Board of Directors (In Public)

Schedule	Friday 22 March 2024, 9:15 AM — 1:30 PM GMT
Venue	Conference Room, Mildenhall Hub, Sheldrick Way, Mildenhall. IP28 7JX
Description	A meeting of the Board of Directors will take place on Friday 22 March, 2024 at 9:15am.
Organiser	Ruth Williamson

Agenda

AGENDA

_WSFT Public Board Agenda - 22 March 2024 - Final.docx

1. GENERAL BUSINESS

9:15 AM — 1.1. Welcome and apologies for absence - Roger Petter, Clement Mawoyo, Nicola Cottington (Matt Keeling deputising)
To Note

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

1.3. Minutes of the previous meeting - 26 January, 2024
To Approve

WSFT Minutes Open Board 26 Jan 2024 - final DRAFT.docx

1.4. Action log and matters arising
To Review

Item 1.4 - Open Action Points - Active.pdf

Item 1.4 - Open Action Points - Complete.pdf

9:20 AM — 1.5. Questions from Governors and the Public relating to items on the agenda

To Note

9:35 AM 1.6. Patient and Staff Story
To Review

9:50 AM 1.7. Chief Executive's report
To inform

Item 1.7 - CEO Board report - March 2024 FINAL.docx

2. STRATEGY

10:00 AM 2.1. Strategic Priorities update report
To Approve

Item 2.1 - Strategic priorities Board March 2024.docx

Item 2.1a - Strategic priorities 2024-25 Board March 2024.pptx

10:25 AM Comfort Break

10:35 AM 2.2. Future System board report
To Assure

Item 2.2 - FS Board Report.docx

10:45 AM 2.3. System Update
To Assure

Item 2.3 - WSA Update report 15 March 2024.doc

2.3.1. Collaborative Oversight Group Report
For Approval

Item 2.3.1 - Cover sheet template 2023 v6_ToR_COG_CEG.docx

Item 2.3.1a - Appendix 1_Collaborative Executive Group Draft ToRs.docx

Item 2.3.1b - Appendix 2_Collaborative Oversight GroupToRs.docx

11:00 AM 2.4. Digital Programme Report

To Assure

Item 2.4 - Trust Board digital report Mar 2024.docx

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3. PEOPLE AND CULTURE

11:10 AM 3.1. National Survey Results
For Discussion

Item 3.1 - Staff Survey slides for BoD March 2024.pptx

11:30 AM 3.2. Involvement Committee report - Chair's Key Issues from the meeting
To Assure

Item 3.2 - Inv CKI 21 Feb 24.doc

11:45 AM COMFORT BREAK

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4. ASSURANCE

11:50 AM 4.1. Insight Committee Report - Chair's Key Issues from the meeting
To Assure

Item 4.1 - INSIGHT CKI report january 2024 FINAL.docx

Item 4.1 - 20240227 INSIGHT CKI report Feb 2024 final.docx

4.1.1. Urgent and Emergency Care Recovery
To inform

Item 4.1.1 - WSFT Public Board Paper - UEC update final Mar 24.docx

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4.2. Finance Report, including 2024/25 budget and capital programme
For Approval

Item 4.2 - Finance Cover - Public Board March 2024.docx

Item 4.2 - M11 Finance Report 2324 FINAL (1).docx

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

To Assure

Item 4.3 - Board assurance committee Feb 24 CKI.docx

4.4. Quality and Nurse Staffing Report
To Assure

Item 4.4 - Nurse Staffing - Jan and Feb board 2024.docx

4.4.1. Maternity Services
Karen Newbury, Kate Croissant & Simon Taylor in attendance
To Approve

Item 4.4.1 - March 2024 Maternity qualtiy safety and performance Board report KN v2.docx

5. GOVERNANCE

1:00 PM 5.1. Board Assurance Framework
To Approve

Item 5.1 - BAF report March 24-Board.docx
Item 5.1 - Annex A Finance BAF 7 2024 03 Mar.docx
Item 5.1 - Annex B WSFT - Risk Appetite Statement Draft v2.docx
Item 5.1 - Annex C Strategic risk review process.docx

1:15 PM 5.2. Governance Report
For Approval

Item 5.2 - Governance report.docx
Item 5.2 - Annex A Modern-slavery-statement 2024.docx
Item 5.2 - Annex B Board development forward plan Mar 2024.docx
Item 5.2 - Annex C Draft Board meeting agenda.docx

1:25 PM 6. OTHER ITEMS

6.1. Any other business
To Note

6.2. Reflections on meeting
For Discussion

6.3. Date of next meeting - 24 May, 2024
To Note

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

SUPPORTING ANNEXES

4.2 IQPR Full Report / Finance Report

Item 4.2 -IQPR Board Report January 2024 (002).pptx

4.4.1 - Maternity

Item 4.4.1a - 60 steps summary Board report BG after SW comments_.docx

Item 4.4.1b - CQCMaternity Survey 2023 Results for WSFT.pptx

5.2 - Governance

Item 5.2 - Audit Committee Terms of Reference 2023-24 Dec 2023.docx

Item 5.2 - Improvement Committee Terms of Reference Jan 2024.docx

Item 5.2 - Insight Committee Terms of Reference March 2024.docx

Item 5.2 - Involvement Committee Terms of Reference Dec23.docx

AGENDA

WSFT Board of Directors – Public Meeting

Date and Time	Friday, 22 March 2024 9:15 – 13:30
Venue	Conference Room, Mildenhall Hub, Sheldrick Way, Mildenhall. IP28 7JX

Time	Item	Subject	Lead	Purpose	Format
1.0 GENERAL BUSINESS					
09.15	1.1	**Welcome and apologies for absence** – Roger Petter, Clement Mawoyo, Nicola Cottington, (Matt Keeling deputising)	Chair	Note	Verbal
	1.2	**Declarations of Interests**	All	Assure	Verbal
	1.3	**Minutes of meeting** – 26 January 2024	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 or Staff Story** To hear a staff story about the experience of the Patient Safety Incident Response Framework (PSIRF)	Chief Nurse	Review	Verbal
10.00	1.7	**CEO report**	Chief Executive	Inform	Report
2.0 STRATEGY					
10:10	2.1	**Strategic priorities update report**	Chief Executive	Approve	Report
10:25 Comfort Break					
10:35	2.2	**Future system board report**	Director of Resources	Assure	Report
10:45	2.3	**System update**	West Suffolk Alliance Director and Director of Integrated Adult Health and Social Care	Assure	Report

Time	Item	Subject	Lead	Purpose	Format
	2.3.1	Collaborative oversight group report	Deputy COO	To inform	Report
11:00	2.4	**Digital programme board report**	Director of Resources	Assure	Report
3.0 PEOPLE AND CULTURE					
11.10	3.1	**National staff survey Results**	Director HR and comms	Discuss	Report
11.30	3.2	**Involvement Committee report** Chair's key issues from meeting	NED Chair	Assure	Report
11:45 Comfort Break					
4.0 ASSURANCE					
11:50	4.1 4.1.1	**Insight committee report** – Chair's key issues from the meetings Urgent and Emergency Care Recovery	NED Chair Deputy COO	Assure	Report
	4.2	**Finance report, including 2024/25 budget and capital programme**	Director of Resources	Assure	Report
12:30	4.3	**Improvement committee report** – Chair's key issues from the meetings	NED Chair	Assure	Report
	4.4	**Quality and nurse staffing report**	Chief Nurse	Assure	Report
	4.4.1	**Maternity services report**	Chief Nurse Karen Newbury Kate Croissant Simon Taylor	Approval	Report
5.0 GOVERNANCE					
13:00	5.1	**Board assurance framework**	Trust Secretary	Assure	Report
13:15	5.2	**Governance Report**	Trust Secretary	Approval	Report
6.0 OTHER ITEMS					
13.25	6.1	**Any Other Business**	All	Note	Verbal
	6.2	**Reflections on meeting**	All	Discuss	Verbal
	6.3	**Date of next meeting** 24 May 2024	Chair	Note	Verbal

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

Supporting Annexes

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

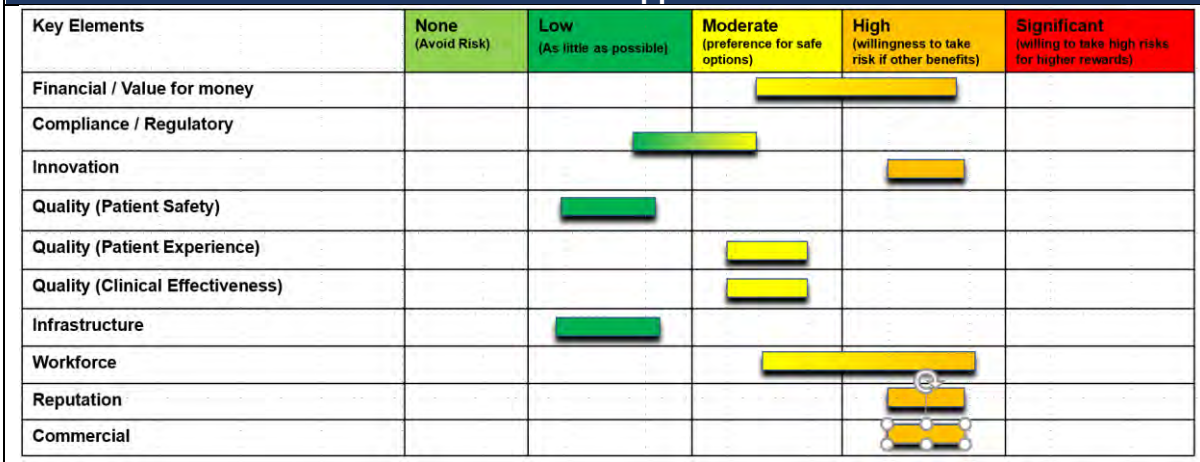
Guidance notes

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

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

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

Our Risk Appetite



1. GENERAL BUSINESS

1.1. Welcome and apologies for absence - Roger Petter, Clement Mawoyo, Nicola Cottington (Matt Keeling deputising)

To Note

1.2. Declaration of interests for items on the agenda

To Assure

1.3. Minutes of the previous meeting - 26 January, 2024

To Approve

NHS
West Suffolk
NHS Foundation Trust

WEST SUFFOLK NHS FOUNDATION TRUST

DRAFT MINUTES OF THE
Open Board meeting

Held on Friday 26 January 2024, 09:15 – 13:30
At Education Centre, West Suffolk Hospital, Hardwick Lane,
Bury St Edmunds IP33 2QZ

Members:		
Name	**Job Title**	
Jude Chin	Trust Chair	JC
Ewen Cameron	Chief Executive Officer	EC
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
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
Michael Parsons	Non-Executive Director	MP
Krishna Yergol	Non-Executive Director	KY
Roger Petter	Non-Executive Director/ Maternity and Neonatal Safety Champion	RP
Clement Mawoyo	Director of Integrated Adult and Social Care Services	CM
Peter Wightman	West Suffolk Alliance Director	PW
In attendance:		
Richard Jones	Trust Secretary & Head of Governance	RJ
Pooja Sharma	Deputy Trust Secretary	PS
Helen Davies	Associate Communications Manager	HD
Jane Sharland	Freedom to Speak to Speak Up Guardian	JS
Carol Steed	Deputy Head of Workforce (deputising for JO)	CS
Dan Spooner	Deputy Chief Nurse	DS
Jodie Glasgow	Assistant Service Manager (shadowing NC)	JG
Karen Newbury	Director of Midwifery (item 4.4.1 only)	KN
Simon Taylor	Associate Director of Operations (item 4.4.1 only)	ST
Kate Croissant	Deputy Clinical Director – Women & Children (item 4.4.1 only)	KC
Ruth Berry	FT Office Manager (minute taking)	RB

Apologies:
Jeremy Over, Executive Director of Workforce and Communications
Geraldine O'Sullivan, Non-Executive Director
Antoinette Jackson, Non-Executive Director

Governors: Jane Skinner, Lead Governor Anna Conochie, Public Governor Sarah Hanratty, Public Governor
Staff: Heidi Rolfe-Hill, Community Staff Side Lead
Members of the public: Mike Gill, Observer from Audit One

1.0 GENERAL BUSINESS		
1.1	**Welcome and apologies for absence**	**Action**
	The Trust Chair (JC) welcomed all to the meeting and the apologies for absences were noted.	
1.2	**Declarations of interest**	
	There were no declarations of interest declared for items on the agenda.	
1.3	**Minutes of the previous meeting**	
	The minutes of the previous meeting on 1 December 2023 were approved as a true and accurate record.	
1.4	**Action Log and matters arising**	
	Open items: Ref 3030 IQPR data metrics The IQPR content is being reviewed through the Board 3i committees' key issues report - **ACTION CLOSED** Ref 3031 Patient and Staff Story - An 'end of life' patient/staff story to come to Board in March - **ACTION** Ref 3048 Prevention, Personalised Care and Health Inequalities Strategy - The current reporting route for public health is via the Clinical Effectiveness Governance Group. This is being reviewed to consider the level of prominence/visibility. A recommendation to come back to Board in March - **ACTION**	**SW** **RJ**
1.5	**Questions from Governors and the public relating to items on the agenda**	
	The Lead Governor raised a query regarding the inclusion of 'red flag events' in the nurse staffing report and whether similar reviews and standards are applied to other departments.	

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	- The Chief Operating Officer (NC) responded stating that while the Trust is close to establishment for medical staff, recent industrial actions have increased strains on the consultants during the period. Other methodologies such as 'getting it right first time' and national benchmarking tools are utilized. It was proposed to consider including medical staffing plans for Council of Governors meetings to enhance visibility. **ACTION:** Consider including medical staffing plans for Council of Governors meetings.	**RJ**
1.6	**Patient Story**	
	A video presentation was shown to the Board which described a patient's experience at West Suffolk Hospital (WSH) in January 2023. Despite initial good treatment, the patient's discharge process was unpleasant due to breakdowns in communication and lack of care. It was noted that the discharge of this patient was not at the standard it should be and there were failures across the discharge process. The PALS team had been in touch with the family, following the complaint and have apologised on behalf of the Trust. The family was aware that the video was being shown to staff, Trust wide and the complaints process had helped some significant learning for the Trust. Although there was a process issue, it was the lack of care and compassion from the staff that was significant and is what needs to be focused on. There were many other factors that could have impacted the care including number of staff on the ward, the environment they were having to work in. The Board noted that the incident prompted various rapid improvement initiatives, including modifications to discharge areas and increased staffing. The discharge waiting area (DWA) now has beds to use, alongside chairs for patients waiting to go home. There are increased numbers of staffing in these areas and volunteers of the hospital help out with food and drink requests of patients waiting. To help with overall patient satisfaction, staff are now shown the complaints that are received by the hospital, to help impact on future patient care experience. The Involvement committee was asked to consider how the staff focus on experience and culture, and review measures for improvement (focus on discharge and wider activities).	

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	The improvement committee was asked to review and monitor progress and updates from the newly formed transfer of care committee. This patient story to be shared with the committee and the DWA. **ACTION:** The involvement committee to focus on understanding patient experiences and measures for improvement. Improvement committee to focus assurances relating to enhancing discharge processes and communication.	**JMO/PM**
1.7	**CEO Report**	
	The Chief Executive Officer (EC) presented the report to the Board and highlighted the following: ▪ The Trust is currently undertaking a pilot initiative, focusing on identifying those most at risk of cardiovascular disease, on the Howard Estate, Bury St Edmunds. There will be signposting to the community, to increase numbers attending GP services for this to be regularly checked, with the data to be looked at by the West Suffolk Alliance and Suffolk and North East Essex Integrated Care System (ICS). This is aligned to our organisation strategy, in relation to prevention of ill health and reducing health inequalities ▪ The Trust's pulmonary rehabilitation service has been awarded national accreditation. The service is only the 12th team in the country to achieve this standard and the 1st in the East of England. The accreditation is run by the Royal College of Physicians, with the aim to improve the quality of pulmonary rehabilitation services throughout the UK ▪ From 1 February, the Trust's virtual ward, will transition into the community division. This is in line with the strategic plan for the virtual ward ▪ On 12 January, there was a groundbreaking event at Newmarket Community Hospital, in relation to the new Community Diagnostic Centre. Once open, it will provide the community faster access to a wide range of diagnostic tests, such as MRI, CT, X-ray The Chief Operating Officer (NC) drew attention of the Board on the performance of the Trust, in relation to the long wait times for patients in the emergency department (ED) at the West Suffolk Hospital, who are waiting for a bed, prompting the Trust to implement strategies for improvement. Plans have been reviewed and more projects are in place to improve performance, including "arrive by 9", which involves getting patients from the ED onto a	

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	ward at 9am, however, does not alone provide a long-term solutions to the issues. The Trust has prioritised improving overall performance, including discharge process and ED avoidance (for those who don't need to be in the department and can use a different service). The Chief Executive Officer (EC), Executive Medical Director (PM) and Executive Chief Nurse (SW) go to the ED on a regular basis, to not only see first-hand experience for patients, but also to provide assurance with visible presence of medical staff. In relation to the Prevention, Health Inequalities and Personalised Care (PHIPC) public plan that the Board signed up to in December, there have been some initiatives that have worked, and a number were in line with what is being implemented at a regional and national level. There needs to be a focus in the Insight committee on the impact of the actions to achieve improvements, including interventions within ED and outside the immediate department that have an impact on flow and discharge. **ACTION:** To bring back metrics for Board to provide greater visibility and consider staff engagement through staff briefing	**NC/PM**
2.0 STRATEGY		
2.1	**Strategic priorities update report**	
	The Chief Executive Officer (EC) presented the updated strategic priorities, highlighting new initiatives aligned with organizational goals. Feedback was provided to focus on outcome measures rather than inputs and it was noted that following recent Board development days and committee workshops, new priorities for the next year were created, some merging with existing priorities. The final set of priorities will be brought to Board for approval, following the next Board development day. This will include progress against measures in update report. **ACTION:** Progress report to focus strategic measures on outcomes rather than inputs.	**EC**
2.2	**Future System Board Report**	
	The Executive Director of Resources (CB) presented the Future System Board report and, updates on planning and accommodation scheduling were provided, with emphasis on addressing internal and external blockers.	

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	▪ There has been continued progress made on planning and the schedule of accommodation. Blocks on our programme outside of the Trust's control (from a national level) include: - constraints on capital – the national budget, against the 40 hospitals due to be built - financial structure with which capital development is based – new assets are significant against existing assets but provide the same services ▪ There have been various reviews on the assumption of the Programme, in relation to governance, by the specialist consultancy firm employed (who focus on organisational health and governance) ▪ As we move closer to the next phase - making important technical, operational and commercial decisions, the Future System team will work with the Non-Executive Directors (NEDs) on governance ▪ Beds are the metrics that are being used nationally, as the methodology for capital cost of a new hospital. Costs increase on a weekly basis (inflation etc). Bed numbers are the variable factor for the New Hospitals Programme. It was **CONFIRMED** that the plan for the number of beds approved in December remains in place and will be subject to review with the national team. A question was raised, given the high possibility of a general election this year, whether there is anything that, as a Trust, could do to mitigate delays or whether there are opportunities to lobby, especially as the Trust is one of the RAAC hospitals. Actions were proposed to mitigate potential delays and Future System team to address internal and external blockers and consider collective lobbying for RAAC hospitals. **ACTION:** The FS team to bring to next meeting points for escalation for internal/external blockers and response. Consider collective approach to lobbying for RAAC hospitals.	**CB**
2.3	**West Suffolk Alliance and SNEE Integrated Care Board**	
	The West Suffolk Alliance Director (PW) presented report from the West Suffolk Alliance and SNEE ICB, with the following highlighted: • Updates were provided on the ICS priorities and a bid for improved transport links. The ICS "Start Well Domain – First 1001 Days" has set the priorities for 2024/25. This is the collective of all the early years and is recommending a multi-level approach, with various community and service	

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	level providers, to address the structural (e.g., government policy) and wider social factors (e.g., attitudes and values) that influence child and family outcomes. The Alliance is looking to identify 2 key objectives for 2024/25, closely linking to actions for Health Inequalities. • A bid, by the integrated transport service, has been submitted to Suffolk County Council, in relation to the transport link from Haverhill to the West Suffolk Hospital site. If successful, it would encompass the current Hospital Ride service, provided for patients/staff. The outcome is expected before the end of January. The Board noted the update and after discussion, following actions were agreed: **ACTION:** With regards the Virtual ward, the emphasis was given to ensure continued focus on VW and engage NEDs to ensure continued focus on this with visibility in the UEC update at the next board. Also, to provide an opportunity for NEDs to engage with team. **ACTION:** It was noted that there is a need to include focus on the ICB activities/issues in this report in future reports. **ACTION:** It was also agreed to schedule update on the SNEE ICB Joint Forward Plan in May.	**PM/NC** **PW** **RJ**
3.0 PEOPLE AND CULTURE		
3.1	**Involvement Committee report**	
	The Non-Executive Director and chair of the involvement committee (KY) commended the key issues from the meetings as follows: - The Committee supported the recommendation from the Car Parking Eligibility group regarding staff car parking and pursuing a 'points-based' system - The People and Culture Plan has now been distributed within the Trust and the measures are both short and long term, with reporting on specific delivery milestones - The West Suffolk College are working on a joint project with the West Suffolk Alliance, to encourage more students into the healthcare sector and increasing opportunities for work experience locally - The new appraisal framework for non-medical staff, has been launched within the Trust. It is getting positive	

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	feedback, leading to much richer conservations. More line managers are attending the training It was noted that the Trust is not currently delivering the Oliver McGowen level of training for learning disability and work is in progress to develop a solution for the Trust.	
3.2	**Freedom to Speak Up Report**	
	The Freedom to Speak Up Guardian (JS), presented the report to Board with the following highlighted: ▪ The number of freedom to speak up (FTSU) issues raised has levelled out over the last 2 quarters, but there had been an increase in anonymous reporting, higher than national levels. There are various areas which could be impacting the numbers – training, more staff networks etc, but data will be looked at to find possible reasons ▪ Further consideration is needed in relation to the trend line for number of FTSU concerns being raised, including review of other sources of intelligence such as the pending national staff survey benchmarking - ▪ As part of the Trust's wellbeing work plan, psychological safety is being focused on more at the entry point into the Trust and also at a training level. The hope is that with more managerial training being introduced, concerns/problems between staff and managers will decrease The Chief Nurse (SW) stated there is some FTSU reporting via the Care Quality Commission (CQC) and the team will link up with the FTSU Guardian to share concerns raised. Freedom to Speak Up Guardian highlighted initiatives to improve staff engagement and address concerns. Actions were proposed to review trends in FTSU reporting and focus on managerial training. **ACTION:** Review trends in FTSU reporting and provide managerial training.	**JMO/JS**
4.0 ASSURANCE		
4.1	**Insight committee report**	
	The Non-Executive Director (RP) on behalf of the Committee Chair, AJ, presented the key issues from the meetings stating progress and challenges in meeting financial targets: - The recent industrial action and the new consultant pay award, will impact on the Trust financial targets. CIP targets are a work in progress for next year	

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	- There was a deep dive session around cancer. There are various audits in place to improve performance and the Trust is on track to deliver the with our faster diagnosis standard.	
4.2	**Finance report**	
	The Executive Director of Resources (CB) presented the report to Board and outlined Trust's position at the end of December which was in line with the financial plan. It was recognised that the Trust's cost improvement plan CIP has been strong over the last couple of months and expected to achieve end of year targets. Recurrent schemes put the Trust in a great starting point for the next financial year's CIPs. It was noted that in line with national guidance the figures for December were to exclude real costs of industrial action in the overall figures - £1.4m. **ACTION:** The budget setting process for next financial year has begun. Final positions on national assumptions will go to Insight committee in February, with final budget going to Board in March. Given the enormous pressure that the Trust is facing due to the financial position, thanks were given to the staff to be able to cope up.	**CB**
4.3	**Improvement committee report**	
	The Non-Executive Director and chair of the improvement committee (LP) presented key issues from the meetings: - There were potential breaches of Ionising Radiation (Medical Exposure) Regulations IR(ME)R, radiology department. This is on the risk register, but the Committee were not assured regarding improvement and departmental compliant and accreditation to be followed up. - Ockenden, WSFT response regarding organisational learning. The Senior Leadership Team undertook a Trust wide self-assurance assessment, which is ongoing at committee. Data is being collated and will come to February meeting, to compile an improvement action plan. - The reviewed and updated Terms of Reference will come to the March Board for approval.	
4.4	**Quality and nurse staffing report**	

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	The Deputy Chief Nurse (DS) reported to the Board, with following highlighted: ▪ Turnover within registered nursing is still under 10%. Fill rates are over 90%. ▪ The existing controls of nursing deployment (to reduce the temporary nurse spend) aren't at the detriment of patient safety. The Trust is engaging with managers to reduce the use of temporary agency staff and the ratio has changed towards bank staff, which reduces costs. The Board recognised the work to reduce temporary spend and made a request to feedback the Board's recognition of this to the applicable teams. **ACTION:** Feedback Board's recognition to the applicable teams.	**SW**
4.4.1	**Maternity services report**	
	The Director of Midwifery (KN) presented the maternity service report and associated documentation: ▪ The Trust continues to be compliant under the majority of the requirements of the Local Maternity and Neonatal System (LMNS) maternity incentive scheme. ▪ The addition of a maternity supernumerary neonatal coordinator would be needed to fully comply with the partially implemented areas. ▪ A staff survey is currently live to capture views regarding current shift patterns and whether they meet work/life balance requirements and to provide ideas for improvement from staff. **ACTION:** It was suggested that the team links up their work to the Trust's strategic plan regarding smoking and helping people to quit. This would relate to the requirements regarding smoking during pregnancy and babies being around smokers. **The Board APPROVED the Clinical Negligence Scheme for Trusts CNST submission and confirmed that they are reassured that steps have been taken to provide safe care and services within the Maternity and Neonatal care settings.** **The completed declaration to be submitted with authorisation from the LMNS, Trust Board, Chief Executive and ICS.**	**PM**
4.5	**Audit committee report**	

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	The Non-Executive Director and chair of the audit committee (MP) highlighted key issues from the December meeting: - The committee looked at the approved annual report for 2022/23 and agreed the areas for development in the financial year, in particular the robustness of the budget setting and CIP delivery process. - The committee are making good process with the 2023/24 audit plan.	
5.0 GOVERNANCE		
5.1	**Governance Report**	
	The Trust Secretary (RJ) reported on the main governance headlines and updated the Board that the Executive Directors and Senior Leadership Team have agreed to shift the focus of its scope and responsibility and expand the membership of the Executive Directors meeting, to include representatives from the clinical divisions. **The Board noted the report and duly approved the terms of reference for the Management executive meeting.**	
5.2	**Board assurance framework**	
	The Trust Secretary (RJ) presented the report on the Board Assurance Framework (BAF), with the following highlighted: - The development of the BAF is continuing, alongside internal auditors - Map sources of assurance for each of the strategic risk, internal and external and ensure that gaps in assurance are understood and managed; and are aligned to a board assurance committee.	
6.0 OTHER ITEMS		
6.1	**Any Other Business**	
	There was no other business.	
6.2	**Reflections on meeting**	
	▪ Feedback was provided regarding meeting logistics, including the need for brief relief breaks. **ACTION:** Next Board meeting agenda to implement brief relief/comfort breaks ▪ Since the Board meetings are back on site at the West Suffolk Hospital, staff should be encouraged to attend the meetings.	**PS/RJ** **JMO/Comms**

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	ACTION: Promote to try and secure local awareness and attendance. ▪ The acoustics in the room were not optimal for a meeting. **ACTION:** Improvements to be made in meeting room acoustics.	**RJ/PS**
6.3	**Date of next meeting** Friday, 22 March 2024	

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1.4. Action log and matters arising

To Review

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
3030	Open	29/9/23	1.5	**Questions from Governors and the public relating to items on the agenda -** To consider how we include total waiting list numbers in the IQPR	The IQPR content is being reviewed through the 3I committee development. It is suggested this be picked up through the planned Insight workshop in the New Year. As Insight Committee dealing suggested this is picked up through the planned Insight workshop in the New Year. **The proposed Insight IQPR metrics paper was deferred from February to March Insight due to lack of time at the February meeting. The list of metrics will be considered at March Insight.**	NC	01/12/23	Green	
3031	Open	29/9/23	1.6	**Patient and Staff Story** - Deep dive into 'end of life' for future board, linked to leadership/ communication within team and with relatives/carers – improvement committee	**An 'end of life' patient/staff story to come to Board in March 2024. Story already booked for March meeting. EOL patient/staff story to come to May Board.**	LP/SW	24/05/2024	Green	
3059	Open	26/1/24	1.6	**Patient Story:** The involvement committee to focus on understanding patient experiences and measures for improvement. Improvement committee to focus on enhancing discharge processes and communication.	**Today's (22.3.24) CKI report refers. Formal process to be established to enable feedback to services on the learning from engagement exercises. To report back to Involvement Committee in 6 months' time.**	JMO/PM	22/03/24	Green	
3062	Open	26/1/24	2.2	**Future System Board Report:** The FS team to bring to next meeting points for escalation for internal/external blockers and response. Consider collective approach to lobbying for RAAC hospitals	**Verbal update to be provided at today's (22.3.24) meeting.**	CB/EC	22/03/24	Green	

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

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
3048	Open	1/12/23	2.1	**Prevention, Personalised Care and Health Inequalities Strategy -** Consider how to monitor healthcare inequalities indicators within the governance structure (as well as the strategy implementation plan)	**The current reporting route for public health is via the Clinical Effectiveness Governance Group to the Improvement Committee. This have been review with the public health consultant and reporing will provide regular visibility of health indicators as part of a strcutured report**	RJ	22/03/24	Complete	22/03/24
3058	Open	26/1/24	1.5	**Questions from Governors:** Consider including medical staffing plans for Council of Governors meetings	This has been included in the Council's forward plan	RJ	22/03/24	Complete	22/03/24
3061	Open	26/1/24	2.1	**Strategic priorities update report:** Progress report to focus strategic measures on outcomes rather than inputs.	**Agenda Item 22.3.24.**	EC	22/03/24	Complete	22/03/2024
3063	Open	26/1/24	2.3	**West Suffolk Alliance and SNEE Integrated Care Board:** **ACTION**: With regards the virtual ward (VW), the emphasis was given to ensure continued focus on VW and engage NEDs to ensure continued focus on this with visibility in the UEC update at the next board. Also, to provide an opportunity for NEDs to engage with team. **ACTION**: It was noted that there is a need to include focus on the ICB activities/issues in this report in future reports. **ACTION**: It was also agreed to schedule update on the SNEE ICB Joint Forward Plan in May.	Virtual ward update included in UEC update for Board and NED visit to Virtual Ward being arranged Included in agenda report This has been scheduled for May.	PM/NC PW RJ	22/03/24	Complete	22/03/24

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
3064	Open	26/1/24	3.2	**Freedom to Speak Up Report:** Review trends in FTSU reporting and provide managerial training	**Freedom to Speak Up trends are reviewed and shared in the quarterly board reports. These trends are also reviewed regularly, and shared with appropriate managers, HR and senior leaders, in regular meetings with the Patient Safety team, and at the Non Medical Clinical Council.** **From reports received by FTSU, staff have reported that their manager has been on training and as a result things have improved, especially where poor communication and lack of feeling valued were issues. There is still work to be done, Jane Sharland will be liaising with Carol Steed to see how the themes from FTSU are being met by the current management training, and how the Trust might reach managers in general with these themes and how to address them, as well as providing appropriate support and training in individual cases**	JMO/JS	22/03/24	Complete	22/03/2024
3065	Open	26/1/24	4.2	**Finance report:** The budget setting process for next financial year has begun. Final positions on national assumptions will go to Insight committee in February, with final budget to Board in March.	**AGENDA ITEM (22.3.24)**	CB	22/03/24	Complete	22/03/2024
3066	Open	26/1/24	4.4	**Quality and nurse staffing report:** The Board recognised the work to reduce temporary spend and made a request to feedback the Board's recognition of this to the applicable teams.	**Actioned.**	SW	22/03/24	Complete	22/03/2024

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
3067	Open	26/1/24	4.4.1	**Maternity services report:** It was suggested that the team links up their work to the Trust's strategic plan regarding smoking and helping people to quit. This would relate to the requirements regarding smoking during pregnancy and babies being around smokers.	**The smokefree pregnancy team and public health team leading on smoking cessation work very closely together alongside ICB colleagues leading on NHS LTP implementation and the Saving Babies Lives requirements. By way of example, our smoking cessation midwife has been fully engaged in the communications around No Smoking Day and there is ongoing close engagement in co-producing our WSFT Tobacco control plan**	NC/PM	22/03/24	Complete	22/03/2024
3068	Open	26/1/24	6.2	**Reflections on meeting:** Next Board meeting agenda to implement brief relief/comfort breaks Promote to try and secure local awareness and attendance. Improvements to be made in meeting space acoustics	Additional comfort break is added on agenda. **Action complete** Meeting details sent to local press for publishing and a post was shared on our social media channels advertising the meeting. **Action closed.** Work is in progress in collaboration with the IT and other Trust colleagues with an aim to put a solution in place before May when the Trust Board meeting is back on site. **Action closed.**	RJ/PS JMO PS	22/03/24	Complete	22/03/2024

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

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

To Note

1.6. Patient and Staff Story

To Review

1.7. Chief Executive’s report

To inform

BOARD OF DIRECTORS

CEO report – March 2024

Report title:	CEO report
Executive lead:	Dr Ewen Cameron, chief executive
Report prepared by:	Helen Davies, associate director of communications Sam Green, communications officer
Previously considered by:	N/A

For approval ☐	For assurance ☐	For discussion ☒	For information ☒
Trust ambitions	FIRST FOR PATIENTS	FIRST FOR STAFF	FIRST FOR THE FUTURE
Please indicate ambitions relevant to this report	x	x	x

Executive summary
The CEO Board report covers a range of operational and strategic updates from across the Trust.
Action required of the Board
For information and discussion.

Risk and assurance:	
Equality, diversity and Inclusion:	
Sustainability:	
Legal and regulatory context:	

As expected, the start of 2024 has been a busy period for our Trust. So far this year, we have seen two further rounds of British Medical Association industrial action following on from the round just before Christmas and our urgent and emergency care services have experienced a challenging winter period. Our community teams have been equally busy

while also been dealing with challenging weather conditions as they provide that all important lifeline to those across west Suffolk. I would like to thank all colleagues for their hard work over this period.

Performance

Despite the challenges our urgent and emergency care (UEC) services are facing, they have worked extremely hard to ensure our patients are seen at the earliest opportunity. Our plan at the start of the year was to ensure 76% of patients are seen within four-hours of attending our emergency department in March 2024. While there is a lot more we need to do to hit this target, there is lots going on within the department and across the hospital and community to help make sure this happens. This focus has resulted in month-on-month improvements from December to February, with the second half of February showing us at just over 70%. In the first half of March, we saw a very significantly improved performance against this metric and others, such as the number of patients spending 12 hours in the emergency department.

With more than 10 days of industrial action having taken place since the start of 2024, there has been an impact on our elective recovery, which will make it more difficult for us to meet our 2023/24 elective recovery objectives by 31 March 2024. As of the end of February 2024, there were 580 patients waiting over 65 weeks. It is worth noting that in April 2023 there were 15,878 patients to treat in the 65-week wait cohort, so this reduction in the number of patients waiting is a huge achievement.

As of the end of February 2024, the number of our longest waiting patients stands at 61 waiting more than 78 weeks (of which 46 are capacity breaches with the others being a mixture of choice, complexity and unfit patients).

One of the ways that we are innovating is to not just provide more appropriate and personalised care, but to ensure we have the capacity in our hospitals to admit those who require inpatient care as quickly as possible, is the virtual ward.

Having matured and expanded since it began accepting patients in November 2022, the virtual ward, in line with its strategic plan, moved into the community division as of 1 March 2024. This offers opportunities for the team to wrap care around patients in their own home, who may otherwise require acute care. From this move, the virtual ward team are developing working with the integrated neighbourhood teams in our communities more. I encourage our patients to ask their care teams about the virtual ward and whether this is something that can help them go home sooner. While we continue to receive positive feedback from our patients, which is tremendous, this service also helps our patients avoid deconditioning and long inpatient stays.

Workforce

The NHS Staff Survey is one of the largest annual workforce surveys in the world, offering a snapshot of how our staff feel across numerous areas of their working lives. Completely anonymous, the results of this survey are a cornerstone of how we best understand where we need to focus our attention over the year ahead to ensure our staff have the best experience at work possible. This is incredibly important as it helps us create a Trust where our communities want to come and work, and once here, to stay and develop. This year, almost 2,500 colleagues completed the survey, which is equivalent to 46% of our entire workforce.

Our results show that we have improved our scores across all nine of the key areas compared to last year. Whilst seven of these areas scored better than the national average, these scores were only slightly above average, showing that we have more to do. The two areas which scored lower than the national average are around having 'a voice that counts' and feeling as though 'we are a team'. These are already areas that we are prioritising under our People and Culture Plan this year and they will continue to be a priority for us going into 2024/25. One result that stood out to me, was around where we sat in the region in relation to whether our staff would 'agree' or 'strongly agree' with recommending our Trust as a place to work. Here, we ranked second in the east of England.

Another measure that jumps out from the results of the survey, is the percentage of our colleagues from ethnic groups other than white that reported having experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months. In this same period nationally, the measure has improved, going from 31% to 28% (which is still a very high rate). For our colleagues, that figure has increased from 31% to 34%. This is more than 12% higher than the rate for our white staff, which stands at 20% - not that this isn't also too high.

Harassment, bullying or abuse has a very significant impact on our ability to do our jobs well, and there is a significant impact on those witnessing it, both our colleagues and patients. Research highlighted by Civility Saves Lives shows that incivility significantly reduces our ability to process information and the quality of our work as well as increasing the likelihood of having to take time off work. Last year, the Board heard the story of one of our junior doctors who had gone through exactly this experience and told us about not only what it felt like to be on the receiving end of this sort of abuse, but also the negative impact it on their ability to do their job. I also got to spend some time talking to one of our nurses who had similarly been subjected to racist and homophobic abuse while at work.

We are committed to tackling harassment, bullying or abuse in all its forms to make this a fair and equal place to work for all our staff. Whilst there's lots we have done this year to improve the experience of those colleagues who are treated unequally while at work, due to characteristics such as race, disability or sexuality, these results show there is a lot more ground we need to cover.

The week commencing 26 February was our annual Love Yourself Week, a time where we encourage our colleagues to think about their own health and wellbeing. Working in healthcare is an extremely demanding profession, and it is so important that colleagues have the tools to take care of themselves, so they can best take care of our patients. The week involved a 'wellbeing carousel' stand in our Time Out restaurant at the West Suffolk Hospital, along with a partnership with The Poetry Pharmacy. This 'walk with words' exhibition displayed poetry in the main walkways across our sites, with poetry representing the trials and tribulations our colleagues may experience. Our organisational development team also set up well-being webinars for colleagues to either watch live or at a time to suit them.

Our Putting You First awards are a way for us to celebrate those who uphold our Trust FIRST values (fairness, inclusivity, respect, safety and teamwork) in their daily working lives, and the recipients have been nominated by their colleagues for the contribution they make to their service or team. It is amazing that we receive so many nominations for these awards, which makes it almost impossible to have to select a few, as all are so deserving. The below nominees however, I am very pleased to announce, are our latest round of winners:

- Alison Devlin, F7 ward manager, wanted to recognise **the F7 team of nurses, nursing assistants and housekeepers**, for: putting patients and each other first

every single day. They encompass everything that the Trust stands for and every single day fulfil the Trust values. Alison says they are the best team ever! A team who cares about each other, helps and supports each other always, to keep patients safe and staff morale lifted. They care with compassion and a shared ambition to make F7 better and safer for staff and patients. Alison says F7 is a true family and a great team, who deserve to be recognised for who they are and the amazing team they are. Alison says she is very proud to be their manager.

- Karen Gleed, phlebotomist and Joanna King, haematology laboratory manager, wanted to recognise **Shan Barnes, phlebotomy manager**, for:
    - (Karen Gleed) being nothing but nurturing and supportive to her and all the newer recruits over the last almost two years, as well as the longer serving colleagues. From initially guiding her through the phlebotomy training and the Care Certification Course as 'complete novices', to encouraging their progression as more experienced members of the team, Shan is not only her manager, she is her work 'mummy'. How well Shan treats them all is 'beyond her', especially due to their diverse personalities. Karen thinks Shan demonstrates the Trust's FIRST strengths beautifully, not only to her colleagues but also to patients, even when under extreme pressure. All in all, Karen says Shan is a good all-round manager, who is always approachable, welcoming, and an absolute pleasure to work for.
    - (Joanna King): leading the phlebotomy team and working tirelessly to ensure the needs of the patient are met and that her staff are supported. Shan is kind, considerate, fair and adaptable, dealing with issues that arise to bring the best out in her team and to ensure that a safe and efficient phlebotomy service is provided. Joanna can always approach Shan when she needs her support or information. Additionally, despite the challenges that she might be facing, Shan is passionate about the phlebotomy service and always has a smile on her face. Shan is a real asset to the team.

Congratulations to the winners. It is delightful to see our colleagues supporting each other, which has never been more important.

Future

As ever, while there is a great deal we are managing now, we must continue to look to the future to ensure we have the right tools available, as and when we need them as we move forwards. A lot of this comes from the way in which we work as a system across our area and we are increasingly working together to provide the best care possible for our communities across Suffolk and north Essex. While collaborative working is nothing new, we have recently formed a provider collaborative with East Suffolk and North Essex NHS Foundation Trust (ESNEFT) to form a structured approach to how joint projects are undertaken, whilst ensuring that the WSFT's priorities are achieved not just in the immediate term, but as we look further ahead.

The collaborative is seeking to ensure it takes into account and provides benefits that stretch right across Suffolk and north Essex. We are also looking at how our community services are delivered and how best we can work to support the needs of our populations, including children and young people.

Furthermore, as a digital exemplar, we are lending our expertise to help ESNEFT implement their own electronic patient record (EPR). This will help standardise treatment, reduce variation in the provision of services and further integrate care across our area.

Working together and pooling our knowledge and strengths will help us improve together and ensure everyone in Suffolk and north Essex receives the highest quality and safest care.

Of course, when looking at the future, the new healthcare facility on Hardwick Manor in Bury St Edmunds to replace the existing West Suffolk Hospital is a keynote project. We have recently made significant strides in relation to our exploratory and preparatory works ahead of the construction phase. Archaeological trenching is due to be completed by the end of March 2024, and we have begun planting buffer trees at the site. For this, we welcomed the New Hospital Programme Government Minister, Lord Markham MBE and our local MPs - Jo Churchill and James Cartlidge - to the site for our new hospital at Hardwick Manor for the ceremonious first buffer tree being planted. These trees will reduce the visual and sound impact of the new healthcare facility and are an important part of the enabling works to prepare the site.

This was another exciting step forward, and means we are still on track to deliver this new facility for 2030. We will continue to work with our New Hospital Programme colleagues and system partners as these plans develop.

Across west Suffolk, we are also seeing construction continue to progress for the Newmarket Community Diagnostic Centre. Remaining on track to see its first patients before Christmas 2024, concrete groundworks are being completed with the steel structure expected to be going up by the end of March 2024. This facility will create additional diagnostic capacity, providing around 100,000 tests a year, which will help us reduce health inequalities and waiting times while giving our communities access to the care they need as quickly as possible.

2. STRATEGY

2.1. Strategic Priorities update report

To Approve

Board of Directors	
Report title:	**Strategic priorities**
Agenda item:	2.1
Date of the meeting:	22 March 2024
Sponsor/executive lead:	Ewen Cameron, Chief Executive
Report prepared by:	Ewen Cameron, Chief Executive

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

Executive Summary

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

s:

In 2023/24, we agreed 5 priorities:

- Delivery of **service pathway changes** as laid out in the Clinical and Care Strategy
- A strong priority on **Equality, Diversity and Inclusion** to address the disparity between different groups where the evidence shows that staff are disadvantaged or feel discriminated against

- A large focus on **line management development** given the feedback from What Matters To You 2, the National Staff Survey and the Freedom to Speak Up Champions alongside the impact this would have on a large portion of the organisation
- A step change in delivery on **prevention and proactive care** given the modelled demand projections and the explicit need for this to support the Future Systems Programme
- Development of **transformation capacity and capability** given the scale of change required for both business-as-usual challenges and to support the Future Systems Programme

Many of the priorities remain for 2024/25 but, through engagement with the Senior Leadership Team and Board, we have produced a set that build on the progress made in 2023/24. These themes are described in greater detail in the slides in the Appendix. The drivers behind these themes include demand addressed through productivity and prevention, the need to develop new models of care that meet the needs of the population, the need for financial sustainability and the imperative to improve experience and equity for staff and patients.

For 2024/25, the priorities we have identified are:

- Delivery of **long term sustainability** for health and care in west Suffolk
- Creating an **inclusive culture** where everyone belongs and **reducing inequalities** in experience for service users
- Supporting and **developing leaders and managers**
- A step change in delivery on **prevention and proactive care**

Action Required of the Board

The Board is asked to approve:

the priorities for the year ahead.

Strategy priorities 2024-25

NHS
West Suffolk
NHS Foundation Trust

Strategic priorities for 2024-25

- Delivery of **long term sustainability for health and care in west Suffolk** (First for Patients and First for the Future)
- 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 (First for Patients and First for Staff)
- 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 (First for Staff)
- 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 (First for the Future)

Priority: Delivery of long term sustainability for health and care in west Suffolk

Rationale and drivers:

- We face significant challenges in the delivery of healthcare over the next 5-10 years with increasing demand and complexity of care, workforce shortages, financial pressures including an underlying deficit and the increasing cost of meeting demand alongside building a new hospital.
- Meeting these challenges requires an extensive programme of work to meet the demands of the population in a sustainable way and development of the capacity and capability to deliver this change.
- Further integration with our local partners as part of the West Suffolk Alliance to provide people with much of the care they need within their local communities will be necessary.
- We will continue to expand our collaboration across the Suffolk and North East Essex Integrated Care System, and beyond, wherever it is in the interests of the population we serve and the sustainability of our services.

Delivery plan 2024-25

SMART actions	Measures of success	By who	Live Well domains/ other strategies
Priority: **Delivery of long term sustainability for health and care in west Suffolk**			
• Plan to implement the components of NHS IMPACT (building a shared purpose and vision; investing in people and culture; developing leadership behaviours; building improvement capability and capacity and embedding improvement into management systems and processes).	• Timebound, resourced plan agreed by Board by Q2	Exec sponsor: Director of Strategy and Transformation (TBA)	
• Proactively grow our community services division through: - new, community-focussed clinical pathways in line with the implementation of the clinical and care strategy (see related action below) - shift of resources and activity from acute divisions to community division - productivity improvements within community services	• In line with national direction, reduce overall workforce growth to 0% net growth, recognising the need to grow community services to support the planned transfer of activity from the acute hospital. • Increase in Urgent Community Response (UCR) activity by 10% by March 2025 compared to 23/24 baseline • Increase in virtual ward activity to 100 bed capacity and 80% occupancy by March 2025, monitoring a monthly trajectory towards this goal • Respond to expected national community productivity measures when released • 24/25 business plans in community and acute divisions reflecting ambitions above, signed off by 31st March 2024	Exec sponsor: Chief Operating Officer (Nicola Cottington) Clinical delivery lead: Clinical Lead for Quality and Safety, Community and Integrated Therapies Division (Karen Line) Operational delivery lead: Associate Director of Community Paediatric Services (Nic Smith-Howell) Associate Director of Community Adult Services (Kevin McGinness)	

Delivery plan 2024-25

SMART actions	Measures of success	By who	Live Well domains/ other strategies
Priority: **Delivery of long term sustainability for health and care in west Suffolk**			
• Improve productivity within acute services.	• Improve capped theatre utilisation to 85% by March 25, monitoring a monthly trajectory towards this goal • Align 85% of high volume, low complexity theatre activity with GIRFT cases per list standards by March 2025 • Implement British Association of Day Surgery recommended rates of day surgery for all specialties by March 2025 • Respond to expected acute productivity measures and incentive scheme when released • Deliver the system specific activity targets for outpatients, driven by the outpatient transformation programme including: 25% of appointments delivered virtually 16% of first attendances managed through Advice and Guidance	Exec sponsor: Chief Operating Officer (Nicola Cottington) Operational delivery lead: Deputy Chief Operating Officer (Matt Keeling)	All Live Well domains Clinical and care strategy
• Deliver reduction in our underlying deficit.	• Delivery of agreed 2024/25 cost improvement plan leading to reduction in underlying deficit.	Exec sponsor: Director of Resources (Craig Black) Clinical delivery lead: Operational delivery lead:	

Delivery plan 2024-25

SMART actions	Measures of success	By who	Live Well domains/ other strategies
Priority: **Delivery of long term sustainability for health and care in west Suffolk**			

• Deliver 2024-25 priority areas for service pathway change as identified by the Clinical and Care Strategy.
 	
• Continue to deliver and embed 2023-24 priorities which are multi-year. Transition to business as usual will be supported by the Change Hub.
	• Outpatients
	  • Transition 25% of appointments to virtual platform.
	  • Transition 25% of face to face appointments to peripheral locations.
	
	• UEC
	  • Develop a Target Operating Model (TOM) for future “emergency village” model of care.
	
	• Integrated Neighbourhood teams
	  • Supporting delivery of responsive and proactive care leading to 10% reduction in unnecessary admissions by March 25.
	
	• Childrens and Young People
	  • Develop a TOM for Children’s and Young Peoples Services.
	
	• Diabetes
	  • Deliver an integrated service model leading to 5% decrease in admissions of patients with complications of diabetes and 50% reduction in length of stay differential between patients with diabetes and people without.
	
	• Service reconfiguration
	  • Deliver test of change to demonstrate “left shift”.
	  • Increase community phlebotomy provision by 25% compared to 23/24 baseline.
		Exec sponsor: Executive Medical Director (Paul Molyneux)
		
		Operational delivery lead: Director of Operations for Future Systems Programme (Alex Baldwin)
			All Live Well domains
			Clinical and care strategy

Priority: Creating an inclusive culture where everyone belongs

We will reduce the differential experience of staff and patients and grow an inclusive culture where people can feel confident to be themselves

Rationale and drivers:

- We want to address the disparity between different groups where the evidence shows that staff and patients are disadvantaged or feel discriminated against. WRES and WDES data, F2SU themes and staff feedback suggest that priorities for this year should focus on reducing bullying, harassment and discrimination and embed more fully inclusive behaviours, practices and processes.
  - *Staff who are bullied are less likely and less willing to raise concerns and admit mistakes*
  - *Increased leadership diversity correlates with better financial performance*
  - *In hospital settings, managing staff with respect and compassion correlates with improved patient satisfaction, infection control, Care Quality Commission (CQC) ratings and financial performance*
  - *High work pressure, staff perceptions of unequal treatment, and discrimination against staff all correlate adversely with patient satisfaction*
  - *A workforce that is compassionate and inclusive for all has higher levels of engagement, motivation and wellbeing, which results in better care and reduced staff turnover*
  - *Fair treatment of every individual in the workforce helps reduce movement of substantive staff into bank and agency roles to avoid discrimination at work*
  - *A diverse workforce that is representative of the communities it serves is critical to addressing the population health inequalities in those communities*
  - *Organisations with more diverse leadership teams are likely to outperform their less diverse peers*
  - *Psychologically safe work environments, where people feel they are treated with dignity and respect, achieve more effective, safer patient care*

- The experience of care strategy focuses on the need to reduce health inequalities in experience and outcomes for our patients, with equity of access for those who may find it more difficult and representation from marginalised communities
  - *Access to reasonable adjustments, information and communication in the format required, including interpreting and translation services*
  - *Involving underrepresented groups in decisions about their own care and service delivery as a whole*
  - *Ensuring everyone can ask questions and give feedback about their (or their loved one's) care in an accessible and equitable way, and make improvements to reduce disparities*
  - *Complete regular Equality Delivery System reviews to assess the inclusivity of our services and make changes where needed*

Priority: Supporting and developing leaders and managers

We will equip leaders and managers to make a positive difference to the engagement of and support for colleagues across WSFT

Rationale and drivers:

- Feedback from What Matters To You 2, the National Staff Survey and the Freedom to Speak Up Champions suggests this remains a key area of focus, with staff suggesting that supporting our leaders and managers will have a direct and positive impact their experience at work, including their career development and career choices
- That at least 70% of the variance in team engagement is explained by the quality of the manager or team leader (Gallup, 2015)
- Line managers are welcoming of the new packages of support provided, feeling valued and supported as they take on these challenging and rewarding roles, and are keen for this support to be continued and expanded
- Analysis of WSFT staff feedback highlighted that staff want to:
    - *Feel valued and appreciated, and that their concerns are welcomed and acted on*
    - *Receive clear feedback, enabled to make improvements and be involved in changes taking place*
    - *Be able to access career development opportunities to reach their full potential*
    - *Feel that their health and wellbeing is important and supported*
    - *Be able to discuss flexible working options to achieve balance with commitments outside of work*

WSFT Strategy priorities 2024/25

SMART actions	Measures of success	By who	Live Well domains / other strategies
Priority: Creating an inclusive culture where everyone belongs and reducing inequalities in experience for service users			
• Proactively focus on reducing bullying, harassment and discrimination, particularly allyship, inclusive leadership practices and behaviours, inclusive recruitment processes, and reducing health inequalities • Embed Equality Impact Assessments into patient and staff facing decision making, policies, strategies, processes, and business activities • Embed guidance and processes for workplace adjustments for patients and staff, including implementation of a digital passport and digital adjustments toolkit for staff, and accessibility of information for patients	• Improvement in related WRES and WDES indicators in 2025 (exact scale of improvement to be agreed before first report in May 2024) • Improvement in related NHS staff survey indicators in 2025 (exact scale of improvement to be agreed before first report in May 2024) • Reduction in patient complaints related to bullying, harassment, discrimination and accessibility of information	Lead: Executive Director of Workforce & Communications (Jeremy Over)	People and culture plan 2024/25
• Ensuring personalised care can be given by knowing patients' individual needs and making reasonable adjustments • Enabling the Trust website to comply with accessibility legal requirements • Improving the patient information process to ensure availability in differing formats, from leaflets to signposting to clinic letters • Involving underrepresented communities in decisions and care to better understand inequalities and improve outcomes	• Development of personalised care and support plan datasets into e-Care, including integration of the patient profile by March 2025 • Increase of 10% in recording of protected characteristics on patient records • Implement a reasonable adjustment policy by September 2024 • Increase of 10% in reasonable adjustment needs recorded on e-Care by December 2024 • Improvements to booking and waiting procedures for those with reasonable adjustments by March 2025 • Accessibility improvements to web content and software by March 2025 • Assessment/completion of the Equality Delivery System by March 2025 • Accessible guides and improvement plans for all Trust sites by September 2024	Lead: Sue Wilkinson, Executive Chief Nurse	Applies to all Live Well domains Experience of care and engagement strategy

WSFT Strategy priorities 2024/25

SMART actions	Measures of success	By who	Live Well domains / other strategies
Priority: Supporting and developing leaders and managers			
• Continue to develop, grow and embed a holistic and inclusive package of learning and development support for all line managers, staff members and teams, including using coaching based conversations and enhancing digital capabilities • Provide practical guidance and easy access to information on how to manage, support and develop colleagues, including the development of a managers 'wellbeing toolkit' • Develop a cohesive approach to succession planning and career development, supporting the growth of leaders, and those in business-critical roles	• Further targeted development and learning support for leaders and managers launched by December 2024 • Development and launch of managers' wellbeing toolkit by March 2025 • Approach to succession planning and career development piloted by December 2024 • Improvement in related NHS staff survey indicators in 2025 (exact scale of improvement to be agreed before first report in May 2024)	Lead: Executive Director of Workforce & Communications (Jeremy Over)	People and culture plan 2024/25

Priority: A step change in delivery on prevention and proactive care

Rationale and drivers:

- The trust has a strategic commitment to make the biggest possible contribution to prevent ill health, increase wellbeing and reduce health inequalities
- The modelled demand projections for the Future System Programme show that the growth in demand for both acute and community services will continue to be driven by the prevalence and severity of long-term conditions, many of which can be prevented or treated proactively with better outcomes for patients
- The trust can make a huge contribution to prevention and proactive care, in how it delivers its clinical services, how it acts as an anchor institution, and as a partner to the shared West Suffolk Alliance goals
- There is an explicit need to increase our efforts on prevention and proactive care to help slow the growth in demand for our own services and those of all our partners, and make the local health and care economy sustainable in the long-term
- Doing this equitably means targeting our efforts towards the people who can benefit most, in order to reduce health inequalities

Delivery plan 2024-25

SMART actions	Measures of success	By whom	Live Well domains/ other strategies
Priority: A step change in delivery on prevention and proactive care			
As part of the WS Alliance, WSFT will play its role in achieving the SNEE ICS goals for identification and management of cardiovascular disease for the West Suffolk population • 80% of the expected number of people with high blood pressure (BP) are diagnosed by 2029 *(71.4% March 23 – goal 74.5% Mar 25)* • 80% of the total number of people already diagnosed with high BP are treated to target as per NICE guidelines by 2029 *(64.2% March 23 – goal 70% Mar 25)* • 85% of the expected number of people with Atrial Fibrillation (AF) are detected by 2029 (*target TBC)* • 90% of patients with AF who are already known to be at high risk of a stroke to be adequately anticoagulated by 2029 (*target TBC)* We will do this by (a) Optimising **use of population health management data** to target capacity as a system (b) Optimising **contacts with patients** for prevention goals (c) Promoting **healthy lifestyle choices**	<u>Use of Population health management data</u> • Reconciliation of hospital data on hypertension with GP practices (Mar 25) • Good use of Trust PHM data in alliance work with target communities <u>Optimise Trust contacts with patients</u> • Community health teams work with those patients on their caseloads where GP practices are seeking improvements in BP & AF recording and management <u>Support Healthy lifestyle choices</u> • Complete blood pressure health promotion campaign with a reach of 50,000 people using WSFT media channels • Increase the impact of exercise referral pathways with Abbeycroft Leisure by 25% by March 2025 • Participate in design and success of Feel Good Suffolk (includes support with exercise, smoking cessation and weight management) – achieve high levels of appropriate WSFT referrals	Exec sponsor: West Suffolk Alliance Director Clinical lead: Clinical lead for public health	Stay Well domain

Comfort Break

2.2. Future System board report

To Assure

Board of Directors	
Report title:	Future System Board Report
Agenda item:	2.2
Date of the meeting:	22nd March 2024
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 conclusion of the discussion around the size and scope of the new hospital and, therefore, the required budget and its ongoing impact on the operational cost of both the Trust and the Integrated Care System (ICS). This output will then form the basis for the creation of an outline business case, securing full planning permission and the appointment of a build partner.

Action Required

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

Risk and assurance:	
Equality, Diversity and Inclusion:	

Sustainability:	
Legal and regulatory context	

Future System Board Report

1.	**Introduction**
1.1	The following paper aims to update the Board on progress being made towards the building of a new hospital in West Suffolk. Specifically, the paper highlights: • Work completed to optimise our schedule of accommodation. • The plan to engage potential construction partners. • Improving future governance as our scheme develops; and • Progress being made on site to ensure readiness to build.
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	In May 2023 an 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 remains a priority and is one of the most advanced of the RAAC projects. 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	**Executive Summary:** At the last Board, we stated the following goals for the forthcoming period: • Outcomes of the five listed reviews (self-review, clinical review, demand review, technical review and regional review) 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 for. • A definitive schedule of accommodation will have been created. • We expect a decision on when we can engage potential suppliers in a procurement process. • Tenders for the creation of buffer planting and the construction of our new access road will have been concluded in line with an expectation that work commences in the first quarter of 2024. Solid progress against these goals has been achieved, specifically: • A review of West Suffolk's demand modelling by both the commissioning support unit and ESNFT / SNEE practitioners has been completed. • A review of "buildability" by Mott McDonald and Mace (national technical consultants) has been completed and ensures technical build parameters align with the current preferences and techniques favoured within the construction industry.

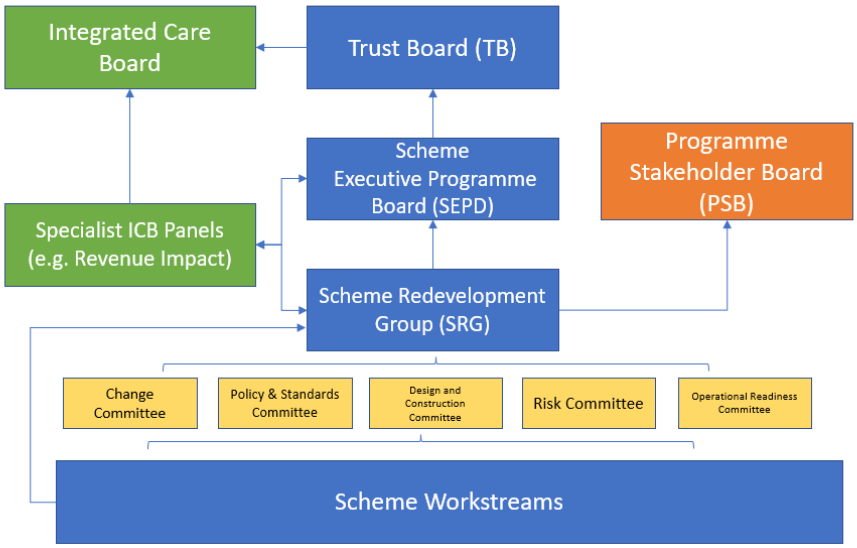
	• A clinical review by the New Hospital Programme (NHP) transformation team, testing adjacencies, benchmarking scale and aligning clinical design to Hospital 2.0 templates has been completed. • A review of our cost modelling, reviewing our calculation of costs against the models developed by NHPs advisors has been completed, ensuring we have applied the perceived cost benefits of modern methods of construction and a programmatic approach. • A benchmarking of West Suffolk design against those of West Herts and Harlow aimed at testing relative size per activity is nearing completion. • Upon the completion of the above reviews, a paper aimed at securing agreement to progress with the development of an outline business case will be submitted to the Joint Investment Committee (JIC). • Archaeological surveys on the development site have been completed and the team are now surveying the neighbouring construction compound. Nothing found thus far suggests delays to our plans. • Buffer tree planting, aimed at reducing the visual impact for neighbours, has commenced. • Work on a new temporary access road, allowing site traffic to access Hardwick Manor development site without disrupting Sharp Road is underway and will be completed in approximately 12 weeks. • The provision of sufficient power for a new, increasingly digital, hospital has been agreed and reserved with UK Power Networks. This removes a significant risk of delays to our construction schedule.
3.2	Having completed the detailed reviews discussed above, the Trust and the New Hospital Programme are now broadly agreed on the forecast of future demand and the "right size" of hospital required. To underpin this, it is imperative that the capacity and clinical and care model proposed for the new hospital support the wider needs and strategy of our Integrated Care System and I am pleased to relay that they do. That said, concerns remain regarding the increased operating costs and the payment of charges associated with the capital investment. To understand and address these concerns, a regional working group has been established. In support of this group, the West Suffolk team has prepared a detailed assessment of how the building of a new hospital, along with the benefits that it will generate, will affect both cash flow and balance sheet. This work predicts a "break even" point around 2036/7. The intervening period may require national financial support (as has happened with the opening of Royal Liverpool). The Commissioning Support Unit (CSU)[1] have now concluded their analysis of WSFTs own demand modelling. The key takeaway is that our demand conclusions are comfortably within the range described by the CSU's simulations, i.e. our conclusions are reasonable and provide a cornerstone for determining the right size of hospital. Alongside the work of the CSU, we have also engaged modelling experts from our neighbouring acute trust and our ICB to ensure our approach is complimentary and in-line with that being developed independently by these groups (important to ensure our view of growth remains in line with system wide funding and development assumptions). An additional benchmark of forecast activity and departmental size between the designs of West Hertfordshire, West Suffolk and Harlow schemes is being conducted on behalf of our region by KPMG. This exercise will compare the activity adjusted sizes of the following departments and will allow us to understand any outliers and differences in approach: • Inpatient areas • Outpatient areas • Accident and Emergency • Maternity

[1] The Midlands and Lancs Commissioning Support Unit are expert demand modellers and have been commissioned by the National New Hospital Programme to build a common means of calculating and understanding how local circumstances could influence future demand and, therefore, future capacity.

	• Radiology • Theatres • Pathology • Diagnostics • Administration The first reports from this exercise highlight how many ways there are to interpret departmental scope and consequently a final round of refinement is planned which we expect to be completed by mid-March. As the reviews have been completed, work to agree their outputs and conclusions have become the area of focus. Sessions have been held with the New Hospital Programme (NHP) team and all adjustments have been / are being clinically co-assessed for safety and operational efficacy. Recommendations, and their impact, will become the basis for the next level of technical and commercial planning. We aim to conclude the "right-size" debate by the end of March with a view to submitting a paper to the Joint Investment Committee (JIC[2]) soon after. This schedule will then allow us to proceed with detailed design drawings which, in turn will allow the completion of our Outline Business case in a timeline that supports the operational opening of a new hospital in 2030. While we finalise this part of the approvals process, we have commenced with stage 2 of the design process defined by the Royal Institute of British Architects (so called RIBA2). Stage 2 aims to produce the initial concept design in line with the schedule of accommodation that results from the co-production and review work carried out thus far. This process will take the current 1:500 designs and increase the detail down to the 1:200 level. We expect these designs to be completed in Autumn 2024. It is highly likely that the cost of building the "right-sized" hospital will exceed the initial capital allocations received from NHP. This issue is shared by most, if not all, of the schemes within the New Hospital Programme and consequently a revised national programme business case is working its way towards HM Treasury and is expected to conclude in May 2024. The other common challenge facing every scheme in the programme concerns the ability of a scheme to attract a construction partner in a market that will be significantly stretched by other hospital projects and, locally, by schemes such as the new Sizewell nuclear power plant. To mitigate the risks associated with this challenge; we are working with colleagues from NHP to develop a common "Major Works Framework" which is designed to maximise the attractiveness of the entire new hospital programme to the construction market. That said, the specific time pressures placed on the replacement of RAAC hospitals may require an independent market approach for West Suffolk which we are also exploring with NHP and representatives from the construction industry.
3.3	Once the right-size of hospital has been agreed, we expect detailed design work and commercial engagement to increase in pace and complexity. Consequently, NHP have engaged Q5 partners[3] to review the governance arrangements of each scheme and, therefore their respective readiness to proceed with the next level of project development. Following a workshop with the Future System Team, Q5 concluded that our model of governance was mature, effective and well established, however, they also made a range of recommendations that we intend to adopt as we move closer to making important technical, operational and commercial decisions. The key change will be the advent of an executive programme board, chaired by a non-executive director, dedicated to the future system programme and comprising key executives and subject matter experts from across the Trust and NHP. The implementation of this Board will not impact the purpose and membership

[2] 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.

[3] Q5 are a specialist consultancy focussing on organisational health and governance.

	of the wider Programme Board which will continue to ensure maximum engagement from system partners. Proposed Model for the OBC / FBC Stage of our Project  • Would be established at the point Scheme is progressed to OBC. • SEPB becomes project specific exec decision making forum. • SRG allows for cross workstream / cross committee discussion of recommendations before forwarding decisions to SEPD and TB as necessary. • Specialist sub committees / panels addressing specific areas of concern established when necessary. • System wide governance maintained.
3.4	In terms of our on-site enabling works, we have secured our position in UK Power Networks programme of works which will ensure the necessary power upgrades are completed (on site and within the wider power network) in advance of a new hospital becoming operational. Archaeological work is underway, progressing well and has yet to make any substantial discoveries which would impact the development of the new hospital. The trenching of the development site has been completed and work on the exploration of our construction compound area has commenced. Planting of buffer trees aimed at reducing the noise, dust and visual impact that a new hospital will have upon our nearest neighbours has commenced. We have undertaken the buffer planting at this early stage so that trees will become as established and effective as soon as possible. To commence the buffer planting we were delighted to welcome Lord Markham and local MPs, Jo Churchill and James Cartlidge to site and for them to plant the first of many trees. This action was symbolic of the support our scheme enjoys and the progress that we are making.

3.5 As previously explained, we have three primary budgets:

- **Team budget** – this covers the costs of the direct future system team. Spending remains in line with budget and we will receive funding for the coming year.
- **Professional fees budget** – this is a two-year budget covering the costs of architects and advisors that underpin the development of our business cases. Spending remains in line with budget and we have requested in increase in budget based on the expectation that the Trust's architects will complete the third level of design.
- **Enabling works budget** – this covers the costs of specific pre-construction tasks such as the construction of our compensatory habitat and the creation of active access routes. Spending remains in line with approved plans and we have now received a memorandum of understanding to cover buffer planting and our new access road projects.

Outside of budget management, the most pressing financial concerns are the long-term affordability of the new hospital in terms of a) its capital charges (e.g. depreciation and public dividends) and b) it's transitional and ongoing running costs (including workforce and any balancing efficiencies). These issues apply to all new hospital schemes and as such a national solution is being sought.

We have now started working on quantifying the potential benefits of opening a new, state of the art hospital and the associated clinical, digital and workforce strategies. These will form a crucial part of the outline business case and we expect to have an agreed set of goals and owners defined within the next few months.

4.	**Next steps**
4.1	By the time of our next meeting: • We will have converged upon an answer to “the right sized hospital” • Submitted our paper to JIC for approval requesting to move forward to the outline business case phase of our project. • RIBA 2 designs will have progressed materially. • Our new access road will be nearing completion. • Archaeological trenching will be complete. • The first phase of buffer planting will be complete with the next phase due at the end of 2024 due to seasonal conditions. • We will have agreed the optimum method and timing for West Suffolk to seek a primary construction partner.
5.	**Conclusion**
5.1	The building of a new West Suffolk Hospital remains a priority within the New Hospital Programme.
5.2	The review of the preferred hospital design is nearing completion and will allow the project to commence with detailed drawings and the completion of its outline business case. Enabling works aimed at discharging our planning conditions and preparing our site for construction continue positively in line with plans.
5.3	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.

2.3. System Update

To Assure

West Suffolk Alliance Director Update March 2024 - Including Committee Meetings of 14 February and 12 March

1. *Physical activity*

Active Suffolk gave a presentation describing the opportunities to collaborate regarding physical activity, including additional targeted funds from Sport England. The Committee emphasised the importance of a joint approach and requested a joint plan for physical activity to be presented to the April or May meeting.

2. *Dementia diagnosis waiting times*

NSFT reported that they have used additional funds to increase team capacity. This has reduced waiting list size from 621 to 507. However, waiting times remain significant (7 months) and further referral increase is expected . The Committee supported a case for further resources to achieve and sustain lower waiting times. Final approval for extra funding sits with the ICB. Other agreed actions include: improving "did not attend" rates, supporting minor cognitive impairment support with PCNs; PCNs to support those diagnosed to have advanced care plans.

3. Health Inequalities

Bury action group (Howard estate)

- The team are working with the community and reviewing data to build an in depth picture of well being needs
- The PCN team have contacted 80 residents with recorded high blood pressure outside of target levels. To date 50 residents have responded to contacts, 35 of these have moved to target levels, 15 are being supported to do so. 30 have not responded and the group is considering options to best approach this group.
- Case-finding: the group is developing options to contact the 1100 people whose health records show they are at risk, but do not have a recent blood pressure reading
- Community involvement and the work of community pharmacies and GP teams remains central.

West Suffolk wide approach

- The Committee is scheduled to review a draft proposal for use of ICB Health inequality funds at the April meeting to include action across West Suffolk

4. First 1000 days

The Committee received an update on the 3 priorities proposed for 2024/25:

- To pilot a collaborative approach to a targeted preconception offer for people who may suffer with obesity, smoke, and/or have high levels of alcohol, and associated poor outcomes.
- To provide a multi-agency support programme for parents at risk of babies becoming Looked After Children at birth, to reduce the likelihood of recurrent pregnancies and removals and associated poor outcomes.
- To map the support offer to new parents and establish how further work with VCSE can be embedded to reduce isolation, postnatal mental health difficulties and promote healthy attachments with children.

5. Discharge Plans

The Committee received and approved proposals for use of the discharge funds which have been constructed between alliance partners (see appendix).

6. *Other*

Funds for **GP streaming contract** to pass from ICB to WSFT to directly contract GP streaming services at WSFT main site.

Noted **prescribing overspend** and actions to mitigate this including:
- Interface pharmacist with WSFT
- Antibiotic Local enhanced service
- Interface paediatric dietician
- Wound care direct supply
- Lidocaine action

The Committee received proposed terms of reference for a specialist **SNEE Dental Commissioning Committee** to take decisions on behalf of the 3 Alliance Committees. The Committee raised issues regarding membership and focus and agreed the TORs on the basis these issues are resolved. Regular updates will be provided, including identifying areas where the alliance can support.

West Suffolk Alliance **Performance indicators** were reported using the live well domain format. This indicated the following performance changes in latest data.

Indicators showing improving performance	Worsening performance
- Increasing GP practice teams - Children and young people (CYP) access to mental health services - CYP asthma admissions - Urgent community response - SMI annual physical health checks - 8 diabetes care processes	- Anti-biotics/STAR-PU - Dementia diagnosis rate

The committee discussed the Alliance approach to the **Alliance Delivery Plan** 2024/25 which is under development.

Appendix - Discharge Funding Plans

Overarching indicators (note targets to be set for 3 areas by 31 Mar 24)

Metric	Baseline	Baseline period	Notes	Overall Target
	West Suffolk			
Delay time between no CTR and discharge - P1	3 days	2022/23	Based on median delay	1 day or less
Delay time between no CTR and discharge - P2	2 days	2022/23	Based on median delay	1 day or less
Delay time between no CTR and discharge - P3	6 days	2022/23	Based on median delay	1 day or less
% of acute bed base occupied by people with no CTR	16%	2022/23		>14 %
Improved reablement rates for people exiting reablement - fully reabled	53%	M1-6 2023/24	Based on HF performance YTD 2023/24	
Improved reablement rates for people exiting reablement - partially reabled	26%	M1-6 2023/24	Based on HF performance YTD 2023/24	
Length of stay in commissioned beds	31.6 days	2022/23		20 days
Reduction in cost of care and support post discharge	Method TBC	TBC	To be agreed based on cohort/scheme	

Schemes approved February 2024

Scheme	Cost 24/25	Full year cost 24/25
Home First – 22/23 schemes continued	£721,724	£721,724
X18 Community Beds – 22/23 schemes continued	£1,000,000	£1,000,000
Wrap around support – 22/23 schemes continued	£340,231	£340,231
External Reablement	£383,250	£383,250
Digital	£255,000	£255,000
Increase STNH Capacity	£493,891	£564,849
Stepping Home	£51,071	£51,071
Total Mobile system licence	£25,000	£25,000
Hospital Social Prescriber	£127,000	£127,000
Total	**£3,397,167**	**£3,468,125**

Current uncommitted amount - £366,668
Full year cost uncommitted - £295,710
Gap - £70,958

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WEST SUFFOLK ALLIANCE
about people & places

Recommended schemes for approval

Schemes put forward for second round of approval have undergone a process where impact, cost, risk to scheme and delivery timeframe have been reviewed. For this process it is recommended the below schemes are approved for use of the remaining discharge fund.

Scheme & description	Start date	Cost 24/25	Full Year cost
Delirium Nurse - Increase in Delirium nurse B7 by 1WTE. To enable more reviews and supported discharges, where P0 and P1 are explored prior to considering P2 or P3. To help reduce the delay in initial assessment and support a timely discharge of patient.	June 2024	£62,906	£72,938
Weekend Care Coordinator - One care coordinator for all medical wards to support discharge	April 2024	£15,715	£15,715
Palliative support Overnight EIT – RN & HCA – Registered nurse with palliative case specialism and a health care assistant to support EIT with night visits 4 days per week, working collaboratively with the community teams on a discharge and admission prevention basis. Based within EIT, along with support to the ambulance Halo and diverting patients to Hospice or other appropriate care.	June 2024	£96,759	£119,011 *one off cost of £9000
Additional discharge Vehicle - With the increased number of pathway 1 patients discharged on a daily basis with the implementation of Home First, External reablement and Total Mobile system, the transport offer that is currently provided to WSFT will not meet the expected demand. The additional d/c vehicle will be able to accommodate 10 further discharges per day, allowing for the expected 12+ pathway 1 discharges per day. This vehicle is part (50%) funded by Additional Capacity UEC Funding.	April 2024	£95,000	£95,000
Total		**£270,380**	**£302,664**

Current uncommitted amount - £366,668
Full Year uncommitted amount - £295,710
Recommended schemes total = £302,664 (full year cost) Overspend - £6,954 (*acknowledge one off cost £9000)
Total therefore - £293,664

#teamwestsuffol

2.3.1. Collaborative Oversight Group Report

For Approval

Committee/Group	
Report title:	Terms of Reference for the Collaborative Oversight Group and the Collaborative Executive Group
Agenda item:	2.3.1
Date of the meeting:	22nd March 2024
Lead:	Nicola Cottington, Chief Operating Officer WSFT
Report prepared by:	Nicola Cottington, Chief Operating Officer WSFT Stephanie Rose, Programme Director Provider Collaborative WSFT/ESNEFT Pooja Sharma, deputy trust secretary, WSFT

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 2019 NHS Long Term Plan sets out a "duty to collaborate" which was further developed in Working Together at Scale (2021), which requires NHS Providers to be part of one or more Provider Collaboratives. In the context of finite resources, increasing demand and health inequalities, it is imperative for organisations to collaborate with partners, where this creates improved outcomes for patients and the population. This is supported by NHS strategy and policy, including the West Suffolk Foundation Trust (WSFT) strategy 2021-2026.

The WSFT and the East Suffolk & North Essex NHS Foundation Trust (ESNEFT) have been developing a collaborative approach over the past two years, including board to board workshops, joint working within functions including procurement, and mutual aid for specific clinical pathways.

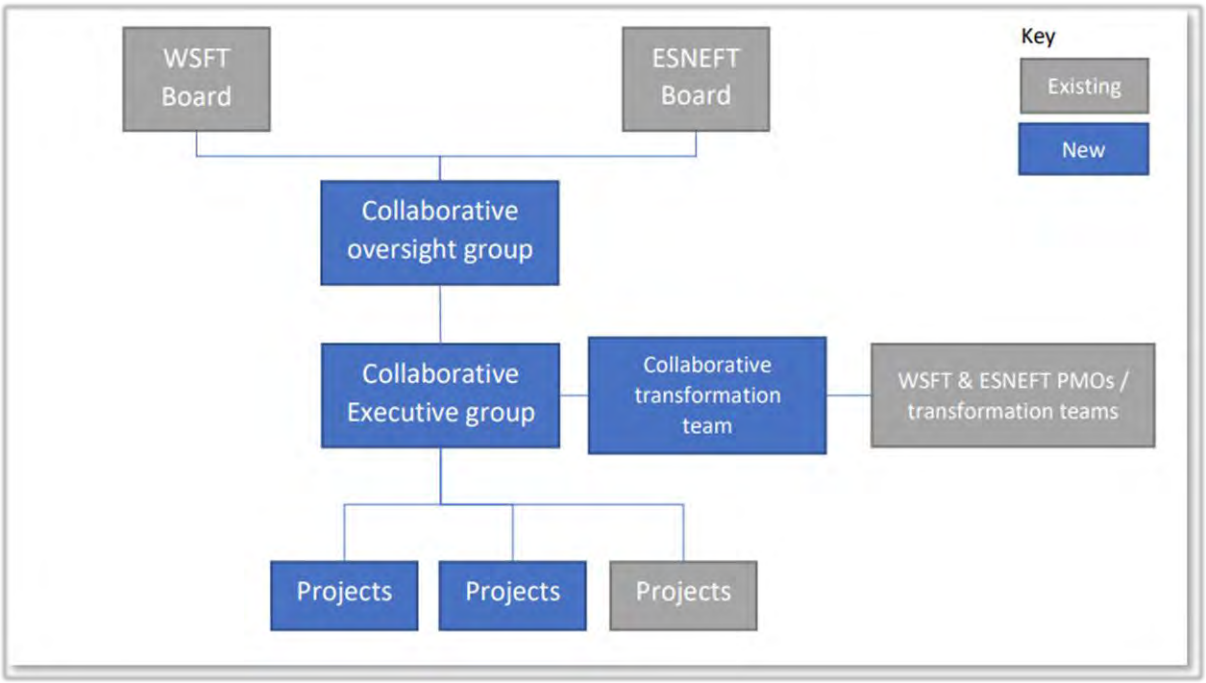
A Board-to-Board meeting was held between both trusts in May 2022 where the boards of both trusts agreed a shared vision and principles for collaboration and adopted the recommendation to create some light-touch joint governance and a collaborative programme management office

In March 2023, both trusts presented proposals to their respective boards for the next steps and the establishment of a governance structure was supported. It was noted that any commitment of resources would need to await the completion of business planning processes. The Boards of WSFT and ESNEFT approved the establishment of the Collaborative Oversight Group (replacing the existing Board to Board meetings) and the Collaborative Executive Group (replacing the existing collaboration working group).

The purpose of the Collaborative Oversight Group is to receive regular collaborative work programmes and updates, as part of developing the shared vision and principles underpinning the existing collaboration arrangements between both the trusts. The Collaborative Oversight Group has a key role in leading strategy towards collaboration and integration and creating a supportive culture for this provider collaborative to flourish.

The purpose of the Collaborative Executive Group is to establish, maintain and drive the collaborative work programme between the East Suffolk & North Essex NHS Foundation Trust (ESNEFT) and the West Suffolk NHS Foundation Trust (WSFT). The Collaborative Executive Group will guide, co-ordinate and hold to account the services across both organisations as well as the transformation teams for delivering this programme of work in line with agreed timescales and objectives.

Table 1: Collaborative governance structure agreed by WSFT and ESNEFT boards May 2023



The Collaborative Oversight Group is now established and had their first meeting as part of the board-to-board meetings. The Collaborative Executive Group is also established and meeting on a monthly basis to drive the work of the Provider Collaborative.

This paper provides the terms of reference for the Collaborative Oversight Group and the Collaborative Executive Group for approval. The latest version of the Collaborative Oversight Group terms of reference has been modified following feedback from the WSFT Board, the ESENFT Board and the Collaborative Executive Group. Both terms of reference have been recommended by the Collaborative Executive Group and ratified by the ESNEFT Board on 11th March 2024.

The terms of reference are provided for approval:

(Appendix 1 Collaborative Oversight Group Terms of Reference for approval)
(Appendix 2 Collaborative Executive Group Terms of Reference for approval)

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

Following consideration and feedback on the Collaborative Oversight Group terms of reference from the ESNEFT Board on 11th January 2024 and the WSFT Board on 26th January 2024 the following amendments have been made to the terms of reference:

- To include *one* non-executive director (NED) in the quorum, rather than "non-executive director*s*" although there is an open invitation to all NEDs
- To rename chairman to chairpersons
- To add deputies to the quorum
- To add NEDs to the 'in attendance' section
- To add The Director of Operations and North-East Essex Community Service to the membership.
- To add a review date of six months
- To add the WSFT logo

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

Following approval of the terms of reference for the Collaborative Oversight Group and the Collaborative Executive Group by the WSFT board, the next step will be to adopt the governance structure as agreed by both boards in March 2023 and to hold an initial Collaborative Oversight Group to replace the Board-to-Board meetings that have been held to date.

Recommendation / action required

The Board is recommended to:

- Approve the Collaborative Oversight Group Terms of Reference
- Approve the Collaborative Executive Group Terms of Reference

Previously considered by:	The Collaborative Oversight Group terms of reference have been considered by: • ESNEFT board meeting 11th January 2024 • WSFT board meeting 26 January 2024 • Collaborative Executive Group meeting 13 February 2024 The Collaborative Oversight Group terms of reference have been ratified by: • ESNEFT board meeting 11th March 2024 The Collaborative Executive Group terms of reference have been considered by: • Collaborative Executive Group meeting 13 February 2024 The Collaborative Executive Group terms of reference have been ratified by: • ESNEFT board meeting 11th March 2024
Risk and assurance:	Working collaboratively provides opportunities to address critical risks together, at a larger scale. There is relevance to all risks on the Board Assurance Framework.

Equality, diversity and inclusion:	Equality, Diversity and Inclusion was one area considered for the sharing of good practice and learning between the two organisations.
Sustainability:	Working together to ensure the most efficient and effective use of our collective resources would contribute to a more sustainable health care system.
Legal and regulatory context:	The Trust is a legal entity and subject to the regulatory framework; the collaboration set out in this paper does not undermine those responsibilities.

Collaborative Executive Group
Terms of Reference

1. Constitution

The purpose of the Collaborative Executive Group is to establish, maintain and drive the collaborative work programme between the East Suffolk & North Essex NHS Foundation Trust (ESNEFT) and the West Suffolk NHS Foundation Trust (WSFT). The Executive Group will guide, co-ordinate and hold to account the services across both organisations as well as the transformation teams for delivering this programme of work in line with agreed timescales and objectives.

2. Authority

The Executive Group will replace the informal working group currently in operation. It will meet monthly, will be jointly chaired by the CMOs of both organisations who will rotate in the Chair role. The group will guide the programme of work and hold individual projects within the wider programme to account. It will utilise the authority of Executive members and hold no delegated powers. It will report to the collaborative oversight group. Executive teams across ESNEFT and WSFT will be responsible for ensuring that visibility and accountability is maintained at all times.

3. Membership

Core members of the Executive Group are:

- Medical Director/Chief Medical Officer ESNEFT – Chair (Joint)
- Medical Director/Chief Medical Officer WSFT – Chair (Joint)
- Director of Strategy, Research & Innovation ESNEFT
- Chief Operating Officer WSFT
- Director of Elective Recovery ESNEFT
- Director of Operations ESNEFT
- Deputy Chief Operating Officer WSFT

In Attendance

- Programme Director, Collaborative Transformation Team
- Transformation Team Lead(s) ESNEFT and
- Transformation Team Lead(s) WSFT
- Representatives of individual services and less senior members of the transformation teams from both ESNEFT and WSFT may periodically be invited to attend the Executive Group in an advisory capacity.

4. Attendance

Group members may nominate a deputy to attend the Executive Group if they are unavoidably absent but should not do so routinely. Members are expected to attend a minimum of 75% of meetings over 12-month period.

5. Quorum

The quorum necessary for the transaction of business shall be two members from each Trust, which must contain as a minimum the Chief Medical Officer/Medical Directors at ESNEFT and WSFT and the Director of Strategy, Research & Innovation ESNEFT and COO WSFT. A duly convened meeting of the Executive Group at which a quorum is present shall be competent to exercise all or any of the authorities and discretions invested in, or exercised, by the Group. Deputies may attend by agreement with the Chair.

6. Frequency and Conduct

The Executive Group shall operate as follows:

- Will meet monthly,
- Items for the agenda should be submitted to the committee secretary a minimum of one week prior to the meeting;
- Papers will be sent out by the committee secretary at least 4 working days before each meeting;
- Membership and terms of reference will only be amended with the approval of the Executive Group and on the recommendation of the Chairs;
- The Executive Group will provide up to date and comprehensive progress updates to be received on a quarterly basis by the Collaborative Oversight Group; and
- The terms of reference of the Executive Group will be reviewed annually and submitted to the Collaborative Oversight Group for approval.

7. Main duties

The Executive Group will:

a. Oversee the development of a collaborative programme of work covering a range of corporate and clinical services and aligned with the agreed joint priorities identified by ESNEFT and WSFT;
b. Submit an up to date, revised programme of work to the Collaborative Oversight Group annually for approval;
c. Provide assurance to the Collaborative Oversight Group that planning is effectively established and managed, and that all risks to delivery of jointly developed plans are effectively managed or mitigated;
d. Review performance against jointly commissioned projects and thoroughly examine the effectiveness of relevant action plans;
e. Provide assurance to the Collaborative Oversight Group on the delivery of agreed collaborative programmes, including regular assurance on benefits realisation;
f. Regularly receive and review a comprehensive and up to date Collaborative Risk Register, and escalate risks to the Collaborative Oversight Group where required;

g. Ensure there are governance arrangements in place to manage any concerns, including those identified as a result of individual project reviews, are addressed and monitored, and appropriate action plans are in place to mitigate these risks;
h. Hold services and transformation teams across ESNEFT and WSFT to account for the delivery of projects, and monitor progress of delivery against agreed milestones;
i. Consider and appraise any initial approaches or proposals for any possible options for further collaboration/joint working between ESNEFT and WSFT, and consider whether there is merit in considering such initial approach or proposal further;
j. Make recommendations to the Collaborative Oversight Group on any such opportunities that may arise which merit further consideration, or which should be proactively pursued, to deliver the identified objectives;
k. Receive and seek advice from the relevant sub-groups as listed in section 9 of this document;
l. Ensure that timely delivery of the programme of work enhances the quality of care, safety and the patient experience provided by both Trusts;
m. Engage key internal and external stakeholders in this work, including clinical leaders, and operational leaders who support the delivery of high-quality, sustainable services; and
n. Involve staff, patients and carers, partner organisations and communities in this work.

8. Key responsibilities

The key responsibilities of the Executive Group will be: to ensure that the programme of work is continuously developed; has clear goals and success measures; and to receive assurance that the transformation teams responsible for the day-to-day delivery of the programme are performing in a way which delivers the programme's objectives/milestones, and has aligned its own objectives with the overarching priorities for collaboration identified by this group and the Provider Collaborative Group.

9. Reporting and Monitoring Responsibilities

Summary notes and an action log will be prepared after each meeting of the Executive Group within a week and circulated to members and others as necessary once confirmed by the Chair.

The following sub-Group(s) will formally report to the Executive Group:

- Collaborative Transformation Team;
- Individual collaborative project steering groups.

The WSFT/ESNEFT PMOs/Transformation Teams will provide updates on relevant projects for information.

10. Monitoring effectiveness

In order to support the continual improvement of governance standards, the Executive Group is required to complete a self-assessment of effectiveness at least annually and advise the Collaborative Oversight Group of any suggested amendments to these terms of reference which would improve the existing governance arrangements.

11. Approval

These terms of reference shall be reviewed by the ESNEFT WSFT Collaborative Oversight Group for approval, and any subsequent amendments will be communicated to the Collaborative Oversight Group.

Review date: 6 months

Collaborative Oversight Group
Terms of Reference

1. Constitution

The purpose of the Collaborative Oversight Group is to receive regular collaborative work programmes and updates, as part of developing the shared vision and principles underpinning the existing collaboration arrangements between the East Suffolk & North Essex NHS Foundation Trust (ESNEFT) and the West Suffolk NHS Foundation Trust (WSFT).

2. Authority

The Oversight Group will not hold delegated powers and will draw its authority from the Executive teams of both Trusts to make decisions within defined parameters as set out in the ESNEFT &WSFT Collaboration Report approved by the Boards of both organisations. The Group will replace the current Board-to-Board meetings between WSFT Board and ESNEFT Board.

3. Membership

Core members of the Programme Board are:

- Chief Executive Officer ESNEFT - Chair (Joint);
- Chief Executive Officer WSFT – Chair (Joint);
- One Non-Executive Director ESNEFT;
- One Non-Executive Director WSFT;
- Medical Director/Chief Medical Officer ESNEFT;
- Medical Director/Chief Medical Officer WSFT;
- Director of Strategy, Research & Innovation ESNEFT; and
- Chief Operating Officer WSFT.

In Attendance

Executive and Non-Executive Directors not listed as members from both ESNEFT and WSFT may attend the Oversight Group in an advisory capacity.

4. Attendance

Group members may nominate a deputy to attend the Oversight Group. Members are expected to attend a minimum of 75% of meetings over 12-month period.

5. Quorum

The quorum necessary for the transaction of business shall be four members from each Trust, which must contain, the Chairpersons, the Medical Director / Chief Medical Officer, the Director of Strategy, Research & Innovation (ESNEFT), the Chief Operating Officer (WSFT) and one Non-Executive Director from each Trust. A duly convened meeting of the Oversight Group at which a quorum is present shall be competent to exercise all or any of the authorities and discretions invested in, or exercised, by the Group.
Deputies may attend by agreement with the Chairperson.

6. Frequency and Conduct

The Oversight Group shall operate as follows:

- Will meet quarterly;
- Items for the agenda should be submitted to the committee secretary a minimum of one week prior to the meeting;
- Papers will be sent out by the committee secretary at least 4 working days before each meeting;
- Membership and terms of reference will only be amended with the approval of the Oversight Group and on the recommendation of the Chairs; and
- The terms of reference of the Oversight Group will be reviewed annually.

7. Main duties

The Oversight Group will:

a. Ensure that the benefits of collaboration are maximised, including by considering proposals from the Collaborative Executive Group/Collaborative Transformation Team for accelerating best practice and standardising care;
b. Provide strategic direction to the programme of work developed by the Collaborative Executive Group;
c. Agree on an annual basis the programme of work developed with the Executive Group, and ensure that this has clear goals and success measures;
d. Measure the effectiveness, strategic focus and visibility of the corporate and clinical collaborative activity included in the approved programme of work;
e. Receive assurance from the Collaborative Executive Group and the Collaborative Transformation Team that the objectives of the transformation programme of work are being achieved through regular updates;
f. Ensure that the set of operational Key Performance Indicators used to monitor progress against milestone achievements are aligned with the agreed principles of collaboration;
g. Receive post-project evaluation reports on the projects completed to date; with an emphasis on learning lessons and exploring the potential to go further, faster;
h. Ensure that the two organisations hold each other to account for the delivery of their shared vision and principles of working;
i. Ensure that the decisions made by the Collaborative Oversight Group support transformation, improve sustainability, reduce health inequalities and eliminate variations in quality;
j. Ensure that clinical and operational leadership is proactively engaged in the delivery of the projects falling within the scope of the collaboration programme of work;
k. Involve staff, patients, partner organisations and other key internal and external stakeholders in this work;
l. Assume shared responsibility for risk oversight and management; and
m. Ensure that the coordinating and project support functions are adequately resourced and supported.

8. Key responsibilities

The key responsibilities of the Oversight Group shall be to receive assurance from the Collaborative Executive Group and the Collaborative Transformation teams over successful delivery of the vision shared by the two organisations.

9. Reporting and Monitoring Responsibilities

Summary notes and an action log will be prepared after each meeting of the Oversight Group within a week and circulated to members and others as necessary once confirmed by the Chair.

The following sub-Group(s) will formally report to the Oversight Group:

- Collaborative Executive Group.

10. Monitoring effectiveness

In order to support the continual improvement of governance standards, the Oversight Group is required to complete a self-assessment of effectiveness at least annually and advise the TMB of any suggested amendments to these terms of reference which would improve the trust governance arrangements.

11. Approval

These terms of reference shall be reviewed by the ESNEFT and WSFT Boards for approval, and any subsequent amendments will be communicated to the Boards.

Review date: 6 months

2.4. Digital Programme Report

To Assure

Trust Board	
Report title:	Digital programme board report
Agenda item:	2.4
Date of the meeting:	23rd March 2024
Lead:	Craig Black
Report prepared by:	Liam McLaughlin, CIO

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

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

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

Sustainability:	
Legal and regulatory context:	

Digital Programme report

1.	**Introduction**
1.1	The digital programme supports the Trust in providing a wide range of technical infrastructure, clinical systems and digital solutions to support the operation and transformation of the organisation
2.	**Background**
2.1	The digital programme consists of 5 main pillars of work: • Clinical systems – primarily e-Care, the main hospital patient record • Regional initiatives including population health management and the ICS shared care record • Community digital initiatives • Digital infrastructure and foundations • Optimisation
2.2	Additionally, the Future System Programme has a digital workstream which is considering and defining work requirements to support a smart hospital and outline that can be carried out in advance of the new hospital. This also includes initiatives to assess the digital capabilities and preparedness of both of staff and patient/carer communities. Several key digital staff are seconded to work on the FSP digital workstream.
2.3	Overall, resources to deliver the programme remain fully committed.
3.	**Detailed sections and key issues**
3.1	**Clinical systems - Pillar 1** There are two major projects underway to replace and extend key functionality in the main patient record, e-Care. This is improved outpatient functionality together with moving critical care onto e-Care. The planned implementation has been delayed due to resource scheduling constraints until early 2025. The roll out of the e-Consent solution, Concentric, to further specialities will continue throughout 2024. It enables patients to sign electronically to consent to surgical or medical procedures. This is a significant stepping stone in the transition to Shared Decision making. The new self check-in kiosk solution has gone live in main outpatients with the roll out planned to other outpatient clinic areas over the coming months. The same solution has been used in the last 4 new hospital builds and so gives us the chance to get familiar with the technology long before the opening of the new hospital. It will include the ability to help direct patients to different waiting areas and give directions to the specific clinic area. Works continues with the East Digital Imaging Network to implement an image sharing solution that will also enable reporting on images across the network wherever the radiologist reporting capacity is available. A replacement for the Emergency Department Digital Integration (EDDI) solution, now withdrawn by NHS England, has been implemented. It enables NHS 111 staff to book directly into ED department 'slots'.

3.2	**Regional initiatives - Pillar 2** WSFT operates the Health Information Exchange (HIE) on behalf of the ICS delivering a shared care record solution for staff to support direct care. It joins up clinical information from primary care, community, secondary care, mental health and social care. Likewise it connects to neighbouring shared care record systems to give seamless clinical information especially covering patients who may move between different ICS providers. Use of the NHS App continues to grow across the region and the Trust has now delivered appointment details so that they are visible in the NHS App. Further use will be made of the app to deliver an increasingly wide range of information. The patient portal provides a wide range of clinical information to registered users and works in conjunction with the Dr Doctor platform to provide appointment letters electronically where applicable. This platform also provides appointment reminders and an increasing level of patient engagement initiatives.
3.3	**Community digital initiatives – Pillar 3** The WSFT digital team that support the Community teams have been focused on a whole series of optimisations to the SystmOne platform that support their clinical and administrative processes. It includes many new and additional data capture templates for a whole range of community teams and services as well as new community units, pathways and careplans. This has been enabled as a result of having a digital resource dedicated to WSFT community optimisation. Work is progressing to identify whether the Trust voice recognition solution (M*Modal) will work for Community teams, taking into account the need for integration with the community EPR (SystmOne)
3.4	**Digital infrastructure – Pillar 4** Significant investment has been in the network infrastructure across the acute and community locations. On the main hospital site, work is underway to upgrade the Wifi access points to support the latest protocols and frequencies. This will initially be a like for like replacement followed by a survey to identify any dead spots that might have been introduced during the remedial building work. Further work is underway to introduce additional internet capacity and upgrade to the infrastructure that specially supports the staff and public facing WiFi service and internet connections. Work to ensure the Trust cyber security continues and a cyber hygiene report is presented at the quarterly Information Governance Steering group and covers the status of our server and workstation patching, CareCERT nationally reported critical patches, threat detections and volumes of e-mail and web site activities. It includes an additional solution that can monitor medical and other Internet of Things (IoT) devices that are connected to the Trust network. The Trust storage area network (SAN) has been upgraded to deliver greater resilience and capacity following the end of the previous managed service platform and data is being migrated in the background. A number of projects are exploring ways in which we can make better use of the range of Microsoft products and solutions that we have based on the current license position. The NHS has negotiated a continued preferential rate from Microsoft for the supply of many of their license specifically to the NHS.

	Working closely with the Information governance team, the teams are preparing for the revised Data Protection Toolkit audit which introduces a range of additional assertions that we need to consider. We achieved re-certification to the ISO 9001 (Quality management system standard) and ISO 27001 (Information Security standard) accreditations and renewal of our NHS secure e-mail status.
3.5	**Optimisation – Pillar 5** Same Day Emergency care activity must be recorded and reported nationally. Revisions to the processes and workflow are being built within the Emergency Department section of e-Care. A number of national initiatives are being progressed including digital ReSPECT form, revised pressure damage assessment tool, reasonable adjustments, National PEWS, revised SEPSIS pathway, digital fit-notes and safeguarding referrals. Consideration of ways in which both results management and the discharge process could be improved and enhanced are underway. These are complex processes that cut across many teams and departments across the organisation. Pillar 5 also includes changes to systems to address clinical safety issues arising from the use of the digital solutions together with use of systems to help mitigate or avoid clinical incidents
3.6	**Other initiatives** The Cerner (now Oracle Health) contract for e-Care has been in place for 10 years in July 2024. Working closely with the contracting and procurement teams we are looking at ways of re-contracting with Cerner. It is planned to bring the proposal to the May board meeting for discussion and approval.
4.	**Next steps**
4.1	The digital programme will continue to support and closely align with the Trust strategy.
5.	**Conclusion**
5.1	The digital programme covers a wide range of projects and initiatives, and these are managed effectively through the pillar structure.
6.	**Recommendations**
	The report provides evidence and assurance that the digital programme is in line with Trust plans

3. PEOPLE AND CULTURE

3.1. National Survey Results

For Discussion

NHS
West Suffolk
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NHS staff survey results 2023

Board of directors briefing: 22 March 2024

Putting you first

Introduction

- The biggest and best opportunity for staff to tell us how they feel about working here – good and bad
- A huge pack of information and analysis for us to work through
- THANK YOU to colleagues for taking part! It absolutely does make a difference
- It's confidential – we can't see individual responses and don't know who said what but can see categorised data (by division, staff group, demographics)
- Published this month along with all other Trusts
- Today: share some of the key headlines and how you and others can be involved in what happens next

The basics

NHS
West Suffolk
NHS Foundation Trust

Organisation details

Survey Coordination Centre NHS

West Suffolk NHS Foundation Trust

2023 NHS Staff Survey

Organisation details

Completed questionnaires	2424
2023 response rate	46%

Survey details

Survey mode	Mixed

This organisation is benchmarked against:

Acute and Acute & Community Trusts

2023 benchmarking group details

Organisations in group: 122

Median response rate: 45%

No. of completed questionnaires: 477643

The headline results – 9 key scores

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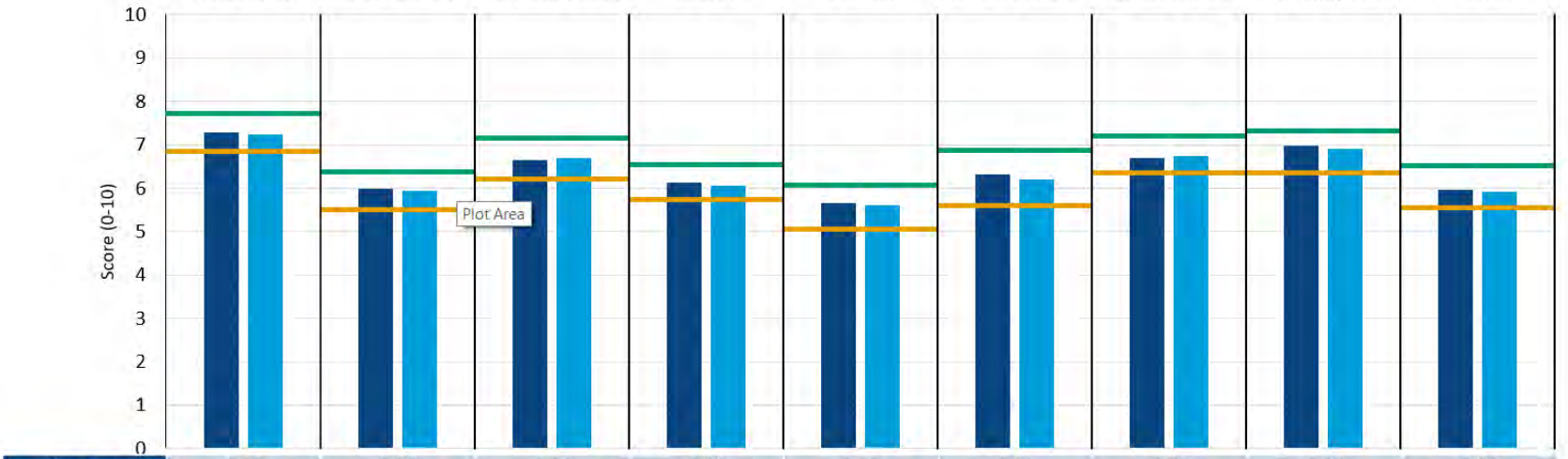
People Promise elements and themes: Overview

Survey Coordination Centre NHS

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.28	5.98	6.64	6.14	5.65	6.31	6.70	6.97	5.96
Best result	7.71	6.37	7.16	6.55	6.07	6.87	7.19	7.32	6.52
Average result	7.24	5.94	6.70	6.06	5.61	6.20	6.75	6.91	5.91
Worst result	6.85	5.50	6.21	5.75	5.05	5.60	6.35	6.34	5.54
Responses	2415	2417	2388	2397	2310	2402	2417	2418	2420

What does this tell us?

- All 9 key scores improved compared to 2022; 5 of those 9 in a significant way (according to the survey provider)
- 7 of the 9 scores are better than the national average; two are lower. These are only *just* better than the national average however - showing plenty of room for further improvement.
- It's positive that our scores have improved over what has been a challenging year generally for us, although the scores are not as high as they were before the pandemic.
- The two scores that are lower than the average relate to things in our people plan that we are already prioritising:
  - 'We each have a voice that counts' – raising concerns and speaking up
  - 'We are a team' – how line managers and teams support each other

How the 9 key scores have changed since 2022

NHS West Suffolk NHS Foundation Trust

Appendix B: Significance testing – 2022 vs 2023

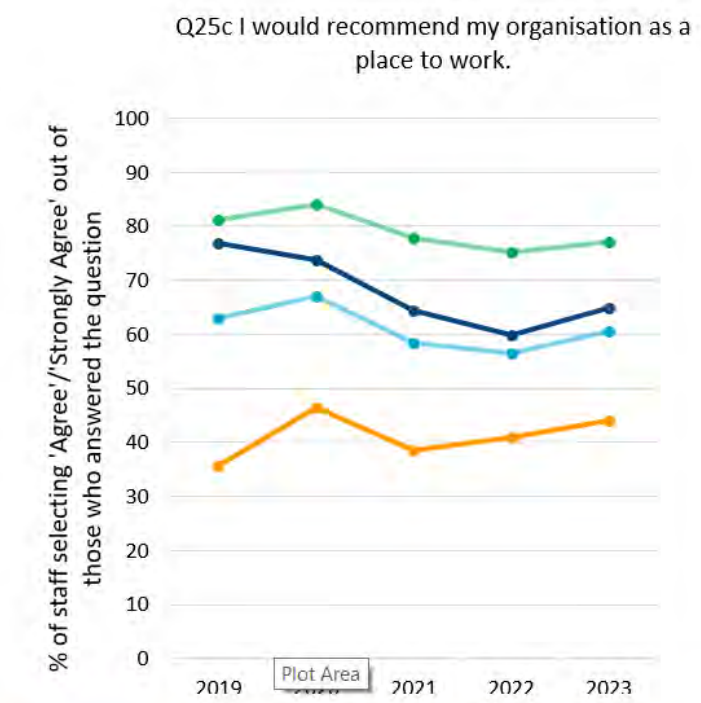
Survey Coordination Centre NHS

Statistical significance helps quantify whether a result is likely due to chance or to some factor of interest. The table below presents the results of significance testing conducted on the theme scores calculated in both 2022 and 2023*. For more details please see the technical document.

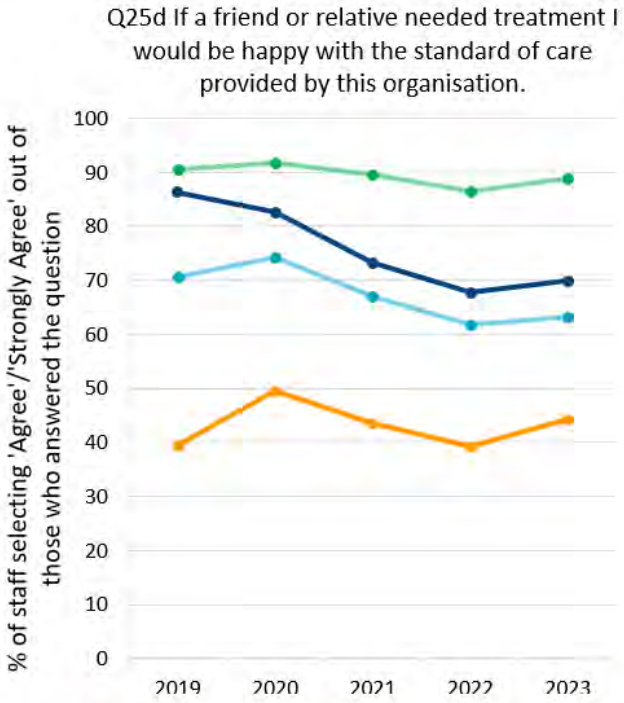
People Promise elements	2022 score	2022 respondents	2023 score	2023 respondents	Statistically significant change?
We are compassionate and inclusive	7.21	1982	7.28	2415	Not significant
We are recognised and rewarded	5.84	1983	5.98	2417	Significantly higher
We each have a voice that counts	6.60	1973	6.64	2388	Not significant
We are safe and healthy	5.93	1977	6.14	2397	Significantly higher
We are always learning	5.34	1934	5.65	2310	Significantly higher
We work flexibly	6.04	1981	6.31	2402	Significantly higher
We are a team	6.60	1981	6.70	2417	Not significant
Themes					
Staff Engagement	6.88	1983	6.97	2418	Not significant
Morale	5.78	1984	5.96	2420	Significantly higher

Would you recommend?

West Suffolk NHS Foundation Trust



	2019	2020	2021	2022	2023
Your org	76.74%	73.67%	64.38%	59.94%	64.90%
Best result	81.18%	83.99%	77.82%	75.24%	77.09%
Average result	62.94%	67.00%	58.40%	56.48%	60.52%
Worst result	35.64%	46.44%	38.47%	41.03%	44.05%
Responses	2001	1895	1927	1976	2404



	2019	2020	2021	2022	2023
Your org	86.22%	82.58%	73.33%	67.84%	69.92%
Best result	90.62%	91.76%	89.51%	86.38%	88.82%
Average result	70.57%	74.32%	66.99%	61.82%	63.32%
Worst result	39.54%	49.58%	43.54%	39.27%	44.31%
Responses	2006	1897	1930	1978	2403

Other things we've noticed so far…

Positives	Concerns
Staff feedback in Community Services and AHP staff groups	A small decrease in experiencing kindness & respect between colleagues
Improvements in scores for appraisals and flexible working	The relative experience of colleagues with a disability / long term condition
Access to nutritious & affordable food at work – almost best score in country!	The relative experience of Black, Asian & minority ethnic colleagues
Small improvements in 'speaking up' questions – much further to go	Staff reporting experiencing poor behaviour, i.e. bullying; unwanted sexual behaviour
More people think there are enough staff here so they can do their job properly	Parts of the organisation where staff experience is less good compared to others
Fewer staff reporting stress / burnout	Being involved in changes that affect my team / department

Our People & Culture plan – 2023/24

- some of our main action areas in development this year

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1. Grow our staff networks to learn from the experience of members
2. Be better at implementing reasonable adjustments for staff with a disability
3. Build an anti-racist organisation to help eliminate discrimination and disadvantage
4. Implement a new e-recruitment system to improve candidate & manager experience
5. Use stay conversations and flexible working to continue to improve retention
6. Increase our support for line manager roles, to better value staff & teams
7. Implement the ‘learning hub’ to improve awareness of and access to opportunities
8. Review & relaunch the appraisal process to staff feel more valued through the process
9. Continue with our speak, listen & follow-up work to value the sharing of concerns
10. Launch Schwartz Rounds as part of our support for wellbeing at work

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What next?

- You can take a look at our reports (and other organisations if you wish) via: www.nhsstaffsurveys.com
- Analysis of the ‘free text’ comments that contributors also shared
- Getting more feedback and reflection from you and others
- Develop a new people and culture plan with actions for 2024 / 25, learning from this analysis
- Divisions, departments and staff groups identifying their own priorities
- Undertake analysis of similar survey of Bank-only colleagues

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Sharing your own reflections on the staff survey

- If there is anything you wanted to tell us in response to this presentation, or from looking at the reports, please contact any of the following:
  - Jeremy Over, Claire Sorenson or Carol Steed
  - Jane Sharland, Freedom to speak up guardian
  - One of the Freedom to speak up champions
  - Paul Pearson, staff side lead, or your own staff representative
  - One of the staff governors
  - Chair and co-chairs of our staff networks
  - Any of the other executive directors
  - Ask your line manager to pass on your comments to us

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

To Assure

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Involvement Committee			Date of meeting: 21 February 2024		
Chaired by: Krishna Yergol - Non executive Director			**Lead Executive Directors: 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	First for Staff: National Staff Survey Results Initial Briefing from Jeremy Over. Briefing on the recently released national staff survey results across the 7 People Promise themes.	Reasonable	The Committee noted the national staff survey results and asked for them to be contextualised for WSFT. WSFT results are slightly better than the national average on most of the People Promise themes however there is scope for establishing WSFT specific targets across all 7 themes.	To bring the report to a future committee meeting with detailed analysis and an action plan. Specific internal targets to be considered. Staff survey results to be shared with all staff in March.	No escalation
6.2	First for Staff: Healthcare Assistant Job Profile Review - Band 2/3 – presented by Jeremy Over Implications of implementing the changes to band 2/3	Reasonable	The committee was supportive of the approach and noted the risks related to finances. Recommended further discussions at Insight and at the Board to seek assurance that the organisation can indeed afford the changes to job profiles.	Financial affordability of the proposals to be scrutinised at Insight Committee.	Insight Committee Board

Originating Committee: Involvement Committee			Date of meeting: 21 February 2024		
Chaired by: Krishna Yergol - Non executive Director			Lead Executive Directors: 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
	roles as per national role profiles for HSCW.				
6.3	First for Staff: Implementation and Impact of Schwartz Rounds. Presented by Cassia Nice. Review of the impact of Schwartz Rounds into WSFT during summer 2023.	Substantial	The committee noted the positive impact of Schwartz Rounds on staff engagement and endorsed the need to sustain momentum.	Consider how under-represented groups can be encouraged to participate in Schwartz Rounds. To consider licencing implications. To codify any organisational learning from insights generated at Schwartz Rounds. Further update to Involvement Committee in Q3 2024.	No escalation
8.1	First for Patients: Maternity Services Patient Survey Findings. Report presented by Karen Newbury.	Substantial	The committee noted the findings and acknowledged the team's positive work. Reported scores for WSFT were either better or remained the same as last year's.	Actions under 'where maternity service users' experience could improve' to be co-produced with service users. To trial the approach to enable the support person to stay overnight with the post-natal patient from March.	No escalation

Originating Committee: Involvement Committee			Date of meeting: 21 February 2024		
Chaired by: Krishna Yergol - Non executive Director			Lead Executive Directors: 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
8.2	First for Patients: Patient Engagement Update presented by Cassia Nice. Update on the impact of patient and public engagement activity throughout 2023.	Reasonable	The committee noted the significant amount of engagement and involvement work through the VOICE network and other organisations that are engaged with WSFT. Committee endorsed plans to develop accessible information and make reasonable adjustments across all services.	To establish a formal process to feedback to services the learning from engagement exercises. To report back to Involvement Committee in 6 months' time.	No escalation
9.1	Governance: People and Culture Leadership Group Report. Presented by Claire Sorenson. Regular update to Involvement Committee.	Reasonable	The committee noted the update and the progress being made on workforce KPIs. Absences, appraisals, and turnover are all on target or better.	Further work to understand why the mandatory training targets are not being met in the areas highlighted in the report, and specific interventions to be pursued. Options appraisal paper on Oliver McGowan training to be presented to a future Involvement Committee meeting.	No escalation

Originating Committee: Involvement Committee			Date of meeting: 21 February 2024		
Chaired by: Krishna Yergol - Non executive Director			Lead Executive Directors: 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:**		
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10.1	Assurance: IQPR extract for Involvement Committee	Reasonable	The committee considered the IQPR extracts and the planned next steps to improve our interventions based on insights from the complaints process. Recommended the inclusion of data to demonstrate the volume of early interventions that stop cases from escalating to the complaint stage.	Further work to demonstrate how the learning from complaints is being fed into services. To review and reconsider the target for monthly appraisal rate. The target is currently outside the defined upper and lower process limits. Feedback from employee relations cases to be presented at the next Involvement Committee meeting.	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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COMFORT BREAK

4. ASSURANCE

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

To Assure

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Insight Committee			Date of meeting: 17 January 2024		
Chaired by: Antoinette Jackson			Lead Executive Director: Nicola Cottington/Craig Black		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
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Urgent and Emergency Care Recovery Plan	**Urgent and Emergency Care** Following improvement over the spring months performance has stagnated. 4-hour performance was 59% in December against a trajectory of 71%. The board committed to achieving the NHS of 76% by March 2024 November for 4-hour waits. The percentage of 12-hour stays has increased also increased. Ambulance handovers within 30 minutes have remained on trajectory. A review of recovery plan shows that some implemented actions did not achieve the desired effect and others still need embedding properly. The committee discussed any wider learning for our approach to improvement.	**3 Partial**	Meeting Urgent and Emergency Care performance metrics ensures that our patients are receiving timely emergency care. Data presented by the Emergency Care Intensive Support team suggests that, based on generalised data, 3 patients per week are coming to harm associated with waits greater than 6 hours. NHS England regional team wrote to Suffolk and North East Essex ICB on 20 December expressing concern with WSFT's performance.	We are continuing to work through phase two of the internal Urgent and Emergency Care (UEC) recovery plan in discussion with the ICB. Additional actions have been identified, some informed by a recent peer visit. These relate to: • Leadership and Culture • Embedding and sustaining best practice flow processes • Creating additional capacity outside of the hospital • Considering how we deal with minor injuries and whether an Urgent Treatment centre is a possible solution as suggested by the regional team This will be kept under review by the Insight Committee.	3 Escalate to Board

Originating Committee: Insight Committee			Date of meeting: 17 January 2024		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Craig Black**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
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Patients Access Governance Group/ IQPR	**Cancer Diagnosis** Faster Diagnosis Standard (FDS) performance has improved from 54.6% in September to 65.4% in October, largely due to a significant increase in Breast performance from 50% to 87%. The 62-day backlog trajectory requires attention to recover trajectory, though the March 2024 ambition of no more than 93 patients is still on track to be met – this will include a reduction in the number of patients waiting 104 days or more.	**2 Reasonable**	Achieving the FDS target of 75% and a 62-day backlog of no more than 93 patients by March 2024 are the key objectives for cancer in 2023/24 planning. Action is required to reduce the 62-day backlog, ensuring patients are not waiting for decisions to close pathways where treatment is complete or results negative for cancer are available.	Additional recruitment into a fixed term Radiographer post will add some resilience into the overall performance for Breast Further actions including temporarily increasing cancer diagnostic capacity may be necessary in Q4 to recover progress against the 75% FDS ambition by March 2024. The East of England Cancer Alliance will be implementing a straight to treatment pathway in Skin, using AI teledermatology.	3 Escalate to Board

Originating Committee: Insight Committee			Date of meeting: 17 January 2024		
Chaired by: Antoinette Jackson			Lead Executive Director: Nicola Cottington/Craig Black		
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	Elective Recovery Our submitted trajectory is to have 94 patients over 65 weeks, of which 44 over 78 weeks, at the end of March 2024. All of these breaches are within the uro-gynae sub-speciality. We are ahead of trajectory for both of these cohorts. The absolute number of 78 week patients remains constant in line with our forecast trajectory however this is likely to be impacted by industrial action. There were no 104 week patients as of the end of November	**2 Reasonable**	Delivering the objective of no patients waiting over 65 weeks by March 2024 is the central focus of 2023/24 planning. Patients are at increased risk of harm and/or deteriorating the longer they wait. This then increases demand on primary and urgent and emergency care services as patients seek help for their condition.	Alternatives to insourced capacity for the uro-gynae pathway are being explored, which include mutual aid. Proposals to use an insourcing provider for Dermatology are due to commence in January 2024	3 Escalate to Board

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Finance Accountability Committee	**Financial Recovery Plan and CIP programme** Month 9 figures are in line with our Financial Recovery Plan to have a £3.6m variance by year end, assuming that we will have a smaller deficit in the last quarter as seen in previous years. The operational Planning guidance is yet to be received which will determine 24-25 funding and performance expectations. For 24/25 the Trust was assuming a deficit £22.9m after a CIP delivery of 2.5% and decisions will need to be made about where the target level of CIP should be set. It is intended to add the underachievement of 23-34 CIP to the overall CIP programme this would give a CIP target of £15.6m	**2. Reasonable assurance on current year progress**	There are still risks inherent in achieving the plan in particular how far ongoing industrial action will be funded. The lack of Planning Guidance has delayed the development of a medium terms financial plan.	Further reports to Insight and then Board. Addressing the 2024/25 target will be challenging and the Board will need to decide how to address the level and allocation of CIP targets and what other policy choices may need to be made to help reduce the deficit long term.	3 Escalate to Board

Guidance notes

The practice of scrutiny and assurance

	Questions regarding quality of evidence…	Further consideration…
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Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Insight Committee			Date of meeting: 17 January 2024		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Craig Black**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
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Urgent and Emergency Care Recovery Plan	**Urgent and Emergency Care** 4-hour performance has continued to flatline and is forecast to improve slightly to 65% in February. The board committed to achieving the NHS target of 76% by March 2024 but this will be a challenge given the current performance against trajectory. The percentage of 12-hour stays increased during January 2024 though the position has improved in the past week (outside of the scope of the IQPR report). Ambulance handovers within 30 minutes remain within target.	**3 Partial**	Meeting Urgent and Emergency Care performance metrics ensures that our patients are receiving timely emergency care. The Committee noted that cultural change was needed across disciplines to support performance improvement.	The Trust is continuing to work through phase two of the internal Urgent and Emergency Care (UEC) recovery plan in discussion with the ICB. The plan for patient flow improvement has 4 objectives: - Increasing the non-admitted 4 hour performance to at least 80% - Improving discharge processes so the weekly number of patients with no criteria to reside is less than 10% - Improved admitted ED performance reducing 12 hour waits to less than 2% - Increase rates of ED avoidance through enhanced medical cover	3 Escalate to Board

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				There is a need to improve informatics support; completion of Internal Professional standards data and clinical leadership to tackle criteria led discharge. The Committee has asked for a report to next meeting from the Medical Director, Chief Nurse and Chief Operating Officer about plans to improve internal partnership working to support performance improvement.	

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Patients Access Governance Group/ IQPR	**Cancer Diagnosis** The Faster Diagnosis Standard (FDS) performance is not being consistently met. The 62-day backlog is still on track to achieve the March 2024 ambition of no more than 93 patients	**3 Partial**	Achieving the FDS target of 75% and a 62-day backlog of no more than 93 patients by March 2024 are the key objectives for cancer in 2023/24 planning.	To achieve 75% compliance by March requires a significant change within the skin pathway where outpatients capacity is being brought in house and a "straight to treatment" pathway goes live on 26 February 24.	3 Escalate to Board
	Elective Recovery Our submitted trajectory is to have 94 patients over 65 weeks, of which 44 are over 78 weeks, at the end of March 2024. We are on track for both of these cohorts but the impact of Industrial Action in February may impact on achieving the target	**2 Reasonable**	Delivering the objective of no patients waiting over 65 weeks by March 2024 is the central focus of 2023/24 planning. Patients are at increased risk of harm and/or deteriorating the longer they wait. This then increases demand on primary and urgent and emergency care services as patients seek help for their condition.		3 Escalate to Board

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Community Paediatrics – Neurodevelopmental Disorders (NDD)	This pathway continues to experience unprecedented demand and given its red risk rating, the Board asked Insight Committee to revive regular updates from the service. There are system wide pressures and the team is currently taking on a backlog of referrals from the Barnardo's co-ordination service. There is a significant backlog of an estimated 558 children, of which 53 children will breach the 65 week waiting time by March 2024.	**3 Partial**	There is not enough clinical resource to meet the demand and so the ICB is supporting outsourcing assessments for those children that have been waiting longest. The ICB has committed £660k of non-recurrent funding to WSFT to support dealing with the backlog, although the initial scoping by the services suggested the costs could be nearer £1.3m The Paediatric team are working hard to address the issues, but the size of the problem makes delivery challenging.	A tender process is underway to commission the outsourced resource. A formal task and finish group has been established with ICB transformation support and a bid is being developed for recurrent funding to support demand. The Trust will be hosting a Programme Manager funded by the ICB to support system improvements in the pathway across health, education and care teams. The Board needs to consider how we can support discussions with the ICB to ensure the issues are fully addressed at system level.	3Escalate to Board

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Finance Accountability Committee	**Financial Recovery Plan and CIP programme** The CIP programme is progressing well. A request for an additional £6m revenue support in Q4 was rejected and a further application has been submitted. Month 10 figures were not fully in line with our Financial recovery plan trajectory due to the costs of Industrial action but we continue to forecast meeting our target of £3.6m variance by year end, assuming that we will have some financial support to cover these costs.	**2. Reasonable assurance on current year progress**	There are still risks inherent in achieving the plan in particular how far ongoing industrial action will be funded. The lack of Planning Guidance continues to be problematic.	Further reports to Insight and then Board.	3 Escalate to Board

Originating Committee: Insight Committee			Date of meeting: 17 January 2024		
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	We still have not received the 24/25 planning guidance which hampers accurate planning for 24/25. We are now forecasting a deficit for 24/25 of £18.2m (not the previously reported £22.9m) as £3m for underfunded inflation has been removed. This is before any additional costs pressures				
Theatre Utilisation Recovery Plan	The Committee had a deep dive into Theatre utilisation. 7 specialities are contributing to an overall performance at end of December 2023 of 70.5% but there is variable performance and underlying issues across specialities.	**2 Reasonable**	Underutilising theatres impacts on waiting lists and adversely patients waiting for procedures. We are rewarded for achieving targets via Elective Recovery Funding so there is also a potential financial impact	The Recovery plan is in place and targets achieving recovery to 85% by December 2024. There will be a formal review of progress in June 2024. The plan has actions in 4 areas: ***Staffing*** (which includes shortages in anaesthetists; sickness levels; retention; and cultural issues around customer and practice	

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				Patients – supporting attendance at their appointments ***Capacity*** – there are some tensions around protecting elective beds and supporting UEC recovery. Plans include looking at layout to maximise physical space and targeting low complexity high volume processes. ***Data –*** need for more effective information that does not rely on manual processes and more accurate comparative data across specialities so good practice and underperformance can be identified. The Committee noted that cultural change was needed across disciplines to support performance improvement as discussed under Urgent and Emergency care above.	

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!
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What next? Exploring what should be **done next** (or not), informing **future** tactic / strategy, agreeing follow-up and future **evidence of impact**		• Recommendations for action • What impact are we intending to have and how will we know we've achieved it? • How will we hold ourselves accountable?

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4.1.1. Urgent and Emergency Care Recovery

To inform

Report to WSFT Public Board Meeting	
Report title:	Urgent and Emergency Care Performance Update and 2024/25 Priorities
Agenda item:	2.3.1
Date of the meeting:	22 March 2024
Lead:	Nicola Cottington, executive chief operating officer
Report prepared by:	Matt Keeling, deputy chief operating officer

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

Executive Summary

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

NHS England's January 2023 delivery plan for recovering urgent and emergency care services, and 2023/24 priorities and operational planning guidance set a clear mandate for delivering at least 76% of patients being admitted, transferred, or discharged within four hours from emergency departments (EDs) by March 2024, and building on this in 2024/25. As a Clinical Review of Standards pilot site, WSFT also had an additional challenge to reintroduce tracking and reporting of the 4-hour standard after four years of reporting on different metrics.

A trajectory was agreed as part of 2023/24 planning linking shadow reported performance in February 2023 to the 76% target in March 2024. Initial performance in June and July 2023 significantly exceeded the trajectory, however, became challenged throughout the autumn months despite comprehensive action plans within the emergency department, patient flow, discharge, and social care.

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

The focus on recovering performance and delivery of the 76% target has become greater in recent months, with a Trust and system-wide analysis identifying the main opportunities for further intervention. The 4-hour standard, alongside priorities of reducing ambulance handover times to an average of less than 30 minutes and 12-hour waits in the Emergency Department are critical patient safety and quality metrics.
WSFT has developed a plan with four objectives and multiple deliverables, providing the interventions to realise those opportunities.

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

The four objectives of the current plan to improve performance are:

- Increase non-admitted 4-hour performance to at least 80%.
- Improve admitted ED performance, reducing 12-hour length of stay to <2% of attendances.
- Further enhance discharge processes to reduce patients with no criteria to reside to consistently <10%.
- Increase ED attendance avoidance rates, through enhanced medical cover for the Early Intervention Team (EIT).

It is proposed to use the 2024/25 Urgent and Emergency Care capacity funding to support delivery of this plan, as well as continuation of interventions that have demonstrated a positive impact on patient flow.

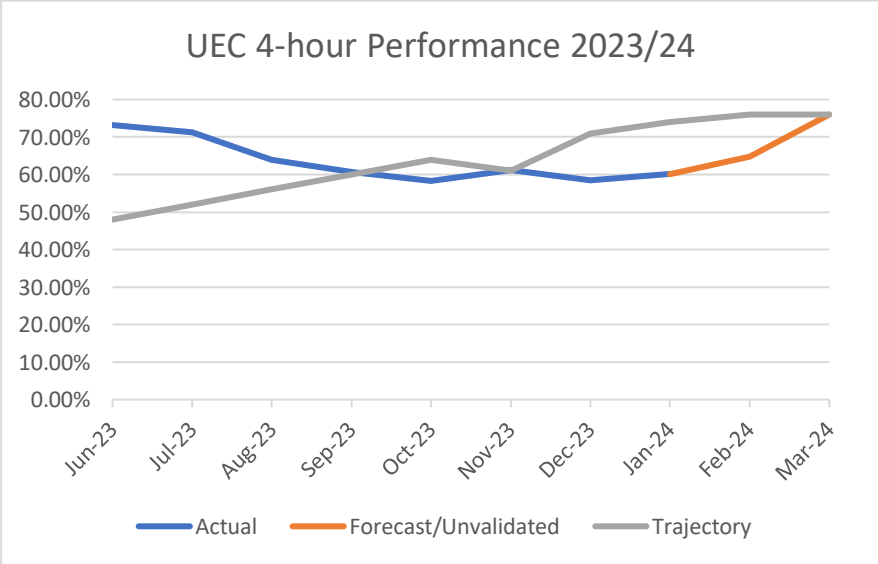
Further targeted actions are in place throughout March 2024 to maximise the opportunity to recover progress against our 4-hour performance trajectory and deliver the 76% ambition. Month to date performance at 15 March 2024 is 74.73%.

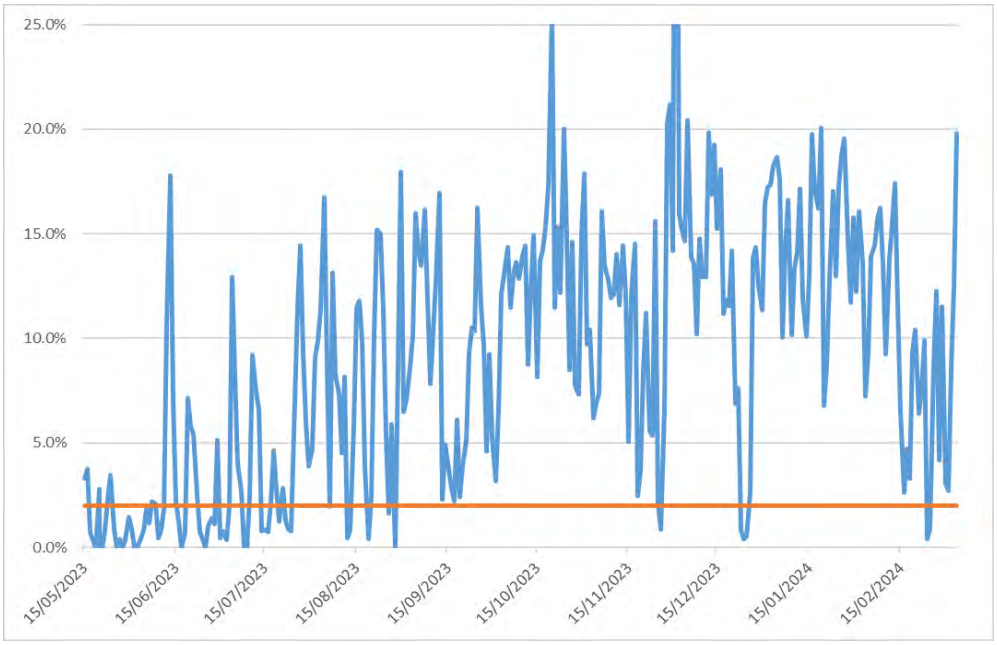
Recommendation / action required

The Board are asked to note the contents of this report and provide feedback on the plan to recover and sustainably deliver the Urgent and Emergency Care standards.

Previously considered by:	WSFT Insight Committee
Risk and assurance:	Risk Assessment BAF3.2 – delivery of operational standards Risk Assessment 5703 – Potential impact on quality and safety of patients within the emergency department
Equality, diversity and inclusion:	All improvement proposals should be assessed and adjusted so as to not create nor exacerbate any issues pertaining to health inequalities and should proactively seek to reduce them. Equitable achievement of access standards across different demographic groups should be monitored and actions put in place to address and variation.
Sustainability:	Evaluation of improvement initiatives will be required to ensure only those which demonstrate sustainable benefits across quality, performance, environment and finance are considered for further adoption.
Legal and regulatory context:	January 2023 NHS England 'Delivery plan for recovering urgent and emergency care services'. NHS 2023/24 priorities and operational planning guidance NHS England letter 'addressing the significant financial challenges created by industrial action in 2023/24, and immediate actions to take', published on 08 November 2023 Letter to SNEE ICB from NHE East of England region, 20 December 2023.

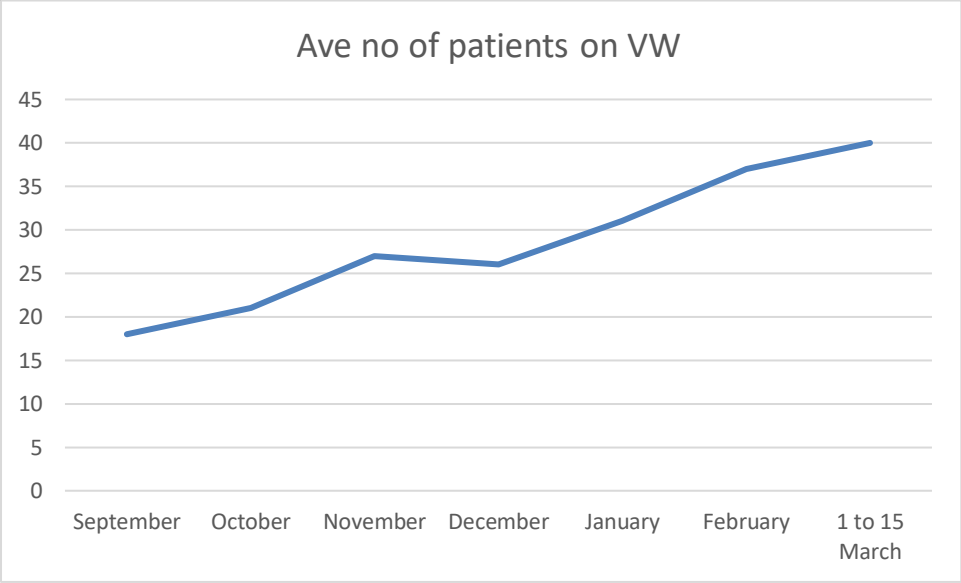
Urgent and Emergency Care Performance Update and 2024/25 Priorities

1.	What? Context and Progress to Date
1.1	In January 2023 NHS England set out the 'Delivery plan for recovering urgent and emergency care services'. The plan acknowledged the impact of slower patient flow through hospitals on emergency departments and ambulance services, creating a very visible and tangible risk in ambulances waiting to hand over patients outside hospitals and rising ambulance response times. The actions specified within the plan are centred around increasing capacity and flow, improving discharge and expanding and better joining up health and care outside hospital. The NHS 2023/24 priorities and operational planning guidance required providers to deliver at least 76% of patients being admitted, transferred, or discharged within four hours from emergency departments (EDs) by March 2024. Performance against this constitutional standard is measured and published nationally. The 2023/24 guidance also formally stood down the Clinical Review of Standards for Urgent and Emergency Care, for which WSFT had been a national pilot site and therefore not recorded nor reported 4-hour performance since 2019, in favour of a suite of clinical quality indicators. Reporting against the 4-hour standard recommenced on 15 May 2023. To support this, Trusts provide acute services were also required to submit trajectories on reducing bed occupancy to below 92% and those providing community services to commit to the Urgent Community Response Standard of 70% within 2 hours. Although, as of 08 March 2024, the NHS 2024/25 priorities and operational planning guidance has not been formally published, it is expected that providers will be required to build on and improve on performance thresholds from this year, as stated in the 2023/24 guidance. NHS England reaffirmed in writing to all providers the commitment to delivering 76% against the 4-hour standard in February 2024. WSFT have also been working to an agreed trajectory on ambulance handovers within 30 minutes and reducing the number of patients spending more than 12 hours in the ED to less than 2% of attendances.
1.2	The chart below demonstrates WSFT's performance against the 4-hour standard in 2023/24, from when the first full month's reporting commenced in June 2023: 

	The 2023/24 trajectory linked a performance position identified from shadow reporting data to February 2023 to the March 2024 76% ambition, based on expected improvements from re-introducing the standard and improving capacity and processes to drive performance. June and July significantly overperformed against our trajectory and expectations. This was due to a favourable set of conditions including stable ED attendance levels, good patient flow (as measured by bed occupancy and lower numbers of patients not meeting the criteria to reside) and similar performance across the system. It is likely that we also benefitted from an initial surge in performance from the high-profile relaunch of the standard in May as well as our winter escalation ward not fully closing until the end of June. However, during the autumn as bed occupancy increased and peaks in admissions could not be absorbed, the number of long waiting patients awaiting admission increased, leading to an overcrowded department, and impacting on the ability to achieve completion of non-admitted and admitted pathways within 4 hours. Against the system priorities of reducing ambulance handover delays and 12-hour waits in ED, WSFT have maintained ambulance handovers within 30 minutes to trajectory except for December 2023 and January 2024, recovering in February 2024. Maintaining 12-hour ED waits to below 2% of attendances has proven more challenging to deliver, given higher bed occupancy and reduced patient flow through the autumn and winter months, though improvement has been observed in February 2024. Percentage of 12-hour waits: 
1.3	In addition to the activities to relaunch the 4-hour standard in Q1 2023/24 and a local action plan within ED, WSFT's seasonal plan to support patient flow and delivery of the 4-hour trajectory centred on a 'Focus on Flow' programme, the use of a winter escalation ward which commenced in December 2023 and using the Better Care Fund to increase capacity for people needing enhanced care at home following their discharge from hospital. This plan was presented to the Board in July 2023. In recognition of the challenges that many providers were facing in delivery of their 4-hour performance trajectories, additional funding was made available regionally in December 2023. WSFT utilised this to increase the opening hours of the Discharge Waiting Area to 24 hours a day,

	7 days a week, to increase patient flow, extending the opening period of the winter escalation ward and a consultant-led in reach service to ED for respiratory medicine and paediatrics. Although the impact of initiatives on their own has been demonstrable, for example reducing the length of stay in our Community Assessment Beds (CAB), the total effect had not been sufficient to keep pace with our performance trajectory. This is likely due to needing to go further with our ambitions, as well as the lag time of effects being observed being greater than expected. The stabilisation and improvement in 4-hour performance seen in January 2024 (often recognised as the most challenging month operationally) would partially validate this.
2.	**So What? The Importance of Timely Urgent and Emergency Care**
2.1	The 4-hour standard and associated priorities to reduce ambulance handover delays and 12-hour waits in ED are important quality and safety measures – it is evidenced and recognised that extended waits in the emergency department setting lead to increased risk and potential for harm, as well as negatively impacting the quality and experience of patients and staff. Recognising our performance challenges, the Associate Director of Nursing Urgent & Elective Care for SNEE ICB was asked to undertake an ED quality and safety audit, which identified that risks were being mitigated well but that sustainable reductions in waits were required to completely mitigate risk. As focus on delivering the 4-hour standard increased, the NHS England East of England regional Chief Operating Officer wrote to the SNEE ICB on 20 December 2023 highlighting concerns in WSFT's 4-hour performance and increased number of 12-hour ED waits. Following this, WSFT and SNEE ICB colleagues met and shared analysis to identify the drivers of overall 4-hour and 12-hour performance and the opportunities for greatest improvement. WSFT developed a plan with four objectives and multiple deliverables, providing the interventions to realise those opportunities. System, regional and national communications throughout Q4 2023/24 have all reiterated the mandated importance of achieving at least 76% against the 4-hour standard in March 2024.
3.	**What Next? Plans and Next Steps**
3.1	In January 2024 in response to the NHS England letter highlighting performance concerns, the existing urgent and emergency care and Focus on Flow plans were consolidated, augmented, and aligned to the analysis conducted by WSFT and SNEE ICB. The four objectives of this new plan are to: • Increase non-admitted 4-hour performance to at least 80%. • Improve admitted ED performance, reducing 12-hour length of stay to <2% of attendances. • Further enhance discharge processes to reduce patients with no criteria to reside to consistently <10%. • Increase ED attendance avoidance rates, through enhanced medical cover for the Early Intervention Team (EIT). The plan is being delivered using the Core Resilience Team (CRT) approach that has been successfully used in managing issues such as RAAC (reinforced autoclaved aerated concrete) remedial works and interim arrangements for secure mobile messaging. CRT meets twice weekly and reports progress on objectives and deliverables, as well as decisions required, to a weekly strategic meeting of the WSFT executive directors. A list of the deliverables assigned to each objective can be found in Annex A. Although the full impact of some deliverables will not be realised until 2024/25, this will support sustainable and consistent delivery of the 2024/25 ambition to further improve performance.

	To support delivery of the plan, WSFT and the West Suffolk Alliance have agreed priorities for using 2024/25 Urgent and Emergency Care capacity funding, of which some are continuations of 2023/24 schemes: • Early Intervention team overnight cover to support timely discharge and admission avoidance. • 7-day cover for integrated acute and community therapies. • Additional discharge vehicle for non-emergency patient transport. • Staffing for corridor cohorting/reverse cohorting to support timely ambulance handovers in ED (3 months). In addition, the trial of a modular build to house a Minor Emergency Care Unit (MECU) will be funded from this source. The MECU will address the issue of non-admitted 4-hour performance being negatively impacted at times when ED is busy by providing additional assessment and treatment space, co-locating existing GP streaming and Emergency Nurse Practitioner services in a dedicated environment. Part of 2024/25's Better Care Fund allocation will be used to fund 50% of the additional discharge vehicle, and the benefits realisation of both funding sources will be jointly analysed at Trust, alliance and system levels. Additional actions have been put in place for March 2024 to provide further focus and support to delivery of the 76% 4-hour ambitions. These include: • A daily performance tracker report, showing the required performance and maximum number of breaches to achieve 76% for the month. • Strategic and tactical objectives for achieving the required level of performance agreed at daily capacity meetings. • Senior operational and nursing leadership presence in ED, including weekends and twilight periods. • Assurance that the 'arrive by 9' early flow initiative (identified wards to take at least one patient from ED or the Acute Assessment Unit by 0900) is happening consistently, and where required a second round of patient moves taking place during the day. • Strategic level assurance that actions within the national Operational Pressures Escalation Level (OPEL) framework and corresponding Tactical Patient Flow Escalation Plan are being delivered or escalated appropriately. Ensuring that we are maximising the use of existing capacity and processes, focussing on delivery of Trust and alliance improvement initiatives, and targeted use of additional actions will all be required in the coming weeks and months to ensure that performance ambitions are met, and that patient and staff quality and experience are maximised. It is important to note that there are also underpinning services which support UEC recovery which are not replicated in the plan referenced as they have their own project governance, for example Virtual Ward. The occupancy of our Virtual Ward continues to increase with an average of 37 patients per day during February and 40 patients during March to date.



The Virtual Ward currently has capacity to care for 40 patients. Formal review of capacity is scheduled for 18 March with a small potential increase with effect from 1 April (dependent on staffing). The service accepted the first surgical patients during February via the new trauma & orthopaedics pathway. Feedback has been received from the national Getting It Right First Time (GIRFT) programme following their review on 29 January. Points of good practice were noted including workforce development, integration of different specialties, work with care homes and the deployment of easy-to-use remote monitoring technology. Recommendations for service development include increasing step-up referrals, review of long stays, usage of high dose IV furosemide, implementation of acuity tool and expansion of point of care testing. These recommendations have been incorporated into the service development plan for 2024/25.

The 4-hour and 12-hour performance to date in March demonstrates the impact of the additional measures, particularly the partnership working across nursing, operations, and medical leadership to track performance and respond in real time, the consistent application of existing processes, e.g., Arrive by 9 and OPEL actions, and the further rapid development of existing pathways e.g., Same Day Emergency Care (SDEC) and other ambulatory pathways, to decompress ED. Month to date performance as at 15 March 2024 is 74.73%. However not all of the additional focus on ED is sustainable beyond March without detriment to staff wellbeing and other priorities and therefore it is imperative we continue to implement the full plan to create continued improvement.

ANNEX A – Patient Flow Improvement CRT Objectives and Deliverables

OBJECTIVE 1	**INCREASE NON-ADMITTED 4-HOUR PERFORMANCE TO AT LEAST 80%**	**SUCCESS MEASURES**
Deliverable 1	Review key pathways with agreement between ED and specialty teams, clearly identifying when patients will be transferred out of ED, measuring adherence to Internal Professional Standards.	Increased percentage compliance with Internal Professional Standards.
Deliverable 2	Identify total potential Type 3 demand and subject to funding, establish a trial of a modular unit through which to run a Minors Assessment Unit to more clearly separate ED streams.	Change in Type 1/Type 3 split, 4-hour performance increase.
Deliverable 3	Secure funding for 2024/25 to enable corridor cohorting/reverse cohorting within ED to continue.	Funding secured for 2024/25
Deliverable 4	Data analysis to inform further deliverables e.g. ED room utilisation	Agreed deliverables from analysis.
Deliverable 5	Secure funding for 2024/25 for ED twilight shift to support activity during this time	Funding secured for 2024/25
OBJECTIVE 2	**IMPROVE ADMITTED ED PERFORMANCE, REDUCING 12-HOUR LOS TO <2% OF ATTENDANCES**	**SUCCESS MEASURES**
Deliverable 1	Extend 'Arrive by 9' to all General & Acute Wards, including additional portering resource.	a) Increase in moves before 0900.
		b) Ward level data - 100% taking a patient before 0900.
		c) Reduction in patients awaiting beds in ED at 0800.
Deliverable 2	Undertake a Multi-Agency Discharge Event focussed on ward processes.	Increase in compliance scores to 2023 ward self-assessments.
Deliverable 3	Develop an equivalent early flow protocol for Community Assessment Beds (CAB).	Increase in transfers to CAB before 1200 and 1700.
Deliverable 4	Identify actions to enable rapid review of potential and referred patients to VW.	Increase in patients onboarded by midday
Deliverable 5	Ensure processes are in place to embed OPEL 3/4 responses into capacity meetings.	Observational audit of capacity meetings/decision logs to reflect action compliance
Deliverable 6	Secure funding for 2024/25 to continue medical flow co-ordinator roles.	Maintain and improve admitted pathway performance
Deliverable 7	Complete scoping exercise and QIA on surge/boarding capacity options.	Complete scoping exercise and QIA and presented to Strategic meeting
Deliverable 8	Complete decision model for Strategic on options around pausing RAAC programme to create additional bed capacity.	Decision model presented to Strategic meeting
Deliverable 9	Review of elective/emergency bed capacity split to support future demand.	Paper to EDs on future bed capacity split

OBJECTIVE 3	FURTHER ENHANCE DISCHARGE PROCESSES TO REDUCE PATIENTS WITH NO CRITERIA TO RESIDE TO CONSISTENTLY <10%	SUCCESS MEASURES
Deliverable 1	Create capacity for 33 patients with case mix currently on winter escalation ward to be cared for outside of the acute hospital footprint (patients medically optimised for discharge) through additional spot purchase capacity with wraparound therapy support.	Decrease in number of patients medically optimised for discharge on winter escalation ward
Deliverable 2	Undertake options appraisal for 33 block purchase care beds to create capacity for 33 patients with case mix currently on winter escalation ward to be cared for outside of the acute hospital footprint (patients medically optimised for discharge).	Options appraisal published and presented to Execs
Deliverable 3	Short stay ward and Acute Assessment Area to reduce LOS and increase daily number of patients accepted from ED.	Reduction in LOS on AAU and F7. Increase in daily transfers.
Deliverable 4	Implement a 'trusted assessment process' to reduce the number of Community Assessment Bed (CAB) referrals declined to zero, without reducing referral rates.	Reduction in CAB referrals declined.
Deliverable 5	ICB and region to develop escalation plan for patients requiring a) out of county beds and b) mental health beds.	Reduction in daily patients awaiting beds.
Deliverable 6	Therapy-led audit of CAB referrals to identify care needs to convert to P1 with implementation of recommendations	Change in P2 to P1 referral ratio.
Deliverable 7	Smooth demand and activity for P1 discharges Monday - Sunday. Effectively utilising all available Home First weekend capacity including introduction of Criteria Led Discharge.	Equalised proportion of discharges across 7 days.
Deliverable 8	P1 referrals to be transferred within 24 hours of referral being made.	Increase in P1 referrals transferred <24 hours.
Deliverable 9	Secure funding for 2024/25 to continue 24/7 opening of Discharge Waiting Area using Band 5 Registered Nurse and Band 2 Nursing Assistants for 3 month extension.	Funding secured to maintained and increased DWA activity.
OBJECTIVE 4	**INCREASE ED ATTENDANCE AVOIDANCE RATES, THROUGH ENHANCED MEDICAL COVER FOR EIT (EARLY INTERVENTION TEAM)**	**SUCCESS MEASURES**
Deliverable 1	Based on findings of first MAAAE, trial implementation of enhancements to EIT (including medical cover) with the potential to reduce attendances and admissions.	a) Increase in patients whose attendance is avoided.

		b) Decrease in declines from EIT of patients referred through cleric.

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?

4.2. Finance Report, including 2024/25 budget and capital programme

For Approval

Board of Directors – Public Board	
Report title:	Finance Board Report – February 2024
Agenda item:	4.2
Date of the meeting:	22nd March 2024
Lead:	Craig Black, Executive Director of Resources
Report prepared by:	Nick Macdonald, Deputy Director of Finance

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

Executive Summary

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

The revised forecast deficit of £6.3m was agreed by SNEE ICB.

The YTD position at February 2024 reports a deficit of £6.2m against a planned deficit of £3.5m (an adverse variance of £2.7m).

During February we received funding of £1.3m in relation to costs incurred as a result of Industrial Action during December and January. We therefore forecast that we will meet the forecast of £6.3m deficit at year end.

Whilst we are awaiting national guidance for 24-25 planning, our first draft plan for 24-25 suggests we would plan for a deficit of £22.9m (after delivering £12.3m CIP). This is subject to assumptions made and planning guidance.

Our planned deficit means we will have a shortfall in cash and therefore the Board is asked to approve the request of £4m revenue support for the first quarter of 2024/25.

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

As a result of our financial performance the ICS have developed plans to compensate for the WSFT position by slipping investments elsewhere within the ICS

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

Continue to monitor financial performance and budget setting through Insight and the Board and take corrective action where necessary.

Recommendation / action required
Review and approve this report The Board is asked to approve the request of £4m revenue support for the first quarter of 2024/25.

Previously considered by:	Parts of this report were discussed at January and February Insight Committee
Risk and assurance:	Financial risk
Equality, diversity and inclusion:	n'a
Sustainability:	Financial sustainability
Legal and regulatory context:	Financial reporting

Guidance notes

The practice of scrutiny and assurance

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

FINANCE REPORT
February 2024 (Month 11)

Executive Sponsor: Craig Black, Director of Resources
Author: Ali Muhammad, Head of Financial Management

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).

- We have agreed a forecast deficit of £6.3m with SNEE ICB. This revised forecast is contingent on:
  - Funding associated with Industrial Action - £3.7m (received)
  - ERF related income - £1.7m
  - Delivering CIP - £5m
  - Improving our run rate - £3.4m
- This forecast includes the benefits resulting from £15m of non-recurring support.
- The reported I&E for February is a surplus of £1.2m, reflecting the receipt of £1.3m funding for Industrial Action received during February.
  - **The Trust is therefore forecasting a deficit of £6.3m in line with the revised plan.**
- The YTD position reports an adverse variance of £2.8m which is largely due to:
  - Underachieved CIP of £3m
- In order to improve our 2024-25 planned deficit (£22.9m) we could consider a more challenging CIP.
- **The Board is asked to approve the request of £4m revenue support for the first quarter of 2024/25.**

Key Risks in 2024-25

- Delivering challenging CIP
- Unanticipated costs of further industrial action (if unfunded).
- 24-25 planned deficit is contingent on planning guidance which is yet to be received

Financial Summary

SUMMARY INCOME AND EXPENDITURE ACCOUNT - February 2024	February 2024			Year to date			Year end forecast		
	Budget	Actual	Variance F/(A)	Budget	Actual	Variance F/(A)	Budget	Actual	Variance F/(A)
	£m	£m	£m	£m	£m	£m	£m	£m	£m
NHS Contract Income	27.6	29.4	1.7	311.6	315.4	3.7	336.8	339.8	3.0
Other Income	3.1	4.9	1.8	35.9	39.5	3.6	42.2	49.1	6.9
Total Income	30.7	34.3	3.5	347.6	354.9	7.3	378.9	388.8	9.9
Pay Costs	20.6	20.4	0.2	236.2	241.1	(4.9)	257.2	259.0	(1.8)
Non-pay Costs	8.6	10.7	(2.1)	95.7	100.0	(4.2)	105.0	115.9	(10.9)
Operating Expenditure	29.2	31.1	(2.0)	331.9	341.0	(9.1)	362.2	374.9	12.7
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
EBITDA	1.5	3.1	1.6	15.6	13.8	(1.8)	16.7	14.0	(2.7)
Depreciation	1.0	1.2	(0.2)	13.2	13.9	(0.7)	12.9	13.8	0.9
Finance costs	0.5	0.7	(0.2)	5.9	6.1	(0.2)	6.5	6.5	0.0
SURPLUS/(DEFICIT)	(0.1)	1.2	1.1	(3.5)	(6.2)	(2.8)	(2.7)	(6.3)	(3.6)

I&E Position YTD	£6.2m	adverse
Variance against Plan YTD	£2.8m	adverse
Movement in month against plan	£1.1m	favourable
EBITDA position YTD	£13.8m	favourable
EBITDA margin YTD	4%	favourable
Cash at bank	£10.9m	

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 – February 2024

Income and Expenditure Summary - February 2024

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)	(49)	1,170	1,219	↑	Green
YTD surplus/ (deficit)	(3,495)	(6,211)	(2,717)	↓	Red
EBITDA YTD	15,642	13,812	(1,830)	↑	Red
EBITDA %	4.5%	3.9%	(0.6%)	↑	Red
Clinical Income YTD	(315,860)	(320,396)	4,536	↑	Green
Non-Clinical Income YTD	(28,893)	(34,465)	5,571	↑	Green
Pay YTD	237,720	241,083	(3,364)	↑	Red
Non-Pay YTD	114,456	119,638	(5,182)	↓	Red
CIP Target YTD	6,506	3,474	(3,032)	↓	Red

Income and Expenditure for 2023-24

Plan

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). However, our Financial Recovery Plan (FRP) revised our forecast to a deficit of £6.7m. We subsequently received additional funding towards inflationary pressures which adjusted this position to a deficit of £6.3m. This £6.3m deficit is now our plan, and represents a £3.6m adverse variance against our original plan.

M11 position

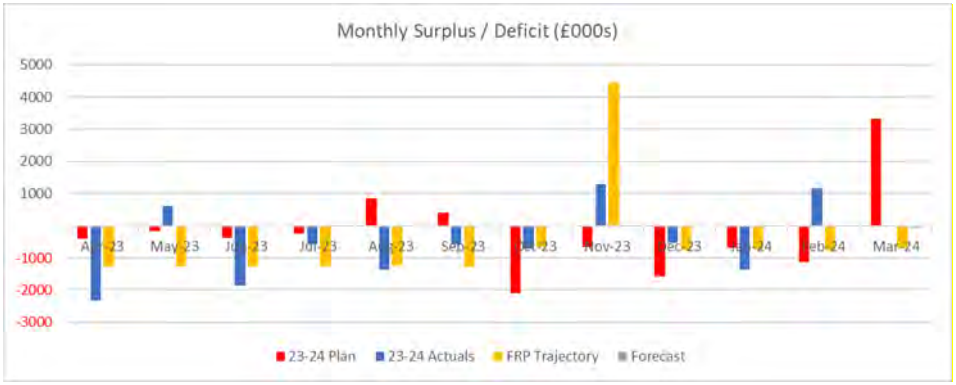
Our reported position as at the end of February was a deficit of £6.2m against our original planned deficit of £3.5m – ie an adverse variance of £2.7m. This position is in line with our forecast adverse variance of £6.3m by year end.

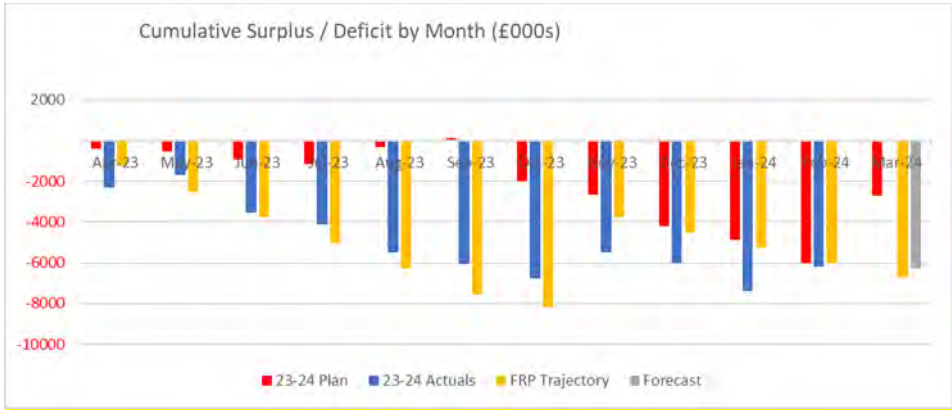
The primary reasons for our adverse variance relate to underperformance against our CIP target in the first half of this year. Whilst there were also pressures relating to the costs of industrial action and inflation these have now been largely funded.

An additional £1.3m income has been received, relating to costs arising from Industrial Actions in December and January. This has meant that the Trust financial position is back on track and is in-line with its revised full year financial forecast.

Forecast

YTD deficit position is in line with our YTD forecast of £6.2m deficit and we continue to forecast that we will achieve the revised planned full year deficit of £6.3m. This is based on an assumption that financial support will be available should any additional costs of Industrial Action arise this financial year





FINANCE REPORT – February 2024

Cost Improvement Programme (CIP) 2023-24

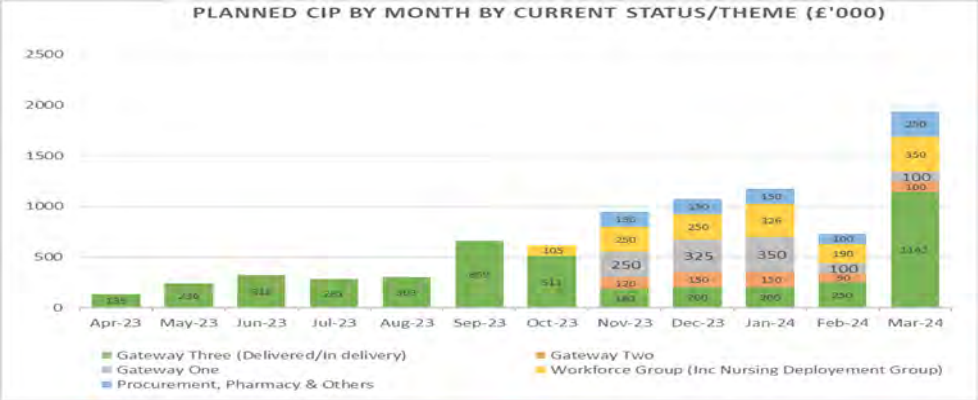
A summary of progress on the CIP plan is included below (£5m), as well as our planned run rate improvements (£3.4m). This £8.4m improvement was approved as part of our Finance Recovery Plan (FRP).

In month progress (February)

- CIPs with a value of £0.7m were delivered during February.
- Total value of identified schemes has reduced slightly by £0.2m to £10.0m (£10.2m at M9).
- All clinical divisions have reduced the unidentified gap assigned to them
- Pipeline PIDs has increased slightly as focus has been on progressing schemes with PIDS through the gateways to delivery (153 at M9)

Table 1 – CIP achievement to date, with current forecast

	Target vs Plan	YTD Target vs YTD Actuals			Target vs Actuals + Forecast			In-Month Delivery		
Division	**Annual Target (£k)**	**Target YTD (£k)**	**Actuals YTD (£k)**	**Variance (£k)**	**Annual Target (£k)**	**Actuals & Forecast In-year 2023/24 (£k)**	**Variance (£k)**	**Target**	**M11 Delivery only**	**Variance**
Medicine	2,610	2,390	699	(1,691)	2,610	707	(1,903)	221	29	192
Surgery	1,978	1,707	1,384	(324)	1,978	1,616	(362)	206	175	31
Women & Children	671	598	636	38	671	683	12	74	45	29
CSS	1,260	1,113	250	(863)	1,260	338	(922)	125	125	0
Community	1,588	1,427	1,094	(333)	1,588	1,328	(260)	161	138	23
Estates & Facilities	677	601	665	64	677	758	81	75	48	27
Corporate	1,817	1,666	621	(1,045)	1,817	1,164	(653)	151	76	75
TW - Workforce Group	-	-	1,017	1,017	-	1,310	1,310	-	98	(98)
TW - Discretionary Spend	-	-	113	113	-	107	107	-		-
TW - Other	-	-		-	-	400	400	-		-
TOTAL	**10,601**	**9,502**	**6,479**	**(3,023)**	**10,601**	**8,411**	**(2,190)**	**1,013**	**734**	**280**



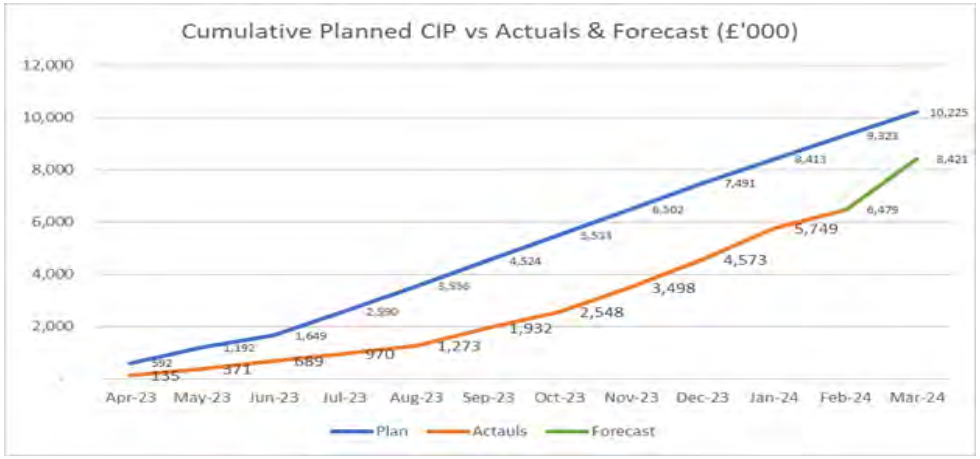


Table 2 – CIP Identification Progress - Non-risk Adjusted – CIP

Division	Target £k	Identified 23/24 £k	Gateway 1 £k	Gateway 2 £k	Gateway 3 £k	Gap £k	Pipeline PIDs
Medicine	2,610	1,328	235	246	846	(1,282)	6
Surgery	1,978	1,688	-	-	1,688	(290)	44
Women & Children	671	683	2	-	681	12	10
CSS	1,260	402	-	-	402	(858)	25
Community	1,588	1,969	1,209	-	760	381	22
Estates & Facilities	677	693	-	-	693	16	8
Corporate	1,817	1,183	-	-	1,183	(634)	8
Sub-Total	**10,601**	**7,945**	**1,447**	**246**	**6,252**	**(2,656)**	**123**
TW - Workforce Group	-	1,344	-	1,020	324	1,344	-
TW - Procurement	-	326	24	-	302	326	7
TW - Pharmacy	-	237	40	-	197	237	3
TW - Discretionary Spen	-	107	-	-	107	107	2
TW - CMH	-	-	-	-	-	-	-
TW - Other	-	-	-	-	-	-	19
Total	**10,601**	**9,958**	**1,511**	**1,266**	**7,181**	**(643)**	**154**

FINANCE REPORT – February 2024

Financial Planning and Budget Setting for 2024-25

The planned deficit for 2024-25 is currently £22.9m after delivering a Cost Improvement Programme of £12.3m, subject to assumptions made and planning guidance. However, there are external expectations that we can improve on this plan which will be discussed at private board.

At the time of writing the detailed planning guidance that had been expected by Christmas has still not been published. However, business planning and budget setting has continued with an expectation that an adjustment will be made once the detailed planning guidance is received. It is likely that this will impact on activity and performance targets as well as funding.

This has caused a delay in the detailed budget setting process. The draft budget setting guidelines and governance arrangements were presented and discussed at FAC on 24th January alongside a first cut of the budget, primarily focussing on staffing budgets.

Business plans have highlighted known cost pressures and investment proposals that have been approved by the Trust Executives on 14th February which are in line with the £22.9m planned deficit.

A summary of current 24-25 budgets by Division will be presented at private board, as well as the 24-25 Cost Improvement Programme

FINANCE REPORT – February 2024

Divisional Financial Performance

MEDICINE	Current Month Budget £k	Current Month Actual £k	Current Month Variance F/(A) £k	Year to date Budget £k	Year to date Actual £k	Year to date Variance F/(A) £k	Forecast Budget £k	Forecast Actual £k	Forecast Variance F/(A) £k
Total Income	(339)	(555)	216	(4,329)	(5,002)	673	(4,668)	(5,346)	678
Pay Costs	5,667	5,998	(331)	61,261	64,102	(2,841)	66,928	70,218	(3,290)
Non-pay Costs	1,901	2,427	(526)	22,400	24,601	(2,201)	24,314	26,863	(2,549)
Operating Expenditure	7,568	8,425	(857)	83,661	88,703	(5,042)	91,242	97,081	(5,839)
SURPLUS / (DEFICIT)	(7,229)	(7,870)	(641)	(79,332)	(83,701)	(4,369)	(86,574)	(91,735)	(5,161)

SURGERY	Current Month Budget	Current Month Actual	Current Month Variance F/(A)	Year to date Budget	Year to date Actual	Year to date Variance F/(A)	Forecast Budget	Forecast Actual	Forecast Variance F/(A)
Total Income	(251)	(306)	55	(2,710)	(3,183)	473	(2,960)	(3,499)	539
Pay Costs	4,407	4,575	(168)	48,445	49,174	(729)	52,852	53,618	(766)
Non-pay Costs	1,358	1,376	(18)	15,458	16,051	(593)	16,749	17,506	(757)
Operating Expenditure	5,765	5,951	(186)	63,903	65,225	(1,322)	69,601	71,124	(1,523)
SURPLUS / (DEFICIT)	(5,514)	(5,645)	(130)	(61,193)	(62,042)	(849)	(66,641)	(67,625)	(984)

WOMENS AND CHILDRENS	Current Month Budget	Current Month Actual	Current Month Variance F/(A)	Year to date Budget	Year to date Actual	Year to date Variance F/(A)	Forecast Budget	Forecast Actual	Forecast Variance F/(A)
Total Income	(154)	(308)	154	(1,852)	(2,801)	949	(2,061)	(2,958)	898
Pay Costs	1,998	2,061	(63)	21,820	22,149	(329)	23,827	24,252	(425)
Non-pay Costs	103	181	(78)	1,332	1,680	(347)	1,420	1,798	(378)
Operating Expenditure	2,100	2,241	(141)	23,152	23,829	(677)	25,247	26,050	(803)
SURPLUS / (DEFICIT)	(1,946)	(1,934)	13	(21,301)	(21,028)	273	(23,187)	(23,092)	95

CLINICAL SUPPORT	Current Month Budget	Current Month Actual	Current Month Variance F/(A)	Year to date Budget	Year to date Actual	Year to date Variance F/(A)	Forecast Budget	Forecast Actual	Forecast Variance F/(A)
Total Income	(233)	(189)	(44)	(2,542)	(2,021)	(521)	(2,775)	(2,310)	(466)
Pay Costs	2,660	2,728	(68)	29,043	30,369	(1,326)	31,703	35,649	(3,946)
Non-pay Costs	1,168	1,451	(282)	13,165	14,472	(1,307)	13,806	16,765	(2,959)
Operating Expenditure	3,828	4,179	(351)	42,208	44,841	(2,633)	45,509	52,414	(6,905)
SURPLUS / (DEFICIT)	(3,595)	(3,990)	(395)	(39,666)	(42,820)	(3,154)	(42,734)	(50,104)	(7,370)

COMMUNITY SERVICES	Current Month Budget	Current Month Actual	Current Month Variance F/(A)	Year to date Budget	Year to date Actual	Year to date Variance F/(A)	Forecast Budget	Forecast Actual	Forecast Variance F/(A)
Total Income	(565)	(625)	59	(6,562)	(6,867)	306	(7,058)	(7,496)	438
Pay Costs	3,621	3,768	(147)	39,743	40,523	(780)	43,303	44,298	(995)
Non-pay Costs	1,426	1,767	(341)	16,184	17,779	(1,596)	17,550	19,295	(1,745)
Operating Expenditure	5,047	5,535	(488)	55,927	58,302	(2,375)	60,853	63,593	(2,740)
SURPLUS / (DEFICIT)	(4,482)	(4,911)	(429)	(49,365)	(51,435)	(2,070)	(53,795)	(56,097)	(2,302)

ESTATES AND FACILITIES	Current Month Budget	Current Month Actual	Current Month Variance F/(A)	Year to date Budget	Year to date Actual	Year to date Variance F/(A)	Forecast Budget	Forecast Actual	Forecast Variance F/(A)
Total Income	(346)	(372)	25	(3,653)	(3,926)	273	(3,999)	(4,303)	304
Pay Costs	1,221	1,254	(33)	13,419	13,775	(356)	14,640	15,031	(391)
Non-pay Costs	1,066	1,052	13	10,653	11,143	(490)	11,516	12,137	(622)
Operating Expenditure	2,287	2,306	(19)	24,072	24,918	(846)	26,156	27,168	(1,013)
SURPLUS / (DEFICIT)	(1,940)	(1,934)	6	(20,419)	(20,992)	(573)	(22,156)	(22,865)	(708)

CORPORATE	Current Month Budget	Current Month Actual	Current Month Variance F/(A)	Year to date Budget	Year to date Actual	Year to date Variance F/(A)	Forecast Budget	Forecast Actual	Forecast Variance F/(A)
Total Income	(28,826)	(31,974)	3,148	(325,915)	(331,682)	5,768	(355,327)	(27,627)	(327,700)
Pay Costs	1,010	29	982	22,388	20,991	1,398	24,200	26,575	(2,375)
Non-pay Costs	1,567	2,592	(1,026)	16,517	15,328	1,189	19,295	17,054	2,241
Capital Charges and Financing Costs	1,595	1,900	(305)	19,134	19,557	(423)	19,447	42,237	
Operating Expenditure	4,172	4,521	(349)	58,039	55,875	2,164	62,942	43,629	19,313
SURPLUS / (DEFICIT)	24,655	27,453	2,799	267,876	275,807	7,931	292,385	(16,002)	(308,388)

TOTAL	Current Month Budget	Current Month Actual	Current Month Variance F/(A)	Year to date Budget	Year to date Actual	Year to date Variance F/(A)	Forecast Budget	Forecast Actual	Forecast Variance F/(A)
Total Income	(30,714)	(34,327)	3,613	(347,562)	(355,483)	7,921	(378,849)	(53,539)	(325,309)
Pay Costs	20,583	20,411	172	236,120	241,083	(4,964)	257,453	269,641	(12,188)
Non-pay Costs	8,588	10,846	(2,258)	95,709	101,054	(5,345)	104,651	111,418	(6,768)
Capital Charges and Financing Costs	1,595	1,900	(305)	19,134	19,557	(423)	19,447	42,237	0
Operating Expenditure	30,766	33,158	(2,391)	350,962	361,694	(10,732)	381,550	381,059	491
SURPLUS / (DEFICIT)	(52)	1,170	1,222	(3,400)	(6,211)	(2,811)	(2,702)	(327,520)	(324,818)

Medicine (Sarah Watson)

For the month of February, the division was behind plan by £0.6m (£4.4m YTD). The division is reporting a £331k adverse variance in month for Pay costs (£2.8m YTD). The key drivers behind the pay YTD variances are.

- £2.8m overspend on medical staffing is due to several reasons including cover arrangements (locums, agency, and Additional consultant sessions) for sickness, industrial action, rota gaps and higher than budgeted establishments for junior doctors.
- £0.17m underspend in nursing compared to budget is mainly due to vacancies in registered nursing that are being filled in a controlled manner by temporary staff.
- £0.3m unmet Pay CIP target.

Non pay costs are 526k behind plan in month (£2.2m YTD), largely driven by the insourcing of Dermatology services to reduce the backlog.

- £0.4m on paramedic cohort to aid the UEC delivery and £0.4m dermatology insourcing, both of which are currently not funded within the budget.
- £0.2m overspend on medical and surgery equipment due to a combination of volume and price.

These cost pressures are offset in part by YTD favourable variance of £0.67m and in-month favourable variance of £0.2m. Key drivers for the in-month variance are revised calculation of clinical staff recharges (a one-off benefit for the year) and further significant private patient income from Tricare members.

Surgery (Moira Welham)

The Surgical division reported an adverse variance of £130k (adverse £849k year to date).

Income reported a £55k over recovery in February (£473k favourable YTD). The YTD favourable variance is due to additional income recovery for medical recharges, non-recurrent income received for 23/24 and an increase in educational and training income against plan. Some of this income offsets the overspends within pay.

Pay reported an adverse variance of £168k in February (adverse variance to date of £729k). In February, the challenges of Industrial action and staffing deficits driven by sickness and vacancies has resulted in the divisions increased usage of temporary staffing to maintain rota compliance and safer staffing levels. In addition, extra contractual work is being undertaken across the specialties to support 65-week clearance, reduce waiting times for first outpatient appointments and improve diagnostic waiting times. These will continue to the end of the financial year.

Non-pay and capital charges combined reported an adverse variance of £18k in month (adverse £593k year to date). The key drivers of the adverse variance YTD include:

- £457k increased usage of supplies linked to inpatient activity delivery, predominantly in main theatres, some of this cost is offset by the reduced costs in activity previously undertaken by external providers.
- £125k increased costs associated with activity growth with services provided by external bodies, not linked to ERF.
- £105k unmet non-pay CIP/slippage in the first half of the year due to scheme delays in prosthesis procurement

Women and Children's (Simon Taylor)

In February, the Division reported a favourable variance of £13k (YTD favourable variance of £273k). Income was £154k ahead of plan (YTD £949k ahead of plan). This was due to the balance of winter funding for paediatrics, plus obstetrics private patient income (£35k) and HEE catch-up funding in obstetrics. The YTD variance is mostly due to large private patient invoices, predominantly in neonatal and funding for specific posts or services offsetting some of the overspends below.

Pay reported a £63k overspend in-month (£329k overspend YTD). This is due to a few main factors:

- Agency usage in paediatrics to support winter pressures (funding noted above in income)
- temporary staff spend to support safe staffing levels during periods of sickness, industrial action and to cover rota gaps
- services which need investment such as paediatric cardiology where recruitment is ongoing for a PEC (successful panel in December 23, recruitment expected in June 24) and the increase in demand for gynaecological services, such as uro-gynae. Noted a large decrease from run rate in bank & agency usage in obstetrics & gynaecology as a result of robust controls put in place by the team.
- The division previously had significant vacancies in the maternity teams and recruitment has been very successful in recent months, meaning we are almost at establishment now (approx. 5 WTE vacancy remaining). The vacancies would have previously offset overspends in other cost centres. Bank usage has been higher due to supernumerary shifts worked with trainees.
- The known over-establishment in paediatric ED when the decision was made to transfer the nursing staff from medicine to paediatrics.

Non-pay reported a £77k overspend in month (YTD £327k overspend). Clinical supplies, premises and CIP are the main drivers in month. Clinical supplies overspends has been driven by a catchup of invoicing for paediatric postmortems and equipment purchased. Midwifery rent accrual has been increased to represent increased clinic usage noted throughout the year. The YTD variances of the highest significance are in clinical supplies (high value purchase of jaundice meters); premises (increase in rent charges for community midwifery bases); drugs (palivizumab spend particularly high in paediatrics) and other costs (including unbudgeted annual licences for Infoflex; and injury benefit scheme charges).

Clinical Support (Simon Taylor)

In February, the Division reported an adverse variance of £395k (YTD adverse variance of £3.2m).

Pay reported a £68k overspend in-month (£1.3m overspend YTD). This is driven by:

- Use of locums and agency staff across medical staff in Xray, mammography and ultrasound
- Use of agency scientific and technical staff in Microbiology to cover consultant vacancies.
- Unachieved pay CIP.
- Continued underspend in Pharmacy as the recruitment into substantive vacancies continues.

Non-pay reported a £273k overspend in month (YTD £1.3m overspend). Drivers of this include:

- The necessary rental of a mobile MRI unit (£240k YTD, anticipated total impact £410k) to provide continuation of service while we wait for the permanent replacement to go-live from June 2024. This project has been delayed by unanticipated environmental issues.

- Continued increased spend (£35k) in stock drugs in-month which is being investigated to assess whether these are costs being incurred in CSS on behalf of other divisions.
- Continued higher than anticipated activity in Pathology increasing the number of sendaway tests. In month, new contracts have started for these sendaway tests and while activity is still forecast to be high, we anticipate that the costs will reduce.

Community Services (Kevin McGinness and Nic Smith-Howell)

The Community Division reported an adverse variance of £429k (£2.1m) adverse YTD) in February. The Virtual Ward service transferred from Medicine to Community in M11 and this is reflected in Division's in-month and YTD budget position.

Income reported an over recovery of £59k in February (£306k favourable YTD). The YTD favourable variance was due to additional income recovered to support the Trust's COVID and flu vaccination programmes and the recovery of some of the additional costs incurred through the Community Equipment Service

Pay reported an adverse variance of £147k in February (£780k YTD). At M11, the pay run-rate has increased above budget, as the division is delivering capacity to support the Urgent Emergency Response services, including enhanced overnight care in the Early Intervention Team, 7-day therapy cover for acute medicine wards, and additional therapist provision in ED. Offsetting income of £811k (FYE) is managed corporately, and the linked additional costs are fully funded.

Due to the division's turnover and vacancies, bank and agency temporary staff were used to cover some vacant roles across services. The use of temporary staffing has reduced and is limited to cover budgeted vacancies only, and/or to fund externally funded posts where that funding is time limited. With HEE funding support, the division has invested in an upskilling programme for community bank nurses and now has a larger pool of bank staff. This means agency staff are used by exception, to ensure continuity of safe care within services facing recruitment challenges and where services have multiple vacancies, particularly those focused on admission avoidance and our urgent care response.

Non-pay reported a £341k adverse variance in M11 (£1,596k adverse YTD). Drivers for the YTD adverse variance are:

- £205k unmet non-pay CIP/slippage in the first half of the year due to scheme delay – the Division has continued to recover this position, with the level of CIP allocated to schemes increasing.
- Significantly increased referrals into wheelchair services in the first half of the year meant that despite increased use of recycled equipment, costs increased. This increased demand (39%) combined with demand and cost inflation for community equipment, has incurred a £831k YTD overspend, partially offset by the increase in income noted above.
- £110K of additional IT hardware and software costs were incurred, primarily for use by the SCARC, partially offset by the increase in income noted above.
- Inflationary cost pressures of £164k were incurred for service contracts
- Staff travel costs (including pool cars and vehicle hire) are £186k over budget.

Estates and Facilities (Chris Todd)

In February, the division recorded a positive variance of £6k, (YTD adverse variance of £573k).

There are positive variances of note in the following areas:

- An increase in income following the reinstatement of staff parking charges has led to £218k surplus YTD in the Car Park management unit.
- An increase in catering income of £294k YTD is the result of customer numbers returning to pre-covid levels and a small increase in prices charged. This increase in income has been partially offset by the use of temporary staff to meet demand.

There are cost pressure in the following areas:

- Newmarket Estates Management (£123k YTD) – This is the result of electricity costs exceeding the budget.
- Medical Physics (£131k YTD) – the cost of spare parts, plus third-party repairs and maintenance contracts are putting pressure on this budget. We have improved our understanding of these cost pressures and revised this cost pressure down since the last report.
- Estates (£443k YTD) – This overspend, increased since the last report, is the result third party servicing and maintenance costs exceeding the YTD budget by £238k and £55k respectively.

FINANCE REPORT – February 2024

Workforce

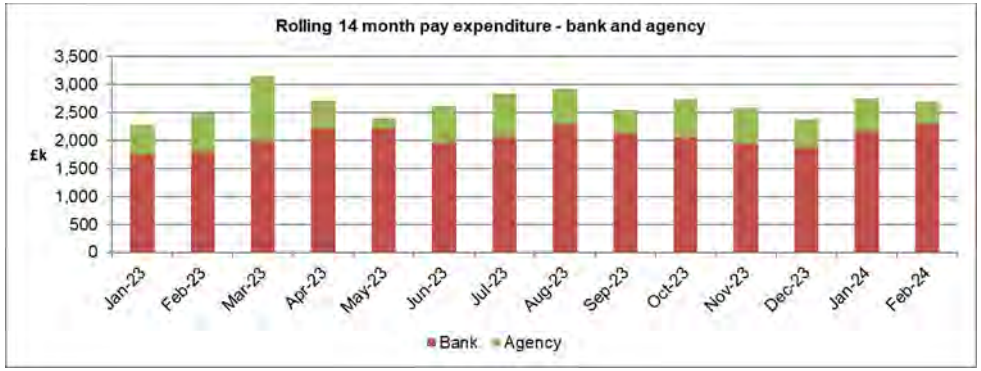
During February the Trust underspent by £0.2m on pay due to a non-recurring adjustment to our annual leave accrual

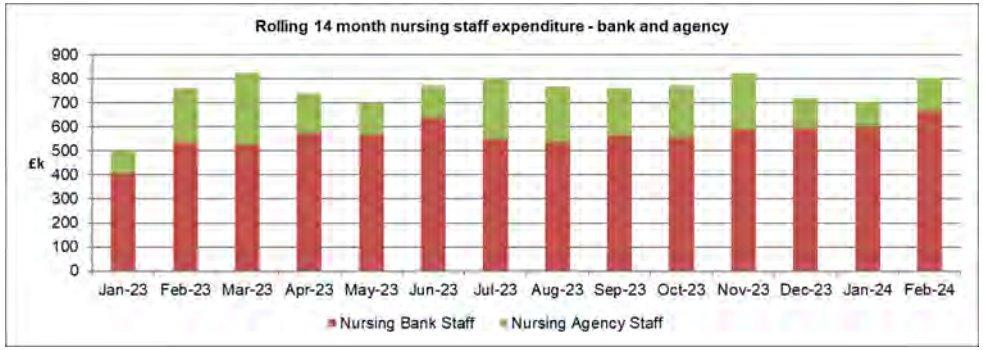
Monthly Expenditure (£)				
As at February 2024	Feb-24	Jan-24	Feb-23	YTD
	£000's	£000's	£000's	£000's
Budgeted Costs in-month	20,583	21,980	20,178	237,720
Substantive Staff	17,724	19,997	18,736	211,896
Medical Agency Staff	110	226	312	1,464
Medical Locum Staff	631	601	369	6,073
Additional Medical Sessions	447	346	246	4,232
Nursing Agency Staff	138	102	227	1,916
Nursing Bank Staff	666	601	533	6,437
Other Agency Staff	149	269	146	2,610
Other Bank Staff	234	218	234	2,549
Overtime	125	116	215	1,667
On Call	187	277	197	2,238
Total Temporary Expenditure	2,687	2,757	2,480	29,187
Total Expenditure on Pay	20,411	22,753	21,216	241,083
Variance (F/(A))	172	(773)	(1,038)	(3,364)
Temp. Staff Costs as % of Total Pay	13.2%	12.1%	11.7%	12.1%
memo: Total Agency Spend in-month	397	598	686	5,990

Monthly WTE				
As at February 2024	Feb-24	Jan-24	Feb-23	YTD
Budgeted WTE in-month	5,024.7	5,024.7	4,826.2	174,664.7
Substantive Staff	4,692.8	4,684.7	4,411.4	50,538.7
Medical Agency Staff	6.9	18.5	13.0	115.5
Medical Locum Staff	46.7	39.8	43.0	474.3
Additional Medical Sessions	11.7	7.2	2.8	112.7
Nursing Agency Staff	19.9	13.3	22.9	239.7
Nursing Bank Staff	168.7	150.3	130.6	1,586.8
Other Agency Staff	27.7	45.1	41.9	464.5
Other Bank Staff	72.3	63.6	80.4	808.5
Overtime	27.1	27.6	51.9	396.3
On Call	7.5	7.9	8.7	76.4
Total Temporary WTE	388.5	373.3	395.1	4,274.6
Total WTE	5,081.3	5,058.0	4,806.5	54,813.3
Variance (F/(A))	(56.6)	(33.3)	19.7	119,851.5
Temp. Staff WTE as % of Total WTE	7.6%	7.4%	8.2%	7.8%
memo: Total Agency WTE in-month	54.4	76.9	77.7	819.7

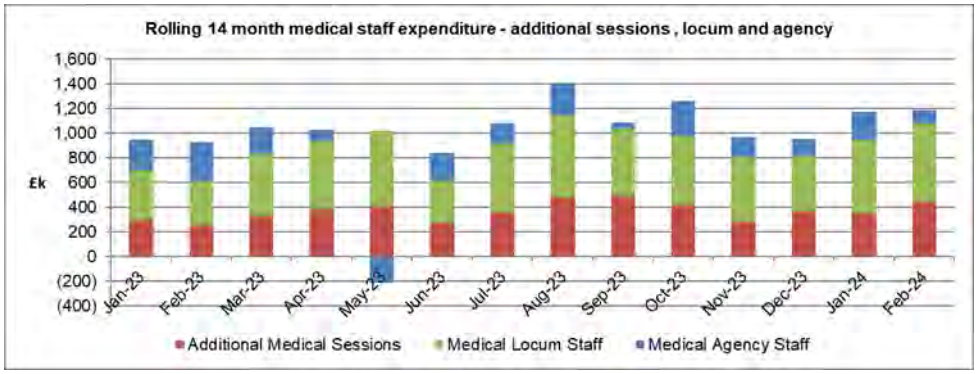
Page 9

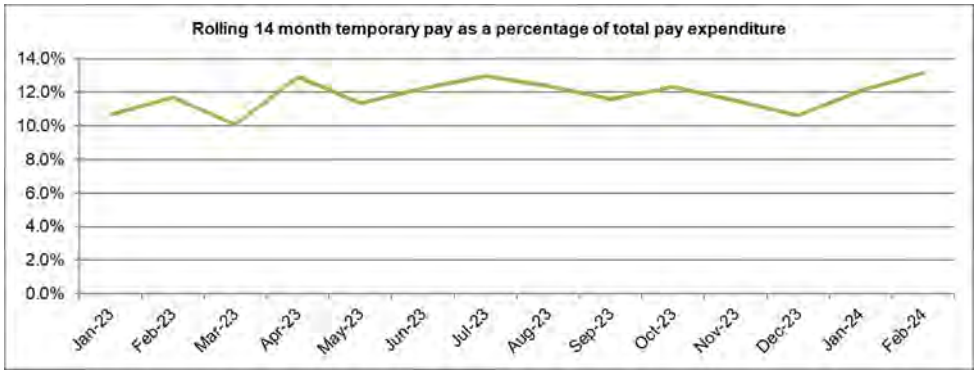
Pay Costs

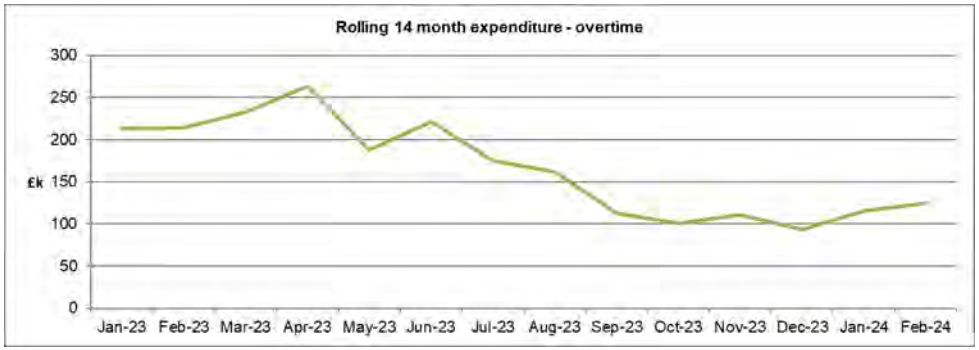




FINANCE REPORT – February 2024







FINANCE REPORT – February 2024

Statement of Financial Position – 29 February 2024

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2023	Plan 31 March 2024	Plan YTD 29 February 2024	Actual at 29 February 2024	Variance YTD 29 February 2024
	£000	£000	£000	£000	£000
Intangible assets	61,869	57,425	57,389	58,030	641
Property, plant and equipment	193,976	227,589	217,948	213,626	(4,322)
Right of use assets	9,817	9,929	10,137	11,647	1,510
Trade and other receivables	6,001	6,341	6,341	6,455	114
Total non-current assets	**271,663**	**301,284**	**291,815**	**289,758**	**(2,057)**
Inventories	4,365	3,800	3,800	4,624	824
Trade and other receivables	41,871	14,991	14,984	21,322	6,338
Non-current assets for sale	520	0	0	520	520
Cash and cash equivalents	7,895	14,298	12,452	10,871	(1,581)
Total current assets	**54,651**	**33,089**	**31,236**	**37,337**	**6,101**
Trade and other payables	(73,503)	(45,862)	(44,594)	(43,633)	961
Borrowing repayable within 1 year	(4,801)	(3,724)	(3,724)	(4,851)	(1,127)
Current Provisions	(64)	(46)	(46)	(62)	(16)
Other liabilities	(1,336)	(5,185)	(5,185)	(9,359)	(4,174)
Total current liabilities	**(79,704)**	**(54,817)**	**(53,549)**	**(57,905)**	**(4,356)**
Total assets less current liabilities	**246,610**	**279,556**	**269,502**	**269,190**	**(312)**
Borrowings	(48,038)	(41,265)	(41,868)	(44,406)	(2,538)
Provisions	(507)	(852)	(852)	(499)	353
Total non-current liabilities	**(48,545)**	**(42,117)**	**(42,720)**	**(44,905)**	**(2,185)**
Total assets employed	**198,065**	**237,439**	**226,782**	**224,285**	**(2,497)**
Financed by					
Public dividend capital	230,215	271,107	261,215	264,246	3,031
Revaluation reserve	12,054	12,640	12,640	12,055	(585)
Income and expenditure reserve	(44,204)	(46,307)	(47,073)	(52,016)	(4,943)
Total taxpayers' and others' equity	**198,065**	**237,440**	**226,782**	**224,285**	**(2,497)**

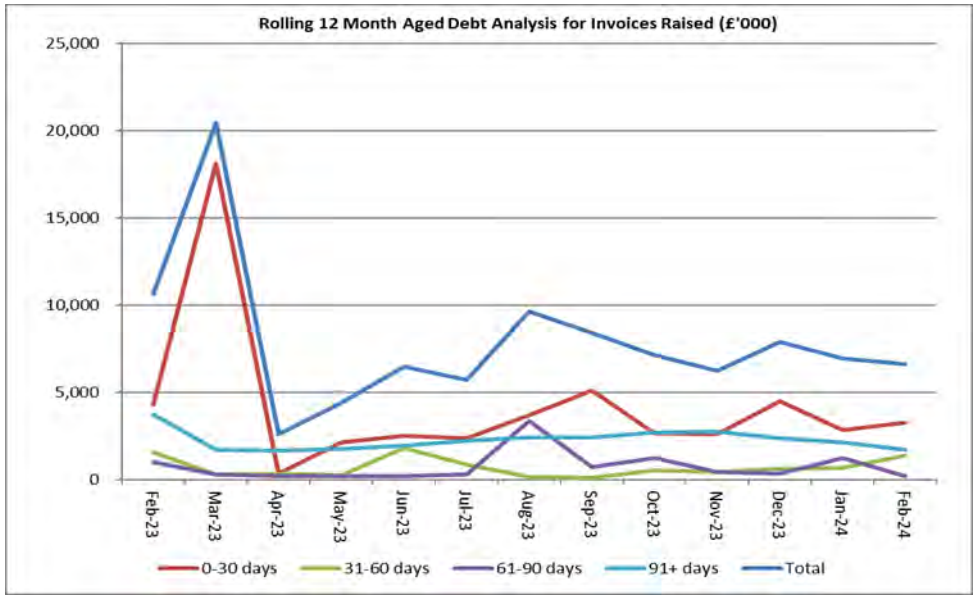
The above table shows the year to date position as at 29 February 2024.

Total reserves are slightly below plan and this is largely due to us reporting a deficit higher than plan.

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

Debt Management

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



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

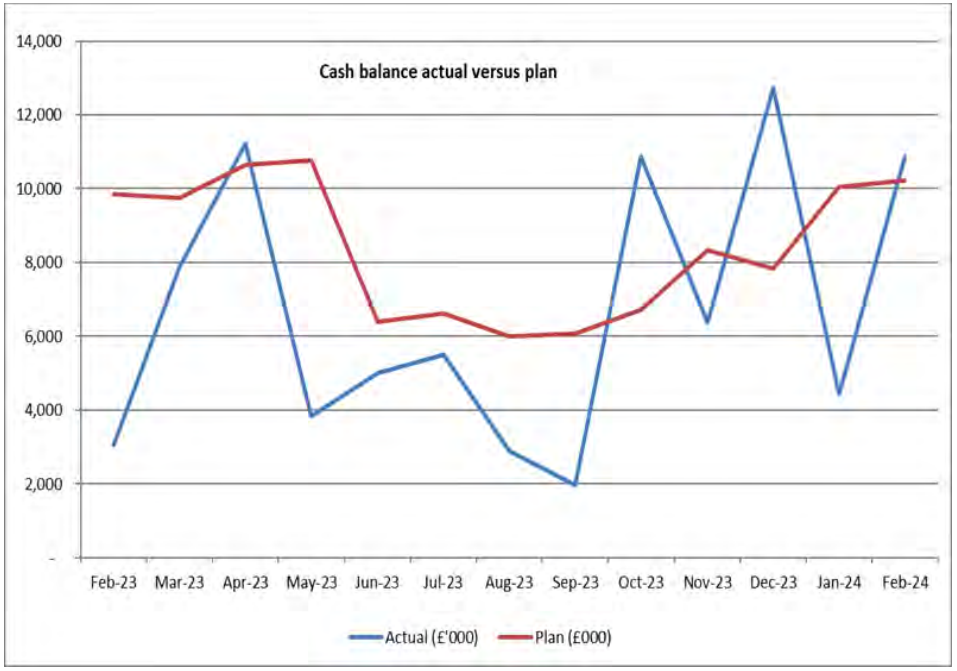
The overall level of sales invoices raised but not paid continues to remain stable and we have been working hard to reach resolution on some of the older debts in order to help the Trust's cash position.

Over 58% of the outstanding debts relate to NHS/WGA Organisations, with 21% of these types of debts being greater than 90 days old.

FINANCE REPORT – February 2024

Cash Balance for the year

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



The Trust's cash balance as at 29 February 2024 was £10.87m. This was made up of £7.87m of cash that is set aside to pay for capital projects and £3m for revenue payments. The large cash balance for capital is due to the remaining PDC funding being received for 2023/24.

Our cash is being rigorously monitored to ensure that we have adequate cash reserves to match our expenditure. However, as the Trust continues to report a deficit, our cash position continues to deteriorate. The Trust applied for £10m in revenue support in September 2023, which was eventually approved in full. We previously requested that the Board approved a further £6m in revenue support back in December 2023, however this was later revised to £10m with authorisation obtained from the Director of Resources. This £10m has now been received from DHSC.

In order to ensure that the Trust has adequate cash support through to the end of June 2024, the Trust is required to request further revenue support from DHSC (through NHSE) for the first quarter of 2024/25. Based on internal cash flow forecasts, the Trust will require a further £4m in revenue support to ensure that we remain within the minimum cash balance of £1.1m.

The support will be requested as working capital support against the Trust's planned deficit. It is expected that the Trust will continue to require revenue support during 2024/25 to support the continuing deficit.

The Board is asked to approve the request of £4m revenue support for the first quarter of 2024/25.

Capital Progress Report

The Capital Plan for 2023/24 has been further revised to £37.907m due to a re-phasing of PDC funding for the New Hospital Project in to 2024/25.

The year to date capital spend at month 11 is £31.017m. The Trust is on track to deliver the full year plan by 31 March 2024. The table below shows the breakdown:

Capital Spend - 29th Feb 2024			Year to Date				
Capital Scheme	Full Year Plan (Original)	Full Year Plan (current)	YTD Original Plan (M11)	YTD Actual (M11)	Variance	Funding Split *Internal*	Funding Split *PDC Available*
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
New Hospital (Future Systems)	15,121	10,946	1,145	9,500	- 8,355	200	10,746
Newmarket CDC	4,689	4,689	11,440	1,852	9,588		4,689
RAAC	10,999	10,900	7,700	8,237	- 537		10,900
Estates	2,835	1,966	1,840	1,625	215	1,966	
IM&T	4,043	6,655	5,723	4,516	1,207	5,989	666
Medical Equipment	672	596	451	2,054	- 1,603	495	101
Imaging Equipment	3,676	1,830	1,673	3,234	- 1,561	1,830	
Other Schemes	-	325	297	-	297	325	
Total Capital Schemes	**42,035**	**37,907**	**30,269**	**31,017**	**- 748**	**10,805**	**27,102**
						37,907	
Overspent vs Original Plan							
Underspent vs Original Plan							

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

To Assure

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Improvement Committee			Date of meeting: 21st February 2024		
Chaired by: Louisa Pepper			**Lead Executive Director: Susan Wilkinson Paul Molyneux**		
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
5.1	IQPR including Divisional PRM packs. Received for information	1	IQPR and PRM reports demonstrate divisional level breakdown of key Trust metrics as well as those specific to each Division.	Deep Dives for C-Diff and post-partem haemorrhage scheduled in 2023/24 programme of assurance. IQPR Datasets – work on-going to propose a way of reporting key quality and safety information as part of the committees assurance process. Data needs to be sensitive enough to cover aspects of patient safety and quality.	1
5.2	Glemsford Surgery CQC Report Progress Improvement Plan	2	Sept 22 CQC report rated the surgery as good. Progress and improvement key issues:- SAFE:- Clinical Pharmacist not yet recruited.	Glemsford Management will progress the improvement plan with support from WSFT. Teams inc. Estates, IT & HR to monitor targets and submission. Update to Improvement Committee in three months to include progress	1

Originating Committee: Improvement Committee			Date of meeting: 21st February 2024		
Chaired by: Louisa Pepper			Lead Executive Director: Susan Wilkinson Paul Molyneux		
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
			EFFECTIVE:-Access to GP appointments = WIP but achievement of target is unlikely; six session GP resigned Feb 24. CARING:- Patient Participation Group not yet set up but exploring a multi surgery group with neighbouring practices. RESPONSIVE:- Reception triaging of patients – training on-going. WELL LED:- Nursing placements well received and positive feedback from all involved.	on the sustainable governance structure.	
6.1	Patient Quality and Safety Group (PQASG) Updates provided from January meetings; - Hospital Transfusion Group	2	Regular monthly report using the Trust's 1-4 assurance level scale. Areas of partial assurance; -	PQASG will continue to maintain oversight of all items reported as emerging concerns through its reporting framework. No actions or escalations for Improvement Committee.	1

Originating Committee: Improvement Committee			Date of meeting: 21st February 2024		
Chaired by: Louisa Pepper			Lead Executive Director: Susan Wilkinson Paul Molyneux		
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
	Deteriorating Patient Group Mortality Oversight Group Drugs & Therapeutics Dementia Steering Group Mortuary & HTA Information Flow Safe Discharge Group End of Life Group		The Blood Safety & Quality Regs require 100% traceability of blood components. IT project with BIQ to review hazards and risks re implementation of closed loop bloods & label printers in Maternity and ITU. Guideline publication review – risk of non-compliance due to staff capacity. Sepsis – paediatric sepsis triggers not consistently identifying a septic child – immediate action to improve. Dementia – referral to memory clinics – review & scoping of improvement on-going. Palliative Care and referrals on Friday afternoon with vague care plans in place. Datix to be completed and PSII for		

Originating Committee: Improvement Committee			Date of meeting: 21st February 2024		
Chaired by: Louisa Pepper			Lead Executive Director: Susan Wilkinson Paul Molyneux		
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
			organisational learning and review. Governance process supporting quality patient care with discharge waiting area. 16/2/24 Risk summit and work on-going with Transfer of Care Group. Discharge – quality and timeliness of discharge summaries – Risk Reg entry & QI project regarding all aspects of discharge – reporting through CEGG. Lidocaine patches – oversight of use.		
6.2	Clinical Effectiveness Governance Group (CEGG)	2	7 new NBP publications. Pathology hold active risks due to the laboratory office space &	CEGG will continue to maintain oversight of all new items	1

Originating Committee: Improvement Committee			Date of meeting: 21st February 2024		
Chaired by: Louisa Pepper			Lead Executive Director: Susan Wilkinson Paul Molyneux		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data** **Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal		**For 'Partial' or 'Minimal' level of assurance complete the following:**		
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	Updates from the meeting:- Pathology Quality- inc accreditation Shared decision making digital consent WSFT response to 2023 MBRACE (Maternity) CEGG TOR		inadequate size of the water shed – restricted by the estate. Pathology- of note the accreditation (achieved) and recommended accreditation of specialisms is testament to the hard work of staff and should be acknowledged. Shared decision-making digital consent. Roll out programme continues at pace and is key to ensuring individuals are involved in personalised care. MBRACE – recognition and management of bleeding and increased risks for black and Asian women (Deep Dive – Post Partem Haemorrhage scheduled in committee programme). ED Lead midwife appointed. TOR – Agreed by CEGG & Improvement Committee	reported as emerging concerns through its framework.	The board to be aware of the challenging decisions being made in light of the ongoing urgent and emergency care pressures and the impact these are likely to have on quality and patient experience.

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7.1	Rapid Improvement Urgent Emergency Care Pathway. Large numbers of patients in ED awaiting a bed. Clinical risk at front door. Large number of patients discharged late in the day.	2	Initiatives:- Arrive by 9am- process to prepare patients for discharge or transfer before 9am undertaken. Activity to reduce and mitigate risk implemented. Phased roll out to wards. Feedback & review underway. Sunrise Bloods – take blood early in the morning. Results are ready for ward rounds & early decision-making regarding discharge & patient flow.	May 24 - Improvement Committee to receive an update on both initiatives.	1
7.2	Internal Professional Standards (IPS) Time taken for speciality review, plan to be documented once a	3	Data is unreliable due to completion of plan on ECare. IPS affects patient care, patients being treated at the right time, as	Further work with clinical leads to improve performance, compliance with the IPS & completion of Ecare. Updated	1

Originating Committee: Improvement Committee			Date of meeting: 21st February 2024		
Chaired by: Louisa Pepper			Lead Executive Director: Susan Wilkinson Paul Molyneux		
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
	referral by ED has been made on ECare.		safely as possible & flow through ED. Delays in speciality review & completion on ECare affect ED 4 hr performance, ambulance handover and crowding in ED.	paper to improvement Committee or via CEGG???	
8.1	Update on Trust Quality Priorities	1	Quality priorities are driven by our strategy & set out key improvements we aim to deliver and the measures we will use to understand progress & success. QP1 – Deliver measurable improvements in safe care & confidence to raise concerns through implementation of our patient safety strategy by March 24. (QP2 – Involvement Committee has oversight).	Improvement Committee to receive quarterly updates – included in the work programme.	1

Originating Committee: Improvement Committee			Date of meeting: 21st February 2024		
Chaired by: Louisa Pepper			Lead Executive Director: Susan Wilkinson Paul Molyneux		
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
			Staff training on safety syllabus – improving esr reporting 85% compliance Patient Safety Partners role – support from ICB until recruitment to post. Duty of Candour – QI project re focus on quality and patient safety aspects of the process. CQC Single Assessment Framework – SAFE metrics to measure safety = under development. Safety Summit – May 24. Learning Analysis Report for teams & divisions produced quarterly for formal learning. ECare – review of patient safety indicators re accuracy, relevance and use to measure quality.		

Originating Committee: Improvement Committee			Date of meeting: 21st February 2024		
Chaired by: Louisa Pepper			Lead Executive Director: Susan Wilkinson Paul Molyneux		
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

*See guidance notes for more detail

Guidance notes

The practice of scrutiny and assurance

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

Assurance level

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

4.4. Quality and Nurse Staffing Report

To Assure

Public Board	
Report title:	Quality and Workforce Report & Dashboard – January and February 2024
Agenda item:	4
Date of the meeting:	22 March 2024
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			
Please indicate Trust strategy ambitions relevant to this report.	☒	☒	☒

Executive Summary
WHAT? *Summary of issue, including evaluation of the validity the data/information*
This paper reports on safe staffing fill rate, contributory factors and quality indicators for inpatient areas for January and February 2024 It complies with national quality board recommendations to demonstrate effective deployment and utilisation of nursing and midwifery staff. The paper identifies planned staffing levels and where unable to achieve, actions taken to mitigate where possible. The paper also demonstrates the potential resulting impact of these staffing levels. It will go onto review vacancy rates, nurse sensitive indicators, and recruitment initiatives within the sphere of nursing resource management. This paper also demonstrates how nursing directorate is supporting the Trust's financial recovery ambitions, following a nursing deployment group established to provide oversight for nursing resource utilisation.
SO WHAT? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*
• Overall RN vacancy rate is positive causation/trend. • Turn over for RN/RM remains under 10% • Combined RN and NA fill rates above 90% continues this in this period and is in a positive improvement trend. • CHPPD target achieved in January but declined in February. • Temporary spend reduced in this period, successfully achieving CIP trajectory M10 and M11 • Inpatient SNCT commenced in February 2024 • Band 2/Band 3 job profile review commenced
WHAT NEXT? *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*
To continue to embed and monitor temporary spend and achievement of CIP. Continued focus on recruitment and retention on Nursing assistants
Action Required
For assurance around the daily mitigation of nurse and midwifery staffing and oversight of nursing and midwifery establishments No action from board required.

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

Quality and Nurse Staffing Report – January and February 2024

1. Introduction

1.1 This paper illustrates how WSFT's nursing and midwifery resource has been deployed for the months of January and February 2024. It evidences how planned staffing has been successfully achieved and how this is supported by nursing and midwifery recruitment and deployment. This paper also presents the impact of achieved staff including nurse and midwifery sensitive indicators such as falls, pressure ulcers, complaints and compliance with nationally mandated staffing such as CNST provision in midwifery. The paper will also demonstrate initiatives underway to review staffing establishments and activities to ensure nursing and midwifery workforce is deployed in the most cost-efficient way.

2. Background

2.1 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 January and February 2024. The following sections identify the processes in place to demonstrate that the Trust proactively manages nurse staffing to support patient safety.

3. Key issues

3.1 **Nursing Fill Rates**

The Trust's safer staffing submission has been submitted to NHS Digital for January and February 2024 within the data submission deadline. Table 1 shows the summary of overall fill rate percentages for these months and for comparison, and the previous four months. Appendix 1a and 1b illustrates a ward-by-ward breakdown for these periods.

	Day		Night	
	Registered	Care Staff	Registered	Care staff
Average fill rate Sept 2023	92%	85%	97%	97%
Average fill rate Oct 2023	93%	87%	98%	101%
Average fill rate Nov 203	94%	86%	98%	104%
Average fill rate Dec 2023	91%	86%	97%	100%
Average fill rate Jan 2024	91%	86%	98%	99%
Average fill rate Feb 2024	90%	84%	97%	102%

Table 1

Average fill rates have moved out of a declining picture in July 2023 and average staffing fill rates (RN and NA combined) have achieved over 90% for the last 9 months. This is a sustained improvement as indicated in the chart 2 below.

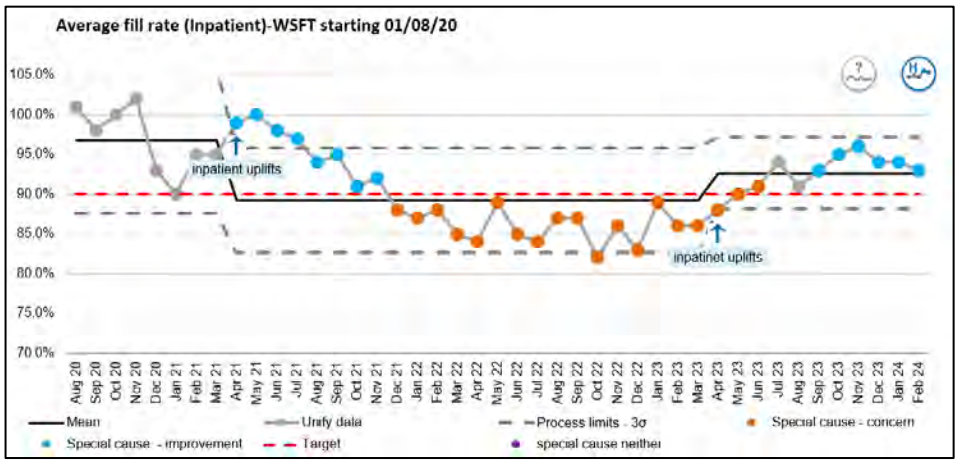


Chart 2

3.2 **Care hours per patient day**

CHPPD is a measure of workforce deployment and is reportable to NHS Digital as part of the monthly returns for safe staffing (Appendix 1). CHPPD is the total number of hours worked on the roster by both

Registered Nurses & Midwives and Nursing Support Staff divided by the total number of patients on the ward at 23:59 aggregated for the month (lower CHPPD equates to lower staffing numbers available to provide clinical care).

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

CHPPD can be affected adversely by opening additional beds either planned or emergency escalation, as the number of available nurses to occupied beds is reduced. Periods of high bed occupancy can also reduce CHPPD. It is expected that while the winter ward (F9) is open this will decrease likelihood of achieving the expected CHPPD for the organisation of our demographic. The winter/seasonal pressures ward was opened in a planned response to 'winter pressures' on 17th December. Although January saw an achievement of expected CHPPD, February declined to 7.0.

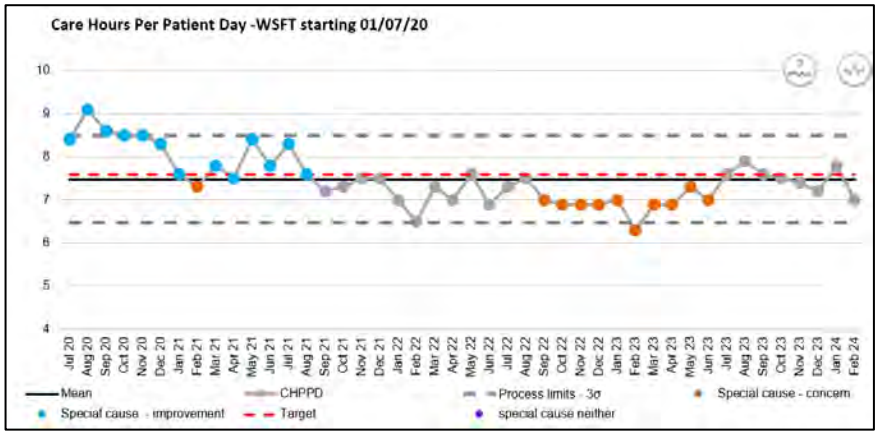


Chart 3

3.3 **Sickness**

High sickness rates were maintained in January, as observed in the previous months, however this has reduced in both registered and unregistered staff in February.

	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Unregistered staff (support workers)	6.05%	5.80%	6.01%	6.30%	6.57%	7.36%	7.24%	6.50%
Registered Nurse/Midwives	4.59%	4.81%	4.78%	6.08%	5.95%	5.96%	5.90%	4.43%
Combined Registered/Unregistered	**5.08%**	**5.14%**	**5.19%**	**6.15%**	**6.16%**	**6.43%**	**6.34%**	**5.11%**

Table 4

Chart 4

3.4 **Recruitment and Retention**

Vacancies: Registered nursing (RN/RM):

Table 5 demonstrates the total RN/RM establishment for the inpatient areas in whole time equivalents (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.

- Inpatient RN/RM vacancy rate has improved over this period from 9.4% to 8.6%
- Total RN/RM vacancy rate has remained static and is 6.5% at month 11.
- Total NA vacancy marginally improved from 11.6% to 11.2%
- Inpatient vacancy rate has improvement by >1% to 11.1% for M11.

Both total and inpatient RN/RM vacancy rates continue to improve and is in special cause improvement (appendix 2). Nursing assistant numbers are currently maintaining with no significant improvement or decline.

	Sum of Month 6	Sum of Month 7	Sum of Month 8	Sum of Month 9	Sum of Month 10	Sum of Month 11	WTE vacancy at M11
RN	688.2	699.7	696.8	689.2	694.8	695.3	**71.6**
NA	401.2	390.6	398.6	398.4	404.7	404.2	**56.5**

Table 5 Inpatient actual substantive staff WTE.

3.4.1 **International Recruitment**

The recruitment pipeline for internationally trained nurses continues and we are on track to achieve intended number for 23/24. Looking forward to 24/25 we are reducing the numbers being onboarded per month from 8 to 5 in recognition of positive vacancy rate but the need to keep this pipeline open.

3.4.2 **New Starters**

	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24
RN	47*	18	15	19	15	46*
NA	23	24	23	25	24	16

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

- In January, 15 RNs completed induction; of these; 11 were for the acute, 3 for bank service and 1 for community services.
- In January, 24 NAs completed induction; of these; 16 NAs are for the acute Trust, and 6 for bank services and 2 for community services.

- In February, 46 RNs completed induction; of these; 31 were for the acute, 3 for community and 7 for bank services and 5 midwifery preceptors.
- In February, 16 NAs completed induction; of these; 11 NAs are for the acute Trust and 5 for bank

3.4.3 **Turnover**

On a retrospective review of the last rolling twelve months, turnover for RNs continues to positively be under the ambition of 10%. Turnover improved to 7.7. NA turnover has also improved from 20.1%. to 17.2%

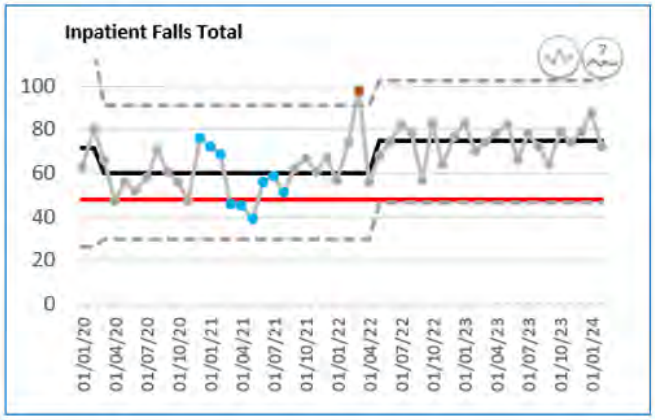
		Turnover	01/03/2023	-	29/02/2024			
Staff Group	Average Headcount	Avg FTE	Starters Headcount	Starters FTE	Leavers Headcount	Leavers FTE	LTR Headcount %	LTR FTE %
Nursing and Midwifery Registered	1,453.50	1,270.4688	78	63.5067	119	97.4067	8.1871%	7.6670%
Additional Clinical Services	626.50	524.2366	273	252.7666	118	90.3933	18.8348%	17.2428%

Table 7. (Data from workforce information)

3.5 **Quality Indicators**

Falls and acquired pressure ulcers.

Both falls and pressure ulcers incidents remain in common cause variation (chart 8 & 9). A full narrative around this quality measure interventions can be found in the IQPR. Improvement projects and oversight is completed through the patient quality and safety governance group (PQSGG).



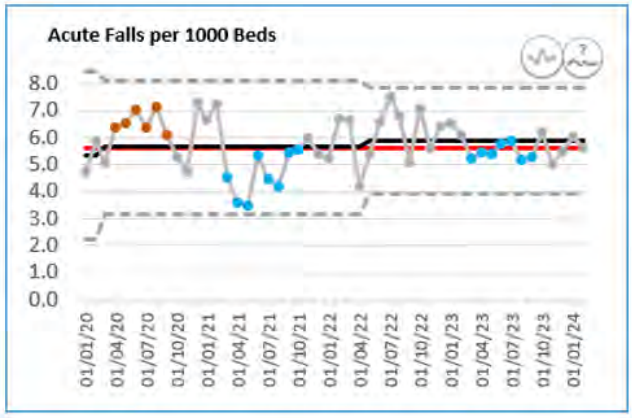
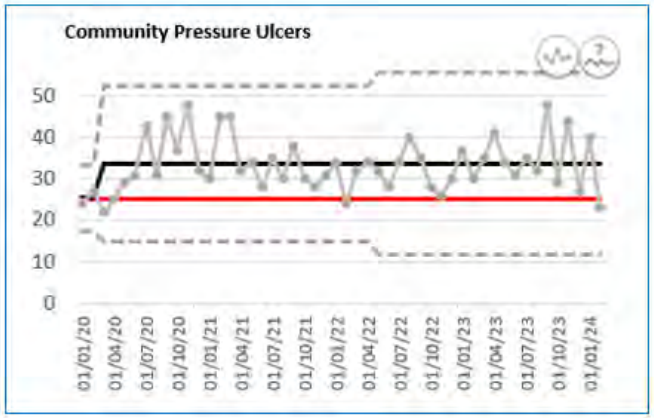


Chart 8 inpatient falls



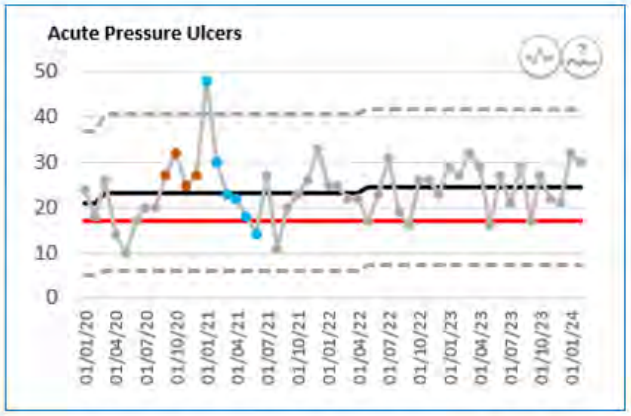


Chart 9 Pressure ulcers acquired in care.

3.6 **Compliments and complaints**

16 formal complaints were received in January. The most consistent theme of these formal complaints in January was clinical treatment with a total of 7. Of these complaints, delays in treatments or procedures most frequently featured.

18 formal complaints were received in February. The most consistent theme of these formal complaints was delays in acting on test results, failure to diagnose and inadequate pain relief.

Chart 10a and 10b demonstrates the incidence of complaints and compliments for this period. The number of complaints is at expected levels for this period, however compliments and positive feedback received has had a sustained improvement over the past 8 months.

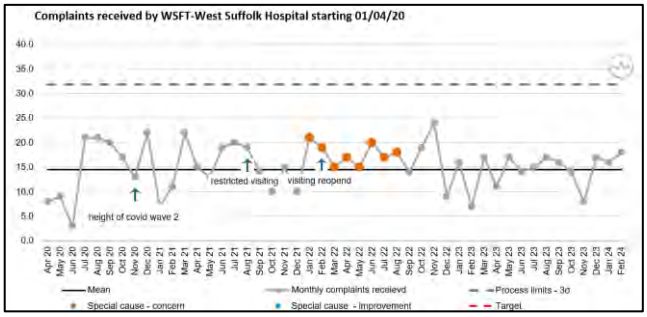


Chart 10a (complaints)

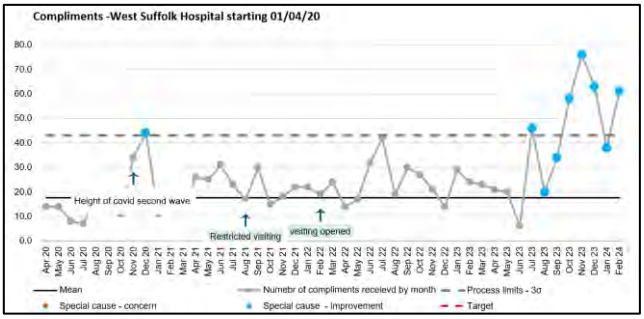


Chart 10b (compliments)

3.7 **Adverse staffing incidents**

Staffing incidences are captured on Datix with recognition of any red flag events that have occurred as per National Quality Board (NQB) definition (Appendix 3). Nursing staff are encouraged to complete a Datix as required, so any resulting patient harm can be identified and if necessary, reviewed retrospectively. For the purpose of this paper only those that meet NQB recommendations of a 'red flag' are included. Staffing not related to nursing are also excluded.

Red Flag	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24
Registered nursing shortfall of more than 8 hours or >25% of planned nursing hours	2	2	3	2	1	1
>30-minute delay in providing pain relief	1	-		1	5	-
Delay or omission of intention rounding	1	4	3	2	3	-
<2 RNs on a shift	4	1	7	2	2	2
Vital signs not recorded as indicated on care plan	-	-	-	2	3	-
Unplanned omissions in providing medication	1	-	1	1	-	1
Lack of appointments (local agreed red flag)	-	1	-	-	-	-
Delay in routine care (locally agreed red flag)	2	2	3	6	8	3
Unable to make home visits locally agreed	2	-	2	-	-	-
GPICS (ITU) standards not met	5	1	-	-	-	1
Impact not described	-	-	-	1	-	-
Total	18	11	19	17	22	8

Table 11

- In January 22 Datixs recorded for nurse staffing that resulted in a Red Flag event (see table 11.). No Harm is recorded for these incidents.
- In February 8 Datixs recorded for inpatient nurse staffing that resulted in a Red Flag event (see table 11). Ares that reported the most incidents were F9 (winter pressures ward] and F6. Two incidents were reported as moderate or severe harm.
    - Incident No. 108371: High acuity with very distressed patient who absconded. Patient returned to hospital no harm sustained, although very distressing episode for staff.
    - Incident No. 108764: Ward left with 2 RNs on weekend day shift due to sickness. No actual harm demonstrated in Datix or patient affected. Datix under investigation.

3.8 **Maternity services**

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

	Standard	September	October	November	December	January	February
Supernumerary Status of LS Coordinator	100%	100%	100%	100%	100%	100%	100%
1-1 Care in Labour	100%	100%	100%	100%	100%	100%	100%
MW: Birth Ratio	1:21	1:20.5	1:23.5	1:21	1:21	1:21	1:21
No. Red Flags reported		6	2	1	2	4	3

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 to stop the situation getting worse. Action includes escalation to the senior midwife in charge of the service and the response include allocating additional staff to the ward or unit. Red Flags are captured on Datix and highlighted and mitigated as required at the daily Maternity Safety Huddle.

- There were four red flag events reported in January.
- There were three red flag events in February.
- No harm was recorded as in impact of these incidents.

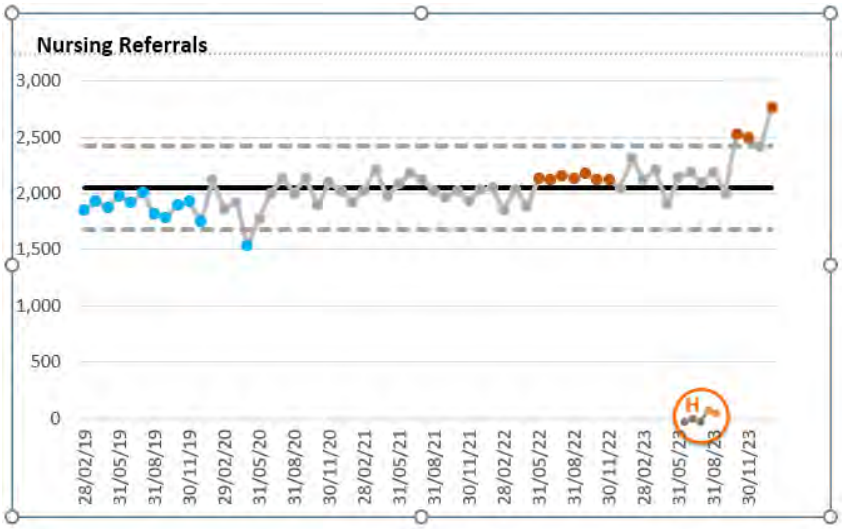
Midwife to Birth ratio
Latest BirthRate plus review undertaken in March 2023 shows that Midwife to Birth ratio at West Suffolk NHS Foundation Trust reduced to 1:21. The ratios are based on the Birthrate Plus® dataset, national standards with the methodology and local factors, such as % uplift for annual,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

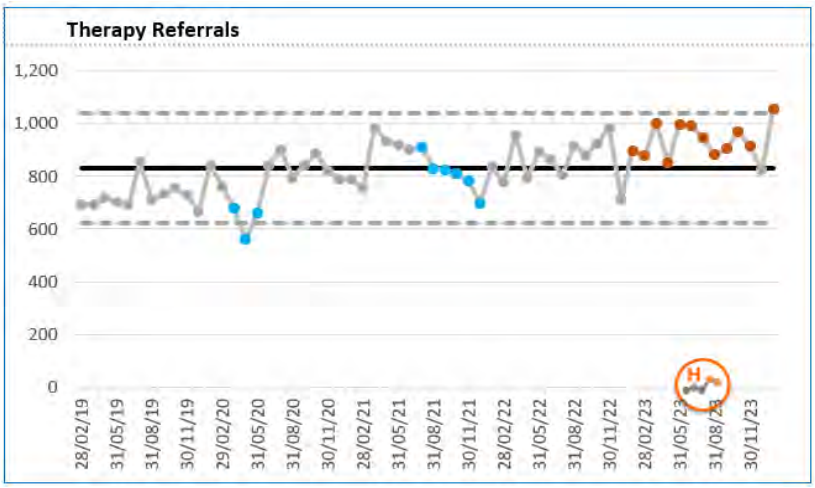
- WSFT midwife to birth rate ratio was 1:21 in both January and February 2024, in line with expected standards.

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 January and February 2024.

3.9 **Community and integrated teams**

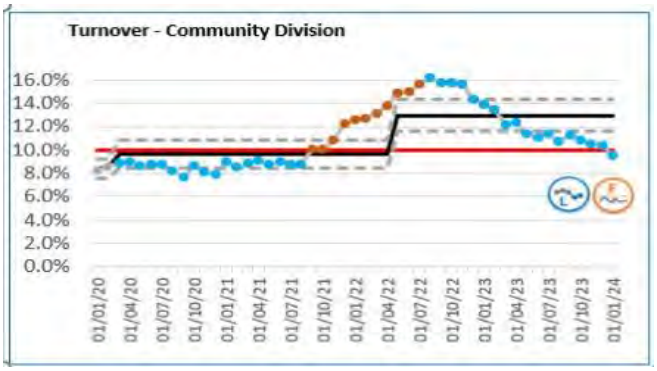
Demand
Below are the referrals until end of January for our Integrated Neighbourhood teams. The demand is above what is the norm, this has been the case for therapy element of the team for a year, and since October 23 for nursing. It is difficult to say what the cause is for this demand, only most other services in NHS are experiencing similar patterns potentially driven by an aging population and increase in numbers of people with multiple co-morbidities.





Sickness & Turnover

Sickness levels are just over the trusts expected 5% sickness level. Sickness levels are reviewed & monitored in various trust wide forums. As the highest incidence for sickness is anxiety and depression, we have set up regular meeting with the wellbeing lead to understand any themes and identify if any further interventions can be utilised to better support our workforce.



What next for community teams

- Third run of the Community Nursing Safer Staffing Tool in March 24. Once this data is inputted and triangulated a paper to summarise results and inform plans to make any changes to INTs will be made.
- Integrated Neighbourhood teams have aligned their establishment / budget to rosters. There needs to be some additional work to standardise the shift patterns on the roster, which wasn't in place when rosters were rolled out. This is expected to be complete by mid-March. This will improve the usefulness of roster reports such as the Unify report.
- Temporary spending -no material increases in spend on agency, bank and overtime. Clear escalation processes in place to review safe staffing and approval of agency.
- INT teams trialling a new dashboard which should be more accurate in determining the nursing OPEL levels. Early indications are its going well.
- Service leads, HR, support services working together on ensuring we are supporting & managing colleagues with mental health conditions in the best way possible.

4. Next steps

4.1 **Nursing Resource oversight Group**

The Nursing Deployment Group continue to meet to review best practice methods of deploying staff and to reduce the temporary nursing spend. Interventions include the commencement of a better rostering subgroup to fully utilise eRostering modules, stringent control over agency and overtime spend and reducing high-cost temporary nursing shifts.

In January and February, the planned CIP was achieved consistently. Current forecast is predicted to exceed the CIP target well. This is evidence of sustained grip and control and commitment to ensuring our nursing workforce is deployed efficiently and cost effectively.

Nursing Temporary Staff Cost Reduction							
Period	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**Totals**
Target/Aim (£000)	**144**	**144**	**144**	**144**	**144**	**144**	**865**
Initiative	**Actual**	**Actual**	**Actual**	**Actual**	**Actual**	**Forecast**	**Forecast**
1. Overtime	15	73	33	10	8	30	**169**
2. Rate Standardisation	0	0	0	0	0	0	**0**
3. Pool reduction	57	86	77	77	79	75	**451**
4. Agency	0	49	75	76	78	70	**348**
5. Rostering	0	0	0	0	0	0	**0**
Achievement (£000)	**72**	**208**	**185**	**163**	**165**	**175**	**968**

4.2	**Establishment reviews** The trust obtained the licence for the revised Safter Nursing Care Tool (November 2023) and is currently running the first round of this audit using new patient discrimination. The new addition to this audit program is better identification of the workforce demands when patients require 1:1 care or 'specialising'.
4.3	**Healthcare support worker role profile review,** In January a revised paper was approved and supported by the executive team and shared with board subcommittees documenting the Trust's intention to review band 2 and band 3 healthcare support worker roles within WSFT [referred to as nursing assistants in this paper]. This review will also include the provision of back pay renumeration to August 2021. The process for formal engagement with staff and staff side representatives commenced in March 2024.
5.	**Conclusion**
5.1	A continued focus on the efficient and effect deployment of nursing and midwifery workforce has significantly contributed to achieving CIP ambitions for nursing temporary spend for this period and these controls appear not to have adversely affected overall fill rates. Registered nurse recruitment continues positively and the trust vacancy rate for both inpatient and total nurses and midwives is consistently under 10%. Nursing assistant recruitment has remained static, it is hoped that the work to align the national job profiles will contribute to further improvement of recruitment and retention of this staff group. Quality indicators continue to be sustained despite seasonal pressures and opening additional escalation areas and wards in this period.
6.	**Recommendations**
	For the board to take assurance around the daily mitigation of nurse and midwifery staffing and oversight of nursing and midwifery establishments,

Appendix 1. Fill rates for inpatient areas (January 2024) Data adapted from Unify submission.
RAG: Red <79%, Amber 80-89%, Green 90-100%, Purple >100

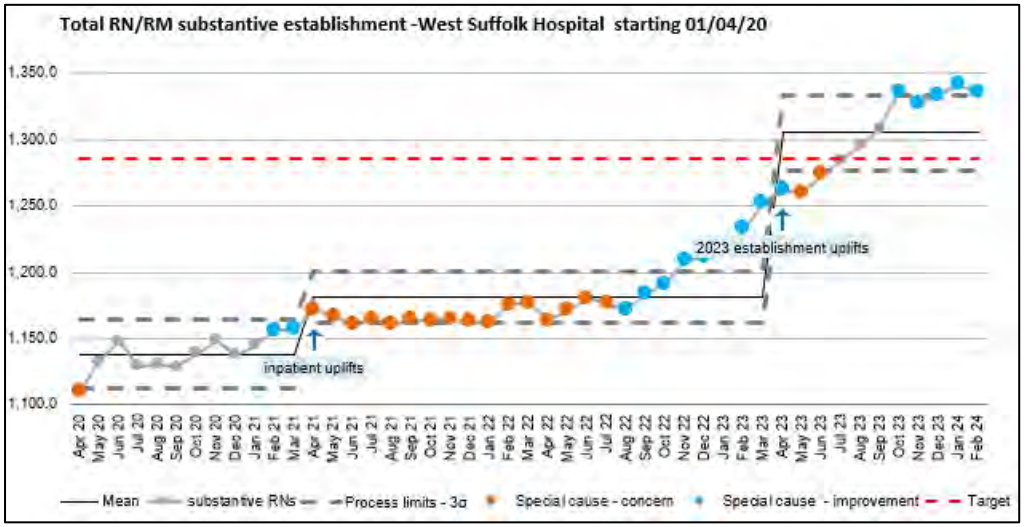
	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	RNs/RMN		Non registered (Care staff)		RNs/RMN		Non registered (Care staff)									
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average Fill rate RNs/RM %	Average fill rate Care staff %	Average Fill rate RNs/RM %	Average fill rate Care staff %	Cumulative count over the month of patients at 23:59 each day	RNS/RMs	Non registered (care staff)	Overall
Rosemary Ward	1428.75	1287.25	1786.25	1589.4167	1069.5	979	1421.5	1419.5	90%	89%	92%	100%	452	5.0	6.7	11.7
Glastonbury Court	708.5	708	1061.75	1043	713	714.5	542.5	536	100%	98%	100%	99%	384	3.7	4.1	7.8
Acute Assessment U	2080.5	2247.9167	2243	1698.5	1748	1842	1395.5	1333.08333	108%	76%	105%	96%	761	5.4	4.0	9.4
Cardiac Centre	1777	1557	1001.5	809	1771	1679	701.5	701.5	88%	81%	95%	100%	632	5.1	2.4	7.5
G10	1753.5	1379	1755	1339.0833	1069.5	1049.416667	1782.5	1472.58333	79%	76%	98%	83%	707	3.4	4.0	7.4
G9	1650	1426	1414.5	1240.8333	1368.5	1321	1046.5	1078.5	86%	88%	97%	103%	752	3.7	3.1	6.7
F12	518	607.5	356.5	331	667	617	352.5	345.5	117%	93%	93%	98%	240	5.1	2.8	7.9
F7	1745	1488.75	1644.5	1557	1357	1221.666667	1765.5	1693.5	85%	95%	90%	96%	683	4.0	4.8	8.7
G1	1424.5	938.5	362	324.5	713	701.5	357	320.5	66%	90%	98%	90%	485	3.4	1.3	4.7
G3	1772.5	1382.5	1769.5	1710.75	1062.5	1012	1056.5	1389	78%	97%	95%	131%	864	2.8	3.6	6.4
G4	1782.5	1492	1774.75	1551.75	1069.5	954	1418.5	1389	84%	87%	89%	98%	896	2.7	3.3	6.0
G5	1419	1211	1782.5	1338	713	1060.5	1426	1226.5	85%	75%	149%	86%	760	3.0	3.4	6.4
G8	1852	1865.5	1425	1383.5	1511.5	1531.816667	1012	1048.25	101%	97%	101%	104%	615	5.5	4.0	9.5
F8	1426	1389.3333	1767.5	1489.5	1069.5	960.25	1426	1390.83333	97%	84%	90%	98%	723	3.2	4.0	7.2
Critical Care	2679	2679.5833	331	168.25	2668	2652.75	0	44	100%	51%	99%	*	388	13.7	0.5	14.3
F3	1611	1332.5	2127.5	1626.5	1069.5	1066	1426	1378.25	83%	76%	100%	97%	732	3.3	4.1	7.4
F4	858	967.66667	629.5	705.5	624	601	506.5	460	113%	112%	96%	91%	633	2.5	1.8	4.3
F5	1842	1732.5	1633	1325.75	1057.5	982	1058	923	94%	81%	93%	87%	698	3.9	3.2	7.1
F6	1736.5	1321.5	1687.75	1572.25	1055	1070.583333	707	1235.16667	76%	93%	101%	175%	942	2.5	3.0	5.5
Neonatal Unit	1288.5	1198	744	573.5	1116	931.5	744	611	93%	77%	83%	82%	116	18.4	10.2	28.6
F1	1682.5	1914.75	713	691.5	1426	1459.25	0	57.5	114%	97%	102%	*	115	29.3	6.5	35.9
F14	372	381.5	324	324	744	756.35	0	0	103%	100%	102%	*	106	10.7	3.1	13.8
F9	1311	1069.75	1412.75	1259.5	1012	886.5	1404	1355.83333	82%	89%	88%	97%	744	2.6	3.5	6.1
Total	34,718.25	31,578.00	29,746.75	25,652.58	26,674.50	26,049.58	21,549.50	21,409.00	**91%**	**86%**	**98%**	**99%**	**13428**	**4.3**	**3.5**	**7.8**
* planned hours are zero, so additional support used on ward to mitigate unfilled nursing hours																

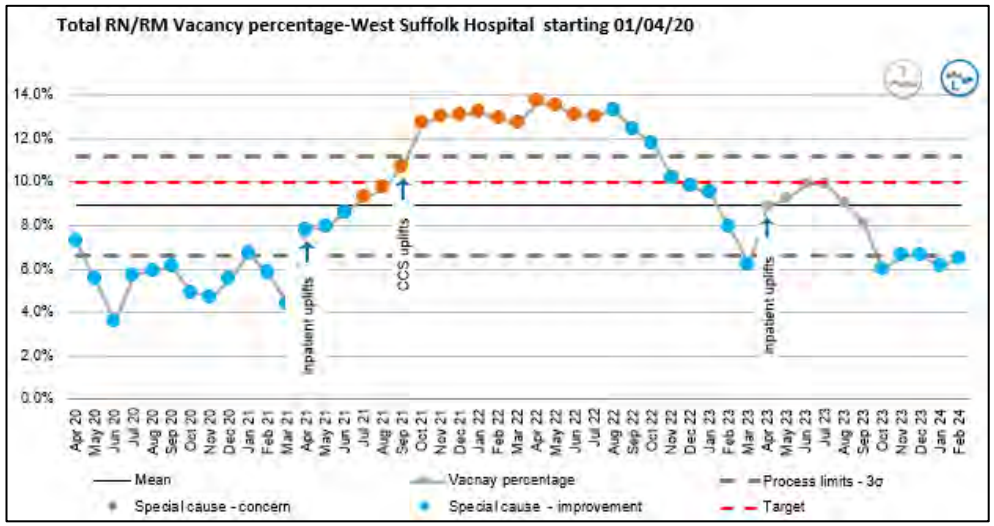
Appendix 1. Fill rates for inpatient areas (February 2024) Data adapted from Unify submission.

	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	RNs/RMN		Non registered (Care staff)		RNs/RMN		Non registered (Care staff)									
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average Fill rate RNs/RM %	Average fill rate Care staff %	Average Fill rate RNs/RM %	Average fill rate Care staff %	Cumulative count over the month of patients at 23:59 each day	RNS/RMs	Non registered (care staff)	Overall
Rosemary Ward	1335.5	1125.25	1668.5	1512.75	1000.5	914.4166667	1334	1313	84%	91%	91%	98%	915	2.2	3.1	11.7
Glastonbury Court	667	672.5	1002.25	972	667	667	504.5	507.5	101%	97%	100%	101%	542	2.5	2.7	7.8
Acute Assessment U	1957.5	2014.45	1714	1446.6667	1656	1602	1104	1189	103%	84%	97%	108%	761	4.8	3.5	9.4
Cardiac Centre	1667.5	1453.5	1000.5	727.5	1667.5	1610	667	687.5	87%	73%	97%	103%	632	4.8	2.2	7.5
G10	1653	1222.3667	1653	1379.5833	1000.48333	996.5	1667.5	1443	74%	83%	100%	87%	707	3.1	4.0	7.4
G9	1581.5	1461.1667	1329.5	1194.0833	1253.5	1304.316667	1000.5	1003.5	92%	90%	104%	100%	752	3.7	2.9	6.7
F12	488.75	627.5	333.5	303.75	591.5	590.75	327.5	339	128%	91%	100%	104%	240	5.1	2.7	7.9
F7	1660.5	1365.5833	1575.5	1418.25	1334	1192	1661	1425	82%	90%	89%	86%	683	3.7	4.2	8.7
G1	1342.5	914.5	333.5	272	667	657.5	331.5	329.833333	68%	82%	99%	99%	485	3.2	1.2	4.7
G3	1664.5	1369.5	1662.5	1392.25	1000.5	962	995.5	1323.5	82%	84%	96%	133%	864	2.7	3.1	6.4
G4	1661.75	1398.5	1667.5	1392	1000.5	954.5	1334	1290	84%	83%	95%	97%	896	2.6	3.0	6.0
G5	1334	1289.5	1663.5	1443.75	667	975	1333.5	1331	97%	87%	146%	100%	760	3.0	3.7	6.4
G8	2307.5	1851.2667	1666.75	1423	1587	1490.866667	1006.5	1102	80%	85%	94%	109%	615	5.4	4.1	9.5
F8	1334	1293.0833	1646.5	1291.25	995	891.9166667	1334	1289.5	97%	78%	90%	97%	723	3.0	3.6	7.2
Critical Care	2507	2434.25	319	142.5	2652.5	2300	0	105.5	97%	45%	87%	*	388	12.2	0.6	14.3
F3	1610	1335.25	2001	1461	1000.5	991.5	1334	1308.16667	83%	73%	99%	98%	732	3.2	3.8	7.4
F4	789	907.5	499	544	598	586.5	514	455	115%	109%	98%	89%	633	2.4	1.6	4.3
F5	1682	1556.6667	1507.5	1255.75	931.5	932.5	1000.5	902.5	93%	83%	100%	90%	698	3.6	3.1	7.1
F6	1644.5	1295.5	1622	1300.75	1000.5	1017.166667	663	983.5	79%	80%	102%	148%	942	2.5	2.4	5.5
Neonatal Unit	1201.5	1028.5	696	540	1044	906	696	516	86%	78%	87%	74%	116	16.7	9.1	28.6
F1	1581	1715.5	667	644	1334	1486.75	0	142.5	109%	97%	111%	*	115	27.8	6.8	35.9
F14	338.5	349	348	345	696	696	0	0	103%	100%	100%	*	106	9.9	3.3	13.8
F9	1288	1288	1288	1083.5	966	887.4166667	966	1230	100%	84%	92%	127%	744	2.9	3.1	6.1
Total	33,297.00	29,968.83	27,864.50	23,485.33	25,310.48	24,612.60	19,774.50	20,216.50	**90%**	**84%**	**97%**	**102%**	**14049**	**3.9**	**3.1**	**7**
* planned hours are zero, so additional support used on ward to mitigate unfilled nursing hours																

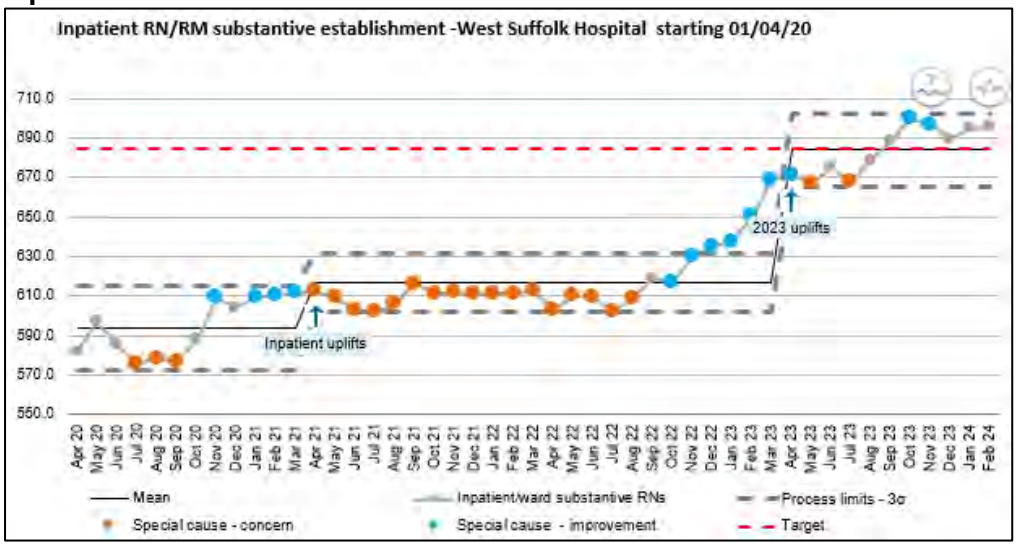
Appendix 2 SPC charts.

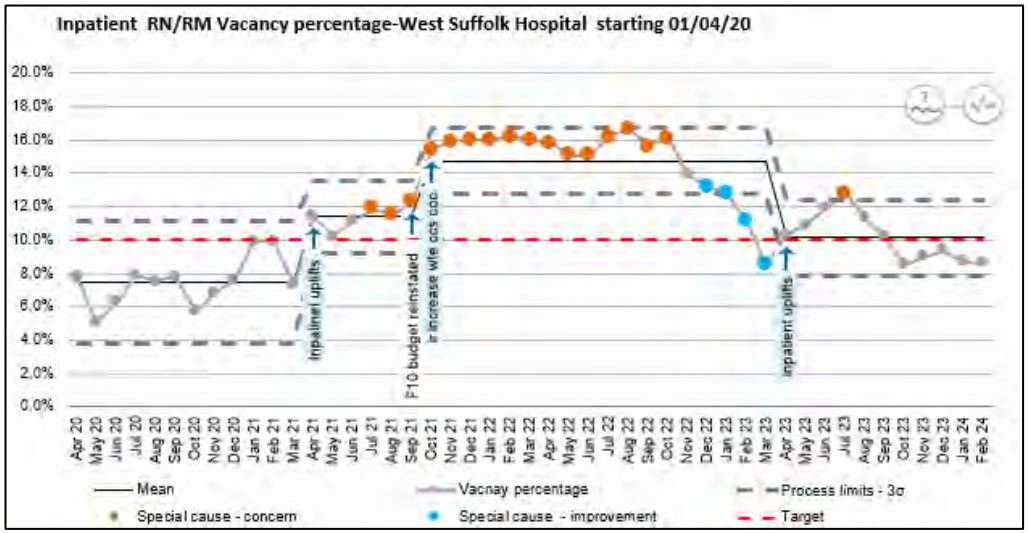
Trust Total RN/RM



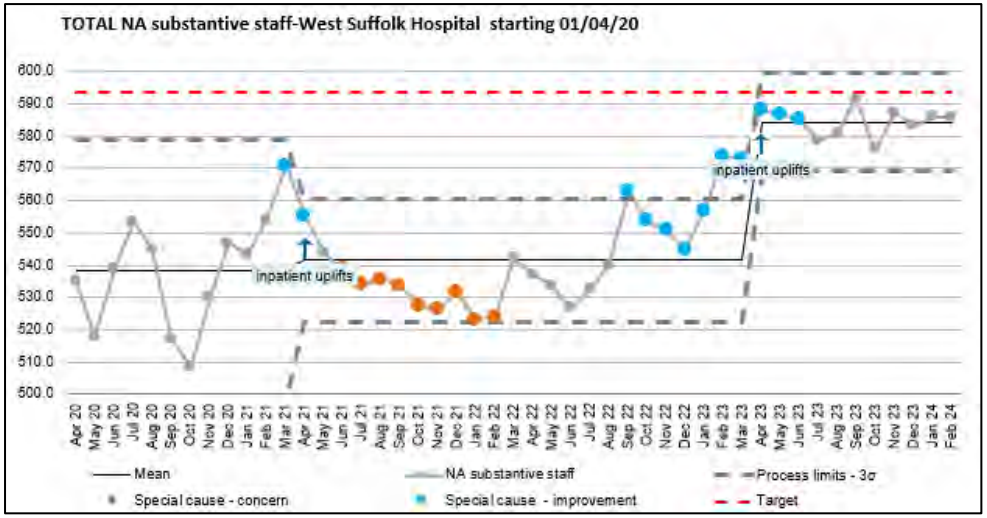


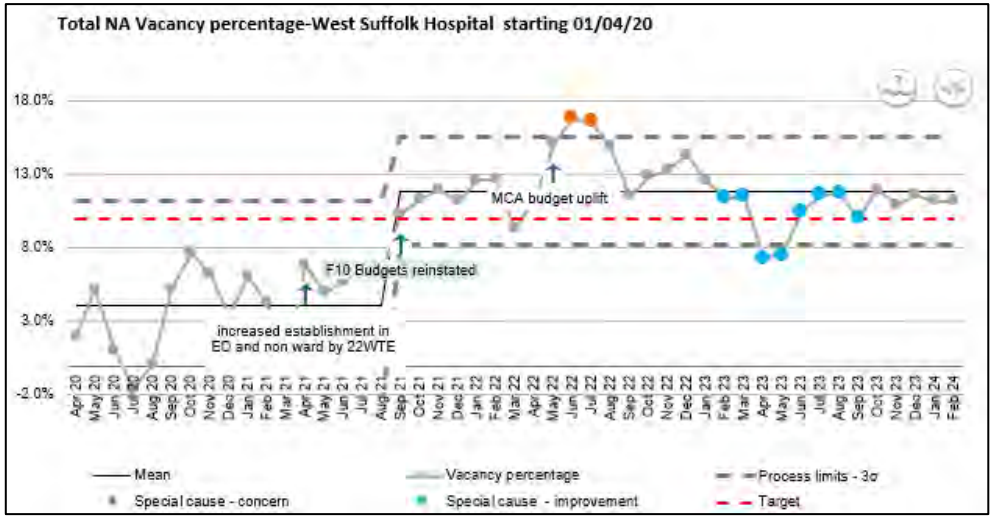
Inpatient RN/RM



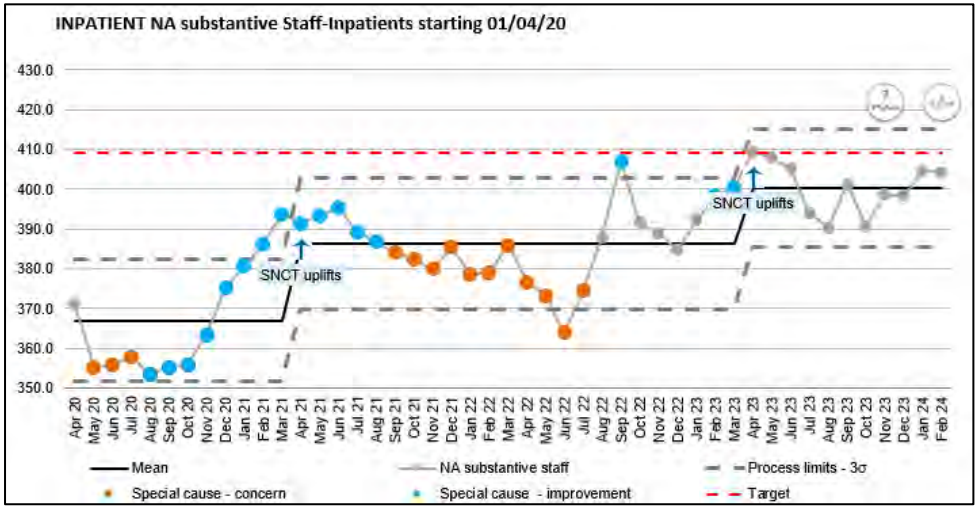


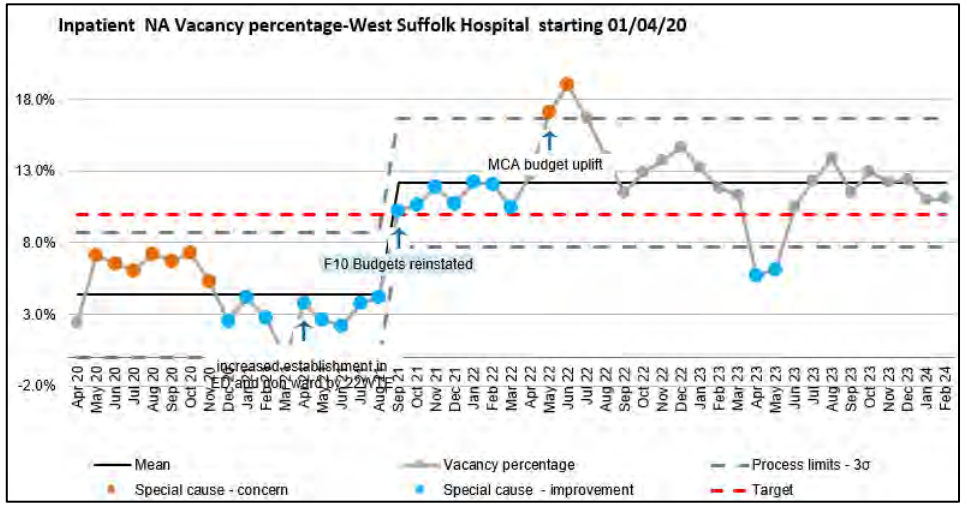
Total NA/unregistered.





Inpatient NA/unregistered.





Appendix 3: Red Flag Events

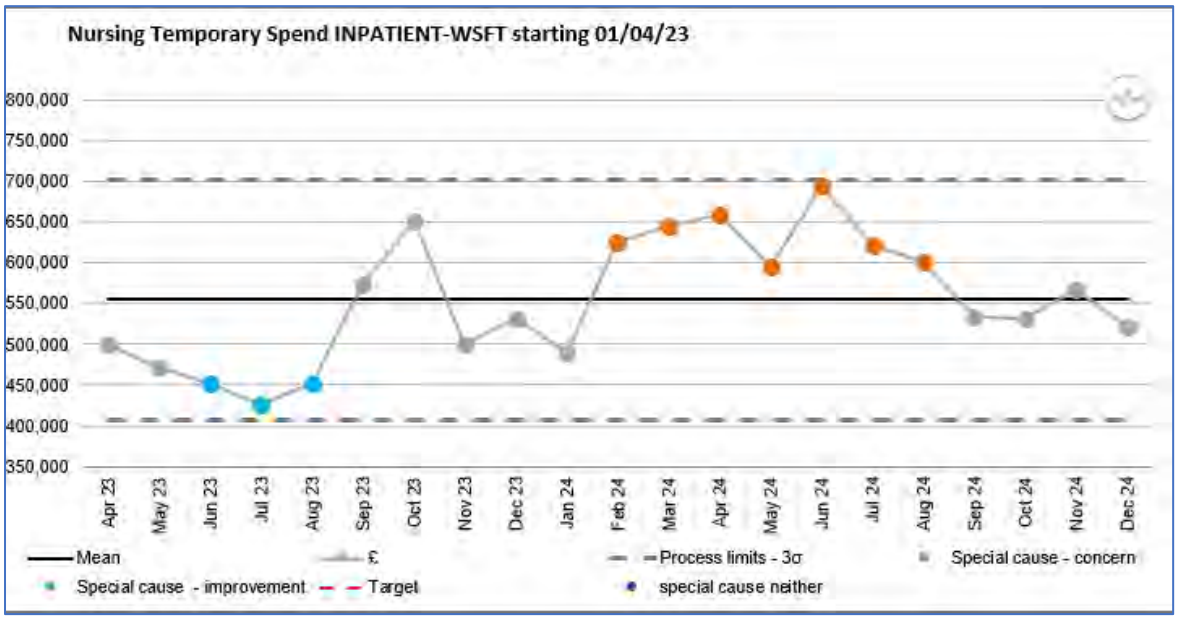
Maternity Services

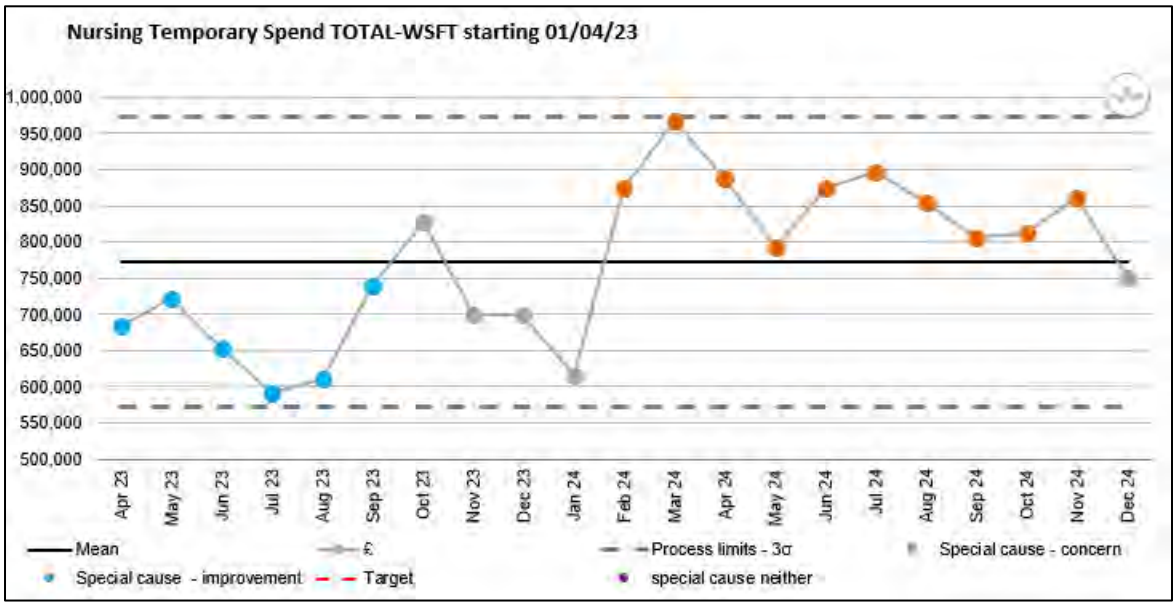
Missed medication during an admission
Delay of more than 30 minutes in providing pain relief
Delay of 30 minutes or more between presentation and triage
Delay of 60 minutes or more between delivery and commencing suturing
Full clinical examination not carried out when presenting in labour
Delay of two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

Acute Inpatient Services

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

Appendix 4: Trust level temporary spend





4.4.1. Maternity Services

Karen Newbury, Kate Croissant & Simon Taylor in attendance

To Approve

Open Trust Board	
Report title:	Maternity quality, safety, and performance report
Agenda item:	4.4.1
Date of the meeting:	22nd March 2024
Sponsor/executive lead:	Sue Wilkinson, Executive Chief Nurse Paul Molyneux, Medical Director & Executive MatNeo Safety Champion
Report prepared by:	Karen Newbury, Director of Midwifery

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

Executive Summary

WHAT?

This report presents a document to enable board scrutiny of Maternity services and receive assurance of ongoing compliance against key quality and safety indicators and provide an update on Maternity quality & safety initiatives in line with the NHS Perinatal quality surveillance Model (Dec 2020). 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
- Training compliance for all staff groups in maternity related to the core competency framework.
- CQC maternity survey results 2023 (Annex A)
- East of England Sixty Supportive Steps to Safety Visit, version 2 (Annex B)
- Perinatal Mortality – closed Board – Quarter 3 2023/24 report (Annex C)
- HSIB/Maternity and Neonatal Safety Investigations (MNSI)/Early Notification Scheme Q3 2023/24 report (Annex D)
- Avoiding Term Admissions into the Neonatal Unit (ATAIN) and Transitional Care Q3 2023/24 report (Annex E)

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 information and record of reports received.

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

Maternity quality, safety, and performance report

1.	**Detailed sections and key issues**
1.1	**Maternity improvement plan** The Maternity and Neonatal Improvement Board (MNIB) receives the updated Maternity improvement plan monthly. This has been created through an amalgamation of the original CQC improvement plan with the wider requirements of Ockenden, Maternity and Newborn Safety Investigations, 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 MNIB monthly. It has been agreed with the exit from the Maternity Safety Support Programme (MSSP) that NHSE regional team and ICS (Integrated Care System) will be invited to attend the MNIB monthly for additional assurance and scrutiny. NHSE and the ICS, with the national chief midwife in attendance, undertook a 60 Supportive Steps visit in December 2023, to provide a systematic review of the Trust's maternity and neonatal service. Feedback on the day was exceptionally positive and the formal report of findings has just been received. The recommendations if not already completed, will be captured in the maternity improvement plan.
1.2	**Safety Champion feedback** The Board-level champion undertakes a monthly walkabout in the maternity and neonatal unit. Staff have the opportunity to raise any safety issues with the Board level champion and if there are any immediate actions that are required, the Board level champion will address these with the relevant person at the time. Individuals or groups of staff can raise the issues with the Board champion. An overview of the Walkabout content and responses is shared with all staff in the monthly governance newsletter 'Risky Business'. Roger Petter our Non-Executive Maternity and Neonatal Safety Champion visited the Neonatal Unit on the 18th of January 2024 and spoke with a range of medical, nursing, administrative staff and well as a parent on the unit. Roger's overall impression was of a well-run unit with excellent teamwork and a healthy atmosphere. A good example of this teamwork is the way that staff volunteered to fill rota gaps over the festive season. On the ward round there was healthy debate and open discussions, with staff showing mutual respect for each other and a very clear focus being the best safest care for the patients. Staff identified that there is new equipment which they have received initial training on, however they would like regular 'hands-on' training sessions, including equipment that they use infrequently. The

plan moving forward is to hold regular training sessions on the Neonatal Unit, including skills drills and equipment use.
Concerns were raised regarding the difficulty in recruiting experienced qualified in speciality nurses, which is affecting gaps in the rota resulting in an increase in sickness and decline in some staff's morale. Recruitment continues to be high on the agenda, including further staff commencing the Qualified in Specialty training. The nursing team have undertaken team listening sessions and identified areas to work on as a team. The Workforce, Human Resources, Wellbeing, and senior management team are supporting the staff through this time.

The medical staff felt that it is a good unit, with well-trained staff who are able to care well for babies. Their one comment was regarding a review of some of the packs for specialist procedures so that they contain all the equipment needed in one pack. This idea will be forwarded to the ward manager. Temperature control of the unit was also raised as it can be affected by the outside temperature, resulting in sub-optimal climate control. This has been escalated and will continue to be monitored via Datix.

The parent Roger spoke to couldn't speak highly enough of the "amazing staff" and was particularly complimentary of the reassurance that they were given after their baby was born, when everything was new and scary. They also commented about the good handovers and continuity of care provided.

In addition to this, as part of the Maternity Improvement Scheme, the Board Safety Champions are mandated to meet with the Perinatal Quadrumvirate quarterly, to identify any support that is required in addressing safety issues. This has been successfully implemented by the Associate Director of Operations for Women and Children Services attending the Safety Champion meetings, where the other members of the quadrumvirate are already in attendance.

1.3 **Listening to Staff**

The National Staff Satisfaction Survey results were published at the end of February 2024. The quadrumvirate will work with their HR Business partner to review the results, share with staff, and clarify next steps.

The maternity and neonatal service continues to promote all staff accessing the Freedom to Speak up Guardians, Safety Champions, Professional Midwifery/Nursing Advocates, Unit Meetings and 'Safe Space'. In addition to this there are maternity and neonatal staff focus groups, and specific care assistant and support worker forum, which all provide an opportunity to listen to staff.

On the back of recent retention data from the national and regional teams, it is recognised that the majority of midwives are leaving the profession 2-5 years after qualification. We are committed to working with the Local Maternity /Neonatal System and regional team to address this. In response to listening to staff regarding the fairness of allocation of shifts, a survey was undertaken to capture staff views regarding their current shift patterns and whether it meets their work/life balance requirements and any ideas for improvement. The results were very positive, with areas for further development. Once the results have been shared via the staff forum a co-produced action plan will be in place.

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	Jan Survey returns	Jan FFT score	Feb Survey returns	Feb FFT Score
F11	80	96%*	49	93.88%*
Antenatal	6	-	14	-
Postnatal Community	2	-	23	-
Labour Suite	32	98.75%*	14	97.14%*
Birthing Unit	16	100 %*	14	93.88%*

NNU	1	93.95%	2	98.33%
Transitional Care	11	91.25%	9	87.43%
Maternity Smoke Free Team	-	-	-	-
Castlehill Team	5	-	4	-
Foresthill Team	1	-	0	-
Gainsborough Team	5	-	0	-

*Target of ≥30% of discharged people providing feedback met.

Plans to increase the number of returns for antenatal and postnatal community were relying on the introduction of a SMS survey response. Due to financial constraints, it has not been possible to pursue this, however a solution has been found via email survey and a trial of this commenced early October 2023. The number of returns has significantly dropped across all areas. The Maternity team are working with the Patient Engagement team to resolve this.

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

On review of enquiries and complaints received during January and February 2024 the main themes continue to be regarding clinical treatment and communication.

The CQC service user survey 2023 results have now been published and will be discussed further in this paper.

1.5 **Reporting and learning from incidents**

During January and February 2024 there was 0 cases that met the referral criteria to the MNSI. From the 1st of October 2023 HSIB transitioned to the Care Quality Commission (CQC) and is now called Maternity and Newborn Safety Investigations (MNSI). 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.

Quarterly reports are shared with the Trust Board to give an overview of any cases, with the learning and assurance that reporting standards have been met to MNSI/EN and the Perinatal Mortality Reporting Tool (PMRT).

1.6 **Maternity dashboards**

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). These will be shared with the Board on a quarterly basis.

1.7 **Training compliance for all staff groups in maternity related to the core competency framework.**

February 2024 Staff Group	Saving Babies Lives 1,2,5,6	GAP/GROW	Maternity Emergencies / PROMPT	Skills and Drills	Personalised Care	Safeguarding	Care in labour & Immediate Postnatal	Neonatal Life Support	Fetal Heart Surveillance	FM Case studies
Midwives	93.79%	95.1%	98.74%	98.74%	15.88%	97.65%	16.08%	97.74%	98%	96%
MCA	NA	NA	100%	100%	NA	95.83%	9.76%	NA	NA	NA
Consultant Obstetrician	25%	93.75%	93.75%	93.75%	0%	79%	25%	NA	100%	100%
Obstetric Registrar	12.5%	100%	100%	100%	0%	80%	12.5%	NA	100%	100%
SHO/Core trainees	N/A	88.89%	100%	100%	N/A	100%	N/A	NA	NA	NA
Sonographer	NA	90%	NA	NA	NA	NA	NA	NA	NA	NA

Consultant Obstetric Anaesthetists	NA	NA	100%	100%	NA	NA	NA	NA	NA	NA
Obstetric Anaesthetists	NA	NA	91.67%	91.67%	NA	NA	NA	NA	NA	NA
Neonatal Consultants	NA	NA	NA	80%	NA	88%	NA	100%	NA	NA
Neonatal Nurses	NA	NA	NA	0%	NA	97%	NA	97%	NA	NA
Neonatal Doctors	NA	NA	NA	100%	NA	54%	NA	100%	NA	NA
ANNP	NA	NA	NA	75%	NA	100%	NA	100%	NA	NA

2. Reports

2.1 **CQC maternity survey results 2023 (Annex A)**

The NHS Patient Survey Programme (NPSP) is commissioned by the Care Quality Commission (CQC); the independent regulator of health and adult social care in England, to collect feedback on maternity care. The CQC use the results from the survey in the regulation, monitoring and inspection of NHS trusts in England. Individuals were invited to participate in the survey if they were aged 16 years or over at the time of delivery and had a live birth at an NHS Trust between 1 February and 28 February 2023. As there were fewer than 300 people within WSFT who gave birth in February 2023, then births from January were also included.

Summary of results

WSFT had a 46% response rate (133 women) and the demographics were very similar to last year's survey and representational of our population.

When compared with other Trusts, WSFT responses indicated that in most questions, it was about the same, somewhat better than expected or better than expected. There were no somewhat worse, worse, or much worse than other Trusts, which is really positive.

In the top 5 questions where the Trust was better than the average Trust, it is apparent that women value the information shared with them in pregnancy and had minimal delays in discharge home.

In the bottom 5 questions where the Trust scored the least on average, the key areas were family or friends being able to stay with the mother when she wanted this. In response to this, the maternity service has taken active steps to gain further insight into people's thoughts on a support person staying overnight during the postnatal period by undertaking a short survey. The survey gained 464 service user responses with a large majority in favour of this. A trial will be introduced in the near future to enable one adult to support overnight.

Compared with the previous year's results, there is marked improvement in some of the 'could improve' results. This demonstrates that service users' feedback is valued and acted upon. In line with Ockenden recommendations, the results will be shared with our Maternity and Neonatal Voice Partnership (MNVP)/service users to enable a co-produced action plan. The Action plan will be monitored locally and via the MNVP and the Local Maternity and Neonatal System.

2.2 **East of England Sixty Supportive Steps to Safety Visit, version 2 (Annex B)**

NHS England East of England is offering to provide each Maternity Unit in the East of England with a bespoke visit to complete the Sixty Supportive Steps to Safety framework version 2, which took place on the 11th of December 2023. Version 1 visit was undertaken in October 2021.

The majority of the issues raised at the visit, were already being addressed and progress has been made in the short space of time since the visit.

The actions required from the recommendations will be progressed further and captured in the Maternity and Neonatal Quality and Safety action plan. The impact of these changes will be monitored through the Maternity and Neonatal Improvement Board, training trackers and dashboards as well as clinical auditing and analysis of clinical outcomes for specific pathways.

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 – closed Board – Quarter 3 2023/24 report (Annex C)** During the period of 1st October 2023 to 31st December 2023 the Trust notified Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE) of 1 case. This was reported within the required timeframe and immediate safety learning has been shared locally. During this reporting period there was one Perinatal Mortality Review completed using the Perinatal Mortality Review Tool (PMRT). Recommendations are being progressed and learning has been shared. During this reporting period all external reporting requirements were met, demonstrating sound processes are in place. This was reflected in the reporting and timely reviews for all cases reported over the last 3 quarters of this year. It is essential that this is maintained to demonstrate the Maternity Services are being responsive, compliant with national reporting requirements and providing bereaved families with timely responses to any concerns they may have and supporting good practice where this is noted. Recommendations from PMRT reports and the requisite actions have been initiated to reduce the chance of loss and harm in the future. The Maternity Services will monitor the actions required, to ensure that these are completed in a timely manner. There will also be steps taken to ensure that any changes are effective and have the desired effect on quality and safety.
3.2	**HSIB/Maternity and Neonatal Safety Investigations (MNSI)/Early Notification Scheme Q3 2023/24 report (Annex D)** All mandatory reporting to the Maternity and Newborn Safety Investigations (MNSI) – formerly Healthcare Safety Investigation Branch (HSIB) – and the Early Notification Scheme (ENS) have been completed during this period of time. Duty of Candour (DoC) has been completed for all relevant cases. Please note HSIB investigations commenced prior to the changeover will still be completed under the HSIB title but published by MNSI. In this reporting period, two babies met the criteria for initial notification to the ENS and both babies were referred to MNSI for review and independent investigation, but one case was declined and is subject to review and local investigation. Duty of candour has been completed verbally and in writing for both families and an explanation of the role of ENS and MNSI has been given. There has been no direct link that would have led to either of the babies being identified as having a greater chance of complication. Further learning may be identified as more in-depth reviews are undertaken by multi-professional groups. The immediate actions and recommendations from each incident will be progressed and learning shared. The views, questions, and comments from parents of the babies will be welcomed to inform further learning and progress against the immediate recommendations.
3.3	**Avoiding Term Admissions into the Neonatal Unit (ATAIN) and Transitional Care Q3 2023/24 report (Annex E)** **ATAIN** (Avoiding Term Admissions into Neonatal units') is a programme to reduce harm leading to avoidable admission to a neonatal unit for infants born at term, i.e., ≥ 37+0 weeks gestation. There were 22 term babies admitted to the neonatal unit in this quarter (October to December 2023), equivalent to 4.1%, out of the 535 babies born in this Trust. This is very similar to last quarter were 4% (21) of the term babies were admitted in that quarter. Therefore for 2 consecutive quarters the WSFT has been below the national target of less than 6%. Four (4) babies were excluded due to not meeting the criteria for the ATAIN programme. The gestation of these 22 babies ranged from 37 to 41+6. Respiratory distress remained the predominant reason for admission, accounting for 14 of the 22 term admissions (64%). The reviewing group concluded that most admissions to the Neonatal Unit were unavoidable. Due to the robustness of the review process, there are always learning points identified, and while not changing the outcome, they offer valuable opportunities to improve the service for the wider population.

	There were positive findings in regard to babies having timely observations through the appropriate pathway chosen for the baby or through the RAPP (Respiratory, Activity, Perfusion, Position) tool carried out for every baby. **Neonatal Transitional Care** (NTC) has an allocated 5-bedded bay on the postnatal ward (F11) and also NTC cots inside rooms on the Neonatal Unit. In this quarter, sixty-one (61) babies (11.4%) were cared for under the Neonatal Transitional Care pathway. This is similar to the figures from last quarter where 65 babies were admitted. Three (3) of these babies were readmitted with jaundice after having been discharged from the NNU, another baby had a second admission with jaundice and one other baby was admitted with jaundice and poor weight gain. There were two additional babies that were born in another Trust but admitted to NTC at this Trust due to geographical location in their address. All babies admitted met the criteria for admission to NTC.
4.	**Next steps**
4.1	Reports will be shared with the external stakeholders as required. Action plans will be monitored and updated accordingly

5. GOVERNANCE

5.1. Board Assurance Framework

To Approve

Board of Directors	
Report title:	**Board Assurance Framework**
Agenda item:	5.1
Date of the meeting:	26 January 2024
Sponsor/executive lead:	Richard Jones, Trust Secretary
Report prepared by:	Mike Dixon, Head of Health, Safety and Risk

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

Executive Summary

WHAT?

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

The board assurance framework (BAF) continues to develop in line with the approach approved at the Board meeting in January. This includes review and **update of the risk themes**:

1. Capability and skills
2. Capacity
3. Collaboration
4. Continuous improvement & Innovation
5. Engagement
6. Digital
7. Estates
8. Finance
9. Governance, Compliance and Professionalism
10. Staff Wellbeing

We have updated the **'at a glance' summary** for the financial risk which now forms part of the full risk assessment. An example is provided for the financial risk (Annex A).

The Board workshop on 8 March reviewed and drafted a **risk appetite statement** for each of the risk themes. The draft risk appetite statement is appended to this report (Annex B). This has been used to:

- Assess whether each risk theme is within the defined risk appetite – based on both the current and future risk ratings (see Table A)
- A process has been drafted to support the assurance committees when reviewing strategic risks within their scope (Annex C). This will be tested through the next assurance committee meeting cycle and developed to include any learning.

It is important that we maintain awareness of internal and external changes that could pose new or emerging strategic risks. This **horizon scanning** is critical to understanding relevant global, local and

stakeholder emerging risks. How we consider and respond to this intelligence needs to be embedded in our risk management processes. A summary of the key emerging risk from RSM's intelligence is provided in Table B. The emerging risks are linked to the relevant Trust risk themes and will be captured in the full risk assessment (as shown in the example in Annex A).

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

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

Failure to effectively identify and manage strategic risks through the BAF places the strategic objectives at risk. It is critical that the Board can maintain oversight of the strategic risks through the BAF and track progress and delivery.

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

To continue with the review and update of the strategic risks within the BAF including:

- Further **develop the risk assessments** for each of the risk themes, focusing on strengthening the sections on controls and current assurance
- Schedule **review by the responsible Board committee** of the risk assessment for the risk within their responsibility, testing the proposed review process. This will include:
    - Assessment of the current and target risk ratings against appetite, recognising that only two of the strategic risks are within risk appetite for future risk rating. This will mean that for most strategic risks the **risk mitigation/improvement plans** will need to be further developed or the risk appetite reviewed
    - Consider the **level of assurance** based on available assurance evidence for the existing controls and assurances
    - Use this work to reflection on the defined **risk appetite** and identify any learning
- Feedback on the work of the Board committees to **report any changes to BAF**, including risk rating, controls, mitigating action, assurance and appetite
- The risk review process set out in this report will be developed and incorporated within the **risk management policy**. This will be reported via the corporate risk governance group to the Insight Committee.

Action Required

1. **Note the report** and progress with the BAF review and development.
2. **Approve the draft risk appetite statement**, recognising this will be reviewed by the relevant assurance committees for each risk theme.
3. **Approve the 'Next steps' actions** and ask the assurance committee to schedule review of their allocated strategic risks and incorporation of the risk review process into the risk management policy.

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

Table A: Risk themes – summary table

Risk Theme	Exec lead	Board comm.	Appetite Level	Appetite score	Current risk score	Target risk score	Assur. level
Capability and skills	HR&C	Involvement	Cautious	9	20	20	Reasonable
Capacity	COO	Insight	Cautious	9	16	12	Partial
Collaboration	DoI	Involvement	Open	12	20	tbc	Partial
Continuous improvement & Innovation	COO	Improvement	Open	12	tbc	tbc	tbc
Engagement	ECN	Involvement	Cautious	9	tbc	tbc	
Digital	DoR	Improvement		9	12	8	
Estates	DoR	Trust Board[1]	Open	12	20	12 [2]	
Finance	DoR	Insight	Cautious	9	20	20	Reasonable
Governance, Compliance and Professionalism	ECN	Improvement	Minimal	6	16	12	Partial
Staff Wellbeing	HR&C	Involvement	Cautious	9	16	12	Reasonable

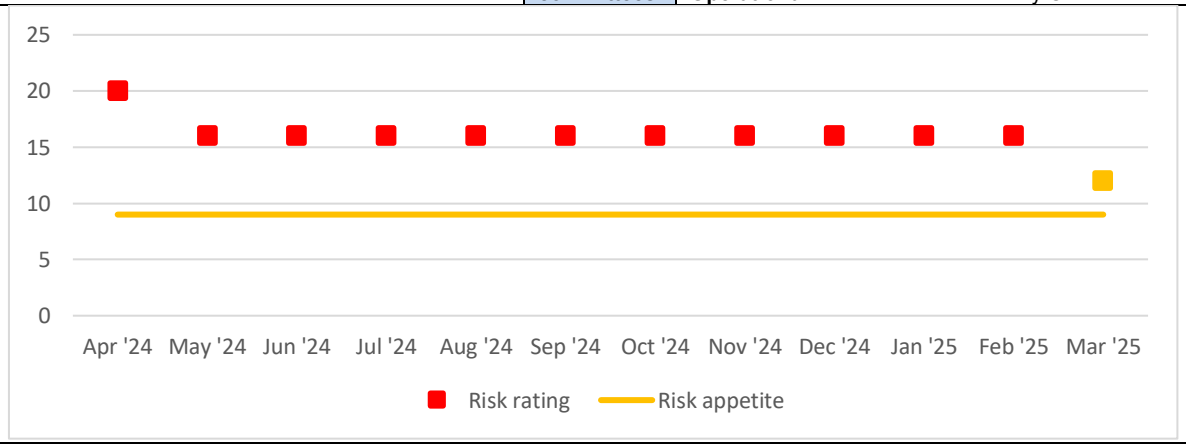
[1] under review
[2] risk rating increases in future years as building reaches end of effective life

Table B: Emerging risk summary
(Source: RSM emerging risk radar dated January 2024)

Emerging risk	Linked risk theme
Political, Policy and Regulation • Change in government and political instability • Geo-political instability, including fall-out from and expansion of conflicts and the influence on society	All
Environmental • Engaging effectively with the Green Agenda including lack of finance and resources to commit to the environment and sustainability.	Continuous improvement & Innovation
Technological • Cyber-attacks increasing in frequency and complexity • Impact of artificial intelligence both positive and negative implications	Digital
Commercial • Economic slow-down resulting from reduction in income through reduced spending • Reduced investment in research and development due to macro-economic conditions	Finance
Governance • Tick box governance – 'Don't walk the talk'. Lack of transparency in decision making, conflicts of interest justified, and loss of accountability	Governance, compliance and professionalism
Economic and Financial • Shifts in inflation, interest rates, salaries and wages, energy costs	Finance
People Resources • Shortages in skills and experience - reduced investment in staff development, temporary contracts more frequent, reduced pool of skilled staff with movement between employers and increasing lack of commitment to longer term career	Capability and skills

Board assurance framework (BAF) – risk report

Section A: 'At a glance' summary

Risk description		Inherent risk score	Current risk score	Future risk score	Assurance level for controls	Assurance level for improvement actions *(if outside to risk appetite)*	
Finance (Ref: 07): Fail to ensure we manage our finances effectively to guarantee the long-term sustainability of the Trust and secure the delivery of our vision, ambitions and values		Major x weekly = Red (20)	Major x Weekly = Red (20)	Major x Annual = Amber (12)	Adequate	tbc	
Executive commentary	Trust financial pressures have impacted the current assurance levels and also have increase the future likelihood from the possible to the likely position.	**Risk appetite statement**	WSFT risk appetite for effective financial management is cautious as making sure we have sound financial management whilst maximising opportunities and cost effectiveness is vital to ensure future success. While we are more receptive in our approach to opportunity we shall remain vigilant to those risks that could have quality, resource, reputational and safety implications that outweigh any perceived financial benefits.			**Risk appetite rating**	Cautious (9)
Lead director	Director of Resources	**Oversight committees**	**Board**: Insight Committee **Operational**: Financial Accountability Committee			**Last reviewed**	17/01/24
Risk trajectory							

Section B: Control and assurance assessment

Risk – Key 'causes' and 'effects'	Existing Risk Controls	Assurance / Evidence 1st Line	Assurance / Evidence 2nd Line	Assurance / Evidence 3rd Line	Assurance & Control Gaps	Assurance level for controls
Cause: C1) Ineffective strategic financial plan C2) Budgeting (Staff) C3) Operational pressures and demand (Patients) C4) External costs (Contractors) C5) Funding income ICS funding increase in activity versus elective activity (Patients) **Effect:** E1) Overspend E2) Budgets inaccurate / unachievable E3) Negative patients / stakeholder experience E4) Inability to deliver strategic plans E5) Continued deterioration of estates **Linked emerging risks (RSM Jan '24):** **Political, Policy and Regulation**	**C1) Effective strategic financial plan** Agreed Trust financial strategy Agreed 12-month delivery of financial plan	Executive team review of financial strategy progress Finance Director leads Executive review of financial models	Approval of financial strategy through Trust wide governance including Finance & Performance Committee and Board	Regulatory review of long-term financial assumptions for the Trust	No gaps currently identified	
	C2) Budgeting Budget setting process Monthly budget monitoring Annual budget targets are set in line with key Trust priorities Reconciliation process for budgeting and cost improvement programme tied to budgeting Budget contingencies in place including explicit winter funding Budgets include specific pressures and relevant modelling The capital budget setting includes EBME IT and estates	Business plans including budgets devolved by each Directorate Finance budget setting documents detail assessments including assumptions Reconciliation process tied to the delivery of plans monitored by the finance team Finance team balance contingencies with affordability and implications for CIP	Insight committee would review and agree budgets Executive directors sign off / Board sign off and approval of budgets Cost improvements are approved by both Executive & Board Reconciliation process approval by Executive & Board Board approval of contingency is tied to CIP	Internal and external audits Benchmarking with ICS Future system projects has been subject to external scrutiny including Mott MacDonald	No gaps currently identified	
	C3) Operational Pressures Dedicated financial systems and processes for financial transactions Agreed budgets for all departments which are monitored monthly via finance systems	Monitoring of budgets and reconciliations of control accounts by finance team Executives with the Divisional Directors and their teams to review KPI's on Budgetary performance and variance	Monitoring of access and review reports (90 day rolling average) Monthly updates on inflationary pressures on financial plans presented to Finance & Performance Committee and Board	Annual internal audit of financial management Annual external audit of accounts Annual submission of cost collection to NHSEI (Financial and patient activity) Monthly ICB Finance reviews		

Risk – Key 'causes' and 'effects'	Existing Risk Controls	Assurance / Evidence 1st Line	Assurance / Evidence 2nd Line	Assurance / Evidence 3rd Line	Assurance & Control Gaps	Assurance level for controls
• Change in government and political instability • Geo-political instability, including fall-out from and expansion of conflicts and the influence on society **Commercial** • Economic slow-down resulting from reduction in income through reduced spending • Reduced investment in research and development due to macro-economic conditions **Economic and Financial** • Shifts in inflation, interest rates, salaries and wages, energy costs	**C4) External Costs** Agreed Estates strategy including 10-year delivery plan 5-year advisory backlog planned which is costed, revised and reviewed annually Estates Infrastructure Regulatory Compliance (EIRC) Capital programme in place and costed	Estate's strategy delivery plan is monitored, reviewed and progress reported to Director of Finance Advisory backlog and planned maintenance are managed by estates and progress including compliance issues reported to Director of Finance	Trust Board Reports on current strategy delivery, exception reports on maintenance issues including backlog and funding RMC Assurance Reports	Estates Infrastructure Regulatory Compliance (EIRC) Capital programme allocation was developed on a risk-based approach from work undertaken by Mott MacDonald	Insufficient capital and revenue funding allocated to address the total backlog Gaps in compliance identified through Authorising Engineers reports	
	C5) Funding Income Agreed Estates strategy including 10-year delivery plan 5-year advisory backlog planned which is costed, revised and reviewed annually Estates Infrastructure Regulatory Compliance (EIRC) Capital programme in place and costed					

Section C: Mitigating action to reduce risk *(if not controlled to risk appetite)*

Planned actions (mitigations)	Summary of progress	Owner	Delivery date	Action status	Impact on future risk score
Agreed financial plan for 2024/25 with regional support to bridge the interim deficit		Dor	30/4/24		Reduce to 16 (QxM)
Delivery of financial performance for 2024/25 which is consistent with plan, and confidence in future year financial plans		DoR	31/3/25		Reduce to 12 (AxM)

Guidance notes

Risk matrix

	1 Insignificant	2 Minor	3 Moderate	4 Major	5 Catastrophic
20 Yearly – Rare (1)	1	2	3	4	5
5 yearly - Unlikely (2)	2	4	6	8	10
Annually – Possible (3)	3	6	9	12	15
Quarterly - Likely (4)	4	8	12	16	20
Weekly - Almost certain (5)	5	10	15	20	25

Action status

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

What is meant by 'assurance'?

***Provides**: Confidence / evidence / certainty*
***To**: Executives / Non-executives / Managers*
***That**: What needs to be happening is actually happening in practice*

1st line: Review of checks within a department for service delivery and day to day management

2nd line: An organisation wide review for example of specialist support, policy and procedures

3rd line: Inspection and review by external or independent body, such as Royal College, internal/external auditor or national team.

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. Identify what actions are needed to improve gaps.
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.

Contents

This risk appetite statement consists of the following elements:

1. Risk appetite overview

Risk is the effect of uncertainty on West Suffolk NHS Foundation Trust (WSFT) ability to achieve its objectives. Risk itself is neither positive nor negative but the outcome of taking risks can be to realise an opportunity or a threat. Only in extreme circumstances is the risk unforeseen. Therefore, through careful consideration and based on information available, WSFT should be able to determine when it can take more risk and when it should not.

Risk appetite is a way of expressing WSFT's attitude to different types of risk and the nature of the risks it is prepared to take. WSFT's appetite for risk can vary dependent on the nature of the risk and the prevailing operating conditions or circumstances.

WSFT has developed an approach to defining its risk appetite. The risk appetite is not absolutely prescriptive but instead provides a number of underlying component parts that encourage structured thinking. The aim of the risk appetite is to allow WSFT to reach an informed conclusion as to whether the risk can be accepted and to what extent.

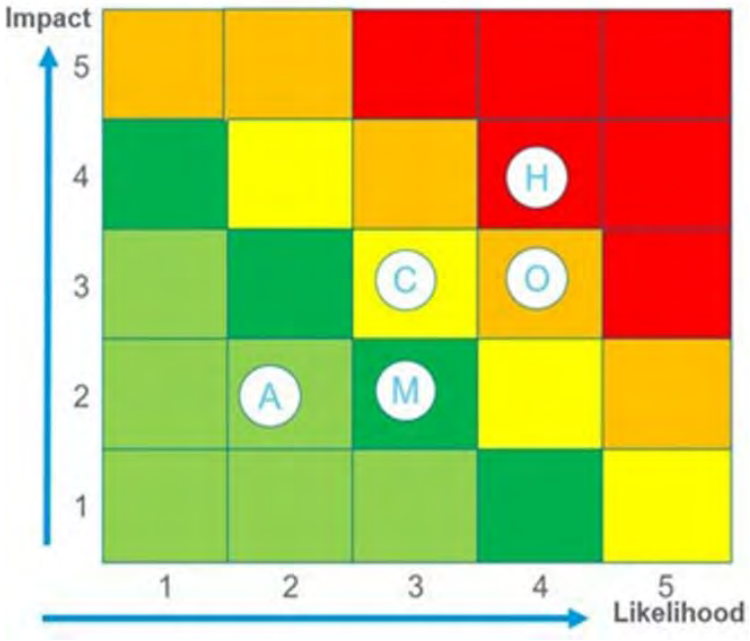
2. Risk appetite description

The Executive has agreed the following levels of risk appetite.

Averse	Avoidance of the risk is the objective. Every reasonable action taken to reduce risk as far as practicably possible.
Minimal	Ultra-safe leading to only minimum risk exposure as far as practicably possible: a negligible / low likelihood of occurrence of the risk after application of controls.
Cautious	Preference for safe, though accept there will be some risk exposure: medium likelihood of occurrence of the risk after application of controls.
Open	Willing to consider all potential options, subject to continued application and / or establishment of controls: recognising that there could be a high-risk exposure.
Hungry	Eager to be innovative and take on a very high level of risk but only in the right circumstances.

3. Risk appetite boundaries

To enable translation of the risk appetite into WSFT's risk scoring methodology, the tolerance for each risk appetite has been plotted on the matrix below i.e. at what point a risk is acceptable (within tolerance) and when it is not (outside tolerance).



Risk Appetite Level	Risk Appetite Threshold
Averse	Score 4 and below
Minimal	Score 6 and below
Cautious	Score 9 and below
Open	Score 12 and below
Hungry	Score 16 and below

4. Risk appetite themes

All risks should be considered in the context of WSFT's risk appetite. To assist this further the Board have identified a number of risk appetite themes against which they have assigned a risk appetite. Therefore, in the instances where risks are associated with the theme and dependent on the risk score assigned, WSFT will be more easily able to determine how to respond and so make best use of mitigation resources.

Risk Theme	Appetite Level	Maximum Risk Score
Capability and skills	**Cautious**	9
Capacity	**Cautious**	9
Collaboration	**Open**	12
Continuous improvement & Innovation	**Open**	12
Digital	**Cautious**	9
Engagement	**Cautious**	9
Estates	**Open**	12
Finance	**Cautious**	9
Governance, Compliance and Professionalism	**Minimal**	6
Staff Wellbeing	**Cautious**	9

The following risk appetite themes and descriptions below were determined by the Board after considering key negative and positive events that might affect the achievement of our goals.

Capability and skills

WSFT will always seek creative opportunities to develop and grow our workforce, building on the operational capability and skills needed to deliver our strategic priorities. However, this should not be to the detriment of safety and the quality of outcomes. To balance the two, we shall have a cautious approach to our risk appetite

Capacity

WSFT will have an open risk appetite to capacity driven by a need to balance demand, productivity, patient safety and understand service delivery implications while promoting innovation, better outcomes and encompassing wider service improvements.

Collaboration

In order to work together with our partners on preventing ill health, increasing wellbeing and reducing health inequalities, we need collaborate, engage and maintain the support of key stakeholders. To achieve this, WSFT shall be open to new ways of working and innovative ideas provided the appropriate mitigations are in place.

Continuous improvement & Innovation

WSFT will have an open risk appetite when looking at continuous improvement and innovation. This openness will be reflected in decisions that will deliver the best possible outcomes and experiences but also encompass wider improvements to productivity and service delivery models, acknowledging that there is a need to ensure the engagement of our communities, staff and partners.

Digital

WSFT while naturally risk averse in relation to IT security understand this position is not practicable when considering innovative approaches that advance our digital and technological capabilities. To balance the risk and opportunity we will have a cautious approach to all aspects of the digital space. However, we will be more receptive where we need to be innovative and ensure the trust remains relevant which includes the operations of IT and digital infrastructure (hardware/software) as well as the use of digital media platforms.

Engagement

To deliver high quality, safe effective services, communicate with our staff and respond to the changing needs in our communities in line with our vision, we must continue to build positive engagement. We will therefore be cautious in our attitude to engagement risks that could impact WSFT being able to effectively influence key stakeholders, lead the local healthcare sector and ensure we continue to be relevant.

Estates

WSFT will have an open risk appetite to risk relating our estates. The Trust is willing to consider all potential options recognising that there is a need to continually invest to improve the standard of our infrastructure and a failure to do so will impact on everyday outcomes and experience, asset deterioration, staff morale and quality of care.

Financial

WSFT risk appetite for effective financial management is cautious as making sure we have sound financial management whilst maximising opportunities and cost effectiveness is vital to ensure future success. While we are more receptive in our approach to opportunity we shall remain vigilant to those risks that could have quality, resource, reputational and safety implications that outweigh any perceived financial benefits.

Governance, Compliance and Professionalism

To ensure effective and proportionate governance, WSFT will have a minimal appetite toward risks that may directly impact or threaten the integrity of our internal control arrangements. We understand that any governance risk could affect compliance, the quality of experiences, outcomes, professional standards, resources and therefore negatively impact the confidence and trust of our stakeholders

Wellbeing

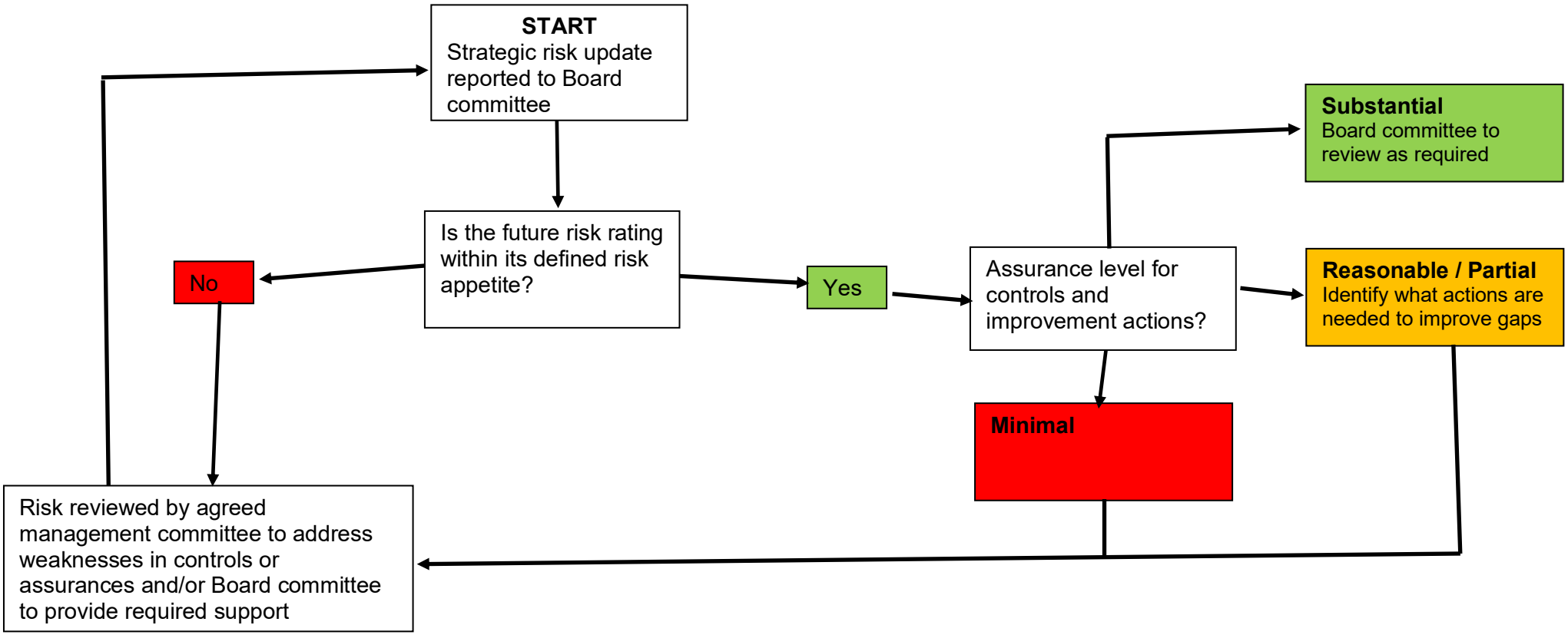
WSFT is committed to promoting an environment that is a great place to work and learn, enabling our people to be empowered, independent and the best that they can be. In order to do so we will be cautious in our risk appetite for building an organisational culture that ensures we live our values; supporting health and wellbeing; embedding an inclusive culture that values diversity across the trust and improving opportunities for professional development and succession planning

5. Risk appetite monitoring and reporting

We will continue to keep under review our risk appetite, fully recognising that this may be subject to change due to various factors both internal and external that could shape the nature and extent of the risks we are prepared to take.

A cycle of reporting by risk appetite will be introduced so that WSFT can understand its risk exposure in connection with the risk appetite themes and ensure an effective response.

Annex C: Strategic risk review process – risk appetite and assurance



5.2. Governance Report

For Approval

Board of Directors (Open)	
Report title:	**Governance report**
Agenda item:	5.2
Date of the meeting:	22 March 2024
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 March 2024, as follows:

- Report of urgent decisions
- Senior Leadership Team report
- Council of Governors report
- Modern slavery statement
- Register of interests
- Well led review report
- NHS competency framework
- Board committee terms of reference (appended to the full Board pack)
- Code of Governance
- Delegated authority for approval of the workplace strategy to Involvement Committee
- Board development session – summary and what next
- Updates to the standing orders, standing financial instructions and scheme of reservation and delegation (reported via the audit committee)
- Use of Trust's seal
- Agenda items for next meeting

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

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

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

The items reported through this report will be actioned through the appropriate routes. Amendments to the terms of reference for SLT and the Executive Directors meeting will be included in the updated governance framework and reported to the Board.

Action Required
The Board is asked to note the report and approve: - Note and approve changes reported via the audit committee for updates to the standing orders, standing financial instructions and scheme of reservation and delegation - terms of reference of the board committees - insight committee, improvement, involvement and audit committees - the updated modern slavery statement - provide delegated authority to the Involvement Committee to review and approve the workplace strategy - share comments on the draft Board development forward plan.

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

Governance Report

1. Report of urgent decisions

In accordance with the Trust's standing orders urgent decisions may be taken with appropriate engagement of executive and non-executive colleagues. Two urgent decisions have been taken since the last Board meeting:

- the Insight Committee was briefed on a tender waiver to provide outsourcing capacity to support the delivery of elective and diagnostic capacity. The proposal had already been supported at Management Executive meeting on 24 January 2024 and was shared with and supported by Trust Chair

- the Involvement Committee considered a report regarding the Health Care Support Worker (HCSW) band two/three project and the proposed approach to implementation. The proposal had already been supported at Management Executive meeting on 31 January 2024. The proposal and questions raised at the assurance committee was shared with all NEDs who also supported the proposal.

2. Senior leadership team (SLT) report

The Senior Leadership Team meeting will take place on Monday, 18 March. A verbal update will be provided for any relevant issues from the agenda which focused on: Trust priorities for 2024/25, financial recovery and national staff survey results.

3. Council of Governors report

After the Governor elections 2023, the Council of Governors meet for the first time on 27 February 2024.

The Council of Governors received an update on people & culture by the executive director of workforce and communications. The update included 2023 national staff survey – early headlines, turnover rates / trend, 2023/24 people and culture plan highlights and staff engagement scores from Q2 2023/24 national pulse survey.

The Council of Governors received the feedback reports from chairs of the board assurance committees and governor observers. A summary of the agenda items was received with the committee's key issues and respective governor observers' reports providing highlight updates for the Council. The Council of Governors also received the audit committee's key issues report.

The Council of Governors agreed membership for its subcommittees: Nominations Committee, Engagement Committee, Standards Committee and the Staff Governors' Group.

The Governors noted the report from Governors' training day held with Governors and Non-Executive Directors on 30 January 2024. The session was facilitated by NHS Providers to provide an introduction to the NHS structure and understanding of the Governor role. This included accountability and holding to account, representing interests of members, the appropriate level of information for the governors to receive and effective questioning/challenge. The session on member and public engagement included discussions on statutory requirements of governors to engage with the members and public, what 'good' look like. The CoG reviewed the priority actions from the session and tasked the Engagement Committee to oversee the development and delivery of these actions as part of its engagement work programme and priorities for 2024-25.

The Council of Governors approved recommendation for introduction of annual process with regard to Fit and Proper Persons Test (FPPT) declarations from Governors. The Council also approved DBS checks for the Governors, as part of initial screening and background checks for the new governors. This would then be subject to annual self-attestation.

The Governors noted and reviewed the governor work programme and forward plan for 2024-2025.

The Council of Governors identified Governor readers for the draft annual report (including quality accounts). The Governors also noted the approach to drafting Governors' commentary for inclusion in the quality accounts. The Governors' Standards Committee will review and draft this commentary with the lead governor. The updated draft commentary will be presented to the CoG in May for discussion and approval for inclusion in the quality accounts.

The Council of Governors also approved proposed amendments to the 'Standing Orders for the practice and procedure of the Board of Directors' which form part of the Trust's Constitution.

4. Modern slavery statement (Annex A)

The West Suffolk NHS Foundation Trust (WSFT) Board supports the government's objectives to eradicate modern slavery and human trafficking. The Board is asked to approve the updated modern slavery statement (Annex A) which will be included on the Trust website.

5. Register of interests

It is a Constitutional requirement that appointed Board of Directors have a duty to avoid conflicts of interest with the Trust. To ensure full openness and transparency, the register of directors' interests is formally reviewed and updated on an annual basis. At each Board meeting declarations are also received for items to be considered.

For accuracy and completeness of our register of interests, we will be sending out the declaration of interest forms to all board members to capture any relevant interests or relationships. Updates from Board members will be requested in April to allow these to incorporated into the annual report for submission to the external auditors. The updated register of interests will be presented to the Board in May.

6. Well led developmental review update

In line with good governance practice, the Trust has commissioned ConsultOne (the consultancy arm of AuditOne) to undertake a well led developmental review of leadership and governance at the Trust. The findings will inform continuous improvement of our governance arrangements.

The process included documentary review; interviews with Board members, members of staff, governors and external stakeholders as well as meeting observations for the Board and its committees, Council of Governors and operational management meetings.

The draft report is expected to be issued to the Trust in late March for factual accuracy checking with plan to consider the final report at the Board development day in April. The report response will be shared at the next Board meeting.

7. NHS Leadership competency framework for board members

The NHS Leadership Competency Framework (LCF) was published on 28 February 2024 for all board members of NHS providers, ICBs and NHS England's Board.

The LCF has been designed with engagement and support from a significant number of NHS chairs, chief executives and other stakeholders, and using insight into best practice in other industries. The LCF provides a framework for board member recruitment and appraisal and will inform future board leadership and management training and development.

A revised Chair Appraisal Framework has also been published for use in 2023/24 chair appraisals, and includes the competencies outlined in the LCF. A new Board Member Appraisal Framework is expected to be launched in the autumn.

In the meantime, all board members are asked to self-assess against the LCF and discuss findings as part of their annual appraisal.

8. Board Committees - terms of reference (ToR)

The following Board sub-committee ToRs are presented as part of annual review and approval. The committees have approved their terms of reference either in the committee meetings or via committee chair's action as indicated.

- Insight committee (reviewed - 20 March 24)
- Improvement committee (reviewed by committee - 17 January 24)
- Involvement committee (reviewed by committee - 20 December 23)
- Audit committee (reviewed by committee - 12 December 23)

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

The Board is asked to approve the terms of reference of Insight, Improvement, Involvement, and Audit committees.

9. NHS Code of Governance (2022)

An updated NHS code of governance for NHS provider trusts was published at the end of 2022 The code sets out an overarching framework for the corporate governance of trusts, supporting delivery of effective corporate governance, understanding of statutory requirements where compliance is mandatory and provisions with which trusts must comply, or explain how the principles have been met in other ways.

The Trust is committed to sustaining the highest standards of governance in accordance with the Code of Governance. In line with our commitment, we have undertaken an internal review of compliance with the new code which assessed our practices, policies and procedures against the expectations of the Code. The overall assessment demonstrates compliance.

The external auditor's review of the Trust's annual report will provide further evidence for our internal review. The assessment will be presented to Audit Committee in July and highlight any areas for development.

10. Board development session

On 8 March the Board held a development session focused on: risk appetite; strategic priorities; and equality, diversity and inclusion (EDI).

There was consensus that the session had been valuable with good contributions.
Consensus on the way forward was reached on a number of items:

- **Risk** – the focus of the session was to gain consensus on the risk appetite for the strategic risks. This is reported in more detail in the 'Board assurance framework' item on today's meeting agenda.

- **Strategic priorities** – the output of the discussion is presented in the 'Strategic priorities update report' item on today's agenda.

- **EDI** – this session was facilitated by representatives from the Centre for Population Health with a focus on issues and challenges for the staff as well as the organisation and the Board's oversight and role in this important area.

The recent staff survey results provided a helpful context to frame the discussion and the challenges that our BAME staff face. This is considered further in the 'National staff survey results' item on today's agenda.

At the end of the session Board members committed to personal pledges. These will be built into people's work in this area.

Discussion also took place on enablers that will help the Trust and the Board do more to deliver its EDI responsibilities:

- Have these conversations with our own teams
- Create time for this!
- Individually and collectively own action
- Have greater visibility of EDI information to better understand impacts and support decision making

A draft forward plan for the Board's development sessions was received and is presented (Annex B) for review to ensure an appropriate balance between strategic, developmental and tactical content. Board members are asked to share comments on the draft either at or after the meeting.

11. Use of Trust Seal

None to report

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

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

Modern Slavery Act Statement

Our organisation

The West Suffolk NHS Foundation Trust (WSFT) provides acute and community healthcare services in West Suffolk, as well as running the West Suffolk Hospital, West Suffolk NHS Foundation Trust is joining up NHS care across the area providing many of the community services in West Suffolk.

The West Suffolk NHS Foundation Trust is committed to ensuring that no modern slavery or human trafficking takes place in any part of our business or our supply chain.

We are fully aware of the responsibilities we bear towards our service users, employees and local communities. We are guided by a strict set of values in all of our business dealings and expect our suppliers (i.e. all companies we do business with) to adhere to these same values.

We have zero tolerance for slavery and human trafficking. Staff are expected to report concerns about slavery and human trafficking and management will act upon them in accordance with our policies and procedures.

The West Suffolk NHS Foundation Trust supports the Government's objectives to eradicate modern slavery and human trafficking and recognises the significant role the NHS has to play in both combatting it and supporting victims. We are committed to ensuring our supply chains and business activities are free from ethical and labour standards abuses. Steps taken to mitigate the risk of modern slavery are outlined in the sections below.

Arrangements to prevent slavery and human trafficking

We are committed to ensuring there is no modern slavery or human trafficking in our supply chains or any part of our business activity.

Our commitment to social and environmental responsibility is covered by our approach to modern slavery and human trafficking, which is part of our safeguarding arrangements.

People

- Appropriate pre-employment checks on directly employed staff and agencies on approved frameworks are audited to provide assurance that pre-employment clearance has been obtained for agency staff
- A range of controls to protect staff from poor treatment and/or exploitation, which comply with all respective laws and regulations. These include provision of fair pay rates, fair Terms and Conditions of employment and access to training and development opportunities
- Consultation and negotiation with Trade Unions on proposed changes to employment, work organisation and contractual relations
- Appropriate adult and children's safeguarding policies are in place to ensure staff are alert to, and report any concerns about patients who may be subject to human trafficking or modern slavery

Speaking up at the Trust

- The Trust believes that every member of staff has a duty to raise concerns at the earliest reasonable opportunity about the provision of care or any other malpractice within the trust where care and/or behaviour/conduct is believed to be inadequate or unacceptable. In addition, staff have duties imposed upon them to raise such concerns through their respective professional regulatory bodies, such as the GMC, NMC, ACCA etc.

Safeguarding/Training

The following arrangements are in place within our safeguarding policies and procedures, training and operations:

- Trafficking is highlighted as a possible risk for unaccompanied asylum seeking children within our safeguarding children policy and there is a link to the Suffolk safeguarding children board's quick guidance on the safeguarding microsite. Any concerns where a child may be considered at risk of abuse follows the same pathway of referral.
- The Trust's domestic abuse and women at risk of social exclusion policies address the risk of modern slavery. The Trust safeguarding specialist midwife would be informed and a multi-agency referral completed. The role of safeguarding specialist midwife is to have concern for the safety and wellbeing of a child or unborn in these circumstances.
- The modern slavery and trafficking statement and information related to the NHS Safeguarding App is part of the WSFT trust induction for adult and children safeguarding training resource.

Supplies and tenders

The Trust complies with the Public Contracts Regulations 2015 and uses the mandatory Crown Commercial Services (CCS) Pre-Qualification Questionnaire on procurements which exceed the prescribed threshold. Bidders are required to confirm their compliance with the modern slavery act.

Sub-contractors

Our procurement and contracting team is qualified and experienced in managing healthcare contracts and have received appropriate briefings on the requirements of the Modern Slavery Act 2015, which includes:

- Requesting evidence of their plans and arrangements to prevent slavery in their activities and supply chain
- Using our routine contract management meetings with our providers to address any issues around modern slavery
- Implementing any relevant clauses contained within the standard NHS contract

Board Approval

This statement has been approved by the Trust Board, who will review and update it on an annual basis.

Approval date: 22 March 2024

Board development - Forward plan

This programme builds on the work delivered by integrated developed (Chris Lake) during 2022 and 2023. This programme focused on how the Board works together.

Agenda items

Scheduled items	Lead	Timescale
Risk management, board assurance framework and risk appetite	RSM facilitator	Nov '23
Strategic priorities for 2024-25	CEO	Nov '23
Prevention, personalised care and health inequalities strategy	Medical director	Nov '23
Board to board with ESNEFT – provider collaboration	Chair/CEO	Dec '23
EDI develop and the Board's oversight/role	Durka Dougall, Centre for Population Health	Feb '24
Board assurance framework and risk appetite	RSM facilitator	Feb '24
Strategic priorities for 2024-25	CEO	Feb '24
Well led review report, including reflection on leadership role and behaviours	AuditOne	26 Apr '24
Diagnostic review report (*and/or Insight*)	Chair/CEO (PA Consulting)	26 Apr '24
EDI follow-up (from session on 8 March 2024)	Director of Workforce and Comms	26 Apr '24
My Wish – role of trustees and wider Board	Facilitated	26 Apr '24
Future System Programme - Moving to outline business case, including governance structure	Director of Resources	Q1/Q2 2024/25 (or Board)
NHS IMPACT reflections	Director of strategy and Transformation	Q1/Q2 2024/25
Future system - Clinical and care strategy – transformation and health promotion	Director of strategy and Transformation and Medical director	Q2/Q3 2024/25
Net zero responsibilities and strategy	COO	Q2/Q3 2024/25
Board's social responsibilities – collaboration and anchor organisation	CEO	Q2/Q3 2024/25
Long term financial model – 3-to-5-year view	Director of Resources	Q3/Q4 2024/25
Strategic priorities for 2025-26	CEO	Q3/Q4 2024/25
Our next five year corporate strategy – shaping review process	CEO	Q3/Q4 2024/25

Other topics will be incorporated within the programme to reflect local and national developments and priorities.

Updated: March 2024

Annex B: Scheduled draft agenda items for next meeting – 24 May 2024

Description	Open		Closed	Type	Source	Director
Declaration of interests	✓		✓	Verbal	Matrix	All
General Business						
Patient/staff story - staff experience of the emerging incident review process	✓		✓	Verbal	Matrix	Exec.
Chief Executive's report	✓			Written	Matrix	EC
Culture						
Organisational development plan	✓			Written	Matrix	JMO
Strategy						
Future System Board Report	✓			Written	Matrix	CB
System update: - West Suffolk Alliance and SNEE Integrated Care Board (ICB) - Wider system collaboration - Collaborative oversight group	✓			Written	Matrix	 PW / CM All execs
SNEE ICB joint forward plan (JFP) update	✓			Written	Matrix	RW (ICB)
Strategic priorities – update	✓			Written	Action	CEO
Digital Board report, including review of the digital strategy	✓			Written	Matrix	CB
Assurance						
Insight Committee – committee key issues (CKI) report - Finance report	✓			Written	Matrix	AJ / NC / SW
Involvement Committee – committee key issues (CKI) report - People and OD Highlight Report o Putting you First award o Staff recommender scores o appraisal performance, including consultants (quarterly) - Safe staffing guardian and FTSU reports - National patient and staff survey and recommender responses - Education report - including undergraduate training (6-monthly) - National patient survey reports - Annual complaint report	✓			Written	Matrix	TD / JMO
Improvement Committee – committee key issues (CKI) report - Maternity services quality and performance report - Nurse staffing report - Quality and learning report, including mortality and quality priorities - Annual strategy review: quality improvement (deferred to July) and patient safety and learning	✓			Written	Matrix	LP / SW / PM

Description	Open		Closed	Type	Source	Director
Audit committee – committee key issues (CKI) report	✓			Written	Matrix	MP
Serious Incident, inquests, complaints and claims report			✓	Written	Matrix	SW

Governance						
Governance report, including - Senior Leadership Team report - Council of Governors report - Register of interests - Well led review report - Use of Trust's seal - Agenda items for next meeting	✓			Written	Matrix	RJ
Confidential staffing matters			✓	Written	Matrix – by exception	JMO
Board assurance framework report	✓			Written	Matrix	RJ
Register of interests	✓			Written	Matrix	RJ
Non-executive directors responsibilities report	✓			Written	Matrix	RJ
Reflections on the meetings (open and closed meetings)	✓		✓	Verbal	Matrix	JC
Annexes to Board pack: - Integrated quality & performance report (IQPR) – annex to Board pack - Others as required						

6. OTHER ITEMS

6.1. Any other business

To Note

6.2. Reflections on meeting

For Discussion

6.3. Date of next meeting - 24 May, 2024

To Note

RESOLUTION

The Trust Board is invited to adopt the following resolution:

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

SUPPORTING ANNEXES

4.2 IQPR Full Report / Finance Report

Assurance Grid

January 2024	ASSURANCE		Not Met
	Pass 	Hit and Miss 	Fail 
VARIANCE: Special Cause Improvement 	**IMPROVEMENT** VTE – All Patients	**INSIGHT** RTT 104+ Weeks Wait **INVOLVEMENT** Staff Sickness – Rolling 12month Staff Sickness	**INSIGHT** RTT 78+ Weeks Waits **INVOLVEMENT** Mandatory Training Appraisal Turnover
VARIANCE: Common Cause 	**INSIGHT** Urgent 2 hour response	Please see box to right	**INSIGHT** Ambulance Handover within 15min 12 Hour Breaches Incomplete 104 Day Waits Diagnostic Performance- % within 6weeks Total **INPROVEMENT** Nutrition – 24 hours
Deteriorating — Special Cause Concern 		**INSIGHT** Ambulance Handover within 60min Reduce Adult General & Acute (G&A) Bed Occupancy **IMPROVEMENT** Sepsis Screening for Emergency Patients	


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
28 Day Faster Diagnosis
IMPROVEMENT:
MRSA
C-Diff
Hand Hygiene
Mixed Sex Breaches
Community Pressure Ulcers
Acute Pressure Ulcers
Inpatient Falls Total
Acute Falls per 1000 Beds
INVOLVEMENT:
Overdue Responses

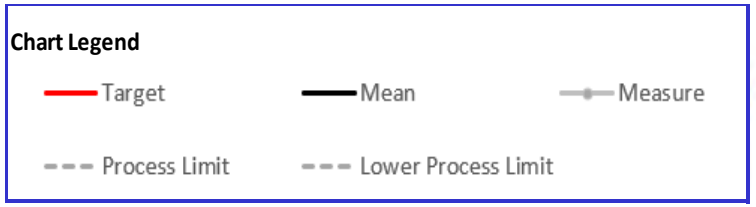
INSIGHT: Glemsford GP Practice – the following KPIs are applicable to the practice:

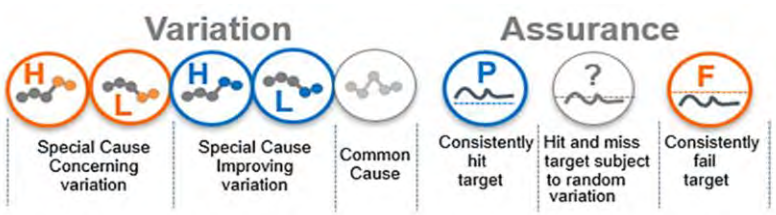
- Urgent appointments within 48 hours
- Routine appointments within 2 weeks
- Increase the % of patients with hypertension treated to NICE guidelines to 77% by March 2024
- Increase the % of patients aged 25-84 years old with a CVD risk score of >20% on lipid lowering therapies to 60%

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

*Cancer data is 1 month behind

Items for escalation based on those indicators that are failing the target, or are worsening and therefore showing Special Cause of Concerning Nature by area:
INSIGHT - Urgent & Emergency Care: Ambulance Handover within 15min, Ambulance Handover within 60min, 12 Hour Breaches, Reduce Adult General & Acute (G&A) Bed Occupancy
Cancer: Incomplete 104 Day Waits
Elective: Diagnostic Performance- % within 6weeks Total, RTT 78+ Weeks Waits
IMPROVEMENT – Safe: Sepsis Screening for Emergency Patients, Nutrition – 24 hours
INVOLVEMENT – Well Led: Mandatory Training, Appraisal, Turnover

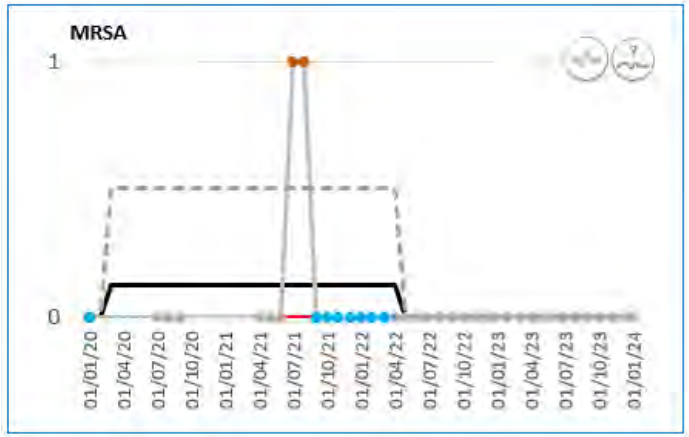


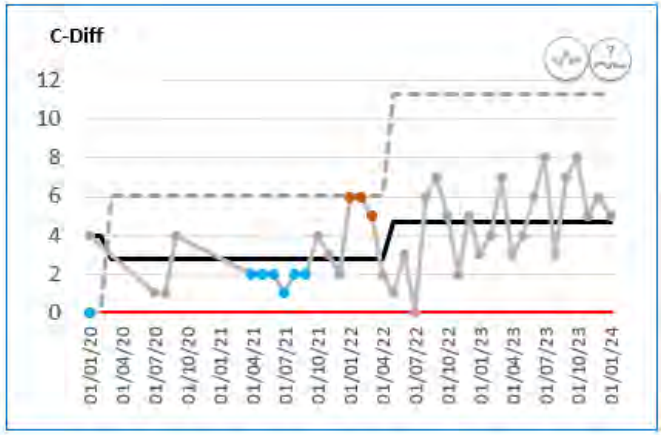


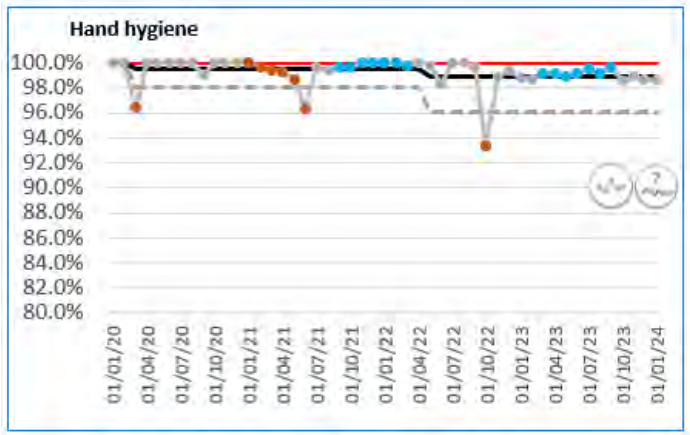
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
MRSA	Jan 24	0	0			0	0	0
C-Diff	Jan 24	5	0			5	-2	11
Hand hygiene	Jan 24	98.6%	100.0%			98.8%	96.1%	101.6%
Sepsis Screening for Emergency Patients	Jan 24	54.5%	100.0%	L		83.4%	55.8%	111.1%
VTE - all inpatients	Jan 24	99.1%	95.0%	H	P	97.7%	95.7%	99.6%
Mixed Sex Breaches	Jan 24	4	0			5	-6	15
Community Pressure Ulcers	Jan 24	40	25			34	13	55
Acute Pressure Ulcers	Jan 24	32	17			24	6	42
Acute Pressure Ulcers per 1000 Beds	Jan 24	2.9	-			2.3	0.6	4.0
Inpatient Falls Total	Jan 24	88	48			75	48	102
Acute Falls per 1000 Beds	Jan 24	6.1	5.6			5.9	3.9	7.9
Nutrition - 24 hours	Jan 24	78.0%	95.0%		F	86.2%	77.7%	94.8%
Patient Safety Incidents per 1,000 OBDs	Jan 24	65.2	-			64.2	53.6	74.8
Patient Safety Incidents Reported	Jan 24	973	-			860	700	1020
Patient Safety Incidents Resulting in Harm	Jan 24	221	-			175	122	227

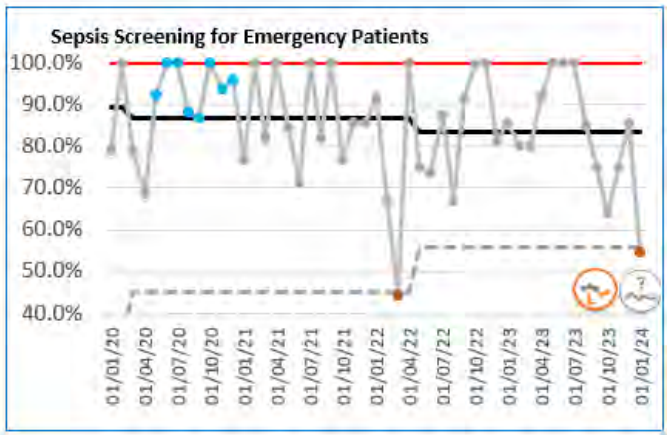
Falls are only counting Inpatients and Exclude Assisted Falls & Outpatient areas.

Safe



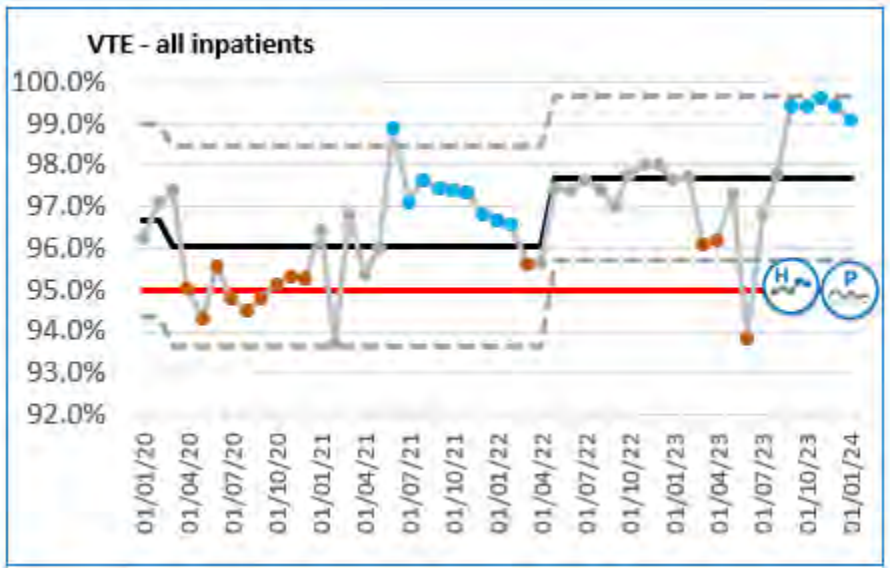


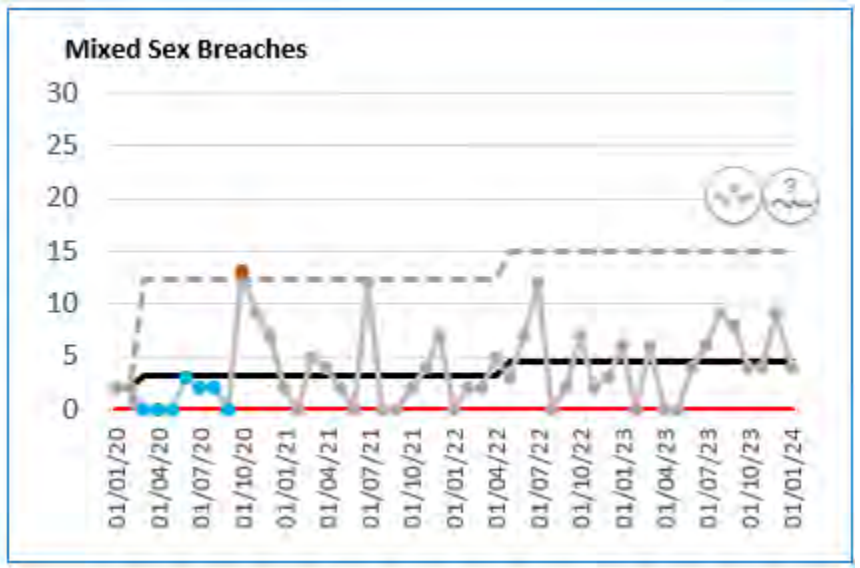




What	So What?	What Next?
There is consistent performance with MRSA Bacteraemia. <u>C-Diff</u> There has been no significant change in month-on-month incident rate although numbers are consistently higher than our average occurrence over the last 5 months. It is recognised Nationally that the rates of *Clostridioides difficile* have increased significantly over the last two reporting years.	Healthcare-associated infections (HCAIs) can develop either as a direct result of healthcare interventions such as medical or surgical treatment, or from being in contact with a healthcare setting. HCAIs pose a serious risk to patients, staff and visitors. They can incur significant costs for the NHS and may cause significant morbidity to those infected. As a result, infection prevention and control is a key priority for all NHS providers.	A Clostridioides difficile Quality Improvement Programme is underway which is expected to be ongoing for at least the next twelve months where we will continue to monitor impacts of immediate actions and learning during this time, reporting to IPCC on a quarterly basis which includes but not limited to the following interventions and reviews: • Completion of primary drivers and associated actions– May 2024 • Retrospective review of antimicrobial prescribing – May 2024 • Review of 'form browsers' populated prior to stool specimen request from positive C.diff cases to identify any targeted learning such as escalation of single side room isolation – May 2024 • C.Diff patient leaflet – March 2024 • Commencement of C.diff allocation caseload within IPC Team – March 2024

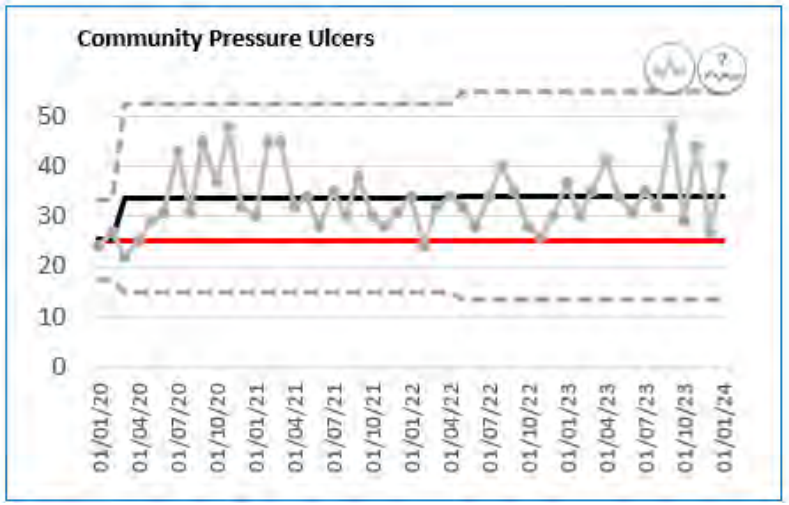
Safe

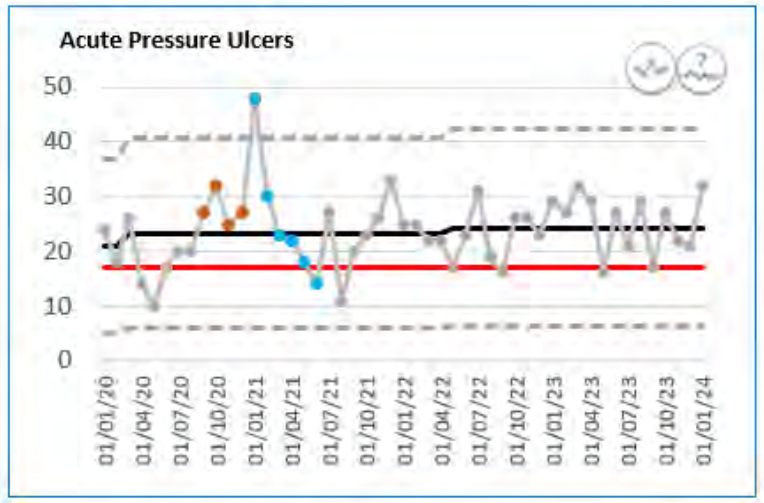


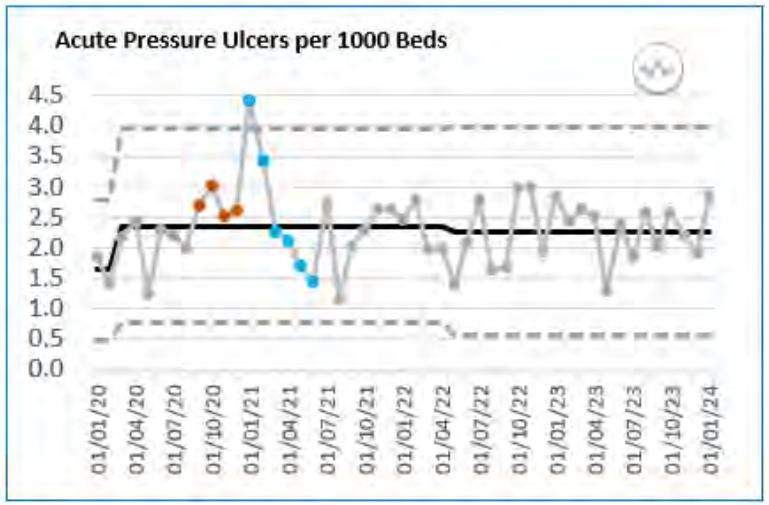


What	So What?	What Next?
VTE: Consistent improvement in VTE assessment compliance 5 months of positive position and achievement of target. VTE consistently achieving target of >95%	High VTE compliance wit the baseline assessment is important to make sure our patients receive appropriate prophylaxis for VTE, an avoidable harms are reduced	Initial review of the improved pictured has been completed to ensure data accuracy is not providing false assurance. Early indications of this review suggest that the data is accurate. Reporting to PQSGG for assurance
MSA Incidents related to delay in step down from critical care or HDU beds. No significant increase or decline in occurnaces	MSA breaches occurring make adversely affect patient experience	Reviewed daily within Nursing safety huddle and bed meetings to reduce and resolve an MSA breaches

Safe

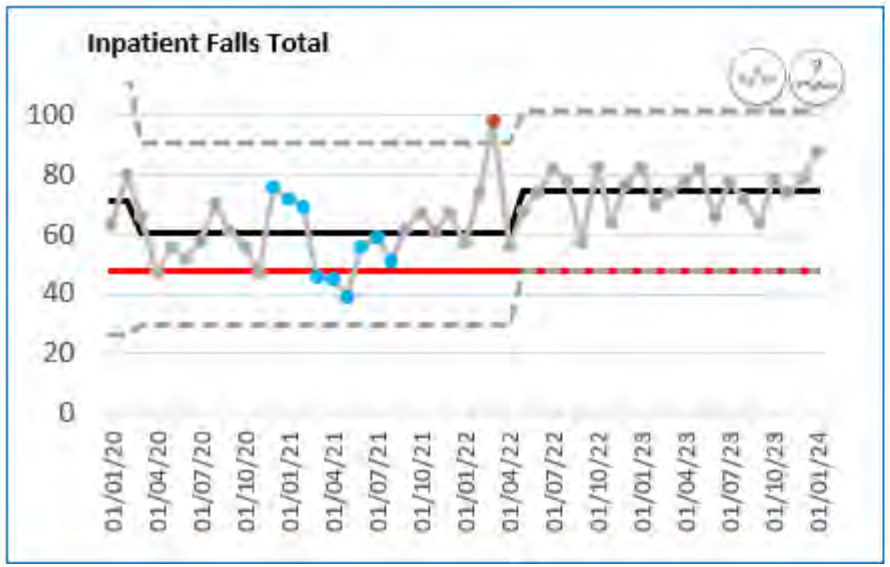


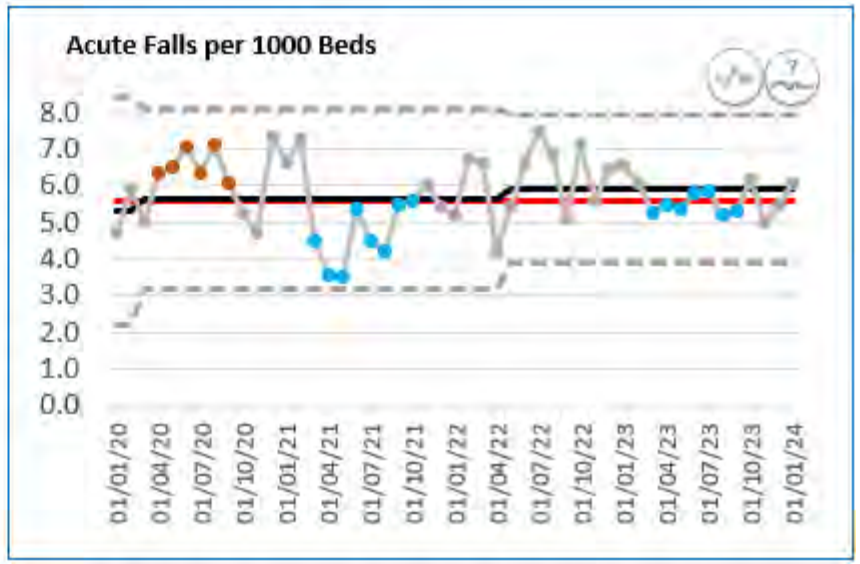




What	So What?	What Next?
The data for January demonstrates both Acute and Community PU incidence have increased when compared to the previous month. PU incidence across the acute trust remain evenly distributed however highest reporting areas are F8 and G10, Critical care have also seen a spike most of these being device related. Community beds Rosemary Ward continue to report highly and Mildenhall and Sudbury reported significantly higher than other localities.	Pressure areas are an avoidable harm having a negative effect on patients health and cost of care provision. We are now transferring to a new reporting system and taking on new guidelines for reporting, this will make PU reporting simpler with few category's to report on. Hopefully this will encourage greater accuracy and quality of reporting.	Continue to monitor pressure ulcer incidents and recognise and act on themes through the Pressure Ulcer Prevention Group. We are developing a 'skin assessment' into the Safety assessment on ecare, this will draw more focus on the skin on admission and signpost staff to look for early onset skin damage as well other skin complaints such as rashes and cellulitis. 'Areas of high incidence' are supported by working with Matrons and clinical staff to improve practice We are incorporating wound care national guidance on reporting and risk assessment (PURPOSE T)which will make reporting process simpler and more robust.

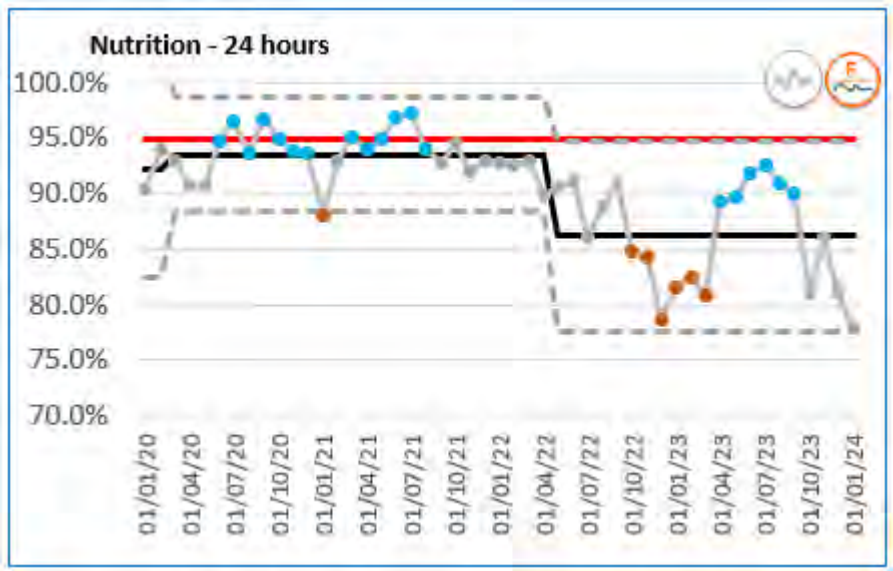
Safe





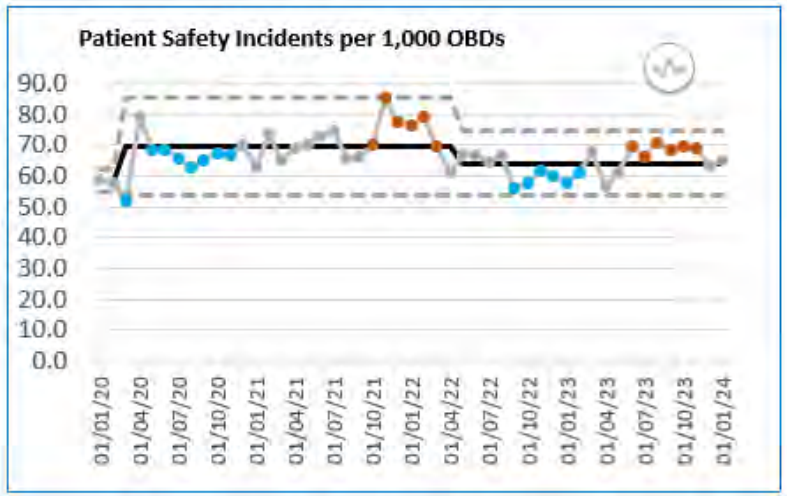
What	So What?	What Next?
There has been no significant change in the number of inpatient falls reported. Although both incidents and falls per 1000 bed days is above average for January This month (January) there was 2 falls reported as moderate harm (L1 endplate fracture and fracture of frontal bone). During the month of January there were 11 repeat fallers with eight patients having 2 falls, one patient having 3 falls, one patient having 4 falls and one patient having 5 falls in the reporting month	The effects of falls within hospital can range increase length of stay due to loss of patient confidence and deconditioning, to life changing severe harm. Its widely acknowledge that mortality of patient suffering from severe harm is greatly increased despite initial recovery. Older adults who fall more than once per year are defined as recurrent fallers and are risk for functional decline and mortality.	A falls study day is planned for April covering falls risk factors and post fall management. The falls with major and moderate harm will be reviewed through PSIRF after action reviews to understand learning and actions NPSA action plan regarding the safe use of bed rails is progressing both in community and acute with oversight with Patient Quality and Safety Governance

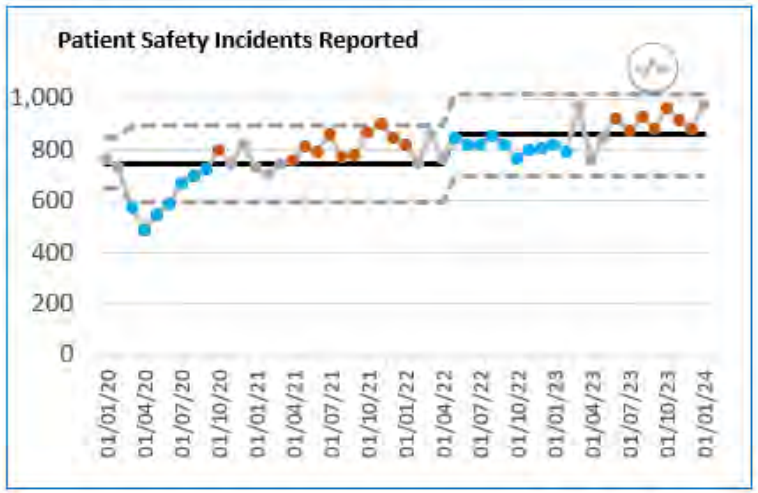
Safe

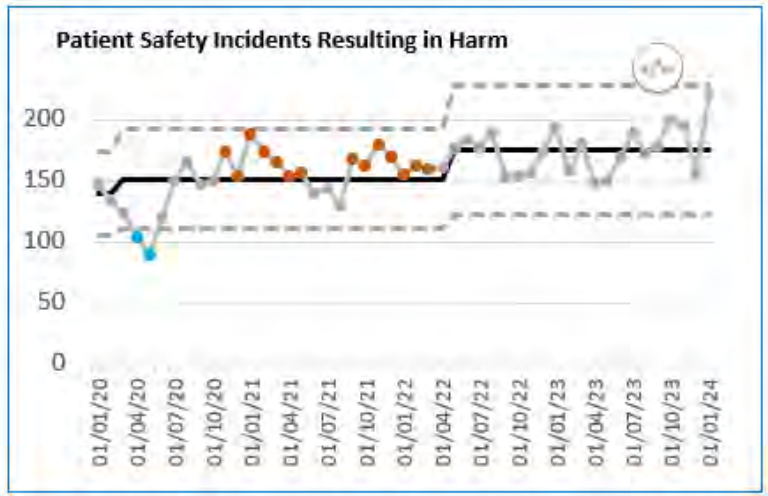


What	So What?	What Next?
There has been a further decline in performance with completing nutritional assessments within 24hrs during January following a challenging month with exceptional capacity pressures. This data directly correlates with Urgent and Emergency Care (UEC) performance within the organisation. As patients are spending long periods in the Emergency Department (ED) awaiting beds, there are delays in patients being transferred to the assessment areas and base ward beds where the assessments are usually performed. This mirrors the previous seasonal pressures On review of the data at 48hrs, the compliance with completing nutritional assessments is 89.8%. A decline from previous months and indicative of the pressures being experienced. There is also continued focus on measured weights being performed in the first 24hrs. This is also a challenge with the current UEC pressures. For January, the compliance is **54.5%** at 24hrs and **74.4%** at 48hrs.	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 plans in place to renew the reporting process to capture the timeliness of assessments when patients are admitted to a ward. This will provide teams with the opportunity to improve the compliance and accuracy of this important metric. Proposed changes to the measurement of this standard will be the time the patient is transferred to the ward.	• Engage and focus on activities to improve the UEC performance and continue to monitor • Review of data at performance meetings and Governance reviews monthly to inform performance • Work with Information team to improve metrics and reporting - Completed • Metrics to change to each ward area being monitored for compliance more accurately- April 2024 • Continue to share the data with teams monthly

Safe

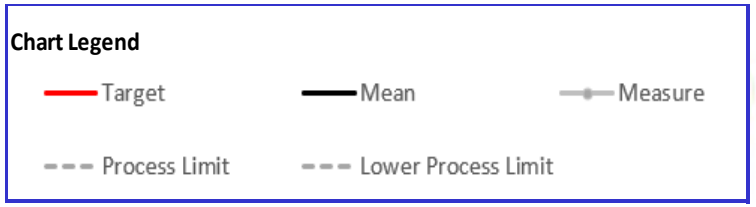


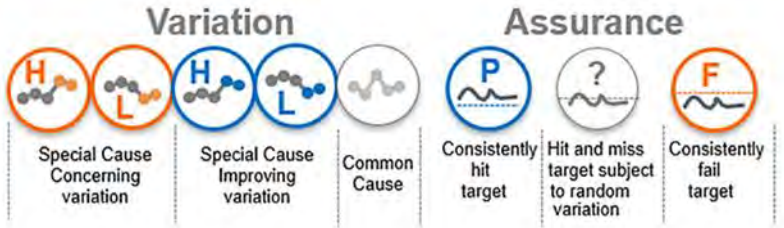




What	So What?	What Next?
After a period of patient safety incidents (PSI) at above average range, PSI reported remains at baseline for an integrated organisation of our size. We encourage staff to report patient safety events to ensure we have an open and candid culture, where colleagues feel able to report incidents without fear of retribution. We have oversight of incidents reported as major or catastrophic at our emerging incident review meeting and ensure proportionate investigation pathway, duty of candour requirements and safety mitigation are addressed. We also review incidents which have not caused harm but are perceived to present the greatest opportunity for system based learning as per PSIRF.	Reported patient safety incidents are not a performance measure but an indication of safety and safety culture. Reporting allows us to target improvement by way of theming and analysis. Reporting of patient safety incidents is a crucial factor in measuring safety however, this should not be the only metric used. PSIRF endorses a system based approach to reviewing incidents. All organisations are moving to PSIRF as of 1st April 2024 under the NHS standard contract.	We are reviewing how we take emerging themes through the EIR, this currently happens through the divisional incidents review meetings but not at Trust level. We are putting actions in place following an EIR scoping meeting with panel members which ensures a balance of good oversight and safety culture. The patient safety team undertake a thematic analysis of incidents on a quarterly basis to target improvement opportunities working with specialist and divisional leads. This is reported to the safety and quality governance group.

Mortality Summary

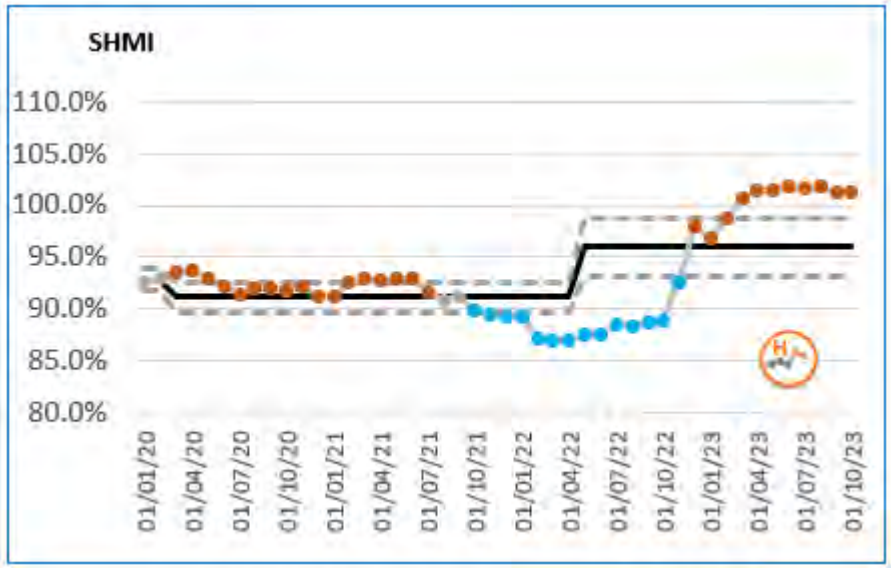


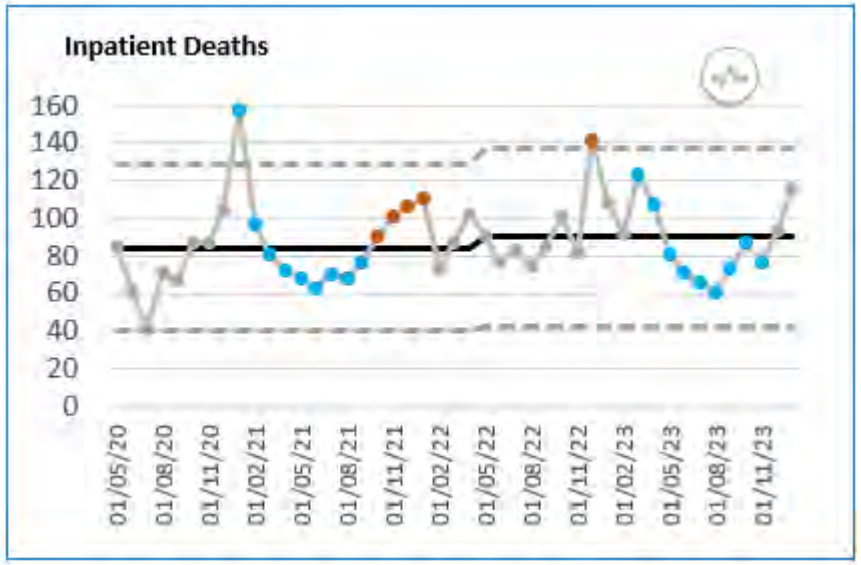


KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
SHMI	Oct 23	101.2%		H		96.0%	93.1%	98.8%
Inpatient Deaths	Jan 24	116				90	43	137

These will be updated once the SHMI data has been published and the Deaths have been agreed

Mortality





What	So What?	What Next?
As previously reported, SHMI chart highlights special cause concern from Dec22. Inpatient deaths (local data) rose in December/ January (following national expected pattern for winter months). This will be kept under review but no concerns have been raised through local review of data.	SHMI is reported 4 months in arrears and is expressed as a "12 months to ..". Current data is reporting deaths to October 2023. SHMI excludes Covid deaths and so does not exactly match local death data (reported up to September). A SHMI of 100% is graded "as expected" meaning that total number of death exactly matches expected deaths. Our SHMI (12 months to October 2023) is currently 101.2% but it had been 80-90% for a considerable period of time up until Nov/Dec23. Until clinical coding issues have resolved, some patient deaths do not have a primary diagnosis. This means that a breakdown by diagnostic groups cannot be replied on to give an accurate picture. Most noticeably group 73 (Pneumonia) and group 101 (Urinary tract infections) are currently flagged as "below expected" with a SHMI of 67.54% and 39.72 respectively. The published data found at https://digital.nhs.uk/data-and-information/publications/statistical/shmi has been annotated by NHSE with a data quality note to reflect these potential inaccuracies at diagnostic coding level. External published data is a source of insight for the CQC and it is therefore important that inaccuracies are recognised.	The mortality oversight group (MOG) have renewed the Learning from deaths data report they review on a monthly basis. This includes number of inpatient deaths (above) and also top ten cause of death, deaths by locations and average age of patients. This enables contextual trend analysis and individual case review if required. The report also includes the number and reason of referrals for subjective judgement review (SJR) and the outcome grading. Cases deemed poor or very poor care are discussed at the peer review meeting with clinical colleagues for consideration for preventability learning.

4.4.1 - Maternity

Report title:	**East of England Sixty Supportive Steps to Safety Version 2**
Agenda item:	Maternity and Neonatal services
Date of the meeting:	22nd March 2024
Sponsor/executive lead:	Paul Molyneux, Trust Board Level Maternity & Neonatal Safety Champion Sue Wilkinson, Chief Nurse
Report prepared by:	Karen Newbury, Director 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

WHAT?

NHS England East of England is offering to provide each Maternity Unit in the East of England with a bespoke visit to complete the Sixty Supportive Steps to Safety framework version 2, which took place on the 11th of December 2023. Version 1 visit was undertaken in October 2021.
A pre-visit meeting can be arranged to answer any questions prior to the support visit.
Following the visit, a short report is sent to the Trust, and the LMNS Senior Responsible Officer (SRO) to feedback the results of the visit. The Trust and LMNS can celebrate positive practices and add areas of care/practice which require improvement to the maternity improvement plan to meet safety regulations.
The report is to be used by the Local Maternity and Neonatal Systems and Integrated Care Systems to improve safety, benchmark and share practices and learning.
The improvements required will be monitored at Regional Perinatal Quality Oversight Group and exceptions escalated at Regional Maternity & Neonatal Programme Board.
If required further support can be provided by the regional maternity team, such as quality improvement methodologies, advice and sharing of best practices.

Overall, the December visit was a very positive visit with many areas of good practice and sustained improvements identified. Evidence of compliance with standards was presented in 44 of the 60 steps.

Suggested areas for further improvement or development:

- **Staffing**

The service needs 2 more Professional Midwifery Advocates (PMA) to ensure ratios of 1 PMA to 20 midwives.

- **Developments in safe, quality care**

The development of Personalised Care Support Plans (PCSPs) is in its infancy due to digital immaturity (limited ability of the information system to be updated to accommodate major changes to clinical processes).
Significant amounts of data need cleansing to be reliable and meaningful.

- **Training**

Staff would like the opportunity for specialist training opportunities to be increased.

- **Information sharing and networking.**

The information leaflets need to be reviewed in line with the ReBirth report.
Further work is ongoing to embed the Maternal Medicine Network pathway.

- **Recovery, theatres, and anaesthetics**

Registered nurses in maternity are completing training and competency checks, to ensure the Royal College of Anaesthetists standards regarding recovery are met.
The enhanced recovery programme needs to be reviewed and compliance audited.

- **Neonatal**

The neonatal nursing staffing is not British Association of Perinatal Medicine (BAPM) compliant due to the shift coordinator not being supernumerary.

- **Antenatal care and Community Midwifery- these comments and issues were raised by the visiting team talking to staff and review of evidence provided:**
  - Not all antenatal appointments in the hospital and/or community are face to face: this was in part due to some processes still being in place and having suitable places for appointments to take place.
  - There are no infection prevention and control (IPC) audits in the community to ensure compliance with safe standards and minimising the risk of cross infection.
  - There is no protected time before or after the community midwife on-call which could result in staff working too many hours in the day/night and this having an impact on their wellbeing and providing effective care.
  - The community on-call is still used for escalation, and this also contributes to the concerns as above.
  - A review of observations at each of the postnatal visits needs to take place to ensure that there is a consistent approach to monitoring the health and wellbeing of mothers and babies in the community setting.
  - Staff are awaiting new lone worker devices to provide reassurance and safety support when working on their own in the community setting.
  - Staff felt they needed more thermometers in order to minimise delays in the monitoring of mothers and babies.
- **Safeguarding**

There is limited administrative support for the team.
The governance processes to share safeguarding information needs reviewing.
A pathway needs to be developed for 1-1 supervision for the safeguarding midwife.

WHAT NEXT?

The majority of the issues raised at the visit, were already being addressed and progress has been made in the short space of time since the visit.
The actions required from the recommendations will be progressed further and captured in the Maternity and Neonatal Quality and Safety action plan. The impact of these changes will be monitored through the Maternity and Neonatal Improvement Board, training trackers and dashboards as well as clinical auditing and analysis of clinical outcomes for specific pathways.
The Trust is committed to sustained improvements in quality and safety for women, babies, their families, and the staff who work in the teams.

Action Required

The Board is asked to receive this summary of the report from the external visit and to note the commitment of the Maternity and Neonatal Services to improve and maintain safe standard of care and services.

Risk and assurance:	There is a risk of non-compliance and safety issues if limited or no response is made to the findings from the visit.
Equality, Diversity, and Inclusion:	There was an opportunity for all staff to contribute to the visit and respond to questions from the visiting team. The service strives to provide equity and equality within its services.
Sustainability:	The Trust aims to sustain meaningful changes to its care pathways and organisational services.
Legal and regulatory context	Failure to provide evidence of improvements made may result in safety issues, legal challenges, and non-compliance with national standards. This could have financial and reputational implications for the Trust as well as a human suffering impact on women, babies, and families.

NHS
West Suffolk
NHS Foundation Trust

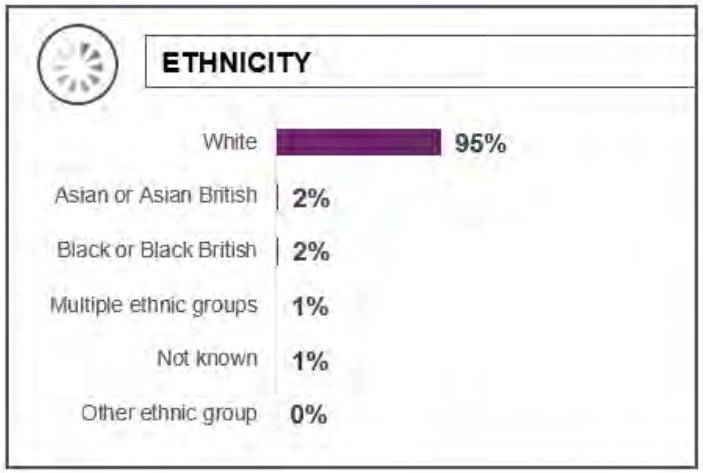
West Suffolk NHS Foundation Trust – NHS Maternity Services Survey 2023

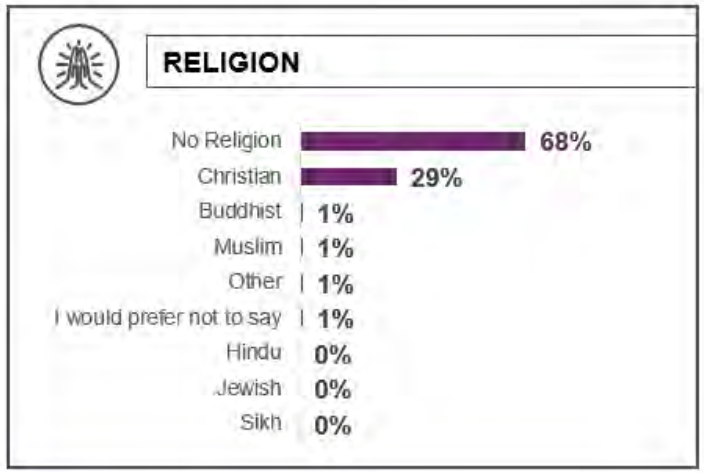
Putting you first

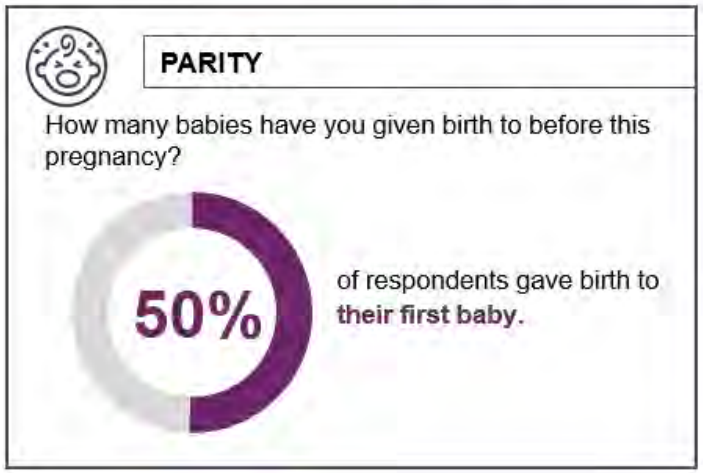
Background and methodology

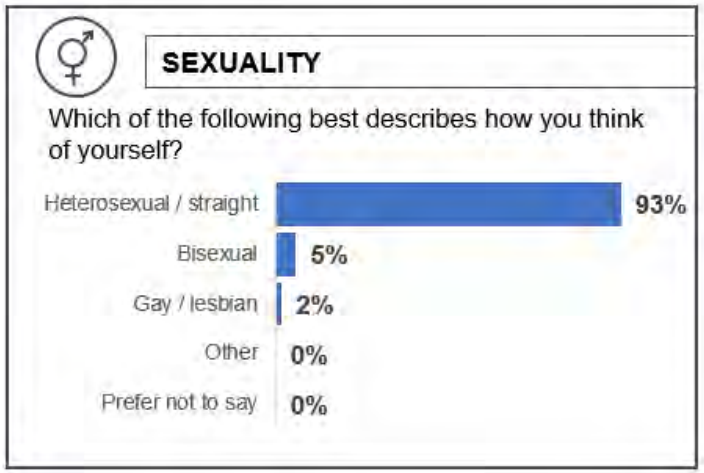
- The NHS Patient Survey Programme (NPSP) is commissioned by the Care Quality Commission (CQC); the independent regulator of health and adult social care in England, to collect feedback on maternity care.
- The CQC use the results from the survey in the regulation, monitoring and inspection of NHS trusts in England.
- Individuals were invited to participate in the survey if they were aged 16 years or over at the time of delivery and had a live birth at an NHS Trust between 1 February and 28 February 2023.
- If there were fewer than 300 people within an NHS trust who gave birth in February 2023, then births from January were included – the WSFT fits into this category.

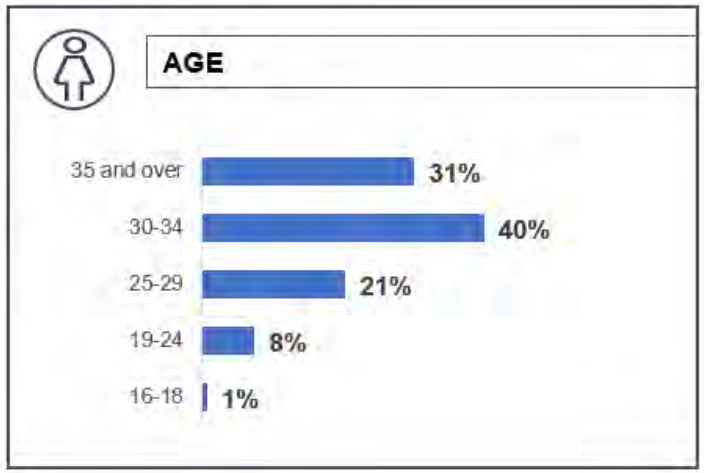
Who took part in the 2023 survey?











Putting you first

Summary of findings for your trust

Comparison with other trusts

The **number of questions** in this report at which your trust has performed better, worse, or about the same compared with most other trusts.

Comparison with results from 2022

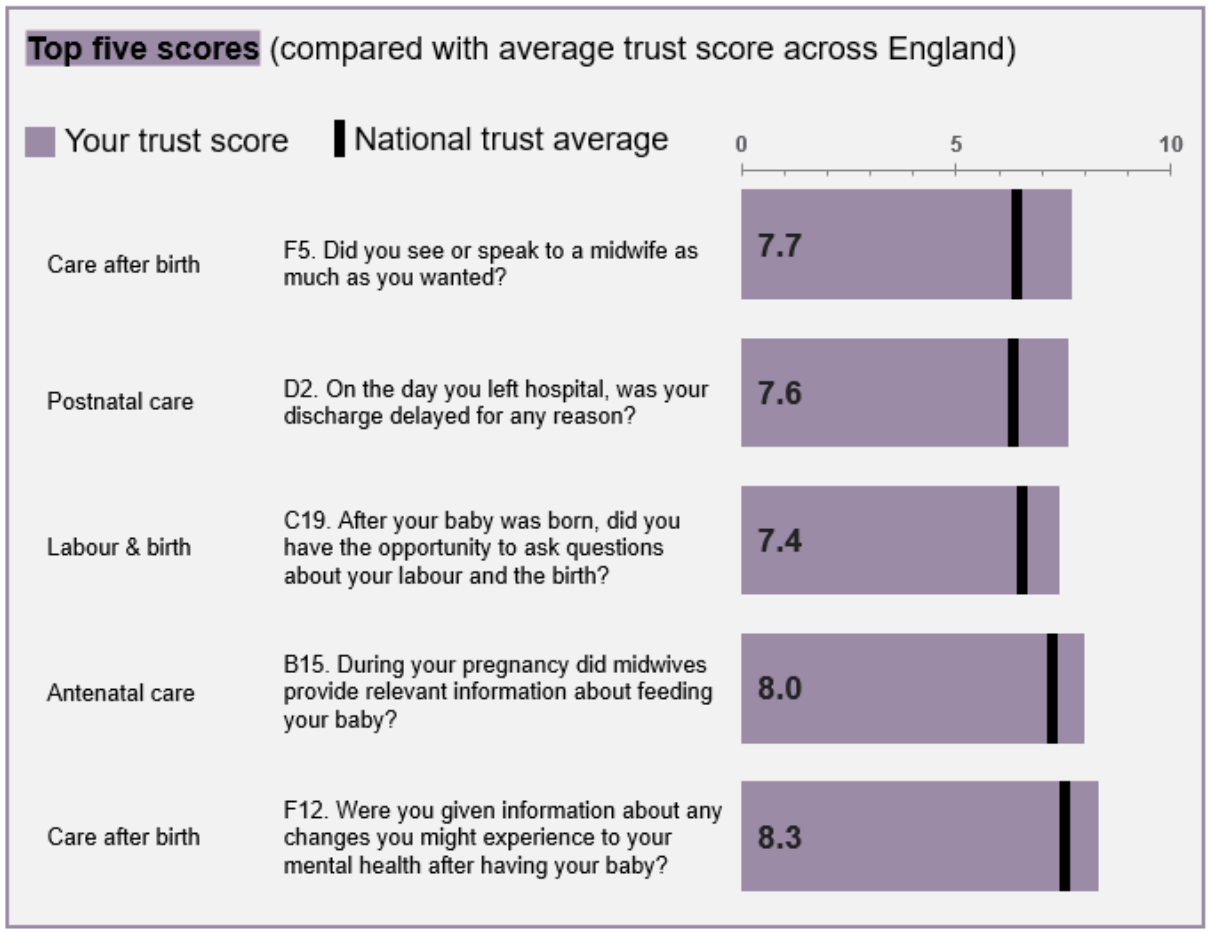
The **number of questions** in this report where your trust showed a statistically significant increase, decrease, or no change in scores compared to 2022 results.

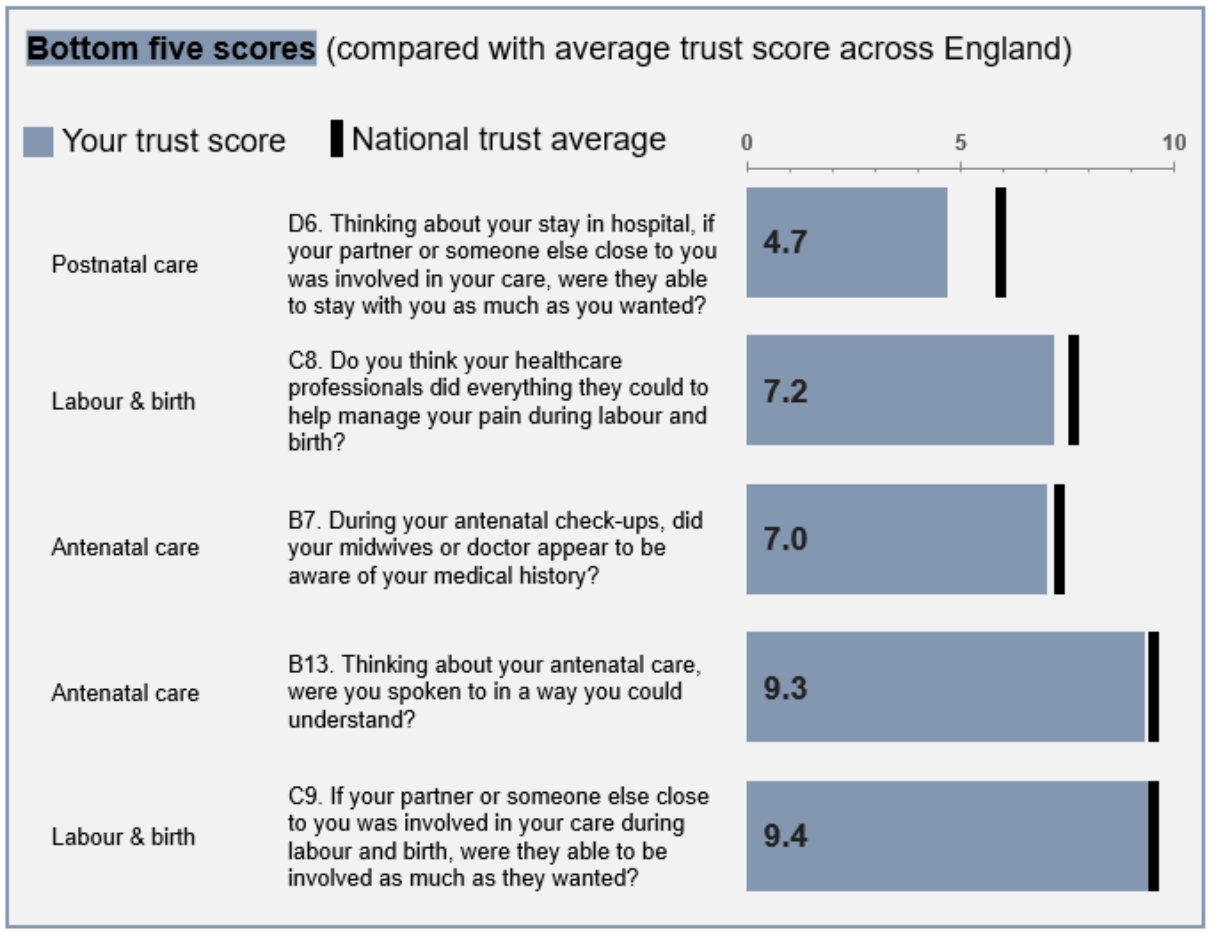
Putting you first

Best and worst performance relative to the trust average

These five questions are calculated by comparing your trust's results to the trust average (the average trust score across England).

- **Top five scores**: These are the five results for your trust that are highest compared with the trust average. If none of the results for your trust are above the trust average, then the results that are closest to the trust average have been chosen, meaning a trust's best performance may be worse than the trust average.
- **Bottom five scores:** These are the five results for your trust that are lowest compared with the trust average. If none of the results for your trust are below the trust average, then the results that are closest to the trust average have been chosen, meaning a trust's worst performance may be better than the trust average.





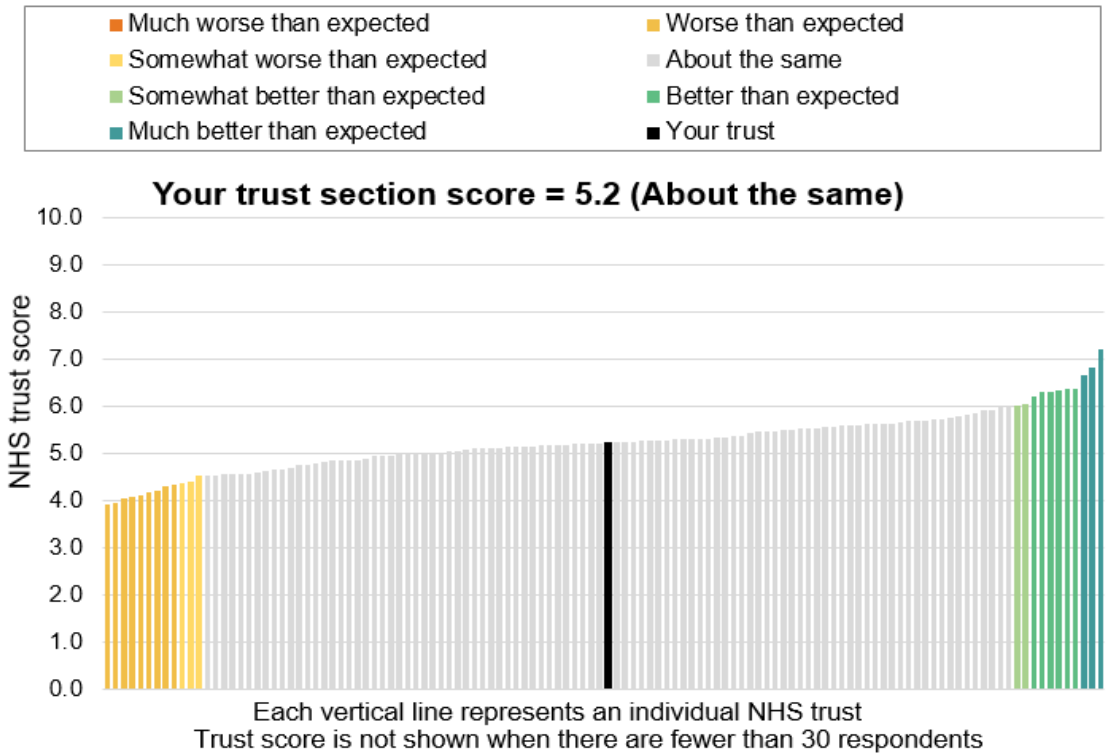
Putting you first

Benchmarking - Antenatal

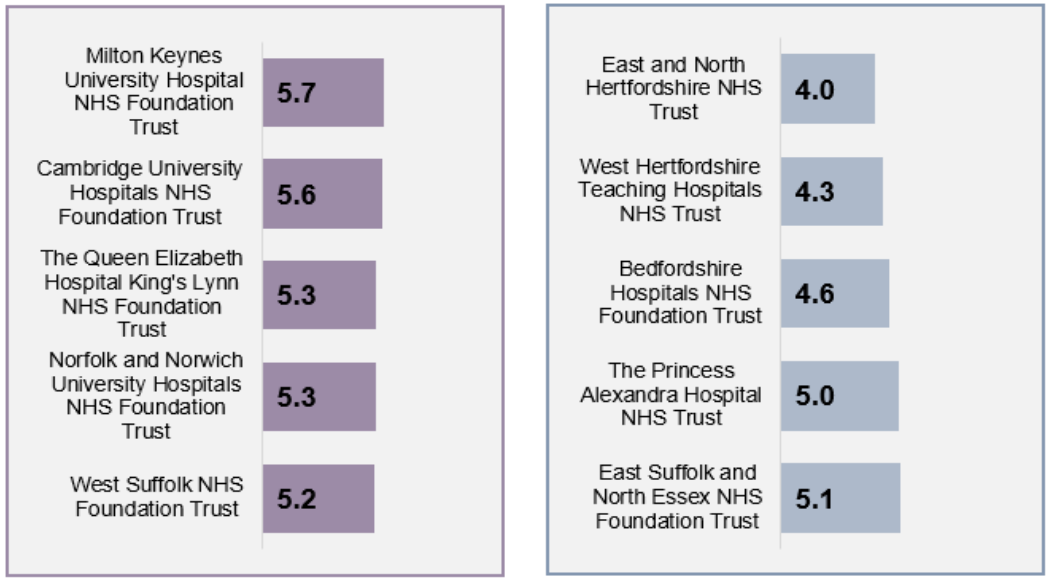
The start of your care during pregnancy

Section score

This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for antenatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'the start of your care during pregnancy' is calculated from questions B3 and B4. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.



Comparison with other trusts within your region

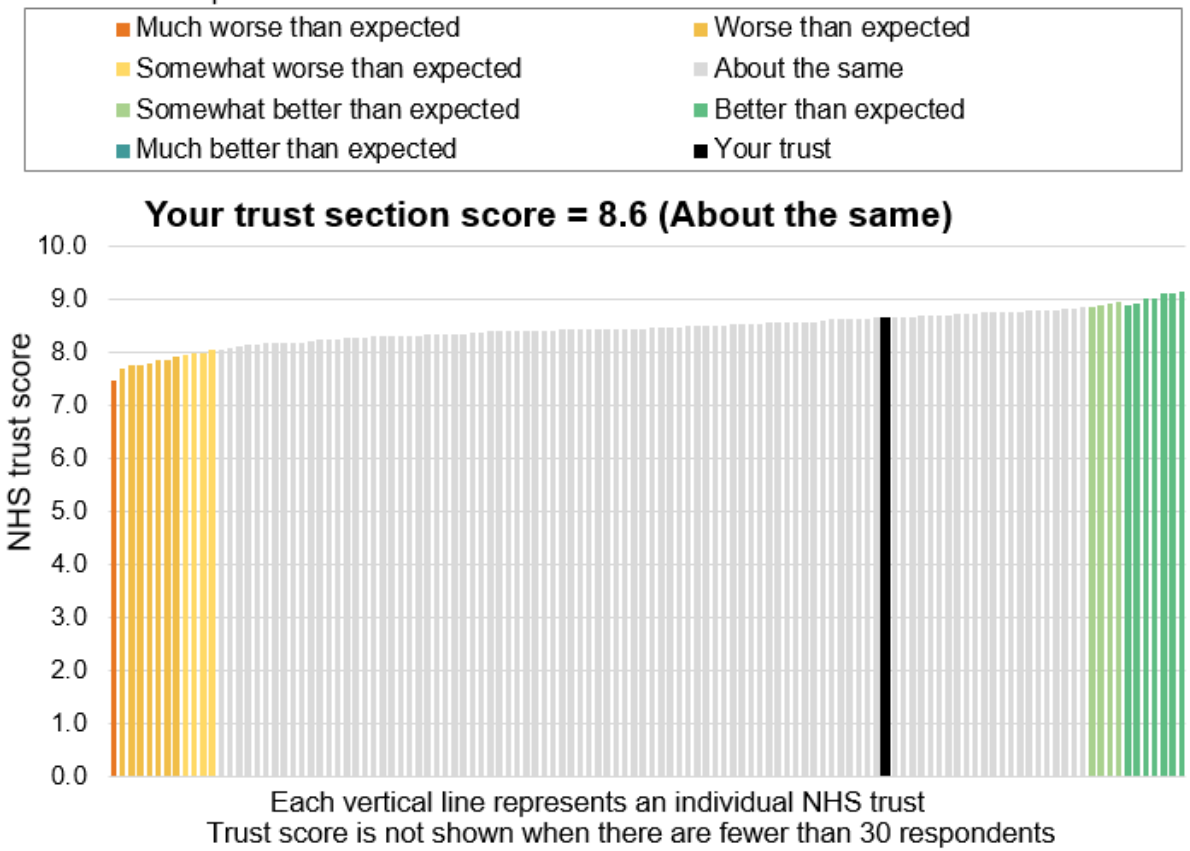


Putting you first

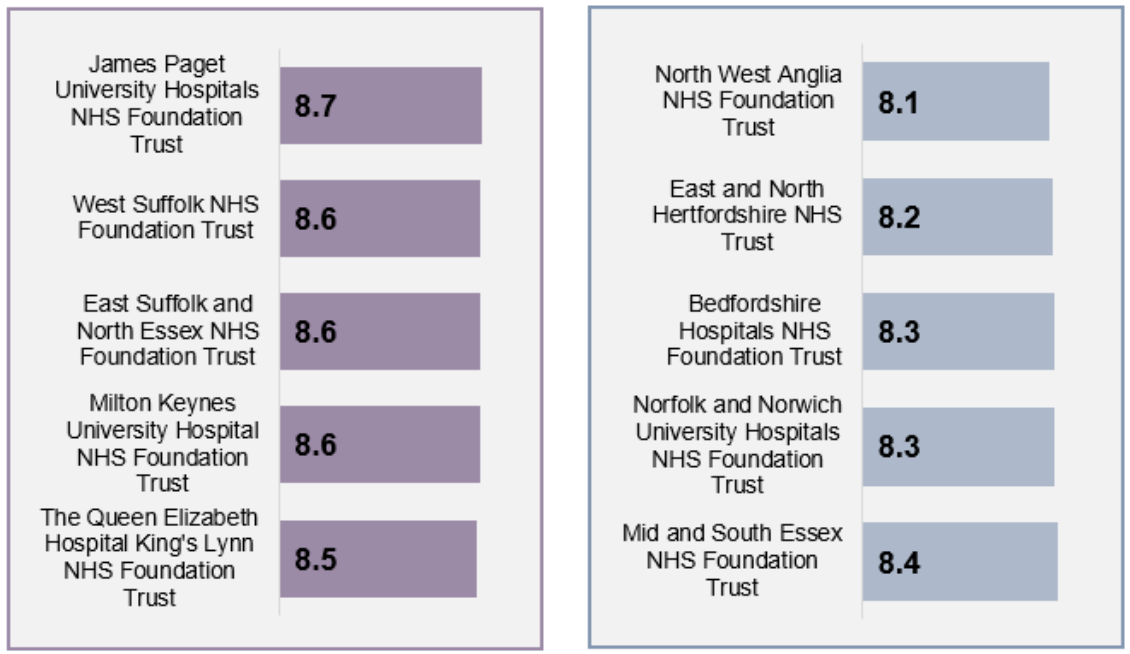
Antenatal check-ups

Section score

This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for antenatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'antenatal check-ups' is calculated from questions B7 to B10. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.



Comparison with other trusts within your region



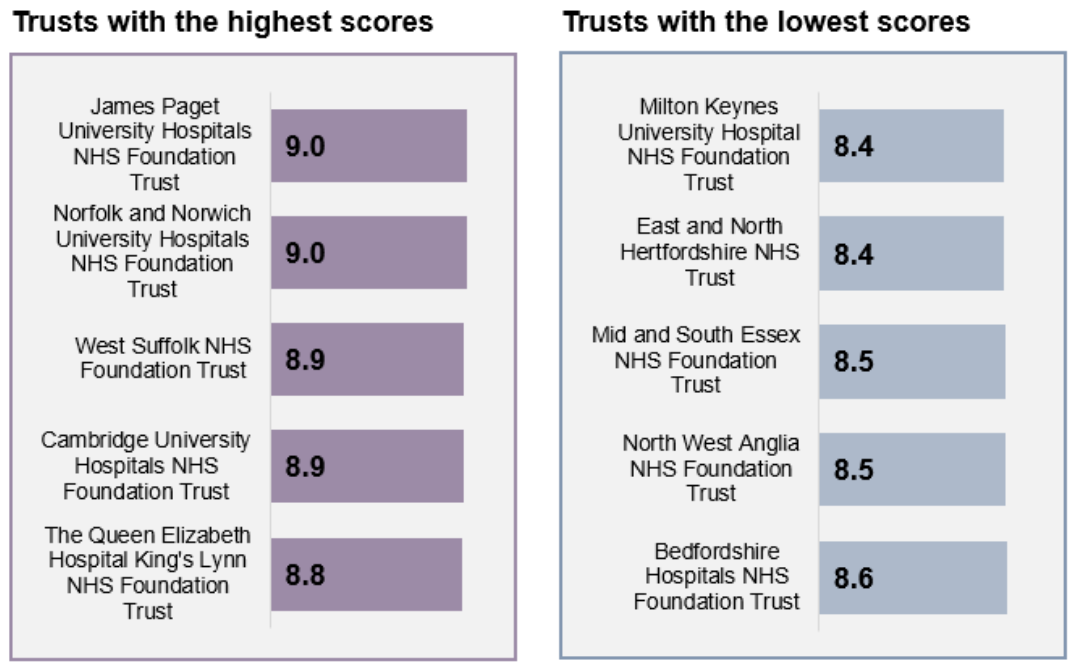
Putting you first

During your pregnancy

Section score

This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for antenatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'during your pregnancy' is calculated from questions B11 to B18. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Comparison with other trusts within your region



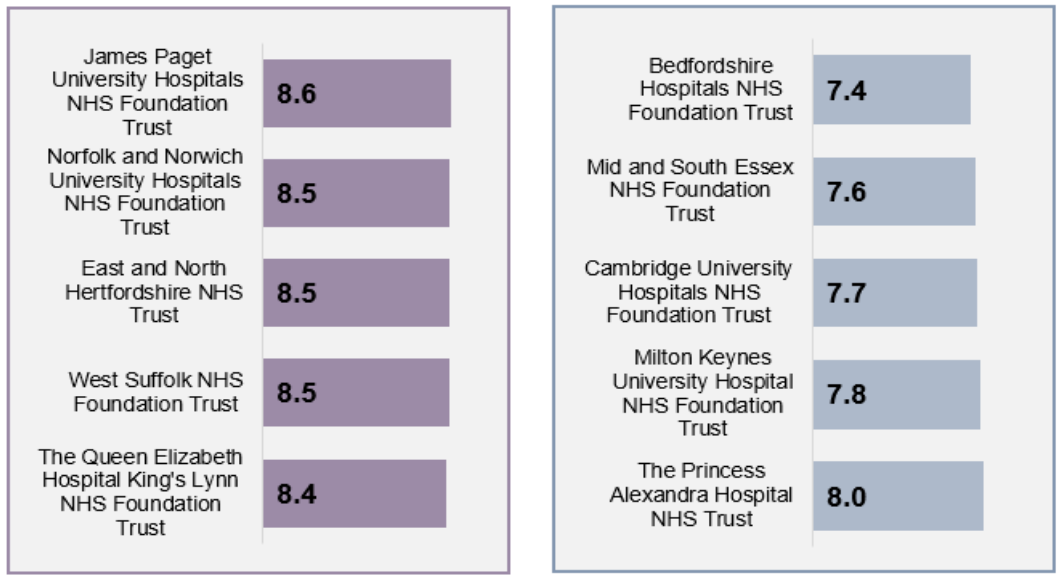
Benchmarking – labour and birth

Your labour and birth

Section score

This shows the range of section scores for all NHS trusts included in the survey. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'your labour and birth' is calculated from questions C4 to C9. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Comparison with other trusts within your region



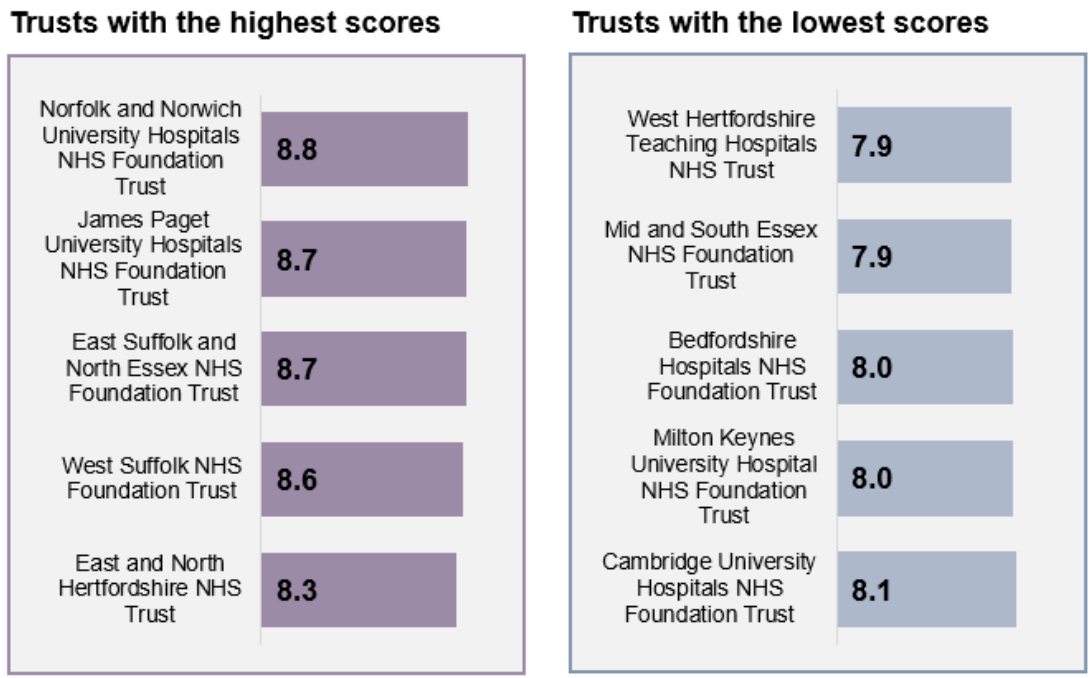
Putting you first

Staff caring for you

Section score

This shows the range of section scores for all NHS trusts included in the survey. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, ‘staff caring for you’ is calculated from questions C10 and C12 to C21. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. The ‘expected range’ analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, a trust could be categorised as ‘about the same’ whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

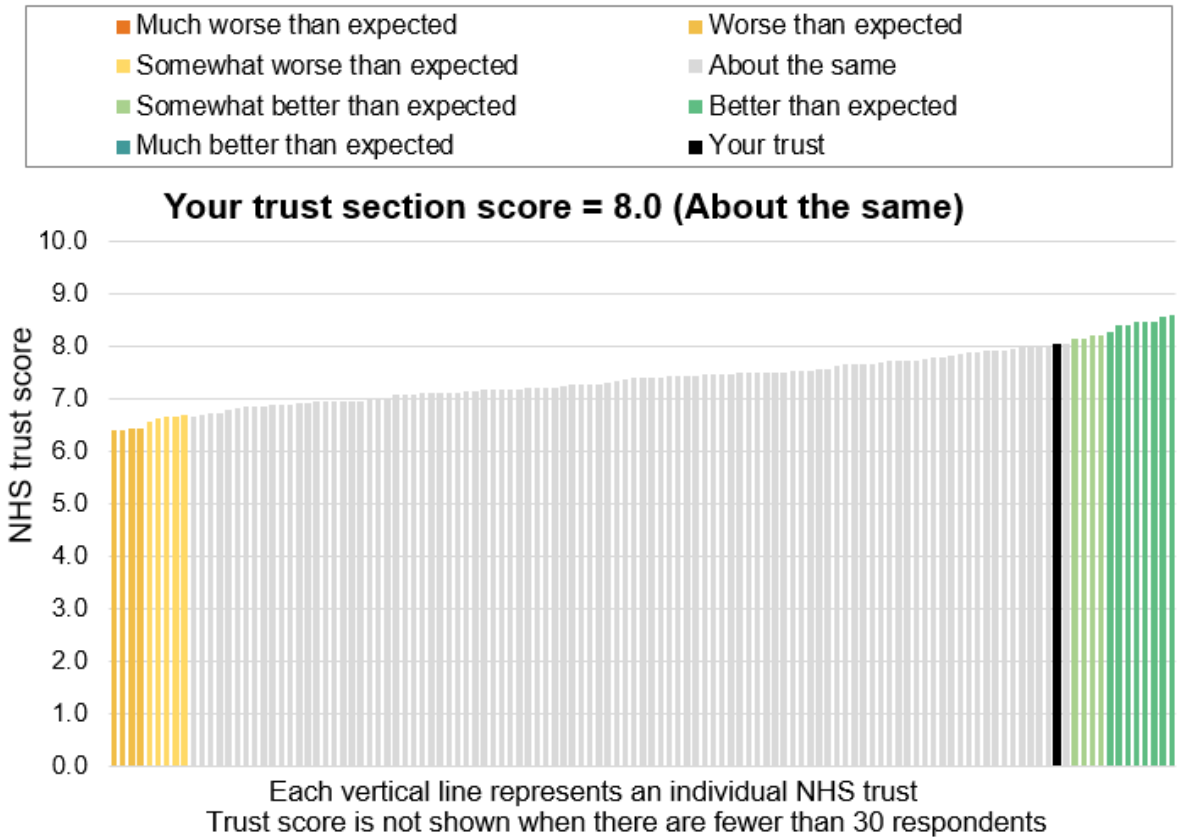
Comparison with other trusts within your region



Care in the ward after birth

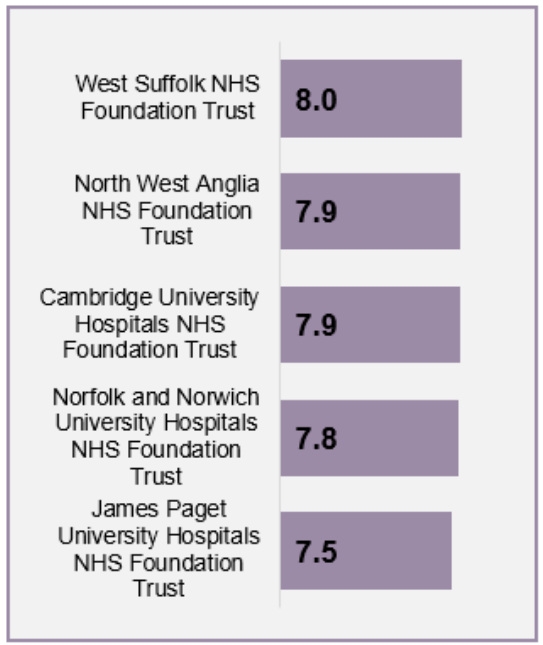
Section score

This shows the range of section scores for all NHS trusts included in the survey. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'care in the ward after birth' is calculated from questions D2 to D8. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

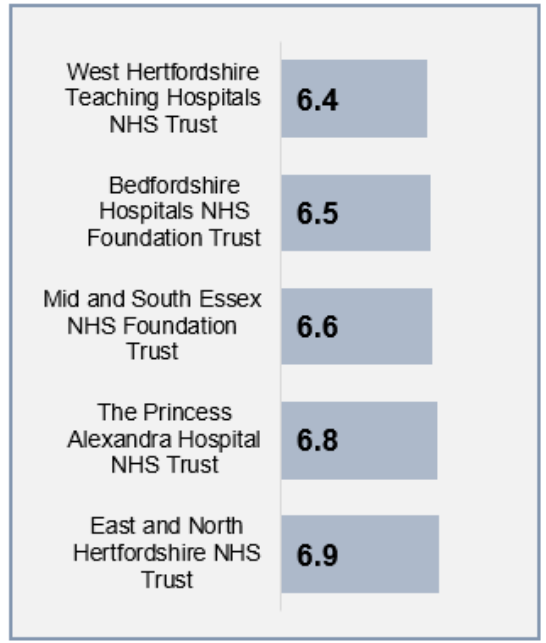


Comparison with other trusts within your region

Trusts with the highest scores



Trusts with the lowest scores

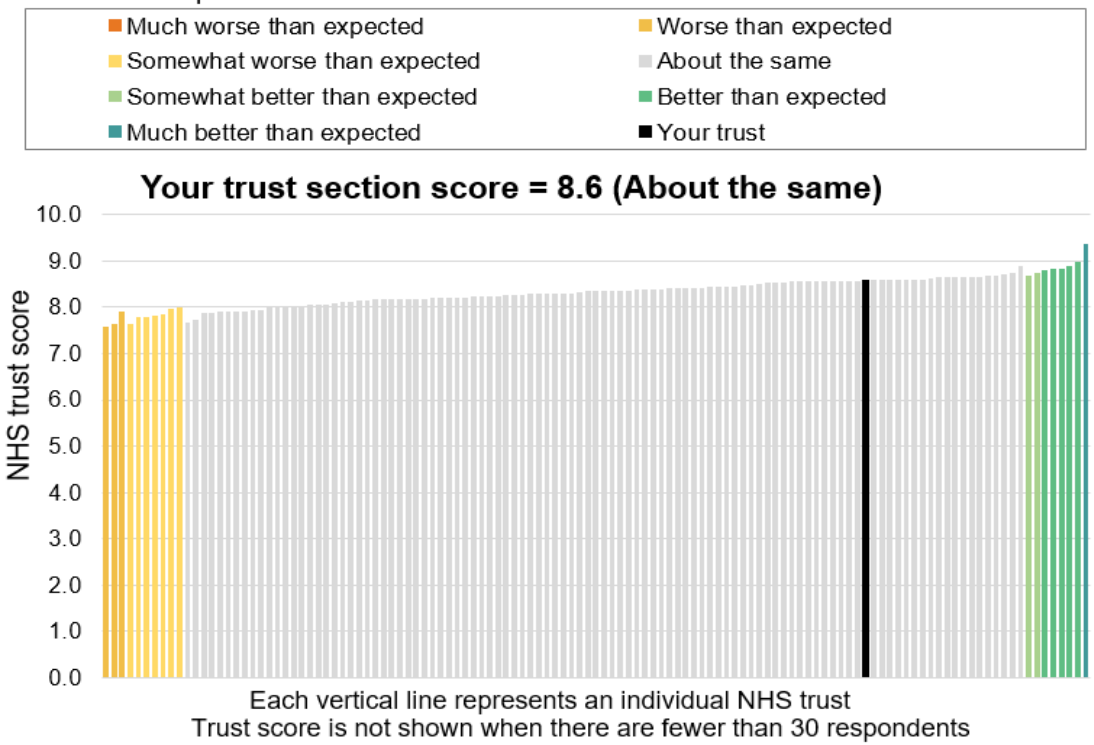


Benchmarking- Postnatal care

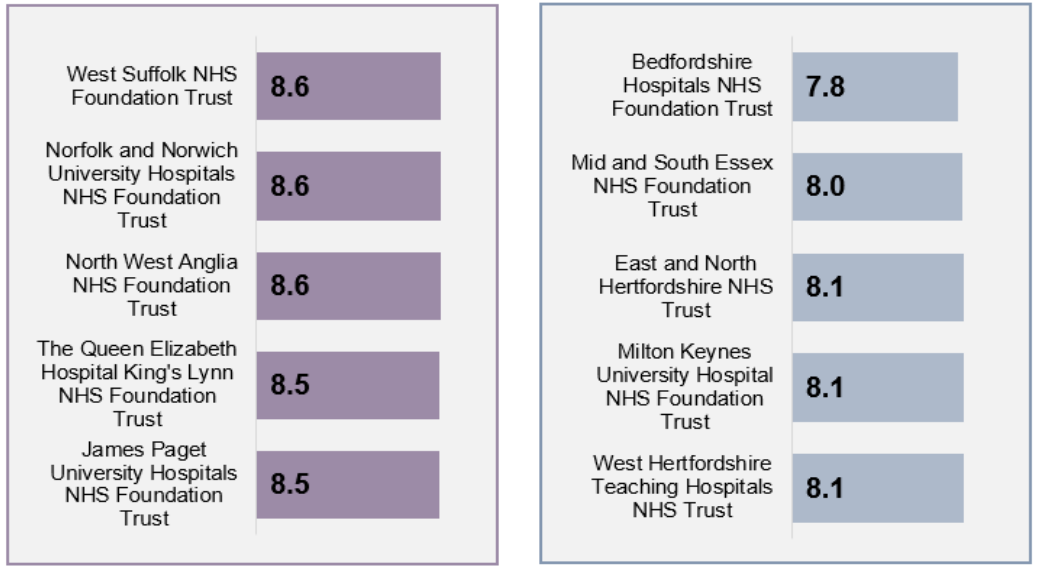
Feeding your baby

Section score

This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for postnatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'feeding your baby' is calculated from questions E2 and E3. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.



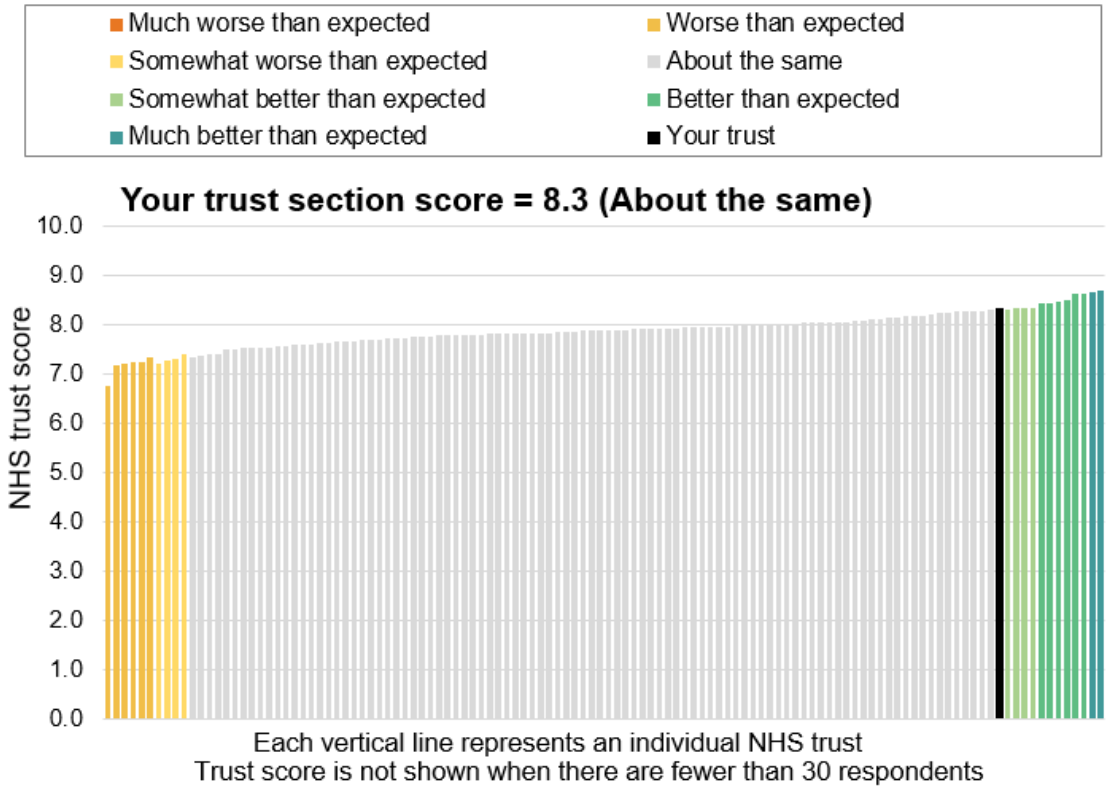
Comparison with other trusts within your region



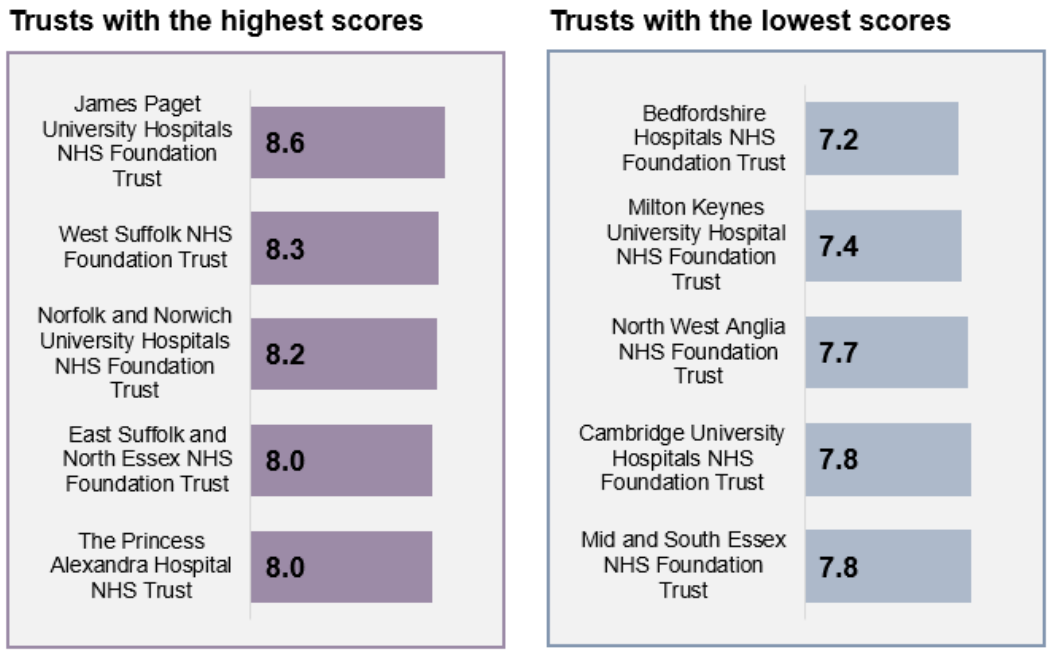
Care at home after birth

Section score

This shows the range of section scores for all NHS trusts included in the survey that submitted attribution data for postnatal care received. Section scores are calculated as the mean of a selection of questions that fall under a particular theme. In this case, 'care at home after birth' is calculated from questions F1 and F2, F5 to F9 and F11 to F17. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. The 'expected range' analysis technique takes into account the number of respondents for each trust, and the scores for all trusts. As a result, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.



Comparison with other trusts within your region



Comparison to 2022 top 5 'could improve' results

No.	Question	2022 WSFT result	2023 WSFT result	2023 survey average
C6	Mothers being involved in the decision to be induced.	8.3	9.2	8.7
C10	Staff introducing themselves when treating and examining mothers during labour and birth.	9.2	9.2	9.1
C12	Mothers (and / or their partner or a companion) being left alone by midwives or doctors at times when it worried them during labour and birth.	7.5	7.8	7.5
C14	Mothers being able to get a member of staff to help when they needed it during labour and birth.	8.6	8.7	8.6
D2	Mothers discharge from hospital not being delayed on the day they leave hospital.	6.2	7.6	6.2
To note 2022 WSFT results did not contain and antenatal or postnatal responses due to attribution data being unavailable. This was resolved for the 2023 survey				

NHS Maternity Survey 2023

Results for West Suffolk NHS Foundation Trust

Where maternity service users' experience is best

- ✓ Maternity service users being able to see or speak to a midwife as much as they wanted during their care after birth.
- ✓ Maternity service users discharge from hospital not being delayed on the day they leave hospital.
- ✓ Maternity service users having the opportunity to ask questions about their labour and the birth after the baby was born.
- ✓ Midwives providing service users with relevant information, during their pregnancy, about feeding their baby.
- ✓ Maternity service users being given information about any changes they might experience to their mental health after having their baby.

Where maternity service users' experience could improve

- ○ Partners or someone else involved in the service user's care being able to stay with them as much as the service user wanted during their stay in the hospital.
- ○ Maternity service users feeling that healthcare professionals did everything they could to manage their pain during labour and birth.
- ○ Midwives or the doctor appearing to be aware of service users' medical history during antenatal check-ups.
- ○ Maternity service users being spoken to in a way they could understand during their antenatal care.
- ○ Partners or someone else close to the service user were involved in their care as much as they wanted to be during labour and birth.

These questions are calculated by comparing your trust's results to the average of all trusts who took part in the survey. "Where maternity service users experience is best": These are the five results for your trust that are highest compared with the average of all trusts who took part in the survey. "Where maternity service users experience could improve": These are the five results for your trust that are lowest compared with the average of all trusts who took part in the survey.

This survey looked at the experiences of individuals in maternity care who gave birth between January and March 2023 at West Suffolk NHS Foundation Trust. Between May and August 2023, a questionnaire was sent to 300 individuals. Responses were received from 133 individuals at this trust. If you have any questions about the survey and our results, please contact [NHS TRUST TO INSERT CONTACT DETAILS].

Putting you first

Next Steps

No.	Question	2023 WSFT result	2023 survey average	Action
B7	During your antenatal check-ups, did your midwives or doctor appear to be aware of your medical history?	7.0	7.2	Engagement to follow with MNVP and service users
B13	Thinking about you antenatal care, were you spoken to in a way you could understand?	9.3	9.4	Engagement to follow with MNVP and service users
C8	Do you think your healthcare professional did everything they could to help mange your pain during labour and birth?	7.2	7.5	Engagement to follow with MNVP and service users
C9	If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted	9.4	9.4	Engagement to follow with MNVP and service users
D6	Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted?	4.7	5.8	Survey with 464 service user responses has already been carried out to determine people's thoughts on a support person staying overnight postnatally

To note all actions will need to be co-produced with service users/Maternity and Neonatal Voice Partnership (MNVP)
The Action plan will be monitored locally and via the MNVP and the Local Maternity and Neonatal System.

Putting you first

5.2 - Governance

AUDIT COMMITTEE

Terms of Reference

1. Purpose of the Committee

1.1. The Board of Directors hereby resolves to establish a committee of the Board to be known as the Audit Committee (the committee). The committee is a non-executive committee of the Board of Directors and has no executive powers, other than those specifically delegated in these Terms of Reference.

1.2. The committee will provide an independent and objective view of the Trust's internal control environment and the systems and processes by which the Trust leads, directs and controls its functions in order to achieve organisational objectives, safety, and quality of services, and in which they relate to the wider community and partner organisations.

1.3. The committee will consider all relevant risks within the Board Assurance Framework and corporate risk register as they relate to the remit of the committee, as part of reporting requirements, and to report any areas of significant concern to the board as appropriate. The committee will also recommend changes to the BAF relating to emerging risks and existing entries within its remit for the executive to consider.

2. Level of Authority

2.1. The committee has overarching responsibility for monitoring specific elements of the systems and processes relating to governance, including financial systems, records and controls; financial information; compliance with law, guidance and codes of conduct; independence of internal and external audit; and the control environment (including measures to prevent and detect fraud). The Committee is responsible for providing an opinion as the adequacy of the integrated governance arrangements and Board Assurance Framework.

2.2. The Board of Directors authorises the committee to investigate any activity within its duties (as detailed below) and grants to the Committee complete freedom of access to the Trust's records, documentation and employees. This authority does not extend, other than in exceptional circumstances, to confidential patient information.

2.3. The committee may seek any information (excluding confidential patient information, other than in exceptional circumstances) or explanation it requires from the Trust's employees who are directed to co-operate with any request made by the Committee.

2.4. The Trust Board authorises the committee to obtain external professional advice or expertise if the committee considers this necessary.

2.5. The committee has a statutory role in respect of assurance, controls, compliance, data and probity. The aim is to ensure complete coverage while avoiding duplication by close liaison and cross-representation between the board assurance committees.

2.6. The committee has authority to make decisions on behalf of the Board but in compliance with the Trust's Standing Financial Instructions and Scheme of Delegation.

2.7. The Committee may establish sub-groups/committees reporting to it. It shall remain accountable to the Board for the work of any group reporting to it.

3. Duties and responsibilities

The key duties and responsibilities of the Committee are as follows:

3.1 Governance and Assurance

3.1.1 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives. The Audit Committee will look to the Trust's other Board Assurance Committees for assurance on items of clinical quality and corporate risk, including: health & safety, research and information governance.

In particular, the Committee shall independently monitor and review:

3.1.1.1 the Annual Governance Statement (AGS) and the assurance system for all other external disclosure statements such as declarations of compliance with the Care Quality Commission registration, and any formal announcements relating to the Trust's financial performance, together with any accompanying Head of Internal Audit opinion, External Audit opinion or other appropriate independent assurances, prior to endorsement by the Board of Directors in order to advise (when requested by the Board or as the Committee deems appropriate) on whether such disclosures taken as a whole are fair, balanced and understandable.

3.1.1.2 the effectiveness of systems of internal financial and budgetary control and the integrity of reporting statements.

3.1.1.3 the effectiveness of systems for ensuring the optimum collection of income.

3.1.1.4 the effectiveness of risk management systems.

3.1.1.5 the effectiveness of the Board Assurance Framework (BAF).

3.1.1.6 The Committee will use a programme of 'deep dive' reviews to test the BAF and its priority areas as part of an assurance programme. The Committee's assessment of the effectiveness of the BAF should be included in the Committee's Annual Report to the Board of Directors.

3.1.1.7 the Quality Report assurance and review alongside the annual report and accounts.

3.1.1.8 the systems for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements, including the NHS Constitution, as set out in relevant guidance.

3.1.1.9 the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud Authority.

3.1.1.10 the adequacy and security of arrangements by which staff or contractors may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters, ensuring that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

3.1.2 In carrying out this work, the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

3.1.3 This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

3.1.4 The Committee will receive the minutes from the Trust's other Board Assurance Committees for the purpose of ensuring: that there is no duplication of effort between the two Committees; that no area of assurance is missed and; as part of its responsibility for reviewing the Annual Governance Statement prior to submission to the Board of Directors.

3.1.5 The Audit Committee shall ensure that there is a system for reviewing the findings of other significant assurance functions, both internal and external to the organisation and consider the implications to the governance of the organisation. These will include, but will not be limited to, NHS Improvement, any reviews by The Department of Health and Social Care or arm's length bodies, regulators/inspectors (CQC, NHS Resolution etc) and professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies etc.)

3.1.6 In addition, the Committee will review the work of other Board Assurance Committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include items in relation to quality, risk, governance and assurance. The conclusion of this review should be referred to specifically in the Committee's Annual Report to the Board of Directors.

3.1.7 The Committee will consider how its work integrates with wider performance management and standards compliance and include this within the Annual Report to the Board of Directors.

3.1.8 In reviewing the work of other Board Assurance Committees and issues around clinical risk management, the Audit Committee will wish to satisfy themselves on the assurance that these Board Assurance Committees gain from the clinical audit function.

3.1.9 The Audit Committee will receive assurance on the arrangements for clinical audit within the Trust, including the process by which clinical audits are selected and agreed actions implemented.

3.2 Internal Audit

The Committee shall ensure that there is an effective internal audit function established by management, which meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and the Board of Directors. An Internal Audit Charter will be agreed annually which will include objectives, responsibilities and reporting lines. This will be achieved by:

3.2.1 considering the appointment of the internal audit service, the audit fee and any questions of resignation and dismissal.

3.2.2 the review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Board Assurance Framework.

3.2.3 consideration of the major findings of internal audit investigations, the effectiveness of the management's response and ensuring co-ordination between the Internal and External Auditors to optimise audit resources.

The will include exception reports of management action beyond deadline and consideration of the findings of Internal Audit "testing" of completed actions.

3.2.4 ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the Trust.

3.2.5 assessing the quality of internal audit work on an annual basis.

3.2.6 Ensuring any material objection to the completion of an assignment which has not been resolved through negotiation is brought to the Committee by the Chief Executive Officer or Director of Resources with a proposed solution for a decision.

3.3 Counter Fraud

The Committee shall ensure that there is an effective counter fraud function established by management that meets the Standards set out by the NHS Counter Fraud Authority and provides appropriate independent assurance

to the Audit Committee, Chief Executive and Board of Directors. This will be achieved by:

3.3.1 consideration of the provision of the Counter Fraud service, the cost of the audit and any questions of resignation and dismissal.

3.3.2 consideration of the major findings of counter fraud work (and management's response).

3.3.3 ensuring that the Counter Fraud function is adequately resourced and has appropriate standing within the organisation.

3.3.4 receiving an annual review of the work undertaken by the counter fraud function.

3.4 External Audit

The Committee shall review the work and findings of the External Auditor appointed by the Council of Governors and consider the implications and management's responses to their work.

3.4.1 Consideration of the appointment, performance and cost effectiveness of the External Auditor, making a recommendation to the Council of Governors on appointment of External Audit.

3.4.2 To ensure that the External Auditor remains independent in its relationship and dealings with the Trust and to review the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements;

3.4.3 To review the annual audit plan and to discuss with the External Auditor, before the audit commences, the nature and scope of the audit.

3.4.4 As part of the audit plan, discuss with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee

3.4.5 To review External Audit reports, including value for money reports and management letters, together with the management response.

3.4.6 To develop and implement a policy on the engagement of the External Auditor to supply non-audit services, considering the impact this may have on their independence, taking into account the relevant regulations and ethical guidance in this regard and reporting to the Board on any improvement or action required.

3.4.7 To develop and implement policy on the engagement of the External Auditor to supply non-audit services, taking into account relevant ethical guidance regarding the provision of non-audit services by the external audit firm; and

3.4.8 To assess the quality of External Audit work on an annual basis.

3.5 Financial Reporting

3.5.1 The Audit Committee shall review the Annual Report and Financial Statements of the Trust and its Charitable funds before submission to the Board, to determine their completeness, objectivity integrity and accuracy. This review will cover but is not limited to:

- the wording in the Annual Governance Statement (AGS) and other disclosures relevant to the Terms of Reference of the Committee;
- changes in, and compliance with, accounting policies and practices;
- explanation of estimates and provisions having material effect;
- unadjusted mis-statements in the financial statements;
- major judgemental areas;
- the schedule of losses and special payments; and
- significant adjustments resulting from the audit.

3.6 Key Trust Documents

3.6.1 Review proposed changes to Standing Orders, Standing Financial Instructions, Scheme of Delegation and Matters Reserved to the Board for approval by the Board of Directors.

3.6.2 To examine the circumstances of any significant departure from the requirements of any of the foregoing, whether those departures relate to a failing, an overruling or a suspension.

3.6.3 To review the Standing Orders, Standing Financial Instructions, Scheme of Delegation and Matters Reserved to the Board on a two-yearly basis for approval by the Board of Directors.

3.7 Other

3.7.1 Review compliance with Standing Orders and Standing Financial Instructions through a schedule of waivers.

3.7.2 Review schedules of losses and compensations.

3.7.3 Monitor the process to ensure that Supply Chain Risk is identified and appropriate actions have been taken.

3.7.4 Entries recorded in the gifts and hospitality register would be considered on an exception basis as reported by the panel considering the entries made.

3.7.5 The Committee shall at its discretion request and review reports, evidence and assurances from Directors and Managers on the overall arrangements for governance, risk management and internal control.

4. Membership

Membership of the Committee will comprise:

4.1. The Committee shall be appointed by the Board of Directors from amongst the Non-Executive Directors of the Trust and shall consist of no fewer than three members, one of whom has recent and relevant finance experience. One of the members will be appointed Chair of the Committee by the Board of Directors.

4.2. At least one member will have a formally recognised professional accountancy qualification and/or a level of relevant financial experience assessed as being appropriate to the role by the Nominations Committee, on behalf of the Board of Directors.

4.3. The Trust Chair will ensure that there is cross-representation by non-executive directors on the Audit Committee and any of the Trust's other Board Assurance Committees.

4.4. The Chair of the Trust shall not be a member of the Committee.

4.5. The committee may invite members of staff, other key stakeholders and advisors to attend meetings as appropriate.

4.6. The committee may ask any other officials of the organisation or representatives of external partners to attend to assist it with its discussions on any particular matter. The committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters

4.7. The Head of Internal Audit and representative of External Audit have a right of direct access to the Chair of the Committee

In attendance:

4.8. The Director of Resources and the Trust Secretary will normally attend all Committee meetings.

4.9. The Head of Internal Audit, the Counter Fraud Specialist and a representative of the Trust's External Auditors will attend as necessary.

4.10. Other members of the Board of Directors have the right of attendance at their own discretion.

4.11. All other attendances will be at the specific invitation of the Committee.

4.12. The Committee will have the over-riding authority to restrict attendance under specific circumstances.

4.13. The Committee will meet with the External and Internal Auditors, without any other Board Director present at least once a year.

4.14. Attendance at meetings will be recorded as part of the normal process of the meeting. A record of attendance will be reported as part of the Committee's Annual Report.

5. Quorum

5.1. The quorum necessary for the transaction of business shall be two members. A duly convened meeting of the committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions invested in, or exercised, by the committee.

5.2. Members are requested to send a deputy with the appropriate skills and knowledge to represent them if they are unable to attend a meeting. Deputies will be counted for the purposes of the quorum.

5.3. 'Virtual' attendance will count towards the quorum.

6. Frequency of meetings

6.1. The committee shall operate as follows:

- Meetings will normally be held at least three times a year
- Special meetings may be convened by the Board of Directors or the Chair of the Committee
- The External Auditors or Internal Auditors may request a meeting if they consider that one is necessary

7. Sub Committees

7.1. The committee shall receive regular reports as appropriate from the sub-groups and speciality committees in place.

8. Arrangements for meetings and circulation of minutes/Administrative support

8.1. The Minutes of Audit Committee meetings shall be formally recorded and a summary of the minutes, which includes a report of the Committee's activities, is submitted to the Board of Directors no less often than three times a year. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action. Once the committee has approved the full minutes, a copy will be available, for information, to the board at its next meeting.

8.2. The Committee shall be supported by Trust office.

9. Accountability and reporting arrangements

9.1. The committee shall be directly accountable to the Board.

9.2. There should be a formal report from the committee to the next meeting of the Board of Directors. The chair of the committee shall draw to the attention of the Trust Board, in private or public as appropriate, any issues that require disclosure to the Board or require executive action. The speed of communication should be proportionate to the seriousness and likely impact of the issue.

9.3. Minutes will be prepared after each meeting of the committee within 5 working days and circulated to members of the committee and others as necessary once confirmed by the Chair of the committee. Once the committee has approved the

full minutes, a copy will be available, for information, to the board at its next meeting.

9.4. The key issues of the committee will be included in the Board of Directors' agenda and papers.

9.5. The committee shall submit an annual report to the Trust Board within the first three months of the new financial year.

9.6. An annual report of the activities of the Audit Committee shall be presented to the Board of Directors and the Council of Governors, identifying any matters in respect of which it considers that action or improvement is needed and making recommendations as to the steps to be taken.

9.7. A separate section of the Trust's Annual Report will describe the work of the Committee in discharging its responsibilities.

9.8. The Committee will report to the Board planned future workload and priorities for approval.

9.9. The Committee will agree on an annual basis a reporting framework for all areas of it terms of reference. This determines standing items for the agenda and items for regular reporting.

9.10. Maintain and monitor performance against the agreed reporting framework.

9.11. Follow-up agreed actions to ensure these are implemented in a timely and effective manner.

10. Monitoring effectiveness and compliance with Terms of reference

10.1. In order to support the continual improvement of governance standards, the Audit Committee shall carry out a self-assessment in relation to its own performance no less than once every two years, reporting the results to the Board of Directors and advise the Trust Board of any suggested amendments to these terms of reference which would improve the trust governance arrangements.

11. Ratification of terms of reference and review arrangements

11.1. The terms of reference shall be reviewed annually and submitted to the Board for approval.

Date approved by the Audit Committee: 12 December 2023
Date approved by the Board of Directors:
Next review date: January 2025

IMPROVEMENT COMMITTEE

Terms of Reference

1. Purpose of the Committee

1.1. The Trust Board hereby resolves to establish an assurance committee to be known as the Improvement Committee (the committee). The committee has no executive powers other than those specifically delegated in these terms of reference. The scope of this assurance committee will focus on quality, patient safety and change management.

1.2. In line with the CQC single assessment framework (SAF) and the NHS Impact, the committee is authorised to provide the board with assurance that there is a culture of high quality, sustainable care and robust systems for learning, continuous improvement and innovation.

1.3. The committee will consider all relevant risks within the Board Assurance Framework and corporate risk register as they relate to the remit of the committee, as part of reporting requirements, and to report any areas of significant concern to the board as appropriate. The committee will also recommend changes to the BAF relating to emerging risks and existing entries within its remit for the executive to consider.

2. Level of Authority

2.1. The committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to request any information from any employee and all employees are directed to cooperate with any request made by the committee. The committee is authorised by the Trust Board to obtain legal advice and to secure the attendance of experts and external representatives or persons with relevant experience/expertise if it considers it necessary.

2.2. The committee has authority to make decisions on behalf of the Board but in compliance with the Trust's Standing Financial Instructions and Scheme of Delegation.

2.3. The committee may establish sub-groups/committees reporting to it. The committee shall remain accountable to the Board for the work of any group reporting to it.

3. Duties and responsibilities

3.1. The key responsibilities of the committee shall be to provide assurance to the board in relation to:

- The effectiveness of the Trust's systems and processes for ensuring clinical governance, quality governance and patient safety is embedded from ward to board
- The Trust's compliance with statutory and regulatory standards, particularly in relation to the Care Quality Commission, Clinical Negligence Scheme for Trusts and the well-led framework
- Oversight of the delivery of statutory and mandatory requirements relating to Quality and Safety of care

- The provision of a platform and forum for the sharing of best practice and improvement learning throughout the Trust
- Trust performance in relation to patient safety outcomes and effectiveness with particular focus on providing assurance to the Board on actions taken to address any major performance variations
- Reports on significant concerns or adverse findings highlighted by external bodies in relation to clinical quality and safety and the actions being taken by management to address them
- The systems and processes in place in the Trust in relation to infection control and to review progress against identified risks to reducing hospital acquired infections
- Reports on actions to address trends relating to adverse events (including serious incidents), claims and litigation.
- Key strategic risks relating to quality and patient safety and consider plans for mitigation as appropriate
- Ensuring that lessons are learnt and implemented across the Trust from patient feedback, including patient safety data and trends, compliments, complaints, patient surveys, national audits/confidential enquiries and learning from the wider NHS community
- Systems within the Trust for obtaining and maintaining licences and accreditations relevant to clinical activity, receiving such reports as required
- Review significant risks including those in the BAF and are relevant to the scope of the committee as allocated by the Board.

4. Membership

4.1. Membership of the Committee will comprise:

Executive Leads:
- Chief Nurse
- Medical Director

Other Members
- At least two non-executive directors, one of whom will chair the meeting
- Director of strategy and transformation
- Chief Operating Officer
- Executive Director of Workforce and Communications

The Chairman and Chief Executive have an open invitation to attend meetings of the committee.

Others in attendance by invitation would be:

- Head of Patient Safety
- Head of Compliance and Effectiveness
- Chair of Patient Quality and Safety Governance Group
- Chair of Clinical Effectiveness governance group
- Clinical directors as required
- Associate Medical Directors
- Trust Secretary/Head of Governance

4.2. The committee may invite members of staff, other key stakeholders and advisors to attend meetings as appropriate.

4.3. The committee may ask any other officials of the organisation or representatives of external partners to attend to assist it with its discussions on any particular matter. The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters

4.4. Attendance at meetings is essential. In exceptional circumstances when an executive member cannot attend they must arrange for a fully briefed deputy of sufficient seniority to attend on their behalf. Members will be required to attend as a minimum 75% of the meetings per year.

5. Quorum

5.1. The quorum necessary for the transaction of business shall be four members of whom at least one must be a non-executive director. A duly convened meeting of the committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions invested in, or exercised, by the committee.

5.2. Members are requested to send a deputy with the appropriate skills and knowledge to represent them if they are unable to attend a meeting. Deputies will be counted for the purposes of the quorum.

5.3. Virtual attendance will count towards the quorum.

6. Frequency of meetings

6.1. The committee shall operate as follows:

- The committee will meet monthly until agreed otherwise
- Items for the agenda should be submitted to the committee secretary a minimum of 6 working days prior to the meeting. Papers on other matters will be put on the agenda only with the prior agreement of the chair.
- Papers will be sent out by the committee secretary at least 4 days before each meeting.
- Membership and terms of reference will only be changed with the approval of the committee and ultimately the board.

7. Sub Committees

7.1. The committee shall receive regular reports from the Patient Quality and Safety Governance Group and the Clinical Effectiveness Governance Group.

8. Arrangements for meetings and circulation of minutes/administrative support

8.1. The Committee shall be supported by Trust office with regard to arrangements for meetings and circulation of minutes/administrative support.

8.2. Minutes will be prepared after each meeting of the committee within 5 working days and circulated to members of the committee and others as necessary once confirmed by the Chair of the committee. Once the committee has approved the full minutes, a copy will be available, for information, to the board at its next meeting.

9. Accountability and reporting arrangements

9.1. The committee shall be directly accountable to the Board.

9.2. There should be a formal report from the committee to the next meeting of the Board of Directors. The chair of the committee shall draw to the attention of the Trust Board, in private or public as appropriate, any issues that require disclosure to the Board or require executive action. The speed of communication should be proportionate to the seriousness and likely impact of the issue.

9.3. The key issues of the committee will be included in the Board of Directors' meeting agenda and papers.

9.4. The committee shall submit an annual report to the Trust Board.

10. Monitoring effectiveness and compliance with Terms of reference

10.1. In order to support the continual improvement of governance standards, this committee is required to complete a self-assessment of effectiveness at least annually and advise the Trust Board of any suggested amendments to these terms of reference which would improve the trust governance arrangements.

11. Ratification of terms of reference and review arrangements

11.1. The Terms of Reference shall be reviewed annually and submitted to the Board for approval.

Date approved by the Improvement Committee: 17 January 2024
Date approved by the Board of Directors:
Next review date: January 2024

INSIGHT COMMITTEE

Terms of Reference

1. Purpose of the Committee

1.1. The Trust Board hereby resolves to establish an assurance committee to be known as the Insight Committee (the committee). The committee has no executive powers other than those specifically delegated in these terms of reference. The scope of this assurance committee will focus on operations, finance and organisational risk.

1.2. In line with the CQC single assessment framework (SAF), the committee is authorised to provide the board with assurance that there are clear and effective processes in place for managing risks, issues and performance and that appropriate and accurate information is being effectively processed, challenged and acted upon.

1.3. The committee will consider all relevant risks within the Board Assurance Framework and corporate risk register as they relate to the remit of the committee, as part of reporting requirements, and to report any areas of significant concern to the board as appropriate. The committee will also recommend changes to the BAF relating to emerging risks and existing entries within its remit for the executive to consider.

2. Level of Authority

2.1. The committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to request any information from any employee and all employees are directed to cooperate with any request made by the committee. The committee is authorised by the Trust Board to obtain legal advice and to secure the attendance of experts and external representatives or persons with relevant experience/expertise if it considers it necessary.

2.2. The committee has authority to make decisions on behalf of the Board but in compliance with the Trust's Standing Financial Instructions and Scheme of Delegation.

2.3. The Committee may establish sub-groups/committees reporting to it. The committee shall remain accountable to the Board for the work of any group reporting to it.

3. Duties and responsibilities

3.1. The key responsibilities of the committee shall be to:

- Receive a regular report on financial and workforce efficiency, noting any trends, exceptions and variances against plans on a Trust-wide and divisional basis and to seek assurance relating to any major performance variations as appropriate
- Receive a regular report on operational performance noting any trends, exceptions and variances against plans on a Trust-wide and divisional basis

and to seek assurance relating to any major performance variations as appropriate

- Advise the board and/or relevant board committee of any risks and issues relating to performance, the assurances it has received of any actions relating to them and any gaps in control or assurance that need to be escalated for attention
- Review significant risks including those in the BAF and are relevant to the scope of the committee as allocated by the Board.

4. Membership

4.1. Membership of the Committee will comprise:

Executive Leads:

- Director of Resources
- Chief Operating Officer

Other Members

- Two non-executive directors, one of whom will chair the meeting
- Chief Nurse
- Medical Director

The Chairman and Chief Executive have an open invitation to attend meetings of the committee.

Others in attendance by invitation would be:

Attendees who are not members of the committee but who will be reporting to the committee on risks and assurances within their remit include the following:

- Deputy Director of Finance
- Deputy Chief Operating Officer
- Deputy Director of Workforce
- Head of Access
- Associate Director of Quality Improvement
- Deputy Chief Nurse
- Deputy Medical Director
- Head of Information Services
- Trust Secretary

4.2. The Committee may invite members of staff, other key stakeholders and advisors to attend meetings as appropriate.

4.3. The Committee may ask any other officials of the organisation or representatives of external partners to attend to assist it with its discussions on any particular matter. The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters

4.4. Attendance at meetings is essential. In exceptional circumstances when an executive member cannot attend they must arrange for a fully briefed deputy of sufficient seniority to attend on their behalf. Members will be required to attend as a minimum 75% of the meetings per year.

5. Quorum

5.1. The quorum necessary for the transaction of business shall be four members of whom at least one must be a non-executive director. A duly convened meeting of the committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions invested in, or exercised, by the committee

5.2. Members are requested to send a deputy with the appropriate skills and knowledge to represent them if they are unable to attend a meeting. Deputies will be counted for the purposes of the quorum.

5.3. 'Virtual' attendance will count towards the quorum.

6. Frequency of meetings

6.1. The committee shall operate as follows:

- The committee will meet monthly until agreed otherwise
- Items for the agenda should be submitted to the committee secretary a minimum of 6 working days prior to the meeting. Papers on other matters will be put on the agenda only with the prior agreement of the chair
- The monthly meetings will alternate between the following:
    - Month 1: Scrutiny and assurance in relation to the reports received from the sub committees listed below, covering two months' activity and performance
    - Month 2: Deep dives into specific performance issues identified through the assurance process, in order to gain deeper understanding of the causes, the actions being taken to remediate issues and the process of improvement
- Papers will be sent out by the committee secretary at least 4 days before each meeting.
- Membership and terms of reference will only be changed with the approval of the committee and ultimately the Board.

7. Sub Committees

7.1. The committee shall receive regular reports from:

- Financial Accountability Committee, including: Capital Strategy Group, Sustainability Net Zero Steering Group, Investment Panel and Contracts & Procurement Panel
- Patient Access Governance Group, including: Urgent and emergency care group and Elective Access meetings
- Corporate Risk Governance Group, including: Health & Safety Committee, Medical Devices Committee, Trust Resilience Group and Information Governance Steering Group
- Other speciality committees as required.

8. Arrangements for meetings and circulation of minutes/administrative support

8.1. The committee shall be supported by Trust office with regard to arrangements for meetings and circulation of minutes/administrative support.

8.2. Minutes will be prepared after each meeting of the committee within 5 working days and circulated to members of the committee and others as necessary once confirmed by the Chair of the committee. Once the committee has approved the full minutes, a copy will be available, for information, to the board at its next meeting.

9. Accountability and reporting arrangements

9.1. The committee shall be directly accountable to the Board.

9.2. There should be a formal report from the committee to the next meeting of the Board of Directors. The chair of the committee shall draw to the attention of the Trust Board, in private or public as appropriate, any issues that require disclosure to the Board or require executive action. The speed of communication should be proportionate to the seriousness and likely impact of the issue.

9.3. The key issues of the committee will be included in the Board of Directors' meeting agenda and papers. Once the committee has approved the full minutes, a copy will be available, for information, to the board at its next meeting.

9.4. The committee shall submit an annual report to the Trust Board.

10. Monitoring effectiveness and compliance with Terms of reference

10.1. In order to support the continual improvement of governance standards, this committee is required to complete a self-assessment of effectiveness at least annually and advise the Trust Board of any suggested amendments to these terms of reference which would improve the trust governance arrangements.

11. Ratification of terms of reference and review arrangements

11.1. The Terms of Reference shall be reviewed annually and submitted to the Board for approval.

Date approved by the Insight Committee: March 2024
Date approved by the Board of Directors:
Next review date: January 2024

INVOLVEMENT COMMITTEE

Terms of Reference

1. Purpose of the Committee

1.1. The Trust Board hereby resolves to establish an assurance committee to be known as the Involvement Committee (the committee). The committee has no executive powers other than those specifically delegated in these terms of reference. The scope of this assurance committee will focus on people and organisational development.

1.2. In line with the In line with the CQC single assessment framework (SAF) and NHS Impact, the committee is authorised to provide the board with assurance that the Trust is engaging and involving people who use the services, the public, the staff and external partners to support high quality sustainable services.

1.3. The committee will consider all relevant risks within the Board Assurance Framework and corporate risk register as they relate to the remit of the committee, as part of reporting requirements, and to report any areas of significant concern to the board as appropriate. The committee will also recommend changes to the BAF relating to emerging risks and existing entries within its remit for the executive to consider.

1.4. Real learning comes from developing insights and understanding across the entire breadth of the committee's remit, and this understanding will drive change and improvement.

2. Level of Authority

2.1. The committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to request any information from any employee and all employees are directed to cooperate with any request made by the committee. The committee is authorised by the Trust Board to obtain legal advice and to secure the attendance of experts and external representatives or persons with relevant experience/expertise if it considers it necessary.

2.2. The committee has authority to make decisions on behalf of the Board but in compliance with the Trust's Standing Financial Instructions and Scheme of Delegation.

2.3. The committee may establish sub-groups/committees reporting to it. The committee shall remain accountable to the Board for the work of any group reporting to it.

3. Duties and responsibilities

3.1. The key responsibilities of the committee shall be to provide assurance to the board in relation to the Trust's strategies, plans and the management of risks, pertaining to:

- 3.1.1. patient and service user experience and engagement;
- 3.1.2. staff experience and engagement;
- 3.1.3. relationships and partnerships with external representative groups;

3.1.4. and the ongoing nurturing and development of the organisation's leadership and culture.

3.2. These themes are cross-cutting and work in one area will likely have impact and benefits across the entirety of the committee's breadth of scope. That being said, there are distinct areas of inquiry and focus, aligned with the Trust's three strategic ambitions, as follows:

(a) First for staff
- Organisational values, leadership & cultural development (inc. speak up culture)
- Staff engagement & feedback (inc. staff survey/s)
- Support for staff health and wellbeing
- Education, training & workforce development
- HR & employment practice

(b) First for patients
- Patient and carer engagement & feedback (inc. patient survey/s)
- Co-production of improvements to quality & service provision
- Sharing and adoption of learning from complaints & incidents

(c) First for the future
- A culture of diversity and inclusion, focusing on outcomes: for patients, services users and staff
- The approach to and development of partnership working with our Alliance and ICS
- Our responsibilities and contribution as an anchor institution
- Meeting statutory duties for public and patient involvement in relation to the planning and provision of services
- Member and governor engagement activities, and their alignment with the Trust's strategic priorities

4. Membership

4.1. Membership of the Committee will comprise:

Executive Leads
- Executive director of workforce and communications
- Executive chief nurse

Other Members
- At least two non-executive directors, one of whom will chair the meeting
- Executive medical director
- Executive chief operating officer
- Executive director of resources
- Executive director of strategy and transformation

The chair and chief executive have an open invitation to attend meetings of the committee.

Others in attendance by invitation would be:
- Head of patient experience
- Associate director of communications
- Deputy directors of workforce & OD
- Trust secretary

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- Governor representative

4.2. The Committee may invite members of staff, other key stakeholders and advisors to attend meetings as appropriate.

4.3. The Committee may ask any other officials of the organisation or representatives of external partners to attend and to assist it with its discussions on any matter. The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of matters.

4.4. Attendance at meetings is essential. In exceptional circumstances when an executive member cannot attend, they must arrange for a fully briefed deputy of sufficient seniority to attend on their behalf. Members will be required to attend as a minimum 75% of the meetings per year.

5. Quorum

5.1. The quorum necessary for the transaction of business shall be three members of whom at least one must be a non-executive director. A duly convened meeting of the committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions invested in, or exercised, by the committee.

5.2. Members are requested to send a deputy with the appropriate skills and knowledge to represent them if they are unable to attend a meeting. Deputies will be counted for the purposes of the quorum.

5.3. 'Virtual' attendance will count towards the quorum.

6. Frequency of meetings

6.1. The committee shall operate as follows:

- The committee will meet every other month until agreed otherwise
- Items for the agenda should be submitted to the committee secretary a minimum of 6 working days prior to the meeting. Papers on other matters will be put on the agenda only with the prior agreement of the chair.
- Papers will be sent out by the committee secretary at least 4 days before each meeting.
- Membership and terms of reference will only be changed with the approval of the committee and ultimately the board.

7. Sub Committees

7.1. The committee shall receive regular reports from the sub-groups and speciality committees / functions in place such as:

- Patient Carer Experience Group
- People and Culture Leadership Group

7.2. Other groups may be invited to report into or attend the meeting on an ad hoc basis to report on various themes, topics and initiatives taken by the organisation.

7.3. The Terms of Reference of the above groups and their effectiveness will be reviewed by the committee annually.

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8. Arrangements for meetings and circulation of minutes/Administrative support

8.1. The Committee shall be supported by Trust office.

8.2. Minutes will be prepared after each meeting of the committee within 5 working days and circulated to members of the committee and others as necessary once confirmed by the Chair of the committee. Once the committee has approved the full minutes, a copy will be available, for information, to the board at its next meeting.

9. Accountability and reporting arrangements

9.1. The committee shall be directly accountable to the Board.

9.2. There should be a formal report from the committee to the next meeting of the Board of Directors. The chair of the committee shall draw to the attention of the Trust Board, in private or public as appropriate, any issues that require disclosure to the Board or require executive action. The speed of communication should be proportionate to the seriousness and likely impact of the issue.

9.3. The key issues of the committee will be included in the Board of Directors' agenda and papers.

9.4. The committee shall submit an annual report to the Trust Board.

10. Monitoring effectiveness and compliance with Terms of reference

10.1. We will focus on values and behaviours to develop our culture and to model this through the organisation. This will include 'setting the scene' at the beginning of the meeting; we will take time to reflect at the end of the meeting using open questions to seek response. We will ensure that colleagues and partners invited to the meeting are always briefed and supported to be comfortable to contribute fully.

10.2. We will consider our membership to ensure we reflect the partners we want to involve and the diversity of leadership we need to see to gain the multiple perspectives we need to achieve our goals.

10.3. In order to support the continual improvement of governance standards, this committee is required to complete a self-assessment of effectiveness at least annually and advise the Trust Board of any suggested amendments to these terms of reference which would improve the trust governance arrangements.

11. Ratification of terms of reference and review arrangements

11.1. The Terms of Reference shall be reviewed annually and submitted to the Board for approval.

Date approved by the Involvement Committee: 20 December 2023
Date approved by the Board of Directors:
Next review date: December 2024