Board of Directors (In Public)

Schedule	Friday 21 July 2023, 9:15 AM — 1:30 PM BST
Venue	Conference Rooms, Denny Brothers, Kempson Way, Bury St. Edmunds. IP32 7AR
Description	A meeting of the Board of Directors will take place on Friday 21 July 2023 at 9:15am.
Organiser	Ruth Williamson

Agenda

AGENDA

_WSFT Public Board Agenda - 21 July 2023 - Final.docx

1. GENERAL BUSINESS

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

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

1.3. Minutes of the previous meeting - 26 May, 2023
To Approve - Presented by Jude Chin

WSFT Minutes Open Board 26 May 2023 DRAFT.docx

1.4. Action log and matters arising
To Review

Item 1.4 - Action Log - Active.pdf

Item 1.4 - Action Log - Complete.pdf

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

9:40 AM	1.6.	Chief Executive's report To inform - Presented by Ewen Cameron Item 1.6 - CEO Board report Friday 28 July 2023 FINAL V2.docx
	2.	STRATEGY
9:55 AM	2.1.	Strategic Objectives & Delivery Plan To Assure - Presented by Ewen Cameron Item 2.1 - Strategy priorities coversheet.docx Item 2.1 Strategy Priorities 2023-24 v5.pdf
10:05 AM	2.2.	Future System board report To Assure - Presented by Craig Black Item 2.2 - WSFT FS public board July 2023.docx
10:20 AM	2.3.	Clinical and Care Strategy To Assure - Presented by Paul Molyneux Item 2.3 - Clinical and Care Strategy - coversheet.docx Item 2.3 - Clinical and care strategy V8.pdf
10:35 AM	2.4.	West Suffolk Alliance and SNEE Integrated Care Board To Assure - Presented by Peter Wightman Item 2.4 - WSA Update report 17 July 2023.doc
10:45 AM	2.5.	Wider System Collaboration To Assure - Presented by Nicola Cottington Item 2.5 - Board paper July 2023 Collaboration final.docx
	3.	PEOPLE AND CULTURE
10:55 AM	3.1.	Patient and Staff Stories relating to equality, diversity and inclusion To Review - Presented by Nicola Cottington and Jeremy Over

11:30 AM	COMFORT BREAK	
11:40 AM	3.2. Involvement Committee report To Assure - Presented by Tracy Dowling	Item 3.2 - Chair's Key Issues Involvement 21 June 2023 cover sheet TD (2) Final.docx Item 3.2 - CKI June 2023 FINAL report.docx.doc
11:50 AM	3.3. People & Organisational Development Plan To Assure - Presented by Jeremy Over	Item 3.3 - People OD highlight July2023.docx Item 3.3 a - 6b - Anti-racism-charter.pdf
	4. ASSURANCE	
12:10 PM	4.1. Insight Committee Report - Chair's Key Issues from the meeting To Assure	Item 4.1 - CKI report Insight 21 June 2023 FINAL.doc
	4.1.1. Summary Reports for:	
	Seasonal Planning Presented by Clement Mawoyo and Matt Keeling	Item 4.1.1 - 20230711 WSFT Board Paper Seasonal Planning 2023.docx
	Elective Backlog Recovery options Moira Welham in attendance To Assure - Presented by Nicola Cottington	Item 4.1.1 - elective recoveryv7.pdf
	4.2. Finance Report To Assure - Presented by Jeremy Over	

Item 4.2 - Finance Cover - June 2023.docx

Item 4.2 - Finance Report June 2023 Final.docx

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

Item 4.3 - CKI IMP Jun23.docx

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

Item 4.4 - Safe Staffing May June Final.docx

4.4.1. Quality and Learning Report, including learning from Deaths
To Assure - Presented by Susan Wilkinson

Item 4.4.1 - QL cover sheet.docx

Item 4.4.1 - 23-July Quality and Learning report.docx

4.4.2. Maternity Services
Karen Newbury & Simon Taylor attendance
For Approval

Item 4.4.2 - July 2023 Maternity Quality Safety and Performance Board Report (003).docx

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1:00 PM 4.5. Audit Committee Report - Chair's Key Issues from the meeting
To Assure - Presented by Michael Parsons

Item 4.5 - CKI Audit June '23.docx

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5. GOVERNANCE

1:05 PM 5.1. Governance report
To Assure - Presented by Richard Jones

Item 5.1 Governance report.docx

1:15 PM 5.2. Board Assurance Framework
To inform - Presented by Richard Jones

Item 5.2 - BAF report July 23-Board.docx

1:25 PM 5.3. Annual Report and Accounts
To Note - Presented by Craig Black and Richard Jones

Item 5.3 - WSFT cover sheet Annual Report & Accounts.docx

1:30 PM 6. OTHER ITEMS

6.1. Any other business
To Note

6.2. Reflections on meeting
For Discussion

6.3. Date of next meeting - 29 September, 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

4.2 IQPR Full Report

Item 4.2 - IQPR Board report May 2023.pdf

4.4.2 Maternity - Annexes

Item 4.4.2 - Audit Obstetric Consultant Presence - draft v1.docx

Item 4.4.2 - Perinatal Quality Surveillance Model version 2 June 2023.docx

Item 4.4.2 - SA 5 Midwifery Staffing Report May 23 oct 22 to mar23 (003).docx

Item 4.4.2 - TC quater 4 report Final.docx

5.1 Governance Report Annexes

Item 5.1 Annex A NHSE Self-Certification 2022-23.pdf

Item 5.1 Annex B Report template update July 2023.docx

Item 5.1 Annex C Draft Board meeting agenda.docx

AGENDA

WSFT Board of Directors – Public Meeting

Date and Time	Friday, 21 July 2023 9:15 – 13:30
Venue	Conference Rooms, Denny Brothers, Kempson Way, Bury St Edmunds. IP32 7AR

Time	Item	Subject	Lead	Purpose	Format
1.0 GENERAL BUSINESS					
09.15	1.1	**Welcome and apologies for absence –** Roger Petter	Chair	Note	Verbal
	1.2	**Declarations of Interests**	All	Assure	Verbal
	1.3	**Minutes of meeting** – 26 May 2023	Chair	Approve	Report
	1.4	**Action log and matters arising**	All	Review	Report
09:20	1.5	**Questions from Governors and the public relating to items on the agenda**	Chair	Note	Verbal
9:40	1.6	**CEO report**	Chief Executive	Inform	Report
2.0 STRATEGY					
9:55	2.1	**Strategic objectives and delivery plan**	Chief Executive	Assure	Report
10:05	2.2	**Future system board report**	Director of Resources	Assure	Report
10:20	2.3	**Clinical and care strategy**	Medical director	Assure	Report
10:35	2.4	**West Suffolk Alliance and SNEE Integrated Care Board**	West Suffolk Alliance Director	Assure	Report
10:45	2.5	**Wider system collaboration**	COO	Assure	Report
3.0 PEOPLE AND CULTURE					
10:55	3.1	**Patient and staff stories relating to equality, diversity and inclusion**	COO / Director of Workforce and comms	Review	In Person
11:30 Comfort Break					

Time	Item	Subject	Lead	Purpose	Format
11.40	3.2	**Involvement Committee report** Chair's key issues from meeting	NED Chair	Assure	Report
11.50	3.3	**People and organisational development** highlight report, incorporating: - People and Culture priorities 2023/24	Director of Workforce	Assure	Report
4.0 ASSURANCE					
12:10	4.1	**Insight committee report** – Chair's key issues from the meetings	NED Chair	Assure	Report
	4.1.1	**Summary reports for:** - Seasonal planning report from Nicola - Elective backlog recovery options	COO Clem Mawoyo & Matt Keeling Deputy COO Matt Keeling & Moira Welham, ADO, Surgery & Anaesthetics	Assure	Report
	4.2	**Finance report**	Director of Resources	Assure	Report
12:30	4.3	**Improvement committee report** – Chair's key issues from the meetings	NED Chair	Assure	Report
	4.4	**Quality and nurse staffing report (to follow)**	Chief Nurse	Assure	Report
	4.4.1	**Quality and learning report, including learning from deaths**	Chief Nurse	Assure	Report
	4.4.2	**Maternity services report**	Chief Nurse Karen Newbury Simon Taylor	Approval	Report
13:00	4.5	**Audit committee** Chair's key issues report **(to follow)**	NED Chair	Assure	Report
5.0 GOVERNANCE					
13.05	5.1	**Governance Report**	Trust Secretary	Assure	Report
13:15	5.2	**Board assurance framework**	Trust Secretary	Inform	Report
13:25	5.3	**Annual report and accounts**	Director of Resources and Trust Secretary	Note	Report

6.0 OTHER ITEMS					
13.30	6.1	**Any Other Business**	All	Note	Verbal
	6.2	**Reflections on meeting**	All	Discuss	Verbal
	6.3	**Date of next meeting** 29 September 2023	Chair	Note	Verbal
	Resolution The Trust Board is invited to adopt the following resolution: “that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicly on which would be prejudicial to the public interest” Section 1(2) Public Bodies (Admission to Meetings) Act 1960				

Supporting Annexes

Agenda item	Description
4.2	IQPR full report
4.4.2	Maternity papers Annexes
5.1	Governance Report Annexes

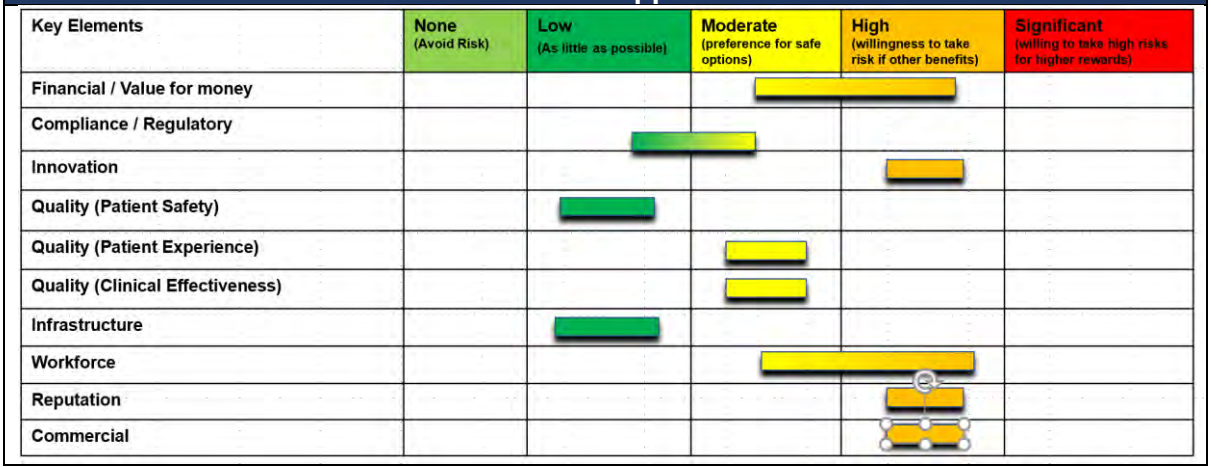
Guidance notes

Trust Board Purpose
The general duty of the Board of Directors and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

Our Vision and Strategic Objectives			
Vision Deliver the best quality and safest care for our local community			
Ambition	First for Patients	First for Staff	First for the Future
Strategic Objectives	• Collaborate to provide seamless care at the right time and in the right place • Use feedback, learning, research and innovation to improve care and outcomes	• Build a positive, inclusive culture that fosters open and honest communication • Enhance staff wellbeing • Invest in education, training and workforce development	• Make the biggest possible contribution to prevent ill-health, increase wellbeing and reduce health inequalities • Invest in infrastructure, buildings and technology

Our Trust Values	
Fair	We value fairness and treat each other appropriately and justly.
Inclusivity	We are inclusive, appreciating the diversity and unique contribution everyone brings to the organisation.
Respectful	We respect and are kind to one another and patients. We seek to understand each other's perspectives so that we all feel able to express ourselves.
Safe	We put safety first for patients and staff. We seek to learn when things go wrong and create a culture of learning and improvement.
Teamwork	We work and communicate as a team. We support one another, collaborate and drive quality improvements across the Trust and wider local health system.

Our Risk Appetite



1. GENERAL BUSINESS

1.1. Apologies for absence - Roger Petter

To Note

Presented by Jude Chin

1.2. Declaration of interests for items on the agenda

To Assure

1.3. Minutes of the previous meeting - 26 May, 2023

To Approve

Presented by Jude Chin

WEST SUFFOLK NHS FOUNDATION TRUST

DRAFT MINUTES OF THE BOARD OF DIRECTORS MEETING OPEN

Held on 26 May 2023 09.15 – 13.30
At Education Centre, West Suffolk NHS Foundation Trust

Members:		
Name	**Job Title**	**Initials**
Jude Chin	Chair	JC
Ewen Cameron	Chief Executive Officer	EC
Louisa Pepper	Non-Executive Director/Deputy Chair	LP
Antoinette Jackson	Non-Executive Director/ Senior Independent Director	AJ
Geraldine O'Sullivan	Non-Executive Director	GO'S
Tracy Dowling	Non-Executive Director	TD
Dr Roger Petter	Non-Executive Director/ Maternity and Neonatal Safety Champion	DP
Michael Parsons	Non-Executive Director	MP
Craig Black	Executive Director of Resources/Deputy CEO	CB
Nicola Cottington	Chief Operating Officer	NC
Sue Wilkinson	Executive Chief Nurse	SW
Paul Molyneux	Medical Director/Maternity and Neonatal Safety Champion	PM
Jeremy Over	Executive Director of Workforce and Communications	JO
Clement Mawoyo	Director of Integrated Adult and Social Care Services	CM
In attendance:		
Richard Jones	Trust Secretary & Head of Governance	RJ
Pooja Sharma	Deputy Trust Secretary	PS
Isabel Taylor	NHS Graduate Management Trainee	IT
Helen Davies	Associate Director of Communications	HD
Amanda Bennett	Freedom to Speak Up Guardian (until item 2.4.1)	AB
Karen Newbury	Head of Midwifery *(4.4.1 item only)*	JS
Kate Croissant	Deputy Clinical Director – Women & Children *(4.4.1 item only)*	KC
Simon Taylor	Associate Director of Operations *(4.4.1 item only)*	ST
Alex Royan	Deputy Director for Strategic Analytics, ICB *(3.3 item only)*	AR
Louise Kendall	EA/Dr Helena Jopling, Associate Medical Director (minute taking)	LK
Apologises: Krishna Yergol, Non-Executive Director Peter Wightman, West Suffolk Alliance Director		
Governors:		
Jane Skinner Liz Steele Elspeth Lees Amanda Keighley Martin Wood	Lead Governor Public Governor Partner Governor Staff Governor Staff Governor	JS LS EL AK MW
Members of Staff:		
Paul Pearson	Staff Side Lead	PP

Janet Watkins	Project Support Officer, Staff Support	JW
Shelley Lee	Senior Matron	SL
Louise Whitworth	Community Staff Nurse	LW
Leanne Thompson	Community Junior Sister	LT
Jennifer Cobern	Community Junior Sister	JC
Tracy McCullagh	Senior Matron	TM
Susan Cheriyan	Deputy Head of Nursing for Medicine	SC
Lisa Rushworth	Senior Matron	LR

1.0 GENERAL BUSINESS		
1.1	**Apologies for absence**	**Action**
	The Chair (JC) welcomed all to the meeting, including Michael Parsons, new non-executive director, Rebecca Jarvis, Deputy Director of Integration, SNEE ICB (representing Peter Wightman), and Isabel Taylor, Graduate Management trainee (shadowing Nicola Cottington). Apologies for the meeting were noted.	
1.2	**Declarations of interest**	
	No declarations of interest were received.	
1.3	**Minutes of the previous meeting**	
	The minutes of the previous meeting held on 31 March 2023 were approved as a true and accurate record, subject to the following amendments: • Section 2.3, page 5, with reference to the 4 hour target it should be added that "Whilst striving to meet the 4-hour target, we must continue to focus on patient safety and appropriate placement of patients." • Section 2.2, page 3, "staff can be used more flexibly" to be replaced by "there is more flexibility of staff with VW". It was noted that with regard to the Improvement Committee report, the patient safety investigation into overcrowding is now completed.	
1.4	**Action log and matters arising**	
	2086 Training relating to patients with learning disabilities This action is closed. **2088** Pledge of support for work of FTSU Guardian The deadline for this action has been pushed back to 21 July.	
2.0 PEOPLE AND CULTURE		
2.1	**Questions from Governors and the public relating to items on the agenda**	
	1. Assurance was sought that in trying to hit targets, patient safety and quality of care remains paramount. The Chief Operating Officer, Nicola Cottington (NC) explained that targets were aimed at in a way which is beneficial to patients. The current situation has significantly impacted on quality and safety, and outcomes can be poorer as a result. 2. Is there any way of assessing whether targets have not resulted in good care?	

	NC said that the aim is to deliver timely care to patients – any adverse impacts will be picked up through the incident reporting system. Returning to operational requirements will improve the quality of patient care. In some situations, more time is needed for the best clinical care to take place which can sometimes mean longer stays in ED for clinical decisions to be made. External peer reviewers have talked to staff about the 4-hour target and fed back that staff understood the guidance. 3. When might the referral to treatment waiting lists of 52 and 78 weeks reduce to pre-covid levels? NC said that this is a challenge. There is no timescale for returning to pre-covid levels but this will be looked at and brought to a future meeting. **Action: bring back a forecast for return to pre-COVID PTL level** The answer lies not only in treating patients, but managing the demand to make sure patients are in the best possible health when having surgery. The waiting list for cancer patients is on track to reduce to pre-covid levels. 4. How are patients on waiting lists monitored for deterioration? The Medical Director, Paul Molyneux (PM) explained that there is a process for communicating with patients during the wait, with a national process for clinical prioritisation. Patients are prioritised if their condition has deteriorated. GPs will keep in close contact with their patients to check on their conditions. A comment was made that the paper on people and culture priorities came across as negative as there seemed to be a focus online managers, who were the pinch point. The sense of professional values did not seem to be reflected. This will be picked up in the People and Organisational Development report.	**N Cottington**
2.2	**Patient / Staff story**	
	The Executive Chief Nurse, Sue Wilkinson (SW) presented a video of an interview with a patient who explained her journey through community services. She had been a wheelchair user for several years with very limited mobility and a number of medical conditions. Following a hospital admission in 2022 with severe covid, she was discharged with a care package in place, which included two carers visiting four times a day, an OT and a physiotherapist. The patient praised the care she received both during her hospital stay, and following her discharge. The patient was set goals for what she wanted to achieve, and she was encouraged to do things for herself. After five months, the patient no longer needed the assistance of carers, and her general health was much better than before her hospital admission. She no longer has pain, and is able to walk much further than before. She especially praised the physiotherapist for her knowledge and expertise. It was noted that this case demonstrates the power of health coaching to enable patients to take control. It was good testament to the level of service provided which is everyday practice. There is however a need to capture the ingredient of the successful physiotherapist in order to train other staff in person centred care and health coaching. The alliance is working towards a strength-based approach, and is continuing to train staff across the alliance.	

	Questions from the presentation Q. How are we selecting patients for these stories? There is a need for balance. SW explained that previous presentations have included uncomfortable stories to bring the balance. The patient experience team works with all service users, but it is dependent on patients who are willing to share their stories – not all want to be publicly involved. Even if patients were referred to anonymously it would be difficult to maintain confidentiality. **Action: PE team to review the balance of positive and challenging patient stories** The Chair, Jude Chin (JC) passed on the Board's thanks to all community staff for the work they do.	**SW**
2.3	**CEO Report**	
	The Chief Executive, Ewen Cameron (EC) highlighted the following points: • The success of the stroke team, the highest rated in the country • ED performance has seen significant improvement and since reporting the 4-hour standard, the experience has dramatically improved for patients and staff. • Thanks to staff for their work during the periods of industrial action. There will be further action next month and preparations for that are underway • Yesterday's announcement from the New Hospitals Programme (NHP) was good news. Details of the exact funding are expected relatively soon and will establish the timescales involved. The Secretary of State visited WSH yesterday. Q. Does the Board have any reflections on Patient Safety Month? SW noted that the team does a fantastic job, but it is not just about the team, it should underpin everyone's practice. The team regularly presents at national forums, but it is something which continues to be progressed, and everyone should be involved. This would give an assurance that investigations are thorough and that we learn through a system-based approach. The team works from a no blame perspective which is very positive and underpins everything we do around improvements. Q. Do we believe we are on the right track with the actions being taken, given the themes in the staff survey results which still show a significant gap in staff views and the level of confidence that the Trust will do what it says? SW explained that in emerging incident reviews discussions, feedback is requested from staff outside of the meeting, but this is a small sample of staff and the biggest challenge is to share that experience with others. Amanda Bennett (AB), Freedom to Speak Up Guardian, said that processes had improved significantly and are now much more inclusive, and good care is celebrated. It was further noted that the best staff experience is reported in community services, and this links in with the priorities for the work plan. It was suggested that a staff story could be given about going through the incident review process. It would also be helpful for non-executive directors to attend emerging incident reviews EIR to provide assurance that the process is robust. A presentation to the Board about the Patient Safety Incident Response Framework (PSIRF) might also be of benefit. **ACTION: Offer opportunity for Board members to join EIR meeting** **ACTION: prioritise a staff story from experience of the EIR process**	**R Jones**

	ACTION: schedule a session for Lucy Winstanley to present to the board	
2.4	**Involvement Committee Report**	
	Non-Executive Director and Chair of the Involvement Committee, Tracy Dowling (TD) reported on the April meeting. The Committee received a good report about the COPD and PALS services. There is still work to do to ensure compliance with the Equality Delivery System. An encouraging report about the maternity service survey was also received, which showed high levels of satisfaction. It was noted that there had been good work around KPIs in critical care and maternity services, with managers being asked to do more in terms of "stay conversations" with staff. Work on the Inclusion Plan was in progress, with a focus on race and disability data. There is still a lot of work to be done to improve practice and opportunities to know that we are a truly equal organisation.	
2.4.1	**People and Organisational Development Highlight report, including Draft People and Culture Priorities 2023/24, and FTSU Guardian Report**	
	The Executive Director of Workforce and Communications, Jeremy Over (JO) highlighted the following: • The Putting You First Award – five colleagues celebrated for their contributions. • Updates about industrial action and the outcome of the national pay negotiations with non-medical unions. There was a mixed set of outcomes by unions in terms of the ballots and the level of support for that negotiated position. The challenge is in rebuilding relationships, although this is not the case at local level. There is a desire to work closely with staff partners to uphold that. • The regional report recently received about the winter vaccination and covid booster programmes, with WSH placed third out of 13 comparable sites. As part of this year's programme a clear message will be sent about vaccination as a contributor to staff welfare and patient safety. <u>Q. Has there been any analysis showing which staff groups are not coming forward for vaccinations and would this inform future approaches?</u> JO explained that it is not clear whether there is any differential between staff groups, but there is a lower uptake among doctors. A working group is planning for the forthcoming seasonal campaign and this will be drawn to their attention. The Freedom to Speak Up Guardian, Amanda Bennett (AB) presented the quarterly report. This highlighted 11 cases of people feeling unsupported by their managers and the Trust should reflect on why that might be. There were also cases of racial discrimination and flexible working requests. The report compares data to previous quarters. With regard to Freedom to Speak Up (FTSU) provision within the Trust, there is no set model from the national office, but the guardian is expected to have protected time, which AB has. There are two parts to the job – reactive (investigations) and proactive (e.g. talking to teams about psychological safety) but there is more to do. The Trust now has 50 champions but not all are as active as others, and following a review, so	

	far 33 still wish to continue. Ongoing training will be provided. There is still room for improvement, e.g. around racial discrimination. People from ethnic minorities find it harder to speak up, and therefore the role of associate guardian may be developed in order to provide more diversity. The Chair, Jude Chin (JC) thanked AB and the FTSU champions for the work they do and asked why the rate of response following case closure is so low. AB explained that the letter sent to staff following closure of a case has changed, in order to encourage completion of the feedback form. JC said that this needed further thought and consider how to increase feedback from those using the service. Q. <u>What was the outcome of racial discrimination cases, and is unconscious bias included as part of the equality, diversity and inclusion training package?</u> AB said that in terms of investigations, concerns were found to be true and action has been taken. Training is not mandatory but is available from the Trust's wellbeing and inclusion manager. There is a significant element in the forward plan about diversity and inclusion **Action: Develop EDI in the forward plan e.g. unconscious basis training** It was noted that the racial discrimination cases are probably the tip of the iceberg. The Trust needs to consider how to respond. Discussion took place about the low feedback response rate and the need to examine different ways of obtaining feedback, including alternatives to completing a form. Information about the closure rate and the closure process would be helpful. Staff want to know that the loop is being closed and action is being taken. JO presented the Draft People and Culture Priorities for 2023/24. This references the Trust's five-year strategy and First ambitions - First for Staff has three strategic objectives and links in with the Board Assurance Framework which demonstrates its importance. A significant amount of analysis has been carried out from staff feedback, which has helped to identify and form the six merged themes described in the annex. The priorities are described in detail and link with the objectives and themes. Referring to the earlier comment about the role of line managers and the negative picture being painted, JO said that the line management role is crucial, and the impact of a line manager is by far the biggest contributor to a staff member's morale and productivity. Equally, line managers are staff too and deserve support, a requirement which must be balanced. There are challenges in being a line manager, which is why the plan focusses on this. Line management development is a reason why the organisational development capacity is being increased to provide more development, coaching and mentoring. JO further noted that professionalism fits within the sixth of the merged themes, about being proud to work for WSFT and being more overt in that. Staff survey results show that staff do not always feel proud to work at WSFT and there has been a deterioration in the mark about recommending care at WSFT. Everything we do contributes to the culture we wish to develop including being proud to work here. The board noted the following feedback on People and culture priorities • Ensure that the language and communication of the priorities emphasises the support for line managers	**JMO**

	• make professionalism more overt in priority 6 • reflect feedback in updated submission to the next Involvement Committee • need to consider how fits with the strategic priorities, resource requirements and monitoring progress and impact through the involvement committee The draft will be finalised in the coming weeks once all comments have been received. Comments and feedback are welcomed, and the paper will be taken to the Involvement Committee in two weeks' time. Q. Has any dedicated work been done with middle managers to understand what gets in the way of their time to be good line managers? The Medical Director, Paul Molyneux (PM) said that this links into the clinical lead model. Many clinicians have 2 hours a week to be a clinical lead, which involves a number of tasks. The clinical leads have very little understanding of the role of a line manager and therefore work is being done on the importance of strong line management. Supportive conversations take time, especially in large groups, and staff need to understand the role and the benefits of good line management. Non-Executive Director Tracy Dowling (TD) paid tribute to the HR team for carrying out an in-depth analysis which shows a genuine effort to understand what staff require, and it is pleasing to see the business plan behind that work. This gave assurance that the team understand the importance of this work, and what action is required to make the six priorities a reality. JC asked how the plan would be monitored, in terms of knowing that deadlines are being met and the impact it has. JO said that the Involvement Committee is expected to scrutinise delivery of the plan. However, the link back to staff feedback is challenging. Culture change takes time and is as much about supporting and developing staff as anything else. It was noted that it would be several months before results can be drawn from the staff survey. The impact will probably be seen in 2024 and beyond. The Board noted the report.	
3.0 STRATEGY		
3.1	**Strategic Objectives 2023/24**	
	The Chief Executive, Ewen Cameron (EC) presented the report, which set out the draft priorities for the work being undertaken to deliver the Trust's strategy. EC noted that there is also a need to do some work in association with the Future System. There are five strategic priorities, including more transformation capability in order to enable the success of the Future System Programme. EC noted the importance of equality, diversity and inclusion (EDI) and the mixed views on a single priority, or a broader approach across all of EDI. The proposal is to develop some actions to go alongside the priorities, and hold a workshop at the end of June to agree these. Q. Is more emphasis required on the issue of financial sustainability, given the scale of the CIP programme, and the likelihood of fewer resources because of the recurring deficit? EC explained that this is a challenge of business as usual. The Trust can only become more sustainable by finding different ways of working.	

	It was noted that the priorities required innovation in order to deliver the transformation. **Action: The Board agreed to discuss the priorities for 2023/24 further at the next Board Development Day. An update will be provided at the next board meeting.**	**R Jones**
3.2	**Future System Board Report**	
	The Executive Director of Resources, Craig Black (CB) provided an update, referring to yesterday's announcement by the Secretary of State about the New Hospitals Programme. There was no detail in the announcement, but the broad message was in line with expectations. A number of discussions are continuing about timescales and funding. A huge amount of work has happened since the last Board meeting, detailed in the report. This is consistent with the funding allocation to progress enabling works. This week, additional funding has been confirmed of £10m this year, to accelerate progress with enabling works and to fund the team. **It was agreed that an operational update would be useful to ensure the programme is being supported from a business-as-usual point of view, particularly in relation to the transformation and change capability in the context of an accelerated Future System Programme (FSP).** **Action:** Q. How important is the scoping of the revenue impact to avoid financial deficit; and how do we ensure that the workforce strategy encompasses all of the elements, including the workforce transformation and carrying out the work in appropriate places? CB explained that the revenue model is high on the agenda of the whole NHP, which is an issue common to all 40 schemes. No coordinated response has been received as yet, and this has been escalated to the regional team who will take it forward as an issue. This will become a significant region-wide issue. With reference to the workforce strategy and workforce transformation, JO said that teams need to be built before the move to the new hospital. The FSP has a workforce lead, and an external consultancy is being recruited to help with planning. The workforce lead sits across both the FSP and HR teams, regularly attends weekly meetings and is involved in the wider HR work. Everything being done in the workforce space will eventually impact staff working in the new building and this is recognised. Discussion took place about the acceleration of the programme and the transformation required. The clinical and care strategy will be presented to the Board in July, which underpins the way the new hospital will be operated, as well as the whole future system. This has a bearing on plans elsewhere in the system and is being worked through. It is not just an acute focus. **Action: schedule session at board to receive delivery plans for the clinical and care strategy.** The capacity for transformation is being included as part of the strategic priorities and consideration will need to be given to the additional resource which may be required. Thought must also be given as to how to educate our students and future staff. With regard to the alliance approach, the workforce enabler focusses on the alliance, and	**R Jones/C Black** **R Jones/N Cottington**

	the clinical and care strategy demonstrates our inclusivity and the changes needed as an alliance.	
3.3	**Integrated Care Board Joint Forward Plan (JFP)**	
	Alex Royan (AR), Deputy Director for Strategic Analytics at the ICB, presented the Joint Forward Plan (JFP) and thanked the Trust for its contribution. AR explained the background to the JFP. It is NHS focussed but touches on key partnerships within which the ICB sits. The priorities reflect those for our community, based on public engagement and colleagues across the ICS. They are underpinned by two priorities: to reduce health inequalities; and EDI principles within the workforce. The Live Well Domains carry through the priorities and have 22 target indicators within them. These focus on the benefits to patients. The JFP has passed through various committees and will be published in the next few weeks. The performance trends and the barriers to delivering targets will need to be understood. It is a five-year delivery plan to be updated every year. <u>Q. What is the position regarding building the infrastructure for the performance analysis?</u> AR explained that this would be done through the existing committee structure. Work is needed with public health analysts to obtain more information. <u>Q. What have we learned from the process rather than the output?</u> AR said that collaboration is challenging but key. Co-production is at the core and is still very important. Capturing priorities as an organisation has been difficult but we can continue to develop our own priorities. It was noted that engagement seems to have focussed on adults. The experiences of children and young people should be taken into account too. <u>Q. Is funding available to achieve everything?</u> AR said that the target indicators are a commitment to hold ourselves to account. Assurance frameworks need to be put in place to surface where we are as a system and have conversations across the ICB. The right balance is needed between transformational improvement and continuous improvement. It was noted that the Trust is an integral part of this plan, and its contribution should be understood in a way which fits into the Trust's strategic priorities. The overall picture should be considered. The Trust should not distance itself – it has a responsibility to be part of the plan. AR requested feedback and views on next steps which would be gratefully received. The Board confirmed its support for the JFP.	
3.4	**System Update: West Suffolk Alliance and SNEE Integrated Care Board**	
	Rebecca Jarvis (RJ), Deputy Director of Integration, SNEE ICB, presented the update and explained the Alliance Delivery Plan, which sets out what action the partnership	

	intends to take in 2023/24 to contribute to our shared outcomes using the Live Well framework. The plan is a partnership agreement intending to complement other strategies including the Trust Strategy and the JFP, and highlights how we intend to work together. RJ explained the key points: • There are four key enablers: workforce, estates, digital & data, and localities. • A distributed leadership model has been established, with nominated sponsors. These are leaders from across all partners. • Key priorities will be designed across the alliance. This is a development journey and we need to mature as an alliance. There will be a new healthy behaviours model by October. Trust colleagues have played a central role in these enablers. There is more detailed work to be done to set out key milestones and how we hold ourselves accountable. The Director of Integrated Adult and Social Care Services, Clement Mawoyo (CM) is the sponsor for the Age Well domain. He noted that it is a good co-produced plan, but one area to develop is to include those with lived experience. The contribution from the voluntary sector is equally important. SW is a sponsor for the Die Well domain which is well established. There is however concern over the clinical leadership. Support is needed before this can be taken forward. This is being examined and remains a priority. NC is a sponsor for the Stay Well domain. There is a need to ensure that the work in the alliance delivery plan is relevant to West Suffolk. It should also be recognised that the enablers are also doing a day job and this needs to be taken into consideration. CB is a sponsor for the digital and data element of the enabling plan. There is a significant internal agenda around digital work, and there is a danger of becoming too acute focussed. The potential impact is much broader than our own organisation and our priorities should be revisited to see if they are correct It was noted that the priorities do not include hypertension, which from a public health perspective gives a good return on healthy living. RJ said that there is no reason why that is not mentioned in the priorities – it could have more of a spotlight. **Action: It was agreed that an update would be provided to the Board after the six-month review of the plan.**	**R Jones**
3.5	**Digital Programme Board Report**	
	The Director of Resources/deputy CEO (CB), presented the report and highlighted two key points for escalation: • The renewal of the Oracle Cerner contract. There are complications associated with the changes at Cerner and ESNEFT's procurement of e-care. • The replacement for Medic bleep. A procurement process is underway, with two companies in the running. Medic Creations, the company which provides Medic bleep, will be withdrawing from the market, therefore a new system will be implemented. There is a risk associated with continuing support for Medic bleep until August, as the company is winding down.	

	Discussion followed about the move away from Medic bleep which will be welcomed by many clinicians. Concerns have been raised about its functionality, and there is confidence that the Trust can find a better system. However, it is unlikely that a replacement will be in place by August. The Trust took on a risk as Medic Creations' only customer, and this is currently being managed. It was noted that this issue was flagged up at the Insight Committee. There is an underlying theme of late procurement exercises – it would be better if these were picked up earlier. CB explained that some contract negotiations are completed at the last minute, which is a calculated risk and is a function of the Trust's financial position. Upcoming contracts are requesting large payment increases and funding is becoming more difficult. Discussion took place about the theme of problematic issues without contingency plans, and whether or not an issue such as this should come to the Board. It was felt appropriate to inform the Board about the Medic bleep risk, which is being managed through the governance process and is part of being transparent. The Board reflected on how to report the CKIs. It should be made clear when there is a need to inform the Board rather than ask for action. There is a structure in place for indicating the level of assurance, and the framework guides how matters are escalated. However, thought needs to be given as to how to use that structure. Committee Chairs should discuss what further improvement could be made to CKIs. The Associate Director for Communications, Helen Davies (HD) informed the Board that Medic bleep was discussed this week by the Core Resilience Team (CRT) and a recommendation will shortly be made to Strategic. A short-term solution could work very well.	
4.0 ASSURANCE		
4.1	**Insight Committee Report**	
	The Chair of the Insight Committee, Antoinette Jackson (AJ) presented the report which is in the new trial framework to identify actions happening next. The following points were highlighted: • Minimal assurance provided on the budget deficit and CIP programme. Further work is ongoing. • Ambulance handover times remain an ongoing issue and work is continuing on a recovery plan. Harm reviews are being undertaken for those patients who wait in ambulances over an hour. • The 2-week suspected breast cancer wait is still underperforming but indicators should be looked at in the round as other areas are improving. • There was continued improvement in some elective pathways. However, a trajectory has been submitted predicting 154 patients waiting over 65 weeks at the end of March 2024, which is not compliant with the national target of zero. • Stroke performance is a real success story. NC added that trajectories are in place for all targets and these are tracked through the patient access governance group. The IQPR is being reviewed in line with the NHS operational priorities. In terms of looking forward, there has been improvement in the 4-hour performance and 12 hour waits which have dramatically reduced, and the	

	positive impact of the Same Day Emergency Care (SDEC) Unit has been seen. Month to date performance for 4 hours is 68% which is above the trajectory figure and indicates that patients are less likely to come to harm in the department. The positive culture of continuous improvement was noted by the recent peer review visit. In response to the Committee's concerns about the late extension of the Allocate contract, CB confirmed that the contract was agreed at the last minute. With regard to Purchase to Pay, a new system is planned to be in place by 27th June. An extension of the existing system has been agreed to mitigate the risk, at a cost of £10,000. Q. At what point are national data going to be produced for the 4-hour target? NC explained that only 11 or 12 Trusts ceased reporting of the 4-hour target, so national data is available. WSFT is in the middle of the pack. The national team has an approach to categorising Trusts by the level of support in relation to emergency care and elective recovery. We are yet to receive formal letters about this although we are in tier two for elective recovery. Q. Will there be a system focus for recovery? The Trust does not have direct exposure to national support but we are examining how we can support ESNEFT. There is an ongoing debate about how much direct support is available and how that is mandated. Joint elective recovery meetings are being held, and trajectories should be credible – tier two is the right place for WSFT currently.	
4.2	**Finance Report**	
	CB presented the report which focusses on FY 2022/23. Accounts were submitted last week to the auditors in line with expectations, showing a £30,000 surplus for last FY. This is matched by colleagues across the ICS. This FY, budgets are still being set which is a reflection on resource issues in the finance department. Given the financial position, this is a concern which was discussed at Insight Committee. **Action: More detail on this year's CIP will be brought to the next Board.** ACTION: include a min/max and most likely for the key financial risks to incorporate the "What/So what/What next" approach in the report narrative There was a potential risk around capital but this did not materialise and support came from region to mitigate against the risk. Q. Is there a sense of the range of risks for 2023/24? CB explained that pay costs are around £250m. A 2.5% uplift has been included in the assumptions, but a 5% pay increase was agreed, therefore £6.25m is outstanding and demonstrates the scale of risk around pay award. Non-pay inflation remains high on non-energy products but is a smaller proportion of overall expenditure. The risks around the costs of industrial action and the inability to deliver the recovery plan are interlinked. Approximately £2m of elective activity will be lost in June. A query was raised about the increase in temporary staff costs and the doubling of agency staff, despite the Trust having more substantive staff than ever. CB explained that the year-to-date figure gives an idea of what an average month costs. March was a high month and comparison is best derived by dividing year to date by the number of months.	**C Black**

	SW added that there is a robust review of agency time and bank work before sign- off. There is some additional capacity and some staff may be filling other slots.	
4.3	**Improvement Committee Report**	
	The Chair of the Improvement Committee, Louisa Pepper (LP) presented the CKIs from the April meeting (there were no CKIs for the May meeting). These have been discussed with the Council of Governors. LP explained that at the May meeting, the assurance structure was used for the first time. A rich discussion took place, with all participants given an opportunity to make a contribution. Areas of full compliance, partial compliance, and some areas with gaps were all examined, with decisions made on actions to be taken. Excellent work had been done in relation to patient safety specialists, and assurance was provided, with key links to PSIRF. <u>Q With regard to the Acorn report, were there any particular areas for improvement to highlight from the May meeting?</u> LP said that assurance was provided around ED actions. One issue has been escalated to SLT about the pathology service lab floor but there was nothing requiring escalation to the Board. Discussion took place about committees starting to meet face to face. It made a positive difference with everyone contributing to the conversations. As an observer, it was much better with far more deep diving and engaging. It was also felt that the discussion was more robust with good quality conversations, and much more inclusive.	
4.4	**Quality and Nurse Staffing Report**	
	The Executive Chief Nurse (SW) presented the highlights of the report: • It was not possible to provide an accurate vacancy rate but WTE for nurses is expected to rise once the agreed increase establishments in inpatient wards are built into the budgets. Improvement continued with the rate currently at 7.1%. • Nursing assistant vacancy rates remain a challenge. • Fill rates have improved in April. • The challenges of industrial action were noted, and SW thanked staff for supporting the Trust to provide safe care for patients. • 90% of student nurses are retained at the Trust following graduation, and we are committed to ensuring all those who wish to remain in the trust have job offers. <u>Q. What impact will the reduction in vacancies have on staff and patient experience?</u> SW explained that it takes 3-6 months for short staffing to show in KPIs. This has been borne out e.g. in pressure ulcers. An improvement is now being seen in nutritional metrics, in pressure ulcers and falls, with staffing on amber for the last few months with sickness reducing. Having the right numbers of staff on wards is all important. <u>Q. Would we expect to see an improvement in the care hours per day patient metric?</u> SW explained that this is related to the number of patients as well as staff. It should reduce, but it is driven by acuity and the number of patients. More detail would be brought back to a future meeting.	**S Wilkinson**

	Action: It was noted that the community services completed its first audit of the community version of the safe staffing tool. SW confirmed that it will be carried out twice more this year. It only examines nurse staffing levels, therefore it would not be used in isolation but with other work being carried out, to incorporate the multi-disciplinary team CM noted that the whole system should be looked at to alleviate some of the challenges. SW confirmed that nursing associates are included in the RN figures. More information on numbers and roles will be provided in the next report. **Action** The Board noted the report.	**S Wilkinson**
4.4.1	**Maternity Services**	
	The Head of Midwifery Karen Newbury (KN), Simon Taylor (ST) and Kate Croissant (KC) reported on Maternity Services and highlighted: • Compliance with asking domestic abuse questions. This is part of the surveillance toolkit. There is an ongoing action plan, with the aim of ensuring that each person is asked at least once in their pregnancy about domestic abuse. • Confirmation from NHS Resolutions of full compliance with CNST. • A problem with the online booking system. KN is aware of one case whereby difficulties occurred. Efforts have been made to reach out to ensure that everyone using the booking system have been able and successful in registering their booking. A plan is in place with mitigation in the system and the issue has been discussed at an emerging incident review. An investigation will be undertaken. It was noted that there was an upward trend in third and fourth degree tears. KC said that the numbers are small but cases will be examined to see if there are any themes. This is being monitored. KN confirmed that the appendices have all been through the maternity / neonatal safety governance process. <u>Q. How representative are the numbers in the service user feedback table? What are the themes and where are they reflected on in the service?</u> KN explained that feedback was actively encouraged, but birthing and neonatal units are representational. Feedback via social media and the CQC is on the whole very positive. Any improvements required are captured via PALS and worked on to address complaints and make improvements. Feedback via the CQC represented a broad range, but there were no details of other media. Healthwatch and Maternity Voice Partnership feedback is broken down.	
5.0 GOVERNANCE		
5.1	**Governance Report**	
	The Trust Secretary and Head of Governance, Richard Jones (RJ) highlighted the following:	

	• The urgent decision taken regarding the outcome of the business case for Newmarket surgical hub. • The report from the Council of Governors. This is a helpful way of structuring the feedback. • Update to the register of interests. • The summary of elements included in the Board Development Workshop. The focus on how the "So What" and "What Next" are being used is of importance. As part of that work, the structure of the information coming into the Board and assurance committees is being examined, as part of day-to-day business. • The summary of progress of actions taken previously. • The changes to the constitution which require Board approval. • The use of the trust seal and the indicative agenda for the next meeting. **The Board approved the changes to the constitution.**	
5.2	**Board assurance framework**	
	RJ presented the report which refers to the review of the detail of the Board Assurance Framework (BAF), through executives and management leads. This work will continue by strengthening the management and governance groups, and will be reported to the Insight Committee. The strategic priorities will be incorporated as they are developed and finalised. The BAF will be used to inform the deep dive and the assurance committees to understand the risks and mitigations within the BAF. It was noted that the development of the BAF is very important and needs to be progressed. The Audit Committee should give assurance on the structure of the BAF and whether risks are being identified adequately and mitigation actions are appropriate. Consideration should also be given as to how to report changes in the BAF to the Board. Furthermore, the risk appetite statement should be revisited. **Action: Schedule review of risk appetite – development session.**	**R Jones**
6.0 OTHER ITEMS		
6.1	**Any Other Business**	
	None raised.	
6.2	**Reflections on meeting**	
	• The warm environment of the room was noted – these are the conditions in which most staff work. • The attendance of non-Board members was welcomed. • Abbreviations should be spelled out to make clear to everyone what is being discussed. • Isabel Taylor (IT), attending as an observer, said that she was pleasantly surprised at the important subjects being discussed, e.g. EDI. • The increase in executive-to-executive challenge was noted. • Summary sheets should be competed better to reflect the impact on staff and patients, and the same with risk and assurance.	

6.3	Date of Next Meeting	
	• 21 July 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

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
3005	Open	26/5/23	2.3	***CEO Report -*** Prioritise a staff story from experience of the emerging incident review meetings (EIRs)	**This has been raised with the engagement and patient safety teams. Aim to provide a suitable staff story later this year. This will include consideration of sharing the experience more widely with staff through video recording.**	RJ	01/12/23	Green	
3014	Open	26/5/23	4.4	***Quality and Nurse Staffing Report - Care Hours per Day Patient Metric*** - More detail would be brought back to a future meeting.	**Verbal update to be provided at September 2023 meeting.**	SW	29/09/23	Green	
3015	Open	26/5/23	4.4	***Quality and Nurse Staffing Report - Safe Staffing Tool*** - More information on numbers and roles to be provided in the next report.	**To be scheduled for September 2023 meeting.**	SW	29/09/23	Green	

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
2088	Open	2/2/23	2.4	***People and Organisational Development Highlight report, including FTSU Guardian Report -*** Pledge of support for the work of the FTSU guardian to be drafted and agreed by the Involvement Committee for publicising to staff	Pledge / commitment describing how the Board values the role of Speaking Up will be considered at forthcoming Involvement Committee meeting / workshop and shared at Board. **Today's (21.7.23) People and Culture Report refers.**	JMO	~~26/05/2023~~ 21/07/2023	Complete	21/07/23
3002	Open	26/5/23	2.1	***Questions from Governors and the public relating to items on the agenda*** - referral to treatment waiting lists - 52 and 78 weeks. Bring back a forecast for return to pre-COVID PTL level.	**Today's (21.7.23) agenda item refers.**	NC	21/07/23	Complete	21/07/2023
3003	Open	26/5/23	2.2	***Patient/Staff Story -*** PE team to review the balance of positive and challenging patient stories	**Actioned.**	SW	21/07/23	Complete	21/07/2023
3004	Open	26/5/23	2.3	***CEO Report -*** Offer opportunity for Board members to join emerging incident review meetings (EIRs)	**The patient safety and quality team are liaising with the Trust office to provide access to the weekly EIR meetings**	RJ	21/07/23	Complete	21/07/2023
3006	Open	26/5/23	2.3	***CEO Report -*** schedule a session for Lucy Winstanley to present to the board	**Included in forward plan for September meeting.**	RJ	21/07/23	Complete	21/07/2023
3007	Open	26/5/23	2.4.1	***People and Organisational Development Highlight report, including Draft People and Culture Priorities 2023/24, and FTSU Guardian Report -*** Develop EDI in the forward plan e.g. unconscious basis training	**Today's (21.7.23) People and Culture Report refers.**	JMO	21/07/23	Complete	21/07/23
3009	Open	26/5/23	3.1	***Strategic Objectives 2023/24*** - The Board agreed to discuss the priorities for 2023/24 further at the next Board Development Day. An update will be provided at the next board meeting	**Further developed at Board workshop on 29 June and agenda item for today's meeting.**	RJ	21/07/23	Complete	21/07/2023
3012	Open	26/5/23	3.4	***System Update - West Suffolk Alliance and SNEE Integrated Care Board*** - It was agreed that an update would be provided to the Board after the six-month review of the plan.	**Included in forward plan for December meeting.**	RJ	01/12/23	Complete	21/07/2023

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
3013	Open	26/5/23	4.2	***Finance Report*** - More detail on this year's CIP will be brought to the next Board.	**Covered in today's (21.7.23) finance report.**	CB	21/07/23	Complete	21/07/2023
3016	Open	26/5/23	5.2	***Board Assurance Framework*** - schedule review of risk appetite – development session.	**To be incorproated into the Board's development forward plan - 21 October 2023**	RJ	01/12/23	Complete	21/07/2023

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

To Note

Presented by Jude Chin

1.6. Chief Executive’s report

To inform

Presented by Ewen Cameron

Board of Directors – 21 July, 2023

Report title:	**CEO Board report**
Agenda item:	1.6
Date of the meeting:	28 July 2023
Sponsor/executive lead:	Dr Ewen Cameron
Report prepared by:	Dr Ewen Cameron

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

Executive Summary
-
Action Required of the Board
To note.

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

CEO Board report – Friday, 28 July 2023

I would like to start with a thank you to all those working at, and with our Trust over these past two months. Again, it has been an incredibly busy time, where we have negotiated industrial action amongst other difficult challenges both clinically and non-clinically. However, thanks to your ever impressive commitment and skill, we have worked through these diligently whilst providing high quality and safe care to our patients.

I would like to encourage all colleagues wherever and whenever possible, to take time to look after yourselves. Whether it is caring for patients in our hospitals, keeping our hospitals and services running or providing care to patients in our communities, it is not easy work. Therefore, it is very difficult to do this well if you do not feel well yourself. Please access our staff psychology support team, staff physiotherapy service, Abbeycroft Leisure or the range of discounts across numerous local and national businesses to help yourself stay well.

I have now visited more than 80 different teams across our Trust at least once, and I am doing my utmost to come and meet as many colleagues as possible to learn about the amazing work you all do every day, which I will outline in more detail below.

Quality and safety

There has been a huge amount we can be proud of in relation to the quality and the safety of the care we provide, especially as these two months represented a proactive period of us engaging internally and externally to promote our services and better care techniques.

Legs Matter Week took place in June, where our integrated tissue viability service held webinars and travelled around our hospitals and community bases to spread awareness of the importance of preventing lower leg and foot conditions. Learning Disability Awareness Week also took place in June, where our patient experience and engagement team, along with our autism liaison colleagues, worked with staff across West Suffolk Hospital. For this, the team produced resources and held awareness sessions for our teams to learn more about how to best care for patients with learning disabilities. Our teams taking the initiative in this way helps our Trust become more informed and better able to provide the highest quality and safest care possible.

In June, we launched our Schwartz Rounds, which provide colleagues with a space to discuss the emotional and social aspects of working in healthcare. The first session was well attended and received positively across many of our staff groups. I hope colleagues continue to utilise this space as a way of talking about the difficulties involved in working in healthcare, and support and empathise with each other. We know that teams with strong psychological safety and resilience can provide better and more empathetic care, so forums such as these are of great value to us all.

Other events include our Trust's annual cancer forum in Bury St Edmunds which took place in May. This event provided support and valuable information to cancer patients, their families, friends and support networks. With well over 200 attendees, there were insightful presentations and interactive sessions throughout the day. I would like to thank My WiSH charity for providing funding for the venue hire and complimentary lunch for attendees as this was hugely appreciated.

Additionally, the Trust held its 'medicine for members' healthy heart event at Sudbury Football Club on 19 July, which provided information on how everyone can take positive steps to looking after their heart health, which is something that it is never too early to be mindful of.

The recently established unscheduled care coordination hub (UCCH) has been a tool that symbolises the benefits of system working and delivering the right care, at the right time, in the right place. This service operates by our urgent community response service attending calls which would previously

have been assigned to an ambulance. Not only has this reduced pressure on our ambulance colleagues and our emergency department, but it has kept people at home by bringing care to them. This is a very positive example of how we must and will continue to innovate to better meet the needs of our communities while mitigating the pressure on our urgent and emergency care services.

Operational performance

During the last two months we have seen further rounds of British Medical Association (BMA) junior doctor strikes, and by the time you read this, there would have been strike action taken by consultant colleagues on 20 and 21 July.

Having spent time talking to colleagues across numerous departments throughout these periods of industrial action, I am proud of the way that teams have pulled together to help care for patients and each other. I would again like to state that we absolutely support your legal right to take strike action, and I ask that colleagues continue to respect each other's decision of whether to take action or not. Going forward, I hope that a resolution to the disputes between the BMA and the government are resolved quickly as I am keen to return our focus to improving services.

Despite the ongoing operational challenges, the reintroduction of the 4-hour standard has so far produced fantastic results. Thanks to excellent work to implement these changes, we have achieved a best weekly ambulance handover performance in the country twice and a top-10 4-hour performance twice in the last month. Most importantly, this will have resulted in our services delivering much safer patient care and much-improved patient and staff experience.

We have also seen the same day emergency care unit (SDEC) and surgical assessment unit (SAU) sharing a ward, offering a quicker pathway out of the emergency department at West Suffolk Hospital. As we progress through the summer and into autumn and eventually winter, these new innovative ways of working will help us meet the demand for our urgent and emergency care services.

Despite the impact of industrial action, progress to clear our waiting lists continues. At the end of June, there were 53 patients waiting more than 78 weeks, which has reduced since our last meeting. Looking forward to our goal of significantly reducing those waiting more than 65 weeks by March 2024, at the end of June, there were 385 patients in this bracket. While this is in line with our trajectory, I would like to reassure our patients that we are working incredibly hard to see you as quickly as possible.

Financial performance

As we reach the end of the first quarter, the increasing pressure we will face on financial performance is becoming clear. We had planned to have a £1.4 million deficit but have a deficit of £3.5 million due to a range of factors (such as keeping our winter contingency ward open longer than planned, the costs of industrial action and having not received full funding for our staff's pay award). We will be working hard to become financially sustainable, and we ask colleagues to help us achieve this.

Workforce and culture

Freedom to Speak Up has been a huge part of how we address concerns across the organisation, and for three years our Freedom to Speak Up Guardian, Amanda Bennett, has been at the heart of this. Amanda has driven our Trust's work to implement a strong speak up culture and has used her position to drive forward positive change. Therefore, it is with great sadness that Amanda will be leaving our Trust at the end of her 3 year tenure later this summer. I would like to thank Amanda for her contribution to our Trust and I wish her well in all her future endeavours.

Creating a strong and positive organisational culture is a key part of my role, and one I take with the utmost seriousness. I am aware that there is more we need to do to make our Trust the best place to work, and I am committed to listening to our colleagues as we make changes and learning when we don't get things right. A big part of this is the 'What Matters To You' engagement programme, and we look forward to delivering our full People and Culture Plan over the next year, which Jeremy Over will be outlining in more detail here.

I recently had the pleasure of experiencing my first annual volunteers' awards tea party which was attended by more than 100 of our volunteers. Here, we were able to present them with awards and serve them refreshments as a small gesture of our gratitude for everything they do. Of the 25 volunteers who received long-service awards this year, three of them were recognised for 25 years' service and another for an incredible 35 years of service. In total, all these long-service awards amounted to more than 400 years of selfless service to our Trust.

Looking to the future

While there are many challenges, there are things to look forward to. We have been designated as a priority Trust under the Government's New Hospital Programme, meaning we can move forward with more certainty on our plans to build a new hospital on Hardwick Manor by 2030. This is an incredible, once in a lifetime opportunity for us to deliver an outstanding, world-class healthcare facility that is fit to meet future healthcare needs and will create a fantastic environment for us all to work in.

On top of this, we have also recently been given planning approval by West Suffolk Council to build a community diagnostic centre at Newmarket Community Hospital. This will provide our patients with quicker access to a range of tests closer to home and reduce the time it takes them to access treatment, if required.

We must be clear that the years ahead will not be easy, however in view of the above, I am certain that we have the capability to make the most of any opportunity to improve the care we deliver for those in west Suffolk.

2. STRATEGY

2.1. Strategic Objectives & Delivery Plan

To Assure

Presented by Ewen Cameron

Board of Directors	
Report title:	**Delivering our strategy – priorities for 2023/24**
Agenda item:	2.1
Date of the meeting:	21 July 2023
Sponsor/executive lead:	Ewen Cameron, Chief Executive
Report prepared by:	Ewen Cameron, Chief Executive Richard Jones, Trust Secretary

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

Our strategy was published in January 2022 (First for our patients, staff and the future,which sets the direction of the organisation over the next five years. A short animation is also available which summarises the strategy, our future direction and how we will get there https://youtu.be/NCVqNCqHXaQ). Powered by our updated FIRST Trust values of fairness, inclusivity, respect, safety and teamwork, the strategy has three equal ambitions:

In considering the priorities for 2023/24 we also took into account the system in which we work. Specifically, the collective ambitions within the Live Well framework of our Integrated Care System.

As a Board, we have been working over the last 3 months to prioritise delivery for 2023/24. This paper sets out those priorities as well as measures for successful delivery.

The priorities we have identified are:

- Delivery of **service pathway changes** as laid out in the Clinical and Care Strategy (Exec lead – PM)
- A strong priority on **Equality, Diversity and Inclusion** to address the disparity between different groups where the evidence shows that staff are disadvantaged or feel discriminated against (Exec lead – JMO)
- A large focus on **line management development** given the feedback from What Matters To You 2, the National Staff Survey and the Freedom to Speak Up Champions alongside the impact this would have on a large portion of the organisation (Exec lead – JMO)
- A step change in delivery on **prevention and proactive care** given the modelled demand projections and the explicit need for this to support the Future Systems Programme (Exec lead – PM)
- Development of **transformation capacity and capability** given the scale of change required for both business-as-usual challenges and to support the Future Systems Programme (Exec lead – NC)

Annex A details rationale and drivers for each of these priorities as well as measures for success. It is proposed that the Board receive regular updates for each of the priorities and progress against the measures for success.

Action Required of the Board

The Board is asked to approve:

1. the priorities for the year ahead
2. that review of progress with priorities in built into the Board's forward plan

Strategy priorities 2023-24

NHS
West Suffolk
NHS Foundation Trust

Strategy priorities for 2023-24

- Delivery of **service pathway changes** as laid out in the Clinical and Care Strategy (Exec lead – PM)
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Priority: Delivery of **service pathway changes** as laid out in the Clinical and Care Strategy

Rationale and drivers:

- 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, both business as usual (e.g. NHS Operational Planning guidance), and the implementation of the clinical and care strategy for the Future System programme, require a transformative approach to change
- Meeting this growth by continuing to deliver services in the way we are today simply isn't an option.
- The starting point for the future model is integration with our local partners as part of the West Suffolk Alliance. This is a path we are already on. By joining up services and sharing resources with primary care, social care, mental health, council services, community organisations and the voluntary sector, we believe we can provide people with much of the care they need within their local communities.
- When people do need specialist care, it will be provided by high quality and efficient acute and subacute services. We already have a number of partnerships in place with other NHS trusts to help us do this well. We will continue to expand our collaboration across the Suffolk and North East Essex Integrated Care System, and beyond, wherever it is in the interests of our population.
- These principles, and the implications they have for how our services and joint working will evolve. Based on these principles, a vision for the future has been co-produced for each individual service.

Delivery plan 2023-24

SMART actions	Measures of success	By who	Live Well domains/ other strategies
Priority: Delivery of **service pathway changes** as laid out in the Clinical and Care Strategy			
• Plan and deliver against the priority areas for service pathway change	• Frailty – deliver integrated frailty model leading to 10% reduction in falls and frailty related admissions by March 2024. • Virtual ward – to deliver 103 virtual beds by March 2024. • Early intervention – increased service provision up to 7 day, 24hr service by March 2024. • Work to bring community and hospital services for children and young people closer together for the benefit of families using our services • Pilot of 15 session weeks – piloted in 1 surgical specialty (electives and OPD) by March 2024. • Agreed 3-5 year project plan for delivery of transformation by March 2024.	Exec sponsor: Medical director (Paul Molyneux) Operational delivery lead: Deputy COO (Alex Baldwin)	All Live Well domains Clinical and care strategy
• Collaborate to provide seamless care at the right time and in the right place for end of life patients	• Advanced care plans in place for 50% of patients at the end of life by March 2024 • Virtual ward effectively utilised – end of life pathway in place and capacity to deliver by March 2024 • 70% of patients die in their preferred place of choice by March 2024 • 10% reduction in admissions within 48 hours of end of life by March 2024 • 24/7 support for end of life patients and their relatives/ carers is available by March 2024 • ReSPECT is in use 100% by March 2024	Exec sponsor: Chief nurse (Sue Wilkinson) Clinical delivery lead: Mary McGregor Operational delivery lead: Sharon Basson	Die well

Priority: **Equality, diversity and inclusion**

Rationale and drivers:

- We want to address the disparity between different groups where the evidence shows that staff are disadvantaged or feel discriminated against. WRES and WDES data, F2SU themes and staff feedback suggest that priorities for this year should be race and disability. Other groups sharing a protected characteristic will also benefit from this work as we focus on being truly inclusive.
- Earlier in June the NHS published a new 'equality, diversity and inclusion improvement plan' identifying six high-impact actions for adoption in all parts of the service. Whilst this is the product of significant national-level engagement, and is something we will want to engage with, it is not a locally-driven plan. We need to consider how this sits alongside or supersedes are existing plans. It does, however, rightly state that:
- Staff who are bullied are less likely and less willing to raise concerns and admit mistakes
- Increased leadership diversity correlates with better financial performance
- In hospital settings, managing staff with respect and compassion correlates with improved patient satisfaction, infection control, Care Quality Commission (CQC) ratings and financial performance
- High work pressure, staff perceptions of unequal treatment, and discrimination against staff all correlate adversely with patient satisfaction
- A workforce that is compassionate and inclusive for all has higher levels of engagement, motivation and wellbeing, which results in better care and reduced staff turnover
- Fair treatment of every individual in the workforce helps reduce movement of substantive staff into bank and agency roles to avoid discrimination at work
- A diverse workforce that is representative of the communities it serves is critical to addressing the population health inequalities in those communities
- Organisations with more diverse leadership teams are likely to outperform their less diverse peers
- Psychologically safe work environments, where people feel they are treated with dignity and respect, achieve more effective, safer patient care

Priority: **Line management development**

Rationale and drivers:

- Feedback from What Matters To You 2, the National Staff Survey and the Freedom to Speak Up Champions and the impact this would have on a large portion of the organisation
- That at least 70% of the variance in team engagement is influenced by the role of line managers and team leaders (Gallup, 2015)
- Line managers are colleagues too, who we must value and support as they take on these challenging and rewarding roles
- Analysis of WSFT staff feedback highlighted that staff want to:
    - *Feel valued and appreciated, and that their concerns are welcomed and acted on*
    - *Receive clear feedback, enabled to make improvements and be involved in changes taking place*
    - *Be able to access career development opportunities to reach their full potential*
    - *Feel that their health and wellbeing is important and supported*
    - *Be able to discuss flexible working options to achieve balance with commitments outside of work*

Putting you first

Delivery plan 2023-24

SMART actions	Measures of success	By who	Live Well domains/ other strategies
Priority: Equality, Diversity and Inclusion			
Our WSFT priorities: • Growing active, engaged staff networks with visible exec support • Based on our Trust values, agreeing and adopting anti-racist behaviours with support provided for line managers and staff to live these fully • Developing inclusive leadership practices for leaders at all levels • Embedding equality into policies, strategies and key focal areas of Trust practice, aligned to WRES and WDES priorities • Establishing guidance and support for all managers and colleagues around reasonable adjustments • Enabling all staff, including those with visible and invisible disabilities, to feel valued at work National EDI improvement plan – high impact actions: 1. Chief executive, chair and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable 2. Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity 3. Develop and implement an improvement plan to eliminate pay gaps 4. Develop and implement an improvement plan to address health inequalities within the workforce 5. Implement a comprehensive induction, onboarding and development programme for internationally-recruited staff 6. Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur	• Prepare to deliver against the Inclusive Leadership and Anti-racism pledge by March 2024 • Action taken with feedback and learning for all EDI-related speak up concerns and reports of harassment, bullying, discrimination or abuse by March 2024 • Framework & guidance for reasonable adjustments published by March ’24 National EDI improvement plan measures: 1a. Annual Chair/CEO appraisals on EDI objectives via Board Assurance Framework (BAF) 2a. Relative likelihood of staff being appointed from shortlisting across all posts 2b. NSS Q on access to career progression and training and development opportunities 2c. Improvement in race and disability representation leading to parity 2d. Improvement in representation senior leadership (Band 8C upwards) leading to parity 2e. Diversity in shortlisted candidates 2f. NETS Combined Indicator Score metric on quality of training 3a. Improvement in gender, race, and disability pay gap 4a. NSS Q on organisation action on health and wellbeing concerns 4b. National Education & Training Survey (NETS) Combined Indicator Score metric on quality of training 5a. NSS Q on belonging for IR staff 5b. NSS Q on bullying, harassment from team/line manager for IR staff 5c. NETS Combined Indicator Score metric on quality of training IR staff 6a. Improvement in staff survey results on bullying / harassment from line managers/teams (ALL Staff) 6b. Improvement in staff survey results on discrimination from line managers/teams (ALL Staff) 6c. NETS Bullying & Harassment score metric (NHS professional groups)	Lead: Executive director of workforce & communications	People and culture plan 2023/24

Delivery plan 2023-24

SMART actions	Measures of success	By who	Live Well domains/ other strategies
Priority: Line management development			
• Reviewing line manager spans of control to ensure roles are sustainable • Agreeing values-based outcomes for what great line management means at WSFT • Developing and delivering a holistic and inclusive package of learning and development for line managers, staff members and teams • Review, revise and re-launch the appraisal process, linking in career conversations and focusing on quality discussions	• No line manager with more than an agreed number of direct reports by March 2024 • Values-based line management standards agreed and published by December 2023 • Coaching and mentoring framework agreed by September 2023 • Learning Hub launched by September 2023 • Line manager development package published and in delivery by December 2023 • Appraisal completion rates at 90% by December 2023 • Improvement in staff survey indicators (longer-term)	Lead: Executive director of workforce & communications	People and culture plan 2023/24

Priority: A step change in **delivery on prevention and proactive care** given the modelled demand projections and the explicit need for this to support the Future Systems Programme

Rationale and drivers:

- The NHS Long Term Plan clearly states that the NHS can and should take more action on prevention, health inequalities and personalised care to help improve the population's health and allow itself the best possible chance of meeting growing demand.
- In Suffolk, we have known for some time that the growth in demand for healthcare services is unsustainable. In 2017, Suffolk County Council published analysis that showed that by 2037, another 2 hospitals the size of West Suffolk Hospital would be needed if the trend in hospital admissions didn't change. We are experiencing this rise in all our services, be it more district nurse visits, more children's community clinics, or more A&E attendances, for example.
- WSFT is helping to tackle this crisis by joining up care within the trust and with other local organisations as a member of the West Suffolk Alliance and Suffolk and North East Essex Integrated Care System; through the Joint Forward Plan, the alliance strategy, our clinical and care strategy and the Future System Programme. It is starting to bear fruit; repeating the analysis in 2022, Suffolk County Council now estimates that only 1.5 new hospitals would be needed by 2042.
- The Trust has an important and powerful role to play in helping people not to get sick in the first place, and making sure that when they do need our help, everyone gets the care they need fairly and tailored to their circumstances.

Priority: Development of **transformation capacity and capability** given the scale of change required for both business-as-usual challenges and to support the Future System Programme

Rationale and drivers:

- 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, both business as usual (e.g. NHS Operational Planning guidance), and the implementation of the clinical and care strategy for the Future System programme, require a transformative approach to change
- An action was agreed through board development workshops in 2022 to: Make better use of the amount of capability and capacity we already have in the people with expertise in change and improvement. The first steps towards this have taken place, with a unified change management function and process (change hub) which went live on 1st April 2023
- The change hub team plan to review the structure following six months of operating as a new function. This bottom-up approach to changing the way we approach change and transformation mirrors the discussions had at further board development sessions, leading to a consensus that we need to review our capacity and capability as a Trust for delivering change and transformation
- This work will be undertaken in the context of wider developments to align transformation capacity across the West Suffolk Alliance, Integrated Care System, and Provider Collaboration.

Delivery plan 2023-24

SMART actions	Measures of success	By who	Live Well domains/ other strategies
Priority: Delivery on prevention and proactive care			
• Launch the WSFT Prevention, health inequalities and personalised care strategy by 31st August 2023 • Train colleagues in prevention, health inequalities or personalised care by 31st March 2024.	• Prevention, health inequalities and personalised care strategy is approved by the board and published on the trust website • 1,000 colleagues trained in prevention, health inequalities or personalised care	Exec sponsor: Executive medical director (Paul Molyneux) Clinical delivery lead: Clinical lead for public health (Helena Jopling)	Be Well
• Continue and expand the inpatient tobacco dependence service, supporting 350 people to stop smoking by March 2024, 40% of whom will live in the most deprived areas	• Number of people who successfully quit for 4 weeks • Percentage of people who successfully quit who live in the 40% most deprived lower super output areas	Exec sponsor: Executive medical director (Paul Molyneux) Public health manager (Jessica Hulbert)	Be Well
Priority: Develop and expand our transformation capacity and capability			
• Review the structure and capacity of the change hub	• Revised structure in place by April 2024 • Explore options in relation to leadership and support to the transformation and change function	Exec sponsor: COO (Nicola Cottington) Operational delivery lead: Deputy COO (Matt Keeling)	All Live Well domains Clinical and care strategy

2.2. Future System board report

To Assure

Presented by Craig Black

Public Board Meeting – 21 July 2023

Report Title:	Future System Board Report
Item No:	2.2
Executive Lead:	Craig Black
Report Prepared by:	Gary Norgate
Previously Considered by:	Future System Programme Board

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

Executive Summary

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

Executive Summary

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

Last month's paper, concluded: "In the next 6 weeks we expect to; have submitted an updated Strategic Outline Business Case (SOC) for sign-off, commenced on-site discussions between statutory consultees and our environmental partner, formally agreed fees for the development of our Outline Business Case, appointed a workforce partner, engaged in a clinical review of our designs with NHP and learnt of any objections to the formal notification of our planning permission…..we may even have received a formal announcement (on capital allocation) from Ministers!"

The following paper will illustrate the extent to which these milestones have been achieved.

1. An independent review of our SOC identified several areas to be updated. This refresh has been successfully completed and the case has now been submitted for consideration.
2. Work progressing the execution of our environmental compensation strategy continues positively. Site visits have been held and soil samples are currently being analysed to ensure the land chosen is the perfect receptor.
3. The optimal commercial mechanism for contracting with our ecological compensation partner is under construction.
4. On 25th May Secretary of State for Health announced to Parliament that Government were committing £20bn to the realisation of its plans to build "40 new hospitals by 2030". In addition, 8 schemes would be added to the programme and that the replacement of hospitals constructed of RAAC planks would be prioritised.

5. With this prioritisation in mind, a significant budget to cover the development of our Outline Business Case been agreed with the New Hospital Programme and WSFT are starting to draw down the money to cover the activities discussed within this report.
6. A capital range for the building of a new West Suffolk Hospital has been confirmed by NHP.
7. The Future System Team has appointed Carados as its partner in the development of a workforce forecast and plan.
8. A series of engagements with the New Hospitals Programme have provided us with a view of the extent to which our co-produced clinical design, demand and capacity model and build costs align with the best practice that they have established. Feedback to date has been positive and divergence is marginal.
9. The period for objecting to the notification of our outline planning permission has passed without challenge. Next steps are focussed on discharging the pre-commencement planning conditions and securing full consent.
10. In the next 6 weeks we expect to; secured sign-off for our updated SOC, secured the commercial agreement with our ecology partner, finalised our schedule of accommodation and aligned our view of scale and scope with that of NHP.
11. Further to the action raised at last month's Board, the following report will also explain progress being made on establishing plans for transformation and establishing a means of managing the revenue impact associated with building a new hospital.

Business Cases and Project Plan

Key activities and milestones:

Following the Ministerial announcement that RAAC schemes will be prioritised, the West Suffolk team been preparing for and considering the risks associated with an accelerated time-line. Discussions with the WSFT Board and ICB have resulted in support for moving at pace, however, as much as bringing the operational date for a new hospital forward reduces risks associated with the current infrastructure, it also places pressure upon the need to transform operations and implement the new clinical strategy.

Our next step is the production of an outline business case (OBC) and the first step towards completing such a case is to gain formal agreement to the strategic outline case (SOC) that was originally prepared in December 2020. To this end, the case has undergone independent review by NHP and areas requiring updates have been identified. These updates have now been completed and the case has been issued to the NHS England Regional team, NHP and the National Clinical Advisory Team who will identify the key areas that require focus within the OBC. The output will be presented to the NHP Investment Committee before being presented to HM Treasury and Joint Investment Committee for information. This process will ensure the OBC is provided with clear direction and that the SOC is formally agreed. The agreement of this pragmatic progressive assurance process is clear evidence of the positive support being provided to the West Suffolk Project.

Further evidence of support is provided in the form of the prompt agreement of funds required to support the development of the OBC and the fulfilment of our pre-construction planning conditions.

The announcement of a £20bn budget for the New Hospital Programme has also allowed the communication of individual capital ranges to each scheme. These ranges have been calculated on the basis of several inputs; a) a "top down" allocation from within the £20bn, b) a "bottom-up" consideration of the preferred way forward contained within respective SOCs and c) outputs from the deep-dives conducted on various schemes to understand the potential costs of delivering each of the solution architypes (e.g. West Suffolk's plans were explored to establish a view of the potential costs of re-building RAAC hospitals).

Before any scheme can reliably determine whether the capital range is sufficient to cover their ambitions, it is necessary to establish the extent to which a plan conforms with the designs, costs and standards of the NHP programme and its Hospital 2.0. With this in mind, West Suffolk has engaged with NHP experts to conduct tests in three key dimensions:

1) a 'critical clinical review' of our designs against NHP standards
2) a comparison between West Suffolk's demand and capacity modelling and that carried out using the central NHP model.
3) A comparison between West Suffolk's costing of its preferred schedule of accommodation and the costs that emerge from the NHP "should cost" model for the same schedule.

Initial results show marginal deviations and suggest that the work conducted by the West Suffolk team are reliable and justifiable. This does not mean that our capital plans are agreed and without challenge. The next step will be a review of departmental sizes and how they relate to Hospital 2.0.

Estates

The critical path to the point of construction is dominated by:

- The execution of our environmental compensation strategy
- The laying on of suitably dimensioned utilities
- The satisfaction of our pre-commencement planning conditions
- Securing full planning permission

Strong progress has been made in all of these areas, specifically;

- We await the outcome of soil sampling that will determine the suitability of our preferred compensatory receptor site.
- We have made significant progress towards determining and agreeing a suitable commercial mechanism for securing and maintaining our compensatory site.
- The period for objecting to our planning outcome has passed without further challenge.
- We have calculated the peak power loading required by the new hospital and received notification from UK Power networks that this infrastructure can be made available in time for our accelerated operational date.
- Detailed plans have been constructed to ensure we are prepared to conclude our full planning application by October 2024.

Clinical Workstream

As mentioned above, a prioritisation of the West Suffolk plan to build a new hospital will inevitably place pressure upon the time within which the Trust and the System can embed the transformation that underpins our capacity modelling. With this in mind, the Clinical Team and Trust have been focussed upon building plans for the implementation of the agreed clinical and care strategy and the wider system transformations.

The content of the clinical and care strategy, specifically the ambitions set out within, form the shape of a significant transformation programme for the Trust. However, it is not for the Future System Team to deliver that transformation. Therefore, attention has turned to the shape and focus of a delivery model.

In early April 2023, an exercise to map the ambitions set out in the clinical and care strategy commenced. This comprised reviewing the strategy contents against the future system dependency matrix, the trusts internal transformation plan – the "One Plan", and the SNEE Joint Forward Plan.

There are 126 individual ambitions identified in the clinical and care strategy. All map directly with the dependency matrix and joint forward plan, but only six map directly with the One Plan. This demonstrates the scale of delivery required.

Following this exercise, and in support of strategic objective setting for 23/24 priority areas for service pathway change have been identified. These are as follows:

- Frailty – to deliver an integrated frailty model leading to a 10% reduction in falls and frailty related admissions by March 24.
- Virtual ward – to deliver 103 virtual beds by March 24.

- Early intervention – to increase service provision up to 27/7 by March 24.
- Childrens and young people services – undertake a review of service configuration and develop an options appraisal by March 24.
- To pilot the delivery of 15 session weeks – piloted in 1 surgical specialty (both electives and outpatients) by March 24.

In addition, a sixth priority has been agreed:

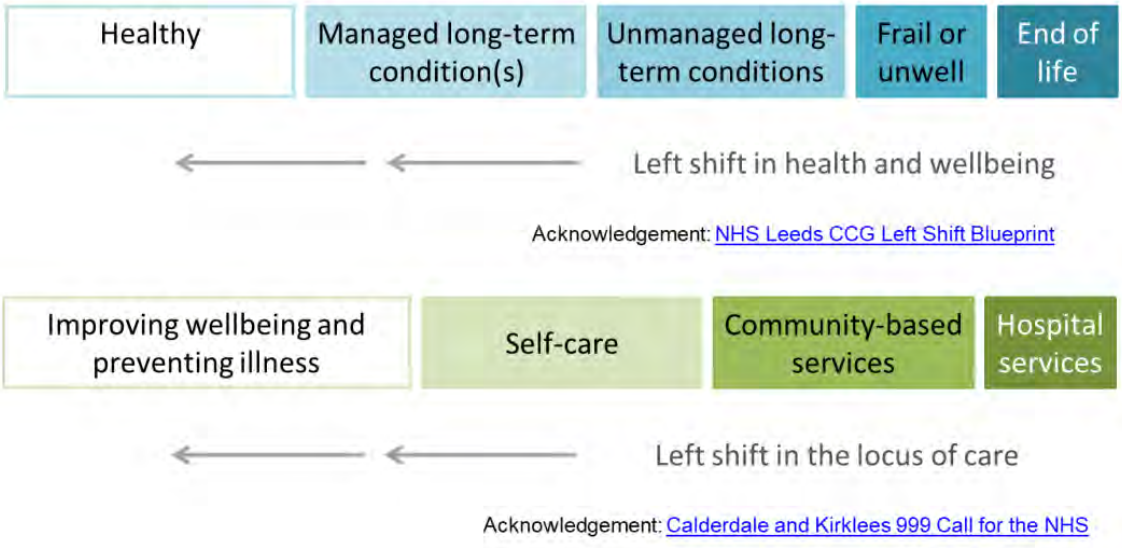
- To have created and agreed a 3–5-year transformation delivery plan by March 24.

In the case of virtual ward, frailty, and early intervention this is an extension of work that has already commenced or is planned to start in 23/24. I.e., additional support will allow these projects to go further and faster in 23/24.

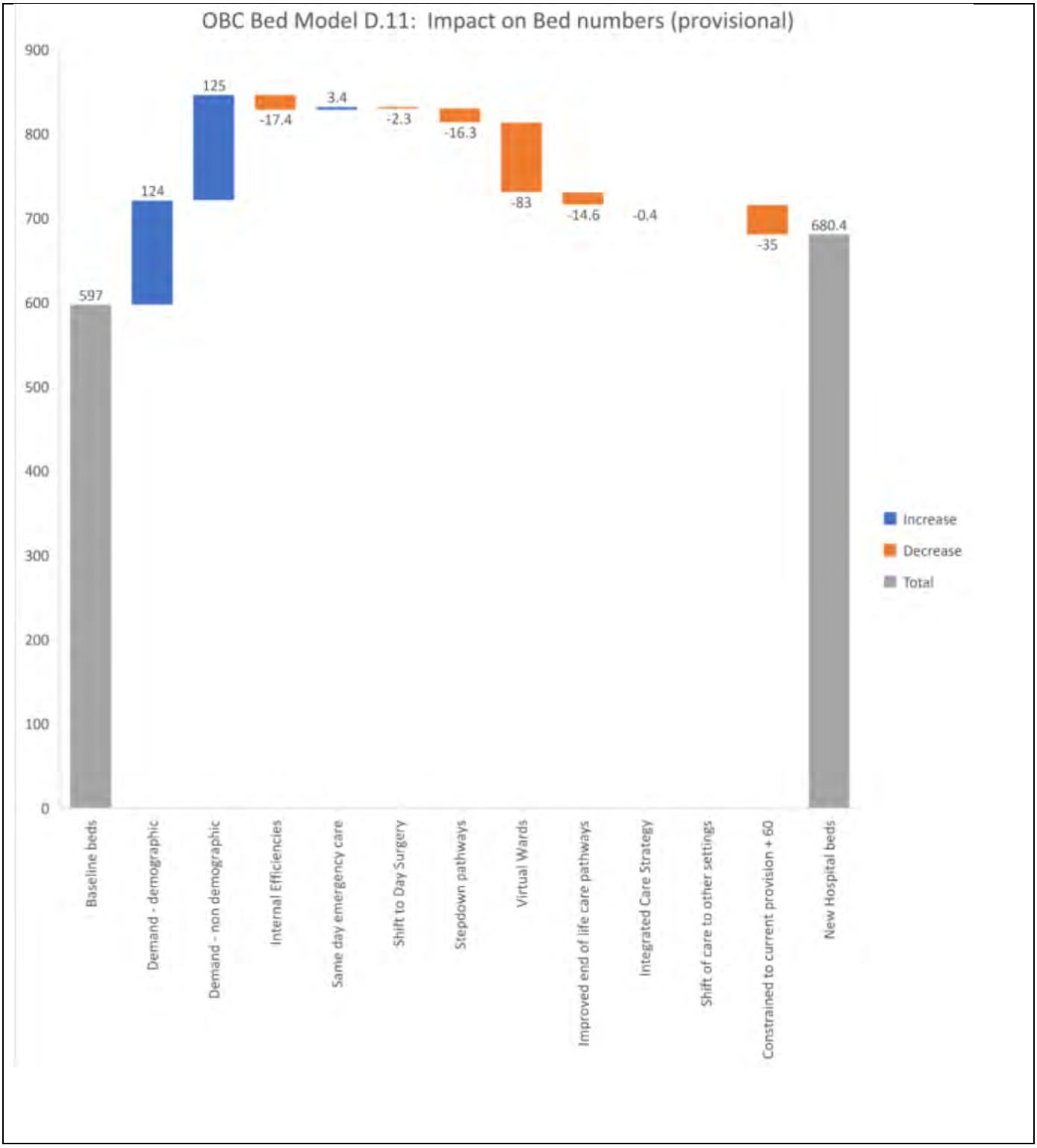
All five projects have been identified by clinical services as priorities that will deliver for today, in addition to supporting delivery for tomorrow.

Delivery of these priorities will be supported by the existing change functions working alongside clinical teams.

Beyond the work underway to implement the clinical and care strategy, our demand and capacity model assumes that some care will be provided differently in the future, in such a way that the need for overnight stays in hospital will be reduced. This is part of what is referred to as the 'left shift' in the locus of care.



The waterfall chart overleaf shows our current position on the assumptions which affect inpatient bed numbers. Each assumption is then listed in the table which follows with a description of how well worked up the proposal is and the level of confidence that it can be achieved. Please note this is work in hand and our knowledge is evolving month-to-month. Only the assumptions which affect inpatient bed numbers are included in this table (as those are the assumptions which are attracting most interest).


OBC Bed Model D.11: Impact on Bed numbers (provisional)
900
800
700
600
500
400
300
200
100
0
597
124
125
-17.4
3.4
-2.3
-16.3
-83
-14.6
-0.4
-35
680.4
Increase
Decrease
Total
Baseline beds
Demand - demographic
Demand - non demographic
Internal Efficiencies
Same day emergency care
Shift to Day Surgery
Stepdown pathways
Virtual Wards
Improved end of life care pathways
Integrated Care Strategy
Shift of care to other settings
Constrained to current provision + 60
New Hospital beds

Proposed reduction	Lead	Effect on bed numbers and RAG	Commentary
Internal efficiencies	WSFT	-17.4	Plans underway and being developed as part of emerging OBC. Effect on bed numbers has reduced following removal of double counting with other initiatives (stepdown pathways in particular). Will be delivered primarily through the quality and patient flow benefits of 100% single rooms and the digital strategy (including capacity management). Order of magnitude validated by two independent sources (Newton and Grant Thornton consultancies). High level of confidence in delivery as long as investment can be made.
Shift to day surgery	WSFT	-2.3	Plans underway and being developed as part of emerging OBC. Represents achievement of recognised and proven national best practice. Relies on extension and refurbishment of existing day surgery unit. High level of confidence in delivery as long as investment can be made in the estate's development.
Step down pathways (discharge to optimise and assess)	West Suffolk Alliance	-16.3	Builds on existing discharge-to-assess improvement project (related to implementation of national Criteria to Reside guidance). Detailed modelling continues to determine workforce requirements and revenue costs. ICB has seen the first phase of modelling and the second phase is being done in alignment with the ICS-wide demand and capacity modelling project. If this confirms it is achievable, implementation will start immediately. Moderate confidence in delivery as although there is a long lead time, the availability of workforce will be the biggest risk.
Virtual wards	WSFT	-83	Plans underway within business-as-usual, as per national planning guidance 2023/4. Assumes that the winter 2023 quantum of virtual beds is achieved and maintained forever. Ratio of virtual beds to real-life beds is not 1:1. Effect on bed numbers is based on local experience to date and correlates with national guidance. High confidence in delivery as although it is a large-scale change, the time for iterative improvement and achievement is long.
Integrated end of life pathways	West Suffolk Alliance	-14.6	Builds on existing end-of-life system priority. Target is based on proven best practice within the ICS (North East Essex Alliance) so considered realistic. Demand and capacity modelling being undertaken to determine workforce requirements and revenue costs. If this confirms it is achievable, implementation will start immediately. Moderate confidence in delivery as although there is a long lead time, the availability of workforce will be the biggest risk.
Integrated Care strategy	SNEE ICS	Being refreshed	Effect size based on the 2018-2023 ICS strategy was modest at 0.4 beds because the strategy was limited in the number of objectives which had quantifiable impacts on the demand for acute services. New ICS Joint Forward Plan 2023-28 has several SMART objectives which are being assessed for effect size.
Shift of care to other settings	WSFT	Being refreshed	Consists of shift to home delivery of renal dialysis (peritoneal dialysis) and shift of high volume, low complexity elective surgery to elective hub(s) in line with the national Getting It Right First Time (GIRFT) recommendations. Will rely on funding, facilities, and workforce.
Constraining adult inpatient beds to current provision +60	West Suffolk Alliance	-35 (number will reduce following the contribution of the two lines above)	This is the least well worked up component of the model. Trust has chosen to voluntarily constrain inpatient beds to +60 on current bed base in order to catalyse more preventative and proactive care. Promising initiatives will be scoped by the community, primary care and hospital workstreams starting with a number of different sources: • Potential to reduce diabetes-related admissions by adopting a new integrated diabetes care model - being developed under the Alliance Delivery Plan (Stay Well domain) • Impact of SNEE community hub pulling ambulance service demand into the Urgent Care Response service • Research conducted by Grant Thornton as part of the ICS demand and capacity project • Virtual ward step-up pathways • Proactive frailty care, building on the integrated frailty model already designed and a recent pilot using population health management to identify mild to moderate frailty Moderate level of confidence despite work-up only just beginning. The model includes no other demand reduction at the moment and is highly realistic in its activity forecasts so as a system we ought to be able to commit to this level of impact through population health management, long term condition management, and prevention.

As work continues on the transformation plans set out above, discussions are underway between leaders from the Trust, Alliance and Integrated Care System to create the links into the West Suffolk Alliance Live Well governance framework that will ensure various transformation workstreams remain aligned and complimentary.

The next key deliverable / milestone of this workstream will be the final schedule of accommodation that will be used as the basis for the outline business case designs and costs.

Workforce Workstream

The Future System Team has appointed Carados as its partner in the development of a workforce forecast and plan. This work will allow us to design and execute a programme aimed at ensuring we have the correct balance/mix of resources and skills required to compliment and exploit our new hospital.

Carados have significant experience in workforce planning, workforce redesign, workforce modelling and workforce strategy development. Recent engagements have seen them work with Health Education England and Lancashire & South Cumbria NHS Foundation Trust to deliver the Workforce Repository & Planning Tool (WRaPT) and other major national workforce planning development programmes. They are uniquely placed to be able to develop our teams to produce:

- ICB and other system workforce strategies and plans
- Provider workforce plans
- Neighbourhood team workforce plans
- Detailed workforce models using the Workforce Repository and Planning Tool

Next steps for the workforce modelling process include the application of the latest demand forecasts, understanding how different budget and capacity scenarios may moderate the predicted volume and mix of resources, and assessing the impact of the recently released NHS Long Term Workforce Plan.

Digital Workstream

With the announcement of prioritised delivery schedule, our digital team will be appointing a partner to work with us on revising our Schedule of Equipment based on updated designs and SOA. The work with MTS Health to cost the digital strategy and identify key benefits has been completed with WSFT stakeholders and technical experts, and we now move into a period of prioritisation based on benefits, ROI and application with the overall plans. Any derogations from the MVP (Hospital 2.0 for digital technology) will require ratification with NHP. We are also progressing with the digital engagement work with both staff and patients. All of these allow us to add detailed costs, plans and engagement to the Outline Business Case.

Communications and Engagement

Work continues to ensure we collect the views of our entire community and involve them in the co-production of strategies for future retail services and public areas within an acute setting.

Following the outcome of recent local elections, plans are underway to engage new councillors in our project and ensure they have opportunity to shape our plans and represent the views of their constituents.

We were delighted to welcome the Secretary of State for Health, Stephen Barclay, MP for Bury St Edmunds, Jo Churchill and MP for South Suffolk, James Cartlidge to West Suffolk Hospital and to take them through our exciting plans for the future.

Finance

Finances and funding continue remain in line with plan and we have now secured full funding for the development of our outline business case.

Our finance team are now focussed on the development of finance and economic cases for the outline business case.

Given the importance of this work and my previous announcement that Terry Sparling will soon be leaving us, I am delighted to announce the recruitment of Amara Zeb who will be attempting the almost impossible task of filling Terry's significant shoes!

In order to ensure a smooth and seamless transition, Terry has started the process of handing over his workload, however, there will inevitably be a risk to continuity and therefore we are engaging interim professional support to act as a bridge between the incoming and outgoing resources.

Whilst developing our plans it has become apparent that the Trust, ICB and East of England Region will face a significant increase in ongoing operational expenditure as a consequence of 'borrowing' the money required to build a new hospital. This cost stems from the payment of a Public Dividend Capital charge that equates to approximately 3.5% of the capital consumed in the creation of the new asset. These charges will impact every scheme in New Hospital Programme and as such is a national issue. With this in mind, the matter has been escalated to NHS England and NHP and a working group has been established to progress the matter to a suitable, and affordable, conclusion. The issue is captured on project and Trust risk registers, thus:

8	The Trust and SNEE may face an annual exposure on a £850M new hospital build cost of circa £30M. This number could be six times as high at a regional level.	Although NHP are providing funding for the building of a new hospital, the additional operational /revenue costs and the cost of the public dividend capital will fall to the Trust. This additional revenue burden will create deficit for the Trust, SNEE and the East of England Region unless the cost is fully funded. If a solution cannot be found, the Trust and SNEE annual exposure on an £850m cost will be in the region of £30m. This number could be six times as high at a regional level. It is expected that any additional operating costs associated with a larger hospital will be offset by productivity gains associated with a modern, digitised facility – however, if these gains are not realised a secondary revenue risk will emerge.	Major	The issue of funding has been flagged to NHP and East of England leaders and a working group is being established to explore possible solutions.

All in all, this period has been one in which several key national milestones have been achieved which in turn have signalled a significant change in pace and certainty for the West Suffolk Project. In the next period we will have:

- Secured sign-off of our SOC
- secured the commercial agreement with our ecology partner,
- finalised our schedule of accommodation and
- aligned our view of scale and scope with that of NHP.

Action Required of the Board

To note the contents of this report.

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

2.3. Clinical and Care Strategy

To Assure

Presented by Paul Molyneux

Trust Board

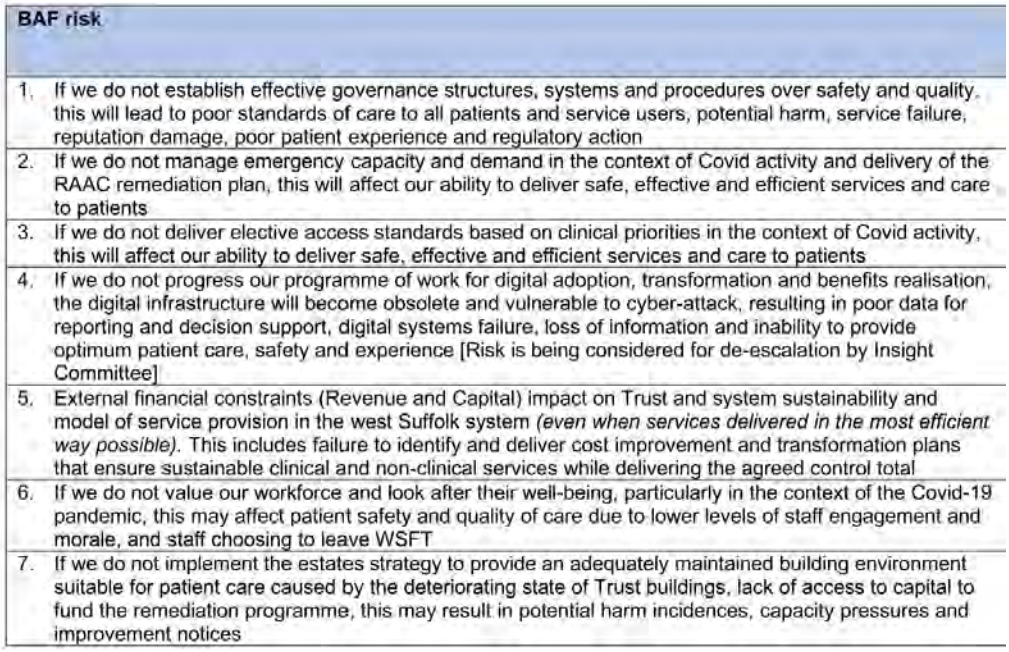
Report title:	**Clinical and care strategy 2023-2031**
Agenda item:	2.3
Date of the meeting:	21 July 2023
Sponsor/executive lead:	Paul Molyneux, Executive Medical Director
Report prepared by:	Helena Jopling, Associate Medical Director (Future System) Alex Baldwin, Deputy Chief Operating Officer

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 Future System Programme has designed a new clinical and care model, through co-production with staff, patients, members of the public and our system partners. Broadly, the resulting change programme could be 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 The FSP was aware that: • Each of those topics would be a hefty undertaking on its own • No member of staff would be untouched by the change that we needed to achieve

	• The change needs to start soon because the demand is already rising, and because it will take several years to make the transformation that we need • 15 months of co-production had surfaced an unavoidable message that strategic change was difficult to achieve at WSFT. Subsequently, the board has been engaged in considering the adaptations the trust would need to make to create change. Under recommendation of the board the co-produced clinical model has been written up together with the divisions' existing priorities and plans, and the resulting document is the trusts Clinical and Care Strategy. Initial delivery of the strategy is focused on six clinical priorities. These are as follows: • Frailty – to deliver an integrated frailty model leading to a 10% reduction in falls and frailty related admissions by March 24. • Virtual ward – to deliver 103 virtual beds by March 24. • Early intervention – to increase service provision up to 27/7 by March 24. • Childrens and young people services – undertake a review of service configuration and develop an options appraisal by March 24. • To pilot the delivery of 15 session weeks – piloted in 1 surgical specialty (both electives and outpatients) by March 24. • To have created and agreed a 3–5-year transformation delivery plan by March 24.
Action required/ recommendation:	The board are asked to approve the following: • The clinical and care strategy • The 23/24 priority areas for service and pathway change.

Previously considered by:	Strategic Leadership Team, 21 November 2022 Clinical Directors, 8th August 5th September and 7th November 2022
Risk and assurance:	Risks 3-5 on the Trust Board Assurance Framework (BAF) are addressed in the clinical and care strategy

	 **BAF risk** 1. If we do not establish effective governance structures, systems and procedures over safety and quality, this will lead to poor standards of care to all patients and service users, potential harm, service failure, reputation damage, poor patient experience and regulatory action 2. If we do not manage emergency capacity and demand in the context of Covid activity and delivery of the RAAC remediation plan, this will affect our ability to deliver safe, effective and efficient services and care to patients 3. If we do not deliver elective access standards based on clinical priorities in the context of Covid activity, this will affect our ability to deliver safe, effective and efficient services and care to patients 4. If we do not progress our programme of work for digital adoption, transformation and benefits realisation, the digital infrastructure will become obsolete and vulnerable to cyber-attack, resulting in poor data for reporting and decision support, digital systems failure, loss of information and inability to provide optimum patient care, safety and experience [Risk is being considered for de-escalation by Insight Committee] 5. External financial constraints (Revenue and Capital) impact on Trust and system sustainability and model of service provision in the west Suffolk system *(even when services delivered in the most efficient way possible)*. This includes failure to identify and deliver cost improvement and transformation plans that ensure sustainable clinical and non-clinical services while delivering the agreed control total 6. If we do not value our workforce and look after their well-being, particularly in the context of the Covid-19 pandemic, this may affect patient safety and quality of care due to lower levels of staff engagement and morale, and staff choosing to leave WSFT 7. If we do not implement the estates strategy to provide an adequately maintained building environment suitable for patient care caused by the deteriorating state of Trust buildings, lack of access to capital to fund the remediation programme, this may result in potential harm incidences, capacity pressures and improvement notices In addition, there is a specific 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:	The Clinical and Care Strategy will support equality, diversity and inclusion through co-production and delivery of high-quality clinical services, which are rooted in the needs of our population, patients, and workforce.
Sustainability:	To ensure sustainable delivery of cost effective, high quality clinical services.
Legal and regulatory context:	N/A

Clinical and care strategy 2023-2031

1.	Background
1.1	At a development day on 08 April 2022, the Trust Board heard of the vast amount of change that will be required over the next few years and beyond, to be able to meet the projected increase in healthcare demands from the local population. The planning for the replacement of West Suffolk Hospital, conducted by the Future System Programme (FSP), has revealed the scale of growth which is forecast to 2031: • 77% growth in emergency department attendances • 32% growth in non-elective admissions (and therefore discharges) • 42% growth in daycase procedures • 37% growth in elective admissions • 69% growth in outpatient appointments NB these figures do not include any allowance for the effects of Covid. The purpose of the forecasts was to plan the size and capacity of the new hospital, but when they were calculated in 2021 it became clear that the new hospital could not be built to match them if we continued to work in our existing ways: a) the construction itself would be unaffordable b) we could not staff it c) we could not afford to run it The Future System Programme had therefore designed a new clinical and care model, through co-production with staff, patients, members of the public and our system partners. Broadly, the resulting change programme could be summarised as: 8. New ways of working within the acute hospital 9. 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 10. Working across multiple sites 11. A world-leading digital strategy 12. 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 13. A workplace strategy supporting flexible and routine working from home 14. Mobilisation into the new facilities The FSP was aware that: • Each of those topics would be a hefty undertaking on its own • No member of staff would be untouched by the change that we needed to achieve • The change needs to start soon because the demand is already rising, and because it will take several years to make the transformation that we need • 15 months of co-production had surfaced an unavoidable message that strategic change was difficult to achieve at WSFT. Hence, at the board development day, the board considered the changes that the trust would need to make to become better at creating change. At a follow up meeting on 29 April 2022 a set of recommendations were accepted to make a start:  An explicit cultural programme to heal and re-form as Team WSFT after the stress and distress of the last 2 years

	 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. Under recommendation 2, the action agreed was that the co-produced future clinical model would be written up together with the divisions' existing priorities and plans, and the resulting document would be adopted as the trust's clinical strategy. The action belonged to the medical director. The document was to include changes that the corporate departments need to make to enable the clinical strategy and would begin with a common narrative which will be used to communicate the need for change - the business case for the future state. Divisional objectives should then start to include the changes that are relevant to them, and those objectives should be cascaded down to departments, wards, teams, and ultimately, to individual PDPs. The clinical and care strategy presented with this report represents the completion of that task.
2.	**Detailed sections and key issues**
2.1	The clinical and care strategy was developed through the following steps: • The trust-wide requirements of the new clinical model, identified through the FSP demand and capacity model and the co-produced trust-wide strategies for managing down the size of the new hospital, were collated in a set of shared objectives (page 13 in the clinical and care strategy) • The service visions for all clinical and corporate services which had been co-produced as part of the FSP were summarised by the Associate Medical Director (Future System). The way that had been summarised was reviewed and corrected by the FSP co-production leads • The divisional leadership teams, via the clinical directors and the community services leaders, added in all the other clinical and care priorities that they already had in hand or knew were on the horizon for their services. They included existing quality and safety programmes e.g., the maternity safety programmes, ICS priorities e.g., provider collaboration for elective recovery, and national policy requirements

	• The corporate leadership teams, via the Director of Workforce and Communications and the Interim Director of Resources, reviewed the content for the corporate division and added in their other known priorities as well • All parties then had the chance to review how the trust-wide objectives had been applied to their divisions, and to each other's, to make sure everyone was comfortable with the language used and the allocation of responsibility. The clinical directors held an away day on 8th August 2022 to consider the content of the clinical strategy in the round and to define the role of clinical leadership in its delivery. It was subsequently approved by the Strategic Leadership Team at an away day held on 21st November 2022. The agenda for the away day is enclosed in appendix 1. The directors used the away day to share the work that the Board had done on change, which set the clinical and care strategy in context. The afternoon was spent developing knowledge and skills in strategic change and laying out the approach that would be taken to enacting recommendation 3 in section 2.1; that is, bringing together the separate teams which hold improvement and transformation expertise across the organisation into a single combined change hub. That work has also proceeded in the meantime with the creation of the West Suffolk Change Hub.
3.	**Delivery**
	The content of the clinical and care strategy, specifically the ambitions set out within, form the shape of a significant transformation programme for the Trust. However, it is not for the Future System Team to deliver that transformation. Therefore, attention has turned to the shape and focus of a delivery model. In early April 2023, an exercise to map the ambitions set out in the clinical and care strategy commenced. This comprised reviewing the strategy contents against the future system dependency matrix, the trusts internal transformation plan – the "One Plan," and the SNEE Joint Forward Plan. There are 126 individual ambitions identified in the clinical and care strategy. All map directly with the dependency matrix and joint forward plan, but only six map directly with the One Plan. This demonstrates the scale of delivery required. Following this exercise, and in support of strategic objective setting for 23/24 priority areas for service pathway change have been identified. These are as follows: • Frailty – to deliver an integrated frailty model leading to a 10% reduction in falls and frailty related admissions by March 24. • Virtual ward – to deliver 103 virtual beds by March 24. • Early intervention – to increase service provision up to 27/7 by March 24. • Childrens and young people services – undertake a review of service configuration and develop an options appraisal by March 24. • To pilot the delivery of 15 session weeks – piloted in 1 surgical specialty (both electives and outpatients) by March 24. In addition, a sixth priority has been agreed: • To have created and agreed a 3–5-year transformation delivery plan by March 24.

	In the case of virtual ward, frailty, and early intervention this is an extension of work that has already commenced or is planned to start in 23/24. I.e., additional support will allow these projects to go further and faster in 23/24. All five projects have been identified by clinical services as priorities that will deliver for today, in addition to supporting delivery for tomorrow. Delivery of these priorities will be supported by the existing change functions working alongside clinical teams. The interim governance arrangements will mirror those of the change hub – via the change hub programme board to SLT and on to board. **2024 - 2025 and beyond** Considering the depth and breadth of transformation required a mid-term solution is required to establish sufficient resource to plan, deliver and embed change before we move to a new hospital building. There are a number of viable solutions which would deliver transformational change in an integrated and planned way. Options being considered include a director level position responsible for strategic change, development of the existing change hub capacity and focus, and/or expansion of the combined alliance transformation resource. One or all these options may be appropriate. Conversations are ongoing internally and with system partners to develop the range of options and present a preferred recommendation. It is expected that a firm recommendation will be made to the board in September.
4.	**Next steps**
4.1	Work to deliver the 23/24 priorities has commenced. This is being managed alongside the Future System clinical workstream to ensure effective management of project dependencies. Delivery of these priorities will be reported via the Change Hub Programme Board and to the Future System Programme Board for information. Establishment of a dedicated and focused resource to deliver the plan beyond the end of 23/24 is required.
5.	**Conclusion**
5.1	The Clinical and Care Strategy is a comprehensive and progressive vision for future service delivery. It is essential that we move to deliver the ambitions so that we can ensure patient services are maintained to a high quality whilst ensuring the hospital only does what it can do best. The development of the strategy, via co-production, demonstrates what can be achieved when working collaboratively. Now we need to turn the strategy in to action.
6.	**Recommendations**
	The board are asked to approve the following: • The clinical and care strategy • The 23/24 priority areas for service and pathway change. The board are also asked to consider the delivery model for future transformation.

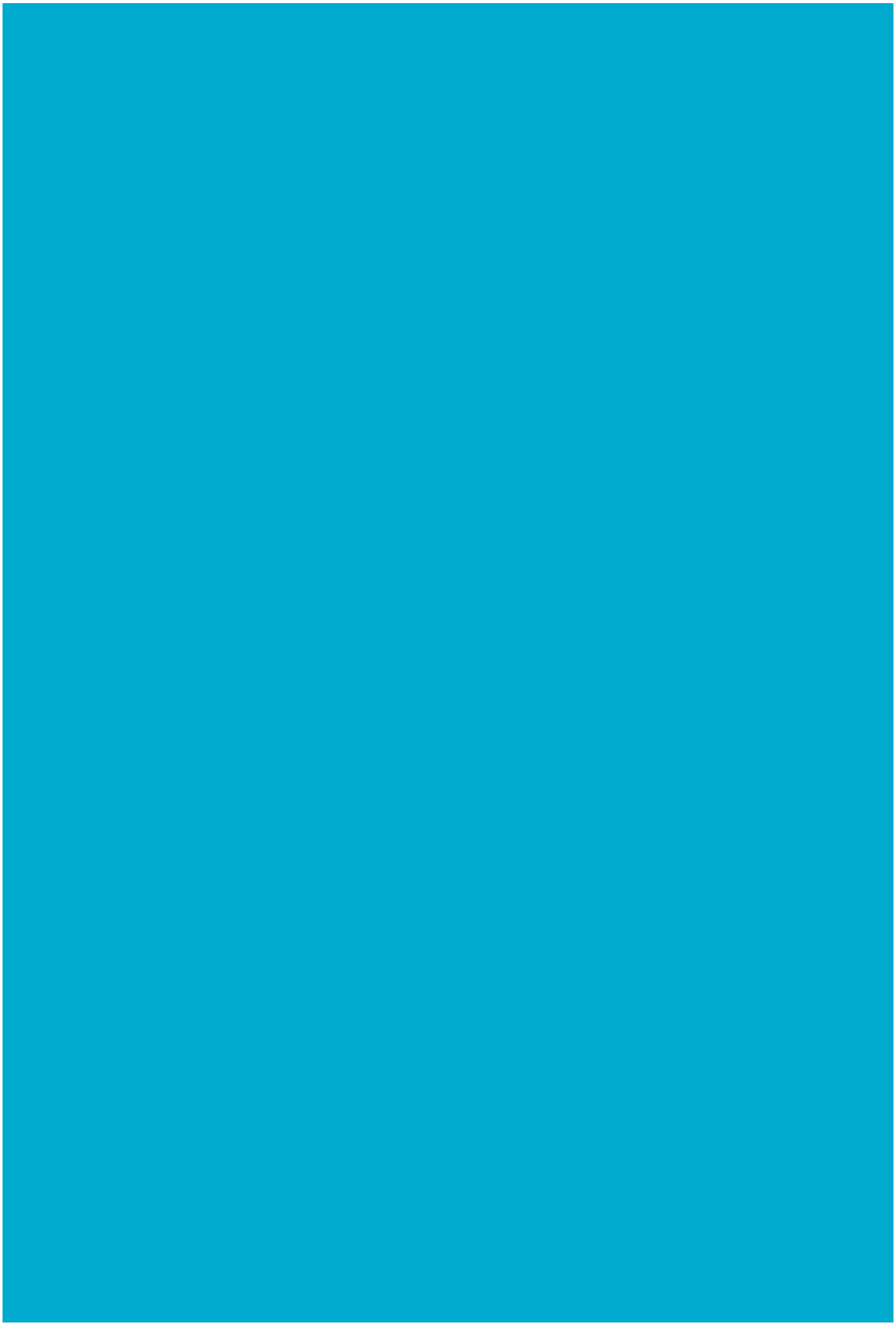
West Suffolk
NHS Foundation Trust

Clinical and Care Strategy

West Suffolk NHS Foundation Trust

2023 - 2031

Putting you first



Contents

Introduction

The West Suffolk NHS Foundation Trust (WSFT) provides hospital and community services to a largely rural geographical area with a population approaching 280,000 people.

The catchment area extends beyond Thetford in the north and Sudbury in the south, to Newmarket to the west and Stowmarket to the east. It serves the population of the west of Suffolk and parts of the neighbouring counties of Essex, Cambridgeshire and Norfolk.

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

This strategy aligns with the Trust's overall direction as illustrated by the diagram below and is powered by our Trust values of fairness, inclusivity, respect, safety and teamwork (FIRST).

Ambition: First for patients

For clinical practice and care delivery, the first for patients ambition sets out the following aims:

Collaborate to provide seamless care at the right time and in the right place

- We will strive to provide a seamless experience, with good communication from beginning to end
- We will treat everyone with dignity and respect, and as quickly as possible
- We will continue to adapt to the presence of COVID so we can provide services without putting anyone at unnecessary risk of infection
- We will join up more care with our neighbouring organisations, following the West Suffolk Alliance strategy
- We will provide more care in people's own homes and in their local areas.

This clinical and care strategy describes how we will achieve this aim between now and 2031.

Use feedback, learning, research and innovation to improve our care and outcomes

- We will ensure patients and families can share their experiences, positive and negative, to help us improve through our experience of care strategy
- We will give everyone the tools and support they need to put quality and safety first, by:
    - making sure everyone has the confidence to raise concerns and to make changes when things go wrong

    - applying our safety and learning strategy to drive forward continuous improvement
    - training more staff in quality improvement methods, human factors and ergonomics
    - sharing learning internally and looking outwards to learn from others
    - taking care with how we use our money, staff, equipment and buildings, so we can continue to afford to invest in better care.
- We will keep the good things that have come out of the Covid-19 pandemic, like the keeping in touch service
- We will do more clinical and non-clinical research, involving patients and members of the public
- We will support and celebrate new ideas and innovations in all parts of the Trust and across all teams.

This aim will be delivered through the associated strategies which can be read here:

- Experience of care strategy
- Patient safety strategy
- Research strategy.

Future needs

The need for a new hospital has given us insight into the future of healthcare that we haven't had before.

The Trust is one of 40 trusts around the country to benefit from the Department of Health and Social Care's New Hospital Programme. West Suffolk Hospital is coming to the end of its life and needs to be vacated by 2030.

To plan its replacement, we have undertaken an unprecedented activity: forecast the growth in demand for hospital care over the next ten years and co-produced a future clinical and care model to meet those predictions.

The future demand has been modelled as if Covid-19 never happened, to provide us with solid baseline numbers while the full impact of the pandemic continues to emerge.

Our local population

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

56/1,000 females give birth per year

96% of people speak English, **4%** speak another language

Life expectancy is **eight years** lower in most deprived areas

89.1% of people are white, **10.9%** are from other ethnic minority groups

16% of people live in deprived areas, 11% of children live in low-income families

Risk factors

32% of children and
61% of adults are
overweight or obese

18% of adults feel lonely

16% of adults smoke

29% of adults are
physically inactive

People's experience of their health

17% of people do not enjoy good health

16.5% of people's day to day activities limited by their health

Digital access

99% of people have access to broadband at speeds more than 10Mbit/s. Access to full fibre has risen rapidly from 3% in September 2019 to 38% in May 2022.

Disease prevalence

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

- 1 in 8 depression
- 1 in 82 heart failure
- 1 in 113 dementia
- 1 in 50 stroke or TIA*
- 1 in 126 severe mental illness
- 1 in 200 learning disability
- 1 in 12 diabetes
- 1 in 13 asthma
- 1 in 23 cancer
- 1 in 44 COPD*

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

* our acronym section can be found at the back of the document.

Our staff

Our staff live in and around the local area. They and their families make up about 8% of the population we serve together. In some ways they are highly representative, in other ways they are different.

4 out of 5

of our staff members

are female

15% are from an

ethnic minority group

3.8% describe

themselves as disabled

Hospital activity forecasts for 2031

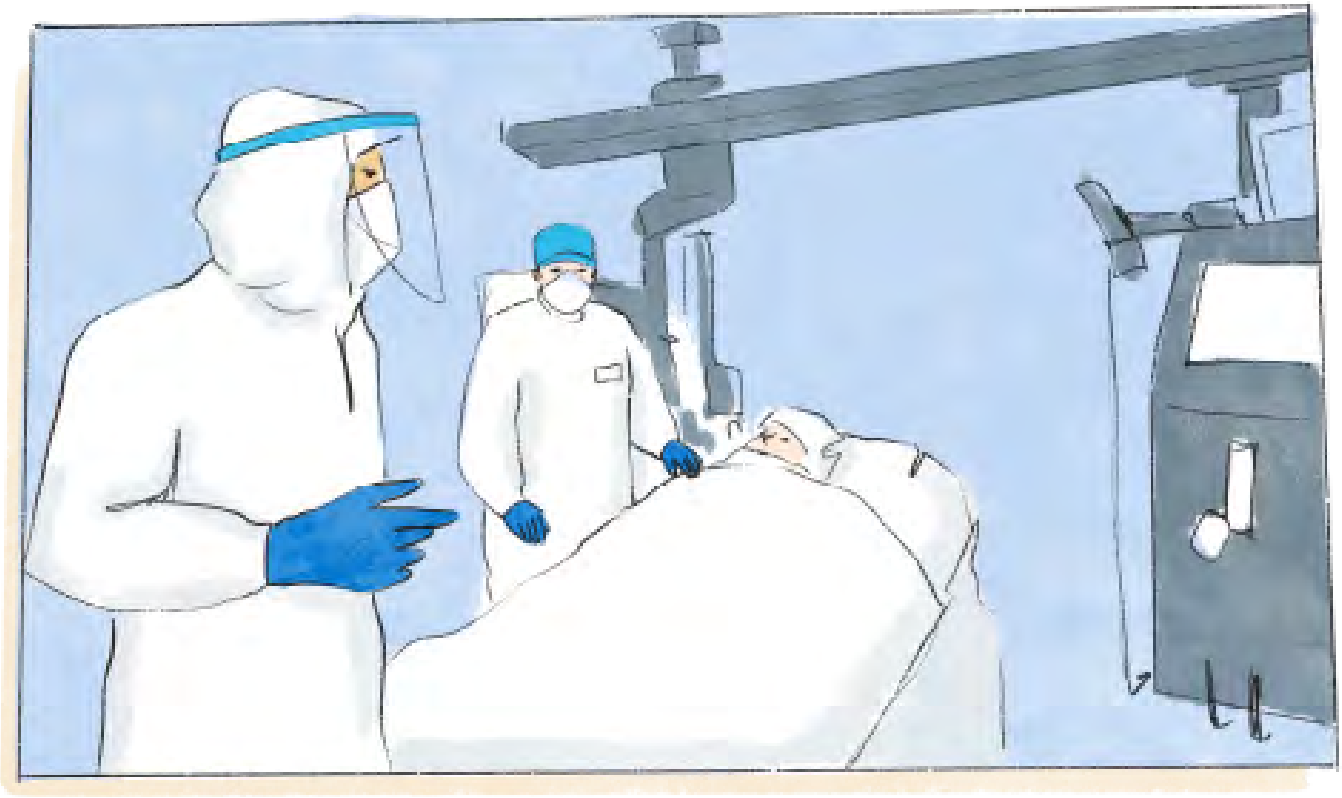
Activity	2021	2031	% increase
ED attendances	79,939	141,641	77%
Non-elective inpatient	20,968	27,688	32%
Non-elective no stay	11,097	15,435	39%
Elective inpatient	3581	4915	37%
Daycase	28,571	40,660	42%
Maternity			
Births	2278	2600	14%
Children			
Daycase	730	912	25%
Elective inpatient	173	221	28%
Non-elective inpatient	1146	1229	7%
Non-elective no stay	3354	4203	25%
Outpatients			
Total activity	390,776	660,092	69%

Costs

- Emergency department attendance = £161
- Overnight stay = £436
- Hospital bed = £143,000 per year
- Cost of building 1m2 of space in the new hospital = £8,569.

Meeting this growth by continuing to deliver services in the way we are today simply isn't an option.

Sources agree that if nothing changes, the number of hospital beds required in west Suffolk will rise by 80 every five years. If we allowed that future to unfold, we wouldn't be able to build a hospital big enough. We couldn't afford to build it; we wouldn't be able to staff it and we couldn't afford to run it. It would also be morally unacceptable to allow that much morbidity to arise when there are things that we can collectively do about it. This situation isn't unique to west Suffolk; it is the driving purpose for the national move towards integrated care which has been happening since 2016.



New model of care

We have designed a new model of care fit for the future that starts to address the predicted growth in a sustainable way. This new model of care has been co-produced with staff, patients, members of public and our partner organisations.

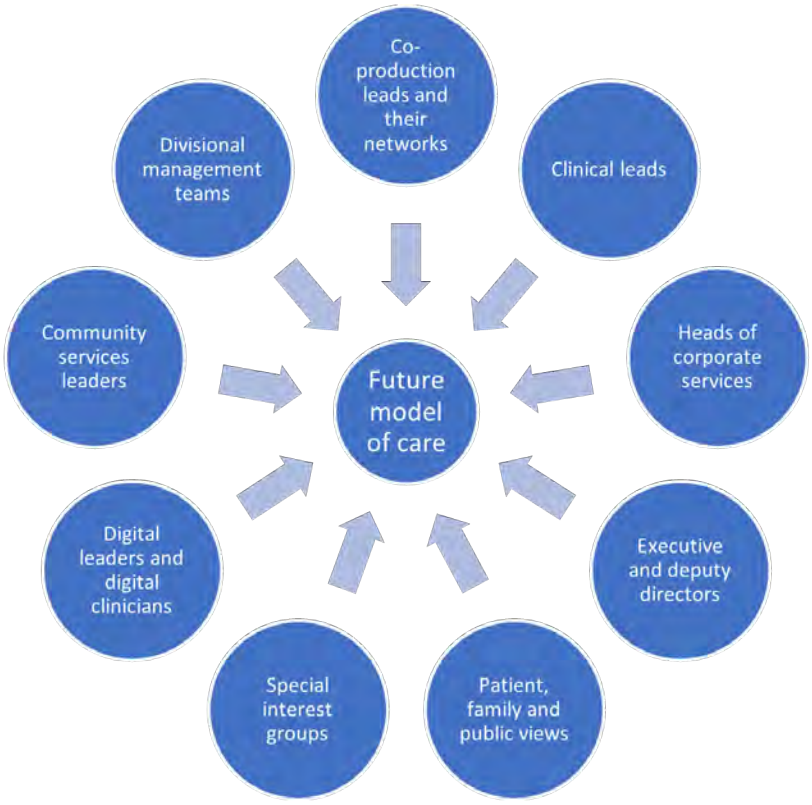
Co-production is a method for designing, evaluating, and improving health and social care services in which people, professionals and decision makers work together as equal partners. With the help of Healthwatch Suffolk, co-production techniques have been used to design a model of care which strikes the right balance between ambition, achievability, and affordability. Co-production is a continuous process, so the work is by no means done and there is a lot still to learn; but as a method it allows the benefits to be balanced between parties when there are no easy answers.

A very wide range of people have taken part in the co-production. This is the first time we have undertaken an exercise of this scale.

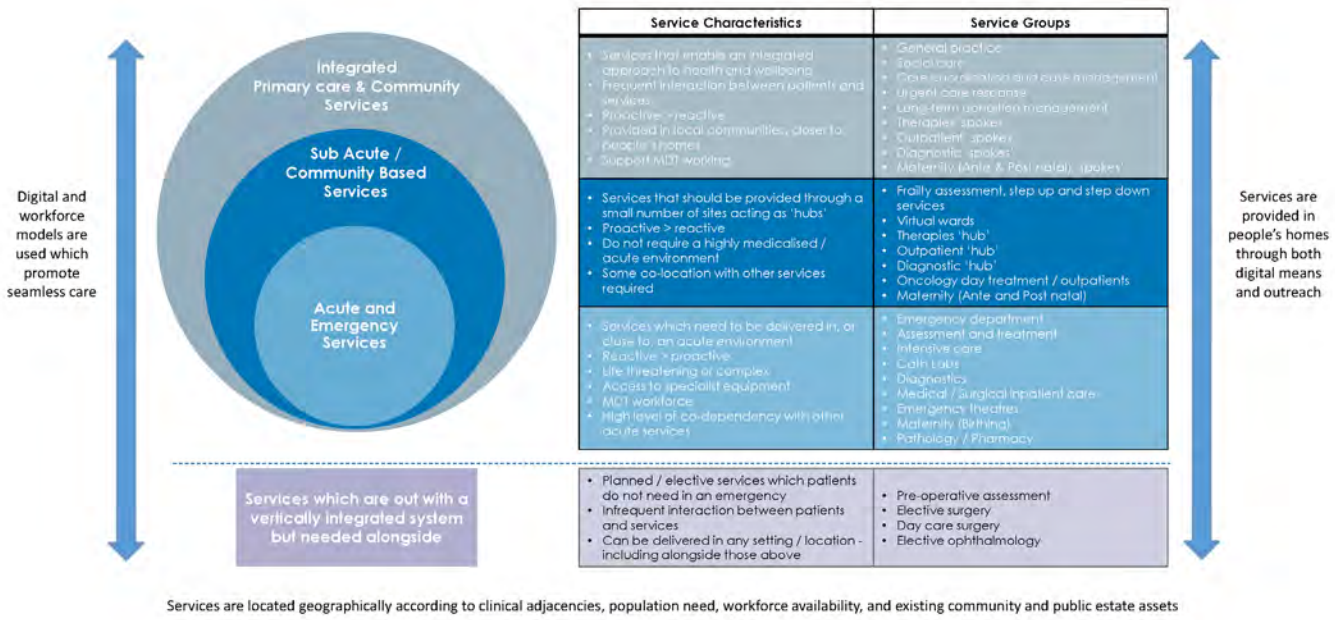
The starting point for the future model is integration with our local partners as part of the West Suffolk Alliance. This is a path we are already on. By joining up services and sharing resources with primary care, social care, mental health, council services, community organisations and the voluntary sector, we believe we can provide people with most of the care they need within their local communities.

When people do need specialist care, it will be provided by high quality and efficient acute and subacute services. We already have a number of partnerships in place with other NHS trusts to help us do this well. We will continue to expand our collaboration across the Suffolk and North East Essex Integrated Care System (SNEE ICS), and beyond, wherever it is in the interests of our population.

These principles, and the implications they have for how our services and joint working will evolve, are summarised in the graphic below. Based on these principles, a vision for the future has been co-produced for each individual service.



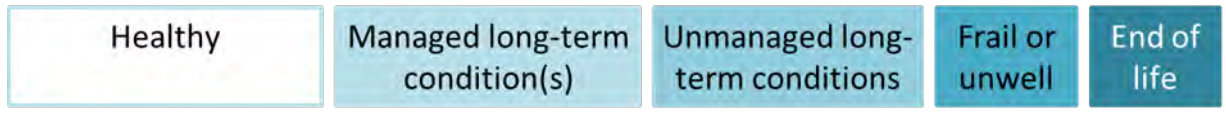
The principles of our future model of care



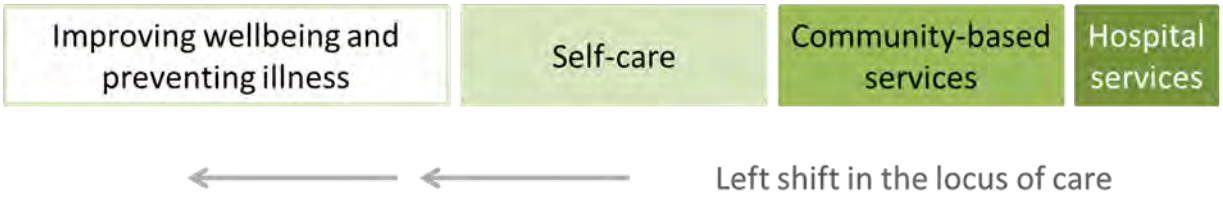
What we are trying to achieve can be described as a "left shift":

- moving the locus of health and wellbeing further towards health and away from illness
- and, to match it, moving the locus of care – and therefore the resources needed to provide it – closer to the people we are trying to serve.

The left shift



Acknowledgement: NHS Leeds CCG Left Shift Blueprint



Acknowledgement: Calderdale and Kirklees 999 Call for the NHS

Clinical and care objectives

The clinical and care objectives are segmented into the specific Trust divisions in which they sit. They are expected to be achieved by 2031.

The vision for the future has been combined with our known short- and medium-term goals to produce two sets of objectives:

- objectives that are trust-wide, where responsibility will be shared between several divisions and with system partners
- objectives that are for the individual divisions and departments.

For the clinical divisions, the objectives provide a comprehensive account of all the strategic change that is planned between now and 2031. For the corporate divisions, the objectives are limited to the strategic changes that the clinical objectives are dependent on. Corporate services also have much wider responsibilities which are described in full in different strategies, so they are not reproduced exhaustively in this document.

The duration of this strategy is from now until 2031 because that is the time horizon for the long-term forecasts. Long-term planning is unusual in the NHS, and it comes with a high degree of uncertainty:

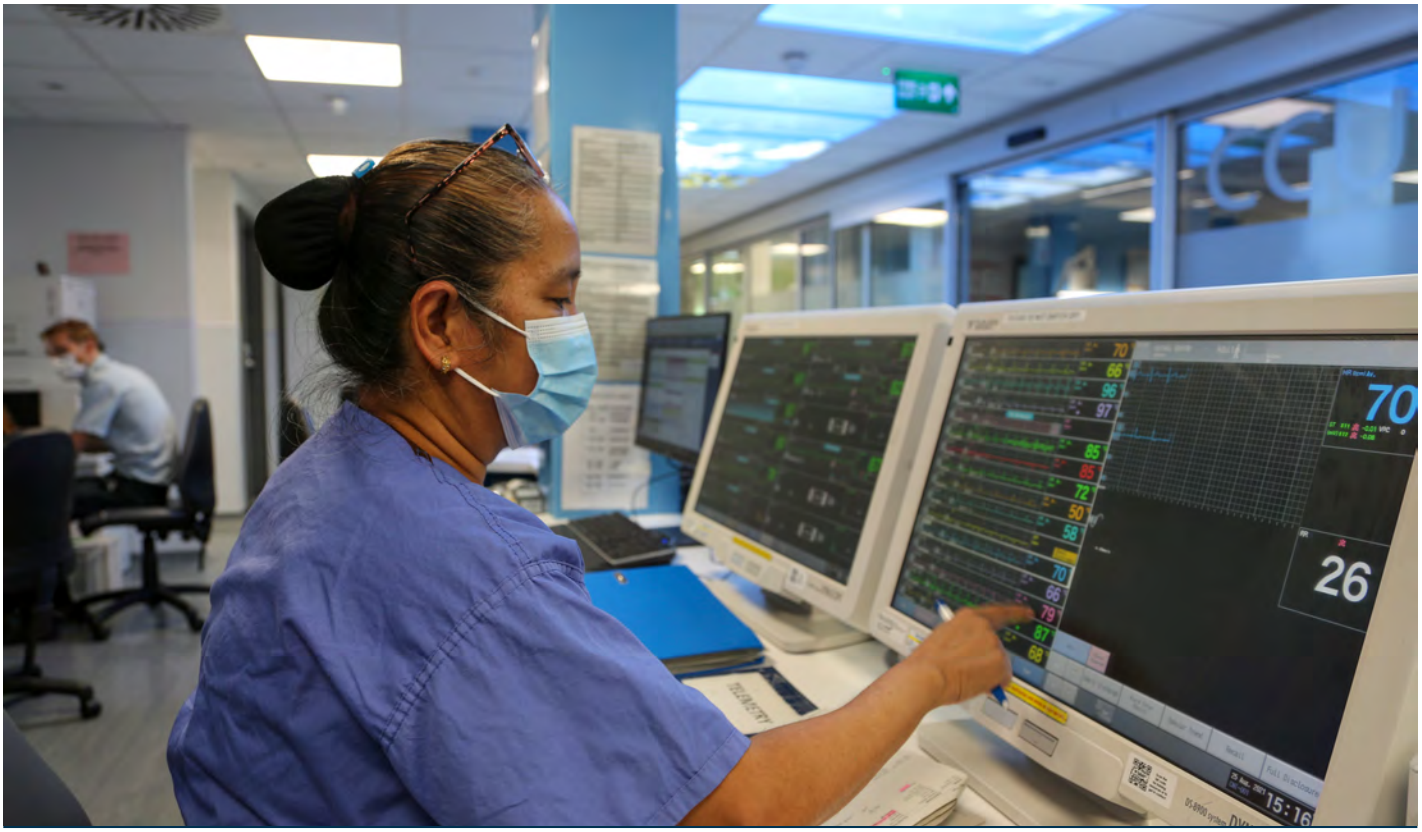
- The forecasts are modelled from a baseline of 2019, and they will inevitably evolve over time
- New directions will also emerge, for example from ICS-wide demand and capacity modelling, national or regional requirements, or unexpected events.

We will acknowledge the uncertainty and treat this strategy as a dynamic document, describing a dynamic plan, which we will adapt and refine proactively over time.

Taking a long-term view allows us to prioritise the things that we know will best help us achieve what we need to for our local population.

These are objectives which can only be achieved through joint effort between several divisions. The responsibility for delivering these objectives will be shared. The objectives which will also rely on collaboration with our system partners are indicated with a green (S).

Collaborate to provide seamless care at the right time and in the right place	Community & Integrated Services	Medicine & Specialist Medicine	Surgery & Anaesthetics	Maternity, Gynaecology & Paediatrics	Clinical Support Services	Corporate Services
Prevention incorporated into all clinical and care pathways (S)	✓	✓	✓	✓	✓	✓
Outpatients: 25% appointments are conducted by telephone or video 25% appointments are conducted in peripheral clinics	✓	✓	✓	✓	✓	✓
Best practice on same day emergency care		✓	✓	✓	✓	✓
Best practice on virtual wards (both capacity and quality) (S)	✓	✓	✓	✓	✓	✓
All inpatients are nursed in single rooms in multipurpose inpatient accommodation		✓	✓			✓
All care for children and adolescents is provided in age-friendly environments, including a 16-24 years inpatient unit	✓	✓	✓	✓	✓	✓
All elective inpatient and outpatient services are fully operational 15 sessions a week	✓	✓	✓	✓	✓	✓
Introduction of elective surgical hub and increase and expand the community hubs (S)	✓	✓	✓	✓	✓	✓
Average length of inpatient admissions reduces year-on-year (S)	✓	✓	✓	✓	✓	✓
Discharge-to-assess pathways for all patients over 65, delivered through a community-based Transfer of Care Hub (S)	✓	✓	✓	✓		✓
70% people who die in west Suffolk, die at home or in a community setting (compared to 62% in 2021) (S)	✓	✓	✓	✓	✓	✓
Adoption of 2021-26 digital strategy and its successors (S)	✓	✓	✓	✓	✓	✓
Healthcare workforce and patient care delivery integrated between acute and community services on multiple pathways	✓	✓	✓	✓	✓	✓
Full adoption of workplace strategy, with the flexibility for routine agile working, including for clinical duties that can be done remotely	✓	✓	✓	✓	✓	✓
Safe and smooth transition into new facilities and adaptation to working across multiple sites	✓	✓	✓	✓	✓	✓



Community and integrated services

Our future programmes

Children and young people's services:

As a partner to the Suffolk Children and Young People Strategic Framework:

- Improve health and reduce inequalities in health and wellbeing
- Improve children and young people's mental health and emotional wellbeing
- Enable all children, including those with special educational needs and disability (SEND), to achieve well and live active, healthy and fulfilling lives as part of their community
- Provide timely support for neurodiverse children and young people, with a strengthened self-help, parenting support, peer networks and community offer
- Provide integrated health and care support and services for children and young people with complex health needs, which are easy to navigate and which improve outcomes.

Integrated neighbourhood teams:

- All teams are based in community hubs within their localities
- Maximum integration of health and social care services
- A strengths-based approach to locality development to support the health and wellbeing of local populations, using sustainable resources and data-led interventions
- Integrated neighbourhood teams undertake the full remit of responsive and proactive care to reduce unnecessary admission and promote population health
- Linking with the Alliance and ICS workforce strategies, develop and provide a safe, effective and efficient workforce; finding solutions for recruitment challenges and career progression.

Therapies:

- One integrated service across all places of care
- Combined proactive and reactive service as part of the Alliance model
- Therapies teams are based in community hubs as part of the integrated neighbourhood teams.

Early intervention team:

- 7-day, 24-hour service
- Acute therapies care provided by staff as members of integrated inpatient teams.

Support to go home service:

- 7-day, 7am to 10pm service, aligned with adult social care services.

Pain service:

- More multidisciplinary working and more integration with Alliance partners
- Collaboration with Norfolk and Suffolk NHS Foundation Trust to enable more self-management.

SNEE ICS and regional programmes

Urgent care response:

- Health and social care integration: joining up care for people, places and populations
- Fitter for surgery initiatives with the surgery and anaesthetics division
- ICS programme for community based neurological rehabilitation for stroke.

Surgery and anaesthetics

Our future programmes

Division-wide:

- Best practice rates for both day surgery and short stay surgery
- Day of surgery admission for inpatient elective care
- Achieve theatre utilisation rates of
  - 15 sessions per week
  - 3.5 hours per session
  - 85% in-session utilisation
  - 95% of scheduled sessions used.
- One-stop pathways wherever possible, e.g. for suspected prostate and colorectal cancer.

Urology and vascular surgery:

- Create a core urology centre of excellence.

General surgery, colorectal, upper gastrointestinal and breast surgery:

- Innovative best practice approaches including robotic surgery, combined onco-plastic breast procedures and capsule endoscopy, resulting in improved patient outcomes, less physical impact on surgeons and reduced length of stay.

Orthopaedics:

- 7-day trauma service
- Ring-fenced elective bed-base to support timely discharge and appropriate management.

Ear, nose and throat surgery (ENT), audiology and plastic surgery:

- More outpatient ENT interventions, more integration with community providers and more multidisciplinary working e.g. with speech and language therapy and physiotherapy
- Shared plastic surgery provision with system partners.

Ophthalmology:

- More integration with community providers, clinics in the community and virtual services.

Anaesthetics, theatres and critical care:

- A sustainable and sustainably resourced anaesthetic and critical care workforce in order to meet the demands on their services.

Quality and safety programmes

- GIRFT High Volume Low Complexity programme
- National Emergency Laparotomy Audit outcomes
- National Hip Fracture Database outcomes
- National Joint Registry
- Anaesthesia Clinical Service Accreditation.

SNEE ICS and regional programmes

- Elective recovery including through collaboration with neighbouring trusts, delivering 130% of baseline elective activity by 2024/25
- Developing new pathways in line with the SNEE ICS cancer strategy, across several divisions.

Maternity, gynaecology and paediatric services

Our future programmes

Maternity services:

- The service user being central to ongoing service improvement
- Working in a supportive learning environment where there is a culture of safety
- Provide continuity of carer for 75% of pregnant people who are from ethnic minority groups and deprived areas
- Deliver integrated specialist care
- Provide high dependency care for complex pregnancies on the labour ward
- Best practice in transitional care to reduce separation of parents and newborns
- A separate obstetric theatre suite.

Gynaecology services:

- Increase the provision of ambulatory care
- Increase the provision of community gynaecology services
- Increase the provision of specialist nurse-led services in gynaecology
- Gynaecology assessment unit providing care 24hrs a day, 7 days a week
- Separate maternity and gynaecology outpatient facilities.

Paediatrics:

- Provide more integrated, multi-disciplinary and multiagency models of care including integrated pathways with community paediatric services and more one-stop clinics
- Children's assessment unit co-located with the paediatric emergency department
- A paediatric day case unit:
  - Increasing the provision of ambulatory care
  - Same day treatments repatriated from Cambridge University Hospitals.

Neonatology:

- More integrated, multidisciplinary and multiagency working and direct referral pathways
- Best practice in transitional care.

Quality and safety programmes

Implementation of recommendations from:

- Ockenden Final Report
- Morecombe Bay Report
- Sixty Supportive Steps to Safety
- Maternity Safety Self-Assessment
- East Kent Report
- Saving Babies Lives

Participation in the Maternity and Neonatal Safety Improvement Programme to:

- Reduce maternal and neonatal deaths, stillbirths and brain injuries that occur soon or after birth by 50% by 2025
- Reduce the rate of preterm births from 8% to 6%.

Clinical support services

Our future programmes

Radiology:

- More imaging in community locations, both existing facilities and in a new community diagnostic centre
- Introduction of a radiology day unit
- Separate inpatient and outpatient workflows
- 24hr service for inpatient and emergency diagnostics
- Core hours of Monday to Friday, 8am-8pm and Saturday to Sunday, 9am-5pm for routine services
- Repatriation of cardiac CT scan from Royal Papworth Hospital.

Pathology:

- More point of care testing in acute and community settings
- More satellite services
- Outpatient, community- and home-based phlebotomy – no one will come to the hospital just to have their blood taken.

Pharmacy:

- Fully integrated across acute, outpatient and community services
- More joint working with community pharmacies
- Inpatient service to 10pm.

Outpatients:

- Greater emphasis on self-care, digitally enabled care and one-stop services.

Endoscopy:

- Ambulatory pathways
- Adopt split-site working to separate high risk and low risk pathways, with both sites JAG-accredited
- Achieve utilisation rates of:
    - 15 sessions per week (Monday -Friday, 8am to 8pm +/- weekend services)
    - 4 hours per session
    - 85% in-session utilisation
    - 95% of scheduled sessions used.

Quality and safety programmes

- United Kingdom Accreditation Service - accreditation for all laboratories: histopathology, microbiology, transfusion and haematology
- Joint Accreditation Group - accreditation for endoscopy.

SNEE ICS and regional programmes

- Reconfiguration and centralisation of some services across ICS (possible).

Mortuary:

- Become the public mortuary for Suffolk (possible).

Medicine and specialist medicine

Our future programmes

Emergency department and emergency assessment unit:

- 'Emergency village' front door model
- Co-located urgent care centre and emergency psychiatry
- 23-hour adult assessment unit
- Children's assessment unit co-located with the paediatric emergency department.

Cardiology:

- 24-hr service for emergency and urgent imaging
- Integrated pathways with primary care and more integration with tertiary centres
- Achieve utilisation rates in the catheter laboratory of:
  - 15 sessions per week
  - 3.5 hours per session
  - 85% in-session utilisation
  - 95% of scheduled sessions used.

Renal medicine:

- Inpatient dialysis provided on a general ward, instead of in the intensive therapy unit
- Nurse-led outpatient dialysis service
- Dialysis access procedures repatriated from Cambridge University Hospitals
- 20% dialysis provided at home.

Oncology:

- More mobile cancer care, integration with community services and care delivered at home
- More shared care with tertiary centres to increase the tumour sites treated.

Haematology:

- Clinical haematology will provide a level **2b service**.

Medical treatment unit:

- More medical day treatment with minimum opening hours of 7am – 7pm, Monday to Friday.

Geriatric medicine:

- Integrated model of care with seamless working with community partners and care homes, complemented by an acute frailty service for those who do require hospital assessment
- Joint inpatient service with Norfolk and Suffolk NHS Foundation Trust for people affected by dementia.

Palliative care:

- Expanded inpatient service to provide better equity of access to good care at the end of life.

Respiratory medicine:

- Comprehensive community-focussed model of care and an expansion of the range of services offered.

Rheumatology:

- Service developments across several conditions, including temporal artery ultrasound and electromyography
- More multidisciplinary working.

Stroke medicine:

- 7-day working across the stroke pathway including the emergency stroke outreach team available 24/7
- Best practice access to imaging and treatment modalities.

Lung function testing:

- More community and home-based delivery
- Development of a physiologist-led sleep service.

Neurology:

- Service developments for several conditions, including the headache service and the service for people with learning disabilities and epilepsy.

Dermatology:

- Build on existing successes with digitally enabled care and secure the specialist workforce required to achieve a sustainable service.

Quality and safety programmes

- Incorporation of the 'Getting It Right First Time' (GIRFT) recommendations in the following specialties:
  - Acute medicine
  - Elderly care
  - Gastroenterology
  - Stroke.
- Telemetry monitoring and response programme
- Upgrade and training on non-invasive ventilation including remote monitoring
- Stroke – SSNAP (Sentinel Stroke National Audit) quality improvement programme.

SNEE ICS and regional programmes

- Maintain joint working with tertiary centres and continue to develop new links and partnerships
- ICS collaborations including:
  - Shared referral and access pathways (renal, diabetes, cardiology)
  - Community management of atrial fibrillation
- Renal service transformation programme to create regional realignment of services
- Stroke thrombectomy service delivery at regional level.

National planning guidance

- COVID medicines delivery unit (CMDU) service specification
- Emergency department performance.

What is a 2b service?

A level 2b service is one which provides treatments that cause prolonged neutropenia, which normally require the patient to be admitted and may be given on weekends as well as on weekdays (people who need this level of treatment have to go to a different hospital at the moment).

Corporate services

Our future programmes

Estates and facilities:

- Several initiatives to improve stock management e.g., just-in-time methodology and utilising local small and medium enterprises in the supply-chain
- Greater focus on waste-management streams
- Improve patient choice for catering, minimise waste
- Ensure a single decontamination service for the Trust
- Progress to digital estate management to make the environment and services more patient and staff focused, reduce waste and enhance performance.

Digital and information services:

- 'Digital first but not digital only' ethos to prevent digital exclusion
- Five digital priorities for enabling clinical care:
    - Supporting work across multiple sites seamlessly to support maximum productivity (including working from home)
    - Supporting patients to remain in their own home
    - Supporting a reduction in the need for waiting/dwelling across the hospital estate
    - Supporting a reduction in the length of stay
    - Supporting a reduction in outpatient space requirements.
- Extensive hardware and software developments e.g., **Smart Hospital**
- Making it the norm for patients to have access to and own their data to enable them to participate in their care
- A focus upon improving the user experience for all our staff (clinical and non-clinical) to make all digital systems simple, efficient, intuitive and a pleasure to use
- Embedding the use and dissemination of data, in an intelligible and accessible format, in all aspects of decision-making within the organisation and the wider system.

Workforce:

- Looking after our people – with quality health and wellbeing support for everyone
- Belonging at WSFT and in the NHS – with a particular focus on tackling the discrimination that some staff face
- New ways of working and delivering care – making effective use of the full range of peoples' skills and experience
- Growing for the future – how we recruit and keep our people, and welcome back colleagues who want to return.

Several departments working together:

- Agile working policies, practices and technologies.

Education:

- Seamless training offer across community, acute and virtual settings, both planned and on-demand
- More simulation training and simulation environments

- More joint working with health and social care partners.

Research:

- More research capacity in order to increase impact through a more varied research portfolio
- More collaboration with partners from other sectors e.g., local government, police
- Maintain existing academic relationships and increase our partnerships with local universities.

Health records:

- Facilitate the achievement of a paper-free/ paper-less environment.

Spiritual care:

- Meet the spiritual care needs of people of all faiths and none throughout our services.

Finance:

- Greater empowerment of services in their own financial management
- Enhanced business planning.

Improvement disciplines:

- Integrated change management model and resources.

Communications:

- Comprehensive digital and non-digital communication methods for service users and staff.

Quality and safety programmes

Estates and facilities:

- Reducing compliance-related risks on the retained estate and maintaining the reinforced autoclaved aerated concrete (RAAC) estate infrastructure to support patient care and experience until no longer required
- Supporting nutritional needs for both inpatients and discharged patients
- Connecting medical devices to patient records to both enrich data for decision-making and identify risk and safety challenges.

Workforce and communications:

- FIRST values and behaviours
- Workforce, leadership and organisational development strategy
- 'What matters to you' staff listening and action
- Workforce resourcing and redesign
- Future of human resources and organisational development programme, including digital development.

SNEE ICS and regional programmes

- Support an ICS-wide estates and facilities plan which demonstrates capital investments across SNEE or all providers, opportunities for One Public Estate schemes and collaboration and a focus on primary care.

What is a smart hospital?

A smart hospital is designed to link the physical and digital environments, including the clinical and facilities management systems, so we can make the building as efficient and well managed as possible. This should provide a seamless visit for service users and a better supported work environment for staff.

How will we know that we are getting there?

The senior responsible officer for the delivery of this clinical and care strategy is the medical director.

The vast quantity of change that this strategy represents cannot be underestimated. Strategic change is not easy to achieve in the NHS; changes for tomorrow are difficult to prioritise when the pressures of today are unrelenting. We know, though, that at WSFT we want to achieve change – our vision for the future has been co-produced together. There is also no plan B. The Trust Board has resolved to create the conditions that will help make achieving change easier.

As laid out by the Trust strategy 2021-2026, we have lots of tools and support available to help with implementation: improvement and transformation methods, specialist expertise, human factors and ergonomics, business planning, patient feedback, learning from within and elsewhere, innovation and research.

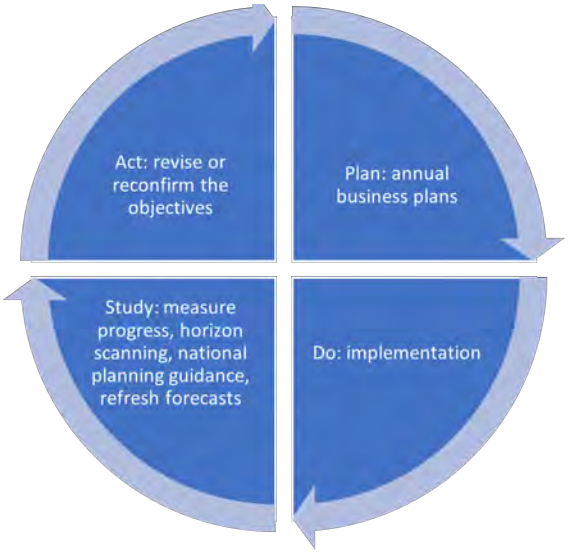
Progress against the clinical and care strategy will be governed through our existing structures for management accountability, under the responsibility of the clinical directors and the divisional management teams.

The emphasis in this clinical and care strategy is on the places and ways in which we provide care rather than on the clinical outcomes which we generate or the population health indicators which we improve. That simply reflects the process-focussed nature of healthcare delivery today. Over time, we will evolve the emphasis towards an outcomes-based approach, in line with the principles of integrated care.

Given the scale of the challenge we face, it could also be said that the strategy is not radical enough. Careful and continuous measurement of appropriate metrics for each objective will allow the departments and divisions to monitor progress individually and together and to escalate problems and barriers for unblocking. The strategy will be refreshed on an annual basis to reflect the progress that has been made and to bring it up to date with our evolving understanding of the internal and external drivers.

Service to Board governance route

A continuous improvement approach to the clinical and care strategy



Finally, the clinical and care strategy will set the brief for other strategies, and their achievability will form part of the feedback loop too. For example:

- the estates strategy will secure and maintain the premises and facilities needed to deliver the clinical model
- the digital strategy will provide the digital infrastructure, software and training needed
- the workforce strategy will describe the roles, training and expertise required, along with plans for recruitment and retention
- the financial strategy will determine the capital and revenue requirements, and hence the affordability.

In the first refresh of this strategy, which will happen at the end of the financial year 2023/24, we will be able to incorporate the findings from each of those enabling strategies.

Additional information

Sources and data

This strategy has been created using mulitple data sources. To view this information please click here or visit the 'Our quality' section of the West Suffolk NHS Foundation Trust website.

Acronyms

COPD - Chronic Obstructive Pulmonary Disease

ENT - Ear, nose and throat

RAAC - Reinforced autoclaved aerated concrete

SNEE - Suffolk and North East Essex

SNNAP - Sentinel Stroke National Audit Programme

TIA - Transient ischaemic attack

WSFT - West Suffolk NHS Foundation Trust

Notes

Notes

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Hardwick Lane
Bury St Edmunds
Suffolk
IP33 2QZ

West Suffolk
NHS Foundation Trust

2.4. West Suffolk Alliance and SNEE Integrated Care Board

To Assure

Presented by Peter Wightman

West Suffolk Alliance Update 17 July 2023 - Peter Wightman, West Suffolk Alliance Director

Headlines from Committee Meeting held 11 July 2023

1. **Primary Care Update**

   Commissioners are working with practices to implement the national GP recovery plan which has the purpose to "tackle the 8 am rush". This includes support for change within practices including enabling minimum standards of cloud-based telephony. Digital tools are at the centre of this work and the committee noted the importance of a consistency across general practices to enable connectivity with the wider system. This programme also includes NHS Trusts working with primary care to reduce bureaucracy at the primary & secondary care interface.

2. **Performance report**

   The Committee received a report on key delegated indicators. The committee identified the need for more up to date and complete information on diabetes performance in West Suffolk and this is scheduled for the next meeting.

3. **Better Care Fund (BCF) 2023/24 and Aging Well Resources**

   Received and endorsed a report on planned use of BCF resources for West Suffolk. Group noted reporting to commence in August. Approved use of Ageing Well resources and noted there is no confirmation nationally that funds will continue beyond March 2024.

4. **Social Prescribing**

   Received a report on review work to date on commissioning social prescribing in west Suffolk which has 3 elements: PCN provided service, hospital based service and intermediate community service. Noted funding for intermediate service to continue to March 2024 and a business case will be provided to the committee in the autumn regarding arrangements thereafter. Group noted importance of connecting people to services that provide wider support; variation between PCNs; importance of data on evaluation; we should enable people to connect directly.

5. **Dementia**

   Report received from Suffolk Healthwatch engagement work with people suffering from dementia and their carers (summary appendix 1). The report identifies serious concerns regarding people's lived experience and in particular the lack of joined up approach between agencies and difficulty for people and their carers navigating the local system. The Committee has previously approved a business case to increase capacity for memory assessment in West Suffolk which is critical to increase dementia diagnosis rates from current levels which are below national average and target. Agreements of funds is in the final stage of negotiation with NSFT and ICB.

   The Committee received a briefing on work starting to develop a Suffolk dementia strategy and gave its feedback and commitment to contribute to the development of the strategy.

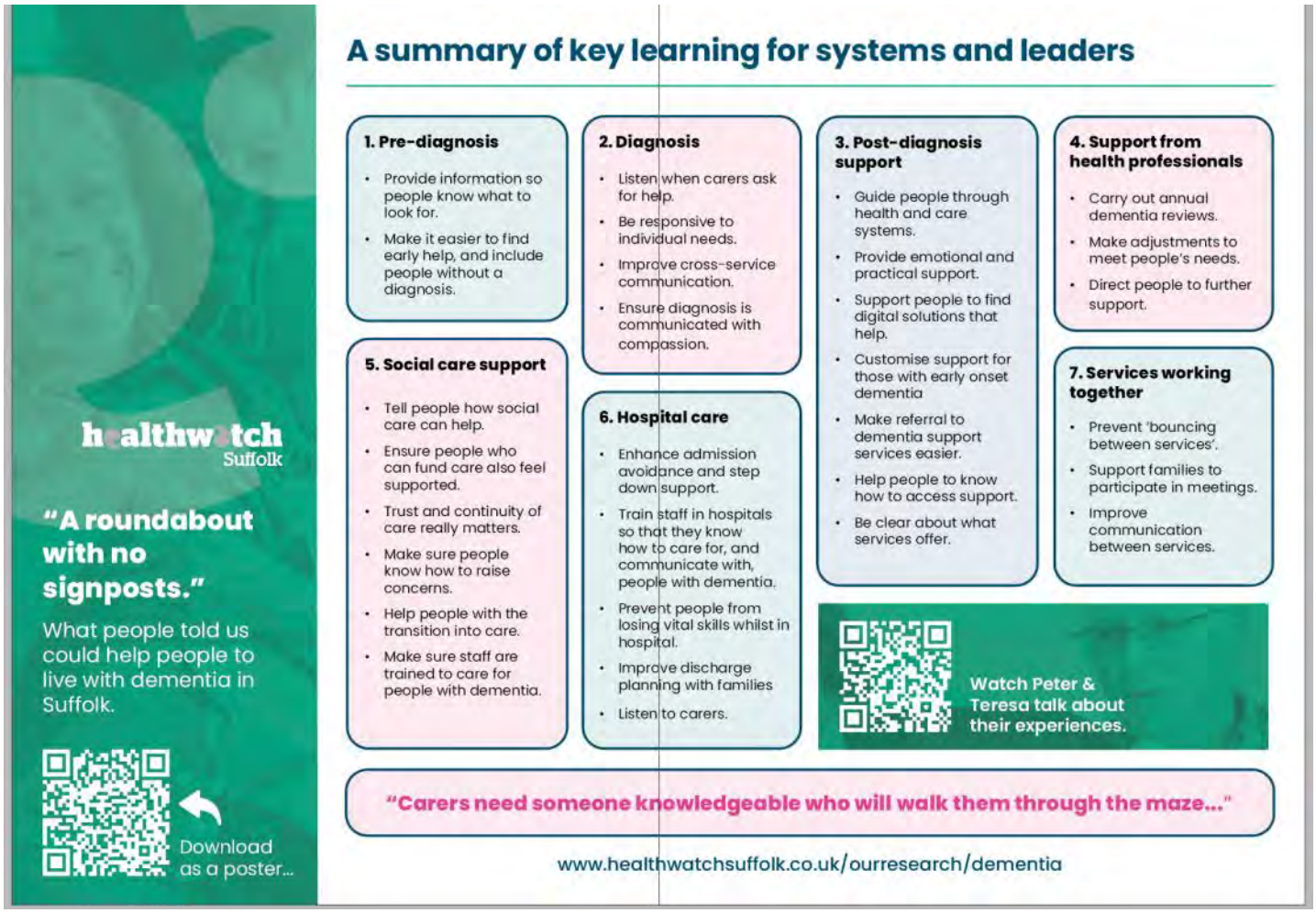
WSA 11/07/23 – RJ

WEST SUFFOLK ALLIANCE
about people & places

6. Implementation of Live Well Delivery Domains

The Committee received an update on progress implementing the Live Well Domains (attached) and noted reporting on specific indicators is developing further, including joint forward plan measures.

Appendix 1 – Healthwatch Suffolk Summary of Report on people's experience of living with dementia



Appendix 2

Live Well Alliance Delivery Plan update for Alliance Committee 11th July 2023					
LWDG: 16th May 20th June	Focus:	Spotlight on quality: How well are the VCFSE part of our system? Spotlight on Evaluation	Outputs:	• Self-assessment showing our strengths as an Alliance and opportunities to work closer with the VCFSE • Improved knowledge and confidence in how we measure the impact of our activity. • Refined workbooks	
Domain		**Action update**		**Outputs**	**Risks**
Start Well		• Ongoing conversations about collaboration and delivery at place and how this contributes to the CYP programme		• Proposal developed to be socialised and plan to bring to Committee in August	• Capacity issues – plan to consider integrated posts
Feel Well		• Ongoing conversations about collaboration and delivery at place and how this contributes to the MH Collaborative		• Agreement for Feel Well to be delivered via the MH collaborative	• Visibility of activity through place – agreement for MH Collaborative to report and feed into WSA Committee
Be Well		• Feel Good Suffolk agreed as the name and brand for the new service, (previously healthy behaviours) • Design sessions ongoing and pathways being mapped out, with key roles and requirements for delivery identified. Work underway to better understand how the partnership can invest in and utilise existing resources • Digital platforms and content design ongoing.		• Stakeholder engagement planned, including engagement with Primary Care July/August • Service pathways and digital framework developed	• Timeline for delivery of new service remains challenging
Stay Well		• 1.5 WTE ACP recruited to EIT, increasing clinical input into team. • Rotational paramedics paperwork completed to join EIT team on secondment – planned timescale end of July 2023. • Integration of Virtual Ward to seasonal plans. • Meeting held with clinicians who have agreed to pilot a direct access pathway for breast lumps for over 50s. Currently scoping feasibility of an IT based form and triage capability. • Funding for TTS pilot to continue into 23/24 agreed. List of additional conditions to include into the service identified. Meeting to explore design of a SystmOne unit to take place in July. • Focus on PIFU as part of national 'Action on Outpatients' initiative. WSFT dashboard operational. Meetings planned with specialties currently not using PIFU to provide support to improve performance. • Integrated Diabetes Service workshop with stakeholders planned for 4 July.		• Current Cleric referral acceptance 01.04.23 – 30.06.23 – 63% accepted & 35% manually rejected, 2 % returned to stack. • Current VW capacity – dashboard established • WSFT OPD dashboard is being used to monitor performance against all OPD KPIs. Data is broken down to specialty level so targeted actions can be agreed with operational teams.	• Minimal medical (Consultant/doctor) input to EIT, therefore failure to increase Cleric referral acceptance rate and direct SDEC access. • Industrial action may impact on meeting national performance target
Age Well		• Established working groups for model of care outcomes. Work stream leads identified, and lead working group established bi-weekly. Finalising timeline for Model of Care through individual working groups • Dementia strategy coproduction held workshop with system partners including VCSE. • Falls mapping underway, shared learning available from NEE regarding a level 1 falls service. • Identification of baseline UCR activity requirements (EIT & INT).		• EIT linking with Medequip and Careline to further develop the falls response • BCF metrics and data assurance to July SNEE committee. • UCR 2-hour dashboard for all three alliances, EIT data – INT data to be built into dashboard.	Part of Model of Care being implemented with Ageing Well funding ceasing March-24. Funding requirement (amount not yet identified) for Level 1 falls service (specification being developed)

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Domain	Action update	Outputs	Risks
Die Well	• Mapping of existing services with key members of every team using virtual meetings. Next steps are to analyse this. • We have been investigating options for capturing data for those in their last year of life and now need to align all these findings into a proposed data capture proposal • Due to financial recovery work within the ICB we have pulled out of compassionate communities' accreditation and patient feedback solutions via a commissioned route.	• Progress on the model of care made and finding out about all the services involved in someone's care end of life. This is captured in a PowerPoint presentation and forms the bases for the analysis.	• Reduced equity across ICB in relation to the provision of specialist palliative services, leading to a risk of sub-optimal care and support at times of increased pressure
Enabler	**Action update**	**Outputs**	**Risks**
Data and digital	• Updated sponsors and strategic lead. • Revised TOR and membership for digital group to align to pull in data and innovation and • encompass ADP delivery priorities. • Ongoing engagement with ICS digital programme to formalise plans for a system-wide clinical safety process • Developing plans to identify for digital and data.	• Innovation embedded in the development of the domain • Dates for super user training of the Optum SNEE wide PHM platform have been established for July which will allow for Optum PHM promotion to commence	• Maintaining momentum and engagement of group members • Scope creep • Capacity
Estates	• Operational group established for re-occupation of Haverhill HC • Expressions of interest received from existing and potential new tenants • Planning well underway for how building reoccupation can work on room-by-room basis • Work commenced to start mapping NHS assets within West Suffolk alliance	Agree governance route and process, engagement with West property group and expand scope of this Identified opportunity to scope similar piece of work for Sudbury Health Centre	Impact of organisational capacity to deliver key milestones
Workforce	• Not received	•	•
Localities	• Continuing to align governance structures using Haverhill as a test bed • Relaunch of Haverhill locality meetings in July • Testing out locality task and finish groups for financial hardship and mental health (using existing structures) and estates. • Other localities are being supported with continued progress to maintain momentum, • information and intelligence gathering (currently collated offline, with the aim of accessible information in the coming year) • Directors of services and service leads have all met to agree in principle to scope what a locality leadership group could look like.	• Governance structure drafted and relationships forming within Haverhill. VCFSE are driving many of the groups and information and intelligence gathering.	• Risk of reduced partnership working as financial constraints emerge • Risk of reduced engagement as people's time stretched

LWDG forward plan	Focus: 18th July 19th Sept	Spotlight : Involving people and communities Spotlight : How will we approach Inequalities	Outputs:	Key principles Existing tools/groups/forums VCSFE Core 20 PLUS 5 - data to support the how

WSA 11/07/23 – RJ

2.5. Wider System Collaboration

To Assure

Presented by Nicola Cottington

Board of Directors

Report title:	**Collaboration and integrated working update**
Agenda item:	2.5
Date of the meeting:	21st July 2023
Sponsor/executive lead:	Nicola Cottington, chief operating officer
Report prepared by:	Nicola Cottington, chief operating officer Kevin McGuinness, associate director of community adult services Nic Smith-Howell, associate director of community children's services Moira Welham, associate director of operations, surgery, and anaesthetics

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:	In the context of finite resources, increasing demand and health inequalities, it is imperative for organisations to collaborate with partners, where this creates improved outcomes for patients and the population. This is supported by NHS strategy and policy, including the West Suffolk Foundation Trust (WSFT) strategy 2021-2026. This paper provides an update of areas of collaborative activity and ongoing plans to further this, including imaging and diagnostic networks, provider collaboration and joint working across health and social care. It demonstrates the scale of collaboration and integration within services, much of which is led by those closest to service users. Some drawbacks and barriers to collaboration are recognised alongside the benefits. The board have a key role in leading strategy towards collaboration and integration, and creating a supportive culture for this to flourish.
Action required/ recommendation:	The Board is asked to note the update and is asked to take an active role in nurturing system relationships and structures to support the collaborative activity.

Previously considered by:	N/A
Risk and assurance:	Working collaboratively provides opportunities to address critical risks together, at a larger scale. There is relevance to all risks on the Board Assurance Framework.
Equality, diversity and inclusion:	Working across the Integrated Care System (ICS) and region to pool resources and knowledge enables organisations and systems to address health inequalities more effectively.
Sustainability:	Working together to ensure the most efficient and effective use of our collective resources contributes to a more sustainable health and care system
Legal and regulatory context:	The Trust is a legal entity and subject to the regulatory framework; the collaboration set out in this paper does not undermine those responsibilities.

Collaboration and integration update

1.	**Introduction**
1.1	This paper provides an update on areas of collaborative activity and examples of integrated working for the benefit of patients and the population. It is not an exhaustive list but provides a summary and demonstrates the culture of collaboration that will underpin future improvements. It also highlights some of the challenges of collaboration. To note, more detailed updates on the ICB and West Suffolk Alliance are provided elsewhere on the board agenda and are not duplicated in this paper.
2.	**Background**
2.1	NHS England has set the expectation that healthcare organisations collaborate to improve outcomes for the people we serve. This is demonstrated in the requirements for regional imaging and pathology networks in the NHS Long Term Plan (2019) and the establishment of Integrated Care Boards in 2022. The 2021 guidance, Working Together At Scale, created a requirement for all NHS providers to be part of one or more provider collaboratives by April 2022. The 2022 Health and Care Act removed the requirement for competition between providers and the need for collaboration was further reinforced in the 2023-24 NHS planning guidance. Locally, the five-year Joint Forward Plan (JFP) for SNEE is explicit about the need for organisations to collaborate to deliver the outcomes of the Live Well domains, and the WSFT strategy (2021-26) highlights the Trust's position as an anchor institution within West Suffolk Alliance.
3.	**Collaboration at regional, system and place level**
3.1	**East Coast Pathology Network (ECPN)** ECPN brings together WSFT, ESNEFT and the Eastern Pathology Alliance. The network has been established for over a year and has embedded governance and leadership arrangements. The Senior Responsible Officer (SRO) role has recently transitioned from Neill Moloney, managing director at ESNEFT to Nicola Cottington, chief operating officer at WSFT, following Neill's secondment. Domain groups have been established comprising of staff from across the network, and each report into a steering group for scrutiny of progress. Key achievements to date include:

	• Programme of offsite network workshops for staff, sharing good practice from elsewhere and enabling staff to contribute to the direction of the network • Co-produced strategy, vision, mission, and values • Agreed network operating model and procurement principles • Review of external contracts across the network to align and gain efficiencies Forward plans include: • Production of a single contract register • Integration/interoperability of Laboratory Information Management System (LIMS) • Leadership development course co-designed with Trust training leads Using the national pathology network maturity matrix, the network is on track to achieve "developing" status by December 2023, with steady progress towards "mature" status. This assessment has been validated by NHSE.
3.2	**Eastern Diagnostic Imaging Network (EDIN)** The NHS Long Term Plan (2019) committed the NHS to establishing imaging networks across England by 2023. West Suffolk Foundation Trust (WSFT) is part of EDIN, which encompasses seven other Trusts within the East of England. The constituent Trusts have signed a Memorandum of Understanding (MOU) and the EDIN five-year strategy is currently progressing through each Trust's governance arrangements for sign off. The network is in the early stages of maturity, and it has taken time to establish effective links between WSFT and the network. The focus to date has been on procurement using the Digital Diagnostic Capability (DDC). Appointments have now been made to all core network leadership roles and the network is gaining pace in establishing its governance structures and engagement.
3.3	**Provider collaboration with ESNEFT** The Boards of both Trusts agreed a shared vision and principles for collaboration in November 2022, and in March 2023 supported progression to a more formalised governance structure, supported by a collaborative transformation team. To date, areas of collaboration between the Trusts have included: • Effective mutual aid between WSFT and ESNEFT in elective care services including orthopaedics, urology, ophthalmology, ENT, and gynaecology • Joint elective care committee in place and planning for shared utilisation of Dame Clare Marx Centre, with WSFT utilising 16 lists per week from August 2024, enabling the delivery of 1,400 procedures per annum • Collaborative working on virtual ward development • Urgent Care Coordination Hub (UCCH) pilot to provide alternatives to ambulance conveyance to emergency departments (see section on UCCH below) • Joint working on procurement Working collaboratively with neighbouring Trusts can be perceived as a threat to the autonomy of individual Trusts and departments. There have been varied perspectives on the future direction, including understandable disappointment that the Trust was not able to secure funding for a local Elective Surgical Centre at Newmarket. It has been critical to listen to a range of views, whilst also providing clear clinical and strategic direction. Forward plans within provider collaboration include: • Possible alignment of plastic surgery provision • Shared urology pathways and joint on call provision • Digital collaboration • Improving equality, diversity and inclusion for staff, patients, and communities

3.4	**Children's and young people's services** The Trust's integrated community paediatric services (ICPS) work in partnership with several agencies to support children and families across both East and West Alliances. The Associate Director for ICPS is a member of the Suffolk County Council children and young people leadership team and sits on several system wide committees and steering groups to support system governance and pathway development. WSFT provide ADHD diagnostic services, as part of an integrated neurodevelopmental disorders (NDD) pathway, alongside a range of support services, Barnardo's and Norfolk and Suffolk Foundation Trust (NSFT). This service is under increased pressure, and there is currently an ICB-led review of the NDD pathway. It is possible that the number of separate providers involved in delivering the service to children and families has added complexity to the pathway and this should be considered when planning collaborative or integrated services.
3.5	**Integrated Neighbourhood Teams (INT)** At their core, the INTs are combined WSFT and Suffolk County Council teams working at a place level delivering health and social care to people in the community. They incorporate social workers, district nurses, occupational therapists, physiotherapists, and INT co-ordinators, among other staff. The wider INT also includes system including the voluntary sector, patient and social groups, and the leisure sector. In West Suffolk, leadership is provided by the Locality Lead role which is pivotal in delivering the Health and Care Act reforms and partnership working to integrate services for individuals and to improve local population health. The role provides leadership and operational oversight of the health and social care team, nurturing integration of the team to pool resources, prevent duplication, and promote a culture of value for money which is outcome based and customer focussed. The INTs have benefitted from a joint leadership programme, whereby leaders from health and social care learnt alongside each other. Working in this integrated way can be challenging at times, including the need to respond to the strategic direction of more than one organisation, and the differences in structure and culture between organisations. However, this is often mitigated by the agility of localised, empowered teams.
3.6	**Integrated Transfer of Care Hub (TOCH)** WSFT hospital discharge processes have been integrated for many years, with health and social care staff working together to plan discharges. The pressures of the pandemic prompted further development and integration (Covid-19 Hospital Discharge Policy, March 2020). In Summer 2022 a review of the hub was undertaken with a view to explore further opportunities for integration, including exploration of pathway 1 (discharge home with care) and pathway 2 (discharge to a bedded facility) processes. A joint Transfer of Care Lead role manages the integrated team of staff from WSFT and Suffolk County Council.
3.7	**Urgent Care Co-ordination Hub (UCCH)** The UCCH consists of a multi-disciplinary team of clinicians, (working from a mix of provider organisations across the SNEE system); based in one geographical location, with direct links to ambulance control and live visibility of 999 demand. The overarching objective is to provide alternative care, if clinically appropriate, rather than dispatching an ambulance. The team can directly access the patient's records (both primary and secondary care systems), to participate in multi-disciplinary discussion; jointly identifying and accessing the right care pathway or plan for the individual patient.

	The UCCH went live on 12th April 2023 and is operational 0800-1600, as a pilot. In the first 50 days, 1323 patients were clinically discussed by the hub, with full access to their previous history, and using real time information (considering real time system pressures) the hub deemed what was the most appropriate service according to the patients' need. Of these, 1048 patients were transferred to alternative services, including WSFT Early Intervention Team, and 795 dispatches were avoided. The next steps for the UCCH include: • Phase 1 is planned to extend to 30 September 23 • Phase 2 aspirations are 0800-2000, 7 days a week in a permanent location. This is a **124% increase** in operational hours and therefore needs 2.73 WTE for every role • **A 124% increase** would also be needed in the referral services, many of which are at capacity already. Different skill mixes would be need in roles which are difficult to recruit to (paramedics, doctors, ANP) • Phase 2 would also integrate mental health and social care into the UCCH MDT and potentially taking referrals from other sources than East of England Ambulance Service Trust (EEAST) stack
5.	**Conclusion**
5.1	The benefits to the population, patients, and staff of working collaboratively include addressing health inequalities and disparity in waiting times, ensuring the most appropriate service is deployed, sharing best practice, pooling resources, creating efficiencies and developing career pathways. There are also barriers to collaboration and integrated working. Managing the process and cultural differences between organisations can take time and patience which could undermine the pace of change. Receiving services from multiple providers can be confusing for patients and could lead to lack of accountability. Clear governance structures, such as those in place for ECPN can provide a framework for effective and timely decision-making. Staff training alongside each other, for example in the INTs, can embed trust and understanding. The board have a key role in leading strategy towards collaboration and integration and creating a supportive culture for this to flourish.
6.	**Recommendations**
	The Board is asked to note the update and is asked to take an active role in nurturing system relationships and structures to support the collaborative activity.

3. PEOPLE AND CULTURE

3.1. Patient and Staff Stories relating to equality, diversity and inclusion

To Review

Presented by Nicola Cottington and Jeremy Over

COMFORT BREAK

3.2. Involvement Committee report

To Assure

Presented by Tracy Dowling

WSFT Board of Directors - Public	
Report title:	**Chair's Key issues: Involvement Committee**
Agenda item:	3.2
Date of the meeting:	21 July 2023
Sponsor/executive lead:	Tracy Dowling, Non-Executive Director
Report prepared by:	Tracy Dowling, Non-Executive Director/Involvement Committee Chair Jeremy Over, Director of workforce and communications

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 report highlights the Chair's Key issues emerged from the Involvement Committee meeting held on 21 June 2023.
Action required / recommendation:	The Trust Board is asked to note the report.
Previously considered by:	NA
Risk and assurance:	-
Equality, diversity and inclusion:	The focus of the Involvement Committee on Equality, Diversity and Inclusion is identified in the CKI Report.
Sustainability:	NA
Legal and regulatory context:	NA

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Involvement Committee			Date of meeting: 21st June 2023		
Chaired by: Tracy Dowling- Non executive Director			**Lead Executive Director: Jeremy Over**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
6.0	Our ambitions and priorities for equality, diversity and inclusion at WSFT	Partial	The papers did provide clarity on priorities and ambition for ED&I. There was a full and detailed discussion regarding the Unison Anti-racism Charter; NHS England ED&I requirements and the use of the WRES and WDES and staff survey data to monitor progress. Clear that this is a minimum 3-5 year commitment to action for the Trust.	• Chair to be asked to support a requirement that NEDS all have an objective relating to ED&I • WSFT ED&I plans developed to incorporate NHSE requirements as well as local priorities • ED&I plan and progress to come to Improvement Committee later in the year to assure detail of actions	3. Escalate to Board for commitment to actions, Anti-racism Charter and priority of race and disability.
7.0	Ockenden Improvement Plan	Minimal	Agreed that a review of the gap analysis needs to be undertaken to map areas that are in progress or business as usual; and areas that require focus and resource additional to this.	• Following this clarity is needed on which areas of Ockenden the Improvement Committee needs to seek assurance on (which will include	• Executive team / SLT to oversee

Originating Committee: Involvement Committee			Date of meeting: 21st June 2023		
Chaired by: Tracy Dowling- Non executive Director			Lead Executive Director: Jeremy Over		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
				workforce planning and workforce sustainability)	
8.0	People and culture plan The plan was approved in full and progress against outcome measures will be monitored at Involvement Committee. The plan has clear focussed actions, responsible persons and measurable outcomes.	Substantial			
9.1	Freedom to Speak Up Guardian The decision of Amanda Bennett to move on after 3 years was shared. It was clear through discussion that there are opportunities through the recruitment opportunity presented have been well thought through and steps are in train to mitigate any risks the turnover in this	Reasonable			

Originating Committee: Involvement Committee			Date of meeting: 21st June 2023		
Chaired by: Tracy Dowling- Non executive Director			Lead Executive Director: Jeremy Over		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
	crucial role present.				
AOB	Reflections One reflection of note to Board is that the agenda for the Involvement Committee is heavily biased towards people and culture issues and further work is needed to ensure that patient experience and engagement has equal focus	Partial	The Involvement Committee Terms of Reference indicate a remit for patient experience and engagement yet agendas and datasets do not currently adequately reflect this as routine business	• Meeting of Chair with relevant execs to explore this remit and how data and reports can be developed to fulfil this role • Away Day in September to focus on this	No escalation

**See guidance notes for more detail*

Guidance notes

The practice of scrutiny and assurance

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

Assurance level

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

3.3. People & Organisational Development Plan

To Assure

Presented by Jeremy Over

Board of Directors

Report title:	**People & OD highlight report**
Agenda item:	3.3
Date of the meeting:	Friday 21 July 2023
Sponsor/executive lead:	Jeremy Over, executive director of workforce & communications
Report prepared by:	Members of the workforce and communications directorate

Purpose of the report:			
For approval ☐	**For assurance** ☐	**For discussion** ☒	**For information** ☒
Trust strategy ambitions			
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 approach has been further augmented by the establishment of the Involvement Committee and this report now sits alongside the CKI report from that group to provide additional background and clarity. In addition to discussing the content of the report, and related issues, continued feedback is welcomed as to the structure and content of this report and how it might be developed in future. This month the report provides updates on the following areas of focus: • Putting You First awards (June/July) • A summary of our work on equality, diversity & inclusion and a recommendation that the Board endorses a position of anti-racism by adopting the UNISON charter • Freedom to speak up guardian recruitment and board pledge • Update on national pay discussions / industrial action 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 (June/July)**
2.1	**Georgie Brown and Kevin Brown, MDT lead education practitioner and senior resuscitation practitioner, maternity and resus and education / staff training** *Nominated by: Theresa Lancaster, Education and practice development lead maternity support worker* Since joining the Maternity unit, Georgie has made a real impact, especially in staging unplanned skills drills in all areas and ensuring staff at all levels are up to date with their training. Georgie has also established a Focus group (Forum) for all Maternity staff where any issues can be raised and possible solutions can be discussed, as well as celebrating positivity and good within the unit. My main reason for nominating Georgie and Kev is regarding the opportunity they now offer for ANY new parents or care givers to attend a FREE education evening, focusing on children's basic life support and choking. These sessions are held monthly and have proved extremely popular and are very well attended. Georgie has quite rightly identified a real need for this education for parents and caregivers and has quickly established the sessions. The sessions are facilitated by Georgie and her husband Kev who are both extremely well qualified to educate the attendees and although extremely professional at all times also ensure it is an enjoyable evening for everyone present. Georgie provides an array of cakes, cookies and refreshments for everyone and this month also organised a free raffle with various appropriate prizes for attendees, and had handmade/ knitted baby items available for anyone to access. Parents also have an opportunity to have their baby weighed and to discuss any feeding ,weaning or relevant issues with the team of professionals who attend to support Georgie and Kev. Georgie and Kev are both such great ambassadors for the Trust , give their time and expertise willingly to support staff and now service users and I really feel that they both deserve recognition for their o going contributions to the Trust.

2.2	**Sam Green, communications officer** *Nominated by Dan Charman, communications manager* Sam has been with us for less than a year and this is his first ever communications job. Since joining, Sam has come in every single day with huge amounts of positivity and eagerness and has never backed down from a challenge. Sam has led a number of projects but one that stands out as really exceptional is the work he has done on International Nurses' Day. Sam worked very closely with the BBC Look East team to produce a video that will be viewed by thousands of people and will detail the experiences of international nurses coming to our Trust. He is regularly praised by people all across our hospitals and community teams and is a joy to work with and manage. He is a great example of someone who is very willing to learn from his peers and take the lead on projects that can be out of a lot of people's comfort zones.
2.3	**Tia-Jade Howlett, acute responsive coordinator, Support to Go Home service** *Nominated by Marguerite Maduz, reablement support worker and Jenna Hurlock, reablement support worker* Tia is a key member of our team, someone we can go to with any problem, and someone who will always find a solution. She's a (super) multi tasker, proactive, knowledgeable and always comes up with fun ideas to entertain us in the office - Christmas decorations, Easter eggs and organises birthday cards and collections for all the team, of which we are many. She also promotes and helps the more junior members of our team to advance in their roles and achieve higher bands. All in all a great person who is very good at her job, that the team appreciates, and deserves a special mention. Tia is a great colleague, she tries to help everyone in our team the best she can, she always tries to make our workload fair and achievable. Tia is always trying to come up with new ideas to make our team better and improve communication. Tia knows how our team works inside out, if you have a problem 9 times out of 10 she can fix it or put you in the right direction. She is quick thinking and if you need something doing you know she will do it, you don't need to ask her twice. I've been struggling with some of my college work of late, not knowing how to put things into words, Tia has taken the time to sit with me and talk things through. She has also really pushed for my colleagues and I to achieve our band 4 roles. Tia is a great colleague and friend; she is always bright and cheerful keeping the hard-working office going with a sing song and with takeaway Fridays.
2.4	**Sophie Riley, nursing and midwifery recruitment lead** *Nominated by Louise Bland, head of resourcing* Sophie always puts in 110% effort into her role and she truly cares about the people she recruits. She has gone above and beyond recently to ensure our international nurse recruits have a smooth arrival at WSFT. This has included travelling to Ipswich regularly to pick up work permits, working over weekends to meet arrivals, and working with HSBC to have them come into the hospital to set up new bank accounts for the international recruits, meaning they can then access their advance pay. She has also worked to revamp the nursing assistant recruitment processes to provide candidates with a greater understanding of the role and the trust, with the aim of reducing NA turnover.
3.	**Our ambitions and priorities for equality, diversity and inclusion at WSFT**
3.1	West Suffolk Foundation Trust strives to be an inclusive and caring organisation, where we want everyone – no matter what role they play in the Trust – to feel valued and listened to. We wish to see kindness, good communication and compassion towards one another as standard behaviours. Whilst it is recognised that such cultural developments remain work in progress, the data from the latest listening exercises with staff suggests that there are critical and urgent steps that still need to

	be taken. It is recognised that there are many areas of inequality for the Trust to tackle, with these being included in the refreshed Inclusion Strategy that will be developed shortly. Fundamentally, we believe that we will make better decisions, be more innovative, and ultimately provide better patient care if all of our staff and patients – especially those from minority groups – feel that they belong at WSFT, can be themselves and do not experience discrimination or disadvantage. Over the past month through the auspices of the Involvement Committee we have reflected on our data, and on the triangulated themes arising from staff listening and feedback. We have also taken stock of the opportunities and challenges facing the wider NHS and our response to that. The themes from the Involvement Committee discussion are covered in the separate CKI report. It included: • Creating a culture of inclusion for all, with a particular emphasis on race and disability in 2022/23 (as reflected in the people and culture plan) • Agreeing a set of personal commitments that members of the executive team wish to adopt and deliver against, which includes asking the Board to formally endorse and adopt an anti-racist charter • Responding to the feedback of our staff disability network to strengthen our approach to how we support and enable reasonable adjustments • Consideration of how we engage with and progress the high impact actions set out in the recently-published NHS England document, equality, diversity and inclusion improvement plan
3.2	Involvement Committee felt that the set of three commitments made through discussion and development within the executive group could and should be adopted by the whole Board. These are as follows: • Commitment 1: to embed EDI and inclusive leadership in the Executive Group • Commitment 2: to embed EDI and inclusive leadership at WSFT • Commitment 3: to embed EDI and inclusive leadership in our personal leadership practice Each of these commitments has a number of underpinning actions. It is recommended that commitment 1 is enhanced to reflect the embedding of EDI and inclusive leadership within the whole Board, and for this to be reflected in the ongoing and future Board's development programme. Amongst other things, commitment 3 will entail individual Board members agreeing a specific component of their objectives to personally contribute to growing a diverse and inclusive culture at WSFT.
3.3	In particular, there is a proposal and recommendation to the Board (from both Involvement Committee and our People and Culture leadership group), that we formally commit to becoming an anti-racist organisation through the endorsement and adoption of the UNISON anti-racist charter (see appendix). This in turn commences a twelve month period of work to develop a range of actions and measures in support of this goal. This work will be incorporated into our overall EDI action plan and Board colleagues are invited to formally adopt the charter and lend the work their personal and active commitment.
3.4	Our local EDI action plan is also being developed to incorporate the high impact actions and measures as set out in the recently-published national equality, diversity and inclusion improvement programme. The plan priorities the following six high impact actions to address the widely-known intersectional impacts of discrimination and bias: 1. Measurable objectives on EDI for Chairs, CEOs and Board members 2. Overhaul recruitment processes and embed talent management processes 3. Eliminate total pay gaps with respect to race, disability and gender

	4. Address health inequalities within the workforce 5. Comprehensive induction and onboarding programme for internationally recruited staff 6. Eliminate conditions and environment in which bullying, harassment and physical harassment occurs
4.	**Freedom to speak up guardian recruitment and board pledge**
	As a Board, our responsibility for and commitment to establishing a culture where everyone can safely share workplace concerns that they hold is fundamental. Whilst we put in place various arrangements to support, listen, train and advocate for staff (including a detailed policy and the function of 'freedom to speak up guardian'), ultimate responsibility rests with us. Colleagues are invited to reaffirm our commitment to this crucial agenda through the following pledge: *"The development of a culture where all colleagues feel confident to speak up and share concerns at work is crucially important to us, where everyone has a voice that counts. We affirm its direct impact on a culture of safety with positive benefits for patient care, quality and staff experience and engagement. It is important to us that everyone feels safe to speak up. Speaking up to us is a gift because it helps us identify opportunities for improvement that we might not otherwise know about. We will not tolerate anyone being prevented or deterred from speaking up or being mistreated because they have spoken up. As a Board we value our relationship with the role of Freedom to Speak Up Guardian, particularly as it enables the sharing of themes or learning where we can take action to protect the interests of patients, colleagues, and the wider organisation".* Board members have separately been updated on Amanda Bennett's recent decision to step down from her role as Freedom to Speak Up Guardian. Amanda joined in 2020 on a 3-year appointment as one of two guardians, our first substantive guardians with dedicated time for the role. She increased her hours as her co-guardian, James Barrett, undertook a career break in 2022, and has continued the development of the profile and influence of the speak up agenda considerably, most notably with members of the Board through her regular attendances and reports. She provides immense support to people behind the scenes, most of it unseen as she works through issues confidentially and discreetly, advocating for colleagues where appropriate. Amanda is returning to her clinical work, namely nursing education within primary care. We will be sad to see her go, whilst looking to build on the valued legacy she leaves behind. We have started work on the recruitment process for what is a unique role in our organisation, which will require considered handling and effective stakeholder engagement. As named NED for freedom to speak up, Antoinette Jackson will oversee the arrangements being put in place by the executive director for workforce and communications.
5.	**National pay discussions / industrial action**

	The Board is asked to note the following:
	
	• The pay award for Agenda for Change staff has now been enacted and colleagues are in receipt of the associated increases to salaries
	• The government has just announced adoption of the pay review body recommendations in relation to medical staff:
	  o The Review Body for Doctors' and Dentists' Remuneration (covering doctors and dentists not in multi-year deals) recommended a 6% increase for the majority of its remit group.
	  o Pay for junior doctors will increase by around 8.8% on average. This is because the DDRB recommended 6% plus £1250 on a consolidated basis
	• There is concern as to the funding arrangements for these awards, and the consequent impact on WSFT's finances
	• It is not anticipated that this decision will bring to an end the ongoing industrial action amongst medical staff in England

	• The recent local ballot of radiography staff by the SoR at WSFT did not achieve a valid outcome to support industrial action as the threshold of 40% of the total eligible membership voting in favour was not met • The national ballot of nursing staff also did not yield a valid outcome to support further industrial action. It remains positive to see progress in the national employment relations situation although it is recognised that not all areas of dispute are yet resolved. With a mixed set of ballot results in relation to the pay offer there is concern regarding the longer-term impact on staff retention and morale in the NHS, and for partnership working with trade unions at national and local level.
6.	**Recommendation**
	To note and provide comment and/or feedback on the report, and agree the adoption of the anti-racist charter.

Anti-Racism Charter

Our organisation pledges we will introduce the following ongoing commitments within 12 months of signing:

Our leaders will

- Recognise the need and benefit in championing a racially diverse workforce.
- Challenge racism internally and externally wherever it arises in relation to the organisation.
- Recognise the impact of racism upon staff members' wellbeing.
- Set and regularly review strategy to improve racial equality, diversity and inclusion so that the organisation reflects the communities it serves.

Our organisation will

- Have a clear and visible race equality policy championed by leadership.
- Have a clear and visible anti-racism programme of initiatives and actions.
- Undertake equality impact assessments for all strategic-level decisions.
- Undertake ethnicity pay gap recording and publicly publish results.
- Undertake workforce ethnicity recording and publicly publish results.
- Provide unconscious bias and anti-racism training for all staff members.
- Provide a racism reporting process for notifying, investigating and recording outcomes.
- Provide robust equality training for managers involved in recruiting, promotions and investigating allegations.
- Provide a wellbeing support facility for staff experiencing racism in the workplace.
- Will be anti-racist, not just non-racist in all we do.

Our equality auditing process will review

- Recruitment processes to identify and address race disparities in equality of opportunity.
- Exit interview results to identify and address race disparities in retention of staff members.
- Promotional processes to identify and address race disparities in equality of opportunity.
- Discipline and grievance to identify and address race disparity in outcomes of comparable cases.
- Policies and research under a duty or commitment to promote solidarity and tackle racism.
- Our mission, values, and support to removing racial discrimination in all its forms.

Employer

Date

UNISON Eastern

4. ASSURANCE

4.1. Insight Committee Report - Chair's Key Issues from the meeting

To Assure

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Insight			Date of meeting: 21 June 2023		
Chaired by: Antoinette Jackson			**Lead Executive Director:**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
Finance Accountability Committee	**Budget deficit and CIP programme** The Finance division has experienced resourcing issues caused by sickness absence. There have been issues with the upload of the current year's budget with divisions receiving budgets without current year assumptions. The CIP programme remains behind where it should be. The new Medic beep contract is in place but has added an additional £50K cot pressure.	**4 Minimal**	The revised budget had to be reissued and therefore was at a lower level than divisions were expecting. This may impact on their CIP assumptions. There is further work needed to identify further CIP savings especially recurrent savings. There is a risk that the ICS system assumptions built into the budget may be too optimistic, giving a risk that targets will not be met. The SNEE system is looking out	Insight Committee have asked for further information on the granularity of the CIP programme as the committee remains concerned about the Trust's ability to close its deficit. There is more work to be done to engage divisions on the budget issues.	3 Escalate to Board

Originating Committee: Insight			Date of meeting: 21 June 2023		
Chaired by: Antoinette Jackson			Lead Executive Director:		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
			of kilter with the rest of the region currently.		
Endoscopy Deep Dive	There was an Endoscopy Deep Dive at this meeting. Additional private sector capacity has been utilised in Ipswich and additional resources have been appointed to support the booking of patients. Oversight and support from NHS England has not identified any significant issues missing in the Trust's approach to tackling the backlog.	2 Reasonable	The new resources mean that trajectory for compliance has come forward from March 25 (the national target) to June 2024. Demand and capacity analysis suggest the service has sustainable capacity once the back log has been cleared.	Insight will continue to monitor performance against the new trajectory.	1.No escalation

Originating Committee: Insight			Date of meeting: 21 June 2023		
Chaired by: Antoinette Jackson			**Lead Executive Director:**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data** **Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal		**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
Patient access Group	The committee were told about an impressive piece of work in relation to the waiting well programme commenced for orthopaedics on 24/05/23. It uses population health data to target patients awaiting orthopaedic surgery and people are stratified based on their level of deprivation and risk of emergency hospitalisation in the next 12 months. An NHS England directive requires contacting patients every 12 weeks to see whether they still need	2 Reasonable	The programme allows the Trust to support potential harm incurred by long waits support to be given to patients based on their risk factors. The Trust is taking the national process a step further and also asking patients how they are doing. They have contacted 2978 patients. 105 came off the list and 178 needed some sort of clinical review.	This is a pilot for six months and if successful, the team will look to roll out to other specialties. Feedback from patients shows they are most interested in when they will be able to have their procedure. Real time outpatient waiting time information is live and the elective surgery average waiting time will be live by the end of the month. They next steps will be to look at diagnostics.	2.Escalate to SLT

Originating Committee: Insight			Date of meeting: 21 June 2023		
Chaired by: Antoinette Jackson			**Lead Executive Director:**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data** **Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal		**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
	to come in for their procedure.			The committee escalated to the Executive team the need to have consistency in documenting patients so that impacts could be properly tracked.	
Patient access Group /IQPR data	The Committee noted that there had been improvement in Urgent and Emergency care indicators in recent weeks. This suggests that the UEC recovery plan was beginning to have some impact.	3 Partial	It is too early to say if the trend is significant, but positive items of note include: Being first in the country for ambulance handovers two weeks running. One week where we were first in the region and fourth in the country for 4 hour waits. The 4-hour month to date	There is a UEC recovery plan which will continue to be implemented. The past, and any future, Industrial action will have an impact on the Trust's ability to meet its trajectories and targets.	1. No escalation

Originating Committee: Insight			Date of meeting: 21 June 2023		
Chaired by: Antoinette Jackson			**Lead Executive Director:**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
			performance in June was 73%. This is ahead of trajectory by a considerable amount and not far off the 76% needed by the end of March 2024. The urgent community response standard is also being met at 70% consistently.		
Patient access Group /IQPR data	Glemsford Surgery It is not possible to obtain automated data on performance in relation to primary care access and quality standards due to difficulties obtaining data form SystmOne	3 Partial	The committee cannot undertake its assurance duty in relation to the performance of Glemsford Surgery	The Information Team are progressing this issue, however there are elements outside of the organisation's control	3 Escalate to Board for awareness of this gap

**See guidance notes for more detail*

Guidance notes

The practice of scrutiny and assurance

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

Assurance level

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

4.1.1. Summary Reports for:

Seasonal Planning

Presented by Clement Mawoyo and Matt Keeling

Board of Directors

Report title:	**Seasonal Planning 2023/24**
Agenda item:	4.1.1
Date of the meeting:	21 July 2023
Sponsor/executive lead:	Nicola Cottington, Executive Chief Operating Officer
Report prepared by:	Matt Keeling, Deputy Chief Operating Officer Clement Mawoyo, Director of Integrated Adult Health and Social Care

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:	Urgent and emergency care services experienced some of the most extreme pressure on record during the winter 2022/23 period, manifested most visibly through front door pressures and cancelled elective activity. Despite the huge efforts made by teams working together, length of stay and bed occupancy continued to increase, exacerbating delays and leading to the Trust declaring multiple Critical Internal Incidents. The NHS 2023/24 priorities and operational planning guidance and January 2023 delivery plan for recovering urgent and emergency care services set out key deliverables and actions for systems to improve flow and reduce bed occupancy. Modelling has demonstrated that an additional 52 beds, or the equivalent of, will need to be delivered in the peak winter period to meet the national objective of maintaining bed occupancy below 92%. Our response centres around three initiatives: a Focus on Flow programme aimed at improving flow through the hospital, an option to use additional escalation capacity and the targeted use of the Better Care Fund to improve discharge processes and support outside of hospital. Each initiative will have delivery monitored and supported through the definition of project specific metrics reported into the governance structures of WSFT and the Suffolk Health & Wellbeing Board, with overall success reflected in the key headline metrics of bed occupancy, Emergency Department (ED) 4-hour performance, ED 12-hour length of stay (LOS),

	ambulance handover times, average inpatient LOS and activity delivery of elective services (including meeting our commitments to reduce long waiting patients).
Action required/ recommendation:	The Board is asked to note the contents of this report and provide feedback on any points raised within it. Executive Directors and the Board are asked to support the plan representing WSFT's response to seasonal pressures in 2023/24.

Previously considered by:	West Suffolk Programme Board, Suffolk Health & Wellbeing Board.
Risk and assurance:	Local Activity ref: BAF 3.2, Trust Risk Register Number: 3651 - Delivery of national NHS objectives set out in Operational Planning Guidance. Assurance metrics on access are reported through the Patient Access Governance Group and Integrated Quality and Performance Report (IQPR), both reporting into the Insight Committee of the Board.
Equality, diversity and inclusion:	All services provided by WSFT should be delivered equitably and with specific focus on reducing health inequalities across access and outcome measures. Although inequalities are not specifically addressed within this paper, monitoring of waiting times by deprivation score and ethnicity are monitored at ICB level.
Sustainability:	Consideration is given within this paper towards delivery of safe and effective services in a way that promotes financial and workforce sustainability. Individual projects managed through the West Suffolk Change Hub One Plan take into account sustainability as part of project prioritisation and monitoring of delivery.
Legal and regulatory context:	Health and Care Act 2022, NHS 2023/24 priorities and operational planning guidance, NHS delivery plan for recovering urgent and emergency care services.

Seasonal Planning 2023/24

1.	**Introduction**
1.1	Urgent and emergency care services experienced some of the most extreme pressure on record during the winter 2022/23 period, impacting the whole health and care system but most visibly manifesting itself as problems at the front door with long waits to offload ambulances and overcrowded emergency departments, poor flow within hospitals leading to the cancellation of valuable elective activity, extended length of stay and patients not being able to receive care in more appropriate settings including their own homes. Locally, WSFT experienced patients waiting longer than 12 hours in the emergency department, and numbers of patients awaiting placement in a hospital bed, at a higher rate than had ever been experienced. This led to multiple Critical Internal Incidents being declared throughout the winter period. Despite extensive planning and best efforts from multiple teams working together, bed occupancy and length of stay (LOS) increased and then remained at exceptionally high levels throughout the winter period and beyond. Although the NHS 2023/24 priorities and operational planning guidance states the need to increase bed capacity in order to reduce occupancy levels and maintain flow, this alone does not provide a sustainable solution and is difficult to deliver: WSFT does not have the physical space to do this whilst ensuring that the programme of RAAC works can continue and additional bed spaces have to be staffed from our existing establishment, increasing risk and the potential for staff dissatisfaction.
2.	**Background**
2.1	The first of the three NHS priorities as set out in the 2023/24 priorities and operational planning guidance is to recover our core services and productivity: improving patient safety, outcomes and experience by improving ambulance response and A&E waiting times and through reducing elective long waits and cancer backlogs. Increasing the ability of the whole system to achieve good patient flow and reduce bed occupancy will be critical to delivering that priority. In addition to the annual priorities and operational planning guidance, the NHS also published a delivery plan for recovering urgent and emergency care services in January 2023. This set an ambitious set of objectives for a system that provides more, and better, care in people's homes, gets ambulances to people more quickly when they need them, sees people faster when they go to hospital and helps people safely leave hospital having received the care they need. The importance of partnerships between acute, community and mental health providers, primary care, social care and the voluntary sector is emphasised – which through our status as a combined acute and community provider and with strong links to social care through the West Suffolk Alliance we can leverage to best effect. The January 2023 plan identifies the following areas for sustained focus which will be delivered through our response to seasonal planning: **Increasing capacity** – investing in more hospital beds and ambulances, but also making better use of existing capacity by improving flow. **Improving discharge** – working jointly with all system partners to strengthen discharge processes, backed up by more investment in step-up, step-down and social care, and with a new metric based on when patients are ready for discharge, with the data published ahead of winter. **Expanding and better joining up health and care outside hospital** – stepping up capacity in out of-hospital care, including virtual wards, so that people can be better supported at home for their physical and mental health needs, including to avoid unnecessary admissions to hospital.

2.2 As part of our submission for central 2023/24 planning, we submitted a trajectory showing what is required to deliver against the national NHS objective of reducing adult general and acute (G&A) bed occupancy to 92% or below, based on what we know about our demand for elective and non-elective beds. This highlights the additional beds, or equivalent bed day savings, that we would need to achieve beyond our core capacity:

Modelling shows that we need to save an equivalent of 33 beds (currently on F9) all year round plus 20 surge beds in winter to meet the 92% occupancy requirement

NON-ELECTIVES												
Average number of overnight G&A beds occupied - adult non-elective (Bed Model)	390	392	400	394	389	401	386	401	405	413	413	405
Average number of overnight G&A beds available - adult non-elective @ 92%	424	426	435	428	423	436	420	436	440	449	449	440
Non-Elective core beds	398	398	398	398	398	398	398	398	398	398	398	398
Non-Elective core beds + escalation (F9)	431	431	431	431	431	431	431	431	431	431	431	431
Occupancy with core	98%	98%	101%	99%	98%	101%	97%	101%	102%	104%	104%	102%
Occupancy with core and escalation	90%	91%	93%	91%	90%	93%	90%	93%	94%	96%	96%	94%
Occupancy with core, escalation and surge (20 beds)									90%	92%	92%	90%
Bed variance from core	-26	-28	-37	-30	-25	-38	-22	-38	-42	-51	-51	-42

Delivery of the 107% net elective activity threshold is modelled as possible with 34 ring fenced beds

ELECTIVES @107%												
Average number of overnight G&A beds occupied - adult elective (plan x average LOS 2.67 days)	24	27	29	27	28	28	29	30	25	25	28	26
Average number of overnight G&A beds available - adult elective @ 92%	26	29	32	29	30	30	32	33	27	27	30	28
Elective core beds	34	34	34	34	34	34	34	34	34	34	34	34
Occupancy with core	71%	79%	85%	79%	82%	82%	85%	88%	74%	74%	82%	76%
Bed variance	8	5	2	5	4	4	2	1	7	7	4	6

Setting local objectives and deliverables across all three focus areas is required to deliver on this trajectory and therefore the ambitions of the 2023/24 priorities and operational planning guidance and delivery plan for recovering urgent and emergency care services.

3. Our response to seasonal planning

3.1 Focus on Flow

A Focus on Flow group has been established to build on the work of previous initiatives such as the winter 2016 programme of change which included the delivery of "Red to Green", rapid improvement events in 2019 and the 2022 Core Resilience Team (CRT), which was stood up to oversee a programme of work aimed to support and improve patient flow in response to extreme pressure, resulting in a high number of critical internal incidents being declared. Several initiatives were identified and developed into a CRT work plan and additional escalation capacity were opened on F9, initially for two weeks, to support a reset of some of the short stay processes which had become overwhelmed.

In May 2023, the group took the decision to cease operating under the CRT model, as the short-term response that CRT's are designed for had been delivered and a review of the evolved work programme and emerging priorities indicated a longer-term delivery model was required.

The CRT has therefore been relaunched as a Focus on Flow programme, supporting ten workstreams each with an executive senior responsible officer (SRO), operational lead and project lead:

Workstream	Objectives
Ward Flow – revisit following Covid (Exec SRO Paul Molyneux/ Margaret Moody)	1. Board rounds/ward rounds 2. Junior doctors 3. Criteria Led Discharge 4. Virtual Wward onboarding 5. Ward nurses/therapist discharge education 6. 48 hour care plans

	7. Patient info 8. Ward discharge data display
Stranded patients (Exec SRO Sue Wilkinson)	1. Review current process and recommendations 2. Roles and responsibility 3. Transfer of Care Hub (TOCH) SOP – ICB wide 4. Escalation
Weekend processes (Exec SRO Nicola Cottington)	1. Review discharge consultant role 2. Identify what is needed for same day discharges
To Take Out (TTO) medications (Exec SRO Paul Molyneux)	1. Continuing with Right Care, Right Time, Right Place objectives.
Patient flow (SRO Matt Keeling)	1. Right patient right bed (patient placement SOP) 2. Discharge Waiting Area optimisation and expansion to 24/7 service
Community beds (incl. interim beds) (Exec SRO Clement Mawoyo)	1. Reducing LoS in NCH and HC 2. 18 commissioned beds – wrap around and patient criteria 3. Patient information 4. Early discharge planning 5. Social prescribing 6. Escalation
Community (Exec SRO Clement Mawoyo)	1. Virtual ward 2. P1 – 7 days 3. Medical cover to EIT 4. IV abx in care homes 5. Enhanced overnight EIT 6. EOL – admission prevention 7. Review of specialist services to optimise responsiveness 8. Community pharmacy
Link to phase 2 UEC recovery programme (Exec SRO Nicola Cottington)	1. Non-ED alternatives for emergency dental
Transfer of Care Hub (TOCH) (Exec SRO Clement Mawoyo)	1. ICB-wide SOP
Non-weight bearing (NWB) pathway (Exec SRO TBC)	

	This programme will be report through the West Suffolk Change Hub Programme Board and upward into the Senior leadership Team committee. The programme board meets monthly and is chaired by the Deputy Chief Operating Officer. To ensure we can deliver the plan the Operational Improvement team will support the wards, 2 wards at a time in the acute and all 3 community assessment bed sites. We plan to start with wards G3 and G5 as they had a formal write up following the rapid improvement work in 2019 this will allow the team to review progress and work with each ward to prioritise areas of improvement. Each workstream will have project specific metrics attached to it to evidence achievement, as well as a clear exit strategy to transition each workstream to business as usual. These will be reviewed and supported through inclusion on the West Suffolk Change Hub One Plan, monitored through Programme Board.
3.2	<u>Escalation and surge capacity</u> Use of F9 as an escalation ward ended in June 2023 so that the RAAC programme of works could recommence across two wards at a time. The F9 failsafe works are scheduled for completion in November 2023 at which point the ward area would become available for use once again. Although the Focus on Flow programme should deliver a reduction in our bed requirements by decreasing LOS and occupancy, it is unlikely that it will deliver the equivalent of 53 beds above core as indicated will be required by our occupancy trajectory. However, we do not envisage opening any additional escalation capacity as soon as it becomes available, previous winters have shown that any additional capacity will be filled as soon as it is opened, and any benefits can quickly get lost as LOS and numbers of outliers increase. It will be imperative to utilise real-time bed modelling to analyse and predict peak demand, opening escalation capacity only when it is needed and to allow time for the processes introduced from the Focus on Flow programme to become embedded and ensure maximum benefit from that capacity, e.g. as a step-down ward closely integrated with a 24/7 Discharge Waiting Area. Flexibly using our physical and workforce capacity is an essential element to planning for increasing in respiratory-related admissions during the winter period for both adult and children's services. Since 2020, our paediatric ward (F1) has increased its core staffing from 3 registered nurses to 4 and makes use of point of care testing for Respiratory Syncytial Virus (RSV), COVID-19 and influenza to ensure most effective use of side room capacity. The ward has a core capacity of 15 patients which can be stretched to 20 for short periods to deal with peaks in demand, with escalation actions of additional ward and board rounds and using community teams for administration of daily intravenous antibiotics where oral alternatives are not suitable, to increase flow. GP referrals requiring urgent review can also be accommodated within a clinic setting rather than the ward to further create capacity. For adult respiratory care, we will build on the model developed during and since the COVID-19 pandemic, using flexible capacity on wards G9 and G10 to create isolation bays for COVID-19 and seasonal influenza. As the capacity requirement for these admissions increases, it will be necessary to co-locate non infectious respiratory medicine patients within a dedicated area with appropriate nursing cover on another ward, to prevent the extended length of stay and increase in risk that can occur when boarding patients in multiple locations. In 2023, a nurse co-ordinator role has been introduced 7 days a week to promote patient flow and to act as a point of escalation. The virtual ward pathway has been used to good effect in respiratory medicine, with three pathways currently in place, with plans to increase this.
3.3	<u>Better Care Fund – Adult Social Care Discharge</u> The Better Care Fund (BCF) aims to support people to live healthy, independent and dignified lives, through joining up health, social care and housing services seamlessly around the person. It

	achieves this by requiring integrated care boards (ICBs) and local government to agree a joint plan, owned by the health and wellbeing board (HWB). Managed through the West Suffolk Alliance, three initiatives form the basis of the 2023/24 plan: **Increasing Home First capacity:** Home First (HF) has needed to continually expand to cope with larger referral numbers and faster discharges. Since March 2020, expansion has primarily been short-term and expensive through agency usage, which has limited the ability for Home First to function as a reablement service and achieve D2A (Discharge to Assess) aims. HF is now in a more stable position and the BCF funding will allow it to deliver the Integrated Reablement Principles signed off by Health & Social Care in Suffolk in November 2022. It meets the ambitions of the BCF discharge fund with these approaches: • Assessment function – will enhance and offer a holistic assessment of people's needs at home post-acute discharge so no assessments take place in a hospital setting. A more in-depth assessment keeps people independent and out of hospital for longer as well as having their reablement period reduced therefore increasing capacity. • 7-day service – HF will have permanent staff employed at weekends therefore ensuring continuity of capacity 7 days a week for both taking referrals and supporting discharges. • Risk assessor capacity – Currently delays are caused by not having enough risk assessor capacity once the person arrives home. This will help support flow by increasing this capacity, again so no risk assessments are carried out in an acute setting. • Integrated Therapy Offer – Strengthening the integration offer not just with service development but also an upskilling of the workforce to be trusted assessors. This supports people with a more therapy led reablement, addresses the vacancy gap with OTs, gives career development to current staff and directs integrated therapists to customers that will most benefit from their skillsets. The expansion of Home First this will allow an increase in Pathway 1 discharges (to patients' own homes with care support), with accepted referrals responded to within 2 hours, a start date within 24 hours, and integrated assessment on day 1 and start a full assessment period within 48 hours of the start of the package. Expansion of Home First, with the support of the overnight enhanced overnight EIT support and Virtual Ward, allows for a conversion of Pathway 2 patients (discharges into a Community Assessment Bed or similar) into Pathway 1, reducing the reliance on Community (interim) beds and increase the number of patients returning to their own homes and reducing their length of stay (LOS) within acute and community beds. This increases the number of Pathway 1 discharges available daily, and with the support of overnight care, Virtual Ward and wrap around support can convert patients who would of previously in 2022/23 been placed in community beds to Pathway 1.To support the conversion of Pathway 2 patients to Pathway 1, ensuring the right patient is placed within the right discharge pathway, the criteria for CAB and community beds is currently being reviewed and will be finalised prior to the seasonal 23/24 period. **Wrap around support and Transfer of Care Hub (TOCH):** Creating an increase in capacity within the TOCH and wrap around support to help improve patient flow, discharge waiting times for Pathway 1 & 2, reduction in Pathway 2 referrals with assessment capacity, wrap around support for the community beds (specialist support where required) and support for people to stay at home with personal goals set. Increased wrap around capacity will improve productivity through the reduction of duplication across teams, a shared approach to reablement and a clear joined up referral and operational process. Actions will include GP cover incorporated for community bed support, 5 social workers and 2 therapists, promoting flexibility within the teams.

	18 Community Beds including complex beds: although this represents a reduction from the 2022/23 seasonal period of 60 community beds, it is still capacity over and above that funded through business as usual routes. In addition, it will include wrap around support required for beds - therapist, social worker and GP cover. The length of stay (LOS) within the Community beds with increased wrap around of therapy supporting reablement, has a target of reducing LOS within these beds from an average of 28 days to 20 days. Improving patient outcomes, returning to their own homes or another appropriate permanent residence and support maximising flow throughout the beds, increasing the number of transfers of care monthly from the acute hospital (3.6 beds days saved per day). An average of 110 bed days saved per month have been forecast from these three initiatives, monitored through the Suffolk Health and Wellbeing Board.
3.4	<u>In-reach therapy Model</u> A pilot will be run for a 6-month period across a medical and surgical ward, with the concept to help reduce hospital-associated deconditioning and promote a reablement ethos amongst staff and patients. Ward led enablement carried out by experienced reablement support workers, in conjunction with nurses and therapist to reduce deconditioning, LOS and ward falls. The concept is currently being carried out in NEE, who have shown to grow their Pathway 0 & 1 discharges in comparison to Pathway 2, significant improvement in patient discharges within 7 days. North East Essex (NEE) noted during seasonal pressure some wards partaking in the scheme, continued to remain stable in their LOS. <u>Model of Care</u> Learning taken from 2022/23 seasonal period has been reviewed across Health and Social Care within West Suffolk Alliance to form a Model of Care for the 23/24 seasonal period. The above schemes are included, along with a number of workstreams to assess criteria of CAB & Community beds, Integrated Therapies within the acute and Community teams, allowing an integrated therapy led approach to reablement, while protecting therapy capacity. Expansion of the Urgent Community Response from EIT into the community teams, with a target for a 10% increase in activity while remaining to reach the national target of 70% 2-hour response to all referrals. Increase in UCR activity, with the support of Virtual Ward will allow greater admission avoidance, therefore reducing the front door activity. Working to increase the UCR acceptance rate of clinically appropriate referrals from Cleric and the Unscheduled Community Care Hub to support the reduction of front door activity and patients to remain safely in their normal place of residence with wrap around support required. Specialist support to CAB and Community beds to assist with reduction in patient LOS within the beds e.g. diabetes specialist nurse support.
4.	**Next steps**
4.1	Each of the responses to seasonal planning in 2023/24 will have progress against delivery monitored through a specified governance route and have started work on delivery: the Focus on Flow programme through the West Suffolk Change Hub Programme Board and the Better Care Fund through the Suffolk Health & Wellbeing Board. The availability of escalation and surge capacity will be identified through updates from the RAAC programme, with its deployment discussed by the Senior Leadership Team committee. The metrics defined for each workstream will be key determinants of success, as well as headline metrics of bed occupancy, ED 4-hour performance, ED 12-hour length of stay (LOS), ambulance handover times, average inpatient LOS and activity delivery of elective services (including meeting our commitments to reduce long waiting patients). These indicators are monitored both internally

	and within the governance structures of the Suffolk and North East Essex Integrated Care Board, with the ability to link back into any of the three seasonal planning responses if the desired impact is not delivered, or if demand for our services and priorities change.
5.	**Conclusion**
5.1	A robust plan across three key domains has been developed to meet our obligations as set out in national guidance which optimises patient safety and the experience for our patients and staff. Although creating additional bed capacity is identified as an objective, it is not sustainable nor deliverable alone if our obligations and ambitions are to be met. Ensuring we have the right capacity available when we need it, backed up by improved processes across acute, community and social care means we can manage the increase in demand over winter that our modelling demonstrates.
6.	**Recommendations**
6.1	The Board is asked to note the contents of this report and provide feedback on any points raised within it. Executive Directors and the Board are asked to support the plan representing WSFT's response to seasonal pressures in 2023/24.

Elective Backlog Recovery options

Moira Welham in attendance

To Assure

Presented by Nicola Cottington

Board of Directors

Report title:	**Achieving Elective Backlog Clearance- Opportunities and Enablers**
Agenda item:	4.1.1
Date of the meeting:	21st July 2023
Sponsor/executive lead:	Nicola Cottington, chief operating officer
Report prepared by:	Moira Welham, Associate Director of Operations-Surgery and Anaesthetics Input from Simon Taylor, Matt Keeling and Hannah Knights

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 paper provides an overview of current position at trust level, focusing on elective recovery across the division of surgery and women and children. The trust has seen significant waiting list growth, 33,412 patients currently on an incomplete pathway, compared to 19,757 on 29th March 2020. In addition, 13,133 patients have waited over 18 weeks for treatment. The lack of an elective hub at Newmarket has put greater reliance on freeing up operating capacity at the main hospital site and therefore this paper provides an overview of three possible options and their impact on elective recovery. There is clearly a revenue implication for 2 of the 3 options although this is not described within this document as financials continue to be worked through. This paper considers the quality and performance impact of three options: - • Option 1- Continue to deliver a full theatre programme, 54% of activity being bolstered by additional sessions and/or agency staffing. Do not backfill vacated theatres when orthopaedic activity moves to Dame Clare Marx Building (DCMB) and no engagement with Portland Group to support Uro-Gynae backlog clearance- results in approximately 2500 patients over 52 weeks at 31/04/25 • Option 2- Continue to deliver a full theatre programme, 54% of activity being bolstered by additional sessions and/or agency staffing. Backfill vacated sessions following the move of orthopaedic activity to DCMB, using additional sessions and agency staff and engage with Portland Group, insourcing provider to clear 80 procedures within 10 weeks. • Option 3- Only deliver elective programme in line with substantive staff availability and do not engage with agency or additional sessional spend. Do not backfill vacated lists following the movement of orthopaedic activity to DCMB and do not use any insourcing solutions.

Action required/ recommendation:	It is requested that Board approve an approach, recognising further work needs to take place regarding the affordability of each option and likely income generation, as a result of increased activity, to approve: - • Option 2, enabling the divisions to fully utilise the space vacated by the lift and shift of 60% of orthopaedic activity, maximising opportunities by migrating a specific case mix to the Dame Clare Marx Centre (DCMB), as detailed in section 2.1 of this paper. • The proposed orthopaedic case mix for migration to DCMB, using the rationale contained within this document to make an informed decision. • Robust ringfencing of the surgical bed base, allowing for the creation of a "hub in a hospital". It is suggested outlying medical patients to surgical wards should be discouraged, recognising outlying increases length of stay.

Previously considered by:	**N/A**
Risk and assurance:	Monitoring of RTT performance
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 mandated performance targets and NHS constitution

Achieving elective backlog clearance-Opportunities and enablers

1. Introduction

1.1 **What is elective recovery**

There is recognition both locally and nationally that the COVID-19 global pandemic has had a massive impact on the NHS and in particular the elective programme. In October 2019, 162,888 people in England had waited more than a year for a non-urgent planned procedure, this being 123 times more than indicated in 2019.[1]

Although the local picture continues to improve in line with NHSE directive, the trust delivering against its 78 week trajectory and achieving against current 65 week trajectory; 52 week backlog clearance represents a significant challenge, the 52 week backlog expected to be approximately 20% larger than the current 65 week cohort.

Short term elective recovery objectives

In the short term it is suggested WSFT should aim to align with NHSE directives, as set out in the 2023/24 planning priorities namely to: -

- Clear 65 week backlog by 31st March 2024, the trust has submitted a trajectory, expecting 87 Uro-gynae patients remaining at year end.
- Deliver 107% of 2019/20 planned elective activity
- Continue to reduce the number of patients over 62 days on a suspected cancer pathway
- 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
- Clear 52 week backlog by 31st March 2025
- Deliver 130% of 2019/20 activity by March 2025

Long term elective recovery objectives

In the longer term it is suggested the Trust should aspire to attainment of 18 week RTT, recognising several surgical specialties were not RTT compliant prior to the pandemic as detailed below.

Waiting List and RTT Compliance- February 2020 compared to July 2023

Specialty	Waiting list size February 2020	Waiting list size 2nd July 2023	RTT attainment against 92% February 2020	RTT attainment against 92% 2nd July 2023
General Surgery	3261	3491	75.2%	64.39%
Urology	1149	1603	84.9%	52.53%
Trauma & Orthopaedics	2787	4727	66.5%	48.83%
Ear, Nose & Throat (ENT)	1842	3070	84.7%	61.14%
Ophthalmology	2093	2121	63.8%	69.07%
Plastic Surgery	336	769	82.1%	46.55%
Gynaecology	2109	2388	73.6%	62.94%

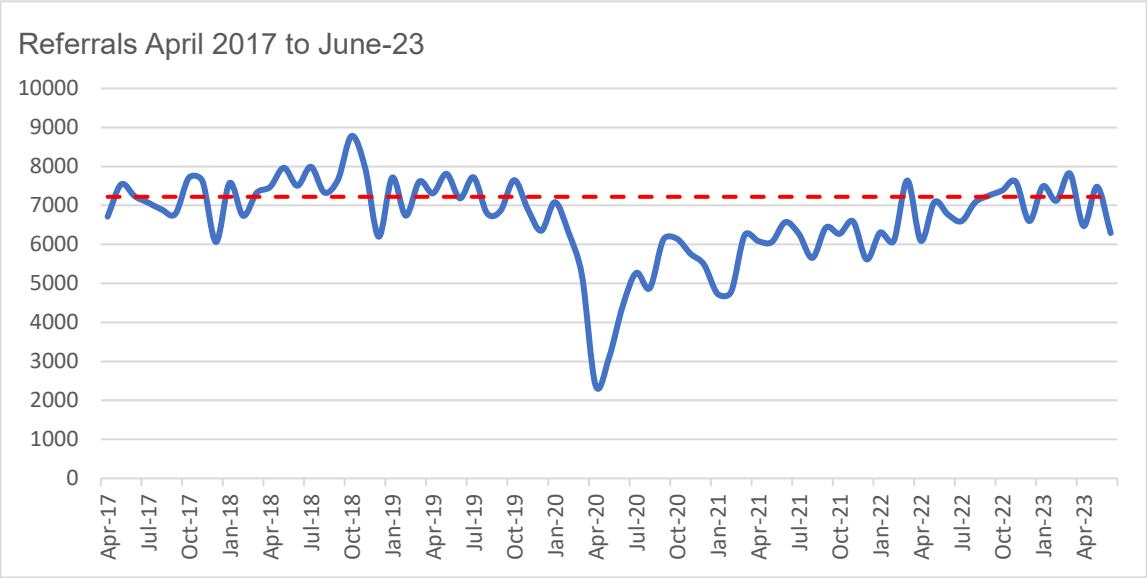
[1] Campbell,D. (2020). Covid's 'devastating impact' on NHS services. *The Guardian*. [Online]. 10 December 2020. Available at https://www.theguardian.com/society/2020/dec/10/covids-devastating-impact-on-nhs-services-exposed-by-latest-figures [Accessed 10 July 2023]

The above highlights significant waiting list increase in all but one of the surgical specialties; Ophthalmology managing to maintain a service as they are not affected by bed capacity issues and are not required to support other divisions during periods of industrial action.

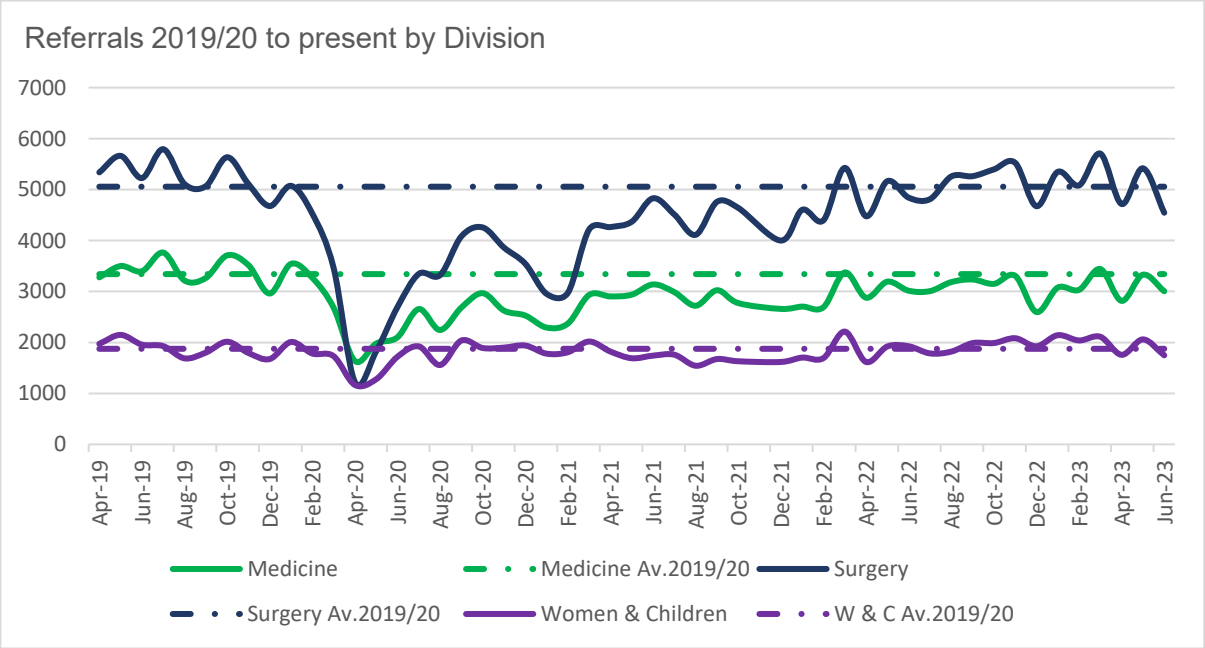
Recognising elective and emergency activity is intrinsically linked it is imperative we consider the local picture when considering options to support elective recovery.

1.2. **The Local Picture**

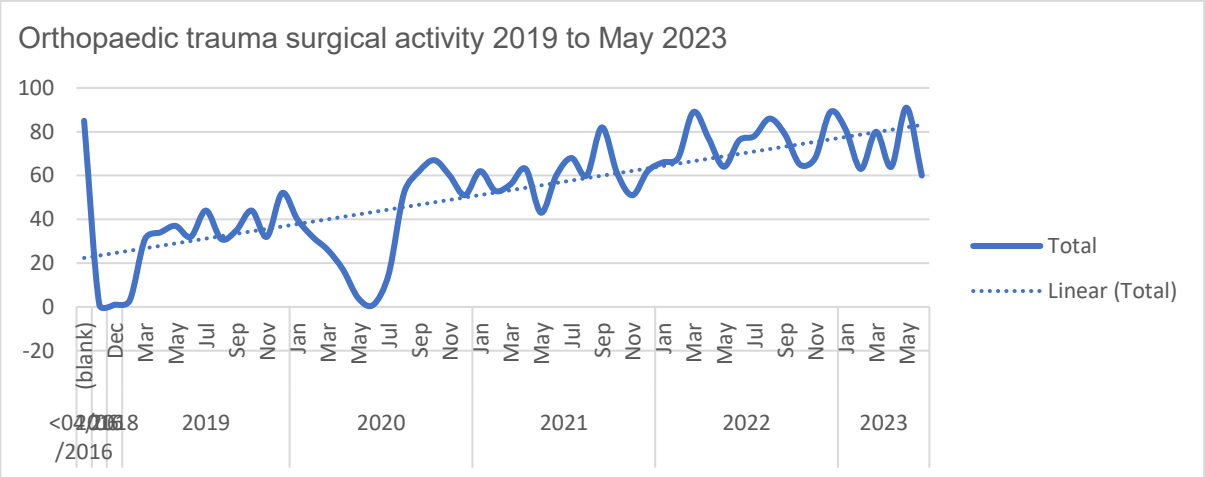
The below highlights referrals into Surgery and Women and Children from April 2017 to present. This illustrates that referrals are often fluctuating above the 2019 average (red line).



Largest referral growth has occurred in surgery, Medicine referrals primarily remaining under 2019/20 average: -



As wait times increased some patients have become deconditioned and conditions have deteriorated, as a result we have seen an increase in emergency admissions and in particular demand for emergency orthopaedic intervention; people who have been housebound during the pandemic venturing from their homes, resulting in an increase in falls: -



The trust consistently achieves the best practice tariff by delivering surgery to a patient with a fractured neck of femur, within 36 hours of admission, there being recognition that outcomes deteriorate beyond this point and therefore during times of excessive demand elective lists are stood down to support these clinically urgent surgeries.

The demand for emergency surgery procedures has also increased, the trust delivering 1962 emergency surgeries in 2019 (excluding orthopaedics) and 2433 in 2022, an increase of 20%.

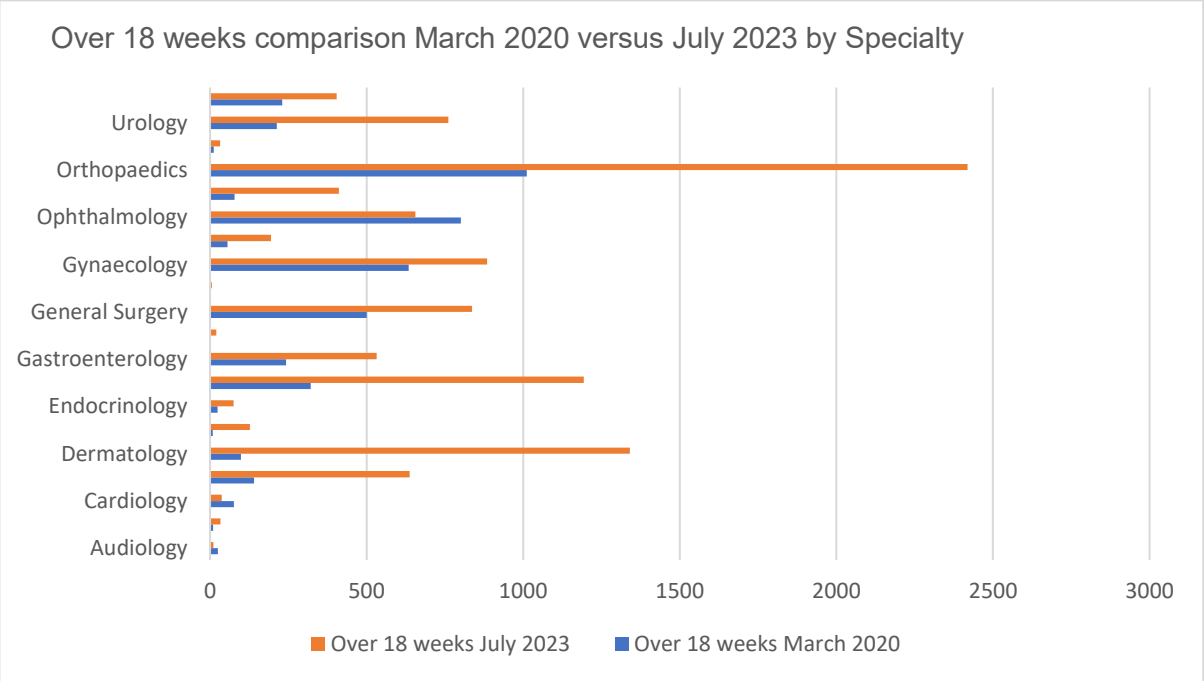
Referral to Treatment/Waiting list current position

1.3. As detailed earlier in this paper the trust has seen significant waiting list growth, currently 33,412 patients are on an incomplete pathway, compared to 19,757 on 29th March 2020. In addition, there are currently 13,133 patients who have waited over 18 weeks for treatment.

Based on the Trust's current activity trajectory and ongoing demand increase it is not possible to reduce the waiting list size to pre pandemic levels and therefore the initiatives articulated within this paper, outpatient transformation and strategic level prioritisation of the elective programme are vital components to support this aspiration.

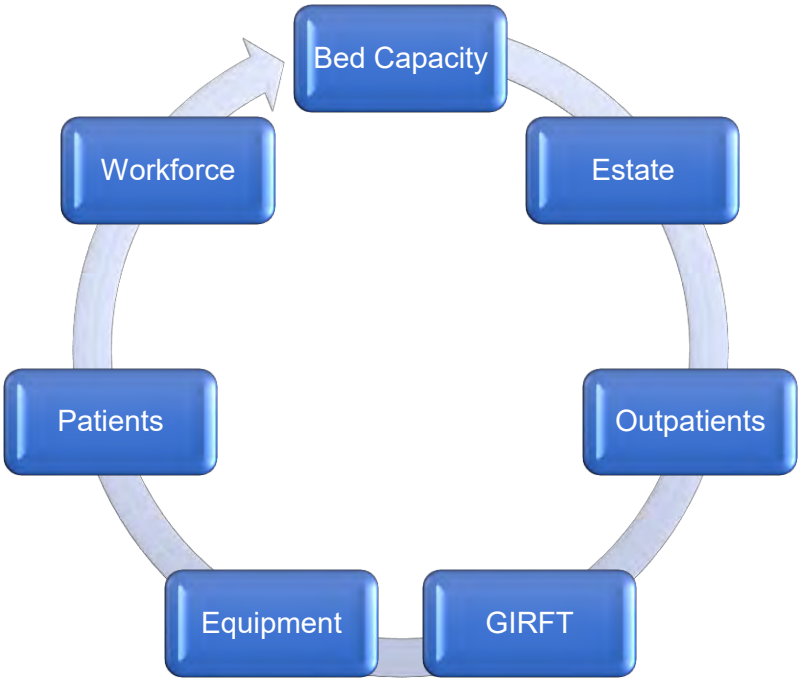
Although waiting list size is an important metric, the NHSE planning guidance has in successive years post-pandemic made it clear that reducing long waits on elective pathways have been the priority, as well as FDS and reducing long waiters on a cancer pathway.

The below highlights 18 week plus growth following the COVID-19 pandemic. Those specialties who have seen the greatest increase were already facing a challenged position prior to its onset.



1.4. **Enablers to Elective Recovery**

There are multiple enablers that support elective recovery as detailed below: -



Bed Capacity- aligning capacity with demand

Bed modelling undertaken by the Trust's informatics team has highlighted that surgery and gynaecology require 54 beds to support the delivery of 130% of 2019/20 elective activity, 32% of day case activity being undertaken in main theatres due to insufficient day surgery capacity and in some cases, patient comorbidities.

Orthopaedics currently has a 33 bedded elective ward which exceeds orthopaedic demand. This results in beds being empty as orthopaedic procedures, as per GIRFT and British Orthopaedic Association guidance should not be mixed with generic surgical procedures, in particular bowel and abdominal wall surgeries due to increased risk of infection.

The below highlights the number of beds required by modality and current deficit/surplus: -

	Inpatient	day-case	Total required	Current capacity	
Orthopaedics	21	2	23	33	10
Gynaecology	7	2	9	6	-3
Others	16	6	22	12	-10

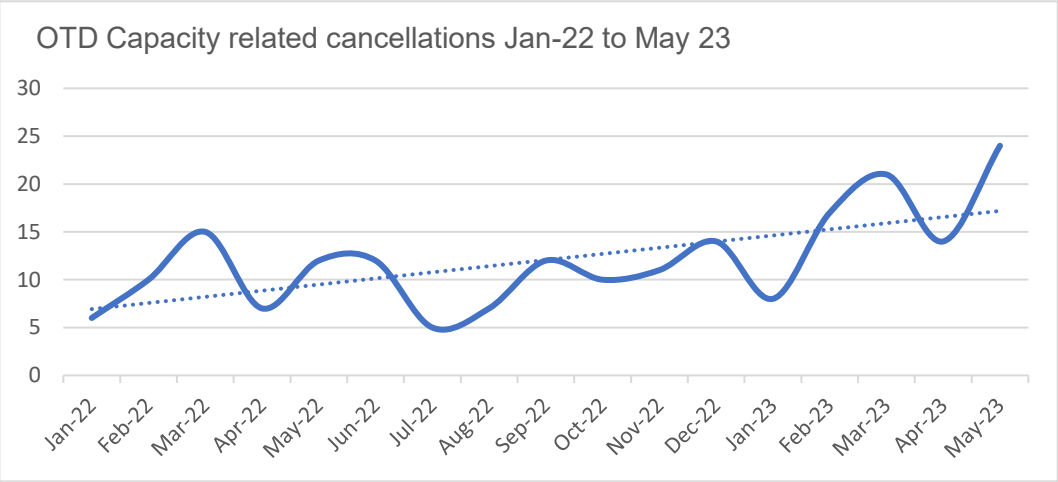
This indicates a 10 bed elective surplus for orthopaedics and a 13 bed deficit across Gynaecology and other surgeries.

The Division has obtained approval to build a temporary wall at the end of F4 in October 2023 as this will enable the movement of surgical SDEC into this space, creating 6 generic surgical beds on F5, the impact detailed below: -

	Inpatient	day-case	Total required	Expected capacity	
Orthopaedics	21	2	23	23	0
Gynaecology	7	2	9	8	-1
Others	16	6	22	20	-2

Breast procedures will continue to use F4. The costs associated with the building of the wall will be absorbed within the RAAC programme.

Bed capacity- balancing emergency and elective flow



On the day (OTD) capacity related cancellations, i.e., those where no bed was available or where the surgeon ran out of list time due to capacity instigated late starts have increased by 68% in the first five months of 2023 compared to the same time in 2022. There are often medical outliers within the elective surgical bed base and an increase in emergency surgical patients has further eroded elective capacity.

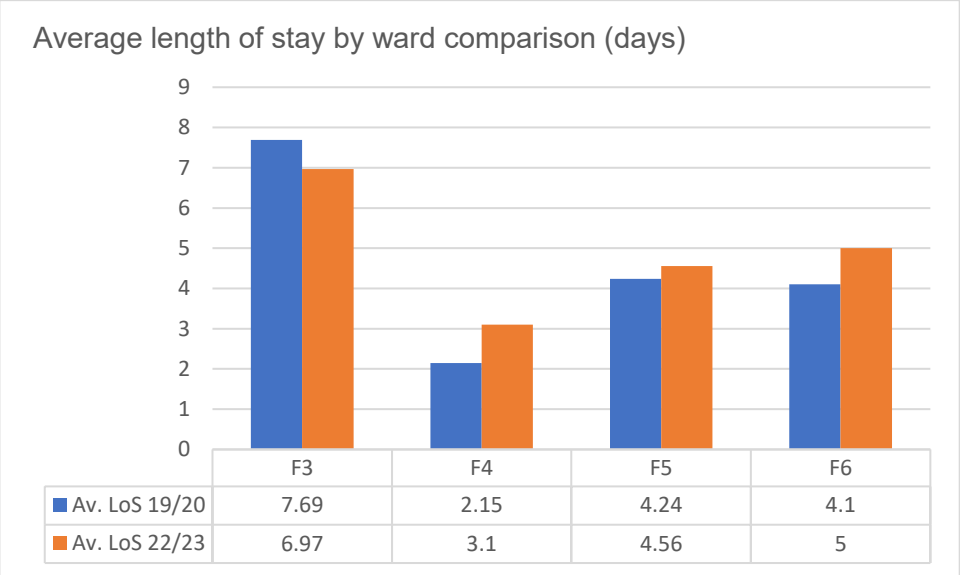
- The creation of a Day Surgery Admissions Unit (DOSA) is cited within the division's element of the trust's Clinical and Care Strategy; this represents a major enabler to attainment of RTT performance metrics and sustained elective recovery. BMC Health Services research (2010) indicating that: -

  " *The efficient and effective management of inpatient beds is essential for the benefit of both patients and the hospital. This means that patients are admitted promptly to an appropriate bed and stay for no longer than is necessary.*

  With the results that were reached with the surgery admission unit we have assessed a significant improvement in bed utilisation efficiency. Due to the shorter length of stay that was achieved we can say that our results could be associated with a decrease in overall costs to the hospital".[2]

[2] Ortega, B et al. (2010). Effectiveness of a Surgery Admission Unit for patients undergoing major elective surgery. *BMC Health Services Research*. 10(23), pp.1472-6963.

As a result of deconditioning and immobility during the pandemic the trust has seen an increased length of stay and therefore beds are full for longer, further impacting on patient flow. This is also indicative of increased medical outliers.



	F3	F4	F5	F6
Av. LoS 19/20	7.69	2.15	4.24	4.1
Av. LoS 22/23	6.97	3.1	4.56	5

With the exception of F3 average length of stay has increased which further impacts on bed capacity.

There are several days where patients do not have beds upon arrival and therefore patient experience is poor. Where possible the discharge waiting area is used to start a patient, to a maximum of 4.

Estate

There is recognition that WSFT has the fewest number of beds per 1,000 population in the region at 1.6 beds, ESNEFT 1.98. The trust has an aging theatre infrastructure which increases the risk of estate related cancellations. Most notably there have been consistent issues with the cooling system that supports the three orthopaedic theatres, this resulting in patient cancellation where temperatures exceed 24 degrees Celsius. Extreme precipitation has resulted in water seeping through the ceiling in the main theatre block. The estates team are responsive to these issues but can only offer a repair.

There are currently 98 consultant surgeons who work within surgery and gynaecology. Most surgeons have between 2 and 3 theatre lists per week within their job plan. If we assume each undertakes a minimum of one full day operating per week, 42 weeks per year this would equate to 8,232 theatre sessions per annum, the trust's estate currently provides 4,680, a deficit of 3,552 lists per annum. This results in reduced operating time per surgeon and is sometimes cited as explanation for failed recruitment.

Workforce

Recruitment within theatres is a national problem, WSFT theatre and anaesthetic staffing remaining a constant challenge. Within the day surgery unit there are currently 6.27 WTE nurse vacancies and 11.45 WTE vacancies within main theatres. There are also 5.69 anaesthetic consultant vacancies. These staffing deficits result is greater reliance on high cost staffing solutions including agency staff, additional sessions, and insourcing/outsourcing.
The team continues to explore recruitment options, recently using the PageTiger methodology to encourage engagement with the trust. We also have three anaesthetic ODP apprentices starting in September and have recruited two overseas anaesthetic technology students. These initiatives will support long term service sustainability but will not provide immediate resolution to ongoing resource deficit.

Theatre practitioner - Theatre-practitioner (pagetiger.com)

Approximately 2.81 WTE of anaesthetic consultant support is delivered via additional sessional spend. The trust currently engaged with ID Medical to support anaesthetic staffing shortfall.

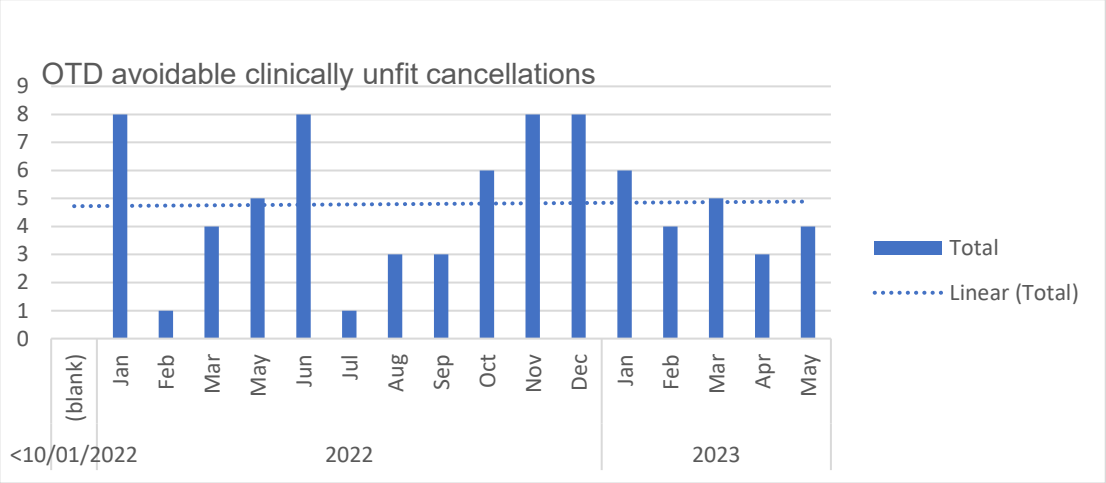
Equipment

Since Britain's departure from the European Union and the subsequent COVID-19 pandemic there have been equipment shortages across several modalities, most notably Stryker implants. Many consumables have also been affected, NHS Supply Chain often sending an alternative which proves to be inadequate, the trust recently receiving extra-long theatre gowns, these representing a trip hazard.

Radiology staffing and equipment is limited and therefore possible c-arm clashes are identified at the weekly theatre scheduling meeting and lists are ordered to mitigate this risk. It is testament to the team that only 2% (n=16) of cancellations occur due to equipment issues.

Patients

26% of on the day cancellations occur due to patient unfitness. Whilst some of this is unavoidable 8% of those who attend on the day present with cold/flu symptoms or diagnosed urinary tract infection. It is suggested the desperation associated with delayed treatment is resulting in patients attending for surgery on the day when they are obviously unwell.



The division is currently exploring the utilisation of an automated system that will check in with the peri-operative patient at 14 days and again at 3 days prior to admission to identify any issues that could prevent surgery, this allowing for backfill.

Outpatients

The primary focus of this paper is elective theatre activity as those who have waited the longest and sit within the 65/52 week cohorts are primarily on an admitted pathway. However, it is worthy of note that attainment of the 18 week referral to treatment (RTT) target is driven by the ability to see and assess a patient by 6 weeks into their pathway.

To ensure we align with the NHSE directive to clear our 65 week backlog, operating is being prioritised over routine outpatient activity and we do not currently have adequate outpatient capacity to meet the growing demand.

The divisions are applying the principles of demand management including utilisation of patient instigated follow up, revised pre-referral guidance and robust validation and application of the ICB level patient access policy to ensure the patient tracking list (PTL) can be managed and any clinical risks due to extended wait times are identified through the validation process. This supported by the 18 week team.

The current polling times, i.e., number of weeks to first appointment are detailed below: -

- Gynaecology routine- 35 weeks
- Colorectal routine- 25 weeks
- ENT routine – 20 weeks
- General Surgery routine- 14 weeks
- Upper GI routine- 14 weeks
- Orthopaedics- 45 weeks for subspecialties

demand-mgnt-good-practice-guid.pdf (england.nhs.uk)

GIRFT

The Get it Right First Time initiative has a wealth of resources which support the objectives to deliver 85% capped theatre utilisation and 85% BADS procedures as day-case. As a trust we are currently at 80.4% for day case rates and 70.6% for capped utilisation. Deterioration is driven by increased capacity related and clinically unfit cancellations. Work continues to create sustained improvement, including: -

- Instatement of a theatre task and finish group
- Late starts/early finish dashboard
- Consultant attendance at theatre scheduling meeting
- Fortnightly retrospective review of performance
- Creation of automated system for peri-operative check-in.

In addition, the high volume, low complexity cases per list benchmarking enables the trust to identify opportunities to make efficiency gains, aiming for 10% in this financial year. As an integrated care system WSFT has been working with ESNEFT to identify and respond to shared learning and exemplary practice.

The Model Health system provides national and regional benchmarking, the trust engaging with trusts who are consistently delivering against mandated metrics.

2. Options Appraisal

The absence of an elective centre at Newmarket has resulted in an ongoing deficit in capacity as detailed earlier in this document. However, WSFT's engagement with the Dame Clare Marx elective orthopaedic centre (DCMB) represents an opportunity to explore how the vacated space is utilised, recognising the revenue costs attached to this. The movement of 60% of orthopaedic activity to the centre creates a major enabler to sustained elective recovery, providing much needed capacity for those specialties who remain at the main hospital site.

2.1. DCMB capacity release

When deciding which orthopaedic procedures should migrate to the DCMB the division has considered what capacity is required at the main hospital as well as the impact this migration has on the ward, our staff and emergency pathways.

Initially the intention was to replicate the model that ESNEFT has employed, i.e., send all orthopaedic inpatient procedures to DCMB, however this has been discounted for the below reasons: -

- An inability to convert elective activity to trauma should demand dictate, resulting in delay to surgery, poor patient outcomes and inability to meet best practice tariff
- Currently 32% of day case activity is delivered in main theatres, releasing more day case capacity would enable the trust to move more activity into the day surgery unit and reduce risk of on the day cancellations, this would enable greater alignment with the national Right Procedure, Right Place initiative, sending all inpatient activity only released 22 day case lists per annum.
- Maintenance of bed base to enable the repatriation of complex patients from the hub. Although it happens rarely it is important there are options for a deteriorating patient, ESNEFT will be removing all orthopaedic inpatient elective capacity from their estate and therefore should WSFT lose their Orthopaedic bed base there would be no orthopaedic inpatient capacity across the system
- Adopting this approach requires an orthopaedic bed-base of 12 beds, creating a 12 bed surplus and therefore this releases income generation opportunities, such as the repatriation of private practice or previously outsourced activity.
- The trust would be able to generate £190K per annum of income by providing Cambridge and Peterborough NHS Trust with an additional Community Dental list which, in turn would reduce existing health inequalities, this being prevalent within this patient cohort.

Procedures to send to the hub		Main theatre release	Day surgery release
Maximum hub capacity	1464		
Send all HVLC	951	435	22
Surplus/deficit	513		
Send daycase	513		257
Surplus/deficit	0		

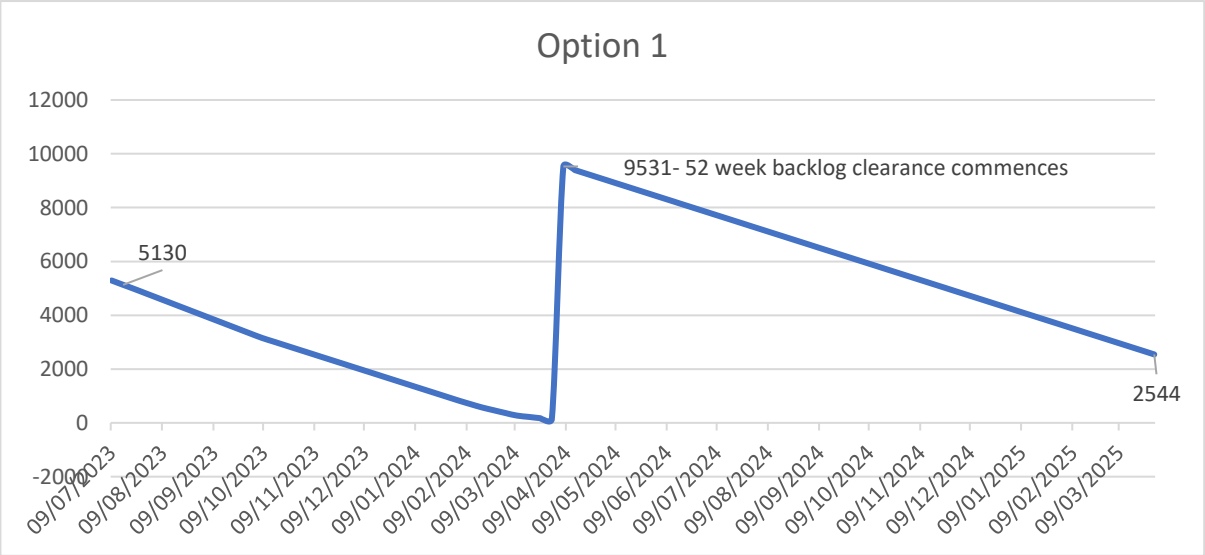
The above illustrates that a total of 435 main theatre lists and 279 DSU lists will be released through the partial migration of orthopaedic surgery

The below options consider the current financial landscape.

Option 1- Continue to deliver a full theatre programme, 54% of activity being bolstered by additional sessions and/or agency staffing. Do not backfill vacated theatres when orthopaedic activity moves to DCMB and no engagement with Portland Group to support Uro-Gynae backlog clearance- results in approximately 2500 patients over 52 weeks at 31/03/25

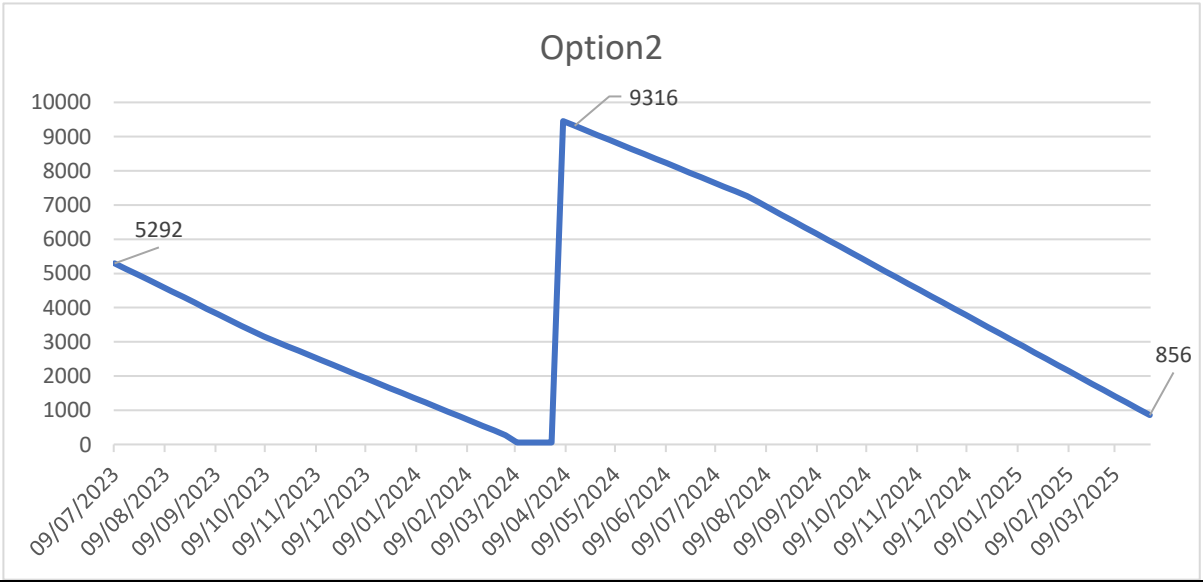
In 2022/23 the trust spent IRO £ 5,231,812 on a combination of additional sessions and agency staffing to support the elective programme. Between April-June 2023 the trust spent £1,046,934, overall expenditure remaining consistent.

Although this option supports 65 week clearance, it does not provide enough capacity to support 52 week clearance, this expected to be 20% larger than current backlog numbers.

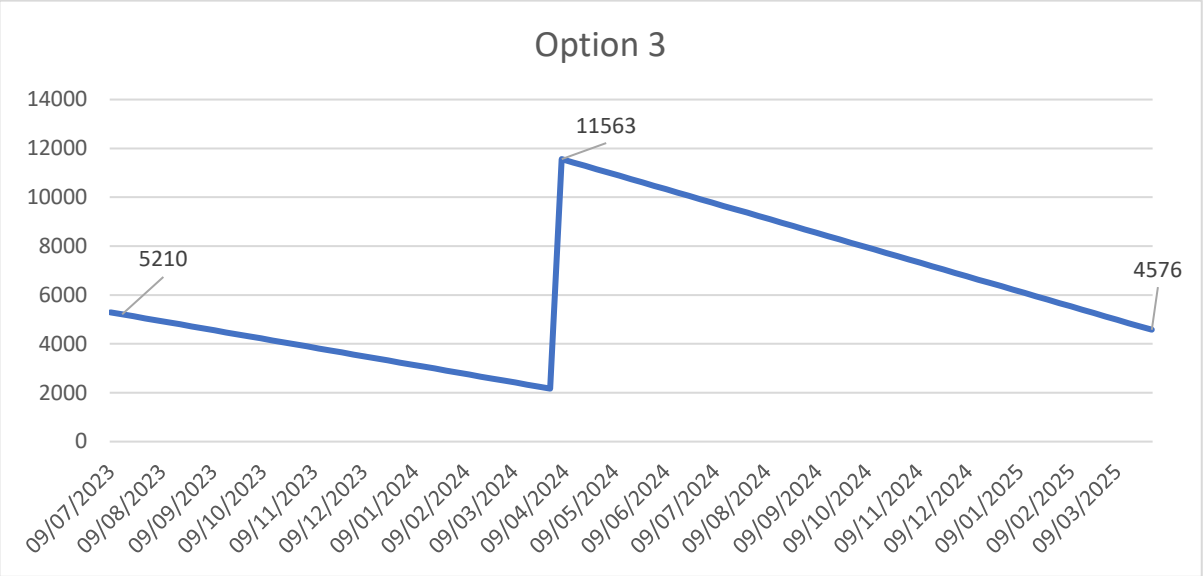


Uro-gynae will have 83 patients over 78 weeks at 31/03/24 if engagement with the Portland Group does not go ahead.

Option 2- Continue to deliver a full theatre programme, 54% of activity being bolstered by additional sessions and/or agency staffing. Backfill vacated sessions following the move of orthopaedic activity to DCMB, using additional sessions and agency staff and engage with Portland Group, insourcing provider to clear 80 Uro-gynae procedures over 10 weeks. Results in approximately 856 patients over 52 weeks at 31/03/25, this equating to a possible end of year zero position, assuming robust validation and 10% efficiency gains would be made.



Option 3- Only deliver elective programme in line with substantive staff availability and do not engage with agency or additional sessional spend. Do not backfill vacated lists following the movement of orthopaedic activity to DCMB and do not use any insourcing solutions. This results in 4576 patients being over 52 weeks at 31/03/25



This represents a significant clinical and reputational risk.

Risks and Benefits

Option	Backlog @ 31/03/25	Risks	Benefits
Option 1- Continue to deliver a full theatre programme, 54% of activity being bolstered by additional sessions and/or agency staffing. Do not backfill vacated theatres when orthopaedic activity moves to DCMB and no engagement with Portland Group to support Uro-Gynae backlog clearance- results in approximately 2500 patients over 52 weeks at 31/04/25	**2544**	• Does not support 52 week clearance • Further patient delays for treatment • Reputational Harm **Uro-gynae will have 83, 78 week patients at 31/03/24 if insourcing is not supported.**	• Supports 65 week clearance • Enables delivery of BAU activity
Option 2- Continue to deliver a full theatre programme, 54% of activity being bolstered by additional sessions and/or agency staffing. Backfill vacated sessions following the move of orthopaedic activity to DCMB, using additional sessions and agency staff and engage with Portland Group, insourcing provider to clear 80 Uro-gynae procedures across 10 weeks.	**856**	• Does not support total 52 week clearance • Further patient delays for treatment • Reputational Harm • High cost solution, revenue costs and likely income to be determined.	• Deficit to 52 week clearance could be absorbed by further efficiency gains • Reduces possible harm to patients • Reduces Uro-gynae backlog to 56 over 65 weeks at 31/03/24 and clear 78 week Uro-gynae. • Better aligns with job planned activity by bridging capacity deficit

				and will support job satisfaction.
	Option 3- Only deliver elective programme in line with substantive staff availability and do not engage with agency or additional sessional spend. Do not backfill vacated lists following the movement of orthopaedic activity to DCMB and do not use any insourcing solutions.	**4576**	• Does not support 65 or 52 week clearance • Extended waits for treatment •Reputational Harm • Possibility already received ERF would be recouped by ICB • Medical and Operational staff could leave due to lack of activity and job satisfaction. • Patient harm and increased throughput via emergency pathways of patients on a planned waiting list.	• Significantly reduces spend

4. Conclusion

This paper has articulated the clear benefits of continuing to engage with high cost solutions to ensure maintenance of the elective programme and whilst there is no funding associated with increased activity at this time there may be opportunities to secure additional income due to a reduction in the elective recovery funding activity threshold; further work is required to model the expected financial gain associated with this.

There is a balance between financial stability and elective recovery, each option creating consequences in terms of reputational and/or clinical or financial harm and therefore careful consideration is required.

An unforeseen risk of reducing surgical activity to align with the financial landscape would be the possible loss of surgical staffing, recognising current estate does not provide sufficient capacity to align with consultant job plans.

There is also a risk that a loss of staffing would result in even greater reliance on agency and additional sessional spend.

5. Recommendation

It is requested that Executive and Board consider the options as detailed above, recognising the financial, social and wellbeing implications of each option. Delaying treatment further may result in additional burden to the wider healthcare landscape, in particular emergency demand as those waiting for planned surgery deteriorate and enter the hospital via an UEC pathway.

The preferred option is option 2, continue to deliver a full theatre programme, 54% of activity being bolstered by additional sessions and/or agency staffing. Backfill vacated sessions following the move of orthopaedic activity to DCMB, using additional sessions and agency staff and engage with Portland Group, insourcing provider to clear 80 Uro-gynaecology procedures within 10 weeks as this represents the best opportunity for the trust to clear it's 52 week surgical backlog across surgery and gynaecology.

	It is requested that Board approve an approach, recognising further work needs to take place regarding the affordability of each option and likely income generation, as a result of increased activity, to approve: - • Option 2, enabling the divisions to fully utilise the space vacated by the lift and shift of 60% of orthopaedic activity, maximising opportunities by migrating a specific case mix to the Dame Clare Marx Centre (DCMB), as detailed in section 2.1 of this paper. • The proposed orthopaedic case mix for migration to DCMB, using the rationale contained within this document to make an informed decision. • Robust ringfencing of the surgical bed base, allowing for the creation of a “hub in a hospital”. It is suggested outlying medical patients to surgical wards should be discouraged, recognising outlying increases length of stay.

4.2. Finance Report

To Assure

Presented by Jeremy Over

Board of Directors – 21st July 2023

Report title:	Finance Board Report – June 2023
Agenda item:	4.2
Executive lead:	Craig Black, Executive Director of Resources
Report prepared by:	Nick Macdonald, Deputy Director of Finance

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

Trust strategy			
Please indicate ambitions relevant to this report	☐	☐	☒

Executive summary

Income and Expenditure and forecast for 2023-24
Our reported position as at the end of June was a deficit of £3.5m against a planned deficit of £1.4m. This has resulted in an adverse variance of £2.1m.

A straight-line extrapolation after adjusting for non-recurring factors could suggest a forecast as high as £17m deficit at March 2024 if no action is taken. In order to improve our financial position we believe that the two most significant areas of focus should be on staffing costs and on delivering our CIP programme.

Plan for 2024-25
Depending on the extent to which we improve our trajectory in 2023-24, the deficit for 2024-25 could be as high as £30m (before any 2024-25 CIP).

Financial Recovery Plan
This paper outlines our process for improving our financial position including setting up a Financial Recovery Group

Action required of the Board

The Board is asked to review this report.

Recommendation

Sustainability:	The paper highlights potential risks to financial performance in 23/24.

FINANCE REPORT
June 2023 (Month 3)

Executive Sponsor : Craig Black, Director of Resources
Author : Nick Macdonald, Deputy Director of Finance

Executive Summary

This report focusses on the YTD adverse variance and the actions required in order to meet our planned deficit (£2.7m) by 31st March 2024, as well as improve our trajectory for 24-25 when we will no longer benefit from non-recurring support (£15m).

- The reported I&E for June is an adverse variance of £1.1m
- The YTD position is an adverse variance of £2.1m which is due to:
  - Underachieved CIP £1.0m
  - Unfunded pay awards £0.4m
  - Unfunded escalation ward (now closed) £0.4m
  - Unfunded industrial action £0.3m
- The plan includes a CIP of £10.6m
  - YTD plan c £1.5m, achieved c £0.5m
- The 23-24 plan is for the Trust to report a deficit of £2.7m
  - Includes the benefit of £15m non-recurring support
  - We should consider whether to review our forecast against this plan and will bring back a proposal to the next Board meeting
- We have already closed the escalation ward and restricted agency nursing to ED, Theatres and the Virtual Ward

Key Risks in 2023-24

- Delivering challenging CIP
- Shortfall on funding of pay awards and non-pay inflation
- Unanticipated costs of industrial action.
- ERF income that may be clawed back for under performance

Financial Summary

SUMMARY INCOME AND EXPENDITURE ACCOUNT - June 2023	June 2023			Year to date			Year end forecast		
	Budget	Actual	Variance F/(A)	Budget	Actual	Variance F/(A)	Budget	Actual	Variance F/(A)
	£m	£m	£m	£m	£m	£m	£m	£m	£m
NHS Contract Income	28.8	28.9	0.1	84.6	84.9	0.3	334.2	334.2	0.0
Other Income	2.8	2.6	(0.2)	7.9	8.0	0.2	34.1	34.1	0.0
Total Income	**31.6**	**31.5**	**(0.1)**	**92.4**	**92.9**	**0.5**	**368.3**	**368.3**	**0.0**
Pay Costs	21.2	21.4	(0.2)	62.4	63.4	(1.0)	250.6	250.6	0.0
Non-pay Costs	9.7	10.4	(0.7)	26.9	28.6	(1.7)	102.0	102.0	0.0
Operating Expenditure	**30.8**	**31.8**	**(1.0)**	**89.3**	**92.0**	**(2.7)**	**352.7**	**352.7**	**0.0**
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
EBITDA	**0.8**	**(0.3)**	**(1.1)**	**3.1**	**0.9**	**(2.2)**	**15.6**	**15.6**	**0.0**
Depreciation	1.0	0.9	0.0	2.9	2.8	0.0	11.4	11.4	0.0
Finance costs	0.6	0.6	(0.0)	1.7	1.7	0.1	6.8	6.8	0.0
SURPLUS/(DEFICIT)	**(0.8)**	**(1.9)**	**(1.1)**	**(1.4)**	**(3.6)**	**(2.1)**	**(2.7)**	**(2.7)**	**0.0**

I&E Position YTD	£3.6m	adverse
Variance against Plan YTD	£2.1m	adverse
Movement in month against plan	£1.1m	adverse
EBITDA position YTD	£0.9m	favourable
EBITDA margin YTD	1%	favourable
Cash at bank	£5m	

Contents:

Key:

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

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

FINANCE REPORT – June 2023

Income and Expenditure Summary - June 2023

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)	(751)	(1,864)	(1,113)	↓	Red
YTD surplus/ (deficit)	(1,411)	(3,563)	(2,152)	↓	Red
EBITDA YTD	3,146	937	(2,208)	↓	Red
EBITDA %	3.4%	1.0%	(2.4%)	↓	Red
Clinical Income YTD	(85,522)	(86,045)	522	↑	Green
Non-Clinical Income YTD	(6,904)	(6,902)	(3)	↔	Amber
Pay YTD	62,075	63,447	(1,372)	↓	Red
Non-Pay YTD	31,773	33,065	(1,292)	↓	Red
CIP Target YTD	1,500	519	(981)	↓	Red

Income and Expenditure Plan for 2023-24

The Income and Expenditure (I&E) budget is for the Trust to record a deficit of £2.7m in 2023-24, which includes achieving Cost Improvements (CIP) of 3% (£10.6m)

Our reported position as at the end of June was a deficit of £3.5m against a planned deficit of £1.4m. This has resulted in an adverse variance of £2.1m. The most significant causes of this adverse variance are:

- Underachieved CIP £1.0m
- Unfunded pay awards £0.4m
- Unfunded escalation ward (now closed) £0.4m
- Unfunded industrial action £0.3m

Forecast 2023-24

A straight-line extrapolation after adjusting for non-recurring factors could suggest a forecast as high as £17m deficit at March 2024 if no action is taken. However, if more optimistic assumptions are used, including improved delivery of CIP and the possibility of earning ERF (Elective Recovery Fund), the forecast deficit could reduce to below £5m. Note these forecasts include the unfunded pay awards and industrial action at around £3m.

The table below outlines the risks and possible mitigations

		£'000
Planned deficit		2,700
Risks		
CIP failure	Recover Q1 shortfall	-
	Continue Q1 shortfall	4,000
	Continue Q1 delivery	4,600
		8,600
Industrial action		1,200
Unfunded pay awards		1,700
Possible pressures later in year		3,000
Total maximum		17,200
Mitigations		
Possible ERF		- 4,000
Possible improvement on worse case		13,200

The baseline and the baseline adjustments in relation to the opportunities and risks associated with ERF haven't yet been confirmed and therefore our position doesn't yet include any adjustment for ERF. However, the table provides a summary of our current ERF position.

	Apr-23	May-23	Total 23-24
Baseline - 19-20 (to be confirmed)	4,431,178	5,023,227	63,247,185
Baseline Adjustment (to be confirmed)	- 155,264	- 181,996	- 2,868,602
Baseline Total (to be confirmed)	4,275,914	4,841,231	60,378,583
Target 108.75%	4,650,056	5,264,839	65,661,709
Actual 23-24	4,640,707	5,404,132	
Actual %	108.53%	111.63%	

In order to improve our financial position we believe that the two most significant areas of focus should be on staffing costs (especially temporary expenditure) and on delivering our CIP programme. More detailed analysis of these two areas is provided below (page 4 and page 7).

In order to revise our forecast we need Board approval. We would then take this to the ICB and then onwards to the Region.

This paper outlines our process for improving our financial position including setting up a Financial Recovery Group (page 8)

Plan for 2024-25

It should also be noted that, depending on the extent to which we improve our trajectory in 2023-24, the deficit for 2024-25 could be as high as £30m (before any 2024-25 CIP). This is largely as a result of losing £15m of non-recurring support and any shortfall in recurrent CIPs which are included within the 2023-24 plan and forecasts.

FINANCE REPORT – June 2023

Trends and Analysis

The following charts demonstrate the movement in WTEs and Expenditure in Medical and Nursing staffing against the 19-20 baseline. They highlight there are opportunities to improve our rate of expenditure if we focus initially on reducing temporary staff costs.

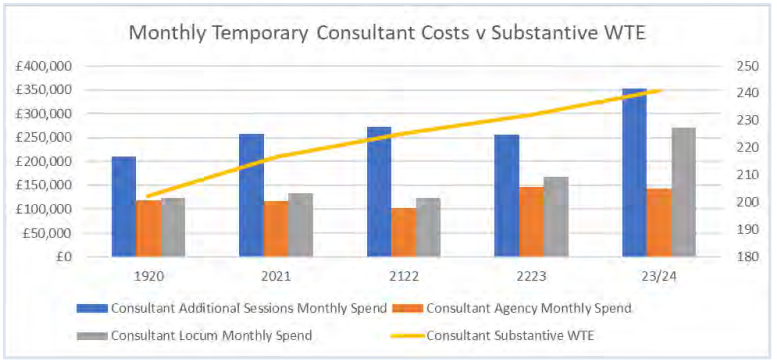
Consultant WTE Analysis

The charts below explain the movements seen in Consultant WTE between 2019/20 and 2023/24 and are based upon the average monthly WTE seen.

Consultant WTE has increased each year since 2019/20. 23/24 level have increased by 39 (17.2%) since 19/20.

The most significant areas of increase by volume T&O, General Surgery and Obstetrics, but with increases seen across a range of specialties.

Increases in substantive medical staff has not seen been offset by decreases in temporary staffing costs. Additional sessions are still higher than 19/20 despite a 19% increase in substantive WTE.



Reducing consultant additional sessions by 50% to reflect the increases in substantive staff could save £1.42m annually, or £0.95m for the remaining 8 months of the 23/24. Reducing by 75% would save £2.23m annually.

There are several areas of further investigation:

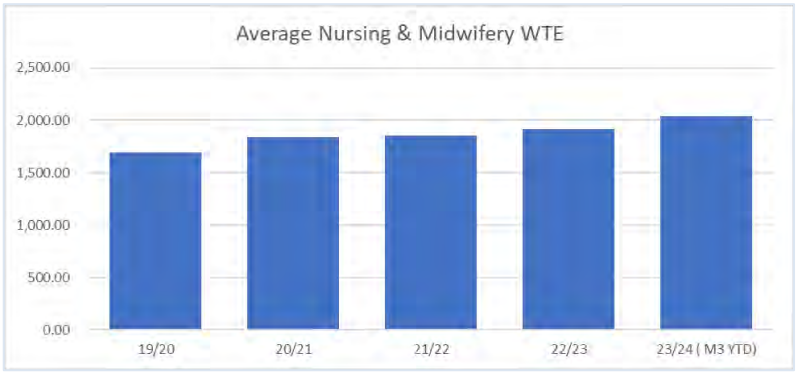
- How much of this increase is driven by activity and should therefore be funded by increases in income?
- How much of temporary pay spend is being driven by cover for strike action?
- How does temporary pay spend and increase in substantive staff compare?
- How much is driven by changes in standards that are not funded through income?
- How much is driven by increases in sickness levels?

- Can the additional session usage be brought down given that substantive staff been recruited to reduce overall costs?

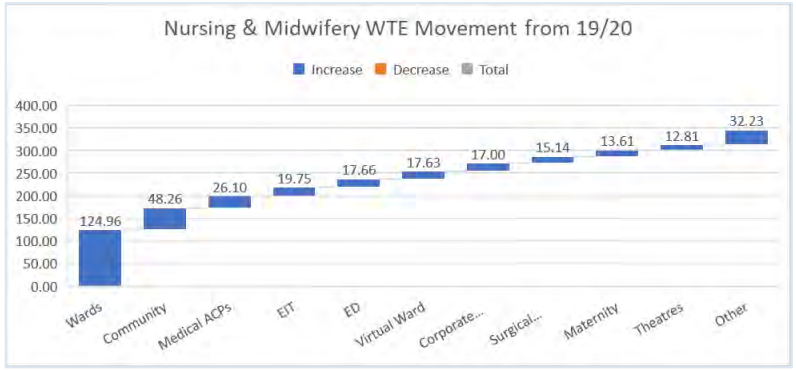
Nursing & Midwifery WTE Analysis

The charts below explain the movements seen in Nursing & Midwifery WTE between 2019/20 and 2023/24 and are based upon the average monthly WTE seen.

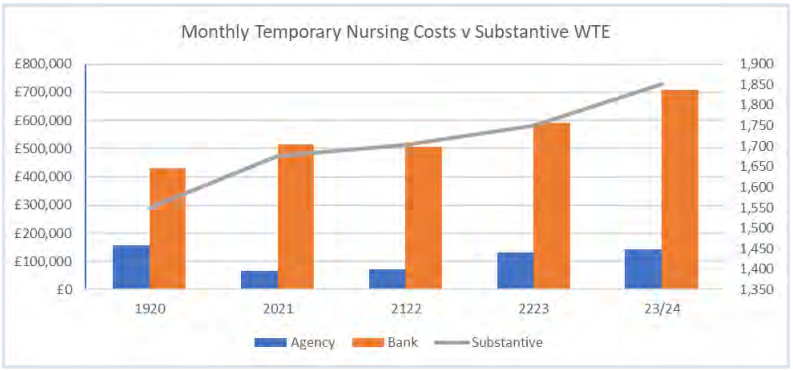
Nursing WTE has increased each year since 2019/20. 23/24 level have increased by 345 (18%) since 19/20.



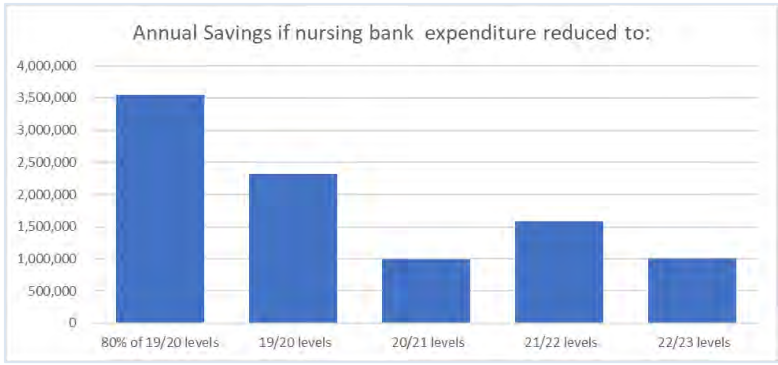
The most significant areas of increase by volume are wards and community, with less growth seen in theatres.



Increases in substantive nursing have not seen been offset by decreases in temporary staffing, with the use of bank staff still increasing.



Reducing temporary nursing to 19/20 levels would save the Trust £2.31m in a year, or £1.54m for the final 8 months of 23/24. Reducing to 80% of 19/20 levels would save £3.55m per year.



There are several areas of further investigation:

- How much of this increase is driven by activity and should therefore be funded by increases in income?
- How much is driven by other factors that are funded (e.g. increases in midwifery attached to specific external funding)?
- How much is driven by changes in standards that are not funded through income?
- How much is driven by increases in sickness levels?
- Can the bank usage be brought down to pre-pandemic levels to reduce overall costs?

FINANCE REPORT – June 2023

Workforce

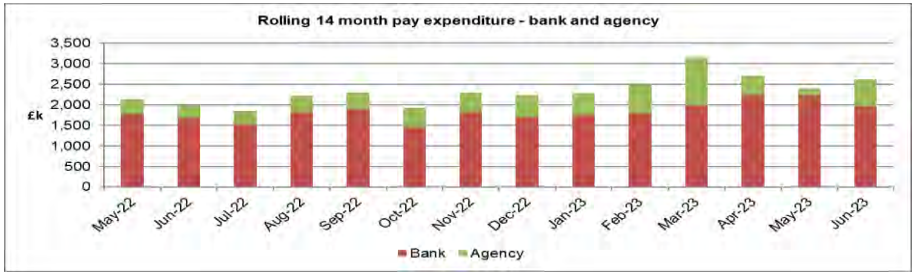
During June the Trust overspent by £0.5m on pay

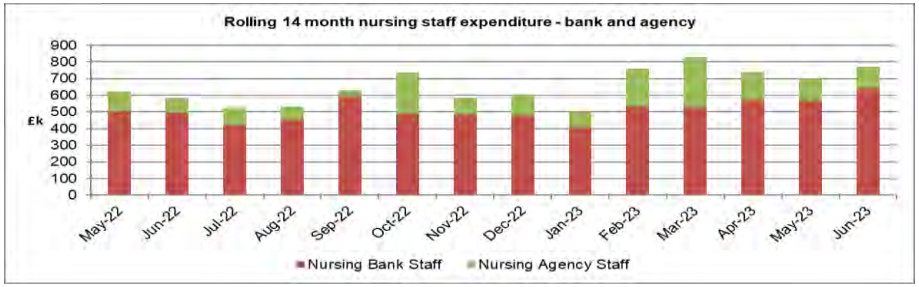
Compared to June 22 we now employ 385 more WTEs (8.6%), of which 288 are substantive and 97 are temporary

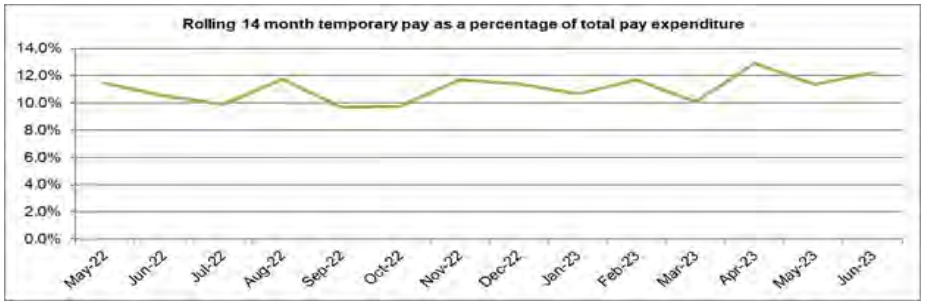
Monthly Expenditure (£)				
As at June 2023	Jun-23	May-23	Jun-22	YTD
	£000's	£000's	£000's	£000's
Budgeted Costs in-month	20,934	20,571	19,159	62,075
Substantive Staff	18,764	18,669	16,872	55,716
Medical Agency Staff	221	(212)	30	96
Medical Locum Staff	346	614	375	1,516
Additional Medical Sessions	271	406	304	1,056
Nursing Agency Staff	130	132	92	427
Nursing Bank Staff	640	566	495	1,781
Other Agency Staff	314	243	194	798
Other Bank Staff	269	225	212	759
Overtime	221	187	144	672
On Call	211	229	144	625
Total Temporary Expenditure	2,622	2,390	1,988	7,731
Total Expenditure on Pay	21,387	21,059	18,860	63,447
Variance (F/(A))	(453)	(488)	298	(1,372)
Temp. Staff Costs as % of Total Pay	12.3%	11.3%	10.5%	12.2%
memo: Total Agency Spend in-month	664	163	315	1,322

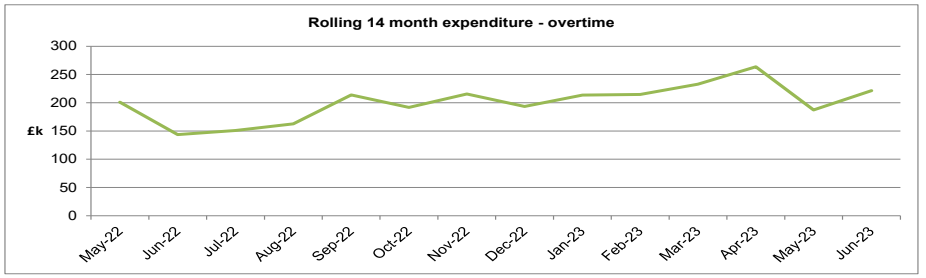
Monthly WTE				
As at June 2023	Jun-23	May-23	Jun-22	YTD
Budgeted WTE in-month	4,928.3	4,928.3	4,806.2	129,479.8
Substantive Staff	4,473.9	4,466.2	4,186.0	8,940.2
Medical Agency Staff	6.7	9.2	0.0	15.9
Medical Locum Staff	48.5	56.9	25.3	105.4
Additional Medical Sessions	12.1	9.5	0.8	21.6
Nursing Agency Staff	22.0	16.1	16.6	38.1
Nursing Bank Staff	138.1	148.2	119.3	286.3
Other Agency Staff	51.0	41.1	15.4	92.1
Other Bank Staff	75.6	91.3	74.6	166.8
Overtime	45.5	66.6	51.8	112.1
On Call	9.5	7.5	8.4	17.0
Total Temporary WTE	408.9	446.3	312.2	855.3
Total WTE	4,882.9	4,912.5	4,498.2	9,795.4
Variance (F/(A))	45.5	15.8	308.0	119,684.4
Temp. Staff WTE as % of Total WTE	8.4%	9.1%	6.9%	8.7%
memo: Total Agency WTE in-month	79.7	66.4	32.0	146.1

Pay Costs









FINANCE REPORT – June 2023

Cost Improvement Programme (CIP)

A summary of progress on the CIP plan for 23-24 and 24-25 is included below

Note these schemes have not yet been risk assessed so the value may fall, and the CIP identified at £5m (non risk adjusted) currently represents 47% of the total CIP. However over 180 potential schemes have yet to be costed.

Identification Progress

Division	Target £000	No of Schemes	Schemes indicative values
Medicine	2,610	40	12
Surgery	1,978	59	7
Women & Children	671	15	1
Clinical Support Services	1,260	38	14
Community	1,588	43	10
Corporate, Estates & Facilities	2,493	59	26
Grand Total	10,600	254	70

Delivery in 2324

Division	FY Target £000	Identified £000	CIP Gap £000	YTD Plan £000	YTD Delivery £000	YTD Under/Over Delivery £000
Medicine	2,610	1,188	(1,422)	297	0	(297)
Surgery	1,978	1,007	(971)	252	201	(51)
Women & Children	671	493	(178)	123	0	(123)
Clinical Support Servic	1,260	1,345	85	336	32	(304)
Community	1,588	381	(1,207)	95	146	51
Corporate, Estates & F	2,493	586	(1,907)	396	140	(256)
Grand Total	**10,600**	**5,000**	**(5,600)**	**1,500**	**519**	**(981)**

223/24 Schemes

Division	Project Name	ull Year Value	TD Non-RAV
Medicine	reduction of additional sessions	246,000	61,500
	lenalidomide	236,298	59,075
	GP Streaming	177,633	44,408
	Dose banding	145,000	36,250
	renal consultant	130,000	32,500
	CRT-P implants	100,000	25,000
	Vasculitis	60,000	15,000
	Cardiac dental patients	50,000	12,500
	bank holiday working	20,000	5,000
	Diamond system retirement	10,000	2,500
	Everolimus	7,480	1,870
	Mutual aid	5,417	1,354
Medicine Total		1,187,828	296,957
Surgery	Vacancy factor	560,000	140,000
	Ophthalmology drugs switch to Biosimilar	200,000	50,000
	Procurement savings	88,084	22,021
	Trauma and Orthopaedic contract for the provision of Trauma Products	85,500	21,375
	Review staffing skill mix	70,000	17,500
	AMBU Scopes	2,100	525
	Ensure Patients are seen by appropriate staff for particular appointments	1,500	375
Surgery Total		1,007,184	251,796
Women & Childr	Vacancy factor	493,000	123,250
Clinical Support Services	Vacancy factor	383,000	95,750
	Ophthalmology biosimilar	250,000	62,500
	Pathology send away tests	191,000	47,750
	Switch to generic lenalidomide	145,000	36,250
	Chemo dose banding	125,000	31,250
	Private patients	100,000	25,000
	LMWH switch	47,500	11,875
	DEXA scans	30,000	7,500
	Increase in use of genomic laboratory hub (GLH)	30,000	7,500
	Pharmacy delivery service	20,000	5,000
	Faecal calprotectin	8,646	2,162
	Saving on band 7 bank costs	7,500	1,875
	Scanning income	6,000	1,500
	Cease paper reports from NHSBT	1,500	375
CSS Total		1,345,146	336,287
Community	Enteral Feeds	145,000	36,250
	Community Equipment - care home equipment (additionality)	80,000	20,000
	Overseas patient charging for Community Services not recorded on E-CARE	50,000	12,500
	Adult Physiotherapy	36,785	9,196
	Community Equipment - social care funding	30,000	7,500
	Integration - Bury Rural Integrated Neighbourhood Team	28,447	7,112
	Community Equipment - P-Stores	6,000	1,500
	Pharmacy & Medicine's management	2,012	503
	Informatics -the provision of Informatics Support and Reporting Services to Suffolk County Council (SCC) Mental Health Crisis Outreach Service.	1,534	384
	Uniforms	1,200	300
Community Total		380,978	95,245
Corporate, Estates & Facilities	car park income WSH	333,333	83,333
	accommodation charges - increase rent by 10%	60,000	15,000
	catering	46,667	11,667
	rates - NCH	26,000	6,500
	rates - WSH	25,000	6,250
	retail outlet income	20,000	5,000
	SLA annual review - NCH	15,645	3,911
	energy(gas & electricity) - WSH	10,000	2,500
	postage	5,000	1,250
	energy(gas & electricity) - NCH	5,000	1,250
	Estates budget has lots of significant non-staff overspends - these areas might merit being looked at. E4404. E4304, E4305, and E4501	5,000	1,250
	Link patient location record to new IT system for ordering meals so that food always sent to right location for patients.	5,000	1,250
	cold takeaway food review % VAT reclaim @ WSH	4,000	1,000
	waste NCH and WSH	3,750	938
	portering train the trainer	3,000	750
	portering supervisors overtime	3,000	750
	SSD sterilizers contract	2,500	625
	LED lighting @ NCH	2,500	625
	LED lighting @ WSH	2,500	625
	roster co-ordinator	2,500	625
	SLA annual review - WSH	2,399	600
	ssd - loan kit arrangements	2,000	500
	cold takeaway food review % VAT reclaim NCH	1,000	250
	Greatix Review	0	0
	What Matters to you 2	0	0
	Training	0	250,000
Corporate, Estates & Facilities Total		585,794	396,449
Trust Totals		4,999,930	1,499,983

Financial Recovery – Immediate Actions

The purpose of this list is to set out potential actions and should be taken in the context of WSFT retaining autonomy as the alternative would likely be a SNEE or even regionally mandated ‘double’ or ‘triple’ lock.

Therefore, this paper makes recommendations to the Board on actions required to enable the Trust to have confidence that all reasonable measures to manage any overspend position are being taken. This will form the basis of an internal financial recovery plan and require an additional 6 WTE to provide support and create an internal turnaround team. Actions recommended are as follows:

1. Set up Financial Recovery Group chaired by CEO with a weekly review of position for each Division that isn’t within budget
2. Establish a Workforce Resource Group to ensure we are managing our workforce effectively.
3. Bring in additional support to improve financial control and CIP delivery and ensure a robust medium term financial model
4. Review and comment on progress against the NHSE financial recovery actions checklist.
5. Review forecast (currently reporting that we will recover to the plan by year end)
6. Communicate our financial position across the organisation.
7. Undertake a review of the control systems, processes and policies that are in place to determine whether they are fit for purpose or need to be enhanced.
8. Review and possibly withdraw support for any investment case with adverse impact on revenue finances. Around £700k has been approved but not yet committed. These will be considered as part of the recovery process.

FINANCE REPORT – June 2023

Statement of Financial Position – 30 June 2023

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2023	Plan 31 March 2024	Plan YTD 30 June 2023	Actual at 30 June 2023	Variance YTD 30 June 2023
	£000	£000	£000	£000	£000
Intangible assets	61,869	57,425	57,101	52,756	(4,345)
Property, plant and equipment	193,976	227,589	192,820	209,321	16,501
Right of use assets	9,817	9,929	11,801	9,818	(1,983)
Trade and other receivables	6,001	6,341	6,341	5,547	(794)
Total non-current assets	**271,663**	**301,284**	**268,063**	**277,442**	**9,379**
Inventories	4,365	3,800	3,800	5,137	1,337
Trade and other receivables	41,871	14,991	17,430	23,647	6,217
Non-current assets for sale	520	0	0	520	520
Cash and cash equivalents	7,895	14,298	6,009	5,010	(999)
Total current assets	**54,651**	**33,089**	**27,239**	**34,314**	**7,075**
Trade and other payables	(73,503)	(45,862)	(38,619)	(56,306)	(17,687)
Borrowing repayable within 1 year	(4,801)	(3,724)	(3,724)	(4,891)	(1,167)
Current Provisions	(64)	(46)	(46)	(64)	(18)
Other liabilities	(1,336)	(5,185)	(3,685)	(7,553)	(3,868)
Total current liabilities	**(79,704)**	**(54,817)**	**(46,074)**	**(68,814)**	**(22,740)**
Total assets less current liabilities	**246,610**	**279,556**	**249,228**	**242,942**	**(6,286)**
Borrowings	(48,038)	(41,265)	(45,910)	(47,918)	(2,008)
Provisions	(507)	(852)	(852)	(505)	347
Total non-current liabilities	**(48,545)**	**(42,117)**	**(46,762)**	**(48,423)**	**(1,661)**
Total assets employed	**198,065**	**237,439**	**202,466**	**194,519**	**(7,947)**
Financed by					
Public dividend capital	230,215	271,107	234,631	230,215	(4,416)
Revaluation reserve	12,054	12,640	12,640	12,054	(586)
Income and expenditure reserve	(44,204)	(46,307)	(44,805)	(47,750)	(2,945)
Total taxpayers' and others' equity	**198,065**	**237,440**	**202,466**	**194,519**	**(7,947)**

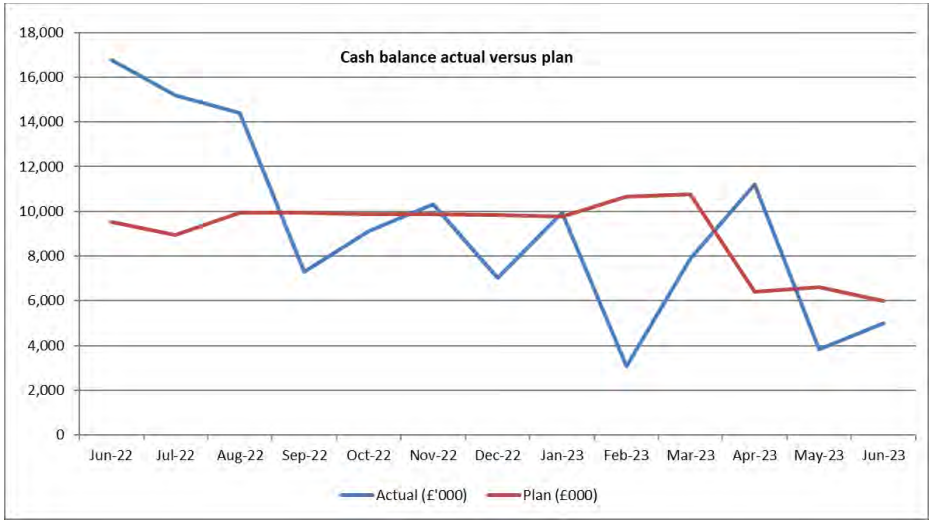
The above table shows the year to date position as at 30 June 2023.

Total reserves are slightly below plan and this is due to the fact that we are reporting a deficit slightly higher than plan. We have not drawn down PDC funding in line with the plan. This is because our capital spend for projects associated with the PDC funding is not in line with the plan (see below capital progress report).

Trade receivables were higher than plan, however are in line with the previous month (£22m at month 2). Trade payables are also higher than plan, but again are in line with the previous month (£59m at month 2).

Cash Balance for the year

The graph illustrates the cash trajectory since June 2022. The Trust is required to keep a minimum balance of £1m.



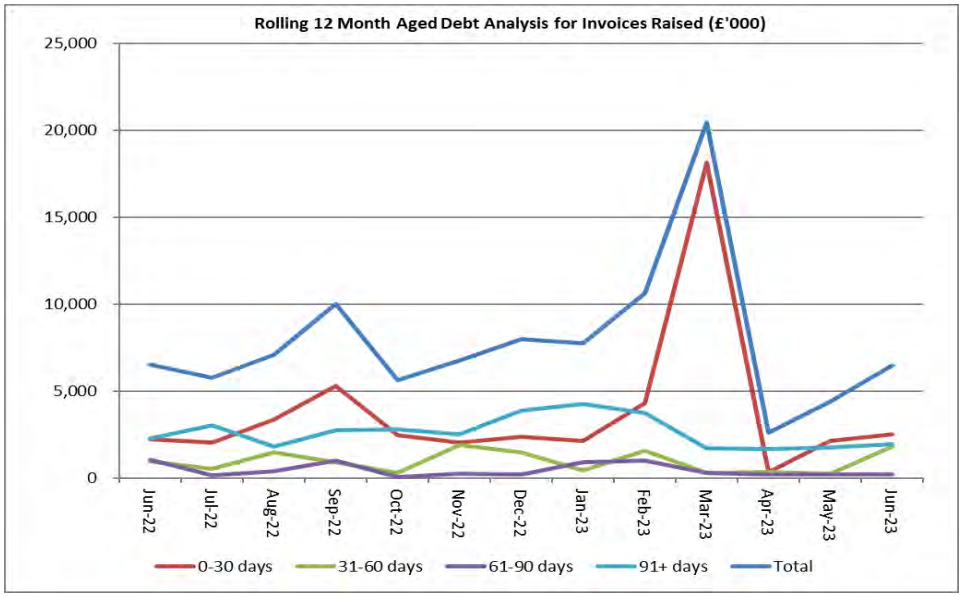
The cash position remains slightly below plan. Our cash is being rigorously monitored to ensure that we have adequate cash reserves to match our expenditure. As the Trust continues to report a deficit, this impacts on our cash position. As a result, the ICB have agreed to pay the Trust £5m in advance (from our block payments) to ensure that we have an adequate cash balance to manage our payments from.

Cash flow forecasts continue to be submitted to NHS England every fortnight to ensure that adequate cash reserves are being held within the NHS. The Trust may need to consider whether revenue funding is required later in 2023/24 to ensure that we maintain the expected levels of cash to meet our financial obligations.

FINANCE REPORT – June 2023

Debt Management

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



It is important that the Trust raises invoices promptly for money owed and that the cash is collected as quickly as possible to maintain an adequate cash balance.

The overall level of sales invoices raised but not paid has remained stable in the first three months of the year and we continue to work hard to ensure that all income is received on a timely basis.

Over 73% of the outstanding debts relate to NHS Organisations, with 27% of these NHS debts being greater than 90 days old.

Capital Progress Report

The Capital Plan for 2023/24 was originally set at £53.913m. However, since this was set and approved, an additional £2.5m in PDC funding has been awarded for the RAAC project. £20m of funding for the Newmarket Elective Hub was not approved. This has resulted in a total revised Capital Plan for 2023/24 of £36.413m.

The month 3 capital spend is £6.135m, which slightly below expected spend per the Plan. Overspends can be seen within Medical Equipment and Imaging Equipment and this is due to the fact that some items were pre-committed in month 12 of 2022/23 and were not delivered in time to be accounted for in 2022/23. These are now reflected in the 2023/24 position. Newmarket CDC is behind plan, however the spend for the year is on track and the majority of the spend will occur in the latter part of the financial year.

The table below shows the year to date capital spend up to month 3:

Capital Spend - 30th June 2023		Year to Date			Funding Split	
Capital Scheme	Full year Original Plan £000's	YTD Original Plan (M3) £000's	YTD Actual (M3) £000's	Variance £000's	Internal £000's	PDC Available £000's
New Hospital (Future Systems)	1,228	341	335	6		1,228
RAAC	10,900	2,100	1,307	793		10,900
Newmarket CDC	12,549	3,120	62	3,058		12,549
Other Estates	2,852	708	270	438	2,852	
IM&T	6,234	1,739	1,768	- 29	5,989	245
Medical Equipment	495	123	849	- 726	495	
Imaging Equipment	1,830	456	1,544	- 1,088	1,830	
Other Schemes	325	81		81	325	
Total Capital Schemes	36,413	8,668	6,135	2,533	11,491	24,922
Overspent vs Original Plan						
Underspent vs Original Plan						

FINANCE REPORT – June 2023

4.3. Improvement Committee Report - Chair's Key Issues from the meeting

To Assure

Presented by Louisa Pepper

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Improvement			**Date of meeting: 21/06/23**		
Chaired by: Geraldine O'Sullivan			**Lead Executive Director: Sue Wilkinson**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	Level of Assurance* 1. Substantial 2. Reasonable 3. Partial 4. Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT 3. To Board
5.1i	IQPR Concerns re data: • is most useful Q&S dataset being reported? • can board be assured through current committee reporting pathways or does there need to be more data available in the IQPR visible at board subcommittee level?	Partial	Pathways in place to scrutinise data / other quality insight at specialist committee level. Assurance and escalation reporting pathways are in place through the PQAS governance group but because of the limited Q&S data set at Improvement Committee, there's lack of evidence to enable strong assurance.	Explore and propose a way of reporting key quality and safety metrics as part of the Improvement committee assurance process. Improvement to receive a proposal in September (no August meeting)	1
5.1ii	<u>Pressure ulcers (PU)</u> Deep dive into PUs to provide data-breakdown and learning / improvement. IQPR shows • Common cause variation • Hit + miss assurance  PSIRF model for investigation and learning = AAR. Common themes identified: end of life, non-concordance, nutritional assessment.	Reasonable	PU one of highest reported incident categories (common to most acute / community trusts). Recognition current data unreliable (double counting using multiple systems: eCare, SystemOne, Datix). Learning from AARs: Recent projects: • pocket mirrors for HCAs, • long stay in ED QI programme, • ward reviews (recognising that differing patient cohorts make ward on ward comparisons unhelpful).	Opportunities to utilise HIE to give access across EPRs (but not transfer of data). Targeted (location and PU location type) training offerings from the TVN team Continuation of improvement programme (tracked through our LifeQI online platform).	1

Originating Committee: Improvement			Date of meeting: 21/06/23		
Chaired by: Geraldine O'Sullivan			Lead Executive Director: Sue Wilkinson		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	Level of Assurance* 1. Substantial 2. Reasonable 3. Partial 4. Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT 3. To Board
5.2	Frailty In depth review of progress since ICB-led QA visit last year. Links to GIRFT and CQUIN highlighted (targets being met for latter). Wider development opportunities highlighted.	Reasonable for the inpatient team	Recognition of increasing number of patients in this category and opportunities for reductions in LoS when identified at the front door (ED).	Aspects of the Frailty Community pathway needs to be strengthened / developed.	Raise with ICS and Alliance re Frailty Community pathway.
6.1	PQAS Received for information. Updates from: • Deteriorating patient group • Dementia, delirium & frailty • Learning from deaths • End of life group • Mortuary and HTA • Safer discharge group	Partial	Only partial assurance / emerging concerns for some items in report: 1. accuracy of patient observations/vital sign recording and staff awareness 2. Current IQPR sepsis measures only addresses small number of patients 3. Current formal Dementia training provision limited and not aligned with national training standards framework 4. Limited governance around learning from incidents where restrictive practice has been used.	1. Task & finish group formed to address improvements in vital sign training and accurate recording. Review in 6 months 2. Sepsis 6 reporting being reviewed for future IQPR (later in 23/24) 3. Training is priority for incumbent Dementia CNS in coming months 4. Working group set up using QI methodology on process for understanding least restrictive practice.	1
6.2	CEGG Received for information. Updates on: • Radiology incl. accreditation • Public health • NICE	Partial	Only partial assurance for some items in report: • Integrating GIRFT into wider improvement structures	National best practice publications (excl. NICE and audit) separate report to be considered in July Improvement meeting alongside agenda item for Ockenden Improvement plan as 2	Executives (Nat Best Practice Guidelines and Ockenden

Originating Committee: Improvement			Date of meeting: 21/06/23		
Chaired by: Geraldine O'Sullivan			Lead Executive Director: Sue Wilkinson		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	Level of Assurance* 1. Substantial 2. Reasonable 3. Partial 4. Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT 3. To Board
	• Maternity response to national HSIB reports • National best practice publications (excl. NICE and audit) Escalation from AMD that clinical guidelines are not being uploaded to Intranet due to system / admin resource gaps.		• One aspect of Ionising radiation compliance not met, being kept under review locally • Community stop smoking service and other lifestyle services by OneLife Suffolk contract ending in Sept23.	responsible execs not present and prior conversation at Execs meeting would enable a more focused and meaningful discussion around way forward to address gaps. CEGG to consider guidelines issue (risk register entry in progress) and bring update to July meeting.	Improvement Plan)
7.1 + 7.2	PSIRF review and report from SIG Received for information. Year two review completed by ICB safety lead. Positive feedback and opportunities for further improvement identified	Substantial	PSIRF is a national requirement as part of the NHS Patient safety strategy. Process is well established at WSH as pilot site.	Year three PSIRP now underway. Ensure good staff buy-in to PSIRP and that safety culture is fully embedded amongst staff.	1

See guidance notes for more detail

Acronyms: Q&S (quality & safety), PQAS (Patient Q&S governance group), PSIRF (patient safety incident response framework), AAR (after action review), HCAs (healthcare support workers), TVN (tissue viability nurse), EPR (electronic patient record), HIE (health information exchange), QI (quality improvement), QA (quality assurance) LoS (length of stay), HTA (Human tissue authority), CNS (clinical nurse specialist), SIG (safety improvement group)

Guidance notes

The practice of scrutiny and assurance

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

Assurance level

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

4.4. Quality and Nurse Staffing Report

To Assure

Presented by Susan Wilkinson

Trust Board – July 2023

Report Title:	Quality and Workforce Report & Dashboard – May and June 2023
Executive Lead:	Sue Wilkinson
Report Prepared by:	Daniel Spooner
Previously Considered by:	N/A

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

Executive Summary

This paper reports on safe staffing fill rates and mitigations for inpatient areas for May and June 2023 It complies with national quality board recommendations to demonstrate effective deployment and utilisation of nursing staff. The paper identifies planned staffing levels and where unable to achieve, actions taken to mitigate where possible. The paper also demonstrates the potential resulting impact of these staffing levels. It will go onto review vacancy rates, nurse sensitive indicators, and recruitment initiatives.

Highlights

- Total RN/RM vacancy rate has increased this period due to the uplifts in budgets, however, remains under 10%. Total WTE for RN/RMs continues on improvement trajectory.
- Turn over for RN/RM remains under 10%
- Winter ward closed on 21st June as per exit plan so benefits of staffing being released back to own area will not be felt in this period.
- Fill rates have improved across all shifts and roles and above 90% for night shifts
- Combined nursing and NA fill rates for June is just above 90% target
- CHPPD remains below expected due to high bed occupancy, additional escalation beds and staffing shortfalls. However, improvements seen in this period
- Combined registered and non-registered sickness below 5%. First time in 12 months

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:	Ensuring a diverse and engaged workforce improves quality patient outcomes. Safe staffing levels positively impacts engagement, retention and delivery of safe care
Sustainability:	Efficient deployment of staff and reduction in temporary staffing and improving vacancy rates contributes to financial sustainability
Legal and regulatory context	Compliance with CQC regulations for provision of safe and effective care

1. Introduction

The National Quality Board (NQB 2016) recommend that monthly, actual staffing data is compared with expected staffing and reviewed alongside quality of care, patient safety, and patient and staff experience data. The trust is committed to ensuring that improvements are learned from and celebrated, and areas of emerging concern are identified and addressed promptly. This paper will identify safe staffing and actions taken in March and April. 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 May and June 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 May and June 2023

	Day		Night	
	Registered	Care Staff	Registered	Care staff
Average fill rate January 2023	87%	80%	93%	95%
Average fill rate February 2023	85%	77%	88%	94%
Average fill rate March 2023	84%	77%	90%	93%
Average fill rate April 2023	87%	78%	92%	95%
Average fill rate May 2023	87%	83%	94%	94%
Average fill rate June 2023	89%	84%	94%	95%

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.

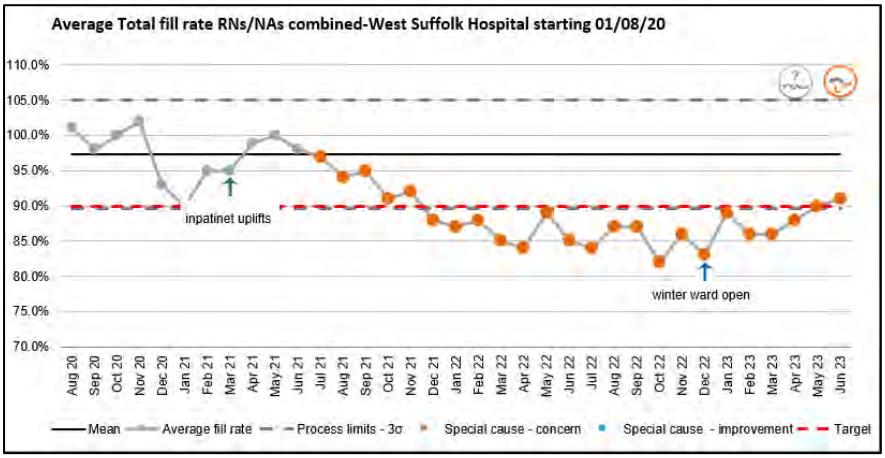


Chart 2.

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 3 (below) demonstrates our achievement of this. Since August 2021 we are not achieving this consistently and further demonstrates the staffing challenges over the last year.

CHPPD can be affected adversely by opening additional beds, as the number of nurses to beds is reduced. Periods of high bed occupancy can also reduce CHPPD. Closing additional beds will improve CHPPD. It is anticipated that this will improve in the next reporting period.

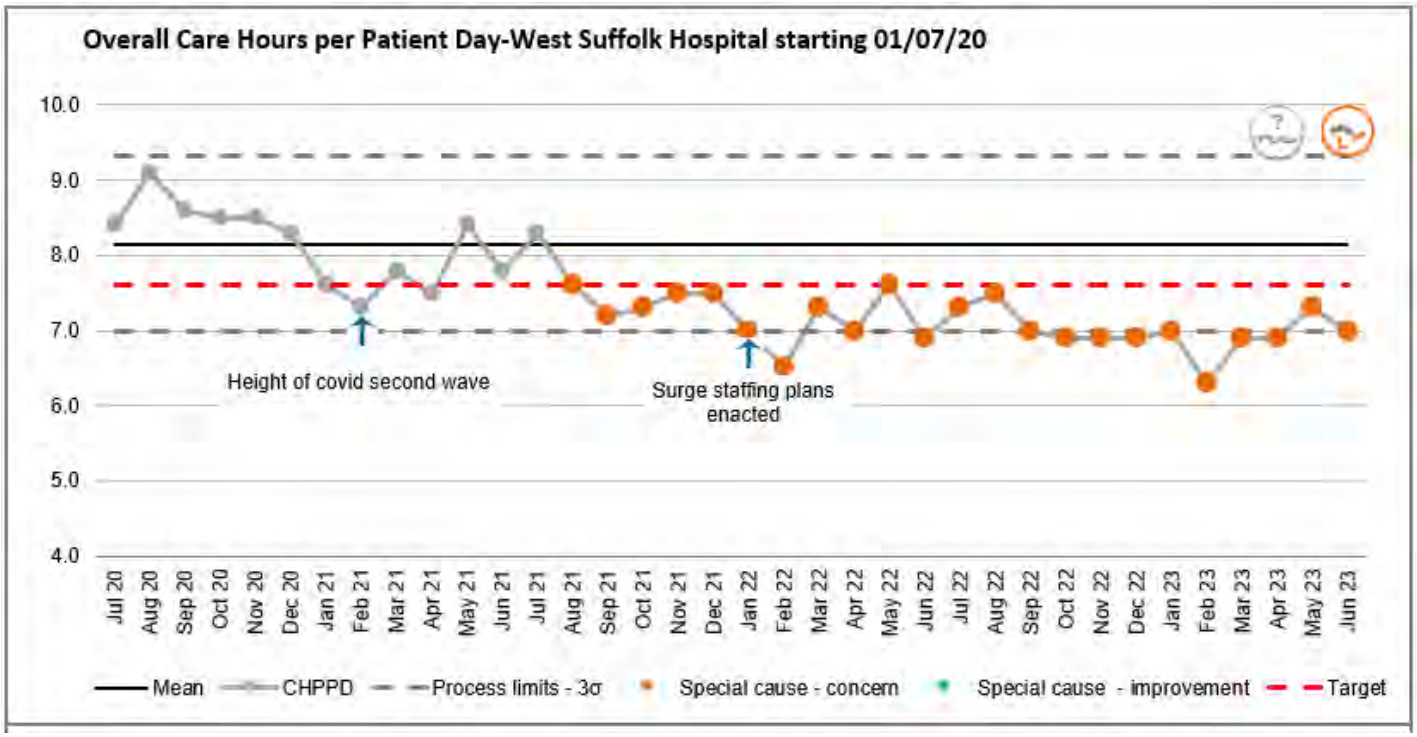


Chart 3 Adapted from model hospital/unify data

3. Sickness

Sickness rates have remained reasonably static within both staff group, and under 5% for combined nursing roles for first time in last 12 months.

	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23
Unregistered staff (support workers)	6.41%	8.76%	7.21%	6.27%	7.27%	7.41%	6.74%	6.63%
Registered Nurse/Midwives	4.91%	6.56%	4.53%	4.89%	4.75%	4.06%	3.84%	4.45%
Combined Registered/Unregistered	**5.42%**	**7.30%**	**5.43%**	**5.36%**	**5.60%**	**5.20%**	**5.42%**	**4.92%**

Table 4

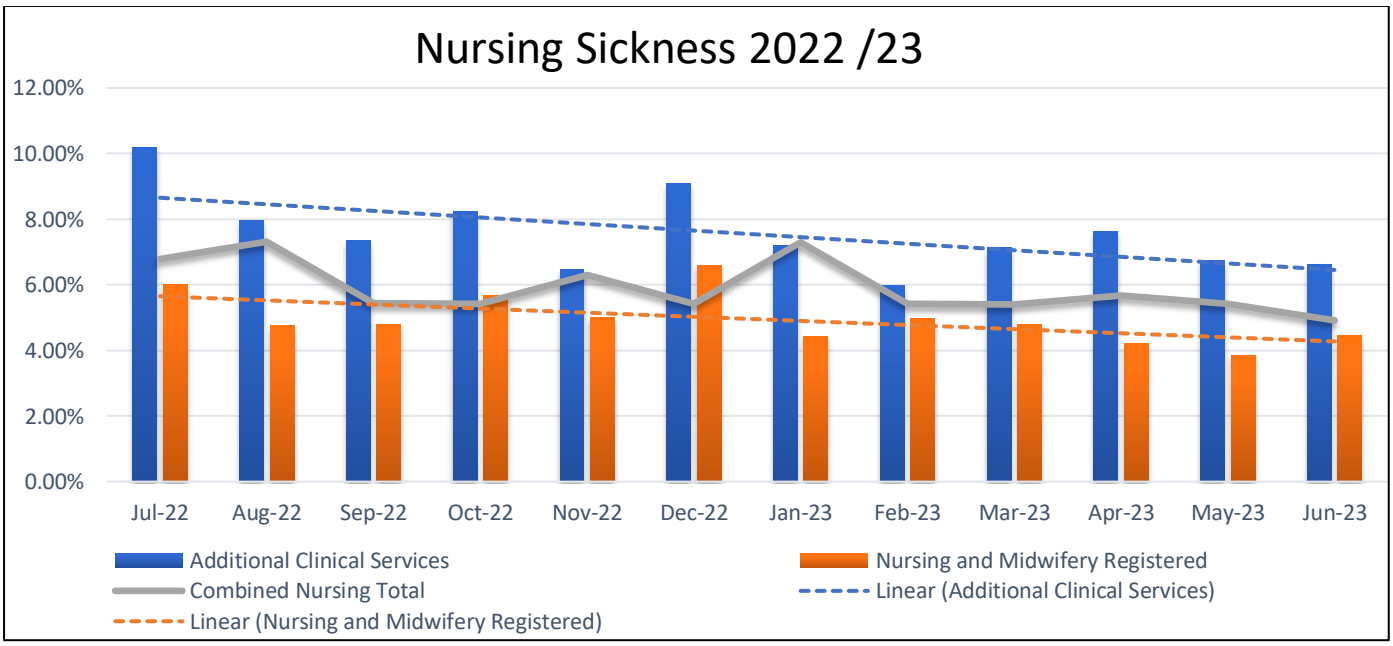


Chart 4

4. Patient Flow and Escalation

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 was provided by an established matron and ward sister to provide consistency. The ward was subsequently moved to F9 which has further increased the bed base. Initial plans were to close at the end of March, however due to sustained capacity and flow issues the decision was made to extend use to end of June 2023.

As per plan agreed at CRT the F9 ward was closed on the 21st June. The result of this extended opening period will have adversely impacted on the nursing temporary staffing spend and fill rates (chart 1) and CHPPD (chart 3). Its is anticipated that both these measures will improve for the next reporting period.

5. Recruitment and Retention

Vacancies: Registered nursing (RN/RM):

- Substantive Inpatient RN/RM WTE and vacancy rate continues in special cause improvement
- Inpatient RN/RM vacancy rate has increased from 10.2 to 11.9 driven by increases in budgeted establishment introduced beginning of this financial year, however WTE continues to increase.
- Total RN/RM vacancy rate has increased from 7.1% to 9.8% driven by establishment increases.
- Inpatient ward NA vacancies percentages over this period has improved from 14.3% to 11.8% and is in common cause variation.
- Total NA vacancy rate has improved from last report of 11.5% to 10.5% despite WTE budget increases
- WTE for NA in both inpatient and trust total is an improving picture and is in special cause improvement

Table 5 demonstrates the total RN/RM establishment for the inpatient areas (WTE). The total number of substantive RNs has seen an improving trend. Full list of SPC related to vacancies and WTE can be found in appendix 2. Areas of concern remain within the non-registered staff group. 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 additional ward mentioned in section 4 which required moving staff from other wards daily and adversely affecting their planned fill rate.

	Inpatient	Sum of Actuals Period 10 (Jan)	Sum of Actuals Period 11 (Feb)	Sum of Actuals Period 12 (March)	Sum of Actuals Period 1 (April)	Sum of Actuals Period 2 (May)	Sum of Actuals Period 3 (June)	WTE VACANCY at period 12
RN/RM Substantive	Ward WTE	629.3	640.3	656.8	671.1	666.6	674.8	91.3
Nursing Unregistered Substantive	Ward WTE	392.2	398.3	400.6	409.4	407.8	40.5.3	47.8

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

6. New Starters and Turnover

International Nurse Recruitment:
The international nursing pipeline has been challenging recently due to external delays with visa acquisitions. The plan was to bring 8 a month and then reduce to 6 but this hasn't been possible due to delays. The monthly target of 8 will need to be continued so that the annual planned target is achieved. The HR team are applying for Visas proactively and we are engaging regularly with the recruiting agency to demonstrate the impact had on the OSCE and induction programs.

8 midwives have passed the OSCE and are working with in the midwifery team. A further 3 are awaiting registration and 1 is pending qualification exam.

International AHP recruitment has begun to progress well, and interviews are planned for funded roles. There has been some success in non-funded roles where departments are picking up some of the cost of IR. Progress has been made recruiting into areas like ODP, Physiotherapy and Radiology.

New starters

	Jan 23	Feb 23	Mar 23*	Apr 23	May 23	Jun 23
Registered Nurses	9	20	33	23	22	17
Non-Registered	23	25	47	23	22	26

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 May, 22 RNs completed induction; of these; 12 were for the acute, 2 for community, 4 for midwifery and 4 for bank services.
- In May, 22 NAs completed induction; of these; 19 NAs are for the acute Trust, and 3 for bank services

- In June, 17 RNs completed induction; of these; 10 were for acute services 3 for community, 1 for midwifery and 3 for bank services
- In June, 26 NAs completed induction; of these; 22 NAs are for the acute Trust, 4 for bank services and 1 for community services

Turnover

On a retrospective review of the last rolling twelve months, turnover for RNs continues to be under the ambition of 10%. Turnover is now 9.3%. NA turnover has increased slightly to 24.4%. The high turnover of this staff group has been escalated through the finance and workforce committee and is being captured at the Trust retention group. Intervention launched this month includes NA open days and group interviews and engagement events including ward tours. This is to ensure that successful candidates are fully aware of the nature of work involved with healthcare and expectations are consistent with lived experience.

		Turnover	01/07/2022	-	30/06/2023			
Staff Group	Average Headcount	Avg FTE	Starters Headcount	Starters FTE	Leavers Headcount	Leavers FTE	LTR Headcount %	LTR FTE %
Nursing and Midwifery Registered	1,375.00	1,193.6257	99	80.6134	137	111.1533	9.9636%	9.3122%
Additional Clinical Services	599.50	503.1012	305	277.9101	155	122.6765	25.8549%	24.3841%

Table 7. (Data from workforce information)

7. Quality Indicators

Falls and acquired pressure ulcers

Both falls and presure ulcers incidents remain in common cause variation (chart 8 & 9). A full narraative around this qulaity measure interventions can be found in the IQPR.

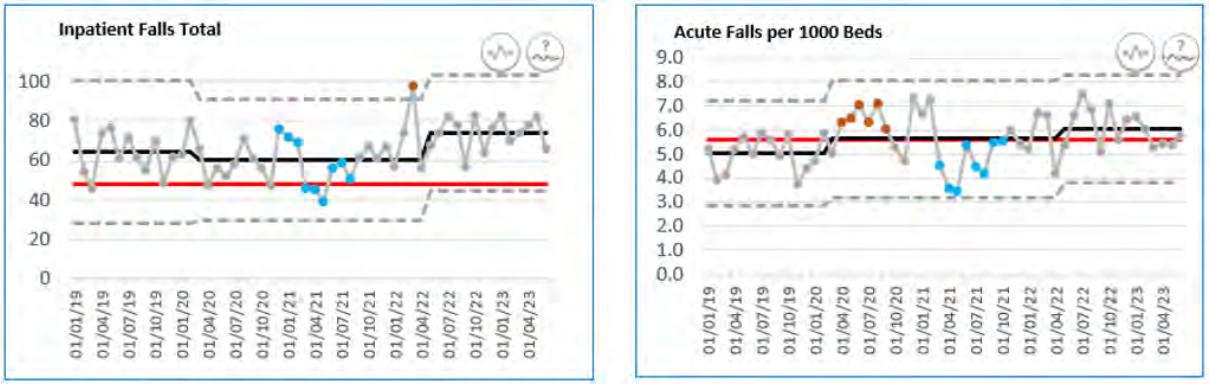


Chart 8

Pressure Ulcers -

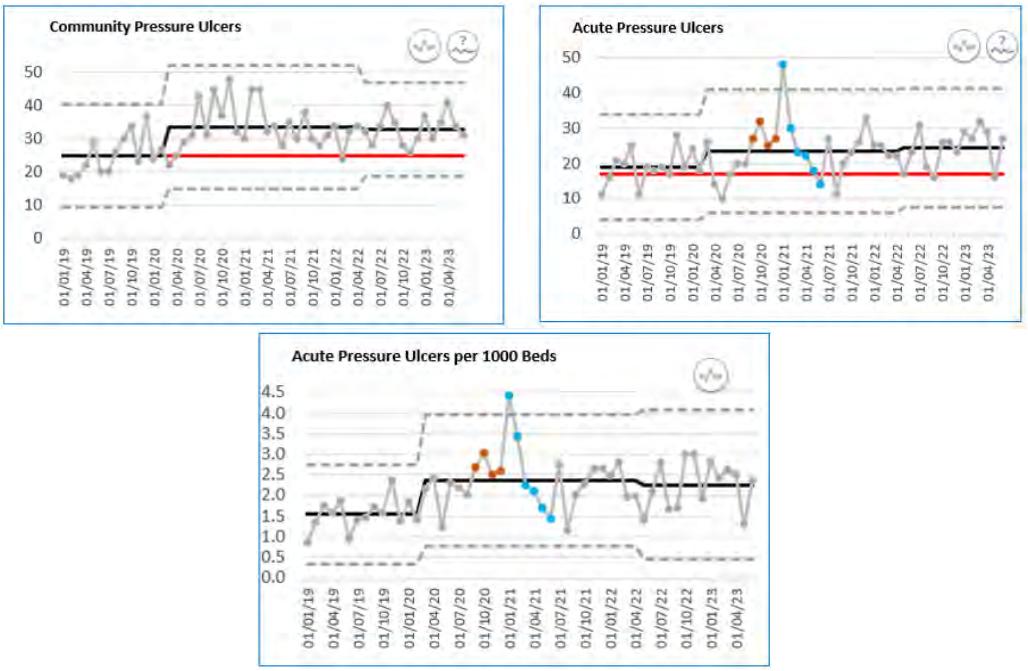


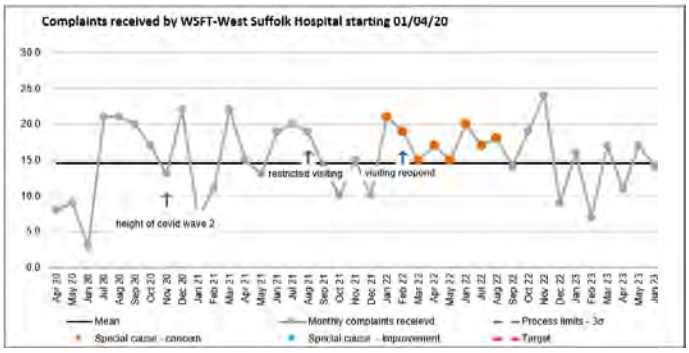
Chart 9

8. Compliments and Complaints

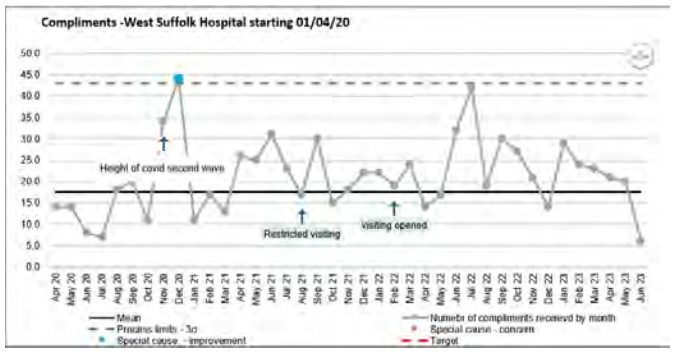
17 formal complaints were received in May. 5 of the complaints received were for the medical division, 8 for the surgical division, 1 for women & children's division and 3 complaints were received for the integrated community services division. The emergency department received the highest number of formal complaints with 3 being received in May 2023. The main theme for complaints in May 2023 was for clinical treatment with 8 complaints being listed under this subject. These complaints include concerns about delays or failure to diagnose and delays in treatment. Communications, values and behaviours of staff each had 3 formal complaints listed under these subjects.

14 formal complaints were received in June. 9 of the complaints received were for the medical division, 3 for the surgical division, 1 for women & children's division and 1 for the corporate division. The emergency department and dermatology department received the highest number of formal complaints with each receiving 2 formal complaints in June. The main theme for complaints in June 2023 was clinical treatment with 5 formal complaints being listed under this subject. Communications received 3 formal complaints listed under this subject.

Chart 10a and 10b demonstrates the incidence of complaints and compliments for this period and both are in common cause variation, indicating a fluctuating incident rate without formal improvement or decline. A sharp decline in complements was seen in June, this is not triangulated with a increase in complaints



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	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23
Registered nursing shortfall of more than 8 hours or >25% of planned nursing hours	7	4	1	8	2	1	1
>30-minute delay in providing pain relief	7	4	1	2	1	1	1
Delay or omission of intention rounding	8	2	5	7	3	-	5
<2 RNs on a shift	7	3	4	2	1	3	3
Vital signs not recorded as indicated on care plan	7	1	-	4	-	-	1
Unplanned omissions in providing medication	1	-	-	2	-	-	1
Lack of appointments (local agreed red flag)		-	-	-	-	1	-
Delay in routine care (new descriptor)	20	6	8	11	4	1	3
Impact not described	-	-	-	-	-	1	2
Unable to make home visits	-	-	-	-	-	1	-
Total	57	20	19	36	11	9	17

Table 11.

- In May 9 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 June 17 Datixs recorded for inpatient nurse staffing that resulted in a Red Flag event (see table 11). No harm is recorded for these incidents

10. Maternity Services

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

	Standard	January	February	March	April	May	June
Supernumerary Status of LS Coordinator	100%	99%	99%	100%	99%	100%	100%
1-1 Care in Labour	100%	100%	100%	100%	100%	100%	100%
MW: Birth Ratio	1:28	1:26	1:25	1:25	1:24	1:26	1.26
No. Red Flags reported		6	11	7	4	4	2

Red Flag events

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

- There were four red flag events in May. No harm was recorded as in impact of these incidents
- There were two red flag events in June. No harm was recorded as in impact of these incidents.

Midwife to Birth ratio

- Midwife to Birth ratio was 1:26 in May and 1:26 in June, which is in accordance with National recommendation of 1:28. Birth rate plus recommendation of 1:27.7 for the reporting period.

- 1:1 care was achieved 100% in both May and June 2023.

Supernumerary status of the labour suite co-ordinator (LSC)
This is a CNST 10 steps to safety requirement and was highlighted as a 'should' from the CQC report in January 2020. The band 7 labour suite co-ordinator should not have direct responsibility of care for women. This is to enable the co-ordinator to have situational awareness of what is occurring on the unit and is recognised not only as best but safest practice. 100% compliance against this standard was achieved in May and June 2023.

11. Community & Integrated services division

11.1 Demand
The SPC charts below show that demand for Integrated Neighbourhood teams (INTs) services, which are primarily nursing and therapy are evening out and not a special cause variation in the past month.

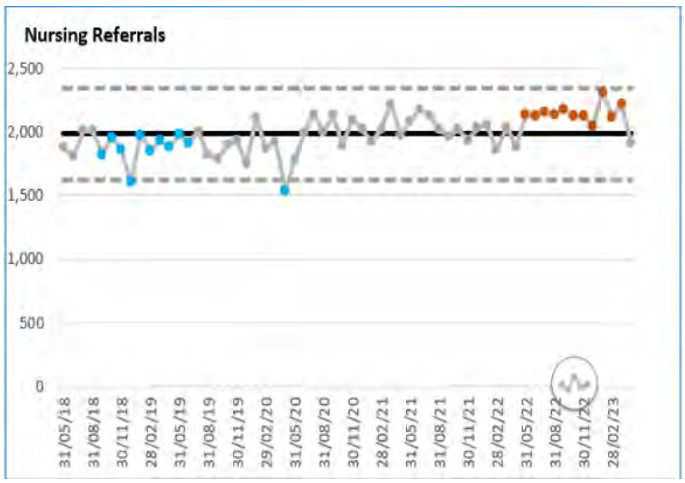


Chart 12a

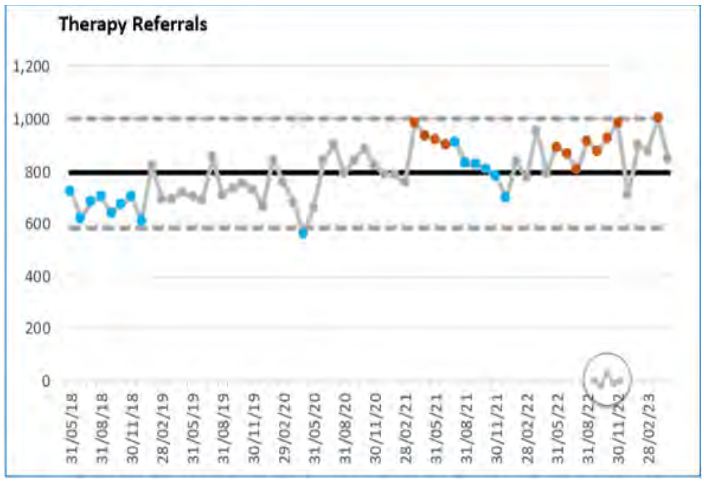


Chart 12b

The nursing staff in the INTs carried out their second census of the Community Nursing safer staffing tool (CNSST) in the last week of June. Providing another round of audit will provide additional assurance when the final assessment of data is completed.

11.2 Sickness
Sickness within the community continues to improve. As can be seen in the SPC (chart 13) the levels of sickness are reducing but still short of the trust target.

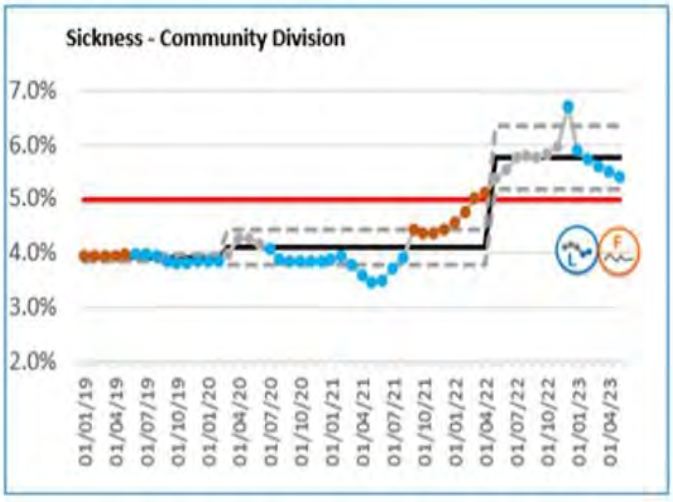


Chart 13.

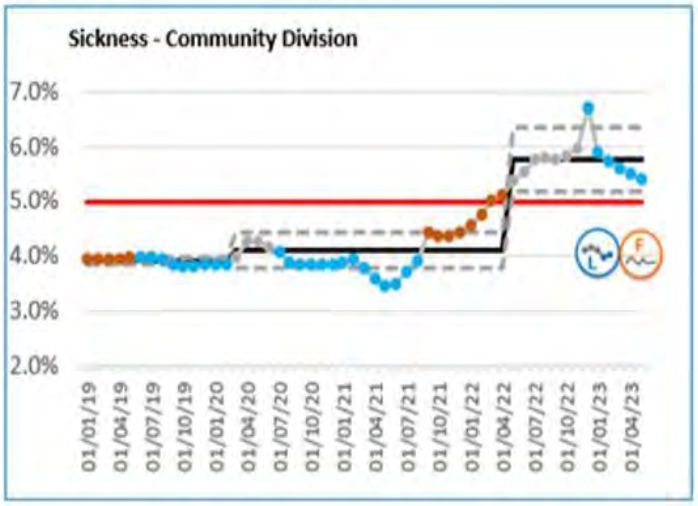


Chart 14

11.4 Turnover

Whilst the data (chart 14) shows that community are not meeting the Trust's target of 10%, the Division has made a significant reduction in turnover since August (2022) when the Division peaked at 16% turnover and continues to reduce month on month. A reduced turnover means a reduction in vacancies and recruitment/ training costs and pressure on remaining colleagues.

11.5 Ongoing actions being taken by division

- Analysis of CNSST, triangulate with quality data and professional judgement for nursing in the INTS.
- Therapists have volunteered to be on National Safer staffing working group to develop safer staffing tool for community therapy.
- A reduced turnover means a reduction in vacancies and recruitment/ training costs and pressure on remaining colleagues. Working with HR to identify what is working well and how to build on this.
- To maintain sustainability initially the INT's will be conducting a benchmarking review for skill mix. Within Benson data & CNSST it can be seen we have the ability to skill mix further within some INT's and enable this in a way that does not compromise patient safety or the quality of care delivery. A review is underway to prioritise this workstream and outline a process to embed this skill mixing within future recruitment planning.
- Other areas within Adults and Integrated therapies will conduct similar horizon scanning to understand if further skill mixing can potentially be undertaken within those teams
- Engagement in weekly regional meetings with NHSE to meet our targets for international AHP recruitment.
- Reviewing vacancies before advertising to consider replacing qualified roles with apprenticeship where possible, although UEA recently withdrew their OT apprenticeship programme which only leaves 1 regional programme available
- £15K from HEE for project focused on OT student experience.

12. Recommendations and actions

- Note the information on the nurse and midwifery staffing and the impact on quality and patient safety
- Note the content of the report and that mitigation is put in place where staffing levels are below planned.
- Note that the content of the report is undertaken following national guidelines using research and evidence-based tools and professional judgement to ensure staffing is linked to patient safety and quality outcomes.

Appendix 1. Fill rates for inpatient areas (May 2023): Data adapted from Unify submission

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

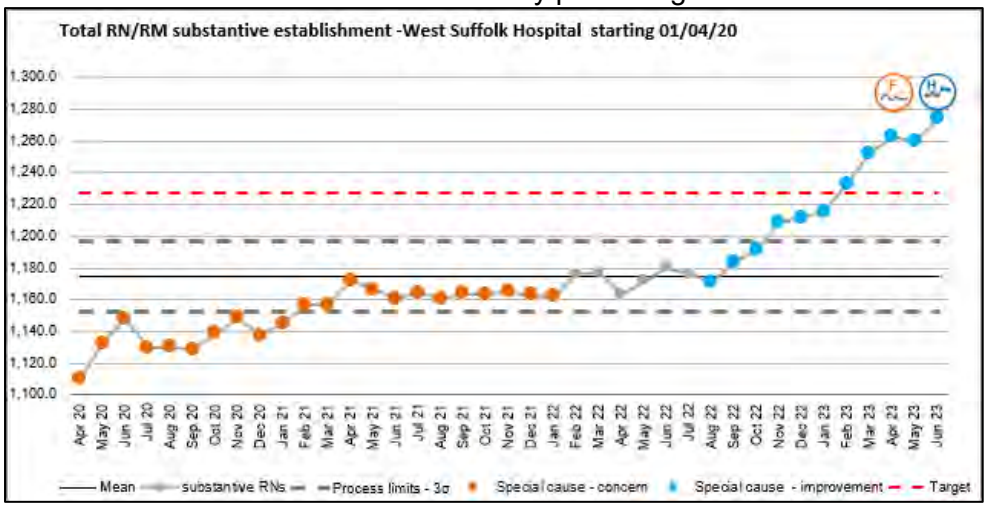
	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	RNs/RMN		Non registered (Care staff)		RNs/RMN		Non registered (Care staff)									
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average Fill rate RNs/RM %	Average fill rate Care staff %	Average Fill rate RNs/RM %	Average fill rate Care staff %	Cumulative count over the month of patients at 23:59 each	RNS/RMs	Non registered (care staff)	Overall
Rosemary Ward	1328.25	1098.25	1772.75	1636.25	1004	831	1426	1448.5	83%	92%	83%	102%	983	2.0	3.1	5.1
Glastonbury Court	719.25	717.5	1067	1028.4833	713	727.5	542.5	522.5	100%	96%	102%	96%	550	2.6	2.8	5.4
Acute Assessment	2131	2025	2484	1310	1782.5	1558.5	1422	1069.5	95%	53%	87%	75%	761	4.7	3.1	7.8
Cardiac Centre	1782.5	1583	1060	824	1782.5	1621.5	713	701.5	89%	78%	91%	98%	632	5.1	2.4	7.5
G10	1771	1429.25	1765.5	1493	1069.5	1061	1782.5	1394	81%	85%	99%	78%	707	3.5	4.1	7.6
G9	1428	1354	1423	1178.5	1426	1391.5	1069.5	1074.16667	95%	83%	98%	100%	752	3.7	3.0	6.6
F12	563.5	710	356.5	266.5	713	666.5	356.5	226	126%	75%	93%	63%	240	5.7	2.1	7.8
F7	1782.5	1540.9167	1773.5	1656.5	1426	1181.083333	1735.5	1386.5	86%	93%	83%	80%	683	4.0	4.5	8.4
G1	1444.75	957	356.5	395.5	713	715	356.5	368	66%	111%	100%	103%	485	3.4	1.6	5.0
G3	1690.5	1366	1774.5	1505.75	1012	987.75	1069.5	1362.98333	81%	85%	98%	127%	864	2.7	3.3	6.0
G4	1782.5	1496	1886	1539	1070	996.5	1426	1339	84%	82%	93%	94%	896	2.8	3.2	6.0
G5	1426	1440.5	1773	1248	713	997	1420.5	1293.5	101%	70%	140%	91%	760	3.2	3.3	6.6
G8	2495.5	2052.25	1791	1452.5833	1795.5	1555.333333	1064.5	1006.83333	82%	81%	87%	95%	615	5.9	4.0	9.9
F8	1713.5	1610.5833	1847	1531.5	1069.5	1008.083333	1427.483333	1408.75	94%	83%	94%	99%	723	3.6	4.1	7.7
Critical Care	2736	2305.5	304	206.25	2691	2266.75	0	11	84%	68%	84%	*	388	11.8	0.6	12.3
F3	1782.5	1439.5	2134.5	1700.5	1069	1055.5	1421	1275.1	81%	80%	99%	90%	732	3.4	4.1	7.5
F4	1237	882	940	564	713	653.5	621	457.5	71%	60%	92%	74%	633	2.4	1.6	4.0
F5	1576	1286	1423	1145.25	1069.5	1012	1058	840	82%	80%	95%	79%	698	3.3	2.8	6.1
F6	1982	1764.8333	1419.11667	1332.25	1426	1187.75	713	861.5	89%	94%	83%	121%	942	3.1	2.3	5.5
Neonatal Unit	1228.5	1259.8	495	549.28333	1044	1117	396	396	103%	111%	107%	100%	116	20.5	8.1	28.6
F1	1888	1637.5	710.25	664.25	1426	1426	0	0	87%	94%	100%	*	115	26.6	5.8	32.4
F14	1387	935	362	171.5	744	743.5	0	0	67%	47%	100%	*	106	15.8	1.6	17.5
F9 (winter esc)	1288	1288	1048	1368	966	1027.5	966	1330	100%	131%	106%	103%	744	3.1	3.6	6.7
Total	37,163.75	32,178.38	29,966.12	24,766.85	27,438.00	25,787.75	20,986.98	19,772.83	**87%**	**83%**	**94%**	**94%**	**14125**	**4.1**	**3.2**	**7.3**
* planned hours are zero, so additional support used on ward to mitigate unfilled nursing hours																

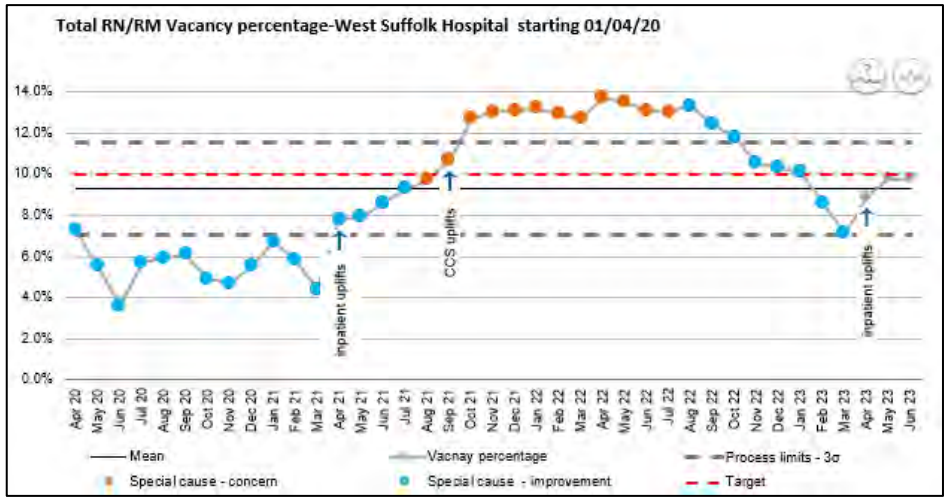
Appendix 1. Fill rates for inpatient areas (June2023) Data adapted from Unify submission

	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	RNs/RMN		Non registered (Care staff)		RNs/RMN		Non registered (Care staff)									
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average Fill rate RNs/RM %	Average fill rate Care staff %	Average Fill rate RNs/RM %	Average fill rate Care staff %	Cumulative count over the month of patients at 23:59 each	RNS/RMs	Non registered (care staff)	Overall
Rosemary Ward	1291.25	1068.25	1730	1644.5	977.5	860	1380	1323	83%	95%	88%	96%	950	2.0	3.1	5.2
Glastonbury Court	698.75	698.5	1029.5	964.5	690	690	525	521	100%	94%	100%	99%	520	2.7	2.9	5.5
Acute Assessment	2068	1895.6667	1607.75	1131.25	1697.5	1680	1035	870.75	92%	70%	99%	84%	761	4.7	2.6	7.3
Cardiac Centre	1713.5	1541	1035	787.5	1725	1633	690	690	90%	76%	95%	100%	632	5.0	2.3	7.4
G10	1720.5	1448.5833	1717.5	1423.5	1023.5	1023.5	1715	1402.16667	84%	83%	100%	82%	707	3.5	4.0	7.5
G9	1377.5	1257.1667	1363	1157.75	1380	1312	1035	1112	91%	85%	95%	107%	752	3.4	3.0	6.4
F12	540.5	696.25	345	366	690	636.5	335.5	356.5	129%	106%	92%	106%	240	5.6	3.0	8.6
F7	1712.5	1499.5	1594.5	1520.6667	1380	1238.416667	1725	1469.5	88%	95%	90%	85%	683	4.0	4.4	8.4
G1	1380	980.5	339.5	343	690	690	345	341.916667	71%	101%	100%	99%	485	3.4	1.4	4.9
G3	1640.5	1329.5	1716.5	1484.1667	989	945	1035	1260	81%	86%	96%	122%	864	2.6	3.2	5.8
G4	1729.5	1454.5	1833	1571.25	1035	989.5	1401	1345.5	84%	86%	96%	96%	896	2.7	3.3	6.0
G5	1380	1359.5	1742.5	1283.45	690	1000.916667	1365.5	1292.5	99%	74%	145%	95%	760	3.1	3.4	6.5
G8	2353.5	1942.1667	1581	1401.3333	1702	1574.083333	1035	1083	83%	89%	92%	105%	615	5.7	4.0	9.8
F8	1571	1487	1675	1425	1035	951.0833333	1380	1388.5	95%	85%	92%	101%	723	3.4	3.9	7.3
Critical Care	2749	2434	294.75	227.25	2754.5	2361	0	40.5	89%	77%	86%	*	388	12.4	0.7	13.0
F3	1724	1344.5	2065.5	1628.6667	1035	1033	1380	1303.5	78%	79%	100%	94%	732	3.2	4.0	7.3
F4	1189	954	934	665.5	644	632.5	594	394.5	80%	71%	98%	66%	633	2.5	1.7	4.2
F5	1345.5	1333.9167	1380	1001	1012	967.5	1035	844	99%	73%	96%	82%	698	3.3	2.6	5.9
F6	1733	1498.75	1345	1236.1667	1379.5	1133.916667	690	908.833333	86%	92%	82%	132%	942	2.8	2.3	5.1
Neonatal Unit	1161	1139.8333	473.8	527.55	936	945.5	492	480	98%	111%	101%	98%	116	18.0	8.7	26.7
F1	1741	1526	674.75	663.25	1334	1331.75	0	11.5	88%	98%	100%	*	115	24.9	5.9	30.7
F14	360	361.16667	0	0	720	720	0	0	100%	*	100%	*	106	10.2	0.0	10.2
F9 (winter esc)	1288	1288	1288	761	966	563.5	966	671.583333	100%	59%	58%	103%	744	2.5	1.9	4.4
Total	34,467.50	30,538.25	27,765.55	23,214.25	26,485.50	24,912.67	20,159.00	19,110.75	**89%**	**84%**	**94%**	**95%**	**14062**	**3.9**	**3.0**	**7**
* planned hours are zero, so additional support used on ward to mitigate unfilled nursing hours																

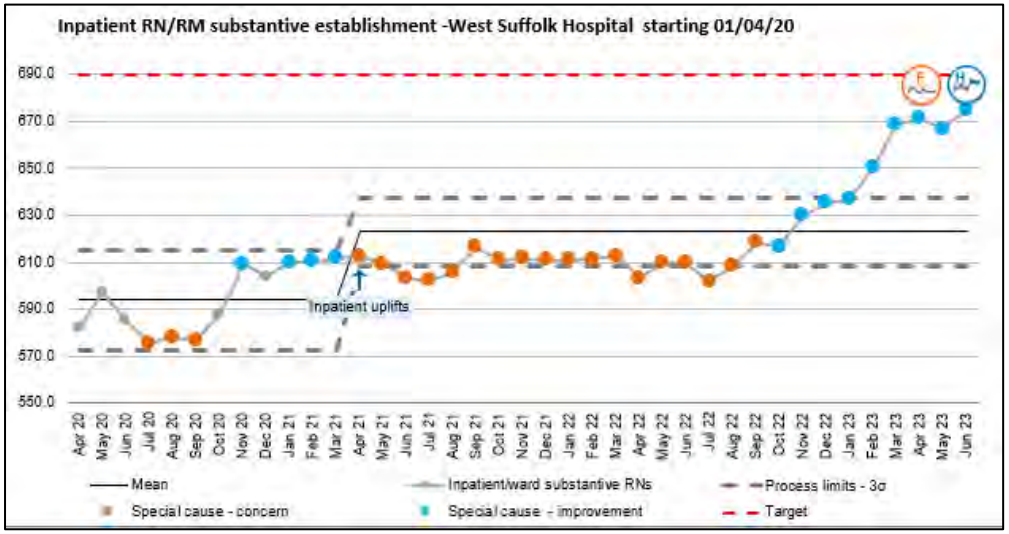
Appendix 2 SPC charts.

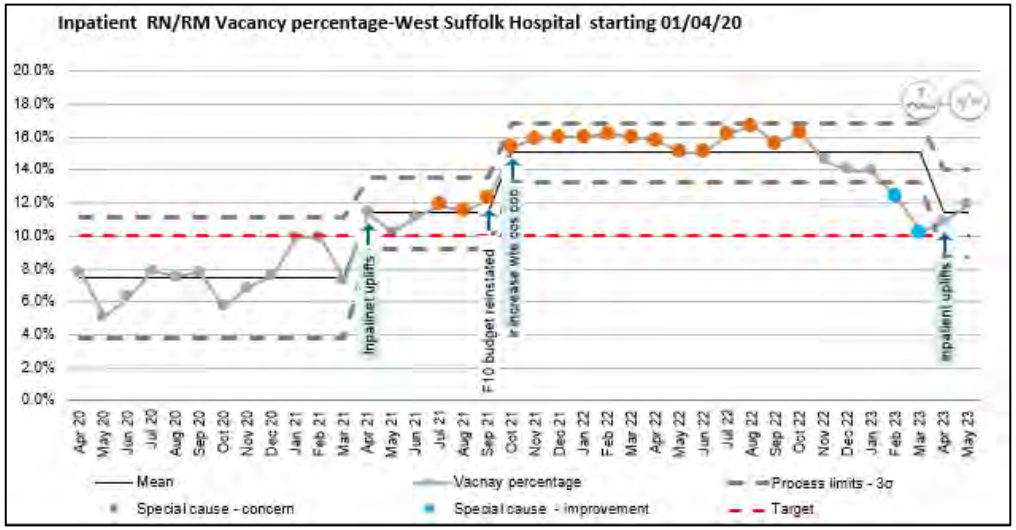
Total RN/RM establishments and vacancy percentage



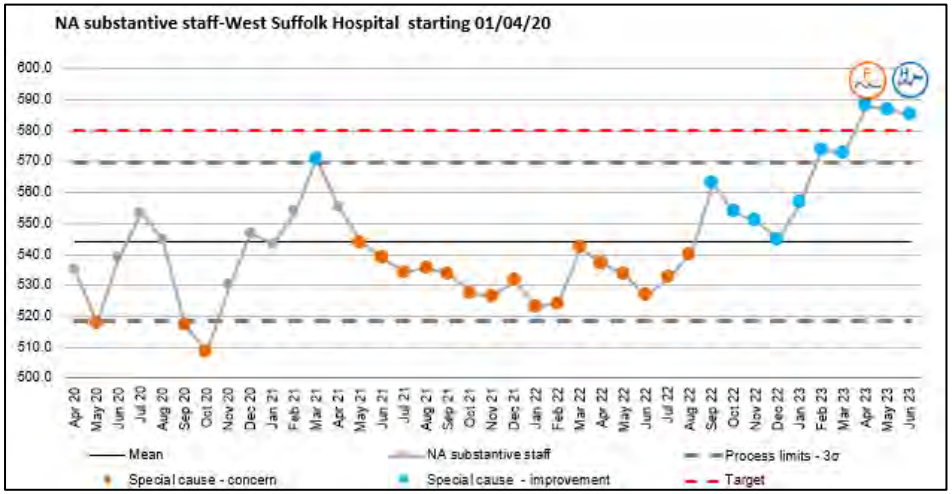


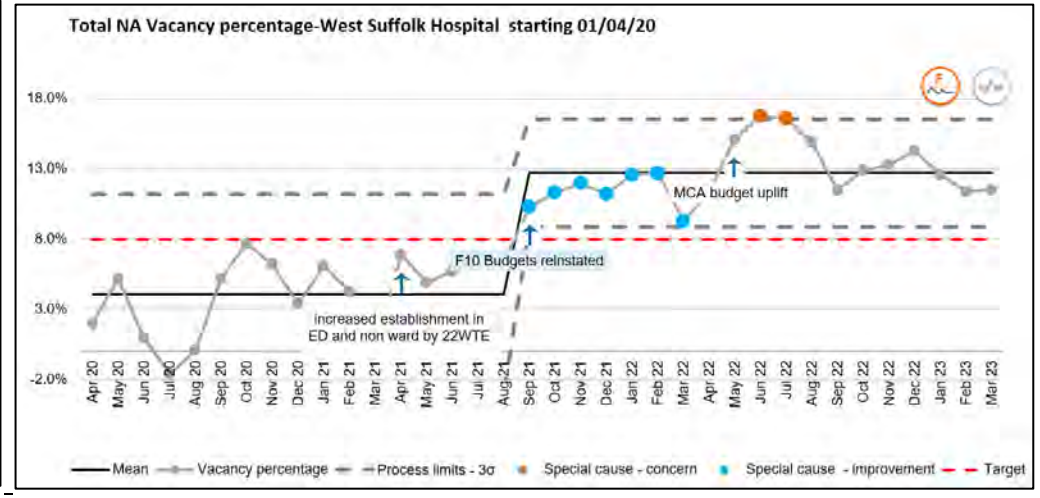
Inpatient RN/RM establishments and vacancy percentage



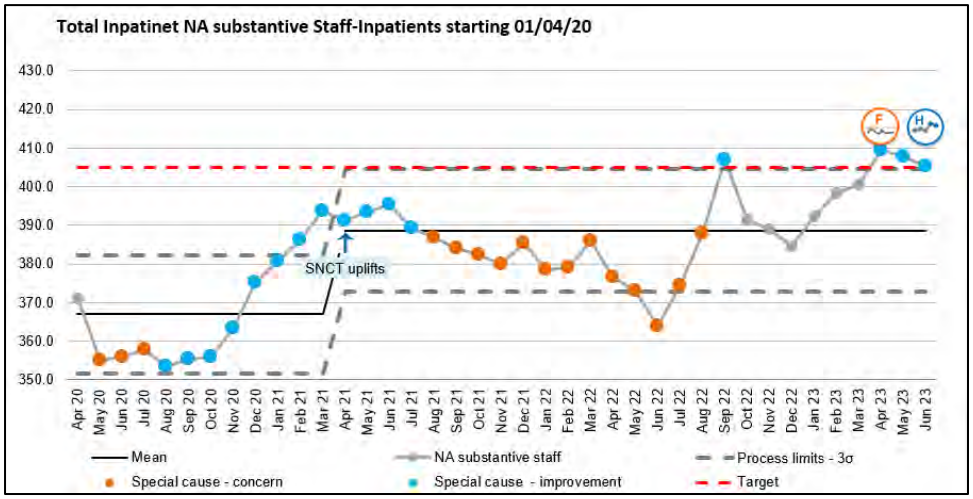


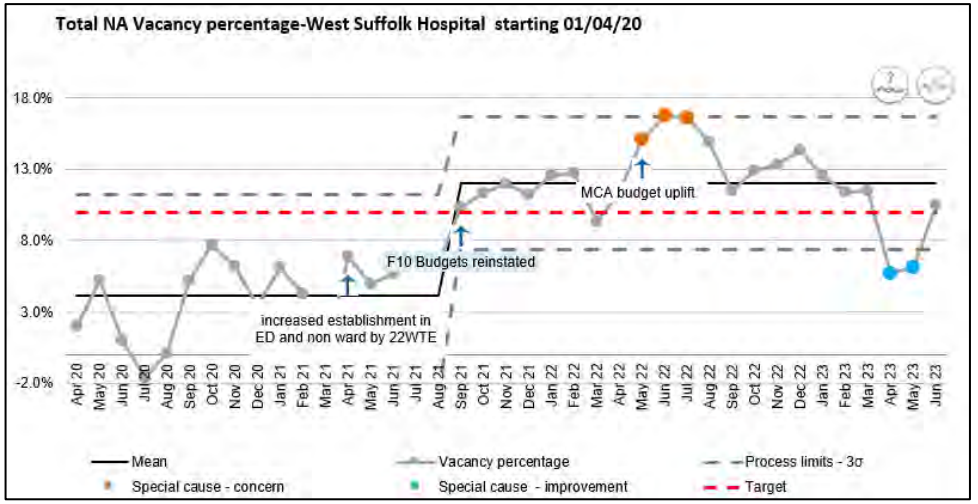
Total NA WTE numbers and vacancy percentages





Inpatient WTE numbers and vacancy percentage





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.
Unable to make home visits

4.4.1. Quality and Learning Report, including learning from Deaths

To Assure

Presented by Susan Wilkinson

Board of Directors

Report title:	**Quality & learning report**
Agenda item:	4.4.1
Date of the meeting:	July 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

What - This report provides the quarterly quality & learning report for the trust in its current format. Usually reported through the Improvement committee, the Board is receiving this report directly in order to make decisions about how it can be improved in future iterations.

So what – It is acknowledged that the current report has a number of flaws including but not limited to:

- Repetition of reporting pathways from some subjects e.g. quarterly incident analysis is already reported via PQASG (Patient quality & safety governance group), learning from deaths is reported via the mortality oversight group reports to PQASG.
- Provides a very basic level of reporting for other subjects e.g. learning from complaints.
- Does not include any details for some subjects e.g. learning from clinical audit.
- Is not replicated through an equivalent pathway to the organisation (only the board get this report, it does not have an equivalent at divisional level).
- It does not provide robust assurance on improvement progress.

What next - The Board is asked to consider a proposal to review the structure of this report to develop a more integrated approach that enables demonstration of learning and improvement from all sources of quality and safety insight. The Improvement committee to have oversight of this development.

Action Required of the Board

1. Receive the report for this quarter
2. Approve proposal with update to be provided to Improvement committee in next meeting (Sept23)

Risk and assurance:	BAF 1(222) Quality governance or service failure
Equality, Diversity and Inclusion:	Not specifically noted
Sustainability:	Not specifically noted
Legal and regulatory context	Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Quality & learning report
Trust Board – 21 July 2023

1. Learning from incidents

1.1 PSII Reports approved since last meeting

The EIR weekly meeting provides a process to allocate learning response to incidents reported as red (major/catastrophic), incidents of concern escalated from the divisions, those which met the definition of our PSIRP categories for PSII and any incidents in the categories nationally requiring a PSII.

WSFT ref.	PSIRP category
WSH-IR-89000	B12 Preventable death
WSH-IR-90005	B10 Emerging concern
WSH-IR-85154	B4 Results management
WSH-IR-89264	B4 Results management
WSH-IR-93155	B11 Never Event

All PSII reports are subsequently reviewed at panel with Executive input (reports shared with the ICB)

Since the last report there have been five PSII reports approved at panel.

Details on the learning / areas for improvement from these can be found in Annex one.

1.2 Quarterly thematic review of incidents reported

The patient safety team undertake a thematic incident review every quarter. The findings of the reviews formed part of the insight informing our PSIRP for 23/24 which went live on 1st June.

Thematic reports also help identify areas for further improvement work in the Trust and findings support the on-going improvement work which the specialist committees are leading on. The report aims to highlight the key trends reported and includes top areas reporting incidents, severity of harm and the key themes in the top six categories reported.

The detailed report is presented to the Patient quality & safety governance group most recently in April (reported to Improvement in May) noted no escalations for concern.

2. Learning from Deaths (LfD)

2.1 Key themes identified

Delayed recognition that a patient is reaching the end of their life continues to be a theme, such that active treatment continues when, with the benefit of hindsight, it was likely to be futile with resultant delay in referral to palliative care.

Our Year three PSIRP has incorporated this into the list of subjects for PSII.

There is also an emerging theme of medicines reconciliation linked to long stays in ED.

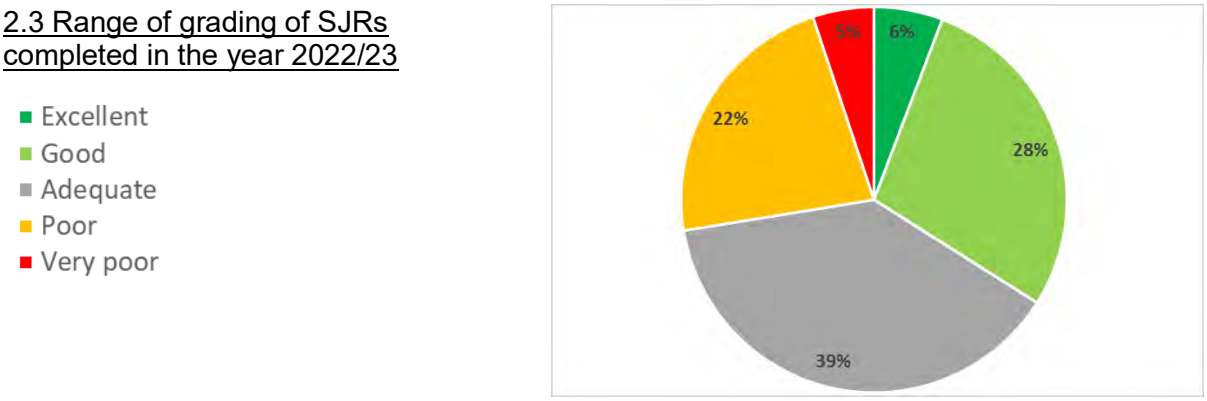
Risk/incident type	Description
1C - Discharge Transfer of care	Barriers to effective discharge due to issues in coordination of system elements (e.g. transport not appropriate for patient needs/arriving home and essential equipment not available so returned to hospital/issues with timing of transport/community carer visit so patient spends night in hospital for non-clinical reason)
2C - Diabetes	Problems with the clinical care / management of diabetic patients when diabetes is not the primary reason for admission to service / hospital
3C - End of life pathways	Patient on an end-of-life pathway receiving unnecessary / inappropriate clinical interventions

2.2 Number of deaths, completion of SJRs and further investigations

	Deaths			
	Total	SJR* completed	With an investigation** completed	Judged as >50% preventable***
Apr-Jun22	271	33/32	2	1
Jul-Sep22	242	32/32	3	1
Oct-Dec22	325	48/48	8	2
Jan-Mar23	321	41/83	2	0
Apr-Jun23	259	8/54		

** SJR - Structured Judgement Review **PSII, PSR, PMRT or HSIB ***PSII only*

2.3 Range of grading of SJRs completed in the year 2022/23



3. Patient and public feedback

The Patient Experience team work closely with the Patient safety team to ensure any incidents of concerns identified through complaints are captured and recorded and collaborate to produce timely feedback on investigations to the complainants. The key themes from patient experience were incorporated into our Year 3 PSIRP.

An example of an improvement action from a complaint is given here.

- A patient suffered a miscarriage and a follow-up appointment was not given. The Maternity department have reviewed their process so that any patient who experiences pregnancy loss after 13 weeks are now automatically offered a follow-up appointment.

4. Learning from claims

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

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

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

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

Report one – WSH-IR-89000
(B12 Preventable death) Rare condition presentation in ED

Safety actions:
- Review and update link and narrative for the Evolve guide to make this more accessible to the ED doctors. (Completed during the investigation)

Areas for improvement:
- There should be clear pathways defined to enable access to specialist teams for patients with complex health needs during out of hours.
- Emergency department doctors to be aware that the ED consultant on-call can be contacted for senior clinical support when making complex decisions during the night.
- Vital information to aid decision making should be easily accessible to the Emergency Department when a patient has rare and complex health needs.

Report two – WSH-IR-90005
(B10 Emerging concern) ED capacity concerns

Safety actions:
- Ensure all manual handling, fire, and evacuation risk assessments are up to date, reflecting the current use of the areas within the ED
- Add signage about the appropriate trolleys to use in the escalation corridor area

Areas for improvement:
- To reduce the number of patients waiting in ED for inpatient beds
- Identify how some project management support might be allocated or prioritised, to ensure the improvements identified to reduce the risk to longer stay ED patients can continue
- Ensure we capture balancing measures associated with improvement initiatives by adopting improvement methodology as business as usual within the organisation
- Review how the education opportunities for staff can be maintained within a risk-based decision-making process related to critical internal incident response demands
- Establish a consistent, clear communication about shortages/issues from the point of care delivery to the level from which appropriate action can be taken
- Consistent use of a structured format for escalation calls
- Ensure acutely ill patients in the waiting room are visible within the system as patients at risk of deterioration
- Clinical input to be included within the risk assessment for offloading ambulances or moving a patient from the waiting room into the main area.
- To ensure there is nursing resource to provide direct care and observation for the patients in the waiting room

- Provide a standard for immediate, essential assessments (e.g., fire/manual handling) to be completed at times of change of use for an area.
- Process for consistent restocking of urgently required items without taking staff from other clinical duties
- Consistent feedback with decision-making after escalation.
- Agree a stream-lined ED escalation/response process which meets operational, tactical, and strategic needs for information to support the service delivery
- Stock and equipment numbers reviewed and set according to the altered patient numbers/needs

Report three – WSH-IR-85154
(B4 Results management) Failure to act on raised blood antibody levels

Areas for improvement:
- Agree standardised processes for results review across the organisation which will enable the right clinician to review test results at the right time
- Establish appropriate safety netting until this is in place
- Effective communication of policy requirements across the organisation, with clear links to audit programmes or other ongoing monitoring processes

Report four – WSH-IR-89264
(B4 Results management) Delay in review of ECG and diagnosis of STEMI (heart attack)

Safety action:
- Risk 'ECG machines within ED failing to upload to e-Care' added to risk register (risk 5819)
- Progress the on-going ECG QI project
- Purchase of eight new ECG machines to replace seven old machines within the ED and to ensure staff are trained and competent to use the machines.
- Add to ED doctor / nurse local induction the need to manually tick the troponin T request within the arrythmia set of blood requests when a troponin T analysis is required.
- Trial new standardised process for laboratory staff to alert the ED clinical team when an abnormal blood result needs to be communicated urgently (this was started during the investigation).

Areas for improvement:
- ECG recordings taken in the ED should be readily accessible to clinical staff to assist in the timely diagnosis of patients with acute coronary syndromes
- For ED clinical team to be alerted promptly when a troponin T sample has haemolysed to enable prompt decision making when time critical interventions are needed.
- There should be a standardised process across the organisation for laboratory staff to follow when there is abnormal blood results that meet the criteria for urgent communication to the clinical teams.

Report five – WSH-IR-93155
(B11 Never Event) Wrong implant/prosthesis

Safety action:
- Bring forward the final implant check to earlier in the operation (completed prior to the investigation)

Areas for improvement:
- Implement a standardised practice for checking implants across the orthopaedic team, so that all staff in the team are clear what to expect.
- Review the way the compatibility check is worded and include this in an updated version of the trust guideline in line with NatSSIPs 2.

Annex 2 – Issues identified, learning and actions from claims

Triangulation of Incidents/claims

Incident reporting confirms the top 4 incident types traditionally recorded each quarter are: Pressure Ulcers, Falls, Medication; and Clinical Care & treatment. There is symmetry between WSFT incident reporting themes and ongoing claims as described below.

There are 82 active claims. No new claims relate to falls, pressure ulcers or medication errors this quarter. The only changes are to the clinical care and treatment sub speciality code. Reference is also made to Early Notification Scheme (ENS) cases for the first time, which although are not formal claims yet, are obstetric cases which are reviewed by NHSR after a HSIB investigation has taken place to see if care satisfies the test for negligence and thus pre-emptive admissions are made if they do:

- **73/82** active cases relate to clinical negligence claims, including:
    - 3 Early Notification Scheme cases under investigation.
    - 3 Covid-19 claims.
    - 59 claims relate to clinical care and treatment.
    - 4 relate to medication errors.
    - 1 involves care of a Pressure Ulcer.
    - 1 re a hospital Fall.
- **9/82** are Personal Injury claims (slips, trips falls/accidents at work etc) involving staff or members of the public.

***How have we improved* - Learning from Claims**

For context, we have received 16 new claims: 12 clinical negligence claims and 4 PI claims. 9 cases have been closed this quarter: 6 clinical negligence cases and 3 PI claims:-

- The PI claims were low value and all related to damage to staff cars parked in the staff car park. 2 relate to strimming incidents where stones broke windscreens and the other related to bins not being properly secured and were blown into a car. Re learning: the Estates Team have now changed the time of day the strimming will occur and found a method to secure the bins to prevent them being blown away in future.
- The Urology group action litigation has finally been closed with last damages payment being made. The service has changed significantly since 81 patients were independently reviewed back in Jan 2016. Only 3 cases resulted in financial compensation being paid by NHSR, out of 20 cases that were referred to them. An action plan was created in 2016 following the independent review and this case is of historical significance only. By way of added reassurance, based on GIRFT data (which looks at costs of claims v activity) WSFT's Urology Service is ranked in Tier 3 – Tier 1 is best and 4 is expensive.

As previously reported, as a failsafe mechanism, all new claims are checked to ensure they have been investigated by the Patient Safety team. Any that have not, have a retrospective Datix incident report raised so that any learning can be identified. Since April 2023, **2 claims have <u>not</u>** previously been the subject of a Datix investigation, or a complaint, prior to being notified to the Claims team and an investigation has commenced.

What do we do well

It is important to note that two clinical negligence cases were successfully defended where clinical care and treatment was endorsed as appropriate and satisfactory by independent expert evidence.

Historic cases

As part of the work following the GIRFT review last year, 18 historic cases were identified as not being investigated as a complaint or incident prior to a claim being raised. This has prompted the Legal team, with assistance from the Incident team, to review all those cases and undertake a retrospective review. All were settled either on a litigation risk basis (where care may have been appropriate but other risks in defending the case to trial may have led to settlement being undertaken) or given the long tail for claims to be raised, were of historical value only.

4.4.2. Maternity Services

Karen Newbury & Simon Taylor

attendance

For Approval

Trust Open Board – 21st July 2023	
Report title:	Maternity quality, safety, and performance report
Agenda item:	4.4.2
Date of the meeting:	21st July 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 Justyna Skonieczny, Deputy Head of Midwifery

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

Executive summary:	This report presents a document to enable board scrutiny of Maternity services and receive assurance of ongoing compliance against key quality and safety indicators and provide an update on Maternity quality & safety initiatives. The papers presented are for information only and issues to note are captured in this summary report. All the attached papers have been through internal governance process including the Maternity and Neonatal Safety Champions and will then be shared with the Local Maternity and Neonatal System. **This report contains:** • Maternity improvement plan • Safety champion feedback from walkabout • Listening to staff • Service user feedback • Reporting and learning from incidents • Maternity Dashboards (Annex A) • MIS Safety Action 5- Midwifery Staffing Report October 2022-March 2023 • Neonatal Transitional Care Q4 Report January to March 2023 • Perinatal Quality Surveillance Model v 2

	• Monitoring of the Obstetric Consultant Presence at clinical scenarios and situations • Maternity Claims Scorecard, incident and complaint data Quarterly review Q1 2023/24 CLOSED BOARD
Action required/ recommendation:	For information and record of reports received.

Previously considered by:	Maternity Quality and Safety Group Maternity and Neonatal Safety Champions Local Maternity and Neonatal System
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.	**Detailed sections and key issues**
1.1	**Maternity improvement plan** The Maternity Improvement Board (MIB) receives the updated Maternity improvement plan monthly. This has been created through an amalgamation of the original CQC improvement plan with the wider requirements of Ockenden, HSIB, external site visits and self-assessment against other national best practice (e.g., MBRRACE, SBLCBv2, UKOSS). In addition, the plan has captured the actions needing completion from the 60 Supportive Steps visit from NHSE/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. To exit the MSSP an overarching Sustainability Plan was submitted and NHSE have requested to review the plan for updates in the near future. Date to be arranged.
1.2	**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'. Roger Petter our new Non-Executive Maternity and Neonatal Safety Champion Safety Champion completed walkabouts in May and June 2023.

	On the 17th of May Roger visited Labour suite and spoke to many different staff groups and grades. The general feedback was very positive, and the atmosphere was good, giving the impression of a happy, efficient well-run unit. An example of the comments made. "I would be happy for my daughter to deliver here" "Feels safe" "Good teamworking" "Worked in two previous maternity units and this is the best" "The senior team are visible and approachable" "Friendly place and I feel valued" "Happy here" "Atmosphere is good" There were some comments relating to areas for improvement including more elective caesarean section slots, inconsistent allocation of breaks on night shifts, handover for staff moving mid shift is not always happening, staff movement to accommodate workflow and support for students/ preceptors and international midwives. To address the comments above; work continues creating more elective section theatre slots, however this is very much dependent on demand which is extremely variable from one week to the next. Inconsistent break prioritisation, handovers and staff movement will be fed back to the leads for Labour suite for awareness. Due to the unpredictable workload, there is always the requirement for a flexible workforce, however this should be approached in a fair manner. Allocation of breaks to be reviewed by the maternity staff forum, including resolution and ongoing monitoring. It has been acknowledged that there is an increased need for support for our staff and to address this we allocated one of the Practice Development midwives to work with all midwives during their preceptorship programme. We have introduced the Legacy Midwife role to support junior staff and allocation of placements have been assessed to ensure no one area is saturated by learners and preceptors at any one time. On the 6th of June Roger visited the Neonatal Unit where he spent a couple of hours talking to staff of different grades and job roles. The overarching impression was of a friendly well-run unit staffed by individuals who pull together as a team and care hugely for their patients. During observation of a ward round, it was felt that there was a good mutual respect between the various members of staff and particularly between the nurses and doctors, with no sense of "them and us". Good team working for the benefit of the patients, good communication and a healthy working atmosphere was also observed. Staff did comment that the current medical cover for the unit can result in a frequent change of management plans, which can be confusing for the parents and, for junior staff it may mean they are unfamiliar with the environment and differing pieces of equipment. The Multi-disciplinary training lead for the department is working with all staff to ensure that the induction process is robust to address this. Staff felt the training offered is good, they were generally happy and felt that they were part of a good unit.
1.3	**Listening to Staff** The National Staff Satisfaction Survey results were published in April 2023 and the divisional operational managers are working on an action plan regarding areas for further development. The maternity and neonatal service continues to promote all staff accessing the Freedom to Speak up Guardians, Safety Champions, Professional Midwifery Advocates, Unit Meetings and 'Safe Space'. In addition to this there are maternity staff focus groups, which provide a forum to listen to staff. On the back of recent retention data from the national and regional teams, it is recognised that the majority of midwives are leaving the profession 2-5 years after qualification. We are committed to working with the Local Maternity /Neonatal System and regional team to address this. In response we have undertaken a flexible working survey, commenced Midwifery Band 6 forums, and are undertaking 'stay conversations' which have been received very positively. The 'Legacy Midwife' role has now

	commenced, and a pilot of self-rostering (as indicated by the flexible working survey results) is underway in differing teams across maternity.
1.4	**Service User feedback** The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether patients are happy with the service provided, or where improvements are needed. It's a quick and anonymous way to give views after receiving NHS care or treatment.

Ward/Dept	May Survey returns	May FFT score	June Survey returns	June FFT Score
F11	62	100	56	98
Antenatal	11	100	10	100
Postnatal Community	6	100	7	100
Labour Suite	39	100	33	100
Birthing Unit	8	88	3	100
NNU	13	100	13	100

Feedback received via FFT:

- "The midwives have been supportive, kind and patient"
- "Was very supportive and helpful and very comforting"
- "Everyone was so friendly and helpful. I felt very welcome and looked after"
- "Thank you so much - everyone e was so caring, thoughtful and professional"

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

On review of enquiries and complaints received during May and June 2023 the main themes continue to be regarding clinical treatment and communication. The aim for 2023 is to develop meaningful personalised care plans from the antenatal period through to the intrapartum and postnatal stages to help address this.

1.5	**Reporting and learning from incidents** During May and June 2023 there were no new cases referred to the Healthcare Safety Investigation Branch (HSIB). The maternity service is represented at the Local Maternity and Neonatal System (LMNS) monthly safety forum, where incidents, reports and learning are shared across all three maternity units.
1.6	**Maternity dashboards (Annex A)** Indicators of maternity safety & quality are regularly reported and reviewed at monthly Maternity Governance meetings. A sub-set are provided for board level performance (the Performance & Governance dashboard). Red rated data will be represented in line with the national NHSI model of SPC charts. Please see below:

	Indicators	Narrative
	Post-partum Haemorrhages (PPH) for Lower Section Caesarean Sections >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 (LMNS) and region and small improvement have been noted in month, however this continues to represent common cause variation PPH risk assessment form introduced. Shared learning in place across the LMNS.
	Smoking at the time of delivery- standard <6%	Smokefree pathway commenced beginning of May 23. Smoking cessation midwife, supported by maternity support workers to work with families that smoke to provide a bespoke model of support. New pathway has been in place for 6 weeks now and better engagement from service users have been noted. However, the data does not yet show significant sustained improvement.
	Compliance with asking Domestic Abuse questions	Although there continues to be a small improvement noted with antenatal compliance the data remains common cause variation. A drop in postnatal compliance in noted is noted but remains common cause variation, further work is required. 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. Differing solutions regarding alerts for non-compliance in discussion as multiple clinicians are responsible for the completion. QI project due to be launch in July 2023.
	3rd/4th degree tears following instrumental deliveries	Small number of cases and therefore to monitor via monthly maternity Quality and Safety meetings. Due to the apparent peak following instrumental deliveries all cases to be reviewed and learning shared with all staff.

1.7 **Maternity Incentive Scheme (MIS) Safety Action 5- Midwifery Staffing Report October 2022- March 2023**

Executive summary:

- National tools, Local Maternity and Neonatal System (LMNS) collaboration and BirthRate Plus methodology have been used to determine the midwifery establishment.
- The funded establishment was agreed by the Trust Board in May 2022. Awaiting confirmation of 23/24 budget.
- Robust escalation processes and team working has mitigated some staffing challenges due to absences but gaps on the rota are still a challenge.
- Essential actions from the Ockenden report and subsequent cessation of target dates to implement MCoC have resulted in temporary suspension of two community-based teams to assist with safe staffing of both the hospital and community services.

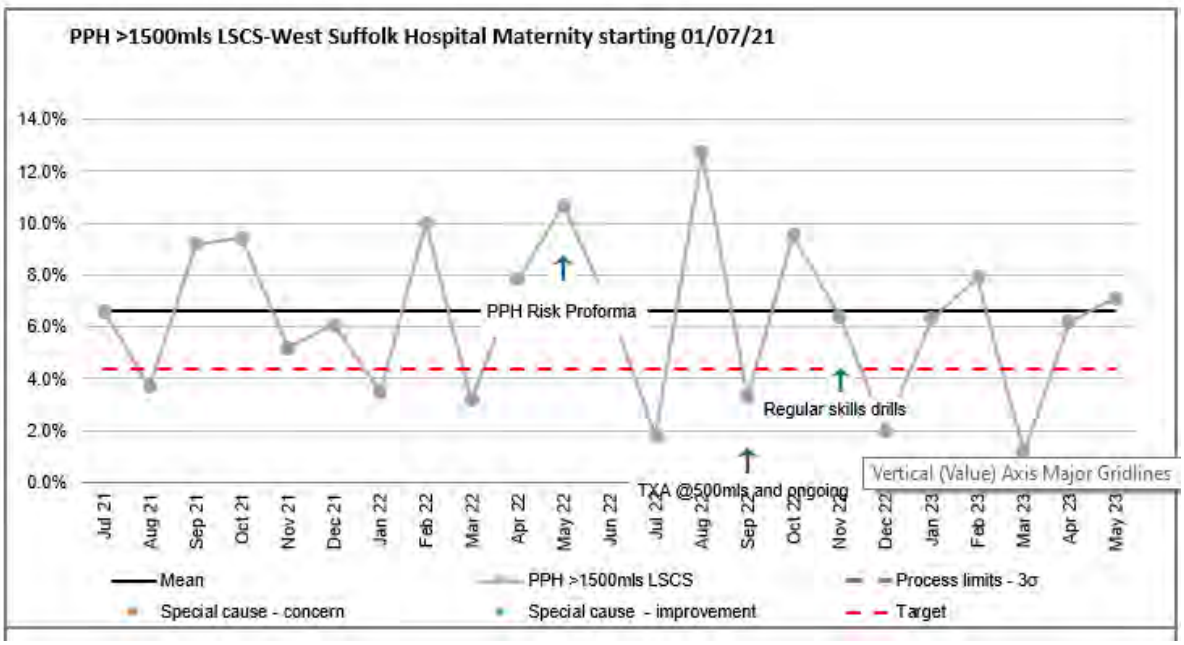
	• One to one care of women in labour over the 6-month period of the report has been maintained at 100% compliance • Supernumerary status of the labour suite co-ordinator (LSC) has been consistently above 99% in this reporting period - October to March 22/23. The aim is for 100%. • Vacancies for experienced band 6 midwives are difficult to fill and whilst recruitment of band 5 midwives and those from overseas has been successful, the support and supervision required is considerable. • Midwife vacancies at the end of March 23 was 29.9 wte which equates to a 22% vacancy rate. The service is currently employing approximately 10.00 wte midwives each month through the bank and staff working additional hours. • The impact of increasing student midwife numbers and return to practice courses will not be realised for at least another 2-4 years. • West Suffolk is actively participating in the regional work of midwifery apprenticeship schemes with the intention of having places on the first cohort when these are in place. • The Midwife to Birth ratio has been set locally at 1:27.7; there were three months when this was not met and a ratio of 1:28 or above was reported. This reflects the vacancy factor. • Red Flags continue to be monitored daily and collated monthly: delays in induction of labour remains the main clinical reason <u>Recommendations:</u> • Close monitoring of the supernumerary status of the LSC will continue, with each instance of non-compliance investigated and themes identified. • Active recruitment to vacancies will continue, with an effective preceptorship process in place to retain and develop staff. • Further Midwifery Continuity of Carer (MCoC) teams will be on hold until safe staffing levels can be assured throughout the service. • Recurring themes from 'red fags' relating to staffing will be reviewed and where appropriate and possible further mitigations in place. • Escalation plans will be used to promote safe care
1.8	**Neonatal Transitional Care (NTC) Q4 Report January to March 2023** An operational Policy for Neonatal Transitional Care CG10602 has been in place since 2021. This has been further updated in March 2023 to reflect the changes introduced as part of the Kaiser® Neonatal Sepsis Calculator which was introduced in December 2022. Babies are admitted to NTC from birth, in the postnatal period in hospital, readmission from the community setting or as a step down from NNU care. There was an increase in the number and proportion of babies admitted to NTC in this quarter. Most babies (33%) admitted to NTC were a stepdown from NNU (neonatal unit). These would be the babies that had been admitted to NNU for more than 4 hours whose condition would have been improved enough to be transferred to NTC with mum with continued medication and care plans in place. This indicates that NTC is being utilised appropriately and often to work towards reducing the time of maternal and neonatal separation which is the main purpose of having a NTC service. The numbers of babies being admitted from birth and from the community are very similar (27% and 26% respectively). The reasons for admission are consistent throughout the months. Babies are being admitted from birth for prematurity, signs of respiratory distress syndrome, maternal and/ or neonatal sepsis and early jaundice and for Kaiser observations. Babies are being referred in to NTC from the community with jaundice, weight loss, vomiting and feeding support. The smallest group is the babies admitted from the postnatal ward (12%) who needed NTC care due to grunting and Kaiser observations. The first results from the audit of the introduction of the Kaiser® Neonatal Sepsis Calculator demonstrate that there were no positive blood cultures in the neonates identified as not requiring antibiotics. This is reassuring that babies were correctly risk assessed using the calculator and no babies were missed who developed a culture confirmed neonatal infection. No babies were readmitted with suspected sepsis in the first 7 days of life. <u>Recommendations:</u> • Audit findings to be shared

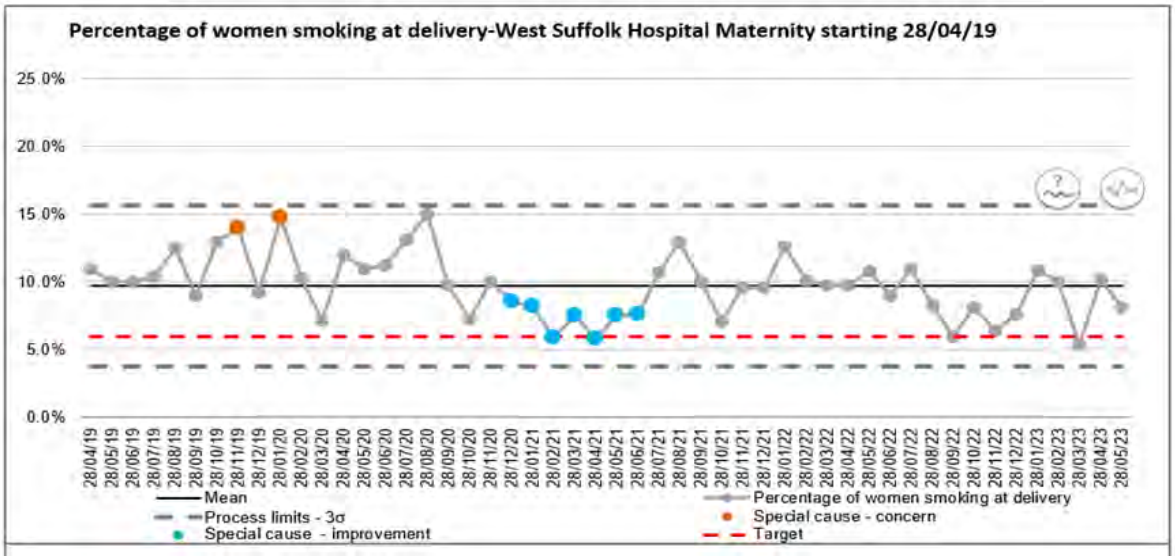
	• Further work is being planned to include moderate to late well preterm neonates into Transitional Care in the Trust in accordance with updated BAPM guidance. • Work on introducing NEWTT 2 assessment and wellbeing observations into practice is being planned when the electronic versions of observation charts are available on the information system in the Trust.
1.9	**Perinatal Quality Surveillance Model v 2** The perinatal quality surveillance model (PQSM) is designed to function in the emerging architecture in the NHS, whereby the Integrated Care Board (ICB) (with full involvement from providers) will be responsible for system planning, governance, accountability, management of performance and reducing unwarranted variation in care and outcomes. Arrangements for quality oversight must be in place for each local system. The local PQSM has been updated to reflect the pathways and shared learning from providers to the National Maternity Programme leads via the LMNS and Regional teams. This has been approved by the Regional Chief Midwife in line with the requirements for meeting the timeframes for Maternity Incentive Scheme Year 5.
2.0	**Monitoring of the Obstetric Consultant Presence at clinical scenarios and situations** Successive maternity reports have identified the important role consultants play in being key clinical decision makers, maintaining standards, reducing variations in patient care and role modelling professional behaviour (RCOG 2021). Maternity care is an ever evolving, active environment where there can be constant workload with unexpected emergencies which require timely expert decision and actions to ensure safety to both mother and baby. The RCOG provide clear guidance as to when consultant attendance is required, and this audit was undertaken to ensure the acute obstetric care provided by West Suffolk Hospital (WSH) is in keeping with these current guidelines. This audit confirms that the Consultant Obstetricians are working within this safety framework.
2..1	**Maternity Claims Scorecard, incident and complaint data Quarterly review Q1 2023/24 (CLOSED BOARD)** This report provides a summary of the maternity claims scorecard from 01/04/2012-31/03/2022 alongside incident and complaint data identifying themes and subsequent learning. For the WSH maternity related claims equate to 11% of the volume of claims but close to 50% of the value. This is in line with the national picture of 12% of the claims and 63% of the total value of those claims. In the last ten years maternity claims for our Trust is approximately £42.8 million with the average claim being about £1.5 million. The detail of the claim's scorecard will be looked at quarterly going forward. The top claims are failure or delay in treatment, obstetrics, unexpected death or delaying diagnosis and failure to monitor. These causes were also reflected in the safety recommendations from historical Healthcare Safety Investigation Branch (HSIB) cases. The Trust has not had any HSIB safety recommendations since mid-2021 and believes that it is quite a strong indication that we have learnt from previous incidents, and we have a more robust process in place to ensure a safe maternity unit. For Quarter 1 2023/24 three themes have been identified; delay in induction of labour, delay in treatment/recognition of a deteriorating patient and incorrect risk assessment at booking. The subsequent learning has been captured in a four-point action plan, three of which have already been completed and the fourth action is in progress with a target date of the end of August 2023

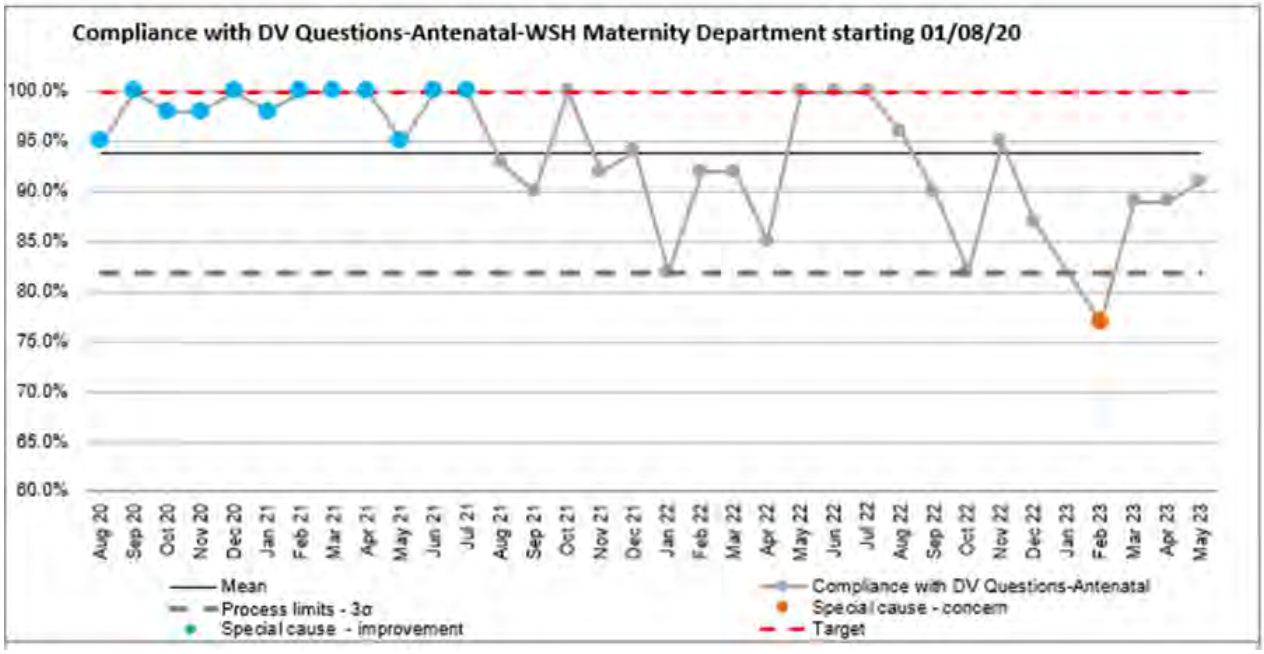
Trust priorities	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**

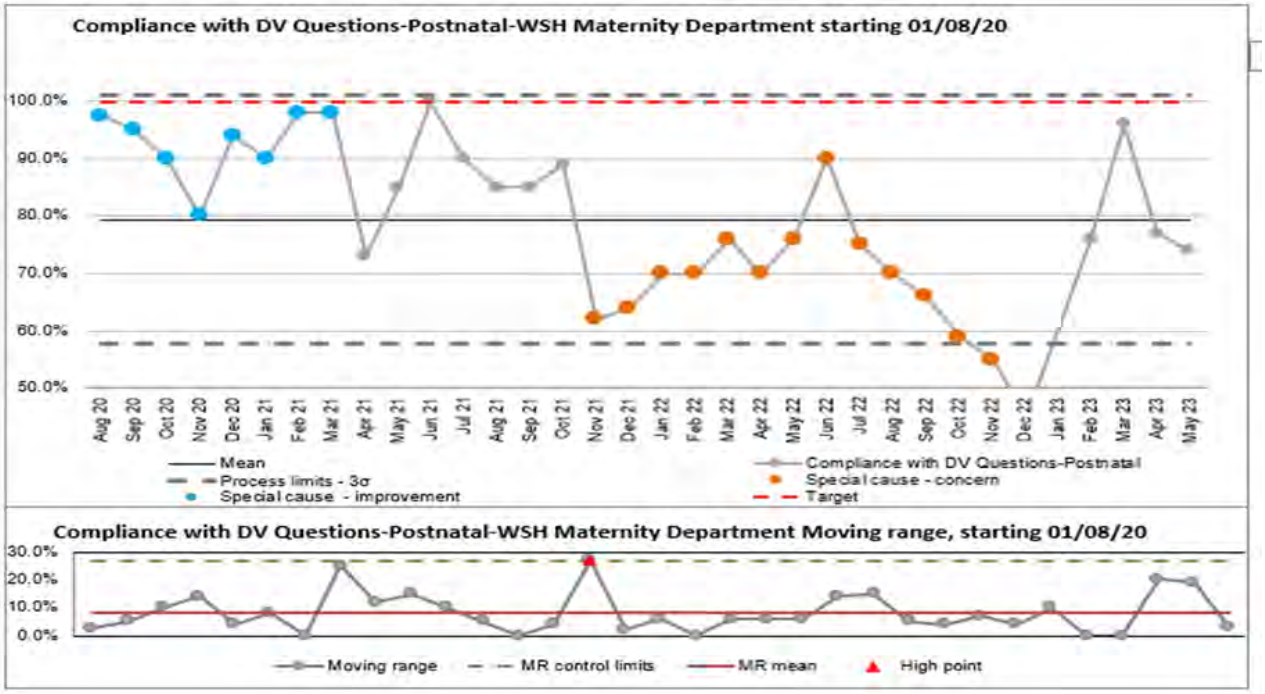
Trust ambitions	Deliver personal	Deliver safe care	Deliver joined-up	Support a healthy	Support a healthy	Support ageing well	Support all our
Previously considered by:	Maternity Quality and Safety Meeting						
Risk and assurance:	Maternity & Neonatal Safety Champion Meeting						
Legislation, regulatory,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

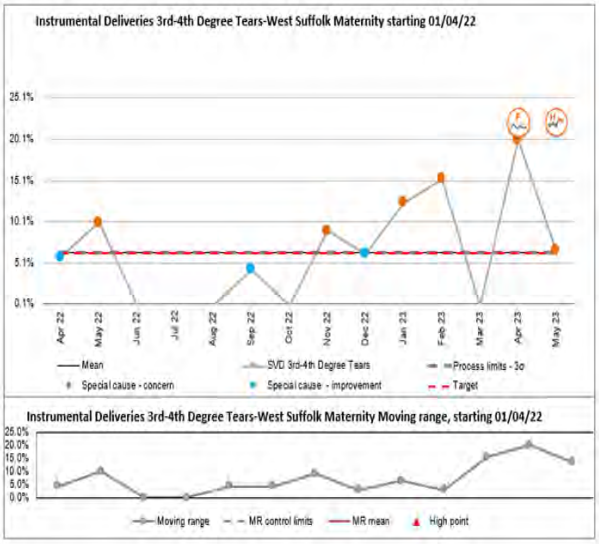
Annex A- Maternity Dashboard SPC Charts:



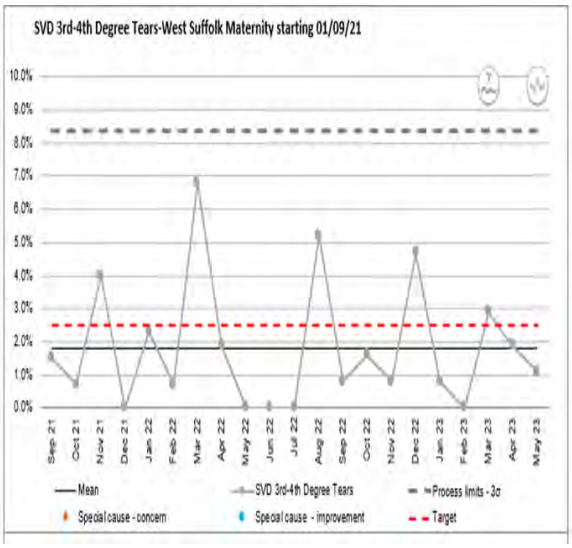

Percentage of women smoking at delivery-West Suffolk Hospital Maternity starting 28/04/19
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
Mean
Process limits - 3σ
Special cause - improvement
Percentage of women smoking at delivery
Special cause - concern
Target

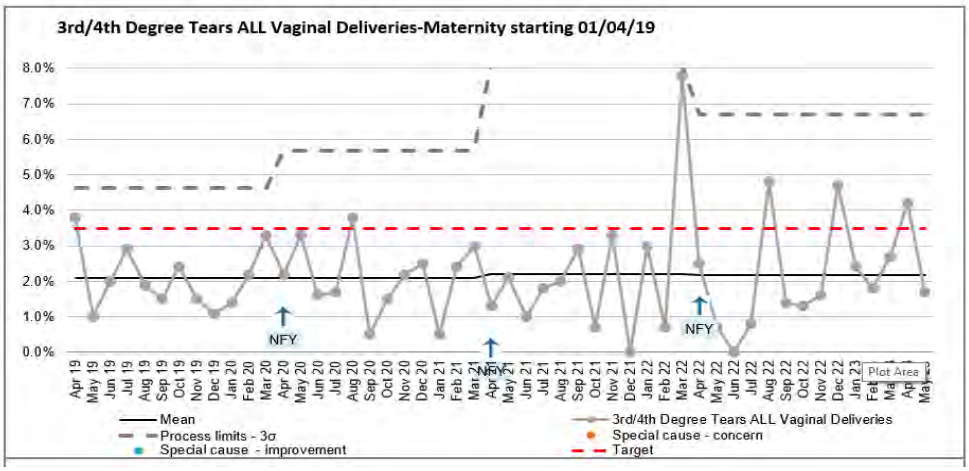

Compliance with DV Questions-Antenatal-WSH Maternity Department starting 01/08/20
100.0%
95.0%
90.0%
85.0%
80.0%
75.0%
70.0%
65.0%
60.0%
Mean
Process limits - 3σ
Special cause - improvement
Compliance with DV Questions-Antenatal
Special cause - concern
Target


Compliance with DV Questions-Postnatal-WSH Maternity Department starting 01/08/20
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
Aug 20
Sep 20
Oct 20
Nov 20
Dec 20
Jan 21
Feb 21
Mar 21
Apr 21
May 21
Jun 21
Jul 21
Aug 21
Sep 21
Oct 21
Nov 21
Dec 21
Jan 22
Feb 22
Mar 22
Apr 22
May 22
Jun 22
Jul 22
Aug 22
Sep 22
Oct 22
Nov 22
Dec 22
Jan 23
Feb 23
Mar 23
Apr 23
May 23
Mean
Process limits - 3σ
Special cause - improvement
Compliance with DV Questions-Postnatal
Special cause - concern
Target
Compliance with DV Questions-Postnatal-WSH Maternity Department Moving range, starting 01/08/20
30.0%
20.0%
10.0%
0.0%
Moving range
MR control limits
MR mean
High point


Instrumental Deliveries 3rd-4th Degree Tears-West Suffolk Maternity starting 01/04/22
25.1%
20.1%
15.1%
10.1%
5.1%
0.1%
Apr 22
May 22
Jun 22
Jul 22
Aug 22
Sep 22
Oct 22
Nov 22
Dec 22
Jan 23
Feb 23
Mar 23
Apr 23
May 23
Mean
SVD 3rd-4th Degree Tears
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target

Instrumental Deliveries 3rd-4th Degree Tears-West Suffolk Maternity Moving range, starting 01/04/22
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
Moving range
MR control limits
MR mean
High point


SVD 3rd-4th Degree Tears-West Suffolk Maternity starting 01/09/21
10.0%
9.0%
8.0%
7.0%
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
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
Jan 23
Feb 23
Mar 23
Apr 23
May 23
Mean
SVD 3rd-4th Degree Tears
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target


3rd/4th Degree Tears ALL Vaginal Deliveries-Maternity starting 01/04/19
8.0%
7.0%
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
NFY
NFY
NFY
Apr 19
May 19
Jun 19
Jul 19
Aug 19
Sep 19
Oct 19
Nov 19
Dec 19
Jan 20
Feb 20
Mar 20
Apr 20
May 20
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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
Jan 23
Plot Area
Mean
Process limits - 3σ
Special cause - improvement
3rd/4th Degree Tears ALL Vaginal Deliveries
Special cause - concern
Target

4.5. Audit Committee Report - Chair's Key Issues from the meeting

To Assure

Presented by Michael Parsons

Board of Directors	
Report title:	**Chair's Key Issues (CKI) report for Audit Committee.**
Agenda item:	**4.5**
Date of the meeting:	**21 July 2023**
Sponsor/executive lead:	**Craig Black**
Report prepared by:	**Liana Nicholson**

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 report highlights the Chair's Key issues that emerged from the Audit Committee meeting held on 27 June 2023.
Action required/ recommendation:	The board is asked to note the report

Board Assurance Committee CKI Report - Audit Committee (27/06/23)

Agenda Item	Details	Level of Assurance - Substantial - Reasonable - Partial - Minimal	Comments	Action / Escalation
External Audit (EA) (KPMG)	Annual Report and Accounts 2022/23	Substantial	KPMG issued their: • Report to those charged with Governance (ISA 260) • Annual Audit Report For the 2022/23 Annual Report and Accounts. An unmodified audit opinion was issued (including Value for Money). As a result, the 2022/23 Annual Report and Accounts were approved by the Audit Committee with a recommendation for Board approval on 29th June 2023.	Management actions were raised by KPMG in their ISA 260 report, which will be monitored in line with other management actions (from Internal Audit).
Internal Audit (RSM)	Head of Internal Audit Opinion 2022/23	Reasonable	Positive report but, recognises that further enhancements to the framework of risk management and governance are required to ensure effective and adequate internal control.	Audit Committee continual review of audit reports, which will then form the basis of the Head of Internal Audit Opinion for 2023/24. Not all audits for 2022/23 were completed in time and have been moved to the 2023/24 plan, however enough audits were completed in order for RSM to issue their opinion.
Internal Audit (RSM)	Elective Recovery review	Substantial	The Trust's controls surrounding elective care are well designed, with comprehensive strategies in place.	Minor control weaknesses identified.

Agenda Item	Details	Level of Assurance - Substantial - Reasonable - Partial - Minimal	Comments	Action / Escalation
Internal Audit (RSM)	Governance Structure and Framework review	Reasonable	Review confirmed that Governance Structure is well defined, with clear reporting lines to the Trust Board and Assurance Committees.	Work is still in progress with the development of the Terms of References for the Committees and RSM were unable to clearly identify Community Services within the governance structure.
Internal Audit (RSM)	Clinical Prioritisation Programme review	Reasonable	Control processes in place were generally positive in design and operation.	Draft Elective Access Policy requires review and formal approval. Clinical Validation and Harm Reviews document requires updating to clearly define the validation process.
Internal Audit (RSM)	Tenders and payments review	Reasonable	Comprehensive contracts register in place and a well supported procurement policy and procurement manual.	Weaknesses in the compliance of the control framework with regards to entering new contracts e.g. contract management meetings were not being consistently held and improvements are needed in regard to the timely management of expiring contracts.
Counter Fraud (RSM)	Functional standard return	Reasonable	The Counter Fraud Functional Standard Return was submitted at the end of May. Overall the Trust was awarded an overall 'green' rating, with 4 areas marked as 'amber'. The amber areas related to the response to the Counter Fraud survey, with the response rate being too low.	It was suggested by RSM that a good way to improve the response rate of any Counter Fraud survey is to include questions on fraud within the Staff Survey, however consideration should be given as to whether these types of questions are considered a priority.
Counter Fraud (RSM)	Annual Plan 2023/24	Substantial	RSM presented their proposed Counter Fraud work for 2023/24. They noted how the plan was geared to ensure the Trust was hitting standards set by the NHS Counter Fraud Authority and to help the Trust mitigate any risks around fraud and bribery.	Continual review of plan and outcomes by the Audit Committee.

Agenda Item	Details	Level of Assurance - Substantial - Reasonable - Partial - Minimal	Comments	Action / Escalation
			Key aspects of the plan include: • Training for staff (coverage for 2023/24 includes consultants, nursing staff and community staff) • Bespoke training around recruitment for HR • Proactive work with internal audit, around annual leave and consultant job planning.	

5. GOVERNANCE

5.1. Governance report

To Assure

Presented by Richard Jones

Board of Directors - Public	
Report title:	**Governance report**
Agenda item:	5.1
Date of the meeting:	21 July 2023
Sponsor/executive lead:	Richard Jones, Trust Secretary
Report prepared by:	Richard Jones, Trust Secretary Pooja Sharma, Deputy Trust Secretary

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

Executive Summary

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

- Senior Leadership Team report
- Report from board development session
- General condition 6 and Continuity of Services condition 7 certificate
- Foundation Trust Membership Strategy
- Updated report template
- Use of Trust's seal
- Agenda items for next meeting

Action Required of the Board

The board is asked to note the report contents and support adoption of the updated coversheet template (using '*What, So what and What next'*)

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

Governance Report

1. Senior leadership team (SLT) report

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

At its recent meetings SLT considered a number of key issues, which has included discussion of national safety standards for invasive procedures (NatSSIPs) and the prevention, personalised care and health inequalities strategy.

NHS Improvement have commissioned the Centre for Perioperative Care (CPOC) to develop NatSIPPs, from those originally published in 2015, designed to support NHS hospitals in the provision of safer surgical care. NatSSIPs2 incorporates an additional three standards to the previous 5: consent and procedural verification; implant check if required; and equipment reconciliation. The importance of this work was recognised and will prioritised for support through the change hub

2. Board development workshop

A board workshop was held on 29 June to consider a number of strategic and developmental issues, including:

- Delivering our strategy – focusing on reviewing the draft priorities for the year
- New hospital update
- Clinical and care strategy
- Board development forward plan

A summary of the key issues and next steps is detailed below.

2.1 Delivering our strategy

A session was held to review the draft priorities for the year, including measures for success. The approach and overall priorities were welcomed and supported. Some areas for development were identified:

- some measures for success were considered to be actions e.g. frailty model implantation with measures for falls and admission. It was also felt helpful to be inclusive of community services in some of the language
- it was recognised that the EDI priority focus is on staff as it sits within the 'First for staff' ambition. There is an option to perhaps widen this or made reference to EDI within the clinical pathway work
- leadership for change/transformation – it was recognised that we need to develop an immediate plan with an option appraisal. This is in the context of the clear need to meet the Future System change requirements

Agreed to bring back to public board in July and progress in the meantime.

2.2 New hospital update and next steps

Gary Norgate provided an update on the Future System programme, including an outline of the options for fast-track delivery with a summary of key milestones:

- Outline Business Case

- Full Planning
- Construction
- Transformation – Trust and system

2.3 Clinical and care strategy

A session was held to introduce the strategy and key challenges to delivery. This included reflection on the focus of the strategy and how the Board could support delivery.

It was emphasised that pathway review needed to be 'end to end', including prevention, primary care, community and acute. As part of this work it was recognised that is would be helpful to identify early opportunities and longer term changes as part of the programme.

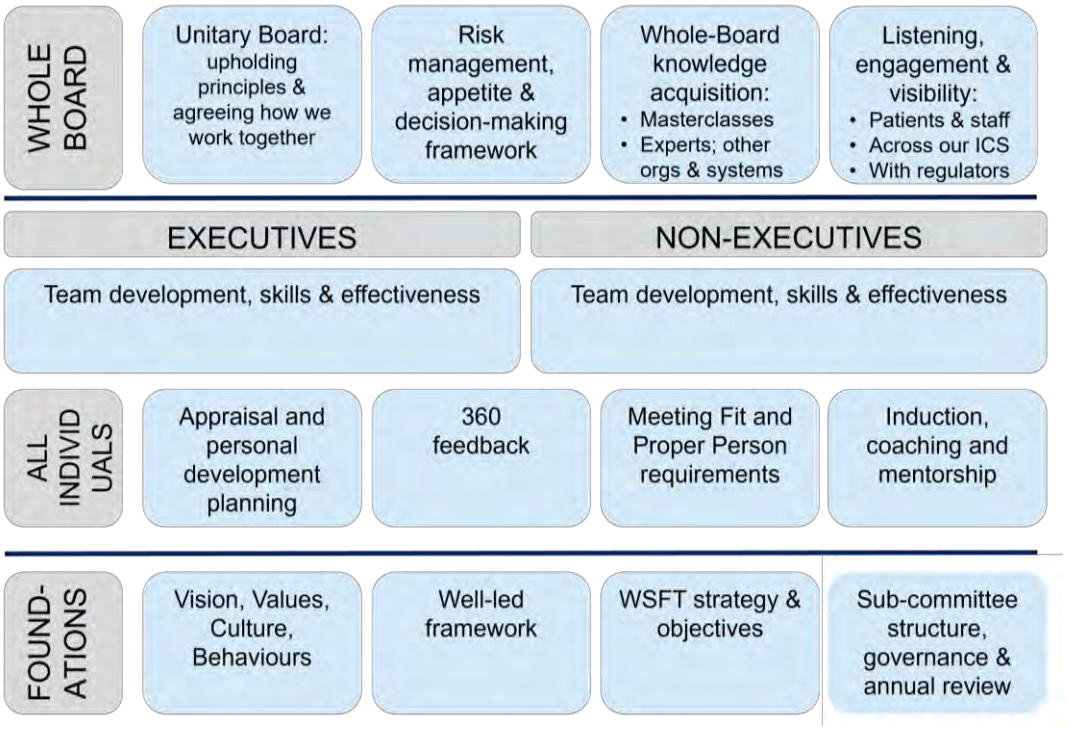
It was recognised that delivery of the strategy clearly links to the strategy priorities discussed early in terms of pathways and change management. There is opportunity for the Board to provide constructive review and exposure to these pathways through for example 15 step visits and presentations and updates including use of the board committees with appropriate focus on the relevant services and pathways.

2.4 Board development forward plan

Jeremy Over led a session which aimed to:

1. Take stock of the work we have done over the past 12-18 months
2. Capture everything that contributes to our development (and therefore, effectiveness) as a Board
3. To reflect on our purpose and what objectives we want to set for ourselves for how we work
4. To start to shape a programme for the next 3 years
5. To prioritise specific areas of focus for inform phasing (i.e. next 6-12 months)

A structured framework for a board development programme was considered and supported.



A prioritisation discussion also took place based on the CQC's well led framework.

The feedback from today and after the session will be used to inform the preparation of an outline programme which will be reported to the Board in July.

2.5 Reflections on session

Feedback from the session was positive and the contributions had been open and transparent. It was agreed that participants be invited to provide any further reflections after the session.

Next steps

1. Take priorities with feedback from today to the July Board
2. Develop preferred option for changes/transformation
3. Build delivery plan for the clinical and care strategy, including Trust and system partner engagement
4. Draft Board development plan

3. Foundation Trust membership engagement strategy

The Trust is committed to being a successful membership organisation and strengthening its links with the local community. The Trust recognises that there is a need to commit resources both in time and effort to developing our membership and engaging with the public. The membership engagement strategy sets out the actions that we will take in support of this.

The draft strategy was discussed at the Engagement Committee of the Council of Governors on 7 June and amendments approved. It was proposed that since this is an evolving strategy that it is subject to further review after the governor elections. The strategy will be presented to the Council of Governors for approval in September 2023.

4. General condition 6 and Continuity of Services condition 7 certificate

NHS England has two self-certification requirements which follow a similar structure and content to previous years and sit alongside the general condition 6 certificate. These were approved by the Board as part of the annual report approval arrangements on 29 June.

The Board is required to report its approval of the annual statements and certifications at a public meeting. These are detailed below and in greater detail within **Annex A**:

1. **Corporate Governance statement - *Confirmed***
   A range of statements are detailed covering compliance with corporate governance best practice; effective systems and processes; and having the correct personnel in place.

   It is proposed to indicate that the requirement has been met. This is supported by a range of assurances including annual governance statement; internal and external audit opinions; review by external agencies, including performance and management information reported to the Board and its subcommittees.

2. **Training of governors - *Confirmed***
   The Board is asked to confirm that it is satisfied that during 2022//23 it provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure governors are equipped with the skills and knowledge they require.

   It is proposed to indicate that the requirement has been met. This is supported by the working and information received at the Council of Governors, its sub-committees and workshops; training provided during the year; and governor attendance at external events. This compliance position is supported by details in the Annual Report:

   To support governors in their role training and development sessions have been held during the year:

   - finance with executive director of resources
   - quality and performance with chief operating officer and executive chief

nurse
- governor training session with external trainer – governance, the Board and the role of the governor; effective questioning and challenge
- joint governor and non-executive director training session with external trainer – the Board and council working together
- Session on Trust's Infection Prevention and Control with Executive Chief Nurse

3. **General condition 6 - Systems for compliance with license conditions (FTs and NHS trusts)**

   Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution – ***Confirmed***

4. **Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)**

   After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate – ***Confirmed***

5. Updated report template

The practice of scrutiny and assurance has been the subject of careful consideration and development by the Board. This has included the use of a structured approach to support a deeper understanding and questioning of key matters through:

- **What** - deepening understanding of the evidence and ensuring its validity
- **So What** - increasing appreciation of the value (importance and impact) – what this means for us
- **What next** - exploring what should be done next (or not), informing future tactic / strategy, agreeing follow-up and future evidence of impact

The use of this approach is being developed through the assurance committees to structure our approach to questioning how we are doing, what action we are taking and why and how we report on this. This is reflected in the assurance committee CKIs reports and it is proposed to support wider implementation by updated the committee report cover page to reflect @what, So what and What next'.

The Board is asked to support adoption of the updated report template (**Annex B**).

6. Use of Trust Seal

No. 155 – Lease – Dencora 2000 Ltd and West Suffolk NHS Foundation Trust – Maple House, unit 24, Hillside Business Park, Bury St. Edmunds. Sealed and witnessed by on 19 June 2023.

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

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

5.2. Board Assurance Framework

To inform

Presented by Richard Jones

Board of Directors	
Report title:	**Board Assurance Framework**
Agenda item:	5.2
Date of the meeting:	21 July 2023
Sponsor/executive lead:	Richard Jones, Trust Secretary
Report prepared by:	Mike Dixon, Head of Health, Safety and Risk

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

Executive summary:	The Board assurance framework is a tool used by the Board to manage its principal risks to its strategic objectives. The BAF risk assessments have been reviewed with the executive leads in order to assess against the Trust's strategy and strategic objectives. Through these reviews six key area of risk have been identified. These are listed below and described in more detail in the report, including aligning to the relevant Board assurance and management committees: • Patient safety • Staffing and workforce • Urgent & emergency care and elective care • Financial constraints • Maintaining existing estate • Digital, including cyber security The Board Assurance Committees have been identified and aligned to each of the BAF risk assessments. The review process has identified which management committee will have ownership of each individual BAF risk assessment so they can undertake regular reviews to ensure all of the relevant mitigation is up to date, outstanding actions have been captured and closed when completed. The management committee will then include the BAF review in their monthly upward report to the relevant assurance committee.

	The Executive Director of Workforce has reviewed and updated the workforce BAF risk into three separate risks to address the elements of the First for Staff strategic ambition: 1) Build a positive, inclusive culture that fosters open and honest communication 2) Enhance staff wellbeing 3) Invest in education, training and workforce development
Action required/ recommendation:	Note the report including the three new workforce risk assessments

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

BAF review update

1.	**Introduction**
	The Board Assurance Framework (BAF) provides a structure and process which enables the Board of Directors to focus on the principal risks to delivery of the strategic objectives. The BAF identifies the key controls which are in place to manage and mitigate those risks and the sources of assurance available to the Board regarding the effectiveness of these controls.
2.	**Background**
	The Board assurance framework is a tool used by the Board to manage its principal strategic risks. Focusing on each risk individually, the BAF documents the key controls in place to manage the risk, the assurances received both from within the organisation and independently as to the effectiveness of those controls and highlights for the board's attention the gaps in control and gaps in assurance that it needs to address in order to reduce the risk to the lowest achievable risk rating.
3.	**Detailed sections and key issues**

The previous BAF risks have been reviewed with the executive leads in order to assess against the Trust's strategy and strategic objectives.

Through these reviews six key area of risk have been identified. These are listed below including aligning to the relevant Board assurance committee and Management committee.

Key risk to strategic objective	Executive Lead	Assurance committee	Management Committee
Quality Governance or service failure	Sue Wilkinson (with Paul Molyneux)	Improvement	Patient safety and quality governance group
Staffing workforce skills, competency and supply (3x BAF risks)	Jeremy Over	Involvement	People & Culture Leadership Group
External financial constraints impact on Trust and system sustainability and model of service provision in the west Suffolk system	Craig Black	Insight	Financial Accountability Committee
Maintaining existing estate	Craig Black	Trust Board	Future System Board RAAC Oversight Group
Digital, including cyber security	Craig Black	Improvement Committee	Digital Programme Board
Ability to deliver sustainable services to meet operational standards in urgent and emergency care, community health services, primary care, elective care, cancer and diagnostics	Nicola Cottington	Insight	Patient Access Governance Group

	A more detailed summary for the risks relating to patient safety (1), communication (2),staff well-being (3), workforce (4), finance (5), estates (6) and digital (7) is provide in Appendix A. This includes risk ratings and mitigating action. These have been subject to executive review. A schedule has been developed to review these risks through the relevant governance / management group with the results reported to the allocated assurance committee. For example, recommendations to improve controls, mitigations and/or assurance.
5.	**Conclusion**
	The work to review the BAF risks is progressing, and this will iterate through the agreement of SMART strategic priorities for 2023/24. The Board assurance committees will update the Board after each meeting when they receive updates on their assigned BAF risks.
6.	**Recommendations**
	Note the report including the three new workforce risk assessments

Appendix A: BAF risk summary report

	Residual Risk	Target Risk
(1) Risk of patient safety incidents resulting in harm, poor patient experience, poor standards of care, service failure, reputational damage and regulatory action. Requires robust governance, oversight, policies, procedures and organisational learning plans and evidence. Requires appropriate infrastructure, personnel and executive and board engagement.	Quarterly x Major = Red	Annual x Major = Amber
Description of additional controls required (actions being taken)	Lead	Due date
Continue to work collaboratively to develop comprehensive quality dashboard	SW	Apr 24
Development of ward managers, matrons and heads of nursing to support quality improvement and organisational learning	SW	Apr 24
Development and publication of Nursing, midwifery and AHP strategy to align with clinical care and trust strategy	SW	Apr 24
Further develop the role of patient safety partners and the patient voice	SW	Apr 24

	Residual Risk	Target Risk
(2) If we do not create a culture where all colleagues, regardless of their background, feel safe to speak up and raise concerns (at both organisational and team level), this may adversely affect retention, staff morale and well-being, our reputation as an employer and, ultimately, the quality and safety of care provided to our patients.	Quarterly x Major = Red	Annual x Major = Amber
Description of additional controls required (actions being taken)	Lead	Due date
Development of WSFT people and culture priorities for 2023/24 which are reported and monitored through the workforce governance structure of People and Culture Leadership Group and the Involvement Committee	JO	March 24
Implementation of the national EDI improvement plan and associated high impact actions	JO	Sept 24

	Residual Risk	Target Risk
(3) If we do not support and value our workforce and look after their well-being, and help them have sustainable working lives, this may affect patient safety and quality of care due to lower levels of staff engagement and morale, and staff choosing to leave WSFT	Quarterly x Major = Red	Annual x Major = Amber
Description of additional controls required (actions being taken)	Lead	Due date
Development of WSFT people and culture priorities for 2023/24 which are reported and monitored through the workforce governance structure of People and Culture Leadership Group and the Involvement Committee	JO	March 24

	Residual Risk	Target Risk
(4) If we do not plan our future workforce and develop our leaders and teams, this may undermine our ability to provide the care our patients need through a gap in skills and by not being able to recruit and retain colleagues to WSFT.	Quarterly x Major = Red	Annual x Major = Amber
Description of additional controls required (actions being taken)	Lead	Due date
Development of WSFT people and culture priorities for 2023/24 which are reported and monitored through the workforce governance structure of People and Culture Leadership Group and the Involvement Committee	JO	March 24

	Residual Risk	Target Risk
(5) External financial constraints (Revenue and Capital) impact on Trust and system sustainability and model of service provision in the west Suffolk system (even when services delivered in the most efficient way possible. This includes failure to identify and deliver cost improvement and transformation plans that ensure sustainable clinical and non-clinical services while delivering the agreed control total	Weekly x Major = Red	Weekly x Major = Red
Description of additional controls required (actions being taken)	Lead	Due date
Delivery of year end position (Board reporting) with escalation as required	DoR	Mar 24
Agree financial position (including anticipated funding for 23-24) with the system and regional team	DoR	Mar 24
Agree budget position internally	DoR	Mar 24
Finalise CIPs to deliver financial plan for 2023/24 (dependant on response to system/regulatory framework)	COO / DoR	Mar '24
Review divisional business plans (underpinned by sustainable clinical models) to reflect the requirements to deliver additional backlog activity	COO	Mar '24
Develop a system wide information strategy with underpinning tools to improve performance monitoring	DoR	Aug '23

	Residual Risk	Target Risk
(6) Implementation of estates strategy to provide a building environment suitable for patient care and adequately maintained with regard to backlog maintenance incorporating the acute and community estate. **Linked to structural risk assessment (ref. 24) rated as Red.**	Quarterly x Major = Red	Annual x Major = Amber
Description of additional controls required (actions being taken)	Lead	Due date
Implementation of controls associated with red risk re RAAC planks (Datix 24) potential failure of the main building structure and front residencies structure (Oak, Cedar, Birch, Larch, Pine, Willow): - Emergency planning - Assessment and repair - Bearing extension programme (to be completed Oct 21) - Remediation (failsafe installation) - Communication - Research and development - Site and system risk (including continued occupation of WSH site)	C Black	June 24
Deliver approved capital programme for 2023-24, including key capacity developments	C Black	March 24
Future system programme in place and linked to this risk assessment (4952)	C Black	2030
Communication strategy for structural risk based on agreed remediation plan with clinical model to support capacity requirements	C Black	On going

	Residual Risk	Target Risk
(7) If we do not progress our programme of work for digital adoption, transformation and benefits realisation, the digital infrastructure will become obsolete and vulnerable to cyber-attack, resulting in poor data for reporting and decision support, digital systems failure, loss of information and inability to provide optimum patient care, safety and experience	Annual x Major = Amber	Annual x Major = Amber
Description of additional controls required (actions being taken)	Lead	Due date
Preparation digital programme plan with funding envelope to Digital Programme Board review	Craig Black	Sept 23
Agreed plan for the delivery of HIMSS 6 and 7 (with key external organisational dependencies) with NHSD/NHSX. To include closed loop blood and medication	Sarah Judge Liam McLaughlin	Mar 24
Deliver programme for population health management in the west of Suffolk, working with local partners and Cerner to develop the solution	Helena Jopling	Mar 24
Key deliverable to support Future System programme: - Engagement with architects and surveyors on development of a digital twin for the new buildings		Ongoing
Regular updates from Pillar Groups to Digital Board and onto Trust Board Pillar Group 1 Acute Developments Pillar Group 2 (Wider Health Community [SNEE]) Pillar Group 3 Community Developments Pillar Group 4 Infrastructure	Craig Black Sue Wilkinson Craig Black Nicola Cottington Paul Molyneux	On-going

5.3. Annual Report and Accounts

To Note

Presented by Craig Black and Richard Jones

Board of Directors Public

Report title:	**Annual Report & Accounts 2022/23**
Agenda item:	5.3
Date of the meeting:	21 July 2023
Sponsor/executive lead:	Craig Black – Director of Resources
Report prepared by:	Liana Nicholson, Assistant Director of Finance Richard Jones, Trust Secretary

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:	As outlined in the report from the audit committee, recommendation was made for approval of the annual report and accounts and reports from the auditors. Following completion and reporting of all testing by the external auditors these documents were approved by the Board on 29 June 2023 and submitted to NHSE within national requirements. Prior to making public the annual report and accounts the Trust is legally required to lay the document before Parliament. This took place on 12 July 2023. The annual report and accounts are available on the Trust's website via: https://www.wsh.nhs.uk/Corporate-information/Information-we-publish/Annual-reports.aspx
Action required/ recommendation:	For information.

Previously considered by:	Audit Committee and Trust Board.

Risk and assurance:	FT annual report manual.
Equality, diversity and inclusion:	Reported within annual report.
Sustainability:	Reported within annual report.
Legal and regulatory context:	The Annual Reports and Accounts have been prepared in accordance with DHSC 2022/23 Group Accounting Manual and the 2022/23 Foundation Trust Annual Reporting Manual.

6. OTHER ITEMS

6.1. Any other business

To Note

6.2. Reflections on meeting

For Discussion

6.3. Date of next meeting - 29 September, 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

4.2 IQPR Full Report

Trust Board	
Report title:	**Integrated Quality and Performance Report**
Agenda item:	4.2
Date of the meeting:	21 July, 2023
Sponsor/executive lead:	Sue Wilkinson, chief nurse and Nicola Cottington, chief operating officer
Report prepared by:	Andrew Pollard, information analyst. Narrative provided by clinical and operational leads.

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

Executive summary:	The Integrated Quality and Performance Report uses the Making Data Count methodology to report on the following aspects of key indicators: 1. Compliance with targets and standards (pass/fail) 2. Statistically significant improvement or worsening of performance over time. Narrative is provided to explain what the data is demonstrating (what?), the drivers for performance, what the impact is (so what?) and the remedial actions being taken (what next?). 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

April 2023		ASSURANCE: Pass (P)	ASSURANCE: Hit and Miss (?)	ASSURANCE: Fail (F) – Not Met
VARIANCE	Special Cause Improvement (H / L)			**INSIGHT:** 78+ Week Waits **INVOLVEMENT:** Staff Sickness – Rolling 12months Staff Sickness Turnover Rate
	Common Cause	**INSIGHT:** Urgent 2 hour Response **IMPROVEMENT:** VTE – All Patients	Please see box to right	**INSIGHT:** Ambulance Handover within 15min 12 Hour Breaches Incomplete 104 Day Wait Diagnostic Performance - % within 6weeks Total **IMPROVEMENT:** Nutrition – 24hours **INVOLVEMENT:** Mandatory Training Appraisal Rate
Deteriorating	Special Cause Concern (H / L)		**INSIGHT:** Reduce Adult General & Acute (G&A) Bed Occupancy	

Indicators for escalation as the variation demonstrated shows we will not reliably hit the target. For these metrics, the system needs to be redesigned to reduce variation and create sustainable improvement.

INSIGHT: Pledge 2 *% Compliance
Ambulance Handover within 30mn
Ambulance Handover within 60min
28 Day Faster Diagnosis
RTT 104+ Week Waits

IMPROVEMENT:
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

INVOLVEMENT: Overdue Responses

INSIGHT: Glemsford GP Practice – the following KPIs are applicable to the practice:

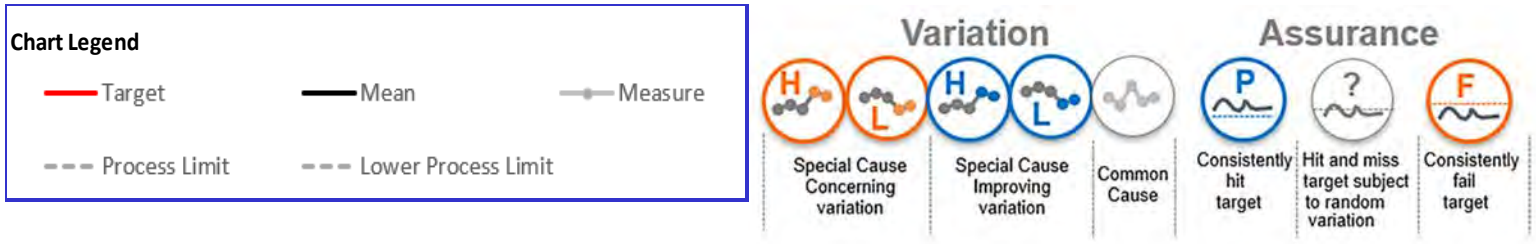
- Urgent appointments within 48 hours
- Routine appointments within 2 weeks
- Increase the % of patients with hypertension treated to NICE guidelines to 77% by March 2024
- Increase the % of patients aged 25-84 years old with a CVD risk score of >20% on lipid lowering therapies to 60%

Currently this data is not available to the Trust, however the Information Team are working to resolve this.

*Cancer data is 1 month behind

Items for escalation based on those indicators that are failing the target, or are worsening and therefore showing Special Cause of Concerning Nature by area:
INSIGHT: Urgent & Emergency Care: Ambulance Handover within 15min, 12 Hour Breaches, Reduce Adult & General (G&A) Bed Occupancy
Cancer: Incomplete 104 Day Wait
Elective: Diagnostic Performance- % within 6weeks Total, RTT 78+ Week Waits
IMPROVEMENT: Safe: Nutrition – 24 hours
INVOLVEMENT: Well-Led: Staff Sickness – Rolling 12months, Staff Sickness, Mandatory Training, Appraisal Rate, Turnover Rate

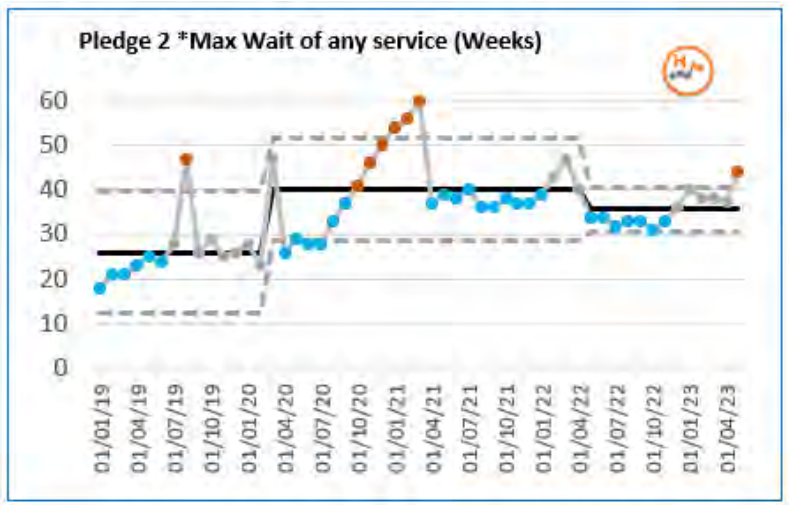
INSIGHT COMMITTEE METRICS

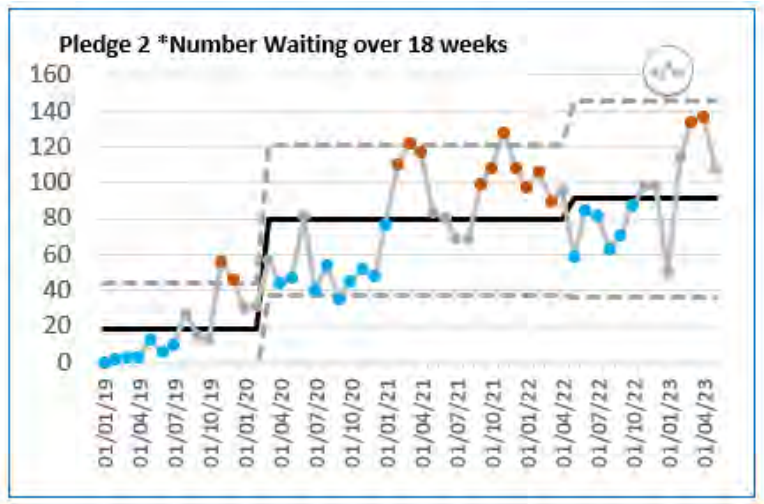


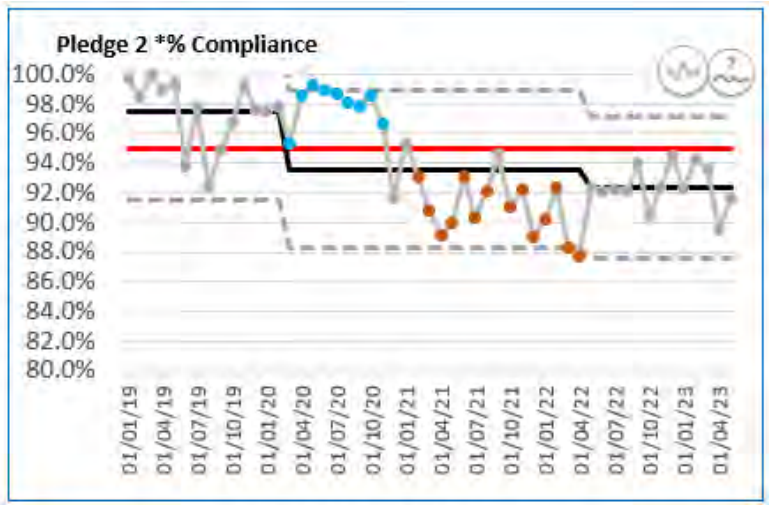
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Pledge 2 *Max Wait of any service (Weeks)	May 23	44				36	31	41
Pledge 2 *Number Waiting over 18 weeks	May 23	108				91	37	146
Pledge 2 *% Compliance	May 23	91.7%	95.0%			92.4%	87.6%	97.2%
Urgent 2 hour response	May 23	92.7%	70.0%			90.2%	82.4%	98.0%
Criteria to reside (Average without reason to reside) Acute	May 23	53				65	55	75
**Criteria to reside (Average without reason to reside) Community	May 23	17				17	12	22

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

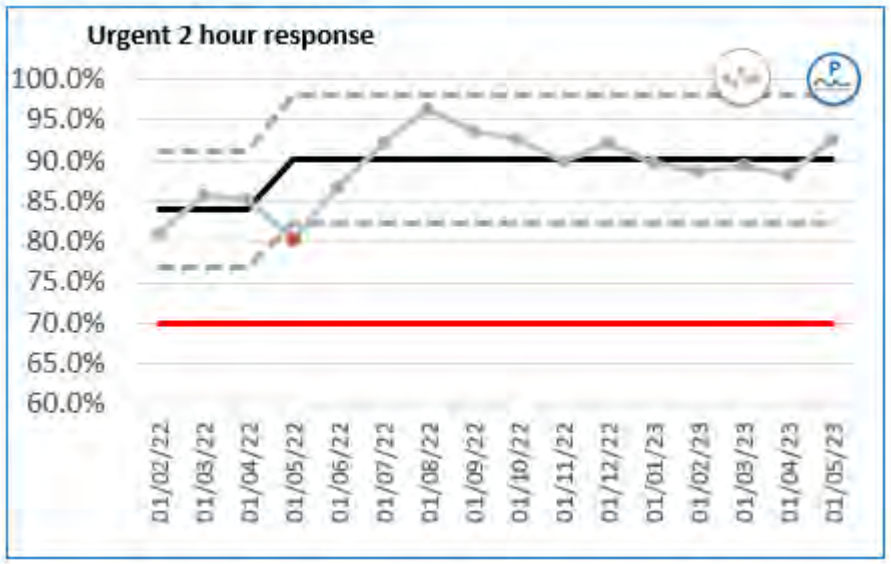
** Figures are for Glastonbury and Newmarket only, data not currently captured at Hazel Court.

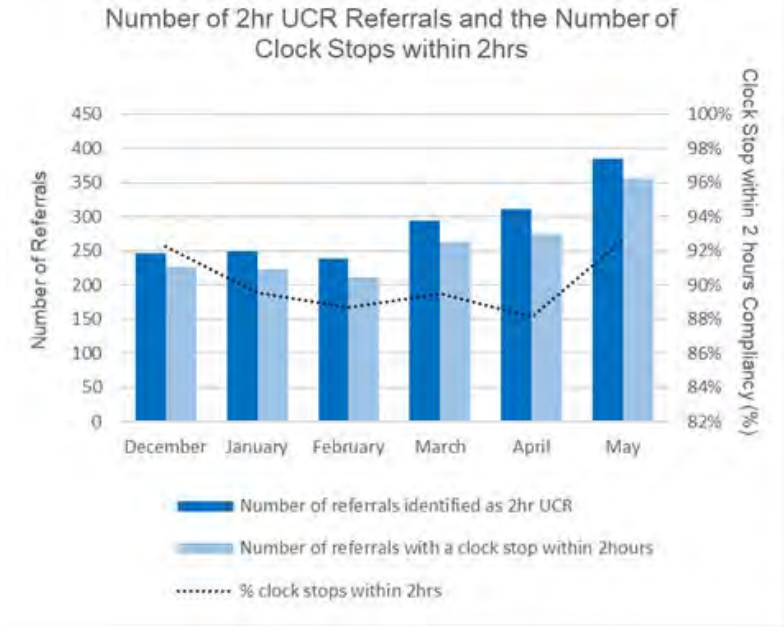




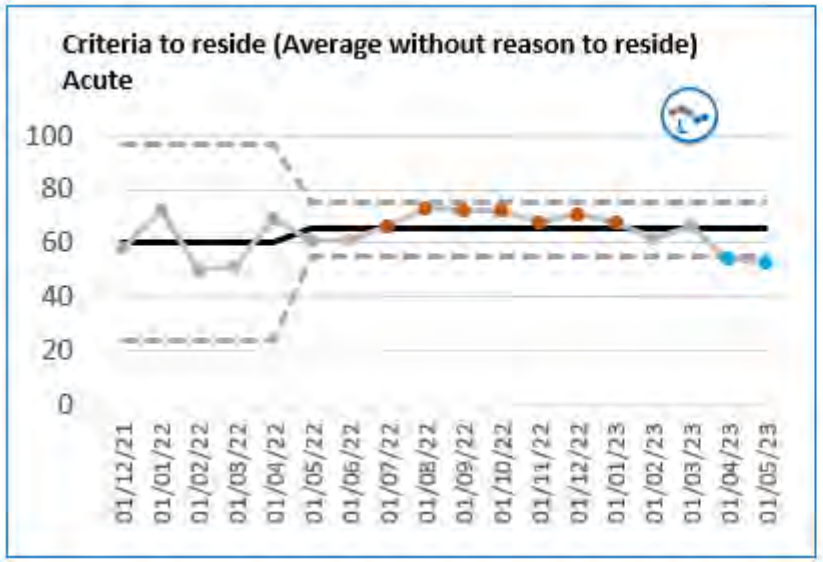


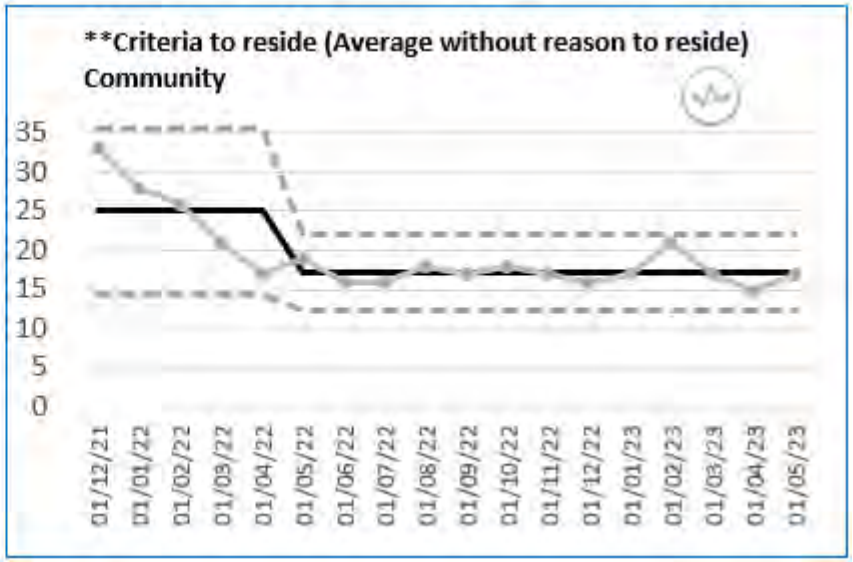
What	So What?	What Next?
There are 53 children waiting over 18wks for initial assessment in Paediatric Speech and Language Therapy team (out of a growing total caseload of 4760). These are young people in community clinics pathway which is impacted by high demand and vacancies. **Wheelchairs** Compliance has increased to 92.06% against a pledge 2 target of 95% Longest wait at 34 weeks, the trend is that waits are reducing where it peaked in January at 40 weeks. Referrals received into service at 6 month high (303 referrals received an increase of 93 from the previous month). Service is on target to achieve personal wheelchair budgets.	Potential impact on early language development if timely advice/strategies are not in place. **Wheelchairs** Gap reduced within service provision however 3% shortfall remains within contractual provision.	Service was on track with plans for recruitment to core vacancies but now at risk due to budget position. Working with ICB and SCC regarding communication strategy in Suffolk (early screening/intervene/re-screen model). Further investment identified for SEND therapy provision. **Wheelchairs** Business case for succession planning underway as risk of future gap in provision. Discussion proceeding with ESNEFT/NHSPS to change/maximise clinical usage. %. Trajectory plan in place to monitor performance. Assurance via Service level review, PRM, PAGG, Insight, Community Contract Meeting.





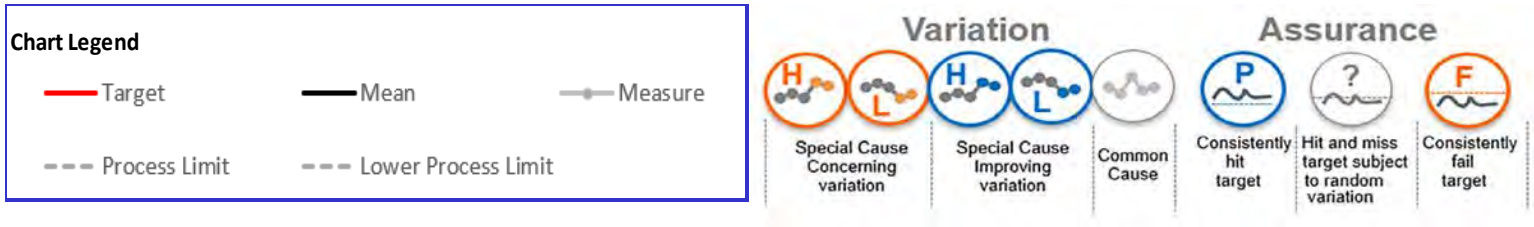
What	So What?	What Next?
• Cleric ambulance referrals increasing • Team continues to exceed 90% target. • Unscheduled care coordinator hub continues to operate Monday to Friday 8- 16 and has helped increase referrals.	•Patients in the community are receiving an urgent response within 2 hours for urgent health needs •Work within the unscheduled care co-ordination hub reduces unnecessary ambulance attendances and conveyances to hospital	•Continuing to record in- depth data around Cleric referrals Working with alliance on developing urgent community response Currently working with alliance on urgent community response strategy for West Suffolk •Working with Trust falls lead to update falls policy around work EIT is doing •ACP interview 29th June- 3 applicants. •SOP for ACP role currently being produced and developing pathways with virtual ward •Await approval from community informatics to remove 4 hour and same day options for recording referrals and focus on 2 hour response. Also await community informatics to approve reasons for decline to be added to SystemOne. •Working with EEAST on band 6 paramedic rotation.



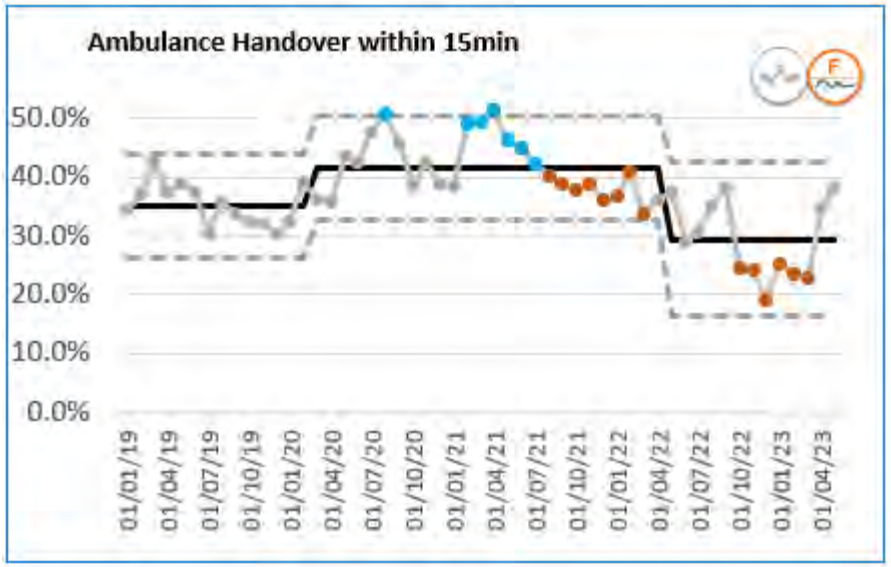


What	So What?	What Next?
Overall numbers of patients in the acute setting without reason to reside continue to show a downward trend with the community beds seeing a slight increase. Referral numbers into the Transfer of Care Hub have been lower this month which has enabled more rapid discharge on both pathways one and two with capacity being available in Home First and Support to Go Home teams. With the reduction in the number of interim beds there has been an increased focus on maintaining flow. A number of complex discharges have contributed to the slight increase in community bed numbers without reason to reside.	Fewer numbers of patients without reason to reside creates more acute bed capacity, improves flow and subsequently impacts the whole patient journey from ambulance handover, through the emergency department and eventually onto base wards. Patients are able to return home, or to their onward place of care quicker, reducing length of stay and the risks associated with prolonged acute hospital admissions.	Patient review/capacity meetings are a Core Resilience Team (CRT) workstream which is progressing as per trajectory – reviewing all meetings currently in place and developing more robust escalation pathways to minimise delays. Pathway 2 criteria for both interim care home beds and community assessment beds is currently being reviewed with the aim to reduce delays and ensure equitable access. Delirium discharge needs to be a priority area of focus. Work continues on the development of the Enhanced Reablement package with the aim to convert more pathway 2 discharges to pathway 1.

Urgent & Emergency Care summary



KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Ambulance Handover within 15min	May 23	38.0%	65.0%		F	29.4%	16.2%	42.7%
Ambulance Handover within 30min	May 23	91.6%	95.0%		?	76.0%	48.4%	103.5%
Ambulance Handover within 60min	May 23	98.8%	100.0%		?	91.8%	76.6%	107.0%
12 Hour Breaches	May 23	367	0		F	685	90	1280
Reduce adult general and acute (G&A) bed occupancy	May 23	93.1%	92.0%	H	?	92.0%	90.6%	93.4%
4 hour breaches - admitted	May 23	2145	0			2145		


Ambulance Handover within 15min
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
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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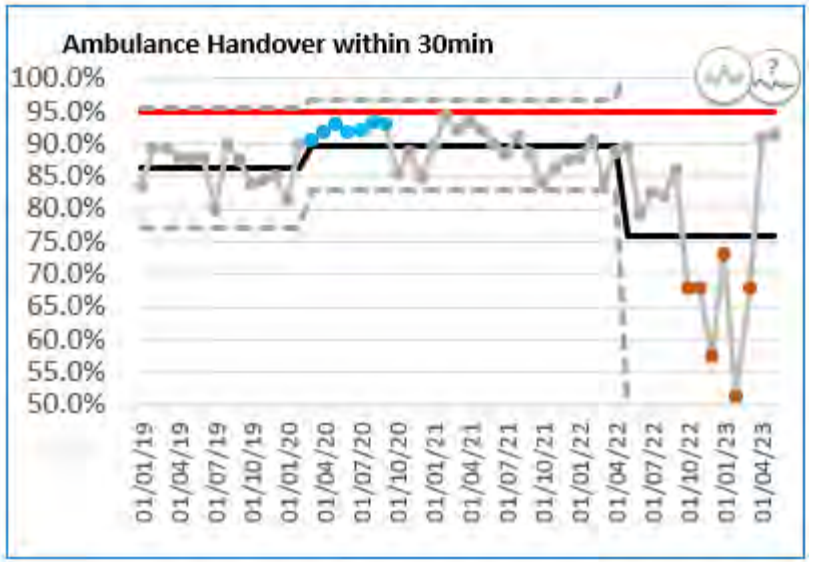
Ambulance Handover within 30min
100.0%
95.0%
90.0%
85.0%
80.0%
75.0%
70.0%
65.0%
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55.0%
50.0%
01/01/19
01/04/19
01/07/19
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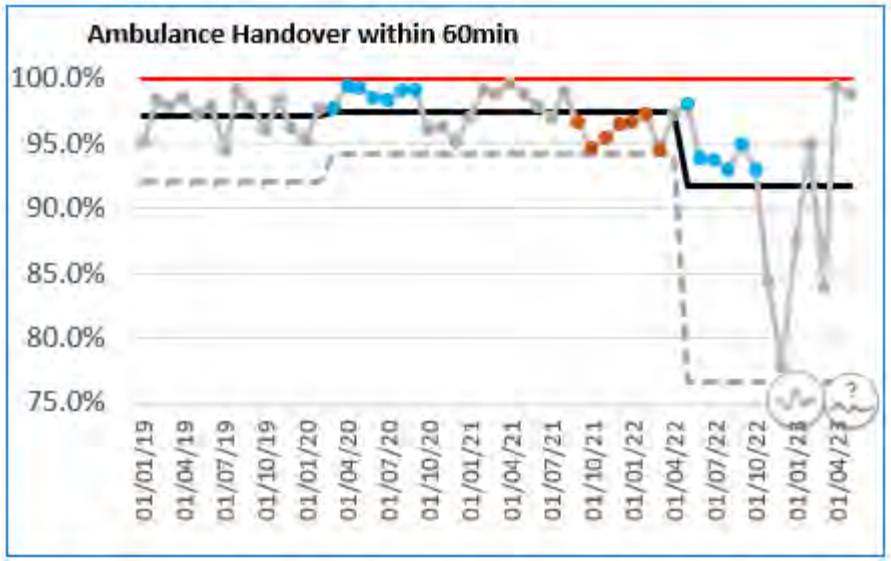
Ambulance Handover within 60min
100.0%
95.0%
90.0%
85.0%
80.0%
75.0%
01/01/19
01/04/19
01/07/19
01/10/19
01/01/20
01/04/20
01/07/20
01/10/20
01/01/21
01/04/21
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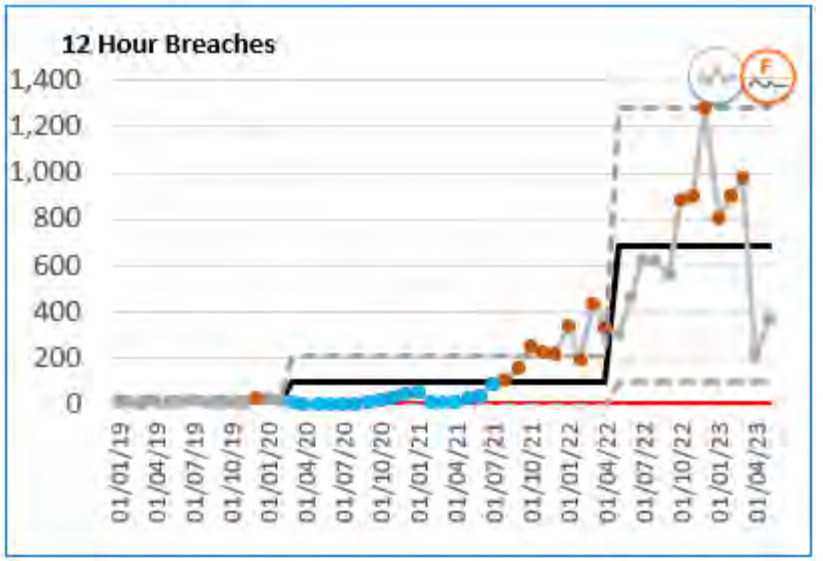
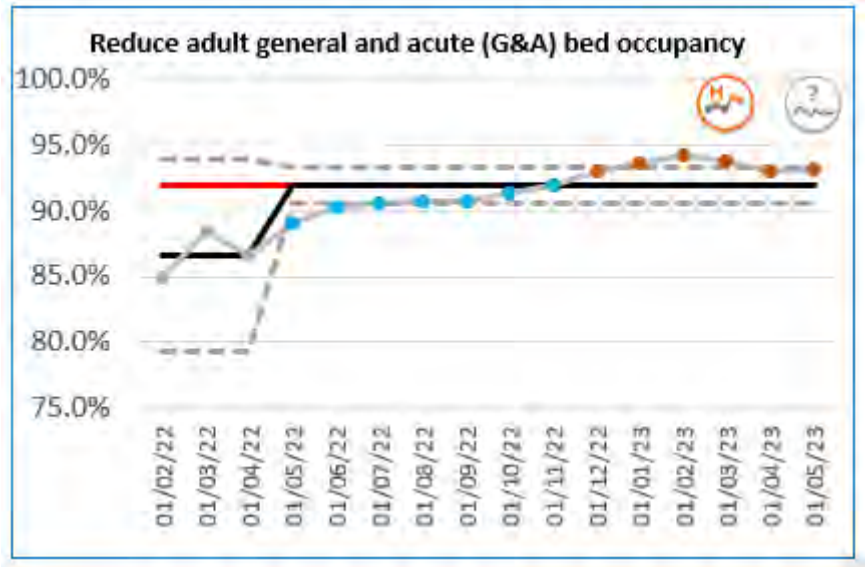
01/04/23


12 Hour Breaches
1,400
1,200
1,000
800
600
400
200
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
01/04/22
01/07/22
01/10/22
01/01/23
01/04/23

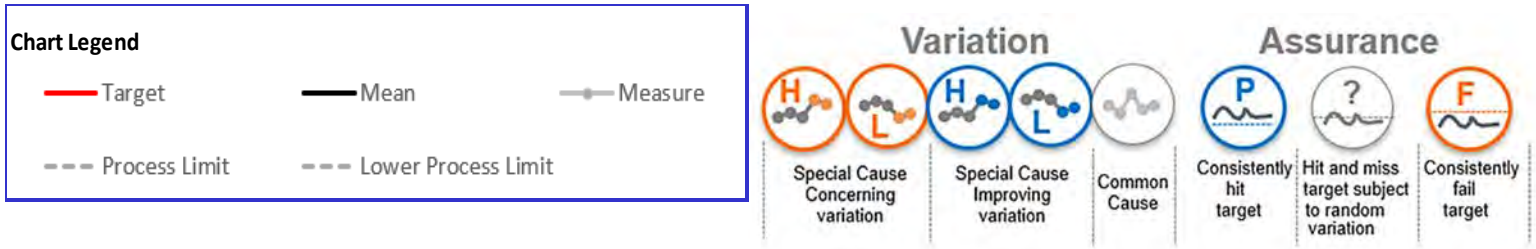
Urgent & Emergency Care (TRUST)

What	So What?	What Next?
12 hour performance does not yet demonstrate significant improvement with 367 breaches and 4.7% of all attendances remaining in the department over 12 hours. Of these 86% occurred in the first 14 days of the month, prior to us reporting the 4 hour standard and implementation of new processes. Ambulance performance continues to see improvements across all 3 metrics with the focus on the 30 mins and 60 mins handovers. Please note that it has been agreed that we would not nationally report the 4 hour standard figures for the month of May, as recording only commenced half way through the month – but for noting: Week commencing • 15th-21st May – 74.08% • 22nd -28th May – 82.22% • 29th-04th June – 80.60%	We have implemented phase one of our internal UEC recovery plan in line with the national reporting date of 15th May for the 4 hour standard. The impact of the workstreams and the implementation of new processes has already shown a significant impact on our UEC performance in the second half of the month. Including being significantly above trajectory for 4 hour performance and a significant reduction in 12 hour breaches (14% compared to 86%) We have seen improved flow throughout the organisation due to timely discharges earlier in the day, increase in PW1 discharges, increased use of DWA with change in opening hours. These factors have ensured that patients have had an improved patient experience throughout the UEC pathway.	We are moving onto phase two of our internal UEC recovery plan whilst working collaboratively with the alliance and the ICB on the 'One Plan' to ensure improved UEC performance. Work continues in monitoring and embedding our processes in relation to achievement of the 4 hour standard and continue to achieve above trajectory. Work streams of phase two recovery plan are: • Metrics • Internal Professional Standards • Internal alternative pathways to ED • External alternative pathways to ED • Hospital Flow • Capacity • General Medicine



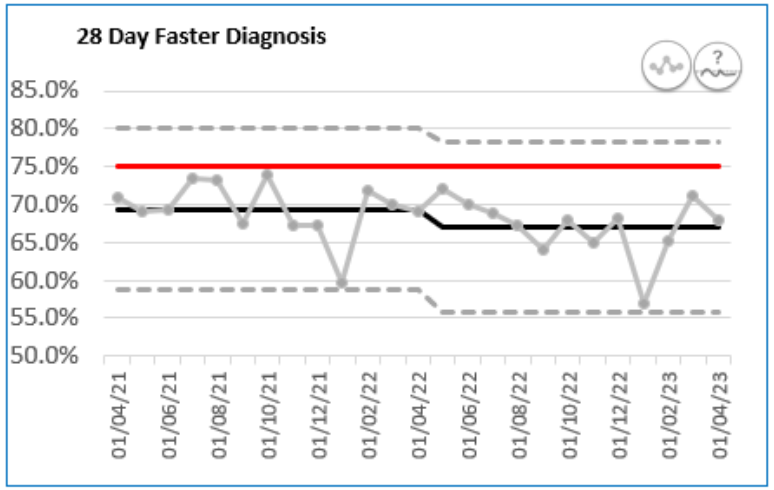
What	So What?	What Next?
Bed occupancy continues to remain above the 92% threshold in line with the increase in average Length of Stay (LOS), demonstrating an increasing level of occupancy since November 2022.	Mitigations in place to reduce bed occupancy are in place through the use of 33 escalation beds throughout the winter and spring period, which will cease to be used during June as operational pressures should reduce and the impact from sustainable initiatives to reduce bed occupancy take effect. Those initiatives are targeted towards enabling patients to be supported to leave the hospital sooner through provision of 18 interim care beds, enhanced wraparound care support and additional workforce. Within the hospital, we have extended the opening hours of our Discharge Waiting Area to 12 hours a day, 7 days a week and introduced two clinical flow managers to support flow and early discharge.	We will continue to monitor progress through the primary metric of bed occupancy but will also be using dependent metrics on early discharge and flow as part of the right care, right place, right time workstreams.

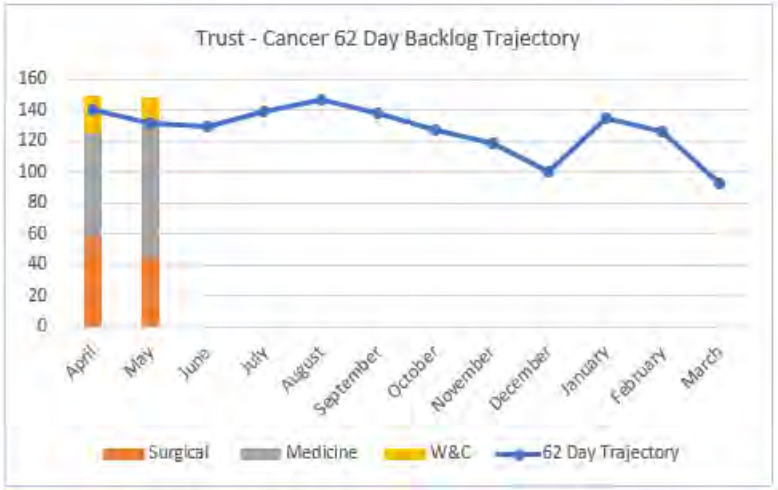
Cancer Access Summary

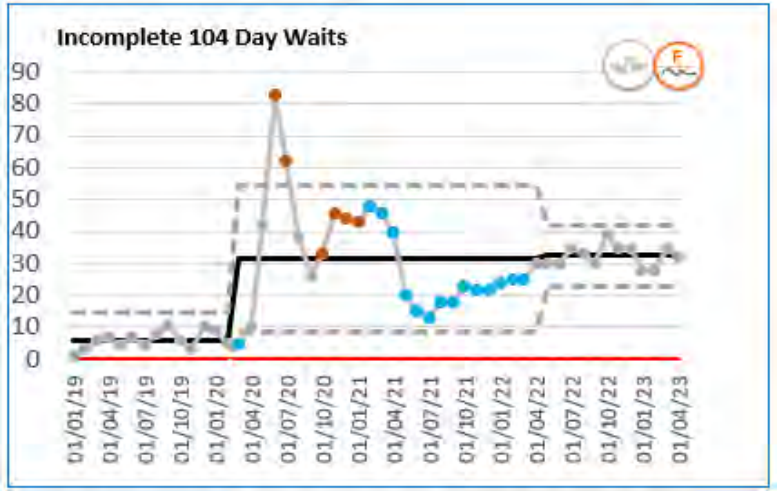


KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
28 Day Faster Diagnosis	Apr 23	67.8%	75.0%			67.1%	55.8%	78.4%
Trust - Cancer 62 Day Backlog Trajectory	May 23	148	132					
Incomplete 104 Day Waits	Apr 23	32	0			33	23	42

Cancer Access (Month Behind)







What	So What?	What Next?

None of the cancer standards demonstrate that they will not reliably hit the target based on the current systems, with none of the KPI's demonstrating an improving trend. The 28 day FDS compliance is on track with the trajectory at 67.8% compliance.
For 2ww performance, Breast continues to be the main driver for under performance at 26% compliance, with all other tumour sites improving.
62 day performance remains static.
104 day waits are not demonstrating any sustained improvements.
	Recovering the cancer standards is key to the operational planning guidance 23/24.
	
	The priorities for this year focus on seeing, diagnosing and treating patients in line with national guidance to improve patient outcomes and maintain standards.
	
	There are actions to improve compliance and ensure pathways are in line with the best practice timed pathway.
		A full quality improvement plan is in place.
		
		Some of the key actions within this include:
		• Recruit to additional posts funded by the cancer alliance, including:
		  • Faster diagnosis nurse for colorectal
		  • Commence the one stop head and neck pathway in Q3
		• Audit of the Gynaecology pathway to commence in light of reduced performance
		• Implement TRACE PTL tracking system from September 2023

Elective Access – Summary: Activity

NHS England - 23/24 (Monthly - IQPR)

** Outpatient weekly data only includes e-care records (no Cardiology Diagnostics or Radiology)*

West Suffolk NHS
NHS Foundation Trust

All

All

Outpatient First

Mon	19/20	107%	23/24	Var %
Apr	6,625	7,089	6,698	101.1%
May	7,453	7,975	8,363	112.2%
Jun	8,097	8,664		
Jul	7,499	8,024		
Aug	7,637	8,172		
Sep	7,729	8,270		
Oct	8,097	8,664		
Nov	8,373	8,959		
Dec	6,717	7,187		
Jan	8,373	8,959		
Feb	7,821	8,369		
Mar	7,591	8,122		
Total (YTD)	**14,078**	**15,063**	**15,061**	**107.0%**

May 2023	
19/20	7,453
107%	7,975
23/24	8,363
Var	388
Var %	112.2%

Daycase

Mon	19/20	107%	23/24	Var %
Apr	1,903	2,033	2,061	108.3%
May	2,175	2,324	2,385	109.6%
Jun	2,338	2,498		
Jul	2,189	2,338		
Aug	2,257	2,411		
Sep	2,284	2,440		
Oct	2,393	2,556		
Nov	2,556	2,731		
Dec	1,985	2,121		
Jan	2,461	2,629		
Feb	2,365	2,527		
Mar	2,284	2,440		
Total (YTD)	**4,078**	**4,357**	**4,446**	**109.0%**

May 2023	
19/20	2,175
107%	2,324
23/24	2,385
Var	61
Var %	109.6%

Outpatient Follow Up

Mon	19/20	85%	23/24	Var %
Apr	14,014	11,912	15,188	108.4%
May	15,766	13,401	18,079	114.7%
Jun	17,128	14,559		
Jul	15,863	13,484		
Aug	16,155	13,732		
Sep	16,350	13,897		
Oct	17,128	14,559		
Nov	17,712	15,055		
Dec	14,209	12,077		
Jan	17,712	15,055		
Feb	16,544	14,063		
Mar	16,058	13,649		
Total (YTD)	**29,780**	**25,313**	**33,267**	**111.7%**

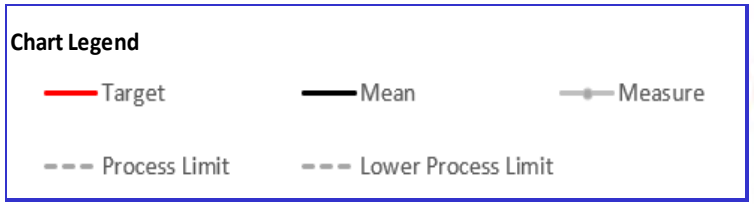
May 2023	
19/20	15,766
85%	13,401
23/24	18,079
Var	4,678
Var %	114.7%

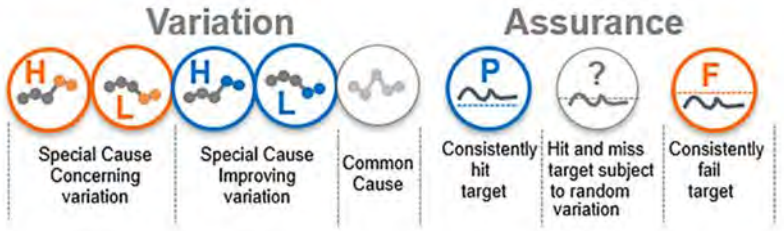
Elective

Mon	19/20	107%	23/24	Var %
May	299	319	290	97.1%
Apr	257	275	237	92.0%
Jun	318	340		
Jul	300	321		
Aug	315	337		
Sep	300	321		
Oct	318	340		
Nov	329	352		
Dec	277	296		
Jan	275	294		
Feb	300	321		
Mar	286	306		
Total (YTD)	**556**	**595**	**527**	**94.8%**

May 2023	
19/20	556
107%	319
23/24	290
Var	(29)
Var %	97.1%

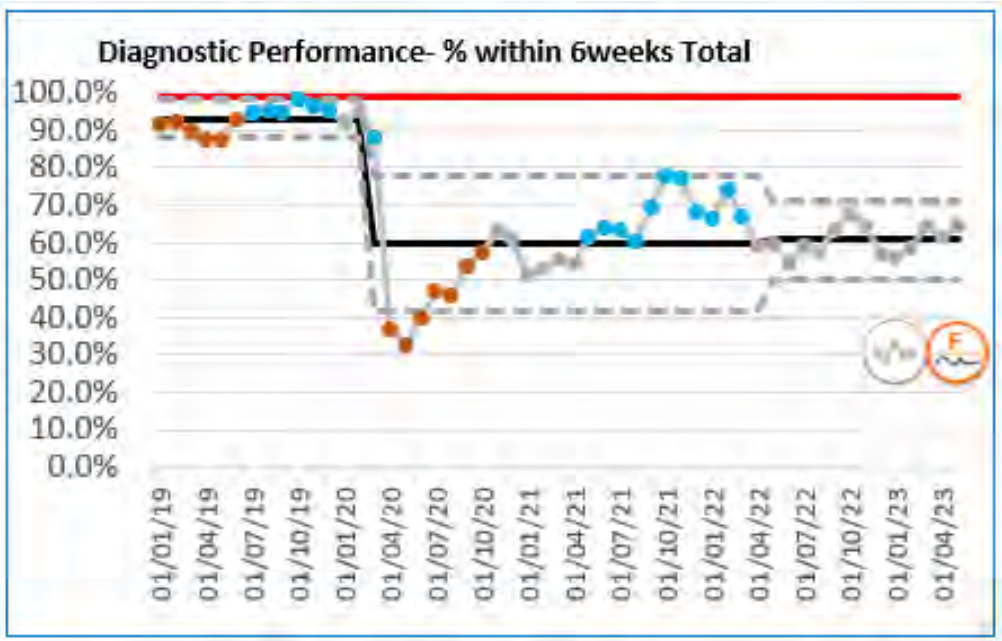
What	So What?	What Next?
Although too early to conclude on the trend and impact for the full year, it is encouraging to note that Outpatient First and Day Case activity is above the 107% target. This suggests a sustainable impact from the initiatives noted last month on improvements to coding and compliance with BADS Day Case rates. Elective activity will have experienced decreases due to industrial action and redeployment of workforce. Work is ongoing to formalise system wide objectives for reducing outpatient follow-up activity.	Divisionally-led plans continue to be rolled out including increasing workforce capacity within Surgery, as well as process improvements to increase efficiency, such as “golden patients”. Medicine too are increasing workforce to delivery additional new activity, as well as process improvements such as ensuring interval diagnostics are booked before appointments.	All divisions have implemented monitoring mechanisms and structures to support and address non-compliance including activity trackers, specialty level business meetings, divisional boards and elective access meetings . A Power BI tracker report has been made available to track monthly progress.





KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Diagnostic Performance- % within 6weeks Total	May 23	64.4%	99.0%		F	60.8%	50.3%	71.2%
RTT 65+ Week Waits	May 23	374				437	282	592
RTT 78+ Week Waits	May 23	58	0	L	F	274	142	407
RTT 104+ Week waits	May 23	2	0		?	18	-7	44
Potential 65+ ww at end of March 2024	May 23	10658				11795	5748	17841

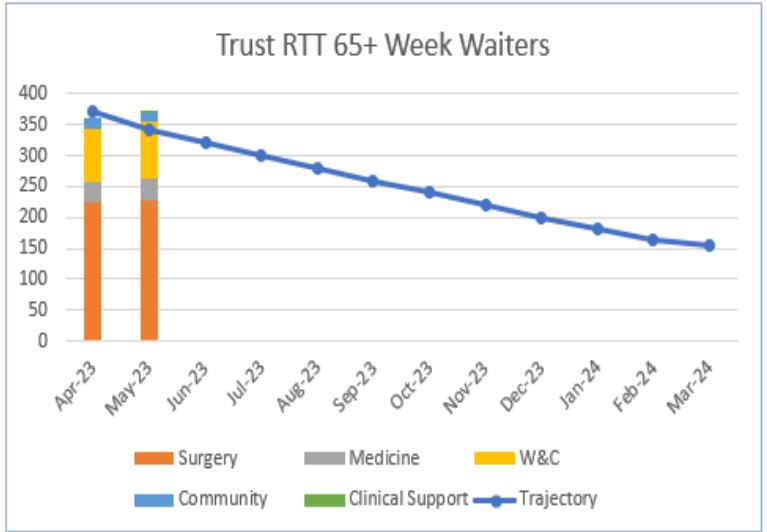
Elective Access

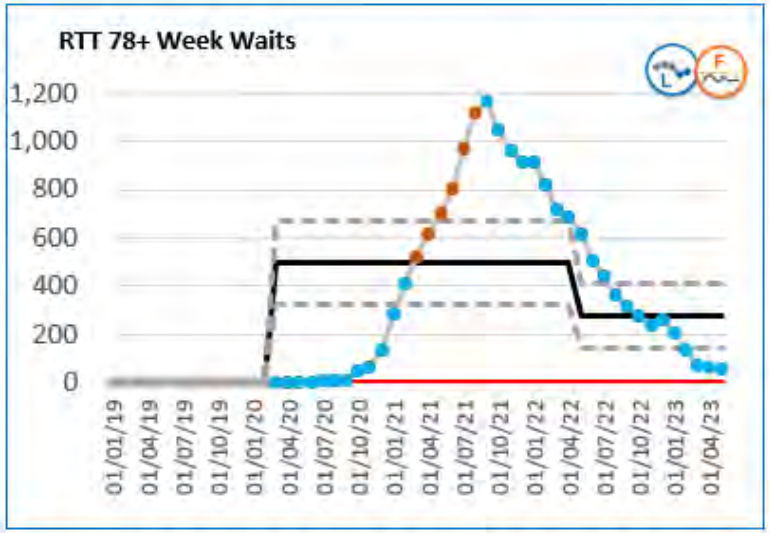


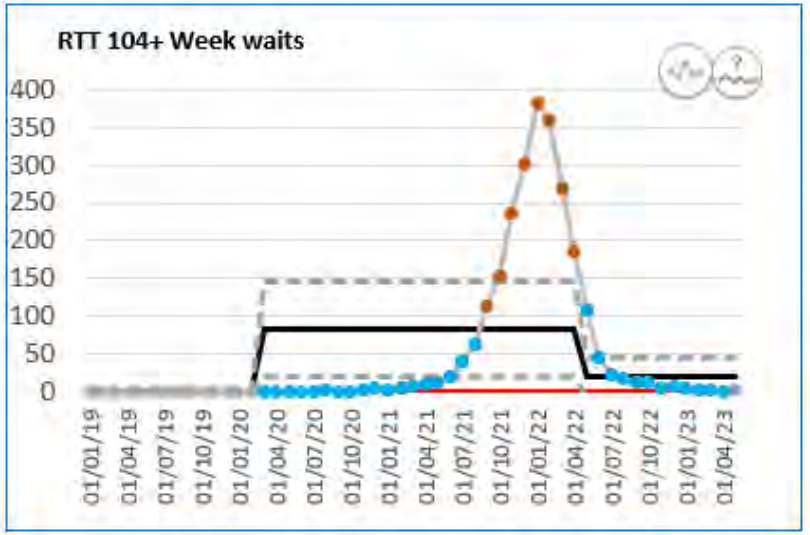
Elective Access

What	So What?	What Next?
Audiology remains on an upward trajectory although has seen a dip over the last two months, this driven by staffing absence, increased demand and lack of space. Urodynamics has seen a dip driven by staff unexpected absence and the residual impact of industrial action. The increase in suspected cancer demand has been prioritised and therefore some urodynamic capacity has been converted to support cystoscopy. The engagement with Xyla is starting to facilitate an improved cystoscopy position as consultants have, in some cases been released from TP biopsy to support this. The Johanna Finn Unit room conversion is now complete, creating additional urology diagnostic capacity. **MRI** - Common cause consistently failing target. Running at full capacity across the seven days but current capacity insufficient. **CT** – Improving trend following recovery from replacement programme and is currently meeting DM01 compliance target. **US** –Improving trend towards DM01 compliance. Sub-speciality analysis within US demonstrates a lower performance for biopsy and neck US. **Endoscopy –** Concerning variation, consistently failing to achieve target. Cancer pathway pressures impacting on routine waiting times. Priority is being given to longest waiting routine patients and priority RTT pathways. Progress continues to be made in reducing numbers of overdue surveillance patients which removes capacity to treat routine pathways. Waiting list reducing but DM01 performance not yet showing consistent improvement.	The service is prioritising the right patients and clearing diagnostic backlog has resulted in more patients being booked to fail. This highlights there is a lack of resource /environment to deliver compliance. Audiology has undertaken a data cleanse so position is driven by capacity. Longer waiting times for diagnosis and treatment	• Ongoing engagement with Xyla (18 weeks total) • Recruitment of 4 additional consultants-~~OTA~~ Advert in 4 weeks time as using PageTiger methodology • Statement of Need for audiology room conversion going to CSG 20th July and then works should commence. • Undertaking urology service review, optimisation of capacity • Enhanced triage of referrals being explored **MRI** –Requests to NHSE/Networks for additional resources have been fed back including a staffed MRI and additional reporting capacity. Ongoing liaison with SNEE partners re: mutual aid but at present only ad hoc capacity is available which would need to be supported with insourced staff at additional cost. Longer term CDC will begin to address. **CT** - performance continues to recover with improvements observed in each of the last 5 months but will be further impacted by CT replacement programme. Longer term CDC will begin to address. **US** – US showing observable improvements across successive months aligning to plans established for recovery. The trajectory will continue to improve with approved funding from cancer alliance for additional consultant PA's to support the biopsy and neck US subspeciality. **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. Current trajectory anticipates compliance in June 2024 against the DM01 target ambition of 95% by March 2025. A SNEE endoscopy forum has been established and will met regularly, facilitated by NHSE, to review system opportunities and support collaborative working across the ICS. Negotiations have secured access to externally funded underutilised InHealth capacity beyond the current plan of September 2023.

Elective Access

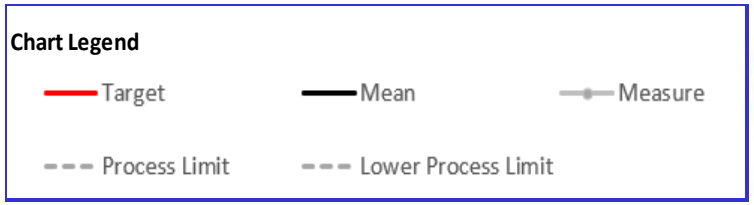


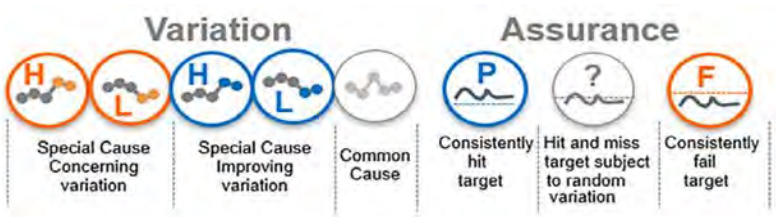




What	So What?	What Next?
The waiting list size is showing significant increase, with the total size now 10,000 larger than pre-covid. The 78 and 104 week wait position continue to be in line with our trajectories.	Reducing our waiting times will have a positive impact on our patient experience and outcomes. Having a larger waiting list makes recovery more challenging, with the largest cohort of patients waiting for a first appointment, the outpatient transformation programme is going to have an impact on the ability to reduce our total waiting list size.	• In conjunction with regional teams, focus on improvement of the 78 week wait position for gynaecology, with clinical pathway reviews, productivity gains, innovation and insourcing all part of the wider plan. • Use of digital mutual aid system for support in areas of capacity constraints • Re-focus on outpatient transformation, with renewed focus on PIFU and demand management.

IMPROVEMENT COMMITTEE METRICS

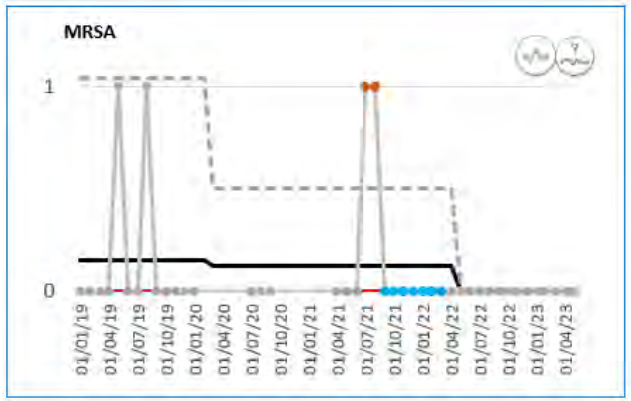


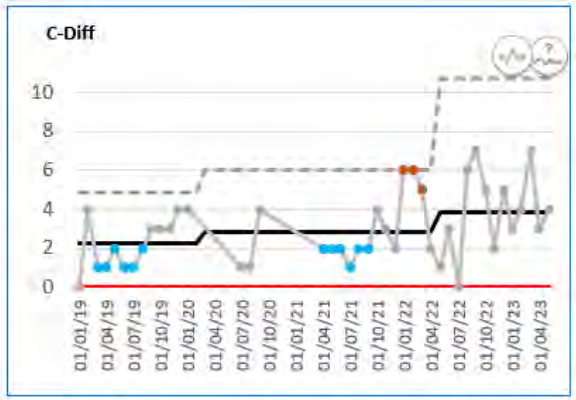


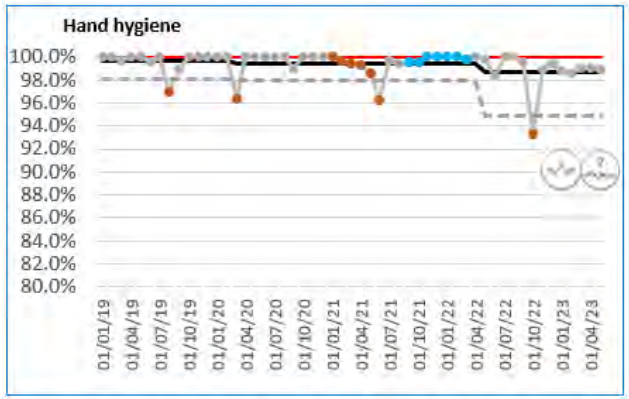
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
MRSA	May 23	0	0			0	0	0
C-Diff	May 23	4	0			4	-3	11
Hand hygiene	May 23	98.9%	100.0%			98.8%	94.9%	102.6%
Sepsis Screening for Emergency Patients	May 23	100.0%	100.0%			85.6%	59.2%	111.9%
VTE - all inpatients	May 23	97.3%	95.0%		P	97.4%	96.2%	98.5%
Mixed Sex Breaches	May 23	0	0			4	-8	16
Community Pressure Ulcers	May 23	34	25			33	18	48
Acute Pressure Ulcers	May 23	16	17			24	8	40
Acute Pressure Ulcers per 1000 Beds	May 23	1.3	-			2.3	0.5	4.0
Inpatient Falls Total	May 23	82	48			75	46	103
Acute Falls per 1000 Beds	May 23	5.4	5.6			6.1	3.7	8.4
Nutrition - 24 hours	May 23	89.7%	95.0%		F	86.1%	77.9%	94.3%
Patient Safety Incidents per 1,000 OBDs	May 23	61.3	-			61.9	50.4	73.5
Patient Safety Incidents Reported	May 23	846	-			825	666	985
Patient Safety Incidents Resulting in Harm	May 23	149	-			169	124	213
Within 10 Days Duty of Candour	May 23	68.0%	-			57.2%	22.2%	92.3%

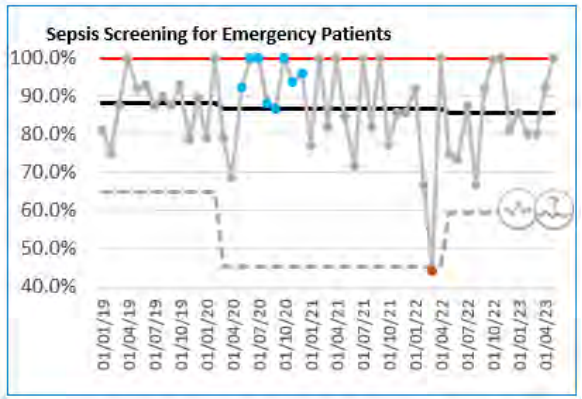
Falls are only counting Inpatients and Exclude Assisted Falls & Outpatient areas.

Safe



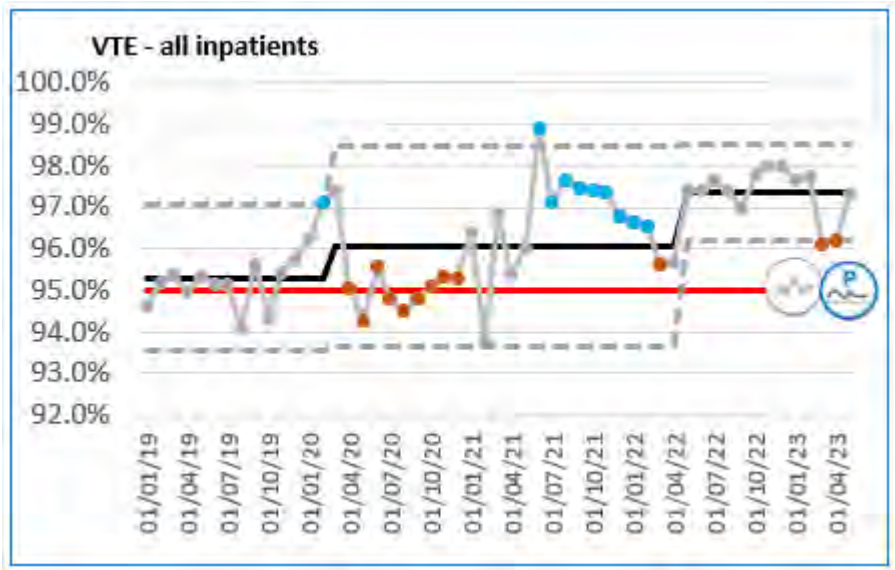


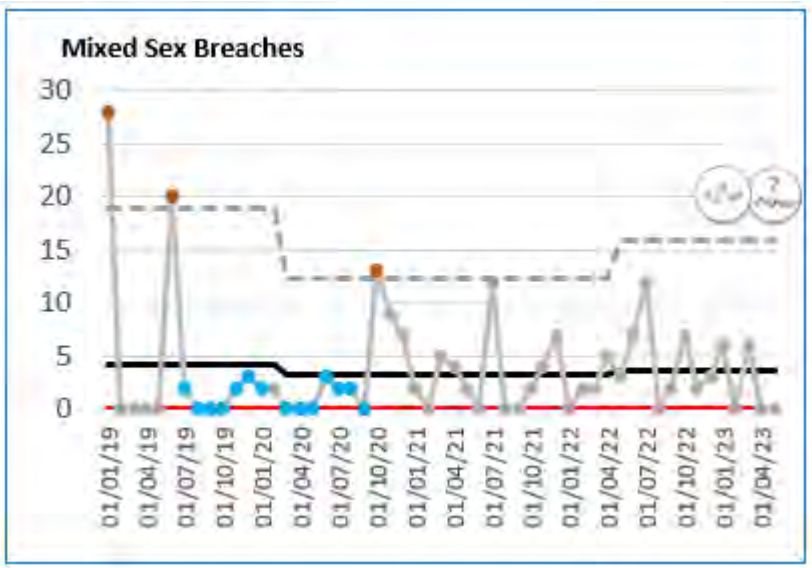




What	So What?	What Next?
Consistent performance with MRSA Bacteraemia. There has been no significant change of late with performance for *Clostridioides difficile* rates with a performance of 4 Hospital Onset, Healthcare Associated cases this month. It is recognised Nationally that the rates of *Clostridioides difficile* have increased significantly over the last two reporting years.	This is important because it could be an indication of rising rates of other Healthcare Associated rates, these are monitored by the infection prevention team, and reported on via National reporting system. This means that individual cases, themes and periods of increase incidence will be identified and reviewed through the Trust process in a timely manner. The impact of this is learning/good practices are formally discussed and taken back to the appropriate teams via the Matron and/or ward representative with a view to reducing the rates of healthcare associated infections. The impact being improved patient outcome and reduced length of stay, benefiting patient flow and availability of beds for the acutely unwell.	Looking forward- there are proposed changes to Ecare for antibiotic course lengths to reduce risk of infection within the gut. There is a Trust *Clostridioides difficile* infection reduction plan submitted to NHS England via the Integrated Care Board. The main actions from this are to Update the cleaning policy and implement the National Standards of Cleanliness including monitoring, as well as prioritisation for single side room isolation. For context, in the reporting period 2022-23 the NHS Standard Contract 2022/243: Minimising Clostridioides difficile and Gram-negative bloodstream infections; the *Clostridioides difficile* Trust threshold for Hospital Associated Cases (both Hospital and Community onset) was '55' with a Trust 'actual' of 52 cases.

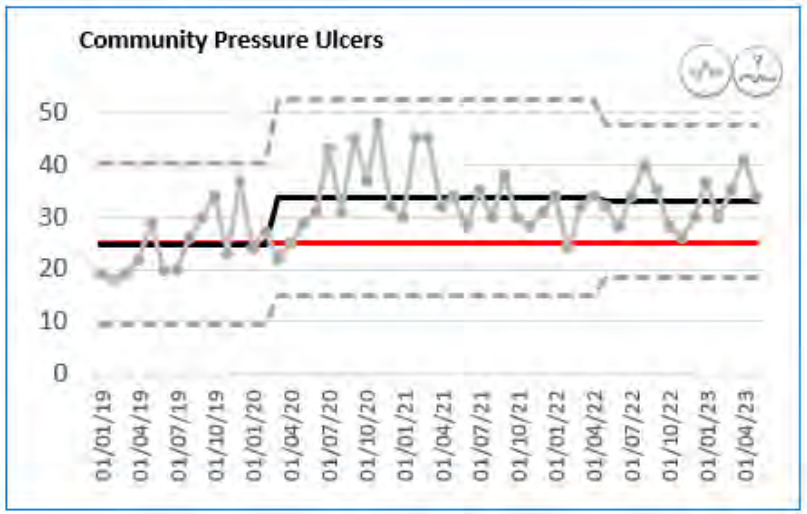
Safe

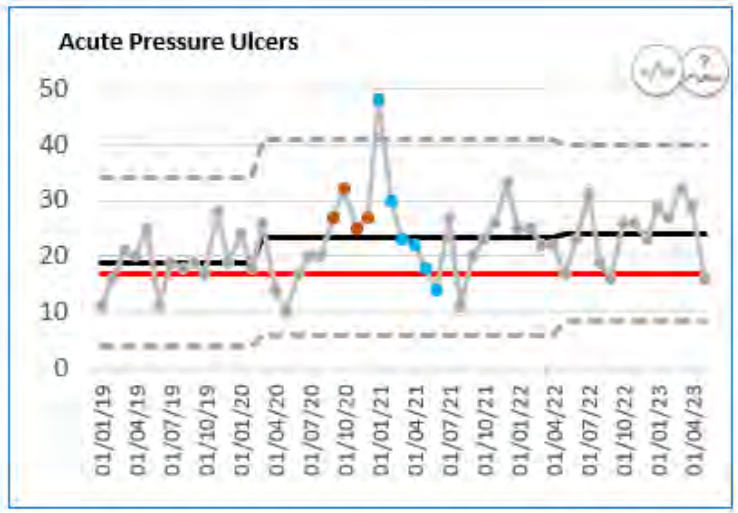


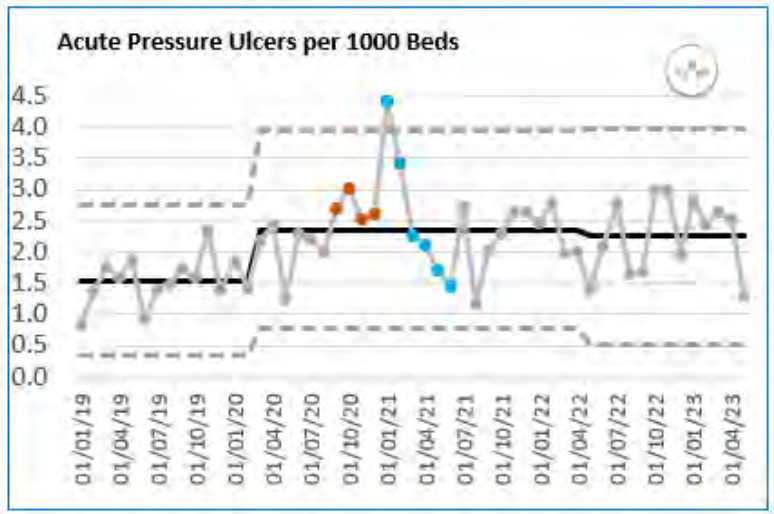


What	So What?	What Next?
The summary statistic has improved from last month to 97.26%. This is because the same day emergency care (SDEC) patients, which were inappropriately included, have been removed this month. The performance is otherwise stable and achievement of 95% is consistently met. The improved performance of AAU at 74.86% has been maintained.	A high compliance with VTE assessment and preventative treatment reduces the chance that our patients have a hospital acquired venous thrombosis event (VTE.)	Monthly monitoring will continue. Data to be shared with areas of low compliance for local improvement

Safe







What

PU incidence have significantly reduced in May particularly across the acute trust , Spread and pattern of reporting remains variable however areas of higher incidences are proactively supported by the TVN team

We have seen a 51% reduction in PU in the acute and 13% reduction in community this month. Data suggests that there is no improving or declining trend and variable achievement of obtaining the target set (which would be a 20% reduction on previous year)

Acute	C2	C3 /unstageable	C4
Community	21	13	1
Acute	14	1	0

So What?

Pressure ulcers are a quality indicator of patient care. A patient having a pressure sore develop can be attributed to many factors including;

- Nutrition
- Concordance
- Risk identification
- Mobilisation
- Associated co-morbidities

- All incidents are reviewed and cases resulting in moderate harm (category 3 and 4) are reviewed through after action reviews. C2 and C3 incidents are low in number

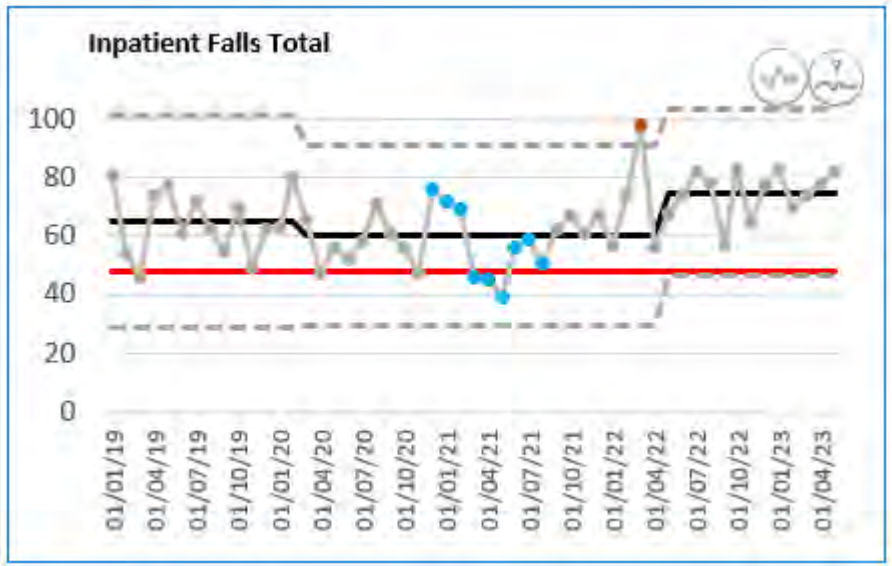
What Next?

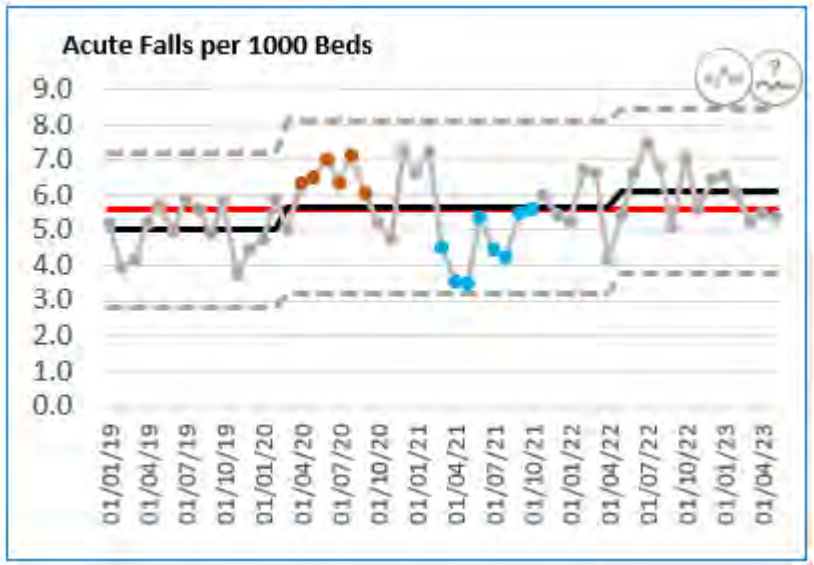
Continue to monitor PU incidents and recognise and act on themes through the Pressure Ulcer Prevention Group.

A working group has been formed looking at health coaching and developing this across the trust to develop better engagement with patients and promote awareness and concordance

These initiatives are part of wider overarching Quality Improvement works across the trust.

Safe





What	So What?	What Next?
In May 2023 there was an increase in the number of inpatient falls reported compared to April 2023. In May there was one fall reported as major harm (fractured neck of femur). There were 17 falls reported as minor harm. During the month of May there 12 were repeat fallers with 9 patients having two falls and 3 patients having three falls in the reporting month. Falls per occupied bed days remains under national average for 3 consecutive months	The effects of falls within hospital can range increase length of stay due to loss of patient confidence and deconditioning, to life changing severe harm. Its widely acknowledge that mortality of patient suffering from severe harm is greatly increased despite initial recovery Important to continue to raise falls awareness and falls prevention to all staff working within the trust with aim to reduce the number of falls. Identifying themes to support with quality improvement projects.	The falls group are working on a number of quality Improvement projects –including • Think yellow-think falls' in ED/ AAU • Increasing supply of low rise beds Subgroups of the falls groups are being convened to address specific areas of falls interventions. • Bed rail assessments • Low rise beds assessment • Floor retrieval Falls Champion meetings have been set up on a monthly basis

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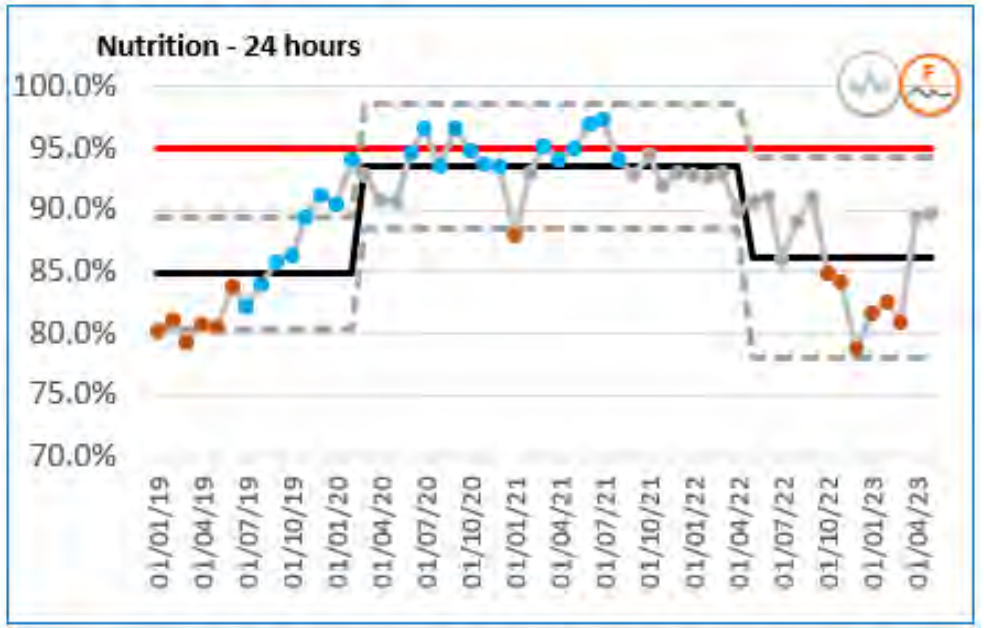

What	So What?	What Next?
There is continued improvement in with compliance in measuring weight and recording the Nutrition Assessment within 24hrs following a period of poor compliance. However there is a consistent non achievement of 95% target since Autumn 2021 On review, it is acknowledged that this has been partly due to long waits for beds by patients in the Emergency Department over the busy winter period. It has become increasingly difficult to meet the expected target as the time for completion starts when a decision is made to admit the patient. However, it is recognised that over 95% of patients are assessed during their admission, even if this is not achieved within the first 24hrs. Weighing patients on admission also continues to be a challenge, though there has been some improvement with this metric with additional focus from all areas. It is noted that at 48hrs, **75%** of patients have a measured weight recorded.	Prompt identification of patients need for additional nutritional support is essential for ensure patients do not decondition while in hospital, and can strongly influence recovery, skin integrity and patient experience. On review of data collection it appears that nutritional assessment is not a mandatory field within eCare enabling this assessment to be bypassed. This is being addressed to further ensure nutrition assessments are completed	The Dieticians are commencing a QI project to improve the quality of the assessment and appropriate referral. This will involve a pilot of eLearning training on 2 wards to monitor for improvements. F3 and G5 will be the pilot wards. There is also a QI project commencing on Ward F3 to pre load patients with supplements prior to fixation of their fractured neck of femur. Other ongoing initiatives are: • Daily spot checks of compliance by Matron and WM • Review of data at performance meetings and Governance reviews. • Continued review of compliance via Tendable audits • Encourage teaching sessions on the wards from the dietician • Continued review of equipment to ensure it is working and effective. • Work with Patient flow team to support improved patient flow through the organisation

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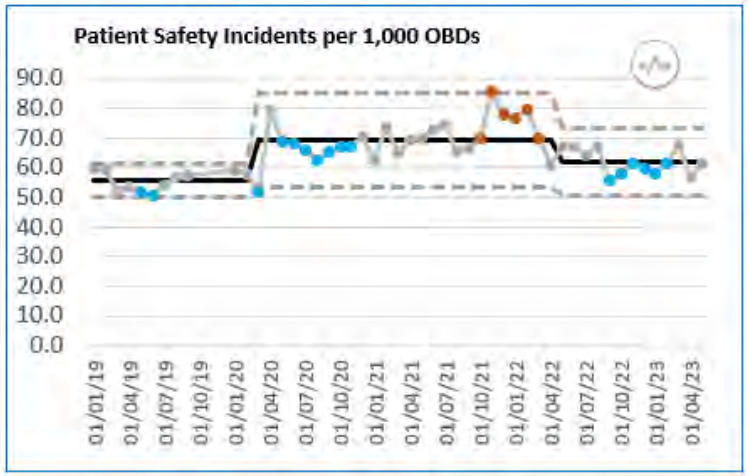
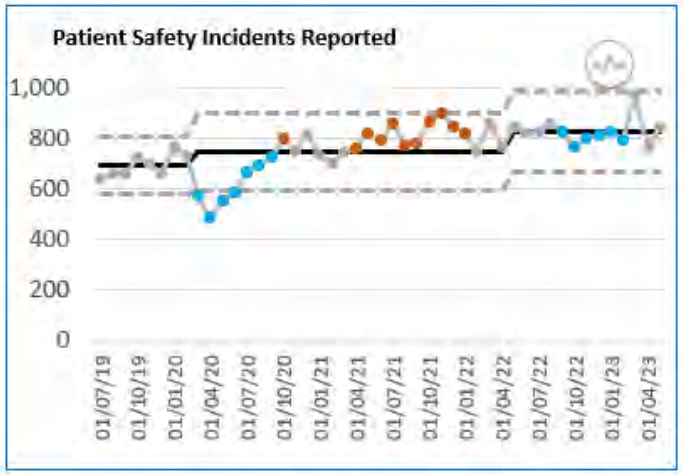
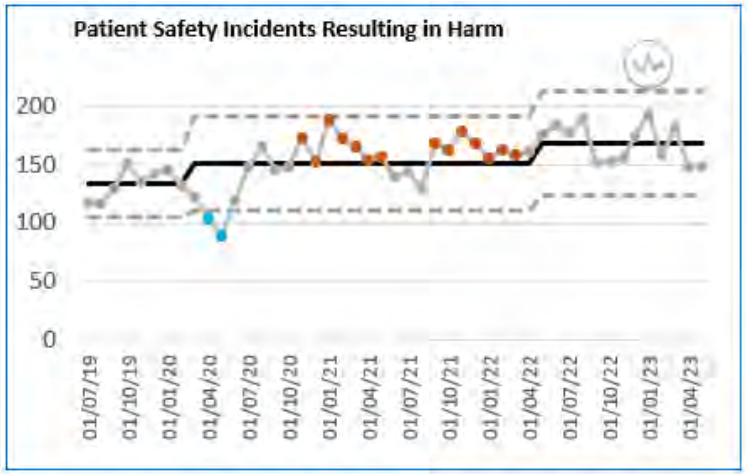
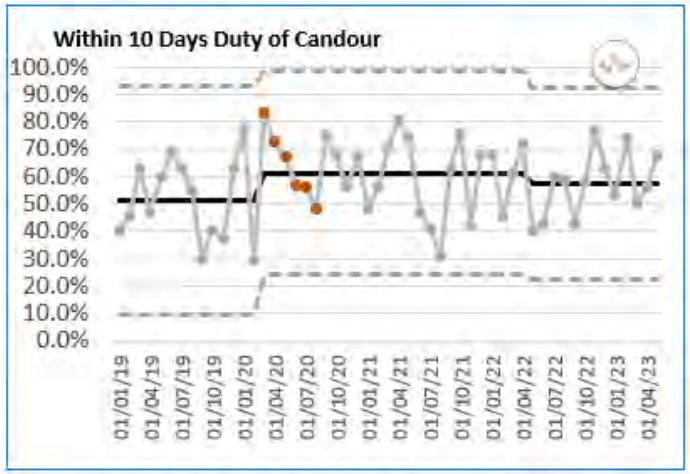


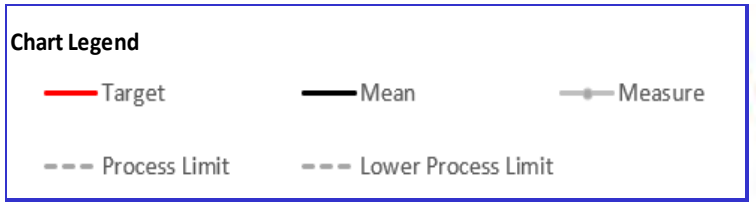


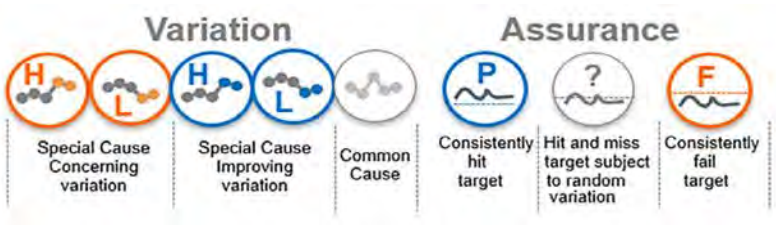




What	So What?	What Next?
Patient safety incident reporting remains consistent, with a reduction in associated harm. This is notable through high reporting categories such as falls and pressure ulcers. There has been an increase in improvement work driven and supported by the specialist groups and reported through PSQGG. DoC within 10 days has seen an improvement and this can be attributed to the compliance elements undertaken on a daily basis by the patient safety team and through discussion at Trust and divisional emerging incident review meetings.	We want to continue to promote a positive safety culture where staff are confident to report incidents to ensure learning. We aim to target improvement work for incidents where there is no or minor harm to ensure the major incidents do not occur. This can be demonstrated through the medication safety incident audits for example.	Development of a quarterly thematic learning report to complement the quarterly thematic analysis document. Encourage staff to access our patient safety education programme modules which were launched during patient safety month by working with comms to ensure the modules are clearly sign posted and accessible. This will continue to help build our positive safety culture.

INVOLVEMENT COMMITTEE METRICS





KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
New Complaints	May 23	17				16	-1	33
Closed Complaints	May 23	14				16	1	31
Overdue Responses	May 23	0	0		?	1	-2	5

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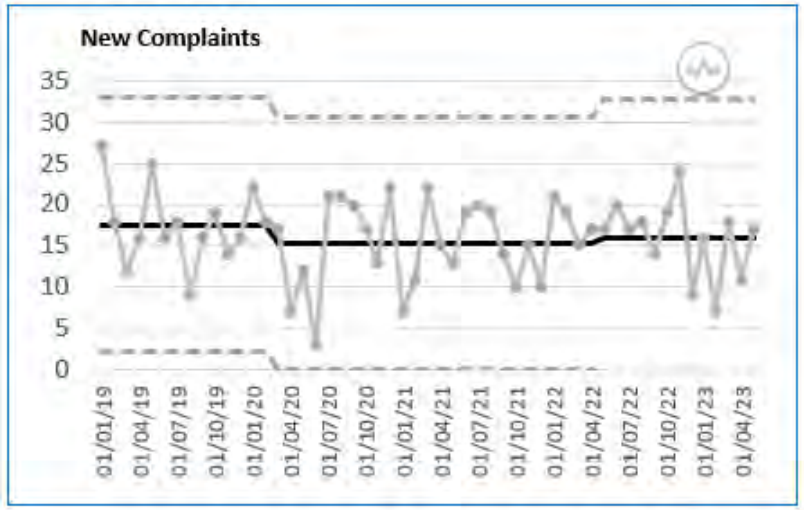
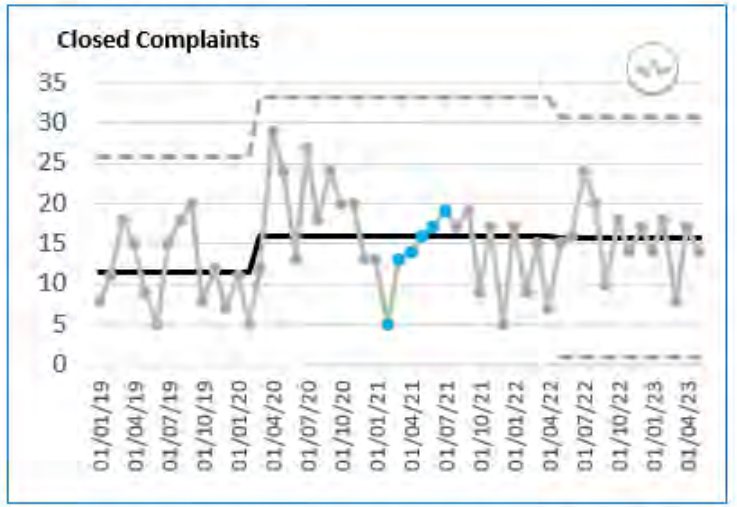
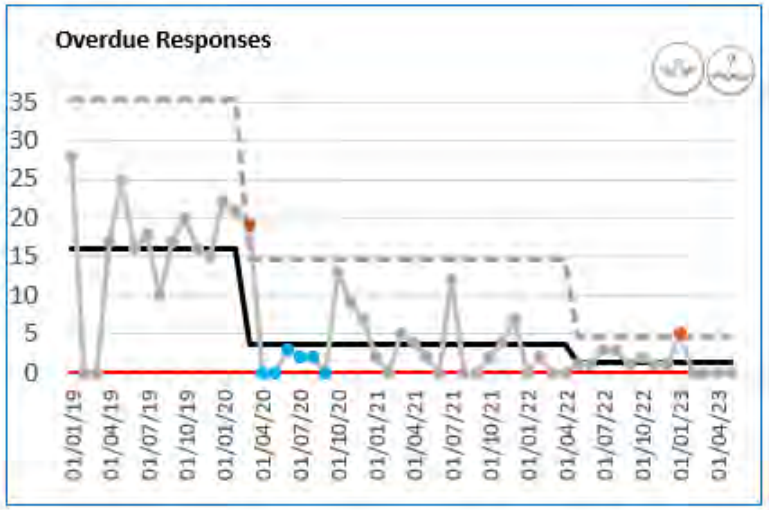
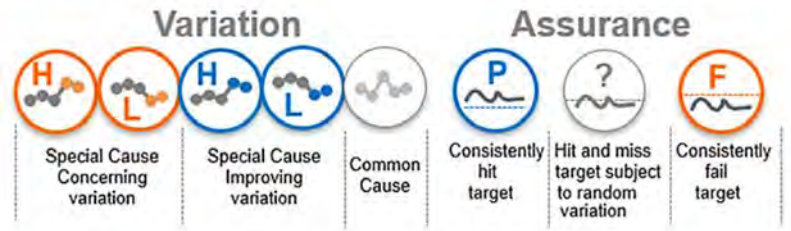




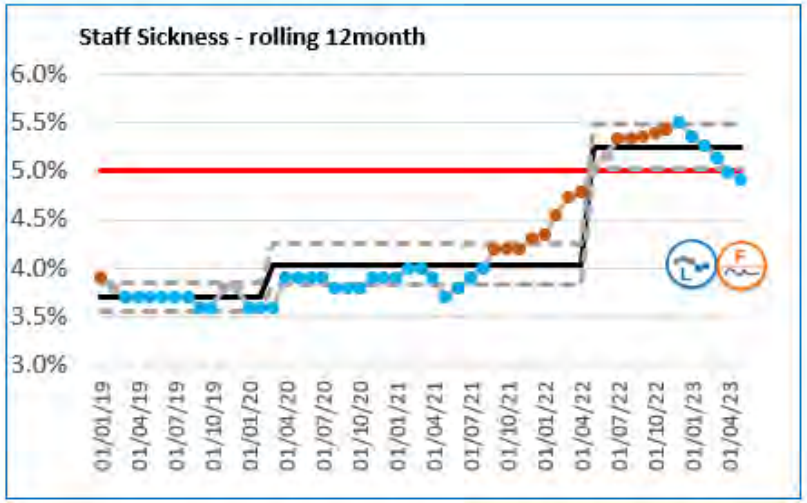


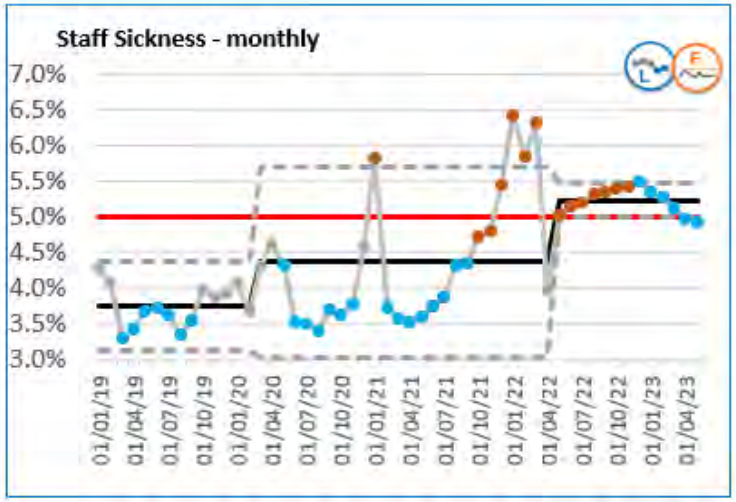
What	So What?	What Next?
An increase in formal complaints received compared to April however the data reflects that these complaints range over a number of different wards and departments and is not showing us any specific trend. There has been not significant change and complaints received are within controlled limits. Closed complaints reduced slightly. After feedback from the team, this was due to some complex cases that took longer than usual, plus a member of staff absent during this period.	We have continued to update patients regularly which is reflected in the low number (zero) of overdue responses.	The team are meeting regularly to ensure timely responses are provided to complainants. Feedback from complainants is overall positive in regards to the complaints pathway. Data will continue to remain within the controlled limits.

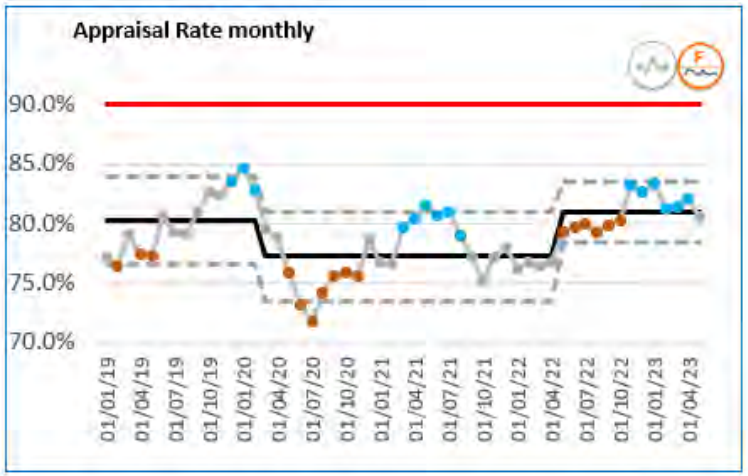


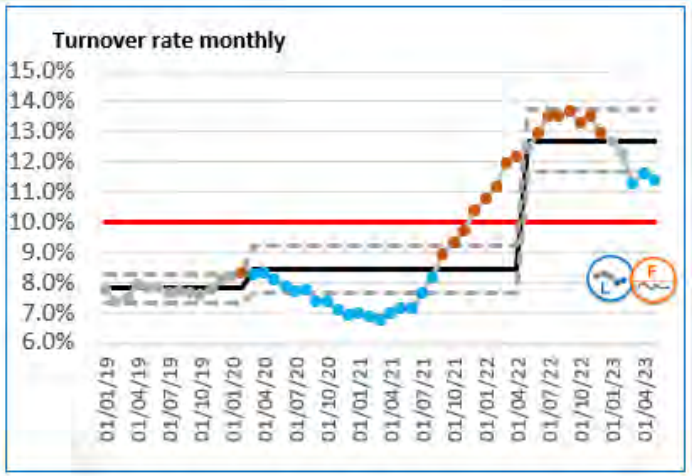
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Staff Sickness - rolling 12month	May 23	4.9%	5.0%	L	F	5.2%	5.0%	5.5%
Staff Sickness - monthly	May 23	4.9%	5.0%	L	F	5.2%	5.0%	5.5%
Mandatory Training monthly	May 23	88.6%	90.0%		F	88.1%	86.7%	89.6%
Appraisal Rate monthly	May 23	80.6%	90.0%		F	81.0%	78.5%	83.5%
Turnover rate monthly	May 23	11.4%	10.0%	L	F	12.7%	11.7%	13.7%

Well Led









What	So What?	What Next?
Sickness – now achieving target following a period of sustained improvement since December 2022 **Mandatory training** – not meeting target overall, however, three divisions are meeting target of 90%+ **Appraisals** – consistently failing to achieve target with significant month on month drops in two divisions which has led to a drop overall of 1.48% **Turnover -** not meeting target but an improving KPI, reducing consistently since November 2022	These workforce key performance indicators directly impact on staff morale, staff retention and, therefore, patient care and safety. Additionally, improvements in these workforce KPI's will strengthen our ability to be the employer of choice for our community and recognised as a great place to work.	Maintain improvements in staff attendance and review findings of sickness management internal audit. Analysis of mandatory training data to identify areas in need of focussed support to achieve and maintain target. Analysis of appraisal data to identify areas in need of support including monitoring of appraisal cancellations and escalation processes to be considered by divisional teams. Delivering our people and culture plan and priorities will aide recruitment and retention.

4.4.2 Maternity - Annexes

West Suffolk NHS
NHS Foundation Trust

Audit of Obstetric Consultant Presence in Acute Obstetric Care

Obstetrics & Gynaecology

Project Team

Name: Nada Al-Shammari	Title/grade: Consultant (OBGYN)
Name: Nicole Lucioni	Title/grade: Consultant (OBGYN)
Name: Victoria Mcwen-Smith	Title/grade: Clinical and Quality Assurance Midwife
Name: Vicky Dekker	Title/grade: Midwife Band 6

Author Vicky Dekker – Labour Suite Core Midwife

09/06/2023

Report status – draft

Background/Rationale

Successive maternity reports have identified the important role consultants play in being key clinical decision makers, maintaining standards, reducing variations in patient care and role modelling professional behaviour (RCOG 2021). Maternity care is an ever evolving, active environment where there can be constant workload with unexpected emergencies which require timely expert decision and actions to ensure safety to both mother and baby. The RCOG provide clear guidance as to when consultant attendance is required and this audit was undertaken to ensure the acute obstetric care provided by West Suffolk Hospital (WSH) is in keeping with these current guidelines.

Aim

To maintain or improve the optimal acute maternity care provided in the WSH maternity unit.

Objectives

To ensure that ALL the emergency/complicated obstetric scenarios are handled by appropriately trained clinicians according to the RCOG guidance and to assess the level of senior support in the maternity unit in order to maintain an effective and safe working environment.

Standards

What standards and guidelines have you compared practice against? What criteria have been used? Please specify the full title, reference and source of the criteria.

No.	Standard	Target %	Exceptions	Definitions
1.	The list of clinical scenarios and situations when consultants should be informed and when they should attend in person	100	N/R	

Methodology

For the period of December 2022 to April 2023 the author performed a retrospective review of birth data to identify those cases in which a consultant obstetrician must have attended according to RCOG guidelines (2021). The incident reporting system (Datix) and quality dashboards were also used to correlate and confirm the numbers.

Where cases in which consultant presence was required were identified, the individual computerised records (eCare) of those women were accessed to review events against the audit standards and confirm consultant presence. The same review was undertaken to identify those cases in which the consultant must attend unless the most senior clinician present had been signed off as being competent. The eCare records of these women were again accessed to review events against the audit standards and confirm consultant or senior clinician presence. Within eCare the template for recording acute or emergency events contains a section which clearly identifies clinician competency and consultant involvement and many clinicians had also documented this within the narrative.

912 births occurred in the period reviewed. Of those, 27 cases required the attendance of a consultant and 82 required the attendance of a consultant or a suitably competent senior clinician. The contemporaneous documentation of who was present in all cases and comparison with the audit standards was made possible by the completion of detailed accounts and standardised forms.

The analysed data was reviewed and agreed action plans were discussed with Consultant Nada Al-Shammari, Consultant Nicole Lucioni, Clinical Risk Manager Karen Green and Clinical and Quality Assurance Midwife Victoria McEwen-Smith. The outcome of the audit will be communicated to the rest of the maternity team at departmental audit meeting.

Results

No.	Standard	Target %	Findings		Comments
			n	%	
1.	Deteriorating condition requiring admission to ITU/HDU	100	4	100%	
2.	Caesarean section with Major Placenta previa/abnormally invasive placenta	100	4	100%	
3.	Caesarean section with BMI >40	100	14	100%	Can be consultant or competent senior doctor*
4.	Caesarean section with BMI >50	100	1	100%	
5.	Caesarean section <28/40 weeks	100	0		
6.	Caesarean section <32/40 weeks	100	0		Can be consultant or competent senior doctor*
7.	Caesarean section in Multiple pregnancy <30/40 weeks	100	0		
8.	Caesarean section at full dilatation	100	22	100%	Can be consultant or competent senior doctor*
9.	Caesarean section for transverse lie	100	2	100%	Can be consultant or competent senior doctor*
10	3rd degree tear	100	20	100%	Can be consultant or competent senior doctor*
11.	4th degree tear	100	0		
12.	Unexpected intrapartum stillbirth	100	1	100%	
13.	Eclampsia	100	0		
14.	Maternal collapse	100	1	100%	
15.	PPH >2L + Major obstetric haemorrhage protocol initiated	100	5	100%	
16.	EBL >1.5L + ongoing bleeding	100	3	100%	
17.	Return to theatre	100	1	100%	
18.	Trial of instrumental delivery	100	23	100%	Can be consultant or competent senior doctor*
19.	Vaginal twin birth	100	1		Can be consultant or competent senior doctor*
20.	Vaginal breech birth	100	1		Can be consultant or competent senior doctor*
21.	Event of high levels of activity e.g. second theatre opened, unit closure due to high levels of activity requiring obstetrician input	100	0		
22.	Team debrief requested	100	2	100%	(This reflects the documented figures identified but it is recognised that informal debrief will also have occurred in some cases)
23.	Requested to attend outside the scenarios above	100	4	100%	

* in these situations the senior doctor and the consultant should decide in advance if the consultant should be informed prior to the senior doctor undertaking the procedure.

Conclusions

It is impressive to see that during the period December 2022 – April 2023, our maternity team in WSH demonstrated 100% compliance by ensuring that consultants and/or competent senior clinicians attended all the acute obstetric cases and complicated scenarios as guided by the RCOG. It is imperative to maintain this standard by making sure the clinical team is familiar with the situations which need seniors' input to ensure prompt attention is requested and this warrants periodical reviews.

Very good communication and teamwork was demonstrated in order to achieve a 100 percent compliance in the audit assessment. The computerised records showed excellent contemporaneous documentation during the acute situations which was very useful in a retrospective review.

Recommendations

To keep up the good work in early recognition and declaration of the obstetric emergency or complications, continue effective team communication and team work to maintain the RCOG recommended optimal acute maternity care.

Learning Points

To maintain the good standard of care.

References

RCOG 2021 Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology by Barber JS, Cunningham S Mountfield J, Yoong W, Morris E June 2021 (Updated May 2022)

Roles and responsibilities of the consultant workforce report (May 2022 update) (rcog.org.uk)

Action Plan

Project title	Monitoring Obstetric Consultant presence in Acute Obstetric Care

Action plan lead	Name: Nada Al-Shammari	Title: Consultant	Contact:nada.alshammari@wsh.nhs.uk

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

Recommendation	**Actions required** *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Comments/action status** *(Provide examples of action in progress, changes in practices, problems encountered in facilitating change, reasons why recommendation has not been actioned etc)*
Continue to keep the compliance at standard	none	N/R	Dr.Nada Al-Shammari (Consultant)	

West Suffolk NHS
NHS Foundation Trust

Perinatal Quality Surveillance Model

Principle 1

Version 2 - June 2023

1. Introduction and Context

'In response to the need to proactively identify trusts that require support before serious issues arise, a new quality surveillance model seeks to provide for consistent and methodical oversight of all services, specifically including maternity services. The model has also been developed to gather ongoing learning and insight, to inform improvements in the delivery of perinatal services.
The provider trust and its board, supported by the senior maternity and neonatal triumvirate and the board-level perinatal safety champion at its centre, ultimately remain responsible for the quality of the services provided and for ongoing improvement to these. As the commissioners of maternity care, Integrated Care Boards (ICBs) also have a statutory role to improve quality, safety and outcomes for their patients. The quality model supports trusts and ICBs to discharge their duties, while providing a safety net for any emerging concerns, trends or issues that are not quickly identified and addressed.

The **perinatal quality surveillance model (PQSM)** is designed to function in the emerging architecture in the NHS, whereby the Integrated Care Board (ICB) (with full involvement from providers) will be responsible for system planning, governance, accountability, management of performance and reducing unwarranted variation in care and outcomes. Arrangements for quality oversight must be in place for each local system.[1]

There are 5 principles:

- Principle 1: **Strengthening Trust Board oversight of perinatal clinical quality** including a requirement for a monthly review using the minimum data set (Year 5 MIS)

- Principle 2: **Local Maternity and Neonatal Service (LMNS) and ICB role in perinatal clinical quality oversight**, ensuring that:
  - A senior representative of the LMNS is a member of the ICB chaired Local Quality Surveillance Group.
  - The LMNS leads on the production of a system quality dashboard.
  - Timely and proportionate action is taken to address any concerns identified.
  - Identified areas for improvement are supported by quality improvement plans
  - Concerns are escalated to the indicated forum for oversight

- Principle 3: **Perinatal clinical quality is routinely reviewed at a regional level committee** which has specific responsibility for perinatal quality oversight. It should involve the Regional Chief Nurse, Regional Chief Midwife and a Lead Obstetrician, who should work closely with regional neonatal leadership.

- Principle 4: **National governance will be aligned to reflect the revised perinatal clinical quality model**. To ensure issues and concerns are integrated into existing national structures the Chairs of the national Maternity Safety Surveillance and Concerns Group will be core members of the national NHSEI Executive Quality Group and the national JSOG.

[1] *Implementing a Revised Perinatal Quality Surveillance Model; December 2020*

- Principle 5: **Agreed principles to support local, regional, and national decision making** as to what would trigger further assurance or action around a perinatal clinical quality concern.

As part of the Ockenden Immediate and Essential Actions (2020) Trusts were asked to implement Principle 1 of the Perinatal Quality Surveillance Model which outlined the responsibilities for the Trust overseeing quality and safety. Principle 2 is to be implemented by the Local Maternity and Neonatal Service (LMNS). The following is the direct quote from the document: **'Implementing a Revised Perinatal Quality Surveillance Model (PQSM) (2020)**

'Principle 1 – Strengthening Trust-level oversight for quality

'Since 2017 all Trust Boards have been required to have a Board-level safety champion, whose remit is to bring together a range of internal sources of insight to provide strategic oversight and leadership for perinatal safety. However, insight gathered from a range of system partners suggests that trust board oversight of perinatal clinical quality in provider organisations remains variable. Reasons for this include:
• perinatal clinical quality is not always reviewed regularly and methodically, using a consistent set of data and information
• variable understanding of maternity services on the part of board members
• variable effectiveness in different models of safety champion
• challenges representing perinatal clinical quality in a context of competing priorities.

We are therefore setting out six requirements to strengthen and optimise board oversight for maternity and neonatal safety':

1. **West Suffolk NHS Foundation Trust (WSFT) - PQSM Principle 1**
   WSFT response to the 6 requirements of Principle 1 are as follows:

Requirement	WSNHSFT
1. To appoint a non-executive director to work alongside the Board-level perinatal safety champion to provide objective, external challenge and enquiry.	1. NED appointed to role as Board-level Safety Champion alongside the medical director and evidence through participation in safety activities and processes.
2. That a monthly review of maternity and neonatal safety and quality is undertaken by the Trust Board.	2. Bi-monthly open and closed Board meetings where maternity and neonatal safety and quality issues are presented and discussed. Monthly MNSC meetings.
3. That all maternity Serious Incidents (SIs) *(now PSII or reports from PSIRF)* are shared with Trust Boards and the LMS, in addition to reporting as required to HSIB.	3. All serious incidents are discussed at the Emerging Incident Review panel and completed clinical reviews and Patient Safety Incident Investigations within the PSIRF principles, PMRT reports and HSIB reports are presented at the Patient Safety Review Panel for approval. Approved reports are presented at the Trust Board and LMNS. Summaries of perinatal losses reported to MBRRACE are included

	in the quarterly Board reports and include learning from the reviews.
4. To use a locally agreed dashboard to include, as a minimum, the measures set out in the source document, drawing on locally collected intelligence to monitor maternity and neonatal safety at board meetings.	4. The Regional Perinatal Quality Group Highlight Report (RPQOG) represents the information from the Trust and is presented at the Trust Board via the Quality and Safety Group, MNSC and at the LMNS/ICS meetings before being submitted to the East of England Regional team via the Regional RPQOG Board and presented as a summary at the Regional Maternity and Neonatal Programme Board. Exception reports will be presented to the Board from Thematic Reviews, Inquests and other external assessments and visits.
5. Having reviewed the perinatal clinical quality surveillance model in full, in collaboration with the local maternity system (LMS) lead and regional chief midwife, formalise how trust-level intelligence will be shared to ensure early action and support for areas of concern or need.	5. The Trust information is shared via the RPQOG and LMNS safety forums. Incidents, complaints, feedback and claims are discussed at local Governance forums and MNSC meetings. The bi-monthly Board reports include all aspects of quality and safety. The LMNS/ICB and Regional teams are invited to and attend the Maternity and Neonatal Improvement Board. Monthly meetings with the LMNS to discuss the risk register. Monthly meetings between LMNS and Regional team.
6. To review existing guidance, refreshed how to guides and a new safety champion toolkit to enable a full understanding of the role of the safety champion, including strong governance processes and key relationships in support of full implementation of the quality surveillance model.	6. The MNSC guideline is reviewed regularly as safety processes are developed and updated and as new guidance and recommendations are made.

A range of further support measures are under consideration, including safety culture leadership training, access to a trust-level dashboard and access to an NHS Resolution developed annual maternity trust claims scorecard to help target interventions aimed at improving patient safety.'

The NHS released the Maternity and Neonatal Safety Champions Toolkit in September 2020. This outlines the national ambition for improving safety within maternity and neonatal services and reducing harm to mothers and babies and the key roles in order to achieve this.

A separate guideline describes the role of the Maternity and Neonatal Safety Champions (MNSC) and their oversight of quality and safety within the Maternity and Neonatal services at West Suffolk NHS Foundation Trust (WSFT).

2. Structures in Place for Learning and Sharing to Take Place

2.1 WSFT Maternity and Neonatal Learning and Sharing

The following table describes the forums where learning and sharing of safety intelligence takes place within the Trust and includes our partners within and outside the Trust setting.

2.2 WSFT Organisational Governance Structures and Committees

The flowchart in 2.2 describes the committees within WSFT who are responsible and accountable for carrying out the Governance functions within the Trust.

2.3 LMNS and ICB PQSM Flowchart

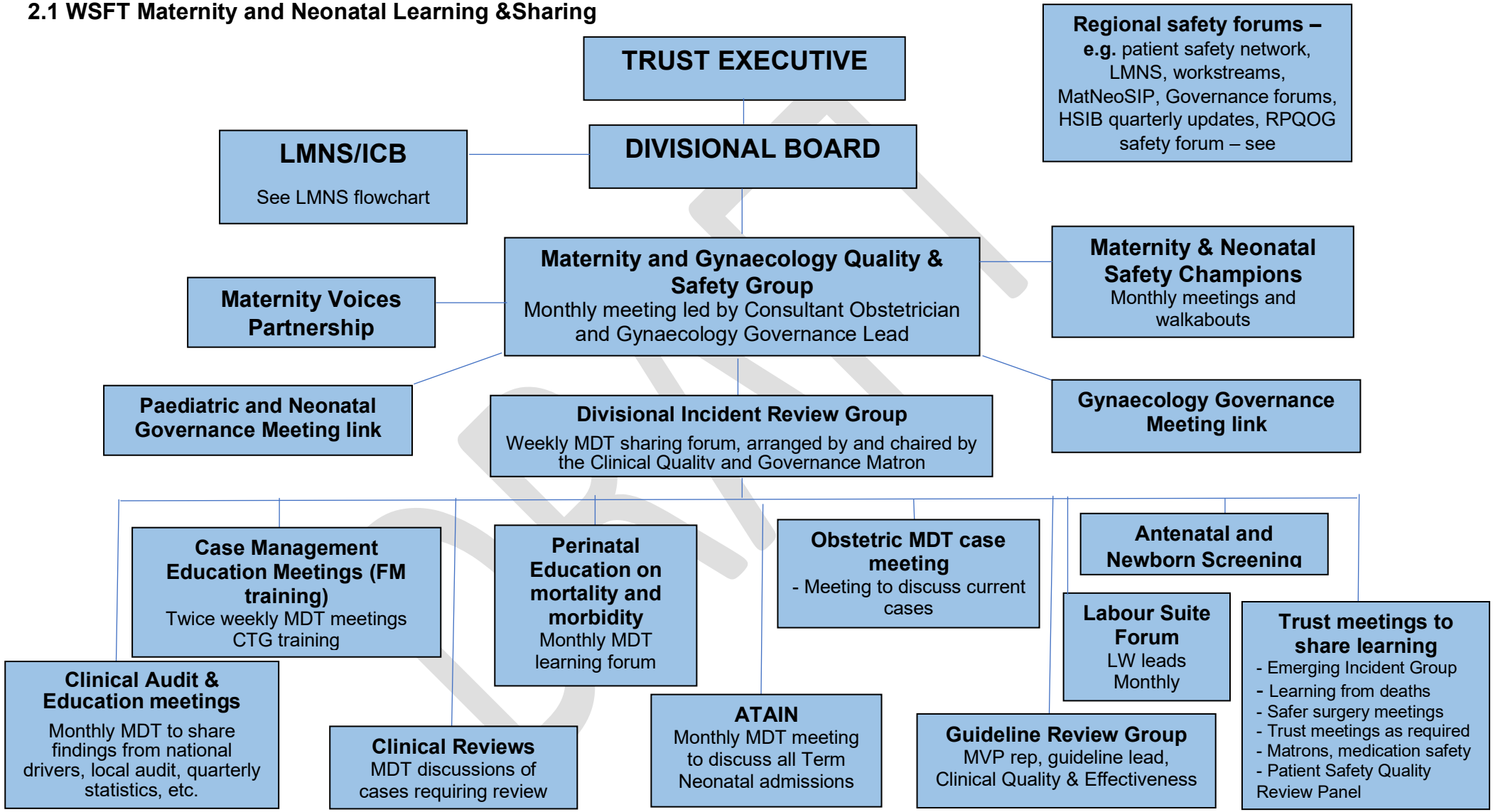
The flowchart in 2.3 describes the relationships between Trusts and the LMNS and the LMNS and Regional teams to carry out their work in relation to Principle 2 of the PQSM.

2.4 Regional and National Oversight of the PQSM

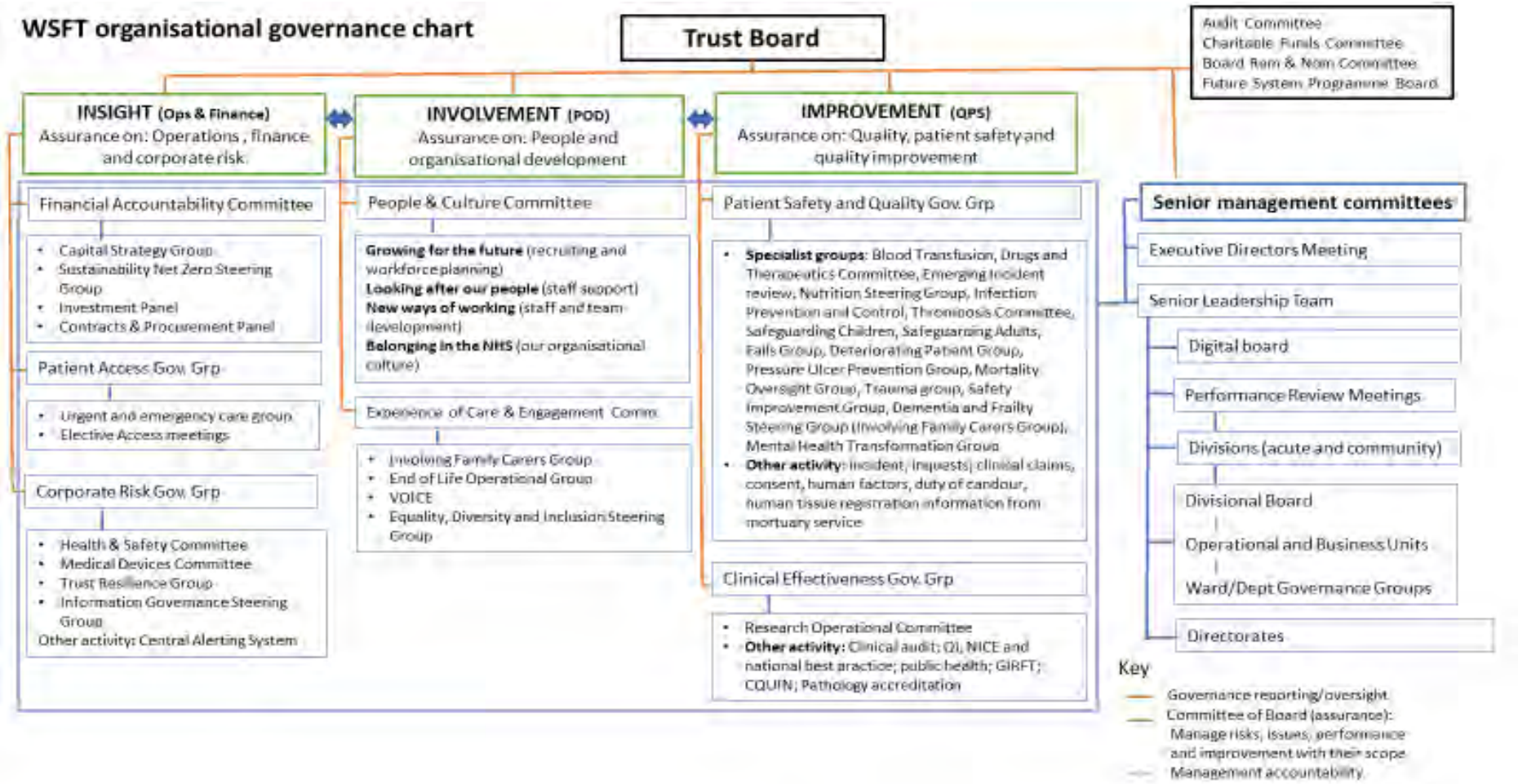
The structural chart in 2.4 demonstrates the links between Trusts, LMNS and ICB and the Regional teams reporting up to and down from the National Maternity Leaders and Programmes

West Suffolk NHS
NHS Foundation Trust

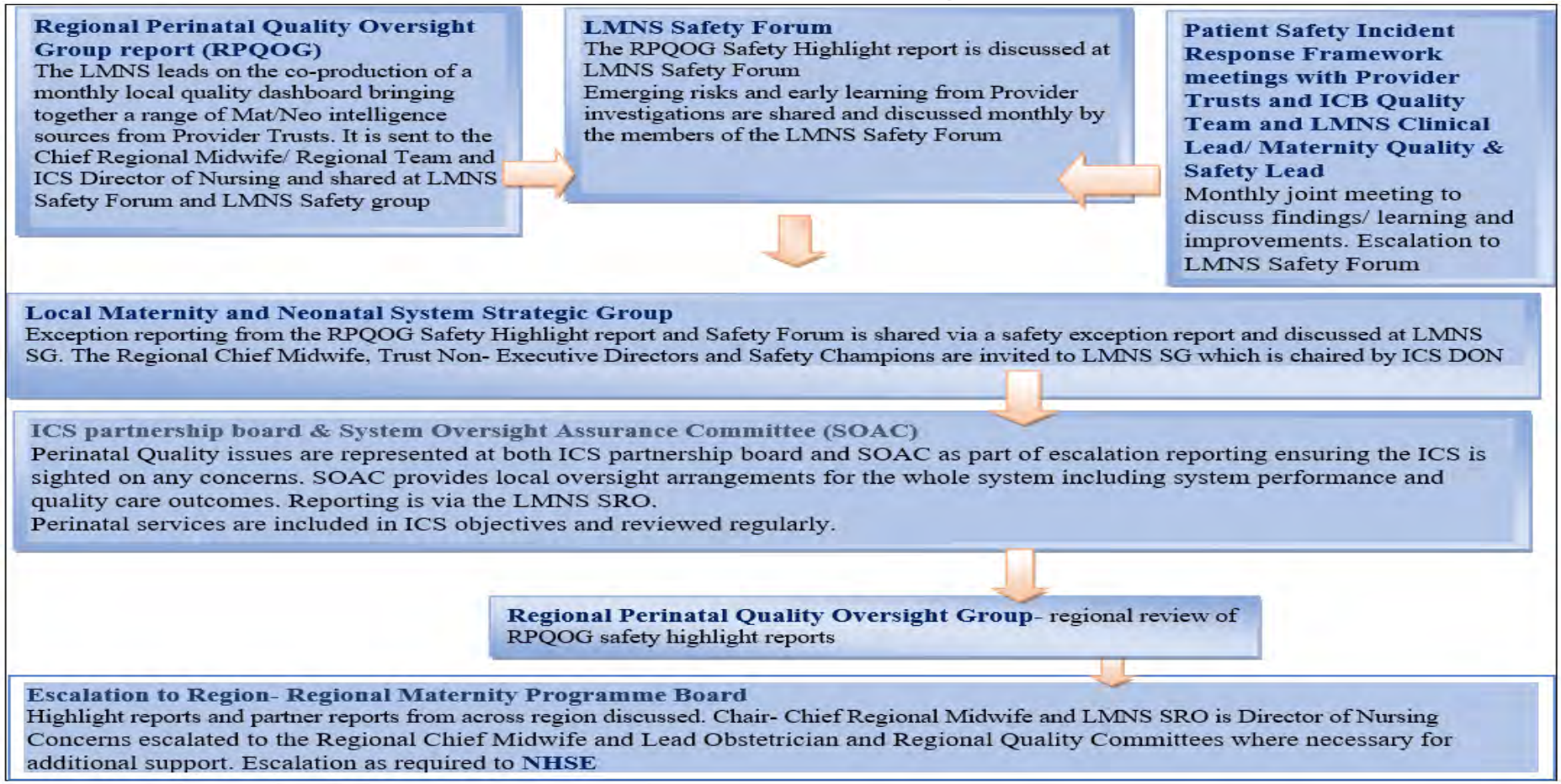
2.1 WSFT Maternity and Neonatal Learning &Sharing



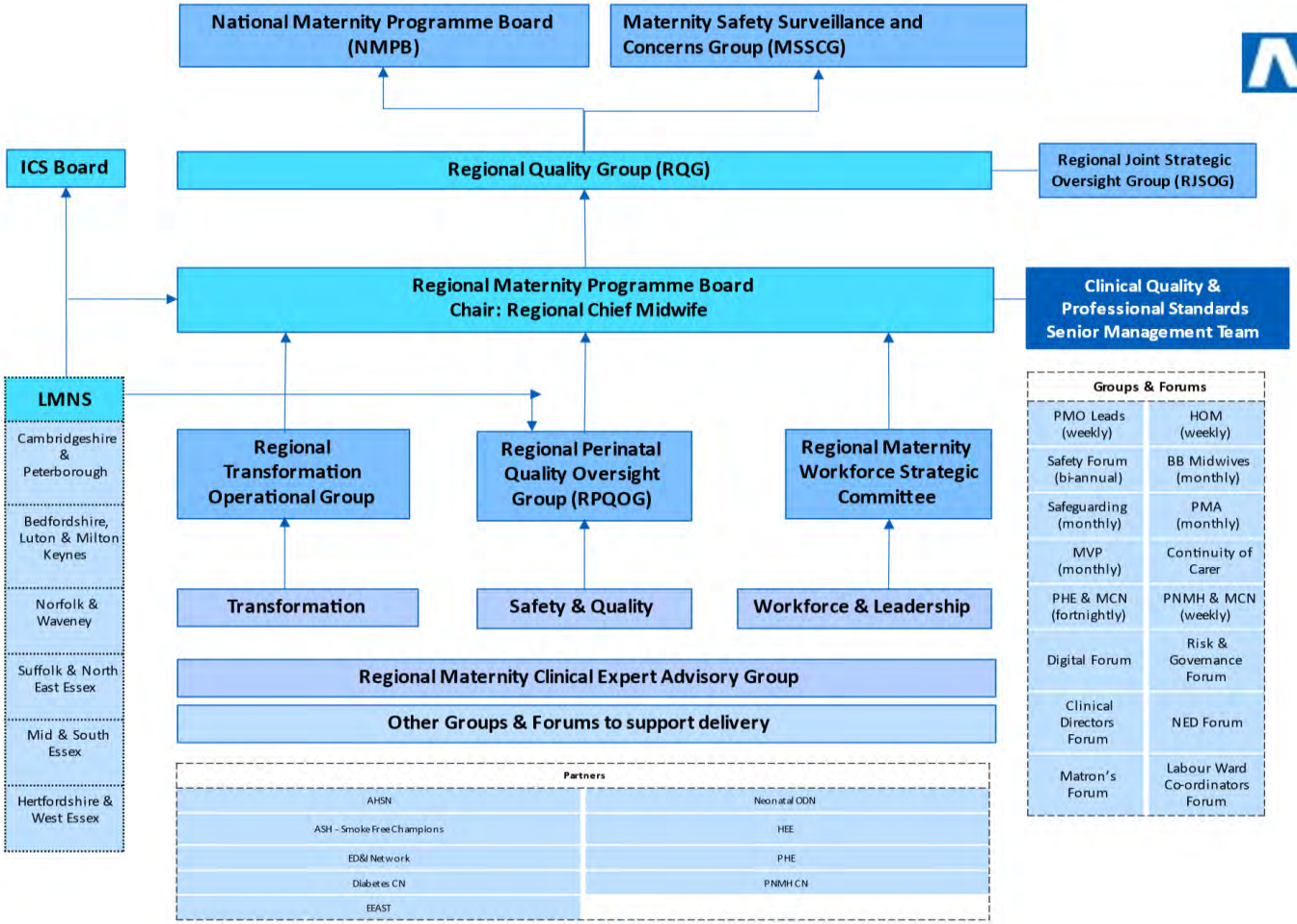
West Suffolk NHS
NHS Foundation Trust



2.3 Perinatal Quality Surveillance Model – LMNS and ICB



2.4 Escalation of Safety and Quality Intelligence from LMNS and ICB to National Maternity Programme Boards



Version control

Version	Author	Date
1.0	Beverley Gordon, Project Midwife	28/6/21
2.0	Beverley Gordon, Project Midwife; Karen Green, Clinical Quality and Governance Matron Approved by Wendy Matthews, Regional Chief Midwife	30/6/23

Appendix 1 Example template for Trust Board to LMNS Reporting Tool for Perinatal Clinical Surveillance Model

Principle 1 – Strengthening trust-level oversight for quality	**Evidence**	IPSWICH	EVIDENCE	COLCHESTER	EVIDENCE	WEST SUFFOLK	EVIDENCE
To appoint a non-executive director to work alongside the board-level perinatal safety champion to provide objective, external challenge and enquiry.	NED + Safety Champion						
	Joint NED/Safety champion/MVP meeting						
That a monthly review of maternity and neonatal safety and quality is undertaken by the trust board	Monthly review of maternity and neonatal safety undertaken at Trust Board						
That all maternity Serious Incidents (SI's) are shared with trust boards and the LMNS, in addition to reporting as required to HSIB	SI's - shared with Board						
	SI's - Shared with LMNS						
To use a locally agreed dashboard to include as a minimum the measures set out in Appendix 2, drawing on locally collected intelligence to monitor maternity and neonatal safety at board meetings	Locally agreed dashboard						
Having reviewed the perinatal clinical quality surveillance model in full, in collaboration with the LMNS lead and regional chief midwife formalise how trust-level intelligence will be shared to ensure early action and support for areas of concern or need.	Formalise how at Trust level						

To review existing guidance, refreshed how to guides and a new safety champion toolkit to enable a full understanding of the role of the safety champion, including strong governance processes and key relationships in support of full implementation of the quality surveillance model.	Intelligence will be shared and existing guidance reviewed						

Women and Children's & Clinical Support Services Division

MATERNITY SERVICES

Midwifery Staffing Report - an effective system of midwifery workforce planning to the required safe standard

Report Title	Bi-Annual Report on Midwifery Workforce – May 2023 for period 1st October 2022 to 31st March 2023
Report for	Approval and Information
Report from	Karen Newbury, Head of Midwifery
Lead for Report	Karen Newbury, Head of Midwifery
Report Authors	Karen Newbury, Head of Midwifery
Report presented for information and approval	Maternity Quality and Safety Group – 19/06/23
	Maternity and Neonatal Safety Champions – due 27/07/23
	Trust Board – due 28/07/23
Date of Report	May 2023
Risk and assurance:	There are financial risks associated with non-compliance with the Maternity Incentive Scheme Year 5 requirements. This report outlines the Trust's position against safe midwifery staffing
Legislation, regulatory, equality, diversity and dignity implications	The information contained within this report has been obtained through due diligence. There are no equality and diversity issues related to this report

Executive summary:

- National tools, LMNS collaboration and BirthRate Plus methodology have been used to determine the midwifery establishment.
- The funded establishment was agreed by the Trust Board in May 2022. Awaiting confirmation of 23/24 budget.
- Robust escalation processes and team working have mitigated some staffing challenges due to absences but gaps on the rota are still a challenge.
- Essential actions from the Ockenden report and subsequent cessation of target dates to implement MCoC have resulted in temporary suspension of two community-based teams to assist with safe staffing of both the hospital and community services.
- One to one care of women in labour over the 6-month period of the report has been maintained at **100% compliance**
- Supernumerary status of the labour suite co-ordinator has been consistently above **99%** between October to March 22/23. The aim is for 100%.
- Vacancies for experienced band 6 midwives are difficult to fill and whilst recruitment of band 5 midwives and those from overseas has been successful, the support and supervision required is considerable.
- Midwife vacancies at the end of March 23 was 29.9 wte which equates to a **22% vacancy rate.** The service is currently employing approximately 10.00 wte midwives each month through the bank and staff working additional hours.
- The impact of increasing student midwife numbers and return to practice courses will not be realised for at least another 2-4 years.
- West Suffolk is actively participating in the regional work of midwifery apprenticeship schemes with the intention of having places on the first cohort when these are in place.
- The Midwife to Birth ratio has been set locally at **1:27.7**; there were three months when this was not met and a ratio of **1:28 or above** was reported. This reflects the vacancy factor.
- Red Flags continue to be monitored daily and collated monthly: delays in induction of labour remains the main clinical reason

Recommendations:

- Close monitoring of the supernumerary status of the LSC will continue, with each instance of non-compliance investigated and themes identified.
- Active recruitment to vacancies will continue, with an effective preceptorship process in place to retain and develop staff.
- Further MCoC teams will be on hold until safe staffing levels can be assured throughout the service.
- Recurring themes from ‘red fags’ relating to staffing will be reviewed and where appropriate and possible further mitigations in place.
- Escalation plans will be used to promote safe care

Introduction

This report is written to provide evidence of the Trust's commitment to safe midwifery staffing levels.
The Trust has assessed the staffing levels using the Maternity Incentive Scheme (MIS) for Trusts and other national reports that have been published where staffing levels have contributed to adverse outcomes and events.

In addition, the final Ockenden[1] report published in March 2022 contains several 'Must Do's' pertaining to midwifery staffing. These are consistent with the requirements for the MIS in that the Maternity and Neonatal Service have staffing levels that provide safe, quality care. The potential impact of the required Ockenden actions are highlighted in this paper to inform the Trust Board and enable the required investment in midwifery services.

Consideration is being given to developing the senior midwifery workforce with a Director of Midwifery and a Consultant Midwife who is involved in undertaking and implementing research and reviews/audits of practice. Discussions continue with the Trust Executive team to agree the way forward.

The purpose of this report is to provide evidence and give the Trust Board assurance that progress is being made towards meeting safe staffing standards within the midwifery workforce including:

- A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated.
- In line with midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board Minutes) of funded establishments being compliant with outcomes or BirtRate+ or equivalent calculations.
- Where Trusts are not compliant with a funded establishment based on BirtRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls.
- The plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners.
- Details of planned versus actual midwifery staffing levels. To include evidence of mitigation/escalation for managing a shortfall in staffing.
    - The midwife to birth ratio
    - The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in the clinical numbers. This includes those in management positions and specialist midwives.
- Evidence from an acuity tool (may be locally developed), local audit and/or local dashboard figures demonstrating 100% compliance with supernumerary status and the provision of 1-1 care in labour. Must include plan for mitigation/escalation to cover any shortfalls.

[1] OCKENDEN REPORT – FINAL FINDINGS, CONCLUSIONS AND ESSENTIAL ACTIONS from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust (DOH: 2022)

Whilst no longer an essential requirement, it is recommended that this report continues to include information on the monitoring of red flag events associated with midwifery staffing.

Evidence against MIS Safety Action 5

a) Assessment of required midwifery staff

A full BirthRate Plus (BR+) assessment was last completed in April 2019 which demonstrated the actual funded establishment of clinical midwives was in line with their recommendations at that time. In partnership working with the LMNS and the Trust's finance team, the midwifery managers have collaborated to ensure the national recommendations relating to midwifery staffing numbers and skill mixes have been applied. This includes maintaining a core service within the hospital service, a traditional community team to care for cross border women, the required specialist midwives and managers to safely support the service and continued commitment to the roll out of the midwifery continuity of carer model (MCoC), when safe staffing levels can be achieved.

Following submission of a variety of business cases, the Trust Board has supported the additional funding required to enable full roll out of MCoC and this was made available in budget from month 11, 2021/21 and into the new financial year. The overall increase in midwifery establishment also includes the 6.00 wte made available with Ockenden monies from earlier in 2021/22.

The agreed funded midwifery establishment for 2022/23 is as follows:

Band	Funded WTE 2022/23
Band 5	9.12
Band 6	89.07
Band 7	30.73
Band 8	4.00
TOTAL	**132.92**

As there have been multiple challenges with employing midwives the decision was made to use band 6 monies to employ staff at band 2 to support the clinical function in the community service. Staff have been employed on a year's fixed term contract and this has made a positive improvement at clinical level. It is envisaged by the end of the one-year fixed term contract; the Band 2 post will no longer be required due to forecasted reduction of midwifery vacancies on the back of international recruitment.

The service has commenced recruitment of registered nurses to enhance the team in supporting the management of women with complex medical conditions and to undertake immediate post-operative recovery for non-general anaesthetic cases. The team are aiming to recruit more substantive nurses to ensure 24 hours a day/ 7days a week cover.

In 2021/22 the midwifery team at West Suffolk introduced 3 MCoC teams into the service. Subsequently, the full Ockenden report was published in March 2022 with one of the essential actions being for services to *'review and suspend, if necessary, the existing provision and*

further roll out of midwifery continuity of carer unless they can demonstrate staffing meets safe minimum requirements'.

b) Agreement of midwifery staffing establishment and budgets

The agreement of midwifery staffing establishment and associated budgets were endorsed by the Trust Board along with the proposal to suspend the introduction of further MCoC teams in May 2022.

In September 2022, NHS England reaffirmed the essential and immediate actions outlined in the Ockenden report in relation to MCoC and removed all target dates associated with achieving compliance with the MCoC model. In response to the Ockenden essential actions the service at West Suffolk has reduced to one community team, the caesarean section team.

Recruitment and retention of midwifery staff and strategies employed to mitigate shortages

The number of midwife vacancies at the end of March 23 was 29.9 wte which equates to a 22% vacancy rate. The service is currently employing approximately 10.00 wte midwives each month through the bank and staff working additional hours.

Recruitment of qualified midwives continues to pose significant challenge to maternity services nationally including the West Suffolk Hospital.

There continues to be a concentrated effort for recruitment of midwives including:

- Regular advertising on NHS jobs including recruitment into specialist midwife and governance roles.
- Rolling advert for midwives on NHS jobs which is constantly monitored with suitable applicants fast tracked and interviewed within 2 weeks of application.
- Collaborative work with LMNS culminating in successful recruitment of midwives from overseas. At the time of this report 8 international midwives have commenced work with a further 5 midwives awaiting start dates and further 5 to recruit. These staff are unable to be entered on the Nursing and Midwifery Council register as midwives until they have completed the Objective Structured Clinical Examination (OSCE). Training and supervision to prepare successfully for the OSCEs is considerable. Additional Clinical Practice facilitator hours have been funded externally to support this. The impact on the clinical care and women's experience with the numbers of student and junior midwives needing supervision will be monitored.
- An increase in midwifery students to enable a larger pool of newly qualified midwives to recruit from in future years.
- Focussed work with HR partners to look at improved ways of retaining staff. This includes work exploring themes around why staff are leaving the Trust following exit interviews.
- 'Growing our own' future midwifery workforce, through:
    - Collaborative working with local HEI's leading to an increase in student midwife places each cohort
    - Accessing the 18-month course to encourage nurses to train as midwives.
    - Offering Return to Practice course for midwives whose registration has lapsed.
    - A programme to develop Midwifery Apprenticeships is being developed across the East of England region. West Suffolk midwifery service are actively participating in this, with a view to having students on the first cohort.

Work on retention of midwives is being undertaken at local, regional and national levels. Initial work indicates that the service has not had a significant increase in the number of 'leavers' in the last 4 years with an average of 8-10 staff leaving each year. The recruitment of staff to replace these has been positive with a similar number of staff joining the Trust each year. However, often experienced band 6 midwives are being replaced by newly qualified band 5 midwives who need to complete their preceptorship programme.
To address this a recruitment and retention role has been introduced to undertake 'stay conversations', pre-exit interviews, staff forums and to represent the Trust at regional forums regarding recruitment and retention.

The service also notes an increase of substantive staff requesting a reduction in hours to enable a better work/life balance. Work is underway to review the current on call arrangements and introduce more flexible working. The current exit interview process will be made more robust and thematic analysis improved.

All Trusts in the country are facing similar challenges to recruitment with an uplift in staff establishment to meet the national agenda which adds to the challenge in attracting staff and encouraging them to move to West Suffolk when they are being offered similar opportunities elsewhere.

Midwifery Staffing Levels

Maintaining safe staffing levels, continues to provide significant challenges to the service. To mitigate against this the service has a robust escalation policy and at times of heightened activity the following actions are deployed:

- The service employs midwives from the established in-house bank plus some staff have also been willing to undertake hours in addition to contract.
- The midwifery service has the support and flexibility to offer an uplift in pay at times when safe staffing levels cannot be achieved. When initiated this does assist the service in filling shifts that are proving difficult to cover.
- Midwives working in specialist roles also work clinically to support safe staffing levels and ensure women receive safe care.
- The community midwifery service in times of escalation has been utilised on the acute site on several occasions. Whilst this can impact on the availability of a midwife for a home birth and routine community duties, maintaining safe care and staffing levels in the hospital service remains a priority.

Monitoring staffing levels

- There is regular liaison with the matrons, deputy HOM and HOM to discuss strategies and actions needed to balance acuity against staffing levels across the day and planning for the next 48 hours.
- The BR+ app is completed 4-hrly with information informing decision making by the senior team.
- Staffing levels are discussed and recorded at the daily safety huddle and actions shared with the MDT.
- There is a midwifery manager on call for each 24-hr period and a unit bleep holder (band 7 Midwife) on site for both day and night shifts 7 days a week.

- Weekly staffing meetings with ward managers and matrons take place to plan ahead and discuss gaps in the rosters and options for maximising staff deployment.

The Head of Midwifery provides information on midwifery staffing that is included in Trust Board papers on a bi-monthly basis. Key elements of this report include the number of shifts not filled, 1-1 care in labour and the MW to birth ratio.

NUMBER OF RM SHIFTS NOT FILLED: 2022/23		
Month	**WTE**	**Shifts per month**
October	3.7	51
November	3.8	53
December	5.14	70
January	2.28	30
February	4.4	60
March	4.7	64

Overall, these figures show a decrease of 8.61 wte unfilled shifts between October -March 22/23 in comparison to the previous 6 months to September 2022. This is likely due to be the vacancy rate improving.

The service currently publishes the number of staff on duty against the minimum staffing levels expected in each clinical area. E-Roster gives more detailed information on the numbers of staff on duty, absences, unfilled shifts and bank shifts utilised. Due to the uncertainty about future midwifery staffing models, it has not been possible to develop the system to deliver bespoke staffing reports. This will continue as an action when future midwifery staffing models have been implemented.

Midwife to birth ratio

The monthly midwife to birth ratio is calculated using information from both e-roster for staffing and E-Care for activity. The Head of Midwifery takes responsibility for this, with the calculations being based on the actual number of midwives in post and working rather than the funded establishment. This is the most accurate way of calculating the true midwife to birth ratio as it enables adjustments to be made for vacant posts, staff on long term sickness and maternity leave. Likewise, midwives employed for additional hours or on a bank contract are included to formulate a true measure of the number of available midwives. This figure is measured against the actual number of births each month and reported on the service dashboard. The figure will fluctuate month on month, due to activity and availability of midwives.

The BirthRate Plus funded establishment gives an overall achievable ratio of 1 Midwife (MW) to 27.7 births which is in line with current national BirthRate Plus recommendations. There were three months when this was not met, which reflects the vacancy factor and number of births that month.

MW TO BIRTH RATIO Standard = 1:27.7	
Date	**Ratio**
October	1:29
November	1:27
December	1:29
January	1:28
February	1:25
March	1:27

This data is recorded on the quality dashboard and is monitored monthly at the Maternity Quality and Safety Group.

Specialist Midwives (SpMW) in post
The service employs a variety of specialist midwives at Band 6 and 7 to support the service. All specialist midwives have a clinical component to their role contributing to the care of women. How this is attributed, depends on the role function, and contracted hours the SpMW works and is discussed and agreed between the SpMW and their line manager. This is managed fairly and equitably, to ensure the specialist function of the midwife's role is not eroded. Specialist MWs also contribute to the service escalation plan at times of heightened activity and acuity.

The service also has two band 7 MW and 1 band 6 posts that are externally funded to support the clinical practice facilitator function and Recruitment and Retention lead.

The total establishment of specialist MW and clinical managers needed to lead the service, constitutes approximately 9% of the total midwifery workforce, which is in line with current BirthRate Plus methodology.

c) Status of the labour suite co-ordinator (LSC) in relation to being supernumerary

Safer Childbirth (RCOG 2007) states that 'each labour ward must have a rota of experienced senior midwives as labour ward shift co-ordinators, supernumerary to the staffing numbers required for one-to-one care to ensure 24-hour managerial cover'. The lack of a supernumerary LSC has been identified as a contributory factor in many cases of maternal and perinatal morbidity and mortality reported at national forums. The LSC role is nationally recognised as being at Band 7.

Changes to the technical guidance for Safety Action 5 in the CNST standards were published in October 2022 adding clarity to the assessment of supernumerary status. The technical guidance in the re-launched Safety Action 5 gives clarity to the supernumerary status of the LSC by stating:

- *The Trust can report compliance with the supernumerary status of the LSC if it is a one-off event and the co-ordinator is not required to provide 1-1 care for a woman in established labour during this time.*

- *If this is a recurrent event (i.e. occurs on a regular basis and more than once a week), the Trust should declare non-compliance with the standard and include actions to address this specific requirement going forward in their action plan.*
- *The role of the co-ordinator includes providing oversight of the labour ward and support and assistance to other midwives. For example: providing CTG 'fresh eyes', giving second opinion and reviews, providing assistance to MW at birth when required, supporting junior midwives undertaking suturing etc. This should not be counted as losing supernumerary status.*
- *Supernumerary status will be lost if the LSC is required to be solely responsible for any 1:1 care for a labouring women or relieve for breaks (or any short period of time) a midwife who is providing 1:1 care for a high-risk woman requiring constant observation. This includes supervising a student midwife providing 1:1 care.*
- *If 100% supernumerary status of the LSC cannot be achieved an action plan detailing how the service intends to achieve 100% supernumerary status for the LSC which has been signed off by the Trust Board and includes a timeline for when this will be achieved. Completion of an action plan will not enable the Trust to declare compliance with this sub-requirement in year 4 of MIS.*

Following review, the service is confident that the methodology deployed meet the standard and no changes are needed in the way supernumerary status is assessed. Robust monitoring of the supernumerary status of the LSC takes place on a daily and monthly basis:

- Every 4 hours the BirthRate Plus app is updated and this includes information on the supernumerary status.
- At the daily Safety Huddle the status of the LSC in last 24-hour period is checked and documented.
- When the LSC is not supernumerary, this is reported as a 'Red flag' event
- Monthly compliance is collated, calculated, and published on the Quality and Safety dashboard.
- Monthly analysis of the reasons why compliance has not been achieved is undertaken and any identified themes highlighted.

Two band 7 MW's are deployed on both day and night shifts to ensure the presence of senior midwifery staff on a 24/7 basis. One of these will be the unit bleep holder who can support the labour suite at times of heightened activity and acuity.

Date	% Compliance:
October	99%
November	99%
December	99%*
January	99%*
February	99%
March	100%

There were two unavoidable instances* where a woman arrived in advanced labour and gave birth rapidly and the LSC needed to prevent harm to the mother and baby by managing the birth themselves. In February the LSC was not deemed supernumerary however this was not to provide 1:1 care.

Whilst the service aspires to achieve 100%, the safety of mothers and babies has to be the priority and these figures show great improvement and will continue to be monitored on a daily and weekly basis and actions taken when required.
To note, the above * does not effect Year 4's CNST submission due to both these incidents occurring after the cut-off date of the 5th December 2022.

d)Provision of 1-1 care in labour

Monitoring of compliance to this standard is provided monthly using the maternity information system e-Care. Midwives enter the information as part of their delivery records and this information is collated monthly and reported on the service quality dashboard.

The provision of 1-1 care is prioritised by the senior management team with staff movement and escalation processes being deployed to ensure women are provided with safe care. The service has been able to maintain 100% compliance to this standard in this six-month period

1-1 Care in Labour	
Date	% Compliance
October	100%
November	100%
December	100%
January	100%
February	100%
March	100%

Monitoring of Red Flags in relation to midwifery staffing

Red flags in maternity services are defined as 'warning signs that something may be wrong with midwifery staffing'. The Red Flag incidents/events currently monitored in relation to midwifery staffing are as follows:

RED FLAGS RELATING TO MIDWIFERY STAFFING:
Redeployment of staff to other services/sites/wards based on acuity
Delayed or cancelled time critical activity
Missed or delayed care (for example, delay of 60 minutes or more in washing or suturing)
Missed medication during admission to hospital or MLBU
Delay of more than 30 minutes in providing pain relief
Delay of 30 minutes or more between presentation and triage
Full clinical examination not carried out when presenting in labour
Delay of two hours or more between admission for induction and beginning process and/or delay of more than 2 hours during the process.
Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)
Any occasion when one midwife is not able to provide continuous 1-1 care in established labour
Unable to facilitate women's choice of birthplace
Labour suite co-ordinator not supernumerary

Red flags are discussed and recorded at the daily safety huddle which is attended by medical, midwifery and nursing staff. These are reported on the Datix incident system. The number of red

flags each month is recorded on the quality dashboard and monitored at the Maternity Quality and Safety Group meeting. Actions taken to mitigate and escalate issues and themes are documented and when a red flag datix is submitted, care is reviewed by the senior team to assess impact and identify trends.

The number of Red Flags submitted each month is as follows:

RED FLAGS – 2022/23	
Month	**Number**
October	11
November	9
December	16
January	6
February	11
March	7
TOTAL	**60**

This is a reduction from the last biannual report (76 in total). To note 49 of all Red Flags submitted during this period were in relation to delays in commencing induction of labour and continuing the process once started. Continued work regarding workflow is required to reduce the delay for induction of labours in addition to further recruitment.

Conclusions

The maternity service continues to strive to achieve safe and effective care for women through the provision of a midwifery workforce that is competent, skilled and trained to meet the needs of the local population.

The service has been supported by the Trust with a significant increase in funding to achieve an establishment of midwives that will meet:

- maintaining safe staffing levels for both in-patient and outpatients' areas in the hospital/community
- provide enough specialist MW and managers currently needed to safely run the service
- the MCoC agenda
- deliver a community service for out of area women

In the last 6-months successfully recruiting into vacant posts has been difficult to realise with changes to national advice coupled with the challenges of recruiting new midwives to the service. There have been new overseas MW starting with the service with more planned in coming months, coupled with new students qualifying which will increase the clinical workforce in time once they have been supported in clinical practise. The additional supervision and support required for these staff groups adds to the workload of the staff and service will continue to be monitored.

Maintaining safe levels of staffing has been a particular challenge in the last 6 months in the main due to the number of vacant MW posts. Other strategies are in place to improve future staff availability with the increase in students, midwifery apprenticeships and return to practice courses but the benefits of these may not be realised for at least another 2-4 years. All adopted practices around improving staff recruitment will be continued until the vacant posts are filled.

The service has been proactive in maintaining a safe level of staff in the hospital service, particularly for women in labour. This has been achieved by having a robust escalation plan and good multi-disciplinary team working to ensure available staff are accessed and moved to areas where needed. This has disrupted normal working for some staff especially those in the community, management, and specialist roles. The positive outcome of the day-to-day operational scrutiny, decision making and action by all members of the midwifery team has enabled the service to achieve high compliance with supernumerary status of the LSC and all women in labour received 1-1 care.

The service has also made the decision to use unspent midwife monies to over establish band 2 and 3 clinical support staff on fixed term contracts, particularly in the community environment.

The covid sickness rates have significantly reduced and with the cessation of one of the MCoC teams temporarily, the service is able to concentrate on the utilisation of staff in the core service. The roll out of MCOC will resume once the vacant midwife posts are filled and further guidance is received from NHS England.

An action plan has been developed and attached as Appendix 1 to highlight where (and how) the service needs to improve compliance. Some actions from the previous report have been carried over for continued monitoring and completed actions have been highlighted. This action plan will be monitored quarterly at the Maternity Quality and Safety meeting and will be updated for the next Board Report due in December 2023.

The completed actions from the previous report in November 2022 and progress against these and new actions are included in the updated action plan below.

Recommendations:

- Close monitoring of the supernumerary status of the LSC will continue, with each instance of non-compliance investigated and themes identified.
- There will continue to monitoring of safe staffing levels, 1-1 care in labour, staff to birth ratios and red flags as part of the processes in place.
- Active recruitment to vacancies will continue, with an effective preceptorship process in place to retain and develop staff.
- Further MCoC teams will be on hold until safe staffing levels can be assured throughout the service.
- Recurring themes from ‘red flags’ relating to staffing will be reviewed and where appropriate and possible further mitigations in place.
- Escalation plans will be used to promote safe care
- The discussions on further roles within maternity services such as a Director or Midwifery and Consultant Midwife are continuing with the Trust Executive team.

Appendix 1 Action Plan

Action Plan Owner:	Karen Newbury	**Role Title:** Head of Midwifery	**Contact:** Karen.newbury@wsh.nhs.uk

RECOMMENDATION		**ACTIONS REQUIRED**	**TARGET DATE**	**PERSON RESPONSIBLE**	**COMPLIANCE MAY 2022**	**COMPLIANCE / PROGRESS May 2023**
1.	Recruitment and retention of workforce	NHS Recruitment and Retention NHS Self-assessment to be completed.	Completed	HOM Matrons HR	N/A	Self-assessment completed October. To be shared at Governance forums and Trust Board
		Review on-call requirements and introduce more flexible working.	End Dec 2023	HOM Matrons HR		Staff focus group now in place. Flexible working survey complete and results shared with staff. Pilot for self-rostering due to commence. On-call requirement still under review.
		Improve quality of exit interviews including thematic reviews annually	End March 2023	HOM Matrons HR		Complete
		Ongoing recruitment plans and commitment to exploring apprenticeships with NHS England	Review progress End Dec 2023	NHS England with local Trusts		Ongoing work – to be evaluated by the end of Dec 2023
		Staff surveys regarding staff satisfaction and areas for further development	Review progress End Dec 2023	PDM's CPF's Deputy HOM	N/A	Delayed due to the number of other staff surveys; flexible working, retention, progression
2.	Aim for supernumerary status of the LSC to be 100%	Communication to LSC team clarifying supernumerary status	On-going monitoring	Head of Midwifery	N/A	Complete regarding communication with LSC.

						At risk due to staffing vacancies. Once staffed to establishment this should be achieved.
		Review escalation policy	July 2023			Delayed due to new guidance - Ongoing work to encompass Neonatal Unit and regional guidance
		Review of staffing template/establishment	July 2023			Review of Birthrate plus recommendation and adjust staffing templates accordingly.
3.	Trust Board to evidence midwifery staffing budget reflects calculated staffing establishment.	Full BR + assessment using the agreed tool to be completed	March 31st 2023	Trust Secretary and Head of Governance	N/A	Completed 10/03/2023
		Annual budget setting to be approved	March 31st 2023	Finance and Maternity leads		Delayed - Work in progress
		Trust Board to provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations.	July 2023	Finance and Maternity leads Trust Board Secretary and Head of Governance		On track

4.	Enable accurate electronic recording of planned versus actual staffing on E-Roster	Review rules and templates on E-Roster to enable the system to generate accurate reports on planned versus actual staffing levels.	Dependent on filling vacant posts and guidance from NHS England	Matron IP services. Ward Managers	Successful completion of this will be dependent on roll out of continuity of carer model of care, which is currently suspended following publication of the Ockenden Report and is out of the services control.	Currently on-hold due to national guidance on MCoC therefore no current actions required
5.	Review staffing levels once MCoC is implemented to ensure safe standards of care are maintained	Review all methodology of monitoring safe staffing levels and acuity when MCoC teams are implemented and established.	Currently no published dates for recommencement of MCOC	HOM Matrons LMNS CCG	Successful completion of this will be dependent on roll out of continuity of carer model of care, which is currently suspended following publication of the Ockenden Report and is out of the services control.	Currently 'on-hold due to national guidance on MCoC
6.	Review the implementation of Must Do's arising from the Ockenden Report	Full Ockenden recommendations are currently under assessment by the MDT and executive. Particular actions in relation to midwifery staffing will be monitored and reported on in this bi-annual report.	On going	HOM Matrons LMNS CCG		Review completed – included in other aspects of staffing reports and developments

Report Title	**Audit of the Operational Pathway of Care into Neonatal Transitional Care 1st January to 31st March 2023 (Q4)**
Report for	Information and Approval
Report from	Women's & Children's Services
Report Authors	Abigail Marquette, Clinical Quality and Assurance Lead Beverley Gordon, Project Midwife Karen Green, Quality and Governance Matron
Date of Report	**May 2023**
Presented to:	Maternity and Gynaecology Quality and Safety Maternity and Neonatal Safety Champions Trust Board

Executive summary:
An operational Policy for Neonatal Transitional Care CG10602 has been in place since 2021. This has been further updated in March 2023 to reflect the changes introduced as part of the Kaiser® Neonatal Sepsis Calculator which was introduced in December 2022. The full impact of this on the use of antibiotics for neonates, admissions to the Neonatal Unit (NNU) and Neonatal Transitional Care (NTC) will not be able to be realised until this is fully embedded and trends can be analysed over a period of time.

Babies are admitted to NTC from birth, in the postnatal period in hospital, readmission from the community setting or as a step down from NNU care.

There was an increase in the number and proportion of babies admitted to NTC in this quarter.

Most babies (33%) admitted to NTC were a stepdown from NNU. These would be the babies that had been admitted to NNU for more than 4 hours whose condition would have been improved enough to be transferred to NTC with mum. Some of these babies would also be continuing their course of antibiotics hence the need to stay in the hospital setting but no continuous monitoring is required. This is a good demonstration that NTC is being utilised appropriately and often to work towards reducing the time of maternal and neonatal separation which is the main purpose of having a NTC service. The importance of reducing separation is that keeping the baby and mum together has an affect on the positive development of the attachment process. Separation can have an affect on establishing breastfeeding and can also affect the woman's mental health.

The numbers of babies being admitted from birth and from the community are very similar (27% and 26% respectively). The reasons for admission are consistent throughout the months. Babies are being admitted from birth due to prematurity, signs of respiratory distress syndrome, maternal and/ or neonatal sepsis and early jaundice and Kaiser observations. Babies are being referred in to NTC from the community with jaundice, weight loss, vomiting and feeding support.

The smallest group is the babies admitted from the postnatal ward (12%) who needed NTC care due to grunting and Kaiser observations.

The first results from the audit of the introduction of the Kaiser® Neonatal Sepsis Calculator demonstrate that there were no positive blood cultures in the neonates identified as not requiring antibiotics. This is reassuring and confirms that babies were correctly risk assessed using the calculator and no babies were missed who developed a culture confirmed neonatal infection. However 11 babies were treated for more than 2 days of antibiotics due to a rise in CRP at 36 hours of age. Of these babies, 9 had recommended empiric antibiotics and 2 had recommended blood cultures only, but empiric antibiotics were started as per EoE guidance. No babies were readmitted with suspected sepsis in the first 7 days of life.

Recommendations:

1. Audit findings to be shared
2. Further work is being planned to include moderate to late well preterm neonates into Transitional Care in the Trust in accordance with updated BAPM guidance.
3. Work on introducing NEWTT 2 assessment and wellbeing observations into practice is being planned when the electronic versions of observation charts are available on the information system in the Trust.

1. Introduction

Neonatal Transitional Care (NTC) is not a place but a service and can be delivered either in a separate Neonatal Transitional Care area, or within the Neonatal Unit and /or in the postnatal ward setting. The West Suffolk Hospital NHS Foundation Trust (WSH) maternity unit has an allocated bay on the postnatal ward (F11) and also NTC cots on the Neonatal Unit.

The principals of NTC include the need for a multidisciplinary approach between maternity and neonatal teams, an appropriately skilled and trained workforce, robust systems for data collection with regards to activity and appropriate admissions and a link to community services. Keeping mothers and babies together should be at the cornerstone of newborn care. NTC supports resident mothers to be the primary care providers for their babies when they have care requirements more than normal well newborn care, but do not need continuous monitoring in a special care setting.

NTC avoids separation of the mother and baby and facilitates the establishment of breast feeding whilst enabling safe and effective management of a baby with additional care needs. NTC also has the potential to prevent admission to the neonatal unit and to provide additional support for small and/or late preterm babies and their families.

NTC helps in the smooth transition to discharge home from the neonatal unit for recovering sick or preterm babies whilst providing specialised support away from the more intensive clinical setting.

At the West Suffolk babies meeting the criteria for NTC are admitted to a defined 5-bedded area within F11, the postnatal ward and cared for by midwifery and neonatal teams. Babies admitted from home requiring NTC are admitted to a side room on the Neonatal Unit.

There are 4 points at which a baby may be admitted to NTC: from birth, from the postnatal ward, from home or as a stepdown from Neonatal Unit Care.

2. CNST Maternity Incentive Scheme

NHS Resolution has completed its fourth year of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme with evidence being submitted in February 2023 to continue to support the delivery of safer maternity care and provide evidence of this.

Neonatal Transitional Care is included in Safety action 3: **Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units.**

This safety action is based on the British Association for Perinatal Medicine (BAPM) Framework for Neonatal Transitional Care (2017) and the Avoiding Term Admissions into Neonatal Units (ATAIN) programme of health improvement from the NHS.

3. Compliance with the Maternity incentive scheme

An operational Policy for Neonatal Transitional Care CG10602 is in place. This was reviewed and updated in October 2021. The guideline has been further updated in March 2023 to include the link to the Kaiser assessment programme and will be submitted to the ODN for approval once the changes have been confirmed.

Quarterly audit and analysis reports are completed to identify whether the agreed standards have been met and therefore embedded. The reports are shared with the Maternity and Neonatal Safety Champions at Divisional and Board level, Local Maternity and Neonatal System (LMNS), and the Integrated Care System (ICS) quality surveillance meeting each quarter.

A data recording process captures transitional care activity each month by the Neonatal unit and the Maternity Quality and Safety team. This is a manual process alongside the electronic neonatal information system Badgernet® and the patient information system E-Care®.

Additional information has been gathered on babies born in the late pre-term gestational period who may be suitable for NTC if future developments of the service are instigated.

Information from the reviews and learning are shared with the Local Maternity and Neonatal System (LMNS) and Integrated Care Board (ICB) as required. Data is submitted to the Operational Delivery Network (ODN) on request or as part of data capture from Badgernet®.

Part of the review of term admissions to the neonatal unit includes ascertaining if a baby could have been admitted or transferred to NTC during their care pathway.

4. Report on Babies admitted to NTC in Q4 January 1st to March 31st 2023

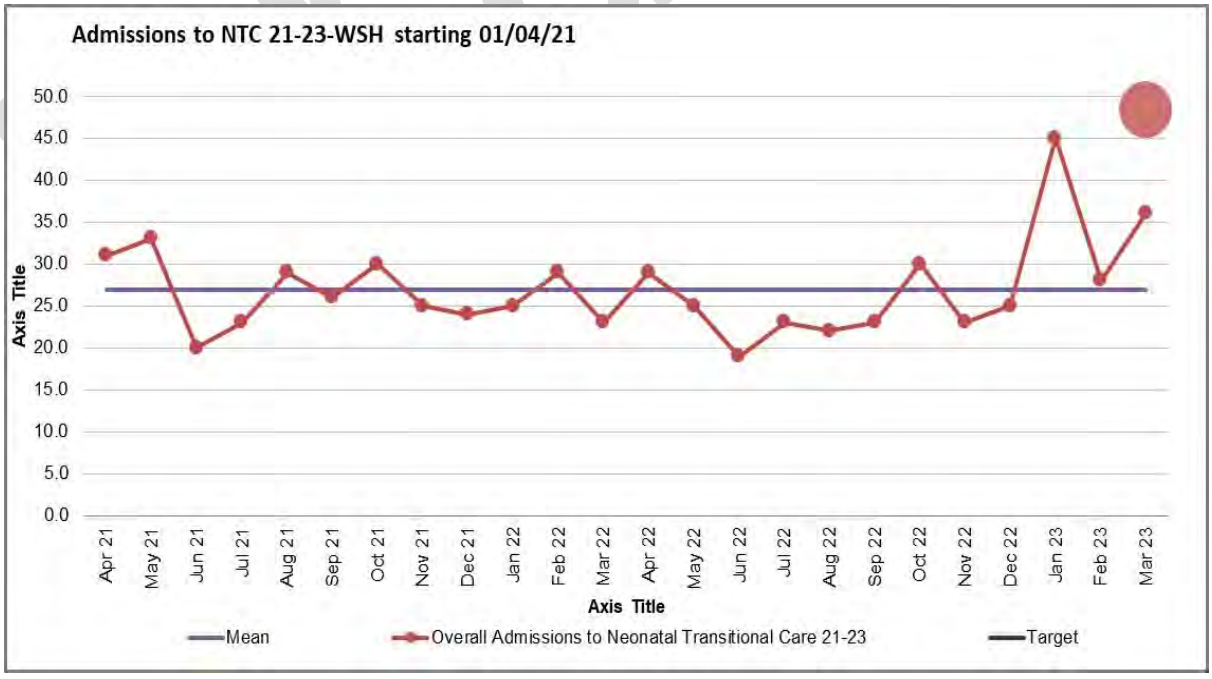
The data was extracted from different sources which included Badgernet, e-Care Maternity system and the Neonatal Admission book.

The Kaiser® neonatal sepsis calculator was introduced in December 2022 and this report includes the results from the audit of the implementation of this.

4a. Summary of Results for Quarter 4

One hundred and eight (108) babies were cared for under the Neonatal Transitional Care pathway in this quarter – 1st January 2023 till 31stMarch 2023. This is an increase from 78 in the previous quarter and an increase in the percentage of babies admitted to NTC from 13.5% to 19.7% which shows that the multidisciplinary team are working towards reducing the separation between mother and baby and also involving the parents in the care of their baby.

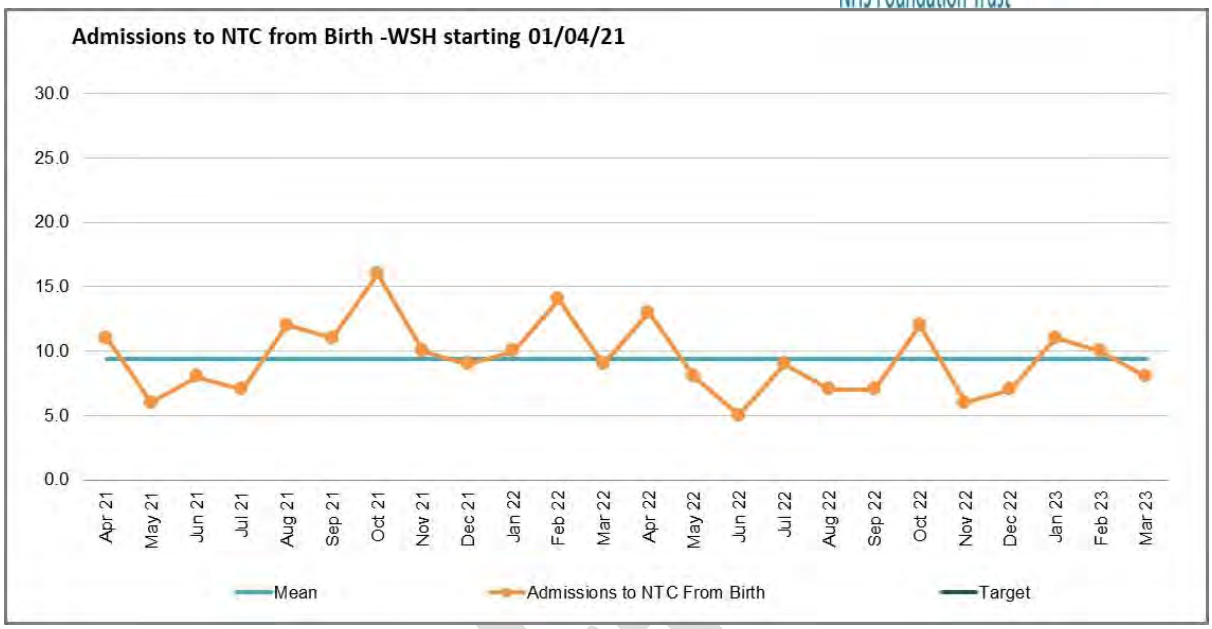
Timing of Admission to NTC	Number
From Birth	29
From Postnatal Ward/area	13
From Community/Home	28
Step down from Neonatal Unit	39
Total	**108**



4b. Summary of details of babies admitted to transitional care from birth

Clinical Standards		Criteria met
Criteria for immediate admission		
Gestational age >34+6 weeks	29/29(100%) of the babies were above this gestational age.	Yes
Not requiring intensive or high dependency care	Babies did not require intensive care	Yes
Birthweight >1600g	29/29 (100%) babies had birthweights above 1600g	Yes
Maternal suspected /confirmed sepsis in labour	4 mothers had suspected sepsis	Yes
Maternal and Fetal symptoms of suspected sepsis.	3 babies had a combined risk of maternal and baby sepsis	Yes
Neonatal risks of Sepsis	3 babies had suspected sepsis	Yes
Preterm within the cohort	15 babies were preterm	Yes
Other reasons	2 babies had Respiratory distress syndrome that did not require respiratory support. One of these babies was diagnosed with Cleft lip and palate antenatally 4 babies was admitted for Kaiser observations 1 baby had an imperforate anus 1 baby was admitted for monitoring due to the presence of materal Syphillis antibodies	Yes No Yes No Yes

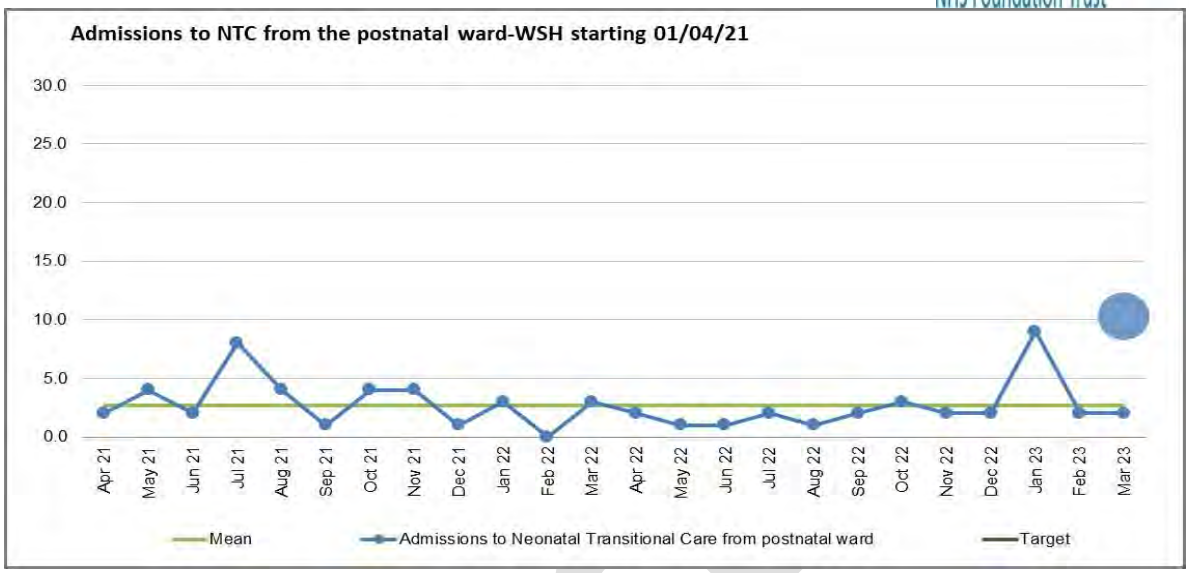
- **27 /29 babies (90%) of the babies admitted to NTC met the criteria according to the local guidance. The 3 babies that did not meet the prescribed criteria did not need admission to the neonatal unit and therefore NTC could be considered to be appropriate in these cases.**



4c. Summary of details of babies admitted to transitional care from the postnatal ward

Clinical Standards		Criteria met
Criteria for admission – developing: Risk factors		
Risk factors for sepsis requiring IV antibiotics	6/13 babies developed or had persistent respiratory symptoms where sepsis was suspected.	Yes
Maternal risk factors for babies requiring TC	1/13 babies required IV antibiotics due to their mother developing signs of sepsis and being GBS positive.	Yes
Other Reasons	1/13 bay was started on Kaiser observations in the postnatal period rather than from birth. 1/13 baby was admitted for social reasons	Yes Yes

All 13 of these babies met the criteria for admission to NTC. The 1 baby that was admitted for social reason, required NAS observations and had an increase in the respiratory rate. This baby benefitted from this closer observation and did not have to be admitted to the Neonatal Unit.



4d. Summary of details of babies admitted to transitional care from the community setting and received transitional care

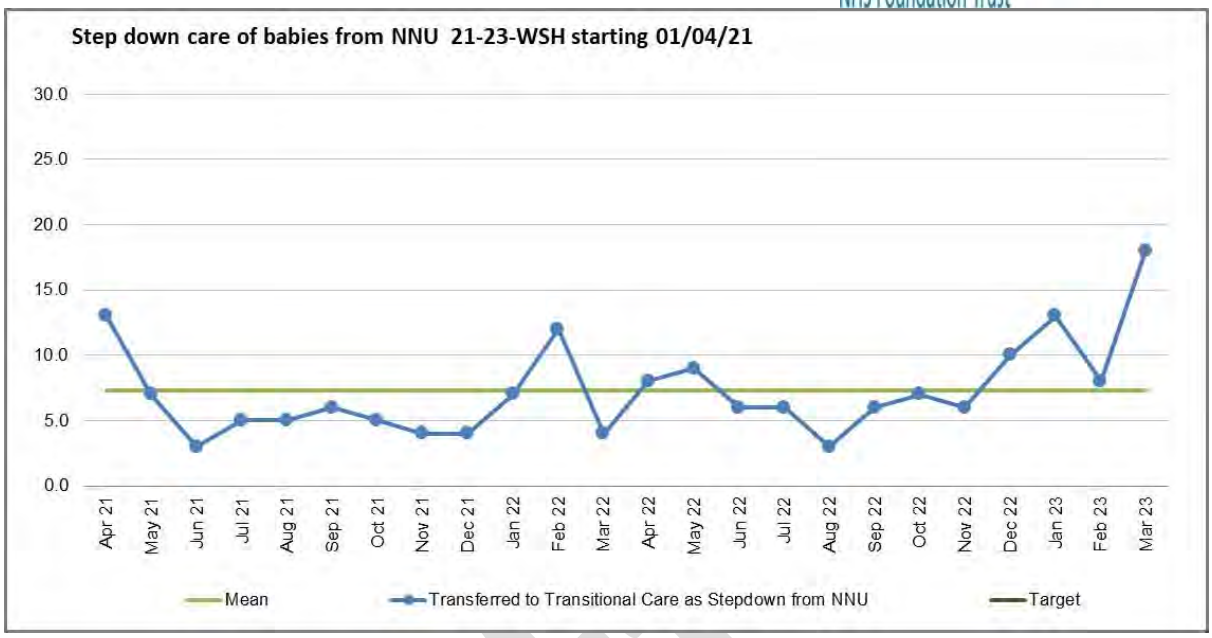
Clinical Standards		Criteria met
Criteria for readmission from community met:		
Requiring phototherapy and serum bilirubin monitoring	21/28 babies were re-admitted with neonatal jaundice. Some of these babies had associated weight loss.	Yes
Weight loss /poor feeding	4/28 babies were readmitted due to problems with feeding and associated weight loss.	Yes

All these babies met the criteria for NTC. One baby was admitted for vomiting and another baby was admitted with prolonged jaundice.

4e. Summary of details of babies admitted to transitional care following stepdown of care from the NNU

Clinical Standards		Criteria met
Criteria for step down from NNU:		
Corrected gestational age > 33+0 and clinically stable.	12/39 babies were preterm and within the agreed criteria for gestational age when they were stepped down from the NNU.	Yes
Observations required no more than 3 hourly	39/39 babies were all on an observation frequency of at least 3 hourly intervals	Yes
Stable baby with sepsis requiring antibiotics	32/39 babies were continuing IV antibiotic treatment.	Yes
Other Reasons	2/39 babies were admitted for feeding support 1/39 had observations carried out post resuscitation 1/39 admitted due to suspected spina bifida and was then transferred to Addenbrookes' for surgical review	Yes Yes Yes

All 39/39 babies met the criteria for step down of their care to NTC from NNU although some conditions are not listed specifically. Continuing a course of antibiotics and being monitored for a longer period of time in NTC allowed mother and baby to be together so NTC could be considered to be appropriate.



4f. Operational Standards

Audit of Operational Standards for staffing		
Operational Standards – Midwifery staffing of NTC		**Criteria met**
Midwife from F11 is allocated to care for women whose baby is in NTC 24/7	A midwife is allocated to oversee postnatal care of women in the NTC bay and works alongside the NNU to undertake joint care	Yes
Operational Standards – NNU staffing of NTC		
A NNU nurse or nursery nurse is allocated to care for the babies in NTC 24/7	A NNU nurse is allocated to provide the care to babies having NTC on F11 and on the NNU's siderooms working alongside the midwife and the shift leader for NNU.	Yes
Operational Standards – Neonatal medical staffing		
A daily review of all babies having NTC is conducted by the consultant paediatrician or the paediatric registrar allocated to NNU	A paediatric ward round led by a consultant paediatrician or a paediatric registrar is undertaken daily for all babies having NTC care on the postnatal ward or NNU. This is recorded on the baby's records on e-care.	Yes

4g. Kaiser® Permanente Sepsis Risk Calculator

Audits have been completed to assess progress on embedding the Kaiser assessment tool from December 5th 2022 to 5th March 2023. The rest of the data until the end of March were collected and assessed outside of the audit.

Early onset sepsis in neonates is associated with high morbidity and mortality. Therefore nearly 15-20% of infants on postnatal wards are screened by risk based algorithms (e.g. NICE guidelines) and treated with prophylactic antibiotics until

infection results are negative. EOE guidelines estimate that the number of infants needing treatment to identify a case of culture proven sepsis in early asymptomatic phase is 1 in 600-800 near term live births. Additionally, prophylactic antibiotics in infants who later are proved to not have sepsis leads to unnecessary antibiotic use, delays discharge and can cause significant stress for parents.

The Kaiser Permanente Sepsis Risk calculator assesses the risk of early onset sepsis using maternal risk factors and the infant's clinical state after birth and has been shown to reduce antibiotic initiation in newborn infants by 50% without missing cases of true sepsis. All babies symptomatic of sepsis must be investigated, and treated promptly with antibiotics within an hour of decision to treat, irrespective of their sepsis risk score. Kaiser Permanente sepsis calculator should be applied up to 1 hour of age. Infants who present after this period or where further information regarding risk of sepsis is identified should receive a **FULL** clinical examination , review and plan of care.

EoE guidelines on use of the Kaiser audit are similar but are still following a more cautious approach of treating with antibiotics when only a blood culture is recommended. Use of the Kaiser calculator has been implemented in maternity/neonatal services at WSH since December 2022, with an e-care risk assessment completed by midwives which triggers their referral to neonatal team for Kaiser risk calculation and clinical assessment to determine management.

A data collection form was created, containing patient hospital number, risk factors, clinical examination and Kaiser calculated score and recommendations. The aim was for the form to be completed for every baby admitted under the neonatal team who met criteria for the Kaiser calculator i.e. 2 amber or 1 red risk factor as per NICE guidelines between the 5th December 2022 and 5th March 2023. These babies were then followed up to record their results for their highest C- Reactive Protein (CRP), blood MCS and any re-admission at 1 week of age with sepsis. The data for the remainder of March was collected manually through the NNU admission book combined with a search on Badgernet. Information collected might not be accurate due to lack of awareness and compliance with admitted the babies that need Kaiser observations under the care of TC.

Babies were excluded if they did not meet the criteria for inclusion under Kaiser i.e. 2 amber or 1 red risk factor in first hour of life and/ or less than 34 weeks' gestation.

Clinical Standards		**Criteria met**
Criteria for Kaiser Permanente Neonatal Calculator:		
The Kaiser Permanente neonatal sepsis calculator can be used for babies born after 34+0 weeks of pregnancy who are being cared for in a neonatal unit, transitional care or postnatal ward	53-total number of babies assessed using the calculator 0/9- number of babies correctly identified by the calculator who develop a culture-confirmed neonatal infection 0/17- number of babies incorrectly identified by the calculator who do	Yes

	not develop a culture-confirmed neonatal infection 0/2- number of babies missed by the calculator who develop a culture-confirmed neonatal infection	
Whilst reviewing data, to also assess for and highlight any difficulties/barriers that have arisen during implementation of the calculator, to identify areas for improvement.	Delayed use of calculator due to confusion regarding number of risk factors using e-care calculator (e.g. maternal pyrexia and maternal chorioamnionitis counting as separate amber risk factors) In one case baby was incorrectly discharged home when should have been have a Kaiser calculation (kaiser recommendation blood culture only)- was readmitted with low BM and hypothermia. Had 48h of antibiotics and negative CRP/blood cultures so antibiotics stopped. Another baby should have been admitted for Kaiser observation (or for antibotics if equivocal clinically). Was highlighted to neonatal team when developed early onset jaundice at which point risk factors noted and commenced on antibiotics at 30h of life. EOE guidelines say that if no red flags/one amber then not for calculator/empiric antibiotics EXCEPT if there is history of a previous GBS sepsis/death related to sepsis of an infant and mother has not received adequate intrapartum prophylaxis – baby appropriately treated but this could have been missed if relying on Kaiser guideline alone. If a twin is having Kaiser calculation then the other twin is required to have that too.	

Kaiser recommendation	No. given recommendation	No. of culture confirmed infection	No. treated with abx for >2 days (suspected sepsis)
No culture, no antibiotic	13	0	0
Blood culture only	10	0	2
Strongly consider starting antibiotics	10	0	5
Empiric antibiotics	18	0	4

Conclusions

The number of babies receiving care under the NTC pathway has increased in this quarter. Whilst some babies did not meet the prescribed criteria for NTC, these babies were able to be cared for safely under the umbrella of NTC care and did not require admission to the NNU as a result of these other conditions.

WSH has a proactive approach to transferring babies to NTC as soon as possible once a clinical review has been undertaken.

The majority of babies admitted to NTC were in fact being stepped down from NNU which demonstrates that staff are utilising the NTC service in order to decrease the separation time between mum and baby.

The Kaiser calculation is still a very new approach and from assessing the data and the admission book, it looks like there is still confusion around admission of these babies under TC and also sometimes uncertainties of whether a baby should have the Kaiser calculation applied. The audit showed that there was a 21.7% reduction in the number of babies receiving antibiotics compared to NICE guidelines, which is the aim of using this calculation.

Improvements and future planning

The Maternity and Neonatal services commenced the Kaiser Neonatal Sepsis calculator in December 2022. This is a tool which establishes risk factors and neonatal condition to estimate each baby's risk factor of early onset neonatal sepsis (EONS). Studies in the US have suggested that implementing this tool resulted in a reduction in antibiotic administration (48%) without evidence of adverse events (RCPCH). Depending on the criteria for what type of care these babies will receive it will have a bearing on the numbers of babies receiving transitional care.

A comparative data review will be undertaken to triangulate all the information to establish if an increase in babies admitted to NTC or decrease in NTC is reflective of any reductions or increases in admissions to NNU or an overall decrease in babies needing additional care after birth. This is too early to determine. The audit covers the number of babies that had Kaiser calculations but that has only been in place since December.

Comparative data will be presented across the LMNS to ascertain trends in neonatal care.

Next steps

The findings of this audit to be shared with all staff via Risky Business monthly publication.

Audit findings are shared with:

- Maternity and Neonatal Safety Champions
- Maternity and Gynaecology Quality & Safety meeting
- Neonatal teams
- Local Maternity and Neonatal System and (LMNS) Quality Surveillance meeting
- Trust Board
- Operational Delivery Network

The Neonatal Transitional Care Policy is being updated to include a link to the Kaiser sepsis calculator.

Further work is being planned to include moderate to late well preterm neonates into Transitional Care in the Trust in accordance with updated BAPM guidance.

Work on introducing NEWTT 2 assessment and wellbeing observations into practice is being planned when the electronic versions of observation charts are available on the information system in the Trust.

References:

British Association of Perinatal Medicine (BAPM) 'A Framework for Neonatal Transitional Care 2017

BAPM 'Early Postnatal Care of the Moderate-Late Preterm Infant A Framework for Practice' January 2023

East of England Neonatal Care Kaiser Sepsis Guideline and Kaiser Neonatal Early-Onset Sepsis Calculator (December 2020)

WSH 'Operational Policy for Neonatal Transitional Care' (NCT) November 2021

Maternity Incentive Scheme (CNST) Year Four Ten Maternity Safety Actions. Safety Action 3. October 2022

https://neonatalsepsiscalculator.kaiserpermanente.org

Appendix 1 Opportunities for Learning and Sharing

Title	**Quarter 3 Audit of the Operational Pathway of care into Neonatal Transitional Care**

Action plan lead	Name: Karen Green	Title: Quality & Governance Matron	Contact: 3275

	Learning Opportunity	Actions required	Action by date	Person responsible	Comments/action status	Status of Action
1.	Share findings of the audit with all staff.	Risky Business publication		Rebecca Warburton		
		Maternity Quality & Safety meeting		Karen Green		
2	Audit findings shared with the Maternity and Neonatal Safety Champions,	Shared audit findings at the MNSC meeting		Karen Newbury HOM		
4	Local Maternity and Neonatal System and (LMNS),	Share findings and learning opportunities at the LMNS meeting.		Karen Newbury HOM		
4.	Quality Surveillance meeting and Trust Board.	Share findings at Trust Board		Karen Newbury HOM		

Appendix 2 CNST Maternity Incentive Scheme (2022) Safety Action 3

NHS Resolution has completed its fourth year of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme with evidence being submitted in February 2023 to continue to support the delivery of safer maternity care and provide evidence of this.

Neonatal Transitional Care is included in Safety action 3: **Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units.**

This safety action is based on the British Association for Perinatal Medicine (BAPM) Framework for Neonatal Transitional Care (2017) and the Avoiding Term Admissions into Neonatal Units (ATAIN) programme of health improvement from the NHS.

Safety Action 3 Standards (2022) and BAPM

A) Pathways of care into Neonatal Transitional Care have been jointly approved by maternity and neonatal teams with neonatal involvement with the focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.

B) The pathway of care into Neonatal Transitional Care has been fully implemented and is audited quarterly. Audit findings are shared with the neonatal safety champion. Local Maternity and Neonatal System (LMNS), commissioner and Integrated Care System (ICS) quality surveillance meeting each quarter.

C) A data recording process (electronic and/or paper based for capturing all term babies transferred to the neonatal unit, regardless of the length of stay, is in place.

D) A data recording process for capturing existing transitional care activity, (regardless of place - which could be a Transitional Care (TC), postnatal ward, virtual outreach pathway etc.) has been embedded. If not already in place, a secondary data recording process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting. The data should capture babies between 34+0-36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered.

E) Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2 are available to be shared on request, with the Operational Delivery Network (ODN) and commissioners to inform capacity planning as part of the family integrated care component of Neonatal Critical Care Transformation Review and to inform future development of transitional care to minimise separation of mothers and babies.

Standards F, G, & H have been excluded in this report as they relate to the ATAIN project relate.

5.1 Governance Report Annexes

Annex A- Corporate Governance Statement (FTs and NHS Trusts) - Financial Year 2022-2023

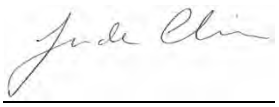
Corporate Governance Statement

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

1	Corporate Governance Statement	Response	Risks and mitigating actions
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS England from time to time	Confirmed	Self-assessment against new NHS Code of Governance in progress
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	

5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	**Confirmed**	Priorities for 2023-24 include review of strategic and change capacity in the organisation
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	**Confirmed**	

Signed on behalf of the board of directors, and having regard to the views of the governors

Signature		**Signature**	
Name	Jude Chin	**Name**	Dr Ewen Cameron
Capacity	Chair	**Capacity**	Chief Executive
Date	29 June 2023	**Date**	29 June 2023

Certification on governance and training of governors

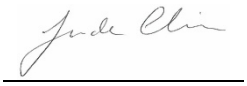
The Board are required to respond "Confirmed" or "Not confirmed" to the following statement. Explanatory information should be provided where required.

2 Training of Governors

The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.

Confirmed

Signed on behalf of the Board of directors, and having regard to the views of the governors

Signature		Signature	
Name	Jude Chin	**Name**	Dr Ewen Cameron
Capacity	Chair	**Capacity**	Chief Executive
Date	29 June 2023	**Date**	29 June 2023

B. Annex B General condition 6 and Continuity of Services condition 7 certificate- Systems for compliance with licence conditions and related obligations- Financial Year 2022-2023

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with license conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	**Confirmed**

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	**Confirmed**

OR

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.	

OR

3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.	

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows: **(Annex 1)**

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	**Jude Chin**	**Name**	**Dr Ewen Cameron**
Capacity	**Chair**	**Capacity**	**Chief Executive**
Date	29 June 2023	**Date**	29 June 2023

Annex 1 Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

After making enquiries, the directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern.

Financial risks considered by the Board included:

- Cost improvement plan delivery risk
- Appropriate inflation funding, in particular for the staff pay award
- Earning elective recovery fund (ERF)

Wider service delivery risks considered by the Board included:

- **Staff engagement and raising concerns**

  The development of a culture where all staff feel confident to speak up and raise concerns at work is crucially important to us. We continue to affirm its direct impact on a culture of safety with positive benefits for patient care, quality and staff experience and engagement.

  The publication of the West Suffolk Review in December 2021 highlighted significant failures of governance and decision-making related to 'speaking up' and during the course of 2022-23 we have been delivering a Board-sponsored organisational development plan to enable the improvement in culture that we have defined and want to see. It contains five themes of work:

  1) strategy & values
  2) Board development
  3) speak up culture
  4) HR practice
  5) staff engagement.

- **Building structure**

  The building structural challenges we face at West Suffolk Hospital are well known and we have long documented that, according to structural engineer experts, our building's 'shelf life' likely won't extend beyond 2030. The Trust has faced estate challenges regarding its roof for a number of years, and has put approved mitigations in place, like reducing weight on it. These mitigations are: recommended by structural engineers, well-managed, and reported to our regulators as part of our planned estates works.

  The need for a new hospital has been nationally acknowledged and WSFT, and the rest of the west Suffolk health system, were delighted that the Trust was named as one of 40 to benefit from the Government's New Hospital Programme. However, whilst this news is very much welcome, any new facility will not be open for several years and we have a duty to ensure that the existing hospital is appropriately maintained and we are able to continue to provide high quality health services for our community.

- **Delivering patient access**

  In 2023-24 the Trust is required to meet the standards set out in the NHS England priorities and operational planning guidance in order to:

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

  The RAAC remedial work in theatres is now largely complete and therefore not impacting on theatre capacity. There is an ongoing operational impact on non-elective capacity of remedial work in ward areas until 2025. In addition, subsequent waves of COVID-19 and flu will continue to impact on bed availability and patient flow. Our plans for delivery of the standards include:

  - elective access, including referral to treatment (RTT), diagnostics and cancer
  - urgent and emergency care
  - community and primary care
  - industrial action.

Committee	
Report title:	
Agenda item:	
Date of the meeting:	
Sponsor/executive lead:	
Report prepared by:	

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

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

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

Annex D: Scheduled draft agenda items for next meeting – 29 September 2023

Description	Open		Closed	Type	Source	Director
Declaration of interests	✓		✓	Verbal	Matrix	All
General Business						
Patient/staff story - staff experience of the emerging incident review process	✓		✓	Verbal	Matrix	Exec.
Chief Executive's report	✓			Written	Matrix	EC
Culture						
Organisational development plan, 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 - Wider system collaboration	✓			Written	Matrix	 PW / CM All execs
Digital Programme Board Report	✓			Written	Matrix	CB
Strategic priorities – plans for future monitoring	✓			Written	Action	CEO
Assurance						
Insight Committee Report - Finance report	✓			Written	Matrix	AJ / NC / SW
Involvement Committee Report - People and OD Highlight Report o Putting you First award o Staff recommender scores o appraisal performance, including consultants (quarterly) o Medical Revalidation annual report - National patient and staff survey and recommender responses	✓			Written	Matrix	TD / JMO
Improvement Committee Report - Maternity services quality and performance report (inc. Ockenden) - Nurse staffing report - Quality and learning report, including learning from deaths and quality priorities 2023-24 - Report from Lucy Winstanley, Head of Patient Safety	✓			Written	Matrix	LP / SW / PM
Audit committee CKI report	✓			Written	Matrix	MP
Remuneration committee CKI report	✓			Written	Matrix	JC
Serious Incident, inquests, complaints and claims report			✓	Written	Matrix	SW

Description	Open		Closed	Type	Source	Director
Governance						
Governance report, including - Use of Trust's seal - Senior Leadership Team report - Council of Governors meeting report - Well-led governance review - Policy on engagement – from standards committee - Code of Governance - Annual reports from specialist areas - Agenda items for next meeting	✓			Written	Matrix	RJ
Confidential staffing matters			✓	Written	Matrix – by exception	JMO
Board assurance framework report	✓			Written	Matrix	RJ
Reflections on the meetings (open and closed meetings)	✓		✓	Verbal	Matrix	JC
Annexes to Board pack: - Integrated quality & performance report (IQPR) – annex to Board pack - Others as required						