NHS
West Suffolk
NHS Foundation Trust

# Board of Directors (In Public)

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| **Schedule** | Friday 26 January 2024, 9:15 AM — 1:30 PM GMT |
| **Venue** | Rooms 19a&B, Education Centre, WSFT |
| **Description** | A meeting of the Board of Directors will take place on Friday 26 January, 2024 at 9:15am. |
| **Organiser** | Joanne Sanger |

## Agenda

AGENDA

_WSFT Public Board Agenda - 26 Jan 2024.docx

1. GENERAL BUSINESS

9:15 AM — 1.1. Apologies for absence - Jeremy Over (Carol Steed deputising)
To Note - Presented by Jude Chin

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

1.3. Minutes of the previous meeting - 1 December, 2023
To Approve - Presented by Jude Chin

Item 1.3 - WSFT Minutes Open Board 1 December 2023 draft minutes final.docx

1.4. Action log and matters arising
To Review

Item 1.4 - Action Points - Open.pdf

Item 1.4 - Action Points - Closed.pdf

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

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| 9:35 AM | 1.6. | Patient and Staff Story<br>To Review - Presented by Susan Wilkinson |
| 10:10 AM | 1.7. | Chief Executive's report<br>To inform - Presented by Ewen Cameron<br>Item 1.7 - CEO Board report January 2024 v2docx.docx |
| | 2. | STRATEGY |
| 10:20 AM | 2.1. | Strategic Priorities update report<br>To Approve - Presented by Ewen Cameron<br>Item 2.1 - Strategic priority progress report Jan '24.docx<br>Item 2.1 Annex B Strategic priorities 2024-25.pptx |
| 10:35 AM | 2.2. | Future System board report<br>To Assure - Presented by Craig Black<br>Item 2.2 - Future system board report.docx |
| 10:45 AM | 2.3. | West Suffolk Alliance and SNEE Integrated Care Board<br>To Assure - Presented by Peter Wightman<br>Item 2.3 - WSA Update report 10 January 2024 v01.doc |
| | 3. | PEOPLE AND CULTURE |
| 11:00 AM | 3.1. | Involvement Committee report - Chair's Key Issues from the meeting<br>To Assure - Presented by Krishna Yergol<br>Item 3.1 - Involvement Committee report.doc |
| 11:15 AM | 3.2. | Freedom to Speak Up Report<br>Jane Sharland, FTSU Guardian in attendance<br>To inform - Presented by Carol Steed<br>Item 3.2 - Freedom to Speak Up Report.doc |

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| 11:30 AM | COMFORT BREAK | |
| | 4. ASSURANCE | |
| 11:50 AM | 4.1. Insight Committee Report - Chair's Key Issues from the meeting<br>To Assure<br>Item 4.1 - Insight committee report.docx | |
| | 4.2. Finance Report<br>To Assure - Presented by Craig Black<br>Item 4.2 - Finance Cover - Public Board January 2024.docx<br>Item 4.2 - Finance Report December 2023 FINAL.docx | |
| 12:30 PM | 4.3. Improvement Committee Report - Chair's Key Issues from the meeting<br>To Assure - Presented by Louisa Pepper<br>Item 4.3 - Improvement Committee report.pdf<br>Item 4.3 - Improvement Commitee report CKIs Dec 2023.docx | |
| | 4.4. Quality and Nurse Staffing Report<br>To Assure - Presented by Susan Wilkinson<br>Item 4.4 - Quality and nurse staffing report.docx | |
| | 4.4.1. Maternity Services<br>Karen Newbury, Kate Croissant & Simon Taylor in attendance<br>To Approve - Presented by Susan Wilkinson<br>Item 4.4.1 - Annex A - January 2024 Maternity qualtiy safety and performance Board report.docx | |
| 1:00 PM | 4.5. Audit committee report<br>To Assure - Presented by Michael Parsons<br>Item 4.5 - Audit committee report.docx | |
| | 5. GOVERNANCE | |

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| 1:10 PM | 5.1. Governance report<br>To Assure - Presented by Richard Jones<br>Item 5.1 Governance report.docx<br>Item 5.1 Annex A Management executive TOR Jan 2024.doc<br>Item 5.1 Annex B NEDs responsibilities Jan 2024.doc<br>Item 5.1 Annex C Draft Board meeting agenda.docx |
| 1:15 PM | 5.2. Board Assurance Framework<br>To Approve - Presented by Richard Jones<br>Item 5.2 BAF report Jan 24-Board.docx |
| 1:25 PM | 6. OTHER ITEMS |
| | 6.1. Any other business<br>To Note |
| | 6.2. Reflections on meeting<br>For Discussion |
| | 6.3. Date of next meeting - 22 March, 2024<br>To Note - Presented by Jude Chin |
| | RESOLUTION<br>The Trust Board is invited to adopt the following resolution:<br>“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 |
| | Terms of reference of financial recovery group<br>03-Financial recovery group Terms of Reference v1.1 20 Nov- |

23.docx

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4.2 IQPR Full Report / Finance Report

- Item 4.2 - IQPR Board Report November 2023.pptx
- Item 4.2 - IQPR Cover Sheet v4.docx
- Item 4.2 - Annex - FSP Dependencies matrix v8 - 12122023.pdf

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4.4.1 Maternity - Annexes

- Item 4.4.1 - Annex B - Safety Action 2 MSDS compliance report.docx
- Item 4.4.1 - Annex C WSuffolk SBL3 board report action plan.docx
- Item 4.4.1 - Annex D - Safety Action 9 MNSC.docx
- Item 4.4.1 - Annex E - Obstetric Anaesthetic Workforce Board Report Q1 and Q2 2023.docx
- Item 4.4.1 - Annex F - Safety Action 8 MDT training report.docx
- Item 4.4.1 - Annex G -Trust Board report on compliance.docx

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# AGENDA

NHS
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NHS Foundation Trust

# WSFT Board of Directors – Public Meeting

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|---|---|
| **Date and Time** | Friday, 26 January 2023 9:15 – 13:30 |
| **Venue** | Education Centre, West Suffolk Hospital, Hardwick Lane Bury St Edmunds IP33 2QZ |

| Time | Item | Subject | Lead | Purpose | Format |
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| **1.0 GENERAL BUSINESS** | | | | | |
| 09.15 | 1.1 | **Welcome and apologies for absence** | Chair | Note | Verbal |
| | 1.2 | **Declarations of Interests** | All | Assure | Verbal |
| | 1.3 | **Minutes of meeting** – 1 December 2023 | Chair | Approve | Report |
| | 1.4 | **Action log and matters arising** | All | Review | Report |
| 09:20 | 1.5 | **Questions from Governors and the public relating to items on the agenda** | Chair | Note | Verbal |
| 9.35 | 1.6 | **Patient or Staff Story** | Chief Nurse | Review | Verbal |
| 10.10 | 1.7 | **CEO report** | Chief Executive | Inform | Report |
| **2.0 STRATEGY** | | | | | |
| 10:20 | 2.1 | **Strategic priorities update report** | Chief Executive | Approve | Report |
| 10:35 | 2.2 | **Future system board report** | Director of Resources | Assure | Report |
| 10:45 | 2.3 | **West Suffolk Alliance and SNEE Integrated Care Board** | West Suffolk Alliance Director and Director of Integrated Adult Health and Social Care | Assure | Report |
| **3.0 PEOPLE AND CULTURE** | | | | | |
| 11.00 | 3.1 | **Involvement Committee report** Chair's key issues from meeting | NED Chair | Assure | Report |
| 11:15 | 3.2 | **Freedom to Speak Up Report** | Jane Sharland, FTSU Guardian | Discuss | Report |
| **11:30 Comfort Break** | | | | | |

| Time | Item | Subject | Lead | Purpose | Format |
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| **4.0 ASSURANCE** | | | | | |
| 11:50 | 4.1 | **Insight committee report** – Chair's key issues from the meetings | NED Chair | Assure | Report |
| | 4.2 | **Finance report** | Director of Resources | Assure | Report |
| 12:30 | 4.3 | **Improvement committee report** – Chair's key issues from the meetings | NED Chair | Assure | Report |
| | 4.4 | **Quality and nurse staffing report** | Chief Nurse | Assure | Report |
| | 4.4.1 | **Maternity services report** | Chief Nurse<br><br>Karen Newbury<br>Kate Croissant<br>Simon Taylor | Approval | Report |
| | 4.5 | **Audit committee report -** Chair's key issues from the meeting | NED Chair | Assure | Report |
| **5.0 GOVERNANCE** | | | | | |
| 13:10 | 5.1 | **Governance Report** | Trust Secretary | Assure | Report |
| 13:15 | 5.2 | **Board assurance framework** | Trust Secretary | Approval | Report |
| **6.0 OTHER ITEMS** | | | | | |
| 13.25 | 6.1 | **Any Other Business** | All | Note | Verbal |
| | 6.2 | **Reflections on meeting** | All | Discuss | Verbal |
| | 6.3 | **Date of next meeting** 22 March 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 |

**Guidance notes**

| Trust Board Purpose |
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| 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 | | | |
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| **Vision**<br>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<br>• Use feedback, learning, research and innovation to improve care and outcomes | • Build a positive, inclusive culture that fosters open and honest communication<br>• Enhance staff wellbeing<br>• Invest in education, training and workforce development | • Make the biggest possible contribution to prevent ill-health, increase wellbeing and reduce health inequalities<br>• Invest in infrastructure, buildings and technology |

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

**Our Risk Appetite**

# 1. GENERAL BUSINESS

# 1.1. Apologies for absence - Jeremy Over (Carol Steed deputising)

To Note

Presented by Jude Chin

# 1.2. Declaration of interests for items on the agenda

To Assure

# 1.3. Minutes of the previous meeting - 1 December, 2023

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 1 December 2023, 09:15 – 13:30**
**At Keystone Innovation Centre, Thetford, IP24 1JD**

| **Members:** | | |
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| **Name** | **Job Title** | |
| Jude Chin | Chair | JC |
| Ewen Cameron | Chief Executive Officer | EC |
| Louisa Pepper | Non-Executive Director/Deputy Chair | LP |
| Antoinette Jackson | Non-Executive Director/ Senior Independent Director | AJ |
| Geraldine O'Sullivan | Non-Executive Director | GO'S |
| Michael Parsons | Non-Executive Director | MP |
| Krishna Yergol | Non-Executive Director | KY |
| Roger Petter | Non-Executive Director/ Maternity and Neonatal Safety Champion | RP |
| Craig Black | Executive Director of Resources/Deputy CEO | CB |
| Nicola Cottington | Executive Chief Operating Officer | NC |
| Sue Wilkinson | Executive Chief Nurse | SW |
| Paul Molyneux | Medical Director/Maternity and Neonatal Safety Champion | PM |
| Jeremy Over | Executive Director of Workforce and Communications | JO |
| Clement Mawoyo | Director of Integrated Adult and Social Care Services | CM |
| Peter Wightman | West Suffolk Alliance Director | PW |
| **In attendance:** | | |
| Richard Jones | Trust Secretary & Head of Governance | RJ |
| Matthew Keeling | Deputy Chief Operating Officer | MK |
| Ceiridwen Fowles | Disability Staff Network Co-Chair (item 1.6 only) | CF |
| Helena Jopling | Clinical Lead for Public Health Team (item 2.1 only) | HJ |
| Jessica Hulbert | Public Health Manager (item 2.1 only) | JH |
| Gail Cardy | Strategy development & Implementation Lead, Adult and Community Services & Suffolk and North East Essex Integrated Care Board (item 2.2 only) | GC |
| Jason Joseph | Strategic Planning and Resources Team, Adult and Community Services & Suffolk and North East Essex Integrated Care Board (item 2.2 only) | JJ |
| Jane Sharland | Freedom to Speak Up Guardian | JS |
| Francesca Crawley | Guardian of Safe Working Hours (item 3.2 only) | FC |
| Anna Hollis | Deputy Head of Communications | AH |
| Justyna Skonieczny | Deputy Head of Midwifery (item 4.4.1 only) | JSk |
| Simon Taylor | Associate Director of Operations (item 4.4.1 only) | ST |

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| Kate Croissant | Deputy Clinical Director – Women & Children (item 4.4.1 only) | KC |
| Ruth Berry | FT Office Manager (minute taking) | RB |
| **Apologies:**<br>Apologies received from:<br>Louisa Pepper (Non-executive director)<br>Peter Wightman (West Suffolk Alliance Director)<br>Karen Newbury (Head of Midwifery) | | |
| **Staff:** | | |
| Heidi Rolfe-Hill | Community Staff Side Lead | HRH |
| Paul Pearson | Community Staff Side Lead | PP |

| **1.0 GENERAL BUSINESS** | | |
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| 1.1 | **Welcome and apologies for absence** | **Action** |
| | The Trust Chair (JC) welcomed all to the meeting and the apologies for absences were noted. | |
| 1.2 | **Declarations of interest** | |
| | No declarations of interest were received for items on the agenda. | |
| 1.3 | **Minutes of the previous meeting** | |
| | The minutes of the previous meeting on 29 September 2023 were approved as a true and accurate record. | |
| 1.4 | **Action Log and matters arising** | |
| | <u>Open items:</u><br><br><u>Ref 3030</u><br>Question raised relating to how we include total waiting list numbers in the Integrated Performance and Quality Report (IQPR).<br>- IQPR content is being reviewed through the 3i Committee development. It is suggested this be picked up through the planned Insight workshop in the New Year.<br><br><u>Ref 3031</u><br>Patient and Staff Story.<br>- An 'end of life' patient/staff story to come to Board in March 2024<br><br><u>Ref 3034</u><br>Strategic Priorities Delivery Plan<br>- The priorities of the Plan were reviewed at the Board workshop and these discussions and actions will be incorporated into the update report, schedules for January's Board meeting.<br><br><u>Ref 3039</u><br>Finance Report on recovery plan<br>- Detail of the recovery plan will be presented in the finance report agenda item, 4.2 – **ACTION CLOSED** | |

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| 1.5 | **Questions from Governors and the public relating to items on the agenda** | |
| | A question came from a Staff Side Lead (PP), concerning the financial situation and the priorities made, in relation to seeking assurance for staff;<br><br>- The Chief Executive Officer (EC) explained that, along with all other NHS Trusts, it is going to be a difficult few years for everyone. Decisions made by Board will only be done if needed and staff can challenge any of those decisions, via the normal channels. | |
| 1.6 | **Patient and Staff Story** | |
| | November is 'Disability history' month and as such, the Board prioritised the Patient and Staff Story to hear stories from the Trust Disability Staff Network Co-Chair (CF), in relation to reasonable adjustments at work.<br><br>There is a legal obligation on employers to make reasonable adjustments to any elements of the job which place a disabled person at a substantial disadvantage, compared to non-disabled people.<br><br>The average cost of an 'adjustment' is £75, but many cost nothing to implement. They can range from having an item to touch during a meeting; to reduce anxiety, to being able to ask a colleague for a sense test, to ensure an understanding of the tone of an email received. Support is needed within the team that the member of staff sits in, otherwise they might feel they have to change roles, to ensure a reasonable adjustment can be made.<br><br>The Trust is looking at equality, diversity and inclusion (EDI) at all levels and across sites, including working with the Future System team to ensure accessibility for the new hospital and within all future plans.<br><br><u>Q. The disability network is the most organised group within the Trust, how do we cross this with the other networks? What else can be done within the Trust to increase awareness?</u><br><br>The Workforce team are looking at training for line managers in relation to this – staff do need to be treated differently. From the recent staff survey, the percentage of staff that considered themselves to have a disability was 20%, which is much higher than the 3.8% which is recorded on the Trust electronic staff record (ESR).<br><br>Staff might not be aware of what reasonable adjustments are available. It needs to be agreed with the line manager, which can be difficult for some staff, if they don't have a good | |

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| | relationship, or it is viewed as special treatment/favouritism by other colleagues, which can be a barrier to access.<br><br>Q. What cultural change, as a Board, needs to happen to help the environment within the Trust?<br><br>Changes are being made to the annual reviews of staff, to help normalise the ask for reasonable adjustments. It is not special treatment or favouritism.<br><br>The disability network is looking at forming a sub-section in relation to autism, especially as there are large numbers of undiagnosed women nationally.<br><br>The Executive Director of Workforce and Communications (JO) presented CF with the staff recognition award for this month. | |
| 1.7 | **CEO Report** | |
| | The Chief Executive Officer (EC) presented the report to the Board.<br><br>It was taken as read and it was acknowledged that as we move into later Autumn/early Winter, the pressures on our emergency department and other services will increase and that colleagues from every team continue to go above and beyond, to provide excellent care for our community.<br><br>It was positive development that the Trust will receive a share of the payment from NHS England, in relation to the financial impact of industrial action. | |
| **2.0 STRATEGY** | | |
| 2.1 | **Prevention, personalised care and health inequalities strategy** | |
| | The Clinical lead for public health (HJ) presented the report relating to the new prevention, health inequalities and personalised care strategy for the Trust, with the following highlighted;<br><br>The Trust has a history of innovation and leadership in prevention, health inequalities and personalised care (PHIPC) and the team are embedded in the Trust.<br><br>The document presents in detail, the meaning of that commitment and the ways in which the Trust will achieve this.<br><br>It is a long-term strategy, going up to 2060. The needs are stable and are able to be implemented throughout the Trust, in collaboration with the Integrated Care System (ICS).<br><br>Actions are reasonably achievable and are classed using the 'SMART' method (specific, measurable, achievable, relevant, time bound). The actions can help reduce resources made by the Trust. | |

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| | The strategy does need to be filtered down through the various existing pathways, but it has a huge potential to reduce costs and waiting lists, through alternative measures.<br><br>To consider options for West Suffolk Hospital becoming a smoke free site to come back as part of priorities in January - **ACTION**<br><br>There is a commitment to push the strategy within the Trust, and the West Suffolk Alliance will help bring everyone together, including proving support, and funding for certain projects.<br><br>**The Board is asked to approve the PHIPC strategy and to note in particular, the collaboration with West Suffolk Alliance partners in the 2023-25 action plan.**<br><br>**Approval by the Board was hereby given to the PHIPC strategy.**<br><br>Consider how to monitor healthcare inequalities indicators within the assurance committee structure (as well as the strategy implementation plan) - **ACTION** | **EC**<br><br>**RJ** |
| 2.2 | **Future System Board Report** | |
| | An update on the new hospital programme was provided by the Executive Director of Resources (CB), with the following highlighted;<br><br>A feature of the programme is that the 'review' process is taking place at the same time as the 'progress' process.<br><br>The outline of numerous reviews that will have a financial impact are currently being reviewed, by external parties. | |
| 2.3 | **West Suffolk Alliance and SNEE Integrated Care Board** | |
| | The Director of Integrated Adult and Social Care Services (CM) reported to the Board on behalf of the West Suffolk Alliance and SNEE ICB and explained that non-recurrent funding of £527,754 has come through to the ICB, to help with reducing health inequalities in West Suffolk. The priorities for use of this funding include supporting people with chronic obstructive pulmonary disease, hypertension and atrial fibrillation.<br><br>The Board welcomed members of the strategic planning and resources team from Adult and Community Services & SNEE ICB (GC & JJ), to present the draft Suffolk Dementia Strategy for 2024-2029:<br><br>i. the strategy paper will be going to the ICB Health and Wellbeing Board in mid-March next year<br>ii. it has been built by those living with dementia, those in the hospitals and throughout the Trust, both acute and community wide | |

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| | iii. it looks at how those patients coming into hospital with dementia are cared for, in an attempt to reduce potential distress<br>iv. there is a need to ensure the pathways (both primary and secondary care) where patients are diagnosed are increased. This includes assessment, which can often be delayed<br>v. the actions from the strategy will be across the whole System, where there is a need to ensure interconnectivity across all the "well domains"<br>vi. more training for managing patients with dementia is needed, both for professionals and carers.<br><br>In relation to the Dementia Strategy, the Board will be kept informed of developments as the strategic approaches final approval – **ACTION** | **SW** |
| 2.4 | **Digital Programme Board Report** | |
| | The Executive Director of Resources (CB) presented the report from the Digital Programme. It was taken as read, with the following highlighted;<br><br>• There has been significant investment in the network infrastructure across the acute and especially community locations, in terms of internet access, with an upgrade to Wi-Fi access points on the main hospital site, to support the latest protocols and frequencies.<br>• Health Information Exchange, which the Trust operates on behalf of the ICS, delivers a shared care record solution for staff to support direct care. It has increased the flow of patient information for clinicians at the point of care. It is a 'read only' system at present. The new system that East Suffolk and North Essex Foundation Trust (ESNEFT) will begin to use will also increase the flow of patient information.<br><br>It was confirmed that there is no intention at present for the Trust to move to the new system that ESNEFT will be using. There is not enough impact for a business case to move from one market leader to another. | |
| **3.0 PEOPLE AND CULTURE** | | |
| 3.1 | **Involvement Committee report** | |
| | Chair's key issues from the meetings<br><br>Non-Executive Director (KY) presented the report, on behalf of the Committee Chair, with the following highlighted;<br><br>There has been a terms of reference update for the Committee, following the recent workshop. The Committee will now split their time equally between issues affecting staff, patients and assurances. | |

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| | It was recognised that more can be done, in terms of promotion, to improve the visibility of the partnership between the Trust and Healthwatch Suffolk (the independent partner that represents the opinions and experiences of patients and public in West Suffolk).<br><br>There was a presentation at the previous meeting from the staff psychology team, looking at the service from a staff point of view. | |
| 3.2 | **People and OD Highlight Report** | |
| | The Executive Director of Workforce and Communications (JO) presented the report to the Board, with the following highlighted;<br><br>The latest quarterly Pulse survey results from staff, for Q2, ranked the Trust 1st in the region for overall engagement (7 out of 10), with best scores being for involvement and motivation. The Trust is starting to see a reverse in scores, following the pandemic.<br><br><u>Safe Working report</u><br><br>The Guardian of Safe Working Hours (FC) presented the Safe Working report to the Board and highlighted that because of recent various industrial actions and following on from the pandemic, doctors' needs for 'safe working' had not been looked at in more detail: more hours are being asked to cover the increasing work hours and whether this is 'safe' or not. Training needs were not being met after often having been delayed due the increase workload.<br><br>However, processes put in place have helped changed the situation for many staff – WhatsApp's groups are being used to help cover hours, consultants being involved more.<br><br><u>Freedom to Speak Up (FTSU) report</u><br><br>The newly appointed Freedom to Speak Up Guardian (JS) presented the FTSU report to the Board;<br><br>JS introduced to the Board and explained that JS worked as an occupational therapist within the Trust, before joining as the FTSU Guardian.<br><br>There have a been a drop in numbers of reports made in Q2. Of those made, the majority came from administration/clerical members of staff. The highest number of concerns related to staff safety or wellbeing.<br><br>Many concerns have been related to strained relationships, which is in line with what is being seen nationally.<br><br>As an organisation, lots has been put in place to deal with themes that have come up through concerns. There are now leadership training programmes available for staff, to help with relationships between managers and staff. | |

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| | The Trust does well in relation to the national guidelines of 'Speak up/Listen up'. All new starters (including student staff) receive training on raising concerns and the hope is to instil that the Trust is committed to speaking up.<br><br>Gap analysis of the 'Champions' within the Trust is being undertaken, to ensure we have people in all areas of the Trust.<br><br>Fear and futility are the main reasons why staff don't speak up. The team is working on these areas to remove barriers to speaking up.<br><br>Information of resolutions through the normal pathways is not yet collected and needs to be included and captured in a future survey.<br><br>Workforce/Communications have been making positive results in terms of making speaking up more staff, to help increase visibility across the Trust.<br><br>Following a newly elected Council of Governors, there is an opportunity to link up with the new Staff Governors.<br><br>FTSU Guardian to be invited to the Staff Governor Group meetings going forward **ACTION** | **RJ** |
| **4.0 ASSURANCE** | | |
| 4.1 | **Insight committee report** | |
| | - Chair's key issues from the meetings<br><br>The Committee Chair (AJ) reported from the last 2 meetings, which included a presentation from Outpatients and a deep dive into Community Paediatrics.<br><br>In relation to the financial recovery plan and the cost improvement plan (CIP), funding has now been granted, so progress is being made.<br><br><u>Q. work stream on waiting times</u><br>With intensive support, the 4-hour timing worked really well, but without the support, the timings don't stand up. In order to make sustainable changes, the intensive support will be to continue, with the support processes in the long term are up in place and actioned. Clinical and operational leadership is key to help embed the changes, in line with national performance.<br><br><u>Q. Winter plan</u><br>The winter plan is modelled for the impact of winter, including the pinch points and pressures. There is a winter capacity plan ready, to open extra space for the period over Christmas and New Year if needed. | |

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| | Insight Committee to keep track of the initiatives - **ACTION** | **Insight Committee** |
| 4.2 | **Finance report** | |
| | The Executive Director of Resources (CB) presented the report, with end of October figures.<br><br>There was an overspend in October of £600,000.00<br><br>In the month of November, a firm decision has been made regarding industrial action back pay. The Trust will receive £3.3 million and will also have a reduction in the Elective recovery Fund. It is therefore expected that we will gain back £5 million, in line with our recovery plan. This trajectory change was expected in March 2024, rather than November 2023<br><br>The Board was asked to approve the Trust applying for £6 million in revenue support from DHSC as cash support, to cover our impacted deficit for 23-24.<br><br>**The Board of Directors approved the application for a £6m of cash revenue support from Department of Health and Social Care, in line with the report presented by the Executive Director of Resources.** | |
| 4.3 | **Improvement committee report** | |
| | – Chair's key issues from the meetings<br><br>KY, on behalf of the Committee Chair, reported to the Board on the previous 2 meetings, which included 2 deep dives, one relating to mental health identification of patients in the emergency department & identification of learning disabilities.<br><br>An analysis was undertaken regarding the Trust mortality data and the underlying causes of unallocated coding of that data. It was noted that these unallocated coded deaths don't affect/increase our mortality rates.<br><br>The outcome of a recent Committee workshop was to move towards more strategic, rather than operational work. | |
| 4.4 | **Quality and nurse staffing report** | |
| | The Executive Chief Nurse (SW) reported to the Board, with the following highlighted;<br><br>Staff service levels (nurses and care staff) are now at 90% throughout the day and night.<br><br>There is still a high turnover of nursing assistants within the Trust, which is continuing to be looked at. There is a need to ensure that those coming into the industry know what the expectations will be for the role to reduce this turnover. | |

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| | There is a below 10% vacancy rate across the Trust, in relation to registered nursing posts. | |
| 4.4.1 | **Maternity services report** | |
| | The Deputy Head of Midwifery (JSk) to reported to the Board, on behalf of the Head of Midwifery, who sent apologises for the meeting.<br><br>The report was taken to be read, with the following highlighted;<br><br>Congratulations were noted for Karen Newbury who has been promoted to the first Director of Midwifery for the Trust.<br><br>Changes to the survey sent to patients, following discharge from the maternity unit, from email to text message have led to an increase in responses, which is positive and welcome.<br><br>Board members thanked the maternity team for all the hard work, which is showing in the survey results. | |
| **5.0 GOVERNANCE** | | |
| 5.1 | **Governance Report** | |
| | The Trust Secretary (RJ) reported on the recent main governance headlines;<br><br>The Senior Leadership Team (SLT) meeting took place in November. The meeting approved that the terms of reference for SLT and the Executive Directors meeting be updated to more clearly define their roles and extend the membership of the Executive Directors' meeting to include representation from the clinical divisions.<br><br>In accordance with the Trust's standing orders, the Insight Committee was briefed on the need to make an urgent submission regarding financial and operational performance to the ICB, as part of a national exercise. This related to addressing the significant financial challenges created by industrial action.<br><br>The Trust Chair (JC) and Chief Executive Officer (EC) approved the return, having consulted with the Executive Director of Resources (CB), Executive Chief Operating Officer (NC), as well as 3 Non-Executive Directors; AJ, MP and RP.<br><br>Report to be uploaded onto Convene for information - **ACTION** | **RJ** |
| 5.2 | **Board assurance framework** | |
| | The Trust Secretary (RJ) presented the report on the Board Assurance Framework (BAF).<br><br>The recent Board development workshop focused on this, BAF and the 10 areas it covers. Further work by Board Committee will focus on these areas. | |

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| | Development of the risk management BAF and the Trust appetite of risk is required, as it is currently 2 years old. This will include what the report looks like and how to track changes in the framework. This is to be brought back to Board in January, for further discussion, together with a revised BAF.<br><br>Patient experience needs to be added to the strategic risks (need to ensure that risks are described as "If X, then Y") - **ACTION** | **RJ** |
| **6.0 OTHER ITEMS** | | |
| 6.1 | **Any Other Business** | |
| | No other business was raised for discussion | |
| 6.2 | **Reflections on meeting** | |
| | A question was raised in relation to the 'assurance' function of the Board, given the assurance committees and whether we are duplicating work or not.<br><br>It was noted that the Board minutes are public records and not everyone is on every committee. It is to allow for discussion in a public forum and to inform our strategy. | |
| 6.3 | **Date of next meeting**<br><br>Friday, 26 January 2024 | |

# 1.4. Action log and matters arising

To Review

| Ref. | Session | Date | Item | Action | Progress | Lead | Target date | RAG rating for delivery | Date Completed |
|---|---|---|---|---|---|---|---|---|---|
| 3030 | Open | 29/9/23 | 1.5 | **Questions from Governors and the public relating to items on the agenda -** To consider how we include total waiting list numbers in the IQPR | **The IQPR content is being reviewed through the 3I committee development. It is suggested this be picked up through the planned Insight workshop in the New Year. As Insight Committee dealing suggested this is picked up through the planned Insight workshop in the New Year.** | NC | 01/12/23 | Green | |
| 3031 | Open | 29/9/23 | 1.6 | **Patient and Staff Story** - Deep dive into 'end of life' for future board, linked to leadership/ communication within team and with relatives/carers – improvement committee | **An 'end of life' patient/staff story to come to Board in March 2024.** | LP/SW | 22/03/2024 | Green | |
| 3048 | Open | 1/12/23 | 2.1 | **Prevention, Personalised Care and Health Inequalities Strategy -** Consider how to monitor healthcare inequalities indicators within the governance structure (as well as the strategy implementation plan) | **The current reporting route for public health is via the Clinical Effectiveness Governance Group. This is being reviewed to consdier the level of prominance/visibility.** | RJ | 22/03/24 | Green | |

| Ref. | Session | Date | Item | Action | Progress | Lead | Target date | RAG rating for delivery | Date Completed |
|---|---|---|---|---|---|---|---|---|---|
| 3034 | Open | 29/9/23 | 2.1 | **Strategic Priorities Delivery Plan -** Consider how to give visibility to trajectory delivery for the SMART objectives (dated and as part of a longer-term delivery plan). Make explicit where delivery is currently monitored and escalated. | **The priorities were reviewed at the Board workshop and these discussions and actions will be incorproated into the update report scheduled for January's board meeting. Engamemnt with NEDs will take place on priorities for 2024/25 ahead of board workshop AGENDA ITEM** | RJ | 01/12/23 | Complete | 26/01/2024 |
| 3039 | Open | 29/9/23 | 4.2 | **Finance Report** - Provide greater detail of recovery schemes for discussion and transparency. Also reflect on level of information provided to understand movements in capital | **Greater detail of the recovery plan will be presented in the finance report agenda item, 4.2.** | CB | 26/01/24 | Complete | 26/01/2024 |
| 3047 | Open | 1/12/23 | 2.1 | **Prevention, Personalised Care and Health Inequalities Strategy -** Options for West Suffolk Hospital becoming a smoke free site to come back as part of priorities update | **Today's agenda refers (26.1.24).** | EC | 26/01/24 | Complete | 26/01/2024 |
| 3049 | Open | 1/12/23 | 2.3 | **West Suffolk Alliance and SNEE Integrated Care Board** - In relation to the Dementia Strategy, a plan needs to be developed for how to inform the Board of the strategic developments | **SW is engaged with the Adult and Community Services team and updates will be escalated through the Dementia and Frailty Steering Group to Improvement.** | SW | 26/01/24 | Complete | 26/01/2024 |
| 3050 | Open | 1/12/23 | 3.2 | **People and OD Highlight Report** - FTSU Guardian to be invited to the Staff Governor Group meetings going forward | FTSU guardian attended first staff governance meeting after election on 9/1/24 and agreed to attend fuure meetings. | RJ | 26/01/24 | Complete | 09/01/2024 |
| 3051 | Open | 1/12/23 | 5.1 | **Governance Report - Urgent Submission - Financial and Operational Performance -** Report to be uploaded onto Convene for information**.** | File aded as annex to December meeting pack | RJ | 26/01/24 | Complete | 26/01/2024 |
| 3052 | Open | 1/12/23 | 5.2 | **Board Assurance Framework -** Patient experience to be added to the strategic risks**.** | Emphasis is being given to patient engagement and experience within the updated strategic risks | RJ | 26/01/24 | Complete | 26/01/2024 |

# 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 – January 2024

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

| For approval ☐ | For assurance ☐ | For discussion ☒ | For information ☒ |
|---|---|---|---|
| **Trust ambitions** |  |  |  |
| 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:** | - |

# CEO Board report – January 2024

## Quality and performance

Our drive to provide and improve healthcare across west Suffolk reaches well beyond the boundaries of the bricks and mortar of the hospitals, centres and homes in which we traditionally deliver our services. As part of the West Suffolk Alliance, a collaboration of health and care service organisations committed to working together to improve the health and care system for everyone in west Suffolk, we are actively going out into our communities to help people look after and improve their health.

One example of this is a new pilot we are running on the Howard Estate in Bury St Edmunds which will focus on identifying those most at risk of cardiovascular disease and helping residents manage high blood pressure. The pilot will see GP surgeries contacting residents whose health records show that they either have high blood pressure or are at risk of high blood pressure. In the future it is anticipated that residents will be able to have blood pressure checks in places such as the local community centre, bringing healthcare even closer to people's homes. Prevention of ill health and reducing health inequalities are important parts of our organisation's strategy and we plan to do more on this agenda in the future to help our communities keep as healthy as possible, reduce demand on our services and ensure that everyone has the access to the healthcare they need and deserve.

In a reflection of the high-quality care we deliver to patients, we've recently had the wonderful news that our pulmonary rehabilitation service has been awarded national accreditation. The service is part of our community and integrated therapies division and provides individualised care to support people with chronic lung or respiratory conditions to achieve their best quality of life and maintain their independence. Run by the Royal College of Physicians (RCP) with the aim to improve the quality of pulmonary rehabilitation services throughout the UK, accreditation is awarded for four years (with annual reviews). This has been a long process, with a huge amount of work going on to meet the high standards of the RCP. Our team is only the twelfth in the country to achieve this accreditation standard and the first in the East of England. I had the pleasure of joining the team on their initial accreditation visit in my first week at the Trust last year and was able to spend some time with the team and some of their patients at Abbeycroft Leisure in Newmarket in the Autumn, so I know the enormous difference this service makes to the quality of life of their patients. A huge congratulations to the team and everyone involved.

## Performance

Industrial action has been a constant feature across the Trust over the last year, with 2023 culminating in a pre-Christmas BMA junior doctor strike and then 2024 beginning with another. The two strikes came during a time when NHS services are traditionally under huge pressure anyway and there is no doubt these strikes added to the challenges. An enormous amount of forward planning was done ahead of the period to ensure patient safety was upheld throughout the strike period, and staff went above and beyond to help provide cover to look after patients. I'd like to thank everyone who worked so hard to keep things going. I know there are repercussions on patients from these strikes, with some appointments and procedures being cancelled, and I am deeply sorry to every patient we have had to postpone - please be assured that we will be in touch with you as soon as possible to rearrange your appointment. I sincerely hope a resolution to this ongoing industrial action can be found between the Government and the BMA as soon as possible, so we can limit any further damage to patients, staff and our services.

We know the area we are experiencing the most pressure in is our emergency department and the demands on our services are having an impact on staff and patients with patients

waiting much longer than we would like. Whilst we have committed to ensuring we meet the standard of 76% for patients being seen in our emergency department within four hours by March 2024, we are falling short of this target and there is a notable number of patients waiting in our emergency department for more than 12 hours. We are undertaking a significant amount of work to improve this position and staff are working as hard as possible to treat everyone as quickly as possible.

With these strikes going on for so long, the impact on our elective recovery is being felt and it will now be more difficult to meet our 2023/24 operational objectives by 31st March 2024. As of 31 December, the number of longest waiting patients stands at 72 patients waiting over 78 weeks (of which 44 are capacity breaches with the others being due to a mixture of choice, complexity and unfit patients); 649 patients have been waiting over 65 weeks and 16,051 patients have been waiting for over 18 weeks. We are doing everything we can to get through our longest waiting patients and we remain on track to achieve our commitment to reduce waiting times to 94 patients over 65 weeks and 55 patients over 78 weeks, by the end of March 2024.

We continue to work hard to improve our financial performance with an enormous amount being done by colleagues throughout the Trust to deliver our cost improvement programme, which is now really beginning to see results. Whilst there is still much do be done, and we are in no way taking our foot off the pedal, December 2023 saw us deliver a £1.1 million cost improvement - the most we have delivered in any month ever. That said, the effects of increased demand, coupled with industrial action, are being acutely felt, and as such our reported position for the year to date (as of December 2023) is £6 million in deficit. I'd like to thank all colleagues involved in helping us deliver these cost savings, particularly when we are so busy dealing with increased demand and industrial action. We will continue to do all we can to recover our position and are still anticipating meeting our planned year end deficit of £6.3 million.

**Workforce**

The NHS would be nothing without its fantastic, diverse workforce. In December we had cause for celebration with national recognition for the pastoral care the Trust provides to healthcare support workers, with us being awarded gold in the NHS England Pastoral Care Quality Award for support workers. Our healthcare support workers provide high-quality care across a range of clinical areas within the Trust and are an integral part of our workforce. The pastoral care available to them means they are extremely well supported every step of their working journey with us - from recruitment to retention; in-role support; learning and development and valuing staff and recognition. To achieve the gold award, the team had to successfully meet a set of standards and demonstrate best practice pastoral care for support workers. The achievement of this gold award, which has only been given out to two NHS Trusts in the East of England, is testament to the commitment we have to support our healthcare support workers and shows the hard work we put into looking after and valuing this important group of colleagues.

Of course, there are many ways we can support our staff and one way we are doing this is by utilising technology to help disabled colleagues overcome barriers in their working lives. We have recently been selected as a winner in the NHS England Equality, Diversity and Improvement Awards, under the category of 'assistive technology' and will be using the extra funding from the award to support the implementation of a digital assistive technology toolkit. Using these kinds of toolkits and platforms, which provides functions such as speaking aloud (text to speech), voice recognition (speech to text), colour changing and magnification helps enable people with disabilities to access the information they need to work here. The diversity of our staff is one of the great strengths of the Trust, and we hugely value

colleagues who have disabilities for the positive contribution they make. There is a real advantage for our workforce, patients, and visitors in having their support to improve services.

I'm delighted to announce our regular staff 'Putting You First' awards in this report. These awards recognise staff who go above and beyond for fellow colleagues or their patients and who exemplify our FIRST Trust values of fairness, inclusivity, respect, safety and teamwork. The award winners are:

- **Jessica White,** who is one of our respiratory consultants. Jessica was nominated by one of our senior house officers, Marie Kershaw, for going above and beyond for her patients, making good clinical plans and being supportive of medical students and junior doctors. Marie said that Jessica makes everyone she works with feel appreciated.
- **Gemma Evans**, our organisational development and learning team leader. Gemma has been nominated by her colleague, Jessica Langley, for being an exceptional team leader, always leading from the front and getting stuck in. Jessica says that Gemma is never too busy to help and has developed a lovely, family team.
- **Community heart failure team.** The team have been nominated by Beckie Rolfe, Gail Gubbins and Elisa Brooklyn due to the tireless work they carry out. They do a fantastic job of looking after heart failure patients at home, in the local clinics they run or in our virtual ward. Their highly specialised work is invaluable to the patients they serve, and they always show compassion and care despite being exceptionally busy.
- **Laura Talbot,** ward manager for G1 ward (oncology/haematology). Nominated by one of our venous access nurses, Andrea Johnson, Andrea is keen that Laura is recognised for the support she has give to the venous access team. Andrea says that as well as her full-time work in oncology/haematology, Laura has taken on managing the venous access team as well and always gives time, advice and encouragement generously and efficiently. In her nomination, Andrea says about Laura "she always works so hard for everyone she is overseeing. Thank you Laura!"
- **Ken Carse and Jabay Nkhwazi**, endpoint engineer and application support officer, IT. Ruth Berry, our Foundation Trust office manager, wanted to recognise the work Ken and Jabay have done in helping our new Trust governors get set up with IT. They attended the governors' induction session and were patient in helping all the new governors and answered any IT related questions with patience and friendliness. Ruth felt they clearly demonstrated the Trust values of inclusivity and respect.
- **Stephen Shrimpton**, MRI assistant. Anthea Thorogood, one of our care co-ordinators, nominated Stephen because he went above and beyond to assist a patient after they left their reading glasses in the MRI suite. Instead of just putting them in lost property, Stephen contacted the patient to let them know he had the glasses, helping them to be reunited with their owner.

Two of our chefs have also been shining brightly recently. Connor Gutsell and Glen Stone recently cooked up a storm at the NHS England Chef of the Year competition and in doing so secured fourth place. The competition saw them compete for six days over two weeks against nine other teams of NHS chefs. I know both chefs gained a huge amount from the competition in terms of learning and experience, which they have bought back to the Trust with them. Our in-house catering team is something we are hugely proud of and this achievement is a fantastic reflection on the chefs' talents and the work of the team as a whole. Congratulations.

**Future**

Our Trust's virtual ward is an important way that we can help our patients leave hospital sooner to continue their recovery at home or in another care setting or prevent them from having to stay in hospital in the first place. From 1 February, in line with our strategic plan for the virtual ward, it will move into the community division.

The virtual ward began in the medicine division to ensure it engaged effectively with acute services and built those important relationships which drive awareness and referrals. Now that it has been caring for our patients for more than one year, it will fully integrate into the community division so that closer working can be achieved with our community teams, and also our primary and social care partners.

The virtual ward is a totally new way of working, and I would like to thank the virtual ward team and all clinicians for helping to get this service off the ground. In its first year, our virtual ward has saved more than 6,600 bed nights in our hospitals, and I know this will continue to grow and develop into a significant way that we manage current and future demand. While nothing will change in the way that the virtual ward is run, we are encouraging our clinicians to continue referring, and for our patients to ask whether the virtual ward is appropriate for them.

On Friday, 12 January, we reached a significant milestone in the delivery of a new Community Diagnostic Centre at the Newmarket Community Hospital (NCH). I was joined by colleagues from our estates, projects and radiography team, along with representatives from our partners involved in the design and construction of the project for the groundbreaking event.

Once open, this facility will provide our communities in the west of the region with faster access to a wide range of diagnostic tests, which include MRI, CT, X-ray, ultrasound, heart scans and blood tests. While helping to tackle health inequalities, reduce waiting times, and expand the services available at the hospital, the facility will also further our green ambitions. I was delighted to learn that as a result of the 123 solar panels that will be installed at the NCH as part of the project, we have surpassed our ambition to generate 10% of the site's energy renewably, with current predictions putting this at a minimum of 46%. I look forward to bringing you further updates on this exciting project throughout 2024.

The Future System Programme continues to make good progress with the rebuilding of West Suffolk Hospital. The translocating (moving) of approximately one hectare of fungi from its current location on Hardwick Manor site in Bury St Edmunds to two new sites, with similar soil characteristics as the donor site, is now complete with habitat recreation continuing at the receiver site.

Archaeological trial trenching commenced on the development site on the 18 December. This will be delivered in two parts with the first phase due to be complete by the end of January 2024.

Engagement regarding digital technology is now complete and the results are now being compiled with the team continue to work on the outline business case.

# 2. STRATEGY

# 2.1. Strategic Priorities update report

To Approve

Presented by Ewen Cameron

| Board of Directors | |
|---|---|
| **Report title:** | **Strategic priorities report** |
| **Agenda item:** | 2.1 |
| **Date of the meeting:** | 26 January 2024 |
| **Sponsor/executive lead:** | Ewen Cameron, CEO |
| **Report prepared by:** | Ewen Cameron, CEO<br>Executive, clinical and operational leads |

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

| **Executive Summary** |
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| **WHAT?**<br>*Summary of issue, including evaluation of the validity the data/information* |
| At its meeting in July the Board approved strategic priorities relating to:<br>• Delivery of **service pathway changes** as laid out in the Clinical and Care Strategy<br>• A strong priority on **Equality, Diversity and Inclusion**<br>• A focus on **line management development**<br>• A step change in delivery on **prevention and proactive care**<br>• Development of **transformation capacity and capability**<br><br>The Board received an update on progress in September 2023 and Annex A of this report provides a further update.<br><br>Work started at our workshop in November on our priorities for 2024/25. Annex B provides a first draft of these objectives. |
| **SO WHAT?**<br>*Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk* |
| This report summaries progress against each of these priorities and describes risks and deliverables (milestones) for the next two months.<br><br>The draft priorities for 2024/25 build on our existing priorities for the year ahead. |
| **WHAT NEXT?**<br>*Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)* |
| The board is asked to note progress with the 2023/25 objectives.<br><br>The draft objectives for 2024/25 will be subject to review with NEDs over the coming week's prior to review at the next Board development session at the end of February. |
| **Action Required** |
| To note the report and next steps. |

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

# Annex A: Strategic priorities 2023/24
Progress report – January 2024

| First for Patients - Delivery of service pathway changes as laid out in the Clinical and Care Strategy | | | |
|---|---|---|---|
| Action | Activities/progress in last 2 months | For the next 2 months:<br>- Key risks<br>- Deliverables / milestones | Measures of success |
| Plan and deliver against the priority areas for service pathway change<br><br>*Exec. lead – Paul Molyneux*<br><br>*Operational delivery lead: Alex Baldwin* | **Frailty –** Integrated frailty action plan has been developed – focus on proactive community identification / management and reactive acute service. In reach reablement to acute wards has been agreed. Acute frailty hub plan is being rolled out. Trust and alliance partners aligned around a single plan.<br><br>**Virtual ward –** Revised roll out plan for clinical pathways and associated capacity increase has been agreed.<br>Arrangements are in place to transfer governance to community division effective 1 Feb 24. Agreement in place for onboarding patients residing in South Norfolk which is a significant development.<br><br>**Urgent Community Response –**<br>Extension of overnight care provided by EIT for patients on discharge.<br>Development of Advanced Clinical Practitioner (ACP) SOP in UCR service.<br><br>**CYP services –** Service review is being finalised with input from community and alliance partners. Recommendations include service improvement, governance arrangements (including rethink review feedback) and direction on future service structures. | **Frailty -** Focus in the next 2 months will be developing the business case for community geriatrician capacity and community clinical director role.<br><br>**Virtual ward –** Impact assessment to be presented. GIRFT review scheduled 29/1 – recommendations to be reviewed and implemented.<br>Development of case for clinical lead for virtual ward (linked to clinical director for community).<br><br>**Urgent Community Response –**<br>Focus on increasing senior medical input to UCR teams – linked to community geriatrician capacity.<br>To develop plans to expand 'step up' pathways to CAB capacity for appropriate patient cohorts (e.g., UTI / increased confusion).<br><br>**CYP services -** Proposal to use clinical vision sessions (co-produced) to agree next steps for clinical management of children's services.<br>Recommendations stemming from service review to be implemented. | • Frailty – deliver integrated frailty model leading to 10% reduction in falls and frailty related admissions by March 2024.<br>• Virtual ward – to deliver 103 virtual beds by March 2024.<br>• Urgent Community Response – increased service provision up to 7 day, 24hr service by March 2024.<br>• Work to bring community and hospital services for children and young people closer together for the benefit of families using our services<br>• Pilot of 15 session weeks – piloted in 1 surgical specialty (electives and OPD) by March 2024.<br>• Agreed 3-5 year project plan for delivery of transformation by March 2024. |

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| | **15 session weeks –** Agreement in place to move to 11 sessions p.w. with T&O and plastics specialties. Detailed productivity plan has been developed in conjunction with NHS England regional improvement team.<br><br>**Transformation plan –** Objectives for 24/25 have been drafted as follows:<br>▪ Outpatients<br>▪ Developing our CYP strategy<br>▪ Scope, review and propose optimal emergency village model.<br>▪ Integrated neighbourhood teams.<br>▪ Deliver a test of change which demonstrates 'left shift'. | **15 session weeks –** Implement 11 session weeks no later than Q1 24/25. Focus for productivity work is in session utilisation, pre-operative assessment, and day case conversion rates.<br><br>**Transformation plan -** Draft plan is being socialised with execs and divisional leads before final plan signed off. Full project initiation documentation to be completed by end of Q4. | |

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| Collaborate to provide seamless care at the right time and in the right place for end-of-life patients<br><br>*Exec. lead – Sue Wilkinson*<br><br>*Clinical delivery lead: Mary McGregor*<br>*Operational delivery lead: Sharon Basson* | • Model of Care – Following on from completion of scoping exercise – Focus groups being established to take forward areas of opportunity.<br>  ○ Moving forward with the following key areas;<br>  ○ Anticipatory/Just in case medicines policy (Linking with the ICS group).<br>  ○ Education and literature (Linking with compassionate Charter).<br>  ○ UCR, INT and Step-up (linking with age well)<br>  ○ Work has commenced to link SPC with EIT and care homes.<br>  ○ Review underway to understand the EOL activity within UCR and how this can be monitored and improved if required.<br>  ○ Virtual ward (Linking with WSFT and the Hospice)<br>  ○ Work has commenced to embed SPC into the existing VW pathways with bi-weekly meetings.<br>  ○ Crisis planning and management<br><br>• Sourcing a solution to identification of people in their last year of life. – request to BI for required reports<br>  ○ New BI dashboard to be used to support the wider programme planning of work for FY24/25.<br><br>• Continue to roll out ReSPECT<br>  ○ Linking the new Macmillan post and the WSA Personalised care manager to help support the model of care focus group around ReSPECT, Personalised care and additional funding/benefit support such as SR1, Grants, blue badge schemes etc. To commence December/January. | **Key risks**<br>• HEST funding has ceased 24/7 hub not available (support provided by 24/7 helpline and Nurses within EIT).<br>• Concerns across the DWDG with regards to inequity across SNEE.<br>• The need to identify some dedicated primary care resource has been highlighted at the recent WSA DWDG.<br><br>**Priorities for next 2 months**<br>• Model of Care – Continue to Identify focus groups for key themes with regard to gaps and opportunities and start to implement positive change<br>• Provision and interpretation of BI data reports to support Identification of people in their last 12 months of life (including Palliative Care register on SystmOne to help identify palliative care case load) linking with primary care.<br>• Collaborative approach to Virtual Ward to support PEoLC. | • Advanced care plans in place for 50% of patients at the end of life by March 2024<br>• Virtual ward effectively utilised – end of life pathway in place and capacity to deliver by March 2024<br>• 70% of patients die in their preferred place of choice by March 2024<br>• 10% reduction in admissions within 48 hours of end of life by March 2024<br>• 24/7 support for end of life patients and their relatives/ carers is available by March 2024<br>• ReSPECT is in use 100% by March 2024 |

| Equality, diversity and inclusion | Measure of success | RAG | Progress update |
|---|---|---|---|
| We will address the disparity between different groups where staff feel discriminated against and not included, by:<br>• Growing active, engaged staff networks with visible exec support<br>• Based on our Trust values, agreeing and adopting anti-racist behaviours with support provided for line managers and staff to live these fully<br>• Developing inclusive leadership practices for leaders at all levels<br>• Embedding diversity principles throughout our recruitment processes, enabling the process to be free from bias at all stages<br>• Embedding equality into policies, strategies and key focal areas of Trust practice, aligned to WRES and WDES priorities<br>• Establishing guidance and support for all managers and colleagues around reasonable adjustments<br>• Enabling all staff, including those with visible and invisible disabilities, to feel valued at work<br>• Enabling staff development & career progression to be accessible to all<br>• Making all induction programmes inclusive | Prepare to deliver against the Inclusive Leadership Pledge by March 2024 | NS | All actions integrated within the Inclusion workplan |
| | Action taken and reported for all EDI-related speak up concerns by October 2024 and ongoing | | All concerns raised are acted upon and reported work. Further work is planned to review details more closely |
| | Framework and guidance for reasonable adjustments published by March 2024 | | Draft governance framework developed, with revised guidance and processes being tested and reviewed |
| | Every reported case of harassment, bullying, discrimination or abuse is acted upon (with feedback) by March 2024 | | Every formal reported case is investigated and an outcome reported back to those concerned. Further work is planned to review details more closely |
| | Assessment / completion of EDS inclusive leadership domain. Increase staff diversity at Band 8a and above (longer term) | NS | Meetings arranged with Patient Experience Team to progress integrated Trust approach |
| | Increase in staff with protected characteristics achieving career progression (longer term) | NS | Integrated actions within the Inclusion workplan |
| | Improvement in WRES & WDES indicators (longer term) | | Integrated actions within the Inclusion workplan |
| | Improvement in staff survey indicators (longer term) | NS | Resultant of these actions. Await national staff survey 2023 results |

| Line management development | Measure of success | RAG | Progress update |
|---|---|---|---|
| We will promote the value of great line management and support, and develop all our current and future line managers:<br>• Reviewing line manager spans of control to ensure roles are sustainable<br>• Agreeing values-based outcomes for what great line management means at WSFT<br>• Developing and delivering a holistic and inclusive package of learning and development for line managers, staff members and teams<br>• Review, revise and re-launch the appraisal process, linking in career conversations and focusing on quality discussions | No line manager with more than an agreed number of direct reports by March 2024 | | Working group formed and progressing in divisions |
| | Values-based line management standards agreed and published by December 2023 | | Work progressing and initial scoping work completed. Timeline extended to March 2024. |
| | Coaching and mentoring framework agreed by September 2023 | | Draft completed, requires final amendment before approval. Delayed due to prioritisation of launch of coaching programmes and change in coaching lead. Plan to finalise when new staff member in post who can own and progress. |
| | Learning Hub launched by September 2023 | | Launched on 27 September after initial pilot period. |
| | Line manager development package published and in delivery by December 2023 | | Aspiring Leadership, Stepping into Leadership and Operational Leadership all launched. 180 places are available with over 150 filled |
| | Appraisal completion rates at 90% by December 2023 | | In October Trust wide completion rates were 87.4%, which is an increase from 83.2% in September. |
| | Improvement in staff survey indicators (longer-term) | NS | Resultant of these actions. Await national staff survey 2023 results |

**Red: Delayed / Not on track** **Amber: At potential risk** **Green: On track** **NS: Not yet started**

| First for the Future - Delivery on prevention and proactive care | | | |
|---|---|---|---|
| Action | Activities/progress in last 2 months | For the next 2 months:<br>- Key risks<br>- Deliverables / milestones | Measures of success |
| Launch the WSFT Prevention, health inequalities and personalised care strategy by 31st August 2023<br><br>Train colleagues in prevention, health inequalities or personalised care by 31st March 2024.<br><br>*Exec. lead – Paul Molyneux*<br>*Clinical delivery lead: Helena Jopling* | The prevention, health inequalities and personalised care strategy was approved and adopted by the Board on 1st December 2023.<br><br>668 colleagues had been trained in PHIPC topics by 31 December 2023. Topics include:<br>• Health coaching<br>• Learning disability and autism awareness<br>• Smoking cessation<br>• Making every contact count | No risks escalated.<br><br>Widen uptake of MECC through Totara platform<br><br>Embed PHIPC into the alliance-wide training passport | • Prevention, health inequalities and personalised care strategy is approved by the board and published on the trust website<br>• 1,000 colleagues trained in prevention, health inequalities or personalised care |

| Action | Activities/progress in last 2 months | For the next 2 months:<br>- Key risks<br>- Deliverables / milestones | Measures of success |
|---|---|---|---|
| Continue and expand the inpatient tobacco dependence service, supporting 350 people to stop smoking by March 2024, 40% of whom will live in the most deprived areas<br><br>*Exec. lead – Paul Molyneux*<br>*Clinical delivery lead: Jessica Hulbert* | Aim partially met: 542 people have received support from the tobacco dependence service. The service is now rolled out to all inpatient wards including Rosemary Ward and is beginning roll out to outpatient clinics.<br><br>• Quit rate is currently 29%<br>• Percentage of people supported from 40% most deprived areas is currently 31%<br><br>The gap in community-based services for follow-up has been filled through extra funding for WSFT to employ a second tobacco advisor – appointed and due to start 01 March 2024.<br><br>WSFT team complimented as having the best data quality in the region.<br><br>The trust continues to support the design and development of the Feel Good Suffolk (FGS) service, contributing to service design and providing shadowing for FGS advisors who are qualifying in smoking cessation support. | No risks escalated.<br><br>Increasing the quit rate is the priority for the rest of the year.<br><br>Inclusion of nicotine replacement therapy in TTO medication and availability in community pharmacies are barriers – risk is being managed by Clinical Effectiveness Governance Group - QI project commenced.<br><br>The new advisor will also be facilitative. A stratified approach will be taken with more intensive support offered to people living in the 40% most deprived areas. | • Number of people who successfully quit for 4 weeks<br>• Percentage of people who successfully quit who live in the 40% most deprived lower super output areas |

| First for the Future - Develop and expand our transformation capacity and capability | | | |
|---|---|---|---|
| Action | Activities/progress in last 2 months | For the next 2 months:<br>- Key risks<br>- Deliverables / milestones | Measures of success |
| Review the structure and capacity of the change hub<br><br>*Exec. lead – Nicola Cottington*<br><br>*Operational delivery lead: Matt Keeling* | • 6-month review of the structure and function of the West Suffolk Change Hub presented at SLT in October 2023.<br>• SLT supported future focus of change hub on implementation of clinical and care strategy<br>• Board and renumeration committee approval for executive director of strategy and transformation post to be established<br>• Executive director of strategy and transformation role advertised in December 2023<br>• Identified Future Systems Clinical & Care Strategy priorities for 24/25<br>• Delivery of a portfolio of programmes presented at Corporate PRM including Focus on Flow as part of seasonal response.<br>• Following self-assessment of the NHS Impact methodology by the Change Hub, this was built on with wider input, at SLT. | Key risks<br>• The organisation does not have an agreed change methodology that is deployed across all services<br>• There is a skills and capacity gap in relation to change methodology and project management across the organisation<br>• Delivery chains, metrics and benefits are not always clear, linked to points above<br><br>Deliverables / milestones<br>• Appointment of executive director of strategy and transformation in Q4.<br>• Metrics, milestones and benefits will continue to be monitored monthly.<br>• Objectives and deliverables linked to Future Systems Clinical and Care Strategy priorities to be finalised in Q4 2023/24<br>• Consolidation of all UEC recovery plans into a single rapid improvement plan for delivery in Q4 | • Revised structure in place by April 2024<br>• Explore options in relation to leadership and support to the transformation and change function |

# Strategy priorities 2024-25

NHS
West Suffolk
NHS Foundation Trust

# Strategic priorities for 2024-25

- Delivery of **long term sustainability for health and care in west Suffolk** (First for Patients and First for the Future)
- A strong priority on **Equality, Diversity and Inclusion** to address the disparity between different groups where the evidence shows that staff are disadvantaged or feel discriminated against (First for Patients and First for Staff)
- A large focus on **line management development** given the feedback from What Matters To You 2, the National Staff Survey and the Freedom to Speak Up Champions alongside the impact this would have on a large portion of the organisation (First for Staff)
- A step change in delivery on **prevention and proactive care** given the modelled demand projections and the explicit need for this to support the Future Systems Programme (First for the Future)

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

Rationale and drivers:

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

# Delivery plan 2024-25

| SMART actions | Measures of success | By who | Live Well domains/ other strategies |
|---|---|---|---|
| Priority: **Delivery of long term sustainability for health and care in west Suffolk** | | | |
| • Plan to implement the components of NHS IMPACT (building a shared purpose and vision; investing in people and culture; developing leadership behaviours; building improvement capability and capacity and embedding improvement into management systems and processes). | • Timebound, resourced plan agreed by Board by Q2 | Exec sponsor: Director of Strategy and Transformation (TBA) | |
| • Proactively grow our community services division through:<br>- new, community-focussed clinical pathways in line with the implementation of the clinical and care strategy (see related action below)<br>- shift of resources and activity from acute divisions to community division<br>- productivity improvements within community services | • In line with Future System workforce modelling, reduce acute workforce whole time equivalent (wte) growth to 2.8% over 24/25 and increase community wte by 3.6%<br>• Increase in urgent community response activity by 10% by March 2025 compared to 23/24 baseline<br>• Increase in virtual ward activity to 100 bed capacity and 80% occupancy by March 2025, monitoring a monthly trajectory towards this goal<br>• 24/25 business plans in community and acute divisions reflecting ambitions above, signed off by 31st March 2024 | Exec sponsor: Chief Operating Officer (Nicola Cottington)<br><br>Clinical delivery lead: Clinical Lead for Quality and Safety, Community and Integrated Therapies Division (Karen Line)<br><br>Operational delivery lead:<br>Associate Director of Community Adult Services (Kevin McGinness) | |

# Delivery plan 2024-25

| SMART actions | Measures of success | By who | Live Well domains/ other strategies |
|---|---|---|---|
| Priority: **Delivery of long term sustainability for health and care in west Suffolk** | | | |
| • Improve productivity within acute services. | • Improve capped theatre utilisation to 85% by March 25, monitoring a monthly trajectory towards this goal<br>• Align 85% of high volume, low complexity theatre activity with GIRFT cases per list standards by March 2025<br>• Implement British Association of Day Surgery recommended rates of day surgery for all specialties by March 2025<br>• Reduce outpatient follow ups in line with trajectory:<br>Q1 0%<br>Q2 -7.5%<br>Q3 -15%<br>Q4 - 25% | Exec sponsor: Chief Operating Office (Nicola Cottington)<br><br>Operational delivery lead: Deputy Chief Operating Officer (Matt Keeling) | All Live Well domains Clinical and care strategy |
| • Deliver reduction in our underlying deficit. | • Delivery of agreed 2024/25 cost improvement plan leading to reduction in underlying deficit. | Exec sponsor: Director of Resources (Craig Black)<br><br>Clinical delivery lead:<br><br>Operational delivery lead: | |

# Delivery plan 2024-25

| SMART actions | Measures of success | By who | Live Well domains/ other strategies |
|---|---|---|---|
| Priority: **Delivery of long term sustainability for health and care in west Suffolk** | | | |
| • Plan and deliver against the 2024-25 priority areas for service pathway change within the Clinical and Care Strategy, in addition to the continuation of the embedding of the 2023-24 priorities which are likely to span multiple years as Change Hub supported projects to shift to business as usual. | • Outpatient department transformation - 25% of appointments to a virtual platform and 25% of appointments to be delivered at peripheral locations<br>• Scope, review and propose an optimal emergency village model of care for front door services (ambitions 30-33)<br>• Develop a programme of work in support of our Integrated Neighbourhood Teams (INTs) including the ambition to reduce unnecessary emergency admissions (ambitions 18-22)<br>• Review and develop children and young people's services (ambitions 13-17)<br>• Deliver a test of change which demonstrates the "left shift" approach by moving the delivery of an identified service from the acute hospital to community<br>• All priorities will be facilitated by the Change Hub | Exec sponsor: Executive Medical Director (Paul Molyneux)<br><br>Operational delivery lead: Director of Operations for Future Systems Programme (Alex Baldwin) | All Live Well domains<br>Clinical and care strategy |

## Priority: Creating an inclusive culture where everyone belongs

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

Rationale and drivers:

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

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

## Priority: Supporting and developing leaders and managers

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

Rationale and drivers:

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

*(we will want to amend this list with early learning from 2023 staff survey)*

# WSFT Strategy priorities 2024/25

| SMART actions | Measures of success | By who | Live Well domains / other strategies |
|---|---|---|---|
| **Priority: Creating an inclusive culture where everyone belongs** | | | |
| • Proactively focus on reducing bullying, harassment and discrimination, particularly allyship, inclusive leadership practices and behaviours, inclusive recruitment processes, and reducing health inequalities<br>• Embed Equality Impact Assessments into patient and staff facing decision making, policies, strategies, processes, and business activities<br>• Embed guidance and processes for workplace adjustments for patients and staff, including implementation of a digital passport and digital adjustments toolkit for staff, and accessibility of information for patients | • Improvement in related WRES and WDES indicators in 2025<br>• Improvement in related NHS staff survey indicators in 2026<br>• Reduction in patient complaints related to bullying, harassment, discrimination and accessibility of information | Lead: Executive Director of Workforce & Communications (Jeremy Over) | People and culture plan 2024/25 |

# WSFT Strategy priorities 2024/25

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

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

Rationale and drivers:

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

# Delivery plan 2024-25

| SMART actions | Measures of success | By whom | Live Well domains/ other strategies |
|---|---|---|---|
| **Priority: A step change in delivery on prevention and proactive care** | | | |
| As part of the WS Alliance, WSFT will play its role in achieving the SNEE ICS goals for identification and management of cardiovascular disease for the West Suffolk population<br><br>• 80% of the expected number of people with high blood pressure (BP) are diagnosed by 2029<br>• 80% of the total number of people already diagnosed with high BP are treated to target as per NICE guidelines by 2029<br>• 85% of the expected number of people with Atrial Fibrillation (AF) are detected by 2029<br>• 90% of patients with AF who are already known to be at high risk of a stroke to be adequately anticoagulated by 2029<br><br>We will do this by<br><br>(a) Optimising **use of population health management data** to target capacity as a system<br><br>(b) Optimising **contacts with patients** for prevention goals<br><br>(c) Promoting **healthy lifestyle choices** | <u>Use of Population health management data</u><br>• Reconciliation of hospital data on hypertension with GP practices (Mar 25)<br>• Good use of Trust PHM data in alliance work with target communities<br><br><u>Optimise Trust contacts with patients</u><br>• Community health teams work with those patients on their caseloads where GP practices are seeking improvements in BP & AF recording and management<br><br><u>Support Healthy lifestyle choices</u><br>• Complete blood pressure health promotion campaign with a reach of 50,000 people using WSFT media channels<br>• Increase the impact of exercise referral pathways with Abbeycroft Leisure by 25% by March 2025<br>• Participate in design and success of Feel Good Suffolk (includes support with exercise, smoking cessation and weight management) – achieve high levels of appropriate WSFT referrals | Exec sponsor:<br>West Suffolk Alliance Director<br><br>Clinical lead:<br>Clinical lead for public health | Stay Well domain |
| • Create a smokefree site at West Suffolk Hospital, using a compassionate approach<br><br>Smoking remains the single biggest cause of preventable illness and death and the biggest cause of health inequalities. | • Trust board to sign the NHS Smokefree pledge and adopt a tobacco control plan by end of Q1<br>• All inpatients and staff on all sites have access to stop smoking support by end of Q2<br>• A measurable reduction in people smoking on the West Suffolk Hospital site by end of Q3 | Exec sponsor:<br>Executive Medical Director<br><br>Clinical lead: Public health manager | Be Well domain |

# 2.2. Future System board report

To Assure

Presented by Craig Black

| Committee | |
|---|---|
| **Report title:** | Future System Board Report |
| **Agenda item:** | Future System Board Report |
| **Date of the meeting:** | 26th January 2023 |
| **Sponsor/executive lead:** | Craig Black |
| **Report prepared by:** | Gary Norgate |

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

| **Executive Summary** |
|---|
| **WHAT?**<br>*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?**<br>*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?**<br>*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 definition will then form the basis for the creation of an outline business case, securing full planning permission and the appointment of a build partner. |
| **Action Required** |
| The Board are asked to note the content of this report. |

| | |
|---|---|
| **Risk and assurance:** | |
| **Equality, Diversity and Inclusion:** | |

| | |
|---|---|
| **Sustainability:** | |
| **Legal and regulatory context** | |

Future System Board Report

| | |
|---|---|
| **1.** | **Introduction** |
| 1.1 | The following paper aims to update the Board on progress being made towards the building of a new hospital in West Suffolk. Specifically, the paper highlights:<br><br>• Work completed to optimise our schedule of accommodation.<br>• The plan to engage potential construction partners.<br>• Improving future governance as our scheme develops; and<br>• Progress being made on site to ensure readiness to build.<br><br>The following paper provides an update on each of these areas. |
| **2.** | **Background** |
| 2.1 | As reported previously, West Suffolk Foundation Trust's plans to build a new hospital are part of the wider Governmental programme that aims to build "40 new hospitals by 2030". |
| 2.2 | More recent developments have seen the announcement that seven new schemes, predominantly those hospitals constructed from reinforced aerated autoclaved concrete (RAAC), have been included in the New Hospital Programme (NHP) and will be 'prioritised' to ensure they are completed in the most efficient way. |
| 2.3 | This announcement has caused some of the other, more complex, schemes (e.g. those representing significant service re-configuration and therefore requiring extensive public consultation) to slip beyond the previously announced 2030 deadline. |
| 2.4 | The West Suffolk scheme is one such priority and as one of the most advanced of the RAAC projects continues to be singled out as a 'pathfinder'. Consequently, WSFT are the only Trust to; have had its strategic case (SOC) formally considered; to have received funding for the development of its outline business case (the second of three mandatory cases) and to have received funding for those enabling works that support the pursuit of full planning permission and the ability to commence construction. |
| **3.** | **Detailed sections and key issues** |
| 3.1 | The work to review the proposed designs for a new West Suffolk Hospital is nearing its conclusion. In addition to the demand, clinical and technical reviews already conducted, an additional benchmark of forecast activity and departmental size between the designs of West Hertfordshire, West Suffolk and Harlow schemes is being conducted on behalf of our Region by KPMG. This exercise will compare the activity adjusted sizes of the following departments and will allow us to understand any outliers and differences in approach:<br><br>• Inpatient areas<br>• Outpatient areas<br>• Accident and Emergency<br>• Maternity<br>• Radiology<br>• Theatres<br>• Pathology<br>• Diagnostics<br>• Administration<br><br>We expect this work to be completed before the end of February. |

| | |
|---|---|
| 3.2 | As the aforementioned reviews are completed, so work to agree their outputs and conclusions becomes an area of focus. To this end, sessions are planned with the New Hospital Programme (NHP) team and all adjustments will be clinical co-assessed for safety and operational efficacy. Recommendations, and their impact, will then be presented to the WSFT Executive team before becoming the basis for the next level of technical and commercial planning. We aim to conclude the "right-size" debate by end of January with a view to submitting a paper to the Joint Investment Committee (JIC[1]) by the end of February. This schedule will then allow us to proceed with detailed design drawings which, in turn will allow the completion of our Outline Business case in a timeline that supports the operational opening of a new hospital by 2030. |
| 3.3 | Capital is far from limitless and Government are appropriately focussed on ensuring value for public money. Consequently, the New Hospital Programme have submitted a revised national programme business case which is currently working its way through the governance system to HM Treasury. An outcome, which will impact the entire programme, is expected in Spring 2024.<br>The other common challenges facing every scheme in the Programme include:<br><br>a) The impact that capital charges and depreciation will have upon the balance sheet and income and expenditure accounts of both Trust's and Integrated Care Systems.<br>b) The ability of a Scheme to attract a construction partner in a market that will be significantly stretched by other hospital projects and, locally, by schemes such as the new nuclear facility at Sizewell. With these two points in mind, we are working with colleagues from across the integrated care system (ICS) and region to drive a national discussion into the revenue impact of a new hospital. The contributing factors, e.g. depreciation, impairment, transition to the new hospital and the cost of capital (termed the public dividend) are understood, however, means of mitigating such charges remain elusive and will apply nationally.<br><br>To ensure the West Suffolk scheme is attractive to the construction market, our designs have been reviewed by a team of construction experts and optimised in terms of their "buildability" i.e. the extent to which they lend themselves to modern methods of construction and comply with national standards and available pre-fabricated elements.<br>With engaging the construction market in mind, we have yet to conclude the ideal time at which to issue a formal tender. On one hand, the traditional approach would be to gain formal agreement to an outline business case and then issue a tender for the preferred option contained within. That said, feedback from earlier schemes in the NHP suggests that it is more efficient to engage construction partners in the earlier design phases. Consequently, it is the recommendation of the Future System team that the tendering process be started in March, following agreement of the "right sized" hospital. Agreement to this approach will be sought from NHP in the coming weeks. |
| 3.4 | Once the right-size of hospital has been agreed, we expect detailed design work and commercial engagement to increase in pace and complexity. Consequently, NHP have engaged Q5 Partners[2] to review the governance arrangements of each scheme and, therefore their respective readiness to proceed with the next level of project development. Following a workshop with the Future System Team, Q5 concluded that our model of governance was mature, effective and well established, however, they also made a range of recommendations that we intend to adopt as we move closer to making important technical, operational and commercial decisions. The key change is the proposed advent of an executive programme board, chaired by a non-executive director, dedicated to the future system programme and comprising key executives and subject matter experts from across the Trust and NHP. The wider Programme Board will continue as a means of ensuring engagement from our System Partners. |
| 3.5 | In terms of our on-site "enabling works", we have secured our position in the schedule of UK Power Networks which will ensure the necessary power upgrades are completed (on site and within the wider power network) in advance of a new hospital becoming operational. Archaeology work is well underway, progressing well. The trenching of our Hardwick Manor site is nearing completion and work on the exploration of our construction compound area will commence in February. |

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

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

| | |
|---|---|
| **4.** | **Next steps** |
| 4.1 | We hope to have concluded the “right size” debate by the end of February which will allow detailed designs to be completed by August which in turn will enable the completion of an OBC by February 2025. These key milestones support a 2026 commencement of construction and the delivery of a new hospital by 2030. |
| 4.2 | As the design works start, understanding and mitigating the revenue impact of a new hospital, the construction of the benefits case and the launch of a tender for the primary construction partner will become the main areas of focus. |
| **5.** | **Conclusion** |
| 5.1 | The building of a new West Suffolk Hospital remains a priority within the New Hospital Programme. |
| 5.2 | The review of the preferred hospital design is nearing completion and will allow the project to commence with detailed drawings and the completion of its outline business case. Enabling works aimed at discharging our planning conditions and preparing our site for construction continue positively in line with plans. |
| 5.3 | Work to satisfy our pre-commencement planning conditions is physically underway. |
| 5.4 | The status of the project to build a new West Suffolk project remains Green |
| **6.** | **Recommendations** |
| | The Board are asked to note the content of this report. |

# 2.3. West Suffolk Alliance and SNEE Integrated Care Board

To Assure

Presented by Peter Wightman

# West Suffolk Alliance Director Update January 2024

## 1. Alliance Partnership Meeting (12 December)

Partners from across the west Suffolk Alliance took part in a workshop-style event to co-design and prioritise the key change activity needed to deliver our vision for a community-based health and care model in west Suffolk (the "left shift"). Discussions at the workshop included public health, future systems programme, people and communities, primary care, care market and integrated neighbourhood teams. The key themes to emerge were: communication; shared vision; workforce; and finance. The Alliance has established a Health and Care Community Delivery Group which will have oversight of this agenda, including shift needed to support future systems programme.

## 2. West Suffolk Alliance Committee Meeting (9 January 2024)

### *2.1 Start Well Domain - First 1001 Days*

The ICS Start Well Domain has set the priority focus to be the first 1001 days of life in 2024/25. This reflects the findings of The Marmot review (2010) which states the following:

> ***"…health equity in the first 1001 days is the starting point and most impactful action to address the social and economic burden of chronic diseases in the population."*** It addresses the "causes of causes" i.e. primary prevention. Emotional health, physical wellbeing, social skills, cognitive and language skills that develop in a child's first 1001 days (from conception) form the foundations for success in school and in later life as well as their health and wellbeing throughout their life.
>
> It recommends a multilevel approach:
>
> - Programme level interventions delivered directly to children and families.
> - Community and service system level interventions that seek to build more supportive communities and better coordinated and effective service systems. "It takes a village to raise a child".
> - Structural and societal level interventions that address the structural (e.g. government policy) and wider social factors (e.g. attitudes and values) that influence child and family outcomes.

The Committee discussed how to take this forward in West Suffolk and agreed next steps as: identifying WS sponsor executive and public health capacity, with a view to identify 2 key objectives for 2024/25. The Committee suggested that this links closely to actions for Health Inequalities.

### *2.2 Virtual Ward*

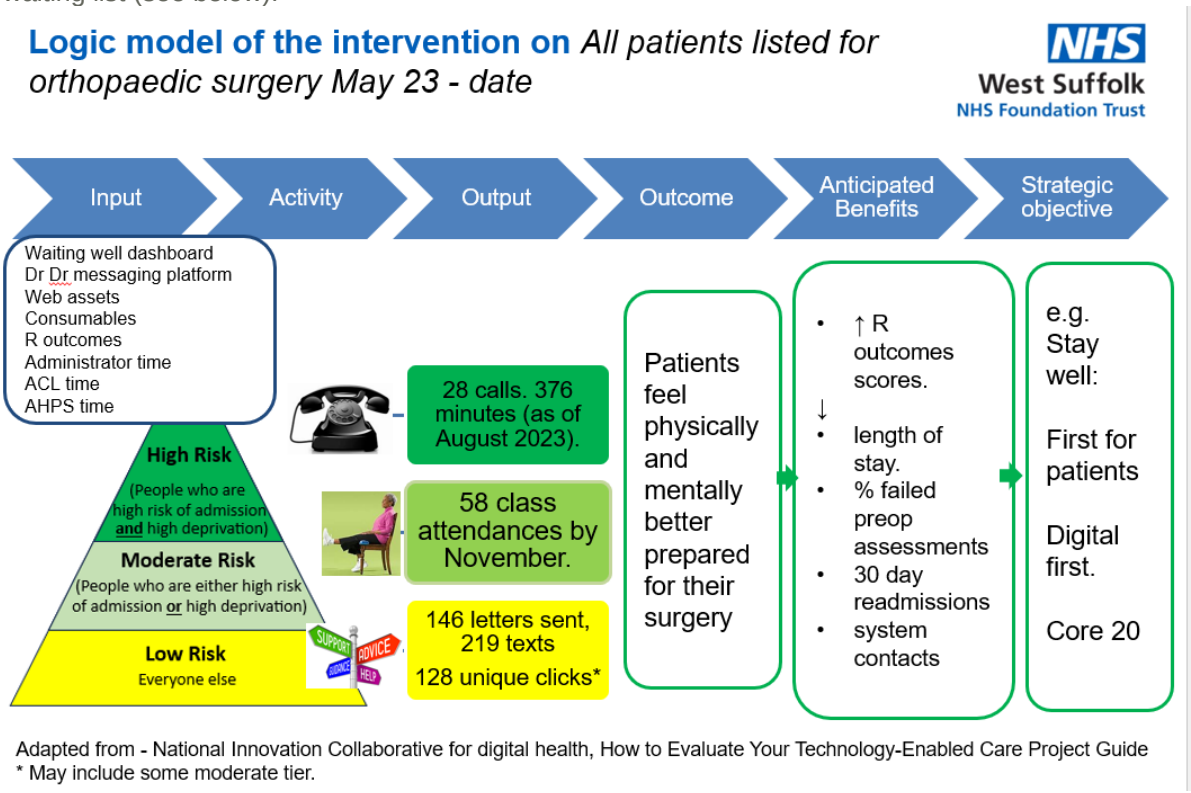
The Committee received an update on the west Suffolk virtual ward launched on 28 November 2022:
- In 13 months 674 patients cared for (6600 bed nights)
- Patients report very high satisfaction rates
- Current capacity is 40 beds, increasing to 60 beds by March 2024
- Currently 5 pathways, more being introduced (including diabetes and trauma and orthopaedics)
- Little workload impact on primary care - patient know it's a WSFT service

Key challenges:
- Staff recruitment and retention, particularly with nursing.
- Clinician confidence and awareness to optimise use of pathways needs to increase to ensure those patients who are eligible do access the service.

The Committee commended the team for their hard work in establishing the virtual ward in west Suffolk and noted the plans for development.

## 3. Waiting Well

The Committee received a presentation on the WSFT Waiting Well pilot with patients on the orthopaedic waiting list (see below).




A survey of 100 patients who were contacted as part of this pilot has shown that 70%+ people now feel ready for surgery, understand how to keep well before and to feel motivated to lead a healthy lifestyle after. There has been relative low uptake to date of offers to attend local exercise classes, and ways to remedy this are being explored. Final evaluation is due August 2024.

## 4. Discharge Fund 2024/25

The Committee noted the initial priorities for use of the discharge funds for 2024/25 (increasing to £3.7m). This will be allocated to schemes that adhere to the principles of the discharge fund. The long list of schemes being prioritised is below. The 2023/24 schemes have been monitored and evaluated and have contributed to the WS low waiting times for pathway 1 and 2 patients. A final decision is due by the end of January. Schemes will be monitored and reported to the Age Well domain and by exception to the Committee during 2024/25.

| Existing schemes continuing | Potential new schemes |
|---|---|
| • 18 Community Beds and wrap around support<br>• Home First expansion<br>• External reablement | • Digital<br>• End of life hospice capacity<br>• Enhanced Overnight support – Early Intervention Team<br>• Stepping Home<br>• Total Mobile System licence<br>• Additional Discharge Vehicle |

| | |
|---|---|
| | • Heart Failure<br>• RN & HCA palliative support<br>• Social Prescribing - Hospital |

## 5. Dementia Strategy

The Committee supported the dementia strategy which is due for approval by the Suffolk Health and Wellbeing Board and SNEE ICB in March. A work plan (bespoke to each Alliance) will then be co-produced and priorities will be established in conjunction with both the Age Well and Die Well domains.

## 6. Primary Care

The Committee noted the following:

- *Forest Health Practice in Brandon:* Procurement process starts is January for the contract for primary medical services (given the current contract is reaching the end of its term). New service to be mobilised by October 2024.
- *Winter appointments* - The Alliance has commissioned practices to offer additional GP team appointments during December – February to support the peak in respiratory activity and create capacity for further proactive respiratory care.
- *System development funding:* The ICB has approved bids for these funds that aim to reduce demand, increase capacity, improve access, integration and working at scale in primary care (appendix 1).

## 7. Integrated Transport Service Bid

The Committee noted that an integrated transport service bid has been submitted to Suffolk County Council. If successful, this bid would encompass the current WSH Ride service from Haverhill to WSFT main hospital site. The bid outcome is anticipated before the end of January 2024.

## APPENDIX – FOCUS ON SYSTEM TRANSFORMATION SUPPORTING PRIMARY CARE

Could we just send Helen's slides with this? I think they're really clear and give a really good amount of information to inform a discussion.

| Scheme | Proposed benefits and outcomes |
|---|---|
| Expanding The Third Space (TTS): Monoclonal Gammopathy of Uncertain Significance (MGUS) Project to include Prostate Specific Antigen (PSA) patients | TTS was set up in June 2022 and pioneers a different approach to managing elements of acute and primary care demand by diverting non-Face to Face workload to a West Suffolk-wide service where patients can be safely managed by a new remote clinical workforce. The aims of The Third Space are to:<br>• Improve quality and safety for these conditions that cross primary and secondary care<br>• Promote patient empowerment and increase knowledge of the condition.<br>• More efficient use of clinical time in primary and secondary care.<br>• Promote the use of digital platforms to implement safe, remote monitoring services.<br>• Develop Alliance working.<br>Continuation and expansion of the project to include Prostate Specific Antigen (PSA) patients and other patient groups identified by clinicians. |
| The Clinical Community Collaboration and Connection Conference "C's the day" | The purpose of this forum will be to provide an opportunity for the West Suffolk professional community, and those that support them, to meet together in person, to network, to debate challenges, to share ideas and to build better relationships at an individual level**.** To create the space for collaboration. |
| Community Diabetes Support (*Increase specialist Diabetes Team, provide fitness trackers and specialist kits* | Recently discharged or diagnosed patients are supported daily for a short intense period to manage their insulin administration, with teaching and confidence building to be independent. |
| Community SystmOne platform – diabetes specialist clinics in primary care (west Suffolk) | WSFT community diabetes specialist nurses currently hold multiple specialist clinics in GP practices for patients with complex diabetes. DSNs currently spend excess time crafting letters containing individual clinic notes to GPs for follow-up, prescribing etc. This will support efficiencies and collaborative working. |
| Consultant: GP diabetes upskilling and education (west Suffolk) | To align provision of Consultant: GP diabetes specialty training with that already provided in IES and NEE. |

# 3. PEOPLE AND CULTURE

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

To Assure

Presented by Krishna Yergol

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

| Originating Committee: Involvement Committee | | | Date of meeting: 20 December 2023 | | |
|---|---|---|---|---|---|
| Chaired by: Krishna Yergol - Non executive Director | | | Lead Executive Directors: Jeremy Over and Sue Wilkinson | | |
| **Agenda item** | **WHAT?** *Summary of issue, including evaluation of the validity the data** | **Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial 4. Minimal | **For 'Partial' or 'Minimal' level of assurance complete the following:** | | |
| | | | **SO WHAT?** *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk* | **WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)* | **Escalation:** 1. No escalation 2. To other assurance committee / SLT 3. Escalate to Board |
| 6.1 | First for Staff: Car Parking Eligibility paper presented by Chris Todd. Paper outlined options for future eligibility for on-site parking and made recommendations for next steps. | Reasonable | The Committee supported the recommendation from the Car Park Eligibility group to pursue a points-based system (Option 4) which includes defined categories for receiving permits or points to support getting a permit if space allows. Committee agreed that the implementation will require a full engagement exercise (Route 3) to ensure feedback from all groups is captured and considered for the planned changes to take effect from October 2024.<br><br>The Committee recognised the importance of balancing the need for further engagement work and the need to build | The committee endorsed the paper's submission to the Trust Board on 26th of January 2024. | No escalation |

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|---|---|---|---|---|---|
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| | | | momentum on implementation of changes, and recommended an iterative approach given the diverse set of problem statements that this work is seeking to address. | | |
| 6.2 | First for Staff: People and Culture Plan update presented by Jeremy Over. Paper provided an update on progress on priorities across the three domains:<br>1. Building a positive, inclusive culture that fosters open and honest communication | Substantial | The committee acknowledged the progress so far and thanked the team for supporting and enabling cultural transformation through the delivery of specific priorities outlined in the plan.<br>The committee recommended the inclusion of long-term measures of success for cultural transformation whilst also reporting on specific delivery milestones. | Further work to be planned to support band 8 diversity and inclusion. To include: Career development, succession planning, and pipeline for senior leadership<br>Further work on selection methodology<br>Formulating the next tranche of actions and priorities based on staff survey results | No escalation |

| Originating Committee: Involvement Committee | | | Date of meeting: 20 December 2023 | | |
|---|---|---|---|---|---|
| Chaired by: Krishna Yergol - Non executive Director | | | Lead Executive Directors: Jeremy Over and Sue Wilkinson | | |
| **Agenda item** | **WHAT?** *Summary of issue, including evaluation of the validity the data** | **Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial 4. Minimal | **For 'Partial' or 'Minimal' level of assurance complete the following:** | | |
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| | 2. Enhance staff wellbeing<br>3. Invest in education, training and workforce development | | | | |
| 7.1 | First for Future: WRES and WDES indicators presented by Carol Steed.<br>Update on WRES and WDES indicators and progress on Inclusion Workplan. | Reasonable | The committee acknowledged and recognised the areas of good performance identified within WRES and WDES – career progression and promotion for colleagues in non-clinical roles, and disabled representation in the workforce. | Committee endorsed the proposed actions on career progression for clinical staff, communication to reiterate what constitutes unacceptable behaviour, and consultation with Black and Asian staff via Reach network.<br>Strengthening reporting mechanisms and collation of data set on ethnicity data. | No escalation |
| 7.2 | First for Future: Education report presented by Carol | Substantial | The committee considered the progress and positive impact of Education and Training to the | Further work to consider whether education programmes can be used as a lever to influence wider marketplace | No escalation |

| Originating Committee: Involvement Committee | | | Date of meeting: 20 December 2023 | | |
|---|---|---|---|---|---|
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| | Steed<br><br>Regular update on training and education issues. | | Trust's FIRST values, including the GMC survey results. | to address skills gaps.<br><br>Further work to consider how the Education and Training levers can be joined-up across the system (ICS). | |
| 8.1 | First for Patients: report from Patient Experience Group presented by Anna Wilson<br><br>Regular update from Patient Experience Group | Reasonable | Committee noted the issues and endorsed the planned actions related to accessibility for Patients (signage, reasonable adjustment flags, website accessibility), patient consent process, learning resources and support, and communications.<br><br>The committee recommended taking a holistic approach to accessibility to ensure that all stakeholder groups are considered. | The committee recommended that feedback from patients is sought to evaluate whether the implementation of changes has resulted in better patient experience.<br><br>The committee also requested an update in 6 months' time. | No escalation |
| 9.1 | Governance: People and Culture Leadership Group update. Paper | Reasonable | Committee noted the updates on WRES/WDES improvement project to improve EDI data, | Further work to monitor and improve appraisal compliance levels, which | No escalation |

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|---|---|---|---|---|---|
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| | presented by Claire Sorenson.<br><br>Assurance on SLT's ambitions and commitments in relation to workforce and organisational culture. | | autism and learning disabilities mandatory training. Endorsed the launch of the 'Welcome to the Trust' project to welcome new colleagues face-to-face. Supported the proposal to set a standard for SPA time.<br><br>The committee was assured on the Workforce KPIs and agreed that further work should be undertaken to monitor and improve appraisal compliance levels. | currently stands at 87%.<br><br>Further work to establish the parameters for compliance on learning disabilities and autism mandatory training (Oliver McGowan) | |
| 9.2 | New Appraisal Framework (non-medical) paper presented by Phillipa Lakins<br><br>New appraisals | Reasonable | The committee noted the summary findings of the internal review and external benchmarking, and feedback from the new appraisals framework pilot. | Endorsed the launch of the new appraisals process from January 2024 and requested an updated in 6 months' time. | No escalation |

| Originating Committee: Involvement Committee | | | Date of meeting: 20 December 2023 | | |
|---|---|---|---|---|---|
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| | process to enable ongoing supportive, performance and development conversations, and promoting wellbeing. | | | | |

**See guidance notes for more detail*

## Guidance notes

### The practice of scrutiny and assurance

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

# 3.2. Freedom to Speak Up Report Jane Sharland, FTSU Guardian in attendance

To inform

Presented by Carol Steed

## Freedom to Speak Up: Guardian's Report Q3 2023 -2024: October, November, December 2023.

### Introduction: What is Freedom to Speak Up?

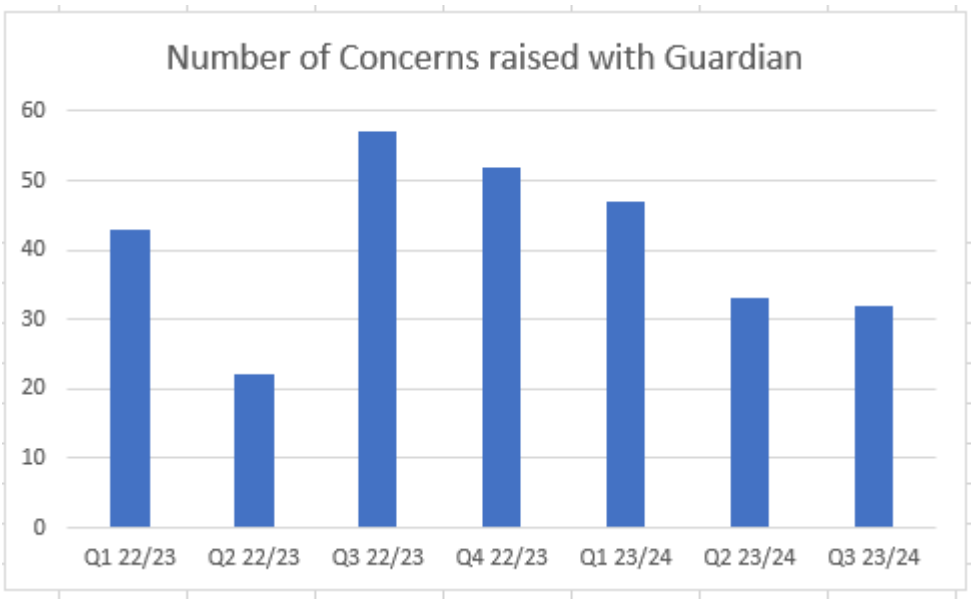
The National Guardian's Office (NGO) 6th annual report for 2022-2023 was laid before Parliament in November 2023. It begins with this definition:

*In healthcare, Freedom to Speak Up is about feeling able to speak up about anything that gets in the way of doing a great job. That could be a concern about patient safety, a worry about behaviours or attitudes at work or an idea which could improve processes or make things even better.*

Throughout this report, I will make comparisons with the national statistics from the NGO report so there is visibility on how we are doing compared to national data.

### Data Sent to National Guardian's Office

In WSFT the number of concerns raised with the Guardian has remained steady from the previous quarter at 32. Nationally there was an increase of 25% on the previous year.

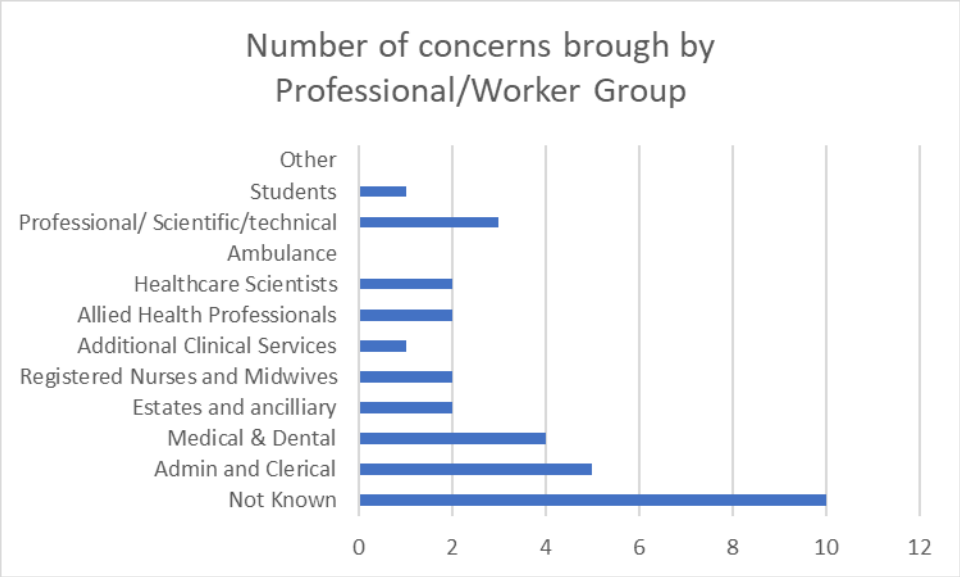


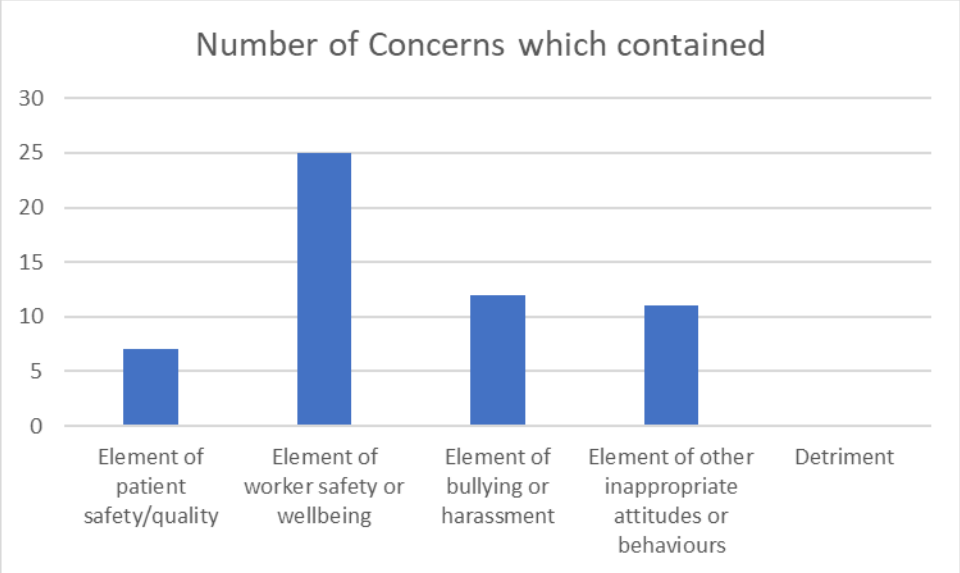

In WSFT, there was an increase in anonymous reporting from 8 last quarter, to 13 this quarter, accounting for 40% of reports. This was much higher than nationally, where anonymous reporting was down to 9.3%. This includes concerns raised to Freedom to Speak Up (FTSU) champions, where the Guardian does not know the name of the person.

This reasons for this significant increase should be examined and addressed. Part of the reason could be greater communication about how to report anonymously, but it could also mean 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.

Further work being done around this includes the new Welcome programme for new starters having a focus on psychological safety and the Guardian is working with 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 highest group is the category ‘not known’ which is likely related to the increase in anonymous reporting. The largest group raising concerns was admin and clerical. Nationally it was nurses and midwives (29%)



## What were people speaking up about?

### Themes from Q3

- Difficulties in relationships between staff and incivility have continued to be the greatest themes in this quarter. Nationally, worker safety and wellbeing and bullying and harassment were elements in 49% of concerns raised. Cases can have an element of one or both of these.
- Two concerns raised were related to discrimination, one by staff anonymously, one by a patient. The patient related concern has been referred to the zero tolerance committee.
- Staff report feeling undervalued and not listened to.
- There were 7 patient safety related concerns raised. This equates to 21% of concerns raised. This is similar to the national figure of 19% One was related to information governance and is currently being investigated. Another was related to infection prevention and control. The rest were all around staffing levels in acute and community teams.

### Summary of learning points

- A focus needs to be maintained on building and maintaining professional relationships and civility especially during very busy and pressured times. The importance of civility, and the Trust value of 'respect' needs to be reiterated throughout all levels of leadership. Many instances of incivility may appear 'mild' and as such they may not be spoken up about, so when they are it is important to take them seriously and investigate further as it is likely to be affecting more than one individual.
- The importance of care in use of language including on group chats and social media.
- Management support and training to ensure staff feel valued and supported. The importance of managers **communicating that they value staff** became clear. Often managers were surprised that staff felt undervalued – they valued staff greatly.
- Importance of all staff being aware of Management of Violence and Aggression Policy and Zero Tolerance procedure.

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 three manager leadership programmes are now well underway and being delivered by the learning and development team. The programmes are for all levels of leaders, which incorporate coaching and reflection to support managers to listen well and deal with uncivil behaviours. Hopefully, as managers develop and graduate from these programmes, a reduction in the concerns around lack of management support and feeling valued will reduce. A fourth programme will be launching in 2024 along with a series of 'management essentials' bite-sized learning events which aim to tackle specific conversation and behavioural based development areas.
- In addition, managers have been encouraged to attend the 'A Kinder Manager' interactive on-line learning sessions from NHS England.

- 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.
- The Infection Prevention and Control (IPC) issue was raised by deputy chief nurse to all wards, and ongoing audits in place to ensure compliance.
- Regarding concerns around out of hours theatre staffing, theatre teams to be increased from March 2024 and work has been completed on an action plan for dealing with theatre staffing shortages out of hours.
- In relation to concerns raised around staffing levels and in particular maternity cover in community team, Senior Community Team management to engage with and listen to teams to address concerns and share demand and capacity data to support decision making.

## 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 Q3.

- Only one response was received this quarter. This low response will be partly due to no carry over from previous cases as they cannot be seen by new Guardian. The person who completed the survey said they would speak up again. Nationally, over 82% of respondents said they would speak up again.
- Free text comments and other feedback received verbally and via email was generally positive. 2 people felt empowered to raise concerns directly with their line manager after speaking with the FTSU Guardian.

Feedback taken from the form and email responses include:

*“I felt comfortable speaking to the Guardian about my concerns.”*

*“The main points were summarised well”.*

**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:

- FTSU pledge has been established for the board:
- Ongoing support from board and SLT for Freedom to Speak Up

Next Steps: CEO to attend FTSU champions 'meet and greets'.

**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.

Next steps:

- New FTSU Guardian to work closely with and have regular meetings with FTSU non-executive director.

**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 (91% and 84% respectively)
- Focus on inclusion and reaching those who may be less likely to speak up e.g., students.

Next steps:

- All staff to meet FTSU Guardian face to face at new starter Welcome, beginning January 2024
- New FTSU 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 Wellbeing Lead to consolidate psychological safety training and ensure appropriate governance around champions.
- FTSU Guardian to support champions by re-starting lunch and learn sessions, working with wellbeing champion lead to establish peer support sessions for champions, and put training in place for new champions, January 2024.

**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
- Individuals report feeling listened to and supported by the Guardian when raising concerns, as evidenced from the feedback survey
- 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.

**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:

- New full-time dedicated FTSU Guardian in post, registered with NGO
- Foundation training completed and reflective conversation completed with Guardian mentor.

Next Steps:

- Guardian to attend ongoing support and training from NGO, Regional meetings, community of practice and access support from Guardian mentor.
- 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 EDI lead 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 face to face sessions with students and new starters
- 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.

Next Steps:

- New FTSU Guardian to undertake FTSU reflection and planning tool to ensure ongoing adherence with National policies and processes
- Policy and all intranet pages relating to FTSU to be updated with new Guardian and champion changes.

As a culture of speaking up grows within the Trust, with staff feeling psychologically safe to raise concerns, and leaders accepting the information brought to them as a gift to allow learning and improvement, more concerns may be raised without the need to involve the FTSU Guardian.

**Final words from Dr Jayne Chidgey-Clark from her foreword to the NGO report:**

"Freedom to speak up is more than an initiative – it is a social movement. All sectors can benefit from the gift which speaking up brings.

"All leaders must make it their mission to instil confidence in their workers to speak up. And as Sir Robert Francis said, "feel pride, not fear" when they speak up – whether to voice a concern or an idea for improvement. Confidence to speak up comes from knowing that when you do, what you raise will be actioned appropriately. If speaking up feels futile, workers may remain silent and we have seen too often that silence can be dangerous".

References:

NGO_AR_2023_Digital.pdf (nationalguardian.org.uk)

# Annex 1

## 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”.

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 December 2023** | | |
|---|---|---|---|---|---|
| **Chaired by: Antoinette Jackson** | | | **Lead Executive Director: Nicola Cottington/Craig Black** | | |
| **Agenda item** | **WHAT?**<br>*Summary of issue, including evaluation of the validity the data** | **Level of Assurance***<br>1. Substantial<br>2. Reasonable<br>3. Partial<br>**4.** Minimal | **For 'Partial' or 'Minimal' level of assurance complete the following:**<br>**SO WHAT?**<br>*Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk* | **WHAT NEXT?**<br>*Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)* | **Escalation:**<br>1. No escalation<br>2. To other assurance committee / SLT<br>**3.** Escalate to Board |
| **Finance Accountability Committee** | **Financial Recovery Plan and CIP programme**<br>The Committee were advised that the Financial Recovery Plan and CIP programme were both on track.<br><br>A bid for additional cashflow support of £3.3m had now been received.<br><br>For 24/25 the Trust was assuming a deficit of £30m and decisions would need to be made about where the target level of CIP should be set. | **2. Reasonable** | The enormous amount of work across the organisation has ensured performance remains is in line with trajectory which is very promising with some recurrent savings of c £1.8m<br><br>There are still risks inherent in achieving the plan in particular how far ongoing industrial action and consultants pay award for Q4 will be funded. The Operational Planning guidance has not yet been received.<br><br>Addressing the 2024/25 target will be challenging target and the Board will need to decide how to address this the CIP target and whether other policy choices should be made. | Further reports to Insight in January and then Board. | 3 escalation to Board |

| Originating Committee: Insight Committee | | | Date of meeting: 20 December 2023 | | |
|---|---|---|---|---|---|
| **Chaired by: Antoinette Jackson** | | | **Lead Executive Director: Nicola Cottington/Craig Black** | | |
| **Agenda item** | **WHAT?**<br>*Summary of issue, including evaluation of the validity the data**<br><br>**Level of Assurance***<br>1. Substantial<br>2. Reasonable<br>3. Partial<br>**4.** Minimal | | **For 'Partial' or 'Minimal' level of assurance complete the following:** | | |
| | | | **SO WHAT?**<br>*Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk* | **WHAT NEXT?**<br>*Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)* | **Escalation:**<br>1. No escalation<br>2. To other assurance committee / SLT<br>**3.** Escalate to Board |
| **Cancer deep dive** | The Committee had a presentation on the work being undertaken to improve Cancer performance and the action plans in place.<br><br>**Backlog** The end of November backlog position was back on track, 2 under trajectory. Skin remains the biggest focus, which is still 43 over trajectory but improving week on week.<br><br>**Faster Diagnosis (FDS) performance** is not yet back to trajectory but it has improved from the summer position in August and September, with Breast, Head and Neck and Urology back on trajectory and some improvement in Skin. | **3 Partial** | Achieving these standards is important for timely diagnosis and treatment.<br><br>The main cause of the backlog is attributed to the significant pathway delays in Skin in the summer months with an inability to see patients in face-to-face clinics for several weeks. This has now improved. | To achieve 75% FDS by March 2024, we need a significant focus on Breast, Skin and Lower GI as our largest tumour sites.<br><br>There are several best practice timed pathways set out by the cancer alliance. We have undertaken best practice timed pathway audits in Lower GI, Gynaecology, Prostate and Breast, with Skin now underway. These audits enable us to pinpoint the areas of focus, and develop a high-level project plan for relevant milestones.<br><br>Looking longer term our participation in the Galleri Trial is showing promise for early detection in asymptomatic patients. | 1 No escalation |

| Originating Committee: Insight Committee | | | Date of meeting: 20 December 2023 | | |
|---|---|---|---|---|---|
| **Chaired by: Antoinette Jackson** | | | **Lead Executive Director: Nicola Cottington/Craig Black** | | |
| **Agenda item** | **WHAT?**<br>*Summary of issue, including evaluation of the validity the data** | **Level of Assurance***<br>1. Substantial<br>2. Reasonable<br>3. Partial<br>**4.** Minimal | **For 'Partial' or 'Minimal' level of assurance complete the following:** | | |
| | | | **SO WHAT?**<br>*Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk* | **WHAT NEXT?**<br>*Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)* | **Escalation:**<br>1. No escalation<br>2. To other assurance committee / SLT<br>**3.** Escalate to Board |
| | | | | | |
| **Patient Access Governance Group /IQPR data** | **4 hour performance** We have fallen below our trajectory for the 4 hour performance with performance at 59.45%<br><br>**Ambulance handover** performance is not demonstrating a significant improvement and remains challenging in all 3 metrics,<br><br>**12 hour length of stay** have continued to decline. | **3 Partial** | Meeting Urgent and Emergency Care performance metrics ensures that our patients are receiving timely emergency care.<br><br>Increased crowding within the emergency department and an increase in the length of stay of patients which results in reduced capacity/delays to offload ambulances.<br><br>The lack of flow out of the Emergency Department during the month has resulted in the opening of escalation areas to assist with this flow. | We are continuing to work through phase two of our internal Urgent and Emergency Care (UEC) recovery plan, working collaboratively with the alliance and the ICB.<br><br>A two week refocus on the 4 hour target commenced on 20th November, this included Senior Operations Managers and Senior Nursing colleagues spending the day observing processes, collecting information on issues and supporting floor coordinators in unblocking issues and escalating where needed. From this an action plan is being developed. | 3 Escalate to Board |

| Originating Committee: Insight Committee | | | Date of meeting: 20 December 2023 | | |
|---|---|---|---|---|---|
| **Chaired by: Antoinette Jackson** | | | **Lead Executive Director: Nicola Cottington/Craig Black** | | |
| **Agenda item** | **WHAT?**<br>*Summary of issue, including evaluation of the validity the data** | **Level of Assurance***<br>1. Substantial<br>2. Reasonable<br>3. Partial<br>**4.** Minimal | **For 'Partial' or 'Minimal' level of assurance complete the following:** | | |
| | | | **SO WHAT?**<br>*Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk* | **WHAT NEXT?**<br>*Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)* | **Escalation:**<br>1. No escalation<br>2. To other assurance committee / SLT<br>**3.** Escalate to Board |
| **Corporate Risk Governance group** | Replacement of the Risk Management system – flagged as a potential risk given its trust wide impact. | **3 Partial** | The system is being replaced and if not effectively implemented by end of March 24 we will need to extend the current provider and in affect be paying for two systems. | There are implementation plans in place which include training and communication. These are being carefully monitored. | 1. No escalation |

**Guidance notes**

**The practice of scrutiny and assurance**

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

# 4.2. Finance Report

To Assure

Presented by Craig Black

| Board of Directors – Public Board | |
|---|---|
| **Report title:** | Finance Board Report – December 2023 |
| **Agenda item:** | |
| **Date of the meeting:** | 26th January 2024 |
| **Lead:** | Craig Black, Executive Director of Resources |
| **Report prepared by:** | Nick Macdonald, Deputy Director of Finance |

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

| **Executive Summary** |
|---|
| **WHAT?**<br>*Summary of issue, including evaluation of the validity the data/information* |
| The revised forecast deficit of £6.3m was agreed by SNEE ICB as a result of additional funding received in November 2023.<br><br>The reported I&E for December is a deficit of £0.5m which is in line with our planned deficit for the month. The YTD position reports a deficit of £6.0m against a planned deficit of £3.3m (an adverse variance of £2.7m). However, this does not include any costs associated with Industrial Action during December (£0.4m)<br><br>Whilst we are awaiting national guidance for 24-25 planning, our first draft plan for 24-25 suggests we would plan for a deficit of £22.9m (after delivering £10m CIP). This is subject to assumptions made and planning guidance. In order to improve this planned deficit we could consider a more challenging CIP and our Future System Programme dependencies have been included within the Finance paper to facilitate a discussion over possible areas to consider. |
| **SO WHAT?**<br>*Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk* |
| As a result of our financial performance the ICS have developed plans to compensate for the WSFT position by slipping investments elsewhere within the ICS |
| **WHAT NEXT?**<br>*Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)* |
| Continue to monitor financial performance through Insight and the Board and take corrective action where necessary |
| **Recommendation / action required** |
| Review and approve this report |

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

# FINANCE REPORT
# December 2023 (Month 9)

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

## Executive Summary

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

- We have agreed a forecast deficit of £6.3m with SNEE ICB. This revised forecast is contingent on:
  - Funding associated with Industrial Action - £3.7m (received)
  - ERF related income - £1.7m
  - Delivering CIP - £5m
  - Improving our run rate - £3.4m
- This forecast includes the benefits resulting from £15m of non-recurring support.
- The reported I&E for December is a deficit of £0.5m which is in line with our planned deficit for the month
- In line with national guidance this does not include costs associated with Industrial Action during December (£400k)
- The YTD position reports an adverse variance of £2.7m which is largely due to:
  - Underachieved CIP
- In order to improve our 2024-25 planned deficit (£22.9m) we could consider a more challenging CIP and our Future System Programme dependencies have been appended to this paper to facilitate a discussion over possible areas to consider

**Key Risks in 2023-24**

- Delivering challenging CIP
- Delivering improvement in run-rate
- Unanticipated costs of further industrial action (if unfunded).

## Financial Summary

| SUMMARY INCOME AND EXPENDITURE ACCOUNT - December 2023 | December 2023 | | | Year to date | | | Year end forecast | | |
|---|---|---|---|---|---|---|---|---|---|
| | Budget | Actual | Variance F/(A) | Budget | Actual | Variance F/(A) | Budget | Actual | Variance F/(A) |
| | £m | £m | £m | £m | £m | £m | £m | £m | £m |
| NHS Contract Income | 31.3 | 31.4 | 0.1 | 255.9 | 258.2 | 2.3 | 336.8 | 339.8 | 3.0 |
| Other Income | 0.5 | 0.4 | (0.0) | 28.8 | 29.3 | 0.5 | 41.8 | 48.7 | 6.9 |
| **Total Income** | **31.8** | **31.8** | **0.0** | **284.7** | **287.5** | **2.8** | **378.6** | **388.5** | **9.9** |
| Pay Costs | 21.8 | 22.4 | (0.6) | 194.0 | 197.9 | (4.0) | 257.6 | 259.4 | (1.8) |
| Non-pay Costs | 7.4 | 6.3 | 1.1 | 78.1 | 79.3 | (1.2) | 104.2 | 115.1 | (10.9) |
| **Operating Expenditure** | **29.3** | **28.7** | **0.6** | **272.1** | **277.2** | **(5.1)** | **361.8** | **374.5** | **12.7** |
| Contingency and Reserves | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| **EBITDA** | **2.5** | **3.2** | **0.6** | **12.6** | **10.3** | **(2.3)** | **16.7** | **14.0** | **(2.7)** |
| Depreciation | 2.5 | 3.0 | (0.4) | 11.1 | 11.4 | (0.3) | 12.9 | 13.8 | 0.9 |
| Finance costs | 0.5 | 0.7 | (0.1) | 4.9 | 4.9 | (0.0) | 6.5 | 6.5 | 0.0 |
| **SURPLUS/(DEFICIT)** | **(0.5)** | **(0.5)** | **0.0** | **(3.3)** | **(6.0)** | **(2.7)** | **(2.7)** | **(6.3)** | **(3.6)** |

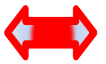
| | | |
|---|---|---|
| **I&E Position YTD** | **£6m** | **adverse** |
| **Variance against Plan YTD** | **£2.7m** | **adverse** |
| **Movement in month against plan** | **£0m** | **on-plan** |
| **EBITDA position YTD** | **£10.3m** | **favourable** |
| **EBITDA margin YTD** | **4%** | **favourable** |
| **Cash at bank** | **£12.7m** | |

## Contents:



## Key:

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

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

# FINANCE REPORT – December 2023

## Income and Expenditure Summary - December 2023

### Summary of I&E indicators

| Income and Expenditure | Original Plan/ Target £000' | Actual/ Forecast £000' | Variance to plan (adv)/ fav £000' | Direction of travel (variance) | RAG (report on red) |
|---|---|---|---|---|---|
| In month surplus/ (deficit) | (543) | (521) | 23 | ↑ | Green |
| YTD surplus/ (deficit) | (3,320) | (6,011) | (2,691) | ↑ | Red |
| EBITDA YTD | 12,643 | 10,297 | (2,346) | ↑ | Red |
| EBITDA % | 4.4% | 3.6% | (0.9%) | ↑ | Red |
| Clinical Income YTD | (259,439) | (262,372) | 2,933 | ↓ | Green |
| Non-Clinical Income YTD | (23,196) | (25,160) | 1,964 | ↑ | Green |
| Pay YTD | 193,956 | 197,919 | (3,962) | ↓ | Red |
| Non-Pay YTD | 94,022 | 95,274 | (1,252) | ↑ | Red |
| CIP Target YTD | 6,506 | 3,474 | (3,032) | ↓ | Red |

### Income and Expenditure for 2023-24

Plan

The Income and Expenditure (I&E) budget is for the Trust to record a deficit of £2.7m in 2023-24, which includes achieving Cost Improvements (CIP) of 3% (£10.6m). However, our Financial Recovery Plan (FRP) revised our forecast to a deficit of £6.7m. We subsequently received additional funding towards inflationary pressures which adjusted this position to a deficit of £6.3m. This £6.3m deficit is now our plan, and represents a £3.6m adverse variance against our original plan.

M9 position

Our reported position as at the end of December was a deficit of £6.0m against our original planned deficit of £3.3m – ie an adverse variance of £2.7m.

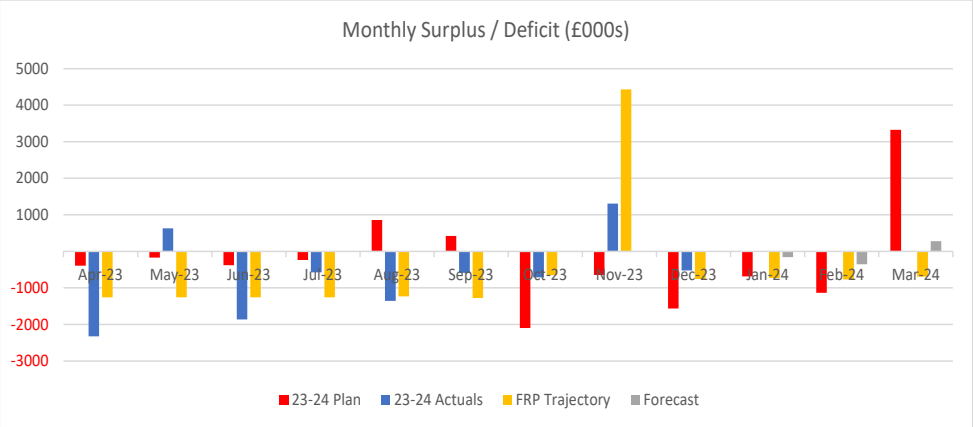
Our income is phased in line with activity and therefore we tend to make a smaller deficit in the final quarter. Therefore, the M9 position is in line with our forecast adverse variance of £3.6m by year end.

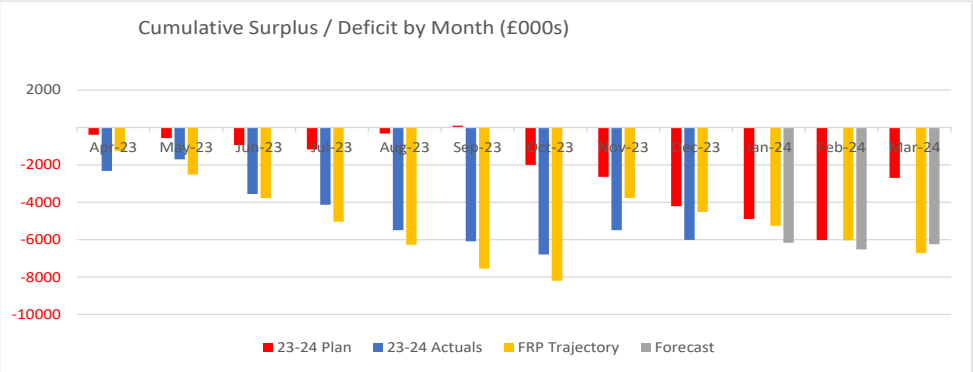
The primary reasons for our adverse variance relate to underperformance against our CIP target in the first half of this year. Whilst there were also pressures relating to the costs of industrial action and inflation these have now been largely funded.

In line with national guidance the M9 position does not include any further costs of Industrial Action. We have calculated these costs at £400k in December which could become a cost pressure if these costs are not funded or other mitigations found. We await further guidance.

Forecast

We continue to forecast that we will achieve the revised planned deficit of £6.3m. However, this is subject to the risks relating to the costs of Industrial Action. The cumulative M9 position includes the support we received for our costs relating to Industrial Action to the end of October. However, the aforementioned IA in December together with IA at the beginning of January (£800k) would add £1.2m of risk to our forecast, as well as any further IA related costs.



**Financial Planning and Budget Setting for 2024-25**

The deficit for 2024-25 is currently forecast to be £22.9m after delivering a Cost Improvement Programme of £10m (2.5%), subject to assumptions made and planning guidance.

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

However, this has caused a delay in detailed budget setting. We have drafted budget setting guidelines and governance arrangements that are due to be discussed at FAC on 24th January alongside a first cut of the budget, primarily focussing on staffing budgets. Business plans will highlight known cost pressures and investment proposals that are due to be discussed by Trust Executives on 14th February so that detailed budgets can be agreed and signed off by budget holders in readiness for final approval at the March 2024 Board meeting.

The allocation of Cost Improvement targets 2024-25 and development of Cost Improvement Plans (CIPs) are inextricably linked to the budget setting timetable and are included within the budget setting guidance and governance arrangements.

There are a number of more challenging CIPs that could be considered that would improve our planned deficit. These form part of the Clinical and Care Strategy and are listed at Appendix A as part of our Future System Plans interdependencies.

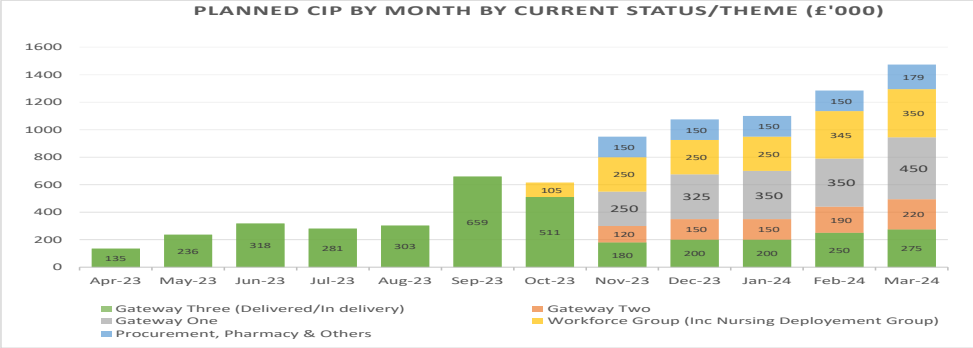
# FINANCE REPORT – December 2023

## Cost Improvement Programme (CIP)

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

*Table 1 – CIP achievement to date, with current forecast*

| | Target vs Plan | YTD Target vs YTD Actuals | | | Target vs Actuals + Forecast | | | In-Month Delivery | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Division | Annual Target (£k) | Target YTD (£k) | Actuals YTD (£k) | Variance (£k) | Annual Target (£k) | Actuals & Forecast In-year 2023/24 (£k) | Variance (£k) | Target | M09 Delivery only | Retrospective delivery reporting in M09 | Actuals (M09 + Prior to M09) | Variance |
| Medicine | 2,610 | 1,949 | 665 | (1,284) | 2,610 | 828 | (1,782) | 221 | 9 | 180 | 189 | (32) |
| Surgery | 1,978 | 1,316 | 1,021 | (295) | 1,978 | 1,663 | (315) | 187 | 180 | 25 | 205 | 18 |
| Women & Children | 671 | 450 | 547 | 97 | 671 | 683 | 12 | 75 | 44 | - | 44 | (31) |
| CSS | 1,260 | 862 | 180 | (682) | 1,260 | 300 | (960) | 125 | 2 | 41 | 43 | (82) |
| Community | 1,588 | 1,106 | 841 | (265) | 1,588 | 1,332 | (256) | 156 | 115 | 30 | 145 | (11) |
| Estates & Facilities | 677 | 451 | 516 | 65 | 677 | 779 | 102 | 74 | 35 | - | 35 | (39) |
| Corporate | 1,816 | 1,363 | 457 | (906) | 1,816 | 973 | (843) | 151 | 137 | - | 137 | (14) |
| TW - Workforce Group | - | - | 269 | 269 | - | 1,368 | 1,368 | - | 163 | 105 | 269 | 269 |
| TW - Procurement | - | - | | - | - | | - | - | - | - | - | - |
| TW - Pharmacy | - | - | | - | - | | - | - | - | - | - | - |
| TW - Discretionary | - | - | 78 | 78 | - | 106 | 106 | - | 33 | - | 33 | 33 |
| TW - Other | - | - | | - | - | 400 | 400 | - | - | - | - | - |
| TOTAL | 10,600 | 7,496 | 4,573 | (2,923) | 10,600 | 8,432 | (2,168) | 990 | 718 | 381 | 1,099 | 109 |



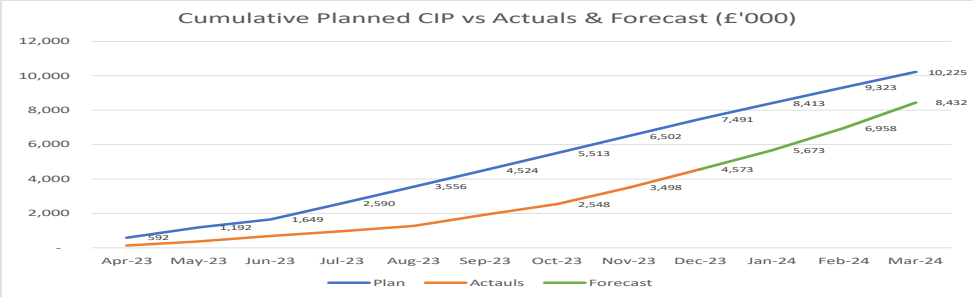




*Table 2 – CIP Identification Progress - Non-risk Adjusted – CIP*

| Division | Target £k | Identified 23/24 £k | Gateway 1 £k | Gateway 2 £k | Gateway 3 £k | Gap £k | Pipeline PIDs |
|---|---|---|---|---|---|---|---|
| Medicine | 2,610 | 1,682 | 716 | 246 | 720 | (928) | 5 |
| Surgery | 1,978 | 1,823 | 38 | 2 | 1,783 | (155) | 19 |
| Women & Children | 671 | 683 | 2 | 0 | 681 | 12 | 11 |
| Clinical Support Services | 1,260 | 599 | 43 | 0 | 556 | (661) | 16 |
| Community | 1,588 | 1,997 | 1,237 | 0 | 760 | 409 | 25 |
| E&F | 677 | 694 | 0 | 0 | 694 | 18 | 12 |
| Corporate | 1,817 | 867 | 0 | 0 | 867 | (950) | 7 |
| **Sub-Total** | **10,601** | **8,345** | **2,036** | **248** | **6,061** | **(2,255)** | **95** |
| Workforce Group | | 1,300 | | 1,020 | 280 | 0 | |
| Procurement | | 180 | | 120 | 60 | 0 | |
| Pharmacy | | 200 | | 150 | 50 | 0 | |
| Discretionary | | 200 | 14 | 94 | 92 | 0 | |
| **Total** | **10,601** | **10,225** | **2,050** | **1,632** | **6,543** | **(376)** | **95** |

### In month progress (December)

- CIPs with a value of £1.1m were delivered during December (of which £381k related to prior months). The majority of these CIPs are recurring.
- Total value of identified schemes has increased by £2.0m to £10.2m (£8.2m at M7).
- All divisions have reduced the unidentified gap assigned to them
- Pipeline PIDs have decreased by 58 as schemes have matured and passed through the gateways to delivery (153 at M7)
-

## Cost Improvement Programme (CIP) 2024-25

The table below highlights that in order to deliver this CIP challenge in 2024-25 around £17.5m of schemes need to be identified, and therefore the sooner these schemes can be in place the more confidence we will have in achieving that.

| Oversight | Areas of focus | Basis of opportunity | 2425 Full Year Budget Potential | Forecast unachieved/ non-recurring 23-24 CIP | 2004-25 plan at 2.5% | CIP to identify (red is work in progress) | CIP delivery (we lose 30% between identifying and delivery) | Identification - % of CIP / Potential |
|---|---|---|---|---|---|---|---|---|
| | | | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| WRG/Nurse Deployment Group | Temp nursing costs (eg bank and agency) | Volume - 2.5% of all nursing budget | 96,000 | | | 2,400 | 1,680 | 2.5% |
| WRG/Medical staffing | Temp medical staffing costs (eg ECW), Job Plans | Volume - 2.5% of all medical staffing budget | 65,000 | | | 1,625 | 1,138 | 2.5% |
| WRG/A&C and other staff groups | Temp costs (non-nursing & non-Med) (eg bank and agency) | Volume - 2.5% of staffing budget | 97,000 | | | 2,425 | 1,698 | 2.5% |
| Procurement * | Contract negotiations | Price | 50,000 | | | 800 | 560 | 1.6% |
| Pharmacy * | Price and alternatives eg biosimilars, | Price and Volume | 8,000 | | | 1,000 | 700 | 12.5% |
| Change Management Hub | Outpatients productivity, | Cash releasing efficiencies | 10,000 | | | 1,000 | 700 | 10.0% |
| Change Management Hub | LOS (linked to INTS, emergency village, C&YP, "left shift") | Productivity (growth) efficiencies | - | | | - | - | 0.0% |
| Surgery | Theatres productivity | Productivity (growth) efficiencies | 10,000 | | | 500 | 350 | 5.0% |
| Medicine | Virtual Ward | Productivity (growth) efficiencies | 3,000 | | | 500 | 350 | 16.7% |
| Change Management Hub | Other productivity opportunities | Improve Weighted Activity Unit costs (WAU) | - | | | 300 | 210 | 0.0% |
| Discretionary Expenditure | Specific separate workstreams | Volume | 12,000 | | | 500 | 350 | 4.2% |
| Contracts | Review and Rationalise Contracts (IT/IS/Maintenance/Estates) | Require resource to review fully | 10,000 | | | 1,000 | 700 | 10.0% |
| Operational Divisions | Local CIPs - not incl within trust wide schemes | Volume | 20,000 | 3,800 | 8,500 | 1,000 | 700 | 5.0% |
| Corporate Divisions | Local CIPs - not incl within trust wide schemes | Price | 10,000 | | 1,500 | 1,000 | 700 | 10.0% |
| Finance | FYE of 2324 CIP that started after 1/4/23 | January 2024 | - | (1,515) | | - | - | 0.0% |
| Finance (ensure no double count) | FYE of 2324 run rate reductions that started after 1/4/23 | January 2024 | - | | | 1,000 | 700 | 0.0% |
| Non-recurring | Similar to 23-24 non-recurring | Similar to 23-24 non-recurring | - | | | 2,500 | 1,750 | 0.0% |
| | | | 391,000 | 2,285 | 10,000 | 17,550 | 12,285 | 4.5% |

# FINANCE REPORT – December 2023

## Divisional Financial Performance

| | Current Month | | | Year to date | | |
|---|---|---|---|---|---|---|
| | Budget | Actual | Variance F/(A) | Budget | Actual | Variance F/(A) |
| MEDICINE | £k | £k | £k | £k | £k | £k |
| Total Income | (339) | (525) | 187 | (3,482) | (4,051) | 569 |
| Pay Costs | 5,781 | 5,715 | 65 | 50,783 | 53,300 | (2,517) |
| Non-pay Costs | 2,021 | 2,317 | (296) | 18,460 | 19,827 | (1,367) |
| Operating Expenditure | 7,801 | 8,032 | (231) | 69,242 | 73,126 | (3,884) |
| SURPLUS / (DEFICIT) | (7,463) | (7,507) | (44) | (65,761) | (69,075) | (3,314) |
| SURGERY | | | | | | |
| Total Income | (251) | (305) | 55 | (2,208) | (2,585) | 377 |
| Pay Costs | 4,409 | 4,409 | (0) | 39,629 | 40,058 | (428) |
| Non-pay Costs | 1,373 | 1,333 | 40 | 12,727 | 13,292 | (565) |
| Operating Expenditure | 5,782 | 5,742 | 40 | 52,356 | 53,349 | (993) |
| SURPLUS / (DEFICIT) | (5,531) | (5,437) | 95 | (50,148) | (50,764) | (616) |
| WOMENS AND CHILDRENS | | | | | | |
| Total Income | (154) | (162) | 8 | (1,544) | (2,104) | 561 |
| Pay Costs | 2,002 | 2,050 | (48) | 17,820 | 18,037 | (218) |
| Non-pay Costs | 92 | 173 | (81) | 1,045 | 1,376 | (331) |
| Operating Expenditure | 2,094 | 2,223 | (129) | 18,865 | 19,414 | (549) |
| SURPLUS / (DEFICIT) | (1,940) | (2,060) | (120) | (17,321) | (17,309) | 12 |
| CLINICAL SUPPORT | | | | | | |
| Total Income | (316) | (122) | (195) | (2,076) | (1,650) | (426) |
| Pay Costs | 2,732 | 2,770 | (39) | 23,723 | 24,728 | (1,005) |
| Non-pay Costs | 1,167 | 1,341 | (174) | 10,746 | 11,574 | (829) |
| Operating Expenditure | 3,898 | 4,111 | (213) | 34,469 | 36,303 | (1,834) |
| SURPLUS / (DEFICIT) | (3,582) | (3,990) | (408) | (32,393) | (34,652) | (2,259) |
| COMMUNITY SERVICES | | | | | | |
| Total Income | (809) | (796) | (13) | (5,396) | (5,636) | 240 |
| Pay Costs | 3,497 | 3,633 | (136) | 31,444 | 31,945 | (501) |
| Non-pay Costs | 1,670 | 1,830 | (159) | 13,200 | 14,145 | (946) |
| Operating Expenditure | 5,168 | 5,463 | (295) | 44,644 | 46,091 | (1,447) |
| SURPLUS / (DEFICIT) | (4,358) | (4,667) | (308) | (39,248) | (40,455) | (1,207) |
| ESTATES AND FACILITIES | | | | | | |
| Total Income | (346) | (344) | (2) | (2,960) | (3,165) | 205 |
| Pay Costs | 1,219 | 1,227 | (8) | 10,977 | 11,239 | (262) |
| Non-pay Costs | 1,067 | 804 | 263 | 8,522 | 9,106 | (584) |
| Operating Expenditure | 2,286 | 2,032 | 255 | 19,499 | 20,345 | (846) |
| SURPLUS / (DEFICIT) | (1,940) | (1,687) | 252 | (16,538) | (17,180) | (641) |
| CORPORATE | | | | | | |
| Total Income | (29,585) | (29,628) | 43 | (266,894) | (268,829) | 1,935 |
| Pay Costs | 2,205 | 2,596 | (391) | 19,580 | 18,611 | 969 |
| Non-pay Costs | 1,518 | (462) | 1,980 | 14,686 | 10,826 | 3,860 |
| Capital Charges and Financing Costs | 1,595 | 2,667 | (1,072) | 14,544 | 15,967 | (1,423) |
| Operating Expenditure | 5,318 | 4,801 | 517 | 48,811 | 45,404 | 3,406 |
| SURPLUS / (DEFICIT) | 24,267 | 24,827 | 559 | 218,084 | 223,425 | 5,341 |
| TOTAL | | | | | | |
| Total Income | (31,800) | (31,883) | 83 | (284,560) | (288,021) | 3,461 |
| Pay Costs | 21,844 | 22,401 | (557) | 193,956 | 197,919 | (3,962) |
| Non-pay Costs | 8,908 | 7,336 | 1,572 | 79,385 | 80,146 | (761) |
| Capital Charges and Financing Costs | 1,595 | 2,667 | (1,072) | 14,544 | 15,967 | (1,423) |
| Operating Expenditure | 32,347 | 32,404 | (57) | 287,885 | 294,031 | (6,146) |
| SURPLUS / (DEFICIT) | (546) | (521) | 26 | (3,325) | (6,011) | (2,685) |

## Medicine (Sarah Watson)

The Medicine division reported an adverse variance of £3.3m as at M9. For the month of December, the division was behind plan by £44k.

The income variance in month (£187k) is largely a result of winter funding received to support the escalation ward. Pay budgets report a year-to-date adverse variance of £2.5m and an in-month favourable variance of £65k. The key drivers behind the pay YTD variances are.

- £2.5m overspend on medical staffing is due to several reasons including cover arrangements (locums, agency, and Additional consultant sessions) for sickness, industrial action, rota gaps and higher than budgeted establishments for junior doctors. It should be noted that the division is reporting a run rate reduction of £0.13m in temporary medical staff over M8 & M9.
- £0.17m underspend in nursing is largely due to vacancies in registered nursing that are being filled in a controlled manner by temporary staff.
- £0.4m unmet Pay CIP target.

Non-Pay budgets report an in-month deficit of £296k (£1.34m adverse YTD). The key drivers behind the non-pay budget variance for the year-to-date are.

- £1m for undelivered CIP. The Division has not been able to identify any significant improvements in their non-pay cost base to meet this target but is continuously reviewing ideas for further efficiencies.
- £0.3m on paramedic cohort, which is currently not funded.

It should be noted that the recent commitment to use the private sector for Dermatology backlogs will deteriorate this position even further (£0.5m planned for M10-12 23-24). The Division has delivered CIP of £0.7m YTD and is forecast to deliver an additional £0.1m at the end of the year.

## Surgery (Moira Welham)

The Surgical division reported a favourable variance of £95k (adverse £616k YTD).

Pay reported a near breakeven position for December (adverse £428k variance YTD). It has been a challenging month in the division due to ongoing vacancies and increased sickness, however the division has seen a decrease in temporary spend due to the industrial action and the bank holidays.

Overall temporary staffing accounts for 8.87% of pay costs in the month which is an improvement from 10.14% in November. It should be noted that Industrial action, staffing deficits and environmental issues are impacting on the ability to achieve the 65-week clearance for the specialties by the end of March and temporary spend is expected to increase in the coming months.

Non-pay reported a favourable variance of £40k in month (adverse £565k YTD). This is due to a reduction in elective activity due to industrial action and Christmas.

## Women and Children's (Simon Taylor)

In October, the Division reported a favourable variance of £120k (favourable £12k YTD).

Although no overall significant variance was noted in income in month, YTD income for Women's services is £561k ahead of plan, mostly due to large private patient invoices or funding for specific posts or services offsetting some of the overspends below.

Pay reported a £48k overspend in-month (£218k overspend YTD). This is due to:

- agency usage in paediatrics to support winter pressures (funding noted above in income)
- temporary staff spend to support safe staffing levels during periods of sickness, industrial action and to cover rota gaps.
- the increase in demand for gynaecological services.
- successful recruitment in maternity teams whose vacancies have previously offset overspends in other cost centres.
- known over-establishment in paediatric ED.

Non-pay reported a £64k overspend in month (YTD £314k overspend).

The largest areas of overspend were on drugs (particularly in paediatrics with spend on palivizumab) and high costs for Liat and Lumira testing for covid, flu and RSV. The YTD variances of the highest significance are in clinical supplies (high value purchase of jaundice meters); premises (increase in rent charges for community midwifery bases); drugs (as noted above, particularly high in the current month as would be expected) and other costs (including unbudgeted annual licences for Infoflex; and injury benefit scheme charges).

## Clinical Support (Simon Taylor)

In October, the Division reported an adverse variance of £408k (YTD adverse variance of £2.3m).

Income was behind plan £195k in-month (£426k YTD). A large component of this is legacy income targets for utilities income within expired managed service contracts in diagnostics which we no longer have. This is offset by underspends in non-pay for these contracts and higher than anticipated income in private patient income and backdated inflationary increases.

Pay reported a £39k overspend in-month (£1.0m overspend YTD). This is driven by:

- Agency usage in Clinical Coding, this is forecast to reduce from January
- Use of locums and agency staff across medical staff in Xray and ultrasound
- Use of agency scientific and technical staff in Microbiology.

These are offset by continued underspend in Pharmacy as the recruitment into substantive vacancies continues.

Non-pay reported a £174k overspend in month (YTD £829k overspend). A large driver of this (£100k YTD, anticipated total impact £300k) is the necessary rental of a mobile MRI unit to provide continuation of service while we wait for the permanent replacement to go-live from April 2024. The division also reported an increase spend in stock drugs in month, this is a timing difference with it forecast to have no impact on the position at year end. These are offset by the underspends for legacy managed service contracts mentioned previously.

## Community Services (Kevin McGinness and Nic Smith-Howell)

The Community Division reported an adverse variance of £308k in M9 (£1.2m adverse YTD).

Income reported an under recovery of £13k in December (£240k favourable YTD). The YTD favourable variance was due to additional income recovered to support the Trust's COVID and flu vaccination programmes and the recovery of some of the additional costs incurred through the Community Equipment Service contract.

Pay reported an adverse variance of £136k in December (£501k YTD). At M9, the pay run-rate has increased above budget as the division is delivering capacity to support the Urgent Emergency Response services, including enhanced overnight

care in the Early Intervention Team, 7-day therapy cover for acute medicine wards, and therapist provision in ED. Offsetting income of £811k (FYE) is managed corporately, and the linked additional costs are fully funded.

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

Non-pay reported a £159k adverse variance in M9 (£946k adverse YTD). Drivers for the YTD adverse variance include:

- £190k unmet non-pay CIP/slippage in the first half of the year due to scheme delay – the division's CIP expect to recover this position in the final quarter of the year, with the level of CIP allocated to schemes increasing.
- Significantly increased referrals into wheelchair services in the first half of the year meant that despite increased use of recycled equipment, costs increased. Increased demand and cost inflation for community equipment and combined this has incurred a £454k YTD overspend. However, some of this is offset by the increase in income noted above.
- £86K of additional IT hardware and software costs were incurred, primarily for use by the SCARC.
- Inflationary cost pressures were incurred for service contracts and staff travel costs (including pool cars and vehicle hire) creating an overspend of £108k YTD.

## Estates and Facilities (Chris Todd)

In December, the division recorded a positive variance of £252k, (£641k YTD adverse variance).

There are positive variances of note in the following areas:

- An increase in income following the reinstatement of staff parking charges has led to £168k surplus YTD in the Car Park management unit.
- An increase in catering income of £202k YTD is the result of customer numbers returning to pre-covid levels and a small increase in prices charged. This increase in income has been partly offset by the increased staff to meet demand.

There are cost pressure in the following areas:

- Newmarket Estates Management (£123k YTD) – This is the result of electricity costs exceeding those anticipated.
- Medical Physics (£125k YTD) – the cost of spare parts, plus third-party repairs and maintenance contracts are putting pressure on this budget. It should be noted that this cost pressure is decreasing due to focused work by the team.
- Estates (£342k YTD) – as a result of third party servicing and maintenance costs exceeding the YTD budget by £238k and £55k respectively.
- Estate Management (£325k YTD) - There has been significant downtime in the Trust's combined heat and power unit this year. This has led to an increase in the volume of electricity used and a corresponding reduction in the amount of gas burned to generate electricity, resulting in a net cost pressure of £281k YTD. This unit is now fully operational so this cost pressure is not anticipated to re-occur during Q4 of 23-24.

# FINANCE REPORT – December 2023

## Workforce

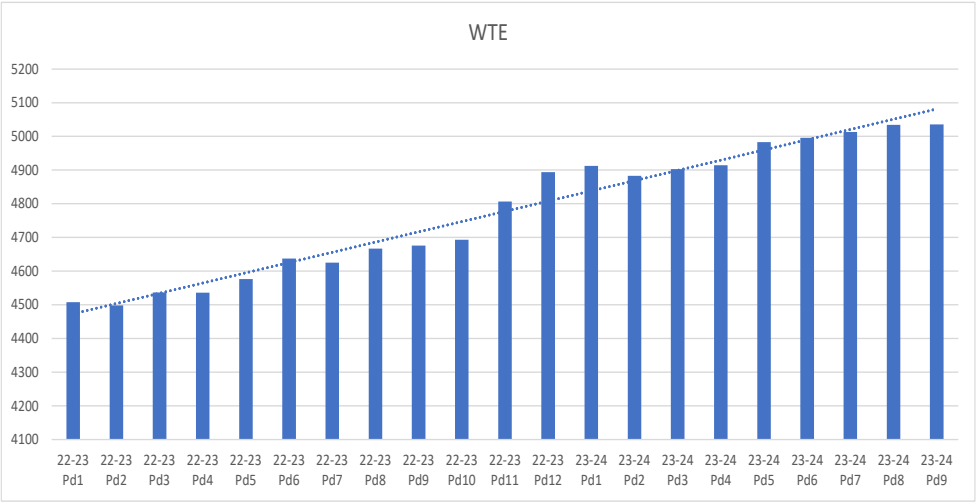
During December the Trust overspent by £0.6m on pay

| Monthly Expenditure (£) | | | | |
|---|---|---|---|---|
| As at December 2023 | Dec-23 | Nov-23 | Dec-22 | YTD |
| | £000's | £000's | £000's | £000's |
| **Budgeted Costs in-month** | 21,844 | 21,724 | 19,615 | 193,956 |
| **Substantive Staff** | 20,021 | 19,926 | 17,305 | 174,175 |
| Medical Agency Staff | 133 | 158 | 259 | 1,127 |
| Medical Locum Staff | 452 | 532 | 413 | 4,841 |
| Additional Medical Sessions | 365 | 277 | 239 | 3,439 |
| Nursing Agency Staff | 124 | 232 | 120 | 1,677 |
| Nursing Bank Staff | 595 | 590 | 479 | 5,170 |
| Other Agency Staff | 249 | 265 | 160 | 2,192 |
| Other Bank Staff | 216 | 226 | 241 | 2,098 |
| Overtime | 94 | 111 | 193 | 1,427 |
| On Call | 154 | 197 | 137 | 1,775 |
| **Total Temporary Expenditure** | 2,380 | 2,588 | 2,242 | 23,744 |
| **Total Expenditure on Pay** | 22,401 | 22,514 | 19,547 | 197,919 |
| Variance (F/(A)) | (557) | (790) | 68 | (3,962) |
| | | | | |
| Temp. Staff Costs as % of Total Pay | 10.6% | 11.5% | 11.5% | 12.0% |
| memo: Total Agency Spend in-month | 505 | 655 | 539 | 4,996 |

| Monthly WTE | | | |
|---|---|---|---|
| As at December 2023 | Dec-23 | Nov-23 | Dec-22 |
| | | | |
| **Budgeted WTE in-month** | 5,008.1 | 5,011.9 | 4,823.0 |
| **Substantive Staff** | 4,670.5 | 4,657.3 | 4,308.6 |
| Medical Agency Staff | 9.1 | 9.2 | 11.3 |
| Medical Locum Staff | 36.2 | 35.3 | 42.6 |
| Additional Medical Sessions | 8.6 | 10.6 | 8.3 |
| Nursing Agency Staff | 15.8 | 30.0 | 13.3 |
| Nursing Bank Staff | 150.1 | 147.0 | 123.1 |
| Other Agency Staff | 48.0 | 40.9 | 29.4 |
| Other Bank Staff | 68.7 | 70.8 | 82.6 |
| Overtime | 22.7 | 26.3 | 50.1 |
| On Call | 5.7 | 7.0 | 6.3 |
| **Total Temporary WTE** | 364.9 | 377.1 | 367.0 |
| **Total WTE** | 5,035.4 | 5,034.4 | 4,675.6 |
| Variance (F/(A)) | (27.3) | (22.4) | 147.4 |
| | | | |
| Temp. Staff WTE as % of Total WTE | 7.2% | 7.5% | 7.8% |
| memo: Total Agency WTE in-month | 72.9 | 80.2 | 54.0 |

**Page 9**

There has been a steady increase in WTEs since April 2022 as below (12%) :



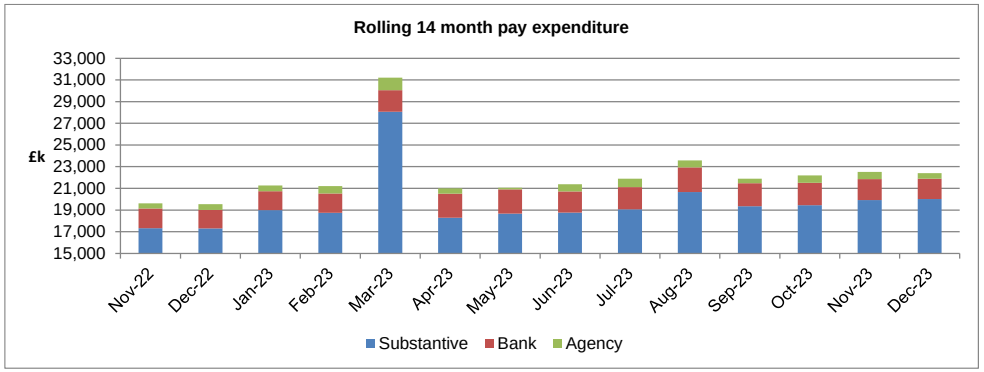

Compared to December 2022 we now employ 360 more WTEs (7.7%), 362 of which are substantive. The increase is summarised below.

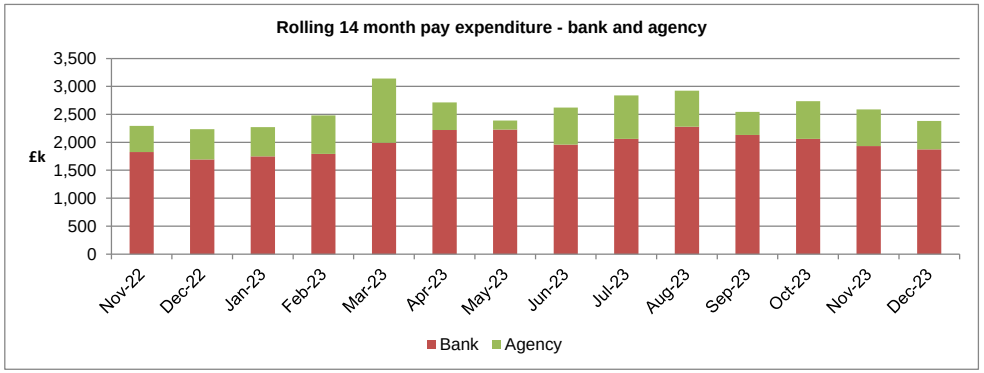
| | Division | | | | | | | Grand |
|---|---|---|---|---|---|---|---|---|
| Staff Type | Medicine | Surgery | W & C | CSS | Community | E & F | Corporate | Total |
| Nursing | 48.1 | 20.4 | 44.2 | 7.5 | 23.9 | 0.0 | 17.8 | 161.9 |
| A&C | (1.3) | 7.3 | 7.6 | 11.5 | 4.0 | 12.3 | 38.5 | 79.9 |
| AHP | 0.9 | 2.9 | 1.0 | 3.2 | 53.9 | 0.0 | 0.5 | 62.4 |
| Medical Staff | 5.8 | (3.5) | 8.3 | 2.6 | 0.4 | 0.0 | 16.6 | 30.1 |
| Sci & Professional | 1.4 | (0.7) | 2.1 | 8.4 | 2.1 | 1.2 | 0.0 | 14.5 |
| Hub Staff | 0.0 | 0.0 | 0.0 | 2.1 | 0.0 | 0.0 | 8.1 | 10.2 |
| Prof & Tech | (2.2) | (1.4) | 0.0 | 4.6 | 8.1 | (1.7) | (0.7) | 6.8 |
| Maintenance Staff | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 2.6 | 0.0 | 2.6 |
| Other | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Overtime Other | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Exec Board Members | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | (1.8) | (1.8) |
| Support Staff | (2.1) | (0.2) | 0.4 | 1.2 | 2.6 | (9.4) | 0.5 | (7.0) |
| **Grand Total** | **50.8** | **24.8** | **63.6** | **41.1** | **95.0** | **4.9** | **79.6** | **359.8** |

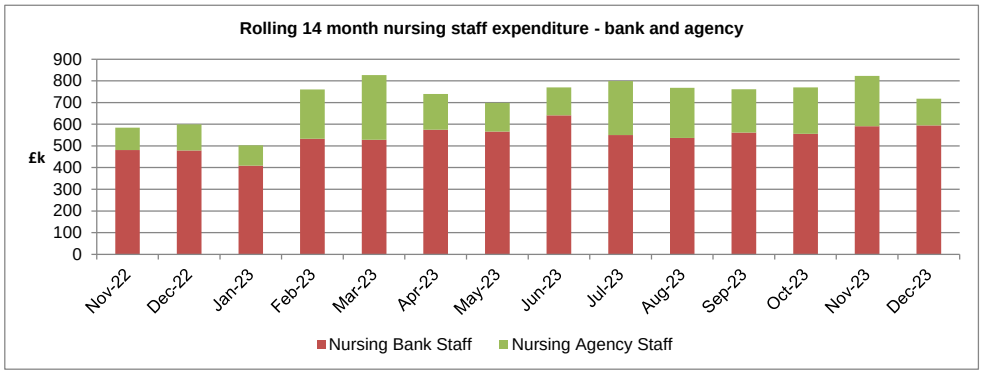
This increase is for a number of reasons, aligned to activity, investments and specific funding. However, this is being fully analysed to determine whether any of this increase is unfunded or fixed term and will be considered within the budgets and cost improvement plans that are being prepared for 2024-25.

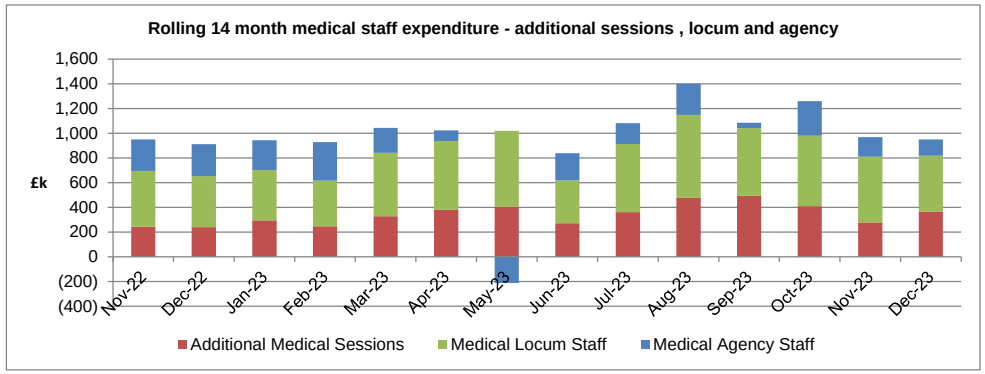
# FINANCE REPORT – December 2023

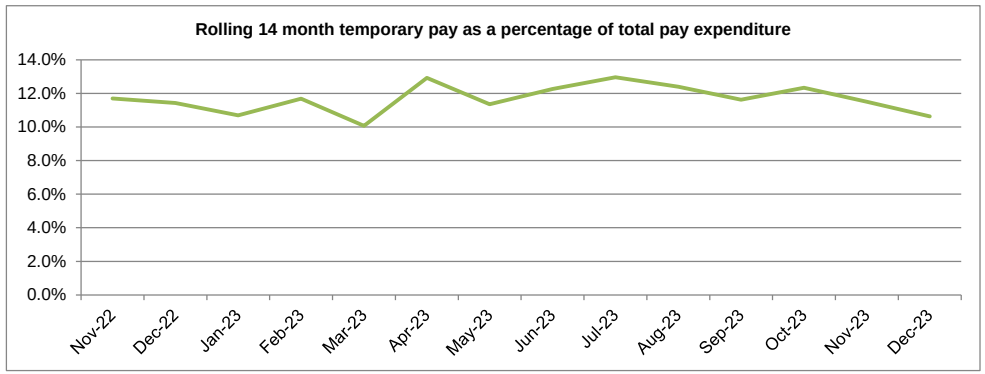
## Pay Costs

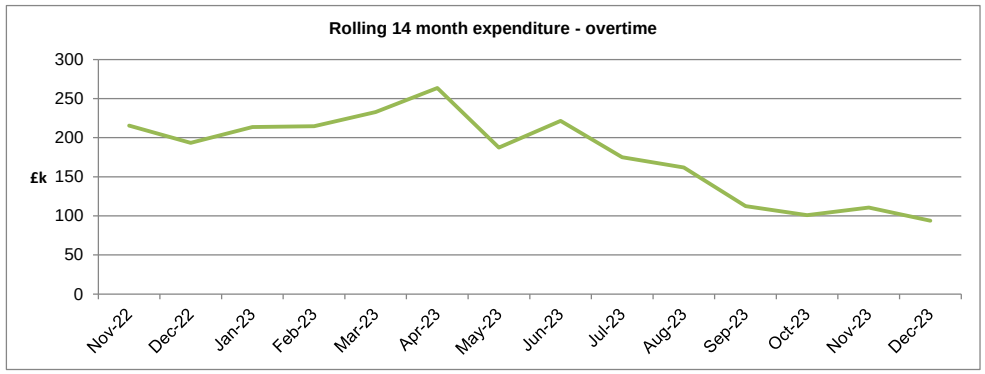


# FINANCE REPORT – December 2023

## Statement of Financial Position – 31 December 2023

STATEMENT OF FINANCIAL POSITION

| | As at 1 April 2023 | Plan 31 March 2024 | Plan YTD 31 December 2023 | Actual at 31 December 2023 | Variance YTD 31 December 2023 |
|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 |
| Intangible assets | 61,869 | 57,425 | 57,317 | 58,296 | 979 |
| Property, plant and equipment | 193,976 | 227,589 | 202,666 | 210,360 | 7,694 |
| Right of use assets | 9,817 | 9,929 | 10,553 | 11,984 | 1,431 |
| Trade and other receivables | 6,001 | 6,341 | 6,341 | 6,455 | 114 |
| **Total non-current assets** | **271,663** | **301,284** | **276,877** | **287,095** | **10,218** |
| Inventories | 4,365 | 3,800 | 3,800 | 4,413 | 613 |
| Trade and other receivables | 41,871 | 14,991 | 14,471 | 23,007 | 8,536 |
| Non-current assets for sale | 520 | 0 | 0 | 520 | 520 |
| Cash and cash equivalents | 7,895 | 14,298 | 10,216 | 12,741 | 2,525 |
| **Total current assets** | **54,651** | **33,089** | **28,487** | **40,681** | **12,194** |
| Trade and other payables | (73,503) | (45,862) | (40,943) | (49,789) | (8,846) |
| Borrowing repayable within 1 year | (4,801) | (3,724) | (3,724) | (5,055) | (1,331) |
| Current Provisions | (64) | (46) | (46) | (64) | (18) |
| Other liabilities | (1,336) | (5,185) | (5,185) | (10,607) | (5,422) |
| **Total current liabilities** | **(79,704)** | **(54,817)** | **(49,898)** | **(65,515)** | **(15,617)** |
| **Total assets less current liabilities** | **246,610** | **279,556** | **255,466** | **262,261** | **6,795** |
| Borrowings | (48,038) | (41,265) | (43,206) | (45,579) | (2,373) |
| Provisions | (507) | (852) | (852) | (499) | 353 |
| **Total non-current liabilities** | **(48,545)** | **(42,117)** | **(44,058)** | **(46,078)** | **(2,020)** |
| **Total assets employed** | **198,065** | **237,439** | **211,408** | **216,182** | **4,774** |
| **Financed by** | | | | | |
| Public dividend capital | 230,215 | 271,107 | 245,569 | 254,342 | 8,773 |
| Revaluation reserve | 12,054 | 12,640 | 12,640 | 12,054 | (586) |
| Income and expenditure reserve | (44,204) | (46,307) | (46,801) | (50,214) | (3,413) |
| **Total taxpayers' and others' equity** | **198,065** | **237,440** | **211,408** | **216,182** | **4,774** |

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

Total reserves are ahead of plan and this is due to a couple of factors. Firstly, we have received more PDC that we had originally planned, relating to revenue support to help our cash position and capital PDC for the New Hospital Project. Secondly, we are reporting a deficit higher than plan.

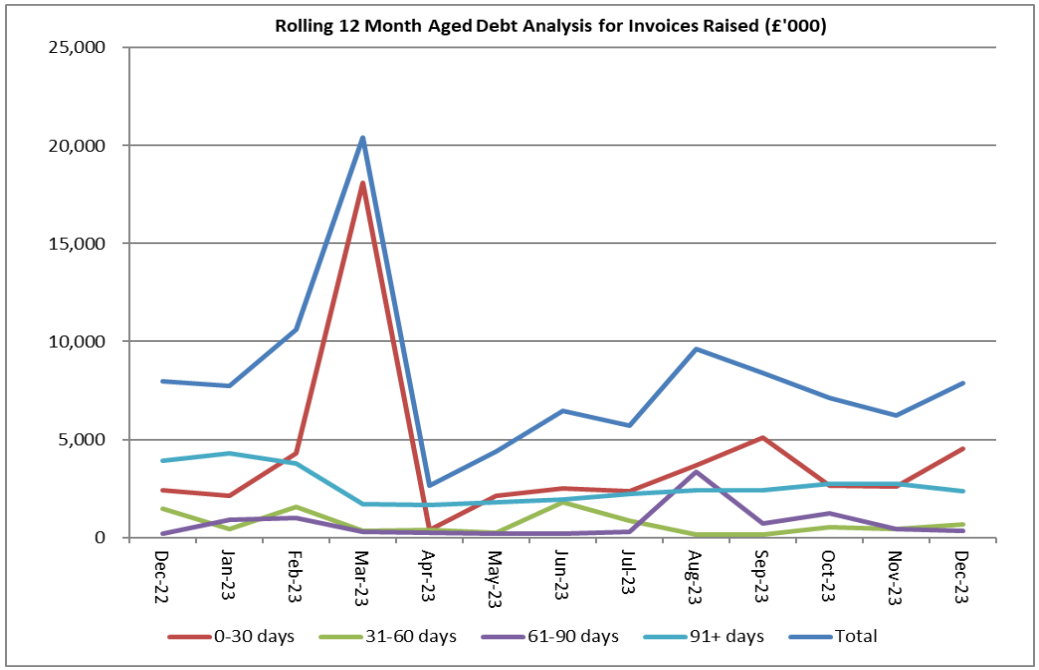
Although the asset base is growing, the phasing of the plan is not in line with actual spend.

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

**Page 11**

## 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.

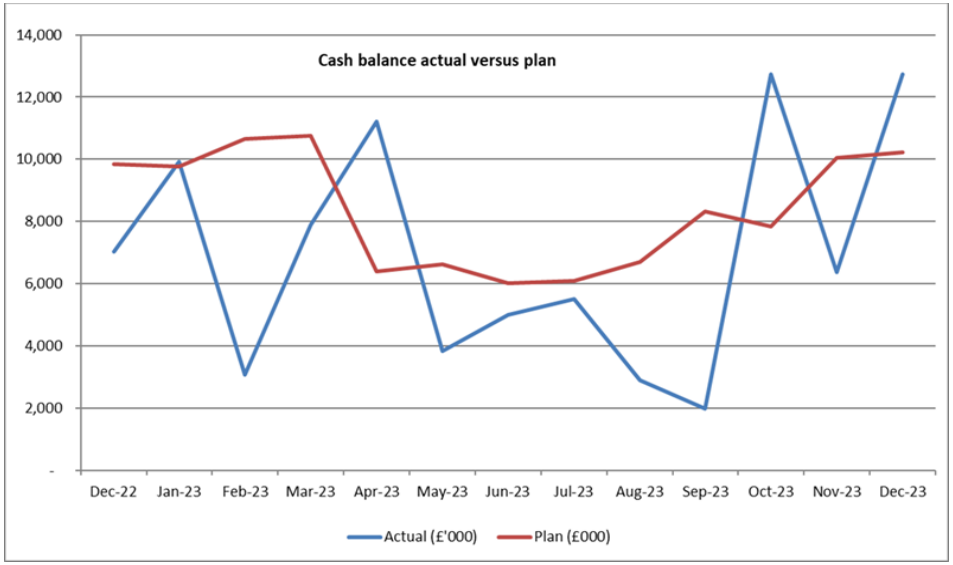
The overall level of sales invoices raised but not paid continues to remain stable and we have been working hard to reach resolution on some of the older debts in order to help the Trust's cash position.

Over 75% of the outstanding debts relate to NHS/WGA Organisations, with 18% of these types of debts being greater than 90 days old.

# FINANCE REPORT – December 2023

## Cash Balance for the year

The graph illustrates the cash trajectory since December 2022. The Trust is required to keep a minimum balance of £1.1m.




The Trust's cash balance as at 31 December 2023 was £12.7m. This was made up of £1.2m of cash that is set aside to pay for capital projects and £11.5m for revenue payments. The large cash balance at the end of the month is due to timing of the last payment run for December being before Christmas, leaving a slightly larger cash position than anticipated.

Our cash is being rigorously monitored to ensure that we have adequate cash reserves to match our expenditure. However, as the Trust continues to report a deficit, our cash position continues to deteriorate. The Trust has received £10m in revenue support from DHSC and we have applied for a further £6m to ensure that we have adequate cash for the 2023/24 financial year. We are waiting to receive confirmation that our application has been successful.

## Capital Progress Report

The previously revised Capital Plan for 2023/24 of £35.527m has now been further increased to £41.975m due to additional PDC funding received for the New Hospital. There continues to be discussions around the phasing of the capital funding for the New Hospital Project and the Newmarket CDC and therefore we may see a reduction in the programme, with expenditure and associated funding being moved to 2024/25.

The year to date capital spend at month 9 capital spend is £25.872m. The table below shows the breakdown:

| **Capital Spend - 31st Dec 2023** | | **Year to Date** | | | | |
|---|---|---|---|---|---|---|
| **Capital Scheme** | Full Year Plan | YTD Original Plan (M9) | **YTD Actual (M9)** | Variance | ***Funding Split*** | |
| | | | | | ***Internal*** | ***PDC Available*** |
| | £000's | £000's | **£000's** | | ***£000's*** | ***£000's*** |
| **New Hospital (Future Systems)** | 15,121 | 959 | **8,450** | - 7,491 | ***200*** | ***15,167*** |
| **Newmarket CDC** | 4,689 | 9,360 | **1,315** | 8,045 | | ***4,689*** |
| **RAAC** | 10,999 | 6,300 | **6,494** | - 194 | | ***10,900*** |
| **Estates** | 2,835 | 1,620 | **1,045** | 575 | ***1,966*** | |
| **IM&T** | 4,043 | 4,727 | **3,844** | 883 | ***5,989*** | ***328*** |
| **Medical Equipment** | 672 | 369 | **1,564** | - 1,195 | ***495*** | ***86*** |
| **Imaging Equipment** | 3,676 | 1,368 | **3,160** | - 1,792 | ***1,830*** | |
| **Other Schemes** | - | 243 | **-** | 243 | ***325*** | |
| **Total Capital Schemes** | 42,035 | 24,946 | **25,872** | - 926 | ***10,805*** | ***31,170*** |
| *Overspent vs Original Plan* | | | | | ***41,975*** | |
| *Underspent vs Original Plan* | | | | | | |

The Trust is on track to deliver the full year plan by 31 March 2024, subject to the phasing of some of the capital spend and associated funding for the New Hospital.

# FINANCE REPORT – December 2023

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

To Assure

Presented by Louisa Pepper

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

| Originating Committee: Improvement Committee | | | Date of meeting: 17th January 2024 | | |
|---|---|---|---|---|---|
| **Chaired by: Louisa Pepper** | | | **Lead Executive Director: Susan Wilkinson Paul Molyneux** | | |
| **Agenda item** | **WHAT?** *Summary of issue, including evaluation of the validity the data** | **Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal | **For 'Partial' or 'Minimal' level of assurance complete the following:** | | |
| | | | **SO WHAT?** *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk* | **WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)* | **Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board |
| 5.1 | IQPR including Divisional PRM packs. Received for information | 1 | IQPR and PRM reports demonstrate divisional level breakdown of key Trust metrics as well as those specific to each Division. | Deep Dives for C-Diff and post-partum haemorrhage scheduled in 2023/24 programme of assurance.<br><br>IQPR Emergency Pathways datasets to be reviewed to establish if the data is sensitive enough to cover aspects of patient safety and quality. | 1 |
| 6.1 | Patient Quality and Safety Group (PQASG)<br><br>Updates provided from December meetings; -<br><br>Trauma Group<br><br>IPC Committee<br><br>Nutrition Steering Group | 2 | Regular monthly report using the Trust's 1-4 assurance level scale.<br><br>Areas of partial assurance; -<br><br>Business case for funding to recruit a Serious Injury Co-ordinator was not supported – other cross division options being considered. WSFT unable | 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 January 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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| | Falls Steering Group<br><br>Pressure Ulcer Prevention Group<br><br>Incident (Information Flow) | | to fully meet all trauma standards.<br><br>Organism Surveillance – C.Diff rates continuing to rise. Improvement plan with system support in place and progressing.<br><br>Non-compliance with FFP3 testing for staff when reviewing national guidance; of note key areas e.g. ITU and Endoscopy had staff trained and equipped.<br><br>Non-compliance with National Patient Safety Alert (Sept 23) for bed rail use. Improvement plan in place, as well as an order of additional low-rise beds. | | |

| Originating Committee: Improvement Committee | | | Date of meeting: 17th January 2024 | | |
|---|---|---|---|---|---|
| Chaired by: Louisa Pepper | | | Lead Executive Director: Susan Wilkinson Paul Molyneux | | |
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| 7.1 | Patient Safety Priorities.<br><br>Updates regarding: -<br><br>Industrial Action<br><br>Winter Pressures | 2 | Patient Safety is key to patient care and a key component of trust strategy.<br><br>Industrial Action – 70% of junior doctors took part. Clinical teams provided cover. Any potential harm was recorded on Datix – none to date. Impact on Outpatient Appointments and planned procedures. Await updates regarding further industrial action.<br><br>Winter Pressures – F9 opened ahead of planned 27/12/23 opening to support. Consultant oversight in ED during industrial action. Ambulance offloads being supported through use of escalation areas. Move before Nine initiative to provide beds for those requiring admission. Datix | Industrial Action – On-going support to staff across all specialisms and roles. Currently further industrial action is unknown Winter Pressures – Improvement Plan in place to improve a range of emergency metrics whilst maintaining a drive to provide the safest care possible. Acknowledging initiatives may have an impact on quality and patient experience. Continue to work on patient flow, including maximising the use of the Virtual ward | 1<br><br>The Board to be aware of the challenging decisions being made in light of the ongoing urgent and emergency care pressures and the impact these are likely to have on quality and patient experience. |

| Originating Committee: Improvement Committee | | | Date of meeting: 17th January 2024 | | |
|---|---|---|---|---|---|
| Chaired by: Louisa Pepper | | | Lead Executive Director: Susan Wilkinson Paul Molyneux | | |
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| | | | system monitoring for emerging issues/harm to patients. | | |
| 8.1 | Ockenden – WSFT response regarding organisational learning | 2 | 15/1/24 – SLT undertook a Trustwide self-assurance assessment utilising the NHS Impact tool and incorporating Ockenden organisational issues in order to ensure strategic, understanding, co-ordination and cohesion of improvement across the organisation. | Update the Feb 23 gap analysis.<br>Compile an improvement action plan to ensure strategic alignment of work streams, and activity to ensure co-ordination, cohesion and overall governance of the process. | 1 |
| 8.2 | CNST- SUBMSSION | 1 | CNST or Maternity Incentive Scheme 2024 submission provides information and evidence of 100% compliance against ten standards. | Improvement Committee recommended submission to the Board for sign off. | 3 (Recommended for Board sign off) |
| 9.1 | BAF Risk Review<br>Ten themes identified. Governance linked to Improvement Committee | 1 | BAF documents key controls to manage the risk, the assurances from within the Trust and independently as to the effectiveness of the controls and | Governance – was acknowledged as key to the Improvement Committees work, however the Board and other sub-committees also share | 3 (Note for consideration at the next Board Development Day) |

| Originating Committee: Improvement Committee | | | Date of meeting: 17th January 2024 | | |
|---|---|---|---|---|---|
| Chaired by: Louisa Pepper | | | Lead Executive Director: Susan Wilkinson Paul Molyneux | | |
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| | | | highlights to the Board and sub-committees the gaps in control and assurance that it needs to address to reduce the risk to the lowest possible level. Failure to do so places objective delivery at risk. | responsibility for Governance. It will be considered at the next Board Development Day. | |
| 9.2 | Improvement Committee – Review of TOR (Terms of Reference) | 1 | TOR reviewed and amended to reflect on-going development of the committee's assurance responsibilities. | TOR to be reviewed annually. | 3 (Submitted to Board for approval) |

**See guidance notes for more detail*

# Guidance notes

## The practice of scrutiny and assurance

| | Questions regarding quality of evidence… | Further consideration… |
|---|---|---|
| **What?**<br>Deepening **understanding** of the evidence and ensuring its **validity** | **Validity** – the degree to which the evidence…<br>• measures what it says it measures<br>• comes from a reliable source with sound/proven methodology<br>• adds to triangulated insight | • Good data without a strong narrative is unconvincing.<br>• A strong narrative without good data is dangerous! |
| **So what?**<br>Increasing **appreciation** of the **value** (importance and impact) – what this means for us | **Value** – the degree to which the evidence…<br>• provides real intelligence and clarity to board understanding<br>• provides insight that supports good quality decision making<br>• supports effective assurance, provides strategic options and/or deeper awareness of culture | • What is most significant to explore further?<br>• What will take us from good to great if we focus on it?<br>• What are we curious about?<br>• What needs sharpening that might be slipping? |
| **What next?**<br>Exploring what should be **done next** (or not), informing **future** tactic / strategy, agreeing follow-up and future **evidence of impact** | | • Recommendations for action<br>• What impact are we intending to have and how will we know we've achieved it?<br>• 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.<br><br>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.<br><br>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.<br><br>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.<br><br>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: 20th December 2023 | | |
|---|---|---|---|---|---|
| **Chaired by: Louisa Pepper** | | | **Lead Executive Director: Susan Wilkinson** | | |
| **Agenda item** | **WHAT?** *Summary of issue, including evaluation of the validity the data** | **Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal | **For 'Partial' or 'Minimal' level of assurance complete the following:** **SO WHAT?** *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk* | **WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)* | **Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board |
| 5.1 | IQPR including Divisional PRM packs. Received for information | 1 | IQPR and PRM reports demonstrate divisional level breakdown of key Trust metrics as well as those specific to each Division. | Deep Dives for C-Diff and post-partum haemorrhage to be considered for 2023/24 programme of assurance.<br><br>Proposal to be developed to incorporate qualitative narrative in respect of IQPR data sets relevant to Improvement Committee as well as expanding metrics in respect of paediatrics. | 1 |
| 6.1 | Patient Quality and Safety Group (PQASG)<br><br>Updates provided from November meetings; -<br><br>Safeguarding Adults<br><br>Mental Health Transformation Group | 2 | Regular monthly report using the Trust's 1-4 assurance level scale.<br><br>Areas of partial assurance; -<br><br>Increased L of S patients requiring MH intervention.<br><br>Increased demand on LD & A services. | 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: 20th December 2023 | | |
|---|---|---|---|---|---|
| **Chaired by: Louisa Pepper** | | | **Lead Executive Director: Susan Wilkinson** | | |
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| | Learning Disability and Autism<br>Duty of Candour<br>Claims<br>Safeguarding Children | | Areas of improvement for LD & A patient group. | | |
| 6.2 | Clinical Effectiveness Governance Group (CEGG)<br>Updates from; -<br>Radiology<br>CQUIN<br>Public Health<br>NICE<br>CEGG Annual Assessment | 2 | 8 new NBP publications.<br>Need to ensure non-medical requestors do not request imaging outside their scope.<br>Potential breaches of IR(ME)R Regulations relating to the Radiology Report.<br>Discharge process workshop early 2024 to bring all stakeholders together to develop an overarching improvement programme.<br>. | CEGG will continue to maintain oversight of all items reported as emerging concerns through its reporting framework.<br>Potential breaches of IR(ME)R – is on the risk register but the Committee were not assured regarding improvement and departmental compliant and accreditation to be followed up through divisional PRM. | 1 |

| **Originating Committee: Improvement Committee** | | | **Date of meeting: 20th December 2023** | | |
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| 7.1 | Patient Safety Oversight Report. Quarterly Update | 2 | Patient Safety is key to patient care and a key component of the Trust strategy. We use patient safety to implement national objectives through our patient safety specialists. | PSIRF – WSFT were early adopters and developed a PSIRP plan to consider top risks to patient safety in our organisation.<br><br>Next steps appoint a WSFT patient safety specialist partner. | 1 |
| 7.2 | Letby response and report.<br><br>Thirwall Enquiry is investigating matters arising from the conviction of Lucy Letby (LL).<br><br>Three key issues: -<br><br>Experiences of parents of the babies named on the indictment.<br><br>Conduct of those working at the Countess of Chester Hospital regarding the actions of LL.<br><br>The effectiveness of NHS management structures, governance and processes inc. | 2 | Response from WSFT by 18th December 2023 – achieved by responding to 44 key questions. | WSFT will continue to respond to any request from this statutory enquiry. | 1 |

| Originating Committee: Improvement Committee | | | Date of meeting: 20th December 2023 | | |
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| | culture, to keep babies in hospital safe and well looked after (sent to all CEO's with a neo-natal unit). | | | | |
| 7.3 | Martha's Rule & Call for Concern (Call 4 Concern)<br><br>Martha's Rule – to respond to concerns from patients and families as well as staff concerns re poor patient outcomes with focus on deterioration of patients.<br><br>Call 4 Concern is a patient safety initiative recognising concerns from patients and relatives re seeking a second opinion. | 2 | WSFT aim to provide a process based on Call 4 Concern and Martha's Rule. | Develop a system where patients and families can contact clinical teams 24/7 with concerns or seek a second opinion as a right.<br><br>PQASG to have oversight. | 1 |

| Originating Committee: Improvement Committee | | | Date of meeting: 20th December 2023 | | |
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| 8.1 | Quality Assurance (QA) Programme inc. CQC Report.<br><br>QA framework sets out principles of QA & how it fits in a wider quality management system.<br><br>New CQC Single Assessment Framework introduced in Nov 23 will be rolled out nationally by March 2024. | 2 | 8th Jan 24 – CQC start using new single assessment framework in London and East of England.<br><br>6th Feb 24 – NHS Trust Well Led assessments begin.<br><br>April 24 – Trust moves to RADAR Risk Management System with functionality that could be used for audit and inspection checks. | Complete Exec led review of resources for evidence/assurance re well led.<br><br>Undertake a review for Safe/Effective/Caring and responsive (proposal to start with Safe and first draft to Improvement Committee Jan 24).<br><br>Review all published sources of outcome measures.<br><br>Each core area to undertake a similar review complimenting points 1-3 above. | 1 |
| 8.2 | Ockenden – WSFT response regarding organisational learning. | 3 | Following a review, the processes adopted have been considered too detailed and complex leading to confusion. A more generic and blended approach is being proposed. | Revert to Feb 23 action gap analysis.<br><br>Consider all actions inc. maternity and add actions as appropriate, whilst identifying strengths, areas for concern and | 3<br><br>(Escalated to Board as we were discussing the process for understanding our current compliance and referring back to Feb 23. Whilst WSFT |

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| | | | If we do not undertake this work there is a risk to our patients and the organisation. | their associated compliance status.<br><br>Allocate Exec ownership.<br><br>Allocate action owners/involvement.<br><br>Track with one simple plan<br><br>Consider integrating with NHS Impact Self-Assessment Tool<br><br>Consider timeline for strategic delivery. | may be compliant in some areas the committee were not assured in respect of the current progress). |
| 9.1 | NRLS Business Continuity during Datix change over. | 2 | WSFT moving from Datix to RADAR healthcare as its incident reporting platform.<br><br>A business continuity plan has been developed to ensure we meet our regulatory requirements. | WSFT plan to move in 2024. NHS England have agreed subject to certain conditions which WSFT have completed, namely: -<br><br>Notify ICB | 1 |

| **Originating Committee: Improvement Committee** | | | **Date of meeting: 20th December 2023** | | |
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| | | | This is an NHS England requirement to make this move. | Develop Business Continuity Plan<br><br>Notify CQC | |
| 9.2 | Internal Audit (all 3i Committees have received this report)<br><br>4 reports issued in Q2 | 2 | The work of internal audit is an important source of assurance on the effectiveness of the control environment regarding key systems and processes. | Medicines Management Audit – partial assurance – Improvement Committee has oversight of this and receives updates as part of its annual programme. Specific actions will be tracked through the medication safety forum. | 1 |

**See guidance notes for more detail*

## Guidance notes

### The practice of scrutiny and assurance

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

# 4.4. Quality and Nurse Staffing Report

To Assure

Presented by Susan Wilkinson

| Committee | |
|---|---|
| **Report title:** | Quality and Workforce Report & Dashboard – November and December 2023 |
| **Agenda item:** | |
| **Date of the meeting:** | **26th January 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 November and December 2023 It complies with national quality board recommendations to demonstrate effective deployment and utilisation of nursing and midwifery staff. The paper identifies planned staffing levels and where unable to achieve, actions taken to mitigate where possible. The paper also demonstrates the potential resulting impact of these staffing levels. It will go onto review vacancy rates, nurse sensitive indicators, and recruitment initiatives within the sphere of nursing resource management. This paper also demonstrates how nursing directorate is supporting the Trust's financial recovery ambitions, following a nursing deployment group established to provide oversight for nursing resource utilisation.

**SO WHAT?**

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

- Overall RN vacancy rate is positive causation/trend.
- Turn over for RN/RM remains under 10%
- High levels of NA sickness seen this period
- Combined nursing and NA fill rates above 90% continues this in this period and no longer within a declining trend.
- CHPPD reduced in December as expected following opening of escalation ward mid month
- Temporary spend reduced in this period, successfully achieving CIP trajectory M8 and M9
- ED SNCT review completed. Skill mix revision within budget has commenced

**WHAT NEXT?**

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

To continue to monitor early Improvements in temporary staffing spend in this period following implementation of Nursing Deployment Group and associated interventions.

**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 needed.

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

# Quality and Workforce Report & Dashboard – November and December2023

## 1. Introduction

1.1 This paper illustrates how WSFT's nursing and midwifery resource has been deployed for the month of November and December 2023. 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 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 November and December 2023. 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 November and December 2023 within the data submission deadline. Table 1 shows the summary of overall fill rate percentages for these months and for comparison, the previous four months. Appendix 1a and 1b illustrates a ward-by-ward breakdown for these periods.

| | Day | | Night | |
|---|---|---|---|---|
| | Registered | Care Staff | Registered | Care staff |
| Average fill rate July 2023 | 91% | 89% | 97% | 100% |
| Average fill rate August 2023 | 91% | 87% | 96% | 100% |
| Average fill rate Sept 2023 | 92% | 85% | 97% | 97% |
| Average fill rate Oct 2023 | 93% | 87% | 98% | 101% |
| Average fill rate Nov 203 | 94% | 86% | 98% | 104% |
| Average fill rate Dec 2023 | 91% | 86% | 97% | 100% |

Table 1

Fill rates have moved out of a declining picture in July 2023 as demonstrated below and average staffing fill rates (RN and NA) have achieved over 90% for the last 7 months.

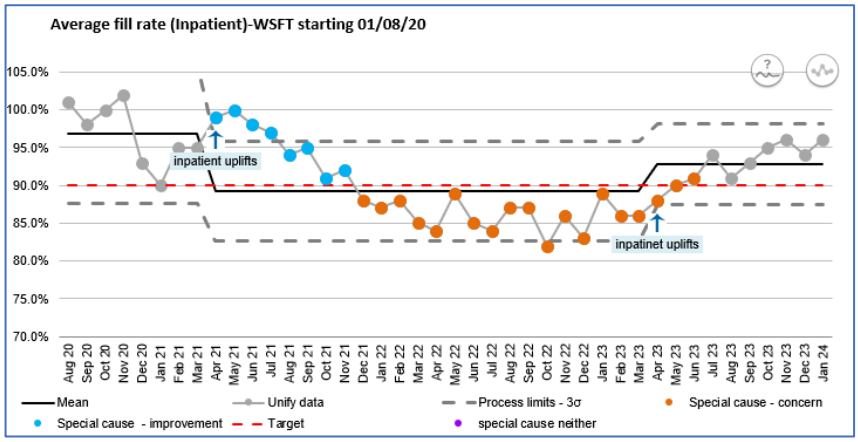



Chart 2

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. It is likely that CHPPD will degrade further in January due to this additional pressure and consistent use of additional escalation areas over the winter period.

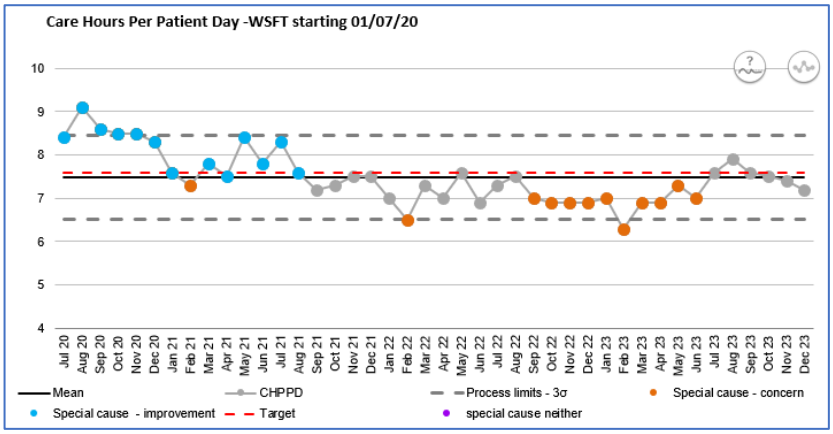



Chart 3

3.3 **Sickness**

Sickness rates seen in non registered roles have risen in this period 7.8% is the highest recorded this year for this staff group. RN sickness has remained static

| | May 23 | Jun 23 | July 23 | Aug 23 | Sep 23 | Oct 23 | Nov 23 | Dec 23 |
|---|---|---|---|---|---|---|---|---|
| Unregistered staff (support workers) | 6.74% | 6.63% | 6.09% | 5.78% | 6.14% | 6.57% | 6.78% | 7.80% |
| Registered Nurse/Midwives | 3.84% | 4.45% | 4.48% | 4.69% | 4.78% | 6.04% | 6.20% | 6.18% |
| Combined Registered/Unregistered | **5.42%** | **4.92%** | **5.02%** | **5.05%** | **5.23%** | **6.21%** | **6.40%** | **6.77%** |

Table 4

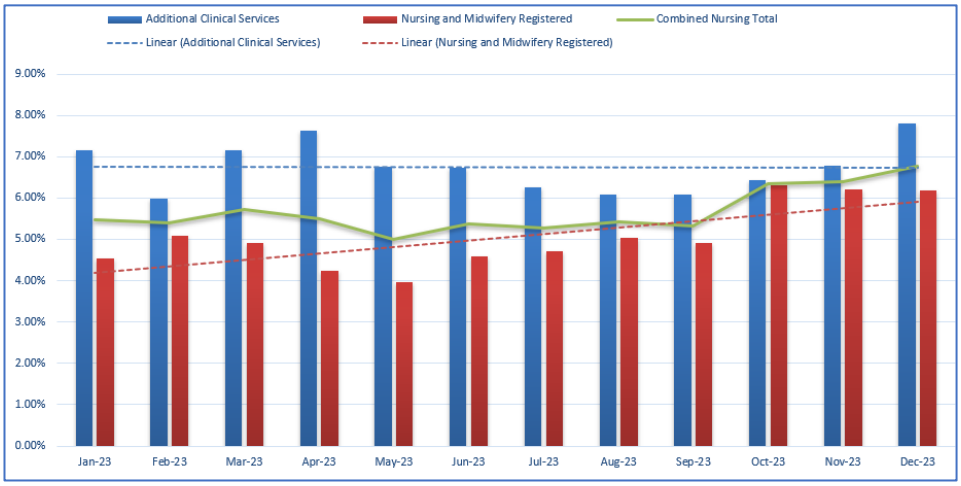



Chart 4

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.

- Substantive Inpatient RN/RM reduced by 10 WTE (budget movement from ED Peads to non ward area)
- Inpatient RN/RM vacancy rate has increased from 8.5% to 9.4% at the end of this period
- Total RN/RM vacancy rate sees minimal increase from 6% to 6.6% in month 9
- Inpatient NA vacancies percentages over this period have reduced slightly 12.4% in month 9
- Total NA vacancy rate has reduced slightly from 12% to 11.6%
- Total trust RN WTE and vacancy rate is an improving picture and is in special cause improvement.

Overall RN/RM vacancy continues to improve and is in special cause improvement. Improvement in inpatient vacancy has moved out of continued improvement to common cause variation. No concerning decline at this point (appendix 2). Nursing assistant numbers are currently maintaining with no significant improvement or decline.

| | Sum of Month 4 | Sum of Month 5 | Sum of Month 6 | Sum of Month 7 | Sum of Month 8 | Sum of Month 9 | WTE vacancy at M9 |
|---|---|---|---|---|---|---|---|
| RN | 667.6 | 678.7 | 688.2 | 699.7 | 696.8 | 689.2 | 71.6 |
| NA | 394.0 | 390.4 | 401.2 | 390.6 | 398.6 | 398.4 | 56.5 |

Table 5 Inpatient actual substantive staff WTE.

3.4.1 **International Recruitment**

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

3.4.2 **New Starters**

| | July 23 | Aug 23 | Sept 23 | Oct 23 | Nov 23 | Dec 23 |
|---|---|---|---|---|---|---|
| RN | 15 | 12 | 47* | 18 | 15 | 19 |
| NA | 12 | 36* | 23 | 24 | 23 | 25 |

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 November, 15 RNs completed induction; of these; 9 were for the acute, 4 for bank service and 2 for community services.
- In November, 23 NAs completed induction; of these; 19 NAs are for the acute Trust, and 2 for bank services and 2 for community services.

- In December, 19 RNs completed induction; of these; 12 were for the acute, 2 for community and 5 for bank services.
- In December, 25 NAs completed induction; of these; 18 NAs are for the acute Trust, 6 for bank services and 1 for community 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 marginally improved to 8.72. NA turnover has also improved from 23.4% to 20.1%.

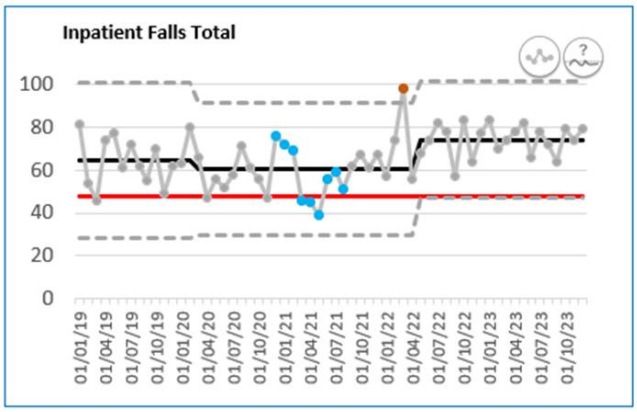
| Staff Group | Average Headcount | Turnover Avg FTE | 01/11/2022 - 31/10/2023 Starters Headcount | Starters FTE | Leavers Headcount | Leavers FTE | LTR Headcount % | LTR FTE % |
|---|---|---|---|---|---|---|---|---|
| Nursing and Midwifery Registered | 1,423.50 | 1,238.0577 | 88 | 72.3400 | 140 | 112.9467 | 9.8349% | 9.1229% |
| Additional Clinical Services | 603.00 | 505.1375 | 301 | 276.2154 | 149 | 118.1986 | 24.7098% | 23.3993% |

Table 7. (Data from workforce information)

3.5 **Quality Indicators**

Falls and acquired pressure ulcers.

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



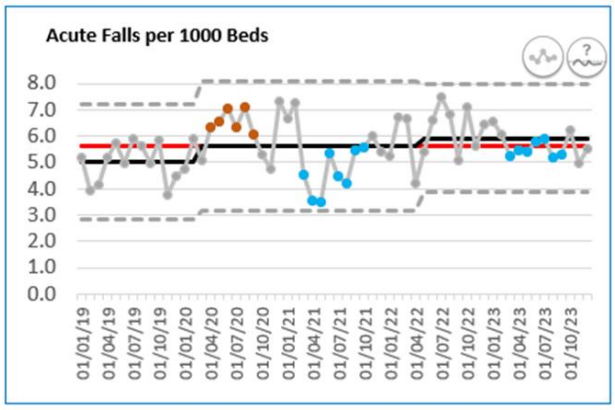
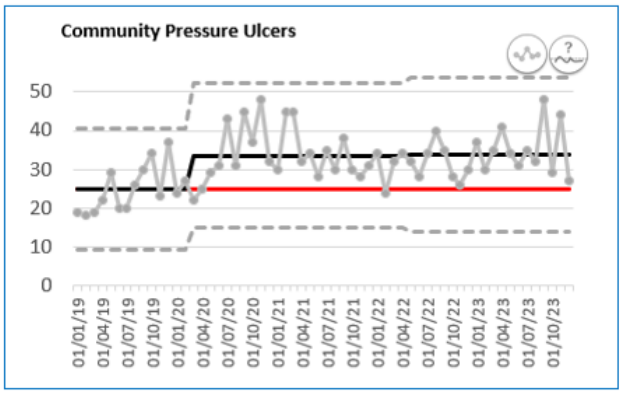




Chart 8 inpatient falls



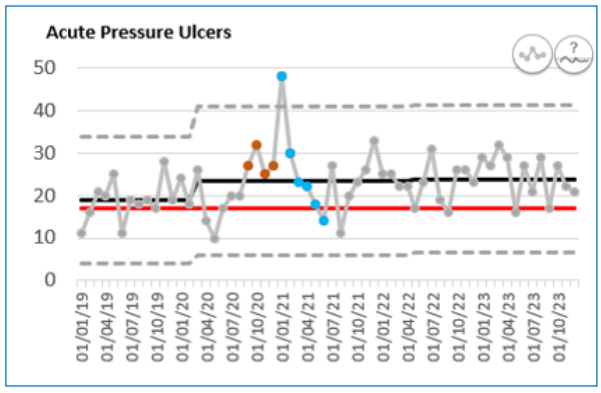




Chart 9 Pressure ulcers acquired in care

3.6 **Compliments and complaints**

8 formal complaints were received in November. No emerging themes or areas of concern this month. The highest category for these formal complaints was clinical treatment with 4 complaints being listed under this subject. The main theme of these complaints was delays in treatment or diagnosis.

17 formal complaints were received in December. 7 formal complaints were listed under the subject clinical treatment. The main theme of these complaints were delays in diagnosis, treatment or undertaking scans. The next highest theme of complaints was communications with 3 being listed under this subject.

Chart 10a and 10b demonstrates the incidence of complaints and compliments for this period. The number of complaints is at expected levels for this period, however November and December saw some of the highest incidents of compliments received by the trust since April 2020.

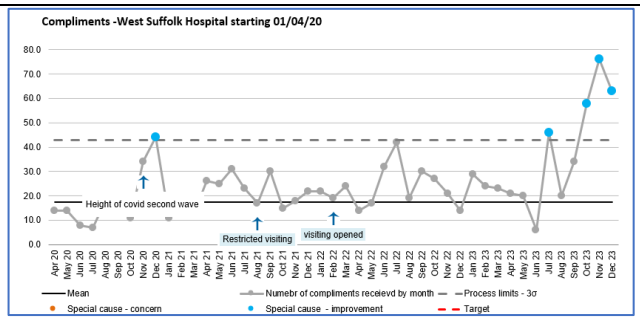



Chart 10a

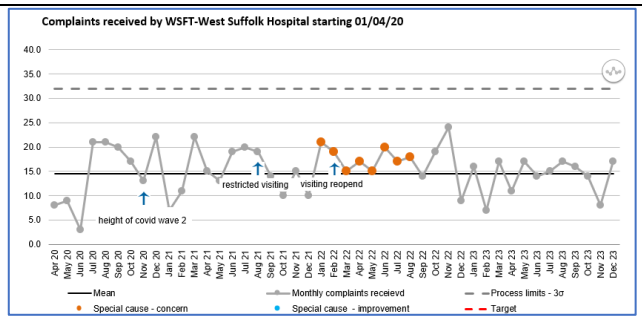



Chart 10b

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 5). Nursing staff are encouraged to complete a Datix as required, so any resulting patient harm can be identified and if necessary, reviewed retrospectively. For the purpose of this paper only those that meet NQB recommendations of a 'red flag' are included.

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

Table 11

- In November 19 Datixs recorded for nurse staffing that resulted in a Red Flag event (see table 11.). No Harm is recorded for these incidents.
- In December 17 Datixs recorded for inpatient nurse staffing that resulted in a Red Flag event (see table 11). No harm is recorded for these incidents.

3.8 **Maternity services**

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

| | Standard | July | August | September | October | November | December |
|---|---|---|---|---|---|---|---|
| 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 | 1:22.5 | 1:20.5 | 1:23.5 | 1:21 | 1:21 |
| | | | | | | | |
| No. Red Flags reported | | 2 | 1 | 6 | 2 | 1 | 2 |

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

- There was one red flag events reported in November
- There were two red flag events in December

No harm was recorded as in impact of these incidents.

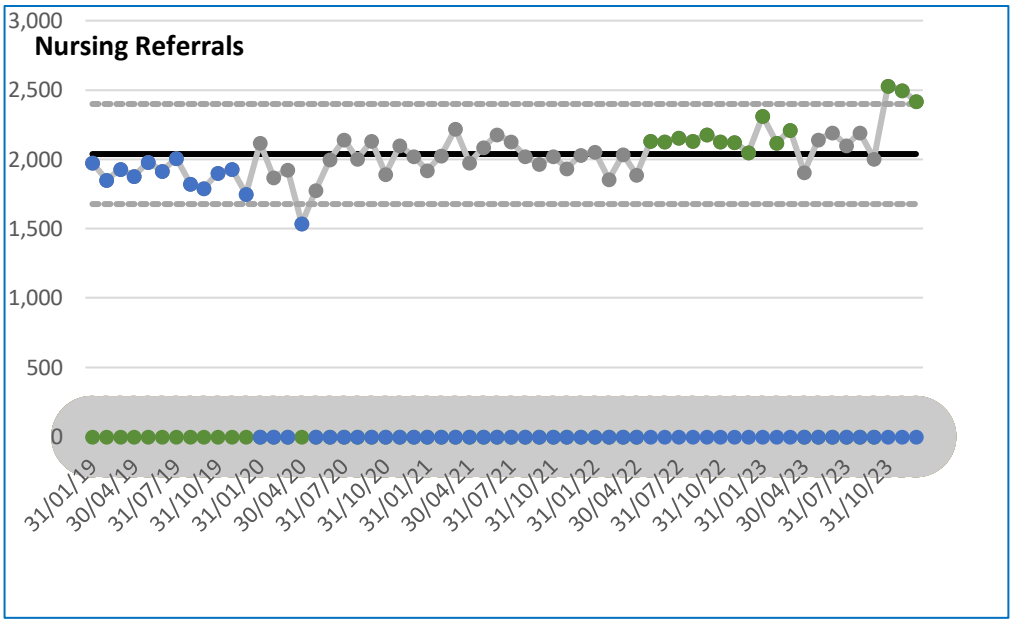
**Midwife to Birth ratio**
Latest BirthRate plus review undertaken in March 2023 shows that Midwife to Birth ratio at West Suffolk NHS Foundation Trust reduced to 1:21. The ratios are based on the Birthrate Plus® dataset, national standards with the methodology and local factors, such as % uplift for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

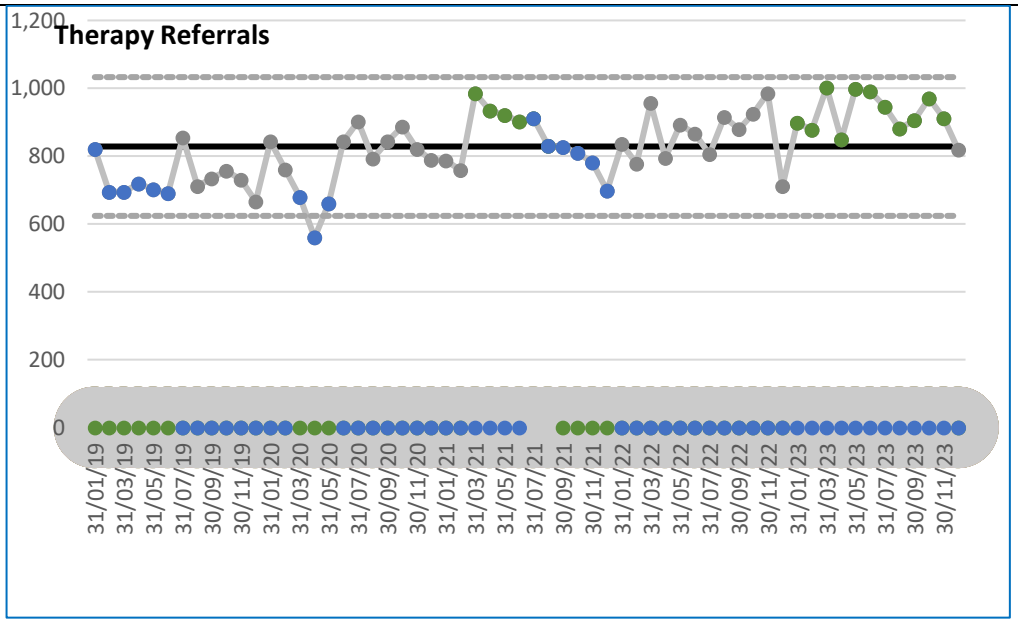
- WSFT birth rate was 1:21 for both November and December

**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 November and December 2023.

3.9 **Community and integrated teams**

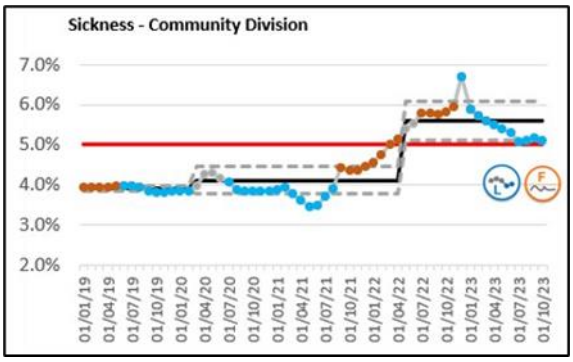
**Demand**
The SPC charts show that demand for both therapy in the INT teams and nursing is consistently increasing, nursing continue to high levels of activity for this period.

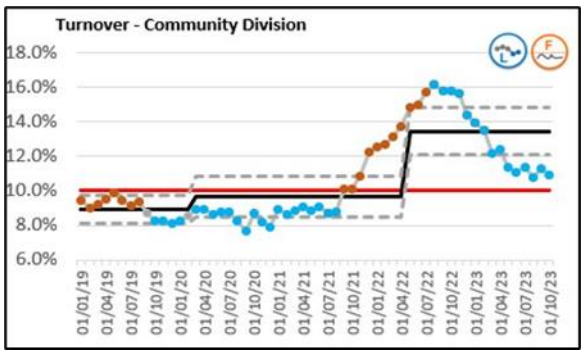





**Sickness & Turnover**

Divisional sickness is at 5.07%, for November, based on 12 month rolling average. This is slightly higher than rest of trust. Some teams have no sickness, 2 INTs have very high sickness at 13%.




**Community Nursing Safer Staffing tool**

The tool has been used twice in 2023 with very consistent results between both censuses. The results are also very similar to (East Suffolk and North Essex NHS Foundation trust ( ESNEFT). The tool forms part of our analysis of workforce review alongside review of quality and professional judgement.

The tool is recommending an uplift in staffing, which fits with a lot of the themes which are reviewed at monthly Quality meetings and 6 monthly service level reviews. The details of this will form a paper or prosed business case. It is also leading to internal discussions on how to prioritise any staffing areas and reviewing the skill mix.

There is no national validated tool to support other professional's workforce reviews, although we are participating in supporting the development of one.

**What next for community teams**

- Health Rosters in INTs have been reviewed and will reflect budgets & actual staffing from mid-February. This will allow for better use of roster reporting.
- New escalation spreadsheet devised. To pilot in Feb, this will support managers to have more accurate data for OPEL reporting.
- Regular meetings set up with senior managers & staff wellbeing lead to hear the themes & to support the right actions to address issues.

| | |
|---|---|
| **4.** | **Next steps** |
| 4.1 | **Nursing Resource oversight Group**<br>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.<br><br>A reduction trajectory has been agreed and was successfully overachieved in November and December. This is evidence of improved grip and control and commitment to ensuring our nursing workforce is deployed efficiently and cost effectively. |

| Nursing Temporary Staff Cost Reduction | | | | | | | |
|---|---|---|---|---|---|---|---|
| Period | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 | Mar-24 | Totals |
| Target/Aim (£000) | 144 | 144 | 144 | 144 | 144 | 144 | 865 |
| Initiative | Actual | Actual | Actual | Forecast | Forecast | Forecast | Forecast |
| 1. Overtime | 15 | 73 | 33 | 30 | 30 | 30 | **211** |
| 2. Rate Standardisation | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| 3. Pool reduction | 57 | 86 | 77 | 50 | 50 | 50 | **370** |
| 4. Agency | 0 | 49 | 75 | 30 | 30 | 30 | **214** |
| 5. Rostering | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Achievement (£000) | 72 | 208 | 185 | 110 | 110 | 110 | 795 |

| | |
|---|---|
| 4.2 | **Establishment reviews**<br>The trust obtained the licence for the revised Safter Nursing Care Tool (November 2023) and will run its next round of audit in February 2024. Training workshops and orientation to the new tool has been delivered in January 2024 to ensure validity in the next round. Its unlikely that any establishment changes will be made this year as at least two points of data are required using new methodology to ensure reliability.<br><br>The emergency department (ED) has conducted its an establishment review using the ED SNCT that was launched in 2022. A briefing paper explaining the process and recommendations can be found in appendix 5. Recommendations and actions following this review will aim to meet some of the recommendations of the SNCT and increase the skill mix within the ED in favour of registered nurses. This will be done within current budget. Further audit needs to be completed to consider increasing the headroom within the ED as per SNCT recommendations considering increasing training requirements and consistent challenges with capacity and flow |
| **5.** | **Conclusion** |
| 5.1 | For this period fill rates have remained favourable although an expected decline in CHPPD was seen. Vacancy rates remain consistent and within RN establishment continue an improvement trend.<br>Positive steps have been made in achieving CIP trajectory within temporary staffing that do not have appeared to have affected fill rates or patient safety. This will continue to be monitored through our patient safety data. |
| **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 (November 2023) Data adapted from Unify submission.
RAG: Red <79%, Amber 80-89%, Green 90-100%, Purple >100

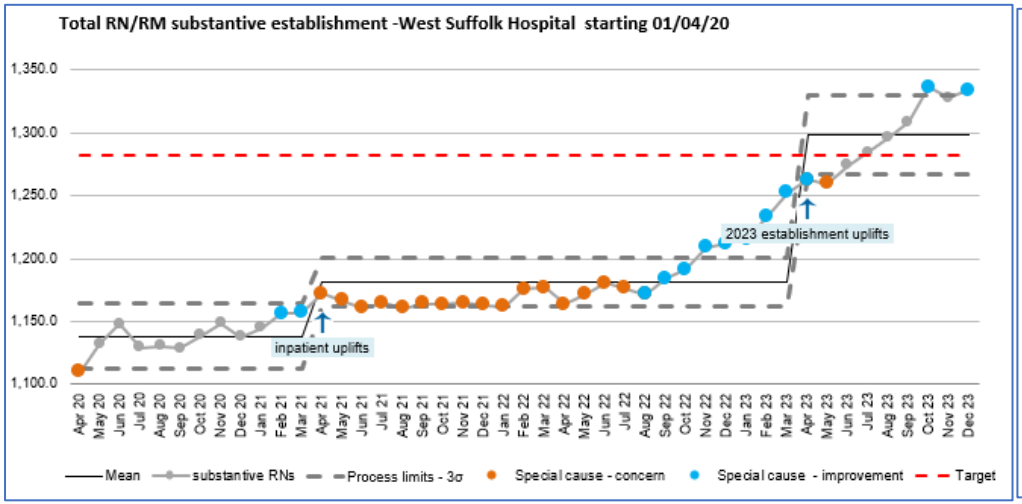
| | Day | | | | Night | | | | Day | | Night | | Care Hours Per Patient Day (CHPPD) | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | RNs/RMN | | Non registered (Care staff) | | RNs/RMN | | Non registered (Care staff) | | | | | | | | | |
| | Total monthly planned staff hours | Total monthly actual staff hours | Total monthly planned staff hours | Total monthly actual staff hours | Total monthly planned staff hours | Total monthly actual staff hours | Total monthly planned staff hours | Total monthly actual staff hours | Average Fill rate RNs/RM % | Average fill rate Care staff % | Average Fill rate RNs/RM % | Average fill rate Care staff % | Cumulative count over the month of patients at 23:59 each day | RNS/RMs | Non registered (care staff) | Overall |
| Rosemary Ward | 1373.75 | 1269.75 | 1717.5 | 1412.75 | 1035 | 1009.083333 | 1380 | 1290 | 92% | 82% | 97% | 93% | 932 | 2.4 | 2.9 | 5.3 |
| Glastonbury Court | 690 | 691.91667 | 1036.5 | 1025.5667 | 690 | 690 | 525 | 525.216667 | 100% | 99% | 100% | 100% | 503 | 2.7 | 3.1 | 5.8 |
| Acute Assessment U | 2043 | 2123.3333 | 2347.75 | 1660 | 1702 | 1610.416667 | 1380 | 1120.58333 | 104% | 71% | 95% | 81% | 761 | 4.9 | 3.7 | 8.6 |
| Cardiac Centre | 1713.5 | 1572 | 1023.5 | 806 | 1702 | 1589 | 690 | 690 | 92% | 79% | 93% | 100% | 632 | 5.0 | 2.4 | 7.4 |
| G10 | 1632.23333 | 1568.5833 | 1663 | 1528.5833 | 989 | 1017 | 1697 | 1486.5 | 96% | 92% | 103% | 88% | 707 | 3.7 | 4.3 | 7.9 |
| G9 | 1612.5 | 1485.75 | 1351 | 1283.5 | 1253.5 | 1245.5 | 1035 | 1110 | 92% | 95% | 99% | 107% | 752 | 3.6 | 3.2 | 6.8 |
| F12 | 528 | 618 | 341.5 | 302 | 678.5 | 630 | 299 | 333.5 | 117% | 88% | 93% | 112% | 240 | 5.2 | 2.6 | 7.8 |
| F7 | 1672.5 | 1551.25 | 1664.25 | 1517 | 1345.5 | 1313.5 | 1696.5 | 1687 | 93% | 91% | 98% | 99% | 683 | 4.2 | 4.7 | 8.9 |
| G1 | 1384.75 | 985.33333 | 348.5 | 307.75 | 690 | 689 | 345 | 337.983333 | 71% | 88% | 100% | 98% | 485 | 3.5 | 1.3 | 4.8 |
| G3 | 1709.5 | 1504.5 | 1652 | 1535 | 1035 | 1034.5 | 1024 | 1450.5 | 88% | 93% | 100% | 142% | 864 | 2.9 | 3.5 | 6.4 |
| G4 | 1694.5 | 1507.25 | 1713.5 | 1592.3333 | 1023.5 | 931.5 | 1357 | 1448 | 89% | 93% | 91% | 107% | 896 | 2.7 | 3.4 | 6.1 |
| G5 | 1357 | 1421.5 | 1369.75 | 1332.75 | 690 | 1022.5 | 1345.5 | 1417 | 105% | 97% | 148% | 105% | 760 | 3.2 | 3.6 | 6.8 |
| G8 | 2053 | 2034.9167 | 1575.08333 | 1461.6667 | 1582 | 1568.166667 | 1012 | 1062.25 | 99% | 93% | 99% | 105% | 615 | 5.9 | 4.1 | 10.0 |
| F8 | 1564 | 1469.5833 | 1649.75 | 1559.0833 | 1018 | 893.8333333 | 1368.5 | 1444.5 | 94% | 95% | 88% | 106% | 723 | 3.3 | 4.2 | 7.4 |
| Critical Care | 2338.75 | 2137 | 330 | 170 | 2379 | 2164.75 | 0 | 151.25 | 91% | 52% | 91% | * | 388 | 11.1 | 0.8 | 11.9 |
| F3 | 1552.5 | 1401 | 2060.5 | 1472.3333 | 1035 | 1028.75 | 1380 | 1382.25 | 90% | 71% | 99% | 100% | 732 | 3.3 | 3.9 | 7.2 |
| F4 | 884.5 | 821.75 | 593 | 704.5 | 667.5 | 667.5 | 536 | 486.5 | 93% | 119% | 100% | 91% | 633 | 2.4 | 1.9 | 4.2 |
| F5 | 1870.5 | 1761.1667 | 1622 | 1080.25 | 1023.5 | 943.75 | 1035 | 986 | 94% | 67% | 92% | 95% | 698 | 3.9 | 3.0 | 6.8 |
| F6 | 1722 | 1313 | 1703.25 | 1399.5 | 1023.5 | 1014 | 690 | 1043.51667 | 76% | 82% | 99% | 151% | 942 | 2.5 | 2.6 | 5.1 |
| Neonatal Unit | 1161 | 1102.5 | 576 | 576 | 912 | 924 | 528 | 540 | 95% | 100% | 101% | 102% | 116 | 17.5 | 9.6 | 27.1 |
| F1 | 1589 | 1861.25 | 690 | 523.25 | 1380 | 1460.5 | 0 | 11.5 | 117% | 76% | 106% | * | 115 | 28.9 | 4.7 | 33.5 |
| F14 | 360 | 361 | 360 | 360 | 720 | 720 | 0 | 0 | 100% | 100% | 100% | * | 106 | 10.2 | 3.4 | 13.6 |
| **Total** | 32,506.48 | 30,562.33 | 27,388.33 | 23,609.82 | 24,574.50 | 24,167.25 | 19,323.50 | 20,004.05 | **94%** | **86%** | **98%** | **104%** | **13283** | **4.1** | **3.3** | **7.4** |
| * planned hours are zero, so additional support used on ward to mitigate unfilled nursing hours | | | | | | | | | | | | | | | | |

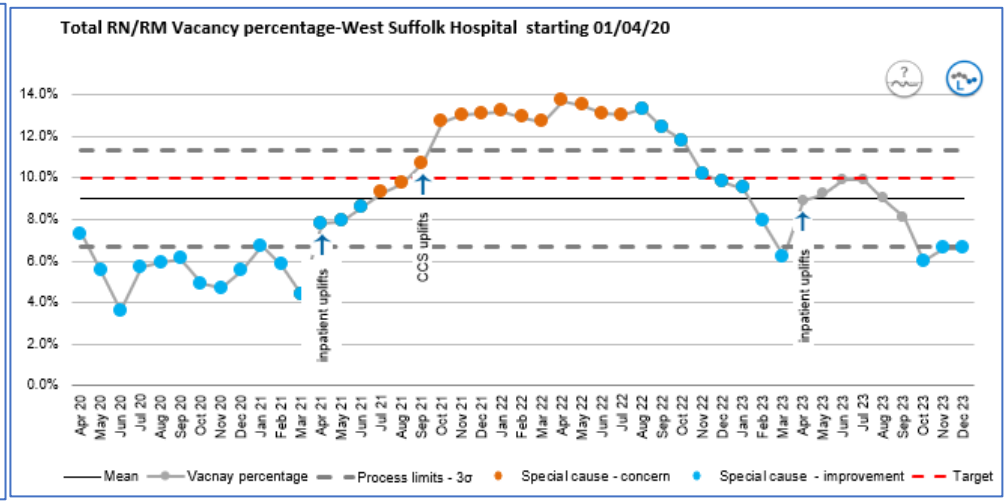
Appendix 1. Fill rates for inpatient areas (December 2023) Data adapted from Unify submission.

| | Day | | | | Night | | | | Day | | Night | | Care Hours Per Patient Day (CHPPD) | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | RNs/RMN | | Non registered (Care staff) | | RNs/RMN | | Non registered (Care staff) | | | | | | | | | |
| | Total monthly planned staff hours | Total monthly actual staff hours | Total monthly planned staff hours | Total monthly actual staff hours | Total monthly planned staff hours | Total monthly actual staff hours | Total monthly planned staff hours | Total monthly actual staff hours | Average Fill rate RNs/RM % | Average fill rate Care staff % | Average Fill rate RNs/RM % | Average fill rate Care staff % | Cumulative count over the month of patients at 23:59 each | RNS/RMs | Non registered (care staff) | Overall |
| Rosemary Ward | 1425 | 1255.25 | 1786.5 | 1651 | 1069 | 1008.833333 | 1424.5 | 1360.75 | 88% | 92% | 94% | 96% | 969 | 2.3 | 3.1 | 5.4 |
| Glastonbury Court | 714.5 | 704.5 | 1062.5 | 1013 | 713 | 701.5 | 542.5 | 533 | 99% | 95% | 98% | 98% | 574 | 2.4 | 2.7 | 5.1 |
| Acute Assessment | 2090.75 | 2214.0667 | 2350.83333 | 1819.0833 | 1771.5 | 1740.5 | 1415.5 | 1310 | 106% | 77% | 98% | 93% | 761 | 5.2 | 4.1 | 9.3 |
| Cardiac Centre | 1782.5 | 1645.5 | 1028 | 832 | 1748 | 1577.5 | 686.5 | 718.5 | 92% | 81% | 90% | 105% | 632 | 5.1 | 2.5 | 7.6 |
| G10 | 1776.75 | 1528.9167 | 1771.25 | 1491.75 | 1069.5 | 1082.25 | 1776 | 1457 | 86% | 84% | 101% | 82% | 707 | 3.7 | 4.2 | 7.9 |
| G9 | 1702 | 1577.5 | 1414.5 | 1334.5 | 1311 | 1335 | 1069.5 | 1092.5 | 93% | 94% | 102% | 102% | 752 | 3.9 | 3.2 | 7.1 |
| F12 | 537.5 | 654.25 | 437 | 313.75 | 644 | 599 | 356.5 | 387.5 | 122% | 72% | 93% | 109% | 240 | 5.2 | 2.9 | 8.1 |
| F7 | 1748 | 1555.3333 | 1621.5 | 1489 | 1403 | 1286.5 | 1753 | 1549 | 89% | 92% | 92% | 88% | 683 | 4.2 | 4.4 | 8.6 |
| G1 | 1433.5 | 1046.75 | 352.5 | 350.5 | 713 | 725 | 356.5 | 317 | 73% | 99% | 102% | 89% | 485 | 3.7 | 1.4 | 5.0 |
| G3 | 1782.5 | 1491 | 1766 | 1626 | 1069.5 | 1069.5 | 1058.5 | 1281 | 84% | 92% | 100% | 121% | 864 | 3.0 | 3.4 | 6.3 |
| G4 | 1791.5 | 1614.75 | 1786 | 1637 | 1069.5 | 987.5 | 1417 | 1448.5 | 90% | 92% | 92% | 102% | 896 | 2.9 | 3.4 | 6.3 |
| G5 | 1403 | 1388.5 | 1656 | 1484.3333 | 713 | 1031.5 | 1368.5 | 1430 | 99% | 90% | 145% | 104% | 760 | 3.2 | 3.8 | 7.0 |
| G8 | 2352.5 | 2049.3333 | 1716.5 | 1313.4167 | 1578.5 | 1516.383333 | 1069.5 | 1113.5 | 87% | 77% | 96% | 104% | 615 | 5.8 | 3.9 | 9.7 |
| F8 | 1604.25 | 1404.8333 | 1655.5 | 1447.75 | 1069.5 | 910.3333333 | 1385 | 1465 | 88% | 87% | 85% | 106% | 723 | 3.2 | 4.0 | 7.2 |
| Critical Care | 2346 | 2242 | 341 | 106 | 2273.5 | 2149.25 | 0 | 30 | 96% | 31% | 95% | * | 388 | 11.3 | 0.4 | 11.7 |
| F3 | 1673 | 1445.75 | 2083 | 1631.4167 | 1069.5 | 1044.5 | 1426 | 1373.5 | 86% | 78% | 98% | 96% | 732 | 3.4 | 4.1 | 7.5 |
| F4 | 773.25 | 772 | 565.5 | 723.5 | 575 | 549.5 | 412 | 392.5 | 100% | 128% | 96% | 95% | 633 | 2.1 | 1.8 | 3.9 |
| F5 | 1842.5 | 1641 | 1622.5 | 1207 | 1069.5 | 936.5 | 1058 | 955.5 | 89% | 74% | 88% | 90% | 698 | 3.7 | 3.1 | 6.8 |
| F6 | 1777.5 | 1259.75 | 1782 | 1531.8333 | 1069.5 | 1074.25 | 713 | 1139 | 71% | 86% | 100% | 160% | 942 | 2.5 | 2.8 | 5.3 |
| Neonatal Unit | 1265.5 | 1121.5 | 653 | 569 | 1116 | 920.5 | 636 | 614 | 89% | 87% | 82% | 97% | 116 | 17.6 | 10.2 | 27.8 |
| F1 | 1597 | 1778.25 | 713 | 676.5 | 1426 | 1492.75 | 0 | 0 | 111% | 95% | 105% | * | 115 | 28.4 | 5.9 | 34.3 |
| F14 | 372 | 441.5 | 372 | 298 | 732 | 779.5 | 0 | 0 | 119% | 100% | 106% | * | 106 | 11.5 | 2.8 | 14.3 |
| F9 | 433.5 | 367 | 487 | 298.5 | 391 | 368 | 540.5 | 425 | 85% | 61% | 94% | 79% | 744 | 1.0 | 1.0 | 2.0 |
| **Total** | 33,791.00 | 30,832.23 | 28,536.58 | 24,546.33 | 25,273.00 | 24,518.05 | 19,924.00 | 19,967.75 | **91%** | **86%** | **97%** | **100%** | **14135** | **4.0** | **3.2** | **7.2** |

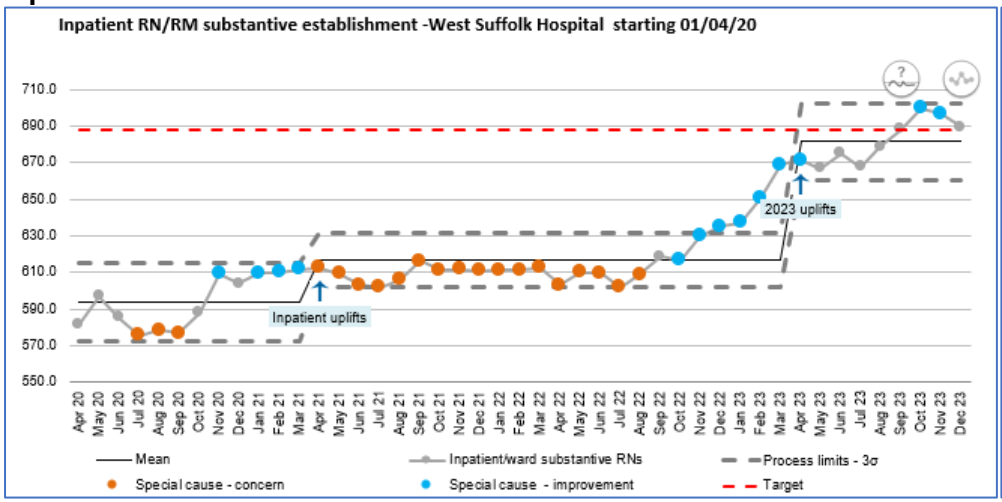
Appendix 2 SPC charts.

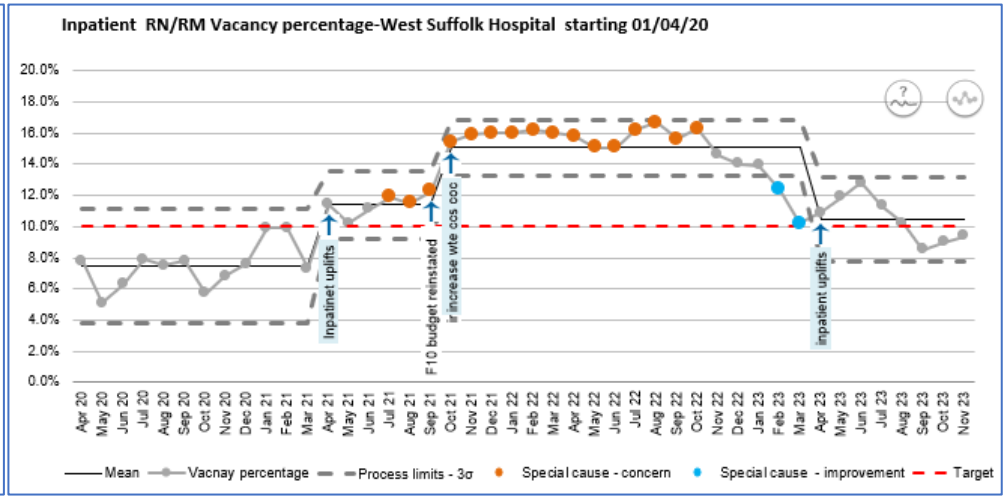
## Trust Total RN/RM



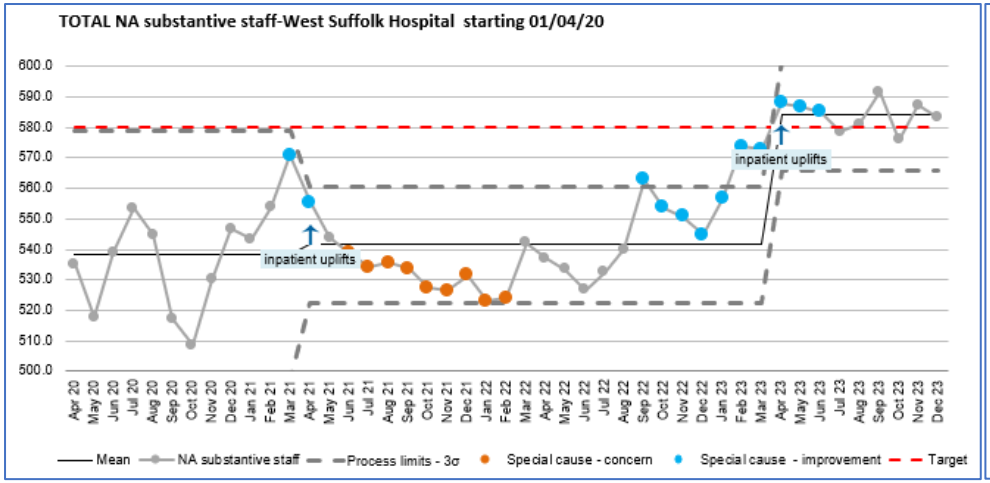



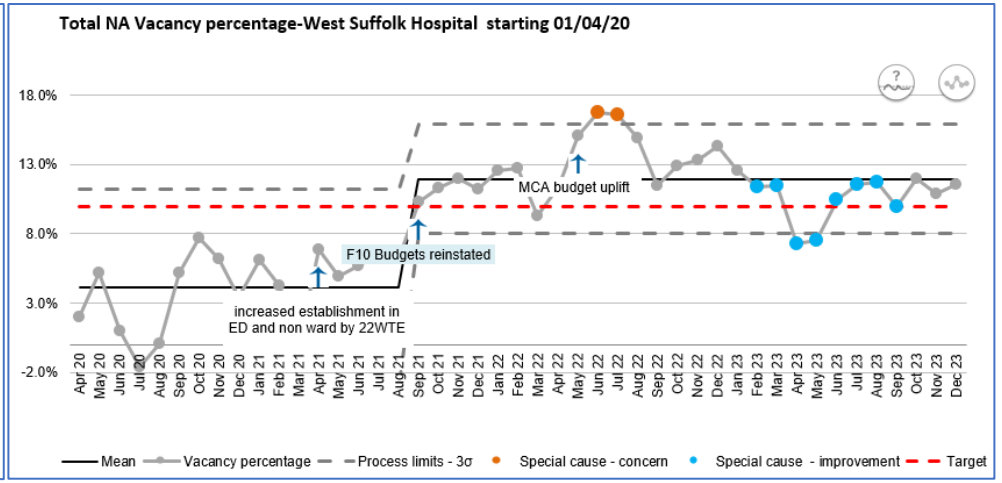

## Inpatient RN/RM



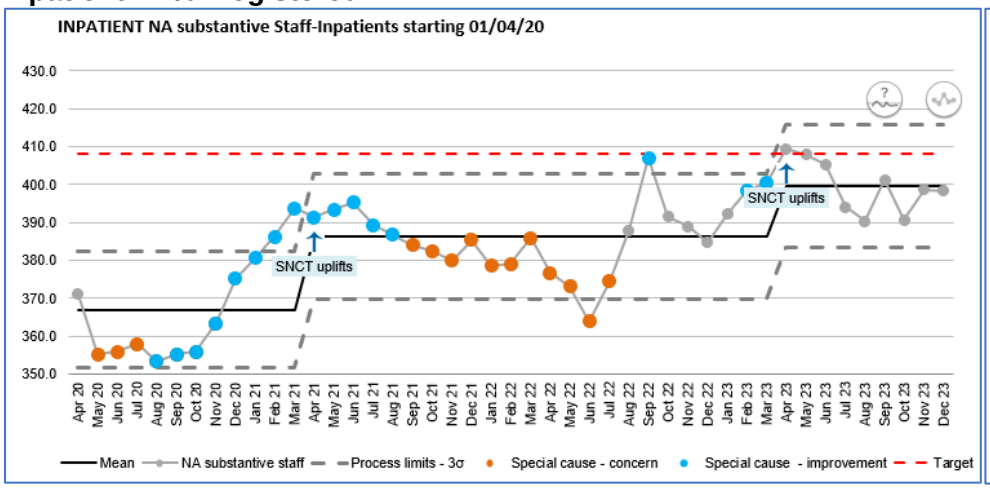



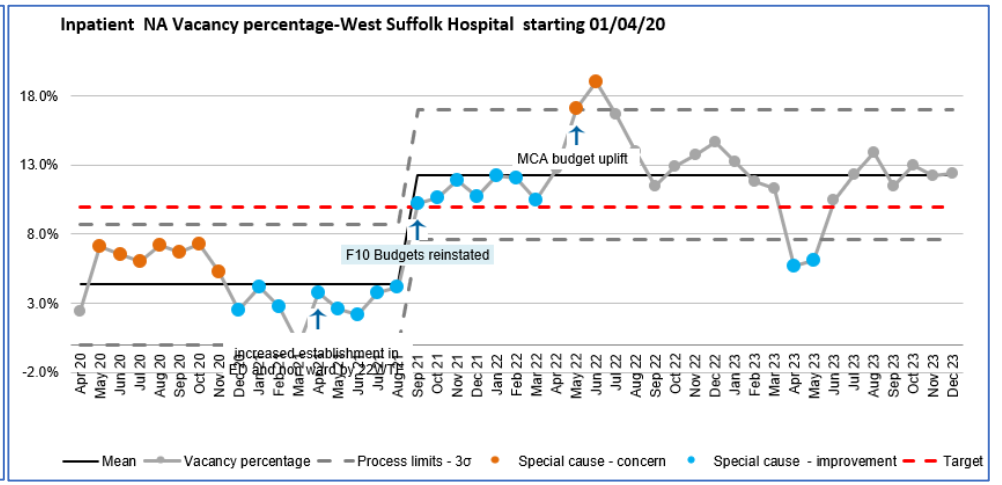
## Total NA/unregistered.




## Inpatient NA/unregistered.



Appendix 3: Red Flag Events

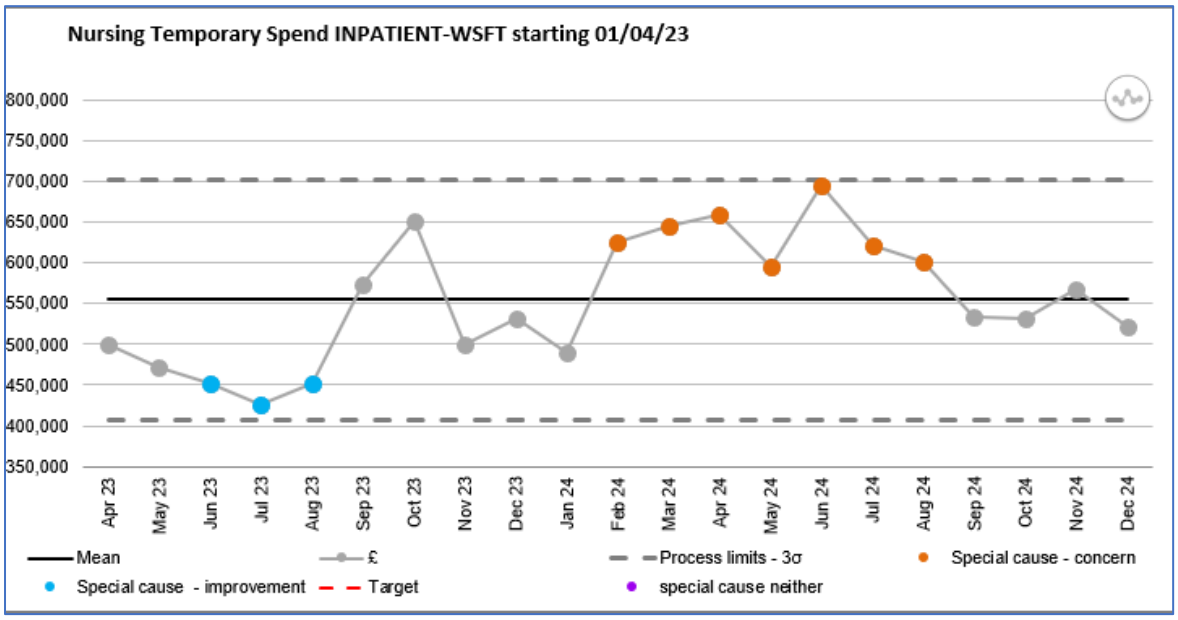
Maternity Services

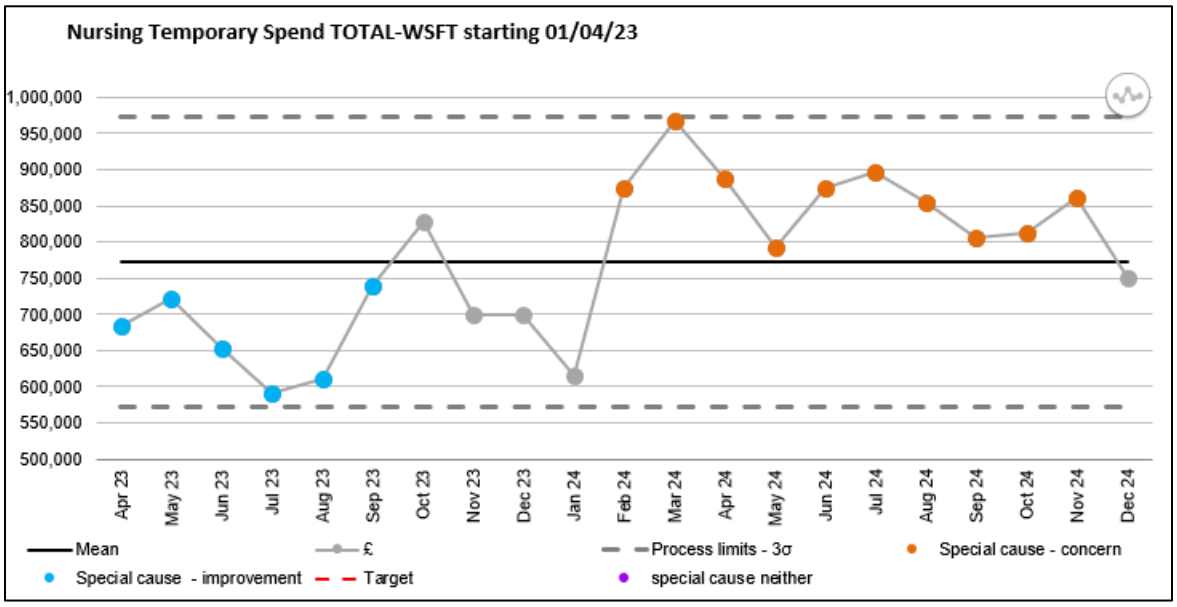
| |
|---|
| Missed medication during an admission |
| Delay of more than 30 minutes in providing pain relief |
| Delay of 30 minutes or more between presentation and triage |
| Delay of 60 minutes or more between delivery and commencing suturing |
| Full clinical examination not carried out when presenting 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:<br>• pain: asking patients to describe their level of pain level using the local pain assessment tool.<br>• personal needs: such as scheduling patient visits to the toilet or bathroom to avoid risk of falls and providing hydration.<br>• placement: making sure that the items a patient needs are within easy reach.<br>• positioning: making sure that the patient is comfortable, and the risk of pressure ulcers is assessed and minimised. |
| A shortfall of more than eight hours or 25% (whichever is reached first) of registered nurse time available compared with the actual requirement for the shift. |
| Fewer than two registered nurses present on a ward during any shift. |
| Unable to make home visits. |

## Appendix 4: Trust level temporary spend



# Emergency Department Establishment review

**(Prepared by Abby Ormes Matron ED & Hannah English Head of Nursing medicine)**

| 1. | **Introduction** |
|---|---|
| 1.1 | The national quality board (NQB) and Care Quality Commission (CQC) requires acute provider organisations to robustly review the nursing establishments within their organisation twice a year to ensure the right staff, with the rights skills, in the right place at the right time. This report has used a robust methodology to review the staff establishments within the emergency department (ED), meeting the expectations of the NQB and NHSI (developing workforce safeguards, 2018).<br>The ED Safer Nursing Care Tool (ED SNCT), developed by the Shelford group, is the only nationally endorsed staffing tool by NICE and NHSI/E for emergency departments.<br><br>The Emergency Department Safer Nursing Care Tool (ED SNCT) has been developed to help NHS hospitals in England measure patient acuity and/or dependency to inform evidence-based decision making on staffing in the Emergency Department, including paediatrics. The tool will also offer nurses a reliable method against which to deliver evidence-based workforce plans to support existing services or the development of new services. It has been adapted to consider the implications of COVID-19 on staffing.<br><br>**Benefits of the Emergency Department SNCT (ED SNCT)**<br>• · Demonstrates how acuity and dependency are measured in emergency department settings.<br>• · Ensures that accurate data can be collected.<br>• · Uses staffing multipliers to support professional judgement in reviewing and setting nursing establishments.<br><br>**The development process**<br>The ED SNCT was developed and validated by NHS emergency department experts. This included large acute trusts, including those with major trauma centres, and district general hospitals caring for adults only or adults and children. It is therefore suitable for determining nurse staffing establishments for all emergency departments (ED).<br><br>The ED SNCT is the only national endorsed product that can inform staffing levels with an ED. Many provider organisations have used the adult inpatient tool for many years since its publication, the ED iteration of this tool was launched in early 2022. |
| **2.** | **Background** |
| 2.1 | It is well considered in nursing research and literature that appropriate staffing levels and the right skill mix both influences, and significantly impacts patient safety and patient harms (Needleman, 2017; Aiken et al 2017). However, despite these recommendations, variations in department geography, skill mixes and patient profiles, there is no agreed national standard for nurse-to-patient ratios (NICE, 2014). This can lead to ambiguity around establishment settings and workforce planning. NHSI (2018) published the 'developing work force safeguards' document to provide recommendations to support making safe and sustainable workforce decisions. Robust staffing establishments reviews should triangulate evidence-based tools with professional judgement and patient outcomes, to ensure the right staff are in the right place at the right time.<br><br>This staffing review has used these principles within these recommendations to inform the outcomes of this establishment review process. The process described in the following sections will provide assurance that planned nursing establishments are meeting the needs of the patients within the ED at WSHFT. |

| | |
|---|---|
| | This establishment review was undertaken for the following reasons: -<br><br>• To comply with Care Quality Commission requirements under the Essential Standards of Quality and Safety, including outcomes 13 (staffing) and 14 (supporting staff).<br>• To provide assurance from the Medical Division to the board, that staffing establishment within the ED is meeting the current need, acuity and dependency of the patients that are cared for.<br>• To ensure that nursing establishment is not purely based on historical models of care and budget setting.<br>• To collaborate with senior nursing teams to improve engagement and confidence in agreed establishments.<br>• To ensure that changes in the department environment and patient profiles over the last 12 months have appropriate staffing levels to meet the needs of our patients.<br>A review of all relevant literature and guidelines was undertaken prior to commencement of this exercise and included:<br><br>• NICE Guidance on Safer Staffing for nursing in accident and emergency departments (2014)<br>• Emergency Department Safer Nursing Care Tool (ED SNCT) Shelford Group (2021)<br>• National Quality Board (2016) Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time (Safe sustainable and productive staffing)<br>• NHSI (2018) Developing Workforce Safeguards: Supporting providers to deliver high quality care through safe and effective staffing.<br>• NHSE (2013) High Quality Care for all, now and for future generations: transforming urgent and emergency care services in England.<br>• NHSE (2023) Delivery plan for recovering urgent and emergency care services.<br>• CQC Patient FIRST: Staffing (2021)<br>• RCPCH Facing the future: Standards for children in emergency care settings (2018)<br>• RCN Nursing Workforce Standards for Type 1 Emergency Departments (2020) |
| 2.2 | **Safer Nursing Care Tool (SNCT) methodology:**<br><br>The tool, when allied to nurse sensitive indicators (NSIs) offers nurses a reliable method of delivering evidence-based workforce plans to support existing services or the development of new services. The emergency departments involved in the development project of the tool included large acute trusts, major trauma centres, and district general hospitals caring for adults only or adults and children, therefore the tool is suitable to determine nurse staffing establishments for all emergency departments. To ensure that staffing recommendations derived from data demonstrating good practice only departments that met the quality standards using the Stockport Quality Audit Tool (initial patient assessment, compliance with patient pathway protocols, management of aspects of patient safety and associated risks and the environment of the department) were included in the study. The ED SNCT is based on the critical care patient classification (Comprehensive Critical Care, DH 2000) and adapted to support measurement across the emergency department, see appendix A.<br>The multiplier (nursing resource) was derived for each level of care following a robust process covering intervention such as, direct patient care, indirect patient care e.g., documentation, education/training, staff appraisals, personal time, patient transfers.<br><br>The tool is built for two different methods of data collection. (1) to use daily average attendance data and apply the national average patient dependency/acuity mix percentages contained in the spreadsheet to determine staffing requirements or (2) to collect patient dependency/acuity data twice a day for a minimum of 12 days to determine the trust specific dependency/acuity mix (a more time-consuming but precise method).<br><br>**Nurse Sensitive Indicators**<br><br>Nursing-sensitive indicators (NSIs) are the criteria for changes in a person's health status that nursing care can directly affect, and they form the foundation for monitoring the quality of nursing care. However, despite the considerable influence of nursing interventions on the quality of healthcare, measuring the quality of nursing care and its effects on patient outcomes and healthcare systems remains challenging. For this review NSIs will be used that correspond to both NICE quality |

standards and local ED NSIs. Such as, time to initial assessment, sepsis DTN, stroke DTCT, patient safety checklists, patient falls with harm, medication incidences, compliance with mandatory/job specific training, friends and family surveys and staff experience/well-being.

2.3 **ED caveats:**

There are a few limitations to the ED SNCT which will affect the output and WTE recommendations therefore professional judgement is a strong feature to be triangulated with data and outcomes, such as

- requirements of additional nursing/non-registered nursing resource for extended bed waits over one hour length of stay within the department i.e., drug rounds, pharmacy ordering, complex discharge planning, ADLs, EOL care, involvement with extended members of MDT.
- the environment/layout of the department/side room capacity, see appendix B.
- large volumes of patient transfer's occurring simultaneously.
- large volumes of inbound ambulances/walk in attendances occurring simultaneously.
- Staffing additional escalation areas when at times of full capacity
- Additional assessment and treatment of patients awaiting on ambulances.

Because of these variations it is important that the output of the ED SNCT is triangulated with professional clinical judgement and NSIs. This approach is advocated by the authors of the SNCT and the expectations within the developing workforce safeguards document (NHSI, 2018).
As the audit results are from patient data from November 22 & December 22 and not reflective of the current activity and demands of the department, another audit using current patient data would be advantageous as well as a piece of work alongside reviewing the extended LOS patients with their additional ward-based care needs to support additional workforce in-line with applying professional judgement.

**3. Results of the audit:**

3.1

| | **Current budgeted staffing levels (including 20% uplift)** | **ED SNCT recommended staffing levels based on acuity & dependency from clinical audit (including nationally recommended 27% uplift)** | | **ED SNCT based on attendance. (Including nationally recommended 27% uplift)** |
|---|---|---|---|---|
| | | **Nov 22** | **Dec 22** | **Attendance Oct 21 -22** |
| **Registered Nurses (exc. Manager & PDN)** | 56.52 WTE | 83.7 WTE | 83.1 WTE | 81.4 WTE |
| **Unregistered** | 37.46 WTE | 20.9 WTE | 20.8 WTE | 20.4 WTE |

The figures above respond to data alone from November 22 and December 22 and does not include additional resource using professional judgement.

The RCN nursing workforce standards for type 1 emergency departments recommends a workforce that comprises of a minimum of 80% Registered Nurses.
The table below shows are current registered/non-registered ratio against the recommendations.

RCN recommended.

- The nursing workforce will comprise a minimum of 80% Registered Nurses

| **Skill mix of the nursing workforce** | | |
|---|---|---|
| | **Current** | **RCN standard** |
| Senior ED nurses | 20% | 30% |
| ED nurses | 40% | 50% |
| Unregistered nursing support | 40% | 20% |

| | |
|---|---|
| | **Headroom**<br>When calculating the nursing workforce WTE a minimum uplift of 27% is recommended to be applied. In addition to the usual headroom that covers annual leave, sickness, unplanned leave and mandatory training additional demand for ED specific training would include training such as ALS, APLS/EPLS, decon/majax, trauma, transfer training, NIV and simulation days, which are all extended skills required for ED nurses.<br><br>Each ED will have a WTE dedicated Practice Development Lead (Band 7/8A).<br><br>In ED's with >75 individuals in the nursing workforce, Practice Educators (Band 6/7) will be required to support the Practice Development Lead**.**<br><br>The preferred registered nurse to nursing assistant skill mix is suggested to range up to 86.2% which would support a workforce ratio for a major trauma centre. Based on professional judgement and the patient demographics of our surrounding district general hospital, we have based our preferred registered nurse percentage at 80%. This ratio supports two non-registered staff on the day and night shifts as well as continuing the four-shift pattern of our non-registered clinical support practitioners, which is the minimum level for our department. |
| **4.** | **Conclusion:** |
| 4.1 | The staffing model to meet the 80/20 split has been reviewed with the finance lead within the medical division. We have been able to manage the recommendation from the ED SNCT, including the additional band 6 practice educator within the current budget, however this only includes the 20% uplift and not the recommended 27%. |
| **5.** | **Next Steps:** |
| 5.1 | To complete another ED SNCT audit using current patient data as well as an additional piece of work reviewing the extended length of stay patients awaiting inpatient beds with the application of clinical professional judgement. |
| **6.** | **Recommendations** |
| | To acknowledge that the review complies to national standard.<br>To receive assurance that the review has been completed with a robust methodology.<br>To recognise the move to better achievement of SNCT recommendations with financial envelope. |

Appendix A

## Levels of Care

### Level 0

Walk-in attendee / minor injuries

Needs met by provision of routine interventions.

### Level 1a

Acutely ill patients requiring intervention or those who are UNSTABLE with a GREATER POTENTIAL to deteriorate.

### Level 1b

Patients who are in a STABLE condition but are dependent on nursing care to meet most or all of their care needs.

### Level 1c

Patients who are in a physiologically STABLE condition but are requiring additional intervention to mitigate risk and maintain safety.

### Level 2

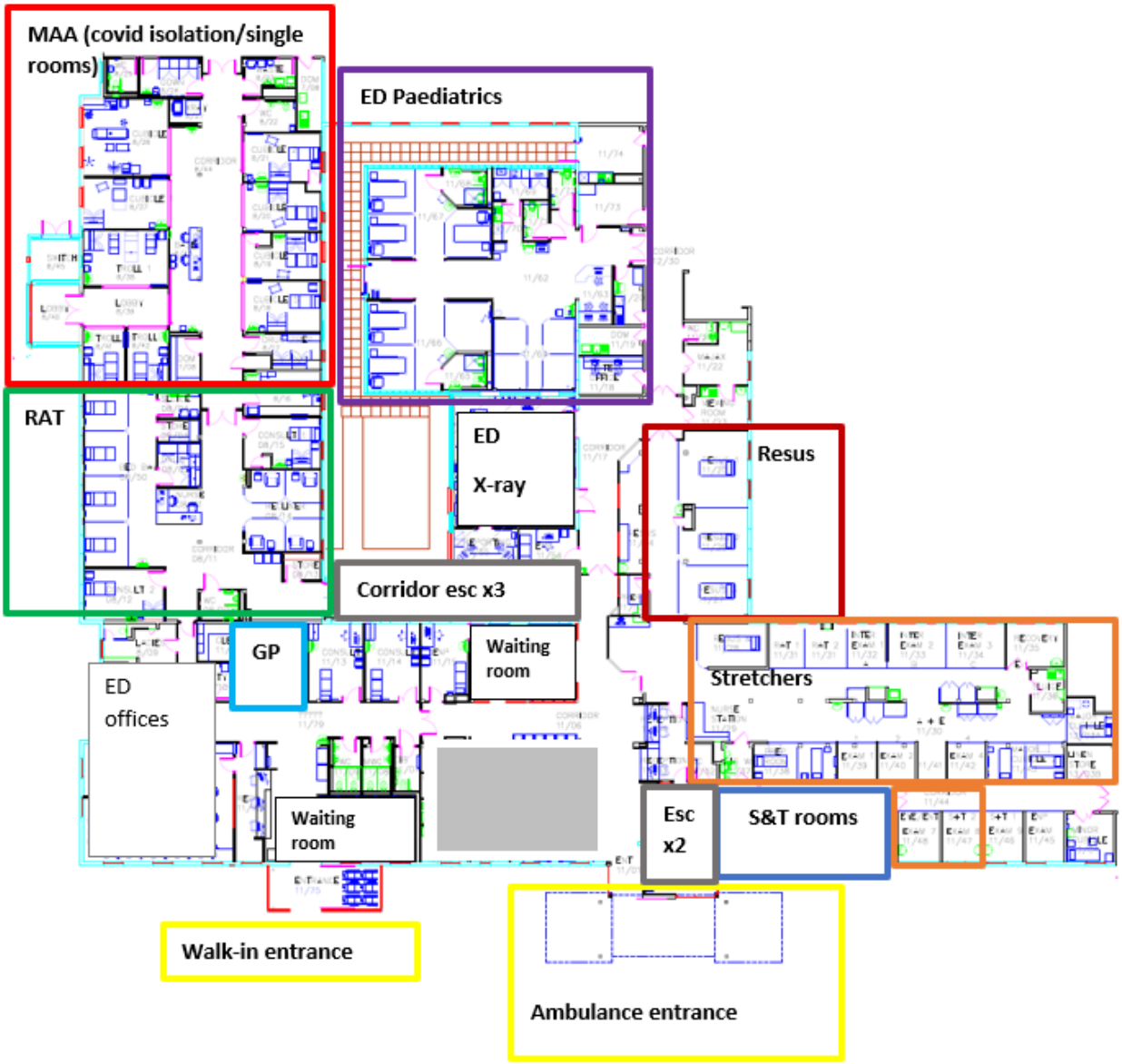
May be managed within clearly identified, designated beds, resources with the required expertise and staffing level

OR may require transfer to a dedicated Level 2 facility / unit.

### Level 3

Patients needing advanced respiratory support and / or therapeutic support of multiple organs.

Appendix B
ED Floor plan



# 4.4.1. Maternity Services

Karen Newbury, Kate Croissant & Simon Taylor in attendance

To Approve

Presented by Susan Wilkinson

| Open Trust Board | |
|---|---|
| **Report title:** | Maternity quality, safety, and performance report |
| **Agenda item:** | Maternity services quality & performance report |
| **Date of the meeting:** | 26th January 2023 |
| **Sponsor/executive lead:** | Sue Wilkinson, Executive Chief Nurse<br>Paul Molyneux, Medical Director & Executive MatNeo Safety Champion |
| **Report prepared by:** | Karen Newbury, Director of Midwifery |

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

**Executive Summary**

**WHAT?**

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

### This report contains:

- Maternity improvement plan
- Safety champion feedback from walkabout
- Listening to staff
- Service user feedback
- Reporting and learning from incidents
- Maternity Dashboards (Annex A)
- Maternity Incentive Scheme Safety Action 2 Maternity Services Data Set (MSDS) – report on compliance (Annex B)
- Maternity Incentive Scheme Safety Action 6 – Saving Babies Lives Implementation Tool, version 3. (Annex C)
- Maternity Incentive Scheme Safety Action 9 Maternity and Neonatal Safety and Quality (Annex D)
- Maternity Incentive Scheme Safety Action 4b Obstetric Anaesthetic Workforce report (Annex E)
- Maternity Incentive Scheme Year 5 Safety Action 8 Maternity and Neonatal MDT training (Annex F)
- Compliance with Year 5 of the Maternity Incentive Scheme Safety Actions 2023/2024 (Annex G)

**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.<br>Quarterly, bi-annual and annual reports will evidence the updates.<br>Reports will be shared with external stakeholders as required. |
| **Action Required** |
| The Board is asked to approve the Maternity Incentive Scheme (year 5) declaration form within the correct timeframe so that final approval can be gained from the Local Maternity and Neonatal System and subsequent sign off from the Chief Executive of the Integrated Care Board. |

| | |
|---|---|
| **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**<br><br>The Maternity and Neonatal Improvement Board (MNIB) receives the updated Maternity improvement plan monthly. This has been created through an amalgamation of the original CQC improvement plan with the wider requirements of Ockenden, Maternity and Newborn Safety Investigations, external site visits and self-assessment against other national best practice (e.g., MBRRACE, SBLCBv2, UKOSS). In addition, the plan has captured the actions needing completion from the 60 Supportive Steps visit from NHSE and continues to be reviewed by the MNIB monthly. It has been agreed with the exit from the Maternity Safety Support Programme (MSSP) that NHSE regional team and ICS (Integrated Care System) will be invited to attend the MNIB monthly for additional assurance and scrutiny. NHSE and the ICS, with the national chief midwife in attendance, undertook a 60 Supportive Steps visit in December 2023, to provide a systematic review of the Trust's maternity and neonatal service. Feedback on the day was exceptionally positive and the formal report of findings has just been received. The recommendations if not already completed, will be captured in the maternity improvement plan. |
| 1.2 | **Safety Champion feedback**<br><br>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.<br><br>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'.<br><br>Roger Petter our Non-Executive Maternity and Neonatal Safety Champion completed two walkabouts throughout December 2023 in the Antenatal Clinic (ANC) and Maternity Day Assessment Unit (MDAU). |

In ANC staff reported good working relationships and leadership. The main concern raised questioned whether the workspace was fit for purpose. Currently the lack of desk space is a risk for musculoskeletal injuries. The team have identified an area that could be utilised more efficiently, however with the overall lack of space within the clinic this would impact other clinicians. Space utilisation within the ANC is under review to determine a hopeful solution to this issue.
Staff also raised the need to improve service user experience in the clinic by communicating delays and what the appointment entails with realistic timeframes. One way to do this is via social media as well at a 'live board' in the ANC with wait times.
Service users who live outside our geographical area but choose to birth at the WSFT was also discussed, with the difficulties this poses in sharing information with the community teams and vice versa. The lead for the service has taken this forward and is working with neighbouring maternity services to resolve.
In MDAU staff reported no safety concerns. They feel they work as part of a good team with a happy working environment. Leadership is visible, accessible and effective and they feel that they offer a good service to their service users.

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

1.3 **Listening to Staff**

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

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

On the back of recent retention data from the national and regional teams, it is recognised that the majority of midwives are leaving the profession 2-5 years after qualification. We are committed to working with the Local Maternity /Neonatal System and regional team to address this. In response we have undertaken a flexible working survey, commenced Midwifery staff forums, and are undertaking 'stay conversations' which have been received very positively. The 'Legacy Midwife' role has now commenced, and a pilot of self-rostering (as indicated by the flexible working survey results) was introduced with a range of teams across maternity. The pilot has now come to an end with only one out of the four teams wishing to continue with self-rostering. A staff survey is currently live to capture staff views regarding their current shift patterns and whether it meets their work/life balance requirements and any ideas for improvement.

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 | Nov Survey returns | Nov FFT score | Dec Survey returns | Dec FFT Score |
|---|---|---|---|---|
| F11 | 57 | 98.25 | 42 | 100 |
| Antenatal | 18 | 94.44 | 13 | 100 |
| Postnatal Community | 10 | 90 | 21 | 95 |
| Labour Suite | 41 | 100 | 19 | 100 |
| Birthing Unit | 10 | 100 | 3 | 100 |
| NNU | 4 | 100 | 5 | 100 |
| Transitional Care | 5 | 100 | 5 | 100 |
| Maternity Smoke Free Team | 1 | 100 | 0 | - |

| | | | | |
|---|---|---|---|---|
| Castlehill Team | 3 | 100 | 0 | - |
| Foresthill Team | 2 | 100 | 0 | - |
| Gainsborough Team | 2 | 100 | 0 | - |

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 November and December 2023 the main themes continue to be regarding clinical treatment and communication. The aim for 2023 was to develop meaningful personalised care plans from the antenatal period through to the intrapartum and postnatal stages to help address this. This will require an electronic solution, which is currently still being explored.

1.5 **Reporting and learning from incidents**

During November and December 2023 there were 2 new cases that met the referral criteria to the MNSI. From the 1st October 2023 HSIB transitioned to the Care Quality Commission (CQC) and is now called Maternity and Newborn Safety Investigations (MNSI). The maternity service is represented at the Local Maternity and Neonatal System (LMNS) monthly safety forum, where incidents, reports and learning are shared across all three maternity units.

Quarterly reports are shared with the Trust Board to give an overview of any cases, with the learning and assurance that reporting standards have been met to MNSI/EN and the Perinatal Mortality Reporting Tool (PMRT). The next quarterly report is not due until the March 24 Board meeting, however to note; for MIS the reporting period was from the 6th December 2022 to 7th December 2023 and the standards required for MIS have been met.

1.6 **Maternity dashboards (Annex A)**

Indicators of maternity safety & quality are regularly reported and reviewed at monthly Maternity Governance meetings. A sub-set are provided for board level performance (the Performance & Governance dashboard). Red rated data will be represented in line with the national NHSI model of SPC charts. Please see below:

| What? | So What? | What Next? |
|---|---|---|
| Post-partum Haemorrhages (PPH) (>1500 mls) for Lower Section Caesarean Sections (LSCS) and Vaginal Births. | The rate is significantly higher than the national target and therefore the Trust is viewed as an outlier.<br>Potential increase of length of stay and additional treatment, reduced family bonding time. | Regional and Local Maternity and Neonatal System to continue to offer support<br>Relaunch of the Maternity PPH QI project in November 2023 and action plan develop to monitor the progress. The following five workstreams have been commenced to provide a systematic approach;<br>Anaemia Workstream<br>Training Workstream<br>Risk Management workstream<br>Equipment workstream<br>Medicines Workstream |
| Compliance with Trust guidance regarding | Nearly one in three women who suffer from domestic abuse during their lifetime report | Antenatal compliance has shown a marked improvement over the last 8 months. |

| | | | |
|---|---|---|---|
| | asking Domestic Abuse questions; **twice** in the antenatal period and **once** in the postnatal period. | that the first incidence of violence happened while they were pregnant.<br><br>A quarter (25%) of children in high-risk domestic abuse households are under 3 years old.<br><br>62% of children living in domestic abuse households are directly harmed by the perpetrator of the abuse, in addition to the harm caused by witnessing the abuse of others | Postnatal compliance is not consistent, therefore indicating processes are not embedded.<br><br>Compliance data through audit, continues to be reviewed weekly. QI work has commenced, and connectivity in the community has been identified as an issue inhibiting access to patient records in community settings. Trial of dongles to boost connectivity has commenced.<br><br>Ongoing training and guidance for staff continues.<br><br>Whilst undertaking the audits it has been noted that 99% of all women are asked at least once in the antenatal/postnatal period regarding domestic abuse. |

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| **2.** | **Reports** |
| 2.1 | **Maternity Incentive Scheme Safety Action 2 Maternity Services Data Set (MSDS) – report on compliance**<br><br>The Maternity services within West Suffolk NHS Foundation Trust are required to provide accurate information and data to evidence the work that is undertaken to national and local standards.<br>This report provides evidence of the quality and accuracy of information provided to NHS Digital against the Maternity Services Data Set (MSDS) requirements.<br>Due to updates to the information systems used to provide the data to MSDS, initially the Trust failed some elements of the reports to NHS Digital in July 2023. With updates to the systems and manual reconciliation, the Trust has now been given assurances that the data requirements have been met to declare compliance with the Maternity Incentive Scheme Safety Action 2. Other organisational arrangements related to this safety action have also been met.<br>The Trust will continue to interrogate information systems and analyse the data to ensure it provides assurances of standards and services. |
| 2.2 | **Maternity Incentive Scheme Safety Action 6 – Saving Babies Lives Implementation Tool, version 3.**<br><br>Version 3 of the Saving Babies Lives (SBL) Care bundle was published at the end of May 2023 and updated in July 2023.The Trust has been using the SBL Implementation tool for ensuring that this has been embedded and progress is being made towards full implementation by March 2024. Due to the recent publication of the updated version, the Maternity Incentive Scheme has set the required standard as 50% compliance in each element (six in total) and an overall compliance rate of 70%. Quarterly compliance meetings have been held with the ICB/LMNS and the ICB lead has signed off the Trust's Board Report and Action Plan. This progress has reached the targets to date whereby 80% and above has be achieved in each element with an overall compliance rate of 90%. The SBL board report and action plan is evidence that the ICB/LMNS were satisfied with the evidence we provided and subsequent compliance rate achieved. |
| 2.3 | **Maternity Incentive Scheme Safety Action 9 Maternity and Neonatal Safety and Quality - Can the Trust demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?**<br><br>The Maternity and Neonatal services have updated the Trust Perinatal Clinical Quality Surveillance Model (PCQSM) and the Guidance for Maternity and Neonatal Safety Champions (MNSC) to ensure |

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| | there are clear pathways for how safety intelligence is gathered, analysed and shared learning takes place across a number of forums both within and outside the Trust. The PCQSM was approved by the Regional Chief Midwife.<br>The Non-Executive Director (NED) appointed as Safety Champion to assist the Trust Board level Safety Champion is actively involved in engaging with staff and reviewing safety issues to enable improvements to be made when required.<br>The Trust Board does not meet monthly but other sub-committees meet to discuss some aspects of safety such as staffing and performance where any immediate concerns can be escalated if required.<br>Safety Intelligence is gathered from a number of sources and analysed as part of the Maternity Governance processes and improvement plans made to address safety and quality issues. These improvement plans are shared with the quadrumvirate and Safety Champions and learning shared across the Local Maternity and Neonatal System (LMNS), Integrated Care Board (ICB) and the Regional Maternity Quality and Safety Forum through the Regional Perinatal Quality Oversight Group (RPQOG).<br>The perinatal quadrumvirate and safety champions meet at least quarterly to discuss safety and culture intelligence within the maternity and neonatal services and identify good practice and areas of improvement required.<br>Whilst the Score Culture Survey has not been completed within the Trust as yet (due April-June 2024), national staff surveys have been used to inform Trust processes for improving staff wellbeing and morale. The Trust Board Safety Champion and NED are registered with the Futures Collaborative Perinatal Culture and Safety workspace. |
| 2.4 | **Maternity Incentive Scheme Safety Action 4b Obstetric Anaesthetic Workforce report for 1st April 2023 to 30th September 2023 (Q1 and Q2 2023/24)**<br>This report has been written to provide evidence of compliance with safe staffing requirements for obstetric anaesthesia within the Maternity Unit of West Suffolk NHS FT (WSNHSFT).<br>The rotas and other information have been used to inform compliance with the Royal College of Anaesthetists (RCoA) Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1. This is the recommended resource to be used as the standard for the Maternity Incentive Scheme Year 5 Safety Action 4.<br>The anaesthetic service prioritises covering the obstetric anaesthetic bleep 770 role and the **rotas demonstrate 100% compliance** with a rostered dedicated obstetric anaesthetist for this period of audit. Industrial action has contributed to some staffing issues over the period of review, but the on-call service has been maintained.<br>The **rota has a named consultant anaesthetist who is available for escalation** of staffing and clinical issues.<br>There are gaps in the rota due to a variety of reasons, such as some training posts not being filled by the deanery as well as recruitment delays for trust doctors and MTI (medical training initiative) doctors. On the occasions where gaps cannot be covered by other means, a consultant anaesthetist will act down to cover the role. However, this cannot be sustained over a long period of time.<br>The Obstetric emergency multi-disciplinary training is now mandated for all anaesthetic staff who provide cover within the maternity service within the Trust and it is expected that the Trust will have reached **the target of more than 90% attendance** for both the consultant anaesthetic staff and the other grades of obstetric anaesthetists for 2023. The anaesthetic services are working towards all staff being rostered as **faculty and candidates from January 2024.**<br><br>The **induction programme** for new staff includes a specific section on obstetric anaesthesia and a handbook is issued to the staff outlining expectations. Both of these aspects are updated to ensure they are still relevant and accurate information to staff. In addition, to enhance the induction of new staff, an obstetric induction video is being developed to help with orientation of new staff on the labour suite.<br><br>As part of the monitoring of workforce within maternity services, compliance with decision to delivery times for category 1 (emergency) and category 2 (urgent) caesarean sections was assessed. The overall compliance for decision to delivery times was met for both urgent and emergency caesarean sections. |

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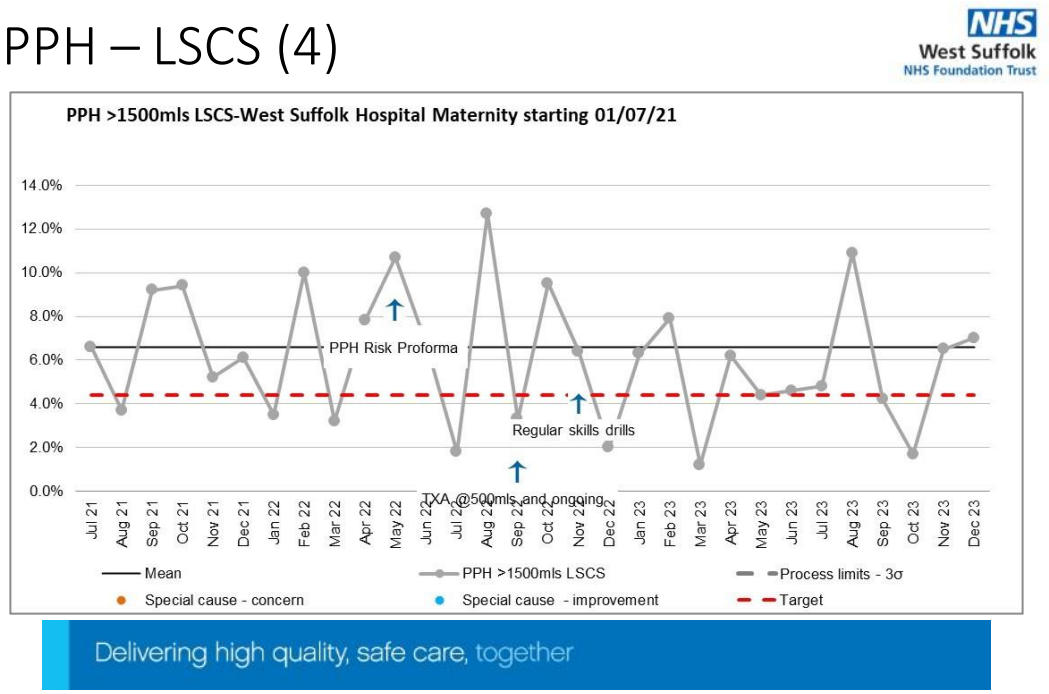
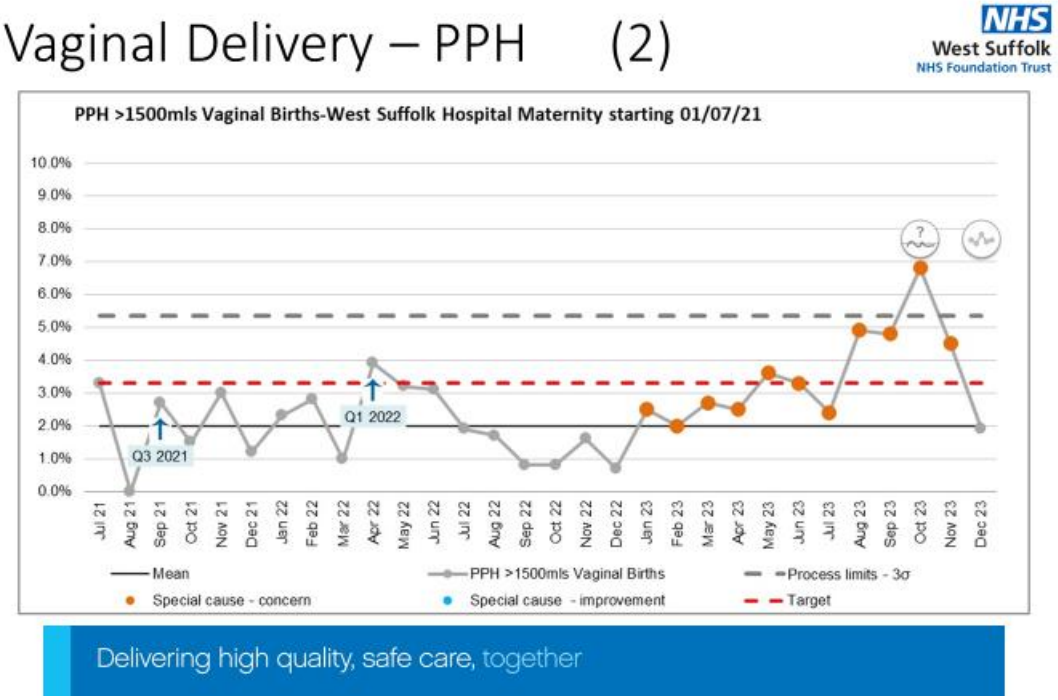
| 2.5 | **Maternity Incentive Scheme Year 5 Safety Action 8 Maternity and Neonatal MDT training**<br>The Maternity and Neonatal Service are required to provide evidence of effective MDT training to the standards expected within the NHS Core Competency Framework v1 and work toward implementation and embedding of v 2.<br>The 3 year training plan has been updated to reflect the requirements of the Core Competency Framework v 2 and this has been approved by the Trust and the LMNS. The trajectory for implementation of this is on track for August 2024. Learning from incidents, claims and patient experience is shared as part of case scenarios – both good practice and areas where improvements can be made. Users of the service are asked for permission for their stories to be shared (anonymously) as part of learning and feedback.<br>The training sessions that are held are multidisciplinary (MDT).<br>The Trust has evidence of compliance with an attendance rate of more than 90% of the individuals within each relevant staff group in the main 3 training elements required for this submission:<br>**Fetal Monitoring** – both attendance at a 1 day session and attendance at regular case study learning sessions; **Maternity Emergency Training (PROMPT)** training days – the Maternity service is also working towards achieving 90% of attendance at skills and drills in the clinical areas;<br>**Neonatal Resuscitation training** – there is compliance with attendance at local sessions, NLS instructors maintaining their updates and skills and leading the local sessions.<br>Training records are maintained and compliance is recorded monthly as part of the quality dashboard. The Maternity and Neonatal Services are committed to maintaining safe standards of practice through effective training and education and sharing learning. |
| 2.6 | **Compliance with Year 5 of the Maternity Incentive Scheme Safety Actions 2023/2024**<br><br>This report outlines how the Trust demonstrates compliance with the Maternity Incentive Scheme Year 5 Safety Actions. The compliance will be declared on submission of the declaration form to NHSR on or before the deadline (1st February 2024). The results of the declaration will be utilised to determine the amount of allocated funds available to the Trust to use to maintain and improve safety within the maternity and neonatal services. Failure to declare accurate information will result in reputational harm and a lack of funding to support ongoing safety and improvement plans.<br>The Trust is able to provide evidence in order to declare compliance with 10 out of 10 Safety Actions. We have indicated that we are not compliant with Safety Action 4d Neonatal Nursing workforce – the shift leader is not currently supernumerary in accordance with the British Association of Perinatal Medicine standards for neonatal nursing staffing standards. This does not however affect the Trust's compliance with this safety action as there is a plan in place to address this issue.<br>The Trust was not compliant with Safety Action 2 requirements for data submitted for July 2023. However, NHS Digital have agreed we can declare compliance as the information service provider has made updates and the Trust passed the data quality tests for September 2023. |
| **3.** | **Next steps** |
| 3.1 | Reports will be shared with the external stakeholders as required<br>Action plans will be monitored and updated accordingly |

## Annex A- Maternity Dashboard SPC Charts:

### Post-Partum Haemorrhages (PPH) for Lower Section Caesarean Sections (LSCS)



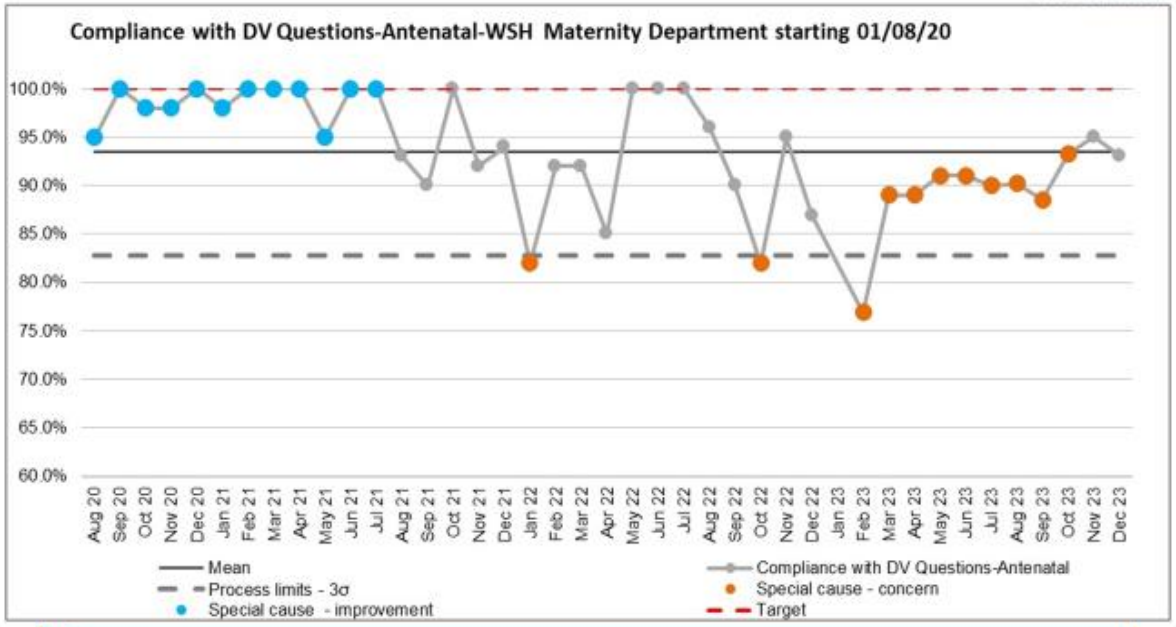

### Post-Partum Haemorrhages (PPH) for Vaginal Births



**Domestic Violence (DV)**

# DV Questions - Antenatal

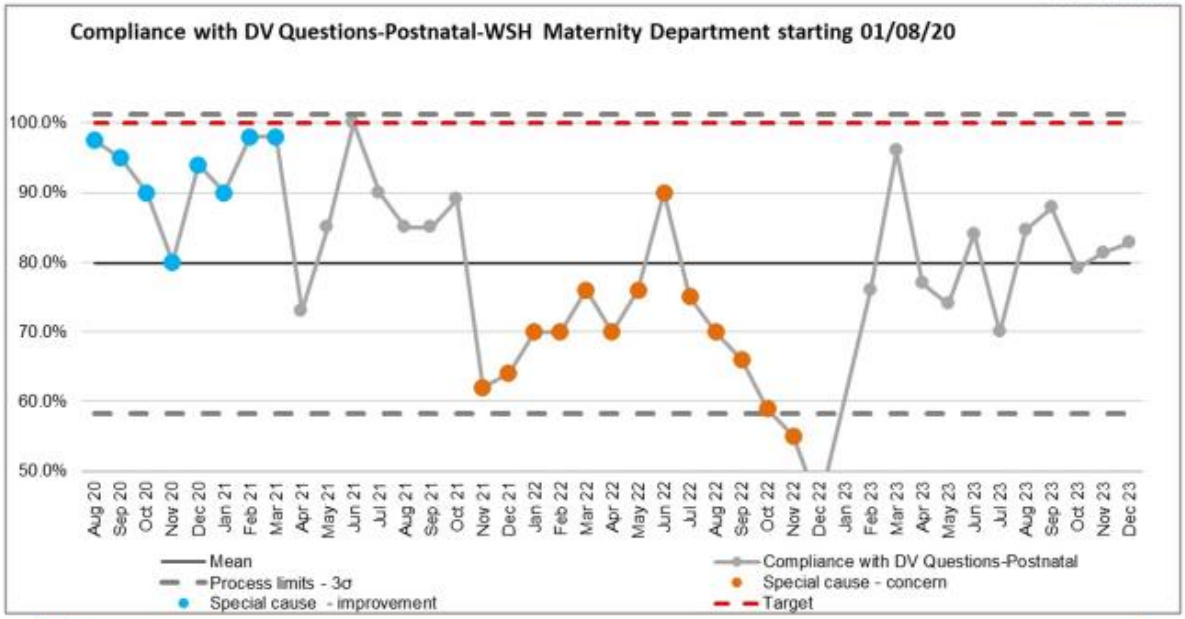
NHS West Suffolk NHS Foundation Trust




Delivering high quality, safe care, together

# DV Questions - Postnatal

NHS West Suffolk NHS Foundation Trust




Delivering high quality, safe care, together

# 4.5. Audit committee report

To Assure

Presented by Michael Parsons

| Board of Directors | |
|---|---|
| **Report title:** | **Chair's Key Issues (CKI) report for Audit Committee** |
| **Agenda item:** | |
| **Date of the meeting:** | 26 January 2024 |
| **Sponsor/executive lead:** | Craig Black, Executive Director of Finance |
| **Report prepared by:** | Michael Parsons, Chair of Audit Committee |

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

| | |
|---|---|
| **Executive summary:** | The report highlights the key issues that emerged from the Audit Committee meeting held on 12 December 2023.<br><br>Continuing good progress with Internal Audit plan; pleasing progress on implementing Internal and External Audit recommendations; positive early progress on developing Internal Audit Plan for 2024/25 and planning for 2023/24 external audit. |
| **Action required/ recommendation:** | Contributions to 2024/25 Internal Audit plan welcomed. |

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

| Agenda Item | Details | Level of Assurance*<br>1. Substantial<br>2. Reasonable<br>3. Partial<br>4. Minimal | Comments | Action / Escalation |
|---|---|---|---|---|
| Audit Committee Annual Report | Approved the Committee's annual report for 2022/23 and agreed development areas | Reasonable | The Committee will pay more attention in 2024 to the robustness of the budget setting and CIP delivery process. | Audit Committee agenda |
| Internal Audit<br><br>(RSM) | Update on delivery of internal audit plan and implementation of recommendations | Reasonable | Continuing good progress with 2023/24 audit plan.<br><br>Insight will discuss the recent audit of Community Wating Lists which had partial assurance opinion.<br><br>Pleasing reduction in outstanding audit actions, although more to do. | Insight Committee<br><br>Executive |
| Internal Audit Plan for 2024/25 | Early draft considered; noted that revised BAF would inform developing IA plan. | Reasonable | Noted importance of understanding alternative sources of assurance and how IA plan complements these.<br><br>Input into draft plan welcomed from Chairs of 3i assurance committees. | Richard Jones<br><br>3i Committee Chairs |
| Counter Fraud | Discussed progress report, including use of AI in fraud. | Substantial | Noted increased sophistication of mandate fraud. | Exec Director of Finance |
| Single Tender Benchmarking report | Comparative report on use of single tender waivers across 55 organisations | Reasonable | Will have further discussion on VFM aspects as part of deep dive into procurement at March meeting | Audit Committee agenda |

| Agenda Item | Details | Level of Assurance*<br>1. Substantial<br>2. Reasonable<br>3. Partial<br>4. Minimal | Comments | Action / Escalation |
|---|---|---|---|---|
| External Audit | Review of previous recommendations and planning for next audit | Substantial | Good progress in implementing past recommendations; collaborative planning for 2023/24 audit underway. | None |

**Assurance level**

| | |
|---|---|
| 1. Substantial | Taking account of the issues identified, the board can take substantial assurance that this issue/risk is being controlled effectively.<br><br>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.<br><br>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.<br><br>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.<br><br>Urgent action is needed to strengthen the control environment and ensure confidence in delivery. |

# 5. GOVERNANCE

# 5.1. Governance report

To Assure

Presented by Richard Jones

NHS
West Suffolk
NHS Foundation Trust

| Board of Directors | |
|---|---|
| **Report title:** | **Governance report** |
| **Agenda item:** | 5.1 |
| **Date of the meeting:** | 26 January 2024 |
| **Sponsor/executive lead:** | Richard Jones, Trust Secretary |
| **Report prepared by:** | Richard Jones, Trust Secretary<br>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 January 2024, as follows:

- Governance framework update - management executive terms of reference
- Senior Leadership Team report
- Council of Governors – election results
- Board to board report (or main agenda item)
- Remuneration committee report
- NED responsibilities
- Well led review update
- 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 the terms of reference for the Management executive meeting (Annex A)

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

# Governance Report

## 1. Governance framework update - management executive terms of reference

In November 2023, the senior leadership team meeting (SLT) agreed to shift the focus of its scope and responsibility. Placing emphasis on its leadership role in shaping strategy and culture. Alongside this change an expanded Executive Directors meeting was agreed as the senior decision-making management committee for the Trust.

Terms of reference for the new management executive meeting have been prepared. The membership for this includes the executive directors as well as representatives from the clinical divisions. **The terms of reference are attached in Annex A for approval.**

Updated terms of reference for SLT have been drafted and will be reviewed at SLT in February. The approved changes will be incorporated into the Trust's 'Organisational framework for governance'.

## 2. Senior leadership team (SLT) report

The Senior Leadership Team meeting in January delivered its leadership role in shaping strategy and culture with a focus on:

- NHS Impact and Ockenden recommendation – group work was undertaken to provide an organisation self-assessment of delivery against these requirements and then considered high impact improvement actions. The results of this work will be collated and reported to the Improvement Committee in February

- Financial update – the latest financial position was considered, including a focus on maintaining delivery in 2023/24 and looking forward to 2024/25.

The meeting in December focused on the workforce strategy and attendees were asked to consider how their teams could work effectively in retained estate and/or off site. Community colleagues were asked to identify external environments with spare capacity that could be used. The output from the session to be incorporated into the schedule of accommodation.

## 3. Council of Governors – election results

The results of the governor elections 2023 were announced in November 2023 and the Trust had a good turnout for 2023 elections, with 31 candidates standing for the 19 seats, with each of the public and staff constituencies strongly contested. Fourteen public governors and five staff governors were elected. The new Council of Governors has met informally and induction sessions are ongoing. A training day facilitated by the NHS Providers is scheduled on 30 January 2024 for Governors and Non-Executive Directors.

More details can be found at Governor elections 2023 (wsh.nhs.uk)

## 4. Board to board report

The West Suffolk NHS Foundation Trust (WSFT) and the East Suffolk & North Essex NHS Foundation Trust (ESNEFT) have been developing a collaborative approach over the past year, including board to board workshops, joint working within functions including procurement, and mutual aid for specific clinical pathways. The Collaborative Oversight Group is now established and had their first meeting on 13 December 2023 which included update on live collaboration schemes, schemes in planning and future opportunities for collaboration.

## 5. Remuneration committee report

At its meeting in January the committee considered the finding of the learning review and agreed next steps.

## 6. Non-executive director responsibilities

Periodically the NEDs review their key responsibilities and membership of Board committees. The latest summary of these responsibilities is provided for information (Annex B).

## 7. Well led review update

In line with good governance practice, the Trust has commissioned ConsultOne (the consultancy arm of AuditOne) to undertake a Well Led review of leadership and governance at the Trust. The ongoing review will take place between December 2023 and March 2024, to inform further development work to support continuous improvement of our governance arrangements.

The well led developmental review of the Board will include document review, interviews with Board members and other key members of staff as well as governors and external stakeholders as well as meeting observations at Board, Committee and operational management meetings. More details and final report will be shared in the future Board meeting/s.

## 8. Use of Trust Seal

None to report

## 9. Agenda Items for the Next Meeting (Annex C)

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

# Management Executive meeting

**Terms of reference**

## 1. Purpose

1.1 The Management Executive is corporately responsible for formulation and delivery of the Trust's strategy, service aims and objectives as approved by the Board of Directors.

1.2 This includes:

1.2.1 developing and delivering the direction, vision, plans & priorities for the organisation
1.2.2 developing and delivering the culture, values and behaviours of the organisation
1.2.3 providing leadership and decision-making at a strategic level
1.2.4 creating a team approach to responding to opportunities and challenges supporting effective quality improvement and transformation
1.2.5 considering and responding to external/regulatory requirements
1.2.6 considering recommendations to address service challenges and opportunities from divisions.

## 2. Level of authority

2.1 The Management Executive is established as the most senior executive forum within the Trust.

2.2 The Management Executive has the authority to make decisions on behalf of the Board of Directors, but in compliance with Trust's Standing Orders and Standing Financial Instructions.

2.3 With the required executive director quoracy for the meeting this is to a maximum annual value of up to £250,000 or a total life of contract value of up to £1m. However, executives and other members of the Management Executive play an equal part in decision making; this supports each member being accountable, both jointly and severally, for the decisions taken.

2.4 Beyond the arrangements described above the Management Executive may also be asked to consider/take decisions on issues requested of it by other management forums e.g. Senior Leadership Team, particularly where there are significant financial and/or corporate implications/risks. However, decision making should take place at the most appropriate level within the delegated limits defined in the Trust's scheme of delegation.

## 3. Duties and responsibilities

3.1 Implement decisions of the Board of Directors to deliver the vision, plans & priorities for the organisation.

### 3.2 Strategy and business planning:

3.2.1 Develop and implement the Trust's strategy, including consideration of all underpinning strategies and delivery plans.

3.2.2 Develop and recommend strategic and operational objectives for consideration by the Board of Directors.

3.2.3 Supported by the business plans and the investment panel evaluate, scrutinise and monitor revenue and investments for service developments and improvement plans through the approval of business cases. It is recognised that during times of financial recovery alternative arrangements may be put in place within the Trust and/or system.

3.2.4 To approve strategies, policies and plans, and consider the allocation of management, financial and physical resources to support the implementation of the Trust's strategy and its delivery plan.

3.2.5 Be cognisant of Alliance, ICS, regional and national strategies and develop these jointly wherever possible, fostering a culture of collaboration.

**3.3 Developing culture, values and behaviours**

3.3.1 Implement the direction of the board of directors in relation to the desired culture of the Trust.

3.3.2 Role model leadership against agreed values and behaviours.

3.3.3 Encourage dissenting views, collaborative enquiry and participation of all members to create the most effective discussions and decisions.

3.3.4 Value diversity and take positive action to ensure all voices are heard.

3.3.5 Ensure discussions and decisions take a balanced approach, incorporating quality, safety, operational, environmental and financial impacts.

**3.4 Delivery and performance**

3.4.1 Maintain business and operational performance for quality, operational, environmental and financial standards.

3.4.2 Supported by the capital strategy group and the investment panel evaluate, scrutinise and monitor revenue and capital investments for service developments and improvement plans through the approval of business cases. It is recognised that during times of financial recovery alternative arrangements may be put in place within the Trust and/or system.

**3.5 Risk and governance**

3.5.1 Receive and review significant quality and performance risks/issues and points of escalation from Board or management committees, Divisional Performance Review meetings. Acting on these as appropriate, including escalation to the Board of Directors.

3.5.2 Review the relevant **internal audit and external audit** reports and ensure an appropriate and timely management response.

3.5.3 Maintain the Board Assurance Framework document and pursue gaps in evidence and assurance to secure the successful achievement of the Board's objectives.

3.6 Engage with the Senior Leadership Team to shape strategic and cultural decisions.

3.7 Escalation of issues as appropriate to the Board of Directors.

## 4. Membership

4.1 Members:

- Chief Executive (**Chair**)
- Executive Director of Resources
- Executive Chief Nurse
- Executive Chief Operating Officer (including paediatric community services)
- Executive Medical Director
- Executive Director of Workforce and Communications
- Executive Director of Strategy and Transformation
- Representative from the clinical divisions – medicine, surgery, anaesthetics women & children, clinical support and community services. The community division will be represented by Director of Integrated Health and Social care (Adults) and COO (Children)
- Director of Integrated Adult and Social Care Services (including adult community services)
- West Suffolk Alliance Director.

4.2 In attendance at the meetings will be:

- Trust Secretary

4.3 The Management Executive can request the attendance of others as appropriate for specific agenda items.

4.4 Apologies for absence are to be notified to the Chief Executive's admin support and deputies should be identified whenever possible.

## 5. Quorum

5.1 A quorum is required of three executive directors and two from the remaining membership. Deputies do not have a vote or count in calculating whether a meeting is quorate.

5.2 For clarity, attendance by a representative from a clinical division's triumvirate will count towards quoracy, attendance by a deputy to any of these roles will not.

## 6. Frequency of Meetings

6.1 Meetings will take place on a weekly basis. Normal business will be conducted at the meetings held on a Wednesday.

## 7. Sub-committees

7.1 The Management Executive will, when required and appropriate establish subcommittees and delegate certain decisions to subcommittees or other management forums.

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

8.1 Agendas will be agreed by the Chief Executive. Agenda items and papers must be submitted by all Management Executive members to the Chief Executive's office **at least** two days prior to the meeting. Papers arriving after this date will not usually be considered for inclusion on the agenda.

## 9. Accountability and reporting arrangements

9.1 The Management Executive is accountable to the Board of Directors.

9.2 The Management Executive may refer matters to Senior Leadership Team (SLT) for review and to help shaping.

## 10. Monitoring effectiveness and compliance with Terms of reference

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

## 11. Ratification of terms of reference and review arrangements

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

**Date approved by the Management Executive:** 10 January 2024
**Date approved by the Board of Directors:** 26 January 2024
**Next review date:** Jan 2025

NHS
West Suffolk
NHS Foundation Trust

# Non-executive directors' responsibilities – January 2024

| | Primary responsibilities | Responsibilities as required | Lead assurance roles (Bold indicates mandated) |
|---|---|---|---|
| **Jude Chin**<br>**Chair and Non-executive director**<br><br>**Fixed Term:** 4 July 2022 – 3 July 2023<br><br>**Appointed:**<br>1 June 2023 – 31 May 2026 | • Board – Public, Closed (**Chair**)<br>• Council of Governors (**Chair**)<br>• Audit Committee (in attendance)<br>• Remuneration Committee (**Chair**)<br><br>Specialist committees:<br>• *Option to attend any other Board committees*<br>• ICS chairs meeting<br>• NHS Confederation Chairs group<br>• NHSE (East of England) CEO and Chairs group | • Board Workshops<br>• External relationships<br>• Consultant appointments<br>• Quality walkabouts<br>• Governor meetings with NEDs<br>• Investigations and appeals | • Integrated care system<br>• NHS England and Improvement<br>• West Suffolk Alliance<br><br>• NED link to CEO |
| **Tracy Dowling**<br>**Non-executive director**<br><br>**Term:** 1 November 2022 – 31 October 2025<br><br>ON HOLD – taken up alternative role from 17 November 2023 for six months | • Board meeting – Public, Closed<br>• Remuneration Committee<br>• Audit Committee<br><br>Specialist committees:<br>• Involvement Committee (**Chair)**<br>• Improvement Committee | • Board Workshops<br>• Consultant appointments<br>• Quality walkabouts<br>• Council of Governors and Governor meetings with NEDs<br>• Investigations and appeals | • Patient experience and public engagement<br>• Equality, diversity and inclusion<br><br>• NED link to Director of Workforce, including OD |

| | Primary responsibilities | Responsibilities as required | Lead assurance roles<br>(Bold indicates mandated) |
|---|---|---|---|
| **Antoinette Jackson**<br>**Non-executive director**<br><br>**Term:** 1 November 2022 – 31 October 2025 | • Board meeting – Public, Closed<br>• Remuneration Committee<br>• Audit Committee<br><br>Specialist committees:<br>• Insight Committee (**Chair**)<br>• Involvement Committee<br>• Charitable Funds Committee<br>• Member of SNEE ICB finance committee | • Board Workshops<br>• Consultant appointments<br>• Quality walkabouts<br>• Council of Governors and Governor meetings with NEDs<br>• Investigations and appeals | • Senior Independent Director<br>• Board freedom to speak up guardian, including whistleblowing<br>• Theatres<br><br>• NED link to Director of Integrated Adult Health and Social Care |
| **Geraldine O'Sullivan**<br>**Non-executive director**<br><br>**Term:** 1 November 2022 – 31 October 2025 | • Board meeting – Public, Closed<br>• Remuneration Committee<br><br>Specialist committees:<br>• Improvement Committee (**Deputy Chair**)<br>• Involvement Committee | • Board Workshops<br>• Consultant appointments<br>• Quality walkabouts<br>• Revalidation Support Group<br>• Council of Governors and Governor meetings with NEDs<br>• Investigations and appeals | • Patient safety, including learning from deaths<br>• Safeguarding adult and children<br><br>• NED link to Chief Nurse |
| **Roger Petter**<br>**Non-executive director**<br><br>**Term:** 1 Mar 2023 – 28 Feb 2026 | • Board meeting – Public, Closed<br>• Remuneration Committee<br><br>Specialist committees:<br>• Insight Committee (**Deputy Chair**)<br>• Improvement Committee<br>• Board maternity and neonatal safety champion (sit on local maternity and neonatal system board, attend Trust's maternity and neonatal safety champions meetings and maternity voice partnership meeting)<br>• Doctors' Revalidation Support Group | • Board Workshops<br>• Consultant appointments<br>• Quality walkabouts<br>• Revalidation Support Group<br>• Council of Governors and Governor meetings with NEDs<br>• Investigations and appeals | • **Maternity and neonatal safety champion**<br>• Doctor appraisal and revalidation<br><br>• NED link to Medical Director |

| | Primary responsibilities | Responsibilities as required | Lead assurance roles (Bold indicates mandated) |
|---|---|---|---|
| **Louisa Pepper**<br>Deputy Chair and **Non-executive director**<br><br>**Term:**<br>1 Sept 2018 – 31 Aug 2021<br><br>**Reappointed:**<br>1 Sept 2021 – 31 Aug 2024 | • Board meeting – Public, Closed<br>• Deputy Chair<br>• Audit Committee<br>• Remuneration Committee<br><br>Specialist committees:<br>• Improvement Committee (**Chair**)<br>• Insight Committee<br>• RAAC Risk Committee | • Board Workshops<br>• Consultant appointments<br>• Quality walkabouts<br>• Council of Governors and Governor meetings with NEDs<br>• Investigations and appeals | • Health and wellbeing guardian<br>• Emergency preparedness, resilience and response (EPRR) – including COVID response<br>• Pathology<br>• Volunteers<br>• Chaplaincy<br>• **Security**<br><br>• NED link to Chief operating office |
| **Michael Parsons**<br>**Non-executive director**<br><br>**Term:** 1 May 2023 – 30 April 2026 | • Board meeting – Public, Closed<br>• Audit Committee (**Chair**)<br>• Charitable Funds Committee (Chair)<br>• Remuneration Committee<br><br>Specialist committees:<br>• Insight Committee<br>• Future System Board<br>• Clinical Excellence & Discretionary Awards Committee | • Board Workshops<br>• Consultant appointments<br>• Quality walkabouts<br>• Council of Governors and Governor meetings with NEDs<br>• Investigations and appeals | • NED link to Director of Finance |
| **Krishna Yergol**<br>**Non-executive director**<br><br>**Term:** 1 November 2022 – 31 October 2025 | • Board meeting – Public, Closed<br>• Remuneration Committee<br><br>Specialist committees:<br>• Digital Programme Board<br>• Future System Board<br>• Involvement Committee (**Chair**) | • Board Workshops<br>• Consultant appointments<br>• Quality walkabouts<br>• Revalidation Support Group<br>• Council of Governors and Governor meetings with NEDs<br>• Investigations and appeals | • Cyber security<br><br>• NED link to CIO |

All NEDs will be invited to attend audit committees (including deep dive presentations) but only those specified above are members of the committee

## Annex B: Scheduled draft agenda items for next meeting – 22 March 2024

| Description | Open | | Closed | Type | Source | Director |
|---|---|---|---|---|---|---|
| Declaration of interests | ✓ | | ✓ | Verbal | Matrix | All |
| **General Business** | | | | | | |
| Patient/staff story - staff experience of the emerging incident review process | ✓ | | ✓ | Verbal | Matrix | Exec. |
| Chief Executive's report | ✓ | | | Written | Matrix | EC |
| **Culture** | | | | | | |
| Organisational development plan | ✓ | | | Written | Matrix | JMO |
| **Strategy** | | | | | | |
| Future System Board Report | ✓ | | | Written | Matrix | CB |
| System update:<br>- West Suffolk Alliance and SNEE Integrated Care Board (ICB)<br>- Wider system collaboration | ✓ | | | Written | Matrix | <br>PW / CM<br>All execs |
| SNEE ICB joint forward plan (JFP) update (*schedule for May 2024*) | ✓ | | | Written | Matrix | RW (ICB) |
| Strategic priorities – update | ✓ | | | Written | Action | CEO |
| Operational plan 2024/25 | ✓ | | | Written | Matrix | Execs |
| Digital Board report | ✓ | | | Written | Matrix | CB |
| **Assurance** | | | | | | |
| Insight Committee – committee key issues (CKI) report<br>- Finance report<br>- 2024/25 budget and capital programme | ✓ | | | Written | Matrix | AJ / NC / SW |
| Involvement Committee – committee key issues (CKI) report<br>- People and OD Highlight Report<br>o Putting you First award<br>o Staff recommender scores<br>o appraisal performance, including consultants (quarterly)<br>- Safe staffing guardian and FTSU reports<br>- National patient and staff survey and recommender responses<br>- Education report - including undergraduate training (6-monthly) | ✓ | | | Written | Matrix | TD / JMO |
| Improvement Committee – committee key issues (CKI) report<br>- Maternity services quality and performance report<br>- Nurse staffing report<br>- Quality and learning report, including mortality and quality priorities | ✓ | | | Written | Matrix | LP / SW / PM |
| Audit committee – committee key issues (CKI) report | ✓ | | | Written | Matrix | MP |
| Serious Incident, inquests, complaints and claims report | | | ✓ | Written | Matrix | SW |

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

# 5.2. Board Assurance Framework

To Approve

Presented by Richard Jones

| Board of Directors | |
|---|---|
| **Report title:** | **Board Assurance Framework** |
| **Agenda item:** | 5.2 |
| **Date of the meeting:** | 26 January 2024 |
| **Sponsor/executive lead:** | Richard Jones, Trust Secretary |
| **Report prepared by:** | Mike Dixon, Head of Health, Safety and Risk |

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

**Executive Summary**

**WHAT?**

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

The Board assurance framework (BAF) is a tool used to manage principal risks to the Trust's strategic objectives. The strategic risks were subject to detailed review at the Board workshop in November and the following broad themes agreed:

1. Capability and skills
2. Capacity
3. Collaboration
4. Continuous improvement and innovation
5. Digital Infrastructure
6. Estates
7. Finance
8. Governance
9. Public, patient and staff engagement
10. Wellbeing

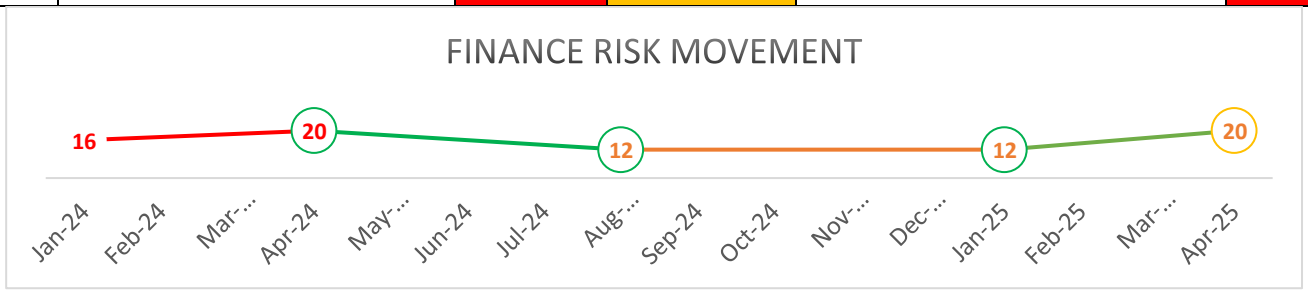
The existing BAF risks have been mapped to these themes which are set out in more detail in Annex A.

The draft strategic risks are being reviewed by each Executive Lead for comment and updating. Annex B shows an example of a reviewed and updated BAF risk for finance.

Below is the BAF summary highlighting the predicted risk movement over the coming strategic reporting period. This is for illustration purposes only as an example of how this could be reported. Future reports will contain an assessment of these changes by the risk owner.

**Board Assurance Framework (BAF) "At a glance" Summary**

| BAF Ref | BAF Risks | Current Risk Level | Current Assurance Level | Executive Commentary | Future risk Level |
|---|---|---|---|---|---|
| 01 | **Finance**<br>Fail to ensure we manage our finances effectively to guarantee the long-term sustainability of the Trust and secure the delivery of our vision, ambitions and values<br>Risk Appetite: Minimal<br>**Executive Lead: Craig Black** | 16 | Adequate | Trust financial pressures have impacted the current assurance levels and also have increase the future likelihood from the possible to the likely position. | 20 |




**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 is able to 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:

- Focus on 'causes' and 'effects'
- Existing controls (to mitigate risk)
- Action to mitigate risk and reduce the risk rating
- Assurance on the effectiveness of controls (internal and external)

As part of the wider update of the risk management arrangements and BAF reporting we will:

- Develop collective understanding of risk tolerance (risk appetite) and use this to inform how risks are reported and escalated at board, assurance and corporate levels. This will be the focus of a facilitated board workshop in February 2024

| |
|---|
| • Map sources of assurance for each of the strategic risk, internal and external and ensure that gaps in assurance are understood and managed e.g. included in internal audit programme |
| **Action Required** |
| 1. Note the report and actions described in the 'Next steps' section of the report<br><br>2. Provide feedback on the amended reporting format set out in the example for the finance risk |

| | |
|---|---|
| **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: Updates strategic risks**

| Strategic risk (new) |
|---|
| 1. Capability and Skills: Fail to ensure the Trust has the capability and skills to deliver the highest quality, safe and effective services that provide the best possible outcomes and experience (Inc developing our current and future staff) |
| Capacity: The Trust fails to ensure that the health and care system has the capacity to respond to the changing and increasing needs of our communities |
| 2. Collaboration: Fail to ensure the Trust can work together with our partners to provide the greatest possible contribution to prevent ill health, increase wellbeing and reduce health inequalities |
| 3. Continuous improvement and Innovation: Fail to ensure the Trust continuously seeks to improve, learn and transform the way we work, to guarantee that Trust activities can safely and sustainably deliver for our patients, our staff and for the future |
| 4. Digital Infrastructure: Fail to ensure the Trust implements secure, cost effective and innovative approaches that advance our digital and technological capabilities to better support the health and wellbeing of our communities |
| 5. Estates: Fail to ensure the Trust estates are safe, fit for purpose while maintained to the best possible standard so that everyone has a comfortable environment to be cared for and work in today and for the future |
| 6. Finance: Fail to ensure we manage the Trust finances appropriately and effectively to guarantee the long-term sustainability of the Trust and secure the delivery of our vision, ambitions and values |
| 7. Governance, Compliance and Professionalism: Fail to ensure the Trust has the appropriate governance structures, principles and behaviours to help us safely deliver the best quality and safest care for our local population (our vision) and ambitions (for patients, staff and the future) in the right way. |
| 8. Public, patient and staff engagement – new proposed risk being developed |
| 9. Wellbeing: Fail to ensure the Trust can effectively support, protect and improve the health, wellbeing and safety of our staff |

| BAF 01<br>Finance | Risk<br>Cause and Effects | Existing Risk Controls | Assurance / Evidence 1st Line | Assurance / Evidence 2nd Line | Assurance / Evidence 3rd Line | Assurance & Control Gaps | Assurance level | Current Risk Score | Planned Actions: Progress on Action | Future Risk Score |
|---|---|---|---|---|---|---|---|---|---|---|
| *Fail to ensure we manage our finances effectively to guarantee the long-term sustainability of the Trust and secure the delivery of our vision, ambitions and values*<br><br>**Inherent Risk Score**<br>**TBC**<br>**Overall Assurance level**<br>**Adequate**<br><br>**Lead Director:**<br>Finance Director<br><br>**Main Oversight Board Committee:**<br>Finance & Risk Committee<br><br>**Improvement Group:**<br>Finance Management Team<br><br>**Last Updated: 17/01/24**<br>**Last Reviewed: 17/01/24** | **Cause:**<br>C1) Ineffective strategic financial plan<br><br>C2) Budgeting (Staff)<br><br>C3) Operational pressures and demand (Patients)<br><br>C4) External costs (Contractors)<br><br>C5) Funding income ICS funding increase in activity versus elective activity (Patients)<br><br>**Effect:**<br>E1) Overspend<br><br>E2) Budgets inaccurate / unachievable<br><br>E3) Negative patients / stakeholder experience<br><br>E4) Inability to deliver strategic plans<br><br>E5) Continued deterioration of estates | **C1) Effective strategic financial plan**<br>Agreed 12-month delivery of financial plan<br><br>Agreed Trust financial strategy<br>**Control Owner: Craig Black** | Finance Director leads Executive review of financial models<br><br>Executive team review of financial strategy progress | Oversight of financial performance and approval of financial strategy through Trust wide governance including Insight Committee and Board | Regulatory review of long-term financial assumptions for the Trust | Financial strategy due for refresh to ensure consistency with Future System OBC | | **I =**<br>**L =**<br>**TBC** | TBC<br>**Action Owner:** TBC | **I =**<br>**L =**<br>TBC |
| | | **C2) Budgeting**<br>Budget setting process<br>Monthly budget monitoring<br>Annual budget targets are set in line with key Trust priorities<br>Reconciliation process for budgeting and cost improvement programme tied to budgeting<br>Budget contingencies in place including explicit winter funding<br>Budgets include specific pressures and relevant modelling<br>The capital budget setting includes EBME, IT and estates<br>**Control Owner: Craig Black** | Business plans including budgets developed by each Directorate<br>Finance budget setting documents detail assessments including assumptions<br>Reconciliation process tied to the delivery of plans monitored by the finance team<br>Finance team balance contingencies with affordability and implications for CIP | Insight committee would review and agree budgets<br>Executive directors sign off / Board sign off and approval of budgets<br>Cost improvements are approved by both Executive & Board<br>Reconciliation process approval by Executive & Board<br>Board approval of contingency is tied to CIP | Internal and external audits<br>Benchmarking with ICS<br>Future system projects has been subject to significant external scrutiny | No gaps currently identified | | | TBC<br>**Action Owner:** TBC | |
| | | **C3) Operational Pressures**<br>Dedicated financial systems and processes for financial transactions<br>Agreed budgets for all departments which are monitored monthly via finance systems<br><br>**Control Owner: Craig Black** | Monitoring of budgets and reconciliations of control accounts by finance team<br><br>Executives with the Divisional Directors and their teams to review KPI's on Budgetary performance and variance | Monitoring of access and review reports (90 day rolling average)<br>Monthly updates on inflationary pressures on financial plans presented to Finance Accountability Committee and Board where appropriate | Annual internal audit of financial management<br>Insight committee oversight of budget setting ahead of Board<br>Annual external audit of accounts<br><br>Annual submission of cost collection to NHSEI (Financial and patient activity)<br><br>Monthly ICB Finance reviews | | | | TBC<br>**Action Owner:** TBC | |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | **C4) External Costs**<br>Agreed Estates strategy including 10-year delivery plan<br>5-year advisory backlog plan which is costed, revised and reviewed annually<br>Estates Infrastructure Regulatory Compliance (EIRC) Capital programme in place and costed<br>**Control Owner: Chris Todd** | Estate's strategy delivery plan is monitored, reviewed and progress reported to Director of Finance<br><br>Advisory backlog and planned maintenance are managed by estates and progress including compliance issues reported to Director of Finance | Trust Board Reports on current strategy delivery, exception reports on maintenance issues including backlog and funding<br>RAAC Assurance Reports | Estates Infrastructure Regulatory Compliance (EIRC) Capital programme allocation was developed on a risk-based approach from work undertaken by The Advisory Board | Insufficient capital and revenue funding allocated to address the total backlog<br><br>Gaps in compliance identified through Authorising Engineers reports | | | TBC<br>**Action Owner:** TBC | |
| | | **C5) Funding Income**<br>Bench marking with ICS<br><br>Explicit winter funding<br><br>Long term financial modelling with the ICS<br>Extra support at Executive level focusing on the transformation programme<br><br>**Control Owner:TBC** | Future systems programme and capital funding<br><br>Insight committee oversight | | | | | | | |

# 6. OTHER ITEMS

## 6.1. Any other business

To Note

# 6.2. Reflections on meeting

For Discussion

## 6.3. Date of next meeting - 22 March, 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

# Terms of reference of financial recovery group

# FINANCIAL RECOVERY GROUP
## Terms of Reference

### 1. Purpose

1.1. The Trust's Executive Directors Meeting resolve to establish a working group to be known as the Financial Recovery Group (the group).

1.2. The group will operate in a manner that is consistent with the Trust's values to delivery its duties and responsibilities.

1.3. The group has no executive powers other than those specifically delegated in these terms of reference. The scope of this group will focus on weekly review of position for each Division that isn't within budget and communication of new financial recovery arrangements issued by Chief Executive Officer/Director of Resources. It is responsible for securing delivery of its delegated functions.

1.4. This group is established following deterioration in the Trust's financial position to consider risks and challenges to deliver their financial plans for 2023/24.

1.5. These terms of reference set out the role, responsibilities, membership, and reporting arrangements of the group under its terms of delegation from the Executive Directors Meeting.

1.6. Relevant areas for improvement are identified and managed. The target areas will form the basis of workstreams/working groups with clearly defined objectives and responsibilities:

- Workforce and pay (chair – COO)
  - Recruitment process and review of vacancies
  - Rostering
  - Temporary staffing / bank / agency controls
  - Other pay controls
- Procurement / non-pay – discretionary spend
- Income
- Financial governance

1.7. Develop, progress and monitor recovery schemes, with a focus on sustainable delivery.

1.8. Grow the savings pipeline to help mitigate any slippage in year.

1.9. Divisions to produce and progress plans at pace to close their current gaps (cost savings and reduction in run rate). The group will task management teams to develop their plans and will continue to drive this at pace through divisional review. Recovery plan ideas received from Divisions will be reviewed and converted into tangible opportunities.

1.10. Comprehensive staff engagement and consideration of 'ideas generation' events to grow the savings pipeline and mitigate slippage.

1.11. Review withdrawn/rejected schemes to reassess their viability and review current non-cash releasing schemes to assess which can be made them cash releasing.

## 2. Level of Authority

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

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

2.3. The group may establish sub-groups/committees/working groups reporting to it. It shall remain accountable to the Executive Directors Meeting / SLT for the work of any group reporting to it.

## 3. Duties and responsibilities

The key responsibilities of the group shall be to:

3.1 To develop and oversee a credible financial recovery plan for the Trust.

3.2 Sponsor and oversee the agreed savings and efficiency programmes

3.3 Ensure appropriate financial recovery actions and expenditure controls are in place (or implemented) across organisation to mitigate financial risk. These controls must be considered and implemented as soon as possible in order to impact earlier in the financial year.

3.3.1 Maintain a full assessment of the expenditure controls document issued by NHSE nationally for all systems with a deficit plan

3.4 All recovery actions are endorsed by clinical and operational leaders with full quality impact assessment (QIA) sign off.

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

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

3.7 Advise the board and/or relevant board committee of any risks and issues relating to performance, the assurances it has received of any actions relating to them and any gaps in control or assurance that need to be escalated for attention.

3.8 Assess, agree and quantify the opportunities for savings and productivity improvements and distinguish between those where:

- responsibility and oversight rests at the level of organisation

- responsibility and oversight rests at the level of collaborative
- responsibility and oversight rests at the level of place
- responsibility and oversight should be undertaken at system level.

3.9 Ensure that the current financial position and future financial position of the Trust and the actions proposed to improve this position, are communicated to the Board in a clear, consistent and transparent manner.

3.10 To review significant risks including those in the BAF and are relevant to the scope of the committee as allocated by the Board.

## 4. Membership

4.1 Membership of the group will comprise:

4.1.1 Executive Leads:

- Chief Executive Officer (chair)
- Director of Resources (deputy)

4.1.2 Other Members

- All executive directors

4.2 Others in attendance:

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

- Non-executive directors
- ADO (Clinical Divisional)
- System representative(s)
- Corporate teams – HR, finance
- Information
- Others as required

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

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

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

## 5. Quorum

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

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

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

## 6. Frequency of meetings

6.1. The committee shall operate as follows:

- The group will meet weekly until agreed otherwise
- Items for the agenda should be submitted to the group admin a minimum of 4 working days prior to the meeting. Papers on other matters will be put on the agenda only with the prior agreement of the chair
- Papers will be sent out by the group secretary at least 2 days before each meeting.
- Membership and terms of reference will only be changed with the approval of the group and ultimately the Executive Directors Meeting.

## 7. Sub Committees

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

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

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

8.2. A record of actions and decisions will be prepared after each meeting of the committee within 4 working days and circulated to members of the group and others as necessary once confirmed by the Chair of the group. Once the group has approved the full minutes, a copy will be available, for information, to the board at its next meeting.

## 9. Accountability and reporting arrangements

9.1. The group shall be directly accountable to the Executive Directors Meeting.

9.2. There should be a formal report from the group to the next meeting of the Executive Directors Meeting.

9.3. The chair of the group shall draw to the attention of the Trust Board, in private or public as appropriate, any issues that require disclosure to the Board. The speed of communication should be proportionate to the seriousness and likely impact of the issue

9.4. Links between the working of the group and the Financial Accountability Committee will be developed and maintained.

## 10. Monitoring effectiveness and compliance with Terms of reference

10.1. In order to support the continual improvement of governance standards, this group is required to complete a self-assessment of effectiveness at least annually and/or at the point that it is desolved.

**11. Ratification of terms of reference and review arrangements**

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

**Date approved by the Executive Directors Meeting:** 26 July 2023
**Date approved by the Financial Recovery Group:**
**Next review date:** Annually

# 4.2 IQPR Full Report / Finance Report

Assurance Grid

| November 2023 | ASSURANCE: Pass (P) | ASSURANCE: Hit and Miss (?) | ASSURANCE: Fail (F) – Not Met |
|---|---|---|---|
| VARIANCE: Special Cause Improvement (H / L) | **IMPROVEMENT**<br>VTE – all patients | **INSIGHT**<br>RTT 104+ Week Waits<br>**INVOLVEMENT**<br>Staff Sickness – rolling 12 months<br>Staff Sickness | **INSIGHT**<br>RTT 78+ Weeks Waits<br>**INVOLVEMENT**<br>Mandatory Training<br>Appraisal<br>Turnover |
| VARIANCE: Common Cause | **INSIGHT**<br>Urgent 2 hour response | Please see box to right | **INSIGHT**<br>Ambulance Handover within 15min<br>12 Hour Breaches<br>Incomplete 104 Day Waits<br>Diagnostic Performance- % within 6weeks Total |
| VARIANCE: Special Cause Concern (H / L) – Deteriorating | | **INSIGHT**<br>Reduce adult general and acute (G&A) bed occupancy | |

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

**INSIGHT:**
Pledge 2 *% Compliance
Ambulance Handover within 30min
Ambulance Handover within 60min
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
Nutrition – 24 hours
**INVOLEMENT:**
Overdue Responses

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

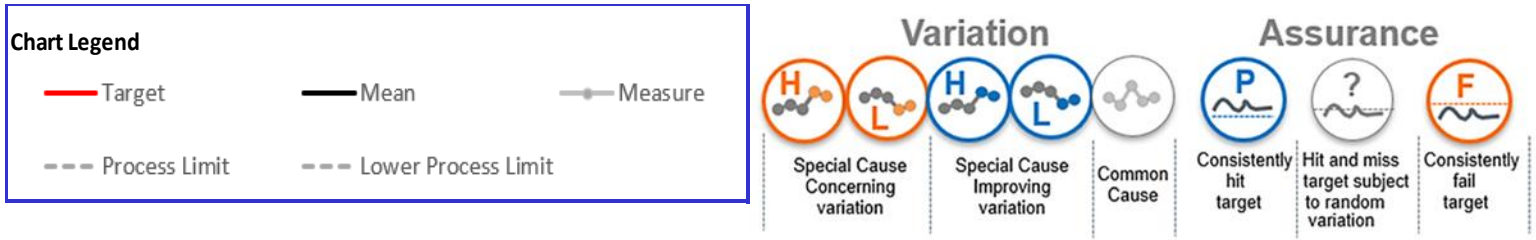
- Urgent appointments within 48 hours
- Routine appointments within 2 weeks
- Increase the % of patients with hypertension treated to NICE guidelines to 77% by March 2024
- Increase the % of patients aged 25-84 years old with a CVD risk score of >20% on lipid lowering therapies to 60%

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

*Cancer data is 1 month behind

**Items for escalation based on those indicators that are failing the target, or are worsening and therefore showing Special Cause of Concerning Nature by area:**
**INSIGHT - Urgent & Emergency Care:** Ambulance Handover within 15min, 12 Hour Breaches, Reduce adult general and acute (G&A) bed occupancy
**Cancer:** Incomplete 104 Day Waits
**Elective:** Diagnostic Performance- % within 6weeks Total, RTT 78+ Weeks Waits
**INVOLVEMENT - Well-Led:** Mandatory Training, Appraisal, Turnover

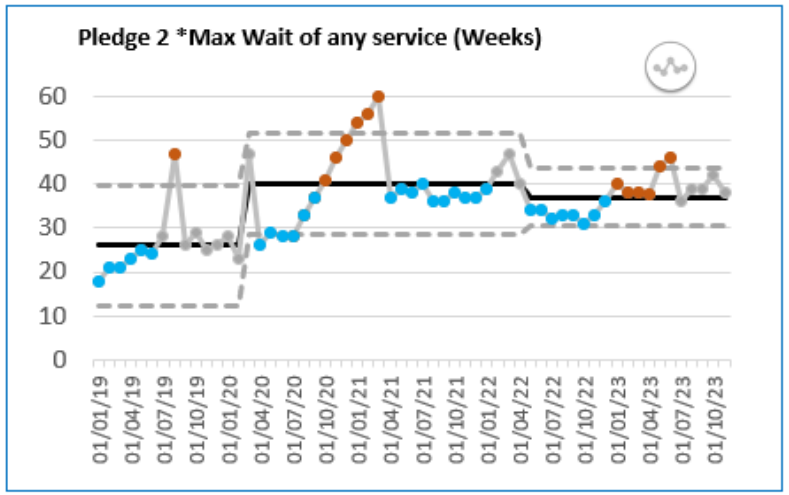
# INSIGHT COMMITTEE METRICS

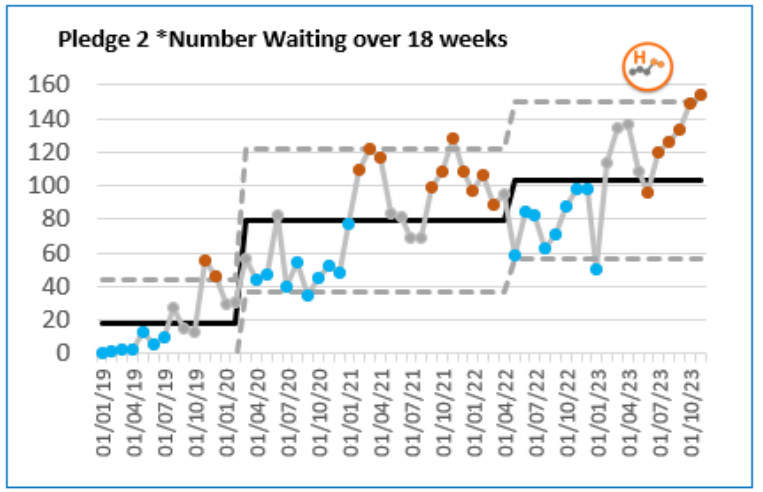


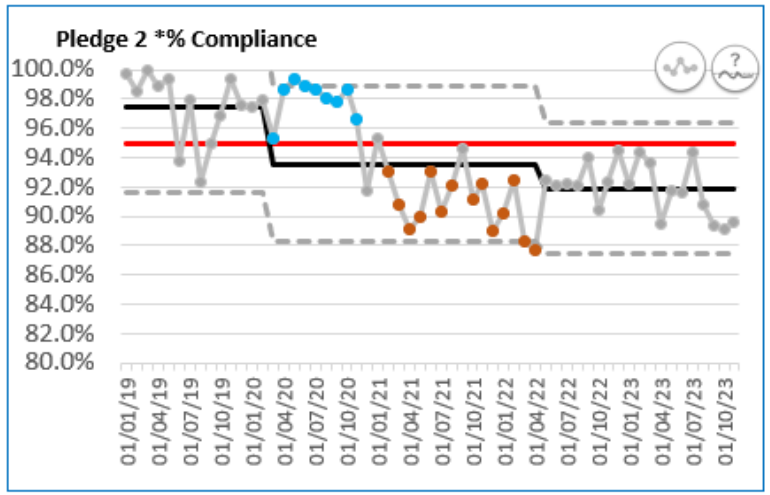

| KPI | Latest month | Measure | Target | Variation | Assurance | Mean | Lower process limit | Upper process limit |
|---|---|---|---|---|---|---|---|---|
| Pledge 2 *Max Wait of any service (Weeks) | Nov 23 | 38 | | | | 37 | 30 | 44 |
| Pledge 2 *Number Waiting over 18 weeks | Nov 23 | 154 | | H | | 103 | 57 | 150 |
| Pledge 2 *% Compliance | Nov 23 | 89.6% | 95.0% | | ? | 91.9% | 87.4% | 96.4% |
| Urgent 2 hour response | Nov 23 | 89.6% | 70.0% | | P | 89.9% | 81.3% | 98.6% |
| Criteria to reside (Average without reason to reside) Acute | Nov 23 | 52 | | | | 59 | 48 | 71 |
| **Criteria to reside (Average without reason to reside) Community | Nov 23 | 17 | | | | 17 | 13 | 21 |

*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.

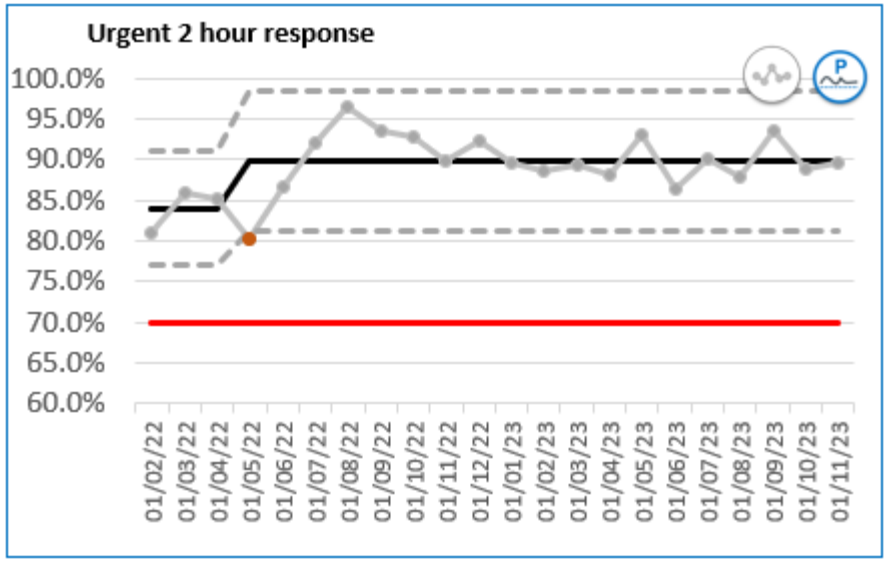
** Figures are for Glastonbury and Newmarket only, data not currently captured at Hazel Court.

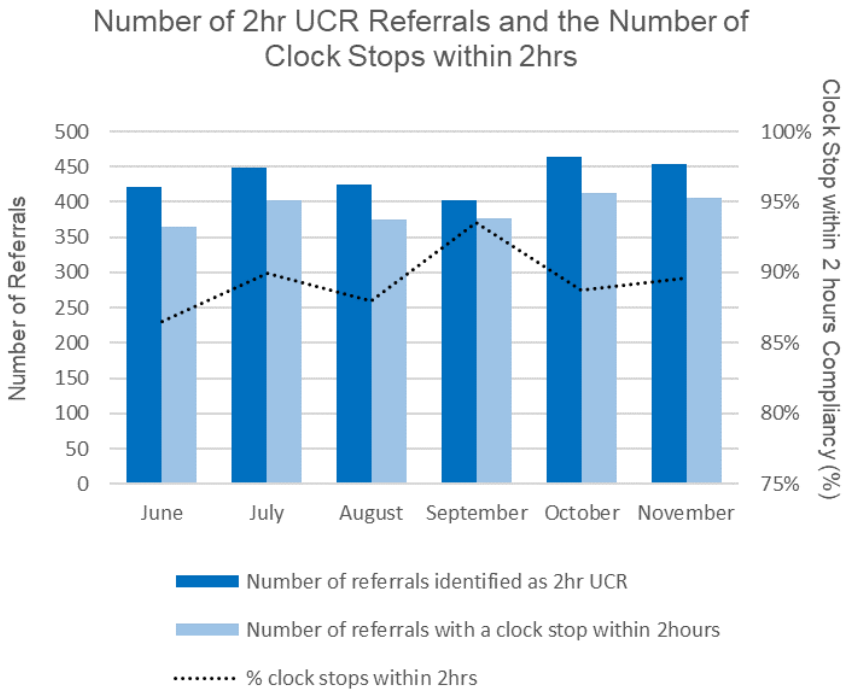


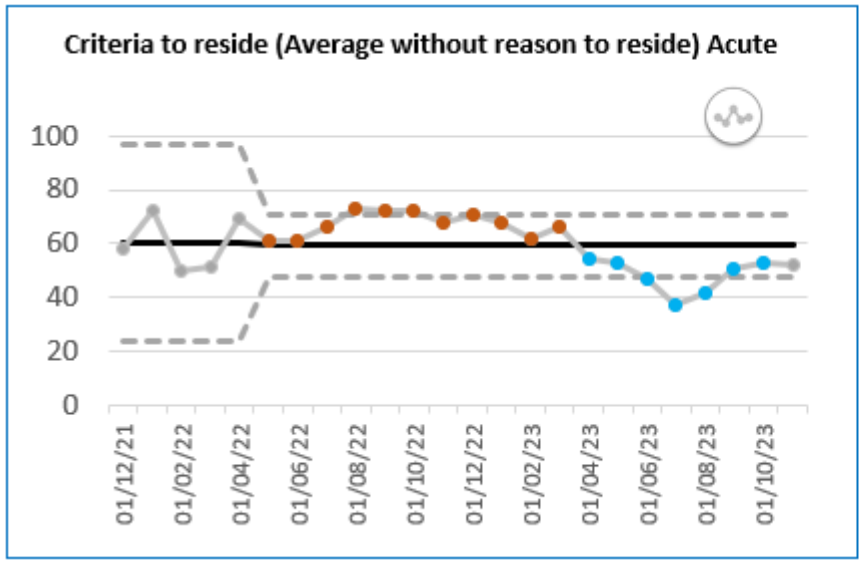



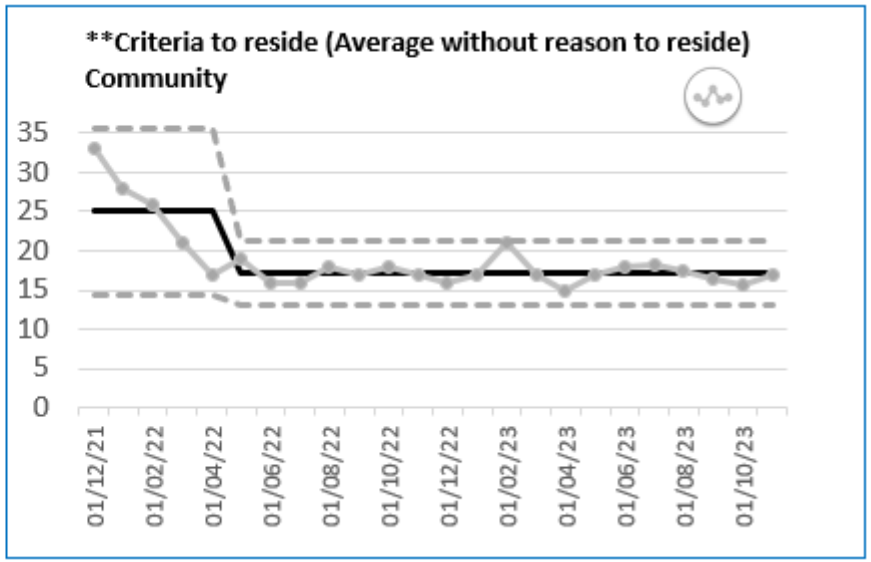

| What | So What? | What Next? |
|---|---|---|
| Wheelchair Services<br>Maximum wait time for handover increased from 37 to 42 weeks (35 weeks in West). Patients waiting over 18 weeks and overall handover compliance remains like previous months. Referral rate continues to be around 26% higher than pre-Covid<br><br>**Paediatric Speech and Language Therapy (SLT:**<br>Common cause variation in 18wk compliance due to sustained referral demand and high service caseload numbers. Some improvement this month to 83.42% with maximum wait time being 38.43wks. | Wheelchair Services<br>Local performance remains in line with national wheelchair services' performance. No specific drivers for increased referral rates – likely indication of complexity and true increased demand<br><br>**Paediatric SLT:**<br>Service caseloads are increasing further with the need to prioritise support for children with an Education Health and Care Plan and children within our pre-school complex needs pathway (who are not represented in this slide as on caseloads with no new clocks) | Wheelchair Services<br>Training of new starter in November to continue. Staff sickness being managed, and long waits prioritised in November.<br>Continue to explore alternative options for environmental controls provision – expression of interest now open across the region.<br><br>**Paediatric SLT:**<br>Recruitment to new posts using Suffolk County Council investment for provision in special schools and specialist units will commence in January but the service anticipates there may be challenges to appoint to these roles. Recruitment plan being discussed with Head of Resourcing. Changes to preschool assessment pathway, utilising group sessions is being scoped to pilot early in the new year. |



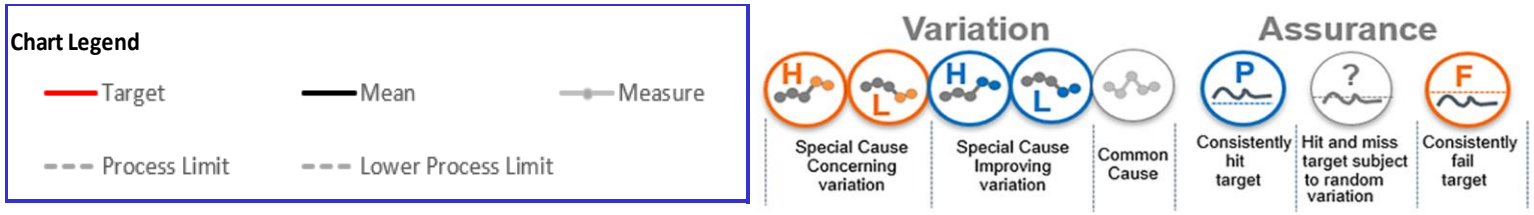




| What | So What? | What Next? |
|---|---|---|
| 1.Early Intervention Team (EIT) data consistently well above 70% target | Patients requiring an urgent response are being assessed in a timely manner across INT (Integrated Neighbourhood Team) and EIT. | 1.Finalise governance processes for Advanced Clinical Practitioners in team to provide more complex assessment and interventions.<br><br>2. Review opportunity to provide enhanced senior medical /geriatrician in community to promote step up to virtual ward and also decrease stack declines.<br><br>3.INT Data to be presented in Making Data Count format once data points achieved.<br><br>4.Baseline for INT's to be inserted once working group outcome achieved early 2024. Suggestion for baseline calculation returned on 22/11/2023.<br><br>5. Closely review data cleansing approach with Team managers to improve reporting.<br><br>6. Opportunity to identify themes and trends with breaches that can be unblocked, such as high activity during certain times of the day |



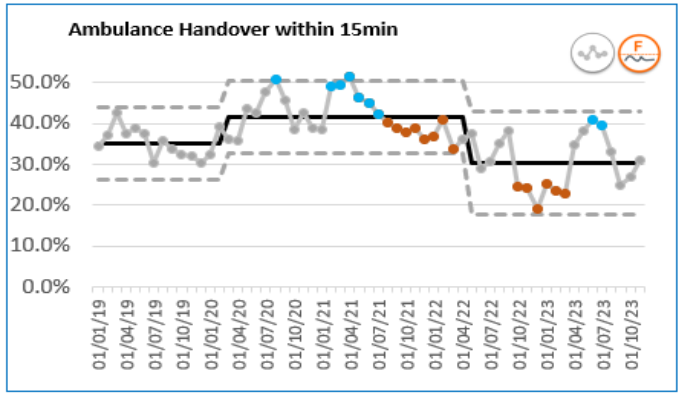



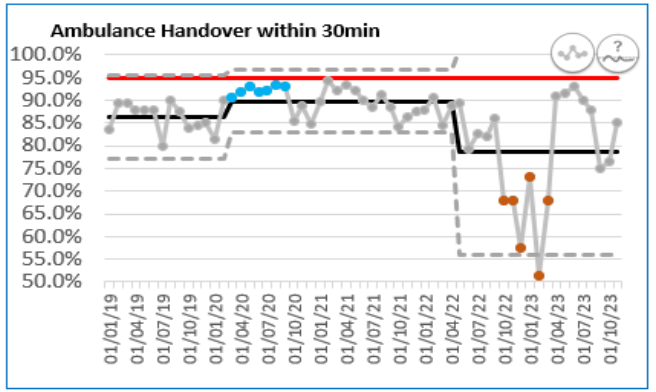

| What | So What? | What Next? |
|---|---|---|
| Acute figures for patients without criteria to reside are static this month. Prior to April 2023, there had been a trend of 11 months of a concerning nature. Meanwhile, patients without criteria to reside (community figures) have been static. | The improvement reflected in the data since April 23 corresponds with the Transfer of care hub seeing some reduction in referrals and discharges over this time period. The differences between the acute and community figures, notably the community data remaining static in comparison to the acutes variation (both of an improving and concerning nature,) would indicate that there may have been a change that has only impacted the acute figures, rather than acute and community figures. | Further evaluation is required to explore what the reasons are for the special cause variation below the mean and outside of the process limits in acute figures, including comparison to total numbers of Pathway 0-3 patients discharged from the acute throughout the above period. Several projects are underway to improve the capacity and speed of our discharges throughout the Trust. There are weekly Focus on Flow meetings occurring to discuss planning for the seasonal period, with the aim for this to impact capacity within the Trust, and criteria to reside numbers. |

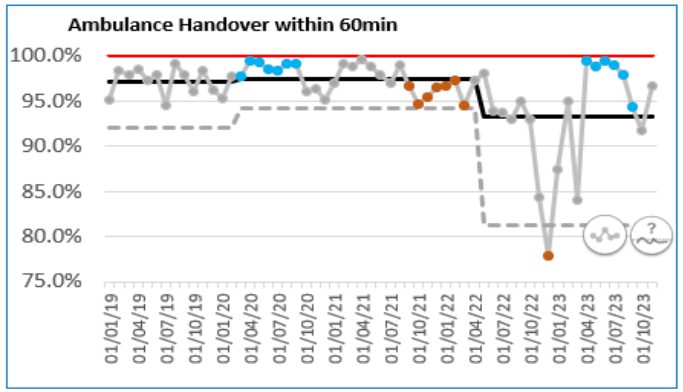


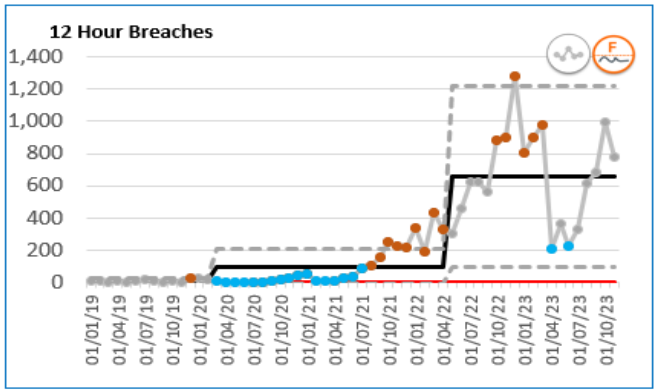

| KPI | Latest month | Measure | Target | Variation | Assurance | Mean | Lower process limit | Upper process limit |
|---|---|---|---|---|---|---|---|---|
| Ambulance Handover within 15min | Nov 23 | 31.0% | 65.0% | | F | 30.5% | 17.9% | 43.1% |
| Ambulance Handover within 30min | Nov 23 | 85.1% | 95.0% | | ? | 78.7% | 56.0% | 101.4% |
| Ambulance Handover within 60min | Nov 23 | 96.7% | 100.0% | | ? | 93.3% | 81.2% | 105.4% |
| 12 Hour Breaches | Nov 23 | 776 | 0 | | F | 659 | 95 | 1223 |
| Reduce adult general and acute (G&A) bed occupancy | Nov 23 | 94.8% | 92.0% | H | ? | 92.7% | 90.9% | 94.4% |
| 4 hour breaches | Nov 23 | 2908 | 0 | | | | | |
| 4 hour performance | Nov 23 | 62.0% | 76.0% | | | | | |

# Urgent & Emergency Care (TRUST)

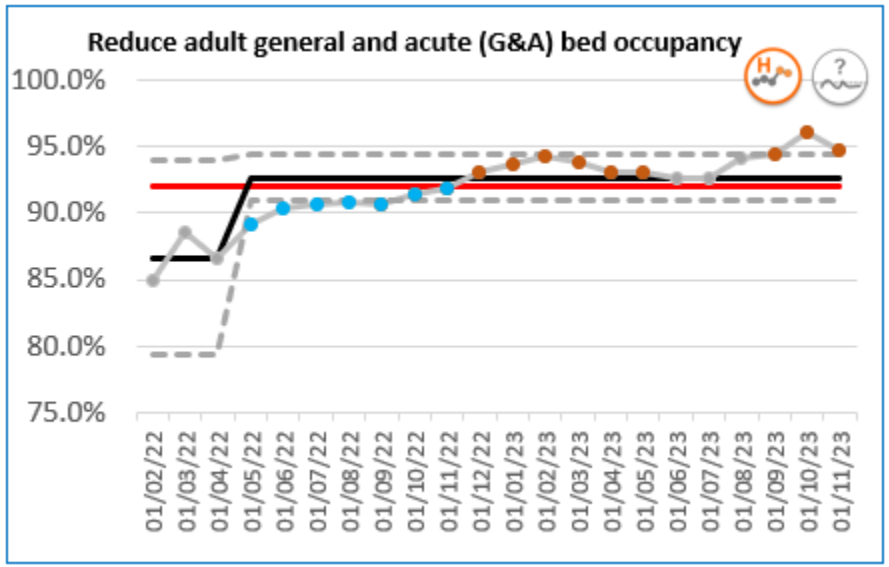


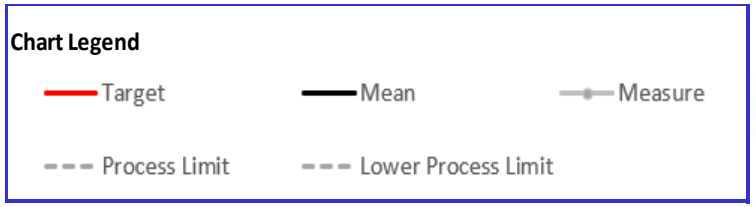



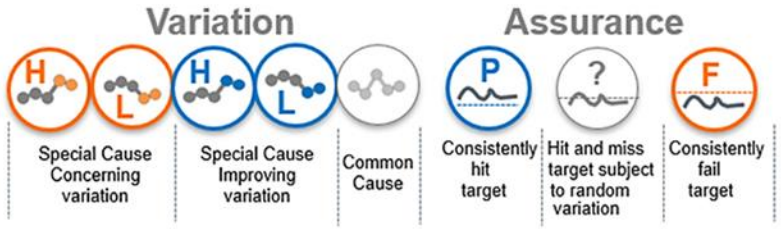

| What | So What? | What Next? |
|---|---|---|
| Overall attendances to the Emergency Department (ED) show no significant change.<br>We remain below our trajectory of 68% in November for 4 hour performance, achieving 61.96%.<br>Ambulance handover performance is not demonstrating any significant change, remaining a challenge in all 3 metrics. This is attributed to the continued overcrowding within the Emergency Department by patients with an increased length of stay, resulting in a reduced capacity to offload ambulances.<br>The number of 12 hour breaches do not demonstrate a significant change and this can be attributed to the high numbers of patients waiting a bed in the Emergency Department. | Meeting the Urgent and Emergency Care (UEC) performance metrics is key to ensuring that our patients are receiving timely care.<br><br>Achieving the ambulance handover metrics and 76% for the 4 hour ED standard will meet the national targets.<br><br>Lack of flow out of ED has resulted in the need to open escalation areas to assist with flow, these areas include the Rapid Assessment Area overnight, ambulance reverse cohorting areas in ED, the Acute Admissions Unit corridor and part of the Same Day Emergency Care Unit. | Work continues on phase two of our internal UEC recovery plan, whilst working collaboratively with the alliance and the ICB on the 'One Plan' to ensure improved UEC performance. UEC performance reported via governance meeting.<br><br>Recent completion of a 2 week refocus on the 4 hour target with work including education sessions, senior management/nursing working alongside ED floor coordinators and clear visual displays for the department to monitor progress with the 4 hour metric. This support work has been extended for a further 6 weeks with particular focus on the use of internal professional standards, and escalating issues.<br><br>"Arrive by nine" project – promoting early movement of patients to free up early capacity.<br>"Sunrise bloods" – pilot areas bloods are requested the previous day for potential discharges, phlebotomists take bloods early and they are analysed in time for the morning board round to enable discharge decisions to be made quickly. |




| What | So What? | What Next? |
|---|---|---|
| Bed occupancy has tracked above the 92% threshold in all months of 2023, reaching a recorded highs in September, October and November, having demonstrated a continuous upward trend since 2022, driven by a corresponding marginal increase in length of stay (although not yet significantly impacting on numbers of stranded patients). 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. | 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 towards or below 92% to ensure patient flow is effective and patients are not left waiting for admission. The Focus on Flow programme being managed by the Operational Improvement team has eight workstreams with the ambition of increasing flow and reducing bed occupancy. WSFT's planning trajectory to keep occupancy below 92% requires this programme, Virtual Ward, discharge funding, surgical SDEC/SAU and the national UEC funding to deliver to deliver the equivalent of 45 beds, with an additional 33 escalation beds forecast to be needed from December which will become available at the end of the month. |

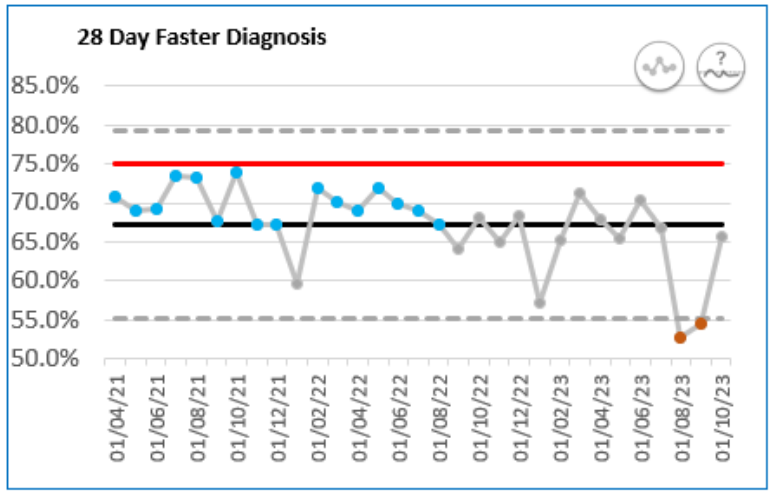
# Cancer Access Summary

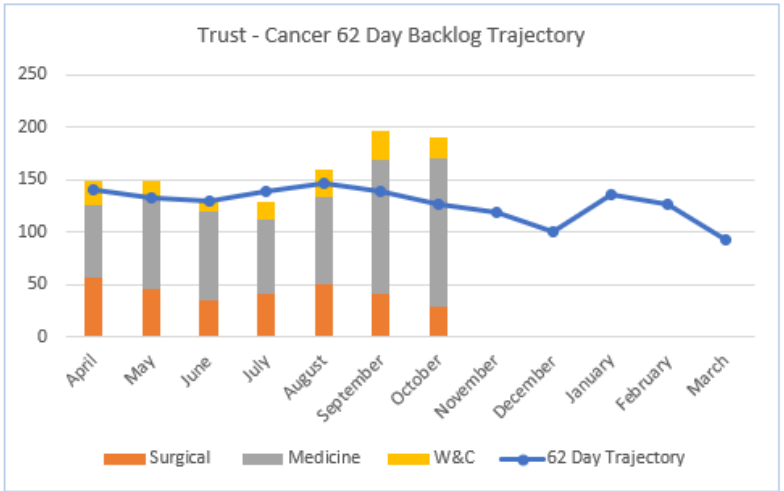


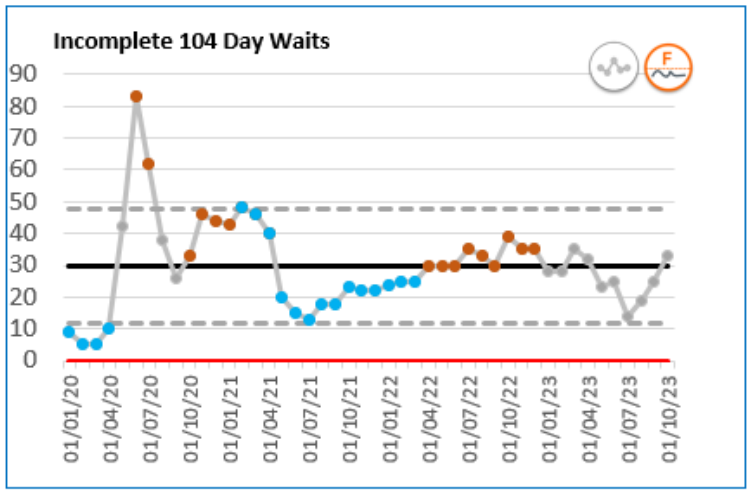




| KPI | Latest month | Measure | Target | Variation | Assurance | Mean | Lower process limit | Upper process limit |
|---|---|---|---|---|---|---|---|---|
| 28 Day Faster Diagnosis | Oct 23 | 65.6% | 75.0% | | | 67.2% | 55.2% | 79.2% |
| Trust Cancer 62 Day Backlog Trajectory | Oct 23 | 191 | 127 | | | | | |
| Incomplete 104 Day Waits | Oct 23 | 33 | 0 | | | 30 | 12 | 48 |

Cancer Access (Month Behind)




| What | So What? | What Next? |
|---|---|---|
| Performance against the 28-day Faster Diagnosis Standard (FDS) is not being consistently met nor demonstrating the improvement trajectory required to deliver the interim quarterly milestones and 75% target by March 2024. The performance has improved from 54.6% in September to 65.4% in October, largely due to a significant increase in Breast performance from 50% to 87%.<br>As at the end of October the 62 day backlog is over trajectory at 173 against a target of 127, this is an improved position however and will be back on trajectory for November 2023.<br><br>The number of 104-day waits has not significantly changed. | 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.<br><br>As well as recovering breast FDS performance to >90%, ensuring skin delivers >90% and improving performance in urology, lower GI, head & neck and gynaecology pathways will be required to meet the 75% target.<br><br>Action is required to reduce the 62-day backlog, ensuring patients are not awaiting decisions to close pathways where treatment is complete or results negative for cancer are available. | Additional recruitment into a fixed term Radiographer post will add some resilience into the overall performance for Breast, with the advert due to go out in December.<br><br>The impact of actions to improve FDS performance in gynaecology, head & neck (one-stop clinics) and urology (nurse-led prostate biopsy) will need to be monitored and further actions identified if necessary.<br><br>As discussed in the East of England Cancer Alliance 'Rapid Cancer Action Team' meeting, there will be implementation of straight to treatment pathways in Skin following AI telderm. |

# 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 | 8,395 | 112.6% |
| Jun | 8,097 | 8,664 | 8,294 | 102.4% |
| Jul | 7,499 | 8,024 | 7,818 | 104.3% |
| Aug | 7,637 | 8,172 | 7,584 | 99.3% |
| Sep | 7,729 | 8,270 | 8,613 | 111.4% |
| Oct | 8,097 | 8,664 | 8,039 | 99.3% |
| Nov | 8,373 | 8,959 | 8,833 | 105.5% |
| Dec | 6,717 | 7,187 | | |
| Jan | 8,373 | 8,959 | | |
| Feb | 7,821 | 8,369 | | |
| Mar | 7,591 | 8,122 | | |
| **Total (YTD)** | **61,511** | **65,816** | **64,294** | **104.5%** |

**November 2023**

| | |
|---|---|
| 19/20 | 8,373 |
| 107% | 8,959 |
| 23/24 | 8,833 |
| Var | (126) |
| Var % | 105.5% |

**Daycase**

| Mon | 19/20 | 107% | 23/24 | Var % |
|---|---|---|---|---|
| Apr | 1,903 | 2,033 | 2,064 | 108.4% |
| May | 2,175 | 2,324 | 2,393 | 110.0% |
| Jun | 2,338 | 2,498 | 2,450 | 104.8% |
| Jul | 2,189 | 2,338 | 2,311 | 105.6% |
| Aug | 2,257 | 2,411 | 2,372 | 105.1% |
| Sep | 2,284 | 2,440 | 2,347 | 102.8% |
| Oct | 2,393 | 2,556 | 2,265 | 94.7% |
| Nov | 2,556 | 2,731 | 2,486 | 97.3% |
| Dec | 1,985 | 2,121 | | |
| Jan | 2,461 | 2,629 | | |
| Feb | 2,365 | 2,527 | | |
| Mar | 2,284 | 2,440 | | |
| **Total (YTD)** | **18,094** | **19,332** | **18,688** | **103.3%** |

**November 2023**

| | |
|---|---|
| 19/20 | 2,556 |
| 107% | 2,731 |
| 23/24 | 2,486 |
| Var | (245) |
| Var % | 97.3% |

**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 | 18,528 | 108.2% |
| Jul | 15,863 | 13,484 | 17,320 | 109.2% |
| Aug | 16,155 | 13,732 | 17,493 | 108.3% |
| Sep | 16,350 | 13,897 | 17,814 | 109.0% |
| Oct | 17,128 | 14,559 | 19,048 | 111.2% |
| Nov | 17,712 | 15,055 | 19,466 | 109.9% |
| Dec | 14,209 | 12,077 | | |
| Jan | 17,712 | 15,055 | | |
| Feb | 16,544 | 14,063 | | |
| Mar | 16,058 | 13,649 | | |
| **Total (YTD)** | **130,117** | **110,598** | **143,17** | **110.0%** |

**November 2023**

| | |
|---|---|
| 19/20 | 17,712 |
| 85% | 15,055 |
| 23/24 | 19,466 |
| Var | 4,411 |
| Var % | 109.9% |

**Elective**

| Mon | 19/20 | 107% | 23/24 | Var % |
|---|---|---|---|---|
| May | 299 | 319 | 295 | 98.8% |
| Sep | 300 | 321 | 295 | 98.2% |
| Apr | 257 | 275 | 239 | 92.8% |
| Jun | 318 | 340 | 278 | 87.3% |
| Oct | 318 | 340 | 273 | 85.8% |
| Nov | 329 | 352 | 270 | 82.1% |
| Aug | 315 | 337 | 258 | 82.0% |
| Jul | 300 | 321 | 243 | 80.9% |
| Dec | 277 | 296 | | |
| Jan | 275 | 294 | | |
| Feb | 300 | 321 | | |
| Mar | 286 | 306 | | |
| **Total (YTD)** | **2,437** | **2,606** | **2,151** | **88.3%** |

**November 2023**

| | |
|---|---|
| 19/20 | 2,437 |
| 107% | 352 |
| 23/24 | 270 |
| Var | (82) |
| Var % | 82.1% |

## What

Year to date, day case and outpatient first totals are above 2019/20 levels however are not meeting the 107% ambition, with electives significantly behind in all months and showing a downward trend. Activity targets were not met across any point of delivery in November 2023, though outpatient first and day case showed an improvement on October activity. Outpatient follow ups are consistently not meeting the 75% of 2019/20 target. Industrial action, with pre-emptive cancellations and increases in on the day cancellations due to bed capacity/emergency demand will have impacted on activity in previous months with some recovery shown in November.

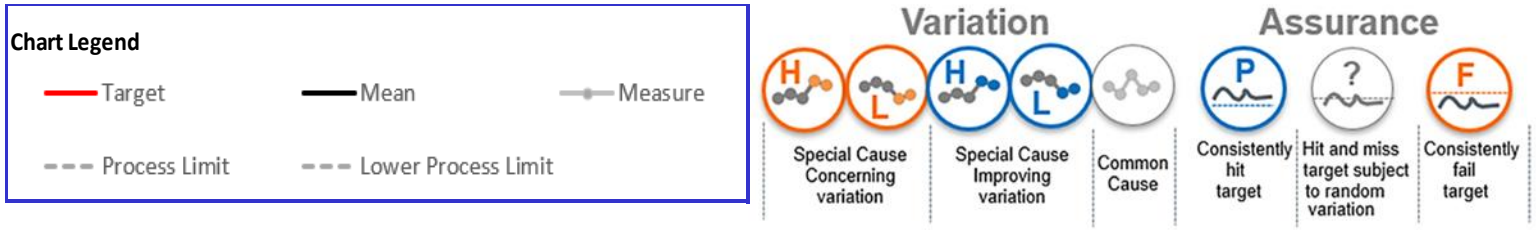
## So What?

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?

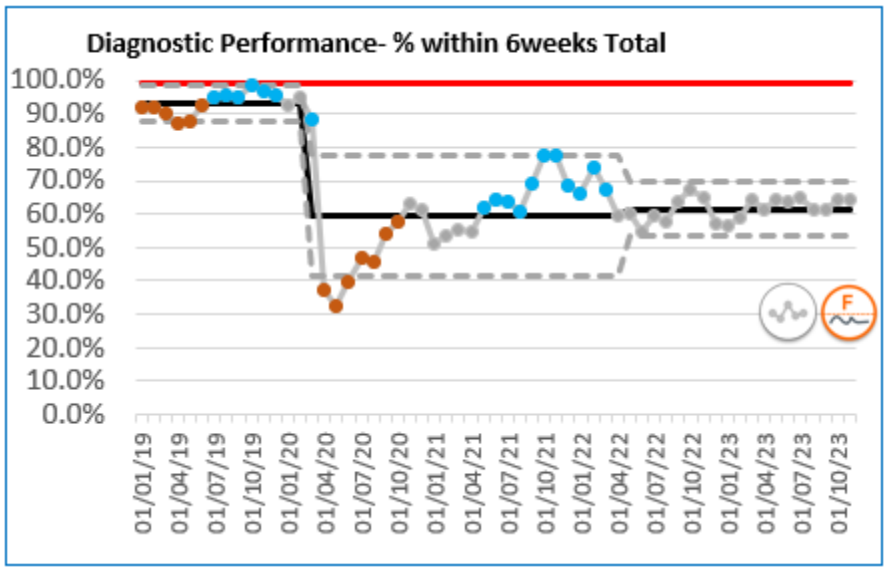
The 107% Elective Recovery Fund activity threshold has been lowered to 103% in recognition of the impact from Industrial Action though recovering increased delivery of activity will be required to meet our long wait elective ambitions whi9ch are expected to be extended in 2024/25. A system wide clinically-led Outpatient Improvement Collaborative has a key priority to reduce follow ups by 25% in line with national expectations. Further work and cultural shift will be required to deliver this locally. Delivering the right level of planned activity to meet planning expectations whilst balancing urgent and emergency care needs will be key in Q4.

# Elective Access Summary



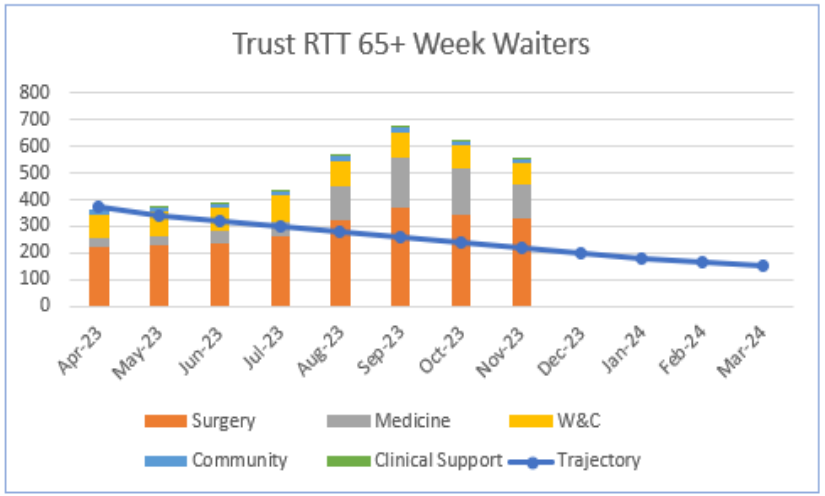

| KPI | Latest month | Measure | Target | Variation | Assurance | Mean | Lower process limit | Upper process limit |
|---|---|---|---|---|---|---|---|---|
| Diagnostic Performance- % within 6weeks Total | Nov 23 | 64.4% | 99.0% | | | 61.5% | 53.3% | 69.8% |
| RTT 65+ Week Waits | Nov 23 | 555 | | | | 487 | 314 | 660 |
| RTT 78+ Week Waits | Nov 23 | 54 | 0 | | | 206 | 112 | 300 |
| RTT 104+ Week waits | Nov 23 | 0 | 0 | | | 13 | -5 | 30 |
| Potential 65+ ww at end of March 2024 | Nov 23 | 2655 | | | | 6958 | 3053 | 10863 |

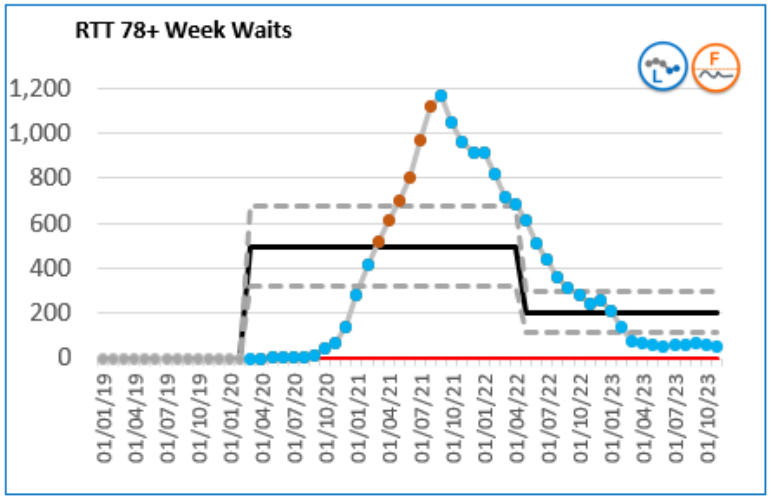
Elective Access

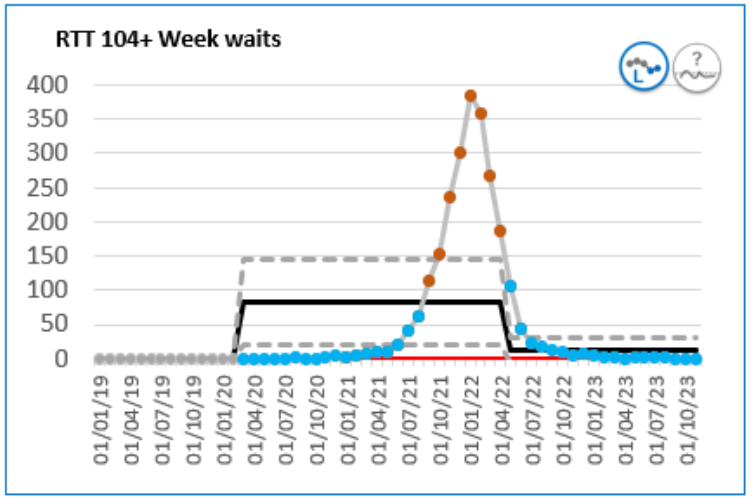


Elective Access

| 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 will be in place to mitigate.<br><br>**CT** –Currently not meeting DM01 compliance target due to replacement programme but expected to return to full compliance when completed.<br><br>**US** –Improving trend towards DM01 compliance but experienced an 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.<br><br>**Endoscopy –**Progress is being made against DM01, with consistent improvements seen in colonoscopy and gastroscopy. Priority is being given to patients on a cancer pathway. Total waiting list has increased but DM01 performance is showing consistent improvement for endoscopy. In month performance has again been negatively impacted due to down time resulting from water quality issues, now resolved.<br><br>**Urology-** urodynamics and cystoscopy remain on an upward trajectory, the specialty continuing to focus on cystoscopy to support delivery of urological cancer pathways. Position at w/e 17/12/23-92.31% for urodynamics and 70% for cystoscopy. The addition of an additional fixed term consultant is supporting diagnostic performance. Service is now using two rooms in the Joanna Finn Unit (JFU) to support adhere to DM01 trajectory. Compliance was expected in late November although this will be delayed due to staff sickness and December's industrial action. There is no opportunity for further service delivery within the unit as currently surgical SDEC has relocated to JFU to enable estates works on F4.<br>**Audiology**- remains on upward trajectory, w/e 17/12/23 at 87.3%. Improved administrative processes have supported a data cleanse which has supported an improvement, trajectory indicates compliance by March 2025, the limiting factor being the absence of adequate soundproofing space.<br>**Elective activity-** elective activity plateaued in month driven by reduced pick of bank shifts by theatre staff and unexpected sickness absence within the anaesthetic team. There were also bed capacity issues which resulted in the prioritisation of day case over inpatient activity. In spite of these issues theatres delivered 917 procedures in November, the highest level of activity since June 2023. OTD cancellations have increased as a result, seeing 28 cancellations in November due to medical sickness and 16 due to capacity constraints. Surgical division remains on trajectory for 65 week clearance. | Longer waiting times for diagnosis and treatment<br><br>The ongoing improvement evidences that current interventions and innovations are working to support timely diagnostic pathways. Most of our patients are receiving a diagnostic test within 6 weeks which reduced their anxiety and distress. | **MRI** – Request made to 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.<br><br>**CT** - Potential impact from CT replacement programme.<br><br>**US** –Plan to up skill Sonographers from the main department to be trained in MSK continues which will help with capacity, reducing waiting times and agency spend. Staffing issues resolved and performance now expected to improve.<br><br>**Endoscopy** - Current trajectory anticipates compliance in June 2024 against the DM01 target ambition of 95% by March 2025. Additional work in liaison with Cambridge University to explore opportunities to maximise efficiency in processes commenced early October.<br><br>**Urology-** out to advert for 4 substantive consultants which will enable the release of high cost locums and provide proportionately more capacity to support diagnostic attainment. Utilisation of second room once vacated by surgical SDEC. More nurses trained in diagnostic procedures.<br>**Audiology-** continuation of current work programme, engaged with paediatric community services but current community based infrastructure has been deemed unsuitable for adult patients as would require additional appointment to complete full breadth of testing.<br>**Elective-** will rebase theatre schedule in January, with agreement of clinical leads to ensure specialties that require capacity to clear 65 week backlog are prioritised. Introduction of TCI calculator App. To ensure patients are booked without breach. |

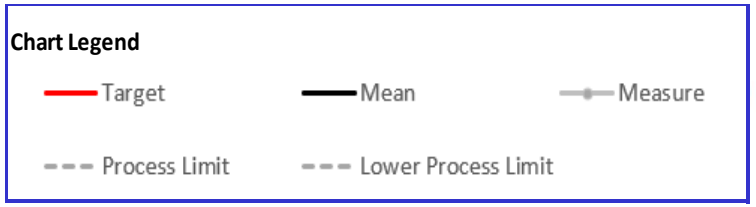


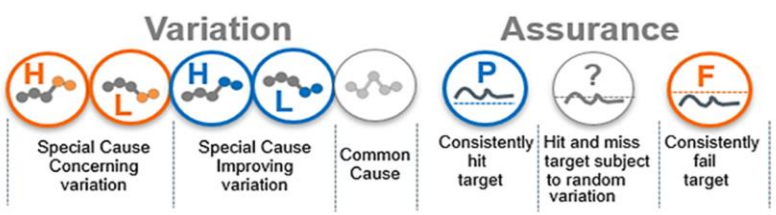




| What | So What? | What Next? |
|---|---|---|
| The total number of patients over 65 weeks has decreased in November by 66 patients following a peak in September 2023. The trajectory for the total cohort of patients who will reach 65 weeks by March 2024 remains on track.<br><br>The absolute number of 78ww patients remains constant in line with our forecast trajectory for capacity breaches (within the uro-gynaecology specialty), however this is likely to be impacted by the upcoming industrial action.<br><br>There were no 104ww patients as of the end of November. | 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. | Additional options will need to be explored for the uro-gynae position, with mutual aid now in discussion.<br><br>Insourcing is being implemented for the dermatology pathway, given a rise in the number of urgent patients needing to be seen which has increased the waiting time of routine patients and which could tip over into the 65 and 78ww cohorts. This is due to commence the 13th/14th January. |

# IMPROVEMENT COMMITTEE METRICS

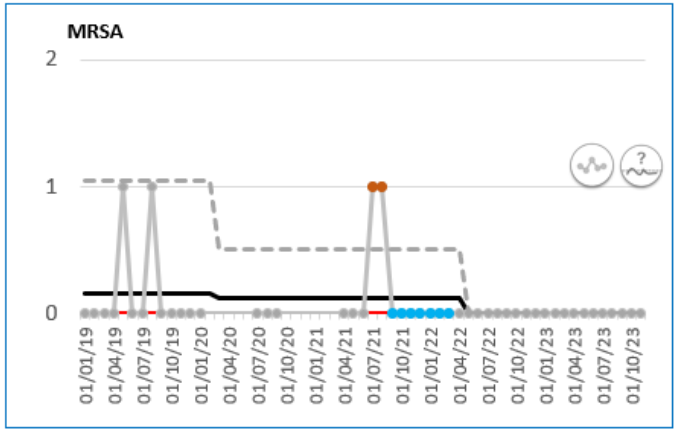


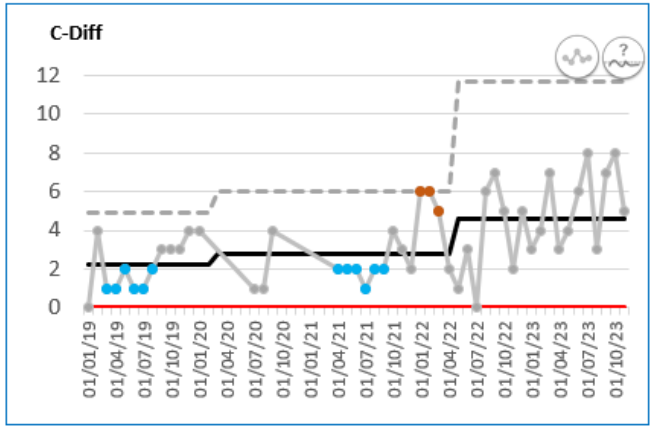



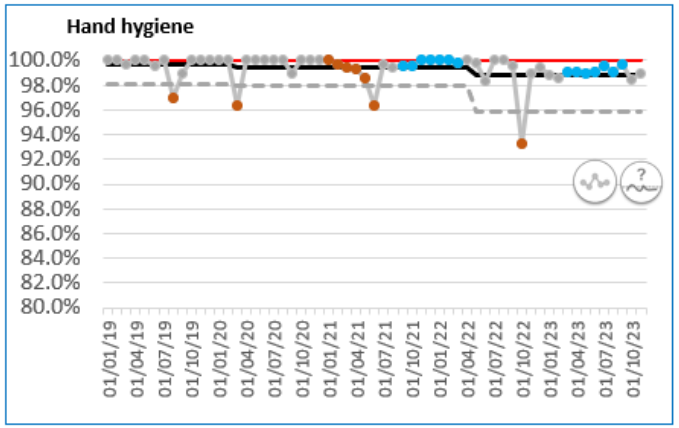

| KPI | Latest month | Measure | Target | Variation | Assurance | Mean | Lower process limit | Upper process limit |
|---|---|---|---|---|---|---|---|---|
| MRSA | Nov 23 | 0 | 0 | | | 0 | 0 | 0 |
| C-Diff | Nov 23 | 5 | 0 | | | 5 | -3 | 12 |
| Hand hygiene | Nov 23 | 98.9% | 100.0% | | | 98.9% | 95.8% | 101.9% |
| Sepsis Screening for Emergency Patients | Nov 23 | 75.0% | 100.0% | | | 84.8% | 60.3% | 109.3% |
| VTE - all inpatients | Nov 23 | 99.6% | 95.0% | H | P | 97.5% | 95.4% | 99.6% |
| Mixed Sex Breaches | Nov 23 | 4 | 0 | | | 4 | -6 | 15 |
| Community Pressure Ulcers | Nov 23 | 44 | 25 | | | 34 | 16 | 53 |
| Acute Pressure Ulcers | Nov 23 | 22 | 17 | | | 24 | 6 | 42 |
| Acute Pressure Ulcers per 1000 Beds | Nov 23 | 2.2 | - | | | 2.3 | 0.5 | 4.0 |
| Inpatient Falls Total | Nov 23 | 74 | 48 | | | 74 | 46 | 102 |
| Acute Falls per 1000 Beds | Nov 23 | 5.0 | 5.6 | | | 5.9 | 3.8 | 8.0 |
| Nutrition - 24 hours | Nov 23 | 86.0% | 95.0% | | | 87.0% | 78.6% | 95.3% |
| Patient Safety Incidents per 1,000 OBDs | Nov 23 | 69.0 | - | | | 64.2 | 53.6 | 74.8 |
| Patient Safety Incidents Reported | Nov 23 | 918 | - | | | 853 | 695 | 1011 |
| Patient Safety Incidents Resulting in Harm | Nov 23 | 195 | - | | | 173 | 131 | 216 |

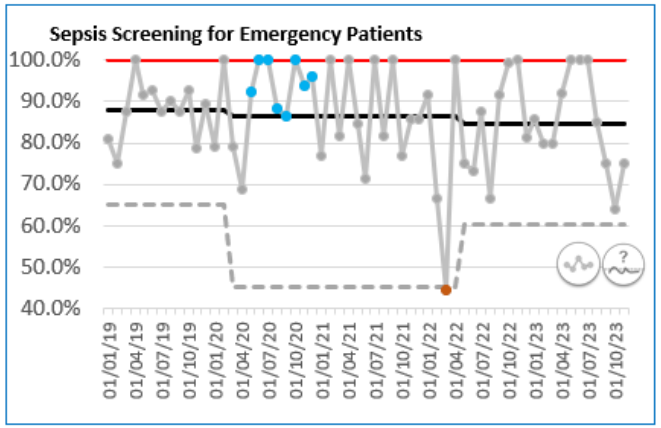
Falls are only counting Inpatients and Exclude Assisted Falls & Outpatient areas.

Safe



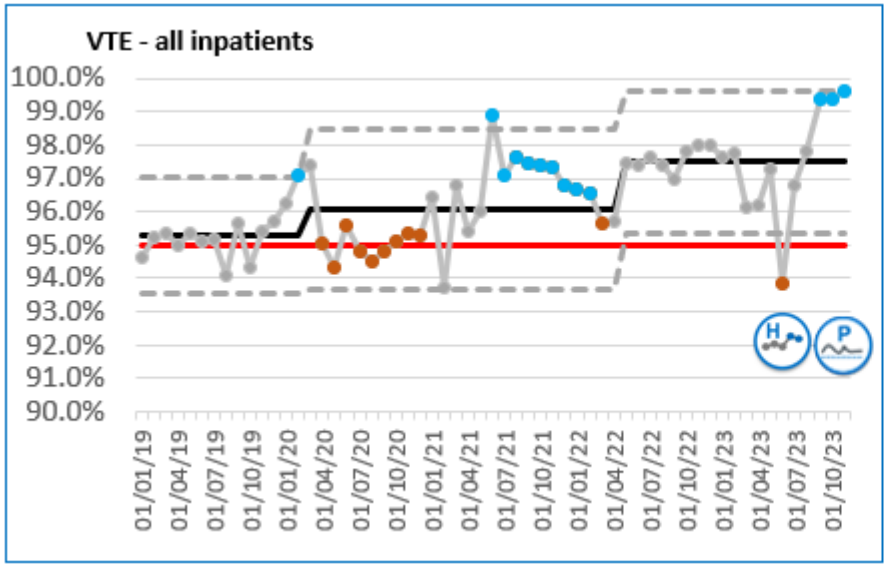



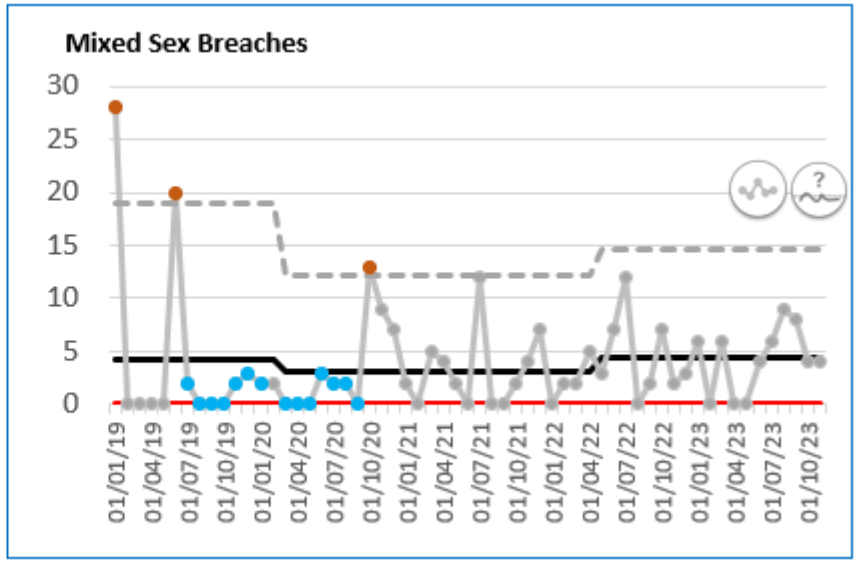




| What | So What? | What Next? |
|---|---|---|
| <u>MRSA Bacteraemia</u><br>There is consistent performance<br><br><u>C-Diff</u><br>Decrease on last month with no significant change in month-on-month incident rate indicating that there is no sustained control on incident currently<br><br>It is recognised Nationally that the rates of *Clostridioides difficile* have increased significantly over the last two reporting years. | Healthcare-associated infections (HCAIs) can develop either as a direct result of healthcare interventions such as medical or surgical treatment, or from being in contact with a healthcare setting.<br><br>HCAIs pose a serious risk to patients, staff and visitors. They can incur significant costs for the NHS and cause significant morbidity to those infected. As a result, infection prevention and control is a key priority for all NHS providers. | Individual cases, themes and periods of increase incidence will be identified and reviewed through the Trust process in a timely manner. The impact of the learning/good practices are formally discussed and shared with the teams via the Heads of Nursing at the Infection Prevention & Control Committee<br><br>The Trust has exceeded the 'threshold' set for the year by NHS England regarding C-diff infection rates and are in regular supportive communications with the ICB.<br><br>A 'Clostridioides difficile Quality Improvement project' launched with support from the Trust's Quality Improvement Lead in December 2023 the project is expected to run for at least next six months to address the escalating picture. |

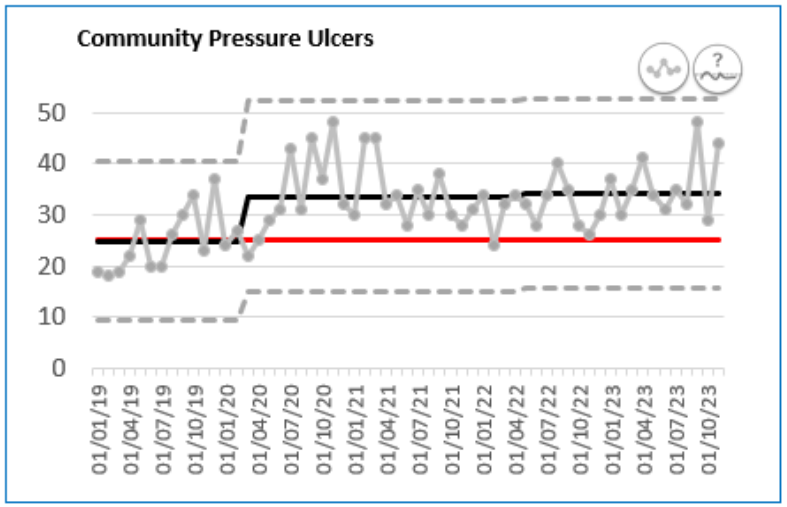
Safe

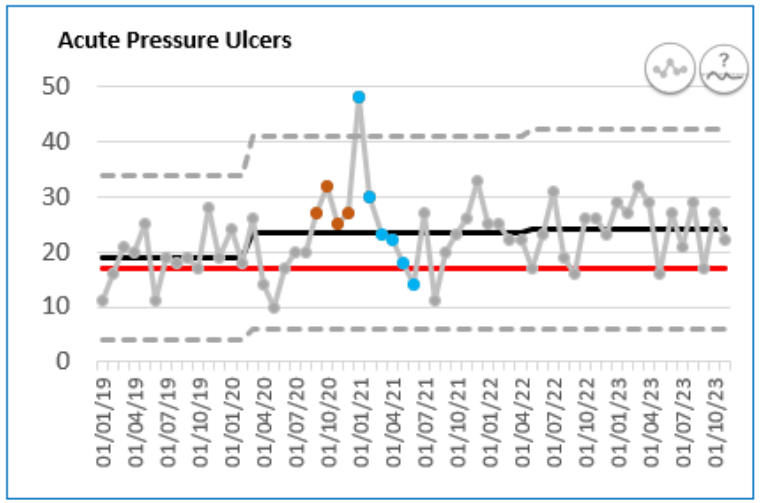


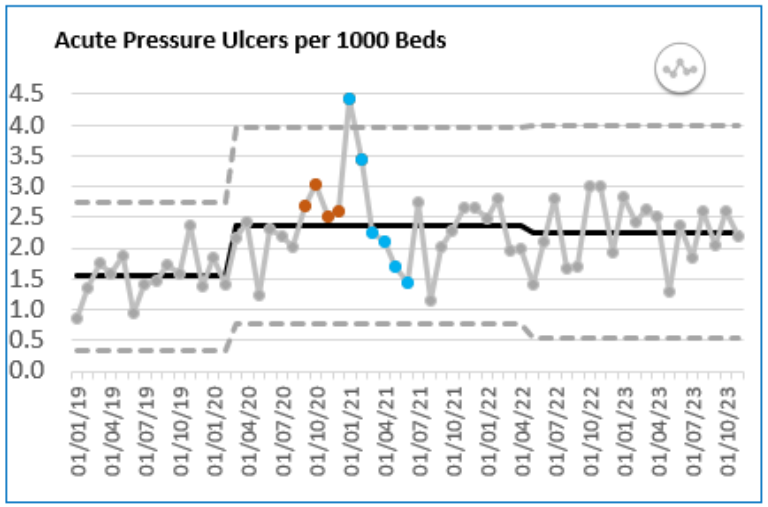




| What | So What? | What Next? |
|---|---|---|
| VTE:<br>The baseline VTE assessment data has been maintained at a high level of 99.6% due to continues high compliance in AAU.<br>The data suggests there is high level of confidence that this target will consistently be met.<br><br>MSAB<br>Incidents occurring as a result of capacity to step of critical care, once high levels of care are not required | High VTE compliance with the baseline assessment is important to make sure our patients receive appropriate prophylaxis for VTE to reduce the associate risk of developing complications and harm as a result of an inpatient stay<br><br>Breaching this guidance reduces our ability to confidently protect and manage our patients privacy and dignity | Compliance is currently high. Monitoring will continue as current process<br><br>Oversight is discussed and reviewed in daily safety huddle and escalated to patient flow team to expedite solutions. Privacy and dignity will remain a priority and be monitored by senior staff during these periods. |

Safe

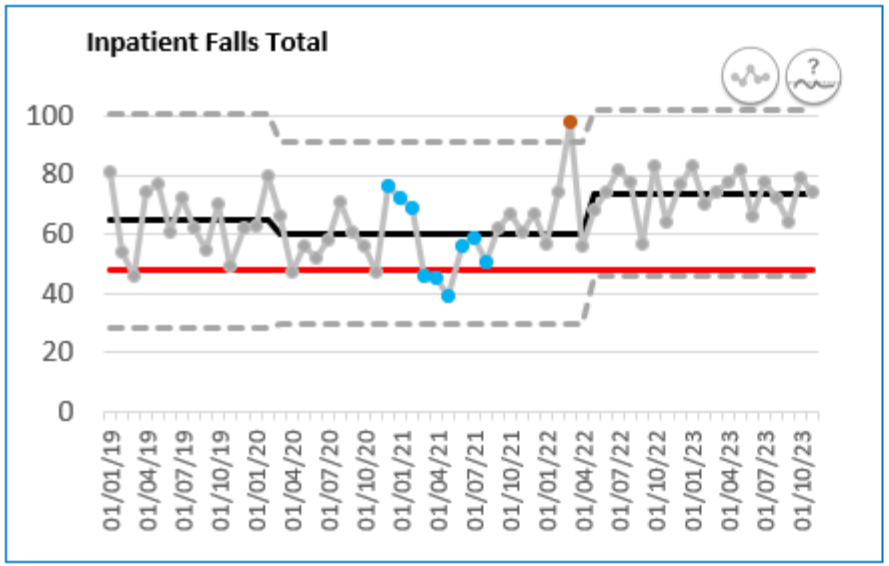


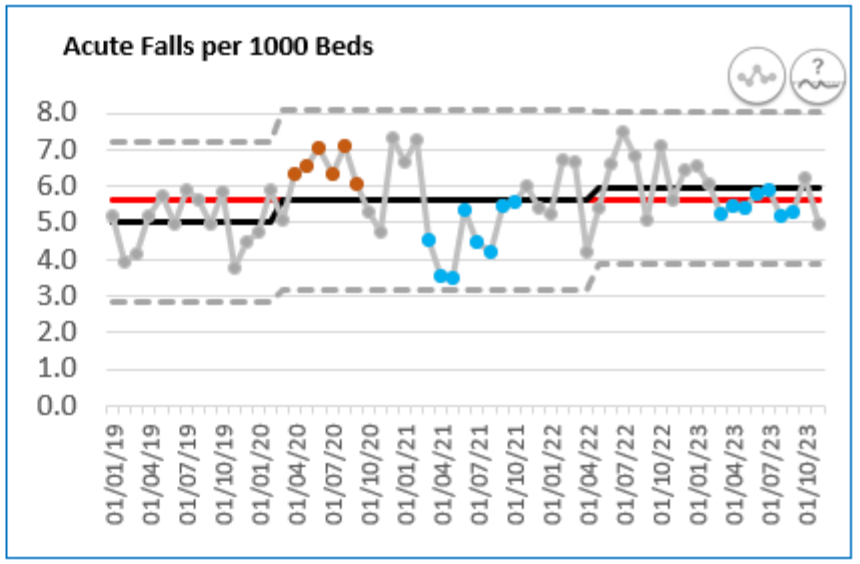




| What | So What? | What Next? |
|---|---|---|
| The data demonstrates Pressure Ulcer incidence has a decrease in Pressure Ulcer in the acute.<br>Community incidents have increased again this month and Community CAB bed Newmarket has again reported higher numbers of pressure ulcers.<br><br>Both acute and community incident rates show no consistent improvement or decline<br><br>Areas in the acute to target remain medical division however no significant issues across anyone department this month. | Pressure areas are an avoidable harm having a negative effect on patients health and cost of care provision.<br><br>A PU has complex influencing factors and these will significantly include patient comorbities.<br><br>Pressure Ulcer reporting is often a reflection of the multi faceted needs of the patients.<br>We have provided awareness and development in pressure ulcer prevention in areas of high incidents this often initially leads to a slight spike due to increased awareness. | Continue to monitor and recognize and act on themes through the Pressure Ulcer Prevention Group (PUPG).<br><br>Quality Improvement projects are overseen and guided through the PUPG through an MDT approach. For example<br>• A&E: dedicated camera procured for improved recording of patients skin integrity at the door<br>• Documentation: QI project on F8 to commenced enhance quality of documentation focus on patient education and skin and wound assessments<br>• Patient education: QI project to ensure patients receive patient leaflets and education<br>Awareness and training programs have been concentrated across the trust particularly in the areas identified as higher needs. |

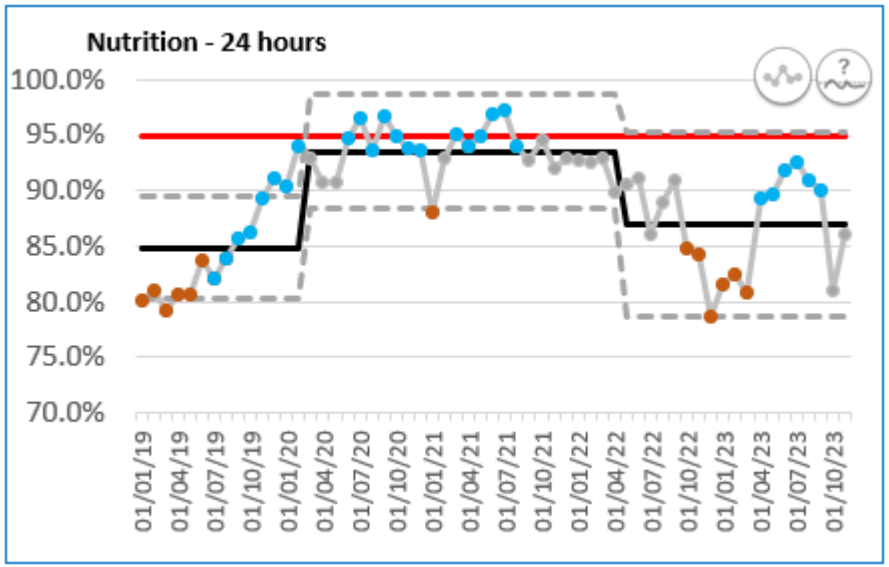
Safe



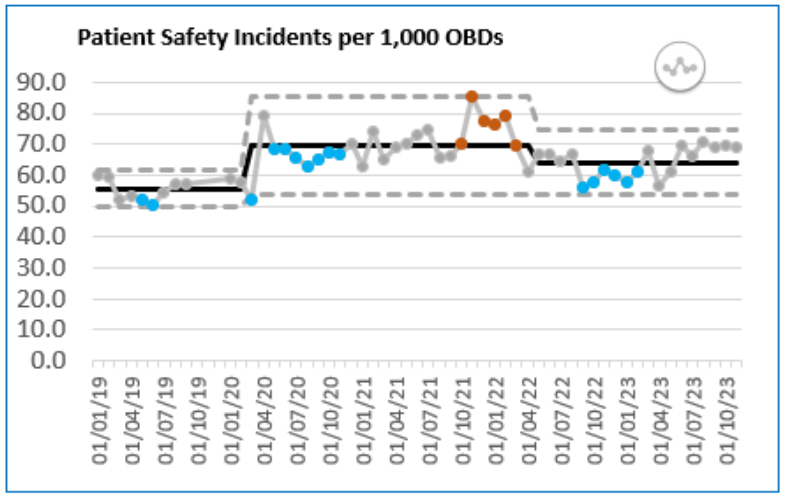

| What | So What? | What Next? |
|---|---|---|
| There has been no significant change in the number of inpatient falls reported. Falls per 1000 bed days under the national average this month.<br><br>This month (November) there weren2 falls reported as moderate harm (fractured humerus and acute subdural haemorrhage (SDH) on background of chronic SDH). There was 1 fall reported as severe harm (periprosthetic distal femoral fracture).<br><br>During the month of November there were 10 repeat fallers with seven patients having 2 falls, one patient having 3 falls, one patient having 5 falls and another patient having 7 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.<br><br>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 | Actions and quality improvement work is continuing and focusing on different aspects of falls prevention and post fall management.<br><br>The National Audit of Inpatient Falls (NAIF) report to be reviewed and to identify how the recommendations can be implemented within our own trust. |

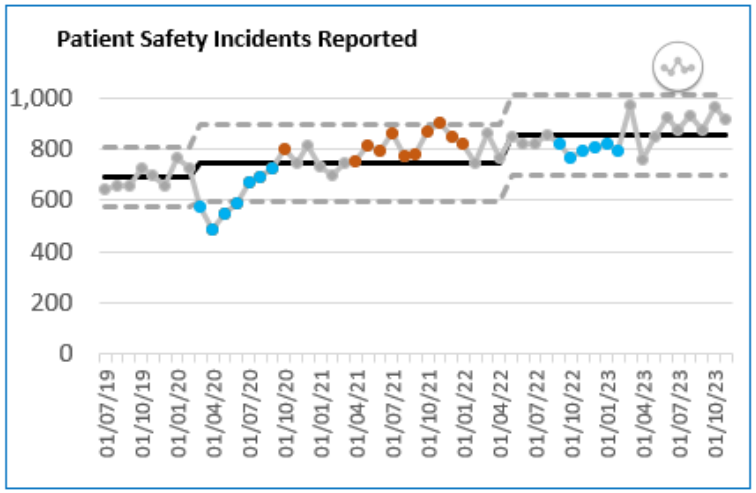
Safe

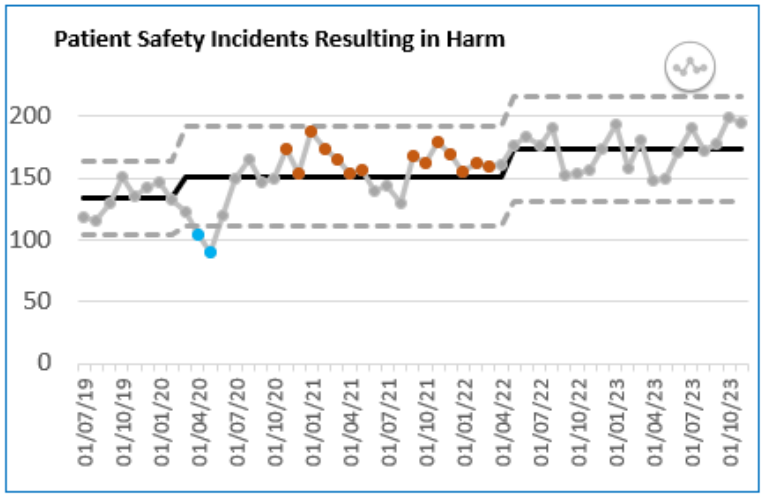



| What | So What? | What Next? |
|---|---|---|
| There has been a slight improvement in performance with assessing nutritional risk within 24hrs in November. This directly correlates with the Urgent and Emergency Care (UEC) performance in month.<br><br>Despite continued delays in patients leaving the Emergency Department (ED) due to capacity pressures, there has been some improved focus on completing the assessments. On review of the data, those areas who receive direct admissions from ED performed better, than those areas who take admissions from the Assessment Unit. This process is under review, to capture the data within 24hrs of patients arriving on the base ward area. | 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.<br><br>Despite the delays in assessment, this has been reviewed at the Nutrition Steering group and there appears to be no harm or obvious impact on the care of the patients.<br><br>There are delays with improving the reporting metrics. It was hoped this would be completed by the end of December, but continues to be outstanding. | • Engage and focus on activities to improve the UEC performance<br>• Review of data at performance meetings and Governance reviews monthly to inform performance<br>• Work with Information team to improve metrics and reporting – For completion and relaunch – Delayed date to be confirmed.<br>• Continue to share the data with teams monthly<br>• mealtimes and the provision of supplements – ongoing QI project<br>• QI work to improve Protected mealtimes – Review January 2024 |

Safe

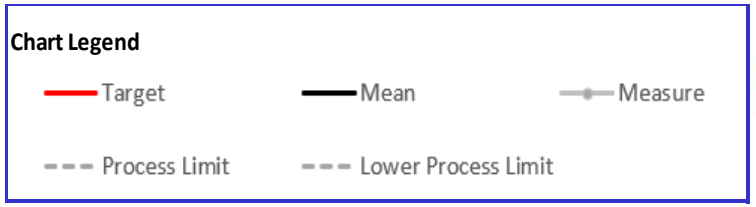


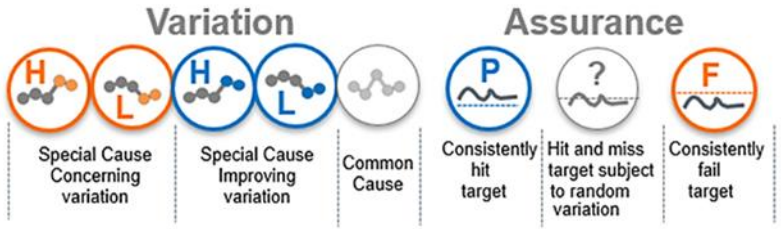




| What | So What? | What Next? |
|---|---|---|
| The number of patient safety incidents reported remains within an expected. We activity encourage reporting of patient safety events to ensure we have an open and candid culture where staff feel able to report incidents without fear of retribution. We have oversight of incidents reported as major or catastrophic at our emerging incident review meeting and ensure proportionate investigation pathway, duty of candour requirements and safety mitigation are addressed. We also review incidents which have not caused harm but are perceived to present the greatest opportunity for system based learning. | Reporting of patient safety incidents is a crucial factor in measuring safety however, this should not be the only metric used. Reporting patient safety incidents allows an opportunity for improvement and change and ultimately a reduction in the number of incidents which occur. | Reported patient safety incident 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. The patient safety team undertake a thematic analysis of incidents on a quarterly basis to target improvement opportunities working with specialist and divisional leads. This is reported to the safety and quality governance group. |

# Mortality Summary

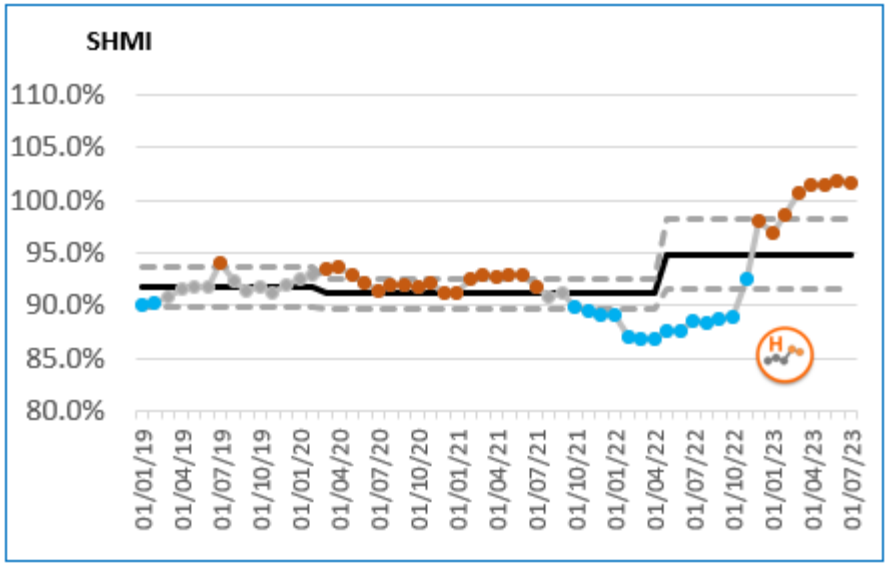


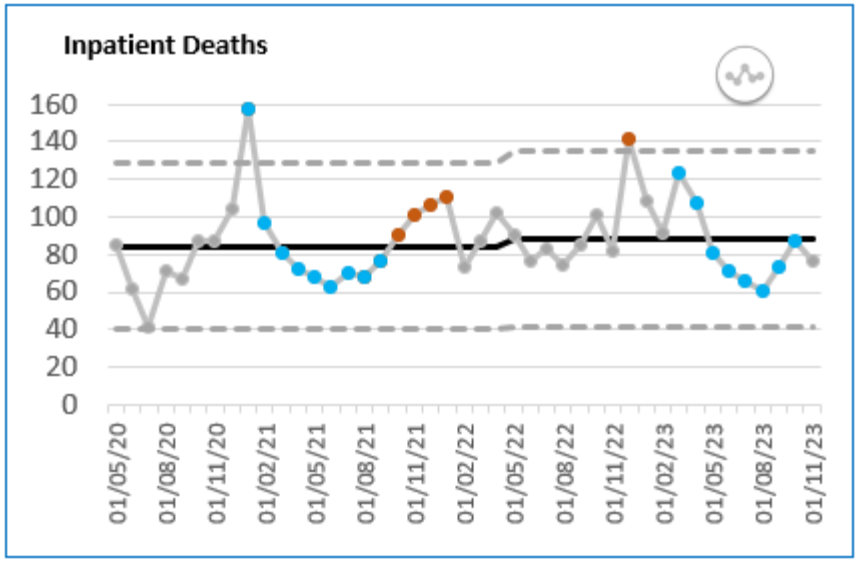




| KPI | Latest month | Measure | Target | Variation | Assurance | Mean | Lower process limit | Upper process limit |
|---|---|---|---|---|---|---|---|---|
| SHMI | Jul 23 | 101.7% | | | | 94.9% | 91.6% | 98.2% |
| Inpatient Deaths | Nov 23 | 77 | | | | 88 | 42 | 135 |

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

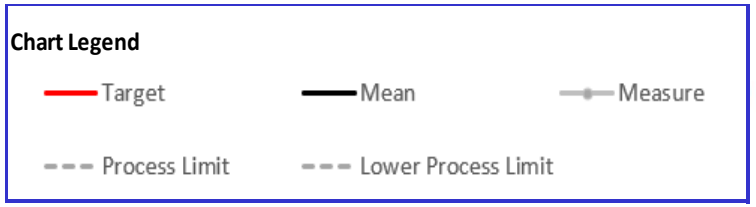
Mortality

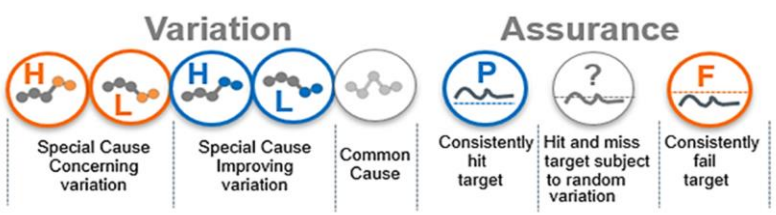



| What | So What? | What Next? |
|---|---|---|
| As previously reported, (Summary Hospital-level Mortality Indicator) SHMI chart highlights special cause concern from Dec22.<br>Inpatient deaths (local data) remain low although it is anticipated that numbers may begin to rise as we enter winter months (following national expected pattern for winter months).<br><br>We do not anticipate the SHMI falling until:<br>Clinical coding backlog for last Nov/Dec is cleared (and this will only result in a drop if NHS England agree recalculation of SHMI from the updated HES data)<br>OR<br>December 2023 deaths are coded and submitted (this will have a time-lag of 3-4 months) | SHMI is reported ~4 months in arrears and is expressed as a "12 months to ..". Current data is reporting deaths to July 2023. SHMI excludes Covid deaths and so does not exactly match local death data (reported up to September). A SHMI of 100% is graded "as expected" meaning that total number of death exactly matches expected deaths. Our SHMI (12 months to July 2023) is currently 101.7% but it had been 80-90% for a considerable period of time up until Nov/Dec23.<br><br>Until clinical coding issues have resolved, some patient deaths do not have a primary diagnosis. This means that a breakdown by diagnostic groups cannot be replied on to give an accurate picture. Most noticeably group 73 (Pneumonia) and group 101 (Urinary tract infections) are currently flagged as "below expected" with a SHMI of 67.54% and 39.72 respectively. The published data found at https://digital.nhs.uk/data-and-information/publications/statistical/shmi has been annotated by NHSE with a data quality note to reflect these potential inaccuracies at diagnostic coding level. External published data is a source of insight for the CQC and it is therefore important that inaccuracies are recognised. | An option to get our back-dated HES (hospital episode statistics) data uploaded into the national SHMI portal is being coordinated by our information team. Were this to be successful, an opportunity to revisit the data would be considered depending on the result of that update (awaiting information from HES).<br><br>The mortality oversight group (MOG) also regularly review death data in terms of: Top ten cause of death, deaths by locations and average age of patients. Any variances in these will be managed using the standard making data count method. |

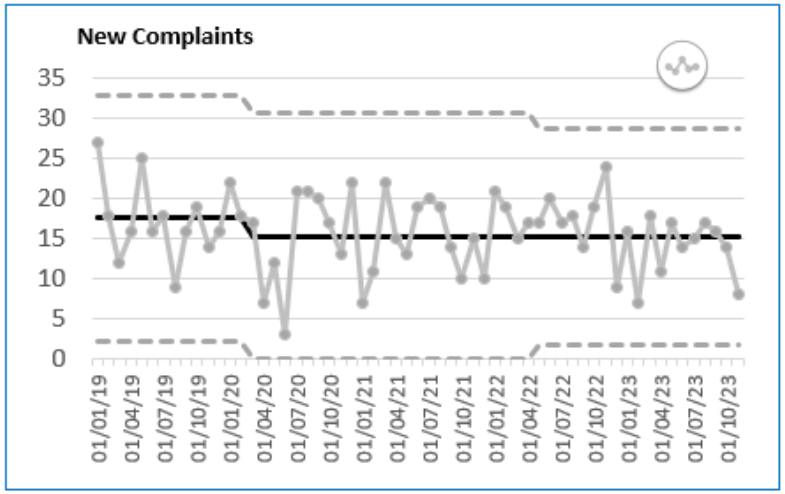
# INVOLVEMENT COMMITTEE METRICS

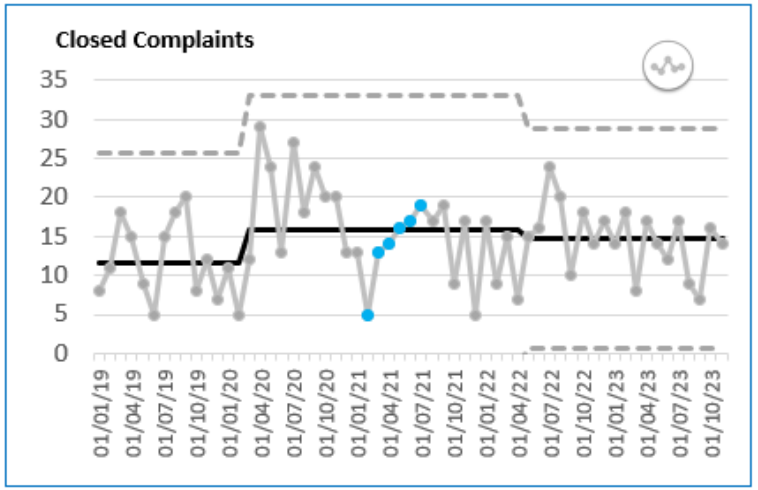


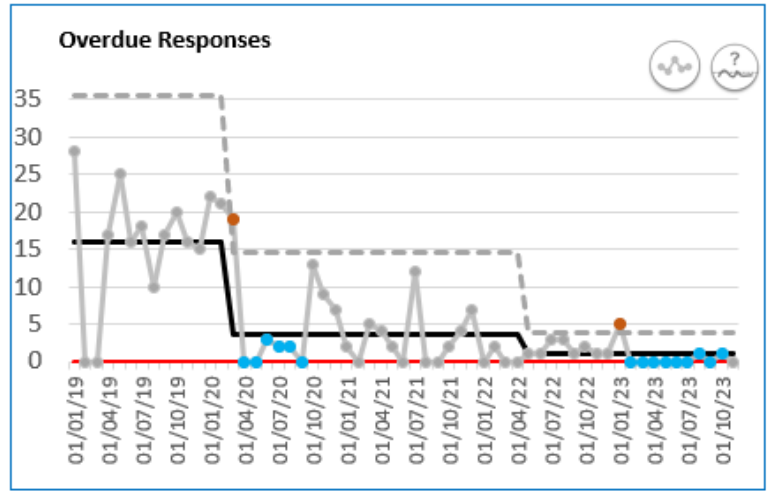




| KPI | Latest month | Measure | Target | Variation | Assurance | Mean | Lower process limit | Upper process limit |
|---|---|---|---|---|---|---|---|---|
| New Complaints | Nov 23 | 8 | | | | 15 | 2 | 29 |
| Closed Complaints | Nov 23 | 14 | | | | 15 | 1 | 29 |
| Overdue Responses | Nov 23 | 0 | 0 | | | 1 | -2 | 4 |

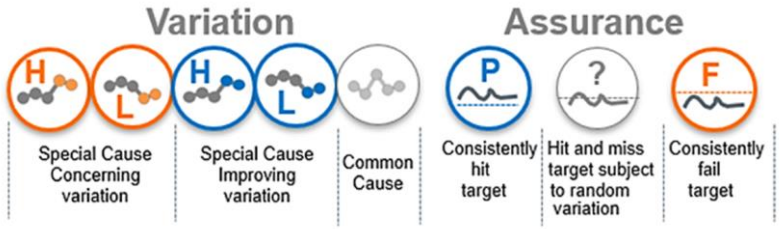
Safe



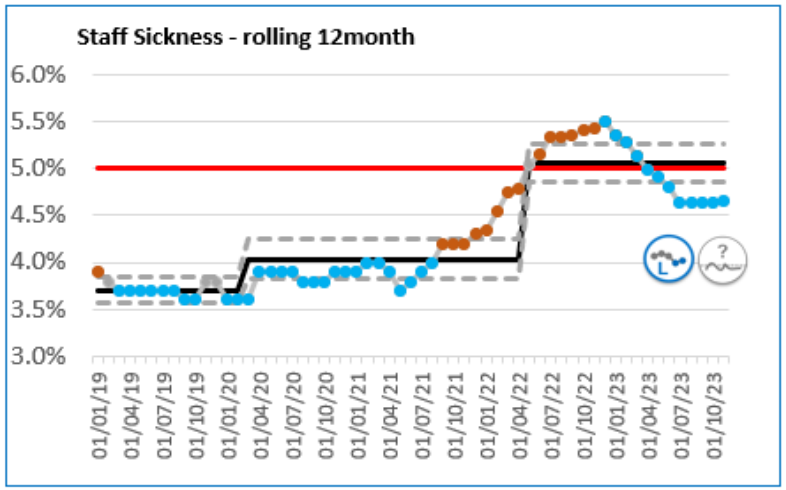



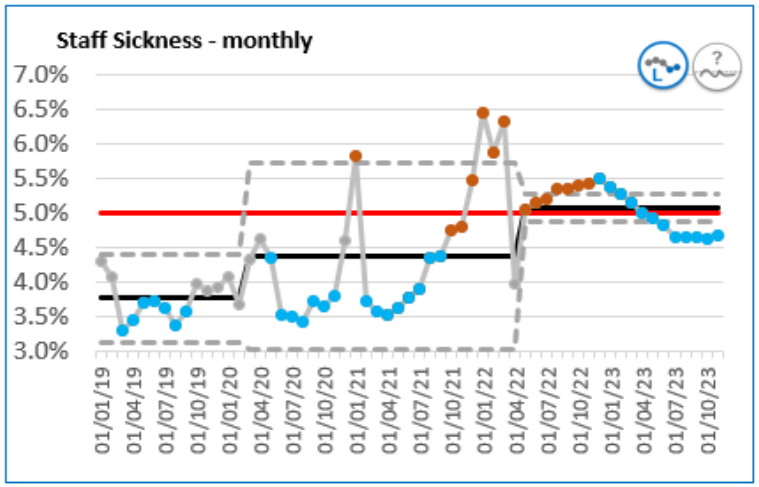

| What | So What? | What Next? |
|---|---|---|
| November saw quite a large reduction in formal complaints received (8) down from 14 the previous month and with 15 being the average. This did allow the team to resolve 14 complaints within November and therefore reducing the volume of current open complaints. All complainants were kept updated and regular updates provided. | Timely responses and minimal second letters provides greater experience for complainants and indicates satisfaction with investigation responses. Survey responses also acknowledge this. Training is on-going with clinical staff on complaint handling and complaint response writing. | We are continuing to develop our responses to complainants by involving them with our initial views. This in turn, provides a higher first time resolution rate and better patient experience through the complaint journey. Data will continue to remain within the controlled limits. |

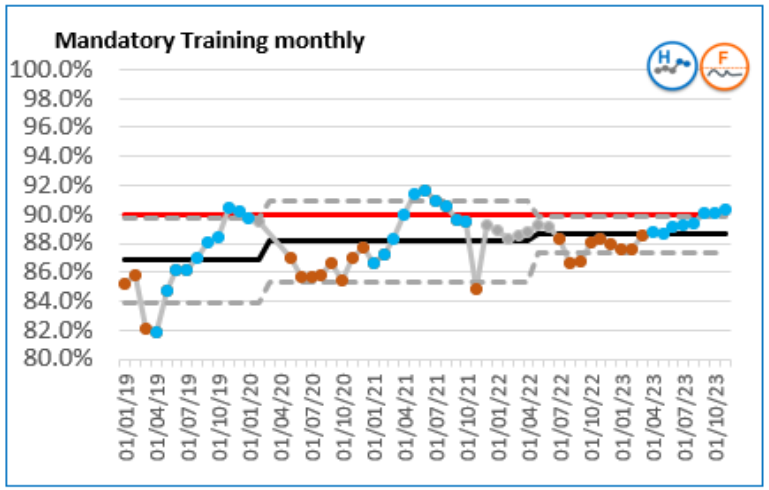


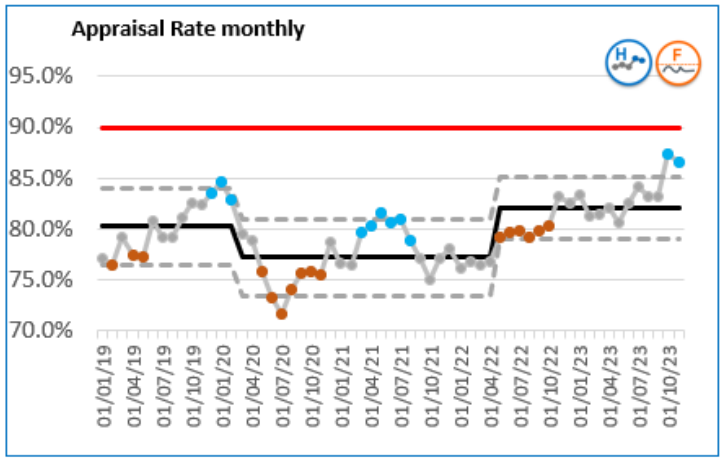

| KPI | Latest month | Measure | Target | Variation | Assurance | Mean | Lower process limit | Upper process limit |
|---|---|---|---|---|---|---|---|---|
| Staff Sickness - rolling 12month | Nov 23 | 4.7% | 5.0% | L | ? | 5.1% | 4.9% | 5.3% |
| Staff Sickness - monthly | Nov 23 | 4.7% | 5.0% | L | ? | 5.1% | 4.9% | 5.3% |
| Mandatory Training monthly | Nov 23 | 90.4% | 90.0% | H | F | 88.6% | 87.4% | 89.8% |
| Appraisal Rate monthly | Nov 23 | 86.6% | 90.0% | H | F | 82.1% | 79.0% | 85.2% |
| Turnover rate monthly | Nov 23 | 9.7% | 10.0% | L | F | 12.0% | 11.1% | 12.9% |

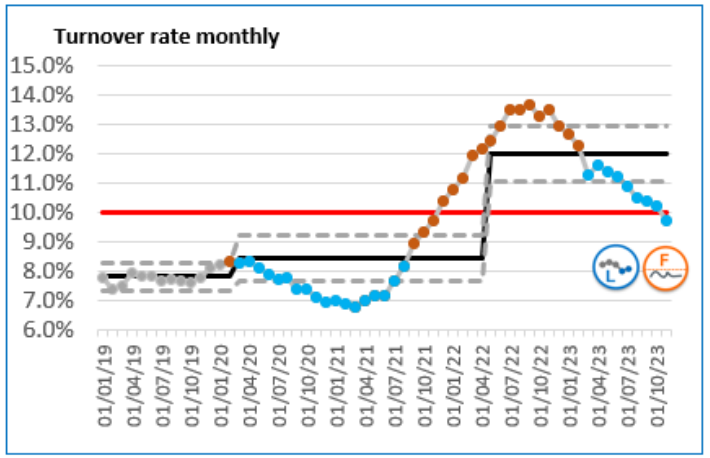
Well Led




| What | So What? | What Next? |
|---|---|---|
| All key performance indicators continue to record an improving variation.<br>**Sickness** – continuing achievement of target following a period of sustained improvement since December 2022.<br>**Mandatory training** – now achieving target for third month.<br>**Appraisal** – a key performance indicator that is consistently failing target, however an improving variation has been maintained.<br>**Turnover** – now achieving target following a period of sustained improvement since November 2022. | These workforce key performance indicators directly impact on staff morale, staff retention, and therefore, patient care and safety.<br><br>Additionally, improvements in these workforce key performance indictors 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 follow up the internal audit findings of the importance of the return to work supportive discussion, every employee every time, which has been communicated trust-wide.<br>Sustain the target compliance of mandatory training ensuring areas and staff groups are identified where further focus and support may be required.<br>Continued analysis of appraisal data to support areas in need of action and improvement; continue to pilot and gather feedback on new appraisal form and guidance documentation.<br>Continued focus on the delivery of our people and culture plan and priorities to aide recruitment and retention. |

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

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

| **Executive summary:** | The Integrated Quality and Performance Report (IQPR) uses the Making Data Count methodology to report on the following aspects of key indicators:<br>1. Compliance with targets and standards (pass/fail)<br>2. Statistically significant improvement or worsening of performance over time.<br>Narrative is provided to explain what the data is demonstrating (what?), the drivers for performance, what the impact is (so what?) and the remedial actions being taken (what next?).<br>The assurance committees are currently reviewing how they operate, including the metrics used within the IQPR.<br>Please refer to the assurance grid for an executive summary of performance.<br>Areas of exception to bring to the board's attention:<br>• 4-hour performance is below trajectory at 61.96% (trajectory 68%). This represents delays to patient care and has required the opening of escalation areas including the Rapid Assessment Area, ambulance cohorting areas, the Acute Admissions Unit corridor and the Same Day Emergency Care unit.<br>• The intense two-week management support to the Emergency Department has been extended for a further six weeks with particular focus on the use of internal professional standards, and escalating issues.<br>• The "Arrive by nine" and "sunrise bloods" projects are promoting early movement of patients to free up early capacity.<br>• Urgent and Emergency Care recovery plans are currently being reviewed considering deteriorating performance.<br>• Performance against the 28-day Faster Diagnosis Standard (FDS) is not being consistently met nor demonstrating the improvement trajectory required to deliver the interim quarterly milestones and 75% target by March 2024. The performance has improved from 54.6% in September to 65.4% in October, largely due to a significant increase in Breast performance from 50% to 87%.<br>• The total number of patients over 65 weeks has decreased in November by 66 patients following a peak in September 2023. The trajectory for the total cohort of patients who will reach 65 weeks by March 2024 remains on track. The absolute number of 78ww patients remains constant in line with our forecast trajectory for capacity breaches |
|---|---|

| | |
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| **Executive summary:** | (within the uro-gynaecology specialty), however this is likely to be impacted by the upcoming industrial action.<br>• Clostridium Difficile infections continue to vary with no sign of significant improvement to date. In order to fully understand and address this a quality improvement plan is in place and will report through to the Infection Prevention Control Committee and Improvement Committee<br>The focus on improving nutritional assessments and management continues. |
| **Action required / Recommendation:** | To receive and approve the report |

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

NHS
West Suffolk
NHS Foundation Trust

**FSP Programme dependencies**

| No. | Description | Includes/Details | Organisation (Leading) | Responsibility | Accountability | FSP Programme board representative for reporting | Timescale for delivery | Forum that provides governance of delivery | Date agreed | Live Well domain or enabler | Impact of non-delivery on the schedule of accommodation | Impact - points of delivery | Impact - certainty | Impact - magnitude | Current Position | Notes on co-production / transformation / project management resources |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **PREVENTION AND PROACTIVE CARE** | | | | | | | | | | | | | | | |
| | Prevention incorporated into all clinical and care pathways (WSFT clinical and care strategy) | - | WSFT | WSFT Clinical Directors | Paul Molyneux | Helena Jopling | Dec-24 | WSFT Strategic leadership team | 21/11/2022 | Be Well | Greyed out in v 7 because impact on beds has been removed in most recent update to bed model. Still has potential to make a sizeable difference but bed numbers getting too low to count as independent contribution | Non-elective admissions<br>Elective admissions (Achievement could also have a positive impact on ED,diagnostics, and outpatients) | Definite | Moderate | Agreed in clinical and care strategy - awaiting plan for delivery | WSFT public health team +<br>WSA healthy behaviours group |
| 1 | Delivery of prevention and population health management objectives in Joint Forward Plan | Objectives across a wide range of risk factors and long-term conditions including intentional self-harm, cancer, asthma, heart failure, respiratory disease, smoking-related illness and stroke | ICB | Nerinda Evans | Richard Watson | Richard Watson | 2023-2028 | ? | JFP published June 2023. Magnitude of impact agreed with Alex Royan 23 July 2023 | Feel Well, Be Well, Stay Well | Inpatient beds are too low (6 beds are modelled to be removed by collective achievement of the quantified objectives) | Non-elective admissions<br>Outpatients<br>ED attendances | Definite | Minor | | Resourcing is through the ICB programme groups and teams |
| 2 | Integrated diabetes model for west Suffolk | Learning from best practice model in NEE | WSA | David Brandon | Nicola Cottington | Nicola Cottington | TBC | Alliance Committee | 01/02/23 - agreement to design a new model of care | Stay Well | Inpatient beds are too low (20 beds are modelled to be removed by better diabetes management and outcomes) | Outpatients<br>Elective admissions<br>Non-elective admissions<br>ED attendances | Probable | Moderate | In planning<br><br>FSP community meeting **8/11/23.** Agreed to review the current diabetes plan against the requirement for 20 beds. Needs agreement of where progress is reported | ICB = transformation manager<br>WSA = GP lead<br>FSP = GP co-production lead + project support officer requested from April 2023 |
| | **PRODUCTIVITY** | | | | | | | | | | | | | | | |
| | **WSFT clinical and care strategy (trust objectives)** | | | | | | | | | | | | | | | |
| 3 | Best practice on same day emergency care | Defined by DAEC standards | WSFT | WSFT Clinical Directors | Paul Molyneux | Nicola Cottington | TBC | WSFT Strategic leadership team | 21/11/2022 | Stay Well | Assessment beds, short stay and inpatient beds are too low | Emergency attendances<br>Non-elective admissions | Definite | Major | In delivery, need to establish current position | |
| 4 | Best practice rates for both day surgery and short stay surgery | Defined by BADS standards | WSFT | WSFT Clinical Directors | Paul Molyneux | Nicola Cottington | TBC | WSFT Strategic leadership team | 21/11/2022 | WSFT internal | Inpatient theatre department is too small and Inpatient beds are too low OR more activity needs to be done in other sites | Day cases<br>Elective admissions | Definite | Major | Agreed in clinical and care strategy - awaiting plan for delivery | |
| 5 | Average length of inpatient admissions reduces by XX% to XX days | [Figures TBC by refreshed D&C model] | WSFT | WSFT Clinical Directors | Paul Molyneux | Nicola Cottington | TBC | WSFT Strategic leadership team | 21/11/2022 | Stay Well, Age Well, Die Well | Inpatient beds are too low | Elective admissions<br>Non-elective admissions | Definite | Major | Agreed in clinical and care strategy - awaiting plan for delivery | |
| 6 | 15 sessions a week for all elective and O/P services | - | WSFT | WSFT Clinical Directors | Paul Molyneux | Nicola Cottington | TBC | WSFT Strategic leadership team | 21/11/2022 | Stay Well | Theatre and outpatient departments are too small OR more theatre activity needs to be done in other sites and more OP activity needs to be done in peripheral clinics | Outpatients<br>Elective care<br>Diagnostics | Definite | Major | Agreed in clinical and care strategy - awaiting plan for delivery | |
| 7 | 25% of all O/P appointments are video/telephone | - | WSFT | WSFT Clinical Directors | Paul Molyneux | Nicola Cottington | TBC | WSFT Strategic leadership team | 21/11/2022 | Stay Well | Outpatient departments are too small OR more appointments need to be done by video/phone | Outpatients | Definite | Moderate | In delivery, 21.7% in 2022 | Outpatient transformation programme |
| 8 | 25% of all O/P are conducted in peripheral clinics | - | WSFT | WSFT Clinical Directors | Paul Molyneux | Nicola Cottington | TBC | WSFT Strategic leadership team | 21/11/2022 | Stay Well | Outpatient departments are too small OR more F2F appointments need to be done in peripheral clinics | Outpatients | Definite | Moderate | In delivery, current position required | |
| 9 | Best practice theatre utilisation | 15 sessions a week<br>3.5 hours per session<br>85% in-session utilisation<br>95% of sessions used | WSFT | WSFT Clinical Directors | Paul Molyneux | Nicola Cottington | TBC | WSFT Strategic leadership team | 21/11/2022 | WSFT internal | Day surgery and inpatient theatre departments are too small OR more activity needs to be done in other sites | Day cases<br>Elective admissions | Definite | Major | Agreed in clinical and care strategy - awaiting plan for delivery | |
| | **WSFT Workforce Strategy** | | | | | | | | | | | | | | | |
| 10 | Creation and delivery of a future workforce model, strategy and plan for the trust | - | WSFT | Jeremy Over | Ewen Cameron | Ewen Cameron | By 2030 | People and Culture Leadership Group | 3112023 | Workforce | Hospital can not be staffed<br>Shared alliance objectives fail | All | Definite | Major | Awaiting plan for creation of workforce model and strategy | FSP = workforce lead starting 27th Feb plus consultancy to be procured spring 2023 |
| 11 | A workforce plan for the system that ensures safe delivery of the new care models | Across primary care, social care, domicilary care, mental health and associated services | ICB | Graham Seward | Amanda Lyes | Richard Watson | TBC | TBC | TBA | Workforce | Demand across all services increases<br>Shared alliance objectives fail | All | Definite | Catastrophic | Unknown | |
| | **WSFT Workplace Strategy** | | | | | | | | | | | | | | | |
| 12 | Creation and delivery of a workplace strategy which will make staff hubs successful | Combines routine agile working with equitable, efficient use of staff facilities on all sites | WSFT | Creation = Helena Jopling<br>Delivery = TBC | Craig Black | Creation = Helena Jopling<br>Delivery = TBC | By 2030 | Strategic leadership team | Due 20/03/2021 | WSFT internal | Staff facilities are too small. More people need to work from home and /or alternative sites, leading to reduced efficiency, increased revenue costs (leases) and poor staff wellbeing | All | Definite | Moderate | Draft strategy going to SLT 20/02/2023 | 16/11/23 - Ind raft awaiting update from HI, date for publication to be agreed along with responable lead |
| | **Digital strategy** | | | | | | | | | | | | | | | |
| 13 | Full implementation of the FSP digital strategy | Fabric and technologies to meet NHP digital strategy | WSFT | Liam McLaughlin | Craig Black | Sarah Judge | By 2030 for FSP but sooner = advantageous for managing growth in the meantime | FSP programme board | Due March 2023 | Digital and data | Reduced efficiency in all services | All | Probable | Major | Approval in March 2023. Currently embedded as a core document for OBC. | FSP = digital lead |
| 14 | Delivery of the trust digital strategy | Sits alongside the FSP strategy and is a key document to support this. | WSFT | Liam McLaughlin | Craig Black | Liam McLaughlin | 2025 | Digital Programme Board | 25/10/2023 | Digital and data | Supports the FSP digital roadmap which can impact on the SOA. Is a key enabler for some of the planned technologies. | All areas | Probable | Major | | |
| 15 | Delivery of the ICB digital and data strategy | Ambitions for digital and data for the ICS | ICB | Jo Lennox | TBC | Liam McLaughlin | End 2023 | ICS DSI Board | 10/03/2023 | Digital and data | Demand across all services increases<br>Shared alliance objectives fail | All | Probable | Major | October 2023 - going through socialisation and approvals process at present. | |
| | **Other strategies required for the OBC (list to be expanded)** | | | | | | | | | | | | | | | |
| 16 | Operational Strategy | The clinical and care strategy is operational and included as such above | | | | | | | | | | | | | | |
| 17 | Equipment strategy | - | WSFT | Debbie Stevenson | Chris Todd | Chris Todd | Oct-23 | Not yet set-up, one option is to include this as part of the Medical Devices Group (MDG) | TBC | WSFT internal | Hospital is unable to open on time<br>Reduced efficiency in all services | All | Definite | Catastrophic (delayed opening) | Equipment schedule complete. Strategy to deliver it needs creating | |
| | **"VERTICAL" INTEGRATION - Shared Alliance objectives** | | | | | | | | | | | | | | | |
| 18 | Primary care capacity and quality | Primary care needs to continue to do everything it currently does, to same level of quality and outcomes (urgent care, long term condition management, referral patterns etc) and meet growth | ICB | PCN clinical directors | Peter Wightman | Mark Hunter | - | ? | N/a | Stay Well | Demand across all services increases<br>Shared alliance objectives fail | All | Definite | Major | Primary care demand and capacity modelling underway (ICB project) | |

| | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 19 | Best practice on virtual wards | 47 beds by Oct 22 for heart failure, AKI, IVAx, frailty, respiratory (COPD) 103 beds by October 23 for T&O, general surgery, expansion of frailty, expansion of respiratory. FSP model assumes 103 beds is maintained permanently. | WSFT | Clement Mawoyo | Paul Molyneux | Clement Mawoyo | TBC | WSFT Strategic leadership team | 21/11/2022 | Stay Well | Assessment beds, short stay and inpatient beds are too low | Emergency attendances Non-elective admissions | Definite | Major | In delivery, below trajectory | FSP = community co-production leads plus 1 GP lead |
| 20 | D2OA pathways for all patients over the age of 65 delivered through a community based transfer of care hub | - | WSFT | Clement Mawoyo | Ewen Cameron | Clement Mawoyo | TBC | TBC | TBC | Age Well | Inpatient beds are too low (**19** beds are modelled to be removed by D2OA pathways) | Elective admissions Non-elective admissions | Definite | Major | In delivery, needs plan for expansion to meet growth | FSP = community co-production leads |
| 21 | 70% of people who die in West Suffolk die at home or in a community setting | Compared to 62% in 2021 | WSA | Sharon Basson (strategic lead for Die Well domain) | Sue Wilkinson (sponsor of Die Well domain) | Linda McEnhill | By 2031 | WSA Die Well domain group | Was agreed at EoL group on 30 Oct 2021 | Die well | Inpatient beds are too low and emergency department is undersized (14 inpatient beds are modelled to be removed by end of life care, and the prevented admissions are modelled to help reduce the annual growth rate in ED attendances from 4.4% to 2.5%) | Non-elective admissions ED attendances | Definite | Moderate | 64% in 2022/23 | Fully owned by Alliance Die Well partnership group. Clinical & care leadership and transformation resource are in place. |
| 22 | Urgent Care Community Response | Development of intergratef UCCR service leading to 10% increase in referrals to UCR. | WSFT | Clement Mawoyo | Kevin McGuniess | Clement Mawoyo | Commenced June 2023 | FSP programme board | 12/12/2023 | Stay Well Live Well Age Well | Emergency department is undersized (The prevented admissions are modelled to help reduce the annual growth rate in ED attendances from 4.4% to 2.5%) | ED attendances | Definite | Moderate | In delivery | |
| | Integrated neighbourhood teams undertake the full remit of responsive and proactive care to reduce unnecessary admission and promote population health | - | WSA | Clement Mawoyo | Peter Wightman | Clement Mawoyo | TBC | TBC | TBC | Stay Well Age Well Locality development | Greyed out in v 7 because impact on beds has been removed in most recent update to bed model. Still has potential to make a sizeable difference but bed numbers getting too low to count as independent contribution | Non-elective admissions (Achievement will also have an impact on ED attendances and elective admissions) | Probable | Moderate | In delivery, needs plan for expansion to meet growth and to implement integrated frailty model | FSP = community co-production leads |
| | Urgent and emergency care transformation | Agreeing a model for UTC and the impact on the ED in WSH | WSFT | Lucy Webb | Nicola Cottington | Nicola Cottington | Decision by end April 2024 | UEC governance group. | 16/02/2023 | Stay Well | Greyed out in v7 - appetite is strong but lack of location and need for capital renders infeasible to include in FSP planning at this stage. May well progress as BAU and be incorporated at a later date. | Emergency attendances | Probable | Major | In planning **8/11/23** - Paper circulated and presented at SNEE UEC committee, remains a dependency for FSP, delivery dates reamins unclear | Needs GP lead and WSA lead. ICB resources? |
| | **HORIZONTAL INTEGRATION** | | | | | | | | | | | | | | | |
| 23 | Elective hub(s) | Shift of elective activity to Dame Clare Marx elective orthopaedic centre at Colchester. Options also being explored for elective endoscopy and day surgery off-site. | WSFT | Moira Welham | Nicola Cottington | Nicola Cottington | DCMX = 2024 | ? | 22/10/2021 | Stay Well Premises | Theatres are too few and beds are too low (3 theatres, 2 endoscopy rooms and 32 beds/recovery spaces are modelled to be removed by use of elective hub(s)) | Elective admissions Outpatient endoscopy | Definite | Major | Clinical engagement with DCMX Business case approved for NCH but unfunded | FSP = Healthcare modeller |
| | **OTHER PREMISES DEVELOPMENTS** | | | | | | | | | | | | | | | |
| | **WSFT retained estate** | | | | | | | | | | | | | | | |
| 24 | New IT block (Digital hub) | "Mini Quince House", IT infrastructure and office space | WSFT | Gary Norgate | Craig Black | Gary Norgate | 2026, to be funded by NHP as enabling works | FSP programme board | | WSFT internal | Delay to construction, critical IT infrastructure and IT need rehousing and corporate offices too small | All | Definite | Catastrophic (delay to programme) | Expired planning permission. Forms part of NHP business case. Need urgent plan to deliver as enabling works | SJ producing paper to take through governance to finalsie scope and agreement re budgets etc. |
| 25 | Catering Block | Housing hard and soft facilities management, MRI suite +/- opthalmology | WSFT | Gary Norgate | Craig Black | Gary Norgate | After new hospital opens (currently scheduled delivery in 2031) | FSP programme board | | WSFT internal | Services need alternative accommodation, incurring extra capital and/or revenue costs | All (FM), diagnostics, ophthalmology | Definite | Major | | |
| 26 | Hardwick Manor | Housing staff wellbeing services | WSFT | Gary Norgate | Craig Black | Gary Norgate | By 2030 | FSP programme board | | WSFT internal | Services need alternative accommodation, incurring extra capital and/or revenue costs | All | Definite | Minor | Forms part of NHP business case. No SoA or 1:200 plans | |
| 27 | Education Centre refurbishment | Improving education and training facilities | WSFT | Chris Todd | Craig Black | Chris Todd | Not fixed by FSP. Currently scheduled delivery in 2029 | Documented in the Estates and Facilities Strategy. Annual prioritisation by ADO's that informs the medium-term Capital Programme, approved by Trust Board and overseen by Capital Strategy Group (CSG) | Summer 2022 (seperated from FSP at this time as not a key enabler) | WSFT internal | Services need alternative accommodation Current facilities will continue to be utilised and form part of lifecycle capital investment | All | Definite | Moderate | SoA complete. 1:500 sketches. No funding within WSFT CDEL allocation identified in medium term plan (it is shown as a pressure). | |
| 28 | Day Surgery refurbishment and extension | Housing larger DSU | WSFT | Chris Todd | Craig Black | Chris Todd | By 2030 for FSP but sooner = advantageous for managing growth in the meantime (currently scheduled delivery in 2031) | Documented in the Estates and Facilities Strategy. Annual prioritisation by ADO's that informs the medium-term Capital Programme, approved by Trust Board and overseen by Capital Strategy Group (CSG). This one still aligned to FSP depending on the model for Day Surgery Opthalmology | Summer 2022 (seperated from FSP at this time as not a key enabler), but this is probably no longer correct | WSFT internal | Day surgery and inpatient theatre departments are too small OR more activity needs to be done in other sites, incurring extra capital and/or revenue costs | Elective admissions Non-elective admissions | Definite | Major | SoA exists, pending finalisation of opthalmology activity. 1:200 sketches. No funding within WSFT CDEL allocation identified in medium term plan (it is shown as a pressure). | |
| 29 | Quince House 2nd floor | Convert cellular offices into open plan workspace | WSFT | Chris Todd | Craig Black | Chris Todd | By 2031, currently scheduled for delivery in 2028 | Documented in the Estates and Facilities Strategy. Annual prioritisation by ADO's that informs the medium-term Capital Programme, approved by Trust Board and overseen by Capital Strategy Group (CSG). | Summer 2022 (seperated from FSP at this time as not a key enabler) | WSFT internal | Corporate offices are too small, more people will need to work from home or alternative sites, leading to reduced efficiency, increased revenue costs (leases) and poor staff wellbeing | Nil | Probable | Minor | Needs plan for delivery. No funding shown within WSFT CDEL allocation identified in medium term plan (it is shown as a pressure) **9/11/23** - SJ producing paper to socialise benefits/impact if not deivered | |
| | **Premises developments - community estate** | | | | | | | | | | | | | | | |
| 30 | Community diagnostic centre | 1 CT, 1 MRI, 2 x-ray, 3 ultrasound, 2 echo, 1 lung function test room | WSFT | Chris Todd | Craig Black | Chris Todd | 2024 | Oversight through CSG | 10/10/2022 | Premises | Radiology department is too small | Diagnostics | Definite | Moderate | In delivery | Estates and Facilities Division - Capital Development Team |
| 31 | Increase/expand other community hubs | Availability of accommodation for peripheral OP clinics, diagnostics and INTs - Haverhill, Sudbury and Bury Rural locality are priorities | WSA | Daniel Turner | Peter Wightman | Peter Wightman | ? | ? | 21/11/22 (WSFT clinical and care strategy) | Premises | Outpatient departments are too small OR more appointments need to be done by video/phone (9 clinic rooms and 6 teleconsultation rooms are modelled to be available in community hubs) | Outpatients Non-elective admissions ED attendances | Definite | Major | ? | FSP = 1 GP lead for Haverhill |

# 4.4.1 Maternity - Annexes

| Maternity and Neonatal Safety Champions and Trust Board | |
|---|---|
| **Report title:** | **Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?** |
| **Agenda item:** | Maternity and Neonatal Services |
| **Date of the meeting:** | Trust Board 26th January 2024 |
| **Sponsor/executive lead:** | Paul Molyneux, Trust Medical Director, Board level Safety Champion |
| **Report prepared by:** | Andrew Pollard, Senior Information Analyst, Women's and Children's Division<br>Karen Newbury, Director of Midwifery<br>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?**

The Maternity services within West Suffolk NHS Foundation Trust are required to provide accurate information and data to evidence the work that is undertaken to national and local standards.
This report provides evidence of the quality and accuracy of information provided to NHS Digital against the Maternity Services Data Set (MSDS) requirements. Due to updates to the information systems used to provide the data to MSDS, initially the Trust failed some elements of the reports to NHS Digital. With updates to the systems and manual reconciliation, the Trust has now been given assurances that the date requirements have been met in order to declare compliance. Other organisational arrangements related to this safety action have also been met.

**SO WHAT?**

Whilst the process for gaining compliance with this safety action was protracted due to technical difficulties, the processes have now been verified and should mean that the Trust will be able to maintain and sustain continued compliance and data verification each month.

**WHAT NEXT?**

The Trust will continue to interrogate information systems and analyse the data to ensure it provides assurances of standards and services.

**Action Required**

The Board is asked to accept this report as evidence of the Trust's compliance with this safety action.

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| **Risk and assurance:** | The Trust is assured that the data provided to NHS Digital is accurate and reflects the standards expected. |
| **Equality, Diversity and Inclusion:** | The Trust is providing data that accurately reflects key elements of the work of the maternity services. |

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| **Sustainability:** | With the updates to information systems and manual oversight of data, the provision of data to NHS Digital should be sustained at the correct level. |
| **Legal and regulatory context** | This report outlines how the Trust evidences compliance with the Maternity Incentive Scheme Year Safety Actions. The compliance will be declared on submission of the declaration form to NHSR on or before the deadline. The results of the declaration will be utilised to determine the amount of allocated funds available to the Trust to use to maintain and improve safety within the maternity services. Failure to declare accurate information will result in reputational harm and a lack of funding to support ongoing safety and improvement plans. |

**Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?**

| | |
|---|---|
| **1.** | **Introduction** |
| 1.1 | **CNST Maternity Incentive Scheme**<br>In May 2023, NHS Resolution has published the Maternity Incentive Scheme year five and updated guidance was received in July 2023. Safety action 2 requires the following information to be evidenced:<br>**Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?** |
| **2.** | **Background** |
| 2.1 | NHS Resolution is operating year five of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to continue to support the delivery of safer maternity care. Safety Action 2 requires certain standards for data quality and submissions to NHS Digital to evidence the quality of services provided by the Trust. These are outlined in 5 criteria as below. |
| 2.2 | Safety Action 2 relates to the quality and completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements.<br>1. Trust Boards to assure themselves that at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023. Final data for July 2023 will be published during October 2023.<br>2. July 2023 data contained valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing, and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)<br>3. Trust Boards to confirm to NHS Resolution that they have passed the associated data quality criteria in the " Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023 for the following metrics:<br>Midwifery Continuity of carer (MCoC) Note: If maternity services have suspended all MCoC pathways, criteria ii is not applicable.<br>i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the CoC pathway indicator completed.<br>ii. Over 5% of women recorded as being placed on a CoC pathway where both Care Professional ID and Team ID have also been provided. These criteria are the data quality metrics used to determine whether women have been placed on a midwifery continuity of carer pathway by the 28 weeks antenatal appointment, as measured at 29 weeks gestation. |

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| | Final data for July 2023 will be published in October 2023.<br>If the data quality for criteria 3 are not met, Trusts can still pass safety action 2 by evidencing sustained engagement with NHS England which at a minimum, includes monthly use of the Data Quality Submission Summary Tool supplied by NHS England (see technical guidance for further information).<br><br>4. Trusts to make an MSDS submission before the Provisional Processing Deadline for July 2023 data by the end of August 2023.<br><br>5. Trusts to have at least two people registered to submit MSDS data to SDCS Cloud who must still be working in the Trust. |
| **3.** | **Detailed Response to the elements of Safety Action 2** |
| 3.1 | The following email has been received as evidence of the Trust's compliance with this Safety Action:<br><br>**<u>Email received 22/12/23 to the WSNHSFT Information Analyst</u>**<br><br>Dear Colleague<br><br>Thank you for completing the WEST SUFFOLK NHS FOUNDATION TRUST MSDS submission for September 2023 data. We have assessed this submission against the Safety Action 2 criteria of this year's Maternity Incentive Scheme which were not met during the assessment month (July 2023 data) and have not had an exemption granted.<br><br>**Please accept this email as confirmation that the action owner for Safety Action 2 (NHS England Maternity Neonatal Programme) has agreed that you have met the requirements of criteria 1, 2, 3 and 4 of this safety action.**<br><br><u>Board Declarations to NHS Resolution</u><br><br>Criteria 5 will be reported to NHS Resolution as part of trusts' self-declaration using the Board declaration form.<br><br>All criteria to be self-certified by the Trust Board and submitted to NHS Resolution using the Board declaration form. If you are able to self-certify compliance with criteria 5, then you should self-certify that you are compliant with Safety Action 2 as a whole in your Board declaration form. If you are unable to self-certify compliance with criteria 5 then you should self-certify that you are not compliant with Safety Action 2 as a whole in your Board declaration form.<br><br>This email has been sent to you as a registered SDCS Cloud user for your organisation. Please share this internally with any colleagues who need this information.<br><br>Many thanks<br><br>Information Analysis Lead Manager for Maternity Services and NHS Talking Therapies<br>Population Health, Clinical Audit and Specialised Care<br>Data and Analytics<br>NHS England<br><br>Website: www.england.nhs.uk<br>NHS England and NHS Digital have merged. <u>Learn more</u><br><br><br>**NB** Progress against further implementation of Maternity Continuity of Care (MCoC) has been suspended within the Trust (as recommended from the Ockenden enquiry and insufficient staffing levels to support this). Therefore, whilst the standard has been set at a low 5% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the CoC pathway indicator |

| | |
|---|---|
| | completed in 3i above, the Trust was unable to achieve this 5% in July due to proportionally small numbers of women in the maternity population served by the Trust. The Trust has been informed by NHS Digital that they can still declare compliance with this as they have acknowledged our rationale for not achieving the 5%.<br><br>**Further details of the criteria for the MSDS can be found in appendix 1. This includes the failed data for July 2023 with confirmation of a pass for September 2023.** |
| 3.2 | **Criteria 5**<br>The Trust has confirmed that it meets criteria 5 of the Maternity Incentive Scheme Safety Action 2 by having 2 people who are registered and trained to submit information and data to NHS Digital with a proposal for a third person to be trained in 2024. |
| **4.** | **Next steps** |
| 4.1 | The quality of data provided within the information systems of the Trust will continue to be monitored and analysed in order to provide accurate information on the standards of care and services within the Trust. |
| 4.2 | As requirements change or are updated, the information systems will be upgraded or changed to allow for this continuous flow of information to continue. |
| **5.** | **Conclusion** |
| 5.1 | The Trust is able to declare compliance with Safety Action 2 – MSDS submissions – following further work with NHS Digital and other information system providers. |
| **6.** | **Recommendations** |
| | The Trust will continue to interrogate information systems and analyse the data to ensure it provides assurances of standards and services. |

## Appendix 1 – Submission of data July 2023 and September 2023

Organisation Name: WEST SUFFOLK NHS FOUNDATION TRUST

Reporting Period: July 2023

NHS England

1.

**CQIMApgar**

| Indicator | Numerator | Denominator | Rate | Rate p/1000 | Result |
|---|---|---|---|---|---|
| CQIMApgar | 5 | 170 | | | Passed |
| CQIMDQ14 | 180 | 185 | 97.3 | | Passed |
| CQIMDQ15 | 180 | 180 | 100.0 | | Passed |
| CQIMDQ16 | 170 | 180 | 94.4 | | Passed |
| CQIMDQ24 | 170 | 170 | 100.0 | | Passed |

**CQIMBreastfeeding**

| Indicator | Numerator | Denominator | Rate | Result |
|---|---|---|---|---|
| CQIMBreastfeeding | 135 | 180 | 75.0 | Passed |
| CQIMDQ08 | 180 | 185 | 97.3 | Passed |
| CQIMDQ09 | 185 | 185 | 100.0 | Passed |

**CQIMPPH**

| Indicator | Numerator | Denominator | Rate | Rate p/1000 | Result |
|---|---|---|---|---|---|
| CQIMDQ10 | 180 | 185 | 97.3 | | Passed |
| CQIMDQ11 | 75 | 180 | 41.7 | | Passed |
| CQIMDQ12 | 10 | 180 | 5.6 | | Passed |
| CQIMPPH | 10 | 180 | | 55 | Passed |

**CQIMPreterm**

| Indicator | Numerator | Denominator | Rate | Rate p/1000 | Result |
|---|---|---|---|---|---|
| CQIMDQ09 | 185 | 185 | 100.0 | | Passed |
| CQIMDQ22 | 180 | 180 | 100.0 | | Passed |
| CQIMDQ23 | 170 | 180 | 94.4 | | Passed |
| CQIMPreterm | 10 | 180 | | 44 | Passed |

**CQIMTears**

| Indicator | Numerator | Denominator | Rate | Rate p/1000 | Result |
|---|---|---|---|---|---|
| CQIMDQ14 | 180 | 185 | 97.3 | | Passed |
| CQIMDQ15 | 180 | 180 | 100.0 | | Passed |
| CQIMDQ16 | 170 | 180 | 94.4 | | Passed |
| CQIMDQ18 | 125 | 180 | 69.4 | | Passed |
| CQIMDQ20 | 5 | 115 | 4.3 | | Passed |
| CQIMTears | 5 | 115 | | | Passed |

**Notes:** The most recent reporting period is based on provisional data. Provisional figures are subject to change and will be reassessed after the submission window closes. If this dashboard is being presented as evidence of your Trust's achievement of criteria within Safety Action 2 of Year 5 of the Maternity Incentive Scheme, please use the information for the assessment month of July 2023 for this purpose.

**CQIMVBAC**

| Indicator | Numerator | Denominator | Rate | Result |
|---|---|---|---|---|
| CQIMDQ14 | 180 | 185 | 97.3 | Passed |
| CQIMDQ15 | 180 | 180 | 100.0 | Passed |
| CQIMDQ16 | 170 | 180 | 94.4 | Passed |
| CQIMDQ18 | 125 | 180 | 69.4 | Passed |
| CQIMDQ26 | 180 | 180 | 100.0 | Passed |
| CQIMDQ27 | 225 | 240 | 93.8 | Passed |
| CQIMDQ28 | 80 | 225 | 35.6 | Passed |
| CQIMVBAC | 5 | 15 | 33.3 | Passed |

**CQIMRobson01**

| Indicator | Numerator | Denominator | Rate | Result |
|---|---|---|---|---|
| CQIMDQ30 | 185 | 185 | 100.0 | Passed |
| CQIMDQ31 | 185 | 185 | 100.0 | Passed |
| CQIMDQ32 | 170 | 185 | 91.9 | Passed |
| CQIMDQ33 | 185 | 185 | 100.0 | Passed |
| CQIMDQ34 | 125 | 185 | 67.6 | Passed |
| CQIMDQ36 | 175 | 185 | 94.6 | Passed |
| CQIMDQ37 | 85 | 175 | 48.6 | Passed |
| CQIMDQ38 | 185 | 185 | 100.0 | Passed |
| CQIMDQ39 | 185 | 185 | 100.0 | Passed |
| CQIMRobson01 | 5 | 30 | 16.7 | Passed |

**CQIMRobson02**

| Indicator | Numerator | Denominator | Rate | Result |
|---|---|---|---|---|
| CQIMRobson02 | 20 | 45 | 44.4 | Passed |

**CQIMRobson05**

| Indicator | Numerator | Denominator | Rate | Result |
|---|---|---|---|---|
| CQIMRobson05 | 20 | 25 | 80.0 | Passed |

**CQIMSmokingBooking**

| Indicator | Numerator | Denominator | Rate | Result |
|---|---|---|---|---|
| CQIMDQ03 | 240 | 185 | 129.7 | Passed |
| CQIMDQ04 | 155 | 240 | 64.6 | Failed |
| CQIMDQ05 | 15 | 155 | 9.7 | Passed |

**CQIMSmokingDelivery**

| Indicator | Numerator | Denominator | Rate | Result |
|---|---|---|---|---|
| CQIMDQ06 | 180 | 180 | 100.0 | Passed |
| CQIMSmokingDelivery | 20 | 180 | 11.1 | Passed |

2.

**EthnicityDQ**

| Indicator | Numerator | Denominator | Rate | Result |
|---|---|---|---|---|
| EthnicityDQ | 235 | 240 | 97.9 | Passed |

3.

**MCoC i**

| Indicator | Numerator | Denominator | Rate | Result |
|---|---|---|---|---|
| COC_DQ04 | 5 | 190 | 2.6 | Failed |

**MCoC ii**

| Indicator | Numerator | Denominator | Rate | Result |
|---|---|---|---|---|
| COC_DQ05 | 0 | 0 | 0.0 | Failed |

4.

**Provisonal Window Submission**

| Indicator | Result |
|---|---|
| Provisional Submission | Passed |

5.

**Submission Portal Registration**

| Indicator | Result |
|---|---|
| Registered Submitters | Passed |

Organisation Name: WEST SUFFOLK NHS FOUNDATION TRUST

Reporting Period: September 2023

NHS England

1.

**CQIMApgar**

| Indicator | Numerator | Denominator | Rate | Rate p/1000 | Result |
|---|---|---|---|---|---|
| CQIMApgar | 5 | 150 | | | Passed |
| CQIMDQ14 | 165 | 180 | 91.7 | | Passed |
| CQIMDQ15 | 160 | 160 | 100.0 | | Passed |
| CQIMDQ16 | 150 | 160 | 93.8 | | Passed |
| CQIMDQ24 | 150 | 150 | 100.0 | | Passed |

**CQIMBreastfeeding**

| Indicator | Numerator | Denominator | Rate | Result |
|---|---|---|---|---|
| CQIMBreastfeeding | 125 | 165 | 75.8 | Passed |
| CQIMDQ08 | 165 | 165 | 100.0 | Passed |
| CQIMDQ09 | 165 | 180 | 91.7 | Passed |

**CQIMPPH**

| Indicator | Numerator | Denominator | Rate | Rate p/1000 | Result |
|---|---|---|---|---|---|
| CQIMDQ10 | 165 | 180 | 91.7 | | Passed |
| CQIMDQ11 | 80 | 165 | 48.5 | | Passed |
| CQIMDQ12 | 10 | 165 | 6.1 | | Passed |
| CQIMPPH | 10 | 165 | | 61 | Passed |

**CQIMPreterm**

| Indicator | Numerator | Denominator | Rate | Rate p/1000 | Result |
|---|---|---|---|---|---|
| CQIMDQ09 | 165 | 180 | 91.7 | | Passed |
| CQIMDQ22 | 160 | 160 | 100.0 | | Passed |
| CQIMDQ23 | 150 | 160 | 93.8 | | Passed |
| CQIMPreterm | 10 | 160 | | 62 | Passed |

**CQIMTears**

| Indicator | Numerator | Denominator | Rate | Rate p/1000 | Result |
|---|---|---|---|---|---|
| CQIMDQ14 | 165 | 180 | 91.7 | | Passed |
| CQIMDQ15 | 160 | 160 | 100.0 | | Passed |
| CQIMDQ16 | 150 | 160 | 93.8 | | Passed |
| CQIMDQ18 | 110 | 160 | 68.8 | | Passed |
| CQIMDQ20 | 5 | 105 | 4.8 | | Passed |
| CQIMTears | 5 | 105 | | | Passed |

**Notes:** The most recent available reporting period is based on the final July 2023 data for the final assessment. For the purposes of CNST the CQIMs are measured only on a single month's data. see the FAQs on page 5 in this scorecard for more information.

**CQIMVBAC**

| Indicator | Numerator | Denominator | Rate | Result |
|---|---|---|---|---|
| CQIMDQ14 | 165 | 180 | 91.7 | Passed |
| CQIMDQ15 | 160 | 160 | 100.0 | Passed |
| CQIMDQ16 | 150 | 160 | 93.8 | Passed |
| CQIMDQ18 | 110 | 160 | 68.8 | Passed |
| CQIMDQ26 | 160 | 160 | 100.0 | Passed |
| CQIMDQ27 | 210 | 230 | 91.3 | Passed |
| CQIMDQ28 | 90 | 210 | 42.9 | Passed |
| CQIMVBAC | 5 | 10 | 50.0 | Passed |

**CQIMRobson01**

| Indicator | Numerator | Denominator | Rate | Result |
|---|---|---|---|---|
| CQIMDQ30 | 165 | 180 | 91.7 | Passed |
| CQIMDQ31 | 165 | 165 | 100.0 | Passed |
| CQIMDQ32 | 150 | 165 | 90.9 | Passed |
| CQIMDQ33 | 165 | 165 | 100.0 | Passed |
| CQIMDQ34 | 110 | 165 | 66.7 | Passed |
| CQIMDQ36 | 155 | 165 | 93.9 | Passed |
| CQIMDQ37 | 70 | 155 | 45.2 | Passed |
| CQIMDQ38 | 165 | 165 | 100.0 | Passed |
| CQIMDQ39 | 165 | 165 | 100.0 | Passed |
| CQIMRobson01 | 5 | 20 | 25.0 | Passed |

**CQIMRobson02**

| Indicator | Numerator | Denominator | Rate | Result |
|---|---|---|---|---|
| CQIMRobson02 | 20 | 40 | 50.0 | Passed |

**CQIMRobson05**

| Indicator | Numerator | Denominator | Rate | Result |
|---|---|---|---|---|
| CQIMRobson05 | 15 | 20 | 75.0 | Passed |

**CQIMSmokingBooking**

| Indicator | Numerator | Denominator | Rate | Result |
|---|---|---|---|---|
| CQIMDQ03 | 230 | 180 | 127.8 | Passed |
| CQIMDQ04 | 165 | 230 | 71.7 | Passed |
| CQIMDQ05 | 20 | 165 | 12.1 | Passed |
| CQIMSmokingBooking | 20 | 165 | 12.1 | Passed |

**CQIMSmokingDelivery**

| Indicator | Numerator | Denominator | Rate | Result |
|---|---|---|---|---|
| CQIMDQ06 | 165 | 165 | 100.0 | Passed |
| CQIMSmokingDelivery | 15 | 165 | 9.1 | Passed |

2.

**EthnicityDQ**

| Indicator | Numerator | Denominator | Rate | Result |
|---|---|---|---|---|
| EthnicityDQ | 220 | 230 | 95.7 | Passed |

3.

**MCoC i**

| Indicator | Numerator | Denominator | Rate | Result |
|---|---|---|---|---|
| COC_DQ04 | 10 | 170 | 5.9 | Passed |

**MCoC ii**

| Indicator | Numerator | Denominator | Rate | Result |
|---|---|---|---|---|
| COC_DQ05 | 5 | 5 | 100.0 | Passed |

4.

**Provisonal Window Submission**

| Indicator | Result |
|---|---|
| Provisional Submission | Passed |

5.

**Submission Portal Registration**

| Indicator | Result |
|---|---|
| Registered Submitters | Passed |

# Board Report and Action Plan on Implementation of the Saving Babies Lives Care Bundle (Version 3)

## Implementation Report

| | |
|---|---|
| Trust | West Suffolk NHS Foundation Trust |
| Date of Report | 06-Dec-23 |
| ICB Accountable Officer | Lisa Nobes (Executive Chief Nurse, SNEE LMNS) |
| Trust Accountable Officer | Ewen Cameron (CEO, WSFT) |
| LMNS Peer Assessor Names | Amanda Rew (Safety & Quality Manager) and Sandra Gosling (Quality & Safety Lead) |

## Background

Version three of the Saving Babies' Lives Care Bundle (SBLCBv3) published on 31 May 2023, aims to provide detailed information for providers and commissioners of maternity care on how to reduce perinatal mortality across England. The third version of the care bundle brings together six elements of care that are widely recognised as evidence-based and/or best practice:

1. Reducing smoking in pregnancy
2. Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR)
3. Raising awareness of reduced fetal movement (RFM)
4. Effective fetal monitoring during labour
5. Reducing preterm birth
6. Management of diabetes in pregnancy

The Care Bundle is now a universal innovation in the delivery of maternity care in England and continues to drive quality improvement to reduce perinatal mortality. It has been included for a number of years in the NHS Long Term Plan, NHS Planning Guidance, the Standard Contract and the CNST Maternity Incentive Scheme, with every maternity provider expected to have fully implemented SBLCBv2 by March 2020.

ONS and MBRRACE-UK data demonstrate the urgent need to continue reducing preventable mortality. Developed 4 years after SBLCBv2, Version 3 of the Care Bundle (SBLCBv3) has been developed through a collaboration of frontline clinical experts, service users and key stakeholder organisations. All existing elements have been updated, incorporating learning from the Clinical Negligence Scheme for Trusts: Maternity Incentive Scheme (CNST MIS) and insights from NHS England's regional maternity teams. SBLCBv3 aligns with national guidance from NICE and the RCOG Green Top Guidelines where available but it aims to reduce unwarranted variation where the evidence is insufficient for NICE and RCOG to provide guidance. SBLCBv3 also includes a new element on optimising care for women with pregnancies complicated by diabetes.

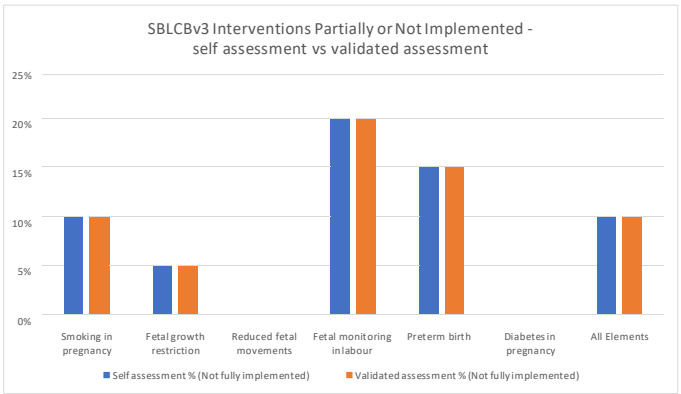
As part of the Three Year Delivery Plan for Maternity and Neonatal Services, all NHS maternity providers are responsible for fully implementing SBLCBv3 by March 2024.

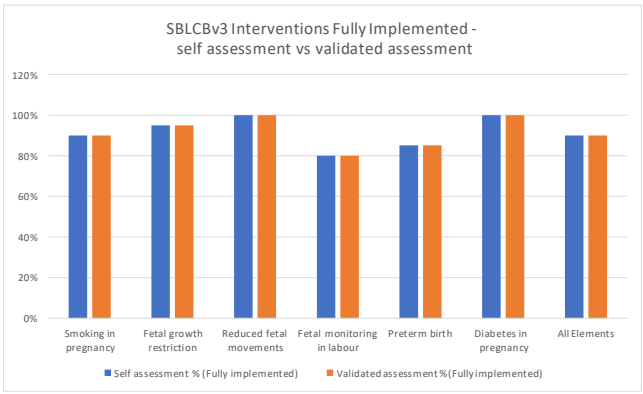
## Implementation Grading

Significant Assurance - Except for specific weaknesses identified the activities and controls are suitably designed and operating with sufficient effectiveness to provide reasonable assurance that the control environment is effectively managed.

## Implementation Progress

| Intervention Elements | Description | Element Progress Status (Self assessment) | % of Interventions Fully Implemented (Self assessment) | Element Progress Status (LMNS Validated) | % of Interventions Fully Implemented (LMNS Validated) | NHS Resolution Maternity Incentive Scheme |
|---|---|---|---|---|---|---|
| Element 1 | Smoking in pregnancy | Partially implemented | 90% | Partially implemented | 90% | CNST Met |
| Element 2 | Fetal growth restriction | Partially implemented | 95% | Partially implemented | 95% | CNST Met |
| Element 3 | Reduced fetal movements | Fully implemented | 100% | Fully implemented | 100% | CNST Met |
| Element 4 | Fetal monitoring in labour | Partially implemented | 80% | Partially implemented | 80% | CNST Met |
| Element 5 | Preterm birth | Partially implemented | 85% | Partially implemented | 85% | CNST Met |
| Element 6 | Diabetes | Fully implemented | 100% | Fully implemented | 100% | CNST Met |
| All Elements | TOTAL | Partially implemented | 90% | Partially implemented | 90% | CNST Met |



## Action Plan

**Element 1**

| Intervention Ref | Self-Assessment Status | LMNS Validated Assessment Status | LMNS Recommendation of Actions Required | LMNS Suggested Improvement Activity |
|---|---|---|---|---|
| **INTERVENTIONS** | | | | |
| 1.1 | Fully implemented | Fully implemented | Focus required on quality improvement intiatives to meet recommended standard. | Stretch targets met. MSDS submission issues overcome. Continue regular audits to ensure ongoing compliance. |
| 1.2 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | Continue to monitor compliance. Improvement noted since last quarterly submission. |
| 1.3 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | New guideline in place. Audit compliance has improved this quarter. Continue with regular auditing to monitor and maintain compliance. |
| 1.4 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | Stretch ambition exceeded. Continue regular auditing to monitor and maintain compliance. |
| 1.5 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | Trust to consider auditing against guideline standards to ensure process is well embedded. |
| 1.6 | Partially implemented | Partially implemented | Focus required on quality improvement intiatives to meet recommended standard. | Trust to develop action plan to continue towards improveemnt with this element, incldluing improving the setting and recording of quit dates. |
| 1.7 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | To continue auditing compliance against this newly implemented process. |
| 1.8 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | Excellent compliance achieved. Continue to monitor training compliance for all relevant staff groups. |
| 1.9 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | Excellent compliance achieved. Continue to monitor training compliance for all relevant staff groups. |
| 1.10 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | To continue to monitor training compliance and ensure staff attend updates when required |

**Element 2**

| Intervention Ref | Self-Assessment Status | LMNS Validated Assessment Status | LMNS Recommendation of Actions Required | LMNS Suggested Improvement Activity |
|---|---|---|---|---|
| **INTERVENTIONS** | | | | |
| 2.1 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | Continue to monitor regularly to ensure sustained implementation. Re-audit prior to next quarterly submission. |
| 2.2 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | Excellent improvement since last submission now e-care changes have been made. Continue to monitor regularly to ensure sustained implementation. |
| 2.3 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | Continue to monitor regularly to ensure sustained implementation. Re-audit prior to next quarterly submission |
| 2.4 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | Continue to monitor regularly to ensure sustained implementation. Re-audit prior to next quarterly submission |
| 2.5 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | None |
| 2.6 | Fully implemented | Fully implemented | Focus required on quality improvement intiatives to meet recommended standard. | Plan in place for introduction of digital BP monitors, however procurement challenged currently. Proceed with procurement plans when possible and continue to monitor via Trust risk register |
| 2.7 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | Continue to monitor regularly to ensure sustained implementation. Re-audit prior to next quarterly submission |
| 2.8 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | Continue to consider FGR risk within PMRT reviews. Consider future audit to ensure sustained compliance. |
| 2.9 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | Consider future audit to ensure sustained compliance |
| 2.10 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | Continue to monitor at regular intervals to ensure sustained implementation and to identify best practice and opportunites for learning. Re-adit before next quarterly submission. |
| 2.11 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | Excellent training compliance achieved - Continue to monitor training compliance for all staff groups. |
| 2.12 | Fully implemented | Fully implemented | Focus required on quality improvement intiatives to meet recommended standard. | Consider future audit to ensure sustained compliance |
| 2.13 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | Consider future audit to ensure sustained compliance |
| 2.14 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | Updated guideline in place. To consider auditing compliance with this guideline standard once embedded. |
| 2.15 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | Guideline reflects SBLCBv3 appendix D. Consider auditing compliance against this standard once new guideline embedded. |
| 2.16 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | Guideline reflects SBLCBv3 appendix D. Consider auditing compliance against this standard once new guideline embedded |
| 2.17 | Partially implemented | Partially implemented | Focus required on quality improvement intiatives to meet recommended standard. | Guideline meets requirement, however is overdue for review. (Review date June 2023) review is currently in progress. Trust to ensure updated guidance continues to comply with NICE guidance. |
| 2.18 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | Continue to monitor to ensure sustained implementation and to identify best practice and opportunites for learning. Re-audit before next quarterly submission. |
| 2.19 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | Continue to monitor to ensure sustained implementation and to identify best practice and opportunites for learning. Re-audit before next quarterly submission. |
| 2.20 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | Guideline reflects SBLCBv3 appendix D. Consider auditing compliance against this standard once new guideline embedded |

Element 3

| INTERVENTIONS | | | | |
|---|---|---|---|---|
| 3.1 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | Consider survey of service users for opportunities for targeted service improvements. |
| 3.2 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | Continue to monitor compliance with these elements. Induction for RFM audit to be repeated for next quarterly submission. |

Element 4

| INTERVENTIONS | | | | |
|---|---|---|---|---|
| 4.1 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | Excellent compliance achieved - to continue to monitor and maintain this. |
| 4.2 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | To strengthen existing risk assessment by modifying wording on EPR to include drop down list. Continue action plan towards stretch target. |
| 4.3 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | Trust to continue with their plan for ongoing monitoring of compliance on a monthly basis. Identify opportunities for celebration, learning and continuous improvement. |
| 4.4 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | Excellent compliance, continue to monitor at regular intervals to ensure sustained implementation and to identify best practice and opportunites for learning. |
| 4.5 | Partially implemented | Partially implemented | Evidence not in place - improvement required. | Trust to provide evidence that obstetric fetal monitoring lead is 0.1 WTE (JD provided says 2 hours/ week, 0.1 is 3.75 hours per week. |

Element 5

| INTERVENTIONS | | | | |
|---|---|---|---|---|
| 5.1 | Not implemented | Not implemented | Focus required on quality improvement intiatives to meet recommended standard. | Trust to develop job descriptions and job plans as required to ensure caacity of the individuals identified to undertake the role. |
| 5.2 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | Trust to continue to monitor preterm birth rates and ensure learning from PMRT is shared with the wider team. |
| 5.3 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | Trust have exceeded stratech target. To re-audit for next quarterly submission to ensure improvement in sustained. |
| 5.4 | Not implemented | Not implemented | Focus required on quality improvement intiatives to meet recommended standard. | Trust working on procurement of resources which the LMNS recognise are challenged and not within Trust control currently. To continue working towards procurement of fFN consumables and |
| 5.5 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | LMNS support the use of the regional guidance which covers East of England and is due to be reviewed soon. Trust to continue to work within regional guidance. |
| 5.6 | Partially implemented | Partially implemented | Focus required on quality improvement intiatives to meet recommended standard. | Trust to update multiple pregnancy guideline and subsequently audit compliance with implementation. |
| 5.7 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | (as per element one) |
| 5.8 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | To continue to monitor periodically to ensure sustained implementation |
| 5.9 | Not implemented | Not implemented | Focus required on quality improvement intiatives to meet recommended standard. | Trust working on procurement of FFN resources which the LMNS recognise are challenged and not within Trust control currently. Trust to continue to work towards procurement of fetal fibronectin |
| 5.10 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | Trust to continue to monitor to ensure sustained implementation |
| 5.11 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | Trust to continue to monitor to ensure sustained implementation; to repeat audit for next quarterly submission. |
| 5.12 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | Trust to continue to monitor to ensure sustained implementation |
| 5.13 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | Trust to consider audit of compliance with appropriate referrals |
| 5.14 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | Hybrid team with focus on equality, diversion and inclusion launched. Consider extending provision to include intraprtum care when safe staffing allows. |
| 5.15 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | Trust to consider gaining service user feedback on information provided. |
| 5.16 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | Excellent improvement seen. To continue with regular audit to ensure sustained implementation |
| 5.17 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | Trust to continue to monitor optimisation compliance through quarterly PERIPrem auditing/reporting. |
| 5.18 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | To consider guideline compliance audit to ensure practice embedded and opportunities for improvement identified. |
| 5.19 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | 100% compliance. Continue to monitor and share learning for any RPOB exceptions. |
| 5.20 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | Very good compliance achieved with this standard. Continue with PERIPrem care reviews for all births < 34 weeks. |
| 5.21 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | No eligible cases, continue with PERIPrem care reviews for all babies born <34 weeks. |
| 5.22 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | Good compliance achieved, continue to work on further improvement. |
| 5.23 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | Stretch target met. Continue to monitor compliance through PERIPrem care reviews. |
| 5.24 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | Stretch target met. Continue to monitor compliance through PERIPrem care reviews. |

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|---|---|---|---|---|
| 5.25 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | Continue with regular auditing striving towards further improvement. |
| 5.26 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | In view of low numbers of babies meeting criteria, continue reviewing care for all babies born <34 weeks. |
| 5.27 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | In view of low numbers of babies meeting criteria, continue reviewing care for any babies born <30 weeks |

**Element 6**

| INTERVENTIONS | | | | |
|---|---|---|---|---|
| 6.1 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | Once new guideline embedded, audit compliance as per auditbale standards listed within guideline. |
| 6.2 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | Trust to ensure staff attend annual update training when due. LMNS System-wide training agreement being developed. |
| 6.3 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | Audit to be repeated / continued for next quarterly submission. |
| 6.4 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | Stretch target met. In view of small numbers, to continue to collect and review data, including ethnicity, regularly. |
| 6.5 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | MMC to work collaboratively with Trusts to formally amend regional pathways. Trust guideline compliant and regional referral centres accepting appropriate referrals. |
| 6.6 | Fully implemented | Fully implemented | Fully meets standard - continue with regular monitoring of implementation. | Once new maternity diabetes guideline embedded, audit compliance as per auditbale standards listed within guideline. Trust DKA guidance meets criteria but needs review (overdue). |

| Trust Board | |
|---|---|
| **Report title:** | **Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?** |
| **Agenda item:** | Maternity & Neonatal services |
| **Date of the meeting:** | 26th January 2024 |
| **Sponsor/executive lead:** | Paul Molyneux, Trust Medical Director, Board Level Maternity and Neonatal Safety Champion<br>Sue Wilkinson, Chief Nurse |
| **Report prepared by:** | Karen Newbury, Director of Midwifery<br>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?**

The NHS Resolution (NHSR) Maternity Incentive Scheme is now in its 5th year and this was published with 10 safety actions that Trusts are required to comply with or make progress towards complying with to improve and maintain safety in maternity and neonatal units. There were minor changes to this safety action in July 2023. This report is part of the ongoing assurance of the Trust's compliance with Safety Action 9: **Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?**
The requirements are as follows:

a) All six requirements of Principle 1 of the Perinatal Quality Surveillance Model must be fully embedded.

b) Evidence that discussions regarding safety intelligence; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework are reflected in the minutes of Board, LMNS/ICS/ Local & Regional Learning System meetings.

c) Evidence that the Maternity and Neonatal Board Safety Champions (BSC) are supporting the perinatal quadrumvirate in their work to better understand and craft local cultures.

**SO WHAT?**

The Maternity and Neonatal services have updated the Trust Perinatal Clinical Quality Surveillance Model (PCQSM) and the Guidance for Maternity and Neonatal Safety Champions (MNSC) to ensure there are clear pathways for how safety intelligence is gathered, analysed and shared learning takes place across a number of forums both within and outside the Trust. The PCQSM was approved by the Regional Chief Midwife.

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| The Non-Executive Director (NED) appointed as Safety Champion to assist the Trust Board level Safety Champion is actively involved in engaging with staff and reviewing safety issues to enable improvements to be made when required.<br>The Trust Board does not meet monthly but other sub-committees meet to discuss some aspects of safety such as staffing and performance where any immediate concerns can be escalated if required.<br>Safety Intelligence is gathered from a number of sources and analysed as part of the Maternity Governance processes and improvement plans made to address safety and quality issues. These improvement plans are shared with the quadrumvirate and Safety Champions and learning shared across the Local Maternity and Neonatal System (LMNS), Integrated Care Board (ICB) and the Regional Maternity Quality and Safety Forum through the Regional Perinatal Quality Oversight Group (RPQOG).<br>The perinatal quadrumvirate and safety champions meet at least quarterly to discuss safety and culture intelligence within the maternity and neonatal services and identify good practice and areas of improvement required.<br>Whilst the Score Culture Survey has not been completed within the Trust as yet (due April-June 2024), national staff surveys have been used to inform Trust processes for improving staff wellbeing and morale. The Trust Board Safety Champion and NED are registered with the Futures Collaborative Perinatal Culture and Safety workspace. |
| **WHAT NEXT?** |
| • Ensure that all aspects of safety intelligence are included in sharing and learning forums.<br>• Embed quarterly review of all safety intelligence at joint quadrumvirate and MNSC meetings. |
| **Action Required** |
| The Trust Board is asked to receive this report as evidence of compliance with NHSR Maternity Incentive Scheme Safety Action 9. |

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| **Previously considered by:** | Maternity Quality & Safety Group: 18/12/23<br>Maternity & Neonatal Safety Champions: 28/11/23 |
| **Risk and assurance:** | This report contains information that has previously been made known to the Trust Board through Board Reports and Dashboards. 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. |

| **Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?** | |
|---|---|
| **1.** | **Introduction** |
| 1.1 | In May 2023, Year 5 of the NHSR Maternity Incentive Scheme was published with 10 safety actions that Trusts are required to comply with or make progress towards complying with to improve and maintain safety in maternity and neonatal units. There were minor changes to some safety actions in July 2023.<br>This report is part of the ongoing assurance of the Trust's compliance with Safety Action 9: **Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?** |
| **2.** | **Background** |
| 2.1 | **Required Standards**<br>a) All six requirements of Principle 1 of the Perinatal Quality Surveillance Model must be fully embedded.<br><br>b) Evidence that discussions regarding safety intelligence; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety |

| | |
|---|---|
| | Incident Response Framework are reflected in the minutes of Board, LMNS/ICS/ Local & Regional Learning System meetings.<br><br>c) Evidence that the Maternity and Neonatal Board Safety Champions (BSC) are supporting the perinatal quadrumvirate in their work to better understand and craft local cultures. |
| 2.2 | **Minimum Evidence**<br><br>**Evidence for point a**) is as per the six requirements set out in the Perinatal Quality Surveillance Model and specifically:<br><br>• Evidence that a non-executive director (NED) has been appointed and is working with the Board safety champion to address quality issues.<br><br>• Evidence that a monthly review of maternity and neonatal quality is undertaken by the Trust Board, using a minimum data set to include a review of thematic learning of all maternity Serious Incidents (SIs).<br><br>• To review the perinatal clinical quality surveillance model in full and in collaboration with the local maternity and neonatal system (LMNS) lead and regional chief midwife, provide evidence to show how Trust-level intelligence is being shared to ensure early action and support for areas of concern or need.<br><br>**Evidence for point b)**<br>• Evidence that in addition to the monthly Board review of maternity and neonatal quality as described above, the Trust's claims scorecard is reviewed alongside incident and complaints data. Scorecard data is used to agree targeted interventions aimed at improving patient safety and reflected in the Trusts Patient Safety Incident Response Plan. This should continue to be undertaken quarterly as detailed in MIS year 4. These discussions must be held at least twice in the MIS reporting period at a Trust level quality meeting. This can be a Board or directorate level meeting.<br><br>**Evidence for point c):**<br>Evidence that the Board Safety Champions have been involved in the NHS England Perinatal Culture and Leadership Programme. This will include:<br>• Evidence that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace to access the resources available.<br>• Evidence in the Board minutes that the Board Safety Champion(s) are meeting with the Perinatal 'Quad' leadership team at a minimum of quarterly (a minimum of two in the reporting period) and that any support required of the Board has been identified and is being implemented. |
| 2.3 | **Timeframes**<br>**Time period for points a and b)**<br>• Evidence of a revised written pathway, in line with the perinatal quality surveillance model, that is visible to staff and meets the requirements detailed in part a) and b) of the action should be in place based on previous requirements. The expectation is that if work is still in progress, this will have been completed by 1st December 2023.<br>• The expectation is that discussions regarding safety intelligence, including the number of incidents reported as serious harm, themes identified, and actions being taken to address any issues; staff and service user feedback; minimum staffing in maternity services and training compliance are continuing to take place at Board level monthly. If for any reason they have been paused, they should be reinstated no later than 1 July 2023.<br>• The expectation is for ongoing engagement sessions with staff as per year 4 of the scheme. If for any reason these have been paused, they should be recommenced no later than 1 July 2023. The reason for pausing feedback sessions should be captured in the minutes of the Board meeting, detailing mitigating actions to prevent future disruption to these sessions.<br>• Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than the 17th July 2023. |

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| | • Evidence that a review of the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions at a Trust level (Board or directorate) quality meeting by 17th July 2023. At least one additional meeting must have been undertaken before the end of the year 5 scheme demonstrating oversight of progress with any identified actions from the first review as part of the PSIRF plan. This should continue to be undertaken quarterly as detailed in MIS year 4.<br><br>**Time period for points c)**<br>• Evidence that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace to access the resources available no later than 1 August 2023.<br>• Evidence in the Board minutes that the Board Safety Champion(s) are meeting with the perinatal 'Quad' leadership team as a minimum of quarterly and that any support required of the Board has been identified and is being implemented. There must have been a minimum of 2 meetings held by 1 February 2024. |
| **3.** | **Compliance with Standards** |

| 3.1 | SA point | Requirement | Target Date | Comments |
|---|---|---|---|---|
| | a) | Perinatal Clinical Quality Surveillance Model (PCQSM) – 6 principles embedded.<br>Non-executive Director (NED) appointed.<br>Monthly Trust Board review of Maternity & Neonatal safety.<br>PCQSM agreed with the Trust Board, LMNS, regional leads.<br>Agreed pathway for sharing of learning | Pathway revised by **1/12/23** with PQSM | a) **Board meetings are bi-monthly but MNSC is usually monthly**<br>✓ Version 2 Perinatal Quality Surveillance Model approved by EoE Chief Midwife 30/6/23<br>✓ Local Maternity and Neonatal Safety Champions – issue 4 approved July 2023<br>✓ Board reports bi-monthly<br>✓ RPQOG submitted to LMNS/ICB, summarised at Trust Board<br>✓ Maternity Claims Scorecard presented in July and November 2023 (quarterly), summary to Board. |
| | b) | Safety Intelligence: staff and patient feedback; claims; complaints; improvement plans; included in PSIRP, Board minutes | Claims scorecard Minuted at least **twice by 7th December 2023, 1st one by 17th July** | ✓ Maternity Claims Scorecard July and November 2023 (quarterly discussions). Triangulation of information resulting from all safety and quality intelligence. |

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|---|---|---|---|---|---|
| | | | | | ✓ Report to Q&S, MNSC in July and November, Closed Trust Board July and December 2023.<br>✓ PSIRF and HSIB/MNSI reports to Trust Board, LMNS/ICB.<br>✓ Perinatal Mortality quarterly reports.<br>✓ Joint MNSC and perinatal quadrumvirate discussions around safety and cultural issues. |
| | | c) | Board level safety champions engaged in the perinatal and Cultural Leadership programme – registered with FuturesNHS site<br>Board minutes re understanding culture within services and support to address | Registered for FuturesNHS by **1st July 2023** | ✓ Emails confirming registration of safety champions with FuturesNHS site.<br>✓ Culture survey to be undertaken April – June 2024<br>✓ Staff surveys undertaken which include cultures and behaviours – results and learning shared within and outside the Trust. |
| 3.2 | The Maternity and Neonatal services can demonstrate the way in which safety intelligence is shared within and outside the organisation in order to improve quality and safety. | | | | |
| **4.** | **Next steps** | | | | |
| 4.1 | Continue to gather safety intelligence from many sources in order to promote safety, quality and learning in order to enhance care and support for women and babies. | | | | |
| 4.2 | These safety reports and processes will be embedded as business as usual. | | | | |
| **5.** | **Conclusion** | | | | |
| 5.1 | The Maternity and Neonatal services have updated the Trust Perinatal Clinical Quality Surveillance Model (PCQSM) and the Guidance for Maternity and Neonatal Safety Champions (MNSC) to ensure there are clear pathways for how safety intelligence is gathered, analysed and share learning takes place across a number of forums both within and outside the Trust. The PCQSM was approved by the Regional Chief Midwife.<br><br>The Non-Executive Director (NED) appointed as Safety Champion to assist the Trust Board level Safety Champion is actively involved in engaging with staff and reviewing safety issues to enable improvements to be made when required. | | | | |

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| | The Trust Board does not meet monthly but other sub-committees meet to discuss some aspects of safety such as staffing and performance where any immediate concerns can be escalated if required.<br><br>Safety Intelligence is gathered from a number of sources and analysed as part of the Maternity Governance processes and improvement plans made to address safety and quality issues. These improvement plans are shared with the quadrumvirate and Safety Champions and learning shared across the Local Maternity and Neonatal System (LMNS), Integrated Care Board (ICB) and the Regional Maternity Quality and Safety Forum through the RPQOG.<br><br>Whilst the Score Culture Survey has not been completed within the Trust as yet (due April-June 2024), national staff surveys have been used to inform Trust processes for improving staff wellbeing and morale. The Trust Board Safety Champion and NED are registered with the Futures Collaborative Perinatal Culture and Safety workspace. |
| **6.** | **Recommendations** |
| | • Ensure that all aspects of safety intelligence is included in sharing and learning forums.<br>• Embed quarterly review of all safety intelligence at joint quadrumvirate and MNSC meetings. |

## Appendix 1 Technical Guidance

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| What is the expectation around the Perinatal Quality Surveillance Model? | The Perinatal Quality Surveillance Model must be reviewed and the local pathway for sharing intelligence updated. This revised pathway should:<br>• Describe the local governance processes in place to demonstrate how intelligence is shared from the floor to Board.<br>• Formalise how Trust-level intelligence will be shared with the LMNS/ICS quality group and regional quality groups involving the Regional Chief Midwife and Lead Obstetrician. |
| What do we need to include in the dashBoard presented to Board each month? | The dashboard can be locally produced, based on a minimum data set as set out in the Board level measures. It must include the number of incidents reported as serious harm, themes identified, and actions being taken to address any issues; SUV feedback; staff feedback from frontline champions' engagement sessions; minimum staffing in maternity services and training compliance. The dashboard can also include additional measures as agreed by the Trust. |
| We had not continued to undertake monthly feedback sessions with the Board safety champion what should we do? | Parts a) and b) of the required standards build on the year three and four requirement of the maternity incentive scheme in building visibility and creating the conditions for staff to meet and establish a relationship with their Board safety champions to raise concerns relating to safety. The expectation is that Board safety champions have continued to undertake quarterly engagement sessions as described above. Part b) requires that progress with actioning named concerns from staff feedback sessions are visible. This builds on requirements made in year three of the maternity incentive scheme and the expectation is that this should have been continued. If these have not been continued, this needs to be reinstated by no later than 1 July 2023. |
| We are a Trust with more than one site. Do we need to complete the same frequency of engagement sessions in each site as a Trust on one site? | Yes. The expectation is that the same number of engagement sessions are completed at each individual site on a quarterly basis. |
| What is the rationale for the Board level safety champion safety action? | It is important to ensure all staff are aware of who their frontline and Board safety champions are if concerns are to be actively shared. Sharing of insights and good practice between providers, their LMNS, ICS and regional quality groups should be optimised. The development of a local pathway which describes these relationships, how sharing of information will take place and names of the relevant leaders, will support this standard to realise its aims. The guidance in the link |

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| | below will support the development of this pathway. Maternity-and-Neonatal-Safety-Champions-Toolkit--2020.pdf |
| Where can I find more information re my Trust's scorecard? | More information regarding your Trust's scorecard can be found here 2021 Scorecards launch - NHS Resolution https://resolution.nhs.uk/2020/10/27/claims-scorecards-for2020/ |
| What are the expectations of the Board safety champions in relation to quality improvement work undertaken by the maternity and neonatal quality improvement programme? | The Board safety Champions will be expected to continue their support for quality improvement by working with the designated improvement leads to participate and mobilise improvement via the MatNeo Patient Safety Networks. Trusts will be required to undertake improvement including data collection and testing work aligned to the national priorities. |
| What is the expectation for Trusts to undertake culture surveys? | Every maternity and neonatal service across England will be involved in the Perinatal Culture and Leadership Programme. As part of this programme every service will be undertaking work to meaningfully understand the culture of their services. This diagnostic will either be a SCORE culture survey or an alternative as agreed with the national NHSE team. It is expected that diagnostic findings are shared with the Trust Board to enable an understanding and garner support for the work to promote optimal safety cultures, based on the diagnostic findings. |
| What if our maternity and neonatal services are not undertaking the SCORE culture survey as part of the national programme? | The national offer to undertake a SCORE culture is a flexible, opt out offer. If your maternity and neonatal services demonstrated that they were already completing work to meaningfully understand local culture, and therefore opted out of the SCORE survey, the expectation is that the Board receives updates on this alternative work. |
| What are the expectations of the NED and Exec Board safety champion in relation to …….. | As detailed in previous years MIS guidance, regular engagement between Board Safety Champions and senior perinatal leadership teams provide an opportunity to share their support for the Perinatal Culture and Leadership Programme (PCLP), culture surveys and ongoing support for the Perinatal 'Quad' Leadership teams? |
| What should be discussed at the bimonthly meetings between the Board Safety Champion(s) and the Perinatal 'Quad' Leadership teams? | safety intelligence, examples of best practice and identified areas of challenge. The meetings should be conducted in an appreciative way, with the perinatal teams being open and transparent and the Board Safety Champions being curious and supportive. As a minimum the content should cover: - Learning from the Perinatal Culture and Leadership Development Programme so far - Plans to better understand their local culture. This will be use of the SCORE culture survey, or suitable alternative as agreed by the national NHS England team. - Updates on |

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| | the SCORE survey, or alternative when undertaken. - Updates on identified areas for improvement following the local diagnostic, along with any identified support required from the Board. NB, a formal report following this work should be presented at Board by the Perinatal leadership team. Progress with interventions relating to culture improvement work, and any further support required from the Board Clarification as to evidence required to meet the standard: Evidence that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace to access the resources available. The NED and Exec Board Safety Champion will be able to evidence they have registered on the FutureNHS Safety Culture - Maternity & Neonatal Board Safety Champions - FutureNHS Collaboration Platform workspace through minutes of a trust board meeting providing confirmation of specific resources accessed and how this has been of benefit. This will be reported as part of the board submission to NHS Resolution. |
| How often should the Board Safety Champions be meeting and engaging with the perinatal 'Quad' team? | Meetings between the Board Safety Champion(s) and Quad member(s) should be occurring a minimum of quarterly. We would expect a minimum of two meetings during this reporting period. |
| Who is expected to have undertaken the Perinatal Culture and Leadership Quad programme? | The expectation is that the senior perinatal leadership team (the Quad) have undertaken the PCLP. This will be representation from the midwifery, obstetric, neonatal, and operational professional groups, usually consisting of the 66 DoM/HoM, clinical lead / CD for obstetrics, clinical lead for neonates and the operational manager. |
| Is there an expectation that the board safety champions have undertaken the programme? | The Board Safety Champions should be supporting the Quad and their work as part of the PCLP, but there is no expectation for them to attend the programme. |
| Evidence that a monthly review – Most Trust meet bi-monthly (every other month) & are unable to meet this requirement | A review must be undertaken at every board meeting. If this is bi-monthly that will be sufficient, but this is the minimum requirement. Examples have been requested for how to review the data from scorecards The key to making this exercise meaningful is the triangulation of the data. Categorisation of the historic claims on the scorecard and any action taken, then presenting these alongside current incidents and complaints. This allows identification of potential themes or trends, identification of the impact of any learning, and allows you to act quickly if any historic themes re-emerged. An example is now available from the MIS team at NHS Resolution, and staff are happy to talk through |

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| | this process if it is helpful. The perinatal quality surveillance model requires review in collaboration with the local maternity and neonatal system (LMNS) lead and regional chief midwife to provide evidence of trust-level intelligence being shared and actions reported on areas of concern. This needs to happen before 1st July and therefore does not give trusts enough time to carry out this review The expectation is that this process should already be in place as it was a requirement in previous years, with the year 4 requirement for this to be in place by 16th June 2022. However, in recognition of the challenges of embedding a new quality surveillance model the timeframe of the 1st July has been amended to 1st December 2023 to allow additional time for trusts. |
| Clarification as to what constitutes a trust board, can sub committees be categorised as a board? | This refers solely to the Board of the trust, and it is a requirement that the board oversees the quality of their perinatal services at every meeting |

| Trust Board | |
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| **Report title:** | **Report on Anaesthetic Staffing within Maternity Services – 1st April 2023 - 30th September 2023** |
| **Agenda item:** | Maternity and Neonatal Services |
| **Date of the meeting:** | 26th January 2024 |
| **Sponsor/executive lead:** | Paul Molyneux, Trust Medical Director, Trust Safety Champion |
| **Report prepared by:** | Beverley Gordon, Project Midwife<br>Dr Christiane Kubitzek, Consultant Anaesthetist, Obstetric Lead |

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

## Executive Summary

### WHAT?

Safe staffing of maternity services is one area of the safety standards and actions expected for the Maternity Incentive Scheme run by NHS Resolution - Year 5. This report has been written to provide evidence of compliance with safe staffing requirements for obstetric anaesthesia within the Maternity Unit of West Suffolk NHS FT (WSNHSFT).

This report covers the period of review from 1st April 2023 to 30th September 2023 (Q1 and Q2 2023/24) and has used the rotas and other information to inform compliance with the Royal College of Anaesthetists (RCoA) Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1. This is the recommended resource to be used as the standard for the Maternity Incentive Scheme Year 5 Safety Action 4.

### SO WHAT?

The anaesthetic service prioritises covering the obstetric anaesthetic bleep 770 role and the rotas demonstrate 100% compliance with a rostered dedicated obstetric anaesthetist for this period of audit.

Industrial action has contributed to some staffing issues over the period of review, but the on-call service has been maintained.

The rota has a named consultant anaesthetist who is available for escalation of staffing and clinical issues.

There are gaps in the rota due to a variety of reasons, such as some training posts not being filled by the deanery as well as recruitment delays for trust doctors and MTI (medical training initiative) doctors. Any gaps will be filled mostly by in-house locums or on occasions by outside locums, who have received induction to the hospital and the obstetric department. On the occasions where gaps cannot be covered in this way, a consultant anaesthetist will act down to cover the role. However, this cannot be sustained over a long period of time.

It is a requirement to meet the safety recommendations for Safety Action 8 of the Maternity Incentive Scheme which is based on the NHS Core Competency Framework v 2 (2023). The Obstetric emergency multi-disciplinary training has not previously been mandated for all anaesthetic staff who provide cover within the maternity service within the Trust, but this has now been agreed and the anaesthetic services are working towards all staff being rostered as faculty and candidates from January 2024.
Despite this being non-mandatory, it is expected that the Trust will reach the target of more than 90% attendance at the training during 2023 in both the consultant anaesthetic staff and the other grades of obstetric anaesthetists.

The induction programme for new staff includes a specific section on obstetric anaesthesia and a handbook is issued to the staff outlining expectations. Both of these aspects are updated to ensure they are still relevant and accurate information to staff. In addition, to enhance the induction of new staff, an obstetric induction video is being developed to help with orientation of new staff on the labour suite.

As part of the monitoring of workforce within maternity services, compliance with decision to delivery times for category 1 (emergency) and category 2 (urgent) caesarean sections was assessed. The overall compliance for decision to delivery times was met for both urgent and emergency caesarean sections.

**WHAT NEXT?**

The Anaesthetic service is required to monitor the use of locums and occurrences of consultants acting down to inform a longer-term staffing plan and recruitment strategy.

There will be monitoring of the attendance at the emergency obstetric MDT training days to ensure that all staff have the opportunity to attend this at least once during the year and thereafter annually. If this impacts on the staffing levels and availability of a competent obstetric anaesthetist, or attendance and compliance is not maintained, further work will be required. This will include submitting a case of need and business planning to achieve the workforce required to maintain this as business as usual.

The Maternity and Anaesthetic services to work together to provide 6 monthly reports on compliance with the standards for staffing levels and progress made against recruitment and retention plans.

The next formal review and report will be completed in 6 months but any concerns regarding safety and staffing levels should be escalated at the time.

**Action Required**

The Trust Board is asked to receive this report and support the recommendations made to improve and maintain safety.

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| **Previously considered:** | Maternity Quality and Safety Committee: 20 /11/23<br>Maternity and Neonatal Safety Champions: new date |
| **Risk and assurance:** | This report outlines the Trust compliance with and recommendations for safe staffing of Maternity Units with obstetric anaesthetists. Whilst we are assured that the rota is covered, there should be short- and long-term plans to ensure all aspects of provision of obstetric anaesthetic are in place and are maintained. |
| **Equality, Diversity and Inclusion:** | This report is inclusive of all staff |
| **Sustainability:** | The staffing levels cannot be sustained unless vacancies are filled and allowance for training time and development of staff is taken into consideration in forward planning of staffing levels. |
| **Legal and regulatory context** | This report outlines how the Trust evidences compliance with the Maternity Incentive Scheme Year Safety Actions. The compliance will be declared on submission of the declaration form to NHSR on or before the deadline. The results of the declaration will be utilised to determine the amount of allocated funds available to the Trust to use to maintain and improve safety within the maternity services. Failure to declare accurate information will result in |

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| | reputational harm and a lack of funding to support ongoing safety and improvement plans. |

| **Report on Anaesthetic Staffing within Maternity Services – 1st April 2023 - 30th September 2023** | |
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| **1.** | **Introduction** |
| 1.1 | NHS Resolution launched its fifth year of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) in May 2023. These standards had minor updates in July 2023 and the submission date for evidence of the Trusts assurances and commitment to safety is expected to be 1st February 2024.<br>The 10 key safety actions build on and continue to support the delivery of safer maternity care and to ensure that they are embedded in the organisation of maternity services within Trusts to ensure that these are safe.<br>It is part of the safety culture that processes that lead to assurance of safe standards are embedded and are 'business as usual'.<br>This report relates to the standards expected for safe staffing in maternity services. |
| **2.** | **Background** |
| 2.1 | The safety action that applies to this report is unchanged from previous years and is as follows:<br>**Safety action 4**:<br>***Can you demonstrate an effective system of clinical workforce planning to the required standard?***<br>This report relates directly to the anaesthetic element of clinical staffing – section b). The requirement for this element is as follows:<br><br>**b) Anaesthetic medical workforce**<br>A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1) |
| 2.2 | **Anaesthesia Clinical Services Accreditation (ACSA) standards and action – in full from 2022 publication**<br>**1.7.2.1**<br>A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients.<br>The rota should be seen to allow obstetrics to take priority where the duty anaesthetist has other responsibilities.<br>A policy should be made available at staff induction regarding prioritising and junior staff should provide verbal confirmation that they have been inducted in this way. |
| 2.3 | **Minimum Evidence Required**<br>The rota should be used to evidence compliance with ACSA standard 1.7.2.1. |

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

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| 2.4 | **Local Arrangements**<br>The on-call anaesthetist holds bleep 770 and this is a baton bleep and handed over directly to the oncoming doctor. The role of the bleep 770 holder is described in the Standard Operating Procedure (SOP) and the operational aspect of the Obstetric Anaesthetic service is described in the Operational Plan – both documents have been updated in September 2023 and are awaiting approval at the Theatres and Anaesthetic Governance Group.<br>In addition, there is a handbook shared with all new staff on commencement of employment and available in a shared drive for staff on an ongoing basis.<br>Aspects of obstetric anaesthetic practice are discussed at induction days along with rotas and support for trainees. |
| **3.** | **Methodology, Findings and Analysis** |
| 3.1 | **Methodology for review**<br>**Rota Review**<br>On the rotas the cover will be seen in the following sections:<br>1. As an allocated doctor in the section labelled 'Obs junior 770' for evenings weekends and public holidays<br>2. Marked in a different section with a purple star: these staff members are allocated to be on call for emergency obstetric cases – marked as obstetric theatre, either on their own or as part of a team of 2-3 doctors 'on call'. One of the team, sometimes a consultant, sometimes a trainee, will hold the on-call bleep 770 and attend the multidisciplinary ward rounds.<br>3. There is a separate allocated doctor for elective caesarean lists.<br>4. If additional support is needed for the trainee out of hours, the consultant named in the section labelled 1st theatre/obstetric on call consultant will be called to assist.<br><br>**Other aspects of Obstetric Anaesthetic staffing**<br>In addition, there has been a review of the induction programmes for new staff and the vacancy levels within the anaesthetic services.<br>Decision to delivery times were reviewed for this period of time to ascertain if there were any anaesthetic reasons for not meeting timeframes for the specific category of caesarean section.<br>The guidance and standard operating procedures have been reviewed and updated as part of the regular review process.<br>Attendance at the multidisciplinary obstetric emergency training was not mandated within the Trust for the obstetric anaesthetic staff at the time but compliance of more than 90% was achieved in both consultant and other anaesthetic doctors during the MIS reporting period. |
| 3.2 | **Rotas** for this period of time were reviewed by the Project Midwife for evidence that there was a dedicated duty anaesthetist allocated for providing support to the maternity patients. These rotas were accessed directly from the electronic rota after the period of the audit was ended so that any changes due to staff absence were accounted for, making it the most accurate record that it could be. |
| 3.3 | **Results**<br>All the rotas demonstrated that a staff member was allocated to hold the on-call bleep 770 during this period of time from 1st April 2023 to 30th September 2023. The rotas show that where the bleep holder is allocated to other duties – e.g. the elective caesarean section list – the bleep holder is working with other anaesthetists who can either continue with the planned activity or attend to provide obstetric anaesthetic services. The rota has a named consultant anaesthetist who is available for escalation of staffing and clinical issues.<br><br>The programme for induction of new staff has been provided and the list of attendees at the most recent induction day. The handbook is given to all new starters at induction days. Both of these are being updated to reflect any changes to practice and an induction video is also being developed to orientate new staff.<br><br>Decision to delivery times for category 1 and 2 caesarean sections were reviewed for this period of time and reasons for not meeting these timeframes were assessed. The standard is for at least 80% to be undertaken within the timeframes and the Trust was compliant during the period of this report. |

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| 3.4 | **Current Vacancies and Challenges**<br>The allocation of trainees to the Trust is made by the Deanery and is outside the control of the Trust. A minimum of 32 trainees are required to cover all the services who require anaesthetic input and currently the Trust has 26.<br>Due to the critical nature of the work of anaesthetists, the obstetric trainees are part of the trained airway management workforce between theatre and ITU and the numbers required to cover this aspect is below that expected (6.7/8).<br>There are currently 2 vacancies for Consultant Anaesthetists across the Trust.<br>It is noted that in this period of time, usage of locums has increased to ensure that rotas are covered.<br>The expansion in the rota to manage 3 tiers of full shift rota has been difficult to meet with the concurrent need to move to a reduced frequency for the school and RCoA guidance for training. Moving from a 1:6 to a 1:8 has had an impact.<br>Further trainees are no longer slot sharing when less than full time (LTFT). Training rotations are allocating LTFT trainees to whole time slots leaving the deficit to be picked up locally.<br>As with many services, staffing levels have been impacted by industrial action and prioritisation has been required.<br>Due to the approval, advertising and recruitment processes involved, there is often a period of time between a post becoming vacant and the post being filled whereby short-term cover is required.<br>Ensuring that all anaesthetic staff who provide care to maternity patients are able to participate in annual multi-disciplinary team (MDT) obstetric emergency training is a challenge with the existing rotas and during the report period, this training was not mandated within the Trust. The decision has now been made to mandate this training and all staff providing obstetric anaesthetic cover will be rostered on to the training days both as faculty members and as attendees. Whilst being outside the timeframe for this report and despite this not being mandated, a compliance rate of more than 90% has been achieved in both the Obstetric Anaesthetic Consultant and other Obstetric Anaesthetic staff groups as of 1st December 2023. |
| **4.** | **Next steps** |
| 4.1 | Continue to monitor the staffing levels and escalate if there are any delays in availability of obstetric anaesthetists to provide analgesia and anaesthesia to maternity patients which affect patient safety and experience. |
| 4.2 | Review of staffing levels to meet the needs of the service and proactive recruitment of staff to vacancies and known retirements and resignations. |
| 4.3 | Ensure that attendance at the MDT Obstetric emergency training is rostered and compliance is maintained at the required level. |
| **5.** | **Conclusions** |
| 5.1 | The anaesthetic service prioritises covering the obstetric anaesthetic bleep 770 role and the rotas demonstrate 100% compliance with a rostered dedicated obstetric anaesthetist for this period of audit. Industrial action has contributed to some staffing issues over this period of time. |
| 5.2 | Due to the approval, advertising and recruitment processes involved, there is often a period of time between a post becoming vacant and the post being filled. There are also a number of training posts that are not currently filled by the deanery. Both of these issues mean that locum cover and acting down is more likely to be needed at this current time and this cannot be sustained over a long period of time. |
| 5.3 | The Obstetric emergency training was not mandated for all anaesthetic staff who provide cover within the maternity service within the Trust during this review period. At the time of writing this report, this is now mandated. This will not only ensure that the Trust is meeting the safety recommendations for Safety Action 8 of the Maternity Incentive Scheme which is based on the NHS Core Competency Framework v 2 (2023) but also ensure that staff are learning and training together and are following best practice guidance. |
| 5.4 | The induction programme for new staff includes a specific section on obstetric anaesthesia and a handbook is issued to the staff. An orientation video is also being developed to assist new staff. |

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| 5.5 | As part of the monitoring of workforce within maternity services, compliance with decision to delivery times for category 1 (emergency) and category 2 (urgent) caesarean sections was assessed. The overall compliance for decision to delivery times was met for both urgent and emergency caesarean sections. |
| **6.** | **Recommendations** |
| 6.1 | • The Anaesthetic service is required to monitor the use of locums and occurrences of acting down to inform a longer-term staffing plan and recruitment strategy.<br><br>• There will be monitoring of the attendance at the emergency obstetric MDT training days to ensure that all staff have the opportunity to attend this at least once during the year and thereafter annually. If this impacts on the staffing levels and availability of a competent obstetric anaesthetist, or attendance and compliance is not maintained, further work will be required. This will include submitting a case of need and business planning to achieve the workforce required to maintain this as business as usual.<br><br>• The Maternity and Anaesthetic services to work together to provide 6 monthly reports on compliance with the standards for staffing levels and progress made against recruitment and retention plans.<br><br>• The next formal review and report will be completed in 6 months but any concerns regarding safety and staffing levels should be escalated at the time. |

## Appendix 1 Current Summary of Compliance for Maternity Incentive Scheme Safety Action 4b

| Clinical Workforce Group | Standard to be met | WSH compliance | Progress Report | Evidence Source |
|---|---|---|---|---|
| Anaesthetic medical workforce | **Anaesthetic medical workforce**<br>A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (ACSA standard 1.7.2.1).<br><br>**1.7.2.1 Evidence required**<br>The rota should be seen to allow obstetrics to take priority where the duty anaesthetist has other responsibilities. A policy should be made available at staff induction regarding prioritising and junior staff should provide verbal confirmation that they have been inducted in this way. | | | |
| | **1.7.2.1** A duty anaesthetist is immediately available for the obstetric unit 24 hours a day. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patient in order to be able to attend immediately to obstetric patients. | **Yes** | **1st April 2023 to 30th September 2023** | Rotas demonstrate 100% compliance for this period of time.<br><br>Report to Trust Board. |

| Trust Board | |
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| **Report title:** | **Safety action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?** |
| **Agenda item:** | Maternity and Neonatal Services |
| **Date of the meeting:** | 26th January 2024 |
| **Sponsor/executive lead:** | Paul Molyneux, Trust Medical Director, Maternity and Neonatal Board Safety Champion<br>Sue Wilkinson, Chief Nurse |
| **Report prepared by:** | Georgie Brown, Lead MDT Educator, Womens and Childrens<br>Beverley Gordon, Project Midwife |

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

**Executive Summary**

**WHAT?**

In May 2023, Year 5 of the NHSR Maternity Incentive Scheme was published with 10 safety actions that Trusts are required to comply with or make progress towards complying with to improve and maintain safety in maternity and neonatal units. There were minor changes to some safety actions in July 2023 and further updates to compliance and evidence required in October 2023. Due to industrial action, some of the requirements have been modified to allow for delays in training.

This report is part of the ongoing assurance of the Trust's compliance with Safety Action 8:

**Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?** Maternity Multidisciplinary Emergency Training, Neonatal Resuscitation and Fetal Surveillance in labour.

**SO WHAT?**

The local training plan meets the requirements of the Core Competency Framework v 2 and has been approved by the Divisional team, Maternity and Neonatal Safety Champions, LMNS and the Trust Board.

The training attendance compliance is high in all staff groups, and this has been improved and maintained over the last 12 months. This reflects the commitment of the attendees and the faculty in delivering the training plan.

The training sessions are multidisciplinary and are delivered by knowledgeable, appropriately trained and experienced staff. The importance of team working and human factors when managing key practices and safe care cannot be underestimated.

Training records are maintained and compliance with attendance is monitored by the training leads and leaders within the departments and clinical areas.

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| The local Training and Education SOP does not reflect the most recent changes to the training programmes and the updated core competency framework, and this requires attention. |
| **WHAT NEXT?** |
| To meet the trajectory for implementation of the Core Competency Framework v 2 by August 2024 and be compliant with the Locally agreed Training Plan.<br>To ensure the Trust commitment to the relevant staff attending the training is continued and maintained at 90% or more in each staff group.<br>To ensure the training is effective and responsive in providing safe, quality care to mothers and babies and sharing of learning and protecting staff. |
| **Action Required** |
| ➢ Update the training and education SOP to reflect changes to training sessions over the last year e.g. fetal monitoring training and clinical scenarios for skills and drills.<br>➢ Embed the Core Competency Framework v 2 training plan and monitor progress.<br>➢ Monitor the effectiveness of the training in meeting the objectives and shared vision, and reducing harm to mothers, babies and staff. |

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| **Risk and assurance:** | The Trust is assured that the training and education programmes meets the requirements to achieve a responsive, effective, safe service and workforce. |
| **Equality, Diversity and Inclusion:** | The Trust is providing training and education to all relevant staff to meet safe standards of care and services to all women and babies. |
| **Sustainability:** | Continued support and commitment from all key personnel is required to maintain the training programmes and resources to enable staff to attend and a suitable environment for learning to take place. |
| **Legal and regulatory context** | This report outlines how the Trust will evidence compliance with the Maternity Incentive Scheme Year Safety Actions. The compliance will be declared on submission of the declaration form to NHSR on or before the deadline. The results of the declaration will be utilised to determine the amount of allocated funds available to the Trust to use to maintain and improve safety within the maternity services. Failure to declare accurate information will result in reputational harm and a lack of funding to support ongoing safety and improvement plans. |

| **Safety action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?** | |
|---|---|
| **1.** | **Introduction** |
| 1.1 | In May 2023, Year 5 of the NHSR Maternity Incentive Scheme was published with 10 safety actions that Trusts are required to comply with or make progress towards complying with to improve and maintain safety in maternity and neonatal units. There were minor changes to some safety actions in July 2023 and further updates to compliance and evidence required in October 2023. Due to industrial action, some of the requirements have been modified to allow for delays in training.<br>This report is part of the ongoing assurance of the Trust's compliance with Safety Action 8:<br>**Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?** Maternity Multidisciplinary Emergency Training, Neonatal Resuscitation and Fetal Surveillance in labour. |

| 2. | Background |
|---|---|
| 2.1 | **Maternity and Neonatal Specific Training 2023**<br>During 2023, an updated Standard Operating Procedure (SOP) for Maternity and Neonatal Training and Education was updated and re-launched. The basic principles of all the training are that staff who work together, train together.<br>The SOP included the following basic training requirements within the Training Needs Analysis (TNA):<br><br>**Fetal Monitoring**<br>Obstetric and Midwifery staff to attend the 4-hour fetal monitoring session as part of the Obstetric Emergency Training Day and a minimum of 4 hours of case study sessions per year. The case study sessions are held for 30 minutes each, twice weekly. The previous online training – K2 – was withdrawn from the Trust at the end of December 2023.<br>The fetal monitoring training has been changed to one full day face to face training from September 2023 with a continuation of two case study sessions per week. Staff are expected to attend a training day and have been expected to also attend case study sessions.<br><br>This training is also provided to meet the needs of Saving Babies Lives Element 4 – Fetal Monitoring training.<br><br>**Obstetric Emergency Training – PROMPT**<br>The Maternity multidisciplinary team to attend one training day per year where various scenarios are discussed and staff are able to update and practice managing these within a simulation suite. In addition, some skills and drills scenarios will take place in the clinical areas to ensure they the environmental and practical issues are related to emergencies. There has been a gradual reintroduction of clinical workplace training since the pandemic eased.<br><br>**Neonatal Life Support training**<br>All staff who may be involved in providing neonatal life support (NLS), should, as a minimum, attend local NLS training annually unless they are:<br>a) A Resuscitation Council NLS instructor, in which case they should teach 2 sessions per year to maintain their skills and attend their updates 3 yearly.<br>b) Have attended an external NLS course in that year.<br><br>The Core Competency Framework v 2 was released at the end of May 2023. The previous 3-year training plan, which was based on v 1, was updated to reflect the changes with a commitment to being compliant with v 2 by August 2024. |
| 2.1 | **Required Standards and Minimum Evidence**<br>1. A local training plan is in place for implementation of Version 2 of the Core Competency Framework (CCF).<br><br>2. The plan has been agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS/ICB.<br><br>3. The plan is developed based on the “How to” Guide developed by NHS England |
| 2.2 | **Timeframes**<br>12 consecutive months should be considered from 1st December 2022 until 1st December 2023 to ensure the implementation of the CCFv2 is reported on and, an appropriate timeframe for Trust Boards to review. |

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| | It is acknowledged that there will not be a full 90% compliance for new elements within the CCFv2 i.e. Diabetes. 90% compliance is required for all elements that featured in CCFv1. |
| 2.3 | **Requirements to meet the standards:**<br>1. A training plan should be in place to cover all six core modules of the Core Competency Framework over a 3- year period, starting from MIS year 4 in August 2021 and up to July 2024.<br>➢ Trusts should update their existing training plans in alignment with Version 2 of the Core Competency Framework.<br>➢ The training requirements set out in the Core Competency Framework require 90% attendance of relevant staff groups. This should be calculated as the 12 consecutive months from the end date used to inform percentage compliance to meet Safety Action 8 in the Year 4 scheme (1st December 2022 to 1st December 2023).<br>**NB The requirement for Year 5 is for 90% attendance/completion/compliance with the 3 core elements for the Core Competency Framework v 1 – Fetal Monitoring; Maternity Emergencies; Neonatal Life Support.**<br><br>2. Can you demonstrate the following at the end of 12 consecutive months ending December 2023?<br>80% compliance at the end of the previously specified 12-month MIS reporting period (December 2022 to December 2023) will be accepted, provided there is an action plan approved by Trust Boards to recover this position to 90% within a maximum 12-week period from the end of the MIS compliance period.<br>➢ In addition, evidence from rotating obstetric trainees having completed their training in another maternity unit during the reporting period (i.e. within a 12 month period) will be accepted.<br>If this is the case, please select 'Yes'.<br><br>**For other technical specifications, please see appendix 1** |
| | **Key issues and local compliance** |
| 3.1 | ***1. A local training plan is in place for implementation of Version 2 of the Core Competency Framework***<br>• The Local Training Plan has been developed and approved based on version 2 of the core competency framework.<br>• The Training Plan has been approved by:<br>Maternity Quality and Safety (Quadrumvirate) – 9th September<br>LMNS/ICB - 4th October 2023<br>Maternity and Neonatal Safety Champions – 26th September 2023<br>Trust Board - 29th September 2023<br><br>• The Training Plan includes all 6 core modules outlined in the Core Competency framework.<br>• The Training Plan includes the 4 main principles – user involvement, local findings from incidents, user feedback and investigation reports, multidisciplinary team, shared learning across the LMNS.<br>• The training is multidisciplinary.<br><br>User involvement in training is achieved by the use of scenarios (with agreement of the mother or family) where learning and good practice can be shared. The cases used have the incident number as an identifier to ensure anonymity and to provide evidence |

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| | on the learning that was shared. Learning is shared with the Local Maternity and Neonatal System (LMNS) at Learning and safety forums and meetings and as part of the Perinatal Quality Surveillance Framework. |
| 3.2 | ***2. The training requirements and attendance to be met in 90% of each staff group for the 3 main elements from version 1 of the Core Competencies Framework***<br>Data from the twelve-month period has been collected and the final compliance as at 1/12/23. |

| **Fetal monitoring and surveillance (in the antenatal and intrapartum period)** | |
|---|---|
| **Staff Group and Requirements** | **Compliance** |
| 90% of obstetric consultants? | 100% |
| 90% of all other obstetric doctors contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor)? | 100% |
| 90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) and maternity theatre midwives who also work outside of theatres? | 97% |
| **Maternity emergencies and multi-professional training** | |
| **Staff Group and Requirements** | **Compliance** |
| 90% of Obstetric consultants? | 98% |
| 90% of all other obstetric doctors including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota? | 100% |
| 90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives? | 99% |
| 90% of maternity support workers and health care assistants attend the maternity emergency scenarios training? | 100% |
| 90% of obstetric anaesthetic consultants? | 100% |
| 90% of all other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) who contribute to the obstetric rota? | 100% |
| Can you demonstrate that **at least one** emergency scenario is conducted in a clinical area or at point of care? | Yes – 3 scenarios held in 3 different clinical areas to date: 8th February 2023; 5th June 2023; 6th November 2023 |
| Can you demonstrate that 90% of all team members have attended an emergency scenario in a clinical area<br>**or**<br>does the local training plan (Q1) include a plan to implement attendance at emergency scenarios in a clinical area for 90% of all team members? | <90%<br><br>The local training plan includes a skills and drills session |

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| | in the clinical area on the PROMPT training day from January 2024 as well as other scenarios that have already taken place and will continue to take place over the year e.g. community setting. |

| **Neonatal basic life support** | |
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| **Staff Group and Requirements** | **Compliance** |
| 90% of neonatal Consultants or Paediatric consultants covering neonatal units? | 96.4% |
| 90% of neonatal junior doctors (who attend any births)? | 100% |
| 90% of neonatal nurses (Band 5 and above who attend any births)? | 100% |
| 90% of advanced Neonatal Nurse Practitioner (ANNP)? | N/A |
| 90% of midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives)? | 99% |
| All trusts must have an agreed plan in place, including timescales, for registered RC-trained instructors to deliver the in-house basic neonatal life support annual updates and their local NLS courses by 31st March 2024. | Yes – compliant currently with Resuscitation Council (RC) trained staff delivering training and more staff attending NLS instructor courses in 2024. |

Each member of staff will have their own period of time and starting point for compliance with training which will usually coincide with their starting date at the Trust but may be financial or calendar year. This means that at any given time, they can provide evidence of this as required and the organisation can also provide overarching reports on compliance at any given time.

Junior doctors who are on a rotational training programme, are complaint if they have completed suitable equivalent training in another Trust. However, they will also be encouraged to complete the training in the Trust with the people they work with to aid safe working practices within the Team.

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| | The evidence of completed training is recorded and maintained on databases to ensure that staff are attending and compliant with training requirements. |
| 3.3 | **Multidisciplinary Training**<br>The training sessions were assessed for compliance with attendance of members of the multidisciplinary team: all the sessions were multidisciplinary. |
| **4.** | **Next steps** |
| 4.1 | To meet the trajectory for implementation of the Core Competency Framework v 2 by August 2024 and be compliant with the Locally agreed Training Plan. |
| 4.2 | To ensure the Trust commitment to the relevant staff attending the training is continued and maintained at 90% or more in each staff group. |
| 4.3 | To ensure the training is effective and responsive in providing safe, quality care to mothers and babies and sharing of learning and protecting staff. |
| **5.** | **Conclusions** |
| 5.1 | The local training plan meets the requirements of the Core Competency Framework v 2 and has been approved by the Divisional team, Maternity and Neonatal Safety Champions, LMNS and the Trust Board.<br>The training attendance compliance is high in all staff groups, and this has been improved and maintained over the last 12 months. This reflects the commitment of the attendees and the faculty in delivering the training plan.<br>The training sessions are multidisciplinary and are delivered by knowledgeable, appropriately trained and experienced staff. The importance of team working and human factors when managing key practices and safe care cannot be underestimated.<br>Training records are maintained and compliance with attendance is monitored by the training leads and leaders within the departments and clinical areas.<br>The local Training and Education SOP does not reflect the most recent changes to the training programmes and the updated core competency framework, and this requires attention. |
| **6.** | **Recommendations** |
| | ➢ Update the training and education SOP to reflect changes to training sessions over the last year e.g. fetal monitoring training and clinical scenarios for skills and drills.<br>➢ Embed the Core Competency Framework v 2 training plan and monitor progress.<br>➢ Monitor the effectiveness of the training in meeting the objectives and shared vision, and reducing harm to mothers, babies and staff. |

## Action Plan

| Recommendation | Action | Lead | Time frame | Completed |
|---|---|---|---|---|
| Update the training and education SOP to reflect changes to training sessions over the last year e.g. fetal monitoring training and clinical scenarios for skills and drills. | The Maternity and Neonatal Training SOP to be updated with the changes to the programme for fetal monitoring training and the introduction and nature of skills and drills in the clinical areas. The Training Needs Analysis section will also reference the updated training requirements from the Core Competency Framework v2 training plan that has been agreed. | Georgie Brown, Lead educator Women's and Children | 31/3/24 | |
| Embed the Core Competency Framework v 2 training plan and monitor progress. | Updated training programmes and training days to be embedded and compliance monitored as part of the monthly Quality and Safety reporting mechanisms. | Georgie Brown, Lead Educator, Women's and Children's | 31/8/24 | |
| Monitor the effectiveness of the training in meeting the objectives and shared vision, and reducing harm to mothers, babies and staff. | Debriefs and feedback from training sessions to be analysed and utilised to enhance or improve training sessions.<br><br>Thematic review of incidents, mortality and morbidity, and claims to ascertain trends and improvements made or required. | Georgie Brown, Lead Educator, Women's and Children's<br><br>Karen Green, Quality and Governance Matron | Ongoing Processes embedded in the Governance framework | |

## Appendix 1 Technical Guidance

**Training to be included:**
All 6 core modules in V2 of the Core Competency Framework (CCFv2) must be covered as detailed in the minimum standards. Trusts must be able to evidence the four key principles:
1. Service user involvement in developing and delivering training.
2. Training is based on learning from local findings from incidents, audit, service user feedback, and investigation reports. This should include reinforcing learning from what went well.
3. Promote learning as a multidisciplinary team.
4. Promote shared learning across a Local Maternity and Neonatal System.

**Which maternity staff should be included for Module 2: Fetal monitoring and surveillance (in the antenatal and intrapartum period)?**
Staff who have an intrapartum obstetric responsibility (including antenatal and triage) must attend the fetal surveillance training**.**
**Maternity staff attendees must be 90% compliant for each of the following groups to meet the minimum standards:**
- Obstetric consultants
- All other obstetric doctors contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor)
- Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives). Maternity theatre midwives who also work outside of theatres.

**Staff who do not need to attend include:**
- Anaesthetic staff
- Maternity critical care staff (including operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit)
- MSWs
- GP trainees

**Which maternity staff should be included for Module 3: Maternity emergencies and multiprofessional training?**

**Maternity staff attendees must include 90% of each of the following groups to meet the minimum standards:**
- Obstetric consultants.
- All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota.
- Midwives (including midwifery managers and matrons), community midwives; birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives.
- Maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum)
- Obstetric anaesthetic consultants.
- All other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) who contribute to the obstetric rota.
- **Maternity theatre staff** are a vital part of the multidisciplinary team and are encouraged to attend the maternity emergencies and multiprofessional training, however they **will not be required to attend to meet MIS year 5 compliance assessment.**

• **Neonatal staff** are a vital part of the multidisciplinary team and are encouraged to attend the maternity emergencies and multiprofessional training, however **there will be no formal threshold for attendance required to meet MIS year 5 compliance.**

• **At least one emergency scenario is to be conducted in the clinical area**, ensuring full attendance from the relevant wider professional team, including theatre staff and neonatal staff

**Which staff should be included for Module 6: Neonatal basic life support?**
Staff in attendance at births should be included for Module 6: Neonatal basic life support. This **includes the staff listed below:**
• Neonatal Consultants or Paediatric consultants covering neonatal units.
• Neonatal junior doctors (who attend any births)
• Neonatal nurses (Band 5 and above)
• Advanced Neonatal Nurse Practitioner (ANNP)
• Midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives.

The **staff groups below are not required to attend** neonatal basic life support training:

- All obstetric anaesthetic doctors (consultants, staff grades and anaesthetic trainees) contributing to the obstetric rota and
- Maternity critical care staff (including operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit).
- Local policy should determine whether maternity support workers are included in neonatal basic life support training.

Refer to guidance re NLS instructors and training.

| Trust Board | |
|---|---|
| **Report title:** | **Compliance with Year 5 of the Maternity Incentive Scheme Safety Actions 2023/2024** |
| **Agenda item:** | Maternity and Neonatal Quality and Safety |
| **Date of the meeting:** | 26th January 2024 |
| **Sponsor/executive lead:** | Paul Molyneux, Trust Medical Director, Board Level Safety Champion<br>Sue Wilkinson, Chief Nurse |
| **Report prepared by:** | Karen Newbury, Director of Midwifery<br>Beverley Gordon, Project Midwife<br>Karen Green, Clinical Quality and Governance Matron |

| **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 outlines how the Trust demonstrates compliance with the Maternity Incentive Scheme Year 5 Safety Actions. The compliance will be declared on submission of the declaration form to NHSR on or before the deadline. The results of the declaration will be utilised to determine the amount of allocated funds available to the Trust to use to maintain and improve safety within the maternity and neonatal services. Failure to declare accurate information will result in reputational harm and a lack of funding to support ongoing safety and improvement plans.

The Trust is able to provide evidence in order to declare compliance with 10 out of 10 Safety Actions. We have indicated that we are not compliant with Safety Action 4d Neonatal Nursing workforce – the shift leader is not currently supernumerary in accordance with the British Association of Perinatal Medicine standards for neonatal nursing staffing standards. This does not however affect the Trust's compliance with this safety action as there is a plan in place to address this issue.

We have also reported that we were not compliant with Safety Action 2 requirements for data submitted for July 2023. However, NHS Digital have agreed we can declare compliance as the information service provider has made updates and the Trust passed the data quality tests for September 2023.

**SO WHAT?**

The Maternity and Neonatal services have safe standards and processes in place to minimise harm to mothers, babies and staff. These standards are embedded and are monitored through various systems and analysed on a regular basis – either monthly, quarterly or annually.

**WHAT NEXT?**

The Maternity and Neonatal services will continue to provide the highest standards of care and services and escalate where this is not possible and mothers, babies and staff are put at risk of harm.

**Action Required**

The Board is asked to confirm that they are reassured that steps have been taken to provide safe care and services within the Maternity and Neonatal care settings.

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| Complete the declaration form within the correct timeframe and confirm approval with the LMNS, Trust Board and Chief Executive |

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| **Risk and assurance:** | This report outlines how the Trust demonstrates compliance with the Maternity Incentive Scheme Year Safety Actions. The compliance will be declared on submission of the declaration form to NHSR on or before the deadline. The results of the declaration will be utilised to determine the amount of allocated funds available to the Trust to use to maintain and improve safety within the maternity services. Failure to declare accurate information will result in reputational harm and a lack of funding to support ongoing safety and improvement plans. |
| **Equality, Diversity and Inclusion:** | The Trust is providing data that accurately reflects key elements of the work of the maternity services. |
| **Sustainability:** | Standards and compliance with Safety Actions will be maintained and sustained by commitment of the Trust to continue investment in safe service and staffing to the agreed levels within the Trust. |
| **Legal and regulatory context** | Failure to meet the standards expected could put mothers, babies and staff at risk of harm and lead to financial penalties and a reduction in funding available to develop and maintain services and training.<br>Failure to declare accurate information will result in reputational harm and a lack of funding to support ongoing safety and improvement plans. |

# Compliance with Year 5 of the Maternity Incentive Scheme for Trusts

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|---|---|
| **1.** | **Introduction** |
| 1.1 | In May 2023, NHS Resolution has published guidance for Year 5 of the Maternity Incentive Scheme (MIS) and updated guidance was received in July 2023. In addition, the Saving Babies Lives Implementation Tool was launched and version 2 of the Core Competency Framework was also published at the same time as the Year 5 guidance was launched. All three publications and guidance provide safe standards of care and services that Maternity and Neonatal Services need to aspire to and maintain to promote safety and effectiveness. |
| **2.** | **Background** |
| 2.1 | Over the previous 4 iterations of the Maternity Incentive Scheme, many processes have been introduced to Trusts to embed safe standards of care and services within Maternity and Neonatal Services. Some of these relate to clinical care, some relate to service provision and others require robust organisational, workforce and assurance processes to be in place. |
| 2.2 | There are 10 safety actions covering different aspects of care and services. |
| 2.3 | Some of the safety actions require monthly monitoring or reporting processes, some quarterly, and others 6 monthly or annual reports. These processes are embedded in the Trust and therefore are available to be interrogated or presented internally and externally throughout the year and not just for the MIS cycle of compliance. |
| **3.** | **Detailed sections and key issues** |
| 3.1 | **Safety Action 1 Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?** |

| Requirements number | Safety action requirements | Requirement met? | Evidence |
|---|---|---|---|
| 1 | Have all eligible perinatal deaths from 30 May 2023 onwards been notified to MBRRACE-UK within seven working days? | Yes | MBRRACE website and quarterly Board reports. Up to date and compliant as at 7th December 2023. |
| 2 | For deaths from 30 May 2023, was MBRRACE-UK surveillance information completed within one calendar month of the death? | Yes | MBRRACE website and quarterly Board reports. . Up to date and compliant as at 7th December 2023. |
| 3 | For at least 95% of all deaths of babies who died in your Trust from 30 May 2023, were parents' perspectives of care sought and were they given the opportunity to raise questions? | Yes | MBRRACE website and DoC and quarterly Board reports. .Up to date and compliant as at 7th December 2023. |

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| | | 4 | Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 30 May 2023 been started within two months of each death?<br>This includes deaths after home births where care was provided by your Trust. | Yes | MBRRACE website and quarterly Board reports. Up to date and compliant as at 7th December 2023. | |
| | | 5 | Were 60% of these reviews completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death? | Yes | MBRRACE website and quarterly Board reports. .Up to date and compliant as at 7th December 2023. | |
| | | 6 | Were 60% of the reports published within 6 months of death? | Yes | MBRRACE website and quarterly Board reports. Up to date and compliant as at 7th December 2023. | |
| | | 7 | Were PMRT review panel meetings (as detailed in standard C) rescheduled due to the direct impact of industrial action, and did this have an impact on the MIS reporting compliance time scales? | | N/A | |
| | | 8 | Is there an action plan approved by Trust Boards to reschedule these meetings to take place within a maximum 12-week period from the end of the MIS compliance period. | | N/A | |
| | | 9 | If PMRT review panel meetings (as detailed in standard C) have needed to be rescheduled due to the direct impact of industrial action, and this has an impact on the MIS reporting compliance time scales, how many meetings in total were impacted? | | N/A | |
| | | 10 | PMRT review panel meetings (as detailed in standard C) have needed to be rescheduled due to the direct impact of industrial action, and this has an impact on the MIS reporting compliance time scales, how many cases in total were impacted? | | N/A | |
| | | 11 | Have you submitted quarterly reports to the Trust Executive Board from 30 May 2023 onwards? This must include details of all deaths reviewed and consequent action plans. | Yes | MBRRACE website and quarterly MNSC/Board reports:<br>Perinatal Mortality Review Q1 2023/24 (29/09/23)<br>Q2 2023/24 (1/12/23)<br>Q3 2023/24 to be completed January 2024. | |
| | | 12 | Were quarterly reports discussed with the Trust maternity safety and Board level safety champions? | Yes | MBRRACE website and quarterly MNSC/Board reports:<br>Perinatal Mortality Review Q1 2023/24 (26/9/23) | |

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| | | | | Perinatal Mortality Review Q2 2023/24 (28/11/23)<br>Perinatal Mortality Review Q3 2023/24 to be completed January 2024. |

3.2 **Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?**
**Trust Board Report January 2024**

| Requirements number | Safety action requirements | Requirement met? | Evidence |
|---|---|---|---|
| 1 | Was your Trust compliant with at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) by passing the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023?<br>Final data for July 2023 will be published during October 2023. | Yes | Screenshot showing all of section 1 questions been a pass other than CQIMDQ04 which would make use 10/11 |
| 2 | Did July's 2023 data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001) | Yes | Screenshot showing 97.9% complaint |
| Has the Trust Board confirmed to NHS Resolution that they have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023 for the following metrics: | | | |
| 3 | i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks also have the Continuity of Carer (CoC) pathway indicator completed. | No | This is the area we failed but due to suspension of further developments to the CoC teams, and small numbers within the Trust, we are able to declare compliance. |
| **If maternity services have suspended all Continuity of Carer (CoC) pathways, criteria ii is not applicable** | | | |
| 4 | ii. Over 5% of women recorded as being placed on a Continuity of Carer (CoC) pathway where both Care Professional ID and Team ID have also been provided. | N/A | CoC suspended |

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| | 5 | Did the Trust make an MSDS submission before the Provisional Processing Deadline for July 2023 data by the end of August 2023? | Yes | Screenshot attached Q4 shows we did get our provisional submission in |
| | 6 | Has the Trust at least two people registered to submit MSDS data to SDCS Cloud who must still be working in the Trust? | Yes | We currently have 2 submitters, hoping to request a 3rd shortly |

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

| Requirements number | Safety action requirements | Requirement met? | Evidence |
|---|---|---|---|
| **a) Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.** | | | |
| 1 | Was the pathway(s) of care into transitional care jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies?<br><br>Evidence should include:<br>• Neonatal involvement in care planning<br>• Admission criteria meets a minimum of at least one element of HRG XA04<br>• There is an explicit staffing model<br>• The policy is signed by maternity/neonatal clinical leads and should have auditable standards.<br>• The policy has been fully implemented and quarterly audits of compliance with the policy are conducted. | Yes | TC Policy and approval meetings / process |
| 2 | Are neonatal teams involved in decision making and planning care for all babies in transitional care? | Yes | TC policy and audits |

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| **b) A robust process is in place which demonstrates a joint maternity and neonatal approach to auditing all admissions to the NNU of babies equal to or greater than 37 weeks. The focus of the review is to identify whether separation could have been avoided. An action plan to address findings is shared with the quadrumvirate (clinical directors for neonatology and obstetrics, Director or Head of Midwifery (DoM/HoM) and operational lead) as well as the Trust Board, LMNS and ICB.** | | | |
| 3 | Is there evidence of joint maternity and neonatal reviews of all admissions to the NNU of babies equal to or greater than 37 weeks? | Yes | ATAIN meetings and reports |
| 4 | Is there an action plan agreed by both maternity and neonatal leads which addresses the findings of the reviews to minimise separation of mothers and babies born equal to or greater than 37 weeks? | Yes | ATAIN action plan and report |
| 5 | Is there evidence that the action plan has been signed off by the DoM/HoM, Clinical Directors for both obstetrics and neonatology and the operational lead and involving oversight of progress with the action plan? | Yes | Minutes of meetings where actions have been agreed – Q&S, MNSC, Trust Board |
| 6 | Is there evidence that the action plan has been signed off by the Trust Board, LMNS and ICB with oversight of progress with the plan? | Yes | Minutes of meetings where actions have been agreed with LMNS/ICB |
| **c) Drawing on the insights from the data recording undertaken in the Year 4 scheme, which included babies between 34+0 and 36+6, Trusts should have or be working towards implementing a transitional care pathway in alignment with the BAPM Transitional Care Framework for Practice for both late preterm and term babies. There should be a clear, agreed timescale for implementing this pathway.** | | | |
| 7 | Is there a guideline for admission to TC that include babies 34+0 and above and data to evidence this occurring? | Yes | Updated TC policy approved |
| 8 | OR An action plan signed off by the Trust Board for a move towards a transitional care pathway for babies from 34+0 with clear time scales for full implementation? | N/A | |

3.4 **Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?**

| Requirements number | Safety action requirements | Requirement met? | Evidence |
|---|---|---|---|
| **a) Obstetric medical workforce** | | | |
| Has the Trust ensured that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas after February 2023 following an audit of 6 months activity : | | | |
| 1 | a. Locum currently works in their unit on the tier 2 or 3 rota? | Yes | Report to Board outlining locum usage |
| 2 | **OR**<br>b. they have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progression (ARCP)? | Yes | |
| 3 | **OR**<br>c. they hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums? | N/A | |
| 4 | Has the Trust implemented the RCOG guidance on engagement of long-term locums and provided assurance that they have evidence of compliance? | Yes | Included in SOP and checklist |
| 5 | **OR**<br>Was an action plan presented to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and Local Maternity and Neonatal System (LMNS) meetings? https://rcog.org.uk/media/uuzcbzg2/rcog-guidance-on-the-engagement-of-long-term-locums-in-mate.pdf | N/A | |
| 6 | Has the Trust implemented RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the | Yes | Included in SOP and report |

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| | following day, and can the service provide assurance that they have evidence of compliance? | | |
| 7 | **OR**<br>Has an action plan presented to address any shortfalls in compliance, to the Trust Board, Trust Board level safety champions and LMNS meetings?<br>https://www.rcog.org.uk/media/c2jkpjam/rcog-guidance-on-compensatory-rest.pdf | N/A | |
| 8 | Has the Trust monitored their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/ when a consultant is required to attend in person? | Yes | Audit results |
| 9 | Were the episodes when attendance has not been possible reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance? | Yes | Audit results and analysis |
| Do you have evidence that the Trust position with the above has been shared: | | | |
| 10 | At Trust Board? | Yes | Board report December 2023 |
| 11 | With Board level safety champions? | Yes | MNSC report November 2023 |
| 12 | At LMNS meetings? | Yes | LMNS/ICB report December 2023 |

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| **b) Anaesthetic medical workforce** | | | |
| 13 | Is there evidence that the duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times? In order to declare compliance, where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1) | Yes | Board report to January Board |
| | The rota should be used to evidence compliance with ACSA standard 1.7.2.1 (A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients) | Yes | Board report |
| **c) Neonatal medical workforce** | | | |
| 14 | Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of medical staffing and is this formally recorded in Trust Board minutes? | Yes | Board report December 2023 |
| 15 | If the requirement above has not been met in previous years of MIS, Trust Board should evidence progress against the previously agreed action plan and also include new relevant actions to address deficiencies.<br>If the requirements had been met previously but they are not met in year 5, Trust Board should develop and agree an action plan in year 5 of MIS to address deficiencies.<br>Does the Trust have evidence of this? | N/A | |
| Was the agreed action plan shared with: | | | |
| 16 | LMNS? | Yes | LMNS/ICB report December 2023 |

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| 17 | ODN? | Yes | Report to ODN via LMNS |
| **d) Neonatal nursing workforce** | | | |
| 18 | Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of nursing staffing? And is this formally recorded in Trust Board minutes? | No | The shift coordinator is not always supernumerary. Board report September 2023, updated December 2023. |
| 19 | If the requirement above has not been met in previous years of MIS, Trust Board should evidence progress against the previously agreed action plan and also include new relevant actions to address deficiencies.<br>If the requirements had been met previously but they are not met in year 5, Trust Board should develop and agree an action plan in year 5 of MIS to address deficiencies.<br>Does the Trust have evidence of this? | Yes | Action plan included in report |
| Was the agreed action plan shared with: | | | |
| 20 | LMNS? | Yes | LMNS/ICB December 2023 |
| 21 | ODN? | Yes | To ODN November 2023 |

3.5 **Safety Action 5: Can you demonstrate an effective system for midwifery workforce planning to the required standard?**

| Requirements number | Safety action requirements | Requirement met? | Evidence |
|---|---|---|---|
| 1 | a) Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed?<br><br>Evidence should include:<br>A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated | **Yes** | BR+ report. Staffing reports to Board and sub-committees. 6 monthly staffing Board report submitted December 2023. |
| 2 | b) Can the Trust Board evidence midwifery staffing budget reflects establishment as calculated in a) above?<br><br>Evidence should include:<br>• Midwifery staffing recommendations from Ockenden, Trust Boards must provide evidence (documented in Board minutes) of funded establishment being compliant with outcomes of BirthRate+ or equivalent calculations.<br>• Where Trusts are not compliant with a funded establishment based on BirthRate+ or equivalent calculations, Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment. The plan must include mitigation to cover any shortfalls.<br>• The plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken, where deficits in staffing levels have been identified must be shared with the local commissioners.<br>• Details of planned versus actual midwifery staffing levels to include evidence of mitigation/escalation for managing a shortfall in staffing.<br>• The midwife to birth ratio<br>• The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 8-10% of the establishment, which are not included in clinical numbers. This includes those in management positions and specialist midwives. | **Yes** | 6 monthly Board Report submitted December 2023. |

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| 3 | c) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service.<br><br>Can you provide evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard figures demonstrating **100% compliance** with supernumerary labour ward co-ordinator status?<br><br>The Trust can report compliance with this standard if failure to maintain supernumerary status is a one off event, however **the Trust cannot report compliance with this standard if the coordinator is required to provide any 1:1 care for a woman and/or care in established labour during this time.**<br><br>If the failure to maintain supernumerary status is a recurrent event (i.e. occurs on a regular basis and more than once a week), the Trust should declare non-compliance with the standard and include actions to address this specific requirement going forward in an action plan. This plan must include mitigation/escalation to cover any shortfalls. Please note - Completion of an action plan will not enable the Trust to declare compliance with this standard. | **Yes** | Monthly monitoring of compliance. During the period of time relating to the MIS submission, 100% compliance. 6 monthly Trust Board report with overall compliance submitted December 2023. |
| 4 | d) Have all women in active labour received one-to-one midwifery care? | **Yes** | Monthly monitoring and 6 monthly Trust Board Report submitted December 2023. |
| 5 | If you have answered **no** to standard d, have you submitted an action plan detailing how the maternity service intends to achieve 100% compliance with 1:1 care in active labour? | **N/A** | N/A |
| 6 | Does the action plan include a timeline for when this will be achieved and has this been signed off by Trust Board? | **N/A** | N/A |
| 7 | e) Have you submitted a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year five reporting period? | **Yes** | 6 monthly Trust Board Reports submitted December 2023. |

3.6 **Safety action 6: Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three? Compliance report for sign-off January 2024**

| Requirements number | Safety action requirements | Requirement met? | Evidence |
|---|---|---|---|
| 1 | Have you provided assurance to the Trust Board and ICB that you are on track to fully implement all 6 elements of SBLv3 by March 2024? | Yes | LMNS report regarding compliance to be signed off by CEO January 2024. |
| 2 | Do you hold quarterly quality improvement discussions with the ICB, using the new national implementation tool?<br><br>Confirmation is required from the ICB with dates, that two quarterly quality improvement discussions have been held between the ICB (as commissioner) and the Trust using the implementation tool that included the following:<br><br>• Details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element.<br>• Progress against locally agreed improvement aims.<br>• Evidence of sustained improvement where high levels of reliability have already been achieved.<br>• Regular review of local themes and trends with regard to potential harms in each of the six elements.<br>• Sharing of examples and evidence of continuous learning by individual Trusts with their local ICB and neighbouring Trusts. | Yes | Quarterly meetings in August and November 2023 ICB confirmation received 19th December 2023 |
| 3 | Using the new national implementation tool, can the Trust demonstrate implementation of 70% of interventions across **all** 6 elements overall? | Yes | Implementation tool completed and ICB confirmation 19th December 2023. |
| 4 | Using the new national implementation tool, can the Trust demonstrate implementation of at least 50% of interventions within **each** of the 6 individual elements? | Yes | Implementation tool completed and ICB confirmation 19th December 2023. |

3.7

**Safety action 7: Listen to women, parents and families using maternity and neonatal services and coproduce services with users**

| Requirements number | Safety action requirements | Requirement met? | Evidence |
|---|---|---|---|
| 1 | Is a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) in place which is in line with the Delivery Plan? | Yes | Trust Board report submitted December 2023 outlining compliance. |
| 2 | Has an action plan been co-produced with the MNVP following annual CQC Maternity Survey data publication (January 2023), including analysis of free text data, and progress monitored regularly by safety champions and LMNS Board? | Yes | Survey Report and action plan submitted to MNVP |
| 3 | Is neonatal and maternity service user feedback collated and acted upon within the neonatal and maternity service, with evidence of reviews of themes and subsequent actions monitored by local safety champions? | | Report to Trust Board and MNSC December 2023. |
| 4 | Can you provide minutes of meetings demonstrating how feedback is obtained and evidence of service developments resulting from co-production between service users and staff? | Yes | Minutes of meetings – MNVP and other Safety and Governance meetings. |
| 5 | Do you have evidence that MNVPs have the infrastructure they need to be successful such as receiving appropriate training, administrative and IT support? | Yes | Report to Trust Board submitted December 2023 and workplan |
| 6 | Can you provide the local MNVP's work plan and evidence that it is funded? | Yes | Workplan and evidence of approval and funding |
| 7 | Do you have evidence that the MNVP leads (formerly MVP chairs) are appropriately employed or remunerated (including out of pocket expenses such as childcare) and receive this in a timely way? | Yes | Evidence of remuneration in Trust Board report December 2023 |
| 8 | Can you provide evidence that the MNVP is prioritising hearing the voices of families receiving neonatal care and bereaved families, as well as women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation? | Yes | Trust Board report submitted December 2023 outlining ways in which care is given equitably |

3.8 **Safety action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training? Trust Board report January 2024**

| Requirements number | Safety action requirements | Requirement met? | Evidence |
|---|---|---|---|
| 1 | A local training plan is in place for implementation of Version 2 of the Core Competency Framework | Yes | Training Plan |
| **Can you evidence that the plan has been agreed with:** | | | |
| 2 | Quadrumvirate? | Yes | Approval minutes |
| 3 | Trust Board? | Yes | Approval Minutes |
| 4 | LMNS/ICB? | Yes | Approval Minutes |
| 5 | Has the plan been developed based on the four key principles as detailed in the "How to" Guide for the second version of the core competency framework developed by NHS England? | Yes | Training Plan meets requirements. |
| 6 | Can you evidence service user involvement in developing training? | Yes | Training schedules and case ID |
| 7 | Can you evidence that training is based on learning from local findings from incidents, audit, service user feedback, and investigation reports? | Yes | Training case ID |
| 8 | Can you evidence that you promote learning as a multidisciplinary team? | Yes | Records of MDT attendance |
| 9 | Can you evidence that you promote shared learning across a Local Maternity and Neonatal System? | Yes | Learning forums |
| **Can you demonstrate the following at the end of 12 consecutive months ending December 2023?<br>80% compliance at the end of the previously specified 12-month MIS reporting period (December 2022 to December 2023) will be accepted, provided there is an action plan approved by Trust Boards to recover this position to 90% within a maximum 12-week period from the end of the MIS compliance period.<br>In addition, evidence from rotating obstetric trainees having completed their training in another maternity unit during the reporting period (i.e. within a 12 month period) will be accepted.<br>If this is the case, please select 'Yes'** | | | |

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| **Fetal monitoring and surveillance (in the antenatal and intrapartum period)** | | | |
| 10 | 90% of obstetric consultants? | 100% | Compliance at 1/12/23 |
| 11 | 90% of all other obstetric doctors contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor)? | 100% | Compliance at 1/12/23 |
| 12 | 90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) and maternity theatre midwives who also work outside of theatres? | 97% | Compliance at 1/12/23 |
| **Maternity emergencies and multiprofessional training** | | | |
| 13 | 90% of Obstetric consultants? | 98.14% | Compliance at 1/12/23 |
| 14 | 90% of all other obstetric doctors including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota? | 100% | Compliance at 1/12/23 |
| 15 | 90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives? | 99% | Compliance at 1/12/23 |
| 16 | 90% of maternity support workers and health care assistants attend the maternity emergency scenarios training? | 100% | Compliance at 1/12/23 |
| 17 | 90% of obstetric anaesthetic consultants? | 100% | Compliance at 1/12/23 |
| 18 | 90% of all other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) who contribute to the obstetric rota? | 100% | Compliance at 1/12/23 |
| 19 | Can you demonstrate that **at least one** emergency scenario is conducted in a clinical area or at point of care? | Yes | Compliance at 1/12/23 |
| 20 | Can you demonstrate that 90% of all team members have attended an emergency scenario in a clinical area<br>**or**<br>does the local training plan (Q1) include a plan to implement attendance at emergency scenarios in a clinical area for 90% of all team members? | <90%<br>3 sessions already taken place.<br>Training plan includes skills | Compliance at 1/12/23 |

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| | | and drills scenario in a clinical setting on each emergency training day from 1st January 2024. Other settings to be used for ad hoc sessions. | |
| **Neonatal basic life support** | | | |
| 21 | 90% of neonatal Consultants or Paediatric consultants covering neonatal units? | 96.4% | Compliance at 1/12/23 |
| 22 | 90% of neonatal junior doctors (who attend any births)? | 100% | Compliance at 1/12/23 |
| 23 | 90% of neonatal nurses (Band 5 and above who attend any births)? | 100% | Compliance at 1/12/23 |
| 24 | 90% of advanced Neonatal Nurse Practitioner (ANNP)? | | N/A |
| 25 | 90% of midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives)? | 99% | Compliance at 1/12/23 |
| 26 | All trusts must have an agreed plan in place, including timescales, for registered RC-trained instructors to deliver the in-house basic neonatal life support annual updates and their local NLS courses by 31st March 2024. | Yes | Compliant |
| 27 | Have you declared compliance for any of Q10-Q25 above with 80-90%? | | |
| 28 | If you are declaring compliance for any of Q10-Q25 above with 80-90%, can you confirm that an action plan has been approved by your Trust Board to recover this position to 90% within a maximum 12-week period from the end of the MIS compliance period? | | |

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| 3.9 | **Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues? Trust Board Report January 2024** |

| Requirements number | Safety action requirements | Requirement met? | Evidence |
|---|---|---|---|
| 1 | **Required Standard A.**<br>**Evidence that all six requirements of Principle 1 of the Perinatal Quality Surveillance Model have been fully embedded and specifically the following:-** | **Yes** | PQSM model/SOP agreed July 2023. |
| 2 | Does your Trust have evidence that a non-executive director (NED) has been appointed and is working with the Board safety champion to address quality issues? | **Yes** | MNSC policy document. |
| 3 | Does your Trust have evidence that a review of maternity and neonatal quality is undertaken by the Trust Board at every Trust Board meeting, using a minimum data set to include a review of the thematic learning of all maternity Serious Incidents (SIs)?<br>It must include:<br>• number of incidents reported as serious harm<br>• themes identified and action being taken to address any issues<br>• Service user voice feedback<br>• Staff feedback from frontline champions' engagement sessions<br>• Minimum staffing in maternity services and training compliance | **Yes** | Trust Board papers on Website including staffing papers and incident summaries.<br>Closed Board reports submitted. |
| 4 | Do you have evidence that the perinatal clinical quality surveillance model has been reviewed in full in collaboration with the local maternity and neonatal system (LMNS) lead and regional chief midwife? And does this evidence show how Trust-level intelligence is being shared to ensure early action and support for areas of concern or need. | **Yes** | PQSM model/SOP agreed LMNS and Regional Lead Midwife July 2023. |
| **Required standard B.**<br>**Have you submitted evidence that discussions regarding safety intelligence; concerns raised by staff and service users; progress and actions relating to a local improvement plan utilising the Patient Safety Incident Response Framework are reflected in the minutes of:** | | | |

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| 5 | The Trust Board? | Yes | PSIRF meetings. Improvement plans from PSIRF. |
| 6 | LMNS/ICS/Local & Regional Learning System meetings? | Yes | LMNS/ICB Safety Forum |
| 7 | Do you have evidence that the progress with actioning named concerns from staff feedback sessions is visible to staff? | Yes | Included in Q&S newsletter, minutes of MNSC meetings and Board meetings. |
| 8 | Do you have evidence that Trust's claims scorecard is reviewed alongside incident and complaint data? Scorecard data is used to agree targeted interventions aimed at improving patient safety and reflected in the Trust's Patient Safety Incident Response Plan. These quarterly discussions must be held at least twice in the MIS reporting period at a Trust level quality meeting. This can be a Board or directorate level meeting. | Yes | Claims scorecard and safety intelligence presented quarterly. Minutes of MNSC meetings. |
| 9 | **Required standard C.**<br>**Have you submitted evidence that the Maternity and Neonatal Board Safety Champions are supporting the perinatal quadrumvirate in their work to better understand and craft local cultures?** | Yes | Quadrumvirate and MNSC meeting at least quarterly. Divisional Board meetings. |
| 10 | Have you submitted the evidence that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace with confirmation of specific resources accessed and how this has been of benefit? | Yes | Email evidence |
| 11 | Have there been a minimum of two quarterly meetings between board safety champions and quadrumvirate members between 30 May 2023 and 1 February 2024? | Yes | Quadrumvirate and MNSC meeting at least quarterly. Attendance at MNSC meetings. |
| 12 | Have you submitted evidence that the meetings between the board safety champions and quad members have identified any support required of the Board and evidence that this is being implemented? | Yes | Minutes of joint meetings and escalations to Board. |

3.10 **Safety Action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch/Maternity and Neonatal Safety Investigations (HSIB/MNSI) and to NHS Resolution's Early Notification Scheme from 6th December 2022 to 7th December 2023?**

| Requirements number | Safety action requirements | Requirement met? | Evidence |
|---|---|---|---|
| 1 | Complete the field on the Claims Reporting Wizard (CMS), whether families have been informed of NHS Resolution's involvement, completion of this will also be monitored, and externally validated. | Yes | Compliance from Litigation |
| 2 | Have you reported all qualifying cases to HSIB/CQC/MNSI from 6 December 2022 to 7 December 2023? | Yes | Q1 report to Trust Board<br>Q2 report to Trust Board<br>Compliance to 7th December – no cases up until 7th December.<br>Q3 report to be completed January 2024. |
| 3 | Have you reported all qualifying EN cases to NHS Resolution's EN Scheme from 6 December 2023 until 7 December 2023? | Yes | Q1 report to Trust Board<br>Q2 report to Trust Board<br>Compliance to 7th December – no cases up until 7th December.<br>Q3 report to be completed January 2024. |
| **For all qualifying cases which have occurred during the period 6 December 2022 to 7 December 2023, the Trust Board are assured that:** | | | |
| 4 | The family have received information on the role of HSIB/MNSI and NHS Resolution's EN scheme | Yes | Q1 report to Trust Board<br>Q2 report to Trust Board<br>Compliance to 7th December – no cases up until 7th December.<br>Q3 report to be completed January 2024. |
| 5 | There has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour | Yes | Q1 report to Trust Board<br>Q2 report to Trust Board<br>Compliance to 7th December – no cases up until 7th December.<br>Q3 report to be completed January 2024. |

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| | **Can you confirm that the Trust Board has:** | | | |
| | 6 | Sight of Trust legal services and maternity clinical governance records of qualifying HSIB/MNSI/EN incidents and numbers reported to HSIB/MNSI and NHS Resolution? | **Yes** | Q1 report to Trust Board<br>Q2 report to Trust Board<br>Compliance to 7th December – no new cases.<br>Q3 report to be completed January 2024. |
| | 7 | Sight of evidence that the families have received information on the role of HSIB/MNSI and the EN scheme? | **Yes** | Q1 report to Trust Board<br>Q2 report to Trust Board<br>Compliance to 7th December – no new cases<br>Q3 report to be completed January 2024 |
| | 8 | Sight of evidence of compliance with the statutory duty of candour? | **Yes** | Q1 report to Trust Board<br>Q2 report to Trust Board<br>Compliance to 7th December – no new cases.<br>Q3 report to be completed January 2024. |

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| **4.** | **Next steps** |
| 4.1 | The Maternity and Neonatal services will continue to embed and sustain safe standards of care and services to mothers and babies and escalate concerns to the Trust when required. |
| 4.2 | The required monitoring and reporting processes will be continued on a monthly, quarterly, 6 monthly and annual basis as required. |
| **5.** | **Conclusion** |
| 5.1 | The Maternity and Neonatal services are assured that the evidence that they have provided demonstrates compliance with the safety actions. Where there has been any doubt or uncertainty, such as with the MSDS submissions, these have been confirmed with the Safety Action Leads at NHS Resolution.<br>The Trust is committed to providing safe care for mothers and babies and protecting staff from situations that might lead to harm or to themselves or patients. The provision of safe care is a constant and not just within the limitations of the CNST framework and timeframes. Systems and processes are embedded within the organisation to protect these standards and services. |
| **6.** | **Recommendations** |
| | Complete the declaration form within the correct timeframe and confirm approval with the LMNS, Trust Board and Chief Executive. |