Board of Directors (In Public)

Schedule	Friday 29 September 2023, 9:15 AM — 1:30 PM BST
Venue	Conference Rooms, Denny Brothers, Kempson Way, Bury St. Edmunds. IP32 7AR
Description	A meeting of the Board of Directors will take place on Friday 29 July 2023 at 9:15am.
Organiser	Ruth Williamson

Agenda

AGENDA

_WSFT Public Board Agenda - 29 September 2023 Final.docx

1. GENERAL BUSINESS

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

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

1.3. Minutes of the previous meeting - 21 July, 2023
To Approve - Presented by Jude Chin

Item 1.3 - WSFT Minutes Open Board 21 July 2023 DRAFT.docx

1.4. Action log and matters arising
To Review

Item 1.4 - Action Points - Active.pdf

Item 1.4 - Action Points - Complete.pdf

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

9:35 AM	1.6.	Patient and Staff Story
10:15 AM	1.7.	Chief Executive's report To inform - Presented by Ewen Cameron Item 1.7 Dr Ewen Cameron Board report - September 2023 FINAL.docx
	1.8.	Reflection of Letby Case To inform - Presented by Ewen Cameron Item 1.8 - Letby Case Reflections.docx
	2.	STRATEGY
10:30 AM	2.1.	Strategic Objectives & Delivery Plan - Progress Report To Assure - Presented by Ewen Cameron Item 2.1 - Strategic priority progress report Sept 23.docx
10:45 AM	2.2.	Future System board report To Assure - Presented by Craig Black Item 2.2 - Future System wsft public board september 23.docx
11:00 AM	2.3.	West Suffolk Alliance and SNEE Integrated Care Board (verbal) To Assure - Presented by Peter Wightman
	2.3.1.	Stay Well Domain: Overview To inform - Presented by Nicola Cottington Item 2.3.1 - v2 Stay Well Domain - Overview WSFT cover sheet.docx Item 2.3.1 - vFinal (2) SW presentation for 29 Sep WSFT Board.pdf
	3.	PEOPLE AND CULTURE
11:10 AM	3.1.	Involvement Committee report

To Assure - Presented by Tracy Dowling

Item 3.1 - Involvement CKI Aug 2023final.doc

11:25 AM 3.2. Putting You First Awards

For Discussion - Presented by Jeremy Over

Item 3.2 - People OD highlight Sept2023.docx

11:30 AM COMFORT BREAK

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4. ASSURANCE

11:40 AM 4.1. Insight Committee Report - Chair's Key Issues from the meeting

To Assure

Item 4.1a - 29 September board Insight CKI.docx

Item 4.1 - INSIGHT CKI report Insight 07 19 July 2023.docx

4.2. Finance Report

To Assure - Presented by Craig Black

Item 4.2 - Finance Cover - August 2023.docx

Item 4.2 - Finance Report August 2023 FINAL.docx

12:10 PM 4.3. Improvement Committee Report - Chair's Key Issues from the meeting

To Assure - Presented by Louisa Pepper

Item 4.3 - IMPROVEMENT CKI report 07 19 Jul 2023.docx

4.4. Quality and Nurse Staffing Report

To Assure - Presented by Susan Wilkinson

Item 4.4 - Safe Staffing July August FINAL.docx

4.4.1. Maternity Services

Karen Newbury, Kate Croissant & Simon Taylor in attendance

For Approval

_Item 4.4.1 - Trust Board report MSSP August 2023 trust Board

copy.docx

12:50 PM	4.5.	Audit Committee Report - Chair's Key Issues from the meeting To Assure - Presented by Michael Parsons Item 4.5 - CKI - Audit.docx
	5.	GOVERNANCE
12:55 PM	5.1.	Governance report To Assure - Presented by Richard Jones Item 5.1 Governance report.docx
1:05 PM	5.2.	Board Assurance Framework To inform - Presented by Richard Jones Item 5.2 BAF report September 23-Board.docx
1:15 PM	5.3.	Meeting Schedule 2024 To Note - Presented by Richard Jones Item 5.3 - Meeting Schedule.docx Item 5.3a - Board Subcommittee Meeting DATES FOR 2024-2025 V1.doc
1:20 PM	6.	OTHER ITEMS
	6.1.	Any other business To Note
	6.2.	Reflections on meeting For Discussion
	6.3.	Date of next meeting - 1 December, 2023 To Note - Presented by Jude Chin
		RESOLUTION

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

SUPPORTING ANNEXES

2.1 Strategic priorities

- Item 2.1 Annex Strategic priority progress report - annex.docx

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4.2 IQPR Full Report

- Item 4.2 - Annex IQPR Cover Sheet v2.docx
- Item 4.2 - Annex IQPR.pdf

4.4.1 Maternity - Annexes

- Anaesthetic staffing report Q3 and Q4 22.23.docx
- Neonatal Nursing staffing report Sep 23 (v4).docx
- September 23 Maternity qualtiy safety and performance Board report approved copy.docx
- TC quater 1 23.24 report Board Copy.docx

5.1 Governance Report Annexes

- Item 5.1 Annex A Policy on Engagement introduction RJ.docx
- Item 5.1 Annex A Policy for Engagement between Board and CoG 2023.docx
- Item 5.1 Annex B Draft Board meeting agenda.docx

AGENDA

WSFT Board of Directors – Public Meeting

Date and Time	Friday, 29 September 2023 9:15 – 13:30
Venue	Conference Room, Denny Brothers, Kempson Way, Bury St. Edmunds. IP32 7AR

Time	Item	Subject	Lead	Purpose	Format
1.0 GENERAL BUSINESS					
09.15	1.1	**Welcome and apologies for absence**	Chair	Note	Verbal
	1.2	**Declarations of Interests**	All	Assure	Verbal
	1.3	**Minutes of meeting** – 21 July 2023	Chair	Approve	Report
	1.4	**Action log and matters arising**	All	Review	Report
09:20	1.5	**Questions from Governors and the public relating to items on the agenda**	Chair	Note	Verbal
9.35	1.6	**Patient and Staff Story**		Review	In Person
10.15	1.7	**CEO report**	Chief Executive	Inform	Report
	1.8	**Reflection of Letby case**	Chief Executive	Inform	Report
2.0 STRATEGY					
10:30	2.1	**Strategic objectives delivery plan – progress report**	Chief Executive	Assure	Report
10:45	2.2	**Future system board report**	Director of Resources	Assure	Report
11:00	2.3	**West Suffolk Alliance and SNEE Integrated Care Board**	West Suffolk Alliance Director	Assure	Report
	2.3.1	**Stay Well Domain: Overview**	Chief Operating Officer	Inform	Report
3.0 PEOPLE AND CULTURE					
11.10	3.1	**Involvement Committee report** Chair's key issues from meeting	NED Chair	Assure	Report

Time	Item	Subject	Lead	Purpose	Format
11.25	3.2	**Putting You First Awards**	Director of Workforce	Discuss	Report
11:30 Comfort Break					
4.0 ASSURANCE					
11:40	4.1	**Insight committee report** – Chair's key issues from the meetings	NED Chair	Assure	Report
	4.2	**Finance report**	Director of Resources	Assure	Report
12:10	4.3	**Improvement committee report** – Chair's key issues from the meetings	NED Chair	Assure	Report
	4.4	**Quality and nurse staffing report**	Chief Nurse	Assure	Report
	4.4.1	**Maternity services report**	Chief Nurse Karen Newbury Simon Taylor	Approval	Report
12:50	4.5	**Audit committee** Chair's key issues report	NED Chair	Assure	Report
5.0 GOVERNANCE					
12:55	5.1	**Governance Report**	Trust Secretary	Assure	Report
13:05	5.2	**Board assurance framework**	Trust Secretary	Inform	Report
13:15	5.3	**Meeting schedule for 2024**	Trust Secretary	Inform	Report
6.0 OTHER ITEMS					
13.20	6.1	**Any Other Business**	All	Note	Verbal
	6.2	**Reflections on meeting**	All	Discuss	Verbal
	6.3	**Date of next meeting** 1 December 2023	Chair	Note	Verbal
	Resolution The Trust Board is invited to adopt the following resolution: "that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicly on which would be prejudicial to the public interest" Section 1(2) Public Bodies (Admission to Meetings) Act 1960				

Supporting Annexes

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

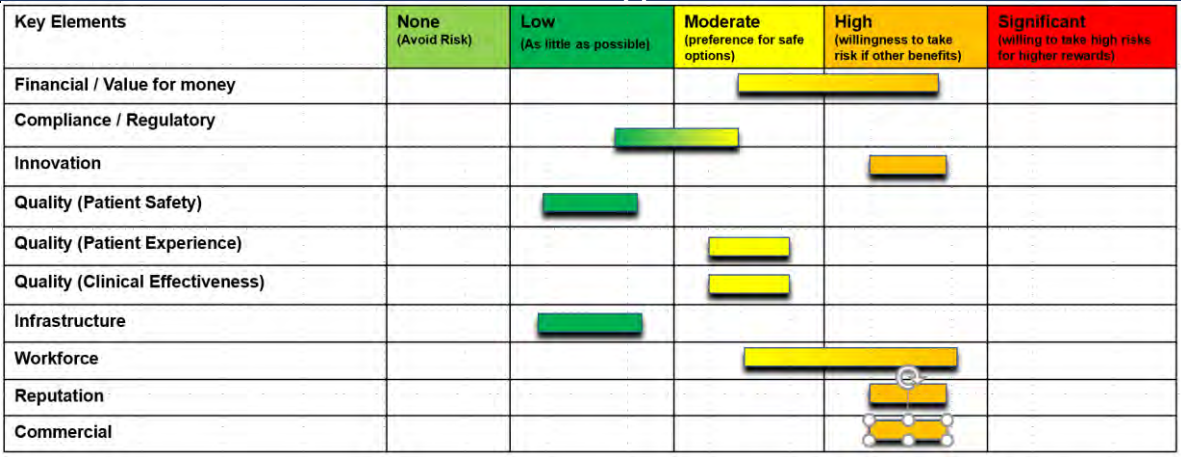
Guidance notes

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

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

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

Our Risk Appetite



1. GENERAL BUSINESS

1.1. Apologies for absence

To Note

Presented by Jude Chin

1.2. Declaration of interests for items on the agenda

To Assure

1.3. Minutes of the previous meeting - 21 July, 2023

To Approve

Presented by Jude Chin

WEST SUFFOLK NHS FOUNDATION TRUST

DRAFT MINUTES OF THE
BOARD OF DIRECTORS MEETING OPEN

Held on 21 July 2023 09.15 – 13.30
At Denny Bros Conference Rooms, Bury St Edmunds

Members:		
Name	**Job Title**	**Initials**
Jude Chin	Chair	JC
Ewen Cameron	Chief Executive Officer	EC
Louisa Pepper	Non-Executive Director/Deputy Chair	LP
Antoinette Jackson	Non-Executive Director/ Senior Independent Director	AJ
Geraldine O'Sullivan	Non-Executive Director	GO'S
Tracy Dowling	Non-Executive Director	TD
Michael Parsons	Non-Executive Director	MP
Craig Black	Executive Director of Resources/Deputy CEO	CB
Nicola Cottington	Executive Chief Operating Officer	NC
Sue Wilkinson	Executive Chief Nurse	SW
Paul Molyneux	Medical Director/Maternity and Neonatal Safety Champion	PM
Jeremy Over	Executive Director of Workforce and Communications	JO
Clement Mawoyo	Director of Integrated Adult and Social Care Services	CM
Peter Wightman	West Suffolk Alliance Director	PW
In attendance:		
Richard Jones	Trust Secretary & Head of Governance	RJ
Pooja Sharma	Deputy Trust Secretary	PS
Reuben Wilcox	Staff member, Wellbeing Team	RW
Helen Davies	Associate Director of Communications	HD
Sujaya Chattopadhyay	FY2, General Medicine *(item 3.1 only)*	SC
Karen Newbury	Head of Midwifery *(4.4.2 item only)*	JS
Moira Welham	ADO, Surgery and Anaesthetics *(4.4.2 item only)*	KC
Simon Taylor	Associate Director of Operations *(4.4.2 item only)*	ST
Matthew Keeling	Deputy Chief Operating Officer *(item 4.1.1 only)*	MK
Dan Spooner	Deputy Chief Nurse *(item 4.4 only)*	DS
Louise Kendall	EA/Dr Helena Jopling, Associate Medical Director (minute taking)	LK
Apologies: Dr Roger Petter, Non-Executive Director/ Maternity and Neonatal Safety Champion		
Governors:		
Jane Skinner Liz Steele Gordon McKay Florence Bevan	Lead Governor Public Governor Public Governor Public Governor	JS LS GM FB
Members of Staff:		
Paul Pearson	Staff Side Lead	PP

Emmanuel Lorejo	Surgical Care Practitioner, Surgical Services and Co-chair of the REACH staff network	EL
Akshay Bavikatte	Registrar, General Surgery and Co-chair of the REACH staff network	AB
Debra Baker	Senior Matron	DB

1.0 GENERAL BUSINESS		
1.1	**Welcome and Apologies for absence**	**Action**
	The Chair, Jude Chin (JC) welcomed all to the meeting. Apologies for the meeting were noted.	
1.2	**Declarations of interest**	
	No declarations of interest were received.	
1.3	**Minutes of the previous meeting**	
	The minutes of the previous meeting held on 26 May 2023 were approved as a true and accurate record, subject to the following amendments: • Section 2.1, Governors' questions, did not adequately reflect the answer to the question regarding the paper on people and culture priorities and requires review. **ACTION: Review and amend answer to question regarding paper on people and culture priorities.**	**J Over / P Sharma**
1.4	**Action log and matters arising**	
	3005 Present a staff story from experience of Emerging Incident Review meetings This is scheduled for September, to be presented by Lucy Winstanley. **3014** and **3015** Quality and Nurse Staffing Report Some information will be covered at today's meeting and the remainder at the September meeting. Other items noted as complete to be covered on today's agenda.	
1.5	**Questions from Governors and the public relating to items on the agenda**	
	1. With regard to the strategy priorities how far will engagement be taken with other agencies/organisations, e.g. the police, to help self-support? It is important to work together to be more proactive The Chief Executive, Ewen Cameron (EC) said that working with partners as part of the West Suffolk Alliance will be critical to deliver on the priorities and hopefully evidence of this will be seen in the coming years. The Trust works with a range of organisations to achieve this. The West Suffolk Alliance Director, Peter Wightman (PW) added that in education specifically, the Alliance is working with young people's groups. The ICB and ICP will be focussing on the prevention agenda in the light of the Joint Forward Plan (JFP), and is being looked at, at every level. The ICP will be	

	meeting in September ('Community Connect' West Suffolk public event, hosted by West Suffolk Alliance) with a particular focus on West Suffolk, and governors are welcome to attend. **ACTION: Other ICB public meeting dates to be shared with governors.** It was noted that the health sector needs to work with wider organisations e.g. housing departments, who manage vulnerable people, and community hubs who can educate people on healthier lifestyles. 2. Concern was expressed about a change in emphasis in Trust communications towards financial recovery, and away from issues such as equality, diversity and inclusion (EDI) and staff welfare, and the effect this has on staff wellbeing and morale. EC said that all of the issues highlighted are important, and the Trust will continue to pay attention to all the areas referred to e.g. EDI, staff welfare etc. We need to be conscious of our values when communicating with staff. 3. How has the consultants' strike impacted on patient safety and care? The Medical Director, Paul Molyneux (PM) reported that because of good teamwork, the Trust is in a strong position in terms of consultant industrial action. Just short of 20% exercised their right to take industrial action, and PM thanked all the staff, including Operating Department Practitioners (ODPs), who made sure as much elective work as possible continued, and kept patients safe. The situation is being managed as well as it possibly can be. Junior doctors have been very supportive, as have the consultants been of the junior doctors. 4. It was noted that an article in the Bury Free Press had been published, about a patient admitted with kidney stones, whose medication was taken from him to give to another patient. Executive Chief Nurse, Sue Wilkinson (SW) said that this was logged as an incident and is being investigated, although no harm came to patients.	**P Sharma**
1.6	**CEO Report**	
	The Chief Executive, Ewen Cameron (EC) presented the report. There were no comments or questions.	
2.0 STRATEGY		
2.1	**Strategic Objectives and Delivery Plan**	
	The Chief Executive, Ewen Cameron (EC) presented the paper, and drew attention to the five priorities from the five-year strategy which was agreed in January 2022. Results of the staff survey and the What Matters To You initiative were also taken into account when distilling the priorities. The paper explained the rationale and drivers for each of the priorities as well as measures for success. The Board has spent a considerable amount of time going through the process and reviewing the priorities, which have been shared with the senior leadership team.	

	The Executive Director of Workforce and Communications, Jeremy Over (JO) confirmed the two priorities which relate to cultural and leadership development, which are aligned with the People and Culture Plan and are mutually supportive. It was emphasised that the priorities do not describe everything which the Trust will be doing over the next year. The hope is that this will enable teams to prioritise their work in the light of a number of competing priorities, and to enable decision making on resources. The process is now set in place for future development. With regard to transformation, listed as a priority, a question was raised about including measures of success, given the backdrop of the financial recovery. It was noted that the fifth priority (the 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) should help to support that. It was further noted that these are not all of the metrics to be monitored. Environmental sustainability is also measured. A question was raised about the EDI priority focusing on staff, and not patients. EC confirmed that this year the focus will be on staff, but this will move more into patient focus next year. The two are not mutually exclusive. The system is working closely to ensure inclusivity. The Chair thanked the Executives and the Board for their work on this. The plan now needs to be monitored, with consideration to what needs to be presented to the Board in the future. The priorities will need to be refreshed for 2024/25 in a timely manner. **ACTION: Review and agree timing for strategy delivery priorities for 2024-25.**	**E Cameron**
2.2	**Future System Board Report**	
	The Executive Director of Resources, Craig Black (CB) presented the report, which includes detail of the underpinning process to secure the future facility. Work is continuing on the production of business cases. The strategic outline case (SOC) has been re-submitted to NHSE and the team is now working on the outline business case (OBC) with the help of additional resources, to be finalised by the beginning of 2024. £10m of support has been provided to produce the business case, including work with advisers and architects. Money is also being spent on enabling works, in particular the responsibilities in respect of planning permission. The report details some of the scrutiny around the process, in particular the number of beds being planned for, which is a key driver for the cost of the project. A degree of consistency is required, to be applied to all of the schemes. The assumptions on numbers of beds have been checked by the New Hospitals Programme (NHP), who have not raised any concerns about the modelling, and are using our model to test other schemes. In terms of scrutiny, our demand and capacity modelling is recognised by the NHP as sound, as is clinical model and the way the Trust has turned these models into a design has been recognised. Trust's costing is also recognised as sound by the NHP. In theory, this should lead to an agreed budget, but there is still work to do on finalising the budget. The allocation made is significant and will produce a great facility for the next 40 years.	

	Q. Does the planning work address the bed model risks specifically, including available staff? Is the workforce planning integrated enough with social care? JO said that the relationship with Carados is in its early days. The national long term workforce plan has been recognised, and in itself has been criticised, but those dimensions will be included in ongoing discussions. The Director of Integrated Adult and Social Care Services, Clement Mawoyo (CM) said that this is being looked at through an alliance lens, taking the Future System Programme into account. Challenges in the care market have improved significantly but is dependent on international recruitment which is a risk and has been highlighted. Q. What are the revenue consequences of the additional beds, and how will they be managed? CB said that there are a number of financial aspects to the new scheme. Demand will increase regardless of the new facility and needs to be planned for appropriately. Much is contingent on the clinical and care strategy, and in terms of finance, the costs of servicing a more expensive asset is significantly more than current - revenue costs are about 6% of the total cost of the asset. The project should provide improved efficiency, but this applies to all new projects and a national solution to the problem is required. Discussions are ongoing and requires resolution imminently. Q. With regard to the budget to support the next stage of preparing the business case, is any created to support the transformation change to be realised in advance? CB said that some of the budget is being used to support the change taking place now. Q. Could the company employed to help develop the workforce forecast be used to explore the current position? CB said that as with all of the work, there is a crossover between what is happening today as well as in the future, so this will be examined, especially the underlying data going into future workforce modelling. It was noted that the funding is in stark contrast to primary care premises funding which is very challenging, and needs to be kept in mind. The ICS is working on an infrastructure facility strategy but is a risk to highlight. The OBC will look at rehousing of current services, which may be configured in a different way, and the Future System Programme will be responsible for covering the costs of that. The impact on the wider system of the demand for services needs to be kept in mind.	
2.3	**Clinical and Care Strategy**	
	The Medical Director, Paul Molyneux (PM**)** presented the report, which explained the background and outlines the agreed priorities for the initial period. Most form part of the wider healthcare network and are fundamentally important in our ability to deliver. PM highlighted the conclusion, which is a “comprehensive and progressive vision for future service delivery. It is essential that we move to deliver the ambitions so that we can ensure patient services are maintained to a high quality whilst ensuring the hospital only does what it can do best.	

The development of the strategy, via co-production, demonstrates what can be achieved when working collaboratively. Now we need to turn the strategy in to action."

A suggestion was made to change the statement about doing only what the hospital does, into a more positive statement.

It was noted that the strategy is dependent on how our communities engage with us, and their views should be supported through the alliance and the ICS. It is a positive step, but the wider system approach to strategy requires examination. The focus on place, and strengthened integrated neighbourhood teams was welcomed.

It was further noted that internal and external communication is key, and in terms of reinforcing ownership of health and wellbeing is different to previously. The associated strategy needs to be focussed on moving forward.

Q. There is a balance between co-production and ensuring service plans are in line with the left shift into the community. What are the opportunities to bring in primary care and others to challenge the co-production ideas?

PM said that visions must reach far and wide and discussions should be facilitated with everyone to strengthen relationships with primary and secondary care.

Q. Are all the resources and knowledge available being used to realise the plans? More is needed about horizon scanning which is not just a local issue.

PM said that the strategy will change as networks show how we can continue to improve. There is also more to be done to embed the work of organisations going forward.

Q. Is there any benefit in articulating the quick wins rather than stopping things we ought to stop?

PM gave the example of patient-initiated follow-up which is something that can be moved out of the hospital and will take place in the next 12 months. There will be other similar initiatives to follow.

It was noted that there is a role for corporate communications. The strategy describes the left shift, and the narrative will be needed to make it compelling and clear to the wider population. Assuming there is overlap with the JFP, more of the mutual benefits of those strategies will need to be made. Clear messaging is needed that we are not just asking staff to do more, and this will have to be led by the clinicians.

The strategy sets out direction well, although outpatient services and diagnostic work need to be described more. There is a risk of pushing services from one part of the system to another, so there is importance in building on the "third space" model. Every surrounding system is addressing these challenges, and the new hospital provides an advantage for the Trust.

The Trust Secretary, Richard Jones (RJ) noted that work was ongoing on how best to achieve an end-to-end vision of clinical pathways.

	ACTION: develop board exposure to end-to-end clinical pathways priorities within the clinical and care pathway **The Board approved the Clinical and Care Strategy and agreed the 2023/24 priorities for service and pathway change.**	**R Jones**
2.4	**West Suffolk Alliance and SNEE Integrated Care Board**	
	The West Suffolk Alliance Director, Peter Wightman (PW) presented the highlights of the last ICB meeting. The topic of dementia was discussed and the report's appendix shows the conclusions from that work, which indicates the challenges and the levels of demand. Q. In terms of collaboration, is there anything the Trust can do better? PW said that having a focus on areas where West Suffolk may be behind is helpful, e.g. diabetes and dementia. The report also points to mental health connections and how NSFT can be brought more into the alliance. He suggested bringing the work on dementia to a future Board meeting. There is a distinction between delirium and dementia and how patients are managed correctly in the community. Discussion took place about new treatments being developed, and finding the right treatment for patients. Until recently, most treatments were minimally effective. New treatments require an early diagnosis, and the scale of tests needed will be challenging, as will the costs. The Healthwatch report on dementia is useful, and investment and pathway design needs to be examined quickly. However, new drugs are decided upon nationally so local expectations should not be raised, although there will be a need to adopt services quickly. It was noted that Healthwatch will give a presentation on dementia at the next Involvement Committee meeting. It was agreed that reporting on the Better Care Fund (BCF) and Ageing Well Resources will be shared with the Board in future. This should include how it is helping discharge and flow within the Trust, and how the six localities are performing on the prevention agenda. It was further agreed that sufficient time is needed for discussion on wider collaboration. **ACTION: Provide report on dementia at a future Board meeting, and provide clear reporting of the benefits achieved through BCF investment.** It was noted that resources are integral to delivering the Die Well plan, and many specialist teams have good pathways for this. JO drew attention to the MyWish strategy which has been looking at specific areas for fundraising - dementia services would be a good candidate. The voluntary sector should also be brought into the discussions.	**P Wightman**
2.5	**Wider System Collaboration**	
	The Chief Operating Officer, Nicola Cottington (NC) presented the report, which is about collaboration and not competition, and in this context not just about taking services to another part of the system. Examples collated reinforced that clinical and	

operational teams are working collaboratively all the time, and the Trust's role is to ensure that the right environment is created, acknowledging and celebrating it, removing some of the perceived barriers and investing for the future.

NC highlighted some examples:

- Progress of the East Coast Pathology Network (ECPN). Initially there was mistrust, suspicion, and fear of loss of identity, but benefits are now starting to be realised;
- Engagement with the Dame Clare Marx Centre. This has been a challenging journey, and sometimes achieving the right outcome is not always easy. The shift in mindset and culture of the teams is tangible. Andrew Dunn has now been appointed as Clinical Director for the Centre.
- Integrated Neighbourhood Teams. We are in a good position as an integrated Trust, and this needs to be maximised.
- Unscheduled care coordination hub (UCCH) which brings together many different organisations. Staff are now very involved and find it very rewarding. It is not always easy but one of our responsibilities is to overcome barriers and develop relationships.

It was noted that this is a very uplifting paper, which demonstrates the need to make connections. There is a strong building of trust in different parts of the system which did not previously exist, and shows that staff want to and are willing to collaborate. A recent visit to the Mildenhall hub was very inspiring and staff are very enthusiastic.

Q. What more could the Board do to support collaboration with partners?

NC said that it is helpful to have that lens when considering other issues, e.g. the financial position. We need to guard against becoming embattled and not continuing to look upwards and outwards. We should take an active role in maintaining external relationships.

It was noted that one of the main drivers is NC's relationship with ESNEFT.

Q. With regard to urgent care, are there any plans for the 111 service to be involved?

NC confirmed that they are integrated in the UCCH project and a project will be set up to examine other ways of expanding the scope.

Discussion took place about engaging all staff to contribute to doing things differently. Consideration should be given to what the barriers may be, in order to diminish them and message staff to make clear that we want them to innovate.

It was noted that one of the barriers is digital services, so the Trust is working closely with ESNEFT on their digital services which can be a real enabler for staff and patients.

It was further noted that the early intervention team has achieved much in 18 months, which is related to confidence and building the ability for staff to make their own decisions. Psychological safety also plays a role, and consideration should be given about how to react when things go wrong. Support from Directors enabled staff to find new ways of working in the community.

	It should not be forgotten that decisions in one setting can influence another, so property and prescribing budgets need to be monitored.	
3.0 PEOPLE AND CULTURE		
3.1	**Patient and Staff Stories relating to Equality, Diversity and Inclusion**	
	The Chief Operating Officer, Nicola Cottington (NC) introduced a story from a member of staff (about his experience as a patient), and Jeremy Over, Executive Director of Workforce and Communications, introduced from a staff perspective. <u>Patient Story</u> Reuben told of his experience of treatment as a patient at WSFT, first related at a meeting of the Pride network when discussing the need for staff training. Reuben is transgender and has accessed gynaecology services at the hospital. The experience was very positive - staff have always shown understanding and sensitivity in their communications with Reuben and made him feel very comfortable whenever he has attended appointments. Staff training in that department was not necessarily needed. In answer to a question about his expectations prior to attending the hospital, Reuben said that he hoped for the best and expected the worst, but did not really know what to expect. The only criticism was with regard to some of the paperwork which is directed towards women and this can be off putting to some transgender patients. All patient information, policies and guidelines to recognise and reference our transgender community. This will be a dynamic process, when documents are updated through the usual process of updating. Authors of the documents will have the responsibility to do this. Communication of this expectation will be disseminated through the relevant committees overseeing sign off of these documents. It was noted that the Women and Children's department is focussed on treating individuals fairly, but it would be helpful to know whether patients have the same experience across the organisation and feedback on that would be welcome. It was further noted that the reputation of the gynaecology department is spreading to other departments including the breast service, which has acknowledged that it would like to improve in this area. <u>Staff Story</u> Sujaya, an F2 in general medicine, told of her experience of facing discriminatory behaviour from a patient, shortly after starting work at the hospital. During a ward round, a patient made a derogatory comment regarding Sujaya's accent. Sujaya explained some of the emotions she felt and the impact this incident had on her. She subsequently contacted the Freedom to Speak Up (FTSU) guardian in the hope of improving other staff experiences. She also highlighted the extensive surveys already carried out about racism at work, and the discussions continuing in other countries about anti-racism as a foundation competency. Another study has shown that the removal of personal details in applications can make the process more neutral and non-biased. Sujaya highlighted some of the things which can be done following such situations:	

	• Invite the conversation. Saying the word "racism" can be scary, but calling it racism can help. • Identify and check bystander behaviour, as sometimes there is a feeling of being afraid to speak up and being perceived as a troublemaker. • Talk with supervisors. • Use the Greatix scheme, which is good for encouraging positive behaviour while highlighting bystander behaviour. • FTSU awareness – there seems to be lack of understanding about staff support which is available. There are subtle changes in behaviour that we can all do, e.g. ensuring preference for pronunciation of names; acknowledging personal preferences; self-education – knowing how racism can look in different clinical settings; eye contact – this depends on the personal level of comfort but lack of eye contact can make people feel uncomfortable. Reflecting on the experience, Sujaya said that at the time, the patient was not in a position to understand the consequences of his actions. She considered whether it would be better to find another time to talk to the patient about it, but sometimes this is not possible if the patient's condition does not improve. If the patient had been in a position to understand, Sujaya would have liked to understand why the patient said what he said. Some explanations can be very objective, but more often than not it is more of a perceptive problem from conditioned behaviour. Sujay referred to the zero tolerance policy, and that facing any discrimination can take a toll. She emphasised the importance of discussing how the person facing the discrimination wants to deal with it. She highlighted the actions which indicate the proactive action taking place and that the problem is being dealt with. Everyone deserves the same compassion. Reflecting on the effect of the experience, Sujaya acknowledged that at the time, she had to withdraw from the ward for the sake of other patients and felt that she lost her enthusiasm for the job. Sujaya finished by expressing her gratitude for the level of support she had received It was noted that Sujaya's experience was not rare in the NHS and although much is being done, there is still more action to be taken. Patients also experience racism from other patients as well as from staff, and not enough is done to publicise and promote our lack of tolerance and our commitment to improve. It is an uncomfortable topic, but only by being public about it and about the consequences of racism and the impact it has, can improvements be made. It was suggested that staff networks could help to deliver key messages JC thanked Reuben and Sujaya for sharing their experiences.	
3.2	**Involvement Committee Report**	
	The Non-Executive Director and Chair of the Involvement Committee, Tracy Dowling (TD) reported on the June meeting.	

	The committee examined in detail the issues of equality, diversity and inclusion, with partial assurance. The committee was assured of the organisation's commitment, but more detail of the plans is needed. This is escalated to the Board for commitment to actions, the Anti-racism Charter, and to support issues of race and disability. The Trust should also incorporate NHS England's plans in local plans and priorities. The committee noted that progress is being made on the Ockenden improvement plan. The FTSU guardian is moving on to another position, and TD expressed thanks for the systems and processes she has introduced. The committee reflected that there is more work to do on patient involvement, and the terms of reference will be examined to see how this area can be made stronger.	
3.3	**People and Organisational Development**	
	The Executive Director of Workforce and Communications, Jeremy Over (JO) presented the report and highlighted the following: • The Putting You First Award – five colleagues celebrated for their contributions. • Reflections on diversity and inclusion, for information and assurance. Further development of this work will take place at the next Involvement Committee • A formal commitment to invite the Board to endorse and adopt the Unison Anti-racism Charter, which has been developed by staff side colleagues. It sets out some particular commitments, actions and auditing to become an anti-racism organisation. Adoption of the charter is now being proposed. It is an intent to develop and deliver the improvements specified • FTSU recruitment. Applications closed today and a recruitment event will be held next month • A renewed pledge about the importance of speaking up as a Board, and a statement is proposed which should reflect how the Board thinks and feels about the freedom to speak up approach • The national industrial relations situation with recent decisions about pay for doctors and dentists, and reflections on ongoing industrial action. • Two requests for Board endorsement. It was noted that there are many reasons why the Board should endorse the anti-racism Charter. It demonstrates helpful partnership working with staff organisations. Staff should role model the behaviour and send a message that racism is not acceptable in our community and our Trust. <u>Q. Is there reassurance that the Trust can actually do what the Charter says?</u> JO said that the HR team will lead predominantly, and the goals are realistically achievable with appropriate resources. It was agreed that involvement committee to develop response to deliver the requirements of the anti-racism charter and provide visibility of progress on an ongoing basis to the Board. **The Board agreed to adopt the anti-racism Charter, and the FTSU pledge.**	

4.0 ASSURANCE		
4.1	**Insight Committee Report**	
	The Non-Executive Director and Chair of the Insight Committee, Antoinette Jackson (AJ) presented the report and highlighted the following points from the June meeting: • The deep dive on endoscopy. It appears that the trajectory will be reached ahead of the national target. • Work on waiting lists in terms of patient harm, with an impressive pilot in orthopaedics. • The gap in automatic data being provided from Glemsford Surgery. This should be improved. At the most recent meeting, the committee spent considerable time discussing the budget. The committee also received a presentation on the review of community paediatrics. In terms of waiting lists, the numbers are now down to one patient over 104 weeks and 58 over 78 weeks. This should be kept under review. Q. With regard to the Glemsford Surgery data, are the actions in place sufficient or does more need to be agreed? Some of the issues are out of the Information Department's control and this feels unsatisfactory. The Executive Director of Resources, Craig Black (CB) said that there are a number of issues with SystmOne, and concerns will be escalated through contacts at the Department for Health to resolve a number of issues.	
4.1.1	**Summary Reports:** **Seasonal Planning; and Elective Backlog Recovery Plans**	
	Seasonal Planning Director of Integrated Adult and Social Care Services, Clement Mawoyo (CM), and Deputy Chief Operating Officer, Matt Keeling (MK) presented the report. MK explained the background. Pressures on services impact the whole health and care system and can lead to cancellation of elective activity. Length of stay increases and patients are not able to receive care in more appropriate settings. Last winter saw the highest rates of patients coming through the Emergency Department and extensive planning took place, but despite best efforts, bed occupancy and length of stay increased, and remained at a high level throughout the period. The first of the three NHS priorities as set out in the 2023/24 priorities and operational planning guidance is to recover core services and productivity. The ability of the whole system needs to be increased in order to deliver on the priorities. The NHS has also published a recovery plan to enable patients to access urgent and emergency care more quickly. West Suffolk is in a good position to deliver that with partners. There are three priorities in that plan: increase capacity and make better use of existing capacity; improve discharge; and expand and improve joining up of health and social care.	

	A trajectory was submitted of the requirements to keep bed occupancy to 92% or below. This showed that based on bed allocation, the Trust would need to provide or save the equivalent of 33 beds all year round. Flow has been the focus, underpinning all that is needed to optimise patient flow. A Focus on Flow group has been set up, which has ten main workstreams as listed in the paper. **The Board is asked to endorse the Focus on Flow programme**. In terms of rolling out the programme, it will report to the West Suffolk Change Hub Programme Board and up to the senior leadership team. A ward by ward approach will be used, starting with G2 and G3. A number of metrics are in development. The second priority is escalation capacity. Works on the escalation ward should be completed by November 2023 to be available for use again. A flexible approach will be used related to available data about any potential use of that capacity. Our existing capacity will also be examined, with a number of initiatives to flex capacity in specialist areas. Q. It is disruptive for staff to open up at short notice. Were any lessons learned from contingency last year? MK said that notice would be weeks rather than days, based on available data. An effective team structure would be developed, and where possible funded sustainably rather than relying on short notice premium payments. SW added that there has been learning gained from contingency. Appropriate equipment is needed now, and a multidisciplinary approach. Experienced staff is of benefit as the leadership is imperative, but the ratio of permanent to temporary staff should be considered. The clinical criteria model worked well but is challenging in times of pressure and patient caseloads could change quickly. It was noted that escalation capacity costs are significant, so it is important to be more specific about timing. The use of a dynamic risk assessment and data is sensible. Alternative actions should also be considered. System pressures last year showed that the plan needs to be enacted, and collaboration and support is required. Work should be done now to create an alternative plan to be enacted when under pressure. Q. What is the methodology to be used for quantifying flow? MK said that measuring flow and keeping occupancy below 92%, as well as reducing length of time for patients waiting for beds will say whether the plans are being delivered. IQPR and structures to be used for Board assurance would go through Insight Committee. CM reported on community initiatives. Managed through the West Suffolk Alliance, three initiatives form the basis of the 2023/24 plan: increasing Home First capacity; wrap around support and Transfer of Care Hub (TOCH); and community beds including complex beds.	

By increasing capacity in Home First, better support can be given through a reablement service on discharge, either the same day or next day. There is a plan to increase the assessment service and provide a 7-day service to improve support for weekend discharges. The reablement service would like to introduce a therapy-led service.

The second initiative focusses on added capacity to help with assessment capacity for discharge and adults stepped into community beds. In planning for the next financial year, there is a commitment to working with the system to increase capacity. There will be an additional 18 community beds to support discharge by commissioning the right type of beds in the right locations. The aim is to discharge more patients into the community to their homes. Other initiatives include an in-reach reablement service, to reduce length of stay and de-conditioning, with the aim of supporting more people at home rather than in care settings. More information will be shared at the West Suffolk Alliance in September.

Q. In terms of seasonal planning, are there any plans for the vaccination programme?

PW said that the vaccination service is making plans, and is waiting for specific guidance about when to start the rollout of the vaccination programme. Once plans are outlined, the service will mobilise quickly.

Q. What is the system doing to reduce the number of patients coming to hospital?

CM said that the Alliance is working closely with primary care colleagues in order to respond to patient needs in a timely way. There are opportunities to minimise pressures, e.g. the virtual wards, and in addition, the unscheduled care coordination centre will respond to the community within 2 hours.

Elective backlog recovery options

The Chief Operating Officer, Nicola Cottington (NC) introduced the paper, the purpose of which is to present options to reduce the elective backlog in the light of the failed attempt to secure national funding for an elective surgical centre at Newmarket hospital.

The ADO for Surgery and Anaesthetics, Moira Welham (MW) presented the report, and explained the definition of elective recovery and the recognition that the Trust will need to deliver more. Elective recovery is difficult - achieving 18-week RTT compliance should be an aspiration, but the Trust needs to be realistic. It is important to examine emergency activity too, and it should be noted that trauma and emergency surgery admissions have increased. The biggest demand for trauma is in the summer months.

There are multiple enablers to support elective recovery, including bed capacity. The aim is to increase generic elective capacity, by taking six beds away from orthopaedics, which has more beds than needed. Estates issues do not provide enough capacity to meet needs, so to optimise movement of capacity to the Dame Clare Marx Centre, the proposal is to build a temporary wall at the end of F4 in October 2023. This will enable the movement of surgical SDEC into this space, creating 6 generic surgical beds on F5.

	Much financial analysis is required, including analysis in relation to a recently announced a reduction in Elective Recovery Fund (ERF) thresholds. Three options are presented to continue with elective recovery, detailed in the paper, along with the benefits and risks of each option. **The Board is asked to approve Option 2 - Continue to deliver a full theatre programme, 54% of activity being bolstered by additional sessions and/or agency staffing. Backfill vacated sessions following the move of orthopaedic activity to the Dame Clare Marx Centre, using additional sessions and agency staff and engage with Portland Group, insourcing provider to clear 80 Uro-gynae procedures across 10 weeks.** In addition, elective surgery beds will need to be robustly ringfenced, allowing for the creation of a "hub in a hospital". It is suggested outlying medical patients to surgical wards should be discouraged, recognising outlying increases length of stay. CB said that in terms of the financial work required, the recommended option is supported, recognising the need to work through the financial details. The ERF is the method through which additional work is reimbursed, and the guidance which underpins the process is slow in being forthcoming. Agreement with ESNEFT will be required about where the income lies with any of the activity which takes place at Colchester. It was noted that it was not possible to approve any recommendations without a complete set of data. The financial model with the Dame Clare Marx Centre is not yet clear, and therefore it is difficult to agree a case mix. Broad support from the Board would be helpful, as there is a range of options within the options. It was confirmed that an earlier paper had been presented to the Executive Directors, but financial information is lacking and therefore the Board could not make a decision. As a general point, it was noted that a number of papers presented lack the information needed as a Board to make decisions. **The Board agreed to delegate to the Executive Directors for a decision when financial information is available, and the Board informed (as long as the decision sits within the Executives' delegated authority).**	
4.2	**Finance Report**	
	The Executive Director of Resources, Craig Black (CB) presented the report and drew attention to the deficit plan of £1.4m, with an outturn of £3.5m at the end of the first quarter. There are three key reasons – shortfall on CIP achievement; the pay awards which are estimated will cost £10.9m with a £1.7m shortfall for the year; and the delayed closure of the escalation ward. Additional costs include staffing vacant shifts in a more expensive way and plays into what could happen for the rest of the year. There is a national response to some of the described additional costs which are common to most acute trusts. Within our ICS, WSFT is the only organisation posting an underperformance against plan. Our ICS is significantly outperforming every other ICS, which is important because it drives some of our external conversations, mostly focussed on colleagues within the ICS.	

	It is suggested that the national response will be an adjustment to elective recovery fund targets by 2% which will be played through for April. The ERF target is £2.3m but if the April target is reduced, an additional £1.3m should be received for April. It also depends on how ESNEFT have performed. If the system is over-performing, WSFT should receive extra funding but that has not yet been examined. This does not change the Trust's fundamental position which would still be of concern. To address the financial position, a number of actions are proposed, including the setting up of a Financial Recovery Group, and a resource group that will examine some of the expenditure on workforce. In terms of discussions at Insight Committee, this will focus particularly on the challenge of risk of potential double-count. There should be no double-count between the CIP programme and good financial control. Discussions have taken place with the ICS about the support they can provide in terms of financial resource as well as transformation resource. With regard to the CIP programme, there is still much detail to be worked through, with some concern about what can be achieved this year and what will have to wait until next year. It was noted that there are challenges of having a credible financial recovery plan which is not yet fully in place. Absolute commitment is required from the whole organisation. Staffing levels are being examined to reduce temporary staff spend. It was further noted that this is no more important than any other priority, including our cultural priority which should not be overlooked. Staff numbers are being assessed in some areas but no decisions have been made.	
4.3	**Improvement Committee Report**	
	The Non-Executive Director and Chair of the last meeting of the Improvement Committee, Geraldine O'Sullivan (GO'S) presented the CKIs from the June meeting. There was reasonable assurance that the majority of pressure ulcers are low level. Frailty was also discussed, with opportunities for reductions in length of stay when identified in the Emergency Department. A frailty community pathway was noted as being required.	
4.4	**Quality and Nurse Staffing Report**	
	The Deputy Chief Nurse, Dan Spooner (DS) presented the report, and noted that the period had been reasonably positive. The following points were highlighted: • New budgets are now in place for inpatient nursing staff. A small increase in vacancy rates will be seen. • The winter ward closed in June, which impacts on fill rates and should be reflected in the next report. • Fill rates continue to improve across all of the roles. • Sickness rates are below 5% for the first time in 12 months. It was noted that the improvement is apparent on wards when talking to staff.	

	One of the key indicators is that staff do not like being moved. Staff moves are reducing which improves morale.	
4.4.1	**Quality and Learning Report, including learning from deaths**	
	The Executive Chief Nurse, Sue Wilkinson (SW) presented the report and asked the Board whether the report met their needs. The information is not presented elsewhere. **The Board agreed that the report should be submitted to the Improvement Committee for consideration in the first instance.**	
4.4.2	**Maternity Services Report**	
	The Head of Midwifery, Karen Newbury (KN) presented the report and highlighted the staffing report and the supernumerary position which does not affect last year's or this year's submission for CNST. There is a requirement for a more robust review of the perinatal quality surveillance model from the first Ockenden report, giving the ICB the responsibility to oversee this. Finally, the scorecard and the triangulation with complaints and incidents will be presented at the closed Board meeting due to the inclusion of potential patient identifiable information. Q. Have the number of claims decreased in line with the improvements made? KN said that immediately after a serious incident, patients are assisted with the claims process which ensures more timely claims. However, patients have up to 21 years to make a claim. There are now very few safety recommendations, which indicate that everything is being done to provide safe care.	
4.5	**Audit Committee Report**	
	The Non-Executive Director and Chair of the Audit Committee, Michael Parsons (MP) presented the report, and noted that there were some audits unable to be completed last year. However, there were sufficient for the head of internal audit to give an opinion.	
5.0 GOVERNANCE		
5.1	**Governance Report**	
	The Trust Secretary and Head of Governance, Richard Jones (RJ) presented the report and noted the following points: • Receipt of certification associated with the Annual Report to be noted • The updated report template, for which Board support is requested in order to present information succinctly. **The Board noted the report contents and supported adoption of the updated coversheet template (using '*What, So what and What next*').**	

	It was noted that a correction was required with regard to the Board Development Forward Plan. There was more work to be done and this would be presented at a future meeting.	
5.2	**Board assurance framework**	
	RJ presented the report, and noted the improvement in the process by which individual risks are managed. It was noted that the Board should consider risk appetite, where this is being achieved, and where more work is required. The BAF should be discussed at a Board Development Day when it is ready for review. It was further noted that many of the actions and mitigations end in March and April 2024. It is possible that some need to finish sooner rather than later. This should form part of the refreshing of the full BAF.	
5.3	**Annual Report and Accounts**	
	RJ presented the report to the Board for information and noted that the Annual Report and Accounts had been laid before the Parliament. The auditors were very complimentary about the work of the finance team in this process.	
6.0 OTHER ITEMS		
6.1	**Any Other Business**	
	There was no other business.	
6.2	**Reflections on meeting**	
	• Routine feedback from those who attended the meeting would be useful. • There is a need for each agenda item to keep to time. • Much time was spent on operational issues, at the expense of other items. • The value is in the discussion (papers have been read). • The context of presentations should be understood.	
6.3	**Date of Next Meeting**	
	• 29 September 2023	

RESOLUTION

The Trust board agreed to adopt the following resolution: -
"That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" Section 1 (2), Public Bodies (Admission to Meetings) Act 1960

1.4. Action log and matters arising

To Review

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
3005	Open	26/5/23	2.3	***CEO Report -*** Prioritise a staff story from experience of the emerging incident review meetings (EIRs)	**This has been raised with the engagement and patient safety teams. Aim to provide a suitable staff story later this year. This will include consideration of sharing the experience more widely with staff through video recording.** **Session postponed to December due to availability.**	RJ	01/12/23	Green	
3015	Open	26/5/23	4.4	***Quality and Nurse Staffing Report - Safe Staffing Tool*** - More information on numbers and roles to be provided in the next report.	**Awaiting upgrade of RNA roster templates.**	SW	29/09/23	Green	
3022	Open	21/7/23	2.4	**West Suffolk Alliance and SNEE Integrated Care Board -** Provide report on dementia at a future Board meeting, and provide clear reporting of the benefits achieved through BCF investment.	**Verbal update to be provided at today's (29.9.23) meeting.**	PW	29/09/23	Green	

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
3018	Open	21/7/23	1.3	***Minutes of Previous Meeting - Governors' questions -*** Review and amend answer to question regarding paper on people and culture priorities.	**Minutes amended to reflect discussion at meeting.**	JMO/PS	29/09/23	Complete	29/09/2023
3019	Open	21/7/23	1.5	**Questions from Governors and the public relating to items on the agenda -** ICB meeting dates to be shared with governors.	**Meeting dates shared with governors, together with website link.**	PS	29/09/23	Complete	29/09/2023
3020	Open	21/7/23	2.1	**Strategic Objectives and Delivery Plan -** Review and agree timing for strategy delivery priorities for 2024-25.	**This will be incorporated into the business planned process which is currently being finalised.**	EC	29/09/23	Complete	29/09/23
3021	Open	21/7/23	2.3	**Clinical and Care Strategy** - develop board exposure to end-to-end clinical pathways priorities within the clinical and care pathway.	**Following review with the team future 15-steps programme to be developed to include focus on frailty. This is an area that would cut across pathways for a number of delivery points (ED, AAU, inpatients, community etc) there would be significant opportunity for learning. There will also be an opportunity to include early intervention into this programme.**	RJ	29/09/23	Complete	29/09/23

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

To Note

Presented by Jude Chin

1.6. Patient and Staff Story

1.7. Chief Executive’s report

To inform

Presented by Ewen Cameron

Board of Directors	
Report title:	**CEO Board report**
Agenda item:	1.7
Date of the meeting:	Friday, 29 September 2023
Sponsor/executive lead:	Dr Ewen Cameron, CEO
Report prepared by:	Dr Ewen Cameron, CEO

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

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

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

We are now reaching a pivotal point in the year, where we prepare to say goodbye to the warmer weather and hello to the upcoming autumn and winter period.

We know this autumn and winter, like the ones before it, will bring with it many challenges which we are preparing diligently for. There is the continued British Medical Association junior doctor and consultant industrial action, a rise in the prevalence of the new BA.2.86 Covid-19 variant, as well as the increased risk of flu within our communities, patients and staff.

There have also been other concerns, such as the widespread impact of reinforced autoclaved aerated concrete across the public sector estate which we ourselves have been managing since 2019 and the recent conclusion of Lucy Letby's trial.

While I will go into more detail on these issues in this paper, I would first like to highlight some of the positive developments which are happening across our Trust.

On Monday, 4 September, we opened our Council of Governors election for nominations. This is an opportunity for the public and our colleagues to become involved in the running of their local NHS Trust and represent the views of patients, families, carers, staff and the wider community.

Our governors have important roles and responsibilities and work closely with the Board to help inform important decisions, as well as consult on the services we offer. Our Foundation Trust members can put themselves forward for consideration to be a governor or vote to choose who they want to represent their views. If you are not already a member then please join. It is free of charge. Please head to the Council of Governors section of our website and complete the short form.

We also had our Annual Members' Meeting on Tuesday, 26 September at the Apex in Bury St Edmunds. This event provided our members and local community with more of an understanding about how we're doing and the chance to learn more about child development from our expert consultant community paediatrician, Dr Ankit Mathur. It was fantastic to see so many people there and I would like to thank all those involved in this event and those who represented our local health and social care partners in the marketplace.

I recently had the pleasure of being a judge in this year's My WiSH Charity Soapbox Challenge, alongside Sarah Lilley of BBC Radio Suffolk and Chloe Ludkin of the headline sponsors, Treatt. This event saw 14 teams tackle the course down Mount Road in Bury St Edmunds. I would like to congratulate all the teams who took the time and effort to enter the race and for all those who donated and helped raise an incredible £23,178. This funding means the charity can continue helping us improve the quality and safety of the care we provide as well as supporting staff. One amazing recent example of the work they do is the Butterfly Garden at West Suffolk Hospital for our end-of-life patients, which opened on Monday, 11 September. This facility will make all the difference to those who are experiencing end-of-life care and their loved ones.

Performance

Now that we know the BA.2.86 Covid-19 variant, otherwise known as 'pirola', is circulating more widely in our communities, we have decided to begin our autumn vaccination campaign earlier than planned. By offering all colleagues the Covid-19 and flu vaccines sooner, we will give our staff greater protection against these illnesses which affect our workforce during the autumn and winter period. While these are not mandatory, we are encouraging all our colleagues, as well as those eligible in our communities, to come forward for their vaccines to help reduce transmission and protect themselves and others.

While we are working very hard to clear our waiting lists, we have been impacted by the ongoing industrial action. At the end of August, there were 57 patients waiting more than 78 weeks. Looking forward to our goal of significantly reducing those waiting more than 65 weeks by March 2024, at the end of August, there were 566 patients in this bracket. I would like to reassure our longest-waiting patients that we are working incredibly hard to see you as quickly as possible.

Following my last update on our financial position in July, we have continued to see rising inflation and the ongoing prominence of factors such as industrial action and the underfunded pay awards, which affect the amount of money we spend on providing our services.

As such, we have seen an increase in the financial deficit we are currently forecasting for the end of this financial year. We are working incredibly hard to improve this position over the coming months and are working on a Trust-wide financial recovery plan. This includes focusing on excess staffing costs and delivering our £10.6 million cost improvement programme, which will be outlined in more detail at this Board meeting.

Quality and safety

Many of you will have seen the recent outcome of the Lucy Letby trial. We have been shocked and appalled by this case and I would like to reassure parents and families about the high quality and safe care we provide in our neonatal services. We take speaking up incredibly seriously and will work to implement the recommendations from the inquiry at the earliest opportunity.

The quality and safety of the care we provide is something we are always looking to improve. Whether that be through improving the mechanisms and procedures we have in place or by training or upskilling our staff.

A perfect example of this was our own Deteriorating Patients Week, which was held from 11 to 15 September, culminating in our Patient Safety Summit on Friday, 15 September. These events enabled us to draw attention to the processes and initiatives we are working on which will help us continually improve the care we provide. During the week our patient safety team visited different wards and areas of our Trust to educate colleagues on the theme of incident reporting and staff feedback and ideas. I am glad that the summit proved to be successful, with staff from different areas of our Trust attending the various talks throughout the day.

Many of you will have seen the recent media coverage in relation to RAAC, and its prevalence across the wider public sector estate. Since finding out about this risk in 2019, we have been open and honest with staff and public alike that our West Suffolk Hospital, and other buildings on the site, are made of this material. We acted swiftly and decisively to assess and then mitigate this risk, starting by mapping every RAAC plank across the Trust and then beginning a rolling programme of monitoring and surveillance, using industry approved methods and technology. We are undertaking an extensive estates maintenance programme and are making excellent progress in these planned works. So far, precautionary measures have been installed across the majority of roof planks. Currently 82% of these planks have ‘failsafe supports’ in place, which provide a support mechanism should there be a plank failure. In addition, we have also now fitted zinc anodes into 100% of our wall panels, which will prevent further deterioration for approximately 10 years.

Additionally, we have worked closely with industry experts, and in 2021 we commissioned Loughborough University, on behalf of other partners, to carry out further research into RAAC to advance understanding and share wider learning.

From the outset we have worked incredibly hard to make sure our West Suffolk Hospital site is as safe as possible for staff working in or patients or visitors coming into the hospital.

The work we have undertaken, which is due to finish next year, will make sure our West Suffolk Hospital remains operational until we can move into our new healthcare facility on Hardwick Manor in Bury St Edmunds by 2030.

I have so far visited more than 90 teams working in various clinical and non-clinical roles at our Trust and from this I know that our workforce consists of truly talented and dedicated people. One team that I have spoken of before is our brilliant stroke team at West Suffolk Hospital. I was delighted to say that they have been nominated for an HSJ award in the category of ‘data to drive and improve patient care and outcomes’. The project behind this nomination showcases how we continue to use digital excellence to improve patient care by harnessing the data we have at our

disposal in real time to ensure we deliver the highest quality and safest care we can. Congratulations to all those involved in this project, and I wish you the best of luck for November when the winners are announced.

Workforce

As I have outlined since assuming this position, I take speaking up incredibly seriously. It has the power to ensure we can learn and improve when things don't go as planned and can help prevent situations from occurring in the first place. Amanda Bennett has been our Trust's Freedom to Speak Up Guardian for the last three years and has done and incredible job to improve our psychological safety - helping our staff feel supported to bring issues to our attention and raising awareness of this as a core part of how we operate as an organisation.

Due to the nature of this position being for three-year tenures, Amanda has now left us and we can now introduce our very own Jane Sharland as our new Guardian. Jane has many years of NHS experience behind her, working as an occupational therapist and now as the lead of the Newmarket integrated neighbourhood team. I, and the Board, look forward to working with Jane to help further embedding speaking up as a core pillar of our Trust culture and I wish her every success as she takes on this new role.

We have recently seen the first strike period where BMA junior doctors and consultants have taken strike action at the same time. There is also a further three-day period on Monday 2, Tuesday 3 and Wednesday 4 of October where these staff groups are taking strike action together. As we have done for every strike period over the past 10 months, we are undertaking extensive planning to ensure we provide safe care during this time. However, due to the pressure these strikes will put on our services, I am asking the public to help us by using our services wisely and taking steps to avoid putting yourselves at undue risk of injury.

While our emergency department will remain open throughout this period, and you should continue to come forward in an emergency or life-threatening situation, we will be seeing patients based on clinical need and therefore, those with minor injuries or illnesses may experience a longer wait than usual. I am encouraging you during these days to contact your GP, visit NHS 111 or utilise your local pharmacist where appropriate, such as for minor cuts and bruises or where over-the-counter medicines and treatments will meet your needs.

Should your appointment or procedure have to be postponed over these days, we will contact you. If you have not been contacted, please attend as planned. We know that any postponement is worrying, and we will be in contact with you to rearrange this at the earliest opportunity. Where possible and based on clinical need, we will bring as many appointments and procedures forward as possible to ensure our patients receive the care they need.

While I hope the BMA and the government can reach an agreement soon so that we can put all our focus on improving our services, I absolutely support our colleagues' legal right to take strike action, and I hope you understand that anyone working in the NHS taking strike action has not made this decision easily.

Looking to the future

We are continuing to make progress on our plans to deliver a new healthcare facility on Hardwick Manor in Bury St Edmunds by 2030. We know that despite the mitigations we have put in place to ensure our West Suffolk Hospital can continue to be operational until we can move into this new facility, we must deliver this as soon as possible. As a designated priority Trust under the Government's New Hospital Programme, we are in a good place to do this, having already made significant headway by securing outline planning permission in November last year and by progressing through our outline business case. We have recently been visited by Lord Markham, the minister responsible for the New Hospital Programme, and our discussions with him and the NHP team mean we feel confident that we will meet our ambitions.

We know though, that as an integrated Trust we must ensure we manage and make improvements to all our sites. We have recently been renovating Glemsford Surgery to improve the disabled access, as well as the facilities at the surgery to make this a better environment to receive care.

We have also made significant progress on our plans to deliver a Community Diagnostic Centre (CDC) at Newmarket Community Hospital by next Spring. We are now at the point where we are demolishing the existing structure and I look forward to bringing you further updates as this project progresses. This facility will help us to provide quicker access for patients to a range of tests and support us in decreasing waiting times.

1.8. Reflection of Letby Case

To inform

Presented by Ewen Cameron

Board of Directors	
Report title:	**Verdict in the case of Lucy Letby**
Agenda item:	1.8
Date of the meeting:	29th September 2023
Sponsor/executive lead:	Ewen Cameron, Chief Executive Officer
Report prepared by:	Claire Sorenson, Carol Steed, Dr Patricia Mills, Dr Marcia Schofield, Cassia Nice, Lucy Winstanley, Ewen Cameron

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

Executive Summary

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

In the aftermath of the verdict in the case of Lucy Letby (accepting that it is unlikely that we will truly understand what happened until the public inquiry has reported), it is important to assess the degree to which structures and culture mitigate the risk of another significant event here at West Suffolk Foundation Trust (WSFT). The arrangements around speaking up, mortality oversight, Medical Examiner Officer, incident monitoring, results management and review, grievances and complaints are laid out.

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

There are a broad range of mitigations in place at WSFT to reduce the risk of a significant event of this type.

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

Ongoing work is required to further develop speaking up, mortality oversight and results management and review through current governance arrangements. We will need to consider and respond to the findings of a public inquiry when this is published. This will be important in understand all of the contributory factors to the case and mitigations required.

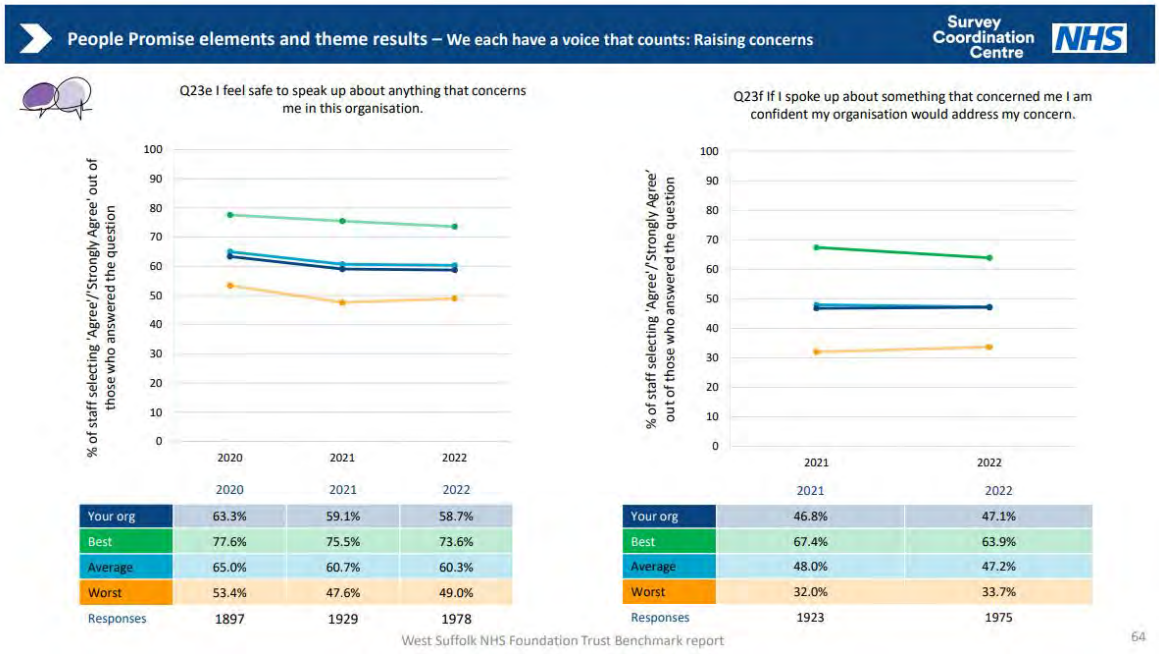
Action Required

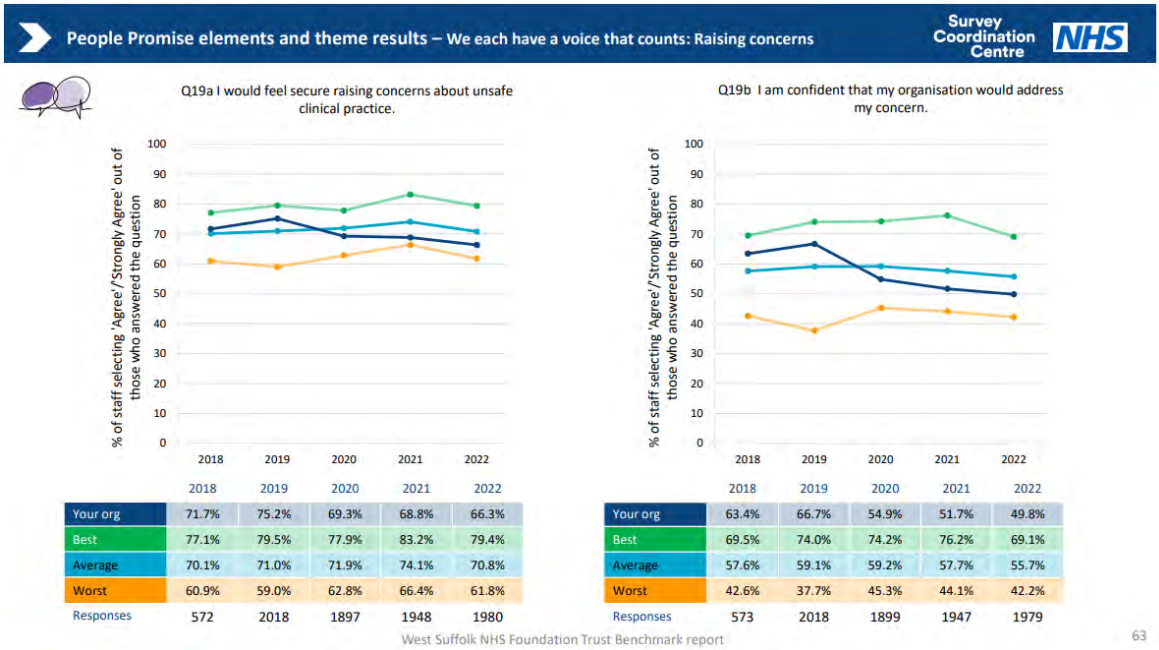
Note and discuss paper.

Risk and assurance:	BAF 1 and 2
Equality, Diversity and Inclusion:	N/A
Sustainability:	N/A
Legal and regulatory context	NHSE letter “Verdict in the trial of Lucy Letby” 18th August 2023.

Verdict in the case of Lucy Letby

1.	**Introduction**
1.1	In the aftermath of the verdict in the case of Lucy Letby in August, there are many unanswered questions about what allowed her to continue to murder and how to prevent something similar happening in the future. It is unlikely that we will truly understand what happened until the public inquiry report is published. However, there is an understandable degree of concern about whether structures and culture within other NHS organisations mitigate the risk of another significant event. Indeed, it is under 2 years since the publication of the West Suffolk review where some of the factors that appear to have existed at the Countess of Chester contributed to those events. The current mechanisms within the Trust which might mitigate against what is currently known about the case are laid out below for information and discussion.
2.	**Mitigations**
2.1	**Speaking up** The WSFT Board has acknowledged its fundamental responsibility to nurture a culture of speaking up, where concerns are appreciated and welcomed. It recently refreshed its pledge in relation to this, as follows: *"The development of a culture where all colleagues feel confident to speak up and share concerns at work is crucially important to us, where everyone has a voice that counts. We affirm its direct impact on a culture of safety with positive benefits for patient care, quality and staff experience and engagement. It is important to us that everyone feels safe to speak up. Speaking up to us is a gift because it helps us identify opportunities for improvement that we might not otherwise know about. We will not tolerate anyone being prevented or deterred from speaking up or being mistreated because they have spoken up. As a Board we value our relationship with the role of Freedom to Speak Up Guardian, particularly as it enables the sharing of themes or learning where we can take action to protect the interests of patients, colleagues, and the wider organisation".* The Board has previously acknowledged the significant leadership failings that took place in the period 2017-2019, encapsulated within the 'West Suffolk Review'. In addition to the shortcomings and failings identified in the specific events, there has doubtless been an impact on the broader attitudes towards speaking up in the organisation. This is demonstrated in the national staff survey data whereby WSFT scores lie below the national average, whereas many other scores for WSFT are better than the national average.





Various actions have been taken as part of our organisational development and culture plan. We have a network of over 50 Freedom to speak up (FTSU) champions who link to our FTSU Guardian (FTSUG). Over the past 3 years the Trust has been working hard to improve the speak up culture, which includes making sure people know how to speak up, leaders listen, and action is taken. Speak up training is now mandatory so all employees should know how to access the FTSUG and that speaking up is welcomed. There are posters throughout the Trust and regular communications highlight the importance of speaking up. Clinical concerns raised via the FTSUG will be escalated either to the chief and deputy chief nurse or medical director, all of whom are very responsive, often responding the same day and ensuring that matters are followed up.

It is mandatory that managers band 7 and above undertake the Listen Up training, helping to make speaking up to managers more accessible and available.

Concerns are monitored by the FTSUG and, in the rare case where it is felt that there is insufficient progress in acting on any concern, this will be escalated to Jeremy Over, Director of Workforce and Communications or Antoinette Jackson, as the named respective executive and non-executive director responsible for FTSU.

	Regular meetings are scheduled between the FTSUG, patient safety teams and PALS to identity common themes which will then be escalated to board members when necessary. A key element to enabling staff to speak up is to create an environment where they feel safe to do so. At WSFT we are introducing a new suite of leadership development programmes open to all staff to enhance our leadership behaviours and practices at all levels. A key strand running through these programmes includes creating an open and trusting environment through understanding psychological safety and implementing coaching-based approaches. We recognise that leaders play a vital role in making sure the concerns of colleagues are listened to and acted upon. Alongside this we are introducing coaching training, with the aim of creating an internal coaching pool that can provide support to colleagues across the Trust. As well as expanding learning and expertise around coaching approaches, this will also provide a vehicle through which individuals can seek support and have their voices heard. From October 2023 we are also introducing coaching for neurodiversity. This aims to increase understanding of working with colleagues who live with neurodivergent conditions. It can be the case that some of these colleagues do not always feel heard so it is hoped that this development will enhance shared understanding and allow more meaningful and open conversations to take place.
2.2	**The Mortality Oversight Group (MOG)** The purpose of this group is to ensure that WSFT learns from and acts upon the quality of care provided to people who die whilst in our care. This is achieved by ensuring that all deaths that meet the requirement for a Structured Judgement Review (SJR) under National and Local priorities have a review completed in a timely fashion by a trained clinical reviewer. Deaths that are categorised as poor or very poor care are then discussed by the SJR review team comprised of senior clinical staff who will make a collective judgement about preventability and complete a Datix to trigger discussion at the Emerging Incident Review meeting. The SJR findings are fed back to clinical teams for discussion at morbidity and mortality meetings. A mortality database is populated with the SJR and the results of morbidity and mortality meeting discussion. MOG reports to the Patient Quality and Safety Group quarterly outlining any areas of key concern or matters for escalation. MOG receives reports from the: • Medical Examiners Service. • Learning from Deaths Team. • Summary Hospital Mortality Indicator (SHMI) which reports mortality at Trust level across NHSE in the form of a ratio of the actual number of patients that die following hospitalisation and the expected number based on average England figures. • Inquest Team which reviews all coronial inquest requests and statements prepared for the coroner. • Patient Experience Team, any complaint received following the death of a patient triggers an SJR and a summary of care is provided to the team to assist with a response. • End of Life Group. The LFD report is discussed and reviewed on a monthly basis. Data included is: • Number of deaths o Total deaths o ED deaths o Elective admission deaths o Maternal o Paediatric deaths

	• Deaths in scope for SJR review • SJR review outcomes (excellent/ good/ adequate/ poor/very poor) • Problems in care (reported for each phase of care) • Deaths for patient safety review (PSII, PSR, AAR) • Preventable deaths • Deaths subject to Inquest • Complaints where death has occurred • Themes occurring from speciality mortality meetings • Summary Level Hospital Index (SHMI) As part of this review, we have identified some opportunities for process improvement within this strand of work.
2.3	**Medical Examiner Officer** The medical examiner system was established in response to the Shipman enquiry. The system is designed to scrutinise and review the cause of death in every hospital patient and to ensure causes of death are recorded accurately; cases are referred to the Coroner if required and to act on relatives' concerns regarding cause of death. The medical examiner system is hosted by an NHS Trust, but separate and independent. Hospital deaths are notified to the Trust's Mortuary and Bereavement team who then notify the medical examiner officers, who carry out the initial scrutiny and register the patient onto our Eden database - these remain the property of the medical examiner's service and are not available on eCare. The medical examiner of the day scrutinises that day's cases and contacts the member of the patient's medical team who is able to complete the death certificate. Any concerns about the death or cause of death such as unexpected deaths are discussed and hospital postmortems can be requested. The team have, on occasion, also discussed concerns with the wider MDT when a member (such as a physio or nurse) has raised a concern. Once all parties agree on cause of death, the medical certificate for the certification of the death can be issued. However, if the Registrar has concerns (such as believing the case should be investigated by a coroner), he or she will independently refer the case to the Coroner's Office. If no consensus can be reached as to the cause of death; or the case has features that require notification to HM Coroner (such as significant trauma; death while under Section of the mental health act; or the patient fulfils the criteria for mandatory referral such as industrial injury), the medical examiner officer and team assist the relevant doctor in completing a coroner's referral. The medical examiner's scrutiny of the case is also added to the coroner's referral for further information; and both the medical team and medical examiner are available to speak to the coroner for further information prior to or during an inquest. The Medical Examiner's office presents a monthly report summarising the activity of the service at MOG. The office can also refer cases for further scrutiny by a medical reviewer if there are concerns raised by the relatives regarding care or treatment. Additionally, subject to discretion, the office can make these available to doctors in the Trust for the purposes of review; and via freedom of Information requests (FOI) to relatives, if asked. The system is designed to identify unexpected clusters and suspicious deaths. The Trust's medical examiner service has the distinction of have a 100% record of scrutinising deaths - unlike most other Trusts.
2.4	**Incident monitoring** All staff are asked to report patient safety incidents where something unintended or unexpected happens during the provision of healthcare via our local risk management system – Datix. All

	incidents reported are reviewed daily by the patient safety manager, who assesses the grading and considers whether any immediate safety mitigation is required. The manager reports incidents of note to the daily safety huddle. WSFT has been an early adopter of the patient safety incident response framework (PSIRF) since February 2021 (a national directive led by NHSE). Organisations who operate under this framework respond to patient safety incidents for the purpose of learning and improvement. We produce a plan, our PSIRP - which sets out our top patient safety risks for the purpose of conducting comprehensive system-based investigation (PSII). There are also national criteria for PSII such as deaths which are thought more likely than not due to problems in care. Any incidents reported as major or catastrophic are presented to the weekly Emerging Incident Review meeting for discussion together with any incident of any harm severity, considered to meet one of our PSII categories. The members decide the most proportionate learning response, confirm harm grading to ensure robust governance, allocation of duty of candour and staff support and well-being. Where there is concern regarding individual staff performance this is referred to HR. The output of the meeting is presented at Board level. We actively encourage reporting of incidents. Where this is not possible the patient safety team are there to support staff who have a concern either via our monthly patient safety drop-in session, directing staff to freedom to speak up or assisting staff to report incidents.
2.5	**Results Management and Review** A Results Management Task and Finish Group was established in early 2023 to address issues that have been identified by clinical staff, IT and the patient safety team. The recurrent themes related to: • Results endorsement in ED (large volume of results is often unmanageable and, where patients are admitted, there is potential duplication of effort in reviewing results). • No standardised practice for ordering and reviewing results amongst specialities. • Differences in results view in both PACS and the 'Trust Integrated Engine' (the TIE). As the project has progressed additional safety concerns have been identified from patient safety investigations. The initial project of completing a document that outlines the current workflow and management within eCare is complete and has been circulated to members of the Senior Medical Leadership Team for their input prior to the next stages which are: • To identify, agree and approve any 'quick wins' related to results management workflows. • To oversee and produce a trust wide SOP outlining expectations regarding the management and endorsement of results. • To contribute, review and approve the results management SOP. • To work collaboratively with WSFT Digital colleagues to establish a time frame for completing practical work related to the points above and explore the 'possible'. • To work collaboratively with WSFT Communications team colleagues to produce, review and approve a comms plan to support the implementation following approval/implementation. • To monitor and evaluate uptake of any newly implemented procedures related to results management. There remains a gap in having assurance that all clinical results are seen and acted on.
2.6	**Grievances** We recognise that disagreements, and at times conflict in the workplace, may occur and in the event that this does happen, colleagues and managers are supported to work together to resolve any disagreements and conflicts constructively, at the earliest opportunity, only resorting to formal procedures where resolution cannot be achieved informally. Our Resolution policy and procedure supports our commitment to promoting and ensuring a safe working environment and good working relationships, where individuals are treated with compassion, respect and courtesy and there is a positive impact on colleague wellbeing and engagement. Our focus is on resolution, and where possible early resolution, providing

	opportunity to resolve issues amicably, maintaining, and where necessary, restoring good relations; we do expect all parties to co-operate constructively in resolving matters.
2.7	**Complaints** There are a number of ways for people to raise concerns or provide feedback about care, services or facilities, including: • Feedback surveys (over 2000 are returned each month in real-time). • The Patient Advice & Liaison Service (PALS) which operates Monday-Friday with several officers manning the telephone line, a member of staff available in person at West Suffolk Hospital, and an email address and answerphone service available 24/7. In person meetings can also be facilitated at other locations or in the person's own environment. • Formal complaints which can be raised via PALS, in writing, via email and with reasonable adjustments where required. • Engagement events – the West Suffolk team attend many local groups and events to speak to the people of Suffolk about their concerns, feedback and suggestions. • The Clinical Helpline Service, which is manned by a team of registered nurses 7 days a week, covering all adult inpatient wards and linking closely with frontline staff and leadership teams. The team frequently speak with hundreds of family members each day allowing opportunity for concerns to be raised and resolved. They also provide follow-up wellbeing calls to patients post-discharge to provide support, advice and signposting. Furthermore, the Clinical Helpline is in the process of conducting an initiative 'Call4Concern' alongside the patient safety and outreach teams, which enables family members to escalate their concerns immediately if they feel that their loved one has deteriorated and they are not being listened to. This enables a mechanism for outreach staff to review these patients promptly and take relative concerns seriously when they are flagging that something is not right. • VOICE network is our community of local groups, organisations, partners, clubs and representatives within Suffolk who have a direct link with us surrounding all things health and care. VOICE hold local intelligence about the needs of our community, including the ability to escalate concerns or feedback which may arise. Our Maternity and Neonatal Voices Partnership (MNVP) work closely within the maternity and neonatal services to represent parents and families, as well as feeding into our VOICE network. • Foundation Trust Governors represent the public and can raise concerns on behalf of patients and families. • Social media activity is quickly flagged to the patient experience team via Communications and users advised to contact PALS with contact details included, enabling us to appropriately investigate issues raised. We also work closely with Healthwatch Suffolk to act on feedback received and ensure recommendations are acted upon. Healthwatch Suffolk run regular feedback sessions across the services we provide, speaking directly with patients and members of the public. Individual cases are flagged and investigated with the leadership teams within the relevant areas and associated actions recorded and monitored. As well as individual case management, thematical analysis of the various feedback channels is conducted and reported via divisional board meetings, the Experience of Care and Engagement Committee, Involvement Committee and to Trust Board. The Patient Experience and Engagement Team have regular review meetings to discuss performance, themes and outcomes/learning. Improvement projects are monitored and reported on to address and mitigate trends in the concerns raised by ensuring learning.
3.	**Conclusion**
3.1	Whilst it is impossible to be completely certain that events such as these could not happen here, there are a range of safeguards in place, many of which were not in place in 2015. There is a continued need for further work, including on speaking up, mortality oversight and results acknowledgement.

	We will also need to consider and respond to the findings of a public inquiry when this is published. This will be important in understand all of the contributory factors to the case and mitigations required.
4.	**Recommendations**
	Note and discuss the report.

2. STRATEGY

2.1. Strategic Objectives & Delivery Plan - Progress Report

To Assure

Presented by Ewen Cameron

Board of Directors	
Report title:	**Strategic priority progress report**
Agenda item:	2.1
Date of the meeting:	29 September 2023
Sponsor/executive lead:	Ewen Cameron, CEO
Report prepared by:	Ewen Cameron, CEO Executive, clinical and operational leads

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

Executive Summary
WHAT? *Summary of issue, including evaluation of the validity the data/information*
At its meeting in July the Board approved strategic priorities relating to: • Delivery of **service pathway changes** as laid out in the Clinical and Care Strategy (Exec lead – PM) • A strong priority on **Equality, Diversity and Inclusion** to address the disparity between different groups where the evidence shows that staff are disadvantaged or feel discriminated against (Exec lead – JMO) • A large focus on **line management development** given the feedback from What Matters To You 2, the National Staff Survey and the Freedom to Speak Up Champions alongside the impact this would have on a large portion of the organisation (Exec lead – JMO) • A step change in delivery on **prevention and proactive care** given the modelled demand projections and the explicit need for this to support the Future Systems Programme (Exec lead – PM) • Development of **transformation capacity and capability** given the scale of change required for both business-as-usual challenges and to support the Future Systems Programme (Exec lead – NC)
SO WHAT? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*
This report summaries progress against each of these priorities and describes risks and deliverables (milestones) for the next two months.
WHAT NEXT? *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*
The executive, clinical and operational leads will continue to focus on delivery against the priorities and provide updates to the Board. As part of business planning for 2024-25 consideration will be given to any review and update of these priorities.
Action Required
To note the report and next steps.

Risk and assurance:	Supporting prioritisation and delivery of our strategy
Equality, Diversity and Inclusion:	Maintain focus and awareness of EDI issues
Sustainability:	No decisions negatively impacting on sustainability
Legal and regulatory context	Supporting prioritisation and delivery of regulatory requirements

Strategic priorities 2023/24
Progress report – September 2023

First for Patients - Delivery of service pathway changes as laid out in the Clinical and Care Strategy			
Action	Activities/progress in last 2 months	For the next 2 months: - Key risks - Deliverables / milestones	Measures of success
Plan and deliver against the priority areas for service pathway change *Exec. lead – Paul Molyneux* *Operational delivery lead: Alex Baldwin*	**Frailty -** Initial plan for an integrated frailty hub is being developed. This will include a test and learn pilot of a community tactical hub. Additional focus has turned to increasing medical support to the community model. Working with SNEE to develop WS frailty community review. **Virtual ward -** Support to virtual ward has focused on agreeing a rollout plan for clinical pathways to ensure delivery of stated ambition and in support for developing a transition plan to move the service to the community division. **Early intervention -** Development of Urgent Community Response (UCR) strategy as driver for increased service provision and service development. Specific objectives agreed to increase service provision by 10% to support patients staying in their usual place of residence through crisis management via UCR teams. **CYP services -** Heads of terms have been agreed with for review of Childrens and Young Peoples services. This will include recommendations for service	**Frailty -** Focus in the next 2 months will be on wrap around support from social, voluntary care and care home market and end of life pathways to ensure appropriate interface and integration plans. **Virtual ward -** Ongoing development of impact assessment for virtual ward project (beyond simple capacity metrics) and continued development of transition plan via co-produced planning events. **Early intervention -** Continued support to the EIT and community teams to deliver the recommendations identified in the UCR strategy. **CYP services -** Proposal to be presented to SLT for information and review. Recommendations to be managed via divisional PRM and exec meetings. It is expected that	• Frailty – deliver integrated frailty model leading to 10% reduction in falls and frailty related admissions by March 2024. • Virtual ward – to deliver 103 virtual beds by March 2024. • Early intervention – increased service provision up to 7 day, 24hr service by March 2024. • Work to bring community and hospital services for children and young people closer together for the benefit of families using our services • Pilot of 15 session weeks – piloted in 1 surgical specialty (electives and OPD) by March 2024. • Agreed 3-5 year project plan for delivery of transformation by March 2024.

	improvement, implementation of previous review recommendations (such as the rethink review) and direction on any changes to service structures. **15 session weeks -** Agreement for pilot in T&O has been reached with further detailed planning ongoing. Continued negotiation is taking place with additional specialities to for a series of test and learn pilots. **Transformation plan -** Initial planning day has been held with project plan for 24-30 in early draft form.	within 2 months a clear proposal for the management of CYP will have been agreed. **15 session weeks -** Continued detailed planning for multiple specialty pilots across all points of delivery. Key risk is ongoing industrial action and financial pressures. **Transformation plan -** Draft plan to be socialised with execs and divisional leads before final plan signed off. This is expected in Q4.	
Collaborate to provide seamless care at the right time and in the right place for end-of-life patients *Exec. lead – Sue Wilkinson* *Clinical delivery lead: Mary McGregor Operational delivery lead: Sharon Basson*	• Model of Care – Scoping exercise to Identify gaps and opportunities undertaken and shared with Live Well Domain and wider contacts, including UCR and Frailty workstream leads, INTs, LTC Specialists, Care Market and Virtual Ward • Continue to roll out ReSPECT across trust and community • Sourcing a solution to identification of people in their last year of life – request to BI for required reports through Die well domain	**Key risks** • Funding not available to roll out the compassionate communities work in west Suffolk or the text messaging feedback service • Funding for HEST service non recurrent and no longer available **Priorities for next 2 months** • Model of Care – Identify focus groups for key themes with regard to gaps and opportunities and start to implement positive change • Provision and interpretation of BI data reports to support Identification of people in their last 12 months of life (including Palliative Care register on SystmOne to help identify palliative care case load	• Advanced care plans in place for 50% of patients at the end of life by March 2024 • Virtual ward effectively utilised – end of life pathway in place and capacity to deliver by March 2024 • 70% of patients die in their preferred place of choice by March 2024 • 10% reduction in admissions within 48 hours of end of life by March 2024 • 24/7 support for end of life patients and their relatives/ carers is available by March 2024 • ReSPECT is in use 100% by March 2024

First for Staff - Delivery of service pathway changes as laid out in the Clinical and Care Strategy			
Action	Activities/progress in last 2 months	For the next 2 months: - Key risks - Deliverables / milestones	Measures of success
Equality, Diversity and Inclusion *Exec. lead – Jeremy Over*	• Inclusive Leadership Charter and Anti-racism pledge actions all integrated into the Inclusion workplan, with assigned action owners • All concerns actioned by FTSU Guardian • Framework for reasonable adjustments in draft form being socialised and enhanced with stakeholders • National EDI improvement plan actions integrated into the Inclusion workplan, with assigned action owners	• Continued tracking and delivery of the Inclusion workplan through workstream owners • New FTSU Guardian to continue review and evaluation work • Continue development of reasonable adjustments framework, including highlighting process and funding changes needed to appropriate committees/forums **Risks**: • Prioritisation of actions (especially EDI) alongside operational pressures • The potential need for systemic changes to enable a robust Trust wide approach to reasonable adjustments in line with our public sector duty	• Prepare to deliver against the Inclusive Leadership and Anti-racism pledge by March 2024 • Action taken with feedback and learning for all EDI-related speak up concerns and reports of harassment, bullying, discrimination or abuse by March 2024 • Framework & guidance for reasonable adjustments published by March '24 • National EDI improvement plan measures
Line management development *Exec. lead – Jeremy Over*	• Line management data analysis underway, alongside gathering of examples of enhanced organisational practice (e.g. ED) • Initial discussions held at the New Ways of Working Group on process and method to be implemented • Coaching and mentoring framework drafted • Learning Hub in testing phase with variety of stakeholder groups pre-launch • Three leadership development programmes launched September 2023 • HRBP's working with divisions to improve appraisal rates. Full review of appraisal process and paperwork underway by OD Lead	• Continued work on scrutinising data and models of best practice (internal and external) for line management span of control • Implementation of stakeholder engagement approach to develop values-based line management standards • Agreement and launch of coaching and mentoring framework and the Learning Hub • Launch of further learning and development portfolio elements to support line managers **Risks**: • Time for key stakeholders to effectively engage in line management span of control and values-based leadership work • Time to learn – the impact of leadership development interventions is dependant on individuals having time to learn and reflect • Budget risks linked to supporting L&D delivery	• No line manager with more than an agreed number of direct reports by March 2024 • Values-based line management standards agreed and published by December 2023 • Coaching and mentoring framework agreed by September 2023 • Learning Hub launched by September 2023 • Line manager development package published and in delivery by December 2023 • Appraisal completion rates at 90% by December 2023 • Improvement in staff survey indicators (longer-term)

First for the Future - Delivery on prevention and proactive care			
Action	Activities/progress in last 2 months	For the next 2 months: - Key risks - Deliverables / milestones	Measures of success
Launch the WSFT Prevention, health inequalities and personalised care strategy by 31st August 2023 Train colleagues in prevention, health inequalities or personalised care by 31st March 2024. *Exec. lead – Paul Molyneux* *Clinical delivery lead: Helena Jopling*	The prevention, health inequalities and personalised care strategy is complete. Board presentation previously scheduled for 29th September has been postponed to 1st December to allow for a board development session on 2nd November. A list of quality-assured in-house and external training courses is available to the internal audience on the intranet https://www.staff.wsh.nhs.uk/corporate/public-health/training-and-support-public-health 262 colleagues have received face-to-face training. We will be able to start reporting online training too from next month.	No risks escalated. The recommended training will be organised into a curriculum linked to the NHS Knowledge and Skills Framework. Promotion campaign for trust colleagues. Discussion with the Alliance Live Well Workforce enabler team about promotion to alliance partners and incorporation into the joint training offer.	• Prevention, health inequalities and personalised care strategy is approved by the board and published on the trust website • 1,000 colleagues trained in prevention, health inequalities or personalised care

Action	**Activities/progress in last 2 months**	**For the next 2 months:** - **Key risks** - **Deliverables / milestones**	**Measures of success**
Continue and expand the inpatient tobacco dependence service, supporting 350 people to stop smoking by March 2024, 40% of whom will live in the most deprived areas *Exec. lead – Paul Molyneux* *Clinical delivery lead: Jessica Hulbert*	The ICB have funded another year for the tobacco dependence team up to February 2025. From April 2023 – August 2023, the team have received referrals for 210 inpatient smokers (chart overleaf), 169 of which have been discharged (discharge date = quit date). • 108 made a quit attempt • 37 received very brief advice only (VBA), mostly opting out of additional support • 15 received support for temporary abstinence whilst an inpatient • 9 were unable to be directly supported e.g., medical condition • 31.1% of people have been from the 40% most deprived areas.	There are risks in availability of community stop smoking services. This is causing difficulties for patients accessing support and nicotine replacement therapy (NRT) when they leave hospital. This also means there is no supported vape option available in Suffolk currently. A new service, Feel Good Suffolk is due to commence 1st October 2023. We currently do not know how much community stop smoking provision will be available from this time. These problems do not affect maternity patients as they are on a different pathway to inpatients.	• Number of people who successfully quit for 4 weeks • Percentage of people who successfully quit who live in the 40% most deprived lower super output areas

First for the Future - Develop and expand our transformation capacity and capability			
Action	Activities/progress in last 2 months	For the next 2 months: - Key risks - Deliverables / milestones	Measures of success
Review the structure and capacity of the change hub *Exec. lead – Nicola Cottington* *Operational delivery lead: Matt Keeling*	• West Suffolk Change Hub created from April 2023 with four central change and transformation pillars: Operational Improvement, Programme Management Office, Performance & Efficiency and Quality Improvement. • Wider membership of the Hub including Divisional Project Managers, Digital, Clinical Governance, etc. provides an interface across all Trust and Alliance change programmes, through a Programme Board reporting into the Senior Leadership Team (SLT) Committee. • Future Systems Clinical & Care Strategy added as a fifth pillar to provide a governance and delivery route for this in summer 2023. • An aligned programme of work defined with delivery and impact measured through a 'One Plan' and highlight reporting process. • Assessment of the NHS Impact methodology undertaken with consideration given to how this could benefit the Change Hub. • Options for strategic leadership of function considered at Executive meeting in September 2023 with recommendation to be presented at renumeration committee	**Key risks** • Change Hub central pillars have rapidly become oversubscribed with multiple sets of competing priorities that cannot all be resourced. • Full homogenisation of disparate programmes of work with differing strategic aims, delivery methodologies and intensity of governance structures is challenging – a 'one size fits all' approach wouldn't work but alignment is where the greatest opportunity sits. • Delivery chains, metrics and benefits are not always clear and will need further refinement and mapping alongside delivery. **Deliverables / milestones** • 6-month review of the structure and function of the West Suffolk Change Hub underway and will be presented at SLT in October 2023. • Pillar, programme and workstream specific metrics, milestones and benefits will continue to be monitored monthly. • A draft set of 2024/25 programmes in each pillar aligned to ICB, Alliance and WSFT priorities, with a focus on the Future Systems Clinical & Care Strategy to be drafted in Q3 2023/24	• Revised structure in place by April 2024 • Explore options in relation to leadership and support to the transformation and change function

2.2. Future System board report

To Assure

Presented by Craig Black

Board of Directors	
Report title:	Future System Board Report
Agenda item:	2.2
Date of the meeting:	29th September 2023
Sponsor/executive lead:	Craig Black
Report prepared by:	Gary Norgate

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

Executive Summary

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

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

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

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

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

The next steps for the project are the agreed definition of the size and scope of the new hospital's services and, therefore, the required budget. This definition will them form the basis for the creation of an outline business case and the appointment of a build partner.

Action Required

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

Risk and assurance:	
Equality, Diversity and Inclusion:	

Sustainability:	
Legal and regulatory context	

Future System Board Report

1.	**Introduction**
1.1	The last report to the Board stated that In the next period we will have: • Secured sign-off of our SOC • secured the commercial agreement with our ecology partner, • finalised our schedule of accommodation and • aligned our view of scale and scope with that of NHP. The following paper provides an update on each of these areas.
2.	**Background**
2.1	As reported previously, West Suffolk Foundation Trust's plans to build a new hospital are part of the wider Governmental programme that aims to build "40 new hospitals by 2030".
2.2	More recent developments have seen the announcement that seven new schemes, predominantly those hospitals constructed from reinforced aerated autoclaved concrete (RAAC), have been included in the New Hospital Programme (NHP) and will be 'prioritised' to ensure they are completed in the most efficient way.
2.3	This announcement has caused some of the other, more complex, schemes (e.g. those representing significant service re-configuration and therefore requiring extensive public consultation) to slip beyond the previously announced 2030 deadline.
2.4	The West Suffolk scheme is one such priority and as one of the most advanced of the RAAC projects continues to be singled out as a 'pathfinder'. Consequently, WSFT are the only Trust to; have had its strategic case (SOC) formally considered; to have received funding for the development of its outline business case (the second of three mandatory cases) and to have received funding for those enabling works that support the pursuit of full planning permission and the ability to commence construction.
3.	**Detailed sections and key issues**
3.1	The West Suffolk Strategic Outline Case (SOC) has been formally heard by the New Hospital Programme (NHP) Investment Committee and passed to the Joint Investment Committee (JIC[1]) for ratification. The case for building a new hospital was widely supported, however, questions were raised with regards the affordability of the scheme in its current form. This is far from uncommon as, at this early strategic stage, cases lack detailed designs and have yet to undergo challenge and rationalisation. With this in mind, WSFT have been asked to work collaboratively with NHP, NHSE and its system partners to revisit designs and return with an agreed view on the size and shape of the new hospital
3.2	This step has always been part of our project plan and the following work is now underway: a. A senior-level, multi-disciplinary self-review, was completed on Friday 15th September and co-produced a number of design amendments and rationalisations that will have reduced space, capital and operational costs significantly (detail to be reported at next Board meeting). b. We are applying the NHP commissioned demand and capacity model to our own modelled assumptions to ensure we have a common view of how increased demand will impact the dimensions of future services.

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

	c. NHP transformation team are reviewing our clinical design and layout with a view to optimising space using nationally derived standards and H2.0.[2] d. NHP funded cost and technical design review with industry partners; MACE, Mott McDonald and Arcadis. **e.** The East of England Regional Team have commissioned a study into how to maximise the investment that the Region is receiving from the NHP programme. This work will seek to compare and contrast individual schemes and identify opportunities for collaboration.
3.3	These reviews are expected to conclude in October and will provide an agreed view of the optimum size, scope and cost of a new West Suffolk Hospital. Once agreed the resultant design parameters and schedule of accommodation will be used as the basis for the creation of an Outline Business Case[3].
3.4	In parallel to the development of business cases. The West Suffolk Team have been working hard to progress the fulfilment of those conditions placed upon its scheme at the time it secured outline planning permission. The most significant of these "pre-commencement" conditions concerns the creation of a new and lasting habitat that will compensate our community for the inevitable disruption to Hardwick Manor caused by the construction of a new hospital.
3.5	To this end, I am pleased to report that a formal commercial agreement for the 125 year lease, production and maintenance of a compensatory habitat have been legally secured. Furthermore, the land has been verified by environmental partners as being suitable for the re-creation of the environment being disrupted and the translocation of turves has commenced. These actions remove significant risk from our project and represent real and tangible progress. Nearby residents have been engaged throughout the process and planning permission for the creation of the new habitat has been secured from Babergh Council.
4.	**Next steps**
4.1	Outcomes of the five listed reviews will be assessed and applied to our strategic design with a view to agreeing the size, scope and cost of the hospital that our outline business case will seek authority to commence. The OBC is expected to be completed in Spring 2024, a full planning application is expected in Autumn 2024 with construction commencing sometime after these two milestones have been met.
4.2	Upon agreement of the size, scope and cost of the new hospital, the project team will commence market engagement with a view to identifying and, eventually, appointing a construction partner with whom the next level of detailed designs will be produced.
5.	**Conclusion**
5.1	The building of a new West Suffolk Hospital remains a priority within the New Hospital Programme.
5.2	The strategic case for the new hospital is now widely agreed and work is underway to optimise and agree the designs that will form the basis of an Outline Business Case.
5.3	Work to satisfy our pre-commencement planning conditions is physically underway.
5.4	The status of the project to build a new West Suffolk project remains Green
6.	**Recommendations**
	The Board are asked to note the content of this report.

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

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

2.3. West Suffolk Alliance and SNEE Integrated Care Board (verbal)

To Assure

Presented by Peter Wightman

2.3.1. Stay Well Domain: Overview

To inform

Presented by Nicola Cottington

Board of Directors

Report title:	**Stay Well Domain: Overview**
Agenda item:	2.3a
Date of the meeting:	29 September 2023
Sponsor/executive lead:	Nicola Cottington, Chief Operating Officer
Report prepared by:	Renu Mandal, Senior Transformation Lead

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

Executive summary:	The purpose of this report is to provide Board with an overview of the key areas of focus of the Stay Well domain. The overarching goal of the domain is for all stakeholders within health, local government and the voluntary, community and faith sectors to work in partnership to support adults with health or care concerns to access support and maintain healthy, productive, and fulfilling lives. This domain is unique in that the priorities are mainly determined by national NHS objectives; however, we are taking an 'end to end' approach to delivery by ensuring we encapsulate all aspects of a patient's journey including prevention, self-management, clinical management and preventing unscheduled episodes of urgent care, in particular involving attendance and admission to hospital. The key priorities for the domain relate to improvements that can be made in relation to urgent and emergency care and community health services; developing direct access pathways in partnership with primary care to improve patient experience; outpatients' transformation; elective care and elective recovery and Diabetes. The domain also has oversight of SNEE wide programmes that fall within its remit such as management of long-term conditions (CVD, Hypertension and Respiratory), early detection of cancer and uptake of learning disabilities and autism health checks. Delivery against programme milestones is steady with key achievements being: • The two-hour urgent emergency community response standard is being met. • Improvements have been identified to reduce the number of cleric rejections, which is resulting in an increase in the number of referrals being accepted. • Model of care is being developed with the Age Well Domain.

	• Waiting well pilot for low, medium and high-risk T&O patients operational. • Waiting time information for surgery and first outpatient appointments is operational and communicated to primary care. • First meeting with primary care clinical directors has taken place and we have identified opportunities to improve quality of referrals from primary care and further conversation is planned to take place to identify where advice and guidance would add value for both primary and secondary care. • WSFT performance against Patient Initiated Follow Up target is improving with targeted work taking place with specialities where take up is low. • A draft model of care for an integrated Diabetes service has been designed with further work in progress to refine the model and design the patient pathway. Key challenges: • Work to develop a direct access pathway for breast lumps in >50 years is on hold due to workforce pressures. • Some workstreams are dependent on recruitment and finance. • Impact of industrial action on meeting NHS national targets. Although the domain sponsor and strategic lead have had oversight of delivery of the priorities, we are in the process of setting up a Steering Group which will provide a better forum for workstream leads to take the whole patient journey into consideration when delivering their priorities.
Action required/ recommendation:	Report is for information.

Previously considered by:	**WSA Committee**
Risk and assurance:	**Relevant to BAF risks related to the delivery of NHS standards.**
Equality, diversity and inclusion:	*Differences highlighted in relation to diabetes and age profile of population of west Suffolk.*
Sustainability:	*Services including urgent community response need to be developed with consideration to carbon impact.*
Legal and regulatory context:	NHS Operating Standards 2023/24

Stay Well Domain - Overview

West Suffolk NHS FT Board 29 September

V Final (2) @ 23 Sept

Contents

WEST SUFFOLK ALLIANCE
about people & places

1. Context - about the Stay Well Domain
2. What is the national context/direction of travel
3. Data – key facts
4. Issues identified
5. Key workstreams for the Domain
6. Stay Well outcomes
7. Milestones and Measures
8. Progress to date

Live Well framework

Live Well in West Suffolk

Workforce

Premises

Digital

Localities

West Suffolk Alliance shared mission

Improving health through partnership:

Have a clear purpose	Act efficiently and inclusively	Optimise ICB and County benefits	Be flexible & adapt
• **Focused on a set of shared outcomes** agreed and reported at Alliance level (with evaluation) • **Use data & insight** to understand the key challenges for population health • **Focus on actions dependent on partnership** (not replicate organisation specific responsibilities)	• **Mandated to act** by the Alliance • **Leading on behalf of each other** where appropriate • Seek help where there are blocks • **Meetings;** map, align and streamline current groups to minimise bureaucracy • **Co-produce** with involvement of relevant partners, person centred solutions	• Recognise the relationship with **ICB programmes and County Leads** to recognise interdependencies and make connections • Import and export **best practice** • Clear where **delivery lead sits at County & ICB level**	• Ensure we review and learn from how we are working to **adapt as we learn**, innovate and deliver • Recognise overlaps & interdependencies exist • **Evaluate** where succeeding & failing

Stay Well Domain - context

Domain outcome

To support adults with health or care concerns to access support and maintain healthy, productive and fulfilling lives

23/24 goals

To deliver this outcome we have agreed a set of priorities for 23/24. This priorities have taken into account the following:

- Data from the Place Based Needs Assessment
- Feedback from stakeholders following a workshop on 1st February '23
- National NHS objectives for 2023/24
- Integrated Care Board (ICB) Joint Forward Plan

Principles

We aim to take an 'end to end' holistic approach to deliver our priorities which will include considering all elements of a person's potential journey such as:

- Prevention
- Self-management and self-care
- Clinical management
- Preventing unscheduled episodes of urgent care (in particular where involving attendance and admission to hospital).

Stakeholders

Stay Well Sponsor – Nicola Cottington, Chief Operating Officer WSFT

Stay Well Strategic Lead – Dr David Brandon, Associate Medical Director West Suffolk Alliance

Stay Well Change Co-Ordinators –Lucy Webb & Renu Mandal, Transformation Leads

West Suffolk NHS Foundation Trust – Operational Teams

Community Teams

Primary Care

Future Systems programme

ICB strategic Programmes

Integrated Therapies

Learning Disabilities & Autism

Public Health

Healthwatch

West Suffolk Council - Abbeycroft Leisure

How will we work together?

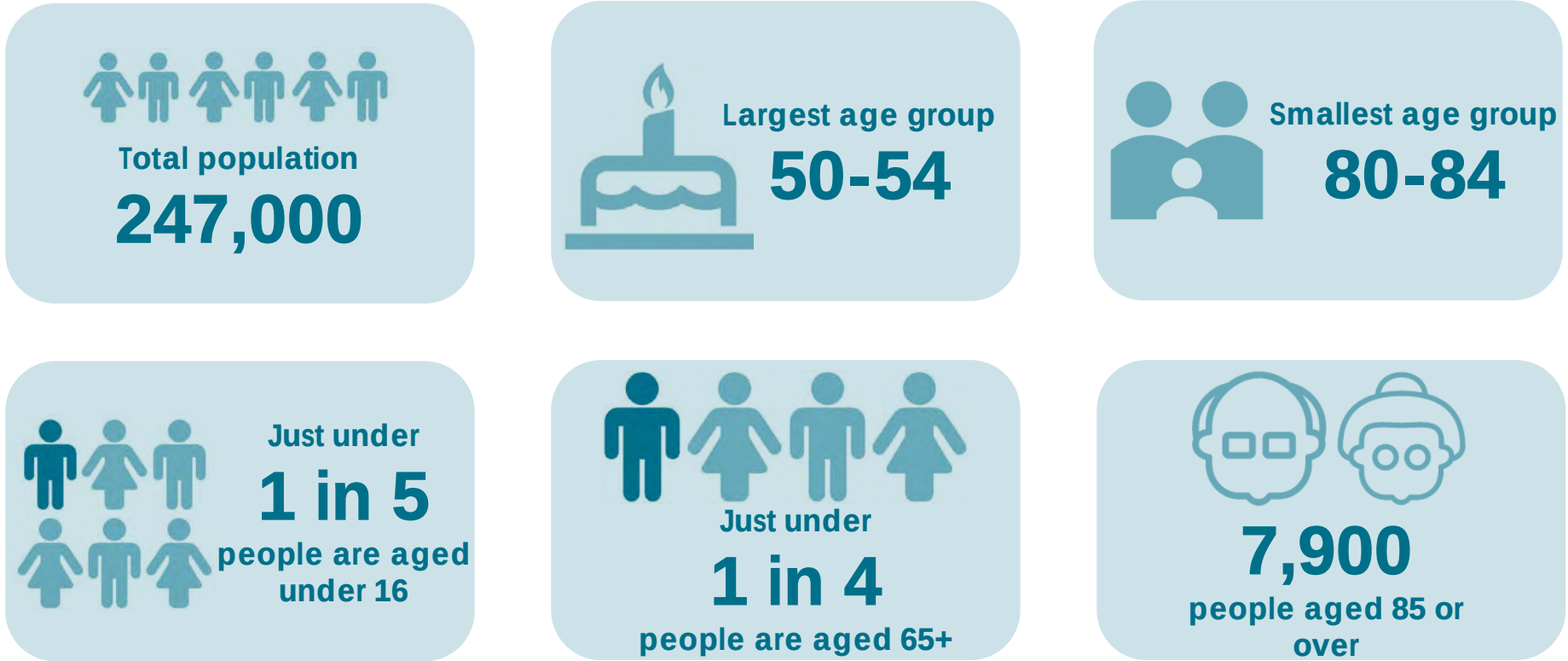
WEST SUFFOLK ALLIANCE
about people & places

Stay Well Domain – National Direction

- Aims in the National Operational Planning Guidance 2023/24:
  - Support recovery of core services and improve productivity in relation to primary care, elective care, cancer and diagnostics
  - Meet urgent and emergency care (UEC) and urgent community response (UCR) targets
  - Reduce outpatient Follow Ups by 25%
  - Increase uptake in cancer screening
  - Increase the uptake of Learning Disability health checks

West Suffolk population – Key facts

- 1 in 5 people in West Suffolk lives in areas that are ranked among the most deprived 40% nationally
- Impact of increasing population in over 65s



18.3%; national average 18.9%

23%; national average 18.7%

3.2% of total population; national average 2.5%

Source: ONS 2020 mid-year population estimates

Deprivation
Key facts

- 1,685 people in West Suffolk live in most deprived 20% of areas in England

4,800
people affected by income deprivation

8.1%
Suffolk average 10.0%

6.6%
of working age people affected by employment deprivation

Suffolk average 8.3%
11,400 people

9,200
children affected by income deprivation

6.6%
Suffolk average 13.6%

6,700
older people affected by income deprivation

9.4%
Suffolk average 10.4%

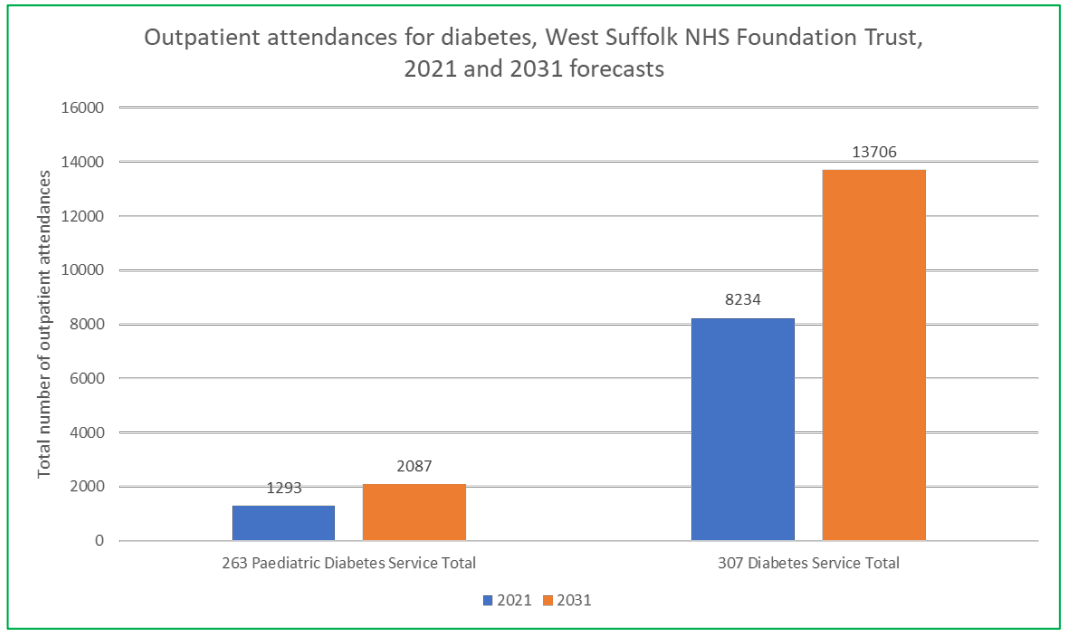
Source: DCLG Index of Multiple Deprivation 2019 and ONS 2020 mid-year population estimates

Diabetes forecast – key facts

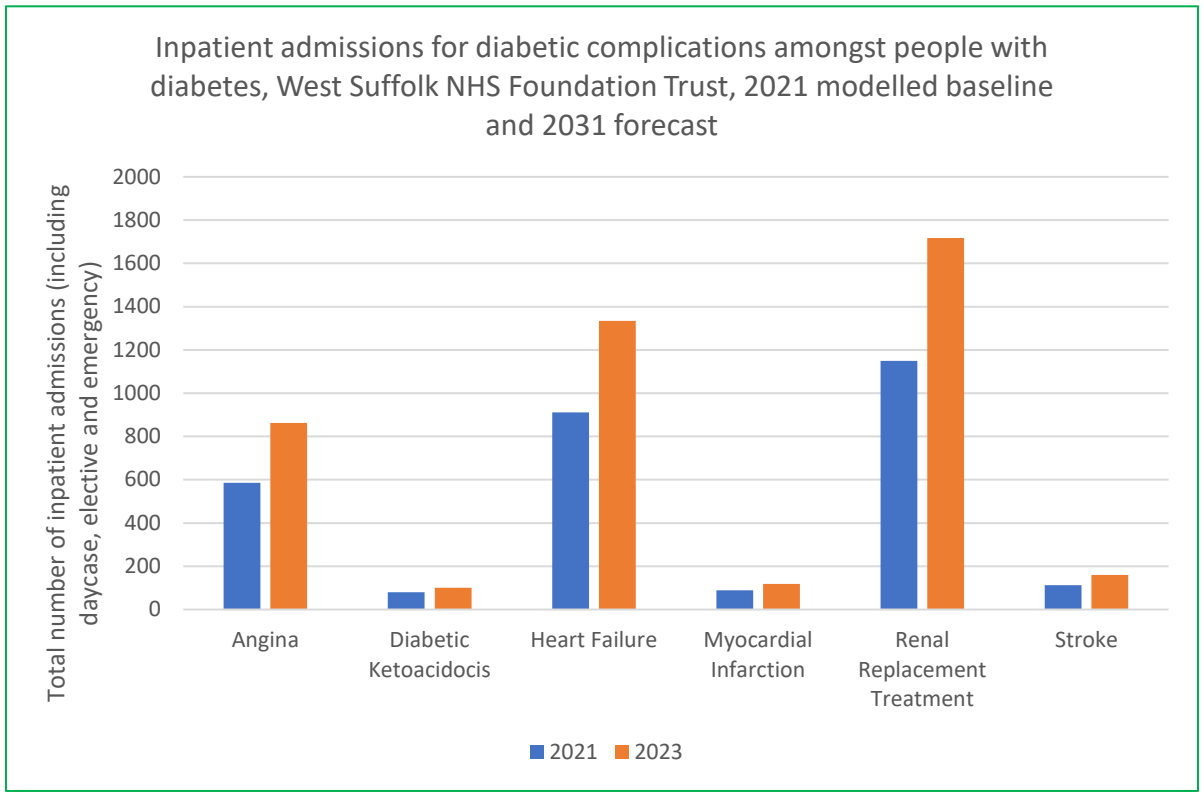
Prevalence and incidence of Diabetes are growing annually.

Between 2021 and 2031:

Demand for outpatient care will rise by 66%



Demand for inpatient care for diabetic complications will rise by 45%



Stay Well – Key work streams

WEST SUFFOLK ALLIANCE
about people & places

Urgent and emergency care and community health services	Long Term conditions - Diabetes	Primary Care	Elective Care & Outpatients Transformation	SNEE wide programmes which Stay Well have oversight of
1. Focus on improving discharge processes and community response to improve flow and reablement outcomes 2.Understand the demand profile across our UEC system and respond accordingly to profile, working collaboratively 3. Urgent Community response (UCR) model embedded within the responsive services of the Integrated Neighbourhood Team (INTs) in collaboration with the Age Well domain 4. Utilisation of Virtual Ward across the west System with early discharge & Admission prevention linking with the INTs & Primary Care	1. Design and develop an Integrated Diabetes model in west Suffolk 2. Improve performance of 8 Diabetes care processes and all 3 treatment targets	1.Work in partnership to develop direct access pathways – explore direct access pathway for patients over 50 years with breast lumps	1.Reduce outpatient follow-ups by 25% against 2019.20 baseline 2.Develop communication and empowerment tools to enable people to stay well. 3.Support the Get it Right First Time (GIRFT) High Volume Low Complexity (HVLC) transformation programmes for Ophthalmology and Trauma & Orthopaedics (T&O) in 2023/24	1.Early detection and screening of cancer 2.Learning Disabilities & Autism – increase uptake of Learning Disabilities health checks 3.Management of Long-term conditions: •Respiratory •Hypertension •CVD

Stay Well – Outcomes

Progress:

- Waiting well pilot for orthopaedic patients underway
- WSFT web pages showing wait times for First Outpatient appointments and Elective wait times is live

Progress:

- Work in progress to design and develop an integrated diabetes model for west Suffolk fit for the Future Systems programme

Progress:

- Model of care being developed with the Age Well Domain with the aim to strengthen the integration of the various individual community services and support people to stay at home through Admission Prevention and Discharge pathways

Stay Well – Milestones and Measures (1)

Workpackage	Milestone Description	Task/Milestone
Urgent and Emergency Care and community health services -		
Focus on improving discharge processes and community response to improve flow and reablement outcomes	System action plan approved that delivers the improvements to discharge processes 7 day/ week supporting reduction in delays	Milestone 1
	Delivery of out of hours response to transfer of care to home in ED	Milestone 2
	Discharge processes aligned to home and reablement first model of care	Milestone 3
Understand the demand profile across our UEC system and respond accordingly to profile, working collaboratively	UEC demand profile at practice/locality level mapped across all services	Milestone 4
	Establish current High Intensity User programme and leads	Milestone 5
	Establish emergency service attendances saved due to HIU programme	Milestone 6
	Establish a 6 monthly reporting process for HIU impact to emergency service contact saved.	Milestone 7
	Integration of HIU into INTs	Milestone 8
Urgent Community response (UCR) model embedded within the responsive services of the INTs in collaboration with the Age Well domain	Consistently meet or exceed 70% two-hour urgent community response standard	Milestone 9
	Review reasons for Cleric rejections, to identify internal/operational improvements	Milestone 10
	Medical cover for Early Intervention Team (EIT) in place	Milestone 11
	Robust pathways in place for UCR to accept all clinically appropriate cleric and UCCH referrals and delivery against plan	Milestone 12
	Establish Mental Health support required within UCR services	Milestone 13
	Implement Mental Health support required	Milestone 14
Utilisation of Virtual Ward across the West System with early discharge & Admission prevention linking with the INTs & Primary Care	100 virtual beds March 2024 across a number of pathways	Milestone 15
	50 virtual beds by September 2023 across a number of pathways	Milestone 16
	80 virtual beds by January 2024 across a number of pathways	Milestone 17

Stay Well – Milestones and Measures (2)

Workpackage	Milestone Description	Task/Milestone
Primary Care: **Direct Access** **(Stay Well Domain Priority)**	Clinical and operational pathway agreed and in place for Direct Access for breast lumps	Milestone 18
	Primary and secondary care clinicians agree access pathway opportunities for breast lumps for >50 years.	Milestone 19
	Opportunities for other potential direct access pathways identified through co-creation and collaboration	Milestone 20
	Third Space pilot in West Suffolk extended	Milestone 21
Long Term Conditions - **Diabetes** **(Stay Well Domain Priority)**	New integrated Diabetes pathway in West Suffolk approved	Milestone 22
Outpatients Transformation	Robust plan in place to reduce outpatient follow-ups by 25% against 2019.20 baseline (Local target set at 12.5%) aligned to GIRFT requirements	Milestone 23
	Specialty level trajectories agreed for 23/24 setting out delivery of key components of national outpatient transformation relating to Advice & Guidance, Patient Initiated Follow Ups & Video consultations targets.	Milestone 24
	Develop joint arrangements with primary and secondary care on referral optimisation opportunities.	Milestone 25
Elective Care & Diagnostics (National Operational Plan: West Suffolk focus)		Milestone 26
Support the Get it Right First Time (GIRFT) High Volume Low Complexity (HVLC) transformation programmes for Opthalmology and T&O in 2023/24	HVLC cases per list for Eye Care and Trauma & Orthopaedics (T&O) will align with GIRFT standards and day case activity will achieve 85% against BADS standards	Milestone 26
	Using GIRFT data unwarranted variation for Eye Care and T&O identified and improvement plan in place	Milestone 27
Deliver the Eye Care national improvement targets	SNEE Urgent Eye Care service specification produced and procurement timetable in place	Milestone 28
Deliver improvements for Eye Care identified specifically for West Suffolk	Proposal for a community led service for HCQ patients produced for review by WSFT & WSA	Milestone 29
	Decision made by WSFT & WSA on proposed community led HCQ pathway	Milestone 30
Personalised communication & empowerment to help people to stay well	Waiting time information on surgery and diagnostics waiting times live on the WSFT website to enable validation of waiting lists	Milestone 31
	6 month Waiting well pilot for low, medium and high-risk T&O patients operational	Milestone 32
Elective Reccovery (National Operational Plan: West Suffolk focus)	Trajectory in place for 23/24 to meet elective wait target to eliminate waits of over 65 weeks by March 24 (except where patients choose to wait longer or in specific specialties) and reporting in place	Milestone 33
	Trajectory agreed for 23/24 to deliver system specific target of 107% activity and reporting in place	Milestone 34

Stay Well – Performance Measures

KPI's	
	KPI/Measure Description
1	Reduction in GP appointments for women over 50 years presenting with breast lumps.
2	Improved percentage of patients with diabetes control achieved (aligned to targets set by NICE)
3	Reduction in Outpatient Follow Up appointments by 25% against 2019/20 baseline
4	5% for patient attendances outcomed as PIFU
5	25% of appointments to be delivered virtually
6	16% of First Attendances are reviewed by A&G
7	Cases per list will align with GIRFT standards and day case activity will achieve 85% against BADS standards
8	Consistently meet or exceed 70% two-hour urgent community response standard
9	Increase acceptance of referrals from Cleric
10	100 virtual beds March 2024 across a number of pathways

Progress to date (1)

Urgent and Emergency Care and Community Health Services:

- Meeting two-hour urgent emergency community response standard.
- Reviewed reasons for cleric rejections and improvements identified.
- Integration of responsive service across West Suffolk being tracked through the Age Well Domain.
- Model of care being developed with the Age Well Domain:
    - Workstreams and timelines for delivery have been established.
    - Data requirements and metrics have been identified.
    - Home First expansion is live in phased approach.
    - Community beds are fully implemented.
    - Virtual Ward is increasing capacity in a phased approach.

Overview of Draft Model of Care – Age Well and Stay Well Focus (1 Cont.)

WEST SUFFOLK ALLIANCE
about people & places

The model of care is designed to meet the Discharge to Assess (D2A) principles:

- **Reablement First** - for all when recovering from an acute care episode and before any assessment of long-term needs is undertaken.
- **Assessment for long term care should never take place in an acute setting** - this should apply to all including those who may potentially need to self-fund care or be CHC eligible.
- **The stay in an acute setting is a short as possible** – this limits deconditioning particularly in older people and gives people the best possible chance at reablement.
- **Our goal is to get people home** - the best way to assess someone's capabilities and any future needs, as well as their potential for improvement, is in their own home. This is where decisions on long term care should be made.
- **A one team approach** – all D2A pathways should be regarded and developed as fully integrated approaches that go beyond some shared communication and good relationships into a fully comprehensive one team approach.
- **System response; System resource** – Resources needed to develop D2A pathways should be viewed as collective responsibility consistent with a one team approach so care costs will not always be met by SCC, clinical care costs may be shared, and staffing resources used flexibly. This principle applies across health providers, ICBs and SCC.

Progress to date (2)

Primary Care:

- Waiting well pilot for low, medium and high-risk T&O patients operational.
- Waiting time information for surgery and first outpatient appointment operational and communicated to primary care.
- First meeting with primary care clinical directors has taken place.
    - Identified opportunities to improve quality of referrals from primary care. Meeting with primary care medical secretaries to be scheduled.
    - Suggestion made to set up a single telephone number for patients on a PIFU pathway.
    - Further conversation to take place to identify where advice and guidance would add value for both primary and secondary care.
- Direct access pathway for breast on hold due to capacity issues.

Progress to date (3)

Elective care & Outpatients Transformation

- Increase in patient initiated follow up (PIFU) performance. West Suffolk close to meeting target of 5% (achieving 4.7% in July) ahead of plan.
- Specialty level dashboard in place with performance trajectories for each of the outpatients' transformation national metrics.
- GIRFT self-assessment checklist for outpatients' transformation completed. High level actions as follows:
    - Review of eRS directory of services required
    - Clinic templates to be reviewed in 5 specialties
    - Local DNA policies to be reviewed and formalised
    - Inequalities in relation to DNA to feed into Trust Prevention, Personalised Care and Health Inequalities Strategy.
- Waiting list validation undertaken at WSFT, resulting in 11% of patients on first OP waiting list who responded for Dermatology and 8% in Gynaecology no longer requiring appointment.
- Implementation of automated messaging utilising Dr Doctor as text messaging system and LUNA PTL for patients that reach 12 weeks by the end of October '23 will go live in September, which will then become business as usual for any patients tipping over 12 weeks, with plan in place to contact patients who do not have mobile numbers.

Progress to date (4)

Long term conditions: Integrated Diabetes model:

- A Steering Group has been set up to support the Recovery programme and design an Integrated Diabetes Service for the Future System
- The Steering Group is using the national best practice framework for integration and best practice models to scope the design of the integrated service. The key enablers of integrated diabetes care are identified in 'Best practice for commissioning services: an integrated care framework', which is widely endorsed by the diabetes community.
- Using the FSP model of care, a draft integrated diabetes model has been scoped to facilitate discussion with all stakeholders

Best practice for commissioning diabetes services - An integrated care framework March 2013 (basw.co.uk)

This framework sets out '5 Pillars of Integration' required to facilitate provision of different elements of Diabetes care:

1. Integrated Information Management and Technology;
2. Aligned finances and responsibility;
3. Care planning;
4. Clinical engagement and leadership;
5. Clinical governance.

Next steps September and October:

- Carry out deep dives into the models of care in North Devon; Wolverhampton; North-East Essex; Portsmouth and Leicestershire & Rutland to establish how patients flow through their integrated pathways.
- Refine the draft west Suffolk integrated Diabetes model of care which is based on the FSP model of care.
- Set up a Patient Group to be involved in the project and link with Be Well to explore how wider stakeholders can deliver elements of the integrated model.

Draft Integrated Diabetes Model of Care

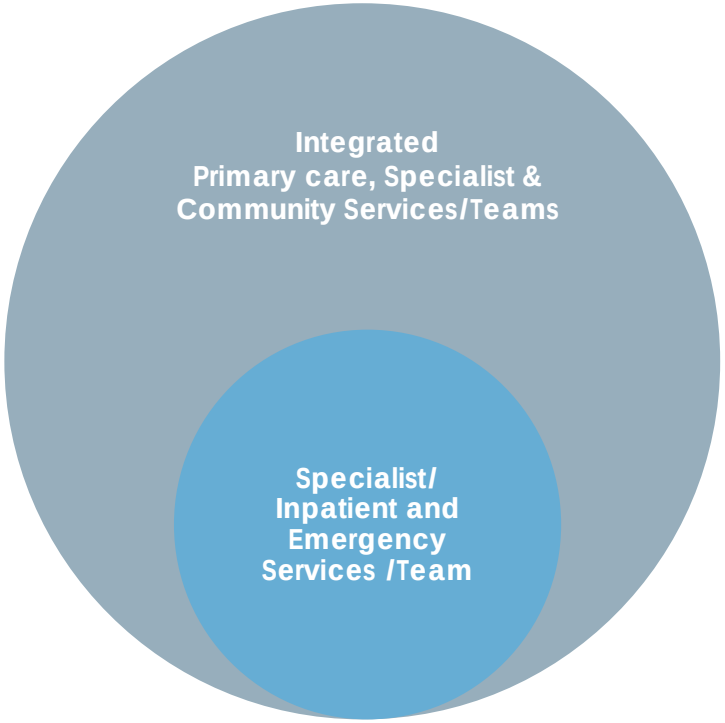
The FSP model of care has been adapted for this draft integrated Diabetes model which includes proposed roles and responsibilities. Work in progress to refine the model and design the patient pathway.

Person: self – help and self-management:

- Prevention services: weight management; exercise; increasing knowledge about Diabetes.
- Pre-Diabetes help and self-help initiatives
- Health coaching
- DESMOND & DAFNE
- Education/Communication events; support groups

Delivered by:

- Primary Care; Community and Secondary care teams (WS Integrated Diabetes Service)
- Local authority – community forums; councillor networks; Local councils
- Health Coaching staff
- People taking responsibility for their health
- National Diabetes Prevention programme



- Underpinned by MDT approach
- Integrated Information Management & Technology
- Aligned finances and responsibility.
- Care planning
- Clinical engagement and leadership
- Clinical governance

Service Characteristics (What will happen)	Service Groups (Who by)
• Patient education programmes • Pregnancy advice for women of childbearing age • Podiatry services • Clinical psychology support • Additional support for those with Type 2 diabetes and poor glycaemic control. • Support MDT working • Annual care planning (treatment targets and 8 care processes) • Care for housebound and non-housebound patients	• An individual's practice MDT will include their GP, practice nurse, and in many cases a community nurse and/or community podiatrist. • Some may also include a sessional increased-access-to-psychological- therapies (IAPT) therapist. • Specialist nurses
Specialist services will include: • Transition service • Diabetic foot service • Diabetic antenatal service • T1DM service, including insulin pump service • Diabetic inpatient service • Diabetic mental health service • Diabetic kidney disease service • Diagnostic service where there is doubt as to type of diabetes. • There should be clear referral routes/criteria	• Specialist care services will be multidisciplinary, with membership of the MDT varying according to the specialty service.

Summary

- The Stay Well Sponsor and Strategic Lead currently have oversight of the workstreams while they have been in development.
- Steering Group meetings will begin from October to provide oversight of the workstreams directly delivered by the Domain leads and those delivered as SNEE wide strategic programmes e.g., Cancer; Long Term Conditions; Learning Disabilities and Autism.
- The Age Well and Stay Well Model of Care is in development.
- UCR is still on target to achieve 70% of 2-hour response with start of 10% increase in capacity.
- Virtual Ward has reached planned capacity 30/30 beds with 87% occupancy.
- On track to meet the PIFU target of 5% before end of March '24. There is still more work to do with specialties to achieve 25% reduction of Follow Ups.
- Wait time information for First OPA and Elective procedures is now live on the WSFT website. Data is updated monthly. We will be working with Primary Care to explore how best to use and communicate this information as a system.

Key challenges which may impact on delivery.

- Workforce recruitment and financial dependency for some workstreams.
- Industrial action may have an impact on delivery of national NHS objectives.

3. PEOPLE AND CULTURE

3.1. Involvement Committee report

To Assure

Presented by Tracy Dowling

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Involvement Committee			Date of meeting: 16th August 2023		
Chaired by: Tracy Dowling- Non executive Director			**Lead Executive Director: Jeremy Over and Sue Wilkinson**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
6.1	CQC Urgent and Emergency Care Survey Presentation from Abby Ormes, ED Matron on actions taken in response to feedback from patients achieved via SMS experience surveys (900 responses per month) and CQC survey.	Reasonable			1. No escalation
6.2	Developing our analysis and usage of patient experience data. Review of report to Private Board regarding complaints and discussion regarding assurance of patient experience.	Partial	In depth discussion regarding how patient experience should be reported and assured. Agreed that report on complaints to private board is not adequate in terms of 'so what' and 'what next'. Points discussed included need to include multiple data sources (e.g. complaints, PALS queries, surveys) and undertake thematic analysis; take a learning approach	In advance of Committee Development workshop in September, proposals for how the Involvement Committee receive and use reports regarding patient experience and engagement will be progressed. These proposals will be developed further at the	1. No escalation

Originating Committee: Involvement Committee			Date of meeting: 16th August 2023		
Chaired by: Tracy Dowling- Non executive Director			Lead Executive Director: Jeremy Over and Sue Wilkinson		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
			to improvement as a result of analysis; ensure feedback is given regarding actions and outcomes; link patient data to staff data to build story of understanding across the organisation; specify timeframes for action and impact.	September workshop. Exec lead - Sue Wilkinson To be developed further by the Committee in September	
7.1	Q1 Freedom to speak up guardian report received with clear definition of the benefit of speaking up on improvements to patient transport, staff moves data, discrimination and violence and aggression	Substantial			
8.0	Equality, Diversity and Inclusion Presentation of Inclusion Plan Update and actions to be developed under the 'Board Responsibilities' workstream	Reasonable	Good progress has been made since the last meeting in developing a stock take of actions (90); grouping these into 7 workstreams with accountable owners, and now developing the delivery plan for each workstream	Each workstream owner to be fully briefed, to develop the actions in their workstream and to be supported to prioritise actions. Board members to respond to JMO by 31st August regarding actions and ownership of Board	1. No escalation

Originating Committee: Involvement Committee			Date of meeting: 16th August 2023		
Chaired by: Tracy Dowling- Non executive Director			Lead Executive Director: Jeremy Over and Sue Wilkinson		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
				responsibilities workstream Progress to be reported back to December meeting of Involvement Committee	
9.1	NHS England Framework for revalidation This was approved by the Committee on behalf of the Board for submission to NHS England.	Substantial			1. No escalation
9.2	Committee self assessment and Annual Report Recommendations for improvement / development agreed and further discussion agreed for Committee development workshop on 19th September 2023	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…
What? Deepening **understanding** of the evidence and ensuring its **validity**	**Validity** – the degree to which the evidence… • measures what it says it measures • comes from a reliable source with sound/proven methodology • adds to triangulated insight	• Good data without a strong narrative is unconvincing. • A strong narrative without good data is dangerous!
So what? Increasing **appreciation** of the **value** (importance and impact) – what this means for us	**Value** – the degree to which the evidence… • provides real intelligence and clarity to board understanding • provides insight that supports good quality decision making • supports effective assurance, provides strategic options and/or deeper awareness of culture	• What is most significant to explore further? • What will take us from good to great if we focus on it? • What are we curious about? • What needs sharpening that might be slipping?
What next? Exploring what should be **done next** (or not), informing **future** tactic / strategy, agreeing follow-up and future **evidence of impact**		• Recommendations for action • What impact are we intending to have and how will we know we've achieved it? • How will we hold ourselves accountable?

Assurance level

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

3.2. Putting You First Awards

For Discussion

Presented by Jeremy Over

Board of Directors

Report title:	**People & OD highlight report - Putting You First Awards**
Agenda item:	3.2
Date of the meeting:	Friday 29 September 2023
Sponsor/executive lead:	Jeremy Over, executive director of workforce & communications
Report prepared by:	Members of the workforce and communications directorate

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

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

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

People and OD highlight report

1.	**Introduction**
1.1	The planned content of this iteration of the regular People and OD highlight report is dissipated throughout various other sections of the Board papers for this September 2023 meeting; this includes: a) A comprehensive summary of current activity and progress as outlined in the Involvement Committee CKI report b) The separate report highlighting progress with the delivery of our top strategic priorities for 2023/24 (which includes our diversity and inclusion and management / leadership development programmes) c) The reflection paper in relation to the current understanding of issues raised by events at the Countess of Chester Hospital following the conviction of a neonatal nurse that worked there (subject to the pending public inquiry) What remains is the pleasure of celebrating the achievements of various colleagues across WSFT as identified through nominations for our Putting You First awards, as follows.
2.	**Putting You First Awards (August/September)**
2.1	**Michelle Vaughan-Williams, clinical nurse specialist – digital** *Nominated by Joanna Clark, PM digital transformation* The end of medic bleep meant that the trust needed an immediate interim replacement medical messaging tool or tools, including critical care messaging (in the form of bleeps). Michelle was fundamental to this role out from the planning, implementation, advice, experience and support. She offered her help at every stage, particularly out of hours and worked several night shifts and the weekend. She had a thorough understanding and empathy of the needs and concerns of clinical staff, the pressures they are under and making sure they were implementing areas fundamental to their roles and daily work; her experience was invaluable. She listened to concerns and issues and returned to wards and clinical areas to make sure in follow up that the interim measures were working for them and they knew where to go for support. She was instrumental in solving problems and issues throughout, be it the day or night shift. Her professional, cheery and helpful demeanour kept the whole team going and we relied heavily on her expertise and she was always there, whatever the hour and I think it's important that her hard work and dedication is recognised and rewarded.
2.2	**Ashwani Kumar, Endpoint engineer – IT** *Nominated by Joanna Clark, PM digital transformation* The end of medic bleep meant that the trust needed an immediate interim replacement medical messaging tool or tools, including critical care messaging (in the form of bleeps). Ashwani was fundamental to this role out from the planning, implementation, advice, experience and support. He offered his help at every stage, particularly out of hours and was instrumental in solving problems and issues throughout, be it the day or night shift. His professional, cheery and helpful demeanour kept the whole team going and we relied heavily on his expertise and he was always there, whatever the hour and I think it's important that his hard work and dedication is recognised and rewarded.
2.3	**Janet Thomas, nursery nurse, neonatal ward** *Nominated by Nicky Tilbrook, ward clerk and Karen Ranson, senior staff nurse* Nicky writes: Janet goes above and beyond for our babies .Not only does she give love and support to the families in her care but she has set up a Discharge Group ,enabling parents to meet and chat to feel like they are apart of a community to help each other and babies to mix and enjoy

	Janet's endless games and creative flair! Only this morning they had a group session and the mums had made a video of past and present babies to pay homage to Janet (Martha has the video). Karen writes: Janet not only works to a high standard in caring for babies in her Clinical Care, but goes the extra mile for families on our Unit, especially parents and siblings. She can often be seen painting babies feet for footprints to make birthday cards for Mums and Dads, and Mothers and Fathers day cards, and also taking off siblings shoes and socks to add their prints too! Not only does she care for the families on the Unit, but she runs an amazing Support Group for parents and their babies when they go home. This is held monthly and all sorts of activities are planned for these meetings, and provides emotional support for parents when they have gone home. Many of the children who attend the group start school this week and thus will leave the group, and some of the Mums put together a video for Janet to show how much she has been appreciated. On seeing this you realise what a difference she has made to the parents' journeys during one of the most difficult times in their lives, and how the Mums have made such firm friendships extending to outside the group. Janet puts in hours of her own time into planning the activities for these sessions, and its only when I attended a meeting and watched the video that I realised what a star she is.
2.4	**LeeAnn Hunt, care coordinator, ward F9** *Nominated by Lois Bull, integrated transfer of care lead* LeeAnn, although new to the role of care coordinator, did a truly fantastic job providing cover for the winter escalation ward. She went above and beyond to support the ward and Transfer of Care Hub to coordinate and facilitate discharges, liaising with patients, families and carers to support solving complex issues which contributed to reducing length of stay and improving patient experience. LeeAnn is always happy to help and was an integral part of the winter escalation ward. Thank you LeeAnn.

COMFORT BREAK

4. ASSURANCE

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

To Assure

Board of Directors	
Report title:	Chairs Key Issues Report Insight Committee
Agenda item:	4.1
Date of the meeting:	29 September 2023
Lead:	Antoinette Jackson, Non-Executive Director
Report prepared by:	Antoinette Jackson, Non-Executive Director

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

Executive Summary
WHAT? *Summary of issue, including evaluation of the validity the data/information*
Attached is the Chair's Key Issues report from Insight Committee held on 19 July 2023
SO WHAT? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*
The report outlines the implications of the issues highlighted which the Board is asked to consider.
WHAT NEXT? *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*
The reports outline actions proposed on the issues highlighted.
Recommendation / action required
To consider the content of the report and whether it gives the Board assurance

Previously considered by:	Council of Governors 4 September 2023
Risk and assurance:	The report offers a range of assurance on the issues it covers
Equality, diversity and inclusion:	None specific in this report
Sustainability:	n/a
Legal and regulatory context:	n/a

Guidance notes

The practice of scrutiny and assurance

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

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Insight			**Date of meeting: 19 July 2023**		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
Community Paediatrics – Community Medical Team (CCMT) demand and capacity review	The capacity review has been prompted by a range of issues within the service. -18 week RTT time performance 12% -Increased caseload and increased complexity within that caseload -Invisible demand -Morale and recruitment issues.	**Partial**	The review has been focused on understanding demand, clinical supply and service quality. It is clear that the service is not fully sighted on demand and links need to be made to other external services within the pathway to understand its totality and to join up responses to that demand.	The review is continuing at pace and some improvements are already being implemented. A report to private Board on 21 July will explore in more detail some of the system wide issues and options being discussed within the SNEE ICB.	3 Escalate to Board
Finance Accountability Committee	**Budget deficit and CIP programme** The Committee were advised that at Q3 the Trust was already predicting a £2.1m adverse variance against target budget. Four issues were driving this: Under-delivery of CIP Unfunded impact of industrial action Underfunded pay awards Unfunded escalation ward.	**Minimal**	If the underlying issues are not addressed the Trust could face a bigger deficit by year end and a very high deficit for 2024-25 (up to a worst-case of potentially £30m before CIP). The ICB needs to balance the budget at system level so any at WSFT deficit impacts system partners. The CIP programme has not been quantified fully and there is	The Board will have the same financial report at its meeting on 21 July. Work is in progress on an urgent recovery plan. A working group chaired by the CEO will oversee the plan and its delivery. Regular meetings are being held with ICB colleagues. There is a need to learn from others who are facing the same challenges but are not in deficit	3 Escalate to Board

Originating Committee: Insight			Date of meeting: 19 July 2023		
Chaired by: Antoinette Jackson			Lead Executive Director: Nicola Cottington		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
			a risk of under delivery. There is a risk of double counting with the urgent recovery plan that is being put in place.	and to be clear where investment is needed to drive transformation. Insight will continue to scrutinise progress at future meetings	
Patient Access Governance Group /IQPR data	**Elective waiting list** – WSFT is in Tier 2 because of the 78 and 65 week wait forecasts especially in Uro-gynae. The total waiting list is an emerging area of concern.	**Partial**	Industrial action continues to impact the waiting list through lost activity, whilst referral levels are unimpacted. Outpatient transformation is key to its reduction.	The Trust is participating in national "Sprint" programme across July designed to drive improvement more quickly. In Uro-gynae NHSE Regional Medical director is conducting review of WSFT pathways and practices and the possibility of joint appointment with neighbouring trusts is being explored. An insourcing solution may provide a step-change in capacity, this is currently being costed.	3.Escalate to Board

Originating Committee: Insight			Date of meeting: 19 July 2023		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
Patient Access Governance Group /IQPR data	Updated detailed recovery trajectories have been developed.	Reasonable	The updated trajectories will enable a focus on sustained improvement rather than monthly changes.	Insight Committee will use the information as part of its assurance work.	1. No escalation

**See guidance notes for more detail*

Guidance notes

The practice of scrutiny and assurance

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

Assurance level

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3. Partial	Taking account of the issues identified, the board can take partial assurance that this issue/risk is being controlled effectively. Further improvement action is needed to strengthen the control environment and/or further evidence to provide confidence in delivery.
4. Minimal	Taking account of the issues identified, the board can take minimal assurance that this issue/risk is being controlled effectively. Urgent action is needed to strengthen the control environment and ensure confidence in delivery.

4.2. Finance Report

To Assure

Presented by Craig Black

Board of Directors – 29th September 2023

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

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

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

Executive summary

Income and Expenditure and forecast for 2023-24

Our reported position as at the end of August was a deficit of £5.5m against a planned deficit of £2.3m. This has resulted in an adverse variance of £3.2m.

In order to improve our financial position we believe that the two most significant areas of focus should be on temporary staffing costs and on delivering our CIP programme. There is also the possibility of funding from the Elective Recovery Fund (ERF). We have therefore submitted a Financial Recovery Plan that improves our forecast deficit to £6.7m.

This deficit has impacted on our cash position which has resulted in an application for revenue support of £10m.

Plan for 2024-25

Depending on the extent to which we improve our trajectory in 2023-24, the deficit for 2024-25 could be as high as £30m (before any 2024-25 CIP). This is subject to assumptions made and planning guidance.

Action required of the Board

The Board is asked to review this report.

Recommendation

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

FINANCE REPORT
August 2023 (Month 5)

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

Executive Summary

This report focusses on the YTD adverse variance and the actions required in order to meet our revised planned deficit (£6.7m) by 31st March 2024, as well as improve our trajectory for 24-25 when we will no longer benefit from non-recurring support (£15m).

- The revised forecast deficit of £6.7m was agreed by the Board in September 2023.
  - This revised forecast is contingent on:
    - ERF income - £5m
    - Delivering CIP - £5m
    - Improving our run rate - £3.4m
- This forecast includes the benefits resulting from £15m of non-recurring support
- The reported I&E for August is an adverse variance of £1.4m
  - This includes an adverse variance of £700k in month (and YTD) relating to national guidance over the treatment of ERF income
  - The August position reported an improvement against the M1-4 trend (before the ERF adjustment)
- The YTD position reports an adverse variance of £3.2m which is largely due to:
  - Underachieved CIP £2.5m
  - Unfunded industrial action £0.7m

Key Risks in 2023-24

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

Financial Summary

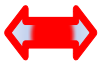
SUMMARY INCOME AND EXPENDITURE ACCOUNT - August 2023	August 2023			Year to date			Year end forecast		
	Budget	Actual	Variance F/(A)	Budget	Actual	Variance F/(A)	Budget	Actual	Variance F/(A)
	£m	£m	£m	£m	£m	£m	£m	£m	£m
NHS Contract Income	28.7	28.9	0.3	140.7	141.7	1.0	336.7	339.7	3.0
Other Income	3.4	3.9	0.5	16.1	17.8	1.7	39.5	46.4	6.9
Total Income	**32.0**	**32.8**	**0.8**	**156.8**	**159.5**	**2.7**	**376.2**	**386.1**	**9.9**
Pay Costs	22.7	23.6	(0.9)	107.5	108.9	(1.5)	256.2	258.3	(2.1)
Non-pay Costs	7.5	8.8	(1.3)	42.6	47.0	(4.4)	100.8	111.7	(10.9)
Operating Expenditure	**30.2**	**32.4**	**(2.2)**	**150.0**	**155.9**	**(5.9)**	**357.0**	**370.0**	**13.0**
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
EBITDA	**1.9**	**0.5**	**(1.4)**	**6.8**	**3.6**	**(3.2)**	**19.2**	**16.1**	**(3.1)**
Depreciation	1.2	1.3	(0.1)	6.2	6.4	(0.2)	15.0	15.9	0.9
Finance costs	0.6	0.5	0.0	2.8	2.6	0.2	6.8	6.8	0.0
SURPLUS/(DEFICIT)	**0.1**	**(1.4)**	**(1.4)**	**(2.3)**	**(5.5)**	**(3.2)**	**(2.7)**	**(6.7)**	**(4.0)**

I&E Position YTD	**£5.5m**	**adverse**
Variance against Plan YTD	**£5.2m**	**adverse**
Movement in month against plan	**£2.2m**	**adverse**
EBITDA position YTD	**£3.6m**	**favourable**
EBITDA margin YTD	**2%**	**favourable**
Cash at bank	**£2.9m**	

Contents:

Key:

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

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

FINANCE REPORT – August 2023

Income and Expenditure Summary - August 2023

Summary of I&E indicators

Income and Expenditure	Original Plan/ Target £000'	Actual/ Forecast £000'	Variance to plan (adv)/ fav £000'	Direction of travel (variance)	RAG (report on red)
In month surplus/ (deficit)	57	(1,359)	(1,416)	↓	Red
YTD surplus/ (deficit)	(2,324)	(5,495)	(3,172)	↓	Red
EBITDA YTD	6,759	3,569	(3,190)	↓	Red
EBITDA %	4.3%	2.2%	(2.1%)	↓	Red
Clinical Income YTD	(142,294)	(143,382)	1,087	↑	Green
Non-Clinical Income YTD	(14,501)	(16,079)	1,578	↔	Green
Pay YTD	107,465	108,925	(1,460)	↓	Red
Non-Pay YTD	51,668	56,036	(4,368)	↓	Red
CIP Target YTD	3,559	1,040	(2,519)	↓	Red

Income and Expenditure Plan for 2023-24

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

Our reported position as at the end of August was a deficit of £5.5m against a planned deficit of £2.3m. This has resulted in an adverse variance of £3.2m. The most significant causes of this adverse variance are:

- Underachieved CIP £2.5m
- Unfunded industrial action £0.7m

The August position reported an improvement against the M1-4 trend (before the ERF adjustment).

Forecast 2023-24

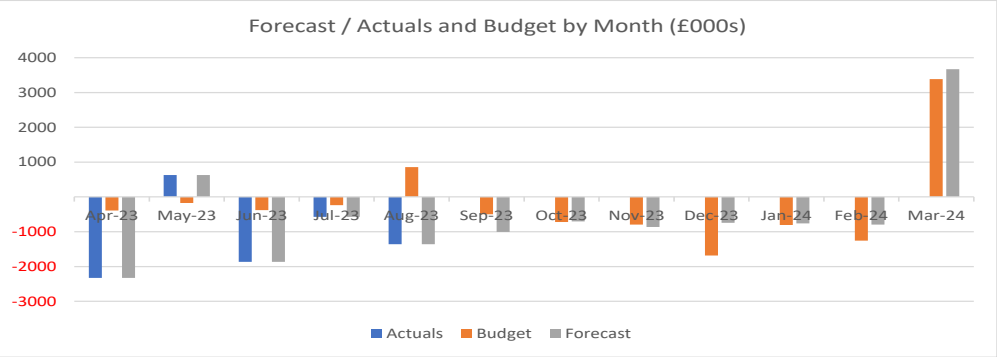
A broadly straight line extrapolation of our deficit could indicate a deficit of around £10m in 2023-24 (£7.3m worse than planned). However, we have submitted a Financial Recovery Plan that has suggested we could revise our forecast deficit to £6.7m (£4m worse than initially planned). This revised forecast is contingent on:

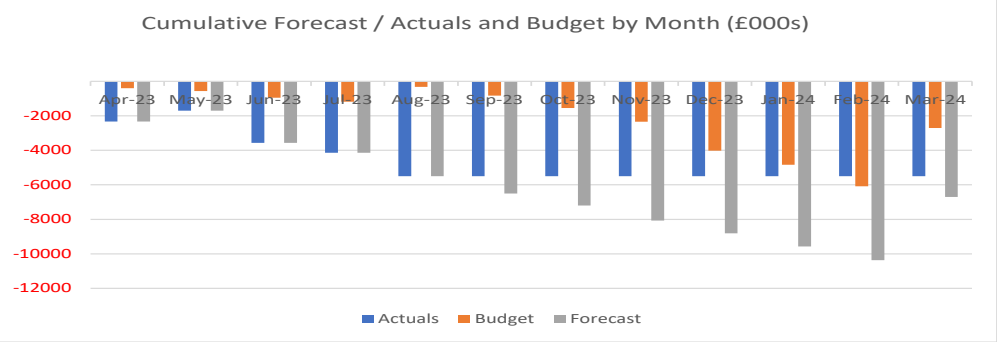
- ERF income £5m
- Delivering CIP £5m
- Improving our run rate (primarily temporary staff costs) £3.4m

The baseline and the baseline adjustments in relation to the opportunities and risks associated with ERF haven't yet been confirmed and the current guidance has led us to include ERF related income of £621k YTD.

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

Our forecast trajectory for the rest of 2023-24 is as below





Plan for 2024-25

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

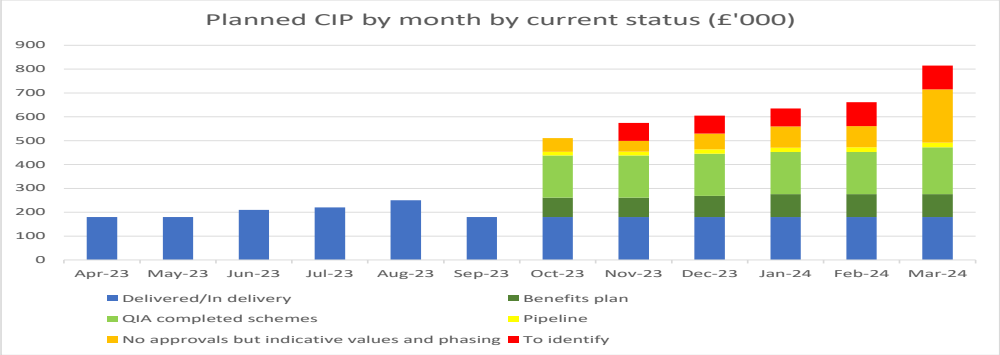
FINANCE REPORT – August 2023

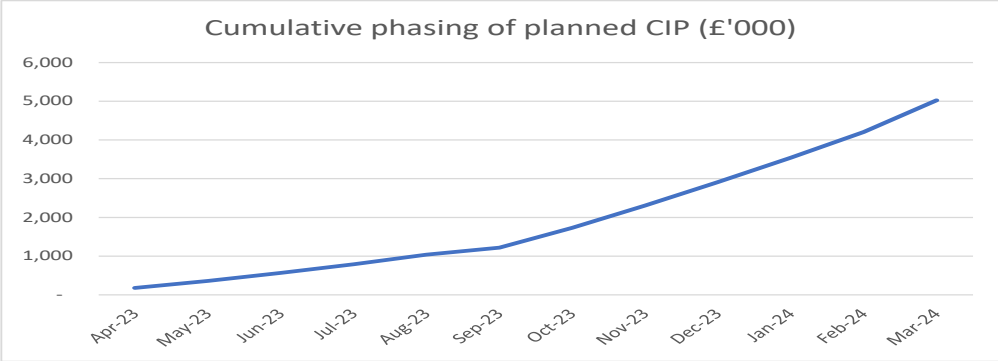
Cost Improvement Programme (CIP)

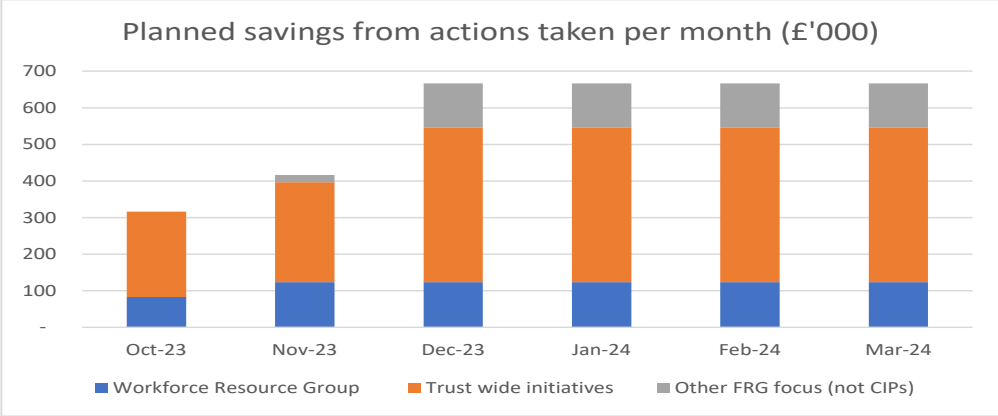
A summary of progress on the CIP plan is included below (£5m), as well as our planned run rate improvements (£3.4m)

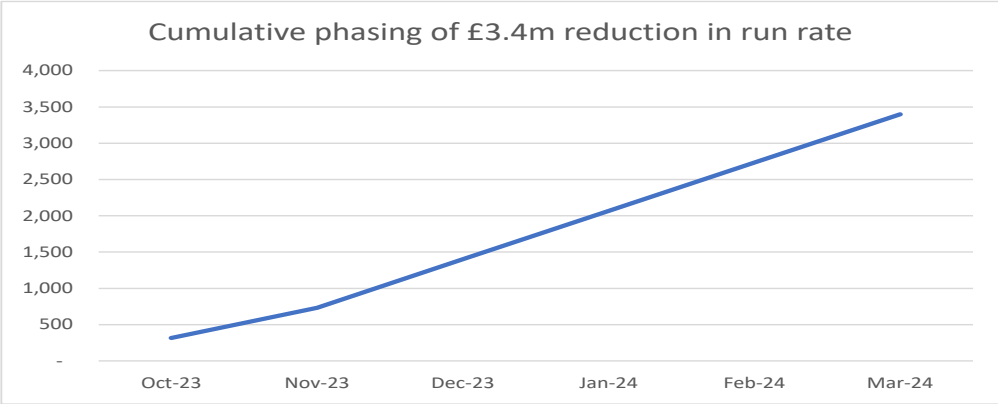
				Note : Not risk adjusted						
Division	Target	Delivered to August	Delivery from September (August recurring)	QIA completed schemes	Benefits plan	Pipeline	No approvals but indicative values and phasing	Identified 23/24 (gross)	To identify	Identified and risk adjusted
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Medicine	2,610	3	17	15	143	50	331	559	2,051	345
Surgery	1,978	383	392	272	237	91	6	1,381	597	1,296
Women & Children	671	0	0	0	322	0	5	327	344	244
CSS	1,260	57	50	0	0	0	202	309	951	208
Community	1,588	334	235	297	15	0	464	1,345	243	1,109
Estates & Facilities and Corporate	2,493	257	572	494	0	0	130	1,453	1,040	1,388
Total	**10,600**	**1,034**	**1,266**	**1,078**	**717**	**141**	**1,138**	**5,374**	**5,226**	**4,591**

Division	Number of PIDs complete	Scheme >£10k (templates completed)	Pipeline PIDs	Total Templates / PIDs complete	23/24 PID Value £k	No. signed off: QIA
Medicine	1	0	11	12	559	3
Surgery	14	11	33	58	1,381	6
Women & Children	0	0	17	0	327	0
Clinical Support Services	8	0	23	31	309	1
Community	33	13	22	64	1,345	11
Corporate + E&F	13	8	0	21	1,453	22
Total	**61**	**32**	**106**	**199**	**5,374**	**43**









FINANCE REPORT – August 2023

Workforce

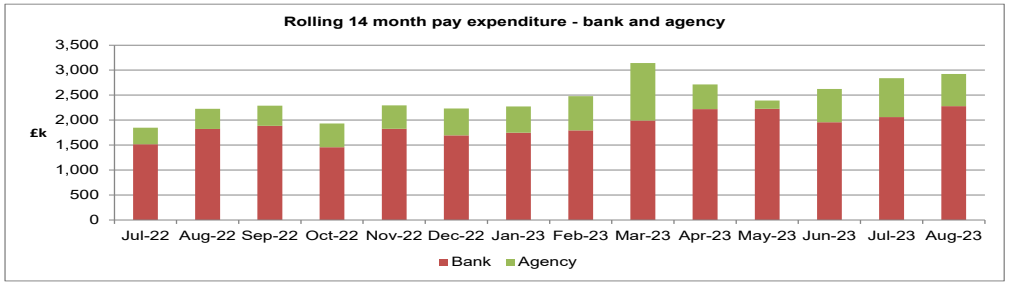
During August the Trust overspent by £0.9m on pay

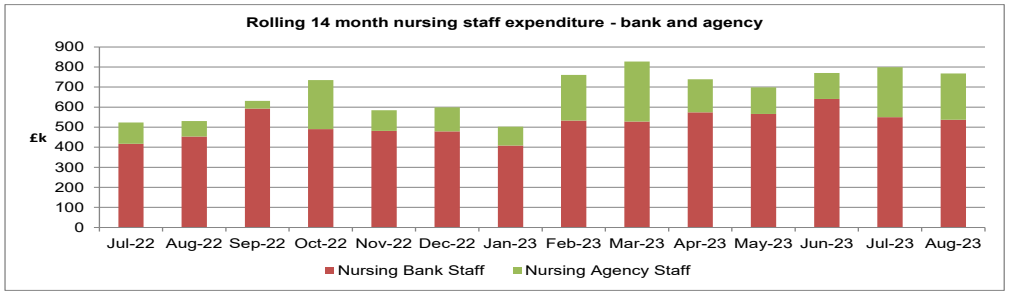
Compared to August 2023 we now employ 407 more WTEs (8.9%), of which 393 are substantive and 14 are temporary

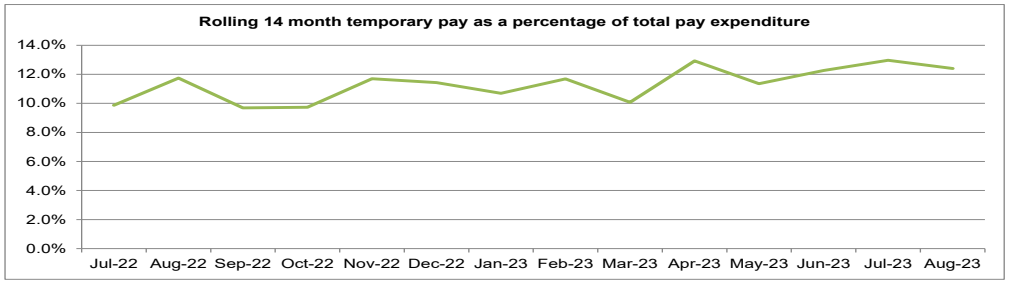
Monthly Expenditure (£)				
As at August 2023	Aug-23	Jul-23	Aug-22	YTD
	£000's	£000's	£000's	£000's
Budgeted Costs in-month	22,717	21,073	19,205	107,465
Substantive Staff	20,657	19,058	16,755	95,432
Medical Agency Staff	251	168	164	515
Medical Locum Staff	672	552	424	2,739
Additional Medical Sessions	476	361	406	1,893
Nursing Agency Staff	231	249	77	907
Nursing Bank Staff	537	550	454	2,867
Other Agency Staff	164	360	163	1,323
Other Bank Staff	211	249	230	1,220
Overtime	162	175	163	1,009
On Call	220	174	147	1,019
Total Temporary Expenditure	2,924	2,839	2,227	13,493
Total Expenditure on Pay	23,581	21,897	18,982	108,925
Variance (F/(A))	(864)	(824)	223	(1,460)
Temp. Staff Costs as % of Total Pay	12.4%	13.0%	11.7%	12.4%
memo: Total Agency Spend in-month	646	777	403	2,745

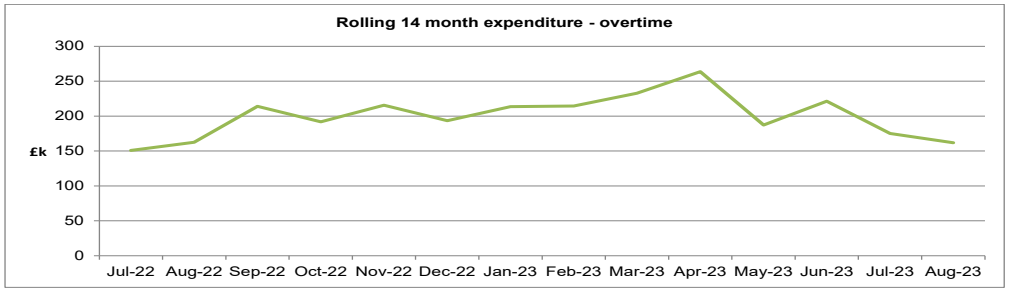
Monthly WTE			
As at August 2023	Aug-23	Jul-23	Aug-22
Budgeted WTE in-month	4,986.3	5,008.4	4,812.0
Substantive Staff	4,612.8	4,520.4	4,219.5
Medical Agency Staff	12.6	5.3	13.3
Medical Locum Staff	38.5	46.3	42.8
Additional Medical Sessions	17.6	7.8	7.5
Nursing Agency Staff	29.2	18.7	13.8
Nursing Bank Staff	132.9	129.4	118.4
Other Agency Staff	29.0	59.7	27.1
Other Bank Staff	66.0	78.7	79.8
Overtime	37.8	41.3	44.5
On Call	6.9	6.9	9.6
Total Temporary WTE	370.3	393.9	356.8
Total WTE	4,983.1	4,914.3	4,576.2
Variance (F/(A))	3.2	94.1	235.7
Temp. Staff WTE as % of Total WTE	7.4%	8.0%	7.8%
memo: Total Agency WTE in-month	70.7	83.7	54.1

Pay Costs









FINANCE REPORT – August 2023

Statement of Financial Position – 31 August 2023

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2023	Plan 31 March 2024	Plan YTD 31 August 2023	Actual at 31 August 2023	Variance YTD 31 August 2023
	£000	£000	£000	£000	£000
Intangible assets	61,869	57,425	57,173	70,167	12,994
Property, plant and equipment	193,976	227,589	196,102	189,533	(6,569)
Right of use assets	9,817	9,929	11,385	9,818	(1,567)
Trade and other receivables	6,001	6,341	6,341	6,001	(340)
Total non-current assets	**271,663**	**301,284**	**271,001**	**275,519**	**4,518**
Inventories	4,365	3,800	3,800	4,322	522
Trade and other receivables	41,871	14,991	15,444	17,746	2,302
Non-current assets for sale	520	0	0	520	520
Cash and cash equivalents	7,895	14,298	6,708	2,882	(3,826)
Total current assets	**54,651**	**33,089**	**25,952**	**25,470**	**(482)**
Trade and other payables	(73,503)	(45,862)	(38,777)	(45,840)	(7,063)
Borrowing repayable within 1 year	(4,801)	(3,724)	(3,724)	(4,790)	(1,066)
Current Provisions	(64)	(46)	(46)	(64)	(18)
Other liabilities	(1,336)	(5,185)	(3,685)	(8,978)	(5,293)
Total current liabilities	**(79,704)**	**(54,817)**	**(46,232)**	**(59,672)**	**(13,440)**
Total assets less current liabilities	**246,610**	**279,556**	**250,721**	**241,317**	**(9,404)**
Borrowings	(48,038)	(41,265)	(44,574)	(46,740)	(2,166)
Provisions	(507)	(852)	(852)	(502)	350
Total non-current liabilities	**(48,545)**	**(42,117)**	**(45,426)**	**(47,242)**	**(1,816)**
Total assets employed	**198,065**	**237,439**	**205,295**	**194,075**	**(11,220)**
Financed by					
Public dividend capital	230,215	271,107	238,277	231,715	(6,562)
Revaluation reserve	12,054	12,640	12,640	12,054	(586)
Income and expenditure reserve	(44,204)	(46,307)	(45,622)	(49,694)	(4,072)
Total taxpayers' and others' equity	**198,065**	**237,440**	**205,295**	**194,075**	**(11,220)**

The above table shows the year to date position as at 31 August 2023.

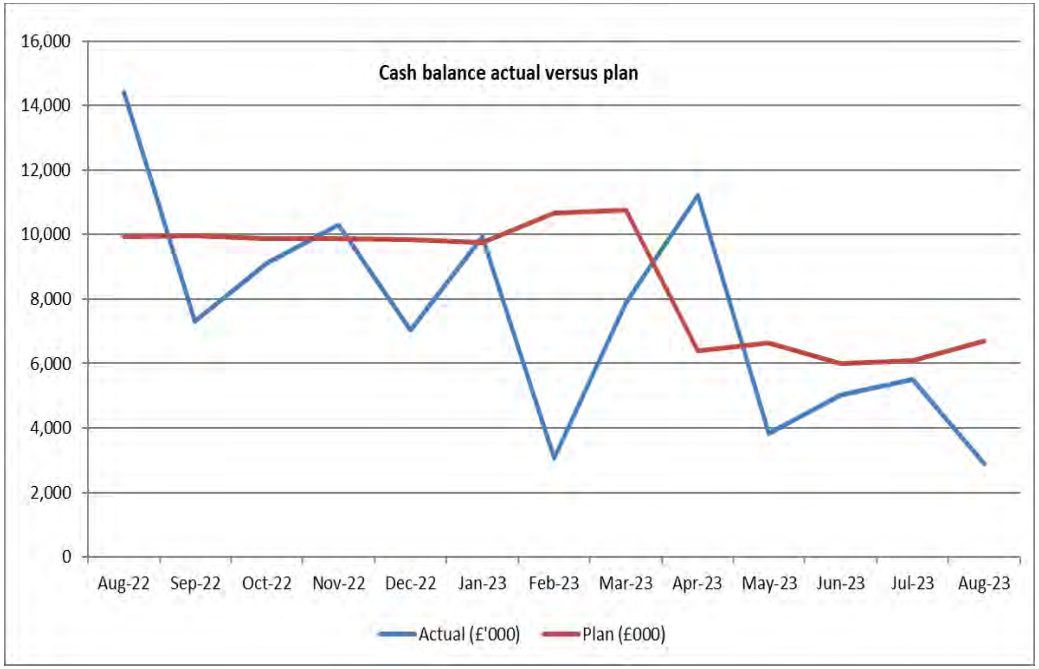
Total reserves are slightly below plan and this is due to the fact that we are reporting a deficit slightly higher than plan. We have not drawn down PDC funding in line with the plan. This is because our capital spend for projects associated with the PDC funding is not in line with the plan (see below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

Trade payables are higher than plan, but are in line with the previous month (£50m at month 4). We expect trade payables to increase as we try to manage our aged creditors and are unable to pay them in line with their payment terms due to our cash position.

Other liabilities are higher than plan due to £5m received from the ICB that is being treated as deferred income as it is contract income received in advance.

Cash Balance for the year

The graph illustrates the cash trajectory since August 2023. The Trust is required to keep a minimum balance of £1.1m.

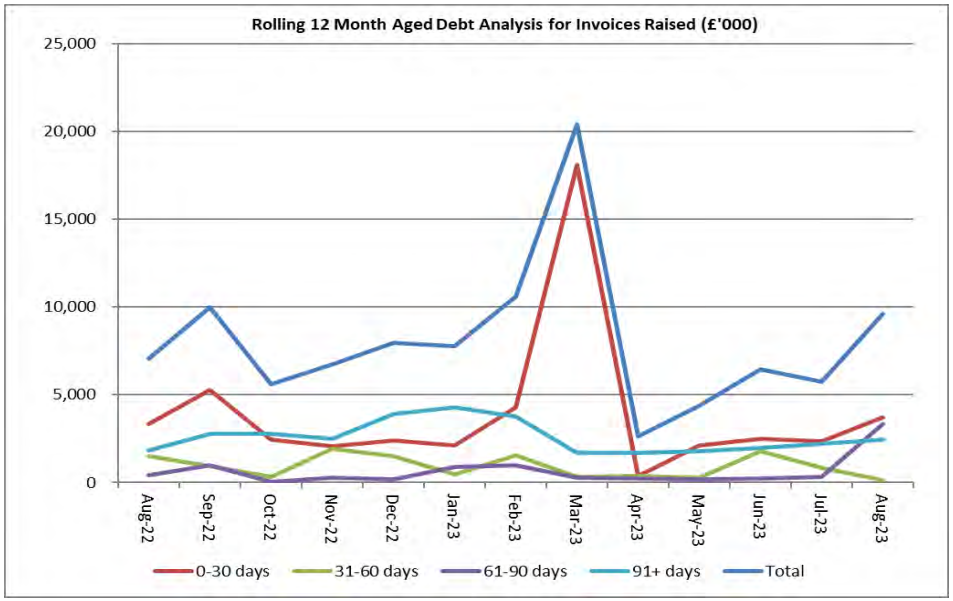


The cash position remains below plan. Our cash is being rigorously monitored to ensure that we have adequate cash reserves to match our expenditure. However, as the Trust continues to report a deficit, our cash position has deteriorated and as a result we have applied for £10m in revenue support. If our application is approved by DHSC we will receive this cash in mid October. Until then, the Trust is having to make critical decisions around the priority in which suppliers can be paid.

FINANCE REPORT – August 2023

Debt Management

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



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

The overall level of sales invoices raised but not paid has remained stable in the first four months of the year, but has increased in month 5. We continue to work hard to ensure that all income is received on a timely basis and to help our cash position.

Over 60% of the outstanding debts relate to NHS Organisations, with 27% of these NHS debts being greater than 90 days old.

Capital Progress Report

The previously revised Capital Plan for 2023/24 of £36.413m has now been further reduced by £886k due to a clawback from the region. This results in a further revised capital plan of £35.527m for 2023/24.

The month 5 capital spend is £10.208m, which is £4.054m below the expected spend per the original Plan of £14.262m, mostly attributed to higher spend for Newmarket CDC originally forecasted in earlier months rather than in the latter part of the financial year.

The table below shows the year-to-date capital spend up to month 5:

Capital Spend - 31st August 2023		**Year to Date**			**Full Year**	
Capital Scheme	Full Year Plan	YTD Original Plan (M5)	**YTD Actual (M5)**	Variance	***Funding Split***	
					Internal	***PDC Available***
	£000's	£000's	**£000's**		***£000's***	***£000's***
New Hospital (Future Systems)	1,228	547	**622**	- 75	***200***	***1,028***
Newmarket CDC	12,549	5,200	**258**	4,942		***12,549***
RAAC	10,900	3,500	**2,652**	848		***10,900***
Estates	1,966	1,180	**388**	792	***1,966***	
IM&T	6,234	2,735	**3,127**	- 392	***5,989***	***245***
Medical Equipment	495	205	**1,025**	- 820	***495***	
Imaging Equipment	1,830	760	**2,136**	- 1,376	***1,830***	
Other Schemes	325	135	**-**	135	***325***	
Total Capital Schemes	35,527	14,262	**10,208**	4,054	***10,805***	***24,722***
Overspent vs Original Plan					***35,527***	
Underspent vs Original Plan						

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

To Assure

Presented by Louisa Pepper

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Improvement			Date of meeting: 19/07/23		
Chaired by: Louisa Pepper			**Lead Executive Director: Sue Wilkinson**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	Level of Assurance* 1. Substantial 2. Reasonable 3. Partial 4. Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT 3. To Board
4.1	Quality strategy	Partial	A WSFT quality strategy is to be developed, led by the Associate Director for QI.	An update to include milestones will be presented to the October Improvement committee	1
5.1	IQPR – Nutrition	Substantial	Presentation using the new QA template.		
5.2i	Duty of candour	Reasonable	Average time to complete verbal DoC = 8 days Audit provides better measure of assurance for timeliness and quality. Audit results will be used to tailor ongoing improvement including systems reviews, and education and training to support staff.	DoC QI project to conclude and report through PQASG DoC audit to provide quality assurance going forwards Improvement committee formally agreed to remove '*DoC within 10 working days'* from IQPR	1
5.2ii	Glemsford CQC inspection progress report	Partial	Good progress to achieve all elements of the Improvement plan following inspection (with Good rating). Concerns around Clinical Pharmacist departure (key to many actions) however post has now been successfully recruited to. Some IPC concerns, mainly related to buildings/estate will be addressed through current/planned building work.	The IPC committee will keep a watching brief on the IPC items and a wider update on all progress to be received by Improvement in January 2024.	1
5.2iii	Peer to peer support network	Reasonable	Update on programme		

Originating Committee: Improvement			Date of meeting: 19/07/23		
Chaired by: Louisa Pepper			Lead Executive Director: Sue Wilkinson		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	Level of Assurance* 1. Substantial 2. Reasonable 3. Partial 4. Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT 3. To Board
7.1	Quality assurance framework	Partial	Updates on progress of the baseline assessment (what have divisions/teams got in place to manage QA currently?). Also reported through SLT. Proposal to use QA template (as trialled by nutrition report) to test subjects with relevance for multiple aspects of CQC regulations. LD & autism chosen as first topic.	Continue to progress baseline assessment with the divisional leads Working with LD&A leads and HoNs to undertake a QA review with a report back to Improvement in October.	1
7.2	National best practice publications & trust response, allocation, pathways and mapping	Partial	Sets out pathways for allocation of simple (clear local ownership) and complex (organisation-wide / no clear owner) publications. Flowchart now (since Apr23) in use by CEGG all following simple pathway.	Paper to SLT to set out pathway and the role of SLT in decision-making and prioritisation. Learning from Ockenden experience to be utilised to ensure future complex reports have a more streamlined and timely response.	2
7.3i	Ockenden Improvement programme	Partial	Structured plan with divisional links required. Allocation of individual elements of the plan to exec lead and assurance committee would be helpful	An update to September Improvement committee will set this out in more detail. The Involvement (and, where/if relevant Insight) will also require an update.	
7.3ii	Ockenden quality assurance	Partial	Example of an element of the Ockenden baseline assessment + gap analysis which had declared full compliance (complaints management). Evidence presented giving substantial assurance for that element.	Links to action in 7.3i re allocation of elements to Exec lead / committee.	

Originating Committee: Improvement			Date of meeting: 19/07/23		
Chaired by: Louisa Pepper			Lead Executive Director: Sue Wilkinson		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	Level of Assurance* 1. Substantial 2. Reasonable 3. Partial 4. Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT 3. To Board
			Consideration as to the benefit of this approach versus a simpler 'list of how all compliant elements would be evidenced"		
8.1	Patient Safety & Quality governance group (June report)	Reasonable	Updates from D&T, IPC, Falls and Nutrition groups. For assurance. No points of escalation to Improvement noted		
8.2	Clinical Effectiveness governance group (June report)	Minimal	Updates flagging risks around Pathology accreditation, Pharmacy staffing (and its impact on R&D activity) and lack of system to process and upload clinical guidelines.	Clinical support division managing risks around Pathology and Pharmacy. Need to address underlying issues and potential solutions re guidelines being followed up outside Improvement committee	
9.1	Emerging risk review (ERR) risks	Reasonable	Received for information		1

Acronyms: D&T (drugs & therapeutics), QI (quality improvement), QA (quality assurance), DoC (Duty of Candour), IPC (infection prevention & control), SLT (Senior leadership team meeting), LD (learning disabilities/Learning difficulties)

4.4. Quality and Nurse Staffing Report

To Assure

Presented by Susan Wilkinson

Board of Directors	
Report title:	Quality and Workforce Report & Dashboard – July and August 2023
Agenda item:	4.4
Date of the meeting:	**29th September 2023**
Sponsor/executive lead:	**Susan Wilkinson**
Report prepared by:	**Daniel Spooner: Deputy Chief Nurse**

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

Executive Summary
WHAT? ***Summary of issue, including evaluation of the validity the data/information***
This paper reports on safe staffing fill rates and mitigations for inpatient areas for July and August 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.
SO WHAT? ***Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk***
• Overall RN/RM vacancy rate is 9% and in common cause variation. • Overall Nursing assistant vacancy rate is 10.5% and in common cause variation. • Turn over for RN/RM remains under 10% • Fill rates have improved across all shifts and roles and above 90% for RNs and night shifts for NAs. • Combined nursing and NA fill rates for July and August above 90% • Expected CHPPD achieved for both July and August • Sickness rates static • Following submission to NHSE, WSFT has achieved 'Gold' accreditation for pastoral care of support workers. • Summer inpatient SNCT completed and reviewed.
WHAT NEXT? ***Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)***

Increased oversight of nursing temporary spend monitored through newly established nursing deployment group
Action Required
For assurance around the daily mitigation of nurse staffing and oversight of nursing establishments No action from board required needed.

Risk and assurance:	Red Risk 4724 amended to reflect surge staffing and return to BAU
Equality, Diversity and Inclusion:	Ensuring a diverse and engaged workforce improves quality patient outcomes. Safe staffing levels positively impacts engagement, retention and delivery of safe care
Sustainability:	Efficient deployment of staff and reduction in temporary staffing and improving vacancy rates contributes to financial sustainability
Legal and regulatory context	Compliance with CQC regulations for provision of safe and effective care

1. Introduction

The National Quality Board (NQB 2016) recommend that monthly, actual staffing data is compared with expected staffing and reviewed alongside quality of care, patient safety, and patient and staff experience data. The trust is committed to ensuring that improvements are learned from and celebrated, and areas of emerging concern are identified and addressed promptly. This paper will identify safe staffing and actions taken in July and August 2023. The following sections identify the processes in place to demonstrate that the Trust proactively manages nurse staffing to support patient safety.

2. Nursing Fill Rate

The Trust's safer staffing submission has been submitted to NHS Digital for July and August 2023 within the data submission deadline. Table 1 shows the summary of overall fill rate percentages for these months and for comparison, the previous four months. Appendix 1a and 1b illustrates a ward-by-ward breakdown for July and August 2023

	Day		Night	
	Registered	Care Staff	Registered	Care staff
Average fill rate March 2023	84%	77%	90%	93%
Average fill rate April 2023	87%	78%	92%	95%
Average fill rate May 2023	87%	83%	94%	94%
Average fill rate June 2023	89%	84%	94%	95%
Average fill rate July 2023	91%	89%	97%	100%
Average fill rate August 2023	91%	87%	96%	100%

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. July and August saw both months above 90% aspiration.

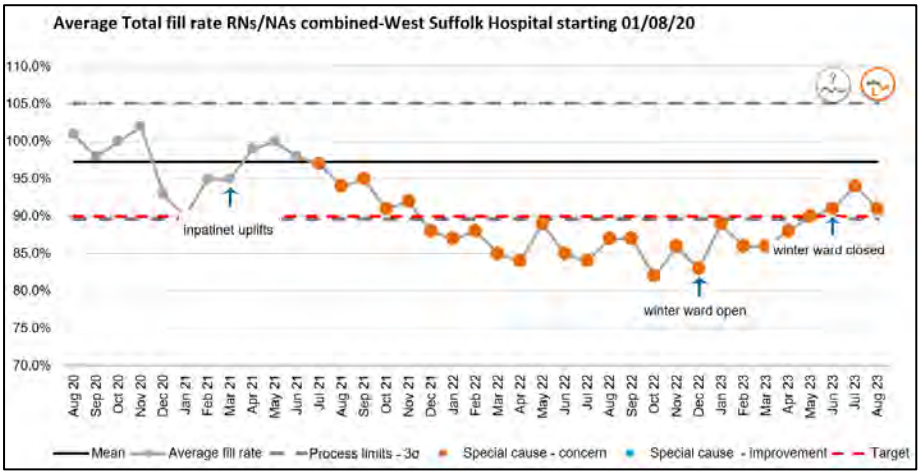


Chart 2.

2.1 Care hours per patient Day (CHPPD)

CHPPD is a measure of workforce deployment and is reportable to NHS Digital as part of the monthly returns for safe staffing (Appendix 1). CHPPD is the total number of hours worked on the roster by both Registered Nurses & Midwives and Nursing Support Staff divided by the total number of patients on the ward at 23:59 aggregated for the month (lower CHPPD equates to lower staffing numbers available to provide clinical care).

Using model hospital, the average Recommended CHPPD for an organisation of our size is 7.6. The chart 3 (below) demonstrates our achievement of this. Since August 2021 we are not achieving this consistently and further demonstrates the staffing challenges over the last year.

CHPPD can be affected adversely by opening additional beds, as the number of nurses to beds is reduced. Periods of high bed occupancy can also reduce CHPPD. Closing additional beds will improve CHPPD. As

anticipated, July and August saw CHPPD in line with the expected number of hours for an organisation of our size

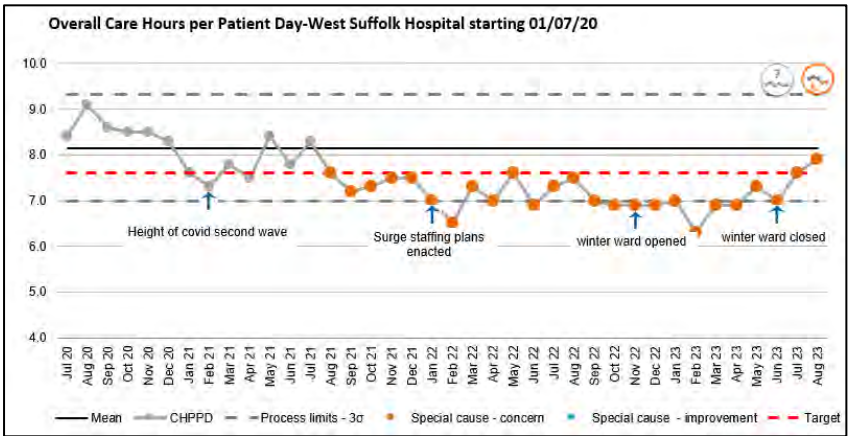


Chart 3 Adapted from model hospital/unify data.

3. Sickness

Sickness rates have remained reasonably static within both staff group.

	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	July 23	Aug 23
Unregistered staff (support workers)	7.21%	6.27%	7.27%	7.41%	6.74%	6.63%	6.09%	5.78%
Registered Nurse/Midwives	4.53%	4.89%	4.75%	4.06%	3.84%	4.45%	4.48%	4.69%
Combined Registered/Unregistered	**5.43%**	**5.36%**	**5.60%**	**5.20%**	**5.42%**	**4.92%**	**5.02%**	**5.05%**

Table 4

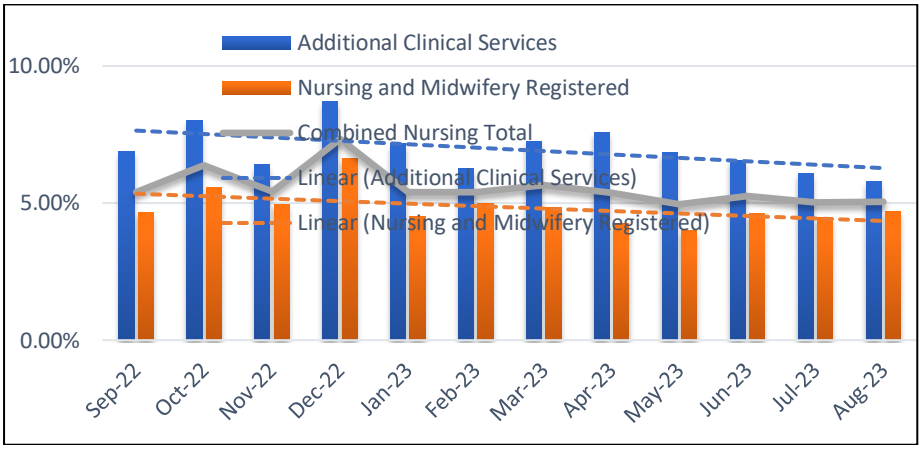


Chart 4

4. Recruitment and Retention

<u>Vacancies: Registered nursing (RN/RM):</u>

Table 5 demonstrates the total RN/RM establishment for the inpatient areas (WTE). The total number of substantive RNs has seen an improving trend. Full list of SPC related to vacancies and WTE can be found in appendix 2. Areas of concern remain within the non-registered staff group.

- Substantive Inpatient RN/RM WTE improved on last period is in common cause variation
- Inpatient RN/RM vacancy rate has reduced from 11.9% to **11.3%** at month 5.

- Total RN/RM vacancy rate has reduced from 9.8% to **9.0%** and has moved into common cause variation
- Inpatient ward NA vacancies percentages over this period has increased to **13.1%** in month 5and is in common cause variation.
- Total NA vacancy rate has increased to **11.2%**, the trend is not as consistent as with registered staff.
- WTE for NA in both inpatient and trust total is an improving picture and is in special cause improvement.

	Inpatient	Sum of Actuals Period 12 (March)	Sum of Actuals Period 1 (April)	Sum of Actuals Period 2 (May)	Sum of Actuals Period 3 (June)	Sum of Actuals Period 4 (July)	Sum of Actuals Period 5 (Aug)	WTE VACANCY at period 5
RN/RM Substantive	Ward WTE	656.8	671.1	666.6	674.8	667.6	678.7	86.4
Nursing Unregistered Substantive	Ward WTE	400.6	409.4	407.8	405.3	394.0	390.4	63.0

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

5. New Starters and Turnover

International Nurse Recruitment:
The international nursing pipeline continues to be challenging recently due to external delays with visa acquisitions. The target of 84 (Jan to Nov 2023) is at risk of not being achieved due to these challenges. This will be offset by successful local recruitment and a reduced pipeline will be considered going forward.

The international midwife pipeline has been successful and has onboarded 13 midwives thus far with a further 3 planned to arrive in September.

New starters

	Mar 23*	Apr 23	May 23	Jun 23	July 23	Aug 23
Registered Nurses	33	23	22	17	15	12
Non-Registered	47	23	22	26	12	36*

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 July, 15 RNs completed induction; of these; 10 were for the acute, 4 for bank service and 1for community.
- In July, 12 NAs completed induction; of these; 10 NAs are for the acute Trust, and 1for bank services and 1 for community services.

- In August, 12 RNs completed induction; of these; 10 were for the acute and 2 for community.
- In August, 36 NAs completed induction; of these; 17 NAs are for the acute Trust, and 15 for bank services and 4 for community services.

Turnover

On a retrospective review of the last rolling twelve months, turnover for RNs continues to positively be under the ambition of 10%. Turnover remains at 9.3% for this period. NA turnover has decreased slightly to 23.7%. The high turnover of this staff group has been escalated through the finance and workforce committee and is

being captured at the Trust retention group. Interventions to address high turnover included more informative onboarding process and this has been positively received by clinical teams.

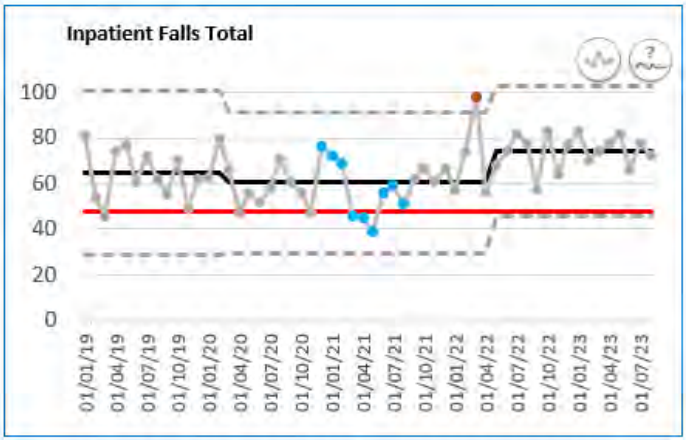
Following submission to the NHS Pastoral Care Quality Award WSFT was awarded 'gold' accreditation. To achieve the award, the Trust successfully met a set of standards, demonstrating best practice pastoral care for support workers, including recruitment and induction; in-role support; ongoing learning and development; valuing staff and recognition. This is a positive achievement and testament to the interventions applied to address the high turnover of this staff group.

		Turnover	01/09/2022	-	31/08/2023			
Staff Group	Average Headcount	Avg FTE	Starters Headcount	Starters FTE	Leavers Headcount	Leavers FTE	LTR Headcount %	LTR FTE %
Nursing and Midwifery Registered	1,386.50	1,203.3240	96	79.6400	140	112.2533	10.0974%	9.3286%
Additional Clinical Services	596.00	502.1961	318	289.2834	151	119.1098	25.3356%	23.7178%

Table 7. (Data from workforce information)

6. Quality Indicators

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



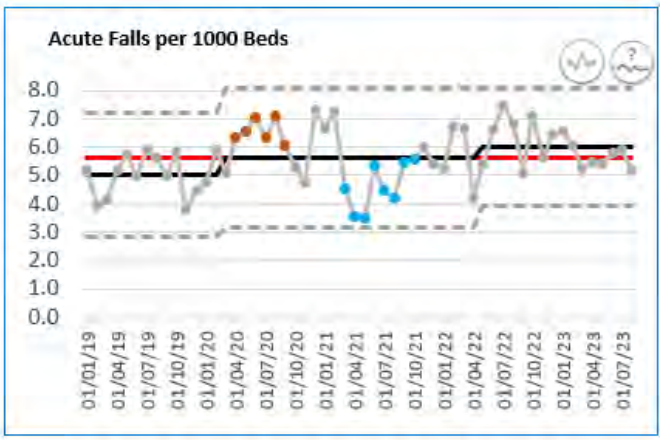
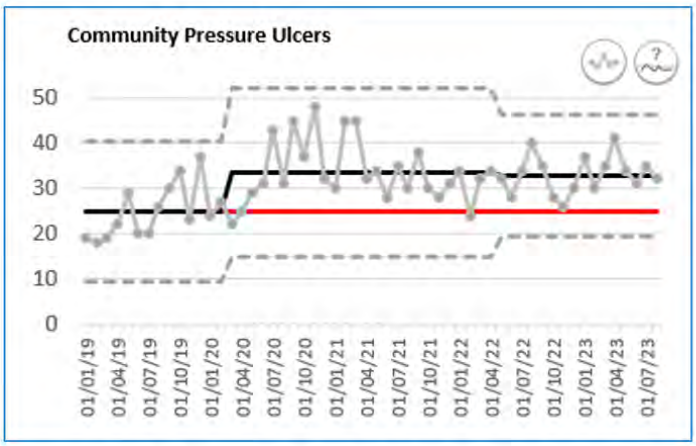
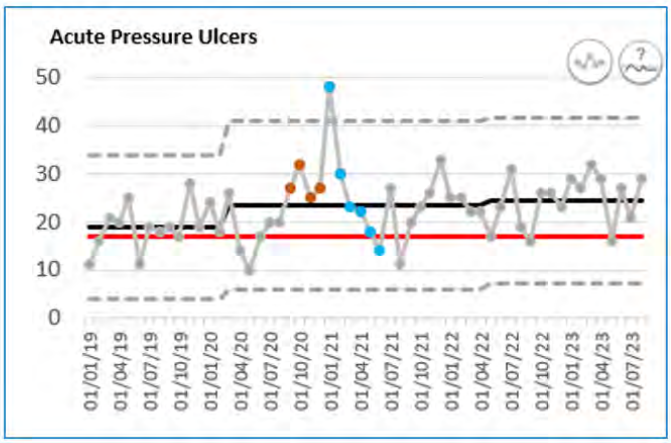


Chart 8
Pressure Ulcers -



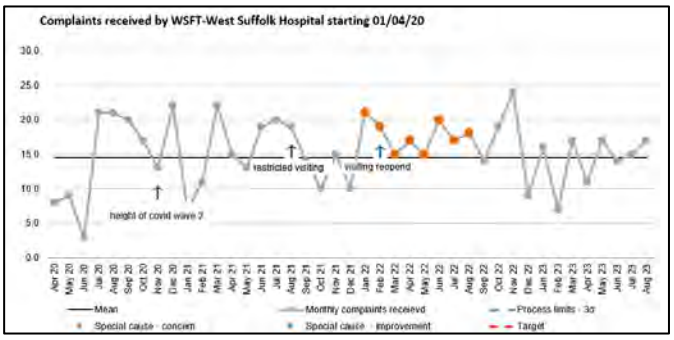


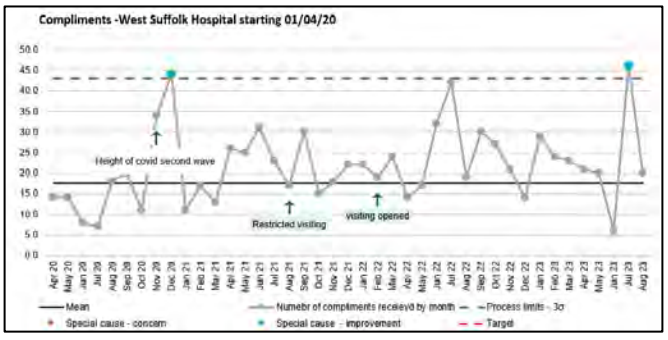
7. Compliments and Complaints

15 formal complaints were received in July. The main theme for complaints in July 2023 was clinical treatment with 7 formal complaints listed under this subject (although these are separated out into areas e.g., clinical treatment – pathology group). Complaints listed under this subject mainly related to disputes or delays of diagnosis, and delays to undertake scans/x-rays. Communications and values & behaviours (staff) each had 2 formal complaints listed under these subjects.

17 formal complaints were received in August. 9 of the complaints received were for the women & children's division, 4 were for the medical division, 3 were for integrated community services and 1 for clinical support division. The main theme for complaints in August 2023 was clinical treatment with 9 complaints being listed under this subject (although these are separated out into areas e.g., clinical treatment – accident & emergency). Clinical treatment – obstetrics and gynaecology were the highest area under this subject with a total of 6 formal complaints being listed under this subject. 3 formal complaints were listed as relating to communications.

Chart 10a and 10b demonstrates the incidence of complaints and compliments for this period and both are in common cause variation, indicating a fluctuating incident rate without formal improvement or decline. A spike in compliments was seen in July prompting special cause case. This is highest number of compliments seen this year.





10a Complaints 10b Compliments

8. Adverse Staffing Incidences

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

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

Table 11.

- In July 6 Datixs recorded for nurse staffing that resulted in a Red Flag event (see table 11.). No harm is recorded for these incidents at the time.

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

9. Maternity Services

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

	Standard	March	April	May	June	July	August
Supernumerary Status of LS Coordinator	100%	100%	99%	100%	100%	100%	100%
1-1 Care in Labour	100%	100%	100%	100%	100%	100%	100%
MW: Birth Ratio	1:21	1:25	1:24	1:26	1:26	1:21	1:22.5
No. Red Flags reported		7	4	4	2	2	1

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

- There were two red flag events in July. No harm was recorded as in impact of these incidents.
- There was one red flag event in August. No harm was recorded for this incident.

Midwife to Birth ratio
Latest Birthrate plus review undertaken in March 2023 shows that Midwife to Birth ratio at West Suffolk NHS Foundation Trust is 1:21. The ratios are based on the Birth-rate Plus® dataset, national standards with the methodology and local factors, such as % uplift for annual, sick & study leave, case mix of women birthing in hospital, provision of outpatient/day unit services, total number of women having community care irrespective of place of birth and primarily the configuration of maternity services.

- July midwife to birth rate was 1:21
- August midwife to birth ratio was 1:22.5 (no harm or delays were recorded)

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

10. Community & Integrated services division

11.1 Demand

The SPC charts show that demand for therapy in the INT teams is higher than normal for the past 8 months. Demand for nursing in the INTs remains steady.

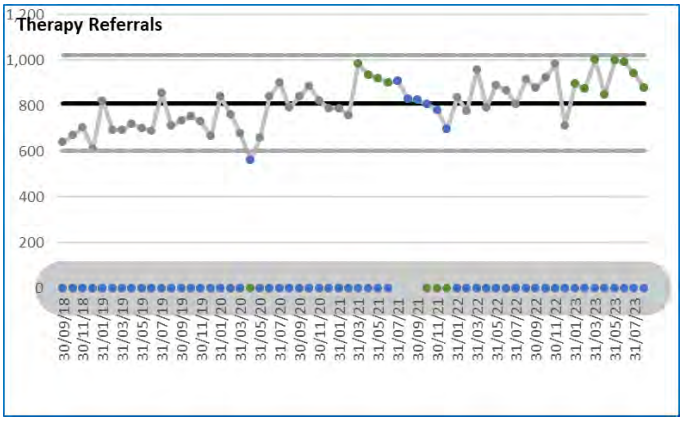


Chart 12a

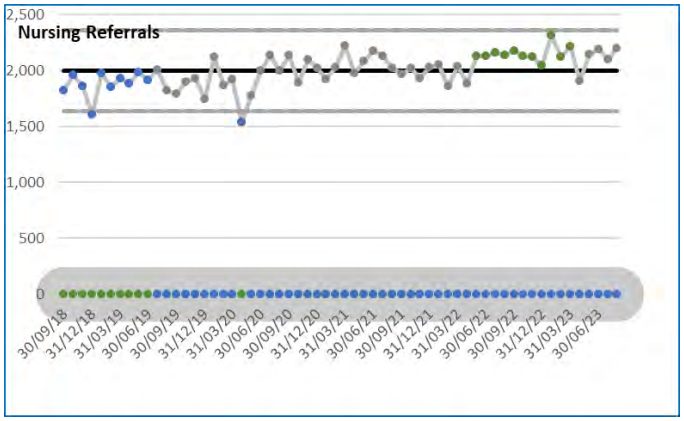
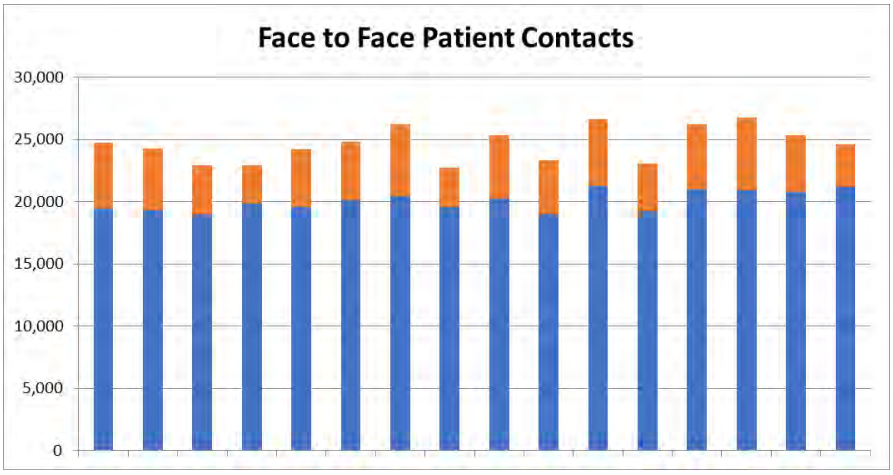


Chart 12b

The amount of face-to-face activity within the division is higher in the last quarter for adults, but not for ICSP



11.2 Sickness & Turnover

Sickness within the community continues to improve. As can be seen in the SPC (chart 13) the levels of sickness are reducing but still short of the trust target. Whilst the data (chart 14) shows that community are not meeting the Trust's target of 10%, the Division has made a significant reduction in turnover since August (2022) when the Division peaked at 16% turnover and continues to reduce month on month. A reduced turnover means a reduction in vacancies and recruitment/ training costs and pressure on remaining colleagues.

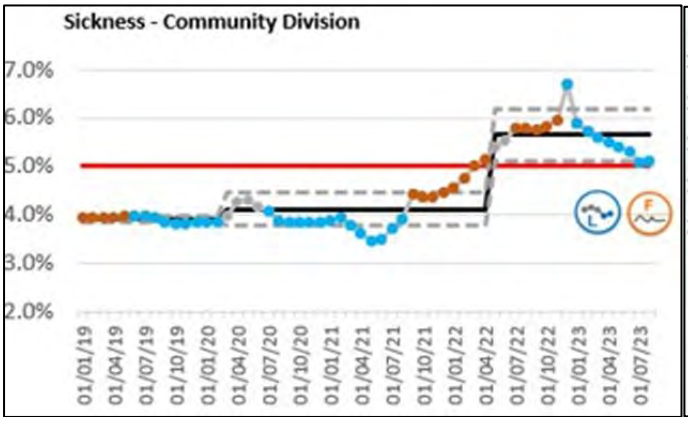


Chart 13.

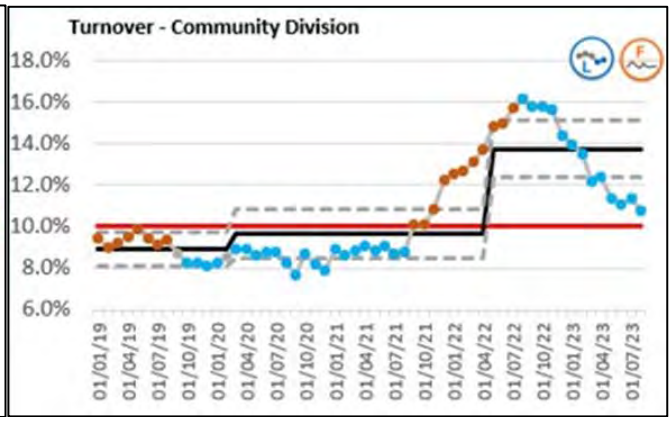


Chart 14

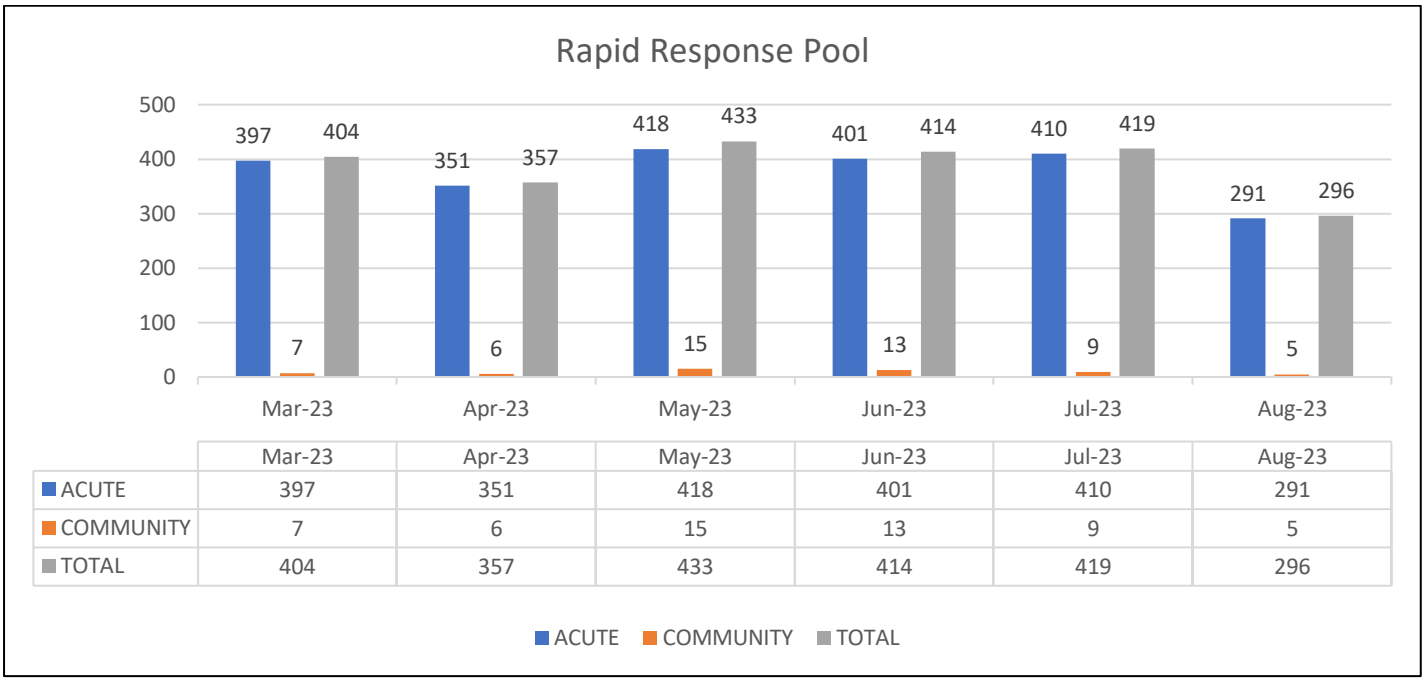
11.5 What next for community teams?

- Review of teams skill mix in INTS of therapists and nursing to review how far we can safely skill mix our teams with registered to non-registered staff.
- Analysis of CNSST, triangulate with quality data and professional judgement for nursing in the INTS. Benchmarking with ESNFT.
- HR supporting service managers to understand the sickness absence in the highest areas and ensure all actions to reduce sickness are completed.

11. Nursing budget and deployment actions.

In response to the challenging financial position of the trust, the corporate nursing division has enacted several actions and work programs to provide additional grip and control over temporary nursing spend. A large work program has commenced (appendix 4)). Actions include.

- Reduction in enhanced rapid response pool shifts in line with improvements in substantive recruitment (table 15)
- Reduction in enhanced rate for pool shifts from 40% to 20%
- Return to pre covid agency lead time and authorisation.
- Established a nursing oversight group to review clear rostering KPIs and temporary spend activity.
- Bespoke improvement program for theatres due to high spend area.



	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
ACUTE	397	351	418	401	410	291
COMMUNITY	7	6	15	13	9	5
TOTAL	404	357	433	414	419	296

Table 15. Number of enhanced rapid response shifts utilised in month.

12. Additional activity of note

12.1 **RSM Audit**

In August the results of the results of the RSM audit in staff staffing was published and reasonable assurance was achieved. Robust measures were observed through a comprehensive Safe Staffing Policy, and a regular review of skill mix for rostering highlighting a proactive approach to optimising staffing levels. Effective rostering practices were also in place for rosters to be appropriately planned and scheduled in advance. Additionally, the implementation of daily staffing meetings for clinical wards allowed the teams to address any issues on a real time and collaborative basis to optimise safe staffing levels and enhance patient care.

Weakness were found regarding the absence of a consistent process for the approval of staff overtime which has been picked through the work program described in section 11 of this paper (appendix 5)

12.2 **Biannual inpatient Safer Nurse Care Tool (SCNT) audit completed.**

The summer iteration of the SCNT was completed in June/July 2023. Following collation of the results the matrons and heads of nursing met with Deputy Chief Nurse (DCN) to triangulate the output and applying 'professional judgement' and outcomes as per NQB recommendations to each individual ward. A summary of the SNCT and the subsequent evaluation can be found in appendix 6. All areas have been identified as meeting the needs of their patient group. There are some opportunities to address skill mixes and WTE within divisional budgets, with potential cost savings and these will be realised following confirmation of WTE template and alignment of budgets in 2023.

13. Recommendations and actions

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

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

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

	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	RNs/RMN		Non registered (Care staff)		RNs/RMN		Non registered (Care staff)									
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average Fill rate RNs/RM %	Average fill rate Care staff %	Average Fill rate RNs/RM %	Average fill rate Care staff %	Cumulative count over the month of patients at 23:59 each	RNS/RMs	Non registered (care staff)	Overall
Rosemary Ward	1253.25	1152.45	1787.75	1602.5	1069	1020.25	1426	1465.75	92%	90%	95%	103%	889	2.4	3.5	5.9
Glastonbury Court	719	721	1069.5	1035.5	713	713	542.5	554	100%	97%	100%	102%	518	2.8	3.1	5.8
Acute Assessment	2108.5	2005.6667	1676.25	1400.25	1756	1705.75	1058	922	95%	84%	97%	87%	761	4.9	3.1	7.9
Cardiac Centre	1782.5	1746	1069.5	895	1782.5	1694	690	667	98%	84%	95%	97%	632	5.4	2.5	7.9
G10	1762.5	1653.9167	1679.25	1431.5	1068.98333	1059.5	1720.416667	1501.25	94%	85%	99%	87%	707	3.8	4.1	8.0
G9	1417.5	1312	1331.5	1205.75	1414.5	1417.5	1069.5	1149.75	93%	91%	100%	108%	752	3.6	3.1	6.8
F12	552	722.33333	322	338	713	675.5	328	317.5	131%	105%	95%	97%	240	5.8	2.7	8.6
F7	1749.25	1649.25	1606	1498.25	1414.5	1238.666667	1736.5	1486.5	94%	93%	88%	86%	683	4.2	4.4	8.6
G1	1426	984.75	334	307.5	713	702.5	356.5	353	69%	92%	99%	99%	485	3.5	1.4	4.8
G3	1656	1392	1753.08333	1586.75	1028.5	1035	1069.5	1395.5	84%	91%	101%	130%	864	2.8	3.5	6.3
G4	1711	1529.5	1766.5	1767.75	1058	954.5	1425.5	1487.75	89%	100%	90%	104%	896	2.8	3.6	6.4
G5	1407	1454.75	1619	1410.5	713	1032	1403	1362.75	103%	87%	145%	97%	760	3.3	3.6	6.9
G8	2397.75	2032	1665.25	1593.1667	1759.5	1686.75	1069.5	1101.5	85%	96%	96%	103%	615	6.0	4.4	10.4
F8	1707.75	1606.75	1796.5	1573.5	1046.5	987.5	1425.5	1704.5	94%	88%	94%	120%	723	3.6	4.5	8.1
Critical Care	2842	2727.5	341	197	2852	2582	0	33	96%	58%	91%	*	388	13.7	0.6	14.3
F3	1759.5	1391	2116	1845.5	1069.5	1070	1426	1362	79%	87%	100%	96%	732	3.4	4.4	7.7
F4	1115.5	901	914.5	568	632.5	632.5	578.5	410.5	81%	62%	100%	71%	633	2.4	1.5	4.0
F5	1747.5	1471.75	1379.5	1220.75	1018	1014	1046.5	842.5	84%	88%	100%	81%	698	3.6	3.0	6.5
F6	1778	1418.75	1744.33333	1497.8333	1334	1104	713	1032	80%	86%	83%	145%	942	2.7	2.7	5.4
Neonatal Unit	1122.5	1113.75	384	412	960	984	492	490.5	99%	107%	103%	100%	116	18.1	7.8	25.9
F1	1540	1587	713	680.25	1426	1414.5	0	11.5	103%	95%	99%	*	115	26.1	6.0	32.1
F14	372	372.5	0	0	744	744	0	0	100%	*	100%	*	106	10.5	0.0	10.5
Total	33,927.00	30,945.62	27,068.42	24,067.25	26,285.98	25,467.42	19,576.42	19,650.75	**91%**	**89%**	**97%**	**100%**	**13255**	**4.3**	**3.3.**	**7.6**
* planned hours are zero, so additional support used on ward to mitigate unfilled nursing hours																

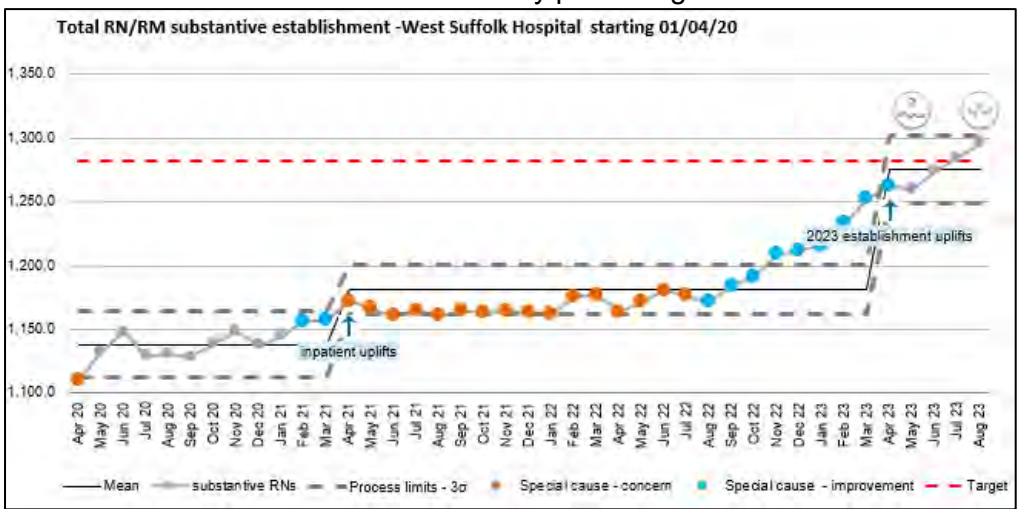
Appendix 1. Fill rates for inpatient areas (August2023) Data adapted from Unify submission.

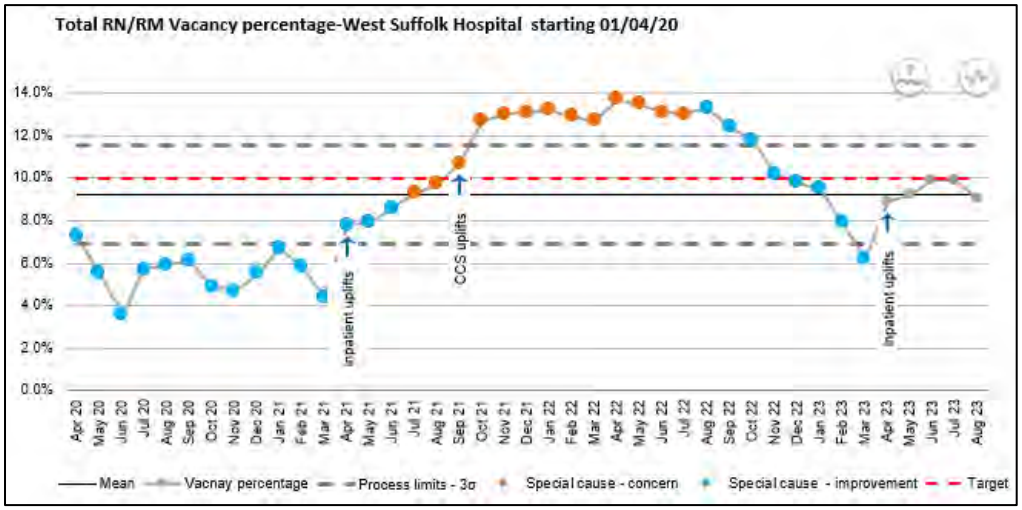
	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	RNs/RMN		Non registered (Care staff)		RNs/RMN		Non registered (Care staff)									
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average Fill rate RNs/RM %	Average fill rate Care staff %	Average Fill rate RNs/RM %	Average fill rate Care staff %	Cumulative count over the month of patients at 23:59 each	RNS/RMs	Non registered (care staff)	Overall
Rosemary Ward	1302.5	1181	1781.25	1511.1667	1023.5	1008.333333	1426	1323.5	91%	85%	99%	93%	452	4.8	6.3	11.1
Glastonbury Court	713	714	1069.5	1046.5	713	699.5	542.5	531	100%	98%	98%	98%	384	3.7	4.1	7.8
Acute Assessment	2133.5	1982.25	2326.5	1530	1782.5	1593.5	1357	1038	93%	66%	89%	76%	761	4.7	3.4	8.1
Cardiac Centre	1771	1628.25	1069.5	798.41667	1782.5	1617.5	701.5	755.75	92%	75%	91%	108%	632	5.1	2.5	7.6
G10	1732	1600.25	1715	1356.5	1069.5	1067.5	1741	1478	92%	79%	100%	85%	707	3.8	4.0	7.8
G9	1426	1307.5	1321.5	1236.8333	1426	1287.75	1052.5	1102	92%	94%	90%	105%	752	3.5	3.1	6.6
F12	563.5	691.5	342.5	316	695.5	628	356.5	383	123%	92%	90%	107%	240	5.5	2.9	8.4
F7	1782.5	1639.0833	1775	1541.75	1426	1294	1782.5	1577.5	92%	87%	91%	88%	683	4.3	4.6	8.9
G1	1436	866	354	349.5	713	713	356.5	356.5	60%	99%	100%	100%	485	3.3	1.5	4.7
G3	1610	1391	1745.5	1516	1023.5	989	1060	1309	86%	87%	97%	123%	864	2.8	3.3	6.0
G4	1771	1448.75	1782.5	1763	1046.5	927	1434	1468.75	82%	99%	89%	102%	896	2.7	3.6	6.3
G5	1391.5	1394	1577.5	1445.25	713	970.3333333	1386.5	1379.5	100%	92%	136%	99%	760	3.1	3.7	6.8
G8	2416	2025	1586.83333	1544.0833	1759.5	1619.966667	1046.5	1098.83333	84%	97%	92%	105%	615	5.9	4.3	10.2
F8	1708.5	1609.5	1717.5	1636.5	1069.5	987.5	1421.5	1603.25	94%	95%	92%	113%	723	3.6	4.5	8.1
Critical Care	2605.5	2593.25	341	130	2610.5	2566.75	0	29	100%	38%	98%	*	388	13.3	0.4	13.7
F3	1654	1361.5	2139	1827	1064	1058.5	1426	1404.5	82%	85%	99%	98%	732	3.3	4.4	7.7
F4	842	787	882	578	598	586.5	531	428.5	93%	66%	98%	81%	633	2.2	1.6	3.8
F5	1829	1838	1301	1206	1046.5	1036	982	1005.5	100%	93%	99%	102%	698	4.1	3.2	7.3
F6	1727.5	1424.75	1691	1484.1667	1098.5	1088.833333	701.5	1016	82%	88%	99%	145%	942	2.7	2.7	5.3
Neonatal Unit	1148.25	1140	468	501.5	912	924	588	588	99%	107%	101%	100%	116	17.8	9.4	27.2
F1	1530.5	1567.9167	707.25	658.25	1426	1426	0	0	102%	93%	100%	*	115	26.0	5.7	31.8
F14	372	372.5	0	0	744	744	0	0	100%	*	100%	*	106	10.5	0.0	10.5
Total	33,465.75	30,563.00	27,693.83	23,976.42	25,743.00	24,833.47	19,893.00	19,876.08	**91%**	**87%**	**96%**	**100%**	**12684**	**4.5**	**3.5**	**7.9**

* planned hours are zero, so additional support used on ward to mitigate unfilled nursing hours

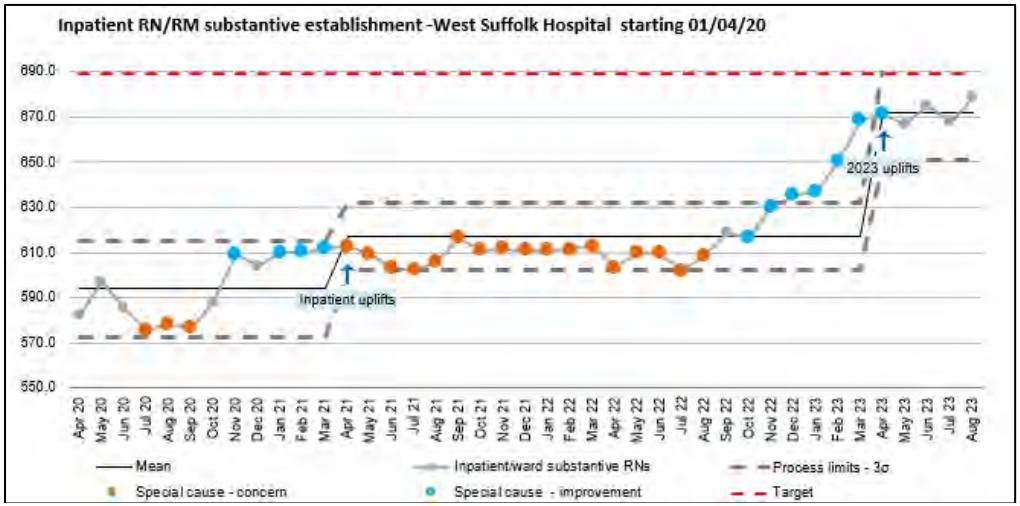
Appendix 2 SPC charts.

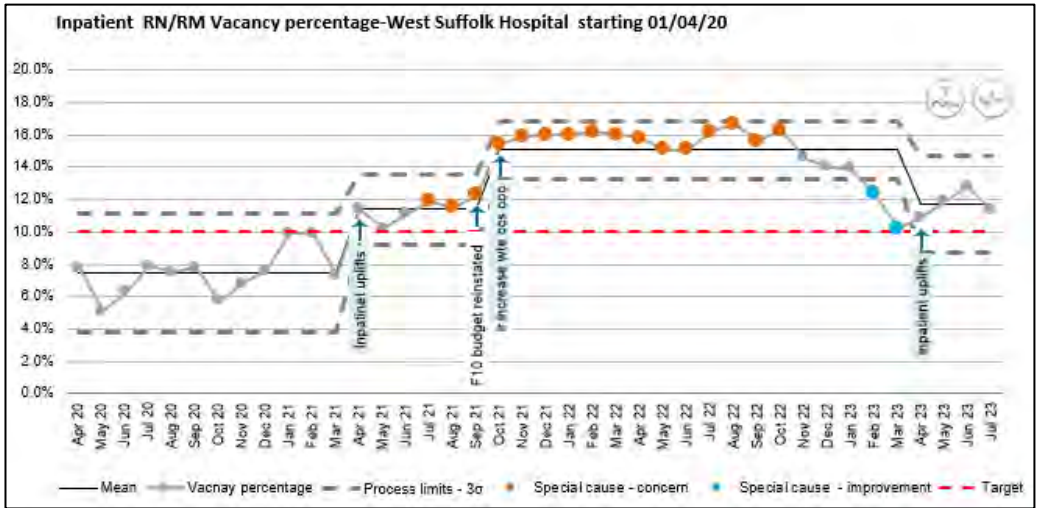
Total RN/RM establishments and vacancy percentage



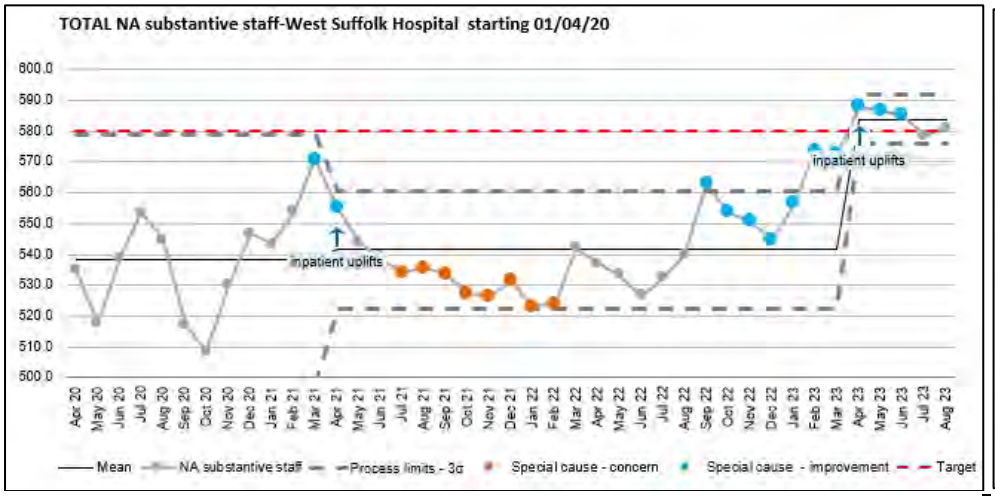


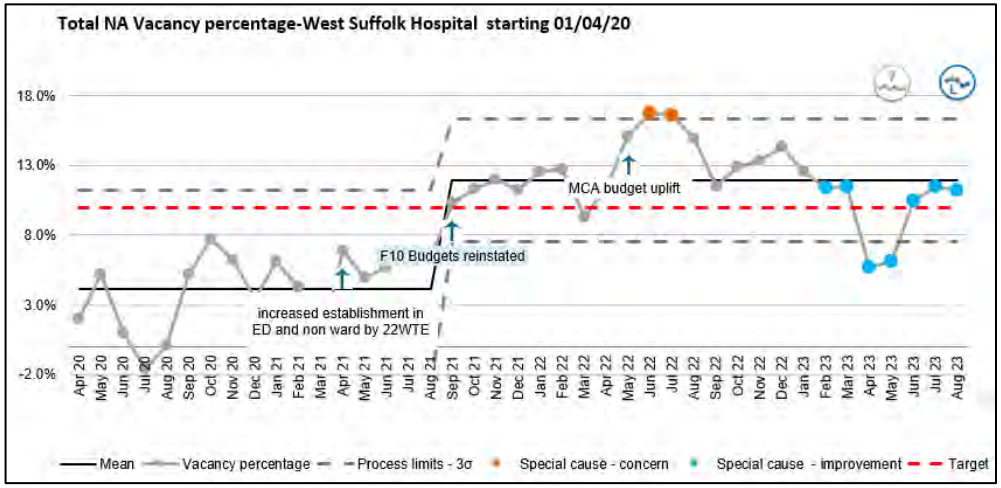
Inpatient RN/RM establishments and vacancy percentage



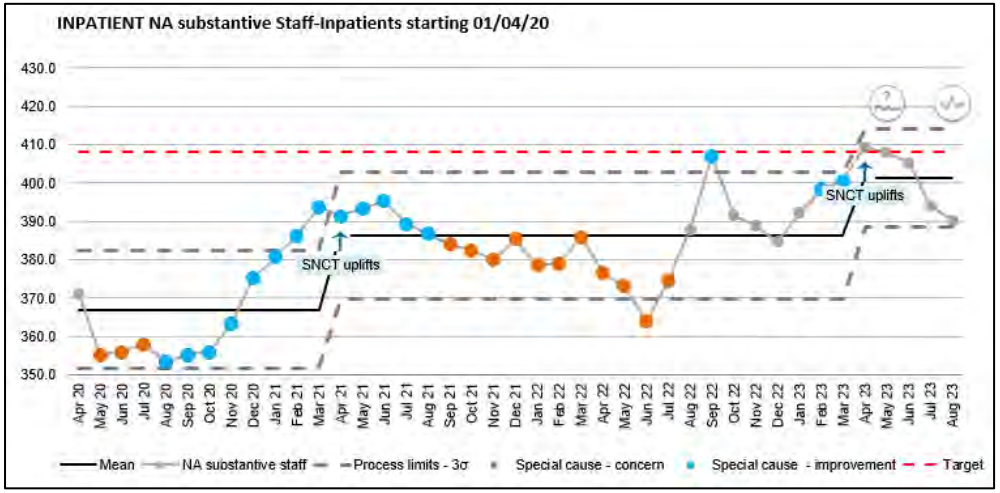


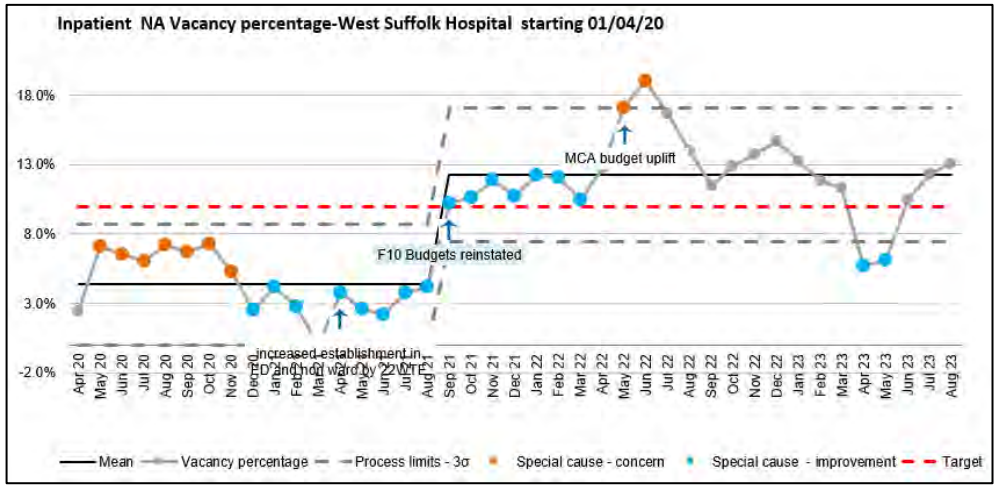
Total NA WTE numbers and vacancy percentages





Inpatient NA WTE numbers and vacancy percentage





Appendix 3: Red Flag Events

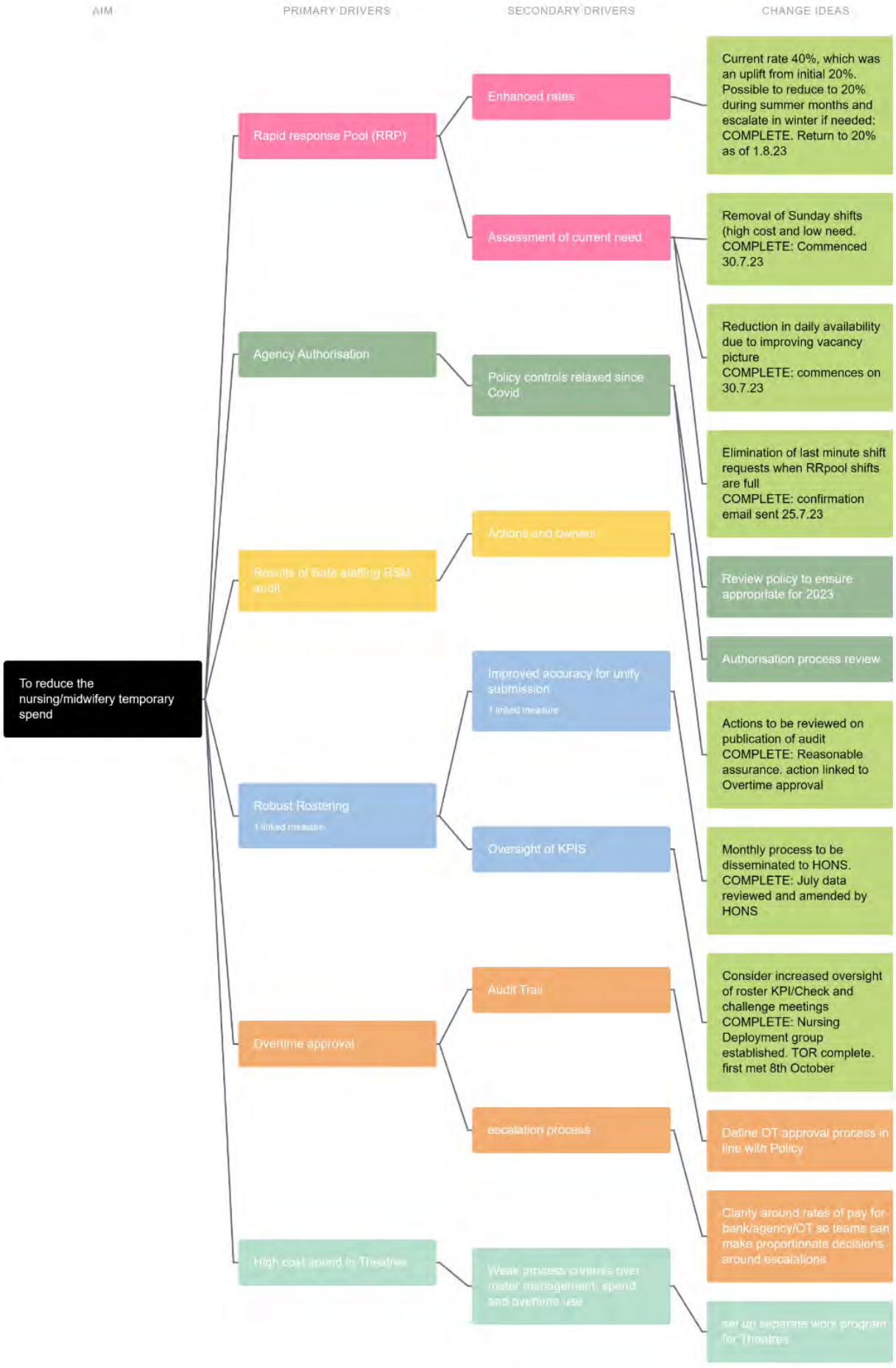
Maternity Services

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

Acute Inpatient Services

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

Appendix 4: Work Program to address temporary spend.



WEST SUFFOLK NHS FOUNDATION TRUST

Safer Staffing

Internal audit report: 2.23/24

FINAL

9 August 2023

1. EXECUTIVE SUMMARY

Why we completed this audit

We have undertaken an audit of Safer Staffing, deferred from the 2022/23 and now delivered as part of the 2023/24 Internal Audit Programme. The purpose of the review was to consider arrangements at the Trust to ensure that wards are adequately supported by staff with the relevant skills. The provision of safe and effective nursing care is a crucial component of healthcare services, and it is essential that the nursing establishment and skill mix are managed efficiently and effectively.

An establishment review is completed twice yearly by the Executive Chief Nurse to determine the safe staffing levels for all wards. These are reviewed and approved by the Trust Investment Board to ensure adequate resources are set aside. The Ward Manager is responsible for ensuring that staffing levels are such that all patient care needs are met on a shift-by-shift basis and that any risks are escalated accordingly. These measures ensure that patient care needs are met, and risks are minimised, providing safe and high-quality care for patients.

The Trust uses the SafeCare data monitoring system to record and oversee safe staffing compliance and manage inadequate levels, known as red flags. The Trust also uses the HealthRoster system to create and publish electronic rosters eight weeks in advance based on the agreed safe staffing levels. Rosters are further reviewed one week in advance to ensure any issues or concerns relating to staffing levels can be mitigated through staff redeployment.

Twice-daily meetings are held to discuss safe staffing and ensure that appropriate staffing levels on a ward-by-ward basis. The SafeCare dashboard is reviewed, and staff cover arranged where appropriate, including utilisation of the Rapid Response Pool, to ensure staffing risks are mitigated. Risks of red flags which cannot be mitigated through redeployment are reported on the Datix incident management system and are subject to investigation. Overall, performance is overseen by the Trust Board. Our review has focussed solely on wards which utilise the HealthRoster and SafeCare systems including which incorporate in-patient services and emergency care.

Conclusion

Through our review, the Trust had in place a comprehensive Safe Staffing Policy, and a regular review of skill mix for rostering highlighting a proactive approach to optimising staffing levels. We found that effective rostering practices were also in place for rosters to be appropriately planned and scheduled in advance. There was also an effective system in place for the management of staffing red flags with prompt reporting and investigation. Clear lines of responsibility for monitoring and oversight were in place through the Trust's governance structure. Additionally, the implementation of daily staffing meetings for clinical wards allowed the teams to address any issues on a real time and collaborative basis to optimise safe staffing levels and enhance patient care.

However, we identified a core control weakness in regard to the absence of a formal and consistent process for the approval of staff overtime and an area where improvement was required in addressing inconsistent recording of professional judgement on SafeCare.

Internal audit opinion:

Taking account of the issues identified, the Board can take reasonable assurance that the controls upon which the organisation relies to manage this area are suitably designed, consistently applied and effective.

APPENDIX 6: SNCT output and narrative summary

	Split WTE		WTE	Audit Results														Budget Vs SNCT comparison
Wards	RN	NA	Budget at M4 202	Sep-20		Feb-21		Jul-21		Jan-22		Jun-22		Jan-23		Jul-23		
				FTE NHP	SNCT	FTE NHP	SNCT	FTE NHP	SNCT	FTE NHP	SNCT	FTE NHP	SNCT	FTE NHP	SNCT	FTE NHP	SNCT	
AAU	30.1	28.3	58.4	30.2	37.4	32.25	41.2	37.15	47.5	No data		34.6	46.7	13/20 days data only		14/20 day data only		insufficent data
Cardiac / G	40.7	15.7	56.4	29.5	35.8	29.05	34.8	44.66	35.9	45.75	36.9	45.73	36.2	47.01	37.2	48.28	38.1	18.3
F12	12.4	7.3	19.7	9.58	11.5	9.87	11.7	9.19	11.9	17 /20Days data only		10.33	13	10.59	14.3	10.4	13.4	6.3
F7	24.9	25.8	50.7	22.9	27.1	17.44	21.6	45.42	57.7	41.03	51.6	43	49.9	43.24	50	44.04	51.5	-0.8
F8	22.0	23.4	45.4	32.64	36.9	24.23	29.9	36.57	48.5	33.73	43.1	33.55	41.4	35.7	44.6	35.13	43.7	1.7
G1	34.3	8.8	43.1	13.22	14.5	15.41	19.5	16.32	20.3	16.3	20.9	16.3	21.2	16.66	21.6	16.21	21.1	22
G3	22.1	24.0	46.1	42.27	51	26.5	32.4	43.7	53.8	17 days data only		44.04	55	43.78	53.9	41.73	49.3	-3.2
G4	22.4	23.6	46.0	39.38	48.8	20.86	24.7	40.14	48	41.71	52.3	41.47	51	38.2	46.5	42.65	53.1	-7.1
G5	21.0	24.1	45.1	43.69	55.9	24.17	28.3	43.65	54.7	15/20 days data only		43.33	55.1	43.31	53.1	15/20 days data only		insufficent data
G8	32.7	20.6	53.3	37.31	48	37.19	51.3	57.48	42.8	59.58	49.4	64.95	49.6	69.34	55.6	66.51	53.1	0.2
G9	25.8	18.0	43.8			29.33	39.6	33.59	39.3	31.37	40.6	33.58	40.7	34.96	43.3	36.45	42.7	1.1
G10	22.3	27.2	49.5	32.21	37.5	33.08	39.8			10/20 days data only		36.01	45.9	37.1	45.7	40.51	47.3	2.2
F3	22.2	25.8	48.0	42.54	51.6	29.14	35.3	41.34	52	37.09	46.5	42.37	56.2	39.69	55.6	42.23	52.4	-4.4
F4 / F10	15.0	12.4	27.4	9.97	11.5	24.44	29.4	6.86	8.6	25.39	29.5	28.05	31.9	19.62	22.3	17	18.5	8.9
F5	24.0	21.7	45.7	36.07	37.3	36.79	42.8	36.34	41.9	36	46.5	39.49	43.9	41.32	46.9	29.72	33	12.7
F6	24.7	17.8	42.5	39.88	44.5	39.69	48	38.69	48.5	17/20 Days data only		42.59	50.5	10/20 days data only		39.29	54.5	-12
F14	21.0	3.9	24.9	6.66	6.4	6.77	6.5	11.66	11.3	8.87	8.5	9.05	8.8	8.2	8.4	7.2	7.5	17.4
F1	26.1	6.7	32.8	8.86	11.5	7.18	7.8	17.44	40	12/20 days data only		22.01	18.2	28.1	21.2	21.3	16.2	16.6
Rosemary	18.4	24.8	43.2	27.66	30.8	25	32.3	31.03	39.8	38.42	51.5	28.61	37.7	43.71	58.3	39.21	53.8	-10.6
Kingsuite	11.8	11.9	23.7	25.42	28.3	22.15	24.9	20.8	23.2	22.46	25.2	22.29	25.7	22.8	26.4	43.86	26.5	-2.8

	Split WTE		WTE	Audit Results			
Wards	RN	NA	Budget at M4 2023	Jul-23		Budget Vs SNCT comparison negative figure suggest uplift	Summary of Triangulation (professional Judgement and outcome measures)
				FTE NHPDD	SNCT		
AAU	30.1	28.3	58.4	14/20 day data only		insufficent data	Data not valid due to insufficient submissions. Increased HON oversight next audit
G7	40.7	15.7	56.4	48.28	38.1	18.3	Staffing meeting needs at current time. SNCT suggests reduction in 18.3 WTE. However Budget is inclusive of cardiac theatres and clinic staff: No Change
F12	12.4	7.3	19.7	10.4	13.4	6.3	Uplift provide in spring 2023. due to changing patient dependency and staff redeployment. Not used within roster template as yet. Possible CIP once budget alignment confirmed.
F7	24.9	25.8	50.7	44.04	51.5	-0.8	Staffing meeting needs at current time. No Change
F8	22.0	23.4	45.4	35.13	43.7	1.7	Uplift provided in spring 2023 due to anticipated increase in vascath patients being stepped down to F8. activity of this is not as yet realised. Potential opportunity to reduce skill mix if activity continues. Review next audit
G1	34.3	8.8	43.1	16.21	21.1	22	Staffing meeting needs at current time. SNCT suggests reduction in 22 WTE. However Budget is inclusive of MacMillian unit day services. Ward running consistently at 75% RNs with no safety concerns or increase in patient harms. Opportunity to review workforce model to include. possible WTE reduction
G3	22.1	24.0	46.1	41.73	49.3	-3.2	staffing levels meeting patient needs. No change
G4	22.4	23.6	46.0	42.65	53.1	-7.1	Validity of data concerns, not consistent with patient profile of best practice wards. Possible excessive scoring of 1B patients resulting in SNCT above budget. Consistent need for 1:1 or specials that is being explored with division and dementia CNS
G5	21.0	24.1	45.1	15/20 days data only		insufficent data	Data not valid due to insufficient submissions. Increased HON oversight next audit
G8	32.7	20.6	53.3	66.51	53.1	0.2	Staffing meeting requirements no concerns. No change
G9	25.8	18.0	43.8	36.45	42.7	1.1	establishment uplifted in spring 2023. no concerns regarding new template
G10	22.3	27.2	49.5	40.51	47.3	2.2	establishment uplifted in spring 2023. no concerns regarding new template

	Split WTE		WTE	Audit Results			
Wards	RN	NA	Budget at M4 2023	Jul-23 FTE NHPDD	Jul-23 SNCT	Budget Vs SNCT comparison negative figure suggest uplift)	Summary of Triangulation (professional Judgement and outcome measures)
F3	22.2	25.8	48.0	42.23	52.4	-4.4	staffing levels meeting patient needs. No change. Potential opportunity to reduce NA numbers in line with medical wards. As ward attenders well supported by ACPs
F4 / F10	15.0	12.4	27.4	17	18.5	8.9	Low elective activity during audit period due to industrial action. Ward to return to a smaller footprint in next few months. Opportunity to reduce WTE to be explored
F5	24.0	21.7	45.7	29.72	33	12.7	F5/F6 are currently reviewing service provision following introduction of surgical SDEC this will result in a reduction in beds for F5. in keeping with the SNCT which suggests a reduction. Opportunity to review workforce model between F5 and F6 is likely to be cost neutral
F6	24.7	17.8	42.5	39.29	54.5	-12	
F14	21.0	3.9	24.9	7.2	7.5	17.4	Uplift spring 2023. staffing levels meeting patient needs. No change. SNCT not recognising the budgeted staff in GAU, EPAU (clinic activity in ward). Caveat that SNCT is weak for small wards like F14/f12
F1	26.1	6.7	32.8	21.3	16.2	16.6	Summer months always predict lower SNCT results due to patient profile. Included in budget is, PDN, play specialist and provision of CAU attendances. No change required. Early winter audit to be planned for November to capture paediatric seasonal variances
Rosemary	18.4	24.8	43.2	39.21	53.8	-10.6	Uplifts received spring 2023. Concerns around changing patient profile, patient group now more complex. Some challenge around data collection and additional assurance check and challenge to be in place during next round
Kingsuite	11.8	11.9	23.7	43.86	26.5	-2.8	staffing meeting needs of patient group. No concerns or changes required

4.4.1. Maternity Services

Karen Newbury, Kate Croissant & Simon Taylor in attendance

For Approval

Trust Open Board

Report title:	Report on progress following the Trust's exit from the NHS England/Improvement Maternity Safety Support Programme (MSSP)
Agenda item:	Maternity Safety Support Programme Report 2023 - 2024
Date of the meeting:	
Sponsor/executive lead:	Sue Wilkinson, Executive Chief Nurse/ Paul Molyneux, Interim Medical Director & Executive MatNeo Safety Champion
Report prepared by:	Karen Newbury – Head of Midwifery & Beverley Gordon – Project Midwife

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

Executive summary:	West Suffolk NHS Foundation Trust entered the NHS England / Improvement Maternity Safety Support programme (MSSP) following the CQC's inspection of WSFT maternity services on 24th September 2019 and was issued a 29a warning notice on 14th November 2019. Following further CQC unannounced inspections on 13th April 2021, the CQC has revised ratings for the WSFT site in the Well-led domain from inadequate to requires improvement. All other domains reviewed remained the same, however the CQC reported they had seen evidence of progression, significant change and culture improvement. The triumvirate were aligned on the challenges to quality and sustainability within the service and had plans in place to address them. This meant that steps had been taken to improve the stability and effectiveness of the leadership of the service. However, at the time of the inspection, the new leadership team was in its infancy. The changes needed to be sustained and embedded before the full impact and effectiveness could be assured but early indications were positive. In January 2022 the Trust entered the Sustainability phase of the MSSP as quality and safety improvement plans and actions were being addressed. The Maternity Improvement Advisor (MIA) reduced the level of support visits whilst maintaining oversight of progress. Sustainability plans were in place and tested to ensure the improvements were sustained and embedded as business as usual. External peer reviews from NHSE/I had taken place in October 2021 (Sixty Supportive Steps to Safety) and May 2022 (Ockenden – one year on).

	The NHS England National Quality Performance Committee agreed that the WSFT maternity service had formally exited the MSSP on the 25th October 2022 and the following report outlines the progress made in continuing and sustaining the improvements made throughout the programme. The main drivers for change and assurances are included in the summaries for each plan and as part of the sustainability plans attached. This paper identifies the supporting evidence for this improvement as well as ongoing work to continue to improve and sustain the quality and safety of Maternity services. Key points outlined in this paper are: • Completed and outstanding actions from the 2019 CQC visit as detailed in the CQC report April 2021 and including additional areas raised in assurance visits. • Updated Governance Structures and Framework • Leadership Structure and sustainability • Workforce structure and sustainability • Compliance with Ockenden (part 1), Morecombe Bay, MIS/CNST, Maternity Self-assessment & 60 Supportive Steps, Ockenden (final report) • Progress made towards assurances that standards are met within the overarching Sustainability Action Plan **Next Steps** The Maternity Services will continue to provide evidence to the Trust Board, NHS England and other external partners to support their continued commitment to quality and safety and progress towards a sustained improvement in key aspects of care and services. Year 5 of the Maternity Incentive Scheme, version 3.0 of Saving Babies Lives, the NHS Core Competency Framework version 2.0 and the 3 Year Delivery Plan all offer further opportunities for the Trust to ensure that the structures, safety processes and strategies continue to shape Maternity and Neonatal Services of the future.
Action required/ recommendation:	

Previously considered by:	
Risk and assurance:	
Equality, diversity and inclusion:	
Sustainability:	
Legal and regulatory context:	

[Insert report title]

1.	**Introduction**
1.1	West Suffolk NHS Foundation Trust entered the NHS England / Improvement Maternity Safety Support programme (MSSP) following the CQC's inspection of WSFT maternity services on 24th September 2019 and was issued a 29a warning notice on 14th November 2019. Following a further CQC unannounced inspection on 13th April 2021 and subsequent submission of evidence, the CQC has revised ratings for the WSFT in the Well-led domain from inadequate to requires improvement.
2.	**Background**
2.1	**The NHS England / Improvement Maternity Safety Support Programme (MSSP)** The overall objective of the MSSP is to deliver a maternity safety support initiative, led by NHS England/ Improvement. The CQC supports this through the provision of intelligence to identify priorities for improvement and assurance that required changes have been made. NHSE/I then provide a programme of support that is designed to be flexible and adaptive to meet the individual needs of the Trust's improvement journey. A Maternity Improvement Advisor (MIA) was allocated to the West Suffolk NHS Foundation Trust to work with the executive clinical directors and divisional leaders to support the delivery outcomes identified in the CQC Report.
2.2	**Supporting evidence to exit MSSP** A number of reviews and self-assessments took place as part of the Trust's support programme and assurance processes. The key results, recommendations, actions, and progress reports were included as part of the supporting evidence to exit the programme. Criteria for leaving the programme is a CQC improved rating by at least one in the safe & well led domains. This has not been achieved but with external recognition of the significant progression made by improving from inadequate to requires improvement in the 'well led' domain, it was agreed that the Trust could exit the programme. Significant improvements have been made and sustained over a period of time and will continue to be monitored and measured.
2.3	**Progress Report – August 2023** A summary of the areas of progress and outstanding actions are included below. The additional databases and spreadsheets provide more detail on the achievements and work still to be done.
3.	**Detailed sections and key issues**
3.1	**The West Suffolk NHSFT Maternity Services CQC Inspection 2019 Action Plans** Five action plans were developed in response to the CQC's section 29a warning notice issued on 14th November 2019 and a further must do action plan relating to other aspects of the CQC's inspection of WSH maternity services on 24th September 2019 was initiated and monitored via departmental governance meetings, Trust Improvement Programme/Board and CQC meetings. Following the CQC unannounced visit on13th April 2021, evidence was reviewed which confirmed that the Trust was now complaint with all aspects of the 29a warning notice. The remaining actions from the CQC assessments and assurance visits continue to be progressed with monthly monitoring via internal and external Governance processes. It should be noted that these actions are part of the overall quality and safety improvement plan, and the aim is for all aspects to be 'business as usual' rather than exception reporting. Two issues remain outstanding:

	• Provision of a suitably trained and competent recovery staff to oversee recovery from maternity operative procedures – theatres and anaesthetics and maternity services are working together to implement and embed a safe effective service. • The Trust-wide issue relating to having open packaging on resuscitation consumable equipment in the clinical areas. There is a Trust-wide agreement on what is acceptable practice which does not fulfil the requirements completely at this stage. More discussions are taking place. In addition, improvement plans are in place to improve compliance with key patient safety interventions such as routine enquiry around domestic abuse and significant improvements have been made.
3.2	**Governance Structure and Framework** Medical and midwifery staff with specific roles within governance are clearly defined with job plans and PA's reflecting the commitment to improve through organisational change and learning. The Maternity Risk and Governance framework was developed and approved by the Board in June 2021. The Trust was involved in being a pilot site for the updated serious incident framework – Patient Safety Incident Response Framework (PSIIRF) and this process is now in place across the Trust including maternity and neonatal services. The Maternity Services uses the Trust governance and reporting processes and framework whilst maintaining the need for reporting to external bodies such as Mothers and Babies Reducing Risk through Audit and Confidential Enquiries across the UK (MBRRACE-UK), Healthcare Safety Investigation Branch (HSIB) – Maternity reporting criteria and NHS Resolution (NHSR) Early Notification (EN) when indicated. The Maternity Risk and Governance Framework is being updated to demonstrate embedding of the PSIRF framework and the reporting requirements for external agencies. Emerging Incident Reviews are held to discuss patient safety incidents and reports with the Trust executives. Learning is also shared at the LMNS safety forum, at Maternity HSIB quarterly meetings and at meetings with the ICB. All completed clinical reviews, PSIIs, PMRT and HSIB reports are shared in full at closed Board meetings. National reports and recommendations from MBRRACE, HSIB and other organisations are reviewed within the Trust and where a gap analysis identifies areas where improvements are required, actions that are required to achieve this are raised as part of the Quality and Safety plans for the Maternity and Neonatal Services. Guidance from national bodies such as NICE, RCOG, and RCM are also used as a basis for changing practice when required. A number of strategies are used to support shared learning which include 'Take Five' communications, Risky Business Newsletters, ward meetings and MDT forums where learning is shared. The Maternity Education and Training strategy and 3-year plan is led by the training and education leads which include the Lead MDT educator, Deputy Head of Midwifery, Practice Development Midwives, Obstetric training lead, Obstetric Anaesthetic lead and the Neonatal trainers and Neonatal PDN. With the publication of the Maternity Incentive Scheme Year 5 safety actions, the Core Competency Framework v 2, Saving Babies Lives v 3 and the 3-year Delivery Plan, the 3-year training plan and programme is being updated to reflect the changing requirements. The Trust is aspiring to meet the national timeframes for achieving these changes and embedding the new processes as business as usual.
3.3	**Leadership Structure and sustainability** **Changes:** • Over the last year, after a period as deputy clinical director, a new Clinical Director has

	been appointed to the Division. Other key senior medical roles have also been filled with job plans updated to reflect this. All senior staff have attended leadership workshops and coaching sessions. • A matron has been appointed to lead neonatal services. There have been some changes to the line management responsibilities within midwifery and nursing staffing. • Legacy midwives have been appointed to support existing staff. • The Risk and Governance, Quality and Safety team has been strengthened by the addition of a clinical and quality assurance lead with responsibility for neonatal projects, assurances and reporting for internal and external assurance. • A lead for MDT education has been appointed to oversee and implement the training programmes across the maternity and neonatal services. An updated structural chart can be found in Appendices 1 and 2. **Outstanding workforce issues include:** • Development of a Midwifery consultant post • A dedicated operational support post for maternity services • There are ongoing discussions regarding allocation of consultant PA's to undertake specific roles and fulfil their responsibilities to the role. • Director of Midwifery: in the interim the Head of Midwifery has direct access and reporting responsibilities to Trust Board. Proposals for development have been submitted for approval by the Board with an expectation that the results of the discussions will be shared in September 2023. **Assurances** Obstetric consultants have been appointed to lead roles for labour ward, risk and governance, fetal monitoring, antenatal care, audit, guidelines, training and education, antenatal and newborn screening, perinatal mortality and morbidity, GROW, diabetes (joint working) maternal medicine and Saving Babies Lives. Equivalent PA's have been funded to undertake these additional roles. The role of the Clinical Lead for obstetrics has been maintained with overall responsibility for quality and safety within the maternity services. Specialist clinics are led by obstetric consultants for women at higher risk of preterm labour, women who are at greater risk of fetal complications such as growth, maternal medicine, diabetes and multiple pregnancies. Midwifery staff have been appointed into specialist roles – safeguarding, bereavement, perinatal mental health, diabetes, antenatal and newborn screening, fetal monitoring, practice development midwives, and newborn feeding. Professional Midwifery Advocates (PMA's) are allocated dedicated time to fulfil their roles in providing support to midwives when required. Two legacy midwives have been appointed to support midwifery staff and promote retention and recruitment of midwives to maintain a safe staff skill mix. The Medical Director and the non-executive director (newly appointed) are the Maternity Board Level Safety Champions and have further enhanced the Trust oversight of maternity services. The Medical Director and Deputy Associate Medical Director continue to support the Division with medical workforce challenges and issues. The Chief Nurse has provided significant, consistent, and essential support to maternity and neonatal services.
3.4	**Workforce Structure and sustainability** The operational team for the Division has been further enhanced within the last year by updating the roles and responsibilities and appointment of personnel into new posts to support the processes required to demonstrate effective management of the services. All aspects of the clinical workforce are continuously reviewed as part of the Maternity Incentive Scheme (MIS- CNST), Ockenden and against the professional standards from the governing bodies, Birthrate+ and professional bodies such as British Association of Perinatal Medicine

(BAPM)All business cases to support an enhancement of staffing levels are submitted through the Trust processes for approval prior to advertisement and appointment to posts.

The Trust currently has gaps in the midwifery workforce and has experienced difficulty with recruitment of band 6 midwives. However, the service should be at full establishment by the end of December 2023.

The nursing leadership of the neonatal services has been strengthened by the appointment of a Neonatal Matron and a clinical quality and assurance lead for Neonatal services.

The Maternity and Neonatal services continue to monitor workforces across the disciplines with Board reports every 6 months or as required.

3.5

NHSE/I Ockenden review of maternity service 2020 - One Year on

The Ockenden initial report on services at Shrewsbury and Telford NHS Trust was published in December 2020. An Insight visit to West Suffolk Hospital NHS Trust services was completed on the 17 May 2022.
Progress has been made to address some of the outstanding issues from these recommendations – these have been marked as green on the table below but will be verified when the next assurance visit is made:

- All clinical reviews, PSII reports, PMRT and HSIB reports are now submitted in full to the Maternity and Neonatal Safety Champions (MNSC), Closed Board and the LMNS/ICB (Q1 iii)
- The Non-executive Safety Champion is working with users, and staff and any issues are discussed, and the outcomes of the discussions are included in risky business (Q2 iii)
- A SOP was agreed for ringfencing training funds – Q3 iii
- Managing complex pregnancies – criteria to tertiary level and Maternal Medicine Centres (MMC) – A SOP and pathway have been implemented locally (Q4 vi)
- SBL risk assessments compliant Q5 iii – this will be monitored further through the Implementation tool v 3 of Saving Babies Lives
- Compliance for fetal monitoring was reached at the time of the CNST deadline but the Trust is working on the new programme in line with updates to the Core Competency Framework – trajectory for July 2024 Q6iii
- 6 monthly reports are submitted for all the workforce elements – Issues remain with regard to compliance with the RCM manifesto

IEA	i	ii	iii	iv	v	vi	vii	viii
1) Enhanced Safety								
2) Listening to Women and Families	N/A	N/A						
3) Staff training and working together								
4) Managing complex pregnancies								
5) Risk assessment throughout pregnancy								
6) Monitoring fetal wellbeing								
7) Informed consent								
Workforce planning								
Guidelines								

Key to RAG rating

Colour	Meaning	Comments
	Evidence of compliance seen and accepted	
	Partial compliance presented and accepted	
	No further actions in this section	Some sections have less elements than others

3.6

Ockenden final report 2022

An assessment has been made against the 92 safety recommendations within the 15 key areas of maternity and neonatal care and services when the final report was published in March 2022. The assessment included whether the Trust was fully compliant, and actions had been completed, actions are on track to be completed to confirm compliance, partial compliance and areas of concern where there is a lack of assurances available at this current time. The 15 areas are headed with the following:

Section 1: Workforce Planning and Sustainability

Section 2: Safe Staffing

Section 3: Escalation and Accountability

Section 4: Clinical Governance Leadership

Section 5: Clinical Governance - Incident Investigation and Complaints Handling

Section 6: Learning from Maternal Deaths

Section 7: Multidisciplinary Training

Section 8: Complex Antenatal Care

Section 9: Preterm Birth

Section 10: Labour and Birth

Section 11: Obstetric Anaesthesia

Section 12: Postnatal Care

Section 13: Bereavement Care

Section 14: Neonatal Care

Section 15: Supporting Families

The total number of points to be assessed and evidence required is **92.** Progress has been made in all areas and the current status is as follows:

- Evidence has been signed off against **28** of the recommendations (blue)
- Assurances of being on track with compliance (green) in **31** areas
- Partial assurances (amber) have been provided in **25** areas
- No current evidence of compliance (red) in **1** area – Maternity core team of trained midwives for HDU cases
- There are **7** areas where the National/Regional team have ownership and actions are in progress.

The Trust will be reviewing updated national and regional guidance on the realisation of these recommendations at a local, regional, and national level. In anticipation of this guidance being in line with the original recommendations, an improvement and action plan has been prepared and leads have been allocated.

3.7

Morecambe Bay Recommendations and review of maternity service

Evidence regarding the progress made by Maternity Service at WSFT towards achieving compliance with the recommendation of the Kirkup Report published in 2015 on maternity service delivered at Morecambe Bay NHS Foundation Trust, was also required to be shared with the Trust Board, LMNS, Regional and National NHSE/I team in February 2022. There were 44 recommendations from the Kirkup report: the first 18 were related to Morecambe Bay but each Maternity Service had to assess their service to make sure there was sufficient assurance of safe working practices and organisational process in place to reduce the risk of similar safety concerns occurring in other Trust. Our current compliance with the recommendations is as follows:

Self-assessed compliance with evidence to support the first 18 recommendations related to Maternity Service:

18 out of 18 recommendations	**Compliant**

The remaining recommendations 19-44 were related to the Trust's wider Governance strategies and other external agencies and Health Care managers to enhance governance and safety processes on a local, regional and national level and these have not been reassessed at this current time. Previous results are as follows:

10 out of remaining 26 recommendations	**Compliant**
14 out of remaining 26 recommendations	**N/A**
2 out of remaining 26 recommendations	**Partially Compliant**

3.8

Maternity Incentive Scheme (MIS - CNST)

The Trust has participated in the Maternity Incentive Scheme since year 1, undertaking a self-assessment against the 10 safety actions as they have evolved. In 2019, the Trust submitted a statement indicating that they were compliant with all 10 safety actions in Year 2 of the scheme. During the CQC review in September 2019, the Trust was asked to review this compliance alongside the evidence required. Subsequently, the Trust declared compliance with only 8 out of 10 of the safety actions and funding received was returned to NHSR. In Year 3, the submission dates were changed, and safety actions updated as a result of Covid 19. The Trust submitted compliance against 5/10 of the safety actions and a bid for additional funding was agreed to support moving towards compliance.

Year 4 MIS Safety Actions were launched in August 2021 and then re-launched in May 2022 and updated in October 2022. The Trust submitted evidence of compliance with 8/10 of the safety actions to the Board and subsequently to NHSR in February 2023. The 2 aspects where it was not possible to provide compliance was in safety action 1 – compliance with the timeframes for completion of the Perinatal Surveillance details on the MBRRACE site and Safety Action 5, compliance with the labour suite coordinator being 100% supernumerary. Following submission of the data to NHSR and reasons why we were not compliant, the NHSR has considered the submissions and has now awarded the Trust 10/10 compliance.

The Trust has continued to embed and maintain the standards required for all 10 safety actions and will provide assurance and exception reports to the Safety Champions and Board when required on a regular basis as part of our business as usual.

Since the launch of year 5 MIS, version 3 of Saving Babies Lives (SBL) and version 2 of the Core Competency Framework in May 2023, the Trust has been making progress towards compliance with the new standards and maintain compliance with pre-existing safety actions and Trust processes for maintaining safe, quality care.

3.9

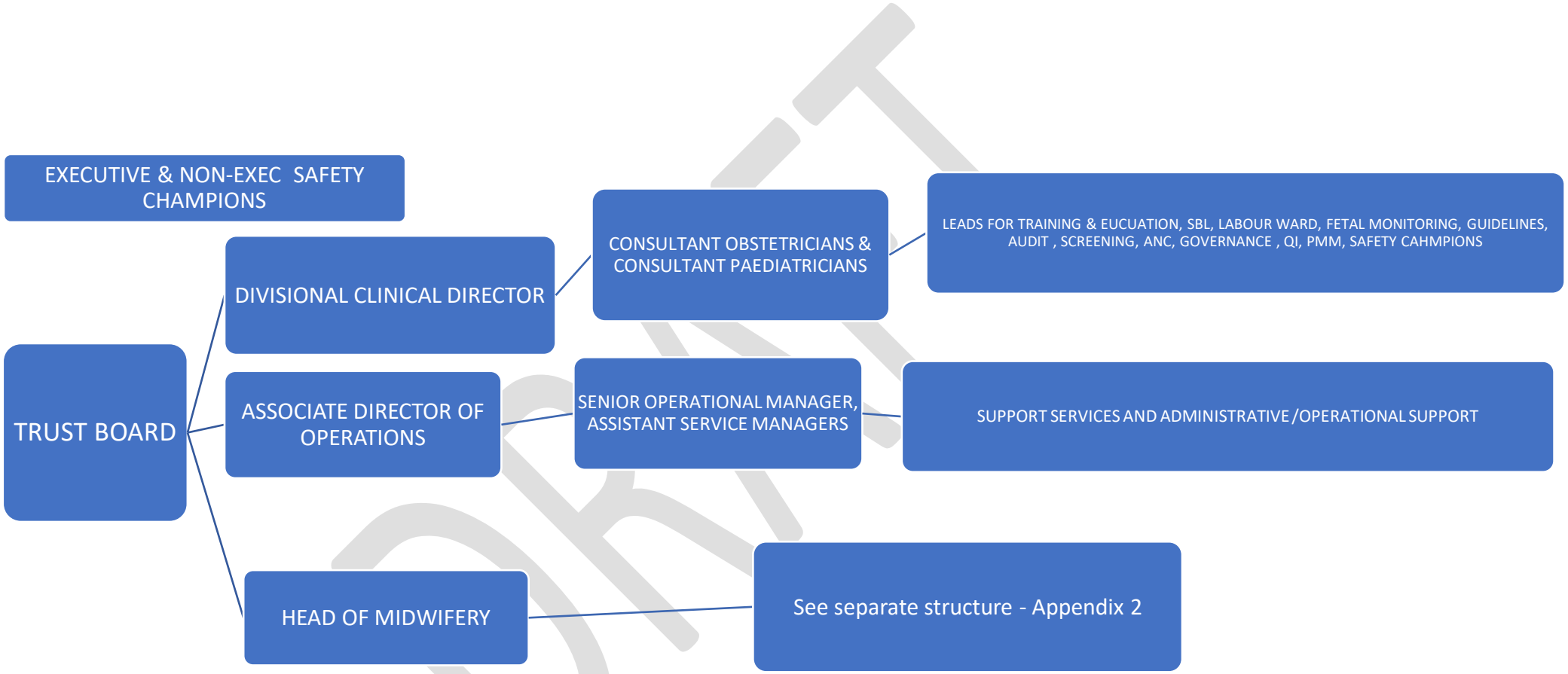
Maternity Safety Self-Assessment (NHS England)

The Trust completed the Self-Assessment document in January 2021: this has been updated as actions and controls have been put in place. The most recent update has been completed in June

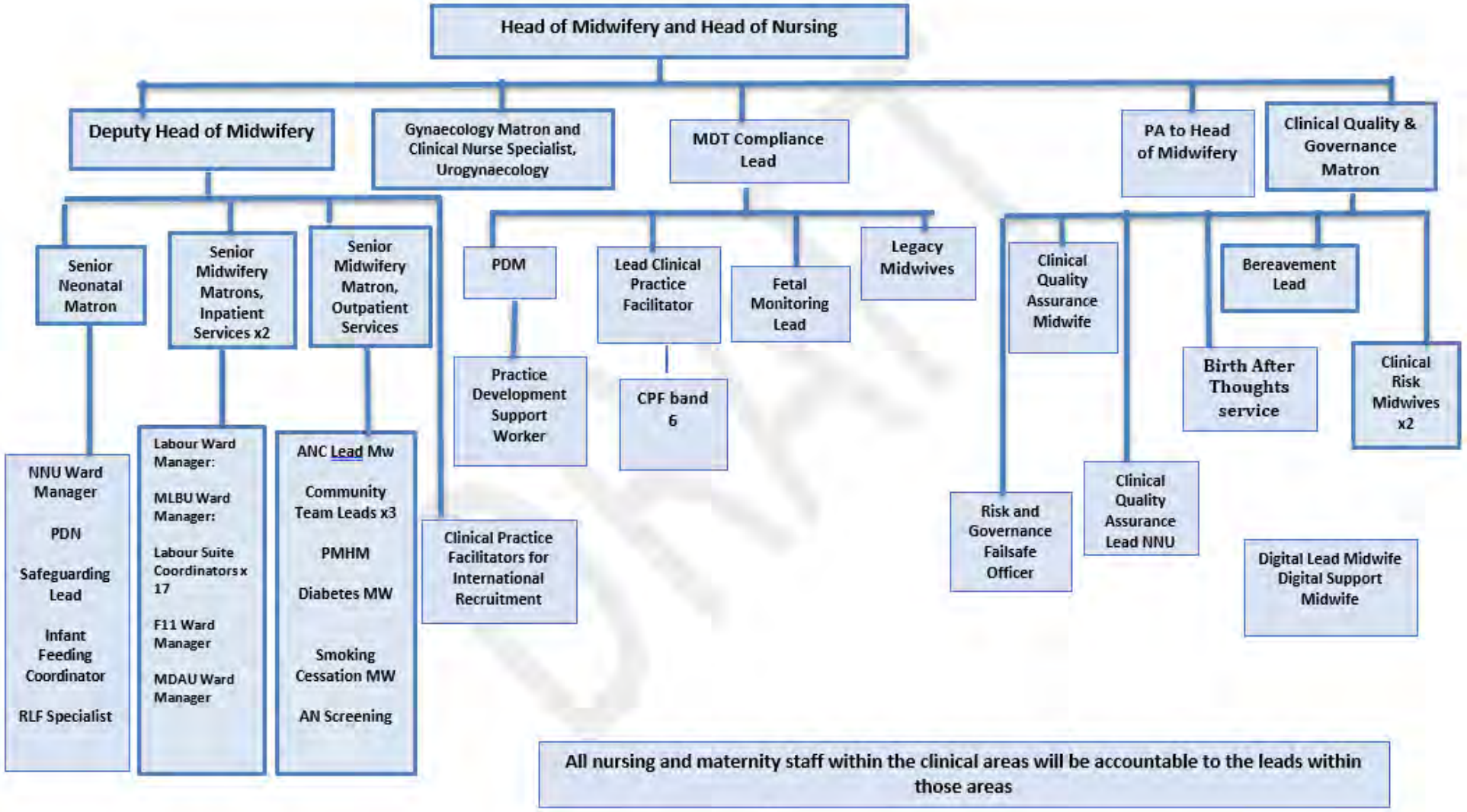
	2022. The self-assessment tool includes 160 areas some of which are maternity specific, and some relate to Trust wide areas. The 7 main sections are: *Directorate/Care Group infrastructure and leadership* *Multi-professional team dynamics* *Governance infrastructure and Ward-to-Board accountability* *Application of National Standards and Guidance* *Positive safety culture across the Directorate and Trust* *Comprehension of Business/contingency plans impact on quality* *Meeting the requirements of Equality and Diversity Legislation and Guidance* These sections are further subdivided into 43 key areas and then within these there are 179 points of evidence required. • **The Maternity Service has currently assessed itself as having evidence for the following areas:** • **Full compliance (green) in162 points** • **Partially compliant (amber) in12 areas** • **Non-compliant (red) in 5 key areas of safety** The 5 areas of non-compliance are as follows: • 3 areas of the non-compliant sections relate to having a job description and Director of Midwifery (DOM) in post. • 2 relate to having local Trust learning forums/conferences on patient safety, safety summits and reporting back to the Division from safety summits. **Key areas of progress** Trust-wide Swartz rounds in place with multiprofessional input and leadership for the forums and a varied programme in place. PSIRF has been embedded and there is a weekly Emerging Incident Review forum where safety incidents are discussed with the Trust executive and learning reports are shared – see above section on Governance. An in-date business plan is in place. This has, however, not been in place for 3-5 years so this remains amber.
3.10	**60 supportive steps to Safety** The 'Sixty Supportive steps to Safety' visit was undertaken by NHSE regional team on 21st October 2021. 15 immediate safety issues were identified. The NHSE regional team reviewed our progress towards the safety actions whilst undertaking their Ockenden Assurance visit on the 17th May 2022 and were assured that only three out of the 15 actions were not fully achieved. Since this visit the Maternity Triage area has been implemented having been delayed due to the structural works that had to take place. The remining two steps that need to be completed are: • MDT compliance with fetal monitoring training needs to reach >90% The training and competency for administration and checking of antibiotics for neonates is in progress and this action will be completed once the relevant staff have achieved this.
4.	**Next steps**
4.1	**Sustainability Action plan** The Trust will maintain oversight of all safety and improvement plans that are in place within

	maternity and neonatal services. The annexe attached to this paper outlines the current status of all of the integral assurance and improvement plans. The information and progress from the Trust's Maternity Action and Improvement Plan will be presented as part of the Governance and Safety reports submitted to the Maternity and Neonatal Safety Champions and the Trust Board via the following governance processes: • Clinical and Quality dashboards monitoring clinical data and outcomes and compliance with quality and safety standards. Specific action and improvement plans will be instigated when persistent non-compliance or concerns are raised with the leads for the area being responsible for ensuring that improvements are sustained. • The Maternity Improvement Board has been changed to the Maternity and Neonatal Improvement Board (MNIB) to reflect the overarching team working across all the services. • Maternity Quality and Safety Action and Improvement plan – the quality and safety action plan will be updated each month and additional actions or improvements made if required. • Maternity and Neonatal Safety Champions (MNSC) walkabouts and meetings, and attendance of Safety Champions at MVP meetings, Board meetings, MNIB and Trust Board. • Monitoring of key safety actions through quarterly reports to Board to provide assurance of safety and governance processes e.g. Perinatal mortality reviews and reporting to MBRRACE; training and education plans, sessions and attendance reports; submission of cases for review by HSIB and reporting to NHSR EN scheme; compliance with local transitional care guidance and review of all babies who are born at or around term who are admitted to the neonatal unit (NNU); and submission of assurance against the standards laid out in the elements of Saving Babies Lives. • Oversight of key successes and concerns at Maternity Improvement Board (MIB) • The Triumvirate present the Maternity Quality, Safety and Performance Board report which is supported by the Chief Nurse and the Trust Medical Director. In addition, the following pathways will provide internal and external oversight: • LMNS – Perinatal Quality Surveillance Principle 1 details are submitted to the LMNS Board – currently through the RPQOG but in future through the agreed PQSM dashboard. • Oversight and confirmation of the progress towards implementing Saving Babies Lives v 3 sits with the LMNS • Regional oversight – attend rotating quarterly meetings; MNIB, Safety Champions, Quality & Safety Meeting. • HSIB quarterly meetings • 60 supportive steps v 2 will be launched at the end of September 2023 • MNVP 15 steps will be completed by the end of 2023 • A regional workforce review was undertaken 31/7/23 • The Perinatal culture and leadership development programme will be starting November 2023 with a view to undertaking the Score survey in 2024. • MIS year 5 Safety Actions – submission date February 2024 • The training plan will be updated in line with the Core Competency Framework v 3 – this will be in place for compliance by August 2024 • The SBL implementation tool will be used to monitor progress towards full embedding of v3 by March 2024. MNSC members will attend Regional and National Patient Safety Forums and MatNeoSip meetings and ODN (COG) meetings when these take place.
5.	**Recommendations**
	The Trust and ICB are asked to receive this report as assurance that the WSFT continues to meet the required threshold for an exit from the MSSP

Appendix 1 Organisational Chart demonstrating Triumvirate structures within the Division that feeds into the Trust Board



Appendix 1a Midwifery and Nursing Leadership structures



1

Annexe – Summary of Sustainability Plan August 2023

Action ID Sustainability Action Plan	Sustainability Action Plan	2022 RAG Rating	2023 RAG Rating	SRO	Action Owner	Target Date/ Timeline
1. CQC	See Quality and Safety Action and Improvement Plan on CQC tab. Links to all other improvement plans			Chief Nurse/Medical Director	Triumvirate	Ongoing monthly reviews of progress through Quality and Clinical Dashboards, over-arching Quality and Safety Plan. Compliance with MDT training and midwifery appraisals not up to ≥ 90%
2. Governance structure and framework	Continue to monitor governance processes through Board repots, external national reporting and LMNS forums with oversight on the PQSM . Ensure processes for shared learning are embedded and demonstrate that any changes are embedded in practice. Links to all other improvement plans and assurances of safe working practices.			'Chief Nurse/Medical Director	Triumvirate	Complete and to be monitored via Quarterly Board reports
	Continue current staffing allocation to Governance and Practice Development roles to enable going safety and quality standards.			Chief Nurse	Triumvirate	Completed and to be monitored via Bi-annual midwifery staffing review

3. Leadership structure and sustainability	Continue with a programme of succession planning for leadership roles, ensure that leadership courses/forums/training are available for all staff in lead roles and wishing to succeed to lead roles. Continue to support clinicians with adequate administrative staff.			Chief Nurse/Medical Director	Triumvirate	Monitored on Quality Dashboard and overall Improvement plans. Proposal for Consultant Midwife submitted; and outcome for business case for a Director of Midwifery awaited. JD being prepared by Chief Nurse. Current arrangements are safe with strong links between the Board and local Safety Champions and direct line from HoM to the Chief Nurse. Neonatal Matron appointed and midwifery and nursing leadership structures updated. Additional support for risk and governance in the neonatal unit in post.
	Review of Obstetric lead roles, ensuring PA allocation is adequate to fulfil the role effectively. Adequate operations support for maternity services. Develop consultant midwife role. Administrative staff to support all lead roles.			Medical Director	Triumvirate	Job plans for consultants completed and allocation of consultants to roles with PA attachment. Awaiting outcome of business case for a dedicated maternity operational manager.
	Maternity Service Safety and Quality performance to be scrutinised via internal governance process, maternity & neonatal safety champions, Trust Board, LMNS & Regional team.			Chief Nurse/Medical Director	Triumvirate	Internal and LMNS oversight formalised, require quarterly attendance of Regional Team to Maternity Safety and Quality meetings.

4. Workforce structure and sustainability	Described in MIS year 4 Board reports regarding gaps in workforce in Paediatrics and Midwifery staffing. Active recruitment plans needed to recruit midwives to maintain safe staffing standards			Chief Nurse/Medical Director/Executive lead for Workforce	Triumvirate	Board reports on staffing levels against standards, escalation of areas of concern in hard to recruit areas, business cases when need to increase establishment and monitoring of staffing levels, red flags and exception reports on missed training etc as these are identified. Proposals for Director of Midwifery and Consultant Midwife submitted.
5. Ockenden 2020	See tab for Ockenden initial report and actions needed against the first 7 IEAs; embed interventions required to improve safety. Link to SBL actions			Chief Nurse/Medical Director	MNSC/Leads	Ongoing reports on progress against areas of non-compliance and ongoing monitoring of key indicators. Proposal for Director of Midwifery and Consultant Midwife submitted.
6. Ockenden final report 2022	See tab for assessment and actions needed against the final report. Embed interventions required to improve safety. Link to SBL actions			Chief Nurse/Medical Director	MNSC/Leads	Progress against areas of non-compliance or partial compliance as part of quality improvement plans and ongoing monitoring against key indicators. The total number of points to be assessed and evidence required is 92. Progress has been made in all areas and the current status is as follows: • Evidence has been signed off against 28 of the recommendations (blue)• Assurances of being on track with compliance (green) in 31 areas •

						Partial assurances (amber) have been provided in 25 areas • No current evidence of compliance (red) in 1 area – Maternity core team of trained midwives for HDU. • There are 7 areas where the assessment has not yet been confirmed.
7. Morecambe Bay recommendations	See tab for assessment and actions required against the recommendations. Embed interventions and processes required to improve safety and quality of care.			Chief Nurse/Medical Director	MNSC/Leads	Progress against areas of non-compliance or partial compliance as part of quality improvement plans and ongoing monitoring against key indicators. Actions completed for Maternity Services. Risk assessments in place for neonates with regard to Kaiser; TC and NNU admission.

9. Maternity Self-assessment	See tab for progress on actions required as part of the self-assessment. Linked to the Q&S action and Improvement plan			Chief Nurse/Medical Director	Leads for various aspects of the self-assessment	Ongoing reports and monitoring as part of overall Q&S action Plan and quality and clinical dashboards and Board reporting. August 2023 • Full compliance (green) in162 points • Partially compliant (amber) in 12 areas • Non-compliant (red) in 5 key areas of safety. The 5 areas of non-compliance are as follows: 3 areas of the non-compliant sections relate to having a job description and Director of Midwifery (DOM) in post. A further 2 relate to having local Trust learning forums/conferences on patient safety, safety summits and reporting back to the Division from safety summits.

10. 60 Supportive steps to safety	See tab for progress on actions and improvements made since the 60 steps was undertaken. Remaining actions ongoing			Chief Nurse/Medical Director	Leads for each area on the 60 steps, overseen by the Triumvirate	Ongoing reports and monitoring as part of overall Q&S action Plan and quality and clinical dashboards and Board reporting. Good progress has been made with the 15 areas of non-compliance identified initially. There are 2 remaining areas of non-compliance: 1. MDT training for CTGs - new training package starting from September 2023. 2. The training and competency for administration and checking of antibiotics for neonates is in progress and this action will be completed once the relevant staff have achieved this.

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

To Assure

Presented by Michael Parsons

Board of Directors	
Report title:	**Chair's Key Issues (CKI) report for Audit Committee**
Agenda item:	4.5
Date of the meeting:	20 September 2023
Sponsor/executive lead:	Craig Black, Executive Director of Finance
Report prepared by:	Michael Parsons, Chair of Audit Committee

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

Executive summary:	The report highlights the key issues that emerged from the Audit Committee meeting held on 20 September 2023. The Committee was pleased with the progress made in delivery of the internal audit plan for 2023-24.
Action required/ recommendation:	The Board is asked to note the report and discuss the timing of a proposed "Well Led" developmental review.

Board Assurance Committee CKI Report - Audit Committee (20/09/23)

Agenda Item	Details	Level of Assurance - Substantial - Reasonable - Partial - Minimal	Comments	Action / Escalation
BAF Review	Update	Reasonable	Noted timetable for review of BAF. Informed of delay in complying with LFPSE due to problems with current risk management system DATIX and intended replacement by RADAR system.	NHSE aware and understanding of delay in compliance.
"Well-Led" review	Proposal for a "Well Led" developmental review to be undertaken during 2023-24	Partial	The value of a review was understood, however the timing needed to be considered alongside the current pressures of managing industrial action and financial recovery.	Board to discuss timing.
Internal Audit (RSM)	Update on delivery of internal audit plan and counter fraud activity – and implementation of recommendations	Reasonable	Outstanding audits from 2022-23 completed; good progress with 2023-24 audit plan. Insight and Improvement will be discussing the two recent audits with negative assurance options. Executive asked to review outstanding audit actions, ensuring historic actions are completed (or re-considered with the auditors if circumstances have changed). Faud benchmarking report noted WSFT have fewer fraud reports relative to size than others – the Committee supported the ongoing awareness and training activity for staff.	Insight & Improvement Committees. Executive.

Agenda Item	Details	Level of Assurance - Substantial - Reasonable - Partial - Minimal	Comments	Action / Escalation
Supply Chain risks	Review of risks in supply chain	Reasonable	The Committee were impressed with the thorough analysis and mitigations in place.	Exec Director of Finance to consider cumulative risk around pharma companies.
Losses and waivers	Annual review of losses, special payments, and waivers	Substantial	The Committee received more detailed information which had been summarised in the Annual Report.	Exec Director of Finance to review plans for final rollout of Allocate system to allow previous system to be decommissioned.
Review of auditors' performance	Review of performance of internal and external audit	Substantial	The Committee was satisfied with the performance of both internal and external audit. It was felt the impact of internal audit could be enhanced if there were fewer low value recommendations.	Extension / renewal of external audit contract to be considered by Council of Governors. Exec Director of Finance to encourage internal audit to make fewer, but more impactful recommendations.

5. GOVERNANCE

5.1. Governance report

To Assure

Presented by Richard Jones

NHS West Suffolk NHS Foundation Trust

Board of Directors

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

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

Executive Summary

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

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

- Senior Leadership Team report
- Remuneration committee report
- Council of Governors meeting report, **including the Policy on Engagement between Board of Directors and Council of Governors for approval**
- Updated fit and proper person test (FPPT) framework
- Use of Trust's seal
- Agenda items for next meeting

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

This report supports the Board in maintaining oversight of key activities and developments relating to organisational governance.

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

If approved the policy on engagement between Board of Directors and Council of Governors will be communicated and implemented through the working of the Board and Council of Governors.

Implementation of the action outlined to deliver the new FPPT framework.

Action Required

The Board is asked to note the report and approve the Policy on Engagement between Board of Directors and Council of Governors

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

Governance Report

1. Senior leadership team (SLT) report

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

At its recent meetings SLT considered a number of key issues, which has included discussion of the latest financial position and response, the Trust's escalation policy and West Suffolk change hub programme. The discharge summaries improvement plan was reviewed and action to support improvement reviewed. Review and evaluation of two facilities took place - surgical assessment unit (SAU) and same day emergency care (SDEC). These facilities will continue with further work to engage medical colleagues and support escalation.

2. Remuneration committee report

At its meeting in July the committee considered a number of issues, which has included discussion: review of the pension deferral scheme in light of recent tax changes; next steps in the substantive appointment of the executive medical director; and objectives and remuneration for executives for 2023-24.

3. Council of Governors meeting report, including policy on engagement

The Council of Governors received an update on new CQC inspection model and that CQC has developed a new single assessment framework (SAF) which is going to be launched from November 2023 starting with South extending to all regions by the end March.

The Council of Governors received 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 noted the report from the nomination committee which highlighted that the 360° feedback reports for non-executive directors were reviewed and discussed. The committee also noted the feedback on the Chair recruitment process and agreed to review the process based on the feedback and lessons learnt. The Council of Governors approved the terms of reference of the nominations committee. The Governors also noted the areas identified for improvement in the annual report of committee's effectiveness.

The Council of Governors noted the report from the engagement committee and an update was received on the governor elections. The Council approved the Engagement Strategy 2023-25. The Governors also noted the areas identified for improvement in the annual report on committee effectiveness.

The Governors noted and reviewed the work programme for 2023-24.

The Council of Governors received a report from Standards Committee which included the draft 'Policy on Engagement between Board of Directors and Council of Governors'. The Council of Governors discussed the draft and subject to minor amendments approved the Policy on Engagement. The updated policy is reported to the Board (**Annex A**) for review and approval.

The Council of Governors also noted the GGI recommendations update, the areas identified for improvement in the annual report on committee effectiveness, Governors' induction and training

programme, development plan from the training and development day held on 17 March 2023 with Governors and non-executive directors.

The Council of Governors received and noted the Register of Governors' Interests 2023-24.

The Council of Governors received Annual Audit Letter which was presented by the Chair on behalf of the external auditor.

4. Updated fit and proper person test framework

NHS England has developed a Fit and Proper Person Test (FPPT) Framework in response to recommendations made by Tom Kark KC in his 2019 review of the FPPT. The framework will introduce a means of retaining information relating to testing the requirements of the FPPT for individual directors, a set of standard competencies for all board directors, a new way of completing references with additional content whenever a director leaves an NHS board, and extension of the applicability to some other organisations, including NHS England and the CQC.

The Framework is effective from 30 September 2023 and should be implemented by all boards going forward from that date. NHS organisations are not expected to collect historic information to populate ESR or local records, but to use the Framework for all new board level appointments or promotions and for annual assessments going forward.

The Framework has introduced some new elements:

- **New appointment** - new appointments into joint roles (e.g. across two trusts where one is the host) will require a letter of confirmation from the host trust to the other contracting NHS organisations to confirm that FPPT has been completed. Where there is a temporary absence, a FPPT needs to be conducted for any individual in an interim cover role of six weeks or more
- **New reference** - a standardised reference is being introduced for board members that will validate six consecutive years of continuous employment or training immediately prior to the appointment. Where an individual is from outside the NHS, or within the NHS but moving into a board role for the first time, two references should be sought. Where an individual is moving from one NHS board role to another NHS board role across organisations, one reference is sufficient. When board member leaves post, the Trust is required to complete the standardised reference document using the annual appraisals of the past three years to guide the content. This needs to be completed regardless of whether a reference request has been submitted, to ensure accurate information is recorded for future checks
- **ESR recording** - new data fields in ESR will record FPPT information for all board members to record initial appointment checks and the annual checks, including self-attestation. The information will only be available to the board members organisation
- **Annual reporting** - the Trust will be required to report on its FPPT compliance via annual submissions to the NHS England Regional Directors. The first submission is expected in March 2024. A standardised report template has been devised, alongside a FPPT checklist.

Alongside these new elements, the framework has introduced standardised documents that will assist with consistency and quality assurance.

The framework states that NHS organisations should conduct a DBS check "in line with their local policy requirements" to meet the good character requirement. It is current Trust policy to conduct a DBS checks only for certain roles of which board members are not one, unless the board member is engaged in a regulated activity (e.g., the board member is also a practicing clinician).

Due to the Trust already having a process in place to manage FPPT, there are minimal changes required. **The next steps for the Trust are**:

- Replace all current templates with the new standardised documents.
- Arrange recording of FPPT checks on ESR when the new fields are available.
- Agree the annual reporting process for the Trust Office to the NHS England Regional Director.
- Use the revised checklist and templates for the annual FPPT and new appointments from 30 September 2023 onwards.
- Consider the Trust DBS policy for board members that do not undertake a regulated activity.

The annual checks are due to be conducted in October 2023 so these will be actioned in line with the new requirements. The annual self-attestation for board members was completed in August 2023, so it is not suggested this needs to be repeated as the information required in the new self-attestation template mirrors that which is in the existing Trust template.

5. Use of Trust Seal

- 156 - S106 Agreement securing ecological compensation land for WSFT – unilateral planning obligation by deed under Section 106 of the Town and Country Planning Act 1990 between: WSFT (1) Heathpatch Ltd (2) to West Suffolk Council (3) Babergh District Council (4) re: land at Hardwick Manor, Hardwick Lane, BSE and land at Sheepden Lane, Lindsey IP7 7BB and land at Ash Street Semer IP7 6PA. Sealed and witnessed on 11th September 2023
- 157 – Lease – Heathpatch Limited and Semer Holidays SA and WSFT. Lease relating to land at Semer, Whatfield and Monks Eleigh, Ipswich. Sealed and witnessed on 14th September 2023
- 158 – Lease – Heathpatch Limited and WSFT lease relating to land at Lindsey, Ipswich. Signed and sealed on 14th September 2023.
- 159 – WFST and Heathpatch Limited – compensation site management agreement relating to land at Sheepden Lane Lindsey, IP7 7BB and Land at Ash Street, Semer, IP7 6RA. Signed and sealed on 14th September 2023
- 160 – Legal Charge relating to Land at Sheepden Lane, Lindsey, IP7 7BB and land at Ash Street, Semer, IP7 6RA. Signed and sealed on 14th September 2023.

6. Agenda Items for the Next Meeting (Annex B)

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

5.2. Board Assurance Framework

To inform

Presented by Richard Jones

Board of Directors	
Report title:	**Board Assurance Framework**
Agenda item:	5.2
Date of the meeting:	29 September 2023
Sponsor/executive lead:	Richard Jones, Trust Secretary
Report prepared by:	Mike Dixon, Head of Health, Safety and Risk

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

Executive Summary

WHAT?

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

The Board assurance framework is a tool used by the Board to manage its principal risks to its strategic objectives. The BAF risk assessments have been reviewed with the executive leads in order to assess against the Trust's strategy and strategic objectives.

Through these reviews six key area of risk have been identified. These are listed below:

- Patient safety
- Culture, staff wellbeing and workforce
- Urgent & emergency care and elective care
- Financial constraints
- Maintaining existing estate
- Digital, including cyber security

These have been subject to further review by the executives including:

- The addition of transformation programme and capacity
- Re-writing of the patient safety risk and controls
- Making explicit the use of information element as part of the digital risk, including the response to the new information strategy
- Making clear the delivery of the change programme as part of the future system risk, including the clinical and care strategy and the prevention and personalised of care strategy

SO WHAT? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*
The Board assurance framework is a tool used by the Board to manage its principal strategic risks. Focusing on each risk individually, the BAF documents the key controls in place to manage the risk, the assurances received both from within the organisation and independently as to the effectiveness of those controls and highlights for the board's attention the gaps in control and gaps in assurance that it needs to address in order to reduce the risk to the lowest achievable risk rating. Failure to effectively identify and manage strategic risks through the BAF places organisational objective delivery at risk.
WHAT NEXT? *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*
1. The updated BAF report is received at the Board in September 2. Internal Audit to review the risk register and BAF and facilitate a session for the Board at November Board development session. This will include review of the Board's risk appetite.
Action Required
Note the report and identified actions

Previously considered by:	The Board of Directors
Risk and assurance:	Failure to effectively manage risks to the Trust's strategic objectives. Agreed structure for Board Assurance Framework (BAF) review with oversight by the Audit Committee. Internal Audit review and testing of the BAF.
Equality, diversity and inclusion:	Decisions should not disadvantage individuals or groups with protected characteristics
Sustainability:	Decisions should not add environmental impact
Legal and regulatory context:	NHS Act 2006, Code of Governance. Well-led framework

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 BAF risks are aligned to the Trust's strategy and strategic objectives. The risks have been reviewed with the executive leads in terms of the focus of the risk, controls and further mitigations. The changes and developments included:

- The addition of transformation programme and capacity
- Re-writing of the patient safety risk and controls
- Making explicit the use of information element as part of the digital risk, including the response to the new information strategy
- Making clear the delivery of the change programme as part of the future system risk, including the clinical and care strategy and the prevention and personalised of care strategy.

Through these reviews eight 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
If we do not have a pro-active and positive culture of safety based on openness and honesty underpinned by robust systems for reporting and investigation we will fail to keep our patients, service users and staff safe, learn lessons and embed good practice	Sue Wilkinson (with Paul Molyneux)	Improvement	Patient safety and quality governance group
If we do not create a culture where all colleagues, regardless of their background, feel safe to speak up and raise concerns (at both organisational and team level), this may adversely affect retention, staff morale and well-being, our reputation as an employer and, ultimately, the quality and safety of care provided to our patients	Jeremy Over	Involvement	People & Culture Leadership Group

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	Jeremy Over	Involvement	People & Culture Leadership Group
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.	Jeremy Over	Involvement	People & Culture Leadership Group
If we don't manage within agreed external financial constraints (Revenue and Capital) this may impact on Trust and system sustainability and the model of service provision within the west Suffolk system. 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.	Craig Black	Insight	Financial Accountability Committee
If we do not effectively implement the estates strategy we risk providing a service from a building environment which is unsuitable/ and or unsafe to provide patient care.	Craig Black	Trust Board	Future System Board RAAC Oversight Group
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	Craig Black	Improvement Committee	Digital Programme Board
If we do not plan to fully mitigate risks from unplanned increases in demand, surges in infectious disease, industrial action and delivery of the RAAC remediation plan, this may undermine our ability to deliver all NHS objectives set out in the NHS England 2023/24 priorities and operational planning guidance	Nicola Cottington	Insight	Patient Access Governance Group

A more detailed summary for the risks is provide in Appendix A. This includes risk ratings and mitigating action. These have been subject to executive review.

A schedule has been developed to review these risks through the relevant governance / management fora with the results of this reported to the relevant assurance committee. For example recommendations to improve controls, mitigations and/or assurance.

As part of the BAF review and development we have commissioned Internal Audit to undertake a review of the risk register and BAF and facilitate a Board workshop to consider risk management responsibilities, review the audit findings and refresh the Board's risk appetite statement.

5.	**Conclusion**
	The work to review the BAF risks is ongoing, and this will iterate through the agreement of SMART strategic priorities for 2023/24. The Board assurance committees will update the Board after each meeting when they receive updates on their assigned BAF risks.
6.	**Recommendations**
	Note the report

Appendix A: BAF risk summary report

	Residual Risk	Target Risk
(1) If we do not have a pro-active and positive culture of safety based on openness and honesty underpinned by robust systems for reporting and investigation we will fail to keep our patients, service users and staff safe, learn lessons and embed good practice.	Quarterly x Major = Red	Annual x Major = Amber
Description of additional controls required (actions being taken)	Lead	Due date
Patient safety: patient safety syllabus, patient safety education programme , patient safety partners, positive safety culture , review and refresh of the e-Care patient safety dashboard to proactively ensure safe care, Learn from patient safety events (LFPSE) and Replacement risk management system	Sue Wilkinson	Apr 24
Quality assurance - Development of a quality assurance framework, National best practice publications response, Updated CQC requirements translated into local measures, Integration of QA and QI to form continuous cycle of improvement and assurance, Trust-wide clinical audit programme	Sue Wilkinson	Apr 24
Patient experience & engagement - Trust-wide patient information project , Timely response and evidence of learning from complaints and feedback, Equality Delivery System assessments of accessibility and inclusivity of patient services , PHSO Complaints Standards updates, Patient experience/customer service training programme, Patient story programme, Public engagement programme	Sue Wilkinson	Apr 24

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

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

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

	Residual Risk	Target Risk
(5) If we don't manage within agreed external financial constraints (Revenue and Capital) this may impact on Trust and system sustainability and the model of service provision within the west Suffolk system. This includes failure to identify and deliver cost improvement and transformation plans that ensure sustainable clinical and non-clinical services while delivering the agreed control total.	Weekly x Major = Red	Weekly x Major = Red
Description of additional controls required (actions being taken)	Lead	Due date
Delivery of year end position (Board reporting) with escalation as required	Craig Black	Mar 24
Agree financial position (including anticipated funding for 23-24) with the system and regional team	Craig Black	Mar 24
Agree budget position internally	Craig Black	Mar 24
Finalise CIPs to deliver financial plan for 2023/24 (dependant on response to system/regulatory framework)	Craig Black	Mar '24
Review divisional business plans (underpinned by sustainable clinical models) to reflect the requirements to deliver additional backlog activity	Craig Black	Mar '24

	Residual Risk	Target Risk
(6) If we do not effectively implement the estates strategy we risk providing a service from a building environment which is unsuitable/ and or unsafe to provide patient care. **Linked to structural risk assessment (ref. 24) rated as Red.** **Linked to Future Planning risk (ref. 4952) rated as Amber.** **Linked to Ability to deliver sustainable services to meet operational standards (ref.3651) rated as Red**	Quarterly x Major = Red	Annual x Major = Amber
Description of additional controls required (actions being taken)	Lead	Due date
Implementation of controls associated with red risk re RAAC planks (Datix 24) potential failure of the main building structure and front residencies structure (Oak, Cedar, Birch, Larch, Pine, Willow): - Emergency planning - Assessment and repair - Bearing extension programme (to be completed Oct 21) - Remediation (failsafe installation) - Communication - Research and development - Site and system risk (including continued occupation of WSH site)	Craig Black	November 24
Deliver approved capital programme for 2023-24, including key capacity developments	Craig Black	March 24
Future system programme in place and linked to this risk assessment (4952)	Craig Black	2030
Communication strategy for structural risk based on agreed remediation plan with clinical model to support capacity requirements	Craig Black	On going
Ensure clarity on change management delivery of the clinical and care strategy and prevention and personalisation of care strategy - covered in BAF risk 3651 - Ability to deliver sustainable services to meet operational standards	Nicola Cottington	March 24

	Residual Risk	Target Risk
(7) If we do not progress our programme of work for digital adoption, transformation and benefits realisation, the digital infrastructure will become obsolete and vulnerable to cyber-attack, resulting in poor data for reporting and decision support, digital systems failure, loss of information and inability to provide optimum patient care, safety and experience	Annual x Major = Amber	Annualx 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	March 24
Key deliverable to support Future System programme: - Engagement with architects and surveyors on development of a digital twin for the new buildings	Sarah judge	December 24
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 4 Infrastructure Pillar Group 5 optimisation	Craig Black	March 24
Implementation of phase 1 new data warehouse	Craig Black	December 23
Ensure engagement with ICS process to secure HSLI funding for developments in the West of Suffolk	Craig Black	March 24
Consider and respond to the Information Strategy • Published (complete) • Engagement with key stake holders • Decision making and implementation plan	Craig Black	March 24

	Residual Risk	Target Risk
(8) If we do not plan to fully mitigate risks from unplanned increases in demand, surges in infectious disease, industrial action and delivery of the RAAC remediation plan, this may undermine our ability to deliver all NHS objectives set out in the NHS England 2023/24 priorities and operational planning guidance	Weekly x Catastrophic = Red	Weekly x Major = Red
Description of additional controls required (actions being taken)	Lead	Due date
Expansion of services included in Urgent Community Response (UCR) standard to reduce conveyances to hospital	Nicola Cottington	September 23
Urgent and emergency care plan to improve performance in place	Nicola Cottington	September 23
Review of change management structure October 2023	Nicola Cottington	October 23
Work with Alliance partners and through Integrated Neighbourhood Teams (INTs) to expand pathway one and two capacity to reduce numbers of patients not meeting criteria to reside in acute and community beds	Nicol Cottington	December 23
Work collaboratively with ESNEFT to create a plan for utilisation of Dame Clare Marx Building in line with ICB orthopaedic strategy	Nicola Cottington	March 24
Review of waiting times for community children's and young people's services and implementation of actions to reduce long waits	Nicola Cottington	March 24
Improve access to primary care at Glemsford Surgery, in line with NHSE IIF (impact and Investment Fund) access requirement: Percentage of appointments where time from booking to appointment was two weeks or less. Target range: 85-90%	Nicola Cottington	March 24
Action plan and trajectory to reduce to zero the number of patients waiting over 65 weeks for an elective procedure (excluding uro-gynae)	Nicola Cottington	March 24
Deliver activity targets as set out in operational planning guidance	Nicola Cottington	March 24
Action plan to achieve 75% against 28day Faster Diagnosis Standard and 62-day backlog of no more than 93 patients for cancer	Nicola Cottington	March 24
Deliver community diagnostic centre at Newmarket	Nicola Cottington	July 24

5.3. Meeting Schedule 2024

To Note

Presented by Richard Jones

Board of Directors	
Report title:	2024 Meeting Schedule
Agenda item:	5.3
Date of the meeting:	29 September, 2023
Lead:	Richard Jones, Trust Secretary
Report prepared by:	Ruth Williamson, Trust Office Manager

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

Executive Summary
WHAT? *Summary of issue, including evaluation of the validity the data/information*
To approve the Board/Committee Meeting Schedule for 2024
SO WHAT? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*
-
WHAT NEXT? *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*
-
Recommendation / action required
For approval.

Previously considered by:	-
Risk and assurance:	-
Equality, diversity and inclusion:	-
Sustainability:	-
Legal and regulatory context:	-

Board & Subcommittee Meeting Dates 2024 - 25

SCHOOL HOLIDAYS

19 – 23 February
3 April – 16 April (Easter)
27 May – 31 May
29 March – 11 April
20 July – 1 September (Summer Holiday)
28 October – 1 November
23 December – 5 January, 2025
17 – 21 February, 2025

BANK HOLIDAYS

1 January
29 March & 1 April (Easter)
6 May
27 May
26 August
25 December
26 December

Committee	Board Dates (Open & Closed)	Board Development Session	Insight Committee	Improvement Programme Board	Involvement Committee	Audit Committee	Charitable Funds Committee	Remuneration Committee	Future Systems Board	Council of Governors
Time	**9:15am – 4.30 pm**	**9.00 am – 5.00 pm**	**3.00 – 5.00 pm**	**12.00 pm – 2.00 pm**	**9.00 – 11.00 am Bi monthly**	**10 am – 12 noon Quarterly (Teams)**	**10:00 am – 12 noon Quarterly (Teams)**	**TBC**	**10 am – 12 noon (Provisional)**	**TBC**
January	26 Ed Centre		17	17					16	
February		23	21	21	21				27	
March	22		20	20		19				
April		26	17	17	17		16		9	
May	24 Ed Centre		15	15					21	
June		28	19	19	19	25 (to include AC Annual Accounts sign off meeting) 27 – 11 am (Private Board only - Accounts Sign-Off)				
July	26		17	17			16		2	
August		23	21	21	21				13	
September	27 Ed Centre		18	18		24			24	
October		25	16	16	16		21 (Annual Accounts Sign-off meeting)			
November	29 Ed Centre		20	20					5	
December			18	18	18	10 (to include Charitable Funds Accounts Sign-Off)	3		17	

6. OTHER ITEMS

6.1. Any other business

To Note

6.2. Reflections on meeting

For Discussion

6.3. Date of next meeting - 1 December, 2023

To Note

Presented by Jude Chin

RESOLUTION

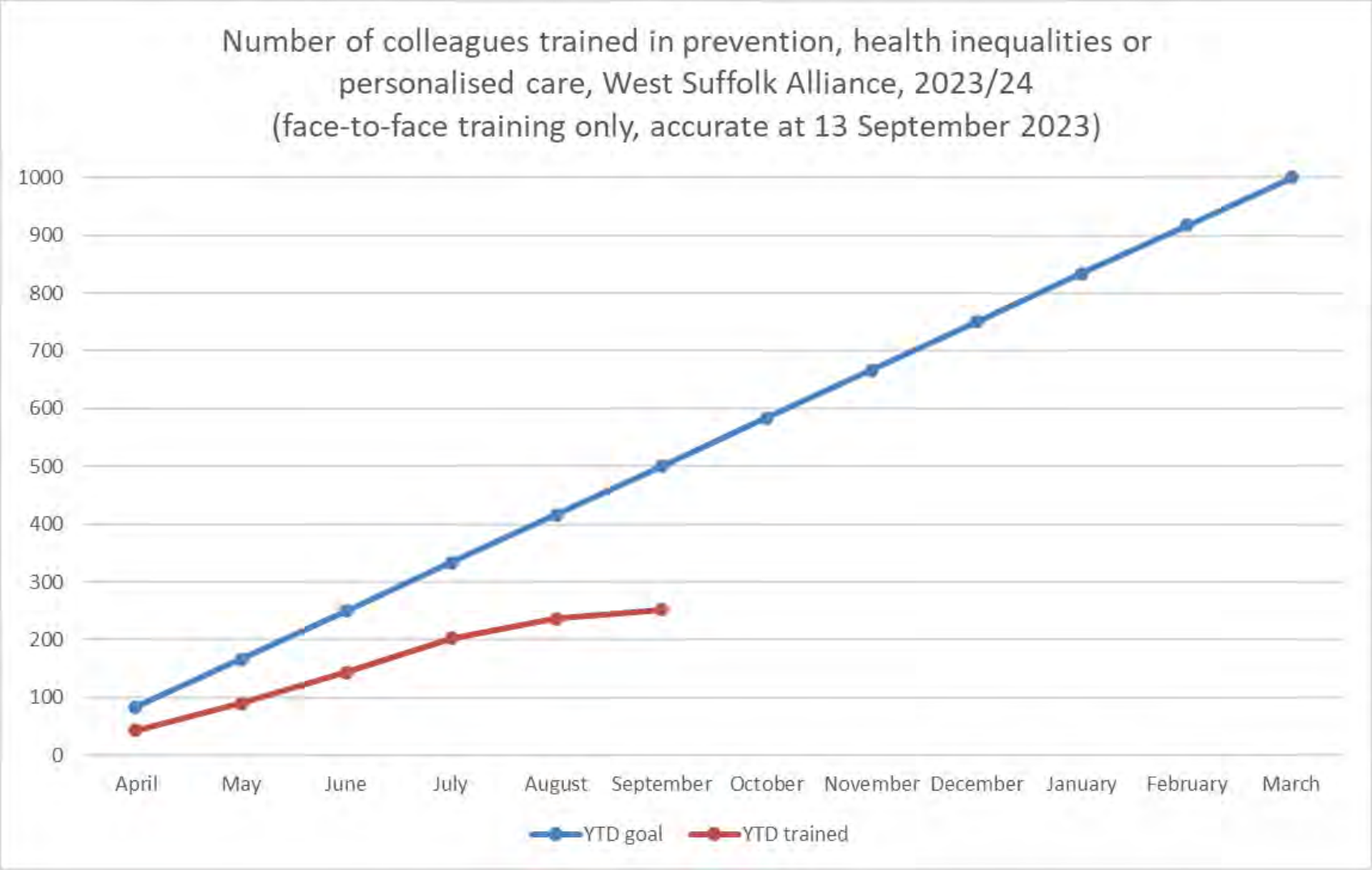
The Trust Board is invited to adopt the following resolution:

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

SUPPORTING ANNEXES

2.1 Strategic priorities

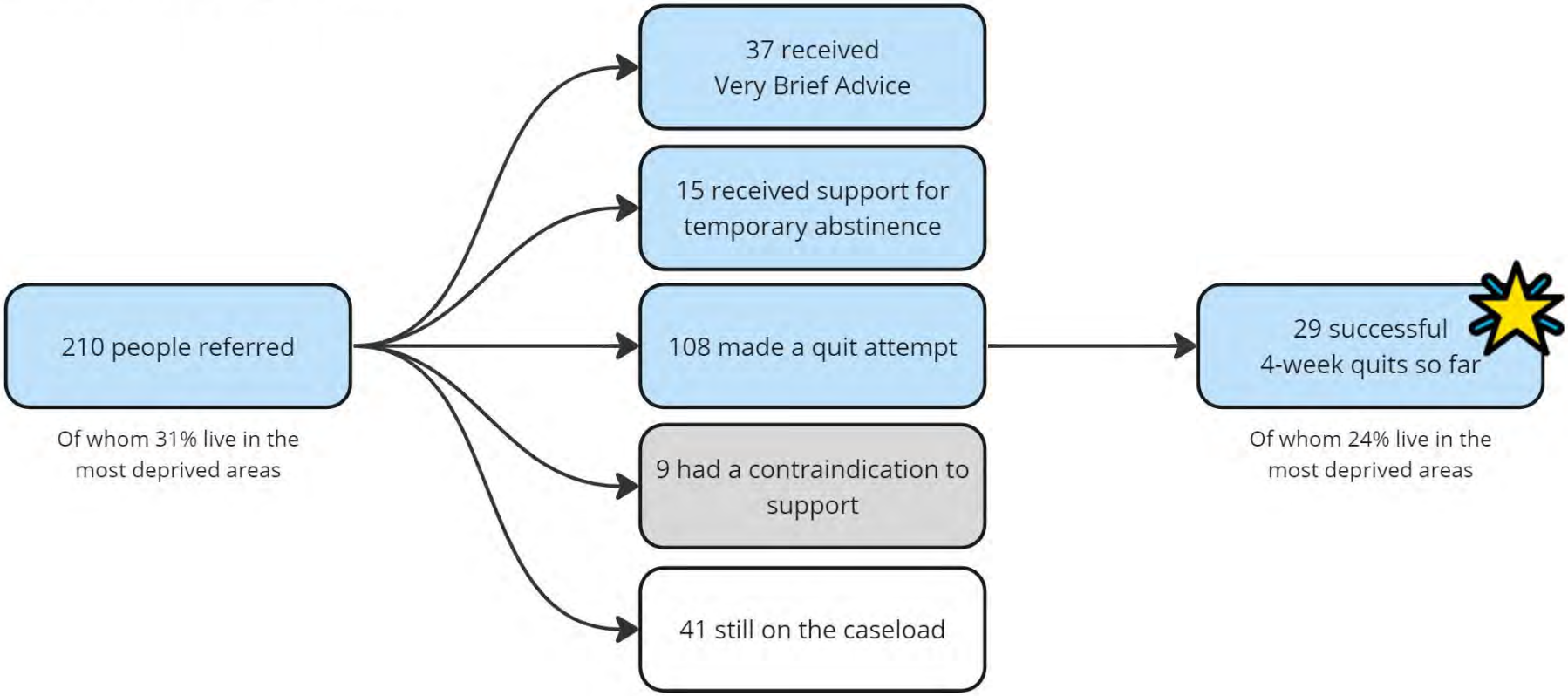
First for the Future - Delivery on prevention and proactive care



Tobacco dependence service outcomes

2023/24

Year-to-date, 31 August 2023



Case studies, September 2023

Preassessment / surgery pathway

- Male patient in his 40's phoned preassessment unit to ask how long he should not smoke for before his surgery. He was advised 24-48 hours and was informed about the reasons why.
- The patient was asked if he would be interested in stopping smoking and if he would like to be referred to the stop smoking service. He said yes.
- The referral was made and the tobacco dependence team (TDT) called the patient and encouraged him to stay stopped beyond his surgery.
- The patient came in for his surgery having stopped smoking.
- The patient spoke to the nurse on the ward following his surgery. The nurse sent another referral to the TDT who visited him on the ward the following day and drew up an action plan for him.

"The patient told me that he had stopped smoking prior to his surgery. I completed a referral on eCare via 'request care plan' to the tobacco dependence service. It was late in the day and the following morning one of the stop smoking advisors came to see him. It was such a quick and easy process". - Staff nurse F5

Patient with cardiac, respiratory and cancer conditions

- The patient has been a lifelong smoker and was down to 20 cigarettes a day.
- He came in via cardiology where he was referred to the TDT, who saw him and organised nicotine replacement therapy (NRT) for him while he was admitted.
- The patient was transferred to Papworth with his NRT. The Papworth tobacco lead went to see him, checked that he was using his NRT ok and to see how he was.
- When the patient was discharged from Papworth, the Papworth tobacco lead informed the WSH TDT and the patient was referred to OneLife Suffolk for onward support.

Respiratory

- Female in her late 70's with COPD, whose home life is very complex.
- The patient had tried to stop smoking several times but was always unsuccessful.
- The patient was visited by the TDT on the cardiac ward and was prescribed NRT and given motivational support.
- She decided to stop smoking for herself and her family.
- She went to a local pharmacy for continued support and NRT.
- The patient was still successfully quit after 4 weeks.

"I'm so glad that I met you and the pharmacist, it came at just the right time for me, thank you". – Patient

4.2 IQPR Full Report

Board of Directors	
Report title:	**Integrated Quality and Performance Report**
Agenda item:	4.2
Date of the meeting:	29 September, 2023
Sponsor/executive lead:	Sue Wilkinson, chief nurse and Nicola Cottington, chief operating officer
Report prepared by:	Andrew Pollard, information analyst. Narrative provided by clinical and operational leads.

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

Executive summary:	The Integrated Quality and Performance Report uses the Making Data Count methodology to report on the following aspects of key indicators: 1. Compliance with targets and standards (pass/fail) 2. Statistically significant improvement or worsening of performance over time. Narrative is provided to explain what the data is demonstrating (what?), the drivers for performance, what the impact is (so what?) and the remedial actions being taken (what next?). Please refer to the assurance grid for an executive summary of performance. "Areas of exception to bring to the board's attention: • Paediatric Speech and Language Therapy (SLT) and Wheelchair services are not compliant with 18 week referral to treatment. Demand and capacity review is underway for Paediatric SLT. Wheelchair services do not have a recovery trajectory, to be addressed through insight Committee. • Sustained reduction in numbers of patients not meeting the Criteria to Reside, which will positively impact on patient flow in the acute hospital. • Significant improvement in ambulance handovers under 15 minutes, although not yet meeting the 65% target. 4 hour performance, reintroduced in May 2023, is above the recovery trajectory submitted In July at 71.2% (trajectory 52%). • Performance against the 28 day faster diagnosis standard for cancer is not yet demonstrating significant improvement, although it is ahead of trajectory. It has been challenging for the breast service to meet the two week wait standard for first appointment, with performance at only 8.4%. Breast clinic appointments are one stop, so diagnostics are provided at the same time, and the service is running "Super Saturday" clinics in September to focus on meeting the 28 day faster diagnosis standard. The standards for cancer access are being streamlined form October 2023, prioritising faster diagnosis and treatment. • Whilst activity has increased compared to the 19/20 baseline, this is not to the target of 107% and outpatient follow ups remain higher than the 85% target. There is a renewed focus on improving productivity including an ICB-wide outpatient transformation programme which WSFT are engaged in, including video consultation project, patient-initiated follow up and the Getting It Right First Time (GIRFT) checklist.

Executive summary:	• The numbers of patients experiencing very long waits for elective care 78 weeks and 14 weeks) continues to decrease, however the overall waiting list size continues to increase and is above trajectory. This is impacted by ongoing industrial action which reduces capacity. The actions to address outpatient productivity are planned to impact positively on the waiting list size. • We are currently reviewing how we can provide assurance via the improvement committee that there is adequate focus and oversight of areas performing well and those performing less well. We plan to use the discussions had through our Divisional performance review meetings (PRM) to evidence this.
Action required / Recommendation:	To receive and approve the report

Previously considered by:	**Component metrics are considered by Patient Safety and Quality Group and Patient Access Governance Group.**
Risk and assurance:	BAF risk 3.1: Failure to manage emergency capacity and demand in the context of Covid activity and delivery of the RAAC remediation plan BAF risk 3.2: Delivery of elective access standards based on clinical priorities, in context of Covid activity and delivery of the RAAC remediation plan (BAF 3.2) and the emergency demand
Equality, diversity and inclusion:	Monitoring of waiting times by deprivation score and ethnicity are monitored at ICB level.
Sustainability:	N/A
Legal and regulatory context:	NHS Act 2006, West Suffolk NHS Foundation Trust Constitution

Assurance Grid

July 2023	ASSURANCE: Pass (P)	ASSURANCE: Hit and Miss (?)	ASSURANCE: Fail (F) — Not Met
VARIANCE: Special Cause Improvement (H / L)		**INSIGHT:** RTT 104+ Weeks Wait **INVOLVEMENT:** Staff Sickness – Rolling 12months Staff Sickness - Monthly	**INSIGHT:** Ambulance Handover within 15min RTT 78+ Weeks Wait **INVOLVEMENT:** Appraisal Turnover
VARIANCE: Common Cause	**INSIGHT:** Urgent 2 Hour Response	Please see box to right	**INSIGHT:** 12 Hour Breaches Incomplete 104 Day Waits Diagnostic Performance - % within 6 Weeks Total **IMPROVEMENT:** Nutrition – 24 Hours **INVOLVEMENT:** Mandatory Training
VARIANCE: Special Cause Concern (H / L) — Deteriorating			


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

INSIGHT: Pledge 2 *% Compliance
Ambulance Handover within 30min
Ambulance Handover within 60min
Reduce Adult General and Acute (G&A) Bed Occupancy
28 Day Faster Diagnosis
IMPROVEMENT:
MRSA, C-Diff
Hand Hygiene
Sepsis Screening for Emergency Patients
VTE – All Inpatients
Mixed Sex Breaches
Community Pressure Ulcers
Acute Pressure Ulcers
Inpatients Falls Total
Acute Falls per 1000 Beds
INVOLVEMENT: Overdue Responses

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

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

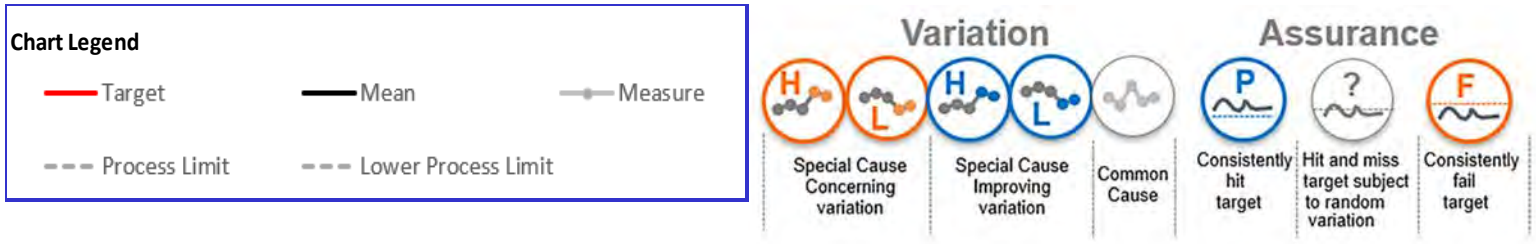
Currently this data is not available to the Trust, however the Information Team are working to resolve this.

*Cancer data is 1 month behind

Items for escalation based on those indicators that are failing the target, or are worsening and therefore showing Special Cause of Concerning Nature by area:
INSIGHT: Urgent & Emergency Care: Ambulance Handover within 15min, 12 Hour Breaches
Cancer: Incomplete 104 Day Waits
Elective: Diagnostic Performance- % within 6 Weeks Total, RTT 78+ Weeks Wait
IMPROVEMENT: Safe: Nutrition – 24 Hours
INVOLVEMENT: Well-Led: Mandatory Training, Appraisal, Turnover

INSIGHT COMMITTEE METRICS

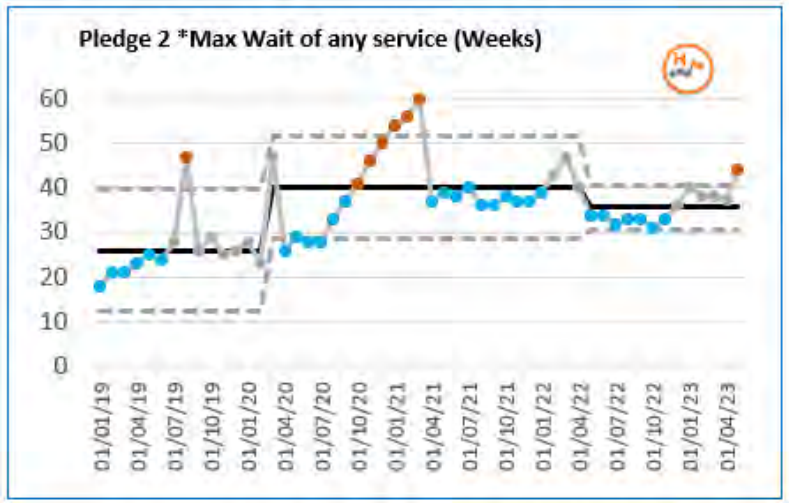
Community Access Summary

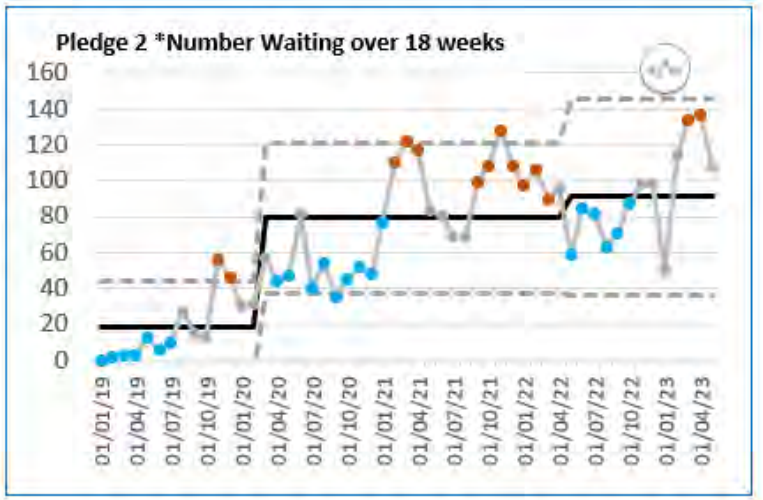


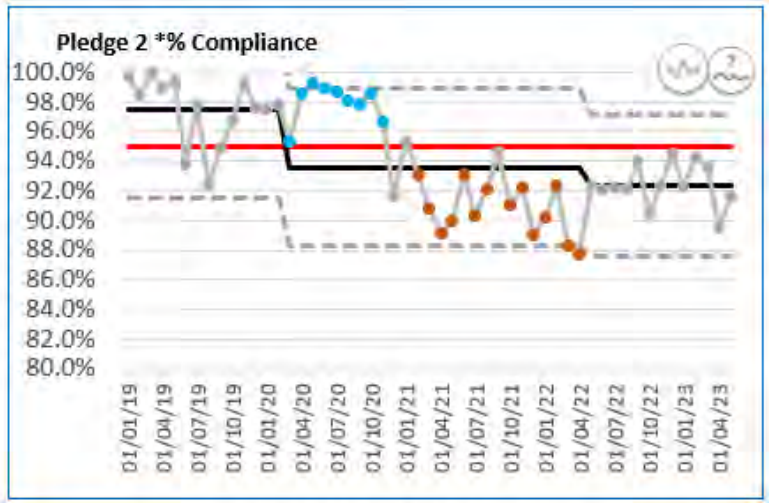
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Pledge 2 *Max Wait of any service (Weeks)	Jul 23	36				36	30	43
Pledge 2 *Number Waiting over 18 weeks	Jul 23	120				94	40	147
Pledge 2 *% Compliance	Jul 23	94.4%	95.0%			92.5%	87.8%	97.1%
Urgent 2 hour response	Jul 23	90.0%	70.0%			89.9%	81.3%	98.5%
Criteria to reside (Average without reason to reside) Acute	Jul 23	37				62	50	74
**Criteria to reside (Average without reason to reside) Community	Jul 23	18				17	13	22

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

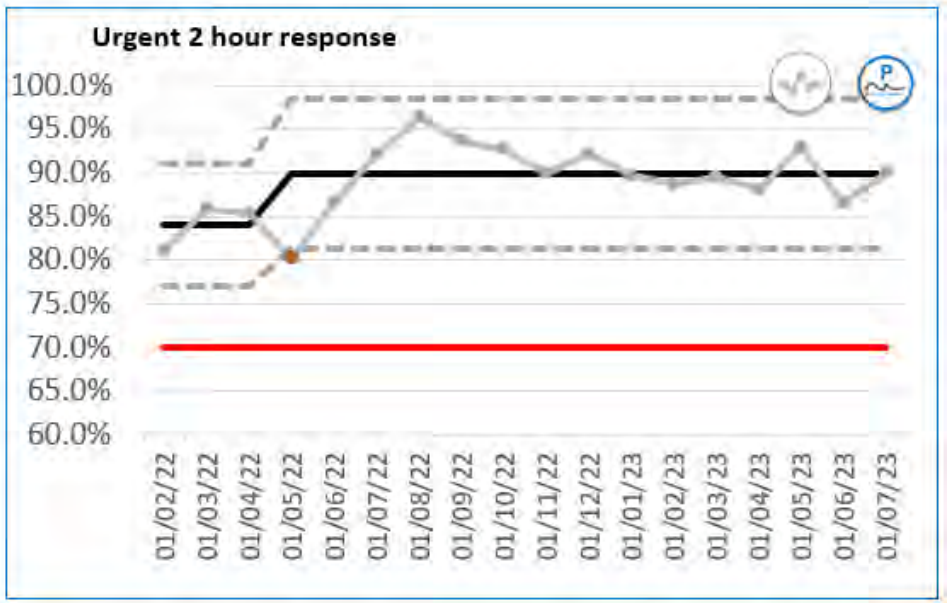
** Figures are for Glastonbury and Newmarket only, data not currently captured at Hazel Court.

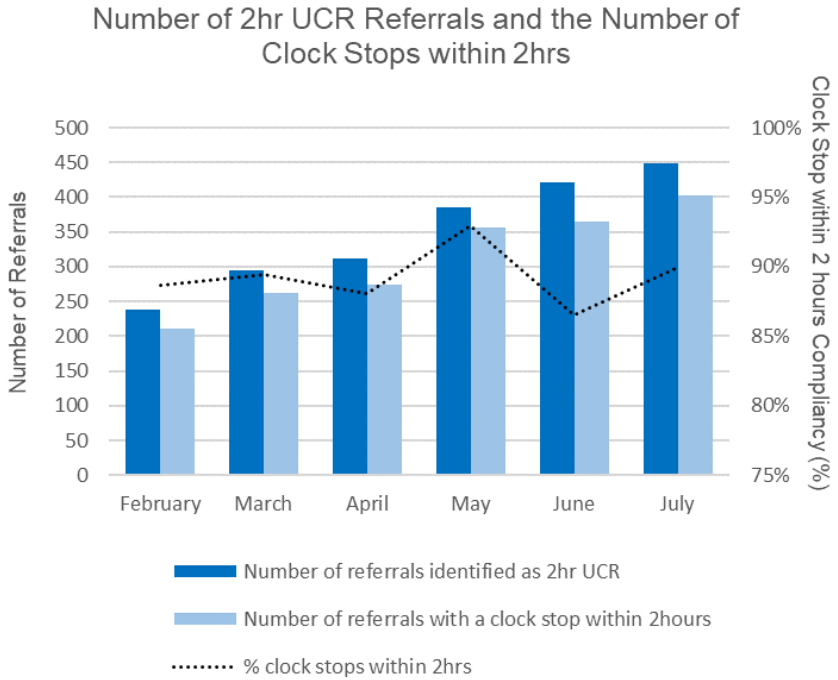




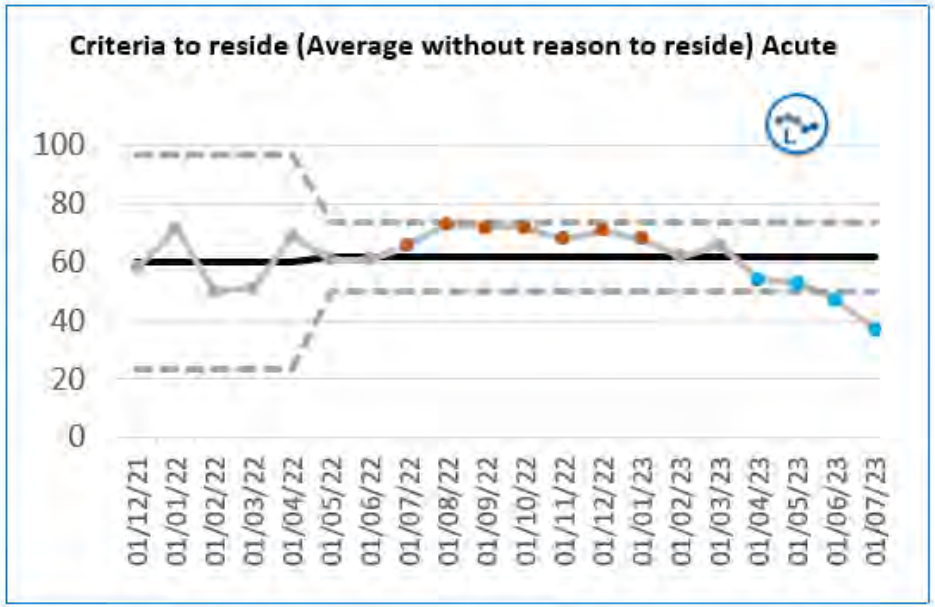


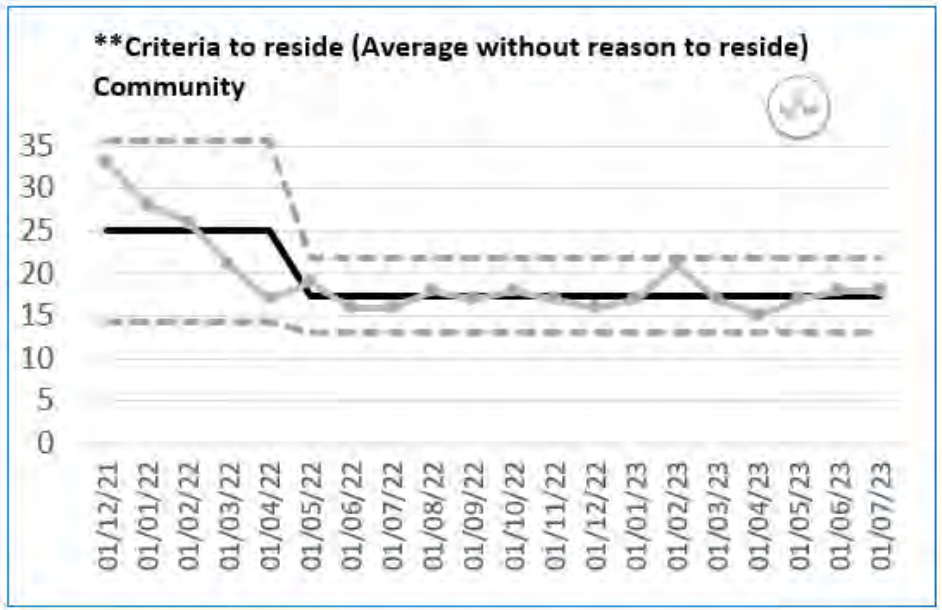
What	So What?	What Next?
Wheelchair Services There has been a decrease from last month to a max wait of 32 weeks, not representative of the case load. Longer wait often attributed to specialist component parts/accessories needing to be produced from worldwide companies. Referrals received this month have reduced back to baseline levels, after 2 consistent months of a 60%+ increase. Paediatric SLT SLT is the only paediatric therapy team with longer waiting times due to higher levels of demand and caseload numbers. There are 50 children waiting over 18wks with the longest wait currently 33 weeks. The average waiting time for initial assessment and implementation of strategies to manage language problems is 9wks.	Wheelchair Services % of patients waiting over 14 weeks is only 17.81% of the case load which indicates most are receiving care within service timescales. Increase of referrals due to seasonality and legacy of covid complexities previously highlighted. Due to impact service in Q3. Paediatric SLT Sustained pressure on the team post pandemic with inconsistent implementation of early screening and intervention in early years/education settings resulting in increased level of need. Further impact on the team loss of capacity due to budget setting reduction in staffing.	Wheelchair Services Service reviews data daily and weekly escalation call for caseload management. Recovery plan in place but service resilience is fragile due to speciality and vulnerable patient group. Additional clinic space being sought. Work underway to progress short term gains: QI Team working with team on task groups to support service improvements. Difficult to determine when service will be on track for performance, above national baseline which is 84.8%. No national data available for max weeks for wheelchair services. Paediatric SLT Service demand and capacity review has commenced – plan to report on outcome in October. Investment from SCC to support SEND therapy provision (not reported in RTT) will positively impact on responsiveness. Team have implemented RTT reporting within S1 to support accurate and timely clock start/stops, avoiding the need for manual checking for performance reports



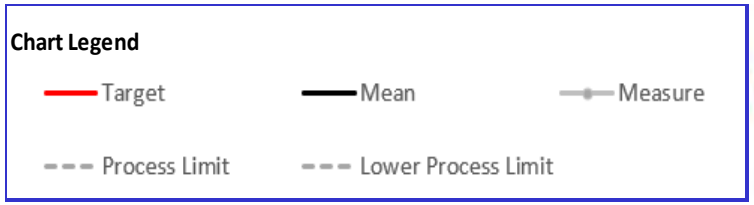


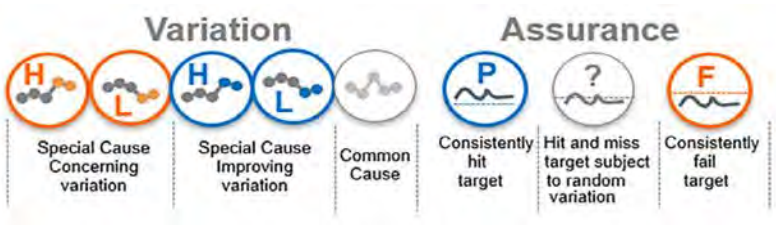
What	So What?	What Next?
-Number of 2 hour referrals continue to increase -The team has accepted more ambulance Cleric referrals.	Still remains well above 70% target	Community nursing and INTs working towards having 2 hour option in September. No date yet for requested data around declined to be added to SystmOne. Team still collecting reasons for decline manually. EIT on track for 10% increase in referrals compared to last year. Currently working on strategy for developing UCR and sustaining targets. Monitor increase in referral rates and impact of peak summer holiday – sustainability model underway



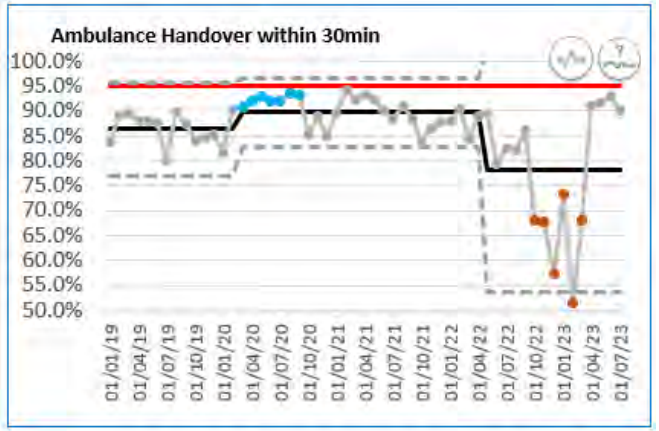


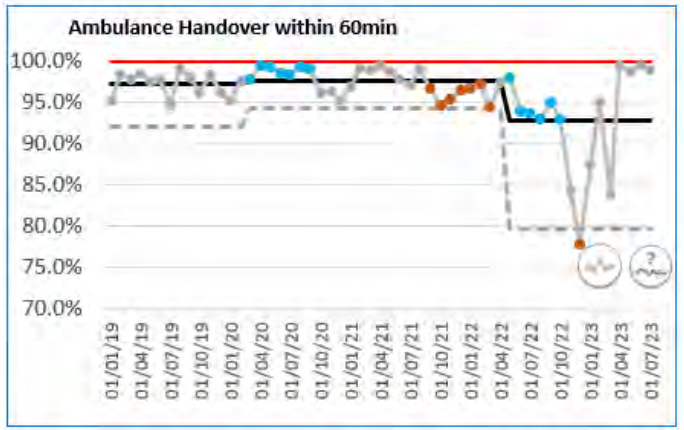
What	So What?	What Next?
For July's data, we continue to see overall numbers of patients who lack reason to reside showing a downward trend, with the community bed settings maintaining similar numbers as June. Similar to June, the Transfer of Care Hub have seen lower referral numbers than was expected for this period – without a clear narrative as to why this may be. This has resulted in Home First, Support to Go Home teams having available capacity for P1 patients throughout the month, alongside capacity within both the Community Assessment Beds and towards the middle of the month, Interim beds. This shows that the reduction of patients without Criteria to Reside is likely not linked to any change of practice within the Transfer of Care Hub but could be linked to the type of patients who are presenting and being admitted to the Trust.	Maintaining less numbers of patients without reason to reside helps contribute towards improved patient flow throughout the whole patient journey. Patients are able to return home, or to their onward place of discharge quicker, reducing length of stay and risks associated with prolonged hospital admissions.	There is ongoing work to develop the Enhanced Reablement package with the aim to convert more Pathway 2 patients to Pathway 1, and look to increase the night support we can offer our Pathway 1 patients. Work also continues with reviewing Pathway 2 criteria, to decrease delays and have the ability to offer a more equitable service. There is also an ongoing project focusing on flow within our Community Assessment Beds.

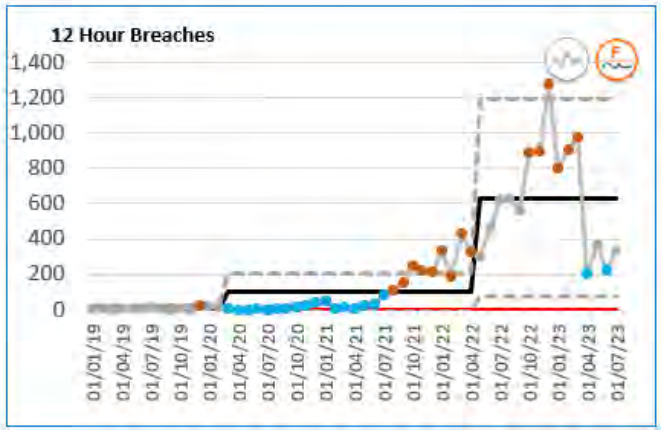




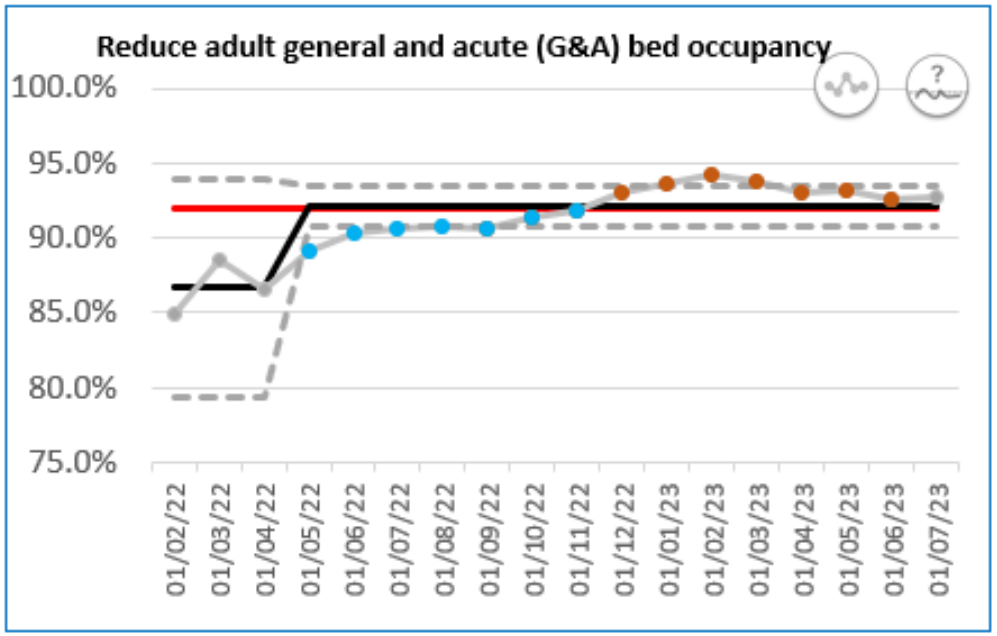
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Ambulance Handover within 15min	Jul 23	39.4%	65.0%	H	F	30.9%	18.6%	43.1%
Ambulance Handover within 30min	Jul 23	90.0%	95.0%		?	78.0%	53.6%	102.5%
Ambulance Handover within 60min	Jul 23	99.0%	100.0%		?	92.8%	79.6%	106.0%
12 Hour Breaches	Jul 23	332	0		F	631	73	1189
Reduce adult general and acute (G&A) bed occupancy	Jul 23	92.7%	92.0%		?	92.1%	90.7%	93.4%
4 hour breaches	Jul 23	2287	0					
4 hour performance	Jul 23	71.2%	76.0%					





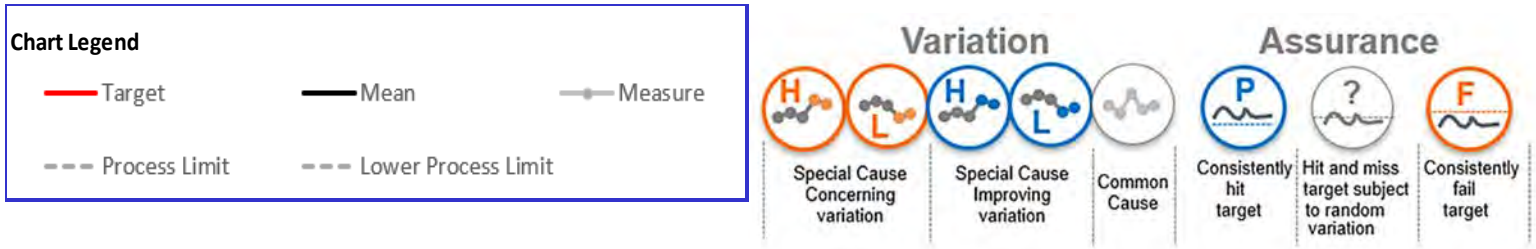


What	So What?	What Next?
There is a trend of significant improvement in ambulance handover performance within 15 minutes, with no significant change within the 30min or 60 min standard. Performance of 4 hour standard (no graph currently) remains above recovery trajectory at 71.2% There has been no significant change in the number of 12 hour breaches at 332.	Although performance remains stable, achieving the targets continues to be challenging, particularly in terms of capacity issues within the Trust resulting in some bed waits within the emergency department for our patients, which in turn causes some delays to ambulance handovers.	We are working through phase two of our internal UEC recovery plan whilst working collaboratively with the alliance and the ICB on the 'One Plan' to ensure improved UEC performance. Work streams of phase two recovery plan are: • Metrics • Internal Professional Standards • Internal alternative pathways to ED • External alternative pathways to ED • Hospital Flow • Capacity • General Medicine



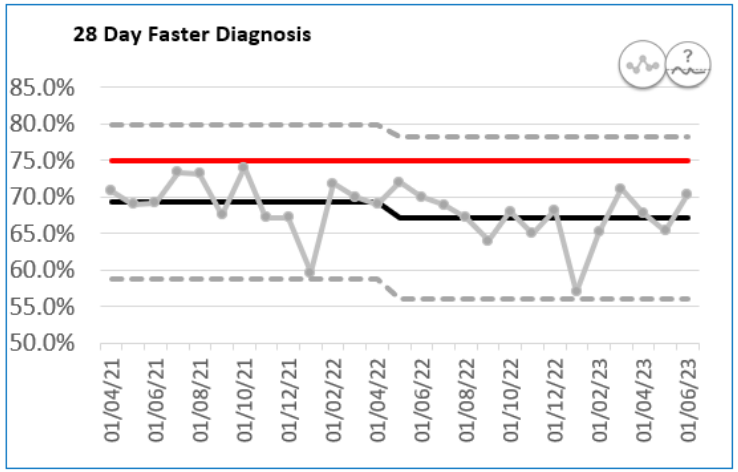
What	So What?	What Next?
Bed occupancy continues to remain above the 92% threshold in line with an increase in average LOS, though does show a stable pattern over recent months, as peaks of operational pressure have become less frequent and less severe.	It is likely that demand for beds and LOS will increase throughout the coming winter months, therefore additional capacity and mitigations will be required to further reduce and maintain bed occupancy at or below 92%.	Our Focus on Flow programme will consolidate and build on the work done by the Right Care, Right Time, Right Place Core Resilience Team (CRT) to implement a number of mitigations and process improvements to reduce bed occupancy. These include ward flow, stranded patients, and overnight Discharge Waiting Area capacity. In addition, the programme will support analysis, decision making and mobilisation of acute inpatient surge capacity as well as supporting delivery of initiatives being funded nationally such as 18 additional community beds with enhanced wraparound support. Each project will use specific metrics to measure progress and impact, but all will make an overarching contribution to the headline measure of reducing bed occupancy.

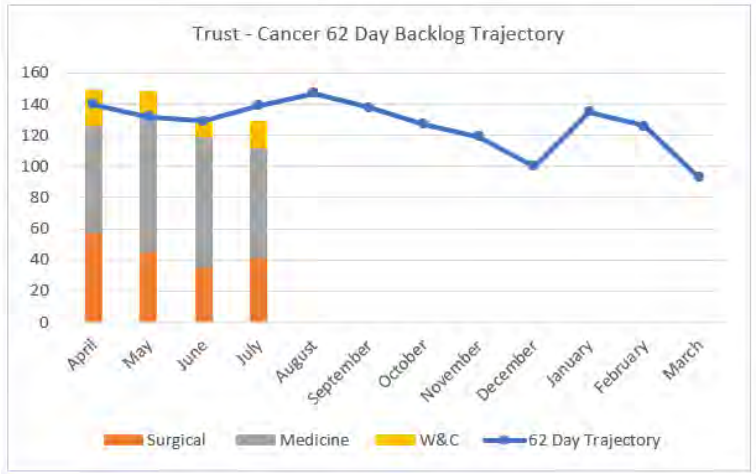
Cancer Access Summary

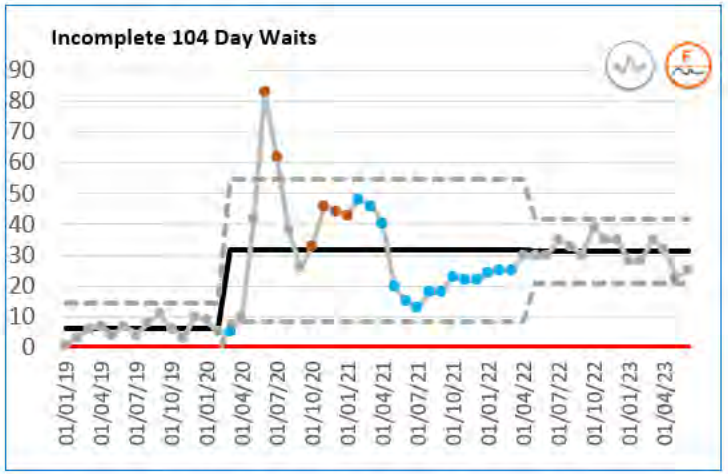


KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
28 Day Faster Diagnosis	Jun 23	70.4%	75.0%			67.2%	56.1%	78.2%
Trust - Cancer 62 Day Backlog Trajectory	Jun 23	129	139					
Incomplete 104 Day Waits	Jun 23	25	0			31	21	42

Cancer Access (Month Behind)







What	So What?	What Next?
The 28 Day Faster Diagnosis standard is not demonstrating sustained improvement, however the June 2023 performance was ahead of trajectory at 70%, with positive improvements in Skin and Head and Neck. The 62 day backlog is currently under trajectory for the end of July position, with positive reduction in Skin and Gynaecology and continued low numbers for Lower GI. The 104 day waits are not yet demonstrating significant improvement.	Recovering the cancer standards is key to the operational planning guidance 23/24. The priorities for this year focus on seeing, diagnosing and treating patients in line with national guidance to improve patient outcomes and maintain standards. A re-group on cancer performance is underway with the national standards changing from October 2023 from 10 standards to 3, with faster diagnosis and treatment as priorities.	The high level actions in place are those that are specifically targeting the faster diagnosis standard: • Implementation of Head and Neck triage tool to commence 31st August • Implementation of Head and Neck one stop clinic to commence 6th October • Gynaecology FDS steering group commenced 21st August, which will have specific actions • Nurse led prostate biopsy project to recommence in September • Super Saturdays to commence in Breast in September

NHS England - 23/24 (Monthly - IQPR)

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

West Suffolk NHS
NHS Foundation Trust

All

All

Outpatient First

Mon	19/20	107%	23/24	Var %
Apr	6,625	7,089	6,718	101.4%
May	7,453	7,975	8,395	112.6%
Jun	8,097	8,664	8,294	102.4%
Jul	7,499	8,024	7,756	103.4%
Aug	7,637	8,172		
Sep	7,729	8,270		
Oct	8,097	8,664		
Nov	8,373	8,959		
Dec	6,717	7,187		
Jan	8,373	8,959		
Feb	7,821	8,369		
Mar	7,591	8,122		
Total (YTD)	**29,674**	**31,751**	**31,163**	**105.0%**

July 2023	
19/20	7,499
107%	8,024
23/24	7,756
Var	(268)
Var %	103.4%

Daycase

Mon	19/20	107%	23/24	Var %
Apr	1,903	2,033	2,064	108.4%
May	2,175	2,324	2,392	110.0%
Jun	2,338	2,498	2,449	104.7%
Jul	2,189	2,338	2,308	105.5%
Aug	2,257	2,411		
Sep	2,284	2,440		
Oct	2,393	2,556		
Nov	2,556	2,731		
Dec	1,985	2,121		
Jan	2,461	2,629		
Feb	2,365	2,527		
Mar	2,284	2,440		
Total (YTD)	**8,605**	**9,194**	**9,213**	**107.1%**

July 2023	
19/20	2,189
107%	2,338
23/24	2,308
Var	(30)
Var %	105.5%

Outpatient Follow Up

Mon	19/20	85%	23/24	Var %
Apr	14,014	11,912	15,188	108.4%
May	15,766	13,401	18,315	116.2%
Jun	17,128	14,559	17,923	104.6%
Jul	15,863	13,484	17,127	108.0%
Aug	16,155	13,732		
Sep	16,350	13,897		
Oct	17,128	14,559		
Nov	17,712	15,055		
Dec	14,209	12,077		
Jan	17,712	15,055		
Feb	16,544	14,063		
Mar	16,058	13,649		
Total (YTD)	**62,771**	**53,355**	**68,553**	**109.2%**

July 2023	
19/20	15,863
85%	13,484
23/24	17,127
Var	3,643
Var %	108.0%

Elective

Mon	19/20	107%	23/24	Var %
May	299	319	295	98.8%
Apr	257	275	239	92.8%
Jun	318	340	278	87.3%
Jul	300	321	243	80.9%
Aug	315	337		
Sep	300	321		
Oct	318	340		
Nov	329	352		
Dec	277	296		
Jan	275	294		
Feb	300	321		
Mar	286	306		
Total (YTD)	**1,175**	**1,256**	**1,055**	**89.8%**

July 2023	
19/20	1,175
107%	321
23/24	243
Var	(78)
Var %	80.9%

What

Although activity across outpatient first and daycase points of delivery remains above the 2019/20 baseline, the overall activity target of 107% is not being met notably due to elective activity which shows a declining trend. Industrial action will have had an impact on delivery, as will bed availability in surgery whilst surgical emergencies are prioritised. However, follow ups remain high – in Medicine many chronic disease services are struggling to reduce their performance against the 2019/20 baseline despite some interventions.

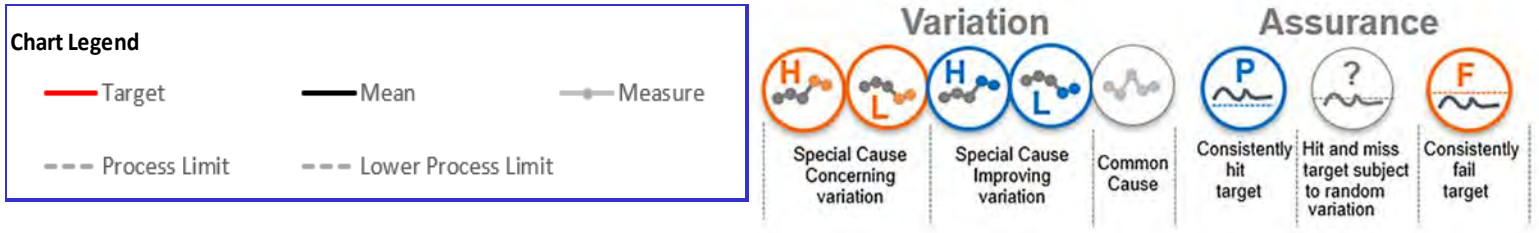
So What?

The operational imperative to eliminate long waits may not always be compatible with ramping up activity levels – if longer waits are accumulated in lower volume specialties. There remains a significant financial and reputational risk to the Trust if the increases in new OP, DC and EL activity and reductions in OP FU activity are not met.

What Next?

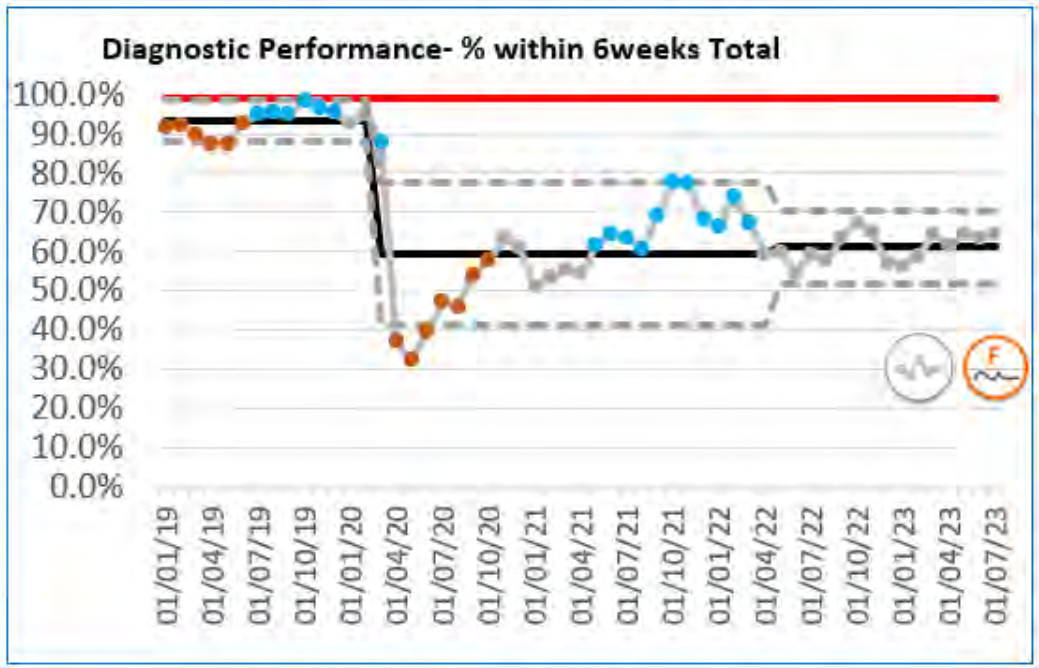
It is possible that the 107% activity thresholds for new OP, DC and EL will be lowered to 104% in recognition of the impact from Industrial Action. Plans are in place to increase activity in surgical specialties, and a refreshed Trust and ICB-wide outpatient transformation programme will have a key priority to reduce follow ups by 25% in line with national expectations. Further work and cultural shift will be required to deliver this.

Elective Access Summary



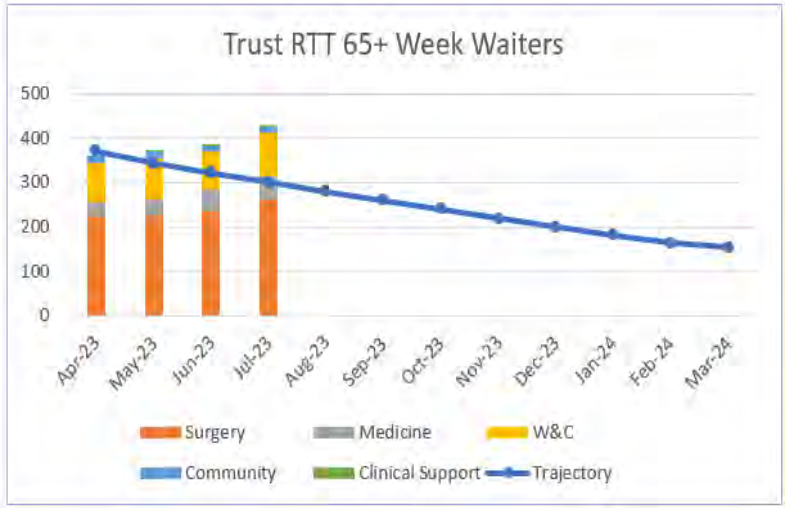
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Diagnostic Performance- % within 6weeks Total	Jul 23	64.6%	99.0%			61.2%	52.0%	70.5%
RTT 65+ Week Waits	Jul 23	430				428	300	557
RTT 78+ Week Waits	Jul 23	60	0			245	129	361
RTT 104+ Week waits	Jul 23	1	0			16	-6	38
Potential 65+ ww at end of March 2024	Jul 23	6871				9689	4316	15062

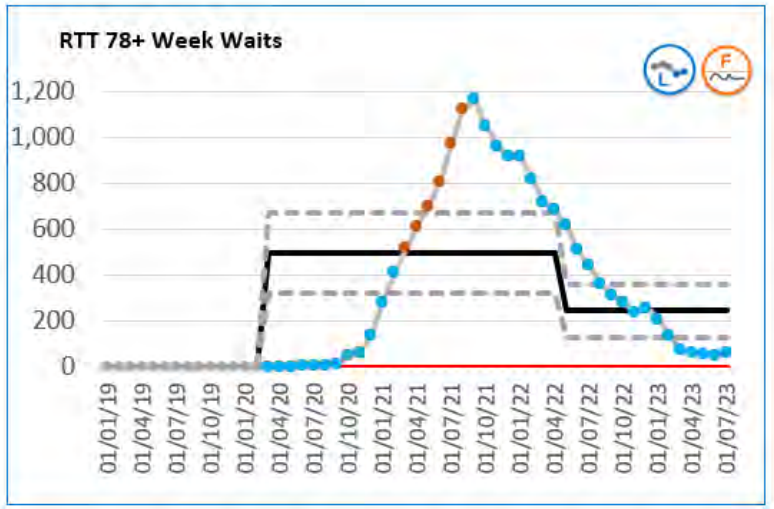
Elective Access

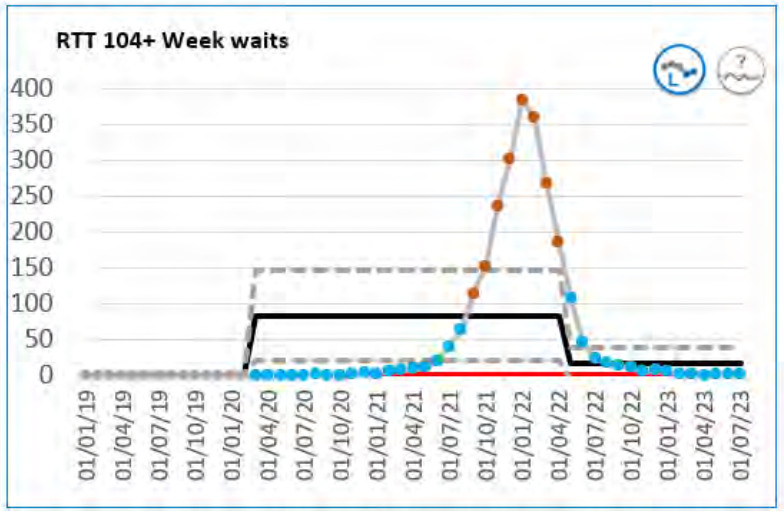


Elective Access

What	So What?	What Next?
Procedures delivered in July reduced from 933 the previous month to 760, a reduction of 19%. This is driven by annual leave, bed related cancellations and unexpected staff absence within theatres and anaesthetics. In spite of this adherence to 65 week recovery is being maintained. There has been an push to increase theatre productivity and therefore several clinicians now attend scheduling which enables further cases to be added to a list, capped utilisation is on an upward trend, achieving 76.7%, the highest level since before 2019. Audiology diagnostic performance is on an upward trajectory, improving by 10% since last month. There is recognition that the service will not fully recover DM01 without room conversion until Feb 2025. Cystoscopy has been prioritised as these are mostly patients on a cancer pathway and as such prioritising one has led to a deterioration in the other. However, a CNS on long term sick returns in September and this will result in an improved Urodynamic position. Cystoscopy remains on an upward trend. Urology diagnostics predict DM01 compliance in November 2023. **MRI** - Performance demonstrates continued decline in position, however this is in line with forecasted worsening position until CDC in July 2024. **CT** – Improving trend following recovery from replacement programme and is currently meeting performance trajectory, the next phase of the CT replacement programme is due to start on the 25th September, which may impact the overall performance. **US** –There has been no significant change with performance at 92%, in line with recovery trajectory. **Endoscopy –** There has been no significant change with performance at 39% for Colonoscopy, 30% for Flexible sigmoidoscopy and 43% for Gastroscopy. However progress is being made in reducing the overall waiting list and overall waiting times. Performance is in line with trajectory.	We are using the capacity we have more efficiently and this supports value for money. Bed related cancellations result in patients being starved unnecessarily and causing patients and staff upset. It means our utilisation is not as high as it could be. Patients are generally receiving necessary diagnostic testing within the target of 6 weeks. The right patients are being prioritised. Longer waiting times for diagnosis and treatment	• "Standby for Surgery" scheme • Substantiation of clinical theatre manager post • Automated patient check in prior to surgery • Locum arrived in late July, focusing on diagnostic pathways (3 month contract) • Ongoing DM01 validation as some planned patients may be incorrectly included in metric • NHS fixed term consultant starts in November 2023 • SoN for audiology room conversion represented to capital strategy group following questions. **MRI** –Requests to NHSE/Networks for additional resources have been fed back including a staffed MRI and additional reporting capacity we are yet to see a result of these bds but are in close liaison with the relevant network and regional teams Ongoing liaison with SNEE partners re: mutual a potential opportunity has arisen to access weekend MRI capacity but this would require additional insourced staffing support. Cost assessment is pending. Longer term CDC will begin to address. **CT** - performance continues to recover with improvements observed in each of the last 6 months but will be further impacted by CT replacement programme. Longer term CDC will begin to address. **US** – US showing observable improvements across successive months aligning to plans established for recovery. The trajectory will continue to improve with approved funding from cancer alliance for additional consultant PA's to support the biopsy and neck US subspeciality. **Endoscopy** - A recovery trajectory for endoscopy has been formulated to meet the national target but this has been impacted by a number of issues including medical recruitment. Current trajectory anticipates compliance in June 2024 against the DM01 target ambition of 95% by March 2025. A SNEE endoscopy forum has been established and will met regularly, facilitated by NHSE, to review system opportunities and support collaborative working across the ICS. Negotiations have secured access to externally funded underutilised InHealth capacity beyond the current plan of September 2023.

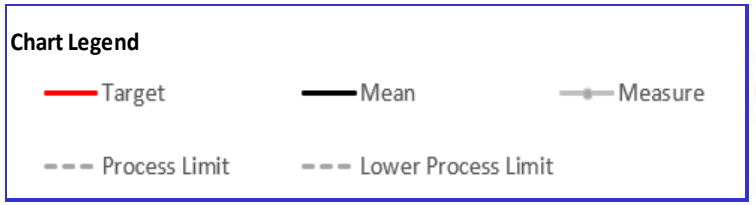


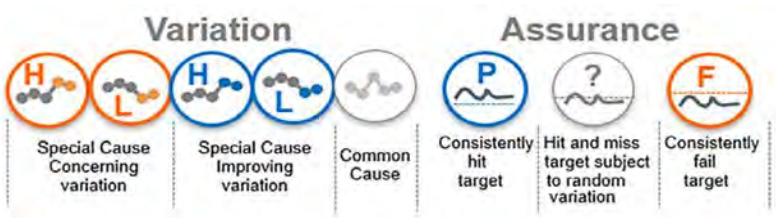




What	So What?	What Next?
The total waiting list size is demonstrating significant increase. The 52 week wait position is now also demonstrating a significant increase. The 78 week and 104 week position continue to be positive. The volume of cancellations due to industrial action will have an impact on the increase of the waiting list and the 52 week waits.	Reducing our waiting times will have a positive impact on our patient experience and outcomes. Patients are more likely to come to harm whilst waiting an excessive amount of time on the waiting list and their conditions can deteriorate. The current performance is placing us into Tier 2 process.	• Continue the tier 2 process with the regional teams and ICB, with insourcing options in discussion for Uro-Gynaecology. • Continue engagement across the ICS and wider for opportunities of mutual aid in challenged specialities With the largest cohort of patients waiting for outpatient appointments, the outpatient transformation programme is key to delivery of reduction in the total waiting list, high level actions include: • Video consultation project in place • Increased focus on PIFU to create additional new patient slots • GIRFT checklist being undertaken by speciality

IMPROVEMENT COMMITTEE METRICS

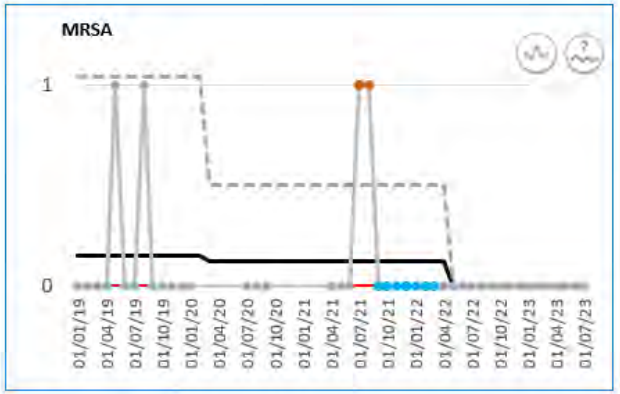


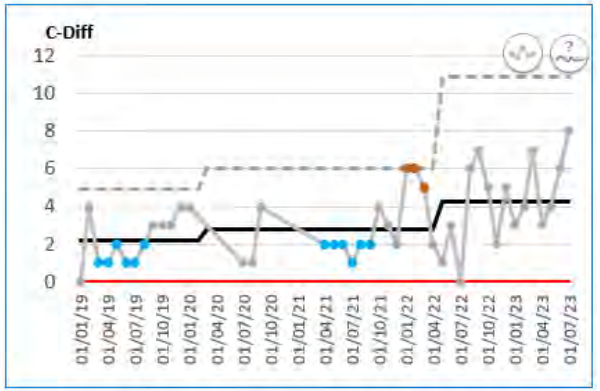


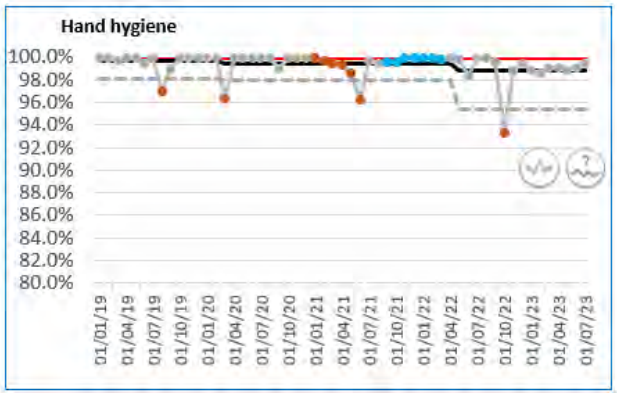
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
MRSA	Jul 23	0	0			0	0	0
C-Diff	Jul 23	8	0			4	-2	11
Hand hygiene	Jul 23	99.5%	100.0%			98.8%	95.4%	102.3%
Sepsis Screening for Emergency Patients	Jul 23	100.0%	100.0%			87.5%	64.9%	110.1%
VTE - all inpatients	Jul 23	96.8%	95.0%			97.1%	94.9%	99.3%
Mixed Sex Breaches	Jul 23	6	0			4	-8	15
Community Pressure Ulcers	Jul 23	35	25			33	19	47
Acute Pressure Ulcers	Jul 23	21	17			24	7	41
Acute Pressure Ulcers per 1000 Beds	Jul 23	1.9	-			2.2	0.5	4.0
Inpatient Falls Total	Jul 23	78	48			74	45	104
Acute Falls per 1000 Beds	Jul 23	5.9	5.6			6.1	4.0	8.2
Nutrition - 24 hours	Jul 23	92.6%	95.0%		F	86.9%	79.4%	94.5%
Patient Safety Incidents per 1,000 OBDs	Jul 23	66.4	-			62.7	50.7	74.8
Patient Safety Incidents Reported	Jul 23	874	-			835	675	994
Patient Safety Incidents Resulting in Harm	Jul 23	190	-			170	124	216

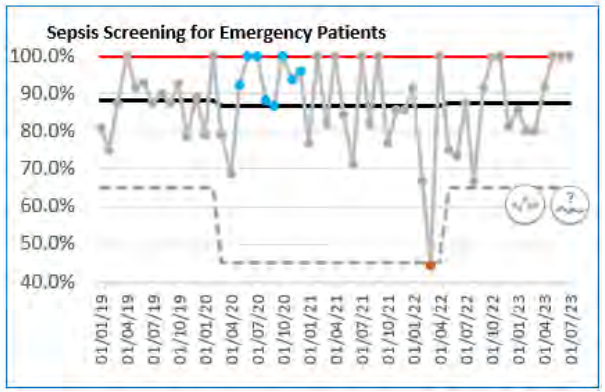
Falls are only counting Inpatients and Exclude Assisted Falls & Outpatient areas.

Safe









What	So What?	What Next?
There is consistent performance with MRSA Bacteraemia. While Clostridioides difficile rate remains in common cause variation we have seen an increase in the number of reportable rates of since June due to appropriate re-sampling of already known cases that have continued to test positive despite antibiotic treatment as per National Guidance (collected outside of 28 day timeframe). It is recognised Nationally that the rates of Clostridioides difficile have increased significantly over the last two reporting years.	This is important because it could be an indication of rising rates of other Healthcare Associated infections. HAIs can contribute to increased mortality, Length of stay Understanding individual cases, themes and periods of increase incidence will be identified and reviewed through the Trust process in a timely manner. The impact of this is learning/good practices are formally discussed and taken back to the appropriate teams via the Matron and/or ward representative with a view to reducing the rates of healthcare associated infections. The impact being improved patient outcome and reduced length of stay, benefiting patient flow and availability of beds for the acutely unwell.	Proposed changes to Ecare for a hard stop to antibiotic course lengths. To encourage a reduction in use Trust Clostridioides difficile infection reduction plan has been submitted to NHS England .The main actions from this are to update the Clostridioides difficile policy and complete the prioritisation for single side room isolation matrix. In the reporting period 2022-23 the 'NHS Standard Contract 2022/243: Minimising Clostridioides difficile and Gram-negative bloodstream infections; the Trust threshold for Hospital Associated Cases (both Hospital and Community onset) was '55' with a Trust 'actual' of 52 cases.

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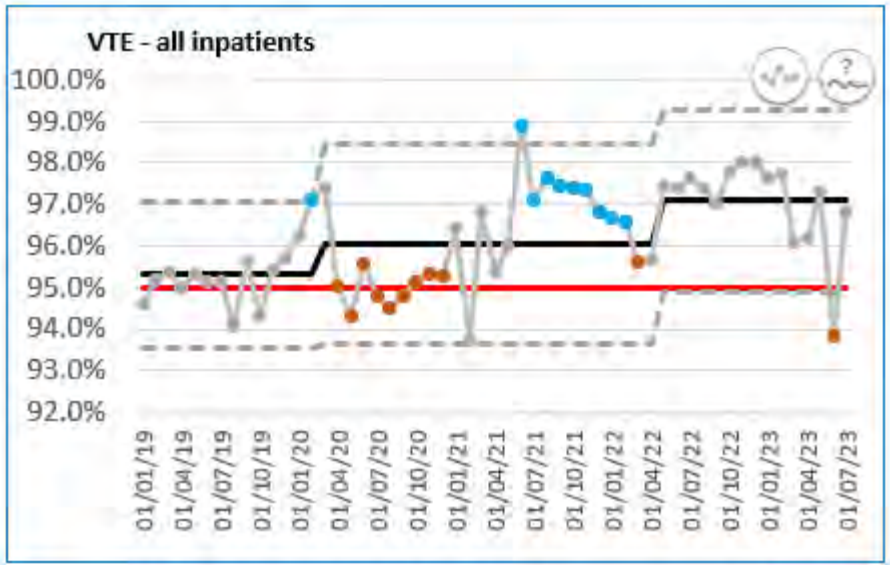
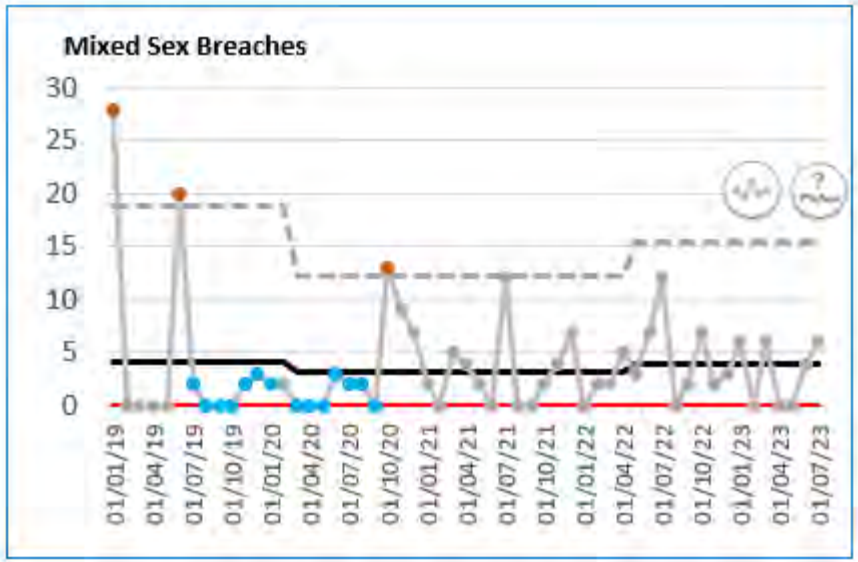
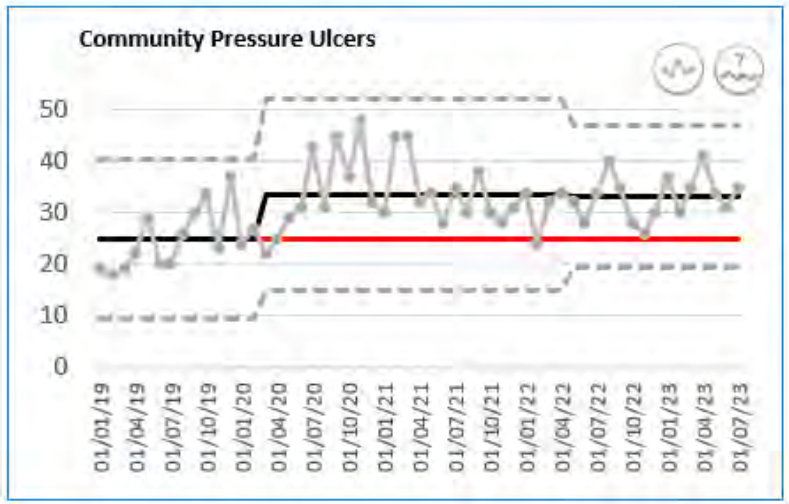
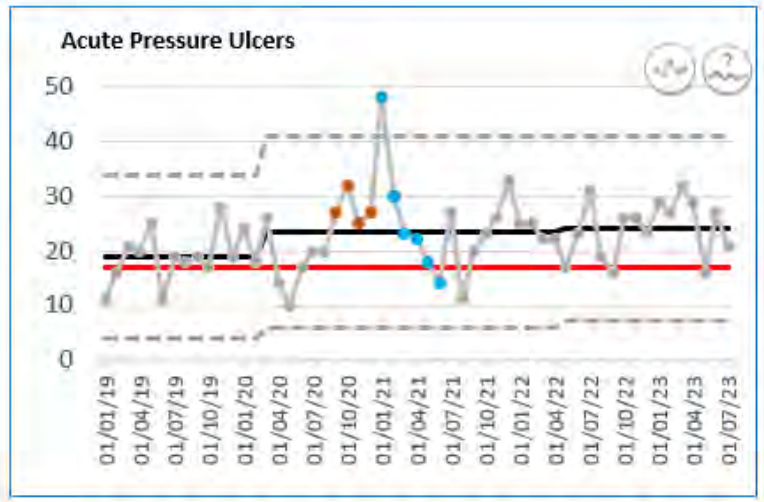


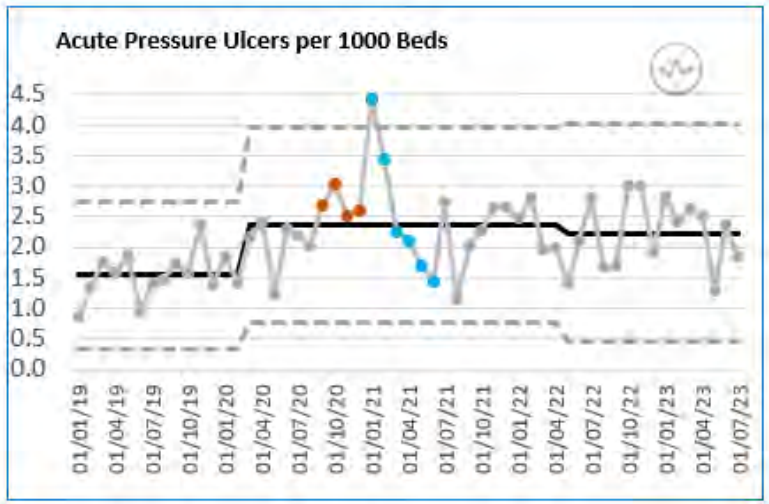


What	So What?	What Next?
<u>VTE</u> Compliance is in common cause variation however achieving target is consistently maintain with only one month falling below target since 2021. The summary statistic has dropped slightly to 97.76%. This remains in range but there over the last few months there has been a gradual fall off in performance on the surgical ward F5 and in two surgical specialties in DSU. <u>Mixed sex breaches</u> Mixed sex breaches are inconsistent in occurrence and driven by the inability to step out of ITU in a timely fashion due to capacity challenges. No mixed sex breaches have occurred outside of this area	VTE assessment is important so that patients can have correct prophylaxis and the risk of VTE can be reduced. A decrease in performance in a clinical area needs to be addressed. Reporting these breaches is mandatory and an expectation of NHS England to ensure that privacy and dignity are maintained at every opportunity	The clinical leads, clinical director and managers of the area have been asked to review the data and remind their teams of the importance of these assessments. More support and detailed data can be provided if necessary. Step downs required out of ITU are discussed and review daily in both the nursing safety huddle and also the site bed meetings to ensure oversight and that actions are taken in a timely manner.

Safe

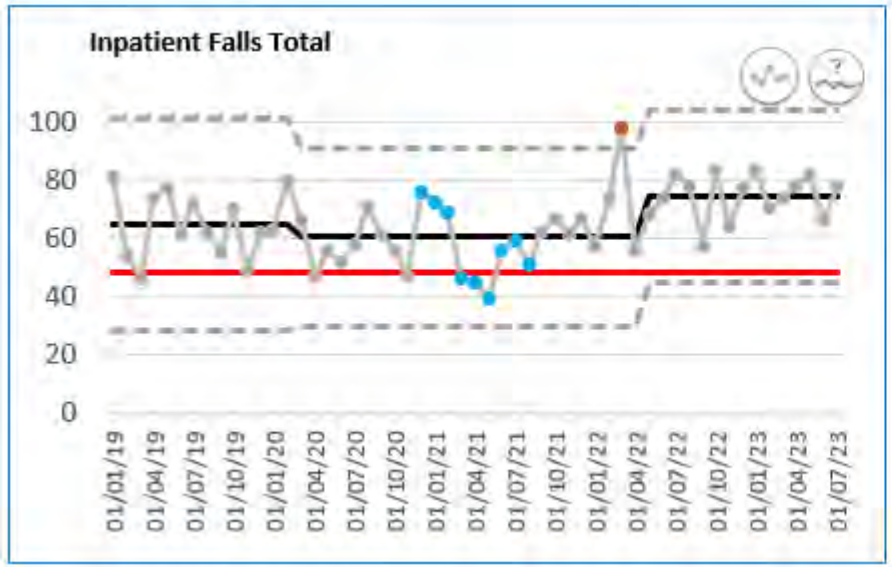


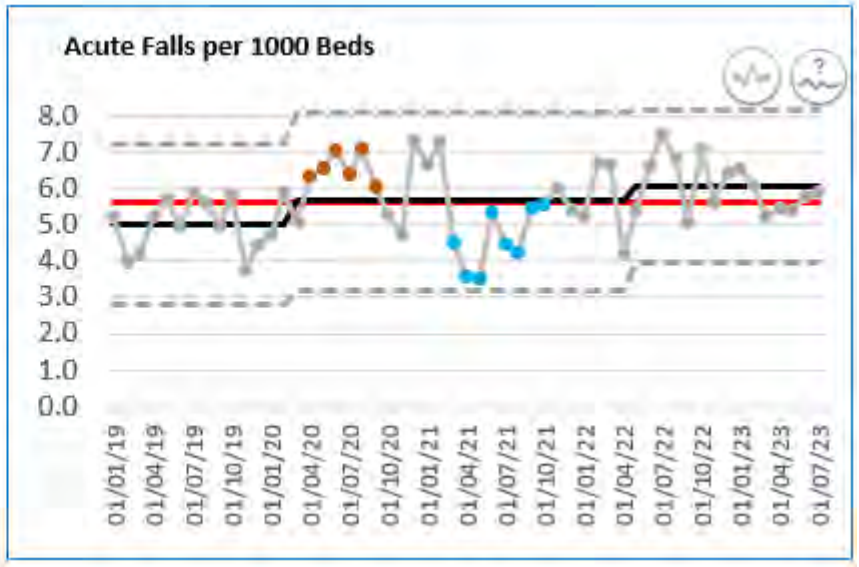




What	So What?	What Next?
Both community and acute incidents remain in common cause variation although the data demonstrates a reduction on Acute pressure ulcer incidence in July, following an initial spike earlier in the summer. Highest reporting team has been the respiratory ward and this has been an emerging theme and interventions to support staff knowledge and skills around pressure ulcer prevention has commenced Community pressure ulcer remain fairly static over the last few months. Highest reporting team being Haverhill.	The cause of HAPU is multifaceted and can be influenced by many things include nutrition, positioning, chronic disease, end of life skin deterioration and concordance. Prompt assessment of risk is essential to personalise care to avoid the development or deterioration of pressure ulcers The impact on a patient developing a pressure area can; • increase LOS and escalate care needs • provide a conduit for infection/sepsis, • pain and discomfort • Poor patient experience	Continue to monitor pressure ulcer incidents and recognise and act on themes through the Pressure Ulcer Prevention Group. These initiatives are part of wider overarching Quality Improvement works across the trust. Continue to target ‘areas of high incidence’ working with Matrons and department staff to develop practice Tissue Viability has been supporting training across the trust through bitesize training and development day across the departments.

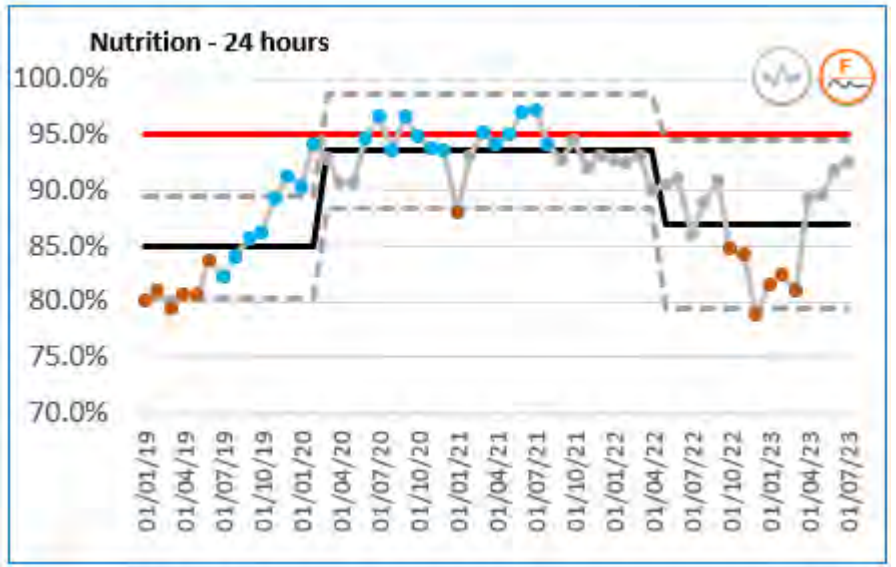
Safe



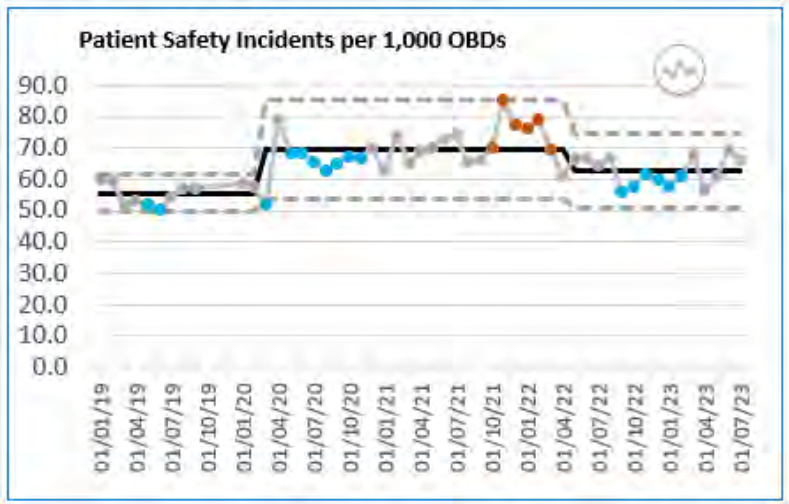


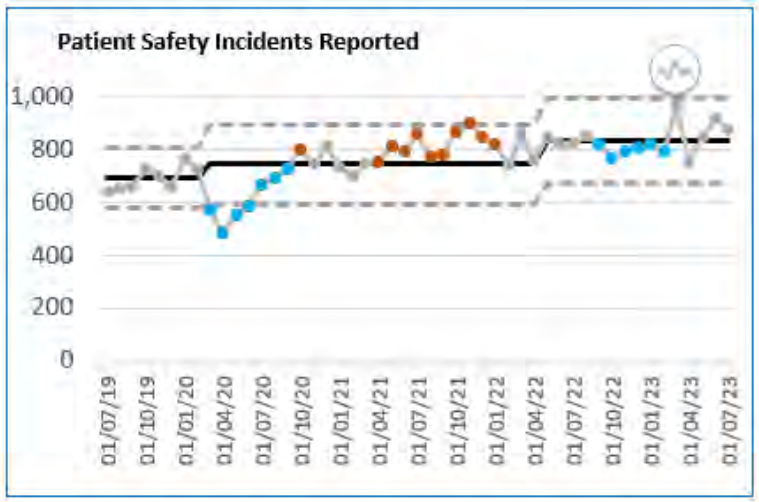
What	So What?	What Next?
Falls incident in the trust suggests common cause variation with no trend in any increase or reduction in falls rates This month there was one fall reported as major harm (fractured neck of femur and basal ganglia haemorrhage) and three falls reported as moderate harm. These will be reviewed through PSIRF after action reviews to understand learning and actions There were 17 falls reported as minor harm. During the month of July there were 11 repeat fallers with 7 patients having two falls, 2 patients having three falls, 1 patient having four falls and 1 patient having six falls in the reporting month.	The effects of falls within hospital can range increase length of stay due to loss of patient confidence and deconditioning, to life changing severe harm. Its widely acknowledge that mortality of patient suffering from severe harm is greatly increased despite initial recovery Important to continue to raise falls awareness and falls prevention to all staff working within the trust with aim to reduce the number of falls. Identifying themes to support with quality improvement projects.	Additional Falls prevention/management training commenced within the qualified nurse induction in July. QI programs of work continue and are reported through PQSGG

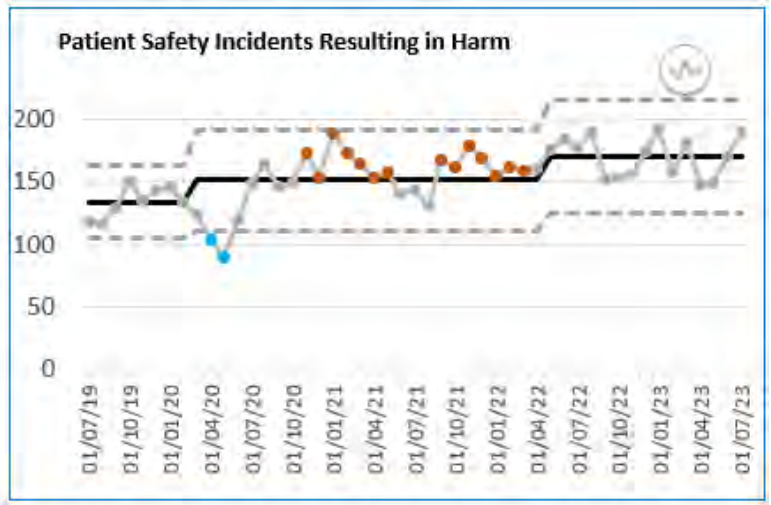
Safe



What	So What?	What Next?
There has been significant improvement with compliance in recording the nutritional assessment within 24hrs of admission over the past 5 months and this is largely due to improvements in the patient journey time from the Emergency Department through to the assessment areas and wards. The metric also continues to be reviewed at 48hrs and there is increasing improvement, providing assurance that the majority of patients are assessed on admission. There has also been increased focus from the ward teams to ensure assessments are completed. In addition, weighing patients on admission also continues to be a challenge, but there has also been improvement with this metric with additional focus from all areas.	Nutrition and hydration is a fundamental element of care and continues to be an area of focus and improvement for all the teams in the Trust. There is improved awareness that this will underpin a positive experience and outcome for the patients in our care. There are a variety of schemes and projects in train around the organisation including a QI project led by Dietetics to improve the education of the teams and subsequent compliance with this important metric. In addition, the Trauma practitioners have commenced a QI project to provide supplement drinks pre and post operatively to those patients with fractured neck of femur to improve outcomes and healing. Early indications are demonstrating a 2-3 day reduction in length of stay for this cohort of patients, which is positive for their overall outcome and is hoped will reduce mortality, though it is too early to measure this yet.	• Liaise with Dieticians to monitor impact of any delayed assessments and share learning. • Review of data at performance meetings and Governance reviews. • Continue to share the data with teams • Encourage daily review of patient safety dashboard by Ward Managers and Matrons • Review of QI projects to support improvements • Monitor impact of changes to eCare and effect of improved UEC performance. • Engagement with the Nutrition focus week • Continued focus on aspects of nutrition including protected mealtimes and the provision of supplements • There are plans for a nutrition week in the autumn to continue to raise the importance of this element of care

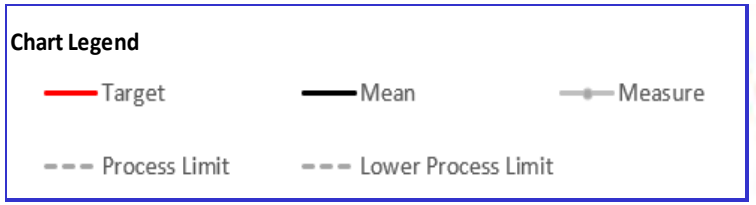


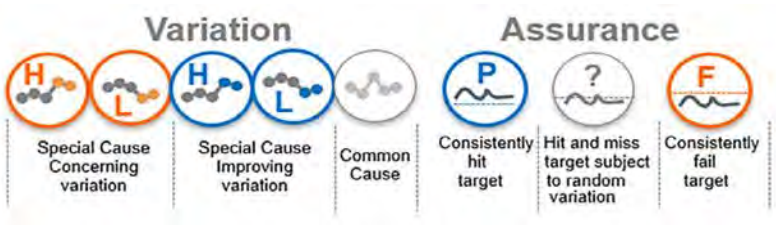




What	So What?	What Next?
Patient safety incidents (PSIs) total, per 1000 bed days and resulting in harm show common cause variation. There is a careful balance to be struck to ensure staff feel able to report patient safety incidents without fear of blame or punitive effects so incident reporting is not a reliable performance measure of safety alone but should be used as part of a suite of metrics. Safety mitigation is considered as part of initial safety investigation and areas for improvement are recommended and actioned through SIG.	Quarterly thematic report produced for sharing and reporting purposes at PQSGG. This enables improvement work by specialist committees such as pressure ulcers or falls which are our most reported patient safety incident categories. The newly formed medication safety group will also take this approach.	Quarterly thematic incident analysis report shared at PSQGG and at specialist and divisional governance committees. The patient safety team work closely with specialist and divisional leads to ensure triangulation of safety insight. Safety improvement worked is mapped on LifeQI. Production of a quarterly thematic shared learning report.

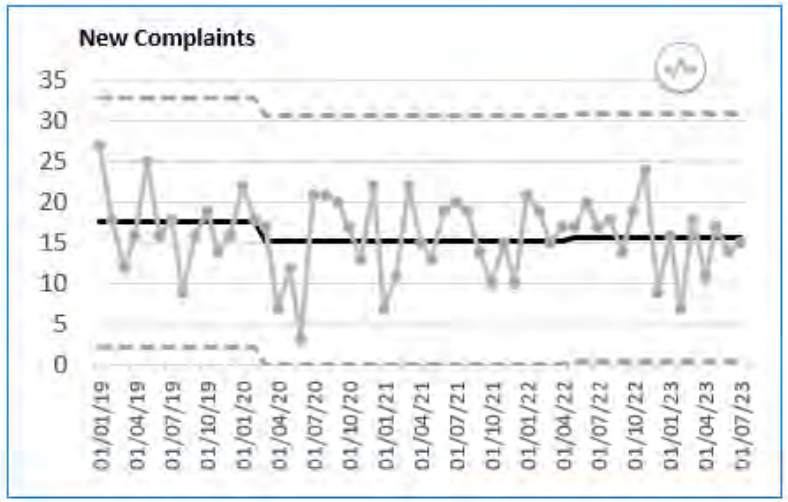
INVOLVEMENT COMMITTEE METRICS

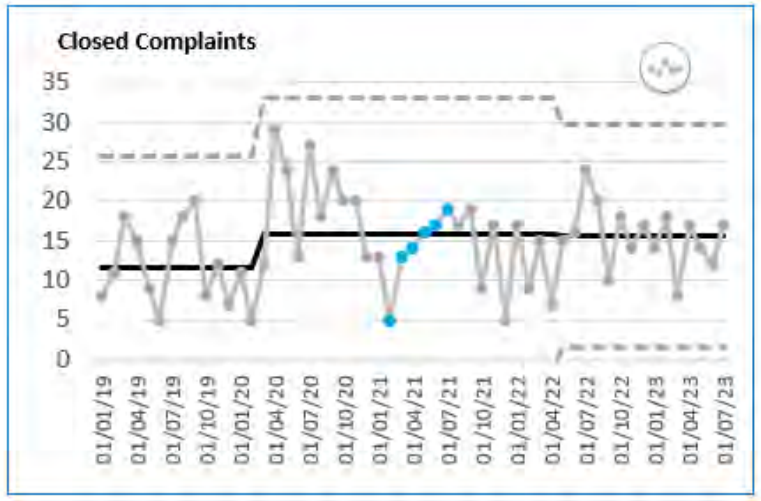


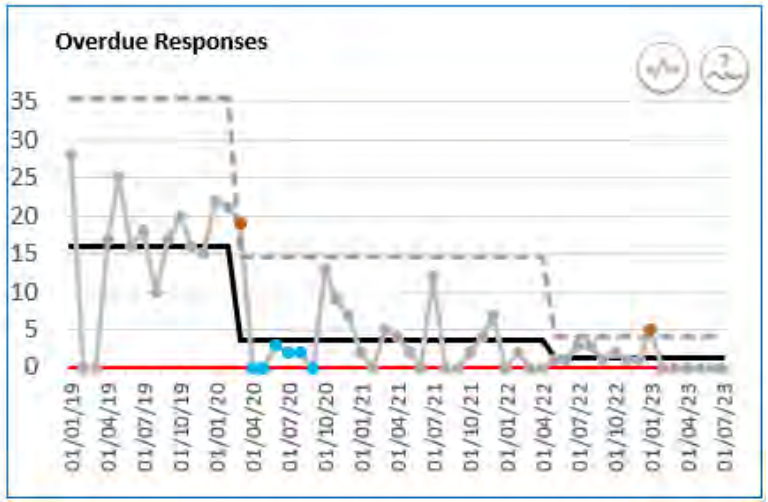


KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
New Complaints	Jul 23	15				16	1	31
Closed Complaints	Jul 23	17				16	2	30
Overdue Responses	Jul 23	0	0			1	-2	4

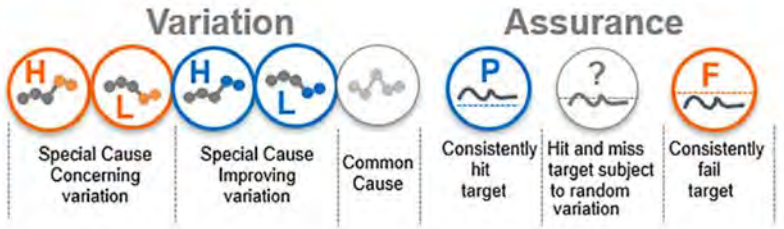
Safe





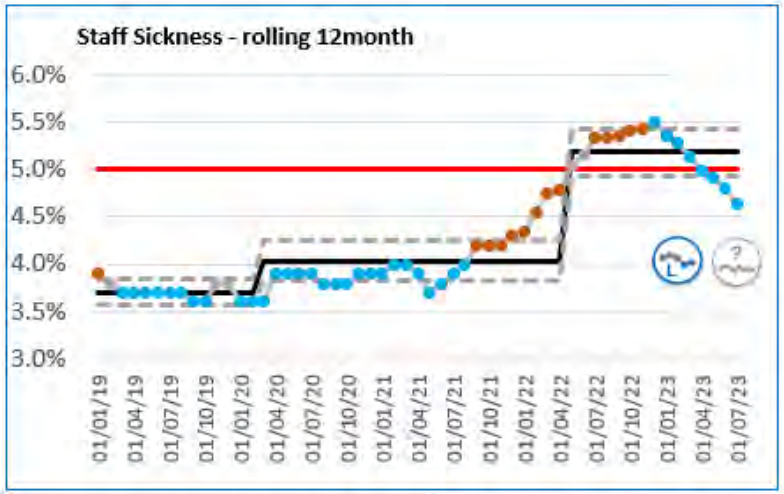


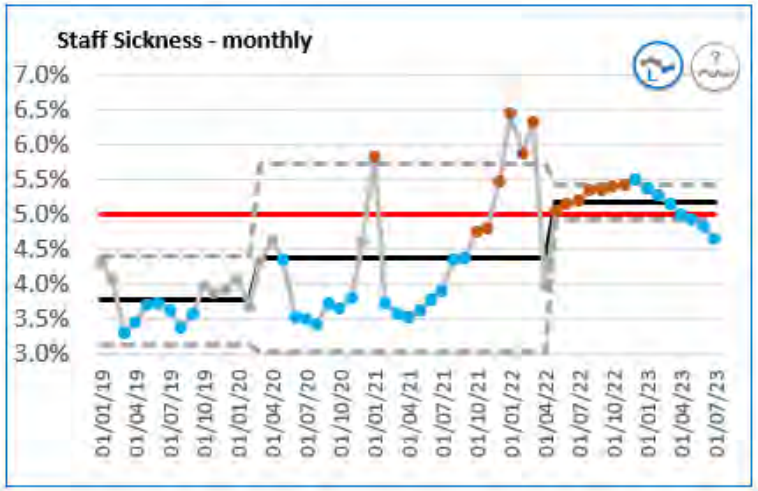
What	So What?	What Next?
July saw 15 new formal complaints logged which is average and within the controlled limits. We also saw a small increase in the amount of complaints closed (17). Again, there were no overdue responses and complainants have been kept updated throughout.	We have continued to update patients regularly which is reflected in the low number (zero) of overdue responses. Timely responses and minimal second letters provides greater experience for complainants and indicates satisfaction with investigation responses. Survey responses also acknowledge this.	We are still providing an option to meet with clinical staff to provide a more timely response and provide more capacity to staff to allow them to focus on clinical duties. The team are also meeting regularly to ensure timely responses are provided to complainants. Data will continue to remain within the controlled limits.

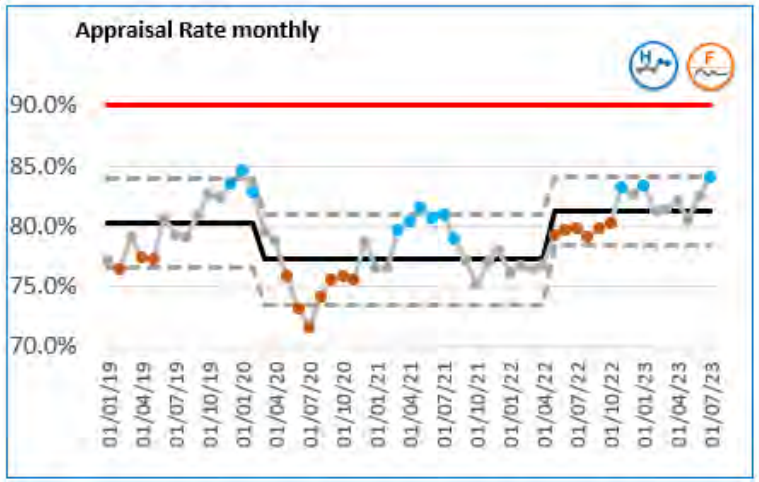


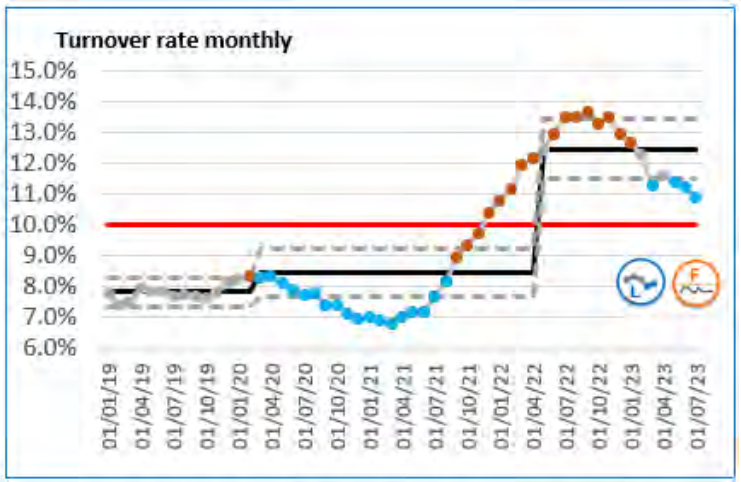
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Staff Sickness - rolling 12month	Jul 23	4.6%	5.0%	L	?	5.2%	4.9%	5.4%
Staff Sickness - monthly	Jul 23	4.6%	5.0%	L	?	5.2%	4.9%	5.4%
Mandatory Training monthly	Jul 23	89.3%	90.0%		F	88.3%	86.9%	89.6%
Appraisal Rate monthly	Jul 23	84.2%	90.0%	H	F	81.3%	78.5%	84.1%
Turnover rate monthly	Jul 23	10.9%	10.0%	L	F	12.5%	11.5%	13.5%

Well Led









What	So What?	What Next?
All KPI's, bar mandatory training are recording an improving variation. **Sickness** – achieving target following a period of sustained improvement since December 2022. **Mandatory training** – marginally below target of 90% at 89.3%. **Appraisals** – consistently failing to achieve target although an improved position is recorded for this month. **Turnover** – not meeting target however a continued improving position sustained since November 2022.	These workforce key performance indicators directly impact on staff morale, staff retention, and therefore, patient care and safety. Additionally, improvements in these workforce KPI's will strengthen our ability to be the employer of choice for our community and recognised as a great place to work.	Maintain improvements in staff attendance and review findings of sickness management internal audit. Analysis of mandatory training data to identify areas of in need of focussed support to achieve and maintain target. Drive to improve medical staff mandatory training rate by declining study leave requests unless mandatory training up to date. Analysis of appraisal data to identify areas in need of support; current support includes appraisal focus groups in medicine division and management essentials training to launch and include support for managers o undertaking an effective appraisal. Focus on delivery of our people and culture plan priorities will aide recruitment and retention.

4.4.1 Maternity - Annexes

Report on Anaesthetic Staffing within Maternity Services – West Suffolk NHS Foundation Trust

Report Title	**Report on compliance with Safe Obstetric Anaesthetic staffing from 1st October 2022 to 31st March 2023**
Report for	**Information and Approval of Actions**
Report from	Women's & Children's Services in collaboration with Theatres & Anaesthetics
Report Author	Beverley Gordon, Project Midwife, WSH
Dates and groups for approval	1. Maternity Quality and Safety 18/9/23 2. Maternity and Neonatal Safety Champions 28/9/23 3. Trust Board 29/9/23

Executive Summary

This report has been written to confirm compliance with safe staffing requirements for obstetric anaesthesia within the Maternity Unit of West Suffolk NHS FT (WSNHSFT).

The last report provided evidence of ongoing compliance with safety standards for obstetric anaesthetic staffing levels in Quarter 1 and 2 of 2022/23. This new report covers the period 1st October 2022 to 31st March 2023 (Q3 and Q4 2022/23).

Findings

The rotas for anaesthetic staff have been independently reviewed to ensure that there is a named staff member covering the on call obstetric rota for each 24-hour period.

The findings confirm that there is allocation and identification of a dedicated anaesthetist on the rota for obstetric cases throughout this 6-month period. The rota has a named consultant anaesthetist who is available for escalation of staffing and clinical issues.

Next steps

The next review and report will be completed in 6 months.

1. Background

NHS Resolution completed its fourth year of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme in February 2023. These standards and safety actions continue to support the delivery of safer maternity care and are embedded in the organisation of maternity services within the West Suffolk NHS Foundation Trust.

In May 2023 NHS Resolution released details of Year 5 Maternity Incentive Scheme Safety Actions. These standards had minor updates in July 2023 and the submission date for evidence of the Trusts assurances and commitment to safety is expected to be 1st February 2024.

It is part of the safety culture processes that lead to assurance of safe standards are embedded and the 6 monthly staffing assessments are 'business as usual'. This allows an opportunity to mark changes in the staffing levels and identify at an early stage where actions and interventions are required to address shortfalls which may affect patient safety. This report is based on the Year 4 Maternity Incentive Scheme standards as the period of review preceded publication of Year 5 Safety Actions.

The safety action that applies to this report is:
Safety action 4:
Can you demonstrate an effective system of clinical workforce planning to the required standard?
This report relates directly to the anaesthetic element of clinical staffing – section b). The requirement for this element is as follows:

b) Anaesthetic medical workforce
A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (ACSA standard 1.7.2.1)

Anaesthesia Clinical Services Accreditation (ACSA) standards and action

1.7.2.1
The rota should be seen to allow obstetrics to take priority where the duty anaesthetist has other responsibilities. A policy should be made available at staff induction regarding prioritising and junior staff should provide verbal confirmation that they have been inducted in this way.

Anaesthetic medical workforce
The rota should be used to evidence compliance with ACSA standard 1.7.2.1.

Technical guidance	
Anaesthesia Clinical Services Accreditation (ACSA) standard and action	
1.7.2.1	A duty anaesthetist is immediately available for the obstetric unit 24 hours a day. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patient in order to be able to attend immediately to obstetric patients.

Local Arrangements
The on-call anaesthetist holds bleep 770 and this is a baton bleep and handed over directly to the oncoming doctor. The role of the bleep 770 holder is described in the Standard Operating Procedure (SOP) and the operational aspects of the Obstetric Anaesthetic service is described in the Operational Plan – both documents were approved in 2021.

2. Frequency of reporting
There is no fixed period of time that the rotas need to be reviewed so the Trust has taken the decision to review the rotas at 6 monthly intervals to ensure there is sustainability within the rota management.

3. Methodology
On the rotas the cover will be seen in one of 3 ways:

1. As an allocated doctor in the section labelled 'Obs junior 770' for evenings weekends and public holidays

2. Marked in a different section (usually theatre 2) with a purple star: these staff members may be allocated as an individual or a team of 2-3 doctors. One trained individual meeting the basic training specifications and having attained the RCoA's Initial Assessment of Competence in Obstetric Anaesthesia, will always be nominated to hold the on-call baton bleep 24/7. The baton bleep holder will attend the MDT unless engaged in emergency obstetric activity.

3. 10 consultant or autonomous Speciality and Specialist (SAS) doctor sessions are staffed each week for obstetric anaesthesia. If additional support is needed for the trainee out of hours, the consultant named in the section labelled 1st theatre/obstetric on call consultant will be called to assist.

Rotas for this period of time were reviewed by the project midwife for evidence that there was a dedicated duty anaesthetist allocated for providing support to the maternity patients. These rotas were accessed directly from the electronic rota after the period of the audit was ended so that any changes due to staff absence were accounted for, making it the most accurate record that it could be.

4. Results

All the rotas demonstrated that a staff member was allocated to hold the on-call bleep 770 during this period of time from 1st October 2022 to 31st March 2023. The rotas show that where the bleep holder is allocated to other duties – e.g. the elective caesarean section list – the bleep holder is working with other anaesthetists who can either continue with the planned activity or attend to provide obstetric anaesthetic services. The rota has a named consultant anaesthetist who is available for escalation of staffing and clinical issues.

5. Current Compliance with Standards

Clinical Workforce Group	Standard to be met	WSH compliance	Progress Report	Evidence Source
Anaesthetic medical workforce	**Anaesthetic medical workforce** A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (ACSA standard 1.7.2.1)			
	1.7.2.1 A duty anaesthetist is available for the obstetric unit 24 hours a day, where there is a 24 hour epidural service the anaesthetist is resident If this service is offered, rotas should be provided as evidence. If this service is not provided, patient information should be seen which relays exactly what services can be offered	**Yes**	**1st October 2022 to 31st March 2023**	Rotas demonstrate 100% compliance for this period of time.

6. Conclusions

The obstetric anaesthetic rotas reflect the 24/7 cover of the obstetric services and therefore the Trust is assured that the standards are met for Anaesthesia Clinical Services Accreditation (ACSA) standard **1.7.2.1.**
The relevant rotas are stored electronically if required for confirmatory evidence.

7. Recommendations

Continue to monitor the standard to provide assurance that the maternity patients are receiving obstetric anaesthetic services when required.
Any delays in care and/or adverse outcomes due to shortages or lack of/delay in providing obstetric anaesthetic services will be highlighted as an incident using the Trusts incident recording system and investigated by the multidisciplinary Quality and Safety team alongside clinical leads in order to identify learning and remedial actions required to improve practice/services.
A further review and report will be presented in October 2023.
No actions have been identified directly as a result of this report.

West Suffolk NHS
NHS Foundation Trust

Maternity Incentive Scheme – Year 5

Report Title	Report for Safety Action 4d - **Can you demonstrate an effective system of clinical* workforce planning to the required standard? Neonatal Nursing Staff**
Report for	Approval and Information
Report from	Maternity and Neonatal Services
Lead for Safety Action	Senior Matron Neonatal Services
Report Author	Maija Blagg, Senior Matron Neonatal Services Beverley Gordon, Project Midwife
Frequency of report:	The Trust is required to formally record to the Trust Board minutes the compliance to the service specification standards annually using the neonatal clinical reference group nursing workforce calculator. Neonatal nursing workforce review should be undertaken at least once during year 4 reporting period. Reporting periods: **1st March 2023 to 31 August 2023**
Date of this report:	12st September 2023
Presented at:	Maternity, Neonatal and Gynaecology Quality & Safety Meeting 18th September 2023 Maternity & Neonatal Safety Champions 26th September 2023 Trust Board 29th September 2023

Executive summary:

The purpose of this report is to provide evidence and give the Board assurance that work continues to be undertaken within neonatal services at West Suffolk NHS Foundation Trust, to demonstrate progress towards meeting safe staffing standards within the neonatal nursing workforce. These standards are outlined in the British Association of Perinatal Medicine (BAPM) guidance and are assessed using the agreed Neonatal Clinical Review Group (CRG) nursing workforce calculator (2020).

This report indicates there is a **shortfall of approximately 1.76 WTE** between the budget and staff in post. This is due to a vacancy rate of 1.76 WTE Band 5, for which recruitment is underway. This equates to approximately **0.75% vacancy rate**.
Other variance highlighted is as there is no budget for band 5 nurses who have completed the Qualified In Speciality (QIS) course, the staff in post at this level contribute to the band 6 roster with some restrictions to their duties. This reflects as 0.8 WTE over budget for QIS staff, and 0.8 WTE under budget for non-QIS staff.

As per the calculator guidance, only workforce that provide direct neonatal patient care on the neonatal unit have been included. Management and administrative roles including the Senior Matron for Neonatal Services, Unit Manager, Practice Development Nurse, and Governance Lead are not included, this equates to 3.15 WTE.
Likewise, staff who cover the Neonatal Transitional Care (NTC) and Neonatal Community Services have not been included. This equates to 5.8 WTE band 4 to cover NTC, 0.32 WTE band 4 to cover the Neonatal Community Service and 0.64 WTE band 6 QIS to cover the Neonatal Community Service. Currently there is no separate budget for these staff groups/ services.

BAPM states that nursery nurses working in NTC should be under the direct supervision and responsibility of a registered nurse or midwife. The Neonatal Unit shift leaders are band 6 QIS. The shift leader is not currently supernumerary, despite this being a national standard from NHSE, BAPM and the DOH Toolkit.
BAPM also state that neonatal workforce planning should include a 25% uplift for nursing time over and above direct clinical care for education, training, professional development, annual leave, sickness, maternity leave, and non-clinical commitments including (but not inclusive of), QI and safeguarding. In addition to this, there should be a shift coordinator for every shift. This should be a senior nurse (generally band 7) who has no clinical commitment during the shift.

The findings of the Neonatal Nursing Workforce Calculator indicate that **cot occupancy is 45.92%** in this 6-month period of audit. However, this does not consider neonates receiving NTC. With the continued aim to reduce term admissions to the Neonatal Unit, this cannot be ignored when calculating the number of nursing staff required. **Neonatal Transitional Care activity equates to approximately 15%** of activity for this period of audit.
The calculator does not consider the **Neonatal Community Service** (NCS) which is also staffed by the neonatal workforce. This work equates to approximately **7%** during this period. BAPM state that ideally neonatal community services will be available 7 days per week. The current service provision is approximately 4 days per week.
The calculator does not consider **Ward Attenders**, neonatal patients who attend the Neonatal Unit by appointment following referral, usually from Community Midwives, but also on occasion from GP's, this equates to approximately **19%** for this period.

Recommendation:
This report is submitted for review and approval at the Maternity, Neonatal & Gynaecology Quality and Safety Group and the Maternity and Neonatal Safety Champions Group and presented for information to the Divisional Board. Following this, the report will be presented at the Trust Board meeting and the Local Maternity and Neonatal Service (LMNS) Board and finally with the East of England Neonatal Operational Delivery Network (ODN).

The Trust board is asked to receive this report as evidence of progress towards safe nursing staff standards in the Neonatal Unit and provide support to address the shortfalls.

1. Background

The Maternity Incentive Scheme (MIS) run by NHS resolution is in its fifth year and builds on the progress made in the previous 4 years. The safety action that this report relates to Safety Action 4d to ensure that the neonatal nursing staffing meets BAPM standards. The year 5 safety actions were released in May 2023 and updated with small amendments in July 2023. This safety action – 4d – is relatively unchanged for year 5.

The West Suffolk NHS Foundation Trust (WSFT) Neonatal Unit (NNU) is commissioned as a level one unit equipped to care for babies ranging from 30 weeks gestation for singletons, 32 weeks gestation for multiples, to full term, according to their clinical conditions and needs. There are 12 cots: 1 Intensive care, 3 High Dependency Care and 8 Special Care. The designated Level Three Unit is Addenbrookes in Cambridge. A baby needing more intensive care is stabilised within the Unit at WSFT and transferred to the nearest Level Two or Three Unit via a designated transport service - PaNDR (Paediatric and Neonatal Decision Support and Retrieval Service) once stable, the baby is transferred back for repatriation and on-going care. Neonatal services at WSFT will follow agreed strategies and guidance as part of the wider East of England Neonatal Network (ODN), which encompasses the 17 Neonatal Units in the region of all levels.

Neonatal Unit capacity is planned in co-ordination with the local maternity service and the neonatal Operational Delivery Network (ODN). This considers the level of care provided in the unit. Capacity should be planned on an average 80% occupancy where possible- this provides reserves to cope with the stochastic nature of NNU admissions, which are unpredictable in terms of quantum and intensity of care required.

This report presents nursing establishment for the Neonatal Unit at West Suffolk NHS Foundation Trust and recommendations following completion of the audit.

The review was undertaken to:

- To provide evidence of safe neonatal nursing staffing levels against BAPM standards and action required because of the audit.
- Provide assurance to the Board that the care delivered on the NNU at WSFT is safe and meets the national standards and recommendations.

The purpose of this report is to provide evidence and give the Board assurance that work continues to be undertaken within maternity and neonatal services at WSFT to demonstrate progress towards meeting safe staffing standards within the midwifery and neonatal nursing workforce.

2. Methodology

The Neonatal CRG Nursing Workforce Tool (2020) has been adapted from the Neonatal Nursing Workforce Calculator (2013) approved by the Neonatal Improvement Board Lead Nurses Group. It is intended to support neonatal nurse managers and their colleagues by providing a consistent method for the calculation of nursing establishment requirements which meet national standards i.e. NHSI (2018); NHSE Neonatal Service Specification e08 (2015); DH (2009); BAPM (2010); NICE (2010) BAPM (2022).

The safety element of this is to ensure that the neonatal unit has the required numbers and experience of staff in post to safely provide care for babies to the required standard. The Trust is required to ensure that there are safe staffing levels on the Neonatal Unit to manage the care of babies who require additional support after birth and to stabilise and transfer in-utero or ex-utero babies who may need care and treatment outside the limitations of the unit.

Staffing on the Neonatal Unit consists of the Senior Matron Neonatal Services, Unit Ward Manager, Practice Development Nurse, Neonatal Community Service, Neonatal Intensive Care trained Nurses (Qualified in Speciality - QIS), supported by Staff Nurses, Nursery Nurses, Ward Clerks, and a Neonatal Information Administrator. There is a lead neonatologist and designated middle grade doctors within the medical team to support the clinical elements.

Other health care professionals attend the unit to input into neonatal care and these include a physiotherapist; dietician; radiologist; ophthalmology specialist; pharmacist; speech & language therapist, occupational therapist, and clinical psychology support. Many of these roles have been allocated additional hours to support the Neonatal Service due to Ockenden funding.

3. Neonatal service requirements:

- Minimum 70% neonatal nurses qualified in speciality (QIS)
- All registered nurses trained and updated in Neonatal Life Support (NLS)
- BAPM, DOH Neonatal Toolkit and NHSE state a supernumerary shift lead in addition to those providing direct clinical care is required. This person would also oversee the non-registered team on NTC
- Neonatal Nurses are required to support the resuscitation of sick, or new-born babies in the Labour Suite, in Theatre, the Postnatal ward and in ED
- Neonatal Nurses are required to support the medical team with enhanced nursing skills such as, cannulation, bloodletting, and the implementation of Patient Group Directives
- Neonatal nurses are required to attend handover, ward round and Multidisciplinary (MDT) safety huddle
- NNU skill mix

4. Neonatal service recommendations:

- BAPM state all NNU's should have a neonatal community service. Ideally this should be available 7 days per week.
- BAPM recommends link roles with protected time and responsibility for the following areas:
    - Infant feeding
    - Family care
    - Developmental care
    - QI in perinatal optimisation
    - Safeguarding
    - Bereavement support and palliative care
    - Discharge planning and community outreach
    - Risk, governance, and patient safety
    - Infection prevention
    - Education and practice development

Clinical Area	Day	Evening	Night
Currently in place:			
Neonatal Unit (including NTC)	2 Neonatal trained nurses/ midwives (QIS) 2 Staff nurses (non-QIS) or Nursery nurses (1 nursery nurse/ nurse allocated to TC) Ward manager (weekdays only) and Practice development nurse (4 weekdays only) 1 Ward clerk (weekdays only) 1 Neonatal Information Administrator (2 weekdays only) 1 Neonatal Community Service staff member (4 weekdays only)	2 Neonatal trained nurses/ midwives (QIS) 2 Staff nurses (non-QIS) or Nursery nurses (1 nursery nurse/ nurse allocated to TC)	2 Neonatal trained nurses/ midwives (QIS) 2 Staff nurses (non-QIS) or Nursery nurses (1 nursery nurse/ nurse allocated to TC)
Service requirements:			
Clinical Area	Day	Evening	Night
Neonatal Unit (including NTC)	1 Supernumerary QIS shift lead 2.5 Neonatal trained nurses/ midwives (QIS) 2 Staff nurses (non-QIS) or Nursery nurses (1 nursery nurse/ nurse allocated to TC) Ward manager (weekdays only) and Practice development nurse (4 weekdays only) 1 Ward clerk (weekdays only) 1 Neonatal information administrator (2 weekdays only) 1 Neonatal Community Service staff member	1 Supernumerary QIS shift lead 2.5 Neonatal trained nurses/ midwives (QIS) 2 Staff nurses (non-QIS) or Nursery nurses (1 nursery nurse/ nurse allocated to TC)	1 Supernumerary QIS shift lead 2.5 Neonatal trained nurses/ midwives (QIS) 2 Staff nurses (non-QIS) or Nursery nurses (1 nursery nurse/ nurse allocated to TC)

Nurse/Patient Ratios for the Neonatal Unit:

- **Transitional Care:** The ratio of nurses looking after TC babies is at least 1:4**.** Registered nurses and non-registered clinical staff may care for these babies under the direct supervision and responsibility of a QIS neonatal nurse. Staffing in TC must be sufficient to ensure that discharge is properly planned and organised, including adequate support for parents.
- **Special Care:** The ratio of nurses looking after SC babies is at least 1:4**.** Registered nurses and non-registered clinical staff may care for these babies under the direct supervision and responsibility of a QIS neonatal nurse. Staffing in SC must be sufficient to ensure that discharge is properly planned and organised, including adequate support for parents.
- **High Dependency Care:** The ratio of QIS neonatal nurses responsible for the care of babies requiring HD care is 1:2. More stable and less dependent babies may be cared for by registered non-QIS nurses, who are under the direct supervision and responsibility of a QIS neonatal nurse.
- **Intensive Care:** Due to the complex needs of both baby and their family the ratio of QIS neonatal nurse to baby is 1:1. This nurse should have no other managerial responsibilities during the time of clinical care but may be involved in the support of a less experienced nurse working alongside them in caring for the same baby.

A clear pathway of escalation to support safe, proactive management in times of increased activity, neonatal emergency, insufficient staffing and/or over capacity is set out in the Maternity Escalation Policy (CG10635) in a section specific to NNU. During working hours, it may be necessary for off-rota nursing staff such as the Ward Manager or PDN, to undertake clinical duties to support the team. The Maternity Bleep Holder should be informed and asked to provide advice and assistance, the Emergency Bed Service (EBS), and the ODN should also be informed and DATIX should be completed.

The nursing establishment in the budget is historically set and based on actual activity of the unit, rather than at the recommended 80% capacity. The budget for this year was set on the number of posts in each band and has increased slightly since last year. This budget covers the NNU, NCS and NTC services. It is a work in progress to separate these budgets.

All band 6 senior staff nurses are Qualified in Specialty (QIS), band 5 nurses are given the opportunity to undertake the Qualified in Specialty (QIS) course after approximately 2 years of experience in a neonatal unit. The course takes approximately 1 year and requires a placement in a level 3 unit. The Unit used for this is the Tertiary Unit in the cluster group - Cambridge. There is a rolling programme to give all band 5 nurses the opportunity to undertake the course which runs each year. In previous years an average of 2 nurses per year (dependant on staff having the relevant pre-course experience) have received funding, either from the Trust, charitable donations or from Health Education England (HEE) Continued Professional Development (CPD) funding.
All band 4 Nursery Nurses are required to complete a Transitional (or Special) Care Module to provide the highest level of care within NTC.

The Unit has a band 6 shift leader. This is a QIS neonatal nurse. The shift leader is not supernumerary despite this being a national standard i.e. NHSE, BAPM and the DOH Neonatal Toolkit.

The number of cots and the breakdown of levels of care has not changed since changing from level 2 to level 1 unit many years ago.

4. MIS Safety action 4: Can you demonstrate an effective system of clinical* workforce planning to the required standard? – year 5

4d) Neonatal nursing workforce
The neonatal unit does not meet the service specification for neonatal nursing standards, as we do not currently have a supernumerary shift leader. If the requirements had not been met in both year 4 and year 5 of MIS, Trust Board should evidence progress against the action plan developed in year 4 of MIS as well include new relevant actions to address deficiencies. If the requirements had been met in year 4 without the need of developing an action plan to address deficiencies, however they are not met in year 5, Trust Board should develop an action plan in year 5 of MIS to address deficiencies and share this with the LMNS and Neonatal Operational Delivery Network (ODN) Lead.

Minimum Evidence

The Trust is required to formally record to the Trust Board minutes, the compliance to the service specification standards, annually, using the neonatal clinical reference group nursing workforce calculator (see above). For units that do not meet the standard, the Trust Board should evidence progress against the action plan developed in year 4 of MIS to address deficiencies.
A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN) Lead.

Time Frames

d) Neonatal nursing workforce
Nursing workforce review has been undertaken at least once during year 5 reporting period.

5. Findings

The audit was undertaken in September 2023 based on the unit activity and staffing levels for the period 1st March 2023 to 31st August 2023. The audit was undertaken by the Senior Matron Neonatal Services. The results were generated electronically based on the data submitted. The East of England Neonatal Operational Delivery Network request that the tool is submitted to themselves for confirmation and verification of the data presented. The tool will also be shared with the Local Maternity & Neonatal System.

Input activity (HRG 2016)			Input staffing numbers (WTE) DIRECT PATIENT CARE ONLY		
	Activity	Declared cots		Budget	In post
HRG 1 (IC)	26	1	Total QIS	15.44	16.24
HRG 2 (HD)	251	3	Total Non QIS	7.16	4.60
HRG 3 (SC)	737	8	Total Non Reg	3.13	3.13
Total	**1,014**	**12**	**Total**	**25.73**	**23.97**

This report indicates there is a shortfall of approximately 1.76 WTE between the budget and staff in post. This is due to a vacancy rate of 1.76 WTE Band 5, for which recruitment is underway. This equates to approximately 0.75% vacancy rate.
Other variance is due to there being no budget for band 5 nurses who have completed the QIS course, the staff in post at this level contribute to the band 6 roster with some restrictions to their duties, specifically taking charge of the shift. This reflects as 0.8 WTE over budget for QIS staff, and 0.8 WTE under budget for non-QIS staff.

As per the calculator guidance, only workforce that provide direct neonatal patient care on the neonatal unit have been included. Management and administrative roles including the Senior

Matron for Neonatal Services, Unit Manager, Practice Development Nurse, and Governance Lead are not included, this equates to 3.15 WTE.
Likewise, staff who cover the Neonatal Transitional Care (NTC) and Neonatal Community Services have not been included. This equates to 5.8 WTE band 4 to cover NTC, 0.32 WTE band 4 to cover the Neonatal Community Service and 0.64 WTE band 6 QIS to cover the Neonatal Community Service.

We do not currently have a supernumerary shift lead to cover and supervise the Neonatal Unit nor Transitional Care.

Activity (HRG 2016)							
	Activity	*For calculations*		Declared cots	Occupancy for period	Cots required to meet activity at average 80% occupancy	Variance: declared cots against required
		80% of daily activity	*WTE (6.07 / BAPM)*				
HRG 1	26	*0.2*	*6.07*	1	14.13%	1	0
HRG 2	251	*1.7*	*3.04*	3	45.47%	1	2
HRG 3	737	*5.0*	*1.52*	8	50.07%	5	3
Total	**1,014**			**12**	**45.92%**	**7**	**5**

The findings of the Neonatal Nursing Workforce Calculator (2020) indicate that cot occupancy is 45.92% in this 6-month period of audit. This does not consider neonates receiving Neonatal Transitional Care (NTC). With the continued aim to reduce Term admissions to the Neonatal Unit, this cannot be ignored when calculating the number of nursing staff required. Neonatal Transitional Care activity equates to approximately 15% of activity for this period.
Neither does the calculator consider the Neonatal Community Service (NCS) which is also staffed by the Neonatal workforce. This work equates to approximately 7% during this period.
Nor does the calculator consider Ward Attenders, neonatal patients who attend the Neonatal Unit by appointment following referral, usually from Community Midwives, but also on occasion from GP's, this equates to approximately 19% for this period.

The following table breaks down the figures for TC including bed days.

Number of babies:	March 2023	April 2023	May 2023	June 2023	July 2023	Aug 2023
In TC	36	18	29	25	20	22
Bed days	92	54	79	68	76	95
Admitted from home	7	4	5	2	12	7
Ward attender	46	15	25	27	32	44
Bed days	93	47	85	83	36	49
Stepdown (NNU to TC)	18	5	4	8	3	10
TOTAL Bed days	185	101	164	151	112	144

6. Nursing Staff against toolkit

Nursing workforce (WTE) DIRECT PATIENT CARE ONLY					
NB total nurse staffing required to staff declared cots = 33.39, of which 23.37 (70%) should be QIS					
	Current position		Required to meet activity at average 80% occ	Variance: budget against required	Variance: in post against required
	Budget	In post			
Total nursing staff	25.73	23.97	19.92	5.81	4.05
Total reg nurses	22.60	20.84	17.64	4.96	3.20
Total QIS	15.44	16.24	12.35	3.09	3.89
Total non-QIS	7.16	4.60	5.29	1.87	-0.69
Total non-reg	3.13	3.13	2.28	0.85	0.85
Reg nurses as % nursing staff	87.8%	86.9%	88.6%		
QIS as % reg nurses	68.3%	77.9%	70.0%		

The results show that 77.9% of staff have completed the QIS course which is above national target of 70%. These figures do not include QIS staff who do not routinely provide direct neonatal care, such as the Ward Manager, PDN, Governance Lead or Senior Matron Neonatal Services, this takes the QIS percentage to 89%.

7. Summary

Neonatal care is a high-cost speciality commissioned by specialised services. It covers all levels of care from intensive through to care in the community. It should also include support and education required for new parents/carers. Acuity and dependency vary according to the individual needs of the neonate. Periods of relatively less intensive activity should be seen as an opportunity for neonatal nursing staff to undertake self-directed learning, unit-based teaching, e.g., simulation sessions, or focus on BAPM recommended link roles.

This report indicates there is a **shortfall of approximately 1.76 WTE** between the budget and staff in post. This is due to a vacancy rate of 1.76 WTE Band 5, for which recruitment is underway. This equates to approximately **0.75% vacancy rate.**
Other variance is due to there being no budget for band 5 nurses who have completed the QIS course, the staff in post at this level contribute to the band 6 roster with some restrictions to their duties, specifically taking charge of the shift. This reflects as 0.8 WTE over budget for QIS staff, and 0.8 WTE under budget for non-QIS staff.

The Neonatal Unit has a band 6 QIS neonatal nurse shift leader. They are required to cover and supervise the NNU and NTC, attend handover, ward round, MDT safety huddle, crash calls, deliveries of anticipated admissions to the NNU, they have extended nursing skills to support the medical team, such as cannulation, bloodletting and are trained to implement patient group directives (PGDs), they are required to support and supervise the junior team, assess ward attenders from home, oversee admissions, deal with any issues or concerns from parents/ carers and facilitate transfers in and out of the Unit, this is usually done with the addition of a patient allocation as the shift leader is not supernumerary, despite this being a national standard i.e. NHSE, BAPM and the DOH Toolkit.

The findings of the Neonatal Nursing Workforce Calculator indicate that **cot occupancy is 45.92% in this 6-month period of audit**. This does not consider neonates receiving Neonatal

Transitional Care (NTC). With the continued aim to reduce Term admissions to the Neonatal Unit, this cannot be ignored when calculating the number of nursing staff required**. Neonatal Transitional Care** activity equates to approximately **15%** of activity for this period.
Neither does the calculator consider the **Neonatal Community Service (NCS)** which is also staffed by the Neonatal workforce. This work equates to approximately **7%** during this period.
Nor does the calculator consider **Ward Attenders,** neonatal patients who attend the Neonatal Unit by appointment following referral, usually from Community Midwives, but also on occasion from GP's, this equates to approximately **19%** for this period.

8. Recommendations

There should be a regular review of the staffing levels and skill mix to enable this to reflect the activity and acuity going forward.

Allowance made for staffing of NTC, NCS and enabling staff to complete training such as the QIS course.

The review should be confirmed by the ODN to ensure that the findings of the toolkit have been applied appropriately.

The action plan (Appendix 4) should be agreed by all interested parties and submitted to the Divisional Management team for approval prior to submission to the Trust Board.

Complete the Neonatal Nursing Workforce calculator or equivalent each year and report on findings to reflect staffing needs and budget setting.

Appendix 1 MIS (CNST) Safety Action 4d Technical guidance

The Trust is required to formally record to the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020). Neonatal Nursing workforce review has been undertaken at least once during year 5 reporting period 30 May 2023 – 7 December 2023.

Technical guidance	
Neonatal nursing workforce standards and action	
Where can we find more information about the requirements for neonatal nursing workforce?	Neonatal nurse staffing standards are set out in the BAPM Service and Quality Standards (2022) https://www.bapm.org/resources/service-and-quality-standards-for-provision-of-neonatal-care-in-the-uk The Neonatal Nursing Workforce Calculator (2020) should be used to calculate cot side care and guidance for this tool is available here: https://www.neonatalnetwork.co.uk/nwnodn/wp-content/uploads/2021/08/Guidance-for-Neonatal-Nursing-Workforce-Tool.pdf Access to the tool and more information will be available through your Neonatal ODN Education and Workforce lead nurse.
Our Trust does not meet the relevant nursing standards and in view of this an action plan, ratified by the Board has been developed. Can we declare compliance with this sub-requirement?	There also needs to be evidence of progress against any previously agreed action plans. This will enable Trusts to declare compliance with this sub-requirement.

Appendix 2 Summary of Safety Action 4d - Compliance with Standards				
Clinical Workforce Group	**Standard to be met**	**WSH compliance**	**Progress Report**	**Evidence Source**
Neonatal nursing workforce	The neonatal unit meets the service specification for neonatal nursing standards. If the requirements have not been met in year 3 and or year 4 and 5 of MIS, Trust Board should evidence progress against the action plan previously developed and include new relevant actions to address deficiencies. If the requirements had been met previously without the need of developing an action plan to address deficiencies, however they are not met in year 5 Trust Board should develop an action plan in year 5 of MIS to address deficiencies. Any action plans should be shared with the LMNS and Neonatal Operational Delivery Network (ODN).	**Green – staffing assessment completed** **Amber- vacancies staff recruitment is taking place** **Red- Currently no supernumerary shift lead**	Between 30 May 2023 – 7 December 2023 each neonatal unit should perform a nursing workforce calculation using the agreed workforce staffing tool.	The Trust is required to formally record to the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020). For units that do not meet the standard, the Trust Board should agree an action plan and evidence progress against any action plan previously developed to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN). **Board Report September 2023**

Appendix 3 Copy of the Neonatal CRG Nursing Workforce Calculator (2020): West Suffolk

Input unit details			
Trust	West Suffolk NHS Foundation Trust		
Unit	West Suffolk		
Designation	SCU		
Completed by	Maija Blagg		
Date completed	08/09/23		
Activity period	01 March 2023 - 31 Aug 2023	Days in period	184

Input activity (HRG 2016)		
	Activity	Declared cots
HRG 1 (IC)	26	1
HRG 2 (HD)	251	3
HRG 3 (SC)	737	8
Total	**1,014**	**12**

Input staffing numbers (WTE) DIRECT PATIENT CARE ONLY		
	Budget	In post
Total QIS	15.44	16.24
Total Non QIS	7.16	4.60
Total Non Reg	3.13	3.13
Total	**25.73**	**23.97**

Activity (HRG 2016)							
	Activity	*For calculations*		Declared cots	Occupancy for period	Cots required to meet activity at average 80% occupancy	Variance: declared cots against required
		80% of daily activity	*WTE (6.07 / BAPM)*				
HRG 1	26	*0.2*	*6.07*	1	14.13%	1	0
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Total	**1,014**			**12**	**45.92%**	**7**	**5**

Nursing workforce (WTE) DIRECT PATIENT CARE ONLY					
NB total nurse staffing required to staff declared cots = 33.39, of which 23.37 (70%) should be QIS					
	Current position		Required to meet activity at average 80% occ	Variance: budget against required	Variance: in post against required
	Budget	In post			
Total nursing staff	25.73	23.97	19.92	5.81	4.05
Total reg nurses	22.60	20.84	17.64	4.96	3.20
Total QIS	15.44	16.24	12.35	3.09	3.89
Total non-QIS	7.16	4.60	5.29	1.87	-0.69
Total non-reg	3.13	3.13	2.28	0.85	0.85
Reg nurses as % nursing staff	87.8%	86.9%	88.6%		
QIS as % reg nurses	68.3%	77.9%	70.0%		

Assumptions For further detail please refer to the narrative sheet.

- Calculations are valid for neonatal unit only - transitional care staffing and activity should be excluded.
- 6.07 WTE is required for 1 nurse per shift. The detail of how this multiplier was calculated is on a separate sheet.
- Staffing requirements are based on activity, and BAPM nurse to baby ratios are used, ie IC 1:1; HD 1:2; SC 1:4.
- Numbers are for nurses **providing direct patient care only**. Exclude additional roles e.g. management, outreach, education.
- A supernumerary nurse in charge is included for all units on all shifts.
- At least 70% of registered nurses should be Qualified In Specialty (QIS).
- All intensive and high dependancy care should be undertaken by registered nurses with QIS training.
- For special care, registered to non-registered staff ratios are calculated at 70:30.
- Cot calculations assume that cots can be flexed up but not down, so round up to the higher level cots. See narrative for more detail.

Appendix 4 Action plan:

Action plan lead	Name: Maija Blagg	Title: Senior Matron Neonatal Services	Contact: Maija.Blagg@wsh.nhs.uk

Recommendation	Actions required	Action by date	Person responsible	Comments/action status
There should be a regular review of the staffing levels and skill mix to enable this to reflect the activity and acuity going forward.	Regular staffing review to be undertaken including succession planning	Ongoing review	Neonatal Unit Ward Manager	Monthly review completed and ongoing
Complete Neonatal Nursing Workforce calculator or equivalent each year and report on findings to reflect staffing needs and budget setting.	Repeat staffing tool assessment yearly and compare findings with current staffing levels	July 2024	Senior Matron Neonatal Services/ Neonatal Unit Ward Manager	Completed for 2023
Allowance made for staffing of NTC, NCS and enabling staff to complete QIS.	Ongoing training	Ongoing	Senior Matron Neonatal Services/ Neonatal Unit Ward Manager/ Neonatal Unit Practice Development Nurse	On track
The review should be confirmed by the ODN to ensure that the findings of the	Nursing workforce calculator submitted to ODN for review and confirmation of findings	Sept 2023	Senior Matron Neonatal Services	Awaiting board receipt

calculator have been applied appropriately				
An action plan should be formulated and agreed by all interested parties and submitted to the Divisional Management team for approval prior to submission to the Trust Board.	Report and action plan to be submitted to Quality and Safety meeting and Safety Champion prior to submission to the Board	Sept 2023	Senior Matron Neonatal Services	Due Sep 23 – Trust Board
There should be a shift leader for every shift. This should be a senior nurse (generally band 7) who has no clinical commitment during the shift i.e. supernumerary	Business case to be developed and presented for additional funding to support supernumerary shift lead	31/3/24 – 30/6/24	Senior Matron Neonatal Services/ Deputy Head of Maternity /Operational Manager	Requires action
The NCS provision should look to extending to a 7 day per week service.	This will require careful consideration, audit of service gaps, patient workload, and possible business case developed and presented to expand the service and secure appropriate funding	31/3/24 – 30/6/24	Senior Matron Neonatal Services/ Deputy Head of Maternity/ Operational Manager	Requires action

Open Trust Board	
Report title:	Maternity quality, safety, and performance report
Agenda item:	Maternity services quality & performance report
Date of the meeting:	29th September 2023
Sponsor/executive lead:	Sue Wilkinson, Executive Chief Nurse Paul Molyneux, Interim Medical Director & Executive MatNeo Safety Champion
Report prepared by:	Karen Newbury, Head of Midwifery

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

Executive Summary

WHAT?

This report presents a document to enable board scrutiny of Maternity services and receive assurance of ongoing compliance against key quality and safety indicators and provide an update on Maternity quality & safety initiatives. The papers presented are for information only and issues to note are captured in this summary report. All the attached papers have been through internal governance process including the Maternity and Neonatal Safety Champions and will then be shared with the Local Maternity and Neonatal System.

This report contains:

- Maternity improvement plan
- Safety champion feedback from walkabout
- Listening to staff
- Service user feedback
- Reporting and learning from incidents
- Maternity Dashboards (Annex A)
- Summary of Mandatory and Essential Training Compliance
- Maternity Safety Support Programme – progress report August 2023
- Anaesthetic staffing report Q3 and Q4 2022/2023
- Core Competency Framework Training Plan
- Transitional Care Q1 April 1st 2023 to June 30th 2023
- Neonatal Nursing Staffing Assessment
- Perinatal Mortality Report – Q1: April 1st to June 30th 2023
- HSIB and Early Notification Report – Q1 April 1st to June 30th 2023
- Avoiding Term Admissions to the Neonatal Unit (ATAIN) Q1 April 1st to June 30th 2023

SO WHAT?

The report meets NHSE standard of perinatal surveillance by providing the Trust board a methodical review of maternity and neonatal safety and quality.
WHAT NEXT?
Action plans will be monitored and any areas for non-completion, escalated as appropriate. Quarterly, bi-annual and annual reports will evidence the updates. Reports will be shared with external stakeholders as required.
Action Required
For assurance and information only.

Risk and assurance:	As below
Equality, Diversity and Inclusion:	This paper has been written with due consideration to equality, diversity, and inclusion.
Sustainability:	As per individual reports
Legal and regulatory context	The information contained within this report has been obtained through due diligence.

Maternity quality, safety, and performance report

1.	Detailed sections and key issues
1.1	**Maternity improvement plan** The Maternity and Neonate Improvement Board (MNIB) receives the updated Maternity improvement plan monthly. This has been created through an amalgamation of the original CQC improvement plan with the wider requirements of Ockenden, HSIB, external site visits and self-assessment against other national best practice (e.g., MBRRACE, SBLCBv2, UKOSS). In addition, the plan has captured the actions needing completion from the 60 Supportive Steps visit from NHSE and continues to be reviewed by the Maternity Improvement Board monthly. It has been agreed with the exit from the Maternity Safety Support Programme (MSSP) that NHSE regional team and ICS (Integrated Care System) will be invited to attend the MIB monthly for additional assurance and scrutiny. To exit the MSSP an overarching Sustainability Plan was submitted and progress report (included in this paper) is now due. In conjunction with this, a visit from the ICS and NHSE regional team is required however this has had be rescheduled due to previous visits coinciding with planned Industrial Action.
1.2	**Safety Champion Walkabout feedback** The Board-level champion undertakes a monthly walkabout in the maternity and neonatal unit. Staff have the opportunity to raise any safety issues with the Board level champion and if there are any immediate actions that are required, the Board level champion will address these with the relevant person at the time. Individuals or groups of staff can raise the issues with the Board champion. An overview of the Walkabout content and responses is shared with all staff in the monthly governance newsletter 'Risky Business'. Roger Petter our Non-Executive Maternity and Neonatal Safety Champion completed three walkabouts throughout July and August 2023. A visit of Ward F11 took place on the 25th July 2023. Although the unit was busy that morning, Roger did manage to speak with a wide variety of staff. Roger noted that the atmosphere was friendly, welcoming, calm, organised, efficient and everything seemed to be operating smoothly.

No concerns or adverse comments were raised to Roger, only an expression of general satisfaction. Roger's overall observation was F11 demonstrated good teamworking and an efficient good atmosphere.

On the 17th August 2023 Roger visited the Midwifery team that covers Haverhill which is currently based at the Leisure Centre due to ongoing repairs to the usual base/clinic. The main issues that were voiced at his visit related to this temporary accommodation and how it inevitably affects a patient's experience and could impact privacy and confidentiality, although steps have been taken to minimise this. Roger found the team to be friendly, professional, and clearly committed to their work. Apart from the location-related issues, no safety issues were raised.

On the 22nd August 2023 Roger visited the Midwifery Led Birthing Unit. Roger felt welcomed onto the unit, which was evidently a well-functioning unit with a healthy atmosphere, good morale, and good leadership.
It appears to have a good working relationship with the adjacent labour unit. Roger gained the impression that staff would feel comfortable speaking up if there were a need to do so. However, no safety or related concerns were expressed.

1.3 **Listening to Staff**

The National Staff Satisfaction Survey results were published in April 2023 and the divisional operational managers are working on an action plan regarding areas for further development.

The maternity and neonatal service continues to promote all staff accessing the Freedom to Speak up Guardians, Safety Champions, Professional Midwifery Advocates, Unit Meetings and 'Safe Space'. In addition to this there are maternity staff focus groups, which provide a forum to listen to staff.

On the back of recent retention data from the national and regional teams, it is recognised that the majority of midwives are leaving the profession 2-5 years after qualification. We are committed to working with the Local Maternity /Neonatal System and regional team to address this. In response we have undertaken a flexible working survey, commenced Midwifery Band 6 forums, and are undertaking 'stay conversations' which have been received very positively. The 'Legacy Midwife' role has now commenced, and a pilot of self-rostering (as indicated by the flexible working survey results) is underway in differing teams across maternity.

1.4 **Service User feedback**

The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether patients are happy with the service provided, or where improvements are needed. It's a quick and anonymous way to give views after receiving NHS care or treatment.

Ward/Dept	July Survey returns	July FFT score	Aug Survey returns	Aug FFT Score
F11	54	100	58	98
Antenatal	6	100	16	94
Postnatal Community	6	100	7	100
Labour Suite	46	98	44	100
Birthing Unit	12	100	10	100
NNU	7	86	11	100
Transitional Care	6	93.19%	9	92.4%

Plans to increase the number of returns for antenatal and postnatal community were relying on the introduction of a SMS survey response. Due to financial constraints, it has not been possible to pursue this, however a solution has been found via email survey which is due to be trialled within the next month.

	In addition to the FFT, feedback is gained via our PALS and the Maternity Voice Partnership (MVP) social media, MVP, CQC and Healthwatch surveys. On review of enquiries and complaints received during July and August 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. This will require an electronic solution to enable it, which is currently being explored.
1.5	**Reporting and learning from incidents** During July and Aug 2023 there was one new case that potentially met the referral criteria to the Healthcare Safety Investigation Branch (HSIB). Following a normal MRI scan the HSIB have declined to investigate as the case no longer meets their criteria. This case will now be reviewed internally with an external member on the panel. The maternity service is represented at the Local Maternity and Neonatal System (LMNS) monthly safety forum, where incidents, reports and learning are shared across all three maternity units.
1.6	**Maternity dashboards (Annex A)** Indicators of maternity safety & quality are regularly reported and reviewed at monthly Maternity Governance meetings. A sub-set are provided for board level performance (the Performance & Governance dashboard). Red rated data will be represented in line with the national NHSI model of SPC charts. Please see below:

Post-partum Haemorrhages (>1500 mls)	QI project and shared learning continues locally and across the Local Maternity and Neonate System (LMNS) and region.
Compliance with asking Domestic Abuse questions	Antenatal compliance has been above 90% for the last 4 months. Postnatal compliance is not consistent, therefore indicating processes are not embedded. Compliance data continues to be reviewed weekly. QI work has commenced, and connectivity in the community has been identified as an issue inhibiting access to patient records in community settings. Solutions are being explored.
3rd/4th degree tears following instrumental deliveries	Although a small number of cases, due to the apparent peak following instrumental deliveries all cases have been reviewed via a patient safety audit. One learning point has been identified and shared with clinicians.
Breastfed babies within 48 hours of birth	Baby Friendly Initiative Training gaps due to new staff. Training dates arranged. Peer supporters would be an effective resource to support infant feeding however currently funding to cover their supervision has not been obtained to continue their service.

1.7	**Summary of Mandatory and Essential Training Compliance** For safer births and maternity/neonatal care, there are several essential training components required for the staff involved in delivering care. The two main areas for training are: a) To provide care which meets the standards outlined in Saving Babies Lives v2.0 and v 3.0 which includes all 6 elements but mainly the first 5: Smoke Free Pregnancy; Monitoring of Fetal Growth; Monitoring Fetal Movements; Monitoring of the Fetal Heart in Labour; Prediction, Prevention and Preparation of Preterm Birth b) To meet the standards for providing emergency obstetric care and neonatal resuscitation. Training compliance is measured each month and recorded on the Quality Dashboard and reported at the Maternity Quality and Safety meeting, Maternity and Neonatal Safety Champions and the LMNS/ICB Board. In order to provide assurance of safe standards, a compliance of 90% completion of training in each staff group is required. This standard is set within the NHSR Maternity Incentive Scheme (MIS) Year 5 as well as against the Core Competency Framework v 2.0 outlined in the 3 year Training Plan. **Successes** Midwives and Maternity Support Workers are ≥ 90% compliant in all training requirements There has been a steady increase in compliance with fetal monitoring training within the Obstetric consultant and other obstetric trainees although this is not yet at 90% **Challenges** The compliance with obstetric and anaesthetic staff attending the MDT obstetric emergency training has not achieved 90%. This is related, in part, to shortages of staff, exacerbated by industrial action and this not being part of the mandatory requirements for anaesthetic staff. The obstetric consultants and other obstetric staff compliance with the training associated with the 5 main Saving Babies Lives elements is consistently below 50%, however a plan is in place with a trajectory to meet the target by the 7th December 2023 (MIS deadline), however if further industrial action is planned this is at risk.
2.	**Reports**
2.1	**Maternity Safety Support Programme – progress report August 2023** West Suffolk NHS Foundation Trust entered the NHS England / Improvement Maternity Safety Support programme (MSSP) following the CQC's inspection of WSFT maternity services on 24th September 2019 and was issued a 29a warning notice on 14th November 2019. Following further CQC unannounced inspections on 13th April 2021, the CQC has revised ratings for the WSFT site in the Well-led domain from inadequate to requires improvement. All other domains reviewed remained the same, however the CQC reported they had seen evidence of progression, significant change and culture improvement. In January 2022 the Trust entered the Sustainability phase of the MSSP as quality and safety improvement plans and actions were being addressed. The Maternity Improvement Advisor (MIA) reduced the level of support visits whilst maintaining oversight of progress. Sustainability plans were in place and tested to ensure the improvements were sustained and embedded as business as usual. External peer reviews from NHSE/I had taken place in October 2021 (Sixty Supportive Steps to Safety) and May 2022 (Ockenden – one year on). The NHS England National Quality Performance Committee agreed that the WSFT maternity service had formally exited the MSSP on the 25th October 2022 and the following report outlines the progress made in continuing and sustaining the improvements made throughout the programme. The main drivers for change and assurances are included in the summaries for each plan and as part of the sustainability plans attached. Key points outlined in this paper are: • Completed and outstanding actions from the 2019 CQC visit as detailed in the CQC report April 2021 and including additional areas raised in assurance visits. • Updated Governance Structures and Framework • Leadership Structure and sustainability • Workforce structure and sustainability

	• Compliance with Ockenden (part 1), Morecombe Bay, MIS/CNST, Maternity Self-assessment & 60 Supportive Steps, Ockenden (final report) • Progress made towards assurances that standards are met within the overarching Sustainability Action Plan **Next Steps** The Maternity Services will continue to provide evidence to the Trust Board, NHS England and other external partners to support their continued commitment to quality and safety and progress towards a sustained improvement in key aspects of care and services. Year 5 of the Maternity Incentive Scheme, version 3.0 of Saving Babies Lives, the NHS Core Competency Framework version 2.0 and the 3 Year Delivery Plan all offer further opportunities for the Trust to ensure that the structures, safety processes and strategies continue to shape Maternity and Neonatal Services of the future.
2.2	**Anaesthetic staffing report Q3 and Q4 2022/2023** This report has been written to confirm compliance with safe staffing requirements for obstetric anaesthesia provision within the Maternity Unit of West Suffolk NHS FT (WSNHSFT) against the national standards. This report covers the period 1st October 2022 to 31st March 2023 (Q3 and Q4 2022/23) and assesses the requirements against the Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1. **Findings** The rotas for anaesthetic staff have been independently reviewed to ensure that there is a named staff member covering the on call obstetric rota for each 24-hour period. The findings confirm that there is allocation and identification of a dedicated anaesthetist on the rota for obstetric anaesthesia throughout this 6-month period. The rota also demonstrates that there is a named consultant anaesthetist who is available for escalation of staffing and clinical issues. **Next steps** The next review and report will be completed for Q1 and Q2 of 2023/2024.
2.3	**Core Competency Framework Training Plan** The 3 year Maternity and Neonatal training plan has been updated in accordance with the Core Competency Framework (CCF) version 2 which was launched in May 2023. Whilst the requirement was to update the final year of our previously agreed training plan, the decision was made to restart the 3 years from 2023. Evidence that this meets the requirements of the CCF and that the Trust is actively developing and enhancing the training for maternity and neonatal staff is part of the requirements for Year 5 Maternity Incentive Scheme Safety Action 6 – Saving Babies Lives – and Safety Action 8 – MDT training. Providers have been asked to use the new national implementation tool to track compliance with the care bundle and share this with the Trust Board and Integrated Care Board (ICB). The Board is asked to approve the training plan and support the service in implementing and maintaining compliance with this
2.4	**Transitional Care Q1 April 1st 2023 to June 30th 2023** An operational Policy for Neonatal Transitional Care CG10602 has been in place since 2021. This has been further updated in March 2023 to reflect the changes introduced as part of the Kaiser® Neonatal Sepsis Calculator which was introduced in December 2022. The full impact of this on the use of antibiotics for neonates, admissions to the Neonatal Unit (NNU) and Neonatal Transitional Care (NTC) is an ongoing process through auditing notes. Further updates have since been made to include uncomplicated late preterm births in the NTC criteria. 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 were less babies admitted to NTC in this quarter with 76 out of the total number of 534 babies born alive, making it 14.2%. This decrease (from 19.7% in Quarter 4 2022/23) is not explained by a

reduction in the number of babies born in this quarter due to only 6 more babies born in the previous quarter.

Most of the babies 20 (26.3%) admitted to NTC were admitted **from birth** i.e., Labour Suite or Theatre. This confirms that NTC is being utilised and thought of when a baby requires additional care straight from birth. The reasons for admission are consistent throughout the months. Babies are being admitted from birth for prematurity, signs of respiratory distress syndrome, maternal and/ or neonatal sepsis.

The second most common reason for babies needing admission to NTC is babies that required **Kaiser** observations. This made up 23.7% (18 babies) of all babies needing NTC. This data relies heavily on correct input on the Neonatal admission book.

The third most common reason after Kaiser was a **stepdown** from NNU. These would be the babies that had been admitted to NNU for more than 4 hours whose condition would have improved enough for them to be transferred to NTC with mum. Some of these babies would also be continuing their course of antibiotics, hence the need to stay in the hospital setting **without continuous** monitoring being required. There were 17 babies (22.4%) in this quarter that were transferred to NTC from NNU. The most common reasons are continuing a course of antibiotics, followed by monitoring after requiring initial respiratory support.

The numbers of babies being referred in **from community** needing admission was 13 (17.1%) and the themes remain the same as in previous quarters, with jaundice requiring treatment and weight loss with occasionally associated poor feeding needing support.

The smallest group remain that of babies admitted **from the postnatal ward,** the number being 8 (10.5%) who needed NTC care due to grunting, signs of respiratory distress, suspected sepsis and hypothermia.

Next steps

1. Audit findings to be shared
2. The Operation Policy for Neonatal Transitional Care guideline has been further updated to include uncomplicated late preterm births in the NTC criteria. This has been approved in the Quality and Safety meeting in June and is currently awaiting approval by the paediatric governance group prior to uploading.
3. Work on introducing NEWTT 2 assessment and wellbeing observations into practice is being planned when the electronic versions of observation charts are available on the information system in the Trust.

Neonatal Nursing Staffing Assessment

The purpose of this report is to provide evidence and give the Board assurance that work continues to be undertaken within neonatal services at West Suffolk NHS Foundation Trust, to demonstrate progress towards meeting safe staffing standards within the neonatal nursing workforce. These standards are outlined in the British Association of Perinatal Medicine (BAPM) guidance and are assessed using the agreed Neonatal Clinical Review Group (CRG) nursing workforce calculator (2020).

This report indicates there is a **shortfall of approximately 1.76 WTE** between the budget and staff in post. This is due to a vacancy rate of 1.76 WTE Band 5, for which recruitment is underway. This equates to approximately **0.75% vacancy rate**.

Another variance highlighted is, as there is no budget for band 5 nurses who have completed the Qualified In Speciality (QIS) course, the staff in post at this level contribute to the band 6 roster with some restrictions to their duties. This reflects as 0.8 WTE over budget for QIS staff, and 0.8 WTE under budget for non-QIS staff.

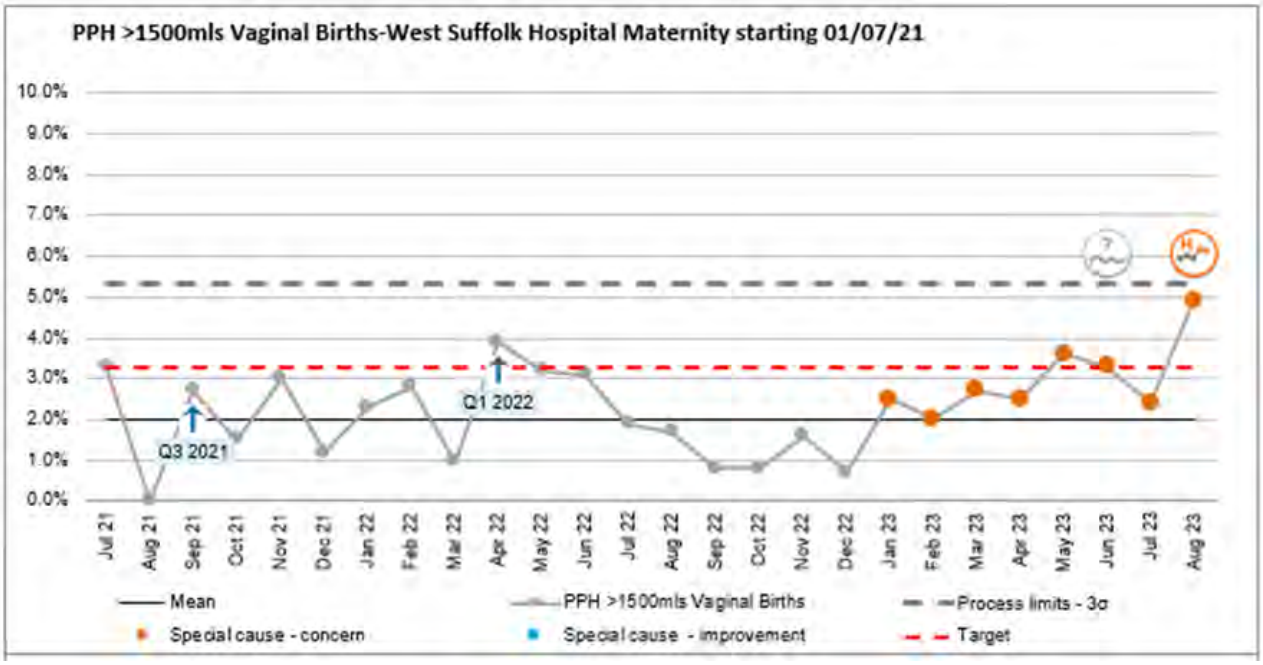
As per the calculator guidance, only workforce that provide direct neonatal patient care on the neonatal unit have been included. Management and administrative roles including the Senior Matron for Neonatal Services, Unit Manager, Practice Development Nurse, and Governance Lead are not included, this equates to 3.15 WTE.

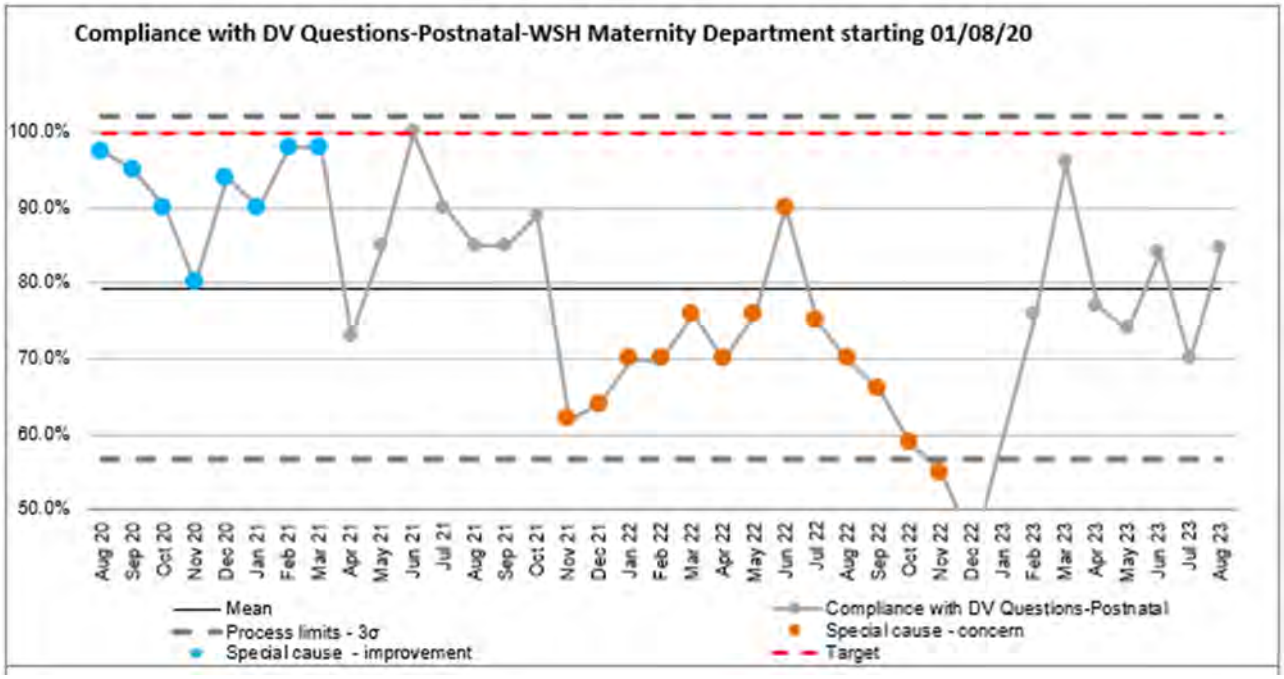
Likewise, staff who cover the Neonatal Transitional Care (NTC) and Neonatal Community Services have not been included. This equates to 5.8 WTE band 4 to cover NTC, 0.32 WTE band 4 to cover the Neonatal Community Service and 0.64 WTE band 6 QIS to cover the Neonatal Community Service. Currently there is no separate budget for these staff groups/ services.

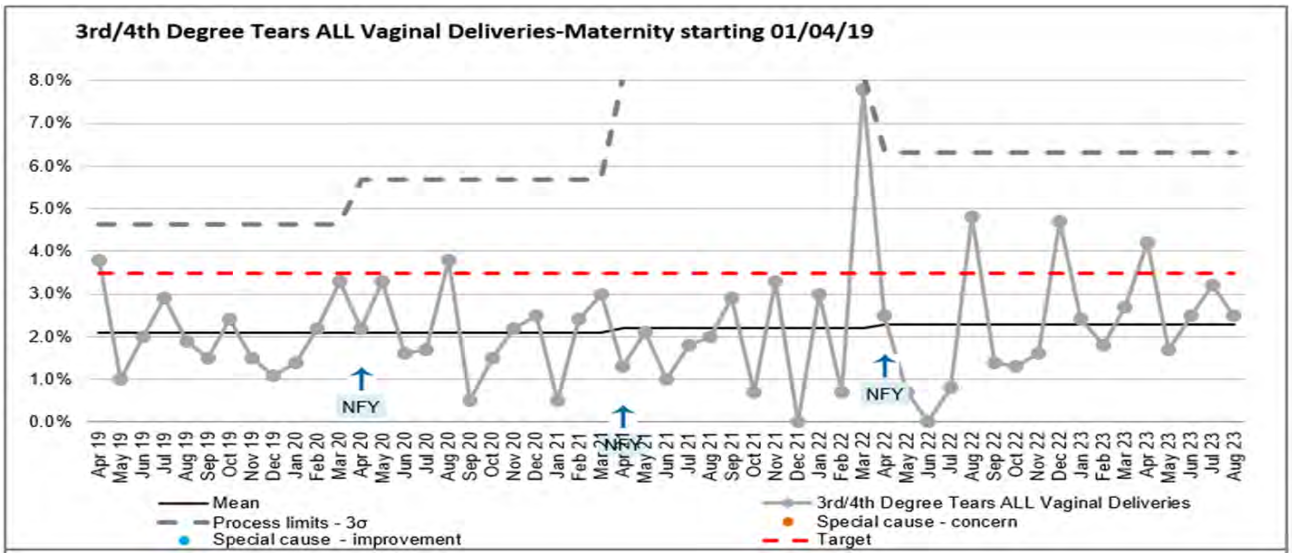
	BAPM states that nursery nurses working in NTC should be under the direct supervision and responsibility of a registered nurse or midwife. The Neonatal Unit shift leaders are band 6 QIS. The **shift leader is not currently supernumerary,** despite this being a national standard from NHSE, BAPM and the DOH Toolkit. BAPM also state that neonatal workforce planning should include a 25% uplift for nursing time over and above direct clinical care for education, training, professional development, annual leave, sickness, maternity leave, and non-clinical commitments including (but not inclusive of), QI and safeguarding. In addition to this, there should be a shift coordinator for every shift. This should be a senior nurse (generally band 7) who has no clinical commitment during the shift. The findings of the Neonatal Nursing Workforce Calculator indicate that **cot occupancy is 45.92%** in this 6-month period of audit. However, this does not consider neonates receiving NTC. With the continued aim to reduce term admissions to the Neonatal Unit, this cannot be ignored when calculating the number of nursing staff required. Neonatal **Transitional Care activity equates to approximately 15%** of activity for this period of audit. The calculator does not consider **Ward Attenders**, neonatal patients who attend the Neonatal Unit by appointment following referral, usually from Community Midwives, but also on occasion from GP's, this equates to approximately **19%** for this period. The Trust board is asked to receive this report as evidence of progress towards safe nursing staff standards in the Neonatal Unit and provide support to address the shortfalls.
3.	**Reports for CLOSED Board** Due to the level of detail required for these reports and subsequently containing possible patient identifiable information, the full reports will be shared at Closed board only.
3.1	**Perinatal Mortality Report – Q1: April 1st to June 30th 2023** In the period from 1st April 2023 to 30th June 2023, the Trust has reported 4 baby losses directly associated with the Maternity Services. One of the losses met the criteria for referral to HSIB but the mother declined referral to HSIB. Any early learning from these losses was shared with the staff and the families. The Trust has met all of the standards for reporting all relevant incidents of perinatal mortality to the relevant national platforms within the appropriate time frames with regard to compliance with reporting to MBRRACE and completion of the surveillance information within the required time frames when required to date. The Trust was 100% **compliant** with duty of candour and informing the women that a PMRT review will be undertaken when indicated and inviting comments or questions to aid the review process. The Trust has **completed all** the PMRT reports that were due to be completed within this reporting timeframe and started the review process for all of these within 2 months of the loss. This report also includes outstanding actions from previously completed PMRT reports for the last year and recently completed actions and shared learning.
3.2	**HSIB and Early Notification Report – Q1 April 1st to June 30th 2023** In this quarter, there was one incident that met the criteria to be reported to HSIB, but the mother of the baby did not consent to the referral. There were no incidents of baby's being affected that met the criteria for referral to the Early Notification scheme. **Completed reports:** One report has been completed and shared with the family, staff involved and the Trust. Whilst there were no safety recommendations from the report, the findings, good practice and learning will be shared with all staff groups. The 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 reports will be shared with the Trust Board and the LMNS. The Trust is assured that the processes are being followed for referral to HSIB and the ENS.

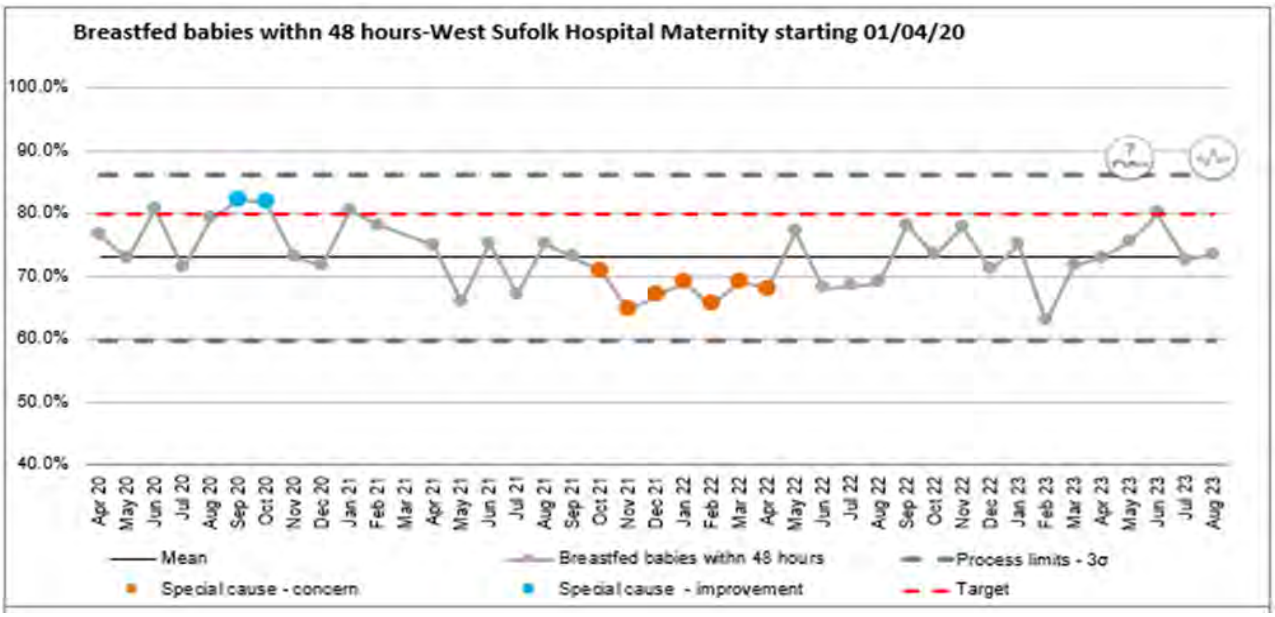
3.3	**Avoiding Term Admissions to the Neonatal Unit (ATAIN) Q1 April 1st to June 30th 2023** There were 18 term babies (3.37% of the 534 babies born alive) admitted to the neonatal unit in this quarter (April to June 2023). This is s a significant reduction from the numbers in the last quarter (31 or 5.67% of babies born alive). This figure does not include an additional 4 babies who were admitted but did not meet the criteria for review under ATAIN. Respiratory distress remained the predominant reason for admission, accounting for 55.6% (10 babies out of 18) of all term admissions. They all required respiratory support in the form of Vapotherm and one baby deteriorated and needed further management with intubation and ventilation, surfactant administration and a transfer to a tertiary unit for ongoing care. All babies also received intravenous antibiotics due to their clinical presentation of whom 40% (4 out of 10 babies) had known risk factors for sepsis, with prolonged rupture of membranes being the most common theme. Half of the babies admitted with respiratory problems were in their 37th week gestation. The other half ranged between 38 to 40+4. Most of the babies had good APGAR scores at birth. One baby was discharged home having lost 11% of its birthweight but was readmitted with a further weight loss. None of the admissions during this quarter were deemed to be avoidable. There was a discussion around the babies that needed to be admitted with a low temperature. However, it was deemed that appropriate measures were taken, and these babies were managed appropriately in the postnatal setting. A request for a paediatric review was completed in a timely manner. These babies were of mothers who had medication which is known to have side effects on the babies in regard to blood glucose levels and consequently a drop in body temperature. All admissions were stepped down to transitional care at the earliest opportunity.
4.	**Next steps**
4.1	Reports will be shared with the external stakeholders as required Action plans will be monitored and updated accordingly

Annex A- Maternity Dashboard SPC Charts:




Compliance with DV Questions-Postnatal-WSH Maternity Department starting 01/08/20
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
Aug 20 Sep 20 Oct 20 Nov 20 Dec 20 Jan 21 Feb 21 Mar 21 Apr 21 May 21 Jun 21 Jul 21 Aug 21 Sep 21 Oct 21 Nov 21 Dec 21 Jan 22 Feb 22 Mar 22 Apr 22 May 22 Jun 22 Jul 22 Aug 22 Sep 22 Oct 22 Nov 22 Dec 22 Jan 23 Feb 23 Mar 23 Apr 23 May 23 Jun 23 Jul 23 Aug 23
Mean
Process limits - 3σ
Special cause - improvement
Compliance with DV Questions-Postnatal
Special cause - concern
Target


3rd/4th Degree Tears ALL Vaginal Deliveries-Maternity starting 01/04/19
8.0%
7.0%
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
NFY
NFY
NFY
Apr 19 May 19 Jun 19 Jul 19 Aug 19 Sep 19 Oct 19 Nov 19 Dec 19 Jan 20 Feb 20 Mar 20 Apr 20 May 20 Jun 20 Jul 20 Aug 20 Sep 20 Oct 20 Nov 20 Dec 20 Jan 21 Feb 21 Mar 21 Apr 21 May 21 Jun 21 Jul 21 Aug 21 Sep 21 Oct 21 Nov 21 Dec 21 Jan 22 Feb 22 Mar 22 Apr 22 May 22 Jun 22 Jul 22 Aug 22 Sep 22 Oct 22 Nov 22 Dec 22 Jan 23 Feb 23 Mar 23 Apr 23 May 23 Jun 23 Jul 23 Aug 23
Mean
Process limits - 3σ
Special cause - improvement
3rd/4th Degree Tears ALL Vaginal Deliveries
Special cause - concern
Target


Breastfed babies withn 48 hours-West Sufolk Hospital Maternity starting 01/04/20
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
Apr 20 May 20 Jun 20 Jul 20 Aug 20 Sep 20 Oct 20 Nov 20 Dec 20 Jan 21 Feb 21 Mar 21 Apr 21 May 21 Jun 21 Jul 21 Aug 21 Sep 21 Oct 21 Nov 21 Dec 21 Jan 22 Feb 22 Mar 22 Apr 22 May 22 Jun 22 Jul 22 Aug 22 Sep 22 Oct 22 Nov 22 Dec 22 Jan 23 Feb 23 Mar 23 Apr 23 May 23 Jun 23 Jul 23 Aug 23
Mean
Breastfed babies withn 48 hours
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target

Report Title	**Audit of the Operational Pathway of Care into Neonatal Transitional Care 1st April to 30th June 2023 (Q1)**
Report for	Information and Approval
Report from	Women's & Children's Services
Report Authors	Abigail Marquette, Clinical Quality and Assurance Lead Beverley Gordon, Project Midwife Karen Green, Quality and Governance Matron
Date of Report	**July 2023**
Presented for approval to:	Maternity and Gynaecology Quality and Safety 18/9/23 Maternity and Neonatal Safety Champions 26/9/23 Trust Board 29/9/2023

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® Neonatal Sepsis Calculator which was introduced in December 2022. The full impact of this on the use of antibiotics for neonates, admissions to the Neonatal Unit (NNU) and Neonatal Transitional Care (NTC) is an ongoing process through auditing notes. Further updates have since been made to include uncomplicated late preterm births in the NTC criteria.

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 were less babies admitted to NTC in this quarter with 76 out of the total number of 534 babies born alive, making it 14.2%. This decrease (from 19.7% in Quarter 4 2022/23) is not explained by a reduction in the number of babies born in this quarter due to only 6 more babies born in the previous quarter.

Most of the babies 20 (26.3%) admitted to NTC were admitted **from birth** i.e. Labour Suite or Theatre. This confirms that NTC is being utilised and thought of when a baby requires additional care straight from birth. The reasons for admission are consistent throughout the months. Babies are being admitted from birth for prematurity, signs of respiratory distress syndrome, maternal and/ or neonatal sepsis.

The second most common reason for babies needing admission to NTC is babies that required **Kaiser** observations. This made up 23.7% (18 babies) of all babies needing NTC. This data relies heavily on correct input on the Neonatal admission book.

The third most common reason after Kaiser was a **stepdown** from NNU. These would be the babies that had been admitted to NNU for more than 4 hours whose condition would have improved enough for them to be transferred to NTC with mum. Some of these babies would also be continuing their course of antibiotics, hence the need to stay in the hospital setting **without continuous** monitoring being required. There were 17 babies (22.4%) in

this quarter that were transferred to NTC from NNU. The most common reasons are continuing a course of antibiotics, followed by monitoring after requiring initial respiratory support.

The numbers of babies being referred in **from community** needing admission was 13 (17.1%) and the themes remain the same as in previous quarters, with jaundice requiring treatment and weight loss with occasionally associated poor feeding needing support.

The smallest group remain that of babies admitted **from the postnatal ward,** the number being 8 (10.5%) who needed NTC care due to grunting, signs of respiratory distress, suspected sepsis and hypothermia.

Recommendations:

1. Audit findings to be shared
2. The Operation Policy for Neonatal Transitional Care guideline has been further updated to include uncomplicated late preterm births in the NTC criteria. This has been approved in the Quality and Safety meeting in June and is currently awaiting approval by the paediatric governance group prior to uploading.
3. Work on introducing NEWTT 2 assessment and wellbeing observations into practice is being planned when the electronic versions of observation charts are available on the information system in the Trust.

1. Introduction

Neonatal Transitional Care (NTC) is not a place but a service and can be delivered either in a separate Neonatal Transitional Care area, or within the Neonatal Unit and /or in the postnatal ward setting. The West Suffolk Hospital NHS Foundation Trust (WSH) maternity unit has an allocated bay on the postnatal ward (F11) and also NTC cots on the Neonatal Unit.

The principals of NTC include the need for a multidisciplinary approach between maternity and neonatal teams, an appropriately skilled and trained workforce, robust systems for data collection with regards to activity and appropriate admissions and a link to community services. Keeping mothers and babies together should be at the cornerstone of newborn care. NTC supports resident mothers to be the primary care providers for their babies when they have care requirements more than normal well newborn care, but do not need continuous monitoring in a special care setting.

NTC avoids separation of the mother and baby and facilitates the establishment of breast feeding whilst enabling safe and effective management of a baby with additional care needs. NTC also has the potential to prevent admission to the neonatal unit and to provide additional support for small and/or late preterm babies and their families.

NTC helps in the smooth transition to discharge home from the neonatal unit for recovering sick or preterm babies whilst providing specialised support away from the more intensive clinical setting.

At the West Suffolk babies meeting the criteria for NTC are admitted to a defined 5-bedded area within F11, the postnatal ward and cared for by midwifery and neonatal teams. Babies admitted from home requiring NTC are admitted to a side room on the Neonatal Unit.

There are 4 points at which a baby may be admitted to NTC: from birth (this includes babies who need Kaiser observations), from the postnatal ward, from home or as a stepdown from Neonatal Unit Care.

2. CNST Maternity Incentive Scheme

In May 2023, NHS Resolution has published the Maternity Incentive Scheme year five and Neonatal Transitional Care is included in Safety action 3:

Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units.

NHS Resolution is operating year five of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to continue to support the delivery of safer maternity care.

This report deals only with the standards and safety actions relating to transitional care.

Safety action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

Required standard

A. Pathways of care into transitional care (TC) have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.

C. Drawing on the insights from the data recording undertaken in the Year 4 scheme, which included babies between 34+0 and 36+6, Trusts should have or be working towards implementing a transitional care pathway in alignment with the BAPM Transitional Care Framework for Practice for both late preterm and term babies. There should be a clear, agreed timescale for implementing this pathway.

Minimum evidential requirement for Trust Board

Evidence for standard A to include:

Local policy/pathway available which is based on principles of British Association of Perinatal Medicine (BAPM) transitional care where:

- There is evidence of neonatal involvement in care planning
- Admission criteria meets a minimum of at least one element of HRG XA04
- There is an explicit staffing model
- The policy is signed by maternity/neonatal clinical leads and should have auditable standards.
- The policy has been fully implemented and quarterly audits of compliance with the policy are conducted.

Evidence for standard C to include:

Guideline for admission to TC to include babies 34+0 and above and data to evidence this is occurring

OR

An action plan signed off by the Trust Board for a move towards a transitional care pathway for babies from 34+0 with clear time scales for full implementation.

This safety action is based on the British Association for Perinatal Medicine (BAPM) Framework for Neonatal Transitional Care (2017).

3. Compliance with the Maternity incentive scheme

An operational Policy for Neonatal Transitional Care has been updated and approved in the June Quality and Safety meeting. It is at present being edited in preparation for review at the paediatric governance group before uploading to conform with the BAPM guidelines.

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 utilising the Neonatal Unit's admission book alongside the electronic neonatal information system Badgernet® and the patient information system E-Care®.

Information from the reviews and learning are shared with the Local Maternity and Neonatal System (LMNS) and Integrated Care Board (ICB) as required. Data is submitted to the Operational Delivery Network (ODN) on request or as part of data capture from Badgernet®.

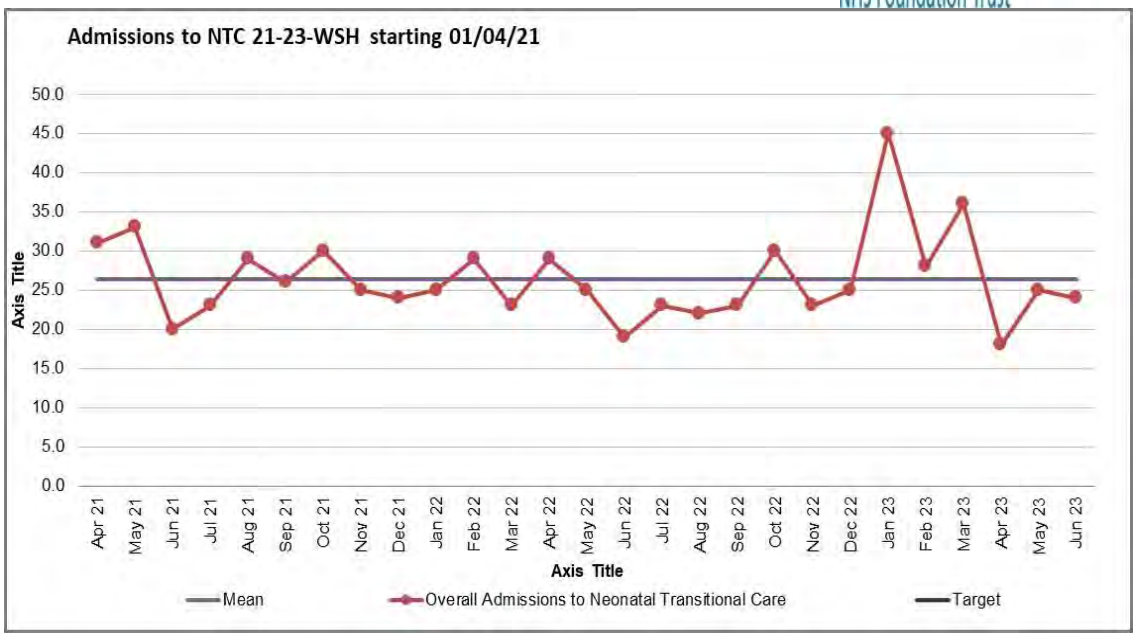
4. Report on Babies admitted to NTC in Q1 April 1st to June 30st 2023

The data was extracted from different sources which included Badgernet, e-Care Maternity system and the Neonatal Admission book.

4a. Summary of Results for Quarter 4

Seventy six (76) babies out of the total number of 534 babies born alive (14.2%) were cared for under the Neonatal Transitional Care pathway in this quarter – 1st April till 30th June 2023. That was a remarkable drop from 108 (17.9%) in the previous quarter. Interestingly there was not an increase in ATAIN numbers which shows that a decrease in NTC admission did not result in an increase in babies being admitted to the Neonatal Unit.

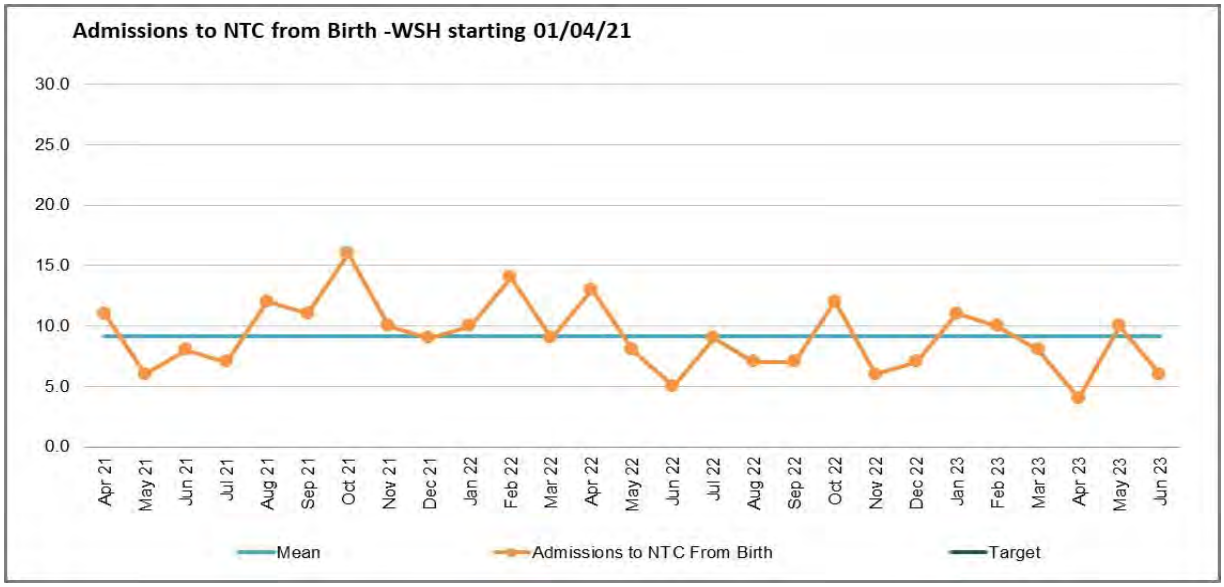
Timing of Admission to NTC	Number
From Birth	20
From Postnatal Ward/area	8
From Community/Home	13
Step down from Neonatal Unit	17
Kaiser observations	18
Total	**76**



4b. Summary of details of babies admitted to transitional care from birth

Clinical Standards		Criteria met
Criteria for immediate admission		
Gestational age >34+6 weeks	19/20(95%) of the babies were above this gestational age. Only one baby did not meet this criteria because they were 34+6 exactly. No harm was caused.	No
Not requiring intensive or high dependency care	Babies did not require intensive care	Yes
Birthweight >1600g	20/20 (100%) babies had birthweights above 1600g	Yes
Maternal suspected /confirmed sepsis in labour	1 mother had pyrexia	Yes
Maternal and Fetal symptoms of suspected sepsis.	1 baby had a combined risk of maternal and neonatal sepsis	Yes
Neonatal risks of Sepsis	10 babies had suspected sepsis	Yes
Preterm within the cohort (less than 37 weeks)	6 babies were preterm	Yes
Other reasons	2 babies were admitted for monitoring due to low birthweight	Yes

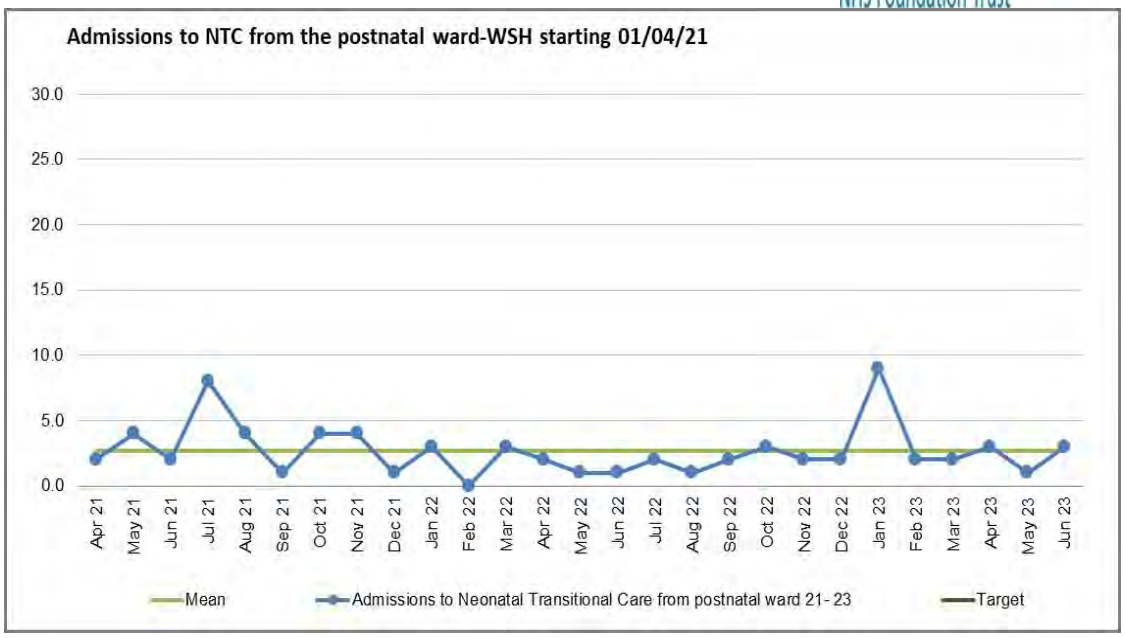
- **19/20 babies (95%) of the babies admitted to NTC met the criteria according to the local guidance. The one baby that did not meet the prescribed criteria did not need admission to the neonatal unit and therefore NTC could be considered to be appropriate in these cases.**



4c. Summary of details of babies admitted to transitional care from the postnatal ward

Clinical Standards		Criteria met
Criteria for admission – developing: Risk factors		
Risk factors for sepsis requiring IV antibiotics	6/8 babies developed or had persistent respiratory symptoms or difficulties maintaining a normothermic temperature where sepsis was suspected.	Yes
Maternal risk factors for babies requiring TC	2/8 babies required IV antibiotics due to their mother developing signs of sepsis and being GBS positive.	Yes

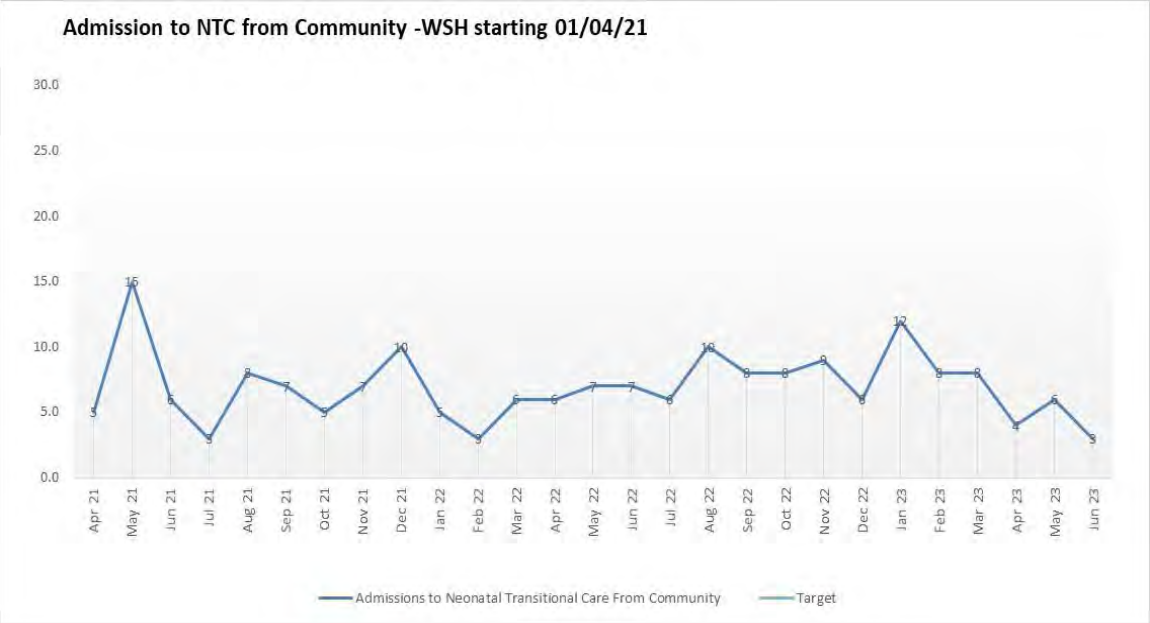
All 8 of these babies met the criteria for admission to NTC.



4d. Summary of details of babies admitted to transitional care from the community setting

Clinical Standards		Criteria met
Criteria for readmission from community met:		
Requiring phototherapy and serum bilirubin monitoring	9/13 babies were re-admitted with neonatal jaundice. Some of these babies had associated weight loss.	Yes
Weight loss /poor feeding	4/13 babies were readmitted due to problems with feeding and associated weight loss.	Yes

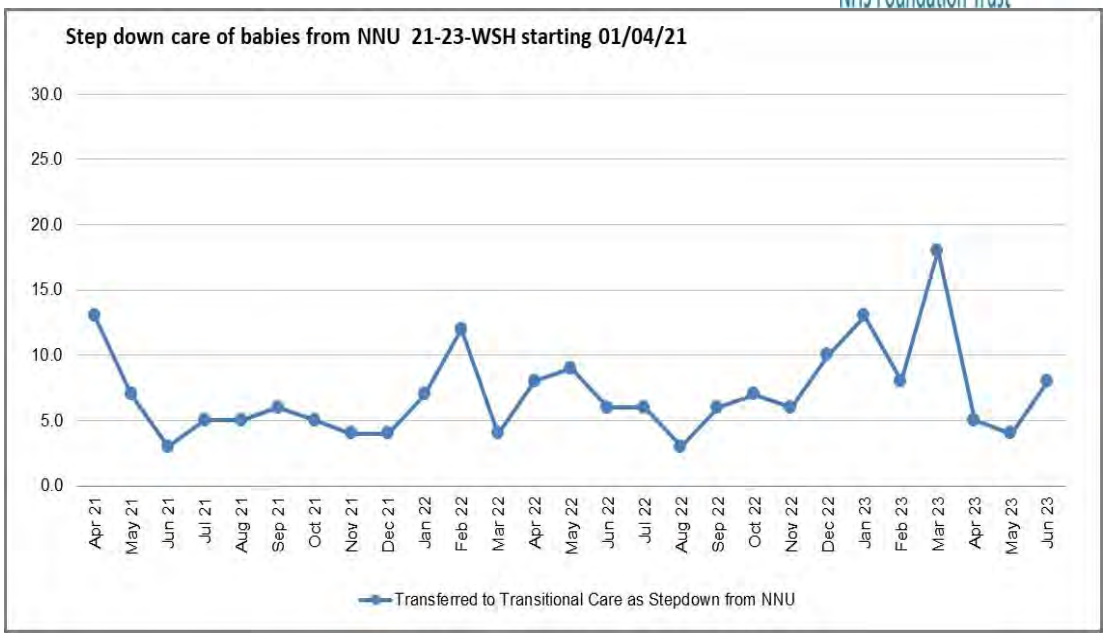
All these babies met the criteria for NTC. One baby was readmitted the day after being discharged with a 12.7% weight loss and poor feeding. This was noted by the junior nursing staff but the importance of this was missed by the medical profession advising the discharge. This Datix was raised and implementation of a thorough discharge process in cases of weight loss was devised.



4e. Summary of details of babies admitted to transitional care following stepdown of care from the NNU

Clinical Standards		Criteria met
Criteria for step down from NNU:		
Corrected gestational age > 33+0 and clinically stable.	17/17 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	17/17 babies were all on an observation frequency of at least 3 hourly intervals	Yes
Stable baby with sepsis requiring antibiotics	17/17 babies were continuing IV antibiotic treatment.	Yes

All 17 babies met the criteria for step down of their care to NTC from NNU. Continuing a course of antibiotics and being monitored for a longer period of time in NTC allowing mother and baby to be together.



4f. Operational Standards

Audit of Operational Standards for staffing		
Operational Standards – Midwifery staffing of NTC		**Criteria met**
Midwife from F11 is allocated to care for women whose baby is in NTC 24/7	A midwife is allocated to oversee postnatal care of women in the NTC bay and works alongside the NNU staff to undertake joint care	Yes
Operational Standards – NNU staffing of NTC		
A NNU nurse or nursery nurse is allocated to care for the babies in NTC 24/7	A NNU nursery nurse is allocated to provide the care to babies having NTC on F11 and in the NNU's siderooms working alongside the midwife and the shift leader for NNU.	Yes
Operational Standards – Neonatal medical staffing		
A daily review of all babies having NTC is conducted by the consultant paediatrician or the paediatric registrar allocated to NNU	A paediatric ward round led by a consultant paediatrician or a paediatric registrar is undertaken daily for all babies having NTC care on the postnatal ward or NNU. This is recorded on the baby's records on e-care.	Yes

Required Standard		
Pathways of care into TC have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are	There is evidence of neonatal involvement in care planning	Yes
	Admission criteria meets a minimum of at least one element of HRG XA04	Yes

involved in decision making and planning care for all babies in TC	There is an explicit staffing model	
	The policy is signed by maternity/ neonatal clinical leads and should have auditable standards	Yes
	The policy has been fully implemented and quarterly audits of compliance with the policy are conducted.	In progress
Drawing on the insights from the data recording undertaken in the Year 4 scheme, which included babies between 34 and 36+6, Trusts should have or be working towards implementing a TC pathway in alignment with the BAPM Transitional Care Framework for Practice for both late preterm and term babies. There should be a clear, agreed timescale for implementing this pathway	Guideline for admission to TC to include babies 34+0 and above and data to evidence this is occurring	**In progress- awaiting guideline to be signed off at Paediatric Governance**

4g. Kaiser® Permanente Sepsis Risk Calculator

The Kaiser Permanente Sepsis Risk calculator assesses the risk of early onset sepsis using maternal risk factors and the infant's clinical state after birth and has been shown to reduce antibiotic initiation in newborn infants by 50% without missing cases of true sepsis. All babies symptomatic of sepsis must be investigated, and treated promptly with antibiotics within an hour of decision to treat, irrespective of their sepsis risk score. Kaiser Permanente sepsis calculator should be applied up to 1 hour of age. Infants who present after this period or where further information regarding risk of sepsis is identified should receive a full clinical examination, review and plan of care.

EoE guidelines on use of the Kaiser audit are similar but are still following a more cautious approach of treating with antibiotics when only a blood culture is recommended. Use of the Kaiser calculator has been implemented in maternity/neonatal services at WSH since December 2022, with an e-care risk assessment completed by midwives which triggers their referral to neonatal team for Kaiser risk calculation and clinical assessment to determine management. The babies are allocated as a 'blue teddy' baby.

For this quarter the babies that had had the Kaiser Sepsis Calculator were identified through the Neonatal Admission book and further information about the care and if antibiotics were required, were extracted from Badgernet and E- care.

Clinical Standards		**Criteria met**
Criteria for Kaiser Permanente Neonatal Calculator:		
The Kaiser Permanente neonatal sepsis calculator can be used for babies born after 34+0 weeks of	18-total number of babies assessed using the calculator	Yes

pregnancy who are being cared for in a neonatal unit, transitional care or postnatal ward	0- number of babies correctly identified by the calculator who develop a culture-confirmed neonatal infection 0- number of babies incorrectly identified by the calculator who do not develop a culture-confirmed neonatal infection 0- number of babies missed by the calculator who develop a culture-confirmed neonatal infection 5- number of babies that were commenced on the Kaiser calcuator but required a septic screen and IV antibiotics	
Whilst reviewing data, to also assess for and highlight any difficulties/barriers that have arisen during implementation of the calculator, to identify areas for improvement.	One calculation was done out of the 1hour window. One of the 17 babies was classed as a Blue Teddy and commenced on Kaiser observations but then converted to the amber pathway	

Conclusions

The number of babies receiving care under the NTC pathway has significantly decreased in this quarter compared to the last quarter. All babies but one met the criteria. The reason that this baby did not meet the criteria was the gestational age. The baby was born at 34+6 and the current admission criteria regarding gestational age states **more than** 34+6. This is however changing when the updated guideline comes into place with the criteria for NTC being from 34 weeks of gestation, in accordance with the BAPM framework for Transitional Care. The majority of admissions were from the delivery setting. The next most common reason for admission was babies needing Kaiser observations and closely followed by babies who stepdown from the NNU. These babies need the continuation of a course of antibiotics and monitoring post respiratory support.

The ongoing monitoring of admissions to NTC show that the multidisciplinary team is working together to avoid separation of the mother and baby.

WSH has a proactive approach to transferring babies to NTC as soon as possible once a clinical review has been undertaken.

The Kaiser calculation is still a very new approach and some improvements are required. This was highlighted in the audit completed for this quarter. After the last report, it was communicated that all babies admitted to TC for Kaiser observations still need to be documented in the admission book and also on Badgernet. It seems that this has been taken on board. A report is being sent by the information team with a list of all the babies that are assigned a 'Blue teddy' pathway status for Kaiser

observations. This will help in capturing all the babies that were started on the Kaiser calculation.

Next steps

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

Work on introducing NEWTT 2 assessment and wellbeing observations into practice is being planned for when the electronic versions of observation charts are available on the information system in the Trust. A gap analysis has been carried out and changes to the current system will be discussed with the IT team.

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. July 2023

https://neonatalsepsiscalculator.kaiserpermanente.org

Appendix 1 Opportunities for Learning and Sharing

Title	**Quarter 1 Audit of the Operational Pathway of care into Neonatal Transitional Care**

Action plan lead	Name: Karen Green	Title: Quality & Governance Matron	Contact: 3275

	Learning Opportunity	Actions required	Action by date	Person responsible	Comments/action status	Status of Action
1.	Share findings of the audit with all staff.	Risky Business publication	August 2023	Rebecca Warburton	Due Sep 23	
		Maternity Quality & Safety meeting	18/9/23	Karen Green	Completed	
2	Audit findings shared with the Maternity and Neonatal Safety Champions,	Shared audit findings at the MNSC meeting	26/9/23	Karen Newbury HOM	Due 26/09/23	
4	Local Maternity and Neonatal System and (LMNS),	Share findings and learning opportunities at the LMNS meeting.	9/23	Karen Newbury HOM	Due Oct 23	
4.	Quality Surveillance meeting and Trust Board.	Share findings at Trust Board	29/9/23	Karen Newbury HOM	Due 29/09/23	

Appendix 2 CNST Maternity Incentive Scheme (2023) Safety Action 3

NHS Resolution has completed its fourth year of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme with evidence being submitted in February 2023 to continue to support the delivery of safer maternity care and provide evidence of this. In May, NHS Resolution has published the Maternity Incentive Scheme year five and Neonatal Transitional Care is included in Safety action 3: **Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units.**

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 transitional care (TC) have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.

B. A robust process is in place which demonstrates a joint maternity and neonatal approach to auditing all admissions to the NNU of babies equal to or greater than 37 weeks. The focus of the review is to identify whether separation could have been avoided. An action plan to address findings is shared with the quadrumvirate (clinical directors for neonatology and obstetrics, Director, or Head of Midwifery (DoM/HoM) and operational lead) as well as the Trust Board, LMNS and ICB.

C. Drawing on the insights from the data recording undertaken in the Year 4 scheme, which included babies between 34+0 and 36+6, Trusts should have or be working towards implementing a transitional care pathway in alignment with the BAPM Transitional Care Framework for Practice for both late preterm and term babies. There should be a clear, agreed timescale for implementing this pathway.

For the purposes of this report, only A &C have been addressed.

Evidence for standard a) to include: Local policy/pathway available which is based on principles of British Association of Perinatal Medicine (BAPM) transitional care where: • There is evidence of neonatal involvement in care planning • Admission criteria meets

a minimum of at least one element of HRG XA04 • There is an explicit staffing model • The policy is signed by maternity/neonatal clinical leads and should have auditable standards. • The policy has been fully implemented and quarterly audits of compliance with the policy are conducted.

Evidence for standard c) to include: Guideline for admission to TC to include babies 34+0 and above and data to evidence this is occurring OR An action plan signed off by the Trust Board for a move towards a transitional care pathway for babies from 34+0 with clear time scales for full implementation.

5.1 Governance Report Annexes

ANNEX A: Policy on Engagement (FOR APPROVAL)

The Code of Governance for NHS provider trusts states that foundation trusts should have a policy for engagement between the Board of Directors and the Council of Governors, which clearly sets out how the two bodies will interact for the benefit of the Trust.

Our Board of Directors and Council of Governors are committed to building and maintaining an open and constructive working relationship. In order to achieve this, there needs to be clarity in relation to the respective roles and responsibilities of each which promotes a shared understanding. This policy aims to clarify the respective roles and responsibilities of our Board of Directors and our Council of Governors, and describes the information flow between the two groups.

The policy describes the involvement of governors in forward planning, through which they represent the views of local people, and the role they play in holding the Board of Directors to account.

This policy also sets out a process that will be followed should the governors have a concern about the performance of the Board of Directors, compliance with the provider license or the performance of the organisation.

It also describes the process should the Council of Governors have significant concerns about the performance of the Chair or any of the Non-Executive Directors.

This policy is intended to provide clear guidance and a useful framework for both our Board of Directors and our Council of Governors and has been approved by each respectively. The policy covers a range of important areas including:

- Relationship between the Trust Board and the Council of Governors
- Handling of concerns
- Powers and duties, roles and responsibilities of the Trust Board and the Council of Governors
- Role of the Senior Independent Director
- Grounds and procedure for the removal of the Chair or a Non-Executive Director
- Dispute Resolution Procedure.

The purpose of this policy is therefore to:

- Set out the systems and structures to promote a constructive working relationship between the Council of Governors and the Board of Directors
- Set out a process for dealing with problems that may arise, as recommended by the NHS England's Code of Governance.

Trust policy and procedure **Document reference no: PP() 481**

Policy for Engagement between the Trust Board and the Council of Governors

For use in:	All areas of the Trust
For use by:	Board of Directors and Council of Governors
Prepared by:	Trust Secretary & Head of Governance
For use for:	To outline the commitment by the Board of Directors and Council of Governors to develop engagement and two-way communication to carry out their respective roles effectively
Document owner:	Trust Secretary& Head of Governance
Status:	Active (after approval)

Author(s)	Trust Secretary & Head of Governance
Contributors	Trust Secretary, Deputy Trust Secretary, Standards committee members and Board members
Approved by	Board of Directors and Council of Governors
Key Contacts	Trust Secretary and Head of Corporate Governance Deputy Trust Secretary Foundation Trust Office Manager Trust Office Manager
Issue no	1

Table of Contents

POLICY FOR ENGAGEMENT BETWEEN THE TRUST BOARD AND THE COUNCIL OF GOVERNORS

1. Introduction

The Trust board is accountable to the community it serves and discharges that responsibility through its relationship with the council of governors. The council of governors represents the community and its major stakeholders, including staff, through elected and nominated members.

The board leads the Trust by undertaking four key roles:

- setting **strategy**
- supervising the work of the executive in the delivery of the strategy and through seeking assurance that **systems of control** are robust and reliable
- setting and leading a positive **culture** for the board and the Trust
- **accountability** to key stakeholders, including the councils of governors.

The statutory general duties of the council of governors are:

- to represent the interests of the members of the Trust as a whole and the interests of the public
- to hold the Non-Executive Directors individually and collectively to account for the performance of the board of directors.

In performing their duties, it should keep in mind that:

- the board of directors manages the Trust and continues to bear ultimate responsibility for strategic planning and performance
- the council must 'promote the success of the Trust so as to maximise the benefits for the members of the Foundation Trust as a whole and for the public'.

The Trust board and council of governors commit to work together constructively, based on openness and transparency, good communication and strong mutual understanding. They respect the different roles of each other, and they have common aim to work in the best interests of the Trust. Examples of the Governors working with the Board include:

- Regular attendance at Trust Board meetings, face to face, where Governors are encouraged to ask questions and report back to all Governors on outcomes of these discussions
- Attending Board meetings and briefings has also educated Governors on key clinical areas and developments, including the Future System programme and the Trust's infection prevention policy
- Working with the NEDs has allowed sharing of information to triangulate areas for further consideration and/or improvement
- Regular briefings have taken place focused on key developments within the operational plan and topics
- Contribution to the appraisals of all NEDs and requesting assurance on areas of concern
- Governors appointed the Chair and NEDs
- Governors attendance at the three assurance committees of the Board as observers (the insight, involvement and improvement committees). This provides insight to the working of the Trust and supports the Governors in their role

- Learning and development which include joint sessions with NEDs held face to face and virtually through MS Teams
- An externally facilitated review was undertaken by the Good Governance Institute for the Council of Governors during 2022. The findings of this have been used to strengthen working arrangements for the Governors, including how they engage with the Board of Directors
- Governors and NEDs undertake visits to clinical and non-clinical areas of the Trust (acute and community) in line with the national 15 steps challenge approach.

This policy describes the activities developed to support engagement between the two bodies (Appendix D) and through this approach directors and governors' commitment to the ethics standards set out with the Nolan principles (Appendix E).

The Trust board and council of governors are committed to building and maintaining an open and constructive working relationship. Underpinning such a relationship is the need for clarity on the respective roles and responsibilities which are described in this policy.

2. Purpose

2.1 This policy has been created in response to the recommendations contained in the code of governance for provider trusts (2022). Its purpose is to describe the methods by which governors can engage with the board of directors when they have concerns about the Board's performance, the compliance with the provider terms of authorisation or the welfare of the Trust. This includes "Addendum to Your statutory duties – reference guide for NHS foundation trust governors - System working and collaboration: role of foundation trust councils of governors" (27 October 2022).

2.2 The policy outlines the mechanisms by which governors and directors will interact and communicate with each other while taking into account the expanded role of governors, set out in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012 (the Act), including the duty to hold the Non-Executive Directors individually and collectively to account for the performance of the board of directors.

2.3 The policy describes the methods by which governors may engage with the board of directors when they have concerns about the performance of the Board of Directors, compliance with the provider licence or the welfare of the Trust.

2.4 The policy provides details of the panel set up by NHS England for supporting governors of foundation trusts in their role and to whom governors may refer a question as to whether we have failed or is failing to act in accordance with the Constitution.

3. Relationship between the Trust Board and the Council of Governors

3.1 Powers and duties, roles and responsibilities

3.1.1 The respective powers and roles of the Trust board and the council of governors are set out in their Standing Orders and the Trust Constitution.

3.1.2 The Trust board and the council of governors should understand their respective roles and seek to follow them in practice. Any concerns or queries should be raised with the Chair, trust secretary or Lead Governor.

3.1.3 The Trust will provide induction and ongoing training regarding roles and responsibilities.

3.2 Trust Board and Council of Governors

3.2.1 In order to facilitate communication between the Trust board and council of governors, governors can raise questions linked to the agenda at each public Trust board meeting. Governors receive Board meeting papers prior to meeting and are able to attend as observers.

3.2.2 Should a governor raise a question at the Trust board, they will receive a response at the meeting or within in a reasonable time after the meeting.

3.2.3 Governors may, by informing the Chair, request an item to be added to the agenda of the council of governors for discussion.

3.2.4 Governors will have the opportunity to raise questions about the affairs of the Trust with any director present at a meeting of the council of governors. Wherever possible, questions should be submitted to the Chair in advance of the meeting, to enable a reasonable time to be allocated during the meeting. Where this is not possible, a response will either be provided at the meeting or within a reasonable time after the meeting.

3.2.5 Whilst a confidential part of board of director meetings will be held in private the agenda and approved minutes from these meetings will be made available for governors. The public Trust board papers will be shared with governors electronically and are also available from the Trust website prior to the meeting.

3.3 Role of the Chair

3.3.1 The Chair is responsible for leadership of the Trust board and the council of governors, ensuring their effectiveness on all aspects of the role and setting their agenda. The Chair is responsible for ensuring that both work together effectively, and that they receive the information they require to carry out their duties.

3.3.2 In the Chair's absence meetings of the council of governors will be chaired by the deputy Chair of the Trust board.

3.3.3 The Chair will ensure that the views of governors and members are communicated to the Trust Board and that the council of governors is informed of key Trust Board decisions.

3.3.4 The Chair will meet with the Lead and Deputy Lead Governors regular and will have meetings with individual governors as reasonably requested.

3.5 Role of Non-Executive Directors and the Senior Independent Director

3.5.1 Non-Executive Directors will be invited to attend meetings of the council of governors, make presentations and answer questions as appropriate.

3.5.2 Non-Executive Directors will commit time to build effective relationships with governors. In addition, governors and Non-Executive Directors will agree to spend time together to understand each others' perspectives and build mutual understanding.

3.5.3 The Senior Independent Director will be available to the council of governors and individual governors if they have concerns which contact through the normal channels via the Chair have failed to resolve or for which such contact is inappropriate. The Senior Independent Director should attend sufficient meetings of the council of governors to listen to their views to help develop a balanced understanding of the issues and concerns of the governors and members.

3.5.4 The role of the Chair and Senior Independent Director is set out in Appendix A.

3.5.5 The process to be followed in dealing with concerns is set out in Section 4.

3.6 Role of Executive Directors

3.6.1 Executive Directors (including the chief executive or deputy/representative) will be invited to attend council of governors' meetings and be asked to contribute to discussions and respond to questions if appropriate.

3.7 Role of the Governors

3.7.1 Governors are required to meet the statutory duties as set out by NHS England, including:

- Hold the non-executive directors, individually and collectively, to account for the performance of the board of directors
- Represent the interests of the members of the Trust as a whole and the interests of the public
- Approve "significant transactions" as defined in the Trust's constitution
- Approve an application by the Trust to enter into a merger, acquisition, separation or dissolution
- Decide whether the Trust's non-NHS work would significantly interfere with its principal purpose, which is to provide goods and services for the health service in England, or performing its other functions
- Approve amendments to the Trust's constitution.

3.7.2 The council of governors may require one or more of the directors to attend a governors' meeting to obtain information about performance of the Trust's functions or the directors' performance of their duties, and to help the council of governors to decide whether to propose a vote on the Trust's or directors' performance.

3.7.3 When the Trust board is engaged in strategic planning (e.g. annual planning, strategic direction) governors will be involved in the process so that the views of members can be properly canvassed and fed into the process.

3.8 Role of the Lead Governor and Deputy Lead Governor of the Council of Governors

3.8.1 The council of governors will maintain a role description for the Lead Governor.

3.8.2 Deputy Lead Governor:

3.8.2.1 The council of governors may also elect a deputy Lead Governor from among the governors. The deputy Lead Governor will deputise in the absence of the Lead Governor and will support the Lead Governor as required.

3.8.2.2 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.

3.9 Role of the Trust Secretary

3.9.1 The trust secretary (and Deputy Trust Secretary) supports the administration of corporate governance. In particular, the trust secretary would normally be expected to:

- ensure good information flows to the board of directors and its committees and between senior management, non-executive directors and the governors where relevant
- ensure that procedures of both the board of directors and the council of governors are complied with
- advise the board of directors and the council of governors (through the chair) on all governance matters
- be available to give advice and support to individual directors, particularly in relation to supporting board members and governors in understanding their duties.

3.10 Accountability

3.10.1 The council of governors has a role to hold the Non-Executive Directors individually and collectively to account for the performance of the Trust Board, including ensuring the Trust Board acts so that the Trust does not breach its licence. The council of governors will be provided with high quality information that is relevant in order to carry out their statutory and general duties. The Trust is expected to ensure that the council of governors is provided with appropriate information, and that the governors are given opportunities to meet the board to raise questions about the trust's role within the system, or systems, of which it is part. The information needs of the council of governors will be discussed as part of the induction process and subject to ongoing review, and the governors will be consulted in the forward plan for agendas of council of governors' meetings.

3.10.2 The Foundation Trust Code of Governance provides that the Trust Board will notify the council of governors of any major new developments or changes to the Trust's financial condition, performance of its business or expectations as to its performance, that if made public would be likely to lead to a substantial change to the financial well-being, healthcare delivery performance or reputational standing of the Trust.

3.10.3 The Health & Social Care Act 2022 places a mandatory duty on the board of directors to consult with and seek the agreement of the council of governors on 'significant transactions' including mergers, acquisition, dissolution, separation, raising additional services from activities other than via its principal purpose and raising the threshold of funds raised from private patients as outlined in the Trust's Constitution.

3.10.4 The council of governors have the powers to call an executive director to the council of governors for the purpose of obtaining information about the trust's performance of its functions or the director's performance of their duties.

4. Handling of Concerns

4.1 A concern, in the meaning of this policy, must be directly related to either:

- The performance of the Trust Board, or
- Compliance with the licence, or
- The welfare of the Foundation Trust

Other matters that do not constitute a concern can be raised with the Chair to be discussed at the appropriate forum (see para 3.2.2-3.2.4).

4.2 In the event that the council of governors has a concern of the type described above, every attempt should be made to resolve the matter informally.

4.3 A detailed description of the process for handling concerns are described in Appendix B – informal (stage 1) and formal (stage 2).

4.4 Action in event of Stage 2 failing to achieve resolution:

4.4.1 If the council of governors does not consider that the matter has been adequately resolved, they have four options:

- Accept the failure to reach a resolution of the matter and consider the matter closed; or
- Seek the intervention of another independent mediator (i.e. a Chair or Senior Independent Director from another NHS Foundation Trust) in order to seek resolution of the matter, or
- Inform NHS England if the Trust is at risk of breaching its licence, or
- Follow the Dispute Resolution Procedure (as outlined at Appendix B - Annex A).

4.5 Removal of the Chair or any Non-Executive Director

4.5.1 In relation to concerns raised in accordance with this policy, the council of governors should only exercise its power to remove the Chair or any Non-Executive Directors after exhausting all other means of engagement with the Trust Board.

4.5.2 The procedure for removing the Chair or a non-executive director is set out in Appendix C.

5. Distribution

This policy document will be made available via intranet and Trust's public website.

6. Monitoring compliance and effectiveness

This policy will be kept under review, compared with the provisions developed by other Foundation Trusts and revised in accordance with emerging best practice and guidance from NHS England.

Appendix A: Role of the Chair and Senior Independent Director

Chair
In their role as governance lead for the board and for the council of governors the Chair is responsible for:

- making sure the board/council operates effectively and understands its own accountability and compliance with its approved procedures – for example, meeting statutory duties relating to annual reporting
- personally, doing the right thing, ethically and in line with the NHS values, demonstrating this to and expecting the same behaviour from the board
- leading the board in establishing effective and ethical decision-making processes
- setting an integrated board/council agenda relevant to the Trust's current operating environment and taking full account of the important strategic issues and key risks it faces and where relevant aligned with the annual planner for council of governors' meetings, developed with the Lead Governor
- ensuring that the board/council receives accurate, high quality, timely and clear information, that the related assurance systems are fit for purpose and that there is a good flow of information between the board, its committees, the council and senior management
- ensuring board committees are properly constituted and effective
- leading the board in being accountable to governors and leading the council in holding the board to account.

In their role as facilitator of the board and the council of governors the Chair is responsible for:

- providing the environment for agile debate that considers the big picture
- ensuring the board/council collectively and individually applies sufficient challenge, balancing the ability to seize opportunities while retaining robust and transparent decision-making
- facilitating the effective contribution of all members of the board/council, drawing on their individual skills, experience, and knowledge and in the case of Non-Executive Directors, their independence
- working with and supporting the Trust board secretary in establishing and maintaining the board's annual cycle of business
- liaising with and consulting the Senior Independent Director

Senior Independent Director
The Senior Independent Director (SID) will be a non-executive director of the Trust board appointed by the board of directors to provide an alternative to the Chair as source of advice to the governors. The SID will share the general duties of Non-Executive Directors, and in respect of these duties will be subject to the normal reporting relationships of Non-Executive Directors.

The SID's role will be

(a) To be available to Governors if they have concerns which have not or cannot be resolved through contact with the Chair, the chief executive or the director of resources or for which such contact is inappropriate.

- This will involve providing Governors with a convenient means of making contact with the SID, and an obligation on the SID to respond to such contacts and to meet privately with Members or governors if appropriate.

(b) To attend sufficient meetings with governors to hear their views and develop a balanced understanding of their issues and concerns.

- This should normally be accomplished by attending ordinary meetings of the council of governors.

(c) To ensure that the issues and concerns of governors are communicated to the other Non-Executive Directors and, where appropriate, the board as a whole.

- The responsibility for communicating the issues and concerns of governors does not rest specifically with the SID. The role of the SID is to monitor the effectiveness of such communications and take action if necessary.

(d) To provide a sounding board for the Chair and serve as an intermediary for the other directors when necessary.

(e) To facilitate and oversee the performance evaluation of the Chair, and to report on this to the council of governors.

- Led by the SID, the Non-Executive Directors should meet without the Chair present at least annually to appraise the Chair's performance, and on other occasions as necessary, and seek input from other key stakeholders.

- Lead the annual evaluation process in consultation with the Non-Executive Directors, governors and others as appropriate.

Appendix B: Handling of Concerns

This appendix describes in detail the arrangements for handling concerns.

1. Stage 1 – Informal

1.1 In the event that the council of governors has a concern of the type described above, every attempt should be made to resolve the matter firstly by discussion with the Chair. Where it affects financial matters, the audit committee Chair and/or director of resources should be involved. The Lead Governor should normally represent the council of governors in these matters, and they will consider whether additional representation is required.

12 Every attempt should be made to resolve concerns in an appropriate way, and as quickly as possible. This may involve the Chair convening a meeting with governors, and/or requesting reports from the chief executive or another director or officer of the trust, or a report from the audit committee or other committee and providing comments on any proposed remedial action.

1.3 The outcome of the matter will be reported to the next formal meeting of the council of governors, who will consider whether the matter has been resolved satisfactorily.

2. Stage 2 – Formal

2.1 This is the formal stage where stage 1 has failed to produce a resolution and the services of an independent person are required. In this case the Senior Independent Director assumes the role of mediator, as recommended by the Code of Governance, and conducts an investigation. Should SID be unavailable or be prevented from participating because of a conflict of interests, the council of governors may choose any other non-executive director to fulfil the role.

2.2 The decision to proceed to Stage 2 and beyond will always be considered by the full council of governors, at an extraordinary, private meeting. This is to ensure that any decision is a collective council of governors' decision. The decision to proceed to Stage 2 must be collectively agreed by a majority of the council of governors present at a meeting which is quorate. In the event that the council of governors does not agree to proceed to Stage 2, that decision is final.

2.3 Evidence requirements

Any concern should be supported by relevant evidence. It cannot be based on hearsay alone, and should meet the following criteria:

- Any written statement must be from an identifiable person(s) who must sign the statement and be willing to be interviewed under either stage of this process.
- Other documentation must originate from a bona fide organisation and the source must be clearly identifiable. Newspaper articles will not be accepted as prima facie evidence but may be admitted as supporting evidence.
- Where the concern includes hearsay, e.g. media reports, the council of governors may require the Trust Board to provide explanations and, if necessary, evidence to show that the hearsay reports are untrue.

2.4 Investigation and decision of the Senior Independent Director.

2.4.1 The Senior Independent Director's role is to seek to resolve the matter in the best interests of the Trust.

2.4.2 The Senior Independent Director will produce a written report of their findings and recommendations and present it to the council of governors and board. The report will address the issues raised by the council of governors, and will also consider whether action is required to repair any breakdown in the relationship between the Trust board and the council of governors.

2.4.3 The decision of the Senior Independent Director will be final in resolving the matter in the best interests of the Trust.

2.4.4 In the event that the council of governors' remain dissatisfied with the Senior Independent Director's decision, the options in paragraph 4.4 of the policy may be considered.

Annex A: Dispute Resolution Procedure

In the event of dispute between the council of governors and the Trust Board, where the above policy has been followed as appropriate through informal (Stage 1) and formal (Stage 2) procedures at outlined at 4.2 and 4.3, the dispute resolution procedure can be considered as a further option should Stage 2 procedures fail to achieve a resolution:

1. In the first instance the Chair on the advice of the Trust Secretary, and such other advice as the Chair may see fit to obtain, shall seek to resolve the dispute.

2. If the Chair is unable to resolve the dispute, the Chair shall appoint a special committee comprising equal numbers of directors and governors to consider the circumstances and to make recommendations to the council of governors and the board of directors with a view to resolving the dispute.

3. If the recommendations (if any) of the special committee are unsuccessful in resolving the dispute, the Chair may refer the dispute back to the Trust board who shall make the final decision.

Appendix C: Grounds and Procedure for the Removal of the Chair or any Non- Executive Director

Introduction

The council of governors has the power to remove the Chair and any non-executive director of the Trust. Such removal must occur at a general meeting of the council of governors and requires the approval of three quarters of the members of the council of governors.

In relation to concerns raised under the Policy for Engagement, the council of governors should only exercise its power to remove a non-executive director after exhausting all other means of engagement with the Trust board, as set out in that policy.

Grounds for removal

The removal of a Non-Executive Director should be based on the following criteria. Grounds for removal can include the following:

- a person who has been made bankrupt or whose estate has been sequestrated and (in either case) has not been discharged.
- 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.
- 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.
- a person who no longer satisfies paragraph 25.1 or 25.2 (if applicable).
- a person who is a member of the Council of Governors
- 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.
- 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.
- 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.
- A person is subject of a disqualification order made under the Company Directors Disqualification Act 1986.
- A person who is the subject of an order under the Sexual Offences Act 2003
- A person who is included in any barred list established under the Safeguarding Vulnerable Groups Act 2006
- A person who has 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.
- 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.
- 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.

- 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).

The following list provides examples of matters which may indicate to the council of governors that it is no longer in the interests of the Trust that a non-executive director continues in office. The list is not intended to be exhaustive or definitive; the council of governors will consider each case on its merits, taking account of all relevant factors.

a) If an annual appraisal or sequence of appraisals is unsatisfactory
b) If the non-executive director loses the confidence of the Trust board
c) If the non-executive director loses the confidence of the public or local community in a substantial way
d) If the non-executive director fails to monitor the performance of the Trust in an effective way
e) If the non-executive director fails to deliver work against pre-agreed targets incorporated within their annual objectives
f) If there is a terminal breakdown in essential relationships, e.g., between a Chair and a chief executive or between a non-executive director and the Chair or the rest of the Trust Board.

Procedure

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.

Removal of the Chair or another non-executive director shall require the approval of three-quarters of the members of the council of governors.

Every matter 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.

The Chair should also consider, however, whether in particular circumstances a conflict of interest arises in dealing with the removal of a non-executive director, and if so, stand aside for that part of the meeting.

For the removal of the Chair, the Deputy Chair/Senior Independent Director will preside at meetings of the council of governors.

Removal and disqualification of governors

The process for the removal and disqualification of governors will be maintained by the Trust.

Appendix D: Guidance for informal Council of Governors & Council of Governors and Non-Executive Director meetings

Informal CoG meetings

- These are meetings which only governors attend
- The meetings are structured to have an informal session to allow time for the governors to interact and discuss issues
- The meeting is facilitated by the Lead Governor
- These meetings are held quarterly with no formal agenda
- Governors discuss and gain consensus on general concerns that they would like to better understand
- These topics can be informed by a number of activities, for example feedback from patients or staff, e.g. Courtyard Café and 15-steps challenge or from information received by the governors e.g. Board or CoG papers
- No formal minute of the meeting is taken but a governor(s) is identified to capture the outcome of the discussion so that there is written consensus in the room on the outcome e.g. using flipchart
- Following the meeting, the Lead Governor shares a summary with council of governors and the Foundation Trust Office.

Informal CoG and NEDs meetings

- These meetings provide an opportunity for informal discussion and engagement between governors and Non-Executive Directors, they are important in team and relationship building
- These meetings are not used for holding Non-Executive Directors to account, this takes place in the CoG meetings where governor's hold Non-Executive Directors to account for the performance of the board
- The meetings are facilitated by the Lead Governor
- These meetings are held quarterly with no formal agenda
- The meetings are an opportunity to discuss general concerns, including topics for which Governors would like to develop a better understanding
- These topics are usually considered at the informal governors meetings in advance
- There is an opportunity to triangulate the engagement findings of the governors with the views of the Non-Executive Directors. Through this collaboration between governors and Non-Executive Directors topics for further review and testing outside the meeting may be identified
- No formal minute of the meeting is taken but the Lead Governor with inputs from the Trust Chair includes a short summary in their report to the CoG meeting

Appendix E: The Nolan Principles - The Seven Principles of Public Life

Selflessness
Holders of public office should take decisions solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends.

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.

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 choices on merit.

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.

Openness
Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

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.

Leadership
Holders of public office should promote and support these principles by leadership and example.

Annex B: Scheduled draft agenda items for next meeting – 1 December 2023

Description	Open		Closed	Type	Source	Director
Declaration of interests	✓		✓	Verbal	Matrix	All
General Business						
Patient/staff story - staff experience of the emerging incident review process	✓		✓	Verbal	Matrix	Exec.
Chief Executive's report	✓			Written	Matrix	EC
Culture						
Organisational development plan	✓			Written	Matrix	JMO
Strategy						
Future System Board Report	✓			Written	Matrix	CB
System update: - West Suffolk Alliance and SNEE Integrated Care Board - Wider system collaboration	✓			Written	Matrix	 PW / CM All execs
Digital Programme Board Report	✓			Written	Matrix	CB
Strategic priorities – plans for future monitoring	✓			Written	Action	CEO
Assurance						
Insight Committee Report - Finance report	✓			Written	Matrix	AJ / NC / SW
Involvement Committee Report - People and OD Highlight Report o Putting you First award o Staff recommender scores o appraisal performance, including consultants (quarterly) - Safe staffing guardian and FTSU reports - National patient and staff survey and recommender responses	✓			Written	Matrix	TD / JMO
Improvement Committee Report - Maternity services quality and performance report - Nurse staffing report - Quality and learning report, including learning from deaths and quality priorities 2023-24 - Report from Lucy Winstanley, Head of Patient Safety	✓			Written	Matrix	LP / SW / PM
Audit committee CKI report	✓			Written	Matrix	MP
Serious Incident, inquests, complaints and claims report			✓	Written	Matrix	SW

Governance						
Governance report, including - Board workshop report - Remuneration committee report - Senior Leadership Team report - Council of Governors meeting report - Code of Governance - Annual reports from specialist areas - Use of Trust's seal - Agenda items for next meeting	✓			Written	Matrix	RJ
Confidential staffing matters			✓	Written	Matrix – by exception	JMO
Board assurance framework report	✓			Written	Matrix	RJ
Reflections on the meetings (open and closed meetings)	✓		✓	Verbal	Matrix	JC
Annexes to Board pack: - Integrated quality & performance report (IQPR) – annex to Board pack - Others as required						