversee submission of the Charity Annual Report and Accounts prior to submission to the Audit Committee and ensure these are submitted in the appropriate form and within the required legislative timetable
- To receive and consider any Internal and External Audit Reports on Charitable Funds and monitor any action being taken to address matters of concern raised.
- To consider any other return required by the Charity Commission or other statutory body.
- To ensure that sound financial control is exercised, assets are safeguarded from fraud, that all income due to the Charity is received and that no breaches of relevant legal and other regulations occur.

Other

- To develop formal links with outside voluntary organisations, such as the League of Friends, to ensure a co-ordinated approach.
- To maintain a strong link to the Trust's Investment Panel and the Capital Strategy Group through the presence of the Chief Operating Officer and Director of Resources.

Powers and duties of Fundholders

- The Fundholder for an individual fund will be a senior staff member as delegated by the Charitable Funds Committee.
- All Fundholders must be employees of West Suffolk NHS Foundation Trust.
- Individual Fundholders hold a delegated responsibility from the Trustees for the individual funds under their stewardship.
- The income and property of the fund must be applied in furtherance of the purpose of the Charity and for no other purpose.
- The Fundholder has a delegated responsibility to ensure that the donor's wishes are complied with.
- The Fundholder has a responsibility in complying with the Standing Orders, Standing Financial Instructions and Scheme of Delegation of West Suffolk NHS Foundation Trust.
- The Fundholder must comply with the authorisation levels as set out in the Charitable Funds policy.

4. Membership

4.1. Membership of the Committee will comprise:

Executive Leads:

- Executive Director of Resources
- Chief Operating Officer
- Executive Director of Workforce and Communications.

Other Members

- Two non-executive directors, one of whom will chair the meeting

The Chairman and Chief Executive have an open invitation to attend meetings of the committee.

Others in attendance would be:

- Head of Fundraising
- Assistant Director of Finance
- Charitable Fund Accountant
- Trust Office Executive Assistant (for minuting purposes)

4.2. The Committee may invite members of staff, other key stakeholders and advisors to attend meetings as appropriate.

4.3. The Committee may ask any other officials of the organisation or representatives of external partners, the Head of Internal Audit or a representative of the Trust's

External Auditors to attend to assist it with its discussions on any particular matter. The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters

4.4. Attendance at meetings is essential. In exceptional circumstances when an executive member cannot attend they must arrange for a fully briefed deputy of sufficient seniority to attend on their behalf. Members will be required to attend as a minimum 75% of the meetings per year.

5. Quorum

5.1. The quorum necessary for the transaction of business shall be any three members, one of whom must be a non-executive director. A duly convened meeting of the committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions invested in, or exercised, by the committee.

5.2. Members are requested to send a deputy with the appropriate skills and knowledge to represent them if they are unable to attend a meeting. Deputies will be counted for the purposes of the quorum.

5.3. Virtual attendance will count towards quorum.

6. Frequency of meetings

6.1. The committee shall operate as follows:

- The committee will meet at least on a quarterly basis.
- The committee chair may convene an ad-hoc meeting if there is urgent business to transact.
- Papers will be sent out by Trust Office at least 5 days before each meeting.
- Membership and terms of reference will only be changed with the approval of the committee and ultimately the board.

7. Sub Committees

7.1. The committee does not have a subcommittee.

8. Arrangements for meetings and circulation of minutes/Administrative support

8.1. The Committee shall be supported by Trust office.
8.2. Minutes will be prepared after each meeting of the committee within 5 working days and circulated to members of the committee and others as necessary once confirmed by the Chair of the committee. Once the committee has approved the full minutes, a copy will be available, for information, to the board at its next meeting.

9. Accountability and reporting arrangements

9.1. The committee shall be directly accountable to the Board.

9.2. There should be a formal report from the committee to the next meeting of the Board of Directors. The chair of the committee shall draw to the attention of the Trust Board, in private or public as appropriate, any issues that require

disclosure to the Board or require executive action. The speed of communication should be proportionate to the seriousness and likely impact of the issue.

9.3. The key issues of the committee will be included in the Board of Directors meeting agenda and papers.

9.4. The committee shall submit an annual report to the Trust Board within the first three months of the new financial year.

10. Monitoring effectiveness and compliance with Terms of reference

10.1. In order to support the continual improvement of governance standards, this committee is required to complete a self-assessment of effectiveness at least annually and advise the Trust Board of any suggested amendments to these terms of reference which would improve the trust governance arrangements.

11. Ratification of terms of reference and review arrangements

11.1. The Terms of Reference shall be reviewed annually and submitted to the Board for approval.

Date approved by the Charitable Funds Committee: Approved by chair's action
Date approved by the Board of Directors:
Next review date: January 2023

Classification: Official

Publication reference: PR2076

Code of governance for NHS provider trusts

27 October 2022

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Equality and health inequalities statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

About this document

This code sets out a common overarching framework for the corporate governance of trusts, reflecting developments in UK corporate governance and the development of integrated care systems.

Key points

- Corporate governance is the means by which boards lead and direct their organisations so that decision-making is effective, risk is managed and the right outcomes are delivered.
- In the NHS this means delivering high quality services in a caring and compassionate environment while collaborating through system and place-based partnerships and provider collaboratives to integrate care.
- Best practice is detailed in the following sections: board leadership and purpose, division of responsibilities, composition, succession and evaluation, audit, risk, internal control and remuneration.

Action required

- Trusts must comply with each of the provisions of the code or, where appropriate, explain in each case why the trust has departed from the code.

Other guidance and resources

- Integrated care systems: design framework
- Working together at scale: guidance on provider collaboratives
- The wider suite of Integrated care systems: guidance

Introduction

1. Why is there a Code of Governance?

1.1. NHS England has issued this Code of Governance (the code) to help NHS providers deliver effective corporate governance, contribute to better organisational and system performance and improvement, and ultimately discharge their duties in the best interests of patients, service users and the public.

1.2. The board of directors is a unitary board. This means that within the board of directors, the non-executive directors and executive directors make decisions as a single group and share the same responsibility and liability. All directors, executive and non-executive, have responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy.

1.3. In this code, we bring together the best practices of the NHS and private sector. We set out a common overarching framework for the corporate governance of trusts that complements the statutory and regulatory obligations they have (these are referenced throughout this document).

1.4. As with the UK Corporate Governance Code, each section of this code is built around a set of principles emphasising the value of good corporate governance to long-term sustainable success. Each section also incorporates a set of more detailed provisions to implement these, which can help trusts demonstrate the effectiveness of governance practices and their contribution to the long-term success of the organisation and its wider system.

2. What is new about this version of the code?

2.1 This version of the code applies from April 2023. A great deal has changed since we last updated the code in 2014. NHS England, Monitor and the NHS Trust Development Authority (TDA) started formally working together on 1 April 2019 to provide better support to delivery of the NHS Long Term Plan (January 2019), which set the direction for greater integration of care with providers collaborating with partners in health and care systems. All systems had achieved integrated care system (ICS) status by April 2021. The Health and Care Act 2022 has merged Monitor and the TDA into NHS England and removed legal barriers to

collaboration and integrated care, making it easier for providers to take on greater responsibility for service planning and putting ICSs on a statutory footing through establishing for each ICS:

- An integrated care partnership (ICP), a statutory joint committee of the integrated care board (ICB) and the upper tier local authorities in the ICS, that brings together organisations and representatives concerned with improving the care, health and wellbeing of the population. Each partnership has been established by the NHS and local government as equal partners and has a duty to develop an integrated care strategy proposing how the NHS and local government should exercise their functions to integrate health and care and address the needs of the population identified in the local joint strategic needs assessment(s).
- An ICB, which brings the NHS together locally, to improve population health and care; its unitary board allocates NHS budget and commissions services, and – having regard to the ICP's integrated care strategy – produces a five-year joint plan for health services and annual capital plan agreed with its partner NHS trusts and NHS foundation trusts.

2.2 The ICP and ICB, together with other key elements of the new arrangements including place-based partnerships and provider collaboratives, are tasked with bringing together all partners within an ICS.

2.3 At the heart of effective collaboration is the expectation that providers will work effectively on all issues, including those that may be contentious for the organisation and system partners, rather than focusing only on those issues for which there is already a clear way forward or which are perceived to benefit their organisation. The success of individual NHS trusts and foundation trusts will increasingly be judged against their contribution to the objectives of the ICS, in addition to their existing duties to deliver high quality care and effective use of resources.[1]

2.4 To support this shift, we have put in place a new single framework for overseeing NHS systems and organisations, the NHS Oversight Framework, which will evolve particularly for 2023/24. Under this new framework we intend to continue to treat

[1] Integrated Care Systems: design framework, p30

providers in comparable circumstances similarly unless there is sound reason not to.

2.5 This updated code therefore applies to both NHS foundation trusts and, for the first time, NHS trusts. NHS foundation trusts and NHS trusts are constituted differently.

- NHS foundation trusts are public benefit corporations and their boards of directors have a framework of local accountability through members and a council of governors. The NHS foundation trust council of governors is responsible for holding the non-executive directors individually and collectively to account. In turn, NHS foundation trust governors are accountable to the members who elect them and must represent their interests and the interests of the public.
- NHS trusts were established by orders of the Secretary of State for Health and Social Care. Their chairs and non-executive directors are appointed by NHS England[2] and they do not have a council of governors or members. Instead, we have a duty to hold the chair and non-executive directors of NHS trusts individually and collectively to account for the performance of the board.

2.6 Despite their different constitutions, there are overarching principles of corporate governance that apply to both NHS trusts and NHS foundation trusts. Where particular provisions of the code apply only to NHS foundation trusts or NHS trusts, we explicitly indicate this. Where we refer to 'trusts' in this code, we mean both NHS trusts and NHS foundation trusts. We use the term 'chief executive' to apply to the chief executives of NHS foundation trusts and the chief officers of NHS trusts, except in sections that are specific to NHS trusts, where we use 'chief officer'. References to 'directors' include the chair, executive and non-executive directors.

2.7 The UK Corporate Governance Code, on which the code has always been based, has also been updated a number of times since 2014. This code is modelled on the 2018 version of the UK Corporate Governance Code.

[2] Chairs and non-executive directors hold a statutory office under the National Health Service Act 2006. The appointment and tenure of office are governed by the NHS Trusts (Membership and Procedure) Regulations 1990. NHS England makes NHS trust chair and non-executive director appointments using powers delegated by the Secretary of State for Health and Social Care. Board appointments are regulated by the Commissioner for Public Appointments to provide independent assurance that they are made in accordance with government's Principles of Public Appointments and Governance Code for public bodies.

3. What is corporate governance?

3.1 A trust board needs to be able to deliver entrepreneurial and effective leadership and prudent and effective oversight of the trust's operations, to ensure it is operating in the best interests of patients, service users and the public.

3.2 Corporate governance is the means by which boards lead and direct their organisations so that decision-making is effective, risk is managed and the right outcomes are delivered. In the NHS this means delivering high quality services in a caring and compassionate environment, while collaborating within ICSs to integrate care and complying with the triple aim duty of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources. Robust governance structures that support collaborative leadership and relationships with system partners and other stakeholders, and strong local accountability will help trusts maintain the trust and confidence of the people and communities they service. Good corporate governance is dynamic. Boards should be committed to improving governance on a continuing basis through evaluation and review.

3.3 Robust corporate and quality governance arrangements complement and reinforce one another. Quality governance is the combination of structures and processes at and below board level to lead on trust-wide quality performance, including (i) ensuring required standards are achieved and (ii) investigating and acting on sub-standard performance. Clinicians are at the frontline of ensuring patients receive quality care. However, the board of directors takes final and definitive responsibility for improvements, successful delivery and, equally, failures in the quality of care. Effective governance therefore requires boards to pay as much attention to quality of care and quality governance as they do to the financial health of their organisation. Boards also set the tone of their organisation by demonstrating shared values and behaviours, and recognising their organisation's role in an ICS and the wider NHS, and the risks and opportunities this may present for quality of care. Further guidance can be found in the Well-led framework for leadership and governance developmental reviews.

4. What should trusts do to fulfil the code's requirements of good governance?

4.1 We seek to support good governance by offering sound guidance. We are keen that trusts have the flexibility to ensure their structures and processes work well now and in the future, while making sure they meet the code's overall requirements for good governance, which are designed with the interests of patients, service users and the public in mind.

4.2 Ultimately only directors can demonstrate and promote the board behaviour needed to guarantee good corporate governance in practice. Good governance requires continuing and determined effort and boards have opportunities within the framework of the code to decide themselves how they should act.

Comply or explain

4.3 The provisions of the code, as best practice advice, do not represent mandatory guidance and accordingly non-compliance is not in itself a breach of Condition FT4 of the NHS provider licence (also known as the governance condition; NHS England has deemed it appropriate that Condition FT4 applies to NHS trusts as well as NHS foundation trusts under it's "shadow" licence regime). However, non-compliance may form part of a wider regulatory assessment on adherence to the provider licence.

4.4 Satisfactory engagement between the board of directors, the council of governors and members of foundation trusts, and patients, service users and the public is crucial to the effectiveness of trusts' corporate governance approach. Directors and, for foundation trusts, governors both have a responsibility for ensuring that 'comply or explain' remains an effective basis for this code.

Disclosure requirements

4.5 To meet the requirements of 'comply or explain' each trust must comply with each of the provisions of the code (which in some cases will require a statement or information in the annual report, or provision of information to the public or, for foundation trusts, governors or members) or, where appropriate, explain in each case why the trust has departed from the code.

4.6 We recognise that departure from the specific provisions of the code may be justified in particular circumstances. Reasons for non-compliance with the code should be explained, with the trust illustrating how its actual practices are consistent with the principle to which the particular provision relates. It should set out the background, provide a clear rationale and describe any mitigating actions it is taking to address any risks and maintain conformity with the relevant principle. Where deviation from a particular provision is intended to be limited in time, the trust should indicate when it expects to conform to the provision.

4.7 The form and content of this part of the statement are not prescribed, the intention being that trusts should have a free hand to explain their governance policies in the light of the principles, including any special circumstances applying to them which have led to a particular approach.

4.8 It is important to note that:

- Some provisions require a statement or information in the annual report. Where information would otherwise be duplicated, trusts need only provide a clear reference to the location of the information within their annual report.
- Other provisions require a trust to make information publicly available or, for foundation trusts, to provide information to their governors or members.
- The remaining provisions are those for which 'comply or explain' applies.
- Schedule A of the code sets out which provisions fall into which category.

5. How does the code fit with other NHS England requirements?

5.1 Although compliance with the provisions in this code is on a 'comply or explain' basis, we have included and clearly identified in the code any relevant statutory requirements. In the first instance, boards, directors and, for foundation trusts, governors should ensure they are meeting the specific governance requirements set out in the NHS provider licence.

5.2 The code sits alongside other NHS England reporting requirements which relate to governance but do not conflict or connect with the code. The code also includes references to other NHS England publications that focus on audit and internal control:

- NHS foundation trust annual reporting manual.[3]

5.3 For clarity, we have provided a detailed explanation of how the different requirements sit together and the purpose of each in Appendix C.

6. Further information

6.1 Trusts may also find it useful to consult other guidance and sources of best practice about governance of public bodies and the NHS. In particular, the following publications are likely to be useful when considered alongside the code:

- Developmental reviews of leadership and governance using the well-led framework: guidance for NHS trusts and NHS foundation trusts
- Guidance on good governance and collaboration under the NHS provider licence
- Your statutory duties: A reference guide for NHS foundation trust governors
- Foundation trust councils of governors and system working and collaboration: An addendum to your statutory duties – A reference guide for NHS foundation trust governors
- Director-governor interaction in NHS foundation trusts: A best practice guide for boards of directors
- The Healthy NHS Board 2013 – Principles for good governance
- The seven principles of public life: covers the standards of behaviour in and principles of public
- Board governance essentials: a guide for chairs and boards of public bodies: developed by CIPFA (the Chartered Institute of Public Finance Accountants), this guide gives advice on the roles of chairs and board members.

[3] This is updated on a yearly basis and published on our website.

Section A: Board leadership and purpose

1. Principles

1.1 Every trust should be led by an effective and diverse board that is innovative and flexible, and whose role it is to promote the long-term sustainability of the trust as part of the ICS and wider healthcare system in England, generating value for members in the case of foundation trusts, and for all trusts, patients, service users and the public.

1.2 The board of directors should establish the trust's vision, values and strategy, ensuring alignment with the ICP's integrated care strategy and ensuring decision-making complies with the triple aim duty of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources. The board of directors must satisfy itself that the trust's vision, values and culture are aligned. All directors must act with integrity, lead by example and promote the desired culture.

1.3 The board of directors should give particular attention to the trust's role in reducing health inequalities in access, experience and outcomes.

1.4 The board of directors should ensure that the necessary resources are in place for the trust to meet its objectives, including the trust's contribution to the objectives set out in the five-year joint plan and annual capital plan agreed by the ICB and its partners, and measure performance against them. The board of directors should also establish a framework of prudent and effective controls that enable risk to be assessed and managed. For their part, all board members – and in particular non-executives whose time may be constrained – should ensure they collectively have sufficient time and resource to carry out their functions.

1.5 For the trust to meet its responsibilities to stakeholders, including patients, staff, the community and system partners, the board of directors should ensure effective engagement with them, and encourage collaborative working at all levels with system partners.

1.6 The board of directors should ensure that workforce policies and practices are consistent with the trust's values and support its long-term sustainability. The workforce should be able to raise any matters of concern. The board is

responsible for ensuring effective workforce planning aimed at delivering high quality of care.

2. Provisions

2.1 The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.

2.2 The board of directors should develop, embody and articulate a clear vision and values for the trust, with reference to the ICP's integrated care strategy and the trust's role within system and place-based partnerships, and provider collaboratives. This should be a formally agreed statement of the organisation's purpose and intended outcomes, and the behaviours used to achieve them. It can be used as a basis for the organisation's overall strategy, planning, collaboration with system partners and other decisions.

2.3 The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.

2.4 The board of directors should ensure that adequate systems and processes are maintained to measure and monitor the trust's effectiveness, efficiency and economy, the quality of its healthcare delivery, the success of its contribution to the delivery of the five-year joint plan for health services and annual capital plan agreed by the ICB and its partners,[4] and that risk is managed effectively. The board should regularly review the trust's performance in these areas against

[4] This may also include working to deliver the financial duties and objectives the trust is collectively responsible for with ICB partners, and improving quality and outcomes and reducing unwarranted variation and inequalities across the system.

regulatory and contractual obligations, and approved plans and objectives, including those agreed through place-based partnerships and provider collaboratives.

2.5 In line with principle 1.3 above, the board of directors should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and performance, ensuring performance reports are disaggregated by ethnicity and deprivation where relevant. Where appropriate and particularly in high risk or complex areas, the board of directors should commission independent advice, eg from the internal audit function, to provide an adequate and reliable level of assurance.

2.6 The board of directors should report on its approach to clinical governance and its plan for the improvement of clinical quality in the context of guidance set out by the Department of Health and Social Care (DHSC), NHS England and the Care Quality Commission (CQC). The board should record where in the structure of the organisation clinical governance matters are considered.

2.7 The chair and board should regularly engage with stakeholders, including patients, staff, the community and system partners, in a culturally competent way, to understand their views on governance and performance against the trust's vision. Committee chairs should engage with stakeholders on significant matters related to their areas of responsibility. The chair should ensure that the board of directors as a whole has a clear understanding of the views of all stakeholders including system partners. NHS foundation trusts must hold a members' meeting at least annually. Provisions regarding the role of the council of governors in stakeholder engagement are contained in Appendix B.

2.8 The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective.

2.9 The workforce should have a means to raise concerns in confidence and – if they wish – anonymously. The board of directors should routinely review this and the reports arising from its operation. It should ensure that arrangements are in place

for the proportionate and independent investigation of such matters and for follow-up action.

2.10 The board of directors should take action to identify and manage conflicts of interest and ensure that the influence of third parties does not compromise or override independent judgement.[5]

2.11 Where directors have concerns about the operation of the board or the management of the trust that cannot be resolved, these should be recorded in the board minutes. If on resignation a non-executive director has any such concerns, they should provide a written statement to the chair, for circulation to the board.

[5] Directors are required to declare any business interests, position of authority in a charity or voluntary body in the field of health and social care, and any connection with bodies contracting for NHS services. The trust must enter these into a register available to the public in line with Managing conflicts of interest in the NHS: Guidance for staff and organisations. In addition, NHS foundation trust directors have a statutory duty to manage conflicts of interest. In the case of NHS trusts, certain individuals are disqualified from being directors on the basis of conflicting interests.

Section B: Division of responsibilities

1. Principles

1.1 The chair leads the board of directors and, for foundation trusts, the council of governors, and is responsible for its overall effectiveness in leading and directing the trust. They should demonstrate objective judgement throughout their tenure and promote a culture of honesty, openness, trust and debate. In addition, the chair facilitates constructive board relations and the effective contribution of all non-executive directors, and ensures that directors and, for foundation trusts, governors receive accurate, timely and clear information.

1.2 Responsibilities should be clearly divided between the leadership of the board and the executive leadership of the trust's operations. No individual should have unfettered powers of decision.

1.3 Non-executive directors should have sufficient time to meet their board responsibilities. They should provide constructive challenge and strategic guidance, offer specialist advice and lead in holding the executive to account.

1.4 The board of directors should ensure that it has the policies, processes, information, time and resources it needs to function effectively, efficiently and economically.

1.5 The board is collectively responsible for the performance of the trust.

1.6 The board of directors as a whole is responsible for ensuring the quality and safety of the healthcare services, education, training and research delivered by the trust, and applying the principles and standards of clinical governance set out by DHSC, NHS England, the CQC and other relevant NHS bodies.

1.7 All members of the board of directors have joint responsibility for every board decision regardless of their individual skills or status. This does not impact on the particular responsibilities of the chief executive as the accounting officer.

2. Provisions

2.1 The chair is responsible for leading on setting the agenda for the board of directors and, for foundation trusts, the council of governors, and ensuring that adequate time is available for discussion of all agenda items, in particular strategic issues.

2.2 The chair is also responsible for ensuring that directors and, for foundation trusts, governors receive accurate, timely and clear information that enables them to perform their duties effectively. A foundation trust chair should take steps to ensure that governors have the necessary skills and knowledge to undertake their role.

2.3 The chair should promote a culture of honesty, openness, trust and debate by facilitating the effective contribution of non-executive directors in particular, and ensuring a constructive relationship between executive and non-executive directors.

2.4 A foundation trust chair is responsible for ensuring that the board and council work together effectively.

2.5 The chair should be independent on appointment when assessed against the criteria set out in provision 2.6 below. The roles of chair and chief executive must not be exercised by the same individual. A chief executive should not become chair of the same trust. The board should identify a deputy or vice chair who could be the senior independent director. The chair should not sit on the audit committee. The chair of the audit committee, ideally, should not be the deputy or vice chair or senior independent director.

2.6 The board of directors should identify in the annual report each non-executive director it considers to be independent. Circumstances that are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director:

- has been an employee of the trust within the last two years
- has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, material shareholder, director or senior employee of a body that has such a relationship with the trust

- has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme
- has close family ties with any of the trust's advisers, directors or senior employees
- holds cross-directorships or has significant links with other directors through involvement with other companies or bodies
- has served on the trust board for more than six years from the date of their first appointment[6]
- is an appointed representative of the trust's university medical or dental school.

Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the non-executive director is independent, it needs to be clearly explained why.

2.7 At least half the board of directors, excluding the chair, should be non-executive directors whom the board considers to be independent.

2.8 No individual should hold the positions of director and governor of any NHS foundation trust at the same time.

2.9 The value of ensuring that committee membership is refreshed and that no undue reliance is placed on particular individuals should be taken into account in deciding chairship and membership of committees. For foundation trusts, the council of governors should take into account the value of appointing a non-executive director with a clinical background to the board of directors, as well as the importance of appointing diverse non-executive directors with a range of skill sets, backgrounds and lived experience.

2.10 Only the committee chair and committee members are entitled to be present at nominations, audit or remuneration committee meetings, but others may attend by invitation of the particular committee.

2.11 In consultation with the council of governors, NHS foundation trust boards should appoint one of the independent non-executive directors to be the senior

[6] But note 4.3 in Section C below, where chairs and NEDs can serve beyond six years subject to rigorous review and NHS England approval.

independent director: to provide a sounding board for the chair and serve as an intermediary for the other directors when necessary. Led by the senior independent director, the foundation trust non-executive directors should meet without the chair present at least annually to appraise the chair's performance, and on other occasions as necessary, and seek input from other key stakeholders. For NHS trusts the process is the same but the appraisal is overseen by NHS England as set out in the Chair appraisal framework.

2.12 Non-executive directors have a prime role in appointing and removing executive directors. They should scrutinise and hold to account the performance of management and individual executive directors against agreed performance objectives. The chair should hold meetings with the non-executive directors without the executive directors present.

2.13 The responsibilities of the chair, chief executive, senior independent director if applicable, board and committees should be clear, set out in writing, agreed by the board of directors and publicly available. The annual report should give the number of times the board and its committees met, and individual director attendance.

2.14 When appointing a director, the board of directors should take into account other demands on their time. Prior to appointment, the individual should disclose their significant commitments with an indication of the time involved. They should not take on material additional external appointments without prior approval of the board of directors, with the reasons for permitting significant appointments explained in the annual report. Full-time executive directors should not take on more than one non-executive directorship of another trust or organisation of comparable size and complexity, and not the chairship of such an organisation.

2.15 All directors should have access to the advice of the company secretary, who is responsible for advising the board of directors on all governance matters. Both the appointment and removal of the company secretary should be a matter for the whole board.

2.16 All directors, executive and non-executive, have a responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy. In particular, non-executive directors should scrutinise the performance of the executive management in meeting

agreed goals and objectives, request further information if necessary, and monitor the reporting of performance. They should satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented.

2.17 The board of directors should meet sufficiently regularly to discharge its duties effectively. A schedule of matters should be reserved specifically for its decisions. For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees and the types of decisions that are delegated to the executive management of the board of directors.

Section C: Composition, succession and evaluation

1. Principles

1.1 Appointments to the board of directors should follow a formal, rigorous and transparent procedure, and an effective succession plan should be maintained for board and senior management. Appointments should be made solely in the public interest, with decisions based on integrity, merit, openness and fairness. Both appointments and succession plans should be based on merit and objective criteria and, within this context, should promote diversity of gender, social and ethnic backgrounds, disability, and cognitive and personal strengths.[7] In particular, the board should have published plans for how it and senior managers will in percentage terms at least match the overall black and minority composition of its overall workforce, or its local community, whichever is the higher.

1.2 The board of directors and its committees should have a diversity of skills, experience and knowledge. The board should be of sufficient size for the requirements of its duties, but should not be so large as to be unwieldy. Consideration should be given to the length of service of the board of directors as a whole and membership regularly refreshed.

1.3. Annual evaluation of the board of directors should consider its composition, diversity and how effectively members work together to achieve objectives. Individual evaluation should demonstrate whether each director continues to contribute effectively.

2. Provisions for NHS foundation trusts board appointments

2.1 The nominations committee or committees of foundation trusts, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors. The nominations committee should give full consideration to succession planning, taking into account the future challenges,

[7] For more information refer to the Equality Act 2010, The NHS' successive Equality Delivery Systems (EDS) and the NHS Workforce Race Equality Standard (WRES).

risks and opportunities facing the trust, and the skills and expertise required within the board of directors to meet them. Best practice is that the selection panel for a post should include at least one external assessor from NHS England and/or a representative from a relevant ICB, and the foundation trust should engage with NHS England to agree the approach.

2.2 There may be one or two nominations committees. If there are two, one will be responsible for considering nominations for executive directors and the other for non-executive directors (including the chair). The nominations committee(s) should regularly review the structure, size and composition of the board of directors and recommend changes where appropriate. In particular, the nominations committee(s) should evaluate, at least annually, the balance of skills, knowledge, experience and diversity on the board of directors and, in the light of this evaluation, describe the role and capabilities required for appointment of both executive and non-executive directors, including the chair.

2.3 The chair or an independent non-executive director should chair the nominations committee(s). At the discretion of the committee, a governor can chair the committee in the case of appointments of non-executive directors or the chair.

2.4 The governors should agree with the nominations committee a clear process for the nomination of a new chair and non-executive directors. Once suitable candidates have been identified, the nominations committee should make recommendations to the council of governors.

2.5 Open advertising and advice from NHS England's Non-Executive Talent and Appointments team is available for use by nominations committees to support the council of governors in the appointment of the chair and non-executive directors. If an external consultancy is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the trust or individual directors.

2.6 Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should have governors and/or independent members in the majority. If only one nominations committee exists, when nominations for non-executives, including the appointment of a chair or a deputy chair, are being discussed, governors and/or independent

members should be in the majority on the committee and also on the interview panel.

2.7 When considering the appointment of non-executive directors, the council of governors should take into account the views of the board of directors and the nominations committee on the qualifications, skills and experience required for each position.

2.8 The annual report should describe the process followed by the council of governors to appoint the chair and non-executive directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference.

2.9 Elected governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The names of governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information.

Relevant statutory requirements

2.10 A requirement of the National Health Service Act 2006 as amended (the 2006 Act) is that the chair, the other non-executive directors and – except in the case of the appointment of a chief executive – the chief executive are responsible for deciding the appointment of executive directors. The nominations committee with responsibility for executive director nominations should identify suitable candidates to fill executive director vacancies as they arise and make recommendations to the chair, the other non-executives directors and, except in the case of the appointment of a chief executive, the chief executive.

2.11 It is for the non-executive directors to appoint and remove the chief executive. The appointment of a chief executive requires the approval of the council of governors.

2.12 The governors are responsible at a general meeting for the appointment, re-appointment and removal of the chair and other non-executive directors.

2.13 Non-executive directors, including the chair, should be appointed by the council of governors for the specified terms subject to re-appointment thereafter at intervals of no more than three years and subject to the 2006 Act provisions relating to removal of a director.

2.14 The terms and conditions of appointment of non-executive directors should be made available to the council of governors. The letter of appointment should set out the expected time commitment. Non-executive directors should undertake that they will have sufficient time to do what is expected of them. Their other significant commitments should be disclosed to the council of governors before appointment, with a broad indication of the time involved, and the council of governors should be informed of subsequent changes.

3. Provisions for NHS trust board appointments

3.1 NHS England is responsible for appointing chairs and other non-executive directors of NHS trusts. A committee consisting of the chair and non-executive directors is responsible for appointing the chief officer of the trust. A committee consisting of the chair, non-executive directors and the chief officer is responsible for appointing the other executive directors. NHS England has a key advisory role in ensuring the integrity, rigour and fairness of executive appointments at NHS trusts. The selection panel for the posts should include at least one external assessor from NHS England.

4. Board appointments: provisions applicable to both NHS foundation trusts and NHS trusts

4.1 Directors on the board of directors and, for foundation trusts, governors on the council of governors should meet the 'fit and proper' persons test described in the provider licence. For the purpose of the licence and application criteria, 'fit and proper' persons are defined as those having the qualifications, competence, skills, experience and ability to properly perform the functions of a director. They must also have no issues of serious misconduct or mismanagement, no disbarment in relation to safeguarding vulnerable groups and disqualification from office, be without certain recent criminal convictions and director disqualifications, and not bankrupt (undischarged). Trusts should also have a policy for ensuring compliance with the CQC's guidance Regulation 5: Fit and proper persons: directors.

4.2 The board of directors should include in the annual report a description of each director's skills, expertise and experience. Alongside this, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the trust. Both statements should also be available on the trust's website.

4.3 Chairs or NEDs should not remain in post beyond nine years from the date of their first appointment to the board of directors and any decision to extend a term beyond six years should be subject to rigorous review. To facilitate effective succession planning and the development of a diverse board, this period of nine years can be extended for a limited time, particularly where on appointment a chair was an existing non-executive director. The need for all extensions should be clearly explained and should have been agreed with NHS England. A NED becoming chair after a three-year term as a non-executive director would not trigger a review after three years in post as chair.

4.4 Elected foundation trust governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The governor names submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information. Best practice is that governors do not serve more than three consecutive terms to ensure that they retain the objectivity and independence required to fulfil their roles.

4.5 There should be a formal and rigorous annual evaluation of the performance of the board of directors, its committees, the chair and individual directors. For NHS foundation trusts, the council of governors should take the lead on agreeing a process for the evaluation of the chair and non-executive directors. The governors should bear in mind that it may be desirable to use the senior independent director to lead the evaluation of the chair. NHS England leads the evaluation of the chair and non-executive directors of NHS trusts.

4.6 The chair should act on the results of the evaluation by recognising the strengths and addressing any weaknesses of the board of directors. Each director should engage with the process and take appropriate action where development needs are identified.

4.7 All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors or governors.

4.8 Led by the chair, foundation trust councils of governors should periodically assess their collective performance and regularly communicate to members and the public how they have discharged their responsibilities, including their impact and effectiveness on:

- holding the non-executive directors individually and collectively to account for the performance of the board of directors
- communicating with their member constituencies and the public and transmitting their views to the board of directors
- contributing to the development of the foundation trust's forward plans.

The council of governors should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice. Further information can be found in Your statutory duties: a reference guide for NHS foundation trust governors and an Addendum to Your statutory duties – A reference guide for NHS foundation trust governors.

4.9 The council of governors should agree and adopt a clear policy and a fair process for the removal of any governor who consistently and unjustifiably fails to attend its meetings or has an actual or potential conflict of interest that prevents the proper exercise of their duties. This should be shared with governors.

4.10 In addition, it may be appropriate for the process to provide for removal from the council of governors if a governor or group of governors behaves or acts in a way that may be incompatible with the values and behaviours of the NHS foundation trust. NHS England's model core constitution suggests that a governor can be removed by a 75% voting majority; however, trusts are free to stipulate a lower threshold if considered appropriate. Where there is any disagreement as to whether the proposal for removal is justified, an independent assessor agreeable to both parties should be asked to consider the evidence and determine whether or not the proposed removal is reasonable. NHS England can only use its enforcement powers to require a trust to remove a governor in very limited

circumstances: where it has imposed an additional condition relating to governance in the trust's licence because the governance of the trust is such that the trust would otherwise fail to comply with its licence and the trust has breached or is breaching that additional condition. It is more likely that NHS England would have cause to require a trust to remove a director under its enforcement powers than a governor.

4.11 The board of directors should ensure it retains the necessary skills across its directors and works with the council of governors to ensure there is appropriate succession planning.

4.12 The remuneration committee should not agree to an executive member of the board leaving the employment of the trust except in accordance with the terms of their contract of employment, including but not limited to serving their full notice period and/or material reductions in their time commitment to the role, without the board first completing and approving a full risk assessment.

4.13 The annual report should describe the work of the nominations committee(s), including:

- the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline
- how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors, governors and individual directors, the outcomes and actions taken, and how these have or will influence board composition
- the policy on diversity and inclusion, including in relation to disability, its objectives and linkage to trust strategy, how it has been implemented and progress on achieving the objectives
- the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served
- the gender balance of senior management and their direct reports.

5. Development, information and support

5.1 All directors and, for foundation trusts, governors should receive appropriate induction on joining the board of directors or the council of governors, and should regularly update and refresh their skills and knowledge. Both directors and, for foundation trusts, governors should make every effort to participate in training that is offered.

5.2 The chair should ensure that directors and, for foundation trusts, governors continually update their skills, knowledge and familiarity with the trust and its obligations for them to fulfil their role on the board, the council of governors and committees. Directors should also be familiar with the integrated care system(s) that commission material levels of services from the trust. The trust should provide the necessary resources for its directors and, for foundation trusts, governors to develop and update their skills, knowledge and capabilities. Where directors or, for foundation trusts, governors are involved in recruitment, they should receive appropriate training, including on equality, diversity and inclusion, and unconscious bias.

5.3 To function effectively, all directors need appropriate knowledge of the trust and access to its operations and staff. Directors and governors also need to be appropriately briefed on values and all policies and procedures adopted by the trust.

5.4 The chair should ensure that new directors and, for foundation trusts, governors receive a full and tailored induction on joining the board or the council of governors. As part of this, directors should seek opportunities to engage with stakeholders, including patients, clinicians and other staff, and system partners. Directors should also have access at the trust's expense to training courses and/or materials that are consistent with their individual and collective development programme.

5.5 The chair should regularly review and agree with each director their training and development needs as they relate to their role on the board.

5.6 A foundation trust board has a duty to take steps to ensure that governors are equipped with the skills and knowledge they need to discharge their duties appropriately.

5.7 The board of directors and, for foundation trusts, the council of governors should be given relevant information in a timely manner, form and quality that enables them to discharge their respective duties. Foundation trust governors should be provided with information on ICS plans, decisions and delivery that directly affect the organisation and its patients. Statutory requirements on the provision of information from the foundation trust board of directors to the council of governors are provided in Your statutory duties: a reference guide for NHS foundation trust governors.

5.8 The chair is responsible for ensuring that directors and governors receive accurate, timely and clear information. Management has an obligation to provide such information but directors and, for foundation trusts, governors should seek clarification or detail where necessary.

5.9 The chair's responsibilities include ensuring good information flows across the board and, for foundation trusts, across the council of governors and their committees; between directors and governors; and for all trusts, between senior management and non-executive directors; as well as facilitating appropriate induction and assisting with professional development as required.

5.10 The board of directors and, for foundation trusts, the council of governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make. The board of directors and, for foundation trusts, the council of governors should agree their respective information needs with the executive directors through the chair. The information for boards should be concise, objective, accurate and timely, and complex issues should be clearly explained. The board of directors should have complete access to any information about the trust that it deems necessary to discharge its duties, as well as access to senior management and other employees.

5.11 The board of directors and in particular non-executive directors may reasonably wish to challenge assurances received from the executive management. They do not need to appoint a relevant adviser for each and every subject area that comes before the board of directors, but should ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis. When complex or high-risk issues arise, the first course of action should normally be to encourage further and deeper analysis within the trust in a

timely manner. On occasion, non-executives may reasonably decide that external assurance is appropriate.

5.12 The board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the trust's expense, where they judge it necessary to discharge their responsibilities as directors. The decision to appoint an external adviser should be the collective decision of the majority of non-executive directors. The availability of independent external sources of advice should be made clear at the time of appointment.

5.13 Committees should be provided with sufficient resources to undertake their duties. The board of directors of foundation trusts should also ensure that the council of governors is provided with sufficient resources to undertake its duties with such arrangements agreed in advance.

5.14 Non-executive directors should consider whether they are receiving the necessary information in a timely manner and feel able to appropriately challenge board recommendations, in particular by making full use of their skills and experience gained both as a director of the trust and in other leadership roles. They should expect and apply similar standards of care and quality in their role as a non-executive director of a trust as they would in other similar roles.

5.15 Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.

5.16 Where appropriate, the board of directors should in a timely manner take account of the views of the council of governors on the forward plan, and then inform the council of governors which of their views have been incorporated in the NHS foundation trust's plans, and explain the reasons for any not being included.

Relevant statutory requirements

5.16 The board of directors must have regard to the council of governors' views on the NHS foundation trust's forward plan.

Insurance cover

5.17 NHS Resolution's Liabilities to Third Parties Scheme includes liability cover for trusts' directors and officers. Assuming foundation trust governors have acted in good faith and in accordance with their duties, and proper process has been followed, the potential for liability for the council should be negligible. While there is no legal requirement for trusts to provide an indemnity or insurance for governors to cover their service on the council of governors, where an indemnity or insurance policy is given, this can be detailed in the trust's constitution.

Section D: Audit, risk and internal control

1. Principles

1.1 The board of directors should establish formal and transparent policies and procedures to ensure the independence and effectiveness of internal and external audit functions, and satisfy itself on the integrity of financial and narrative statements.

1.2 The board of directors should present a fair, balanced and understandable assessment of the trust's position and prospects.

1.3 The board of directors should establish procedures to manage risk, oversee the internal control framework, and determine the nature and extent of the principal risks the trust is willing to take to achieve its long-term strategic objectives.

1.4 Organisations should also refer to Audit and assurance: a guide to governance for providers and commissioners.

2. Provisions

2.1 The board of directors should establish an audit committee of independent non-executive directors, with a minimum membership of three or two in the case of smaller trusts. The chair of the board of directors should not be a member and the vice chair or senior independent director should not chair the audit committee. The board of directors should satisfy itself that at least one member has recent and relevant financial experience. The committee as a whole should have competence relevant to the sector in which the trust operates.

2.2 The main roles and responsibilities of the audit committee should include:

- monitoring the integrity of the financial statements of the trust and any formal announcements relating to the trust's financial performance, and reviewing significant financial reporting judgements contained in them
- providing advice (where requested by the board of directors) on whether the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's position and performance, business model and strategy

- reviewing the trust's internal financial controls and internal control and risk management systems, unless expressly addressed by a separate board risk committee composed of independent non-executive directors or by the board itself
- monitoring and reviewing the effectiveness of the trust's internal audit function or, where there is not one, considering annually whether there is a need for one and making a recommendation to the board of directors
- reviewing and monitoring the external auditor's independence and objectivity
- reviewing the effectiveness of the external audit process, taking into consideration relevant UK professional and regulatory requirements
- reporting to the board of directors on how it has discharged its responsibilities.

2.3 A trust should change its external audit firm at least every 20 years. Legislation requires an NHS trust to newly appoint its external auditor at least every five years. An NHS foundation trust should re-tender its external audit at least every 10 years and in most cases more frequently than this. These timeframes are not affected by an NHS trust becoming a foundation trust.

2.4 The annual report should include:

- the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed
- an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans
- an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.

2.5 Legislation requires an NHS trust to have a policy on its purchase of non-audit services from its external auditor. An NHS foundation trust's audit committee should develop and implement a policy on the engagement of the external auditor to supply non-audit services. The council of governors is responsible for appointing external governors.

2.6 The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.

2.7 The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.

2.8 The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.

2.9 In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual, which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over a going concern are expected to be rare.

Section E: Remuneration

1. Principles

1.1 Levels of remuneration should be sufficient to attract, retain and motivate directors of quality, with the skills and experience required to lead the trust successfully, and collaborate effectively with system partners. Trusts should avoid paying more than is necessary for this purpose and should consider all relevant and current directions relating to contractual benefits such as pay and redundancy entitlements. Trusts should follow NHS England's Guidance on pay for very senior managers in NHS trusts and foundation trusts and NHS trusts should also follow Guidance on senior appointments in NHS trusts.

1.2 Any performance-related elements of executive directors' remuneration should be transparent, stretching and designed to promote the long-term sustainability of the NHS foundation trust. They should also take as a baseline for performance any required competencies specified in the job description for the post.

1.3 The remuneration committee should decide if a proportion of executive directors' remuneration should be linked to corporate and individual performance. The remuneration committee should judge where to position its NHS foundation trust relative to other NHS foundation trusts and comparable organisations. Such comparisons should be used with caution to avoid any risk of an increase in remuneration despite no corresponding improvement in performance.

1.4 The remuneration committee should also be sensitive to pay and employment conditions elsewhere in the NHS, especially when determining annual salary increases.

1.5 There should be a formal and transparent procedure for developing policy on executive remuneration and for fixing the remuneration packages of individual directors. No director should be involved in deciding their own remuneration.

1.6 The remuneration committee should take care to recognise and manage conflicts of interest when receiving views from executive directors or senior management, or consulting the chief executive about its proposals.[8]

1.7 The remuneration committee should also be responsible for appointing any independent consultants in respect of executive director remuneration.

1.8 Where executive directors or senior management are involved in advising or supporting the remuneration committee, care should be taken to recognise and avoid conflicts of interest.

1.9 NHS trusts should wait for notification and instruction from NHS England before implementing any cost of living increases.

2. Provisions

2.1 Any performance-related elements of executive directors' remuneration should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels. In designing schemes of performance-related remuneration, the remuneration committee should consider the following provisions.

- Whether the directors should be eligible for annual bonuses in line with local procedures. If so, performance conditions should be relevant, stretching and designed to match the long-term interests of the public and patients.
- Payouts or grants under all incentive schemes should be subject to challenging performance criteria reflecting the objectives of the trust. Consideration should be given to criteria that reflect the performance of the trust against some key indicators and relative to a group of comparator trusts, and the taking of independent and expert advice where appropriate.
- Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed, and must be limited to the lower of £17,500 or 10% of basic salary.
- For NHS foundation trusts, non-executive terms and conditions are set by the trust's council of governors.

[8] For further information on conflicts of interest see Managing conflicts of interest in the NHS: Guidance for staff and organisations.

- The remuneration committee should consider the pension consequences and associated costs to the trust of basic salary increases and any other changes in pensionable remuneration, especially for directors close to retirement.

2.2 Levels of remuneration for the chair and other non-executive directors should reflect the Chair and non-executive director remuneration structure.

2.3 Where a trust releases an executive director, eg to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.

2.4 The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing director's obligation to mitigate loss. Appropriate claw-back provisions should be considered where a director returns to the NHS within the period of any putative notice.

2.5 Trusts should discuss any director-level severance payment, whether contractual or non-contractual, with their NHS England regional director at the earliest opportunity.[9]

2.6 The board of directors should establish a remuneration committee of independent non-executive directors, with a minimum membership of three. The remuneration committee should make its terms of reference available, explaining its role and the authority delegated to it by the board of directors. The board member with responsibility for HR should sit as an advisor on the remuneration committee. Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the trust.

2.7 The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior management. The board

[9] Severance payment includes any payment whether included in a settlement agreement or not, redundancy payment, a secondment arrangement, pay in lieu of notice, garden leave and pension enhancements.

should define senior management for this purpose and this should normally include the first layer of management below board level.

Relevant statutory requirements

2.8 The council of governors is responsible for setting the remuneration of a foundation trust's non-executive directors and the chair.

Schedule A: Disclosure of corporate governance arrangements

Trusts are required to provide a specific set of disclosures to meet the requirement of the Code of Governance. These should be submitted as part of the annual report (as set out for foundation trusts in the NHS foundation trust annual reporting manual and for NHS trusts in DHSC group accounting manual.

The provisions listed below require a supporting explanation in a trust's annual report, even in the case that the trust is compliant with the provision. Where the information is already in the annual report, a reference to its location is sufficient to avoid unnecessary duplication.

Provision	Requirement
Section A, 2.1	The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.
Section A, 2.3	The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.
Section A, 2.8	The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based

Provision	Requirement
	partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective. The board should set out how the organisation's governance processes oversee its collaboration with other organisations and any associated risk management arrangements.
Section B, 2.6	The board of directors should identify in the annual report each non-executive director it considers to be independent. Circumstances which are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director: • has been an employee of the trust within the last two years • has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the trust • has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme • has close family ties with any of the trust's advisers, directors or senior employees • holds cross-directorships or has significant links with other directors through involvement with other companies or bodies • has served on the trust board for more than six years from the date of their first appointment • is an appointed representative of the trust's university medical or dental school.

Provision	Requirement
	Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the non-executive director is independent, it needs to be clearly explained why.
Section B, 2.13	The annual report should give the number of times the board and its committees met, and individual director attendance.
Section B, 2.19 (NHS foundation trusts only)	For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees and the types of decisions which are delegated to the executive management of the board of directors.
Section C, 2.5 (NHS foundation trusts only)	If an external consultancy is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the trust or individual directors.
Section C, 2.8 (NHS foundation trusts only)	The annual report should describe the process followed by the council of governors to appoint the chair and non-executive directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference.
Section C, 4.2	The board of directors should include in the annual report a description of each director's skills, expertise and experience.
Section C, 4.7	All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the

Provision	Requirement
	annual report and a statement made about any connection it has with the trust or individual directors.
Section C, 4.13	The annual report should describe the work of the nominations committee(s), including: • the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline • how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors and individual directors, the outcomes and actions taken, and how these have or will influence board composition • the policy on diversity and inclusion including in relation to disability, its objectives and linkage to trust vision, how it has been implemented and progress on achieving the objectives • the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served • the gender balance of senior management and their direct reports.
Section C, 5.15 (NHS foundation trusts only)	Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.
Section D, 2.4	The annual report should include: • the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed

Provision	Requirement
	• an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans • where there is no internal audit function, an explanation for the absence, how internal assurance is achieved and how this affects the external audit • an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.
Section D, 2.6	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.
Section D, 2.7	The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.
Section D, 2.8	The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.
Section D, 2.9	In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material

Provision	Requirement
	uncertainties regarding going concern. Trusts should refer to the *DHSC group accounting manual* and *NHS foundation trust annual reporting manual* which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over going concern are expected to be rare.
Section E, 2.3	Where a trust releases an executive director, eg to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.

For the provisions listed below, **the basic 'comply or explain' requirement applies**. The disclosure in the annual report should therefore contain an explanation in each case where the trust has departed from the code, explaining the reasons for the departure and how the alternative arrangements continue to reflect the principles of the code. Trusts are welcome but not required to provide a simple statement of compliance with each individual provision. This may be useful in ensuring the disclosure is comprehensive and may help to ensure that each provision has been considered in turn. In providing an explanation for any variation from the code, the trust should aim to illustrate how its actual practices are consistent with the principles to which the particular provision relates. It should set out the background, provide a clear rationale, and describe any mitigating actions it is taking to address any risks and maintain conformity with the relevant principle. Where deviation from a particular provision is intended to be limited in time, the explanation should indicate when the trust expects to conform to the provision.

Provision	Requirement
Section A, 2.2	The board of directors should develop, embody and articulate a clear vision and values for the trust, with reference to the ICP's integrated care strategy and the trust's role within system and place-based partnerships, and provider collaboratives. This should be a formally agreed statement of the organisation's purpose and

Provision	Requirement
	intended outcomes and the behaviours used to achieve them. It can be used as a basis for the organisation's overall strategy, planning, collaboration with system partners, and other decisions.
Section A, 2.4	The board of directors should ensure that adequate systems and processes are maintained to measure and monitor the trust's effectiveness, efficiency and economy, the quality of its healthcare delivery, the success of its contribution to the delivery of the five-year joint plan for health services and annual capital plan agreed by the ICB and its partners, and to ensure that risk is managed effectively. The board should regularly review the trust's performance in these areas against regulatory and contractual obligations, and approved plans and objectives, including those agreed through place-based partnerships and provider collaboratives.
Section A, 2.5	The board of directors should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and performance. Where appropriate and particularly in high risk or complex areas, the board of directors should commission independent advice, eg from the internal audit function, to provide an adequate and reliable level of assurance.
Section A, 2.6	The board of directors should report on its approach to clinical governance and its plan for the improvement of clinical quality in the context of guidance set out by the Department of Health and Social Care (DHSC), NHS England and the Care Quality Commission (CQC). The board should record where in the structure of the organisation clinical governance matters are considered.
Section A, 2.7	The chair should regularly engage with stakeholders including patients, staff, the community and system partners, in a culturally competent way, to understand their views on governance and performance against the trust's vision. Committee chairs should engage with stakeholders on significant matters related to their

Provision	Requirement
	areas of responsibility. The chair should ensure that the board of directors as a whole has a clear understanding of the views of the stakeholders including system partners. NHS foundation trusts must hold a members' meeting at least annually. Provisions regarding the role of the council of governors in stakeholder engagement are contained in Appendix B.
Section A, 2.9	The workforce should have a means to raise concerns in confidence and – if they wish – anonymously. The board of directors should routinely review this and the reports arising from its operation. It should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for follow-up action.
Section A, 2.10	The board of directors should take action to identify and manage conflicts of interest and ensure that the influence of third parties does not compromise or override independent judgement.
Section A, 2.11	Where directors have concerns about the operation of the board or the management of the trust that cannot be resolved, these should be recorded in the board minutes. If on resignation a non-executive director has any such concerns, they should provide a written statement to the chair, for circulation to the board.
Section B, 2.1	The chair is responsible for leading on setting the agenda for the board of directors and, for foundation trusts, the council of governors, and ensuring that adequate time is available for discussion of all agenda items, in particular strategic issues.
Section B, 2.2	The chair is also responsible for ensuring that directors and, for foundation trusts, governors receive accurate, timely and clear information that enables them to perform their duties effectively. A foundation trust chair should take steps to ensure that governors have the necessary skills and knowledge to undertake their role.
Section B, 2.3	The chair should promote a culture of honesty, openness, trust and debate by facilitating the effective contribution of non-executive

Provision	Requirement
	directors in particular, and ensuring a constructive relationship between executive and non-executive directors.
Section B, 2.4 (NHS foundation trusts only)	A foundation trust chair is responsible for ensuring that the board and council work together effectively.
Section B, 2.5	The chair should be independent on appointment when assessed against the criteria set out in Section B, provision 2.6. The roles of chair and chief executive must not be exercised by the same individual. A chief executive should not become chair of the same trust. The board should identify a deputy or vice chair who could be the senior independent director. The chair should not sit on the audit committee. The chair of the audit committee, ideally, should not be the deputy or vice chair or senior independent director.
Section B, 2.7	At least half the board of directors, excluding the chair, should be non-executive directors whom the board considers to be independent.
Section B, 2.8	No individual should hold the positions of director and governor of any NHS foundation trust at the same time.
Section B, 2.9	The value of ensuring that committee membership is refreshed and that no undue reliance is placed on particular individuals should be taken into account in deciding chairship and membership of committees. For foundation trusts, the council of governors should take into account the value of appointing a non-executive director with a clinical background to the board of directors, as well as the importance of appointing diverse non-executive directors with a range of skill sets, backgrounds and lived experience.

Provision	Requirement
Section B, 2.10	Only the committee chair and members are entitled to be present at nominations, audit or remuneration committee meetings, but others may attend by invitation of the particular committee.
Section B, 2.11	In consultation with the council of governors, NHS foundation trust boards should appoint one of the independent non-executive directors to be the senior independent director: to provide a sounding board for the chair and serve as an intermediary for the other directors when necessary. Led by the senior independent director, the foundation trust non-executive directors should meet without the chair present at least annually to appraise the chair's performance, and on other occasions as necessary, and seek input from other key stakeholders. For NHS trusts the process is the same but the appraisal is overseen by NHS England as set out in the chair appraisal framework.
Section B, 2.12	Non-executive directors have a prime role in appointing and removing executive directors. They should scrutinise and hold to account the performance of management and individual executive directors against agreed performance objectives. The chair should hold meetings with the non-executive directors without the executive directors present.
Section B, 2.14	When appointing a director, the board of directors should take into account other demands on their time. Prior to appointment, the individual should disclose their significant commitments with an indication of the time involved. They should not take on additional external appointments without prior approval of the board of directors, with the reasons for permitting significant appointments explained in the annual report. Full-time executive directors should not take on more than one non-executive directorship of another trust or organisation of comparable size and complexity, and not the chairship of such an organisation.

Provision	Requirement
Section B, 2.15	All directors should have access to the advice of the company secretary, who is responsible for advising the board of directors on all governance matters. Both the appointment and removal of the company secretary should be a matter for the whole board.
Section B, 2.16	The board of directors as a whole is responsible for ensuring the quality and safety of the healthcare services, education, training and research delivered by the trust and applying the principles and standards of clinical governance set out by DHSC, NHS England, the CQC and other relevant NHS bodies.
Section B, 2.17	All members of the board of directors have joint responsibility for every board decision regardless of their individual skills or status. This does not impact on the particular responsibilities of the chief executive as the accounting officer.
Section B, 2.18	All directors, executive and non-executive, have a responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy. In particular, non-executive directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, receive adequate information and monitor the reporting of performance. They should satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented.
Section B, 2.19	The board of directors should meet sufficiently regularly to discharge its duties effectively. A schedule of matters should be reserved specifically for its decisions.
Section C, 2.1 (NHS foundation trusts only)	The nominations committee or committees of foundation trusts, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors. The nominations committee should give full consideration to succession planning, taking into account the future challenges, risks and

Provision	Requirement
	opportunities facing the trust and the skills and expertise required within the board of directors to meet them. Best practice is that the selection panel for a post should include at least one external assessor from NHS England and/or a representative from the ICB, and the foundation trust should engage with NHS England to agree the approach.
Section C, 2.2 (NHS foundation trusts only)	There may be one or two nominations committees. If there are two committees, one will be responsible for considering nominations for executive directors and the other for non-executive directors (including the chair). The nominations committee(s) should regularly review the structure, size and composition of the board of directors and recommend changes where appropriate. In particular, the nominations committee(s) should evaluate, at least annually, the balance of skills, knowledge, experience and diversity on the board of directors and, in the light of this evaluation, describe the role and capabilities required for appointment of both executive and non-executive directors, including the chair.
Section C, 2.3 (NHS foundation trusts only)	The chair or an independent non-executive director should chair the nominations committee(s). At the discretion of the committee, a governor can chair the committee in the case of appointments of non-executive directors or the chair.
Section C, 2.4 (NHS foundation trusts only)	The governors should agree with the nominations committee a clear process for the nomination of a new chair and non-executive directors. Once suitable candidates have been identified, the nominations committee should make recommendations to the council of governors.
Section C, 2.5 (NHS foundation trusts only)	Open advertising and advice from NHS England's Non-Executive Talent and Appointments team should generally be used for the appointment of the chair and non-executive directors.

Provision	Requirement
Section C, 2.6 (NHS foundation trusts only)	Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should have governors and/or independent members in the majority. If only one nominations committee exists, when nominations for non-executives, including the appointment of a chair or a deputy chair, are being discussed, governors and/or independent members should be in the majority on the committee and also on the interview panel.
Section C, 2.7 (NHS foundation trusts only)	When considering the appointment of non-executive directors, the council of governors should take into account the views of the board of directors and the nominations committee on the qualifications, skills and experience required for each position.
Section C, 3.1 (NHS trusts only)	NHS England is responsible for appointing chairs and other non-executive directors of NHS trusts. A committee consisting of the chair and non-executive directors is responsible for appointing the chief officer of the trust. A committee consisting of the chair, non-executive directors and the chief officer is responsible for appointing the other executive directors. NHS England has a key advisory role in ensuring the integrity, rigour and fairness of executive appointments at NHS trusts. The selection panel for the posts should include at least one external assessor from NHS England.
Section C, 4.1	Directors on the board of directors and, for foundation trusts, governors on the council of governors should meet the 'fit and proper' persons test described in the provider licence. For the purpose of the licence and application criteria, 'fit and proper' persons are defined as those having the qualifications, competence, skills, experience and ability to properly perform the functions of a director. They must also have no issues of serious misconduct or mismanagement, no disbarment in relation to safeguarding vulnerable groups and disqualification from office, be without certain recent criminal convictions and director disqualifications, and not bankrupt (undischarged). Trusts should also have a policy for

Provision	Requirement
	ensuring compliance with the CQC's guidance Regulation 5: Fit and proper persons: directors.
Section C, 4.3	The chair should not remain in post beyond nine years from the date of their first appointment to the board of directors and any decision to extend a term beyond six years should be subject to rigorous review. To facilitate effective succession planning and the development of a diverse board, this period of nine years can be extended for a limited time, particularly where on appointment the chair was an existing non-executive director. The need for extension should be clearly explained and should have been agreed with NHS England.
Section C, 4.4 (NHS foundation trusts only)	Elected foundation trust governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The governor names submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information. Best practice is that governors do not serve more than three consecutive terms to ensure that they retain the objectivity and independence required to fulfil their roles.
Section C, 4.5	There should be a formal and rigorous annual evaluation of the performance of the board of directors, its committees, the chair and individual directors. For NHS foundation trusts, the council of governors should take the lead on agreeing a process for the evaluation of the chair and non-executive directors. The governors should bear in mind that it may be desirable to use the senior independent director to lead the evaluation of the chair. NHS England leads the evaluation of the chair and non-executive directors of NHS trusts. NHS foundation trusts and NHS trusts should make use of NHS Leadership Competency Framework for board level leaders.

Provision	Requirement
Section C, 4.6	The chair should act on the results of the evaluation by recognising the strengths and addressing any weaknesses of the board of directors. Each director should engage with the process and take appropriate action where development needs are identified.
Section C, 4.8 (NHS foundation trusts only)	Led by the chair, foundation trust councils of governors should periodically assess their collective performance and regularly communicate to members and the public how they have discharged their responsibilities, including their impact and effectiveness on: • holding the non-executive directors individually and collectively to account for the performance of the board of directors • communicating with their member constituencies and the public and transmitting their views to the board of directors • contributing to the development of the foundation trust's forward plans. The council of governors should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice. Further information can be found in Your statutory duties: a reference guide for NHS foundation trust governors and an Addendum to Your statutory duties – A reference guide for NHS foundation trust governors.
Section C, 4.10 (NHS foundation trusts only)	In addition, it may be appropriate for the process to provide for removal from the council of governors if a governor or group of governors behaves or acts in a way that may be incompatible with the values and behaviours of the NHS foundation trust. NHS England's model core constitution suggests that a governor can be removed by a 75% voting majority; however, trusts are free to stipulate a lower threshold if considered appropriate. Where there is any disagreement as to whether the proposal for removal is justified, an independent assessor agreeable to both parties should be asked to consider the evidence and determine whether or not the proposed removal is reasonable. NHS England can only use its

Provision	Requirement
	enforcement powers to require a trust to remove a governor in very limited circumstances: where they have imposed an additional condition relating to governance in the trust's licence because the governance of the trust is such that the trust would otherwise fail to comply with its licence and the trust has breached or is breaching that additional condition. It is more likely that NHS England would have cause to require a trust to remove a director under its enforcement powers than a governor.
Section C, 4.11	The board of directors should ensure it retains the necessary skills across its directors and works with the council of governors to ensure there is appropriate succession planning.
Section C, 4.12	The remuneration committee should not agree to an executive member of the board leaving the employment of the trust except in accordance with the terms of their contract of employment, including but not limited to serving their full notice period and/or material reductions in their time commitment to the role, without the board first completing and approving a full risk assessment.
Section C, 5.1	All directors and, for foundation trusts, governors should receive appropriate induction on joining the board of directors or the council of governors and should regularly update and refresh their skills and knowledge. Both directors and, for foundation trusts, governors should make every effort to participate in training that is offered.
Section C, 5.2	The chair should ensure that directors and, for foundation trusts, governors continually update their skills, knowledge and familiarity with the trust and its obligations for them to fulfil their role on the board, the council of governors and committees. The trust should provide the necessary resources for its directors and, for foundation trusts, governors to develop and update their skills, knowledge and capabilities. Where directors or, for foundation trusts, governors are involved in recruitment, they should receive appropriate training

Provision	Requirement
	including on equality diversity and inclusion, including unconscious bias.
Section C, 5.3	To function effectively, all directors need appropriate knowledge of the trust and access to its operations and staff. Directors and governors also need to be appropriately briefed on values and all policies and procedures adopted by the trust.
Section C, 5.4	The chair should ensure that new directors and, for foundation trusts, governors receive a full and tailored induction on joining the board or the council of governors. As part of this, directors should seek opportunities to engage with stakeholders, including patients, clinicians and other staff, and system partners. Directors should also have access at the trust's expense to training courses and/or materials that are consistent with their individual and collective development programme.
Section C, 5.5	The chair should regularly review and agree with each director their training and development needs as they relate to their role on the board.
Section C, 5.6 (NHS foundation trusts only)	A foundation trust board has a duty to take steps to ensure that governors are equipped with the skills and knowledge they need to discharge their duties appropriately.
Section C, 5.8	The chair is responsible for ensuring that directors and governors receive accurate, timely and clear information. Management has an obligation to provide such information but directors and, for foundation trusts, governors should seek clarification or detail where necessary.
Section C, 5.9	The chair's responsibilities include ensuring good information flows across the board and, for foundation trusts, across the council of governors and their committees; between directors and governors; and for all trusts, between senior management and non-executive

Provision	Requirement
	directors; as well as facilitating appropriate induction and assisting with professional development as required.
Section C, 5.10	The board of directors and, for foundation trusts, the council of governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make. The board of directors and, for foundation trusts, the council of governors should agree their respective information needs with the executive directors through the chair. The information for boards should be concise, objective, accurate and timely, and complex issues should be clearly explained. The board of directors should have complete access to any information about the trust that it deems necessary to discharge its duties, as well as access to senior management and other employees.
Section C, 5.11	The board of directors and in particular non-executive directors may reasonably wish to challenge assurances received from the executive management. They do not need to appoint a relevant adviser for each and every subject area that comes before the board of directors, but should ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis. When complex or high-risk issues arise, the first course of action should normally be to encourage further and deeper analysis within the trust in a timely manner. On occasion, non-executives may reasonably decide that external assurance is appropriate.
Section C, 5.12	The board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the trust's expense, where they judge it necessary to discharge their responsibilities as directors. The decision to appoint an external adviser should be the collective decision of the majority of non-executive directors. The availability of independent external sources of advice should be made clear at the time of appointment.

Provision	Requirement
Section C, 5.13	Committees should be provided with sufficient resources to undertake their duties. The board of directors of foundation trusts should also ensure that the council of governors is provided with sufficient resources to undertake its duties with such arrangements agreed in advance.
Section C, 5.14	Non-executive directors should consider whether they are receiving the necessary information in a timely manner and feel able to appropriately challenge board recommendations, in particular by making full use of their skills and experience gained both as a director of the trust and in other leadership roles. They should expect and apply similar standards of care and quality in their role as a non-executive director of a trust as they would in other similar roles.
Section C, 5.16 (NHS foundation trusts only)	Where appropriate, the board of directors should in a timely manner take account of the views of the council of governors on the forward plan, and then inform the council of governors which of their views have been incorporated in the NHS foundation trust's plans, and explain the reasons for any not being included.
Section C, 5.17	The trust should arrange appropriate insurance to cover the risk of legal action against its directors. Assuming foundation trust governors have acted in good faith and in accordance with their duties, and proper process has been followed, the potential for liability for the council should be negligible. Governors may have the benefit of an indemnity and/or insurance from the trust. While there is no legal requirement for trusts to provide an indemnity or insurance for governors to cover their service on the council of governors, where an indemnity or insurance policy is given, this can be detailed in the trust's constitution.
Section C, 2.1	The board of directors should establish an audit committee of independent non-executive directors, with a minimum membership of three or two in the case of smaller trusts. The chair of the board

Provision	Requirement
	of directors should not be a member and the vice chair or senior independent director should not chair the audit committee. The board of directors should satisfy itself that at least one member has recent and relevant financial experience. The committee as a whole should have competence relevant to the sector in which the trust operates.
Section C, 2.2	The main roles and responsibilities of the audit committee should include: • monitoring the integrity of the financial statements of the trust and any formal announcements relating to the trust's financial performance, and reviewing significant financial reporting judgements contained in them • providing advice (where requested by the board of directors) on whether the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's position and performance, business model and strategy • reviewing the trust's internal financial controls and internal control and risk management systems, unless expressly addressed by a separate board risk committee composed of independent non-executive directors or by the board itself • monitoring and reviewing the effectiveness of the trust's internal audit function or, where there is not one, considering annually whether there is a need for one and making a recommendation to the board of directors • reviewing and monitoring the external auditor's independence and objectivity • reviewing the effectiveness of the external audit process, taking into consideration relevant UK professional and regulatory requirements • reporting to the board of directors on how it has discharged its responsibilities.

Provision	Requirement
Section D, 2.3	A trust should change its external audit firm at least every 20 years. Legislation requires an NHS trust to newly appoint its external auditor at least every five years. An NHS foundation trust should re-tender its external audit at least every 10 years and in most cases more frequently than this.
Section D, 2.5	Legislation requires an NHS trust to have a policy on its purchase of non-audit services from its external auditor. An NHS foundation trust's audit committee should develop and implement a policy on the engagement of the external auditor to supply non-audit services.
Section E, 2.1	Any performance-related elements of executive directors' remuneration should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels. In designing schemes of performance-related remuneration, the remuneration committee should consider the following provisions. • Whether the directors should be eligible for annual bonuses in line with local procedures. If so, performance conditions should be relevant, stretching and designed to match the long-term interests of the public and patients. • Payouts or grants under all incentive schemes should be subject to challenging performance criteria reflecting the objectives of the trust. Consideration should be given to criteria which reflect the performance of the trust against some key indicators and relative to a group of comparator trusts, and the taking of independent and expert advice where appropriate. • Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed and must be limited to the lower of £17,500 or 10% of basic salary. • The remuneration committee should consider the pension consequences and associated costs to the trust of basic

Provision	Requirement
	salary increases and any other changes in pensionable remuneration, especially for directors close to retirement.
Section E, 2.2	Levels of remuneration for the chair and other non-executive directors should reflect the Chair and non-executive director remuneration structure.
Section E, 2.4	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing director's obligation to mitigate loss. Appropriate claw-back provisions should be considered in case of a director returning to the NHS within the period of any putative notice.
Section E, 2.5	Trusts should discuss any director-level severance payment, whether contractual or non-contractual, with their NHS England regional director at the earliest opportunity.
Section E, 2.7	The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior management. The board should define senior management for this purpose and this should normally include the first layer of management below board level.

The provisions listed below require information to be made **available to governors,** even in the case that the trust is compliant with the provision.

Provision	Requirement
Section C, 4.9	The council of governors should agree and adopt a clear policy and a fair process for the removal of any governor who consistently and

Provision	Requirement
(NHS foundation trusts only)	unjustifiably fails to attend its meetings or has an actual or potential conflict of interest which prevents the proper exercise of their duties. This should be shared with governors.
Section C, 5.7 (NHS foundation trusts only)	The board of directors and, for foundation trusts, the council of governors should be given relevant information in a timely manner, form and quality that enables them to discharge their respective duties. Foundation trust governors should be provided with information on ICS plans, decisions and delivery that directly affect the organisation and its patients. Statutory requirements on the provision of information from the foundation trust board of directors to the council of governors are provided in Your statutory duties: a reference guide for NHS foundation trust governors.

The provisions listed below require supporting information to be made **available to members**, even in the case that the trust is compliant with the provision.

Provision	Requirement
Section C, 2.9 (NHS foundation trusts only)	Elected governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The names of governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information.

The provisions listed below require information to be made **publicly available,** even in the case that the trust is compliant with the provision. This requirement can be met by making supporting information available on request

Provision	Requirement
Section B, 2.13	The responsibilities of the chair, chief executive, senior independent director if applicable, board and committees should be clear, set out in writing, agreed by the board of directors and publicly available.
Section C, 4.2	Alongside this, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the trust. Both statements should also be available on the trust's website.
Section E, 2.6	The board of directors should establish a remuneration committee of independent non-executive directors, with a minimum membership of three. The remuneration committee should make its terms of reference available, explaining its role and the authority delegated to it by the board of directors. The board member with responsibility for HR should sit as an advisor on the remuneration committee. Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the trust.

Appendix A: Role of the trust secretary

The trust secretary has a significant role in the administration of corporate governance. In particular, the trust secretary would normally be expected to:

- ensure good information flows to the board of directors and its committees and between senior management, non-executive directors and the governors where relevant
- ensure that procedures of both the board of directors and the council of governors are complied with
- advise the board of directors and the council of governors (through the chair) on all governance matters
- be available to give advice and support to individual directors, particularly in relation to the induction of new directors and assistance with professional development.

Appendix B: Council of governors and role of the nominated lead governor

1. Principles

1.1 The powers and obligations of governors of NHS foundation trusts are set out in the 2006 Act, as amended by the 2012 Act. This appendix describes the relevant areas of the governors' role. In addition, *Your statutory duties: A reference guide for NHS foundation trust governors* (August 2013) examines how governors can deliver their duties and an addendum to this document, System working and collaboration: The role of foundation trust councils of governors (October 2022) clarifies how governors can continue to perform their duties within the context of system working.

1.2 The council of governors has a duty to hold the non-executive directors individually and collectively to account for the performance of the board of directors. This includes ensuring the board of directors acts so that the foundation trust does not breach the conditions of its licence. It remains the responsibility of the board of directors to design and then implement agreed priorities, objectives and the overall strategy of the NHS foundation trust.

1.3 The council of governors is responsible for representing the interests of NHS foundation trust members, the public at large, and staff in the governance of the NHS foundation trust. Governors must act in the best interests of the NHS foundation trust and should adhere to its values and code of conduct.

1.4 To discharge their duty to represent the public, councils of governors are required to take account of the interests of the public at large. This includes the population of the local system of which the trust is part and the whole population of England as served by the wider NHS.

1.5 Governors are responsible for regularly feeding back information about the trust, its vision and its performance to members, the public at large, and the stakeholder organisations that either elected or appointed them. The trust should ensure governors have appropriate support to help them discharge this duty.

1.6 Governors should discuss and agree with the board of directors how they will undertake these and any additional roles, giving due consideration to the circumstances of the NHS foundation trust and the needs of the system and wider NHS and emerging best practice.

1.7 Governors should work closely with the board of directors and must be presented with, for consideration, the annual report and accounts and the annual plan at a general meeting. The governors must be consulted on the development of forward plans for the trust and any significant changes to the delivery of the trust's business plan.

1.8 Governors should use their voting rights to hold the non-executive directors individually and collectively to account and act in the best interest of patients, members and the public at large. If the council of governors does withhold consent for a major decision, it must justify its reasons to the chair and the other non-executive directors, bearing in mind that its decision is likely to have a range of consequences for the NHS foundation trust, the system and the wider NHS. The council of governors should take care to ensure that reasons are considered, factual and within the spirit of the Nolan principles.

2. Provisions

2.1 The council of governors should meet sufficiently regularly to discharge its duties. Typically the council of governors would be expected to meet as a full council at least four times a year. Governors should make every effort to attend these meetings. The NHS foundation trust should take appropriate steps to facilitate attendance.

2.2 The council of governors should not be so large as to be unwieldy. The council of governors should be of sufficient size for the requirements of its duties. The roles, structure, composition and procedures of the council of governors should be reviewed regularly.

2.3 The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor. A record

should be kept of the number of meetings of the council and the attendance of individual governors and it should be made available to members on request.

2.4 The roles and responsibilities of the council of governors should be set out in a written document. This statement should include a clear explanation of the responsibilities of the council of governors towards members and other stakeholders and how governors will seek their views and keep them informed.

2.5 The chair is responsible for leadership of both the board of directors and the council of governors but the governors also have a responsibility to make the arrangements work and should take the lead in inviting the chief executive and other executives and non-executives, as appropriate, to their meetings. In these meetings other members of the council of governors may ask the chair or their deputy, or any other relevant director present at the meeting, questions about the affairs of the NHS foundation trust.

2.6 The council of governors should establish a policy for engagement with the board of directors for those circumstances where they have concerns about the performance of the board of directors, compliance with the provider licence or other matters related to the overall wellbeing of the NHS foundation trust and its collaboration with system partners. The council of governors should input to the board's appointment of a senior independent director.

2.7 The council of governors should ensure its interaction and relationship with the board of directors is appropriate and effective, in particular, by agreeing the availability and timely communication of relevant information, discussion and the setting in advance of meeting agendas and, where possible, using clear, unambiguous language.

2.8 The council of governors should only exercise its power to remove the chair or any non-executive directors after exhausting all means of engagement with the board of directors. The council should raise any issues with the chair with the senior independent director in the first instance.

2.9 The council of governors should receive and consider other appropriate information required to enable it to discharge its duties, eg clinical statistical data and operational data.

2.10 The chair (and the senior independent director and other directors as appropriate) should maintain regular contact with the governors to understand their issues and concerns.

2.11 Governors should seek the views of members and the public on material issues or changes being discussed by the trust. Governors should provide information and feedback to members and the public at large regarding the trust, its vision, performance and material strategic proposals made by the trust board.

2.12 It is also incumbent on the board of directors to ensure governors have the mechanisms in place to secure and report on feedback that enables them to fulfil their duty to represent the interests of members and the public at large.

2.13 The chair should ensure that the views of governors and members are communicated to the board as a whole. The chair should discuss the affairs of the NHS foundation trust with governors. Non-executive directors should be offered the opportunity to attend meetings with governors and should expect to attend them if requested to do so by governors. The senior independent director should attend sufficient meetings with governors to hear their views and develop a balanced understanding of their issues and concerns.

2.14 The board of directors should ensure that the NHS foundation trust provides effective mechanisms for communication between governors and members from its constituencies. Contact procedures for members who wish to communicate with governors and/or directors should be clear and made available to members on the NHS foundation trust's website and in the annual report.

2.15 The board of directors should state in the annual report the steps it has taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, eg through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.

3. Additional statutory requirements

3.1 The council of governors has a statutory duty to hold the non-executive directors individually and collectively to account for the performance of the board of directors.

3.2 The 2006 Act, as amended, gives the council of governors a statutory requirement to receive the following documents. These documents should be provided in the annual report as per the NHS foundation trust annual reporting manual:

(a) the annual accounts
(b) any report of the auditor on them
(c) the annual report.

3.3 The directors must provide governors with an agenda prior to any meeting of the board, and a copy of the approved minutes as soon as is practicable afterwards. There is no legal basis on which the minutes of private sessions of board meetings should be exempted from being shared with the governors. In practice, it may be necessary to redact some information, eg for data protection or commercial reasons. Governors should respect the confidentiality of these documents.

3.4 The council of governors may require one or more of the directors to attend a meeting to obtain information about the trust's performance of its functions or the directors' performance of their duties, and to help the council of governors decide whether to propose a vote on the trust's or directors' performance.

3.5 Governors should use their rights and voting powers from the 2012 Act to represent the interests of members and the public at large on major decisions taken by the board of directors. These voting powers require:

- More than half the members of the board of directors who vote and more than half the members of the council of governors who vote to approve a change to the constitution of the NHS foundation trust.
- More than half the governors who vote to approve a significant transaction.
- More than half the governors to approve an application by a trust for a merger, acquisition, separation or dissolution.
- More than half the governors who vote to approve any proposal to increase the proportion of the trust's income earned from non-NHS work by 5% a year or more. For example, governors will be required to vote where an NHS foundation trust plans to increase its non-NHS income from 2% to 7% or more of the trust's total income.
- Governors to determine together whether the trust's non-NHS work will significantly interfere with the trust's principal purpose, which is to provide

goods and services for the health service in England, or its ability to perform its other functions.

3.6 NHS foundation trusts are permitted to decide themselves what constitutes a 'significant transaction' and may choose to set out the definition(s) in the trust's constitution. Alternatively, with the agreement of the governors, trusts may choose not to give a definition, but this would need to be stated in the constitution.

3.7 In taking decisions on significant transactions, mergers, acquisitions, separations or dissolutions, governors need to be assured that the process undertaken by the board was appropriate, and that the interests of the public at large were considered. A council may disagree with the merits of a particular decision of the board on a transaction, but still give its consent because due diligence has been followed and assurance received. To withhold its consent, the council of governors would need to provide evidence that due diligence was not undertaken.

3.8 The external auditors of a foundation trust must be appointed or removed by the council of governors at a general meeting of the council.

4. Lead governor

4.1 The lead governor has a role in facilitating direct communication between NHS England and the NHS foundation trust's council of governors. This will be in a limited number of circumstances and, in particular, where it may not be appropriate to communicate through the normal channels, which in most cases will be via the chair or the trust secretary, if one is appointed.

4.2 It is not anticipated that there will be regular direct contact between NHS England and the council of governors in the ordinary course of business. Where this is necessary, it is important that it happens quickly and in an effective manner. To this end, a lead governor should be nominated and contact details provided to NHS England, and then updated as required. Any of the governors may be the lead governor.

4.3 The main circumstances where NHS England will contact a lead governor are where we have concerns about the board leadership provided to an NHS foundation trust, and those concerns may in time lead to our use of our formal powers to remove the chair or non-executive directors. The council of governors appoints the chair and non-executive directors, and it will usually be the case that

we will wish to understand the views of the governors as to the capacity and capability of these individuals to lead the trust, and to rectify successfully any issues, and also for the governors to understand our concerns.

4.4 NHS England does not, however, envisage direct communication with the governors until such time as there is a real risk that an NHS foundation trust may be in breach of its licence. Once there is a risk that this may be the case, and the likely issue is one of board leadership, we will often wish to have direct contact with the NHS foundation trust's governors, but quickly and through one established point of contact, the trust's nominated lead governor. The lead governor should take steps to understand our role, the available guidance and the basis on which we may take regulatory action. The lead governor will then be able to communicate more widely with other governors. Similarly, where individual governors wish to contact us, this would be expected to be through the lead governor.

4.5 The other circumstance where NHS England may wish to contact a lead governor is where, as the regulator, we have been made aware that the process for the appointment of the chair or other members of the board, or elections for governors or other material decisions, may not have complied with the NHS foundation trust's constitution, or alternatively, while complying with the trust's constitution, may be inappropriate. In such circumstances, where the chair, other members of the board of directors or the trust secretary may have been involved in the process by which these appointments or other decisions were made, a lead governor may provide us with a point of contact.

Appendix C: The code and other regulatory requirements

Although compliance with the provisions in this guide is not necessarily mandatory, some of the provisions in this document are statutory requirements because they are enshrined elsewhere in legislation.

In the first instance, boards, directors and, for NHS foundation trusts, governors, should ensure that they are meeting the governance requirements for NHS foundation trusts as set out in the 2006 Act (as amended by the 2012 Act) and reflected in the NHS provider licence. This code sits alongside a number of other NHS England reporting requirements that relate to governance.

NHS England uses reasonable evidence, from disclosures made to us by NHS foundation trusts and NHS trusts, to determine if there is a risk of a breach of the licence condition 'Foundation Trust Condition 4: Governance in the NHS foundation trust' and to make a decision regarding intervention.

The information we receive includes: a **forward looking** disclosure on corporate governance (the corporate governance statement); a **backward looking** disclosure on corporate governance (the code of governance for NHS provider trusts); and a **backward looking statement on internal control, risk and quality governance** (the annual governance statement).

For clarity, here we have provided a brief explanation of how the different requirements sit together and the purpose of each.

- **Corporate governance statement – in the annual plan**

  To comply with the provider licence, the Annual Plan also includes a requirement for a corporate governance statement. This is a mandatory requirement. This is a forward looking statement of expectations regarding corporate governance arrangements over the next 12 months and trusts should be aware that **"issues not identified and subsequently arising can be used as evidence of self-certification failure"**. The requirement for the completion of the corporate governance statement is separate to the disclosure requirements of this code.

- **The code disclosure requirements – listed in this document and the NHS foundation trust annual reporting manual and Department of Health and Social Care Group accounting manual**

  This document is designed to set out **standards of best practice for corporate governance.** It is not mandatory to comply with this guidance, however, the NHS foundation trust annual reporting manual and Department of Health and Social Care group accounting manual do require trusts to make some specific disclosures on a 'comply or explain' basis regarding the provisions listed in this document. (A detailed list of the disclosures required is provided in Schedule A of this.) This is a backward looking statement which should be submitted with the annual report.

- **Annual governance statement – in the NHS foundation trust annual reporting manual and Department of Health and Social Care Group accounting manual**

  In addition to listing the code disclosure requirements, the NHS Foundation trust annual reporting manual and Department of Health and Social Care Group accounting manual also require an annual governance statement. The annual governance statement is a backward looking statement which captures information on risk management and internal control, and includes some specific requirements on quality governance.

  Completion of the Annual governance statement is a **mandatory requirement**. The annual governance statement does not relate to this code.

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

NHS
West Suffolk
NHS Foundation Trust

Programme Board

Future System Terms of Reference

17th January 2023 Version 9

Future System Programme Board – Terms of Reference
[1] Gov.uk website
[2]ICS website

DOCUMENT MANAGEMENT

REVISION HISTORY

Version	Date Issued	Brief Summary of Change	Owner
1	July 2020		G Norgate
2	8th December 2020	Updated.	C Giles
3	21st May 2021	Updated	C Giles
4	24th May 2021	Updated	C Giles
5	8th June 2021	Updated list of participants	C Giles
6	12th October 2021	Adding the West Suffolk Alliance Delegation of Authority	C Giles
7	27th October 2022	Change to Scope statement, change to SRO, NHP sponsor added and list updated – new draft for review	C Giles
8	27th October 2022	Updated	C Giles
9	2nd December 2022	Updated to WSFT new template	C Giles

REVIEWERS

This document must be reviewed by the following people:

Reviewer Name	Title Responsibility	Date	Version
Gary Norgate	Project Director		Version 2
Gary Norgate	Project Director	26.5.2021	Version 4
Gary Norgate	Project Director	12.10.2021	Version 6
Programme Board	FS Programme	19.10.2021	Version 7
Gary Norgate	Project Director	2.11.2022	Version 8
Gary Norgate	Project Director	13.12.2022	Version 9

APPROVED BY

This document must be approved by the following people:

Reviewer Name	Title Responsibility	Date	Version
Gary Norgate	Project Director	26.5.2021	Version 4

Future System Programme Board – Terms of Reference
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Gary Norgate	Project Director	12.10.2021	Version 6
Programme Board	FS Programme	19.10.21	Version 7
Gary Norgate	Project Director	2.11.2022	Version 8
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Future System Programme Board	FS Programme Board	17.01.2023	Version 9

Future System Programme Board – Terms of Reference

[1] Gov.uk website

[2]ICS website

FUTURE SYSTEM PROGRAMME BOARD

Terms of Reference

1. Purpose of the Committee

[1*]In October 2020 the Prime Minister announced details of 40 hospitals to be built by 2030, as part of the government mandate and in consequence as part of the biggest hospital building programme in a generation. The New Hospital Programme was launched by the Health & Social Care Secretary with 21 NHS Trusts receiving seed funding to develop their plans for a new hospital. The Future System Programme was set with the specific remit to develop the new health and care physical infra-structure of the existing West Suffolk Hospital and has a direct report into the New Hospital Programme as a project within its portfolio of 40 hospital builds. West Suffolk Hospital is designated as a Cohort 4 new hospital build.

The West Suffolk Future System Programme Board (FSPB) brings together stakeholders from across the West Suffolk Health and Social Care System to oversee and steer the development of a new health and care facility to replace the existing West Suffolk Hospital.

[2*]West Suffolk NHS Foundation Trust is a part of the Suffolk & North East Essex Integrated Care System (SNEE) which was set up on 1st July 2022. (This was formed under the Health and Care Act 2022 as a statutory basis for Integrated Care Systems (ICS), established Integrated Care Partnerships (ICP) and Integrated Care Board (ICB). The ICP brings together a wide range of partner organisations who are contributors to the wider detriments of health – this ethos underpins the Future System Programme. (The ICB is the statutory body responsible for commissioning healthcare services).

The FSPB is clinically led, chaired by the SRO of the Future System Programme and will facilitate a high degree of meaningful co-production from across the West Suffolk system. This approach will ensure the eventual clinical and estates models are aligned with WSFT (The Trust) and ICS (Integrated Care System) strategies and annual business plans.

The NHP Project sponsor is also in attendance to add support and validation to the project outputs and direction.

The programme Board was set up in July 2020.

1.1 Key Objectives

- Shapes and directs the overall delivery of a new West Suffolk health and care facility.
- Governs and contributes to the co-production of clinical and estates strategies, ensuring alignment between Trust and wider System goals.

[1] Gov.uk website
[2]ICS website

- Maintains and governs the balance between time, cost and quality objectives.
- Reflects and balances the external drivers created by political and safety imperatives.
- Models the principles of co-production, ensuring the overall programme is truly inclusive.
- Provides the forum to resolve issues, share learning and remove barriers.
- Tracks the progress of business case development, maximising contribution from across the system and ensuring support from all stakeholders.
- Maintains programme risk register and decides, actions and oversees timely mitigation.
- Provides rich input from the fullest range of perspectives, informing, challenging and inspiring work stream owners to deliver optimised outcomes.

2. Limitations of Authority

Authority is limited to decisions associated with delivery of the new West Suffolk health and care facility – as defined within the New Hospital Cohort 4 programme.

The members of the Programme Board each represent important elements of the wider Health and Care System. The nature of the Future System Programme means that some decisions will be beyond the authority of the representatives. In this event, representatives will take decisions back to their own Boards for ratification. Any decisions that sit squarely in the domain of WSFT, as the accountable entity for the project, will be discussed and informed by the programme board but will ultimately be submitted to the WSFT Board for ratification (e.g., the choice of preferred site was debated at Programme Board and the decision was referred to WSFT Board.

If ratification of a decision is required outside of the regular monthly cycle of meetings convened for the Programme Board, then an extraordinary meeting will be called.

Accountable to: SRO, Peter Wightman, Director of West Suffolk Alliance

The New Hospital Programme Project Sponsor, Peter Cox providing assurance to the New Hospital Programme.

Subsidiary Workstreams

- Individual Workstreams (see annex 1)

2.1 Members of the Programme board act with delegated authority from their respective organisations.

The programme board has authority to make decisions on behalf of their respective organisation within their delegated levels of authority.

Future System Programme Board – Terms of Reference
[1] Gov.uk website
[2]ICS website

3. Duties and responsibilities

3.1 The Future System Programme Board shall undertake the following:

- Regularly (at least six-monthly) review and approve the Future System Programme's project plan and strategic direction to ensure it appropriately reflects the priorities of the Board, divisions and specialists as well as the external operating environment and regulators. All aspects of the plan to be allocated to an appropriate Workstream Lead for delivery.

- Receive, consider and approve any additions / changes to the Programme Plan and allocate to an appropriate Workstream Lead.

- Ensure appropriate resource is available to support delivery, oversight and assurance of the Programme Plan.

- Receive Workstream Lead reports, which support the following:

  - Monitoring and review of progress with the overall Programme Plan agreed Workstream plan.

  - Review of issues for escalation, including adverse progress status of "red" (action beyond due date) or "Amber" (action at risk of missing due date) supported by Programme Dashboard.

  - Receive and approve recommendations to change project plans, including changes to delivery dates and delivery plans.

  - Receive evidence and approve recommendations to change action status to green.

  - Receive evidence and approve recommendations to change action status to green (action implemented and assurance evidence that action is embedded within agreed cycle of ongoing assurance).

  - Approve the assurance cycle for actions with and receive evidence that this assurance model is being delivered.

  - Approve changes to the assurance cycle for individual actions based on the assurance findings. This includes the ability to move an action back to active to further mitigate and improve delivery.

  - Promote learning and sharing for improvement activity, both from within and outside of the Trust.

[1] Gov.uk website
[2]ICS website

- Review and approve the 5 stage business plans for SOC, OBC and FBC.

- Contribute to the Trust's Annual Report and Internal Audit programme.

4. Membership

4.1 Membership of the FSPB will comprise:

- Peter Wightman – Director, West Suffolk Alliance
- Gary Norgate – Further System Programme Director
- Craig Black – Interim Chief Executive Officer – WSFT
- Linda McEnhill – CEO, St Nicholas' Hospice
- Mark Pattison – West Suffolk Service Director – NSFT
- Nick Macdonald – Interim Finance Director – WSFT
- Nicola Cottington – Chief Operating Officer – WSFT
- Helena Jopling – Associate Medical Director – Future System Prog WSFT
- Andy Yacoub – CEO – Healthwatch Suffolk
- Community Dev Manager – Healthwatch Suffolk
- Nigel Littlewood – Regional Head of Strategic Change
- Richard Davies – Non-Executive Director – WSFT
- Clement Mawoyo – Director of Integrated Adult and Social Care
- Jacqui Grimwood – Estates Lead Future System Programme
- Richard Taylor – NHS England and NHS Improvement
- Amanda Lyes – Director of Workforce and People – Suffolk and North Essex ICB
- James Heathcote – Associate Medical Director, Primary Care WSFT
- Alex Wilson – Strategic Director – West Suffolk Council
- Will Wright – Families and Communities Team Leader, West Suffolk Council
- Daniel Turner – Senior Estates Development Manager – Suffolk and North East Essex ICB
- Richard Watson – Deputy CEO and Director of Strategy and Transformation – Suffolk and North East Essex ICB
- Sandie Robinson – Deputy Director of Strategy and Transformation – Suffolk and North East Essex ICB
- Peter Smye – GP LMC representative
- Godfrey Reynolds – LMC representative and deputy for Peter Smye
- Simon Morgan – Head of Communications & Patient Engagement – SNEE
- Margaret Marks – Councillor – West Suffolk County Council
- Heike Sowa – Councillor – Suffolk County Council
- Julie Flatman – Councillor – Mid Suffolk District Council
- Laura Cook – Senior Strategic Change Manager – NHSE/I
- Peter Cox – Sponsor – NHS New Hospitals Programme
- Matthew Norman – Project Director – Castons
- Chris Todd – Associate Director Estates & Facilities – WSFT
- Mark Hunter – GP, Future System Co-production Lead for Primary Care - WSFT

[1] Gov.uk website
[2]ICS website

Future System Team Members

- Mark Manning – Head of Nursing – FS Team
- James Butcher – Operational Lead – FS Team
- Tracy Morgan – Programme Manager, Clinical Workstream, FS Team
- Caroline Giles – Programme Management Office Lead – FS Team
- Terry Sparling – Finance Lead, FS Team
- Hannah Sharland – Deputy Estates Lead
- Emma Jones – Communications and Engagement Lead – FS
- Liam McLaughlin – Chief Information Office WSFT
- Sarah Judge – Future System Digital Programme Lead and Deputy CIO – WSFT

Observers

- Carol Steed – Deputy Director of Workforce, Organisational Development and Learning

In Attendance

- Guest speakers will attend upon request
- WSFT representation will vary
- NHP – representation from Project sponsor

4.1. The FSPB may invite members of staff, other key stakeholders and advisors to attend meetings as appropriate.

4.2. The FSPB may ask any other officials of the organisation or representatives of external partners to attend to assist it with its discussions on any particular matter. The FSPB may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

4.3. Attendance at meetings is essential. In exceptional circumstances when an executive member cannot attend they must arrange for a fully briefed deputy of sufficient seniority to attend on their behalf. Members will be required to attend as a minimum 75% of the meetings per year.

5. Quorum

5.1 The number of members required for a quorum shall be six including at least one clinician.

5.2. Members are requested to send a deputy with the appropriate skills and knowledge to represent them if they are unable to attend a meeting. Deputies will be counted for the purposes of the quorum.

5.3. Virtual attendance will count towards the quorum.

6. Frequency of meetings

6.1 Meetings are held on a six-weekly cycle for 120 minutes and in between times for significant issues and/or decisions.

[1] Gov.uk website
[2]ICS website

7. Sub Committees

7.1 The FSPB shall receive regular reports from the Programme Group.

7.2 Standing Agenda

- Usual meeting governance (apologies, previous meetings, actions etc)
- To receive Future System Programme dashboard (this will give high level overall RAG rated overview of all major milestones).
- To receive exception reports on any red rated milestone (single page escalation reports on every milestone which is rated red i.e., at risk of failing with no clear mitigations in place)
- To receive Estates workstream update (inc. IM&T)
- To receive clinical workstream update
- To receive Engagement / Co Production workstream update.
- To receive Financial workstream update.
- To receive Digital and IM&T workstream update.
- To review Workforce workstream update.
- To review Programme strategic risk register (red risks as a minimum)

In addition, at each meeting it is proposed to invite a deep dive into a specific activity, milestone or project – the topic to be agreed with the chair.

8. Arrangements for meetings and circulation of minutes/Administrative support

8.1 The FSPB shall be supported by Programme Management Office Lead and EA to the Associate Medical Director of Future System Programme.

8.2 Agenda and papers to be sent out by the Programme Management Office at least 5 working days before each meeting.

9. Accountability and reporting arrangements

9.1 The programme board is made up of stakeholders from across the ICS. Each member is responsible to take decisions to its own board and these decisions are signed off by their own boards. The accountability for the successful delivery of the Future system programme sits with the WSFT board. The delivery of the new hospital is accountable to the New Hospital Programme as a project within the overall programme.

9.2 The Programme Director shall provide a report to the WSFT Board after each meeting outlining areas of key discussion and any actions taken or issues for escalation.

9.3 The minutes of the committee meetings shall be formally recorded and submitted for approval to the next meeting of the Programme Board following their approval. Minutes will be prepared after each meeting of the committee and circulated to members of the committee and others as advised once confirmed by the Chair of the committee within 7 days of the meeting. Once the committee has approved the full minutes, a copy will be available, for information, to the parent committee at its next meeting.

Future System Programme Board – Terms of Reference
[1] Gov.uk website
[2]ICS website

10. Monitoring effectiveness and compliance with Terms of reference

10.1 The FSPB shall carry out an annual review of its effectiveness against its terms of reference.

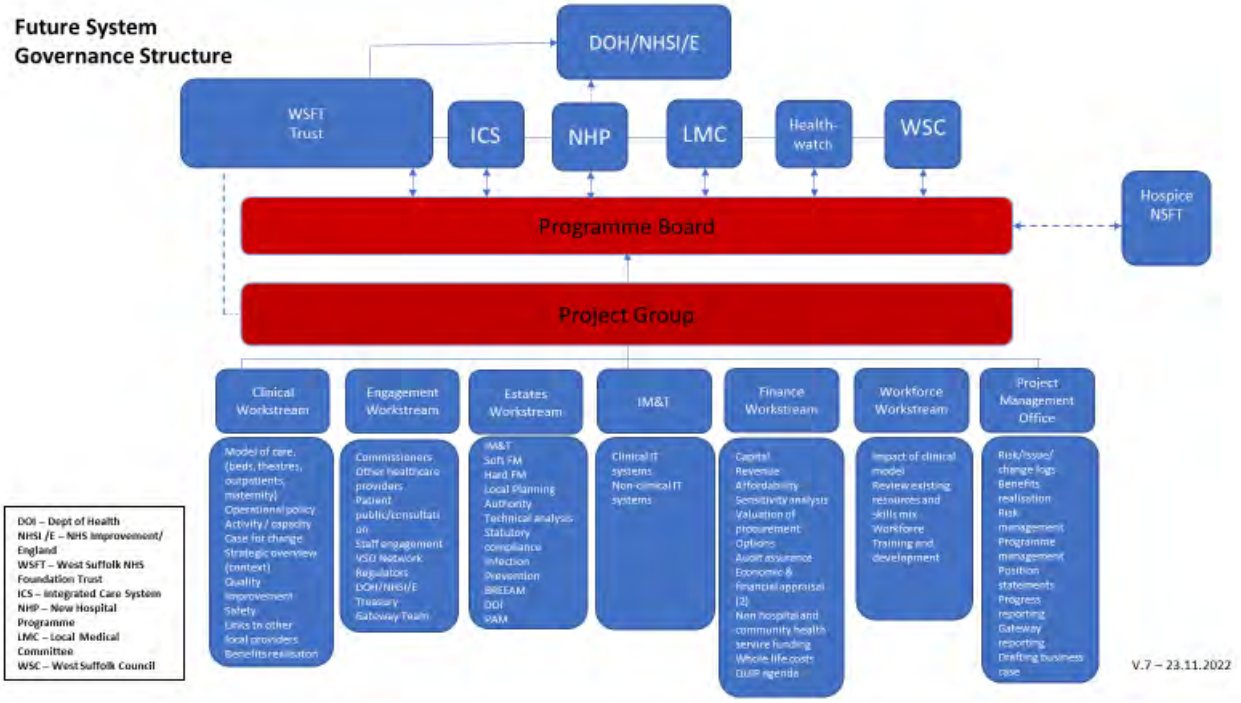
11. Ratification of terms of reference and review arrangements

11.1 The Terms of Reference shall be reviewed by FSPB on a six-monthly basis and submitted to the Trust Board for approval.

Date approved by the Future System Programme Board: 17 January 2023
Date approved by the West Suffolk Hospital Foundation Trust Board:
Next review date: 9th May 2023

Future System Programme Board – Terms of Reference
[1] Gov.uk website
[2]ICS website

Annex 1. Future System Programme Governance Structure



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