

# Board of Directors (In Public)

<b>Schedule</b>	Friday 26 May 2023, 9:15 AM — 1:30 PM BST
<b>Venue</b>	Room 16a/b, Education Centre, WSFT, Hardwick Lane, Bury St. Edmunds. IP33 2QZ
<b>Description</b>	A meeting of the Board of Directors will take place on Friday 26 May 2023 at 9:15am.
<b>Organiser</b>	Ruth Williamson

## Agenda

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### AGENDA

 [\\_WSFT Public Board Agenda - 26 May 2023 - Final.docx](#)

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### 1. GENERAL BUSINESS

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9:15 AM 1.1. Apologies for absence - Peter Wightman (Rebecca Jarvis deputising),  
Krishna Yergol  
To Note

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

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1.3. Minutes of the previous meeting - 31 March, 2023  
To Approve

 [Item 1.3 - WSFT Minutes Open Board 31 March 2023 DRAFT.docx](#)

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1.4. Action log and matters arising  
To Review

 [Item 1.4 - Board action points - Public - Active.pdf](#)

 [Item 1.4 - Board action points - Public - Complete.pdf](#)

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### 2. PEOPLE AND CULTURE


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9:20 AM 2.1. Questions from Governors and the Public relating to items on the agenda  
To Note


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9:40 AM 2.2. Patient / staff story - Virtual Ward  
To Review



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10:05 AM 2.3. Chief Executive's report  
To inform  
 Item 2.3 CEO Board report - 26 May 2023 FINAL.docx

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10:25 AM 2.4. Involvement Committee report  
For Approval  
 Item 2.4 - Chair's Key Issues Involvement 18 April 2023 TD PS.docx


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10:35 AM 2.4.1. People & Organisational Development Plan  
To Assure  
 Item 2.4.1 - People OD highlight May2023.docx  
 Item 2.4.1a - Appendix 2 - DRAFT People and Culture priorities 2023-24 FINAL.pptx.pdf


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### 3. STRATEGY

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10:50 AM 3.1. Strategic Objectives 2023  
To Assure  
 Item 3.1 - Strategic objectives paper v2.docx

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11:00 AM 3.2. Future System board report  
To Assure  
 Item 3.2 - WSFT FS public board May 2023.docx


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11:10 AM 3.3. Integrated Care Board Joint Forward Plan (JFP)  
Alex Royan, Deputy Director for Strategic Analytics, SNEE in

attendance

To Review

 Item 3.3 - JFP - Cover.docx

 Item 3.3a - 15427 SNEE ICB Joint Forward Plan 2023-2028  
PROOF\_13.pdf

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11:40 AM COMFORT BREAK

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11:50 AM 3.4. System update - West Suffolk Alliance and SNEE Integrated Care Board

Rebecca Jarvis presenting

To Assure

 Item 3.4 - System Update FC.pdf

 Item 3.4a - WSA D Plan V2 final 18 May 23.pdf

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12:00 PM 3.5. Digital Programme Board Report

To Assure

 Item 3.5 - Trust Board - Digital board report May 2023.docx

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#### 4. ASSURANCE

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12:10 PM 4.1. Insight Committee Report - Chair's Key Issues from the meeting

To Assure

 Item 4.1a - Insight Chair's Key Issues Insight 3 April 2023.docx

 Item 4.1b - Insight CKI report 17 May 2023 FINAL version  
20.05.23.docx

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4.2. Finance Report

To Assure


 Item 4.2 - Finance Cover - April\_2023\_Final.docx

 Item 4.2a - Finance Report- April\_2023\_Final.docx

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12:30 PM 4.3. Improvement Committee Report - Chair's Key Issues from the meeting

To Assure

 Item 4.3 - Committee Chair's Key Issues Improvement 17 April 2023.docx


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4.4. Quality and Nurse Staffing Report  
To Assure

 Item 4.4 - Safe Staffing MarchApril FINAL.docx

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4.4.1. Maternity Services  
Karen Newbury, Simon Taylor & Kate Croissant in attendance  
For Approval

 Item 4.4.1 - May 2023 Maternity Quality Safety and Performance Board Report.docx

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## 5. GOVERNANCE

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1:00 PM 5.1. Governance report  
To inform

 Item 5.1 Governance report.docx

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1:15 PM 5.2. Board Assurance Framework  
To inform

 Item 5.2 - BAF report May 23-Board.docx

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## 1:25 PM 6. OTHER ITEMS

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6.1. Any other business  
To Note

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6.2. Reflections on meeting  
For Discussion

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6.3. Date of next meeting - 21 July, 2023  
To Note

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## RESOLUTION

The Trust Board is invited to adopt the following resolution:

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

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## SUPPORTING ANNEXES


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### 4.2 Finance - IQPR Full report March 2023

 [Item 4.2a - IQPR report March 2023.pdf](#)


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### 4.4.1 Maternity - Annexes

 [Item 4.4.1b - Paeds staffing March to August 2022 for approval.docx](#)

 [Item 4.4.1c - Q3 Final Report 22-23 Neonatal Transitional Care Report.docx](#)


 [Item 4.4.1d - 2022 ATAIN Quarter 4 Jan-Mar 2023.docx](#)

 [Item 4.4.1d - ATAIN ROLLING ACTION PLAN 22-23 Board Copy.docx](#)

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### 5.1 Governance Report Annexes

 [Item 5.1 Annex A Register of Interests summary May 2023.docx](#)

 [Item 5.1 Annex B NEDs responsibilities May 2023.doc](#)

 [Item 5.1 Annex C Scrutiny and assurance practice.doc](#)

 [Item 5.1 Annex D WSFT Constitution April 2023 DRAFT V3.1.docx](#)

 [Item 5.1 Annex E Draft Board meeting agenda.docx](#)

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# AGENDA

## WSFT Board of Directors – Public Meeting

<b>Date and Time</b>	Friday, 26 May 2023 9:15 – 13:30
<b>Venue</b>	Room 16a/b, Education Centre, West Suffolk NHS Foundation Trust

Time	Item	Subject	Lead	Purpose	Format
<b>1.0 GENERAL BUSINESS</b>					
09:15	1.1	<b>Welcome and apologies for absence</b> <ul style="list-style-type: none"> <li>- Welcome to Michael Parsons, non-executive director</li> <li>- Apologies received from – Peter Wightman and Krishna Yergol</li> </ul>	Chair	Note	Verbal
	1.2	<b>Declarations of Interests</b>	All	Assure	Verbal
	1.3	<b>Minutes of meeting – 31 March 2023</b>	Chair	Approve	Report
	1.4	<b>Action log and matters arising</b>	All	Review	Report
<b>2.0 PEOPLE AND CULTURE</b>					
09:20	2.1	<b>Questions from Governors and the public relating to items on the agenda</b>	Chair	Note	Verbal
09:40	2.2	<b>Patient / staff story</b>	Chief Nurse	Review	Video
10:05	2.3	<b>CEO report</b>	Chief Executive	Inform	Report
10:25	2.4	<b>Involvement Committee report</b> Chair's key issues from meeting	NED Chair	Approve	Report
10:35	2.4.1	<b>People and organisational development</b> highlight report, incorporating: <ul style="list-style-type: none"> <li>- <b>Draft People and Culture Priorities 2023/24</b></li> <li>- <b>FTSU report</b></li> </ul>	Director of Workforce  Amanda Bennett	Assure	Report
<b>3.0 STRATEGY</b>					
10:50	3.1	<b>Strategic objectives 2023/24</b>	Chief Executive	Assure	Report
11:00	3.2	<b>Future system board report</b>	Chief Executive	Assure	Report

Time	Item	Subject	Lead	Purpose	Format
11:10	3.4	<b>Integrated Care Board joint forward plan (JFP)</b>	Alex Royan	Review	Report
<b>11:40 Comfort Break</b>					
11:50	3.3	<b>System update: West Suffolk Alliance and SNEE Integrated Care Board</b>	Rebecca Jarvis	Assure	Verbal
12:00	3.5	<b>Digital Programme Board Report</b>	Director of Resources	Assure	Report
<b>4.0 ASSURANCE</b>					
12:10	4.1	<b>Insight committee report</b> – Chair’s key issues from the meetings	NED Chair	Assure	Report
	4.2	<b>Finance report</b>	Director of Resources	Assure	Report
12:30	4.3	<b>Improvement committee report</b> – Chair’s key issues from the meetings	NED Chair	Assure	Report
	4.4	<b>Quality and nurse staffing report</b>	Chief Nurse	Assure	Report
	4.4.1	<b>Maternity services report</b>	Chief Nurse Karen Newbury Simon Taylor Kate Croissant	Approval	Report
<b>5.0 GOVERNANCE</b>					
13:00	5.1	<b>Governance Report</b>	Trust Secretary	Inform	Report
13:15	5.2	<b>Board assurance framework</b>	Trust Secretary	Inform	Report
<b>6.0 OTHER ITEMS</b>					
13.25	6.1	<b>Any Other Business</b>	All	Note	Verbal
	6.2	<b>Reflections on meeting</b>	All	Discuss	Verbal
	6.3	<b>Date of next meeting</b> • 21 July 2023	Chair	Note	Verbal
<p><b>Resolution</b> 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</p>					

### Supporting Annexes

Agenda item	Description
4	IQPR full report – March, 2023
4.4.1	Maternity papers Annexes
5.1	Governance Report Annexes
5.2	Constitution



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
<b>Strategic Objectives</b>	<ul style="list-style-type: none"> <li>Collaborate to provide seamless care at the right time and in the right place</li> <li>Use feedback, learning, research and innovation to improve care and outcomes</li> </ul>	<ul style="list-style-type: none"> <li>Build a positive, inclusive culture that fosters open and honest communication</li> <li>Enhance staff wellbeing</li> <li>Invest in education, training and workforce development</li> </ul>	<ul style="list-style-type: none"> <li>Make the biggest possible contribution to prevent ill-health, increase wellbeing and reduce health inequalities</li> <li>Invest in infrastructure, buildings and technology</li> </ul>

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					
Key Elements	None (Avoid Risk)	Low (As little as possible)	Moderate (preference for safe options)	High (willingness to take risk if other benefits)	Significant (willing to take high risks for higher rewards)
Financial / Value for money				—————	
Compliance / Regulatory			—————		
Innovation				—————	
Quality (Patient Safety)		—————			
Quality (Patient Experience)			—————		
Quality (Clinical Effectiveness)			—————		
Infrastructure		—————			
Workforce				—————	
Reputation				—————	
Commercial				—————	

# 1. GENERAL BUSINESS

1.1. Apologies for absence - Peter  
Wightman (Rebecca Jarvis deputising),  
Krishna Yergol

To Note

## 1.2. Declaration of interests for items on the agenda

To Assure

## 1.3. Minutes of the previous meeting - 31 March, 2023

To Approve

**WEST SUFFOLK NHS FOUNDATION TRUST**

**DRAFT MINUTES OF THE  
BOARD OF DIRECTORS MEETING OPEN**

**Held on 31 March 2023 09.15 – 13.30  
At Db Conference Rooms, Bury St Edmunds**

<b>Members:</b>		
<b>Name</b>	<b>Job Title</b>	<b>Initials</b>
Jude Chin	Chair	JC
Ewen Cameron	Chief Executive Officer	EC
Alan Rose	Non-Executive Director	AR
Louisa Pepper	Non-Executive Director	LP
Antoinette Jackson	Non-Executive Director	AJ
Geraldine O’Sullivan	Non-Executive Director	GO’S
Krishna Yergol	Non-Executive Director	KY
Tracy Dowling	Non-Executive Director	TD
Dr Roger Petter	Non-Executive Director	DP
Craig Black	Executive Director of Resources	CB
Nicola Cottingham	Chief Operating Officer	NC
Sue Wilkinson	Executive Chief Nurse	SW
Ravi Ayyamuthu	Deputy Medical Director	RA
<b>In attendance:</b>		
Richard Jones	Trust Secretary & Head of Governance	RJ
Clare Sorenson	Deputy Director of Workforce & Communications	CS
Peter Wightman	West Suffolk Alliance Director	PW
Helen Davies	Associate director of communications	HD
Andy Vowles	Cambridge Health Consulting ( <i>item 3.3 only</i> )	AV
Karen Newbury	Head of Midwifery ( <i>4.4.1 item only</i> )	JS
Simon Taylor	Associate Director of Operations ( <i>4.4.1 item only</i> )	ST
Kate Croissant	Deputy Clinical Director – Women & Children ( <i>4.4.1 item only</i> )	KC
Ruth Berry	Foundation Trust Office Manager (minute taking)	RB
<b>Apologises:</b>		
Jeremy Over, Executive Director of Workforce & Communications		
Paul Molyneux, Executive Medical Director		
Clement Mawoyo, Director of Integrated Adult and Social Care Services		
<b>Governors:</b>		
Jane Skinner	Lead Governor	JS
Liz Steele	Public Governor	LS
Florence Bevan	Public Governor	FB
<b>Members of the public:</b>		
Paul Pearson	Staff Side Lead	PP
Janet Watkins	Project Support Officer, Staff Support	JW

Miriam Ghaemi	Senior Reporter, Bury Free Press/Suffolk News	MG
<b>1.0 GENERAL BUSINESS</b>		
<b>1.1</b>	<b>Apologies for absence</b>	<b>Action</b>
	The Chair (JC) welcomed all to the meeting, including Ravi Ayyamuthu (RA) and Claire Sorenson (CS), who were deputising in place of Paul Molyneux (PM) and Jeremy Over (JO) respectively. Apologies for the meeting were noted.	
<b>1.2</b>	<b>Declarations of interest</b>	
	No declarations of interest were received.	
<b>1.3</b>	<b>Minutes of the previous meeting</b>	
	The minutes of the previous meeting held on 2 February 2023 were approved as a true and accurate record.	
<b>1.4</b>	<b>Action log and matters arising</b>	
	<p><b>2077 System Update – ESNEFT</b> Discussion took place on this work and it was recognised that we continue to progress the structures that support the provider collaboration. It was noted that an internally we have comms planned. <b>Action closed</b></p> <p><b>2086 Patient/staff story – learning disability training for staff</b> Currently there is no core/mandatory training relating to patients with learning disabilities, training is delivered currently as part of the Care Certificate at WSFT. It was confirmed that we are currently looking at now this can be included in the introduction training for staff. The specialist nurse is also providing bite size training for staff. <b>Action closed</b></p> <p>Remaining actions are covered in meeting agenda.</p>	
<b>2.0 PEOPLE AND CULTURE</b>		
<b>2.1</b>	<b>Questions from Governors and the public relating to items on the agenda</b>	
	<p>1. An update was requested in relation to hospital transport for patients.</p> <p>The executive chief nurse, Sue Wilkinson (SW) explained that the WSFT is part of the re-contracting with the ICB regarding transport for patients. It was confirmed that the relevant stakeholders have been involved in the contract review.</p> <p>2. It was asked by a member of staff that Board meeting papers are made available as early as possible, to give those who attend the time to read through the papers.</p> <p><b>Action</b></p>	<b>R Jones</b>
<b>2.2</b>	<b>Patient / Staff story</b>	
	<p>The executive chief nurse, Sue Wilkinson (SW) presented a short video produced by the team, putting into life the experiences of being treated via the Virtual Ward (VW) system. The value of the VW was recognised as very beneficial for patients to be able to be treated/cared for in their home.</p> <p>The WSFT is continuing to build capacity in the VW – extending the pathways, which is a very positive move. WSFT currently has capacity for 33 patients on the VW. Staff</p>	

recruitment and training is underway to achieve the target of 100 by this time next year.

Discussion recognised the different way of working for staff within the service and therefore the importance of training and support. It was emphasised that it is not considered as a failed discharge if a patient comes back into the hospital as medical conditions do fluctuate, just as they do in the hospital setting.

There are some challenges and complexities around patient catchment areas and the community staff. There are at present five clinical pathways, with more to be developed, inclusive pathways with community care.

Questions from the presentation

Q. Does the hybrid approach allow for more fluidity for staff?

We have seen some community staff involved. There is some crossover between acute and community staff. We will need to identify where we move from community division.

Q. Have there been any patients where the VW has subsequently not been the right route to take?

SW explained that not all patients will stay in the VW unless required. The aim is that we would care for patients in their home as much as possible.

The chief executive officer Ewen Cameron (EC) noted that staff can be used more flexibly with VW.

The deputy medical director (RA) highlighted that there have been some occasions where patients have attended the emergency department (ED), which is normal, but the hospital is well prepared for such occasions.

Q. VW numbers & going forward?

It is inevitable that numbers of patients in the VW will grow. Even if they come back to hospital, they will be a different type of patient. Are there ambitions to extend throughout the ICB?

EC emphasised that it is really important that the right patients go onto the VW and the chief operating officer Nicola Cottington (NC) stated that it is clear that the patients would reside on the acute side of care.

Peter Wightman (PW), the West Suffolk Alliance Director explained that the VW is a national programme and WSFT have done well to implement it so quickly and recognise that virtual care is an important part of future care delivery. We need a range of digital services for patients. This is phase one of the VW programme for the trust and patients.

The associate director of communications Helen Davies (HD), explained that the comms team have done a lot of work regarding the VW pathways, including producing videos and leaflets to the public regarding information about the VW service.

Q. How do we use the information/data from the VW to enable the valuation of the beds saved?



	<p>NC explained that it is built into the bed modelling. It is one of the planks to support us in getting this right.</p> <p><u>Q. What will acute care look like going forward and are the clinicians reaching out to the community?</u></p> <p>RA explained that many patients have different medical requirements which may include the need to consult specialists. Introducing this new type of job plan as part of their training will help the staff understand the role better.</p> <p><u>Q. How well are these digital solutions performing with the next generation of digital systems?</u></p> <p>CB said that patients accessing technology via VW have not provided any negative feedback and from a care perspective updated versions of tech are coming along all the time.</p> <p>SW explained that the next steps relate to what is happening with the data collected and how useful it is. There is a need to ensure that there is community framework, and the data is filtered to make a difference to care and measure performance.</p>	
<b>2.3</b>	<b>CEO Report</b>	
	<p>The chief executive (EC) took the opportunity to thank Craig Black for stepping into the CEO role in interim, especially during such a difficult time.</p> <p>It has been six weeks since EC has started and he shared that he has been very impressed with the staff from his visits to various wards/units/departments,. It is clear that the public is informed of the integration between the community and acute services and that there are lots of opportunities to develop in the future.</p> <p>There have been operational pressures on emergency pathways and wards have been kept open to support this pressure.</p> <p>EC said that there have been a number of specific challenges recently, including industrial action. The next strike planned will be difficult following the bank holiday weekend and it is important to support all staff during this time.</p> <p>NC explained that the short term is about managing the logistics of keeping the service going during strike days, including critical services (ED, cancer care etc).</p> <p>EC said that there will be an inevitable negative impact on waiting times, and the staff are working prior to the dates to help ease this.</p> <p>Cancer pathways will continue, as will clinically urgent care. Some surgery has been brought forward and forward planning for those due care is being prioritised. During the last strike, over 1,000 outpatient appointments were lost.</p> <p>NC added that the Trust is going ahead with cancer care programmes, as we recognise the importance of the 'first' pathway appointment. RA said that some planning is bringing clinics forward to be over the weekend before.</p> <p><u>Workforce</u> – The NHS Staff Survey 2022 results have recently been published, which unfortunately shows the continued deterioration of what it's like to work in the NHS. At our Trust, this is no different, however there are areas that remain strong and for most part the Trust remains above or at the national average. There is a lot of work to do to improve the experience our colleagues have of working at our Trust, and we</p>	

	<p>are committed to making this organisation an even better and more attractive place to work.</p> <p>EC congratulated the stroke team for retaining an ‘A’ rating in the Stroke Sentinel National Audit Programme for 19 consecutive quarters. This is a massive achievement and something that should be noted and recognised.</p> <p><u>Q. With all the adverse press, what is being done to share the positive with the public?</u> <u>It is really important to spread good news</u></p> <p>HD explained that positive public relations go out each week from the comms team regarding WSFT, including positive stories to publish. The team has to maintain a balance between positive and negative stories</p> <p><u>Q. Thoughts were requested on when we expect to have a drop in the 12-hr trolley wait?</u></p> <p>NC stated that the 4hr and 12hr models’ standards remain challenging. Reintroduction of the 4-hour standard with the aim of at least 76% of patients being seen and treated within emergency care by March 2024. There will be a deep dive at the next Insight Committee regarding emergency care and monitoring the quality and safety within the emergency department.</p> <p>SW stated that they want to guard against the effect on other patients, e.g. moving existing patients to other wards. The whole approach is to avoid moving patients unnecessarily as this can increase the hospital stay time.</p> <p><u>Q. Are the waiting lists numbers a true record?</u></p> <p>CB explained that there is an internal audit re validation to identify the real numbers. The Trust is assessed annually, and we perform well in terms of data validity.</p>	
<p><b>2.4</b></p>	<p><b>People and Organisational Development Highlight report, including FTSU Guardian Report</b></p>	
	<p>The Deputy Director of Workforce &amp; Communications (CS) presented the People and Organisational Development highlight report, on behalf of JMO and the Workforce team. CS drew attention to the following:</p> <p><u>Industrial action</u> – Workforce team has worked collaboratively with union reps regarding the industrial action. This has been a key to success with comms between the two parties.</p> <p><u>Staff survey</u> – analysis of the completed staff survey will come to Board in May.</p> <p><u>Resource groups for staff</u> – voluntary services at the hospital have over 300 active members, who provide support to staff and patients. 7,000 hrs have been given to the Trust since 2021.</p> <p>New opportunities for volunteers are always being explored and recently there has been a patient flow role created to support the site manager. From April a full rota of volunteers will also be supporting the Emergency Department again from Monday to Friday.</p>	

	<p>There are currently 142 apprentices at the Trust as of March 2023, growing to 160 by October 2023. There are 28 different apprenticeship courses being offered, with this increasing to 35 by October 2023.</p> <p>It was commented that the programme is well managed, and the volunteers are passionate about their work.</p> <p>TD asked about the apprenticeships and whether there is a longer-term trajectory to grow further and use of the levy. CS stated that there is a need to consider a longer-term trajectory for apprenticeships (including work as part of SNEE collaborative). Student volunteers could be targeted for the apprenticeships.</p> <p>PW highlighted that West Suffolk College have apprenticeships schemes, which could be looked at in an integrated approach. Richard Jones (RJ), Trust Secretary informed the Board that recently Elspeth Lees, Director of Higher Education from the West Suffolk College has taken up the role of partner governor on the Council and is also linking with key Trust staff.</p> <p>The Board noted to consider a longer-term trajectory for apprenticeships (including work as part of SNEE collaborative, this will be reported through Involvement committee.</p> <p>It was noted that the schedule for next Board meeting will include the staff survey detailed report and improvement plan. This will include a focus on discrimination of marginalised groups and variation of finding across divisions and services.</p> <p>NC mentioned about the Suffolk communication aids resource centre (SCARC) service, using digital aids for those children who are nonverbal, has had very positive feedback/comments so far.</p> <p><b>The Board noted the report.</b></p>	
<p><b>2.5</b></p>	<p><b>Involvement Committee Report</b></p>	
	<p>The Non-Executive Director and Chair for the Involvement Committee (AR) presented the report from the recent meetings.</p> <p>The committee received assurance on the efforts of all concerned to manage the challenges around industrial action, but recognised the concern over resources diverted to achieve this, the delay in work recovery and other management tasks, the hidden health effects of delays to patients and the continuing toll on workforce morale.</p> <p>There were concerns over indicators in the National staff survey that performance is down in a number of areas. 2,000 staff took part. The areas where performance was down included 'Freedom to Speak Up' (FTSU) reporting. It was noted that analysis and correlation with WMTY2 is still in progress.</p> <p>It was acknowledged that there had been excellent work with the area team regarding shift staff and rota patterns - delivering more flexibility which is a real positive. Turnover and sickness are areas that need to be worked as performance reported in the IQPR continues to be a concern for these indicators.</p>	

	<p>GO'S reflected that staff feedback about the safety and culture could have been better. EC stated that he has heard of both sides, positive and negative. As staffing numbers improve, turnover and sickness have gone down. It was recognised that overall the NHS results are lower in the last two years.</p> <p>LP mentioned that it was good to see positive changes relating to shift working within the radiology department. She asked if it can be built into the 15 steps visits that governors and non-executive director visit, to include this area and the pathology department.</p> <p>AJ stated that we need to look at the data, alongside the turnover figures etc, to sign post improvement, working with the teams to support change.</p> <p>It was noted that radiology had had been inspected in January. Various workstreams were now happening, but Board will gain further oversight through the radiology accreditation report to be presented at Improvement committee.</p> <p>TD explained that a lot of analysis has been drawn together into the six themes in the report, to create an action/work plan to communicate with staff. It was emphasised that the focus on cultural changes is still happening.</p> <p>It was emphasised that staff are still reporting incidents, which is important. The focus needs to be on ensuring they receive feedback and the process is valued.</p> <p>In terms of next steps it was emphasised that there is a need to undertake further analysis of the information e.g. divisional and staff groups with the HR partners. This will be included in the report to the Board in May.</p>	
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**3.0 STRATEGY**

3.1	<b>Future System Board Report</b>	
	<p>The Future System Board report was presented by the executive director of resources (CB) and stated that having secured outline planning permission, the team have been working with the local planning authority to agree terms for the section 106 agreement. These terms have been signed by the WSFT Board, agreed by our local and county councils and are now progressing through National Highways.</p> <p>An agreement has now been secured in principle for the funding of those enabling works that underpin the pre-commencement conditions of our planning application.</p> <p>The programme business case (PBC), covering the scope and budget for all of the "40 Hospitals" in the new hospital programme (NHP), made what we are told is its final appearance before the major projects review group (MPRG) on 24 February. We expect an announcement on what this means for the project by 31 March.</p> <p>Work has commenced on a formal business case for the creation of a "Bury St Edmunds Community Hub". This work encompasses previous discussions about the use of Western Way and will ensure we identify the optimum option and that it is both deliverable and supported.</p> <p>West Suffolk Foundation Trust has been chosen as a lens through which the National Audit Office will assess the value for money and effectiveness of the NHP. Phase 5 of the co-production process has commenced with several workshops aimed at revisiting and updating our 1:200 departmental designs.</p>	

	<p>In the next six weeks it is expected to sign a section 106 agreement, receive the first of the co-produced national standards / designs and understand the consequences of PBC / MPRG discussions (which will inform the likely size of our capital envelope). HD highlighted that due to local elections in early May, we will be in purdah and may not be able to comment on any announcements during that period.</p>	
3.2	<p><b>System Update – ICS and West Suffolk Alliance</b></p> <p>The West Suffolk Alliance Director (PW) presented the System Update report. Items noted at the meeting included:</p> <ul style="list-style-type: none"> <li>- new target time of 4 hour waits for general practices. It is a big change and details for general practices will follow</li> <li>- high overspend in primary care on medicine. The West Suffolk Alliance is looking to work with the System, community teams etc on how this is being managed. It will depend on the current patient engagement level</li> <li>- There has been a significant change with the discharge funding in relation to community services. It is now all bundled up into one allocation, rather smaller numbers linked to specific programmes</li> <li>- There will be a ‘Livewell’ session on 18<sup>th</sup> April at Mildenhall hub, which will show the draft of the plan of what the Alliance will we be doing for 2023/24</li> <li>- An estates update for Haverhill - the health centre is reopening in July, which is positive news. Planning will be needed in relation to the link with Addenbrookes, which is used primarily by Haverhill residents.</li> </ul> <p>It was noted that an update on the Integrated Care Board’s joint forward plan will be received at the next Board meeting.</p> <p><u>Q. Medicine practice and Glemsford</u> PW stated the Alliance is working with every practice to work out what to do. Cultural changes will need to be looked at. It is good to see improvement from recent patient satisfaction.</p> <p>NC noted that as a provider of primary care at Glemsford, the Trust has a responsibility to ask about access and satisfaction. We also need to think how we track (with the Alliance) information about Glemsford.</p> <p><u>Q. What securities do we have going forward with community services, contract ends 2027?</u> A restatement from the ICB on the commitment to continue.</p> <p><u>Q. Will the plan coming back to Board give the detail on non-recurrent funding?</u> CB confirmed that there is a lot of nonrecurrent fund. A desire to be explicit in what is being funded and where is a priority.</p>	
3.3	<p><b>Establishment of the Suffolk Mental Health Collaborative</b></p>	
	<p>Andy Vowles (AV) from Cambridge Health Consulting was welcomed to the Board meeting to present the item of the establishment of the Suffolk Mental Health</p>	

Collaborative. He explained that in order to accelerate implementation of the Suffolk Mental Health Strategy, partners have, following an inclusive design process, agreed to establish a system Mental Health Collaborative. Establishing the Collaborative (which will be a sub-committee of the Suffolk and North East Essex Integrated Care Board) will enable partners to collectively take decisions about all aspects of mental health in the county, including determining strategy and planning, how funds are invested and how services are configured and delivered. It is envisaged that over time the Collaborative will in effect become the 'Board' for mental health.

In 2019 partners from across Suffolk published the East and West Suffolk Mental Health and Emotional Wellbeing 10 Year Strategy (2019-2029). This document was the culmination of an extensive period of co-production with service users, families and carers, staff and the wider public.

It is a system-led collaborative and a decision-making formula for how we plan and resource primary and secondary care for mental care. A key feature is that it is an all age, end to end, structure to include various partners/supporting groups.

The Board was asked to endorse the establishment of the Suffolk Mental Health Collaborative. The reports are being taken to all partners' Boards and Committees during March 2023, including the ICB, Norfolk and Suffolk FT, Suffolk County Council, East Suffolk and North Essex FT and West Suffolk FT. Subject to approval from all Boards/Committees, the Collaborative will be formally established from April 2023.

Questions from Board;

Q. Where would the accountability fall for this collaborative?

The challenge is getting clarity on a collaborative body. The ICB is legally accountable, with the committee making decisions.

There will be a blurring of accountability, but this was considered worth it, in terms of the services we can provide. This will develop over time.

NC welcomed taking this to the next level of partnership collaboration. It may be helpful to have a Memorandum of Understanding, to clarify the governance of this collaborative.

AV confirmed that ToR are going back to the ICB Board setting out what type of decisions will be made and who will make it.

There are a set of issues relating to Suffolk County Council, which would see it be parallel with the other providers. We can't be entirely clear on the decisions flow at present. They wouldn't always go to the collaborative.

It was emphasised that user voices of the various services will need to be supported.

Q. Other mental health services

While it is was great that this is a County wide alliance for mental health, there was no mention of the East of England Collaborative in the paper.

	<p>AV confirmed that there is cross membership between this new group and the East of England Collaborative.</p> <p>PW explained that mental health has to be part of everything – primary, secondary, community care etc. We will need to look at where the current responsibility lies and look at the accountability. There are two voices and this collaborative - WSFT and West Suffolk Alliance.</p> <p><u>Q. Commissioning under this collaborative?</u>        Where will the act of commissioning fall under this new collaborative?</p> <p>CB confirmed that the ICB would continue to commission acute and community services. You would go to the service that you wished to use.</p> <p><u>Q. Why mental health?</u>        There needs to be an alignment across the different services, to collectively understand and deliver the services required.</p> <p>TD said that we know from history, the voice of mental health does not get heard and are not understood. Mental health services have the knowledge to make decisions on services.</p> <p><b>Following discussions, it was agreed that the WSFT Board would endorse the establishment of the Suffolk Mental Health Collaborative and that the WSFT would be a full and active member of this collaborative.</b></p> <p>AV will action this endorsement and will come back to Board when the establishment of the collective has progressed.</p>	
<b>4.0 ASSURANCE</b>		
<b>4.1</b>	<b>Insight Committee Report</b>	
	<p>The Chair of the Insight Committee, AJ, presented the reports of the meetings since the Board last met and drew attention to the following:</p> <ul style="list-style-type: none"> <li>- The committee referred issue of long waiters and the cross over with clinical harm reviews which sat across the two committees currently</li> <li>- There has been significant increase in referrals to the community paediatric services including the neurodevelopmental disorders pathway. This was escalated to the ICB at the end of 2022 and a 3-month deep dive is underway that will report back to the SNEE System Oversight Assurance Committee.</li> <li>- Ambulance Handover times still not achieving handover standards within 15/30/60 minutes. ED attendances remain high with a 4.6% increase on previous the month. The department are taking actions to address this including agency paramedics for cohorting and are visiting James Paget to learn from the handover pod there. Historically, the Trust compares well against the rest of the region.</li> <li>- Glemsford is behind the national standard of 85% of patients to be waiting less than 2 weeks for a routine appointment by March 2023. The number of locums and space needed to achieve target is a challenge.</li> <li>- There were a high number of indicators which are not meeting target with common cause variation The Committee agreed some deep dives were needed into these indicators as part of its future work programme</li> </ul>	

	<p>A request for the MRI recovery plan was made to come back to the Insight Committee.</p> <p>The budget deficit will be coming back for review at the next meeting. A lot more detail has now been given in the finance report.</p> <p><u>Q. Our performance against metrics and how we fair alongside the national levels?</u> NC explained that this will be brought back to Insight committee. Execs get data on a weekly basis. We can look against region/nationally levels. We compare well in other areas.</p> <p><u>Q. Paediatrics</u> How are we going to cope with the increase in services? It has been under resourced for so long. NC confirmed that this is ICB led, but this set up of services has not eased this. Multi agencies outside of the NHS is a factor in this.</p>	
<p><b>4.2</b></p>	<p><b>Finance Report</b></p>	
	<p>The Executive Director of Resources (CB) presented the finance report to Board, with the following highlighted:</p> <ul style="list-style-type: none"> <li>• The reported income and expenditure for February is breakeven (YTD £0.2m deficit). A break-even position for 2022/23 is forecast in line with our budget. In 22/23, a number of factors lead us to estimate that the Trust has an underlying recurring deficit of £15m. However, the SNEE ICS has been allocated non-recurrent support which will enable the achievement of the mandated breakeven position.</li> <li>• The forecast capital spend as at month 11 is £45.6m representing a planned overspend £6.1m</li> <li>• The proposed income and expenditure (I&amp;E) budget for the Trust is to make a deficit of £9.92m which includes achieving a cost improvement programme (CIP) of 3% (£10.6m).</li> </ul> <p>The Board noted a planned deficit of £20m in February 2023. This has improved, due largely to central non-recurrent funding being made available to support our position in 23-24. However, it is important to note that the Trust needs to demonstrate a trajectory of recurring financial improvement for 2024-25 due to the non-recurrent nature of the funding included in the 23-24 plan.</p> <p>Budget for 2023/24 - in late 2022/23, the SNEE ICS has been allocated non-recurrent support which will enable the achievement of the mandated breakeven position. Non-recurrent funding is being relocated from the ICB – a system level support to this organisation.</p> <p>It was noted that very few ICBs have reported break-evens, so we are averaging well. The focus needs to be on avoiding reliance on nonrecurring funding i.e., financial sustainability.</p> <p>It was noted that schemes with a value of £7.8m (approx. 73% of target) have been identified with a remainder of £2.8m to be identified. External support has been sourced to support this work and benchmarking with ESNFT.</p> <p>The divisions are working on longer term plans. CB stated that the increase of staffing has not increased the output. We need to build in the deficiency into the budget.</p>	



	<p><u>Q. Regarding the non-recurrent funding – are we then held to it?</u> CB confirmed that there is the activity plan that underpins the budget. The board would need to agree what our appetite is for non-recurrent funding.</p> <p><u>Q. Language used around vacancies</u> The level of ownership of the programmes within the organisation need to be worked on. For example, the non-clinical workforce, rather than the clinicians. In relation to CIP, we haven't delineated away from the Board. It is an area for improvement.</p> <p><u>Q. Areas for consideration</u> Do we look at certain areas first in terms of the budget? CB confirmed areas that don't impact patient care, for example car parking or procurement are looked at first.</p> <p><u>Q. Priorities</u> What are the priorities across the organisation over the next year? How is that articulated?  PW explained that it is parallel within the system and that we need to manage levels of communication.</p>	
<b>4.3</b>	<b>Improvement Committee Report</b>	
	<p>The Chair of the Improvement Committee presented the report from the previous meeting. Highlights included:</p> <ul style="list-style-type: none"> <li>- Extended emergency department (ED) waits were discussed. More assurance on the impact of long waits and patient safety was required. A presentation from the ED will be at the next meeting.</li> <li>- Recording of nutrition within 24hrs of admission is not meeting the target. This may be being impacted by the length of stay in ED extending into that 24hr period. There is a high level of confidence that a 48hr timeframe is being met, however the eCare reporting does not enable automated monitoring of that data. 24hrs is the national best practice target.</li> <li>- A new group that will report to the Drugs &amp; Therapeutics Committee has been constituted to provide a focused platform for people in a position to review and make changes to improve safety, reporting etc.</li> <li>- Subgroups are challenged in progressing improvement through poor attendance to group and mandatory training. Recognised that Trust has faced significant challenges and the ability to release clinical staff for improvement roles. Cancellation of meetings and educational opportunities are common and the impact of this is difficult to measure.</li> </ul> <p>Shared decision making (SDM) and ReSPECT to be rolled out nationally and launched across the Suffolk ICS in March. Forms regarding resuscitation shared decision-making are to be integrated with community. This could digitalise the yellow folders currently used which patients bring into hospital</p>	
<b>4.4</b>	<b>Quality and Nurse Staffing Report</b>	
	<p>The executive chief nurse (SW) presented the quality and nurse staffing report to the Board. The following points were noted:</p> <ul style="list-style-type: none"> <li>• Improved vacancy rates for this period for both registered nurses (RNs) and nursing assistants (NAs)</li> </ul>	

	<ul style="list-style-type: none"> <li>• Inpatient RNs and registered midwives (RMs) vacancy percentage achieved special cause improvement in February at 12.4%, an improvement of 2% from last reporting period</li> <li>• Total RN/RM vacancy rate continues in special cause improvement and is now below 10% vacancy target at 8.4%</li> <li>• Turnover in NA roles continues to be high, and actions are being taken to address the retention of this staff group</li> <li>• Significant reduction in staffing shortfall [red flag]</li> <li>• Winter escalation areas remain open during this period with 4 internal critical incidents declared in February requiring the staffing of additional escalation</li> <li>• Fill rates improved in January with both RN and NA night shifts above 90%</li> <li>• Fill rates deteriorated in February across all shifts</li> <li>• Industrial action for RCN members impacting on fill rates in both January and February</li> </ul> <p>The Board noted the report.</p>	
<b>4.4.1</b>	<b>Maternity Services</b>	
	<p>The Head of Midwifery Karen Newbury (KN), Simon Taylor (ST) and Kate Croissant (KC) reported on Maternity Services and highlighted:</p> <ul style="list-style-type: none"> <li>• National NHS Maternity Survey 2022: The Trust had a 55% response rate. Whilst this was lower than the 2021 response, it was higher than the Trust average nationally. There were no responses for the antenatal or postnatal questions due to the current patient information system being unable to collate the data required. The digital team and maternity services continue to work to identify how improvements in data retrieval can be achieved to avoid manual processes being required.</li> <li>• Maternity Incentive Scheme: NHS Resolutions have reviewed MIS declaration form and informed that based upon description of events around midwifery staffing, the safety action lead has agreed that this would meet the criteria stated in the technical guidance and therefore the Trust can declare compliance with Safety Action 5</li> </ul> <p>The Board commended that the Head of Midwifery, KN, has won the Inspiring Leader Award at the NHS East of England Regional Maternity Team Maternity Awards and congratulated for the hard work.</p> <p>The single delivery plan was agreed with NHSE and there is a lot of work to be done around addressing the inequalities. It is an ongoing piece of work for the team and the recommendations in the report will be looked at in a more forward-thinking way. Areas where support will be needed from external parties, include those minority groups where English is not the first language.</p> <p>It is acknowledged that the Trust needs to strengthen the operational support of the team and ensure there are resources in place, to be able to address the recommendations.</p>	
<b>4.5</b>	<b>Audit committee report</b>	
	<p>The Chair of the Audit committee AR presented the report to the Board and highlighted the following:</p>	

	<ul style="list-style-type: none"> <li>• More training of FTSU Champions and emphasis at inductions. Continual support for line management, due to their crucial role on this</li> <li>• Finance team to manage the tighter oversight of setting/agreeing realistic target deadlines for Internal Audit actions. Audit Committee to be stricter on requiring timely completions</li> <li>• Standing Financial Instructions and Scheme of Delegation adjustments were made. A number of relatively minor adjustments, proposed by Senior Leadership Team; these reflect inflation, management structure changes and other considerations</li> <li>• Positive feedback gained on private discussion between NEDs and both Audit Firms of the quality and appropriateness of the relationship with WSFT Management</li> </ul> <p>The committee has listened to feedback and adopted the same language used by other committees in the CKI report. A discussion took place on the template of Chair's Key Issues (CKIs) template and it was agreed that the template be developed further to incorporate feedback.</p> <p><b>The Board approved the Standing Financial Instructions and Scheme of Delegation.</b></p>	
<b>5.0 GOVERNANCE</b>		
<b>5.1</b>	<b>Estates and Facilities Strategy</b>	
	<p>The estates and facilities strategy brings together the performance of estates and facilities management (EFM) of the Trust, the challenges and opportunities in operating current estate and demonstrates the direction of development and service change for the next 5 years. The Board was asked to approve the estates and facilities strategy and consider it as a rolling document, which includes the forward plan in relation to the new hospital.</p> <p><b>The Board approved the estates and facilities strategy.</b></p>	
<b>5.2</b>	<b>Governance Report</b>	
	The Board noted the report, including the summary of the Board away day.	
<b>5.3</b>	<b>Board assurance framework</b>	
	<p>The Trust Secretary (RJ) presented the report on the Board assurance framework and stated that the key focus of the review will be working on updating the risks with the relevant assurance committees. The BAF risk assessments are being reviewed with the executive leads in order to assess against the Trust's strategy and strategic objectives.</p> <p>Work has also begun to prioritise SMART objectives for 2023/24 which underpin the strategy delivery and link to the priorities within the system and nationally. This work will inform the BAF development as the risks to the objectives are assessed along with mitigations and sources of assurance. Report to the Board will be provided on a regular basis.</p>	
<b>6.0 OTHER ITEMS</b>		
<b>6.1</b>	<b>Any Other Business</b>	

	<p>The Chair noted the following:</p> <ul style="list-style-type: none"> <li>- one of our public governors (Margaret Rutter) sadly passed away in February. Sympathies from the Trust were offered, and a representative attended the funeral.</li> <li>- Hilary McCallion has stepped down as a NED for work commitment reasons. As such, KY will be stepping up to a full NED role.</li> <li>- Alan Rose leaves today, after six years in office. Thanks from the Board were expressed for his work, questioning and commitment to the Trust.</li> </ul>	
<b>6.2</b>	<b>Reflections on meeting</b>	
	<p>It was positive to note that good discussions took place during the meeting with the right challenges made.</p> <p>It was agreed to look at the technology for future meetings to improve acoustics and provisions for use of audio and accessibility to help and support attendees with hearing issues.</p>	<b>Pooja Sharma</b>
<b>6.3</b>	<b>Date of Next Meeting</b>	
	<ul style="list-style-type: none"> <li>• 26 May 2023</li> </ul>	
<b>RESOLUTION</b>		
<p>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</p>		

## 1.4. Action log and matters arising To Review

**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.**

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
2086	Open	2/2/23	2.2	<b>Patient/staff story -</b> SW to check with the education team that training relating to patients with learning disabilities is part of the core training for nurses and medical students	<b>There is no core/mandatory training. Learning Disabilities Training is delivered currently within WSFT as part of the Care Certificate. With respect to the current curriculum, all branches have to meet the same standards. In annex A there are quite specific descriptions of communication related to disability.</b>	SW	31/03/23	Green	
2088	Open	2/2/23	2.4	<b>People and Organisational Development Highlight report, including FTSU Guardian Report -</b> Pledge of support for the work of the FTSU guardian to be drafted and agreed by the Involvement Committee for publicising to staff	<b>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.</b>	JMO	26/05/2023 21/07/2023	Green	

**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.**

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
2077	Open	25/11/2022	3.2	<b>System Update - ESNEFT</b> - It was agreed that both trusts should publicise the vision and principles for the collaboration internally and externally.	Meeting planned with Comms to progress in mid-January. Discussion has taken place with communications team. The plan was originally to include a section in the all staff update and plan future public communication. The inclusion in staff update was postponed due to industrial action. Communications team working with ESNEFT regarding public communication. <b>Presentation to all staff briefing taking place on 6 June, 2023.</b>	NC	02/02/2023	Complete	26/05/23
2087	Open	2/2/23	2.2	<b>Patient/staff story</b> - Involvement Committee to monitor the effectiveness of processes to ensure appropriate care of patients with learning disabilities	<b>Added to Involvement Committee work programme.</b>	JMO / TD	26/05/23	Complete	26/05/23
2089	Open	2/2/23	3.2	<b>System Update - ICS and West Suffolk Alliance - To discuss the Joint Forward Plan (JFP) and the alliance in West Suffolk at the Trust Board in May or in a Board development session</b>	<b>Today's agenda item (26.5.23) refers.</b>	PW	31/03/23	Complete	26/05/23
2090	Open	2/2/23	3.2.1	<b>Presentation on example from domains - Die Well</b> Involvement Committee to receive deep dives on remaining domains, with short presentation to the Open Board	<b>Added to Involvement Committee work programme</b>	SW/JMO	26/05/23	Complete	26/05/23
2094	Open	31/3/23	2.1	<b>Questions from Governors and the public relating to items on the agenda</b> It was asked by a member of staff that Board meeting papers are made available as early as possible, to give those who attend the time to read through the papers.	<b>Convene access given to relevant individual. Action closed.</b>	RJ	26/05/23	Complete	26/05/2023
2095	Open	31/3/23	6.2	<b>Reflections on Meeting</b> - It was agreed to look at the technology for future meetings to improve acoustics and provisions for use of audio and accessibility to help and support attendees with hearing issues.	<b>Microphones will be made available, where possible, at future public board meetings to help and support attendees with hearing issues.</b>	PS	26/05/23	Complete	26/05/2023

## 2. PEOPLE AND CULTURE



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

To Note

## 2.2. Patient / staff story - Virtual Ward




To Review

## 2.3. Chief Executive's report

To inform

## Board of Directors - Public

<b>Report title:</b>	<b>CEO Report</b>
<b>Agenda item:</b>	2.3
<b>Date of the meeting:</b>	26 May, 2023
<b>Sponsor/executive lead:</b>	Ewen Cameron, CEO
<b>Report prepared by:</b>	Daniel Charman, Communications Manager

<b>Purpose of the report:</b>			
<b>For approval</b> <input type="checkbox"/>	<b>For assurance</b> <input type="checkbox"/>	<b>For discussion</b> <input type="checkbox"/>	<b>For information</b> <input checked="" type="checkbox"/>
<b>Trust strategy ambitions</b>			
Please indicate Trust strategy ambitions relevant to this report.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

<b>Executive Summary</b>
A round up of key issues and projects across the Trust
<b>Action Required of the Board</b>
For information

<b>Risk and assurance:</b>	-
<b>Equality, Diversity and Inclusion:</b>	-
<b>Sustainability:</b>	-
<b>Legal and regulatory context</b>	-

## **CEO Board report – May 2023**

### **Introduction**

These past few months have represented a significant challenge for the NHS, and this has been felt here as well. I would like to express my gratitude to all our colleagues for their ever-impressive work ethic and commitment to providing the best quality and safest care possible while under these sustained periods of pressure.

I have continued to visit teams across our Trust – both out in the community and our hospitals. While I have visited 82 teams so far, I am doing my utmost to come and meet as many colleagues as possible and learn more about the amazing work you do day-in, day-out.

During these past few months, while we have been under pressure, I am proud that we continue to improve our standards and accomplish amazing feats within the health and social care sector. As I will go on to explain in more detail below, these achievements should not be underestimated, and all those involved should be immensely proud.

### **Quality and safety**

Our stroke team have achieved what I can only describe as astonishing. For the last quarter reported (at the end of 2022) by the Sentinel Stroke National Audit Programme (SSNAP), which is a major national healthcare quality improvement programme, they achieved the highest score of any Acute Admitting Stroke unit. Added to this, they have upheld the highest 'A' rating for nearly five years in a row. For a small district general hospital with limited resources, for them to achieve the highest possible rating for so long is a truly impressive achievement. Congratulations to the whole team.

May signifies our first ever 'WSFT patient safety month', where we put a spotlight on the processes and mechanisms we have which help create a strong patient safety culture. During this month, we have launched our new Patient Safety Incident Response Plan (PSIRP) for 2023/24, which will help create a safer culture and drive improvement, and is a requirement under the national Patient Safety Incident Response Framework (PSIRF). This plan helps us show how the learning identified during safety investigations is translated into improvements. This month also saw the launch of our new patient safety education programme to help our colleagues better understand how we all have a role to play in fostering a strong patient safety culture.

Another way we can help improve the quality and safety of the care we provide is by fostering a culture of psychological safety within our teams. I would like to echo the recent calls from our Freedom To Speak Up Guardian, Amanda Bennett, who has been advocating for this, as it forms the bedrock of speaking up. Psychological safety is defined as "a shared belief held by members of a team that it's ok to take risks, to express ideas and concerns, to speak up with questions, and to admit mistakes — all without fear of negative consequences." As such we must continue working towards this culture and disseminate this message so that we can instil an ethos of learning when things don't go as planned. An important part of this culture always continuing to push the bar higher – so that we take our experience and learnings to keep making improvements. I know all our teams strive for this and I thank you for your commitment and please know that I am committed to this also.

### **Operational performance**

While we have experienced another challenging period since our last meeting, we have seen a significant improvement in our urgent and emergency care (UEC) performance during

April. This wouldn't have been possible without all those who contribute to this area working together and supporting each other, and for that, I thank all of you.

As we are glad to have seen an increase in our overall UEC performance, we have recently seen the reintroduction of the 4-hour standard in our emergency department (ED) following the Delivery Plan for Recovering Urgent and Emergency Care Services being announced by NHS England. The 4-hour standard – which refers to the time a patient attending our ED should be admitted, transferred or discharged – will need to hit 76% by March 2024 for our Trust to be compliant. There is a lot of work that will need to be done to meet this, however I know that through teamwork we will do this. I look forward to bringing you further updates on this over the coming year.

While we continued to deal with the impact of industrial action, which has unfortunately meant that appointments and procedures had to be postponed, we are still working very hard to clear our waiting lists. I am pleased that we now have no patients waiting more than 104 weeks for any procedure, and we are making significant progress with our other longest waiting patients. We have reduced the number of patients waiting 78 weeks to 66 at the end of April, where the majority of these patients have either chosen to delay their treatment, are currently unfit for their procedure or lie within areas of identified capacity deficits. For those that are still waiting, please know that we are doing all we can to get you your treatment at the earliest opportunity. In addition to this, we are now beginning to turn our attention to reducing the number of patients waiting more than 65 weeks. It is our ambition to reduce this down significantly by the end of March 2024.

## **Workforce**

Following the meeting of the numerous unions which make-up the NHS Staff Council, the pay offer put forward by the Government has been accepted by the majority of unions. We are doing all we can to implement this change quickly, so our colleagues see this pay increase as soon as possible.

We continue to horizon scan for any signs of future industrial action, both from the British Medical Association and those NHS Staff Council unions which did not agree to the Government's offer. If required, we will again carry out meticulous planning ahead of these periods to ensure we can be there for those who need us.

We are incredibly fortunate to have the staff we do, and whenever possible, we should celebrate them. On Friday, 5 May, it was the International Day of the Midwife and on Friday, 12 May, it was International Nurses Day. These occasions provide us with the opportunity to say thank you to these dedicated and exceptionally talented colleagues. It also gives us an opportunity to thank those who join us from overseas, leaving behind so much, to come and give their all to our Trust. These days were certainly causes for celebration, and to mark the occasion, many cakes and treats were indulged in. With thanks to our staff networks, I was also delighted to see that an event supported by the My WiSH Charity in Bury St Edmunds was well attended.




I took time recently to sign more than 200 long-service certificates to those members of our workforce who have served between 20 and 45 years in the NHS. Their loyalty and commitment to the NHS and our community is humbling and signing these certificates are one of the most rewarding parts of being a leader. Thank you, and congratulations to you all.

## 2.4. Involvement Committee report

For Approval

## WSFT Board of Directors - Public

<b>Report title:</b>	<b>Chair's Key issues: Involvement Committee</b>
<b>Agenda item:</b>	2.4
<b>Date of the meeting:</b>	26 May 2023
<b>Sponsor/executive lead:</b>	Tracy Dowling, Non-Executive Director
<b>Report prepared by:</b>	Tracy Dowling, Non-Executive Director/Involvement Committee Chair Jeremy Over, Director of workforce and communications

<b>Purpose of the report:</b>			
For approval <input type="checkbox"/>	For assurance <input checked="" type="checkbox"/>	For discussion <input type="checkbox"/>	For information <input checked="" type="checkbox"/>
<b>Trust strategy ambitions</b>			
<b>Please indicate Trust strategy ambitions relevant to this report.</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Executive summary:</b>	The report highlights the Chair's Key issues emerged from the Involvement Committee meeting held on 18 April 2023.
<b>Action required / recommendation:</b>	The Trust Board is asked to note the report.
<b>Previously considered by:</b>	NA
<b>Risk and assurance:</b>	-
<b>Equality, diversity and inclusion:</b>	NA
<b>Sustainability:</b>	NA
<b>Legal and regulatory context:</b>	NA



### Board assurance committee CKI report - INVOLVEMENT

Agenda item	Details of Issue (summary of discussion)	Level of Assurance (1, 2, 3 or 4): 1. Substantial 2. Reasonable 3. Partial 4. Minimal	Reason/s for 'Partial' or 'No assurance' and actions to mitigate (with timescale) *	Action / escalation (1, 2, 3 or 4): 1. No action/escalation 2. Action by the committee with timescale (target date) 3. Refer to other assurance committee / SLT for action 4. Escalate to Board
<b>6.0</b>	<b>First For Patients:</b>			
6.1	<p><b>Equality Delivery System for patients and service users</b></p> <p>The report summarised the actions taken by the Patient Experience and Engagement Team with regards to the implementation of the Equality Delivery System (EDS), and analysis of data gathered. The purpose is to review and improve performance for people with protected characteristics, particularly with regard to accessibility.</p> <p>This report only covers domain 1 of EDS – Commissioned or provided services. For 2022-23 COPD and PALS services were reviewed.</p> <p>Recommendations were presented for both services and approved. The report is also being presented to the EDI Steering Group, published on the Trust website and submitted to NHEngland.</p>	Partial	<p>Domain 1 of EDS has been assessed in 2022-23.</p> <p>Domain 2: Workforce and Domain 3: Inclusive Leadership are due for assessment in 2023-24.</p> <p>With this in mind, it is for the Board to role model inclusive leadership and continue to develop that particular area of our accountability. As such this needs to be explicitly incorporated into our programme for board development.</p>	<p>2. Action by the committee to gain further assurance during 2023-4 that all three domains of the EDS are assessed in 2023-24.</p> <p>Additional action to gain assurance that Equality Impact Assessments (EIAs) are embedded in use across the Trust. (Patient Experience and Engagement Team action)</p>

6.2	<p><b>Maternity Service Survey</b></p> <p>Results of the NHS Patient Survey Programme for maternity care were presented. The Trust scored above average or average in all areas. Areas for improvement have been identified and are being progressed</p>	Substantial		1. No action or escalation
6.3	<p><b>Industrial Action- status update and current position</b></p> <p>Verbal updates received from the Medical Director and Chief Nursing Officer</p>	Substantial	Whilst fully assured of the actions taken to manage industrial action to date; the Committee discussed the risks of future potential action, and the negative impact on wait times for elective care patients, staff exhaustion and impact on staff morale.	1. No action / escalation
7.0	<b>First for Staff</b>			
7.1	<p><b>National Staff Survey / What Matters to You 2/ Freedom to Speak Up analysis</b></p> <p>Carol Steed presented a detailed paper which triangulated staff feedback from the above three sources. The Committee discussed in detail and approved the 6 themes identified, but sought more focus on ED&amp;I – particularly ethnicity discrimination; on the difference between organisational divisions and staff groups; and advised checking with staff that the 6 priorities reflect that we have heard the important elements accurately before we complete action plans.</p>	Partial	<p>This is an impressive piece of analysis but is still a work-in-progress. The action plans need to be co-produced and involve the staff networks. There is a need to identify phasing of actions and the expected impacts.</p> <p>The Committee noted that staff will be surveyed again in November 2023, and whilst progress is expected in this time, many actions</p>	<p>2. Action by Committee – oversight of the action plan development and implementation</p> <p>4. Escalate to Board – the importance of this work also requires Board oversight</p>

			will take longer to fully impact on scores.	
7.2	<b>Review of Confidential Staffing Matters – Paper content and process</b> A verbal report was received.	Reasonable		1. No action / escalation
7.3	<b>Workforce KPIs</b> Update on work to drive improvement including a comprehensive report on improving retention through 'Stay Conversations' which had been piloted in Maternity and Critical Care Services. There was strong support and it was agreed these should be further developed and rolled out across the Trust.	Substantial		1. No action / escalation
7.4	<b>Inclusion Plan / WRES / WDES update</b> A verbal update on work in progress was presented	Partial	This work is at an early stage of development with a focus on getting the fundamentals in place first	1. Action by the Committee to oversee this work as it develops over the next 3-6 months
7.5	<b>Education and Training Report</b> A detailed report demonstrating a strong culture of education and learning across the Trust, and effective relationships with Health Education England (HEE) and our partner Universities and Colleges	Substantial		1. No action / escalation
8.1	<b>People and Culture Leadership Group Feedback</b> The group is establishing its membership, terms of reference and cycles of business. In future	Reasonable		2. Action by Committee




	written reports will be required from this executive management group.			
8.2	<p><b>IQPR data – Patient experience and Workforce data</b></p> <p>This was reviewed – of note some reductions in turnover rates over recent months but still common cause variation.</p>	Reasonable	Suggest review of data and metrics as part of strategic information review	1. No action / escalation
8.3	<p><b>Draft Quality Improvement Project (QIP)</b></p> <p>Not discussed in detail due to time pressures. Feedback requested by email on content</p>	Partial	Work in progress	2. Action by Committee for next meeting (June 23)
9.0	<p><b>Any Other Business</b></p> <p>It was agreed to have an Away ½ Day planning session to consider the roles and remit of the Improvement Committee and how Committee members may want to improve how we deliver on our Terms of Reference. Governors who observed the meeting were also invited to take part in this. It was agreed that all future meetings will be face to face</p>			
12	<p><b>Reflections on the meeting</b></p> <p>Feedback received as follows:</p> <p>Positive experience</p> <ul style="list-style-type: none"> <li>• Good depth and quality in discussion</li> <li>• Clear need to move from analysis to action</li> <li>• ? enough time for challenge</li> </ul>			

## 2.4.1. People & Organisational Development Plan

To Assure

## Board of Directors - Public

<b>Report title:</b>	<b>People &amp; OD highlight report</b>
<b>Agenda item:</b>	2.4.1
<b>Date of the meeting:</b>	Friday 26 May 2023
<b>Sponsor/executive lead:</b>	Jeremy Over, executive director of workforce & communications
<b>Report prepared by:</b>	Members of the workforce and communications directorate Freedom to Speak Up Guardian

<b>Purpose of the report:</b>			
<b>For approval</b> <input type="checkbox"/>	<b>For assurance</b> <input checked="" type="checkbox"/>	<b>For discussion</b> <input checked="" type="checkbox"/>	<b>For information</b> <input type="checkbox"/>
<b>Trust strategy ambitions</b>			
Please indicate Trust strategy ambitions relevant to this report.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

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

<b>Previously considered by:</b>	N/A
<b>Risk and assurance:</b>	Research demonstrates that staff that feel more supported will provide better, higher quality and safer care for our patients.
<b>Equality, diversity and inclusion:</b>	A core purpose of our 'First for Staff' strategic priority is to build a culture of inclusion.
<b>Sustainability:</b>	Our role as an anchor employer, and staff retention.
<b>Legal and regulatory context:</b>	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

<b>1.</b>	<b>Introduction</b>
1.1	<p>The People &amp; 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.</p> <p>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.</p> <p>This month the report provides updates on the following areas of focus:</p> <ul style="list-style-type: none"> <li>• Putting You First awards (April/May)</li> <li>• Freedom to Speak Up Guardian Report Q4 2022/23</li> <li>• Developing our people and culture priorities for 2023/24, incorporating what matters to you, speaking up and staff survey feedback</li> <li>• Update on national pay discussions / industrial action</li> <li>• Winter vaccination campaign (2022/23)</li> </ul> <p>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.</p>
<b>2.</b>	<b>Putting You First Awards (April/ May)</b>
2.1	<p><b>Lorna Young, ward sister, F10 (F4)</b>  <i>Nominated by Samantha Jover, wellbeing and inclusion manager</i></p> <p>During Neurodiversity Awareness Week, Lorna created and put together an awareness-raising display on her ward. This was great to see within the ward and it's amazing that Lorna took the time to do this for her colleagues.</p> <p>Lorna is a member of the Trust's Disability Network and this type of awareness-raising really helps the Trust create a culture of inclusion for all. Thank you Lorna, for being an active part of awareness-raising within the Trust.</p>
2.2	<p><b>Linda Mills, midwife</b>  <i>Nominated by Meghann Munoz, senior midwife, labour suite</i></p> <p>Linda is a joy to work alongside; she is reliable, flexible, and always willing to help her colleagues. She truly cares about the women she looks after and provides women with a high standard of women-centred care. Her organisation, clear communication, thoroughness, and work ethic means that triage runs smoothly when she's on shift and she deserves recognition for the hard work she puts in.</p> <p>An excellent, detailed example of the personalised care that Linda provides was included in the citation however due to reasons of patient confidentiality it has not been included in this paper. The nominator described it as "just one example of the high standard of care that Linda provides; she routinely goes above and beyond for women, and MDAU/triage runs so smoothly when she is on shift!"</p>
	<p><b>Lisa Rushworth, senior matron and Natalie Bailey, head of mental health</b>  <i>Nominated by Helen Beard, head of nursing</i></p> <p>I would like to nominate Lisa Rushworth and Natalie Bailey for their tireless and patient centred work and care for a patient to plan and facilitate a safe discharge which was extremely complex. This individual required specialist support and both Natalie and Lisa advocated for the patient, coordinating the multi professional team to support their discharge. Both Natalie and Lisa went above and beyond to ensure the needs of the patient was supported, with Lisa even accompanying the patient to their home to settle them in.</p>

	<p><b>Allison Olson, ward clerk, G9</b>  <i>Nominated by Phillippa Lawson, consultant physician</i>  Allison deserves special mention. For a long time, I have observed how she interacts with others when I am on G9 on a Friday. Her telephone manner is patient and gentle as well as her being so very helpful and good natured. With other staff, she is always checking in with them and supporting them. Today I observed her putting her arm round some of the nursing staff in gentle support. She also encourages them to learn to be independent! She is such a vital part of the ward and is always missed when she is not there. She brightens everyone's day.</p>
<b>3.</b>	<p><b>Freedom to Speak Up Guardian report – Q4 2022/23</b></p> <p>Amanda Bennett, Freedom to Speak Up Guardian will present her Q4 report at the Board meeting on 26 May, which is included as appendix 1 to this item.</p> <p>The Board will wish to reflect carefully on the themes in the report that are particularly pertinent for our leadership role, that we have already identified as priorities for us. This includes the identified theme of staff experiencing discrimination on the grounds of race, and development and support for line managers.</p>
<b>4.</b>	<p><b>Developing our people and culture priorities for 2023/24, incorporating what matters to you, speaking up and staff survey feedback</b></p> <p>Appendix 2 to this report represents a draft set of people and culture priorities for 2023/24 that has been developed to join-up the work we want to do to deliver our strategic 'first for staff' ambition with the priorities identified by staff through various feedback mechanisms.</p> <p>It sets out the first for staff objectives, the six themes that have emerged from the staff feedback, and a draft set of measurable actions for both the short and longer term.</p> <p>These actions will be led by the workforce team and will require the engagement and support of the Board and leaders and managers at all levels of the organisation.</p> <p>It is proposed that we use the next few weeks to consult with staff representatives about the draft plan and then move to communicate with staff and deliver it.</p> <p>Board members are asked to scrutinise and comment on the draft, and endorse the approach outlined.</p>
<b>5.</b>	<p><b>National pay discussions / industrial action</b></p> <p>In addition to the narrative in the Involvement Committee CKI report, Board members will wish to note that the NHS Staff Council, the representative body for the trade unions that represent NHS staff on Agenda for Change (AfC) contracts, reached a majority decision to recommend that the Government's pay offer for 2022/23 and 2023/24 be accepted. Following this the Secretary of State for Health and Social Care confirmed that the new pay deal will be implemented for all AfC staff, which incorporates:</p> <ul style="list-style-type: none"> <li>• For 2022/23 (last financial year): a one-off payment, made up of two parts – an award of 2% of an individual's current salary, plus an additional 'NHS Backlog Bonus', the amount of which is dependent on an individual's current pay band, but which has an average value of 4%, and is designed to recognise the sustained pressure facing the NHS following the pandemic</li> <li>• For 2023/24 (current financial year): an increase in pay of 5% for all AfC staff. Details of the new pay bands can be found here.</li> <li>• A series of non-pay measures to support the protection, retention and career development of the NHS workforce.</li> </ul> <p>The Workforce team is now working with our payroll provider to implement this outcome, which is expected to be in June.</p>



	<p>Further updates:</p> <ul style="list-style-type: none"> <li>• At the time of writing this report no further dates for action in the junior doctor dispute have been announced</li> <li>• The BMA is undertaking a national ballot of consultant medical staff</li> <li>• A number of the unions on the NHS staff council remain in dispute in relation to the pay deal reached, most notably the RCN and UNITE. There remains a risk of further industrial action taking place, subject to each union having a continued mandate from their memberships.</li> </ul> <p>It is 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.</p>
<b>6.</b>	<b>Winter vaccination (2022/23) performance</b>
	<p>The Board will recall that in March we recognised and celebrated the particular achievements of our vaccination team through a Putting You First award for the head of that team, Michael Round. Since then, we have received the final regional report for vaccine take-up by Trust across the east of England region, placing West Suffolk:</p> <ul style="list-style-type: none"> <li>• 3rd out of 13 comparable Trusts for the covid booster</li> <li>• 3rd out of 13 comparable Trusts for the seasonal flu vaccine</li> </ul> <p>These figures were approximately 5-10% points better than the regional average.</p> <p>We will build further on this success as we look towards the 2023/24 winter vaccine programme.</p> <p>As well as noting this success it is clear that the NHS as a whole, including West Suffolk, still has room to improve its vaccine take-up rates. The importance of individuals protecting themselves, their patients, colleagues and loved ones cannot be understated and a clear signal on this from Board colleagues will be a powerful message.</p>
<b>7.</b>	<b>Recommendation</b>
	To note and provide comment and/or feedback on the report.

## Appendix 1:

### Freedom to Speak Up: Guardian's Report Q4 2022 - 2023: January to March 2023

#### Introduction

The total number of concerns raised with the Guardian has decreased slightly from the previous quarter to 52

#### Data

Data submitted to the NGO for Q4 is shown below:

<b>Total number of cases</b>	52
<b>Raised by professional group:</b>	
Allied Health professionals	4
Medical and Dental	4
Ambulance	0
Registered Nurse and Midwife	9
Administrative and Clerical	7
Additional professional and scientific and technical	5
Additional clinical services	7
Estates and Ancillary	3
Healthcare Scientists	1
Students	0
Not known	12
Other	0

Number raised anonymously	11
Number with an element of patient safety / quality	11
Number with an element of worker safety or wellbeing	33
Number with an element of bullying and harassment	6
Number with an element of inappropriate attitudes and behaviours	15

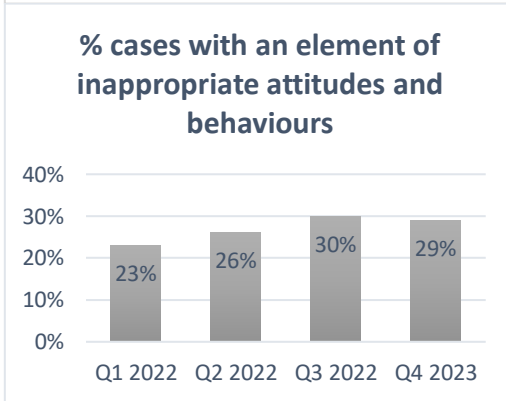
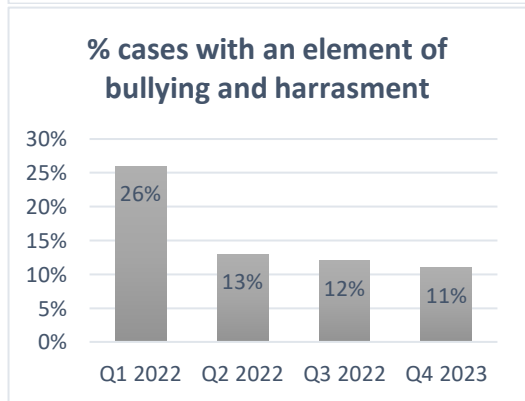
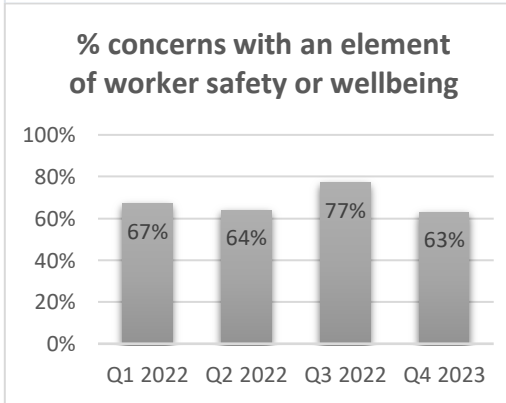
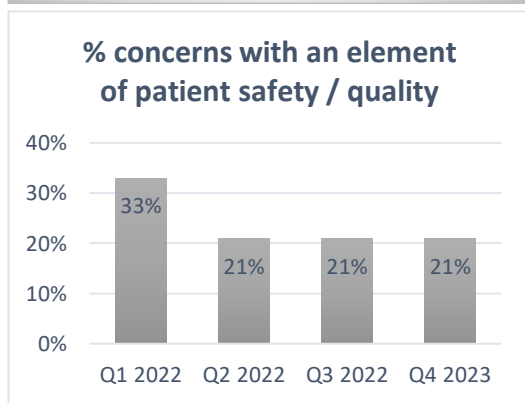
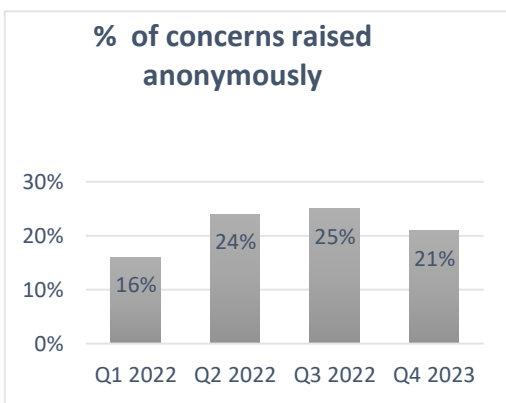
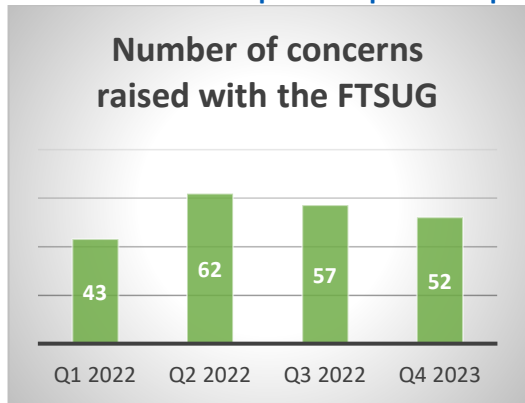
#### Key Themes

11 cases related to colleagues feeling insufficiently supported by their manager/s, often leading to strained relationships within the team. This has been shared with the OD lead and additional suite of management training will soon be available.

6 cases had an element of racial discrimination, these included concerns around biased recruitment and, separately, direct comments from a patient and colleagues. This has led to several investigations, a review of policies and a range of additional EDI training becoming available.

5 cases related to employment processes, predominantly lack of flexible working.

**2022-2023 Data compared to previous quarters**



**Feedback on the Freedom to Speak Up Process**

Following closure of each FTSU case, the person speaking up is sent an evaluation form to report their experience of the process. In Q4, 2 responses were received. All respondents felt that they had not suffered detriment because of speaking up and did not require any further action. Both said they would speak up again and reported that they felt listened to and had a positive experience of speaking up.

**Summary of learning points and highlights**

A focus needs to be maintained on supporting managers. Trust equality and inclusion policies and processes require reviewing and training would help colleagues ensure that these are adhered to.

Trust leaders and colleagues are invited to watch the sessions from the recent NGO Conference 2023.

[Watch the conference session on YouTube](#)

# Our WSFT people and culture priorities for 2023/24

Our People & Culture priorities for 2023/24  
**DRAFT for comment / feedback**



# Our WSFT People & Culture priorities – 2023/24

## From our 5-year strategy:

**FIRST FOR STAFF** - we must all take good care of each other, so together we can take good care of our patients. We will strive together to build a culture of fairness, openness and learning, that is inclusive and supports all staff to be the best they can be. We want to be recognised as a great place to work

Build a positive, inclusive culture that fosters open and honest communication

*Why? - if we do not create a culture where all colleagues, regardless of their background, feel they belong, 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*

Enhance staff well-being

*Why? – 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*

Invest in education, training and workforce development

*Why? – 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*

Powered by our FIRST Values: **Fairness, Inclusivity, Respect, Safety & Teamwork**

Delivering high quality, safe care, together

# Developing our plan – key data sources

## NHS staff survey 2022

- Open October – December 2022 to all staff, including bank staff
- 1985 staff completed the survey = 41% response rate
- Average response rate in acute and community benchmarks group was 44%

## What Matters to You 2

- September – December 2022 open to all staff
- c.300 staff engaged in listening sessions at 19 acute and 19 community locations
- 290 responses to an online questionnaire
- 3408 comments received and reviewed

## Freedom to Speak Up analysis

- Review of data themes since 2020

# Our WSFT People & Culture priorities – 2023/24



**West Suffolk**  
NHS Foundation Trust

## Merged themes from listening and staff feedback:

(What matters to you, national staff survey, speak up themes)

	Theme heading	Theme detail
1	<b>Rest, recovery and facilities</b>	We want everyone to have access to time, space and amenities for rest and recovery, (including hot food and drink 24/7), and safe access to work, in order to be the best they can be every day at work. We also want to build further on the accommodation support options we are able to offer to staff.
2	<b>The role of leadership and management</b>	We want to support the development of leaders and managers at all levels, particularly so that team members: <ul style="list-style-type: none"> <li>• Feel valued and appreciated, and that their concerns are welcomed and acted on</li> <li>• Receive clear feedback, enabled to make improvements and be involved in changes taking place</li> <li>• Are able to access career development opportunities to reach their full potential</li> <li>• Feel that their health and wellbeing is important and supported</li> <li>• Are able to discuss flexible working options to achieve balance with commitments outside of work</li> </ul>
3	<b>Speaking up, listening and taking action</b>	We want to ensure staff work in an environment where they feel confident and safe to speak up to raise concerns they may have, knowing that action will be taken and feedback provided
4	<b>Building a strong West Suffolk workforce</b>	We want to continue to grow our focus on excellent recruitment and retention practices, so that colleagues choose to join and stay at WSFT. This also involves undertaking effective workforce and resource planning to ensure that there are enough staff in the right places, at the right time, with the right tools to do the work that is needed – this includes for our future system programme
5	<b>Growing a culture where everyone belongs</b>	We want to address the disparity between different groups where the evidence shows that staff are disadvantaged or feel discriminated against. The data suggest that our priorities for this are race and disability, and other minority groups will also be important as we focus on being truly inclusive
6	<b>Feeling proud to be part of Team WSFT</b>	We want to be the best place to work and be cared for. All staff should feel proud of their contribution to providing a caring environment for patients, relatives and each other. We want to support teams to work effectively together, appreciate and celebrate their achievements, and build better understanding of each other's roles and ways of working (including across acute and community services)

# Our People & Culture plan – 2023/24

- 'You said, we will' aligned with First for staff objectives (1/4)



West Suffolk  
NHS Foundation Trust

SMART action	Measures of success	By who	Link to theme	Other links
<b>1. Build a positive, inclusive culture that fosters open and honest communication</b>				
<p>1a. A new WSFT People &amp; Culture plan for 2023/24, that responds to the latest priorities identified by staff in their feedback (staff survey / WMTY2), will be delivered and will set clear goals for our organisational culture. It will be enabled by:</p> <ul style="list-style-type: none"> <li>Continued work to embed our speak up processes and culture, in partnership with our speak up guardian and champions to ensure concerns are welcomed, action is taken and feedback provided</li> <li>Identifying divisional and/or team-specific actions, informed by drill-down analysis of staff survey, celebrating successes as well as areas for development and support</li> <li>A renewed commitment to partnership-working with trade union staff representatives to reaffirm local working relationships following the extended period of national industrial action</li> <li>Incorporation of Alliance and SNEE workforce priorities to ensure alignment and joined-up partnership working</li> <li>Delivering our internal communications business plan to increase awareness of and engagement with our values, culture and priorities</li> </ul>	<ul style="list-style-type: none"> <li>New plan published by June 2023</li> <li>All staff raising concerns receiving feedback by September 2023</li> <li>Speak up training rates at target levels by December 2023</li> <li>Reduction in turnover compared to recent historical trend by March 2024</li> <li>Improvement in quarterly staff engagement indicators (longer term)</li> <li>Year on year rise of colleagues visiting news and events sections of the intranet at least once a week</li> <li>Measuring open email rates and click through rates on stories, we aim for year-on-year increase</li> <li>20% increase year on year of colleagues attending fortnightly 'all staff updates' or watching back (current average: 70-100)</li> </ul>	<p>Exec sponsor: EDWC</p> <p>Delivery leads: DDoW (HR), DDoW (OD) and Associate Dir of Comms</p>	<p>Speaking up, listening and taking action</p> <p>Growing a culture where everyone belongs</p> <p>Feeling proud to be part of Team WSFT</p>	<p>NHS People Plan</p> <p>Trust Council partnership working</p> <p>Communications business plan</p>

Delivering high quality, safe care, together



# Our People & Culture plan – 2023/24

## - ‘You said, we will’ aligned with First for staff objectives (2/4)

SMART action	Measures of success	By who	Link to theme	Other links
<b>1. Build a positive, inclusive culture that fosters open and honest communication</b>				
<p>1b. We will address the disparity between different groups where staff feel discriminated against and not included, by:</p> <ul style="list-style-type: none"> <li>• Growing active, engaged staff networks with visible exec support</li> <li>• Based on our Trust values, agreeing and adopting anti-racist behaviours with support provided for line managers and staff to live these fully</li> <li>• Developing inclusive leadership practices for leaders at all levels</li> <li>• Embedding diversity principles throughout our recruitment processes, enabling the process to be free from bias at all stages</li> <li>• Embedding equality into policies, strategies and key focal areas of Trust practice, aligned to WRES and WDES priorities</li> <li>• Establishing guidance and support for all managers and colleagues around reasonable adjustments</li> <li>• Enabling all staff, including those with visible and invisible disabilities, to feel valued at work</li> <li>• Enabling staff development &amp; career progression to be accessible to all</li> <li>• Making all induction programmes inclusive</li> </ul>	<ul style="list-style-type: none"> <li>• Signing the Inclusive Leadership Pledge by July 2023</li> <li>• Decrease in EDI-related speak up concerns by March 2024</li> <li>• Framework and guidance for reasonable adjustments published by March 2024</li> <li>• Reduction in the number of staff reporting harassment, bullying, discrimination or abuse by March 2024</li> <li>• Assessment / completion of EDS inclusive leadership domain</li> <li>• Increase staff diversity at Band 8a and above (longer term)</li> <li>• Increase in staff with protected characteristics achieving career progression (longer term)</li> <li>• Improvement in WRES and WDES indicators (longer term)</li> <li>• Improvement in staff survey indicators (longer term)</li> </ul>	<p>Exec sponsor: EDWC</p> <p>Delivery lead: DDoW (OD)</p>	<p>Growing a culture where everyone belongs</p> <p>Building a strong West Suffolk workforce</p> <p>Feeling proud to be part of Team WSFT</p>	<p>People &amp; culture plan</p> <p>Inclusion action plan</p> <p>Public Sector Equality Duty</p> <p>WRES / WDES</p> <p>NHS Equality Delivery System</p>

# Our People & Culture plan – 2023/24

## - 'You said, we will' aligned with First for staff objectives (3/4)

SMART action	Measures of success	By who	Link to theme	Other links
<b>2. Enhance staff well-being</b>				
<p>2a. We will promote the value of great line management and support, and develop all our current and future line managers:</p> <ul style="list-style-type: none"> <li>Reviewing line manager spans of control to ensure roles are sustainable</li> <li>Agreeing values-based outcomes for what great line management means at WSFT</li> <li>Developing and delivering a holistic and inclusive package of learning and development for line managers, staff members and teams</li> <li>Review, revise and re-launch the appraisal process, linking in career conversations and focusing on quality discussions</li> </ul>	<ul style="list-style-type: none"> <li>No line manager with more than an agreed number of direct reports by March 2024</li> <li>Values-based line management standards agreed and published by August 2023</li> <li>Coaching and mentoring framework agreed by September 2023</li> <li>Learning Hub launched by September 2023</li> <li>Line manager development package published and in delivery by December 2023</li> <li>Appraisal completion rates at 90% by December 2023</li> <li>Improvement in staff survey indicators (longer-term)</li> </ul>	<p>Exec sponsor: EDWC</p> <p>Delivery lead: DDoW (OD) and DDoW (HR)</p>	<p>The role of leadership and management</p> <p>Speaking up, listening and taking action</p> <p>Building a strong West Suffolk workforce</p> <p>Growing a culture where everyone belongs</p>	<p>People &amp; culture plan</p> <p>Learning and development strategy</p>
<p>2b. We will do everything we can to protect and improve the health, wellbeing and safety of our staff</p> <ul style="list-style-type: none"> <li>Strengthening and delivering actions as defined in our wellbeing action plan</li> <li>Promoting staff wellbeing offers to ensure maximum take-up</li> <li>Broadening the use of 'stay conversations' to support retention and career development</li> <li>Focusing on work-related stress, identifying and working to address key contributing factors</li> <li>Developing clearer principles for managers and staff around agile, hybrid, flexible and remote working</li> </ul>	<ul style="list-style-type: none"> <li>Increase in staff utilisation of Abbeycroft by March 2024</li> <li>Reduction in waiting time for staff psychology service by March 2024</li> <li>Attainment of occupational health contract KPIs throughout 2023/24 and by year end</li> <li>Reduction in sickness absence levels by March 2024</li> <li>Reduction in MSK injuries reported through Occupational Health by March 2024</li> <li>Stay conversations used in all divisions / corporate depts</li> </ul>	<p>Exec sponsor: EDWC</p> <p>Delivery lead: DDoW (OD) and DDoW (HR)</p>	<p>Rest, recovery and facilities</p> <p>The role of leadership and management</p> <p>Building a strong West Suffolk workforce</p>	<p>People &amp; culture plan</p> <p>Wellbeing action plan</p> <p>Accommodation &amp; rest provision for staff</p>

# Our People & Culture plan – 2023/24

## - 'You said, we will' aligned with First for staff objectives (4/4)




SMART action	Measures of success	By who	Link to theme	Other links
<b>3. Invest in education, training and workforce development</b>				
<p>3a. We will create more new roles and use novel approaches to recruitment to reduce vacancies; and we will deliver education, training and development that supports our staff to be ready for the future requirements of the health and social care sector by:</p> <ul style="list-style-type: none"> <li>Implementing a new e-recruitment system to speed up recruitment and empower managers and recruitment teams</li> <li>Working with finance colleagues to streamline the VAF system to reduce bureaucracy whilst retaining financial control</li> <li>Investing in pro-active recruitment campaigns, including campaigns that support those from disadvantaged backgrounds to consider health and care as a profession</li> <li>Continue to review and strengthen our mandatory training to ensure the right staff receive the best learning in the most appropriate way, with impact measures defined and tracked</li> <li>Increasing our use of the Apprenticeship Levy, to invest in upskilling our staff, including linking these to new and developing roles where possible using 'Career Starter' apprenticeships</li> <li>Introducing learning and development to enhance skills around digital capability and confidence</li> <li>Launch the Learning Hub, which will provide all staff with easier access to learning and development opportunities available from the Trust and beyond</li> </ul>	<ul style="list-style-type: none"> <li>Recruitment system launched and operational by September 2023 (subject to business case approval)</li> <li>Learning Hub launched by September 2023</li> <li>Learning and development resources to support digital development launched by December 2023</li> <li>Reduction in average time to hire indicators by March 2024</li> <li>Reduction in vacancy rates by March 2024</li> <li>Apprentices recruited to carer starter apprenticeships by June 2024</li> <li>Mandatory training governance strengthened matrix updated by October 2023</li> <li>Mandatory training packages reviewed and updated by December 2023</li> </ul>	<p>Exec sponsor: EWDC</p> <p>Delivery lead: DDoW (OD) and DDoW (HR)</p>	<p>Building a strong West Suffolk workforce</p> <p>Feeling proud to be part of Team WSFT</p>	<p>First for patients</p> <p>First for the future</p> <p>Alliance delivery plans</p> <p>National NHS workforce plan</p>

### 3. STRATEGY

## 3.1. Strategic Objectives 2023

To Assure

<b>Board of Directors</b>	
<b>Report title:</b>	<b>Strategic priorities</b>
<b>Agenda item:</b>	3.1
<b>Date of the meeting:</b>	26 May 2023
<b>Sponsor/executive lead:</b>	Ewen Cameron, Chief Executive
<b>Report prepared by:</b>	Richard Jones, Trust Secretary

<b>Purpose of the report:</b>			
<b>For approval</b> <input type="checkbox"/>	<b>For assurance</b> <input type="checkbox"/>	<b>For discussion</b> <input checked="" type="checkbox"/>	<b>For information</b> <input checked="" type="checkbox"/>
<b>Trust strategy ambitions</b>			
Please indicate Trust strategy ambitions relevant to this report.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

## Executive Summary

### Background

Discussion at the Board workshop held on the 4 May highlighted the value of agreeing a **set of priorities** for the next year to frame the work being undertaken to deliver the Trust's strategy. This paper describes the first draft of these priorities with a proposal to develop our approach.

The starting point for these priorities is **our strategy** [First for our patients, staff and the future](https://youtu.be/NCVqNCqHXaQ) 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>.

Our strategy has **three ambitions** (First for Patients, First for Staff and First for the Future). Each ambition has several objectives.

The amount of work required to deliver the strategy is substantial and sits alongside other demands of the health service. Navigating this complex agenda is supported by our divisional business planning. These plans include actions and improvements to deliver the **objectives within the strategy** in the context of:

- Quality and safety improvements
- Operational planning standards
- Financial sustainability.

Annex A summarises **examples of progress** with the strategic ambitions during 2022-23. Development of the business planning process for 2023-24 is currently underway and will report via the Insight Committee.

### Proposal

When considering this complex agenda, the Board recognised the value of **championing a small set of priorities** to frame the work to deliver the strategy this year. These priorities will provide focus for the

work of the Board and Executive and can be used to structure meeting agendas and discussions with the Board and senior leaders.

After a wide-ranging discussion at the Board workshop, it was agreed to identify a small number of priorities with clear deliverables that are SMART (specific, measurable, achievable, realistic and time-bound) and a narrative to describe how we have come to prioritise the areas we have.

Based on discussion at the Board workshop there was a strong steer towards the following priorities:

1. 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.
2. A step change in delivery on **prevention / demand reduction** given the modelled demand projections and the explicit need for this to support the Future Systems Programme.
3. A strong priority on **Equality, Diversity and Inclusion** with mixed views on whether this should be a single priority of becoming an anti-racist organisation or a broader approach, with a steer towards the former.
4. Delivery of a portion of the **service pathway changes** required by the Future System Programme as laid out in the Clinical and Care Strategy.
5. A large focus on **line manager 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.

### Next steps

The Board are asked to review and confirm the proposed priorities at the meeting on 26 May. For each priority we will then:

- Develop a narrative which sets out the rationale for prioritisation
- Agree SMART actions for 2023-24 (up to two for each priority).

An example of this approach is detailed in Annex B. In the context of the First for the Future ambition, this describes the rationale for the prioritisation and SMART actions for priorities 1 and 2 above.

If supported this approach will be developed and applied to each of the priorities. There will be an opportunity for the Board to review this at its workshop in June prior to receiving the report at its public meeting in July.

The priorities will also provide an opportunity to frame the work of the Board and Executive and can be used to structure the meeting agendas and discussions with the Board and senior leaders.

### Action Required of the Board

The Board is action to:

- Support the proposed approach and approve the draft priorities
- Approve the next steps, including the development for each priority of a rationale and SMART actions (Annex B)

## Annex A: Examples of progress against strategy (2022-23)

### First for Patients

This year saw the launch of the Suffolk and North-East Essex Integrated Care Board (SNEE ICB), and as a leading provider in the integrated care system (ICS), across the Trust we are committed to partnership working on the strategy and delivery of healthcare in the future.

Providing seamless care at the right time in the right place to meet people's individual needs and wishes means working in collaboration with partners across the NHS and other healthcare providers, the private sector, local councils, charity and voluntary services. We know that integrated working is the way forward, and this year progress has been made on ensuring the care we provide is joined-up, timely and effective.

We are using feedback, learning, research and innovation to improve care and outcomes. We have kept innovations which worked well during the pandemic, such as telephone and video consultations, wellbeing calls, patient-initiated follow up and ways for patients to stay in touch with loved ones in our care: Keeping in Touch and the clinical helpline.

The movement of patients through our services, especially the acute hospital, has been a major focus of our work this year as we strive to reduce the numbers of people waiting for care. We have extended the hours of our clinics and theatres to help us reduce the numbers of people on our waiting lists; and in November we launched virtual wards, part of a national programme which allows patients to receive care at home, instead of needing to reside in hospital. Using digital technology, patients can safely be monitored from the comfort of their own homes as part of their health and care needs. This year social prescriber Stefan Currington joined us at the acute hospital, offering support for people to improve their independence and quality of life after discharge, and preventing readmission.

We have made significant investment in our patient safety and quality improvement teams, using learning, best practice, new models and frameworks to support continuous improvement. We were a pilot trust for the PSIRF patient safety framework, aimed at improving the response to patient safety incidents, and are now helping to roll PSIRF out across the NHS and are just entering into our third year of our patient safety plan based on the new framework. An improvement event run by our medical division inspired and captured ways to make positive change, using and developing ideas that came from staff.

This year a number of our teams, projects and services have been nominated for, and won, prestigious national awards and been recognised for their work.

Clinical nurse specialists (CNSs) are crucial in providing expert support for our patients, but a study by Macmillan Cancer Support found that 37 per cent of the current workforce is over 50 years old. Our Macmillan Unit team created an innovative way of tackling this potential future workforce shortage, with a bespoke 18-month programme to support band 5 nurses to progress into CNS positions. This won the Macmillan Professionals Innovation Excellence Award, which is an incredible achievement.

A pilot scheme pioneered on our acute renal ward was nominated for an HSJ (Health Service Journal) Patient Safety Pilot of the Year award and Nursing Times Best Use of Workplace Technology award. The team identified and introduced equipment that allowed staff to improve the accuracy of measuring and monitoring how much fluid each patient consumed.

The Trust's research team is recognised and praised for its participation in a wide range of regional, national and international research studies. One of our clinical research practitioners, Angharad Williams, was named the recipient of the 2022 Advancing Healthcare Awards for Clinical Research Practitioner (CRP) Leadership from the Academy of Healthcare Sciences. She won the award in recognition for her work in developing a regional network and national work to develop an approved accreditation scheme and register for CRPs.



The co-ordinators of the prestigious ORION-4 research study have congratulated WSFT colleagues on recruiting more than 100 participants. Consultant cardiologist Dr Pegah Salashouri, lead research nurse Jo Godden and research nurse Lily John were praised for their significant contribution to this collaborative research into a cholesterol lowering injection.

The SIREN (SARS-CoV2 immunity and reinfection evaluation) is a large-scale partnership launched two years ago with NHS workers, to evaluate the immune response to COVID-19, build understanding of the protection offered by vaccines and provide insight into COVID-19 reinfections. At the WSFT, 598 colleagues signed-up to participate, many of whom are continuing to support the study today.

Dr Justin Zaman and the cardiology research team have received national recognition for their work on the REACH HFpEF trial. The team have placed second in the country for the number of participants recruited, an amazing achievement.

Our stroke service has recently received its results from the Sentinel Stroke National Audit Programme (SSNAP), for acute admitting stroke units. Our service is ranked number one nationally during the October – December 2022 quarter (which is the latest data available at present) and was ranked joint second in the previous quarter. This achievement is due to the hard work, dedication and commitment of all the members of the stroke service.

Our Trust was shown to be performing better than most NHS acute trusts in the country in several areas of care, according to an adult inpatient survey from the Care Quality Commission. There is always room for improvement, but the findings underlined the efforts made to ensure our patients have a good experience. This year we also received a “Good” CQC rating for the Glemsford GP practice that is part of the WSFT, with the staff’s kindness and respect for patients highlighted.

Patient experience is enhanced by our volunteers, a valued group of people now fully back with us after the pandemic. From helping people find their way around, to keeping our courtyard gardens planted and tidy, supporting ward staff, and offering companionship to people at the end of their lives, the volunteers make a real difference and we are grateful for their support.

We have recently achieved a Work Experience Quality Standard award for the student programme delivered through our voluntary services. The offers valuable opportunities for young people interested in a healthcare career. With the support of clinical and medical colleagues the programme provides invaluable clinical shadowing opportunities, and a digital student academy programme.

Nutrition and hydration are a vital element in the care and recovery of our patients, and this year our award-winning catering team have maintained their excellent hygiene rating, scoring the highest score of 5, which means standards are “very good”. Meanwhile, two of our apprentice chefs won through to the national finals of the NHS chef of the year competition.

The My WiSH charity continues its sterling work to enhance the care the Trust provides, from funding posts such as a staff support psychologist and a play specialist for young patients in our emergency department, to supporting major appeals and projects. The charity receives amazing support from our community, with local people organising their own fundraising, or supporting My WiSH events such as the Soapbox Challenge, which returned this year to great success.

## **First for Staff**

We know when staff feel confident that they have a voice, can speak up and raise concerns, there is a positive impact on patient safety and care.

In an Autumn of active listening, colleagues were able to respond to the annual NHS staff survey; a travel survey; and ‘What Matters to you 2’, which followed up on the 2020 staff engagement programme. The aim is to continue conversations with staff so that Trust leadership hear about what is important and can take action to improve. We know it is also important to show where and how we have listened – ‘You Said, We Did’.

We also focused on Freedom to Speak Up (FTSU), and have a growing number of FTSU champions throughout the Trust. We have relaunched our peer support networks for disabled people, LGBTQ+ colleagues, and those from the global majority. We have introduced wellbeing champions from diverse backgrounds, supported by the My WiSH charity, who are also helping us to build a positive and inclusive culture. After listening to concerns raised by staff, we have developed a more supportive and compassionate HR culture.

Another of our key objectives is showing that we value our staff by enhancing their well-being. We have expanded our dedicated staff psychology team; extended our free gym membership for all staff and modernised facilities in the Chaplaincy, including dedicated facilities for Muslim colleagues and visitors. Our vaccination team has ensured free and easy access to both the COVID-19 and seasonal flu vaccinations, as well as running a comprehensive programme in our wider community.

Nominations for our Putting You First awards have come from peers, and their citations are both moving and inspiring. The contribution that people have made to the NHS, often for their whole working lives, is marked through our long service awards – we have this year recognised people who have served for 50 years.

We are investing in education, training and workforce development, because we want staff, who come from all over the world to work with us, to build their careers here. One in five of our staff come from overseas, representing more than 80 countries. This year we were proud to receive the NHS Pastoral Care Quality Award in recognition of our commitment to providing high-quality pastoral care for internationally educated nurses and midwives.

We have a strong learning and training offer, recognised this year with six nominations in the Nursing Times Workforce Awards, including Best UK Employer of the Year for Nursing Staff. Two of our clinical education team were nominated for Student Nursing Times Awards, with Alex Levitt-Powell winning Learner of the Year: post-registration category.

Throughout our organisation the year has been marked by celebrating the opportunities and funding staff can access for continuous personal development. Our professional nurse advocates are trained to listen and understand challenges and demands of fellow colleagues, and to lead, support and deliver quality improvement initiatives.

We have been joined by a corporate lead to facilitate advanced clinical practice, supporting colleagues in acute and community services to take up the challenge of advanced practice. Six new registered nursing associates are now working in acute and community settings, an investment in a recently-developed NHS role that brings significant benefits in patient care.

A supervisor role has been introduced in our health care support worker (HCSW) workforce, aimed at giving new HCSWs support and mentoring on our inpatient wards. This has improved retention of these important staff who do so much to care for our patients.

Keeping staff throughout the Trust informed is a priority for our communications team, which this summer developed and launched a new and improved intranet site, working with colleagues across the Trust. Using digital innovations, the team is exploring new ways to ensure our busy staff can easily access information to support patient safety and best practice, as well as the wellbeing support on offer. The team works closely with colleagues across the Trust and the wider system to drive awareness and engagement, in a rapidly changing environment for health and care.

## **First for the Future**

This ambition in our strategy reflects how we are taking the organisation forward and our role as a large, anchor organisation in west Suffolk with the SNEE ICB.

A huge part of our priority to invest in infrastructure, buildings and technology is the work we are doing to plan for the new healthcare facility to replace the West Suffolk Hospital here in Bury St

Edmunds. The new hospital, which is one of 40 to be built as part of the Government's New Hospital Programme, should be completed by 2030. Plans are well under way with outline planning permission agreed for our preferred site of Hardwick Manor.

While we work with our partners and our community to plan for a new hospital, our current hospital is reaching the end of its life. It was built in 1974, using reinforced autoclaved aerated concrete (RAAC) planks, and has a life expectancy of 30 years. Every day, our estates team has continued its programme of essential maintenance to ensure our buildings remain as safe as possible for patients and staff.

Through our Future System project, we are looking at ways to develop services we provide in the heart of our community, so that many more people can be cared for without coming into the acute hospital. A diagnostic centre is planned for our Newmarket community hospital site, which will increase capacity and give people greater choice to be treated closer to home.

Planning for the future has meant looking at what the next decades will mean for west Suffolk and its population – which is likely to grow in number and in age. The most important asset in caring for people of all ages will be a highly-trained and skilled workforce, and we are exploring ways of supporting young people to become our staff in years to come.

As well as the commitment to “grow our own” through training, development and apprenticeships, we are celebrating 15 years of partnership with West Suffolk College. BTEC students joined us for work experience; and later this year we will welcome students on T-Level courses on placements. This partnership aims to give the workforce of tomorrow the skills they need to hit the ground running when they start their careers.

We have continued to fulfil our role as a key partner within the West Suffolk Alliance, with Trust Executive Directors taking roles as Sponsors of Live Well domains as part of the West Suffolk Alliance Delivery Plan.

To support our goal of making the biggest contribution to prevent ill health, increase wellbeing and reduce health inequalities, our community health services are increasingly being co-located with partner organisations – for example at the Mildenhall Hub. The alliance working model of integrated neighbourhood teams allows us to care for people's individual needs where and how they live. Closer working with key allies such as the county council in social care and housing, but also providers such as Abbeycroft Leisure, has allowed us to improve patient care and experience.

Green commitments in strategy already achieved:

- Net Zero delivery:
  - Training taking place with ICS support summer 2023
- Purchase energy from 100% renewable sources from April 2021
  - Electricity – Achieved
  - Gas – no current market for renewables
  - 20% reduction in CO2 emissions (2021-22 v 2020-21; TBC for 2022-23)
- Desflurane use to less than 10% of total volatile anaesthetic gases:
  - Achieved – (8% in 2021-22, TBC for 2022-23)

This year saw changes to the membership of our Board, who will be leading on the work to take the Trust forward. As well as a new chief executive officer, we have been joined by new non-executive directors (NEDs), who bring a wealth of experience with them to our foundation trust. We were delighted to be able to hold our Annual Members' Meeting in person once again, to reflect on the past, present and future, and hear the opinions and questions of local people. As well as engagement through Future System, we have undertaken a travel survey, and organised and attended events across the county, including in Glemsford, where we run the GP surgery.

Many challenges remain, including in recent months, extensive periods of industrial action. We recognise these disputes are between the unions and the Government and we support the legal right to strike. The willingness of our colleagues to help us plan and work flexibly around these actions has shown once again their commitment to each other and to our patients, and their dedication to serve the people of West Suffolk.

Strategic objectives for 2023/24:  
First for the Future 1: Develop and expand our transformation capacity and capability

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 The first steps  
towards this have taken place, with a unified change management function and process change hub which went live on <sup>st</sup> April 202

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

The strategic objective, FFF, sets out this  
intention, and how it will be delivered through SMA Actions

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

Putting you first

# Strategic objectives for 2023/24: First for the Future 1

Objective	SMART actions	Measures of success	By who	Live Well domains/ other strategies
<b>FFF1: Develop and expand our transformation capacity and capability</b>	<p>FFF1.1 Review the structure and capacity of the change hub with a recommendation for an expanded structure by October 2023. Implementation of new structure by April 2024</p> <p>FFF1.2 Propose a new joint director of strategy and transformation role across WSFT and West Suffolk Alliance (ICB), by August 2023. if agreed, to be implemented by April 2024</p>	<p>Expanded change hub structure in place by April 2024</p> <p>Explore director of strategy and transformation role by April 2024</p>	<p>Exec sponsor: Nicola Cottington, Chief Operating Officer</p> <p>Clinical delivery lead: tbc</p> <p>Operational delivery lead: Matt Keeling, Deputy Chief Operating Officer</p>	<p>All Live Well domains Clinical and care strategy</p>

Putting you first

## Strategic objectives for 2023/24:

First for the Future 2: Launch the prevention, health inequalities and personalised care strategy

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 2019, Suffolk County Council published analysis that showed that by 2042, 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 0.5 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.

Putting you first

# Strategic objectives for 2023/24: First for the Future 2

Objective	SMART action	Measures of success	By who	Live Well domains/ other strategies
<b>FF2.1 Develop the WSFT Prevention, health inequalities and personalised care strategy</b>	<p>Launch the WSFT Prevention, health inequalities and personalised care strategy by x date</p> <p>Prioritise 5 areas for prevention work in 2023/4, by July 2023</p> <p>Train 1000 colleagues in prevention, health inequalities or personalised care by March 2024.</p>	<p>Launch of prevention and demand reduction strategy</p> <p>Achievement of metrics identified in 5 areas of prevention work</p> <p>1000 colleagues trained in prevention, health inequalities or personalised care by March 2024</p>		Be Well
<p><b>FF2.2 Address health inequalities:</b></p> <p>2.2.1 We will understand our population better, the inequalities they are subject to and the nature of their needs</p> <p>2.2.2 We will use this knowledge to:</p> <ul style="list-style-type: none"> <li>Remove structural barriers to fair access and equal outcomes</li> <li>Tailor how care is provided to meet people's different needs better</li> <li>Address the CORE20PLUS5 priorities, jointly with local partners</li> </ul>	<p>Deliver the trust's tobacco control plan by March 2024, across inpatient, outpatient and maternity services and for staff</p>	<p>Support X number of people to stop smoking by March 2024, Y% of whom will live in the 40% most deprived areas (X and Y to be defined by mid May)</p>	<p>Exec sponsor:</p> <p>Clinical delivery lead:</p> <p>Operational delivery lead:</p>	<p>Be Well</p> <p>Personalised Care Strategy (draft)</p>




Putting you first



## 3.2. Future System board report

To Assure

<b>Board of Directors - Public</b>	
<b>Report title:</b>	<b>Future System Board Report</b>
<b>Agenda item:</b>	3.2
<b>Date of the meeting:</b>	26 May, 2023
<b>Sponsor/executive lead:</b>	Craig Black, Director of Resources
<b>Report prepared by:</b>	Gary Norgate, Programme Director

<b>Purpose of the report:</b>			
<b>For approval</b> <input type="checkbox"/>	<b>For assurance</b> <input checked="" type="checkbox"/>	<b>For discussion</b> <input type="checkbox"/>	<b>For information</b> <input checked="" type="checkbox"/>
<b>Trust strategy ambitions</b>			
<b>Please indicate Trust strategy ambitions relevant to this report.</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Executive Summary</b>
<p>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:</p> <ol style="list-style-type: none"> <li>1. A “section 106<sup>1</sup>” agreement has now been agreed and signed by all statutory partners. This significantly de-risks our ongoing programme and has allowed the local planning authority to formally issue notification of our outline planning consent.</li> <li>2. Our process for identifying a preferred partner in the provision of a compensatory environment has concluded and we have agreed and signed ‘Heads of Terms’ with Heathpatch Limited. This signifies a significant step towards satisfying the most challenging of our “pre-commencement planning obligations”.</li> <li>3. Our team made a successful and highly informative visit to the new Royal Liverpool Hospital. The headline lessons will be discussed within the clinical section below.</li> <li>4. We have agreed a memorandum of understanding with NHP for “enabling works” funding – this allows us to progress with early planting of a tree belt to protect our nearest neighbours from disruption and the execution of a compensation strategy aimed at counter-balancing the inevitable impact of building a new hospital on a green field site.</li> </ol>

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

5. We have submitted a budget and cash flow to NHP aimed at covering the cost of professional support (architects etc) required to complete the production of a fully compliant outline business case (OBC) and to secure full planning permission.
6. Phase 5 of our co-production process continues to refine our preferred schedule of accommodation, specifically focussing on the concept of shared hubs, digital opportunities and the role of human factors and ergonomics in the design process.
7. Engagement sessions between the New Hospital Programme and Schemes continue to highlight the progress being made towards the development and agreement of common design standards and delivery options.
8. We are in the process of procuring professional support for the translation of our demand forecast and schedule of accommodation into a plan for our future workforce.
9. The formal announcement of programme funding is, at the time of writing, imminent, however, as much as this is impacting our colleagues in RAAC hospitals who await confirmation of their inclusion in the programme, our own scheme continues to be supported by NHP and as such our progress is not being unduly affected.
10. With the prompt completion of a fully compliant outline business case in mind, we are keen to secure sign-off of our strategic outline case. Said case will be updated to reflect our latest schedule of accommodation and its associated costs before being formally submitted to NHSE and the Joint Investment Committee.
11. In the next 6 weeks we expect to; have submitted our updated SOC for sign-off, commenced on-site discussions between statutory consultees and our environmental partner, formally agreed fees for the development of our OBC, 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 from Ministers!

### **Business Cases and Project Plan**

Key activities and milestones:

In the last month, we have significantly reduced the risks of commencing with the build of our hospital by formally closing both the Section 106 agreement and a “head of terms” to work with Heathpatch limited on the development of an environment aimed at compensating for the development of Hardwick Manor. These developments have been facilitated by the provision of funding from NHP. Next steps include the co-design and execution of buffer planting at the end of Sharp Road, the joint design of the new compensatory environment with statutory partners (Suffolk Wildlife Trust etc), season specific surveys (e.g. migratory bird survey), the translocation of turf, engagement with utility companies and the re-commencement of archaeological surveys at Hardwick Manor.

The closure of the Section 106 agreement has allowed the local planning authority to formally issue notice of our planning consent. This announcement signals the beginning of a 6-week period in which requests for judicial review of the planning process through which our application passed can be raised.

Delays to a formal ministerial announcement on the future membership and schedule for the execution of the new hospital programme continue, however, this is not impacting the advancement of the West Suffolk project as we have sufficient support from NHP and NHSE to continue to progress the formal recognition of our Strategic Outline Case, essential time critical enabling works (above) and the development of our outline business case.

### **Clinical Workstream**

Having visited the newly opened Royal Liverpool Hospital (one of NHP’s Cohort 1 Schemes) our team have distilled several key lessons that can be summarised thus:

The NHP team continue to engage Trusts in a series of workshops aimed at ensuring the benefits of a programmatic approach are captured and explaining how said benefits will be achieved. The following two slides explain how a wide range of stakeholders (including Royal Colleges and the Trusts

themselves) are being engaged in the design process. The second slide describes the engagement process and WSFT are positioning themselves for an early “clinical and technical deep dive” that will allow us to share the outcome of our co-production process and progress the development of our OBC with confidence.

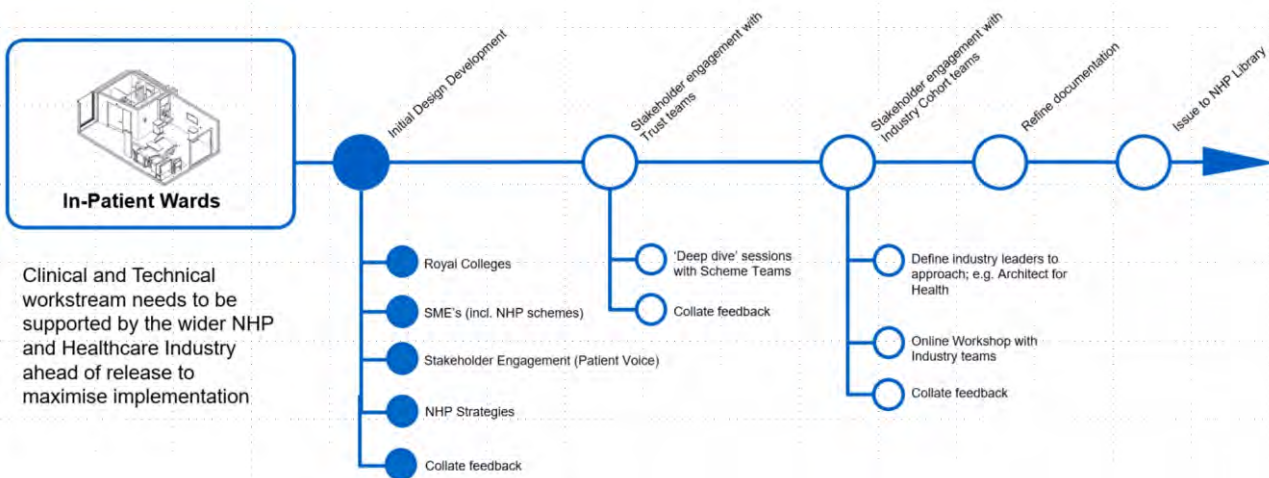
## Combining the Transformational Strategy with the Methodical design process generates best practice

- **100% single rooms** driving improved patient experience
- **Digital solutions** overlaid to reduce workforce burden
- **More efficient spaces** that are ergonomically tested
- **Buy-in from a wide range of stakeholders:**
  - Royal Colleges
  - Patient Engagement Groups
  - Subject Matter Experts
- **Addresses a large impact area for the Programme**

**Highlights**

- 
**Improved patient experience** through improved sleep & privacy, better engagement with therapies and rehab as well as enhanced patient comfort
- 
 Our design studies indicate we can make **efficiencies of up to 2m<sup>2</sup> per bedroom** without impacting patient care
- 
**Design optimised** around workforce productivity e.g., minimising walking distances to reduce fatigue and allow greater observation
- 
 Digital solution enabling **streamlined clinical workflows** through wearable patient monitoring, real-time location services & smart rostering

## Hospital 2.0 Spatial Design Process: Trust Engagement Process



Members of our Clinical and Finance teams visited the recently completed Royal Liverpool Hospital (one the projects impacted by the collapse of Carillion and finished under Cohort 1 of the NHP). The following slide highlights some of the key lessons learnt.

### The Royal Liverpool University Hospital

- 640 single rooms (similar to the number proposed for the new West Suffolk Hospital)
  - 40 Critical Care Service Beds (vs. 16 in WSFT)
  - 18 theatres (similar size to WSFT (12) but less variety)
- RLUH urged the need to understand the number of staff required to safely run services in the new hospital and to plan recruitment / development of necessary skills as early as possible.
  - They delivered the transition to the new site over a 6 week period as they felt a more protracted move would have compromised the training people had received in advance.
  - Planning the move prior to occupation was essential and was achieved using dedicated resources (e.g. you can't expect your established procurement team to procure the equipment needed for the new hospital as the scale and scope is too great).
  - They deployed dedicated transitional teams.
  - RLUH underestimated the costs, time and resources associated with decommissioning the old hospital.
  - They urged the need to understand the revenue impact that a new hospital will have and to establish sufficient tracking for the realisation of financial benefits. Without a full appreciation of these aspects a new hospital could rapidly contribute to a financial deficit.



## The West Suffolk Hospital Way Forward - Healthcare for the future

These lessons highlight the importance of our Workforce (see below) and transformation works streams while also providing valuable insights to potential pitfalls. With specific regards to the revenue impact of building a new hospital, the issue has been flagged and will be progressed nationally as it will apply to every scheme in the programme.

Next steps include the completion of Phase 5 of our co-production process and the subsequent completion of what is aimed to be the final version of our schedule of accommodation.

### **Workforce Workstream**

Following the recruitment of a dedicated leader of Workforce workstream, we have commenced the process for securing the professional support required to model the impact that; future demand; implementation of our clinical strategy and our new hospital (including its digital enablement) will have upon our workforce. 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.

### **Digital Workstream**

Our digital team have been heavily engaged in the co-production of the vision and standards that will underpin the design of the “digital minimum viable product” for all new hospitals.

Special thanks to members of the NHP Transformation Special Interest Group for their assistance and feedback. This included representatives from the following organisations:

The Hillingdon Hospitals NHS Foundation Trust  
James Paget University Hospitals NHS Foundation Trust  
Leeds Teaching Hospitals NHS Trust  
Manchester University NHS Foundation Trust  
Milton Keynes University Hospital NHS Foundation Trust  
NHS Midlands & Lancashire CSU  
The Princess Alexandra Hospital NHS Trust  
West Suffolk NHS Foundation Trust

This work has culminated in the release of the New Hospitals Programme Digital Manual, an overview of which will be presented later in our agenda. It easy to take our own relative digital maturity for granted when the reality for some Trusts in the scheme is that they have yet to move to digital basics such as electronic patient record systems.

## 🏠 | 01 | The NHP Digital Vision

### Introducing the Intelligent Hospital

#### The Intelligent Hospital Concept

The Intelligent Hospital ideal has been designed to enable Trusts to plan NHP Schemes with the future of health care delivery at the centre. It incorporates many moving parts and interdependencies and is continually evolving to maintain pace with emerging technologies and capabilities.

'Intelligent Hospital' will mean different things to different people depending on context, for this reason, there is no single unified definition. Instead, the Intelligent Hospital can be thought of as a convergence of concepts, operational processes, technologies and capabilities spanning physical building/s, environments, assets and the people who interact with these day to day.

New technologies present powerful, and at times daunting opportunities for Trusts to reinvent how care is delivered. The NHP digital programme outlines this motivation and provides the guiding measure for Trusts to develop future-ready, Intelligent Hospitals.

#### Target Digital Outcomes

Derived from the NHP vision for digital are five target outcomes (digital themes) that facilitate realisation of the NHP ambition and aid in steering the Intelligent Hospital concept, these are:

1. Digitally empowered patients;
2. Digitally enabled staff;
3. Hospitals without walls supporting integrated care;
4. Smart buildings;
5. Interoperable and intelligent systems.

NHP Trusts should use these foundational target outcomes as a basis, adapting them to suit their own programme requirements where required. Refer to [Section 02, page 15](#) for a detailed overview of the Target Digital Outcomes.

#### Intelligent Hospital MVP

The NHP Intelligent Hospital Minimum Viable Product (MVP) represents the minimum complete set of digital technologies that should be implemented by Trusts in order to deliver on the NHP ambition and digital vision and respond to target outcomes. The MVP is relevant for Cohort 3 and 4+ Schemes and supports delivery of the NHP mandate and strategic objectives.

Refer to [Section 02, page 28](#) for a detailed over of the Intelligent Hospital MVP.



Figure 1.0

The digital workstream has also been involved in the phase 5 workshops to disseminate the core information from the digital strategy and engage people in the digital ambitions we have going forward.

## Finance

Finances and funding continue remain in line with plan and we are confident of securing full funding for the development of our outline business case. With this case in mind, there will be significant work for our finance team to:

- 1) Update our strategic outline case to reflect the latest version of our schedule of accommodation and its associated costs.
- 2) The development of finance and economic cases for the outline business case.

In order to maintain momentum and avoid lengthy approval processes, the OBC will be 'progressively assured' by colleagues from NHSE, Department of Health and NHP – meaning that, at the point of formal submission, any issues and concerns with our case will have been flagged and mitigated.

As positive as this sounds, all in the finance garden is not rosy and it is with a heavy heart that I have to announce the departure of our Finance Lead, Terry Sparling, who will be leaving us in August to take up an exciting new opportunity in the Private Sector. We obviously wish Terry every success and have commenced the process for the recruitment of a fitting replacement that Terry will work with to ensure an effective hand-over.

All in all, this has been a period in which we have made progress towards the de-risking of our programme and towards the development of our outline business case. In the next period we will have:

- Submitted our updated SOC for sign-off,
- Commenced on-site discussions between statutory consultees and our environmental partner,

- Formally agreed fees for the development of our OBC,
- 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.

**Action Required of the Board**

To note the contents of this report.

<b>Risk and assurance:</b>	-
<b>Equality, Diversity and Inclusion:</b>	-
<b>Sustainability:</b>	-
<b>Legal and regulatory context</b>	-

### 3.3. Integrated Care Board Joint Forward Plan (JFP)




Alex Royan, Deputy Director for Strategic Analytics, SNEE in attendance

To Review



## Board of Directors - Public

<b>Report title:</b>	<b>Suffolk and North East Essex (SNEE) Integrated Care Board (ICB) Joint Forward Plan (JFP)</b>
<b>Agenda item:</b>	3.3
<b>Date of the meeting:</b>	26 May, 2023
<b>Sponsor/executive lead:</b>	-
<b>Report prepared by:</b>	Richard Watson, Deputy Chief Executive, NHS SNEE ICB

<b>Purpose of the report:</b>			
<b>For approval</b> <input type="checkbox"/>	<b>For assurance</b> <input checked="" type="checkbox"/>	<b>For discussion</b> <input checked="" type="checkbox"/>	<b>For information</b> <input type="checkbox"/>
<b>Trust strategy ambitions</b>			
Please indicate Trust strategy ambitions relevant to this report.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

### Executive Summary

1. As mandated by the Health and Care Act 2022, ICBs and partner NHS Trusts / Foundation Trusts must prepare a five-year Joint Forward Plan (JFP) in collaboration with local Health and Wellbeing Boards (HWBs). The JFP describes how Suffolk and North East Essex Integrated Care Board (SNEE ICB) and its partner trusts intends to arrange and provide NHS services to meet its population's physical and mental health needs and how it will work with partners across the Integrated Care System to achieve this. This includes consideration for the delivery of universal NHS commitments and addressing the ICS's four core purposes.
2. As part of the process the JFP has to come to the HWB(s) which are within the geographic area that the JFP covers for discussion and approval.

### Action Required of the Board

To consider and discuss the SNEE JFP as agreed by the ICB Board on 23 May 2023.

<b>Risk and assurance:</b>	
<b>Equality, Diversity and Inclusion:</b>	
<b>Sustainability:</b>	

<b>Legal and regulatory context</b>	
-------------------------------------	--

## SNEE ICB Joint Forward Plan 2023-2028

### 1. Background

As mandated by the Health and Care Act 2022, ICBs and partner NHS Trusts / Foundation Trusts must prepare a five-year Joint Forward Plan (JFP) in collaboration with local Health and Wellbeing Boards (HWBs). The JFP describes how Suffolk and North East Essex Integrated Care Board (SNEE ICB), and its partner trusts intends to arrange and provide NHS services to meet its population's physical and mental health needs and how it will work with partners across the Integrated Care System to achieve this. This includes consideration for the delivery of universal NHS commitments and addressing the ICS's four core purposes.

National guidance states that JFPs must be reviewed and updated or confirmed annually before the start of each financial year. NHSE shared guidance on the development of JFPs with ICBs on 24 December 2022. Key components noted by the guidance for inclusion in the Plan are:

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

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

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

## 2. Overview of JFP and Key Activities

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

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

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

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

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

<b>Start Well</b>	<b>Feel Well</b>	<b>Be Well</b>	<b>Stay Well</b>	<b>Age Well</b>	<b>Die Well</b>
<ul style="list-style-type: none"> <li>• Maternity &amp; Neonatal Care</li> <li>• Children &amp; Young People incl. CAMHS, Neuro Developmental, SEND, Community and LTCs</li> </ul>	<ul style="list-style-type: none"> <li>• Mental Health &amp; Wellbeing</li> <li>• Suicide Prevention</li> <li>• Addictions</li> <li>• Trauma and Abuse</li> </ul>	<ul style="list-style-type: none"> <li>• Healthy Behaviours</li> <li>• Personalised Care</li> <li>• Women's Health</li> <li>• Dental / Oral Health</li> <li>• Eye Health</li> </ul>	<ul style="list-style-type: none"> <li>• Elective Care &amp; Diagnostics</li> <li>• Urgent &amp; Emergency Care incl. community</li> <li>• Cancer</li> <li>• Diabetes</li> <li>• Respiratory</li> <li>• Cardiovascular Disease</li> <li>• Stroke &amp; Stroke Rehab</li> <li>• ME and CFS</li> <li>• Neuro Rehab</li> </ul>	<ul style="list-style-type: none"> <li>• Ageing Well Programme</li> <li>• Dementia</li> <li>• Carers</li> </ul>	<ul style="list-style-type: none"> <li>• End of Life</li> </ul>

- Learning Disabilities & Autism

**Table 1: Joint Forward Plan Live Well Domains**

Each of the areas identified above follows a common methodology in the JFP through setting out:

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

Underpinning our key outcomes, we have developed a small set of top commitments the ICB will make to the population it serves to deliver by 2028. The methodology for developing these takes account of:

- Public engagement feedback
- Partner engagement feedback
- Joint Strategic Needs Assessment (JSNA) findings
- ICS Strategy and Health and Wellbeing Board Strategies
- NHS Long Term Plan and other key national priorities and guidance

Figure one below sets out our seven top commitments to achieve over the next five years.

<b>Our vision</b>	<i>Deliver the best possible health outcomes for every one of the one million people living in Suffolk and North East Essex</i>						
<b>Our outcomes</b>	<b>Start Well:</b> Giving children and young people the best start in life	<b>Feel Well:</b> Supporting the mental wellbeing of our population	<b>Be Well:</b> Empowering adults to make healthy lifestyle choices	<b>Stay Well:</b> Supporting adults with health or care concerns to access support and maintain healthy, productive and fulfilling lives		<b>Age Well:</b> Supporting people to live safely and independently as they grow older	<b>Die Well:</b> Giving individuals nearing end of life choice around their care
<b>Our Five Year Commitments</b>	We will ensure that children and young people have the best chance in life with a particular focus on those most in need	We will support people with mental health needs, including those with learning disabilities or autistic spectrum disorders, to get support in the community to live and thrive.	We will empower people to lead healthy lifestyles and reduce the number of preventable deaths	<b>Access to care:</b> We will support people to access the right support, in the right time, in the right place for their health and care needs	<b>Early intervention:</b> We will support adults with timely access to services to enable early detection and diagnosis of disease and risk factors to give people the best chance of maintaining a good quality of life.	We will ensure that people who are ageing are able to live safely and independently, experiencing a good quality of life	We will enable people and their families to have high quality care and support from all health and care professionals involved at the end of their life
<b>Our cross-cutting priorities</b>	<b>Address health inequalities</b>			<b>Enshrine Equality, Diversity and Inclusion in our ways of working</b>			
<b>Our principles</b>	<b>Collaborative    Compassionate    Courageous    Community focussed    Creative    Cost-effective</b>						
<b>Enablers</b>	<b>Workforce    Estates    Digital Intelligence    Procurement    Communications &amp; Engagement    Research &amp; Innovation    Sustainability</b>						

**Figure One: SNEE JFP Strategic Framework**

For each of the seven commitments we have also set out then the key indicators which we will measure and how we will know we have been successful in achieving our commitment – these can be found within the main body of the JFP at appendix one.

Alongside the six Live Well Domains and the top commitments, the JFP has key sections covering:

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

Our Plan will be delivered through our three place-based Alliances, Ipswich and East Suffolk, North East Essex and West Suffolk, and each is working on their own localised delivery plan by the end of May 2023.

Appendix One to this report provides a copy of the final SNEE JFP which is made up of a short executive summary and then the main document. A series of appendices are available on request which provide further detail of each of the Live Well domain plans and other linked strategic plans.

### **3. Patient and Public Engagement**

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

A JFP Communications and Engagement Sub-Group was established to plan out key activities to support the promotion of the public engagement exercises. This involved use of newspaper advertisements, social media promotion, press releases, articles in stakeholder briefings and website content.

Rather than starting a fresh gathering insight and experience for the JFP, the ICB was able to refer back to priorities and issues raised in numerous engagement and coproduction activities that have taken place across Suffolk and NEE. On this basis the aim of engaging people and communities in the JFP was to enable effective and meaningful involvement and to ensure all people and communities have the opportunity to comment, either on the sections most important to them or the whole document. In planning how to involve people meaningfully.

The engagement was designed to follow the domains, mirroring the format of the plan itself. Using the engagement platform LetsTalkSnee.co.uk a series of web pages were developed to define and break down each domain, outlining the key priorities. A series of public meetings were held for people who preferred to take part in person.

The engagement activity ran from Monday 16<sup>th</sup> of January until Wednesday 22<sup>nd</sup> February. During which time there were over 1000 visits to the engagement platform, 340 voted using quick polls, 280 ideas were submitted and there were 330 downloads of the draft document and executive summary. Approximately 100 people attended an in person meeting.

There were eight core themes raised through the engagement activity:

1. **Access** – This related to access to any service, primary care, secondary care, specialist care and community services, or to opportunities and activities to support healthy living. It also included the ability to get to and from appointments and activities
2. **Mental health** – This included services for both children and young people and adults
3. **Prevention, health education and information** – Supporting and enabling people and communities to manage their own health, stay health and know how to access support
4. **Personalisation and reasonable adjustments** – Both personalised care in response to a person's specific conditions and the adjustments made to support good health outcomes This might include communication, physical access or cultural competence
5. **Digitalisation** – To be aware of both the innovation and progress that can be provided through the use of new technology, whilst also recognising that not everyone is willing or able to use technology
6. **Workforce** – This included recruitment, retention, training and wellbeing
7. **Primary Care** – Further development of primary care across Suffolk and North east Essex
8. **Children and Young people with Special Educational Need** – services, support and interventions to support young people with a special educational need

#### 4. Next Steps

The JFP has gone through the Suffolk and Essex Health and Wellbeing Boards and was considered by the SNEE ICB for approval at its meeting on 23 May 2023. The JFP will then be formally published during early June 2023.

Thereafter, the JFP will be refreshed on an annual basis including a stocktake of how far we have achieved the priorities set out within the plan.

A photograph of a doctor in a white coat and a young woman sitting at a table. The doctor is on the left, looking towards the woman. The woman is on the right, smiling. A stethoscope is on the table in front of her. The image is overlaid with a large, semi-transparent graphic of overlapping geometric shapes in shades of green and blue on the left side.

# Joint Forward Plan 2023 – 2028

JUNE 2023



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# 1 Foreword

## By Chair and Chief Executive

We are delighted to introduce our Joint Forward Plan for NHS Suffolk and North East Essex Integrated Care Board (ICB). It has been built on the views of the community that we listened to during our engagement exercise and drafted with the input of many colleagues in our system. Our vision is to deliver the best possible outcomes for every one of the million people in Suffolk and North East Essex.

Our ICB is part of an equal partnership across the NHS, Local Government and Voluntary, Community and Social Enterprise Sector (VCSE) increasingly characterised by positive relationships between local health and care leaders, courageous joint action to address problems and a genuine 'Can Do' attitude that enables meaningful partnership and integrated thinking and working at every level. We are committed to improving health and wellbeing outcomes for the local population we serve and we are ambitious about what we can achieve together.

Our ICB plays an important role in this system by bringing the local NHS together in a spirit of collaboration and driving forward improvements to our services. In the past year we have seen extraordinary efforts to reduce long waiting times, significantly increase volumes of cancer treatments and to maintain safe services during periods of industrial action, to name three examples. In the coming years, we are determined to deliver further improvements across a wide range of areas captured

in this Joint Forward Plan. The golden thread that runs through this plan is our ambition to tackle health inequalities, namely the significant gap in life expectancy that we see in our system.

The plan sets out a series of commitments based upon our 'live well' domains, beginning with 'start well' through to 'die well'. We will assess our performance in delivering our commitments over the next five years by measuring performance against one or more target indicators in each domain. These are the lead key performance indicators that we wish to 'target' improvements in, with a particular focus on reductions in health inequalities. We have so many enablers and assets in Suffolk and North East Essex to deliver this plan. Our most important asset is our communities and workforce and the culture of collaboration that we aim to build.

We hope you enjoy reading the plan and that it inspires you to support its delivery. Thank you for everything you do to support the health and wellbeing of our population in Suffolk and North East Essex.



*Will Pope, Chair  
Suffolk and North East Essex ICB*



*Ed Garratt, Chief Executive  
Suffolk and North East Essex ICB*



## 2 Executive Summary

### 2.1 Scope of the Joint Forward Plan

This document sets out a five-year delivery plan for the Suffolk and North East Essex (SNEE) Integrated Care Board (ICB)<sup>1</sup>. The Joint Forward Plan (JFP) explains how SNEE ICB, as a statutory organisation, will contribute to the collective ambitions of the SNEE Integrated Care System (ICS), through its role as an NHS commissioner as well as through its role in bringing together health and care partners to deliver shared leadership and joint action to improve the health and wellbeing of the one million people who live locally.

ICBs and their partner NHS Trusts and NHS Foundation Trusts are required to prepare an annual JFP in line with the legal responsibilities of the ICB and its partners as set out in the Health and Care Act 2022. This delivery plan describes a series of delivery priorities and measurable targets the SNEE ICB aims to attain over the period 2023 to 2028. It articulates detailed delivery plans and how delivery priorities are informed by local, regional, and national strategic drivers.

In doing so, this document aligns to the three principles of JFPs<sup>2</sup>:

- Fully aligned with the wider system partnership's ambitions
- Supporting subsidiarity by building on existing local strategies and plans as well as reflecting the universal NHS commitments
- Delivery-focused, including specific objectives and milestones for the ICB to attain by 2028

NHS bodies have a common duty (referred to as the 'Triple Aim') to have regard to wider effect of their decisions on:

- The health and wellbeing of our people
- The quality of services provided or arranged by SNEE ICB and other relevant bodies
- The sustainable and efficient use of resources by SNEE ICB and other relevant bodies

The JFP articulates SNEE ICB's wholehearted commitment to delivering on the 'Triple Aim' by improving public health, preventing ill-health, and reducing health disparities for our population.

<sup>1</sup> The SNEE ICB covers the whole of Suffolk except Waveney which is part of the Norfolk and Waveney ICB

<sup>2</sup> Guidance on Developing the Joint Forward Plan December 2022

<https://www.england.nhs.uk/wp-content/uploads/2022/12/B1940-guidance-on-developing-the-joint-forward-plan-december-2022.pdf>

## 2.2 Our Population

There are 1,058,560 people registered with General Practitioners (GPs) across SNEE – 413,188 in Ipswich and East Suffolk 370,589 in North East Essex and 265,688 in West Suffolk<sup>3</sup>.

Of the population whose ethnicity is known, the majority are White (94.7%), higher than the national average of 86.7%. Of the remaining population, 2.1% are Asian/Asian British (national average is 7%), 1% are Black/African/Caribbean/Black British (national average is 3.1%), 1.7% are Mixed/Multiple Ethnic Groups (national average is 2.1%) and 0.5% are classified as Other (national average is 0.95%). The proportion of people aged over 65 across SNEE is 23%, higher than the England average of 19%<sup>4</sup>.

SNEE is spread across a mix of urban, rural and coastal areas, with pockets of significant deprivation - there are 116,673 people in SNEE living in the 20% most deprived areas nationally, of which the majority live in Tendring and Ipswich. This includes the Brooklands and Broadway areas of Jaywick, which are the most deprived Lower Super Output Areas (LSOAs)

in the country, whilst Ipswich is the most deprived area in Suffolk; 46% of LSOAs in Ipswich are in the most deprived 30% nationally. West Suffolk has one LSOA in the 20% most deprived nationally in St Edmundsbury in Bury St Edmunds.

Differences in the level of deprivation across SNEE has undoubtedly accelerated the emergence of health inequalities. There is a life expectancy gap between individuals born in the most deprived communities in SNEE and those in the least deprived. The difference in average life expectancy is 7.4 years in men and 5.9 years in women<sup>5</sup>.

Different causes of death contribute to the difference in life expectancy between our most deprived and least deprived communities. Leading causes of death include circulatory conditions, cancer and respiratory conditions. Several underlying risk factors are implicated in their causation, including tobacco, high body mass index, diabetes, dietary risks, high blood pressure and alcohol.

## 2.3 Engagement feedback

SNEE ICS has a collective ambition for everyone in *Suffolk and North East Essex to be able to 'Get Involved' in our work*. Consistent with this, the JFP is built on the engagement work carried out in the development of the ICS Strategy, which took place with people living and working in SNEE from September to December 2022. Over 600 people responded via online surveys, community group discussions, a pop-up video booth and direct contact with the ICP team to inform the strategy. Between 16 January and 22 February 2023, further engagement was undertaken on the draft JFP. During this period, there were over 1,000 visits to the LetsTalkSNEE platform, 340 people voted using quick polls, 280 ideas were submitted and there were 330 downloads of the draft document and executive summary. Approximately 100 people attended an in-person

meeting. The aim was to enable effective and meaningful involvement and to ensure all people and communities had the opportunity to contribute to the development of this document.

Eight core themes on what matters most to people were identified:

1. **Access** – Including access to all services as well as opportunities and activities to support healthy living. People also noted the ability to get to and from appointments and activities
2. **Mental health** – Including services for both children and young people and adults
3. **Prevention, Health Education and Information** – Supporting and enabling people and communities to manage their own health, stay healthy and knowing how to access support

<sup>3</sup> Patient registered at a GP practice (March 2023) NHS Digital  
<https://digital.nhs.uk/data-and-information/publications/statistical/patients-registered-at-a-gp-practice/march-2023>

<sup>4</sup> Source: Shape and ONS data 2023

<sup>5</sup> Source: <https://www.gov.uk/government/publications/health-inequalities-place-based-approaches-to-reduce-inequalities/place-based-approaches-for-reducing-health-inequalities-main-report>

4. **Personalisation and reasonable adjustments** – Both personalised care in response to a person’s specific conditions and the adjustments made to support good health outcomes. This might include communication, physical access or a person’s cultural beliefs and values
5. **Digitalisation** – The importance of being aware of innovations and progress that can be enabled through the use of new technology, whilst also recognising that not everyone is willing or able to use technology
6. **Workforce** – Consideration for recruitment, retention, training and wellbeing
7. **Primary Care** – Development of primary care across SNEE
8. **Children and Young people with Special Educational Need** – services, support and interventions to support young people with a special educational need

The JFP explains how we have incorporated this feedback into identification of our priorities and delivery plans and how this has been triangulated with other strategic drivers. Please see Appendix xx for a full report on our engagement work.

## 2.4 Strategic drivers

There are a number of strategic drivers at a national, regional or local level that influence the priorities and delivery plans set out in the JFP.

### 2.4.1 National context

The **NHS Long Term Plan (2019-2029)** sets out the national 10-year strategy to make the NHS fit for the future and improve care by:

- Making sure everyone gets the best start in life
- Delivering world-class care for major health problems
- Supporting people to age well

As an ICB, we will collaborate across all sectors to deliver the objectives of the NHS LTP by listening to what local people say, and co-produce solutions that provide the right care and support for people and communities.

The JFP also provides our response to how we will deliver on **universal NHS commitments**, including (but not limited to) commitments on service recovery, such as the ‘delivery plan for tackling the COVID-19 backlog of elective care’ and the ‘delivery plan for recovering urgent and emergency care services’.

Published in May 2022, the **Fuller Stocktake Report** considers how the implementation of integrated primary care can be accelerated by incorporating the current four pillars of general practice, community pharmacy, dentistry, and optometry across systems.

SNEE ICB’s local response to the LTP and Fuller Stocktake Report is set out through the JFP.

### 2.4.2 Regional and local context

The Integrated Care Strategy for SNEE ICS ([www.sneeics.org.uk](http://www.sneeics.org.uk)) describes a shared vision from the perspective of ‘what matters’ to people living in SNEE. The ICS is united on four collective ambitions:

- The **best health and wellbeing** a genuine reality for all
- The opportunity of **health equality** for everyone
- Everyone able to **‘Live Well’** – Start Well, Be Well, Stay Well, Feel Well, Age Well, Die Well
- A genuinely **‘Can Do’ Health and Care System** that people can trust

The Essex and Suffolk **Joint Strategic Needs Assessments (JSNAs)** assess the current and future health and care needs of the SNEE population and the key priorities are set out in the local **Joint Health and Wellbeing Strategies**. This includes priorities across public health, mental health and wellbeing, children, and young people’s services, supporting independent living, and addressing the wider determinants of health and health inequalities.

The JFP responds to all these regional and local ambitions, setting out the ICB’s contribution to their achievement.

### 2.4.3 Service demand

Across the country the performance of health and care organisations is set against a challenging backdrop of increasing demand for services. There are underlying demand pressures driven by demographic growth and morbidity changes. The NHS is currently experiencing challenges with workforce retention and skills gaps persist nationally.

The population of SNEE ICS is estimated to increase by 10% by 2036<sup>6</sup> and the proportion of the population aged over 75 will increase from 10.3% in 2018 to 13.8% in 2032, an additional 45,000 people. The prevalence of multimorbidity (people with more than two illnesses or diseases) is between two and three times greater in the plus 75-year-old population relative to working age adults and an ageing population will have a greater health and care need. The JFP sets out how we will respond to this through initiatives to manage demand for services and maximise the capacity of our services.

### 2.4.4 Cost of living challenges

SNEE ICB is conscious of the ongoing cost of living challenges driven by sharp increases in the cost of energy and food prices and ongoing inflationary pressures.

SNEE ICB will respond to this through a commitment to:

- Contribute to wider initiatives to co-ordinate and promote support to those who need it most
- Combat the stigma of needing support
- Identifying the people who use our services who are struggling
- Identifying our staff and volunteers who may be struggling

### 2.4.5 Financial position

Prior to the pandemic, the NHS organisations in SNEE had delivered strong financial performance. Extraordinary amounts of additional funding were provided to systems as part of the emergency financial regime put in place by NHSE in response to the pandemic. In 2022/23, as part of the move towards “normal” funding levels, the impact on the system was a funding reduction of £97m (5%) of our total allocation. We are expecting a similar level of financial challenge for each of the next two financial years and based on the current economic outlook it would be difficult to assume an improvement in the funding position beyond 2025. This, in common with the wider NHS, has had the effect of exposing an underlying and recurrent financial deficit which will require addressing over the short and medium term. The JFP is, therefore, a key milestone as it is the first opportunity post the pandemic response to outline how we will endeavour to deliver within financial constraints over the medium term.

## 2.5 Our vision and principles

Our vision, shared with ICS partners, is to deliver the **best possible health outcomes for every one of the one million people living in SNEE**. This JFP set outs the ICB’s contribution to delivering on this vision over the next five years.

A collective ambition of the SNEE ICS is to *enable everyone in SNEE to ‘Live Well’*. SNEE ICB has therefore adopted, organised itself, and defined its delivery priorities using the six domains of the Live Well model which also set out our six overall outcomes we wish to achieve as below:

1. Start Well – Giving children and young people the best start in life

2. Feel Well – Supporting the mental wellbeing of our population
3. Be Well – Empowering adults to make healthy lifestyle choices
4. Stay Well – Supporting adults with health or care concerns to access support and maintain healthy, productive and fulfilling lives
5. Age Well – Supporting people to live safely and independently as they grow older
6. Die Well – Giving individuals nearing end of life choice around their care

<sup>6</sup>Office for National Statistics. Population projections for clinical commissioning groups and NHS regions. <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/clinicalcommissioninggroupsinenglandtable3>. Published 2020. Accessed November 2022.

Our six Live Well Domains and the priorities there within are underpinned by a focus upon reducing health inequalities for our local population. SNEE ICB will contribute to the ICS collective ambitions to make *the **best health and wellbeing** a genuine reality for all and provide the opportunity of **health equality** for everyone* through the way in which it will work, by embedding a population health management approach and strong focus on directly targeting and addressing health inequalities.

Furthermore, SNEE ICB will work with its health and care partners across the system, in placed-based Alliances, across both counties, and within neighbourhoods to achieve the ICS collective ambition for all parts of the local health and care system to be **working together as ONE team**.

SNEE ICB will do this by adopting the ICS' six core principles for achieving a **'Can Do' Health and Care System that people can genuinely trust**.

- **Collaborative** – by focusing on system leadership and culture, supporting our people and workforce across all sectors
- **Compassionate** – by focusing on personalised care in all sectors, supporting family carers and enabling genuine co-production
- **Courageous** – by focusing on enabling equity, inclusion and social justice, ensuring clinical and care quality across all sectors and enhancing the roles of all clinical and care professionals
- **Community focussed** – by focusing on enabling a resilient VCFSE sector, the importance of volunteering and the roles of Community Connectors, Anchor Institutions and community pharmacy
- **Creative** – by focusing on the use of digital, data and technology, innovation and research and environmental sustainability
- **Cost-effective** – by focusing on financial sustainability and the effective use of our collective health and care

## 2.6 Our delivery priorities

### 2.6.1 Health inequalities

Health inequalities are unfair and avoidable differences in health and wellbeing across the population, and between different groups within society. These inequalities are evident for people living in SNEE. Addressing health inequalities therefore is a key priority for SNEE ICB. Effective action to address health inequalities in SNEE will require a coordinated and whole-system approach, with targeted prevention work using population health management as an enabler.

Our work on Health Inequalities will be informed by seven key areas:

1. Reducing health inequalities by levelling up is core business for everybody
2. We will match resources to need
3. We are data informed and evidence based
4. We do this work through community centred approaches and coproduction
5. We target our efforts through a Core 20 Plus 5 and prevention frame
6. We use our position as Community Anchors to tackle the 'causes of the causes'
7. Our services and communication are digitally inclusive

These priorities will be overseen by the Health Inequalities and Prevention Committee (HIPC) chaired by the Suffolk Director of Public Health to provide a focal point and strategic leadership on reducing health inequalities and embedding prevention across the ICB.

In addition, current system-wide actions are being taken to address health inequalities themed around five priority areas:

- Restoring NHS services inclusively
- Mitigating against digital exclusion by providing equitable options through digital and non-digital routes, whilst understanding that some people prefer not to use technology
- Ensuring datasets are complete and timely
- Accelerating preventative programmes that proactively engage those at greatest risk of poor health outcomes (including Core 20 Plus 5 approach)
- Strengthening leadership and accountability

## 2.6.2 Equality, diversity and inclusion in the workforce

The work delivered by SNEE ICB would not be possible without the critical contribution of its diverse workforce. Diversity includes an array of characteristics – including ethnicity, disability, gender, national origin, sexual orientation, age and religion – some of which are under-represented in certain NHS careers.

SNEE ICB has committed to delivering the principles agreed by the SNEE ICP in December 2022 to ensure equality, diversity and inclusion (EDI) is enshrined within its ways of working. SNEE ICB will develop a five-year EDI strategy and objectives by the end of June 2023. This will articulate how we shall provide safe environments for learning and encourage a system-wide understanding, discourse and reduction of bullying, harassment or any other form of victimisation of people from protected characteristics. To date, our system-based work has focussed on race, including a commitment to deliver the regional anti-racism strategy. However, our body of work will expand to drive improvement in the following areas across the ICS:

- We will fully own our individual and collective responsibility to take immediate action to get the basics right, recognising the fundamental importance of EDI in the health and care workforce

- We will have a collective vision that in the future we should think about EDI as a business-as-usual function in health and care, because we will all be accepting of diversity and difference
- We will encourage diversity of thinking in system and pathway transformation
- We will empower our staff in health and care with appropriate resource and education

## 2.6.3 Our commitments

As part of the ICS shared vision to deliver the **best possible health outcomes for every one of the one million people living in SNEE**, we want to *enable everyone in SNEE to 'Live Well'*. Our delivery priorities are organised on the six live well domains and are underpinned by a focus upon reducing health inequalities for our local population and ensuring EDI is central to our work.

The table below shows our strategic framework. For each Live Well domain, which articulates the outcomes we are aiming to achieve, SNEE ICB are making an overarching five-year commitment. These commitments relate to the outcomes we will strive to deliver, as articulated in the SNEE ICS strategy, what we heard is important to our population, and what our workforce and partners tell us that we need to do better or do differently to improve the services we deliver.





Table 1: Our Strategic Framework

<b>Our vision</b> Deliver the best possible health outcomes for every one of the one million people living in Suffolk and North East Essex							
Our outcomes	Start Well:	Feel Well:	Be Well:	Stay Well:		Age Well:	Die Well:
	Giving children and young people the best start in life	Supporting the mental wellbeing of our population	Empowering adults to make healthy lifestyle choices	Supporting adults with health or care concerns to access support and maintain healthy, productive and fulfilling lives		Supporting people to live safely and independently as they grow older	Giving individuals nearing end of life choice around their care
Our Five Year Commitments	We will ensure that children and young people have the best chance in life with a particular focus on those most in need	We will support people with mental health needs, including those with learning disabilities or autistic spectrum disorders, to stay mentally well and to get support in the community to live and thrive when they need it	We will empower people to lead healthy lifestyles and reduce the number of preventable deaths	Access to care: We will support people to access the right support, in the right time, in the right place for their health and care needs	Early intervention: We will support adults with timely access to services to enable early detection and diagnosis of disease and risk factors to give people the best chance of maintaining a good quality of life	We will ensure that people who are ageing are able to live safely and independently, experiencing a good quality of life	We will enable people and their families to have high quality care and support from all health and care professionals involved at the end of their life
Our cross-cutting priorities	Reduce health inequalities		Enshrine Equality, Diversity and Inclusion in our ways of working				
Our principles	Collaborative    Compassionate    Courageous    Community focussed    Creative    Cost-effective						
Enablers	Workforce    Estates    Digital    Intelligence    Procurement Communications & Engagement    Research & Innovation    Sustainability						

We will assess our performance in delivering our commitments over the next five years by measuring performance against one or more target indicators in each domain. These are the lead key performance indicators that we wish to 'target' improvements in, with a particular focus on reductions in health inequalities. Delivery against the target indicators will be achieved through a broad programme of work detailed in full in the JFP and supporting annexes.

## Start well:

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- Reduce the neonatal mortality rate by end of 2023/24 and reduce each year thereafter, addressing inequalities by prioritising reduction in unwanted variation in neonatal mortality
- By 2028, no child or young person waits more than 12 weeks for Child and Adolescent Mental Health Services (CAMHS) or 18 weeks for Neurodevelopmental Diagnostic (NDD) Services, prioritising reductions in waiting times for ethnic minorities and those living in the 20% most deprived areas
- Reduce the hospital admission rate due to asthma of children or young persons living in the most deprived 20% of areas

## Feel well:

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- Achieve a 5% year-on-year increase in the number of adults supported by community mental health services
- Achieve a year-on-year reduction in hospital admission rate for mental health conditions
- Identify and reduce health inequalities amongst people with severe mental illness, by ensuring at least 90% of people, including those in all disadvantaged groups, receive a full annual physical health check and follow-up interventions by 2028

## Be well:

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- Halt recent increases in the number of overweight and obese children in reception and year 6 by 2028 and maintain prevalence below the national average
- Reduce the number of smokers in our population in line with only 5% of the population being smokers by 2030
- Increase each year the number of units of NHS dental activity delivered

## Stay well:

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### Access to care

- Increase our GP practice teams each year to meet the growing demand whilst increasing the number of trainees and apprentices
- No one waits more than one year for elective care by March 2025
- Increase by 10% each year the number of cases seen by the urgent community response service;
- By 2028, 95% of patients attending A&E services wait no longer than 4 hours
- Reduce the number of acute hospital bed days utilised by people without a criterion to reside that are discharged on complex pathways (1-3)

Early intervention, prioritising early diagnosis and treatment for people living in the 20% most deprived areas

- Increase the percentage of cancers diagnosed at stages 1 and 2 to 75% by 2028
- 80% of people with high blood pressure are identified and treated by 2028
- More than 85% of people with Atrial Fibrillation are identified and 90% of those at high risk of stroke are treated by 2028

## Age well:

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- Reduce each year the rate of emergency hospital admissions due to falls amongst the population aged over 65
- Reduce each year emergency acute hospital bed use (bed days per capita) for those over 65 years old
- Achieve the national 66.7% dementia diagnosis rate by October 2024 and an increase in dementia annual care plan reviews completed each year

## Die well:

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- Increase each year the percentage of people identified as approaching the end of life

## Health Inequalities (cross cutting):

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- By 2028, reduce the number of deaths in under 75s considered preventable, reducing inequalities in our most deprived areas and amongst disadvantaged groups

The table below sets out the work programmes within each Live Well domain. However, SNEE ICB recognises that there are key cross-cutting themes that apply to all areas of an individual's health, such as GP primary care, personalised care, access to physical care for people with learning disabilities, consideration of carers and prevention, and parity in healthcare access for all which should be considered across each of the domains. Across each domain we will target our efforts through a health inequalities (including Core 20 Plus 5) and prevention frame.

Table 2: Work programmes in each Live Well domain

Work Programmes	
<b>Start Well</b>	<ul style="list-style-type: none"> <li>• Maternity and Neonatal Care</li> <li>• Children and Young People incl. CAMHS, Neuro Developmental, SEND, Community and Long Term Conditions</li> </ul>
<b>Feel Well</b>	<ul style="list-style-type: none"> <li>• Mental Health and Wellbeing</li> <li>• Suicide Prevention</li> <li>• Addictions</li> <li>• Trauma and Abuse</li> </ul>
<b>Be Well</b>	<ul style="list-style-type: none"> <li>• Healthy Behaviours</li> <li>• Personalised Care</li> <li>• Women's Health</li> <li>• Dental / Oral Health</li> <li>• Eye Health</li> </ul>
<b>Stay Well</b>	<ul style="list-style-type: none"> <li>• Elective Care and Diagnostics</li> <li>• Urgent and Emergency Care incl. community</li> <li>• Cancer</li> <li>• Diabetes</li> <li>• Respiratory</li> <li>• Cardiovascular Disease</li> <li>• Stroke and Stroke Rehab</li> <li>• ME and CFS</li> <li>• Neuro Rehab</li> <li>• Learning Disabilities and Autism</li> </ul>
<b>Age Well</b>	<ul style="list-style-type: none"> <li>• Ageing Well Programme</li> <li>• Dementia</li> <li>• Carers</li> </ul>
<b>Die Well</b>	<ul style="list-style-type: none"> <li>• End of Life</li> </ul>

## 2.7 How we will work differently

The SNEE ICB will focus on twelve key areas where we will work differently to achieve the delivery priorities of the Live Well domains. We will work in a collaborative way, contributing to the ICS achieving its collective ambition for all parts of the local health and care system to be **working together as ONE team**. And we will do this by embodying the ICS' six core principles of a **'Can Do' Health and Care System**.

**1. Collectively accountable:** SNEE ICB has developed in partnership a framework that describes how we will work together while ensuring public accountability of the whole health and care system. We have developed a Functions and Decision Map which sets out the governance for the new integrated NHS in SNEE<sup>7</sup>

**2. Alliances:** Our three 'place-based systems of care' are known locally as Alliances: 'North East Essex', 'West Suffolk' and 'Ipswich and East Suffolk' Alliance, each defined by the footprint of local health and care partners as well as natural geography. The Alliances of NHS, local authority, independent, voluntary and community sector partners work together with common purpose to plan and delivery meaningful integrated care to their local populations, given their distinct needs and assets

<sup>7</sup><https://suffolkandnortheastsex.icb.nhs.uk/about-us/our-policies/>

3. **Neighbourhoods:** Neighbourhoods will enable health and care teams to focus on smaller, identifiable populations based on particular characteristics or needs. This enables greater flexibility by allowing different areas to find unique solutions for their challenges. Alliances oversee and support neighbourhood arrangements that cater to local populations, further embedding collaboration. Integrated Neighbourhood Teams and Care Closer to Home teams will bring together physical, mental health and social care practitioners that work with General Practices (GPs) to provide a single coordinated care response for people, underpinned by prevention, self-care, early intervention, reablement and rehabilitation
4. **General practice and Primary Care Networks (PCNs):** GP Primary care remains the first point of contact for many people seeking health services. PCNs are crucial to the implementation of both the NHS Long Term Plan and this JFP, through more resilient delivery in local neighbourhoods, and the integration of health and care services to better respond to the needs of local populations. PCNs are key to addressing the wider ICS ambitions to improve population health and wellbeing, and building lasting relationships between partners, as recommended in the Fuller Stocktake Report. There are 22 PCNs across SNEE, providing essential primary care services with comprehensive coverage of the whole ICS area
5. **Collaboratives:** Collaboratives see providers come together to provide the best possible services at scale. There are three core Provider Collaboratives in SNEE. The two integrated community and acute Trusts, West Suffolk NHS Foundation Trust (WSFT) and East Suffolk and North Essex NHS Foundation Trust (ESNEFT), are increasingly working together as one collaborative, whilst we are now establishing a new Suffolk Mental Health Collaborative and we are exploring development of a new Southend, Essex and Thurrock All Age Mental Health System Implementation Group
6. **Voluntary, Community and Social Enterprise:** Our local VCSE infrastructure organisations see a range of opportunities to increase the impact of the sector and build on the commitment to the VCSE sector being an equal partner within the ICS. The SNEE ICB fully endorses these opportunities and is committed to turning them into a reality
7. **Specialised Commissioning:** Specialised services support people with a range of rare and complex conditions. NHSE has stated that specialised commissioning functions and budgets for some specialised services will be delegated from NHSE to ICBs from April 2024
8. **Population Health Management (PHM):** In line with our PHM Strategy, we have made significant investment our digital and data infrastructure and intelligence on population health need, and this will enable the design and delivery of a PHM approach. We will be deploying this new resource to understand both the causes and consequences of health inequalities in SNEE, supporting the development of new interventions and service models
9. **Medium Term Financial Plan:** We are committed to using our resources in the most efficient and cost-effective way possible. We will develop a medium term financial plan underpinned by realistic and deliverable plans at an organisational level as well as cross-system transformation. We aim to develop sustainable solutions that will enable us to recover service standards whilst continuing to transform local services
10. **Quality and Safety:** We will improve the quality and safety of health services for people in SNEE and create a health service that people and staff are proud of by: sharing and getting better at what we are good at, working closely with the public and our communities, clearly describing how we will improve and monitor quality, and working closely together to share responsibility for our work. The ICB has described how it intends to achieve this in the SNEE ICS Quality Improvement Strategy
11. **Clinical and Professional Leadership:** Health Equality for Everyone requires our health and care professional leaders to work together as partners to deliver services which meet the distinct needs of our people. SNEE ICS currently offers high impact One Team leadership development programmes for clinicians, managers, nurses, social workers and allied health professionals. These programmes are designed to build a network of effective leaders who can address the challenges in the health and social care system now and in the future
12. **Working in Partnership with People and Communities:** SNEE ICB strives to involve local people and communities in activities by promoting a culture of collaboration, respect, equality and transparency. We use a combination of virtual and face to face forums to ensure a wide range of people are engaged in our work

## 2.8 Enablers

The SNEE ICB will focus on eight key enablers to the successful delivery of the JFP, as noted below:

- 1. Workforce:** Strengthening our health and care workforce is the key enabler to delivering the benefits to the people living in SNEE. We will enable this to happen by following the four pillars of the NHS People Plan: looking after our people, belonging in the NHS, new ways of working and delivering care, growing for the future. Our ambition for our population is to have an integrated workforce that delivers care at the right time; in the right way; in the right place; by the right person
- 2. Estates:** Our ambition for our population is to have an integrated estate that allows the delivery of care at the right time; in the right way; in the right place; by the right person. Our Estates Infrastructure Strategy will address an ageing estate and maintenance backlogs, population growth, high levels of demand for services, pressures on revenue budgets for ongoing and future estate development, and a national desire to move service from acute sites to within community settings
- 3. Digital:** We will focus on i) leading system-wide action on data and digital: working with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services to put people at the centre of their care; and ii) using joined-up data and digital capabilities to understand local priorities, track delivery of plans, monitor and address unwarranted variation, health inequalities and drive continuous improvement in performance and outcomes. How will deliver this is set out in the SNEE ICS Digital, Data and Technology (DDaT) Strategy
- 4. Intelligence:** We aim to maximise the utility and value of our data and to use insights from analysis of data to become an intelligence-led system. This means integrating our data across organisations and providing insights on our population's health and care needs, from person to system level. We will provide analysis to drive a shift towards PHM and to support decision making processes, including by ensuring all ICB Committees are supported by an up-to-date understanding of activity, performance, and health inequalities
- 5. Procurement:** The principal aim of procurement is to deliver essential goods and services and improve outcomes, while increasing value from every pound spent by the NHS. The SNEE ICB and partner Trusts are moving towards closer collaboration to procure common items together. The ICB will act as an Anchor Organisation to procure for social benefit. We are working to further develop and integrate the use of a single e-commercial system which enables NHS organisations to have visibility of each other's sourcing and contract management systems
- 6. Communications and Engagement:** ICB communications, public relations and engagement is central to service changes, new ways of working and communicating with internal and external audiences. We are dedicated to ensuring everyone has an opportunity to influence our decisions and co-design NHS services. We work with our partners in the NHS, local authority and VCSE sector to support people to better manage their health and meaningfully engage with the public, patients and carers to influence and support our commissioning decision making
- 7. Research and Innovation:** Our ambition is to build a culture of research and innovation across our ICS that is responsive to those in most need in our communities. We will align innovation priorities with research strategy and ensure timely translation of research in to practice. We will embed coproduction in research and innovation to ensure the patient voice is integral to our work. We will develop a peer network of researchers and innovators to offer a range of opportunities to meet, learn, collaborate, share, and review research and innovation. We will share learning within our ICS and more widely, to help promote best practice regionally and nationally. With all our system partners, we will research and deliver innovative solutions that address our key local challenges and that make a positive and lasting health impact for our people

**8. Sustainability:** We are acutely aware of the importance of sustainability in all our work, now and in the future. Environmental protection, tackling climate change and restoring nature are intrinsically linked to the health of our communities. Sustainability therefore not only supports the delivery of the JFP, but it also

underpins its overarching needs. A Green Plan<sup>8</sup> for 2022 to 2025 for SNEE ICB has been agreed, detailing our current sustainability goals. We will continue to work closely with our partners across health, VCSE and public sector organisations. We will use our position to provide leadership and identify, share, and integrate resources and expertise

## 2.9 Managing delivery of the Joint Forward Plan

SNEE ICB has established several committees to assist it with the discharge of its duties and functions, including the delivery of the key priorities and goals set out in the JFP. The ICB Board remains accountable for all functions, including those that it has delegated to committees and subcommittees.

The ICB will undertake a continuous appraisal of the position, performance, and delivery of the key priorities and goals set out in the JFP via the ICB committees. The System Oversight and Assurance Committee (SOAC) has been established by the Board to support managing improvement, development and performance at ICS level. SOAC is a data-driven, evidence-based and rigorous committee that provides focus on supporting the spread and adoption of innovation and best practice between partners.

SNEE ICB is held to account by NHSE for performance through the NHS Oversight Framework which sets out a broad range of measures. In addition, the JFP has set out local performance priorities that are important to the local population. Together these metrics form the ICB's performance framework.

The ICB will publish an Annual Report in accordance with any guidance published by NHSE that sets out how it has discharged its functions and fulfilled its duties in the previous financial year.

The JFP is a public document that will be reviewed, updated and confirmed annually.



<sup>8</sup>[www.sneeics.org.uk/can-do-health-and-care/creative/environmental-sustainability](http://www.sneeics.org.uk/can-do-health-and-care/creative/environmental-sustainability)



## 3 Scope of this Document

### 3.1 Scope of the Joint Forward Plan

In line with the Health and Care Act 2022, Integrated Care Boards (ICBs) and their partner NHS Trusts and NHS Foundation Trusts are required to prepare an annual Joint Forward Plan (JFP) at the beginning of the financial year. Legal responsibility for the Suffolk and North East Essex (SNEE)<sup>9</sup> JFP resides with the ICB and partner NHS Trusts and NHS Foundation Trusts. Primarily, this document sets out a shared five-year delivery plan for the ICB to contribute to the achievement of the ambitions of the integrated care strategy of SNEE Integrated Care System (ICS).

This Plan has therefore been developed in collaboration with a range of groups from across the system including stakeholders from:

- Acute and Community Trusts
- Care Homes
- Community Care
- Essex Health and Wellbeing Board
- Healthwatch Suffolk and Healthwatch Essex
- Hospices
- Local Alliances – West Suffolk, North East Essex and Ipswich and East Suffolk

- Local Government – Essex County Council and Suffolk County Council and the various district and borough councils within SNEE
- Mental Health and Learning Disability (LD) providers
- Primary Care
- Suffolk Health and Wellbeing Board
- Voluntary, Community and Social Enterprise (VCSE) partners

This Plan demonstrates how the ICB intends to address the key physical and mental health requirements of the population of SNEE, describing a series of outcomes, priorities and key metrics to be attained over the period 2023 to 2028. These are aligned to the core national, regional and local strategic drivers of the NHS including the NHS Long Term Plan (LTP), the Health and Care Act and the Core20PLUS5 approach, as well as the recent 2022 ICS Strategy developed by SNEE Integrated Care Partnership (ICP). The JFP also sets out a series of actions in achieving both the universal NHS commitments and ambitions of the Joint Local Health and Wellbeing Strategies (JLHWS) for Suffolk and Essex.

<sup>9</sup>The SNEE ICB covers the whole of Suffolk except Waveney which is part of the Norfolk and Waveney ICB

This document aligns to the three principles of JFPs denoted within the 'Guidance on developing the joint forward plan'<sup>10</sup> circulated in December 2022:

- **Principle 1:** Fully aligned with the wider system partnership's ambitions
- **Principle 2:** Supporting subsidiarity by building on existing local strategies and plans as well as reflecting the universal NHS commitments
- **Principle 3:** Delivery-focused, including specific objectives and milestones for the ICB to attain by 2028

The JFP for SNEE ICB considers the 'Triple Aim', which is the duty to have regard to wider effect of our decisions on inequalities in the system as well as:

- The health and wellbeing of our people
- The quality of services provided or arranged by SNEE ICB and other relevant bodies
- The sustainable and efficient use of resources by SNEE ICB and other relevant

The core requirements of the Triple Aim are therefore embedded within this JFP by our wholehearted commitments to improving public health, preventing ill-health, and reducing health disparities for our wider population.

Legislative requirements of the JFP are shown below, alongside the accompanying section of this document where it is covered:

- Describing the health services for which the ICB proposes to make arrangements (Section 5)

- Duty to promote integration (Sections 3, 5)
- Duty to have regard to wider effect of decisions (Sections 5.3, 6)
- Financial duties (Section 6.7)
- Implementing JLHWS (Section 3)
- Duty to improve quality of services (Section 6.9)
- Duty to reduce inequalities (Section 5)
- Duty to promote patient involvement (Section 5.6.3.2)
- Duty to promote public involvement (Section 7.1)
- Duty to patient choice (Section 5)
- Duty to obtain appropriate advice (Section 8)
- Duty to promote innovation (Section 7.8)
- Duty in respect of research (Section 7.8)
- Duty to promote education and training (Section 7.2)
- Duty as to climate change (Section 7.9)
- Addressing the particular needs of children and young people (Section 5.4)
- Addressing the particular needs of victims of abuse (Section 5.5.3.4)

The JFP for SNEE ICB is a public document which will be ratified by the Essex Health and Wellbeing Board (HWB) and Suffolk HWB in May 2023 followed by the ICB Board in late May 2023 and thereafter published by the end of June 2023. As JFPs are a five-year planning document, this document will be reviewed and updated / confirmed annually before the start of each financial year.

## 3.2 Purpose, Functions and Governance of Suffolk and North East Essex Integrated Care Board

The Health and Care Act 2022 completed the parliamentary process and received Royal Assent on 28 April 2022. This was an important step on the journey towards establishing ICSs, moving them onto a statutory footing with the establishment of ICBs. Each ICS has an ICB, a statutory organisation bringing the NHS together locally to improve population health and establish shared strategic priorities within the NHS. When ICBs were legally established, Clinical Commissioning Groups (CCGs) were abolished.

The ICB has taken on the NHS commissioning functions of CCGs as well as some of NHSE's commissioning functions. It is accountable for NHS spend and performance within the system.

SNEE ICB brings together partners responsible for planning and delivering health and care across SNEE to ensure shared leadership and joint action to improve the health and wellbeing of the one million people who live locally. The ICB Board is accountable to NHS England (NHSE), THE Department of Health and Social Care and Department for Levelling Up, Housing and Communities.

<sup>10</sup> Guidance on Developing the Joint Forward Plan December 2022  
<https://www.england.nhs.uk/wp-content/uploads/2022/12/B1940-guidance-on-developing-the-joint-forward-plan-december-2022.pdf>



The ICB Board meets as a unitary board and is collectively accountable for the performance of the ICB's functions. The ICB Board is made up of a Chair and three non-executive members alongside the Chief Executive and executive director team and several partner members. Our partner members are:

- Three partner members NHS and Foundation Trusts
- Two partner members Primary Medical Services
- Two partner members Local Authorities
- One partner member for the VCSE sector

The ICB has agreed a Scheme of Reservation and Delegation (SoRD) which is published in full in the ICB Governance Handbook. The SoRD sets out:

- Those functions that are reserved to the board
- Those functions that have been delegated to an individual or to committees and sub-committees
- Those functions delegated to another body or to be exercised jointly with another body

The ICB Board has established several committees to assist it with the discharge of its functions including three place based Alliance Committees alongside Finance, Quality, System Oversight and Assurance and an Executive Committee amongst others.

The ICB Board remains accountable for all the ICB's functions, including those that it has delegated and therefore appropriate reporting and assurance mechanisms are in place as part of agreeing terms of a delegation.

The ICB Committees have further delegated some functions to sub-committees (known as Groups). These include the underpinning structures for the committees as well as system wide transformation programmes and place-based Alliance programmes.

The ICB Governance Handbook features the SoRD, the Functions and Decisions Map and the Terms of Reference for all ICB Committees and can be found on the SNEE ICB Website<sup>11</sup>.

In consultation with local partners, ICBs will produce a five-year plan – the JFP (updated annually), for how NHS services will be delivered to meet local needs.

## 3.3 Population needs

There are 1,058,560 people registered with General Practitioners (GPs) across SNEE – 413,188 in Ipswich and East Suffolk 370,589 in North East Essex and 265,688 in West Suffolk<sup>12</sup>. The population within SNEE is projected to grow by 10% by 2036 which will likely increase demand on health and social care needs across the region.

Essex and Suffolk County Councils produce comprehensive and on-going analyses to inform their respective JLHWSs. These Joint Strategic Needs Assessments (JSNAs) examine the current and future health and care needs of local populations in order to guide the planning and commissioning of services. This evidence-base underpins strategic development at the local authority level, ICB level and Alliance level. Across the ICS, small area analysis is being used increasingly, for example, at ward and parish levels.

SNEE is spread across a mix of urban, rural and coastal areas, each with contrasting levels of deprivation. There are pockets of significant deprivation concentrated in certain communities including coastal

areas; the most deprived neighbourhood in England according to the 2019 Index of Multiple Deprivation (IMD) is to the east of the Jaywick area of Clacton on Sea. As of 2019, Ipswich is the most deprived area in Suffolk, 45.8% of Lower Super Output Areas (LSOAs) in Ipswich are in the most deprived 30% nationally. The most deprived LSOA in Ipswich is located across the Priory Heath area. West Suffolk has one LSOA in the 20% most deprived nationally in St Edmundsbury in Bury St Edmunds. The mix of urban, rural and coastal populations will likely contribute to a further increase in healthcare services across SNEE over the next five years.

Differences in the level of deprivation across SNEE has undoubtedly accelerated the emergence of some health inequalities (as detailed in Section 5.2). For example, the gap in life expectancy between the most and least deprived areas of Essex has widened to 7.5 years for men and 5.8 years for women. Similarly, in Suffolk, this gap is 7.4 years for men and 5 years for women.

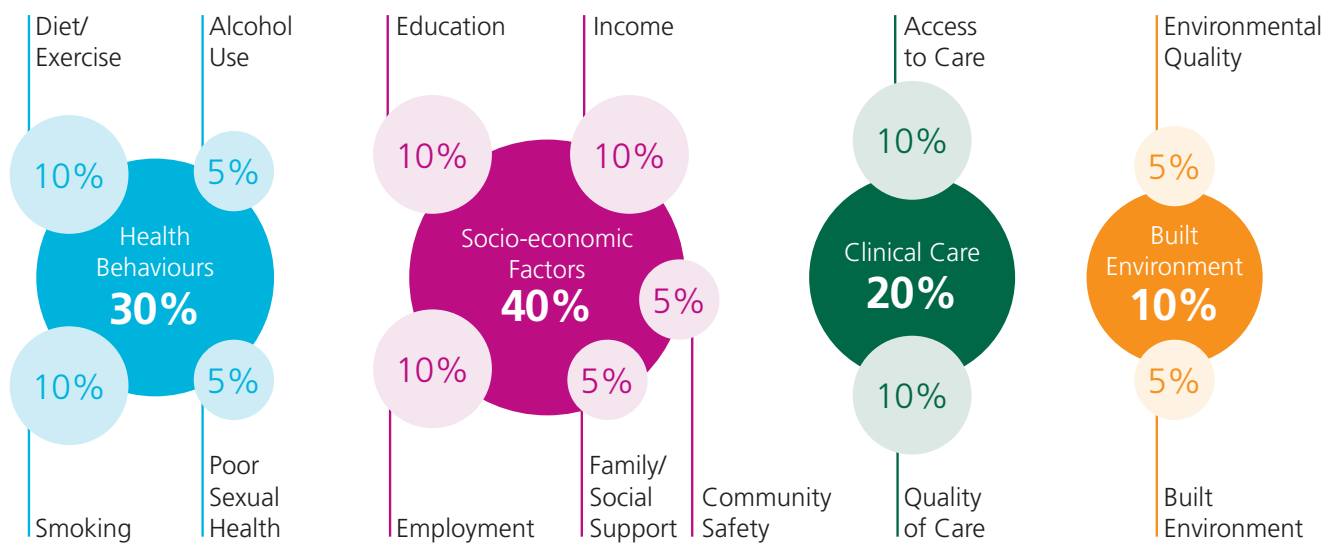
<sup>11</sup> <https://suffolkandnortheastsex.icb.nhs.uk/about-us/our-policies/>

<sup>12</sup> Patient registered at a GP practice (March 2023) NHS Digital <https://digital.nhs.uk/data-and-information/publications/statistical/patients-registered-at-a-gp-practice/march-2023>

The population of SNEE is predominantly White (94.7%), much higher than the national average of 86.7%. Of the remaining population, 2.1% are Asian/Asian British (national average is 7%), 1% are Black/African/Caribbean/Black British (national average is 3.1%), 1.7% are Mixed/Multiple Ethnic Groups (national average is 2.1%) and 0.5% are classified as Other (national average is 0.95%). The proportion of people aged over 65 across SNEE is 23%, mean than the England average of 19% which will exert further pressure on healthcare services from 2023 to 2028<sup>13</sup>.

There is alignment across SNEE in the use of a model developed by the Population Health Institute of the University of Wisconsin<sup>14</sup> which provides a framework for considering the wider determinants of health. This model recognises a range of impacts on an individual’s health and demonstrates how to tackle these elements by focusing on those that have the greatest impact on health outcomes – Health Behaviours, Socio-Economic Factors, Clinical Care and the Built Environment, as shown below.

Figure 1: Model for Determining the Wider Determinants of Health



SOURCE: Robert Wood Johnson Foundation and University for Wisconsin Population Health Institute in US to rank countries by health status

The framework is referenced in the Essex JLHWS, Suffolk JLHWS and the SNEE ICS Strategy, demonstrating a commonality of approach to public health of local alliances across the region.

Appendix 1 provides a summary of the Essex and Suffolk JSNAs.

## 3.4 Key factors driving the need for a JFP

### 3.4.1 Demand and Capacity

Across the country the performance of health and care organisations is set against a challenging backdrop of increasing demand for services. There are underlying demand pressures on the NHS and social care, driven by demographic growth and morbidity changes, with the pandemic increasing demand and negatively impacting on staff absence. This has caused an increase in elective waiting lists, in particular.

The NHS is currently experiencing challenges with workforce retention and skills gaps persist nationally.

SNEE ICS has shown a 27% growth in the workforce over the last six years, however retention challenges remain across the system. From April 2021 to April 2022 the turnover rate of care workers in Suffolk was 32.4% and the vacancy rate was 11.4%. Across Essex this was 36.3% and 15%. This compares unfavourably against a turnover rate of 29% and vacancy rate of 10.7% for the whole of England and 32.2% and 11.3% in the Eastern region. This suggests a combination of retention issues of existing staff and the inability to fill additional roles created by new customer demand.

<sup>13</sup> Source: Shape and ONS data 2023

<sup>14</sup> <https://www.countyhealthrankings.org/sites/default/files/differentPerspectivesForAssigningWeightsToDeterminantsOfHealth.pdf>

The population of SNEE ICS is estimated to increase by 10% by 2036<sup>15</sup>. The population is also ageing, with the proportion of the population aged over 75 increasing from 10.3% in 2018 to 13.8% in 2032, an additional 45,000 people. The prevalence of multimorbidity (people with more than two illnesses or diseases) is between two and three times greater in the plus 75 year old population relative to working age adults.

Additionally, older people typically have more frequent contact with GPs and are at higher risk of emergency admissions. Therefore, an ageing population will have a greater health need and associated demand on primary care services. With outpatient referral rates ranging from around 4% to 6%, this will add demand for planned secondary care. If additional capacity in primary care cannot be achieved, this will also increase demand for urgent and emergency care services.

As shown in section 3.3, Essex and Suffolk County Councils produce JSNAs and this evidence base provides insight on the drivers of demand. This includes a wide-ranging assessment of the most prominent health inequalities affecting care or access to care and how inequalities manifest as drivers of demand.

More proactive planning of services based on an understanding of current population and the drivers of future demand for services, through a Population Health Management (PHM) approach will enable us to reduce demand for reactive care services and use those resources to provide better proactive care for more people. Section 6.6 provides further detail of our PHM approach and work.

### 3.4.2 Cost of Living Challenge

SNEE ICB is conscious of the ongoing cost of living challenge driven by sharp increases in the cost of energy and food prices and ongoing inflationary pressures. In December 2022, SNEE ICP set out a series of actions to better support local people during this challenges. SNEE ICB is equally committed to meeting these goals, as set out below:

- We will contribute to wider initiatives to co-ordinate and promote support to those who need it most
- We will combat the stigma of needing support
- We will identify the people who use our services who are struggling
- We will identify our staff and volunteers who may be struggling

### 3.4.3 Financial Position

Prior to the pandemic, the NHS organisations in SNEE had delivered strong financial performance and met national financial targets consistently for a number of years. However, in line with the rest of the NHS, the difficulty the system was facing in meeting the increasing demands on services within financial constraints was intensifying.

Extraordinary amounts of additional funding were provided to systems as part of the emergency financial regime put in place by NHSE as part of the response to the pandemic. For SNEE in 2021/22, this equated to circa £292m (20%) of funding beyond “normal” levels.

In 2022/23 as part of the move towards “normal” funding levels the impact on the system was a funding reduction of £97m (5%) of our total allocation. We are expecting a similar level of financial challenge for each of the next two financial years and based on the current economic outlook it would be difficult to assume an improvement in the funding position beyond 2025.

The JFP is a key milestone in developing our system’s future as it will be the first opportunity post the pandemic response, to outline how we will endeavour to deliver on the strategy within financial and non-financial constraints over the medium term.

Further detail on our approach to financial management can be found in Section 6.7.



<sup>15</sup> Office for National Statistics. Population projections for clinical commissioning groups and NHS regions. <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/clinicalcommissioninggroupsinenglandtable3> Published 2020. Accessed November 2022.

## 3.5 What people have told us

As part of the ICS Strategy development, a series of engagement events took place with people living and working in SNEE from September to December 2022. Over 600 people responded via online surveys, community group discussions, a pop-up video booth and direct contact with the ICP team to inform the strategy. Key messages from these workshops are summarised below and have been considered throughout the priority setting for SNEE ICB as part of the JFP work:

- Timely access to health and care services
- Access to and the quality of primary care services
- Waiting for diagnosis, treatment and support has impacted significantly on people's physical and mental health
- A need for joined up care by a competent, caring and compassionate workforce
- Inclusive, anti-discriminatory, individualised care
- A challenged health and care system but a system where people want the best health and care for everyone

The ICB built on the engagement work carried out in the development of the ICS Strategy through a range of engagement exercises on the draft JFP between 16 January and 22 February 2023. NHSE guidance on JFPs states that ICBs and partners are expected to engage with people for whom they have a responsibility and anyone else they feel is appropriate. During development of the JFP, SNEE ICB continuously referred back to numerous engagement and coproduction activities that have taken place in recent years across the region. On this basis, the aim was to enable effective and meaningful involvement and to ensure all people and communities had the opportunity to comment, either on the sections most important to them or the whole document.

Engagement was designed to follow the structure of the Live Well domains, mirroring the format of the plan itself. Using the engagement platform LetsTalkSnee.co.uk a series of web pages were developed to define and break down each domain, outlining the key priorities. A series of public meetings were held to reach people who prefer to take part in person.

During the engagement period, there were over 1,000 visits to the LetsTalkSNEE platform, 340 people voted using quick polls, 280 ideas were submitted and there were 330 downloads of the draft document and executive summary. Approximately 100 people attended an in-person meeting.

Eight core themes were raised through the engagement activity:

1. **Access** – Including access to all services across primary care, secondary care, specialist care and the community as well as opportunities and activities to support healthy living. People also noted the ability to get to and from appointments and activities
2. **Mental health** – Including services for both children and young people and adults
3. **Prevention, Health Education and Information** – Supporting and enabling people and communities to manage their own health, stay healthy and knowing how to access support
4. **Personalisation and reasonable adjustments** – Both personalised care in response to a person's specific conditions and the adjustments made to support good health outcomes. This might include communication, physical access or a person's cultural beliefs and values
5. **Digitalisation** – The importance of being aware of innovations and progress that can be enabled through the use of new technology, whilst also recognising that not everyone is willing or able to use technology
6. **Workforce** – Consideration for recruitment, retention, training and wellbeing
7. **Primary Care** – Development of primary care across SNEE
8. **Children and Young people with Special Educational Need** – services, support and interventions to support young people with a special educational need

A fuller report on our engagement can be found in Appendix 2.

## 3.6 National context

An overview of national and regional priorities is provided in this section which have collectively influenced the content of the JFP. Specialist national commitments and strategies are subsequently referenced within each of the individual subsections of Section 5 Our Priorities. Local commitments are also detailed in Appendix 3 Our Partners' Aligned Plans.

### The NHS Long Term Plan<sup>16</sup>

The NHS LTP (2019-2029) sets out the national 10-year strategy to make the NHS fit for the future. It aims to improve care by:

- Making sure everyone gets the best start in life
- Delivering world-class care for major health problems
- Supporting people to age well

These ambitions will be achieved through a number of ways:

- Doing things differently
- Preventing illness and tackling health inequalities
- Making further progress on care quality and outcomes
- Making sure NHS staff get the backing they need
- Making better use of data and digital technology
- Getting the most out of taxpayers' investment in the NHS

As an ICB, we will collaborate across all sectors to deliver the objectives of the NHS LTP by listening to what local people say, and co-produce solutions that

provide the right care and support for people and communities. We will use our resources effectively, maximising the assets in our people and communities and together we will think imaginatively, to continually learn and develop. SNEE ICB's local response to the LTP is set out through the document.

### Next Steps for Integrating Primary Care: Fuller Stocktake Report<sup>17</sup>

Published in May 2022, the Fuller Stocktake Report considers how the implementation of integrated primary care can be accelerated by incorporating the current four pillars of general practice, community pharmacy, dentistry, and optometry across systems.

Key challenges identified in the report include access and continuity of care, with frustrations shared by both people and staff alike.

The Report finds that integrated neighbourhood 'teams of teams' need to evolve from Primary Care Networks (PCNs) and be rooted in a sense of shared ownership for improving the health and wellbeing of the population. PCNs should promote a culture of collaboration and pride, create the time and space within these teams to problem solve together, and build relationships and trust between primary care and other system partners and communities.

SNEE ICB's local response to the Fuller Report is set out in Section 5.7.3.2 Urgent and Emergency Care including Community and Section 6.3 GP and Primary Care Networks.



<sup>16</sup> NHS Long Term Plan: <https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf>

<sup>17</sup> Fuller Stocktake Report: <https://www.england.nhs.uk/wp-content/uploads/2022/05/next-steps-for-integrating-primary-care-fuller-stocktake-report.pdf>

## 3.7 Regional context

### Essex Health and Wellbeing Board - Joint Health and Wellbeing Strategy 2022 to 2026<sup>18</sup>

This JFP takes account of the Essex Joint Health and Wellbeing Strategy 2022 to 2026. The overall aim of this strategy is to see an improvement in health and wellbeing outcomes for people of all ages, and a reduction in health inequalities, by having a focus on supporting poor health prevention and promoting health improvement. This aligns to the ambitions of the JFP to support people to Live Well.

The Strategy's vision is to *"improve the health and wellbeing of all people in Essex by creating a culture and environment that reduces inequalities and enables residents of all ages to live healthier lives."*

The Strategy sets out five key priority areas which align to our JFP:

1. Improving mental health and wellbeing, aligned to our intention to ensure people in SNEE "Feel Well" (Section 5.5)
2. Physical activity and healthy weight, as discussed in Section 5.6.3.1
3. Supporting long term independence, as highlighted in Section 5.6.3
4. Alcohol and substance misuse, as discussed in Section 5.5.3.3
5. Health inequalities and the wider determinants of Health, as noted throughout Section 5, in particular Section 5.2

### Suffolk Health and Wellbeing Board Transitional Joint Health and Wellbeing Strategy 2022 to 2023<sup>19</sup>

The SNEE ICB JFP also takes account of the key priorities of the Suffolk Transitional Joint Health and Wellbeing Strategy 2022 to 2023. This strategy was developed by considering the wider determinants of health using an asset-based approach by working in collaboration with others.

The vision described in the strategy is *"to work with our communities and partners to put in place the building blocks required to make Suffolk a place where everyone can lead a longer, healthier and happier life"*

Key priorities include:

1. Public mental health: More people will have positive mental wellbeing. As discussed throughout section 5.5 Feel Well
2. Good work and health: More people will have access to good quality jobs and fair work as detailed throughout Section 6 Our Priorities and Section 7.2 Workforce of the JFP
3. Listening and engaging with local voices: Residents and communities will become more involved in decisions that affect their lives, health and wellbeing as evidenced through the engagement undertaken on the JFP and in Sections 7.1 and 8
4. Wellbeing of children and young people: All our Children and Young People should be able to live happy, healthy, and fulfilled lives in communities where they feel safe, as noted within Section 5.4 Start Well

### Suffolk and North East Essex ICS Strategy

The Integrated Care Strategy for SNEE ICS is underpinned by a detailed new website [www.sneeics.org.uk](http://www.sneeics.org.uk) that sets out this work in a flexible, collective and central manner. The strategy builds on and brings together earlier work and thinking from across local partners and describes a shared vision from the perspective of 'what matters' to people living in SNEE. The ICS is united on four collective ambitions, which align to this JFP:

- The **best health and wellbeing** a genuine reality for all
- The opportunity of **health equality** for everyone
- Everyone able to **'Live Well'** – Start Well, Be Well, Stay Well, Feel Well, Age Well, Die Well
- A genuinely **'Can Do' Health and Care System** that people can trust

The strategy was developed through an inclusive process involving stakeholders from across SNEE including people with lived experience, clinicians and other professionals, elected leaders and others.

The JFP responds to each of these ambitions, setting out the ICB's contribution to their achievement.

<sup>18</sup> Essex Joint Health and Wellbeing Strategy 2022 – 2026

<https://assets.ctfassets.net/448kPT/4e1087574de56130bf7c82374758b5d5/Essex-joint-health-and-wellbeing-strategy-2022-2026.pdf>

<sup>19</sup> Suffolk Transitional Joint Health and Wellbeing Strategy 2022 – 2023

[https://www.healthysuffolk.org.uk/uploads/Transitional\\_JHWS.pdf](https://www.healthysuffolk.org.uk/uploads/Transitional_JHWS.pdf)



## 4 Our Vision, Outcomes and Principles

### 4.1 Vision and outcomes for the ICS

The ICS shared vision is to deliver the **best possible health outcomes for every one of the one million people living in SNEE**. In addition, one key collective ambition of the ICS is for everyone at all stages of their life to be able to **'Live Well'** across the region of SNEE. We have therefore adopted, organised ourselves and defined the outcomes we wish to achieve using the six domains of the Live Well model:

- **Start Well – Giving children and young people the best start in life**

We want to ensure that children and young people across SNEE have the best possible start in life from preconception onwards and can have their physical and mental health supported as they grow and develop by reducing health inequalities and adopting tailored approaches where needed.

- **Feel Well – Supporting the mental wellbeing of our population**

The best possible mental health and resilience is essential if everyone in SNEE is to live well and age well. Good mental health is a state of wellbeing in

which every individual realises their own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to her or his community. Like physical health, people can experience both temporary and long-term mental ill-health.

- **Be Well – Empowering adults to make healthy lifestyle choices**

Everyone in SNEE should be able to live a healthy life with good physical, mental and social wellbeing. There is a clear social gradient in the harm to health from health behaviours and lifestyle factors which have been exacerbated by the Covid-19 pandemic. Action is needed to reduce health inequalities and prioritise the prevention of ill health.

- **Stay Well – Supporting adults with health or care concerns to access support and maintain healthy, productive and fulfilling lives**

Supporting adults with health or care concerns to access the right support, in the right time in the right place will enable them to live healthy, productive and fulfilling lives.

- **Age Well – Supporting people to live safely and independently as they grow older**

We will ensure that everyone ages well across SNEE and be enabled to live safely and independently. If and when they need support it will be provided proactively and support their needs.

- **Die Well – Giving individuals nearing end of life choice around their care**

End of Life care will impact everyone in SNEE at some time, including those approaching the end of their lives, those that care for them and those who are bereaved. Over 10,000 people in SNEE are in the last year of their life and we wish to ensure that over this time they and those who care for them have the best and most equitable care and support from the resources we have available.

SNEE ICB will contribute to the ICS collective ambitions to make *the best health and wellbeing a genuine reality for all* and provide *the opportunity of health equality for everyone* through the way in which it will work, in particular by embedding a population health management approach and strong focus on directly targeting and addressing health inequalities. Our six Live Well Domains and the priorities therewithin are underpinned by a focus upon reducing health inequalities for our local population.

To support our vision and achievement of our outcomes, we believe that people and communities should always be given opportunity to be our partners in coproducing our services. To apply co-production purposefully, we will involve service users and/or carers in identifying the need and the approach, and then in the gathering of intelligence, through to making decisions, from start to finish. We intend for all development work to consider and share what elements can be co-produced, the approach taken, and, where necessary to explain when and why it is impractical to apply co-production. We recognise that the availability of resources and time factors may necessitate concentrating on co-producing a part(s) of service development rather than the whole.

Furthermore, SNEE ICB will work with its health and care partners across the system, in placed-based Alliances, across both counties, and within neighbourhoods to achieve the ICS collective ambition for all parts of the local health and care system to be **working together as ONE team**.

SNEE ICB will do this by adopting the ICS' six core principles for achieving a **'Can Do' Health and Care System that people can genuinely trust**.

- **Collaborative** – by focusing on system leadership and culture, supporting our people and workforce across all sectors
- **Compassionate** – by focusing on personalised care in all sectors, supporting family carers and enabling genuine co-production
- **Courageous** – by focusing on enabling equity, inclusion and social justice, ensuring clinical and care quality across all sectors and enhancing the roles of all clinical and care professionals
- **Community focussed** – by focusing on enabling a resilient VCFSE sector, the importance of volunteering and the roles of Community Connectors, Anchor Institutions and community pharmacy
- **Creative** – by focusing on the use of digital, data and technology, innovation and research and environmental sustainability
- **Cost-effective** – by focusing on financial sustainability and the effective use of our collective health and care







# 5 Our Priorities

## 5.1 Introduction to the 'Live Well' domains

As noted in 4, our vision is for everyone to Live Well in SNEE, as demonstrated by our adoption of the six Live Well domains which set out our overarching six outcomes for our local population. SNEE ICB's key priorities for 2023 to 2028 are therefore organised based on these domains, as detailed in this section

of the Plan. Subsections for each of the Live Well domains outline key sub outcomes, priorities and metrics to achieve over the JFP timeframe of 2023 to 2028.

The Live Well domains are organised as set out below:

Start Well	Feel Well	Be Well	Stay Well	Age Well	Feel Die
<ul style="list-style-type: none"> <li>• Preconception, Maternity and Neonatal Care</li> <li>• Children and Young People incl. CAMHS, Neuro Developmental, SEND, Community and Long Term Conditions</li> </ul>	<ul style="list-style-type: none"> <li>• Mental Health and Wellbeing</li> <li>• Suicide Prevention</li> <li>• Addictions</li> <li>• Trauma and Abuse</li> </ul>	<ul style="list-style-type: none"> <li>• Healthy Behaviours</li> <li>• Personalised Care</li> <li>• Women's Health</li> <li>• Dental / Oral Health</li> <li>• Eye Health</li> </ul>	<ul style="list-style-type: none"> <li>• Elective Care and Diagnostics</li> <li>• Urgent and Emergency Care incl. community</li> <li>• Cancer</li> <li>• Diabetes</li> <li>• Respiratory</li> <li>• Cardiovascular Disease</li> <li>• Stroke and Stroke Rehab</li> <li>• ME and CFS</li> <li>• Neuro Rehab</li> <li>• Learning Disabilities and Autism</li> </ul>	<ul style="list-style-type: none"> <li>• Ageing Well Programme</li> <li>• Dementia</li> <li>• Carers</li> </ul>	<ul style="list-style-type: none"> <li>• End of Life</li> </ul>

Our six Live Well Domains and the priorities therewithin are underpinned by a focus upon reducing health inequalities for our local population and ensuring equality, diversity and inclusion is central to our work as detailed in the next two sections. The Live Well Domains offer a methodology and structure to organise the contents of the JFP and the ensuring programmes of work. However,

SNEE ICB recognises that there are key cross-cutting themes that apply to all areas of an individuals health, such as GP primary care, personalised care, access to physical care for people with learning

disabilities, consideration of carers and prevention and parity in healthcare access for all which should be considered across each of the domains.

## 5.2 Health inequalities

### 5.2.1 Why is this important for people in Suffolk and North East Essex?

Health inequalities are unfair and avoidable differences in health and wellbeing across the population, and between different groups within society. These inequalities are evident for people living in SNEE ICS.

There is a life expectancy gap between individuals born in the most deprived communities in SNEE and those in the least deprived. The difference in average life expectancy is 7.4 years in men and 5.9 years in women<sup>20</sup>. This has increased over time, showing that health inequalities are widening.

Health inequalities have also been documented between population groups across the four dimensions below:

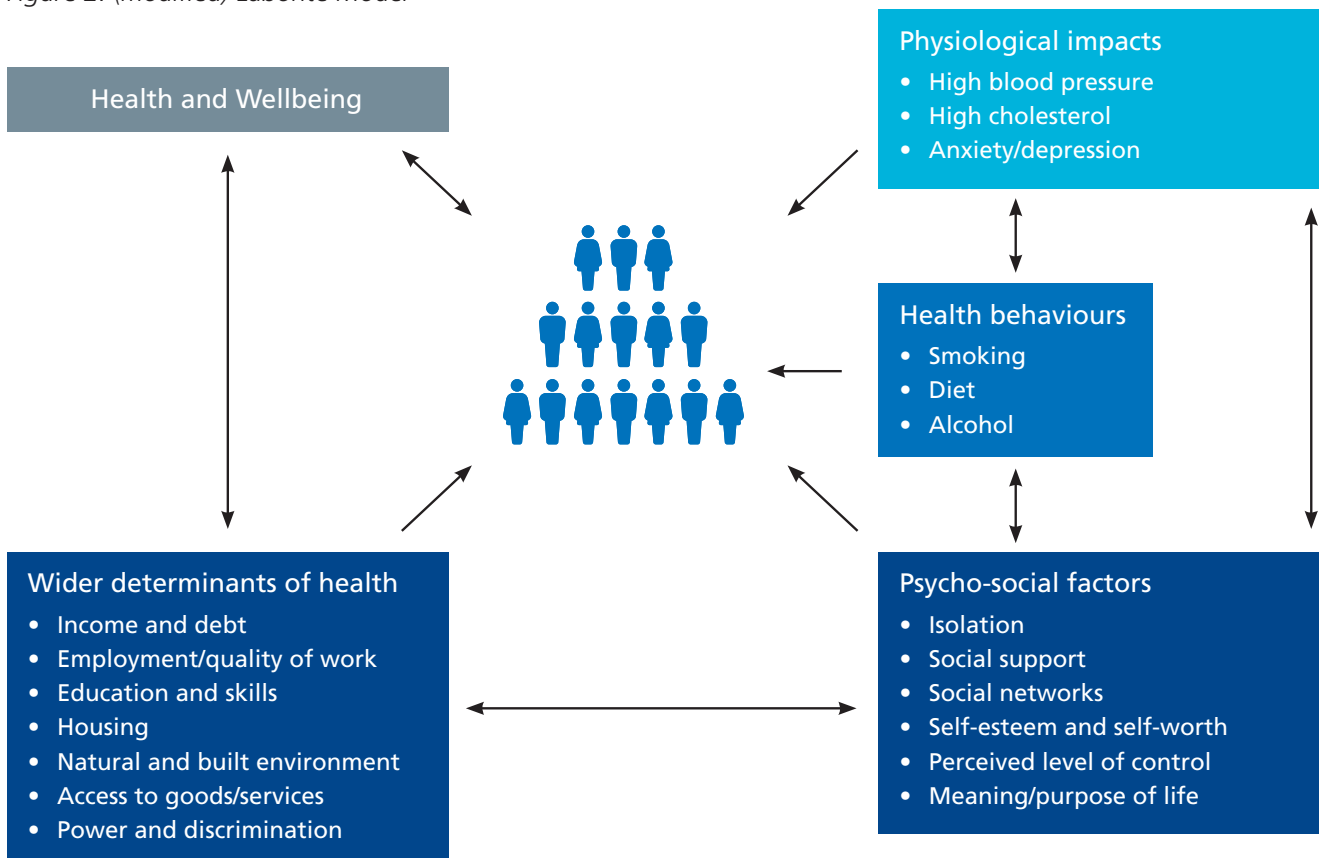
- Protected characteristics outlined in the Equality Act (2010) e.g., age, gender, race, sexual orientation, and disability

- Socio-economic status and deprivation e.g., unemployment, low income, living in a deprived area, poor housing, and poor education
- Vulnerable groups in society (inclusion health groups) e.g., homeless people, Gypsy, Roma, and Traveller communities, vulnerable migrants and sex workers
- Geography e.g., rural or urban areas

Addressing health inequalities therefore is a key priority for SNEE ICB. Understanding the causes and drivers of health inequalities and identifying opportunities for action across the ICS will help us do this effectively.

The modified Labonte model (fig 3) illustrates how a broad and complex range of factors drive health inequalities. Effective action to address these will require us to adopt a population health approach. This aims to improve physical and mental health outcomes across the population, while reducing health inequalities. It takes into consideration the wider factors that influence these outcomes and recognises the need to work with communities and across partner agencies.

Figure 2: (modified) Labonte Model



<sup>20</sup> Source: <https://www.gov.uk/government/publications/health-inequalities-place-based-approaches-to-reduce-inequalities/place-based-approaches-for-reducing-health-inequalities-main-report>

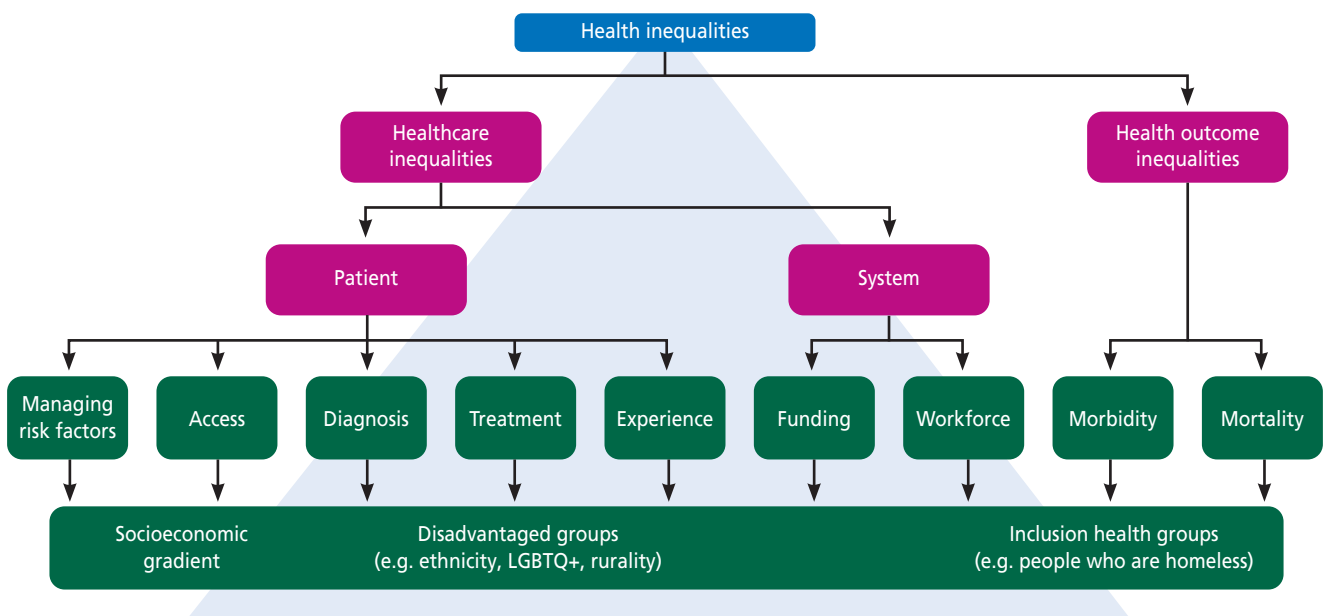
## 5.2.2 What do we know about people’s local experiences?

Across SNEE, different causes of death contribute to the difference in life expectancy between our most deprived and least deprived communities. Leading causes of death include circulatory conditions, cancer and respiratory conditions. Several underlying risk factors are implicated in their causation, e.g., tobacco, high body mass index, diabetes, dietary risks, high blood pressure and alcohol. Focused action to tackle these risk factors will not only prevent people from developing these conditions but will also reduce health inequalities. A system-wide focus on prevention, targeting areas where we have the strongest evidence for inequalities, is therefore important.

A draft of the JFP was shared on the online platform LetsTalkSNEE in January 2023 to gather feedback on key aspects of the document. Findings included:

- The need to address health inequalities in dental and oral health for marginalised groups
- For women’s health, 50% of respondents said that *“understanding women’s health inequalities”* was the most important action for SNEE ICB. The remaining 50% were focused on the *“development of a programme of analytics”* in this field. All respondents felt that a reduction in inequalities was the most important measure for women’s health
- 100% of respondents said that *“high quality care and reduced health inequalities”* was the most important action for ME and Chronic Fatigue Syndrome

Figure 3: Framework for Health Inequalities



Reducing health inequalities was also a core ambition identified by Healthwatch Sussex in the development of the SNEE ICS strategy.

## 5.2.3 How do we plan to make a difference?

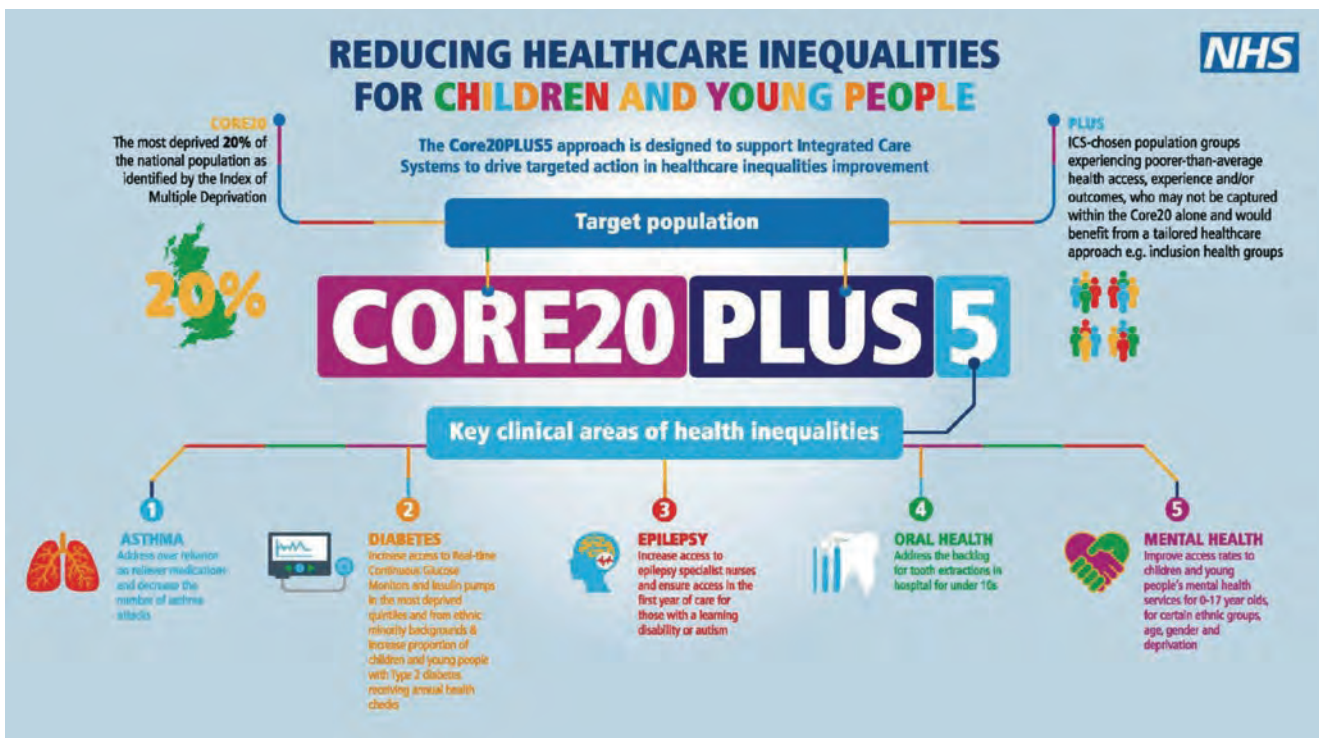
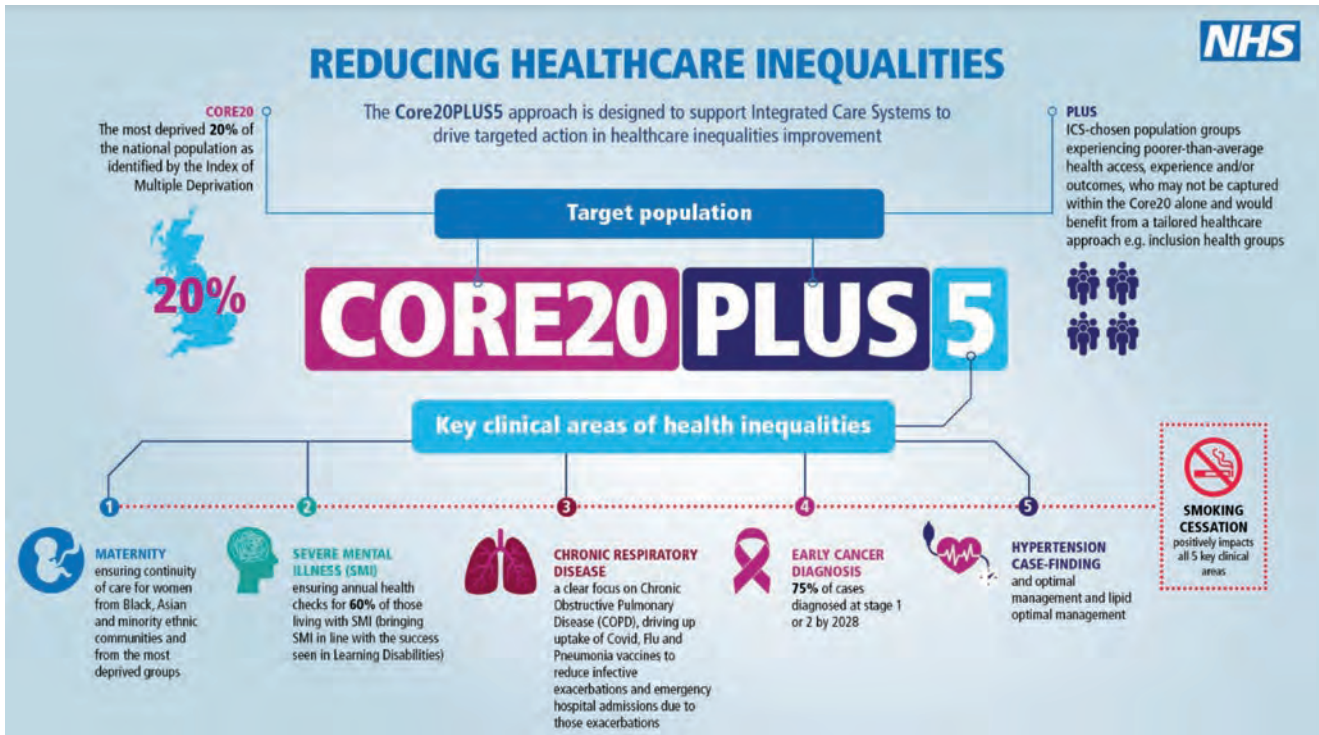
Effective action to address health inequalities in SNEE will require a coordinated and whole-system approach, with targeted prevention work using PHM as an enabler.

PHM data will help the system to identify areas of focus and individuals or communities for targeted interventions. Linked datasets will provide insight into current and future population needs, allow targeted action to prevent ill health and reduce health inequalities, and enable the delivery of better coordinated care and better use of scarce resources. It will enable us to move from data to action and have much greater impact than could be achieved previously.

Figure 4 provides a useful framework for consideration by health and care organisations across SNEE. It illustrates key areas for action across the spectrum of health and care. These include, for example, the distribution of health system resources like funding and workforce, looking at the access to, quality and experience of services, and major drivers of morbidity and mortality and their underlying risk factors.

The Core20PLUS5 framework is an NHSE national approach to help ICS' reduce health inequalities, as shown in the below infographics:

Figure 4: Infographics for the Core20Plus5 Approach



**Core20** Across SNEE, 2019 IMD data showed that:

- 12.5% of LSOAs in SNEE fall into the 20% most deprived areas, as identified by national IMD data, including the Brooklands and Broadway areas of Jaywick which are the most deprived LSOAs in the country
- The data shows there are 116,673 people in SNEE living in the 20% most deprived areas nationally, of which the majority live in Tendering and Ipswich

**PLUS** populations –Across SNEE these groups have been identified as:

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

**Five** – Clinical focus areas including:

- **Maternity:** see Section 5.4 for further information
- **Severe Mental Illness (SMI):** This is covered in more detail in Section 5.5 Feel Well
- **Chronic Respiratory Disease** Please see Section 5.7 (5.7.3.5 – 5.7.3.7) for further details on respiratory ambitions of SNEE ICB
- **Early Cancer Diagnosis:** Our plans for Cancer are detailed in Section 5.7.3.3 of the JFP
- **Hypertension Case-Finding and optimal management and lipid optimal management:** Further information on Stroke and Stroke Rehab is available in Section 5.7.3.8

In addition, NHSE has more recently published an equivalent CORE20PLUS5 for children and young people. Further details are provided in Section 5.4 of the JFP

Our work on Health Inequalities will be informed by seven key areas of work:

### **1. Reducing Health inequalities by levelling up is core business for everybody**

- Delivery of a continued programme of training and resources to ensure we all understand health inequity and how to reduce it
- Health Inequality Impact Assessments and associated principles embedded across ICB planning, design and delivery of services

- Health inequalities as a core consideration across all governance structures and reporting e.g. board papers, performance frameworks

### **2. We will match resources to need**

- Inequalities included in investment and prioritisation decisions
- Shifting financial and staffing resources (proportionate universalism) to where the need is

### **3. We are data informed and evidence based**

- Driven by PHM, JSNA and Health Equity Audits
- Focusing on data quality and completeness of data

### **4. We do this work through community centred approaches and coproduction by:**

- Building on community capacity to act together
- Focusing on enhancing individuals’ capabilities to provide advice, information and support or organise activities around health and wellbeing in their or other communities
- Communities and local services working together at all stages of planning cycle, from identifying needs through to implementation and evaluation
- Connecting people to community resources, practical help, group activities and volunteering opportunities to meet health needs and increase social participation

### **5. We target our efforts through a Core 20 Plus 5 and prevention frame**

- Focusing on the Core 20% most deprived population and PLUS groups
- Preventing and managing those conditions which are the biggest drivers of health inequalities (secondary prevention)
- Targeting behavioural risk factors (primary prevention)

### **6. We use our position as Community Anchors to tackle the ‘causes of the causes’ through:**

- Maximising social value
- Sharing our assets with our communities
- Recruiting a diverse workforce that is inclusive and representative of the local population

### **7. Our services and communication are digitally inclusive**

- Provide reliable easy-to-understand health information in accessible formats for all people and communities

These priorities will be overseen by the newly formed Health Inequalities and Prevention Committee (HIPC) chaired by the Suffolk Director of Public Health to provide a focal point and strategic leadership on reducing health inequalities and embedding prevention across the ICB.

Reducing variation in performance will be a key priority across the JFP, with a particular focus on reducing health inequalities among the population living within the 20% most deprived areas and disadvantaged groups, in line with NHSE's Core 20 Plus 5 strategy. Within the first year of the JFP, the HIPC will define the SNEE ICB's approach to reducing health inequalities and the specific targets for performance indicators. However, an overall aim of the committee is to reduce the number of deaths in under 75s considered preventable, prioritising a reduction in inequalities in our most deprived areas and amongst disadvantaged groups, by 2028.

In addition, current system-wide actions are being taken to address health inequalities themed around five priority areas:

- Restoring NHS services inclusively
- Mitigating against digital exclusion by providing equitable options through digital and non-digital

routes, whilst understanding that some people prefer not to use technology

- Ensuring datasets are complete and timely
- Accelerating preventative programmes that proactively engage those at greatest risk of poor health outcomes (including CORE20PLUS5 approach)
- Strengthening leadership and accountability

Please see Appendix 4 for a more detailed plan on the above five areas.



*Tackling health inequalities is the primary ambition of our Integrated Care System, as well as the one that drives me as a leader. I am very proud of the progress that has been made by so many partners in this ambition, albeit with so much work still to do. We don't see the NHS as an illness service, but one that fights for social justice and is orientated towards prevention. Our challenge is to keep building positive impact through collaboration and to keep centred on the communities we serve rather than the service we work for.*

**Ed Garratt, Chief Executive SNEE ICB**



## 5.3 Equality, diversity and inclusion in the workforce

### 5.3.1 Why is this important for people in Suffolk and North East Essex?

Within the NHS Constitution for England (Department of Health and Social Care 2015) it states that 'high-quality care requires high-quality workplaces'; it also pledges to provide 'a positive working environment' to staff in addition to the legal right that 'you are treated fairly, equally and free from discrimination'<sup>21</sup>

In addition, there are two important pieces of legislation related to equality, diversity and inclusion (EDI):

1. The Equality Act 2010
2. Human Rights Act (1998)

As a public authority the ICB must ensure that none of our policies, procedures or strategies infringes the human rights of staff or patients. In practice this means treating individuals with fairness, respect, equality, dignity and autonomy whilst also safeguarding the

rights of the wider community when developing policies and procedures and carrying out our functions.

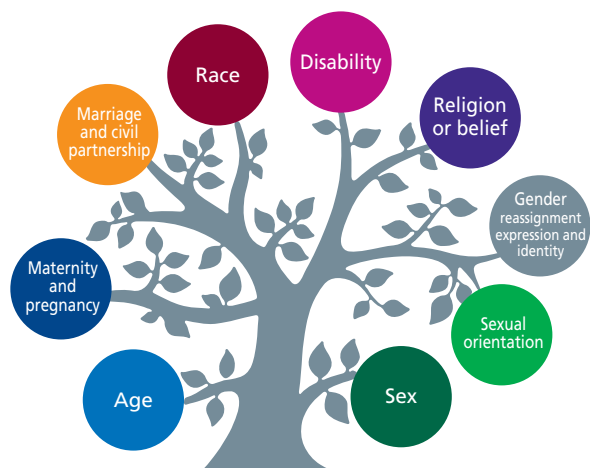
It is widely recognised that the work delivered by the NHS would not be possible without the critical contribution of its diverse workforce. Diversity includes an array of characteristics – including ethnicity, disability, gender, national origin, sexual orientation, age and religion – some of which are under-represented in certain NHS careers. Consequently, there is clearly more scope for the NHS to become a more inclusive, diverse and equitable at every level.

The SNEE ICP agreed a set of commitments to ensure equality, diversity and inclusion is enshrined within its ways of working; this agreement was received and approved in December 2022. Further to this, SNEE ICB have also pledged to commit to these ambitions. Alongside our ICP partners the ICB will ensure that equality, diversity and inclusion is embedded in every strand of our organisation, and to support better outcomes for the people we serve.

<sup>21</sup> Ross, S. Jabbal, J. Chauhan, K et al., (2020). Workforce race inequalities and inclusion in NHS providers. The Kings Fund. Accessed at: <https://www.kingsfund.org.uk/publications/workforce-race-inequalities-inclusion-nhs>

## It is against the law to discriminate against someone because of:

Figure 5: Protected Characteristics



## What do we know about people's local and lived experiences?

Across the NHS broadly, themes around people's experience include the increased likelihood of staff from ethnic minority backgrounds being performance managed and experiencing higher levels of bullying and harassment<sup>22,23,24</sup>. National data informs us that discrimination remains all too common for health and care colleagues, as well as service users and patients from the LGBTQ+ communities. A 2018 national report<sup>25</sup> found that one in eight (13%) of the 5'000 LGBTQ+ people surveyed, experienced unequal and unfair treatment from healthcare staff and this ranged from micro-aggressions and homophobic bullying. Further studies describe significant health inequalities relating to outcomes, provision of services and health risk factors<sup>26,27</sup>

Despite efforts to improve equality, inclusion and diversity in the SNEE ICS workforce, for example increasing ethnic minority representation in very senior roles, progress and improvement has been slow, as evidenced in our workforce data interrogation. Workforce data and staff survey results provide further evidence that barriers still exist with respect to career progression. For example, our workforce is predominantly female (72% in secondary care), but this percentage decreases when reviewing colleagues at senior paygrades within secondary care. One in five of our workforce are from

an ethnic minority background (13.9% within the ICB itself) across all professional groups. This increases to 28% for Band 5s and it is evident that there are very few signs of progression to more senior roles.

As we review experiences over the last couple of years, we are mindful that there have been unique challenges in the NHS. However, our ethnic minority communities have been disproportionately impacted by COVID-19<sup>28</sup>, this has also been the case for disabled communities - with many more lives lost to the virus, not least among our ethnic minority health and social care colleagues<sup>29</sup>. When reviewing these issues, we shall ensure that we are considerate of ways in which protected characteristics (listed in the above graphic) interweave and cross-over on multiple levels (intersectionality). This approach to addressing discrimination and social inequalities, from a systemic and structural perspective, will ensure that we are able to capture patterns of discrimination, which previously may have been 'invisible' or overlooked.

## How we plan to make a difference?

The NHS People Promise (2020)<sup>30</sup> stated "We are compassionate and inclusive", and "We each have a voice that counts". Our mission will therefore be to understand and embrace EDI across the ICB. New EDI objectives and a strategy plan will be devised by the end of June 2023 for the next five years.

We shall provide safe environments for learning and encourage a system-wide understanding, discourse and reduction of bullying, harassment or any other form of victimisation of people with protected characteristics. To date, our system-based work has focussed on race, including a commitment to deliver the regional anti-racism strategy.

However, our body of work will expand to drive improvement in the following areas across the ICS:

- We will fully own our individual and collective responsibility to take immediate action to get the basics right - because that is the right thing to do - recognising the fundamental importance of EDI in the health and care workforce
- We will have a collective vision that in the future we should think about EDI as a business-as-usual function in health and care, because we will all be accepting of diversity and difference

<sup>22</sup> Archibong, U. Kline, R. Eshareturi, C and McIntosh, B (2019). Disproportionality in NHS Disciplinary Proceedings. British Journal of Health Care Management 25(4) p1-7. Accessed at: <https://www.magonlinelibrary.com/doi/full/10.12968/bjhc.2018.0062>

<sup>23</sup> NHS England. NHS workforce race equality standard: 2018 data analysis report for NHS trusts. Leeds: NHS England; 2019

<sup>24</sup> Kline, R and Prabh, U (2015). Race inequality of NHS staff is putting patients at risk. *HSJ* Accessed at: <https://www.hsj.co.uk/leadership/race-inequality-of-nhs-staff-is-putting-patients-at-risk/5082766.article>

<sup>25</sup> Stonewall's 2018 report on the health of LGBTQ+ People in Britain. Accessed at: <https://www.stonewall.org.uk/resources/lgbt-britain-health-2018>

<sup>26</sup> Trevena, L (2023). The Diversity Dividend. *The Podiatrist* v26 (1)

<sup>27</sup> McDermott, E. Nelson, R and Weeks, H (2021). The Politics of LGBTQ+ Health Inequality: Conclusions from a UK Scoping Review. *Int J Environ Res Public Health* v18 (2) 826. Accessed at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7835774/pdf/ijerph-18-00826.pdf>

<sup>28</sup> Katikireddi SV, Lal S, Carrol ED, et al. (2021). Unequal impact of the COVID-19 crisis on minority ethnic groups: a framework for understanding and addressing inequalities. *J Epidemiol Community Health* v75:970-974. Accessed at: <https://jech.bmj.com/content/jech/75/10/970.full.pdf>

<sup>29</sup> Elwell-Sutton, T. Deeny, S & Stafford, M (2020). Emerging findings on the impact of COVID-19 on black and minority ethnic people - COVID-19 chart series.

Accessed at: <https://www.health.org.uk/news-and-comment/charts-and-infographics/emerging-findings-on-the-impact-of-covid-19-on-black-and-min>

<sup>30</sup> NHS England (2020). NHS People Plan. Accessed at: <https://www.england.nhs.uk/wp-content/uploads/2020/07/We-Are-The-NHS-Action-For-All-Of-Us-FINAL-March-21.pdf>

- We will encourage diversity of thinking in system and pathway transformation
- We will empower our staff in health and care with appropriate resource and education

Please see Appendix 5 for our fuller EDI plan detailing specific commitments under each of these headings.

### 5.3.2 How we will know we are making a difference:

The EDI programmes and workstreams will be monitored by:

- Workforce Race Equality System Data
- Workforce Disability Equality System Data
- Organisational recruitment and retention data
- Equality Delivery System reporting
- Staff Survey analysis
- Contact reports of the Health and Care Academy
- Appropriate promotional campaign analytics
- Project reports and evidence from committee members

Staff Networks were launched over the last 12 months, sustainability of these networks will be key to driving lasting change and also key to understanding have we made a difference. We shall evaluate growth, maturity and understanding of the group objectives as this will be a marker of success.

The networks are listed below, with plans for development of further networks. We will have ICB networks mapped into provider networks and regional networks also.

- Race, Equality and Cultural Heritage (REACH) Staff Network (previously known as BAME Staff Network) was re-launched in October 2021 - The SNEE ICB REACH Staff

- Disability Staff Network – Launched March 2022
- LGBTQ+ Staff Network – Launched March 2022

We shall also be looking for improvements with respect to numbers completing staff surveys and the negative experiences of staff and patients/public. The data which demonstrates our current situation with respect to workforce and representation will be reviewed and benchmarked across the region as well as nationally, with senior leaders held to account regarding these objectives.

These will be aspirational for international recruits and students/learners from diverse backgrounds, this should hopefully see growth in this sector of our workforce. Over the duration of our plan we shall ultimately hope to see a reduction in health inequalities and outcomes across all protected characteristics.



*We are very keen to create diverse and energetic teams in our health and care system and therefore capitalise on the differences in how people think and use their lived experiences to achieve the best outcomes for our people. We must get organisations to focus their resources and efforts in gaining insight and understanding of who the under-represented groups are in the system, rather than focussing on the most obvious ones. With all of the available data supporting diversity in the health and care workforce, it is critical we push our ambition from 'desirable' to 'must have' in order to optimise our patient outcomes and encourage more health and care staff to come and work in our Integrated Care System.*

**Ganesh Baliah, SNEE ICS Strategic AHP Workforce Lead**

## 5.4 Our commitments

As part of the ICS shared vision to deliver the **best possible health outcomes for every one of the one million people living in SNEE**, we want to enable everyone in SNEE to **'Live Well'**. Our delivery priorities are organised on the six live well domains and are underpinned by a focus upon reducing health inequalities for our local population and ensuring EDI is central to our work.

The table below shows our strategic framework. For each Live Well domain, which articulates the outcomes we are aiming to achieve, **SNEE ICB are making an overarching five year commitment**. These commitments relate to the outcomes we will strive to deliver, as articulated in the SNEE ICS Strategy, what we heard is important to our population, and what our workforce and partners tell us that we need to do better or do differently to improve the services we deliver.



**We will assess our performance in delivering our commitments over the next five years by measuring performance against one or more target indicators in each domain.** These are the lead key performance indicators that we wish to

'target' improvements in, with a particular focus on reductions in health inequalities. Delivery against the target indicators will be achieved through a broad programme of work detailed in full in the JFP and supporting annexes.

<b>Our vision</b>							
<i>Deliver the best possible health outcomes for every one of the one million people living in Suffolk and North East Essex</i>							
<b>Our outcomes</b>	<b>Start Well:</b> Giving children and young people the best start in life	<b>Feel Well:</b> Supporting the mental wellbeing of our population	<b>Be Well:</b> Empowering adults to make healthy lifestyle choices	<b>Stay Well:</b> Supporting adults with health or care concerns to access support and maintain healthy, productive and fulfilling lives		<b>Age Well:</b> Supporting people to live safely and independently as they grow older	<b>Die Well:</b> Giving individuals nearing end of life choice around their care
<b>Our Five Year Commitments</b>	We will ensure that children and young people have the best chance in life with a particular focus on those most in need	We will support people with mental health needs, including those with learning disabilities or autistic spectrum disorders, to stay mentally well and to get support in the community to live and thrive when they need it	We will empower people to lead healthy lifestyles and reduce the number of preventable deaths	Access to care: We will support people to access the right support, in the right time, in the right place for their health and care needs	Early intervention: We will support adults with timely access to services to enable early detection and diagnosis of disease and risk factors to give people the best chance of maintaining a good quality of life	We will ensure that people who are ageing are able to live safely and independently, experiencing a good quality of life	We will enable people and their families to have high quality care and support from all health and care professionals involved at the end of their life
<b>Our cross-cutting priorities</b>	<b>Reduce health inequalities      Enshrine Equality, Diversity and Inclusion in our ways of working</b>						
<b>Our principles</b>	<b>Collaborative    Compassionate    Courageous    Community focussed    Creative    Cost-effective</b>						
<b>Enablers</b>	<b>Workforce    Estates    Digital    Intelligence    Procurement Communications &amp; Engagement    Research &amp; Innovation    Sustainability</b>						

## Start well

The first two years of life are a uniquely important period that set the foundations for lifelong emotional and physical wellbeing. As part of the SNEE ICS collective ambition for all to live well, we want children to start well - before conception, during pregnancy and birth, through childhood and into adolescence – including by supporting families who are experiencing, or at risk of experiencing, disadvantage. We want to ensure that children and young people have the best possible start and are also supported to grow and develop. This includes by tackling conditions such as asthma, the most common-long-term medical condition in children in the UK and a leading cause of health inequalities among children living in the most deprived areas, and by supporting children to have good emotional wellbeing by reducing unnecessary delays for specialist mental health care.

**Commitment** - We will ensure that children and young people have the best chance in life with a particular focus on those most in need

- Reduce the neonatal mortality rate by end of 2023/24 and reduce each year thereafter, addressing inequalities by prioritising reduction in unwanted variation in neonatal mortality
- By 2028, no child or young person waits more than 12 weeks for Child and Adolescent Mental Health Services (CAMHS) or 18 weeks for Neurodevelopmental Diagnostic (NDD) Services, prioritising reductions in waiting times for ethnic minorities and those living in the 20% most deprived areas
- Reduce the hospital admission rate due to asthma of children or young persons living in the most deprived 20% of areas

## Feel well

Good mental health is a state of wellbeing in which every individual realises their own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to their community. Our population wants help to self-care, be involved in their care decisions, have better signposting to support services, and have that support better embedded in their community. SNEE ICS has a collective ambition that the best health and wellbeing is a genuine reality for everyone.

There are stark health inequalities associated with severe mental illness, including death from avoidable medical causes, and we want to take proactive and decisive action in addressing these. We will enable people to maintain good mental health and achieve good recovery whilst living in resilient communities, by delivering the best quality integrated mental health services and by tailoring them to the needs of those who need specialist care.

**Commitment** - We will support people with mental health needs, including those with learning disabilities or autistic spectrum disorders, to get support in the community to live and thrive.

- Achieve a 5% year-on-year increase in the number of adults supported by community mental health services
- Achieve a year-on-year reduction in hospital admission rate for mental health conditions
- Identify and reduce health inequalities amongst people with severe mental illness, by ensuring at least 90% of people, including those in all disadvantaged groups, receive a full annual physical health check and follow-up interventions by 2028

## Be well

By investing in health as an asset and by promoting the conditions for good health we can move towards realising SNEE's higher ambition for a healthy life for everyone. Everyone in SNEE should be able to live a healthy life with good physical, mental and social wellbeing and people tell us that with our support they can be empowered to make healthy lifestyle changes. We also know that access to NHS dentistry is an increasingly important issue for our population and SNEE ICB have ambitious plans to improve oral health. There is a clear social gradient in the harm to health from negative health behaviours and lifestyle factors, including increased prevalence of obesity and smoking. We will therefore support people to make decisions consistent with good health.

**Commitment** - We will empower people to lead healthy lifestyles and reduce the number of preventable deaths

- Halt recent increases in the number of overweight and obese children in reception and year 6 by 2028 and maintain prevalence below the national average
- Reduce the number of smokers in our population in line with only 5% of the population being smokers by 2030
- Increase each year the number of units of NHS dental activity delivered

## Stay well – Access to care

Timely access to all health and care services is one of the highest priorities for our communities. Location, convenience, and familiarity of services are important to people. Rising demand has placed challenges on services; however, long waits can leave people frustrated and risks increasing the acuity of conditions. Our population has experienced significant delays in access to the health and care it needs. We plan to support people access the right support, in the right time, in the right place, by enabling timely access across urgent care services and by reducing waits for planned care.

**Commitment** - We will support people to access the right support, in the right time, in the right place for their health and care needs

- Increase our GP practice teams each year to meet the growing demand whilst increasing the number of trainees and apprentices
- No one waits more than one year for elective care by March 2025
- Increase by 10% each year the number of cases seen by the urgent community response service
- By 2028, 95% of patients attending A&E services wait no longer than 4 hours
- Reduce the number of acute hospital bed days utilised by people without a criterion to reside that are discharged on complex pathways (1-3).

## Stay well - Early intervention, prioritising early diagnosis and treatment for people living in the 20% most deprived areas

We want to support adults with health or care concerns to maintain healthy, productive and fulfilling lives and the best quality treatment, care and support is needed if people are to 'stay well'. This includes a significant focus on prevention, including early detection and diagnosis of disease and risk factors as well as timely intervention. Awareness of symptoms and prompt access to testing also enables early diagnosis. We know that the number of people living with cancer is increasing in SNEE and we know that earlier diagnosis of cancer is needed to address inequalities among our most deprived communities. We also know that cardiovascular, diabetes and respiratory diseases are greatly associated with health inequalities and if not treated can lead to life-threatening conditions such as myocardial infarction and stroke.

**Commitment** - We will support adults with timely access to services to enable early detection and diagnosis of disease and risk factors to give people the best chance of maintaining a good quality of life.

- Increase the percentage of cancers diagnosed at stages 1 and 2 to 75% by 2028
- 80% of people with high blood pressure are identified and treated by 2028
- More than 85% of people with Atrial Fibrillation are identified and 90% of those at high risk of stroke are treated by 2028

## Age well

SNEE ICS has a collective ambition for everyone to live well as they grow older, particularly if they are living with frailty or dementia. The number of people living in SNEE aged 65 or older is set to increase by 33% in the next twenty years. One in ten people aged over 65 are living with frailty and an increasing number of people are living with dementia, including many who do not have a diagnosis, and dementia accounts for more expenditure than heart disease and cancer combined. It is important to prevent frailty, prevent deterioration in those already frail, and mitigate the risk of preventable hospital admissions, such as due to falls.

**Commitment** - We will ensure that people who are ageing are able to live safely and independently, experiencing a good quality of life

- Reduce each year the rate of emergency hospital admissions due to falls amongst the population aged over 65
- Reduce each year emergency acute hospital bed use (bed days per capita) for those over 65 years old
- Achieve the national 66.7% dementia diagnosis rate by October 2024 and an increase in dementia annual care plan reviews completed each year

## Die well

Over 10,000 people in SNEE are in the last year of their life and we wish to ensure that over this time they and those who care for them have the best and most equitable care and support from the resources we have available. Key to this is the timely identification of the people who are approaching the end of their lives, communicating this with them and those who are important to them with sensitivity and honesty.

**Commitment** - We will enable people and their families to have high quality care and support from all health and care professionals involved at the end of their life

- Increase each year the percentage of people identified as approaching the end of life

## Health inequalities (cross-cutting)

**Commitment** - We will ensure a focus on reducing health inequalities by taking a systematic approach to identifying and resourcing opportunities to improve health and care access, experience and outcomes

- By 2028, reduce the number of deaths in under 75s considered preventable, reducing inequalities in our most deprived areas and amongst disadvantaged groups



## 5.5 Start Well – Giving children and young people the best start in life

### Overall Outcome:

Giving children and young people the best start in life

### Overall Commitment:

We will ensure that children and young people have the best chance in life with a particular focus on those most in need

### 5.5.1 Why is this important for people in Suffolk and North East Essex?

We want to ensure that children and young people across SNEE have the best possible start in life from preconception onwards and can have their physical and mental health supported as they grow and develop by reducing health inequalities and adopting tailored approaches where needed.

### 5.5.2 What do we know about people's local experiences?

Key challenges and factors noted include:

- Variation in the quality and quantity of services across SNEE leading to inequality and unacceptably long waiting times
- There is not enough focus on early intervention and prevention
- Longer waiting times for assessment and treatment with a significant increase in referrals
- Gaps in the current commissioned offer, particularly around Tics and Tourette's, Sensory and epilepsy needs
- Physical and mental health care is not joined up enough
- Families unable to access support in a timely way
- Families need support with healthy eating and lifestyle
- People feeling safe, having a positive birth experience, choice, and support
- Better sources of information, delivered through various types of media, which is accessible and enable them to make informed decisions about what they want for their care

- Personalising care to their individual situation to feel safe and to have a positive experience
- More flexible visiting times and overnight stays for hospital births, and birthing partners wanted to be more involved
- Better communication and need professionals to use language which is easily understood and inclusive of their needs
- Better awareness and recognition of perinatal mental health by healthcare professionals and other support postnatally such as signposting to community resources and infant feeding advice

### 5.5.3 How we plan to make a difference

Our priorities for Start Well are set out broken down into preconception, maternity and neonatal care and children and young people.

#### 5.5.3.1 Preconception, Maternity and Neonatal Care

The key priorities we will achieve by 2028 are:

- All babies and families will receive high quality care based on the best evidence available
- Women with heightened risk of preterm birth or a complex pregnancy will receive targeted care to keep them and their babies well during their pregnancy and birth
- Fewer babies will be born to parents who smoke during pregnancy reducing the number of
- babies born prematurely and/or with low birth weight
- miscarriages and neonatal deaths
- babies who have long term health conditions such as respiratory conditions, cardiovascular disease and obesity
- Families will have continuity of carer during pregnancy, birth and the postnatal period. In particular, we will ensure continuity of care for women from minority ethnic communities and most deprived groups, aligned to the ambitions of the Core20Plus5 approach

- Families will be able to access services and information in a more convenient and efficient way. Digital technologies will help them make informed choices about their care, enabling them to have personalised care according to their needs and wishes
- Families will have an enhanced experience during the worrying period of neonatal critical care. Families and their babies will receive high quality specialist neonatal care. Neonatal care will be safe, effective, co-ordinated, and based on best practice
- Pregnant people, babies and families will be able to access joined-up antenatal care, birth facilities, postnatal care, mental health, specialist services, health visiting and social care services
- Families will be better supported to feed using evidence-based best practice
- Mothers, birthing people and their partners will have improved access to high quality perinatal mental health care
- Women will have improved postnatal physiotherapy to support them to recover from birth
- We will develop and support our workforce to offer high quality, kind and compassionate care for our service users and partners

We will know we are making a difference because we will see:

- Reduce the neonatal mortality rate by end of 2023/24 and reduce each year thereafter, addressing inequalities by prioritising reduction in unwanted variation in neonatal mortality

- A reduction in the rate of infants with a brain injury occurring during or soon after birth from 5.33 per 1000 live births in 2017 to 2.50 in 2023/24

Further details on the plans for Preconception, Maternity and Neonatal Care are available in Appendix 6 – Start Well.



**“** Maternity and neonatal services have a critical role in providing every child with the best start in life. The Local Maternity and Neonatal System will focus on ensuring our services are based on the most recent research and national guidance, will support our staff to provide compassionate and personalised care, and will work with System partners to reduce any health inequalities our families may face. We strive to provide excellent care and support to all families within SNEE. **”**

**Frances Bolger, Director of Midwifery**

**Public feedback:**

*“Living in a rural setting made my pregnancy and early parenthood isolated and lonely”.*

*“Every pregnancy should have a named midwife and continuity of care”.*

**Case Study**

**Anna’s Story**

Two and a half years ago I had a traumatic assisted delivery at Colchester Hospital which left me with a beautiful healthy baby boy, but a grade 4 tear and significant post-partum haemorrhage. It took me months to recover. We were told then that any future children would need to be delivered by caesarean section. I became pregnant again late last year.

When I arrived in triage for my pre-op I was incredibly nervous to even be in the building again. I cannot convey to you enough how wonderful Denise (midwife) and the whole team were on that day, putting us at ease and explaining everything. On the day of our

caesarean section, Denise and the whole team were wonderful and made our section and daughter’s birth so special, we felt safe and cared for.

The continuity of having one main person care for us was the main factor in this, we completely trusted her and she was wonderful! I was home within 24hrs after the lovely Zelia and the obstetrician had checked us over. A few days later we had a follow up call from Denise to check I was fine and recovering well.

Working for the NHS myself, I am fully aware of the constraints placed on services, and I would therefore like to congratulate you on achieving what felt like gold standard care within what I am sure are very limited resources. We will be forever grateful to Denise and the Venus team for giving us a wonderful birth experience.

### 5.5.3.2 Children and Young People

The key priorities we will achieve by 2028 are:

- **Neurodevelopment Services** – Children, young people and families have access to a care pathway that facilitates a standardised and improved ways of working across the system to achieve better outcomes
- **Mental Health** – Children, young people and families will have access to excellent mental health and emotional wellbeing supporting everyone to get the right support, at the right time, from the right people, in the right place and in the right way
- **SEND** – Children, young people and families can access appropriate therapeutic support promptly, with identification of need at the earliest possible opportunity
- **Asthma** - Children, young people and families will be more confident in managing their long term condition and get the correct interventions and support when needed with the hope of their asthma not worsening
- **Epilepsy** - Children, young people and families will have access to epilepsy specialist nurses to support long term conditions. Those with learning disabilities or autism will have access in the first year of care
- **Diabetes** – Children, young people and families will have access to diabetes teams to help manage their long term condition through childhood and in the transition period to adulthood and related services

- **Learning Disability and/or Autism** – Through a Dynamic Support Register (DSR), Key Working Function (KWF) and Short Breaks Provision – children and young people with a learning disability and/or autism with a co-existing mental health condition and/or who display behaviour that challenges, will not be admitted to a specialist hospital for treatment unless absolutely necessary. They will receive support that will enable them and their families to navigate the multidisciplinary system

We will know we are making a difference because we will see:

- Consistent reduction in Autistic Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) assessment waiting times by September 2024 (18-month recovery plan)
- 95% of children and young people in care under 25 commence mental health treatment within 15 weeks of referral
- Meeting access and waiting time standards in Eating Disorder Services with 95% seen within one week for urgent and within four weeks for non-urgent
- Reducing wait times for assessment and treatment in mental health services. We expect an improvement towards the four weeks for referral to assessment and 18 weeks for referral to treatment standards in the next six months and to meet standards by December 2024

Further details on the plans for children and young people are available in Appendix 6 – Start Well.



*We have worked hard over many years listening to the voice of children and families so that we can shape services to the needs of the local population, this plan sets out those key areas that we continue to develop jointly with all our system partners including children and families to delivery better outcomes for all.*

**Allan Cadzow, Corporate Director for Children and Young People, Suffolk County Council**



#### Public feedback:

*"Happy, healthy children = happy, healthy futures"*

## Case Study



### Crisis, Help and Risk Intervention Service

Adam is a 16-year-old male who was referred to the Crisis, Help and Risk Intervention Service (CHRIS) following several visits to ED. Adam was seen in hospital five times during the same week prior to the CHRIS referral being received. He had tried to end his life by taking tablets, tying a ligature around his neck, and was found by police at the top of a railway bridge where he said he intended to jump. The formulation indicated that Adam's crisis could be attributed to him being 'stuck in the belief that he would only be safe in hospital, and the only action available to him was to be admitted. CHRIS work was mainly focused in helping Adam to shift from that belief and start to 'see and accept that he can be better supported in the community.

CHRIS practitioners held consistent professionals' meetings to ensure that the same messages were being conveyed to Adam - that he would no longer be admitted to hospital and that, as an alternative, his needs would be met by the community. CHRIS offered individual work with Adam (based on acceptance, value-based goals, belonging) and systemic work with the parents and the wider system. When closing the case, a structured and planned ending was provided to support the change being sustained.

Adam spoke of the ending being "sad but good sad" which was massive step forward in his ability to tolerate emotions, something he could not do before. At the time of discharge, Adam had no incidents requiring him to attend Emergency Department (ED) for over a month. He has acquired a gardening job and starting to spend more time with his friends and was starting college in September 2022.

## 5.6 Feel Well – Supporting the mental wellbeing of our population

### Overall Outcome:

Supporting the mental wellbeing of our population

### Overall Commitment:

We will support people with mental health needs, including those with learning disabilities or autistic spectrum disorders, to stay mentally well and to get support in the community to live and thrive when they need it

### 5.6.1 Why is this important for people in Suffolk and North East Essex?

The best possible mental health and resilience is essential if everyone in SNEE is to live well and age well. Good mental health is a state of wellbeing in which every individual realises their own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a

contribution to her or his community. Like physical health, people can experience both temporary and long-term mental ill-health.

### 5.6.2 What do we know about people's local experiences?

Key factors and challenges noted include:

- People want help to self-care and understand the mental health benefits of balance and moderation in their lifestyle choices
- People want to be involved in care decisions, have the same choices and rights regardless of location, and have access to advocacy
- Better signposting is needed to support services including peer support groups, voluntary sector and therapeutic activities including art, singing and exercise
- People want mental health support to be better embedded in primary care and the community. Timely advice and guidance on physical and mental health issues together is needed to improve outcomes



- Every death by suicide can have a devastating effect on families, friends, colleagues, witnesses, frontline staff such as first responders and entire communities. Preventing suicide is a major public health issue and is a priority for health and wellbeing partners in SNEE. In North East Essex for the same time period, the age standardised suicide rate was 16.0 per 100,000 (n=138). This is the third highest rate in England
- Access, continuity of care and co-ordination is an issue, better support for finances and social issues is needed on discharge from acute services and organisations should communicate better and use the same terms
- Follow up support after a crisis episode or assessment in ED should be improved. People should have a 'safety net' to return back into care facilities if needed
- Further support is needed following a bereavement
- In 2020 the Commission on Alcohol Harm published a report 'It's Everywhere' - Alcohol's Public Face and Private Harm<sup>31</sup>". The report describes the burden alcohol misuse places on public services and the economy - in England, the total cost of alcohol was estimated to cost the NHS £3.6 billion, while alcohol-related crime in England and Wales was estimated to cost society around £11.4 billion per year
- Prompt access to mental health support for people and their carers by providing improved access to community-based integrated therapies and support. These services will cater to people with the most complex needs, people experiencing racial disparities in services and carers
- Ensuring people receive the best quality integrated services to achieve recovery and good mental health, delivered in the right way, in the right place and at the right time. We will ensure our people receive the best quality community-based person-centred care, the best quality inpatient care provided locally and support people with gender dysphoria to receive high quality care
- Ensuring people receive the best care and support when experiencing a mental health crisis. We will achieve this by providing access to people in mental health crisis and their carers to community-based support to help avoid crisis and acute inpatient admission. In addition, we will provide prompt access to those who need crisis mental health services and the best quality emergency first response care to people in mental health crisis and their carers. We will also ensure people in emergency care settings have full access to mental health assessment and support

We will know we are making a difference because we will see<sup>32</sup>:

### 5.6.3 How we plan to make a difference

Our priorities for Feel Well are broken down between mental health, suicide prevention, addictions and trauma and abuse.

#### 5.6.3.1 Mental Health

The key priorities we will achieve by 2028 are:

- Enabling people to maintain good mental health and physical health and be resilient by providing information and support on potential risks to mental health and how to maintain wellbeing. We will also provide greater access to resources that support and protect people's wellbeing
- Ensure people live in resilient and inclusive communities by providing local community services that work together to support people's mental health throughout their lives
- Delivery of the ongoing annual NHSE Mental Health Investment Standard (MHIS) providing increased parity across mental health and physical health services investment
- Increasing in 2023/24 the proportion of people with severe mental illness receiving a full annual health check and follow-up interventions from 2022/23 reported levels
- Delivering Early Intervention in Psychosis services at EPUT and NSFT at NICE standards Level 3 or above including expansion of At Risk Mental Health Services by March 2025
- Working to eliminate inappropriate adult acute out of area placements by March 2025 and reduce the days spent in inappropriate out of area placements by adults needing non-specialist acute mental health inpatient care from 2022/23 levels
- An increase in coverage of 24/7 adult crisis resolution and home treatment teams, and community support by March 2024
- Increasing access to specialist perinatal mental health care in 2023/24 against reported 2022/23 levels

<sup>31</sup> Available: <https://ahauk.org/resource/commission-on-alcohol-harm-report/#:~:text=on%20Alcohol%20Harm-,%20%20evenwhere'%20%E2%80%93%20alcohol's%20public%20face%20and%20private%20harm%3A,the%20harm%20caused%20by%20alcohol>

<sup>32</sup> **Note:** As at February 2023, we have reached the end of the NHSE Five Year Mental Health Long Term Plan covering 23/24. Further targets will be agreed during 23/24 covering 24/25 to 27/28 and will be included in the subsequent refresh of the JFP

- Reduction in hospital admissions for mental health conditions by 2026 supported by increased recruitment to primary care mental health practitioners and focus on early prevention and intervention approaches

Further details on the plans for Mental Health are available in Appendix 7 – Feel Well.

**Public feedback:**

*“Clarity of where to get help early will stop crisis developing”*

*“As well as talking about mental illness we need to support and encourage mental wellness”*



*Supporting the mental health and emotional wellbeing of our population is a key priority for our SNEE system. Good mental health and emotional wellbeing is achieved by ensuring that individuals, their families and carers can meet their emotional needs and they can access the right support at the right time. In SNEE we are committed to working with our partner agencies and service users with experience, to ensure that all parts of the system make mental health everybody’s responsibility and that the broader determinants of mental health are fully considered as part of the solution including preventive measures.*



**Richard Watson,**  
SNEE ICB SRO for Mental Health and  
Deputy Chief Executive, NHS SNEE ICB



## Case Study



### Healthy Together (Suffolk Users Forum) – John’s Story (2022)

The SUF Healthy Together Service offers peer support for people with SMI, which includes Bipolar Disorder, Schizophrenia and Psychosis, who following a SMI annual physical health check would benefit from additional support to achieve physical health and wellbeing goals.

John was referred to Healthy Together for healthcare follow up appointments, including podiatry care, as his toenails had not been cut for over a year and he found walking painful. We called John the day after his referral from the SPHT and his biggest concern on the day was that his kitchen sink has been blocked for six weeks. Despite him calling his housing provider, he had not been able to get the problem resolved. Following our call to the provider a plumber went out that evening and the sink was unblocked. John was pleased.

He had been so upset because the issue had been going on for so long. He’d been unable to use his sink, his dishes were piled up high, and as it was summer, he was struggling the high number of flies in his flat.

Working together we went on and arranged for a private podiatrist to visit John at home. This has revolutionised his life, he is now pain-free and mobile. John has gone on to build a good relationship with podiatrist, growing in self-confidence to arrange ongoing podiatry appointments. With support John has attended other health care appointments and now has more confidence to arrange and attend these by himself. He is now engaging well with his GP and NHS staff in both primary and secondary care.

John told us - “Brilliant work, since you have been on board, we have been chipping away at my healthcare needs and things are moving forward. Before nothing was happening. I’m so happy that you managed to get my sink unblocked as the people I tried to speak to weren’t very nice.”

### 5.6.3.2 Suicide Prevention

The key priorities we will achieve by 2028 are:

- Focusing on evidenced-based interventions to reduce the risk of suicide in key high-risk groups
- Reducing access to the means of suicide
- Providing better information and support to those bereaved or affected by suicide
- Support is given to the media to help deliver sensitive approaches to suicide and suicidal behaviour
- Improved research, data collection and monitoring of suicides
- Embedding a system-wide focus on self-harm prevention in children and young people and adults, because it is a key indicator of suicide risk

We will know we are making a difference because we will see:

- Age standardised suicide rates in Suffolk not rising above England or regional averages by 2028 (Suffolk current position at the England average)
- Age standardised suicide rates in North East Essex reducing downwards to those of England or regional averages by 2028 (current North East Essex position as a national outlier)
- SNEE ICB investing in a twelve-month dedicated suicide prevention role in North East Essex hosted by Essex County Council from April 2023
- The role will review annual suicide data and real time suicide surveillance (RTSS) suicide reports, identify recommendations and focus attention on the factors driving higher rates of suicide within key groups and local communities
- An agreed SNEE cluster response protocol is in place by 2024, which will ensure a timely and coordinated response to suspected clusters of suicides
- 100% of people reported to have been bereaved or affected by a suspected suicide will be provided with information about support services available by 2025
- An increase in the knowledge, training and confidence of general practitioners and primary care staff around suicide prevention practice from 2025
- All interventions applied to identified high risk groups will be based on nationally recognised best practice by 2028
- A system wide self-harm plan in place by the end of 2023, with actions delivered by 2028

Further details on the plans for Suicide Prevention are available in Appendix 7 – Feel Well.



*Every suicide is a tragedy that causes devastating impacts on families, friends, and broader communities. Seven out of ten people dying by suicide are not known to Mental Health Services, which demonstrates that the factors leading to someone taking their own life are complex and multi-dimensional. This is why Suicide Prevention, although led by Public Health teams, requires a system wide approach across SNEE. We will continue to work together to ensure that these avoidable deaths are prevented at every opportunity.*

**Sara Dunling-Hall, Consultant in Public Health, Suffolk Public Mental Health & Health Care Public Health**



### 5.6.3.3 Addictions

The key priorities we will achieve by 2028 are:

- Children, adults and older people avoid the dangers of tobacco. We will enable this by supporting people to live in a healthier, smoke-free environment and by 2028 and we will have demonstrated progress towards the national smokefree 2030 target
- People are able to avoid or reduce alcohol and drug related harm. We will enable this by sharing public health messages on vaping as a smoking cessation aid by October 2023. By 2024, everyone entering hospital as an inpatient in acute mental health or maternity services will be asked about their smoking status
- People are able to avoid or reduce alcohol or drug related harm through the delivery of awareness campaigns and training programmes across SNEE
- People with serious gambling problems receive high quality specialist support by expanding NHS specialist clinics, and integrated working to help more people with serious gambling problems

We will know we are making a difference because we will see:

- Achieve a year-on-year reduction in hospital admission rate for mental health conditions
- Smoking-attributable mortality will have reduced from 2017-19 rates and will have remained below the England level by 2028
- We will have halted the rise in alcohol-related mortality and maintained mortality at below England level by 2028
- We will have halted the rise in deaths from drug misuse and maintained mortality rates at below England level
- Smoking attributable hospital admissions will have reduced and will be maintained at below England levels by 2028
- The rate of smoking at the time of delivery will have reduced to 6% or less in line with national targets by 2028
- By 2024/25 all smokers who are inpatients in acute and mental health settings will be referred to smoking cessation services on an opt out basis

- The proportion of people who successfully complete alcohol treatment will have increased to at least the England rate (36.6% at 2021) by 2028
- The rates of successful completion of drug treatment (opiates) will have increased to 7% from the current rate of 6.1% by 2028
- More people will have successfully completed gambling addiction programmes

Further details on the plans for Addictions are available in Appendix 7 – Feel Well.



*Alcohol and Substance misuse seriously impacts on a person's life, work and relationships, and on those of the people around them. We will ensure commissioned services to support those who experience issues are integrated and consider their needs in the round. Smoking continues to be the leading preventable cause of illness and premature death with areas such as Ipswich having some of the highest rates of smoking in the East of England – we will renew our collective efforts to help local residents.*



**Stuart Keeble, Director of Public Health, Suffolk County Council**



## Case Study



### Supporting Communities of Drug and Alcohol Recovery in Suffolk

Peer support is an invaluable tool to support people to maintain their recovery and reduce harm from substance misuse. An effective example of this is the Recovery's Got Talent Programme, initially funded through the Recovery Grant Scheme and now part funded through income generation from their activities. The Recovery Grant Scheme awards small grants to financially assist in developing projects that will improve and sustain the recovery of clients engaged with, or who have completed drug and alcohol treatment and rehabilitation.

The programme is led by people in recovery via a steering group supported by a dedicated worker

from the specialist drug and alcohol treatment service. The group plan and put on an annual celebration of recovery – 'Recovery's Got Talent'.

The show is now in its sixth year and has provided people in recovery from addictions a platform to showcase their talents from poetry performance, singing dancing and even stand-up comedy. As a direct result of meeting due to Recovery's Got Talent, a group of talented people in recovery have now formed the 'East Coast Poets' who meet virtually every week and have been invited to perform their poems and stories at the Theatre Royal and the Primadonna and SaxFest festivals. People state that finding a meaningful use for their time is one of the hardest aspects of sustaining recovery from addiction and preventing relapse. The creative communities of recovery which have developed across Suffolk as a direct result of the success and appetite for Recovery's Got Talent provide this.

#### 5.6.3.4 Trauma and Abuse - Safeguarding Children and Adults at Risk

The key priorities we will achieve by 2028 are:

- Safe at home: All healthcare services will have a domestic violence and abuse policy, have a lead person responsible for the response to domestic violence and abuse and will train staff to recognise the signs of possible domestic violence and abuse
- Safe in our communities: Health Strategic Needs Assessments will be completed and a strategy will be developed that reflects the voices and lived experiences of the communities in SNEE by the 31st January 2024
- Safe safeguarding systems across SNEE: We will continue to explore system issues and processes to improve and maintain compliance with national requirements via initial health assessment reviews. Designated professionals for looked after children will continue to explore and support health assessment provision for the increased numbers of separated migrant children placed into SNEE

We will know we are making a difference because we will see:

- By 2024 we aim to have a data sharing and reporting framework that provides regular data intelligence of domestic and sexual violence and abuse
- Ensure that there is appropriate commissioning within SNEE ICB to prevent, treat and manage serious violence by January 2024
- Deliver bespoke training sessions on the Mental Capacity Act for primary in 2023 across SNEE



*It has been said that the true measure of any society can be found in how it treats its most vulnerable. We will continue to work in partnership across the ICB to raise awareness of abuse and support those who have experienced trauma through the life course. This JFP reflects our joint ambition to ensure the population of SNEE ICB are safer at home, safer in our communities, supported and protected by our safeguarding systems.*

**Fiona Ellis, OBE, Co-founder and CEO of Survivors in Transition**



## Case Study



As a result of work completed by the Designated team domestic violence notifications from the Police are now shared and added to health records but this has not always been the case. Below is a real local case study which clearly demonstrates the significant benefits to this process.

Jack is a 4 year old boy with speech delay, his Mum and Dad's relationship is an abusive one with at least 2 domestic violence Police notifications attached to his health record. His speech therapist (SALT) was due to see Jack and was reviewing his records before the appointment when she noted the Domestic violence notification, she also noted a recent Multi-Agency Safeguarding Hub (MASH) entry to his record which stated following the Police involvement a safeguarding referral had been made to consider the risk to Jack following his Dad's violent outburst towards his Mum. The outcome from the MASH was that Mum had been spoken to and confirmed the relationship had ended and Dad was no longer having contact with Jack, MASH then made the decision that there was no need for social care involvement. However, it was noted on the MASH entry to the health record that

if professionals had evidence the relationship had resumed a further MASH referral should be made.

During the speech therapy appointment, they discussed what Jack did at the weekend and Mum explained they'd had a lovely time with Dad at the beach.

Following some advice from the Named Nurse the SALT was clear she would need to discuss this with Mum after the appointment without Jack present when she was able to explain her concern and the need to make a further safeguarding referral. Mum understood the need for this and appreciated the therapist's honesty. Between the SALT and MASH they agreed a safe time for MASH to contact Mum to discuss the concerns (ensuring Dad was not with her). She was then supported by social care to safely separate from Dad and move to a new area.

This identification of ongoing risk and Mum's consequent safe separation from Dad was as a direct result of the sharing of information from Police into health records and the clear outcome MASH had recorded for health professionals to see. It demonstrates excellent partnership working between the SALT and MASH putting the safety and wellbeing of Jack and his Mum as a high priority.

## 5.7 Be Well – Empowering adults to lead healthy lifestyles

### Overall Outcome:

Empowering adults to lead healthy lifestyle choices

### Overall Commitment:

We will empower people to lead healthy lifestyles and reduce the number of preventable deaths

### 5.7.1 Why is this important for people in Suffolk and North East Essex?

Everyone in SNEE should be able to live a healthy life with good physical, mental and social wellbeing. There is a clear social gradient in the harm to health from health behaviours and lifestyle factors which have been exacerbated by the Covid-19 pandemic. Action is needed to reduce health inequalities and prioritise the prevention of ill health.

### 5.7.2 What do we know about people's local experiences?

Key factors and challenges noted include:

- People tell us that information on behaviour change would help them use a healthy living service or group
- Services that are relevant to people and convenient for them to use are important. People are seeking a flexible offer that fits around their lives and is responsive to changing needs. We also need to do more to reach communities who have not traditionally engaged in services and to address the determinants of poor health and wellbeing
- People commented on language around health behaviours noting the need to avoid stigmatising and blame
- Although women in the UK on average live longer than men, women spend a significantly greater proportion of their lives in ill health and disability. It is important to note that our focus on women's health is inclusive, when we refer to women we include those who are intersex, non-binary and transgender men where appropriate

- In a national call for evidence in 2021 84% of respondents felt that women's voices in relation to healthcare were not listened to. Not enough focus is placed on women-specific issues like miscarriage or menopause, and women are under-represented when it comes to important clinical trials
- According to data from 2018, nearly 4 out of 10 adults in Essex (38.9%) have active tooth decay which is the highest among similar counties. This is much higher than England (26.8%) and East of England (24.9%) average, Suffolk is in line (25%) with the East of England and below the average for England
- Poor eyesight not only leads to social isolation and loneliness but also is a known risk factor to comorbid chronic illness and cognitive decline, dementia, falls and mortality. For most people a decline in eye health is avoidable and treatable
- All people should:
  - Be seen as a whole person within the context of their whole life, valuing their skills, strengths and experience and important relationships
  - Experience hope and feel confident that the care and support they receive will deliver what matters most to them
  - Access information and advice that is clear, timely and meets their individual information needs and preferences
  - Be listened to and understood in a way that builds trusting and effective relationships with people
  - Be valued as an active participant in conversations and decisions about their health and wellbeing
  - Be supported to understand their care, treatment and support options and, where relevant, to set and achieve their goals
  - Have access to a range of support options including peer support and community-based resources to help build knowledge, skills and confidence to manage their health and wellbeing
  - Experience a coordinated approach that is transparent and empowering

## 5.7.3 How we plan to make a difference

Our priorities for Be Well are broken down into healthy behaviours, personalised care, women's health, dental/oral health and eye health.

### 5.7.3.1 Healthy Behaviours / Healthy Life for Everyone

The key priorities we will achieve by 2028 are:

- Children, adults and older people are supported to stop smoking
- Children, adults and older people are supported to maintain a healthy weight, be physically active and to eat and drink healthily
- Children, adults and older people are supported to get the sleep that they need by better understanding the principles of good sleep hygiene and ensuring vulnerable people of all ages have a safe and healthy environment to sleep
- Young people, adults and older people have good sexual and reproductive health by providing information on how to maintain good sexual and reproductive health, providing the support needed to those with unplanned pregnancies. We will also ensure there is timely access to testing and treatment for sexually transmitted infections and ensure services and support are provided equally to the population of SNEE
- Children, adults and older people are socially connected and avoid loneliness by running awareness campaigns to tackle the stigma of loneliness, encouraging people to volunteer to feel better connected
- Children, adults and older people are able to live in a clean and sustainable environment
- Weight Management - the NHS Long-Term plan committed to a stronger focus on prevention and in reducing the serious health concerns that people living with obesity can experience. It is the social, economic, and commercial environments that drive obesity and not a lack of personal will power. It isn't as simple as eat less and move more. It is complex with many factors that drive our health more broadly. SNEE has more than 70% of adults of BMI greater than or equal to 25, compared to the East of England as a whole. We will improve access to all Tiers of care locally starting in 2023-2024 for Suffolk Tier 2, we will be recommissioning and reimagining our Tier 2 services in the community led by Suffolk County Council (SCC) Public Health. In addition, over the next 5 years we will also look have improved pathways of care for an integrated Tier 1-4 adult weight management

We will know we are making a difference because we will see:

- Healthy life expectancy for males and females will increase and the social gradient in healthy life expectancy will reduce over the course of this strategy to 2028
- By 2028, reduce the number of deaths in under 75s considered preventable, reducing inequalities in our most deprived areas and amongst disadvantaged groups
- The proportion of adults (aged 18+) classified as overweight or obese will reduce to below 60% and stay below the national level
- The prevalence of overweight and obesity in children in reception and year 6 of primary school will have halted by 2028 and be maintained at below the national level
- By 2028 the rate of conceptions in people aged 17 years and under will have reduced by 5%
- By 2030 we will have reviewed options for the recommissioning of Tier 3 and 4 services by 2030 and created an integrated offer for Tier1-4 services

Further details on the plans for Healthy Behaviours are available in Appendix 8 – Be Well.



*So much of the work we do is about preventing ill health. This means understanding the factors that keep people well, ensuring they enjoy as many years as possible in relatively good health. While there are many issues that affect health, from the quality of people's environment to their education and opportunities for good work, we also know that certain behaviours can also have a significant positive or detrimental impact on personal wellbeing. That's why we empower people to be healthy across a range of services and with different partners and our accompanying campaign and social marketing work also encourage people to make small changes to improve their health.*

*From our current integrated healthy lifestyle service, we are also developing a new partnership model with district and borough councils in Suffolk to provide a more localised, tailored offer to support people to lose weight, quit smoking and to be more active.*

**Cllr Andrew Reid, Suffolk County Council  
Cabinet Member for Public Health and  
Public Protection and Chairman of  
Suffolk Health and Well-Being Board**



### Public feedback:

*"Volunteering is vital, volunteers underpin healthy communities"*

*"To enable healthy communities it is necessary to tackle issues such as better public transport, cheaper healthy food, housing"*

## Case Study

### Tackling physical inactivity in Essex head on

Essex was chosen by Sport England as one of 12 areas in England to tackle physical inactivity in a ground-breaking way. Our Local Delivery Pilot focuses on three localities across Essex, two of which are Colchester and Tendring.

We aim to improve physical activity for everyone, but with a targeted focus on three populations: older people, families with dependent children

and people with poor mental health. We are taking a whole system approach, increasing community engagement and cohesion through new social movements, networks and communications.

We are developing community capacity and creating active environments. We are also learning from our experiences and creating sustainability. We are already developing new partnerships and aligning our strategies and priorities to this work. We will continue to work closely with all our partners to ensure our whole system change work links closely with wider developments and to share our learning.

### 5.7.3.2 Personalised Care

The key priorities we will achieve by 2028 are:

- People can manage their own health and wellbeing by providing the appropriate advice and support needed to self-manage their care
- People have maximum choice and control over their health and wellbeing care and support. We will ensure people's care and support is based on what matters to them and their individual strengths and needs as well as ensuring all medical records are made and shared in line with best practice. We will support people with long term conditions and disabilities to have more choice and control over how the funds for their health and wellbeing are spent and provide access to support for people's health and wellbeing within their local communities
- People have expert support to make the care decisions that are right for them in partnership with professionals who are caring for them through shared decision making across the system
- We work as a system to deliver personalised care for all our population in SNEE that respects personal choice, addresses inequalities and increases independence and wellbeing

We will know we are making a difference because we will see:

- An increase in personalised care and support plans either patient held or recorded in our system to 78,000 by 2027/28
- An increase in personal health budgets to 6,500 by 2027/28, linked to personalised care and support plans



*We have listened to what people say about their health and care, and about services in SNEE. They want us to adopt a personalised approach and talk to how this will lead to better health outcomes and a reduction in health inequalities.*

**Andrew Kelso, Medical Director,  
NHS SNEE ICB**



### Public feedback:

*"This is the key to all good quality services and should run through every element of the Plan"*  
*"Personalisation is what every person accessing the NHS deserves and what all services should aim to deliver."*

Further details on the plans for Personalised Care are available in Appendix 8 – Be Well.



## Case Study



### Pam's Story

Pam was admitted to hospital following a fall at home. The medical team deemed her medically fit to go home. Her daughter contacted the ward and explained Pam had been showing signs of confusion and had left the gas hob on 3 times. It would have been unsafe for Pam to return home to the same situation.

#### Personalised Care and Support Plan

Pam was seen by the ward based social prescriber. She told him she felt highly anxious about going back home. She knew that her memory "sometimes let her down" and she knew that she might fall again and might forget to turn off the gas hob. What mattered to Pam was to remain at home, to be able to look after herself and to carry on cooking, just as she always had done.

#### What the Social Prescriber did

Purchased an electric hob using the discharge PHB fund. Pam was able to return home with a minimised risk of readmission or further harm or injury. Once home, Pam could cook and care for herself in the independent way she valued. With Pam's agreement, she was referred to the fire brigade for a safety assessment. The social prescriber followed this up a week post discharge and liaised with the family to make sure they had the information they needed to act on the assessment outcomes for improved home safety.

#### Personalised Care Outcomes

- Discharge was not delayed due to non-medical reasons.
- Bed days saved = £2,800
- Immediate health and safety concerns were addressed.
- The PHB was used to meet Pam's personalised wish to remain at home and to carry on cooking independently for herself.
- Pam felt she had been listened to and she and her family felt happier about her going home.



### 5.7.3.3 Women's Health

The key priorities we will achieve by 2028 are:


- Appointment of a women's health ambassador to advocate for women in all aspects of health and care from research to training and commissioning and design of services by December 2023
- Creation of a menopause centre of excellence working with the University of Suffolk, the University of Essex, Healthwatch Suffolk and Essex and partners by December 2023
- Formation of a system women's health forum to hold accountability for the aims and deliverables by March 2024
- Female representation at all decision-making forums, mirroring that which is happening at national level at both system and local level by March 2024
- Creation of an EDI workstream building on the research completed with University of Suffolk regarding EDI and menopause. To review issues such as gender and screening programmes, equality of access and diversity research by December 2024
- Collation of baseline data both quantitative and qualitative and creation of KPIs by July 2024
- Triangulation of existing research on women's health system-wide and creation of a research workstream to increase clinical research on women's health by December 2024

- We will work with colleagues in Public Health to better understand women's health inequalities
- We will also ensure we consider the differences experienced by women of different ethnicity and culture, sexual orientation and the challenges experienced by women with disabilities as examples of the diverse population that we serve
- We want to ensure that our healthcare professionals can understand and spot the signs of abuse. We also want to ensure that survivors of abuse and violence have access to trauma-informed services, and work with our partners to provide information for our local employers to support women and girls in and out of the workplace

We will know we are making a difference because we will see:

As scoping and consultation work completes, priority KPIs will be agreed as part of a dashboard. Performance will be monitored via the Women's Health Forum, and governance agreed to ensure board oversight<sup>33</sup>.

Further details on the plans for Women's Health are available in Appendix 8 – Be Well.



**“** *The Women's Health Strategy described stark inequalities in the outcomes that women can expect from health and care in the NHS. This is simply not good enough. We have a moral imperative to make this right, starting by listening to the women in our system and what they want us to deliver on.*

**Lucy Wightman, Director of Public Health, Essex County Council**

**”**

## Case Study

### Clinical Consultant Working in a Local Acute Trust

'I am a bit shocked at how ill-informed I am (as a doctor). I had very little useful undergraduate training on menopause (although that was >25 years ago and I would hope things are changing)

and I suddenly find I am of that age and need to know this stuff! I think awareness is improving thanks to e.g. Davina McCall, but there is still a significant way to go. The NHS has a very high proportion of staff who will be directly affected by menopause, and I am very grateful to you for setting up these sessions to better inform staff who will be affected PLUS the organisation that employs these staff.'

<sup>33</sup>Women's Health is an area of development nationally and within SNEE ICB. Further detail will be provided in the 2024/25 JFP once commitments are more defined

### 5.7.3.4 Oral Health

The key priorities we will achieve by 2028 are:

- Children, adults and older people can be provided with behaviour-management advice and techniques that reduce or prevent oral health problems through public health campaigns, working with schools, universities and health care professionals (Prevention)
- Children, adults and older people have access to high quality oral health services (Access)
- People have equality of access to oral health services (Access)
- No urgent treatment for acute or mental health will be delayed by people not being able to access NHS Dentistry (Urgent and Emergency Care Access)
- Nobody in pain or after trauma is unable to get advice, support and timely treatment from the NHS Dental service across SNEE (Urgent and Emergency Care Access)
- People will be able to access a single point of contact, to identify where their nearest NHS dentist is available and get a check-up in a timely manner (Access)
- All domiciliary and community specialist care services in SNEE can assess people in a timely manner, with courses of treatment being undertaken to support the long-term care of this cohort (Specialist Access)
- People have oral health services that are integrated and based on best practice (Integration)

- There is local training capacity for dental professionals (Training and Development)

We will know we are making a difference because we will see:

- Access to NHS dentistry available to all people within SNEE with improved access to NHS dentistry for children and adults, including in residential settings by September 2023
- Increases each year in the number of units of NHS dental activity delivered
- 10% fewer children with one or more decayed, missing or filled teeth by 2026
- 20% fewer hospital admissions for dental decay in children aged 0-5 years by 2026



*“ Access to dental services is complex and there are a multitude of challenges and barriers that influence an individual’s ability or willingness to access care. It is important to recognise that no single approach will improve access for all. The ICBs dental plans are ambitious, and we believe routine dental care should be available to all who want or need it.*

**Richard Watson, Deputy Chief Executive, NHS SNEE ICB**

Further details on the plans for Oral Health are available in Appendix 8 – Be Well.

## Case Study



Mrs B, a 37 year old female who had undiagnosed gastric reflux disease which caused the enamel on her teeth to be severely damaged. Mrs B woke up with significant pain on the left side of her mouth, and contacted her GP. The GP was unable to provide support and signposted Mrs B to 111 for advice on where to get help. 111 provided her with a website, and advice on local dental practices on where to get help. Mrs B was unable to get help at any local practice, all reporting that they had no capacity. Within a week Mrs B’s

pain had increased so much that she called 999, 999 sent an ambulance crew, who were unable to control the pain, so transferred her to the hospital’s ED. She was assessed by the oral surgeons at ED and it was agreed to remove multiple teeth for Mrs B. Mrs B was then admitted for 7 days. The above plan when implemented will offer Mrs B many more options to resolve her dental pain before having to have surgery under a general anaesthetic.

### 5.7.3.5 Eye Health

#### Why is this important for people in Suffolk and North East Essex?

The key priorities we will achieve by 2028 are:

- Extend the collaborative approach across our ICS to deliver high volume surgical hubs that improve equity of access and productivity (from 2024 to 2028) and increase utilisation and collaborative working with community ophthalmology partners to maximise capacity within a community setting'
- Implement standardised and integrated pathways across cataracts, Community Urgent Eye Services/ Minor Eye Care Services, Medical Retina and glaucoma pathways including:
  - Primary, secondary, community and independent sector eye care services (2023 to 2025)
  - Risk stratification approach to support new to follow up outpatient appointments (2023 to 2024)
  - Development of our primary care optometrists as first contact practitioners to deliver 'Optometry First' managing low risk people in the community as much as possible (2023 to 2025)
- Embed digitally enabled system transformation including (2023 to 2028)
  - Implementation of electronic eye care referrals between primary optometry and hospital eye care services (2024 to 2025)
  - Implementation of a scalable model of home care monitoring using multiple channels including PIFU, symptoms monitoring and video consultation (2023 to 2024)
  - Develop a scalable model of digital eye care hubs that can receive clinical data from any source and respond with the clinical expertise required to support non-hospital settings (2025 to 2027)
  - Develop plans for longer term integrated diagnostic digital diagnostics and care capabilities (2023 to 2024)
- Continue to improve delivery of all elements of the 'adapt and adopt' Outpatient Transformation programme relating to Patient Initiated Follow Up (PIFU), Advice and Guidance and Virtual Consultation (2023 to 2027)

- Greater focus on children and young people; specifically, eye screening and examinations which can detect eye health problems and prevent sight deficiencies (Years 1-2 2023-2025). NHS sight test known as General Ophthalmic Services only covers the first steps of the assessment. School screening services for children aged 5 only check vision
- Education – ensuring that people know what services are available to them and how to access them. As part of this education for other health providers (GPs/Pharmacists / EDs etc.) to ensure people are properly sign posted to the correct services for their needs (Years 1-2 2023-2025)

We will know we are making a difference because we will see:

- Improved equity of access and ensuring our local population have access to the right care first time wherever they live across the SNEE ICS. Standardise all pathways, contracts, and finances 100% across the SNEE system by 2028
- Increasing utilisation of our community optometrists by at least 25% to support more people near their own home and therefore reducing demand on secondary care services. Optometry First becoming the first contact practitioner service for eye care

Further details on the plans for Eye Health are available in Appendix 8 – Be Well.

#### Quotes from service users:

- *"Convenient appointment with excellent care and clear information"*
- *"Very helpful and efficient. Excellent treatment and everybody helpful, cheerful and polite"*
- *"I felt every care was being taken with my eyes, which is very important to me"*
- *"Excellent caring service in a clean and well appointed environment with friendly staff. It was a very professional experience and I would highly recommend the service"*

## Case Study



### Glaucoma Care in Ipswich and East Suffolk

Early diagnosis of glaucoma is vital so the condition can be monitored and treated before the individual loses vision or to reduce the rate of visual loss. Across Ipswich and East Suffolk, there has been a successful glaucoma service operating for over 8 years under a Lead Provider framework, with a number of commissioned glaucoma pathways including:

- Glaucoma Referral Refinement - Primary Care Optometry
- Glaucoma 'See and Treat' - Community Ophthalmology Service
- Glaucoma Management - Community Ophthalmology Service / Primary Care Optometry

The community model includes risk stratification, multidisciplinary working, virtual clinics and active discharge of 'stable' patients from the hospital into the community service. The integrated care pathway allows for people to be managed within the community pre-referral, reducing the number of false positives, and utilising the multidisciplinary capacity provided by the Community

Ophthalmology Service. An integrated IT platform underpins the service, including provision of electronic referrals, a remote triage platform, centralised patient centric medical eye records and telemedicine for remote consultant clinical decision making.

Key outcomes achieved in 2021/22 include:

- Over 100 people seen on the GRR pathway were discharged - 70% discharged from service, 30% onward referred to Community Ophthalmology/HES for glaucoma diagnosis
- Over 1,500 people with suspect glaucoma were managed within the community service. 88% were managed in the community - 61% diagnosed with glaucoma and treatment initiated, 27% discharged and 12% onward referred to HES
- Over 3,700 stable glaucoma patients managed within the community service
  - 88% managed within the service
  - 4% onward referred to HES
  - 4% discharged

With this established glaucoma service, a minimum of 5000 HES outpatient appointments were saved. Whilst providing essential capacity within the community and supporting the HES capacity challenges, People are also being seen closer to home.



## 5.8 Stay Well – Supporting adults with health or care concerns to access support and maintain healthy, productive and fulfilling lives

### Overall Outcome:

Supporting adults with health or care concerns to access support and maintain healthy, productive and fulfilling lives

### Overall Commitment:

Access to care - We will support people to access the right support, in the right time, in the right place for their health and care needs

Early Interventions - We will support adults with timely access to services to enable early detection and diagnosis of disease and risk factors to give people the best chance of maintaining a good quality of life

### 5.8.1 Why is this important for people in Suffolk and North East Essex?

Supporting adults with health or care concerns to access the right support, in the right time in the right place will enable them to live healthy, productive and fulfilling lives.

### 5.8.2 What do we know about people's local experiences?

Key factors and challenges noted include:

- Access to primary care remains one of the highest priorities for our communities. People can be frustrated by extended waits to access services. Many people recognise however that primary care is simply challenged by the level of demand being placed on it
- Location, convenience and familiarity of services is important to people; positive past experiences influence future decisions
- People are willing to travel to another hospital within the east of England to reduce their waiting time

- Honest, open communication is important to people, particularly surrounding wait time for treatment
- People find communication and information inconsistent and this leads to miscommunication. Appropriate, accessible information supports mental and physical wellbeing
- Our population have experienced significant delays in accessing urgent and emergency care with our hospitals not able to meet the required ED standards and ambulance response times also falling short
- Since 2010, the number of older people asking for council help has increased, but fewer now qualify for support in their own home or in care homes, with the average weekly cost of care being significantly higher in SNEE compared to the rest of England
- We know that the total number of people living with cancer is increasing in SNEE as it is across England. However, the percentage of people with cancer in SNEE is higher than the England average (4% vs 3.3%)
- In 2020/21, over 60,000 (7.1%) people registered to a GP practice had been diagnosed with diabetes in SNEE, with an estimated 12,600 people who have the condition who have not yet been diagnosed. The observed to expected ratios range from 77% for Ipswich and East Suffolk CCG, to 92% for West Suffolk CCG and 83% for North East Essex CCG
- The percentage of people living with diabetes receiving all eight care processes in SNEE ICS dropped from 70% in 2019/20 to 52% in 2020/21 and then recovered to 62% in 2021/22. The percentage of people living with diabetes achieving all three diabetes treatment targets in SNEE ICS dropped from 42% in 2019/20 to 39% in 2020/21 meaning an estimated 27,700 people did not achieve their three treatment targets that year. HbA1c is consistently the least well achieved treatment target

- Respiratory diseases are also greatly associated with health inequalities. Someone from the most deprived section of society is two-and-a-half times more likely to have COPD, and nearly twice as likely to develop lung cancer, as someone from the least deprived section of society
- Specialist fatigue management is important but access to the chronic fatigue service is variable and there is a long waiting list
- An individual personalised care plan is one of the most important aspects of supporting recovery for people living with long COVID. Actively listening to people and asking, 'what matters to you?' supports planning and shared decision-making based on what matters most to individuals
- Although standards are in place that describe good control of hypertension, it is estimated that only four in ten adults in SNEE with high blood pressure are both aware of their condition and are managing it properly
- In SNEE, there were 11,800 people with a Heart Failure (HF) diagnosis in 2020/21 (1.1% of the population). Only 31% of HF patients are receiving an annual review in SNEE (2020/21) though this is better than England average
- In SNEE, we have 2% of people registered with a GP recorded as having stroke or transient ischemic attack (TIA), this is higher than the England and the East of England Region both at (1.8%). At least one-third of stroke survivors will have some form of depression within the first year, which may be as high as 60% in all stroke survivors
- Data held by GPs across Ipswich and East Suffolk and West Suffolk, records a total of 3,376 individuals with a learning disability aged 14 or over, on their registers in 2022, (2,175 for Ipswich and East Suffolk and 1,201 for West Suffolk)
- Data held by GPs across North East Essex records a total of 2,284 individuals with a learning disability aged 14 or over, on their registers in 2022

## 5.8.3 How we plan to make a difference

Our priorities for Stay Well are broken down into elective and diagnostics, urgent and emergency care including community, cancer, diabetes, respiratory, cardiovascular disease, stroke and stroke rehab, ME and CFS, neuro rehab and learning disabilities and autism.

### 5.8.3.1 Elective Care and Diagnostics

The key priorities we will achieve by 2028 are:

- People have the right treatment and support to prevent, treat and manage conditions by improving access to diagnostics and providing access to services that support maintenance and optimisation of health whilst waiting for treatment
- People have planned and non-emergency treatment and surgery when they need it, and in the place of their choice. We will enable this by reducing the time from referral to treatment and creating sustainable capacity to enable waiting times to fall and increasing our capacity by 30% from 2019/20 levels by 2024/25
- People have the best experience of planned and non-emergency care by reducing health inequalities and identifying clinical harm and taking appropriate action to develop a digitally driven proactive process for the delivery and management of clinical harm assessments. We will also continue to support mutual aid across our ICS

We will know we are making a difference because we will see:

- 18 month waits from referral to treatment eliminated by March 2023 with the exception of patient choice and clinically complex patients
- 15 month waits from referral to treatment eliminated by March 2024 with the exception of patient choice and clinically complex patients
- 12 month waits from referral to treatment eliminated by March 2025 with the exception of patient choice and clinically complex patients
- Diagnostic waiting times for 95% of people reduced to six weeks by March 2025
- Theatre utilisation increasing towards the best practice levels of 85%
- Greater choice in outpatient clinics through increasing advice and guidance to 16%, patient initiated follow ups to 5%, virtual clinic options at 25% by March 2023

- Throughput to reach 130% of 2019/20 levels by 2024/25
- No differences in the amount of time people wait for treatment between the most deprived 20% of our population and ethnic minorities to the rest of the population
- 10% reduction in on the day cancellations due to being unfit for surgery
- 5% reduction in length of stay for total hips and knees
- Reduction in complaints pertaining to extended wait times

Further details on the plans for Elective Care and Diagnostics are available in Appendix 9 – Stay Well.



*Following the challenges created by the pandemic we are committed to reducing long waiting times which we know are detrimental to health and wellbeing, we will do everything we can to ensure people can navigate the system easily and receive excellent care.*



**Paul Gibara, Director of Performance Improvement, NHS SNEE ICB**



## Case Study



In October 2022, WSFT implemented a clinical harm review pilot, utilising a methodology developed within the Norfolk and Waveney ICB. To test the pathway a questionnaire was sent to the 100 longest waiting patients within General Surgery. Respondents were asked to provide detail on their current health, highlighting any deterioration in condition as well as their general physical and mental wellbeing. They were also asked whether they

had engaged with their GP or other health or social care providers whilst waiting for surgery. 46 responses (46%) were received, 34% (18) requiring clinical review.

The team are now working with Informatic colleagues to determine which digital platform is most suited to host a further roll out to everyone experiencing prolonged waits for treatment.

### 5.8.3.2 Urgent and Emergency Care including Community

The key priorities we will achieve by 2028 are:

- People are signposted to the most appropriate service for their needs every time, all the time by continuing to develop our Same Day Emergency Care (SDEC) model across all our acute providers to cover a minimum of 12 hours a day 7 days a week by March 2024
- People in need receive timely emergency ambulance care and conveyance, with minimal delays
- Within the ED, people with an emergency are managed in a timely manner with agreed professional ED standards in place by December 2023
- Clinical care and treatment are delivered on time - aligned with best practice. Safety is never compromised
- Staff are in the right place, at the right time with the appropriate skills to care for people and keep them safe
- People with urgent and minor ailments/illnesses are managed outside of the ED, by urgent care services, every time, first time. This will be supported by our Urgent Treatment Centre (UTC) in Harwich and Clacton and the plans to develop UTCs at West Suffolk and Ipswich
- We will work jointly with all system partners to strengthen and improve discharge processes. We will continue to develop the Trusted Assessor model to be a key link between our hospitals and care homes to ensure safe and timely discharge by March 2024
- ICBs take responsibility for oversight of urgent and emergency care recovery, improvement, and transformation through the implementation of robust governance arrangements across the ICS and place-based systems



We will know we are making a difference because we will see:

- People will experience an integrated single point of contact model of care, choosing which services are most appropriate for their immediate needs. This will be a single system-wide approach to managing integrated urgent care, to guarantee same-day care for people and a more sustainable model for services
- We will improve A&E waiting times so that no less than 76% of people are seen within 4 hours by March 2024 with further improvement in 2024/25 building to 95% by March 2028
- We will improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25 and work towards no one waiting more than 15 minutes by March 2028
- We will reduce adult general and acute (G&A) bed occupancy to 92% or below
- Fewer people cared for in EDs as more are supported in Urgent Community Response Services and integrated urgent care services, with an increase of 10% each year in the number of cases seen by the urgent community response service
- Fewer emergency admissions and a reduction in the rate of emergency inpatient hospital admissions for people aged 65

- A reduction in the number of acute hospital bed days utilised by people without a criterion to reside that are discharged on complex pathways (1-3)
- Improved quality and timing of ambulance responses, performance and patient handovers
- Increased capacity and quality of mental health support in emergency care 24/7
- Improved quality, capacity and health outcomes of frailty assessments, therapy and social work services in emergency departments



*This JFP outlines ways that Suffolk and North East Essex can develop and improve urgent and emergency care provision for our communities. It gives clear guidance on the advancements for 23/24 including reducing ambulance response times for the most urgent cases and ambitious targets for A&E waiting times. The plan brings together the many services already striving for patients to receive the right care, at the right time, in the right place, every time"*

**Neill Moloney, Managing Director, ESNEFT**  
**Nicola Cottington, Executive Chief Operating Officer, WSFT**

Further details on the plans for Urgent and Emergency Care are available in Appendix 9 – Stay Well.

## Case Study



### Co-ordination of Care for Mr A

Mr A, an elderly gentleman, who lived independent alone in his family home, called 999 after having a fall in his kitchen and was unable to get himself up. The ambulance call handler assessed his clinical needs and made a referral to the urgent community response team, who were able to respond quickly, with a therapist and a nurse attending Mr A. Using dedicated lifting equipment, he was picked off the floor and then have full holistic assessment. In agreement with Mr A, it was deemed that there was no need for any further emergency treatment, but he would

struggle with personal care for a few days, support worker came in for the next week to assist him as well as help with some exercises to regain his mobility.

The team noticed that Mr A had been struggling to maintain his home and this was also the second fall he had had in a short period. Equipment to help around the house and prevent further falls was added, along with a digital device that he could wear around his neck to obtain help if he needed. Mr A was referred to strength and balance classes at his local leisure centre and was visited by a social prescriber, who arranged some cleaning and shopping support from a local volunteer service. Once Mr A was recovered, a social care worker made a visit to discuss any ongoing support with care.

### 5.8.3.3 Cancer

The key priorities we will achieve by 2028 are:

- All communities are enabled to live healthy lifestyles, are aware of concerning symptoms and know how to seek appropriate help (Prevention)
- People have access to a wide range of high quality and timely services (including screening), which will lead to an earlier diagnosis (Access and Earlier Diagnosis)
- Workforce and infrastructure are in place to ensure faster diagnosis (Faster Diagnosis and Sustainable Capacity)
- Reduce variation in diagnosis and treatment by ensuring appropriate personalised support (Patient Focus / Personalised Care)
- Courageous approach to innovation and research to improve quality of life and survival (Innovation)

We will know we are making a difference because we will see:

- Delivery of the Faster Diagnosis Standard so that people are diagnosed or have cancer ruled out within 28 days from referral by the GP or via screening by 2024
- An increase in people diagnosed at an earlier stage so that 75% of people will be diagnosed at Stage 1 or 2 by 2028 in line with the LTP
- Increased responses from across all communities and increased scores for the National Quality of Life (QoL) Survey and National Patient Experience Survey (CPES)
- The current response QoL response rate is 50% on average with a greater proportion of white people responding to the surveys

- Through the actions described we will show a greater uptake across all communities and tumour sites to enable this data to drive changes in our services
- For CPES we will demonstrate improvements each year until 2028 via annual review
- A reduction in the difference between under 75-year cancer mortality in deprived and less deprived communities. We will show improvements each year
- Achievement of the national screening targets for breast, colorectal and cervical across all the communities, considering deprivation and addressing pockets of worse performance. We will show incremental improvements each year until 2028

Further details on the plans for Cancer are available in Appendix 9 – Stay Well.



*Building on the foundations in our 2018-2022 strategy, we want to utilise every practical prevention opportunity to minimise avoidable risk of developing cancer. Similarly, when cancer is suspected or established, our goal is to deliver high quality, timely and person-centred care for the people of SNEE. Our workforce will be supported to deliver all elements of care in the most effective manner. We thank our current and past patients and people of SNEE in helping us to shape our approach going forwards.*

**Dr Christopher Scras,  
Macmillan Lead for Cancer**



## Case Study



### ESNEFT Pre-Diagnosis Cancer Service

The Pre-Diagnosis Cancer Service received a referral for a 79-year-old gentleman who had been delaying Colonoscopy and Gastroscopy for two months due to a chest infection. These tests were requested after his CT scan which showed a suspicious lump within his intestine which could have been cancer.

A referral was made to the Pre-Diagnosis Service to discuss with the patient the outstanding investigations and how important they were. He was also offered practical and emotional support to enable him to attend. He had been referred initially by his GP into to the colorectal team on a suspected cancer pathway because he had rectal bleeding and a change in his bowel habits. The GP had performed a blood test which showed iron deficiency anaemia Faecal Immunochemical Test which was raised.

The Pre-Diagnosis Cancer Nurse assessed people over the telephone and the conversation highlighted the following concerns: Rectal bleeding requiring incontinence pads, ongoing weight loss, reduction in appetite, recent blood transfusion for anaemia, fatigue, low mood, reduction in independence and quality of life. The Pre-Diagnosis Cancer nurse contacted the GP via e-mail and a telephone call to raise concerns about patient's physical symptoms and general poor health. The GP subsequently made a same day home visit.

The Pre-Diagnosis Cancer team also made immediate contact with the Colorectal specialty team to flag concerns regarding symptoms and possible bowel obstruction. The Consultant requested urgent admission to hospital for symptom management and further tests. The patients was diagnosed with cancer.

Several factors contributed to the delays in the patient being able to access the specialist help he required in a timely way. Through the work of the pre-diagnosis nurse the patient was able to access the support he required, the diagnosis was made, and he could start his treatment. Without this service it is likely he would have presented to ED and his cancer diagnosis would have been delayed.

#### 5.8.3.4 Diabetes

The key priorities we will achieve by 2028 are:

- People at risk of diabetes are supported to prevent developing the condition, in particular those in high-risk populations, such as ethnically diverse communities, have support to prevent developing the condition
- People living with diabetes have access to the best possible care and support they need to live well with diabetes, close to their homes in community-based services. We will ensure people with diabetes are supported during their inpatient specialist care hospital stays and those living with type 2 diabetes have nutritional support to manage their condition or even achieve remission. We will also ensure children and young people with diabetes have access to high quality care and carers of people with diabetes have support to stay well

- People living with diabetes can monitor and self-manage their condition effectively. We will focus on providing support to people with diabetes to enable them to self-manage their condition as well as better enabling pregnant women with Type 1 diabetes to monitor their glucose levels more effectively
- We will reduce health inequalities for people living with diabetes and increase our use of (PHM) data to help us do this

We will know we are making a difference because we will see:

- Increase in referrals to the National Diabetes Prevention Programme (NDPP) in-line with contractual requirements
- Increase the diabetes diagnosis rate from 6.1% to 7.5% to support those living with undiagnosed diabetes

- Reduction in the rate of people developing type two diabetes
- Increase in the number of people putting their diabetes into remission via introduction of the planned Low-Calorie Diet programme
- Levelling up in the completion national diabetes care processes to pre-Covid levels (60% completion by end 2024/25)
- Levelling up in the achievement of the diabetes treatment targets with an aspiration that all practices reach 45% achievement by end 2024/25
- Improved access to and uptake of Structured Education classes by a further 10% from current baseline for both newly diagnosed and established patients
- Improving access to glucose monitoring technology for:
  - Pregnant type 1 people
  - Adult type 1 people
  - Adult type 2 people
  - Type 1 children and young people
- Reduce the rate of new type 2 diabetes who are of minority ethnic origin
- Increased access to mental health services for people with long term conditions
- 5% reduction in diabetic emergency admissions and re-admissions (Hypo and Hyper) by 2025/26

- Fewer diabetes-related amputations (above/below the knee – Major/Minor)
- Reduce diabetes mortality rates
- All three alliances will once again have their “outstanding” performance rating for diabetes services



*All Alliances in our ICS have previously been rated as outstanding in the Improvement and Assessment Framework reports from NHSE and the ICS remains outstanding for delivery of the 8 Diabetes Care Processes and Outcomes. We should rightly feel proud of this however, we aim to do better as there is still so much more we can do. The proposals outlined in this strategy plan document will deliver significantly better services for those of all ages and ethnicities, living with type 1 and type 2 diabetes in SNEE as well as reduce the growing number of people developing type 2 diabetes. Our ultimate aim is to improve the lives of our population of people with diabetes and their families, as well as those at risk of the condition.*



**Professor Dr Gerry Rayman, ICS Diabetes Clinical Lead Consultant Physician at the Diabetes and Endocrine Centre, East Suffolk and North Essex NHS Foundation Trust**



Further details on the plans for Diabetes are available in Appendix 9 – Stay Well.

## Case Study



### Enabling patients to understand how to keep themselves healthy - structured education

People who have Diabetes live well with it and are able to manage their condition. Structured Education improves outcomes by enabling people to understand what they need to do to keep themselves healthy. However, take-up among people newly diagnosed with diabetes is very low. As a system we were able to bid for funding from NHSE and SNEE was awarded NHSE Transformation funds of £955k to transform Diabetes Management (including DESMOND and DAFNE selfcare programmes). We developed ICS wide governance and appointed a clinical lead to provide steering and oversight. We have:

- Recruited and trained DESMOND and DAFNE educators
- Increased the number of DESMOND and DAFNE places and venues available.
- Central referral and booking service
- Introduced a diabetes lifestyle navigator role in North East Essex
- Developed and implemented the ‘Big Impact’ campaign
- Commissioned a digital diabetes Structured Education provide to offer an alternative method
- Promoted better glycaemic control.

As the full expanded Structured Education service did not come into place straight away and year end data is still not available, it is still early days in terms of fully evaluating the outcomes of the service. However, in the last three years the expanded Structured Education service has so far almost doubled the numbers of people attending the programme.

### 5.8.3.5 Respiratory

The key priorities we will achieve by 2028 are:

- People's respiratory conditions are diagnosed early through earlier diagnosis and detection of people living with breathing and respiratory problems. We will maintain a clear focus on the delivery of a locally accessible asthma and COPD diagnostic service and ensuring local access to diagnosis & monitoring of these conditions, by 2026, aligned to the ambitions of the Core20Plus5 approach
- People with respiratory conditions are supported to live well by ensuring they receive the right medication to manage their condition. We will provide high quality support including high quality rehabilitation services and ensure people with respiratory conditions receive the best hospital and community based respiratory care
- People at higher risk of respiratory infections have access to high quality care and support by ensuring people with respiratory conditions know how to prevent risk of worsening health
- People with respiratory conditions or at risk of respiratory infections have awareness of the impact of air pollution in health and are supported to reduce health deterioration associated with air pollution
- People with respiratory conditions and other long term conditions are empowered to make decisions to the reduce risk of worsening respiratory symptoms through prevention and population health management collaborative approach

We will know we are making a difference because we will see:

- Reduction in emergency respiratory admissions in adults and children by 2027 to below England average compared to 2023 emergency respiratory admission rate
- 70% of respiratory patients have completed a pulmonary rehabilitation exercise programme as per quality improvement national recommendation by 2027
- 85% of people with respiratory conditions are starting a pulmonary rehabilitation programme within 90 days of referral as per national target

- Increase in number of people who have switched to a dry powder inhaler, where clinically appropriate
- 78% uptake of flu and pneumonia vaccinations in people with respiratory disease including among groups with protected characteristics by 2027
- 100% of pulmonary rehabilitation (PR) services across SNEE accredited by 2027
- Reduction in business mileage and nitrogen dioxide and fine particulate matter (PM2.5) pollution levels by 2028 compared to 2023 and England average
- Increased public awareness of air pollution and practical strategies to improve health outcomes and reduce air pollution from 2025

Further details on the plans for Respiratory are available in Appendix 9 – Stay Well.



*The West Suffolk Pulmonary Rehabilitation Service have been going through the accreditation journey for a couple of years and have recently had our site assessment, which was very successful. The accreditation process has enabled us to review our service and carry out a number of service improvements to both meet the needs of the accreditation and provide gold standard service to our patients. Areas we have worked successfully on is the creation of our SuperSOP, with mini-SOP's embedded to ensure that our service is standardised across West Suffolk. Re-designing our website to ensure that it is patient and carer friendly as well as appropriate for health care professionals. Embedded in this is our new self-referral platform. We have amended our patient and carer feedback surveys to ensure we capture feedback from the whole pulmonary rehabilitation pathway and have started to feedback to patients any service changes as a result of their feedback. We have started patient and carer involvement sessions at our local Breathe Easy group to ensure that we remain accessible to our patients and prospective patients.*

**Jenny Steedman,**  
**Pulmonary Rehabilitation Team Leader,**  
**West Suffolk NHS Foundation Trust**



## Case Study



### Coproduction -inhaler switching

*"I was asked to join a group of clinicians as a patient rep to discuss how to promote the use of dry powder inhalers in place of MDI inhalers to reduce harmful emissions. I was extremely sceptical as my inhalers are critical to my wellbeing especially "Fostair".*

*Anyway, we discussed the design of a leaflet which shows a clear comparison of emissions*

*between MDI inhalers and powder inhalers and that leaflet has since been published. After some deliberation I decided to try the powder inhalers and discussed with my consultant who was all for it as a trial meaning I could change back if I didn't feel that the powder inhalers gave me as much relief. So back in August 2022 I switched from "Salamol Easy Breathe" to "Ventolin Accuhaler" and from "Fostair" to "Fostair Nexthaler" I have not noticed any detrimental effect and continue to use the powder inhalers."*

Phil Gladwell – Patient representative from Breathe Easy.

#### 5.8.3.6 Long Covid

The key priorities we will achieve by 2028 are:

- People in all our communities can access Suffolk and North East Essex Long Covid Assessment Service (SNELCAS). We aim to reduce health inequalities through close collaboration with VCSE teams, community pharmacy teams and social prescribers to ensure everyone can access the service
- People have access to a wide range of timely, appropriate specialist resources whilst they wait to be seen by the service (e.g. widespread access to Your Covid Recovery - Supporting Recovery for Long Covid NHS website)
- We take a proactive, courageous approach to innovation and research which could improve quality of life and self-management
- We will ensure people receive appropriate personalised support throughout their entire pathway and have access to digital resources to review their progress
- We will consider the use of "one-off" PHBs to support personalised care choices linked to individuals personalised care and support plan by working closely with our personalised care team

We will know we are making a difference because we will see:

- Achieve 80% of people triaged and seen within six weeks by 2025
- 100% of people will continue to be assessed within 14 weeks of referral as per national target. In SNEE we have consistently met this standard

- 60% of people have reported improved outcomes from national quality of life tool EQ-5D-5L
- 70% of people waiting no longer than three months for inhouse rehabilitation support. As inhouse rehabilitation expands we would expect a reduction in onward referral to specialist rehabilitation services
- Over the next year the SNELCAS service will capture more activity metrics, such as MDTs, self-management, to ensure the whole offer of local services is tracked for continuous improvement



*I would like to say a big thank you. This is the first time I've felt heard in a long time. It was so refreshing to see that we were talked to as individuals, and next steps catered to our individual requirements. Sarah couldn't have been more perfect for this role!*

*I felt heard, calm and for once didn't waste my energy on having to get my thoughts and feelings heard. This is a big step, which is very much underestimated in preventing anxiety and depression. So thank you.*

*I whole-heartedly wish this approach was taken for FND (Functional neurological disorder), as there are a number of similarities in how patients can have similar or different symptoms. It was nice not to be labelled, put in a box and forgotten about. Thank you to all.*

Mel – Service user



Further details on the plans for Long Covid are available in Appendix 9 – Stay Well.

### 5.8.3.7 Myalgic encephalomyelitis and chronic fatigue syndrome (ME&CFS)

The key priorities we will achieve by 2028 are:

- Adults and children with suspected ME&CFS are diagnosed early within three months
- People with ME&CFS and their carers/families are supported to live well
- People with ME&CFS have access to high quality care and addresses health inequalities and inequity<sup>34</sup>

We will know we are making a difference because we will see:

- 60% of people with ME&CFS have reported improved outcomes from national quality of life tool EQ-5D-5L
- Increase in number of people with ME&CFS diagnosed within three months as per national guidance by late 2024

- Increase in number of people /carers reporting satisfaction and confidence in their care plan as part of new commissioned services by 2025
- ME&CFS e-learning training programme is established and accessible by health and social care professionals by 2024



*Patient Groups would like to thank NHS Suffolk for their long-term support, together with the Local Authority Norfolk & Suffolk Health Overview Scrutiny and Joint HOCS Committees, who have been crucial to chances of resolution and success.*

**Barbara Robinson and Tina Rodwell, Suffolk Youth and Parent support group ME&CFS**



Further details on the plans for ME&CFS are available in Appendix 9 – Stay Well.

## Case Study



### Coproduction driving ME&CFS Service Redesign and Development

A robust feedback process is in place across Suffolk which empowers people to provide commentary via platforms such as 'Let us Talk' and 'Have Listened'. In 2018, this coproduced approach resulted in a new Consultant led ME&CFS service for Suffolk people to better cope with unmet demand for services.

The voices of the ME community are being listened to, enabled by the coproduction

process that SNEE has in place with our people and communities. We are now beginning to break down barriers, stopping stigma and bringing ME&CFS into the wider public lens.

Transformation Programme Manager, Alexis Johnys, has empowered this process and all those involved, so that clinicians, healthcare practitioners, social care professionals and local authority education staff can work together with the ME&CFS community.

Improving the understanding of complex unmet needs and current inequalities of care for those with ME&CFS and treating them according to their needs ensures the best, most cost effective and highest quality of life outcomes for people and carers. This also better enables health quality prospects for their future.

<sup>34</sup> <https://www.longtermplan.nhs.uk/online-version/chapter-2-more-nhs-action-on-prevention-and-health-inequalities/stronger-nhs-action-on-health-inequalities/>

### 5.8.3.8 Cardiovascular Disease

The key priorities we will achieve by 2028 are:

- People have the information and support they need to reduce the risk of developing cardiovascular disease by providing prevention services based on best clinical practice and ensuring people routinely check their “ABCs” (AF, blood pressure and cholesterol)
- People with cardiovascular disease have the right treatment and support to manage and where possible improve their condition. We will ensure people experiencing breathlessness have better access to tests for heart failure and heart valve disease and people with heart failure and heart valve disease are supported by integrated community services. In addition, we will work in partnership with diabetes teams to support people to self-manage their condition
- People have the best possible treatment and care for survival and recovery from cardiovascular disease. We will ensure people who have a cardiac arrest have access to urgent treatment in their community, people receive high quality cardiac and vascular care based on best practice and provide the best chance of recovery from heart attack, surgery or procedure
- We will reduce health inequalities for people with cardiovascular disease

We will know we are making a difference because we will see:

- More people with AF will be detected (85%+ of expected by 2029) and have their condition managed (90% of detected with AF who are already known to be at high risk of a stroke to be adequately anticoagulated by 2028)

- More people with high blood pressure will be detected (80%+ of expected by 2028) and managed (80% of detected to be treated to NICE guidelines target)
- 45% of people aged 40 to 74 identified as having a 20% greater ten-year risk of developing cardiovascular disease in primary care are treated with statins by 2028
- Drop from the 10th (poorest) decile to at least the 8th lower decile by end 2025/26 in the use of high intensity statins over low/medium intensity statins resulting in more people having their lipids optimised
- 5% reduction in acute admissions with a first presentation of heart failure
- 5% reduction in deaths from cardiovascular related disease
- Reduce the gradient in cardiovascular disease mortality across different levels of deprivation

#### Patients have told us: -

*“The cardiac service and intervention is excellent giving me complete peace of mind when I was dealt with immediately”*

*“This year was two years post heart attack. I received a letter from my surgery inviting me to see the Practice Nurse for my Coronary Heart Disease annual check. I think it is an excellent idea for reassurance to have an annual check in the surgery, it was worthwhile having a BP, urine and weight check.”*

Further details on the plans for cardiovascular disease are available in Appendix 9 – Stay Well.

## Case Study

### Brian’s Story

Brian had a long history of heart problems, but had recently become significantly frailer, had lost weight and had fallen multiple times. Brian was very low in mood and frustrated that he was not improving and had stopped engaging in social activities.

The Market Cross Frailty Project – a proactive approach to frail people living in their own home – carried out a Comprehensive Geriatric Assessment, a falls assessment and a medication review completed with Brian and

his wife at home. As a result they changed his medications (which helped reduce his weight loss and helped his balance), obtained specialist advice from the local Bladder and Bowel service (which saved Brian and unnecessary visit), provided nutritional advice and information on domiciliary dentistry, arranged a personal alarm, helped Brian with welfare benefits and gave his wife information on Suffolk Family Carers.

Brian’s appetite is improved, he is walking more steadily and has had no further falls and has restarted physiotherapy. He has support from Heart Failure nurses and his mood is monitored through ongoing reviews.



### 5.8.3.9 Stroke Services

The key priorities we will achieve by 2028 are:

- People know how to stay healthy and avoid a stroke, increasing awareness of the risk factors
- People are identified as being at risk of stroke, by improving detection and treatment of the high-risk conditions; AF, high blood pressure and high cholesterol, working with other programmes such as cardiovascular disease and diabetes
- People receive the best quality treatment and care following a stroke
- People will have access to the best possible stroke services in the community following discharge from inpatient care by implementation of the Integrated Community Stroke Service Model
- People have the best experience of recovery after a stroke, integrated care delivery in partnerships with voluntary and other care sectors to improve outcomes at six months and beyond

We will know we are making a difference because we will see:

- Increase the number of people returning to work post stroke by 2026
- Increase access and the intervals offer for therapies, so that by 2025 all people will have access to 45 minutes of the appropriate therapy within an inpatient and community care setting. For 2023-2025 this will mean doubling our time periods
- Reduce the mortality rates by 20% in SNEE in particular for the under-75 mortality rate

- More people discharged home and able to manage independently or with a carer
- We will have developed a flexible, future-proofed competency-based stroke workforce
- Improved outcomes for the most complex Category A patients with a reduced risk of secondary complications

Further details on the plans for Stroke Services are available in Appendix 9 – Stay Well.



*From stroke prevention through targeted detection of Atrial Fibrillation and case finding of those with high blood pressure to improving access to mechanical thrombectomy in order to save lives and reduce the disability stroke can give, we are committed to being ambitious for better outcomes. Not content with maintaining the quality of our acute stroke teams and the way in which our primary care teams manage risk factors, we want to use data and technology to intervene in early detection, optimising our prevention and challenge thinking that restricts access to high value interventions, saving lives at every opportunity. We also want to ensure that we have the right support for those who have sustained injury from stroke, including those who care for them and be ambitious about what can be achieved.*

**Nerinda Evans, Deputy Director Strategy and Strategic Programmes, NHS SNEE ICB**



## Case Study

### George's Story

A 60 year old man had a left total anterior circulation stroke, he was thrombolysed and then discharged to the Early Supported Discharge team, then onward referral to Icanho with assessment 5 months later. He had moderate-severe aphasia and mild dysarthria, resolved dysphagia, limited use right upper limb (reduced muscle strength/dexterity). He had cognitive impairment – attention/memory, fatigue, depression/emotional lability and was avoiding social situations.

The team worked on his vocational rehabilitation to support his goals to improve right hand dexterity and writing, to get back to fishing, sailing and adventure sports. He needed to find strategies to manage fatigue, improve speech and be able to drive again and most of all to return to work.

The Therapy Plan involved physiotherapist 1:1 sessions, occupational therapist/vocational rehabilitation 1:1 sessions, speech and language therapist: 1:1 sessions, clinical psychology advice/review, a social worker – available for support to partner too...and then COVID lockdown but this resulted in periods of rehabilitation being offered via remote channels, demonstrating that technology can help in continuation of care.

Getting back to work and life involved workplace assessment and liaison with company managers, analysis of duties/roles alongside capability with practical assessment with observation of work tasks/use of equipment. Reasonable adjustments suggested based on grading hours and duties, then very gradual phased return starting 2 hours/ twice a week non-consecutive days to build strength and general work tolerance. The success was he went back to work and most of all started to drive again.

### 5.8.3.10 Neuro Rehabilitation

The key priorities we will achieve by 2028 are:

- People requiring rehabilitation have support as early as possible through early identification of people's needs and better establishing networks for referral
- People requiring rehabilitation are supported to live well by increasing access and provision of vocational rehabilitation by 2026, establishing new Motor Neurone Disease (MND) clinics in North East Essex by 2025 and improving access for people with disabilities in developing knowledge and skills for self-help, care, management, and decision-making
- People requiring rehabilitation will be better able to manage their condition through high quality support by increasing the level of provision of step-down rehabilitation provision and providing the best quality neurological services
- People with rehabilitation will be better able to manage their condition through a more integrated model of care and cohesive workforce. We will focus on primary and secondary prevention to address health inequalities and equity and improve information sharing, joint working, and uncomplicated processes for interagency referrals. In 2023, we will identify any gaps in referral pathways and we aim to have a higher proportion of psychology/counselling staff by 2027/28
- People with rehabilitation requirements will have access to technology and the appropriate level of care when needed

We will know we are making a difference because we will see:

- Patient Centred Rehabilitation tailored to individual requirements with person-centre approach
- People with neurological disabilities will have a greater degree of independence and confidence. Higher rates of people returning to employment, training or alternate meaningful activity
- Reduction in long term care and support costs as people achieve more independence

- Decrease the numbers of people with acquired brain injury (ABI) coming into contact with the criminal justice system by 8% by 2027/28
- Decrease by 10% numbers of people with ABI within the homeless population
- Decrease numbers of people with ABI finding themselves in crisis services
- Reduce the number of later complications by 20% by 2026
- Reduce the risk of re-admission to acute hospital or mental health services by 30% by 2027/28
- Each person will have a sharable, personalised care and support plan which records what matters to them, their outcomes and how they will be achieved
- Timely and improved rehabilitation processes for accurate assessment of individual needs and personalised goal setting to form the cornerstone of rehabilitation
- Improve data recording, sharing and collation
- Improved discharge planning and service integration across NHS, voluntary and Charitable organisations
- Increase availability and quality of rehabilitation services
- A reduction in disability levels on those with neurological conditions
- Patient Reported Outcome Measures / Patient Reported Experience Measures data will indicate and assist the involvement of the patient/carer voice at all stages of rehabilitation development

Further details on the plans for Neuro Rehabilitation are available in Appendix 9 – Stay Well.



*Rehabilitation after stroke requires a multi-professional, multi-agency approach to move forwards and live well after the event. Stroke and Neuro Rehabilitation needs Specialist Rehabilitation delivered by skilled team members 7 days a week to regain meaningful activities, lessen ongoing care needs and provide psychological support for survivors and their carers within their home.*

**Louise Dunthorne, Physiotherapy Clinical Specialist (Stroke)**



## Case Study



### Suspected Stroke, delayed discharge but returns to independent living

The patient was admitted to hospital with a suspected stroke but was diagnosed with autoimmune encephalitis. They have previously been completely independent as a family carer for their partner, attended a gym 3 times a week and spent time with her children and grandchildren. On admission they spent 2.5 months as an inpatient as there was no appropriate subacute discharge destination identified. They had poor sequencing of basic tasks, difficulty with planning and problem solving (cognitively and in terms of motor planning), a lack of problem-solving skills, disorientated in time and place but once discharged and care in place they were walking independently and mobile after 3 weeks. Staged discharge with afternoons at home with family prior to discharge.

When discharged home with 24-hour care support (aided by social services) and twice weekly outreach by hospital therapy staff. Goals now focused at getting Mrs A more independent in accessing community resources and caring for her husband more independently. Support for fatigue management and involvement from Icanho and Headway for ongoing therapy too and extended family. What worked to facilitate rehabilitation and support to live independently again was the flexibility with rehab options is essential in truly patient focused care. It was a great example for the team to accept Neuro patients in their service model to allow neuro-specific rehabilitation within the home environment. There was recognition of the specialist support required to meet the demand identified in this case. If this was a more established pathway positive impact on length of stay and the reduce the significant time required to establish discharge plan (reduced therapy time on the wards for rehabilitation)

#### 5.8.3.11 Learning Disabilities and Autism

The key priorities we will achieve by 2028 are:

- Primary and / or community-based services are provided to keep people healthy in the community
  - High quality services are provided to adults with learning disability and / or autistic adults
  - We provide good quality health and care services that work in an integrated way to optimise outcomes
  - Action will be taken to tackle the causes of morbidity and preventable deaths in people with a learning disability and for autistic people
  - The whole NHS will improve its understanding of the needs of people with learning disabilities and autism and work together to improve their health and wellbeing
  - Investment is increased in intensive, crisis and forensic community support
  - We will focus on improving the quality of inpatient care across the NHS and independent sector
- Annual Health Checks: a minimum of 75% of people aged 14 and over with a learning disability on GP learning disability register will have had an annual health check by 2023-24
  - Learning from Lives and Deaths - Learning Disability Mortality Reviews (LeDeR): A continued focus on achieving LeDeR reviews to ensure that 100% in-scope reviews are completed in six months
  - Autism: For people who have been referred to an autism diagnosis service, ICBs will ensure that people wait no longer than 18 weeks from referral to first appointment by 2024-25
  - Inpatients: For everyone million adults, there will be no more than 30 people with a learning disability and/or autism cared for in an inpatient unit by 2023-24
  - All Care (Education) and Treatment Reviews (C(E) TRS) Standards are met



We are committed as part of the Suffolk Learning Disability partnership board and in partnership with the SET Learning Disabilities Health Equalities Board in delivering through partnership and coproduction the ambitions set out in the JFP and NHS LTP.



Lisa Nobes, Senior Responsible Officer for Learning Disabilities and Autism and Executive Chief Nurse, NHS SNEE ICB



#### Public feedback:

"Learning disability is not a health condition: it is who I am. My learning disability should not mean that I have poorer health".

## Case Study

### Alice's Story

Alice is a 63 year old diagnosed with a moderate learning disability and mood disorder. She lives in supported accommodation in a shared living placement. When unwell, Alice can display behaviours that challenge to herself, to the environment and to others.

In the past Alice has experienced frequent mental health crises resulting admissions to hospitals under the mental health act. Alice's mental

health began to deteriorate and through the dynamic support register, the system responded. A care education and treatment review took place which identified key actions for the local system to consider. The local system increased community support and health support through the Intensive Support Team. Unfortunately, remaining in her home became unsustainable so Alice became a resident of Lavenham Place admission avoidance service. She received individualised care, assessment and treatment from health and social care services. Following a short stay Alice was able to return home.

## 5.9 Age Well- Supporting people and their carers to live safely and independently as they grow older

#### Overall Outcome:

Supporting people to live safely and independently as they grow older

#### Overall Commitment:

We will ensure that people who are ageing are able to live safely and independently, experiencing a good quality of life

### 5.9.1 Why is this important for people in Suffolk and North East Essex?

We will ensure that everyone ages well across SNEE and be enabled to live safely and independently. If and when they need support, it will be provided proactively and support their needs.

<sup>35</sup> Source: <https://fingertips.phe.org.uk/profile/healthy-ageing/data>

### 5.9.2 What do we know about people's local experiences?

Key factors and challenges noted include:

- People in England are living longer than ever before, and as result, the number of older people in England is growing significantly and is projected to increase further over the next 20 years. The number people living in SNEE aged 65+ is set to increase by 33% in the next twenty years (compared with 33% for England)<sup>35</sup>
- Older people can have complex health and care needs, long-term conditions, functional, sensory or cognitive impairment are the highest cost and volume group of service users. Dementia accounts for more expenditure than heart disease and cancer combined. Frailty is more common with increasing age, with 10% of those aged over 65 living with frailty. It is important to prevent frailty and deterioration in those already frail

- Over 33,000 people who are 65 and over provide unpaid care in SNEE<sup>36</sup>
- Through recent consultation, we heard that adjusting to the role of carer and finding that you have less time for yourself is seen as a big challenge, however carers also stated that the role of a carer can also be rewarding
- Carers in Essex recently reported (2021) being tired, feeling isolated and guilty, and having poor emotional wellbeing. It was also noted that carers often feel that others do not understand the responsibilities and pressures they face. Many carers would welcome more support from our clinicians, an improvement in social care assessments and reviews, and employers recognising their rights as carers

### 5.9.3 How we plan to make a difference

Our priorities for Age Well are set out broken down in to ageing well, dementia and carers.

#### 5.9.3.1 Ageing Well Programme

The key priorities we will achieve by 2028 are:

- To enable the ageing population to live a healthier life for longer in the persons' preferred place of residence by anticipating the health, care and wellbeing needs of the population by identifying people at an earlier stage and providing a multi-disciplinary approach to their needs through the neighbourhoods model from 2023. We will enable this by supporting people to prepare for later life, supporting older people to stay healthy and ensuring older people do not face stigma, discrimination or disadvantage
- People with frailty are supported at home and unnecessary hospital admissions are avoided by achieving the 70% two-hour target for urgent community response to deliver care in people's home from 2023. We will enable this by ensuring older people are safe in their homes and closely monitoring their health to identify risks and prevent frailty, illness or injury. In addition, we will ensure older people have access to integrated physical and mental health support tailored to their health needs, can connect with their communities and have greater choice and control over their care

- To have an active ageing population by improving the amount of referrals into the Strength and Balance programme and boosting delivery to more residents, including care homes from 2023. An active ageing population can reduce the impact of mental and physical health conditions resulting in a healthier and longer life

We will know we are making a difference because we will see:

- Increase disability-free life expectancy for our population at age 65 by 2028
- Increase the amount of people with severe frailty to have advanced care plans in place by 2028
- Fewer emergency hospital admissions due to falls in people aged 65 and over by 2028
- Higher rates of people with joined up mental and physical health services for the older population by 2028
- More carers identified, registered with their GP and supported into appropriate community pathways with support by 2028
- Reduce each year emergency acute hospital bed use (bed days per capita) for those over 65 years old



*Our new strategy for frailty will be based on our understanding that it is a chronic health condition which needs many specialist interventions, including medical and social. The strategy is being developed with all our system partners and in particular with neighbourhood teams. We know that frailty has a significant impact on many people and those close to them in our communities. It also is a major cause of increasing pressure throughout health and social care. Our new strategy and partnership work aims to address both.*

**Angela Tillett, Medical Director, ESNEFT**



<sup>36</sup> Source: <https://fingertips.phe.org.uk/profile/healthy-ageing/supporting-information/carers>



We are working to develop person centred services to enable people to age well. Our frailty strategic framework focuses on embedding an end-to-end approach from prevention, earlier identification, support when frail and at end of life. We will embed this in all parts of the health and social care system working with our partners supporting front line staff to develop and maintain the skills and have available to them the tools to offer this support well and consistently. Our work around anticipatory care and population health management are great examples of how we can strengthen our approach to prevention and early support to our most vulnerable population. Working with our community leisure providers and voluntary sector we are beginning to see how proactive support can begin to change the way in which people can live their lives to the fullest right into old age.



Paul Molyneux, Medical Director, WSFT



**Public feedback:**

*"It's great to see ageing being acknowledged as an opportunity to get fitter and improve your health – it's never too late"*

Further details on the plans for the Ageing Well Programme are available in Appendix 10 – Age Well.

**Case Study**



**Strength and Balance Programme**

Mr J is an 80 year old gentleman residing in a care home in Colchester. he has Insulin dependent diabetes mellitus, Hypertension and Vascular Dementia. He moved to the care home in 2020 as he was having lots of falls at home and could not cope living independently. He relied heavily on his walker frame and was falling over at least once a week.

He completed all 12 sessions of his strength and balance course which was hosted at his care home. By the end of the programme he had stopped having falls all together and has not had a fall since. Mr J continues to complete his Otago exercises with encouragement from the activities coordinator at the care home. He has his own booklet that he ticks off as he completes the exercises each day.

Mr J is feeling stronger and appears more confident, he is now completing short walks without his walker and is helping out at activity time at the care home by picking up the bowls equipment.

**5.9.3.2 Dementia**

The key priorities we will achieve by 2028 are:

- Achievement of the national 66.7% dementia diagnosis rate by October 2024 and an increase in dementia annual care plan reviews completed year on year until 2028
- The reduction of memory assessment backlogs and delivery of a timely dementia diagnosis in line with national standards by March 2025
- In line with transforming models of care within communities, individuals will be able to obtain a dementia diagnosis within primary and community care settings (where appropriate) by 2026
- Delivery of a seamless integrated package of services linked to frailty services to respond proactively to those with dementia or suspected dementia and their carers in their own homes and community settings by 2027
- An ongoing awareness and information programme across the next five years focused on both health and social care professionals as well as wider community services with a focus on those hard to reach and from marginalised communities. This could include delivery of the Virtual Dementia Tour, the Dementia Infolink and general dementia awareness education across the system

- Continue working with system partners to derive dementia friendly communities, expanding community assets to support those living with dementia inclusive of family and carers via the relevant system governance including the SNEE Alliance's and Essex and Suffolk Health and Wellbeing Boards

We will know we are making a difference because we will see:

- Delivery of the SNEE ICB diagnosis rate of at least 66.7% by October 2024
- Every individual diagnosed with dementia inclusive of carer or family offered and able to access support within communities to support later life modifiable risk factors by 2025
- Evidence of dementia assessments/diagnosis taking place outside of specialist services and within the community environments by 2026
- Delivery of the diagnosis pathway that presents an average duration of referral to diagnosis for dementia within 6 weeks by 2027
- Year on year increase of annual care plan reviews being completed for those diagnosed with dementia up until 2028



*The prevalence of dementia is ever increasing and those that live with such diseases are still people. They have their own unique personality and character and are frequently capable of so much more than we can imagine. With the appropriate facilities to obtain a timely diagnosis and the right awareness and support, it is possible for people living with dementia to remain and live in communities happily and with a good sense of purpose and value. In SNEE we are committed to working in partnership with all agencies including those with dementia and their family / carers to improve and build networks and relationships across communities to enable better access to care and support that is compassionate, grounded and available in every facet of day to day life.*

**Georgia Chimbani, Director of Adults and Community Services, Suffolk County Council and Co-Chair of SNEE & Waveney Dementia Forum**



Further details on the plans for Dementia are available in Appendix 10 – Age Well.

## Case Study



### Anne's Story

Anne has had a longstanding history of depression and anxiety due to a number of significant bereavements. Anne was given a CPN via the GP who she saw for monthly sessions to discuss her depression, and also paid for private counselling. By 2018 Anne's memory loss began to become more prominent when her daughter received a distressed phone call when she had had a complete memory lapse, she could not remember where her daughter lived or how to get there by car. Her daughter took her to a GP who was very dismissive of her symptoms putting this down to her long history of depression and anxiety. The GP implied that her mother was articulate and because of this her daughter felt that her decline in memory loss was not taken seriously. A GP COG was undertaken and the results were seen as ok, despite the concerns of her daughter.

At the end of 2019 Anne's daughter paid for a private psychiatrist as they had seen 2-3 different GPs and a CPN who all appeared dismissive of the daughter's concerns. The psychiatrist concluded that Anne's memory loss was more than just

anxiety and depression and wrote to the GP with the recommendation that Anne attend a memory clinic. Anne attended a memory assessment clinic in 2020, followed by CT and MRI scans and a psychology assessment. In November 2020 this resulted in a diagnosis of Alzheimer's Disease, which was given over the phone due to the pandemic. Her daughter was left to have difficult conversations with her mother about giving up driving as she was increasingly concerned that her mother's ability and safety had further deteriorated over the diagnosis period.

Anne's daughter felt that a carer's concerns about the health of their loved ones should be taken seriously at the early stages as they know that person more than anyone else, despite continuing to flag with professionals she felt that her opinions was dismissed.

Having a diagnosis has helped Anne's daughter understand why she has behaved the way she has over the years, to understand the diagnosis and help find coping mechanisms to support Anne and prepare for the future. Anne has little understanding of her own diagnosis and frequently forgets that she has dementia, which has led to challenging conversations regarding her mother's ability and safety.

### 5.9.3.3 Carers

The key priorities we will achieve by 2028 are:

- Carers are identified at the earliest opportunity
- Carers can easily access information, advice and support when needed
- Young and young adult carers' health, education/ life skills, choices and opportunities are not adversely affected by their caring role, and that they are supported through transition in readiness for their adult caring responsibilities
- We have systems and services in place that work for and support carers, which are developed and influenced by our local carers
- Carers can enjoy improved health and well-being across SNEE

We will know we are making a difference because we will see:

- An increase of carers identified on GP systems from the 2023 level of 3.4% across SNEE, to 5% by 2028
- Increase in number of carers registered with a contingency plan, year on year
- Increase in number of GP surgeries attaining Carers Quality Markers developed by NHSE or equivalent, year on year
- Increased referral and signposting of Carers across all healthcare settings

- Carers telling us that they feel recognised, informed and supported via established surveys and provider feedback
- Improved signposting to carers assessments with tailored support packages and ongoing review as required



*It is encouraging to see that the JFP recognises the importance of family carers and has aligned its ambitions with the Suffolk All Age Carers Strategy and the Essex Carers Strategy. This will ensure that family carers are given due consideration within the context of the ICB's priorities.*

**Kirsten Alderson, Chief Executive  
Suffolk Family Carers and Chair,  
SNEE VCSE Assembly**



#### Public feedback:

*"[Unpaid] Carers are an essential asset and should be protected and supported as a priority"  
"Carers feel shame when they need to ask for help. How can we support carers to reach out and access what they need?"*

Further details on the plans for Carers are available in Appendix 10 – Age Well.

## Case Study



### Shona and Brandon

Shona and Brandon care for each other. Shona, 51, supports her son Brandon with his learning and mental health difficulties. Brandon, 24, provides Shona with practical support to help her manage the symptoms of her kidney disease.

Shona said "Having someone there just to talk to if I need to have advice or somebody just to listen has helped me immensely as time progressed. I now feel supported which has really changed my caring role for the better. Being registered with Carers First in North East Essex has given me a sense of no longer being alone."

Brandon said "Caring for mum can be quite difficult, it's a big responsibility, especially as my mum doesn't have anyone else coming in to support her, but she is worth it! Having the opportunity to go to different groups and events is a nice distraction."



## 5.10 Die Well – Giving individuals nearing end of life choice around their care

### Overall Outcome:

Giving individuals nearing end of life choice around their care

### Overall Commitment:

We will enable people and their families to have high quality care and support from all health and care professionals involved at the end of their life

### 5.10.1 Why is this important for people in Suffolk and North East Essex?

End of Life care will impact everyone in SNEE at some time, including those approaching the end of their lives, those that care for them and those who are bereaved. Over 10,000 people in SNEE are in the last year of their life and we wish to ensure that over this time they and those who care for them have the best and most equitable care and support from the resources we have available.

### 5.10.2 What do we know about people's local experiences?

Key factors and challenges noted include:

- Each person is seen as an individual
- Each person get fair access to care
- Maximising comfort and wellbeing
- Care is co-ordinated
- All staff are prepared to care
- Each community is prepared to help

### 5.10.3 How we plan to make a difference

The key priorities we will achieve by 2028 are:

- The timely identification of the people who are approaching the end of their lives, communicating this with them and those who are important to them with sensitivity and honesty
- The eliciting, recording and supporting of people's preferences for care in the last phase of life ensuring these are accessible to all parts of the health and social care system
- The treatment of people at the end of life equitably as individuals, with dignity, compassion, and empathy, controlling symptoms 24 hours a day

We will know we are making a difference because we will see:

- In 2023/24 we will collaborate to measure the baseline of how many people are being identified in the last year of life in SNEE
- We will then demonstrate an incremental annual growth in the percentage of people known to be approaching the end of life
- We will achieve an increase in the proportion of people passing away in their preferred place of death
- We will measure the satisfaction of people with the quality of the conversations by survey and show an annual improvement in the results
- We shall measure the achievement of this priority by recording the number of people who have recorded an advance care plan, and the equity of access across the community as well as the access to these plans for health and social care professionals to support coordinated care. We shall ensure that residents of care homes are able to access advance care planning and care coordination services. We will demonstrate an annual improvement from the baseline figure identified in 2023

- We shall also measure the extent to which care was coordinated around people's priorities by recording what proportion of people are cared for in their preferred place and by surveying people as to whether they received the right care for their needs and show an annual incremental improvement
- We shall measure the dignity and symptom control that people experience by survey
- In 2023 we shall continue the patient and carer survey system currently running in North East Essex and develop an equivalent survey system across Suffolk
- We will know that we have made a difference by demonstrating annual improvements in outcome feedback results

Further details on the plans for End of Life are available in Appendix 11 – Die Well.



*This JFP gives us the opportunity to improve dignity and choice for people approaching the last phase of life in Suffolk and North East Essex. It focuses on what people have told us is important to them and allows us to build on what is working well, learning together to address inequalities.*



**Dr Karen Chumbley, SNEE ICS  
Clinical Lead for End-of-Life Care**



**Public feedback:**

*"We need a better understanding of what palliative care is – it's not just for cancer and the last few days of life?"*  
*"If everyone has confidence to talk about dying we can honour choices and avoid crises."*

## Case Study



### Compassionate communities

Paddy was identified as likely to be entering the last year of his life. His GP matched him with a local compassionate companion volunteer who had been trained to support people by End of Life Doula UK. The companion supported Paddy to record his wishes for his end of life care and communicate this to his family and health care professionals. She also supported Paddy emotionally and practically. As a result of this,

Paddy's next of kin and health care partners were able to work together to support Paddy's wishes and, Paddy died in his own home. His family and health care professionals were reassured that his end of life wishes were respected.

Paddy was a great advocate of the Compassionate companion and his legacy has continued with Paddy designing a daisy emblem which is now the logo brand for the scheme. The pins are given to all companions once they have completed the training. Paddy also has a starring role in an informational video for compassionate companions. [www.compassionate-communities.co.uk](http://www.compassionate-communities.co.uk)





# 6 How will we work differently to achieve our priorities?

## 6.1 Alliances

Our three 'place-based systems of care' are known locally as Alliances. They are 'North East Essex', 'West Suffolk' and 'Ipswich and East Suffolk' Alliance, each defined by the footprint of local health and care partners as well as natural geography. The Alliances have distinct and shared population needs and assets.

The Alliances of NHS, local authority, independent, voluntary and community sector partners work together with common purpose to provide the focus for planning and delivering meaningful integrated care to their local populations.

### Alliances provide the focus for:

- Working with people to understand the wellbeing, social and healthcare needs of the local population and developing outcomes and solutions together
- Producing and resourcing a detailed plan to deliver the overarching strategy
- Ensuring clinical and professional engagement
- Developing and managing partner relationships
- Working collectively to identify improvements to individual services and across services

- Delivering joined up (integrated) health and care
- Ensuring the principles of good system governance are embedded
- Understanding and reducing health and social inequalities across each Alliance
- Demonstrating accountability to Alliance members, local people, stakeholders, and regulators
- Ensuring continuous improvement and innovation in the quality and delivery of services
- Ensuring the delivery of high quality, safe and caring services
- Managing risk – finance, operational, quality and performance
- Ensuring good financial management, financial governance and value for money

All three Alliances have a dedicated committee with delegated decision-making for specific NHS services including primary care, community mental and physical health services, prescribing as well as children's services and accountability for planning and delivery of a wider plan, as agreed by partners within each local Alliance area.

They are supported by dedicated Executive Delivery Groups, Integrated Quality Groups and Primary Care Groups. They may meet in common where it is appropriate to efficient and effective decision making and to share learning.

Each of our three Alliances is developing its own local delivery plan for the end of April 2023. Each plan will demonstrate how the ICP strategy will be realised locally. The plans will be organised within the six agreed Live Well Domains aligned to the JFP.



*The Alliance model gives us opportunities to improve health through partnership in so many ways. For example: improving prevention through exercise with our leisure services; taking a one public estate approach to our current and future buildings; communicating bringing together health and care providers and education networks to build the future workforce.*



**Peter Wightman, Alliance Director,  
West Suffolk Alliance**



## 6.2 Neighbourhoods

Neighbourhoods provide a focus for smaller, identifiable populations based on particular characteristics or needs, agreed within Alliances. Without the need to meet the requirements of a fixed size or model, different areas can find different solutions for different problems. Alliances will play a key role in oversight and support of effective neighbourhood arrangements that deliver for local populations. These neighbourhoods might be based around GP catchment areas or local government ward boundaries, with local partners working together in networks, responding to the characteristics and needs of the local population. Equally neighbourhoods may act in a three-dimensional way being defined by a school community or a virtual community meeting needs through the use of social media. At neighbourhood level the role of district and borough councils and the voluntary and community sector are key.

### Integrated Neighbourhood Teams and Care Closer to Home

The Integrated Neighbourhood Teams and Care Closer to Home teams bring together physical, mental health and social care practitioners that work with GPs and VCSE partners within a locality to provide a single coordinated care response for people, underpinned by prevention, selfcare, early intervention, reablement and rehabilitation, (including people living in nursing and care homes).

There are four main objectives:

- Fewer people need unplanned care and support (reduction in crisis situations)
- Greater numbers of people have access to and are supported by activity outside of statutory services

- Resources in the delivery of community-based health and care support are used more efficiently
- The ongoing costs of supporting people are reduced as people's independence is increased

In Suffolk, there is a focus on the Integrated Neighbourhood Teams identifying local issues that relate to their specific populations, and developing a joint plan as to how they, as a system, can begin to address these, with support of the respective Alliance.

The Integrated Neighbourhood Teams work with wider partners in their locality, making sure that wider issues of health and wellbeing can be addressed. To support this work, named leaders have been identified for each area, and some functions picked up alliance wide where this makes sense, for example data analysis and training development. We now have the opportunity to closer align these teams with PCNs.

In North East Essex, work is underway to develop similar locality-based teams with an ambition to roll these out across the Alliance during 2023/24.



*Our Integrated Neighbourhood Teams are leading the way in joining up care for patients in our communities; working across health and care and with community leaders to consider the most effective and efficient approaches to helping people to stay well at home. We will continue this journey with collective energy and clearly articulated delivery plans.*



**Maddie Baker-Woods, Alliance Director,  
Ipswich and East Alliance**



## 6.3 General Practice (including Primary Care Networks)

### Why is this important for people in Suffolk and North East Essex?

GP Primary care remains the first point of contact for most people seeking health services in their local community; providing prevention services such as vaccinations and screening; urgent and emergency care; as well as complex long term condition management for people of all ages. GP primary care acts as a front door to secondary care and specialist services, when needed.

Professionals working in GP primary care respond to a broad range of physical and psychological needs; this means that GP primary health care is focused on caring for people holistically – delivering personalised care. Since primary care practitioners often care for people over extended periods of their lifetime; the relationship between a patient and general practice team is particularly important; with practitioners both acting as the patient's advocate and co-ordinating their care.

Demand for health and social care services is rising – a quarter of the population experience long-term conditions, which may be related to age or circumstances associated with - or exacerbated by - stress, diet, activity levels, alcohol, smoking, air quality, poverty, isolation or poor housing. People with long-term conditions such as diabetes, COPD, arthritis and hypertension account for around 50% of all GP appointments. Whilst workloads for our health and care professionals are high and increasing; workforce recruitment and retention challenges have been deepening across primary care. Specific workforce challenges include:

- The number of primary care vacancies, specifically including GP, nursing and pharmacist roles with changing aspirations towards portfolio careers and working within more defined parameters
- Imminent retirements with the loss of experienced staff
- The scale and nature of the estate required to meet current and forecast care needs and to enable education and training (crucial to recruitment and retention)

### What do we know about people's local experiences?

We know that access to GP primary care remains one of the highest priorities for our communities. Our local surveys tell us that most people make contact with GP Primary Care over the phone, although in some areas almost half make contact via a website or app. For those making contact via the telephone, the wait for a response can vary but we know that people would be willing to try more online options for making contact.

Based on the 2022 GP Patient Survey results, 97% of people say they were satisfied with the types of appointment offered. People have told us that they are being offered a range of appointment options, including telephone triage (e-consult) and same day appointments. 62% say they were satisfied with practice appointment times with options for enhanced or extended hours timings (before 8am or after 6.30pm on weekdays and/or at the weekend) and opportunities to see a range of healthcare professionals. The vast majority of people are offered a face to face appointment with someone at their practice. The Survey results show that 79% of people had a good overall experience of their GP Practice.

We know many praise the staff they meet as caring and kind but there are times when people's experience falls below the standards. People can be frustrated by extended waits to access services. Many people recognise however that primary care is simply challenged by the level of demand being placed on it.

We have strong Patient Participation Groups (PPG) working alongside practices. Members of the Groups are committed to supporting good quality care and better outcomes for patients; working with the practices to develop their approach. We have three PPG Networks in SNEE each supporting development and collaboration with their communities.

## How do we plan to make a difference?

Our priorities are:

- To embark on an intense programme of work with primary care leaders to develop a clear forward strategy and action plan
- To facilitate delivery of the national contract changes for 2023-24, specifically as related to access, prevention and tackling inequalities and prepare for future contractual changes, as they become known
- To review Local Enhanced Services and the Suffolk PMS to ensure they are effective in their outcomes and support vibrant and sustainable primary care
- To work with our Primary Care Networks and Integrated Neighbourhood Teams/Localities to further join up care for patients as close to home as possible
- To embed primary care workforce as an integral part of system thinking, planning and delivery
- Develop plans alongside local people and communities and review outcomes relating to their population

*We are now embarking on an intense programme of work with primary care leaders to develop a clear forward strategy and action plan. The purpose is to enable sustainable GP primary care, which responds to patients' needs and supports the workforce's confidence, capacity and career aspirations. The plan will include the following actions which will be delivered within 2023/24:*

- Model demand and capacity for GP primary care services to ensure same-day, urgent care and continuity of planned care models are supported
- Include approaches to managing integrated urgent care and same-day care for patients - considering models within groups of practices or PCNs to manage demand effectively and safely
- Ensure continued Enhanced Access provision for all patients, maximising capacity and utilisation
- Support access to practices and clinicians in appropriate and timely ways, via a variety of methods including digital pathways and enhanced telephony
- Further review pathways to community and secondary services in the most streamlined way
- Ensure integration with 111/EIT/Ambulance Service responses

*We will further review Local Enhanced Services and the Suffolk PMS to ensure they are effective in their outcomes and support vibrant and sustainable primary care.*

We will do this in the context of our forward strategy and plan and national contract developments during 2023/24. We will give clear consideration to the opportunities for collaboration with other primary care providers and for the role of primary care within the whole health and care system.

*We will work with our Primary Care Networks and Integrated Neighbourhood Teams/Localities to further join up care for patients as close to home as possible.*

This will involve:

- Exploring further co-location opportunities and mapping these with the PCN estates' strategies to be completed by September 2023
- Creating and actively using Place Based Needs Assessment and/or population health data sets for each Locality/Neighbourhood by October 2023 to enable improved local responses to needs
- Devolving further local decision-making including resource allocation. These levels will be determined by the Alliance committees and will vary depending on maturity levels of individual neighbourhood teams/localities by 2026
- Mapping the opportunity and outcomes of the Primary Care Network Directed Enhanced Services and Impact and Investment Funds with INT outcomes to ensure alignment by September 2023
- Extending joint or hosted roles and training across INTs and PCNs to enable further integration where opportunities arise
- Ensuring a local INT/PCN voice in Place/Alliance decision making, building better relationships with PCNs and INTs via Executive Delivery Groups and Alliance Committees; adapting terms of reference to make this possible
- Ensuring all PCNs to have a Health Inequality Lead who supports oversight and data, linking in with Neighbourhood Teams and partners to agree services linked to place based needs of the PCN's local population
- Mapping inequalities to existing service provision and reviewing resources to meet those needs on an ongoing basis

*We will embed primary care workforce as an integral part of system thinking, planning and delivery. We will do this by:*

- Increasing capacity within the Training Hub to supply clinical supervision to more roles
- Linking the Training Hub into the wider system workforce to align and ensure collaboration with all workforces and to ensure integrated planning by April 2024
- Developing additional apprenticeship schemes to recruit into primary care from April 2024
- Improving workforce data from primary care to provide up-to-date information that can be used for modelling and system planning
- Continuing to mature the mental health community model; increasing practitioners in place by September 2023
- Embedding the Health Education East Star methodology into transformation plans

*We commit to work alongside local people and communities to develop plans and review outcomes.*

This will enable a more holistic plan that supports outcomes matched to population needs, using real experience and people's stories. This will be demonstrated by regular feedback from the engagement teams and PPG networks during 2024-2026.

## **We will know we will be making a difference because we will see:**

### **Access**

- By April 2024, all GP Practices will have the digital capabilities in place to offer appointments
- Access to practices, measured by the GP Patient survey for the requirement 'ease of getting through on the phone' will be reported at above the England average for all practices by 2025

- No patient will experience a wait of more than 2 weeks for a routine appointment by April 2024
- 100% of all Enhanced Access slots will be provided and utilised by 31st March 2024
- Cloud based telephony will be in place in every practice by 2024/25

### **Prevention and health inequalities**

- Prevention programmes effectively embedded into system working, ensuring appropriate presentations in primary care by 2026
- Progress will be made each year to improve prevention performance at practice level for CORE+20 populations to include:
  - Long term condition identification and management (e.g. Hypertension)
  - Practice managed screening and immunisations

### **Quality assurance, workforce and resilience**

- All practices will be rated as at least 'Good' by the CQC by 2025
- There will be no Practice List Closures by April 2024
- Practices will be more sustainable (evidenced by improved recruitment and retention rates and the primary care assurance framework)



*Our aim as an ICB is to provide the commissioning environment to enable GP teams to adapt and thrive at the centre of our health care systems and communities, and thereby ensure Suffolk and North East Essex primary care is an attractive place for professionals to work and patients to register.*

**Dr Nick Rayner and Dr Freda Bhatti,  
Primary Care Partners, SNEE ICB**

## **Case Study**

### **Examples of PCN progress**

ARRS is being utilised by all PCNs, bringing additional roles into primary care, allowing for more MDT approaches to care, with a focus on personalisation and care planning

All care homes have been aligned to specific PCNs providing a consistent approach and access

to primary care teams – supporting education, personalised care planning and additional support.

A new Enhanced Access service is being provided by PCNs allowing patients to be able to access appointments every weekday evening from 6.30pm to 8pm and every Saturday 9am to 5pm – this is supporting increased access to appointments Mental health roles are now within GP practices supporting greater access to mental health support

## 6.4 Collaboratives

### 6.4.1 ESNEFT and WSFT Collaboration

The two integrated community and acute Trusts, WSFT and ESNEFT, are increasingly working together in order to provide the best care to the population of SNEE. This means bringing together the best of what each organisation can offer and collaborating where it makes sense to do so. This includes addressing health inequalities across the ICS and improving access to services.

Both during and following the COVID-19 pandemic, WSFT and ESNEFT successfully supported each other with elective care services including Orthopaedics, Urology, Ophthalmology, Ear, Nose and Throat (ENT) and Gynaecology. A joint elective care committee has been established, with co-chairs, and there has also been joint working in relation to procurement. The two Trusts have agreed to establish joint governance for their collaborative work, and have set out shared principles for collaborative work:

1. We will work together to deliver the best quality and access to care
2. We will challenge and hold each other to account for the delivery of our vision
3. We will make shared decisions where this supports positive transformation, improves sustainability of services for our communities and reduces variation in quality. We recognise and respect our separate duties and accountabilities, acknowledging that we will need to act separately in other matters
4. We will support and empower our staff to work together, for the benefit our people and communities, through standardising care and reducing variation in quality
5. We recognise the importance of clinical leadership and governance in all our work, and the vital role of operational leadership in delivering high-quality, sustainable services
6. We will actively involve our staff, people, partner organisations and communities in our work
7. We will take shared responsibility for delivering agreed priorities and managing risks

The boards of the two trusts have been meeting regularly in “Board to Board” sessions to explore further opportunities for collaboration and agree the joint governance. The Trusts have identified areas for future collaboration:

- **Digital** - working together on the implementation of an Electronic Patient Record (EPR) for ESNEFT. The aim is to enable standardisation of treatment, reduction of variation and integration of care
- **Workforce development** including EDI as a priority for our people, staff and communities to ensure everyone is welcome and included and receives equity of treatment
- **Virtual wards** building on the excellent work already underway in this development to provide care which would usually take place in an acute hospital, in people’s homes. Already an ICS-wide project, the integrated Trusts are able to maximise the integration of community and acute services to embed virtual wards
- **Elective care** - moving beyond mutual aid between the Trusts, there are opportunities to work together to improve services in a range of specialities to deliver high-volume, low complexity care and more specialised services
- **Diagnostics** - both Trusts are part of the East Coast Pathology Network and the East 1 Imaging Network, which work over a larger geographical footprint to collaborate in procurement, quality and workforce planning. The two Trusts are also working together to plan the CDC at Newmarket, learning from the successful implementation of a CDC at Clacton
- Additional corporate services, including
  - Estates and Facilities
  - Procurement
  - Information governance
  - Organisational policies and procedures



*Collaboration between WSFT and ESNEFT has already delivered a number of benefits to patients as we recover from the pandemic. There are exciting opportunities for us to continue to work together so that all of our population receives the highest quality of care possible.*

**Ewan Cameron, Chief Executive WSFT**  
**Nick Hulme, Chief Executive ESNEFT**





## 6.4.2 Suffolk Mental Health Collaborative

Our comprehensive 10-year strategy for Mental Health and Emotional Wellbeing in Suffolk (#averydifferentconversation) was launched in 2019. Built on the views of service users, the public, staff and stakeholders, our strategy sets out an ambitious programme of change to transform mental health support in Suffolk.

To accelerate the implementation of our strategy, we are now establishing a new Suffolk Mental Health Collaborative as a sub committee of the ICB. Our Collaborative will bring together all the main partners from across Suffolk who have a role in funding, planning, delivering and receiving mental health services. This encompasses:

- Service users and the public representation
- VCSE • SNEE ICB • Suffolk County Council
- NSFT • ESNEFT • WSFT • Suffolk GP Federation

As a result, there will for the first time be a single leadership forum in Suffolk that is focused entirely on mental health that has delegated authority to take decisions on how the available funding is used, how services are configured and who is best placed to deliver them.



*The 2019 Suffolk Mental Health and Emotional Wellbeing Strategy sets out a bold vision for a very different experience for our communities in Suffolk, a commitment, together, to transform mental health and emotional wellbeing. Building on strong foundations of partnership working the establishment of our Suffolk Mental Health Collaborative I believe offers a genuine opportunity to create innovative models of integrated care, centred on evidence base and lived experience, putting the needs of our communities, service users and carers at the heart of what we do. Together, through Collaboratives, we will improve the health outcomes of those children, adults and older people in Suffolk with mental health needs and the communities of which they are part. We believe there is hope for a brighter future, where collaboration to improve wider determinants of health, tackle inequalities, and intervene early when people experience ill health will best address population need, promote parity of esteem and transform lives.*

**Stuart Richardson, Chief Executive NSFT**



The Board will also have oversight of quality, operational and financial performance. We will mobilise the Collaborative from April 2023.

## 6.4.3 Southend, Essex and Thurrock Mental Health Collaboration

We are working with partners across Southend, Essex and Thurrock (SET) to develop a refreshed 5 year All Age Mental Health and Emotional Wellbeing strategy, informed by the views of service users, staff and stakeholders by the end of May 2023. The strategy lays out a programme of consolidation and change to continue the transformation of mental health support in SET.

To oversee and support implementation of the refreshed strategy, we are exploring development of a new Southend, Essex and Thurrock All Age Mental Health System Implementation Group. This will bring together all the main partners from across SET who have a role in funding, planning, delivering and receiving mental health services. This encompasses:

- Service users and the public representation
- VCSE • SNEE ICB • Mid and South Essex ICB
- Hertfordshire and West Essex ICB
- Southend City Council • Thurrock Council
- Essex County Council • EPUT
- North East London Foundation Trust [NELFT]
- Essex Police

The System Collaborative Group will focus on coordinating and overseeing the existing work of pan SET groups and identify key priorities for joint work. Decision-making and overall governance will remain with the statutory organisations and three relevant HWBs

The Implementation Group involves a broad range of partners and will focus on promoting wellbeing and supporting people of all ages with mental health problems. The Group will also review the needs, models and outcomes across each place and locality in SET to identify and drive action around health inequalities, and to support collective learning.



*I'm proud of the work that has gone into The Southend, Essex and Thurrock All Age Mental Health Strategy. This is an important opportunity for us to raise the standard of care for local communities as well as taking steps towards tackling inequality of access, provision and outcome. We will only succeed in doing this if we act together across the sector, working with our partners - and this is at the core of this strategy. As the main provider of community and inpatient mental health services, as well as some physical health services, EPUT is in a unique position to deliver key improvements across this large and diverse area. We're committed to consolidating our psychologically informed approach to delivery of care, partnering with those who use our services, as well as their carers and families, so that together we can shape the future of our services. We're also working to create a culture where our staff and patients are encouraged to provide constructive feedback so we can learn and continuously improve. We will continue to collaborate creatively with our system partners to ensure that care is focussed on the needs of our communities to enable maximum support at an early stage, reduce the risk of mental health crisis and help people home in a timely and safe manner. I am optimistic for the future of mental health services in Southend, Essex and Thurrock with sustained improvement in the care we offer to the communities that rely on us.*

**Paul Scott, Chief Executive EPUT**



## 6.5 Specialised Commissioning

Specialised services support people with a range of rare and complex conditions. They often involve treatments provided to people with rare cancers, genetic disorders or complex medical or surgical conditions. They deliver cutting-edge care and are a catalyst for innovation, supporting pioneering clinical practice in the NHS

Although ICBs have assumed responsibility for commissioning most NHS services, responsibility for some, often low-volume, high-cost, services and drugs currently remains with NHSE. NHSE has stated that specialised commissioning functions and budgets for some specialised services will be delegated from NHSE to ICBs from April 2024.

SNEE ICB is part of a regional working group, together making progress on the arrangements for transition of responsibility from the East of England (EoE) Direct Commissioning Programme Board and the EoE Joint Commissioning Committee for Specialised Commissioning and Health and Justice to ICBs.

In 2023/24, the intention is to have a 'shadow' year, where NHSE will set up a statutory Joint Commissioning Committee (JCC) for Specialised Services, which will require ICB leadership, engagement and representation in the Committee. Through 2023/24, the statutory JCC will manage either the full or more likely a nationally agreed portfolio of specialised services before transfer expected in April 2024.

## 6.6 Population Health Management

We already have access to many sources of data and intelligence that tell us about the health, care and wider needs of our population. The JSNAs for Suffolk and Essex bring these published data sources together to highlight key health and care strengths, needs, and risks for our local populations, as detailed in Appendix 1 of the JFP.

However, the data used in JSNAs are mostly held separately by individual services and their commissioners. This limits the information that can be provided and the questions that can be answered.

Showing the entirety of an individual's care allows a better understanding of which factors have the largest influence on health and care outcomes within the local population. This is where PHM comes in to play.

PHM is about using **linked data** to provide new insight, and then taking **linked action** to improve the social, physical and mental health outcomes and wellbeing of people within and across a defined population, while reducing health inequalities.

PHM will mean that:

- Health and care services are more proactive in helping people to manage their health and wellbeing
- More personalised care is provided when it is needed
- Local services work together to offer a wider range of support closer to people's homes
- Solutions which may already be available become easier to access, improving outcomes, reducing duplication and using our resources more effectively
- Care and support are designed and delivered to meet individual needs, ensuring the right care is given at the right time by the right person
- Greater and more holistic understanding of the health and care needs of the local population enables commissioners to commission accordingly and ensure health and care providers work together to achieve maximum benefits

Our focus will be to understand the health and care needs in our population, and use key enablers such as workforce, IT appropriate estate and PHM to build and deliver health and care services to meet those needs and deliver benefits that we know improve health and care outcomes, including:

- People having access to the information tools and support to stay well and prevent ill-health
- People benefitting from earlier diagnosis
- People with long-term conditions being better supported to manage their condition well and prevent complications
- People with complex co-morbidities benefitting from tailored individual support that meets their unique needs
- Reduced demand for reactive care services so we can use those resources to provide better proactive care for more people

- People identified as being at the end of life receiving coordinated personalised care
- Power to evaluate complex interventions across organisational boundaries
- Critical gaps in data, or areas where data quality is poor, being identified and addressed, improving the usefulness of that data
- Helping to design effective interventions, which need to be multi-factorial, are not within the control of any one partner in the ICS, and which may need to be much wider, more creative, and more localised than traditional commissioned interventions or pathways
- Tracking the progress made through these interventions against the key priorities for the ICS

Our PHM Strategy has been developed over the past three years and has now approved by both our ICB and ICP Boards in late 2022<sup>37</sup>. We have procured a dataset to cover the whole of our SNEE ICS population by April 2023 and are currently creating a dedicated PHM team. Our next step is to develop our 2023/4 delivery plan which will be in place by June 2023.



*Population health management offers new and powerful approaches to improving health and care outcomes, and to reducing inequalities. We are looking forward to the insights that our new PHM data will bring, and on working with teams across the SNEE ICS to design, develop and implement new interventions in response to these new insights which will improve outcomes.*

**Laura Taylor-Green, Alliance Director,  
North East Essex Alliance**



## 6.7 Medium Term Financial Plan

As spenders of public money, we have a duty to taxpayers and the Treasury to use the funding available as efficiently and effectively as possible, maximising the improvement in health and care which can be gained from each pound spent. Public Sector organisations, including the NHS, have a statutory duty to break-even and are held to account for failure to deliver that target.

The system now has statutory financial duties both applicable to individual organisations and collectively through the delivery of system financial balance for those organisations within the system control total; NHS SNEE ICB, ESNEFT, WSFT, East of England Ambulance Service NHS Trust.

<sup>37</sup> Further information on the SNEE PHM Strategy and additional PHM Flip books are available here: [Population Health Management - Suffolk & North East Essex Integrated Care System \(Suffolk and North East Essexics.org.uk\)](https://www.nhs.uk/healthcare-teams/suffolk-and-north-east-essex-integrated-care-system/)

The key statutory duties are:

- To at least break even individually and collectively
- Ensure both capital and revenue resources do not exceed the limit set by NHSE

In addition, SNEE ICB is required to:

- Achieve the MHIS which requires the investment in mental health services to increase at a higher percentage than the overall rise in allocation from NHSE each year
- Ensure expenditure on running costs does not exceed the limit set by NHSE

In addition, as part of the move from the Covid-19 financial regime NHSE requires all organisations to:

- Improve recurrent efficiency
- Fully engage in national savings initiatives
- Reinstate pre pandemic financial controls
- Improve compliance against national standards for improving financial sustainability

We have agreed the following principles that will underpin our approach to achieving system efficiency:

- We will focus on management of financial risk through the four lenses of efficiency improvement – cost reduction, cost avoidance, income generation and service productivity improvements
- We will develop a medium-term financial plan for the system which is underpinned by realistic and deliverable plans at an organisational level as well as cross-system transformation. This planning process is currently underway and details will be included in the final version of the JFP
- We will develop plans to include a balance of system transformation and transactional opportunities, supporting existing programmes of work rather than starting new. We will partner and work with stakeholders to reduce overall system cost, enhance productivity, strengthen partner integration and improve experience and population health outcomes

- Short term measures that result in long term pressure will not be pursued
- To further strengthen system governance and support development of a financially astute culture, the system will adopt a recognised approach to forecasting and evaluating Return on Investment
- We will avoid shifting activity and costs from one area of the system to another – instead identifying and supporting a range of different options to achieve savings
- We will seek to avoid making the mistake of spending new money in ‘old ways’ – we will instead explore ways to use money differently in the future
- We will listen to the ideas of frontline staff, test out their ideas and scale up what works
- We will help frontline staff to better understand how their work impacts budgets and resources
- We will use technology to operate more efficiently and effectively
- We will use buildings more effectively, sharing spaces and resources
- We will take a regional approach where appropriate, achieving alignment and consistency across borders

Our focus is on opportunities to:

- Reduce cost
- Avoid cost
- Improve productivity
- Increase system funding



**“** Delivery of our objectives as set out in the Joint Forward Plan goes hand in hand with a system wide focus on improving our cost efficiency, productivity, and therefore in ensuring we can demonstrate value for money in all that we do. At its heart this is about delivering a sustainable NHS for the population of Suffolk and North East Essex.

**Howard Martin, Director of Finance** **”**

## 6.8 Quality and Safety

### 6.8.1 Current Picture

The ICB must be able to prove to people in SNEE that services are safe and of high quality, and that all the different organisations that provide health services have systems in place to check the quality and safety of care provided.

The ICB has agreed how it wants to achieve this and has described this in the “SNEE ICS Quality Improvement Strategy”. As well, this JFP provides more detail on how it will happen in real life.

We will improve the quality and safety of health services for people in SNEE and create a health service that people, and staff are proud of by:

- Sharing and getting better at what we are good at (“Strength Based Approach”)
- Working closely with the public and our communities (co-production)
- Clearly describing how we will improve and monitor quality (our “Quality Management System”)
- Working closely together to share responsibility for our work (“Collective Accountability”)

### 6.8.2 Why is this important for people in Suffolk and North East Essex?

The people providing health services in SNEE already perform an outstanding job every day. Due to a lack of available trained staff, financial strain, relentless pressure from infectious diseases, cancer, trauma and long-term conditions (like diabetes and high blood pressure), and a growing waiting list of people waiting for operations and other non-urgent care, sometimes it can be difficult for our staff to provide the quality of service that they would like to. From time to time, despite rigorous safety checks, people come to harm, and sometimes that harm might have been avoided if we had worked in a different way.

It is because of this that all health and care teams need to check that the work they do is high quality and safe. The best way to do this is to create a “system” – a way of doing things that means that we can be alerted to problems as soon (or even before) they happen, so that we can learn from our mistakes and stop them from happening again.

### 6.8.3 How we plan to make a difference

#### Agreeing on quality

We have followed the guidance of NHSE and think that their description of quality is the same as ours. This includes care and treatment that avoids causing harm (Safe), does what it is meant to do (Effective), and takes into account the needs and feelings of people (Experience).

#### Working together

We will take “collective accountability” by working together to make sure that we provide high quality and safe services. By each of us taking responsibility for what happens not just for in services that we provide, but for all the health services across SNEE, we can learn to trust each other, look out for each other’s patients, and join up services to provide the sort of care that the public expect.

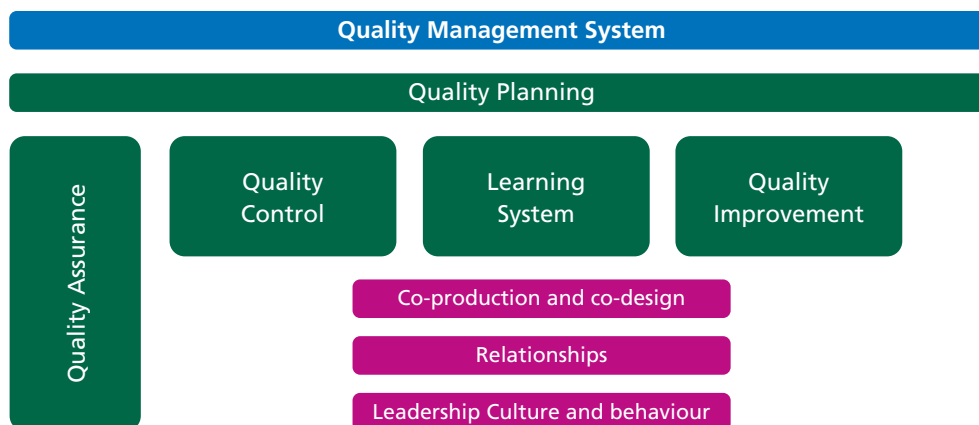
Our “Accountability Framework” is a document that describes how this will work, setting out how we:

- Are all clear on what we are responsible for
- Respect each other and how we work
- Agree how we will behave with each other
- Aim to hear from everyone in SNEE, even those people that sometimes are not heard
- Will change how we work to improve quality and safety and know that we will need to be leaders to do this
- Will ensure our staff have the time and skills to measure and improve quality and safety
- Make the best use of each other’s time

#### Organising quality and safety improvement

We have designed and will use a management system to be sure that we are doing what we need to do via our Quality Management System.

Figure 6: Quality Management System



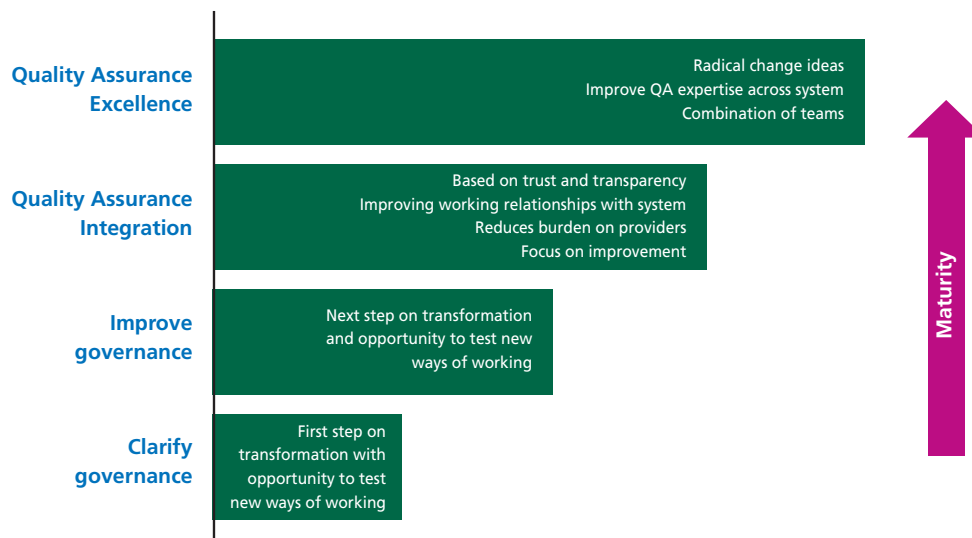
## Measuring quality and safety

Using our Quality Dashboard, we will measure how safe we are and have picked things to measure that will help us to work out where problems might happen before they harm people. We will make this information available to everyone that is responsible for improving quality.

## Developing how we work

We will take advice and continue to pay attention to how we are with each other, to improve our working relationships, so that we can make the biggest difference to the health of the people that we look after. How we work with each other is closely linked to safe treatment and care (safety culture), and we will invest in our colleagues to make sure that they can be honest, talk about and learn from their mistakes, and without being frightened about discussing when things go wrong.

Figure 7 Quality Assurance Maturity Framework



## Treating people fairly

Not everyone in SNEE has access to the treatment and care they need, and not everyone's treatment is as effective as it might be, i.e. health inequalities exist. We will make sure that we look for inequality in all of our work, whether that is caused by poverty, ethnicity, sex, religion, or address, and will work hard to reduce inequality.

## Listening to the right people

People and communities know what good quality health and care looks like and can describe what's important to them. We want to improve the right things. Through a regular meeting (People and Communities Quality and Safety Forum) we will share what we know about the quality of care we are providing and listen to people when they tell us what is important to them.

## Working on the right things

At the start of every year, we will agree what our priorities are going to be, based on what is important to people and communities, and then focus on improving them.

## 6.8.4 We will know we are making a difference because we will see

### Evidence that we are working more closely and better together

- By the end of 2023 we will produce documents that describe how our committees work together that are understood and accepted by all members (Terms of Reference, Agendas, Agenda planning meetings)
- By 2025 we will do joint visits to assess quality in local hospitals and clinics (Peer Review schedule) and reports will be brought to Quality Committee.
- We will also be working with other counties to improve quality and safety in the same way (Inter-ICB Service Level Agreements)
- We will be running educational events to teach people how to create better quality and safety together (System Quality Assurance Masterclass)
- By 2028 we will have people working to improve quality and safety in more than one hospital/clinic (Joint Appointments)

## Evidence of reduced harm to people

Using a clinical quality dashboard to review our performance, by 2028 we will:

- Reduce the rate of haemorrhage after childbirth (post-partum haemorrhage, PPH) to the national target of 3.3% for a vaginal birth and 4.5% for a caesarean birth
- Through the improvement of standards across the system, every year we will reduce all categories of infections (hospital and community attributable infections, HCAs) and hospital-associated outbreaks. Detail on how much we will improve varies from infection to infection, and is described in our infection control strategy

## Those who inspect our services will agree that they are safe

- We will work together to support our hospitals, GP practices, optometrists, community pharmacies and dental surgeries to improve their safety
- By 2028 the CQC will have given a minimum of a Good rating for Safety in all of our hospitals
- By 2028 the CQC will have given a Good rating for Safety in 85% of our primary care services, and we will have firm joint plans for improvement where there are concerns about safety
- At our next inspection (expected in 2023) the CQC will give SNEE ICS a minimum of a Good rating for Safety

## We can expect to be well

The Quality Committee does not set targets in reducing health inequalities but works continuously with the Directors of Public Health in Essex and Suffolk County Council to check and challenge inequalities in health care.

## Our leaders will know that our health services are high quality and safe

We will give our health and care leaders the right information about quality and safety of healthcare, and they will be confident that they have access to the right information at the right time. We will start taking stories from people to our ICB and use these in our internal papers immediately (from 2023). We will assess this by commissioning a peer review of our ICB's Quality Assurance maturity in 2024

## We will develop a healthy safety culture

By 2026 our staff will be able to talk about and report quality and safety concerns freely without fear of being criticised – 65% of staff will feel safe to speak up about anything that concerns them in their organisation, as measured by the NHS Staff Survey. By 2028 this number will be 70%.

## Our people will tell us

By 2023 with our people and communities we will have codesigned a meaningful measure of quality and safety and an improvement target for the subsequent five years. We are doing it this way so that we can make sure that we are measuring something that our people and communities want us to measure.



*Being involved in the Quality Committee allows us to ensure patient voice and lived experience are central to the decisions made. The ability to directly share experiences to the committee and providing the role of critical friend ensures scrutiny and integration. The opportunity to keep focus on the citizen throughout clinically led decisions enables safe, well led, compassionate care to be prioritised.*

**Sam Glover, Chief Executive  
Healthwatch Essex**



## 6.8.5 Case Study

EPUT psychological therapies team have been using three new initiatives to support young people in their care.

They have set up groups for young people to learn specific skills to manage their emotions, distress, and relationships more effectively.

Individual positive behavioural support plans help best support young people when they are distressed. These are put together by the young person, their parents and carers, and our staff.

The team are also working with young people to identify alternatives to prescribing medicine to manage their emotional distress, such as weighted animal and fidget toys.



## 6.9 Clinical and Professional Leadership

‘Health Equality for Everyone’ requires that our Health and Care Professional Leaders work together as partners to achieve services which meet the distinct needs of our people in localities and place and that our innovations and improvements encompass the expertise of our health and care professionals who represent:

- All sectors of health and care, including social care, voluntary and charitable organisations, integrated neighbourhood teams, mental health services, primary, secondary, and tertiary care
- A broad range of health and care professions, social workers, GPs, community pharmacists, acute consultants, nurses, and physician associates for example
- A vibrant and diverse community with varied ethnicity, age, gender, sexuality and disability with an ability to represent all
- The broad geography and the distinctions this encompasses including urban areas, rural areas, and seaside towns

Our ICS draws on the wide range of expertise, knowledge, and experience of our health and care professional leaders to shape better prevention and outcomes for our people and inform innovations and future plans. Our leadership team aim to work together with one collective voice and a culture of shared learning.

### Leadership in Practice

End of Life care will impact everyone in SNEE including those approaching the end of their lives, those that care for them and those who are bereaved. Working together with the community they serve, health and care professional leaders aim to deliver personalised and coordinated care centred around what is important to each person. Within each service, they address each priority, focussing on equality of access across all parts of our community. This ensures that care is personalised and equitable regardless of age, ethnicity, diagnosis, gender, mental health condition or level of deprivation.

Work is on-going with carer support networks, hospices, GPs, social care, hospitals, voluntary sector, community teams and health and care professionals across sectors and areas, making collective decisions to improve support for carers and those who are end of life. An approach of co-production like this with the needs and considerations of the local population at

the heart, means better quality of care and outcomes for our people as well as best use of available funding and resource.

Our health and care professional leaders in turn require support with leadership skills and their own health and wellbeing. The ICS currently offers the high impact One Team leadership development programmes for clinicians, managers, nurses, social workers and allied health professionals. These programmes are expressly designed to build a network of effective leaders who can together address the key challenges in the wider health and social care system. The programmes focus on skills but also on mindsets. They enhance mutual respect, highlight how our clinical skills complement each other and show how transferable those skills are to managing change in the teamwork environment, as well as in people’s lives.



*One of the greatest compliments given to the programmes was that participants felt that when they walked in the room with their colleagues there was not a sense of who they worked for organisationally, but that they were working together as one to improve their own working lives, that of their teams and that of their patients.*



### 6.9.1 How we Plan to Develop the Health and Care Professional Leadership Program

In February 2023 we held a Health and Care Professional Leadership workshop with invited attendance across SNEE from all sectors. We asked questions and collected outcome themes.

Two of the questions discussed and key themes included

#### 1. What does a high achieving leadership culture look like?

- There is visible collaboration
- Leadership is earned through modelling positive behaviour
- There is a culture of psychological safety
- There is a shared commitment to do right by people



- Opportunities for leadership training and progression are offered and invested in
- A variety of voices are heard equally
- There is a more collective model of leadership
- There is diversity in leadership
- Staff are supported
- There is transparency and communication

**2. What needs to be in place to ensure that health and care professional leaders are included and listened to, so that the right decisions are made?**

- A dedication to building an inclusive culture
- Psychological safety to speak up and to support others to speak up
- Staff being motivated to contribute their views
- People can work flexibly to enable collaboration across boundaries
- Investment of funds, space to talk and time to listen
- Mechanisms to ensure that the right people are included in the decision making

- Forums and communication mechanisms for people to be heard
- Space for new joiners to share ideas and different perspectives
- Hierarchy is flattened
- Critical thinking about how programmes of change are best delivered

Further events will focus on how we take these outcomes forward into actions and deliverables.



*Integrated care requires that professional leadership, both for health and social care has leaders that can understand both aspects to be well informed and understand the needs of our population. We need to ensure that all leaders understand what is happening at neighbourhood and place in both care and in health and that there is a golden thread of understanding, aspirations, and actions.*

**Sarah Nasmyth-Miller,**  
Assistant Director Mental Health,  
Learning Disabilities & Autism & Access

## 6.10 Voluntary, Community and Social Enterprise

### 6.10.1 Context

Like our public sector, our VCSE organisations are driven to address need and provide opportunities to create the best lives for our population. The VCSE in Suffolk and North East Essex is largely made up of a diverse network of small and medium sized organisations.

#### Suffolk

- 2,943 registered charities are active, with an estimated 12,000-18,000 other small community groups and organisations too small to register
- Over 1000 not for profit organisations registered with other bodies
- 88% have turnover of less than £100,000 and the majority of these will be volunteer only organisations

#### Colchester

- 186 active charities are registered in Colchester, plus other national and regional charities and faith and sports groups

- Of those registered, 52% have an annual income of under £25,000 and so are likely to be volunteer led
- Another 73 have an income of under £500,000

#### Tendring

- Estimated 900 voluntary groups with 20,000 volunteers including trustees
- There are almost no large charities based in Tendring or Colchester
- Most Tendring VCSE groups' income is below £50,000

Suffolk and Essex Community Foundations are independent charities, part of the UK Community Foundation network of 46 Foundations across the UK. Together, the network members are the fastest growing charitable foundations in the country.

The Community Foundation model aligns and channels funding from public sector, other trusts and foundations and local philanthropy, to provide grant funding to support local charitable and community groups.

## 6.10.2 Strategy

Our local VCSE infrastructure organisations see a range of opportunities to increase the impact of our sector and build on the commitment to the VCSE sector being an equal partner within the ICS. These opportunities include:

- More effective engagement between VCSE and public services on key challenges and solutions to maximise reach into communities and manage demand together. This starts with a principle of how not whether the VCSE sector can be a delivery partner
- Embedding our VCSE Resilience Charter, including a more consistent approach to grant funding and commissioning by local and national funders, and an approach which: identifies and supports what is already working; makes best use of assets and partnerships; and focuses on tackling unmet need across SNEE
- Committing to a greater proportion of funding being spent on the VCSE sector to support delivery of the priorities set out in the JFP
- Supporting individuals to engage in wider and more varied volunteer and social action and providing parity to volunteers in our programmes of work
- Developing more effective business/employer volunteering and social mobilisation to include time credits, local giving and other forms of engagement

- Supporting VCSE organisations to improve their sustainability through effective financial planning, marketing, support for training and development and supporting 21st century fundraising and income generation opportunities
- Developing digital solutions to provide efficiencies, resilience through new forms of income generation and smarter tracking of impact and outcomes

The ICB fully endorses these opportunities and is committed to turning them into a reality.



*We welcome the commitment to responding to lived experience and working differently that is so central to this Forward Plan. The Suffolk and North East Essex system clearly understands that our local charities and community groups are a vital and equal part of our health and care services, so often reaching the most vulnerable in our community, and there for people, at the most difficult of times. These groups also understand and share the voice of those with lived experience, which can be harder for those delivering public sector services. Delivering such joint working will be challenging but vital if we wish to avoid costly duplication and to increase impact.*

**Andy Yacoub and Wendy Herber,**  
CEO, Healthwatch Suffolk CIC

**healthwatch**  
Suffolk





## 7 Enablers to Success

### 7.1 Working in partnership with people and communities

In July 2022 NHSE published new statutory guidance for how NHS bodies should support effective partnership working with people and communities<sup>38</sup>. In response to the guidance, SNEE ICB developed a strategy<sup>39</sup> which outlines our principles and approaches for working with people and communities so that they are involved in priority setting and decision making.

The SNEE people and communities strategy recognises that outcomes are better when communities, partners, providers and commissioners work together to shape the delivery of our health and care. Understanding how people experience health and care support is a fundamental part of learning how to improve quality and safety. Engagement and coproduction will underpin and guide all activity of the ICB, working at neighbourhood, place and system level to lead change.

Moving from understanding how people experience the care and support of single services or providers, to partners listening together to learn how they can provide better joined-up care - acting as a system - will enable us to develop a clear and concise vision for the future. We have developed strong relationships with existing networks and community assets. Working together, we identify collective priorities, common themes and opportunities and agree a system response which draws on the skills and experience within the partnership.

<sup>38</sup> Source: <https://www.england.nhs.uk/wp-content/uploads/2022/07/B1762-guidance-on-working-in-partnership-with-people-and-communities.pdf>

<sup>39</sup> <https://suffolkandnortheastsex.icb.nhs.uk/wp-content/uploads/2023/04/SNEE-People-and-communities-strategy-Final-Approved-July-2022.pdf>

### 7.1.1 What are our principles?

The guidance sets out ten principles upon which our work with people and communities should be built. They provide ways of working, culture and best practice. We collaborated with people and communities in SNEE to identify what they would mean to us locally;

1. Ensure people and communities have an active role in decision-making and governance
2. Involve people and communities at every stage and feed back to them about how it has influenced activities and decisions
3. Understand your community's needs, experiences, ideas and aspirations for health and care, using engagement to find out if change is working
4. Build relationships based on trust, especially with marginalised groups and those affected by inequalities
5. Work with Healthwatch and the VCSE as key partners
6. Provide clear and accessible public information
7. Use community-centred approaches that empower people and communities, making connections to what works already
8. Use co-production, insight and engagement methods so that people and communities can actively participate in health and care services
9. Tackle system priorities and service reconfiguration in partnership with people and communities
10. Learn from what works and build on the assets of all partners – networks, relationships, and activity in local places

### 7.1.2 How will we work with people and communities – what approaches will we take?

Involvement and collaboration with the public right relies on developing strong relationships with local communities and individuals, building trust and respect. We are committed to a set of values which will underpin all our involvement and collaboration activity:

- **Collaboration** – working together and creating partnerships to understand people's experience throughout all parts of the organisation
- **Respect** – building trusted relationships between people, organisations and communities based on inclusivity, mutual understanding and accessibility so that everyone feels they belong in the conversation

- **Listening** – taking every opportunity to hear people's experience, paying attention and being curious about what local people say and acting on what we are told
- **Equality** – we will ensure that a diverse range of voices are heard and that people who are seldom heard are able to take part in every opportunity
- **Transparent** – we will be open and honest about our activity, be clear about parameters and decision making
- **Meaningful** – activity will be relevant and purposeful
- **Influential** – all activity will seek to have impact and lead to positive change, QI or better decision making

Developing strong and enduring relationships with our diverse people and communities relies on an equally diverse range of ways to collaborate and work with people. We will take an asset-based approach to community involvement. Investing in bespoke approaches in communities, creating a culture of transparent decision making and open discussions. Often this will mean taking a narrative-based approach to understanding experience, utilising storytelling, creative expression, or content analysis.

### 7.1.3 How will we support online involvement?

We already know that meetings, forums and face to face collaboration is not right for everyone. Many people want to collaborate with us at times and circumstances which suit them. Consequently, we have developed an online engagement platform to support engagement and collaboration with communities which can be found at <https://www.letstalksnee.co.uk/>.

Each of our three place-based Alliances have their own hubs on the platform, reflecting their own priorities and programmes of work. Details on strategic programmes which work across the ICB are also shared on the platform. This platform enables forum discussions, quick polls, sharing news and information, surveys and idea development. Where possible these pages will be codesigned with local people to maximise accessibility and engagement.

### 7.1.4 How will we work in partnership across Suffolk and North East Essex?

Good health relies on more than NHS services and the ICB cannot do this alone. Wider determinates of health – for example, poverty, discrimination, educational attainment, employment and housing have just as much influence on our health and wellbeing. By working collaboratively with our partners to understand the wider determinants of health, gathering a system wide view of equality and working with communities on joined up solutions we stand a better chance of improving the health outcomes of people in SNEE.

We are working with partners from across the wider ICS to jointly lead work with people and communities. These partners include local people, Healthwatch, the VCSE, Acute and Community Trusts, Foundation Trusts, Local Government, Public Health and Social Care. Working together we have committed to:

- Identify collective priorities and common themes and identify opportunities for system responses
- Identify areas of concern and issues being raised across different parts of the system (organisation, neighbourhood, Alliance) and bring these to the attention of the ICB Board
- Respond to system priorities identified at the ICB Board with insight and voices of experience, drawing on the range of expertise and experience of the committee partnership
- Look ahead at potential issues or areas of work and work together with people and communities to influence strategy and decision making
- Understand collective feedback loops and system communications about engagement, making sure opportunities are transparent and open and outcomes shared widely

As the wider ICP develops, we will continue to review our approach and how we work in partnership with people and communities. In particular we will focus on the communities identified through the CORE20Plus5 (children, young people and adults) to make decisions collaboratively on how to address their specific health and care needs, agree ambitions and plans to improve health outcomes through commissioning and service delivery. Adopting the Core20plus5 approach we will work alongside the place-based Alliance partnerships to identify local communities experiencing significant health inequalities or worse outcomes and those who would benefit most from a tailored approach.

For example, the fishing community working out of our large ports, migrant agricultural workers working in our rural communities and transgender people. We will work with our strategic programmes to support specific clinical areas to ensure we have an inclusive and equitable approach to working with people and communities.

### 7.1.5 What are the governance arrangements?

The governance structure for involvement and coproduction with people and communities ensures that insight and collaboration with people and communities happens at all levels across SNEE. We have worked with local people to design and develop the most effective governance route for people to come together, reflect on insight and experience, contribute to decision making and raise important issues. The work of the People and Communities strategy is therefore required to report through quality governance processes at both system and alliance level.

People have identified that building on existing work in localities and neighbourhoods and working in partnership at neighbourhood level is the most effective and appropriate approach. This work will be brought together at place level to form part of the Alliance delivery plans and local quality groups. Finally, all place-based and system programme work will be heard in the ICB subcommittee to provide assurance and deliver oversight to the ICB. We will be working closely with Alliance committees, the ICB Board and strategic partnerships to embed the people and communities' narrative so that it is seen as an essential part of the infrastructure.

## 7.2 Workforce

Strengthening our health and care workforce is the key enabler to delivering the benefits to the people living in SNEE described in this plan. We will enable this to happen by following the four pillars of the NHS People Plan:

- Looking after our people – with quality health and wellbeing support for everyone
- Belonging 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 our people’s skills and experience
- Growing for the future – how we recruit and keep our people, and welcome back colleagues who want to return

We recognise that many of our solutions will crosscut all four pillars. We have adopted an integrated approach to workforce, working closely with performance and finance to make sure our workforce plans are realistic and meet the needs of our local population.

Our ambition for our population is to have an integrated workforce that delivers care at the right time; in the right way; in the right place; by the right person. We will adopt an integrated approach to workforce with system partners which will allow us to think differently and develop a collaborative workforce strategy, to achieve local ambitions and the aspirations set out in national policy. The triangulation of workforce, activity and finance, and the alignment with the digital and estates strategies are intrinsically linked to system integration.

Our plan needs to address our greatest challenges highlighted below:

- At this current time there are significant issues being faced to recruit, support, develop and retain our workforce
- Coming out of the pandemic staff survey responses and increasing turnover show that we have a workforce tired and burnt out from responding to Covid-19
- These feelings have been heightened by increasing inflation and rising cost of living. As such, staff are looking for opportunities with independent providers or alternative sectors and geographical locations, in particular administrative, IT and physiotherapy staff

- We have an ageing staff profile, particularly within key primary care services

### 7.2.1 Workforce Planning

Working closely with system partners in health we will have a numeric long-term view of the workforce which will be aligned to activity and finance. This will be shared with system partners so that we can align our workforce plans as the system identifies areas of need throughout the ICS, allowing us to produce operational solutions in a co-ordinate strategic collaboration. This will be triangulated with finance and activity. We seek to improve service delivery and inform action plans and strategic direction, by linking strategic (workforce), operational and financial planning with population need. In addition, we will:

- Quantify workforce needed for both our supply lines and activity levels, that is financial costed for the next five years
- Have a system approach to workforce planning we have the right staff levels through the health and care system to meet demand without one area negatively impacting on the other
- Have one integrated strategic plan for the system

### 7.2.2 How we plan to meet the needs of our changing workforce profile to in turn meet the needs of our local population

#### **Growing for the future – how we recruit, retain and welcome back people who want to return.**

The system has shown a 27% growth in the workforce over the course of the last six years. The latest national figures available showed vacancies within social care of 7.5% and in secondary care at 4.7%. Within this, there are particularly prevalent professions, including care workers, midwives, occupational therapists, physiotherapists and diagnostics staff.

The system is exceeding its target for growth relating to nurses, although this has predominantly been due to a reliance on international recruitment. This has created greater disparity between care and health following the UK’s departure from the EU.

Organisations primarily operate independently to recruit staff, but there is appetite to apply learning and best practice across the sector. The system's Health and Care Academy and Talent Academy have provided support through advertising campaigns and career guidance to local communities and are managing the system's work experience offer.

We have ambitious targets for transferral of staff from agency and bank to substantive roles. We have been successful in recruiting good numbers to the reservist model in our system.

## Looking after our people – with quality health and wellbeing support for everyone

The system's staff turnover rates are particularly concerning – within secondary care our 12-month rolling turnover rate is over 14% and within social care it is 31.4%. There are particular concerns relating to care support workers and allied health professionals.

The cost of living crisis is becoming the key area of concern for retaining our workforce. Currently organisations are adopting individual responses to this issue and sharing best practice. However, it is acknowledged that we will need more radical solutions, particularly with the additional financial incentives available within other sectors and geographic areas.

Over the next five years we want to:

1. Improve our staff engagement and morale scores from the 2022 staff survey
2. Reduce the 12-month rolling turnover rates
3. Develop innovative action plans to ensure those most affected by increased inflation and cost of living are supported and improve access to affordable housing
4. Ensure our staff can work safely and improve the working lives
5. Deliver a compassionate working culture at all levels
6. Ensure that all staff are able and know how to access appropriate wellbeing and psychological support

## New ways of working and delivering care – making effective use of the full range of our people's skills and experience

Over the next five years we want to:

1. Work with the Integrated Care Academy to lead and support our new ways of working
2. Enable collaboration and integration of the VCSE workforce and volunteer base
3. Support system colleagues in exploring new models of delivering care
4. Have embedded a culture of training and progressive development across the system and in all roles
5. Develop and deliver a system-oriented career and leadership pathway
6. Increase the use of apprenticeships
7. Work with educational institutions to develop training and placement opportunities to address key skills gaps, identified by workforce planning

## Belonging in the NHS – with a particular focus on tackling the discrimination that some staff face

During the pandemic we became more critically aware of the need for enhancing social justice, equality, diversity and inclusion. Our workforce is predominantly female (72% in secondary care), although these figures drop when looking at senior paygrades within secondary care. 20% of our workforce is from an ethnic background, with 28% of Band 5 staff from an ethnically diverse background, but with few signs of progression to more senior roles.

There are clear barriers to progression, as recognised by our Workforce Race Equality Standard (WRES) and staff survey results including more ethnically diverse staff being in performance management and higher levels of bullying and harassment. A range of additional information on our equality and diversity initiatives is hosted on the SNEE ICB website<sup>40</sup>.

For our detailed approach please see section 5.3: Equality, Diversity and Inclusion in the Workforce.

Over the next five years we want to:

1. Create an open culture, where the principles of EDI are embedded as the personal responsibility of every leader and member of staff

<sup>40</sup> <https://suffolkandnortheastsexes.icb.nhs.uk/about-us/equality-and-diversity/>

2. Ensure staff have equity of opportunity across the system by developing understanding and reducing unconscious bias
3. Improve representation of staff with protected characteristics in senior leadership positions across our system
4. Reduce experiences of bullying and harassment across our system

## We will know we are making a difference because we will see

- Improved staff retention rates
- More providers' CQC ratings as 'Well Led'
- Reduced vacancy rates across all staff clinical and non-clinical
- Reduced sickness absence rates
- Positive annual NHS Staff Survey feedback
- Greater numbers of apprentices
- More young people recruited into health and care career pathways
- Improved supply and quality of pre-qualifying student placements
- Implementation and effectiveness of e-rostering system
- Closing of the gender and race pay gaps in partner organisations

- Increased diversity of employees with protected characteristics at all levels
- Improved support to NHS Boards to review their WRES and Disability Equality Standard and develop relevant implementation plans across their workforce



*The future of the workforce in the NHS is a great responsibility. Although we have great challenges, we also have great opportunities. We are looking at the future health needs of the population and what new and old skills and technologies our workforce will need. By ensuring that we are creating and communicating relevant and sustainable career pathways we can attract the next generation of the NHS workforce. We will continue to strive to improve the working lives of our current NHS heroes, so that they feel truly valued and can continue to give the care they are so rightly known for. We are a constantly evolving workforce but some things do not change and that is the skill, dedication, compassion and care of those that work in the NHS.*

**Amanda Lyes, Director of Workforce and People, NHS SNEE ICB and SRO for Sustainability**



## 7.3 Estates

Where services are located, the choice of services offered and the environment in which care is delivered can enhance or reduce people's personal health and wellbeing. Creating an estate where more people can access services at the right time, in the right place and be seen by the right person therefore supports people to improve their lives. Our priorities include:

- Providing ease of access to services that maintain health and wellbeing including acute, primary, community, mental health, VCSE and leisure as close to home as possible
- Providing treatment in environments that ensure privacy and dignity are protected
- Taking views into account when an estates scheme is being developed
- Being confident that as our population increases over time, our estate can meet the population needs
- Ensuring that our buildings are safe, efficient and well-maintained

- Enabling appointments with health and care professionals in a timely manner using a method of their choice

We are adopting an integrated approach to estate development, use and planning, working closely with workforce, finance, sustainability and digital to ensure our estate plans and solutions meet the needs of the growing local population. Adopting this approach allows us to think differently and creates a unified and collaboratively produced approach for the development of a system Estates Infrastructure Strategy (EIS).

### 7.3.1 Estates Objectives

Our ambition for our population is to have an integrated estate that allows the delivery of care at the right time; in the right way; in the right place; by the right person.



Our EIS will address our key challenges as highlighted below:

- Complex and fragmented estate management arrangements
- An ageing estate across the system which will require investment into mitigating the high levels of backlog maintenance over the coming years
- High levels of planned population growth across the system over the next 15-20 years, with clusters of significant growth in a few specific localities
- High demand across the system for limited amounts of capital investment
- Significant pressures on current and future revenue budgets to support ongoing and future estate development
- The desire to move services from the acute sites where these can/should be delivered within a community setting

### 7.3.2 Estate planning

The ICB Estates Committee has a strong membership and leadership and is directly accountable to the ICB. The Committee has access to and uses a wide range of data and information to understand the use, condition and planned development of the system estate.

Whilst areas of data collection have improved particularly across primary care the collective review, analysis and development of a system prioritised strategy is yet to be undertaken. Therefore, it has not been possible to develop a true system view of how, where and when to develop the estate. To do this requires a system, regional and national approach. The SNEE ICS EIS, once completed, will inform this discussion to construct a system wide 'data bank' and planning system to be used by all partners and overseen by the ICB.

Where we want to be:

- To develop effective and efficient estate management arrangements through increased coordination and collaboration between individual EFM teams and consolidated estate ownership within the ICS area
- Have a consistent but appropriate and proportionate methodology for collecting, reporting and presenting data relevant to the system estate, ensuring we have a fuller understanding of the entire system estate

- Work to develop a system EIS which will look to create a prioritised delivery pipeline of system estates development schemes as well as optimisation of existing premises and opportunities for disposals
- Demonstrate value for money in the design, construction and operational management of the system's estate through collaborative working between system partners
- Optimise, through collaboration with One Public Estate the utilisation of public buildings and infrastructure for the health care benefits of the population we serve
- Development of a collaborative, highly skilled Estates and Facilities workforce with all system partners able to access the right expertise in the right place through the potential establishment of integrated Estates and Facilities services
- Achieve the targets contained within the SNEE ICS Green Plan and the overall NHS net zero ambitions, as noted in Section 7.9
- Create an estate infrastructure to deliver transformational models of care, supported by system wide technological innovation and enhancements
- Have a 'Single source of the Truth' in Estates data and information for the entire ICS Estate to inform and enable accurate planning of the Healthcare Infrastructure System from this JFP

### 7.3.3 How we plan to make a difference

#### Development of Primary Care Estate Strategies

Historically, estate development with primary care has been considered at individual GP practice level. However, there will be a growing demand on primary care and wider community estates due to the growth and expansion of services which will be delivered through PCNs via the ARRS as well as the migration of services from acute hospital sites to the community. Therefore, estate planning must be collectively undertaken at PCN level taking account of GPs as well as community and wider public and VCSE sector estate opportunities.

Services have been commissioned for the development of PCN estates strategies across each of the three alliances. Initial drafts are planned to be completed by the end of March 2023. The development of these strategies will enable:

Over the next five years we want to:

- Improve primary care estate data and further integrate this within wider planning and estate development
- Identify opportunities to address short-, medium- and long-term capacity issues through estate development, optimisation and utilisation
- Optimise the use of the Public Estate to maximise the benefits for Primary Care health facilities
- Prioritise primary care estate investment and development to support the delivery of services within the community
- Maximise the existing primary care estate through improved cost management, waste eradication and funding release, to enhance each of the PCNs
- Support practices with the development of additional estate capacity to support the expansion of the ARRS workforce as well as opportunities for new ways of working

## Development of a System Estates Infrastructure Strategy

Through the work of the ICB Estates Committee progress is being made on developing the first SNEE ICS EIS. The strategy will include the current costs, location and condition of the existing estate and consider the changes required to enable successful delivery of the JFP and future SNEE ICS strategy. The document also includes extensive links into the ICS Workforce and Digital strategies recognising the importance of both in the delivery of a patient focussed, technology enabled environment.

The EIS will provide a comprehensive assessment of the current and entire estate across the ICS, along with a strategy of what the estate solution requirements will look like in the future (10years+) and how the ICS will develop that solution.

Over the next five years we want to:

- Develop a single infrastructure strategy which prioritises and aligns infrastructure development projects across all system partners to the system and national priorities
- Support system and organisational finance leads to develop finance plans and budget allocations which align to the delivery of system infrastructure priorities
- Support the development and delivery of care closer to home and in locations most appropriate for service and people's need
- Deliver the short-, medium- and long-term outputs from the EIS

## Future Systems

WSFT sits within the New Hospital Programme as a cohort four scheme to deliver a replacement for the current West Suffolk Hospital Reinforced Aeriated Autoclaved Concrete (RAAC) building before 2030. With outline planning permission secured and the Outline Business Case being submitted in 2023, WSFT is on-target to achieve this goal. This will provide a fantastic new facility for the population of West Suffolk and work continues with stakeholders to deliver a successful project. development is taking through co-production is key to minimise risks.

The Future System Programme can support WSFT's credentials as an anchor organisation and ensure the best economic benefit to the West Suffolk area; maximising positive impact and minimising negative impact in a sustainable way is a key driver to not only how we operate estates and facilities now but also for the future.

The next five years of the management of the estate and facilities services are focused on ensuring we keep an appropriately high level of compliance on the estate to be demolished ensuring safety and quality, but not to over-maintain this estate beyond its operational life. For WSFT, the ongoing investment to support the RAAC building through the failsafe programme will see c.£74m invested over a four year period, this does not extend the life of the asset but supports the mitigation of risk whilst the building continues to be used.

Supporting the drive to bring care closer to home, the Estates and Facilities Strategy must work alongside Workforce Planning and Digital Strategies to ensure these are aligned. Supporting investments at Newmarket such as the Elective Surgery Unit (under development) and Community Diagnostic Hub (agreed) are part of that programme but ensuring there are appropriately trained and skilled staff to safely provide that service.

Over the next five years we want to:

- Ensure a successful new WSFT hospital estate is well underway
- Work as a system to ensure the system infrastructure underpins new ways of working
- Work alongside and ensure our strategies are aligned with other key enablers including workforce planning and digital
- Align estate intelligence and planning to our activity, performance, and finance planning, to create a sustainable estate to meet health population needs

## Developing Centres of Excellence

The new Dame Clare Marx Building at Colchester Hospital will provide a three-storey building on the southwest of the site using modular construction and will open in August 2024. It will include eight theatres, a 16-bed Post Anaesthesia Care Unit (PACU) Stage 1, three 24-bed inpatient wards (67% en-suite single rooms), a diagnostic imaging suite and associated facilities including receptions, waiting areas and outpatient rooms.

Key benefits of the new elective orthopaedic centre for patients and staff include:

- Shorter waiting times for surgery and shorter stays in hospital
- Minimal risk of cancellation of surgery in a pandemic resilient surgical facility
- Better clinical outcomes from the standardisation of care
- Improved patient and staff experience of the physical environment
- New opportunities for training, education, research, and innovation
- Delivery of clinically and financially sustainable acute services
- Support the transformation of health and social care across the ICS

## One Public Estate

Within SNEE ICS we have a strong relationship with the three One Public Sector Estate Groups (one per Alliance). Through these relationships the system has developed some key initiatives including the co-location of NHS and local authority services.

Over the next five years we want to continue to engage with and support key initiatives through the one public estate framework to promote and develop co-location and integration of key public, health and voluntary sector partners where possible.

## Meeting the future demand from an increasing population

We continue to develop excellent relationships with the six local planning authorities across the ICS, enabling the development of a collaborative working arrangement. This will ensure that sufficiently detailed strategic infrastructure delivery plans are in place to support the mitigation that the effects of housing growth will continue to have on the local health infrastructure.

The ICB has identified that it is important that developers' contributions support the whole healthy economy and therefore the ICB Estates team continue to coordinate system wide responses to planning applications, Local Plans, Infrastructure Delivery Plans and Neighbourhood Plans. This approach looks to ensure that people are not disadvantaged through population growth, whilst also ensuring the increased population has adequate access to a fit for purpose health system.

Over the next five years we want to:

- Work with the local authorities to understand, plan for and mitigate the proposed housing growth planned within each district, borough and city Local Plan to ensure health care provision is adequate for increased population
- Work to secure adequate and appropriate mitigations from housing developments to support the development and expansion of health and wellbeing services to meet the growth in population
- Consult with the local population on major changes to the estates infrastructure to ensure the future estate is patient focussed, increases social value to the population it serves and is flexible to adapt to new practices, technologies and increasing activity
- Improve patient and staff experience by providing high quality, technologically enabled, estate to enhance clinical service delivery and aid health outcomes

## Ownership and management of properties

The ownership and management of the NHS estate can directly and indirectly impact on the delivery of services to the population and therefore needs to be managed in such a way that maximises the benefit to people's care. Changes in the Department of Health and Social Care policy over the last few years have meant that NHS Trusts can apply to transfer the ownership of assets from NHS Property Services to themselves if it can be shown that there is benefit to care through management of the premises at a local level.

The Health and Social Care Act 2022 enables ICBs to hold estate, which has not been possible since the abolition of Primary Care Trusts in 2013. Whilst national policy and financial controls are yet to be developed to support ICBs in holding estate, this change presents the system with an opportunity to plan, develop and manage their estate for the benefit of the system and patient population at a local level.

Over the next five years we want to work as a system to ensure assets are owned by the most appropriate system partner to benefit the delivery of care.

### 7.3.4 We will know we are making a difference because we will see:

- Improved estate optimisation and greater integration with One Public Estates partners in the use of the public estate
- A rationalised and prioritised capital pipeline
- A single system delivery plan with organisations and partners working towards the same system objectives and priorities
- Wider sharing of estate across the system for the benefit of service delivery
- Reduced backlog maintenance
- Improved efficiency and effectiveness of estates and facilities services through closer collaboration to support clinical delivery
- Services located in the right place to meet the demands of the population

- Disposal of redundant or non-viable estate
- Improved staff recruitment and retention through improved estate
- Demonstration of clear value for money for the public purse



*Our ambition is to have an integrated estate that allows the delivery of care at the right time; in the right way; in the right place; by the right person. This means an estate which is in a good condition, is functionally suitable, and is flexible, accessible, and affordable. Our Estate Infrastructure Strategy will respond to the needs of this Joint Forward Plan, not vice versa, by delivering an estate which is focussed around the needs of the population we serve.*

**Paul Fenton, MBE, Chair of the SNEE ICB Estates Committee and ICB Strategic Estates Advisor**



## 7.4 Digital

Out of the 12 core functions of the new ICB, two focus on digital:

- Leading system-wide action on data and digital: working with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services to put people at the centre of their care
- Using joined-up data and digital capabilities to understand local priorities, track delivery of plans, monitor and address unwarranted variation, health inequalities and drive continuous improvement in performance and outcomes

It is therefore the responsibility of SNEE ICB to create and enable the levers that make this happen. A key ambition is to provide more joined up care that better enables information to flow across the system in a consistent and coherent manner. Ensuring that we join up data from multiple systems in real time will ensure that we can deliver safer, better quality care. This will in turn lead to improved health outcomes and a more positive experience for people, staff and carers.

The SNEE ICS Digital, Data and Technology (DDaT) Strategy 2022 to 2025 and corresponding DDaT Strategic Delivery Plan are aligned to the ICS Strategy and Live Well Outcomes, The Design Framework and Suffolk and Essex Health and Wellbeing Strategies, What Good Looks Like and our ICS Core Values. The DDaT Strategy can be found in Appendix 12.

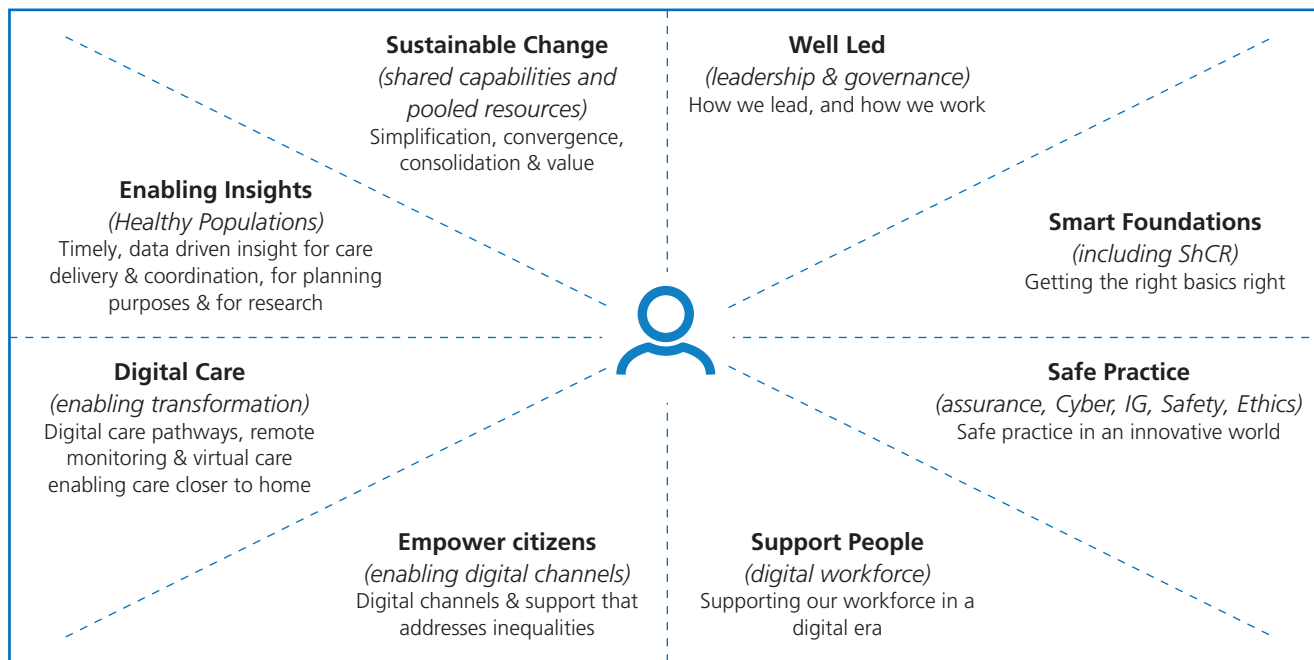
Priorities over the coming financial year and beyond for the ICB DDaT Project Management Office through this transition stage are to:

1. Foster professional leadership throughout the ICS, and implement a Strategic Delivery Plan that aligns to the annual investment cycles to make best collective use of public money and asset
2. Establish Smart Foundations for projects, procurements and services that free up time to care and implement systemwide delivery models, e.g. shared care records and personalised care planning
3. Build our multi-disciplinary approach to Safe Practice, and communities of specialists to enable this across the ICS
4. Enable support for our health and care community to 'thrive in a virtual world' by embracing a culture of continuous learning

5. Develop a common digital front door for our people and actively improve channels that support our most vulnerable
6. Enable an approach to digital care technologies and remote care to increase capacity that may empower our provider collaboratives
7. Enable a linked data set platform that will provide data insights for a range of purposes
8. Form and operationalise Provider Collaboratives, and support Alliances to adopt capabilities that enable integrated care

Figure eight below sets these out pictorially.

Figure 8 - SNEE ICB digital principles



### 7.4.1 Delivering digital transformation

We are currently undertaking an appraisal and baselining exercise of options to make the best use of our existing collective resources and programmes / projects to mitigate duplication. The DDaT PMO team will work with partners to develop our ICB digital approach by following eight key principles which stem from the success measures of the What Good Looks Like framework<sup>41</sup>. These serve as our overarching direction to align our priorities in the context of the wider DDaT landscape and such priorities will develop over time in both shape and pace of delivery.

Key principles and corresponding priorities of the strategy are noted below:

- **Be Well Led** - Goal: Lead and enable our strategy
  - Agree a strategy for digital transformation and collaboration that drives 'levelling up' across the ICS and is underpinned by a sustainable financial plan by July 2023 which will be responsive to our people's health and care needs over the next 3-5 years
- **Smart Foundations** - Goal: Invest in core digital technologies and 'levelling up' whilst establishing convergence pathways
  - Develop the DDaT Strategic Delivery Plan and the resources to progress by September 2023
  - Support organisations to progress to minimum digital foundations, including digitising social care, electronic patient records (EPRs) and shared care records as part of the ongoing programme of investment scheduled for 2023/24 and 2024/25
  - Establish a data strategy that encompasses all the ICS partner organisations by Q3 2023/24
  - Develop and recognise digital skills embedding continuing professional development and recognising DDaT professions within our continued programme of work in 2023/24
  - Secure investment in EPR and diagnostics to stabilise and improve infrastructure for partners and providers in 2023/24
  - Enhance systemwide governance for Shared Care Records and Care Planning (Personalisation) starting in Q1 2023/24

<sup>41</sup> Directed at all NHS leaders, this framework sets out what good looks like at both a system and organisation level. It describes how arrangements across a whole ICS, including all its constituent organisations can support success. Further information is available here: <https://transform.england.nhs.uk/digitise-connect-transform/what-good-looks-like/what-good-looks-like-publication/>

- **Safe Practice** Goal: Maintain trust, transparency, security and resilience
  - Develop a specialised team to work across the system, bringing together considerations around Cyber and Standards, Information Governance and Policy, Clinical Safety and Data Management and Ethics in 2023/24
  - Support local communities of practice, enable programme progress across other principles and their delivery plans, and develop cross-organisational governance, policies and processes in 2023/24
- **Support People – Digital Workforce** Goal: Support our workforce to thrive in a digital world and develop our DDaT professionals
  - Baseline DDaT skills and knowledge across the system as well as the current available assets at national, regional, ICS, place and organisational levels which will follow the baselining of our resource options in Q2 2023/24
  - Develop our skills development network, with a focus on analytics, cyber and core capability skills during 2023 across the ICS and established links in the EoE and nationally
  - Develop a repeatable and sustainable approach to digital skills adoption for the frontline with a focus on digital care and integrated team working by 2025
  - Developing support models for hybrid working by 2025
- **Empower People** Goal: People at the centre of digitally enabled care, which ensures Equality and Equity
  - Develop a systemwide digital inclusion strategy and ICS Equality and Equity Toolkit across key digital services in 2023/24
  - Enable the use of NHS login with our key local digital services in 2023/24
  - Enable people with advance care needs for end of life to contribute to their co-produced record by December 2023
  - Begin to further test the process of people having access and contributing to their healthcare information and taking an active role in their health and wellbeing. This includes an ambition to scale to diabetes by 2024
- **Digital Care** Goal: Digitally enabled care closer to home that is clinically led, unified and resilient
  - Form a systemwide Digital Care Delivery Board by the end of Q1 2023/24 to coordinate digital options including remote care, virtual consultations, remote monitoring and virtual wards
  - Enhance our programme of work to enable virtual wards and 'Hospital at Home' models to develop further from the progress in 2022/23
  - Facilitate and enable clinically led, virtual wards and other digital care; aligning operating models to support staff in 2023
  - Establish a delivery plan to scale these capabilities throughout the system, whilst decommissioning those capabilities that become obsolete or remain siloed by June 2023
  - Baseline our digital decision support and establish our strategic plan by July 2023
- **Enabling Insights** Goal: Make best use of the information assets we hold
  - Develop a systemwide data strategy in 2023/24
  - Revisit the Data Management Maturity model with providers in 2023/24
  - Supporting the Intelligence Function in developing capacity and tools in 2023/24
- **Sustainable change shared capabilities and resources** Goal: Enable sustainable change
  - Form and operationalise Provider Collaboratives and support Alliances to adopt capabilities that enable integrated care in 2023/23
  - Start creating digital exemplar hubs in the community in 2023/23
  - Explore strategies to achieve a SNEE people portal in 2023/24



*“Shared care records, where the whole of our personal medical history is available to each of the medical parties seeking to help us, should be a fundamental foundation in creating effective integration. Being asked for the same information several times is both wearing for the citizen and creates the potential for inconsistent understanding.”*

**Cllr John Spence, Co-Chair of the SNEE ICP and Chair of the Essex Health and Wellbeing Board**

## 7.5 Intelligence

### 7.5.1 Background

Aligning with national guidance and to further progress our approach to PHM, SNEE ICS is developing an ICS Intelligence Function.

The vision for the Intelligence Function is to develop shared, cross-system intelligence and to use information to improve decision-making at every level. The Intelligence Function will be a shared analytical resource that will work on cross system priorities. It will use linked data to help design and deliver improvements to population health and wellbeing, making best use of collective resources, and will ensure that insights from data are used to improve outcomes and address health inequalities.

In particular, the Intelligence Function will undertake modelling to improve our understanding of future demand across the system over the longer term to inform strategic, workforce and financial planning.

### 7.5.2 Our Priorities

- We will develop a SNEE Intelligence Function to provide additional analytical skills and capacity and ensure intelligence from data informs strategic decision making
- We will develop the data infrastructure and supporting information governance processes to enable the Intelligence Function to operate effectively and lawfully
- We will ensure ICB Committees are supported by high-quality Business Intelligence (BI) to ensure there is an up-to-date understanding of activity and performance
- We will co-develop our intelligence plans with partners, exploiting opportunities to work across boundaries to join-up data and expand our insights on the drivers of health
- We will work to the highest standards in how we use, share, and store data, adhering strictly to appropriate information governance processes as well as security, ethical, and quality standards

### 7.5.3 Progress to date

Our Intelligence Function has been co-developed with partners across the ICB. It will address gaps in analytical capabilities, ensuring the ICS is well served by a sophisticated and high performing analytical function. We are diversifying and broadening our intelligence capabilities, by investing in skills such as health economics, impact evaluation, and data science. This will enable us to maximise the utility and value of our data and ensure that intelligence from data informs decisions on prioritisation, change, and operational planning.

We have developed a modern cloud-based integrated data and analytics platform to give our analysts the opportunity for shared access to linked data with modern analytical tools.

From this data, we are developing a PHM intelligence platform that provides system-wide insights on our populations' health, from person to system. This gives clinicians and operational managers across the ICS access to intelligence on population health, including at risk cohorts and trends in long-term conditions, enabling the identification of appropriate proactive interventions.

We have developed a suite of dashboards which cover a wide variety of activity, resource and performance metrics. The localised monitoring of System Oversight Framework and national priority metrics has been developed and aligned to the Making Data Count approach. These reports are made available to partners across the system and are aligned to the ICB Committee structure.

Substantial quantitative analysis has been undertaken to 'model' services and establish statistically robust demand projections given assessments of population need and service activity. This takes into consideration demographic and non-demographic drivers of demand. We will continue to use this analysis to identify what we must do as a system to meet sustainably our population's health and care needs

## 7.5.4 Our partners

The Intelligence Function is a collaboration of organisations across the ICB but will also seek partnerships with wider organisations, such as in the VCSE, and in other networks and ICSs.

It will also work with the Offices for Data and Analytics in Suffolk and Essex, important enablers for undertaking analysis on linked datasets across health and care and wider determinants of health including education, housing, welfare, and environment.

The Suffolk Office of Data Analytics (SODA) is a collective endeavour between Suffolk public service organisations to make better use of data to generate new insights into public services and the needs they serve, and to apply these insights to improve policy and service design and delivery. SODA achieves this through analysing data from multiple sources and linked datasets and by applying robust analytical techniques to generate insight. The SODA partners are the SNEE ICS, Suffolk's six Local Authorities, and Suffolk Police. Going forward, SODA will focus on bringing together partnership datasets, while also continuing with longer-term evaluations of the Suffolk Criminal Exploitation Programme and the Suffolk Tackling Poverty Strategy.

The Essex Centre for Data Analytics is a partnership venture between Essex County Council, Essex Police and the University of Essex that seeks to promote the use of data sharing and analytics to improve outcomes for local people. It focuses on having system-wide impact by enabling partners to work together to generate new insights on a range of topics that support strategy development, targeting of early intervention, service design and outreach. Future work includes developing a holistic view of vulnerabilities amongst the residents in North East Essex and assessing disparities in waiting lists and using joint data to inform an action plan on how best to manage this to reduce inequalities.



*Data has tremendous utility, and our aim is to translate data into rich insights that will inform decisions on how we work now and in future and how we can deliver our priorities such as meeting the growing demand for health and care services or health inequalities.*

**Alex Royan, Deputy Director  
Strategic Analytics**



## 7.6 Procurement/Supply Chain

Procurement is the act of obtaining or buying goods or services and covers all spend undertaken within the ICB. Spend within the ICB is wide ranging and may be the purchase of information technology hardware, legal services, healthcare services or human resource. Every element of spend is regulated by the internal Standing Financial Instructions, internal policies and external regulations and guidance.

The principal aim of procurement undertaken by NHS organisations is to deliver essential goods and services and improve outcomes, while increasing value from every pound spent by the NHS.

Procurement across the ICS is moving towards working more closely in collaboration to procure common items together. To start this integration the ICB and partner Trusts have started to align standing financial instructions to ensure approaches to procurement are more aligned. The integration will develop once the ICB and its partner Trusts are able to share common spend categories across the spectrum of procurement.

Working as Anchor Organisations, the ICB and its partner Trusts are jointly responsible for procuring for social benefit, by embedding social value into procurement activities to ensure positive environmental, social and economic impacts are realised through commissioning and purchasing goods and services<sup>42</sup>.

Aligned social value commitments will be agreed between procurement teams and the wider system to support the delivery of the benefits and achievements of the ICS wide Green Plan (as discussed in Section 7.9).

To achieve the above commitments, strategies and policies the ICS is working to further develop and integrate the use of a single e-commercial system which enables NHS organisations to have visibility of each other's sourcing and contract management systems. The adoption of the Atamis Health Family System across the ICS will allow greater sharing of data, processes, spend analysis and market intelligence, allowing joint procurement to be developed with greater ease.

<sup>42</sup> Source: <https://www.gov.uk/government/publications/procurement-policy-note-0620-taking-account-of-social-value-in-the-award-of-central-government-contracts>



# 7.7 Communications and engagement

## 7.7.1 Context

The fundamental change the ICB brings is that all organisations and services, across physical, mental health and social care, will work together to create seamless services and joined up working. Effective communications, public relations and engagement is pivotal to this.

Engagement refers to engaging with people and stakeholders about significant service change. Any approach should be discussed and agreed beforehand with Healthwatch as the system's lead on public involvement and engagement and Health Overview and Scrutiny Committee (HOSC) in Suffolk and Essex.

Getting the right messages to our people, stakeholders, staff and communities through the most appropriate channels at the right time is central to effective communications and engagement. The ICB will continue to inform and share information as well as listen to the views people have about the services they receive or any proposed changes to the way these services may be provided in the future.

## 7.7.2 Public relations and engagement

Our communities and people have frequently told us that the complexities in the way our health and care system has previously worked is too confusing and has added to their levels of stress when they or their loved one is experiencing ill health. For:

- **People**, this means a local health and social care system that they are able to navigate with ease and take an even greater role in managing their own health and wellbeing
- **Patients/service users**, this means local services that work seamlessly together to meet their individual needs and values their time
- **Staff**, this means an environment in which they are able to work together to deliver the very highest standards of care under effective leadership
- **Organisations**, this means genuine collaboration - equally value their own success and that of the wider local health and care system

## 7.7.3 Aims and objectives

A detailed set of aims and objectives will be co-produced with partners such as Healthwatch, local service provider organisations and the charitable sector that will seek to achieve outstanding communications and engagement in 2023. However, at the very least, the ICB communications and engagement teams will seek to ensure the following aspirations are achieved:

- Stronger stakeholder and partner relationships
- Greater levels of trust among staff, patients and the public
- Better solutions and outcomes for people based on feedback
- Influence behavioural change among patients and the public concerning the correct use of services
- Feedback to people on how engagement has influenced decision-making – 'you said, we did'
- To position the organisation as a leader of the NHS

The objectives are to:

- Build credibility and trust in the NHS in SNEE so the ICB can maintain a reputation with partners, stakeholders, patients and the public as a high performing, responsive organisation
- Build continuous and meaningful engagement with the public, patients and carers to influence and support us in our commissioning decision making process
- Ensure member practices feel fully informed about the work of the ICB, are ambassadors for the ICB and advocates for their patients
- Establish robust and effective mechanisms to gather feedback relating to significant service change
- Work closely with Healthwatch Suffolk and Essex and other independent sources to understand additional feedback from communities

## 7.7.4 Key messages

Our key messages will be coproduced with our local stakeholders. This will be achieved through a separate workshop that will be independently facilitated. However, the following messages will be used in most communications produced by the ICB, until this workshop takes place, where appropriate:

- We are committed to ensuring that the public voice is at the heart of the ICB's work to ensure everyone has an opportunity to influence our decisions and co-design NHS services
- We fund quality services to meet the health needs of communities across SNEE
- We work with our partners in the NHS, local authority, community and voluntary sector to support people to manage their health and remain independent, whilst avoiding unnecessary hospital admissions
- The ICB is committed to exploring innovative approaches to support people with their health needs, such as social prescribing and advance care planning for end-of-life care
- Through its partnership, the ICB will seek to deliver care close to people's homes and enable a more personalised approach to meet their health needs
- The ICB will work to educate and support people to better understand the importance of prevention and early diagnosis

## 7.7.5 Communication tools and approaches

- **Social media:** The ICB has three Twitter and three Facebook accounts which were a legacy from the previous CCG organisations. The ICB kept these accounts to maintain the high volume of followers it has gained and will seek to further increase good quality, locally relevant and engaging content on all its digital platforms. The Communications team will develop a robust social media plan which will explore additional channels and platforms most relevant for target audiences to keep our communications relevant
- **Media relations:** The Communications team will continue to work closely with local, regional and national media to get the ICB's messages across. We will also work with the media to explain why we make decisions and provide an honest and transparent response when we are scrutinised or challenged about any aspect of our commissioning role

- **Campaigns:** Throughout the year, the Communications team will contribute to and promote various healthcare or seasonal campaigns, that link to our priorities. We will adopt a creative and targeted approach to campaigns, based on clinical evidence. We will evaluate our campaigns to ensure learning is captured for future work and continue to amplify public health messaging
- **Websites:** The Communications team maintains content on [www.sneevaccine.org.uk](http://www.sneevaccine.org.uk) (the SNEE Vaccination Service website) and on [www.sneewellbeing.org.uk](http://www.sneewellbeing.org.uk) (a site which supports people to stay well – one of the main channels for the ICB's winter campaign). It also recently launched a new ICB site which contains corporate information about the organisation - [www.suffolkandnortheastsex.icb.nhs.uk](http://www.suffolkandnortheastsex.icb.nhs.uk) and is currently developing a SNEE wide 'tolivewithdying' website which offers support and advice to people affected by bereavement or end of life issues
- **Parliamentary briefings:** The ICB will respond to urgent parliamentary briefing requests and queries from local Members of Parliament (MPs) in a timely manner. The ICB will actively engage with local MPs to ensure they are aware of our plans and to hear the voices of their constituents as well as continue to share the monthly ICB briefing with them
- **Internal communications:** The ICB will continue to communicate and engage effectively with its staff. It will continue to deliver virtual staff briefings and identify agenda items to share with staff. The ICB will also promote the work of its staff networks within the organisation and, where appropriate, will increase awareness about the work of the networks that exists within its partners too. This is to highlight the breadth of diversity and support that exists within our system area
- **Different ways to involve diverse groups:** We aim to use a range of communication and co-production methods to reach our diverse population to ensure we are including groups that are potentially excluded and can be seldom heard. The pandemic allowed the Communications team to develop and strengthen relationships with local community leaders and groups and we will continue to explore new and innovative ways of reaching these groups. Through the ICP and Healthwatch, we will continue to build on and create new links with VCSE groups

- **Accessible information:** The ICB will ensure all public facing information is accessible; our public documents and campaign materials will be produced in Easy Read and film versions when required. Other formats such as languages other than English can also be provided as required and on request. We will also ask patient groups to review documents such as leaflets and surveys to help ensure we communicate effectively
- **Working with partners:** We aim to work with communication and engagement partners, operating across organisational boundaries and building a coalition of advocates to achieve our aims. Our partners will include local authorities, NHS foundation trusts, PCNs, VCSE organisations and groups, local Healthwatch, neighbouring ICBs and patient groups



*Working together with our patients, partners, public and communities is central to everything we do as an Integrated Care Board.*



*The overarching aim of our communications and engagement work is to support this Joint Forward Plan's vision to deliver the best possible health outcomes for the one million people living across Suffolk and north east Essex. A key aspect of this work will be to generate understanding about these aspirations. We are committed to doing this in the most effective way possible which requires ongoing co-production with our communities and health and care providers. It is vital we share our vision, plans and progress in a way that local people can fully access, understand and respond to. As such, using the most appropriate channels and platforms of communication to reach our different audiences will be crucial.*

**Simon Morgan, Communications Lead**



## 7.8 Research and Innovation

Our ambition is to build a culture of research and innovation across our ICS that is responsive to those in most need in the communities that it serves. We recognise that there is a continuum to research and innovation and we will align the innovation priorities with the research strategy and aims to ensure timely translation of research in to practice for our people. We will embed coproduction in research and innovation with our people and communities to ensure the patient voice is integral to our work.

Our ICS will encourage research and innovation by organisations, communities, Alliances and as a whole system that improves the design, delivery and outcomes of health and care services. We will develop a peer network of researchers and innovators to offer a range of opportunities to meet learn, collaborate, share and review research and innovation. Building and strengthening these partnerships gives opportunities to identify and develop ideas, and apply for funding to support research and innovation, at a system wide level. We will share learning within our ICS and more widely, to help promote best practice regionally and nationally.

Individual partners across SNEE have a strong track record of delivering and collaborating on research and innovation. In collaboration with all our system partners, we will research and deliver innovative solutions that address our key local challenges and that make a positive and lasting health impact for our people.

### 7.8.1 Research

Our ICS regularly delivers research, collaborates on studies between organisations, and has a strong history of research across our Trusts and primary care. We have established a five-year research strategy in order to develop our system wide research infrastructure and create a research rich environment which aims to:

- Build a flexible, system-wide approach to research across our ICS
- Build on our academic partnerships to develop research ideas and achieve research funding
- Empower research teams, services, service users and carers to work as partners to help deliver, develop and support high quality research
- Work towards embedding a culture of research, innovation and use of evidence across the ICS
- Make research both meaningful and accessible

We have established strong connections with our local academic partners. The priorities of the Integrated Care Academy at the University of Suffolk purposefully align with those of the ICS. Academic links are also established with the University of Essex, and the University of East Anglia Health and Social Care Partnership. In order to build on our existing collaborations, we will in the short term undertake a systematic mapping of our current research, the identification of research need and understanding of opportunities for research funding, which will enhance the future resilience of our local research collaboration infrastructure.

We will also map the ways in which the system engages with our population around research, for example existing Public and Patient Involvement groups. This will support the initiation of conversations with our population about research and the many ways they can be involved

In the medium term, we will explore joint appointments between ICS partners focussed on the generation of research ideas and competitive applications for research funding. We will explore and provide appropriate training to support co-produced research for staff, service users and carers, working with the Integrated Care Academy's co-production hub at the University of Suffolk. We will also support applications for externally funded fellowships.

We recognise the importance of making research accessible to everyone. Therefore, we will increase communication and visibility of research in a format that is accessible and inclusive to support the development of a research culture within our ICS. We will hold annual 'celebration of research' events to raise awareness, celebrate progress and disseminate findings with our staff and population.

In the next two years, we also aim to develop a digital platform for sharing research and innovation activity and support across the ICS.

By 2028 we will have achieved:

- Research grant success centred on SNEE priorities
- Invested in local structures to support the ICS to work with academic colleagues and developed a centre of excellence located within SNEE
- Developed fellowship opportunities and embedded researcher models of practice across the different ICS partners
- Developed dedicated posts centred on research and evidence use across the ICB/ICS
- Embedded the use of evidence in the policy documents at an ICS level e.g., key part of commissioning documents
- An agreed, programme of work across the ICS to communicate about research and research opportunities with our population and our workforce

## 7.8.2 Innovation

Our ICS recognises the importance of innovation as a key driver of improved outcomes and efficiency. Innovations in health and care may include a process, service, product or technology, which represent a step change on what has gone before, that when implemented results in better health and care. We have built strong foundations for the innovation programme, including the adoption and spread of many noteworthy innovations that have already made a difference.

We have developed a two week wait skin cancer pathway that has an integrated teledermatology approach that has improved people's experiences and reduced the average time to their first appointment by five days (as discussed in the case study later in this section). This was supported following a successful innovation exchange developed to horizon scan and identify future innovations in this area.

As we look ahead our priorities include:

- Creating a culture of innovation readiness and collaboration across our system:
  - Develop an innovation partnership group with stakeholders to provide innovation oversight to drive and coordinate activities, by the end of 2023
  - Identify mechanisms by which to maximise investment in innovation within and between organisations, by 2025
  - Embed innovation to support cross-cutting priorities including but not limited to: reducing health inequalities; enabling and supporting our workforce; working to net-zero, by 2028
- Maximising public and patient engagement in health and care innovation:
  - Co-produce our approach to innovation with our people, by 2024
  - Share information and learning between regional and local patient and public involvement partners, by 2028

- Accelerating the prioritisation, development and uptake of innovation that addresses the needs of the NHS and partner organisations, based on input from people, staff and key stakeholders:
  - Coordinate an ongoing series of innovation exchanges that support system partner engagement with innovators, by 2023
  - Develop landing zones for innovation to maximise communication and engagement with both internal and external innovators, by 2024
  - In partnership with Eastern Academic Health Science Network (AHSN), provide a clear framework to work openly and transparently with healthcare industry partners, by 2023
- Increasing system capacity so innovations that can be developed, tested and evaluated in real world settings in our ICS:
  - A clear communication strategy to share innovation best practice, to loop learning back into the wider system and to increase engagement in innovation, by 2023
  - Develop open access-training to upskill staff to be confident to develop, adopt and implement innovations at the front line, by 2025
  - Identify collaborative funding opportunities that will support research and innovation, by 2028

We will work in partnership with Eastern AHSN to undertake horizon scan activities and innovation exchanges to find innovations that meet our specific challenges and develop a clear approach to working with wider health care industries, e.g. pharmaceutical, health and care technology, digital and analytic. We will engage with innovators to support the early development of innovations in our system which meet our known challenges.

We will support the adoption and spread of proven and successful innovations from elsewhere. We will focus on innovations shown to have had the highest impact to influence our priorities moving forward, as well as ensuring rapid adoption can be achieved, thus benefiting people more quickly. We will deliver innovative solutions to challenges to transform systems, ensuring evidence-based outcomes, and reducing inequalities.

Together with our strategic priorities and areas of focus, then on looking back from five years' time we will have achieved the following:

- We will be recognised as system leaders in the development and delivery of high-impact innovations
- We will have a programme of horizon scanning and pipeline of innovations to support our approaches to the most-pressing challenges
- We will have significantly grown our portfolio of innovation programmes in partnership with industry and Eastern AHSN and increased investment in innovation into our local system
- We will have established and embedded system wide knowledge and expertise in innovation, and developed innovation fellowships
- We will have increased our capability to provide real world evidence to validate the impact of innovations that will be shared regionally and nationally



*We have a growing ambition to realise the enormous potential innovation can bring and we are committed to working together to ensure that the best new innovations reach our patients and clinicians fast than ever.*

**Caroline Angus, Head of Innovation**

## Case Study



### Skin Cancer Innovation

There continues to be an increase in the number of skin cancer referrals both nationally and locally. To address this issue, WSFT set up a skin cancer assessment service using innovative artificial intelligence (AI)-driven technology (machine learning tools to identify skin cancer based on (dermoscopic) images of skin lesions). People attend a 'photography clinic' where images are taken and uploaded to the Tele dermatology AI service.

The digital platform provides an immediate opinion with images also reviewed by Trust Dermatologists virtually. Those with benign

skin lesions are discharged and those with possible skin cancer are sent an urgent appointment to attend a clinic at the soonest opportunity. The AI technology has supported improvements with faster detection and treatment of skin cancers. This has technology is now being adopted in other areas in SNEE.

Feedback from people is positive and they have commented that a second visit to the hospital has not been an issue with the speed and professionalism of staff noted. One patient praised how quick and efficient the service was. They saw their GP with a suspected skin cancer and within a few days attended the photography clinic. Three days later they were informed that they did not have skin cancer. They were relieved how quick the service was and their anxiety greatly reduced.

## 7.9 Sustainability

### 7.9.1 Sustainability and Health

Environmental protection, tackling climate change and restoring nature are intrinsically linked to the health of our communities. Sustainability therefore not only supports the delivery of the JFP, but it also underpins its overarching needs. For instance, if the UK hits its climate change targets, we could save up to 144,000 lives per year<sup>43</sup> through more active lifestyles, less vehicle pollution and healthier carbon friendly diets, thereby improving outcomes in population health.

These outcomes alone tackle an array of health issues we face including obesity, diabetes, cardiovascular disease, respiratory disease, cancer and mental health and wellbeing<sup>44</sup>. Tackling inequalities in outcomes, experience, and access through digital models of care reduces travel and inconvenience. As such, we view sustainability actions as preventative health and wellbeing actions.

Social prescribing teams utilise green and blue models which link people to nature-based interventions and activities thereby accessing and improving nature and green spaces and supporting mental health and wellbeing. Actions to reduce air pollution will help our respiratory patients (as noted in Section 5.7.3.5) and is a preventative health measure that will reduce incidences of heart disease, cancer, stroke, dementia and childhood asthma<sup>45</sup>. Being more resource efficient, wasting less, reducing reliance on pointless/single use plastics and embracing circular economy principles in all our activities will save money, time and natural resources thereby, enhancing productivity and value for money.

Delivering social value to our communities through supporting broader social and economic development will also maximise taxpayers' investment in the NHS, it is also intrinsic in how healthcare has been repositioned following the health and care act.

<sup>43</sup> Source: [https://www.thelancet.com/journals/lanph/article/PIIS2542-5196\(20\)30249-7/fulltext](https://www.thelancet.com/journals/lanph/article/PIIS2542-5196(20)30249-7/fulltext)

<sup>44</sup> Sources: <https://www.rcplondon.ac.uk/projects/outputs/every-breath-we-take-lifelong-impact-air-pollution>; [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/904146/gear-change-a-bold-vision-for-cycling-and-walking.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/904146/gear-change-a-bold-vision-for-cycling-and-walking.pdf)

<sup>45</sup> Source: <https://www.gov.uk/government/news/new-tool-calculates-nhs-and-social-care-costs-of-air-pollution>

## 7.9.2 Sustainability in action in Suffolk and North East Essex

Embracing sustainability has inspired our Medicines Management team to deliver an award-winning training programme and approach to reduce the carbon emission impact of inhaler use. As noted in Section 5.7.3.5., inhaler switches and optimisation improve respiratory health. Safe disposal of canisters through our pharmacies has also been established. These projects tackle the biggest carbon issue within primary care, delivering cost savings and reducing waste.

Our HR team established a staff salary sacrifice scheme for low emission and electric vehicles thereby reducing air pollution. Our Trusts are embarking on energy efficiency projects, assessing renewable energy sources, reducing waste, providing electric vehicle charging and reducing greenhouse gas emissions by changing anaesthetic practices.

In partnership with Suffolk County Council, we have secured a Department of Transport social prescribing fund to support more walking and cycling which will have huge health and wellbeing benefits linked to developing active travel infrastructure.

With Essex County Council, the Sustainability team has championed developing the retrofit agenda to make buildings carbon positive. Upgrading infrastructure to deliver carbon reduction targets is also an opportunity to develop local green based jobs and investment for our local economy. Retrofit also helps address the cost-of-living crisis through tackling fuel poverty via building improvements.

## 7.9.3 Sustainably supporting our staff and communities

Despite all the benefits, the links between climate change and health are not commonly realised. Therefore, one major objective of our forward plan is to engage with our staff, system partners and communities to overcome this barrier to change; this is the building block of all future activity. This aligns with our Green Plan. Our JFP will provide targeted focus on areas within the ICS Green Plan where the ICB is best placed to be a lever for change. This means our role as commissioners, contract managers and key partner will all play a part.

Partnerships are critical and our role within the wider ICS working with our system partners will provide a cumulative benefit to our communities. Addressing areas such as air pollution and being members of the Suffolk Climate Change and Energy Board and Essex County Council Anchors networks reduces duplication and integrates public sector health and sustainability impact and outcomes.

A Green Plan<sup>46</sup> for 2022 to 2025 for SNEE ICB has been agreed, detailing our current sustainability goals:

- Tackling the causes and effects of health inequalities and poverty
- Reducing the impacts of air pollution on health
- Reducing and mitigating the impacts of climate change on the system and population health
- Delivering the NHS LTP (value for money, staff development, embracing digital and doing things differently) and
- Providing leadership through actions, partnerships, engagement

The Green Plan also supports the four core purposes of the ICS formation following the Health and Care Act further re-iterating its importance to supporting the overall JFP.

- “The adoption of activities and interventions which slow the associated health impacts of climate change, which can **improve population health**, e.g. reducing the number of heatwave-related excess deaths and pollution-related respiratory illnesses
- Supporting action to address poor air quality, which disproportionately affects vulnerable and deprived communities in the UK through prevalence of respiratory illnesses, therefore tackling existing **inequalities in outcomes, experience, and access**
- Enhancing **productivity and value for money**, by planning to improve energy efficiency and switching to renewable energy sources across NHS estate across an ICS footprint, reducing long-term energy bills for the NHS
- Driving **broader social and economic development** by ensuring all NHS procurements include a minimum 10% net zero and social value weighting and adhere to future requirements set out in the NHS Net Zero Supplier Roadmap

<sup>46</sup> <https://www.sneecs.org.uk/can-do-health-and-care/creative/environmental-sustainability/#:~:text=As%20an%20ICS%20we%20are%20already%20working%20with,transport%20patients%2C%20staff%20and%20materials%20to%20reducing%20waste.>

Through the JFP, we will continue to work closely with our partners across health, VCSE and public sector organisations. We will use our position to provide leadership and identify, share and integrate resources and expertise. This will allow us to target future innovation, investment and resource allocation thereby ensuring we provide value for money and deliver greater health and sustainability outcomes.

We will know we are making a difference because we will see :

- Carbon footprint reducing
- Transport related air pollution emissions reducing
- Waste reducing
- Increased green spaces and supporting biodiversity through environmental stewardship
- System partners and suppliers carbon footprints reducing

- Measures in place to be more climate resilient as a system
- Our actions inspire the public and our staff to adopt more sustainable and healthy lifestyles



*The climate emergency is often described as a health emergency. Climate change is recognised as the greatest threat to healthcare in the 21st Century by The Lancet. Our approach is to treat the climate and health emergency as an opportunity. It is an opportunity to improve how we deliver care, how we work with our partners and communities to prevent illness and be more sustainable in our day-to-day business.*

**Amanda Lyes, Director of Workforce and People, NHS SNEE ICB and SRO for Sustainability**







## 8 Managing delivery of the Joint Forward Plan

### 8.1 Communication and explaining the plan to key stakeholders

SNEE ICB is committed to ensuring an open and transparent exercise is conducted in the development of the JFP to incorporate public and stakeholder views in planning arrangements. The first part of this has been the stakeholder engagement and community liaison activities during January and February 2023 to ensure such feedback is gathered, considered and ultimately reflected in the plan in its final draft in March 2023.

#### 8.1.1 Approach

From December 2022 to January 2023, the draft JFP was separated into manageable and meaningful sections to enable effective engagement and comment on the work. The aim of this process was to share the JFP in an accessible, creative and inclusive way to encourage interaction and discussion. This method helped ensure all people and communities had the opportunity to comment on the JFP, either on the sections most important to them or the whole document.

A mixed methodology was used to enable the ICB to reach a wide audience through both online and in person discussions. Clear, transparent and honest information about the purpose, governance and accountability of the JFP was shared during these sessions.

#### Online

In January 2023, key components of the JFP were published on the <https://www.letstalksnee.co.uk/> platform to reinforce the approach taken. Each Live Well domain was given an individual page/section on the site, setting out key priorities. People and communities from SNEE were then asked to comment on sections and the people reported outcome measures. A full stakeholder mapping exercise was also undertaken for dissemination and involvement.

## In-person

In February 2023, three hour in-person workshops were held in each Alliance in addition to one online workshop. Key priorities of the Live Well domains were discussed during these sessions and an overview of feedback to date was also shared. The adopted approach, reflections and ideas will be considered by stakeholders. These workshops also enabled the ICB to use quick fire 'ideation' and creative curiosity techniques to generate conversation about each domain and section area. Attendees included a broad range of individuals including members of the People and Communities Groups and Patient and Public Group (PPG) Networks.

## Quality considerations

Whilst the people and communities' engagement takes place, a supplementary conversation was held about the development of the Quality Dashboard. As part of the programme of meetings in Alliances about the JFP, a fourth meeting will be held to develop the quality dashboard to enable the ICB to better understand what good looks like and how best to collect that data.

## Communication and formal engagement with stakeholders

During February, a programme of engagement with stakeholders commenced. The ICB asked strategic external audiences for their view on the JFP to date (which also incorporated feedback from the public groups). Strategic stakeholders were asked to consider the content within the JFP, its vision and core priorities.

The following groups are identified as key strategic stakeholders:

- ICB staff
- GPs / PCNs
- ESNEFT
- WSFT
- EPUT
- NSFT
- ISCRE
- Hospices
- MPs
- Suffolk County Council
- Essex County Council
- District and borough councils
- Community Action Suffolk
- Community 360

- Community Voluntary Services Tendring
- Healthwatch Suffolk and Essex
- Carers organisations
- Councillors incl. HOSC and the Suffolk and Essex HWBs

To communicate with these strategic stakeholders, the ICB produced:

- A one-sided crib sheet to support staff in communicating key elements/overview of the plan with stakeholders. This was shared with Health Overview and Scrutiny Committee (HOSC) prior to any patient and public engagement work
- A shortened summary document for stakeholders, taken from the plan's Executive Summary, which highlights key messages / aspirations from the plan with details of milestones and timeframes
- A story for inclusion in the ICB stakeholder briefing which outlines the purpose of the plan
- A recorded video message for the ICB website so the core information is available in audio format
- A PowerPoint slide deck for presentations with stakeholders if needed so senior ICB colleagues can share details of the plan in meetings with partners

In addition, the ICB regards its staff as important internal stakeholders. To ensure they are aware of the purpose and contents of the plan, the Communications team:

- Produced an item for inclusion in the Buzz (internal newsletter)
- Uploaded the full version of the document as well as summarised versions on the intranet
- Gave an overview of the plan during a future virtual staff briefing

A full report outlining the outcomes of our engagement exercises on the draft JFP can be found at Appendix 2. Section 3.6 sets out the main themes which then influenced the final version of the JFP.

## 8.2 Managing and reporting progress

SNEE ICB will manage and report on its statutory duties and aim to:

- **Improve quality of services** for those at home, in the community, seeking secondary care and those with long term conditions (LTCs). This is discussed in Section 6.9
- **Address health inequalities** by understanding the demographics of those most in need. This is discussed in Section 5.2
- **Promote involvement of each person in their care** by expanding the choices and control that people have over their own care. This is discussed in Sections 5 and 7.1
- Ensure that needs of children and young people are met and they have the best start to life. This is discussed in Section 5.4
- **Address needs of victims of abuse** by ensuring that the proper systems are in place to help. This is discussed in Section 5.5.3.4
- **Promote innovation** by leveraging the benefits of innovation to enable positive change in the way that health and care is delivered. This is discussed in Section 7.8
- **Support and encourage contribution to national research** by increasing the number of people participating in health research and promoting opportunities for people to register. This is discussed in Section 7.8
- **Promote education and training**, enabling career development. Strengthening our health and care workforce is a key priority. This is discussed throughout the JFP, in particular in Sections 7.2, 7.4 and 7.9
- **Promote integration** by working with system partners to align and integrate service delivery across sectors to create efficiencies in practice and improve outcomes for the local population. This is discussed in Sections 6.1 to 6.6 and throughout the JFP
- **Help the fight against climate change**, by supporting national efforts to reduce the NHS's carbon footprint. This is discussed in Section 7.9
- Have regard to the wider effects of decisions or the 'triple aim'. This is discussed in Section 5 and throughout the JFP

SNEE ICB has established several committees to assist it with the discharge of its duties and functions, including the delivery of the key priorities and goals set out in the JFP. The ICB board remains accountable for all functions, including those that it has delegated to committees and subcommittees and therefore, appropriate reporting and assurance arrangements are in place and documented in terms of reference. All committees and sub committees that fulfil delegated functions of the ICB, will be required to:

- Submit regular decision and assurance reports to the board
- Submit minutes of committee meetings to the board
- Ensure that the committee Chair or designated deputy attends meetings of the board as necessary
- Comply with internal audit findings and committee effectiveness reviews

The ICB will undertake a continuous appraisal of the position, performance, and delivery of the key priorities and goals set out in the JFP via the ICB committees. The committees will monitor the performance and delivery and agree plans to mitigate any concerns regarding underperformance or under delivery, where necessary reporting these to the Board through exception reporting or if appropriate via the Board Assurance Framework (BAF).

## 8.3 Escalation and remediation

Our BAF provides the ICB Board with a simple but comprehensive method for the effective and focused management of risk. Through the BAF the ICB Board gains assurance that risks are being appropriately managed throughout the organisation.

The BAF identifies which of the organisation's strategic objectives may be at risk because of inadequacies in the operation of controls, or where the ICB has insufficient assurance. At the same time, it encompasses the control of risk, provides structured assurances about where risks are being managed and ensures that objectives are being delivered. This allows the ICB Board to determine how to make the most efficient use of resources and address the issues identified to improve the quality and safety of care.

## 8.4 Assurance and accountability

The ICB will publish an Annual Report in accordance with any guidance published by NHSE that sets out how it has discharged its functions and fulfilled its duties in the previous financial year. The annual report will:

- Explain how the ICB has discharged its duties
- Review the extent to which the ICB has exercised its functions in accordance with the plans published including achievement of the key priorities and goals set out in the JFP
- Review the extent to which the ICB has exercised its functions consistently with NHSE's views about how functions relating to inequalities information should be exercised
- Review any steps that the ICB has taken to implement any joint local health and wellbeing strategy

The ICB has also put in place arrangements that will effectively facilitate and support NHSE's annual assessment of how effectively the ICB has exercised its functions. The ICB has established effective arrangements via the delegation to Committees and subsequent reporting cycles to enable the Board of the ICB to provide an effective and timely account of its performance to key internal and external stakeholders and the public.

The ICB will seek reports and assurance from directors and managers as appropriate, concentrating on the delivery of the key priorities and goals set out in the JFP including the systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. Reports will have consistent foundations based on underlying assurance processes that indicate the degree of achievement of the priorities and the effectiveness of the delivery and performance.

The System Oversight and Assurance Committee (SOAC) has been established by the Board to support managing improvement, development and performance at ICS (system) level. SOAC is a data-driven, evidence-based and rigorous committee that provides focus on supporting the spread and adoption of innovation and best practice between partners.

The SOAC will:

- Oversee the development of a dashboard of key outcome, performance, and quality and transformation metrics for the ICB, linking with the system Data and Intelligence function
- Take an overview of performance and transformation at whole system, place and organisation levels in relation to the key priorities and goals set out in the JFP, specifically those where primary responsibility for taking remedial action lies with other components of the thus ensuring the ICB has effective levers available to enable remedial action should it be necessary
- Creates links with external organisations
- Lead the development of a framework for peer review and support for the ICS and oversee its application
- Make recommendations to the ICB Board on the deployment of improvement support across the ICS, and on the need for more formal action and interventions
- Receive reports from ICS priority programmes and enabling workstreams on issues which require escalation

## 8.5 Integrated Care Board performance

SNEE ICB is held to account by NHSE for performance through the NHS Oversight Framework which sets out a broad range of measures. In addition, the ICB has set out local performance priorities that are important to the systems' population. Together these metrics form the ICB's performance framework.

The performance framework will continue to be developed as priorities are expressed and refined by our population, informed by our partners, and shaped by data intelligence.

The ICB will monitor and seek to improve performance by delegating responsibility through its locality, transformation and corporate committees. These committees will be responsible for improving all areas of our commissioning responsibilities.

Each committee will have detailed datasets which are summarised in a data dashboard. The committees will report on their dashboards each month to the SOAC where performance will be scrutinised to form a judgement on whether the ICB is assured that controls are in place to maintain or improve performance, or not assured in which case a remedial action plan will be required from the committee.

We aim to maintain or recover performance against our statutory responsibilities, further information on these is outlined in the specific sections in this document, in particular Section 5. Over time the ICB intends to increase the number and breadth of outcome measures, experience measures and quality measures informed by feedback from patients, the public and clinicians. The ICB intends to further develop a culture of continual improvement and person-centred healthcare across all areas.



# 9 Supporting Information

## 9.1 Glossary of Terms

A glossary of terms used throughout the JFP is provided below.

ABI	Acquired Brain Injury	DMS	Discharge Medicines Service
ACE	Anglian Community Enterprise	DSR	Dynamic Support Register
ACTs	Alcohol Care Teams	EACH	East Anglia's Children's Hospices
ADHD	Attention deficit hyperactivity disorder	EAHSN	Eastern Academic Health Science Network
AF	Atrial Fibrillation	EAU	Emergency Assessment Unit
AI	Artificial Intelligence	ECG	Electrocardiogram
AHSN	Academic Health Science Network	ED	Emergency Department
ARMS	At Risk Mental State	EHIIAs	Equality and Health Inequalities Impact Assessments
ASD	Autism Spectrum Disorder	EIP	Early Intervention in Psychosis
BAF	Board Assurance Framework	EIS	Estates Infrastructure Strategy
BI	Business Intelligence	ENT	Ear, Nose and Throat
CAS	Clinical Assessment Service	EoE	East of England
CCG	Clinical Commissioning Group	EoL	End of Life
CHC	Continuing Health Care	EPR	Electronic Patient Record
CHRIS	Crisis Help and Risk Intervention Service	ESNEFT	East Suffolk and North Essex NHS Foundation Trust
COPD	Chronic Obstructive Pulmonary Disease	FeNO	Fractional Exhaled Nitric Oxide
CPES	Cancer Patient Experience Survey	FH	Familial Hypercholesterolaemia
CQC	Care Quality Commission	GP	General Practitioner
CRHTTs	Crisis Resolution and Home Treatment Teams	HALOS	Hospital Ambulance Liaison Officer
CRtP	Clinically Ready to Proceed	HF	Heart Failure
DDaT	Digital, Data and Technology		

HOSC	Health Overview and Scrutiny Committee	PHB	Personal Health Budgets
HWB	Health and Wellbeing	PHM	Population Health Management
IAPT	Improved Access to Integrated Therapies	PPG	Patient Participation Groups
IBA	Identification and Brief Advice	PREP	Pre Exposure Prophylaxis
ICB	Integrated Care Boards	QoL	Quality of Life
ICOPE	Integrated Care for Older People	RAAC	Reinforced Aeriated Autoclaved Concrete
ICP	Integrated Care Partnership	REACH	Race, Equality and Cultural Heritage
ICS	Integrated Care System	ReSPECT	Recommended Summary Plan for Emergency Care and Treatment
IMD	Index of Multiple Deprivation	SALT	Speech and Language Therapist
IP	Independent prescriber	SAU	Surgical Assessment Unit
JCC	Joint Commissioning Committee	SDEC	Same Day Emergency Care
JFP	Joint Forward Plan	SEND	Special Educational Needs and Disabilities
JLWHS	Joint Local Health and Wellbeing Strategy	SET	Southend, Essex and Thurrock
JSNA	Joint Strategic Needs Assessments	SMI	Severe Mental Illness
KWF	Key Working Function	SNEE	Suffolk and North East Essex
LA	Local Authority	SNELCAS	Suffolk and North East Essex Long Covid Assessment Service
LD	Learning Disability	SOAC	System Oversight and Assurance Committee
LD&A	Learning Disability and Autism	SSS	Stop Smoking Services
LeDeR	Learning Disability Mortality Review	T&O	Trauma and Orthopaedics
LMNS	Local Maternity and Neonatal System	TIA	Transient Ischaemic Attack
LPNs	Local Professional Networks	UCR	Urgent Community Response
LSOA	Lower Super Output Areas	UTC	Urgent Treatment Centre
LTC	Long-Term Condition	VCSE	Voluntary, Community and Social Enterprise
LTP	Long Term Plan	VLCD	Very Low-Calorie Diet
MASH	Multi-Agency Safeguarding Hub	WHO	World Health Organisation
ME&CFS	Myalgic Encephalomyelitis and Chronic Fatigue Syndrome	WRES	Workforce Race Equality Standard
MHIS	Mental Health Investment Standard	WSFT	West Suffolk Foundation Trust
MP	Member of Parliament		
NDD	Neuro-Developmental Delay		
NHSEI	NHS England and NHS Improvement		
NICU	neonatal intensive care unit		
NIHR CRN	National Institute for Health Research Clinical Research Network		
NMS	New Medicines Service		
NSFT	Norfolk and Suffolk Foundation Trust		
OHID	Office of Health Improvement and Disparities		
ONS	Office of National Statistics		
PCN	Primary Care Network		

## 9.2 Appendices

Appendices are available upon request:

- **Appendix 1:** Summary of Essex and Suffolk JSNAs
- **Appendix 2:** Summary of engagement undertaken
- **Appendix 3:** Our Partners' Aligned Plans
- **Appendix 4:** National Five Priority Areas for Tackling Health Inequalities
- **Appendix 5:** SNEE ICB Equality Diversity and Inclusion in the Workforce Plan
- **Appendix 6:** Live Well Domains - Start Well
- **Appendix 7:** Live Well Domains - Feel Well
- **Appendix 8:** Live Well Domains - Be Well
- **Appendix 9:** Live Well Domains - Stay Well
- **Appendix 10:** Live Well Domains - Age Well
- **Appendix 11:** Live Well Domains - Die Well
- **Appendix 12:** DDaT Strategy (Digital)





**Suffolk and  
North East Essex**  
Integrated Care Board

[suffolkandnortheastsex.icb.nhs.uk](https://suffolkandnortheastsex.icb.nhs.uk)

**COMFORT BREAK**

### 3.4. System update - West Suffolk

Alliance and SNEE Integrated Care Board

Rebecca Jarvis presenting

To Assure

## Executive Summary

The Alliance Delivery Plan, (ADP), for West Suffolk Alliance sets out what action the partnership intends to take in 23/24 to contribute to our shared outcomes using the Live Well framework specified in the ICB Joint Forward Plan (JFP). The ADP is a partnership agreement and complements other planning documents including the ICP strategy, WSFT strategy and JFP. The plan sets out how we intend to work together and focus on a small set of priorities prioritised as areas where we can make the most impact by working together.

## Background

The Alliance has:

- Identified 4 enablers where we can make the greatest impact by working together: workforce, estates, digital & data, and localities.
- Established a distributed leadership model with nominated Sponsors, Strategic Leads and Change Coordinators for each domain and enabler. This model includes leaders from across Health, Social Care, VCFSE, Education and Local Government
- Galvanised wider partners from across the Alliance around each domain and enabler to co-design key priorities and actions for 23/24
- Established the Live Well Delivery Group to oversee the implementation of the Live Well framework, find and develop connections and synergies across each domains and enablers and report progress into West Suffolk Alliance Committee
- Aligned activity to the wider JFP objectives and target indicators
- This remains a development journey and the ADP sections reflect the fact that different domain groups are at different stages in specifying their actions.
- Engaged West Suffolk Alliance Committee and wider Partnership Group throughout the development of the plans, including a system-wide workshop in April and signing off the ADP in May.

WSFT colleagues have played a central role in each of the domains along with place based ICB staff and local partners.

## Next steps

1. Put in place detailed workbooks setting out key milestones to deliver and track our progress for each domain/enabler. This includes being more specific about the change we will make as each group evolves.
2. Develop a shared approach to evaluation to measure impact
3. Establish a reporting rhythm from each domain and enabler to West Suffolk Alliance Committee
4. Hold a 6-month review in person in November 2023
5. Ensure West Suffolk change teams work closely together in their work including wider prevention, community health and care services, in hospital services and cross-ICS change.

# West Suffolk Alliance Delivery Plan 23/24

Improving health through partnership

May 2023



# Document Control & History

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# 1. Executive Summary






# Executive Summary

## This Plan

- Focuses on what collective action we can take to improve the health and well-being of the West Suffolk population in 2023/24
- Is a partnership agreement and complements other planning documents including those that are organisation specific, county-wide or ICS-wide
- uses the Live Well framework to organise our partnership work in line with the SNEE ICB Joint Forward Plan
- Selects a smaller number of achievable priorities to focus our partnership efforts and contributes to the Live Well outcomes
- will continue to evolve as we develop, agree and review how to measure the impact of the action we plan to take
- provides the foundation to assess our progress during 2023/24. A formal 6 month progress review will take place in November 2023.




# West Suffolk Alliance Delivery Plan Summary

WSA Vision: "For everyone at all stages of their life to be able to Live Well across West Suffolk."

Key Workstreams		Priority actions in 2023/24	By When	Sponsor
<p><b>Start Well</b></p> 	<ul style="list-style-type: none"> <li>• Collaboration</li> <li>• Insight and Intelligence</li> <li>• Resources</li> </ul>	<ul style="list-style-type: none"> <li>• A system wide partnership group</li> <li>• Understand wider system shared challenge</li> <li>• Develop a coproduced decision making structure</li> <li>• Early education programmes.</li> </ul>	<ul style="list-style-type: none"> <li>• July 2023</li> <li>• July 2023</li> <li>• October 2023</li> <li>• October 2023</li> </ul>	<p><b>Garry Joyce</b> Deputy Director of Transformation Children and Young People SNEE ICB</p>
<p><b>Feel Well</b></p> 	<ul style="list-style-type: none"> <li>• Sleep</li> <li>• ADHD</li> <li>• Carers</li> </ul>	<ul style="list-style-type: none"> <li>• Improved data and information regarding sleep</li> <li>• Create resources to help improve awareness</li> <li>• Lived experience involvement approach.</li> <li>• Understand carer needs and plans for improvement in carer support.</li> <li>• Joint plan to improve ADHD service.</li> <li>• Create "Wait Well" resources and services</li> <li>• Improve early identification in primary care</li> </ul>	<ul style="list-style-type: none"> <li>• July 2023</li> <li>• Sept 2023</li> <li>• July 2023</li> <li>• November 2023</li> <li>• November 2024</li> <li>• February 2024</li> <li>• March 2024</li> </ul>	<p><b>Vanessa Wragg</b> Deputy Service Director, NSFT</p> <p><b>Belinda Danso - Langley</b> - Service Director Suffolk Care Group, NSFT</p>
<p><b>Be Well</b></p> 	<ul style="list-style-type: none"> <li>• Healthy Behaviours</li> <li>• Dentistry</li> </ul>	<ul style="list-style-type: none"> <li>• Development of a new model of healthy behaviours</li> <li>• Work with key stakeholders to develop locally designed programmes.</li> <li>• Improve alignment.</li> <li>• Understand the dentistry landscape especially the challenges and issues including: <ul style="list-style-type: none"> <li>➢ Identify opportunities to transform and integrate dental services into our local system</li> <li>➢ Work collaboratively with other domains to improve dental outcomes.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• October 2023</li> <li>• March 2024</li> <li>• March 2024</li> <li>• November 2023</li> </ul>	<p><b>Ian Gallin</b> Chief Executive West Suffolk Council</p> <p><b>Kathy Nixon</b> Deputy Chief Executive Babergh and Mid Suffolk District Councils</p>

# West Suffolk Alliance Delivery Plan Summary

WSA Vision: "For everyone at all stages of their life to be able to Live Well across West Suffolk."

Key Workstream/s		Priority actions in 2023/24	By When	Sponsor
<p><b>Age Well</b></p> 	<ul style="list-style-type: none"> <li><b>Community Model of Care</b></li> </ul>	<ul style="list-style-type: none"> <li>Further development of Integrated Neighbourhood Teams and alignment with Primary Care</li> <li>Community Nursing and Therapy Demand and Capacity review</li> <li>Strengthen the Home and Reablement first Model of Care</li> </ul>	<ul style="list-style-type: none"> <li><b>December 20 23</b></li> <li><b>November 2023</b></li> <li><b>October 2023</b></li> </ul>	<p><b>Clement Mawoyo</b> Director of Integrated Adult Health and Social Care West Suffolk</p> <p><b>Sandie Robinson</b> Deputy Director Transformation SNEE ICB</p>
<p><b>Stay Well</b></p> 	<ul style="list-style-type: none"> <li><b>Demand Management</b></li> <li><b>Urgent Community Response</b></li> <li><b>Discharge and Flow</b></li> <li><b>Direct Access</b></li> <li><b>Diabetes</b></li> </ul>	<ul style="list-style-type: none"> <li>Enhancing our Urgent Community Response to deliver &gt;10% increase in admission avoidance</li> <li>Focus on improving discharge to improve flow and reablement outcomes</li> <li>Explore direct access pathway opportunities</li> <li>Redesign the end to end diabetes pathway</li> </ul>	<ul style="list-style-type: none"> <li><b>October 2023</b></li> <li><b>October 2023</b></li> <li><b>February 2024</b></li> <li><b>March 2024</b></li> </ul>	<p><b>Nicola Cottington</b> Chief Operating Officer West Suffolk NHS Foundation Trust</p> <p><b>Dr David Brandon</b> Associate Medical Director SNEE ICB</p>
<p><b>Die Well</b></p> 	<ul style="list-style-type: none"> <li><b>Co-ordinated 24/7 care</b></li> <li><b>Personalised Plans</b></li> <li><b>Compassionate Communities</b></li> </ul>	<ul style="list-style-type: none"> <li>Further development of the End of Life Model of Care</li> <li>Access to 24/7 specialist support</li> <li>Integrated and collaborative training and support package for staff</li> <li>RESPECT rolled out</li> <li>Accessible dashboard of those within the last year of life</li> <li>Digital solution identified for offering two-way care planning communication between person end of life and support network</li> <li>Die well information campaign planned</li> </ul>	<p>August 2023</p> <p>August 2023</p> <p>March 2024</p> <p>March 2024</p> <p>March 2024</p> <p>March 2024</p> <p>March 2024</p>	<p><b>Susan Wilkinson</b> Chief Nurse West Suffolk NHS Foundation Trust</p>

# West Suffolk Alliance Delivery Plan Summary - Enablers

**WSA Vision: "For everyone at all stages of their life to be able to Live Well across West Suffolk."**

Vision & Key Workstreams		Priority actions	By When	Sponsor
<b>Workforce</b>	<p><b>Support organisations to build workforces that enable them to effectively serve populations by taking a system approach to</b></p> <ul style="list-style-type: none"> <li>Implement an Education and Training Digital Passport</li> <li>Improve Equity to International Recruitment Opportunities for Alliance Stakeholders</li> </ul>	<p>For each workstream there will be a focus on;</p> <ul style="list-style-type: none"> <li>Improving supply</li> <li>Upskilling staff</li> <li>Creation of new roles</li> </ul>	<ul style="list-style-type: none"> <li>March 2024</li> </ul>	<p><b>Ewen Cameron</b> Chief Executive West Suffolk Foundation Trust</p>
<b>Digital &amp; data</b>	<p><b>A shared planned approach for the use of digital and data at place across the system.</b></p> <ul style="list-style-type: none"> <li>Promotion and adoption</li> <li>Evaluation</li> </ul>	<ul style="list-style-type: none"> <li>Design an approach that promotes and facilitates the adoption and usage of use cases, dashboards, digital technologies and innovation with all partner organisations.</li> <li>An agreed evaluation model for comparing different dashboards/ technology offerings to assist the GIRFT (getting it right first time) principle</li> </ul>	<ul style="list-style-type: none"> <li>November 2023</li> <li>March 2024</li> </ul>	<p><b>Craig Black</b> Executive Director of Resources West Suffolk Foundation Trust</p> <p><b>Dr Molly Thomas-Meyer</b> (Public Health Suffolk)</p>
<b>Estates</b>	<p><b>Create and manage one public estate that is driven by service needs; run and planned as one system</b></p> <ul style="list-style-type: none"> <li>Optimise use of existing estate</li> <li>New Hospital Programme</li> <li>Plan for population growth</li> </ul>	<ul style="list-style-type: none"> <li>Use Haverhill locality as an exemplar to:                             <ul style="list-style-type: none"> <li>Identify service and clinical requirements</li> <li>Be clear on all assets available in each locality</li> <li>Be a proactive partner with District and Borough Councils</li> </ul> </li> <li>Pilot single management of shared buildings</li> <li>Ensure system decision making governance in place for shared spaces</li> <li>Support estates requirements flowing from Future Systems programme</li> <li>Estates domain operational group to engage with each locality</li> </ul>	<ul style="list-style-type: none"> <li>November 2023</li> <li>Review January 2024</li> <li>July 2023</li> <li>March 2024</li> <li>January 2024</li> </ul>	<p><b>Peter Wightman</b> West Suffolk Alliance Director</p>
<b>Localities</b>	<p><b>Enable coordination at a locality level</b></p> <ul style="list-style-type: none"> <li>Empower localities to have a locally owned shared purpose and plan to live healthy, connected lives</li> </ul>	<ul style="list-style-type: none"> <li>Prioritise Haverhill Locality in the first instance whilst supporting the other Localities to maintain a level of engagement and development</li> </ul>	<ul style="list-style-type: none"> <li>November 2023</li> </ul>	<p><b>Chris Abraham</b> (Suffolk Community Action CX)</p>

## 2. Context – Strategic & Local

# West Suffolk Alliance – part of SNEE



the *statutory committee where partners set the health and well being strategy*  
*Suffolk and North East Essex*

All partners developing a single collective **STRATEGY** to improve health and wellbeing outcomes for SNEE.

*Integrated Care Strategy 23-28*



the NHS *statutory body* that plans and buys healthcare services for the local population.

The NHS working with partners to **PLAN** how best to invest the NHS budget to deliver the Integrated Care Strategy for the population.

*Joint Forward Plan 23-28*



the *local mechanism* for delivering integrated care and services for the population of West Suffolk

Local partners working together to co-ordinate **DELIVERY** of services and initiatives in places, communities and neighbourhoods.

*Alliance Delivery Plan 23-24*



# ICP – Integrated Care Strategy



## OUR INTEGRATED CARE STRATEGY IN SIX NUMBERS



1



### ONE MILLION PEOPLE

We are **ONE** team with a shared vision of the best possible health outcomes being a reality for every **ONE** of the **ONE** million people that we all serve.

4



### FOUR COLLECTIVE AMBITIONS

We are united around our **FOUR** collective ambitions:

- the **best health and wellbeing** a genuine reality for all
- the opportunity of **health equality** for everyone
- everyone able to **'Live Well'** – Start Well, Be Well, Stay Well, Feel Well, Age Well, Die Well
- a genuinely **'Can Do' Health & Care System** that people can trust.



2

### TWO COUNTIES

We work flexibly with wider partners across the **TWO** counties of Suffolk and Essex



5

### FIVE EQUAL SECTOR PARTNERS

We believe in parity between all **FIVE** sectors in the ICS – NHS, primary care, social care, public health and the voluntary community social enterprise and faith (VCSEF) sector.



3



### THREE LOCAL ALLIANCES

We co-ordinate delivery as locally as possible through our **THREE** local place-based alliances

6



### SIX 'CAN DO' VALUES

The way we work together as a 'Can Do' Health and Care System is underpinned by our **SIX** core values: Collaborative, Creative, Courageous, Compassionate, Cost Effective, Community Focused

# ICB - Joint Forward Plan

The ICBs five year plan, the Joint Forward Plan (JFP), clearly sets out how the ICB plans to contribute to the implementation of the ideas set out in the Integrated Care Strategy as well as our county based Health and Wellbeing Strategies and the national NHS Plan.

Like the ICB Strategy, the Joint Forward Plan also utilises the Live Well Model.

Identified priority areas within the JFP include;

- Health Inequalities
- Children and Young People
- Mental Health
- Healthy Behaviours
- Access to Care
- Early Intervention
- Frailty
- End of Life Care

All three alliances in Suffolk and North East Essex are using the Live Well model to shape their Alliance Local Delivery Plans.



Health Inequalities

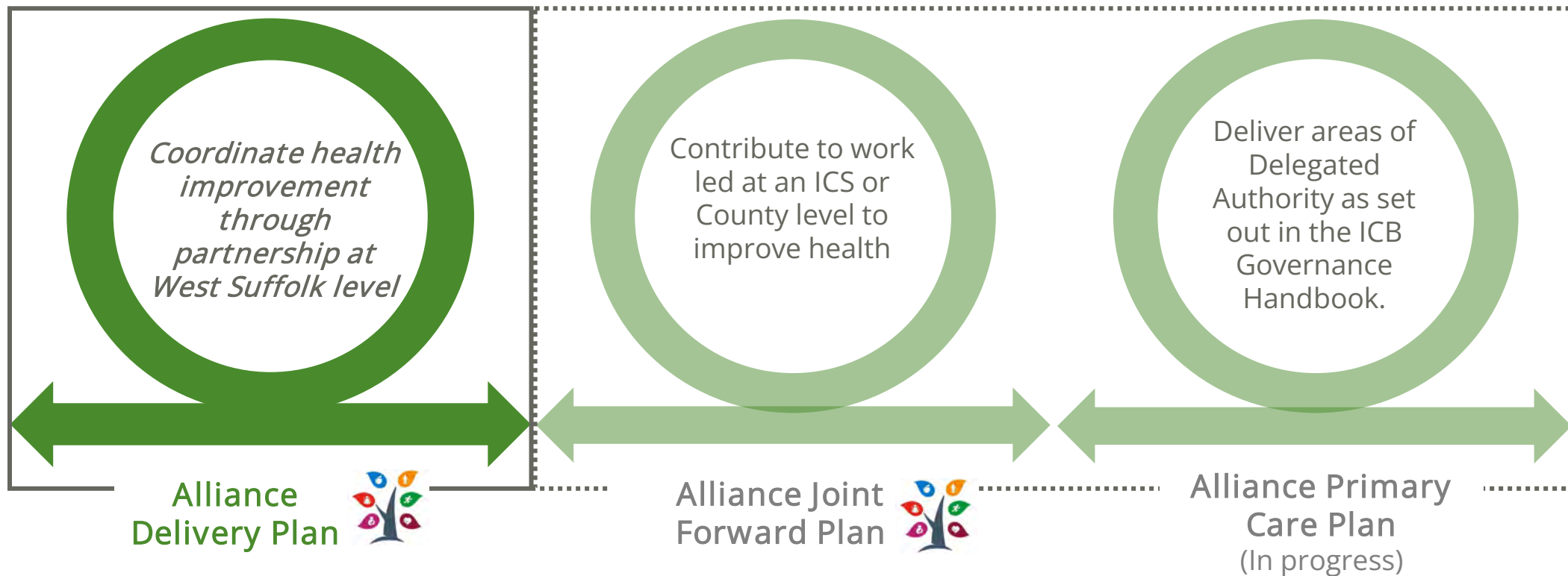
You can find the details of the Joint Forward Plan in Appendix 1.



# West Suffolk Alliance Delivery Plan

This plan focuses on 2023/24 actions related to improving health through partnership working. The Alliance Committee has two other functions which are described in other documents

## Alliance roles



# West Suffolk Alliance Partners

## NHS & Council Statutory Bodies

- Suffolk and North East Essex ICB
- West Suffolk NHS Foundation Trust
- Norfolk and Suffolk NHS Foundation Trust
- Suffolk County Council
- West Suffolk District Council
- Babergh and Mid Suffolk District Councils

## Service Providers

- GP teams and Primary Care Networks
- Dentists, pharmacists & optometrists
- Suffolk GP Federation
- Care Market
- Allied Health Professionals CIC
- West Suffolk College
- Abbeycroft Leisure

## Voluntary Community Faith and Social Enterprise

- Community Action Suffolk
- Healthwatch Suffolk
- Multiple local & national VCSFE Partners including:
- St. Nicholas Hospice Care
- Abbeycroft Leisure
- Home Start
- Reach Haverhill



Integrated  
neighbourhood  
teams in 6  
localities

# Local Geography & Need

## West Suffolk population:

- Total: 274,000 with the largest age group being 50 – 54.
- It is expected that our population will grow by 7% in general and 34% in older people over the next 20 years.
- Largest population growth areas are expected in Bury and Haverhill.
- 3.2% aged 85+ (vs 2.5% national)
- 1,685 people in West Suffolk live in the most deprived 20% areas in England.
- 8.1% are affected by income deprivation.
- 6.6% of working age people are affected by employment deprivation.

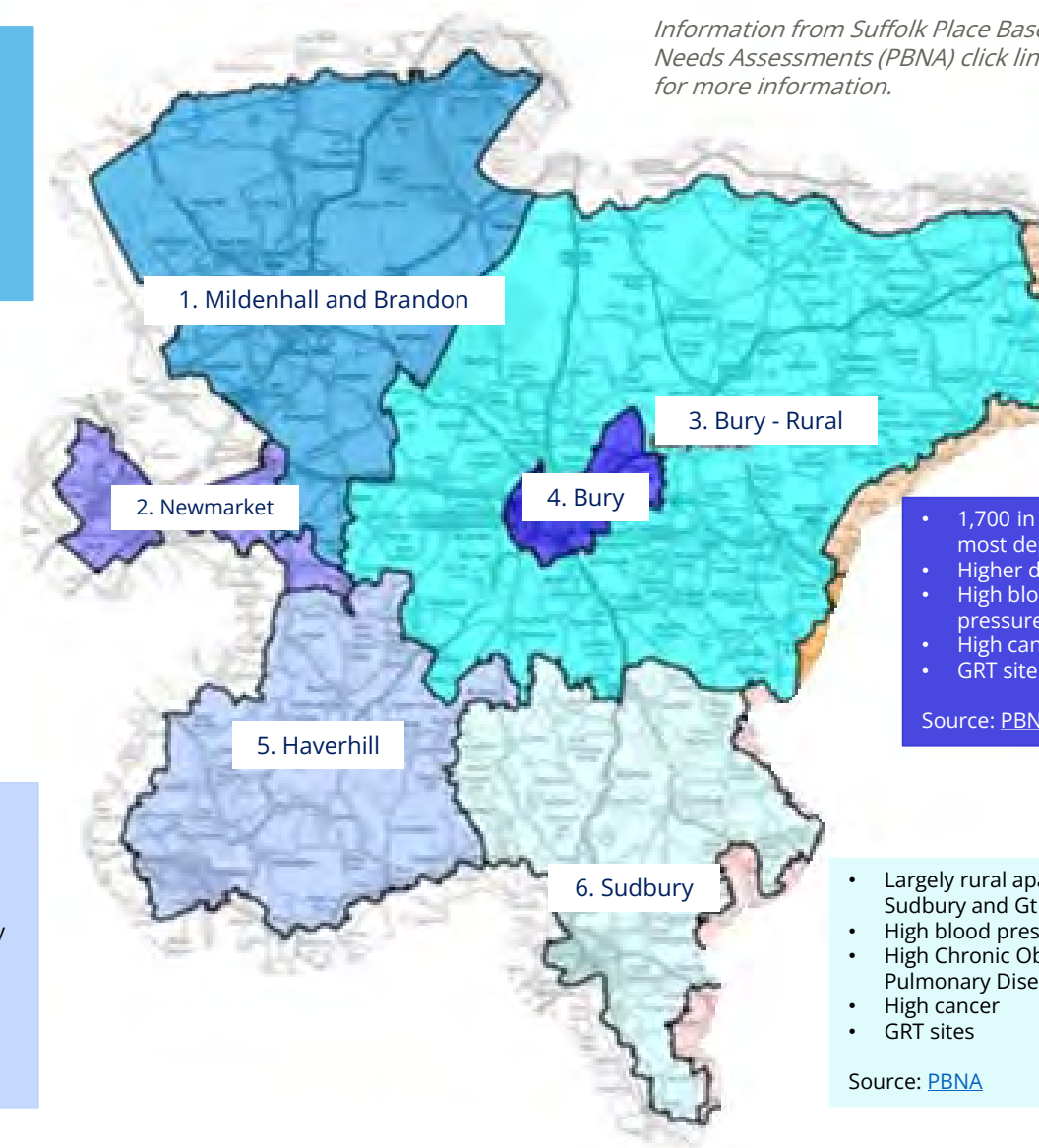
Our local plans uses public health information like this and the Core20PLUS5 data to evidence our required areas of focus in the Alliance Delivery Plan.

- Higher diversity
  - Armed forces personnel
  - Higher births
  - High blood pressure
  - High Chronic Obstructive Pulmonary Disease
  - High smoking
  - High cancer
  - GRT sites
- Source: [PBNA](#)

- Higher diversity
  - High smoking
  - Higher births
- Source: [PBNA](#)

- Rural populations (excluding central Haverhill)
  - High blood pressure
  - High Chronic Obstructive Pulmonary Disease
  - High smoking
  - High cancer
  - GRT site
- Source: [PBNA](#)

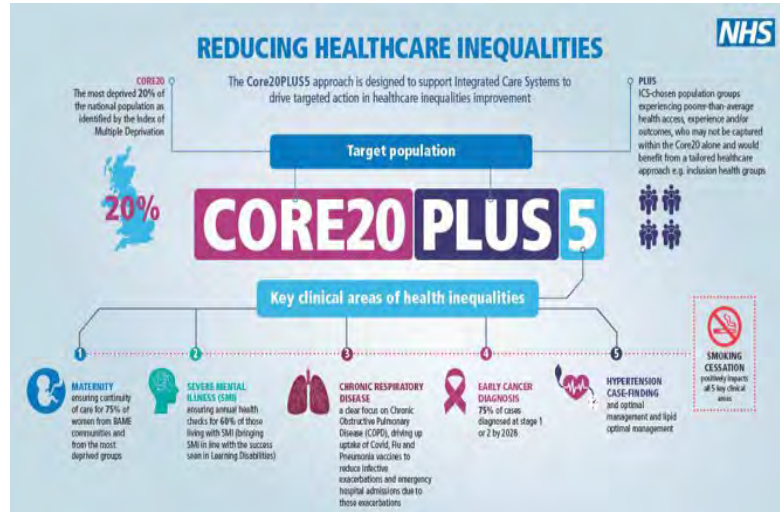
Information from Suffolk Place Based Needs Assessments (PBNA) click links for more information.



Please note, the boundaries of Bury and Bury Rural have changed since this work was completed.

# Reducing Health Inequalities in West Suffolk

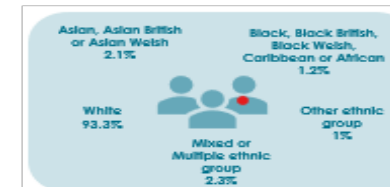
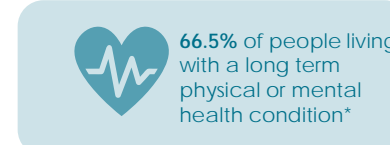
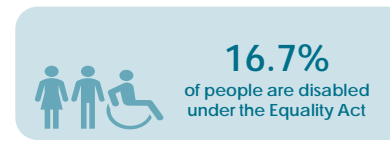
**VISION:** Work with partner organisations and communities across West to reduce inequalities using the Core20Plus5 framework, focussing on raising awareness and action to support everyone to Live Well, with specific actions to support our most vulnerable communities.



We need to support the health needs of the approx. 1700 people in West Suffolk who live in areas that are ranked among the most deprived 20% in England\*\*. They are likely to experience health inequalities and poorer physical and mental wellbeing. While there is not always data available on all the Core20Plus5 populations at a very local level, there are some specific ways in which we can support our Core20Plus5 key areas in West:

- Increase by nearly double the number of individuals with SMIs who receive health checks.
- Boost vaccination rates to prevent influenza.
- Reduce smoking prevalence by two thirds to meet upcoming government ambitions
- Increase early detection of cancer rates by 16 percentage points
- When looking at West Suffolk – nearly 19,000 people are estimated to have undiagnosed hypertension.
- Nearly 12,000 people in West Suffolk are estimated to diagnosed with hypertension but not having their blood pressure optimally managed.

Data Source: Census 2021, west alliance profile, Public Health Outcomes Framework 2020/21, State of Suffolk Report 2019  
\* = west Suffolk district boundaries not alliance boundaries  
\*\* Source: DCLG Index of Multiple Deprivation 2019 & ONS 2020 population estimates.



Everyone should have the opportunity to have and maintain good health and wellbeing. We know this does not always happen, and certain communities and populations experience health inequalities based on a range of factors. Some areas of need in West are:

The new ICB **Health Inequalities & Prevention Committee** has outlined key principles which will support our approach in West:

- Reducing Health inequalities by levelling up is core business for everybody.
- We will match resources to need.
- We are data informed and evidence based.
- We do this work through Community - Centred Approaches and Coproduction
- We target our efforts through a Core 20 Plus 5 and prevention frame.
- We use our position as Community Anchors to tackle the 'causes of the causes'
- Our services and communication are digitally inclusive.
- Key Public Health priorities are hypertension and smoking, and we will look to develop specific initiatives in West with partners.

## The Health Inequalities Plan for West Suffolk Alliance

1. We will develop proposals for an approach to Health Inequalities and Prevention for West Suffolk Alliance, aligning with the principles above. This will include evidence-based actions for key stakeholders to consider, and articulating outcomes. This will align and build with the ICB Committee plans which are underway and will look to increase engagement across partners to enact the agreed approach.
2. We will promote data including Population Health Management initiatives to support ongoing aims.
3. We will work with the Alliance Live Well domain/enabler groups and West based organisations to enact actions
4. We will develop some targeted work on hypertension and smoking -- given their key key role in preventing ill health.
5. Live Well Delivery Group: we will work with this central group to support embedding operational actions.
6. Reporting : we will provide quarterly updates on workstream progress to the Alliance Committee.

# Wider Determinants of Health - Focus on Education

In partnership with West Suffolk College, we want to leverage education to collaborate with our Primary, Secondary and Further Education school's network and connect with CYP and families to improve the health of the people of West Suffolk

## Relative contribution of the determinants of health

Health Behaviours 30%	Socio-economic Factors 40%	Clinical Care 20%	Built environment 10%
Smoking 10%	Education 10%	Access to Care 10%	Environmental Quality 5%
Diet/Exercise 10%	Employment 10%	Quality of care 10%	Built Environment 5%
Alcohol use 5%	Income 10%		
Poor sexual health 5%	Family/Social Support 5%		
	Community Safety 5%		

Source: Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute. Used in US to rank counties by health status

Together we will will:

- Deliver early education programmes for families via primary school awareness .
- Work with Education to increase understanding of support methods for emotional wellbeing and mental health via primary and secondary schools, as well as adults via post-18 provision.
- Use primary and secondary schools, as well as post 16 providers to engage young people and families in understanding the risks associated with poor habits, diet, and physical activity.
- Use post-18 providers to educate on the provision and level of support available to those dealing with frailty and dementia.
- Increase knowledge base of opportunities available to support end of life via post 18 education providers.

# Primary Care Networks

We have 25 practices organised into 6 primary care networks

120 additional roles staff in place and set to increase further in 23/24

Role type	Number
Care Coordinator	41
Social Prescriber	17
Clinical Pharmacist	16
Mental Health Practitioner	12
Paramedic	12
Pharmacy Technician	8
Trainee Nurse Associate	6
Nursing Associate	2
First Contact Physiotherapist	6
	<b>120</b>

PCN	Practices in the PCN	Patient numbers
Blackbourne	Botesdale Health Centre	9,756
	Stanton Surgery	5,328
	Woolpit Health Centre	15,551
	Ixworth Surgery	9,080
Bury St Edmunds	Angel Hill Surgery	14,125
	Guildhall & Barrow Surgery	12,834
	Mount Farm Surgery	15,109
	Swan Surgery	12,654
	Victoria Surgery	10,885
Forest Heath	Brandon Medical Practice	5,239
	Forest Surgery	7,610
	Lakenheath Surgery	5,376
	Oakfield Surgery	7,395
	Orchard House Surgery	12,024
	Reynard Surgery	10,019
	Rookery Medical Centre	13,937
Sudbury	Hardwicke House	24,336
	Siam Surgery	11,218
WGGL	Glemsford Surgery	4,683
	Guildhall – Clare Surgery	5,319
	Long Melford Practice	8,991
	Wickhambrook Surgery	5,268
Haverhill	Unity Health Care	17,781
	Haverhill Family Practice	17,530

# West Suffolk summary - strengths, progress & opportunities

	Strengths & progress	Opportunities to improve
<b>Well Being</b>	Public health focus at WSFT; staff well being offers; leisure services; social prescribing	Opportunities for diet, exercise and mental health improvement
<b>Primary Care</b>	Comparatively stable GP teams	Variation in access experience contacting GP Teams GP team Workload & workforce pressure Severe dental access problems
<b>VCSFE sector</b>	Established relationships and commissioned services and funded activities	Greater partner awareness and understanding of the VCFSE Improved collaboration and partnership working with VCFSE Increased resilience support for the VCFSE sector
<b>Health &amp; social care integration</b>	Joint leadership roles and aligned teams	Scope for further prevention and move to home based model PCNs and INTs not well aligned
<b>Mental health</b>	Talking therapies	Community mental health teams and PCNs
<b>Hospital &amp; community integration</b>	Integrated NHS trust	Planning for and resourcing "left shift"
<b>Estate</b>	Mildenhall, Sudbury, Newmarket & Brandon hubs	Hospital needs replacement Primary care capacity & hub opportunities in Bury and Haverhill
<b>Joint approach to commissioning &amp; change</b>	Alliance Committee with delegated powers. Live well domain working has started	Live well domain maturity
<b>Finance</b>	SNEE system in balance	Overspending at WSFT & primary care medicines budgets

# 3. Our Delivery Approach





# Working in partnership with people and communities

*Creating together through the power of collaboration.*

*“To achieve real impact, we need systems to look beyond those who are typically involved – building partnerships across traditional boundaries and working with people, communities and those who represent them to create real change”*

**Working in partnership with people and communities: statutory guidance (2022)**

People and Places are the centre of everything we seek to do in West Suffolk Alliance.

West Suffolk Alliance recognises that by working in partnership with people and communities is critical if we are to create service which offer personalised care, work for everyone and deliver the best outcomes.

Our approach seeks to actively develop partnerships and networks with our communities to enhance transparency, accountability and collaboration to build enduring relationships.

West Suffolk Alliance will develop a local people and communities delivery plan to ensure the people of West Suffolk act as an important reference point and ensure that we don't lose sight of the ultimate goal of improving people's lives through health and care.

Our people of West Suffolk are experts by lived experience and will create qualitative information evidence base to overlay with our data led approach and meaningfully challenge the proposals we seek to develop.

Our partners will seek to see the solutions we **develop** through the eyes of our communities ensuring compassionate led leadership remains at the heart of West Suffolk Alliance.

# Ten Principles of working with people and communities

The Alliance is committed to following the Guiding Principles of working with people and communities. By using these principles within our Alliance we know we are contributing to an *equitable engagement approach with our partners, people and communities.*

1. Centre decision-making and governance around the voices of people and communities
2. Involve people and communities at every stage and feed back to them about how it has influenced activities and decisions
3. Understand your community's needs, experiences, ideas and aspirations for health and care, using engagement to find out if change is working
4. Build relationships based on trust, especially with marginalised groups and those affected by health inequalities
5. Work with Healthwatch and the voluntary, community and social enterprise sector
6. Provide clear and accessible public information
7. Use community-centred approaches that empower people and communities, making connections what works already
8. Have a range of ways for people and communities to take part in health and care services
9. Tackle system priorities and service reconfiguration in partnership with people and communities
10. Learn from what works and build on the assets of all health and care partners – networks, relationships and activity in local places.

# Organise our partnership working around 6 live well domains and 4 Enablers

In West Suffolk we have identified four enablers that are integral to the successful delivery of the Alliance Delivery Plan.

a. Workforce

b. Digital & Data

c. Premises

d. Localities



# We aim to collaborate by

Having a clear purpose	Acting efficiently and inclusively	Working also at ICP and County level as needed	Being flexible & adapting
<ul style="list-style-type: none"> <li>• Focus on a set of <b>shared outcomes</b> agreed and reported at Alliance level with a shared approach to evaluation of both quality and impact</li> <li>• <b>Use data &amp; insight</b> to understand the key challenges for population health</li> <li>• Focus on actions <b>dependent on partnership</b> (not replicate organisation specific responsibilities)</li> </ul>	<ul style="list-style-type: none"> <li>• Mandated to act by the Alliance</li> <li>• <b>Leading on behalf of each other</b> where appropriate</li> <li>• Seek help where there are blocks</li> <li>• <b>Meetings;</b> map, align and streamline current groups to minimise bureaucracy</li> <li>• <b>Co-produce</b> with involvement of relevant partners, person centred solutions</li> </ul>	<ul style="list-style-type: none"> <li>• Recognise the relationship with ICB programmes and <b>County Leads</b> to recognise interdependencies and make connections</li> <li>• Import and export <b>best practice</b></li> <li>• Clear where <b>delivery lead sits at County &amp; ICB level</b></li> </ul>	<ul style="list-style-type: none"> <li>• Ensure we review and learn from how we are working to <b>adapt as we learn</b>, innovate and deliver</li> <li>• Recognise overlaps &amp; <b>interdependencies</b> exist</li> <li>• <b>Evaluate</b> quality &amp; impact of delivery where succeeding &amp; failing</li> </ul>

# Distributed Leadership Model as of 09/05/23

Committee Member  
(Mandated Authority)

Alliance Partner  
(From local organisations)

Delivery Support  
(Health Resource)

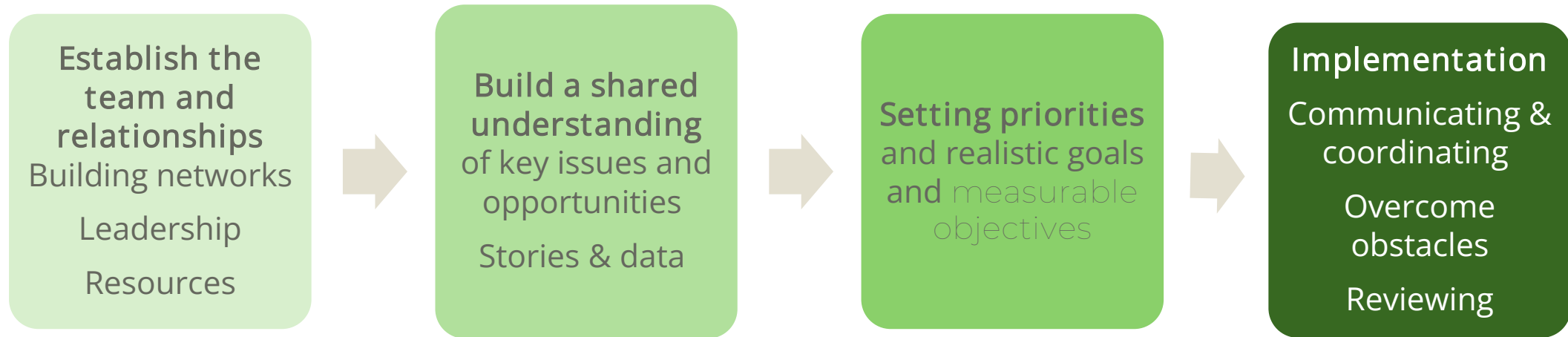
Domain	Sponsor	Strategic Lead	Change Co-ordinator
Start Well	Gary Joyce (ICB/SCC)/Angela Whatley (SEND with WS College)	Tara Spence (HomeStart - VCSFE)	Jamie Mills/Helen Bowles
Feel Well	Vanessa Wragg/Belinda Danso-Langley (NSFT)	Jon Neal (Suffolk Mind - VCSFE)	Hannah May
Be Well	Ian Gallin (WSC) /Kathy Nixon (B&MS)	Helena Jopling (WSFT)	Jennie McCrory/Trisha Stevens
Stay Well	Nicola Cottington (WSFT)	Dr David Brandon Associate MD (ICB alliance)	Renu Mandal and Lucy Webb
Age Well	Clement Mawoyo (ASC)	Sandie Robinson (ICB Alliance)	Lesley Standring and Michelle Glass
Die Well	Sue Wilkinson (WSFT)	Sharon Basson (St Nicholas Hospice)	Cara Twinch
Enabler Domains			
Estates	Peter Wightman (ICB Alliance)	WSC/BMS Chris Todd	Daniel Turner
Workforce	Ewen Cameron (WSFT)	Phill Stittle (WSC)/Mark Smith (AHPS CIC)	Graham Seward and Paul Firth
Digital	Craig Black (WSFT) and Molly – Thomas Meyer (PH)	Liam McLaughlin (WSFT)	Nicola Chalk and Phil Nice
Locality Development	Chris Abraham ( CAS - VCSFE)	Sandie Robinson (ICB alliance)	Sarah Hedges

# 4. The Plan



The potential is exciting but integrating and moving to a prevention approach is challenging

Our domain groups are at different stages of development



# WSA Live Well Framework – Problem Statements

**Overarching aim in all domains : Health Inequalities**  
Need to systematically identify and allocate resources towards improving access, experience, and outcomes of healthcare to reduce health inequalities.

**Be Well**  
Decreasing healthy behaviours and access to dentistry services.

**Feel Well**  
Need more collaborative approaches for whole person physical and mental health improvement.

**Start Well**  
Inequitable health outcomes during pregnancy and birth and long waits for children and young persons mental health services.



**Age Well**  
An ageing population with increases in demand on all services and increasing complexity.

**Stay Well**  
Demand for health and social care services is rising with a quarter of the population experiencing long-term conditions.

**Die Well**  
Need to increase the numbers of people who have control and clear death wishes while providing a 24/7 service/.

Workforce

Digital & Data

Premises

Localities



## Start Well: Giving children and young people the best start in life in West Suffolk

Domain Workstream	Focus Areas	Key Deliverables	Intended Impact
<b>Collaboration</b>	<ol style="list-style-type: none"> <li><b>Building collaboration with system partners</b> across West Suffolk to provide a wider focus on CYP and families agenda</li> <li><b>Identify areas where we need to collaborate further</b> to deliver our local priorities for CYP and families. This will include colleagues from education, district and borough councils and safeguarding partnerships</li> <li><b>Early education</b> for families via primary school awareness programmes</li> </ol>	<ul style="list-style-type: none"> <li>A system wide partnership group, with representation from key sector leads across West Suffolk</li> <li>Establish and deliver early education programmes across West Suffolk</li> </ul>	Partners across West Suffolk Alliance working together to agreed shared action focused on on giving CYP the best start in life
<b>Insight and intelligence</b>	<ol style="list-style-type: none"> <li>Gather <b>data and insight</b> to better understand strengths and need to promote Start Well, address wider determinants of health and reduce inequalities</li> </ol>	<ul style="list-style-type: none"> <li>Establish local challenges with health, social care and Education colleagues with leads with input from service users</li> </ul>	Better understanding of needs and key action plan setting out local shared outcomes
<b>Resources</b>	<ol style="list-style-type: none"> <li><b>Identify resources and community assets</b> to support the delivery of agreed outcomes across the Start well domain</li> <li><b>Agree collective outcomes, identify indicators and prioritise actions</b> for system wide improvements that will make the greatest impact in West Suffolk for CYP &amp; families</li> </ol>	<ul style="list-style-type: none"> <li>Develop a coproduced decision making structure for the Start Well domain</li> </ul>	Shared platform to enable decision making at place and allocation of resources with the mandate to deliver

## Feel Well: Supporting the mental wellbeing of our local population of West Suffolk

Domain Workstream	Focus Areas	Key Deliverables	Intended Impact
Sleep	<ol style="list-style-type: none"> <li>1. <b>Increase the number of people who say they feel rested after sleep.</b></li> <li>2. <b>Increase awareness of the importance of sleep</b> across West Suffolk.</li> <li>3. <b>Create guidance</b> for people working in the system to have the confidence to ask people about their sleep and provide information on the tools to improve it.</li> </ol>	<ul style="list-style-type: none"> <li>• Support research, data collection and monitoring to target improved sleep outcomes.</li> <li>• Create resources to help improve awareness and also access to practical support for both patients and staff within West Suffolk.</li> </ul>	Reduction in the negative health and social impact of living with poor sleep experiences.
ADHD	<ol style="list-style-type: none"> <li>1. <b>Reduce wait times and improve experience</b> of ADHD services.</li> <li>2. <b>Support patients and their families/ carers to “Wait Well”</b> though Improved accessible resources and signposting to local and national support services.</li> <li>3. <b>Improve early diagnoses</b> to reduce risk of suicide and/ or development of wider mental health conditions.</li> </ol>	<ul style="list-style-type: none"> <li>• Review ADHD service processes and create plan to improve service access and wait times across West Suffolk.</li> <li>• Create “Wait Well” resources and services in areas such as peer support, exercise, diet etc.</li> <li>• Ensure people with lived experience are shaping the delivery of any future services and provisions.</li> <li>• Work with primary care to help early identification and referrals.</li> </ul>	<p>Improve the outcomes of people living with ADHD through timely diagnosis and treatment.</p> <p><i>JFP: Achieve a 5% year-on-year increase in number of adults supported by community mental health services</i></p>
Carers	<ol style="list-style-type: none"> <li>1. <b>Understand how local mental health services can better support carers</b> both with their carers responsibility and the impact on their own health and wellbeing.</li> <li>2. Ensure all mental health services have <b>clear processes for identifying and working with carers.</b></li> <li>3. <b>Support carers to feel properly informed and empowered to care by Improving information sharing</b> between carers and the related health and care organisations.</li> </ol>	<ul style="list-style-type: none"> <li>• Work in partnership with the Integrated Care Academy (ICA) to understand and improve carer needs.</li> <li>• Develop and provide guidance to services on how to ensure carers should be included in patient care.</li> <li>• Review information sharing practices and ensure they meet the needs of carers and safeguarding requirements .</li> </ul>	Reduce the burden that mental health services unintentionally place on carers of people with mental health needs.

**Note: The Suffolk Mental Health charter describes the full range of actions being taken with regards to mental health improvement including those contributing to further JFP targets**

- Achieve a year-on-year reduction in hospital admission for mental health.
- Tackle health inequalities by ensuring at least 90% receive a full annual physical health check and follow-up intervention.
- And strengthening community mental health teams between NSFT and PCNs

## Be Well: Empowering adults to lead healthy lifestyles in West Suffolk

Domain Workstream	Focus Areas	Key Deliverables	Intended Impact
<b>Healthy Behaviours</b>	<ol style="list-style-type: none"> <li><b>1. Improve opportunities to help people lead healthy lifestyles</b> across key areas including;               <ol style="list-style-type: none"> <li>1. Reduction in <b>smoking</b> and tobacco dependency</li> <li>2. Increasing <b>physical activity</b></li> <li>3. Maintaining a <b>healthy weight</b>, reduce obesity, eat healthy foods and drinks.</li> </ol> </li> <li><b>2. Creating an aligned and collaborative new approach</b> to Healthy Behaviours across West Suffolk to increase uptake and reduce health inequalities.</li> </ol>	<ul style="list-style-type: none"> <li>• Development of a new model of healthy behaviours provided via a digital resource and locally delivered programmes, courses, advice and support.</li> <li>• Work with Public Health, District and Borough Councils, VCFSE partners, acute, primary and community care services and the health and care workforce, including social prescribers, to develop locally designed programmes.</li> <li>• Align the current healthy behaviours pathways in West Suffolk, to the new delivery model.</li> </ul>	<p>Improve health outcomes for the people of West Suffolk preventing ill health and need to access health services where possible.</p>
<b>Dental Health</b>	<ol style="list-style-type: none"> <li><b>1. Improve access to dental services</b> for the people of West Suffolk.</li> <li><b>2. Reduce health inequalities and locality variation</b> in access to services.</li> <li><b>3. Increase awareness of the importance of good dental health</b> in relation to wider physical and mental health needs.</li> <li><b>4. Improve healthy behaviours in relation to dentistry.</b></li> </ol>	<ul style="list-style-type: none"> <li>• To have a better understanding of the commissioning arrangements for dentistry after the transfer of Dental services to ICBs as part of Pharmaceutical, Ophthalmic, Dental (POD) services.</li> <li>• To better understand the challenges and issues facing dentistry, including a lack of access, a lack of access routes for specialist dentistry and a lack of prevention and health promotion.</li> <li>• To understand how the West Suffolk Alliance can be involved in opportunities to transform and integrate dental services into our local system</li> <li>• To provide support, as part of a joined up approach with the other Live Well domains and domain enablers, to promote good dental health and reduce dental caries</li> </ul>	<p><i>Improve the dental health of the people of West Suffolk.</i></p>

**Age Well: Supporting adults with health or care concerns to access support and maintain healthy, productive and fulfilling lives In West Suffolk**

Domain workstream	Focus Areas	Key Deliverables	Intended Impact
<p>Strengthen the model of care at Locality level to ensure the delivery of reablement and responsive care at INT level is optimised</p>	<ol style="list-style-type: none"> <li>We will review and re-baseline the <b>Maturity Matrix for each INT</b> to identify the development priorities aligned to support delivery of the Model of Care</li> <li>We will have a <b>clear understanding of the capacity and demand</b> for agreed services within each INT including community nursing, community therapy and domiciliary care.</li> <li>We will implement a <b>7 day locality offer of home and reablement</b> first at all 6 localities with 24/7 wrap around support</li> </ol>	<ul style="list-style-type: none"> <li>INT development plan in place to address opportunities for further maturity to deliver the enhanced model of care ahead of winter 2023</li> <li>Demand and Capacity review completed and plan in place to inform operational alignment and future planning</li> <li>Enhanced Home first business case approved using National Discharge Funding and outcomes through BCF plan agreed</li> <li>Virtual Ward business case approved and alignment of key pathways to Model of Care in place</li> <li>Pathways for frailty, EOL and UCR refreshed to improve resilience of Model of Care to support more people at home</li> </ul>	<p>Increase in number of people supported in their crisis at home (10% above 22/23 baseline) Reduction in waiting times for therapy by x% Increase in number of pathway 1 discharges by x% against 21/22 baseline</p> <p>Quantify demand and capacity across INTs to inform strategic, financial and workforce planning</p> <p>Improved <b>reablement</b> outcomes for people, improved flow and reduced demand across the system,</p>

**Stay Well: Supporting adults with health or care concerns to access support and maintain healthy, productive and fulfilling lives in West Suffolk**

Domain Workstream	Focus Areas	Key Deliverables	Intended Impact
Demand management	Understand the demand profile across our UEC system and respond accordingly to profile, working collaboratively	<ul style="list-style-type: none"> <li>Establish data required for the UEC demand profiling.</li> </ul>	Better understanding of demand profile for UEC
Urgent Community Response.	(UCR) model embedded within the responsive service of the INTs in collaboration with the Age Well domain priorities	<ul style="list-style-type: none"> <li>UCR enhanced to include wider offer of support to deliver growth in admission avoidance activity including accepting more activity from Community Hub</li> <li>Wrap around model of UCR in place to support localities to keep more people at home through their crisis</li> </ul>	Consistently meet or exceed 70%-two hour urgent community response standard. 10% growth UCR activity
Discharge and flow	Focus on improving discharge processes and community response to improve flow and reablement outcomes	<ul style="list-style-type: none"> <li>Map, using the 100 day challenge approach, the current discharge pathway against the high impact areas to identify opportunities for improvement.</li> <li>Re-launch Criteria Led Discharge (acute &amp; Community beds)</li> <li>Specialist Virtual Ward Pathways to assist with early discharge.</li> <li>Review of data for delays in discharge for patients no longer with a Criteria to Reside and introduce regular audits of this data.</li> <li>Capacity &amp; demand review of specialist community services to optimise responsiveness to referrals to ensure timely transfer of care.</li> </ul>	Reduction in general and acute bed occupancy to 92% or below. Planned discharge across 7 days of the week.
Direct access	Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals. Phase 1 focus is to design a direct access pathway for breast lumps for women over 50	<ul style="list-style-type: none"> <li>Work with primary and secondary care to explore direct access pathway opportunities for breast lumps for &gt;50 years</li> <li>Develop plan to increase GP direct access to diagnostics where feasible</li> <li>List of potential additional direct access pathways</li> </ul>	Direct access pathway for breast lump for >50 developed and implemented
Diabetes	Design an integrated diabetes service in West Suffolk	<ul style="list-style-type: none"> <li>Gather information on current service provision</li> <li>Identify national best practice models</li> <li>Identify opportunities for non NHS system partners to play a part in supporting people with Diabetes</li> <li>Set up workshops to scope the design of an integrated diabetes service</li> </ul>	Improved percentage of patients with diabetes control achieved (aligned to targets set by NICE)

## Die Well: Giving individuals nearing end of life choice around their care

Domain Workstream	Focus Areas	Key Deliverables	Intended Impact
<p>Seamless and coordinated end of life and bereavement care and support for people and their families 24/7 through a collaborative, cohesive appropriately trained workforce.</p>	<ol style="list-style-type: none"> <li>1. <b>Develop an End of Life Model of Care</b> that focuses on providing compassionate, well communicated care for those end of Life or bereaved.</li> <li>2. <b>Support staff to have difficult conversations</b>, supporting advance care planning and death literacy</li> <li>3. <b>Training and support rollout</b> - difficult conversations, What Matters to you? Personalised Care and Support Plan, etc</li> <li>4. Rollout of RESPECT</li> <li>5. Source a solution for identifying people in their last year of life</li> <li>6. Identify a solution for an accessible person owned record of their wishes, which includes their preferred place of death and preferred choices.</li> <li>7. <b>Plan the campaign</b> with earlier availability of information to support die well conversations</li> </ol>	<ul style="list-style-type: none"> <li>• Model of care agreed and supported at the Die Well Domain group</li> <li>• Specialist end of life telephone and face to face support available 24/7</li> <li>• Integrated and collaborative training and support package for staff</li> <li>• RESPECT rolled out</li> <li>• Accessible dashboard of those within the last year of life</li> <li>• Digital solution identified for offering two-way care planning communication between person end of life and support network</li> <li>• Die well information campaign planned</li> </ul>	<p>Progress achieved towards 70% of individuals supported to remain at home or in a community setting (as the patient wishes) by March 2024</p>

# 4. Key Enablers



**VISION: To support organisations to build workforces that enable them to effectively serve populations**

**Key Info:** Our partners are Suffolk County Council, Public Health and Communities; District and Borough Councils; acute, community and mental health trusts; Primary Care, West Suffolk Alliance

Workstream	Domain Actions	Milestones	Intended impact
<p><b>Implement an Education and Training Digital Passport</b></p>	<p><b>Supply</b></p> <ul style="list-style-type: none"> <li>Work with stakeholders to create a shared Alliance training programme available to the workforce regardless of organisation</li> </ul> <p><b>Upskilling</b></p> <ul style="list-style-type: none"> <li>Produce a joint induction package that can be utilised by Alliance stakeholders to onboard the workforce</li> <li>Work with alliance partners to produce a set of common principles for training and education</li> <li>Work with stakeholders to develop a career conversations framework</li> </ul> <p><b>New roles</b></p> <ul style="list-style-type: none"> <li>Proactively collaborate with the Education Sector within the Alliance footprint to develop content of existing courses and establish new courses to meet the qualification needs of the workforce</li> </ul>	<p><b>Supply</b></p> <ul style="list-style-type: none"> <li>Current training offers mapped using themes of mandatory, CPD etc.</li> </ul> <p><b>Upskilling</b></p> <ul style="list-style-type: none"> <li>Gather information on provider' inductions so as to identify essential requirements, commonalities and best practice</li> <li>As above</li> <li>Career Framework for Alliance produced</li> </ul> <p><b>New roles</b></p> <p>Share workforce data and liaise with education institutions to tailor courses to meet workforce need</p>	<p>Knowledge, skills and expertise utilised from within the West Suffolk System</p> <p>Visible career pathway across the system</p> <p>Joined up workforce planning</p>
<p><b>Improve Equity to International Recruitment Opportunities for Alliance Stakeholders</b></p>	<p><b>Supply</b></p> <p>Support stakeholders to make the process of international recruitment less challenging and more co-ordinated such as pastoral care and coaching</p> <p><b>Upskilling</b></p> <p>Produce a joint induction package that can be utilised by Alliance stakeholders to onboard the workforce</p> <p><b>New roles</b></p> <p>Implement a joint, cross sector leader's network and forum</p>	<p><b>Supply</b></p> <ul style="list-style-type: none"> <li>Subject matter expert forums implemented, with representatives from across the Alliance, to identify current challenges</li> </ul> <p><b>Upskilling</b></p> <p>Gather information on provider' inductions so as to identify essential requirements, commonalities and best practice</p> <p><b>New roles</b></p> <ul style="list-style-type: none"> <li>Work with communications team to produce guidance document outlining aims of a leaders network</li> <li>Send open invitation to leaders across the Alliance to join network and forums</li> </ul>	<p>Joined-up workforce planning</p> <p>Increased supply and improved capacity</p>



**Vision** - A shared planned approach for the use of digital, data and innovation at place, across the system.

**Key Info** – PHM to be the driver for data provision and consideration for innovation and digital technologies and inclusion to be a default consideration for all new and redesigned services.

Workstream	Domain Actions	Milestones	Impact
<b>Promotion and Adoption</b>	Design an approach that promotes and facilitates the adoption and usage of use cases, dashboards, digital technologies and innovation with all partner organisations.	<ul style="list-style-type: none"> <li>• Create an agile environment/deployment process which allows data, digital technology and innovation to respond quickly to a localised /specific need.</li> <li>• Promote digital technologies, data tools and innovation as the way forward for service re(design), decision making and targeted approaches.</li> <li>• Understand all data, digital and innovation options, identifying any gaps that there may be in order to improve provision.</li> </ul>	<ul style="list-style-type: none"> <li>• A faster reaction in response to NHS England funding/alternative funding provision and changes.</li> <li>• A significant reduction in deployment delays.</li> <li>• Committed investment into cultural change/behaviour change( including Human Resources documentation and shared partnership agreements and priorities.)</li> <li>• Committed investment to a “pool resource” to be used for technology solutions/innovation/artificial intelligence.</li> <li>• A proven model of delivery which can be used to scale up delivery at pace as desired.</li> <li>• Increased adoption of community based, preventive care.</li> <li>• Maximised use of existing digital technologies, data platforms and innovation through appropriate promotion, training and co-design of new tools.</li> <li>• Work with partnership organisations and Human Resource teams to make digital, data and innovation everyone's priority as part of job descriptions and mandatory training.</li> <li>• An embedded process to ensure people/communities are involved in the co-design of innovation and digital and data services, with innovation, digital and data becoming the norm for service (re) design tools from point of bid to implementation.</li> <li>• A full gap analysis of missing technologies and data provision with an action plan to reduce this gap through sourcing new innovations, technologies, datasets, dashboards etc in response to community/clinical demands.</li> </ul>
<b>Evaluation Model</b>	An agreed evaluation model for comparing different dashboards/ technology offerings to assist the GIRFT (getting it right first time) principle	<ul style="list-style-type: none"> <li>• To be clear on our return on investment and the impact our interventions have had at place</li> <li>• Develop a common evaluation approach to measure quality and impact of the actions agreed in the ADP</li> <li>• Lessons learned and full evaluations to become the norm in all new projects and programmes in order to fully understand the needs and implications of digital technologies and data provision.</li> </ul>	<ul style="list-style-type: none"> <li>• Identified cost analysis, improved statistics and an overall healthier and happier population as a result of service improvements and redesigns that have been implemented.</li> <li>• Increase number of lived experiences and case studies at the forefront of all our work.</li> <li>• An increased number of innovation, new technology and digital alternatives to face to face consultations, leading to more efficient and appropriate use of clinical staff time.</li> <li>• An increased number of pilot projects and programmes turning into business as usual due to successful evaluations promoting the benefits of larger scale rollout.</li> <li>• A reduction in technologies and use case offerings where the appropriateness and needs of the services have not been considered first.</li> </ul>

**VISION:** Create and manage one public estate that is driven by service needs, run and planned as one system

**Key Info:** Our partners are Suffolk County Council, Public Health and Communities; District and Borough Councils; acute, community and mental health trusts; Primary Care, West Suffolk Alliance

Workstream	Domain Actions	Milestones	Intended Impact
<p><b>Optimise use of existing estate &amp; enable co-location of linked services where possible and appropriate</b></p>	<ul style="list-style-type: none"> <li>• <b>Identify service and clinical requirements</b> within each locality to support estate development and optimisation plans – Live Well domains</li> <li>• <b>Be clear on all assets available</b> in each locality and their use including VCSFE &amp; wider opportunities such as high street</li> <li>• <b>Use Haverhill locality as an exemplar:</b> Reoccupation of health centre and other sites in Haverhill based on integrated service visions &amp; occupation principles</li> <li>• Pilot single management of shared buildings (e.g. reception, bookings, utilisation)</li> <li>• <b>Ensure system decision making governance in place for shared spaces</b></li> </ul>	<p><i>Live Well accommodation visions:</i> Work with each of Live Well Domains to identify service and clinical requirements across all localities October 23</p> <p>Asset Map including their use – December 23 initial review &amp; then ongoing through appropriate governance</p> <p>Haverhill</p> <ul style="list-style-type: none"> <li>• Decisions May/June 23</li> <li>• Occupation &amp; Communication June/July 23</li> <li>• Review January 24</li> </ul> <p>Review and ensure in place September 23</p>	<ul style="list-style-type: none"> <li>• Supports integration vision</li> <li>• Increased capacity reducing need for new estate</li> <li>• Greater value for money</li> </ul>
<p><b>New hospital programme</b></p>	<ul style="list-style-type: none"> <li>• Support estates requirements flowing from <b>Future Systems programme</b> including: <ul style="list-style-type: none"> <li>• Outline Business Case produced in line with national timetable when published</li> <li>• As part of this, work with services to define services moving to a community setting</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Date TBC</li> <li>• Quantification of intended service transfer and estates requirement date TBC</li> </ul>	<ul style="list-style-type: none"> <li>• Enables appropriate shift to community setting</li> <li>• Address essential standards issues</li> </ul>
<p><b>Planning for population growth</b></p>	<ul style="list-style-type: none"> <li>• Be a proactive partner with District and Borough Councils as part of their <b>local plan development process</b>, ensuring health provides input on population mitigation measures</li> <li>• Estates domain operational group to engage with each locality to understand service development need to meet with existing and planned population growth and to start development of longer term alliance based strategic mitigation measures. –</li> </ul>	<ul style="list-style-type: none"> <li>• Summer 2023</li> <li>• ongoing aim to complete all localities during 23.</li> <li>• Early priorities Haverhill and Bury</li> </ul>	

**Vision:** Strengthen the infrastructure at place to enable local communities and services to strengthen their role in delivering the very best for the local people and for communities to flourish. Provide a vehicle for the Domain priorities to be supported and delivered.

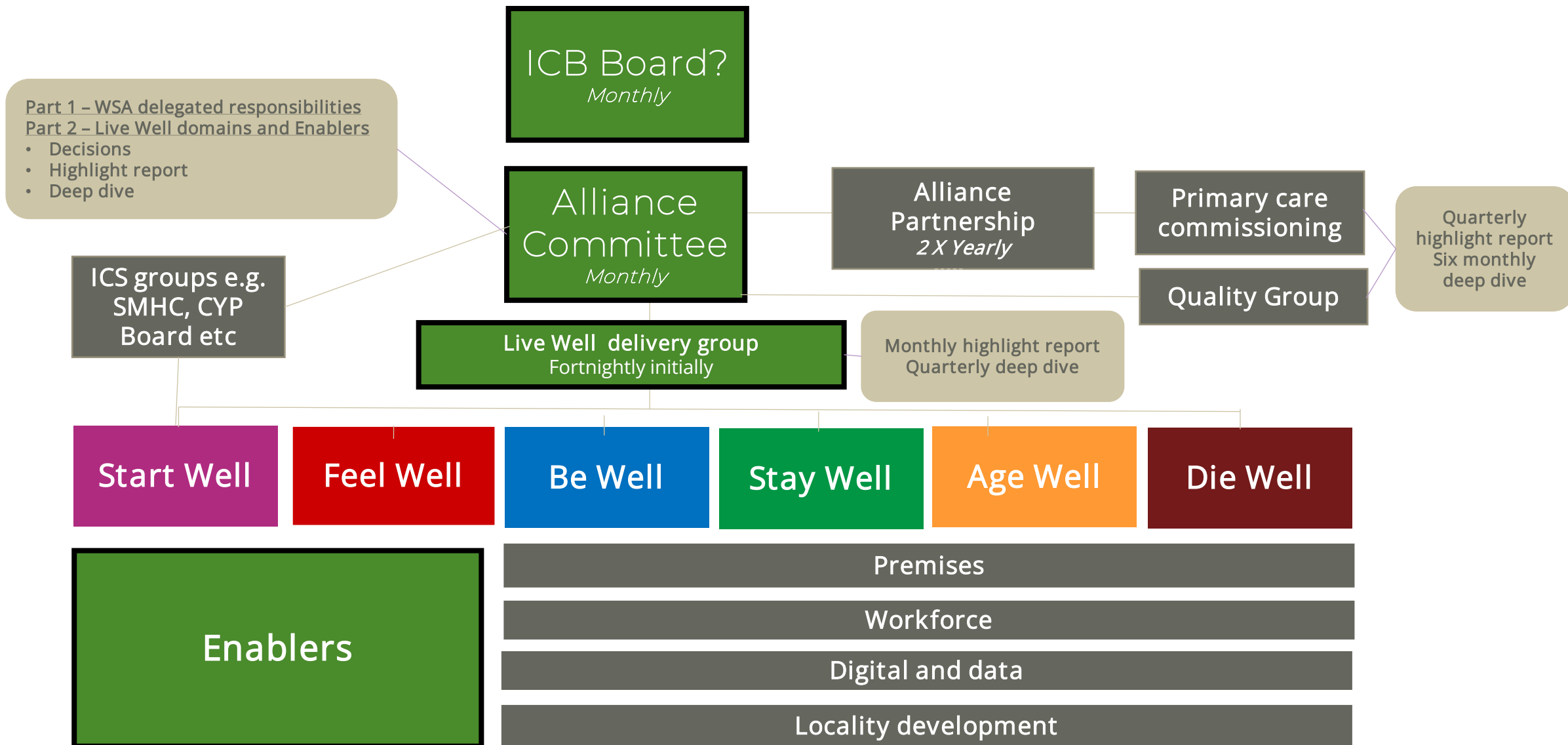
**Key Info:** *In scope* = Localities and the supporting mechanisms to achieve sustainability. *Out of scope* INT, PCN and service specifics.

Workstream	Domain Actions	Milestones	Impact
<p>Empower localities to have a locally owned shared purpose and plan to live healthy, connected lives</p>	<p>Prioritise Haverhill Locality in the first instance whilst supporting the other Localities to maintain a level of engagement and development</p>	<ul style="list-style-type: none"> <li>• Support each locality to have a meeting structure in place which brings diverse partner organisations together to consider what good looks like locally, network, share learning, develop &amp; implement local actions and build trust &amp; sustainability</li> <li>• Align local and Alliance governance structures in a simplified way</li> <li>• Support partners to develop a leadership structure, which facilitates locality integrated/coordinated working</li> <li>• Understand funding sources available at a locality level:                             <ul style="list-style-type: none"> <li>➢ Map and develop at Alliance level the funding pots and alignment of governance associated with spending</li> <li>➢ Develop a proposal for how funding is aligned to a locality level</li> </ul> </li> <li>• Collate community discovery work to understand the needs/diversity in the community and look at them from a ABCD approach to develop the locality actions</li> <li>• Support each locality to have a closed loop cycle of engagement and communication</li> <li>• Develop a clear and simple locality strategy, which communicates:                             <ul style="list-style-type: none"> <li>➢ the aspired change behaviours required to facilitate integrated/coordinated working at place level</li> <li>➢ the engagement/communication plan for localities</li> <li>➢ A plan for sharing of information/resource regardless of organisational boundaries</li> <li>➢ A plan for shared place based, person-centred, fit for purpose funding opportunities</li> </ul> </li> <li>• Identify the barriers to integrated working at a locality level including alignment or principles of how physical boundaries can work across PCNs and Integrated Neighbourhood Teams</li> <li>• Align actions required with other domains and enablers</li> </ul>	<ul style="list-style-type: none"> <li>• Locality meetings functional within all 6 localities</li> <li>• Governance structures in place, linking localities with the Alliance/ICB</li> <li>• Agreed locality leadership structure in place across partners</li> <li>• Place based shared funding proposal taken to the Alliance Committee and Locality Boards (where in place)</li> <li>• Clear and accessible database in place for aligning intelligence from all localities and providers/community</li> <li>• Closed loop communication stream between people – locality - West Suffolk Alliance in place and functional</li> <li>• Locality strategy signed off by all Alliance Committee partners</li> <li>• Paper identifying the barriers to locality working submitted to the Livewell delivery group</li> </ul>

# 6. Implementation



# Governance & Reporting



# Appendix



# Joint Forward plan target indicators

We will assess our performance in delivering our commitments over the next five years by measuring performance against one or more target indicators in each domain. These are the lead key performance indicators that we wish to 'target' improvements in, with a particular focus on reductions in health inequalities. Delivery against the target indicators will be achieved through a broad programme of work detailed in full in the JFP and supporting annexes.

## Start well:

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- Reduce the neonatal mortality rate by end of 2023/24 and reduce each year thereafter, addressing inequalities by prioritising reduction in unwanted variation in neonatal mortality
- By 2028, no child or young person waits more than 12 weeks for Child and Adolescent Mental Health Services (CAMHS) or 18 weeks for Neurodevelopmental Diagnostic (NDD) Services, prioritising reductions in waiting times for ethnic minorities and those living in the 20% most deprived areas
- Reduce the hospital admission rate due to asthma of children or young persons living in the most deprived 20% of areas

## Stay well:

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### Access to care

- Increase our GP practice teams each year to meet the growing demand whilst increasing the number of trainees and apprentices
- No one waits more than one year for elective care by March 2025
- Increase by 10% each year the number of cases seen by the urgent community response service;
- By 2028, 95% of patients attending A&E services wait no longer than 4 hours
- Reduce the number of acute hospital bed days utilised by people without a criterion to reside that are discharged on complex pathways (1-3)

### Early intervention, prioritising early diagnosis and treatment for people living in the 20% most deprived areas

- Increase the percentage of cancers diagnosed at stages 1 and 2 to 75% by 2028
- 80% of people with high blood pressure are identified and treated by 2028
- More than 85% of people with Atrial Fibrillation are identified and 90% of those at high risk of stroke are treated by 2028

# Joint Forward plan target indicators (2)

## Feel well:

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- Achieve a 5% year-on-year increase in the number of adults supported by community mental health services
- Achieve a year-on-year reduction in hospital admission rate for mental health conditions
- Identify and reduce health inequalities amongst people with severe mental illness, by ensuring at least 90% of people, including those in all disadvantaged groups, receive a full annual physical health check and follow-up interventions by 2028

## Be well:

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- Halt recent increases in the number of overweight and obese children in reception and year 6 by 2028 and maintain prevalence below the national average
- Reduce the number of smokers in our population in line with only 5% of the population being smokers by 2030
- Increase each year the number of units of NHS dental activity delivered

## Age well:

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- Reduce each year the rate of emergency hospital admissions due to falls amongst the population aged over 65
- Reduce each year emergency acute hospital bed use (bed days per capita) for those over 65 years old
- Achieve the national 66.7% dementia diagnosis rate by October 2024 and an increase in dementia annual care plan reviews completed each year

## Die well:

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- Increase each year the percentage of people identified as approaching the end of life

## Health Inequalities (cross cutting):

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- By 2028, reduce the number of deaths in under 75s considered preventable, reducing inequalities in our most deprived areas and amongst disadvantaged groups



# Links to referenced documents




- Integrated Care Partnership – [Integrated Care Strategy 23-28](#)
- Integrated Care Board – [Joint Forward Plan 23-28](#)
- ICB - [Governance Handbook](#)

## 3.5. Digital Programme Board Report

To Assure

## Board of Directors - Public

<b>Report title:</b>	<b>Digital Board report</b>
<b>Agenda item:</b>	3.5
<b>Date of the meeting:</b>	26 <sup>th</sup> May 2023
<b>Sponsor/executive lead:</b>	Craig Black
<b>Report prepared by:</b>	Liam McLaughlin

<b>Purpose of the report:</b>			
For approval <input type="checkbox"/>	For assurance <input checked="" type="checkbox"/>	For discussion <input type="checkbox"/>	For information <input type="checkbox"/>
<b>Trust strategy ambitions</b>			
Please indicate Trust strategy ambitions relevant to this report.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

<b>Executive summary:</b>	The Digital Board meets quarterly to consider the ways in which digital is supporting progress towards Trust objectives and to review any matters escalated to the Digital board from the Pillar groups.
<b>Action required/ recommendation:</b>	The board accepts the report as appropriate assurance

<b>Previously considered by:</b>	
<b>Risk and assurance:</b>	
<b>Equality, diversity and inclusion:</b>	
<b>Sustainability:</b>	
<b>Legal and regulatory context:</b>	

<b>1.</b>	<b>Introduction</b>
1.1	To provide the Trust Board with assurance that digital is supporting the delivery of the Trust objectives
<b>2.</b>	<b>Background</b>
2.1	The Digital Board meeting was held on 3 <sup>rd</sup> May 2023
<b>3.</b>	<b>Detailed sections and key issues</b>
3.1	<p>Highlights from the Pillar reports are:</p> <p><u>Pillar 1 - e-Care programme</u></p> <p>The team is currently implementing a full code and mPages upgrade planned for June 2023. No projects were reported as exceptions.</p> <p><u>Pillar 2 - Population Health Manager (PHM) and Shared Care Records (ShCR)</u></p> <p>The 4 Is of population health management, infrastructure, intelligence, interventions, and impact provides the structure for the work the team is doing. This has proved useful to differentiate between the development of the models and the interventions that may result from the intelligence.</p> <p>The work is closely aligned with the Live Well strategic framework of the West Suffolk Alliance and plans to explore opportunities for linking further data that is presented by the commissioning of an ICS wide PHM platform.</p> <p>Shared Care Records for the ICS are available through the Health Information Exchange (HIE) which is managed and delivered by the team at WSFT. All major providers are connected and the next phase of development, working closely with each of the connected partners, is planned to provision a wider range of data and also move to receive more structure data.</p> <p><u>Pillar 4 - Digital infrastructure</u></p> <p>A number of projects, including a major upgrade to the Trust Wifi network, have been enabled as a result of additional funding that was received late in the previous financial year. Further work is ongoing to plan the roll out of the upgraded equipment.</p> <p>This additional funding also enabled the purchase of additional cyber security tools that brings improved management of Internet of Things (IoT), sensors and medical devices.</p> <p>Work is ongoing with the roll out of multi-factor authentication to provide industry required levels of security to our accounts and therefore our data.</p>
3.2	<p><u>Oracle Cerner</u></p> <p>Oracle Cerner, who attend the meeting as a key digital partner, outlined the progress on the merger of Oracle and Cerner and provided assurance on the way that Oracle will bring additional resources and wider cloud capabilities to the Cerner platform.</p>

3.3	<p><u>NATSIPPS 2</u></p> <p>Dr Nicholas Levy presented on revised National Safety Standards for Invasive Procedures (NatSSIPs 2), designed to reduce misunderstandings or errors and to improve team cohesion.</p> <p>The standards, written by clinicians from multiple professions and specialties, re-launches the WHO checklist. It mandates key stop moments when the standard pathway is confirmed, and patient-specific details clarified. This improves both patient safety and team-working. NatSSIPs 2 also newly includes 'proportionate counts' for more 'minor' procedures. 'Standardisation, Harmonisation and Education' are recommended.</p> <p>These national standards cover all invasive procedures including those performed outside of the operating department.</p> <p>Dr Levy requested support from digital which was acknowledged but considered a much wider ask across the whole Trust.</p>
3.4	<p><u>Escalation from the Information Governance Steering Group</u></p> <p>The chair of the IG Steering group requested that the issue with printing some historic documents, when required for subject access requests, be escalated to the Digital Board. This is a long-standing issue that has been addressed for new documents but requires a fix from Cerner for the historic documents. Oracle Cerner acknowledged this as a fault that is being addressed by their development team. No timescale for a permanent correction was given to the meeting but is being progressed through the regular performance meetings.</p>
3.5	<p><u>Clinical messaging platform</u></p> <p>Re-procurement is underway for a clinical messaging application (bleep replacement system) to ensure we get best value for money given the length of the current contract with Medic Creations. It is unlikely that they will decide to respond to the tender and so we are planning on a replacement for the current Medic Bleep product.</p>

<p>3.6</p>	<p><u>Governance Framework</u></p> <p>A proposal for a revised digital governance structure was presented and approved. This aims to align the governance structure with the key Trust and corresponding digital objectives.</p> <p>Further work will follow, as part of the business planning and change processes, to implement a robust and transparent prioritisation method that aligns digital with the wider Trust and Divisional objectives</p>
<p>3.7</p>	<p><u>Future System Digital workstream</u></p> <p>Digital remains at the heart of the expectation of the National Hospital Programme (NHP). To this end they have recently published their Minimum Viable Product (MVP) specification that defines the digital technologies expected in a smart hospital. As we have been engaged with NHP on the definition of MVP, it is very much in line with our plans.</p> <p>The Future System Programme (FSP) digital strategy has been approved and outlines the detail of the digital technologies that will be at the heart of the new hospital. Further socialisation and engagement is underway on the range of technologies and this is also being fully costed to feed into the Outline Business Case (OBC)</p>
<p>3.8</p>	<p><u>Digital Maturity assessment</u></p> <p>NHS England have engaged with McKinsey to develop a 3 year programme of digital maturity assessment. This is built on the What Good Looks Like framework and is designed to assess digital maturity but more importantly help develop action plans to improve.</p> <p>WSFT has been involved in a peer review process and has been scored favourably in the upper quartile of assessments and is in line with comparable digitally mature Trusts within the region and nationally.</p>

3.9	<p><u>Oracle Cerner contract renewal</u></p> <p>Under the terms of the current 10 year contract with Cerner for their electronic patient record system (EPR), known locally as e-Care, the Trust has the option to extend for up to 5 years. Because of the commercial sensitivities, this was discussed under Digital board reserved matters.</p> <p>The current contract runs until July 2024</p>
<b>4.</b>	<b>Next steps</b>
4.1	The next meeting of the Digital board will be on 27 <sup>th</sup> September 2023
<b>5.</b>	<b>Conclusion</b>
5.1	The Digital board aims to be closely aligned with the Trust objectives
<b>6.</b>	<b>Recommendations</b>
	The board accepts the report as appropriate assurance

## 4. ASSURANCE



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

### Board assurance committee CKI report

<b>Originating Committee: Insight Committee</b>	<b>Date of meeting: 3 April 2023</b>
<b>Chaired by: Antoinette Jackson</b>	<b>Lead Executive Director: Nicola Cottingham</b>

<b>Agenda item</b>	<b>Details of Issue (summary of discussion)</b>	<b>Level of Assurance (1, 2, 3 or 4):</b> 1. Substantial 2. Reasonable 3. Partial 4. Minimal	<b>Reason/s for 'Partial' or 'No assurance' and actions to mitigate (with timescale) *</b>	<b>Action / escalation (1, 2, 3 or 4):</b> 1. No action/escalation 2. Action by the committee with timescale (target date) 3. Refer to other assurance committee / SLT for action 4. Escalate to Board
<b>Finance Accountability Committee</b>	<b>New Purchase to Pay (P2P) IT system</b>	Reasonable	Current P2P contract expires on 1 July and if the current implementation plan should fail to deliver by 30 June the Trust would need to revert to a paper-based procurement system.	Weekly meetings in place with provider to ensure implementation stays on track but there is still some residual risk.

Agenda item	Details of Issue (summary of discussion)	Level of Assurance (1, 2, 3 or 4): 1. Substantial 2. Reasonable 3. Partial 4. Minimal	Reason/s for 'Partial' or 'No assurance' and actions to mitigate (with timescale) *	Action / escalation (1, 2, 3 or 4): 1. No action/escalation 2. Action by the committee with timescale (target date) 3. Refer to other assurance committee / SLT for action 4. Escalate to Board
<b>Finance Accountability Committee</b>	<b>Capital Programme</b> We are forecasting an overspend of £6.1m due to unsuccessful diagnostic funding bid.	<b>Partial</b>	We require regional underspends elsewhere to break even. Should this not occur there is a risk that next year's capital programme will be top-sliced and we will not be able to deliver our programme as planned.	4 Escalation to Board
<b>Finance Accountability Committee</b>	<b>Budget deficit and CIP programme</b> The benchmarking work underway has identified some new areas for focus but there remains a gap between target and planned savings of around £3m	<b>Partial</b>	Will need careful monitoring going forward.	4 Escalation to Board
<b>Patient Access Governance Group</b>	<b>MRI Recovery Action Plan</b> MRI operating at full capacity across 7 days, but demand is outstripping capacity. The recovery trajectory is dependent on the opening of Newmarket CDC.	<b>Partial</b>	The options for a temporary scanner to help in the meantime is being reviewed but this is an expensive option and funding would need to be identified.	2 Follow-up of progress

Agenda item	Details of Issue (summary of discussion)	Level of Assurance (1, 2, 3 or 4): 1. Substantial 2. Reasonable 3. Partial 4. Minimal	Reason/s for 'Partial' or 'No assurance' and actions to mitigate (with timescale) *	Action / escalation (1, 2, 3 or 4): 1. No action/escalation 2. Action by the committee with timescale (target date) 3. Refer to other assurance committee / SLT for action 4. Escalate to Board
<b>Patient Access Governance Group</b>	<p><b>Elective Access</b></p> <p>We noted the hard work that has gone into reducing long waits and the impact this is beginning to have. There has been good progress made on the number of patients waiting over 104 weeks with just one remaining; 139 waiting over 78 weeks; and 1235 over 52 weeks – all improved positions.</p>	<b>Reasonable</b>	The 23/34 focus will be on patients waiting over 65 weeks which will be challenging, with a trajectory assuming 187 will be waiting more than this by March 2024, against a target of zero.	2 Follow-up of progress
<b>Patient Access Governance Group</b>	<p><b>Glemsford</b></p> <p>There have been improvements in the number of patients waiting over two weeks for an appointment.</p>	<b>Reasonable</b>	The new 23/24 GP contract has implication for ways of working at the practice (they can no longer ask patients to call back so may have to make more appointments available). The likely impact of this is currently being assessed.	2 Follow-up of progress

Agenda item	Details of Issue (summary of discussion)	Level of Assurance (1, 2, 3 or 4): 1. Substantial 2. Reasonable 3. Partial 4. Minimal	Reason/s for 'Partial' or 'No assurance' and actions to mitigate (with timescale) *	Action / escalation (1, 2, 3 or 4): 1. No action/escalation 2. Action by the committee with timescale (target date) 3. Refer to other assurance committee / SLT for action 4. Escalate to Board
<b>Deep Dive Urgent and Emergency Care recovery</b>	<p><b>Urgent and Emergency Care recovery</b></p> <p>There is a comprehensive action plan in place in two phases. Phase 1 has an 8-week acute focus and Phase 2 a longer-term system focus.</p> <p>4-hour performance is being monitored internally, with external reporting commencing from 15<sup>th</sup> May, with a trajectory to reach 76% by March 2024.</p>	<b>Partial</b>	Confidence is higher with regard to Phase 1 of the action plan as it is within the Trust's control to deliver. Phase 2 is more challenging as it relies on the whole system to deliver.	2 Follow-up of progress
<b>IQPR</b>	<p><b>IQPR</b></p> <p>Work has begun to see how we can better report future performance trajectories in Assurance Committee reports.</p>	<b>Substantial</b>		

## Board assurance committee - Committee Key Issues (CKI) report

Originating Committee:			Date of meeting:		
Chaired by:			Lead Executive Director:		
Agenda item	WHAT? <i>Summary of issue, including evaluation of the validity the data*</i>	Level of Assurance* 1. Substantial 2. Reasonable 3. Partial 4. Minimal	For 'Partial' or 'Minimal' level of assurance complete the following:		
			SO WHAT? <i>Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk</i>	WHAT NEXT? <i>Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)</i>	Escalation: 1. No escalation 2. To other assurance committee / SLT 3. Escalate to Board
<b>Finance Accountability Committee</b>	<b>Budget deficit and CIP programme</b> The CIP programme has identified savings of £6.8m against a target of £10.6 but only £5.6m are recurrent savings. There are 41 schemes planned for 23/24 delivery but only 2 have been through the QIA process.	4 Minimal	There is further work needed to identify further savings especially recurrent savings	Finance Accountability Committee is doing further work on this and will report back to June Insight Committee	3. Escalate to Board
<b>Finance Accountability Committee</b>	<b>Purchase to Pay</b> There is a lack of confidence that the new system would be available for the 1 July.	3 Partial	If the system is not live there will be implications for the payments process across the Trust and an operational impact on services. Even if implemented there would still be around 400 requisitioners who will	Two options are being explored 1 extending the existing contract with an unsupported system 2 paper based requisitioning	3. Escalate to Board

Originating Committee:			Date of meeting:		
Chaired by:			Lead Executive Director:		
Agenda item	WHAT? <i>Summary of issue, including evaluation of the validity the data*</i>	Level of Assurance* 1. Substantial 2. Reasonable 3. Partial 4. Minimal	For 'Partial' or 'Minimal' level of assurance complete the following:		
			SO WHAT? <i>Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk</i>	WHAT NEXT? <i>Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)</i>	Escalation: 1. No escalation 2. To other assurance committee / SLT 3. Escalate to Board
			require training on the new system.		
<b>Finance Accountability Committee</b>	<b>Contract Issues</b> Allocate rostering system	4 Minimal	An extension has not been agreed and current contract ends in April 2023	Talks are being held with supplier to resolve	3. Escalate to Board
	Medi bleep contract	3 Partial	The current supplier will cease and the new contract will not be in place until after June 2023  The committee questioned the number of late tendering exercises	Business continuity plans are in place.  Work is being developed on procurement contract register to improve forward planning for all tendering processes	3. Escalate to Board

Originating Committee:			Date of meeting:		
Chaired by:			Lead Executive Director:		
Agenda item	WHAT? <i>Summary of issue, including evaluation of the validity the data*</i>	Level of Assurance* 1. Substantial 2. Reasonable 3. Partial 4. Minimal	For 'Partial' or 'Minimal' level of assurance complete the following:		
			SO WHAT? <i>Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk</i>	WHAT NEXT? <i>Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)</i>	Escalation: 1. No escalation 2. To other assurance committee / SLT 3. Escalate to Board
Patient access Group /IQPR data	<p>Urgent and Emergency Ambulance handover times remain a challenging picture, failing to meet the targets and with no significant improvement demonstrated.</p> <p>Similarly, no improvement has taken place in the number of 12-hour length of stay patients, in March 12.9% of attendees remained in department more than 12 hours.</p>	3 Partial	<p>March was a challenging month in terms of flow, the Trust experienced 2 critical internal incidents, a three-day period of industrial action from junior doctors, multiple bay and ward closures for norovirus. There was also an increase in Covid activity, with an average number of 50 patients per day across March. These incidents had a direct influence on the flow out of ED as seen in the increase in 12 hour waits.</p>	<p>UEC recovery plan in place currently focusing on Phase 1 actions.</p> <p>A "Missed Opportunities" Audit with NHSE Improvement reviewed all patients attending ED in a 24-hour period. Colleagues across system involved to identify alternative pathways.</p> <p>Harm Reviews being undertaken for a percentage of 12 hours stays and patients waiting in ambulances for more than 1 hour. Outcomes will be reported to Insight in June 23</p>	3 Escalate to Board



<b>Originating Committee:</b>			<b>Date of meeting:</b>		
<b>Chaired by:</b>			<b>Lead Executive Director:</b>		
Agenda item	WHAT? <i>Summary of issue, including evaluation of the validity the data*</i>	Level of Assurance* 1. Substantial 2. Reasonable 3. Partial 4. Minimal	For 'Partial' or 'Minimal' level of assurance complete the following:		
			SO WHAT? <i>Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk</i>	WHAT NEXT? <i>Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)</i>	Escalation: 1. No escalation 2. To other assurance committee / SLT 3. Escalate to Board
Patient access Group /IQPR data	<p><b>Cancer access</b></p> <p>Increase in referrals.</p> <p>None of the KPI's demonstrating an improving trend as of yet, there is a trajectory in place for the 28-day standard and 62-day backlog as operational priorities for 23/24.</p> <p>For 2-week wait performance, Breast Cancer continues to be the main driver for under performance at 12% compliance.</p>	3 Partial	Breast Cancer is successfully maintaining over 88% compliance for 28-day pathways despite the low performance against the 2 week wait standard, underlining the need to look at the data in the round and not just single indicators.	A quality improvement plan is in place and recovery is monitored through SNEE Cancer Board and Cancer Alliance forums.	3 Escalate to Board

Originating Committee:			Date of meeting:		
Chaired by:			Lead Executive Director:		
Agenda item	WHAT? <i>Summary of issue, including evaluation of the validity the data*</i>	Level of Assurance* 1. Substantial 2. Reasonable 3. Partial 4. Minimal	For 'Partial' or 'Minimal' level of assurance complete the following:		
			SO WHAT? <i>Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk</i>	WHAT NEXT? <i>Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)</i>	Escalation: 1. No escalation 2. To other assurance committee / SLT 3. Escalate to Board
	The 62 day backlog was 121 patients at the end of March 2023 and well on track to deliver 98 by March 2024, as has been set by the national team.				
Patient access Group /IQPR data	<p><b>Elective Access</b></p> <p>The 52-week and 78-week position is demonstrating continued improvement, with the 78-week end of year position at 41 capacity breaches, following an original forecast of 200 and revised forecast of 100.</p> <p>The number of patients over 104 weeks was 2, both of</p>	3 Partial	The focus continues to be on reducing the longest waiters. The 2 patients over 104 weeks had been referred elsewhere and new process have been put in place to track this more effectively.	ICB Transformation project in place, taking a cross discipline approach including outpatients and theatre productivity.  65-week actions include review by NHSE Regional Medical Director, demand and capacity review using national intensive support team tools,	3 Escalate to Board

<b>Originating Committee:</b>			<b>Date of meeting:</b>		
<b>Chaired by:</b>			<b>Lead Executive Director:</b>		
<b>Agenda item</b>	<b>WHAT?</b> <i>Summary of issue, including evaluation of the validity the data*</i>	<b>Level of Assurance*</b> 1. Substantial 2. Reasonable 3. Partial 4. Minimal	<b>For 'Partial' or 'Minimal' level of assurance complete the following:</b>		
			<b>SO WHAT?</b> <i>Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk</i>	<b>WHAT NEXT?</b> <i>Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)</i>	<b>Escalation:</b> 1. No escalation 2. To other assurance committee / SLT 3. Escalate to Board
	<p>which were picked up on revalidation.</p> <p>A Trajectory has been submitted predicting 154 patients waiting over 65 weeks at end of March 2024, therefore not compliant with national target of zero.</p>			<p>exploration of mutual aid with neighbouring Trusts.</p> <p>The trajectory will continue to be monitored through PAGG for impact of additional actions.</p>	

Originating Committee:			Date of meeting:		
Chaired by:			Lead Executive Director:		
Agenda item	WHAT? <i>Summary of issue, including evaluation of the validity the data*</i>	Level of Assurance* 1. Substantial 2. Reasonable 3. Partial 4. Minimal	For 'Partial' or 'Minimal' level of assurance complete the following:		
			SO WHAT? <i>Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk</i>	WHAT NEXT? <i>Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)</i>	Escalation: 1. No escalation 2. To other assurance committee / SLT 3. Escalate to Board
Patient access Group /IQPR data	We noted CT recovery achieved 99% and there has also been some improvement in MRI, Ultrasound, Audiology and Urodynamics.	3 Partial		MRI discussions with SNEE re mutual aid but only ad hoc at present. Funding discussions on going.  Endoscopy deep dive to be considered by Insight in June.	3 Escalate to Board
Patient access Group /IQPR data	<b>Stroke performance</b>  We noted WSFT was highlighted as the top performing stroke unit nationally for the last quarter.	1 substantial			3 Escalate to Board for information

*\*See guidance notes for more detail*

## Guidance notes

### The practice of scrutiny and assurance

	Questions regarding quality of evidence...	Further consideration...
<p><b>What?</b></p> <p>Deepening <b>understanding</b> of the evidence and ensuring its <b>validity</b></p>	<p><b>Validity</b> – the degree to which the evidence...</p> <ul style="list-style-type: none"> <li>• measures what it says it measures</li> <li>• comes from a reliable source with sound/proven methodology</li> <li>• adds to triangulated insight</li> </ul>	<ul style="list-style-type: none"> <li>• Good data without a strong narrative is unconvincing.</li> <li>• A strong narrative without good data is dangerous!</li> </ul>
<p><b>So what?</b></p> <p>Increasing <b>appreciation</b> of the <b>value</b> (importance and impact) – what this means for us</p>	<p><b>Value</b> – the degree to which the evidence...</p> <ul style="list-style-type: none"> <li>• provides real intelligence and clarity to board understanding</li> <li>• provides insight that supports good quality decision making</li> <li>• supports effective assurance, provides strategic options and/or deeper awareness of culture</li> </ul>	<ul style="list-style-type: none"> <li>• What is most significant to explore further?</li> <li>• What will take us from good to great if we focus on it?</li> <li>• What are we curious about?</li> <li>• What needs sharpening that might be slipping?</li> </ul>
<p><b>What next?</b></p> <p>Exploring what should be <b>done next</b> (or not), informing <b>future</b> tactic / strategy, agreeing follow-up and future <b>evidence of impact</b></p>		<ul style="list-style-type: none"> <li>• Recommendations for action</li> <li>• What impact are we intending to have and how will we know we've achieved it?</li> <li>• How will we hold ourselves accountable?</li> </ul>

### Assurance level

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




## 4.2. Finance Report

To Assure

## Board of Directors – 26<sup>th</sup> May 2023

<b>Report title:</b>	Finance Board Report – April 2023
<b>Agenda item:</b>	4.2
<b>Executive lead:</b>	Craig Black, Executive Director of Resources
<b>Report prepared by:</b>	Nick Macdonald, Deputy Director of Finance

<b>For Approval</b> <input type="checkbox"/>	<b>For Assurance</b> <input checked="" type="checkbox"/>	<b>For Discussion</b> <input checked="" type="checkbox"/>	<b>For Information</b> <input checked="" type="checkbox"/>
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<b>Trust strategy</b>			
Please indicate ambitions relevant to this report	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

<b>Executive summary</b>
<p>The attached report predominately covers the month 12 position for 2022-23. It was felt appropriate to share the results for the 2022-23 financial year with the Trust Board. The report also provides a high-level summary of the position for month 1 of 2023-24.</p> <p><b>Income and Expenditure 2022-23</b></p> <p>Our reported position as at the end of 2022-23 was a surplus of £30k (after allowable adjustments), which is currently subject to audit. This is in line with our plan to break even, but we achieved this as a result of £15m of non-recurring support via SNEE ICB</p> <p><b>Income and Expenditure Plan for 2023-24</b></p> <p>The Income and Expenditure (I&amp;E) budget for the Trust is for a deficit of £2.7m in 2023-24, which includes achieving a Cost Improvement Programme (CIP) of 3% (£10.6m)</p> <p>The paper presented to Board in February 2023 noted a planned deficit of £20m to be submitted. This has improved significantly, due largely to central non-recurrent funding being made available to support our position in 2023-24. However, it is important to note that the Trust needs to demonstrate a trajectory of recurring financial improvement for 2024-25 due to the non-recurrent nature of the funding included in the 2023-24 plan.</p> <p>The I&amp;E position for April 2023 is broadly on plan.</p> <p><b>Capital 2022-23</b></p> <p>Our reported position as at the end of 2022/23 was a deficit of £4.2m, in line with our forecast previously agreed. This deficit was largely due to diagnostic equipment funding being unavailable, a position that was only communicated during March when the Trust had already ordered equipment at risk. This was an additional cost to the Trust in terms of cash, but the CDEL limit has been covered utilising underspends from elsewhere within the regional capital budgets.</p> <p>The capital position for April 2023 is on plan.</p>



<b>Action required of the Board</b>	
The Board is asked to review this report.	
<b>Recommendation</b>	
<b>Sustainability:</b>	The paper highlights potential risks to financial performance in 23/24.

# FINANCE REPORT

## April 2023 (Month 1)

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

### Financial Summary

I&E Position YTD	£0m	on-plan
Variance against Plan YTD	£0m	on-plan
Movement in month against plan	£0.2m	favourable
EBITDA position YTD	£18.2m	favourable
EBITDA margin YTD	5%	favourable
Cash at bank	£7.9m	

### Executive Summary

- The reported I&E for April is a small deficit in line with our plan
  - Plan includes delivering a CIP of £10.6m
  - Plan includes non-recurring support and
  - We require a trajectory that improves our underlying position
- This report focusses on the final position for 2022-23 (March 2023)
  - £30k surplus, in line with our plan to break even (subject to audit)
  - Includes £15m of non-recurring support via SNEE ICB
  - Capital overspend of £4.2m, of which the additional CDEL was covered by regional underspends

### Key Risks in 2023-24





- Shortfall on funding of pay awards and non-pay inflation
- Delivering challenging CIP
- Unanticipated costs of industrial action.
- Inability to earn ERF for performance





SUMMARY INCOME AND EXPENDITURE ACCOUNT - March 2023	March 2023				Year to date			Year end forecast		
	Budget	Actual	Variance F/(A)	Variance to Prior Month F/(A)	Budget	Actual	Variance F/(A)	Budget	Actual	Variance F/(A)
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
NHS Contract Income	25.0	28.6	3.6	1.3	314.5	322.2	(322.2)	314.5	322.2	(322.2)
Other Income	3.5	15.2	11.7	10.2	39.1	51.8	(51.8)	39.1	51.8	(51.8)
<b>Total Income</b>	<b>28.5</b>	<b>43.8</b>	<b>15.3</b>	<b>11.5</b>	<b>353.6</b>	<b>374.0</b>	<b>(374.0)</b>	<b>353.6</b>	<b>374.0</b>	<b>(374.0)</b>
Pay Costs	20.3	31.2	(10.9)	(10.0)	241.1	250.1	250.1	241.1	250.1	250.1
Non-pay Costs	7.0	10.5	(3.6)	(2.4)	97.4	105.6	105.6	97.4	105.6	105.6
<b>Operating Expenditure</b>	<b>27.3</b>	<b>41.8</b>	<b>(14.5)</b>	<b>(12.5)</b>	<b>338.5</b>	<b>355.8</b>	<b>355.8</b>	<b>338.5</b>	<b>355.8</b>	<b>355.8</b>
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
<b>EBITDA excl STF</b>	<b>1.2</b>	<b>2.0</b>	<b>0.8</b>	<b>(1.0)</b>	<b>15.1</b>	<b>18.2</b>	<b>(18.2)</b>	<b>15.1</b>	<b>18.2</b>	<b>(18.2)</b>
Depreciation	0.8	1.5	(0.7)	(0.6)	9.8	11.9	11.9	9.8	11.9	11.9
Finance costs	0.4	0.3	0.1	1.8	5.3	6.3	6.3	5.3	6.3	6.3
<b>SURPLUS/(DEFICIT)</b>	<b>(0.0)</b>	<b>0.2</b>	<b>0.2</b>	<b>0.2</b>	<b>(0.0)</b>	<b>0.0</b>	<b>(0.0)</b>	<b>(0.0)</b>	<b>0.0</b>	<b>(0.0)</b>

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➤ Capital	Page 6

**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 – April 2023

## Income and Expenditure Summary as at April 2023

### Income and Expenditure Plan for 2023-24

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

The paper presented to board in February 2023 noted a planned deficit of £20m to be submitted. This has improved significantly, due largely to central non-recurrent funding being made available to support our position in 23-24. However, it is important to note that the Trust needs to demonstrate a trajectory of recurring financial improvement for 24-25 due to the non-recurrent nature of the funding included in the 23-24 plan.

Our position at month 1 is broadly in line with our plan. However, since there was no Board report provided at the year end we have focussed our reporting this month on the 2022-23 outturn position and our CIP progress for 2023-24.

### Income and Expenditure 2022-23

Our reported position as at the end of 2022-23 was a surplus of £30k, which is currently subject to audit. This is in line with our plan to break even, but we achieved this as a result of £15m of non-recurring support via SNEE ICB

## Summary of I&E indicators

Income and Expenditure	Plan/ Target £000'	Actual/ Forecast £000'	Variance to plan (adv)/ fav £000'	Direction of travel (variance)	RAG (report on red)
In month surplus/ (deficit)	(0)	199	199	↑	Green
YTD surplus/ (deficit)	0	30	30	↑	Green
EBITDA YTD	15,101	18,200	3,099	↑	Green
EBITDA %	4.3%	4.9%	0.6%	↓	Green
Clinical Income YTD	(327,770)	(333,766)	5,996	↑	Green
Non-Clinical Income YTD	(25,852)	(40,213)	14,360	↑	Green
Pay YTD	240,868	250,137	(9,269)	↓	Red
Non-Pay YTD	112,770	122,992	(10,222)	↓	Red
CIP Target YTD					Green

Page 3

## Cost Improvement Programme (CIP)

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

### Identification Progress

Division	Target (£'000)	No of schemes	Schemes with indicative value	Indicative value (£'000)	Notes
Medical Services	2,610	13	7	1,160	Includes full saving of drugs switch
Surgical Services	1,978	55	15	1,838	Includes full saving of drugs switch
Womens and Childrens Services	671	14	-	-	
Clinical Support Services	1,260	29	9	1,633	Excludes share of drugs switch
Community Services	1,588	36	8	585	
Estates and Facilities	676	34	14	626	Includes Car Parking & Catering increase
Corporate Services	1,817	1	1	1,000	
<b>Total</b>	<b>10,600</b>	<b>182</b>	<b>54</b>	<b>6,842</b>	

### Delivery for 23-24

Division	Schemes planned for 23/24 delivery	CYE (£'000)	Of which recurrent (£'000)	Non-recurrent (£'000)	Schemes at QIA	Value of schemes at QIA (£'000)
Medical Services	7	1,160	1,160	-	2	160
Surgical Services	6	1,103	1,103	-	-	-
Womens and Childrens Services	-	-	-	-	-	-
Clinical Support Services	9	1,633	1,633	-	-	-
Community Services	4	283	283	-	-	-
Estates and Facilities	14	626	626	-	-	-
Corporate Services	1	1,000	-	1,000	-	-
<b>Total</b>	<b>41</b>	<b>5,805</b>	<b>4,805</b>	<b>1,000</b>	<b>2</b>	<b>160</b>

### Delivery for 24-25

Division	Recurrent value in 24-25 of 23-24 delivery (£'000)	Identified schemes for 24-25
Medical Services	1,160	2
Surgical Services	1,603	3
Womens and Childrens Services	-	5
Clinical Support Services	1,633	2
Community Services	313	-
Estates and Facilities	928	12
Corporate Services	-	-
<b>Total</b>	<b>5,637</b>	<b>24</b>

# FINANCE REPORT – April 2023

## Trends and Analysis

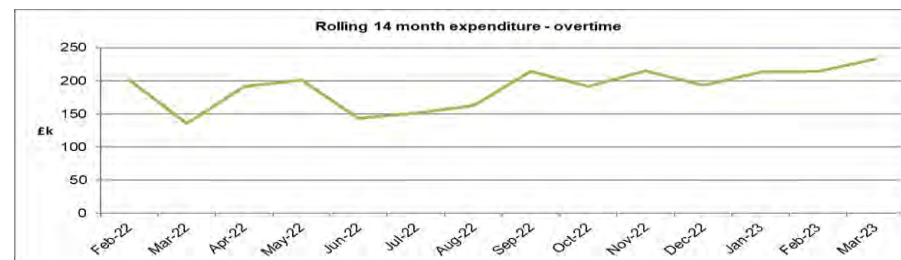
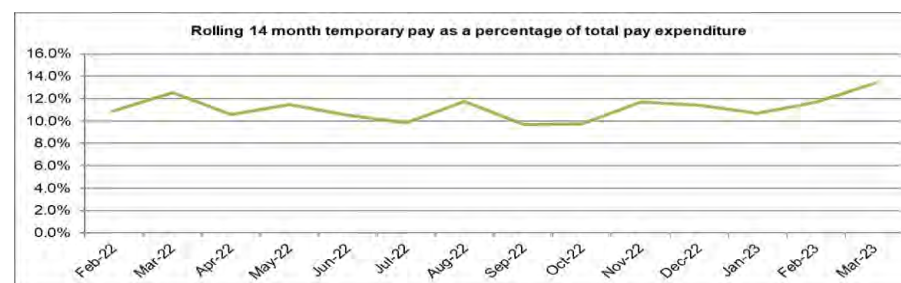
### Workforce

During February the Trust overspent by £1.0m on pay

Monthly Expenditure (£)				
As at March 2023				
	Mar-23	Feb-23	Mar-22	YTD
	£000's	£000's	£000's	£000's
<b>Budgeted Costs in-month</b>	20,117	20,178	18,374	240,868
<b>Substantive Staff</b>	20,337	18,736	20,020	215,578
Medical Agency Staff	202	312	158	2,242
Medical Locum Staff	514	369	522	4,824
Additional Medical Sessions	327	246	208	3,065
Nursing Agency Staff	299	227	131	1,584
Nursing Bank Staff	528	533	455	5,890
Other Agency Staff	650	146	243	2,067
Other Bank Staff	227	234	224	2,856
Overtime	233	215	179	2,325
On Call	163	197	126	1,949
<b>Total Temporary Expenditure</b>	3,142	2,480	2,246	26,800
<b>Total Expenditure on Pay</b>	23,479	21,216	22,266	242,379
Variance (F/(A))	(3,362)	(1,038)	(3,892)	(1,511)
Temp. Staff Costs as % of Total Pay	13.4%	11.7%	10.1%	11.1%
memo: Total Agency Spend in-month	1,151	686	532	5,893

Monthly WTE				
As at March 2023				
	Mar-23	Feb-23	Mar-22	YTD
<b>Budgeted WTE in-month</b>	4,825.1	4,826.2	4,647.2	69,619.1
<b>Substantive Staff</b>	4,456.8	4,411.4	4,189.9	51,302.8
Medical Agency Staff	21.9	13.0	10.7	137.4
Medical Locum Staff	50.1	43.0	27.9	482.7
Additional Medical Sessions	11.0	2.8	6.7	61.6
Nursing Agency Staff	25.7	22.9	15.5	193.9
Nursing Bank Staff	133.5	130.6	119.9	1,490.0
Other Agency Staff	53.5	41.9	23.9	349.1
Other Bank Staff	78.0	80.4	72.8	958.9
Overtime	57.4	51.9	45.1	578.9
On Call	6.3	8.7	6.8	97.5
<b>Total Temporary WTE</b>	437.3	395.1	329.4	4,350.0
<b>Total WTE</b>	4,894.1	4,806.5	4,519.3	55,652.8
Variance (F/(A))	(69.0)	19.7	127.9	13,966.3
Temp. Staff WTE as % of Total WTE	8.9%	8.2%	7.3%	7.8%
memo: Total Agency WTE in-month	101.0	77.7	50.1	680.4

## Pay Costs



# FINANCE REPORT – April 2023

## Statement of Financial Position as at 31 March 2023

### STATEMENT OF FINANCIAL POSITION

	As at		Plan		Plan YTD		Actual at		Variance YTD	
	1 April 2022	31 March 2023	31 March 2023	31 March 2023	31 March 2023	31 March 2023	31 March 2023	31 March 2023	31 March 2023	
	£000	£000	£000	£000	£000	£000	£000	£000	£000	
Intangible assets	52,039	56,905	56,905	61,869	4,964					
Property, plant and equipment	170,887	188,990	188,990	193,976	4,986					
Right of use assets		12,425	12,425	9,817	(2,608)					
Trade and other receivables	5,807	6,341	6,341	6,001	(340)					
<b>Total non-current assets</b>	<b>228,733</b>	<b>264,661</b>	<b>264,661</b>	<b>271,663</b>	<b>7,002</b>					
Inventories	3,574	3,689	3,689	4,365	676					
Trade and other receivables	15,069	18,362	18,362	41,871	23,509					
Non-current assets for sale	0	0	0	520	520					
Cash and cash equivalents	33,323	10,767	10,767	7,895	(2,872)					
<b>Total current assets</b>	<b>51,966</b>	<b>32,818</b>	<b>32,818</b>	<b>54,651</b>	<b>21,833</b>					
Trade and other payables	(60,164)	(38,925)	(38,925)	(73,503)	(34,578)					
Borrowing repayable within 1 year	(5,858)	(9,684)	(9,684)	(4,801)	4,883					
Current Provisions	(38)	(46)	(46)	(64)	(18)					
Other liabilities	(2,888)	(5,685)	(5,685)	(1,336)	4,349					
<b>Total current liabilities</b>	<b>(68,948)</b>	<b>(54,340)</b>	<b>(54,340)</b>	<b>(79,704)</b>	<b>(25,364)</b>					
<b>Total assets less current liabilities</b>	<b>211,751</b>	<b>243,139</b>	<b>243,139</b>	<b>246,610</b>	<b>3,471</b>					
Borrowings	(44,002)	(47,927)	(47,927)	(48,038)	(111)					
Provisions	(415)	(852)	(852)	(507)	345					
<b>Total non-current liabilities</b>	<b>(44,417)</b>	<b>(48,779)</b>	<b>(48,779)</b>	<b>(48,545)</b>	<b>234</b>					
<b>Total assets employed</b>	<b>167,334</b>	<b>194,360</b>	<b>194,360</b>	<b>198,065</b>	<b>3,705</b>					
<b>Financed by</b>										
Public dividend capital	200,285	227,311	227,311	230,215	2,904					
Revaluation reserve	11,704	11,704	11,704	12,054	350					
Income and expenditure reserve	(44,655)	(44,655)	(44,655)	(44,204)	451					
<b>Total taxpayers' and others' equity</b>	<b>167,334</b>	<b>194,360</b>	<b>194,360</b>	<b>198,065</b>	<b>3,705</b>					

The above table shows the position for 2022/23 as at 31 March 2023. This position is draft and is subject to audit.

The Trust's net assets have grown significantly and this is mainly due to the increase in the asset base and supporting PDC funding as a result of the Trust's large capital programme.

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

right of use assets balance is also the result of some disposals that we incurred for assets no longer owned by the Trust.

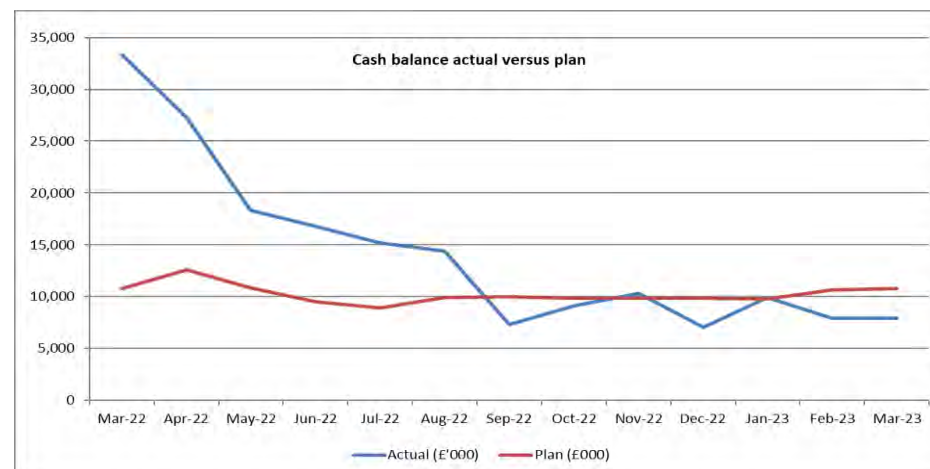
Trade receivables were higher than plan and this was due to £15m of additional funding given to the Trust by the ICB along with over £8.5m of funding for the 2022/23 pay award.

Trade payables have also increased, largely due to the number of capital creditors at the year end of £18.9m along with accrued expenditure of £8.9m for the pay award.

The Trust received additional PDC towards the end of the financial year to fund capital projects, which was not included in the original plan.

### Cash Balance for the year

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

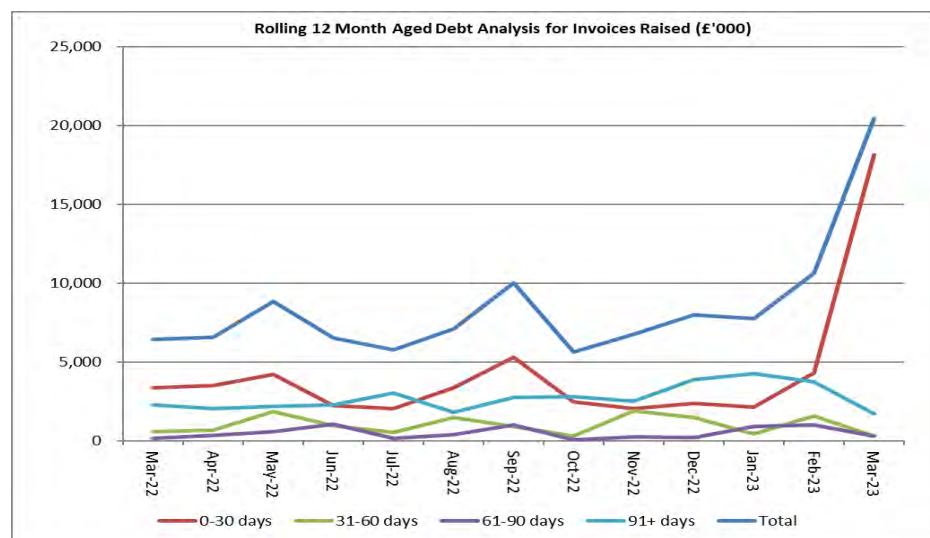


The cash position finished slightly below plan at month 12. Some of this relates to the fact that debtor balances remained outstanding at the year end. Cash flow forecasts continue to be submitted to NHS England every fortnight to ensure that adequate cash reserves are being held within the NHS.

# FINANCE REPORT – April 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 minimise the amount of money the Trust needs to borrow.

The overall level of sales invoices raised but not paid increased at the year end. This mainly relates to an invoice of £15m raised to the ICB which was not paid until April. If this balance was removed from the data, then the overall aged debt would be £5.4m.

Over 92% of the outstanding debts relate to NHS Organisations, with 7% of these NHS debts being greater than 90 days old.

## Capital Progress Report

Our reported position as at the end of 2022/23 was a deficit of £4.2m, in line with our forecast previously agreed. This deficit was largely due to diagnostic equipment funding being unavailable, a position that was only communicated during March when the Trust had already ordered equipment at risk. This was an additional cost to the Trust in terms of cash, but the CDEL limit has been covered utilising underspends from elsewhere within the regional capital budgets.

The table below shows the capital spend for 2022/23 against the original plan.

Capital Spend - 31st March 2023	Year to Date			Funding Split		Full Year Forecast to 31st Mar 2023	Total Full Year Variance Actual vs Available Funds
	YTD Original Plan	YTD Actual	Variance	Internal £000's	PDC Available £000's		
	£000's	£000's	£000's			£000's	£000's
New Hospital (Future Systems)	1,060	2,152	- 1,092	1,000	1,332	2,332	180
RAAC	21,000	22,579	- 1,579		22,500	22,500	79
Estates	1,435	3,643	- 2,208	1,435	2,318	5,073	110
IM&T	5,675	10,191	- 4,516	5,675	1,713	10,688	2,803
Medical Equipment	400	1,800	- 1,400	400	759	1,159	641
Imaging Equipment	1,740	4,859	- 3,119	740	1,308	3,526	2,811
Disposals	-	1,840	1,840	-	-	1,840	1,840
<b>Total Capital Schemes (excluding IFRS16 impact)</b>	<b>31,310</b>	<b>43,384</b>	<b>- 12,074</b>	<b>9,250</b>	<b>29,930</b>	<b>45,278</b>	<b>4,204</b>

The Capital Plan for 2023/24 is £56.4m, which includes an additional £2.5m of funding awarded for the RAAC project. The capital position for April 2023 is on plan.

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



### Board assurance committee CKI report

<b>Originating Committee: Improvement Committee</b>			<b>Date of meeting: 17 April 2023</b>	
<b>Chaired by: Louisa Pepper</b>			<b>Lead Executive Director: Sue Wilkinson</b>	
<b>Agenda item</b>	<b>Details of Issue (summary of discussion)</b>	<b>Level of Assurance (1, 2, 3 or 4):</b> 1. Substantial 2. Reasonable 3. Partial 4. Minimal	<b>Reason/s for 'Partial' or 'No assurance' and actions to mitigate (with timescale) *</b>	<b>Action / escalation (1, 2, 3 or 4):</b> 1. No action/escalation 2. Action by the committee with timescale (target date) 3. Refer to other assurance committee / SLT for action 4. Escalate to Board
Quality and Safety Datasets	Nutrition assessments within 24hours – current performance is 82.5% (although of note all patients were/are assessed within 48 hours). Gap analysis being undertaken with some indications that this is <u>partially</u> linked with ED extended length of stays.	Partial	Full analysis of the subject to be undertaken and areas identified for improvement.	The Committee agreed to review this subject in three months.
Increasing the Safety of Long Stay Patients within ED, when above a safe level of capacity.	The committee discussed this matter at length and was assured that a number of complex issues e.g. PU's, Mental Health was considered and mitigation including the use of equipment, specialist staff and digital solutions to improve the quality of patient experience and flow through the department.	Reasonable	An on-going complex improvement plan has been scoped and developed.	The Committee agreed to review this subject in three months.
Clinical Effective Governance	Biochemistry – Committee discussed the accreditation of the laboratory and	Partial	On-going debate with Estates to identify a solution. The Committee acknowledged the	Referral to SLT.

Originating Committee: Improvement Committee			Date of meeting: 17 April 2023	
Chaired by: Louisa Pepper			Lead Executive Director: Sue Wilkinson	
Agenda item	Details of Issue (summary of discussion)	Level of Assurance (1, 2, 3 or 4): 1. Substantial 2. Reasonable 3. Partial 4. Minimal	Reason/s for 'Partial' or 'No assurance' and actions to mitigate (with timescale) *	Action / escalation (1, 2, 3 or 4): 1. No action/escalation 2. Action by the committee with timescale (target date) 3. Refer to other assurance committee / SLT for action 4. Escalate to Board
Group	the concern that due to the estate, the laboratory was unlikely to achieve accreditation.		balance of spending money on an aging building whilst a new hospital is being developed.	Escalate to Board.
Clinical Effective Governance Group.	National Safety Standards for Invasive Procedures Centre for Perioperative Care. This is a recent NHS framework with a requirement to develop an improvement plan (like Ockenden with specific areas and wider organisational implications).	? too early to say	This is a new publication with associated actions for both Boards and the wider Trust. The Committee is seeking assurance in respect of the capacity for the Trust to address this and other improvement plans.	Refer to Involvement Committee for People and OD aspects of the framework.  Escalate to the Board.
Quality Priorities 2023/24	The committee received the final draft of the quality priorities for inclusion in the 2022/23 annual report and quality accounts.	Substantial		Mention to board.
Ockenden Plan - Organisation	The Committee were assured that a gap analysis had been undertaken and areas demonstrating compliance with associated supporting information and areas for development and action had been undertaken. The Committee will receive a comprehensive update at the	Partial	On-going improvement plan developed and associated organisational work being undertaken.	Refer to Involvement Committee for People and OD aspects of the plan.  Escalate to Board.

<b>Originating Committee: Improvement Committee</b>			<b>Date of meeting: 17 April 2023</b>	
<b>Chaired by: Louisa Pepper</b>			<b>Lead Executive Director: Sue Wilkinson</b>	
<b>Agenda item</b>	<b>Details of Issue (summary of discussion)</b>	<b>Level of Assurance (1, 2, 3 or 4):</b> 1. Substantial 2. Reasonable 3. Partial 4. Minimal	<b>Reason/s for 'Partial' or 'No assurance' and actions to mitigate (with timescale) *</b>	<b>Action / escalation (1, 2, 3 or 4):</b> 1. No action/escalation 2. Action by the committee with timescale (target date) 3. Refer to other assurance committee / SLT for action 4. Escalate to Board
	next meeting			




\* Please provide any supporting papers separately

## 4.4. Quality and Nurse Staffing Report

To Assure

### Board of Directors - Public

<b>Report title:</b>	<b>Quality and Workforce Report &amp; Dashboard – March and April</b>
<b>Agenda item:</b>	4.4
<b>Date of the meeting:</b>	26 May, 2023
<b>Sponsor/executive lead:</b>	Sue Wilkinson, Chief Nurse
<b>Report prepared by:</b>	Dan Patterson, Deputy Chief Nurse

<b>Purpose of the report:</b>			
<b>For approval</b> <input type="checkbox"/>	<b>For assurance</b> <input checked="" type="checkbox"/>	<b>For discussion</b> <input type="checkbox"/>	<b>For information</b> <input type="checkbox"/>
<b>Trust strategy ambitions</b>			
Please indicate Trust strategy ambitions relevant to this report.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

<b>Executive Summary</b>
<p>This paper reports on safe staffing fill rates and mitigations for inpatient areas for March and April 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.</p> <p><b>Highlights</b></p> <ul style="list-style-type: none"> <li>• Total RN/RM vacancy rate continues in special cause improvement and below 10% vacancy target at 7.1%</li> <li>• Turn over for RN/RM has improved further and remains under 10%</li> <li>• Turnover for NAs has improved for this rolling 12 months for the first time following sustained increase</li> <li>• Sustained capacity pressures have resulted in the continuation of the winter escalation ward throughout April, planned to close in June 2023</li> <li>• Fill rates have improved across all shifts and roles in April 2023 and above 90% for night shifts</li> <li>• Further industrial action taken by the RCN April. Robust mitigation taken</li> <li>• CHPPD remains below expected due to high bed occupancy and staffing shortfalls</li> <li>• Community services completed first audit of the community version of the safe staffing tool</li> </ul>
<b>Action Required of the Board</b>
<p>For assurance around the daily mitigation of nurse staffing and oversight of nursing establishments No action needed</p>

<b>Risk and assurance:</b>	Red Risk 4724 amended to reflect surge staffing and return to BAU
<b>Equality, Diversity, and Inclusion:</b>	N/A
<b>Sustainability:</b>	Efficient deployment of staff and reduction in temporary staffing and improving vacancy rates contributes to financial sustainability
<b>Legal and regulatory context</b>	<i>Compliance with CQC regulations for provision of safe and effective care</i>

## 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 March and April within the data submission deadline. Table 1 shows the summary of overall fill rate percentages for these months and for comparison, the previous four months. Appendix 1a and 1b illustrates a ward-by-ward breakdown for March and April 2023

	Day		Night	
	Registered	Care Staff	Registered	Care staff
Average fill rate November 2022	87%	74%	89%	94%
Average fill rate December 2022	84%	72%	85%	86%
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%

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

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

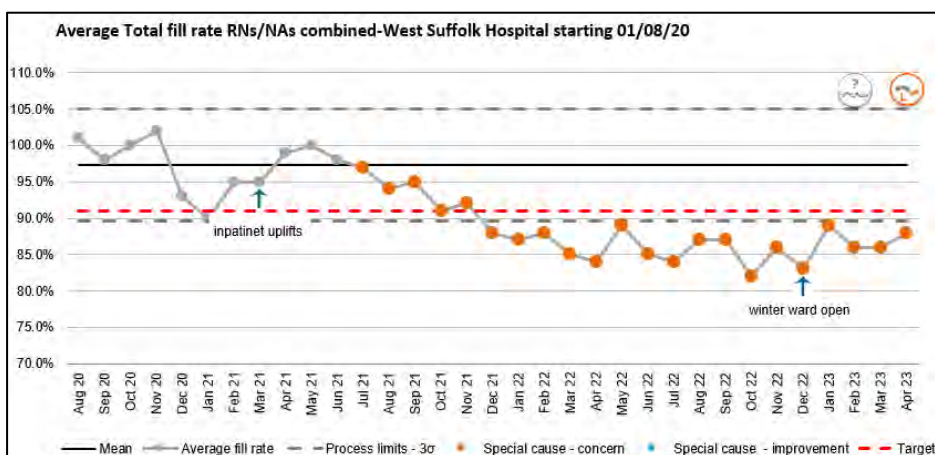


Chart 2.

### Care hours per patient Day (CHPPD)

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

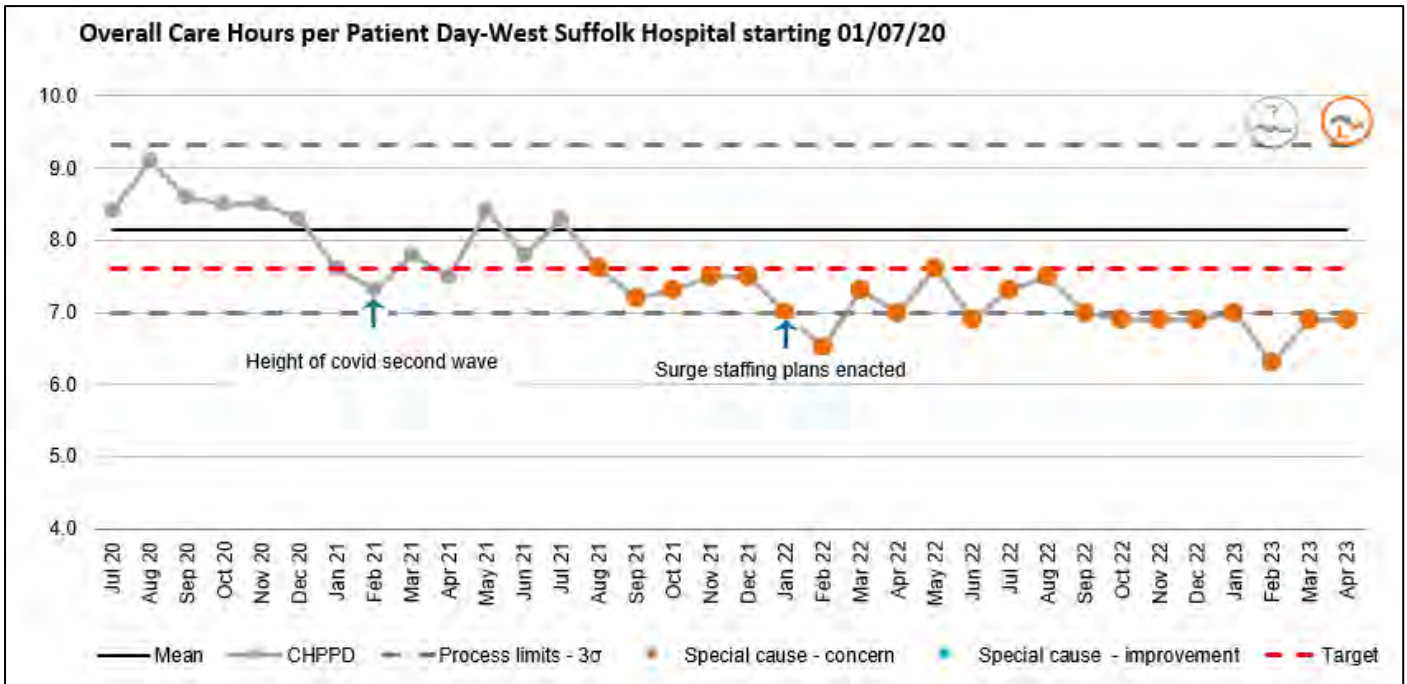


Chart 3 Adapted from model hospital/unify data

### 3. Sickness

Sickness rates have remained reasonably static within both staff groups. With RN sickness at lowest rate in last year.

	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 2
Unregistered staff (support workers)	6.84%	7.95%	6.41%	8.76%	7.21%	6.27%	7.27%	7.41%
Registered Nurse/Midwives	4.68%	5.44%	4.91%	6.56%	4.53%	4.89%	4.75%	4.06%
Combined Registered/Unregistered	<b>5.42%</b>	<b>6.29%</b>	<b>5.42%</b>	<b>7.30%</b>	<b>5.43%</b>	<b>5.36%</b>	<b>5.60%</b>	<b>5.20%</b>

Table 4

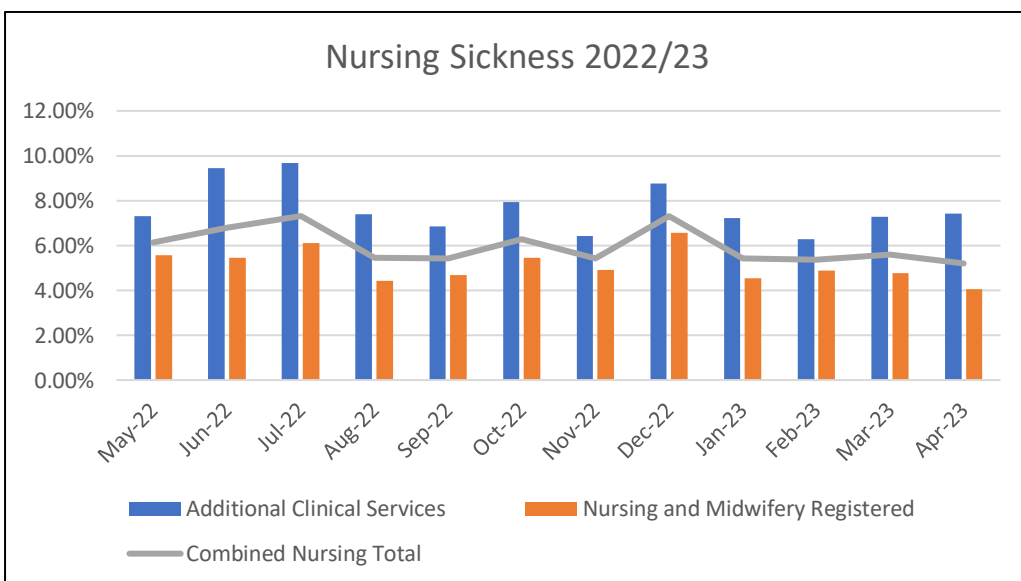


Chart 4a



#### 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 has been provided by an established matron and ward sister to provide consistency. This ward remains open at the time of writing. However, it has now moved to F9 which has further increased the bed base.

Following continued demand and capacity challenges the additional ward, now F9 has been agreed to remain open for an additional two months with a phased closure commencing in June. This further extends the challenges to staffing fill rates and will negatively impact on the potential benefits of the improved RN staffing picture

#### 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 improved from 12.4% to 10.2% (March)
- Total RN/RM establishment and vacancy rate continues special cause improvement in this reporting period and is now below 10% target ambition of 7.1%
- 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 remained static 11.4% to 11.5% and is common cause variation. Static vacancy rate has been driven by uplift in x-ray and outpatient budgets in period 11
- 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 requires moving staff from other wards daily and adversely affecting their planned fill rate.

	Inpatient	Sum of Actuals Period 08 (Nov)	Sum of Actuals Period 09 (Dec)	Sum of Actuals Period 10 (Jan)	Sum of Actuals Period 11 (Feb)	Sum of Actuals Period 12 (March)	Sum of Actuals Period 1 (April)	WTE VACANCY at period 12
RN/RM Substantive	Ward WTE	624.8	629	629.3	640.3	656.8	671.1	74.4*
Nursing Unregistered Substantive	Ward WTE	389	384.7	392.2	398.3	400.6	407.8	49.2*

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

\*At the time of writing 23/34 budget are pending formal sign off so assumptions around vacancies cannot be documented for April as known uplifts in a small number of areas will affect accuracy”

#### 6. New Starters and Turnover

International Nurse Recruitment:

The well-established international nursing pipeline continues, and we are on track to achieve our 2023 target. We have declined the additional NHSE offer of further funding to increase our pipeline as our current plans are progressing well and will meet our current demands. Due to the success of the pipeline we are finding

areas that are now fully recruited and unable to take on further recruits so adding to current plans is not necessary at this time. The international midwifery program is progressing well, and we currently have eleven international midwives that are completing their studies, four of these have already completed and are practicing as registered midwives.

International AHP recruitment has progressed to formal engagement with a recruitment agency and roles are currently out to advert with anticipated interviews mid May.

New starters

	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23*	Apr 23
Registered Nurses	24	25	9	20	33	23
Non-Registered	40	9	23	25	47	23

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 March, 33 RNs completed induction; of these; 26 were for the acute, 4 for community and 3 for midwifery
- In March, 47 NAs completed induction; of these; 23 NAs are for the acute Trust, 10 for bank services and 14 for community services
- In April, 23 RNs completed induction; of these; 12 were for acute services, 7 for bank, 2 for maternity 2 for community services
- In April, 23 NAs completed induction; of these; 14 NAs are for the acute Trust, 5 for bank services and 1 for community services

Turnover

On a retrospective review of the last rolling twelve months, turnover for RNs has improved again to under the ambition of 10%. Turnover is now 8.9%. NA turnover has reduced following a significant period of sustained increase from 25.02% to 24.5%. 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.

Staff Group	Turnover		01/05/2022 - 30/04/2023		Leavers Headcount	Leavers FTE	LTR Headcount %	LTR FTE %
	Average Headcount	Avg FTE	Starters Headcount	Starters FTE				
Nursing and Midwifery Registered	1,363.00	1,182.8025	101	81.4134	133	104.8000	9.7579%	8.8603%
Additional Clinical Services	597.50	499.4716	300	270.3634	153	122.6098	25.6067%	24.5479%

Table 7. (Data from workforce information)

**7. Quality Indicators**

Falls and acquired pressure ulcers

Both falls and pressure ulcers incidents remain in common cause variation (chart 8 & 9). A full narrative around this quality measure interventions can be found in the IQPR (not inclusive of April data)

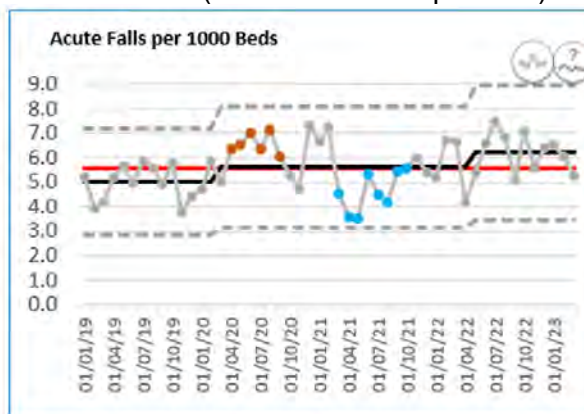
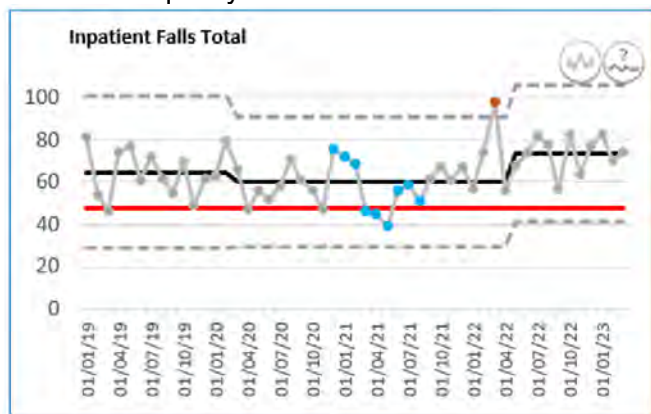


Chart 8  
Pressure Ulcers

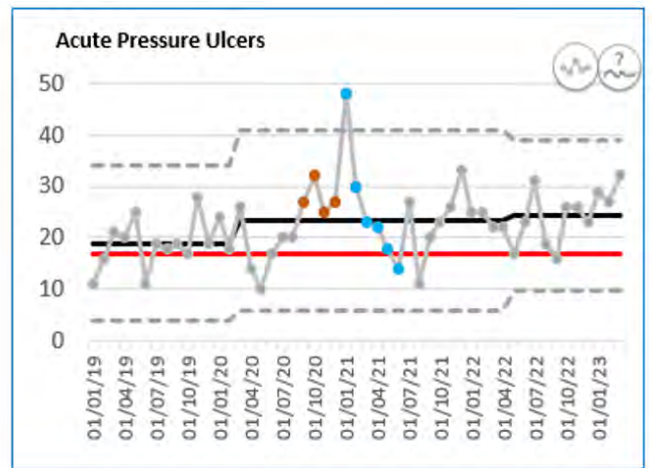
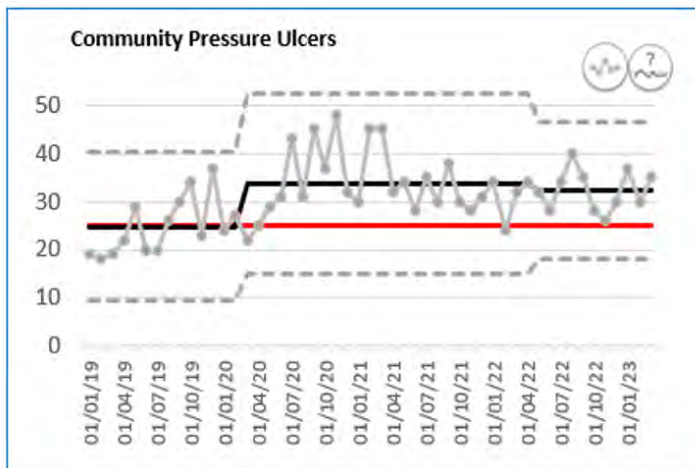


Chart 9

8. Compliments and Complaints

17 formal complaints were received in March. 10 of the complaints received were for the medical division, 1 for the surgical division, 1 for women & children’s division, 3 complaints were received for the integrated community services division and 2 were received for the clinical support division.

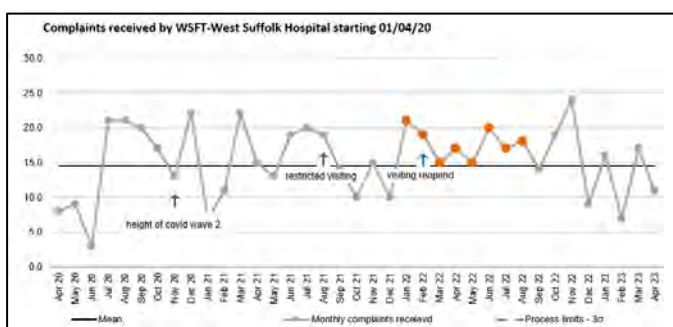
The emergency department received the highest number of formal complaints with 7 being received in March 2023. Dermatology department office and community paediatric SLT each received 2 formal complaints.

The main theme for complaints in March 2023 was for clinical treatment with 9 complaints being listed under this subject. These complaints include concerns about delays or failure to diagnose and delays in treatment. The next highest subjects were access to treatment or drugs and values & behaviours (staff) with 2 complaints being listed under each of these.

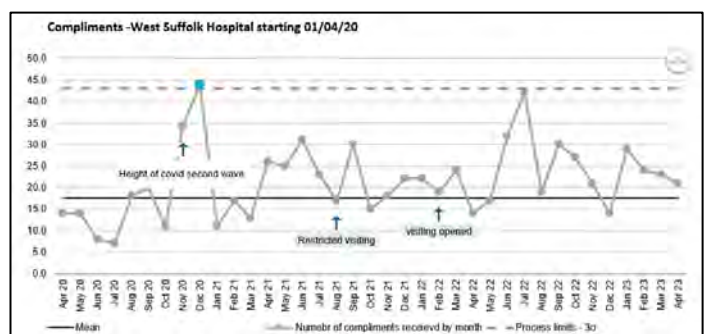
11 formal complaints were received in April. 6 of the complaints received were for the medical division, 1 for the surgical division, 2 for women & children’s division, 1 for clinical support division and 1 for the corporate division.

Ward F7 received the highest number of formal complaints with 2 complaints being received in April 2023. The main theme for complaints in April 2023 was communication and clinical treatment with 3 formal complaints being listed under each of these subjects.

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.



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	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23
Registered nursing shortfall of more than 8 hours or >25% of planned nursing hours	2	5	7	4	1	8	2
>30-minute delay in providing pain relief	2	2	7	4	1	2	1
Delay or omission of intention rounding	12	4	8	2	5	7	3
<2 RNs on a shift	7	5	7	3	4	2	1
Vital signs not recorded as indicated on care plan	2	3	7	1	-	4	-
Unplanned omissions in providing medication	-	1	1	-	-	2	-
Lack of appointments (local agreed red flag)	1	1	-	-	-	-	-
Delay in routine care (new descriptor)	17	19	20	6	8	11	4
Impact not described	1	-	-	-	-	-	-
<b>Total</b>	<b>44</b>	<b>40</b>	<b>57</b>	<b>20</b>	<b>19</b>	<b>36</b>	<b>11</b>

Table 11.

- In March 36 Datix 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 April 11 Datix 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	September	October	November	December	January	February	March	April
Supernumerary Status of LS Coordinator	100%	92%	99%	99%	99%	99%	99%	100%	99%
1-1 Care in Labour	100%	100%	100%	100%	100%	100%	100%	100%	100%
MW: Birth Ratio	1:28	1:29	1:29	1:27	1:29	1:26	1:25	1:25	1:24
No. Red Flags reported		15	11	9	11	6	11	7	4

### Red Flag events

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

- There were seven red flag events in March. No harm was recorded as in impact of these incidents
- There were Four red flag events in April. No harm was recorded as in impact of these incidents.

### Midwife to Birth ratio

- Midwife to Birth ratio was 1:25 in March and 1:24 in April, both months were below Birth-rate Plus recommendations of 1:27.7.
- 1:1 care was achieved 100% in both March and April 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 any women. This is to enable the co-ordinator to have situational awareness of what is occurring on the unit and is recognised not only as best but safest practice. In March 100% compliance was achieved and April 99% compliance against this standard was achieved. This was due to rapid progress of labour and LS being the only person available to support the women at the time, escalation plans were activated, and LS coordinator handed over the care to other midwives shortly after birth. This was for a total of 1 hour when LS coordinator was not supernumerary.

## 11. Community & Integrated services division

### 12.1 Demand

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

The division has completed its first Community Nursing Safer Staffing Tool audit, which is a nationally endorsed comparable tool to inform workforce planning. The results from our first census demonstrated a need of 25 additional whole-time equivalents. However, two further audits will be completed this year before a full assessment on workforce need is concluded.

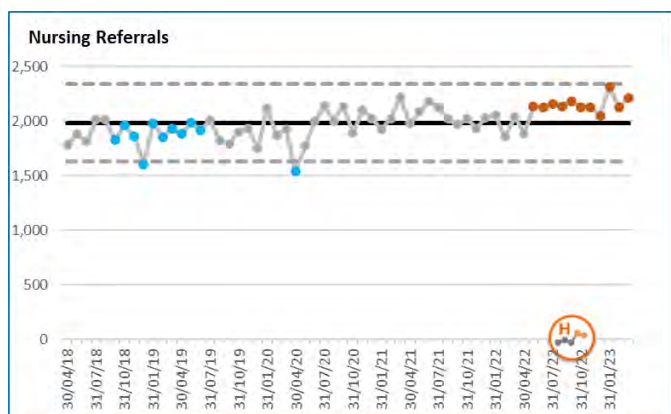


Chart 12a

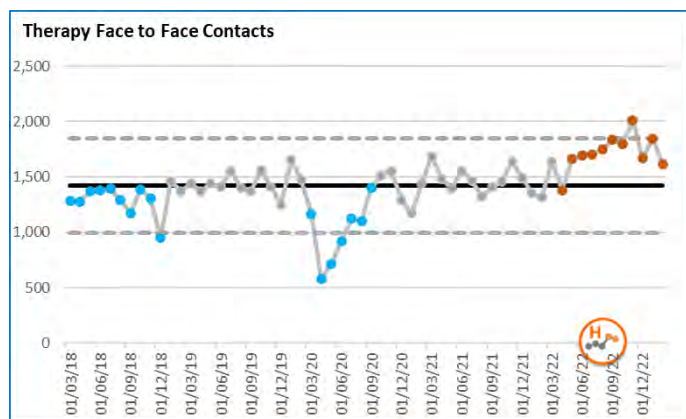


Chart 12b

### 12.2 Prioritisation of nursing patients

All patients are prioritised using rag rated care plans. This allows the senior team to identify, which are most urgent and require prioritisation. This allows the team to have flexibility when managing nursing/therapy resource and can defer low urgency visits to the following day. There is currently no automated method to calculate the care hours. Care plan hours are calculated manually and balanced against WTE staffing levels. Escalation is provided via an OPEL agreed framework and surge plan enacted if required.

### 12.3 Sickness

Sickness within the community division is improving following a single point of concern. For this period, it is consistently below average for the last year (chart 13). Sickness is still above the Trust average.

### 2.4 Ongoing actions being taken by division

- CNSST to be repeated twice more in 2023. Current results are being triangulated with professional judgement and quality data.
- Newmarket hospital have improved their workforce with successful recruitment of overseas staff. Execs will be aware of risks of losing staff from Newmarket because of accommodation issues. Project group working on addressing this.
- HR managers working with managers on attendance. Stage 1 meetings & long-term absence managed appropriately.

- We are aware there has been an increase in resignations in the last month. Exit interviews are being held for all resignations receive.
- Staff survey Workshop/meetings to discuss results and agree action plan for the forthcoming 6 months.

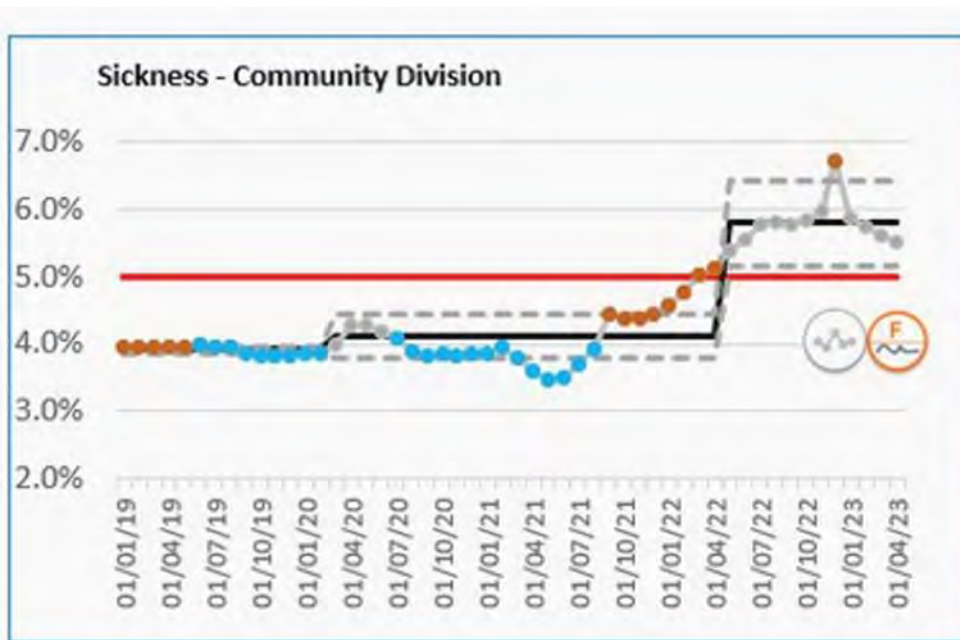


Chart 13.

## 12. Organisational activity of note

Within this period, a third round of industrial action was taken by the Royal College of Nursing. On this occasion industrial action was taken over a weekend, night and bank holiday, and no derogations were presented by the RCN. This presented an increased risk, not seen in previous rounds, as staff available to redeploy and mitigate risk was significantly reduced. However, robust forward planning resulted in minimal disruption enabling the mitigation of any patient safety concerns.

To provide global assurance increased senior nursing oversight was provided throughout this period to ensure decision making was supported and collaborative. Currently the RCN are re-balloting their members for future rounds of industrial action and the ballot will be open from 23<sup>rd</sup> May to 23<sup>rd</sup> June

## 13. Recommendations and actions

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

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

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

	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	RNs/RMN		Non registered (Care staff)		RNs/RMN		Non registered (Care staff)									
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average Fill rate RNs/RM %	Average fill rate Care staff %	Average Fill rate RNs/RM %	Average fill rate Care staff %	Cumulative count over the month of patients at 23:59 each day	RNS/RMs	Non registered (care staff)	Overall
Rosemary Ward	1313.5	1013.5	1839.75	1583	1069.5	894	1426	1368	77%	86%	84%	96%	1015	1.9	2.9	4.8
Glastonbury Cour	701.5	709.53333	1057.5	1056	713	702.5	542.5	536	101%	100%	99%	99%	573	2.5	2.8	5.2
Acute Assessment	2093.5	1782.25	2473.75	1294.75	1782.5	1489	1422	1065.5	85%	52%	84%	75%	761	4.3	3.1	7.4
Cardiac Centre	1775	1485.5	1064.5	721.5	1782.5	1495	710.0166667	721.5166667	84%	68%	84%	102%	632	4.7	2.3	7.0
G10	1644	1357.8333	1648.5	1412	1068	1023	1651.5	1407	83%	86%	96%	85%	707	3.4	4.0	7.4
G9	1423.25	1354.5	1426	1092.5	1426	1291.25	1069.5	1167.48333	95%	77%	91%	109%	752	3.5	3.0	6.5
F12	563.5	631.5	348.5	270.5	713	594	356.5	263.25	112%	78%	83%	74%	240	5.1	2.2	7.3
F7	1782.5	1334.75	1782.5	1383.75	1414.5	1163.25	1769.016667	1240	75%	78%	82%	70%	683	3.7	3.8	7.5
G1	1434.5	1017.6667	354.5	302.5	713	701.75	356.5	268.5	71%	85%	98%	75%	485	3.5	1.2	4.7
G3	1671.5	1231.6667	1770	1456	1058	982.25	1069.5	1343	74%	82%	93%	126%	864	2.6	3.2	5.8
G4	1781.5	1390.75	1815.5	1520.5	1069	862.5	1426	1339	78%	84%	81%	94%	896	2.5	3.2	5.7
G5	1420	1243.25	1767.5	1523.75	713	945.5	1426	1445.5	88%	86%	133%	101%	760	2.9	3.9	6.8
G8	2504	1785.3333	1792.5	1465.25	1781.51667	1497.65	1069.5	1043	71%	82%	84%	98%	615	5.3	4.1	9.4
F8	1424.5	1399.25	2133	1281.9167	1069.5	887.5	1426	1156	98%	60%	83%	81%	723	3.2	3.4	6.5
Critical Care	2841.5	2529.25	332.5	315.75	2853	2485.666667	0	66	89%	95%	87%	*	388	12.9	1.0	13.9
F3	1782.5	1498.5	2133.5	1324	1069.5	1069.5	1426	1354.01667	84%	62%	100%	95%	732	3.5	3.7	7.2
F4	1099	870	900.5	486.5	655.5	639	471.5	371	79%	54%	97%	79%	633	2.4	1.4	3.7
F5	1782.5	1413.5	1426	1027.5	1070.25	1008.5	1069.5	939.5	79%	72%	94%	88%	698	3.5	2.8	6.3
F6	2014.46667	1667.7167	1359.75	1151	1426	1094.25	713	864	83%	85%	77%	121%	942	2.9	2.1	5.1
Neonatal Unit	1288.5	1270.25	576	474.3	1080	1094.75	564	422.5	99%	82%	101%	75%	116	20.4	7.7	28.1
F1	1890	1586.45	706.25	668.5	1437.5	1288.75	0	82	84%	95%	90%	*	115	25.0	6.5	31.5
F14	565	534.5	360	319.91667	744	744	132	0	95%	89%	100%	*	106	12.1	3.0	15.1
F9 (winter esc)	1288	1109.9333	1288	1314.8333	966	955	966	1164.33333	86%	102%	99%	103%	744	2.8	3.3	6.1
<b>Total</b>	<b>36,084.22</b>	<b>30,217.38</b>	<b>30,356.50</b>	<b>23,446.22</b>	<b>27,674.77</b>	<b>24,908.57</b>	<b>21,062.53</b>	<b>19,627.10</b>	<b>84%</b>	<b>77%</b>	<b>90%</b>	<b>93%</b>	<b>14180</b>	<b>3.9</b>	<b>3.0</b>	<b>6.9</b>

\* planned hours are zero, so additional support used on ward to mitigate unfilled nursing hours

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

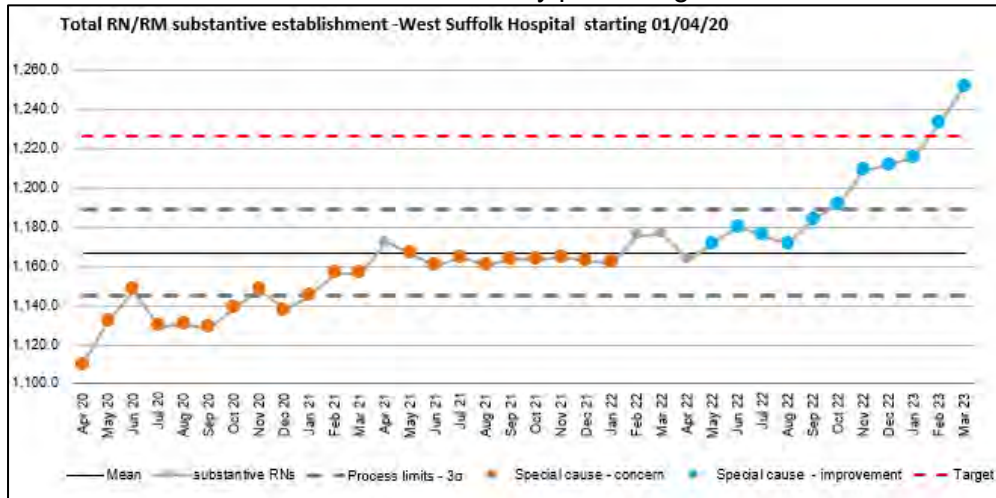
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	RNs/RMN		Non registered (Care staff)		RNs/RMN		Non registered (Care staff)									
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average Fill rate RNs/RM %	Average fill rate Care staff %	Average Fill rate RNs/RM %	Average fill rate Care staff %	Cumulative count over the month of patients at 23:59 each day	RNS/RMs	Non registered (care staff)	Overall
Rosemary Ward	1217	964.75	1753.05	1517.25	1013	843.5	1370.5	1367	79%	87%	83%	100%	957	1.9	3.0	4.9
Glastonbury Cour	693	700	1031	1023.5	690	690	525	501.5	101%	99%	100%	96%	516	2.7	3.0	5.6
Acute Assessmer	2070	1918.5	2403.5	1304.5	1725	1531	1360	1070.5	93%	54%	89%	79%	761	4.5	3.1	7.7
Cardiac Centre	1718.5	1553.5	1024	858.5	1725	1556	682	661	90%	84%	90%	97%	632	4.9	2.4	7.3
G10	1679	1274.9167	1707	1474.25	1035	963	1709.5	1343.5	76%	86%	93%	79%	707	3.2	4.0	7.2
G9	1380	1328.8167	1373	1063	1380	1299.5	1035	1147.5	96%	77%	94%	111%	752	3.5	2.9	6.4
F12	540	644.75	339	318.75	690	633.25	345	254.5	119%	94%	92%	74%	240	5.3	2.4	7.7
F7	1725	1440.25	1725	1316.5	1380	1101.916667	1718.5	1415.5	83%	76%	80%	82%	683	3.7	4.0	7.7
G1	1374	1029.5	345	332.5	690	689.75	345	304.5	75%	96%	100%	88%	485	3.5	1.3	4.9
G3	1644.5	1300.25	1717	1401.5	1000.5	984.5	1030	1338.5	79%	82%	98%	130%	864	2.6	3.2	5.8
G4	1729.75	1453.5	1810	1516.5	1035	918.5	1380	1305.5	84%	84%	89%	95%	896	2.6	3.1	5.8
G5	1380	1352	1735	1331	690	932.5	1380	1341	98%	77%	135%	97%	760	3.0	3.5	6.5
G8	2415.5	1951.3333	1728.25	1397	1725	1460.833333	1035	1013.86667	81%	81%	85%	98%	615	5.5	3.9	9.5
F8	1372.83333	1498	2047.5	1245.5	1035	900	1380	1245.5	109%	61%	87%	90%	723	3.3	3.4	6.8
Critical Care	2745.75	2332.5	315	336.5	2748.75	2333	0	22	85%	107%	85%	*	388	12.0	0.9	12.9
F3	1716.5	1476.75	2064.5	1293.25	1035	1022.5	1365	1303	86%	63%	99%	95%	732	3.4	3.5	7.0
F4	1150	795.5	920	437	690	575	575	325.5	69%	48%	83%	57%	633	2.2	1.2	3.4
F5	1725	1275	1375.5	1004.25	1035	932.833333	1035	956.5	74%	73%	90%	92%	698	3.2	2.8	6.0
F6	1928.5	1700.75	1321	1103.5	1380	1149	690	757.5	88%	84%	83%	110%	942	3.0	2.0	5.0
Neonatal Unit	1198.5	1182	348	404.8	960	1044	360	374	99%	116%	109%	104%	116	19.2	6.7	25.9
F1	1812.75	1589.75	690	625.25	1380	1347.25	0	31.9166667	88%	91%	98%	*	115	25.5	5.7	31.3
F14	360.5	365	96	96	720	718	0	0	101%	100%	100%	*	106	10.2	0.9	11.1
F9 (winter esc)	1288	1171	1288	1254.75	966	875	966	1212.83333	91%	97%	91%	103%	744	2.8	3.3	6.1
<b>Total</b>	<b>34,864.58</b>	<b>30,298.32</b>	<b>29,156.30</b>	<b>22,655.55</b>	<b>26,728.25</b>	<b>24,500.83</b>	<b>20,286.50</b>	<b>19,293.12</b>	<b>87%</b>	<b>78%</b>	<b>92%</b>	<b>95%</b>	<b>14065</b>	<b>3.9</b>	<b>3.0</b>	<b>6.9</b>

\* planned hours are zero, so additional support used on ward to mitigate unfilled nursing hours

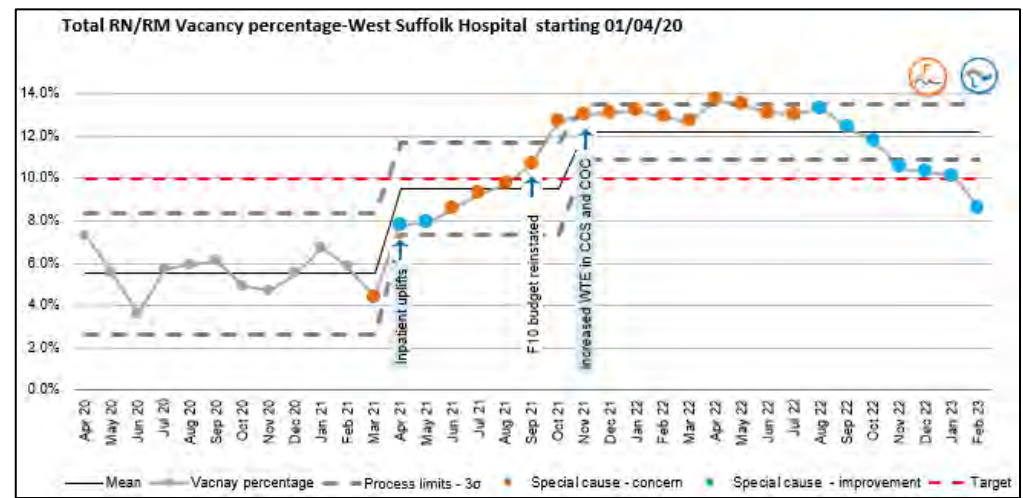


Appendix 2 SPC charts.

Total RN/RM establishments and vacancy percentage

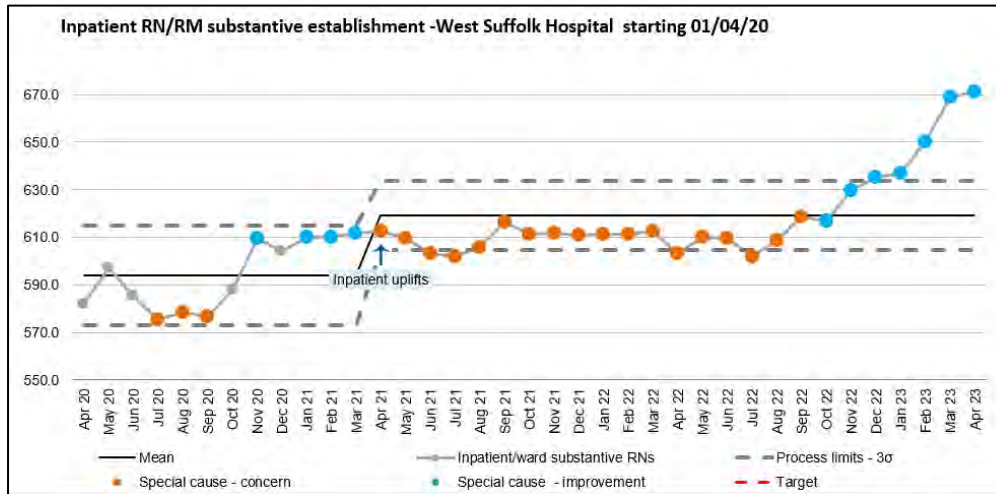


\*April update not available

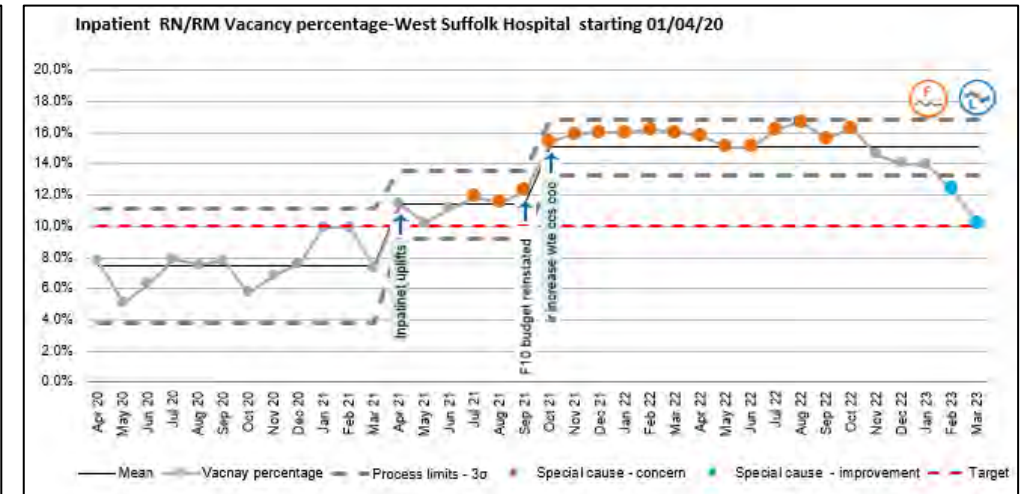


\*April update not available

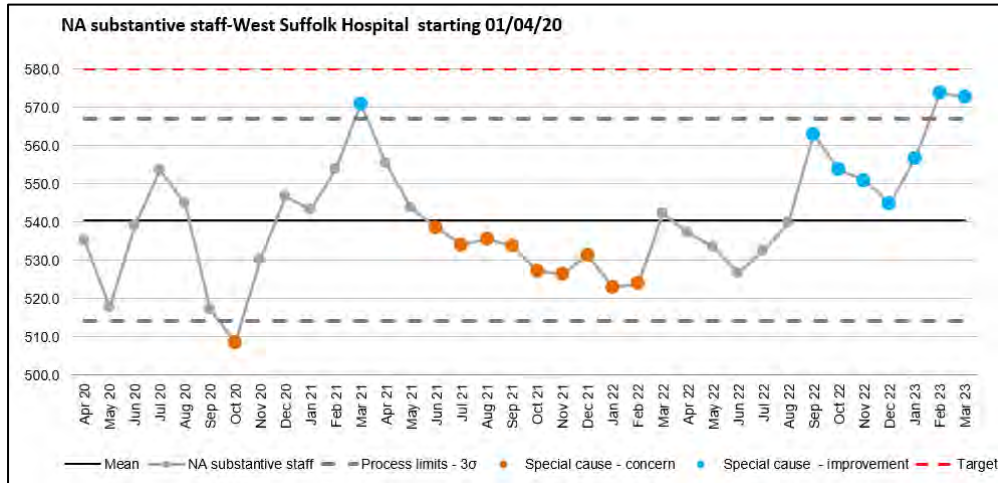
Inpatient RN/RM establishments and vacancy percentage



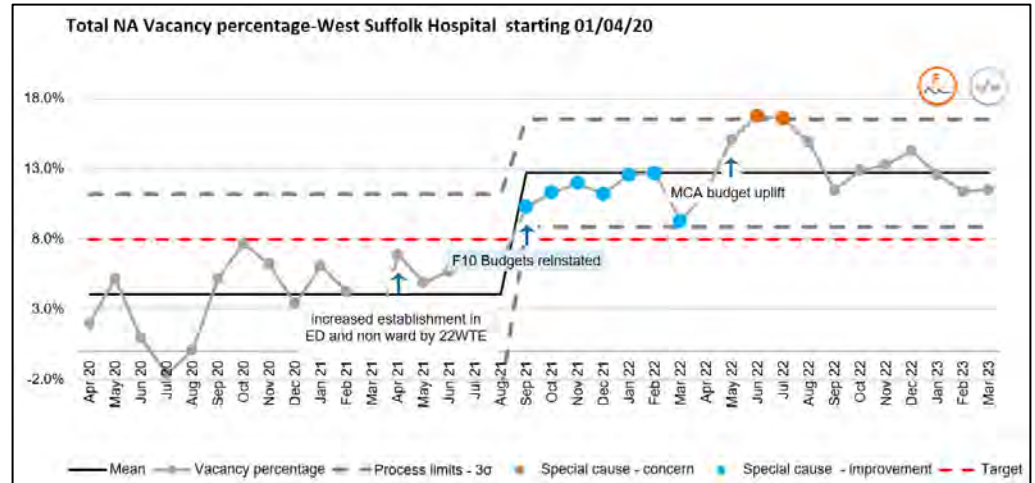
\*April update not available



Total NA WTE numbers and vacancy percentages

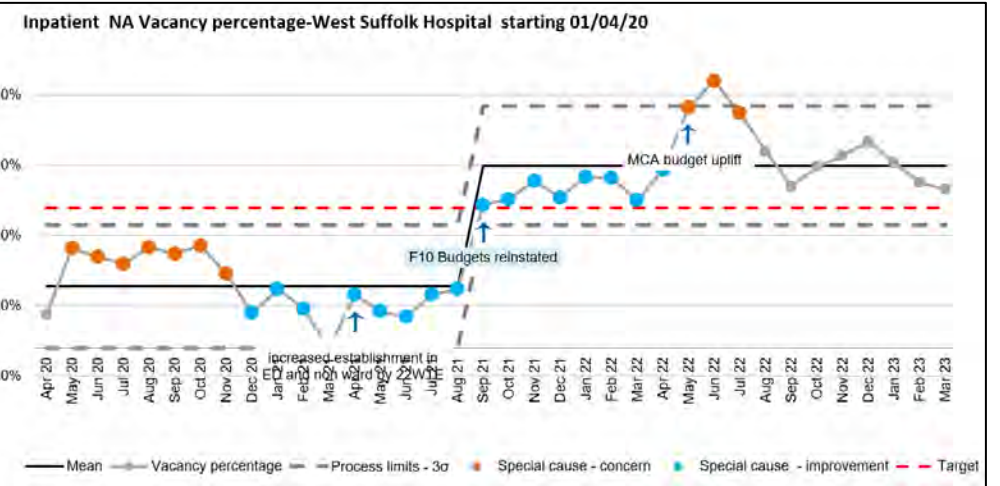
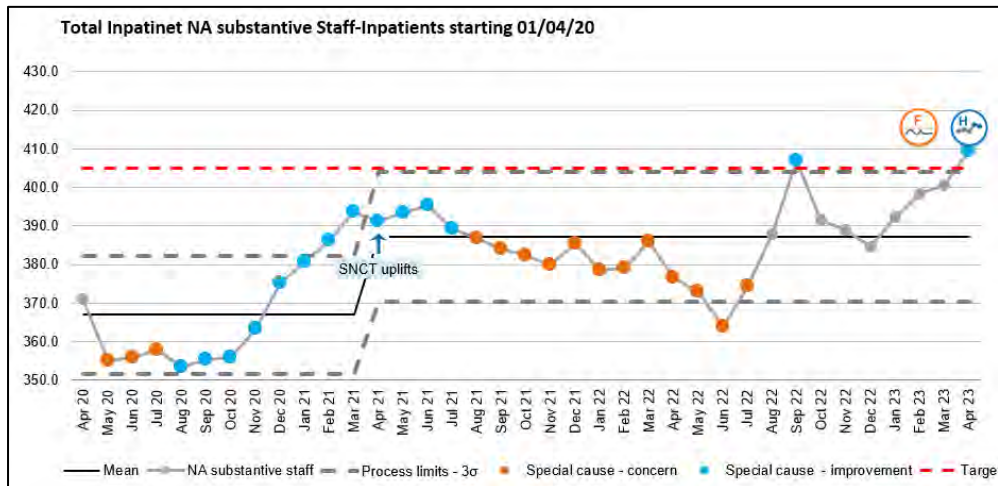


April update not available



April update not available

Inpatient WTE numbers and vacancy percentage



April update not available

Appendix 4: 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 MEOVS
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.
<p>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:</p> <ul style="list-style-type: none"> <li>• pain: asking patients to describe their level of pain level using the local pain assessment tool</li> <li>• personal needs: such as scheduling patient visits to the toilet or bathroom to avoid risk of falls and providing hydration</li> <li>• placement: making sure that the items a patient needs are within easy reach</li> <li>• positioning: making sure that the patient is comfortable, and the risk of pressure ulcers is assessed and minimised.</li> </ul>
A shortfall of more than eight hours or 25% (whichever is reached first) of registered nurse time available compared with the actual requirement for the shift
Fewer than two registered nurses present on a ward during any shift.

## 4.4.1. Maternity Services




Karen Newbury, Simon Taylor & Kate

Croissant in attendance

For Approval

## Board of Directors - Open

<b>Report title:</b>	Maternity quality, safety and performance report
<b>Agenda item:</b>	Maternity services quality & performance report
<b>Date of the meeting:</b>	26 <sup>th</sup> May 2023
<b>Sponsor/executive lead:</b>	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
<b>Report prepared by:</b>	Karen Newbury, Head of Midwifery

Purpose of the report:			
For approval <input checked="" type="checkbox"/>	For assurance <input type="checkbox"/>	For discussion <input type="checkbox"/>	For information <input type="checkbox"/>
Trust strategy ambitions			
Please indicate Trust strategy ambitions relevant to this report.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

<b>Executive summary:</b>	<p>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 &amp; safety initiatives. The papers presented are for information only and issues to note are captured in this summary report. All of the attached papers have been through internal governance process including the Maternity and Neonatal Safety Champions and will then be shared with the Local Maternity and Neonatal System.</p> <p><b>This report contains;</b></p> <ul style="list-style-type: none"> <li>• Maternity improvement plan</li> <li>• Safety champion feedback from walkabout</li> <li>• Listening to staff</li> <li>• Service user feedback</li> <li>• Reporting and learning from incidents</li> <li>• Maternity Dashboards (Annex A)</li> <li>• Healthcare Safety Investigation Branch (HSIB) Referral and Early Notification (EN) Reporting Quarterly Reports on Compliance – Report for Quarter 4, 2022/23 <b>for CLOSED Trust Board</b></li> </ul>
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	<ul style="list-style-type: none"> <li>Quarterly Report on reporting of Perinatal deaths to MBRRACE and the use of the National Perinatal Mortality Tool to review Perinatal deaths. Quarter 4, <b>for CLOSED Trust Board</b></li> <li>Paediatric/Neonatal Medical staffing Biannual report (Annex B)</li> <li>Neonatal Transitional Care Q3 October to December 2022 (Annex C)</li> <li>Avoiding Term Admissions to the Neonatal Unit (ATAIN) Q4 and rolling Action Plan (Annex D)</li> </ul>
<b>Action required/ recommendation:</b>	For information and record of reports received.

<b>Previously considered by:</b>	Maternity Quality and Safety Group Maternity and Neonatal Safety Champions Local Maternity and Neonatal System
<b>Risk and assurance:</b>	
<b>Equality, diversity and inclusion:</b>	This paper has been written with due consideration to equality, diversity and inclusion.
<b>Sustainability:</b>	There are no sustainability issues related to this report
<b>Legal and regulatory context:</b>	The information contained within this report has been obtained through due diligence.

<b>Maternity quality, safety and performance report</b>	
<b>1.</b>	<b>Detailed sections and key issues</b>
1.1	<p><b><u>Maternity improvement plan</u></b></p> <p>The Maternity Improvement Board (MIB) receives the updated Maternity improvement plan on a monthly basis. This has been created through an amalgamation of the original CQC improvement plan with the wider requirements of Ockenden, HSIB, external site visits and self-assessment against other national best practice (e.g. MBRRACE, SBLCBv2, UKOSS). In addition, the plan has captured the actions needing completion from the 60 Supportive Steps visit from NHSE/I and continues to be reviewed by the Maternity Improvement Board every two weeks. It has been agreed with the exit from the Maternity Safety Support Programme (MSSP) that NHSE regional team and ICS will be invited to attend the MIB monthly for additional assurance and scrutiny. 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.</p>
1.2	<p><b><u>Safety Champion Walkabout feedback</u></b></p> <p>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.</p>

	<p>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'.</p> <p>Roger Petter our new Non-Executive Maternity and Neonatal Safety Champion started the role in March 2023 and undertook his first official walkabout on the 20<sup>th</sup> April 23, on the antenatal/postnatal ward and triage. Roger reported that he was able to speak to a wide range of staff and no adverse issues were raised. Staff reported they were happy at work and how they felt part of a good team. The general atmosphere of the area was calm, happy and one of a well-run and functioning team.</p>																																			
1.3	<p><b><u>Listening to Staff</u></b></p> <p>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.</p> <p>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. Moving forward we will be introducing the role of a 'Legacy Midwife' next month and piloting self-rostering as indicated by the flexible working survey results.</p>																																			
1.4	<p><b><u>Service User feedback</u></b></p> <p>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.</p> <table border="1" data-bbox="204 1205 1528 1482"> <thead> <tr> <th>Ward/Dept</th> <th>March Survey returns</th> <th>March FFT score</th> <th>April Survey returns</th> <th>April FFT Score</th> </tr> </thead> <tbody> <tr> <td>F11</td> <td>48</td> <td>100</td> <td>52</td> <td>98</td> </tr> <tr> <td>Antenatal</td> <td>15</td> <td>100</td> <td>4</td> <td>100</td> </tr> <tr> <td>Postnatal Community</td> <td>11</td> <td>91</td> <td>6</td> <td>100</td> </tr> <tr> <td>Labour Suite</td> <td>34</td> <td>100</td> <td>40</td> <td>100</td> </tr> <tr> <td>Birthing Unit</td> <td>7</td> <td>100</td> <td>4</td> <td>100</td> </tr> <tr> <td>NNU</td> <td>17</td> <td>100</td> <td>10</td> <td>100</td> </tr> </tbody> </table> <p>In addition to the FFT, feedback is gained via our and the Maternity Voice Partnership (MVP) social media, MVP, CQC and Healthwatch surveys.</p> <p>On review of enquires and complaints received during March and April 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.</p>	Ward/Dept	March Survey returns	March FFT score	April Survey returns	April FFT Score	F11	48	100	52	98	Antenatal	15	100	4	100	Postnatal Community	11	91	6	100	Labour Suite	34	100	40	100	Birthing Unit	7	100	4	100	NNU	17	100	10	100
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1.5	<p><b><u>Reporting and learning from incidents</u></b></p> <p>During March and April 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, whereby incidents, reports and learning is shared across all three maternity units.</p>																																			
1.6	<p><b><u>Maternity dashboards (Annex A)</u></b></p> <p>Indicators of maternity safety &amp; quality are regularly reported and reviewed at monthly Maternity Governance meetings. A sub-set are provided for board level performance (the Performance &amp;</p>																																			

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. PPH risk assessment form introduced. Shared learning in place across the LMNS.
Compliance with asking Domestic Abuse questions	Marked improvement noted with further work 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.
3 <sup>rd</sup> /4 <sup>th</sup> degree tears following instrumental deliveries	Small number of cases and therefore to monitor via at 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.
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.

1.7 **Healthcare Safety Investigation Branch (HSIB) Referral and Early Notification (EN) Reporting Quarterly Reports on Compliance – Report for Quarter 4 2022/23**

This report provides details of the Trust compliance for Q4 2022/2023 in reporting maternity incidents that meet the criteria for HSIB Maternity Investigations and the NHS Resolution Early Notification Scheme. In this quarter 4 – 1<sup>st</sup> January 2023 to 31<sup>st</sup> March 2023 – there were no cases that met the criteria to be reported to HSIB or the Early Notification scheme. Two reports have been completed and shared with the families, staff involved and the Trust. Whilst there were no safety recommendations from the reports, the findings, good practice and learning will be shared with all staff groups.

Draft HSIB reports are shared with the Trust for factual accuracy and final reports from HSIB are shared with families, staff who have been associated with the reports, other Trust staff and through the internal and external safety and learning forums. The full reports will be shared with the Trust Board and the LMNS as per Ockenden requirements for Perinatal Surveillance. The Trust is assured that the processes are being followed for referral to HSIB and the ENS. Both full HSIB reports have been submitted to the Closed Trust Board this month for acknowledgement and information.

1.8 **Quarterly Report on reporting of Perinatal deaths to MBRRACE and the use of the National Perinatal Mortality Tool to review Perinatal deaths. Quarter 4**

The report outlines the details of Perinatal deaths occurring within the Trust, which includes the reviews and subsequent actions. This provides evidence of the Trust's commitment to safe effective care through the compliance with The Maternity Incentive Scheme (year 4) Safety Action 1. This Safety



	<p>action is mainly relating to the use of the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths.</p> <p>In the period from 1<sup>st</sup> January 2023 to 31<sup>st</sup> March 2023, the Trust has reported 6 baby losses directly associated with the Maternity Services.</p> <p>The Trust has met all of the standards for reporting relevant incidents of perinatal mortality to MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) and completion of the surveillance information within the required time frames when required to date.</p> <p>The Trust was 100% <b>compliant</b> with duty of candour and informing the women that a PMRT review will be undertaken when indicated and inviting comments or questions to aid the review process. The Trust has <b>completed all</b> the PMRT reports that were due to be completed within this reporting timeframe and started the review process for all of these within 2 months of the loss. This report also includes outstanding actions from previously completed PMRT reports for the last year. These actions are recorded and managed on an overarching action plan and as part of the individual datix incident report. Learning is shared via the Risky Business Newsletter and at perinatal mortality and morbidity meetings and educational forums.</p>
1.9	<p><b><u>Paediatric/Neonatal Medical staffing Biannual report (Annex B)</u></b></p> <p>This report provides evidence of safe staffing levels within the neonatal and maternity services through a review of the paediatric junior medical staffing over a 6-month period from the 1<sup>st</sup> March to the 31<sup>st</sup> August 2022, to ensure the staffing meets the British Association of Perinatal Medicine (BAPM) standards for a level 1 Special Care Unit.</p> <p>The Trust meets the standards expected during this period of time. This has been achieved by rota management, the use of locums and staff acting down when required to provide safe staffing levels. It is not always clear from the rotas when clinical activities or training has been restricted due to shortages.</p> <p>Further work is required to ensure the process for obtaining safe staffing levels is formalised and embedded and the systems accurately reflect the work involved in maintaining standards. Whilst this work is being undertaken effectively and there are no concerns with the rota cover or management, a written and agreed process would make this clear and available to all. It is planned that the neonatal and paediatric medical staff health roster will be fully electronic when the resources are available. There should be evidence of escalation if there are concerns regarding the staffing establishment and allocation of trainees to the Trust. This would include business case presentation to the Division and Trust if required, for maintenance of a safe service, service development and improvement. With the pandemic easing, there should be quarterly reports on the use of locums to demonstrate that the appropriate staffing levels are in place and locum usage is appropriate and reducing if vacancies are filled and the establishment is correct.</p> <p>This report will need to be repeated every 6 months as assurance of standards being maintained and progress on other safety and quality actions and the next report on the current vacancies and resources required will include an up to date status.</p>
2.0	<p><b><u>Neonatal Transitional Care Q3 October to December 2022 (Annex C)</u></b></p> <p>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 programme (risk assessment of babies to establish the risk of early onset neonatal sepsis and subsequent antibiotic administration) which was introduced in December 2022. The full impact of this on the use of antibiotics for neonates and 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</p>

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. The majority of babies met the agreed criteria for admission to NTC. The babies that did not meet the criteria had other reasons to be monitored and it appears appropriate for NTC to be used for these purposes. The babies that did not meet the criteria for NTC did not have any adverse outcomes as a result and all of them stepped down from NTC after a period of monitoring.

Nearly a third of the babies were admitted to NTC from birth with slightly fewer in both the groups of babies being admitted from the community setting and as a step down from NNU care. The smallest proportion of babies (around 10%) were admitted from the postnatal ward.

The staffing of NTC on F11 is by an allocated staff member from the NNU with oversight of the neonatal medical team.

2.1 **ATAIN Q 4 January -March 2023 and Rolling Action Plan (Annex D)**

There were 31 term babies admitted to the neonatal unit in this quarter (January – March 2023). Respiratory distress syndrome (RDS) remained the predominant reason for admission, accounting for 74% of admissions. All but one required supplementary oxygen support and all 23 received intravenous antibiotics due to their clinical presentation, with 39% (9 of 23) having known risk factors for sepsis.








Mode of delivery highlighted itself as a potentially contributing factor with 15 of the 23 admissions for RDS born via caesarean section (a mixture of elective and emergency procedures) which accounts for 65%. The gestations ranged from 37+0 to 42+0 and the majority born with good APGARs. Risk factors for sepsis and respiratory distress also varied with no dominating theme. Of the remaining 8 admissions, 4 were admitted for suspected sepsis and were treated with prophylactic antibiotics. Two were admitted with low oxygen saturations which was their only presenting symptom. One infant was admitted for observation following resuscitation and another due to abnormal tone. January and February both showed a notable majority of term admissions born in the 37th week of gestation which may have been an influencing factor in their need for additional support after birth. Two admissions this quarter were thought to have been potentially avoidable. Though it is recognised that retrospective review cannot take in to account all contributing variables. One admission was suspected to have been exacerbated by a sub-optimal body temperature while under the care of the postnatal ward. However, it was also recognised that other factors may have contributed to the decision to admit to NNU. In February, it was the opinion of the review group that an expedited delivery may have been beneficial, but it could not be conclusively stated if this would have impacted on the need for further care on the NNU. Actions were taken to raise awareness and learning around these issues following review. All admissions were stepped down to transitional care at the earliest opportunity.

Recommendations and Next Steps Some minor opportunities for learning were identified this quarter, which were thought to have impacted the admission.

- Importance of Thermoregulation of the new-born
- Quality of CTG during labour and delivery
- Importance of paired cord samples

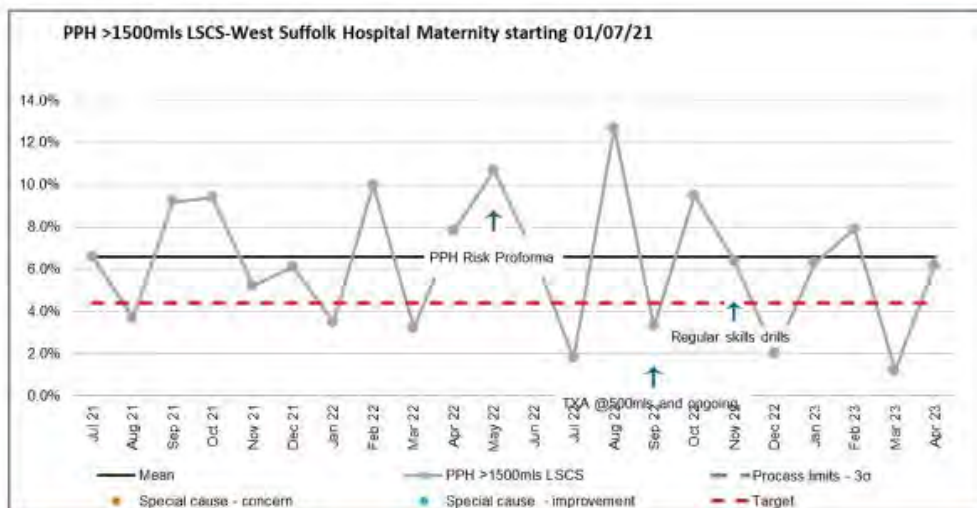
All opportunities for learning are discussed and a relevant action or pathway for shared learning agreed upon. The rolling action plan is also attached for information and review.

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

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

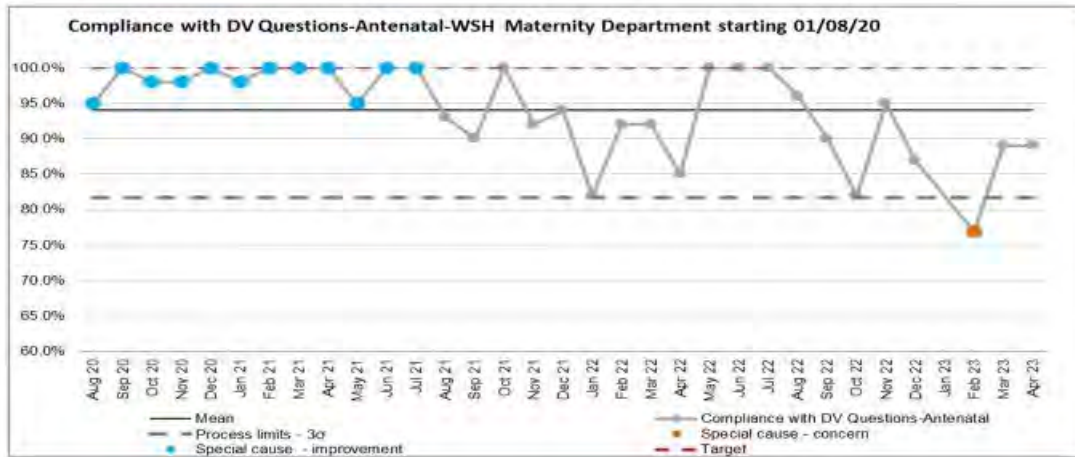
## Annex A- Maternity Dashboard SPC Charts;

### PPH – LSCS



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# Domestic Abuse - Antenatal



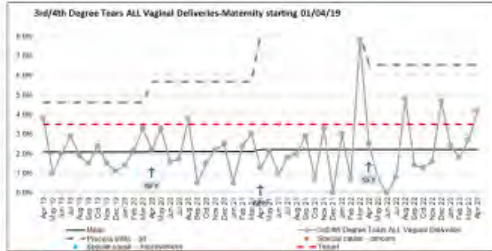
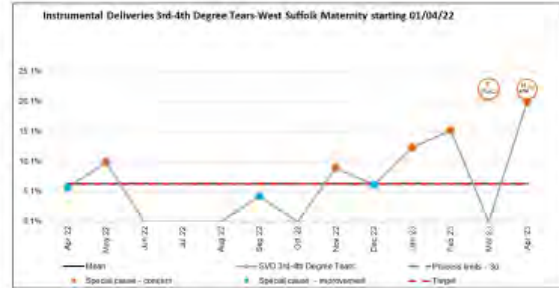
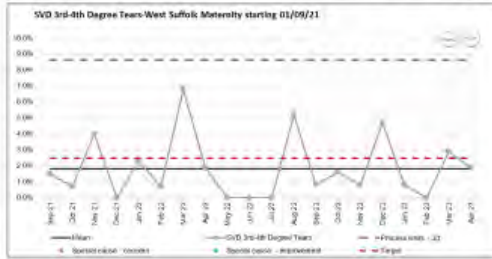
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# Domestic Abuse Question - Postnatal



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# 3<sup>rd</sup> Degree Tears

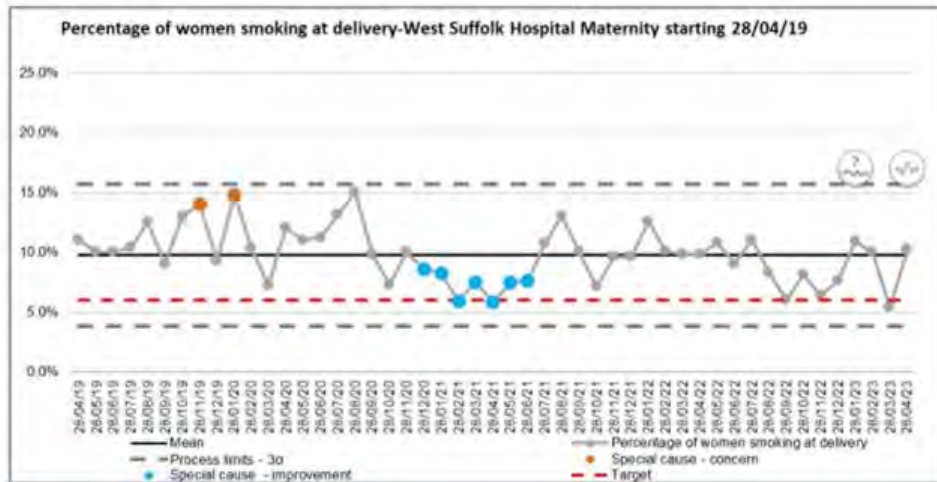


Standards  
SVD – 2.5%  
Instrumental – 6.3% (9.2% in Q4 22/23)

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# Smoking at Delivery – Standard 6%

10.2% in April 8.6% for the year 2022/2023






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## 5. GOVERNANCE

## 5.1. Governance report

To inform

<b>Board of Directors - Public</b>	
<b>Report title:</b>	<b>Governance report</b>
<b>Agenda item:</b>	5.1
<b>Date of the meeting:</b>	26 May 2023
<b>Sponsor/executive lead:</b>	Richard Jones, Trust Secretary
<b>Report prepared by:</b>	Richard Jones, Trust Secretary Pooja Sharma, Deputy Trust Secretary

<b>Purpose of the report:</b>			
<b>For approval</b> <input checked="" type="checkbox"/>	<b>For assurance</b> <input type="checkbox"/>	<b>For discussion</b> <input type="checkbox"/>	<b>For information</b> <input checked="" type="checkbox"/>
<b>Trust strategy ambitions</b>			
Please indicate Trust strategy ambitions relevant to this report.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Executive Summary</b>	
<p>This report summarises the main governance headlines for May 2023, as follows:</p> <ul style="list-style-type: none"> <li>• Urgent decision re Newmarket</li> <li>• Council of Governors meeting report</li> <li>• Register of interests</li> <li>• NED responsibilities</li> <li>• Senior Leadership Team report</li> <li>• Report from board development session</li> <li>• Amendments to the Trust's Constitution</li> <li>• Use of Trust's seal</li> <li>• Agenda items for next meeting</li> </ul>	
<b>Action Required of the Board</b>	
<p>The board is asked to note the report contents as outlined above and to approve the following:</p> <ul style="list-style-type: none"> <li>- amendments to the <b>Trust's Constitution</b></li> <li>- development and roll out of the use of <b>What, So what and What next</b> as the approach to scrutiny and assurance</li> </ul>	
<b>Legal and regulatory context</b>	NHS Act 2006, Health and Social Care Act 2013



# Governance Report

## 1. Urgent Board decision

An opportunity arose to submit a business case to develop elective care capacity on the Newmarket Hospital site. This was in the context of national capital to support urgent and emergency care (UEC) delivery.

After consideration the Board approved submission of the business case, recognising that further work was required. This included developing a sustainable model for the revenue costs associated any facility.

## 2. Council of Governors report

The Council of Governors noted the resignation of Allen Drain (Public Governor) and appointment of Elspeth Lees (Appointed Governor). The CoG also noted the appointment of Michael Parsons as Non-Executive Director.

The Council of Governors noted the feedback report from chairs of the board assurance committees and governor observers. The coversheet summarised the agenda items discussed in the meetings, with the chairs' key issues and respective governor observers' reports providing highlight updates for the council.

The Council of Governors approved the Chair and NED appraisal process for the year 2023 and nominations were sought from the Governors wishing to act as observers (appraisers).

The Council of Governors noted the report from the nomination committee which highlighted a summary of the current position regarding the Chair appointment.

The Council of Governors noted the report from the engagement committee. With the Governor elections 2023 and election work now beginning, the Committee made a recommendation to invite governor colleagues to join the committee and support to take forward the engagement programme.

The Council of Governors received a report from Standards Committee and noted the Governor election timetable 2023. The committee approved the Lead and deputy lead governor election process and role specification. The committee discussed and agreed on a number of recommended amendments to the Trust's Constitution.

The Council of Governors was asked to identify Governors as readers for the Annual Report and Quality Accounts. The Council approved the Governor commentary for the Quality Accounts 2022-23.

The Council of Governors received the report from the training and development day held on 17 March with Governors and non-executive directors. It was emphasised that the session was positive and the full evaluation on the actions emerging from the session will be reported to the Standards Committee to inform the structure and content of future sessions.

## 3. Register of interests

It is a Constitutional requirement that appointed board Directors have a duty to avoid conflicts of interest with the Trust.

To ensure full openness and transparency, the register of directors' interests is formally reviewed and updated on an annual basis. At each Board meeting declarations are also received for items to be considered.

The Board is asked to note the summary of the register of directors' interests (Annex A).

#### 4. Non-executive director responsibilities

Periodically the NEDs review their key responsibilities and members of Board committees. The latest summary of these responsibilities is provided for information.

#### 5. 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 strategic issues, which has included discussion of, developing a quality assurance framework, pathology accreditation, advanced practice update, patient safety incident response plan (PSIRP) update, staff survey results and people and culture committee report as well as update of terms of reference for the performance review meetings.

An update was received from the strategic delivery support team. This was followed by specific consideration of financial sustainability governance and monitoring. The business plans for the clinical divisions were considered and plans from non-clinical will also be shared.

#### 6. Board development workshop

The board workshop on 4 May was facilitated by Integrated Development. The morning session included a recap on a number of key principles. Including:

- Function of a unitary board
- Assurance vs reassurance

The board also reflected on the journey so far and reviewed a self-assessment on the working of the Board in areas such as vision & strategy, accountability & governance and culture.

The practice of scrutiny and assurance was also reviewed in terms of:

- **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

A more detailed summary is provided in Annex C. The use of this approach will be 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 already being reflected in the latest assurance committee CKIs reports and action agreed to further develop this approach.

The after session reflected on the complex agenda that the Trust faces. The Board recognised the value of championing a small set of priorities to frame the work to deliver the strategy this year. These priorities can then provide focus for the work of the Board and Executive and can be used to structure meeting agendas and discussions with the Board and senior leaders.

After a wide-ranging discussion at the Board workshop, it was agreed to identify a small number of priorities with clear deliverables that are SMART (specific, measurable, achievable, realistic and time-bound) and a narrative to describe how we have come to prioritise the areas we have.

This is considered elsewhere on the agenda and the work will be received at the next Board meeting.

Previous actions from Board workshop session remain ongoing with a focus on:

- the **IQPR** – an updated version of the report will be received at the next round of assurance committee meetings
- the **assurance committees** – this working is ongoing but improvements/actions have included: structured review of the IQPR, prioritisation of topics on the agenda, face-to-face meetings and agreeing workplans for assurance review topics
- sharing the **new focus and approach** – this will be driven through the development and roll out of the use of “What, So what and What next” as the approach to scrutiny and assurance. This will include incorporating this structure into the guidance for **content of reports** e.g. coversheets
- **Engage governors** in the changes – the CKI structure was reviewed in the Governor training day and suggestions for improvements incorporated.

## 7. Proposed developments to constitution

The Council of Governors approved a number of amendments to the Trust’s Constitution at its meeting in May. Legal advice has been sought on proposed amendments to the Constitution. This is to ensure that any changes do not undermine the Constitution as a legal instrument.

The following summarises the changes and the full constitution is providing in the supporting annexes for the meeting pack (Annex D).

### a) Consolidate the Trust’s existing membership area into a **single public constituency**

Change description	Reference
<b>Membership area</b> - single public constituency for members living within the whole of Suffolk, Norfolk, Cambridgeshire or Essex.	Annex 1, p.27

### b) Review of the **Partner Governor constituency**

Change description	Reference
<b>Partner Governor constituency:</b>	
(a) Updated existing West Suffolk CCG reference to reflect current system structures and be titled “ <b>Suffolk &amp; Northeast Essex Integrated Care Board</b> in consultation with local general practitioners and West Suffolk Alliance Partners to provide a range of views and perspectives”	Annex 3, p.29
(b) existing Friends of West Suffolk Hospital seat to be restructured to be based on <b>Trust Volunteers</b> in consultation with the Friends of West Suffolk Hospital	Annex 3, p29

### c) Options to review the **composition of the Council of Governors**

Change description	Reference
<b>Composition of the Council</b>	Annex 3, p.29
- <b>Elected public:</b> 14 (leaves capacity for one additional appointed governor)	
- <b>Elected staff:</b> 5 (no change)	
- <b>Appointed:</b> 7 (no change)	
- <b>Total:</b> 26	

d) Clarifying the clause relating to **non-attendance at Council of Governors meetings**

Change description	Reference
<p><b>Non-attendance at public Council of Governors meetings</b></p> <p>14.2 If a Governor fails to attend three consecutive public meetings held in public of the Council of Governors his tenure of office is to be terminated unless the other Governors agree by a majority vote that:</p> <p>14.2.1 the absence was due to a reasonable cause; and</p> <p>14.2.2 he/she will be able to start attending meetings of the Council of Governors again within such a period as they consider reasonable</p>	<p>Para 14.2 and Code of Conduct Para 7.1.2, p.82</p>

e) Amending the **male language** throughout the Constitution to be more inclusive

f) **Alignment of other areas of the constitution** with arrangements, including NHS Code of Governance; Lead/Deputy Lead Governor roles; the code of conduct; and sanctions for breaching the code of conduct

Change description	Reference
Amend reference to <b>Monitor</b> throughout the document	Para 46 “Interpretation and definitions” and throughout (except Election rules)
Update the Lead/Deputy Lead Governor role specifications and moved to a separate Annex to simplify making any future changes	Annex 7 Para 9, p.96
Also updated para 3.16 of Council’s standing orders to clarify who chair’s a meeting in absence of Chair and others	Annex 7 Para 3.16, p.87
Reflected the code of conduct approved by CoG in March in the Constitution with update re non-attendance at meetings (4 above)	Annex 6, p.80
<p>The Constitution makes provision for barring an individual from standing at future Governor elections if breaches Code of Conduct</p> <p>12.8 A person may not stand for election as a Governor or be appointed as a Governor in accordance with clause 10 if their tenure as a governor was terminated following a breach of the Governors’ Code of Conduct.</p>	Para 12.8

The Board is asked to **approve** the proposed changes which, with the existing Council approval, will then come into effect immediately.

## 8. Use of Trust Seal

No. 154 – Planning obligation by deed under Section 106 of the Town & Country Planning Act 1990 relating to land at Hardwick Manor, Hardwick Lane Bury St. Edmunds – West Suffolk Council, Suffolk County Council and West Suffolk NHS Foundation Trust. Sealed and witnessed by on 17 April 2023.

## **9. Agenda Items for the Next Meeting (Annex E)**




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

## Board of Directors - Public

<b>Report title:</b>	<b>Board Assurance Framework</b>
<b>Agenda item:</b>	5.2
<b>Date of the meeting:</b>	26 May 2023
<b>Sponsor/executive lead:</b>	Richard Jones, Trust Secretary
<b>Report prepared by:</b>	Mike Dixon, Head of Health, Safety and Risk

Purpose of the report:			
For approval <input checked="" type="checkbox"/>	For assurance <input type="checkbox"/>	For discussion <input type="checkbox"/>	For information <input checked="" type="checkbox"/>
<b>Trust strategy ambitions</b>			
Please indicate Trust strategy ambitions relevant to this report.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

<b>Executive summary:</b>	<p>The Board assurance framework is a tool used by the Board to manage its principal risks to its strategic objectives.</p> <p>The BAF risk assessments are being reviewed with the executive leads in order to assess against the Trust's strategy and strategic objectives.</p> <p>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:</p> <ul style="list-style-type: none"> <li>• Patient safety</li> <li>• Staffing and workforce</li> <li>• Urgent &amp; emergency care and elective care</li> <li>• Financial constraints</li> <li>• Maintaining existing estate</li> <li>• Digital, including cyber security</li> </ul> <p>The Board Assurance Committees have been identified and aligned to each of the BAF risk assessments. The review process is now considering which management committee should 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</p>
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	<p>Work is currently taking place by the Executive Director of Workforce to structure the workforce BAF risk to address the three elements of the First for Staff strategic ambition:</p> <ol style="list-style-type: none"> <li>1) Build a positive, inclusive culture that fosters open and honest communication</li> <li>2) Enhance staff wellbeing</li> <li>3) Invest in education, training and workforce development</li> </ol> <p>These developments will be included in the BAF presented at the July Board meeting.</p>
<b>Action required/ recommendation:</b>	<p>Note the report including:</p> <ul style="list-style-type: none"> <li>- Next steps to update the BAF based on agreed strategic priorities for 2023/24</li> <li>- Alignment of the risks to the assurance committee and management Committee with the Board to receive findings of assurance reviews that are undertaken</li> </ul>

<b>Previously considered by:</b>	The Board of Directors
<b>Risk and assurance:</b>	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.
<b>Equality, diversity and inclusion:</b>	
<b>Sustainability:</b>	
<b>Legal and regulatory context:</b>	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

	<p>Work is underway to prioritise SMART objectives for 2023/24 which underpin the strategy delivery and link to the priorities within the system and nationally. This work will inform the BAF development as the risks to these priorities are assessed.</p> <p>A more detailed summary for the risks relating to patient safety (1), finance (3), estates (4) and digital (5) is provide in Appendix A. This includes risk ratings and mitigating action. These have been subject to executive review and similar reviews and updates have been scheduled for the remaining risks these will be reported at the next Board meeting.</p> <p>A schedule is being developed to review these risks through the relevant governance / management fora with the results of this reported to the relevant assurance committee. For example recommendations to improve controls, mitigations and/or assurance.</p>
<b>5.</b>	<b>Conclusion</b>
	<p>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.</p>
<b>6.</b>	<b>Recommendations</b>
	<p>Note the report including:</p> <ul style="list-style-type: none"> <li>- Next steps to update the BAF based on agreed strategic priorities for 2023/24</li> <li>- Alignment of the risks to the assurance committee and management Committee with the Board to receive findings of assurance reviews that are undertaken</li> </ul>

## Appendix A: BAF risk summary report

	Residual Risk	Target Risk
<b>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.</b>	Quarterly x Major = Red	Annual x Major = Amber
<b>Description of additional controls required (actions being taken)</b>	<b>Lead</b>	<b>Due date</b>
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
<b>(3) 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</b>	Weekly x Major = Red	Weekly x Major = Red
<b>Description of additional controls required (actions being taken)</b>	<b>Lead</b>	<b>Due date</b>
Delivery of year end position (Board reporting) with escalation as required	DoR	Mar 23 *
Agree financial position (including anticipated funding for 23-24) with the system and regional team	DoR	Mar 23 *
Agree budget position internally	DoR	Mar 23 *
Finalise CIPs to deliver financial plan for 2023/24 (dependant on response to system/regulatory framework)	COO / DoR	Mar '23 *
Review divisional business plans (underpinned by sustainable clinical models) to reflect the requirements to deliver additional backlog activity	COO	Mar '23 *
Develop a system wide information strategy with underpinning tools to improve performance monitoring	DoR	Jun '23
Respond to national guidance for operational planning cycle for 2023/24	NC	Apr '23 *

\* Deliver under review through the Financial Accountability Committee

	Residual Risk	Target Risk
<b>(4) 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.</b>  <b>Linked to structural risk assessment (ref. 24) rated as Red.</b>	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): <ul style="list-style-type: none"> <li>- Emergency planning</li> <li>- Assessment and repair</li> <li>- Bearing extension programme (to be completed Oct 21)</li> <li>- Remediation (failsafe installation)</li> <li>- Communication</li> <li>- Research and development</li> <li>- Site and system risk (including continued occupation of WSH site)</li> </ul>	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
<b>(5) 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</b>	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
Ensure engagement with ICS process to secure HSLI funding for developments in the west of Suffolk	Craig Black	Complete
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: <ul style="list-style-type: none"> <li>- Engagement with architects and surveyors on development of a digital twin for the new buildings</li> </ul>		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



## 6. OTHER ITEMS

## 6.1. Any other business

To Note

## 6.2. Reflections on meeting

For Discussion



**6.3. Date of next meeting - 21 July, 2023**

To Note

## RESOLUTION

The Trust Board is invited to adopt the following resolution:

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

# SUPPORTING ANNEXES







## 4.2 Finance - IQPR Full report March 2023

Trust Board	
Report title:	Integrated Quality and Performance Report
Agenda item:	
Date of the meeting:	
Sponsor/executive lead:	Sue Wilkinson, chief nurse and Nicola Cottingham, chief operating officer
Report prepared by:	Brain Alldis, information analyst. Narrative provided by clinical and operational leads.

Purpose of the report:			
For approval <input type="checkbox"/>	For assurance <input type="checkbox"/>	For discussion <input type="checkbox"/>	For information <input type="checkbox"/>
Trust strategy ambitions			
Please indicate Trust strategy ambitions relevant to this report.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>


Executive summary:	The Integrated Quality and Performance Report uses the Making Data Count methodology to report on the following aspects of key indicators: 1. Compliance with targets and standards (pass/fail) 2. Statistically significant improvement or worsening of performance over time. Narrative is provided to explain what the data is demonstrating the drivers for performance, actions being taken and assurance mechanisms. Please refer to the assurance grid for an executive summary of performance.
Action required / Recommendation:	To receive and approve the report.

Previously considered by:	Component metrics are considered by Patient Safety and Quality Group and Patient Access Governance Group.
Risk and assurance:	BAF risk 3.1: Failure to manage emergency capacity and demand in the context of Covid activity and delivery of the RAAC remediation plan  BAF risk 3.2: Delivery of elective access standards based on clinical priorities in context of Covid activity and delivery of the RAAC remediation plan (BAF 3.2) and the emergency demand
Equality, diversity, and inclusion:	Monitoring of waiting times by deprivation score and ethnicity are monitored at ICB level.
Sustainability:	N/A
Legal and regulatory context:	NHS Act 2006, West Suffolk NHS Foundation Trust Constitution

March 2023		ASSURANCE		
		Pass 	Hit and Miss 	Fail 
VARIANCE	Special Cause Improvement 			<u>Insight</u> RTT 78+ Week Waits VTE – All Inpatients <u>Involvement</u> Turnover Rate
	Common Cause 	2 week wait rapid chest pain	Please see box to right	<u>Insight</u> Ambulance Handover - 15 mins 12 hour Breaches Cancer 2 Week Wait for Urgent GP Referrals Total Cancer 62 Day GP Referrals Incomplete 104 Day Waits Diagnostic Performance - % withing 6 weeks Total <u>Improvement</u> Nutrition - 24 hours <u>Involvement</u> Staff Sickness Mandatory Training Appraisal Rate
	Special Cause Concern 		<u>Insight</u> Cancer 2 Week Wait for Breast Symptoms Total	<u>Insight</u> Cancelled Operations

Deteriorating

Not Met

  
**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  
18 Week % Compliance  
Ambulance Handover within 30 mins  
Ambulance Handover within 60 mins  
Cancer 28 Day Faster Diagnosis  
Cancer 62 Day Screening  
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

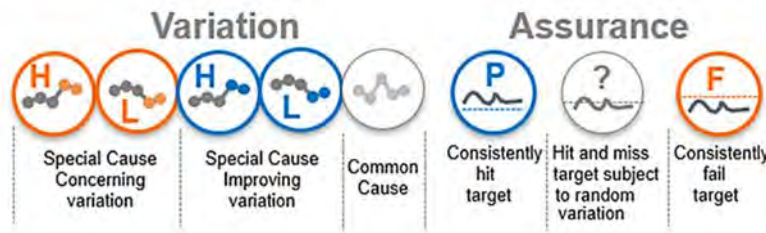
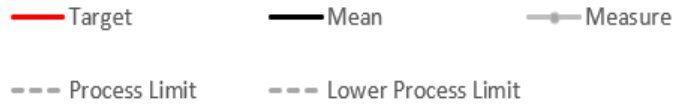
\*cancer data is 1 month behind

**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 15 mins, 12 hour Breaches  
 Cancer: Cancer 2 Week Wait for Urgent GP Referrals Total, Cancer 2 Week Wait for Breast Symptoms Total, Cancer 62 Day GP Referrals Total, Incomplete 104 Day Waits  
 Elective: RTT 78+ Week Waits, Diagnostic Performance - % withing 6 weeks Total, Cancelled Operations  
 Safe: VTE – All Inpatients, Nutrition -24 hours  
Involvement: Staff Sickness, Mandatory Training, Appraisal Rate, Turnover Rate



# INSIGHT COMMITTEE METRICS

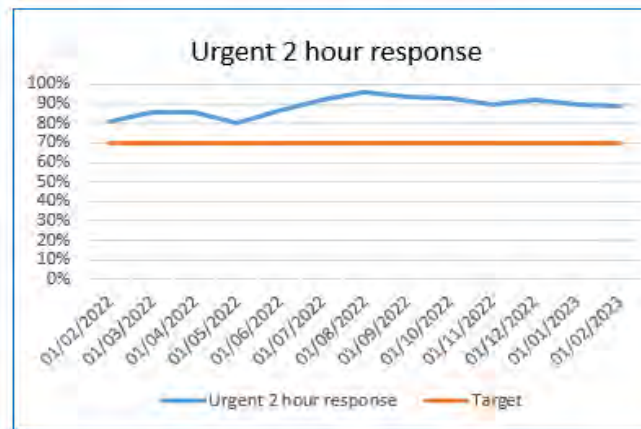
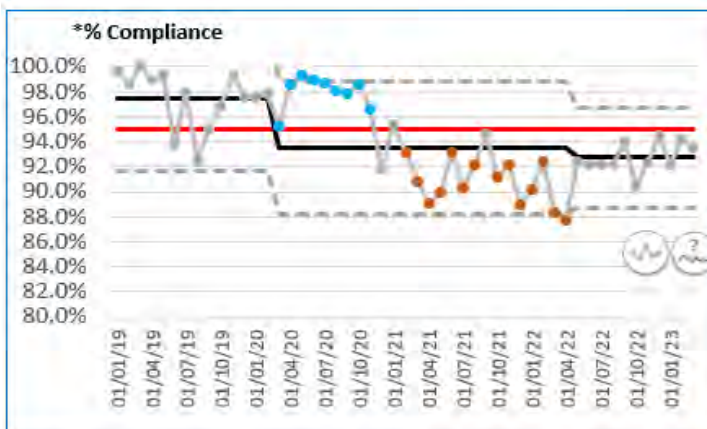
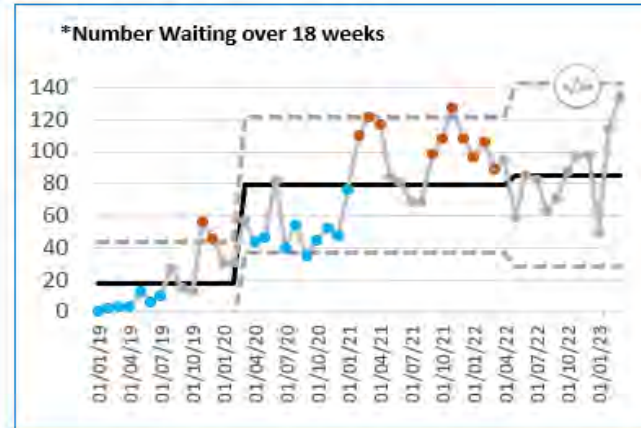
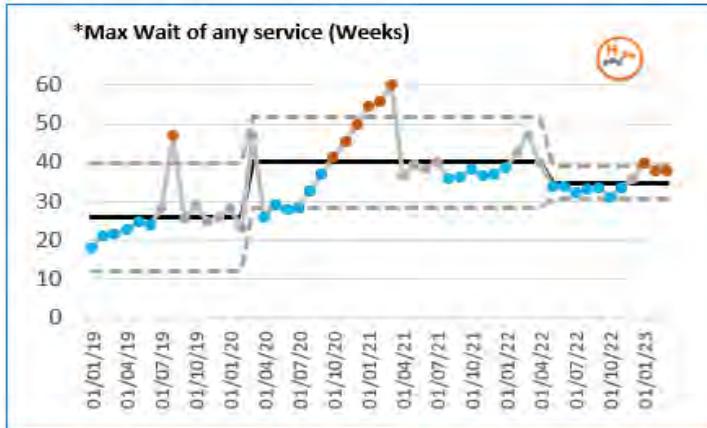
Chart Legend



KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
*Max Wait of any service (Weeks)	Mar 23	38	-			35	31	39
*Number Waiting over 18 weeks	Mar 23	134	-			86	28	143
*% Compliance	Mar 23	93.6%	95.0%			92.7%	88.7%	96.8%
Urgent 2 hour response	Mar 23	89.6%	70.0%					
Criteria to reside (Average without reason to reside) Acute	Mar 23	66	-			65	48	82
Criteria to reside (Average without reason to reside) Community	Mar 23	17	-			20	13	26

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





## Summary

### EIT

- A good month- Urgent Care Response (UCR) 2- hour response referrals are increasing.
- Paramedic in post helping team to broaden accepted referrals from Cleric
- EIT trainee ACPs rotations with Frailty and virtual ward
- Unable to recruit to Advanced Clinical Practice (ACP) post

### Wheelchairs

Compliance has slightly declined to 93% (with longest wait of 38 weeks) against a target of 95%. Revised trajectory from January as long-term sickness has affected performance against plan. IT implementation behind schedule and impacting on resource.

## Action

### EIT

- PGD to support paramedic and ACP occupational therapist-geriatrician has agreed to support but no agreed time frame of completion
- Requested to remove 4 hour response time- await community informatics to approve
- Meeting with integrated Neighbourhood Teams (health and social care), Dementia Intensive Support Team and hospice to look at UCR across the alliance on 27.04.23
- Step up to virtual ward agreed and due to commence early May

### Wheelchairs

- Discussion with ESNEFT/NHSPS to change/maximise clinical usage. Business case for succession planning underway as risk of future gap in provision. Alignment with NEE in PWB performance to ensure consistency in processes.

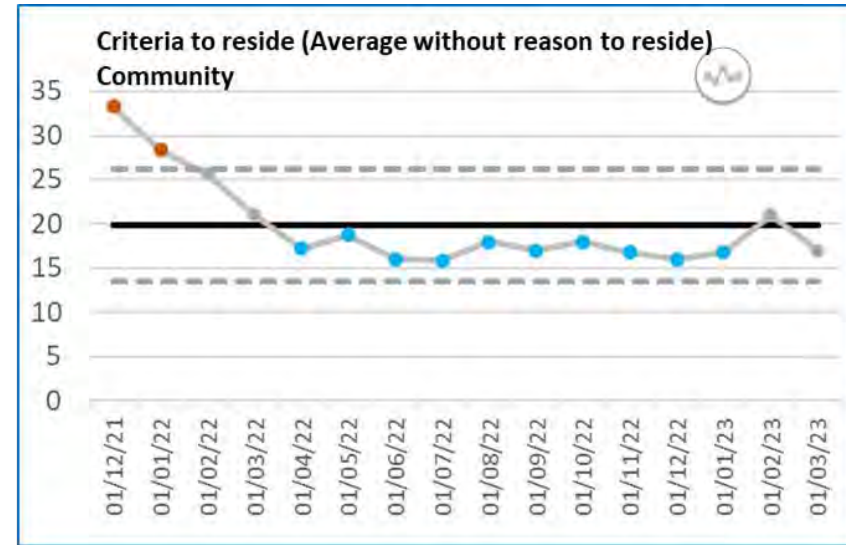
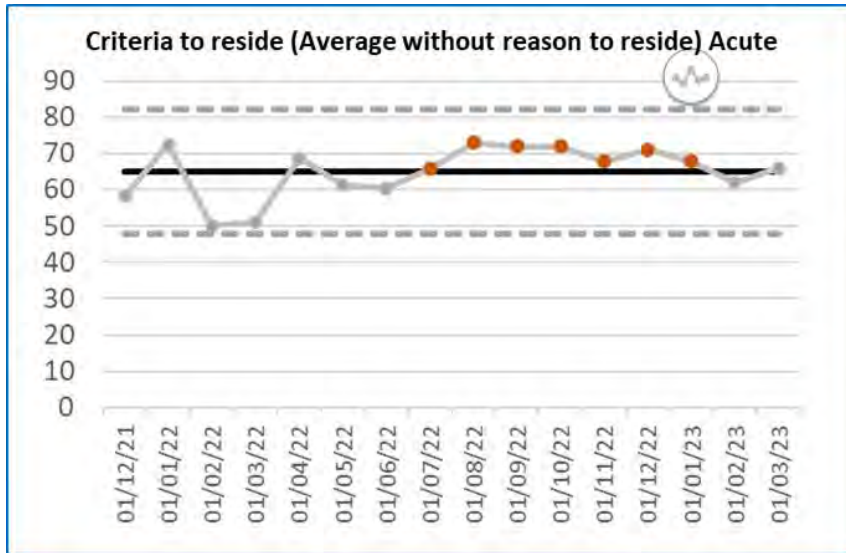
## Assurance

### EIT

- Monitoring data to look at trends and activity
- Review use of paramedic and increase in referrals
- Aim to move to 2 hour response only by June
- PRM, PAGG, ICB, Eastern Region, NHSE

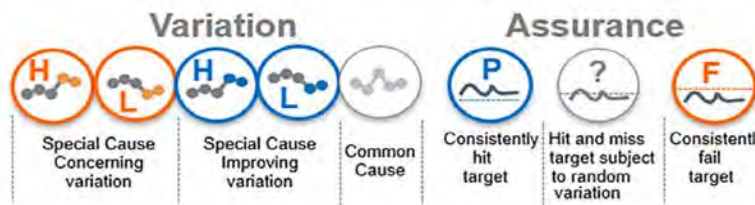
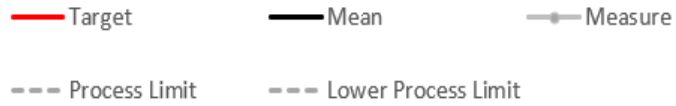
### Wheelchairs

Assurance via Service level review, PRM, PAGG, Insight, Community Contract Meeting.

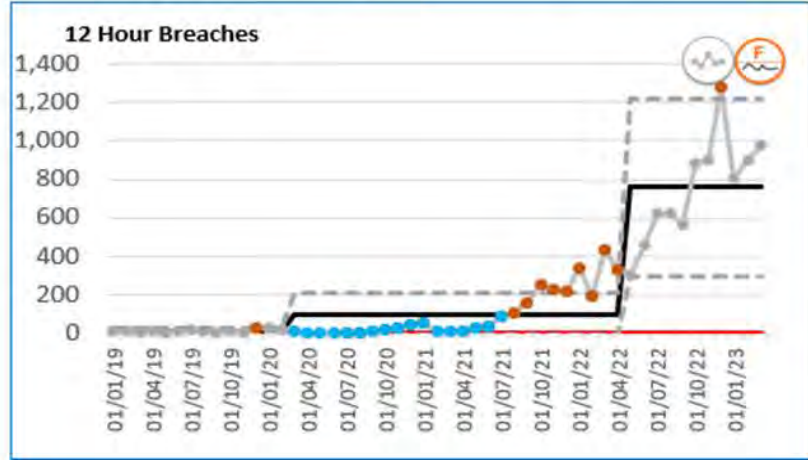
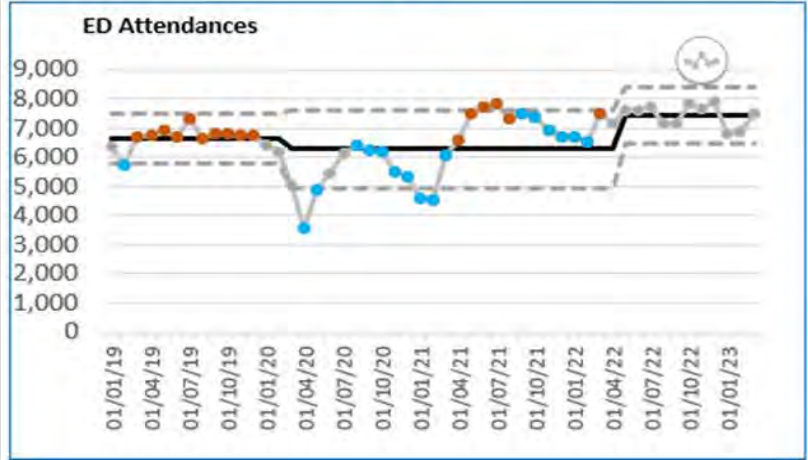
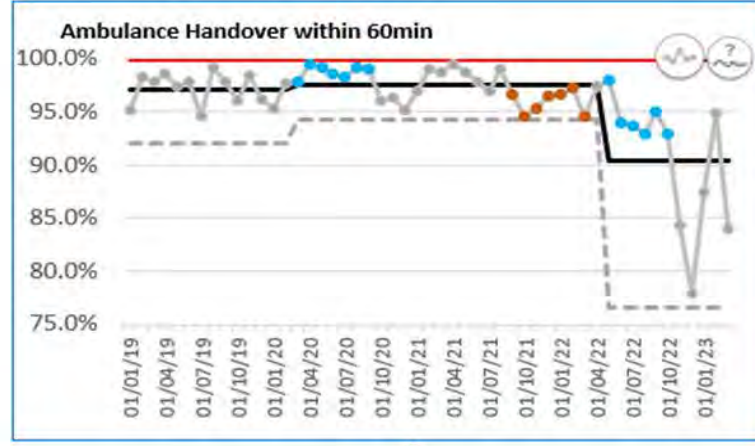
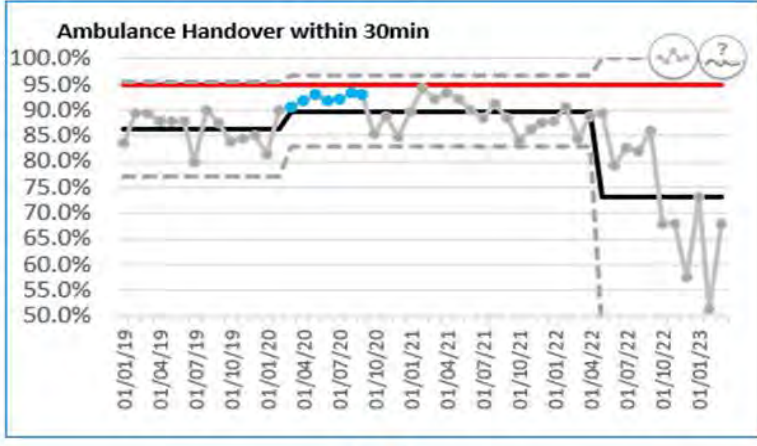
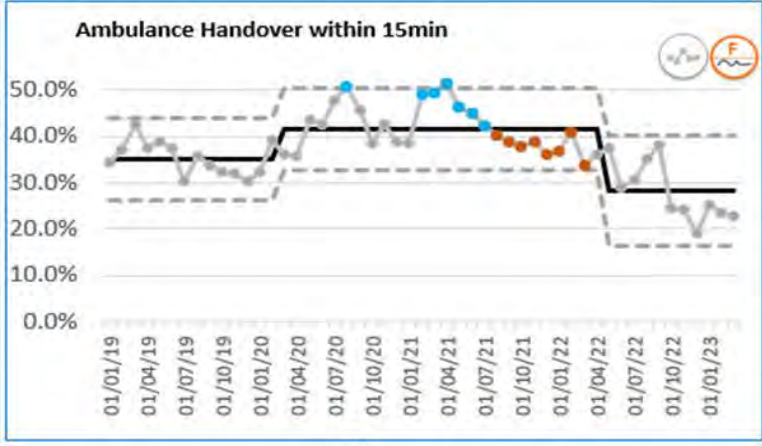


Summary	Action	Assurance
<p>Acute reason to reside numbers demonstrate an increasing trend. Reasons include ongoing challenges with very complex patients with behavioural/cognitive issues and delirium patients whose discharge are often complicated by finding homes who are able to meet their needs. There continued to be a number of pathway 2 and 3 patients who tested positive for covid on discharge swabs increasing length of stay due to the ongoing isolation requirements – care homes are always asked if they will accept covid positive patients however very few accept.</p>	<p>With the number of interim beds available reducing significantly from 1<sup>st</sup> April 2023 work is being undertaken to review admission criteria in conjunction with acute and community teams. Ensuring early assessment by Adult Social Care and therapies once patients are transferred to interim beds will help minimise discharge delays and maximise flow through bed bases. Further focused work on improving flow through Newmarket, Glastonbury Court and Hazel Court is also being undertaken with support from the trust operational improvement team. Review of the Non-Weight Bearing pathway is to be undertaken as this cohort of patients are seeing lengthy stays in the CAB settings, impacting on flow and bed availability.</p>	<p>System and Alliance focus on building capacity to enhance transfer of care arrangements through the Alliance Operational Delivery Group and the SNEE Urgent and Emergency Care group. Daily monitoring through Transfer of Care Hub meetings of both acute and community delays. Work is currently being undertaken by the trust information team to create a power BI discharge dashboard to provide greater detail around discharge pathways, length of stay and a number of other discharge related metrics.</p>

**Chart Legend**



KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Ambulance Handover within 15min	Mar 23	22.9%	65.0%			28.2%	16.3%	40.0%
Ambulance Handover within 30min	Mar 23	68.0%	95.0%			73.2%	46.4%	100.0%
Ambulance Handover within 60min	Mar 23	84.0%	100.0%			90.5%	76.6%	104.4%
ED Attendances	Mar 23	7525	-			7448	6497	8399
12 Hour Breaches	Mar 23	978	0			758	291	1224



## Summary

Ambulance handover times remain a challenging picture, failing to meet the targets and no significant improvement demonstrated.

Similarly, no improvement has taken place in the number of 12 hour length of stay patients, in March 12.9% of attendances remained in department >12 hours.

March was a challenged month in terms of flow, the trust experienced 2 critical internal incidents, a 3 day period of industrial action from junior doctors, multiple bay and ward closures for norovirus. We also saw an increase in covid activity, with an average number of 50 patients per day across March. These incidents had a direct influence on the flow out of ED as seen in the increase in 12 hour waits.

## Action

Agency paramedic company providing paramedic/technician crews to consistently manage reverse cohorting/ambulance cohorting areas.

Exploring use of 'flexible' cohort space within AAU corridor to provide 5 additional cohort spaces. Flexible refers to the use as either ambulance offloads or 'reverse cohort' where patients have been seen and treated and are awaiting onward transfer – this could either be from ED or from AAU. This cohort only utilised during times of extreme pressure (Opel 4)/critical incident.

To ensure patient safety ED Consultants are reviewing and initiating investigations for patients in any queuing ambulances if cohorting area is full. Post take ward rounds continuing for long stay patients

12 hour length of stay action plan focussing on areas for improvement and actions.

UEC recovery plan to include plans for the return of the 4 hour standard and reporting in May 2023.

Weekly UEC meetings commenced with focus on work streams within phase 1 of recovery plan

New pathways into SDEC – to relieve pressure in ED – working with the ambulance service to commence direct SDEC referrals.

During March NHSE Improvement colleagues facilitated a Missed Opportunities Audit within WSFT. Colleagues across the system attended event and reviewed all patients attending ED over 24 hour period. Aim to review if alternative pathways could have been utilised instead of ED attendance. Outcomes and opportunities of review are included on phase 2 of UEC recovery plan.

## Assurance

Continue to monitor GP utilisation.

Harm reviews ongoing for a % of all 12 hour length of stays and patient waiting on ambulances greater than 1 hour.

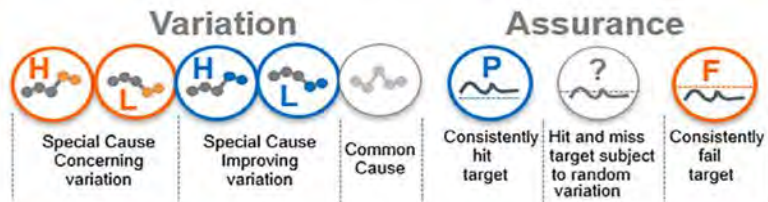
UEC metrics monitored via Patient Access Governance group feeding into WSFT Insight group and West Suffolk Alliance Operational Resilience Group

Core Resilience Team (CRT) workstreams focussing on key projects around Right Care, Right Place, Right Time

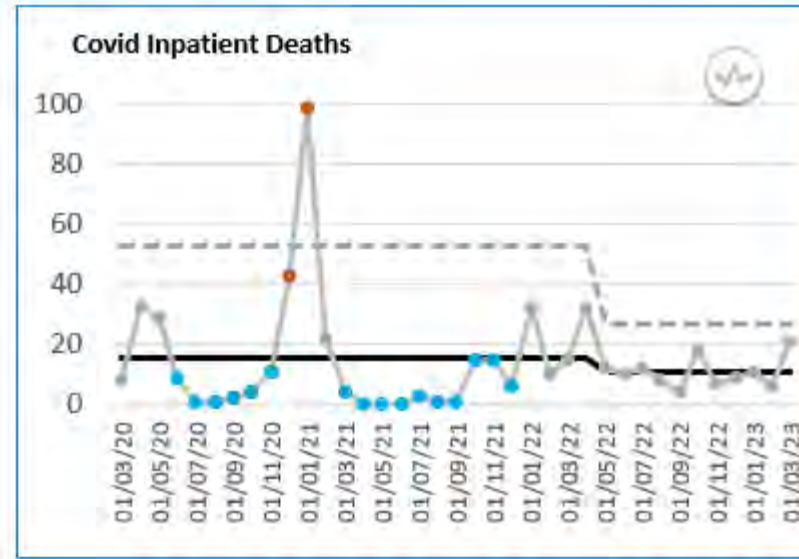
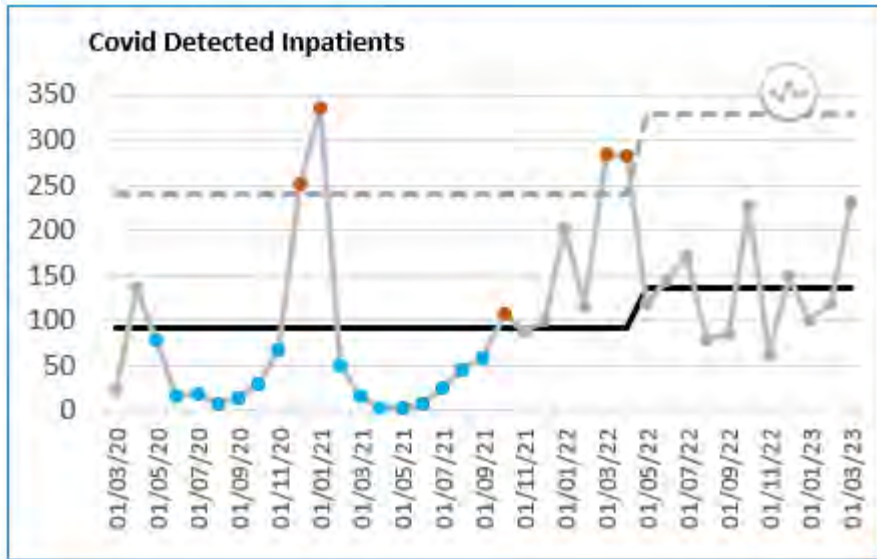
Weekly UEC Recovery Plan meetings feeding into PAGG

Chart Legend

- Target
- Mean
- Measure
- Process Limit
- Lower Process Limit

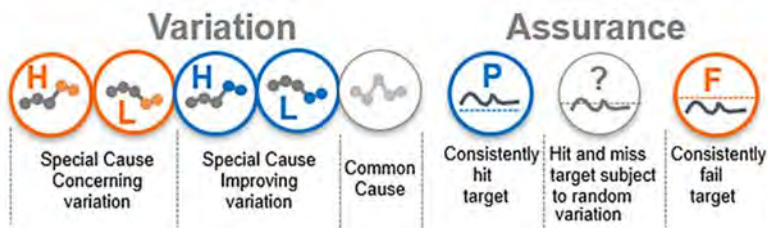
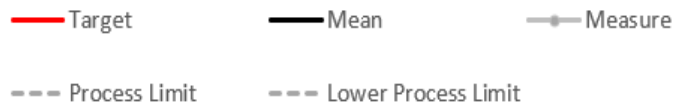


KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Covid Detected Inpatients	Mar 23	232				135	-58	329
Covid Inpatient Deaths	Mar 23	21				11	-5	27



Summary	Action	Assurance
<p>Increasing inpatient numbers seen in March consistent with increasing community prevalence. Increased numbers include some nosocomial transmission but not in significant numbers.</p> <p>This fluctuant variance is what is predicted to been seen over the coming months, however modelling is more difficult to predict due to reduction in community testing and self testing</p>	<p>Patients isolated within dedicated ward and side rooms as per current process</p> <p>Changes in national guidance regarding inpatient and staff testing was released 31<sup>st</sup> March 2023. In summary this is a reduction in testing regime for admissions and for inpatient management. This will be considered and presented to IPCC committee for formal sign off and change to current policy</p>	<p>Potential clusters and outbreaks identified through IPC surveillance</p> <p>Changed to national guidance will be adopted after assessment and consideration of impact and co-dependencies</p>

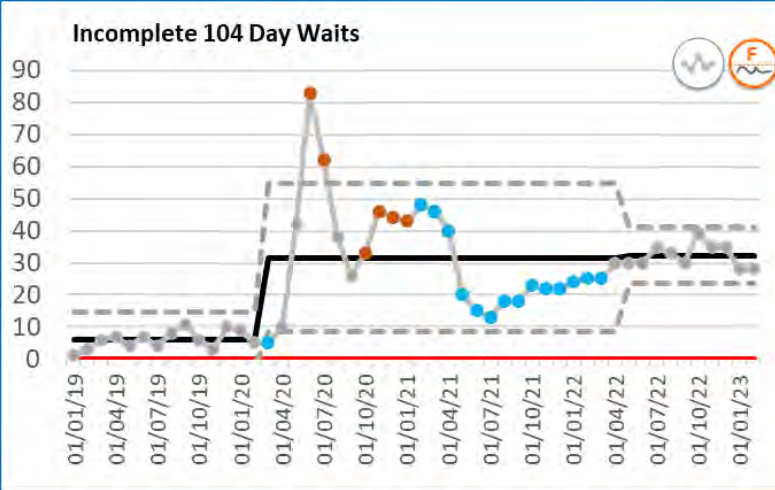
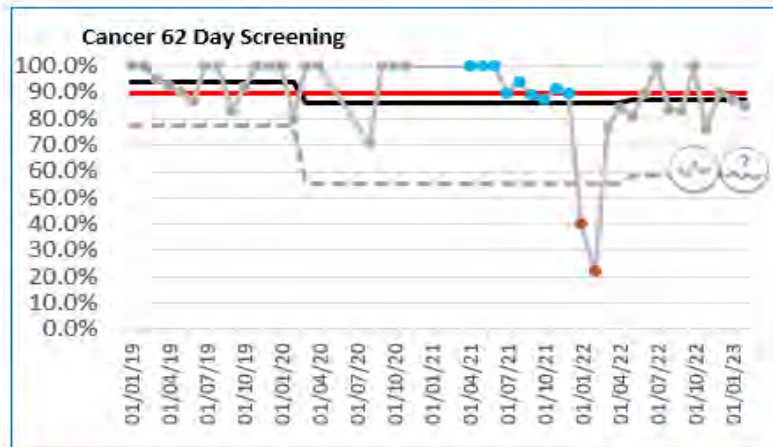
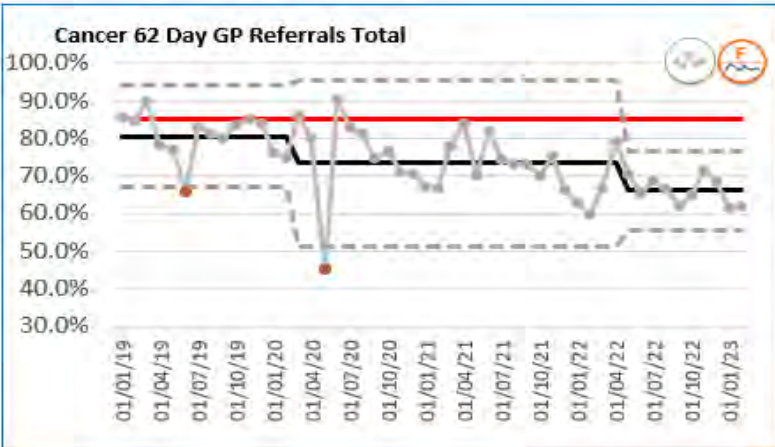
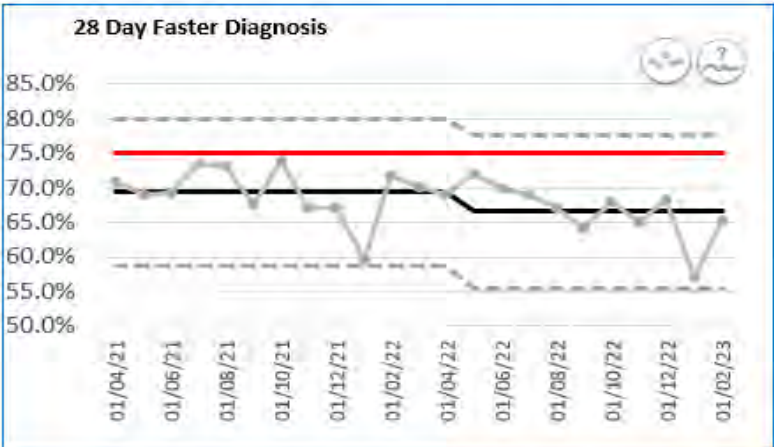
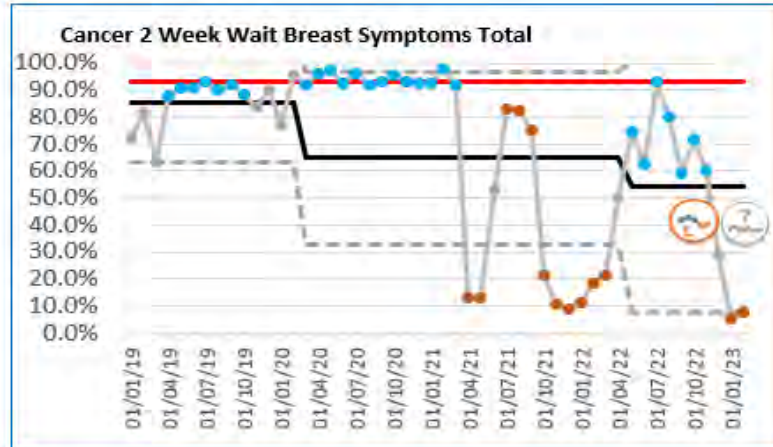
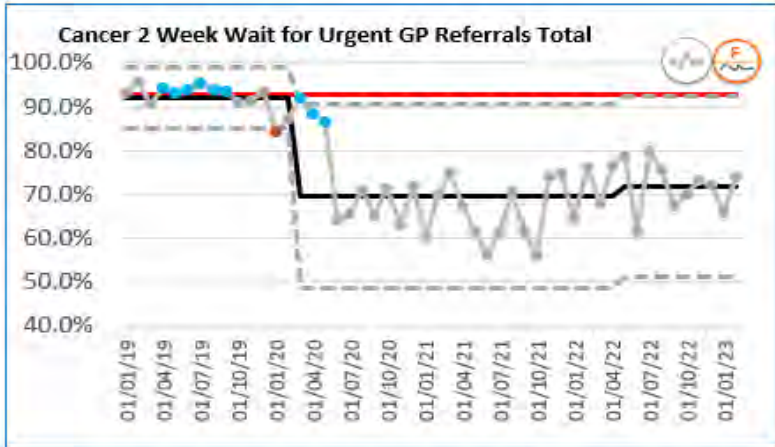
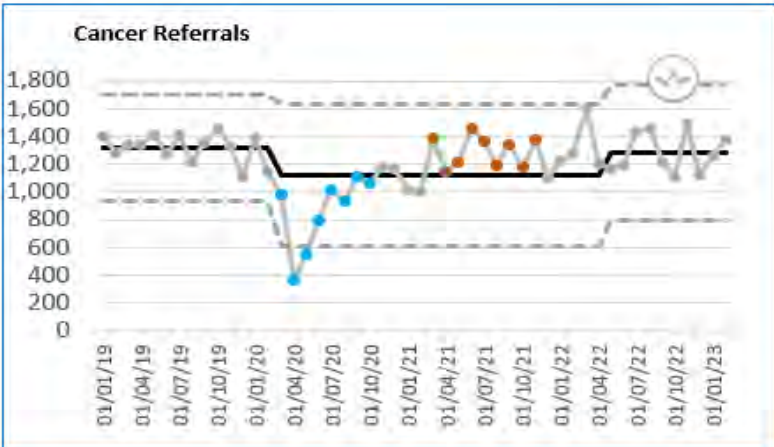
Chart Legend



KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Cancer Referrals	Feb 23	1378	-			1284	794	1773
Cancer 2 Week Wait for Urgent GP Referrals Total	Feb 23	74.1%	93.0%			71.9%	51.4%	92.5%
Cancer 2 Week Wait Breast Symptoms Total	Feb 23	7.5%	93.0%			54.4%	7.8%	100.9%
28 Day Faster Diagnosis	Feb 23	65.2%	75.0%			66.6%	55.5%	77.7%
Cancer 62 Day GP Referrals Total	Feb 23	62.1%	85.0%			66.2%	55.7%	76.7%
Cancer 62 Day Screening	Feb 23	84.6%	90.0%			87.6%	58.8%	116.4%
Incomplete 104 Day Waits	Feb 23	28	0			32	23	41

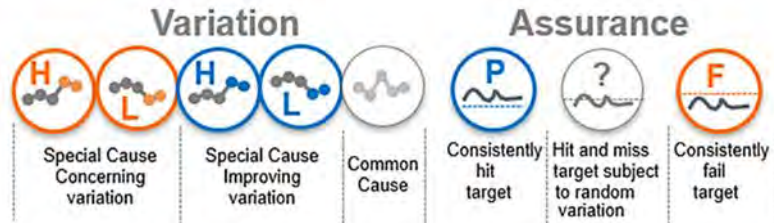
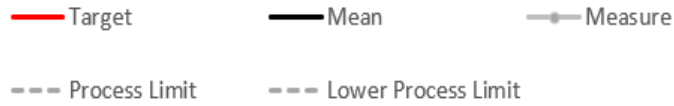


# Cancer Access (Month Behind)

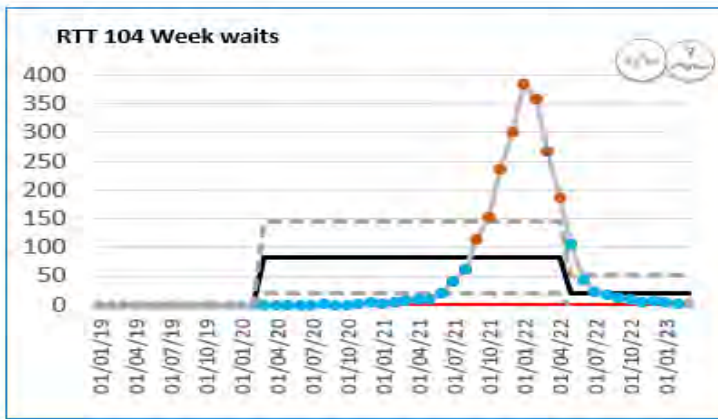
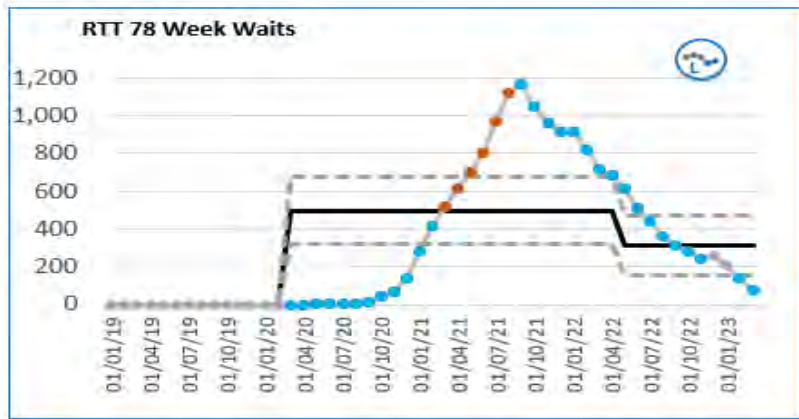
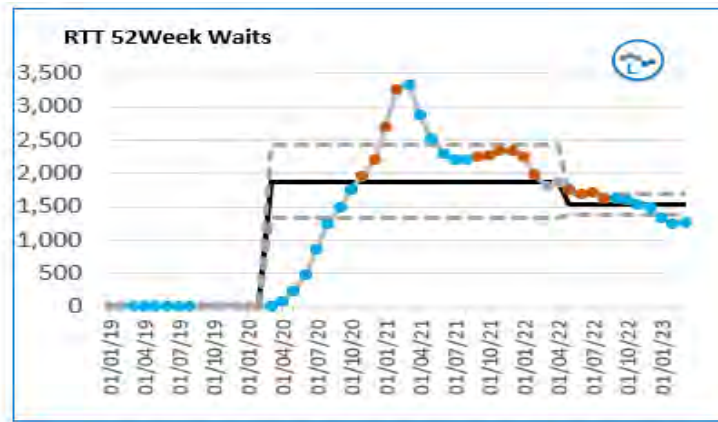


Summary	Action	Assurance
<p>All of the cancer standards demonstrate a variation in compliance, with none of the KPI’s demonstrating an improving trend as of yet, there is a trajectory in place for the 28 Day standard and 62 day backlog as operational priorities for 23/24. We forecast the 28 day position to begin to demonstrate improving variation from March 2023 onwards through to March 2024 compliance.</p> <p>For 2ww performance, Breast continues to be the main driver for under performance at 12% compliance. Lower GI demonstrated some improvement to 60%, with Head and Neck, Lung and Skin all compliant with the standard and Urology and Gynaecology both over 84% compliant. Breast is successfully maintaining over 88% compliance for 28 day pathways despite the 2ww under performance.</p> <p>For 62 day performance, Lower GI (23%), Urology (73%) and Skin (70%) are again the main drivers for the under performance, however it’s worth noting the overall wait time improved in these areas.</p> <p>The 62 day backlog was 121 patients at the end of March 2023 and well on track to deliver 98 by March 2024 as has been set for us by the national team.</p>	<p>A full quality improvement plan is in place.</p> <p>Some of the key actions within this include:</p> <ul style="list-style-type: none"> <li>• Complete actions from BPTP for Skin and Colorectal for which only one is now outstanding: <ul style="list-style-type: none"> <li>• Increasing scope of Colorectal STT nurses to support with non-cancer results – with additional funding now secured</li> </ul> </li> <li>• Complete the Prostate BPTP and present back to clinical teams to ascertain improvement actions.</li> </ul> <p>In addition to the above, actions that were discovered as part of the BPTP audits but will provide tumour site wide improvements:</p> <ul style="list-style-type: none"> <li>• Interface between Somerset and e-Care</li> <li>• Template letters</li> <li>• Real time updating of PTL</li> <li>• Live dashboard showing when results reported</li> </ul> <ul style="list-style-type: none"> <li>• Review of head and neck pathway, improved triage and one stop US +/- biopsies – funding now secured to commence in Q3 23/24.</li> </ul>	<p>Recovery is monitored through local Cancer PTL meeting as well as SNEE wide Cancer Board and Cancer alliance level forums.</p> <p>Performance against trajectory for 62 day backlog is monitored via Insight committee.</p>

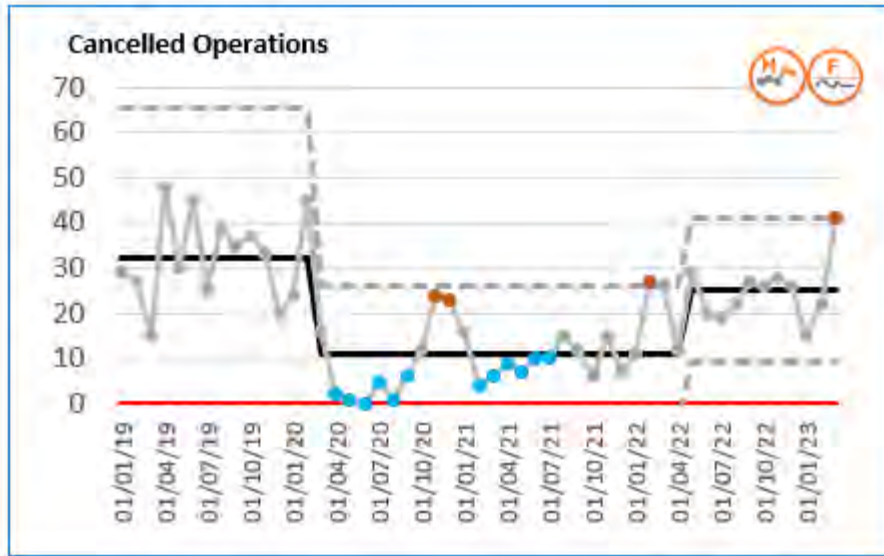
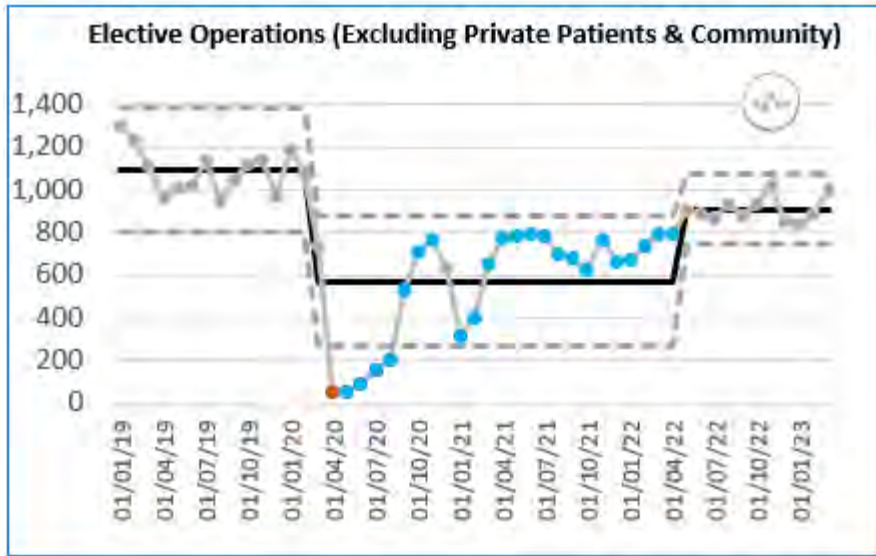
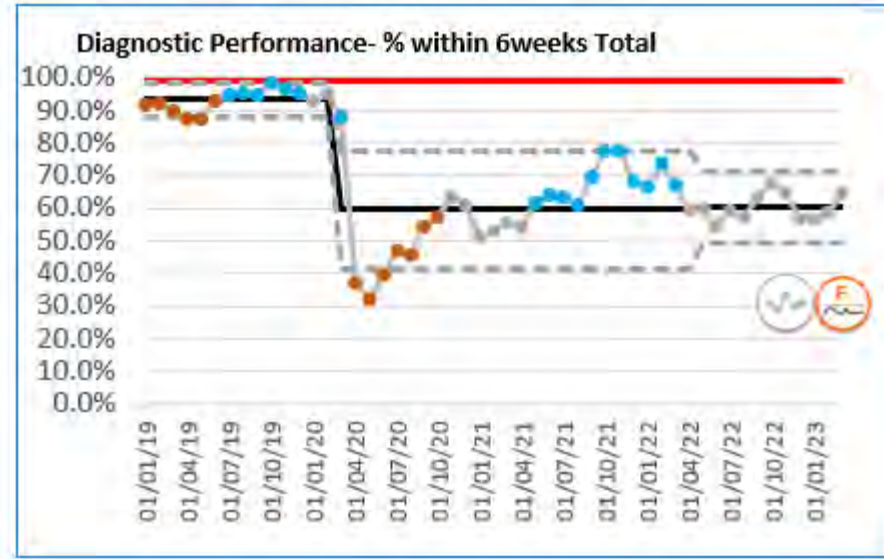
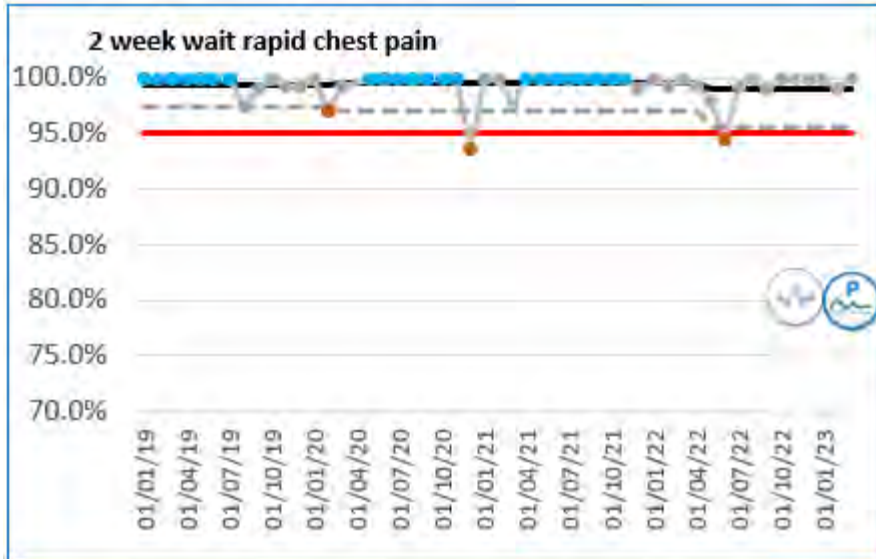
**Chart Legend**



KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
RTT Waiting List	Mar 23	31376				30300	28565	32034
RTT 52+ Week Waits	Mar 23	1255				1531	1381	1682
RTT 65+ Week Waits	Mar 23	384						
RTT 78+ Week Waits	Mar 23	73	0			313	158	468
RTT 104+ Week waits	Mar 23	2	0					
2 week wait rapid chest pain	Mar 23	100.0%	95.0%			99.1%	95.7%	102.4%
Diagnostic Performance- % within 6weeks Total	Mar 23	64.5%	99.0%			60.4%	49.4%	71.3%
Elective Operations (Excluding Private Patients & Community)	Mar 23	997						
Cancelled Operations	Mar 23	41	0			25	9	41
Cancelled Operations 2nd time	Mar 23	0						



Summary	Action	Assurance
<p>The total waiting list size has shown an increase but is not a concerning variation and is likely to be partly contributed to the reduction in activity and therefore clock stops due to industrial action. The 52 week and 78 week position is demonstrating continued improving variation, with the 78 week end of year position at 41 capacity breaches, following an original forecast of 200 and revised forecast of 100. The number of patients over 104 weeks was 2, both of which were revalidated pathways, there was a common cause for this with revised process' in design to avoid this in the future as much as possible.</p>	<p>The focus continues to be in reducing the longest waiting patients, and to achieve a maintained 0 position for 104 week waits and continue to reduce the 78 week capacity breaches. The actions to achieve this include:</p> <ul style="list-style-type: none"> <li>• Increased focus on all elements of validation – technical/administrative/clinical as required to ensure waiting list is cleansed</li> <li>• Use of digital mutual aid system for support in areas of capacity constraints</li> <li>• Continued review of ICS waiting lists to ensure equity across system.</li> <li>• Monitor reduction in 65 week wait cohort size.</li> </ul>	<p>Progress against trajectory and action plans are monitored at the weekly access meetings, which feed into the insight committee.</p> <p>The position is also monitored across the ICS via the operational hub meetings feeding into the SNEE Elective and Diagnostic Committee</p>



Summary	Action	Assurance
<p>Common cause variation, no significant change. The system is not capable and will fail to consistently meet target without significant change.</p> <p><b>MRI</b> - Running at full capacity across the seven days but current capacity insufficient.</p> <p><b>CT</b> – performance negatively has been impacted by the replacement programme but is currently meeting DM01 compliance target.</p> <p><b>US</b> –Sub-speciality analysis within US demonstrates a lower performance for biopsy and neck US. Vascular performance is not reportable under DM01 and has now been excluded from the data is but monitored closely within the service and via weekly access meeting.</p> <p><b>Endoscopy</b> – 2WW 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.</p> <p>The utilisation of CNS resource in cystoscopy to support delivery and locum additional sessions has supported ongoing improvement in urology. However, March was a challenge and although a validated position is not available due to delayed coding we are predicting a 20% deterioration based on demand for TP biopsies and COVID related staff absence. To mitigate this loss we are working with Xyla again, who will be delivering 8 weekends of TP activity, this may be extended once cancer alliance funding confirmed. This will release substantive staff to deliver cystoscopy/urodynamics. Manager undertaking concentrated focus on monitoring compliance and this aligns with start of upward trend.</p> <p>Audiology validation continues to support improvement but additional estate is required to support compliance, audiology clinical recruitment successful so room capacity is limiting factor.</p>	<p><b>MRI</b> –Assessment against projected CDC opening being undertaken to establish potential funding required. Two weeks of additional capacity has temporarily improved DM01 performance but this will return to previous levels now that this has ceased. 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.</p> <p><b>CT</b> - performance continues to recover with improvements observed in each of the last 3 months but will be further impacted by CT replacement programme. Longer term CDC will begin to address.</p> <p><b>US</b> – US showing observable improvements across the last three successive months aligning to plans established for recovery. The trajectory will improve pending cancer alliance funding for additional consultant PA’s to support the biopsy and neck US subspeciality.</p> <p><b>Endoscopy</b> - 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.</p> <p>Current trajectory anticipates compliance in January 2025 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. A further paper to exec colleagues is due in Early May to explore further options to support the service.</p> <p>The additional IS capacity available via InHealth (160 patients/month) and at the BMI (48 patients/month) has now been established and is moving forward which will have a positive influence on performance from April onwards. This is not yet demonstrable in the March data. Gastroenterology consultant recruitment is still pending with interviews imminent.</p> <ul style="list-style-type: none"> <li>• Building on current improvement trajectory to support DM01 compliance. Urology, in particular does not have adequate workforce to support demand and population size. BC going to investment panel May to support service growth.</li> <li>• Ongoing monitoring of position</li> </ul>	<ul style="list-style-type: none"> <li>• Ongoing performance will be monitored at the weekly CSS access meeting, Divisional PRM and the Elective Access Insight Meeting.</li> <li>• Business meeting</li> <li>• Divisional Board</li> <li>• Pre-PTL</li> <li>• Access meeting</li> </ul>

## 4.4.1 Maternity - Annexes

**Report on Paediatric Medical Staffing for the Neonatal Unit - Report for 1<sup>st</sup> March 2022 – 31<sup>st</sup> August 2022**

<b>Report Title</b>	<b>Paediatric Medical Staffing in the Neonatal Unit 1<sup>st</sup> March 2022 to 31<sup>st</sup> August 2022</b>
<b>Report for</b>	Information and Approval
<b>Report from</b>	Women's & Children's Services
<b>Report Author</b>	Beverley Gordon, Project Midwife, WSH Dr Jageer Mohamed, Neonatal Safety Champion Tayyaba Aamir, Lead for Neonatal Services
<b>Approval</b>	Maternity Quality & Safety 20 <sup>th</sup> March 2023 Maternity & Neonatal Safety Champions 23 <sup>rd</sup> March 2023 Trust Board 26 <sup>th</sup> May 2023

**Executive Summary**

In order to evidence safe staffing levels within the neonatal and maternity services, a review of the paediatric junior medical staffing has taken place over a 6-month period to ensure the staffing meets the British Association of Perinatal Medicine (BAPM) standards for a level 1 Special Care Unit.

**Conclusions**

The Trust meets the standards expected during this period of time. This has been achieved by rota management, the use of locums and staff acting down when required to provide safe staffing levels. It is not always clear from the rotas when clinical activities or training has been restricted due to shortages.

**Next steps**

Further work is required to ensure the process for obtaining safe staffing levels is formalised

and embedded and the systems accurately reflect the work involved in maintaining standards. Whilst this work is being undertaken effectively and there are no concerns with the rota cover or management, a written and agreed process would make this clear and available to all.

It is planned that the neonatal and paediatric medical staff health roster will be fully electronic when the resources are available.

There should be evidence of escalation if there are concerns regarding the staffing establishment and allocation of trainees to the Trust. This would include business case presentation to the Division and Trust if required, for maintenance of a safe service, service development and improvement.

With the pandemic easing, there should be quarterly reports on the use of locums to demonstrate that the appropriate staffing levels are in place and locum usage is appropriate and reducing if vacancies are filled and the establishment is correct.

This report will need to be repeated every 6 months as assurance of standards being maintained and progress on other safety and quality actions.



## 1. Background

NHS Resolution is operating a fourth year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care. There are 10 safety actions for Trusts to have in place to assure the women, families and the NHS of their commitment to safety.

The neonatal unit at the West Suffolk Hospital NHS Trust is a designated Special Care Baby Unit (level 1).

In the submission for evidence in year 3 of the Maternity Incentive Scheme in July 2021, the Trust declared that they were compliant with the BAPM requirements and therefore an action plan was not required.

In August 2021, year 4 Maternity Incentive Scheme was launched the Safety Action was relatively unchanged and the expectation is that Trust embeds the process for assessing and responding to the findings on a 6-monthly basis. This is to ensure that medical staffing of neonatal services continues to meet the standards expected for safety and quality of care for neonates from birth. After a period of being on hold, the safety standards were re-launched in October 2022.

### **Processes involved in review and rota management**

The rotas have been reviewed for the period of time covered by this report – 1<sup>st</sup> March to 31<sup>st</sup> August 2022.

The Paediatric medical staff rotas are kept up to date by the Assistant Service Manager, the rota coordinator, and one of the personal assistants to the Consultant Paediatrician.

The Consultant Paediatrician day to day rota is recorded on an Excel spreadsheet and includes data on the consultant paediatrician's rota for 4 key areas: the consultant paediatrician on call for the week (or day); the consultant paediatrician on call for the night; the consultant paediatrician who is allocated/dedicated to the neonatal unit cover Monday, Wednesday and Friday mornings; the consultant allocated to Children's Assessment Unit (CAU) and the Emergency Department (ED) 9.00-13.00 and 13.00-17.00 Monday to Friday (except Public Holidays). There are 15 consultants on the rota, 3 of these are acute consultants. There is a partial use of the electronic health roster for recording planned leave, and when the consultant is rostered to undertake a planned on call at a lower grade to cover the rota. It is hoped that the rota will become fully electronic when resources are available.

The rota does not give details of any other clinical activity such as clinics so the information on how the escalation works in practice when consultant paediatricians have to be diverted from one activity to cover the on call is limited.

An electronic health roster is used for the Tier 1 and Tier 2 paediatric staff. The roster gives details of the Tier 1 and Tier 2 doctors allocated to various aspects of the paediatric service. During the normal working day – Mondays to Fridays 9.00-17.00 – there is specific Tier 1 and Tier 2 cover to the Neonatal Unit, Maternity wards and attendance at births when required. From 17.00-21.00 and overnight and weekends there is one Tier 1 and one Tier 2 doctor covering the paediatric services including neonatal unit, maternity wards and attendance at births.

Some support for neonatal care is provided by Registered Nurses who have completed training to Advanced Children's Nurse Practitioner level (NB not neonatal nurse practitioner level). The nurse practitioners who cover neonatal care undertake the

Neonatal Life Support (NLS) training locally and the 3 yearly external training. They are not included on the on-call rota. In addition, Physician Associates (PA's) are employed to assist the Tier 1 doctors. They are also not on the on-call rota.

The health roster gives details of the consultant paediatrician's leave – planned and unplanned, planned training days/courses and indicates if the consultant is covering the rota at Tier 1 and Tier 2 level. Some of this cover is planned as part of their role (the acute consultants for example) and some as part of escalation to cover staffing shortages.

The electronic health roster gives the names of locums used across all grades. If the shift is not covered, this will be in red on the roster. Usually a locum is requested if time allows and if this is not successful, existing staff will be asked to provide cover either by reallocating planned work or by providing cover as a locum. If this is also unsuccessful, the consultants will be asked to 'act down' and another consultant will take over the on-call duties.

Some of the 'acute' consultants cover the work of the Tier 2 on a regular, planned basis. The experienced Specialist doctor (Staff, Associate Specialist and Speciality doctor - SAS) provides cover at Consultant level when required as well as at Tier 2.

The consultants usually cover the day and night from Friday morning through to Monday morning and the full 24 hours of public holidays.

## 2. Standard to be achieved:

### **Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?**

This report relates to the neonatal medical workforce specifically.

#### **Standard expected for the Neonatal medical workforce**

*The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing.*

#### **Neonatal medical workforce**

*The Trust is required to formally record in Trust Board minutes whether it meets the recommendations of the neonatal medical workforce training action. If the requirements are not met, Trust Board should evidence progress against the action plan developed in year 3 of MIS to address deficiencies.*

*If the requirements had not been met in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies.*

*If the requirements had been met in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies.*

#### **Technical Guidance: Neonatal Workforce standards and action**

### **Do you meet the BAPM national standards of junior medical staffing depending on unit designation?**

*If no, Trust Board should outline progress with the action plan developed in year 3 of MIS and submit this to the Neonatal ODN.*

*There should also be an indication whether the standards not being met is due to insufficient funded posts or no trainee or/suitable applicant for the post (rota gap). There should also be a record of the rota tier affected by the gaps.*

**BAPM**

*“Optimal Arrangements for Neonatal Intensive Care Units in the UK. A BAPM Framework for Practice” 2021*

or

*“Optimal arrangements for Local Neonatal Units and Special Care Units in the UK including guidance on their staffing: A Framework for Practice” 2018*

**Special Care Unit (SCU)****Tier 1**

A resident tier 1 practitioner dedicated to the neonatal service in day-time hours on weekdays and a continuously immediately available resident tier 1 practitioner to the unit 24/7. This person could be shared with a co-located Paediatric Unit out of hours.

**Tier 2**

A resident tier 2 to support the tier 1 in SCUs admitting babies requiring respiratory support or of very low admission weight <1.5kg. This Tier 2 would be expected to provide cover for co-located paediatric services but be immediately available to the neonatal unit

**Reporting Period**

A review has been undertaken any 6-month period before 30 June 2022. Whilst this is a fixed period of time set by the MIS year 4 safety actions, it is expected that this process is an ongoing process of assessment and review each and every year. The Ockenden recommendations indicate that a 6 monthly reporting process is required to maintain standards and identify areas we need to escalate and manage.

**3. Findings****Review of rotas**

Having reviewed the rotas, there were ‘red’ areas on the rota where it appeared that shifts were not covered. On closer inspection and enquiry, however, and a review of all the staff on duty, the majority of these shifts appear to have been covered with existing staff being reallocated, locum staff or acting down meaning that the rota has no unfilled shifts. There was one occasion where, due to sickness, a short period of one shift on the neonatal unit where the registrar cover was provided by the on call registrar but this was risk assessed at the time and accepted.

This review and analysis confirm that **the Trust meets the BAPM standards of junior medical cover** for the Neonatal Services provided by the Trust and the Special Care Baby Unit during this period of time.

**Additional findings**

- There were a number of absences when staff across all grades had to isolate due to Covid 19 restrictions and high levels of infection in this period of time.
- **Consultant Paediatricians:**  
It is noted that during this period of review that there was a delay in the commencement of the neonatal lead consultant – she commenced work in August 2022 which will alleviate the need for usage of some locum consultants. Some short and long-term shifts have been covered by reallocation of duties,

locum consultants and the SAS doctor has also provided consultant cover in addition to covering Tier 2 shifts as a routine basis.

## Planning and Staff Vacancies

### Consultant:

August 2022 – Onward

### Gaps:

1. *6 PA Acute consultant gap approx. 0.2 WTE on the acute rota affected by this.*

- **Tier 1 and 2:**

The use of locums continues to provide short and longer-term cover when required. There are internal and external locums: the internal locums are staff who do additional hours to their contracted hours. The number of additional hours undertaken is kept within the maximum hours allowed under these circumstances for any one individual doctor. The external locums are obtained through the agreed Trust processes.

In addition, some consultants will be required to act down to fill rota gaps, especially if this is required at short notice. If the consultant on call needs to act down, another consultant will be requested to take over the on-call role.

As the consultants usually cover the day and night cover from Friday morning through to Monday morning and the full 24 hours of public holidays, where the consultant is covering as a locum in these periods of time, only one session for the whole 24 hours has been counted in the numbers. At all other times, during normal week days and nights, this is counted as individual sessions of locum cover for day and/or night.

## Planning and staff vacancies

### Tier 1

As at August 2022 the vacancies at **Tier 1** are:

### Gaps:

- *1.1 WTE, both Paeds training gaps, mitigated through locum cover and rota adjustments in advance.*

### Trajectory:

*September to December - no gaps.*

### Tier 2

For August and September 2022, the vacancies at **Tier 2** are:

### Gaps:

1. *0.5 WTE SAS Doctor, only affecting OOH's, in hours mitigated by clinical fellow post. OOH mitigated through locum cover and rota adjustments in advance.*
  - a. *SAS doctors start Sept 1<sup>st</sup> 2022, but supernumerary 3 months*

2. *6 PA Acute consultant gap, this affects approx.. 0.2 WTE on the registrar OOH's rota. OOH mitigated through locum cover and rota adjustments in advance.*
  - a. *Awaiting Panel date for recruitment*
3. *0.4 WTE Trainee gap, only affecting OOH's, in hours mitigated by clinical fellow post. OOH mitigated through locum cover and rota adjustments in advance.*

*TOTAL = 1.1 WTE OOH only*

**Trajectory:**

October 2022 – December 2022

1. *1 WTE SAS Doctor, only affecting OOH's, in hours mitigated by clinical fellow post. OOH mitigated through locum cover and rota adjustments in advance.*
  - a. *0.5 WTE SAS starts Sept 2022 supernumerary until end of November*
  - b. *0.5 WTE SAS leaves at the end of October 2022, awaiting VAF to advertise*
2. *6 PA Acute consultant gap, this affects approx. 0.2 WTE on the registrar OOH's rota. OOH mitigated through locum cover and rota adjustments in advance.*
  - a. *Awaiting Panel date for recruitment*
3. *1 WTE Trainee gap, only affecting OOH's, in hours mitigated by clinical fellow post. OOH mitigated through locum cover and rota adjustments in advance.*
  - a. *Currently out to advert, clinical fellow*

*Total = 2.2 WTE OOH only, Nov 2022  
1.7 WTE*

<b>4. Compliance with Standards - Does the Trust meet the BAPM national standards of junior medical staffing depending on unit designation?</b>				
<b>Workforce Group</b>	<b>Standard to be met</b>	<b>WSH compliance</b>	<b>Progress Report</b>	<b>Evidence Source</b>
Neonatal medical workforce	<p>The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing.</p> <p>If the requirements had not been met in both year 3 and year 4 of MIS, Trust Board should evidence progress against the action plan developed in year 3 of MIS as well include new relevant actions to address deficiencies.</p> <p>If the requirements had been met in year 3 without the need of developing an action plan to address deficiencies, however they are not met in year 4, Trust Board should develop an action plan in year 4 of MIS to address deficiencies.</p> <p>If no, please submit a Trust board approved action plan to the Neonatal ODN. There should also be an indication whether the standards not being met is due to insufficient funded posts or no trainee or/suitable applicant for the post (rota gap). There should also be a record of the rota tier affected by the gaps. BAPM "Optimal Arrangements for Neonatal Intensive Care Units in the UK including</p>	Yes	<b>GREEN</b>	<p><b>Neonatal medical workforce</b> Neonatal medical workforce Six-month period between 1<sup>st</sup> March 2022 and 31<sup>st</sup> August 2022.</p> <p>Evidence received to say rota covered with correct tiers as per guidance - rotas reviewed as evidence. Physical rotas for consultants and Health Roster analysed for Tier 1 and Tier 2.</p> <p>Report written and submitted through the Divisional Governance processes and formal record in Trust Board minutes that the Trust meets the recommendations of the neonatal medical workforce training action or if the requirements are not met, action plan to meet the recommendations and evidence that this is signed off by the Trust Board.</p>

	<p>guidance on their Medical Staffing” 2014 or “Optimal arrangements for Local Neonatal Units and Special Care Units in the UK including guidance on their staffing: A Framework for Practice” 2018</p> <p><b>SCU Special Care Unit</b></p> <p><b>Tier 1</b>          A resident tier 1 practitioner dedicated to the neonatal service in day-time hours on weekdays and a continuously immediately available resident tier 1 practitioner to the unit 24/7. This person could be shared with a co-located Paediatric Unit out of hours.</p> <p><b>Tier 2</b>          A resident tier 2 to support the tier 1 in SCUs admitting babies requiring respiratory support or of very low admission weight &lt;1.5kg. This Tier 2 would be expected to provide cover for co-located paediatric services but be immediately available to the neonatal unit.</p>			
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#### 4. Conclusions

The Trust meets the expected standards for medical staffing of the Neonatal Unit according to BAPM levels of care and the rotas are covered appropriately, albeit with the use of locums on regular occasions during this period of time. There were a small number of occasions when the expected neonatal unit cover was not as expected during normal working hours and this was addressed by escalating to the out of hours model of staffing after risk assessing the situation.

Whilst the Trust is compliant with the BAPM standards, the review included the way in which we can continue to be compliant and provide evidence on this by streamlining some of the processes:

- The paediatric medical staff rotas are split between a spreadsheet basis for the consultant rota and an electronic rota for the Tier 1 and 2 staff. The consultant rota will become electronic when the rota coordinator is filled.
- It has not been possible to capture how often training and learning opportunities are lost for individuals and when training may have been postponed due to shortages of staff.

#### 5. Recommendations

- It is recommended that the staffing plan is formalised which describes the processes for ensuring that the BAPM standards are consistently met.
- This review of staffing is to be repeated over the next 6 months to monitor the use of locums to manage the services, recruitment to vacancies and to ensure that the establishment is correct for the needs of the service. The next report to be prepared and submitted in April for September 2022 to February 2023 rotas.
- To build on the electronic rota to include the consultants when the rota coordinator is in post.
- Monitor the use of the escalation plan for short- and long-term shortages and cover of the service in all areas and present findings as part of a regular report to the Governance meeting.



## 6. Action Plan

<b>Action plan lead</b>	Name: Dr Tayyaba Aamir Neonatal Lead	Title: Neonatal Safety Champion and Lead	Contact:
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Recommendation	Actions required	Action by date	Person responsible	Comments/action status
It is recommended that a staffing plan is formally described with the processes for ensuring that the BAPM standards are consistently met.	Paediatric medical staffing operational plan to be confirmed	30/6/23	Clinical Director Neonatal Lead Assistant Service Manager	Supported by administrative staff
This review of staffing is repeated over the next 6 months to monitor the use of locums to manage the services, recruitment to vacancies and to ensure that the establishment is correct for the needs of the service.	Repeat staffing review against BAPM standards. Information to be gathered over the 6-month period September 2022 to February 2023	30/4/23	Neonatal Leads Assistant Service Manager	Supported by administrative and governance staff

## Appendix 1 Documents reviewed as part of evidence

British Association of Perinatal Medicine (BAPM) Optimal Arrangements for Neonatal Intensive Care Units in the UK including guidance on their Medical Staffing A Framework for Practice June 2014

<https://www.bapm.org/resources/31-optimal-arrangements-for-neonatal-intensive-care-units-in-the-uk-2014>

Optimal arrangements for Local Neonatal Units and Special Care Units in the UK including guidance on their staffing: A Framework for Practice November 2018

<https://www.bapm.org/resources/2-optimal-arrangements-for-local-neonatal-units-and-special-care-units-in-the-uk-2018>

Rotas – Consultant and juniors

<b>Report Title</b>	<b>Audit of the Operational Pathway of Care into Neonatal Transitional Care October to December 2022 (Q3)</b>
<b>Report for</b>	Information and Approval
<b>Report from</b>	Women's & Children's Services
<b>Report Authors</b>	Beverley Gordon, Project Midwife Karen Green, Quality and Governance Matron Abi Marquette, Clinical Quality and Assurance Lead
<b>Date of Report</b>	March 2023
<b>Presented to:</b>	Maternity and Gynaecology Quality and Safety 17 <sup>th</sup> April 2023 Maternity and Neonatal Safety Champions May 2023 Trust Board 26 <sup>th</sup> May 2023

**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 programme which was introduced in December 2022. The full impact of this on the use of antibiotics for neonates and 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. The majority of babies met the agreed criteria for admission to NTC. The babies that did not meet the criteria had other reasons to be monitored and it appears appropriate for NTC to be used for these purposes. The babies that did not meet the criteria for NTC did not have any adverse outcomes as a result and all of them stepped down from NTC after a period of monitoring.

Nearly a third of the babies were admitted to NTC from birth with slightly fewer in both the groups of babies being admitted from the community setting and as a step down from NNU care. The smallest proportion of babies (around 10%) were admitted from the postnatal ward.

The staffing of NTC on F11 is by an allocated staff member from the NNU with oversight of the neonatal medical team.

**Recommendations and Next Steps:**

1. Audit findings to be shared
2. The Neonatal Transitional Care Policy is being updated to include a link to the Kaiser sepsis calculator. Audits are being completed to assess progress on embedding the Kaiser assessment tool.
3. 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.
4. 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.

### **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.

### **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 Q3 October to December 2022

The data was extracted from different sources which included Badgernet, e-Care Maternity system and the Neonatal Admission book.

NB. The audit noted that during this quarter the postnatal ward (F11) remained in the relocated area to allow for structural work to be undertaken. F11 moved back to its original location midway in December 2022. The relocated area/ward did not allow for a specific transitional care bay, however during this period all babies requiring transitional care continued to receive this type of care beside their mothers within the ward area.

##### 4a Summary of Results for Quarter 3

Seventy-eight (78) babies were cared for under the Neonatal Transitional Care pathway in this quarter – October 1<sup>st</sup> 2022 to December 31<sup>st</sup> 2022. This is an increase from 69 in the previous quarter and an increase in the percentage of babies admitted to NTC from 12.4% to 13.5%.

Timing of Admission to NTC	Number
From Birth	25
From Postnatal Ward/area	7
From Community/Home	23
Step down from Neonatal Unit	23
<b>Total</b>	<b>78</b>

##### 4b Summary of details of babies admitted to transitional care from birth

Clinical Standards	Criteria met
Criteria for immediate admission	

Gestational age >34 <sup>+6</sup> weeks	25/25(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 >1800g	25/25 (100%) babies had birthweights above 1800g	Yes
Maternal suspected /confirmed sepsis in labour	15 mothers had suspected sepsis	Yes
Maternal and Fetal symptoms of suspected sepsis.	0 babies had a combined risk of maternal and baby sepsis	N/A
Neonatal risks of Sepsis	3 babies had suspected sepsis	Yes
Preterm within the cohort	5 babies were preterm	Yes
Other reasons	1 baby had mild respiratory symptoms without needing oxygen or respiratory support.	No
	1 baby had NTC for monitoring of bowel movements when an imperforate anus was suspected.	No

**23 /25 babies (92%) of the babies admitted to NTC met the criteria according to the local guidance. The 2 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
<b>Criteria for admission – developing: Risk factors</b>		
Risk factors for sepsis requiring IV antibiotics	4/7 babies developed or had persistent respiratory symptoms where sepsis was suspected.	Yes
Maternal risk factors for babies requiring TC	2/7 babies required IV antibiotics due to their mother developing signs of sepsis.	Yes
Other Reasons	1/7 baby had transient tachypnoea of the newborn (TTN)	No

**6/7 of these babies met the criteria for admission to NTC. The 1 baby that had TTN did not meet the criteria but this settled and the baby did not need admission 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
<b>Criteria for readmission from community met:</b>	

Requiring phototherapy and serum bilirubin monitoring	19/23 babies were re-admitted with neonatal jaundice. Some of these babies had associated weight loss.	Yes
Weight loss /poor feeding	4/23 babies were readmitted due to problems with feeding and associated weight loss.	Yes

**All these babies met the criteria for NTC**

#### 4e Summary of details of babies admitted to transitional care following stepdown of care from the NNU

Clinical Standards	Criteria met
<b>Criteria for step down from NNU:</b>	
Corrected gestational age > 33+0 and clinically stable.	10/23 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	23/23 babies were all on an observation frequency of at least 3 hourly intervals Yes
Stable baby with sepsis requiring antibiotics	3/23 babies were continuing IV antibiotic treatment. Yes
Other Reasons	8/23 babies had been monitored for respiratory symptoms which had settled, oxygen supplementation had stopped and a course of antibiotics was being completed in NTC. Yes
	1/23 baby had hypoglycaemia which had settled Yes
	1/23 had investigations for cardiac problems and once these were confirmed as normal, a period of monitoring as NTC was advised. Yes

**All 23/23 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

<b>Audit of Operational Standards for staffing</b>	
Operational Standards – Midwifery staffing of NTC	Standards 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
<b>Operational Standards – NNU staffing of NTC</b>		
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 working alongside the midwife and the shift leader for NNU.	Yes
<b>Operational Standards – Neonatal medical staffing</b>		
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

## 5. 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 are admitted from birth which demonstrates that staff are using the assessment tools to identify babies in pregnancy, labour and at birth who will benefit from NTC.

### 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.

The Maternity and Neonatal service now has a nursery nurse allocated from the NNU workforce for care of the babies in the NTC bay on F11. This nursery nurse works alongside the midwife allocated to oversee the postnatal women whose babies are having NTC on the ward and liaises with the shift leader and NTC lead on the NNU.

Comparative data will be presented across the LMNS to ascertain trends in neonatal care.

## 6. Next steps

1. The findings of this audit are to be shared with all staff via the Maternity Risky Business newsletter and 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
2. The Neonatal Transitional Care Policy is being updated to include a link to the Kaiser sepsis calculator. Audits are being completed to assess progress on embedding the Kaiser assessment tool.
  3. 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.
  4. 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

## Appendix 1 Opportunities for Learning and Sharing

<b>Title</b>	<b>Quarter 3 Audit of the Operational Pathway of care into Neonatal Transitional Care</b>
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<b>Action plan lead</b>	Name: Karen Green	Title: Quality & Governance Matron	Contact: 3275
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	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	May 2023	Rebecca Warburton		
		Maternity Quality & Safety meeting	17 <sup>th</sup> April 2023 &	Karen Green		
2	Audit findings shared with the Maternity and Neonatal Safety Champions,	Shared audit findings at the MNSC meeting	27 <sup>th</sup> April 2023	Karen Newbury HOM		
4	Local Maternity and Neonatal System and (LMNS),	Share findings and learning opportunities at the LMNS meeting.	May 2023	Karen Newbury HOM		
4.	Quality Surveillance meeting and Trust Board.	Share findings at Trust Board	May 2023	Karen Newbury HOM		

## ATAIN Programme

**Avoiding Term Admissions to the Neonatal Unit**

**Progress Report Quarter 4 January - March 2023**

April 2023

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

<b>Report presented for information and approval</b>	<b>Maternity Quality and Safety Group – 17<sup>th</sup> April 2023</b>
	<b>Maternity and Neonatal Safety Champions -11<sup>th</sup> May 2023</b>
	<b>Trust Board 26<sup>th</sup> May 2023</b>
<b>Date of Report</b>	<b>14<sup>th</sup> April 2023</b>

## **Executive Summary**

There were 31 babies admitted to the neonatal unit in this quarter (January – March 2023). This figure does not include an additional 4 babies who were admitted but did not meet the criteria for review under ATAIN.

Respiratory distress syndrome (RDS) remained the predominant reason for admission, accounting for 74% of admissions. All but one required supplementary oxygen support and all 23 received intravenous antibiotics due to their clinical presentation, with 39% (9 of 23) having known risk factors for sepsis.

Presenting symptoms continued to vary this quarter with low saturations and increased work of breathing the most predominant. Mode of delivery highlighted itself as a potentially contributing factor with 15 of the 23 admissions for RDS born via caesarean section (a mixture of elective and emergency procedures) which accounts for 65%. The gestations ranged from 37+0 to 42+0 and the majority born with good APGARs. Risk factors for sepsis and respiratory distress also varied with no dominating theme.

Of the remaining 8 admissions, 4 were admitted for suspected sepsis and were treated with prophylactic antibiotics. Two were admitted with low oxygen saturations which was their only presenting symptom. One infant was admitted for observation following resuscitation and another due to abnormal tone.

January and February both showed a notable increase of term admissions born in the 37<sup>th</sup> week of gestation which may have been an influencing factor in their need for additional support after birth.

Two admissions this quarter were thought to have been potentially avoidable. Though it is recognised that retrospective review cannot take in to account all contributing variables. One admission was suspected to have been exacerbated by a sub-optimal body temperature while under the care of the postnatal ward. However, it was also recognised that other factors may have contributed to the decision to admit to NNU. In February, it was the opinion of the review group that an expedited delivery may have been beneficial, but it could not be conclusively stated if this would have impacted on the need for further care on the NNU. Actions were taken to raise awareness and learning around these issues following review.

All admissions were stepped down to transitional care at the earliest opportunity.

### **Recommendations and Next Steps**

Some minor opportunities for learning were identified this quarter, which were thought to have impacted the admission. They were:

- Importance of Thermoregulation of the new-born
- Quality of CTG during labour and delivery
- Importance of paired cord samples

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

## 1. Background to project

**ATAIN** (an acronym for ‘avoiding term admissions into neonatal units’) is a programme of work to reduce harm leading to avoidable admission to a neonatal unit for infants born at term, i.e.  $\geq 37+0$  weeks gestation.

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

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

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

## 2. Local reviews

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

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

### Process for review

The neonatal and midwifery team review the maternal and neonatal records prior to the ATAIN meeting using the approved NHS improvement tools.

Updated safety actions for CNST state that the care of all babies transferred or admitted to the NNU for *any period of time* should be reviewed, in some capacity, and reported under the ATAIN project. This is a change from previous guidance which required review only for babies admitted to NNU. Therefore, since May 2022 any baby that attends NNU briefly prior to transfer to transitional care (TC) has also been recorded. From July 2022 these babies, and any baby that attends NNU for care while an inpatient on the maternity unit, will be recorded. Initially these attendances were reported to the East of England Neonatal operational delivery network (ODN) along with information on reason for attendance, parental accompaniment and any emerging themes, however, as of February 2023 the ODN have advised this monthly reporting is no longer necessary, but data should still be recorded.

## 3. Findings

During the past quarter, monthly Term admissions were below the target level of < 5% in only 1 of the 3 months; with the admission rates for January and March, both, calculated at 6.4%. The reason for this spike is unknown and cannot be attributed to a higher rate of delivery for these months compared to previous. There were 31 admissions in total, with 4 additional term babies admitted to NNU this quarter that did not meet the criteria for review under ATAIN; they included 2 transfers in from other hospitals, one admission due to the mother being

medically incapacitated and one social admission. They are not included in the overall admission numbers but are referenced for transparency.

Cases were reviewed carefully to identify any areas for learning and improvement.

Respiratory distress remained the predominant reason for admission accounting for 74% of admissions. All babies admitted for respiratory support also underwent a septic screen; the majority of whom had risk factors for sepsis (risk factors varied with no dominating themes apparent).

January and February both showed a notable increase of term admissions born in the 37<sup>th</sup> week of gestation which may have been an influencing factor in their need for additional support after birth.

Two of the admissions this quarter were deemed as potentially avoidable, though it was recognised that retrospective review cannot account for all contributing variables.

## **Monthly Summaries**

### ***January 2023***

In January there were 11 term admissions. One additional baby was admitted due to the mother being incapacitated and thus did not meet the criteria for review under ATAIN. Seven were treated for signs of respiratory distress and 4, solely, for suspected sepsis. All 11 babies were screened for sepsis and treated with prophylactic antibiotics and the 7 infants exhibiting respiratory distress received oxygen therapy, either via nasal cannula or vapotherm. The predominant presenting symptoms were low saturations and grunting. Over half of the babies had known risk factors for sepsis, including GBS (Group B Strep), Meconium, PROM (Prolonged Rupture of Membranes) and PPRM (Preterm Premature Rupture of Membranes) but there was not one dominating theme. One of the 11 babies was initially suitable for transitional care but was admitted to NNU due to concerns following an x-ray. These concerns were subsequently unfounded and the baby was returned to transitional care once the x-ray was reviewed externally and care was stepped down.

Notably, 7 of the 11 admissions were born in the 37<sup>th</sup> week of gestation, 4 via elective caesarean section, 2 via SVD and 1 via forceps. The gestations for the elective sections were felt to be appropriate in the clinical circumstances but may have contributed to their need for additional support.

One admission, of an infant that began grunting while being cared for on the postnatal ward and found to have a sub-optimal body temperature, was queried as being potentially avoidable although it was recognised that this infant had been reviewed on NNU previously for grunting and had a twin sibling that was already admitted to NNU with a suspected infection. All babies were stepped down to TC when clinically suitable.

### ***February 2023***

In February there were 8 term admissions. All 8 were admitted due to signs of respiratory distress with all but one requiring vapotherm oxygen therapy. The predominant presenting symptoms were low saturations and increased work of breathing such as grunting, chest recessions and nasal flaring. Two infants had “dusky” episodes shortly after birth, of unknown causation; though one was later found to have a culture positive for Group B strep. One infant presented with significant tachypnoea and had a known bilateral cleft lip and palate.

Only 3 of the 8 infants had known risk factors for sepsis but all 8 were screened and treated with intravenous antibiotics based on their clinical presentation.

Five of the 8 were born in the 37<sup>th</sup> week of gestation; 4 by caesarean section and one via SVD. The timing of the caesarean sections was deemed appropriate in all cases but may have contributed to their need for extra support.

One admission in February was classified as potentially avoidable. It was felt that an earlier review of the CTG in labour may have prompted earlier intervention and thus expedited delivery. However, it is recognised that this is suggested in retrospect without any detailed knowledge of the staffing and acuity at the time. We are unable to definitively state if this would have prevented NNU admission

All infants were ready to be stepped down to transitional care in a timely manner, one transfer was delayed by 24 hours due to maternal preference.

### **March 2023**

In March there were 12 Term admissions which met the criteria for ATAIN. A further 3 were admitted that were transferred from other units and thus do not meet the criteria for review under ATAIN. Eight were admitted due to signs of respiratory distress, all treated with vapotherm and underwent a septic screen with prophylactic IV antibiotic treatment. The predominant presenting symptoms included grunting and low saturations. Only 3 of the 8 had known risk factors for sepsis.

Two of the remaining four infants were admitted due to low oxygen saturations, both requiring oxygen support. Another was admitted for observation following resuscitation at birth and the final baby was admitted due to exhibiting abnormal posture and eye rolling; CFM (Cerebral Function Monitoring) was commenced but remained normal. The baby also underwent a septic screen and was treated with IV antibiotics.

Of the 12, 8 were delivered via caesarean section, the remaining 4 vaginally, with one requiring forceps.

One infant was admitted to NNU with a sub-optimal body temperature and was placed on a warming mat. This baby had undergone significant resuscitation in theatre under the care of the paediatric team and was transferred directly to NNU for observation. A new towel warmer is now present and working in Theatre to help reduce infants exposure to cold air when being cared for in Theatre.

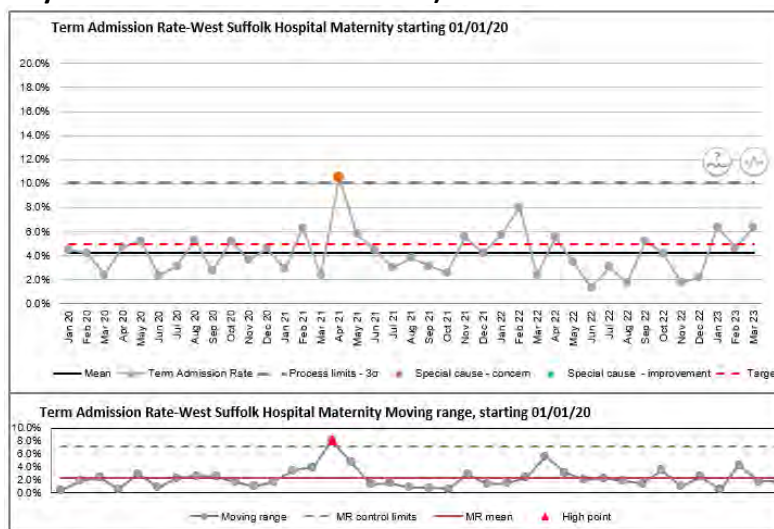


All infants were stepped down to transitional care in a timely manner, as soon as deemed stable enough.

#### 4. Progress

In February clarification was sought on the preferred way to calculate the term admission rates due to suspected national inconsistency; with historical calculations at West Suffolk and within the LMNS using the number of live *term* births as the denominator. Guidance from the Maternity and Neonatal Transformation programme, NHS England, stated that the national denominator should be *all live births*; a method that was felt to skew the figures less than using all term births. As such, admission rates for February and March were calculated using *all live births*.

##### (Monthly admission rates since Jan 2020)



#### 5. Opportunities for learning and improvement

One case was referred for a second opinion on the intrapartum management due to the opinion that expedited delivery may have impacted on the level of care required after birth. This learning was shared via CTG monitoring training and risky business.

There were no other significant opportunities for learning identified this quarter but some smaller issues were noted during the review of the antenatal, intrapartum and postnatal care.

##### January

- Thermoregulation – three infants were admitted with sub-optimal body temperatures; though one was already being cared for in a warming cot and another had a normal temperature less than 30 minutes before admission indicating a discrepancy between thermometers. Patient information leaflets have now been distributed to F11 for each postnatal bed space to help raise awareness for families about the importance of keeping

babies warm. The thermoregulation QI continues with the aim to maintain awareness of the importance of thermoregulation for all members of the maternity unit.

- Loss of Contact on CTG – A reminder was placed on Risky Business about the importance of maintaining contact on the CTG during labour, and documenting any challenges or concerns to reflect the full clinical picture.

### **February**

- Escalation and Review in the 2<sup>nd</sup> stage – Local practice promotes early review in the second stage, in the presence of meconium. This is not currently reflected in the local guidance, which is due for review in May 2023 and this issue will be discussed at this time.

### **March**

- Thermoregulation – 1 infant was admitted with a sub-optimal body temperature; however, it was noted that this infant was under the case of the paediatric team from birth requiring significant resuscitative input which may have impacted on thermoregulation. The option of checking temperature prior to transfer to NNU will be explored on a trial basis.
- Paired blood sampling – recurring incidences of single blood samples has been noted for cord blood gasses. Awareness to be raised around unit, via staff Facebook page and risky business on technique for drawing samples and importance of both arterial and venous.

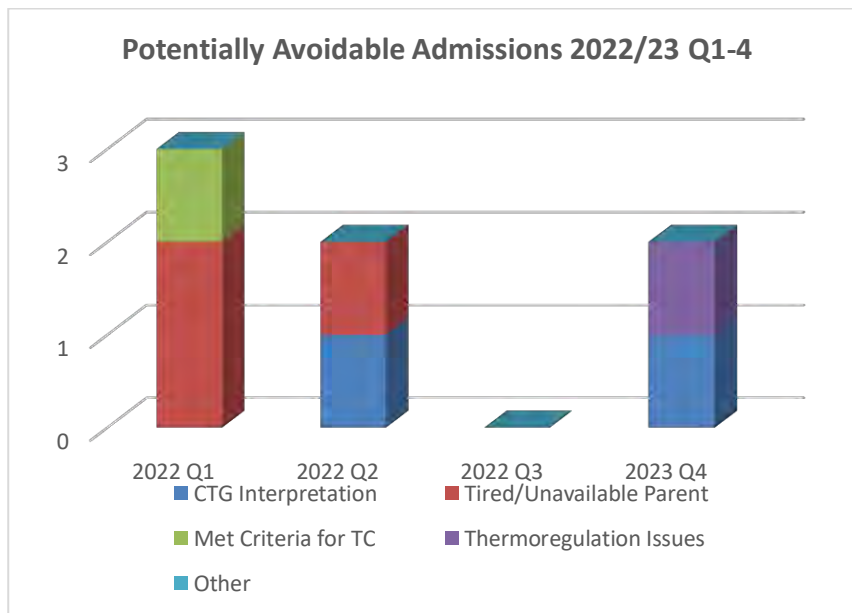
## **6. Action Plans**

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

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

## **7. Potentially Avoidable admissions**

Two potentially avoidable admissions were identified this quarter. Learning was shared in Risky Business and via the fetal monitoring training programme.



## 8. Progress and learning with the key reasons for admission

Symptoms of respiratory distress remained the primary reason for admission in quarter 4, accounting for 74% of admissions (23 out of 31 babies). All were treated with vapotherm and intravenous antibiotics due to their clinical presentation, with 39% (9 of 23) having known risk factors for sepsis.

Presenting symptoms continued to vary this quarter with low saturations and increased work of breathing the most predominant. Mode of delivery highlighted that 14 of the 23 admissions for RDS this quarter were born via caesarean section (a mixture of elective and emergency procedures) which accounts for 60%. The gestations ranged from 37+0 to 42+0 and the majority born with good APGARs. Risk factors for sepsis and respiratory distress also varied with no dominating theme.

### **January 23**

- 7 of 11 babies were admitted to NNU with signs of respiratory distress
- All 7 treated with oxygen (vapotherm or nasal cannula oxygen) and IV antibiotics
- 5 of the 7 presented with low oxygen saturations
- 2 of 7 had known risk factors for sepsis
- 4 were delivered by caesarean section and 3 vaginally (one requiring forceps)

### **February 23**

- 8 of 8 babies were admitted to NNU with signs of respiratory distress
- 7 of 8 treated with oxygen and all treated with IV antibiotics
- 3 of 8 had known risk factors for sepsis
- 5 were born via caesarean section, 2 via forceps and 1 spontaneous vaginal delivery.

### **March 23**

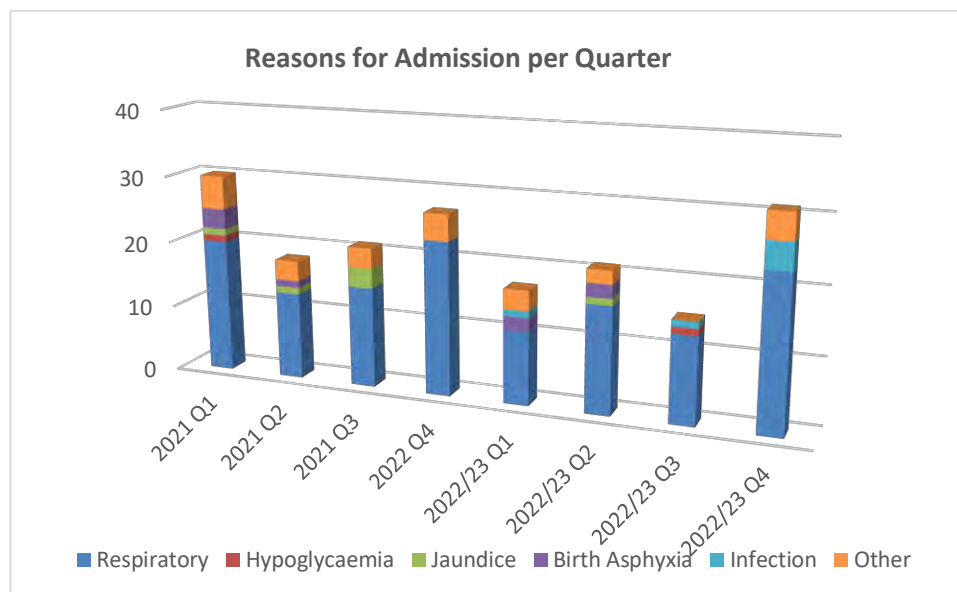
- 8 of 12 babies were admitted to NNU with signs of respiratory distress
- All 8 treated with oxygen and IV antibiotics
- 3 of the 8 babies had known risk factors for sepsis

- 5 were born by caesarean section and 3 were born vaginally (one requiring forceps)

### 9. Quarterly Comparison

The chart below shows the reasons for admission per quarter in the 2021-2022 and 2022-23 year; demonstrating respiratory issues as the predominant reason for admission each quarter. No underlying common theme has been identified to date though it was noted that over 39% of babies admitted with respiratory concerns had recognised risk factors.

**Figure 3: Reasons for Admission - Quarter by Quarter comparison**



### 10. Transitional Care admissions via NNU

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

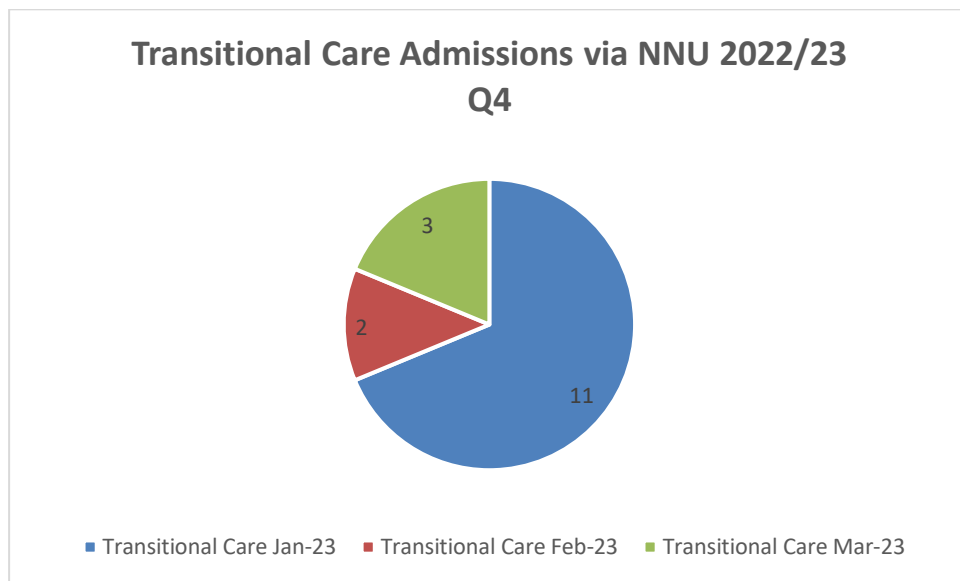
Further guidance from the regional clinical oversight group has clarified that any baby who attends NNU for care, without being admitted, (e.g. IV cannulation, repeat blood test) should have the following information recorded: parental accompaniment, reason for attendance and any themes or learning identified.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

The Neonatal Unit are currently recording any short term NNU attendances from babies undergoing inpatient care on the maternity unit (under TC or Midwifery care) along with parental accompaniment data. Initially this was reported to the East of England Neonatal operational delivery network on a monthly basis (commenced July 2022) but this is no longer required. Data collection remains a requirement and will continue to be collected.

Since December 2022 transitional care is now able to run 24/7 on the postnatal ward. This has significantly reduced the number of infant/parent separation episodes, with the majority of medications and blood tests now able to be undertaken on the ward, reducing the need for babies to physically attend the NNU and thus reducing separation from the mother.

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

The charts below detail the infants who attended NNU this quarter prior to transfer to Transitional Care. The total number of infants admitted to TC is not commented on in this report.



## 11. Quality improvement in this quarter

### Thermoregulation QI Project

There is a continued drive raise awareness and to improve admission temperatures of babies admitted to NNU at term, with a QI project ongoing.

This quarter has resulted in 16% of admissions with a sub-optimal body temperature (5 of 31 babies). The QI project will continue with further actions developed to help maintain awareness around the unit with the aim of sustaining optimal body temperatures for all infants.

Quarter 4 (2021/22)	No. of babies with sub-optimal temp ( $\leq 36.5$ )	%
January 2022	2/10	20%
February 2022	5/13	38%
March 2022	1 /4	25%
<b>Quarter 1 (2022/23)</b>		
April 2022	2/9	22%
May 2022	2/6	33%
June 2022	1/2	50%

<b>Quarter 2 (2022/23)</b>		
July 2022	2/6	33.3%
August 2022	1/3 (2 additional admissions for cooling not inc)	33.3%
September 2022	3/10	30%
<b>Quarter 3 (2022/23)</b>		
October 2022	0/8	0%
November 2022	0/3	0%
December 2022	0/4	0%
<b>Quarter 4 (2022/23)</b>		
January 2023	3/11	27%
February 2023	1/8	12.5%
March 2023	1/12	8%

## 12. Current/On-going Actions

Action	Plan	Comments
Raising awareness among the maternity team	<ul style="list-style-type: none"> <li>Educational piece in Risky Business</li> <li>Message in Take 5</li> </ul>	Monthly updates from ATAIN and learning in Risky Business – <b>Monthly Action</b>
Instructions added to Warming Cots on F11	<ul style="list-style-type: none"> <li>Add instructions to all warming cots to ensure correct usage of equipment</li> </ul>	Updated warming cot instructions added to warming cots on unit. <b>Action completed.</b>
Explore possibility of procurement of Towel Warmer for Theatre	<ul style="list-style-type: none"> <li>Towel warmer for Theatre/LS</li> </ul>	For Theatres/LS. Promote maintenance of appropriate temperature at delivery and in early newborn period. <b>Action completed.</b>
Information videos for Staff facebook page	<ul style="list-style-type: none"> <li>Informational video “Thermoregulation of the Newborn” on staff facebook page.</li> </ul>	Video awaiting sign off. <b>In-progress</b>
Handover “Hot Topic”	<ul style="list-style-type: none"> <li>Remind staff at handover about importance of keeping babies warm (in Theatre, LS and F11)</li> </ul>	Facilitated by inpatient matron in communications to Band 7 area leads. <b>Action Completed.</b>
Parental Education Poster/Leaflet	<ul style="list-style-type: none"> <li>Poster/Leaflet to display in LS rooms/F11 bays to increase awareness in parents</li> </ul>	In development. <b>Action completed.</b>
Parental Education – Cot Cards “Keep me Warm”	<ul style="list-style-type: none"> <li>Cot cards for all cots on LS, MLBU and F11</li> </ul>	<b>Action completed</b>
Signs for Resuscitaires demonstrating how to keep babies warm	<ul style="list-style-type: none"> <li>Posters made with visual aid for resuscitaires in Theatre, LS and MLBU</li> </ul>	<b>Action Completed</b>

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

# ATAIN Programme

Avoiding Term Admissions to the Neonatal Unit

Project commencement date: September 2018

ROLLING ACTION PLAN from January 2022



## Background to project

### Trends and admission rates

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

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

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

### Review structure

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

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

### Local reviews

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

Learning is identified and included on a rolling action plan.

The review group includes:

Neonatal ward manager / neonatal practice development nurse

Clinical risk manager / clinical risk midwife

Consultant paediatrician

Consultant obstetrician (may review records outside of the ATAIN meeting)

The review meetings commenced September 2018.

### Process for review

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

### Learning and improving

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

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

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

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

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

		Instructions attached to warming cots.	30/04/22	<b>Completed</b>	Instructions for warming cots in situ.
		Educational piece in Risky Business	30/04/22	<b>Completed 30/04/22</b>	Risky Business – April (pages 1-3)
		Message on Take 5	30/04/22	<b>Completed 14/04/22</b>	Take 5 April 14/04/22
	Consistent information regarding antenatal steroids.	Information sheet in line with RCOG guidance to be produced for clinicians.	31/12/22	<b>Completed</b>	
<b>April 2022</b>	Multiple cannulation attempts before switching to IM administration of Antibiotics.	Issue highlighted in Risky Business  Feedback to be given to team by Neonatal Lead	30/06/22	<b>Completed 30/06/22</b>	Risky Business

	Vapotherm commenced at 6 litres/min (Vapotherm guidance recommends between 6-8 litres/min) but local preference is to commence at 8 litres.	Issue highlighted in Risky Business  Feedback to be given to team by Neonatal Lead	30/06/22	<b>Completed</b> <b>30/06/22</b>	
<b>May 2022</b>	Increase awareness around thermoregulation (ongoing drive)	Risky Business	30/06/22	<b>Completed</b>	
<b>June 2022</b>	Thermoregulation of the newborn	Information video for staff facebook page	31/12/22	<b>In-Progress</b>	
		Parental education poster/leaflet	31/12/22	<b>Completed</b>	Now available in bed spaces on F11 and for women on LS

		Handover “Hot Topic”	30/06/22	<b>Completed</b>	Not evidenced.
	Syringe/Cup Feeding in the Community0	New infant feeding guideline to contain guidance around syringe and cup feeding outside of the immediate postnatal period	30/09/22	<b>Completed July 2022</b>	Completed July 2022
<b>August 2022</b>	Throat swab omitted from septic screen (no impact on outcome but point of learning)	Septic Screen Audit	31/12/22	<b>No longer Applicable</b>	<p>After further discussion with the labour suite lead consultant and taking advice e from the Trust sepsis specialist nurse it was decided that throat swabs are only necessary as part of a septic screen where the woman is symptomatic (sore throat) or has had known contact with someone with step A infection.</p> <p>This has been communicated in Risky Business – September 2022 issue.</p>

<b>Sept 2022</b>	<p>Opportunities for learning noted during review (which did not impact on need for admission).</p> <ul style="list-style-type: none"> <li>• Need to prioritise cord gasses where indicated</li> <li>• Correct use of Oxygen Sats monitor</li> <li>• Utilisation of CFM monitoring</li> <li>• Improved detail in documentation</li> </ul>	<p>“Learning from ATAIN” in Risky Business</p>	<p>31/11/22</p>	<p><b>Completed</b></p>	<p>November 2022 Risky Business</p>
<b>Oct 2022</b>	<p>Opportunities for learning noted during review (which did not impact on need for admission).</p> <ul style="list-style-type: none"> <li>• Placental Histology</li> <li>• Sepsis Guideline</li> <li>• Incorrect Care Pathway</li> </ul>	<p>“Learning from ATAIN” in Risky Business</p>	<p>31/12/22</p>	<p><b>Complete</b></p>	<p>November 2022 Risky Business</p>
<b>November 2022</b>	<p>Opportunities for learning noted during review (which did not impact on need for admission).</p> <ul style="list-style-type: none"> <li>• Importance of having a complete, interpretable CTG, before discontinuing continuous fetal monitoring,</li> </ul>	<p>“Learning from ATAIN” in Risky Business</p>	<p>31/12/22</p>	<p><b>Complete</b></p>	<p>December 2022 Risky Business</p>

<b>December 2022</b>	No opportunities for learning identified				
<b>January 2023</b>	<p>Opportunities for learning noted during review (which did not impact on need for admission).</p> <ul style="list-style-type: none"> <li>• Importance of Thermoregulation</li> <li>• Minimising LOC on CTG during delivery and importance of robust documentation.</li> </ul>	“Learning from ATAIN” in Risky Business		<b>Complete</b>	February Risky Business 2023
<b>February 2023</b>	<p>CTG referred for second opinion due to consensus that expedited delivery may have improved the outcome and reduced level of care needed post-delivery.</p> <p>Opportunities for learning noted during review (which did not impact on need for admission).</p>	<p>“Learning from ATAIN” in Risky Business</p> <p>Second opinion from Lead LS Consultant</p> <p>Learning case for CTG monitoring</p>		<b>Complete</b>	<p>March 2023 Risky Business</p> <p>CTG Monitoring Case Study</p>

	<ul style="list-style-type: none"> <li>• Importance of Thermoregulation</li> </ul>				
<b>March 2023</b>	<p>Opportunities for learning noted during review (which did not impact on need for admission).</p> <ul style="list-style-type: none"> <li>• Paired cord samples</li> <li>• Importance of thermoregulation</li> </ul>	“Learning from ATAIN” in Risky Business		<b>In progress</b>	



## 5.1 Governance Report Annexes

## REGISTER OF DIRECTORS' INTERESTS

The Codes of Conduct and Accountability for NHS Trusts requires all Trusts to draw up and maintain a register of director's interests. This register consequently lists all interests, defined by the Codes as relevant and material for all its Board and non-Board directors.

The definition of interests is as follows:

- Directorships held in private companies or plcs.
- Ownership or part ownership of private companies, businesses or consultancies, likely or possibly seeking to do business with the NHS.
- Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.
- A position of authority in a charity or a voluntary body in the field of health and social care.
- Any connection with a voluntary or other body contracting for NHS services.

	Declared Interest	Date Reviewed / Amended
<b>Trust Chair</b>		
Jude Chin	Director of SSAT (The Schools Network) Ltd Shareholder of SSAT (The Schools Network) Ltd Trustee The Academies Enterprise Trust	15 May 2023
<b>Non-Executive Directors</b>		
Louisa Pepper	Elected Parish Councillor for the village of Thorpe Morieux	15 May 2023
Antoinette Jackson <i>(started on 1 Nov 2022)</i>	Director and chair of Trustees in Arthur Rank Hospice Charity Director and chair of Trustees in Arthur Rank Limited Director and chair of Trustees in Cambridge and District Citizens Advice	15 May 2023
Tracy Dowling <i>(started on 1 Nov 2022)</i>	Chairman of Eastern Academic Health Science Network – Company Limited by Guarantee Eastern Academic Health Science Network does business with NHS organisations	15 May 2023
Geraldine O'Sullivan <i>(started on 1 Nov 2022)</i>	Non-executive director at BPHA (Housing Association)	15 May 2023
Krishna Yergol <i>(started on 1 Nov 2022)</i>	Director Shashikala Properties Ltd Director Shashikala Digital Ltd Director SP Norfolk Electricals Ltd	15 May 2023
Dr John Roger Petter <i>(started on 1 Mar 2023)</i>	Nil	15 May 2023

	<b>Declared Interest</b>	<b>Date Reviewed / Amended</b>
Michael Parsons <i>(started on 1 May 2023)</i>	Bursar - Christ's College Cambridge Non-Executive Director - University of Cambridge – Property Board Non-Executive Director - Parliamentary and Health Services Ombudsman Chair - Dance Square Residents' Association Member of Chartered Institute of Public Finance & Accountancy (CIPFA)	15 May 2023
<b>Executive Directors</b>		
Ewen Cameron <i>(started 20 Feb 2023)</i>	Nil	15 May 2023
Craig Black	Nil	15 May 2023
Nicola Cottington	Nil	15 May 2023
Paul Molyneux	Director of a private company, PD Molyneux Neurology Consultancy Ltd. This company offers private neurology consultancy work at the BMI Bury St Edmunds.	15 May 2023
Jeremy Over	Nil	15 May 2023
Susan Wilkinson	Nil	15 May 2023
<b>Other attendees</b>		
Clement Mawoyo	Nil	16 May 2023
Peter Wightman	Nil	16 May 2023
Richard Jones	Director of Friars 699 Limited (which changed its name to "The Pathology Partnership Limited"), dissolved via voluntary strike-off on 20/4/2021. Councillor of Brockley Parish Council (voluntary position)	15 May 2023

## Non-executive directors' responsibilities – May 2023

	Primary responsibilities	Responsibilities as required	Lead assurance roles (Bold indicates mandated)
<p><b>Jude Chin</b>  <b>Chair and Non-executive director</b></p> <p><b>Term:</b> 4 July 22 – 3 July 23</p>	<ul style="list-style-type: none"> <li>• Board – Public, Closed (<b>Chair</b>)</li> <li>• Council of Governors (<b>Chair</b>)</li> <li>• Audit Committee (in attendance)</li> <li>• Remuneration Committee (<b>Chair</b>)</li> </ul> <p>Specialist committees:</p> <ul style="list-style-type: none"> <li>• <i>Option to attend any other Board committees</i></li> <li>• ICS chairs meeting</li> <li>• NHS Confederation Chairs group</li> <li>• NHSE (East of England) CEO and Chairs group</li> </ul>	<ul style="list-style-type: none"> <li>• Board Workshops</li> <li>• External relationships</li> <li>• Consultant appointments</li> <li>• Quality walkabouts</li> <li>• Governor meetings with NEDs</li> <li>• Investigations and appeals</li> </ul>	<ul style="list-style-type: none"> <li>• Integrated care system</li> <li>• NHS England and Improvement</li> <li>• West Suffolk Alliance</li> <li>• NED link to CEO</li> </ul>
<p><b>Tracy Dowling</b>  <b>Non-executive director</b></p> <p><b>Term:</b> 1 November 2022 – 31 October 2025</p>	<ul style="list-style-type: none"> <li>• Board meeting – Public, Closed</li> <li>• Remuneration Committee</li> <li>• Audit Committee</li> </ul> <p>Specialist committees:</p> <ul style="list-style-type: none"> <li>• Involvement Committee (<b>Chair</b>)</li> <li>• Improvement Committee</li> </ul>	<ul style="list-style-type: none"> <li>• Board Workshops</li> <li>• Consultant appointments</li> <li>• Quality walkabouts</li> <li>• Council of Governors and Governor meetings with NEDs</li> <li>• Investigations and appeals</li> </ul>	<ul style="list-style-type: none"> <li>• Patient experience and public engagement</li> <li>• Equality, diversity and inclusion</li> <li>• NED link to Director of Workforce, including OD</li> </ul>

	Primary responsibilities	Responsibilities as required	Lead assurance roles (Bold indicates mandated)
<p><b>Antoinette Jackson</b> <b>Non-executive director</b></p> <p><b>Term:</b> 1 November 2022 – 31 October 2025</p>	<ul style="list-style-type: none"> <li>• Board meeting – Public, Closed</li> <li>• Remuneration Committee</li> <li>• Audit Committee</li> </ul> <p>Specialist committees:</p> <ul style="list-style-type: none"> <li>• Insight Committee (<b>Chair</b>)</li> <li>• Involvement Committee</li> <li>• Charitable Funds Committee</li> </ul>	<ul style="list-style-type: none"> <li>• Board Workshops</li> <li>• Consultant appointments</li> <li>• Quality walkabouts</li> <li>• Council of Governors and Governor meetings with NEDs</li> <li>• Investigations and appeals</li> </ul>	<ul style="list-style-type: none"> <li>• Senior Independent Director</li> <li>• Board freedom to speak up guardian, including whistleblowing</li> <li>• Theatres</li> </ul> <ul style="list-style-type: none"> <li>• NED link to Director of Integrated Adult Health and Social Care</li> </ul>
<p><b>Geraldine O’Sullivan</b> <b>Non-executive director</b></p> <p><b>Term:</b> 1 November 2022 – 31 October 2025</p>	<ul style="list-style-type: none"> <li>• Board meeting – Public, Closed</li> <li>• Remuneration Committee</li> </ul> <p>Specialist committees:</p> <ul style="list-style-type: none"> <li>• Improvement Committee (<b>Deputy Chair</b>)</li> <li>• Involvement Committee</li> </ul>	<ul style="list-style-type: none"> <li>• Board Workshops</li> <li>• Consultant appointments</li> <li>• Quality walkabouts</li> <li>• Revalidation Support Group</li> <li>• Council of Governors and Governor meetings with NEDs</li> <li>• Investigations and appeals</li> </ul>	<ul style="list-style-type: none"> <li>• Patient safety, including learning from deaths</li> <li>• Safeguarding adult and children</li> </ul> <ul style="list-style-type: none"> <li>• NED link to Chief Nurse</li> </ul>
<p><b>Roger Petter</b> <b>Non-executive director</b></p> <p><b>Term:</b> 1 Mar 2023 – 28 Feb 2026</p>	<ul style="list-style-type: none"> <li>• Board meeting – Public, Closed</li> <li>• <del>Audit Committee</del></li> <li>• Remuneration Committee</li> </ul> <p>Specialist committees:</p> <ul style="list-style-type: none"> <li>• Insight Committee (<b>Deputy Chair</b>)</li> <li>• Improvement Committee</li> <li>• Board maternity and neonatal safety champion (sit on local maternity and neonatal system board, attend Trust’s maternity and neonatal safety champions meetings and maternity voice partnership meeting)</li> <li>• Doctors’ Revalidation Support Group</li> </ul>	<ul style="list-style-type: none"> <li>• Board Workshops</li> <li>• Consultant appointments</li> <li>• Quality walkabouts</li> <li>• Revalidation Support Group</li> <li>• Council of Governors and Governor meetings with NEDs</li> <li>• Investigations and appeals</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Maternity and neonatal safety champion</b></li> <li>• Doctor appraisal and revalidation</li> </ul> <ul style="list-style-type: none"> <li>• NED link to Medical Director</li> </ul>

	Primary responsibilities	Responsibilities as required	Lead assurance roles (Bold indicates mandated)
<p><b>Louisa Pepper</b> Deputy Chair and <b>Non-executive director</b></p> <p><b>Term:</b> 1 Sept 2018 – 31 Aug 2021</p> <p><b>Reappointed:</b> 1 Sept 2021 – 31 Aug 2024</p>	<ul style="list-style-type: none"> <li>• Board meeting – Public, Closed</li> <li>• Deputy Chair</li> <li>• Audit Committee</li> <li>• Remuneration Committee</li> </ul> <p>Specialist committees:</p> <ul style="list-style-type: none"> <li>• Improvement Committee (<b>Chair</b>)</li> <li>• Insight Committee</li> <li>• RAAC Risk Committee</li> </ul>	<ul style="list-style-type: none"> <li>• Board Workshops</li> <li>• Consultant appointments</li> <li>• Quality walkabouts</li> <li>• Council of Governors and Governor meetings with NEDs</li> <li>• Investigations and appeals</li> </ul>	<ul style="list-style-type: none"> <li>• Health and wellbeing guardian</li> <li>• Emergency preparedness, resilience and response (EPRR) – including COVID response</li> <li>• Pathology</li> <li>• Volunteers</li> <li>• Chaplaincy</li> <li>• <b>Security</b></li> <li>• NED link to Chief operating office</li> </ul>
<p><b>Michael Parsons</b> <b>Non-executive director</b></p> <p><b>Term:</b> 1 May 2023 – 30 April 2026</p>	<ul style="list-style-type: none"> <li>• Board meeting – Public, Closed</li> <li>• Audit Committee (<b>Chair</b>)</li> <li>• Charitable Funds Committee (Chair)</li> </ul> <p>Specialist committees:</p> <ul style="list-style-type: none"> <li>• Insight Committee</li> <li>• Future System Board</li> <li>• Clinical Excellence &amp; Discretionary Awards Committee</li> </ul>	<ul style="list-style-type: none"> <li>• Board Workshops</li> <li>• Consultant appointments</li> <li>• Quality walkabouts</li> <li>• Council of Governors and Governor meetings with NEDs</li> <li>• Investigations and appeals</li> </ul>	<ul style="list-style-type: none"> <li>• NED link to Director of Finance</li> </ul>
<p><b>Krishna Yergol</b> <b>Non-executive director</b></p> <p><b>Term:</b> 1 November 2022 – 31 October 2025</p>	<ul style="list-style-type: none"> <li>• Board meeting – Public, Closed</li> <li>• Remuneration Committee</li> </ul> <p>Specialist committees:</p> <ul style="list-style-type: none"> <li>• Digital Programme Board</li> <li>• Future System Board</li> <li>• Involvement Committee (<b>Deputy Chair</b>)</li> </ul>	<ul style="list-style-type: none"> <li>• Board Workshops</li> <li>• Consultant appointments</li> <li>• Quality walkabouts</li> <li>• Revalidation Support Group</li> <li>• Council of Governors and Governor meetings with NEDs</li> <li>• Investigations and appeals</li> </ul>	<ul style="list-style-type: none"> <li>• Cyber security</li> <li>• NED link to CIO</li> </ul>

All NEDs will be invited to attend audit committees (including deep dive presentations) but only those specified above are members of the committee

## The practice of scrutiny and assurance

	Questions regarding quality of evidence...	Further consideration...
<p><b>What?</b></p> <p>Deepening <b>understanding</b> of the evidence and ensuring its <b>validity</b></p>	<p><b>Validity</b> – the degree to which the evidence...</p> <ul style="list-style-type: none"> <li>• measures what it says it measures</li> <li>• comes from a reliable source with sound/proven methodology</li> <li>• adds to triangulated insight</li> </ul>	<ul style="list-style-type: none"> <li>• Good data without a strong narrative is unconvincing.</li> <li>• A strong narrative without good data is dangerous!</li> </ul>
<p><b>So what?</b></p> <p>Increasing <b>appreciation</b> of the <b>value</b> (importance and impact) – what this means for us</p>	<p><b>Value</b> – the degree to which the evidence...</p> <ul style="list-style-type: none"> <li>• provides real intelligence and clarity to board understanding</li> <li>• provides insight that supports good quality decision making</li> <li>• supports effective assurance, provides strategic options and/or deeper awareness of culture</li> </ul>	<ul style="list-style-type: none"> <li>• What is most significant to explore further?</li> <li>• What will take us from good to great if we focus on it?</li> <li>• What are we curious about?</li> <li>• What needs sharpening that might be slipping?</li> </ul>
<p><b>What next?</b></p> <p>Exploring what should be <b>done next</b> (or not), informing <b>future</b> tactic / strategy, agreeing follow-up and future <b>evidence of impact</b></p>		<ul style="list-style-type: none"> <li>• Recommendations for action</li> <li>• What impact are we intending to have, by when and how will we know we've achieved it?</li> <li>• How will we hold ourselves accountable?</li> </ul>

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# West Suffolk NHS Foundation Trust

## Constitution

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May 2023  
DRAFT v3.1

**PLEASE NOTE PAGE NUMBERS ARE SUBJECT TO CHANGE DURING EDITING**



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## **1. Name**

The name of the foundation trust is West Suffolk NHS Foundation Trust (the trust).

## **2. Principal purpose**

- 2.1** The principal purpose of the trust is the provision of goods and services for the purposes of the health service in England.
- 2.2** The trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

## **3. Other purposes and powers**

- 3.1** The trust may provide goods and services for any purposes related to:
  - 3.1.1** the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and
  - 3.1.2** the promotion and protection of public health.
- 3.2** The trust may also carry on activities other than those mentioned in the above paragraph for the purpose of making additional income available in order better to carry on its principal purpose.
- 3.3** The powers of the trust are set out in the 2006 Act.
- 3.4** All the powers of the trust shall be exercised by the Board of Directors on behalf of the trust.
- 3.5** Any of these powers may be delegated to a committee of Directors or to an Executive Director.

## **4. Membership and constituencies**

The trust shall have members, each of whom shall be a member of one of the following constituencies:

- 4.1** the public constituencies or
- 4.2** the staff constituency

## **5. Application for membership**

An individual who is eligible to become a Member of the trust may do so on application to the trust.

## **6. Public Constituency**

- 6.1** An individual who lives in the area specified in Annex 1 as an area for a public constituency may become or continue as a Member of the trust.
- 6.2** Those individuals who live in the area specified for a public constituency are referred to collectively as the Public Constituency for that area.
- 6.3** The minimum number of Members in each Public Constituency is specified in Annex 1.

## **7. Staff Constituency**

- 7.1** An individual who is employed by the trust under a contract of employment with the trust may become or continue as a member of the trust provided:
  - 7.1.1** they are employed by the trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or
  - 7.1.2** they have been continuously employed by the trust under a contract of employment for at least 12 months.
- 7.2** Individuals who exercise functions for the purposes of the trust, otherwise than under a contract of employment with the trust, may become or continue as members of the staff constituency provided such individuals have exercised these functions continuously for a period of at least 12 months. For clarity this does not include individuals who exercise functions for the purposes of the trust on a voluntary basis.
- 7.3** The Trust Secretary must have regard to Chapter 1 of Part 14 of the Employment Rights Act 1996 for the purposes of determining whether an individual has been continuously employed by the Trust, or has continuously exercised functions for the purposes of the Trust.
- 7.4** Those individuals who are eligible for membership of the trust by reason of the previous provisions are referred to collectively as the Staff Constituency.

7.5 The minimum number of members in the Staff Constituency is specified in Annex 2.

**Automatic membership by default – staff**

7.6 An individual who is:

7.6.1 eligible to become a Member of the Staff Constituency, and

7.6.2 invited by the trust to become a Member of the Staff Constituency,

shall become a Member of the trust as a Member of the Staff Constituency without an application being made, unless they inform the trust that they do not wish to do so. This does not apply to staff who are eligible for membership under 7.2, who must make an application for membership.

**8. Restriction on membership**

8.1 An individual who is a Member of a constituency, or of a class within a constituency, may not while membership of that constituency or class continues, be a Member of any other constituency or class.

8.2 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any constituency other than the Staff Constituency.

8.3 An individual must be at least 16 years old to become a member of the trust.

8.4 Further provisions as to the circumstances in which an individual may not become or continue as a member of the trust are set out in Annex 10 – Further Provisions.

**9. Annual Members' Meeting**

9.1 The Trust shall hold an annual meeting of its members ('Annual Members' Meeting'). The Annual Members' Meeting shall be open to members of the public.

**10. Council of Governors – composition**

10.1 The trust is to have a Council of Governors, which shall comprise both elected and appointed Governors.

10.2 The composition of the Council of Governors is specified in Annex 3.

10.3 The aggregate number of public Governors is to be more than half the total membership of the Council of Governors.

**10.4** The members of the Council of Governors, other than the appointed members, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency. The number of Governors to be elected by each constituency, or, where appropriate, by each class of each constituency, is specified in Annex 3.

**11. Council of Governors – election of governors**

**11.1** Elections for elected members of the Council of Governors shall be conducted in accordance with the Model Rules for Elections.

**11.2** The Model Rules for Elections as published from time to time by the Department of Health form part of this Constitution. The Model Rules for Elections current at the date this constitution is approved are attached at Annex 4. Elections for elected members of the Council of Governors shall be conducted using the first past the post system. Thus, where appropriate, the alternative rules marked "FPP" (First Past the Post) should be used.

**11.3** A subsequent variation of the Model Rules for Elections by the Department of Health shall not constitute a variation of the terms of this Constitution for the purposes of paragraph 46 of the Constitution (amendment of the constitution).

**11.4** An election, if contested, shall be by secret ballot.

**11.5** Where a vacancy arises for an elected Governor the trust may, instead of holding a by-election, fill the vacancy by appointing the highest polling unsuccessful candidate at the most recent election of governors for the constituency or class in respect of which the vacancy has arisen. Any person so appointed shall hold office for the unexpired term of office of the retiring Governor.

**12. Council of Governors - tenure**

**12.1** An elected Governor may hold office for a period of up to 3 years.

**12.2** An elected Governor shall cease to hold office if they cease to be a member of the constituency or class by which they were elected.

**12.3** Subject to Paragraph 12.4 below, an elected Governor shall be eligible for re-election at the end of their term.

**12.4** An elected Governor may not hold office for longer than 9 years or be re-elected if, by virtue of this paragraph 12.4, they would not be able to remain in office for the full three year period.

- 12.5 An appointed Governor may hold office for a period of up to 3 years.
- 12.6 An appointed Governor shall cease to hold office if the appointing organisation withdraws its sponsorship of them.
- 12.7 An appointed Governor shall be eligible for re-appointment at the end of their term, but may not hold office for more than nine years.
- 12.8 A person may not stand for election as a Governor or be appointed as a Governor in accordance with clause 10 if their tenure as a governor was terminated following a breach of the Governors' Code of Conduct.

**13. Council of Governors – disqualification and removal**

- 13.1 The following may not become or continue as a member of the Council of Governors:
  - 13.1.1 a person who has been made bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;
  - 13.1.2 a person who has made a composition or arrangement with, or granted a trust deed for, their creditors and has not been discharged in respect of it;
  - 13.1.3 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on them.
- 13.2 Governors must be at least 16 years of age at the date they are nominated for election or appointment.
- 13.3 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Council of Governors are set out in Annex 5.

**14. Council of Governors – Termination of tenure**

- 14.1 A Governor may resign from that office at any time during the term of that office by giving notice in writing to the Secretary to the trust.
- 14.2 If a Governor fails to attend any meeting of the Council of Governors, for a period of one year or three consecutive public meetings (whichever is the shorter) their tenure of office is to be terminated unless the other Governors agree by a majority vote that:
  - 14.2.1 the absence was due to a reasonable cause; and

**14.2.2** he will be able to start attending meetings of the Council of Governors again within such a period as they consider reasonable.

**14.3** Where a person has been elected or appointed to be a Governor and they become disqualified for appointment under paragraph 13, they shall notify the Secretary in writing of such disqualification.

**14.4** If it comes to the notice of the Secretary at the time of their appointment or later that the Governor is so disqualified, they shall immediately declare that the person in question is disqualified and notify them in writing to that effect.

**14.5** Upon receipt of any such notification, that person's tenure of office, if any, shall be terminated and they shall cease to act as a governor.

## **15. Council of Governors – Vacancies**

Where membership of the Council of Governors ceases, Public and Staff Governors shall be replaced in accordance with paragraph 11.5, and appointed Governors shall be replaced in accordance with processes agreed with their appointers.

## **16. Council of Governors – duties of governors**

**16.1** The general duties of the Council of Governors are –

**16.1.1** to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors, and

**16.1.2** to represent the interests of the members of the trust as a whole and the interests of the public.

**16.2** The Trust must take steps to secure that the governors are equipped with the skills and knowledge they require in their capacity as such.

## **17. Council of Governors – meetings of governors**

**17.1** The Chair of the trust (i.e. the Chair of the Board of Directors, appointed in accordance with the provisions of paragraph 26.1 or paragraph 27.1 below) or, in their absence the Deputy Chair (appointed in accordance with the provisions of paragraph 28 below), shall preside at meetings of the Council of Governors.

**17.2** Meetings of the Council of Governors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons. The Chair may also exclude any member of the public from a meeting of the Council of Governors if they are interfering with or preventing the proper conduct of the meeting.



**17.3** For the purposes of obtaining information about the trust's performance of its functions or the Directors' performance of their duties (and deciding whether to propose a vote on the trust's or Directors' performance), the Council of Governors may require one or more of the Directors to attend a meeting.

**18. Council of Governors – standing orders**

The standing orders for the practice and procedure of the Council of Governors, as may be varied from time to time in accordance with paragraph 46, are attached at Annex 7.

**19. Council of Governors – referral to the Panel**

**19.1** In this paragraph, the Panel means a panel of persons appointed by NHS England to which a governor of an NHS foundation trust may refer a question as to whether the trust has failed or is failing—

**19.1.1** to act in accordance with its Constitution, or

**19.1.2** to act in accordance with provision made by or under Chapter 5 of the 2006 Act.

**19.2** A Governor may refer a question to the Panel only if more than half of the members of the Council of Governors voting approve the referral.

**20. Council of Governors - conflicts of interest of governors**

If a Governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the Governor shall disclose that interest to the members of the Council of Governors as soon as they become aware of it. The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

**21. Council of Governors – travel expenses**

The trust may pay travelling and other expenses to members of the Council of Governors at rates determined by the trust.

**22. Council of Governors – further provisions**

Further provisions with respect to the Council of Governors are set out in Annex 5 and Annex 10.

**23. Board of Directors – composition**

**23.1** The trust is to have a Board of Directors, which shall comprise both Executive Directors and Non-Executive Directors.

**23.2** The Board of Directors is to comprise:

**23.2.1** a Non-Executive Chair;

**23.2.2** up to 7 other Non-Executive Directors; and

**23.2.3** up to 7 Executive Directors.

**23.3** One of the Executive Directors shall be the Chief Executive.

**23.4** The Chief Executive shall be the Accounting Officer.

**23.5** One of the Executive Directors shall be the Finance Director.

**23.6** One of the Executive Directors is to be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984).

**23.7** One of the Executive Directors is to be a registered nurse or a registered midwife.

**24. Board of Directors – general duty**

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.

**25. Board of Directors – qualification for appointment as a non-executive director**

A person may be appointed as a Non-Executive Director only if –

**25.1** they are a member of a Public Constituency, or

**25.2** where any of the trust's hospitals includes a medical or dental school provided by a university, they exercise functions for the purposes of that university, and

**25.3** they are not disqualified by virtue of paragraph 31 below.

**26. Board of Directors – appointment and removal of chair and other non-executive directors**

**26.1** The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chair of the trust and the other Non-Executive Directors.

**26.2** Removal of the Chair or another Non-Executive Director shall require the approval of three-quarters of the members of the Council of Governors.

**27. Board of Directors – appointment of deputy chair**

The Council of Governors at a general meeting of the Council of Governors shall appoint one of the Non-Executive Directors as a Deputy Chair.

**28. Board of Directors - appointment and removal of the Chief Executive and other executive directors**

**28.1** The Non-Executive Directors shall appoint or remove the Chief Executive.

**28.2** The appointment of the Chief Executive shall require the approval of the Council of Governors.

**28.3** A committee consisting of the Chair, the Chief Executive and the other Non-Executive Directors shall appoint or remove the other Executive Directors.

**29. Board of Directors – disqualification**

The following may not become or continue as a member of the Board of Directors:

**29.1** a person who has been made bankrupt or whose estate has been sequestrated and (in either case) has not been discharged.

**29.2** a person who has made a composition or arrangement with, or granted a trust deed for, their creditors and has not been discharged in respect of it.

**29.3** a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on them.

**29.4** a person who no longer satisfies paragraph 25.1 or 25.2 (if applicable).

**29.5** a person who is a member of the Council of Governors

**29.6** a person whose tenure of office as a chair or as a member or director of a national health service body has been terminated on the grounds

that their appointment is not in the interests of public service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest.

- 29.7** A person who has been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the cause of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity.
- 29.8** A person where disclosure revealed by a Disclosure and Barring Service check against such a person are such that it would be inappropriate for them to become or continue as a Director or would adversely affect public confidence in the Trust or otherwise bring the Trust into disrepute.
- 29.10** A person is subject of a disqualification order made under the Company Directors Disqualification Act 1986.
- 29.11** A person who is the subject of an order under the Sexual Offences Act 2003
- 29.12** A person who is included in any barred list established under the Safeguarding Vulnerable Groups Act 2006
- 29.13** A person who has been been erased, removed or struck off by a direction from a register of professionals and has not subsequently had their qualification re-instated or suspension lifted.
- 29.14** A person who has within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a national health service body.
- 29.15** A person who has failed to agree (or having agreed, fails) to abide by the value of the trust's principles as set out in Annex 9.
- 29.16** A person does not meet the criteria set out in Regulation 5(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Fit and Proper Persons' Regulations) (including any modification or re-enactment).

### **30. Board of Directors – meetings**

- 30.1** Meetings of the Board of Directors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.
- 30.2** Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as

practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

**31. Board of Directors – standing orders**

The standing orders for the practice and procedure of the Board of Directors, as may be varied from time to time in accordance with paragraph 46, are attached at Annex 8.

**32. Board of Directors - conflicts of interest of directors**

**32.1** The duties that a Director of the trust has by virtue of being a Director include in particular –

**32.1.1** A duty to avoid a situation in which the Director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the trust (a "Conflict").

**32.1.2** A duty not to accept a benefit from a third party by reason of being a Director or doing (or not doing) anything in that capacity.

**32.2** The duty referred to in sub-paragraph 32.1.1 is not infringed if –

**32.2.1** The situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or

**32.2.2** The matter has been authorised in accordance with the Constitution.

**32.3** The duty referred to in sub-paragraph 32.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

**32.4** In sub-paragraph 32.1.2, "third party" means a person other than –

**32.4.1** The trust, or

**32.4.2** A person acting on its behalf.

**32.5** If a Director of the trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the trust, the Director must declare the nature and extent of that interest to the other Directors.

**32.6** If a declaration under this paragraph proves to be, or becomes, inaccurate, incomplete, a further declaration must be made.

**32.7** Any declaration required by this paragraph must be made before the trust enters into the transaction or arrangement.

- 32.8** This paragraph does not require a declaration of an interest of which the Director is not aware or where the Director is not aware of the transaction or arrangement in question.
- 32.9** A Director need not declare an interest –
- 32.9.1** If it cannot reasonably be regarded as likely to give rise to a conflict of interest;
  - 32.9.2** If, or to the extent that, the Directors are already aware of it;
  - 32.9.3** If, or to the extent that, it concerns terms of the Director's appointment that have been or are to be considered –
    - 32.9.3.1** By a meeting of the Board of Directors, or
    - 32.9.3.2** By a committee of the Directors appointed for the purpose under the Constitution.
- 32.10** A matter shall have been authorised for the purposes of paragraph 32.2.2 above if:
- 32.10.1** The Directors, in accordance with the requirements set out in this paragraph 32.10, authorise any matter or situation proposed to them by any Director which would, if not authorised, involve a Director (an "Interested Director") breaching their duty under paragraph 32.1.1 above to avoid Conflicts:
    - 32.10.1.1** the matter in question shall have been proposed by any Director for consideration in the same way that any other matter may be proposed to the Directors under the provisions of this Constitution;
    - 32.10.1.2** any requirement as to the quorum for consideration of the relevant matter is met without counting the Interested Director or any other Interest Director; and
    - 32.10.1.3** the matter was agreed to without the Interested Director voting or would have been agreed to if the Interested Director's and any other Interested Director's vote had not been counted.
  - 32.10.2** Any authorisation of a Conflict under this paragraph 32.10 may (whether at the time of giving the authorisation or subsequently):
    - 32.10.2.1** extend to any actual or potential conflict of interest

which may reasonably be expected to arise out of the Conflict so authorised;

32.10.2.2 provide that the Interested Director be excluded from the receipt of documents and information and the participation in discussions (whether at meetings of the Directors or otherwise) related to the Conflict;

32.10.2.3 impose upon the Interested Director such other terms for the purposes of dealing with the Conflict as the Directors think fit;

32.10.2.4 provide that, where the Interested Director obtains, or has obtained (through their involvement in the Conflict and otherwise than through their position as a Director of the Trust) information that is confidential to a third party, they will not be obliged to disclose that information to the Board of Directors, or to use it in relation to the Trust's affairs where to do so would amount to a breach of that confidence; and

32.10.2.5 permit the Interested Director to absent themselves from the discussion of matters relating to the Conflict at any meeting of the Directors and be excused from reviewing papers prepared by, or for, the Directors to the extent they relate to such matters.

**32.11** Where the Directors authorise a Conflict, the Interested Director will be obliged to conduct themselves in accordance with any terms imposed by the Directors in relation to the Conflict.

**32.12** The Directors may revoke or vary such authorisation at any time, but this will not affect anything done by the Interested Director, prior to such revocation or variation in accordance with the terms of such authorisation.

**32.13** A Director is not required, by reason of being a Director, to account to the Trust for any remuneration, profit or other benefit which they derive from or in connection with a relationship involving a Conflict which has been authorised by the Directors (subject in each case to any terms, limits or conditions attaching to that authorisation) and no contract shall be liable to be avoided on such grounds.

### **33 Board of Directors – remuneration and terms of office**

- 33.1** The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and the other Non-Executive Directors.
- 33.2** The trust shall establish a committee of Non-Executive Directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other Executive Directors;
- 33.3** On appointment, the duration of a term of office for a Non-Executive Director (including the Chair) shall be three (3) years. Subject to satisfactory appraisal, a Non-Executive Director (including the Chair) may be re-appointed by the Council of Governors for a further full term, normally service a maximum of six (6) years. Exceptionally, the Council of Governors may agree to extending the term of Office of a Non-Executive Director (including the Chair) by a further twelve (12) months in order to maintain continuity of knowledge and experience within the Board.
- 33.4** The maximum aggregate period of office of any Non-Executive Director shall not exceed seven (7) years, save that in the event that any Non-Executive Director takes office as Chair after they have been a Non-Executive Director for two (2) or more years, the maximum aggregate period of office for that Non-Executive Director shall not exceed nine(9) years

#### **34 Registers**

The trust shall have:

- 34.1** a register of Members showing, in respect of each Member, the constituency to which they belong and, where there are classes within it, the class to which they belong;
- 34.2** a register of members of the Council of Governors;
- 34.3** a register of interests of Governors;
- 34.4** a register of Directors; and
- 34.5** a register of interests of the Directors.

#### **35 Registers – inspection and copies**



- 35.1** The trust shall make the registers specified in paragraph 36 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.
- 35.2** The trust shall not make any part of its registers available for inspection by members of the public which shows details of any Member of the trust, if the Member so requests.
- 35.3** So far as the registers are required to be made available:
- 35.3.1** they are to be available for inspection free of charge at all reasonable times; and
- 35.3.2** a person who requests a copy of or extract from the registers is to be provided with a copy or extract.
- 35.4** If the person requesting a copy or extract is not a Member of the trust, the trust may impose a reasonable charge for doing so.

### **36 Documents available for public inspection**

- 36.1** The trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:
- 36.1.1** a copy of the current Constitution;
- 36.1.2** a copy of the latest annual accounts and any report of the auditor on them; and
- 36.1.3** a copy of the latest annual report;
- 36.2** The trust shall also make the following documents relating to a special administration of the trust available for inspection by members of the public free of charge at all reasonable times:
- 36.2.1** a copy of any order made under section 65D (appointment of trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L (trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act.
- 36.2.2** a copy of any report laid under section 65D (appointment of trust special administrator) of the 2006 Act.

- 36.2.3** a copy of any information published under section 65D (appointment of trust special administrator) of the 2006 Act.
- 36.2.4** a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act.
- 36.2.5** a copy of any statement provided under section 65F(administrator's draft report) of the 2006 Act.
- 36.2.6** a copy of any notice published under section 65F(administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA(NHSE's decision), 65KB (Secretary of State's response to NHSE's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act.
- 36.2.7** a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act.
- 36.2.8** a copy of any final report published under section 65I (administrator's final report),
- 36.2.9** a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act.
- 36.2.10** a copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.
- 36.3** Any person who requests a copy of or extract from any of the above documents is to be provided with a copy.
- 36.4** If the person requesting a copy or extract is not a member of the trust, the trust may impose a reasonable charge for doing so.

### **37 Auditor**

- 37.1** The trust shall have an auditor.
- 37.2** A person may only be appointed auditor if they (or the case of a firm, each of its members) are a member of one or more of the bodies referred to in Paragraph 23 (4) of Schedule 7 to the 2006 Act.
- 37.3** The Council of Governors shall appoint or remove the auditor at a general meeting of the Council of Governors.
- 37.4** The auditor shall carry out its duties in accordance with Schedule 10

to the 2006 Act and in accordance with any directions given by NHS England on standards, procedures and techniques adopted.

### **38 Audit committee**

The trust shall establish a committee of Non-Executive Directors as an Audit Committee to perform such monitoring, reviewing and other functions as are appropriate.

### **39 Accounts and Records**

**39.1** The trust must keep proper accounts and proper records in relation to the accounts.

**39.2** NHS England may with the approval of the Secretary of State give directions to the trust as to the content and form of its accounts.

**39.3** The accounts are to be audited by the trust's auditor.

**39.4** The trust shall prepare in respect of each financial year annual accounts in such form as NHS England may with the approval of the Secretary of State direct.

**39.5** The functions of the trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

**39.6** In preparing its annual accounts or in preparing any accounts by virtue of paragraph 39.4 above, the Trust must comply with any directions given by NHS England with the approval of the Secretary of State as to:

39.6.1 The methods and principles according to which the annual accounts must be prepared: and/or

39.6.2 The content and form of the annual accounts.

**39.7** The Trust must:

39.7.1 Lay a copy of the annual accounts, and any report of the auditor on them, before Parliament; and

39.7.2 Send copies of the annual accounts, and any report of the auditor on them to NHS England within such a period as NHS England may direct

### **40 Annual report, forward plans and non-NHS work**

**40.1** The trust shall prepare an annual report and send it to NHS England.

- 40.2** The trust shall give information as to its forward planning in respect of each financial year to NHS England.
- 40.3** The document containing the information with respect to forward planning (referred to above) shall be prepared by the Directors.
- 40.4** In preparing the document, the Directors shall have regard to the views of the Council of Governors.
- 40.5** Each forward plan must include information about:
- 40.5.1 the activities other than the provision of goods and services for the purposes of the health service in England that the trust proposes to carry on, and
  - 40.5.2 the income it expects to receive from doing so.
- 40.6** Where a forward plan contains a proposal that the trust carry on an activity of a kind mentioned in sub-paragraph 40.5.1 the Council of Governors must:
- 40.6.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfillment by the trust of its principal purpose or the performance of its other functions, and
  - 40.6.2 notify the Directors of the trust of its determination.
- 40.7** The Trust may implement a proposal to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of health service in England the proposal only if more than half of the members of Council of Governors of the trust voting approve its implementation.

**41** **Presentation of the annual accounts and reports to the Governors and Members**

- 41.1** The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:
- 41.1.1 the annual accounts
  - 41.1.2 any report of the auditor on them
  - 41.1.3 the annual report.

**41.2** The documents shall also be presented to the Members of the trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.

**41.3** The trust may combine a meeting of the Council of Governors convened for the purposes of sub-paragraph 43.1 with the Annual Members' Meeting.

## **42 Indemnity**

The Secretary of the trust and members of the Council of Governors and Board of Directors who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their functions, save where they have acted recklessly, and the trust may also take out and maintain at its own cost insurance against such risks, both for its own benefit and for the benefit of such persons.

## **43 Instruments**

**43.1** The trust shall have a seal.

**43.2** The seal shall not be affixed except under the authority of the Board of Directors as outlined in the Standing Orders for the Practice and Procedure of the Board of Directors at Annex 8.

## **44 Amendment of the constitution**

**44.1** The trust may make amendments of its Constitution only if:

44.1.1 More than half of the members of the Council of Governors of the trust voting approve the amendments, and

44.1.2 More than half of the members of the Board of Directors of the trust voting approve the amendments.

**44.2** Amendments made under paragraph 46.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the Constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act

**44.3** Where an amendment is made to the Constitution in relation the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the trust):

44.3.1 At least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment, and

44.3.2 The trust must give the Members an opportunity to vote on whether they approve the amendment.

**44.4** If more than half of the Members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the trust must take such steps as are necessary as a result.

**44.5** Amendments by the trust of its Constitution are to be notified to NHS England. For the avoidance of doubt, NHS England's functions do not include a power or duty to determine whether or not the constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

## 45 Mergers etc. and significant transactions

**45.1** The trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors.

**45.2** The trust may enter into a significant transaction only if more than half of the members of the Council of Governors of the trust voting approve entering into the transaction.

**45.3** "Significant transaction" means a transaction which meets the definition set out in Table 1 below:

Table 1: Significant transaction

Ratio	Description	Significant
Assets	The gross assets* subject to the transaction, divided by the gross assets of the trust	>25%
Income	The income attributable to assets or contract associated with the transaction, divided by the income of the trust	>25%
Consideration to total NHS foundation trust capital	The gross capital** of the company or business being acquired/divested, divided by the total capital*** of the trust following completion or the effects on the total capital of the trust resulting from a transaction	>25%

\* Gross assets is the total of fixed assets and current assets

\*\* Gross capital equals the market value of the target's shares and debt securities, plus the excess of current liabilities over current assets

\*\*\* Total capital of the foundation trust equals taxpayers' equity

## **46 Interpretation and definitions**

Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in this Constitution shall bear the same meaning as in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012.

References to statutory provisions shall be deemed to include references to any provision amending, re-enacting or replacing them and to such provisions as amended from time to time.

Words importing the masculine gender only shall include the feminine gender; words importing the singular shall import the plural and vice-versa.

**the 2006 Act** is the National Health Service Act 2006.

**the 2012 Act** is the Health and Social Care Act 2012.

**Accounting Officer** means the Officer responsible and accountable for discharging the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act, which shall be the Chief Executive.

**Adviser** means a person formally appointed by resolution of the Council of Governors to advise the Council of Governors at meetings of the Council of Governors in an advisory and non-voting capacity.

**Annual Members Meeting** is defined in paragraph 9 of the constitution.

**Audit Committee** means a committee whose functions are concerned with the arrangements for providing the Board with an independent and objective review on its financial and risk systems, financial information and compliance with laws, guidance, and regulations governing the NHS and with the arrangements for the monitoring and improving the quality of healthcare for which the trust has responsibility.

**Board of Directors (“the Board”)** means the Executive and Non-Executive Directors including the Chair as constituted in accordance with the Constitution as the Board of Directors.

**Chair** is the person appointed by the Council of Governors to lead the Council of Governors and Board of Directors and to ensure that they successfully discharge their overall responsibility for the trust as a whole. The expression “the Chair of the trust” shall be deemed to include the Deputy Chair of the trust if the Chair is absent from the meeting or is otherwise unavailable.

**Chief Executive** means the accounting officer of the trust.

**Committee members** means in the context of a Committee persons formally appointed by the Council of Governors or Board of Directors to be members of the

Committee.

**Council of Governors** means the elected and appointed Governors of the trust collectively as a body, as constituted in accordance with the Constitution.

**Constitution** means this constitution and all annexes to it.

**Deputy Chair** means the Non Executive Director appointed by the Council of Governors to take on the Chair duties if the Chair is absent for any reason.

**Director** means a Member of the Board.

**Executive Director** means a Member of the Board who holds an executive office of the trust.

**Finance Director** means the Chief Financial Officer of the trust.

**Governor** means a person who is a member of the Council of Governors.

**Licence** issued by Monitor the Licence sets out a range of conditions that the Trust must meet.

**Member** means any person registered as a member of the trust, and authorised to vote in elections to select Governors.

**Monitor** is the body corporate known as Monitor, as provided by Section 61 of the 2012 Act, which, at the time of the preparation of this document operates as NHS England.

**Motion** means a formal proposition to be discussed and voted on during the course of a meeting.

**NHS England** means NHS England leads the National Health Service (NHS) in England. Other than paragraph 46, references to Monitor or NHS Improvement in the Constitution have been updated to refer to NHS England.

**Non Executive Director** means a member of the Board of Directors who is not an Executive Director of the trust.

**Officer** means employee of the trust or any other person holding a paid appointment or office with the trust.

**Secretary** means a person who may be appointed to act independently of the Council of Governors to provide advice on corporate governance issues to the Council of Governors, and the Chair and monitor the trust's compliance with the law, Standing Orders and guidance of the NHSE.

**SFIs** means Standing Financial Instructions.

**SOs** mean Standing Orders.



**Voluntary Organisation** is a body, other than a public or local authority, the activities of which are not carried on for profit.

## **ANNEX 1 – THE PUBLIC CONSTITUENCY**

The trust shall have a single Public Constituency. The area of the Public Constituency will be made up of the wards specified below and the minimum number of Members in the Public Constituency shall be 100.

All local government electoral areas/wards of Suffolk, Norfolk, Cambridgeshire and Essex.

## **ANNEX 2 – THE STAFF CONSTITUENCY**

The Staff Constituency will comprise a single class. The minimum number of Members in the Staff Constituency shall be 100.

### ANNEX 3 – COMPOSITION OF COUNCIL OF GOVERNORS

<b>A. Elected Governors - public members</b>	14
<b>B. Elected Governors - staff members</b>	5
<b>C. Appointed Governors:</b>	
(a) Local Authority Governors:	
i. Suffolk County Council	1
ii. West Suffolk Council in consultation with Babergh, Braintree, Breckland, East Cambridgeshire, Ipswich, King's Lynn and West Norfolk, Mid Suffolk, South Norfolk, Suffolk Coastal and Waveney councils	1
(b) University of Cambridge Governor	1
(c) Other appointing organisations: (specified for the purposes of sub-paragraph 9(7) of Schedule 7 of the 2006 Act)	
i. Volunteers of WSFT in consultation with the Friends of West Suffolk Hospital	1
ii. Suffolk & Northeast Essex Integrated Care Board in consultation with local general practitioners and West Suffolk Alliance partners to provide a range of views and perspectives	2
iii. University Campus Suffolk (UCS) in consultation with West Suffolk College	1
Or in each case such other organisations as may be the successors to their functions.	

## **ANNEX 4 –THE MODEL RULES FOR ELECTIONS**

### **PART 1: INTERPRETATION**

1. Interpretation

### **PART 2: TIMETABLE FOR ELECTION**

2. Timetable
3. Computation of time

### **PART 3: RETURNING OFFICER**

4. Returning officer
5. Staff
6. Expenditure
7. Duty of co-operation

### **PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS**

8. Notice of election
9. Nomination of candidates
10. Candidate's particulars
11. Declaration of interests
12. Declaration of eligibility
13. Signature of candidate
14. Decisions as to validity of nomination forms
15. Publication of statement of nominated candidates
16. Inspection of statement of nominated candidates and nomination forms
17. Withdrawal of candidates
18. Method of election

### **PART 5: CONTESTED ELECTIONS**

19. Poll to be taken by ballot
20. The ballot paper
21. The declaration of identity (public and patient constituencies)

#### *Action to be taken before the poll*

22. List of eligible voters
23. Notice of poll
24. Issue of voting information by returning officer
25. Ballot paper envelope and covering envelope
26. E-voting systems

#### *The poll*

27. Eligibility to vote

- 28. Voting by persons who require assistance
- 29. Spoilt ballot papers and spoilt text message votes
- 30. Lost voting information
- 31. Issue of replacement voting information
- 32. ID declaration form for replacement ballot papers (public and patient constituencies)
- 33. Procedure for remote voting by internet
- 34. Procedure for remote voting by telephone
- 35. Procedure for remote voting by text message

*Procedure for receipt of envelopes, internet votes, telephone vote and text message votes*

- 36. Receipt of voting documents
- 37. Validity of votes
- 38. Declaration of identity but no ballot (public and patient constituency)
- 39. De-duplication of votes
- 40. Sealing of packets

**PART 6: COUNTING THE VOTES**

- STV41. Interpretation of Part 6
- 42. Arrangements for counting of the votes
- 43. The count
- STV44. Rejected ballot papers and rejected text voting records
- FPP44. Rejected ballot papers and rejected text voting records
- STV45. First stage
- STV46. The quota
- STV47. Transfer of votes
- STV48. Supplementary provisions on transfer
- STV49. Exclusion of candidates
- STV50. Filling of last vacancies
- STV51. Order of election of candidates
- FPP51. Equality of votes

**PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS**

- FPP52. Declaration of result for contested elections
- STV52. Declaration of result for contested elections
- 53. Declaration of result for uncontested elections

**PART 8: DISPOSAL OF DOCUMENTS**

- 54. Sealing up of documents relating to the poll
- 55. Delivery of documents
- 56. Forwarding of documents received after close of the poll
- 57. Retention and public inspection of documents
- 58. Application for inspection of certain documents relating to election



## **PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION**

- FPP59. Countermand or abandonment of poll on death of candidate
- STV59. Countermand or abandonment of poll on death of candidate

## **PART 10: ELECTION EXPENSES AND PUBLICITY**

### *Expenses*

- 60. Election expenses
- 61. Expenses and payments by candidates
- 62. Expenses incurred by other persons

### *Publicity*

- 63. Publicity about election by the corporation
- 64. Information about candidates for inclusion with voting information
- 65. Meaning of “for the purposes of an election”

## **PART 11: QUESTIONING ELECTIONS AND IRREGULARITIES**

- 66. Application to question an election

## **PART 12: MISCELLANEOUS**

- 67. Secrecy
- 68. Prohibition of disclosure of vote
- 69. Disqualification
- 70. Delay in postal service through industrial action or unforeseen event



**1. Interpretation**

1.1 In these rules, unless the context otherwise requires:

“*2006 Act*” means the National Health Service Act 2006;

“*corporation*” means the public benefit corporation subject to this constitution;

“*council of governors*” means the council of governors of the corporation;

“*declaration of identity*” has the meaning set out in rule 21.1;

“*election*” means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the council of governors;

“*e-voting*” means voting using either the internet, telephone or text message;

“*e-voting information*” has the meaning set out in rule 24.2;

“*ID declaration form*” has the meaning set out in Rule 21.1; “internet voting record” has the meaning set out in rule 26.4(d);

“*internet voting system*” means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;

“*lead governor*” means the governor nominated by the corporation to fulfil the role described in Appendix B to The Code of Governance (NHSE, 2022) or any later version of such code.

“*list of eligible voters*” means the list referred to in rule 22.1, containing the information in rule 22.2;

“*method of polling*” means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;

“*NHSE*” means the corporate body previously known as Monitor as provided by section 61 of the 2012 Act;

“*numerical voting code*” has the meaning set out in rule 64.2(b)

“*polling website*” has the meaning set out in rule 26.1;

“*postal voting information*” has the meaning set out in rule 24.1;

*“telephone short code”* means a short telephone number used for the purposes of submitting a vote by text message;

*“telephone voting facility”* has the meaning set out in rule 26.2;

*“telephone voting record”* has the meaning set out in rule 26.5 (d);

*“text message voting facility”* has the meaning set out in rule 26.3;

*“text voting record”* has the meaning set out in rule 26.6 (d);

*“the telephone voting system”* means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;

*“the text message voting system”* means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;

*“voter ID number”* means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting,

*“voting information”* means postal voting information and/or e-voting information

1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

## PART 2: TIMETABLE FOR ELECTIONS

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### 2. Timetable

2.1 The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	Time
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination forms to returning officer	Not later than the twenty eighth day before the day of the close of the
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

### 3. Computation of time

3.1 In computing any period of time for the purposes of the timetable:

- (a) a Saturday or Sunday;
- (b) Christmas day, Good Friday, or a bank holiday, or
- (c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, “bank holiday” means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

## PART 3: RETURNING OFFICER

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**4. Returning Officer**

4.1 Subject to rule 69, the returning officer for an election is to be appointed by the corporation.

4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

**5. Staff**

5.1 Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as they consider necessary for the purposes of the election.

**6. Expenditure**

6.1 The corporation is to pay the returning officer:

- (a) any expenses incurred by that officer in the exercise of his or her functions under these rules,
- (b) such remuneration and other expenses as the corporation may determine.

**7. Duty of co-operation**

7.1 The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

**PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS**

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**8. Notice of election**

8.1 The returning officer is to publish a notice of the election stating:

- (a) the constituency, or class within a constituency, for which the election is being held,
- (b) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
- (c) the details of any nomination committee that has been established by the corporation,
- (d) the address and times at which nomination forms may be obtained;
- (e) the address for return of nomination forms (including, where the

return of nomination forms in an electronic format will be permitted, the e-mail address for such return) and the date and time by which they must be received by the returning officer,

- (f) the date and time by which any notice of withdrawal must be received by the returning officer
- (g) the contact details of the returning officer
- (h) the date and time of the close of the poll in the event of a contest.

## **9. Nomination of candidates**

9.1 Subject to rule 9.2, each candidate must nominate themselves on a single nomination form.

9.2 The returning officer:

- (a) is to supply any member of the corporation with a nomination form, and
- (b) is to prepare a nomination form for signature at the request of any member of the corporation,

but it is not necessary for a nomination to be on a form supplied by the returning officer and a nomination can, subject to rule 13, be in an electronic format.

## **10. Candidate's particulars**

10.1 The nomination form must state the candidate's:

- (a) full name,
- (b) contact address in full (which should be a postal address although an e-mail address may also be provided for the purposes of electronic communication), and
- (c) constituency, or class within a constituency, of which the candidate is a member.

## **11. Declaration of interests**

11.1 The nomination form must state:

- (a) any financial interest that the candidate has in the corporation, and
- (b) whether the candidate is a member of a political party, and if so, which party,

and if the candidate has no such interests, the paper must include a statement to that effect.

## **12. Declaration of eligibility**

- 12.1 The nomination form must include a declaration made by the candidate:
- (a) that they are not prevented from being a member of the council of governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,
  - (b) for a member of the public or patient constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

### **13. Signature of candidate**

- 13.1 The nomination form must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:
- (a) they wish to stand as a candidate,
  - (b) their declaration of interests as required under rule 11, is true and correct, and
  - (c) their declaration of eligibility, as required under rule 12, is true and correct.

- 13.2 Where the return of nomination forms in an electronic format is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

### **14. Decisions as to the validity of nomination**

- 14.1 Where a nomination form is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:
- (a) decides that the candidate is not eligible to stand,
  - (b) decides that the nomination form is invalid,
  - (c) receives satisfactory proof that the candidate has died, or
  - (d) receives a written request by the candidate of their withdrawal from candidacy.
- 14.2 The returning officer is entitled to decide that a nomination form is invalid only on one of the following grounds:
- (a) that the paper is not received on or before the final time and date for return of nomination forms, as specified in the notice of the election,
  - (b) that the paper does not contain the candidate's particulars, as

required by rule 10;

- (c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11,
- (d) that the paper does not include a declaration of eligibility as required by rule 12, or
- (e) that the paper is not signed and dated by the candidate, if required by rule 13.

14.3 The returning officer is to examine each nomination form as soon as is practicable after they have received it, and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination form, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination form. If an e-mail address has been given in the candidate's nomination form (in addition to the candidate's postal address), the returning officer may send notice of the decision to that address.

## **15. Publication of statement of candidates**

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:

- (a) the name, contact address (which shall be the candidate's postal address), and constituency or class within a constituency of each candidate standing, and
- (b) the declared interests of each candidate standing,

as given in their nomination form.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination forms to the corporation as soon as is practicable after publishing the statement.

## **16. Inspection of statement of nominated candidates and nomination forms**

16.1 The corporation is to make the statement of the candidates and the nomination forms supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

16.2 If a member of the corporation requests a copy or extract of the statement of candidates or their nomination forms, the corporation is to provide that member with the copy or extract free of charge.

**17. Withdrawal of candidates**

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

**18. Method of election**

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the council of governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the council of governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be council of governors, then:

- (a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and
- (b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by them in consultation with the corporation.

**PART 5: CONTESTED ELECTIONS**

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**19. Poll to be taken by ballot**

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.



- 19.3 The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.
- 19.4 The corporation may decide that voters within a constituency or class within a constituency for whom an e-mail address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.
- 19.5 Before the corporation decides, in accordance with rule 19.3 that one or more e-voting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:
- (a) if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:
    - (i) configured in accordance with these rules; and
    - (ii) will create an accurate internet voting record in respect of any voter who casts his or her vote using the internet voting system;
  - (b) if telephone voting to be a method of polling, the telephone voting system to be used for the purpose of the election is:
    - (i) configured in accordance with these rules; and
    - (ii) will create an accurate telephone voting record in respect of any voter who casts his or her vote using the telephone voting system;
  - (c) if text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:
    - (i) configured in accordance with these rules; and
    - (ii) will create an accurate text voting record in respect of any voter who casts his or her vote using the text message voting system.

## **20. The ballot paper**

- 20.1 The ballot of each voter (other than a voter who casts his or her ballot by an e-voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.
- 20.2 Every ballot paper must specify:

- (a) the name of the corporation,
- (b) the constituency, or class within a constituency, for which the election is being held,
- (c) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
- (d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
- (e) instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available,
- (f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and
- (g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

**21. The declaration of identity (public and patient constituencies)**

21.1 The corporation shall require each voter who participates in an election for a public or patient constituency to make a declaration confirming:

- (a) that the voter is the person:
  - (i) to whom the ballot paper was addressed, and/or
  - (ii) to whom the voter ID number contained within the e-voting information was allocated,
- (b) that they have not marked or returned any other voting information in the election, and
- (c) the particulars of his or her qualification to vote as a member of the constituency or class within the constituency for which the election is being held,

("declaration of identity")

and the corporation shall make such arrangements as it considers appropriate to facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form ("ID declaration form") or the use of an electronic method.

21.2 The voter must be required to return his or her declaration of identity

with his or her ballot.

- 21.3 The voting information shall caution the voter that if the declaration of identity is not duly returned or is returned without having been made correctly, any vote cast by the voter may be declared invalid.

*Action to be taken before the poll*

**22. List of eligible voters**

- 22.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

- 22.2 The list is to include, for each member:

(a) a postal address; and,

(b) the member's e-mail address, if this has been provided

to which his or her voting information may, subject to rule 22.3, be sent.

- 22.3 The corporation may decide that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list.

**23. Notice of poll**

- 23.1 The returning officer is to publish a notice of the poll stating:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class with that constituency,

(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,

(f) the methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3,

(g) the address for return of the ballot papers,

- (h) the uniform resource locator (url) where, if internet voting is a method of polling, the polling website is located;
- (i) the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located,
- (j) the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located,
- (k) the date and time of the close of the poll,
- (l) the address and final dates for applications for replacement voting information, and
- (m) the contact details of the returning officer.

**24. Issue of voting information by returning officer**

24.1 Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by post to each member of the corporation named in the list of eligible voters:

- (a) a ballot paper and ballot paper envelope,
  - (b) the ID declaration form (if required),
  - (c) information about each candidate standing for election, pursuant to rule 61 of these rules, and
  - (d) a covering envelope;
- ("postal voting information").

24.2 Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by e-mail and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/ or rule 19.4 may cast his or her vote by an e-voting method of polling:

- (a) instructions on how to vote and how to make a declaration of identity (if required),
  - (b) the voter's voter ID number,
  - (c) information about each candidate standing for election, pursuant to rule 64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate, (d) contact details of the returning officer,
- ("e-voting information").

24.3 The corporation may determine that any member of the corporation shall:

- (a) only be sent postal voting information; or
- (b) only be sent e-voting information; or
- (c) be sent both postal voting information and e-voting information;

for the purposes of the poll.

24.4 If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list, then the returning officer shall only send that information by e-mail.

24.5 The voting information is to be sent to the postal address and/ or e-mail address for each member, as specified in the list of eligible voters.

## **25. Ballot paper envelope and covering envelope**

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The covering envelope is to have:

- (a) the address for return of the ballot paper printed on it, and
- (b) pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –

- (a) the completed ID declaration form if required, and
- (b) the ballot paper envelope, with the ballot paper sealed inside it.

## **26. E-voting systems**

26.1 If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as "the telephone voting facility").

- 26.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as “the text message voting facility”).
- 26.4 The returning officer shall ensure that the polling website and internet voting system provided will:
- (a) require a voter to:
    - (i) enter his or her voter ID number; and
    - (ii) where the election is for a public or patient constituency, make a declaration of identity;in order to be able to cast his or her vote;
  - (b) specify:
    - (i) the name of the corporation,
    - (ii) the constituency, or class within a constituency, for which the election is being held,
    - (iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,
    - (iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,
    - (v) instructions on how to vote and how to make a declaration of identity,
    - (vi) the date and time of the close of the poll, and
    - (vii) the contact details of the returning officer;
  - (c) prevent a voter from voting for more candidates than they are entitled to at the election;
  - (d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of-
    - (i) the voter’s voter ID number;
    - (ii) the voter’s declaration of identity (where required);
    - (iii) the candidate or candidates for whom the voter has voted; and
    - (iv) the date and time of the voter’s vote,
  - (e) if the voter’s vote has been duly cast and recorded, provide the

voter with confirmation of this; and

(f) prevent any voter from voting after the close of poll.

26.5

The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:

(a) require a voter to

(i) enter his or her voter ID number in order to be able to cast his or her vote; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) instructions on how to vote and how to make a declaration of identity,

(v) the date and time of the close of the poll, and

(vi) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than they are entitled to at the election;

(d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

26.6

The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:

- (a) require a voter to:
  - (i) provide his or her voter ID number; and
  - (ii) where the election is for a public or patient constituency, make a declaration of identity;
 in order to be able to cast his or her vote;
- (b) prevent a voter from voting for more candidates than they are entitled to at the election;
- (d) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:
  - (i) the voter's voter ID number;
  - (ii) the voter's declaration of identity (where required);
  - (ii) the candidate or candidates for whom the voter has voted; and
  - (iii) the date and time of the voter's vote
- (e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;
- (f) prevent any voter from voting after the close of poll.

*The poll*

**27. Eligibility to vote**

- 27.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

**28. Voting by persons who require assistance**

- 28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.
- 28.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as they consider necessary to enable that voter to vote.

**29. Spoilt ballot papers and spoilt text message votes**

- 29.1 If a voter has dealt with his or her ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.
- 29.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if they can obtain it.



- 29.3 The returning officer may not issue a replacement ballot paper for a spoiled ballot paper unless they:
- (a) are satisfied as to the voter's identity; and
  - (b) have ensured that the completed ID declaration form, if required, has not been returned.
- 29.4 After issuing a replacement ballot paper for a spoiled ballot paper, the returning officer shall enter in a list ("the list of spoiled ballot papers"):
- (a) the name of the voter, and
  - (b) the details of the unique identifier of the spoiled ballot paper (if that officer was able to obtain it), and
  - (c) the details of the unique identifier of the replacement ballot paper.
- 29.5 If a voter has dealt with his or her text message vote in such a manner that it cannot be accepted as a vote (referred to as a "spoiled text message vote"), that voter may apply to the returning officer for a replacement voter ID number.
- 29.6 On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoiled text message vote, if they can obtain it.
- 29.7 The returning officer may not issue a replacement voter ID number in respect of a spoiled text message vote unless they are satisfied as to the voter's identity.
- 29.8 After issuing a replacement voter ID number in respect of a spoiled text message vote, the returning officer shall enter in a list ("the list of spoiled text message votes"):
- (a) the name of the voter, and
  - (b) the details of the voter ID number on the spoiled text message vote (if that officer was able to obtain it), and
  - (c) the details of the replacement voter ID number issued to the voter.

### **30. Lost voting information**

- 30.1 Where a voter has not received his or her voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

- 30.2 The returning officer may not issue replacement voting information in respect of lost voting information unless they:
- (a) are satisfied as to the voter’s identity,
  - (b) have no reason to doubt that the voter did not receive the original voting information,
  - (c) have ensured that no declaration of identity, if required, has been returned.
- 30.3 After issuing replacement voting information in respect of lost voting information, the returning officer shall enter in a list (“the list of lost ballot documents”):
- (a) the name of the voter
  - (b) the details of the unique identifier of the replacement ballot paper, if applicable, and
  - (c) the voter ID number of the voter.

**31. Issue of replacement voting information**

- 31.1 If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, they are also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.
- 31.2 After issuing replacement voting information under this rule, the returning officer shall enter in a list (“the list of tendered voting information”):
- (a) the name of the voter,
  - (b) the unique identifier of any replacement ballot paper issued under this rule;
  - (c) the voter ID number of the voter.

**32. ID declaration form for replacement ballot papers (public and patient constituencies)**

- 32.1 In respect of an election for a public or patient constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity.

*Polling by internet, telephone or text*

**33. Procedure for remote voting by internet**

- 33.1 To cast his or her vote using the internet, a voter will need to gain access to the polling website by keying in the url of the polling website provided in the voting information.
- 33.2 When prompted to do so, the voter will need to enter his or her voter ID number.
- 33.3 If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote.
- 33.4 To cast his or her vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom they wish to cast his or her vote.
- 33.5 The voter will not be able to access the internet voting system for an election once his or her vote at that election has been cast.

**34. Voting procedure for remote voting by telephone**

- 34.1 To cast his or her vote by telephone, the voter will need to gain access to the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.
- 34.2 When prompted to do so, the voter will need to enter his or her voter ID number using the keypad.
- 34.3 If the telephone voting facility authenticates the voter ID number, the voter will be prompted to vote in the election.
- 34.4 When prompted to do so the voter may then cast his or her vote by keying in the numerical voting code of the candidate or candidates, for whom they wish to vote.
- 34.5 The voter will not be able to access the telephone voting facility for an election once his or her vote at that election has been cast.

**35. Voting procedure for remote voting by text message**

- 35.1 To cast his or her vote by text message the voter will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.
- 35.2 The text message sent by the voter must contain his or her voter ID number and the numerical voting code for the candidate or candidates, for whom they wish to vote.

- 35.3 The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

*Procedure for receipt of envelopes, internet votes, telephone votes and text message votes*

**36. Receipt of voting documents**

- 36.1 Where the returning officer receives:
- (a) a covering envelope, or
  - (b) any other envelope containing an ID declaration form if required, a ballot paper envelope, or a ballot paper,
- before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.
- 36.2 The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:
- (a) the candidate for whom a voter has voted, or
  - (b) the unique identifier on a ballot paper.
- 36.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

**37. Validity of votes**

- 37.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.
- 37.2 Where the returning officer is satisfied that rule 37.1 has been fulfilled, they are to:
- (a) put the ID declaration form if required in a separate packet, and
  - (b) put the ballot paper aside for counting after the close of the poll.
- 37.3 Where the returning officer is not satisfied that rule 37.1 has been fulfilled, they are to:
- (a) mark the ballot paper “disqualified”,
  - (b) if there is an ID declaration form accompanying the ballot paper, mark it “disqualified” and attach it to the ballot paper,

- (c) record the unique identifier on the ballot paper in a list of disqualified documents (the “list of disqualified documents”); and
- (d) place the document or documents in a separate packet.

37.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

37.5 Where the returning officer is satisfied that rule 37.4 has been fulfilled, they are to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

37.6 Where the returning officer is not satisfied that rule 37.4 has been fulfilled, they are to:

- (a) mark the internet voting record, telephone voting record or text voting record (as applicable) “disqualified”,
- (b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents; and
- (c) place the document or documents in a separate packet.

**38. Declaration of identity but no ballot paper (public and patient constituency)<sup>1</sup>**

38.1 Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:

- (a) mark the ID declaration form “disqualified”,
- (b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper, and
- (c) place the ID declaration form in a separate packet.

**39. De-duplication of votes**

39.1 Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.

39.2 If the returning officer ascertains that a voter ID number has been

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<sup>1</sup> It should not be possible, technically, to make a declaration of identity electronically without also submitting a vote.

used more than once to cast a vote in the election they shall:

- (a) only accept as duly returned the first vote received that was cast using the relevant voter ID number; and
- (b) mark as “disqualified” all other votes that were cast using the relevant voter ID number

39.3 Where a ballot paper is disqualified under this rule the returning officer shall:

- (a) mark the ballot paper “disqualified”,
- (b) if there is an ID declaration form accompanying the ballot paper, mark it “disqualified” and attach it to the ballot paper,
- (c) record the unique identifier and the voter ID number on the ballot paper in the list of disqualified documents;
- (d) place the document or documents in a separate packet; and
- (e) disregard the ballot paper when counting the votes in accordance with these rules.

39.4 Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:

- (a) mark the internet voting record, telephone voting record or text voting record (as applicable) “disqualified”,
- (b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents;
- (c) place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet, and
- (d) disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

#### **40. Sealing of packets**

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:

- (a) the disqualified documents, together with the list of disqualified documents inside it,
- (b) the ID declaration forms, if required,
- (c) the list of spoilt ballot papers and the list of spoilt text message votes,
- (d) the list of lost ballot documents,

- (e) the list of eligible voters, and
- (f) the list of tendered voting information

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

## PART 6: COUNTING THE VOTES

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### STV41. Interpretation of Part 6

STV41.1 In Part 6 of these rules:

*“ballot document”* means a ballot paper, internet voting record, telephone voting record or text voting record.

*“continuing candidate”* means any candidate not deemed to be elected, and not excluded,

*“count”* means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,

*“deemed to be elected”* means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,

*“mark”* means a figure, an identifiable written word, or a mark such as “X”,

*“non-transferable vote”* means a ballot document:

- (a) on which no second or subsequent preference is recorded for a continuing candidate,

or

- (b) which is excluded by the returning officer under rule STV49,

*“preference”* as used in the following contexts has the meaning assigned below:

- (a) *“first preference”* means the figure “1” or any mark or word which clearly indicates a first (or only) preference,
- (b) *“next available preference”* means a preference which is the

second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and

- (c) in this context, a “second preference” is shown by the figure “2” or any mark or word which clearly indicates a second preference, and a third preference by the figure “3” or any mark or word which clearly indicates a third preference, and so on,

“*quota*” means the number calculated in accordance with rule STV46,

“*surplus*” means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballot documents from the candidate who has the surplus,

“*stage of the count*” means:

- (a) the determination of the first preference vote of each candidate,
- (b) the transfer of a surplus of a candidate deemed to be elected, or
- (c) the exclusion of one or more candidates at any given time,

“*transferable vote*” means a ballot document on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,

“*transferred vote*” means a vote derived from a ballot document on which a second or subsequent preference is recorded for the candidate to whom that ballot document has been transferred, and

“*transfer value*” means the value of a transferred vote calculated in accordance with rules STV47.4 or STV47.7.

## **42. Arrangements for counting of the votes**

42.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

42.2 The returning officer may make arrangements for any votes to be counted using vote counting software where:

- (a) the board of directors and the council of governors of the corporation have approved:
  - (i) the use of such software for the purpose of counting votes in the relevant election, and



- (ii) a policy governing the use of such software, and
- (b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

**43. The count**

43.1 The returning officer is to:

- (a) count and record the number of:
  - (iii) ballot papers that have been returned; and
  - (iv) the number of internet voting records, telephone voting records and/or text voting records that have been created, and
- (b) count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

**STV44. Rejected ballot papers and rejected text voting records**

STV44.1 Any ballot paper:

- (a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,
- (b) on which the figure “1” standing alone is not placed so as to indicate a first preference for any candidate,
- (c) on which anything is written or marked by which the voter can be identified except the unique identifier, or
- (d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words “one”, “two”, “three” and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.2 The returning officer is to endorse the word “rejected” on any ballot paper which under this rule is not to be counted.

STV44.3 Any text voting record:

- (a) on which the figure “1” standing alone is not placed so as to indicate a first preference for any candidate,
- (b) on which anything is written or marked by which the voter can be identified except the unique identifier, or
- (c) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the text voting record shall not be rejected by reason only of carrying the words “one”, “two”, “three” and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.4 The returning officer is to endorse the word “rejected” on any text voting record which under this rule is not to be counted.

STV44.5 The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of rule STV44.1 and the number of text voting records rejected by him or her under each of the sub-paragraphs (a) to (c) of rule STV44.3.

**FPP44. Rejected ballot papers and rejected text voting records**

FPP44.1 Any ballot paper:

- (a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,
- (b) on which votes are given for more candidates than the voter is entitled to vote,
- (c) on which anything is written or marked by which the voter can be identified except the unique identifier, or
- (d) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.2 and FPP44.3, be rejected and not counted.

FPP44.2 Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP44.3 A ballot paper on which a vote is marked:

- (a) elsewhere than in the proper place,
- (b) otherwise than by means of a clear mark,
- (c) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that they can be identified by it.

FPP44.4 The returning officer is to:

- (a) endorse the word “rejected” on any ballot paper which under this rule is not to be counted, and
- (b) in the case of a ballot paper on which any vote is counted under rules FPP44.2 and FPP 44.3, endorse the words “rejected in part” on the ballot paper and indicate which vote or votes have been counted.

FPP44.5 The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:

- (a) does not bear proper features that have been incorporated into the ballot paper,
- (b) voting for more candidates than the voter is entitled to,
- (c) writing or mark by which voter could be identified, and
- (d) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of ballot papers rejected in part.

FPP44.6 Any text voting record:

- (a) on which votes are given for more candidates than the voter is entitled to vote,
- (b) on which anything is written or marked by which the voter can be identified except the voter ID number, or
- (c) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.7 and FPP44.8, be rejected and not counted.

FPP44.7 Where the voter is entitled to vote for more than one candidate, a text voting record is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP44.8 A text voting record on which a vote is marked:

- (a) otherwise than by means of a clear mark,
- (b) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the text voting record is marked does not itself identify the voter and it is not shown that they can be identified by it.

FPP44.9 The returning officer is to:

- (a) endorse the word “rejected” on any text voting record which under this rule is not to be counted, and
- (b) in the case of a text voting record on which any vote is counted under rules FPP44.7 and FPP 44.8, endorse the words “rejected in part” on the text voting record and indicate which vote or votes have been counted.

FPP44.10 The returning officer is to draw up a statement showing the number of rejected text voting records under the following headings:

- (a) voting for more candidates than the voter is entitled to,
- (b) writing or mark by which voter could be identified, and
- (c) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of text voting records rejected in part.

**STV45. First stage**

STV45.1 The returning officer is to sort the ballot documents into parcels according to the candidates for whom the first preference votes are given.

STV45.2 The returning officer is to then count the number of first preference votes given on ballot documents for each candidate, and is to record those numbers.

STV45.3 The returning officer is to also ascertain and record the number of valid ballot documents.

**STV46. The quota**

STV46.1 The returning officer is to divide the number of valid ballot documents by a number exceeding by one the number of members to be elected.

STV46.2 The result, increased by one, of the division under rule STV46.1 (any fraction being disregarded) shall be the number of votes sufficient to

secure the election of a candidate (in these rules referred to as “the quota”).

STV46.3 At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules STV47.1 to STV47.3 has been complied with.

**STV47. Transfer of votes**

STV47.1 Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot documents on which first preference votes are given for that candidate into sub-parcels so that they are grouped:

- (a) according to next available preference given on those ballot documents for any continuing candidate, or
- (b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.2 The returning officer is to count the number of ballot documents in each parcel referred to in rule STV47.1.

STV47.3 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.1(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.4 The vote on each ballot document transferred under rule STV47.3 shall be at a value (“the transfer value”) which:

- (a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and
- (b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot documents on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

STV47.5 Where at the end of any stage of the count involving the transfer of ballot documents, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot documents in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

- (a) according to the next available preference given on those ballot documents for any continuing candidate, or
- (b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.6 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.5(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.7 The vote on each ballot document transferred under rule STV47.6 shall be at:

- (a) a transfer value calculated as set out in rule STV47.4(b), or
- (b) at the value at which that vote was received by the candidate from whom it is now being transferred,

whichever is the less.

STV47.8 Each transfer of a surplus constitutes a stage in the count.

STV47.9 Subject to rule STV47.10, the returning officer shall proceed to transfer transferable ballot documents until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

STV47.10 Transferable ballot documents shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

- (a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or
- (b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

STV47.11 This rule does not apply at an election where there is only one vacancy.

#### **STV48. Supplementary provisions on transfer**

STV48.1 If, at any stage of the count, two or more candidates have surpluses, the transferable ballot documents of the candidate with the highest surplus shall be transferred first, and if:

- (a) The surpluses determined in respect of two or more candidates are equal, the transferable ballot documents of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and
- (b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between

those candidates by lot, and the transferable ballot documents of the candidate on whom the lot falls shall be transferred first.

STV48.2 The returning officer shall, on each transfer of transferable ballot documents under rule STV47:

- (a) record the total value of the votes transferred to each candidate,
- (b) add that value to the previous total of votes recorded for each candidate and record the new total,
- (c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and
- (d) compare:
  - (i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with
  - (ii) the recorded total of valid first preference votes.

STV48.3 All ballot documents transferred under rule STV47 or STV49 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot document or, as the case may be, all the ballot documents in that sub-parcel.

STV48.4 Where a ballot document is so marked that it is unclear to the returning officer at any stage of the count under rule STV47 or STV49 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot document as a non-transferable vote; and votes on a ballot document shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

## **STV49. Exclusion of candidates**

STV49.1 If:

- (a) all transferable ballot documents which under the provisions of rule STV47 (including that rule as applied by rule STV49.11) and this rule are required to be transferred, have been transferred, and
- (b) subject to rule STV50, one or more vacancies remain to be filled,

the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule STV49.12 applies, the candidates with the then lowest votes).

- STV9.2 The returning officer shall sort all the ballot documents on which first preference votes are given for the candidate or candidates excluded under rule STV49.1 into two sub-parcels so that they are grouped as:
- (a) ballot documents on which a next available preference is given, and
  - (b) ballot documents on which no such preference is given (thereby including ballot documents on which preferences are given only for candidates who are deemed to be elected or are excluded).
- STV49.3 The returning officer shall, in accordance with this rule and rule STV48, transfer each sub-parcel of ballot documents referred to in rule STV49.2 to the candidate for whom the next available preference is given on those ballot documents.
- STV49.4 The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.
- STV49.5 If, subject to rule STV50, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballot documents, if any, which had been transferred to any candidate excluded under rule STV49.1 into sub- parcels according to their transfer value.
- STV49.6 The returning officer shall transfer those ballot documents in the sub-parcel of transferable ballot documents with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballot documents (thereby passing over candidates who are deemed to be elected or are excluded).
- STV49.7 The vote on each transferable ballot document transferred under rule STV49.6 shall be at the value at which that vote was received by the candidate excluded under rule STV49.1.
- STV9.8 Any ballot documents on which no next available preferences have been expressed shall be set aside as non-transferable votes.
- STV49.9 After the returning officer has completed the transfer of the ballot documents in the sub-parcel of ballot documents with the highest transfer value they shall proceed to transfer in the same way the sub-parcel of ballot documents with the next highest value and so on until they have dealt with each sub-parcel of a candidate excluded under rule STV49.1.
- STV49.10 The returning officer shall after each stage of the count completed under this rule:
- (a) record:



- (i) the total value of votes, or
- (ii) the total transfer value of votes transferred to each candidate,
- (b) add that total to the previous total of votes recorded for each candidate and record the new total,
- (c) record the value of non-transferable votes and add that value to the previous non-transferable votes total, and
- (d) compare:
  - (i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with
  - (ii) the recorded total of valid first preference votes.

STV49.11 If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules STV47.5 to STV47.10 and rule STV48.

STV49.12 Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

STV49.13 If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:

- (a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and
- (b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

**STV50. Filling of last vacancies**

STV50.1 Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

STV50.2 Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

STV50.3 Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

**STV51. Order of election of candidates**

- STV51.1 The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule STV47.10.
- STV51.2 A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which they obtained the quota.
- STV51.3 Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.
- STV51.4 Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

**FPP51. Equality of votes**

- FPP51.1 Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

**PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS**

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**FPP52. Declaration of result for contested elections**

- FPP52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:
  - (a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of governors from the constituency, or class within a constituency, for which the election is being held to be elected,

- (b) give notice of the name of each candidate who they have declared elected:
  - (i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chair of the NHS Trust, or
  - (ii) in any other case, to the chair of the corporation; and
- (c) give public notice of the name of each candidate whom they have declared elected.

FPP52.2 The returning officer is to make:

- (a) the total number of votes given for each candidate (whether elected or not), and
- (b) the number of rejected ballot papers under each of the headings in rule FPP44.5,
- (c) the number of rejected text voting records under each of the headings in rule FPP44.10,

available on request.

## **STV52. Declaration of result for contested elections**

STV52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

- (a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,
- (b) give notice of the name of each candidate who they have declared elected –
  - (i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chair of the NHS Trust, or
  - (ii) in any other case, to the chair of the corporation, and
- (c) give public notice of the name of each candidate who they have declared elected.

STV52.2 The returning officer is to make:

- (a) the number of first preference votes for each candidate whether elected or not,
- (b) any transfer of votes,
- (c) the total number of votes for each candidate at each stage of the count at which such transfer took place,

- (d) the order in which the successful candidates were elected, and
- (e) the number of rejected ballot papers under each of the headings in rule STV44.1,
- (f) the number of rejected text voting records under each of the headings in rule STV44.3,

available on request.

**53. Declaration of result for uncontested elections**

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

- (a) declare the candidate or candidates remaining validly nominated to be elected,
- (b) give notice of the name of each candidate who they have declared elected to the chair of the corporation, and
- (c) give public notice of the name of each candidate who they have declared elected.

**PART 8: DISPOSAL OF DOCUMENTS**

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**54. Sealing up of documents relating to the poll**

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

- (a) the counted ballot papers, internet voting records, telephone voting records and text voting records,
- (b) the ballot papers and text voting records endorsed with “rejected in part”,
- (c) the rejected ballot papers and text voting records, and
- (d) the statement of rejected ballot papers and the statement of rejected text voting records,

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

54.2 The returning officer must not open the sealed packets of:

- (a) the disqualified documents, with the list of disqualified documents inside it,
- (b) the list of spoiled ballot papers and the list of spoiled text message votes,
- (c) the list of lost ballot documents, and
- (d) the list of eligible voters,

or access the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage.

54.3 The returning officer must endorse on each packet a description of:

- (a) its contents,
- (b) the date of the publication of notice of the election,
- (c) the name of the corporation to which the election relates, and
- (d) the constituency, or class within a constituency, to which the election relates.

**55. Delivery of documents**

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

**56. Forwarding of documents received after close of the poll**

56.1 Where:

- (a) any voting documents are received by the returning officer after the close of the poll, or
- (b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or
- (c) any applications for replacement voting information are made too late to enable new voting information to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chair of the corporation.

**57. Retention and public inspection of documents**

57.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

**58. Application for inspection of certain documents relating to an election**

58.1 The corporation may not allow:

- (a) the inspection of, or the opening of any sealed packet containing –
  - (i) any rejected ballot papers, including ballot papers rejected in part,
  - (ii) any rejected text voting records, including text voting records rejected in part,
  - (iii) any disqualified documents, or the list of disqualified documents,
  - (iv) any counted ballot papers, internet voting records, telephone voting records or text voting records, or
  - (v) the list of eligible voters, or
- (b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage,

by any person without the consent of the board of directors of the corporation.

58.2 A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The board of directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to –

- (a) persons,
- (b) time,
- (c) place and mode of inspection,

(d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:

- (a) in giving its consent, and
- (b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

- (i) that his or her vote was given, and
- (ii) that NHSE has declared that the vote was invalid.

## **PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION**

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### **FPP59. Countermand or abandonment of poll on death of candidate**

FPP59.1 If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

- (a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class, and
- (b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

FPP59.2 Where a new election is ordered under rule FPP59.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

FPP59.3 Where a poll is abandoned under rule FPP59.1(a), rules FPP59.4 to FPP59.7 are to apply.

FPP59.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 38 and 39, and is to make up separate sealed packets in accordance with rule 40.

FPP59.5 The returning officer is to:

- (a) count and record the number of ballot papers, internet voting records, telephone voting records and text voting records that have been received,
- (b) seal up the ballot papers, internet voting records, telephone voting records and text voting records into packets, along with the records of the number of ballot papers, internet voting records, telephone voting records and text voting records and

ensure that complete electronic copies of the internet voting records telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

FPP59.6 The returning officer is to endorse on each packet a description of:

- (a) its contents,
- (b) the date of the publication of notice of the election,
- (c) the name of the corporation to which the election relates, and
- (d) the constituency, or class within a constituency, to which the election relates.

FPP59.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to rules FPP59.4 to FPP59.6, the returning officer is to deliver them to the chair of the corporation, and rules 57 and 58 are to apply.

**STV59. Countermand or abandonment of poll on death of candidate**

STV59.1 If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

- (a) publish a notice stating that the candidate has died, and
- (b) proceed with the counting of the votes as if that candidate had been excluded from the count so that –
  - (i) ballot documents which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and
  - (ii) ballot documents which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.



STV59.2 The ballot documents which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot documents pursuant to rule 54.1(a).

## **PART 10: ELECTION EXPENSES AND PUBLICITY**

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### *Election expenses*

#### **60. Election expenses**

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to NHSE under Part 11 of these rules.

#### **61. Expenses and payments by candidates**

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

- (a) personal expenses,
- (b) travelling expenses, and expenses incurred while living away from home, and
- (c) expenses for stationery, postage, telephone, internet (or any similar means of communication) and other petty expenses, to a limit of £100.

#### **62. Election expenses incurred by other persons**

62.1 No person may:

- (a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or
- (b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

### *Publicity*

**63. Publicity about election by the corporation**

63.1 The corporation may:

- (a) compile and distribute such information about the candidates, and
- (b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

- (a) objective, balanced and fair,
- (b) equivalent in size and content for all candidates,
- (c) compiled and distributed in consultation with all of the candidates standing for election, and
- (d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

**64. Information about candidates for inclusion with voting information**

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:

- (a) a statement submitted by the candidate of no more than 250 words,
- (b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility (“numerical voting code”), and

(c) a photograph of the candidate.

**65. Meaning of “for the purposes of an election”**

65.1 In this Part, the phrase “for the purposes of an election” means with a view to, or otherwise in connection with, promoting or procuring a candidate’s election, including the prejudicing of another candidate’s electoral prospects; and the phrase “for the purposes of a candidate’s election” is to be construed accordingly.

65.2 The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

**PART 11: QUESTIONING ELECTIONS AND THE CONSEQUENCE OF IRREGULARITIES**

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**66. Application to question an election**

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to NHSE for the purpose of seeking a referral to the independent election arbitration panel ( IEAP).

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to NHSE by:

- (a) a person who voted at the election or who claimed to have had the right to vote, or
- (b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:

- (a) describe the alleged breach of the rules or electoral irregularity, and
- (b) be in such a form as the independent panel may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election. NHSE will refer the application to the independent election arbitration panel appointed by NHSE.

66.6 If the independent election arbitration panel requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

- 66.7 NHSE shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.
- 66.8 The determination by the IEAP shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.
- 66.9 The IEAP may prescribe rules of procedure for the determination of an application including costs.

## **PART 12: MISCELLANEOUS**

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### **67. Secrecy**

67.1 The following persons:

- (a) the returning officer,
- (b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

- (i) the name of any member of the corporation who has or has not been given voting information or who has or has not voted,
- (ii) the unique identifier on any ballot paper,
- (iii) the voter ID number allocated to any voter,
- (iv) the candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.

67.3 The returning officer is to make such arrangements as they think fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

### **68. Prohibition of disclosure of vote**

68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom

they have voted.

**69. Disqualification**

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

- (a) a member of the corporation,
- (b) an employee of the corporation,
- (c) a director of the corporation, or
- (d) employed by or on behalf of a person who has been nominated for election.

**70. Delay in postal service through industrial action or unforeseen event**

70.1 If industrial action, or some other unforeseen event, results in a delay in:

- (a) the delivery of the documents in rule 24, or
- (b) the return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as they consider appropriate.

## ANNEX 5 – ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS

A person may not become or continue as a Governor of the trust if –

- (a) they, in the case of a staff Governor or public Governor, ceases to be a Member of the constituency they represents;
- (b) they, in the case of a appointed Governor, have their sponsorship withdrawn by their sponsoring organisation;
- (c) they have within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a national health service body;
- (d) their tenure of office as the chair or as a member or director of a national health service body has been terminated on the grounds that their appointment is not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;
- (e) they are an Executive Director or Non-Executive Director of the trust, or a governor, non executive director, chair, chief executive officer of an organisation the nature of whose business is to give rise to potential conflicts of interest of a personal or prejudicial nature to such a degree as to prevent the person from the proper exercise of their duties as a Governor of this Trust. This may include other NHS Foundation Trusts;
- (f) they are a person who has been been erased, removed or struck off by a direction from a register of professionals and has not subsequently had his qualification re-instated or suspension lifted.
- (g) they have been declared, by a sub-committee of the Council of Governors, to be a vexatious complainant;
- (h) they have failed to agree (or having agreed, fails) to abide by the Code of Conduct for Governors as set out in Annex 6 and the value of the trust's Principles as set out in Annex 9; or
- (i) they have been previously removed as a Governor pursuant to paragraph 12.8 of the Constitution.

## **ANNEX 6 - CODE OF CONDUCT FOR GOVERNORS**

### **1. Introduction**

- 1.1 The NHS Act 2012 sets out the powers of and obligations upon, governors of NHS Foundation Trusts, details of which form part of the Constitution. If Governors operate outside the powers assigned to them or fail to adhere to the obligations of public office, the NHS Act gives the Foundation Trust the power, through its Constitution, to remove them from office.
- 1.2 This Code seeks to outline appropriate conduct for Governors and addresses both the requirements of office and their personal behaviour. Ideally any penalties for non-compliance would never need to be applied, however, a Code is considered an essential guide for Governors, particularly those who are newly elected.
- 1.3 The West Suffolk NHS Foundation Trust operates a just and learning culture, with an emphasis on learning from mistakes rather than blaming individuals. We expect high standards of conduct from our elected and appointed governors and we expect them to take responsibility and be accountable when they fall short. Any investigation into code breaches, as well as establishing the facts, will also seek to understand the reasons for the breach, with a view to remediation rather than punishment.
- 1.4 The Code seeks to expand on or complement the Constitution. Copies will be made available for the information of all Governors and for those considering seeking election to the Council of Governors.
- 1.5 This Code of Conduct does not limit or invalidate the right of the Governors or the Trust to act under the Constitution.
- 1.6 The Code applies to all forms of communication and interaction, including:
  - 1.6.1 at face to face meetings
  - 1.6.2 at online or telephone meetings
  - 1.6.3 in written communication
  - 1.6.4 in verbal communication
  - 1.6.5 in non-verbal communication
  - 1.6.6 in electronic and social media communication, posts, statements and comments.

### **2. Qualifications for office**

- 2.1 Members of the Council of Governors must continue to comply with the qualifications required to hold elected office throughout their period of tenure as defined in the Constitution. The Trust Secretary should be advised of any changes in circumstances, which disqualify the Governor from continuing in office. An example of this would be a public Governor becoming an employee of the Trust, given that the number of employees sitting on the Trust's elected bodies is limited.

- 2.2 Where a Governor has resigned from office, that governor must promptly return to the Trust Secretary any Trust property or confidential paperwork relating to the Trust and the work of the Council of Governors as the Governor may have in his or her possession and continue to comply with the requirements of the Constitution, this Code and Standing Orders for the Council of Governors until such time as this resignation takes effect.

### **3. General Principles**

- 3.1 Governors should at all times:

- 3.1.1 adhere to the Trust's values and supporting behaviours; rules and policies; and support the agreed vision and aims of the Trust in developing a successful Trust for the people of West Suffolk.
- 3.1.2 act in the best interests of the Trust at all times and in accordance with the Constitution, the Standing Orders for the Council of Governors and this Code.
- 3.1.3 contribute to the workings of their Council of Governors in order for it to fulfil its role and functions.
- 3.1.4 recognise that the Council of Governors exercises collective decision-making on behalf of local people, stakeholders and staff and abide by such decisions as are made within that forum.
- 3.1.5 acknowledge that, other than when attending meetings and events as a Governor, Governors will have no rights or privileges over any other Member of the Trust.
- 3.1.6 recognise that the Council of Governors has no managerial role within the Trust and that the roles and responsibilities of a governor are not of a managerial or executive nature.
- 3.1.7 conduct themselves in a manner that reflects positively on the Trust, and act as an ambassador for the Trust.

### **4. Confidentiality**

- 4.1 Governors will receive confidential information during the conduct of their duties and will be expected to respect the confidentiality of that information. Governors are required not to disclose information given to them in confidence by anyone, or information acquired by them which they believe or ought reasonably to be aware, is of a confidential nature.
- 4.2 Matters discussed in closed meetings of the Council of Governors and any meetings relating to disciplinary or code of conduct matters must be assumed to be confidential and not discussed or disclosed to anyone outside the meeting.

### **5. Trust Policies**

- 5.1 The Governors shall comply with the following Trust policies (revised Trust policies will be notified to the Governors from time to time):
- 5.1.1 Email and Internet Policy



- 5.1.2 Respect for Others Policy
- 5.1.3 Equality, Diversity and Inclusion Supporting Equal Opportunities
- 5.1.4 Freedom to Speak up
- 5.1.5 Data Protection Policy
- 5.1.6 Management of Violence and Aggression Policy
- 5.1.7 Such other reasonable Trust policies as are notified to the Governors in writing from time to time.

## **6. Conflict of interests**

- 6.1 Governors should act with the utmost integrity and objectivity and in the best interests of the Trust in performing their duties. They should not use their position for personal advantage or seek to gain preferential treatment. Any Governor who has a material interest in a matter as defined by the Constitution, shall declare such interest to the Council of Governors and:
  - 6.1.1 shall not vote on any such matters.
  - 6.1.2 shall not be present except with the permission of the Council of Governors in any discussion of the matter.
- 6.2 If in any doubt they should seek advice from the Trust Secretary. It is important that conflicts of interest are addressed and are seen to be actioned in the interests of the Trust and all individuals concerned.
- 6.3 Any Governor who fails to disclose any interest required to be disclosed under the preceding paragraph must permanently vacate their office if required to do so by a majority of the remaining Governors.

## **7. Conduct in meetings**

- 7.1 Governors should at all times:
  - 7.1.1 be aware that they have a responsibility to attend meetings of the Council of Governors. When this is not possible they should submit an apology to the meeting administrator in advance of the meeting.
  - 7.1.2 be aware that failure to attend three successive public meetings of the council of governors without good reason and prior explanation as set out in the constitution is ground for dismissal from their office, unless the grounds for absence are deemed to be acceptable by the council of governors.
  - 7.1.3 be aware that they are expected to attend for the duration of the meeting.
  - 7.1.4 maintain good practice with respect to the conduct of meetings and respect the views of their fellow council members. Governors should not conduct private conversations when a meeting is taking place.

- 7.1.5 respect the integrity of the decision-making process in meetings of the Council of Governors and its committees and not undermine that process by their actions outside those meetings.
- 7.1.6 respect the confidentiality of matters discussed at closed meetings and not reveal details of information received, discussions, outcomes or individual voting decisions of those present at those meetings without their permission and/or outside due process.
- 7.1.7 comply with Standing Orders of the Council of Governors and draw the Trust Secretary's attention to any perceived breaches of the Standing Orders.

## **8. Personal conduct**

- 8.1 Governors are required to adhere to the highest standards of conduct in the performance of their duties as holders of public office.
- 8.2 Governors must, whilst carrying out their role of Governor:
  - 8.2.1 acknowledge that the Trust is an apolitical organisation.
  - 8.2.2 adhere to good practice in respect of the conduct of meetings and respect the views of their fellow elected governors.
  - 8.2.3 recognise that it is not acceptable or appropriate to represent any trade union, political party or other organisation of which they are a member or represent their views whilst conducting themselves as governor.
  - 8.2.4 be honest and act with integrity and probity at all times.
  - 8.2.5 accept responsibility for their actions.
  - 8.2.6 show their commitment to working as a team member by working with colleagues in the NHS and wider community.
  - 8.2.7 share collective responsibility for all Council decisions regardless of personal opinion.
  - 8.2.8 be mindful of conduct which could be deemed to be unfair or discriminatory and support inclusivity.
  - 8.2.9 treat other governors, members of the public, Directors (executive and non-executive) and other employees with respect and in accordance with the Trust's policy against bullying and harassment.
  - 8.2.10 not intimidate or attempt to intimidate any person who is or is likely to be involved in the administration of any investigation or proceedings in relation to an allegation that a governor has failed to comply with this code of conduct.
  - 8.2.11 recognise that the Council of Governors, the Board of Directors and management have a common purpose, i.e. promote the success of the Trust, and adopt a team approach and support inclusivity

8.2.12 act appropriately in all engagement with the media and, where appropriate, act in accordance with the guidance for governors on dealing with the media.

8.2.13 conduct themselves in such a manner as to reflect positively on the Trust. When attending external meetings or any other events at which they are present, it is important for Governors to be ambassadors for the Trust.

8.2.14 uphold the seven principles of public life as detailed by the Nolan Committee as set out in Annex 9 of the Trust's Constitution.

## **9. Accountability**

9.1 Governors are accountable to the membership and should demonstrate this by attending members' meetings and other key events, which provide opportunities to interface with their electorate in order to best understand their views.

9.2 Governors are also accountable to NHS England for their conduct.

## **10. Induction and development**

10.1 Training is essential for Governors, in respect of the effective performance of their current role. Governors are required to adhere to the Trust's policies in all respects and undertake identified training and develop to allow them to effectively undertake their role.

10.2 Governors must participate in the Trust's induction programme for Governors

## **11. Visits to trust premises**

11.1 Where Governors wish to visit the premises of the trust in a formal capacity as opposed to individuals in a personal capacity, the Council of Governors should liaise with the Secretary to make the necessary arrangements.

## **12. Non-compliance with the Code of Conduct**

12.1 Governors should be aware that non-compliance with the code of conduct, any other action which may be detrimental to the Trust or breach of any other condition for qualification as stated in the Constitution will be dealt with in accordance with the procedure for Managing Governor conduct and expected standards.

12.2 This Code of Conduct does not limit or invalidate the right of the Governors or the trust to act under the Constitution.

## **ANNEX 7 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS**

### **1. INTERPRETATION**

- 1.1 Save as otherwise permitted by law, at any meeting the Chair of the trust shall be the final authority on the interpretation of Standing Orders (of which they should be advised by the Chief Executive or Secretary).
- 1.2 Any expression to which a meaning is given in the National Health Service Act 2006 (“2006 Act”) or in the Constitution shall have the same meaning in these Standing Orders.

### **2. THE COUNCIL OF GOVERNORS**

- 2.1 **Composition of the Council of Governors** - The composition of the Council of Governors shall be in accordance with the Constitution.
- 2.2 **Appointment of the Chair and members** – The Chair is appointed by the Council of Governors, as set out in the Constitution.
- 2.3 **Terms of Office of the Chair and members**- The regulations setting out the period of tenure of office of the Chair and members and for the termination or suspension of office of the Chair and members are contained in the Constitution.
- 2.4 **Appointment and Powers of Deputy Chair** – subject to Standing Order 2.5 below; members of the Council of Governors may appoint one of the Non- Executive Directors, to be Deputy Chair for such period, not exceeding the remainder of their term as a Non-Executive Director of the trust, as they may specify on appointing them.
- 2.5 Any Non-Executive Director so appointed may at any time resign from the office of Deputy Chair and the Council of Governors may thereupon appoint another Non Executive Director as Deputy Chair in accordance with the provisions of Standing Order 2.4.
- 2.6 Where the Chair of the trust has died or has ceased to hold office or where they have been unable to perform their duties as Chair owing to illness or any other cause, the Deputy Chair shall act as Chair until a new Chair is appointed or the existing Chair resumes their duties, as the case may be, and references to the Chair in these Standing Orders shall, so long as there is no Chair able to perform their duties, be taken to include references to the Deputy Chair.

### **3. MEETINGS OF THE COUNCIL OF GOVERNORS**

- 3.1 *Admission of the Public and the Press* – The public and representatives of the press shall be afforded facilities to attend all formal meetings of the Council of Governors but shall be required to withdraw upon the Council of Governors (including a majority of the public Governors present at the meeting) resolving as follows:

*“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”*

- 3.2 The Chair (or Deputy Chair) shall give such directions as they think fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the trust’s business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Council of Governors (including a majority of the public Governors present at the meeting) resolving as follows:

*“That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Council of Governors to complete business without the presence of the public”*

- 3.3 Nothing in these Standing Orders shall require the trust to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place, without the prior agreement of the Council of Governors.

- 3.4 **Calling Meetings** – Meetings of the Council of Governors shall be held at such times and places as the Council of Governors may determine.

- 3.5 The Council of Governors will hold at least four meetings each year, one of which is the Annual Members Meeting.

- 3.6 The Chair of the trust may call a meeting of the Council of Governors at any time. If the Chair refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of members of the Council of Governors, has been presented to them, or if, without so refusing, the Chair does not call a meeting within seven days after such requisition has been presented to them at the trust’s headquarters, such one-third or more members may forthwith call a meeting.

- 3.7 **Notice of Meetings** - Before each meeting of the Council of Governors, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chair or by an officer authorised by the Chair to sign on their behalf shall be delivered to every Governor, by e-mail to the valid email address or sent by post to the usual place of residence of each Governor, so as to be available to them at least five days before the meeting.

- 3.8 Want of service of the notice on any Governor shall not affect the validity of a meeting.

- 3.9 In the case of a meeting called by Governors in default of the Chair, the notice shall be signed by those Governors and no business shall be transacted at the meeting other than that specified in the notice.

- 3.10 Agendas will be sent by post or e-mail to Governors five days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be dispatched no later than three days before the meeting, save in emergency. A notice shall be presumed to have been served one day after posting or delivery of e-mail.

- 3.11 Before each meeting of the Council of Governors a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the

trust's office at least three days before the meeting, save where the meeting is convened by electronic communication.

- 3.12 **Setting the Agenda** - The Council of Governors may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted. (Such matters may be identified within these Standing Orders or following subsequent resolution shall be listed in an Appendix to the Standing Orders).
- 3.13 A Governor desiring a matter to be included on an agenda shall make their request in writing to the Chair at least 10 (ten) clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than ten days before a meeting may be included on the agenda at the discretion of the Chair.
- 3.14 **Petitions** - where a petition has been received by the trust the Chair of the Council of Governors shall include the petition as an item for the agenda of the next Council of Governors meeting.
- 3.15 **Chair of Meeting** - At any meeting of the Council of Governors, the Chair, if present, shall preside. If the Chair is absent from the meeting the Deputy Chair, if there is one and they are present, shall preside. If the Chair and Deputy Chair are absent another Non Executive Director as the members present shall choose who shall preside.
- 3.16 If the Chair, Deputy Chair and other non-executive directors are all absent or have a conflict of interest, the Lead Governor shall preside. In the event of the Lead Governor being absent, the Deputy Lead Governor shall preside. In the event the Deputy Lead Governor also being absent a representative appointed from amongst the governors attending that meeting of the Council shall preside at the meeting and shall have a casting vote.
- 3.17 **Meetings: electronic communication** - In this SO, "electronic communication" means a communication transmitted (whether from one person to another, from one device to another or from a person to a device or vice versa): (a) by means of an electronic communications network; or (b) by other means but while in an electronic form.
- 3.17.1 In the Chair's absolute discretion, a meeting of the Council of Governors may be held by way electronic communication. A meeting of the Council of Governors held by way of electronic communication can be (a) held exclusively by electronic communication; or (b) where a select number of Governors are present at the meeting by way of electronic communication whilst the majority attending are physically present at the meeting of the Council of Governors.
- 3.17.2 A Governor in electronic communication with the Chair and all other parties to a meeting of the Council of Governors or of a committee or sub-committee of the Governors shall be regarded for all purposes as personally attending such a meeting provided that, but only for so long as, at such a meeting they have the ability to communicate interactively and simultaneously with all other parties attending the meeting including all persons attending by way of electronic communication.

- 3.17.3 A meeting at which one or more of the Governors attends by way of electronic communication is deemed to be held at such a place as the Governors shall at the said meeting resolve. In the absence of such a resolution, the meeting shall be deemed to be held at the place (if any) where a majority of the Governors attending the meeting are physically present, or in default of such a majority, the place at which the Chair of the meeting is physically present.
- 3.17.4 Meetings held in accordance with this SO are subject to SO 3.37 (Quorum). For such a meeting to be valid, a quorum must be present and maintained throughout the meeting.
- 3.17.5 The minutes of a meeting held in this way must state that it was held by electronic communication and that the Governors were all able to hear each other and were present throughout the meeting.
- 3.18 **Notices of Motion** – A member of the Council of Governors desiring to move or amend a Motion shall send a written notice thereof at least 10 (ten) clear days before the meeting to the Chair, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any Motion being moved during the meeting, without notice on any business mentioned on the agenda.
- 3.19 **Withdrawal of Motion or Amendments** – A Motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and consent of the Chair.
- 3.20 **Motion to Rescind a Resolution** – Notice of Motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the member who gives it and also the signature of four other Governors. When any such Motion has been disposed of by the Council of Governors, it shall not be competent for any Governor other than the Chair to propose a Motion to the same effect within six months however the Chair may do so if they consider it appropriate.
- 3.21 **Motions** - The mover of a Motion shall have a right of reply at the close of any discussion on the Motion or any amendment thereto.
- 3.22 When a Motion is under discussion or immediately prior to discussion it shall be open to a member to move:
- An amendment to the Motion,
  - The adjournment of the discussion or the meeting
  - That the meeting proceed to the next business (\*)
  - The appointment of an ad hoc committee to deal with a specific item of business
  - That the Motion be now put (\*)
  - A Motion resolving to exclude the public (including the press).

\* In the case of sub-paragraphs denoted by (\*) above to ensure objectivity Motions may only be put by a member who has not previously taken part in the debate and who is eligible to vote.

No amendment to the Motion shall be admitted if, in the opinion of the Chair of the meeting, the amendment negates the substance of the Motion.

- 3.23 **Chair's Ruling** - Statements of members of the Council of Governors made at meetings of the Council of Governors shall be relevant to matter under discussion at the material time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be final.
- 3.24 **Voting** - every question at a meeting shall be determined by either a majority of the votes of the Governors present, qualified to vote on the issue and voting on the question unless the Constitution requires otherwise. In the case of the number of votes for and against a Motion being equal, the Chair of the meeting, or the person presiding over that issue if the Chair is absent, shall have a second or casting vote.
- 3.25 All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands, unless at the discretion of the Chair, a vote is held by postal or e-mail vote, or by way of written resolution. A paper ballot may also be used if a majority of the Governors present so request. At all times, no Governor may vote by proxy.
- 3.26 If at least one-third of the Governors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each governor voted or abstained.
- 3.27 If a Governor so requests, their vote shall be recorded by name upon any vote (other than by paper ballot).
- 3.28 In no circumstances may an absent Governor vote by proxy. Absence is defined as being absent at the time of the vote.
- 3.29 A person attending the Council of Governors to represent a Governor during a period of incapacity or temporary absence without formal appointment as a Governor may not exercise the voting rights of the Governor. A person's status when attending a meeting shall be recorded in the minutes.
- 3.30 **Written resolution** - at the discretion of the Chair, the Chair may specify in a notice of a meeting any matter which requires approval by a written resolution and such a matter may be approved in writing provided that at least three quarters of the Governors, and a majority of the elected Governors, approve the resolution in writing within the timescale imposed in such a notice.
- 3.31 **Special provisions relating to the Chair exercising their discretion to call a postal or e-mail vote**
- 3.31.1 The Chair's discretion to hold a postal or e-mail vote may be exercised at any time, and for any reason.
- 3.31.2 If the Chair exercises their discretion to hold a postal or e-mail vote, then the Governors must vote by post or e-mail by sending their postal or e-mail vote back to the Trust Secretary or an employee of the trust holding a paid appointment or office within the trust who is administering and counting the postal or e-mail votes by the Deadline Date. For the avoidance of doubt, if the Chair exercises their discretion to hold a postal or e-mail vote, this postal or e-mail vote will form the only method of voting and no meeting will be held.



- 3.31.3 An individual Governor may only cast one vote unless a second further vote is required owing to the previous vote not being passed. Once a postal or e-mail vote has been cast by a Governor, the vote cannot be revoked or altered in any way.
- 3.31.4 **Protocol for voting by post** - The Trust Secretary is to publish a notice of the postal vote stating:
- 3.31.4.1 the details of the Motion;
  - 3.31.4.2 the date and time at which postal votes are required to be sent out to the Governors;
  - 3.31.4.3 the address for return of postal votes including the date and time by which they must be received by the Trust Secretary ("**Deadline Date**"); and
  - 3.31.4.4 the contact details of the Trust Secretary.
- 3.31.5 As soon as reasonable practicable on or after the publication of the notice of postal vote, the Trust Secretary is to deliver to, or send by post to the usual place of residence of every Governor, so as to be available to them at least 7 (seven) clear days before the Deadline Date, the following information:
- 3.31.5.1 a ballot paper and ballot paper envelope (ballot paper envelope must have clear instructions to the Governor printed on it, instructing the Governor to seal the ballot paper inside the envelope once the ballot paper has been marked);
  - 3.31.5.2 an ID declaration form (if required);
  - 3.31.5.3 information about the Motion to be voted on; and
  - 3.31.5.4 a covering return envelope providing:
    - 3.31.5.4.1 the address for the return of the ballot paper printed on it;
    - 3.31.5.4.2 pre-paid postage for return to that address;
    - 3.31.5.4.3 clear instructions, either printed on the covering return envelope or elsewhere, instructing the Governor to seal a completed ID declaration form (if required) and the ballot paper envelope, with the ballot paper sealed inside it and return to the Trust Secretary by the Deadline Date.
- 3.31.6 **Protocol for voting by e-mail** – The Trust Secretary is to email a notice of the email vote to the valid email address of every Governor stating:
- 3.31.6.1 The details of the Motion;
  - 3.31.6.2 The date and time at which the e-mail votes are required to be sent out to the Governors;
  - 3.31.6.3 The e-mail address for return of e-mail votes includes the date and time by which they must be received by the Trust Secretary; and
  - 3.31.6.4 The contact details of the Trust Secretary.

- 3.31.7 As soon as is reasonably practicable on or after the e-mail of the notice of the e-mail vote, the Trust Secretary is to e-mail to the valid e-mail address of every Governor, so as to be available to them at least 7 (seven) clear days before the Deadline Date, the following information:
- 3.31.7.1 a ballot paper attachment in accessible electronic format with clear instructions as to how to cast their vote by e-mail;
  - 3.31.7.2 an ID declaration form (if required);
  - 3.31.7.3 information about the Motion; and
  - 3.31.7.4 a covering email providing:
    - 3.31.7.4.1 the e-mail address for return of the ballot paper;
    - 3.31.7.4.2 clear instructions for the Governor as to how to return their e-mail vote to the Trust Secretary by the Deadline Date.
- 3.32 **Minutes** - The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it.
- 3.33 No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.
- 3.34 Minutes shall be circulated in accordance with Governors' wishes. Where providing a record of a public meeting the minutes shall be made available to the public as required by Code of Practice on Openness in the NHS.
- 3.35 **Variation and Amendment of Standing Orders** – will be undertaken in accordance with paragraph 46 of the Constitution.
- 3.36 **Record of Attendance** – the names of the Chair and Governors present at the meeting shall be recorded in the minutes.
- 3.37 **Quorum** – No business shall be transacted at a meeting unless at least one third of the whole number of the Governors are present, the majority of whom are from a public constituency. If at any meeting there is no quorum within 30 minutes of the time fixed for the start of the meeting, the meeting shall stand adjourned for 7 days and upon reconvening, those present shall constitute a quorum.
- 3.38 If the Chair or Governor has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see Standing Orders 6 or 7) they shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. The meeting must then proceed to the next business.

#### 4. ARRANGEMENTS FOR DELEGATION

- 4.1 **Committees** – The Council of Governors shall agree from time to time to the delegation of matters for consideration by committee, or sub-committees which it

has formally constituted in accordance with the Constitution. The constitution and terms of reference of these committees or sub-committees and their specific powers shall be approved by the Council of Governors. Such committees and subcommittees shall be advisory only and not decision-making.

- 4.2 **Overriding Standing Orders** – If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Council of Governors for action or ratification. All members of the Council of Governors and staff have a duty to disclose any non-compliance with these Standing Orders to the Chair as soon as possible.

## 5. COMMITTEES

- 5.1 Subject to any guidance or best practice advice as may be issued by NHSE, the Council of Governors may and, if directed by NHSE, shall appoint committees of the Council of Governors to assist it in the proper performance of its functions, consisting wholly or partly of the Chair, Governors, and others, including Advisers.
- 5.2 A committee appointed under Standing Order 5.1 may, subject to such directions as may be given by the Council of Governors, appoint sub-committees consisting wholly or partly of members of the committee.
- 5.3 These Standing Orders, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Council of Governors with the terms “Chair” to be read as a reference to the Chair of the committee, and the term “Governor” to be read as a reference to a member of the committee as the context permits. There is no requirement to hold meetings of committees, established by the Council of Governors in public.
- 5.4 Each such committee shall have such terms of reference and powers and be subject to such conditions as the Council of Governors shall decide and shall be in accordance with the 2006 Act, the Constitution, and any best practice advice and/or guidance issued by NHSE, but the Council of Governors shall not delegate to any committee any of the powers or responsibilities which are to be exercised by the Council of Governors at a formal meeting.
- 5.5 Where committees are authorised to establish sub-committees they may not delegate their powers to the sub-committee unless expressly authorised by the Council of Governors.
- 5.6 Any committee or sub-committee established under this Standing Order 5.1 may call upon outside advisers to assist them with their tasks including any Advisers, subject to the advance agreement of the Board of Directors.
- 5.7 The Council of Governors shall approve the appointments to each of the committees which it has formally constituted.
- 5.8 Where the Council of Governors is required to appoint persons to a committee to undertake statutory functions, and where such appointments are to operate independently of the Council of Governors, such appointments shall be made in accordance with applicable statute and regulations and with best practice advice and/or guidance issued by NHSE.

- 5.9 Where the Council of Governors determines that persons who are neither Governors, nor Directors or Officers of the Trust, shall be appointed to a committee, the terms of such appointment shall be determined by the Council of Governors subject to the payment of travelling expenses and other allowances being in accordance with such sum as may be determined by the Board of Directors.
- 5.10 The Council of Governors may appoint members to serve on joint committees with the Board of Directors or committees of the Board of Directors on the request of the Chair.
- 5.11 The Secretary or their deputy will attend all meetings of the Committees in support of them.

## **6. DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS**

- 6.1 **Declaration of interests** – The Constitution and the trust’s Code of Conduct requires Governors to declare interests which are relevant and material to the Council of Governors of which they are a member. All existing Governors should declare such interests. Any Governors appointed subsequently should do so on appointment.
- 6.2 Interests which should be regarded as “relevant and material” are:
- 6.2.1 Directorships, including non-executive directorships held in private companies or public limited companies (with the exception of those of dormant companies).
  - 6.2.2 Ownership, part-ownership or directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.
  - 6.2.3 Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.
  - 6.2.4 A position of trust in a charity or Voluntary Organisation in the field of health and social care
  - 6.2.5 Any connection with a voluntary or other organisation contracting for NHS services
  - 6.2.6 To the extent not covered above, any connection with an organisation, entity or company considering entering into or having entered into a financial agreement with the NHS Foundation Trust, including but not limited to, lenders or banks.
  - 6.2.7 Any other commercial interest in the decision before the meeting
- 6.3 At the time Governors’ interests are declared, they should be recorded in the Council of Governors minutes. Any changes in interests should be declared at the next Council of Governors meeting following the change occurring.
- 6.4 Governors’ directorships of companies likely or possibly seeking to do business with the trust should be published in the Council of Governors Annual Report. The information should be kept up to date for inclusion in succeeding annual reports.

- 6.5 During the course of a Council of Governors meeting, if a conflict of interest is established, the member concerned should withdraw from the meeting and play no part in the relevant discussion or decision.
- 6.6 There is no requirement in the Code of Conduct for the interests of Governors' spouses or partners to be declared. However Standing Order 7 requires that the interest of members' spouses, if living together, in contracts should be declared. Therefore the interests of Governors' spouses and cohabiting partners should also be regarded as relevant.
- 6.7 If Governors have any doubt about the relevance of an interest, this should be discussed with the Chair. Financial Reporting Standard No 8 (issued by the Accounting Standards Council) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.
- 6.8 **Register of Interests** – The Secretary will ensure that a register of interests is established to record formally declarations of interests of members. In particular the register will include details of all directorships and other relevant and material interests which have been declared by both elected and appointed members.
- 6.9 These details will be kept up to date by means of an annual review of the register in which any changes to interests declared during the preceding twelve months will be incorporated.
- 6.10 The register will be available to the public and the Secretary will take reasonable steps to bring the existence of the register to the attention of the local population and to publicise arrangements for viewing it.

## **7. DISABILITY OF CHAIR AND MEMBERS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST**

- 7.1 Subject to the following provisions of this Standing Orders, if the Chair or a Governor has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the trust at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.
- 7.2 The Council of Governors may exclude the Chair or a member of the Council of Governors from a meeting of the Council of Governors while any contract, proposed contract to other matter in which they have a pecuniary interest, is under consideration.
- 7.3 Any remuneration compensation or allowances payable to the Chair or a member of the Council of Governors by virtue of the Constitution shall not be treated as a pecuniary interest for the purpose of this Standing Order.
- 7.4 For the purpose of this Standing Order the Chair or a member of the Council of Governors shall be treated as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

- a. They, or a nominee of theirs, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or
- b. They are a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration;

And in the case of married persons living together the interest of one spouse shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

7.5 The Chair or a member shall not be treated as having a pecuniary interest in any contract, proposed contract or any other matter by reason only:

- a. of their membership of a company or other body, if they have no beneficial interest in any securities of that company or other body; or
- b. of an interest in any company, body or person with which they are connected which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a member in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

7.6 Where the Chair or a member of the Council of Governors has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and the total nominal value of these securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company body, whichever is the less, and if the share capital is of more than one class, the total nominal value of shares of any one class in which they have beneficial interest does not exceed one-hundredth of the total issued share capital of that class, this Standing Order shall not prohibit them from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it, without prejudice however to their duty to disclose their interest.

7.7 The Standing Order applies to a committee or sub-committee as it applies to the trust.

## **8. SENIOR INDEPENDENT DIRECTOR**

8.1 The Council of Governors is entitled to be consulted by the Board of Directors on the appointment of the Trust's Senior Independent Director.

8.2 The role of the Senior Independent Director is as set out in the Trust's "Senior Independent Director Role Specification" as amended from time to time. For the avoidance of doubt the "Senior Independent Director Role Specification" does not form part of the Constitution.

## **9. LEAD GOVERNOR AND DEPUTY LEAD GOVERNOR**

9.1 The Council of Governors shall appoint from the governors a Lead Governor.

9.2 The role of the Lead Governor is as set out in Annex 11 of the Constitution.

- a)
- 9.3 The Council of Governors shall also appoint a Deputy Lead Governor from the governors, who will take up the role and responsibilities of the Lead Governor on a temporary basis, in the event the Lead Governor is absent for any reason.

## **ANNEX 8 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS**

### **SECTION A**

INTERPRETATION AND DEFINITIONS FOR STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS

### **SECTION B – STANDING ORDERS**

1. INTRODUCTION
2. THE BOARD
3. MEETINGS OF THE TRUST
4. APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES
5. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION
6. OVERLAP WITH OTHER TRUST POLICY STATEMENTS/PROCEDURES, REGULATIONS AND THE STANDING FINANCIAL INSTRUCTIONS
7. DUTIES AND OBLIGATIONS OF DIRECTORS UNDER THE STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS
8. CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS



## **SECTION A**

### **1. INTERPRETATION AND DEFINITIONS FOR STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS**

- 1.1 Save as otherwise permitted by law, at any meeting the Chair of the trust shall be the final authority on the interpretation of Standing Orders (on which they should be advised by the Chief Executive or Secretary to the Board).
- 1.2 All references in these Standing Orders to the masculine gender shall be read as equally applicable to the feminine gender and vice-versa.

## **SECTION B – STANDING ORDERS**

### **1. INTRODUCTION**

#### **1.1 Statutory Framework**

The trust is a public benefit corporation which was established under the 2006 Act on 1 March 2009.

1.1.1 The powers of the trust are set out in the 2006 Act subject to any restrictions in the Constitution or the License.

1.1.2 The Constitution requires the Board to adopt Standing Orders for the regulation of its proceedings and business. The trust must also adopt Standing Financial Instruction (SFIs) as an integral part of Standing Orders setting out the responsibility of individuals.

1.1.3 The trust will also be bound by such other statute, legal provisions and binding guidance from NHSE which governs the conduct of its affairs.

1.1.4 As a statutory body, the trust has specified powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable.

#### **1.2 Delegation of Powers**

1.2.1 The powers of the trust shall be exercised by the Board of Directors on behalf of the trust.

1.2.2 Any of those powers may be delegated to a committee of Directors or to an Executive Director. The Standing Orders set out the detail of these arrangements. Under the Standing Order relating to the Arrangements for the Exercise of Functions (SO 5) the trust is given powers to "make arrangements for the exercise, on behalf of the trust of any of their functions by a committee or subcommittee, or by an Officer of the trust, in each case subject to such restrictions and conditions as the trust thinks fit. Delegated Powers are covered in a separate document (Reservation of Powers to the Board and Delegation of Powers). This document has effect as if incorporated into the Standing Orders. Delegated Powers are covered in a separate document entitled – 'Schedule of Matters reserved to the Board and Scheme of Delegation' and have effect as if incorporated into the Standing Orders and Standing Financial Instructions.

## **2. THE BOARD**

### **2.1 Composition of the Board**

The composition of the Board shall be in accordance with the Constitution.

### **2.2 Appointment and Powers of Deputy Chair**

2.2.1 In accordance with paragraph 28 of the Constitution and subject to Standing Order 2.2.2 below, the Council of Governors may appoint a Non Executive Director, to be Deputy Chair, for such period, not exceeding the remainder of their term as a member of the Board, as they may specify on appointment.

2.2.2 Any Non Executive Director so appointed may at any time resign from the office of Deputy Chair by giving notice in writing to the Chair (in the Chair's capacity as Chair of the Board and the Council of Governors). The Council of Governors may thereupon appoint another Non Executive Director as Chair in accordance with the provisions of Standing Order 2.2.1.

2.2.3 Where the Chair of the trust has died or has ceased to hold office, or where they have been unable to perform their duties as Chair owing to illness or any other cause, the Deputy Chair shall act as Chair until a new Chair is appointed or the existing Chair resumes their duties, as the case may be; and references to the Chair in these Standing Orders shall, so long as there is no Chair able to perform those duties, be taken to include references to the Deputy Chair.

### **2.3 Appointment and Powers of Senior Independent Director**

2.3.1 Subject to Standing Order 2.3.2 below, the Board of Directors (in consultation with the Council of Governors) may appoint any Member of the Board, who is also a Non Executive Director, to be the Senior Independent Director, for such period, not exceeding the remainder of their term as a Member of the Board, as they may specify on appointment. The Senior Independent Director shall perform the role set out in the Trust's "Senior Independent Director Role Description", as amended from time to time by resolution of the Board.

2.3.2 Any Non-Executive Director so appointed may at any time resign from the office of Senior Independent Director by giving notice in writing to the Chair. The Chair (in consultation with the other Non Executive Directors and the Council of Governors) may thereupon appoint another member of the Board as Senior Independent Director in accordance with the provisions of Standing Order 2.3.1.

### **2.4 Appointment and Powers of Deputy Chief Executive**

The Chair and Chief Executive may jointly appoint or remove one of the Executive Directors as the deputy chief Executive. The powers of the Deputy chief executive are defined in the Board's Scheme of Delegation.

### **2.5 Role of Directors**

The Board will function as a corporate decision making body and Non Executive and Executive Directors will be full and equal Board members. Their role as members of the Board will be to consider the key strategic and managerial issues facing the trust in carrying out its statutory and other functions. In exercising these functions, the Board will consider guidance from NHSE “The Code of Governance” as amended from time to time.

## 2.6 Corporate role of the Board

2.6.1 All business conducted by the trust shall be conducted in the name of the trust.

2.6.2 All funds received in trust shall be held in the name of the trust as corporate trustee.

2.6.3 The powers of the trust established under statute subject to the License shall be exercised by the Board in private session except as otherwise provided for in Standing Order 3.

## 2.7 Schedule of Matters reserved to the Board and Scheme of Delegation

2.7.1 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in the ‘Schedule of Matters Reserved to the Board’ and shall have effect as if incorporated into the Standing Orders. Those powers which it has delegated to Officers and other bodies are contained in the Scheme of Delegation.

## 2.8 Lead Roles for Directors

2.8.1 The Chair will ensure that the designation of Lead roles as set out in any statutory or other guidance will be made in accordance with that guidance or statutory requirement (e.g. appointing a Lead Board Director with responsibilities for Infection Control or Child Protection Services etc).

## 3. MEETINGS OF THE TRUST

### 3.1 Calling meetings

3.1.1 Meetings of the Board shall be held at regular intervals at such times and places as the Board may determine.

3.1.2 The Chair may call a meeting of the Board at any time.

3.1.3 One third or more Directors of the Board may requisition a meeting in writing. If the Chair refuses, or fails, to call a meeting within seven days of a requisition being presented, the Directors signing the requisition may forthwith call a meeting.

### 3.2 Notice of Meetings and the Business to be transacted

3.2.1 Before each meeting of the Board a written notice specifying the business proposed to be transacted shall be delivered to every Director, or sent by post to the usual place of residence of each Director, so as to be available to Directors at least five days before the meeting. The notice shall be signed

by the Chair or by an Officer authorised by the Chair to sign on their behalf. Want of service of such a notice on any Director shall not affect the validity of a meeting.

3.2.2 In the case of a meeting called by Directors in default of the Chair calling the meeting, the notice shall be signed by those Directors.

3.2.3 No business shall be transacted at the meeting other than that specified on the agenda, or emergency Motions allowed under Standing Order 3.6.

3.2.4 A Director desiring a matter to be included on an agenda shall make their request in writing to the Chair at least 15 days before the meeting. The request should include appropriate supporting information. Requests made less than 15 days before a meeting may be included on the agenda at the discretion of the Chair.

3.2.5 In the event that a meeting of the Board is to be held in public pursuant to paragraph 3.17.1, a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the trust's principal offices at least three days before the meeting.

### 3.3 Agenda and Supporting Papers

3.3.1 The Agenda will be sent to Directors five days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be dispatched no later than three days before the meeting, save in emergency.

### 3.4 Petitions

Where a petition has been received by the trust the Chair shall include the petition as an item for the agenda of the next meeting.

### 3.5 Notice of Motion

3.5.1 Subject to the provision of Standing Orders 3.7 'Motions: Procedure at and during a meeting' and 3.8 'Motions to rescind a resolution', a Director of the Board wishing to move a Motion shall send a written notice to the Chief Executive who will ensure that it is brought to the immediate attention of the Chair.

3.5.2 The notice shall be delivered at least 10 clear days before the meeting. The Chief Executive shall include in the agenda for the meeting all notices so received that are in order and permissible under governing regulations. This Standing Order shall not prevent any Motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

### 3.6 Emergency Motions

3.6.1 Subject to the agreement of the Chair, and subject also to the provision of Standing Order 3.7 'Motions: Procedure at and during a meeting', a Director of the Board may give written notice of an emergency Motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the trust Board at the commencement of the business

of the meeting as an additional item included in the agenda. The Chair's decision to include the item shall be final.

### 3.7 Motions: Procedure at and during a meeting

#### 3.7.1 Who may propose

A Motion may be proposed by the Chair of the meeting or any Director present. It must also be seconded by another Director.

#### 3.7.2 Contents of Motions

The Chair may exclude from the debate at their discretion any such Motion of which notice was not given on the notice summoning the meeting other than a Motion relating to:

- the reception of a report;
- consideration of any item of business before the trust Board;
- the accuracy of minutes;
- that the Board proceed to next business;
- that the Board adjourn;
- that the question be now put.

#### 3.7.3 Amendments to Motions

A Motion for amendment shall not be discussed unless it has been proposed and seconded.

Amendments to Motions shall be moved relevant to the Motion, and shall not have the effect of negating the Motion before the Board.

If there are a number of amendments, they shall be considered one at a time. When a Motion has been amended, the amended Motion shall become the substantive Motion before the meeting, upon which any further amendment may be moved.

#### 3.7.4 Rights of reply to Motions

##### a) Amendments

The mover of an amendment may reply to the debate on their amendment immediately prior to the mover of the original Motion, who shall have the right of reply at the close of debate on the amendment, but may not otherwise speak on it.

##### b) Substantive/original Motion

The Director who proposed the substantive Motion shall have a right of reply at the close of any debate on the Motion.

### 3.7.5 Withdrawing a Motion

A Motion, or an amendment to a Motion, may be withdrawn.

### 3.7.6 Motions once under debate

When a Motion is under debate, no Motion may be moved other than:

- an amendment to the Motion;
- the adjournment of the discussion, or the meeting;
- that the meeting proceed to the next business;
- that the question should be now put;
- the appointment of an 'ad hoc' committee to deal with a specific item of business;
- that Director be not further heard;

In those cases where the Motion is either that the meeting proceeds to the 'next business' or 'that the question be now put' in the interests of objectivity these should only be put forward by a Director of the Board who has not taken part in the debate and who is eligible to vote.

If a Motion to proceed to the next business or that the question be now put, is carried, the Chair should give the mover of the substantive Motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

## 3.8 Motion to Rescind a Resolution

3.8.1 Notice of Motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Director who gives it and also the signature of three other Directors, and before considering any such Motion of which notice shall have been given, the trust Board may refer the matter to any appropriate Committee or the Chief Executive for recommendation.

3.8.2 When any such Motion has been dealt with by the trust Board it shall not be competent for any Director other than the Chair to propose a Motion to the same effect within six months. This Standing Order shall not apply to Motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive.

## 3.9 Chair of meeting

3.9.1 At any meeting of the trust Board the Chair, if present, shall preside. If the Chair is absent from the meeting, the Deputy Chair (if the Board has appointed one), if present, shall preside.

3.9.2 If the Chair and Deputy Chair are absent, such Director (who is not also an Executive Director of the trust) as the Directors present shall choose shall preside.

### 3.10 Chair's ruling

The decision of the Chair of the meeting on questions of order, relevancy and regularity (including procedure on handling Motions) and their interpretation of the Standing Orders and Standing Financial Instructions, at the meeting, shall be final.

### 3.11 Quorum

3.11.1 No business shall be transacted at a meeting unless at least one-third of the whole number of the Chair and Directors (including at least one Executive Director and one Non Executive Director) is present.

3.11.2 An Officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

3.11.3 If a Director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see Standing Order 7) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

### 3.12 Voting

3.12.1 Save as provided in Standing Orders 3.13 - Suspension of Standing Orders and 3.14 - Variation and Amendment of Standing Orders, every question put to a vote at a meeting shall be determined by a majority of the votes of Directors present and voting on the question. In the case of an equal vote, the person presiding (i.e.: the Chair of the meeting) shall have a second, and casting vote.

3.12.2 At the discretion of the Chair all questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chair directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot.

3.12.3 If at least one third of the Directors present so request, the voting on any question may be recorded so as to show how each Director present voted or did not vote (except when conducted by paper ballot).

3.12.4 If a Director so requests, their vote shall be recorded by name.

3.12.5 In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote.

3.12.6 A manager who has been formally appointed by the Board to act up for a Director during a period of incapacity or temporarily to fill a Director vacancy as an Acting Director or Interim Director under paragraph 4 and 5 respectively of Annex 10 of the constitution shall be entitled to exercise the voting rights of the Director.

3.12.7 A manager attending the Board meeting to represent a Director during a period of incapacity or temporary absence who is not an acting Director or

an interim Director for the purposes of the Constitution may not exercise the voting rights of the Director. An Officer's status when attending a meeting shall be recorded in the minutes.

### 3.13 Suspension of Standing Orders

3.13.1 Except where this would contravene any provision in the Constitution, the License, any statutory provision, any binding guidance issued by NHSE, or the rules relating to the Quorum (Standing Order 3.11), any one or more of the Standing Orders may be waived at any meeting, provided that at least two-thirds of the whole number of the Directors are present (including at least one Executive Director and one Non Executive Director) and that at least two-thirds of those Directors present signify their agreement to such suspension. The reason for and decision to waive shall be recorded in the trust Board's minutes.

3.13.2 A separate record of matters discussed during the waiver of Standing Orders shall be made and shall be available to the Chair and Directors of the trust.

3.13.3 The Audit Committee shall review every decision to suspend Standing Orders.

### 3.14 Variation and amendment of Standing Orders

3.14.1 These Standing Orders shall only be varied in accordance with paragraph 46 of the Constitution.

### 3.15 Record of Attendance

The names of the Chair and Directors present at the meeting shall be recorded.

### 3.16 Minutes

The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they shall be signed by the person presiding at it.

No discussion shall take place upon the minutes except upon their accuracy or where the Chair considers discussion appropriate.

### 3.17 Admission of public and the press

3.17.1 Board meetings shall be held in public but the whole or any part of a meeting may be held in private if the Board so resolves.

3.17.2 In that event members of the public and the press will be excluded from all or part of a Board meeting.

#### 3.17.3 General disturbances

In the event that the public and press are admitted to all or part of a Board meeting pursuant to paragraph 3.17.1 and 3.17.2 above, the Chair (or Deputy Chair if one has been appointed) or the person presiding over the meeting shall give such directions as they think fit with regard to the



arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the trust's business shall be conducted without interruption and disruption and, the public and/or press maybe required to withdraw from a Board meeting at any time and for any reason whatsoever.

#### 3.17.4 Use of Mechanical or Electrical Equipment for Recording or Transmission of Meetings

Nothing in these Standing Orders shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the trust or Committee thereof. Such permission shall be granted only upon resolution of the trust.

#### 3.18 Observers at trust meetings

The trust will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the trust Board's meetings and may change, alter or vary these terms and conditions as it deems fit.

#### 3.19 Meetings: electronic communication

3.19.1 In this SO, "electronic communication" means a communication transmitted (whether from one person to another, from one device to another or from a person to a device or vice versa): (a) by means of an electronic communications network; or (b) by other means but while in an electronic form.

3.19.2 A Director in electronic communication with the Chair and all other parties to a meeting of the Board of Directors or of a committee or sub-committee of the Directors shall be regarded for all purposes as personally attending such a meeting provided that, but only for so long as, at such a meeting they have the ability to communicate interactively and simultaneously with all other parties attending the meeting including all persons attending by way of electronic communication.

3.19.3 A meeting at which one or more of the Directors attends by way of electronic communication is deemed to be held at such a place as the Directors shall at the said meeting resolve. In the absence of such a resolution, the meeting shall be deemed to be held at the place (if any) where a majority of the Directors attending the meeting are physically present, or in default of such a majority, the place at which the Chair of the meeting is physically present.

3.19.4 Meetings held in accordance with this SO are subject to SO 3.11 (Quorum). For such a meeting to be valid, a quorum must be present and maintained throughout the meeting.

3.19.5 The minutes of a meeting held in this way must state that it was held by electronic communication and that the Directors were all able to hear each other and were present throughout the meeting.

#### **4. APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES**

4.1 Subject to the Constitution, the Board shall appoint committees of the Board, consisting wholly of Directors.

#### 4.2 Appointment of Committees

Subject to the Constitution, the trust Board may appoint committees of the trust.

The trust shall determine the membership and terms of reference of committees and sub-committees and shall if it requires to, receive and consider reports of such committees.

#### 4.3 Applicability of Standing Orders and Standing Financial Instructions to Committees

The Standing Orders and Standing Financial Instructions of the trust, as far as they are applicable, shall as appropriate apply to meetings and any committees established by the trust. In which case the term "Chair" is to be read as a reference to the Chair of other committee as the context permits, and the term "member" is to be read as a reference to a member of other committee also as the context permits. (There is no requirement to hold meetings of committees established by the trust in public.)

#### 4.4 Terms of Reference

Each such committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide and shall be in accordance with any legislation. Such terms of reference shall have effect as if incorporated into the Standing Orders.

#### 4.5 Delegation of powers by Committees to Sub-Committees

Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Board.

#### 4.6 Approval of Appointments to Committees

The Board shall approve the appointments to each of the committees which it has formally constituted. Where the Board determines, and regulations permit, that persons, who are neither members nor Officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board. The Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

#### 4.7 Committees established by the trust Board

The committees and sub-committees established by the Board may vary from time to time as per operational requirements, legislation and best practice. Their terms of reference may be obtained from the Secretary to the trust.

4.8 The Board of Directors may appoint persons to serve as members on joint committees with the Council of Governors or committees of the Council of Governors on the request of the Chair.

## **5. ARRANGEMENTS FOR THE EXERCISE OF TRUST FUNCTIONS BY DELEGATION**

### **5.1 Delegation of Functions to Committees, Officers or other bodies**

Subject to the Constitution and License and such guidance as may be given by NHSE, the Board may make arrangements for the exercise, on behalf of the Board, of any of its functions by a committee, sub-committee appointed by virtue of Standing Order 4, or by an Officer of the trust, in each case subject to such restrictions and conditions as the trust thinks fit.

### **5.2 Emergency Powers and urgent decisions**

The powers which the Board has reserved to itself within these Standing Orders (see Standing Order 2.7) may in emergency or for an urgent decision be exercised by the Chief Executive and the Chair after having consulted at least two non-Executive Directors. The exercise of such powers by the Chief Executive and Chair shall be reported to the next formal meeting of the trust Board for noting.

### **5.3 Delegation to Committees**

The Board shall agree from time to time to the delegation of executive powers to be exercised by other committees, or subcommittees, which it has formally constituted in accordance with the Constitution, the License, binding guidance issued by NHSE and the 2006 Act. The Constitution and terms of reference of these committees, or sub-committees, and their specific executive powers shall be approved by the Board in respect of its sub-committees.

### **5.4 Delegation to Officers**

5.4.1 Those functions of the trust which have not been retained as reserved by the Board or delegated to other committee or sub-committee or joint-committee shall be exercised on behalf of the trust by the Chief Executive. The Chief Executive shall determine which functions they will perform personally and shall nominate Officers to undertake the remaining functions for which they will still retain accountability to the trust.

5.4.2 The Chief Executive shall prepare a Scheme of Delegation identifying their proposals which shall be considered and approved by the Board. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board.

5.4.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Finance Director to provide information and advise the Board in accordance with the Constitution, License and any statutory requirements, or provisions required by NHSE.

### **5.5 Schedule of Matters Reserved to the trust and Scheme of Delegation of powers**

The arrangements made by the Board as set out in the "Scheme of Reservation and Delegation" of powers shall have effect as if incorporated in these Standing Orders.

## 5.6 Duty to report non-compliance with Standing Orders and Standing Financial Instructions

If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board for action or ratification. All Directors of the trust Board and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

## 6. OVERLAP WITH OTHER TRUST POLICY STATEMENTS/PROCEDURES, REGULATIONS AND THE STANDING FINANCIAL INSTRUCTIONS

### 6.1 Policy statements: general principles

The trust Board will from time to time agree and approve Policy statements/procedures which will apply to all or specific groups of staff employed by the trust. The decisions to approve such policies and procedures will be recorded in an appropriate trust Board minute and will be deemed where appropriate to be an integral part of the trust's Standing Orders and Standing Financial Instructions.

### 6.2 Specific Policy statements

Notwithstanding the application of Standing Order 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following Policy statements:

- the Standards of Business Conduct policy for trust staff;
- the staff Disciplinary and Appeals Procedures adopted by the trust both of which shall have effect as if incorporated in these Standing Orders.

### 6.3 Standing Financial Instructions

Standing Financial Instructions adopted by the trust Board in accordance with the Financial Regulations shall have effect as if incorporated in these Standing Orders.

### 6.4 Specific guidance

Notwithstanding the application of Standing Order 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following guidance and any other binding guidance issued by NHSE:

- Caldicott Principles 1997;
- Human Rights Act 2018;
- Freedom of Information Act 2000.

## 7. DUTIES AND OBLIGATIONS OF DIRECTORS UNDER THESE STANDING ORDERS

### 7.1 Declaration of Interests

#### 7.1.1 Requirements for Declaring Interests and applicability to Board Directors

- (a) All existing Board Directors should declare any relevant and material interests. Any Director appointed subsequently should do so on appointment.

#### 7.1.2 Interests which are relevant and material

- (a) Interests which should be regarded as "relevant and material" are defined under paragraph 34 of the Constitution.
- (b) Any Director who comes to know that the trust has entered into or proposes to enter into a contract in which they or any person connected with them (as defined in Standing Order 7.3 below and elsewhere) has any pecuniary interest, direct or indirect, the Director shall declare their interest by giving notice in writing of such fact to the trust as soon as practicable.

#### 7.1.3 Advice on Interests

If Board Directors have any doubt about the relevance of an interest, this should be discussed with the Chair or with the Secretary.

Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

#### 7.1.4 Recording of Interests in trust Board minutes

At the time Directors' interests are declared, they should be recorded in the trust Board minutes.

Any changes in interests should be declared at the next trust Board meeting following the change occurring and recorded in the minutes of that meeting.

#### 7.1.5 Publication of declared interests in Annual Report

Board Directors' Directorships of companies likely or possibly seeking to do business with the NHS should be published in the trust's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

#### 7.1.6 Conflicts of interest which arise during the course of a meeting

During the course of a Board meeting, if a conflict of interest is established, the Director concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

### 7.2 Register of Interests

- 7.2.1 The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Board or Committee Directors. In particular the Register will include details of all directorships and other relevant

and material interests (as defined in SO 7.1.2) which have been declared by both executive and non-executive trust Board Directors.

7.2.2 These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated.

7.2.3 The Register will be available to the public and the Chief Executive will take reasonable steps to bring the existence of the Register to the attention of local residents and to publicise arrangements for viewing it.

### 7.3 Exclusion of Chair and Directors in proceedings on account of pecuniary interest

#### 7.3.1 Definition of terms used in interpreting 'Pecuniary' interest

For the sake of clarity, the following definition of terms is to be used in interpreting this Standing Order:

- (a) "spouse" shall include any person who lives with another person in the same household (and any pecuniary interest of one spouse shall, if known to the other spouse, be deemed to be an interest of that other spouse);
- (b) "contract" shall include any proposed contract or other course of dealing.
- (c) "Pecuniary interest"

Subject to the exceptions set out in this Standing Order, a person shall be treated as having an indirect pecuniary interest in a contract if:-

- (i) they, or a nominee of theirs, is a member of a company or other body (not being a public body), with which the contract is made, or to be made or which has a direct pecuniary interest in the same, or
- (ii) they are a partner, associate or employee of any person with whom the contract is made or to be made or who has a direct pecuniary interest in the same.

#### (d) Exception to Pecuniary interests

A person shall not be regarded as having a pecuniary interest in any contract if:-

- (i) neither they or any person connected with them has any beneficial interest in the securities of a company of which they or such person appears as a member, or
- (ii) any interest that they or any person connected with them may have in the contract is so remote or insignificant that it cannot reasonably be regarded as likely to influence them in relation to considering or voting on that contract, or

- (iii) those securities of any company in which they (or any person connected with them) has a beneficial interest do not exceed £5,000 in nominal value or one per cent of the total issued share capital of the company or of the relevant class of such capital, whichever is the less.

Provided however, that where paragraph (iii) above applies the person shall nevertheless be obliged to disclose/declare their interest in accordance with Standing Order 7.1.2 (ii).

#### 7.3.2 Exclusion in proceedings of the trust Board

- (a) Subject to the following provisions of this Standing Order, if a Director has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Board at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.
- (b) The Board may exclude a Director from a meeting of the Board while any contract, proposed contract or other matter in which they have a pecuniary interest is under consideration.
- (c) Any remuneration, compensation or allowance payable to a Director.
- (d) This Standing Order applies to a committee or subcommittee as it applies to the trust.

### 7.4 Standards of Business Conduct

#### 7.4.1 Trust Policy

All trust staff and Directors must comply with the trust's Standards of Business Conduct Policy. This section of standing orders shall be read in conjunction with this document.

#### 7.4.2 Interest of Officers in Contracts

- (a) Any Officer or employee of the trust who comes to know that the trust has entered into or proposes to enter into a contract in which they or any person connected with them (as defined in SO 7.3) has any pecuniary interest, direct or indirect, the Officer shall declare their interest by giving notice in writing of such fact to the Chief Executive or trust's Secretary as soon as practicable.
- (b) An Officer should also declare to the Chief Executive any other employment or business or other relationship of theirs, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the trust.
- (c) The trust will require interests, employment or relationships so declared to be entered in a register of interests of staff.

#### 7.4.3 Canvassing of and Recommendations by Directors in Relation to Appointments

- (a) Canvassing of Directors or of any Committee of the trust directly or indirectly for any appointment under the trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.
- (b) Directors shall not solicit for any person any appointment under the trust or recommend any person for such appointment; but this paragraph of this Standing Order shall not preclude a Director from giving written testimonial of a candidate's ability, experience or character for submission to the trust.

#### 7.4.4 Relatives of Directors or Officers

- (a) Candidates for any staff appointment under the trust shall, when making an application, disclose in writing to the trust whether they are related to any Director or the holder of any office under the trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render them liable to instant dismissal.
- (b) The Chair and every Director and Officer of the trust shall disclose to the Board any relationship between themselves and a candidate of whose candidature that Director or Officer is aware. It shall be the duty of the Chief Executive to report to the trust Board any such disclosure made.
- (c) On appointment, Directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the trust whether they are related to any other Director or holder of any office under the trust.
- (d) Where the relationship to a Director/Officer of the Trust is disclosed, the Standing Order headed 'Disability of Chair and Directors in proceedings on account of pecuniary interest' (Standing Order 7) shall apply.

### **8. CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS**

#### 8.1 Custody of Seal

The common seal of the trust shall be kept by the Chief Executive or a nominated Officer by them in a secure place.

#### 8.2 Sealing of Documents

Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of two Directors or a Director and the Secretary duly authorised by the Board.

#### 8.3 Register of Sealing



The Chief Executive shall keep a register in which they, or another manager of the Authority authorised by them, shall enter a record of the sealing of every document.

#### 8.4 Signature of documents

Where any document will be a necessary step in legal proceedings on behalf of the trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any Executive Director.

In land transactions, the signing of certain supporting documents will be delegated to Officers and set out clearly in the Scheme of Delegation but will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

## ANNEX 9 – STATEMENT OF TRUST PRINCIPLES

The West Suffolk NHS Foundation Trust will operate within a governance framework which reflects best practice within the NHS. In particular it will adopt the seven principles of public life, determined by the Nolan Report. It will also from time to time develop mission statements, corporate values, codes of conduct and other governance statements.

Nolan Principles: - the seven principles of public life

1. **Selflessness:** Holders of public office should take decisions solely in terms of the public interest. They should not do so to gain financial or other material benefit for themselves, their family or their friends.
2. **Integrity:** Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.
3. **Objectivity:** In carrying out public business, including making public appointments, awarding contracts or recommending individuals for rewards and benefits, holders of public office should make choice on merit.
4. **Accountability:** Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.
5. **Openness:** Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.
6. **Honesty:** Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.
7. **Leadership:** Holders of public office should promote and support these principles by leadership and example.

## **ANNEX 10 – FURTHER PROVISIONS**

### **1. Trust Secretary**

- 1.1 The trust shall have a Secretary who may be an employee. The Secretary may not be a Governor, or the Chief Executive or the Finance Director.
- 1.2 Minutes of every meeting of the Council of Governors and of every meeting of the Board of Directors are to be kept by the Secretary.
- 1.3 The Secretary is to be appointed and removed by the Chair and Chief Executive acting jointly.

### **2. Vacancy of Governor or Director position**

- 2.1 The validity of any act of the trust is not affected by any vacancy among the Directors or the Governors or by any defect in the appointment of any Director or governor.

### **3. Absent Director**

#### 3.1 If:

3.1.1 an Executive Director is temporarily unable to perform their duties due to illness or some other reason (the "Absent Director"); and

3.1.2 the Board of Directors agree that the duties of the Absent Director need to be carried out;

then the Chair (if the Absent Director is the Chief Executive) or the Chief Executive (in any other case) may appoint an acting Director as an additional Director to carry out the Absent Director's duties temporarily.

3.2 For the purposes of paragraph 3.1 of this Annex, the number of Directors appointed under paragraph 23.2.3 of the Constitution shall be relaxed accordingly.

3.3 The acting Director will vacate office as soon as the Absent Director returns to office or, if earlier, the date on which the person entitled to appoint them under this paragraph notifies them that they are no longer to act as an acting Director.

3.4 The acting Director shall be an Executive Director for the purposes of the 2006 Act. They shall be responsible for their own acts and defaults and they shall not be deemed to be the agent of the Absent Director.

### **4. Vacant Positions**

#### 4.1 If:

4.1.1 an Executive Director post is vacant ("Vacant Position"); and

4.1.2 the Board of Directors agree that the Vacant Position needs to be filled by an interim postholder pending appointment of a permanent postholder, then the Chair (if the Vacant Position is the Chief Executive) or the Chief

Executive (in any other case) may appoint a Director as an interim Director (“Interim Director”) to fill the Vacant Position pending appointment of a permanent postholder.

4.1.3 The appointment of an interim Chief Executive shall require the approval of the Council of Governors

4.2 The Interim Director will vacate office on the appointment of a permanent postholder or, if earlier, the date on which the persons entitled to appoint them under this paragraph notifies them that they are no longer to act as an Interim Director.

4.3 The Interim Director shall be an Executive Director for the purposes of the 2006 Act.

## **5. Title of “Director”**

5.1 The trust may confer on senior staff the title “Director” as an indication of their corporate responsibility within the trust but such persons will not be Directors of the trust for the purposes of the 2006 Act (“statutory Directors”) unless their title includes the title “Chief” or “Executive” or “Non Executive Director” or “Chair” or “Chair” and will not have the voting rights of statutory Directors or any power to bind the trust.

## **6. Disqualification of membership**

6.1 An individual may not become or continue as a member of the Trust if:

6.1.1 the individual has been specifically excluded in writing from any of the Trust’s premises or other facilities in whole or in part following a decision of the Board of Directors that such a course of action is necessary because, for example, the individual concerned has been violent, aggressive, has committed an act of gross misconduct or any other action deemed inappropriate; or

6.1.2 the Board of Directors considers that an individual has or is likely to cause harm or detriment to the Trust and after the Trust has consulted with or made reasonable efforts to consult with the individual about the concerns of the Board and the Board notifies the individual about their disqualification accordingly.

6.2 Notwithstanding anything contained in this Constitution, no person who ceases to be a member of the Trust pursuant to paragraph 6.1.1 or 6.1.2 above shall be re-admitted to membership except by a decision of the Board of Directors.

6.3 It is the responsibility of Members to ensure their eligibility and not the trust, but if the trust is on notice that a Member may be disqualified from membership, they shall carry out all reasonable enquiries to establish if this is the case.

6.4 The Board of Directors may not disqualify a governor from membership unless that governor has been removed from the Council of Governors by a resolution approved in accordance with Annex 6, paragraph 17.

**7. Termination of membership**

7.1 A member shall cease to be a member if that member:

7.1.1 resigns by notice to the Secretary or the Chief Executive;

7.1.2 ceases to fulfill the requirements of paragraph 6 or 7 of the Constitution;

7.1.3 is disqualified under any other provision of this constitution;

7.1.4 dies; or

7.1.5 the Council of Governors, having made reasonable enquiries, determines that the member no longer wishes to be a member or they cease to be eligible as a member for whatever reason.

## **ANNEX 11 – LEAD GOVERNOR AND DEPUTY LEAD GOVERNOR**

### **Lead Governor role specification**

The roles and responsibilities set out in the document can also be read as the responsibilities of the Deputy Lead Governor whilst undertaking their role.

#### **1. Introduction**

The lead governor of West Suffolk NHS Foundation Trust (WSFT) will be appointed to carry out the role described in Appendix B of NHS England's Code of Governance for NHS provider trusts (2022) or any subsequent amendments.

NHS England (NHSE) requires only that the lead governor act as a point of contact between NHSE and the council when needed. Directors and Governors should always remember that the Council of Governors as a whole has responsibilities and powers in statute, and not individual governors. Further guidance on NHSE's expectation of the role is provided as an annex to this role description.

This role description will be kept under review and is subject to approval by the Council of Governors.

Public, Staff and Governors appointed by partners are eligible for the role of Lead Governor.

#### **2. Key working relationships**

Trust Chair, Council of Governors, Trust Secretary, Deputy Trust Secretary, FT Office Manager, Senior Independent Director and NHS England (NHSE).

#### **3. Role description**

- 3.1 To act as the point of contact between the Governors and NHSE in circumstances where it would not be appropriate for the Chair of the Board of Directors, Senior Independent Director (SID) or the Trust Secretary to deal with a particular matter to contact NHSE directly, or vice versa
- 3.2 To work with the Chair to facilitate effective relations between the Board of Directors and the Council of Governors. This could include joint meetings/workshops with the Board of Directors and attendance of Non-Executive Directors at Council of Governors meetings
- 3.3 To sit on the Nominations and Remuneration Committee for the purpose of appointing the Chair and other Non-Executive Directors and discussing remuneration including allowances and other terms of office
- 3.4 To contribute to the Chair's annual appraisal by the Senior Independent Director, including receiving comments from Governors not directly involved in the appraisal process
- 3.5 To contribute to the appraisal of the non-executive directors (NEDs) by the Chair
- 3.6 To meet with the Chair to help plan and prepare for Council of Governors meetings

- 3.7 To chair meetings of the Council of Governors which cannot be chaired by the Trust Chair, Deputy Chair or other non-executive director due to a conflict of interest. These occasions are likely to be infrequent
- 3.8 Chair informal Governor-only meetings, if required
- 3.9 To ensure a process is in place to understand the views of all Governors
- 3.10 To help ensure a process is in place to support new Governors and to support the induction process for any newly appointed governor.
- 3.11 To help ensure that Governors comply with the Council's Code of Conduct.

#### **4. Person Specification**

To be able to fulfil this role effectively, the Lead Governor should ideally have some or all of the following attributes:

- 4.1 Have the confidence of Governor colleagues and of members of the Board of Directors
- 4.2 Ability to commit the necessary time to the role
- 4.3 Ability to influence and negotiate at different levels
- 4.4 Ability to present a well-reasoned view on complex issues
- 4.5 Committed to the success of the Foundation Trust
- 4.6 Demonstrate an understanding of the Trust's constitution and how the Trust is influenced by other organisations.

#### **5. Terms and conditions**

- 5.1 The Lead Governor will be a governor who is currently in their elected term of office and will not be eligible to continue in this role if they are not re-elected
- 5.2 Any Governor wishing to stand as Lead Governor will be required to relinquish other responsibilities e.g. committee chair
- 5.3 The term of office for the lead Governor will normally run for three years until one year after Governor elections \*
- 5.4 A Governor will not be eligible to stand for election during their final eligible term of office as a Governor
- 5.5 The role specification of the Lead Governor will be reviewed by Standards Committee of the Council of Governors following engagement with the Board of

Directors and the Council of Governors and will include the relevant provisions of Appendix B of the NHS Foundation Trust Code of Governance

5.6 If the Lead Governor leaves the role then the Deputy Lead Governor will take up the role until a further Lead Governor election takes place.

\* *The timing of the Lead Governor term aims to avoid appointment to the role being held immediately after Governor elections. This is because at this point a new governing body has been formed who will need to work together to understand their role and get to know each other. It is recognised that on occasions election of the Lead Governor may be necessary at this time, but the approach tries to minimise this occurrence.*

#### **Deputy Lead Governor role specification:**

The Council of Governors may also elect a Deputy Lead Governor from among the governors to meet the demands of the increasing level of responsibility. The Deputy Lead Governor will deputise in the absence of the Lead Governor and will support the Lead Governor in all the duties as specified.

In general, the Deputy Lead Governor is a discretionary role and has no specific powers or responsibilities other than to deputise in the absence of the Lead Governor (with the advance agreement of the Lead Governor). This provides additional resilience and support for the Lead Governor and the smooth running of the Council.

#### **Removal of Lead Governor/Deputy Lead Governor**

Removal of the Lead or Deputy Lead Governor before their term of office is over will require approval by the majority of Governors at a meeting of the Council of Governors



## **NHS England expectations of lead governor role (Appendix B of Code of Governance 2022)**

### **Lead governor**

The lead governor has a role in facilitating direct communication between NHS England and the NHS foundation trust's council of governors. This will be in a limited number of circumstances and, in particular, where it may not be appropriate to communicate through the normal channels, which in most cases will be via the chair or the trust secretary, if one is appointed.

It is not anticipated that there will be regular direct contact between NHS England and the council of governors in the ordinary course of business. Where this is necessary, it is important that it happens quickly and in an effective manner. To this end, a lead governor should be nominated and contact details provided to NHS England, and then updated as required. Any of the governors may be the lead governor.

The main circumstances where NHS England will contact a lead governor are where we have concerns about the board leadership provided to an NHS foundation trust, and those concerns may in time lead to our use of our formal powers to remove the chair or non-executive directors. The council of governors appoints the chair and non-executive directors, and it will usually be the case that we will wish to understand the views of the governors as to the capacity and capability of these individuals to lead the trust, and to rectify successfully any issues, and also for the governors to understand our concerns.

NHS England does not, however, envisage direct communication with the governors until such time as there is a real risk that an NHS foundation trust may be in breach of its licence. Once there is a risk that this may be the case, and the likely issue is one of board leadership, we will often wish to have direct contact with the NHS foundation trust's governors, but quickly and through one established point of contact, the trust's nominated lead governor. The lead governor should take steps to understand our role, the available guidance and the basis on which we may take regulatory action. The lead governor will then be able to communicate more widely with other governors. Similarly, where individual governors wish to contact us, this would be expected to be through the lead governor.

The other circumstance where NHS England may wish to contact a lead governor is where, as the regulator, we have been made aware that the process for the appointment of the chair or other members of the board, or elections for governors or other material decisions, may not have complied with the NHS foundation trust's constitution, or alternatively, while complying with the trust's constitution, may be inappropriate. In such circumstances, where the chair, other members of the board of directors or the trust secretary may have been involved in the process by which these appointments or other decisions were made, a lead governor may provide us with a point of contact.

## Annex D: Scheduled draft agenda items for next meeting – 26 July 2023

Description	Open	Closed	Type	Source	Director
Declaration of interests	✓	✓	Verbal	Matrix	All
<b>General Business</b>					
Patient/staff story	✓	✓	Verbal	Matrix	Exec.
Chief Executive's report	✓		Written	Matrix	EC
<b>Culture</b>					
Organisational development plan, including: safe staffing guardian, FTSU guardian reports	✓		Written	Matrix	JMO
<b>Strategy</b>					
Future System Board Report	✓		Written	Matrix	CB
System update: West Suffolk Alliance and SNEE Integrated Care Board - Include focus on Hewitt report findings	✓		Written	Matrix	PW / CM
Digital Programme Board Report	✓		Written	Matrix	CB
Strategic priorities	✓		Written	Action	CEO
<b>Assurance</b>					
Annual review of the IQPR	✓		Written	Matrix	AJ / NC / SW
Insight Committee Report - Finance report - Urgent and emergency care improvement plan	✓		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 - Annual quality accounts	✓		Written	Matrix	LP / SW / PM
Serious Incident, inquests, complaints and claims report		✓	Written	Matrix	SW
<b>Governance</b>					
Governance report, including - Use of Trust's seal	✓		Written	Matrix	RJ

Description	Open	Closed	Type	Source	Director
<ul style="list-style-type: none"> <li>- Senior Leadership Team report</li> <li>- Council of Governors meeting report</li> <li>- Annual review of governance</li> <li>- Foundation Trust Membership Strategy</li> <li>- Register of interests</li> <li>- General condition 6 and Continuity of Services condition 7 certificate</li> <li>- Agenda items for next meeting</li> </ul>					
Audit Committee report	✓		Written	Matrix	NED
Annual report and accounts		✓	Written	Matrix	CB
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: <ul style="list-style-type: none"> <li>- Integrated quality &amp; performance report (IQPR) – annex to Board pack</li> <li>- Others as required</li> </ul>					