NHS
West Suffolk
NHS Foundation Trust

Board of Directors (In Public)

Schedule	Friday 24 May 2024, 9:15 AM — 1:15 PM BST
Venue	Education Centre, West Suffolk Foundation Trust
Description	A meeting of the Board of Directors will take place on Friday 24th May, 2024 at 9:15am.
Organiser	Gemma Wixley

Agenda

AGENDA
Presented by Jude Chin

WSFT Public Board Agenda - 24 May 2024 (2).docx

1. GENERAL BUSINESS
Presented by Jude Chin

9:15 AM — 1.1. Welcome and apologies for absence - Craig Black , Paul Molynuex & Helen Davies
To Note - Presented by Jude Chin

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

9:20 AM — 1.3. Minutes of the previous meeting - 22nd March 2024
To Approve - Presented by Jude Chin

WSFT Minutes Open Board 22 March 2024 DRAFT.docx

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

1.4 Action Log - Active - Open.pdf

1.4 Action Log - Complete - Open.pdf

9:25 AM — 1.5. Questions from Governors and the Public relating to items on the

		agenda To Note - Presented by Jude Chin
9:45 AM	1.6.	Patient and Staff Story - To Review - Presented by Susan Wilkinson
10:10 AM	1.7.	Chief Executive's report To inform - Presented by Ewen Cameron Item 1.7 CEO Board report May 2024 FINAL.docx
	2.	STRATEGY
10:20 AM	2.1.	Future System board report To Assure - Presented by Ewen Cameron Item 2.1 wsft public board May 24_FINAL.docx
10:30 AM		Comfort Break
10:40 AM	2.2.	System Update To Assure Item 2.2 WSA Committee update May 2024 V3x (002).docx
	3.	PEOPLE AND CULTURE
10:55 AM	3.1.	Involvement Committee report - no meeting To Assure
11:10 AM	3.1.1.	People and OD highlight report, including FTSU report To Assure - Presented by Jeremy Over Item 3.1.1 People OD highlight May2024.docx Item 3.1.1DRAFT PC plan 2425.docx.pptx
11:20 AM		COMFORT BREAK

4. ASSURANCE

11:25 AM **4.1. Insight Committee Report - Chair's Key Issues from the meeting**
To Assure

- Item 4.1 INSIGHT CKI report b 20 Mar 2024 FINAL AJ.docx
- Item 4.1 INSIGHT CKI report c 17 Apr 2024 FINAL AJ.docx

11:35 AM **4.1.1. NHS 2024/25 Priorities and operational planning guidance**

- Item 4.1.1 - Planning for Insight V1_final NC.docx
- Item 4.1.1 Planning Guidance.pptx

11:45 AM **4.1.2. Finance Report, including 2024/25 budget and capital programme**
For Approval

- Item 4.1.2 M1 Finance Cover 2425.docx
- Item 4.1.2 M1 Finance Report 2425 Final.docx

11:55 AM **4.2. Improvement Committee Report - Chair's Key Issues from the meeting**
To Assure

- Item 4.2 IMPROVEMENT CKI report b 20 Mar 2024 FINAL LP.docx
- Item 4.2 IMPROVEMENT CKI report c 17 Apr 2024 FINAL LP.docx

12:05 PM **4.3. Quality and Nurse Staffing Report**
To Assure

- Item 4.3 Safe Staffing report March April 2024 FINAL.docx

12:15 PM **4.3.1. Maternity & Neonatal Services**
Karen Newbury, Kate Croissant & Simon Taylor in attendance
To Approve

- Item 4.3.1 May 2024 Maternity quality safety and performance Board report (002) (002).docx

12:25 PM **4.4. Audit Committee Report**
To Assure - Presented by Richard Jones

Item 4.4 AUDIT CKI report 19 Mar 2024 MP.docx

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5. GOVERNANCE

12:35 PM 5.1. Board Assurance Framework
To Assure - Presented by Jude Chin

Item 5.1 BAF report May 24-Board.docx

12:50 PM 5.2. Governance Report
For Approval - Presented by Jude Chin

Item 5.2 Governance report.docx

Item 5.2 Annex A Register of Interests summary April 2024.docx

Item 5.2 Annex B Draft Board meeting agenda.docx

1:00 PM 6. OTHER ITEMS
Presented by Jude Chin

1:05 PM 6.1. Any other business
To Note - Presented by Jude Chin

1:10 PM 6.2. Reflections on meeting
For Discussion - Presented by Jude Chin

6.3. Date of next meeting - 26th July, 2024
To Note - Presented by Jude Chin

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

SUPPORTING ANNEXES

Presented by Jude Chin

Item 4.1 IQPR Report
Presented by Nicola Cottington

Board Report March 2024.pptx

4.3.1 Maternity papers Annexes

Item 4.3.1 Appendix B Updated Board approval processes May 2024.docx

Item 4.3.1MNSI Q4 report FINAL_.docx

4.4 Audit committee:
App1 - scheme of reservation and delegation
App 2 - standing financial instructions (SFIs)

Item 4.4 Annex SFIs and SOD.docx

Item 4.4 Annex Appx 1 Scheme of reservation and delegation March 24.docx

Item 4.4 Annex Appx 2 SFIs March 24.docx

5.2 Governance report
- Well led review executive summary

xAnnex Linked to Item 5.2 WSFT - Well led report cover.docx

AGENDA

Presented by Jude Chin

WSFT Board of Directors – Public Meeting

Date and Time	Friday, 24 May 2024 9:15 – 13:30
Venue	Education Centre, West Suffolk Hospital

Time	Item	Subject	Lead	Purpose	Format
1.0 GENERAL BUSINESS					
09.15	1.1	**Welcome and apologies for absence** – CB, PM	Chair	Note	Verbal
	1.2	**Declarations of Interests**	All	Assure	Verbal
09.20	1.3	**Minutes of meeting** – 22 March 2024	Chair	Approve	Report
	1.4	**Action log and matters arising**	All	Review	Report
09:25	1.5	**Questions from Governors and the public relating to items on the agenda**	Chair	Note	Verbal
09.45	1.6	**Patient or Staff Story** To hear a patient story relating to end of life care	Chief Nurse	Review	Verbal
10.10	1.7	**CEO report**	Chief Executive	Inform	Report
2.0 STRATEGY					
10.20	2.1	**Future system board report**	Director of Resources	Assure	Report
10:30 Comfort Break					
10:40	2.2	**System update**	West Suffolk Alliance Director and Director of Integrated Adult Health and Social Care	Assure	Report
3.0 PEOPLE AND CULTURE					
10.55 11.10	3.1	**Involvement Committee report** – no meeting 3.1.1 - People and OD highlight report, including FTSU report	 Dir HR & Comms FTSU Guardian	Approval	Report
11:20 Comfort Break					

Time	Item	Subject	Lead	Purpose	Format
4.0 ASSURANCE					
11.25	4.1	**Insight committee report** – Chair's key issues from the meetings	NED Chair	Assure	Report
11.35	4.1.1	**NHS 2024/25 priorities and operational planning guidance**	COO	Assure	Report
11.45	4.1.2	**Finance report, including 2024/25 revised financial plan**	Director of Resources	Assure	Report
11.55	4.2	**Improvement committee report** – Chair's key issues from the meetings	NED Chair	Assure	Report
12.05	4.3	**Quality and nurse staffing report**	Chief Nurse	Assure	Report
12.15	4.3.1	**Maternity services report**	Chief Nurse Karen Newbury Kate Croissant Simon Taylor	Approval	Report
12.25	4.4	**Audit committee report**	NED Chair	Assure	Report
5.0 GOVERNANCE					
12.35	5.1	**Board assurance framework**	Trust Secretary	Assure	Report
12.50	5.2	**Governance Report**	Trust Secretary	Approval	Report
6.0 OTHER ITEMS					
13.00	6.1	**Any Other Business**	All	Note	Verbal
13.10	6.2	**Reflections on meeting**	All	Discuss	Verbal
	6.3	**Date of next meeting** 26 July 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
4.5	Audit committee: App 1 - Scheme of reservation and delegation App 2 – Standing financial instructions (SFIs)
5.2	Governance report - Well led review executive summary

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.

1. GENERAL BUSINESS

Presented by Jude Chin

1.1. Welcome and apologies for absence - Craig Black , Paul Molynuex & Helen Davies

To Note

Presented by Jude Chin

1.2. Declaration of interests for items on the agenda

To Assure

Presented by Jude Chin

1.3. Minutes of the previous meeting - 22nd March 2024

To Approve

Presented by Jude Chin

NHS
West Suffolk
NHS Foundation Trust

WEST SUFFOLK NHS FOUNDATION TRUST

DRAFT MINUTES OF THE
Open Board meeting

Held on Friday 22 March 2024, 09:15 – 13:30
At Mildenhall Hub, Mildenhall, IP28 7JX

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
Matt Keeling	Deputy Chief Operating Officer (deputising for NC)	MK
Dan Spooner	Deputy Chief Nurse	DS
Stephanie Rose	Programme Director, Provider Collaborative (shadowing NC)	SR
Lucy Winstanley	Head of Patient Safety and Compliance	LW
Karen Newbury	Director of Midwifery (item 4.4.1 only)	KN
Patricia Mills	Associate Medical Director for Patient Safety, Quality and Culture	PMi
Ruth Berry	FT Office Manager (minute taking)	RB
Apologies: Clement Mawoyo, Louisa Pepper, Nicola Cottington, Roger Petter		
Governors observing: Public Governors; Val Dutton, Jane Skinner, Clare Rose		

Staff Governors; Andy Morris, J-P Holt
Staff: Hannah Wray, Caroline Daly, Pippa Sharp, Amanda Keighley, Becky Fletcher
Members of the public: Will Matthews, Kaia Nichol

1.0 GENERAL BUSINESS		
1.1	**Welcome and apologies for absence**	**Action**
	The Trust Chair (JC) welcomed all to the meeting and apologies for absence, detailed above, were noted.	
1.2	**Declarations of interest**	
	There were no declarations of interest for items on the agenda.	
1.3	**Minutes of the previous meeting**	
	The minutes of the previous meeting on 26 January 2024 were accepted as a true and accurate reflection of the meeting.	
1.4	**Action Log and matters arising**	
	Open items **3030 – IQPR** Deferred discussions from Insight meeting in February, due to go to March meeting for metrics to be considered. **Action CLOSED.** **3031 – Patient and Staff story** End of life patient story to come to May meeting. **3059 – Patient story** Measurement of the longer-term outcomes from the stories presented at Board to include patients and staff attending the meetings in person. **3062 – Future System Board Report** Item on today's agenda – **Action CLOSED**	**SW**
1.5	**Questions from Governors and the public relating to items on the agenda**	
	Q. re staff survey Was the Workforce team too optimistic in its presentation to staff Trust wide, given the average scores? It was confirmed that the survey results had only just been published with highlights reported to staff at this stage. Once all the data has been considered, a more substantial report will be given. Q. re CEO report Reporting of the reduction of the 65-week waiting list was excellent work from clinical teams and admin colleagues.	

1.6	**Staff Story**	
	The Executive Chief Nurse (SW) and the WSFT Associate Medical Director for Patient Safety, Quality and Culture (PMi) presented to the Board in relation to the Patient Safety Incident Response Framework (PSIRF). The Trust were early adopters of the PSIRF and have been following it for 3 years, with the Emerging Incident Review (EIR) meetings stemming from this. The weekly meetings consider incidents reported via the Datix system, from the local medical examiner, incidents which meet certain criteria or, via the Patient Engagement team. Incidents follow the specific pathway decided on from the various investigation tool kits that categorise incidents, following which the most appropriate investigation route is decided and followed, where the Trust can look at what happened in all aspects and make changes, via a Quality Improvement Plan. This can include recommendations and immediate safety actions in order to avoid further similar incidents. Clinicians are involved at every stage of the process. Having the PSIRF and the EIR meetings helps to ensure the Trust has a rapid response to incidents. Following questions were raised: <u>How can we ensure the learning from rare incidents are not forgotten with turnover of staff etc?</u> It is a matter of continual learning. Processes are in place to imbed pathways already followed. <u>How are incidents tracked?</u> Tracking is via the Datix system which is the method for maintaining a record of incidents. There are areas for improvement and themes are linked to good governance. <u>How can we make a change in culture, moving away from blame, into learning?</u> The more people who go through the process, the more barriers will come down; it is about getting the learning right. We can change the narrative to wanting to learn from major or minor incidents. The EIR and processes are more inclusive and involve staff and system review. It reduces individual blame becoming the focus.	

	With the move into the new hospital, with single rooms, more tech being used etc., is it possible to move the learning into the Future System project? It was confirmed that there was no answer to this at present, with new learning for staff required. The team would need to be involved in the process. If there are incidents in the wider community, do staff know who to contact, if not the Outreach Team on site at WSH? The hospital has good links in primary care in terms of learning in the community. Everyone is invited to the review and the Trust is working with colleagues to develop an Integrated Care System (ICS) level EIR team to help with incidents that cross boundaries/pathways. Learning can then be shared on a wider platform. Is there something we can learn from the EIR processes to the complaints and patient experience, which is not as robust? Any new complaints that come via patient engagement that have potential incidents requiring review, will come to the EIR. Themes will then be collated and shared through the Involvement Committee.	
1.7	**CEO Report**	
	The Chief Executive Officer (EC) presented the report, which was taken as read, with the following highlighted; Waiting lists will be impacted again, with the upcoming industrial action planned by junior doctors. The staff survey results indicate an increase in harassment and abuse of black/minority staff by patients. Progress is being made on the Newmarket diagnostic centre, opening at the end of the year.	
2.0 STRATEGY		
2.1	**Strategic priorities update report**	
	The strategic priorities for 2024/25 were presented in the report. The following was highlighted; Consolidated from last year to 4 priorities. The final report will come to May's Board relating to the targets agreed for the next year. The virtual ward programme is now coming to community services and will continue to grow and form an integral part of the care offered by the Trust. Targets will increase for the next year, following on this year's success.	

	More is being done internally to increase awareness and to ensure the confidence of those consultants cautious at joining the Virtual Ward.	
2.2	**Future System Board Report**	
	The Executive Director of Resources (CB) presented the report, which was taken as read, with the following highlighted; An announcement on budgets for the new build are anticipated from the Treasury shortly. Progress is being made within the east of England, to ensure business cases being prepared are largely consistent. Senior representatives are meeting soon to push for acceleration of the programme for existing RAAC hospitals. Noted the scale of financial growth is large. Today's Board will undertake a discussion regarding the governance required.	
2.3	**West Suffolk Alliance and SNEE Integrated Care Board**	
	The West Suffolk Alliance Director (PW) presented to the Board. The paper was taken as read, with the following highlighted; Dementia care is seeking additional funding. The Howard Estate project is making good progress. A scheme is in operation to monitor the high blood pressure of patients not currently accessing primary care. Noted the discharge scheme has been approved, with key indicators/targets being monitored. Evaluation, in terms of finance, is also being monitored closely. Mental health care access for children in the region has increased, but long waiting lists remain.	
2.3.1	**Collaborative Oversight Group Report**	
	The Collaborative Oversight Group report was brought to Board by the Deputy Chief Operating Officer (MK) and the Programme Director for the Provider Collaborative (SR). The measure of success of this project has been the move from board-to-board meetings to the creation of an oversight group. The next action for the group will be to agree the work plan for 2024/25. The requirement for a Non-Executive Director (NED) in the oversight group was agreed. **Action: The Chair to consider who to be appointed to the role.**	**JC**

	The Terms of reference for Collaborative Oversight Group and Collaborative Executive Group were approved by the Board.	
2.4	**Digital Programme Report**	
	The Director of Resources (CB) presented the report to the Board. This was taken as read, with the following highlighted; The Trust is looking to renew its contract with Oracle Cerner, following the end of the current 10-year contract. This system encompasses e-Care and question raised as to whether there was a more agile service that could better meet the needs of the Trust. Noted there were some areas the Trust was looking to improve upon; local changes to a centralised system, particularly in respect of system updates. The Trust wanted an improvement in responsiveness and bespoke add-ons to improve the organisations use. Oracle Cerner are aware of these requirements. Noted Maternity and Critical Care have been brought into e-Care within the last year. Improvements in speed of inclusion of other areas on to e-Care, including community, have been highlighted.	
3.0 PEOPLE AND CULTURE		
3.1	**National Staff Survey results**	
	The Executive Director of Workforce (JO) presented the national survey results to the Board. Noted a small increase in participation of staff in the national survey, from 41% to 46%. The Trust was ranked second in the region for recommendation as a place to work. There were 9 key scores/indicators that results were presented under. The Trust was better than average in 7 of the 9 areas, but lower in 2; speaking up and support of line managers, part of the Trust's key strategic objectives. Scores achieved were lower than pre-pandemic and improvement remained a focus for the Trust. Feedback from staff working in community and NHP roles were the most positive across the Trust. Food at the Trust, (provided for staff), was the highest score nationally and this has been highlighted internally, following previous years' feedback. Those staff with a disability or a in a minority reported worsening experiences at work, from both patients and colleagues. This was of concern as the level of incidents being reported had increased in the last 12 months. Data is being analysed. There will be	

	bespoke responses to the areas that have been highlighted and consideration given to delivery of the outcomes/issues raised. Noted the Trust is to adopt the new NHS charter regarding sexual harassment. The Trust 'people and culture plan' model is to be renewed, through the Involvement Committee.	
3.2	**Involvement Committee report**	
	The report from the Committee's previous meeting was presented by one of the Non-Executive Directors (KY, on behalf of the meeting Chair). Noted focus on staff survey results with targets to be agreed. Learning from Schwartz Rounds is to be discussed, including encouragement of minority groups to attend. Query to be raised with the services using, whether the metrics were meaningful.	
4.0 ASSURANCE		
4.1	**Insight committee report**	
	The Chair of the Insight Committee (AJ) presented the report, with the following highlighted; For community paediatrics and children with neurological disorders, the scale of the backlog and non-recurrent funding was noted. Some progress has been made at System level. Capacity issues and the need to protect beds for recovery in terms of theatre utilisation was discussed. Agreed that more real time data was needed in these areas.	
4.1.1	**Urgent and Emergency Care Recovery**	
	The Deputy Chief Operating Officer, (MK) reported to the Board on the Urgent and Emergency Care Recovery; Noted the increase in performance improvement rate over the last two months has been significant. This is due to the large amount of work undertaken by the staff involved. NHSE planning guidance from January 2023 has focused on the mandate of early intervention of emergency care. Next year, there will be an increase in the mandate of 76%. Targeted actions and day to day management have helped the Trust meet performance objectives.	

	Daily attendances this month have regularly been over 300. The data is being looked at to ascertain reasons, as not obvious at this stage. This is challenging for staff and not sustainable in the long term.	
4.2	**Finance report**	
	The Director of Resources reported to the Board, with the following areas highlighted; The end of year delivery plan target is £6.3m. There has been improvement over the second half of the year, linked to the cost improvement plans in place. This has necessitated much work from finance staff in ensuring CIP delivery. Budgets for next year are on the agenda for Closed Board. National targets anticipated at the end of December have yet to be received. **The Board gave approval to the request for receipt of £4m in cash for the first quarter of 24/25.**	
4.3	**Improvement Committee Report**	
	Non-Executive Director, GOS, reported to the Board on the last committee meeting, with the following highlighted; Noted progression at Glemsford, following October's CQC rating. The recruitment of a Clinical Pharmacist remains outstanding. The discharge waiting area is now operating 24/7, with additional staff. A strategic oversight group has been established to look at discharge summary communication. An action plan is in place. Noted a presentation was undertaken at the last meeting regarding C.diff and actions being taken to mitigate a rise in the level of infections. **Action: Look at how the Trust can work with the Alliance, to provide oversight on areas at the WSFT primary care interface.**	**PW**
4.4	**Quality and nurse staffing report**	
	The Executive Chief Nurse, (SW) presented a report to the Board, which was taken as read with the following highlighted; • Noted a positive increase in nursing assistant retention. • CIP delivery will be met by year end. • Band 2/3 profiles are progressing.	

4.4.1	**Maternity services report**	
	The Director of Midwifery (KN) reported to the Board; Prenatal tool kit – the training update is not reflective overall, as the framework was brought in mid-year and some training remains outstanding. CQC results – discharge work completed and reflected in the results, which are positive. An internal survey has been undertaken, with over 400 respondents. This has been useful when looking at in conjunction with the CQC results. Retention of midwives has improved. Reported that where appropriate safeguarding required for those without a partner staying following the birth will be addressed and undertaken.	
5.0 GOVERNANCE		
5.1	**Board assurance framework**	
	The Trust Secretary (RJ) presented the framework to the Board; The Board Assurance Framework (BAF) now needs to be embedded within the Committees and Board. Noted a recent workshop undertaken on risk appetite, which included a review of current and future risk ratings. Noted the summary table depicted some risk appetite figures as high. These will be continuously reviewed. Q. In relation to the System and our BAF, what will they tolerate in terms of risk/appetite? Work is ongoing within the System in this regard. Q. What input into the current risk appetite is there from an executive lead? Further discussion is required at executive and Board level, including agenda and forward planning for the assurance committees. Collective planning is required to ensure meetings can run effectively and include deep dives.	
5.2	**Governance Report**	
	The Trust Secretary, (RJ) presented the report to Board. The following was noted; Terms of reference for all board assurance and audit committees. **APPROVED.**	

	Annual update on modern slavery statement, reflecting a refreshed statement. **APPROVED and ADOPTED.** Delegated authority for the Workplace Strategy to a 3i committee. **APPROVED.** April Board Development Workshop – agenda items to be prioritised to ensure sufficient time for discussion.	
6.0 OTHER ITEMS		
6.1	**Any Other Business**	
	Update on Audit Committee (19.4.24) provided by the Non-Executive Director Chair (MP) as follows; Procurement deep dive presented at meeting, including contract management Annual governance statement – additional detail required on financial challenge faced by the Trust. Minor changes made to the Standard Financial Instructions. Internal Audit Plan on track to give opinion for end of year. Forward planning for year ahead agreed at committee.	
6.2	**Reflections on meeting**	
	None noted.	
6.3	**Date of next meeting** 24 May 2024.	

1.4. Action log and matters arising

To Review

Presented by Jude Chin

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
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 (COMPLETE) Included in agenda report (COMPLETE) Previously scheduled for May but the ICB have asked that this is received at the July meeting to fit with their annual reporting schedule	PM/NC PW RJ	26/7/24 ~~24/05/2024~~	Green	
3075	Open	22/3/24	2.3.1	**Collaborative Oversight Group Report** - The requirement for a Non-Executive Director (NED) in the oversight group was agreed. Chair to consider who to be appointed to the role.	**Substantive appointment to be delayed until appointment of new non-executive directors currently being undertaken.**	JC	24/05/24	Green	
3076	Open	22/3/24	4.3	**Improvement Committee Report** - Look at how the Trust can work with the Alliance, to provide oversight on areas at the WSFT primary care interface.		PW/NC	26/07/24	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
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. **Agenda item**	LP/SW	24/05/2024	Complete	24/05/2024
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. Measurement of the longer-term outcomes from the stories presented at Board to include patients and staff attending the meetings in person. **Matter passed to Involvement for action and ongoing management.**	JMO/PM	22/03/24	Complete	24/05/2024

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

Presented by Jude Chin

1.6. Patient and Staff Story -

To Review

Presented by Susan Wilkinson

1.7. Chief Executive’s report

To inform

Presented by Ewen Cameron

BOARD OF DIRECTORS

CEO report – May 2024

Report title:	CEO report
Executive lead:	Dr Ewen Cameron, chief executive
Report prepared by:	Helen Davies, associate director of communications
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:	

Performance

Financial update

We begin this financial year in a difficult position, as we have agreed a planned deficit of £15.2 million by the end of the financial year 2024/25. This is larger than our final position for

2023/24 (£6.3m deficit), due largely to us receiving £15 million in non-recurrent support in 2023/24. To achieve the planned deficit, we must deliver a cost improvement programme of £16.5 million, which is 4% of our expenditure. This is broadly in line with other NHS organisations' cost improvement programmes. However, while it is significantly more than last year, it is worth noting that almost all the savings last year were delivered after the financial recovery plan started.

This year's CIP will focus on various areas, which include:

- improving productivity by identifying areas where services can be delivered more efficiently
- reducing temporary staffing costs
- procurement
- reviewing opportunities to use more cost effective drugs
- system-wide working with colleagues.

A key challenge that affects all trusts is that we must deliver all our activity, and meet our performance targets, with the same number of whole-time equivalent (WTE) staff as we had in 2023/24. This means we cannot grow our workforce beyond the size it was on 31 March 2024 during this financial year. This will be a challenge, but this has been imposed because trusts have grown their workforce by 20-25% over the last five years with only a single figure percentage increase in patients treated.

As we look at regaining our financial footing, we are working hard to ensure that whatever decisions we take have as minimal an impact as possible on the high quality and safe patient care we provide to our communities.

A diagnostic review, commissioned by the ICB and carried out by PA Consulting has been completed. The purpose of the review was to assess the drivers and causes of the Trust's financial position. The report and its recommendations have been reviewed by the Insight Committee and the Board. The findings of the report and its recommendations have been accepted fully by the Trust and work is underway to respond to the report with a strategic plan to address the issues raised. Once the plan has been approved by the Board and the ICB, it will be shared along with the process we will adopt to monitor progress.

Urgent and emergency care

There has been a huge amount of work around achieving the nationally mandated target of seeing 76% of patients in our emergency department within four hours by 31 March 2024. The efforts of colleagues are paying off as we have seen month-on-month improvements since December and in March we achieved 74%. This massive effort from our colleagues meant we were the sixth most improved Trust nationally between January and the end of March.

Elective recovery

Despite repeated rounds of industrial action, we continue to make progress in our elective recovery. At the end of March, there were:

- 407 patients waiting more than 65 weeks (this is compared to April 2023, when the cohort of patients who needed to be treated was 15,878). We are now working towards eliminating 65 weeks waits by the end of September
- 47 patients waiting more than 78 weeks, of which 37 were capacity related breaches
- 16,226 patients waiting more than 18 weeks for treatment.

We continue to work hard to get through our waiting lists and treat people as soon as possible.

Cancer performance

Data from March shows we were the highest performing NHS provider in the East of England in terms of 62-day Referral to Treatment performance targets, with 85.5% of patients having a confirmed cancer diagnosis and treatment being started within that timeframe. This is significantly above the national ambition of 70%.

As well as surpassing the target to diagnose and begin treatment sooner, I'm also pleased to say that the volume of patients waiting over 62 days on the cancer pathway has reduced from 189 in September 2023 to 68 at end of March 2024, ahead of our trajectory end of year position of 93. There has been particular focus on the skin cancer pathway, including holding weekend theatre lists to increase our capacity. The team has also initiated a 'straight to treatment' pathway to reduce face to face appointments and waiting times.

Our performance against the 28-day Faster Diagnosis Standard for cancer has increased from 54% in September 2023 to 76% in March 2024, which exceeds the national standard of 75% with a steady improvement across all tumour sites, with notable improvements around lower gastrointestinal, gynaecology and head and neck.

There have also been other notable improvements and developments in cancer services including:

- Development of new cancer frailty service
- Participation in Galleri blood test trial
- Reinvigorated cancer patient group
- Seven day a week palliative care service in place
- New Macmillan allied health professionals in place.

These improvements are hugely important to those affected by cancer. The quicker we can make a cancer diagnosis and start treatment the better the outcome for our patients.

I know a lot of hard work has gone into making these improvements to our services and it is due to the excellent engagement from all clinical leads, multi-disciplinary team leads, operational leads and the whole cancer team that this has been possible.

A huge congratulations and thanks to everyone caring for and supporting our patients who are dealing with this disease.

Achievement for hip fracture care

The latest data from the National Hip Fracture Database (NHFD) confirms West Suffolk Hospital (WSH) patients are receiving some of the best hip fracture care in England and Wales.

Not only is the Trust top in the country for meeting best practice criteria for patients treated for a hip fracture, but it also recorded its highest ever best practice score of 96.4% of patients meeting all eight criteria. This is compared to a national average of 50.1%.

100% scores were achieved for all patients receiving a perioperative medical assessment; as well as nutritional risk, falls and bone health assessments.

It is a huge multidisciplinary team effort to achieve this high standard in the NHFD metrics, and the best possible holistic care for our patients. Our hip fracture group includes champions from trauma orthopaedic surgeons, ortho-geriatricians, anaesthetists,

physiotherapy, occupational therapy, nursing teams (both specialist and ward staff), and our data management officer. There are other vital staff from further afield including the East of England Ambulance Service NHS Trust, as well as our emergency department, radiology, dietetics, and rehabilitation colleagues in the community, all of whom contribute to the success. It is a testament to the hard work and commitment of the whole team to achieve these results. Congratulations.

Delivering improving patient safety – launch of Call 4 Concern

As well as working hard to improve our performance and waiting times for patients, we are also deeply committed to improving the safety of the care we provide for patients.

At the beginning of the month we launched a new public-facing patient safety initiative called 'Call 4 Concern' at the West Suffolk Hospital.

Already in place in a number of NHS Trusts, Call 4 Concern (C4C) allows inpatients and their loved ones to call for immediate help from our critical care outreach team (CCOT) if they are worried about their condition deteriorating. Activated by the public through phoning our West Suffolk Hospital switchboard, C4C will trigger a bedside review from our CCOT who work alongside ward staff to ensure potential warning signs of deterioration are not missed and care and treatment is adjusted as necessary.

On the back of the communications launch for Call 4 Concern, we had a significant amount of media interest, which resulted in it being covered on local radio stations and on ITV Anglia. I'm aware that since the launch there have been a number of calls made, so it's clear that the process is working well.

Workforce

Celebrating Nurses' Day

On Friday, 10 May the Trust celebrated Nurses' Day, recognising and acknowledging everything our WSFT nurses do for our patients. Sunday, 12 May was International Nurses' Day, traditionally marked on the anniversary of the birth of Florence Nightingale, which this year had the theme 'Our Nurses. Our Future. The economic power of care'.

We held a number of events and activities to mark the day including 'best dressed clinical area' and 'The Great WSFT bake-off'. We also held a service in our West Suffolk Hospital chapel and in the Education Centre there were a range of activities such as a seminar led by our chief nurse, Sue Wilkinson, accompanied by Catherine Morgan, chief nurse for the East of England.

Introduction of new staff recognition scheme - STAR

The Trust has recently changed its incident reporting system from Datix to RADAR. As part of this our route for highlighting staff's efforts and good practice has also changed from Greatix to STAR, which stands for Special Thanks and Recognition.

The name for STAR was chosen on the back of a survey carried out earlier this year which sought staff views on what to rename Greatix.

STAR is a way to recognise colleagues, to say thank you, well done or to acknowledge new or outstanding practices. Anyone working in the Trust can submit a STAR and since it went live last month over 80 people have submitted a STAR to recognise the great work their colleagues are doing around the Trust.

One of these STARs has gone to new porter, Freddie, who has been recognised by his colleagues for his efforts at the Trust after only being here for a few weeks. Freddie received a STAR nomination for always being kind, and with a 'can do' approach. Freddie, who is 18 years old came from his home in Wellington, in New Zealand's North Island last December and is clearly already proving to be a great team member. Congratulations to Freddie and everyone else who has been recognised through our STAR system.

Future

Proposal to move some planned elective orthopaedic activity to the Essex and Suffolk Elective Orthopaedic Centre (ESEOC)

Over the last eighteen months, the Trust has been exploring plans to move some of our elective orthopaedic services from West Suffolk Hospital to a new, state of the art, dedicated centre in Colchester, called the Essex and Suffolk Elective Orthopaedic Centre (ESEOC), which will be housed in the Dame Clare Marx Building (DCMB).

The plan is to move approximately 55% (still to be confirmed) of our elective orthopaedic procedures. The table below outlines the volume of activity for each procedure we are planning on moving:

Procedures	Volume of activity to move to Colchester	Volume of activity to remain at West Suffolk Hospital
Hip	80% (232)	20% (58
Knee	80% (252)	20% (63)
Upper limb	50% (160)	50% (160)
Foot and ankle	25% (28)	75% (84)
Shoulders	40% (35)	60% (50)
Day case procedures (for example, arthroscopies, removal of metal work)	50% (750)	50% (750)
Total indicative throughput cases	55% (1,457)	45% (1,165)

This would equate to around 1,500 elective orthopaedic surgical procedures moving from West Suffolk Hospital to the ESEOC each year.

It is proposed that all remaining elective orthopaedic procedures, all orthopaedic trauma and paediatric orthopaedic surgery will remain at West Suffolk Hospital.

In March 2024, an extraordinary Suffolk and North East Essex Integrated Care Board (SNEE ICB) and WSFT Board meeting was held to discuss the proposal and the need to carry out public engagement regarding the possible movement of these services. The ICB unanimously approved the recommended approach to carry out public engagement.

The ICB and WSFT communications and engagement teams have been working closely on plans to carry out robust engagement with the public and patients, which involve gathering views on the plans and how people will be affected by the proposal, as well as any issues and concerns people may have. This public engagement exercise is being led by the ICB, with extensive WSFT involvement.

The public engagement period started on 20 May and will run until 20 June 2024, after which the data gathered will be analysed and then presented to the ICB for consideration.

Legs Matters event

On Tuesday 13 May we held one of our ‘Medicine for Members’ events. This time, it focused on ‘Legs Matters: preventing ulcers and venous disease.’ The event, which was held in the evening at the King Edward Memorial Hall in Newmarket featured a presentation from one of our consultant vascular surgeons, Manjit Gohel, who spoke about how to improve leg health.

We know that problems affecting the health of people’s legs is a significant issue – patients can be in huge amounts of pain and discomfort, and we know that ulcers can be difficult to resolve. Speaking about measures people can take to try to prevent ulcers and other conditions is a really important way to help people to stay as healthy as possible.

2. STRATEGY

2.1. Future System board report

To Assure

Presented by Ewen Cameron

Public Board Committee	
Report title:	Future System Board Report
Agenda item:	Future System Update
Date of the meeting:	24th May 2024
Sponsor/executive lead:	Craig Black
Report prepared by:	Ewen Cameron, CEO

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

Executive Summary
WHAT? *Summary of issue, including evaluation of the validity the data/information*
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 Systems 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: • The plan to conclude our strategic outline case and progress to an Outline Business Case. • The plan to engage potential construction partners. • Progress made towards confirming detailed designs; 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: • We will have converged upon an answer to "the right sized hospital" • Submitted our paper to Joint Investment Committee 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 trial 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. Solid progress against these goals has been achieved, specifically: • We have received written confirmation from NHP that our SOC does not need to be re-visited and that we will commence with an Outline Business Case via. a baselining exercise.

- NHP have also agreed with our proposal for early contractor engagement and have established a working group to construct to the appropriate contracting framework.
- Our clinical colleagues have been communicating the design outcomes from our NHP review process and the resultant RIBA2 1:500 designs are on track to be completed by the end of May.
- Following significant work with our local clinical colleagues and experts from the East Anglian Air Ambulance team and local planners, it has been decided that the Helipad will remain in its current location.
- The digital data centre will be located in the vicinity of the Education Centre in order to optimise the provision of essential power and communications infrastructure.
- The IT services hub is likely to be provided adjacent to Quince House.
- The new temporary construction access road, connecting our current site to Hardwick Manor, allowing the closure of the Sharp Road entrance, is nearing completion. Anyone using Car Park D can now view the Manor's walled garden through the aperture created by the new road.
- Having navigated HM Treasury's approval process, the Trust expects formal communication of the outcome the Programme Business Case[1] by the end of the month.
- Phase 1 of our buffer planting has been completed on-time.
- Archaeological trial trenching has been completed without material discovery and without any future risk to our programme.

3.2

Project Plan

Task Name	Duration	Start	Finish
"Right Sizing" Hospital	83 days?	Fri 02/02/24	Tue 28/05/24
RIBA Stage 2 Design	191 days	Fri 02/02/24	Fri 25/10/24
Main Contractor Procurement (First Stage of Two Stage Process)	130 days	Mon 03/06/24	Fri 29/11/24
RIBA Stage 3 Technical Design	145 days	Mon 16/09/24	Fri 18/04/25
Reserved Matters Planning Approval & Planning Conditions	80 days	Mon 21/04/25	Fri 08/08/25
Outline Business Case (OBC) - Based on RIBA Stage 3	185 days	Mon 16/09/24	Fri 13/06/25
OBC Approval (ICB / NHP / NHSE / Treasury)	120 days	Mon 16/06/25	Fri 28/11/25
RIBA Stage 4 Design (Contractor Led)	190 days	Mon 21/04/25	Fri 23/01/26
Guaranteed Maximum Price (GMP)	180 days	Mon 20/10/25	Fri 10/07/26
Full Business Case	150 days	Mon 01/12/25	Fri 10/07/26
FBC Approval (ICB / NHSE / NHP / Treasury)	105 days	Mon 13/07/26	Fri 04/12/26

The outline project plan remains on track with the following updates:

- Having agreed the "right sized hospital", the Trust have now had formal confirmation that our next step is to construct what is described as "an OBC Baseline". This report is the means through which we will communicate and conclude all of the changes to our preferred way forward that have resulted in the review process undertaken since we submitted our strategic outline case. A template for this work is expected by the end of May and will be completed as part of our OBC process.
- The first step of the RIBA2 design process has been to ensure our staff understand and have the opportunity to co-produce the design changes that have resulted from the review process. To this end several workshops have been held and we will be in a position to conclude the co-ordinated[2]

[1] Programme Business Case – this is the overarching case for the entire new hospital programme (i.e., "the 40 hospitals"). Approval of the case will provide schemes with a reliable indication of capital budget and agreement of the timing of their respective business cases (which in turn will allow the projection of a build date).
[2] Previous design stages have allowed us to design departments, RIBA 2 begins to co-ordinate these designs within the structure of the new building.

	1:500 designs by the end of May. This work will flow seamlessly into the creation of co-ordinated departmental layouts down to the 1:200 level which we plan to complete by October – ready to inform RIBA3 designs and our OBC. • Following several discussions with potential construction partners, it is clear that the best method of avoiding costly re-work is to engage them in the design process at the earliest possible opportunity. To this end we have now agreed with NHP that we will seek to appoint a construction partner to work alongside our architects during the RIBA3 process. Colleagues at NHP must make sure that such "pre-construction service agreements" do not undermine future construction frameworks. Consequently, a small working group has been established to construct the appropriate agreements in a way that they can be safely used by all "40" hospitals. • The concept of "designing once and applying to all" is obviously central to the programmatic approach of NHP and the end of May will bring with it the highly anticipated launch of two key resources; the first is release of a letter to Trust CEO's detailing the capital budget (revised following the agreement of the programme business case) and the expected milestones for each project and the second is the "drop" of Hospital 2.0 designs and templates that will provide details on key aspects of the new hospitals. These resources are essential to the successful progression of schemes to the development of their respective business cases.
3.3	**Progress on Site** As well as finalising archaeology, phase 1 of the buffer planting and the new temporary construction access road, the team have been working with partners from across our Trust and System to conclude designs and locations for three critical elements of our infrastructure: Helipad – given the frequency of flights and the restrictions created by noise, downdraught etc. It has been agreed that the Helipad will remain on Hardwick Heath (moved slightly to avoid rights of way issue) with transfer to the new emergency department via dedicated electric ambulance. Data Centre – as we increase our adoption of digital services, so the need for secure and optimally connected space for servers and communication equipment becomes essential. With this in mind a dedicated building is being planned in the vicinity of the Education Centre which will allow access to site transformers and cabling. IT Data Hub – rather than include expensive "medical grade" space within the new hospital, an IT Data hub is planned for the site to the left of Quince House. This building will be used to locate essential on-site IT resources and is being planned in conjunction with the overall Workplace Strategy that will optimise space and flexible working for non-clinical staff.
3.4	**Finance** Our project has three primary budgets: • **Team budget** – this covers the costs of the direct future system team. Spending remains in line with budget and funding has been confirmed for 24/25. • **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 funding for the development of our OBC throughout 24/25 has been confirmed. • **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 funding covers our named projects (buffer planting, access road etc.) throughout 24/25.

	Outside of budget management, the discussion concerning ongoing “revenue affordability” has been escalated to both NHP and NHS Director of Finance. A paper highlighting the impact that building a new hospital will have upon Trust and ICB operational finances has been submitted to NHS Director of finance and we will continue to track progress via our programme board and a specialist panel comprising representatives from NHSE, Trust, ICB and ESNFT.
4.	**Next steps**
4.1	By the time of our next meeting: • We will have received our NHP letter confirming capital budget and project milestones. • We will have received the latest H2.0 design drop – including the template for our OBC baseline paper. • We will have agreed the contractual means through which to engage a construction partner. • We will be significantly advanced in a re-run of the demand and capacity modelling exercise (applying the latest innovations made to the central model). • We will have a complete set of RIBA2 co-ordinated 1:500 designs. • The new access road will be complete.
5.	**Conclusion**
5.1	The building of a new West Suffolk Hospital remains a priority within the New Hospital Programme.
5.2	The Trust will soon have confirmation of its capital budget and will commence the writing of an OBC baseline report whilst progressing the development of increasingly detailed drawings. 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.

Comfort Break

2.2. System Update

To Assure

West Suffolk Alliance Update including Committee meetings of 17 April and 15 May.

1. Transport collaboration Suffolk County Council

- Suffolk County Council Local Transport Authority attended the committee and described their statutory role including supporting 40 routes across Suffolk through 26 contracts.
- BS/P2 Funding has been granted at £1.8m/year for 23/24 and 24/25 with requests to parishes, operators for ideas on services. Variation has been funded which adds WSFT to three routes in addition to evening and Sunday services to Sudbury and Haverhill. NHS developed scheme not funded but is being taken forward as a separate project and presented to the Department for Transport (DfT).

Next steps:

- WSFT to promote bus routes to patients and staff attending WSFT routinely (e.g. outpatient letters)
- Conversations in Localities on key issues

2. Health Inequalities

The Committee agreed a proposal for use of SNEE ICB Health inequality funds in West Suffolk including:

- Support for people with hypertension and AF to optimise their health outcomes
- Work with Cancer programmes to support targeting work on screening and early diagnosis
- Targeting populations where data shows greatest opportunity, including the 15 local populations showing higher relative social challenges

3. Physical health commissioning (April)

Committee agreed a Strategic Partnership approach to review all partner funding and current pathway design for physical activity to optimise plans and use. To include and develop a standard approach to evaluation linking to the healthy behaviours offer. This includes opportunities for working with Sport England.

4. Approach to partnership at locality level

Committee agreed its strategic approach to working in partnership at locality level: Haverhill, Newmarket, Mildenhall & Brandon, Bury St Edmunds, Bury Rural and Sudbury. Committee noted locality working is progressing well in Haverhill.

5. Primary Care Medical Strategy 2024-29

The Committee discussed and supported the SNEE ICB primary care strategy which has been co-produced with local professionals and patient groups. It describes the challenges and goals for 8 aspects of primary care.

The Alliance can play a key role including joint approaches with regards to estates, workforce, using digital technology and working better together at the interface of primary care and other services.

1) Workforce

2) Estates

3) Access with Capacity

4) Resilience

5) Working Better Together

6) Clinical Safety and Safe Working Practices

7) Contracts and Investment

8) Using Digital Technology

6. Planning for 2024/25

Partner views

Partners discussed their priorities and ambitions for 2024/25. The discussion noted the serious pressures being faced in terms of demand, capacity, and finance. The discussion noted the importance of being open and realistic in this context as well as the aspirations for improvement through partnership.

SNEE Joint Forward Plan (JFP)

ICB analysts identified the key areas where data on West Suffolk population shows improvement or concern with regards to JFP targets. The Committee noted the Alliance Delivery Plan covers the majority of these areas but notes the need for more work to clarify plans for children's asthma admissions and children's obesity levels at year six.

Alliance Delivery Plan 2024/25

The group received and approved the Alliance Delivery plan which has been developed in co-consultation and agreed – for review in November 2024

7. Diabetes Review

An ICS-wide review has been completed for diabetes. It identifies the strengths and key challenges being faced and considers options for the future. It recommends option (3) - a *common ICS service specification focused on outcomes but commissioned locally for each Alliance.*

The Committee supported the review and this option and noted the importance of funded dedicated time for specialist clinical leaders to achieve the integrated model envisaged.

The strategy is due to be decided formally at the SNEE ICB Board in July.

8. Other Alliance Business

- **Minor surgery contract extension** – 2-year extension agreed to existing contract with Swan Surgery
- **Sustainability Impact Assessment** received and supported
- **Feel Good Suffolk -** performance report received

West Suffolk Alliance Delivery Plan 24/25

Improving Health & Care Through Partnership

April 2024

Context

West Suffolk Alliance

What is the Alliance?

A "place based" system of care defined by the local footprint of health and care partners, as well as natural geography. The partners work together for a common purpose to provide the focus for planning and delivering integrated care for the population.

What does the Alliance do?

- Work with people and partners to understand the wellbeing, social and healthcare needs of the local population and develop outcomes and solutions together
- Work collectively to identify improvements to individual services
- Deliver joined up (integrated) health and care
- Ensure continuous improvement and innovation in the quality and delivery of services
- A monthly Alliance Committee is held to provide the governance and all alliance partners are invited to be the voice of the respective organisations and partners.

Who is in the Alliance

NHS & Council Statutory Bodies

- Suffolk and Northeast Essex ICB
- West Suffolk NHS Foundation Trust
- Norfolk and Suffolk NHS Foundation Trust
- Suffolk County Council
- West Suffolk District Council
- Babergh and Mid Suffolk District Councils

Service Providers

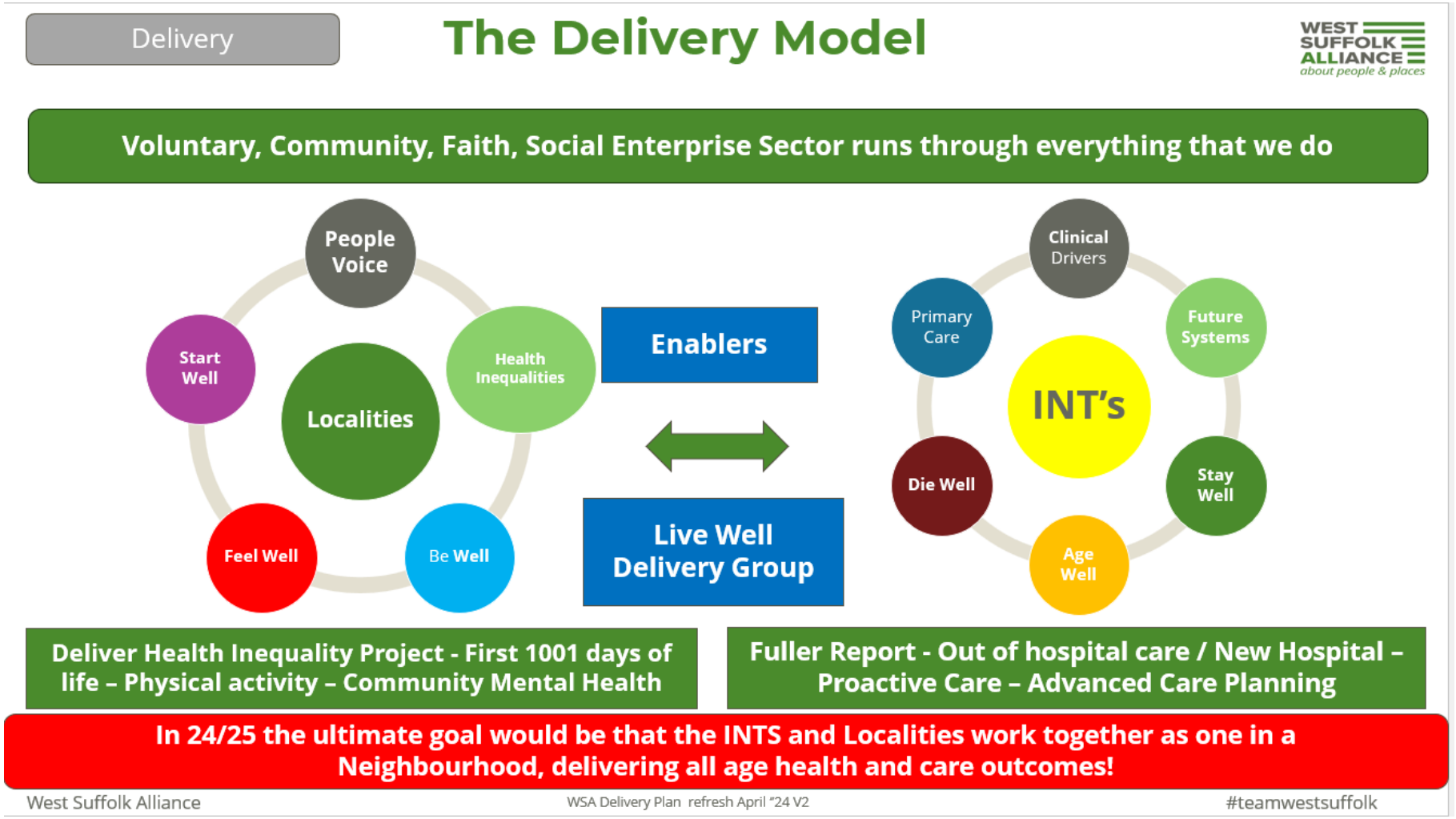
- GP teams and Primary Care Networks
- Dentists, pharmacists & optometrists
- Department for Work & Pensions
- St. Nicholas Hospice Care
- Care Market
- Allied Health Professionals CIC
- West Suffolk College
- Abbeycroft Leisure

Voluntary Community Faith and Social Enterprise

- Community Action Suffolk
- Healthwatch Suffolk
- Active Suffolk
- Suffolk Libraries
- Multiple local & national VCFSE Partners
- Home Start
- Reach Haverhill

Delivery

The Delivery Model



INT – integrated neighbourhood team

Delivery

West Suffolk Alliance Delivery Plan Summary

WSA Vision: "For everyone at all stages of their life to be able to Live Well across West Suffolk."

	JFP Objectives	Wider system Focus	Alliance Priority	By When	Leadership
Start Well	• **Increase the number of pregnant women supported by Midwifery Continuity of Carer within targeted communities** • **No child or young person waits more than 12 weeks for CAMHS or 18 weeks for neurodevelopmental diagnostic services** • **Reduce hospital admission rate due to asthma**	1. Preconception, Maternity and Neonatal Care 2. Children and Young People including CAMHS, Neuro Developmental, SEND, 3. Community 4. Long Term Conditions	**First 1001 days of life:** 1. 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. 2. To provide a multi-agency support programme for parents at risk of babies becoming LAC at birth, to reduce the likelihood of recurrent pregnancies and removals and associated poor outcomes. 3. To map the support offer to new parents and establish how further work with VCFSE can be embedded to reduce isolation, postnatal mental health difficulties and promote healthy attachments with children.	• Commence service 01/10/24 • Scoping underway • Scoping underway	**Strategic Nic Smith-Howell** Associate Director of Integrated Community Paediatric Services **Change Coordinator Helen Bowles** Maternity & Neonatal Programme Manager SNEE ICB
Feel Well	• **Achieve 5% year on year increase in adults supported by community MH** • **Year on year reduction in hospital admission rates** • **90% SMI Health Checks by 2028** • **85% of people on the learning disability register to have an annual health check**	1. Mental Health and Wellbeing 2. Suicide Prevention 3. Addictions 4. Trauma and Abuse	• **Haverhill Community Integration –** Integrated Community Model including PCN MH Practitioners, new MH Recovery Teams, Integrated Neighbourhood Teams & NEE Neighbourhood Teams • Increase access to **SMI physical health checks**, meaning that by 2028/29 over 90% of people with an SMI have received an annual check • Deliver dementia action plan and **achieve Dementia diagnosis target of 67%** • Provide dedicated support to people waiting for an **ASD/ADHD assessment and diagnosis**	• March 2025	**Peter Henson** Service Director Suffolk Care Group, NSFT **Hannah May** Transformation Lead
Be Well	• **Halt increase in overweight and obese children** • **Reduce number of smokers to 5%** • **Year on year increase of NHS dental activity delivered**	1. Healthy Behaviours 2. Personalised Care 3. Women's Health 4. Dental / Oral Health 5. Eye Health	**Physical Activity:** • Establish a universal offer for physical activity and secure good and equitable **uptake** • **Increase the impact of the WSFT exercise referral pathways with Abbeycroft Leisure by 25%** • **Establish a strategic partnership approach to funding for physical activity providers to improve value for money and evaluation** **Overarching measure:** • **Percentage of physically inactive adults reduces from 19% to 17%**	• March 2025	**Ian Gallin** Chief Executive West Suffolk Council **Kathy Nixon** Deputy Chief Executive Babergh and Mid Suffolk District Councils

Delivery

West Suffolk Alliance Delivery Plan Summary

WSA Vision: "For everyone at all stages of their life to be able to Live Well across West Suffolk."

	JFP Objectives	Wider System Focus	Alliance Priority	By When	Leadership
Age Well	• **Reduce rate of emergency hospital admission due to falls** • **Achieve 66.7% dementia diagnosis rate**	• **Healthier life for longer in preferred place of residence** • **Avoid unnecessary hospital admissions** • **An active ageing population** • **Joined up mental and physical health** • **More carers identified**	**Proactive Care** • Training of INT / Locality teams to recognise Frailty at an earlier stage • Frailty Toolkit being delivered across the system to inform where the person should be signposted to • Social Prescribers actively working with and recording outcomes of people to prevent deterioration and reduce risk of admission. **Falls Service** • Implementation of Suffolk wide Level 1 Falls service – linked to onward referral to INTs/EIT and preventative services.	**March 2025**	**Clement Mawoyo** Director of Integrated Adult Health and Social Care **Michelle Glass / Lucy Webb** Senior Transformation Lead
Stay Well	• **Increase GP teams to meet demand** • **No one to wait more than 15 months for elective care** • **Increase UCR delivery by 10% each year** • **78% 4 hour wait in A & E** • **Reduce hospital bed days without criteria to reside** • **Increase cancer diagnosed at stage ½** • **80% of people with high blood pressure identified and treated** • **85% AF identified and 90% of high stroke risk treated**	• **Elective care and diagnostics** • **Urgent and emergency care including community** • **Cancer** • **Respiratory** • **Cardiovascular disease** • **Stroke services** • **ME and CFS** • **Neurological rehabilitation** • **Learning disabilities & Autism** • **Diabetes** • **Virtual Ward 80% bed occupancy**	**Future System Transformation Programme** • Programme/implementation of Clinical Care Strategy: • Virtual Ward – supporting the reduction of acute beds, moving to Virtual beds as supported early discharge or step up from community. 24/25 Focus on roll out of further pathways and community step up. • Outpatients – maximise virtual clinical appointments and increase provision at peripheral clinics. • UEC – Target Operating Model for 'Emergency Village'. Develop implementation plan for Emergency Village Model of Care. • UCR – Development of Hub and Spoke model for UCR service, to reduce unnecessary admission and promote population health.	**March 2025**	**Nicola Cottington** Chief Operating Officer West Suffolk NHS Foundation Trust **Renu Mandal / Lucy Webb** Senior Transformation Lead
Die Well	• **Increase % of people being identified as being at End of Life**	• **Co-ordinated 24/7 care** • **Personalised Plans** • **Compassionate Communities**	**Advanced care planning** • Increased number of residents in care homes having advanced care plan discussions being offered and documented. • Social Finance implementation to increase people being identified • Training for advance care planning, particularly for care home staff		**Susan Wilkinson** Chief Nurse West Suffolk NHS Foundation Trust **Michelle Glass** Senior Transformation Lead

Delivery

West Suffolk Alliance Delivery Plan Summary - Enablers

WSA Vision: "For everyone at all stages of their life to be able to Live Well across West Suffolk."

	JFP Objectives	Wider System Focus	Alliance Priority	By When	Sponsor
Workforce	• **Work with the Integrated Care Academy to lead new ways of working** • **Enable collaboration with VCFSE** • **New models of delivering care** • **Embed a culture of training and progressive development in roles** • **Develop and deliver a system orientated career and leadership pathway** • **Increase use of apprenticeships** • **Work with education to develop training and placement opportunities to address gaps**	**Support organisations to build workforces that enable them to effectively serve populations by taking a system approach to** • Implement an Education and Training Digital Passport • Improve Equity to International Recruitment Opportunities for Alliance Stakeholders	**Focus on supply/recruitment in 24/25** • Develop a young people's network to support engagement with the future workforce • Determine how to proceed with future recruitment processes for young people that meets their needs	• March 2025	**Ewen Cameron** Chief Executive West Suffolk Foundation Trust
Digital & data	• **Leading system-wide action on data and digital: working with partners across the NHS and with local authorities to put in place smart digital and data foundations to connect health and care services to put people at the centre of their care** • **Using joined-up data and digital capabilities to understand local priorities, track delivery of plans, monitor and address unwarranted variation and health inequalities and drive continuous improvement in performance and outcomes**	**1. implement a Strategic Delivery Plan** 2. **implement systemwide delivery models,** e.g. shared care records and personalised care planning 3. **build our multi-disciplinary approach** to safe practice 4. by embracing a culture of **continuous learning** 5. develop a common **digital front door** for our people 6. enable an approach to **digital care technologies and remote care** 7. enable a **linked data set platform** that will provide data insights for a range of purposes 8. form and operationalise **provider collaboratives, and integrated care**	**Integrated digital systems within the INT / Locality space** Investigate the options to improve the co-ordination of care between teams within the Integrated Neighbourhood Teams (INTs) using digital solutions. Investigate the opportunity to improve communication across partners and provide a shared service directory and referral platform. **Supporting key themes:** • A reduction in health inequalities • Decreased digital exclusion • An increased ability to promote healthy behaviours. • Empowering people to engage with community/home-based care models.	• March 2025	**Craig Black** Executive Director of Resources West Suffolk Foundation Trust **Nicola Chalk** Change Coordinator
Estates	• **Optimise estates for integration with partners** • **Rationalised and prioritised capital pipeline** • **A single system delivery plan** • **Wider sharing of estate across the system** • **Reduce backlog maintenance** • **Improved efficiency and effectiveness of estates to support clinical delivery** • **Services in the right place to meet demand** • **Disposal of redundant estate**	**Create and manage one public estate that is driven by service needs; run and planned as one system** • Optimise use of existing estate • New Hospital Programme • Plan for population growth	**Multidisciplinary approach to optimisation of building assets.** • Agree re-occupation of Haverhill HC • Agree multi-partner occupation agreement • Understand current usage of Sudbury Health Centre across all partners • Co-locate and integrate services: Taking on board learning from re-occupation of Haverhill Health Centre, consolidate and optimise service locations within the health centre implementing co-location opportunities wherever possible and appropriate to support integration.	• March 2025	**Peter Wightman** West Suffolk Alliance Director

Delivery

West Suffolk Alliance Delivery Plan Summary - Enablers

WSA Vision: "For everyone at all stages of their life to be able to Live Well across West Suffolk."

	JFP Objectives	Wider System Focus	Alliance Priority	By When	Sponsor

Localities 	• **Ensure communities have an active role in decision making and governance**
	• **Understand the communities needs**
	• **Build relationships based on trust**
	• **Work with system VCFSE partners**
	• **Provide clear public information**
	• **Use community centred approaches that empower people**
	• **Use co-production to tackle priorities**
	• **Learn from what works and build on community assets**
		Enable coordination at a locality level
		• Empower localities to have a locally owned shared purpose and plan to live healthy, connected lives
			• **To improve communication, relationships and trust across staff within West Suffolk Alliance to facilitate successful community connections and healthy living**
			  • We will work with our localities to evolve the distributed leadership partnership to include key stakeholders and sectors around the table either within the knitters, champions and voice
			  • We will develop individuals within asset-based community development/One Team training to empower them to be accountable for the local priorities collectively identified
			  • We will align language and branding to develop a system wide understanding
				• Novembe r 2023	**Mark Shorter** Head of Alliance Development
					
					Sarah Hedges Integrated Transformation Lead

INT's 	• **Fewer people need unplanned care and support in crisis**
	• **Greater numbers have access to care and supported by activity outside of statutory services**
	• **Resources in the delivery of community-based health and care are used more efficiently**
	• **Ongoing costs of supporting people reduce as people's independence is increased**
		• **Focus on personalisation**
		• **Increase co-production**
		• **Digital tools to increase independence**
		• **Embedding equality, diversity and inclusion throughout the system**
		• **Improved support for more vulnerable and complex people**
		• **Prevention via integrated services**
		• **Measuring and communicating quality outcomes**
		• **Work at a locality level supported by PHM**
		• **Continue learning disabilities, Autism and Mental health transformation through partnership and collaboratives**
			• **Haverhill – Severely Frail Project**
			  • To explore the art of the possible with integrated system partners working in the Haverhill area to improve the outcomes of the severely frail
			  • To deep dive with Population Health Management Data to understand the needs of the patients
			  • To understand the current offer available to the population across the teams in the system
			  • To deliver an intervention that is sustainable and interoperable that can be widened into other localities
				• March 2025	**Clement Mawoyo**
					
					Kevin McGinness

Delivery

Primary Care Priorities in West Suffolk

Priority	Actions	Milestones
Finalise Primary Care Strategy	Develop action plan	1.4.24
Primary Care Primary Care Networks	Enhanced Access – ensure 100% of required slots are provided and utilised Additional roles reimbursement – ensure full utilisation of budget to support population need and work with Training Hub to maximise development and training opportunities Monitor capacity and access to ensure improvement, particularly around patient experience	Monthly returns from PCNs. Monthly validation and sign-off Quarterly F2F monitoring meetings
Further join-up PCN and INT Teams	Work with Clinical Directors and wider practice teams to develop INT relationships Utilisation of clinical shutdown to progress relationships Map inequalities utilising PHM to existing service provision/PC activity and review resources to meet those needs	Ongoing 2024 shutdown schedule Ongoing
Modernise General Practice	Support all Practices to move to digital telephony Introduction of online consultations; particularly where access and patient experience is below national average Consistent approach to care navigation, including signposting to Pharmacy First	10 Practices in Phase 1 7/25 Practices have a fully digital model Development of a local offer
Quality and Resilience	Continue to support practices with CQC to remain in a 'good' status Deep dive into minor surgery at practice level (currently delivered under a DES) to ensure SOP etc. in place Primary Care Assurance Framework and supporting data – includes many ICB functions to ascertain risks at practice level	One Practice currently in RI Estimated start date 1.4.24 Bi-monthly meetings
Implement national Improving Access Plan	Reduce time spent liaising with hospital, improving PC interface. National target implementation of electronic fit notes, in testing phase at WSFT Support Level Frameworks completed for each practice and encourage uptake of the General Practice Improvement Programme Empowering patients by increasing self-referral pathways, looking specifically at vasectomy pathway in west Suffolk Enable over 90% of practices to see their records and practice messages, book appts and order repeat prescriptions. Ongoing T&F group working with Alliance Partners to increase uptake. Facilitate better uptake of Pharmacy First: ICB-funded initiative to improve relationships between practices and their local community pharmacists.	20.6.24 collaboration forum 12/25 enrolled or completed GPIP 4/7 National PWs up and running 100% practice compliance and 53% of patient's utilisation Ongoing

3. PEOPLE AND CULTURE

3.1. Involvement Committee report - no meeting

To Assure

3.1.1. People and OD highlight report, including FTSU report

To Assure

Presented by Jeremy Over

Board of Directors

Report title:	**People & OD highlight report**
Agenda item:	
Date of the meeting:	Friday 24 May 2024
Sponsor/executive lead:	Jeremy Over, executive director of workforce & communications
Report prepared by:	Members of the workforce and communications directorate Freedom to Speak Up Guardian

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

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

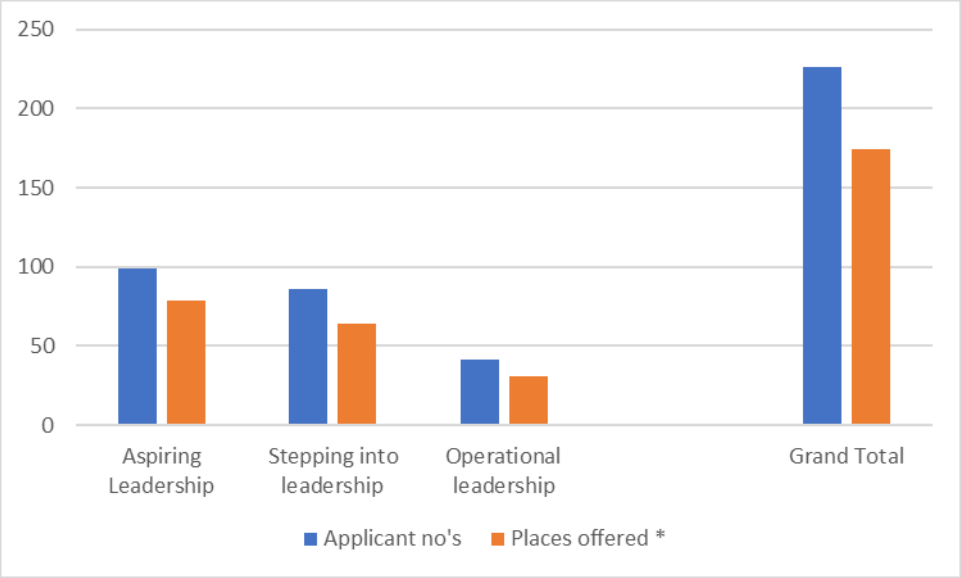
Previously considered by:	N/A
Risk and assurance:	Research demonstrates that staff that feel more supported will provide better, higher quality and safer care for our patients.
Equality, diversity and inclusion:	A core purpose of our ‘First for Staff’ strategic priority is to build a culture of inclusion.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

People and OD highlight report

1.	**Introduction**
1.1	This People & OD highlight report is shared with the Board to focus on key, current national and local workforce issues and to inform the Board's focus on how we support our people, grow our culture and develop leadership at all levels. This is particularly the case this month as the Involvement Committee did not meet in the cycle since the previous meeting of the Board. In addition to discussing the content of the report, and related issues, continued feedback is welcomed as to the structure and content of this report and how it might be developed in future. This month the report provides updates on the following areas of focus: • Putting You First awards (April/May) • Freedom to Speak Up Guardian Report Q4 2023/24 • Developing our people and culture priorities for 2024/25, incorporating the workforce team's contribution to our focus on financial sustainability • Improving the working lives of doctors in training • NHS sexual safety charter • Leadership Development Update • Statutory and Mandatory Training We routinely measure the impact of our approach through a set of workforce key performance indicators, which are included within the integrated performance report and also monitored through the Involvement Committee.
2.	**Putting You First Awards (April/ May)**
2.1	**Martin Webster, biomedical scientist, transfusion lab** *Nominated by Claire Couch* Martin was incredibly helpful when the Eastern Organ Donation Team needed assistance to access a patient's pre transfusion blood group result to enable organ donation to proceed in another Eastern Hospital. Martin's help meant that organ donation was able to proceed as part of an individual's end of life care, and 5 people received a life-saving organ transplant as a result - an incredible outcome and a great example of multi-agency team working.
2.2	**Nicky Faulkner, community diabetes nurse specialist** *Nominated by Sandra Webb* Nicky has developed a new role in the community as a diabetes nurse specialist, initiating new ways of working, reviewing all community nursing caseload diabetic patients, training community nurses and working with Primary care and Residential Care Homes. In just less than a year she has developed excellent working relationships, redefined patient processes and ensured patients are receiving good quality, evidenced based treatment and care, including screening. Individually Nicky has improved patient outcomes, released capacity within the community teams and supported staff development.
2.3	**Marilla Soper, cleanliness auditor (WSH and Newmarket), estates and facilities** *Nominated by Kerry Robinson* Milly's role is crucial as it directly impacts the wellbeing of our patients, colleagues, and visitors by ensuring a safe and clean environment. Since joining us from the housekeeping department, Milly has singlehandedly taken on the responsibility of ensuring that all cleanliness audits across both sites are conducted to the highest standard. She approaches her responsibilities with diligence, precision, and a genuine passion for maintaining the highest standards of hygiene and safety within our hospitals. Milly is caring and approachable and has been instrumental in supporting colleagues understanding of the cleanliness audits in line with the new standards implemented in 2021.

	In the often-demanding environment of cleanliness audits, Milly's ability to maintain her composure and take such responses in her stride is truly commendable. She approaches each situation with a positive attitude, seeking to understand concerns and address them with empathy and professionalism. Milly's capacity to navigate challenging situations while upholding the highest standards of professionalism reflects her commitment to ensuring the well-being of our patients, colleagues, and visitors. Her ability to maintain a positive attitude and remain focused on the task at hand, is a testament to her exceptional character and dedication to her role.
3.	**Freedom to Speak Up Guardian report – Q4 2023/24**
	Jane Sharland, Freedom to Speak Up Guardian will present her Q4 report at the Board meeting on 24 May, which is included as appendix 1 to this item. The Board will wish to reflect carefully on the themes in the report that are particularly pertinent for our leadership role, that we have already identified as priorities for us. This includes the following identified themes: • Lack of, or poor communication; in particular the communication of major changes to large groups of staff. • Difficulties in relationships between staff and incivility • Estates and facilities concerns, involving toilets and environmental controls • 8 (18% of the total) concerns pertained to issues related to patient safety The full detail, including further context and action, is included in the appendix.
4.	**Developing our people and culture plan for 2024/25**
	Having a single People and Culture plan for last year helped to set clear priorities and drive relevant action to improve our people services and organisational culture. The delivery of this plan was monitored throughout the year by the Involvement Committee and through the performance review process for the Workforce & OD directorate. Appendix 2 to this report represents a new, draft people and culture plan for 2024/25 that has been developed to join-up the work we want to do to deliver our strategic 'first for staff' ambition with the priorities identified by staff through various feedback mechanisms. The plan also incorporates actions in relation to the workforce team's contribution to the financial recovery and sustainability challenge facing WSFT, including the response to the recommendations of the PA Consulting report. These actions will be led by the workforce team and will require the engagement and support of the Board and leaders and managers at all levels of the organisation. The plan will be shared over the next few weeks by way of engagement with key stakeholders, ahead of approval at the Involvement Committee in June. Board members are asked to scrutinise and comment on the draft, and endorse the approach outlined.
5.	**Improving the working lives of doctors in training**
	Late April 2024 all NHS Trusts received formal communication from NHS England directing the requirements of all providers to 'improve the working lives of doctors in training'; this is a key strategic priority, as made clear in the NHS Long Term Workforce Plan, and again in the NHS Priorities and Operational Planning Guidance for 2024/25. WSFT is already committed to improve the working lives of our entire workforce, including doctors in training, however it is evident there are some national priorities for improvement. The actions outlined are specifically aimed at addressing concerns of doctors in training and those who rotate. Rotations mean that doctors in training can experience low levels of choice and flexibility of when and where they work, high levels of uncertainty and competition about next steps on the training pathway and duplicative inductions and unacceptable pay errors as they move between employers. As well as frustration and lost productivity, this can result in a reduced sense of belonging, making it harder to retain our future workforce.

	Our priorities as part of the delivery of this place include: • Increase choice and flexibility from better rota management and deployment, this includes providing work schedules at least 8 weeks in advance and finalising duty rosters 6 weeks in advance; monitoring of compliance will be reinstated by NHS England • Reduce duplicative inductions and pay errors and streamline and improve HR support by paying specific attention to payroll accuracy and handling queries quickly; a board governance framework is to be implemented for monitoring and reporting payroll errors by the end of July 2024 • Create a sense of value and belonging to our doctors; employers are asked to protect training time, for both learners and educators, address the unique issues caused by rotations, align to the Core Skills Training Framework by the end of June 2024, adopt the NHS Digital Passport, take action to improve the experience of trainees by reviewing the Training and Education Survey and the GMC Survey, with clear action plans that undergo board review NHS England will: • Provide support to providers with the highest need in relation to payroll errors • Make it easier for staff to move between organisations on a Memorandum of Understanding (MOU) for providers to recognise others' training • Reduce the time burden of statutory and mandatory training and reform the existing approach and create a new non-professional "StatMand" framework by December 2024 • Reverse the system for paying course fees so that the NHS pays these upfront A team including Medical Staffing, our Guardian of Safe Working Hours and colleagues from PGME are currently reviewing our position on these actions and will update Trust Board on our progress.
6.	**Our new learning and development portfolio, including leadership development**
	A broad portfolio of learning and development support has been launched across the Trust over the past 8 months. This includes: • 3 x leadership programmes, all delivered internally. A fourth leadership programme is planned for launch autumn 2024 • Operational essentials launched for Ops managers and service leads • 2 x coaching programmes launched • Management skills webinar series – 1 topic per month • Revised Trust welcome event • Learning Hub online resource environment launched on Totara • Range of team development sessions delivered • 2 x 360 assessments developed and integrated into activities • 1:1 coaching • New manager study day in development A full evaluation framework has been developed with impact measures identified for year 1, year 2, and year 3 and beyond. Data has started to be collected and is informing the development and targeting of programmes moving forward. It currently shows: *Leadership programmes data - engagement*



Applications and places offered

* Difference between applicant numbers and places offered due to applicant withdrawal or applicant moved to appropriate programme resulting in additional application

Leadership programmes data - initial impact data (only two cohorts completed so far)

3. Listed below are the main topic areas we covered in the programmes. Please rank them in order of learning value to you. Most valuable at the top and least valuable at the bottom.

More Details

What do you put into practice most often?

My leadership skills continue as before, although I have greater knowledge and awareness. Supporting colleagues in the absence of the Nursing Lead.
I have a better self-awareness and I use health coaching to help my patients
Communication and understanding others, and practice calm
I evaluate my decisions based on where the team need to go and how my leadership approach is perceived, therefore I can adapt my responses.
Inspiring others to be the best they can be everyday, so that we can provide the best possible care to our patients.

Webinar feedback

99% of responders to the feedback questionnaire after each event (71 people) would recommend the webinar to a colleague.

They said the most useful aspects have been:

- interactive discussion around approaches, processes and recent changes
- sharing ideas on the group chat
- hearing other people's thoughts and sharing tips
- inclusion of case studies to help people think.

Individual comments included:

- I left the session feeling confident and fully informed
- an engaging and informative presentation
- an effective session and not too long, covered the essentials
- useful and practical.

7. Statutory and Mandatory Training

NHS England have recently announced a national programme of work which aims to optimise, rationalise and reform statutory and mandatory training. This programme will focus only on the 11 core subjects within the Core Skills Training Framework, covering both elearning and face to face delivery, with the aim of standardisation. There is a focus on having nationally produced content which will reduce the cost of locally created content, eliminate unnecessary repetition, and enable greater portability between NHS organisations.

A small number of immediate actions to initiate this work are required, all of which are being completed by the Learning and Development team.

This national programme aligns well with the governance and content refresh work that has already been underway over the last 12 months at WSFT. Internally we have already:

- Developed and launched a new mandatory training governance framework, including new criteria by which subjects can be classed internally as mandatory training.
- A requirement for all Subject Matter Experts (SMEs) to provide key performance indicators (KPIs) as part of their application which demonstrate how the impact of the learning is to be measured, not just completion of the learning.
- Required SMEs to submit new application forms for all mandatory training provided by WSFT using these new criteria in order to ensure there is an audit trail of decision making and KPIs are captured. SMEs are being required to justify why elearning and face to face methods are being used, and how the impact of each is to be measured to understand which is most effective.
- A revised process which requires executive colleagues to own the mandatory training being submitted, and for SMEs to own and report back on the KPI's identified within 12-24 months to demonstrate the impact of the learning. Where KPI improvements are not being identified, a review of the method, content and requirement of the mandatory training will be expected.
- Started to refresh the current internally produced mandatory training elearning packages, with the learning focused on achieving the outcomes required from the KPIs identified – providing greater clarity and focus to the learning.

We appear to be at the forefront of thinking nationally in terms of the integration of KPIs in our approach and have been invited to discuss our learning with the national team as part of this wider programme.

8. NHS Sexual Safety Charter

On 4 September 2023, NHS England launched its first ever sexual safety charter in collaboration with key partners across the healthcare system. Signatories to this charter commit to taking and enforcing a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours within the workplace, and to ten core principles and actions to help achieve this. This is something that all Trusts have been asked to ensure they are committed to implementing and upholding.

	The commitments within the charter reflect our existing mission to create and nurture a safe workplace for all of our colleagues and comprises the following: *"Those who work, train and learn within the healthcare system have the right to be safe and feel supported at work.* *"Organisations across the healthcare system need to work together and individually to tackle unwanted, inappropriate and/or harmful sexual behaviour in the workplace.* *"We all have a responsibility to ourselves and our colleagues and must act if we witness these behaviours.* *"As signatories to this charter, we commit to a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours towards our workforce. We commit to the following principles and actions to achieve this:"* 1. *We will actively work to eradicate sexual harassment and abuse in the workplace.* 2. *We will promote a culture that fosters openness and transparency, and does not tolerate unwanted, harmful and/or inappropriate sexual behaviours.* 3. *We will take an intersectional approach to the sexual safety of our workforce, recognising certain groups will experience sexual harassment and abuse at a disproportionate rate.* 4. *We will provide appropriate support for those in our workforce who experience unwanted, inappropriate and/or harmful sexual behaviours.* 5. *We will clearly communicate standards of behaviour. This includes expected action for those who witness inappropriate, unwanted and/or harmful sexual behaviour.* 6. *We will ensure appropriate, specific, and clear policies are in place. They will include appropriate and timely action against alleged perpetrators.* 7. *We will ensure appropriate, specific, and clear training is in place.* 8. *We will ensure appropriate reporting mechanisms are in place for those experiencing these behaviours.* 9. *We will take all reports seriously and appropriate and timely action will be taken in all cases.* 10. *We will capture and share data on prevalence and staff experience transparently.* *"These commitments will apply to everyone in our organisation equally."* To date, actions already contained within our inclusion workplan have been mapped to the Charter principles. This shows that we are already taking action in some areas, including updating and re-launching our unacceptable behaviour policy; starting to roll out bystander and allyship training; and including EDI monitoring as part of our FTSU process. Additional actions are needed to meet all the Charter requirements, which will be formulated and progressed over the coming months. The Board is asked to formally endorse our commitment to this Charter.
9.	**Recommendation**
	To note and provide comment and/or feedback on the report. Formally endorse our commitment to the Sexual Safety Workplace Charter.

Appendix 1:

Freedom to Speak Up: Guardian's Report Q4 2023 -2024: January, February, March 2024.

Introduction: Why Freedom to Speak Up?

The third theme within the NHS People Promise states:

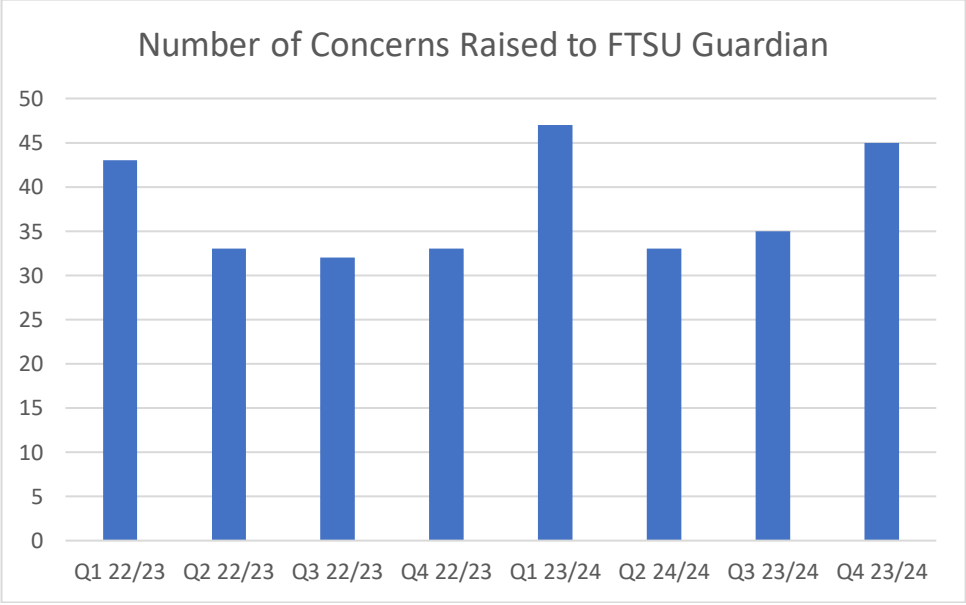
'*We all have a voice that counts. We all feel safe and confident when expressing our views. If something concerns us, we speak up, knowing we will be listened to and supported. Our teams are safe spaces where we can work through issues that are worrying us'.*

The Freedom to Speak up service at WSFT aims to support the development of a culture where that promise is fulfilled.

Data Sent to National Guardian's Office

FTSU Guardian's for each organisation are required to submit data around the concerns raised to them each quarter. (NGO Guidance, 20240. This is to inform the NGO's understanding of the implementation and utilisation of the Guardian role and the themes and trends in speaking up. It is also felt that observing that the guardian actively submits data may increase workers confidence in the effectiveness of the guardian route and potentially increase confidence in choosing to speak up.

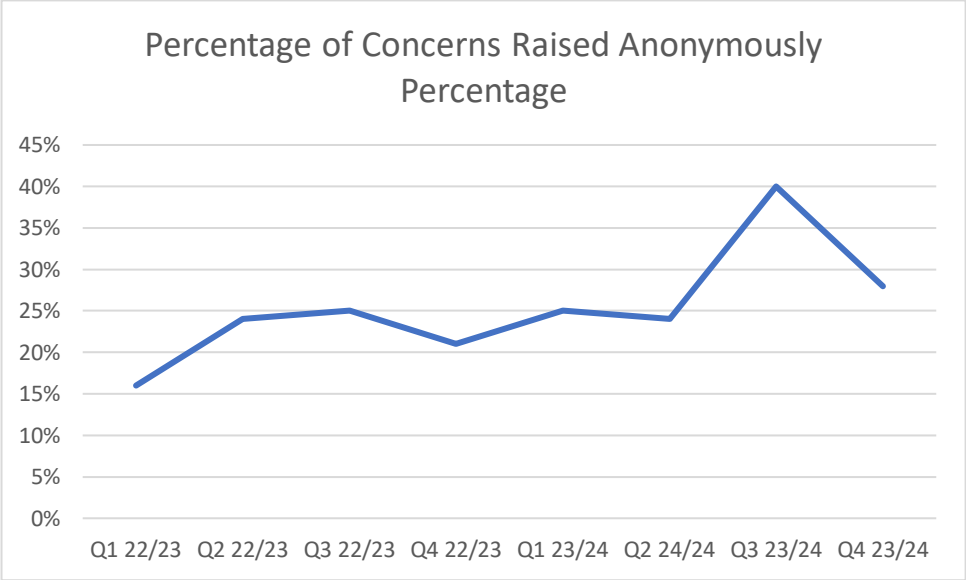
In WSFT the number of concerns raised with the Guardian has increased from the previous quarter to 45



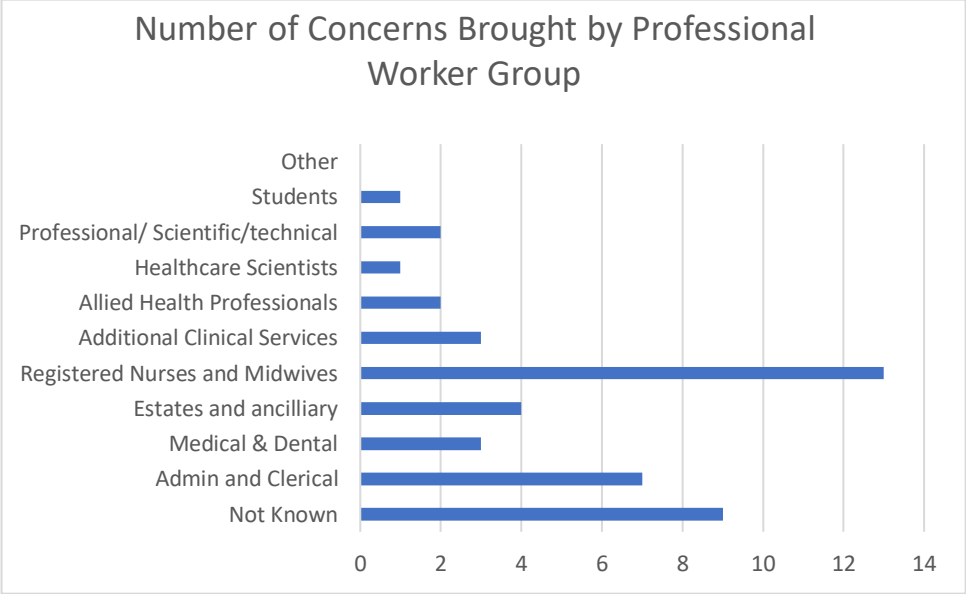
Anonymous Reporting

An increase in anonymous reporting was noted in the previous report (Quarter 3).
The possible reasons for that increase were examined including concerns that it could indicate that colleagues may feel less psychologically safe to report with their identity known. This would suggest further work on supporting psychological safety of staff and communicating this through training and other outreach needs to be done. The second of the Trust's Health and Wellbeing Workplan priorities is fostering psychological safety. Actions under this priority relate to contributing to the development of a culture whereby safe, good quality relationships can be formed to ensure colleagues feel connected to a sense of value, purpose and belonging.

Work has continued around this including the new Welcome programme for new starters having a focus on psychological safety and the Guardian working with the Speak Up champions to tackle barriers to speaking up and to assure staff that detriment to those who do speak up will not be tolerated in the Trust. The Guardian is also working closely with the wellbeing team to understand barriers to speaking up highlighted in their work, and how to provide appropriate re-assurance.

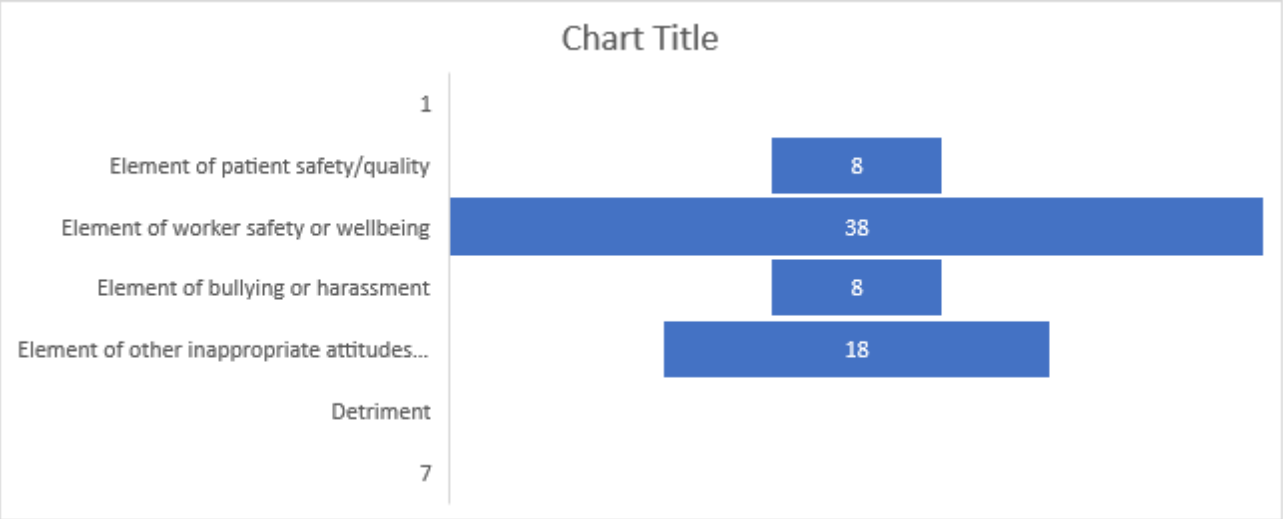


This quarter, the percentage of anonymous reporting has dropped back to closer to the levels seen over the previous 18 months, and whilst this one figure cannot be taken as a trend, it is a move in the right direction.



Looking at the worker groups who have used FTSU service, the largest group raising concerns was nurses and midwives. This mirrors the national trend.

What were people speaking up about?



Themes from Q4

- Lack of, or poor communication has been a theme again this quarter. In particular the communication of major changes to large groups of staff.
- Difficulties in relationships between staff and incivility have continued to be a theme in this quarter. There was an element of worker safety or wellbeing in 84% of concerns raised.
- Estates and facilities concerns, involving toilets and environmental controls. New reporting systems will allow accurate and timely reporting of estates and facilities issues which in turn will allow for timely action, available via Estates Helpdesk on Intranet
- There were 8 patient safety related concerns raised. This equates to 18% of concerns raised. This is just below the national figure of 19%. Each of these cases has been investigated and addressed individually. The Trust has a patient safety team and robust systems in place for reporting these issues such as Datix/Radar, which may account for the low percentage of these issues within FTSU.

Summary of learning points

Every Freedom to Speak Up concern is dealt with on an individual basis and raised with the appropriate senior leader**.** However, the Trust continues to address broad themes raised via FTSU, and accepts the information gained as a gift to support future learning and development to help support improvements across the organisation.

- The importance of communicating effectively, and using a variety of mediums, including face to face where possible, emphasising the relevance of the Trust's First for Staff ambition to "Build a positive, inclusive culture that fosters open and honest communication"

- The importance of management support and training in communication. This is being supported by the Trust's leadership programmes being delivered by the Trust's learning and development team. 160 colleagues have already signed up/participated in the leadership programmes.

- A focus needs to be maintained on building and maintaining professional relationships and civility. The importance of civility, and the Trust value of 'respect' needs to be reiterated throughout all levels of leadership. The Values Based Line Management Standards Framework will support this. Civility training has already taken place within maternity, as commissioned by NHS England. Further training of this kind may be beneficial in other areas.

- Ongoing encouragement of the Freedom to Speak Up culture, and management training on how to receive a concern raised, including understanding the barriers to speaking up and the importance of psychological safety.

Feedback on the Freedom to Speak Up Process

Following closure of each FTSU case, the person speaking up is sent an evaluation form to report their experience of the process. The figures below show a summary of evaluations received in Q4.

- 5 Responses were received to the FTSU feedback survey. 5/5 respondents said they would speak up again.
- Free text comments and other feedback received verbally and via email was generally positive. Feedback taken from the form and email responses include:

"This is the first time I have contacted a FTSUG and it was a very satisfactory result. I know senior medical staff are starting to use and value this process but it needs to be further embedded as a valuable resource."

"*I received a prompt response to my concerns and felt listened to and supported during the process".*

"The Guardian listened attentively and summarised my main points very well"

NHS Staff Survey Results

The results for the 2023 NHS staff survey were released in this quarter.

There are four questions, within the 'We have a voice that counts' Element, which relate to Raising Concerns.

Raising Concerns Sub-Group Score WSFT: 6.28/10 – Average: 6.41/10

Q20a – **I would feel secure raising concerns about unsafe clinical practice** WSFT 67.27% (last year 66.28)- Average70.24%

Q20b – **I am confident that my organisation would address my concern** WSFT 52.51% (last year 49.8%) - Average 55.9%

Q25e- **I feel safe to speak up about anything that concerns me in this organisation** 60.92% (last year 58.68%) - Average 60.89%

Q25f - **I am confident that my organisation would address my concern –** 49.05% (last year 47.1%) Average 48.65%

The results from this survey show a very slight improvement on last year and WSFT results are close to average for the NHS as a whole. However, as the average score is low, with approximately a third of staff feeling unsafe to report a concern or lacking confidence that action will be taken to address their concern. So, although positive progress has been made there is still a lot of work to be done with improving psychological safety, listening, following up and, very importantly, feeding back on actions taken.

The Guardian and FTSU champions are working to improve the culture of speaking up throughout WSFT. Our actions are categorised under eight key areas aligned with the National Guardian's Office guidance for leaders and managers.

Principle 1: Value Speaking Up:

For a speaking-up culture to develop across the organisation, a commitment must come from the top.

What's going well:

- Ongoing support from board and SLT for Freedom to Speak Up
- CEO or Principle Director for Workforce & Communications, attend FTSU champions 'meet and greets'.

Next Steps:

- Non-Executive Director for FTSU to attend Champion Meeting and to review FTSU contribution to Welcome Session

Principle 2: Senior leaders are role models of effective speaking up and set a health Freedom to Speak Up Culture

What's going well:

- FTSU non-executive director in post.
- CEO supporting the role of FTSU Guardian and promoting Speaking Up culture in staff briefing and public communications.
- NED and Exec walkabouts to ask colleagues for opinions, and feedback on improvements which could be made.
- Regular meetings established between FTSU NED and Guardian.

Principle 3: Ensure workers throughout the organisation have the capability, knowledge, and skills they need to speak up themselves and feel safe and encouraged to do so.

What's going well:

- FTSU continues to be promoted throughout the Trust. Training sessions by FTSU Guardian for preceptorship, new starter Welcome and student training programmes.
- 'Speak Up' and Listen Up' mandatory training is promoted, and we have high numbers of staff completing this (94% and 88% respectively)
- Focus on inclusion and reaching those who may be less likely to speak up
- All staff meeting FTSU Guardian at Welcome Session.
- Champion Gap analysis completed and active recruitment undertaken in areas lacking champions.
- Champion support sessions established

Next steps:

- FTSU Guardian to continue to visit wards and departments including community site to further increase visibility and awareness of Speaking Up at WSFT
- Further development of FSTU champion network
- Culture continues to improve to enable psychological safety in all teams. It is hoped this will be achieved through continued FTSU training and promotion, and work undertaken around values and behaviours. FTSU Guardian to work with OD Manager – Health & Wellbeing, to consolidate psychological safety training and ensure appropriate governance around champions.

Principle 4: Respond to Speaking Up; when someone speaks up they are thanked, listened to and given feedback.

What's going well:

- Individuals are thanked for speaking up, and told they are they are helping to identify areas of learning and improvement
- Champions offer valuable support by listening to colleagues, especially during times of pressure
- All leaders complete 'Listen Up' mandatory training
- Leadership programmes are now in place which will support listening skills and promotion of Speaking Up culture as business as usual.

Next steps:

- Increased promotion regarding Trust's stance on protecting staff who speak up and a zero-tolerance approach to detriment. Focus on psychological safety in welcome session.
- Senior Leaders to complete 'Follow Up' training.

Principle 5: Information provided by speaking up is used to learn and improve

What's going well:

- Where possible and obvious, swift action is taken to address concerns, to learn and improve.
- Regular meetings set up to share and explore themes identified with patient safety team and PALS to support organisational learning.

Next steps:

- Continue to work closely with HR business partners, department leads and executive to ensure concerns are shared and used for learning and improvement.

Principle 6: Appointment and support of Freedom to Speak Up Guardian
Aim to support Guardian to fulfil their role in a way that meets worker's needs and NGO requirements.

What's going well:

- Full-time dedicated FTSU Guardian in post, registered with NGO
- Foundation training completed and reflective conversation completed with Guardian mentor.
- On-going support from Guardian Mentors and Community of Practice

Next Steps:

- FTSU Guardian to undertake coaching and mentoring training.

Principle 7: Barriers to speaking up are identified and tackled

What's going well:

- Regular and ongoing face to face sessions for speak up training.
- Inclusion training session offered for FTSU champions.
- EDI data collection form has been created by Guardian and OD Manager – EDI, and is now established as part of the FTSU process.

Next Steps:

- FTSU champion to continue to work closely with newly appointed EDI lead to ensure barriers to speaking up are identified and overcome
- FTSU Guardian to cover out of hours shifts to ensure equal visibility to OOH staff.

Principle 8: Speaking up policies and processes are effective and constantly improved. Freedom To Speak Up is consistent throughout the health and care system

What's going well:

- New FTSU policy , in line with NGO guidance, adopted and adapted to suit WSFT easily available online on the Trust's intranet, Freedom to Speak Up section.

- FTSU Guardian working closely with NGO and local area FTSU Guardian network to ensure adherence with national policies and processes.
- Working with Communications and Information Governance Team, Website and Intranet information on FTSU has been updated to reflect current contacts.

Next Steps:

- New FTSU Guardian with NED to undertake FTSU reflection and planning tool to ensure ongoing adherence with National policies and processes – this has begun by Guardian and NED working together

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References:

NGO, February 2023, Recording Cases and Reporting Data (nationalguardian.org.uk)

Estates Helpdesk: WebEstates (fmfirst.co.uk)

Annex 1

WSFT Board FTSU Pledge

The development of a culture where all colleagues feel confident to speak up and share concerns at work is crucially important to us, where everyone has a voice that counts. We affirm its direct impact on a culture of safety with positive benefits for patient care, quality and staff experience and engagement. It is important to us that everyone feels safe to speak up.

“Speaking up to us is a gift because it helps us identify opportunities for improvement that we might not otherwise know about. We will not tolerate anyone being prevented or deterred from speaking up or being mistreated because they have spoken up. As a Board we value our relationship with the role of Freedom to Speak Up Guardian, particularly as it enables the sharing of themes or learning where we can take action to protect the interests of patients, colleagues, and the wider organisation”.

NHS
West Suffolk
NHS Foundation Trust

WSFT People and Culture plan 2024/25

Version 0.9
13 May 2024

Putting you first

Summary of Previous Year 2023/24

Performance

- Staff survey feedback shows improved performance in all 9 people promise areas, 5 at a level that is statistically significant
- WRES / WDES data collated, reported and actions underway as part of fully developed inclusion workplan
- Equality Delivery System (EDS) first full submission, with a score of 19, which is at the top end of the 'developing' score range
- Launch of a new Parent and Carers network, with 3 other networks operating well
- 160 colleagues signed-up / participated in leadership and management development programmes

Quality

- New governance structure embedded and working well
- New appraisal process launched aiming to improve the quality of appraisal conversations
- New recruitment system launched with increased number of applications being received
- Review of reward and recognition underway to improve the quality and visibility of such mechanisms for staff
- Launch of the new 'Trust Welcome' as an improved way of welcoming new colleagues to the Trust

Workforce

- Increased staffing levels Trust wide – support provided
- Highly collaborative approach across the Trust / Alliance / ICS to support and enable workforce needs
- Achievement of all workforce key performance indicators (for workforce directorate)
- Supported delivery of improved KPI's for Trust; three out of four achieving target
- Team and whole Directorate development sessions to continue to enhance learning and shared engagement

Finance

- Successful bid awarded to support the development of a Digital Assistive Technology Toolkit (c£12k)
- CIP target for 2023/24 over-achieved
- Continued focus on investing in activities that support Trust priorities through careful financial planning and management

National Requirements for 2024/25

The national requirements are driven by the NHS People Plan and the future of NHS human resources and organisational development 2030 vision:

- Prioritise the health and wellbeing of all our people – we will take a positive and proactive approach in supporting the health, safety and wellbeing of colleagues ensuring that work has a positive impact addressing health inequalities at work and in our communities
- Create a great employee experience- we will understand the diverse needs, expectations and experiences of all colleagues, and use that insight to tailor our service. We will attract and retain people in health and care, creating a positive impact on our communities
- Ensure inclusion and belonging for all – we will use our expertise and influence to create an inclusive culture, which values and celebrates our diversity, listening to colleagues and act to ensure equity for everyone
- Support and develop the people profession (HR and OD) – we will support each other to be at our very best and reach our potential and together we will provide an outstanding HR/OD service
- Harness the talents of all of our people – we will help our colleagues to fulfil their ambition and potential and will build strong leadership and management capabilities at all levels
- Lead improvement, change and innovation, across HR and OD – we need to be productive, efficient and responsive. We will deliver transformation and embed innovation across organisations and systems
- Embed digitally enabled solutions – we must make best use of technology and digital solutions to deliver great people services. We will develop our digital capability to equip ourselves for the future
- Enable new ways of working and planning for the future – we will enable colleagues to work differently and support new models of care. We need to anticipate the needs of the health and care system and create a sustainable supply of workforce which meets the needs of our patients now and for the future

Trust priorities and Alliance Strategy

Future direction

Vision:
To deliver the best quality and safest care for our local community

Ambition: First for patients

- 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.

Ambition: First for staff

- Build a positive, inclusive culture that fosters open and honest communication
- Enhance staff wellbeing
- Invest in education, training and workforce development.

Ambition: First for the future

- Make the biggest possible contribution to prevent ill health, increase wellbeing and reduce health inequalities
- Invest in infrastructure, buildings and technology.

Powered by our First Trust Values
Fairness • Inclusivity • Respect • Safety • Teamwork

People and Culture Strategy – to 2030

NHS West Suffolk NHS Foundation Trust

Our strategy is both led and informed by divisional business plans, national policies and frameworks, and emergent events e.g. industrial action. Our emergent People and Culture Strategy supports and enables the four NHS People Plan pillars and our First for Staff ambition. Within this we have identified three long term priorities which will guide our overall focus. These are in draft form and will be further developed over the coming months:

Building an organisation that is ready for the future

- Attract and recruit talented people who live our FIRST values.
- Provide organisational design expertise to facilitate strategic workforce, talent management & succession planning to meet our future needs.
- Engender a learning culture of continuing professional development that encourages staff to be accountable for their own personal development.
- Develop & implement a well-designed & targeted learning & development framework aligned with our strategic priorities supported by regular career conversations.
- Ensure succession planning and talent management is driven by business need to flexibly deploy our future and aspiring talent.
- Grow a culture that is not intimidated by change, providing expert advice and skills development in organisational change and transformation.
- Support a high-performance culture through personal effectiveness, while addressing under-performance, thereby nurturing & creating opportunity for people to realise their potential.
- Harness the benefits of digital solutions, and support the workforce in embracing agile, flexible and efficient working practices.
- Collaborate with other system partners to benchmark our performance, develop and evaluate our delivery against metrics, identify new practices, exchange information and deliver key projects.

Living our FIRST values

- Cultivate our values-led culture setting out the behaviours that define our way of working.
- Ensure our leaders and managers champion and role model those values and behaviours, enabling everyone to live these and to take responsibility for challenging those who do not, and speaking up where this does not happen.
- Build competent and confident teams of authentic and compassionate leaders and managers who inspire and empower colleagues who feel valued and strive for excellence.
- Nurture an enabling, engaging and inclusive culture through collaborative, innovative and creative working.
- Identify, select and grow our leaders and managers at all levels to drive leadership excellence and capability.
- Work together towards our organisational ambitions and priorities and through change to enhance capability at individual, team and systemic levels.
- Enhance effectiveness of strategic business partnerships with a focus on collective leadership style and culture that prioritises relationships and networks.

Employee wellbeing and experience

- Nurture a fair, inclusive and respectful working culture in which everyone is valued, recognised and praised for their efforts, and success is shared and celebrated.
- Create a working environment in which health and wellbeing is an integral part, and its impact is considered strategically significant in the interests of our physical health and mental wellbeing.
- Provide affordable, transparent and simple-to-understand reward and flexible benefits which are reflect our FIRST values, inspire performance and support employee recruitment to deliver our aims.
- Create professional career pathways to enable everyone to plan their career journey.
- Build a psychologically safe culture where everyone feels valued, heard and informed, and is able to provide feedback through meaningful dialogue and active involvement.
- Build on the strength of our partnerships with our union representatives, shaping a positive organisational culture to achieve our aspirations.

People & culture plan – 2024/25 First for Staff 1. Build a positive, inclusive culture that fosters open and honest communication

SMART action	Measure of success	By when	Strategies
1a. Further development of the WSFT People & Culture plan, that responds to the latest priorities identified by staff in their feedback, will be delivered and will set clear goals for our organisational culture. It will be enabled by: • Development of a co-produced People and Culture strategy that will support the strategic direction of our work through to 2030 • Continued work to embed our speak up processes and culture, in partnership with our speak up guardian and champions to ensure • concerns are welcomed, action is taken and feedback provided • Continued commitment to partnership-working with trade union staff representatives following election of a new staff-side lead • Review and redevelopment of our approaches to staff reward and recognition, including a new Total Rewards package; reviewing and updating Putting You First, Long service and the replacement of Greatix. • Develop knowledge mobilisation tools and techniques resource to support shared learning • Underpin Knowledge and Library Services strategy, policy and guidelines with evidence-based information, synthesis and summaries • Optimise system funded (12 months) Retention Partner role to understand and improve turnover	Development and launch of People and Culture Strategy	March 2025	NHS people plan Freedom to Speak Up
	Speak up metrics that support the tracking of an enhanced speak up culture developed	Dec 2024	
	Reward and recognition metrics dashboard developed to demonstrate improvement in quality and number of appropriate rewards and recognition provided, and improved engagement with wider benefits packages	Oct 2024	
	Increase the number of staff undertaking knowledge mobilisation training (specifically, managers)	March 2025	
	QIOF – uplift to level 3 medium (from level 2 high) for outcome 2 [All NHS decision making is underpinned by high quality evidence and knowledge mobilised by skilled library and knowledge specialists.]	March 2025	
	Turnover rate sustained at <10%	March 2025	
	Improvement in quarterly engagement indicators and National Staff Survey results	March 2025	
1b. We will address the disparity between different groups where staff feel discriminated against and not included, by: • Embed the newly created guidance and support for all managers and colleagues around reasonable adjustments • Implement a digital passport for reasonable adjustments, in compliance with the introduction of the guidance and digital adjustments toolkit • Develop and embed an Equality Impact Assessment (EIA) process, including an agreed Trust wide template for the Trust, governance structure and communication of why these are important • Embed allyship into existing learning and development sessions, including development of resources to encourage deliberate and intentional allyship • Embedding diversity principles throughout our recruitment processes, enabling the process to be free from bias at all stages • Sign the NHS Sexual safety in healthcare charter and start delivering actions aligned to the 10 principles within the charter • Encourage the adoption, sharing and diffusion of knowledge mobilisation tools and techniques to raise the profile of the benefits of inclusivity and embed this into line management support • Underpin strategy, policy and guidelines with evidence-based information, synthesis and summaries, and prioritise EDI evidence searches over 'business as usual' searches	Increase the percentage of our disabled staff reporting they have suitable reasonable adjustments in place from 76.3% to 80%	March 2025	Inclusion action plan Public Sector Equality Duty WRES / WDES NHS Equality Delivery System WSFT strategic priorities for 2024/25
	Embedding of EIA's consistently and routinely initially within HR and business critical policies, processes and decisions throughout the Trust, with further roll out to all areas	Feb 2025	
	Increased understanding Trust wide of allyship and being effective allies, including greater confidence to challenge behaviours and process that disadvantage groups of people, as evidenced by increasing Q14d of the NHS staff survey	March 2025	
	Sign the NHS Sexual safety in healthcare charter	June 2024	
	Improvement in staff survey indicators Q17a and Q17b	March 2025	
	Completion of a full review of recruitment processes through an inclusion lens, with actions taken to enhance inclusive recruitment practices, drawing on external best practice	Dec 2024	
	Increase awareness, engagement and membership of the staff networks	March 2025	
	QIOF – uplift to level 3 medium (from level 2 high) for outcome 2	March 2025	
	Increase the number of evidence searches and readership of information bulletins on EDI issues	Dec 2024	

People & culture plan – 2024/25 First for Staff 2. Enhance staff well-being

SMART action	Measure of success	By when	Support which strategies
2a. We will promote the value of great line management and support, and develop all our current and future line managers: • Agreeing values-based outcomes for what great line management means at WSFT • Continue to develop, deliver and embed a holistic and inclusive package of learning and development for line managers, staff members and teams • Coaching and mentoring provision developed and expanded to include a vibrant internal coach pool, reverse mentoring and targeted coaching approaches for line managers • Learning and development evaluation strategy developed, with initial data captured, analysed and informing activity • Development of L&D communications Strategy • Develop inclusive leadership learning and resources for senior managers that provides information, practical guidance and empowers colleagues to champion diverse workforces and become active bystanders • Support leaders and managers with resources and learning on how to understand racism, its impact within the organisation, and becoming anti-racist • Continue to source and provide relevant content for the Learning Hub • Provision of resources to support line management, leadership and learning and development courses on the Learning Hub • Launch the new appraisals process, including career conversation, wellbeing conversation and better quality discussion • Conduct a 6 and 12 month review on the effectiveness of the new appraisal process – looking at the direct and indicative impacts of the new appraisal process	Values-based line management standards agreed and published , in line with the new Leadership Academy's "Expectations of Line Managers"	Sept 2024	Trust corporate strategy WSFT strategic priorities for 2024/25
	Strategic Leadership Programme launched	Oct 2024	
	People project completed and launched on the intranet	Sept 2024	
	Continued development of Management Essentials bite-sized interventions available on Learning Hub Internal coach pool available for internal coaching assignments	Oct 2024	
	Reverse mentoring programme in place	Jan 2025	
	Bite sized learning programme developed and launched	August 2024	
	L&D evaluation strategy developed and implemented	Sept 2024	
	L&D Intranet developed and launched	July 2024	
	Increased understanding Trust wide of allyship and being effective allies, including greater confidence to challenge behaviours and process that disadvantage groups of people, as evidenced by increasing Q14d of the NHS staff survey	March 2025	
	Managers contribute towards and role model a culture of inclusivity and compassion. Colleagues report feeling a sense of belonging and psychologically safe at work, and that they are supported by their managers (NHS staff survey Q9f – 9i)	March 2025	
	Increase in NHS staff survey Q16b and WRES 4b/c – reducing discrimination from line managers and colleagues	March 2025	
	Increase the usage of resources related to management, leadership and learning and development	March 2025	
	Increase usage of the Learning Hub, particularly resources related to management and leadership.	March 2025	
	Improved NHS staff survey Q23b-d related to the impact of appraisals	March 2025	
	90% completion rate for appraisals	March 2025	

People & culture plan – 2024/25 **First for Staff** **2. Enhance staff well-being**

SMART action	Measure of success	By when	Support which strategies
2b. We will do everything we can to protect and improve the health, wellbeing and safety of our staff • Delivering priority actions as defined in our wellbeing action plan and evaluating our progress against the NHS Framework diagnostic tool • Strengthening our use of data analytics to assess the benefit and effectiveness of our wellbeing interventions, enabling evidence-based adjustments for optimal workforce support • Develop and implement a managers' 'wellbeing toolkit', to streamline and aid leaders to proactively improve the health and wellbeing of team members • Provide our workforce with the opportunity and interventions to learn more about to how make healthier choices, to support their own sense of wellbeing at work • Continue to provide, promote and improve, the physical space in the Library as a wellbeing hub • Analyse data analytics of wellbeing interventions and expand the online and physical wellbeing collections via targeted marketing and promotion • Underpin strategy, policy and guidelines with evidence-based information, synthesis and summaries, and prioritise wellbeing evidence searches over 'business as usual' searches. • Deliver actions in line with 'improving the working lives of doctors in training'	Improvement in progress against NHS Health and Wellbeing Framework results, in particular sections around 'managers and leaders' 'data insights' and 'personal health and wellbeing'	Feb 2025	Staff support and retention WSFT corporate strategy SNE joint forward plan
	Increase in conversion of registered members to active members, in our ACL Partnership	Dec 2024	
	Increased support for line managers to utilise opportunities to prevent poor health and wellbeing within their teams	Sep 2024	
	Improvement in staff survey indicators (longer term)	Ongoing	
	Stabilisation in reported sickness absence	March 2025	
	Reduction in MSK related injury	March 2025	
	Improvement in NHS staff survey results specifically related to H&WB indicators	March 2025	
	Increase usage of the Library wellbeing area 24/7	Dec 2024	
	Increase usage of wellbeing collections	Dec 2024	
	QIOF – uplift to level 3 medium (from level 2 high) for outcome 2 [All NHS decision making is underpinned by high quality evidence and knowledge mobilised by skilled library and knowledge specialists.]	March 2025	
	All measures and interventions in place	August 2024	

People & culture plan – 2024/25 **First for Staff** **3. Workforce development**

SMART action	Measure of success	By when	Support which strategies
3a. We will create more new roles and use novel approaches to recruitment to reduce vacancies; and we will deliver education, training and development that supports our staff to be ready for the future requirements of the health and social care sector by: • Underpin workforce planning, including Future System, with evidence-based information, synthesis and summaries • Support delivery of major collaborative service developments across the system, most notably the elective orthopaedic centre and the new community diagnostic centre • Develop a cohesive approach to succession planning and career development, supporting the growth of our leaders, and those in business-critical roles • Introduce learning and development to enhance skills around digital capability and confidence • Developing a WSFT volunteer strategy tailored to address specific hospital and community need. • Continue to review and strengthen our mandatory training to ensure the right staff receive the best learning in the most appropriate way, with impact measures defined and tracked (C/F from 23/24 plan) • Increasing our use of the Apprenticeship Levy, to invest in upskilling our staff, including linking these to new and developing roles where possible using 'Career Starter' apprenticeships (C/F from 23/24 plan) • Introducing learning and development to enhance skills around digital capability and confidence (C/F from 23/24 plan) • Continued development of Learning Hub • Implementation of Welcome to the Trust three-part approach	Successful design and delivery of workforce plans for ESEOC and CDC	December 2024	SNEE joint forward plan NHS people plan Education & career development
	Increase the number of workforce evidence searches provided QIOF – uplift to level 3 medium (from level 2 high) for outcome 2	March 2025	
	Approach to succession planning and career development piloted	Dec 2024	
	Launch digital literacy resources on the Learning Hub, and integrated into wider leadership provision	Dec 2024	
	Publication of a volunteer services strategy	Dec 2024	
	Continue Mandatory Training rationalisation in line with emerging national guidance	March 2025	
	Matrix review completed and ESR updated	March 2025	
	Business case developed for MT to be moved from ESR to Totara with a move to full implementation	March 2025	
	Conflict Resolution and Breakaway training being delivered in Community as well as Acute sites	Sept 2025	
	Apprentices recruited to career starter apprenticeships	June 2024	
	Digital Skills/Literacy tile available on Learning Hub	Sept 2025	
	Learning Hub development plan Phase 2 implemented to include additional range of topics, learning areas and the development of reporting metrics	Sept 2025	
	Welcome to the Trust three-part approach Year 1 evaluation	Jan 2025	

People & culture plan – 2024/5 **First for Staff** **4. Financial recovery & sustainability**

SMART action	Measure of success	By when	Support which strategies

4a. We will further develop our workforce-related systems and controls to support the organisation in meeting its financial plans. These initiatives will focus on impact both in-year, and beyond, as follows:
• Delivery of defined actions in the organisation's planned response to the PA Consulting report, including:
  • Review and implementation of additional recruitment oversight and controls
  • Enhanced reporting of workforce utilisation, focusing on the perceived drivers of our current deficit
  • Review of our local process for undertaking AFC job matching and evaluation
  • Identify and implement further standardisation of temporary staffing rates, including assessment against regional benchmarks
• Implement StaffDirect module of our Allocate system to enable direct engagement of more temporary workers, thus improving controls and enabling savings
• Improve our understanding of WSFT workforce trends and our capability to analyse our data through implementation of an analysis tool developed by SNEE system colleagues
	Implementation of enhanced vacancy oversight and recruitment controls that supports achievement of CIP and financial recovery	June 2024	Financial recovery and sustainability

	Implementation of TRAC functionality related to recruitment authorisation that improves transparency and removes system double-entry	June 2024	
	Enhanced WTE utilisation report developed and produced weekly that supports better financial decision-making	From August 2024	
	Local job matching and evaluation processes that are better integrated with workforce and financial plans	September 2024	
	Delivery of cost savings through implementation and go-live of StaffDirect system	From August 2024	
	Utilisation of new analytics tool to enhance our workforce planning and associated decisions / prioritisation	From September 2024	

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: 20 March 2024		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington and 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:**		
			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
Patients Access Governance Group/ IQPR	**Urgent and Emergency Care** There was an improvement on the January position in February, delivering the best performance since August 2023, which was a great achievement. The month to date performance was 74.67%.	**2 Reasonable**	Meeting Urgent and Emergency Care performance metrics ensures that our patients are receiving timely emergency care. The progress made is a result of an enormous amount of work put in across the Trust. The committee noted that improved performance was partially due to increased direct senior involvement, but some processes were not yet fully embedded. The Committee had requested feedback from the Medial Director, Chief Nurse and Chief Operating Officer on the strength of cross discipline working. We were assured that substantial improvement had been made in this regard and the three Executives and their teams were showing leadership in tackling issues in an open and collaborative way.	The Trust is continuing to work through the combined Patient Flow Improvement & Urgent and Emergency Care (UEC) recovery plan. Including piloting a Minor Emergency Care unit from April. The challenge going into 24/25 will be to achieve sustainable ways of working that can be fully embedded as some of the current approaches will not be sustainable long term.	1 no escalation

Originating Committee: Insight Committee			Date of meeting: 20 March 2024		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington and 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:**		
			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
	Elective Recovery The revised trajectory for 78 weeks was zero breaches by the end of March 2024 except in Uro-gynae where the submitted forecast is 55 patients. Our submitted trajectory for 65 week waits is to have 94 patients in Uro-gynae. Whilst performance had remained on an upward trajectory the industrial action by junior doctors in March will have a negative impact on performance including in surgery and dermatology. Current estimates suggested a best-case position of 335 patients still waiting, and worse case of 410.	**3 Partial**	Delivering the objective of no patients waiting over 65 weeks by March 2024 is the central focus of 2023/24 planning. It is likely that this target will be extended to Sept 2024 in the new Operational Planning Guidance 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.	Plans are being developed to achieve a zero backlog in all specialties including Uro-gynae by September 2024, where modelling shows there to be a residual backlog with current activity levels.	3 Escalate to Board

Originating Committee: Insight Committee			Date of meeting: 20 March 2024		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington and 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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	Cancer Diagnosis The Faster Diagnosis Standard (FDS) performance has recovered in January showing performance of 74% against a target of 75% by March 24. Provisional figures for February suggest further improvement to 77% The 62-day backlog is still on track to achieve the March 2024 ambition of no more than 93 patients, with a backlog of 55 patients currently.	**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.	The Committee noted to efforts that had gone in to achieving such improved performance	1 No escalation

Originating Committee: Insight Committee			Date of meeting: 20 March 2024		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington and 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:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
Finance Accountability Committee	**Current year** The month 11 position was in line with the Financial Recovery Plan target of £6.3m. An additional £1.3m income had been received in February for costs of Industrial action.	**2 Reasonable**	The plan for the current year is on track against the forecast submitted to the ICB in our Financial recovery plan for 23/24 but there is still some risk in relation to additional funding for the Consultants pay award.	Work continues on CIP delivery	3 Escalate to Board
	2024/25 budget Final Operational Planning Guidance is yet to be received. The current assumption is planned deficit for 2024-25 is currently £22.9m assuming a CIP of £12.3m improvement programme.	**3 Partial**	The Committee considered options for reducing the proposed deficit to £18.m and agreed to recommend these to the Board. The committee also supported approval of a request for £4m revenue support in the first quarter of 24/25. The Committee endorsed the 24/25 long term capital plan.	The Board will need to consider whether the proposed CIP programme is ambitious enough and what the target should be for the planned level of deficit The committee requested that further information on the risks and assumptions built into the budget be made available to the Board meeting.	3 Escalate to Board

Originating Committee: Insight Committee			Date of meeting: 20 March 2024		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington and 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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Financial Diagnostic Review of WSFT	SNEE ICB commissioned a review to identify some of the drivers behind the Trust's income and expenditure position and projected financial deficit. Themes that emerged from the analysis included the additional costs WSFT faced costs in dealing with RAAC; an increase in whole time equivalents (WTE) from 4000 to 5000 over the last five years; and expenditure not reducing in line with the removal of some non-recurrent funding. Benchmarking suggested IT and estates costs appear higher than in other similar Trusts. The report included a list of recommendations for action.	**3 Partial**	The Committee welcomed the report and detailed analysis within it. It fully supported the recommendations and noted that the report highlighted actions for the Board itself and across the organisation.	A number of recommendations have already been responded to and an action plan will be developed over the next few weeks which can be shared with the ICB. The plan will also reflect learning from a comparison of ESNEFT and WSFT financial processes. The action plan cannot be seen as a finance led process, it needs to be collectively owned by the whole Board. The analysis will inform Board consideration of the 24/25 budget.	3 Escalate to Board

Originating Committee: Insight Committee			Date of meeting: 20 March 2024		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington and 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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Actions from insight Committee workshop	The Committee reflected on our recent workshop and how we balanced our time as a committee to ensure we were focused on assurance. We had identified behaviours that we wished to see in our meetings in line with Trust values and needed to actively consider how we met these in our meetings.	**2 Reasonable**	The workshop gave us time to reflect on how well we did as an assurance committee of the Board.	We agreed to develop our forward plan to ensure we had good coverage of the committee's areas of responsibility. We will pilot arranging the agenda to give more of a finance or operational focus on alternate months.	1 No escalation

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.
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Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Insight Committee			Date of meeting: 17 April 2024		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington and 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	**Urgent and Emergency Care** The Trust achieved 74% by the end of March for the 4-hour standard, against a target of 76%. This was the 6th most improved Trust nationally and additional capital funding of £2m will be received because of this improvement. 12 Hour breaches remain higher than target. Ambulance handover performance remains challenging against all three measures (15,30 and 60 minutes).	**2 Reasonable**	Meeting Urgent and Emergency Care performance metrics ensures that our patients are receiving timely emergency care. The progress made on 4-hour waits is a result of an enormous amount of work put in across the Trust. The aim has been to try to move non-admitted patients through more quickly, to free up space for patients who need to be admitted. The risk of harm is higher for patients waiting longer than 12 hours so getting the balance right in a way that is best for patients remains a challenge.	As reported following the last meeting, the challenge going into 24/25 is to achieve sustainable ways of working that can be fully embedded as some of the current approaches will not be sustainable long term. Insight will continue to keep progress under review By March 2025 we will need to achieve at least 78% against the 4-hour standard. The Terms of Reference for an Alliance UEC Working Group will come back to a future meeting of Insight.	1 no escalation

Originating Committee: Insight Committee			Date of meeting: 17 April 2024		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington and Craig Black**		
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	Elective Recovery The revised trajectory for 78 weeks was zero breaches by the end of March 2024 except in Uro-gynae where the submitted forecast was 55 patients. The actual March 2024 position was only 47 patients waiting more than 78 weeks. The 65-week trajectory suggested 94 patients over target by end of March but impact of industrial action by junior doctors in March means there are still 407 patients l waiting longer than 65 weeks.	**2 Reasonable**	Delivering the objective of no patients waiting over 65 weeks by March 2024 was a central focus of 2023/24 planning. This target has been extended to Sept 2024 in the new Operational Planning Guidance 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.	Plans are being developed to achieve a zero backlog in all specialties including Uro-gynae by September 2024. This will require some different ways of working. Clinicians in Surgery and Women and Children will be meeting to agree priorities. Insight has asked for feedback on the joint plan in May 24.	3 Escalate to Board for information
	Cancer Diagnosis The Faster Diagnosis Standard (FDS) performance has continued to recover, showing performance of 77% In February against a target of 75% by	**2 Reasonable**		Significant effort has gone in to achieving such improved performance which was recognised by the committee.	1 No escalation

Originating Committee: Insight Committee			Date of meeting: 17 April 2024		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington and Craig Black**		
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	March 24, with similar performance being expected in March. The 62-day backlog achieved the March 2024 ambition of no more than 93 patients, with a backlog of 68 patients at the end of March.			The committee discussed how it might capture the learning from this improvement.	
Finance Accountability Committee	**Current year** The month 12 position was in line with the Financial Recovery Plan target of £6.3m.	**2 Reasonable**	The plan for the current year is on track against the forecast submitted to the ICB in our Financial Recovery Plan for 23/24.		1 no escalation
	2024/25 budget At its last meeting the Board agreed to plan for a £18m deficit with a recurring CIP of £12.5m over three years to break even. At the end of 24/25 the Trust should have a workforce of Whole Time equivalent (WTE) staff no greater than	**3 Partial**	Because not all business cases have been through an agreed process there might be competing priorities for funding and choices that the Board may need to make which have not been identified in the proposed budget. The recent announcement about the limits on WTE growth may have an impact on those business cases which had previously been	The Committee agreed to approve the draft budget subject to the Investment Panel looking at all growth bids in the round.	3 Escalate to Board

Originating Committee: Insight Committee			Date of meeting: 17 April 2024		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington and Craig Black**		
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	that employed in 2023/24. This will be a complicated process to manage especially given the planned growth in staffing for the Community Diagnostic Centre (CDC). The draft Budget included some business cases for growth funding but did not include some projects currently funded by partners. These had not all been reviewed by the Exec. The Capital programme is over subscribed but this will be partially offset by the new capital received for UEC performance The new Cerner Oracle Contract is due to be signed off by the Board in May 2024 but is going more slowly than anticipated due to the takeover by Oracle.		earmarked for approval in the budget. And it is possible that those projects not in the budget could have greater strategic importance than those already included. The CIP target will be challenging and will need sustained focus. It will be imperative to move the schemes through the gateway process in a timely way. Capital spend will need to be prioritised by the Capital Strategy Group.	Insight will review the progress against plan at each meeting. Discussions continue with Cerner Oracle to keep the contract to deadline	

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Action Plan in response to Financial Diagnostic Review of WSFT	SNEE ICB commissioned a review to identify some of the drivers behind the Trust's income and expenditure position and projected financial deficit. This was reviewed at the last Insight Committee, including a list of recommendations for action which were endorsed. This Insight meeting was considering the first draft of the proposed action plan in response. The report also suggested some additional posts to help deliver the programme, although some of these were suggested to be recurrent posts. A request would be made to the region for funding to support these.	**4.minimal**	The Committee was expecting a strategic action plan which showed - the issues which had already been built into the budget and CIP programme - the additional actions which would be undertaken to deliver further savings, especially in relation to WTE and areas where the report suggested the Trust was higher than the benchmark - the improvements that would be made to internal financial governance and capacity - a sense of how all of this would help deliver £38m of CIP over the next three years.	The Committee did not support the current action plan and asked for further work to be done on it before submission to the ICB. The Committee also asked for further work on the additional support required, in particular why existing resources could not be used for these tasks. Any additional support requested should be subject to a proper business case and focused on what was need to support our three year programme to remove the deficit.	3 Escalate to Board

Originating Committee: Insight Committee			Date of meeting: 17 April 2024		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington and Craig Black**		
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			The first draft of the action plan was not strategic, was very focused on process and addressed recommendations one by one rather than showing a joined-up approach that would help the Trust achieve its financial ambitions and give the ICB confidence.	The issues would be considered further at the Board development day on 26 April.	

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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4.1.1. NHS 2024/25 Priorities and operational planning guidance

Report to Insight Committee	
Report title:	NHS 2024/25 priorities and operational planning guidance
Agenda item:	11
Date of the meeting:	15 May 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

The NHS 2024/25 priorities and operational planning guidance were released in late March 2024, against which final plans were submitted on 25 April 2024. The guidance contains 32 national objectives which require numerical activity and/or performance trajectories to be submitted alongside a narrative description of how delivery will be achieved. The submission is created and owned by the Suffolk and North East Essex Integrated Care Board (SNEE ICB) however WSFT as a main provider within the ICB must provide trajectories and narrative contributions across elective activity, diagnostics, cancer and urgent and emergency care. Community and primary care services delivered by WSFT are managed within the planning process at the system level.

Many objectives represent continuations or going further on those from 2023/24, however not all were achieved in full last year and therefore additional activity and/or performance improvement will be required to achieve them. There are a set of assumptions behind the trajectories set out and explained in Annex A, where prioritisation and trade-offs may be required so as to not compromise on the plans set out in parallel for finance and workforce. All performance expectations are planned to be met, except our absolute elective activity targets are not forecast to achieve the required 108.09% of 2019/20 levels. This should be mitigated when value-weighted activity is taken into consideration.

SO WHAT?

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

Meeting the performance metrics set out in the planning guidance ensures that our patients are receiving timely care and reduces the risk of harm and/or deteriorating the longer they wait. This can in turn increase demand on primary and urgent and emergency care services as patients seek help for their condition.

Delivery of the NHS objectives ensures we are compliant with contractual operational requirements and supports delivery of our parallel finance and workforce plans.

WHAT NEXT? *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*
Monitoring of delivery is through the governance structures of the ICB, West Suffolk Alliance and WSFT.
Recommendation / action required
The group is requested to note the requirements and WSFT response, providing scrutiny and gaining assurance of delivery.

Previously considered by:	Patient Access Governance Group membership WSFT Council of Governors Management Executive Group
Risk and assurance:	Risk Assessment BAF3.2 – delivery of operational standards
Equality, diversity and inclusion:	All delivery 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.
Sustainability:	Evaluation of delivery will be required to ensure plans demonstrate sustainable benefits across quality, performance, environment and finance are considered for further adoption.
Legal and regulatory context:	NHS 2024/25 priorities and operational planning guidance Supplementary guidance – Elective care, Cancer and Diagnostics planning

NHS 2024/25 priorities and operational planning guidance

1.	**Introduction**
1.1	Each year, NHS England issue a document setting out the priorities and operational planning guidance for the year. This is normally published alongside guides for workforce and finance in the December of the previous year, however this year was not released until the end of March 2024. Providers compile trajectories which are then combined with those of other providers within Integrated Care Boards (ICB's) and a narrative description of how delivery will be achieved. This has previously been an iterative process to allow feedback from NHS England regional teams to be incorporated and submissions refined, however this has been limited given the late issuing of the final guidance. There are 32 national NHS objectives for 2024/25, with many similarities to the 31 objectives in 2023/24. Our final trajectories and narrative descriptions will be submitted to the NHS England East of England regional team on 25 April 2024.
2.	**Current status and key information**
2.1	<u>Elective activity and long waits</u> Delivery of elective activity in 2023/24 was intended to meet the system's activity target of 107% of 2019/20 activity levels, linked to a value-weighted activity threshold (the Elective Recovery Fund or ERF) which provides additional income when met. However, significant activity was lost during 2023/24 due to industrial action (9,226 outpatient appointments and 848 elective procedures – not including the lost opportunity of pre-emptive cancellations of clinics, slots and lists). In recognition of this, the ERF threshold was reduced from 107% to 103%. However, guidance for 2024/25 states to assume zero impact from industrial action, with the system level activity target for our ICB being 108.09% of 2019/20 levels. Actual delivery of activity at WSFT in 2023/24 did not meet the original 107% ambition across any point of delivery: • Outpatient first attendances: 104.9% • Daycase: 101.7% • Elective: 86.5% • Outpatient follow up: 111.9% (where the target was to achieve 25% less activity, i.e. 75% of 2019/20). However, achievement of the ERF threshold in value-weighted activity was achieved, realising additional income. We have assumed a similar specialty case mix to 2023/24 and basing our trajectory on a 5% increase from activity lost to industrial action and a further 1.6% from additional working days. The impact from any activity which will transfer to the Essex and Suffolk Elective Orthopaedic Centre has not been included, as it is assumed that it will be replaced with a similar quantity of elective activity across a range of specialties as agreed at Management Executive Group in April 2024. Any potential activity increases from the supplementary planning guidance requirements to increase theatre utilisation and day case rates to 85% have not been included – realisation of these could either be translated into additional activity, and therefore additional income, within current levels of resource or delivery of the same activity with reduced expenditure. The 2023/24 planning guidance requirement to eliminate elective waits of 65 weeks or more has been extended by six months to be delivered by the end of September 2024. For WSFT, this will

	require the end of March backlog of 407 patients to be cleared, as well as patients whose waits are not yet at 65 weeks but will be by the end of September deadline. This will require additional activity within the sub-specialty of uro-gynae as we have committed to eliminating the residual backlogs against waiting times ambitions that have been included in planning trajectories for 2022/23 and 2023/24. This will need to be balanced against recovery within surgical specialties and may require a combination of outsourcing, insourcing and additional internal activity to deliver. The capacity constraints of theatres and elective beds will need to be carefully allocated as part of a detailed plan to achieve this. Although not a formal planning guidance requirement, WSFT have modelled an overall static position for the number of patients waiting greater than 52 weeks and the total waiting list, with clock starts equalling clock stops. Additional activity and potential resource to deliver this would need to be identified to support a reduction in either of these cohorts.
2.2	Outpatients The blanket expectations of previous years' planning guidance to reduce outpatient follow ups have been replaced by a new productivity metric that states our ICB must increase the proportion of outpatient attendances that are either a first attendance or a 'clock stopping' follow up attendance including a procedure to 46.2%, from a H1 2023/24 baseline of 44.5%. It is anticipated that this can be achieved from a combination of reducing follow ups with no procedures, swapping this capacity for either first attendances or procedure clinics. It will be critical to ensure that all activity is counted and coded correctly so that our reported position is accurate. The follow-up reduction will be modelled as taking effect in Q2, as transformation schemes will need to be identified and delivered to support this.
2.3	Diagnostics and Cancer The two-year objective of 95% of diagnostic tests delivered within 6 weeks by March 2025 is reiterated in this year's planning guidance. Given that all diagnostic modalities at WSFT committed to the delivery of this last year and there have been no material impacts to demand or capacity we are recommitting to this objective in planning for 2024/25. The Community Diagnostic Centre (CDC) at Newmarket, expected to open in November 2024, will provide a significant step change in some modalities, but further activity increases from existing recovery plans will be required alongside, particularly in endoscopy where there will be no additional CDC capacity. Our strong performance against the cancer ambitions for 2023/24 of 75% against the 28-day Faster Diagnosis Standard and reducing the 62-day backlog will support delivery of the 2024/25 objectives of 77% against the Faster Diagnosis Standard and 70% against the combined 62-day standard (urgent suspected cancer, screening and consultant upgrade referrals). However, services and pathways will need to build on improvements and transformation work already completed, particularly to respond to increases in demand across the high volume pathways in suspected breast, lower GI and skin cancers. Consideration will need to be given as to how transformation which has been delivered through non-recurrent Cancer Alliance service development funding will be sustainably achieved.
2.4	Urgent and Emergency Care The headline metric for urgent and emergency care (UEC) will continue to be the emergency department (ED) 4-hour standard, which will increase from 76% to 78% by March 2025. Additional indicators of average ambulance handover times will need to be maintained below 30 minutes and the number of patients waiting 12 hours or more in ED will need to be reduced from current levels.

	Key to delivery and further improvement will be consolidating and continuing workstreams from 2023/24 plans including those funded by the UEC capacity and discharge fund streams, alongside new developments such as the six month trial of a minor emergency care unit. Within the department, lessons learned from the additional senior operational and clinical leadership support in March 2024 will need to be captured and embedded within an evolved recovery plan. This additional support may need to be deployed again should performance significantly deviate from trajectory or as the critical milestone of March 2025 is approached. We are planning to close the current winter escalation ward (F9) by the end of May 2024 to support completion of the RAAC remedial works by the end of 2024. This will remove 33 beds from our core total (as per national definition) and we have modelled their reinstatement from December 2024 to March 2025. However, this is dependent on the longer term planning for this ward area, which will subject to Management Executive Group discussion in May 2024. Even with using overnight capacity on the Discharge Waiting Area as additional escalation, bed occupancy is modelled to continue above 92% for most months of the year (where 92% is generally accepted as an upper threshold. Without additional physical capacity, a decrease in patients admitted and an increase in patients discharged will be required to reduce bed occupancy and upstream overcrowding within ED. Whilst work will continue from the discharge fund and Patient Flow Improvement Core Resilience Team workstreams to increase flow, clinically led decisions on risk thresholds to reduce admissions and increase discharges may be required. Although both have increased over time, the ability to mitigate unmatched peaks in demand within the constraints of a finite bed base becomes limited which translates into increased numbers of patients awaiting admission within ED, driving up numbers of patients waiting 12 hours or more. Options for further physical surge capacity on site and are limited with any such space also requiring a staffing establishment. Virtual ward at 40 beds is included in the baseline bed demand calculations, with the proposed increase to 100 beds included on a separate line as per the planning template. As other admission avoidance and discharge schemes are largely continuations of those in 2023/24, these have again not been quantified separately.
3.	**Recommendations**
3.1	The group is recommended to approve the 2024/25 activity and performance trajectories as included in Annex A, and the key assumptions of: • Based on forecast activity levels the system activity target of 108.09% will not be reached at WSFT but we expect the value-weighted activity target to be met. • Realisation of theatre productivity increases could either be translated into either additional activity within current levels of resource or delivery of the same activity with reduced expenditure, but not both. • No reduction is planned of the 52-week wait cohort or total waiting list size, which would require additional activity. • 2025/26 business planning will need to consider how transformation of cancer pathways can be sustained and made ‘business as usual’. • Improvement opportunities identified from senior operational and clinical leadership support within ED in March 2024 will need to be fully embedded or this support redeployed to deliver required UEC performance. • Continuing initiatives to support patient flow may not be sufficient to consistently reduce bed occupancy to <92% and a clinically led discussion on risk thresholds for admission and discharge may be required. This requirement will be increased should longer term proposals for F9 (or equivalent ward) not facilitate winter escalation capacity of 33 beds.
4.	**Conclusion**
4.1	Although the NHS 2024/25 priorities and operational planning guidance objectives largely represent going further on existing performance standards and operational ambitions, delivering efficiencies and additional improvement will be required to achieve them, within the contexts of

	not increasing the size of our workforce, the limitations of our physical estate and delivery of our financial plan for 2024/25 and beyond.

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NHS 2024/25 priorities and operational planning guidance

Annex A to Insight Committee paper
May 2024

Putting you first

The SNEE 2024/25 planning submission sets out how we'll deliver the 32 national NHS objectives detailed in the planning guidance

West Suffolk NHS Foundation Trust

Area	Objective
Quality and patient safety	• Implement the Patient Safety Incident Response Framework (PSIRF)
Urgent and emergency care	• Improve A&E waiting times, compared to 2023/24, with a minimum of 78% of patients seen within 4 hours in March 2025
	• Improve Category 2 ambulance response times to an average of 30 minutes across 2024/25
Primary and community services	• Improve community services waiting times, with a focus on reducing long waits
	• Continue to improve the experience of access to primary care, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within 2 weeks and those who contact their practice urgently are assessed the same or next day according to clinical need
	• Increase dental activity by implementing the plan to recover and reform NHS dentistry, improving units of dental activity (UDAs) towards pre-pandemic levels
Elective care	• Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest (except where patients choose to wait longer or in specific specialties)
	• Deliver (or exceed) the system specific activity targets, consistent with the national value weighted activity target of 107%
	• Increase the proportion of all outpatient attendances that are for first appointments or follow-up appointments attracting a procedure tariff to 46% across 2024/25
	• Improve patients' experience of choice at point of referral
Cancer	• Improve performance against the headline 62-day standard to 70% by March 2025
	• Improve performance against the 28 day Faster Diagnosis Standard to 77% by March 2025 towards the 80% ambition by March 2026
	• Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028
Diagnostics	• Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%
Maternity, neonatal and women's health	• Continue to implement the Three-year delivery plan for maternity and neonatal services, including making progress towards the national safety ambition and increasing fill rates against funded establishment
	• Establish and develop at least one women's health hub in every ICB by December 2024, working in partnership with local authorities
Mental health	• Improve patient flow and work towards eliminating inappropriate out of area placements
	• Increase the number of people accessing transformed models of adult community mental health (to 400,000), perinatal mental health (to 66,000) and children and young people services (345,000 additional CYP aged 0–25 compared to 2019)
	• Increase the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies to 700,000, with at least 67% achieving reliable improvement and 48% reliable recovery
	• Reduce inequalities by working towards 75% of people with severe mental illness receiving a full annual physical health check, with at least 60% receiving one by March 2025
	• Improve quality of life, effectiveness of treatment, and care for people with dementia by increasing the dementia diagnosis rate to 66.7% by March 2025
People with a learning disability and autistic people	• Ensure 75% of people aged 14 and over on GP learning disability registers receive an annual health check in the year to 31 March 2025
	• Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, to the target of no more than 30 adults or 12–15 under 18s for every 1 million population
Prevention and health inequalities	• Increase the % of patients with hypertension treated according to NICE guidance to 80% by March 2025
	• Increase the percentage of patients aged 25–84 years with a CVD risk score greater than 20% on lipid lowering therapies to 65% by March 2025
	• Increase vaccination uptake for children and young people year on year towards WHO recommended levels
	• Continue to address health inequalities and deliver on the Core20PLUS5 approach, for adults and children and young people
Workforce	• Improve the working lives of all staff and increase staff retention and attendance through systematic implementation of all elements of the People Promise retention interventions
	• Improve the working lives of doctors in training by increasing choice and flexibility in rotas, and reducing duplicative inductions and payroll errors
	• Provide sufficient clinical placements and apprenticeship pathways to meet the requirements of the NHS Long Term Workforce Plan
Use of resources	• Deliver a balanced net system financial position for 2024/25
	• Reduce agency spending across the NHS, to a maximum of 3.2% of the total pay bill across 2024/25

- **Most of these objectives apply to WSFT**, given our status as an integrated acute and community provider that also delivers primary care services at Glemsford Surgery.
- **Many are continuations of 2023/24 objectives**, however will represent a stretch with increased thresholds or representing targets that weren't fully met last year.
- We are expected to **plan and deliver a balanced net system financial position** in collaboration with other integrated care system (ICS) partners. Given the investment in significant extra capacity over the last three years and total NHS funding flat in real terms for 2024/25 we now need to consolidate.

- Trajectories and narratives will be finalised on 25 April 2024.
- Separate submissions for finance and workforce were completed in Q4 20-23/24, with primary care and community planning managed centrally by the ICB.

A balance needs to be achieved across delivery of timely planned and emergency care

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- **Planned care** activity trajectories reflect activity targets to achieve value-weighted ERF thresholds and assume no impact from industrial action.
  - Theatre utilisation and day case rates of 85% will support this activity growth.
  - 46% of outpatients should either be first attendances or include procedures.
- **Elective waits of >65 weeks** must be eliminated by September 2024 (6 month extension).
- **Urgent and emergency care** requires 78% against the 4-hour standard to be achieved through reducing bed occupancy to 92% (locally defined target).
- **Cancer** objectives focus on achieving 70% against the 62-day standard and achieving an increase in the 28-day Faster Diagnosis Standard of 77%.
- **Diagnostics** must achieve 95% within 6 weeks by March 2025.
- **Community services** waiting times should improve, with a focus on reducing long waits.
- **Primary care** access should continue to improve, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within 2 weeks and those who contact their practice urgently are assessed the same or next day according to clinical need.

- These objectives are the main focus of the operational response, however they need to be delivered alongside those that focus on quality and safety, workforce and finance.
- For example, the three year delivery plan for maternity and neonatal services, or implementing the Patient Safety Incident Response Framework (PSIRF).
- More detailed supporting objectives are contained both within the main document and in supplementary guidance.

Elective activity will need to increase to meet the system elective activity threshold of 108.09% of 2019/20 levels

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Assumptions behind the trajectory (compared to 2023/24 outturn):

- No activity lost from industrial action (5% increase) and a 1.6% increase from more working days.
- Activity transferred to the Essex and Suffolk Elective Orthopaedic Centre will be replaced with other elective activity (as agreed by Management Executive Group).

Our baseline and assumptions aren't sufficient to meet the target in actual or monetary terms:

- Achieving the activity target supports our financial position through income from the Elective Recovery Fund and is also required to reduce the number of long waiting elective patients and deliver on cancer targets.
- There are a number of plans to achieve and exceed this target:
  - To meet the separate target of 46.2% of outpatient attendances being first appointments or follow ups including a 'clock stopping' procedure code we could increase outpatient procedures by 15,000, worth circa £2m.
  - Increased theatre productivity and day case rates will need to increase to meet the separate 85% ambition for these.
  - Activity could be switched from outpatients to theatre sessions, with clinics then backfilled.
  - Additional elective activity could take place at weekends.

Trajectories link our elective activity plans to delivery of key access standards and objectives

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- Elective waits of >65 weeks will need to be eliminated in all specialties by September 2024, including in uro-gynae where we have forecast non-zero trajectories previously.

We plan to eliminate 65 week waits, but 52 week waits and the total waiting list will remain static

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
The number of incomplete Referral to Treatment (RTT) pathways (patients yet to start treatment) of 52 weeks or more	1,884	1,887	1,890	1,893	1,896	1,899	1,902	1,905	1,908	1,911	1,914	1,917
The number of incomplete Referral to Treatment (RTT) pathways (patients yet to start treatment) of 65 weeks or more	485	638	542	446	188	0	0	0	0	0	0	0
The number of incomplete Referral to Treatment (RTT) pathways	35,513	36,415	36,723	36,315	35,917	35,742	35,673	35,617	35,575	35,612	35,511	35,497

Outpatient trajectories for Patient Initiated Follow Up (PIFU) and First Attendance/Procedure appointments

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Total outpatient attendances (all TFC; consultant and non consultant led)	43,907	44,438	41,817	46,761	41,252	43,907	48,088	45,500	40,223	47,591	42,347	45,235
Number of episodes moved or discharged to patient initiated outpatient follow-up pathway as an outcome of their attendance	1,625	1,689	1,631	1,870	1,691	1,844	2,068	2,002	1,810	2,237	2,075	2,262
Consultant-led first outpatient attendances (Spec acute)	9,132	9,242	8,697	9,725	8,579	9,132	10,001	9,463	8,365	9,898	8,807	9,408
Consultant-led follow-up outpatient attendances (Spec acute)	18,065	18,283	17,204	19,239	16,972	18,065	19,785	18,720	16,549	19,580	17,423	18,611
Outpatient procedures - ERF scope	6,419	6,497	6,114	6,837	6,031	6,419	7,031	6,652	5,881	6,959	6,192	6,614
Outpatient first attendances without a procedure - ERF scope	9,354	9,467	8,908	9,961	8,788	9,354	10,245	9,693	8,569	10,138	9,021	9,636
Outpatient follow up attendances without procedure - ERF scope	22,136	22,403	21,081	23,574	20,797	22,136	24,243	22,939	20,278	23,992	21,349	22,805
OP New/Proc Ratio	41.61%	41.61%	41.61%	41.61%	41.61%	41.61%	41.61%	41.61%	41.61%	41.61%	41.61%	41.61%
PIFU	3.70%	3.80%	3.90%	4.00%	4.10%	4.20%	4.30%	4.40%	4.50%	4.70%	4.90%	5.00%

- PIFU needs to be at 5% by March 2025 and further work will be needed to deliver 46.2% of attendances as first appointments or with procedures

Cancer and diagnostic ambitions focus on the delivery of core access standards by March 2025

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Cancer objectives reintroduce the 62-day standard alongside improvement in the Faster Diagnosis Standard

- The focus will shift this year from 62-day backlog reduction to delivery of the combined 62-day (urgent suspected cancer, screening and upgrade pathways) of 70%.
- The threshold for achieving the 28-day Faster Diagnosis Standard will rise from 75% to 77%.
- We are forecasting delivery of both these indicators.

	Apr 2024-Mar 2025	April 2024	May 2024	June 2024	July 2024	August 2024	September 2024	October 2024	November 2024	December 2024	January 2025	February 2025	March 2025
Percentage of patients seen within 62 days	66.9	64.13	64.13	65.52	65.17	66.32	66.96	67.29	67.37	68.18	68.42	69.14	70.27
Percentage of patients receiving a communication of diagnosis for cancer or a ruling out of cancer, or a decision to treat if made before a communication of diagnosis within 28 days following	75.87	74.98	75	74.95	75.45	75.47	75.97	75.98	75.94	76.44	76.49	76.45	76.98

We are forecasting compliance with the DM01 6-week diagnostic standard by March 2025

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Diagnostic Tests - Magnetic Resonance Imaging	1,185	1,185	1,128	1,298	1,185	1,185	1,298	1,317	1,711	1,868	1,744	1,845
Diagnostic Tests - Computed Tomography	2,669	2,669	2,542	2,923	2,669	2,669	2,923	2,875	3,451	3,773	3,502	3,698
Diagnostic Tests - Non-Obstetric Ultrasound	2,984	2,984	2,842	3,269	2,984	2,984	3,269	3,138	3,523	3,859	3,562	3,755
Diagnostic Tests - Colonoscopy	338	338	322	371	338	338	371	338	322	354	322	338
Diagnostic Tests - Flexi Sigmoidoscopy	146	146	139	160	146	146	160	146	139	153	139	146
Diagnostic Tests - Gastroscopy	407	407	387	446	407	407	446	407	387	426	387	407
Diagnostic Tests - Cardiology - Echocardiography	687	687	654	752	687	687	752	735	866	948	878	927
Diagnostic Tests - DEXA Scan	73	73	70	80	73	73	80	73	70	77	70	73
Diagnostics Tests - Audiology	358	358	341	392	358	358	392	358	341	375	341	358

- CDC capacity plus additional activity in endoscopy will be required to deliver the 95% target, modelled above.

Bed modelling shows that even with escalation beds our occupancy will be above 92%

West Suffolk NHS Foundation Trust

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

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Average number of overnight G&A beds occupied - adult	412	414	397	396	397	398	428	421	433	474	470	456
Average number of overnight G&A core beds available - adult	463	463	430	430	430	430	430	430	463	463	463	463
Average number of overnight G&A escalation beds available - adult	0	0	0	0	0	0	0	0	0	8	8	0
Average number of overnight G&A beds occupied - paediatric	6	8	7	8	6	9	9	12	9	13	12	10
Average number of overnight G&A core beds available - paediatric	15	15	15	15	15	15	15	15	15	15	15	15
Average number of overnight G&A escalation beds available - paediatric	0	0	0	0	0	0	0	0	0	0	0	0
Adult G&A bed occupancy calculated from above	89.0%	89.4%	92.3%	92.1%	92.3%	92.6%	99.5%	97.9%	93.5%	100.6%	99.8%	98.5%

- If we cannot vacate F9 in May then this will also delay the RAAC programme, incurring additional costs.
- Re-opening 33 beds in December has been included, however will be dependent on longer term plans for F9.
- Options for further physical surge capacity on site and are limited with any such space also requiring a staffing establishment.
- Virtual ward at 40 beds is included in the baseline demand, with the proposed increase to 100 beds included on a separate line.
- As other admission avoidance and discharge schemes are continuations of those in 2023/24, these have not been quantified separately.

Achieving 78% against the 4-hour standard is the key focus of Urgent and Emergency Care Planning

5% growth, inline with the growth experienced this year.
Trajectory as follows to get to the target of 78% by March 25.

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
68%	69%	70%	70%	71%	72%	73%	74%	75%	70%	74%	78%

We will build on the progress made in 2023/24 to achieve delivery of 78% by March 2025:

- Identifying opportunities from the senior leadership support to ED in March 2024 will be translated into an evolved improvement plan.
- This will report into a WSFT delivery group that will also support continuation of some Patient Flow Improvement CRT workstreams.
- The UEC Performance Governance Group will shift to being based at the Alliance level, bringing together all improvement work including discharge fund and UEC capacity funding initiatives.
- This will report into the WSFT Insight Committee and SNEE ICB UEC Committee.

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

For Approval

Board of Directors – Public Board	
Report title:	Finance Board Report – April 2024
Agenda item:	4.1.2
Date of the meeting:	24th May 2024
Lead:	Nick Macdonald, Interim Executive Director of Resources
Report prepared by:	Nick Macdonald, Interim Executive Director of Resources

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

Income and Expenditure position

We have agreed a planned I&E deficit of £15.2m after delivering a Cost Improvement Programme of £16.5m (4%)

The reported I&E for April is a deficit of £2.8m against a planned deficit of £2.4m. This results in an adverse variance of £0.4m due to non-recurring cost pressures in April.

Cost Improvement programme

We achieved our planned CIP of £507k in April. However, the target increases substantially from July onwards.

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

Our adverse variance in April is largely non-recurrent. Whilst this presents a cost pressure in April the May results will provide a better indication of our underlying financial position.

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

Our risks table highlights areas of focus for the organisation to ensure we meet our financial plan, specifically around CIP and staffing controls.

Recommendation / action required

Review and approve this report

Previously considered by:	Parts of this report were discussed at the May 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
April 2024 (Month 1)

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

Executive Summary

This report focusses on the 2024-25 financial performance.

We have agreed a planned I&E deficit of £15.2m after delivering a Cost Improvement Programme of £16.5m (4%)

The reported I&E for April is a deficit of £2.8m against a planned deficit of £2.4m. This results in an adverse variance of £0.4m due to non-recurring cost pressures in April.

Key Risks and Mitigations in 2024-25

The table below outlines the risks and mitigations and will be updated throughout the year.

	Impact on position	
	Best case £'000	Worst case £'000
Within our control		
ERF *	1,000	0
CIP under delivery (£13.7m target)	0	(2,600)
Time slippage against Risk adjusted CIP *	0	(1,500)
Stretch CIP *	0	(1,400)
Staffing growth above budget *	0	0
RAAC related costs	1,000	0
CDC margin	500	0
Lost margin from Elective activity (6 months)	0	(1,150)
Winter pressure/UEC	500	(500)
	3,000	(7,150)
Outside of our control		
Inflationary costs unfunded	0	(3,200)
Industrial Action costs unfunded*	0	0
Utilities (if budgets have been overstated)	500	0
	500	(3,200)
Total range (impact on proposed plan)	**3,500**	**(10,350)**

* see detail below at page 2 for signiicant changes

Financial Summary

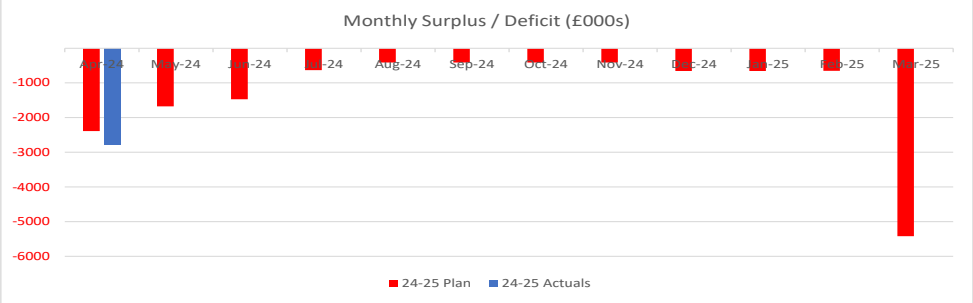
SUMMARY INCOME AND EXPENDITURE ACCOUNT - April 2024	April 2024 Budget £m	April 2024 Actual £m	April 2024 Variance F/(A) £m	Full Year 24-25 Budget £m	Full Year 24-25 Actual £m	Full Year 24-25 Variance F/(A) £m
NHS Contract Income	29.1	29.2	(0.1)	350.1	350.1	0.0
Other Income	3.2	3.2	(0.1)	36.9	36.9	0.0
Total Income	**32.4**	**32.3**	**(0.1)**	**386.9**	**386.9**	**0.0**
Pay Costs	23.5	23.9	(0.4)	272.8	272.8	0.0
Non-pay Costs	9.4	9.5	(0.1)	105.9	105.9	0.0
Operating Expenditure	**33.0**	**33.5**	**(0.5)**	**378.8**	**378.8**	**0.0**
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0
EBITDA	**(0.6)**	**(1.1)**	**(0.5)**	**8.2**	**8.2**	**0.0**
Depreciation	1.3	1.2	0.1	16.0	16.0	0.0
Finance costs	0.5	0.4	0.1	7.4	7.4	0.0
SURPLUS/(DEFICIT)	**(2.4)**	**(2.8)**	**(0.4)**	**(15.2)**	**(15.2)**	**0.0**

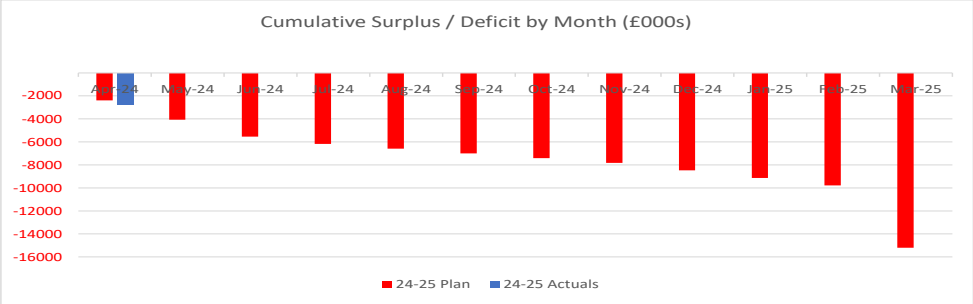
I&E Position YTD	**£2.8m**	**adverse**
Variance against Plan YTD	**£0.4m**	**adverse**
Movement in month against plan	**£0.4m**	**adverse**
EBITDA position YTD	**£1.1m**	**adverse**
EBITDA margin YTD	**4%**	**adverse**
Cash at bank	**£5.3m**	

FINANCE REPORT – April 2024

Income and Expenditure Summary - April 2024

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)	(2,391)	(2,778)	(387)	↓	Amber
YTD surplus/ (deficit)	(2,391)	(2,778)	(387)	↓	Amber
EBITDA YTD	(599)	(1,147)	(548)	↓	Amber
EBITDA %	(1.9%)	(3.5%)	(1.7%)	↓	Amber
Clinical Income YTD	(29,339)	(29,407)	68	↑	Green
Non-Clinical Income YTD	(3,013)	(2,931)	(82)	↓	Amber
Pay YTD	23,527	23,936	(408)	↓	Amber
Non-Pay YTD	11,216	11,181	35	↑	Green
CIP Target YTD	507	507	0	↔	Amber





Note the phasing above includes reserves of £3.9m that are held in M12 to be released as agreed business cases start incurring costs.

Page 2

Income and Expenditure for 2024-25

Plan

The Income and Expenditure (I&E) budget is for the Trust to record a deficit of £15.2m in 2024-25, which includes achieving Cost Improvements (CIP) of 4% (£16.5m).

M1 position

Our reported position as at the end of April was a deficit of £2.8m against our planned deficit of £2.4m – ie an adverse variance of £0.4m. This adverse variance relates largely to non-recurring expenditure :

- ED expenditure in April relating to our UEC improvement £150k
- Escalation ward open in April (unfunded) £155k
- Backdated APA claims £126k

We achieved our CIP target for April (£507k).

Forecast

At this early stage of the year we forecast meeting our financial plan of a £15.2m deficit, subject to the risks and mitigations outlined above.

Risks and Mitigations

The risks and mitigations table included under the Executive Summary provides a high level summary. Significant movements since this was previously shared:

- ERF. Best case has reduced from £3m to £1m. This is due to
  - £750k being included within the stretch CIP and
  - an assessment of overperformance based on April
- Staffing Growth above budget. Zero risk.
  - assumes strong workforce controls are implemented and
  - any pay related variance in April is largely non-recurring
- Industrial action costs unfunded. Worst case improved from £2m to zero.
  - assumes these do not materialise or are funded
- The Risk associated with CIP delivery have been increased by £3.5m:
  - risks associated with the stretch CIP
  - risks of slippage against timeframes for CIP delivery

FINANCE REPORT – April 2024

Cost Improvement Programme (CIP) 2024-25

A summary of progress on the CIP plan is included below (£16.5m). This includes £1.4m of CIP relating to the FYE of CIPs that started in 2023-24. It also includes a stretch CIP of £2.8m

In month progress (April)

The table below provides a summary of our most up to-date risk adjusted CIP plan (14th May 2024).

		RA By:	55%	35%	15%			
Division	Target (£k)	Identified 24/25 £k	Gateway 1 RA 55% £k	Gateway 2 RA 35% £k	Gateway 3 RA 15% £k	Plans 24/25 after RA £k	Plan to Target Gap £k	Pipeline PIDs
Medicine	2,211	467	93	33	178	304	1,907	14
Surgery	2,621	1,085	5	-	913	918	1,703	30
Women & Children	542	4	2	-	-	2	540	10
CSS	939	108	23	-	49	72	867	28
Community	1,613	809	364	-	-	364	1,249	21
Estates & Facilities	936	519	129	-	199	327	609	12
Corporate	4,724	192	27	-	113	140	4,584	14
Division Specific	**13,585**	**3,184**	**641**	**33**	**1,452**	**2,126**	**11,459**	**129**
TW - Workforce Group	-	1,101	379	-	220	599	(599)	-
TW - Procurement	-	759	320	-	41	361	(361)	8
TW - Pharmacy	43	934	187	-	441	628	(585)	3
TW - Discretionary Spend	71	71	-	-	61	61	11	1
TW - CMH	-	2,700	1,215	-	-	1,215	(1,215)	-
TW - Other	-	2,400	-	-	2,040	2,040	(2,040)	19
Stretch	2,800	-	-	-	-	-	2,800	-
Total	**16,500**	**11,151**	**2,742**	**33**	**4,255**	**7,030**	**9,470**	**160**

Whilst around £11.1m of CIP schemes have been identified (FYE) after risk adjusting these schemes we would anticipate these would deliver £7.0m of savings (if they were delivered from 1st April 2024). This includes the £1.4m FYE from 23-24

Since we have agreed a target of £16.5m for 24-25, a further £9.5m CIP needs to be delivered (notwithstanding slippage), which translates to a further £13m needing to be identified urgently. There are 160 schemes in the pipeline that should contribute to this £13m.

However, any slippage due to timeframes of implementation would heighten the challenge, therefore it is important to identify opportunities and that all schemes are moved to gateway 3 (delivery) ASAP.

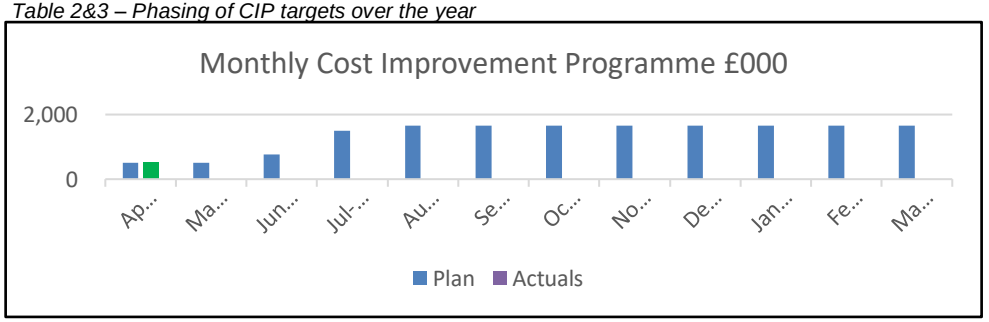
We achieved our CIP target for April (£507k).

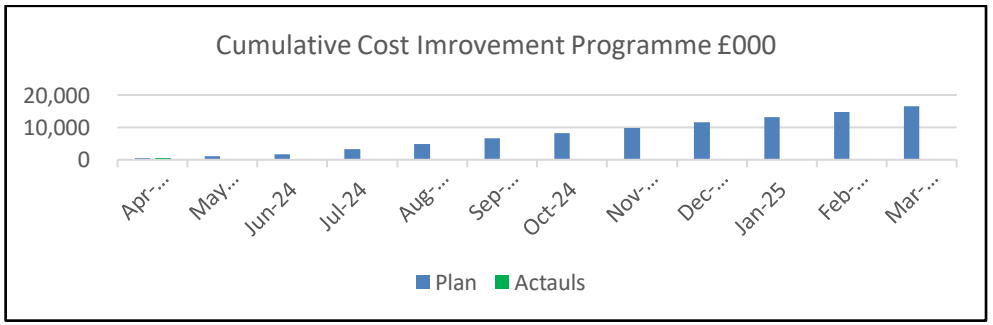
Table 1 – CIP achievement to date, with current forecast

Division	Annual Target £k	In-Month Target £k	In-Month Actuals £k	In-Month Variance £k	Annual Target £k	Actuals/ Forecast 2024-2025 £k	Variance £k
Medicine	2,211	68	-	(68)	2,211	304	(1,907)
Surgery	2,621	81	102	22	2,621	918	(1,703)
Women & Children	542	17	-	(17)	542	2	(540)
CSS	939	29	18	(11)	939	72	(867)
Community	1,613	50	17	(33)	1,613	364	(1,249)
Estates & Facilities	936	29	38	10	936	327	(609)
Corporate	4,724	231	120	(111)	4,724	140	(4,584)
Division Specific	**13,585**	**503**	**296**	**(208)**	**13,585**	**2,127**	**(11,458)**
TW - Workforce Group	-	-	-	-	-	599	599
TW - Procurement	-	-	-	-	-	361	361
TW - Pharmacy	43	1	3	2	43	628	585
TW - Discretionary Spend	71	2	7	5	71	61	(10)
TW - CMH	-	-	-	-	-	1,215	1,215
TW - Other	-	-	199	199	-	2,040	2,040
Stretch	2,800	-	-	-	2,800	-	(2,800)
Total	**16,500**	**507**	**504**	**(3)**	**16,500**	**7,031**	**(9,469)**

The tables below show the phasing of CIP plans and delivery for 24-25. 40% of our CIP is phased in the first half of the year.

Table 2&3 – Phasing of CIP targets over the year





FINANCE REPORT – April 2024

Divisional Financial Performance

	Current Month			Forecast
	Budget £k	Actual £k	Variance F/(A) £k	Annual Budget £k
MEDICINE				
NHS Contract Income	0	0	0	0
Other Income	(337)	(382)	44	(4,614)
Total Income	**(337)**	**(382)**	**44**	**(4,614)**
Pay Costs	5,797	6,116	(319)	69,380
Non-pay Costs	2,235	2,420	(185)	25,564
Operating Expenditure	**8,032**	**8,536**	**(504)**	**94,944**
SURPLUS / (DEFICIT)	**(7,695)**	**(8,155)**	**(460)**	**(90,330)**
SURGERY				
NHS Contract Income	0	0	0	0
Other Income	(245)	(261)	16	(3,074)
Total Income	**(245)**	**(261)**	**16**	**(3,074)**
Pay Costs	4,463	4,755	(292)	52,802
Non-pay Costs	1,424	1,508	(84)	16,507
Operating Expenditure	**5,886**	**6,263**	**(376)**	**69,308**
SURPLUS / (DEFICIT)	**(5,642)**	**(6,002)**	**(360)**	**(66,235)**
WOMENS AND CHILDRENS				
NHS Contract Income	(37)	(26)	(12)	(448)
Other Income	(119)	(116)	(3)	(2,151)
Total Income	**(157)**	**(142)**	**(15)**	**(2,600)**
Pay Costs	2,048	2,256	(208)	24,470
Non-pay Costs	166	170	(4)	1,727
Operating Expenditure	**2,213**	**2,426**	**(212)**	**26,197**
SURPLUS / (DEFICIT)	**(2,057)**	**(2,284)**	**(228)**	**(23,598)**
CLINICAL SUPPORT				
NHS Contract Income	(11)	(4)	(7)	(131)
Other Income	(177)	(215)	38	(2,138)
Total Income	**(188)**	**(219)**	**31**	**(2,269)**
Pay Costs	2,816	2,941	(125)	33,598
Non-pay Costs	1,349	1,408	(59)	14,952
Operating Expenditure	**4,165**	**4,349**	**(184)**	**48,549**
SURPLUS / (DEFICIT)	**(3,978)**	**(4,130)**	**(152)**	**(46,281)**
COMMUNITY SERVICES				
NHS Contract Income	(19)	(11)	(9)	(327)
Other Income	(547)	(516)	(31)	(6,694)
Total Income	**(567)**	**(527)**	**(39)**	**(7,021)**
Pay Costs	3,862	3,931	(69)	45,190
Non-pay Costs	1,590	1,674	(84)	18,651
Operating Expenditure	**5,453**	**5,605**	**(153)**	**63,841**
SURPLUS / (DEFICIT)	**(4,886)**	**(5,078)**	**(192)**	**(56,820)**
ESTATES AND FACILITIES				
NHS Contract Income	0	0	0	0
Other Income	(393)	(441)	48	(4,714)
Total Income	**(393)**	**(441)**	**48**	**(4,714)**
Pay Costs	1,314	1,314	1	15,584
Non-pay Costs	1,150	991	159	11,229
Operating Expenditure	**2,465**	**2,305**	**160**	**26,812**
SURPLUS / (DEFICIT)	**(2,072)**	**(1,864)**	**208**	**(22,098)**
CORPORATE				
NHS Contract Income	(29,054)	(29,142)	88	(349,161)
Other Income	(1,333)	(1,269)	(64)	(13,475)
Total Income	**(30,387)**	**(30,411)**	**24**	**(362,636)**
Pay Costs	3,228	2,623	604	27,959
Non-pay Costs	1,546	1,335	211	21,619
Capital Charges and Financing Costs	1,675	1,718	(43)	22,896
Operating Expenditure	**6,450**	**5,676**	**773**	**72,474**
SURPLUS / (DEFICIT)	**23,937**	**24,734**	**797**	**290,162**
TOTAL				
NHS Contract Income	(29,122)	(29,182)	60	(350,067)
Other Income	(3,151)	(3,200)	49	(36,860)
Total Income	**(32,273)**	**(32,382)**	**109**	**(386,927)**
Pay Costs	23,527	23,936	(408)	268,982
Non-pay Costs	9,461	9,507	(46)	110,248
Capital Charges and Financing Costs	1,675	1,718	(43)	22,896
Operating Expenditure	**34,664**	**35,160**	**(496)**	**402,127**
SURPLUS / (DEFICIT)	**(2,391)**	**(2,778)**	**(387)**	**(15,200)**

Medicine (Sarah Watson)

For the month of April, the division was behind plan by £0.46m. The division is reporting a £320k adverse variance for pay costs and £230k for non-pay which are partially offset by a favourable variance of £44k on income and £45k on capital charges. The main drivers behind these variances are:

- **Cause**: £155k cost relating to escalation ward that remained opened in April and was not budgeted for.
  Action: Division has developed and implemented a plan to close the escalation ward completely by end of May

- **Cause:** non occurring £150k in ED expenditure in April relating to our UEC improvement (76% achievement)

- **Cause:** £71k back dated payment for consultant's additional PA relating 23/24 that was not budgeted for.
  Action: The division has now implemented the use of a allocate system to record additional sessions, this should help improve monitoring and accuracy of reporting going forward.

There is also an adverse variance of £185k on high-cost drugs which is a pass through cost and the trust holds this income centrally

Surgery (Moira Welham)

For the month of April, the division was behind plan by £0.4m. The division is reporting a £292k adverse variance for pay costs and £119k for non-pay which are partially offset by a favourable variance of £16k on income.

Pay costs £292k over budget. Key drivers of this variance include:

- **Cause:** Extra contractual work (ECW) accounts for £140k of the spend in month. The division continues to undertake ECW across the specialties to treat more elective patients & reduce long waits.
  Action: ECWs are being monitored to ensure value for money and that the use of sessions remain appropriate. Whilst ECWs are predicted to continue, expectation is that the division will attract ERF monies to offset this cost.

- **Cause**: Salary arrears paid in month (£52k), primarily relating to consultant job plans being signed off and backdated.
  Action: Work is being undertaken to identify if there is any further financial impact expected from 24/25 job planning sign off. In addition, the division

are reviewing and improving the process to ensure the prospective sign off job plans and consider the short term and long-term financial impact.

- **Cause:** Agency usage (£72k) predominantly within Anaesthetics and Main Theatres. Agency spend is being used to support vacancies, sickness, and new starters whilst in their induction period.
  Action: Expectation is that spend will decrease further over the coming months as staff come into the numbers following their supernumerary period.

Non-pay costs £119k over budget. Key drivers of this variance include:

- **Cause:** In month, the division delivered more elective work than the planned baseline. Day case activity increased by 3.5% and Elective increased by 2.1%. Overall Theatre activity remains high, with 10% more patients treated in month than the 23/24 average which is contributing to the department's £90k adverse variance in the procurement of clinical supplies.
  Action: As with ECWs the expectation is that the division will attract ERF monies to offset this cost.

Women and Children's (Simon Taylor)

For the month of April, the division was behind plan by £0.23m. The division is reporting a £208k adverse variance for pay costs, £6k for non-pay and £15k on income.

Pay costs £208k over budget. Key drivers of this variance include:

- **Cause**: Paediatric and obstetric medical spend – significant rota gaps and staff on reduced duties with agency staff filling the night/premium pay shifts. Extra clinics for allergy service and prioritisation of urogynaecology and cancer services to meet demand.
  Action: Close review of costs on dashboards to monitor reasons, alongside frequent review with clinical and operational teams. Substantive vacancies are actively being recruited to and agency usage reduced wherever practical.

- **Cause:** Midwifery bank usage – significant recruitment but temporary spend still appearing high. Supernumerary shifts for trainees and international recruitment alongside high levels of annual leave in March.
  Action: Work ongoing with clinical teams to ensure annual leave is used evenly across the year and review is undertaken on a regular basis and reported into Nursing and Midwifery group.

Clinical Support (Simon Taylor)

For the month of April, the division was behind plan by £0.15m. The division is reporting a £125k adverse variance for pay costs and £55k for non-pay which are partially offset by a favourable variance of £28k on income.

Pay costs £125k overspend in-month. Key drivers of this variance include:

- **Cause**: the Division recorded the use of 639 WTE to deliver its services against a budget of 629 WTE. Following central guidance received late in the planning cycle, the budget for 24/25 was set at M11 outturn in line with the directive for Trusts not to increase their WTE over 23/24 levels. This increase in WTE is believed to represent the vacancies already being recruited to when the guidance on freezing the guidance was received, with no offsetting reduction in bank and agency usage.

- **Cause**: The cost of using bank and agency to cover substantive vacancies is higher than the average used in 23/24. The average cost in 23/24 was used to set the 24/25 budget.
  Action: Business units are being asked to forecast whether any further effect of the recruitment lag is expected, to provide a trajectory to bring the WTE in line with budget (including the CIP target) and a trajectory to reduce the cost of higher cost bank and agency. Reporting tools are being developed to support this.

Non-pay reported a £59k overspend in month. Key drivers of this variance include:

- **Cause:** The late receipt of an invoice for the maintenance contract for a CT scanner for FY 23/24. This will cause an in-year cost pressure against budget of £100k (£40k PY costs, £60k unbudgeted cost for 24/25).
  Action: The division is reviewing its major contracts to assess whether there is the scope to release budget to support this cost. Also, budget holders are being reminded of the purchase-to-pay process which requires receipting against purchase orders in a timely manner.

Community Services (Kevin McGinness and Nic Smith-Howell)

For the month of April, the division was behind plan by £0.19m. The division is reporting a £69k adverse variance for pay costs, £84k for non-pay and £39k for income.

Non-pay costs £84k over budget. Key drivers of this variance include:

- **Cause:** Demand for Community Equipment (CES) has continued to increase. To enable timely discharge to support seasonal plans and

patient flow through the escalation ward, a cost pressure of £29k was incurred.
Action: The Division will recover any aspect of the overspend incurred on behalf of Social Care, ESNEFT (acute) and Continuing Health Care patients. The Division will work with Alliance Partners to ensure an appropriate risk share of overspend that may recur in 24/25 following the removal of Hospital Discharge funding support.

- **Cause:** The increased demand for Wheelchair equipment has continued, following a significant increase in referrals (39% increase in the last 12 months).
  Action: The division will continue to invest in recycled equipment to contain cost increase as far as possible.

- **Cause:** The impact of 2024/25 inflation on service contracts incurred a £33k adverse variance in April.
  Action: The Division will work to offset cost increases as far as possible, for example by undertaking regular 'true up' of costs. The Division will provide a detailed schedule for Executive oversight, so that the impact of 2024/25 non-pay inflation can be evidenced to Commissioners.

Income £39k under budget. Key drivers of this variance include:

- **Cause:** A £64k under recovery was incurred following the cessation of prior year external investment in schemes to support improved patient flow and discharge.
  Action: The Division is working with Alliance partners to mitigate the financial risk to WSFT, because withdrawal of service would reduce capacity in some services to 2022/23 funded levels. The Division has also developed a local action plan, with specific local actions to be taken to address the financial risk.

Estates and Facilities (Chris Todd)

For the month of April, the division was ahead of plan by £0.21m. The division is reporting a £48k positive variance for income and a £157k positive variance for non-pay costs.

Income £48k over achievement. Key drivers of this variance include:

- **Cause:** £25k increase in catering income & a £14k increase in car-parking income.
  Action: Achievement against income targets will be monitored throughout the year to assess whether the current targets are appropriate.

Non-pay £157k positive variance. Key drivers of this variance include:

- **Cause:** Underspend on the cost of Gas noted in the month (£41k).
  Action: The department are monitoring the use of Gas to ascertain whether this represents a seasonal/non-recurrent reduction, or whether it represents a recurrent reduction in costs.

- **Cause:** Underspend on the cost of maintenance (building and gardens) recorded in month and a reduction in laundry costs (£43k).
  Action: The department are reviewing the maintenance & contract schedules to ascertain whether this represents a seasonal/non-recurrent reduction, or whether it represents a recurrent reduction in costs.

FINANCE REPORT – April 2024

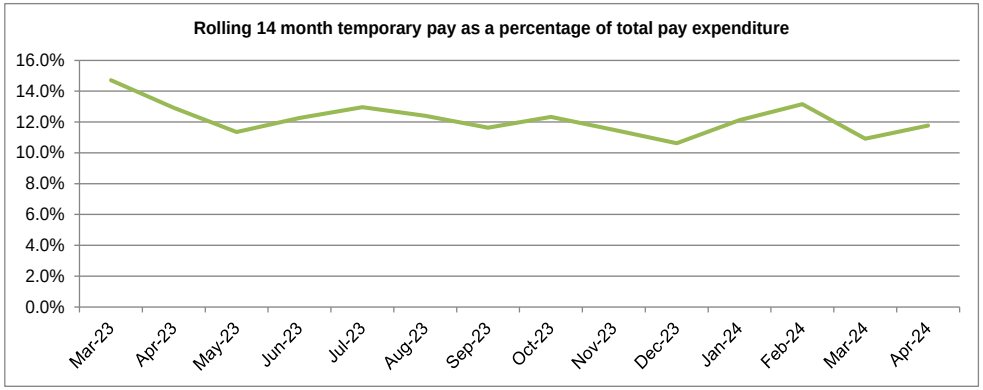
Workforce

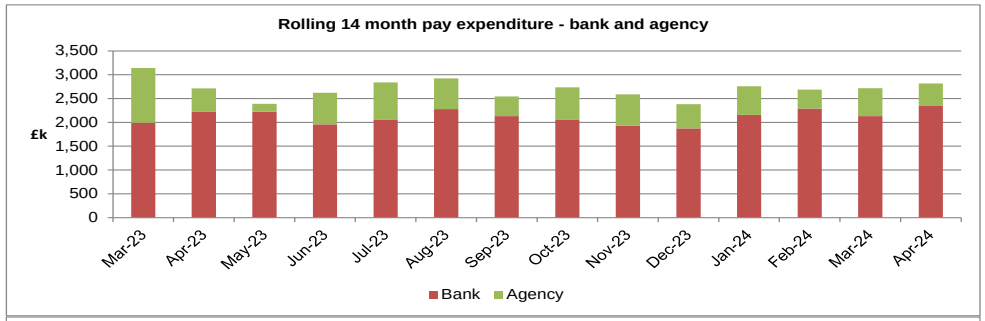
During April the Trust overspent by £0.4m on pay due to largely to non-recurring costs in ED, Escalation Ward and APAs).

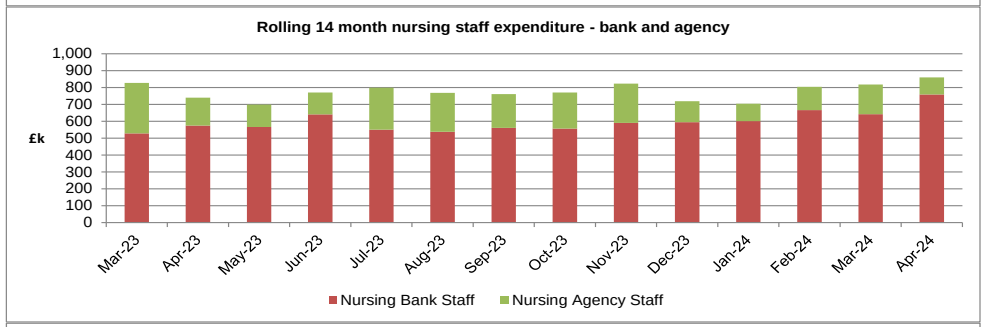
The pay related costs include an accrual of 2% in anticipation of pay awards (which are budgeted). Any variance from this will be reflected in the month these are paid. It is assumed pay awards will be fully funded and therefore budgets will align to any associated costs.

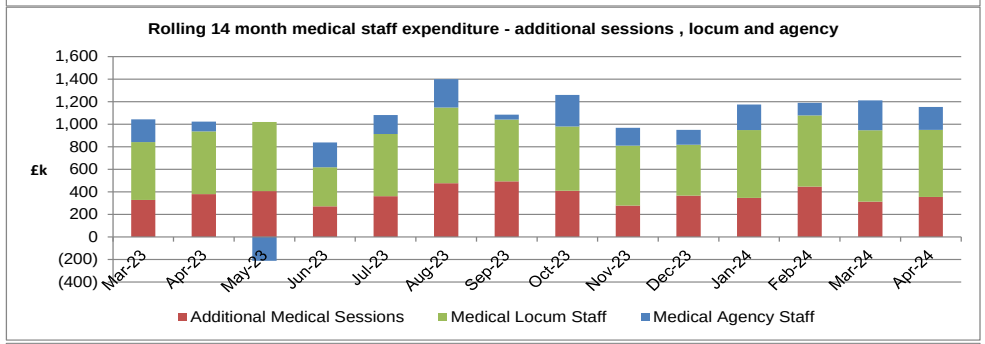
Pay Costs

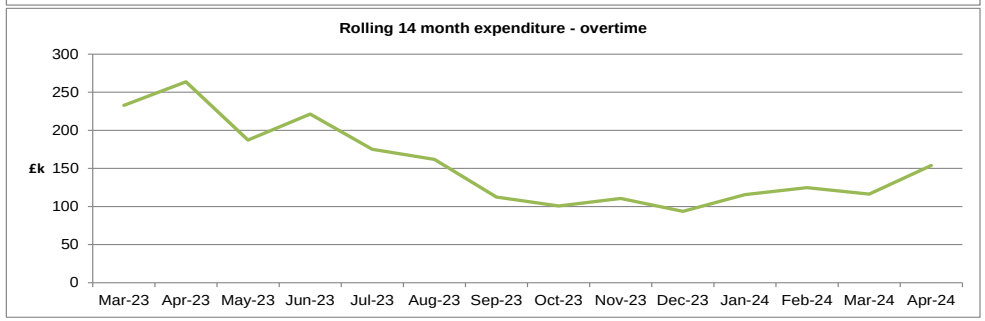
Monthly Expenditure (£)				
As at April 2024	Apr-24	Mar-24	Apr-23	YTD
	£000's	£000's	£000's	£000's
Budgeted Costs in-month	23,527	21,805	20,570	23,527
Substantive Staff	21,119	22,182	18,282	21,119
Medical Agency Staff	204	265	88	204
Medical Locum Staff	595	633	556	595
Additional Medical Sessions	354	312	380	354
Nursing Agency Staff	101	176	165	101
Nursing Bank Staff	758	641	574	758
Other Agency Staff	166	145	242	166
Other Bank Staff	246	223	265	246
Overtime	154	116	264	154
On Call	238	207	186	238
Total Temporary Expenditure	2,817	2,717	2,719	2,817
Total Expenditure on Pay	23,936	24,899	21,001	23,936
Variance (F/(A))	(408)	(3,094)	(431)	(408)
Temp. Staff Costs as % of Total Pay	11.8%	10.9%	12.9%	11.8%
memo: Total Agency Spend in-month	471	585	495	471











FINANCE REPORT – April 2024

Workforce - WTEs

Monthly WTE				
As at April 2024	Apr-24	Mar-24	Apr-23	YTD Average
Budgeted WTE in-month	5,053.0	5,026.3	4,928.3	5,053.0
Substantive Staff	4,703.8	4,709.7	4,466.2	4,703.8
Medical Agency Staff	14.7	14.3	9.2	14.7
Medical Locum Staff	35.8	52.3	56.9	35.8
Additional Medical Sessions	10.3	11.5	9.5	10.3
Nursing Agency Staff	13.2	23.1	16.1	13.2
Nursing Bank Staff	182.9	159.4	148.2	182.9
Other Agency Staff	41.2	22.6	41.1	41.2
Other Bank Staff	75.7	67.3	91.3	75.7
Overtime	33.1	28.0	66.6	33.1
On Call	9.9	7.7	7.5	9.9
Total Temporary WTE	416.7	386.1	446.3	416.7
Total WTE	5,120.5	5,095.8	4,912.5	5,120.5
Variance (F/(A))	(67.5)	(69.5)	15.8	(67.5)
Temp. Staff WTE as % of Total WTE	8.1%	7.6%	9.1%	8.1%
memo: Total Agency WTE in-month	69.1	59.9	66.4	69.1

In future reports this table will be extended to include a breakdown of substantive staff groups too.

The report will also provide a planned trajectory of WTEs with actuals plotted against it, initially for 2024-25 and then for the following two years.

FINANCE REPORT – April 2024

Statement of Financial Position – 30 April 2024

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2024	Plan 31 March 2025	Plan YTD 30 April 2024	Actual at 30 April 2024	Variance YTD 30 April 2024
	£000	£000	£000	£000	£000
Intangible assets	57,724	51,078	57,170	57,161	(9)
Property, plant and equipment	130,806	156,484	133,274	132,376	(898)
Right of use assets	11,624	9,512	11,448	11,624	176
Trade and other receivables	7,158	7,158	7,158	7,158	0
Total non-current assets	**207,312**	**224,232**	**209,050**	**208,319**	**(731)**
Inventories	4,640	4,600	4,600	4,696	96
Trade and other receivables	20,378	18,378	17,378	20,317	2,939
Non-current assets for sale	490	490	490	490	0
Cash and cash equivalents	9,315	1,107	4,360	5,304	944
Total current assets	**34,823**	**24,575**	**26,828**	**30,807**	**3,979**
Trade and other payables	(41,934)	(26,587)	(38,372)	(41,922)	(3,550)
Borrowing repayable within 1 year	(4,732)	(4,722)	(4,722)	(4,656)	66
Current Provisions	(58)	(58)	(58)	(55)	3
Other liabilities	(1,776)	(2,685)	(1,776)	(1,661)	115
Total current liabilities	**(48,500)**	**(34,052)**	**(44,928)**	**(48,294)**	**(3,366)**
Total assets less current liabilities	**193,635**	**214,755**	**190,950**	**190,832**	**(118)**
Borrowings	(44,049)	(39,160)	(43,783)	(43,957)	(174)
Provisions	(407)	(407)	(407)	(407)	0
Total non-current liabilities	**(44,456)**	**(39,567)**	**(44,190)**	**(44,364)**	**(174)**
Total assets employed	**149,179**	**175,188**	**146,760**	**146,468**	**(292)**
Financed by					
Public dividend capital	277,694	319,239	277,694	277,694	0
Revaluation reserve	11,941	11,941	11,941	11,941	0
Income and expenditure reserve	(140,455)	(155,992)	(142,875)	(143,167)	(292)
Total taxpayers' and others' equity	**149,180**	**175,188**	**146,760**	**146,468**	**(292)**

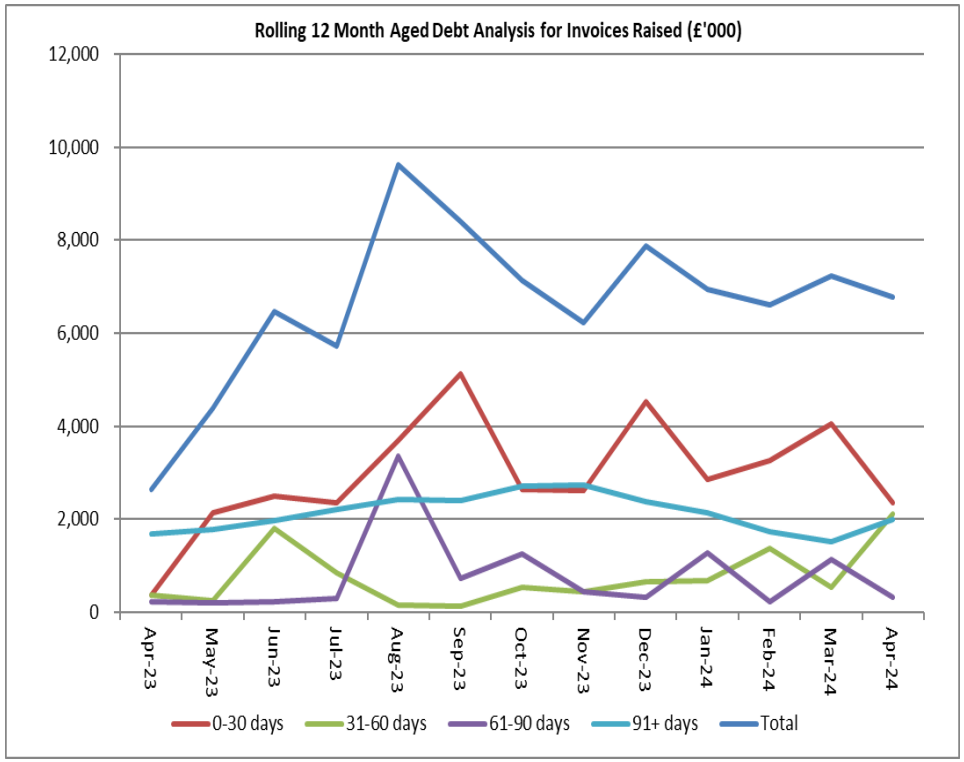
The above table shows the year to date position as at 30 April 2024.

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

Although both receivables and payables are higher than plan, they are in line with the 2023/24 outturn position.

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.

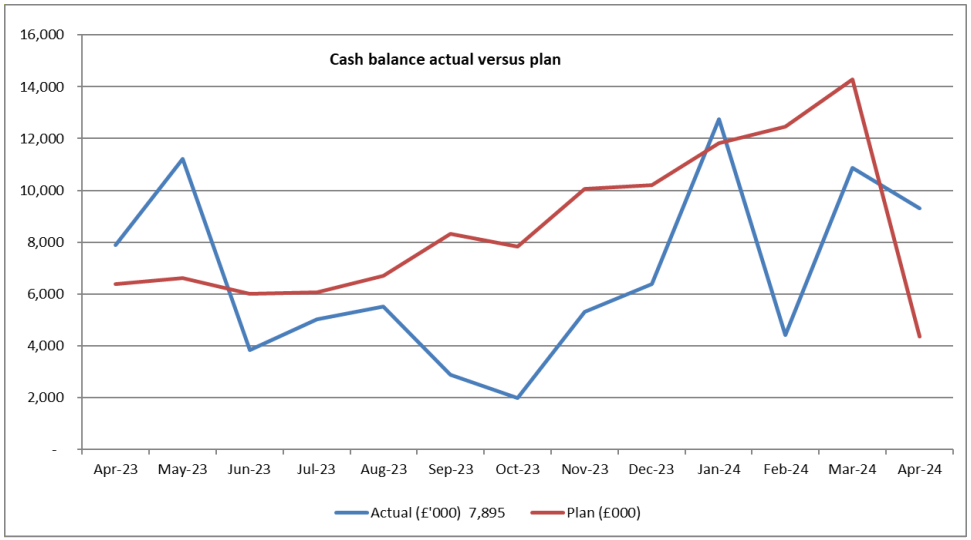
The overall level of sales invoices raised but not paid continues to remain stable and we have been working hard to reach resolution on some of the older debts in order to help the Trust's cash position.

Over 67% of the outstanding debts relate to NHS/WGA Organisations, with 16% of these types of debts being greater than 90 days old.

FINANCE REPORT – April 2024

Cash Balance for the year

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



The Trust's cash balance as at 30 April 2024 was £5.3m. This was made up of £1m of cash that is set aside to pay for capital projects and £4.3m for revenue payments.

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.

In order to ensure that the Trust has adequate cash support through to the end of June 2024, the Trust has requested a further £4m in revenue support. This was approved by the Board in March. We are waiting to receive the outcome of our application to DHSC.

It is expected that the Trust will continue to require revenue support during 2024/25 to support the continuing deficit.

Capital Progress Report

The Capital Plan for 2024/25 has been set at £33.54m. £9.99m will be internally funded, with the remaining £23.55m being funded by PDC.

The year to date capital spend at month 1 is £2.187m. The table below shows the breakdown:

Capital Spend - 30th Apr 2024	In Month			Year to Date			Full Year		
Capital Scheme	M1 Plan	M1 Actual	Variance to Plan	YTD Plan	YTD Actual	Variance to Plan	Full year Plan	Funding Split	
								Internal	PDC Available
	£000's	£000's		£000's	£000's		£000's	£000's	£000's
RAAC Programme	751	415	336	751	415	336	5,900		5,900
Newmarket CDC	964	876	88	964	876	88	7,860		7,860
New Hospital Programme	641	385	256	641	385	256	9,354		9,354
Digital Pathology	-	6	- 6	-	6	- 6	86		86
Image Sharing	-	-	-	-	-	-	345		345
Other capital projects:	767	507	260	767	507	260	9,999	9,999	
Estates		*102*							
IM&T		*281*							
Medical Equipment		*39*							
Imaging Equipment		*84*		-	-	-	-		
Total Capital Schemes	3,123	2,187	936	3,123	2,187	936	33,544	9,999	23,545
Overspent vs Plan								33,544	
Underspent vs Plan									

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4.2. 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: 20th March 2024		
Chaired by: Louisa Pepper			**Lead Executive Director: Susan Wilkinson and 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 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 committee's assurance process. Data needs to be sensitive enough to cover aspects of patient safety and quality.	1
5.2	C-Diff – Deep Dive (clostridioides difficile are bacteria found in the gut which usually cause no harm. However, when the balance of bacteria is disturbed, they multiply producing toxins which cause illness e.g. diarrhea.	2	WSFT C-Diff infection rate (hospital and community) continue to increase exceeding the threshold of a count of 49 as set out in the NHS Standard Contract 2023/24. We are an outlier.	QI programme being developed to include: - IPC Nurses. Education/training for staff at induction & on-going learning. C-Diff caseload.	1

Originating Committee: Improvement Committee			Date of meeting: 20th March 2024		
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			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
			Challenges that may have an impact on infection rates: - F12 isolation ward capacity prioritised for respiratory illness. Increased bed moves. RAAC challenges, no decant wards to allow for deep cleans. Ward pressures and challenges with IPC standard infection control precautions being followed. Repeat sampling. Decision to admit – inconsistencies regionally. HOHA/COHA.	Review of FM First cleaning scores at Patient Environment Group. Pharmacist/Microbiology Consultants – antibiotic stop at seven days. Weekly C-Diff review. Estates – hand basins in sluices & working collaboratively to include IPC plans. Report to Infection Prevention Control Committee & PQ & SG.	
5.4	Discharge Summaries/Transfer of Care. (The Transfer of Care Committee TOCC has been established to	3	Over the last year the Patient Safety & Quality Team have highlighted increased concerns regarding the quality, timeliness	Agree reporting pathways for four specific specialist groups, namely: -	

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			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
	consider a coordinated approach to on-going challenges that occur when transferring patients to external health and social care providers.		& absence of detail in transfer of care communications. This adversely impacts patient experience. In addition, the Trusts performance in relation to correspondence with GP's following discharge requires improvement. Transfer of Care Programme Chair – Mr Ravi Ayyamuthu.	Safer Discharge Group. Discharge Summary Group. Patient Flow Group. Complex Transfer of Care Group. Agree metrics to form a TOCC dashboard & other sources of insight (incidents & patient experience feedback). Develop a QI programme to monitor individual QI project ideas from initiation to sustained improvement. Improvement Committee update Sept 24.	
6.1	Patient Quality and Safety Group (PQASG)	2	Regular monthly report using the Trust's 1-4 assurance level scale.	PQASG will continue to maintain oversight of all items reported as emerging concerns through its reporting framework. No actions	1

Originating Committee: Improvement Committee			**Date of meeting: 20th March 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 provided from the following meetings: - Safeguarding Children & Young People Safeguarding Adults Learning Disabilities Human Factors Claims Duty of Candour		Areas of partial assurance: - Safeguarding Level 3 training compliance for ED staff needs to improve. Non-Accidental Injury maps require updating. MCA/DOL assessment quality along NICE Guidelines currently 55%compliance – needs improvement. Sec 42- Safeguarding enquiries increasing. LD & Autism training – on-going debate between Trust and CQC regarding levels for staff. LD & Autism CNS capacity. Duty of Candour – audit process continues to understand Q3 dip in performance (no trend identified).	or escalations for Improvement Committee.	

Originating Committee: Improvement Committee			Date of meeting: 20th March 2024		
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6.1.2	Discharge Waiting Area (DWA) Risk Summit – Outcomes & Plan. (Raised following several concerns over the quality & patient experience of the DWA)	2	DWA is a clinical area that delivers direct patient care that does not sit within a clinical division. Whilst there have been improvements in staffing, admin support & the environment – move to F2 is positive, there are still some vulnerabilities and risks.	Several recommendations have been identified and solutions scoped to improve patient & staff experience & overall governance of the area. An improvement plan has been compiled with no assurance levels identified. Improvement Committee – update June 24.	1
6.2	Clinical Effectiveness Governance Group (CEGG) Updates from the meeting: - - CQUIN - QI - National & Local Clinical Audit	1	5 new NBP publications. To compliment the revised TOR, CEGG will compile a development plan using the draft NHS Impact's maturity matrix. CEGG's new Chair is Professor Nicholas Levy.	CEGG will continue to maintain oversight of all new items reported as emerging concerns through its framework.	1

Originating Committee: Improvement Committee			Date of meeting: 20th March 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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7.1	Patient Safety Incident Response Plan & Safety Improvement Group Report – Quarterly Update.	1	Patient Safety is fundamental to patient care & a core component of our Trust Strategy. As an early adopter of PSIRF, the Trust transitioned to this framework in Feb 21 following approval by the Board, ICB and NHS England.	PSIRF will be adopted by all providers and commissioners of healthcare under NHS contract from 1/4/24. Patient Safety Incident Response Plan to continue – Dec 24. Improvement Committee agreed with proposed response to National consultation on Never Events framework- this was the option to abolish framework and list in its current format as it feels punitive and doesn't allow for consideration of proportionate learning responses which would complement other frameworks	1

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				used for other patient safety incidents. Improvement Committee fully supported the proposed Safety Summit scheduled for May 24.	

**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.

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Improvement Committee			Date of meeting: 17th April 2024		
Chaired by: Louisa Pepper			**Lead Executive Director: Susan Wilkinson and 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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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. Areas of Note: - The number of patients in the acute hospital who do not meet the criteria to reside has not reduced significantly. Patients not meeting criteria to reside in community beds has increased. The 4-hour performance is below trajectory at 64.83% and a comprehensive improvement plan is in place. Cancer performance remains on track to meet the 62-day backlog	Subjects for future Deep Dives under consideration by the Committee.	1

Originating Committee: Improvement Committee			Date of meeting: 17th April 2024		
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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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			reduction target and Faster Diagnosis standard. Trajectories for 65- and 78-week waits has been revised due to industrial action. It is anticipated up to 400 patients will be waiting over 65 weeks and 55 patients over 78 weeks due to capacity. Plan to reduce these to zero by end Sept 24. Clostridium Difficile rates are a cause for concern – improvement programme in place. Update to Improvement Committee – Sept 24.		
5.1.2	IQPR Content – Proposal for on-going future data sets for the Improvement Committee reporting key quality and safety information as part of	1	PSIRF methodology provides opportunities to report on quality and safety priorities that have been identified as requiring further learning and oversight. The data has been received to understand the need to retain,	Improvement Committee assured regarding the methodology/IQPR review and support the addition, removal, and variation of the metrics, which will provide more meaningful oversight of patient safety and quality data.	3 (for awareness).

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	the Committee's assurance process.		revise or remove from the data pack. Any area removed will have a clear route to improvement through a specialist group, e.g. PQSGG. Infection Prevention – retain C-Diff only. VTE/MSA breaches – remove (PQSGG oversight). HAPU – remove (PQSGG oversight). Falls – remove (PQSGG oversight). Nutrition – refine (additional data set). Patient Safety Incidents – refine (link with PSIRF/safety culture). SHMI- retain.	New data scheduled for May reporting.	

Originating Committee: Improvement Committee			Date of meeting: 17th April 2024		
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			Complaints – refine (to better reflect patient experience). Well led – retain.		
5.2	Post-Partum Haemorrhage (PPH) – severe bleeding after childbirth. WSFT are an outlier and have one of the highest PPH in the region.	2	PPH rates were identified as a frequently occurring safety incident at WSFT in 2021. A QI Improvement Plan was initiated in Feb 2022 and included in the PSIRP for 2022/23. Every PPH over 1500ml is discussed at a Multi-disciplinary Divisional Incident Review. On-going QI Project. Maternity Team participates in Local Maternity and Neo-Natal system PPH workstream and regional PPH QI programme.	Continue QI work until PPH are within an acceptable range. Multi-disciplinary representation at QI workshops. Site visit to maternity units with acceptable range of PPH. Undertake a 'So What' review in relation to PPH. Trust data – requires validation to reduce duplication of entries.	3

Originating Committee: Improvement Committee			Date of meeting: 17th April 2024		
Chaired by: Louisa Pepper			**Lead Executive Director: Susan Wilkinson and Paul Molyneux**		
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6.1	Patient Quality and Safety Group (PQASG) Updates provided from the following meetings: - Pressure Ulcer Steering Group Falls Steering Group Incidents (Patient Safety Team) Nutrition Steering Group Infection Prevention Trauma	1	Regular monthly report using the Trust's 1-4 assurance level scale. Areas of partial assurance: - Bed rails assessment NPSA compliance. Provision of low-rise beds (9 in the Trust, 50 arriving in May 24). Tier 2 weight management services commissioned through SNEE no longer available. Of note: - Food satisfaction survey positive results, 90% patients report food as fair or good.	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: 17th April 2024		
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6.2.1	Clinical Effectiveness Governance Group (CEGG) Updates from the meeting: - Public Health Radiology (including accreditation) CEGG Development Plan	1	No new NBP publications. Radiology remains QSI accredited. Ten updates given, three are outside the scope of Radiology to resolve: - NMR requesting imaging outside of scope. Orthopaedic pre-assessment clinic 0% compliance with IR(ME)R record keeping. New radiation protection risk identified. Risk of radiation errors due to Trust IT procedures affecting CRIS.	CEGG will continue to maintain oversight of all new items reported as emerging concerns through its framework.	1

Originating Committee: Improvement Committee			**Date of meeting: 17th April 2024**		
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			CEGG Development Plan compiled using the NHS Impact Maturity Matrix Template. CEGG's new Chair is Professor Nicholas Levy and they are seeking a Deputy Chair - Ravi agreed to do this		
9.2	Paediatric Audiology Service – Apr 24 - NHS England initiated a Paediatric Hearing Services Improvement Programme for providers and ICB's to improve the service quality.	(as the letter was dated 9th April too soon to make an assessment).	Report to CQC to include: - IQUIPS accreditation including any improvement recommendations. Whether the service is working towards IQUIPS accreditation. What stage work has reached and Board assurance levels regarding the service using IQUIPS standards. Timeline for accreditation.	NHS England require this issue to be considered at the next available Board meeting. The Board is required to consider assurance levels of safety, quality, and accessibility of children's hearing services. A report answering key questions to be submitted to CQC by 30th June 2024.	3

Originating Committee: Improvement Committee			**Date of meeting: 17th April 2024**		
Chaired by: Louisa Pepper			**Lead Executive Director: Susan Wilkinson and 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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			Number and severity where a child has suffered due to delay, misdiagnosis or treatment or not received timely follow up care and support.		

**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.

4.3. Quality and Nurse Staffing Report

To Assure

NHS
West Suffolk
NHS Foundation Trust

Public Board	
Report title:	Quality and Workforce Report & Dashboard – March and April 2024
Agenda item:	4.3
Date of the meeting:	24th May 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 March and April 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 the 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 at expected levels • Overachievement of temporary spend CIP by £65k. • Inpatient SNCT completed in February 2024. No intended adjustments to establishments due to new license and audit update • Band 2/Band 3 profile review supported by union and progressing as intended
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 – March and April 2024

1. Introduction

1.1 This paper illustrates how WSFT's nursing and midwifery resource has been deployed for the months of March and April 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 March and April 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 March and April 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 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%
Average fill rate March 2024	93%	92%	92%	98%
Average fill rate April 2024	92%	88%	96%	104%

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 11 months. This is a sustained positive improvement as indicated in the chart 2 below.

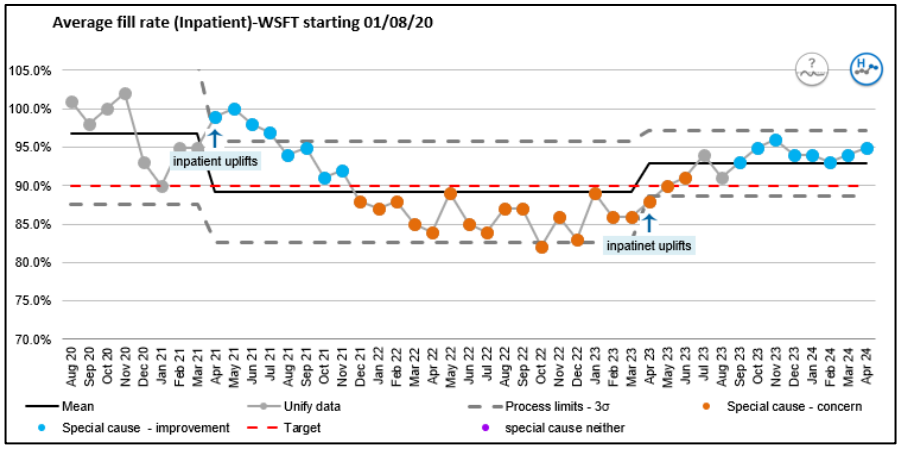


Chart 2

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. March achieved expected level of CHPPD of 7.6 and April declined slightly to 7.4.

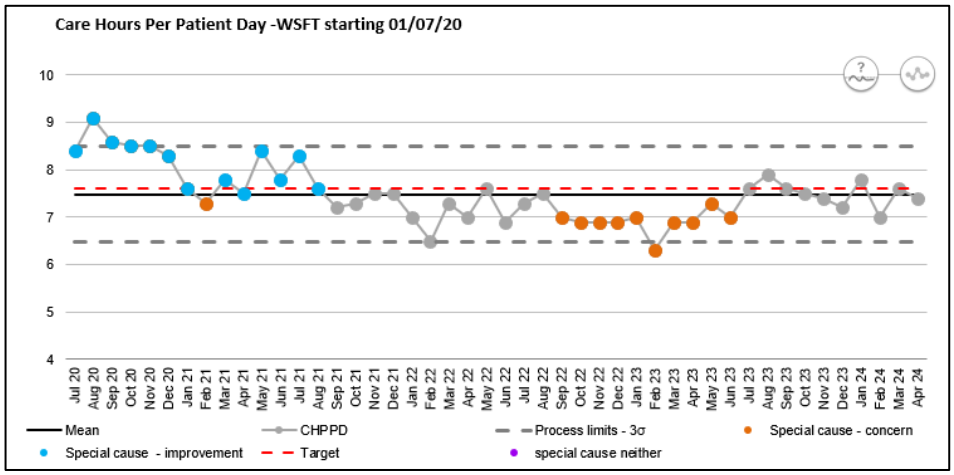


Chart 3

3.3 **Sickness**

High sickness rates declined over this period in both staff groups. Registered nursing under 5% for both months

	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar 24	Apr 24
Unregistered staff (support workers)	6.01%	6.30%	6.57%	7.36%	7.24%	6.50%	5.66%	5.99%
Registered Nurse/Midwives	4.78%	6.08%	5.95%	5.96%	5.90%	4.43%	4.49%	4.20%
Combined Registered/Unregistered	**5.19%**	**6.15%**	**6.16%**	**6.43%**	**6.34%**	**5.11%**	**4.87%**	**4.78%**

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 over this period has increased from 8.6% to 9.1%
- Total RN/RM vacancy rate has increased from 6.5% to 8.4%.
- Total NA vacancy has improved from 11.2% to 10.3%
- Inpatient vacancy rate has improved from 11.1% to 8.4%.

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.

Despite moves in vacancy rates in M1 substantive WTE staff numbers have remained reasonably static. The changes in vacancy rate are attributed in part, to skill mix changes in ED now reflected in budgets [increased RNS and reduced NAs]

	Sum of Month 8	Sum of Month 9	Sum of Month 10	Sum of Month 11	Sum of Month 12	Sum of Month 1	WTE vacancy at M11
RN	696.8	689.2	694.8	695.3	701.6	706.3	**70.3**
NA	398.6	398.4	404.7	404.2	404.7	404.5	**37.3**

Table 5 Inpatient actual substantive staff WTE.

3.4.1 **International Recruitment**

As per plan, the Trust successfully achieved its target of the recruitment of 84 international nurses for 2023/24. Due to the positive vacancy position for registered nurses, it is getting increasingly difficult to place these nurses into vacancies. In response to this, international nurse recruitment will pause with our last cohort within our current cohort will arrive in June 2024. Future recruitment will be paused until September 2024, within anticipated arrivals in Q3. We are anticipating c35 student nurses, who will qualify in September, will be seeking employment at WSFT, this is another reason for temporarily pausing other recruitment routes such as international recruitment.

3.4.2 **New Starters**

	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24
RN	15	19	15	46*	20	17
NA	23	25	24	16	11	22

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 March, 20 RNs completed induction; of these; 12 were for the acute, 6 for bank service, 1 for community services and 1 for midwifery services.
- In March, 11 NAs completed induction; of these; 6 NAs are for the acute Trust, 2 for bank services, 2 for community services and 1 for midwifery services.

- In April, 17 RNs completed induction; of these; 6 were for the acute, 5 for community, 6 for bank services and 5 midwifery preceptors.
- In April, 22 NAs completed induction; of these; 15 NAs are for the acute Trust, 6 for bank and 1 for midwifery services

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 7.2%. NA turnover also contuse to improve on last reporting period from 17.2% to 14.9%

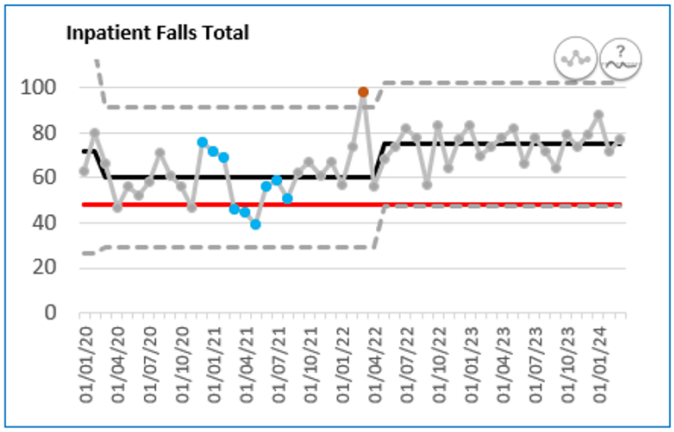
Staff Group	Average Headcount	Turnover Avg FTE	01/05/2023 Starters Headcount	- Starters FTE	30/04/2024 Leavers Headcount	Leavers FTE	LTR Headcount %	LTR FTE %
Nursing and Midwifery Registered	1,460.50	1,277.9632	79	64.9267	110	91.9400	7.5317%	7.1943%
Additional Clinical Services	616.50	517.0850	241	223.8066	100	76.4333	16.2206%	14.7816%

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). NB. April data not available at time of writing due to RADAR change over.



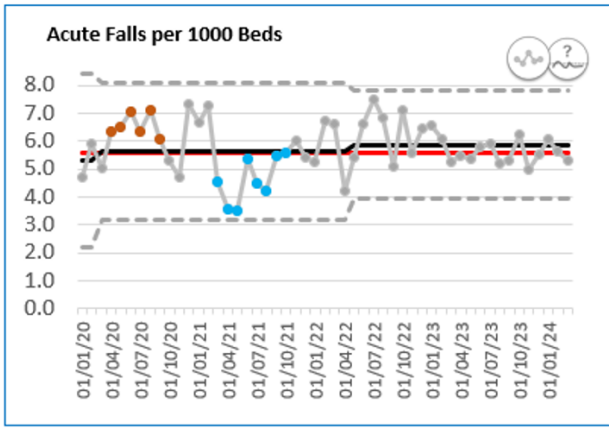
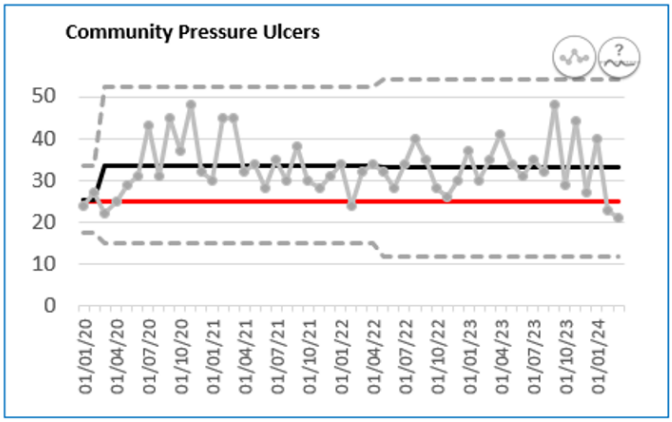


Chart 8 inpatient falls (April data not available at time of writing due to RADAR change over)



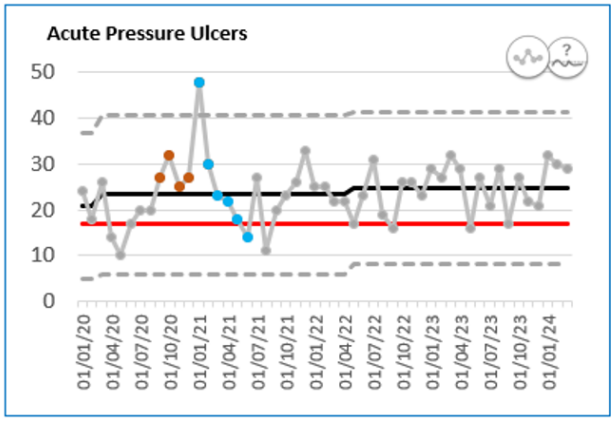


Chart 9 Pressure ulcers acquired in care.

3.6 **Compliments and complaints**

13 formal complaints were received in March. ED received the highest number of complaints. The most common theme of complaint this month was admission and discharge process. 55 compliments were received this month, which ED received the highest number.

9 formal complaints were received in April. No area received multiple complaints this month. The most consistent theme of these formal complaints was patient care needs not being met. 35 compliments were received this month with ED receiving the highest amount.

Chart 10a and 10b demonstrates the incidence of complaints and compliments for this period. The number of complaints is below average for both month 11 and month1, however compliments and positive feedback received has had a sustained improvement over the past 10 months.

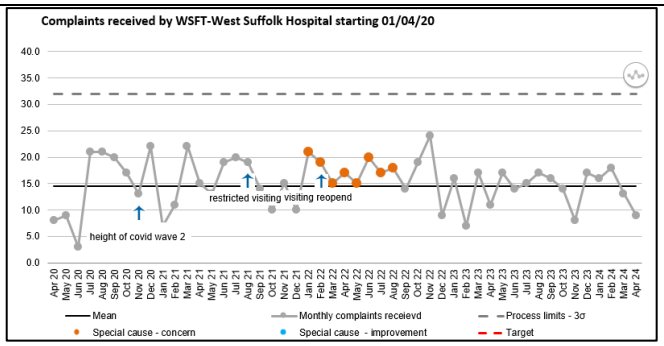


Chart 10a (complaints)

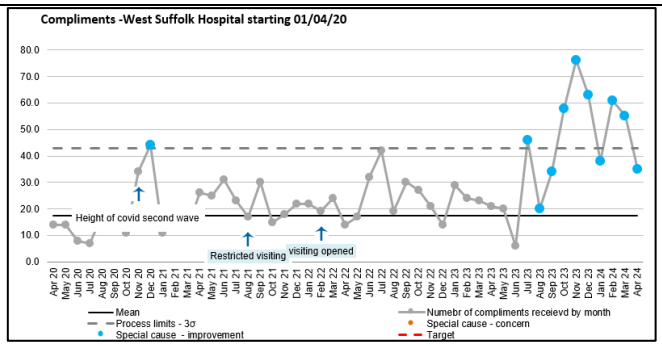


Chart 10b (compliments)

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 an incident form as required, so any resulting patient harm can be identified and if necessary, reviewed retrospectively. For this paper only those that meet NQB recommendations of a 'red flag' are included. Staffing not related to nursing are also excluded.

Red Flag	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Registered nursing shortfall of more than 8 hours or >25% of planned nursing hours	2	3	2	1	1	1
>30-minute delay in providing pain relief	-		1	5	-	-
Delay or omission of intention rounding	4	3	2	3	-	3
<2 RNs on a shift	1	7	2	2	2	3
Vital signs not recorded as indicated on care plan	-	-	2	3	-	1
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	3	6	8	3	3
Unable to make home visits locally agreed	-	2	-	-	-	-
GPICS (ITU) standards not met	1	-	-	-	1	1
Impact not described	-	-	1	-	-	-
Total	11	19	17	22	8	13

Table 11

- In March 13 Datixs recorded for nurse staffing that resulted in a Red Flag event (see table 11.). One incident is recorded as moderate harm, relating to a patient self-harming whilst in a toilet.
- April data not available at time of writing due to RADAR changes.
  -

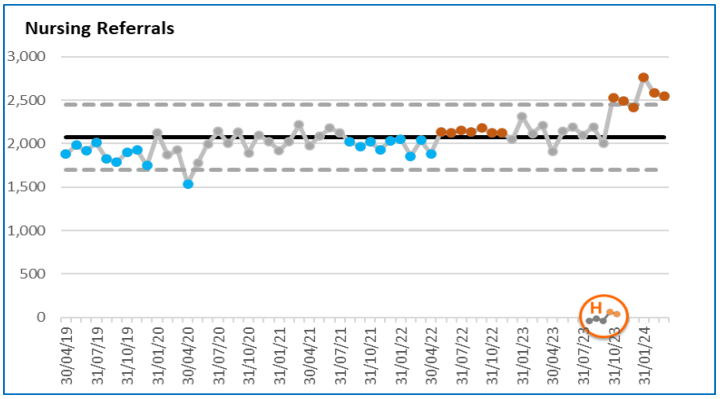
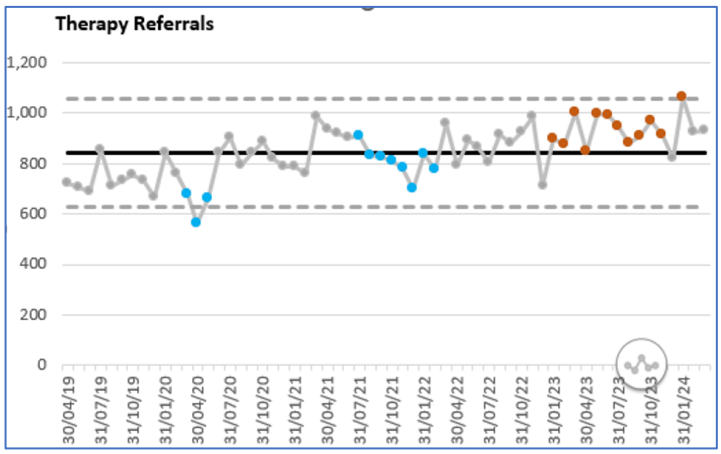
3.8 **Maternity services**

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

	Standard	November	December	January	February	March	April
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	1:21	1:21	1:21	1:21	1:19	1:21
No. Red Flags reported		1	2	4	3	0	TBC

Red Flag events

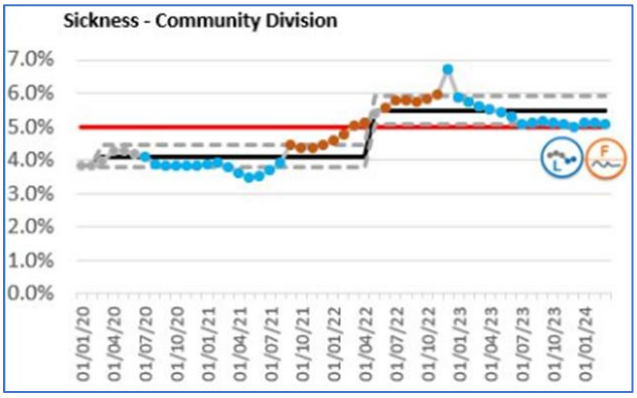
NICE Safe midwifery staffing for maternity settings 2015 defines Red Flag events as events that are immediate signs that something is wrong, and action is needed to stop the situation getting worse.

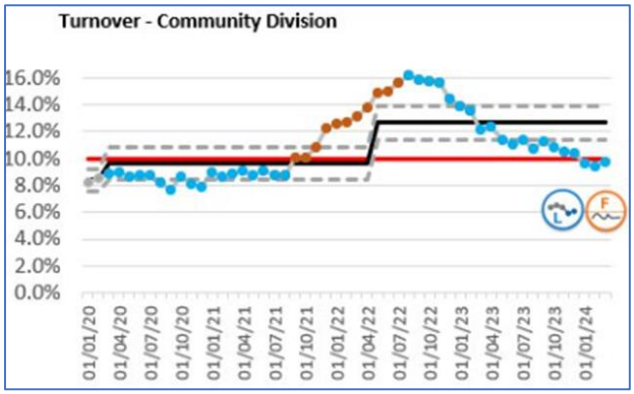
	Action includes escalation to the senior midwife in charge of the service and the response include allocating additional staff to the ward or unit. Red Flags are captured on Datix and highlighted and mitigated as required at the daily Maternity Safety Huddle. • There were no red flag events reported in March and April **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 1:19 in March and 1:21 April 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 March and April 2024.
3.9	**Community and integrated teams** **Demand** Below are the referrals until end of March 2024 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. Demand for nursing referrals is in special cause deteriorating indicating a sustained demand on this service.  

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.

The turnover figure continues to reduce and is just below the Trust target of 10%, sitting at 9.7% for March & Aril 2024. Team managers are focused on retention. Following results of the staff survey they have different strategies for actions that will support retention.





What next for community teams

- looking at the reason for absence around Anxiety, Stress Depression, and looking at what training/support can be put in place for those areas with high absences with a view of creating a more resilient workforce.
- To undertake an absence audit, arranged for May 2024, of all areas across Community to ensure absence is managed appropriately.
- Review results of CNST and triangulate in detail with quality data and professional judgement.
- Following triangulation, a paper will be written to identify improvements required.
- 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 the new dashboard use is going well, it is used daily to support any staff moves and reviewed on weekly basis to justify if any temporary spending on staffing will be needed in next 2 weeks.
- 2 Teams still have high levels of vacancies which do require temporary spending, Bury Town and virtual ward.

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. The CIP target of £865K was exceeded by £65k at the end of M12. This is evidence of sustained grip and control and commitment to ensuring our nursing workforce is deployed efficiently and cost effectively. CIP delivery is being scoped for 24/25 to explore additional opportunities in addition to those laid out below while maintaining quality and safe service provision.

	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	Actual	Actual
1. Overtime	15	73	33	10	8	0	**139**
2. Rate Standardisation	0	0	0	0	0	0	-
3. Pool reduction	57	86	77	77	79	82	**458**
4. Agency	0	49	75	76	78	55	**333**
5. Rostering	0	0	0	0	0	0	-
Achievement (£000)	72	208	185	163	165	137	930

4.2	**Establishment reviews** The trust obtained the licence for the revised Safter Nursing Care Tool (November 2023) and ran the first iteration of this audit in February 2024. The full outcome of this can be found in Appendix 4. Now that the tool has changed, with improved analysis on 1:1 care, three points of data will need to be collected to robustly validate the data. Therefore, is unlikely that any adjustments to inpatient nursing establishments will be made until FY25/26 unless there is a significant change in patient profile within an area.
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. At the time of writing, we have received formal notification that following engagement and balloting of their members, that unison is supportive of our intended approach. This process can now progress for staff to be moved to the relevant banding appropriate for their level of skill and competence.
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 or quality outcomes. 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 (March 2024) Data adapted from Unify submission.
RAG: Red <79%, Amber 80-89%, Green 90-100%, Purple >100

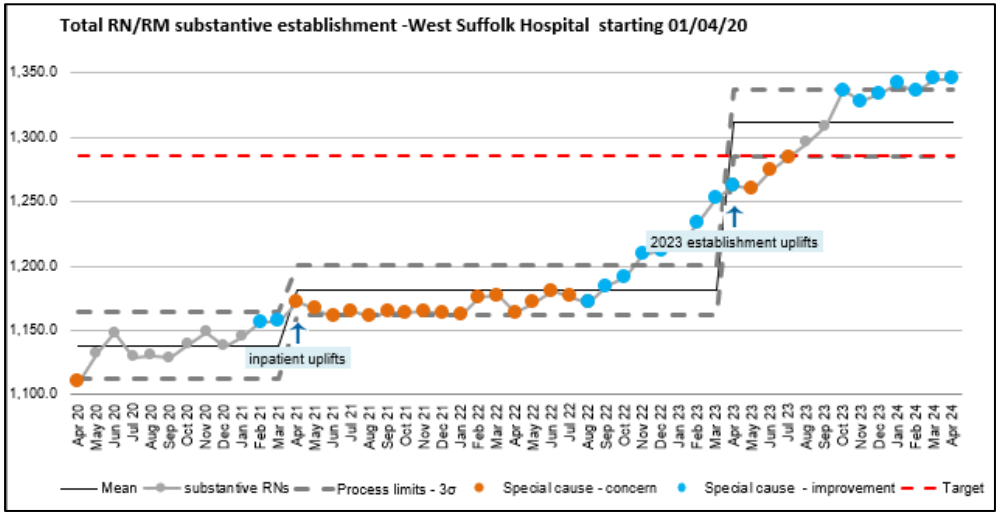
	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	RNs/RMN		Non registered (Care staff)		RNs/RMN		Non registered (Care staff)									
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned 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	1432.75	1330.25	1785	1647.75	1069.5	982	1426	1396.5	93%	92%	92%	98%	966	2.4	3.2	5.5
Glastonbury Court	715.5	717	1078.75	1035	713	713	542.5	539.5	100%	96%	100%	99%	532	2.7	3.0	5.6
Acute Assessment Unit	2093	2342	2240	1695	1766	1790.5	1322.5	1387	112%	76%	101%	105%	761	5.4	4.0	9.5
Cardiac Centre	1717.5	1603.5	1056.5	878.5	1736.5	1667.5	701.5	678.5	93%	83%	96%	97%	632	5.2	2.5	7.6
G10	1779	1403.25	1754.5	1535.4167	1069.5	1069.5	1781.516667	1600	79%	88%	100%	90%	707	3.5	4.4	7.9
G9	1726.75	1628.5	1391.5	1242.6667	1426	1394.5	1058	1100	94%	89%	98%	104%	752	4.0	3.1	7.1
F12	535.5	653.25	319.5	256	684.5	634.75	345	345	122%	80%	93%	100%	240	5.4	2.5	7.9
F7	1741.5	1476.4167	1757	1644.25	1391.5	1269.75	1724	1565.5	85%	94%	91%	91%	683	4.0	4.7	8.7
G1	1431.5	1031.5	354	267.5	713	701.5	345	331	72%	76%	98%	96%	485	3.6	1.2	4.8
G3	1778.5	1417.75	1782.5	1637	1069.5	1035	1069.5	1445	80%	92%	97%	135%	864	2.8	3.6	6.4
G4	1786	1485	1778	1626.5	1069	1046	1422	1451	83%	91%	98%	102%	896	2.8	3.4	6.3
G5	1426	1292	1713.5	1579.5	713	1047.5	1426	1448	91%	92%	147%	102%	760	3.1	4.0	7.1
G8	1940.75	1882.45	1490.25	1423.4167	1552.5	1503.933333	1054.5	1114.5	97%	96%	97%	106%	615	5.5	4.1	9.6
F8	1415	1375.0833	1771	1495.5	1064	955.5	1426	1439.5	97%	84%	90%	101%	723	3.2	4.1	7.3
Critical Care	2566	2529.75	345.25	212.25	2599	2599.75	0	121	99%	61%	100%	*	388	13.2	0.9	14.1
F3	1765	1470	2041.5	1826	1069.5	1042	1426	1428	83%	89%	97%	100%	732	3.4	4.4	7.9
F4	863.5	1027.5	527.5	570	678.5	644	494.5	416	119%	108%	95%	84%	633	2.6	1.6	4.2
F5	1887	1892	1434.5	1242.25	1058	1012	1069.5	998	100%	87%	96%	93%	698	4.2	3.2	7.4
F6	1627	1305	1690.5	1379.5	1069.5	995.5	701.5	1127.5	80%	82%	93%	161%	942	2.4	2.7	5.1
Neonatal Unit	1273.5	1042.75	744	684	1116	1020	744	540	82%	92%	91%	73%	116	17.8	10.6	28.3
F1	1720.5	1965.75	713	667	1426	1436.5	0	75	114%	94%	101%	*	115	29.6	6.5	36.0
F14	372	405.5	360	335.5	744	759.15	0	0	109%	100%	102%	*	106	11.0	3.2	14.2
F9	1288	1288	1288	1256.75	966	928.75	966	1394.75	100%	98%	96%	144%	744	3.0	3.6	6.5
Total	34,881.75	32,564.20	29,416.25	26,137.25	26,764.00	26,248.58	21,045.52	21,941.25	**93%**	**89%**	**98%**	**104%**	**14049**	**4.2**	**3.4**	**7.6**
* planned hours are zero, so additional support used on ward to mitigate unfilled nursing hours																

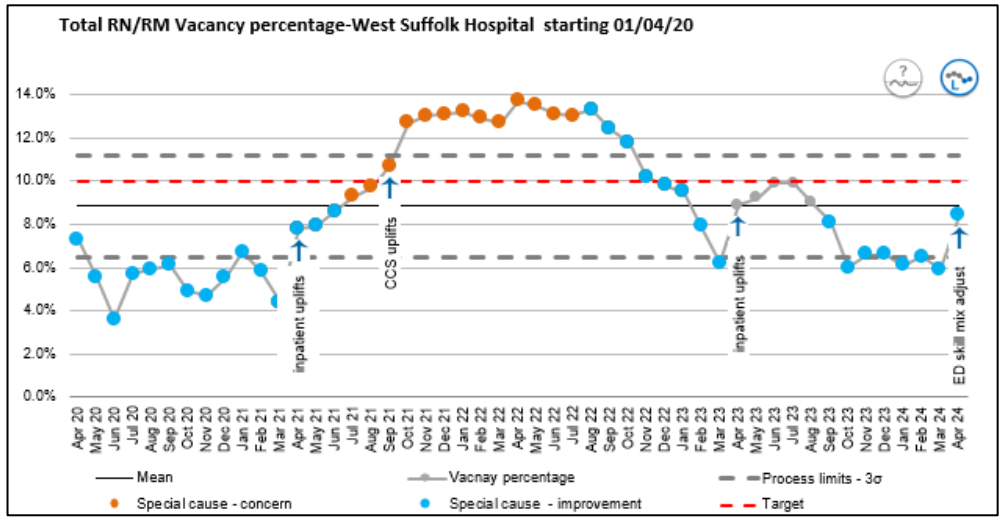
Appendix 1. Fill rates for inpatient areas (April 2024) Data adapted from Unify submission.

	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	1390.08333	1258.8333	1735.25	1556.5	1035	926.8333333	1380	1326.75	91%	90%	90%	96%	933	2.3	3.1	5.4
Glastonbury Court	690	690	1030	994.5	690	679.5	525	538	100%	97%	98%	102%	539	2.5	2.8	5.4
Acute Assessment Unit	2062.5	2159.75	2353.5	1814.5	1713.5	1672.75	1380	1365.5	105%	77%	98%	99%	761	5.0	4.2	9.2
Cardiac Centre	1721	1517	1035	925.5	1725	1542	690	740.5	88%	89%	89%	107%	632	4.8	2.6	7.5
G10	1715.5	1345.75	1695.75	1471.75	1035	1002.75	1728	1561	78%	87%	97%	90%	707	3.3	4.3	7.6
G9	1648.5	1431	1380	1291.6667	1357	1299.5	1035	1041.5	87%	94%	96%	101%	752	3.6	3.1	6.7
F12	529	652	363.5	326	678.5	644	345	346.5	123%	90%	95%	100%	240	5.4	2.8	8.2
F7	1725	1480.8333	1712	1521.25	1380	1272.5	1725	1530.5	86%	89%	92%	89%	683	4.0	4.5	8.5
G1	1382.5	1042.75	345	278.25	690	692	345	333.5	75%	81%	100%	97%	485	3.6	1.3	4.8
G3	1718	1422.6667	1713	1640.25	1029	997.3333333	1030	1426	83%	96%	97%	138%	864	2.8	3.5	6.3
G4	1732.5	1510.5	1731.5	1600.5	1035	1001.5	1379	1427.33333	87%	92%	97%	104%	896	2.8	3.4	6.2
G5	1380	1370	1725	1529.6667	690	1035	1380	1379.5	99%	89%	150%	100%	760	3.2	3.8	7.0
G8	2392	1832.35	1726.75	1471.6833	1644.5	1570.833333	1034.5	1104	77%	85%	96%	107%	615	5.5	4.2	9.7
F8	1373	1387.8333	1719.5	1413.75	1023.5	848.0833333	1380	1368.75	101%	82%	83%	99%	723	3.1	3.8	6.9
Critical Care	2417	2312.25	307	205.75	2415	2385.5	0	146	96%	67%	99%	*	388	12.1	0.9	13.0
F3	1564	1474.5	1989.5	1661	1035	1010	1368.5	1360.25	94%	83%	98%	99%	732	3.4	4.1	7.5
F4	877.75	914.5	621	532	690	609.5	529	445	104%	86%	88%	84%	633	2.4	1.5	4.0
F5	1819.5	1814.5	1362	1226.5	1023.5	983.5	1023.5	976	100%	90%	96%	95%	698	4.0	3.2	7.2
F6	1656	1244.1667	1702	1333	1035	993.25	690	1056.5	75%	78%	96%	153%	942	2.4	2.5	4.9
Neonatal Unit	1241	1108.25	720	688.5	1080	869	720	685	89%	96%	80%	95%	116	17.0	11.8	28.9
F1	1706.75	1782	688.25	730	1380	1357	0	34.5	104%	106%	98%	*	115	27.3	6.6	33.9
F14	1304	1392	360	357.5	720	721.5	0	0	107%	100%	100%	*	106	19.9	3.4	23.3
F9	1288	1288	1288	1118	966	893.5	966	1271.5	100%	87%	92%	132%	744	2.9	3.2	6.1
Total	35,333.58	32,431.43	29,303.50	25,688.02	26,070.50	25,007.33	20,653.50	21,464.08	**92%**	**88%**	**96%**	**104%**	**14064**	**4.1**	**3.4**	**7.4**
* planned hours are zero, so additional support used on ward to mitigate unfilled nursing hours																

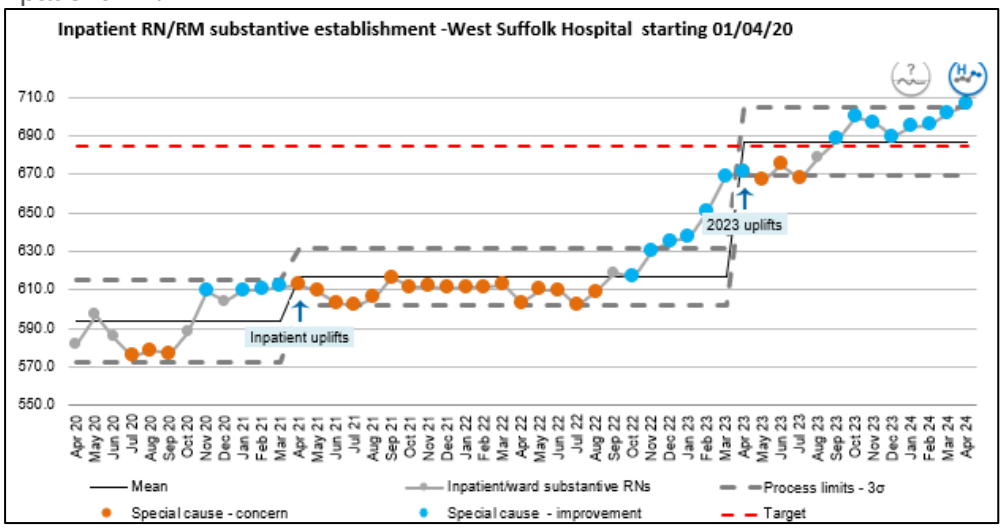
Appendix 2 SPC charts.

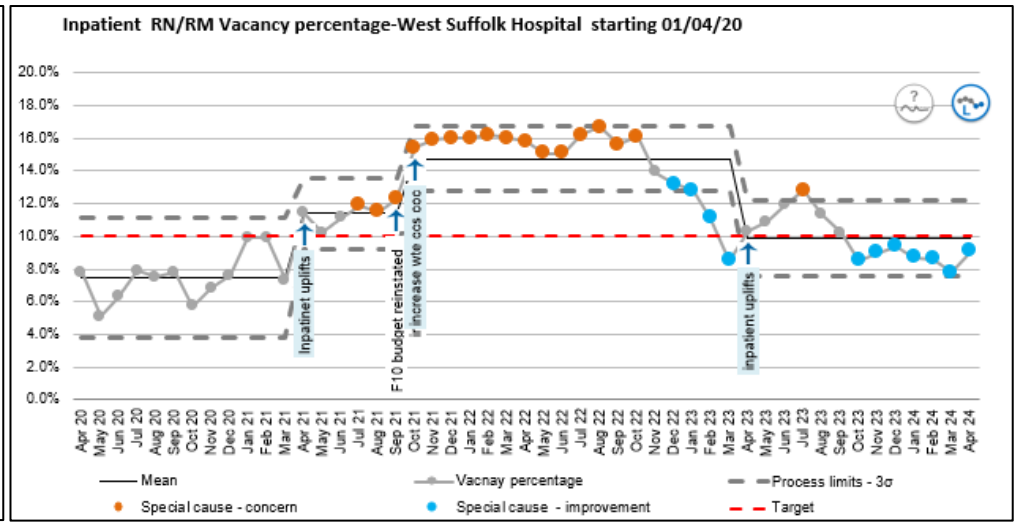
Trust Total RN/RM



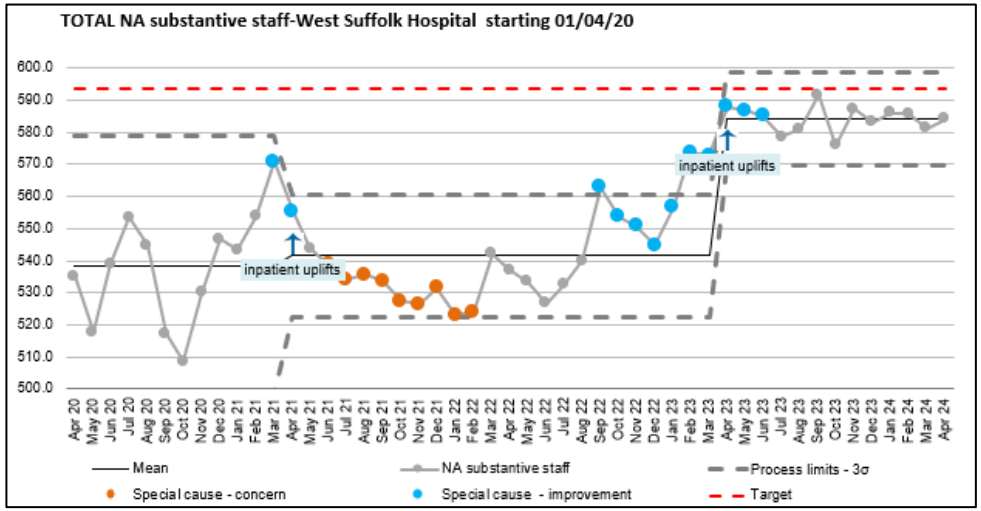


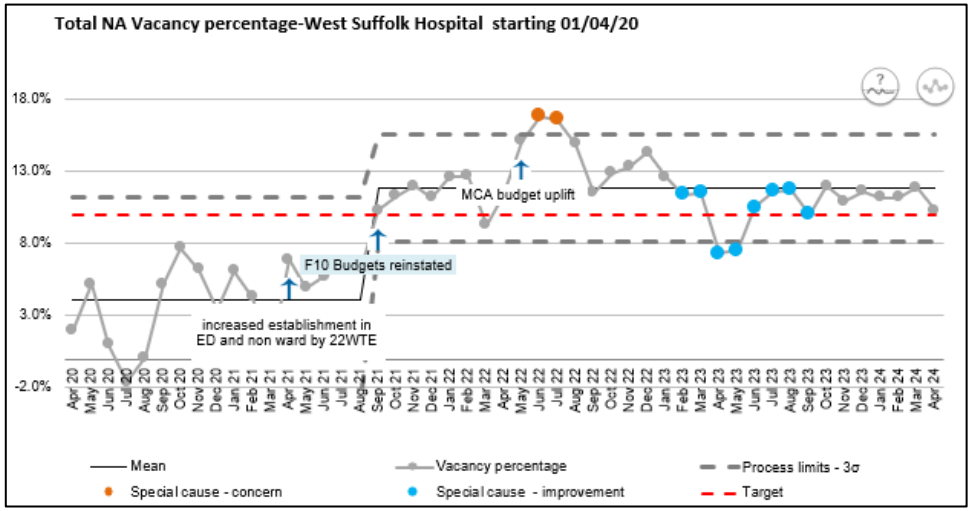
Inpatient RN/RM



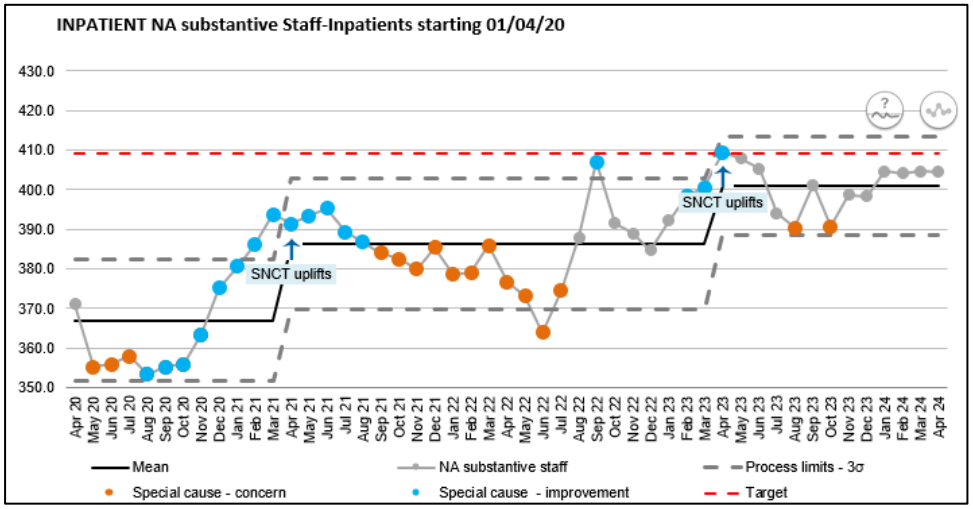


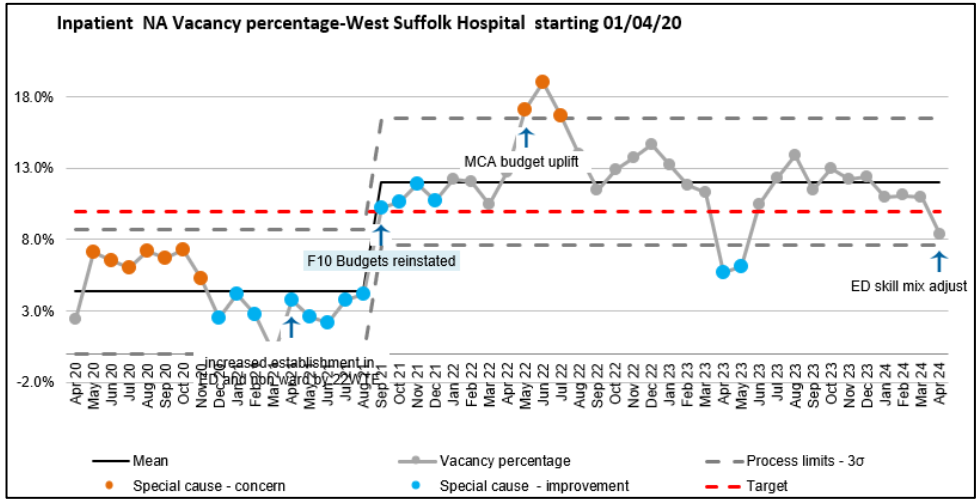
Total NA/unregistered.





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 Safer Nursing care output Feb 2024 [using new licence/patient discriminators]

	Split WTE		WTE	Audit Results					
	RN	NA	Budget at 2024 M11	February/March 2024					
				Includes provision for staffing for 1-1		Provision for staffing for 1-1 separately		Difference in 1:1 care provided in budget	Difference with No 1:1 care budget
Wards				FTE	CHPDD	FTE	CHPDD		
AAU	30.1	28.3	58.4	30.1	5.68	29.51	5.58	-28.4	-28.9
Cardiac / G7	40.7	15.7	56.4	38.0	7.37	37.71	7.31	-18.4	-18.7
F12	12.4	7.3	19.7	11.9	6.25	11.45	6.03	-7.8	-8.3
F7	24.9	25.8	50.7	50.5	6.3	49.64	6.2	-0.2	-1.1
F8	22.0	23.4	45.4	40.1	6.28	39.08	6.12	-5.3	-6.3
G1	34.3	8.8	43.1	18.9	6.59	18.27	6.37	-24.2	-24.8
G3	22.1	24.0	46.1	53.2	6.82	44.56	5.72	7.1	-1.5
G4	22.4	23.6	46.0	55.0	7.49	45.08	6.14	9.0	-0.9
G5	21.0	24.1	45.1	51.4	6.58	51.23	6.55	6.3	6.1
G8	32.7	20.6	53.3	53.7	8.33	50.43	7.83	0.4	-2.9
G9	25.8	18.0	43.8	44.5	6.91	43.46	6.75	0.7	-0.3
G10	22.3	27.2	49.5	50.2	6.59	44.56	5.86	0.6	-4.9
F3	22.2	25.8	48.0	43.6	7.02	39.2	6.3	-4.4	-8.8
F4	15.0	12.4	27.4	16.7	4.26	16.68	4.26	-10.7	-10.7
F5	24.0	21.7	45.7	31.4	4.91	30.81	4.82	-14.3	-14.9
F6	24.7	17.8	42.5	40.9	5.44	39.09	5.2	-1.6	-3.4
F14	20.9	4.0	24.9	8.5	4.34	8.52	4.34	-16.4	-16.4
Rosemary	25.1	24.8	49.9	55.8	7.18	53.95	6.94	5.9	4.1
Kingsuite	11.8	11.9	23.7	27.5	6.31	27.53	6.31	3.8	3.8

4.3.1. Maternity & Neonatal Services

Karen Newbury, Kate Croissant & Simon Taylor in attendance

To Approve

Open Trust Board	
Report title:	Maternity quality, safety, and performance report
Agenda item:	Maternity and Neonatal services
Date of the meeting:	24th May 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 Justyna Skonieczny Head of Midwifery

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

Executive Summary

WHAT?

This report presents a document to enable board scrutiny of Maternity services and receive assurance of ongoing compliance against key quality and safety indicators and provide an update on Maternity quality & safety initiatives 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.
- Maternity Incentive Scheme Board approval process (Annex B)
- HSIB/Maternity and Neonatal Safety Investigations (MNSI)/Early Notification Scheme Q4 2023/24 report (Annex C)
- Perinatal Mortality – closed Board – Quarter 4 2023/24 report (Annex D)

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. For the Maternity Incentive Scheme Board approval process to be approved.

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 been captured in the maternity improvement plan. NHSE and the ICS have agreed that a follow up visit will not be required and to move to annual visits.
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 Maternity Triage on the 27th February 2024 and spoke with several clinical and non-clinical staff, including students. They came across as a cohesive team who communicate well and work together to provide the best standard of care. It is evident that their working situation can be stressful at times, especially when there is high activity and on occasions, they can feel geographically isolated due to the location of triage away from the labour suite.

	With both in mind, there is the recognition for the need of increased obstetric presence in triage. To allocate an obstetrician solely in triage only, would require an increase in the workforce with subsequent business plan and available finances. Whilst this is currently not viable, the on-call obstetric team have commenced introducing themselves to the Triage team as part of their ward rounds, but this is yet to be fully embedded into practice. Waiting times for triage reviews continues to be audited monthly to ensure people are seen within the recommended timeframes and are meeting the regionally agreed target. Staff also highlighted the need for closer oversight regarding workload and potential temporary redeployment of staff in times of high activity. This will be shared with the ward managers and bleep holders. A discussion was also had regarding the fast pace of work and the need for regular breaks, although there was not a consensus of agreement regarding how often etc. Moving forward a short staff survey would be advantageous to capture all triage staff's views regarding shift times and break allocation. On a very positive note, the student midwife on duty, felt very much welcomed as part of the team, is happy and gaining excellent experience. On the 27th of March 2024 Roger conducted a 'walkabout' on the labour suite and observed harmonious working practices with staff pulling together, communicating well, and working as an effective team. The majority of staff that he spoke to have no concerns or comments and were satisfied with their current circumstances. The following comments were passed on for consideration: It was felt that staffing levels are currently better than they have been, which staff were grateful for. However, a view was expressed that the induction of labour rate is quite high, and this can put a strain on staffing levels at times. The ideal plan would be to equally distribute the inductions of labour, however due to the nature of the service this is not always possible, however it is managed where able. The theme of breaks was also raised, which has been shared with the ward managers at the departmental meeting to action. Room climate control was raised as an issue and how this can hinder keeping babies warm. This has been escalated and it is hoped a solution will be available by the end of April 24. Sharing equipment from room to room can make it difficult to locate and ensure that it is in good working order when required. The suggestion was for a dedicated set per room. This has been actioned where financially possible and to enable equipment movement to be tracked, a tag system will be fitted.
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 fora, all of which 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. Our recruitment and retention lead has offered all band 6's a 'stay conversation' and continues to update line mangers and the senior leadership team of any themes identified so that solutions can be sought. In response to listening to staff regarding the allocation of breaks, frequency, duration, and ability to take a survey has been undertaken to find a solution. There is also a focused survey underway to find the most viable way of covering a homebirth service 24 hours a day, 7 days a week. The staff survey approach ensures that the solutions found are co-produced and informed by the staff involved.

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	March Survey returns	March Very good and good %	April Survey returns	April Very good and good %
F11	67	95.24%	59	98.23%
Antenatal	42	97.01%	17	100%
Postnatal Community	33	81.82%	4	100%
Labour Suite	17	100%	16	100%
Birthing Unit	5	100%	-	-
NNU	2	100%	2	100%
Transitional Care	13	100%	16	100%

*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.

Healthwatch Suffolk Maternity care and support survey

Healthwatch Suffolk published Maternity care and support a summary of lived experience briefing in April 2024. This general summary of patient's experience was collected between February 2023- 16th April 2024. Communication about the opportunity to feedback was launched on the Healthwatch Suffolk website and promoted widely on social media. A total of 124 comments have been exported from the Healthwatch Suffolk Feedback Centre and included in the analysis, 41 out of 124 were specific to WSFT.

Service- total for Suffolk	Positive	Mixed	Negative	No of comments
2023-2024	56%	26%	19%	124
2021-2022	46%	12%	41%	147

There is an overall uplift in positive sentiment evident across the feedback since compared to 2021/ 2022 survey and WSFT had the highest rating across Suffolk (4.4)

1.5 **Reporting and learning from incidents**

During March and April 2024 there was one case that potentially meets the referral criteria to the Maternity and Newborn Safety Investigations (MNSI), confirmation of this is still being awaited. 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/Early Notification Scheme 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.

What?	So What?	What Next?
Increased rate of predominantly 3rd degree tears:	Not meeting the standard for spontaneous vaginal births (SVD) <2.5% and Instrumental births of 6.3%) Physical, psychological, financial implications for the person, family, and Trust. Interferes with the precious first hour after birth. Increase chance of mental health problems, depression, and relationship breakdown.	Re-launch of Obstetric anal sphincter Injury (OASI) bundle this includes: 1. Anetnatal education- will increase service users awarness of perineal trauma and action to take to reduce the risk of of it occuraing during birth. 2. Manual perineal protection- effective comminication with the women to encourage a slow and quided birth. 3. Episiotomy if clinically indicated- performated at an angle of 60 degrees from midline at crowning. 4. Systematic examination post birth even if the perineum appears intact.

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

April 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	98.79%	93.6%	96.93%	96.93%	27.06%	95.38%	32%	96.93%	98%	94%
MCA/MSW	NA	NA	100%	100%	NA	94.12%	17.95%	100%	NA	NA
Consultant Obstetrician	50%	81.25%	81.25%	81.25%	12.5%	89%	37.5%	NA	94%	94%
Obstetric Registrar	25%	100%	100%	100%	0%	89%	12.5%	NA	100%	100%
SHO/Core trainees	N/A	37.5%	12.5%	12.5%	N/A	89%	N/A	NA	NA	NA
Sonographer	NA	66%	NA	NA	NA	NA	NA	NA	NA	NA
Consultant Obstetric Anaesthetists	NA	NA	93.75%	93.75%	NA	NA	NA	NA	NA	NA
Obstetric Anaesthetists	NA	NA	92.85%	92.85%	NA	NA	NA	NA	NA	NA
Neonatal Consultants	NA	NA	NA	No Data	NA	100%	NA	100%	NA	NA
Neonatal Nurses	NA	NA	NA	22%	NA	92%	NA	85%	NA	NA
Neonatal Doctors	NA	NA	NA	No Data	NA	100%	NA	100%	NA	NA

	ANNP	NA	NA	NA	No Data	NA	100%	NA	100%	NA	NA
	To note; January and February's data presented at the last board, showed significant low compliance with some staff groups for safeguarding training. It has now been confirmed that this was due to a data collection issue and not that the training had been undertaken. Clarity has been sought regarding the structure of safeguarding training to the neonatal doctors and a process is now in place to ensure that the Electronic Staff Records captures the compliance of this.										

2. Reports

2.1 **Maternity Incentive Scheme Board approval process (Annex B)**

Year 6 of the NHS Resolution Maternity Incentive Scheme (MIS) was launched in April 2024 with ten key Safety Actions to be achieved and maintained by the Maternity and Neonatal Services provided by West Suffolk NHS Foundation Trust. Whilst there have been some minor changes to the safety requirements for this year in some of the Safety Actions, one of the key changes has been to the processes and pathways for Trust sub-committee and Board oversight. This has afforded the Trust the opportunity to optimise the reporting structures and assurance processes to ensure that each report has appropriate oversight and approval during this time.
The Trust Board will need to be assured of the evidence at the end of the period of reporting prior to the MIS declaration form being signed off by the Trust Executive Board and CEO by the 3rd March 2025.
This brief document outlines the updated processes for approval of reports through maternity and neonatal quality and safety meetings, the Maternity and Neonatal Safety Champions and the Board sub-committee - Improvement Committee. The Improvement Committee will provide assurances to the Board with regard to meeting the minimum requirements for evidence against the Safety Actions. The timetable in Appendix 1 outlines which reports will be approved by which Committees and Board along with the meeting dates.

The Trust Board is requested to approve the updated reporting processes and pathways in order that the approval of reports is effective, and assurances are provided.

2.2 **HSIB/Maternity and Neonatal Safety Investigations (MNSI)/Early Notification Scheme Q4 2023/24 report (Annex C)**

All cases that may meet the criteria for mandatory reporting to the Maternity and Newborn Safety Investigations (MNSI) and the Early Notification Scheme (ENS) have been considered during this period of time. However, none of the cases have been accepted for investigation as they do not meet the criteria set by MNSI. There have been no completed reports received from MNSI in this quarter. One investigation is still in progress.
If there are any cases of maternal death, suspected neonatal hypoxic ischaemic encephalopathy, intrapartum stillbirth or a neonatal death related to labour, there is an immediate review and consideration of whether the incident meets the criteria for referral to MNSI for investigation. There is evidence that this review and discussion with MNSI has taken place, but no cases have been accepted by them.

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 4 2023/24 report (Annex D)**

During the period of 1st January 2024 to 31st March the Trust notified MBRRACE of 2 perinatal deaths. These deaths were reported within the required timeframes and immediate safety issues have been discussed 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.
Neither of the perinatal losses met the requirement for reporting to the Maternity and Neonatal Safety Investigation (MNSI) team for investigation.
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 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. There is a direct link between the MBRRACE standards and the Maternity Incentive Scheme Safety Actions – namely safety action 1.
4.	**Next steps**
4.1	Reports will be shared with the external stakeholders as required. Action plans will be monitored and updated accordingly

4.4. Audit Committee Report

To Assure

Presented by Richard Jones

NHS
West Suffolk
NHS Foundation Trust

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Audit Committee			**Date of meeting: 19th March 2024**		
Chaired by: Michael Parsons			**Lead Executive Director: 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:**		
			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
Procurement & Contract Management	Deep dive on arrangements for procurement / tendering and contract management, including timeliness, value for money, collaboration opportunities, single tenders, and forward look.	Reasonable	The Committee was reassured by the comprehensive presentation and the engaging discussion. However, there was a lack of data to provide assurance and it was agreed that the new procurement dashboard being introduced from April 2024 should be reported to the Insight Committee periodically.	Insight Committee to consider procurement dashboard periodically to gain assurance.	2 -> Insight
Annual Governance Statement (AGS), Matters relating to Year-end 2023/24, Fit & Proper Persons Annual Report	Review of AGS including internal control issues; updates to governance documents (standing orders, scheme of delegation, etc); review of year-end accounting policies (going concern, significant estimates, etc); review of Fit	Substantial	The Committee agreed that the financial challenge (inc maturity, capability and processes) should be included in the AGS and also that the new hospital programme should be mentioned. The Committee asked that financial controls around	Some of these items will require formal Board approval in due course.	3 -> Board approval where required **SEE SEPARATE PAPER REQUESTING APPROVAL**

Originating Committee: Audit Committee			**Date of meeting: 19th March 2024**		
Chaired by: Michael Parsons			**Lead Executive Director: 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:**		
			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
	and Proper Persons annual report.		workforce should be reviewed, considering the PA report. The Committee agreed the preparation of the accounts on a going concern basis. The Fit and Proper Persons annual report was welcomed; the extension of DBS checks was noted.		
Internal Audit (RSM)	Approval of Internal Audit Plan for 2024/25. Update on delivery of internal audit plan and implementation of recommendations.	Reasonable	The Committee approved the Internal Audit Plan for 2024/25 and noted continuing good progress with delivering the 2023/24 audit plan. The Committee reviewed progress with implementation of recommendations, inc. those relating to business continuity.	Pleasing reduction in outstanding audit actions, although requires continuing focus by management.	2 -> Management Executive
Counter Fraud (RSM)	Approval of workplan for 2024/25.	Substantial	The Committee approved the workplan for 2024/25 and	Benchmarking data will be considered at a future meeting.	1. No escalation

Originating Committee: Audit Committee			**Date of meeting: 19th March 2024**		
Chaired by: Michael Parsons			**Lead Executive Director: 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:**		
			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
	Discussion on CF activities, including results from a recent fraud questionnaire.		noted actions on awareness and training. Fraud benchmarking data would be available in a few months. Discussed cyber security and noted that a cyber review was included in the 2024/25 IA plan.		
External Audit (KPMG)	Approval of audit plan and planning for upcoming audit.	Substantial	The Committee approved the audit plan and noted key points. The good working relationship between the external auditors and the trust finance team was welcomed; timeliness of information provision and responsiveness to queries during the audit will be essential to achieve timelines.	None	1. No escalation

**See guidance notes for more detail*

Guidance notes

The practice of scrutiny and assurance

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

Assurance level

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.

5. GOVERNANCE

5.1. Board Assurance Framework

To Assure

Presented by Jude Chin

Board of Directors	
Report title:	**Board Assurance Framework**
Agenda item:	5.1
Date of the meeting:	24 May 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

This report provides an update on development of the board assurance framework (BAF). The BAF remains structured around the agreed **10 strategic risks:**

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

The assessment of each BAF risk continues to be developed in line with the approach approved at by Board, including review by the agreed governance group and Board assurance committee.

Annex A of this report **maps movement for each of the BAF risk** according to the risk score for 'current' (with existing controls in place) and 'future' (with identified additional controls in place). These assessments are being reviewed and confirmed for four risks: Improvement (4); Digital (5); Patient engagement (9); and Staff wellbeing (10).

All of the BAF risk assessments have either recently been reviewed and updated. The following **summarises changes since the last report**:

- **BAF 1 Capability** - reviewed by the executive to update the risk scores and the assurances. The risk is still being reviewed and will be presented and signed off at the People and Culture leadership group prior to reporting to the Involvement Committee

- **BAF 2 Capacity** - reviewed by the executive to update the risk scores, the assurances and the actions. The risk needs to be presented and signed off at the next Patient Access Governance Group prior to reporting to the Insight Committee
- **BAF 3 Collaboration** - reviewed by the executive to update the risk scores, causes and effects, the risk assurance and the risk actions. The risk will need to be presented and signed off at Collaborative Executive Group for SNEE NHS Provider Collaborative, Alliance Committee, System Oversight and Assurance Group
- **BAF 6 Estates** - reviewed by the ADO to update the risk scores, cause and effects, the risk assurances and the risk actions. The risk will need to be signed off by the executive before forward reporting to the relevant committee
- **BAF 7 Finance** – being reviewed by the Deputy Finance Director to update the risk score in light of current financial position and findings of the financial diagnostic review
- **BAF 9 Patient engagement** - reviewed by the Head of Patient Experience & Engagement to update the cause and effects, the risk assurances and the actions. This is still work in progress and will need to be signed off by the Executive prior to reporting to the Involvement Committee.

Based on the current assessments **only one risk will achieve the risk appetite** rating approved by the Board based on the identified additional mitigations and future risk score (Annex B). This position will form part of the review and challenge by the relevant assurance committee of the Board for all of the risks – testing the risk rating, additional controls and risk appetite.

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:

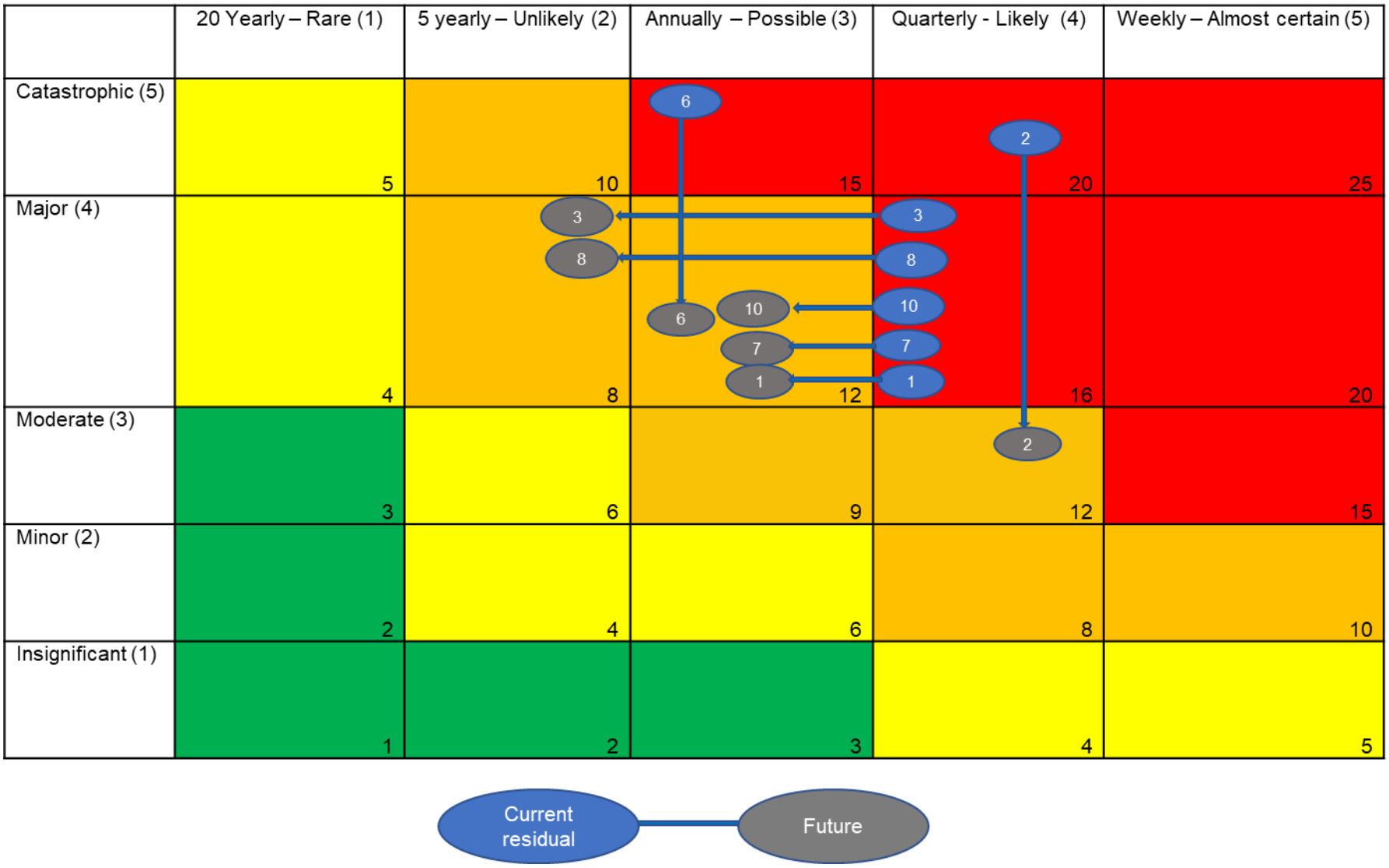
- **Completion of BAF update** to be reported to the next Board meeting, including oversight by the relevant assurance committees, moving to business-as-usual review and risk tracking through this report to the Board
- **Review by the responsible Board committee** to include:
    - Assessment of the 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.

Action Required

1. **Note the report** and progress with the BAF review and development
2. **Approve the 'Next steps' actions** and ask the assurance committee to schedule review of their allocated strategic risks.

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

Annex A: BAF risk movement



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

Annex B: Risk themes – summary table

Risk Theme	Exec lead	Board comm.	Appetite Level	Appetite score	Current risk score	Target risk score	Within risk appetite?	Assur. level
Capability and skills (BAF 1)	HR&C	Involvement	Cautious	9	16	12	No	Adequate
Capacity (BAF 2)	COO	Insight	Cautious	9	20	12	No	Partial
Collaboration (BAF 3)	DoI	Involvement	Open	12	16	8	No	Partial
Continuous improvement & Innovation (BAF 4) [1]	COO	Improvement	Open	12	tbc	tbc	tbc	tbc
Digital (BAF 5) [1]	DoR	Improvement	Cautious	9	tbc	tbc	tbc	tbc
Estates (BAF 6) [2]	DoR	Trust Board	Open	12	15	12	Yes	Reasonable
Finance (BAF 7)	DoR	Insight	Cautious	9	16	12	No	Reasonable
Governance, Compliance and Professionalism (BAF 8)	ECN	Improvement	Minimal	6	16	8	No	Partial
Engagement (BAF 9) [1]	ECN	Involvement	Cautious	9	tbc	tbc	tbc	tbc
Staff Wellbeing (BAF 10) [1]	HR&C	Involvement	Cautious	9	tbc	tbc	tbc	tbc

[1] under review

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

5.2. Governance Report

For Approval

Presented by Jude Chin

WSFT Board of Directors (Open)	
Report title:	**Governance report**
Agenda item:	5.2
Date of the meeting:	24 May 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 May 2024, as follows: • Council of Governors report • Risk oversight group report • Register of interests • Well led review report • 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 receipt of the report, including: Register of interests and Well led review report

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

Governance Report

1. Council of Governors report

The Council of Governors met on 9 May 2024.

The Council of Governors received an update on **NHS 2024/25 priorities and operational planning guidance** by the chief operating officer and programme director gave an overview of Future System programme.

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 Governors noted the report from **Nomination Committee** which highlighted NED composition of Board, as well as providing an update on non-executive directors' recruitment. The Council of Governors approved the NEDs appraisal process. Following the Council of Governors meeting the Nomination Committee have undertaken longlisting and agreed to meet in early June for shortlisting of NED candidates. Interviews are being scheduled for mid-June 2024.

The Council of Governors received a report from the **engagement committee** to draw attention to Future System programme engagement activity, initiatives around patient engagement and governor activities. It was agreed that an additional meeting of the committee will be convened to discuss in detail the engagement priorities for 2024-25 and to review the terms of reference for the Committee to ensure they are fit for purpose and reflect the Trust's over-arching strategy.

The Council noted the implementation of **Fit and Proper Persons Test** and Disclosure and Barring Service (standard) checks for governors.

The Council of Governors approved the **Governors commentary for inclusion in the quality accounts 2023-24** and identified Governor readers for the draft annual report (including quality accounts). The Council of Governors reviewed the governor work programme and forward plan for 2024-2025.

The Council of Governors noted the **governance report**, including register of Governors' interests, membership of Council of Governors sub-committees 2024, Governor work programme and forward planner 2024-25 and an overview of board assurance framework. It was recognised that in light of the recent NED resignations, at present the Board has five non-executive directors and up to seven executive directors (currently six). Whilst working to fill in the current vacancies at the earliest opportunity, the Trust is compliant in terms of the legality of decisions as long as the Board is quorate in its meetings.

The Council in the closed meeting also noted the report on **financial diagnostic review** from PA Consulting who were commissioned by the Integrated Care Board (ICB), on behalf of the ICS to work with the Trust to understand the drivers and causes of its financial position. Governors will be kept informed of the Trust's reports to the report.

2. Risk oversight group report

The Trust's risk register currently includes risk 24, which records the potential failure of the main building structure and front residencies structure (Oak, Cedar, Birch, Larch, Pine, and Willow) as an active risk. This risk has been regularly reviewed since 2010 as the main Trust risk associated with its Reinforced Aeriated Autoclaved Concrete (RAAC) infrastructure. Risk 24 is currently valued at 20 and has oversight from the Trust's monthly (latterly bi-monthly) Risk Oversight Group.

Reporting to the Risk Oversight Group, a multidisciplinary group were asked to assess the progress made on the investment programme to establish if the current likelihood (Likely) was still representative. This group last met on 26 February 2024 and reported to Risk Oversight Group in April 2024 that given all the Trust's work to mitigate the risks associated with its RAAC roof infrastructure, that it should advise the Risk Oversight Group to reduce the likelihood to Possible, reducing the overall score from 20 to 15 which demonstrates progress although still supports this to be a red risk. Risk Oversight Group were assured by the evidence demonstrated that this is appropriate and recommend to Trust Board the reduction in this risk.

3. Well led review

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 review process included documentary assessment; 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 was issued in April for factual accuracy checking and discussed at the Board workshop on 26 April 2024. Below is extracted from the session delivered by consultOne:

Top well-led strengths highlighted by consultOne:

1. Culture, culture, culture
2. FIRST values and organisational strategy
3. Staff wellbeing
4. Patient / carer engagement activities
5. Governance structure and processes
6. Local (West Suffolk) partner working and integration

Top well-led areas of focus highlighted by consultOne:

1. Ambition, drive and focus
2. Strategy – BAU – Strategy – clear line of sight
3. Wider system partnering and collaboration
4. Clinical leadership
5. Accountability
6. Use of information - data led, evidence based, insightful reporting leading to informed decisions
7. Risk management focus and profile

A summary of findings and recommendations from the consultOne review is appended to paper for today's meeting.

An improvement plan to address the findings of the report will be prepared which will be structured around the recent CQC guidance[1] which describes how they will assess the well led question and what good looks like.

[1] Guidance for NHS trusts and foundation trusts: assessing the well-led key question - Care Quality Commission (cqc.org.uk)

4. Register of interests

It is a Constitutional requirement that appointed board Directors have a duty to avoid conflicts of interest with the Trust.

To ensure full openness and transparency, the register of directors' interests is formally reviewed and updated on an annual basis. At each Board meeting declarations are also received for items to be considered.

The Board is asked to note the summary of the register of directors' interests (Annex A).

5. 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.

6. Use of Trust Seal

- 161 – Deeds for Vehicle access road document, Castons Chartered Surveyors, signed and sealed 5th May 2024.

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

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

REGISTER OF DIRECTORS' INTERESTS

The Codes of Conduct and Accountability for NHS Trusts requires all Trusts to draw up and maintain a register of director's interests. This register consequently lists all interests, defined by the Codes as relevant and material for all its Board and non-Board directors.

The definition of interests is as follows:

- Directorships held in private companies or plcs.
- Ownership or part ownership of private companies, businesses or consultancies, likely or possibly seeking to do business with the NHS.
- Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.
- A position of authority in a charity or a voluntary body in the field of health and social care.
- Any connection with a voluntary or other body contracting for NHS services.

	Declared Interest	Date Reviewed / Amended
Trust Chair		
Jude Chin	Director of SSAT (The Schools Network) Ltd Shareholder of SSAT (The Schools Network) Ltd Trustee The Academies Enterprise Trust	17 April 2024
Non-Executive Directors		
Louisa Pepper	Elected Parish Councillor for the village of Thorpe Morieux	17 April 2024
Antoinette Jackson	Director and chair of Trustees in Arthur Rank Hospice Charity Director in Arthur Rank Limited Director and chair of Trustees in Cambridge and District Citizens Advice	17April, 2024
Tracy Dowling *(started on 1 Nov 2022)* **term paused for 6 months w.e.f. 17 Nov 2023*	Chairman of Eastern Academic Health Science Network – Company Limited by Guarantee Eastern Academic Health Science Network does business with NHS organisations	15 May 2023
Geraldine O'Sullivan	Non-executive director at BPHA (Housing Association)	26 March 2024
Krishna Yergol	Director Shashikala Properties Ltd Director Shashikala Digital Ltd Director SP Norfolk Electricals Ltd	27 March, 2024
Dr John Roger Petter	Nil	26 March, 2024

	Declared Interest	Date Reviewed / Amended
Michael Parsons	Bursar - Christ's College Cambridge (registered charity) Director & Company Secretary – Christ's College Enterprises Ltd Director & Company Secretary – Christ's College Trading Ltd Non-Executive Director - University of Cambridge – Property Board Non-Executive Director - Parliamentary and Health Services Ombudsman (PHSO) Member of Chartered Institute of Public Finance & Accountancy (CIPFA) (Professional Body)	15 April, 2024
Executive Directors		
Ewen Cameron	Nil	1 April, 2024
Craig Black	Helena Jopling, Associate Medical Director (Future System) is live-in partner	17 April, 2024
Nicola Cottington	Nil	29 March, 2024
Paul Molyneux	Director of a private company, PD Molyneux Neurology Consultancy Ltd. This company offers private neurology consultancy work at the BMI Bury St Edmunds. Spouse employed in the Trust (bank vaccination nurse) - no line management responsibilities for the vaccination team and no direct or indirect interactions in work capacity.	27 March, 2024
Jeremy Over	Nil	25 March 2024
Susan Wilkinson	Nil	17 April 2024
Other attendees		
Clement Mawoyo	Nil	27 March, 2024
Peter Wightman	Nil	17 April, 2024
Richard Jones	Director of Friars 699 Limited (which changed its name to "The Pathology Partnership Limited"), dissolved via voluntary strike-off on 20/4/2021.	17 April, 2024

Annex B: Scheduled draft agenda items for next meeting – 26 July 2024

Description	Open		Closed	Type	Source	Director
Declaration of interests	✓		✓	Verbal	Matrix	All
General Business						
Patient/staff story	✓		✓	Verbal	Matrix	Exec.
Chief Executive's report	✓			Written	Matrix	EC
Culture						
Organisational development plan	✓			Written	Matrix	JMO
Strategy						
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 and trajectories for year	✓			Written	Action	CEO
Future System Board Report	✓			Written	Matrix	CB
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
- Medical Revalidation annual report
- Clinical Excellence Awards Scheme annual report
	✓			Written	Matrix	NED / 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	✓			Written	Matrix	LP / SW / PM

Description	Open		Closed	Type	Source	Director
- Annual strategy review: quality improvement (deferred to July) and patient safety and learning						
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 - Organisational improvement plan, incorporating well led review - General condition 6 and Continuity of Services condition 7 certificate - 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
Annual report and quality accounts			✓	Written	Matrix	EC/CB
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

Presented by Jude Chin

6.1. Any other business

To Note

Presented by Jude Chin

6.2. Reflections on meeting

For Discussion

Presented by Jude Chin

6.3. Date of next meeting - 26th July, 2024

To Note

Presented by Jude Chin

RESOLUTION

The Trust Board is invited to adopt the following resolution:

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

SUPPORTING ANNEXES

Presented by Jude Chin

Item 4.1 IQPR Report

Presented by Nicola Cottington

Assurance Grid

March 2024		ASSURANCE: Pass (P)	ASSURANCE: Hit and Miss (?)	ASSURANCE: Fail (F) – Not Met
VARIANCE	Special Cause Improvement	**IMPROVEMENT** VTE – all inpatients	**INSIGHT** RTT 104+ Week Waits **INVOLVEMENT** Staff Sickness – rolling 12months Staff Sickness Mandatory Training	**INSIGHT** Incomplete 104 Day Waits RTT 78+ Week Waits **INVOLVEMENT** Appraisal Turnover
VARIANCE	Common Cause	**INSIGHT** Urgent 2 hour response	Please see box to right	**INSIGHT** Ambulance Handover within 15min 12 Hour Breaches Diagnostic Performance- % within 6weeks Total **IMPROVEMENT** Nutrition – 24 hours
Deteriorating	Special Cause Concern			

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

INSIGHT:
Pledge 2 *% Compliance
Ambulance Handover within 30min
Ambulance Handover within 60min
Reduce adult general and acute (G&A) bed occupancy
28 Day Faster Diagnosis
IMPROVEMENT:
MRSA
C-Diff
Hand Hygiene
Sepsis Screening for Emergency Patients
Mixed Sex Breaches
Community Pressure Ulcers
Acute Pressure Ulcers
Inpatient Falls Total
Acute Falls per 1000 Beds
INVOLVEMENT:
Overdue Responses

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

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

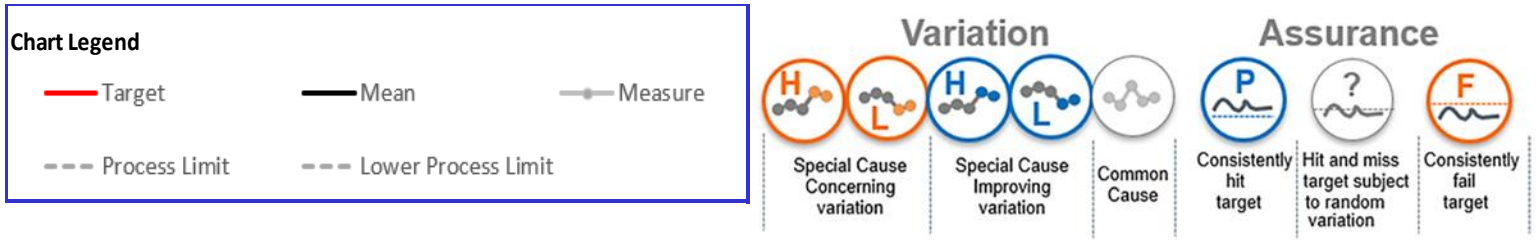
Currently this data is not available to the Trust, however the Information Team are working to resolve this.

*Cancer data is 1 month behind

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

INSIGHT COMMITTEE METRICS

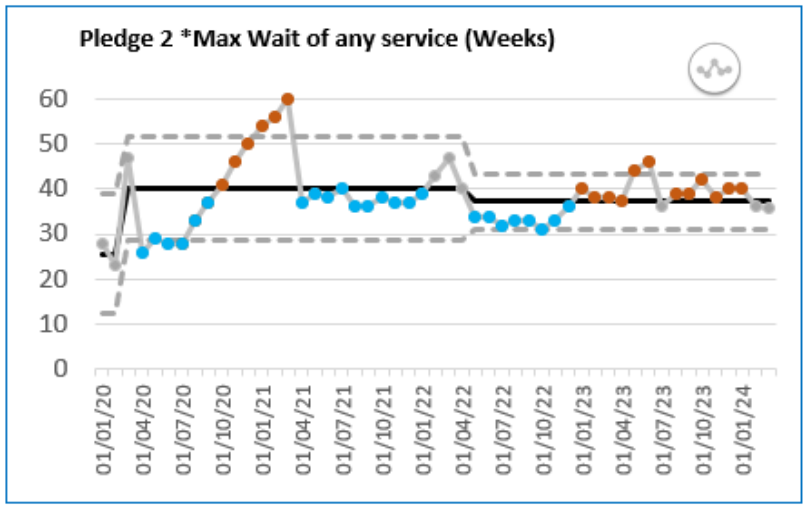
Community Access Summary

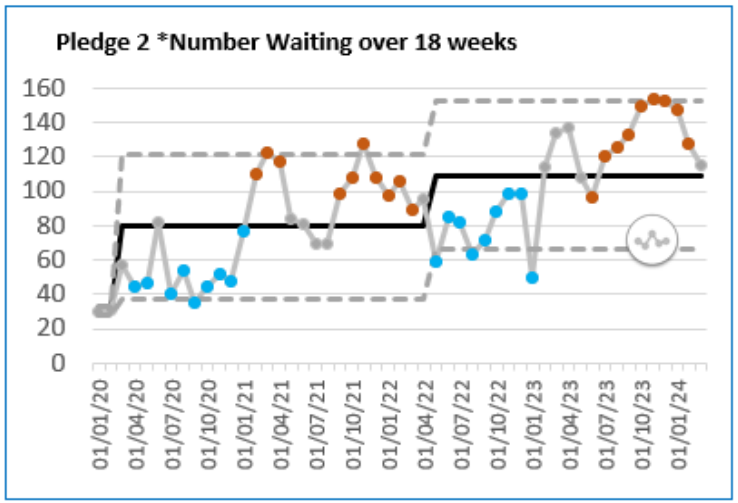


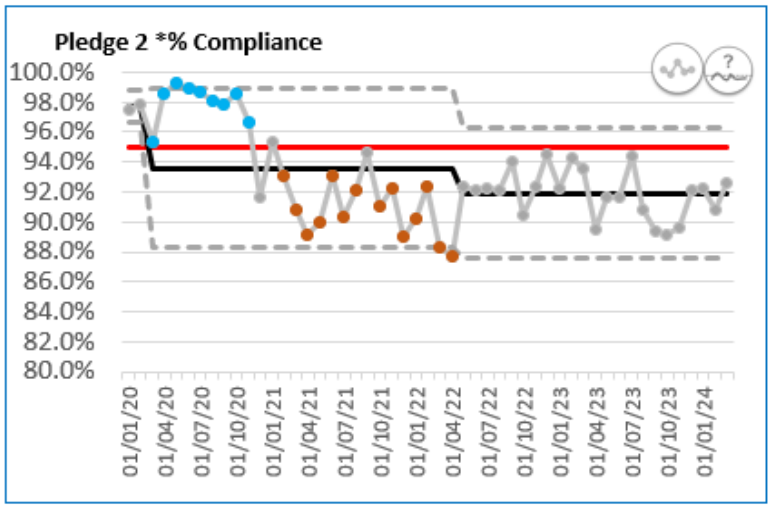
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Pledge 2 *Max Wait of any service (Weeks)	Mar 24	36				37	31	43
Pledge 2 *Number Waiting over 18 weeks	Mar 24	115				109	66	152
Pledge 2 *% Compliance	Mar 24	92.6%	95.0%			91.9%	87.5%	96.3%
Urgent 2 hour response	Mar 24	93.4%	70.0%			90.2%	82.3%	98.1%
Criteria to reside (Average without reason to reside) Acute	Mar 24	54				59	45	74
**Criteria to reside (Average without reason to reside) Community	Mar 24	21				17	13	22

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

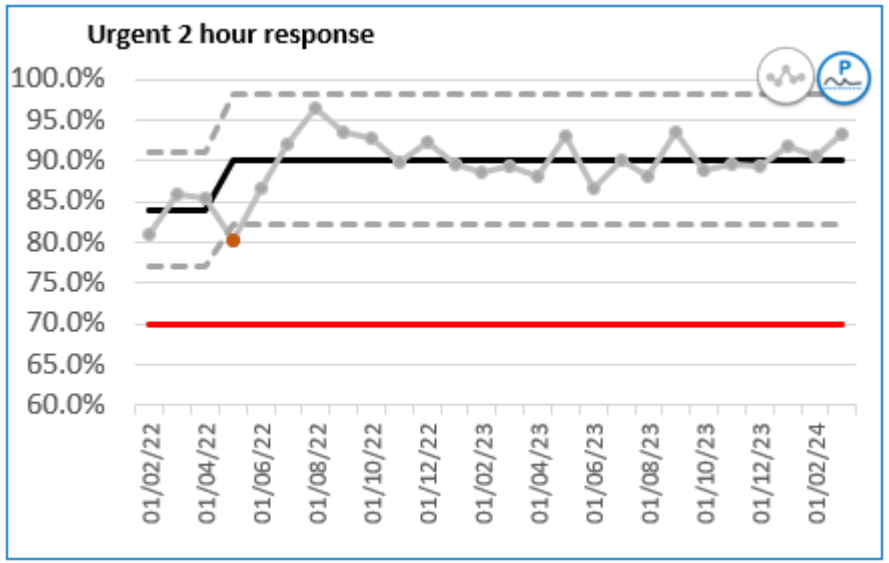
** Figures are for Glastonbury and Newmarket only, data not currently captured at Hazel Court.

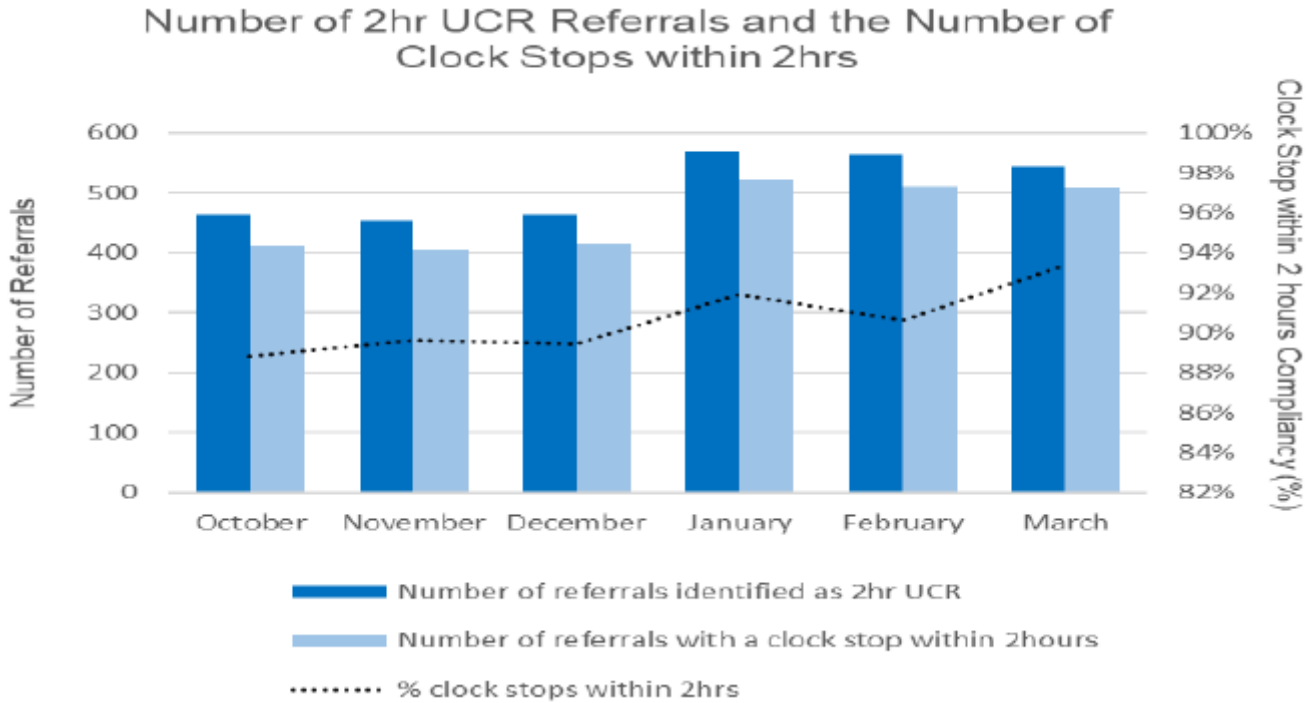






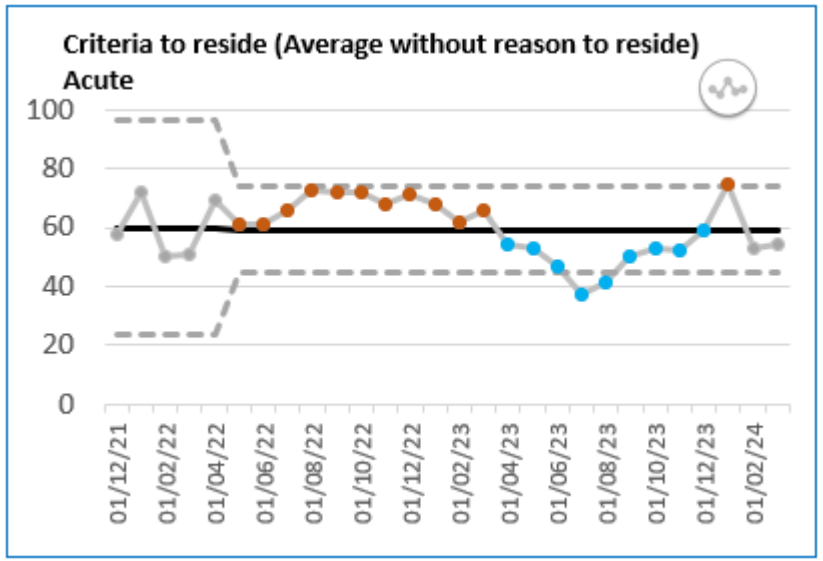
What	So What?	What Next?
Wheelchair Services : 27 patients waiting over 18 weeks – reduced by a further 10 patients from last month which was then the lowest since June 2022. 95.20 % compliancy of patients seen within 18 weeks– Highest performance since Covid-19 91.60 % of equipment handed over within 18 weeks **Paediatric Speech and Language Therapy (SLT)** Compliance with 18wks = 79.8% Number waiting over 18wks = 87 Longest wait = 43wks	**Wheelchair Services:** Local performance is 6% higher than national wheelchair services' performance for both adults and children. https://www.england.nhs.uk/statistics/wpcontent/uploads/sites/2/2024/02/National-Wheelchair-Data-Collection-Statistical-Briefing-October-December-2023.pdf **Paeds SLT:** Caseloads remain at high levels Preschool complex needs assessment pathway trial proving effective but is impacting on intervention pathway	**Wheelchair Services:** Contracting team to contact NHSE again in May 2024 to confirm exit date from environmental controls contract – this will free up capacity. Readvertise specialist wheelchair OT vacancy in May 2024 – no applicants April 2024 Aim to maintain performance: unlikely to significantly improve further without additional investment. **Paeds SLT:** System wide engagement and joint commissioning discussion needed in response to levels of need and requirement to consider sufficiency planning linked to area SEND inspection action plan.

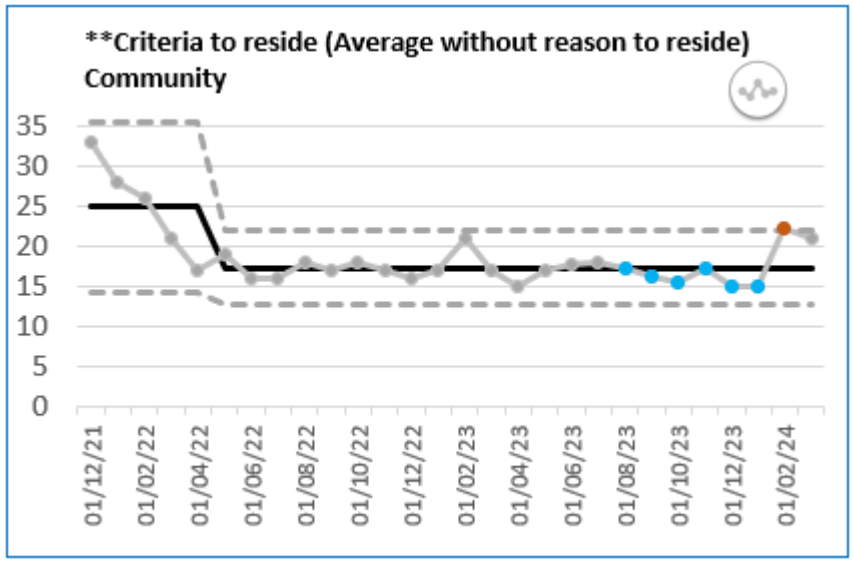




What	So What?	What Next?
The Early Intervention Team's (EIT) 2 hour performance remains consistently above the 70% target	•Admission avoidance visits are being completed in a timely manner, supporting patients to remain at home when possible. •Impact of 2- hour response has meant some delays to meeting internal 15- minute target of EIT therapy response to ED.	•Continue work with Mildenhall and Brandon INT and virtual ward on developing more collaborative working to sustain performance and make every contact count. •Analyse demand from community, Emergency Department/Acute Assessment Unit (ED/AAU) and develop sustainable model for EIT provision inclusive of funding across different areas, including options for relocation.

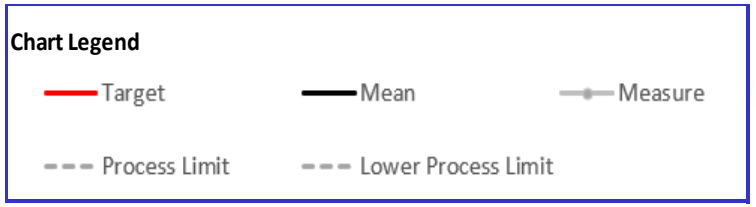
Criteria to reside

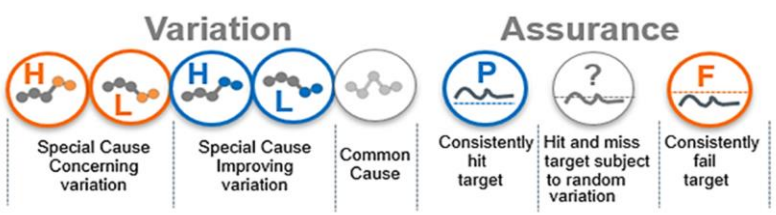




What	So What?	What Next?
Acute figures remained static since February following a period of high referral rate into the Transfer of Care Hub in January. This shows a return to the trend of lower numbers in 2023 Community figures, showed an increase in February and March which mirrors performance from last year over the same time period. Work commenced mid-January 2024 to increase pathway 1 discharges: This has accelerated an increase in capacity in Community Access Beds (CAB) which are now at times utilised for non-traditional CAB patients, to support acute hospital flow. Some of these patients will already lack reason to reside upon arrival in CAB and will impact these figures	Patients remaining unnecessarily in hospital, negatively impacts patient flow across the system. Lower figures of patients without criteria to reside mean patients are able to return home, or to their onward place of care quicker, reducing length of stay and the risks associated with prolonged acute hospital admissions.	Complete detailed review in May of reasons for patients without Criteria to Reside (C2R) in CAB , and present results in June PRM Agree more robust process for oversight of CAB patients without C2R and present in June PRM. Conversion of CAB referrals to P1: Repeat audit end of May to aim for zero inappropriate CAB referrals. Increase in rapid Cassius/digital tech installation – performance review in May P1 project: target = 1 day median between referral and discharge: ongoing monthly review ECIST review in May 2024 to explore P2 CAB bed provision and modelling with aligned national benchmarks

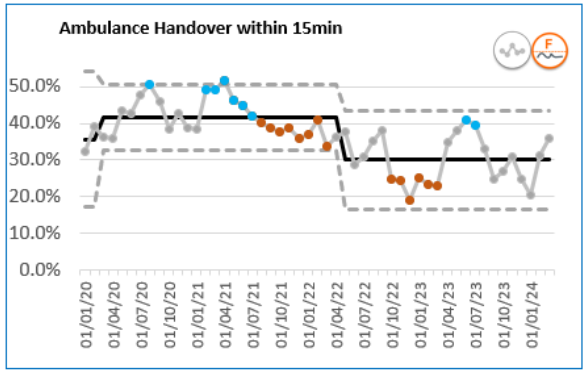
Urgent & Emergency Care summary

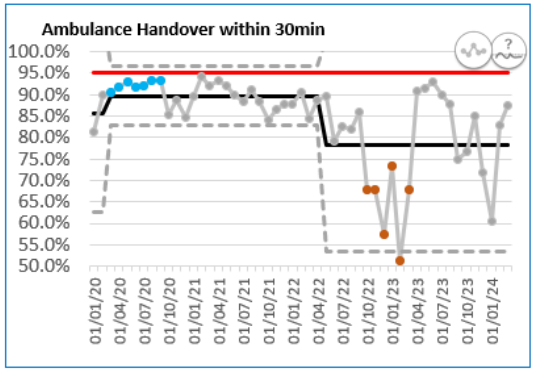


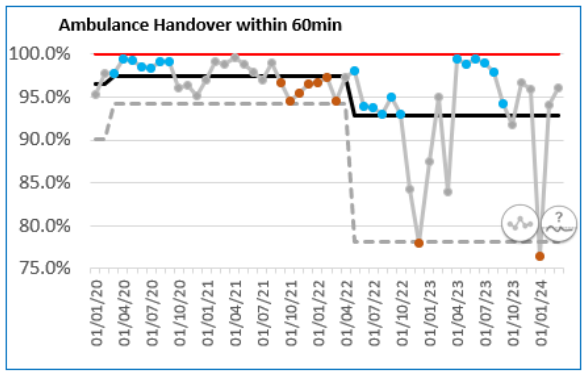


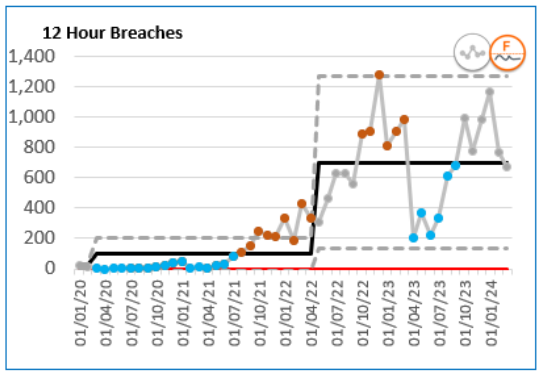
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Ambulance Handover within 15min	Mar 24	36.0%	65.0%		F	30.1%	16.7%	43.5%
Ambulance Handover within 30min	Mar 24	87.4%	95.0%		?	78.2%	53.3%	103.0%
Ambulance Handover within 60min	Mar 24	96.1%	100.0%		?	92.8%	78.1%	107.5%
12 Hour Breaches	Mar 24	668	0		F	700	132	1269
Reduce adult general and acute (G&A) bed occupancy	Mar 24	94.7%	92.0%		?	93.0%	91.3%	94.7%
4 hour breaches	Mar 24	2285	0					
4 hour performance	Mar 24	74.0%	76.0%					

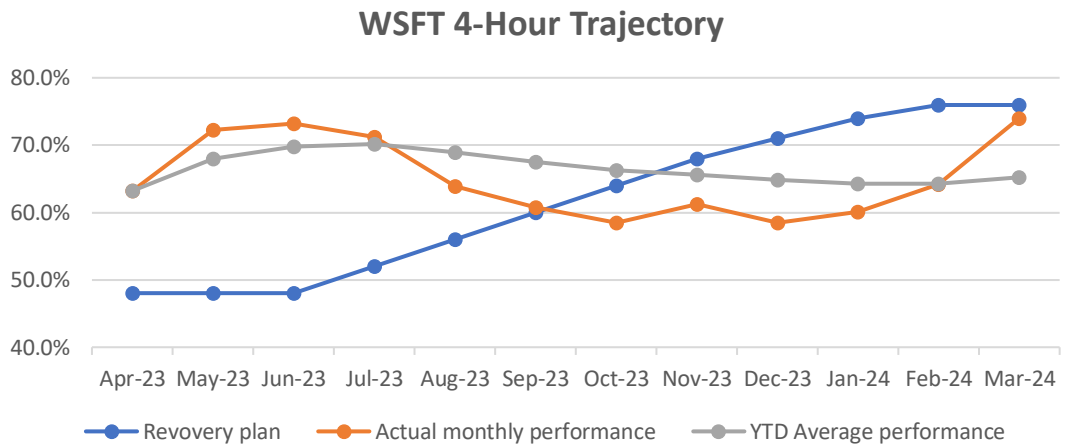
Urgent & Emergency Care (TRUST)











What

There remains no significant change to Ambulance Handover performance. Achieving the metrics remain challenging in all 3 areas. These challenges are attributed to the continued overcrowding within the Emergency Department (ED) by patients with an increased length of stay, resulting in the need to cohort patients in escalation areas within the department including the Rapid Assessment Treatment Area (RAT) which in turn reduces our capacity/ability to offload ambulances.
The number of 12 hour breaches although continuing to reduce do not demonstrate a significant change. These 12 hour breaches are attributed to the high numbers of patients waiting a bed within the Emergency Department.

So What?

Meeting the Urgent and Emergency Care (UEC) performance metrics is key to ensuring that our patients receive timely, safe care.

Achieving the ambulance handover metrics will meet national targets.

Overcrowding and delays in offloading ambulances makes achieving the ED 4hr metric of 78% by the end of March 2025 more challenging.

Lack of flow out of ED has resulted in the need to open additional escalation areas, including the Rapid Assessment Treatment Area overnight, ambulance reverse cohorting areas in ED, the Acute Admissions Unit corridor and part of the Same Day Emergency Care Unit. The Winter Escalation Ward remains fully open.

What Next?

In collaboration with ICB and Alliance partners we have developed a revised governance model to monitor UEC performance, UEC forward plan and associated funding streams and monitoring of outcomes. New structure to be signed off and commenced in June 2024.

Revised action plan developed with trajectory to achieve 78% 4hr ED target by Mach 2025.

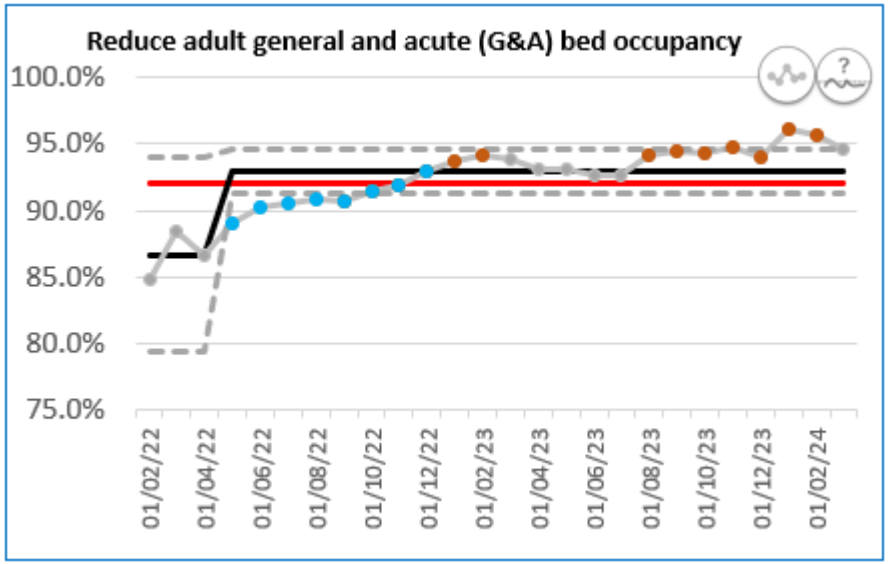
Recording of data in relation to adherence of Internal professional standards commenced in May 2024 – report to be shared with specialities end of May 2024

Focus on work with SDEC to develop pathway direct from point of streaming in addition to triage with aim to operationalise this by July 2024

Rapid project underway for installation of a modular unit – Minor Emergency Care Unit (MECU). This will house ED GP patients and minor injuries patients, thus reducing crowding in the department and providing extra consultation space for doctors to see their patients. This will reduce length of stay and increase flow through the department thus enabling improved ambulance offload times. Project planned for delivery in July 2024.

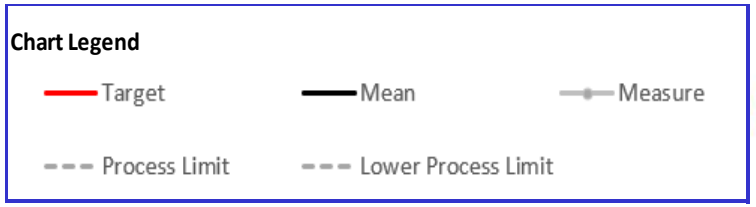
NHSE Improvement team (ECIST) visit due May 2024 to review UEC pathways with a return visit in month to review community pathways

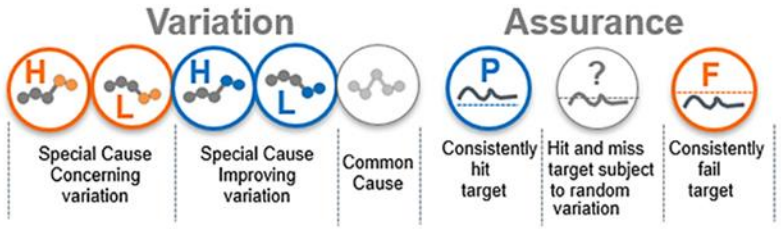
Urgent & Emergency Care (TRUST)



What	So What?	What Next?
Bed occupancy has tracked above the 92% threshold in all months of 2023, reaching record highs in the last 8 months and having demonstrated a continuous upward trend since 2022. It is unclear as to the long term drivers of this, given that length of stay and discharges have remained relatively unchanged. Recent months tracking above the upper control limit has directly resulted in a higher number of patients awaiting beds in the hospital in our Emergency Department. January, February and March 2024 represent the highest bed occupancy figures in the last two years as admissions have continued to increase whilst discharges on some individual days have failed to keep pace, driving up occupancy and leading to 35-50 patients awaiting admission in the Emergency Department. However, March's reduced bed occupancy correlated with fewer patients waiting beds in ED (as an output) and patients not meeting the criteria to reside being below 5% (as a cause).	Increasing bed occupancy within a finite bed stock reduces timely and effective patient flow, as rates of admissions have stayed constant. This increases the likelihood of patients waiting for beds in the Emergency Department and Acute Assessment Area, in some cases for many hours. This in turn impacts on the timely delivery of care within the Emergency Department, worsening 4-hour and 12-hour performance.	Bed occupancy will need to reduce below 92% to ensure patient flow is effective and patients are not left waiting for admission. Additional bed capacity, or savings, will need to be identified and implemented to bring occupancy down. The Patient Flow Improvement Core Resilience Team (CRT) identified that by reducing patients not meeting the criteria to reside to below 10% and initiatives to improve early flow reduced the number of patients awaiting admission within the Emergency Department. Reducing bed occupancy, improving flow, reducing the number of patients not meeting the criteria to reside and increasing absolute numbers of discharges will need to be key areas of focus for 2024/25 given our limited options to increase physical bed capacity.

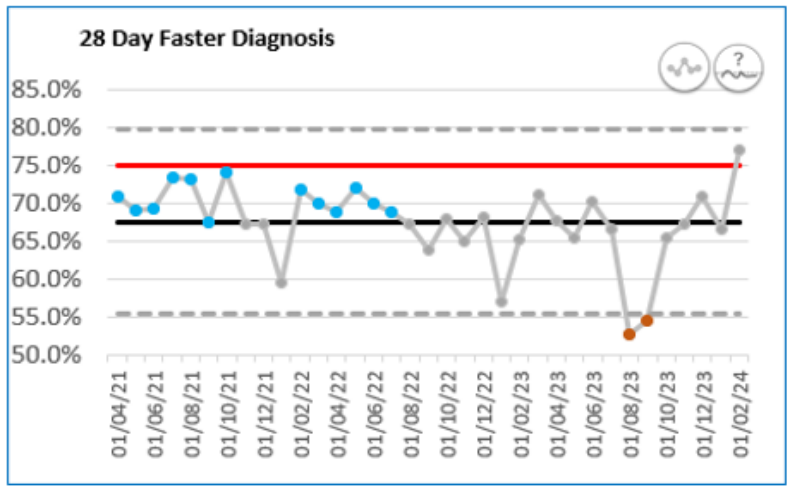
Cancer Access Summary

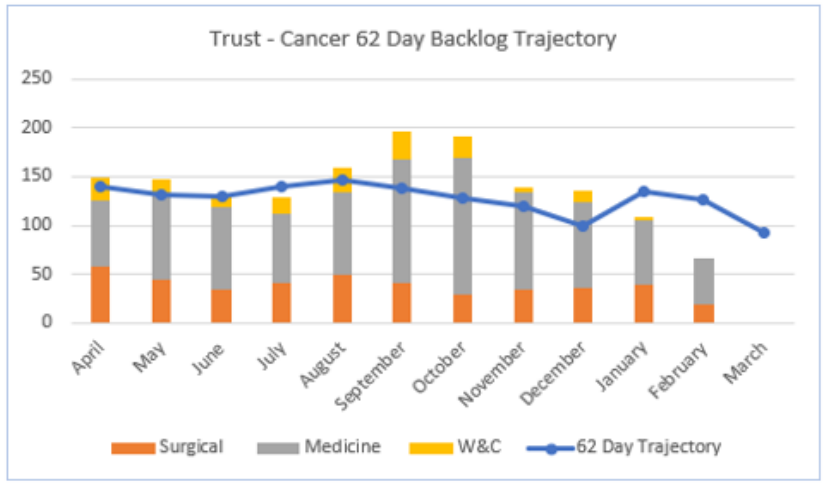


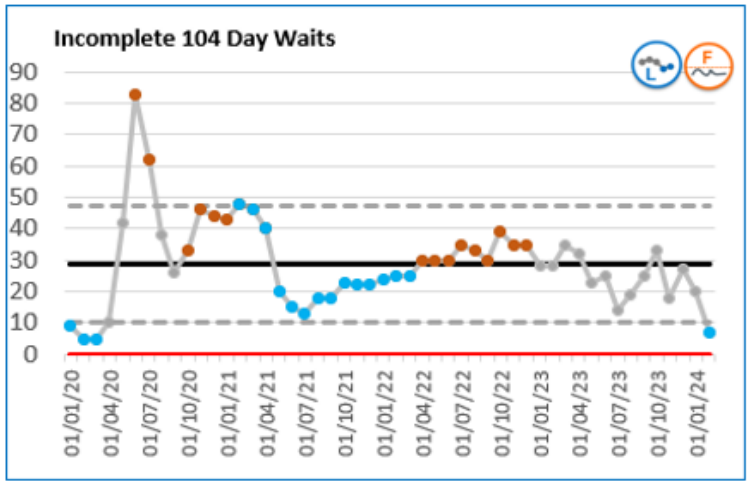


KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
28 Day Faster Diagnosis	Feb 24	77.1%	75.0%			67.6%	55.4%	79.7%
Trust - Cancer 2 Day Backlog Trajectory	Feb 24	66	126					
Incomplete 104 Day Waits	Feb 24	7	0			29	10	48

Cancer Access (Month Behind)







What	So What?	What Next?
Performance against the 28-day Faster Diagnosis Standard (FDS) is not being consistently met, however the standard was met in February 2024 at 77%. As at the end of February the 62 day backlog stood at 62 against a trajectory of 126.	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.	Continue FDS steering groups in Gynaecology, Breast, Colorectal and Skin as the focus areas. We will continue to monitor these actions and re-audit against the BPTP for improvements. Specific actions that are still live include: • Review of Dermatology schedules to increase scheduled review times for telederm, with initial demand vs capacity to be presented on the 28th May 2024 • Recruit into additional alliance funded posts, which are due to go out to advert W/C 13th May following approval from the alliance at the end of April • Implement the cancer alliance priorities, with specific focus on Gynaecology HRT and Urology re-stratification in line with national objective by Q3

Elective Access – Summary: Activity

NHS England - 23/24 (Monthly - IQPR)

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

West Suffolk NHS
NHS Foundation Trust

All

All

Outpatient First

Mon	19/20	107%	23/24	Var %
Apr	6,625	7,089	6,718	101.4%
May	7,453	7,975	8,383	112.5%
Jun	8,097	8,664	8,292	102.4%
Jul	7,499	8,024	7,812	104.2%
Aug	7,637	8,172	7,584	99.3%
Sep	7,729	8,270	8,612	111.4%
Oct	8,097	8,664	8,030	99.2%
Nov	8,373	8,959	8,877	106.0%
Dec	6,717	7,187	6,999	104.2%
Jan	8,373	8,959	9,286	110.9%
Feb	7,821	8,369	8,586	109.8%
Mar	7,591	8,122	9,159	120.7%
Total (YTD)	**92,013**	**98,453**	**98,338**	**106.9%**

March 2024

19/20	7,591
107%	8,122
23/24	9,159
Var	1,037
Var %	120.7%

Daycase

Mon	19/20	107%	23/24	Var %
Apr	1,903	2,033	2,063	108.4%
May	2,175	2,324	2,393	110.0%
Jun	2,338	2,498	2,448	104.7%
Jul	2,189	2,338	2,311	105.6%
Aug	2,257	2,411	2,372	105.1%
Sep	2,284	2,440	2,345	102.7%
Oct	2,393	2,556	2,264	94.6%
Nov	2,556	2,731	2,501	97.9%
Dec	1,985	2,121	1,977	99.6%
Jan	2,461	2,629	2,230	90.6%
Feb	2,365	2,527	2,275	96.2%
Mar	2,284	2,440	2,472	108.2%
Total (YTD)	**27,189**	**29,049**	**27,651**	**101.7%**

March 2024

19/20	2,284
107%	2,440
23/24	2,472
Var	32
Var %	108.2%

Outpatient Follow Up

Mon	19/20	85%	23/24	Var %
Apr	14,014	11,912	15,188	108.4%
May	15,766	13,401	18,315	116.2%
Jun	17,128	14,559	18,526	108.2%
Jul	15,863	13,484	17,320	109.2%
Aug	16,155	13,732	17,491	108.3%
Sep	16,350	13,897	17,813	108.9%
Oct	17,128	14,559	19,089	111.4%
Nov	17,712	15,055	20,707	116.9%
Dec	14,209	12,077	16,148	113.6%
Jan	17,712	15,055	20,538	116.0%
Feb	16,544	14,063	19,191	116.0%
Mar	16,058	13,649	17,412	108.4%
Total (YTD)	**194,640**	**165,442**	**217,731**	**111.9%**

March 2024

19/20	16,058
85%	13,649
23/24	17,412
Var	3,763
Var %	108.4%

Elective

Mon	19/20	107%	23/24	Var %
Apr	257	275	233	90.5%
May	299	319	289	96.8%
Jun	318	340	273	85.8%
Jul	300	321	240	79.9%
Aug	315	337	257	81.7%
Sep	300	321	292	97.2%
Oct	318	340	271	85.1%
Nov	329	352	270	82.1%
Dec	277	296	230	83.0%
Jan	275	294	230	83.5%
Feb	300	321	243	80.9%
Mar	286	306	264	92.3%
Total (YTD)	**3,576**	**3,824**	**3,092**	**86.5%**

March 2024

19/20	3,576
107%	306
23/24	264
Var	(42)
Var %	92.3%

What

March 2024 finished the year in a strong in-month position for new outpatients and daycases with a good recovery in elective, however the annual target of 107% was not met for any of these areas. Industrial action, with pre-emptive cancellations and increases in on the day cancellations due to bed capacity/emergency demand will have impacted on most months however other organisations have maintained and increased activity in spite of this.

Outpatient follow ups have consistently not met the target of 75% of 2019/20 totals, though there was a 7.6% in-month decrease from February to March 2024.

So What?

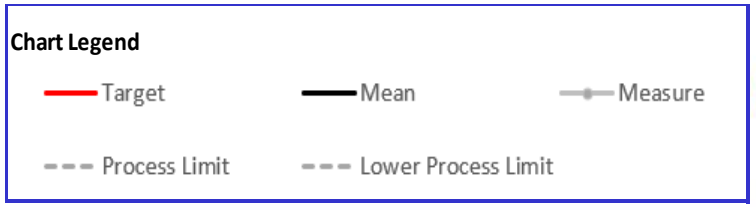
Not achieving activity level targets impacts on our ability to deliver key requirements to reduce the number of long waiting patients, outpatient transformation ambitions and achieve the Elective Recovery Fund activity thresholds which are part of our financial modelling and overall recovery.

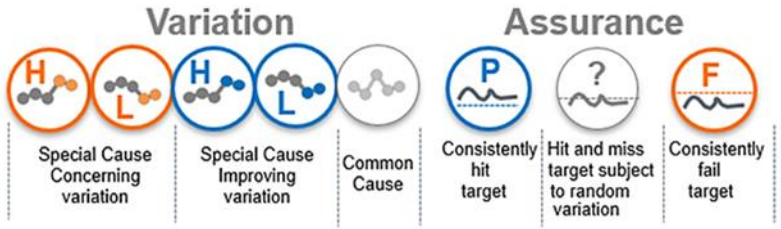
What Next?

Theatre productivity and outpatient transformation will be key to the delivery of national standards and with specific actions as follows:

- Further faster action plans to be developed by speciality following the initial benchmarking by the end of Q2.
- Initial advice & guidance project has commence with terms of reference in development, this will support both increase in A&G and potential reduction in demand with GP's requesting more 'top tips' prior to referral.
- Mentorship of anaesthetic technology students in theatres for independent working within Q1.
- Finalisation of day of surgery admissions pilot
- Continued delivery and monitoring of theatre utilisation

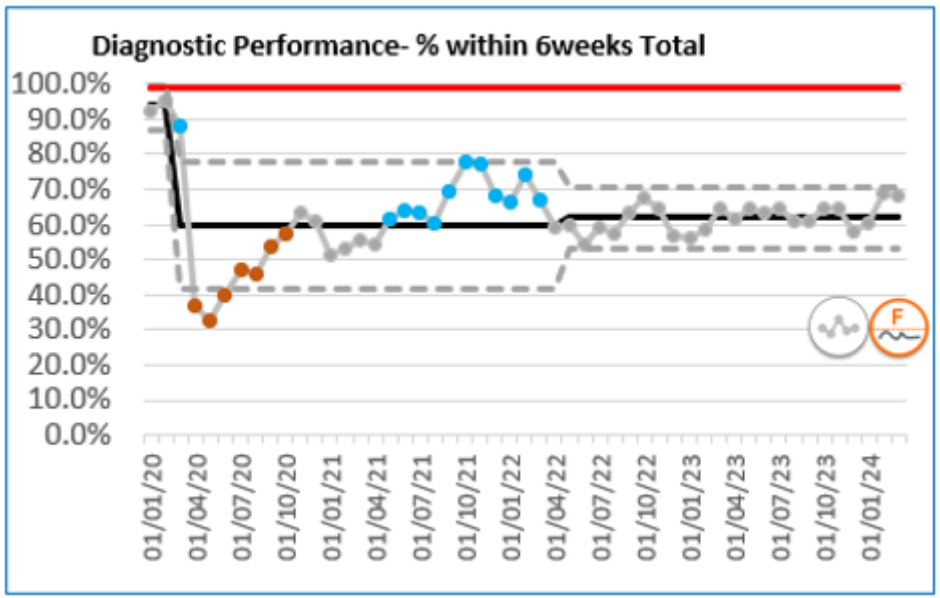
Elective Access Summary





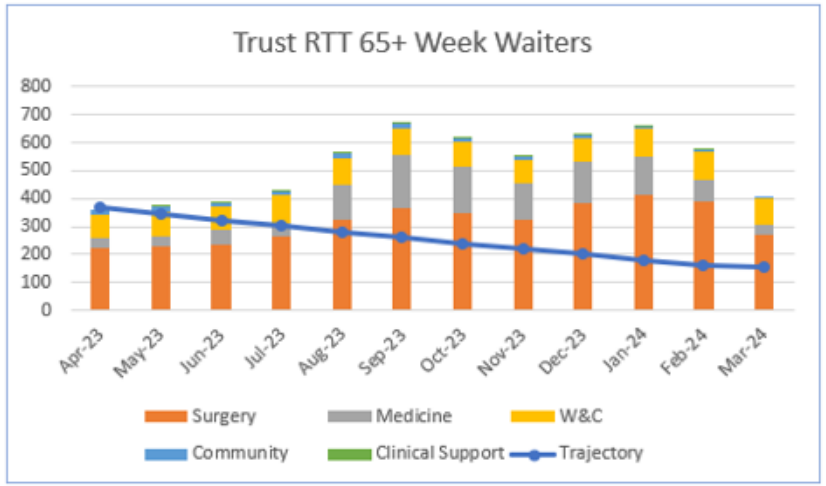
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Diagnostic Performance- % within 6weeks Total	Mar 24	68.2%	99.0%		F	62.0%	53.0%	70.9%
RTT 65+ Week Waits	Mar 24	407				510	316	703
RTT 78+ Week Waits	Mar 24	47	0	L	F	180	99	262
RTT 104+ Week waits	Mar 24	0	0	L	?	11	-4	25
Potential 65+ ww at end of March 2024	Mar 24	407		L		4994	1966	8023

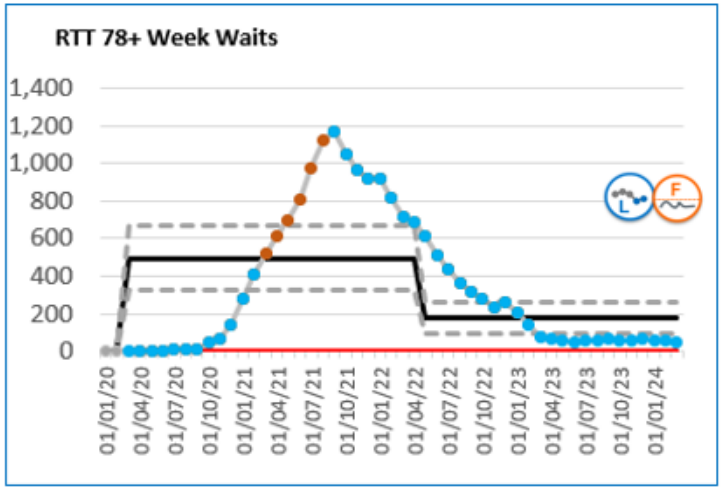
Elective Access

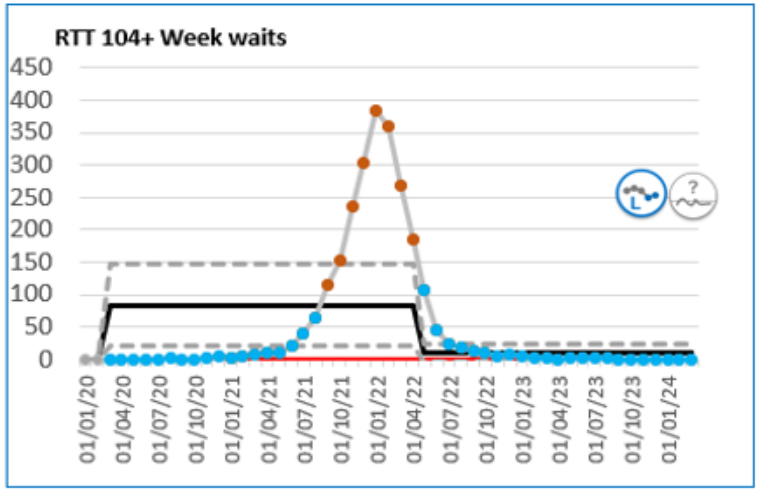


Elective Access

What	So What?	What Next?
MRI Common cause consistently failing target. Running at full capacity across the seven days but current capacity insufficient. MRI 2 replacement programme commenced 27/11/2023 – temporary mobile capacity in place to mitigate. Programme delays due to unforeseen ground works, completion date 22/06/2024. **CT** Currently not meeting DM01 compliance target due to replacement programme but expected to return to full compliance now this has been completed. DM01 has been impacted by increased 28-day FDS demand resulting in a slower recovery than anticipated. This has now stabilised and an improvement in the recovery trajectory can be observed. **US** DM01 compliance had plateaued following the unexpected decline in performance in the late summer owing to staffing challenges. These have been resolved with an expected return to our trajectory for DM01 compliance by May 2024. US Biopsy performance vulnerable to bed capacity pressures but this will now improve following recovery capacity being agreed with the MTU. A step increase in the recovery trajectory can be observed but this remains statistically insignificant **Endoscopy** Priority is being given to patients on a cancer pathway requiring a rebalancing of capacity to support. Performance has also been hindered by industrial action. Cohort of low complexity, low risk patients suitable for outsourcing and nurse endoscopists (NE) has been exhausted with limited scope for flexing of the criteria with outsourced provider. This has led to a compound effect and a plateauing of performance. **Urology and Audiology** Cystoscopy saw an improvement in month (3.7%), this reflective of the prioritisation of suspected cancer diagnostics., urodynamics taking a dip of 9%. This is also indicative of the residual impact of SDEC temporarily moving to JFU which resulted in reduced diagnostic capacity. JFU is now restored to normal and there is a plan in place to support recovery. Haematuria referrals remain a concern as they are on the rise. Audiology has seen a dip in performance, recognising compliance based on demand is not achievable without a second room. The teams have removed patients from the PTL who are waiting for planned procedures (as per RTT rules) and this is improving position.	Longer waiting times for diagnosis and treatment	**MRI** Request approved by NHSE CDC regional/national teams to support three months of temporary MRI capacity as part of the CDC activity plan, ahead of its scheduled go-live date. Combined mitigations would see MRI reaching DM01 compliance in Q3 2024/25. Longer term CDC will begin to address. **CT** Impact from CT replacement programme is now expected to recover. With an expected return to DM01 compliance by Q1 of 24/25. **US** Staffing issues resolved, and performance now expected to improve. **Endoscopy** Current trajectory being revised due to impact of cancer demand and case mix limitations with IS provider. Anticipated compliance with the DM01 target ambition of 95% by March 2025. Actions focussed on increasing NE opportunities and review of core job planned capacity for medical and surgical consultant endoscopists. **Urology and Audiology** • Ongoing recruitment of urology consultants • Fixed term urology consultant in place, focusing on diagnostics • Exploration of training opportunities to increase staff with relevant skill set (urology) • Audiology demand versus capacity review commenced • Urology CNS recruitment • Review of haematuria numbers and pathway to ensure maximum efficiency. • Validation of audiology

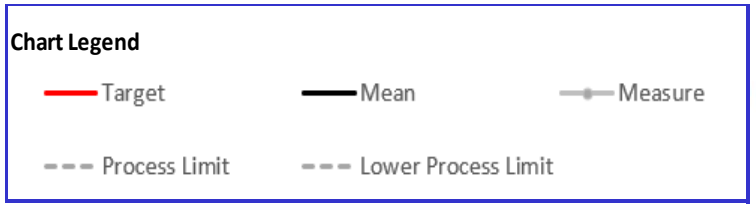


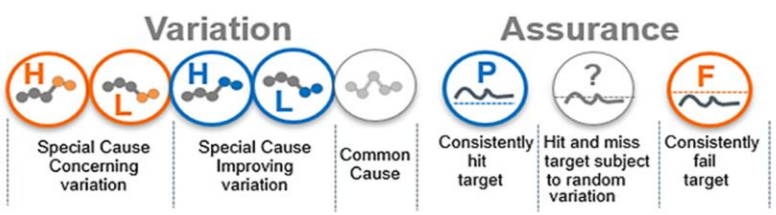




What	So What?	What Next?
The total number of patients over 65 weeks reduced throughout March to end with a total end of year position of 408 patients, this was over our original trajectory of 97, because of industrial action. As a result of the industrial action, the national objective to clear 65ww was moved to September 2024. The total number of 78 week waits for the end of year position was 47 patients, of which 37 were capacity breaches. This was under our original trajectory of 46 capacity breaches.	Delivering the objective of no patients waiting over 65 weeks by March 2024 is the central focus of 2023/24 planning, delivering an improved set of outcomes and experience for our patients – as patients are at increased risk of harm and/or deteriorating the longer they wait. This increases demand on primary and urgent and emergency care services as patients seek help for their condition.	Urogynaecology continues to be the area with continued 78ww capacity breaches, discussions are underway with the Nuffield at Ipswich for additional capacity. Trajectories for 65ww to be redeveloped.

IMPROVEMENT COMMITTEE METRICS

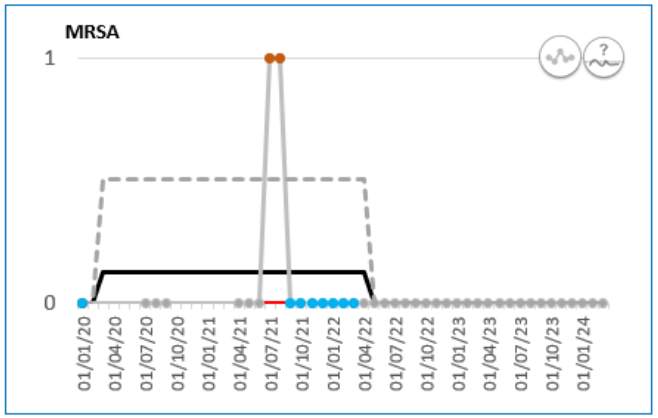


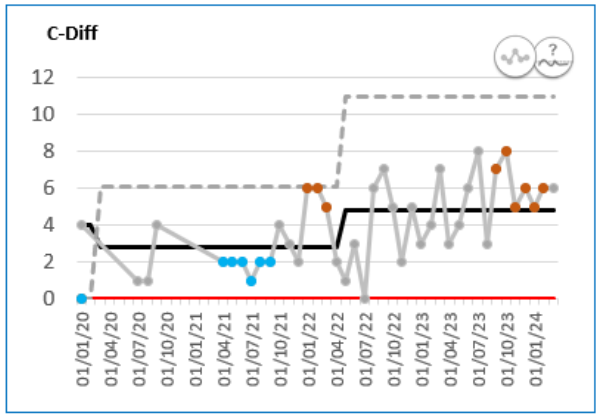


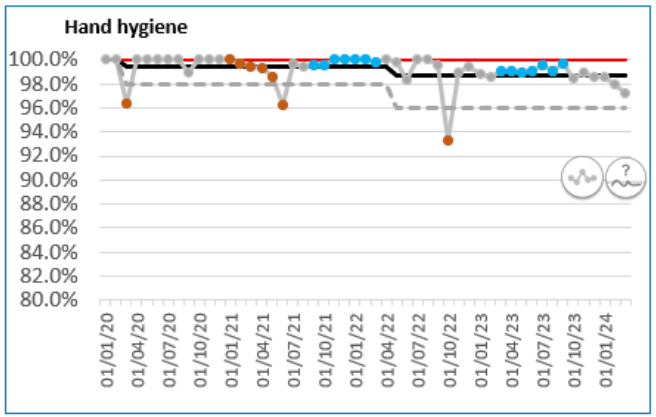
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
MRSA	Mar 24	0	0			0	0	0
C-Diff	Mar 24	6	0			5	-1	11
Hand hygiene	Mar 24	97.2%	100.0%			98.7%	96.0%	101.4%
Sepsis Screening for Emergency Patients	Mar 24	71.4%	100.0%			82.7%	54.0%	111.4%
VTE - all inpatients	Mar 24	99.1%	95.0%	H	P	97.8%	96.0%	99.6%
Mixed Sex Breaches	Mar 24	6	0			5	-5	15
Community Pressure Ulcers	Mar 24	21	25			33	12	54
Acute Pressure Ulcers	Mar 24	29	17			25	8	41
Acute Pressure Ulcers per 1000 Beds	Mar 24	2.3	-			2.3	0.7	3.9
Inpatient Falls Total	Mar 24	77	48			75	48	102
Acute Falls per 1000 Beds	Mar 24	5.3	5.6			5.9	4.0	7.8
Nutrition - 24 hours	Mar 24	87.0%	95.0%		F	86.0%	77.1%	94.9%
Patient Safety Incidents per 1,000 OBDs	Mar 24	49.1	-	L		63.4	51.8	75.0
Patient Safety Incidents Reported	Mar 24	737	-			856	682	1030
Patient Safety Incidents Resulting in Harm	Mar 24	171	-			175	121	229

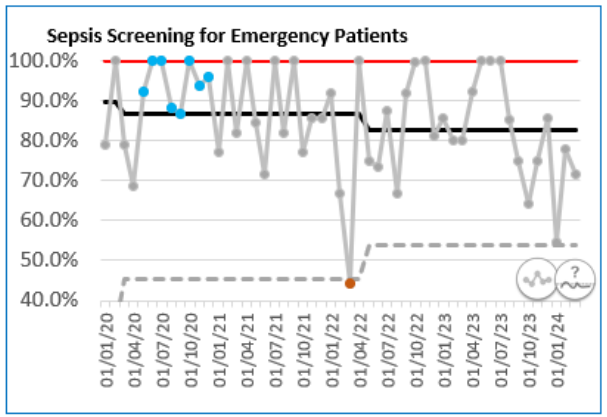
Falls are only counting Inpatients and Exclude Assisted Falls & Outpatient areas.

Safe



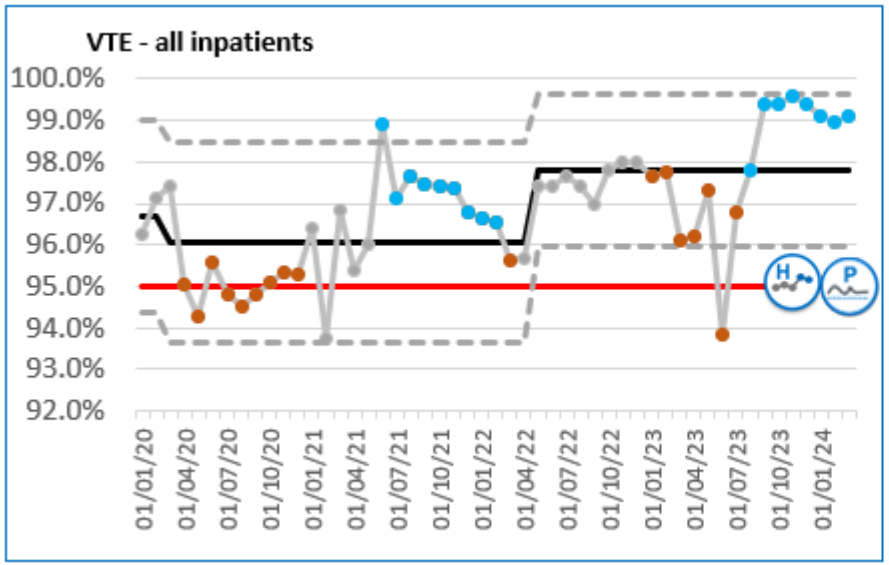


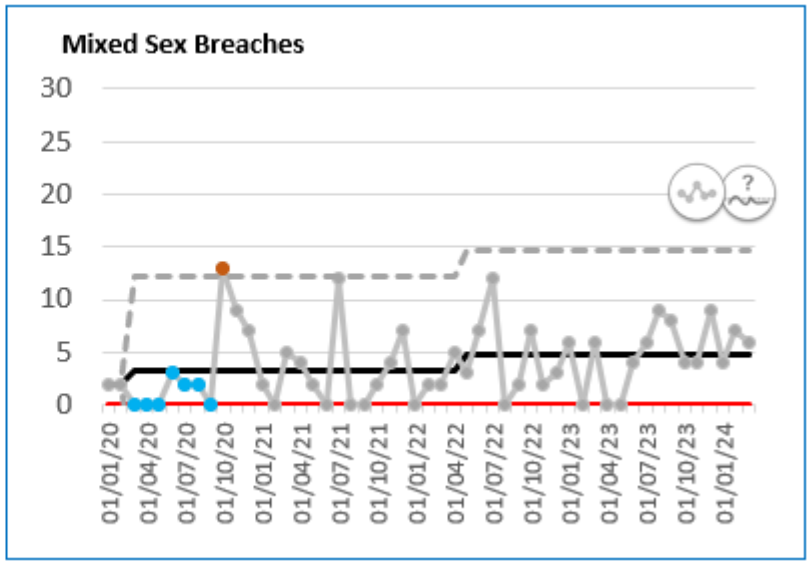




What	So What?	What Next?
There is consistent performance with MRSA Bacteraemia. <u>C-Diff</u> There has been no significant change in month-on-month incident rate measured against the current baseline however the set threshold for cases is 49 which is significantly exceeded, at 97 cases total for the year.	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.	Deep dive for Cdiff rates presented to improvement February 2024, planned update September with monthly reporting into the Patient Quality & Safety Group for oversight and progress of Quality Improvement Programme (QIP) The QIP will run for at least 12 months once the measures are agreed. There will be six subgroups – April 2025. Immediate actions: • Completion of driver diagrams and measures – May 2024 – subgroups formed for cleaning, PPE/hand hygiene & Antibiotics, regular meetings organised. • Hand hygiene week early May – base line audit/PPS of compliance with hand hygiene, bare below the elbows and PPE wearing (with ad hoc training) , review of results, short pp for ward managers to share followed by repeat audit/pps and review – May 2024. • Retrospective review of antimicrobial prescribing – May 2024. • C.Diff patient leaflet – April 2024 – has gone to appropriate committee for review • Commencement of C.diff allocation caseload within IPC Team – April 2024 – in infancy however now embedding into regular work flow.

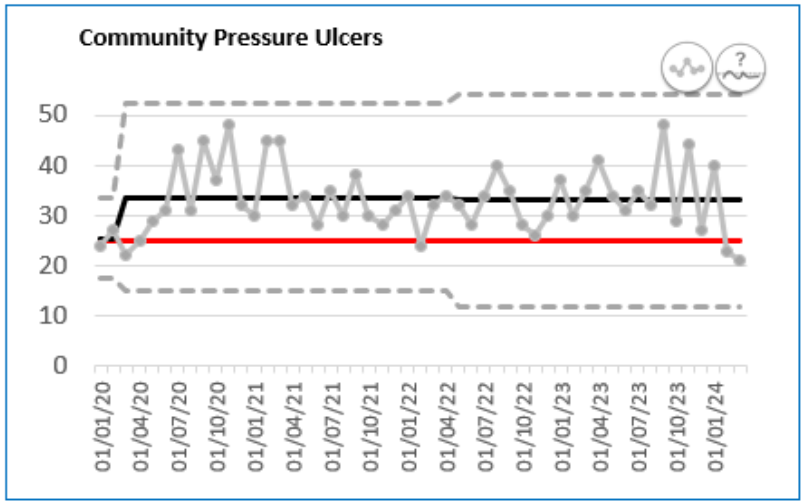
Safe

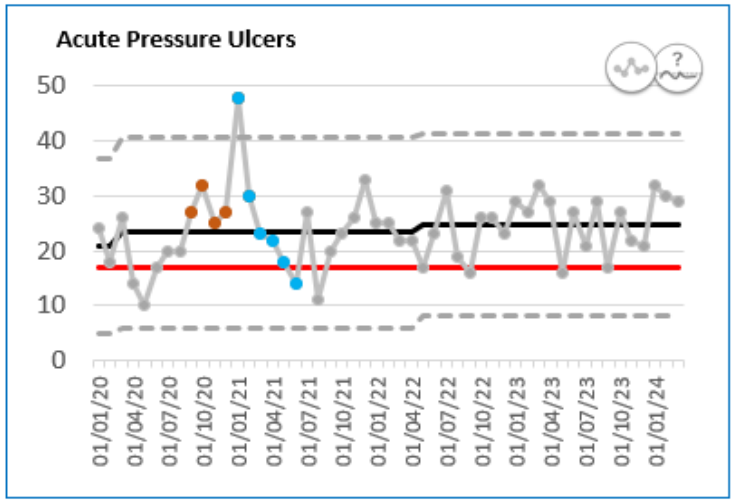


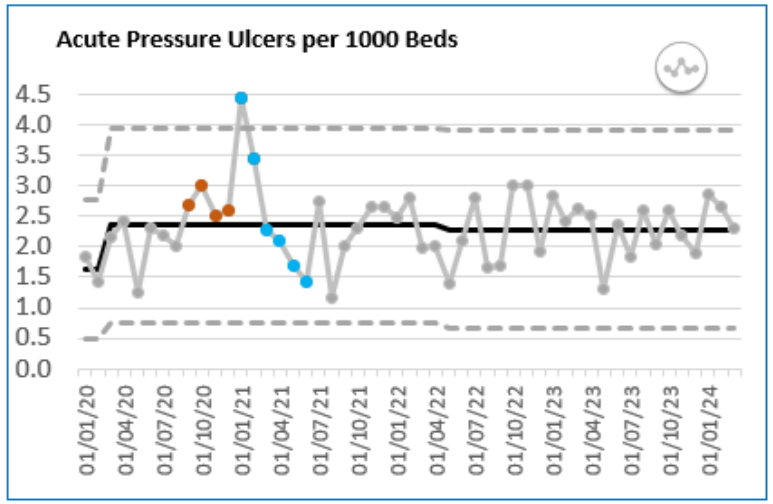


What	So What?	What Next?
VTE: achievement of >95% is consistently and confidently achieved and in special cause improvement. Data	VTE assessment is important so that patients reive the correct prophylaxis to reduce the incidence of VTE.	Continued interrogation of data to identify areas of concern as they occur. Data has been validated ensuring confidence in positive compliance
MSA: incidents above average this month, not improvement or deterioration in incidents. MSA occurring in CCU when unable to move patients out of CCU care into ward environment.	Risk to patient experience within CCU when unable to step out into ward environment due to capacity challenges	Reviewed daily at safety huddle and at bed meeting to balance risk of MSA versus crowding in UEC pathway

Safe

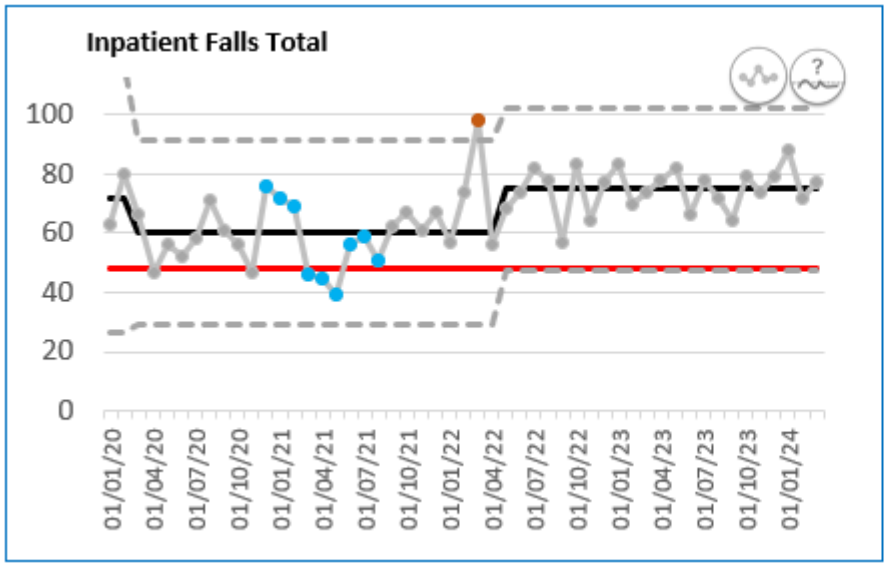


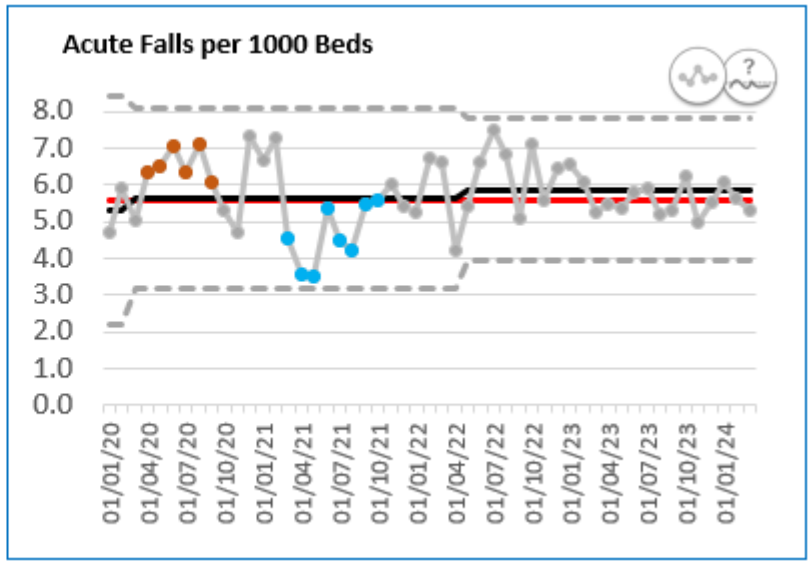




What	So What?	What Next?
The data for March demonstrates a very slight decrease in Acute and Community PU incidence, however not a consistent improvement trend In the acute there are increases noted on our escalation ward and F7 otherwise no significant areas of concern. Community teams all continue to demonstrate reduced PU reporting on previous months Haverhill and Sudbury higher than other teams in the locality this month. And area of focus namely NCH CAB is beginning to report less than previous months .	Pressure areas are an avoidable harm having a negative effect on patients health and cost of care provision. We continue to provide targeted prevention training and raise awareness in areas of high incidents. Area of particular concern has been G9 over previous months which consistently reported high numbers of PU. This month reported no pressure ulcers following a noted reduction in the previous 2 months demonstrating the effectiveness of this targeted approach. We rolled out a new reporting system and coincided this with the release of new pressure area guidelines that will see simplification of current category's making reporting simpler and more effective. We have created a Tissue Viability Competency pack including pressure ulcer management and prevention, this will be rolled out and support staff with PU prevention.	Last year a positive engagement project was delivered, distributing pocket mirrors to all staff to aid wound assessment and pressure ulcer prevention. This was successful in both engaging with the HCA staff and demonstrated an increase in the identification of 'present on admission' PU which potentially were not being picked up previously and reported as New. This project is being repeated to engage and refresh awareness with new staff We will be repeating this across the acute trust with all HCA capturing any new staff and reengaging with existing. We will monitor closely New and Present on Admission and look for improvements with detection and monitoring to provide assurance that this project is effective. All these initiatives are measurable as we continue to monitor Pressure ulcer incidence monthly to identify trends and measure the effectiveness of actions. We continue to adopt QI measures to monitor PU incidence using SPC to highlight impact of training and initiatives on pressure ulcer incidence

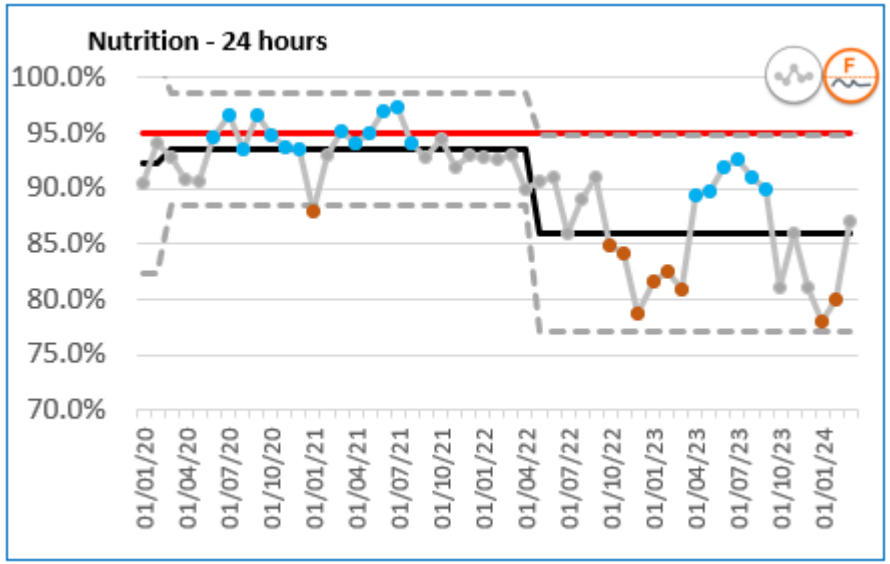
Safe





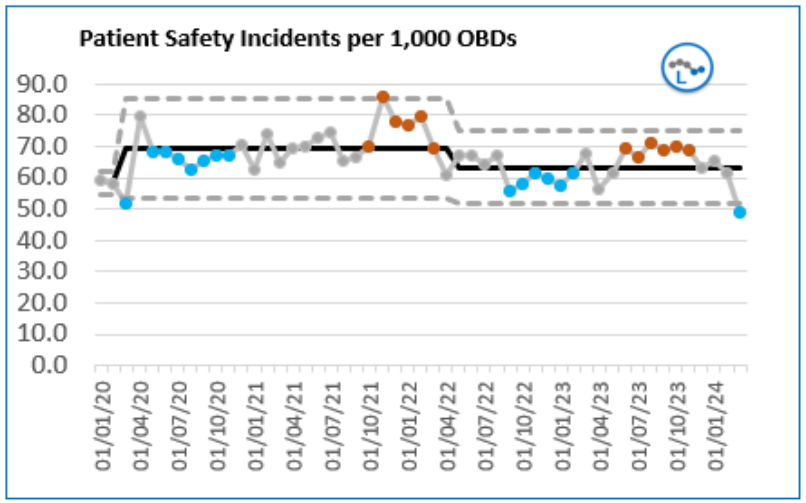
What	So What?	What Next?
There has been no significant change in the number of inpatient falls reported. Falls per 1000 bed days were below expected mean but does not represent any significant variation. This month (March) there was 1 fall reported as moderate harm (#humerus) and 1 fall reported as severe harm (#NOF). During the month of March there were 8 repeat fallers with 7 patients having 2 falls and 1 patients having 3 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. Important to continue to raise falls awareness and falls prevention to all staff working within the trust with aim to reduce the number of falls. Identifying themes to support with quality improvement projects. The falls with major and moderate harm will be reviewed through PSIRF after action reviews to understand learning and actions	Reviewing the falls assessment currently used within ecare to support in identifying falls risk factors and compliance with multifactorial falls assessment. If risk factors are identified appropriate falls prevention strategies can be implemented to support the patient reducing the risk of fall. Proactive ward based teaching to be delivered to high incident areas. Trust wide falls study day delivered end of April 2024 –this will include assessment of risk factors, assessment following a fall and manual handling techniques following a fall.

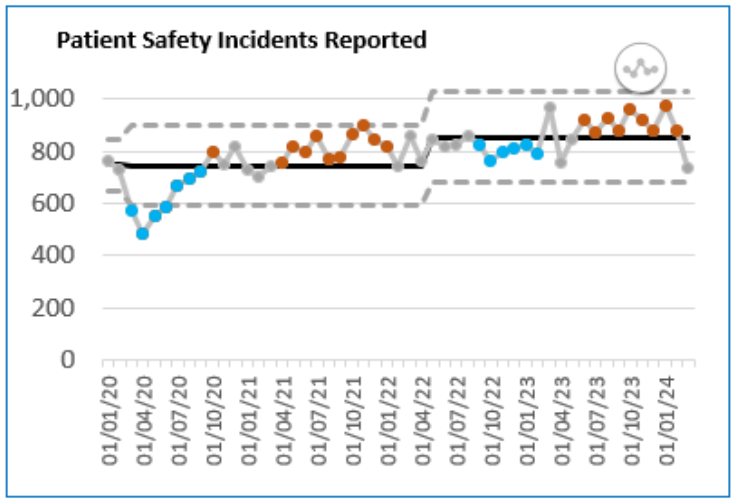
Safe

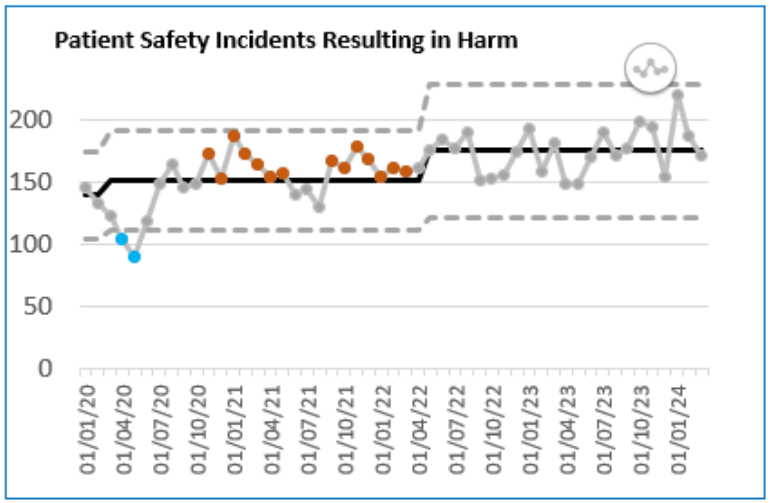


What	So What?	What Next?
There has been improvement in performance with completing nutritional assessments within 24hrs during March following another challenging month with capacity pressures. During March there was heightened focus on UEC performance across the Trust which has directly influenced this improvement with assessing patients within 24hrs. Performance was above average this month The ward teams are exepected to complete these assessments on transfer to the base wards from the assessment areas or ED, but currently this data is not being captured. The Information team are working on being able to report this metric but there is no date to commence this currently. On review of the data at 48hrs, the compliance with completing nutritional assessments improves, providing assurance that once the patient is based on a ward, the assessment is completed. Going forward, the metric will be measured in this way to gain assurance that each ward and department is engaged with ensuring assessments are completed for those in their care. is 93.8%. An increase from previous months. 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 March, the compliance is **66.5%** at 24hrs, an improvement from 55% in February. At 48hrs this is at 81.5%.	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. There have been delays in making this change due to the work being completed on the data warehouse. It is expected this change will not occur until April 2024 however, this has not been confirmed.	• Engage and focus on activities to improve the UEC performance and continue to monitor these improvements against the nutrition assessment data. • Review of data at performance meetings and Governance reviews monthly to inform performance in each ward / department to identify areas of focus and improvement • Information team to change reporting metrics to ensure each ward area is being accurately monitored for compliance - April 2024 • Continue to share the data with teams monthly to provide awareness to the teams where areas of improvement need to be made or highlight improvements made • Monitor for incidents or complaints raised regarding nutritional intake or support at department level to gain assurance.

Safe

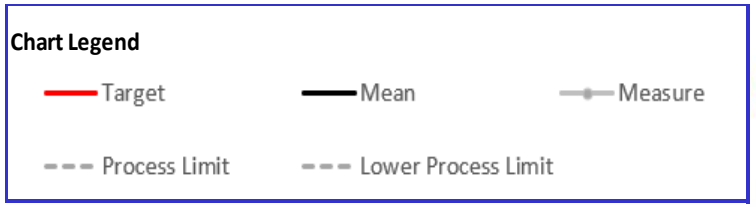


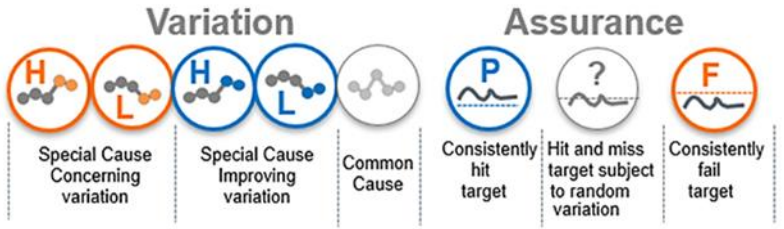




What	So What?	What Next?
There has been a reduced amount of patient safety incidents (PSI) reported in March 2024 which was unexpected. The reduction is in relation to pressure ulcer reporting. This will be monitored as per SPC methodology. Although PSI reported as improving variation, we encourage the reporting of PSI to demonstrate we are an open, safe organisation with a positive safety culture where staff feel able to report PSI for improvement and learning.	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 an important component of safety insight.	The organisation has transitioned to a new risk management system – Radar, therefore it is expected there will be a variance in incident reporting whilst staff familiarise themselves with the new system.. All PSI are triaged by the patient safety team and actioned using the workflow process. Incidents of note are escalated to the daily safety huddle, the divisional incident review meeting, or the trust wide emerging incident review meeting (EIR). Training on incident reporting on Radar is available for all staff on Totara (eLearning) and the uptake of the training is being monitored by the patient safety team. In addition, the team are supporting reporting of incidents and monitoring trends. Pressure ulcer reporting will be monitored over the next month and form part of the quarterly thematic incident report which is reported to PSQGG. This is in addition to the IQPR where PU data is also reported.

Mortality Summary

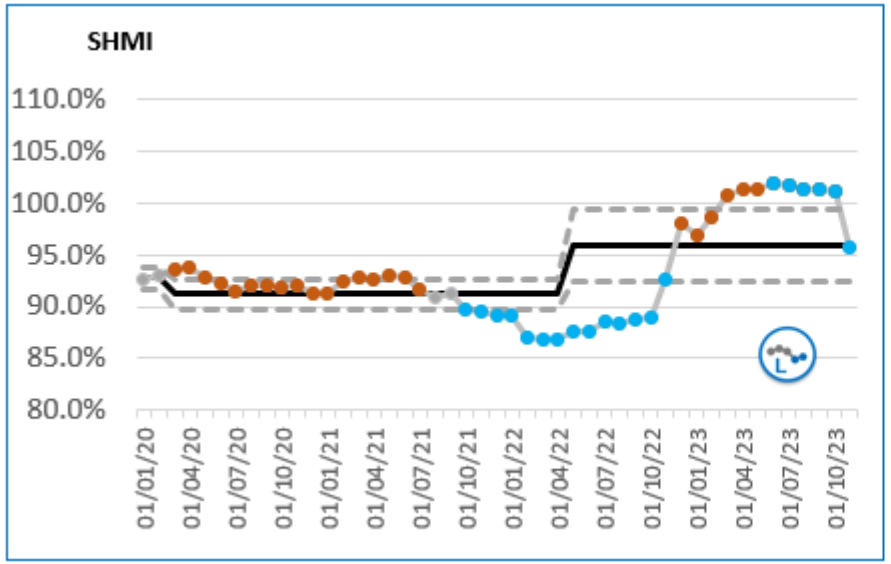


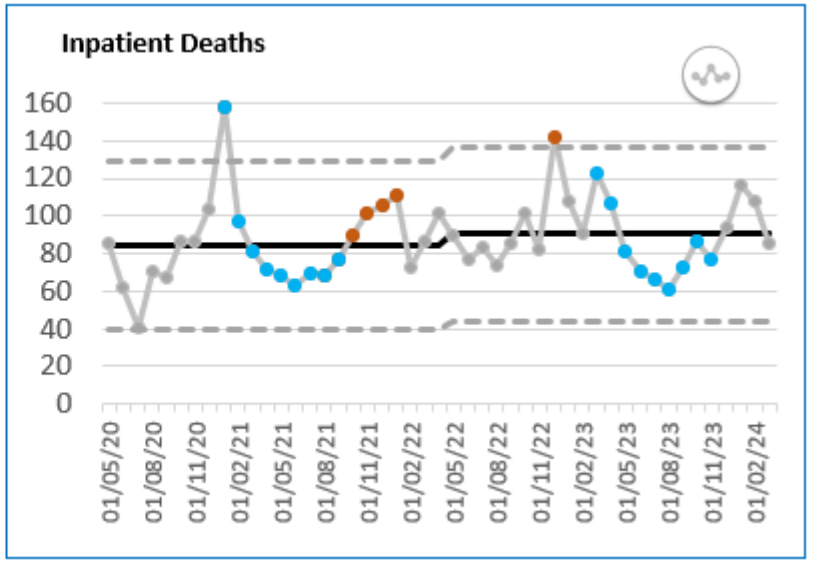


KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
SHMI	Nov 23	95.7%				95.9%	92.5%	99.4%
Inpatient Deaths	Mar 24	86				91	44	137

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

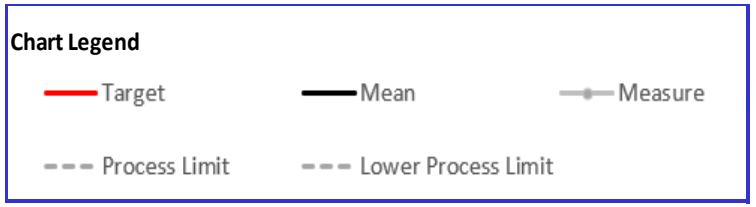
Mortality

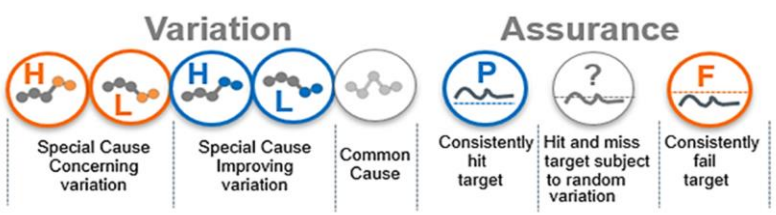




What	So What?	What Next?
The SHMI is returning towards the figure we would expect. This is because the months of Nov/Dec 2022 which were submitted uncoded at the time are no longer included in the "12 months up to .." total	Now the coding issue has been resolved the SHMI is returning to where we would expect it to be. Our inpatient deaths figure is in line with what we would expect to see both in terms of numbers, locations and age	We envisage that our SHMI will return to the figure it was prior to the anomalous period with Nov/Dec 2022 uncoded data however this will be kept under observation on a monthly basis by the mortality oversight group. Now the data is all coded, the diagnosis groups can be monitored for changes below the trust-wide total figure.

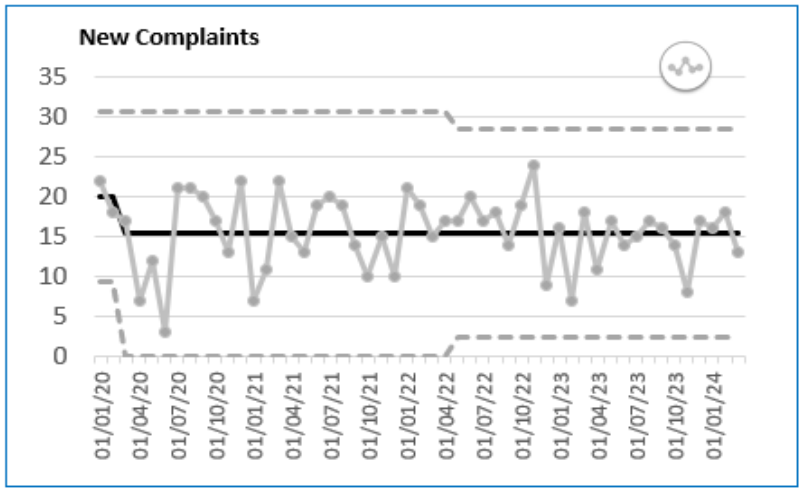
INVOLVEMENT COMMITTEE METRICS

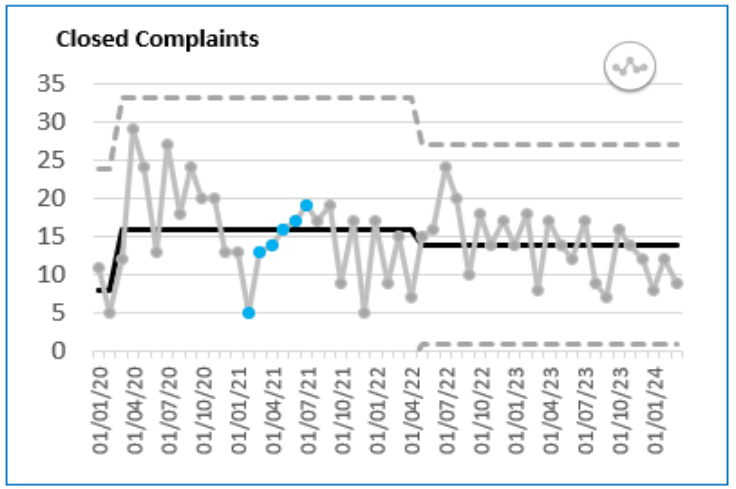


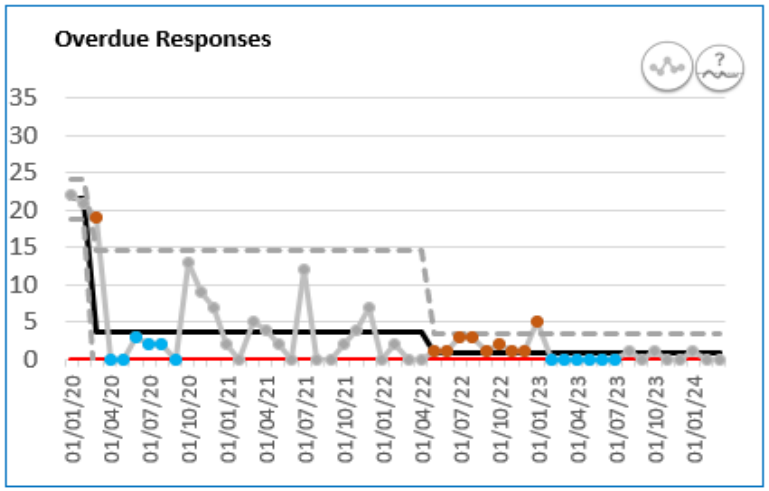


KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
New Complaints	Mar 24	13				15	2	28
Closed Complaints	Mar 24	9				14	1	27
Overdue Responses	Mar 24	0	0			1	-2	3

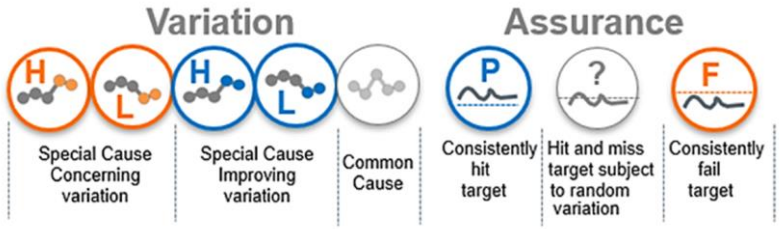
Safe





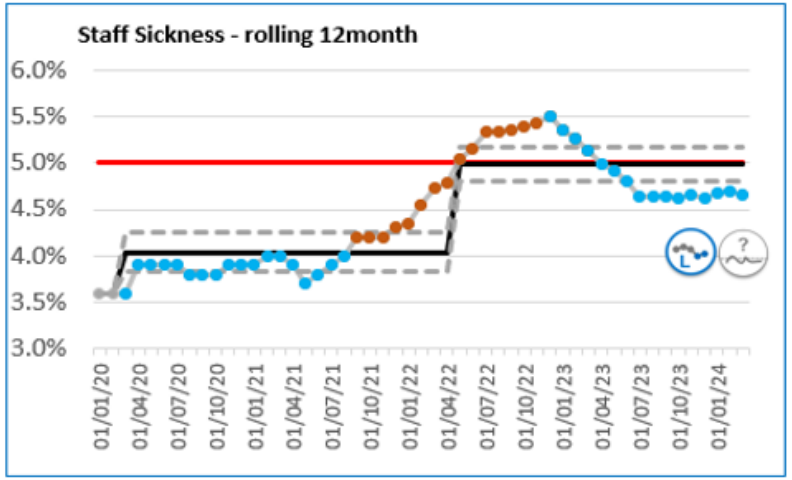


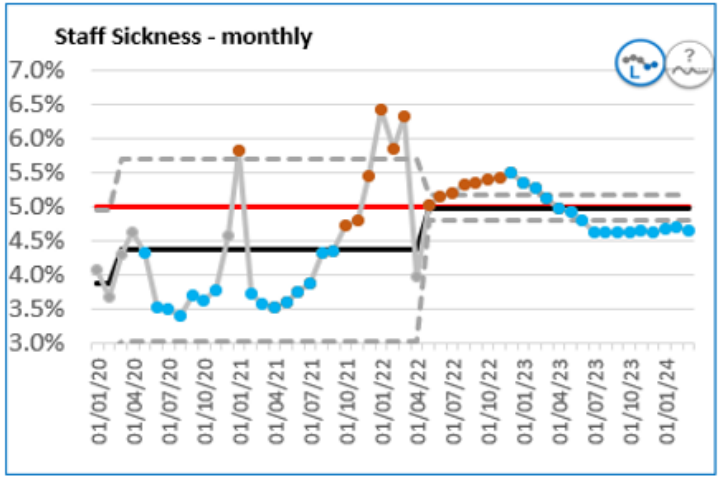
What	So What?	What Next?
March saw a slight reduction in new complaints received from 18 to 13 which is below average for what we would normally see at this time of year however still within the controlled limits. We resolved 9 complaints all within the agreed timeframe.	We are reviewing different methods in responding to complainants including meeting with complainants accompanied with clinical staff for more timely responses and ensuring that patients and families are involved in our investigations.	Continue to perform within control limits. The team is planning a QI test and learn pilot throughout quarter one, with an aim to meet with 50% of complainants as part of their resolution. Measurements will be included in Q2-Q4 on this pilot to determine success.

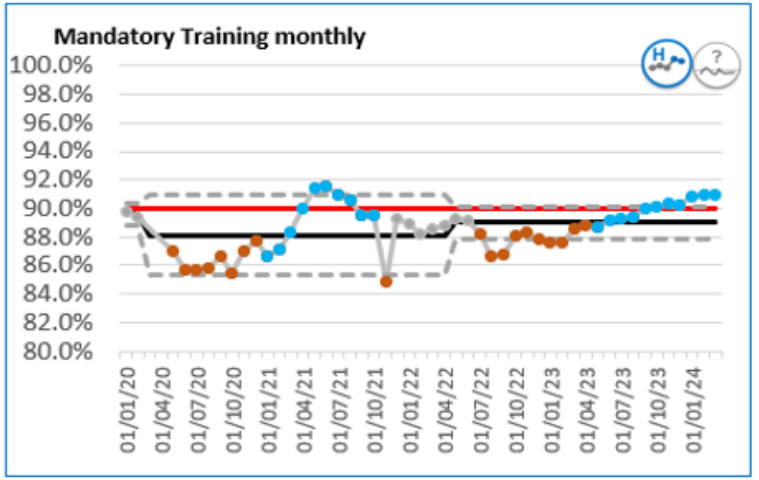


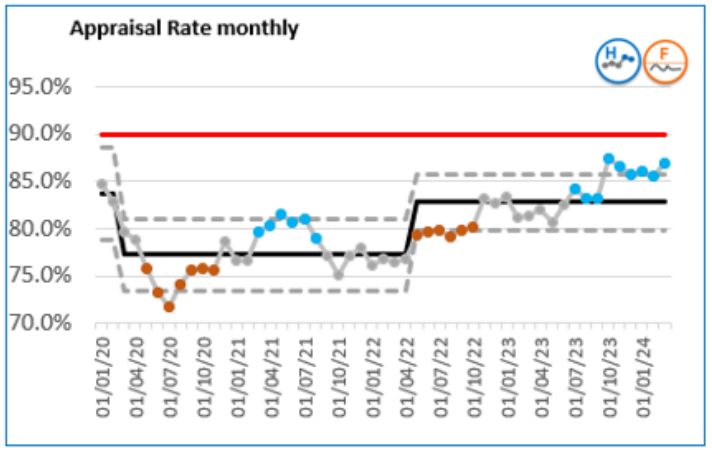
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Staff Sickness - rolling 12month	Mar 24	4.7%	5.0%	L	?	5.0%	4.8%	5.2%
Staff Sickness - monthly	Mar 24	4.7%	5.0%	L	?	5.0%	4.8%	5.2%
Mandatory Training monthly	Mar 24	91.0%	90.0%	H	?	89.0%	87.9%	90.1%
Appraisal Rate monthly	Mar 24	86.9%	90.0%	H	F	82.8%	79.9%	85.7%
Turnover rate monthly	Mar 24	9.1%	10.0%	L	F	11.5%	10.6%	12.4%

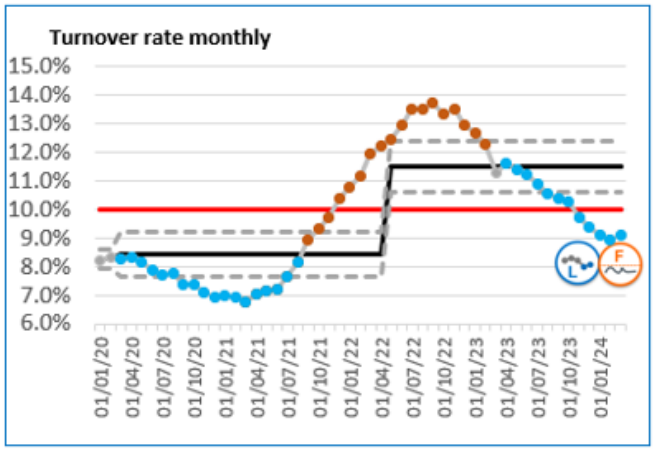
Well Led











What	So What?	What Next?
All key performance indicators continue to record an improving variation. **Sickness** – Achieving target, sustained improvement since December 2022 **Mandatory training** – achieving target for seventh consecutive month **Appraisal** – consistently failing target, +1.4% on previous month **Turnover** – achieving target, sustained improvement since November 2022	These workforce key performance indicators directly impact on staff morale, staff retention, and therefore, patient care and safety. Additionally, improvements in these workforce key performance indicators will strengthen our ability to be the employer of choice for our community and the recognition as a great place to work.	Maintain improvements in staff attendance and continue to monitor at department level. Sustain the target compliance of mandatory training ensuring areas and staff groups are identified where further focus and support may be required. Continued analysis of appraisal data to support and challenge areas in need of action and improvement. Maintain focus on the delivery of our people and culture plan and priorities.

4.3.1 Maternity papers Annexes

Annex B

Trust Board	
Report title:	**Updated Reporting Arrangements for Quality and Safety Assurance Reports for Year 6 of the Maternity Incentive Scheme 2024/25**
Agenda item:	Maternity and Neonatal services
Date of the meeting:	24th May 2024
Sponsor/executive lead:	Paul Molyneux, Trust Medical Director, Maternity and Neonatal Safety Champion, Susan Wilkinson, Executive Chief Nurse Richard Jones, Director of Governance
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?
Year 6 of the NHS Resolution Maternity Incentive Scheme was launched in April 2024 with ten key Safety Actions to be achieved and maintained by the Maternity and Neonatal Services provided by West Suffolk NHS Foundation Trust. Whilst there have been some minor changes to the safety requirements for this year in some of the Safety Actions, one of the key changes has been to the processes and pathways for Trust committee and Board oversight. This has afforded the Trust the opportunity to optimise the reporting structures and assurance processes to ensure that each report has appropriate oversight and approval during this time. Reports to provide assurance in each Safety Action can be monthly, quarterly, six-monthly, annually or as a one-off oversight report at the end of the reporting period for sign-off prior to submission. Many of the reporting processes are embedded into business as usual for the services so are continued out with the Maternity Incentive Scheme (MIS). The Trust Board will need to be assured of the evidence at the end of the period of reporting prior to the MIS declaration form being signed off by the Trust Executive Board by the 3rd March 2025. This brief document outlines the updated processes for approval of reports by the Maternity and Neonatal Safety Champions and the Board sub-committee - Improvement Committee. The Improvement Committee will provide assurances to the Board with regard to meeting the minimum requirements for evidence against the Safety Actions. The timetable in Appendix 1 outlines which reports will be approved by which Committees and Board along with the meeting dates. Where the reports may not be ready due to the timing of particular meetings, an alternative date is provided as a backup. These are indicated using italics.
SO WHAT?
Sub-committees will provide an overview and assurances to the Trust Board that reports have been approved and any concerns with safety and quality of care or issues that need escalating.

Annex B

Exception reports may be needed if compliance with any Safety Action is in doubt or needs additional assurance.
WHAT NEXT?
The timetable for meetings will be shared with Safety Action Leads with the expectation that evidence of compliance with or actions required to achieve compliance will be included in any reports within the timeframes for the approval committee. Once the report has been submitted and approved to the correct committee, this will be marked as complete. A copy of the approved report will be filed for evidence in the locally held folder for the Maternity Incentive Scheme.
Action Required
The Trust Board is requested to approve the updated reporting processes and pathways in order that the approval of reports is effective, and assurances are provided.

Risk and assurance:	The Trust Board is assured that the oversight of quality and safety reports is robust and effective. There is a risk to compliance with the MIS Safety Actions if the reports are not approved in a timely manner or the approving Committee does not meet the necessary reporting timeframes or level of scrutiny required prior to submission of the declaration form.
Equality, Diversity, and Inclusion:	There are no issues with equality or diversity within this report
Sustainability:	Whilst the Safety Actions are provided in an annual process, the nature of the Safety Actions should be business as usual.
Legal and regulatory context	There could be financial penalties and reputational issues if reports are approved or submitted that do not contain accurate information with regard to compliance with the MIS year 6 standards. There could be safety concerns if the Trust does not meet the minimum requirements for MIS.

West Suffolk NHS Foundation Trust

Appendix 1 Maternity Incentive Scheme Reporting Timetable 2024/25

Element	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb
Safety Action 1 Are you using the National Perinatal Mortality Tool to review perinatal deaths from 8 December 2023 to 30 November 2024 and to the required standard	Q 24th May		Q 15th July Q 25th July Q 26th July	*Q 19th August* *Q 22nd August*	*Q 27th September*	Q 21st October Q 24th October	*Q 18th November* *Q 28th November* Q 29th November		Q 20th January Q 23rd January A 15th January Q/A 31st January	*Q 17th February* *Q 27th February*
Safety Action 2 Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?						A 21st October A 24th October	*A 18th November* *A 28th November* A 29th November		A 15th January 31st January	
Safety Action 3 Can you demonstrate that you have transitional care services in place and undertaking quality improvement to minimise separation of parents and their babies?	Q 20th May Q 30th May		Q 15th July Q 25th July	*Q 19th August* *Q 22nd August*		Q 21st October Q 24th October	*Q 18th November* *Q 28th November*	A 16th December A 2nd January 25	Q 20th January Q 23rd January A 15th January A 31st January	*Q 17th February* *Q 27th February*
Safety Action 4A Can you demonstrate an effective system of clinical workforce planning to the required standard for **Obstetric medical** workforce?	S 20th May S 30th May	S 19th June				S 21st October S 24th October	*S 18th November* *S 28th November* S 20th November	A 16th December A 2nd January 25	A 15th January A 31st January	
Safety Action 4B Can you demonstrate an effective system of clinical workforce planning to the required standard for **Anaesthetic medical** workforce?		S 17th June S 27th June	S 17th July			S 21st October S 24th October	*S 18th November* *S 28th November* S 20th November	A 16th December A 2nd January 25	A 15th January A 31st January	
Safety Action 4C Can you demonstrate an effective system of clinical workforce planning to the required standard for **Neonatal medical** workforce?		S 17th June S 27th June	S 17th July			S 21st October S 24th October	*S 18th November* *S 28th November* S 20th November	A 16th December A 2nd January 25	A 15th January A 31st January	
Safety Action 4D Can you demonstrate an effective system of clinical workforce planning to the required standard for **Neonatal nursing** workforce?			A 15th July A 25th July	A 21st August				A 16th December A 2nd January 25	A 15th January A 31st January	
Safety Action 5 Can you demonstrate an effective system of midwifery workforce planning to the required standard?		17th June 27th June 19th June						16th December 2nd January 25 18th December	A 15th January A31st January	
Safety Action 6 Can you demonstrate that you are on track to achieve compliance with all elements of the Saving Babies Lives Care Bundle Version Three?	20th May 30th May	Q 17th June Q 27th June	15th July 25th July	19th August 22nd August	Q 16th September Q 26th September	21st October 24th October	18th November 28th November	A 16th December A 2nd January 25	Q 20th January Q 23rd January A 15th January A 31st January	*Q 17th February* *Q 27th February*
Safety Action 7 Listen to women, parents and families using maternity and neonatal services and coproduce services with users.								A 16th December A 2nd January 25	A 20th January A 23rd January A 15th January A 31st January	
Safety Action 8 Can you evidence the following 3 elements of local training plans and 'in-house', one day multi-professional training?	M 20th May M 30th May M 24th May	M 17th June M 27th June	M 15th July M 25th July M 26th July	M 19th August M 22nd August	M 16th September M 26th September M 27th September	M 21st October M 24th October	M 18th November M 28th November M 29th November	M 16th December M 2nd January 25	M/A 20th January M/A 23rd January A 15th January A 31st January	M 17th February M 27th February
Safety Action 9 Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal, safety and quality issues?	Q 20th May Q 30th May	Q 17th June Q 27th June Q 19th June	*Q 15th July* *Q 25th July*	Q 21st August		Q 21st October Q 24th October	Q 20th November	A 16th December A 2nd January 25	Q 20th January Q 23rd January A 15th January A 31st January	*Q 17th February* *Q 27th February* Q 19th February
Safety Action 10 Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programmed and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?	Q 24th May		Q 15th July Q 25th July Q 26th July	*Q 19th August* *Q 22nd August*	Q 27th September	Q 21st October Q 24th October	*Q 18th November* *Q 28th November* Q 29th November		Q 20th January Q 23rd January A 15th January Q/A 31st January	*Q 17th February* *Q 27th February*

Quality & Safety
Safety Champions
Improvement Committee
Trust Board

M = Monthly
Q = Quarterly
S = Six-monthly
A = On off overarching or annually

Dates in italics are alternative dates if initial date is not met.

Trust Board	
Report title:	**Maternity and Newborn Safety Investigations (MNSI) formally Healthcare Safety Investigation Branch (HSIB) Referral and Early Notification Reporting – Report for Quarter 4 2023/24 1st January 2024 to 31st March 2024**
Agenda item:	Maternity and Neonatal services
Date of the meeting:	24th May 2024
Sponsor/executive lead:	Paul Molyneux, Medical Director, Board Maternity and Neonatal Safety Champion Sue Wilkinson, Chief Nurse
Report prepared by:	Karen Green, Midwifery Clinical Quality and Governance Matron Beverley Gordon, Project Midwife

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

Executive Summary

WHAT?

All cases that may meet the criteria for mandatory reporting to the Maternity and Newborn Safety Investigations (MNSI) and the Early Notification Scheme (ENS) have been considered during this period of time. However, none of the cases have been accepted for investigation as they do not meet the criteria set by MNSI. There have been no completed reports received from MNSI in this quarter. One investigation is still in progress.

SO WHAT?

If there are any cases of maternal death, suspected neonatal hypoxic ischaemic encephalopathy, intrapartum stillbirth or a neonatal death related to labour, there is an immediate review and consideration of whether the incident meets the criteria for referral to MNSI for investigation. There is evidence that this review and discussion with MNSI has taken place, but no cases have been accepted by them.

WHAT NEXT?

The investigation that is in progress with MNSI will be completed and shared with the family, the staff who have assisted with the investigation and the wider members of the team in the Trust.

Actions Required

The Board is asked to note this brief summary and be assured that the processes for referral and review have been followed with learning being shared.

Previously considered by:	Maternity Quality and Safety Group: 15/4/24 Maternity and Neonatal Safety Champions: 23/4/24
Risk and assurance:	This report contains information that has previously been made known to the Trust Board through Board Reports. There is a risk to patient safety if these processes are not embedded and the maternity and neonatal services do not respond to safety intelligence.

Equality, Diversity, and Inclusion:	All maternity and neonatal services are committed to provide equality of care and treatment to all.
Sustainability:	The Maternity and Neonatal Services will sustain these processes by having appropriate governance pathways and escalations in place.
Legal and regulatory context	This report outlines evidence of the Trust's compliance with NHSR Maternity Incentive Scheme. This evidence will be verified in order that the claim for funding from the scheme is legitimate.

4.4 Audit committee:

App1 - scheme of reservation and delegation

App 2 - standing financial instructions (SFIs)

Trust Board

Report title:	**Standing Financial Instructions and Scheme of Reservation and Delegation of Powers**
Agenda item:	Item 4.5
Date of the meeting:	24 May 2024
Sponsor/executive lead:	Nick Macdonald, Interim Director of Resources
Report prepared by:	Liana Nicholson, Assistant Director of Finance

Purpose of the report:

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

Executive summary:	The Trust's Standing Financial Instructions, Scheme of Reservation and Delegation of Powers and Standing Orders have been reviewed and updated. These documents were last reviewed and approved in March 2023 and do not need to be reviewed every year, however, some changes have been required to these documents. This paper details the key changes that have been made to these documents. These policies have already been reviewed and approved by the Audit Committee in March 2024. The full documents are provided as Annexes within the meeting papers.
Action required/ recommendation:	The Board is asked to review and approve the changes to these 2 documents: • Scheme of Reservation and Delegation of Powers (SoD) • Standing Financial Instructions (SFIs)
Previously considered by:	These documents were reviewed by the Audit Committee in March 2024 and FAC in May 2024.
Risk and assurance:	These documents are a fundamental part of ensuring that the Trust has sufficient financial governance arrangements in place.

Equality, diversity and inclusion:	N/A
Sustainability:	N/A
Legal and regulatory context:	These documents include the requirements of NHSE and DHSC around financial governance.

SFIs and Scheme of Reservation and Delegation of Powers

1. Introduction

The Trust's SFIs, Scheme of Reservation and Delegation of Powers (SoD) and Standing Orders were last reviewed and updated in March 2023. At the last review it was agreed that although a full review was not required on an annual basis, these documents would undergo an on-going review and any required amendments would be taken to the Audit Committee and Trust Board as required.

Further amendments may be required in due course and will be brought back to the Trust Board for approval as required.

Each of the changes have been noted below.

2. Key Changes to Scheme of Reservation and Delegation

Some minor changes have been required to the Scheme of Reservation and Delegation, mainly around job titles or expanding on officer's job titles within the 'Authority Delegated To' boxes.

There have also been some items added, which are noted below. A copy of the full document, showing track changes, is attached at appendix 1.

2.1 **Expenditure and Business Cases (section 2)**

This section has been updated to reflect some new requirements around Cabinet Office spend controls, which were implemented from 1 February 2024. This section now includes the following:

Delegated Matter	Authority Delegated To
• **Any spend (revenue or capital) > £10m for length of contract*** *Note that this does not apply where the contract is NHS to NHS or for spend on the New Hospital Project. This does apply to any spend in collaboration with another NHS body that is greater than £10m in aggregate e.g. a contract with one supplier for NHS bodies across the region.	Cabinet Office

2.2 **Special Payments (section 15)**

This section has been updated to incorporate all special payments in to one place – note that some were previously included in section 14. The approval amounts have also been removed, in line with guidance issued by Hm Treasury on 'Managing the Public Purse'

2.3 **Credit Notes (section 16 – new)**

The authorisation of credit notes was not previously included in the Scheme of Reservation and Delegation – this has now been added. Authorisation around credit notes had only been included in a process note previously.

	<table><tr><th>Delegated Matter</th><th>Authority Delegated To</th></tr><tr><td>Where a credit note is required to be issued against an invoice raised by the Trust which will result in income being credited, it must be authorised as follows: • Up to £1,000 • £1,000 up to £10,000 • Over £10,000</td><td>Accounts Receivable Manager and Financial Controller Financial Controller and Assistant Director of Finance Assistant Director of Finance and Executive Director of Resources</td></tr></table>
2.4	**Non Pay Revenue Expenditure (section 3)** Expenditure greater than £500k and up to £2m must be approved by the Trust Executive Group (previously Senior Leadership Team).
3.	**Key Changes to Standing Financial Instructions** Some minor changes have been made to the SFIs in line with the spend controls introduced by the Cabinet Office, on page 30.
4.	**Recommendations**
	The Trust Board is asked to review and approve the changes to these 2 documents: • Scheme of Reservation and Delegation of Powers (SoD) • Standing Financial Instructions (SFIs)

West Suffolk NHS
NHS Foundation Trust

Trust Policy and Procedure **Document Ref. No: PP366**

Scheme of reservation and delegation of powers

For use in:	All areas of the Trust
For use by:	All Trust staff
For use for:	Financial Governance matters
Document owner:	Assistant Director of Finance
Status:	Final

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1. Introduction

1.1 Under the Standing Order relating to the Arrangements for the Exercise of Functions by Delegation (Standing Order 5) the Trust is given powers to:

> Make arrangements for the exercise, on behalf of the Board, of any of its functions by a committee, sub-committee appointed by virtue of Standing Order 4, or by an Officer of the Trust, in each case subject to such restrictions and conditions as the Trust thinks fit. [SO para 5.1]

1.2 Furthermore The Code of Accountability for NHS Boards requires the Board of Directors to demonstrate the existence of comprehensive governance arrangements, which may be delegated, and draw up a schedule of decisions reserved to it. The schedule must also ensure that management arrangements are in place to enable the clear delegation of other responsibilities.

1.3 This document sets out the powers reserved to the Board of Directors and the Scheme of Delegation, including financial limits and approval thresholds. However, the Board of Directors remains accountable for all of its functions, including those which have been delegated, and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

1.4 All powers of the Trust which have not been retained as reserved by the Board of Directors or delegated to a Board of Directors Committee shall be exercised on behalf of the Board of Directors by the Chief Executive. The Scheme of Delegation identifies any functions which the Chief Executive shall perform personally and those delegated to other directors or officers. All powers delegated by the Chief Executive can be re-assumed by him/her should the need arise.

2. Scope

2.1. All Trust staff (including permanent, locum, secondee, students, agency, bank and voluntary) must follow the policies agreed by the Trust. Breaches of adherence to Trust policy may have potential consequences for the employee, including in some cases, formal action.

2.2. The Scheme of Delegation covers only matters delegated by the Board of Directors. This should be used in conjunction with specific matters referred to in the Standing Financial Instructions (SFIs) and Standing Orders (SOs) and other established procedures within the Trust.

2.3. The Chief Executive shall exercise all powers of the Trust, which have not been retained as reserved by the Board of Directors or delegated to an executive committee or sub-committee, on behalf of the Board of Directors. The Chief Executive shall prepare a Scheme of Delegation identifying which functions him/her shall perform personally and which functions have been delegated to other Directors and Officers.

All powers delegated by the Chief Executive can be re-assumed by him/her should the need arise. As Accounting Officer the Chief Executive is accountable to NHS England (NHSE) for the funds entrusted to the Trust.

2.4. Powers are delegated to Directors and officers on the understanding that they would not exercise delegated powers in a matter that in their judgment was likely to be a cause for public concern.

2.5. In the absence of a Director or Officer to whom powers have been delegated, those powers shall be exercised by that Director or Officer's superior unless alternative arrangements have been approved by the Board. If the Chief Executive is absent, powers delegated to him/her may be exercised by the Deputy Chief Executive.

2.6. The Board of Directors may determine that certain of its powers shall be exercised by Standing Committees. The composition and terms of reference of such committees shall be that determined by the Board of Directors from time to time taking into account where necessary, the requirements of regulators e.g. NHSE and the Charity Commissioners. The Board of Directors shall determine the reporting requirements in respect of these committees. In accordance with Standing Orders, committees may not delegate executive powers to sub committees unless expressly authorised by the Board of Directors.

3. Scheme of reservation and delegation – decisions reserved to the Board

Policy Area	No.	Decision	Reserved to the Board	Or Authority Delegated to:	Further Details
1. Regulation and Control	1.1	Approve this Scheme of Reservation and Delegation	✓		Ratified by the Audit Committee.
	1.2	Approve Standing Orders and Standing Financial Instructionss	✓		Ratified by the Audit Committee.
	1.3	Suspend, vary or amend SOs	✓		Ratified by the Audit Committee.
	1.4	Ratify any urgent decisions taken by the Chair and Chief Executive outside of Board meetings.	✓		
	1.5	Receive the Register of Interests and determine the extent to which any member may remain involved in the matter under consideration.	✓		
	1.6	Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto.	✓		
	1.7	Receive reports from committees including those that the Trust is required by the Secretary of State or other regulation to establish and on which to take appropriate action.	✓		
	1.8	Confirm the recommendations of the Trust's committees where the committees do not have executive powers.	✓		
	1.9	Approve arrangements relating to the discharge of the Trust's responsibilities as a Corporate Trustee for funds held on trust.	✓		

Policy Area	No.	Decision	Reserved to the Board	Or Authority Delegated to:	Further Details
	1.10	Establish terms of reference and reporting arrangements for all committees and sub-committees that are established by the Board	✓		
	1.11	Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property.	✓		**Should this be delegated?**
	1.12	Authorise the use of the Trust seal.	✓		
	1.13	Ratify, or otherwise, instances of failure to comply with Standing Orders brought to the Chief Executive's attention.	✓		
	1.14	Consider the action, formal or informal, for members of the Board or employees who are in breach of statutory requirements or Standing Orders.	✓		
	1.15	Prepare the Trust's overarching scheme of reservation and delegation which sets out those decisions of the Trust reserved to the Board and those delegated to the: - Trust Board committees and sub-committees - Members of the Trust Board - An individual who is an employee of the Trust but not a member of the Trust Board		Trust Secretary	
	1.16	Prepare Standing Orders (SOs) and Standing Financial Instructions (SFIs)		SOs - Trust Secretary SFIs - Executive Director of Resources	

Policy Area	No.	Decision	Reserved to the Board	Or Authority Delegated to:	Further Details
	1.17	Prepare detailed financial policies that underpin the Trust's prime financial policies.		Executive Director of Resources	
	1.18	Approve detailed financial policies.		Insight Committee	Dependent upon the policy being approved.
	1.19	Final authority in interpretation of Standing Orders.		Chair	Advised by the Chief Executive and Trust Secretary
	1.20	Review decisions to suspend Standing Orders.		Audit Committee	
	1.21	Execute Powers reserved to the Board outside of Board meetings.		Chair and Chief Executive	At least two non-executive directors must be consulted.
	1.22	Maintain the Register of Interests		Trust Secretary	
	1.23	Maintain an effective system of financial control.		Executive Director of Resources	
	1.24	Approve proposed prepayment arrangements.		Executive Director of Resources	
2. Meetings of the Trust	2.1	Call Meetings.		Chair	
	2.2	Chair all Board meetings and associated responsibilities.		Chair	
	2.3	Give final ruling in questions of order, relevancy and regularity of meetings.		Chair	
3. Annual Reports, Accounts and Audit	3.1	Receive and approve the Trust's Annual Report and Annual Accounts.	✓		Advised by the Audit Committee
	3.2	Receive and approve the Annual Report and Accounts for Charitable Funds (delegated authority from the Trust Board)		Audit Committee	Advised by members of the Charitable Funds Committee.

Policy Area	No.	Decision	Reserved to the Board	Or Authority Delegated to:	Further Details
	3.3	Receive an annual report from the Internal Auditor and agree action on recommendations where appropriate.		Audit Committee	
	3.4	Agree the make-up of the Audit Panel (responsible for the appointment and dismissal of the External Auditors).		Audit Committee	Appointment of External Auditors is by the Council of Governors
	3.5	Approval of external auditors' arrangements for the separate audit of funds held on trust.		Audit Committee	Advised by members of the Charitable Funds Committee.
	3.6	Review the Auditors Annual Report received from the External Auditor and agree proposed action, taking account of the advice, where appropriate, of the Audit Committee.	✓		
	3.7	Review the Trust's annual accounts prior to submission to NHS England/Department of Health & Social Care		Audit Committee	
	3.8	Ensure an adequate internal audit service is provided.		Audit Committee	
	3.9	Approve the annual internal audit plan.		Audit Committee	
	3.10	Receive and approve the Trust's Quality Account	✓		Advised by the Audit Committee
4. Workforce	4.1	Appoint the Deputy Chair of the Board		Council of Governors	
	4.2	Appoint, appraise, discipline and dismiss Executive Directors.		Remuneration Committee	
	4.3	Determine the broad remuneration policy and performance management framework and to set individual remuneration arrangements for the Trust's Executive Directors.		Remuneration Committee	

Policy Area	No.	Decision	Reserved to the Board	Or Authority Delegated to:	Further Details
	4.4	Make recommendations to the Board on any termination arrangements for executive directors.		Remuneration Committee	
	4.5	Make recommendations to the Board on special/exceptional payments covering any individual member of staff or staff group.		Remuneration Committee	
	4.6	Approve variation to funded establishment of any department including temporary staffing, appointments and re-grading, in line with the Budget Setting Policy.		Workforce Committee	
5. Strategy, Plans and Budgets	5.1	Define the strategic aims and objectives of the Trust.	✓		
	5.2	Approve proposals for ensuring quality and developing clinical governance in services provided by the Trust, having regard to any guidance issued by the Secretary of State.	✓		Advised by the Improvement Committee
	5.3	Approve annual financial plan, including the capital programme.	✓		Advised by the Insight Committee
	5.4	Approve annually Trust's proposed organisational development proposals.	✓		Advised by the Involvement Committee
	5.5	Ratify proposals for acquisition, disposal or change of use of land and/or buildings.	✓		
	5.6	Approve private finance initiative (PFI) proposals.	✓		
	5.7	Approve the opening and closing of bank accounts.	✓		
	5.8	Approve Business Cases for revenue over £500k.	✓		

Policy Area	No.	Decision	Reserved to the Board	Or Authority Delegated to:	Further Details
	5.9	Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £2m (revenue) or £1m (capital) for the life of the contract.	✓		Advised by Finance Accountability Committee
	5.10	Grant new substantial interest of land owned by the Trust to third parties.	✓		
	5.11	Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Executive Director of Resources (for losses and special payments) previously approved by the Board.		Audit Committee	Advised by Finance Accountability Committee
	5.12	Approve individual compensation payments over £50k.	✓		
	5.13	Review use of NHS Resolution risk pooling schemes (LPST/CNST/RPST).	✓		
	5.14	Approve a list of employees authorised to make short term borrowings on behalf of the Trust (this must include the Chief Executive and the Executive Director of Resources)	✓		
6. Quality and Safety	6.1	Approve the Trust's arrangements for handling complaints.	✓		Advised by Involvement Committee
	6.2	Propose arrangements, including supporting policies, to minimise clinical risk, maximise patient safety and to secure continuous improvement in quality and patient outcomes.		Improvement Committee	
	6.3	Receive and scrutinise independent investigation reports relating to patient safety issues and agree publication plans.		Improvement Committee	

Policy Area	No.	Decision	Reserved to the Board	Or Authority Delegated to:	Further Details
7. Operational and Risk Management	7.1	Approve the Trust's policies and procedures for the management of risk.	✓		Advised by Insight Committee
	7.2	Approve arrangements for risk sharing and/or risk pooling with other organisations.	✓		
	7.3	Approve the Trust's counter fraud and security management arrangements.		Audit Committee	
8. Communications	8.1	Approve arrangements for the handling of Freedom of Information requests.		Corporate Risk Governance Group	
9. Monitoring	9.1	Receive such reports as the Board sees fit from committees in respect of their exercise of powers delegated.	✓		
	9.2	Continually appraise the affairs of the Trust by means of the provision to the Board as the Board may require from directors, committees, and officers of the Trust as set out in management policy statements.	✓		
	9.3	Receive reports from Executive Director of Resources on financial performance against budget and annual business plan.	✓		Advised by Insight Committee

Further details of delegation can be found in the NHS foundation trust accounting officer memorandum (April 2015)

4. Detailed scheme of delegation for standing financial instructions (SFIs)

Delegated matters in respect of decisions which may have a far reaching effect must be reported to the Chief Executive. ***The delegation shown below is the lowest level to which authority is delegated.*** *Delegation to lower levels is only permitted with written approval of the Chief Executive who will, before authorising such delegation, consult with other Senior Officers as appropriate. All items concerning Finance must be carried out in accordance with Standing Financial Instructions and Standing Orders.*

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
1. Management of Budgets Responsibility for keeping expenditure within budgets: **a)** At specialty/department level **b)** For the totality of a Division **c)** Corporate Function **Revenue Budget Virement** • All virements between pay and non-pay • All other virements within single cost centre • All other virements between cost centres	 Designated Budget Holder Divisional Director/Divisional Associate Director of Operations Relevant Executive Director Executive Director of Resources Designated Budget Holder Designated Budget Holder of all affected areas	SFIs Section 3
2. Expenditure process & Business Cases Each officer who commits the Trust to expenditure must do so in line with the Standing Financial Instructions and this Scheme of Reservation and Delegation. Before expenditure is committed, consideration needs to be considered as to whether this is within the budget set or whether a business case is required. Business cases are required for any new requests for funds that is over and above existing resources and must be submitted to the Investment Panel for approval. Further approval is required as follows:		Link to Business Case Pathway

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
• **Gross annual revenue costs <= £10,000 per annum**		
- and/or one-off capital costs <= £10,000	Divisional Board	
- Capital costs >£10,000 up to £50,000	Chief Operating Officer or Executive Director of Resources	
- Capital costs >£50,000	Chief Operating Officer or Executive Director of Resources and Capital Strategy Group	
• **Gross annual revenue >£10,000 up to £50,000 per annum**		
- and/or one-off capital costs <= £10,000	Divisional Board with recommendation to the Chief Operating Officer or Executive Director of Resources	
- Capital costs >£10,000 up to £50,000	Chief Operating Officer or Executive Director of Resources	
- Capital costs >£50,000	Chief Operating Officer or Executive Director of Resources and Capital Strategy Group	
• **Gross annual revenue >£50,000 up to £250,000 per annum**		
- and/or one-off capital costs <= £10,000	Executive Group	
- Capital costs >£10,000 up to £50,000	Executive Group	
- Capital costs >£50,000	Executive Group and Capital Strategy Group	
• **Gross annual revenue >£250,000 per annum**		
- and/or one-off capital costs <= £10,000	Trust Board	
- Capital costs >£10,000 up to £50,000	Trust Board	
- Capital costs >£50,000	Trust Board and Capital Strategy Group	

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
• **Any spend (revenue or capital) > £10m for length of contract*** *Note that this does not apply where the contract is NHS to NHS or for spend on the New Hospital Project. This does apply to any spend in collaboration with another NHS body that is greater than £10m in aggregate e.g. a contract with one supplier for NHS bodies across the region. The Trust introduced a policy of 'no purchase order, no pay' in 2015. All items of expenditure must have a purchase order raised before a commitment to expenditure is made. The purchase order number must be quoted on the invoice from the supplier. Once items are received, they must be receipted on the purchase ordering system immediately to ensure the prompt payment of the invoice to the supplier. There are exceptions to this process e.g., for services provided by other NHS Organisations, and some agency expenditure payments where a separate approval route is in place. Points of clarity: - All financial limits within this document should be treated as VAT inclusive regardless of whether the VAT can be reclaimed or not except for contracts that may require Trust Board approval. - For those contracts which may need Trust Board approval the amount net of reclaimable VAT should be the value used to determine the level of authorisation required. Finance must confirm the correct VAT treatment before this decision can be made.	Cabinet Office	

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
- NB items must not be split across multiple requisitions. All 'call off orders' must have an indicative level of activity and therefore an indicative value for which the following limits should be applied. - When considering the delegated matters determined by the 'annual value' or 'life of contract' which drives the most senior decision must be used. The 'annual value' should be based on the average value for the contract life.		
3. Non Pay Revenue Expenditure **(a) Pharmacy Orders**		
• <= £500,000 within agreed contracts	Chief Pharmacist	SFIs Section 11
• > £500,000 up to £1,000,000 within agreed contracts	Chief Executive or Executive Director of Resources	
• > £1,000,000	Trust Board	
(b) All Other Revenue requisitions, orders and invoices (based on total contract value)*		SFIs Section 11
• <= £10,000 – requires up to 3 written quotations at the discretion of procurement for items over £5,000 - informal	Budget Holder per authorised signatory list **	
• > £10,000 up to £50,000 – requires 3 written quotations - formal	Associate Director of Operations or Associate Director of service area **	
• >£50,000 up to £100,000 – requires 3 written quotations - formal	Executive Director**	
• >£100,000 up to £500,000 – requires 5 written tenders or maximum suppliers in the market if less than 5	Chief Executive and Executive Director of Resources	

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
• >£500,000 up to £2m – requires 5 written tenders or maximum suppliers in the market if less than 5 • >£2m – requires 5 written tenders or maximum suppliers in the market if less than 5 **Where a contract includes the option to extend, the above values apply to the full term of the contract including any possible extensions.** ***All requisitions must have the highest level of Divisional Sign off as well as the relevant Committee sign off.**	Chief Executive and Executive Director of Resources (in consultation with the Trust Executive Group) Chief Executive or Executive Director of Resources (on the instruction of the Trust Board) ** within their authorised budget areas only	
4. Pay Costs • Where the cost pressure to the Trust is <=£50,000: a) <= Band 7 b) Band 8a c) Band 8b and above • Where a Band 8 or higher post is new To determine the authorisation for pay it is the annual gross cost to the Organisation that should be considered i.e. including employer national insurance and pension contributions.	 Associate Director of Operations Divisional Board Investment Panel Investment Panel	SFIs section 10
5. Capital Purchases & Schemes **a)** All capital schemes or capital purchases must be listed in the Trust Board approved Capital Programme and must be agreed with the Executive Director of Resources prior to implementation or purchase. Note that this also includes all expenditure in relation to leases (new and extensions) and right of use assets. Note that the below values are for the life of the contract.		SFIs section 14

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
• <= £500,000	Executive Director (on instruction from the Capital Strategy Group)	
• £500,000 - £1,000,000 (for scheme's included in the approved capital programme)	Chief Executive or Executive Director of Resources (in consultation with the Capital Strategy Group and the Finance Accountability Committee)	
• £500,000 - £1,000,000 (for scheme's not included in the approved capital programme)	Chief Executive or Executive Director of Resources (in consultation with the Trust Board and the Capital Strategy Group)	
• £1,000,000 - £15,000,000	Trust Board	
• £15,000,000 to £50,000,000*	NHS England and The Department of Health and Social Care	
• Over £50,000,000*	NHS England, The Department of Health and Social Care and HM Treasury	
* may be reduced to £15,000,000 by NHS England if the Trust is in financial distress		
b) Selection of architects, quantity surveyors, consultant engineer and other professional advisors within EU regulations	Associate Director of Estates and Facilities	
c) Granting and termination of leases within the Trust's delegated limit	Chief Executive or Executive Director of Resources	
d) Transfers between Revenue/Capital	Executive Director of Resources	
6. Waiving of Competition and Contract Signature **a) Waiving of Competition**		SFIs section 7.5.3

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
• Waiving of quotations irrespective of value	Head of Procurement	
• Waiving of quotations <=£10,000	Assistant Director of Finance or Deputy Director of Finance	
• Waiving of quotations >£10,000 <=£100,000	Executive Director of Resources or Chief Executive	
• Waiving of quotations >£100,000 <=£500,000	Chief Executive or Executive Director of Resources, with ratification from the Financial Accountability Committee.	
• Waiving of quotations >£500,000	Chief Executive or Executive Director of Resources, with ratification from the Trust Board.	
b) Healthcare Service Level Agreements	Chief Executive or Executive Director of Resources	
c) Signing of contracts with suppliers following approval of expenditure in line with the Scheme of Delegation	Chief Executive or Executive Director of Resources	
7. Setting of Fees and Charges		
a) Private Patient, Overseas Visitors, Income Generation and other patient related services	Executive Director of Resources or Nominated Deputy	SFIs Section 6
b) Price of NHS Contracts/Service Agreements	Executive Director of Resources	SFIs Section 7 and 8
8. Engagement of Staff not on the Establishment and Professional Advisers		
a) Non-Medical Consultancy Staff		
Where aggregate commitment (or total commitment) in any one year is less than £75,000	Executive Director with permission from NHS England where relevant	

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
Where aggregate commitment (or total commitment) in any one year is > £75,000	Chief Executive or Executive Director of Resources with permission from NHS England where relevant	
b) Engagement of Trust's Solicitors	Executive Director or Trust Secretary	
c) Temporary & Bank staff, including locums, overtime and additional sessions	Budget Holder/Assistant Director of Operations	
9. Petty Cash Disbursements		
a) Expenditure up to £100 per item	Petty Cash Holder	
b) Expenditure >£100	Financial Accountant	
c) Reimbursement of patient's monies up to £100	Patient Affairs Officer	
d) Reimbursement of patient's monies in excess of £100	Executive Director of Resources or Assistant Director of Finance	
10. Expenditure on Charitable Funds		Charitable Funds Policy
• Up to £5,000 per request	Head of Fundraising and Fund Holder	
• >£5,000 up to £25,000	2 of either Executive Chief Operating Officer, Executive Director of Resources or Director of Workforce	
• >£25,000 up to £100,000	Charitable Funds Committee	
• >£100,000	Trust Board	
The Head of Fundraising must approve all expenditure to ensure that it is in line with the charitable objective. All expenditure must be spent and approved in line with the Charitable Funds Policy. Retrospective approvals will not be given. Where expenditure is over £5,000 then a 2nd competitive quote should be obtained as a minimum, or a waiver completed in line with section 6 of this		

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
Scheme of Reservation and Delegation.		
11. Maintenance / Operation of Bank Accounts		
• CHAPS and 'Faster' Payments	Executive Director of Resources/Authorised Signatory for Bank Account	SFIs Section 6.4.6
12. Agreements/ Licences For Use of Trust Property		
a) Preparation and signature of all tenancy agreements/licences for all staff subject to Trust Policy on accommodation for staff	Director of Workforce & Communications or nominated Deputy	SFIs section 12.3
b) Extensions to existing property leases	Executive Director of Resources and Associate Director of Estates and Facilities	
c) Letting of existing premises to outside organisations	Executive Director of Resources and Associate Director of Estates and Facilities	
d) Approval of rent based on professional assessment	Executive Director of Resources and Associate Director of Estates and Facilities	
13. Condemning & Disposal of Assets and Supplies		
a) Condemning		SFIs section 16
• Items obsolete, obsolescent, redundant, irreparable or cannot be repaired cost effectively and where the value exceeds £5,000:	Head of Procurement or Head of EBME or Capital Accountant	
b) Disposal		
• Where the item being disposed of has a net book value of over £5,000	Capital Accountant	
• Where the net book value is greater than £50,000	Executive Director of Resources	
14. Losses, Write-off & Compensation		SFIs section 16
a) Losses in relation to:		

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
- Cash - Fruitless payments (including abandoned projects) - Patients, staff and visitors for loss of personal effects - Bad debts and claims abandoned (including overpayments) - Damage or loss to buildings, fittings, furniture, equipment, property, stores		
• Up to £5k	Executive Director of Resources	
• Between £5k up to £25k	Executive Director of Resources and Chief Executive	
• £25k up to £250k	Audit Committee	
• Over £250k	Trust Board	
b) For clinical negligence		
• Up to £10,000	Legal Services Manager	
• >=£10,000	NHS Resolution	
c) For personal injury		
• Up to £10,000 staff	Legal Services Manager having taken legal advice and consulted with the Trust insurers	
• Up to £3,000 public Liability	Legal Services Manager having taken legal advice and consulted with the Trust insurers	
Greater than above limits	NHS Resolution or relevant body	

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
Note that all losses and special payments are to be reported to the Audit Committee on an annual basis.		
15. Special Payments The following items require approval from HM Treasury before being committed to and therefore the Executive Director of Workforce and the Executive Director of Resources must be alerted to any such instances (note that a value does not apply unless specifically stated): **Special Payments** • Extra contractual payments to contractors • Compensation payments (e.g. for personal injury outside of the Injury Benefit Scheme, traffic accidents and damage to property) • Extra statutory and extra regulatory payments • Ex-gratia payments beyond statutory cover or legal liability (e.g. payments for hardship or out of court settlements) **Special Severance Payments** • Any severance payments (contractual and non-contractual) made to any Director of Chief Executive. • Non-contractual severance payments to staff (e,g, gardening/special leave, compensation payments, settlement agreements outside of the normal contract arrangement).	Executive Director of Resources and HM Treasury The Trust Board should also be aware. Executive Director of Workforce and Executive Director of Resources and HM Treasury The Trust Board should also be aware.	

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
• Contractual payments to staff over £100,000. • Any payment in lieu of notice (PILON). • Any payment that is considered to be novel, contentious or could cause repercussions elsewhere in the public sector.		
16. Credit Notes Where a credit note is required to be issued against an invoice raised by the Trust which will result in income being credited, it must be authorised as follows: • Up to £1,000 • £1,000 up to £10,000 • Over £10,000	 Accounts Receivable Manager and Financial Controller Financial Controller and Assistant Director of Finance Assistant Director of Finance and Executive Director of Resources	
17. Reporting of Incidents to the Police **a)** Where a criminal offence other than fraud is suspected **b)** Where a fraud against the Trust is suspected	 In line with Trust Policy Executive Director of Resources	SFIs Section 2 & 16
18. Receiving Hospitality Gifts and hospitality should be declined where possible. If not, any items valued over £25 must be declared and recorded on the Gifts and Hospitality Register. Approving the acceptance of hospitality by employees except for trivial gifts as defined in the NHS England guidance:	 Trust Secretary	Standards of Business Conduct

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
'Managing Conflicts of Interest in the NHS' (Publications Gateway Reference 06419)		
19. Maintenance & Update of Trust Financial Procedures	Executive Director of Resources	
20. Implementation of Internal and External Audit Recommendations	Executive Director of Resources	SFIs Section 2
21. Investment of Funds		
a) Trust Funds	Executive Director of Resources	SFIs Sections 12, 19
b) Charitable Funds (Investment advisors).	Charitable Funds Committee	
22. Workforce & Pay		
a) Authority to fill funded post with permanent staff	Divisional Boards and in line with section 4 above	HR Policies
b) <u>Pay and banding adjustments</u>		
All requests for pay and banding adjustments shall be dealt with in accordance with Trust Procedure	See section 4 above	HR Policies
c) <u>Pay</u>		
• Authority to agree starting salary	Budget Holder in consultation with HR and in line with section 4 above	HR Policies/Workforce Committee
• Authority to complete standing data forms effecting pay, new starters, variations and leavers	Budget Holder	
• Authority to authorise overtime	Line Manager	
• Authority to authorise travel & subsistence expenses	Line Manager	
• Authority to waive contractual notice period	Budget Holder in consultation with HR	

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
23. Authorisation of New Drugs		
a) Annual cost < £25,000	Drugs & Therapeutics Committee	
b) Annual cost > £25,000	Drugs & Therapeutics Committee and Executive Director of Resources	
24. Authorisation of Sponsorship deals	Chief Executive	
25. Authorisation of Research Projects	Chief Executive or Medical Director and Research Committee	
26. Authorisation of Clinical Trials	Research Operational Committee	
27. Insurance Policies and Risk Management	Chief Executive	SFIs section 23
28. Patients & Relatives Complaints		
a) Overall responsibility for ensuring that all complaints are dealt with effectively	Executive Chief Nurse	
b) Responsibility for ensuring complaints relating to a care group are investigated thoroughly.	Executive Chief Nurse	
29. Relationships with Press		Media Policy (PP119)
a) Non-Emergency General Enquiries		
• Within Hours	Associate Director of Communications	
• Outside Hours	Tactical Manager on call	
b) Emergency		
• Within Hours	Chief Executive or Associate Director of Communications	
• Outside Hours	Tactical Manager on Call or Strategic Manager on Call	
30. Infectious Diseases & Notifiable Outbreaks	Tactical Manager on Call or Control of Infection Doctor	
31. Extended Role Activities	Executive Chief Nurse	

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
Approval of Nurses to undertake duties / procedures which can properly be described as beyond the normal scope of Nursing Practice.		Nurse/Midwives/Health Visitors Act Midwives Rules/Code of Practice UKCC Code of Professional Conduct
32. Patient Services Variation of operating and clinic sessions within existing numbers and all proposed changes in bed allocation and use.	Executive Chief Operating Officer	
33. Facilities for staff not employed by the Trust to gain practical experience Professional Recognition & Insurance of Medical Staff, honorary contracts, work experience students	Director of Workforce and Communications	Honorary Contracts (Protocols for Issue) PP107
34. Review of all statutory compliance legislation Health and Safety requirements including control of Substances Hazardous to Health Regulations Employment Law	 Trust Secretary Executive Director of Workforce & Communications	
35.Review of Medicines Inspectorate Regulations	Chief Pharmacist	
36. Review of Trust's compliance with the Data Protection Act	Data Protection Officer	
37. Review the Trust's compliance with the Access to Records Act	Health Records Manager	Health Records Policy (PP136)
38. Review the Trust's compliance with the Confidentiality Code of Practice, NCRS Acceptable Use Policy and Caldicott Principles for information sharing with other Authorities and Third Party Contractors.	Data Protection Officer	Safe haven policy (PP126)
39. The keeping of a Declaration of Interests Register	Trust Secretary	SOs Section 7
40. Attestation of sealings in accordance with Standing Orders	Two Board Directors or a Board Director and the Trust Secretary	SOs Section 8
41. The keeping of the Gifts and Hospitality Register	Trust Secretary	Standards of business conduct (PP)54)

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
42. Ensuring compliance with regulations in respect of the retention of records	Managers and Heads of Department in accordance with referenced policy	Retention, storage and disposal policy (PP192)
43. Clinical Audit	Medical Director and Improvement Committee	
44. Patients Property • Release of patients property where: - Value of deceased patients property <=£5,000 - forms of indemnity required. - Value of deceased patients property >£5,000 production of Probate or Letters of Administration	 Executive Director of Resources or Delegated Officer Executive Director of Resources or Delegated Officer	Patient Property (PP042)

5. Interpretation and definitions

Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in this document shall bear the same meaning as in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012.

References to statutory provisions shall be deemed to include references to any provision amending, re-enacting or replacing them and to such provisions as amended from time to time.

Words importing the masculine gender only shall include the feminine gender; words importing the singular shall import the plural and vice-versa.

- **the 2006 Act** is the National Health Service Act 2006.
- **the 2012 Act** is the Health and Social Care Act 2012.
- **Accountable Officer** means the NHS Officer responsible and accountable for funds entrusted to the Trust. The officer shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.
- **Adviser** means a person formally appointed by resolution of the Council of Governors to advise the Council of Governors at meetings of the Council of Governors in an advisory and non-voting capacity.
- **Annual Members Meeting** is defined in paragraph 9 of the constitution.
- **Audit Committee** means a committee whose functions are concerned with the arrangements for providing the Board with an independent and objective review on its financial and risk systems, financial information and compliance with laws, guidance, and regulations governing the NHS and with the arrangements for the monitoring and improving the quality of healthcare for which the Trust has responsibility.
- **Board of Directors ("the Board")** means the Executive and Non-Executive Directors including the Chairman as constituted in accordance with the Constitution as the Board of Directors.
- **Chair** means the person appointed in accordance with the Constitution to ensure that the Board of Directors and Council of Governors successfully discharge their overall responsibilities for the Trust as a whole. The expression "Chair" shall be deemed to include the Deputy Chair if the Chair is absent or otherwise unavailable.

- **Chief Executive** means the Accountable Officer of the Trust , to ensure that the Trust meets its statutory requirements and service obligations as set out in its Provider License.

- **Committee Members** means in the context of a Committee persons formally appointed by the Council of Governors or Board of Directors to be members of the Committee.

- **Corporate Trustee** means the Trustee of the My Wish Charity. The Directors of West Suffolk NHS Foundation Trust act on behalf of the Corporate Trustee in exercising their duty with regards to the Charity Commission's public benefit guidance when exercising any powers or duties to which this guidance is relevant.

- **Council of Governors** means the elected and appointed Governors of the Trust collectively as a body, as constituted in accordance with the Constitution.

- **Constitution** means this constitution and all annexes to it.

- **Deputy Chair** means the Non Executive Director appointed by the Council of Governors to take on the Chair duties if the Chair is absent for any reason.

- **Director** means a Member of the Board.

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- **Executive Director of Resources** means the Chief Financial Officer of the Trust.

- **Governor** means a person who is a member of the Council of Governors.

- **Licence** , originally issued by Monitor, the Licence sets out a range of conditions that the Trust must meet.

- **Member** means any person registered as a member of the Trust, and authorised to vote in elections to select Governors.

- **Monitor** is the body corporate known as Monitor, as provided by Section 61 of the 2012 Act. Monitor were part of NHS Improvement who were subsequently dissolved to become part of NHS England in June 2022.

- **Motion** means a formal proposition to be discussed and voted on during the course of a meeting.

- **Non Executive Director** means a member of the Board of Directors who is not an Executive Director of the Trust.

- **Officer** means employee of the Trust or any other person holding a paid appointment or office with the Trust.

- **Secretary** means a person who may be appointed to act independently of the Council of Governors to provide advice on corporate governance issues to the Council of Governors, and the Chair and monitor the Trust's compliance with the law, Standing Orders and relevant guidance.

- **SFIs** means Standing Financial Instructions.

- **SOs** mean Standing Orders.

- **Voluntary Organisation** is a body, other than a public or local authority, the activities of which are not carried on for profit.

Author(s):	Richard Jones, Trust Secretary Liana Nicholson, Assistant Director of Finance
Other contributors:	Craig Black, Executive Director of Resources Debbie Stevenson, Head of Procurement Claire Sorenson, Deputy Director of Workforce Jeremy Over, Executive Director of Workforce
Approvals and endorsements:	Audit Committee and Trust Board
Consultation:	
Issue no:	
File name:	
Supercedes:	Reservation and delegation of powers PP(17)222
Equality Assessed	Yes
Implementation	Policy is a standard reference document for Trusts
Monitoring: (give brief details how this will be done)	Policy monitored through financial systems and procedures
Other relevant policies/documents & references:	Standing Financial Instructions Standing Orders
Additional Information:	

West Suffolk NHS
NHS Foundation Trust

Trust Policy and Procedure **Document Ref. No: PP364**

Standing Financial Instructions (SFIs)

For use in:	All areas of the Trust
For use by:	All Trust staff
For use for:	Financial Governance matters
Document owner:	Assistant Director of Finance
Status:	Final

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1. INTRODUCTION

These SFIs are issued in accordance with the Trust (Functions) Directions 2000 issued by the Secretary of State which require that each Trust shall agree SFIs for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. They shall have effect as if incorporated in the SOs.

Save as otherwise permitted by law, at any meeting the Chair of the Trust shall be the final authority on the interpretation of SFIs and SOs (on which they should be advised by the Chief Executive).

1.1 PURPOSE

These SFIs detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They also act to protect individuals against accusations of impropriety, fraud or failure to ensure value for money. They should be used in conjunction with the Schedule of Decisions Reserved to the Board and the Scheme of Delegation adopted by the Trust. Use of the Trust in this context implies the Foundation Trust and the My Wish Charity

1.2 SCOPE

These SFIs identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations including trading units. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Executive Director of Resources, the Deputy Director of Finance or the Assistant Director of Finance.

Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Executive Director of Resources or their nominated representative must be sought before acting. The user of these SFIs should also be familiar with and comply with the provisions of the Trust's SOs.

The failure to comply with SFIs and SOs can in certain circumstances result in potential consequences for the employee, including in some cases, formal action. Where a breach constitutes a criminal offence, the matter may be subject to criminal investigation and will be handled in accordance with the Trust's Anti-Fraud, Financial Irregularities and Anti-Bribery Policy.

Overriding SFIs – If for any reason these SFIs are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these SFIs to the Executive Director of Resources as soon as possible.

This document must be read in conjunction with:

- Standing Orders
- Scheme of Reservation and Delegation
- Financial Procedures
- Procurement Procedural documents

1.3 DEFINITIONS

Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in this Constitution shall bear the same meaning as in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012.

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Council of Governors, and the Chair and monitor the Trust's compliance with the law, Standing Orders and relevant guidance.

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- **SOs** mean Standing Orders.
- **Voluntary Organisation** is a body, other than a public or local authority, the activities of which are not carried on for profit.

Amounts referred to include VAT regardless of whether or not the VAT is reclaimable.

1.4 Responsibilities and delegation

1.4.1 The Trust Board

The Board exercises financial supervision and control by:

(a) formulating the financial strategy;

(b) requiring the submission and approval of budgets within approved allocations/overall income;

(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);

(d) defining specific responsibilities placed on members of the Board and employees as indicated in the Scheme of Reservation and Delegation document.

(e) Approval of monitoring information received by the Board.

The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the '"Scheme of Reservation and Delegation" document. All other powers have been delegated to such other committees as the Trust has established.

1.4.2 The Chief Executive and Executive Director of Resources

The Chief Executive and Executive Director of Resources will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accountable Officer to the Secretary of State, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's

activities; is responsible to the Chair and the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

It is a duty of the Chief Executive to ensure that Members of the Board, employees and all new appointees are notified of these instructions in way they can understand their responsibilities within these Instructions.

1.4.3 **The Executive Director of Resources**

The Executive Director of Resources is responsible for:

(a) implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;

(b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;

and, without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Executive Director of Resources include:

(d) the provision of financial advice to other members of the Board and employees, excluding personal financial advice which prohibited;

(e) the design, implementation and supervision of systems of internal financial control;

(f) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

1.4.4 **Board Members and Employees**

All members of the Board and employees, severally and collectively, are responsible for:

(a) the security of the property of the Trust;

(b) avoiding loss;

(c) exercising economy and efficiency in the use of resources;

(d) conforming with the requirements of SOs, SFIs, Financial Procedures and the Scheme of Delegation.

1.4.5 **Contractors and their employees**

Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

For all members of the Board and any employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board and employees discharge their duties must be to the satisfaction of the Executive Director of Resources.

2. AUDIT

2.1 Audit Committee

2.1.1 In accordance with SOs, the Board shall formally establish an Audit Committee, with clearly defined terms of reference and following relevant guidance which will support the Board in advising on key risks and provide an independent and objective view of internal control. The Committee shall:

(a) monitor and 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;

(b) 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 Trust Board;

(c) 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 the Trust Board;

(d) review the work and findings of the External Auditor, appointed by the Governors, and consider the implications and management's responses to their work;

(e) review the Annual Report and Financial Statements of the Trust before submission to the Board, to determine their completeness, objectivity integrity and accuracy;

(f) review and approve the Annual Report and Financial Statements of the Charitable Funds before submission to the Charity Commission (delegated authority from the Trust Board);

(g) review proposed changes to SOs, SFIs, Scheme of Reservation and Delegation of Powers for approval by the Board. 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; and

(h) review the SOs, SFIs, Scheme of Reservation and Delegation on a two yearly basis for approval by the Board.

2.1.2 Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chair of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to the Department of Health and Social Care (DHSC).

2.1.3 It is the responsibility of the Executive Director of Resources to ensure an adequate Internal Audit service is provided and the Audit Committee shall be involved in the selection process when an Internal Audit service provider is changed.

2.1.4 The Board shall satisfy itself that at least one member of the Audit Committee has recent and relevant financial experience.

2.2 Executive Director of Resources

2.2.1 The Executive Director of Resources is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;

(b) ensuring that the Internal Audit is adequate and meets the NHS Internal Audit Standards;

(c) deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption and in conjunction with the Local Counter Fraud Specialist (LCFS) and NHS Counter Fraud Authority (NHSCFA) in instances of fraud, bribery or corruption;

(d) ensuring that an Internal Audit Annual Report is prepared for the consideration of the Audit Committee. The report must cover:

(i) a clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the Department of Health and Social Care including for example compliance with control criteria and standards;
(ii) major internal financial control weaknesses discovered;
(iii) progress on the implementation of internal audit recommendations;
(iv) progress against plan over the previous year;
(v) strategic audit plan covering the coming three years;
(vi) a detailed plan for the coming year.

2.2.2 The Executive Director of Resources, designated auditors or LCFS are entitled without necessarily giving prior notice to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) access at all reasonable times to any land, premises or members of the Board or employee of the Trust;

(c) the production of any cash, stores or other property of the Trust under a member of the Board and an employee's control; and

(d) explanations concerning any matter under investigation.

2.3 Role of Internal Audit

2.3.1 Internal Audit should fulfil its terms of reference by systematic review and evaluation of risk management, control and governance which comprises the policies, procedures and operations in place to:

(a) establish, and monitor the achievement of, the organisation's objectives;

(b) identify, assess and manage the risks to achieving the organisation's objectives;

(c) ensure the economical, effective and efficient use of resources;

(d) ensure compliance with established policies (including behavioural and ethical expectations), procedures, laws and regulations;

(e) safeguard the organisation's assets and interests from losses of all kinds, including those arising from fraud, irregularity or corruption;

(f) ensure the integrity and reliability of information, accounts and data, including internal and external reporting and accountability processes.

2.3.2 Internal Audit should devote particular attention to any aspects of the risk management, control and governance affected by material changes to the organisation's risk environment.

2.3.3 Internal Audit shall also independently verify the Assurance Statements in accordance with guidance from DHSC.

2.3.4 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Executive Director of Resources must be notified immediately, and the matter referred to the LCFS.

2.3.5 The Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chair and Chief Executive of the Trust.

2.3.6 The Head of Internal Audit shall be accountable to the Executive Director of Resources. The reporting system for Internal Audit shall be agreed between the Executive Director of Resources, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Standards. The reporting system shall be reviewed at least every three years. Where, in exceptional circumstances, the use of

normal reporting channels could be seen as a possible limitation on the objectivity of the audit, the Head of Internal Audit shall have access to report to the Chief Executive, Chair or any non-executive Director of the Trust.

2.3.7 If the Head of Internal Audit or the Audit Committee considers that the level of audit resources or the terms of reference in any way limit the scope of Internal Audit, or prejudice the ability of internal audit to deliver a service consistent with the definition of internal auditing, they should advise the Board accordingly.

2.4 External Audit

2.4.1 The External Auditor is appointed by the Council of Governors and paid for by the Trust. The Audit Committee must ensure a cost-efficient service. If there are any problems relating to the service provided by the External Auditor, then this should be raised with the External Auditor and referred on to the Council of Governors if the issue cannot be resolved.

2.4.2 External audit responsibilities (in compliance with the requirements of the Independent Regulator) are:

a) To be satisfied that the accounts comply with the directions provided, i.e. that the accounts comply with the Annual Reporting Manual issued by NHS England and the Group Accounting Manual issued by DHSC;

b) To be satisfied that the accounts comply with the requirements of all other provisions, contained in, or having effect under, any enactment which is applicable to the accounts;

c) To be satisfied that proper practices have been observed in compiling the accounts;

d) To be satisfied that proper arrangements have been made for securing economy, efficiency and effectiveness in the use of resources;

e) To comply with any directions given by the National Audit Office as to the standards, procedures and techniques to be adopted, i.e. to comply with the Audit Code;

f) to consider the issue of public interest report;

g) to certify the completion of the audit;

h) to express an opinion on the accounts; and

i) to refer the matter to the Independent Regulator if the Trust, or any officer or director of the Trust, makes or are about to make decisions involving potentially unlawful action likely to cause a loss or deficiency.

2.4.3 External Auditors will ensure that there is a minimum of duplication of effort between themselves and other agencies. The auditors will discharge this responsibility by:

a) reviewing the statement made by the Chief Executive in the Annual Governance Statement and making a negative statement within the audit opinion if the Annual Governance Statement is not consistent with their knowledge of the Trust;

b) reviewing the results of the work of relevant assurers, for example the Care Quality Commission and Internal Audit, to determine if the results of the work have an impact on their responsibilities; and

c) Undertaking any other work that they feel necessary to discharge their responsibilities.

2.5 Fraud, Bribery and Corruption

2.5.1 The Trust Chief Executive and Executive Director of Resources have overall responsibility for ensuring that there are sound systems of internal control (e.g. procedures, guidance notes and effective supervision) to minimise the opportunities for fraud, bribery and corruption within the day-to-day business of the Trust and its contractors. This responsibility extends to ensuring that policies and procedures for all work related to fraud and bribery is implemented and the findings from investigations and proactive counter fraud work are acted upon accordingly.

In line with their responsibilities, the Chief Executive and the Executive Director of Resources will monitor and ensure compliance with the NHS Standard Contract and the NHSCFA Standards for Providers.

2.5.2 The Trust shall nominate a suitable person to carry out the duties of the LCFS as specified by NHSCFA guidance;

2.5.3. The LCFS shall report to the Executive Director of Resources and shall work with staff in the NHSCFA in accordance with the NHSCFA Standards.

2.5.4. **Fraud:** any person who dishonestly makes a false representation to make a gain for themselves or another, or who dishonestly fails to disclose to another person, information which he is under a legal duty to disclose or commits fraud by abuse of position including any offence as defined in the Fraud Act 2006.

Bribery: giving or receiving a financial or other advantage in connection with the "improper performance" of a position of trust, or a function that is expected to be performed impartially or in good faith.

Where the organisation is engaged in commercial activity it could be considered guilty of a corporate bribery offence if an employee, agent, subsidiary or any other person acting on its behalf bribes another person, intending to obtain or retain business or an advantage in the conduct of business for the organisation and it cannot demonstrate that it has adequate procedures in place to prevent such.

2.5.5 The LCFS will provide a written report, and attend the Audit Committee to present, at least annually, on counter fraud work within the Trust.

2.5.6 The Trust will complete a Self-Review Tool, inclusive of a summary of the counter fraud, bribery and corruption work conducted over the previous twelve months, for submission to the NHSCFA.

2.5.7 The Executive Director of Resources must prepare a fraud response plan that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it.

2.5.8 All suspected incidents of potential fraud, bribery or corruption should be reported to the Trusts' LCFS, either directly (contact details can be found on the Trusts' intranet pages) or by contacting the National Fraud and Corruption reporting line by telephoning 0800 028 40 60. Your call will be treated in confidence and you can remain anonymous. You may also report your concerns on-line at www.cfa.nhs.uk/reportfraud.

2.6 Security Management

2.6.1 In line with their responsibilities, the Trust Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management.

2.6.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS security management.

2.6.3 The Trust shall nominate a Non-Executive Director to be responsible to the Board for NHS security management, through representation on the Corporate Risk Committee.

2.6.4 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Associate Director of Estates and Facilities .

3. ALLOCATIONS, PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

3.1 Preparation and Approval of Plans and Budgets

3.1.1 The Chief Executive will compile and submit to the Board a Plan which takes into account financial targets and forecast limits of available resources. The Business Plan will contain:

(a) a statement of the significant assumptions on which the plan is based;

(b) details of major changes in workload, delivery of services or resources required to achieve the plan.

3.1.2 Prior to the start of the financial year the Executive Director of Resources will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board. Such budgets will:

(a) be in accordance with the aims and objectives set out in any planning guidance issued from the Department of Health and Social Care and relevant regulatory bodies;

(b) accord with workload and workforce plans;

(c) be produced following discussion with appropriate budget holders;

(d) be prepared within the limits of available funds or be clear about the funding strategies for any planned deficit; and

(e) identify potential risks.

3.1.3 The Executive Director of Resources shall monitor financial performance against budget and plan, periodically review them, and report to the Board.

3.1.4 All budget holders must provide information as required by the Executive Director of Resources to enable budgets to be compiled.

3.1.5 Budget holders at an appropriate level will sign up to their allocated budgets at the commencement of each financial year.

3.1.6 The Executive Director of Resources has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

3.2 Budgetary Delegation

3.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

(a) the amount of the budget;
(b) the purpose(s) of each budget heading;
(c) individual and group responsibilities;
(d) authority to exercise virement;
(e) achievement of planned levels of service;
(f) the provision of regular reports.

3.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board without prior authority.

3.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

3.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Executive Director of Resources.

3.3 Budgetary Control and Reporting

3.3.1 The Executive Director of Resources will devise and maintain systems of budgetary control. These will include:

(a) monthly financial reports to the Board in a form approved by the Board containing:

(i) income and expenditure to date showing trends and forecast year-end position;

(ii) summary balance sheet;

(iii) movements in working capital;

(iv) Movements in cash and capital;

(v) capital project spend and projected outturn against plan;

(vi) explanations of any material variances from plan;

(vii) details of any corrective action where necessary and the Chief Executive's and/or Executive Director of Resources' view of whether such actions are sufficient to correct the situation;

(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

(c) investigation and reporting of variances from financial, workload and workforce budgets;

(d) monitoring of management action to correct variances; and

(e) arrangements for the authorisation of budget transfers.

3.3.2 Each Budget Holder is responsible for ensuring that:

(a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board. Cost containment plans will be prepared and presented to Board within 1 month of the overspend being reported;

(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement;

(c) permanent employees are appointed in line with the SoD.

3.3.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Trust Plan and a balanced budget over time.

3.3.4 All employees of the Trust, especially those involved with the budgetary processes, have a responsibility to the Board for identifying all possible opportunities to make savings or to use resources more effectively. All such opportunities should be brought to the attention of the appropriate Executive Director.

3.3.5 The budgetary process requires adherence to particular timescales for the performance of routines and duties. These timescales change periodically and will be issued by the Finance Department annually. The Executive Director of Resources is responsible for issuing and reviewing guidance on budgetary timetables. It is the responsibility of all Executive Directors to adhere to such timetables and to inform the Executive Director of Resources of any reasons preventing the achievement of a specific deadline.

3.3.6 The Executive Director of Resources reserves the right to have access to all Budget Holders and has the authority to require explanations on performance, spending and income trends within the remit of the Budget Holder.

3.4 Capital Expenditure

3.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in SFI 14).

3.5 Monitoring Returns

3.5.1 The Chief Executive is responsible for ensuring that the returns are submitted to DHSC and regulatory bodies as required.

4. ANNUAL ACCOUNTS AND REPORTS

4.1 The Executive Director of Resources, on behalf of the Trust, will:

(a) prepare financial returns in accordance with the accounting policies and guidance given by relevant regulatory bodies, the Trust's accounting policies, and other relevant accounting requirements;

(b) prepare and submit annual financial reports to the relevant regulatory body certified in accordance with current guidelines;

(c) submit financial returns to the relevant regulatory body for each financial year in accordance with the timetable prescribed.

4.2 The Trust's Annual Accounts must be audited by an Auditor appointed by the Trust's Council of Governors. The Trust's audited Annual Accounts must be presented to a public meeting and made available to the public.

4.3 The Trust will publish an Annual Report, in accordance with guidelines on local accountability, and present it at a public meeting. The document will comply with the relevant guidance and timetable.

5. BANK AND GBS ACCOUNTS

5.1 General

5.1.1 The Executive Director of Resources is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance/ Directions issued from time to time by DHSC. In line with 'Cash Management in the NHS' Trusts should minimise the use of commercial bank accounts and consider using Government Banking Service (GBS) accounts for all banking services.

5.1.2 The Board shall approve the banking arrangements.

5.2 Bank and GBS Accounts

5.2.1 The Executive Director of Resources is responsible for:

(a) bank accounts and Government Banking Service (GBS) accounts;

(b) establishing separate bank accounts for the Trust's charitable funds;

(c) ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made;

(d) reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.

(e) monitoring compliance with guidance from DHSC and the relevant regulatory body on the level of cleared funds.

5.3 Banking Procedures

5.3.1 The Executive Director of Resources will prepare detailed instructions on the operation of bank and GBS accounts which must include:

(a) the conditions under which each bank and GBS account is to be operated;

(b) those authorised to sign cheques or other orders drawn on the Trust's accounts.

5.3.2 The Executive Director of Resources must advise the Trust's bankers in writing of the conditions under which each account will be operated.

5.3.3 No Trust monies or donated funds can be held in any personal bank accounts. Any accounts linked to the Trust; either by name or address should be managed and controlled by Finance, individual accounts held by departments is strictly forbidden and can lead to identified personnel being referred to counter fraud or HR which may in turn result in an investigation and / or dismissal.

5.3.4 The Executive Director of Resources will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's commercial banking business.

6. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

6.1 Income Systems

6.1.1 The Executive Director of Resources is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

6.1.2 The Executive Director of Resources is also responsible for the prompt banking of all monies received.

6.2 Fees and Charges

6.2.1 The Trust shall follow DHSC and other relevant regulatory guidance in setting prices for NHS and non NHS contracts.

6.2.2 The Executive Director of Resources is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by DHSC or by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered, the guidance in DHSC's Commercial Sponsorship – Ethical standards in the NHS shall be followed.

6.2.3 All employees must inform the Executive Director of Resources promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

6.2.4 Invoices for income due to the Trust must be raised in a controlled manner and must only be done so by the Finance Department.

6.3 Debt Recovery

6.3.1 The Executive Director of Resources is responsible for the appropriate recovery action on all outstanding debts.

6.3.2 Income not received should be dealt with in accordance with losses procedures.

6.3.3 Overpayments by the Trust should be detected (or preferably prevented) and recovery initiated.

6.4 Security of Cash, Cheques and other Negotiable Instruments

6.4.1 The Executive Director of Resources is responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

(b) ordering and securely controlling any such stationery;

(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;

(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

6.4.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs.

6.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Executive Director of Resources.

6.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

6.4.5 Any loss or shortfall of cash, cheques or other negotiable instruments, however occasioned, shall be reported immediately in accordance with losses procedures.

6.4.6 All payments made on behalf of the Trust to third parties should normally be made using the Bankers Automated Clearing System (BACS) or by Faster Payments and drawn in accordance with these instructions, except with the agreement of the Executive Director of Resources, as appropriate, who shall be satisfied about security arrangements.

6.4.7 To comply with money laundering legislation, under no circumstances will the Trust accept cash payments in excess of £10,000 in respect of any single transaction. Any attempts by an individual to effect payment above this amount shall be notified immediately to the Executive Director of Resources.

7. TENDERING AND CONTRACTING PROCEDURE

7.1 The procedure for making all contracts by or on behalf of the Trust shall comply with these SOs and SFIs (except where Standing Order No. 3.13 Suspension of SOs is applied).

7.2 EU Directives Governing Public Procurement

Directives by the Council of the European Union (EU) promulgated by the Department of Health and Social Care (DHSC) prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these SOs and SFIs. Following any changes to membership of the EU any replacement regulations will apply in the same way.

7.3 Capital

The Trust shall comply as far as is practicable with the requirements of the DHSC Group Accounting Manual and NHSE Capital Guidance in respect of capital investment and estate and property transactions.

7.4 Formal Competitive Tendering

7.4.1 General Applicability

The Trust shall ensure that competitive quotes/ tenders are invited for:

- the supply of goods, materials and manufactured articles;
- the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DH);

- For the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens);

7.4.2 **Health Care Services**

Where the Trust elects to invite tenders for the supply of healthcare services these SOs and SFIs shall apply as far as they are applicable to the tendering procedure and need to be read in conjunction with SFI No. 8 and No. 9.

7.4.3 **Exceptions and instances where formal tendering need not be applied**

All amounts referred to are inclusive of VAT regardless of whether the VAT is reclaimable or not.

Formal tendering procedures **need not be applied** where:

(a) the estimated expenditure or income for the contract period does not, or is not reasonably expected to, exceed **£100,000**;

(b) where the supply is proposed under special arrangements negotiated by the DHSC in which event the said special arrangements must be complied with;

(c) regarding disposals as set out in SFI No. 16;

Formal tendering procedures **may be waived** in the following circumstances:

(d) in very exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Trust record;

(e) where the requirement is covered by an existing contract;

(f) where National Framework agreements are in place. Use can be approved by the Board in line with the SoD;

(g) where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;

(h) where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender;

(i) where specialist expertise is required and is available from only one source;

(j) when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

(k) there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;

(l) for the provision of legal advice and services providing that any legal firm or partnership commissioned by the Trust is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned.

(m) where the Provider Selection Regime (PSR) allows direct award under route A, B & C

The Executive Director of Resources will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.

The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported to the Financial Accountability Committee quarterly and the Audit Committee annually.

7.4.4 **Fair and Adequate Competition**

Due consideration is required of 7.5.3 above and the exceptions in SFI 17apply. The Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate. In most cases there should be no less than two firms/individuals, having regard to their capacity supply the goods, materials, services or works required, invited to bid for work. It is noted that where computer software and hardware are involved, compatibility issues may reduce choice.

7.5 **Items which subsequently breach thresholds after original approval**

Items estimated to be below the limits set in this SFI for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Executive, and be recorded in an appropriate Trust record. Such cases should be reported to the Audit Committee at the earliest opportunity.

7.6 Contracting/Tendering Procedure

7.6.1 **Invitation to tender**

(i) all invitations to tender shall state the date and time as being the latest time for the receipt of tenders. The invitation to tender shall state that no tender will be considered unless it is received by the date and time stipulated in the invitation to tender.

(ii) all invitations to tender shall state that no tender will be accepted unless:

(a) the prescribed electronic submission process is followed if coordinated by Purchasing; or

(b)

(i) submitted in a plain sealed package or envelope bearing a pre-printed label supplied by the Trust (or the word "tender" followed by the subject to which it relates) and the latest date and time for the receipt of such tender addressed to the Chief Executive or nominated Manager;
(ii) that tender envelopes/ packages shall not bear any names or marks indicating the sender. The use of courier/postal services must not identify the sender on the envelope or on any receipt so required by the deliverer.
(iii) every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.
(iv) every tender for building or engineering works (except for maintenance work, when Estmancode guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract amended to comply with concode; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents shall be modified and/or amplified to accord with DHSC guidance and, in minor respects, to cover special features of individual projects.

7.6.2 **Receipt and safe custody of tenders**

The Chief Executive or their nominated representative will be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening.

The date and time of receipt of each tender shall be endorsed on the tender envelope/package.

7.6.3 **Opening tenders and Register of tenders**

(i) As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be either:

(a) Opened by two senior officers/managers designated by the Chief Executive and not from the originating department.

(b) Unlocked in the e-tendering portal

(ii) A member of the Trust Board will be required to be one of the two approved persons present for the opening of tenders estimated above £100,000. The rules relating to the opening of tenders will need to be read in conjunction with any delegated authority set out in the Trust's SoD.*

(iii) The 'originating' Department will be taken to mean the Department sponsoring or commissioning the tender.

(iv) The involvement of Executive Director of Resources' staff in the preparation of a tender proposal will not preclude the Executive Director of Resources or any approved Senior Manager from the Executive Director of Resources directorate from serving as one of the two senior managers to open tenders.

(v) All Executive Directors/members will be authorised to open tenders regardless of whether they are from the originating department provided that the other authorised person opening the tenders with them is not from the originating department.

The Trust Secretary will count as a Director for the purposes of opening tenders.

(vi) Every tender received shall be marked with the date of opening and initialled by those present at the opening.

(vii) A register shall be maintained by the Chief Executive, or a person authorised by them, to show for each set of competitive tender invitations despatched:

- the name of all firms individuals invited;
- the names of firms individuals from which tenders have been received;
- the date the tenders were opened;
- the persons present at the opening;
- the price shown on each tender;
- a note where price alterations have been made on the tender.

Each entry to this register shall be signed by those present.

A note shall be made in the register if any one tender price has had so many alterations that it cannot be readily read or understood.

(viii) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon their own initiative either orally or in writing after the due

time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders. (SO No. 17.6.5 below).

*Note that point (iii) to (viii) does not apply to tenders made via the e-tendering portal.

7.6.4 **Admissibility**

i) If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.

(ii) Where only one tender is sought and/or received, the Chief Executive and Executive Director of Resources shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

7.6.5 **Late tenders**

(i) Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive or their nominated officer decides that there are exceptional circumstances i.e. despatched in good time but delayed through no fault of the tenderer.

(ii) Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the Chief Executive or their nominated officer or if the process of evaluation and adjudication has not started.

(iii) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Chief Executive or their nominated officer.

7.6.6 **Acceptance of formal tenders (See overlap with SFI No. 7.7)**

(i) Seeking clarification of a Tender whether in writing or by way of a meeting is permitted to clarify technical aspects of the tender. However, the Head of Procurement or Legal advisor must be consulted and a written record of the clarification sought and resolution should be kept.

(ii) The lowest tender shall be accepted based on price or published scoring method for Most Economically Advantageous Method (MEAT), if payment is to be made by the Trust. Or, accepted if the highest payment is to be received by the Trust. Exception: There are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record and held with the tender documentation in accordance with statutory records retention management requirements.

It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

(a) experience and qualifications of team members;

(b) understanding of client's needs;

(c) feasibility and credibility of proposed approach;

(d) ability to complete the project on time.

Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

(iii) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.

(iv) The use of these procedures must demonstrate that the award of the contract was:

(a) not in excess of the going market rate / price current at the time the contract was awarded;

(b) that best value for money was achieved.

(v) All tenders should be treated as confidential and should be retained for inspection in accordance with statutory records retention and management requirements.

7.6.7 **Tender reports to the Trust Board**

Reports to the Trust Board will be made on an exceptional circumstance basis only. However, a Tender report summary, normally generated by a sub-committee, will be brought to Finance Accountability Committee for information.

7.6.8 **List of approved firms for Estates and Facilities**

(a) **Responsibility for maintaining list**

A manager nominated by the Chief Executive shall on behalf of the Trust maintain lists of approved firms for Estates and Facilities from who tenders and quotations may be invited. The approved list shall be kept under frequent review with no company or individual retained for longer than three years without financial or qualitative assessment. The lists shall include all firms who have applied for permission to tender and as to whose technical and financial competence the Trust is satisfied. All suppliers must be made aware of the Trust's terms and conditions of contract.

(b) **Building and Engineering Construction Works**

(i) Invitations to tender shall be made only to firms included on the approved list of tenderers compiled in accordance with this Instruction or on the separate maintenance lists compiled in accordance with Estmancode guidance (Health Notice HN(78)147).

ii) Firms included on the approved list of tenderers shall ensure that when engaging, training, promoting or dismissing employees or in any conditions of employment, shall not discriminate against any person because of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation and will comply with the provisions of the Equality Act 2010, Modern Slavery Act 2015 and any amending and/or related legislation.

iii) Firms shall conform at least with the requirements of the Health and Safety at Work Act and any amending and/or other related legislation concerned with the health, safety and welfare of workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution. Firms must provide to the appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

(c) **Financial Standing and Technical Competence of Contractors**

The Executive Director of Resources may make or institute any enquiries they deem appropriate concerning the financial standing, financial suitability or economic stress of approved contractors through new business or supply chain partners. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical / medical competence.

7.6.9 **Exceptions to using approved contractors**

After consultation with the Associate Director of Estates and Facilities, if in the opinion of the Chief Executive and the Executive Director of Resources or the Director with lead responsibility for clinical governance, it is impractical to use a potential contractor from the list of approved firms/individuals (for example where specialist services or skills are required and there are insufficient suitable potential contractors on the list), or where a list for whatever reason has not been kept up to date, the Chief Executive should ensure that appropriate checks are carried out as to the technical and financial capability of alternatives. This may be through an existing external framework, Constructionline or through open market quotation / tender.

An appropriate record in the contract file should be made of the reasons for inviting a tender or quote other than from an approved list.

7.7 Quotations: Competitive and non-competitive

7.7.1 **General Position on quotations**

Written quotations are required where formal tendering procedures are not adopted where the intended expenditure or income is reasonably expected to exceed £5,000

but not expected to exceed £100,000. For orders below £5,000 2 verbal quotes should be sought and recorded by the authoriser.

7.7.2 **Competitive Quotations**

(i) Quotations should be obtained from at least 2 firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Trust for contracts up to £10,000. 3 formal quotes should be obtained for contracts in excess of £10,000 but less than £100,000.

(ii) Quotations should be in writing for all orders over £5,000 unless the Chief Executive or their nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

(iii) All quotations over £5,000 should be treated as confidential and should be retained for inspection.

(iv) The Chief Executive or their nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation if payment is to be made by the Trust, or the highest if payment is to be received by the Trust, then the choice made and the reasons why should be recorded in a permanent record.

7.7.3 **Non-Competitive Quotations**

Non-competitive quotations in writing may be obtained in the following circumstances:

(i) the supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion of the responsible officer, possible or desirable to obtain competitive quotations;

(ii) the supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts;

(iii) miscellaneous services, supplies and disposals;

(iv) where the goods or services are for building and engineering maintenance the responsible works manager must certify that the first two conditions of this SFI (i.e.: (i) and (ii) of this SFI) apply.

7.7.4 **Quotations to be within Financial Limits**

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Chief Executive or Executive Director of Resources.

7.8 Authorisation of Tenders and Competitive Quotations

Providing all the conditions and circumstances set out in these SFIs have been fully complied with, formal authorisation and awarding of a contract may be decided by the following staff to the value of the contract as follows:

Designated budget holders	up to	£10,000
Associate Director of Operations	up to	£50,000
Executive Director	up to	£100,000
Chief Executive and Executive Director of Resources	up to	£500,000
Trust Executive Group	Up to	£2m
Trust Board	over	£2m
Cabinet Office	over	£10m

These levels of authorisation may be varied or changed and need to be read in conjunction with the Trust Board's SoD.

In accordance with the Quotation procedures tenders are not required under £100,000.

At the time of approval the Trust Board may delegate the responsibility for signing of orders / requisitions to the Chief Executive and the Executive Director of Resources.

Formal authorisation must be put in writing. In the case of authorisation by the Trust Board this shall be recorded in their minutes.

7.9 Instances where formal competitive tendering or competitive quotation is not required

Where competitive tendering or a competitive quotation is not required the Trust should adopt one of the following alternatives:

(a) the Trust shall use NHS Supply Chain for procurement of all goods and services unless the Chief Executive or nominated officers deem it inappropriate. The decision to use alternative sources must be documented.

(b) If the Trust does not use NHS Supply Chain - where tenders or quotations are not required, because expenditure is below £10,000, the Trust shall procure goods and services in accordance with procurement procedures approved by the Executive Director of Resources.

7.10 Private Finance for capital procurement (see overlap with SFI No. 24)

The Trust must assess the most competitive funding source for capital projects. This may include borrowing from DHSC (or delegated departments), borrowing commercially or PFI/ PPP schemes. The selection of the most competitive funding sources will be from a combination of business case shortlisting and competitive tendering. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and for PFI/ PPP genuinely transfers risk to the private sector.

(b) Where the sum exceeds delegated limits, a business case must be referred to NHS England and DHSC for approval or treated as per current guidelines.

(c) The proposal must be specifically agreed by the Board of the Trust.

(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

7.11 Compliance requirements for all contracts

The Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

(a) The Trust's Standing Orders and Standing Financial Instructions;

(b) EU Directives and other statutory provisions including any replacement regulations after leaving the EU (Note: From 1st July 2022 it is intended that the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013 will be revoked and patient choice provisions in the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 will be amended, and new guidance will be issued as part of the ongoing implementation of the Health and Care Act 2022);

(c) any relevant directions including Health Building Note 00-08 Strategic Framework for the Efficient Management of Healthcare Estates and Facilities and guidance on the Procurement and Management of Consultants;

(d) NHS Standard Contract Conditions or NHS Supply of Goods & Services Contacts, Service Level agreements or other structured agreements as are required to deliver services;

(e) contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance;

(f) Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited; and

(g) In all contracts made by the Trust, the Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

7.12 Personnel and Agency or Temporary Staff Contracts

The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

7.13 Health and care Services Agreements

Service agreements with NHS providers for the supply of healthcare services shall be drawn up in accordance with the NHS and Community Care Act 1990 and administered by the Trust. Service agreements are not contracts in law and therefore not enforceable by the courts. However, a contract with a Foundation Trust, being a Public Body Corporate (PBC), is a legal document and is enforceable in law.

7.14 Disposals (See overlap with SFI No. 26)

Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or their nominated officer;

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;

(c) items to be disposed of with an estimated sale value of less than £5,000, this figure to be reviewed on a periodic basis;

(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

(e) land or buildings concerning which DHSC or NHS England guidance has been issued but subject to compliance with such guidance, or One Public Estate requirements.

7.15 In-house Services

7.15.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

7.15.2 In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) stakeholder group, comprising the Chief Executive or nominated officer/s and specialist;

(b) in-house tender group, comprising a nominee of the Chief Executive and technical support; and

(c) evaluation team, comprising normally of a sector or Market Specialist, a procurement Specialist and a representative of the Executive Director of Resources. For services having a likely annual expenditure exceeding £250,000, a non-Executive Director should be a member of the evaluation team. Additional Consultancy support can also be sought from external organisations.

7.15.3 All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

7.15.4 The evaluation team shall make recommendations to the Board.

7.15.5 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

7.16 Applicability of SFIs on Tendering and Contracting to funds held in trust

These Instructions also apply to works, services and goods purchased from the Trust's charitable funds and private resources.

8. NHS SERVICE AGREEMENTS FOR PROVISION OF SERVICES (see overlap with SFI No. 7.13)

8.1 Service Level Agreements (SLAs)

8.1.1 The Chief Executive, as the Accountable Officer, is responsible for ensuring the Trust enters into suitable Service Level Agreements (SLA) with service commissioners for the provision of NHS services.

All SLAs should aim to implement the agreed priorities contained within any planning guidance and priorities issued by DHSC and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

- the standards of service quality expected;
- the provision of reliable information on cost and volume of services;
- the NHS Outcomes Framework;
- that SLAs build where appropriate on existing Joint Investment Plans;
- that SLAs are based on integrated care pathways;
- the priorities and operational planning guidance for the ICB.

8.2 Involving Partners and jointly managing risk

A good SLA will result from a dialogue of clinicians, users, carers, public health professionals, wider Trust management, other public sector partners in the ICB and the voluntary sector. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The SLA will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way the Trust can jointly manage risk with

all interested parties.

8.3 Reports to Board on SLAs

The Chief Executive, as the Accountable Officer, will need to ensure that regular reports are provided to the Board detailing actual and forecast income from the SLA, including information on costing arrangements.

9. COMMISSIONING

Not applicable to NHS Foundation Trusts.

10. TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF DIRECTORS, EMPLOYEES, VOLUNTEERS, OFF-PAYROLL WORKERS AND OFFICERS

10.1 Remuneration and Terms of Service (see overlap with SO No. 4)

10.1.1 In accordance with SOs the Board shall establish a Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

10.1.2 The Board's Remuneration and Nominations Committee will decide on appropriate remuneration and terms of service of the Chief Executive and other Executive Directors (and other very senior Officers) including:

(i) all aspects of salary (including any performance-related elements/bonuses);

(ii) provisions for other benefits, including pensions and cars;

(iii) arrangements for termination of employment and other contractual terms and will advise the Board of Directors of any decisions made;

10.1.3 Regular reviews of the remuneration and terms of service of the Chief Executive and other Executive Directors (and other senior Officers) will be carried out to ensure they are fairly rewarded for their individual contribution to the Trust – having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements where appropriate. To decide the appropriate remuneration of the Chief Executive and other Executive Directors and advise the Board of Directors of any decisions made. Any decisions made by the Remuneration Committee shall be recorded in the minutes of the meetings.

10.1.4 The Remuneration Committee shall monitor and evaluate the performance of individual Executive Directors (and other senior Officers).

10.1.5 The Committee shall also advise on and oversee appropriate contractual arrangements for all Directors and Officers, including the proper calculation and

scrutiny of termination payments taking account of such national guidance as is appropriate (including approval required for special payments).

10.1.6 The Board of Directors will after due consideration and amendment if appropriate approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those Officers and Officers not covered by the Committee.

10.1.7 The Trust will pay allowances to the Chair and other Non- Executive Directors in accordance with the decision of the Council of Governors in accordance with the Constitution.

10.2 Funded Establishment

10.2.1 The Workforce plans incorporated within the annual budget will form the funded establishment.

10.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive, those with the delegated authority or as determined by the workforce plan taking into account management of changes and business cases.

10.3 Staff Appointments

10.3.1 No officer or Member of the Trust Board or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

(a) unless authorised to do so by the Chief Executive or those with the delegated authority;

(b) it is within the limit of their approved budget and funded establishment; and

(c) it is in accordance with any local or Trust-wide controls placed on recruitment to vacant positions.

10.3.2 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service etc. for employees.

10.3.3 A manager may only action such a change against those cost centres/budgets for which they have formal responsibility.

10.4 Processing Payroll

10.4.1 The Executive Director of Resources is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;

(b) the final determination of pay and allowances;

(c) making payment on agreed dates;

(d) agreeing method of payment; and

(e) performance managing the outsourced payroll provision to ensure it is in line with the contract and service continuity is maintained and where necessary reporting any variations to the contract or significant areas of risk in relation to the service to the Board.

10.4.2 The Executive Director of Resources will issue instructions regarding:

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the Data Protection Act;

(g) methods of payment available to various categories of employee and officers;

(h) procedures for payment by cheque, bank credit, or cash to employees and officers;

(I) procedures for the recall of cheques and bank credits;

(j) pay advances and their recovery;

(k) maintenance of regular and independent reconciliation of pay control accounts;

(l) separation of duties of preparing records and handling cash;

(m) a system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust.

10.4.3 Appropriately nominated managers have delegated responsibility for:

(a) submitting time records, and other notifications in accordance with agreed timetables;

(b) completing time records and other notifications in accordance with the Executive Director of Resources's instructions and in the form prescribed by the Executive Director of Resources;

(c) submitting termination forms via HR in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Executive

Director of Resources and Executive Director of Workforce must be informed immediately.

10.4.4 Regardless of the arrangements for providing the payroll service, the Executive Director of Resources shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

10.5 Contracts of Employment

10.5.1 The Board shall delegate responsibility to an officer for:

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation;

(b) dealing with variations to, or termination of, contracts of employment.

10.6 Consultant staff appointments

10.6.1 Additional Consultant Staff can only be appointed on the basis of a clearly defined and approved Business Case. Additional consultant recommendations must show that that they are in line with Divisional Business Plans and Strategic direction of the Trust.

10.6.2 Replacement Consultant (medical) staff should be appointed after review by the Chief Operating Officer, Medical Director and Director of Nursing to ensure that such replacements are in line with Divisional Business Plans and existing service requirements.

11. NON-PAY EXPENDITURE

11.1 Delegation of Authority

11.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

11.1.2 The Chief Executive will set out:

(a) the list of managers who are authorised to place requisitions for the supply of goods and services; and

(b) the maximum level of each requisition and the system for authorisation above that level.

11.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

11.2 Requisitioning, Ordering, Receipt and Payment for Goods and Services (see overlap with Standing Financial Instruction No. 17)

11.2.1 **Requisitioning**

The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's Procurement Team shall be sought. Where this advice is not acceptable to the requisitioner, the Executive Director of Resources (and/or the Chief Executive) shall be consulted.

11.2.2 **Under no circumstances should a requisition be split in such a way to circumvent particular spending limits attached as per the Scheme of Delegation.**

11.2.2 System of Payment and Payment Verification

The Executive Director of Resources shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance. Methods of payment can include use of commercial bank accounts, Government banking Services accounts, Government Procurement cards and Trust authorised credit cards.

11.2.3 The Executive Director of Resources will:

(a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in Standing Orders and Standing Financial Instructions and regularly reviewed;

(b) prepare procedural instructions or guidance within the Scheme of Delegation on the obtaining of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) A list of Board employees (including specimens of their signatures) authorised to certify invoices.

(ii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;

- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;

- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have

been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;

- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;

- the account is arithmetically correct; and

- the account is in order for payment.

(iii) A timetable and system for submission to the Executive Director of Resources of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received. The only exceptions are where it is normal industry practice to pay in advance such as travel tickets, hotel bookings, course bookings and maintenance contracts.

(f) Be responsible for ensuring payments to suppliers are supported by an order that has been receipted unless the service supplied has been approved as an exception.

11.2.4 **Prepayments**

In accordance with HM Treasury guidance, prepayments are a risk and only permitted where the industry norm requires payment in advance such that it is impossible to negotiate alternative terms e.g. software licences and maintenance contracts. The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

11.2.5 Official orders

Official purchase orders must be raised in advance of any commitment of expenditure on the Trust procurement system and:

(a) be consecutively numbered;

(b) be in a form approved by the Executive Director of Resources;

(c) state the Trust's terms and conditions of trade;

(d) only be issued to, and used by, those duly authorised by the Chief Executive.

11.2.6 **Duties of Managers and Officers**

Managers and officers must ensure that they comply fully with the guidance and limits specified by the Executive Director of Resources and that:

(a) all contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Executive Director of Resources in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement or relevant legislation after leaving the EU;

(c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by DHSC;

(d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

(ii) conventional hospitality, such as lunches in the course of working visits;

(This provision needs to be read in conjunction with Standing Order No. 6, the principles outlined in the national guidance contained in HSG 93(5) "Standards of Business Conduct for NHS Staff" and the principles set out in the Bribery Act 2010);

(e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Executive Director of Resources on behalf of the Chief Executive;

(f) all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash;

(g) verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity [(1).] These must be confirmed by an official order and clearly marked "Confirmation Order" as soon as practicably possible but not more than 60 days;

(h) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(i) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(j) changes to the list of employees and officers authorised to certify invoices are notified to the Executive Director of Resources;

(k) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Executive Director of Resources; and

(l) petty cash records are maintained in a form as determined by the Executive Director of Resources.

(m) All goods, services or works received are promptly checked and receipted to ensure prompt payment of invoices.

(1) Any procurement or work contracted in response to an event that is classified as a Major Incident will be deemed to be compliant if it is line with the powers of the Emergency Planning Officer or business continuity responsible officer.

11.2.7 The Chief Executive and Executive Director of Resources shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with best practice guidance and Health Building Note 00-08 Strategic Framework for the Efficient Management of Healthcare Estates and Facilities. The technical audit of these contracts shall be the responsibility of the relevant Director.

11.3 Joint Finance Arrangements with Local Authorities and Voluntary Bodies (see overlap with Standing Order No. 9.1)

11.3.1 Payments to local authorities and voluntary organisations must comply with the powers of section 28A of the NHS Act 1977 as Amended whereby there are conditions on any payments made under section 76 and 256/257 of the NHS Act 2006. (See overlap with Standing Order No. 9.1)

12. FINANCING

12.1 External Borrowing

12.1.1 The Executive Director of Resources will advise the Board concerning the Trust's ability to pay dividend on, and repay Public Dividend Capital and any proposed new borrowing, within the limits set by DHSC. The Executive Director of Resources is also responsible for reporting periodically to the Board concerning the PDC debt and all loans and overdrafts.

12.1.2 The Board will agree the list of employees (including specimens of their signatures) who are authorised to make short term borrowings on behalf of the Trust. This must include the Chief Executive and the Executive Director of Resources.

12.1.3 The Executive Director of Resources must prepare detailed procedural instructions concerning applications for loans and overdrafts, which are in line with guidance issued by NHS England and DHSC.

12.1.4 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position, represent good value for money, and comply with the latest guidance from DHSC.

12.1.5 Any short-term borrowing must be with the authority of two members of an authorised panel, one of which must be the Chief Executive or the Executive Director of Resources. The Board must be made aware of all short term borrowings at the next Board meeting.

12.1.6 All long-term borrowing must be consistent with the plans outlined in the current Business Plan and be approved by the Trust Board.

12.2 Investments

12.2.1 Temporary cash surpluses must be held only in such public or private sector investments as notified by the Secretary of State and authorised by the Board.

12.2.2 The Executive Director of Resources is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

12.2.3 The Executive Director of Resources will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

12.3 Leases and right of use assets

12.3.1 The Executive Director of Resources, or their Deputy, must be consulted on any lease arrangement (including managed service arrangements) that the Trust is considering entering in to. A full options appraisal must be completed on whether a lease arrangement is appropriate, the best value for money and that funding options allow.

12.3.2 Only the Executive Director of Resources or their Deputy has the authority to authorise a lease in the Trust's name.

13. FINANCIAL FRAMEWORK

13. 1 The Executive Director of Resources should ensure that members of the Board are aware of the Financial Framework. This document contains directions which the Trust must follow. It also contains directions to NHS England regarding resource and capital allocation and funding to Trust's. The Executive Director of Resources should also ensure that the direction and guidance in the framework is followed by the Trust.

14. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

14.1 Capital Investment

14.1.1 The Chief Executive:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

(c) shall ensure that the capital investment is not undertaken without confirmation of purchaser(s), support and the availability of resources to finance all revenue consequences, including capital charges. Any resource required outside of agreed budgets will be taken through the required authorisation process.

(d) That the Capital Plan is produced on an annual basis and is submitted and approved by the Board prior to the start of the financial year.

14.1.2 For every capital expenditure proposal the Chief Executive shall ensure:

(a) that a statement of need is produced setting out:

(i) an option appraisal of potential benefits for all capital purchases (including proposals to lease, hire or rent asses) and their impact on the Trust's ability to achieve its financial targets;

(ii) the involvement of appropriate Trust personnel and external agencies (e.g. legal advice);

(ii) appropriate project management and control arrangements;

(b) that the Executive Director of Resources has certified professionally to the costs and revenue consequences detailed in the business case.

14.1.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of "Health Building Note 00-08 Strategic Framework for the Efficient Management of Healthcare Estates and Facilities" as well as Trust SOs and SFIs and in accordance with relevant HM Treasury and DHSC guidance.

14.1.4 The Executive Director of Resources shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

14.1.5 The approval of a capital programme shall not constitute approval for expenditure on any scheme.

The Chief Executive shall issue to the manager responsible for any scheme:

(a) specific authority to commit expenditure;

(b) authority to proceed to tender (see overlap with SFI No. 17.6);

(c) approval to accept a successful tender (see overlap with SFI No. 17.6).

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with best practice guidance and the Trust's Standing Orders. Contracts will be constructed using an accepted format such as Joint Contracts Tribunal (JCT) and legal advice will be sought where appropriate.

14.1.6 The Executive Director of Resources shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account the delegated limits for capital schemes set by NHS England and DHSC.

14.2 Asset Registers

14.2.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Executive Director of Resources concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted periodically.

14.2.2 The Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers is determined by International Accounting Standard (IAS) 16 which requires each asset component to be treated separately for depreciation purposes.

14.2.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architect's certificates, supplier invoices and other documentary evidence in respect of purchases from third parties;

(b) stores, requisitions and wages records for own materials and labour including appropriate overheads;

(c) contract agreements in respect of assets held under a lease or managed service arrangement.

14.2.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

14.2.5 The Executive Director of Resources shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

14.2.6 The value of each class of asset will be determined by the Executive Director of Resources with reference to IAS 16 which states that revaluations should be carried out with sufficient regularity that the carrying amount does not differ materially from that which would be determined using fair value at the balance sheet date.

14.2.7 The value of each asset shall be depreciated as determined by the Chief Financial Officer to comply with the requirements of IAS 16.

14.2.8 The Executive Director of Resources of the Trust shall calculate and pay capital charges (depreciation and public dividend capital (PDC)) as specified by the Group Accounting Manual, issued by DHSC.

14.3 Security of Assets

14.3.1 The overall control of fixed assets is the responsibility of the Chief Executive.

14.3.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Executive Director of Resources. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

(e) periodic verification of the existence of, condition of, and title to, assets recorded;

(f) identification and reporting of all costs associated with the retention of an asset;

(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

14.3.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Executive Director of Resources.

14.3.4 Whilst each employee and officer has a responsibility for the security of property of the Trust, it is the responsibility of Board members and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

14.3.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and employees in accordance with the procedure for reporting losses.

14.3.6 Where practical, assets should be marked as Trust property.

15. STORES AND RECEIPT OF GOODS

15.1 General position

15.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;

(b) subjected to annual stock take;

(c) valued at the lower of cost and net realisable value.

15.2 Control of Stores, Stocktaking, condemnations and disposal

15.2.1 Subject to the responsibility of the Executive Director of Resources for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by him to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Executive Director of Resources. The control of any pharmaceutical stocks shall be the responsibility of a designated Pharmacy Manager; the control of any fuel oil and coal of a designated Estates Manager.

15.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager. Wherever practicable, stocks should be marked as health service property.

15.2.3 The Executive Director of Resources shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

15.2.4 Stocktaking arrangements shall be agreed with the Executive Director of Resources and there shall be a physical check covering all items in store at least once a year.

15.2.5 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Executive Director of Resources.

15.2.6 The designated manager shall be responsible for a system approved by the Executive Director of Resources for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated manager shall report to the Executive Director of Resources any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI No. 16 Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

15.3 Goods supplied by NHS Supply Chain

15.3.1 For goods supplied via the NHS Supply Chain central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note and retain evidence for 2 years before accepting the charge.

16. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

16.1 Disposals and Condemnations

16.1.1 **Procedures**

The Executive Director of Resources must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

16.1.2 When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will determine and advise the Executive Director of Resources of the estimated market value of the item, taking account of professional advice where appropriate.

16.1.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Executive Director of Resources;

(b) recorded by the Condemning Officer in a form approved by the Executive Director of Resources which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Executive Director of Resources.

16.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Executive Director of Resources who will take the appropriate action.

16.2 Losses and Special Payments

16.2.1 **Procedures**

The Executive Director of Resources must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

16.2.2 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Executive Director of Resources or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Executive Director of Resources and/or Chief Executive. Where a criminal offence is suspected, the Executive Director of Resources must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Executive Director of Resources must inform the LCFS in accordance with NHSCFA Standards for Providers.

All fraud investigations will be reported to the NHSCFA, the External Auditor and the Audit Committee.

16.2.3 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Executive Director of Resources must immediately notify:

(a) the Board,

(b) the External Auditor.

16.2.4 Within limits delegated to it by DHSC, the Board shall approve the writing-off of losses.

16.2.5 The Executive Director of Resources shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

16.2.6 For any loss, the Executive Director of Resources should consider whether any insurance claim can be made.

15.2.7 The Executive Director of Resources shall maintain a Losses and Special Payments Register in which write-off action is recorded.

16.2.8 No special payments exceeding delegated limits shall be made without the prior approval of DHSC.

16.2.9 All losses and special payments must be reported to the Financial Accountability Committee quarterly and to the Audit Committee annually.

17. INFORMATION TECHNOLOGY – FINANCIAL DATA

17.1 Responsibilities and duties of the Executive Director of Resources

17.1.1 The Executive Director of Resources, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which the Director is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 2018;

(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Director may consider necessary are being carried out.

17.1.2 The Executive Director of Resources shall need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

17.1.3 The Executive Director of Resources shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about our Trust that we make publicly available.

17.2 Responsibilities and duties of other Directors and Officers in relation to computer systems of a general application

17.2.1 In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of Trust's in the Region wish to sponsor jointly) all responsible directors and employees will send to the Executive Director of Resources:

(a) details of the outline design of the system;

(b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

17.3 Contracts for Computer Services with other health bodies or outside agencies

The Executive Director of Resources shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

Where another health organisation or any other agency provides a computer service for financial applications, the Executive Director of Resources shall periodically seek assurances that adequate controls are in operation.

17.4 Risk Assessment

The Executive Director of Resources shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

17.5 Requirements for Computer Systems which have an impact on corporate financial systems

Where computer systems have an impact on corporate financial systems the Executive Director of Resources shall need to be satisfied that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) Executive Director of Resources staff have access to such data;

(d) such computer audit reviews as are considered necessary are being carried out.

18. PATIENTS' PROPERTY

18.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

18.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets; ***(notices are subject to sensitivity guidance)***
- hospital admission documentation and property records;
- the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

18.3 The Executive Director of Resources must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

18.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

18.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

18.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

19. FUNDS HELD ON TRUST

19.1 Corporate Trustee

(1) Standing Order No. 2.8 outlines the Trust's responsibilities as a corporate trustee for the management of funds it holds on trust, along with SFI 4.9.3 that defines the need for compliance with Charities Commission latest guidance and best practice.

(2) The discharge of the Trust's corporate trustee responsibilities are distinct from its responsibilities for trust funds and may not necessarily be discharged in the same

manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

The Executive Director of Resources shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

19.2 Accountability to Charity Commission and Secretary of State for Health

(1) The trustee responsibilities must be discharged separately and full recognition given to the Trust's dual accountabilities to the Charity Commission for charitable funds held on trust and to the Secretary of State for all funds held on trust.

(2) The Scheme of Reservation and Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Trust Board members and Trust officers must take account of that guidance before taking action.

19.3 Applicability of Standing Financial Instructions to funds held on Trust

(1) In so far as it is possible to do so, most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust. (See overlap with SFI No 17.16).

(2) The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately for trust funds.

20. ACCEPTANCE OF GIFTS BY STAFF AND LINK TO STANDARDS OF BUSINESS CONDUCT (see overlap with SO No. 6 and SFI No. 21.2.6 (d))

The Executive Director of Resources shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff. The Standards of Business Conduct policy follows the guidance contained in the NHS England 'Managing Conflicts of Interest in the NHS, June 2017. This is also deemed to be an integral part of these SOs and SFIs (see overlap with SO No. 6).

21. PAYMENTS TO INDEPENDENT CONTRACTORS

Not applicable to NHS Foundation Trusts.

22. RETENTION OF RECORDS

22.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with NHS England and DHSC.

22.2 The records held in archives shall be capable of retrieval by authorised persons.

22.3 Records held in accordance with latest NHS England and DHSC guidance shall only be destroyed at the express instigation of the Chief Executive. Detail shall be maintained of records so destroyed.

23. RISK MANAGEMENT AND INSURANCE

23.1 Programme of Risk Management

The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with current NHS England DHSC assurance framework requirements, which must be approved and monitored by the Board.

The programme of risk management shall include:

a) a process for identifying and quantifying risks and potential liabilities;

b) engendering among all levels of staff a positive attitude towards the control of risk;

c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

d) contingency plans to offset the impact of adverse events;

e) audit arrangements including; Internal Audit, clinical audit, health and safety review;

f) a clear indication of which risks shall be insured;

g) arrangements to review the Risk Management programme.

The existence, integration and evaluation of the above elements will assist in providing a basis to make the Annual Governance Statement- within the Annual Report and Accounts as required by the current DHSC guidance.

23.2 Insurance: Risk Pooling Schemes administered by NHS Resolution (NHSR)

The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHSR self-insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

23.3 Insurance arrangements with commercial insurers

23.3.1 The Board must assess the overall adequacy of insurance in place and where risks are not covered by NHSR commercial insurance must be considered and reviewed annually.

23.4 Arrangements to be followed by the Board in agreeing Insurance cover

(1) Where the Board decides to use the risk pooling schemes administered by the NHSR the Executive Director of Resources shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Executive Director of Resources shall ensure that documented procedures cover these arrangements.

(2) Where the Board decides not to use the risk pooling schemes administered by NHSR for one or other of the risks covered by the schemes, the Executive Director of Resources shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Executive Director of Resources will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

(3) All the risk pooling schemes require scheme members to make some contribution to the settlement of claims (the 'deductible'). The Executive Director of Resources should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

Author(s):	Richard Jones, Trust Secretary and Head of Governance Liana Nicholson, Assistant Director of Finance
Other contributors:	
Approvals and endorsements:	Audit Committee and Trust Board
Consultation:	
Issue no:	
File name:	
Supercedes:	Standing orders, reservation and delegation of powers and standing financial instructions PP(17)346
Equality Assessed	Yes
Implementation	Policy is a standard reference document for Trusts
Monitoring: (give brief details how this will be done)	Policy monitored through financial systems and procedures
Other relevant policies/documents & references:	Scheme of Delegation Standing Orders
Additional Information:	

5.2 Governance report

- Well led review executive summary

Council of Governors – 9 May 2024	
Report title:	**Well led review report**
Agenda item:	Annex linked to agenda item 6
Date of the meeting:	9 May 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

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 review process included documentary assessment; 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.

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

The draft report was issued in April for factual accuracy checking and discussed at the Board workshop on 26 April 2024. Below is extracted from the session delivered by consultOne:

Top well-led strengths highlighted by consultOne:

1. Culture, culture, culture
2. FIRST values and organisational strategy
3. Staff wellbeing
4. Patient / carer engagement activities
5. Governance structure and processes
6. Local (West Suffolk) partner working and integration

Top well-led areas of focus highlighted by consultOne:

1. Ambition, drive and focus
2. Strategy – BAU – Strategy – clear line of sight
3. Wider system partnering and collaboration
4. Clinical leadership

5. Accountability
6. Use of information - data led, evidence based, insightful reporting leading to informed decisions
7. Risk management focus and profile

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

A summary of findings and recommendations from the consultOne review is appended to this report.

An improvement plan to address the findings of the report will be prepared which will be structured around the recent CQC guidance[1] which describes how they will assess the well led question and what good looks like.

[1] Guidance for NHS trusts and foundation trusts: assessing the well-led key question - Care Quality Commission (cqc.org.uk)

Action Required

The Council is asked to note the report and to be kept in formed of the Trust's response.