NHS
West Suffolk
NHS Foundation Trust

Board of Directors (In Public)

Schedule	Friday 22 July 2022, 9:15 AM — 12:45 PM BST
Venue	Ashlar House, 23 Eastern Way, Bury St Edmunds IP32 7AB
Description	A meeting of the Board of Directors will take place on Friday, 22 July 2022 at 9:15am.
Organiser	Karen McHugh

Agenda

AGENDA

_WSFT Public Board Agenda - 22 July 2022 1.docx

1. GENERAL BUSINESS

1.1. Apologies for absence: Helen Davies
To Note - Presented by Jude Chin

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

1.3. Minutes of the previous meeting - 27 May 2022
To Approve - Presented by Jude Chin

Item 1.3 - Open Board Minutes 27 May 2022 Draft.docx

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

Item 1.4 - Board Action Points - Active.pdf

Item 1.4 - Board Action Points - Complete.pdf

1.5. Patient story
To Note - Presented by Susan Wilkinson

1.6. Questions from Governors and the Public
To Note - Presented by Jude Chin

1.7. Chief Executive's report
To inform - Presented by Craig Black

Item 1.7 - CEO Board report - July 2022.docx

2. CULTURE

2.1. People & OD highlight report
To Assure - Presented by Jeremy Over

Item 2.1 - People OD highlight July 2022.docx

2.2. Guardian of safe working report
For Report - Presented by Francesca Crawley

Item 2.2 - Guardian of safe working report - cover sheet July 2022.docx

Item 2.2 - Guardian of safe working annual report 2021-2022.docx

2.3. Medical revalidation report
To Assure - Presented by Paul Molyneux

Item 2.3 - Medical Appraisal and Revalidation 2021.docx

2.4. Car parking (staff benefits)
To Approve - Presented by Nick Macdonald

Item 2.4 - Car Parking and staff benefits July 2022 FINAL.docx

3. STRATEGY

3.1. Future system board report
To Assure - Presented by Craig Black

Item 3.1 - WSFT Future System public board July 2022.docx

3.2. Strategic update

3.2.1. Alliance

To inform - Presented by Clement Mawoyo

Item 3.2.1 - Alliance Integration report July.ppt

3.2.2. SNEE Integrated Care Board

To inform - Presented by Craig Black

Item 3.2.2 - Strategic update - ICB.docx

Comfort Break

4. ASSURANCE

4.1. Insight Committee Report - June & July 2022 - Chair's Key Issues from the meeting

To Assure - Presented by Richard Davies

Item 4.1 - Insight Committee CKIs - June July 2022.docx

Item 4.1 - Chair's Key Issues June 2022.docx

Item 4.1 - Chair's Key Issues July 2022.docx

4.2. Finance and Workforce Report

To Note - Presented by Nick Macdonald

Item 4.2 - Finance Report- June 2022_Front_Sheet_Final.docx

Item 4.2 - Finance Report- June 2022_FInal.docx

4.3. IQPR - see Annexes 7.0

To Note - Presented by Susan Wilkinson and Nicola Cottington

4.4. Improvement Committee Report - June & July 2022 Chair's key issues from the meetings

To Assure - Presented by Jude Chin

Item 4.4 - 22-06-13 - Chairs key issues - Improvement Committee report for board - June 2022.docx

Item 4.4 - 22-07-11 - Chairs key issues - Improvement Committee report for board - July 2022.docx

4.5. Quality and Nurse Staffing Report
To Assure - Presented by Susan Wilkinson

Item 4.5 - Quality and nurse staffing report -May and June 22 Final.docx

4.6. Maternity services

4.6.1. Maternity services: quality & performance report
To Assure - Presented by Susan Wilkinson

Item 4.6.1 - July 22 Maternity Quality Safefy and Performance Board Report.docx

4.6.2. Maternity safety support programme
To inform - Presented by Susan Wilkinson

Item 4.6.2 - Exit MSSP Board Paper draft 4 with plan A 130722.docx

4.7. Involvement Committee Report - June 2022 Chair's key issues
To Assure - Presented by Alan Rose

Item 4.7 - Chair's Key Issues - IVC; from 200622 meet for 220722 Board - final.docx

5. GOVERNANCE

5.1. Governance report
To inform - Presented by Richard Jones

Item 5.1 - Governance Report.docx

6. OTHER ITEMS

6.1. Any other business
To Note

6.2. Reflections on meeting
For Discussion

6.3. Date of next meeting - 30 September 2022
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

7. Annexes for information:
To inform

4.3 - IQPR

- Item 4.3 - IQPR May 2022 v1.pptx

4.4 - Improvement committee - Supporting Annexes

- Item 4.4 Annex 1 - Improvement June - Quality and Learning report.docx
- Item 4.4 Annex 2 - Improvement June - CQC new model of assessment.docx
- Item 4.4 Annex 1 - Improvement July - PQAS.docx
- Item 4.4 Annex 2i - Improvement July - Safety strategy cover.docx
- Item 4.4 Annex 2ii - Improvement July - Safety strategy.docx
- Item 4.4 Annex 3 - Improvement July - QIPs.pdf

4.6.1 - Maternity services quality and performance board report - Supporting annexes

- Item 4.6.1 Annex B - Element 4 SBL Audit report for compliance fetal monitoing May 2022 final.docx
- Item 4.6.1 Annex C - WSFTmaternity-self-assessment-tool-v6 June 22 (002).docx

5.1 - Governance report - Supporting annexes

- Item 5.1 Annex A(i) - Audit Committee Annual Report 2122.doc
- Item 5.1 Annex A(ii) - Audit Committee - Review of Terms of Reference 2223

update post AC.doc

AGENDA

WSFT Board of Directors – Public Meeting

Date and Time	Friday, 22 July 2022 9:15 – 12:45
Venue	Ashlar House, 23 Eastern Way, Bury St Edmunds IP32 7AB

Time	Item	Subject	Lead	Purpose	Format
1.0 GENERAL BUSINESS					
09.15	1.1	**Apologies for absence**	Chair	Note	Verbal
	1.2	**Declarations of Interests**	All	Assure	Report
	1.3	**Minutes of meeting – 27 May 2022**	Chair	Approve	Report
	1.4	**Action log and matters arising**	All	Review	Report
09:20	1.5	**Patient story**	Chief Nurse	Note	Verbal
	1.6	**Questions from Governors and the public**	Chair	Note	Verbal
09:50	1.7	**CEO report**	CEO	Inform	Report
2.0 CULTURE					
10.00	2.1	**People and organisational development highlight report**	Director of Workforce	Assure	Report
	2.2	**Guardian of safe working report**	Guardian	Assure	Report
	2.3	**Medical revalidation report**	Medical Director	Assure	Report
	2.4	**Car Parking (staff benefits)**	CEO	Approve	Report
3.0 STRATEGY					
11:00	3.1	**Future system board report**	Chief Executive	Assure	Report
	3.2	**Strategic update**			
	3.2.1	**Alliance**	Clement Mawoyo	Inform	Report
	3.2.2	**SNEE Integrated Care Board**	Craig Black	Inform	Report
11:30 Comfort Break					
4.0 ASSURANCE					
11:40	4.1	**Insight committee report** – June & July 2022 – chair's key issues from the meeting	NED Chair	Assure	Report
	4.2	**Finance and workforce report**	Director of Resources	Assure	Report
	4.3	**Integrated Quality and Performance Report (IQPR)** (See Annexes)	COO / Chief Nurse	Note	Report

Time	Item	Subject	Lead	Purpose	Format
12:00	4.4	**Improvement committee report** – June & July 2022 chair's key issues from the meeting	NED Chair	Assure	Report
	4.5	**Quality and nurse staffing report**	Chief Nurse	Assure	Report
	4.6	**Maternity services:**			
	4.6.1.	**Quality & performance report**	Chief Nurse	Assure	Report
	4.6.2	**Maternity Safety Support programme**	Chief Nurse	Approve	Report
12:20	4.7	**Involvement committee report** – June 2022 chair's key issues	NED Chair	Assure	Report
5.0 GOVERNANCE					
12:40	5.1	**Governance Report**	Trust Secretary	Inform	Report
6.0 OTHER ITEMS					
12.55	6.1	**Any Other Business**	All	Note	Verbal
	6.2	**Reflections on meeting**	All	Discuss	Verbal
	6.3	**Date of next meeting** • **30 September 2022**	Chair	Note	
	Resolution The Trust Board is invited to adopt the following resolution: "that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicly on which would be prejudicial to the public interest" Section 1(2) Public Bodies (Admission to Meetings) Act 1960				

Supporting Annexes

Guidance notes

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

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

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

Our Risk Appetite

1. GENERAL BUSINESS

1.1. Apologies for absence: Helen Davies

To Note

Presented by Jude Chin

1.2. Declaration of interests for items on the agenda

To Assure

Presented by Jude Chin

1.3. Minutes of the previous meeting - 27 May 2022

To Approve

Presented by Jude Chin

DRAFT

MINUTES OF BOARD OF DIRECTORS MEETING

HELD ON 27 MAY 2022 9.15-12.45
ASHLAR HOUSE

COMMITTEE MEMBERS			
		Attendance	**Apologies**
Jude Chin	Interim Chair	•	
Alan Rose	Deputy Chair/Non-Executive Director	•	
Louisa Pepper	Non-Executive Director	•	
Richard Davies	Non-Executive Director (Maternity Safety Champion)	•	
Christopher Lawrence	Non-Executive Director	•	
Craig Black	Interim Chief Executive	•	
Nicola Cottington	Chief Operating Officer	•	
Sue Wilkinson	Executive Chief Nurse	•	
Nick Macdonald	Interim Executive Director of Finance	•	
Paul Molyneux	Interim Executive Medical Director (Maternity Safety Champion)	•	
Jeremy Over	Executive Director of Workforce and Communications	•	
In attendance			
Richard Jones	Trust Secretary		
Helen Davies	Head of Communications		
Alex Baldwin	Deputy Chief Operating Officer		
Pooja Sharma	Deputy Trust Secretary (minutes)		
Gylda Nunn	Deputy Director of Integrated Services		
Karen Newbury	Head of Midwifery (for item 4.6 only)		
Simon Taylor	ADO (for item 4.6 only)		
Kate Croissant	Clinical Lead ((for item 4.6 only))		
Amanda Bennett	Freedom to Speak Up Guardian		
Governors in attendance (observation only): Florence Bevan, Carol Bull and Liz Steele			
Members of the Public: Councillor Margaret Marks from West Suffolk Council			

Action

1.0 GENERAL BUSINESS

1.1 APOLOGIES FOR ABSENCE

There were no apologies for absence.

1.2 DECLARATION OF INTERESTS FOR ITEMS ON THE AGENDA

No declarations of interest were received.

1.3 MINUTES OF MEETING HELD ON 25 MARCH 2022

The minutes of the previous meeting were approved as a true and accurate record.

1.4 ACTION LOG AND MATTERS ARISING

The ongoing actions were reviewed and updated.

1.5 QUESTIONS FROM GOVERNORS AND THE PUBLIC

- In relation to staff survey and in the context of culture and wellbeing, what assurance can be received that staff are given time for training and appraisal? (Liz Steele).

  It was informed that during the pandemic there were challenges around bringing everyone together for training and teams have set themselves trajectories to improve and to get back on track over the next 3-6 months' time. The Involvement Committee has an oversight and closely monitors this issue. There are discussions going on around how best the data can be presented to reflect accurate numbers.

- In the IQPR, the sepsis screening of ED patients has dropped to 40% from previous levels of 80%. There appears to be no relevant explanation or comment. Can the assurance be provided that this anomaly has been picked up by a review mechanism and will be addressed going forward? (Clive Wilson).

  It was told that the Patient Safety and Quality Group has initiated a quality improvement process that they are working specifically with regard to sepsis and this is being addressed through running various audits and improvement programmes.

1.6 CHIEF EXECUTIVE'S REPORT

The Chief Executive (Craig Black) presented the report and provided an overview of the key national and local developments, achievements and challenges that the West Suffolk NHS Foundation Trust (WSFT) is addressing at present.

The Trust received positive feedback from the Ockenden team and it was stated that the WSFT maternity team is showcasing good work around quality, culture and leadership to drive improvement to ensure the families using services are safe and well-cared for. A formal feedback report is expected to be received in the coming weeks which will be shared with the Board.

The Board noted that the second and final Ockenden Report has recently been published and contains a wide range of recommendations and requirements. Whilst some of these items are specifically for maternity services (and will best be managed through the Maternity Improvement Plan), many are relevant to the organisation as a whole.

Action: To share the formal Ockendon report with the Board when received. **S Wilkinson**

2.0 CULTURE

2.1 PEOPLE AND OD HIGHLIGHT REPORT

The Executive Director of Workforce & Communications (Jeremy Over) commended the report and drew the Board's attention to the 'Putting You First awards (April/May)' nominations, Quarterly report to the Board from Freedom to Speak Up Guardians, Staff Survey 2021 and Consultant appointments.

A reference was made to extend the scope of 'Putting You First Awards' to recognize the efforts of those who contributed towards making alliance between the Trust and community possible and how it can be linked to the Trust Strategy.

The Board emphasised the need to build relationships with the wider system and it is timely as the alliance governance is being reshaped on various fora where this can be discussed and developed.

ACTION: To consider a regular and more responsive way on how the horizon of these awards can be expanded to alliance working with the community to recognise staff across the alliance and be linked to the Trust Strategy. **J Over**

JO provided an overview of the Staff Survey 2021 and highlighted the following:

- The survey was undertaken across England following eighteen months of working during a global pandemic. The results at a national level appear to reflect the impact of this with unprecedented reductions in average scores as compared with the previous year. It is likely that most if not all Trusts have experienced a deterioration in their scores.
- The situation at West Suffolk reflects the national position, with the majority of scores reducing at a similar level to the national average. There are a number of measures where the reduction is more pronounced, and a number that have fared better as compared with the national average.
- Overall, the 9 key measures for the survey show that WSFT compares favourably to the national average. One of the 9 measures is equal to the national average, the other 8 are better than the national average. None are below the national average, although there are certain component scores that contribute to these 9 measures that are weaker.
- The key focus area for the Trust is related to speaking up.
- There remains a continuous focus on key areas of improvement through the Involvement Committee and there is alignment with the OD plan priorities and the actions within that will continue the themes of staff engagement and staff support.
- Rising levels of staff turnover is another NHS wide problem which has affected the WSFT as well but not as much as to other Trusts. There is a need to think about how staff retention can be improved by focussing on dealing with stress and burnout and by providing good quality peer support and line management to make staff feel valued.

The Board noted that the Involvement Committee has an oversight of the focus areas and recommendations made as actions to deep dive into specific themes and trends to mitigate the gaps. The team is working with the specific leaders and groups to focus on hotspot areas of concerns. There is also a need to develop better ways of getting detailed data from the patients as at present the data received from patients is very anecdotal and small in volume. It was stated that patient feedback surveys are extended to look into how learning from peer organisations can be brought together to improve the overall patient safety and experience.

2.1a FREEDOM TO SPEAK UP GUARDIAN

The Freedom to Speak Up Guardian (Amanda Bennett) presented the Quarter 4 2021-22 report and drew attention of the Board to the following:

- The number of concerns raised with the guardians has consistently increased over the past 4 quarters, rising to 35 concerns in Q4. FSUGs continue to promote Freedom to Speak Up, expanding the Champions network presenting at team meetings and the staff briefing.
- Common themes from feedback in Q4 included relationship with managers, staffing levels / shift allocation, equality and inclusion, etc.
- There is a need for continuing education and support for managers. The Guardians are working to improve the culture of speaking up throughout the Trust. Actions are categorised under 8 key workstreams.

- A network of Members of East of England FTSU Guardians has been established and WSFT FSUGs have attended quarterly meetings. NGO GAP analysis is being carried out. The team is working with the Associate Medical Director (Patient Safety) in all concerns raised with an element of patient safety.
- The National Guardian's office has commissioned a new e-learning package with 3 training modules 'Speak Up, Listen Up, Follow Up'. The first module 'Speak Up' is a core training module which is mandatory across the Trust, including senior leaders' training.

Action: The Board needs to complete senior leaders' training around 3 modules. "Follow up" training is also now available for Senior leaders. It is highly recommended that all board members, senior leaders and governors undertake this training. **J Over**

It is important that the culture of speaking up is promoted/advertised across the Trust and assurance to the staff of being heard which can be achieved with the three-step model of 'Speak up, Listen up and Follow up' from the National Guardian's Office. The feedback is crucial which can be facilitated through dialogue and proper explanation, even if the concern cannot be resolved at the time it is raised.

The Board requested that in future one of the FSUP Champions attend a Board meeting to share details of their role and experience of the work they do. It was suggested that this be proposed to the Involvement Committee in the first instance and appropriate consideration be given to the discussion before it comes to the Board.

The Board thanked the FSUGs for the work undertaken to improve the relationships between FTSUG and senior leaders which has enabled open discussions and dissemination of learning throughout the organisation.

3.0 STRATEGY

3.1 FUTURE SYSTEM BOARD REPORT

The Chief Executive (Craig Black) presented the report and updated that following the successful submission of the outline planning application, the Local Planning Authority has launched formal consultation on the plans to build a new hospital on Hardwick Manor. Consultees include in excess of 3000 households and statutory organisations.

CB informed that the main area of concern raised by the public focuses on highways, traffic management and the impact of the new build on biodiversity. The New Hospitals Programme (NHP) has committed to support the successful completion of the planning application and a funding plan / budget has been agreed.

CB also stated that a prioritised schedule of when individual schemes within the NHP can expect to commence construction is expected to emerge from a further presentation to the Major Projects Review Group planned for October. This list is expected to reflect the unique challenges faced by RAAC hospitals.

It was explained that there will be standardisation in templates for key construction elements with a common approach to demand and capacity modelling to ensure construction largely happens in a consistent way but with a flexibility to configure some elements as per the specific needs of the Trust.

A query was made around transformation and working across the Integrated Care System and if the future report includes an update around clinical workstreams,

implementation of the transformational changes and its implications on GP surgeries, community hubs, diagnostic centres, etc.

Action: Future report to include an update around clinical workstreams, implementation of the transformational changes and its implications on GP surgeries, community hubs, diagnostic centres, etc. **G Norgate**

The Board noted the Future System Programme Board report.

4.0 ASSURANCE

4.1 INSIGHT COMMITTEE REPORT – April & May 2022 – Chair's Key Issues

The Insight Committee Chair (Dr Richard Davies) presented the report and said that this was the first meeting of the Insight Committee with its new scope and there was a recognition that the previous 3i structure risked work duplication and uncertainty around ownership of issues. The Insight Committee now focuses on Finance & Workforce, Patient Access and Corporate Risk.

RD mentioned that the committee needs to be more data driven and it is important that the Committee provides assurance to the Board and the Council of Governors regarding the processes through which specialist subgroups and departmental Performance Review Meetings (PRMs) analyse and escalate Trust data.

The interim IQPR is evolving. The current iteration was reviewed and received very positively. More work needs to be done to provide assurance around IQPR developments. One of the issues that was regularly discussed by this committee was the ongoing pressures on access targets, although plans were in place to mitigate risks.

There have been some improvements over the past month within ED 12 hour waits, Cancer 2WW performance and in the 104 day wait position. There are still concerns regarding diagnostic performance particularly CT and MRI.

RD further drew attention of the Board to the Sustainability Programme and explained that the new approach focusses on sustainability rather than cost improvement with an expectation that this will necessarily drive quality improvement and cost saving. This significant change in focus requires a radical culture shift across the organisation. There have been resultant delays in finalising budgets and processing business cases.

The Committee also discussed how Glemsford Surgery access and performance data feeds into the Trust governance and assurance processes. It was recognised that teams within the acute Trust have limited experience of understanding GP access and performance data which means that visibility of this data within the Trust and support for the Surgery has not been as effective as it could be. A review of how Glemsford Surgery fits into the Trust governance processes will be brought back to Insight.

The Board noted the concerns around the quality of data available across the organisation and its impact on supporting the decision making. The Board advised that the executive team collectively looks into how the quality of data can be improved and if additional support or resources are required, a proposal is brought to the Board for consideration.

4.2 FINANCE AND WORKFORCE REPORT

The Interim Executive Director of Finance (Nick Macdonald) presented the finance report and reported that income and expenditure for April was breakeven and after

assessing the available guidance around activity plans, workforce plans and regulatory requirements the Trust has set a budget of break-even for 2022/23. This position does carry with it a number of risks such as ongoing impact of Covid on capacity and operational capability, impact of inflation, RAAC programme and winter pressures.

NM stated that at present, it is anticipated that there are sufficient mitigations to be able to offset these risks. A key part of these mitigations is identifying opportunities to remove additional costs of Covid wherever possible and developing, embedding and delivering a robust sustainability programme.

The Board noted that the cash position remained strong, however, there has been a slight decrease in April as a number of creditors were just after the year end. Cash flow forecasts continue to be submitted to NHS England every fortnight to ensure that adequate cash reserves are being held within the NHS.

It was clarified that the achieved targets for the divisions are against the regional plan. Also, a forecast to achieve breakeven is based on the assumption that a funding of £7m, out of which £4m has been received through central funding and remaining £3m will be internally funded.

Action: A request was also made to add information around the sustainability programme and it was informed that the future reports will include an update on Central Savings Target and sustainability programme. **N Macdonald**

4.3 INTEGRATED QUALITY AND PERFORMANCE REPORT IQPR – MARCH 2022 DATA

The Chief Operating Officer (Nicola Cottington) and Executive Chief Nurse (Sue Wilkinson) presented the IQPR and highlighted the following:

- Patients waiting up to 47 weeks for wheelchairs due to cancellations as a result of Covid, and it has been that identified additional resource is required and a business case will follow.
- In March, 438 patients were in the emergency department for more than 12 hours against a target of 0, due to increased attendances and difficulty with flow out of the department to wards. A range of actions are planned to create better flow including implementing Criteria to Admit and increasing Same Day Emergency Care (SDEC). Monitoring is via the Patient Access Governance Group, Urgent and Emergency Care Steering Group, Insight Committee and Board, and also at Alliance and ICS Urgent and Emergency Care meetings.
- There were 268 patients waiting over 104 weeks for an elective procedure at the end of March 2022, just over the revised trajectory of 265. Recovery plans are in place including weekend lists, use of the independent sector and mutual aid across the ICS.
- WSFT are predicting to have 0 patients waiting over 104 weeks at the end of June 2022. Performance is monitored at Patient Access Governance Group, Insight Committee and Board, and also at ICS level weekly hub meetings and the Suffolk and North East Essex SNEE Recovery and Restoration Board.
- There has been no significant improvement in two week wait performance for cancer with breast symptomatic pathway significantly below the standard. A full recovery plan is in place for all cancer metrics.
- Performance against improvement trajectories is monitored at weekly Cancer PTL meetings, Cancer Board, Insight Committee and ICS Cancer Board.

- Covid positive patients are relatively high in the organisation, within the region and nationally. They are from ward outbreaks and the Trust is managing them in line with instant management team meetings within the organisation and the region. The CCG is fully supportive of the way the situation is being managed.
- In March, patient falls went up above the national average, mainly due to staffing levels, but they have now returned to normal levels within April. Work continues on how to mitigate patient falls.
- There is a robust system around Patient Safety Incidents and the incidents are reviewed weekly by the emerging Instant Review Panel. The reviews are very inclusive and transparent with all those involved, including patients and service users.
- Work is in progress around duty of candour, but even if a formal duty of candour is not required, it is encouraged to be open and transparent with the patients and service users. It is important to see some pace in the improvement of duty of candour and how it can be delivered in a more qualitative way.

A query was raised on what is being done in terms of communication with the public on the waiting lists. The Board was informed that regular updates to GPs are provided directly through the website and direct communication about general waits and specific issues. There are mechanisms in place to contact individual patients about their way through to a doctor and through written communication. A number of pilot initiatives have been introduced to improve communication with the waiting patients.

The Board noted that Paediatric Community Standards were raised as a concern, particularly in relation to the ASD (Autism Spectrum Disorders) pathway for school age children, but also for paediatric speech and language and clinical psychology services. A recovery plan agreed with the CCG is being hampered by difficulties in staff recruitment.

Action: Present a report to the appropriate Board sub-committee to provide an assurance that actions are being taken or will be taken in future to improve Paediatric Community Standards and to include an update in the IQPR. — **S Wilkinson/ N Cottington**

An update on pressure ulcers was also provided and it was explained that an improvement plan in relation to the PUs is presented to the Improvement Committee which oversees the delivery of the plan.

Action: An update on PUs to be shared with the Board at the next meeting. — **S Wilkinson**

4.4 PATIENT STORY

The Executive Chief Nurse (Sue Wilkinson) informed the Board that the patient has recorded her experience and expressed thanks and gratitude for the good care that she received for the maternity services at the WSFT.

The Board noted the patient story and thanked the patient for sharing their experience.

4.5 IMPROVEMENT COMMITTEE REPORT – April & May 2022 Chair's Key Issues

The Trust Chair and Improvement Committee Chair (Jude Chin) commended the report and asked the Board to formally approve the proposal for decommissioning IPB (Improvement Programme Board) as part of the transition of the improvement committee operating as a board assurance committee.

The Board noted the report and approved the decommissioning of IPB.

4.6 MATERNITY SERVICES QUALITY & PERFORMANCE REPORT

The Head of Midwifery (Karen Newbury) presented the report and drew attention of the Board to the following:

- Final Ockenden report has not been received yet, however, the high-level feedback is very positive.
- The Safety Champion Walkabout took place on the 14th April 2022 and various concerns were raised. The HoMw is currently looking at all aspects of midwifery staffing in view of the latest Ockenden report.
- There has been a review of the sustainability of the continuity of carer teams whilst the midwifery vacancy rate remains high. The final Ockenden report which gives further recommendations about this and details of proposals for further roll-out or delays were presented to the Board.
- In addition to the Freedom to Speak up Guardians, Safety Champions, Professional Midwifery Advocates, Unit Meetings and 'Safe Space' volunteers have now come forward to participate in focus groups to take ideas forward that arose from the last midwifery staff survey late last year. The focus groups will also be planning the Maternity Listening Event as recommended by the Ockenden final report

The Board asked if some support was needed to achieve compliance around the Clinical Negligence Scheme for Trusts (CNST) Maternity and if there was a process in place to receive assurance that the data around Swab Count Compliance was accurate. It was noted that CNST non-compliance was around the training aspect and MDT attendance at each training session. Whilst this has improved, further improvement was required so that each session was an MDT. Whilst quality of data from attendance reports and training databases has improved, there are still gaps in training records on the training databases. There are some software issues in the system which need to be addressed. In terms of Swab Count Compliance, the process was explained and noted that the data around Swab Count Compliance is affected by the process to capture the swab counts.

A discussion took place around how service collaborations with other providers in the region would improve shared learning to get the system right at the Trust and it was advised that there was a sharing forum where incidences, learning data, QI projects, etc, were shared with the alliance to ensure stronger relationships, better communication and learning.

A query was raised with regard to the position on Midwives in post 2022, which set out the challenges at a national level in relation to supply and it was asked if a trajectory could be put in place over a long period of time to track the status. KN informed the meeting that as part of the next steps a Birthrate Plus review will be undertaken. A revised trajectory for achieving roll out of all 8 teams will be submitted so that Midwifery Continuity of Carer MCoC becomes the default model of care by end March 2024. Further there are 8 International Midwives in the pipeline but due to delays in their visas they are unlikely to be in post until the summer at the earliest.

The Board were cognisant of the fact that the right funding was required to make the service improvements, not necessarily internally but also from the national team.

4.7 QUALITY AND NURSE STAFFING REPORT

- The Executive Chief Nurse (Sue Wilkinson) presented the report and highlighted the following: Average RN fill rates remain under 90% since October 2021 They have remained static this month following preceding months of decline.
- Following a further peak in sickness in February, sickness rates have fallen for both RNs and NAs in March and April.
- For this reporting period an additional ward was reopened to enable flow through the emergency pathway and to address significant capacity challenges. This was supported by the current nursing establishment. The ward was opened on 17th March following significant operational pressures and closed on the 28th April.
- Falls per 100 bed days exceeded the national average in March with a high point of concern seen within the SPCs. This returned to levels normally observed in April and below national average (per 1000 bed days). This is driven in part by patients with multiple falls and potentially the shortfall of nursing staff that has been experienced.
- Both March and April saw a reduction in pressure ulcers within the acute setting, however the increasing trend continues, following positive reductions seen prior to the previous months.
- The team has managed to secure funding to continue with the nurse specific and AHPs recruitment. A lead for nursing is being recruited.

The Board noted the workforce and sickness level related issues which have been prevalent over the last few years and emphasised that it was important to have such discussions at Board level to seek assurance on such matters.

4.8 INVOLVEMENT COMMITTEE REPORT – May 2022 Chair's Key Issues

The Deputy Chair and Chair of the Involvement Committee (Alan Rose) presented the report and drew attention of the Board to the following:

- Good assurance was received, but some focus to be given to improving feedback on and measurement of quality of education and training.
- Assurance was given to the Board that the Trust is ready to enact, but raised concern about the impact of the approach on future vaccination programmes.
- Good assurance of activity, but it was queried whether staff networks need the investment to develop further. There was a concern as to whether enough attention is being paid to support the whole range of EDI initiatives.

5.0 GOVERNANCE

5.1 BOARD ASSURANCE FRAMEWORK (BAF) SUMMARY AND RISK REPORT

The Trust Secretary (Richard Jones) presented the Board Assurance Framework and reminded that the Board had approved its risk appetite statement at the October meeting, following which the BAF risks were reviewed individually with the executive team during November 2021. BAF and red risks are allocated to Board governance committee for oversight. The process to manage and maintain this oversight is currently under review.

RJ informed that the Board assurance committees will update the Board at every meeting when they will receive updates on any of the BAF strategic risks. The BAF risks have been allocated to the relevant assurance committee and governance/specialist group. The templates are being developed which will be used

for reporting into the assurance committees to support that work and will including consideration of escalation of risks.

The Board noted that the original RAAC work programme was scheduled and had assumed that three decant wards would be available during the summer (April to September) and two decant wards over winter (October to March). Unfortunately, over recent weeks the programme has been working with just one decant ward due to operational pressures and capacity issues. Planning is now in place to deliver the programme with two decant wards by May 2024.

The Board recognised that there was a need to take into consideration various risks based on the fact that there were some based on external factors beyond the organisation's control and further how these residual risks can be brought down to a resilient risk of lower rating.

5.2 GOVERNANCE REPORT

The Board received and noted the content of the report.

The Board was asked to provide delegated authority to the Improvement Committee to approve the Annual Quality Accounts.

The Board continues to work with Integrated Development on a programme to support a model of working. A session took place on 8th April, with two further sessions planned for the year.

It was informed that the stage 1 meetings were held with the Chair candidates on 5th and 9th May. As a result, three candidates have been identified for stage 2 interviews and stakeholder events. Interviews will take place on 23 June 2022. The Governors, staff and partner organisations are invited to participate in the stakeholder panel.

6.0 OTHER ITEMS

6.1 ANY OTHER BUSINESS

There was no further business.

6.2 REFLECTIONS ON MEETING

- The discussions demonstrated greater depth and exploration of issues which was positive.
- It would be good idea to receive feedback from everyone attending and presenting at a Board meeting
- It was a good meeting and a sense of a unitary board approach. Much more integrated and independent conversation.

6.3 DATE OF NEXT MEETING

Friday 22 July 2022, 9.15am

RESOLUTION

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

1.4. Action log and matters arising

To Review

Presented by Jude Chin

Board meeting - action points

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
2029	Open	25/3/22	1.5	Staff story: consider staffing levels in community services at a future board meeting.	**Information captured and further work being undertaken.**	SW	22/07/22	Green	
2031	Open	25/3/22	2.1	West Suffolk Review ODP:consider how board members would implement cultural changes through their own behaviour and interactions and how they would get feedback on this in practice.	**Executive director 360 feedback exercise completed this month. NED 360 agreed at COG meeting on 18 May. To be completed by the end of July.** **WMTY2 to define behaviours (inc. leadership behaviours) that reflect FIRST values.**	JO	22/07/22	Green	
2040	Open	27/5/22	2.1	To consider a regular and more responsive way on how the horizon of these awards can be expanded to alliance working with the community to recognise staff across the alliance and be linked to the Trust Strategy	**Work is ongoing.**	JO	22/07/22	Green	
2041	Open	27/5/22	2.1	The Board needs to complete senior leaders' training around 3 modules. "Follow up" training is also now available for Senior leaders. It is highly recommended that all board members, senior leaders and governors undertake this training.	**An update is provided in the Freedom to Speak Up report in the 'Culture' section of today's agenda.**	JO	22/07/22	Green	
2044	Open	27/5/22	4.3	Present a report to the appropriate Board sub-committee to provide an assurance that actions are being taken or will be taken in future to improve Paediatric Community Standards and to include an update in the IQPR.	**Report provided to Insight committee 4th July, and referenced in CKIs from Insight. Improvement trajectory to be presented to August Insight, also recognising system element of issues.**	SW/NC	22/07/22	Green	

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

Board meeting - action points

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
2039	Open	27/5/22	1.6	To share the formal Ockendon report with the Board when received	**Actioned.**	SW	22/07/22	Complete	22/07/2022
2042	Open	27/5/22	3.1	Future report to include an update around clinical workstreams, implementation of the transformational changes and its implications on GP surgeries, community hubs, diagnostic centres, etc.	**Today's report (22.7.22) refers.**	GN	22/07/22	Complete	22/07/2022
2043	Open	27/5/22	4.2	To add information around the sustainability programme and it was informed that the future reports will include an update on Central Savings Target and sustainability programme.	**Today's (22.7.22) agenda item (Strategy) refers.**	NM	22/07/22	Complete	22/07/2022
2045	Open	27/5/22	4.3	An update on PUs to be shared via the improvement committee at the next Board meeting	**Today's (22.7.22) agenda item refers.**	SW	22/07/22	Complete	22/07/2022

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

1.5. Patient story

To Note

Presented by Susan Wilkinson

1.6. Questions from Governors and the Public

To Note

Presented by Jude Chin

1.7. Chief Executive’s report

To inform

Presented by Craig Black

Board of Directors – Friday 22 July 2022

Report Title:	Item 1.7 - CEO report
Executive Lead:	Craig Black
Report Prepared by:	Samuel Green
Previously Considered by:	N/A

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

Executive Summary
This report provides an overview of some of the key national and local developments, achievements and challenges that the West Suffolk NHS Foundation Trust (WSFT) is addressing. More detail is also available in the other board reports.
Action Required of the Board
For information

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

Ongoing pressure

There is currently immense pressure on our services, and this is taking a toll on our staff.

With Covid-19 resurging, and the ongoing estate maintenance programme impacting our capacity, our colleagues are now also being put under pressure due to an increase in demand for our services, partly due to the recent spell of warm weather.

In response, last week, we declared a critical internal incident. Following no improvement in the situation at the Trust or others in the region, and a growing number of staff members being unable to work due to Covid-19, this incident was extended.

We have, and will continue to do everything in our power to mitigate this pressure, including working with external partners to support discharges and using bank and agency staff to fill gaps in staffing to maintain our current service level.

We recognise, and continue to be amazed by the unbelievable commitment our staff have showed through this period, and we will work to support them to ensure that they and our patients are cared for.

None of this is easy for staff and I am urging staff to take up our wellbeing opportunities and look after themselves, and to speak up should you have any growing concerns or ideas you would like to raise.

Waiting times

As you may have seen, waiting times is a topic that has received much attention in the media.

We continue to make every effort possible to treat patients as quickly and safely as possible; prioritising those with the greatest clinical need. We are also continuing to work collaboratively with local health partners in the region to ensure those who have experienced the longest waits are given the option to receive treatment at another Trust. We ourselves have treated patients from other Trusts, demonstrating the benefits of joint-working.

I am pleased to report that as a result of our efforts, the number of patients waiting 104 weeks or more has dropped significantly. This has now fallen from 411 in February to 39 as of 5 July 2022. Of these 39 patients, 23 have opted to wait to be treated at the Trust, and 16 patients are currently unable to receive treatment due to clinical reasons.

We are also running extended theatre lists and clinics, including at weekends; increased diagnostics to support timely access to scans; and offering digital appointments where appropriate – all to try to treat patients as soon as possible.

Launch of the Suffolk and North East Essex Integrated Care System

On Friday 1 July, the board of the new Suffolk and North East Essex Integrated Care System (SNEE ICS) was launched. This represents a new chapter for the NHS, where local health and care partners, such as NHS Trusts, GP teams, local authorities and the voluntary sector will be encouraged to work more closely together. This new approach will ensure those in our communities get the best possible care, in the right place and at the right time.

To mark this occasion, our ICS held the CanDo Health and Care Expo 2022 at Newmarket Racecourse, where I was pleased to see so many health and care colleagues in attendance.

We have been developing this approach over several years, but the changes will ensure decisions on health and social care are properly joined up, strengthening and building upon ongoing collaboration, improving the quality of decision-making and the services provided. I believe that our continued commitment to this approach will enable us to make further progress in our ambition to provide personalised and empathetic care to those in our communities.

I will represent the Trust on the Suffolk and North East Essex Integrated Care Board, which gives us a greater voice in how decisions are made in regard to health and care in the region. I look forward to progressing this with our health and care partners to ensure effective collaboration between various aspects of the health, care, social care and voluntary sectors so that we can reduce health inequalities in the region.

East Coast Pathology Network

Alongside East Suffolk and North East Essex NHS Foundation Trust (ESNEFT) and Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH), the Trust has joined the newly formed East Coast Pathology Network. The aim of the network is to bring together regional pathology services to work collaboratively to share best practice; provide a service fit for the future; and work together to address the significant increase in demand for services to benefit local communities. This is an exciting new partnership with the first network strategy workshop due to take place in August and recruitment beginning to take place for the network's lead roles.

CQC inspection of Glemsford

The Care Quality Commission is currently inspecting Glemsford Surgery. We are doing everything we can to support the team at the surgery and will continue to do so throughout the process.

As a Trust, we continually work to achieve the highest standards of care and safety for our patients and staff. We look forward to receiving the result of this inspection, and will take on board any opportunities for learning and improvement.

Launch of the new intranet

A project which forms part of our ambition to make ongoing digital improvements within the Trust, has recently been launched.

After 18 months of work and development, the new intranet is now up-and-running, providing staff with a modern, ergonomic and insightful tool that will help staff in their day-to-day working lives.

The new intranet contains information on what is going on around the Trust, and allows staff to more easily access the information they need to be as effective as possible.

We will work to continually improve this, so that it will become an increasingly helpful tool.

A celebration of our staff and the NHS

Despite this period of pressure, it is fantastic to still be able to celebrate the achievements of our staff.

A number of our staff members have reached incredible lengths of service. Marion Rolph, a nursery nurse within West Suffolk Hospital's neonatal unit, was recently awarded her 45-year long-service badge. Marion has been caring for women and babies locally for 48 years, which is an astonishing length of time to serve the community. While this is an astonishing achievement, what is truly exceptional is the high regard Marion is held in by patients, families and colleagues alike, which I believe is truly inspiring.

In honour of Mike Bone - the chief information officer at the Trust who sadly passed away in January 2021 - the Suffolk and North East Essex Integrated Care System has created a unique programme to develop talent in digital, data and technology roles. Following the submission of applications earlier this year, I am delighted to say that Josh Wigley, Peter White and Graham Mason from the Trust's digital services team have been awarded places on the Mike Bone People Potential Programme. This will bring together academic and technical learning, whilst utilising mentoring and development opportunities from within the ICS, and partner suppliers. I wish all three of our colleagues the best of luck.

In recognition for our work during Covid-19, Her Majesty the Queen has awarded the NHS the George Cross. This is only the third time that a George Cross has been awarded to an organisation rather than to an individual. I hope all staff recognise this award as testament to their ongoing professionalism, dedication and steadfastness in serving their communities.

On 5 July, the NHS celebrated 74 years of continuous service. This represents almost three-quarters of a century of providing world-leading healthcare to both West Suffolk, and the nation as a whole. While the NHS has adapted and changed much since 1948, we look forward to carrying on innovating and improving the standard of care into the future. By doing so, we can continue helping our local communities throughout their lifetimes.

2. CULTURE

2.1. People & OD highlight report

To Assure

Presented by Jeremy Over

Board of Directors – Friday 22 July 2022

Report Title:	2.1 - People & OD Highlight Report
Executive Lead:	Jeremy Over, Executive Director of Workforce & Communications
Report Prepared by:	Amanda Bennett, Freedom to Speak Up Guardian Carol Steed, Deputy Director of Workforce (OD & Learning) Jeremy Over, Executive Director of Workforce & Communications
Previously Considered by:	N/A

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

Executive Summary
The People & OD highlight report was established during 2020-21 as a regular report to strengthen the Board's focus on how we support our people, grow our culture and develop leadership at all levels. This format will continue to be developed, alongside the CKI report from Involvement Committee, to reflect the work that is ongoing, bringing together various reports that the Board has routinely received into one place. In addition to discussing the content of the report, and related issues, continued feedback is welcomed as to the structure and content of this report and how it might be developed in future. This month the report provides updates on the following areas of focus: • Putting You First awards (June/July) • Quarterly report to the Board from our Freedom to Speak Up Guardians • Development of our Learning and OD capacity (and mandatory training update) • Quarterly Staff Survey 2022/23 (Q1) headlines
Action Required of the Board
For discussion and noting

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

Putting You First – June/July awards

Elizabeth Flett
Nominated by Della Chubb

I am the service lead of the Suffolk Communication Aids Resource Centre (SCARC). I would like you to consider a nomination for Liz Flett – SCARC Highly Specialist Speech and Language Therapist. Liz has been supporting a little girl as part of our mainstream outreach service since 2019 providing regular Speech and Language Therapy (SALT). She has supported E, who is a communication aid user, to integrate her communication aid into all environments. This September E is transitioning to a special school and thus, Liz's support with E will come to an end.

I really do feel this award would be a fitting recognition of Liz's hard work in supporting the journey of communication aid users across Suffolk including E.

Speak Up Report

Our Freedom to Speak Up Guardian, Amanda Bennett, has shared her quarterly report (Q1, 2022/23) which is attached as **appendix 1**. This reflects the learning, influence and experience over the past quarter, and advice to the Board. Amanda will be in attendance to present and discuss her report at our meeting on 22 July.

Colleagues will note the significant theme of concerns highlighted by Amanda that relate to *staffing*, the associated pressures, and the impact on colleagues and teams. Executive directors have scheduled further discussions about this at their meeting on 20 July and a verbal update on our collective reflections and response will be summarised at Board. More importantly, we will agree how best to ensure staff are aware of our appreciation of these concerns and how we are responding. From discussion with Amanda, her challenge to us as a Board is as follows: ***"What can you do to ensure that a health care assistant, nurse, midwife or AHP knows that you are listening and taking action on the concerns raised around short staffing?"***

Development of our Learning and OD capacity

In support of the OD plan, and in particular in response to embedding our strategy and living our values; investing in and transforming HR services; and supporting leaders, managers and staff to be part of a more authentic and positive culture; a full review of the learning and organisational development portfolios at WSFT is underway – led by Carol Steed who has recently joined as our new deputy director of workforce for OD & Learning.

In consultation with key stakeholders, a full business case will be developed for the expansion of provision across a range of critical areas including:

- Leadership and management development
- Coaching and mentoring
- Apprenticeships
- Individual and team development support
- Diagnostics (360's etc.)
- New leader, manager and staff induction
- On line and eLearning support and tools
- Career development and succession planning

Alongside this a health, wellbeing and inclusion workplan is being developed to consolidate and grow activities in these areas, including the revitalisation of staff networks. Work to improve compliance with mandatory training is also being prioritised, with full review of the end-to-end process planned.

In addition, a pilot has been undertaken across the Workforce and Communications directorate to start team-based conversations about how the Trust values translate into behaviours, and what actions we need to collectively take to live our values. Once reviewed, a wider roll out may be considered, with potential for the results to be collated into a behavioural framework for the Trust.

Appendix 2 provides the Board with an overview of the latest performance indicators for mandatory training. These demonstrate a gradually improving position overall, (89% compliance), with a focus on where we stand divisionally and by staff group. It is notable that if we were able to close the compliance gap for medical staff, this would enable the overall Trust to meet its target level.

Quarterly Staff Survey (2022/23 Q1)

In addition to the annual NHS staff survey a shorter, quarterly survey is run across the service in England. The results provide an opportunity to understand our current position and maintain and build our focus on the experience of our people. The quarterly survey is built around three themes (each with three questions), to form an overall engagement score.

The results of the three most recent quarterly surveys are shown in the table below:

Section	Description	NQPS Q2 21/22	NQPS Q4 21/22	NQPS Q1 22/23
Advocacy	Would recommend organisation as place to work	7.00	6.93	6.73
	If friend/relative needed treatment would be happy with standard of care provided by organisation	7.40	6.95	7.26
	Care of patients/service users is organisation's top priority	7.00	6.35	7.69
	Advocacy overall	**7.40**	**7.23**	**7.23**
Involvement	Able to make suggestions to improve the work of my team/dept	6.90	7.69	6.94
	Opportunities to show initiative frequently in my role	6.80	6.74	6.92
	Able to make improvements happen in my area of work	6.30	7.27	6.35
	Involvment overall	**6.70**	**6.74**	**6.74**
Motivation	Often/always look forward to going to work	6.30	6.29	6.28
	Often/always enthusiastic about my job	7.20	7.17	7.16
	Time often/always passes quickly when I am working	7.40	7.54	7.54
	Motivation overall	**7.00**	**7.00**	**7.00**
Staff Engagment Score		**7.00**	**6.99**	**6.99**

NB: a quarterly survey is not run in Q3 as this is when the full national staff survey is carried out. Therefore, these results represent a 12-month period.

Headlines:

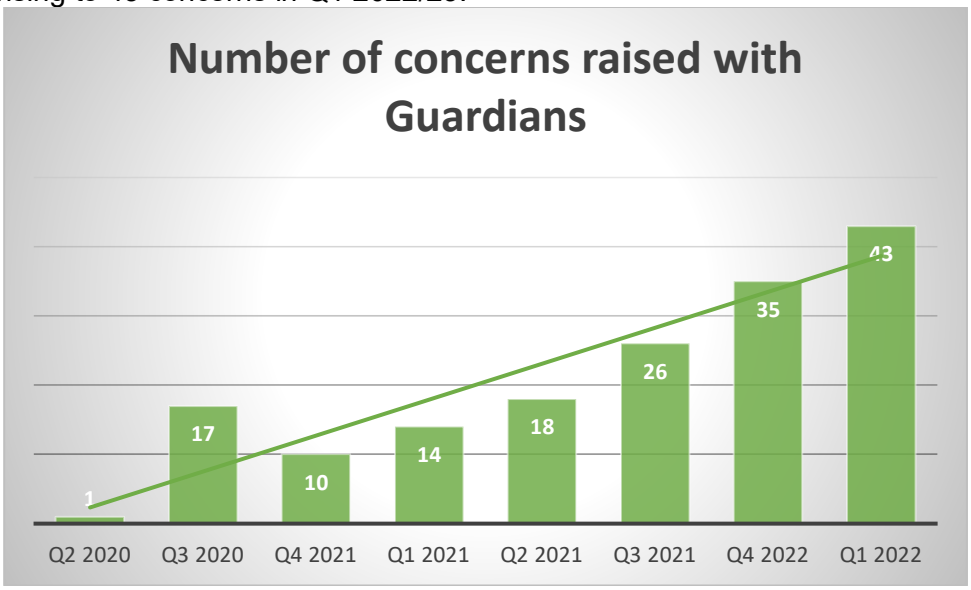
- The overall staff engagement score has remained static over the course of the year. The WSFT score for staff engagement for the full survey in Q3 was 7.0. (The acute and community trust average for this score in the most recent full national survey was 6.8)
- There has been a reduction in the “recommend as a place to work” score in Q1.
- There are notable improvements in the two advocacy scores related to patient care.
- Overall motivation and involvement scores remain unchanged.

These results will be presented for further discussion and analysis at the next meeting of the Involvement Committee of the Board.

Appendix 1: Freedom to Speak Up: Guardian's Report Q1 2022: July 2022

Introduction

The number of concerns raised with the guardians has consistently increased over the past 5 quarters, rising to 43 concerns in Q1 2022/23.



James has now left and Amanda has increased her hours to cover. Amanda continues to promote Freedom to Speak Up and manage concerns. She is supported by a network of 47 champions.

Data

Data due to be submitted to NGO for Q1 2022	
Number of cases brought to FTSUGs per quarter	43
Numbers of cases brought by professional level	
Worker	34
Manager	4
Senior leader	1
Not disclosed	4
Numbers of cases brought by professional group	
Allied Health Professionals	2
Medical and Dental	1
Registered Nurses and Midwives	12
Nursing Assistants or Healthcare Assistants	6

Corporate Services	0
Administration, Clerical & Maintenance/Ancillary	11
Not Known	9
Other	2

Of which there is an element of

Number of cases raised anonymously	7
Number of cases with an element of patient safety/quality	14
Number of cases with an element of bullying or harassment	11
Number of cases with an element of inappropriate attitudes or behaviours	10
Number of cases with an element of worker safety or wellbeing	29
Number of cases where disadvantageous and/or demeaning treatment as a result of speaking up (often referred to as 'detriment') is indicated*	0

Themes from Q1

Themes seen in previous quarters continue to dominate as concerns, the most significant being staffing concerns. Patient transport, poor relationships with managers and fear and actual harm from patients (lacking capacity) are also continuing themes.

Although no staff have reported suffering detriment as a result of speaking up with a concern in this quarter, general feedback from when some colleagues have raised concerns (via the Guardian and in other ways) indicate that improvements are required to build and maintain trust in the speaking up process.

Staffing concerns

In total 12 concerns related to staffing concerns. In addition, the Champions have raised staffing as a key concern. Staffing is a particular concern from NMC registrants, Allied Health professionals and health care support workers (although not limited to this group). Below are the voices (direct quotes) of staff members and champions:

"When I visit the nurses I just see broken faces…staff are broken"

"People don't want to talk anymore, they just want to cry"

"If I could say something to the Board it would be "Stop moving staff"

"…All I got told is that they have to ensure the service is safe and able to offer the service to the public…but what about the staff?"

(Champions Feedback)

"…We work long, extremely busy shifts but it's just considered normal…it is not right. It's an endless cycle and we feel completely discouraged." (newly recruited nurse)

"I see the majority of my team are close to burn out…I really don't know how much longer things can continue like this…"

"*I understand there is a shortage of midwives but it breaks my heart to see the members in my team struggle with the stress of this job...I am not blaming [managers/leaders]…I do not know what to do"*

(Staff concerns)

Concerns with Speaking up

Feedback has been given indicating that some people have had a poor experience when speaking up. In two separate cases, where people spoke up in confidence, it was reported that the managers were then asking and wishing to find out who had spoken up making the individuals very uncomfortable. Another case reported that the individual was "told off" by their manager for "going about their heads" and another where staff felt discouraged from raising any points or suggestions as these were taken a personal offence from the senior staff. In a further case, the person Speaking up was criticised or doing so.

Summary of learning points

- There is a need for increased feedback / wider communications to staff at all levels to show how suggestions are being responded to and how staffing levels are being improved
- There is a need for continuing education and support for listening and responding to concerns
- Anxiety and stress is caused by reallocation of staff, both of those moved and those left behind to cope.

The Guardians are working to improve the culture of speaking up throughout the WSFT. Our actions are categorised under 8 key workstreams:

Workers throughout the organisation have the capability, knowledge, and skills they need to speak up themselves and to support others to speak up.

What's going well:
- Promotion and training continue to be given across the Trust
- Increased visibility by increasing the number of Champions and visits to departments by Guardian.

Even better if:
- Induction programme to be expanded with increased face to face conversations with new starters

Speaking up policies and processes are effective and constantly improved

What's going well:
- New FTSU policy and guidance available from NGO / NHSE.

Even better if:
- WSFT FTSU Policy to be updated and launched in October for Speak Up Month.

Senior leaders are role models of effective speaking up

What's going well:
- Quarterly meetings in place with senior leaders and FTSUG.
- "Follow up" training now available for Senior leaders. It was highly recommended that all senior leaders undertake this training. To access please follow this link to follow up training (and scroll to the bottom of the page). Senior leaders are asked to confirm completion of training and share any reflections on how to Improve FTSU by e-mailing: Amanda.bennett@wsh.nhs.uk

Even better if:

- Senior leaders responsible for FTSU to complete the new FTSU Reflection and planning tool (published June 2022)
- FTSU pledge to be established for Board (following training)

All workers are encouraged to speak up

What's going well:

- Increasing number of concerns raised to the Guardians and Champions active in teams
- On-line Champion's training developed and two group sessions undertaken
- Champions from variety of backgrounds trained e.g. International nurses, apprentices, Chaplain

Even better if:

- New posters distributed throughout Trust
- Culture continues to improve to enable psychological safety
- Access to virtual or physical suggestion boxes in teams

Individuals are supported when they speak up

What's going well:

- Individuals report feeling supported by the Guardians when raising concerns
- Guardians supported by senior leaders
- Many managers are promoting Speaking up and supporting their staff to Speak up; e.g. Guardian recently received very warm welcome and offered to visit their teams by housekeeping and portering managers

Even better if:

- "Listening to concerns skills" to be promoted to supervisors and managers via "Cascaded conversations" and FTSU e-learning.
- Increased promotion regarding Trust stance on protecting staff who speak up and a zero-tolerance approach to detriment as a result of speaking up

Barriers to speaking up are identified and tackled

What's going well:

- The difficulty faced by international staff in speaking up recognised and actions taken to try to overcome
- Face to face visits to staff who do not use computers to explain FTSU and introduce Guardian

Even better if:

- Increased transparency / openness regarding actions taken as a result of speaking up
- Enabling changes from the ground up e.g. Staff who are "doing the job" are consulted about how best to "do the job".
- People knowing that their voice results in action e.g. a barrier to speaking up being the belief *"Say what you like, nothing ever happens round here"*

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.

Even better if:

- In relation to inadequate staffing levels and staff exhaustion, Staff report feeling that “there is no point in speaking up because nothing changes”

Freedom to speak up is consistent throughout the health and care system, and ever improving

What’s going well:

- Continue to be members of East of England FTSU Guardian Network

Even better if:

- Adoption of updated NGO guidance in near future
- Find ways to work with ICS partners to improve FTSU

People and OD Report – Appendix 2

Table 2: Trust and divisional mandatory training analyses July 2022

Division	January 2022 % compliance	July 2022 % compliance	Red-rated subjects (less than 70%)	Change from January report %
Overall	89	89	Freedom to speak up (see below)	No change
Clinical Support	93	93	BPT (49%), CR (69%), MHC (67%), SGC L3 (0% n=2)	No change
Community	93	92	BPT (67%)	-1%
Corporate Services	89	88	CR (40%), MHC (61%), SGC L3 (25% n=4)	-1%
Estates & facilities	89	86	CR (23%)	-3%
Medicine	86	86	BPT (67%)	No change
Surgery	87	88	CR (68%), SGC L3 (0%)	+1%
Women and Children	93	91	None	-2%

Key: CR = conflict resolution; MHNC = manual handling non-clinical; MHC = manual handling clinical; BLS = basic life support; BPT = blood products and transfusion; SGC L3 = safeguarding children level 3

Table 3: staff group mandatory training analysis

	Jan-22 % compliance	Jul-22 % compliance	Change from Jan 2022 %
Add Prof Scientific and Technic	89	90	+1%
Additional Clinical Services	90	91	+1%
Administrative and Clerical	92	91	-1%
Allied Health Professionals	94	94	No change
Estates and Ancillary	87	84	-3%
Healthcare Scientists	97	96	-1%
Medical and Dental	76	77	+1%
Nursing and Midwifery Registered	91	91	No change
Students	69%	92	+23%

Freedom to speak up training was introduced as mandatory for all staff in December 2021 and compliance data is currently excluded from totals as including this new topic has a distorting effect on the overall compliance percentage. New requirements for some staff for moving and handling training are also excluded for the same reason. Overall progress with compliance for both of these subjects is given below.

Subject	January 2022	July 2022
Freedom to speak up – core training for all workers	24%	57%
Moving and handling clinical – level 2	94%	85%

2.2. Guardian of safe working report

For Report

Presented by Francesca Crawley

Trust Board – 22 July 2022

Report Title:	Item 2.2 - Safe Staffing Guardian Annual Report – April 2021 – March 2022
Executive Lead:	Paul Molyneux, Medical Director
Report Prepared by:	Francesca Crawley, Guardian of Safe Working
Previously Considered by:	

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

Executive Summary
The report is compiled by the Guardian of Safe Working Hours (GOSW), a role appointed as part of the new contract. The purpose of the report is to provide evidence of safe rostering and compliance with the TCS, to highlight any difficulties which have arisen, and to explain how they are being addressed.
Action Required of the Board
For information.

ANNUAL REPORT APRIL 2021 - MARCH 2022 ON ROTA GAPS AND VACANCIES:

DOCTORS AND DENTISTS IN TRAINING

This report covers the twelve month period (1st April 2021 – 31st March 2022 inclusive). During that time there have been quarterly reports from which this summary is drawn.

Introduction

This is the sixth annual report produced since the introduction of the 2016 Terms and Conditions of Service (TCS) for Doctor and Dentists in Training by NHS Employers. Full details of this contract are to be found here: http://www.nhsemployers.org/your-workforce/need-to-know/junior-doctors-2016-contract

The report is compiled by the Guardian of Safe Working Hours (GOSW), a role appointed as part of the new contract. The purpose of the report is to provide evidence of safe rostering and compliance with the TCS, to highlight any difficulties which have arisen, and to explain how they are being addressed. A system of Exception Reporting is in place, which replaced monitoring of working hours.

The report is also informed by the monthly Junior Doctors' Forum. This meeting is held in two parts: The first is an open (unminuted) forum for all junior doctors; the second is chaired by the GOSW and includes Junior Doctor representatives, including the mess president, and BMA representatives, and also the Director of Education, the Foundation Programme Director, Medical Staff Manager, rota co-ordinators, and BMA advisors. This meeting is minuted.

All trainees taking up appointments are on the new contract. It should be noted that a further 63 doctors are currently working in Trust grade positions are on contracts that mirror the new contract due to filling either Trust posts, or vacant training posts. They also have the ability to exception report to ensure that all issues within departments are highlighted.

Summary data

Number of doctors / dentists in training (total):	148
Number of doctors / dentists in training on 2016 TCS (total):	148(includes p/t trainees)
Amount of time available in job plan for guardian to do the role:	1 PAs / 4 hours per week
Admin support provided to the guardian (if any):	0.5WTE
Amount of job-planned time for educational supervisors:	0.125 PAs per trainee[1]
Amount of job-planned time for Clinical Supervisors:	0, included in 1.5 SPA time[1]

Exception Reporting

A process is in place on Allocate for the Junior Doctors to fill in an exception report (ER). Doctors are expected to discuss any ER's logged with either their clinical or educational supervisor. Details of the exception report are sent to the Guardian and Clinical /Educational Supervisor.

EXCEPTION REPORTS BY DEPARTMENT (APRIL 2021 – MARCH 2022)				
Quarter **Specialty**	Quarter 1 (April – June 2021)	Quarter 2 (July – September 2021)	Quarter 3 (October – December 2021)	Quarter 4 (January – March 2022)
Surgery	16	63	30	21
Medicine	21	48	89	124
Woman & Children	4	14	24	19
TOTAL	**41**	**125**	**143**	**164**

Exception Reporting: accuracy

It is clear that not all doctors' exception report. During the pandemic the trust has run a mainly virtual induction which includes a presentation by the GOSW encouraging ER

Patterns of Exception Reporting

The number of ER in surgery has fallen significantly since the introduction of a Physician's Associate to the team alongside an additional doctor covering from 1700-2100.

Various reasons for exception reporting are detailed using the Allocate system and these are generally about workload or particularly sick patients.

Work Schedule Reviews.

There have been no formal Work Schedule Reviews reported as difficulties have been handled promptly by service managers.

Fines

Total breach fines paid by the Trust from August 2017 to date are £13,137.75 and the Guardian Fund currently stands at £3708.84.

Vacancies by quarters:

VACANCIES BY QUARTERS – APRIL 2021 – MARCH 2022						
Department	**Grade**	**Quarter 1** Apr – June 2021	**Quarter 2** July – Sept 2021	**Quarter 3** Oct – Dec 2021	**Quarter 4** Jan – Mar 2022	Average gaps per quarter
Emergency	ST3+	2.5	3.1	2	3.6	2.8
	FY2 / GP/ ST1-2		1	1		0.5
Anaesthetics	ST3+	1	0.2			0.3
	Specialty Doctor		3	1.6		1.15
	CT1-2		1.25	1.6		0.7
ENT	ST1-2		0.2	0.2		0.1
Medicine	ST1-2		1		1	0.5
	ST3+	1.2	1.7	1.6		1.1
Obs & Gynae	ST3+	1.3	2			0.8
	ST1-2		0.4			0.1
T&O	ST3+		1			0.25
Paediatrics	ST3+		1.1			0.2
	ST1-3			1.1	0.5	0.4
Opthalmology	Specialty Doctor				1	0.5
Total		**6**	**15.95**	**9.1**	**6.1**	**9.28**

Key issues from host organisations and actions taken

The main issue this year has been provision of food out of hours. As part of the 2016 contract, it is obligatory to provide access to food at night for junior doctors. The catering team provide free food in the canteen, but this goes quickly and often before everyone has had a chance to access it.

I am grateful to Craig Black for prompting the catering team to engage with this. They are costing a fridge for the mess (with an accurate thermostat, where canteen food can be stored) and a card reader for the vending machine on the ground floor (currently, the need for cash precludes using this).

We have utilised the 'Fight Fatigue' money provided pre-pandemic to refurbish several rooms in Rowan house and to buy two 'sleeping pods' for the mess. I am grateful to the accommodation team for their support with this. We will have a drive around the August changeover to ensure that all doctors working nights are aware of the 'too tired to drive' rooms and also the emergency accommodation which is available to all.

The mess continues to be valued.

The juniors have asked me to thank the board for the £300 to recognise working through the pandemic. They also want to recognise the implementation of self-development time.

Although the pandemic is 'over', this is not the case on the shop floor and the trust has struggled all year with short notice gaps resulting from sickness and requiring locum cover. Again, I am grateful to everyone, both doctors, service managers and rota coordinators, who has contributed to keep patients safe.

Summary

This year has again been dominated by the pandemic and I would like to thank the juniors for generally stepping up, not complaining, and risking their own health to continue working. I would also like to thank the trust, on behalf of the doctors, for the provision of free hot drinks and free parking

I would also like to thank all the service managers who attend the GOSW meeting and have tried to facilitate changes such as Supported Development Time.

Finally, I would again like to thank Helen Kroon as medical staffing manager who has provided considerable support (much of it out of hours) for all juniors via the WhatsApp group and personal conversations throughout this year. Many of them have commented how helpful this has been.

2.3. Medical revalidation report

To Assure

Presented by Paul Molyneux

Trust Open Board – 22 July 2022

Report Title:	Item 2.3 - Appraisal and Revalidation
Executive Lead:	Dr Paul Molyneux – Responsible Officer
Report Prepared by:	Dr Katherine Rowe – Appraisal Lead
Previously Considered by:	

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

Executive Summary

Appraisal update

In the last 12 months the following has occurred within the Appraisal team:

- Appointment of 8 new Appraisers
- Stepping down of 6 appraisers (retirement x 3, sabbatical x 1, unknown x 2)
- Current pool of 52 trained medical Appraisers
- Regular Appraisal training sessions
- Commencement of F2F Appraiser training – June 22
- Cleansing of Allocate software

Data for the last year

Name of Organisation	West Suffolk Hospital
Total number of doctors with a prescribed connection as at 31st March 2022	328
Total number of appraisals undertaken between 1st April 2021 and 31st March 2022	278
Total number of appraisals not undertaken between 1st April 2021 and 31st March 2022	50
Total number of agreed exceptions	18

For the 32 appraisals not completed within the appraisal year and not agreed by the appraisal team the data can be broken down into two groups.

Group One

17 doctors
Appraisal completed – but not within the GMC appraisal year.

Group Two

15 doctors
Appraisal not completed

Revalidation update

The Revalidation support Group has met monthly and two monthly to catch up with all the revalidation decisions that were postponed by the GMC for the appraisal year 20/21.
Data for the last year (June21/June22).

78 Doctors were discussed within revalidation support group meetings

- 60 doctors received a positive revalidation recommendation
- 6 doctors received a deferral revalidation recommendation (neutral act)
- 12 doctors require further inputs and discussion before a revalidation recommendation can be made

Action Required of the Board
The board is asked to note the contents of the Appraisal and Revalidation Group report.

Risk and assurance:	N/A
Equality, Diversity and Inclusion:	N/A
Sustainability:	N/A
Legal and regulatory context	N/A

2.4. Car parking (staff benefits)

To Approve

Presented by Nick Macdonald

Trust Board – 22nd July 2022

Report Title:	Item 2.4 – Car parking and staff benefits
Executive Lead:	Craig Black, Interim Chief Executive
Report Prepared by:	Nick Macdonald, Executive Director of Resources Jeremy Over, Executive Director of Workforce and Communications Clare Farrant, E & F Travel and Sustainability Manager Julie Pettitt, E & F Head of Business Richard Canning, Finance Manager
Previously Considered by:	Executives and Senior Leadership Team

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

Executive Summary

This paper has been discussed at SLT requesting a recommendation which is provided.

During the pandemic the Trust implemented a number of initiatives to support staff well-being. Except for free car parking these were decided locally, and other Trusts adopted various strategies with the same aim.

In line with our prioritisation to look after staff health and well-being, we have approved the continuation of the staff psychology service and free gym membership with Abbeycroft Leisure for all staff.

This paper focusses on recommendations that, in line with Department of Health funding and the majority of other NHS Trusts, we re-introduce charges for staff car parking. It is important to highlight that we appreciate that charging staff for parking at WSFT is not a popular or easy decision – particularly with cost of living in mind.

However, continuing to provide free staff car parking represents a cost pressure to the Trust of £600k for 2022-23 that the Board would be asked to approve. Around half of this is not currently included in our forecast. This cost pressure would require non-recurring funding from our investment fund.

Staff representatives have been consulted in making this decision, and whilst they viewed charging staff as regressive and that this would harm recruitment and retention, it is unfortunately the case that we cannot continue to fund this shortfall beyond 2022-23.

This paper also proposes that free hot drinks and evening meals for staff cease with effect from 1st September 2022.

Background

The Department of Health and Social Care announced that the free parking funding for NHS staff, introduced during the pandemic, would come to an end on 31st March 2022. Decisions to reinstate staff charges now rest with individual Trusts.

The government guidance is as follows:

> *Free parking in hospital car parks for NHS staff introduced during the pandemic will also come to an end on 31 March. However, over 93% of NHS trusts that charge for car parking have implemented free parking for those in greatest need, including NHS staff working overnight.*

The majority of Trusts intend to follow this guidance and locally ESNEFT re-introduced staff car parking charges on 1st May 2022. We have delayed as much as possible, mindful of the costs to our staff, and pending Board approval. We have also discussed with staff representatives in the 'Staff representative views' section of this paper.

It is likely that free staff car parking has impacted on available parking capacity at WSFT and the re-introduction of charges may discourage staff who have other options from parking at WSFT, thus improving on car parking availability.

In recognition of concerns staff have over the cost of living we have delayed re-implementing parking charges to our staff for as long as possible. We have also proposed that the 2019-20 tariffs are reduced by almost 30% for 2022-23, as outlined in Option 2 below. For example, the pay-as-you-go rate is being proposed at £1.50 per day (reduced from £2.10).

Car parking charges for patients, visitors and staff were first introduced at WSFT in 1996 and are an established income stream. Patient and visitor parking charges were reinstated on 29th June 2020 at the 2019-20 Trust Board approved rates.

Re-investing the income
We have always been transparent that the income from car parking is reinvested into services for patients. There is signage around the Trust informing people of this including the large sign at the hospital entrance and at the ticket machines in the main entrance. The Trust website has this statement in the car parking section:

> *All the money that the Trust makes from car parking is reinvested into our services and providing care to patients, and across a year, this car parking income is roughly equivalent to a full ward's worth of nurses.*

Contractor charging
Contractor charging was approved in the tariff review for 2020-21 at the Trust Board 29th November 2019, however was not implemented due to the pandemic. It is proposed these charges are reintroduced on 1st September 2022

Ending free hot drinks and evening meals
This paper also proposes that free hot drinks and evening meals cease with effect from 1st September 2022. The cost pressure relating to this initiative is currently £55k per month and our forecast assumes that this ceases at this date.

This paper provides options around if and when parking charges should be reintroduced, and a review process for both eligibility and a revised charging methodology.

Action Required of the Board

1. To approve that staff parking charges be reinstated (as per Options 1-4 below).
    a. If so, agree when this should be effective (based on Options 1-3 below)
2. Agree that a full review of methodology and eligibility be carried out to be effective 1st April 2023, (as outlined under 'next steps') with a quantum of income broadly similar to 2019-20 (£600k).
3. Implement parking charges for contractors at the 2019-20 staff daily rate (£2.10 per day).
4. Approve the withdrawal of free hot drinks and evening meals with effect from 1st September 2022

Staff representative views

Staff representatives met with the Executive Director of Resources (DoR) and the Executive Director of Workforce and Communications (DoW) on 11th July 2022 and voiced their concerns over the re-introduction of staff car parking charges. They suggested they would need to discuss with their staff.

It was clear that staff representatives are opposed to the reintroduction of car park charging – particularly over and above a level that recoups the costs incurred through provision and maintenance of the car parks. The DoW stressed the importance of clear communication and transparency with staff around the rationale for any decision and the level of any future charges. He also noted the tight timescales given the wish to implement from September.

Staff representatives asked for this paper to demonstrate that the income earned from car parking covered the costs of managing and maintaining the car parks. This information has been included in the tables below.

A number of specific issues were raised around fairer and more equitable charging methodologies. It was also suggested that the prices being proposed at WSFT were high compared to ESNEFT and when compared with inflation since 1996 when charges were originally introduced.

These issues will be considered as part of the proposed wider tariff review that would take place in the autumn of 2022 in readiness for a new charging methodology to be introduced in April 2023.

Staff representatives felt the reintroduction of charges is being suggested at a particularly difficult time for staff given concerns over the cost of living. They asked whether this could await the review and therefore WSFT continue to offer free car parking for staff until April 2023.

The DoR explained that the majority of Trusts had already reintroduced charges and WSFT had tried to delay for as long as possible despite the financial pressure this created. The proposal to discount the rate previously agreed in 19-20 by nearly 30% is an attempt to help mitigate the costs to staff.

The DoR also highlighted that other initiatives designed to support staff health and well-being (free gym membership and staff psychology service) would remain, and that these were available to all staff whereas free car parking only benefitted those who drive to work.

The Options

Option 1 - continue to provide parking free of charge for WSFT Trust staff until 31st March 2023.

This proposal would commit to charges being re-implemented in April 2023 with a revised methodology and charging criteria, that generated similar income to that received in 2019-20 (£600k)

	2018/2019 actual	2019/2020 actual	2020/2021 actual	2021/2022 actual	2022/2023 forecast
Income patient & visitor	1,274,918	1,411,828	423,599	665,184	825,000
Income Staff *	546,394	605,069	0	0	0
Gross Income	**1,821,312**	**2,016,897**	**423,599**	**665,184**	**825,000**
Car Parking Costs	408,133	422,106	430,436	372,159	392,000
Net Income	**1,413,179**	**1,594,791**	**(6,837)**	**293,025**	**433,000**
Budget	1,592,265	1,588,749	1,557,025	1,625,588	1,605,996
Surplus/Deficit	(179,086)	6,042	(1,563,862)	(1,332,563)	(1,172,996)

*2019-20 tariff paper - finance estimated staff element of car park income was 30% of total car parking income, this methodology has been used in this paper.

Option 2 - reinstate parking charges for WSFT Trust staff at discounted 2019/20 rates from 1st September 2022

- Charge WSFT staff £1.50 per day (reduction of 30% rounded to nearest 50p)
- Staff monthly deduction payments (reduction of 30% rounded to nearest 50p)
- Senior staff car park monthly deduction payments (no reduction)
- Charge non-WSFT staff including NSFT the staff daily rate (£1.50 per day - currently £2.10).
- Implement a daily parking charge for contractors (£2.10).

	Proposed September 2022 £

Daily rate WSFT staff including non-exec directors	1.50
On site residents including Cambridge Graduates	Included in rent charge
Holders of a valid blue badge	Free of charge
Monthly deduction/payment in advance (inc car free day):	
Up to 15 hours per week	6.00
15.5 – 22.5 hours per week	11.50
23 – 30 hours per week	17.00
Over 30 hours per week	21.50
Senior staff car park (pro rata for number of days on site)	61.20
New employees since 2014	No automatic access to Site
Shuttle Bus	Free of charge
Rugby Club	Free of charge

	2018/2019 actual	2019/2020 actual	2020/2021 actual	2021/2022 actual	2022/2023 forecast
Income patient & visitor	1,274,918	1,411,828	423,599	665,184	825,000
Income Staff *	546,394	605,069	0	0	250,000
Gross Income	**1,821,312**	**2,016,897**	**423,599**	**665,184**	**1,075,000**
Car Parking Costs	408,133	422,106	430,436	372,159	392,000
Net Income	**1,413,179**	**1,594,791**	**(6,837)**	**293,025**	**683,000**
Budget	1,592,265	1,588,749	1,557,025	1,625,588	1,605,996
Surplus/Deficit	(179,086)	6,042	(1,563,862)	(1,332,563)	(922,996)

Forecast for 2022-23 assumes 7/12 of annual forecast for staff income.

Option 3 - reinstate parking charges for WSFT Trust staff at 2019/20 rates from 1st September 2022

	£
Daily rate NHS staff including non-exec directors	2.10
On site residents including Cambridge Graduates	Included in rent charge
Holders of a valid blue badge	Free of charge
Monthly deduction/payment in advance (inc car free day):	
Up to 15 hours per week	8.20
15.5 – 22.5 hours per week	16.40
23 – 30 hours per week	24.50
Over 30 hours per week	30.60
Senior staff car park (pro rata for number of days on site)	61.20
New employees since 2014	No automatic access to Site
Shuttle Bus	Free of charge
Rugby Club	Free of charge

	2018/2019 actual	2019/2020 actual	2020/2021 actual	2021/2022 actual	2022/2023 forecast
Income patient & visitor	1,274,918	1,411,828	423,599	665,184	825,000
Income Staff *	546,394	605,069	0	0	350,000
Gross Income	**1,821,312**	**2,016,897**	**423,599**	**665,184**	**1,175,000**
Car Parking Costs	408,133	422,106	430,436	372,159	392,000
Net Income	**1,413,179**	**1,594,791**	**(6,837)**	**293,025**	**783,000**
Budget	1,592,265	1,588,749	1,557,025	1,625,588	1,605,996
Surplus/Deficit	(179,086)	6,042	(1,563,862)	(1,332,563)	(822,996)

<u>Option 4</u> - Do not reinstate parking charges for WSFT Trust staff (table as per Option 1)

Next steps

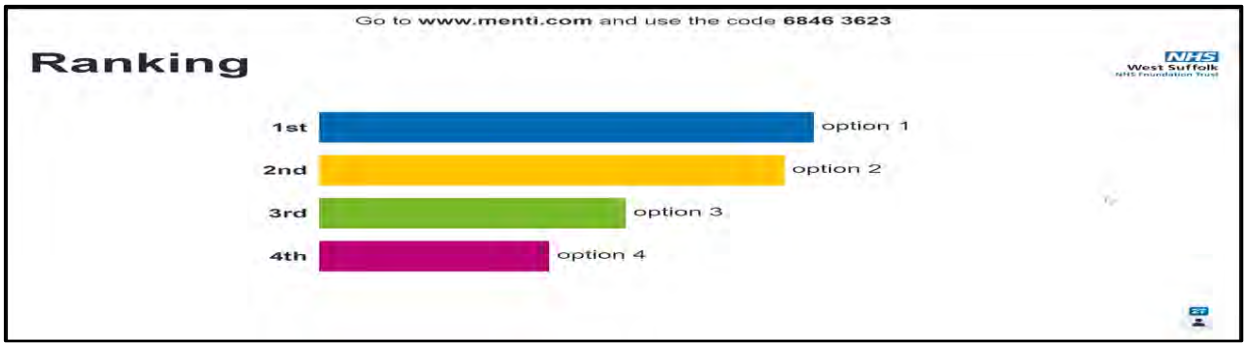
If the parking charges for staff are reinstated it is proposed that there will be a review of the:

1. Methodology for calculating parking charges for staff including options for:
    a. Current rates
    b. Percentage of salary
    c. Percentage of banding (ESNEFT model)

2. Rates (staff, patients, visitors and contractors) to be applied from 1st April 2023, including inflation and comparison with other Trusts.

3. Eligibility criteria for on-site parking as part of the Travel, Transport and Access Plan, which will include a staff travel habits survey. This links to the Trust Green Plan and the NHS commitment for the carbon emissions we can influence, including staff commuting, to be net zero by 2045.

This paper was discussed and voted for by 27 members of SLT utilising the Menti board, with the results as below:



Recommendation

1. The Trust Board is asked to approve Option 1

2. It is also recommended that a review of all car park tariffs, charging methodology and eligibility is carried out during the latter part of 2022 to be effective 1st April 2023.

3. Implement parking charges for contractors at the 2019-20 staff daily rate (£2.10 per day).

4. Free hot drinks and evening meals will cease on 1st September 2022

Risk and assurance:	*[Please reference if this relates to a BAF risk or a new risk that is being escalated for the Board's attention or delete line if not applicable]*
Equality, Diversity and Inclusion:	Following government guidance free parking will be provided for • Holders of a valid blue badge (including staff) • Staff working overnight
Sustainability:	The reintroduction of staff parking tariffs may result in the reduction of single occupier car journeys to site.
Legal and regulatory context	Government guidance 23 March 2021 **Publication approval reference: C1164**-*hospital car parking free for those in greatest need* NHS Standard Contract 2022-2023 – service conditions: 17:10

3. STRATEGY

3.1. Future system board report

To Assure

Presented by Craig Black

Public Board Meeting – 22 July 2022

Report Title:	Item 3.1 - Future System Board Report
Executive Lead:	Craig Black
Report Prepared by:	Gary Norgate
Previously Considered by:	Future System Programme Board

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

Executive Summary

Executive Summary

Note: the clinical workstream section of this report contains an update of progress being made towards transforming the way we work and as such addresses the action raised at the last Board meeting.

As a general indication of health, the status of those tasks within the control of Future System Programme remain unchanged as 'Green' and significant strides having been made in several key areas:

1. Our Local Planning Authority has completed the first phase of its formal public consultation. Having sent direct mails to over 3000 members of the public and statutory consultees, c.50 direct responses were received. The feedback received is now in the process of being discussed and the Trust's responses will form the basis for a second round of consultation.
2. The main areas of concern focus on; traffic management, the impact of the building on bio-diversity and its visual impact.
3. Positive discussions with Highways and Suffolk Wildlife Trust lead the Future System (FS) team to believe that solutions to said concerns are possible and that the goal to receive a formal determination by the close of Autumn 2022 remains on track.
4. Work continues on the definition of a bio-diversity strategy and on re-modelling possible access mechanisms that will ensure the efficient flow motorised road traffic whilst promoting and protecting pedestrians and cyclists.
5. The FS team have signed a memorandum of understanding with The New Hospitals Programme (NHP)[1] that allows us to access the funds necessary to support our planning application.
6. Building on the conclusions drawn from our extensive co-production programme, the FS team have committed to support NHP in the development of a set of clinical design standards. This work will take place throughout the summer and is expected to influence the model hospital design (termed Hospital 1.0) that is expected by Christmas.
7. The NHP Programme Business Case[2] has now been formally agreed and signed by both the Joint Investment Committee and the Major Projects Review Group[3].

[1] The New Hospitals Programme is the central body appointed by Department of Health to oversee the delivery of the Government's commitment to build 48 'new hospitals' by 2030.
[2] The Programme Business case sets the approach, strategic fit, benefits and budget for the entire New Hospital Programme, i.e. is the case for all 40 / 48 projects in the programme.
[3] The MPRG works with HM Treasury and other government departments to provide independent assurance on major projects.

8. The 1:200 level design workshops for the new West Suffolk Hospital are complete and will continue to be co-refined as the project progresses. The final report is in draft and will be formally signed off by the end of July.
9. The Clinical Workstream are also making excellent progress on several fronts including; the movement of services to community venues, the development of an ICS wide demand and capacity model, the application of lessons emerging from Human Factors research and exploration of synergies between community, primary and secondary care (e.g. Denosumab).
10. A prioritised schedule of when individual schemes within the NHP can expect to commence construction is expected to emerge from a presentation to the Major Projects Review Group planned for October. This list is expected to reflect the unique challenges faced by RAAC[4] hospitals.

Business Cases and Project Plan

Key activities and milestones:

- **The submission and conclusion of our application for outline planning consent**. Working in conjunction with the local planning authority, we are now seeking a dedicated meeting with the planning committee at the end of October. This plan reflects the complexity of our case and remains in-line with our programme plan.
- **The translation of our co-produced clinical model and its associated schedule of accommodation into a relatively detailed 1:200 outline design**. Clinical co-production workshops, dedicated patient workshops and human factors / ergonomics analysis have now been completed and have resulted in a set of 1:200 designs and accompanying comments / caveats. Next steps will be the sharing of this rich and valuable insight with NHP with a view to informing the national standards / model hospital design (Hospital 1.0). This work will run throughout the summer and outputs are expected around October.

In my last update I listed a number of 'milestones' that I expected to make significant progress towards in time for this meeting. An update on each is contained below:

…. in time for our next meeting we should:

- **Know the extent to which the Programme Business Case is formally supported (including, therefore, a view of overall budget and an agreed method for progressing the entire programme).**

NHP have confirmed that sign-off has been received. This formally establishes NHP as a national programme, funds the completion of cohort 1 and cohort 2[5] projects and agrees the recommended programmatic approach.

- **Understand the outcome of the first round of planning consultation and the nature of any associated risks.**

The first round of planning consultation has been completed. Although significant work remains, no "show stoppers" have been identified and significant progress has been made towards agreeing an appropriate bio-diversity compensation strategy and the most effective means of balancing ease of access for vehicular, pedestrian and cyclist access.

[4] RAAC = reinforced autoclaved aerated concrete – a form of lightweight concrete that was used extensively in the construction of our current hospital and those such as Queen Elizabeth Kings Lynne.

[5] The new hospitals programme has divided the 40 schemes into 4 cohorts – cohort 1 are those major builds that are already "in-flight" e.g. Liverpool, Birmingham, Brighton, Cohort 2 are a set of smaller agile projects such as the cancer hospital at Cambridge, Cohort 3 are major schemes that are typically well developed such as the new hospital at Whipps Cross, these schemes are also known as 'pathfinders' and Cohort 4 are the less developed, schemes such as West Suffolk and James Paget, these are set to be 'full adopters' of the standards developed by NHP. An additional 8 projects are set to be announced in the Autumn – these will be badged as Cohort 5.

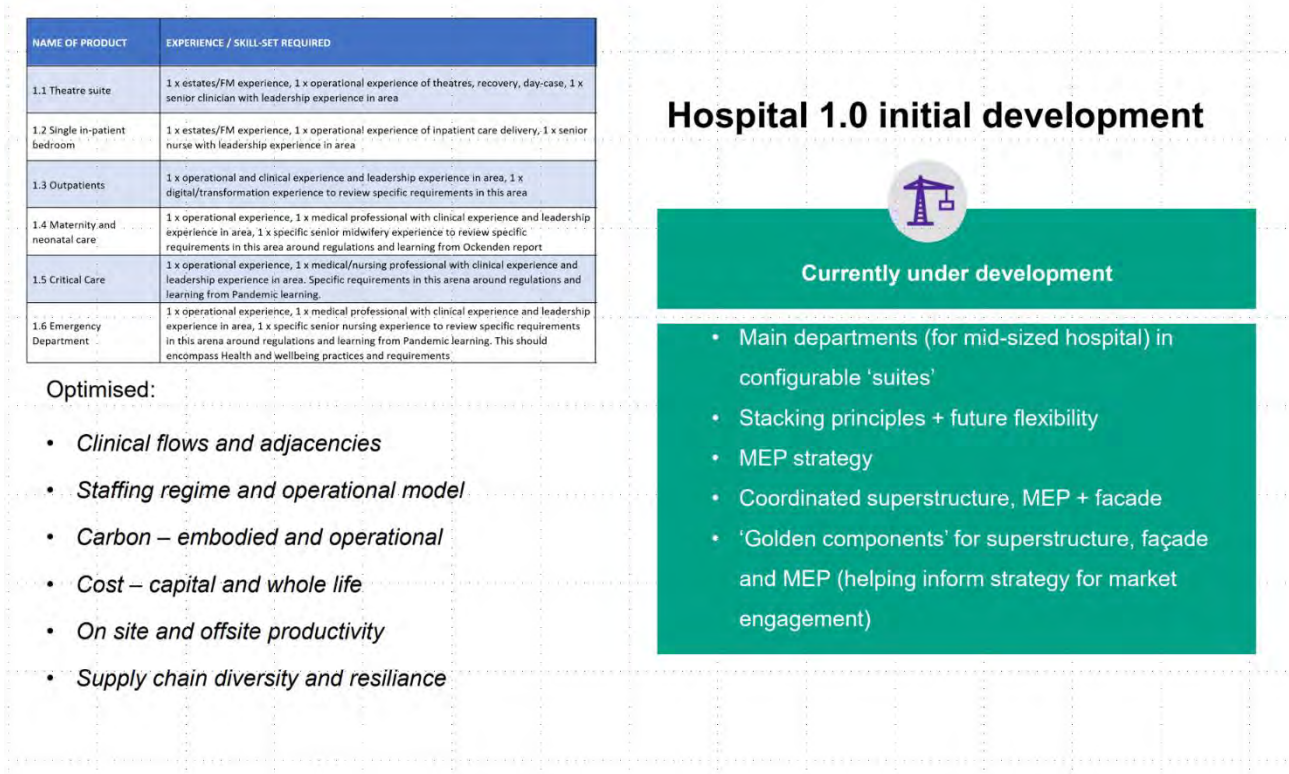
- **Have a clear method for the production of a model OBC and what it means for our Future System Plans**

The national team have written to the programme directors of cohort 3 & 4 schemes to ask for expressions of interest to participate and collaborate on a number of "products"[6] that they are developing. They are looking for support to co-create 'Hospital 1.0' - that is standardised architectural designs for rooms, departments, floors and ultimately a whole hospital - and are asking for colleagues to be seconded into the national design team to help develop them. They have asked for specific experience in clinical, operational and estates professions.

There is a formal process for application, and we are pleased to confirm that 5 colleagues from WSFT have applied to support these areas. We expect a response and clarification of the next steps in the coming weeks.

- **Have a clear understanding of the depth to which standard hospital design intends to go and what this means for our own co-produced designs.**

The NHP design team attended our team meeting and presented the detail of their plans to create a model hospital. This exercise is known as Hospital 1.0 where the "1.0" denotes perfect compliance with the defined standard (which is based on the needs of a medium district general hospital). In reality nobody is expected to achieve full compliance, however, the slide below illustrates the areas in which optimisation / standardisation is expected to be possible and also includes the areas into which individual projects such as ours have been asked to deploy resources in order to apply their experience and inform the eventual standard. This approach is expected to provide the means through which the FS team can share its work whilst protecting the integrity of our own co-produced designs.



NAME OF PRODUCT	EXPERIENCE / SKILL-SET REQUIRED
1.1 Theatre suite	1 x estates/FM experience, 1 x operational experience of theatres, recovery, day-case, 1 x senior clinician with leadership experience in area
1.2 Single in-patient bedroom	1 x estates/FM experience, 1 x operational experience of inpatient care delivery, 1 x senior nurse with leadership experience in area
1.3 Outpatients	1 x operational and clinical experience and leadership experience in area, 1 x digital/transformation experience to review specific requirements in this area
1.4 Maternity and neonatal care	1 x operational experience, 1 x medical professional with clinical experience and leadership experience in area, 1 x specific senior midwifery experience to review specific requirements in this area around regulations and learning from Ockenden report
1.5 Critical Care	1 x operational experience, 1 x medical/nursing professional with clinical experience and leadership experience in area. Specific requirements in this arena around regulations and learning from Pandemic learning.
1.6 Emergency Department	1 x operational experience, 1 x medical professional with clinical experience and leadership experience in area, 1 x specific senior nursing experience to review specific requirements in this arena around regulations and learning from Pandemic learning. This should encompass Health and wellbeing practices and requirements

Optimised:

- *Clinical flows and adjacencies*
- *Staffing regime and operational model*
- *Carbon – embodied and operational*
- *Cost – capital and whole life*
- *On site and offsite productivity*
- *Supply chain diversity and resiliance*

In essence, this method illustrates that clinical input is being sought to determine the optimum design and approach to the provision of; theatre suites, single in-patient bedrooms, outpatients, maternity and neonatal care, critical care and emergency departments. This information will then determine the configurable layout for the main hospital departments, clinical flow and adjacencies, operational models and principles for the stacking of services. In terms of the physical construction process, Hospital 1.0

[6] The New Hospital Project are centrally developing a set of standard building blocks and standards for use by Cohort 3,4 and 5 schemes. These building blocks, termed 'products', cover a standard demand model, construction principles and elements of clinical design and layout. Collectively, the products flow into the model hospital design known as Hospital 1.0.

will define the optimum means for how a new hospital will achieve net zero carbon goals whilst exploiting a common superstructure that will allow the most effective use of constrained market capacity and, therefore, optimise time and commercial efficiency.

This approach does not rule out specific variations that support the unique circumstances of a project, but it does provide a benchmark to accelerate design, minimise risk and ease the passage of compliant business cases through the Treasury process.

- **Be in a position to triangulate the FS team view of demand and capacity with that which arises from the NHP model and that which is expected across the ICS.**

We await confirmation of the method through which a central demand and capacity model will be finalised. In the mean-time, work continues with our consultants, Grant Thornton, on the production of an ICS wide model.

- **Have a full set of 1:200 drawings along with a set of comments and caveats that will be progressively reconciled.**

Drawings are now complete and are being actively refined. In addition to the inputs received from patient and staff co-production, expert human factors / ergonomic input has now been added (an overview of which is provided below).

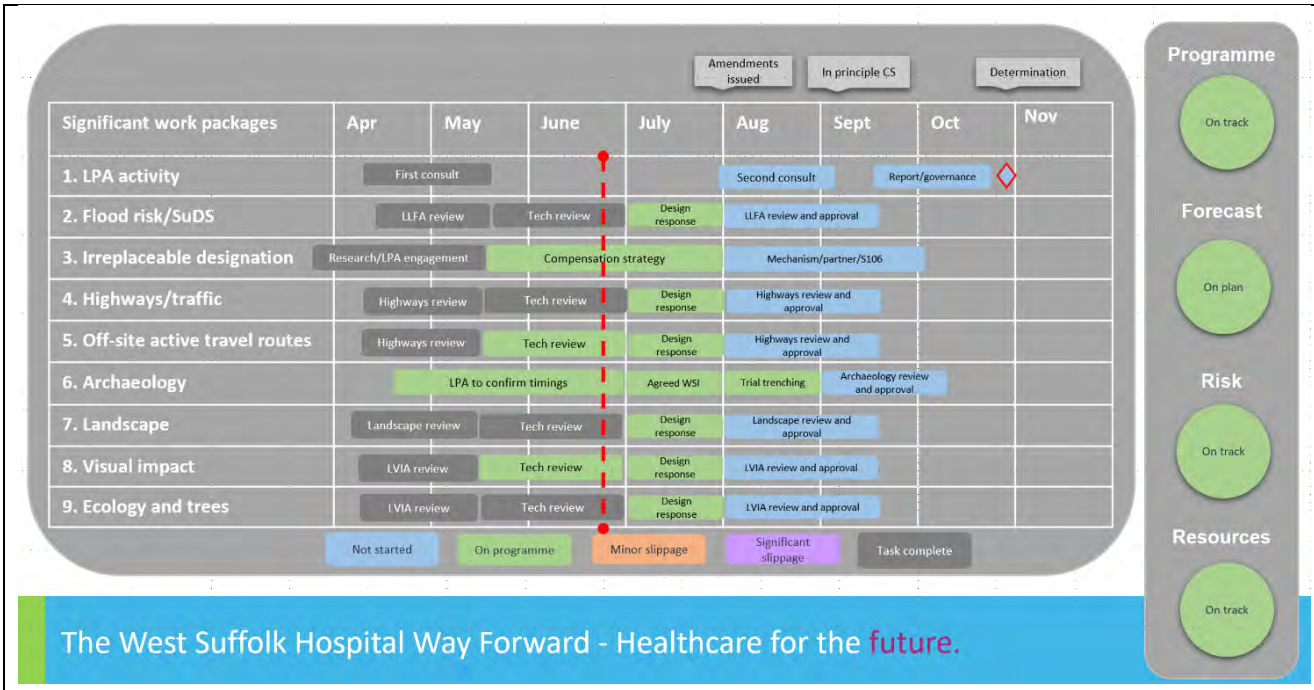
Looking forward, October continues to represent a significant watershed by which time we should:

- Know the outcome of our planning application
- Have a view of scheme prioritisation within the NHP and understand the plans for how Government / Department of Health intend to treat RAAC[7] hospitals.
- Have made significant strides towards completing the first central frameworks for demand and capacity modelling and Hospital 1.0

Estates Workstream

Securing a positive outcome for our outline planning application remains the single most important short-term milestone in our programme. Failure to secure consent to build on Hardwick Manor would represent a significant set-back that would almost certainly delay our construction date. With this in mind, the following dashboard explains progress to date:

[7] RAAC = reinforced aerated autoclaved concrete, a popular material used in the construction of buildings in the 1960s/70s that has limited future viability.



Key points of progress include:

- Negotiation and agreement of an achievable bio diversity compensation strategy that will, in principle at this stage, see the creation of a new public nature reserve that will significantly exceed the total area of the, previously private, Hardwick Manor site.

- Identification of access options that address the concerns raised by our public and Highways consultees whilst providing a better balance between the needs of drivers and pedestrians / cyclists. This is likely to change the proposed roundabout to signal controls and moving the entrance / exit further from the Barons road / Hardwick Lane junctions.

- Agreement on an archaeological approach that will minimise disruption to our ecology whilst ensuring sufficient understanding of the site's history.

- Agreement that the complexity of our case is best heard in a dedicated meeting in which the members of our planning committee will have the maximum time to consider the many facets of our case.

- Completion of the first round of public consultation in which 50 responses were received from over 3000 direct invitations (26 neighbour, 1 councillor and 23 statutory consultees).

- Further investigations into the visual impact that could change the height of the building and increase the number of "fingers".

This represents an enormous amount of work that has to be completed in time for the second round of public consultation that is scheduled for 1st August.

In addition to the money already provided to fund our planning application, support may need to be sought from NHP for enabling works that cover:

- The cost of archaeological surveys.
- The acquisition of land upon which the aforementioned nature reserve will be developed.
- The advanced installation of the power infrastructure required to run a new hospital.
- The early planting of natural screening that will protect our nearest neighbours from the unavoidable disruption created by the building of new hospital.

- Great Crested Newt District Level Licensing (required due to positive edna result in a nearby pond on an adjoining farm) requires an Impact Assessment and Conservation Payment Certificate.

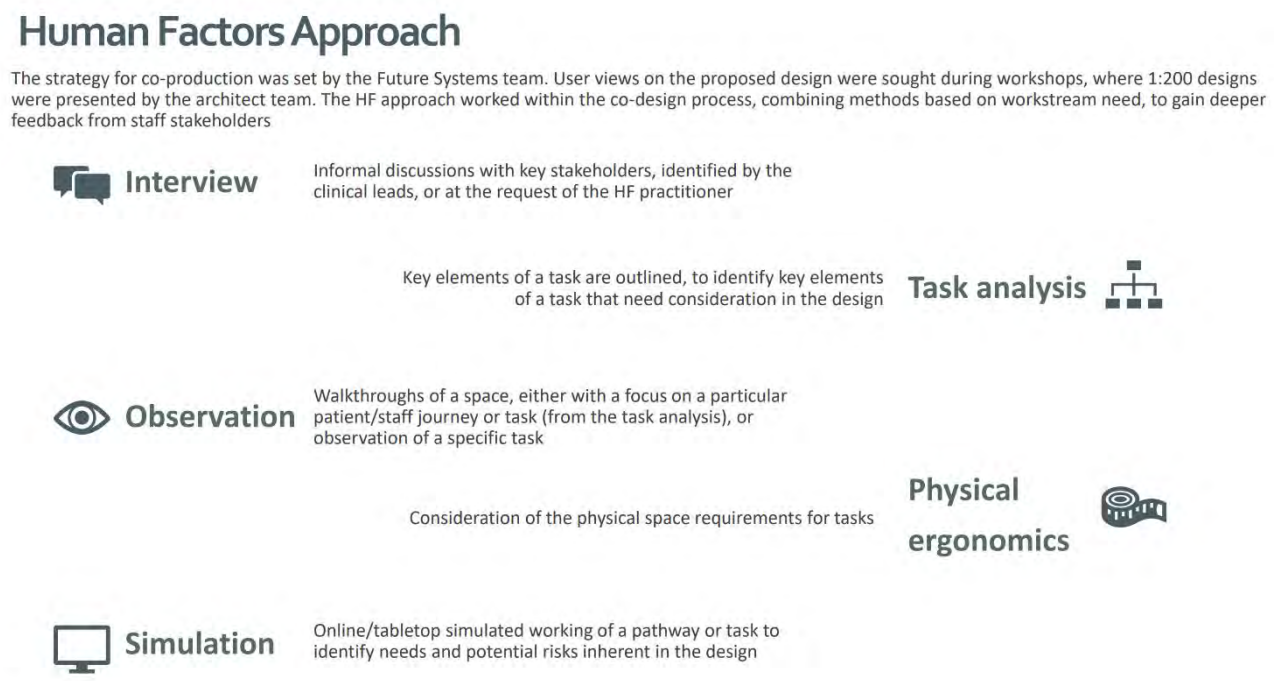
Clinical / Digital Workstream

In spite of the subtle shift of focus away from the creation of a unique West Suffolk Outline Business Case (OBC) towards a contribution to system wide transformation and the creation of central design standards, the clinical and digital workstreams have been extremely busy. Work remains very much on track and highlights include:

A visit to the King Faisal Specialist Hospital & Research Centre to explore the potential of "Smart Rooms"

Progress on the development of an ICS model to understand the nature of future demand and corresponding capacity.

Continued refinement and co-production of our 1:200 designs, including an examination of our initial conclusions through the lens of human factors / ergonomics. This innovative approach (approach outlined below) highlights, once again, the Clinical Team's outstanding commitment to continuous improvement and demonstrates how the perpetual nature of co-production provides so many more opportunities to learn than that of simple "engagement".



Co-evaluation of options for the relocation of services to the One Public Estate in Western Way.

Continued work to test and evaluate options for collaboration with Primary Care and Community Services (Denosumab)

Continued evaluation of potential for the creation of a One Haverhill Hub.

A busy couple of months!!

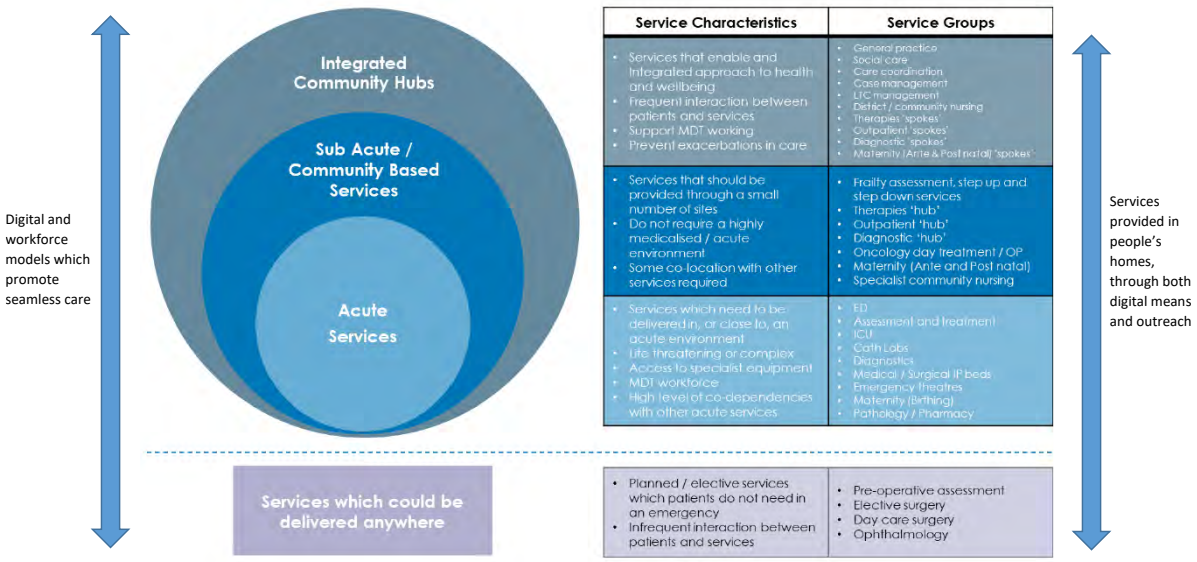
Addressing action 3.1 from the board meeting on 27 May 2022:

The strategic principles of the Future System Programme are:

- An ethos of co-production will be developed and applied throughout the entire life cycle of the programme
- Create an environment that attracts, supports and develops staff
- Maximise the positive impact on local economic growth, education and skills
- The services provided within an acute facility should be limited to those that can only be performed by such a facility – i.e., the hospital will only do what only the hospital can do
- The money follows transformed services
- Be future facing and innovative
- Any new facilities must be affordable, deliverable and sustainable

A paradigm for how this could manifest in our local system, in the context of our shared objectives as members of the West Suffolk Alliance and Suffolk and North East Essex Integrated Care System (SNEE ICS), was adopted in December 2020:

The paradigm below will be used to develop each of these visions further, to define the most appropriate and sustainable model for each service type in the context of our location system, workforce and population:



Services are located geographically according to population need, workforce availability and existing community and public estate assets

This paradigm has been, and will continue to be, used to develop the future clinical model through co-production with staff, patients, members of the public and partners. The future clinical model is the basis for the building designs. Considering the paradigm, it is clear that a number of services that are currently provided in the acute hospital would be well placed being provided in a different location (either physically or virtually), and this is enacted in the scheme that we are currently proposing as the preferred option for the NHP outline business case.

The schedule of accommodation for the new main acute hospital on Hardwick Manor is accompanied by proposals to disperse services into a number of different locations across the catchment area:

- A community diagnostic hub, providing one CT scanner and one MRI scanner
- An elective surgical hub to provide protected 'cold-site' capacity for planned operations and procedures
- Retaining the buildings on the current hospital site which are not affected by RAAC planks, and repurposing them to create a day treatment campus
- 25% of outpatient appointments being delivered in peripheral clinics and 25% being provided remotely
- Other outpatient services which do not require the infrastructure of an acute emergency hospital being provided from the new health centre in Western Way.

Through the community and primary care workstreams we are also working up new ways of delivering services with partners in line with the alliance ambitions. The future clinical model will continue to iterate and evolve through the ongoing co-production, and the building designs will respond accordingly, but to establish the high-level objectives and allow the work of implementing them to begin, the clinical model as it currently stands is being written up into a clinical strategy at the moment and will be published in the autumn.

Design work is now on pause while we wait for several critical enablers to progress:

1. A team from Suffolk and North East Essex Integrated Care System (SNEE ICS) are appraising our demand and capacity model, as part of a wider project to create a single demand and capacity model for hospital services, community services, adult social care and primary care for the whole ICS.

2. The national New Hospital Programme has:
    a. a team of data specialists creating a standardised demand and capacity model for all new hospital sites to use
    b. an architectural team creating standardised departmental designs
    c. its own business case going through approvals by HM Treasury, in order that it can set the budgets for each individual site (as mentioned above the, the programme business case has been signed and a second case seeking to secure budgets for cohort 3 and 4 trusts is scheduled for October)

3. The future workforce requirements are being calculated, which will tell us whether the size of the services that we have designed are realistic and affordable to staff.

4. We are waiting to know whether a community diagnostic hub and/or an elective surgical centre at Newmarket Hospital will be able to be built, and for the outcome of the Western Way business case.

5. We need to know the outcome of the planning application.

While the estates, digital, communications and engagement and finance workstreams all continue, the clinical workstream is focussing on topics that can safely be moved forwards without the risk of work needing to be redone when the external results come in.
[The recording of the presentation to the Council of Governors on 12 July 2022 gives a more thorough explanation of the future clinical model and the co-production process that has produced it.]

Communications and Engagement

Having completed the latest round of patient focus groups Emma will now focus on working with the clinical team to ensure any service changes associated with a potential[8] move to Western Way (or any other of the transformational activities) are thoroughly and formally consulted upon.

Said public and patient workshops were held to provide an opportunity to comment on the latest 1:200 designs. These workshops, attended by nearly 100 people, were complimented by a survey that received more than 400 responses (88% of which were from patients). Overall, the feedback was strongly positive with specific comments relating to the extent to which the latest designs reflected the comments previously supplied.

Finance

The FS programme is currently spending in line with budget. We have signed an MOU with NHP that allows us to draw down the funds required to progress and determine our planning application.

[8] A business case that positions the options for moving services to the One Public Estate at Western Way is scheduled for presentation to the WSFT Board in July. The resultant decision will then allow the Team to determine the extent to which Public Consultation is necessary and to design the appropriate process for ensuring any such consultation is efficient and effective.

Additional NHP funding will be made available to cover the support provided by the FSP team in the development of national standards. We expect the process for the allocation of funds for enabling works to be available mid to late July. At present, the immediate opportunities for enabling works are, advanced landscaping (to provide screening for neighbours before construction work commences); preparatory cable laying to ensure the power requirements of the new hospital can be met; archaeological surveys and the acquisition of land for the aforementioned 'nature reserve and Great Crested Newt conservation payment certificate'.

Table 1 : Current Programme costs against Original Plan

Row Labels	Sum of YTD Budget	Sum of YTD Actual	Sum of YTD Variance	Sum of Plan	Sum of Y/E Forecast	Sum of Y/E Variance
1.Programme Management	185,046	129,847	55,199	1,150,310	1,006,035	144,275
2.Co-Production	57,290	29,576	27,714	343,727	201,775	141,952
3.Non-Pay	54,000	7,425	46,575	324,000	339,753	-15,753
4.Castons	320,054	329,895	-9,841	1,920,298	935,000	985,298
Grand Total	616,390	496,743	119,647	3,738,335	2,482,562	1,255,773

All in all, this has been a period in which significant progress has been made in the development of our clinical design and the negotiation of our planning application. That said, the next period should see the culmination of several key activities:

- Work on the co-development of national standards will be significantly advanced.
- Our response to the issues raised in planning consultation will have been formulated and the second round of public consultation will be underway (scheduled for 1st August).
- If agreed, the recommendations contained within the Western Way business case, including public consultation, will be in the process of being executed.
- We should have a clear view of future demand and capacity for the Hospital and across the ICS.
- An application for enabling works funding will have been made and we could be in a position to demonstrate deliverability of our bio diversity strategy.

Exciting times!!!

Action Required of the Board
To note the contents of this report.

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

3.2. Strategic update

3.2.1. Alliance

To inform

Presented by Clement Mawoyo

Integration report

Integration report - summary

Alliance Development

- Governance

Strategic planning

- Community Discovery
- Locality Development

Innovation in Integration

- Cognitive stimulation
- Community vaccination
- Primary Care
- Urgent and emergency care
- Cassius +

West Suffolk Alliance Development

Governance:

- As a result of the Health and Care Act, on the 1st July the CCGs ceased to exist and all functions were taken over by the Integrated Care Board, working as part of the Suffolk and North East Essex Integrated Care System. The Alliance governance has developed to respond to this, and as previously reported the Alliance Health, Care and Wellbeing Committee is now formally a committee of the Integrated Care Board, and has delegated functions, and corresponding accountabilities. The governance structure is attached at the end of this report.

- The first meeting of the Committee is on the 12th July. This new way of working creates more structure within the Alliance, for instance around reporting, alongside new opportunities for collaboration.

- A West Suffolk Quality Group and a Workforce Group are being established, engagement will have a higher profile and a renewed focus on localities is being developed – starting with a workshop later in July.

- Peter Wightman has joined the Alliance from North West Essex as the new Alliance Director, replacing Sandie Robinson who has been interim in the role since Kate Vaughton moved into a new role with the East of England Ambulance Service.

Cognitive Stimulation and communication group

- An innovative collaboration between dementia specialist speech and language therapist (WSFT Speech and Language Community Team) and dementia training practitioner (WSFT Acute Specialist Nursing Team) has been established to support those with a recent dementia diagnosis.
- Participants are recruited from the Speech and Language Therapy Team caseloads but also via frontline dementia services in the community with or without an identified communication difficulty. The goals are focussed on improving quality of life, education and to support self-management and admission prevention.
- This group has now completed its third cohort and is delivering great outcomes. All of the last cohort and their supporters/partnersshowed improvement on a quality-of-life questionnaire, particularly around relationships with friends and family despite some reporting a decline in physical health. All participants reported increased confidence in their communication with others, all participants reported a better understanding about how dementia affects their communication, enjoyed meeting other people with dementia and would recommend the group to others.

"the group had a positive effect on my well-being. It gave me a purpose for the week and it was lovely to meet the same people regularly in a familiar and friendly setting – thank you"

"Very nice people in the group. News and topics and things I can remember all good. Carers running the course are well prepared and involve everyone. I'm sorry it has ended. Good to be with the same people with the same problems …… above and beyond kindness

"I liked the people. The speech was always a problem. I liked the way they spoke to us and always gave us time and understood, particularly to me because of my speech, as my speech can be long when I try to finish my words"

Community vaccination and health pop up clinic

- Our West Suffolk vaccination team took advantage of a local event to run a pop up clinic at the Haverhill Show. The clinic was organised by the West Suffolk Lead for vaccine inequalities – employed by West Suffolk Council and the WSFT clinical team, and ran alongside colleagues from Health Watch Suffolk and the Pre Diabetic team.
- Approached by the organisers of the event they requested the vaccination team to attend their show as a community engagement and vaccination clinic piece. They had been involved in and seen the collaborative work of the "Wellbeing event" that had been organised in partnership with Abbeycroft Leisure and a number of health providers and voluntary sector groups in conjunction with a vaccination clinic; and wanted to replicated something similar in the Haverhill Show.

Kelly, the event organiser emailed – "*Just wanted to say thank you for making the clinic & the other stalls happen, for our first time having health represented in his way was a brilliant success and I really hope it leads to bigger and better things for the town as far as access to health opportunities are concerned.*"

Community discovery

Aim: Deliver a focused discovery to better understand the impact of community activity

Approach: Co-design the discovery with a focus on 2 areas in West Suffolk, (Red Lodge/Glemsford) and use this learning to inform the social prescribing redesign and to build a long-term plan for how we work with communities to promote wellbeing in West Suffolk.

High-level findings:

- **Every community has a history and story that influences what is happening now**
- **A feeling of belonging is crucial to a person's individual and community wellbeing** - It affects how involved people are, how connected they are and their motivation to organise
- **It is harder to organise outside of your own social and friendship groups** - This can leave boundaries and gaps between groups leaving some people isolated and excluded
- **Informal encounters enable us to feel connected** - Creating opportunities and places where informal encounters can happen is vital to connection
- **Community facilities enable us to live connected lives** - there is a marked difference in social capital in communities where they exist
- **The lack of local services polarises communities** - the physical isolation of communities is compounded for those who are already experiencing some form of disadvantage or barrier
- **The power in communities is fragmented, difficult to access, and sometimes held in unexpected people and places** -the barriers for people to self-organise in a community can be high

Report due end of July

Locality development

Building on what works – Focus on Newmarket

Examples of key deliverables:

- The MH sub-group has 8 active members, from the VCSE, St Nicholas Hospice, Primary Care and the Racing Community. Achievements to date include:
- provision of free online mental health first aid training and access to further supportive tools.
- knowledge sharing and understanding.
- awareness campaign on volunteering including. a feature on BBC Suffolk and Our Special Friends.
- The group asked for a Peer to Peer space – we have not managed to establish this yet.

Key learning: By dividing the tasks utilising the skills, knowledge and the interest of a group you can achieve good outcomes.

Alliance Delivery Group are hosting a workshop on the 25th July to co-design how we approach locality development in West Suffolk

Primary Care

- Our PCNs have made excellent progress in recruiting to roles under the additional roles reimbursement scheme (ARRS); with 84 appointed ARRS roles across west Suffolk PCNs, these include Social Prescribers, Pharmacy Techs, Physician Associates and Paramedics plus more.
- Feedback from the Clinical event on 29 June has been positive and we saw 120+ clinicians attend on the day.
- GP Surgeries in Haverhill, Unity Healthcare and Haverhill Family Practice were congratulated by Matt Hancock MP and Ed Garratt, ICB Chief Executive, for their remarkable work during the pandemic and their resilience/innovative ways of working to deliver excellent patient care.

Urgent and Emergency Care

- **Project Stack and the Cleric Portal**. The west urgent community response (UCR) teams have been working with EEAST ambulance service since late 2022, on improving the referral pathways for non-life threatening 999 calls being transferred to the appropriate community service, therefore reducing the burden on ambulance performance and long waits that some vulnerable people have had awaiting medical attention. The next phase in the project is a digital solution to optimise a portal so that UCR's teams can select the appropriate cases from the calls that are waiting for responses.

- **Virtual Ward. Virtual Ward.** To ensure that the Virtual ward pathways were both clinically and operationally coproduced, multiple workshops were held and attended by clinical and operational leads (acute, community and primary care, including therapy), social care colleagues, service managers, digital and information teams and clinicians. The aim was to identify and enable to the right pathways for the patients of West Suffolk, along with the desired bed numbers and implementation for October 2022 & 2023. Nationally, Frailty and Respiratory were mandated for year 1 pathways and across the ICS there has been collaborative working for both these pathways, with coproduction ongoing for further collaboration. The next phase in the project is to implement the first 5 pathways for October 2022 with appropriate digital technology and start the development for year 2 pathways with our ICS and Alliance partners.

- **Read Once Share Insight (ROSI)** A group reflecting organisations across the system including primary care community health, the acute hospital and care homes have been working together to develop a new advance care plan solution for people approaching end of life with first stage implementation in Bury Town commencing September 2022. Rosi provides a shared record including ROSI and Me APP for people and their carers supporting individual choice and wishes. Innovative solution which replaces My Care Wishes including CPR decision in line with RESPECT

Cassius + - Unified remote monitoring

Cassius+ is a national first in **joining up advanced digital health and care technology** looking to revolutionise the way integrated services are delivered in the community.

- It will use technology to **monitor and assess a person's ongoing health needs** and prevent further deterioration, especially for people who are frail or with long term conditions.
- The service will **work in parallel with virtual wards** in west Suffolk, creating seamless remote monitoring that will manage people's health and care needs together in their own home.
- Clinicians, carers and social work **practitioners will also benefit** from this approach – reducing duplication, repetition, enhancing communication and improving health outcomes.
- This progressive approach is **led by the West Suffolk Alliance** – a partnership between the local NHS organisations, West Suffolk Council and Suffolk County Council.
- This initial project will **provide a blueprint for further roll-outs** and will help gather information about the impacts, outcomes and benefits to people.

Action – To deliver this, we need to identify and agree a Clinical Lead.

3.2.2. SNEE Integrated Care Board

To inform

Presented by Craig Black

WSFT Open Board – 22 July 2022

Report Title:	Item 3.2.2 – Strategic update: SNEE Integrated Care Board
Executive Lead:	Craig Black, Interim CEO
Report Prepared by:	Karen McHugh, EA to CEO
Previously Considered by:	n/a

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

Executive Summary

On Friday 1 July, the board of the new Suffolk and North East Essex Integrated Care System (SNEE ICS) was launched. This represents a new chapter for the NHS, where local health and care partners, such as NHS Trusts, GP teams, local authorities and the voluntary sector will be encouraged to work more closely together. This new approach will ensure those in our communities get the best possible care, in the right place and at the right time.

To mark this occasion, our ICS held the CanDo Health and Care Expo 2022 at Newmarket Racecourse, where I was pleased to see so many health and care colleagues in attendance. Also, a public board took place which covered the following topics:

- ICB Constitution;
- Agreement of Standing Financial Instructions;
- Approval of Statutory Committee Terms of Reference;
- Agreement of the ICB Governance Handbook;
- Confirmation of key ICB roles;
- Adoption of key policy – standards of business conduct;
- Current and future NEM capacity and diversity;
- Building our Board – Board development session.

Action Required of the Board

To note this report

Risk and assurance:	Failure of the Board to maintain oversight of key developments/activities
Equality, Diversity and Inclusion:	n/a
Sustainability:	n/a
Legal and regulatory context	**n/a**

Comfort Break

4. ASSURANCE

4.1. Insight Committee Report - June & July 2022 - Chair's Key Issues from the meeting

To Assure

Presented by Richard Davies

Board of Directors – 22 July 2022

Report Title:	Item 4.1 – Insight Committee June & July 2022 – Chair's key issues
Executive Lead:	Dr Richard Davies, NED, Insight Committee Chair Louisa Pepper, NED, Insight Committee Deputy Chair
Report Prepared by:	Dr Richard Davies, NED, Insight Committee Chair Louisa Pepper, NED, Insight Committee Deputy Chair
Previously Considered by:	n/a

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

Executive Summary
The Insight Committee met on 6 June and 4 July 2022. Below is the Chair's Key Issues document which will constitute the standard template for Insight Committee reports to Board.
Action Required of the Board
To approve the reports

Risk and assurance:	The development of and transition to a new structure for organisational governance may result in a failure to escalate significant risks to management, the executive team and the board of directors, caused by a disruption to the previous information and communication flows whilst new arrangements are being established.
Equality, Diversity and Inclusion:	*n/a*
Sustainability:	*n/a*
Legal and regulatory context	Well-Led Framework NHSI FT Code of Governance

Chair's Key Issues

Originating Committee	**Insight Committee**	**Date of Meeting**	**6th June 2022**
Chaired by	**Louisa Pepper**	**Lead Executive Director**	**Nicola Cottington**

Item	**Details of Issue**	**For: Approval/ Escalation/Assurance**	**BAF/ Risk Register ref**	**Paper attached? ✓**
IQPR	Data development	**Information**		
SIP/Business Case	Assurance re support of development of BC's as well as communicating decisions to ensure transparency and accountability	**Assurance**		
Cancer Recovery Trajectories/performance	Assurance re capital programme replacement of CT's and timescales for delivery.	**Assurance**		
Date Completed and Forwarded to Trust Secretary		**11.7.22**		

Chair's Key Issues

Originating Committee	Insight Committee	Date of Meeting	4th July 2022
Chaired by	Richard Davies	Lead Executive Director	Nicola Cottington

Item	Details of Issue	For: Approval/ Escalation/Assurance	BAF/ Risk Register ref	Paper attached? ✓
Workforce Divisional Scorecards	There are ongoing concerns about staff turnover rates which continue to climb. It was acknowledged that this is not unique to WSFT and relates in part to nationwide pressures on NHS staff. Whilst the organisation has worked to understand staff concerns and to put in place some strategies to improve retention (such as the focus on staff welfare and current developments in flexible working), there is a need for a clear organisational action plan covering staff retention as well as recruitment, with clarity around responsibilities, monitoring and timelines. It was agreed that an action plan will be developed and brought back to Insight.	**Information and approval**	**BAF 2**	
Paediatric Community Standards and Wheelchair Services	Review of Paediatric Community Standards and of Wheelchair Services provide summaries of the current situation and actions identified, however there are currently no timescales or recovery trajectories. This makes it impossible to provide assurance. Whilst the difficulties of providing timelines and recovery trajectories were acknowledged, it was agreed that providing this detail was important for Board understanding and assurance, and it was agreed that this information should be brought back to Insight.	**Partial Assurance**	**BAF 2**	
BAF Risk 3 (Digital Transformation)	Currently this risk is overseen by Insight. However, it was noted that Digital Board does not report into Insight and has previously reported straight to the Trust Board. It was agreed that the governance process for reporting on Digital Transformation and oversight of BAF Risk 3 needs to be reviewed and progress on this will be reported back to Insight	**Information**	**BAF 3**	
104 Week Waits	The Committee received a verbal report explaining that at the end of June there were 0 patients waiting over 104 weeks for elective care due to capacity breaches (excluding 16 patients who were over 104 weeks but not fit for procedure and a number of patients who had chosen to wait longer). This is a fantastic achievement and should be recognised as such.	**For Information and Celebration**	**BAF 2**	
Date Completed and Forwarded to Trust Secretary		**7.7.22**		

4.2. Finance and Workforce Report

To Note

Presented by Nick Macdonald

Board of Directors – 22 July 2022

Report Title:	Item 4.2 - Finance and Workforce Board Report – June 2022
Executive Lead:	Nick Macdonald, Executive Director of Resources (Interim)
Report Prepared by:	Charlie Davies, Deputy Director of Finance (Interim)
Previously Considered by:	N/A

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

Executive Summary

The reported I&E for June is a small deficit against budget of £0.2m (YTD £0.2m deficit). At present, it is still appropriate to anticipate a break-even position for 22/23 in line with our budget. Achieving break even does carry with it a number of risks:

- Ongoing impact of Covid on our capacity and operational capability
- Impact of unfunded Covid cost pressures such as temporary staffing, retained IP controls and staff sickness.
- Impact of unfunded inflation
- Impact of RAAC programme such as our operational capacity and revenue impact of the capital programme
- Achievement of ERF

At present we anticipate there being sufficient mitigations to be able to offset these risks. However, we continue to monitor the likelihood and impact of these risks arising so that we can plan for any impact on the financial position of the Trust as soon as possible.

Audit FY 21/22

In November 2021 the Trust appointed KMPG as our external audit provider following the resignation of our previous auditor. An extension to the audit deadline was granted by NHSE/I so as to fit in with KPMG's pre-existing commitments. This was set as 31 July 2022. At present, there have been no significant issues raised by KPMG.

However, due to unanticipated issues caused by it being the 1st year of the engagement and Covid, the audit is currently 1-2 weeks behind schedule. When combined with anticipated resourcing constraints within KPMG over the summer holiday period it has been deemed prudent to delay the signing-off of the accounts until early September. This has been agreed between the chair of the Audit Committee and the Audit Partner in KPMG.

Action Required of the Board

The Board is asked to review this report

Sustainability:	*The paper highlights potential risks to financial performance in 22/23.*

FINANCE AND WORKFORCE REPORT
June 2022 (Month 3)

Executive Sponsor : Nick Macdonald, Director of Resources (Interim)
Author : Charlie Davies, Deputy Director of Finance (Interim)

Financial Summary

I&E Position YTD	£0.2m	adverse
Variance against Plan YTD	£0.2m	adverse
Movement in month against plan	£0.2m	adverse
EBITDA position YTD	£3.9m	favourable
EBITDA margin YTD	5%	favourable
Cash at bank	£16.8m	

Executive Summary

- The reported I&E for June is a £0.2m deficit against budget (YTD £0.2m deficit).
- Forecast break-even position for 2022/23
- Audit completion for FY 21/22 is now anticipated in September 2022.

Key Risks in 2022-23

- Costs and income associated with revised activity plan
- Costs associated with increased capacity pressures relating to COVID-19 and RAAC planks.
- Revenue costs associated with RAAC plank works
- Impact of unfunded inflation
- Achievement of ERF

SUMMARY INCOME AND EXPENDITURE ACCOUNT - June 2022	June 2022 Budget £m	June 2022 Actual £m	June 2022 Variance F/(A) £m	Year to date Budget £m	Year to date Actual £m	Year to date Variance F/(A) £m
NHS Contract Income	26.4	26.1	(0.3)	76.5	76.4	(0.1)
Other Income	3.3	3.1	(0.2)	9.4	8.9	(0.5)
Total Income	**29.6**	**29.2**	**(0.4)**	**85.9**	**85.3**	**(0.6)**
Pay Costs	19.2	18.9	0.3	57.4	56.1	1.3
Non-pay Costs	9.3	9.3	(0.0)	24.9	25.3	(0.4)
Operating Expenditure	**28.5**	**28.2**	**0.3**	**82.4**	**81.4**	**1.0**
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0
EBITDA	**1.2**	**1.0**	**(0.1)**	**3.5**	**3.9**	**0.4**
Depreciation	0.8	0.8	(0.0)	2.3	2.5	(0.2)
Finance costs	0.4	0.4	(0.0)	1.3	1.6	(0.3)
SURPLUS/(DEFICIT)	**0.0**	**(0.2)**	**(0.2)**	**(0.0)**	**(0.2)**	**(0.2)**

FINANCE AND WORKFORCE REPORT – June 2022

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 AND WORKFORCE REPORT – June 2022

Income and Expenditure Summary as at June 2022

The reported I&E for June is a small deficit against budget of £0.2m (YTD £0.2m deficit). At present, it is still appropriate to anticipate a break-even position for 22/23 in line with our budget. Achieving break even does carry with it a number of risks:

- Ongoing impact of Covid on our capacity and operational capability
- Impact of unfunded Covid cost pressures such as temporary staffing, retained IP controls and staff sickness.
- Impact of unfunded inflation
- Impact of RAAC programme such as our operational capacity and revenue impact of the capital programme
- Achievement of ERF

At present we anticipate there being sufficient mitigations to be able to offset these risks. However, we continue to monitor the likelihood and impact of these risks arising so that we can plan for any impact on the financial position of the Trust as soon as possible.

Summary of I&E indicators

Income and Expenditure	Plan/ Target £000'	Actual/ Forecast £000'	Variance to plan (adv)/ fav £000'	Direction of travel (variance)	RAG (report on red)
In month surplus/ (deficit)	0	(179)	(180)	↓	Amber
YTD surplus/ (deficit)	(0)	(180)	(180)	↓	Amber
EBITDA YTD	3,545	3,897	352	↑	Green
EBITDA %	4.1%	4.6%	0.4%	↑	Green
Clinical Income YTD	(79,641)	(79,349)	(292)	↓	Amber
Non-Clinical Income YTD	(6,279)	(5,952)	(326)	↓	Amber
Pay YTD	57,427	56,088	1,339	↑	Green
Non-Pay YTD	28,496	29,400	(903)	↓	Amber

Audit FY 2021/22

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Sustainability and central CIP position.

A key part of the mitigations to the financial position is achieving the reduction in our costs of £7.5m in 22/23. In previous years, this was achieved through the overall target being apportioned to divisions and divisions delivering cost improvement programmes (CIPs) against these targets.

This year, rather than focusing on CIPs as the means to achieve financial improvement, the Trust is developing and embedding the Sustainability Programme as a key driver of improvement generally (in terms of quality, safety, environmental impact etc) across the organisation.

From this programme it is anticipated that, whilst not being the primary driver, a proportion of the schemes will enable us to deliver services more cost effectively such that costs will reduce. As a result, and to reflect this change in perspective, the overall cost reduction target is being held centrally in 22/23 rather than apportioned to divisions.

While the Sustainability programme is being established, there are some schemes under the CIP banner that have been developed for 22/23 which will contribute to the central target of £7.5m. As detailed below, there are both new schemes for 22/23 and the carried forward effect of those started part way through last year.

	Target (£k)	Risk adj (£K)	Non Risk Adjusted (£k)
22/23 Current CIP Position	7,500	676	1,091
of which:			
Anticipated roll forward of 21/22	-	*459*	*459*
New schemes in 22/23	-	*218*	*632*

FINANCE AND WORKFORCE REPORT – June 2022

Trends and Analysis

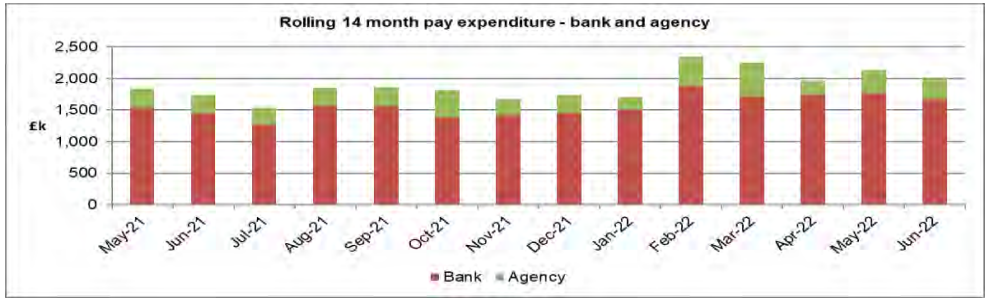
Workforce

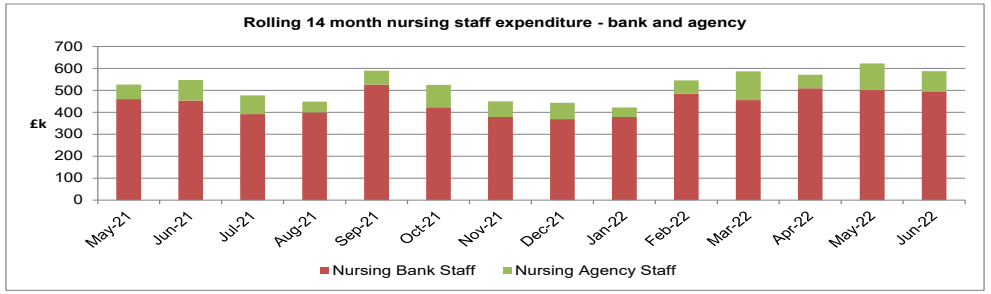
During June the Trust underspent by £0.3m on pay.

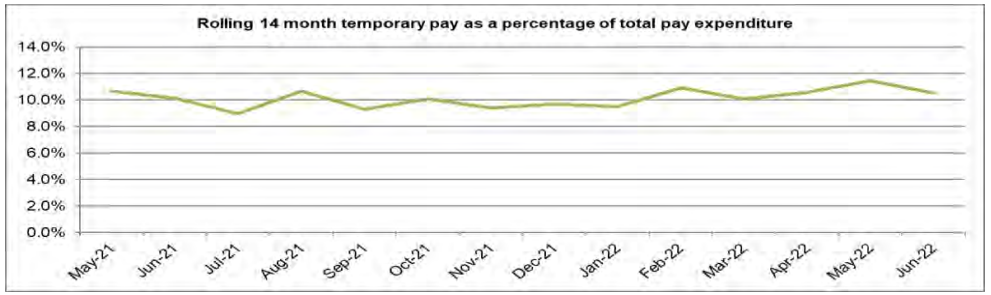
Monthly Expenditure (£)				
As at June 2022	Jun-22	May-22	Jun-21	YTD
	£000's	£000's	£000's	£000's
Budgeted Costs in-month	19,159	19,409	16,860	57,427
Substantive Staff	16,872	16,515	15,449	50,002
Medical Agency Staff	30	161	128	251
Medical Locum Staff	375	410	203	1,167
Additional Medical Sessions	304	264	378	821
Nursing Agency Staff	92	122	93	275
Nursing Bank Staff	495	501	453	1,506
Other Agency Staff	194	85	77	385
Other Bank Staff	212	238	189	694
Overtime	144	201	98	536
On Call	144	152	121	452
Total Temporary Expenditure	1,988	2,134	1,739	6,086
Total Expenditure on Pay	18,860	18,649	17,188	56,088
Variance (F/(A))	298	760	(329)	1,339
Temp. Staff Costs as % of Total Pay	10.5%	11.4%	10.1%	10.9%
memo: Total Agency Spend in-month	315	368	298	912

Monthly WTE				
As at June 2022	Jun-22	May-22	Jun-21	YTD
Budgeted WTE in-month	4,806.3	4,701.2	4,371.2	25,467.4
Substantive Staff	4,190.0	4,186.0	4,063.0	12,529.7
Medical Agency Staff	12.8	0.0	9.4	17.7
Medical Locum Staff	26.3	25.3	22.8	79.2
Additional Medical Sessions	2.5	0.8	8.0	3.9
Nursing Agency Staff	19.9	16.6	9.5	42.6
Nursing Bank Staff	132.7	119.3	129.4	391.7
Other Agency Staff	30.3	15.4	25.9	80.2
Other Bank Staff	74.7	74.6	78.1	234.1
Overtime	37.8	51.8	22.5	137.6
On Call	9.5	8.4	8.2	25.8
Total Temporary WTE	346.5	312.2	313.8	1,012.7
Total WTE	4,536.4	4,498.2	4,376.7	13,542.5

Pay Costs







FINANCE AND WORKFORCE REPORT – June 2022

Income and Expenditure Summary by Division

	Current Month			Year to date		
	Budget	Actual	Variance F/(A)	Budget	Actual	Variance F/(A)
MEDICINE	£k	£k	£k	£k	£k	£k
NHS Contract Income	(8,139)	(8,075)	(65)	(24,217)	(23,593)	(624)
Other Income	(341)	(320)	(21)	(1,024)	(897)	(128)
Total Income	**(8,481)**	**(8,395)**	**(86)**	**(25,241)**	**(24,489)**	**(752)**
Pay Costs	4,862	4,852	10	14,585	14,764	(179)
Non-pay Costs	1,660	1,942	(282)	4,691	5,768	(1,077)
Operating Expenditure	**6,521**	**6,793**	**(272)**	**19,276**	**20,532**	**(1,256)**
SURPLUS / (DEFICIT)	**1,960**	**1,602**	**(358)**	**5,966**	**3,957**	**(2,009)**
SURGERY						
NHS Contract Income	(5,458)	(6,113)	654	(16,522)	(16,855)	333
Other Income	(162)	(189)	27	(510)	(556)	45
Total Income	**(5,620)**	**(6,301)**	**682**	**(17,033)**	**(17,411)**	**378**
Pay Costs	3,970	3,881	89	11,935	11,504	431
Non-pay Costs	1,154	1,853	(699)	3,492	4,314	(823)
Operating Expenditure	**5,124**	**5,734**	**(610)**	**15,427**	**15,818**	**(391)**
SURPLUS / (DEFICIT)	**496**	**568**	**72**	**1,606**	**1,593**	**(13)**
WOMENS AND CHILDRENS						
NHS Contract Income	(2,091)	(2,466)	374	(6,313)	(6,505)	192
Other Income	(67)	(56)	(11)	(201)	(247)	46
Total Income	**(2,158)**	**(2,521)**	**363**	**(6,514)**	**(6,752)**	**239**
Pay Costs	1,675	1,631	43	5,024	4,858	166
Non-pay Costs	176	236	(60)	522	676	(154)
Operating Expenditure	**1,851**	**1,867**	**(16)**	**5,546**	**5,534**	**12**
SURPLUS / (DEFICIT)	**307**	**654**	**347**	**967**	**1,218**	**250**
CLINICAL SUPPORT						
NHS Contract Income	(627)	(528)	(99)	(1,879)	(1,583)	(295)
Other Income	(151)	(120)	(30)	(452)	(446)	(6)
Total Income	**(778)**	**(649)**	**(129)**	**(2,331)**	**(2,029)**	**(302)**
Pay Costs	2,245	2,300	(55)	6,734	6,727	7
Non-pay Costs	1,010	1,574	(564)	3,025	4,157	(1,132)
Operating Expenditure	**3,254**	**3,873**	**(619)**	**9,759**	**10,884**	**(1,125)**
SURPLUS / (DEFICIT)	**(2,476)**	**(3,225)**	**(749)**	**(7,428)**	**(8,855)**	**(1,426)**
COMMUNITY SERVICES						
NHS Contract Income	(2,968)	(3,199)	231	(8,883)	(9,144)	261
Other Income	(1,285)	(1,218)	(68)	(3,837)	(3,540)	(297)
Total Income	**(4,254)**	**(4,417)**	**163**	**(12,720)**	**(12,684)**	**(36)**
Pay Costs	3,029	3,007	21	9,032	8,782	250
Non-pay Costs	1,442	1,360	82	4,343	4,027	317
Operating Expenditure	**4,471**	**4,368**	**103**	**13,375**	**12,808**	**567**
SURPLUS / (DEFICIT)	**(217)**	**49**	**266**	**(656)**	**(125)**	**531**
ESTATES AND FACILITIES						
NHS Contract Income	0	0	0	0	0	0
Other Income	(488)	(207)	(281)	(1,464)	(805)	(659)
Total Income	**(488)**	**(207)**	**(281)**	**(1,464)**	**(805)**	**(659)**
Pay Costs	1,061	1,033	27	3,182	3,147	35
Non-pay Costs	773	839	(66)	2,320	2,540	(220)
Operating Expenditure	**1,834**	**1,872**	**(38)**	**5,501**	**5,687**	**(185)**
SURPLUS / (DEFICIT)	**(1,346)**	**(1,665)**	**(319)**	**(4,037)**	**(4,882)**	**(845)**
CORPORATE						
NHS Contract Income	(7,091)	(5,734)	(1,356)	(18,700)	(18,684)	(16)
Other Income	(762)	(1,013)	251	(1,915)	(2,507)	592
Total Income	**(7,853)**	**(6,748)**	**(1,105)**	**(20,616)**	**(21,191)**	**576**
Pay Costs	2,319	2,157	162	6,936	6,307	629
Non-pay Costs	3,073	1,490	1,583	6,543	3,761	2,782
Capital Charges and Financing Costs	1,185	1,264	(79)	3,555	4,211	(656)
Operating Expenditure	**6,577**	**4,911**	**1,666**	**17,034**	**14,278**	**2,756**
SURPLUS / (DEFICIT)	**1,276**	**1,837**	**561**	**3,582**	**6,913**	**3,331**
TOTAL						
NHS Contract Income	(26,375)	(26,115)	(261)	(76,514)	(76,364)	(150)
Other Income	(3,256)	(3,124)	(133)	(9,404)	(8,997)	(406)
Total Income	**(29,632)**	**(29,238)**	**(393)**	**(85,918)**	**(85,361)**	**(556)**
Pay Costs	19,159	18,860	298	57,427	56,088	1,339
Non-pay Costs	9,287	9,293	(6)	24,936	25,243	(307)
Capital Charges and Financing Costs	1,185	1,264	(79)	3,555	4,211	(656)
Operating Expenditure	**29,631**	**29,418**	**213**	**85,918**	**85,541**	**376**
SURPLUS / (DEFICIT)	**0**	**(180)**	**(180)**	**(0)**	**(180)**	**(180)**

Medicine (Sarah Watson)

At the end of June, the Medicine division is behind plan by £358k (£2.0m YTD).

Clinical income is behind plan by £65k in month. A&E activity and outpatient activity were both 10% up on plan in the first two months. In-patient activity, whilst recovering slightly from April, remained behind plan largely due to elective day cases. Outpatient activity includes nearly 100% over plan for telephone consultation whilst under plan in attendance and procedure levels.

Table 1 : Current Medicine Performance against, plan, 24 month average

Activity	Versus Plan	Versus 24mth Avg	Versus 19/20 Avg
Non-Elective	5%	18%	13%
Outpatients	12%	11%	6%
Elective	-18%	12%	-12%

Excluding clinical income, the division is behind plan by £303k in the month (£1.3m YTD), almost entirely due to non-pay cost variances. For the first three months, Non-pay reports a £1.1m adverse variance whilst pay budget variances total £180k (1.2% of budget).

The key drivers behind the non-pay budget variance for June are:

- £124k pressure on drugs, £86k of which is on Rheumatology and Dermatology and also a result of an in-month correction to the YTD position. This continued overspend on Drugs (£688k YTD) is being investigated to see if any high cost drugs can be reclaimed.
- £36k on Equipment leases and £15k for MSE in Cardiology.

Although pay budget broke even in the month of June, there were large compensating variances against budget.

- £191k under budget for Registered Nurses attributable to 11% of posts being vacant (compared to 6% for the Directorate as a whole.)
- £32k unregistered Nurses pay costs to compensate for Registered Nurses vacancies.
- £102k over-spend on Medical Doctors largely due to Junior doctor costs

Surgery (Moira Welham)

The overall financial position for the division was £72k ahead of plan in month and £13k behind plan YTD.

Clinical income is ahead of plan by £654k in month (£333k YTD). Whilst the division are making improvements within its outpatient and elective activity, overperformance within the division is mainly driven by the high levels of emergency activity.

Pay expenditure reported an underspend of £89k in month (£431k YTD). Underspends are being driven by vacancies within anaesthetics, theatres and ward-based nursing. These underspends are in part offset by the use of temporary staffing.

Non-pay expenditure was overspent by £699k in month (£823k YTD). This is expected to continue as the division focuses on meeting the priorities detailed within the 22/23 planning guidance. To enable recovery, the division are reviewing theatre efficiency, increasing POA and using external providers and mutual aid where possible. To date, the use of external providers has been the main cost driver behind the non-pay overspends (£532k YTD) offsetting pay underspends to deliver activity.

Women and Children's (Simon Taylor)

In June, the Division reported a favourable variance of £347k (YTD £250k).

Clinical Income was £374k ahead of plan in-month driven by elective Obstetrics, Paeds outpatients and Antenatal services being ahead of plan in month.

Pay reported a £44k underspend in-month as the Maternity Service continues to struggle to fill vacancies due to the national shortage of midwives. The maternity service has successfully appointed to a number of posts and plans to have the new staff starting shortly.

Non-pay reported an unanticipated £60k overspend in-month due largely to overspends on drugs within Obstetrics and Paediatrics, partly a result of the increased activity noted above.

Clinical Support (Simon Taylor)

In June, the Division reported an adverse variance of £749k (£1.4m YTD).

Income was £99k behind plan in-month because the Radiology Service was behind plan for outpatient, elective interventional radiology and direct access activity. Despite still having issues, the performance of the second CT scanner improved in the month, and the service is continuing to progress replacement of CT 2 and the installation of the third CT scanner

Pay reported a £55k overspend in-month, with Pathology and Diagnostics both incurring additional costs, offset partially by vacancies in Pharmacy and Outpatients.

Non-pay reported a £564k overspend in-month as the Trust continued to overspend on recovery measures for CT and endoscopy, as well as an in-month correction of YTD drugs spend.

Community Services (Clement Mawoyo)

The Community Division reported a favourable variance of £266k in M3 of 2022/23

Income reported a £163k over recovery in June (£36k adverse YTD) driven by a YTD adjustment to recognise move acute contract income. We anticipate Clinical income to be in line with budget allocation in 2022/23.

Pay reported a favourable variance of £21k in June (£250k YTD). Pay expenditure has continued to increase in line with budget in quarter one of the 2022/23 financial year, to reflect recruitment to the externally funded urgent community (responsive) additional roles as well as new roles funded via external business case or other external grant.

Despite the division's increased staff turnover (15% in June) and vacancies, temporary staff were used to cover some vacant roles across the division. Additional agency capacity has been allocated to the Early Intervention Team to provide additional capacity to support admission avoidance and urgent care response. Recruitment to vacant roles is ongoing despite recruitment challenges with a key areas of challenge being Reablement Support Workers. A focused review group has been established to deliver improved recruitment and retention with a focus on staff engagement to inform next steps.

Non-pay reported a £82k favourable variance in June (£317k YTD). Pressures noted under community equipment costs (driven by increased need) were offset by a number of in-month underspends for Wheelchair Services. Reduced expenditure on Wheelchair equipment was enabled by increased recycling of equipment - a key initiative of the Division's Sustainability Programme.

Estates and Facilities

In June, the division recorded an adverse variance of £319k (YTD £844k adverse).

Income in Estates is behind plan in month driven by underachievement in car park (£79k, £277k YTD) and restaurant income (£92k, £287k YTD), both a result of measures introduced as part of the Trust's response to the pandemic. Discussions are ongoing with staff representatives about the re-introduction of staff car parking charges. There are similar conversations taking place with IPC about Time Out being used again by visitors. Therefore, we will continue to see these variances occur until such a time as decisions are taken on these two points.

Pay costs exceeded budget by £27k in month (2% of monthly budget (£1.06m). Work has commenced in month to reduce overtime payments to Security staff following substantive recruitment, with the expectation that the resulting overspends will reduce.

Non-Pay costs gave an adverse variance to monthly budget of £66k (£219k YTD adverse). Laundry (£31k) and Service Contract Costs (£71k) present two significant variances in the period. The laundry contract is due to expire at calendar year end and possibilities are being explored surrounding the option of using a wash and return model to save costs in this area. Discussions are ongoing as the division looks to embrace the challenges that the current inflation level presents.

Statement of Financial Position at 30 June 2022

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2022 (Draft)	Plan 31 March 2023	Plan YTD 30 June 2022	Actual at 30 June 2022	Variance YTD 30 June 2022
	£000	£000	£000	£000	£000
Intangible assets	52,039	56,905	56,941	54,210	(2,731)
Property, plant and equipment	170,887	201,415	184,189	176,689	(7,500)
Trade and other receivables	5,807	6,341	6,341	5,807	(534)
Total non-current assets	**228,733**	**264,661**	**247,471**	**236,706**	**(10,765)**
Inventories	3,574	3,689	3,689	3,603	(86)
Trade and other receivables	15,069	18,362	18,362	19,652	1,290
Cash and cash equivalents	33,323	10,767	9,535	16,765	7,230
Total current assets	**51,966**	**32,818**	**31,586**	**40,020**	**8,434**
Trade and other payables	(60,164)	(38,925)	(35,873)	(56,816)	(20,943)
Borrowing repayable within 1 year	(5,858)	(9,684)	(12,861)	(7,094)	5,767
Current Provisions	(38)	(46)	(46)	(16)	30
Other liabilities	(2,888)	(5,685)	(5,685)	(2,471)	3,214
Total current liabilities	**(68,948)**	**(54,340)**	**(54,465)**	**(66,397)**	**(11,932)**
Total assets less current liabilities	**211,751**	**243,139**	**224,592**	**210,329**	**(14,263)**
Borrowings	(44,002)	(47,927)	(50,595)	(42,759)	7,836
Provisions	(415)	(852)	(852)	(415)	437
Total non-current liabilities	**(44,417)**	**(48,779)**	**(51,447)**	**(43,174)**	**8,273**
Total assets employed	**167,334**	**194,360**	**173,145**	**167,155**	**(5,990)**
Financed by					
Public dividend capital	200,285	227,311	206,096	200,285	(5,811)
Revaluation reserve	11,704	11,704	11,704	11,704	0
Income and expenditure reserve	(44,655)	(44,655)	(44,655)	(44,834)	(179)
Total taxpayers' and others' equity	**167,334**	**194,360**	**173,145**	**167,155**	**(5,990)**

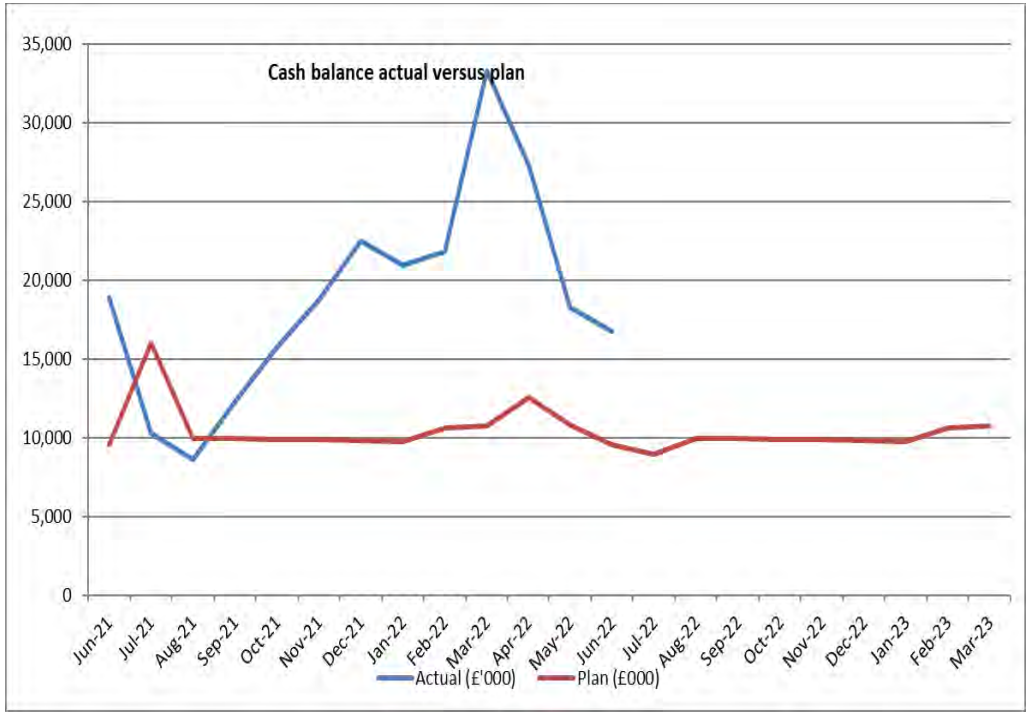
The opening balances shown in the table above remain subject to audit. The significant variance between fixed assets and borrowings is due to right of use assets (leases). The plan has these included on the balance sheet, however these have not yet been reflected on the ledger. A project is underway to bring these assets on to the balance sheet.

Trade payables is higher than plan, but is in line with the year end position as at 31 March 2022, showing a small movement. This links to the fact that the cash position is slightly higher than plan.

We have not yet drawn down the PDC allocated to us in line with the plan and this will be drawn down imminently.

Cash Balance Forecast for the year

The graph illustrates the cash trajectory since June 2021. The Trust is required to keep a minimum balance of £1m.

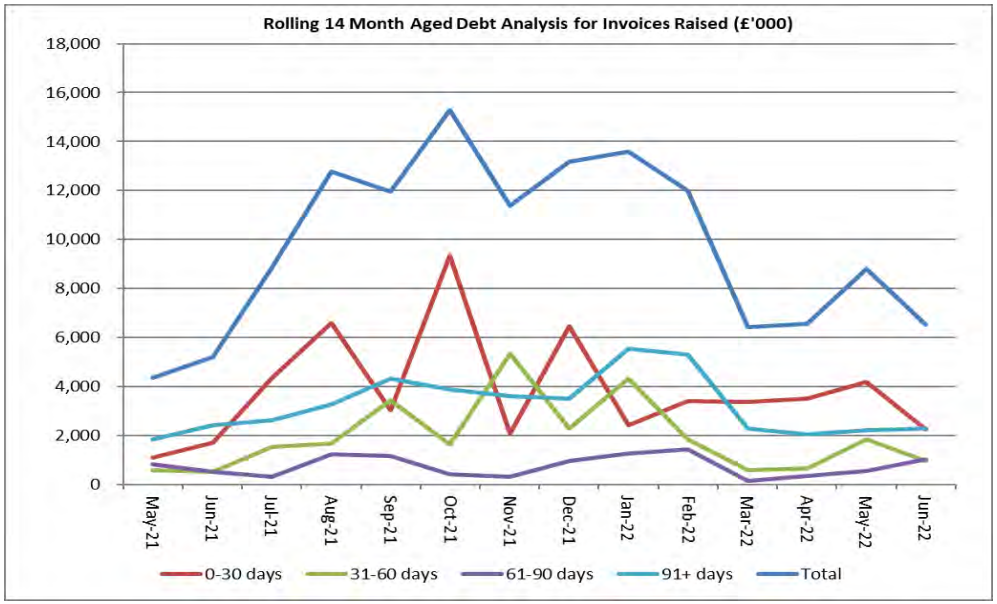


The cash position remains ahead of plan at month 3, however we will closely monitor the position to ensure that it remains in line with the year-end forecast of £10.7m.

Cash flow forecasts continue to be submitted to NHS England every fortnight to ensure that adequate cash reserves are being held within the NHS.

Debt Management

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



It is important that the Trust raises invoices promptly for money owed and that the cash is collected as quickly as possible to minimise the amount of money the Trust needs to borrow.

The overall level of sales invoices raised but not paid has remained steady and has improved in month 3. The large majority of the debts outstanding are historic debts, although these are reducing. Over 78% of these outstanding debts relate to NHS Organisations, with 29% of these NHS debts being greater than 90 days old. We are actively trying to agree a position with the remaining corresponding NHS Organisations for these historic debtor balances and a significant amount of work has been completed in this area to help reduce these historic balances.

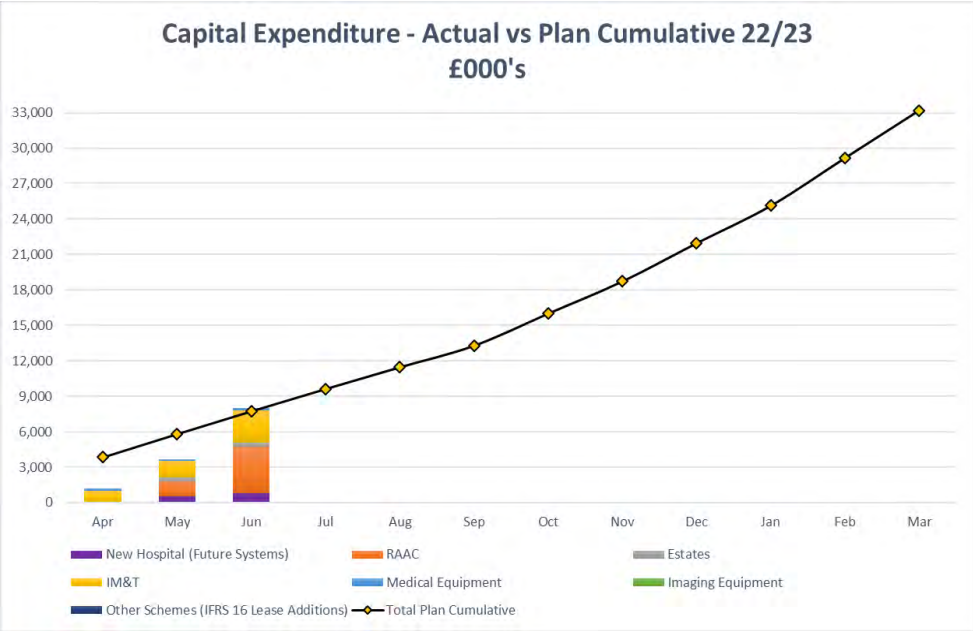
Capital Progress Report

The 2022/23 Capital Programme has been set at £33.2m with £21m of this relating to structure works.

With the implementation of the new accounting standard in relation to leases (IFRS 16) the Trust will also be required to transfer any operating leases that the Trust had as at 31 March 2022 onto the balance sheet as a capital item. This will count towards the Trust's capital allocation, but will be fully funded for this transitional year.

The year to date capital spend for month 3 was £8m. At this early stage the projects are all being forecast to come in at around the plan figure.

Capital Spend - 30 Jun 2022	In Month			Year to Date			Forecast		
Capital Scheme	M3 Original Plan	M3 Actual	Variance	YTD Original Plan	YTD Actual	Variance	Full year Original Plan	Full Year Forecast 31 Mar 2023	Total Full Year Variance Against Forecast
	£000's	£000's	£000's		£000's		£000's		£000's
New Hospital (Future Systems)	88	291	-203	268	803	-535	1,060	1,060	-
RAAC	1,083	2,609	-1,526	3,249	3,913	-664	21,000	21,000	-
Estates	195	58	137	610	339	271	1,680	1,680	-
IM&T	508	1,365	-857	1,584	2,772	-1,188	5,430	5,430	-
Medical Equipment	50	59	-9	150	202	-52	400	400	-
Imaging Equipment	-	-	-	-	-	-	1,740	1,740	-
Other Schemes (incl. IFRS 16 Lease Additions)	-	-	-	1,891	-	1,891	1,891	1,891	-
Total Capital Schemes	1,924	4,382	-2,458	7,752	8,029	-277	33,201	33,201	0
Overspent vs Plan									
Underspent vs Plan									


Capital Expenditure - Actual vs Plan Cumulative 22/23
£000's
33,000
30,000
27,000
24,000
21,000
18,000
15,000
12,000
9,000
6,000
3,000
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
New Hospital (Future Systems)
RAAC
Estates
IM&T
Medical Equipment
Imaging Equipment
Other Schemes (IFRS 16 Lease Additions)
Total Plan Cumulative

4.3. IQPR - see Annexes 7.0

To Note

Presented by Susan Wilkinson and Nicola Cottington

4.4. Improvement Committee Report - June & July 2022 Chair's key issues from the meetings

To Assure

Presented by Jude Chin

Board of Directors Open – 22 July 2022

Report Title:	Item 4.4 - Improvement Committee report and Chair's Key Issues June 2022
Executive Lead:	Jude Chin – Non-Executive Chair Improvement Committee
Report Prepared by:	Rebecca Gibson – Head of Compliance & Effectiveness
Previously Considered by:	n/a

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

Executive Summary
The Improvement Committee met on 13 June 2022. Attached is the Chair's Key Issues document which will constitute the standard template for Improvement Committee reports to Board. The report includes two appendices: A. Quality & learning report B. CQC new model of assessment
Action Required of the Board
To approve the report

Risk and assurance:	BAF risk 1. Quality governance or service failure If we do not establish effective governance structures, systems and procedures over safety and quality, this will lead to poor standards of care to all patients and service users, potential harm, service failure, reputation damage, poor patient experience and regulatory action
Legal and regulatory context	Well-Led Framework NHSI FT Code of Governance Health and Social Care Act 2008 (HSCA 2008)

Chair's Key Issues

Part A

Originating Committee	Improvement Committee	**Date of meeting**	13 June 2022
Chaired by	Jude Chin	**Lead Executive Director**	Sue Wilkinson

Agenda item	Details of issue	For: Approval/ Escalation/ Assurance	BAF/ Risk Register ref	Paper attached? ✓
3.	Action point 34 (Action oversight) – systems are in place to manage identification of incidents, investigation methods and review of completed reports with executive oversight. Assurance can be gained that these processes are working well. Enabling findings and recommendations into actions and improvement is less well established and was the only action noted in the CCG review of our year one PSIRP. In particular the need for a more robust framework for safety improvement is required and a new group the Safety Improvement Group (SIG) is being developed, chaired by Dr Mills (AMD-Q&S). The SIG will begin with the oversight of recommendations arising from PSIIs only, then once established, will expand its scope to encompass all sources of patient safety learning.	Partial Assurance		
4.1	IQPR – Meeting received sub-set of the current IQPR identified as within the remit of Improvement. The 'making data count' method enables oversight of indicators which require a narrative and the pressure ulcer data was reviewed as an example. It was noted that the specialist committees which report to Improvement via the PQAS are not all represented in the current data and a specific action to collate a 'long list' from all the specialist committees has been requested.	Assurance		
5.1	Patient Quality & Safety group (PQAS) – The report and minutes of PQAS noted: • Rise in staffing related IG breaches and need for increased education on standards • Mortuary maintaining HTA (human tissue authority) license	Assurance		

Agenda item	Details of issue	For: Approval/ Escalation/ Assurance	BAF/ Risk Register ref	Paper attached? ✓
6.1	Quality and Learning report – Quarterly report previously provided directly to the Board. Summary of learning outcomes from range of patient safety sources (incidents and investigations, learning from deaths, patient and public feedback, and staff feedback.)	Assurance		✓ Imp CKIs Appendix 1 - Quality and Learning
6.2.1	Learning from patient safety events (LFPSE) – A new national reporting framework being introduced to replace the national incident reporting platforms NRLS and STEIS which will be decommissioned by April 2023. Healthcare organisations need to commence transition to LFPSE as soon as possible ahead of the decommission date. This new framework will have a significant impact for WSFT including Datix redesign. The case for a one year project management role is being developed, this will also be used as an opportunity to review our wider risk management and assurance systems to ensure fit for purpose. We will collaborate with local providers in these considerations	Escalation		
7.1	CQC Insight – Publication (issued by CQC) which lists key data items CQC uses to build a risk profile of an organisation, forms one element of evidence to support inspection scheduling. 188 indicators are linked to the key questions (Safe, Effective, Caring, Responsive and Well-led). Trusts are rated on a continuum from Much better to Much worse for each item. Many items already included in reporting data-sets within the 3i framework (e.g. A&E >12 hour waits, cancer targets, national staff and patient survey results, national audits, HES data and HSMR / SHMI). Action to devise oversight process of the publication in progress.	Assurance		
7.2	CQC new model of assessment – Provided to raise organisational awareness of changes in future CQC assessment framework and overview of the model.	Information and awareness		✓ Imp CKIs Appendix 2 - CQC new model of
Date completed and forwarded to Trust Secretary				

Board of Directors Open – 22 July 2022

Report Title:	Item 4.4 - Improvement Committee report and Chair's Key Issues – July 2022
Executive Lead:	Jude Chin – Non-Executive Chair Improvement Committee
Report Prepared by:	Rebecca Gibson – Head of Compliance & Effectiveness
Previously Considered by:	n/a

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

Executive Summary

The Improvement Committee met on 11 July 2022. Attached is the Chair's Key Issues document which will constitute the standard template for Improvement Committee reports to Board.

The report includes three appendices:

- Patient quality & safety governance group report including Pressure ulcer report (Board action point 2045)
- Patient Safety strategy
- 2022/23 Quality Priorities

Action Required of the Board

To **agree** closure of the final outstanding action from the 2020 CQC improvement plan

To **note** the escalation point re 'making data count'

To **receive** the patient safety strategy

Risk and assurance:	BAF risk 1. Quality governance or service failure If we do not establish effective governance structures, systems and procedures over safety and quality, this will lead to poor standards of care to all patients and service users, potential harm, service failure, reputation damage, poor patient experience and regulatory action
Legal and regulatory context	Well-Led Framework NHSI FT Code of Governance Health and Social Care Act 2008 (HSCA 2008)

Chair's Key Issues

Part A

Originating Committee	Improvement Committee	**Date of meeting**	11 July 2022
Chaired by	Jude Chin	**Lead Executive Director**	Sue Wilkinson

Agenda item	Details of issue	For: Approval/ Escalation/ Assurance	BAF/ Risk Register ref	Paper attached? ✓
3.2	Community pain assessment recording – The final open action from the 2020 CQC report improvement plan, this report provided assurance that the improvements seen in the last report six months earlier had been maintained as BAU and there was a local (divisional) ongoing oversight of the data. Board is asked to **agree** closure.	Approval		
3.3	Specialist committee data reporting – A review of data items used by groups reporting into PQAS (Patient Quality & Safety Governance Group) is underway. This aims to enhance the current IQPR by ensuring meaningful and useful data is contained within an IQPR that is representative of all aspects of quality and safety. The meeting noted the need for a wider piece of work to support the 'making data count' implementation as well as ensuring staff are trained in methodology including the narrative to support SPC variances. There needs to be structured focus on how this will all be achieved and by who / when. The opportunity to update the contract data-set to reflect this was noted and acknowledged as beneficial by the ICS representation in the meeting.	Escalation		
4.1	IQPR Noted five items of special cause variation within the remit of PQAS MRSA + Hand hygiene (*improving*) : Verbal duty of candour, Patient safety incidents reported, resulting in harm (*concerning*) Highlighted anomaly whereby pressure ulcers data is *Consistently failing target* but pressure ulcers per 1,000 bed days is *Consistently hitting target*. Targets may need updating to reflect an improvement trajectory	Assurance		✓ IQPR in annex

Agenda item	Details of issue	For: Approval/ Escalation/ Assurance	BAF/ Risk Register ref	Paper attached? ✓
5.1	Patient Quality & Safety governance group – June Report and minutes provided. Reports provided for: Drugs and Therapeutics, Falls, Pressure Ulcers and Infection Prevention & Control			✓ Report in annex (action 2045)
5.2	Clinical Effectiveness governance group – June Report provided. Reports provided for: Local clinical audits, NICE, Radiology, Public Health, Research & development Emerging concerns - Radiology 'no report required'. AMD (patient safety) assisting to improve performance, no further action for Improvement committee at this time. Emerging concerns – Clinical audit participation: concern that time allocated for quality activities is being limited by operational work pressures. Improvement committee agreed requires further scrutiny	Partial assurance		
6.1	Patient Safety strategy and implementation plan - Final version now complete and linked to trust strategy. Strategy will be launched in September as part of WSFT Patient safety month.	Assurance		✓ Strategy in annex
6.2	Ockenden (organisational wide) – Initial baseline assessment of wider organisational opportunities in publication. Next steps include gap analysis and allocation wherever possible to existing groups. Oversight including 3i allocation to be agreed.	Assurance		
6.3	Duty of Candour – quality assurance report received. More detail in closed board report Incidents, claims, complaints, inquests + other external reviews	Assurance		See closed board paper
7.1	Quality priorities – Allocation of executive leads to oversee improvement progress reporting to be discussed and agreed at 13th July Execs meeting	Assurance		✓ List of QIPs in annex
9.2	Update from Associate Medical Directors (Patient Safety / Clinical Effectiveness) Noted a rolling programme of updates from AMDs. To start with mortality (Aug) and shared decision-making (Sept)	Assurance		
Date completed and forwarded to Trust Secretary		15/07/22		

4.5. Quality and Nurse Staffing Report

To Assure

Presented by Susan Wilkinson

Trust Board – 22 July 2022

Report Title:	Item 4.5 – Quality and Workforce Report & Dashboard – Nursing May and June 2022
Executive Lead:	Sue Wilkinson
Report Prepared by:	Daniel Spooner
Previously Considered by:	N/A

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

Executive Summary

This paper reports on safe staffing fill rates and mitigations for inpatient areas for May and June 2022. It complies with national quality board recommendations to demonstrate effective deployment and utilisation of nursing staff. The paper identifies planned staffing levels and where unable to achieve, actions taken to mitigate where possible. The paper also demonstrates the potential resulting impact of these staffing levels. It will go onto review vacancy rates, nurse sensitive indicators, and recruitment initiatives.

Highlights

- Average RN fill rates in the day remain under 90% since October 2021 Improvements in fill rate seen in May and June
- Inpatient RN vacancy rate percentage has slightly improved again for this period
- NA vacancy has increased significantly driven by an increase in budgeted establishment for MCAs and reduction in WTE
- Reduction in sickness rates in RN/RM group
- High sickness in NA/support staff
- Maternity KPIs maintained good performance,
- Summer SNCT commenced and ED establishment review planning commenced

Action Required of the Board

For assurance around the daily mitigation of nurse staffing and oversight of nursing establishments
No action needed

Risk and assurance:	Red Risk 4724 amended to reflect surge staffing and return to BAU
Equality, Diversity and Inclusion:	*N/A*
Sustainability:	*N/A*
Legal and regulatory context	*Compliance with CQC regulations for provision of safe care*

1. Introduction

Whilst there is no single definition of 'safe staffing', the NHS constitution, NHS England, CQC regulations, NICE guidelines, NQB expectations, and NHS Improvement resources all refer to the need for NHS services to be provided with sufficient staff to provide patient care safely. NHS England cites the provision of an *"appropriate number and mix of clinical professionals"* as being vital to the delivery of quality care and in keeping patients safe from avoidable harm. (NHS England 2015).

West Suffolk NHS Trust is committed to ensuring that levels of nursing staff, which includes Registered Nurses, Midwives and Nursing Associates and Assistant Practitioners, match the acuity and dependency needs of patients within clinical ward areas in the Trust. This includes ensuring there is an appropriate level and skill mix of nursing staff to provide safe and effective care using evidence-based tools and professional judgement to support decisions. The National Quality Board (NQB 2016) recommend that on a monthly basis, 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 the safe staffing and actions taken in May and June 2022. The following sections identify the processes in place to demonstrate that the Trust proactively manages nurse staffing to support patient safety.

2. Nursing Fill Rate

The Trust's safer staffing submission has been submitted to NHS Digital for May and June 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

	Day		Night	
	Registered	Care Staff	Registered	Care staff
Average fill rate for January 2022	87%	81%	82%	97%
Average fill rate February 2022	85%	81%	84%	100%
Average fill rate March 2022	84%	78%	83%	96%
Average fill rate April 2022	84%	76%	81%	93%
Average fill rate May 2022	87%	80%	89%	98%
Average fill rate June 2022	87%	74%	88%	92%

Table 1: Fill rates are RAG rated to identify areas of concern (Purple >100%, Green: 90-100%, Amber 80-90%, Red <80).

Highlights

- Improvement in fill rates for RNs for this period
- Lowest fill rate in day shift NAs in June.
- Lowest fill rate of NA in critical care as their 2WTE both on long-term sick/leave in June.

Care Hours per Patient Day (CHPPD)

CHPPD is a measure of workforce deployment and is reportable to NHS Digital as part of the monthly returns for safe staffing (Appendix 1). CHPPD is the total number of hours worked on the roster by both Registered Nurses & Midwives and Nursing Support Staff divided by the total number of patients on the ward at 23:59 aggregated for the month (lower CHPPD equates to lower staffing numbers available to provide clinical care). Using model hospital, the average Recommended CHPPD for an organisation of our size is 7.6. The chart below demonstrates our achievement of this. Recommended CHPPD was achieved in May, but below this target in June.

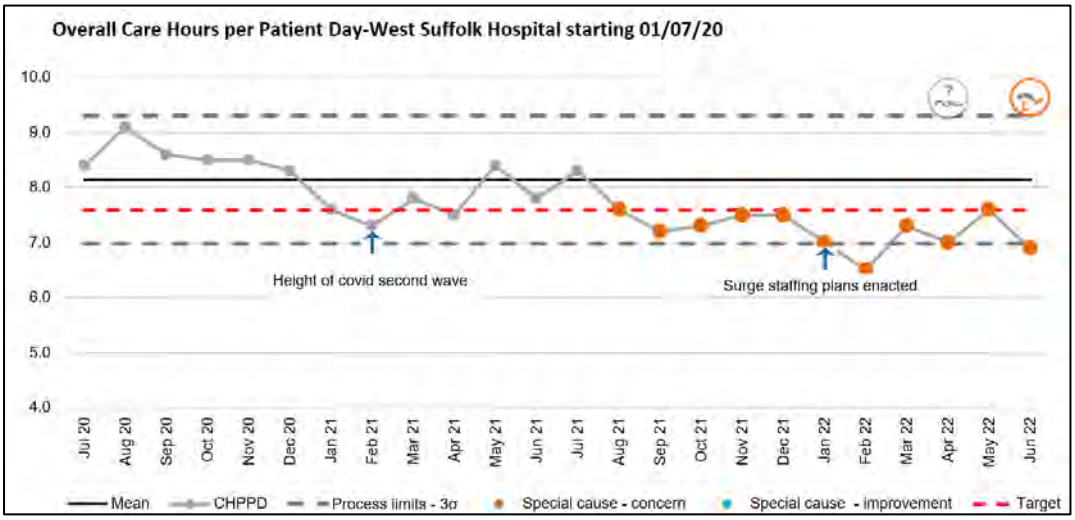


Chart 2: Adapted from model hospital/unify data

3. Sickness

Community prevalence of Covid has increased in June potentially driving an increase in absences this month. RN sickness rates have declined marginally over the last four months. (Chart 2).

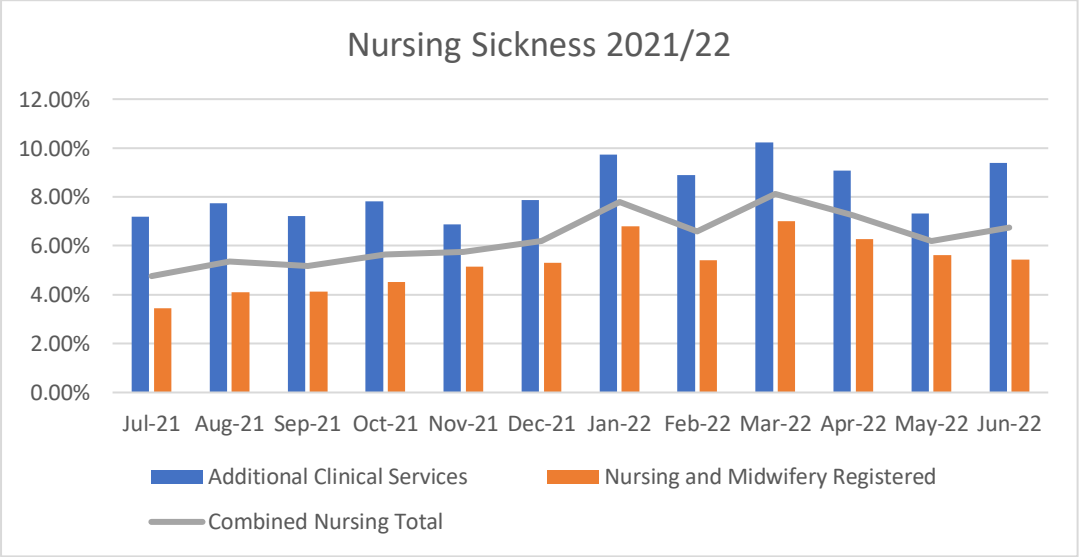


Chart 2.

	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Unregistered staff (support workers)	6.89%	7.88%	9.74%	8.89%	10.24%	9.07%	7.32%	9.40%
Registered Nurse/Midwives	5.15%	5.30%	6.79%	5.42%	7.00%	6.27%	5.63%	5.43%
Combined Registered/Unregistered	**5.75%**	**6.19%**	**7.80%**	**6.60%**	**8.12%**	**7.25%**	**6.20%**	**6.76%**

Table 2b

Challenges to providing safe staffing have also been exacerbated by staff that are required to self-isolate, either due to exposure to Covid 19, or due to a member of their household being symptomatic. This is captured separately to sickness and is demonstrated below (chart 3). It should be noted that in May, national guidance on self-isolation, following close contact with Covid 19, was amended and isolation is no longer mandatory. This should enable an increase opportunity for staff to return to work. Twice weekly lateral flow testing and a risk-based approach is now the required action, this is demonstrated in the reduction of staff isolations in May and June.

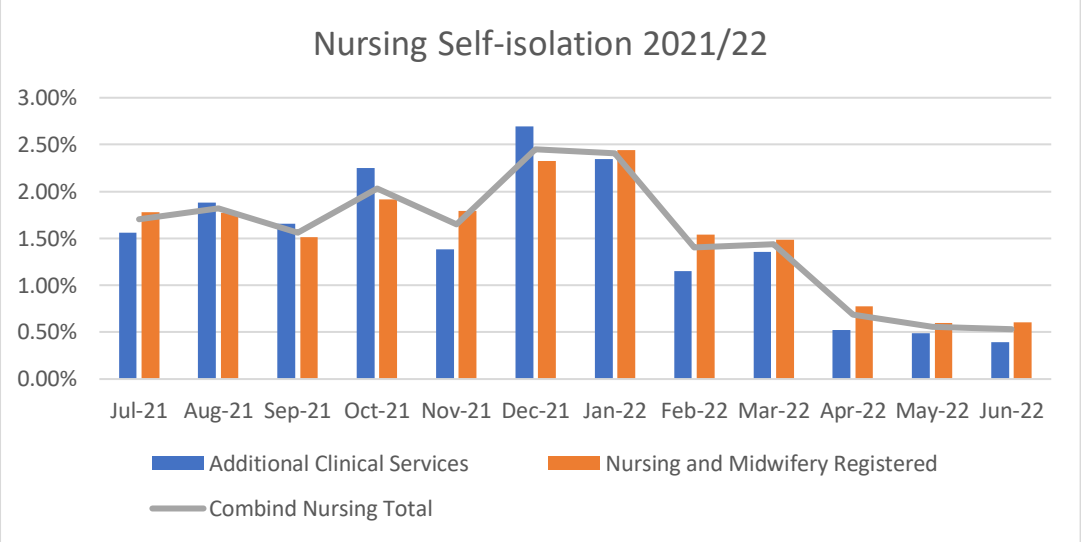


Chart 3

4. Patient Flow and Escalation

Good patient flow is central to patient experience, clinical safety and reducing the pressure on staff. It is also essential to the delivery of national emergency care access standards (NHSI 2017). Ward closures and moves can add additional staffing challenges and opportunities. In recent months ward relocations and structural repair have challenged flow and staffing.

No additional wards open during this period which has greatly assisted in addressing staffing challenges. Surge areas as part of BAU have been used consistently in this reporting period which requires the sourcing of one RN and one NA for the duration of its function. While this appears small numbers, it is additional pressure on the current shortfall and reduces the efficacy of the same day emergency care pathway.

Ward relocations in this period.

- F11 to F9

5. Recruitment and Retention

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

- Inpatient RN/RM WTE has remained static in this period
- Inpatient ward RN vacancies (excluding RM) is 13.7% a reduction of 1.7% from last report (appendix 2).
- Total RN/RM vacancies (all areas) h has reduced from 13.7% to 13.1%
- Nursing assistants and unregistered staff vacancies has increased significantly from 12.7% to 19%, this is driven by a reduction in WTE from last report (10WTE) and an increase of budgeted establishment by 26.4 WTE. The increase in budget is driven by an increase in midwifery care assistant establishment (appendix 2. Pg. 17)

	Inpatient	Sum of Actuals Period 10 (Jan)	Sum of Actuals Period 11 (Feb)	Sum of Actuals Period 12 (Mar)	Sum of Actuals Period 01 (Apr)	Sum of Actuals Period 02 (May)	Sum of Actuals Period 03 (Jun)	WTE VACANCY at period 1
RN/RM Substantive	Ward WTE	611.1	611.3	612.5	603.5	609.9	609.5	108.8
Nursing Unregistered Substantive	Ward WTE	378.6	379.1	385.9	376.7	373.1	364	85.2

Table 4. Ward/Inpatient actual substantive staff with WTE vacancy

Chart 4a demonstrates the total RN/RM establishment for the inpatient areas (WTE). The total number of substantive RNs has seen an improving trend until March this year. Full list of SPC related to vacancies can be found in appendix 2. Appendix 3 provides a full list of ward by ward vacancies.

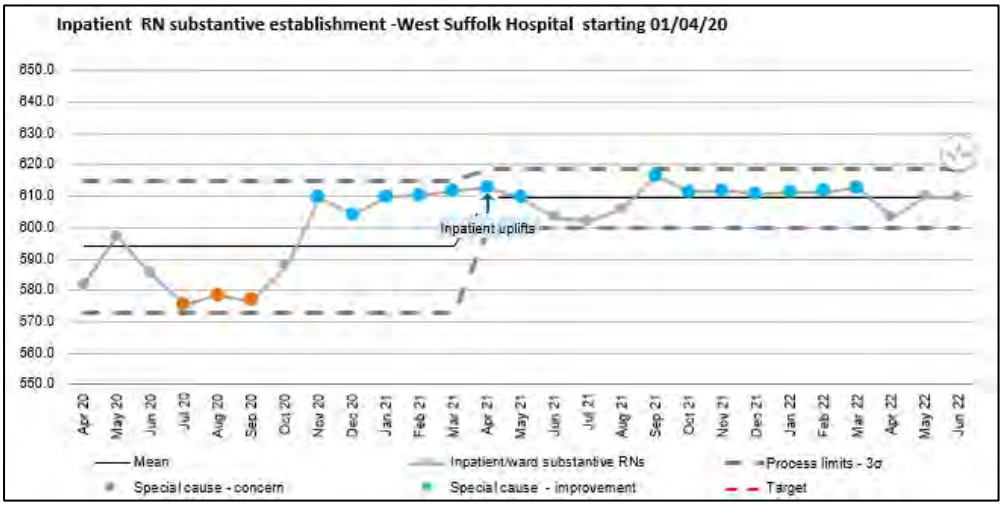


Chart 4a: SPC data adapted from finance ledger

6. New Starters and Turnover

International Nurse Recruitment:

In May, there were continued challenges with visa applications and only five nurses arrived in May. This was a national issue and outside of local influence. However, we remain on trajectory to achieve our annual target as capacity with accommodation has increased to enable the arrival of ten nurses a month. This increase in capacity has meant that the issues with visa application will not affect our trajectory in the long term.

In June 9 nurses arrived. With a further 30 nurses in the pipeline. Interviews continue to ensure we are meet our annual ambition by March 2023.

New starters

	January 22	February 22	March 22	April 22	May 22	June 22
Registered Nurses*	15	28	23	23	7	16
Non-Registered	24	18	8	22	12	35

Table 6: Data from HR and attendance to WSH induction program

- In May, seven RNs completed induction; of these; three were for acute services, one for pure bank, and three for community services joined this cohort

- In May, twelve NAs completed induction; of these nine NAs are for the acute Trust, one for bank services and two for community.

- In June, sixteen RNs completed induction; of these; thirteen were for acute services, two for bank services and one for community
- In June, thirty-five NAs completed induction; of these, twenty five NAs are for the acute Trust, six for bank services and four for community services

Turnover

On a retrospective review of the last rolling twelve months, turnover for RNs has increased from 11.3% to 11.9%, above the trust ambition of <10%. NA turnover has also increased from 18.83% to 20.92%. The escalating turnover has been escalated through the finance and workforce committee and is being captured at the Trust retention group

Turn Over 01/07/2021 - 30/06/2022								
Staff Group	Average Headcount	Avg FTE	Starters Headcount	Starters FTE	Leavers Headcount	Leavers FTE	LTR Headcount %	LTR FTE %
Nursing and Midwifery Registered	1,304	1,124.39	106	77.84	167	133.93	12.81%	11.91%
Additional Clinical Services	574.50	482.71	211	188.94	120	100.96	20.89%	20.92%

Table 7. (data from workforce)

7. Quality Indicators

Falls

Increase in falls seen in May and June althogh not presenting an adverse trend at present. This is possibly driven by the increasing NA vacacny rate and absences where availability to provide specials and enhanced observation is reduced.

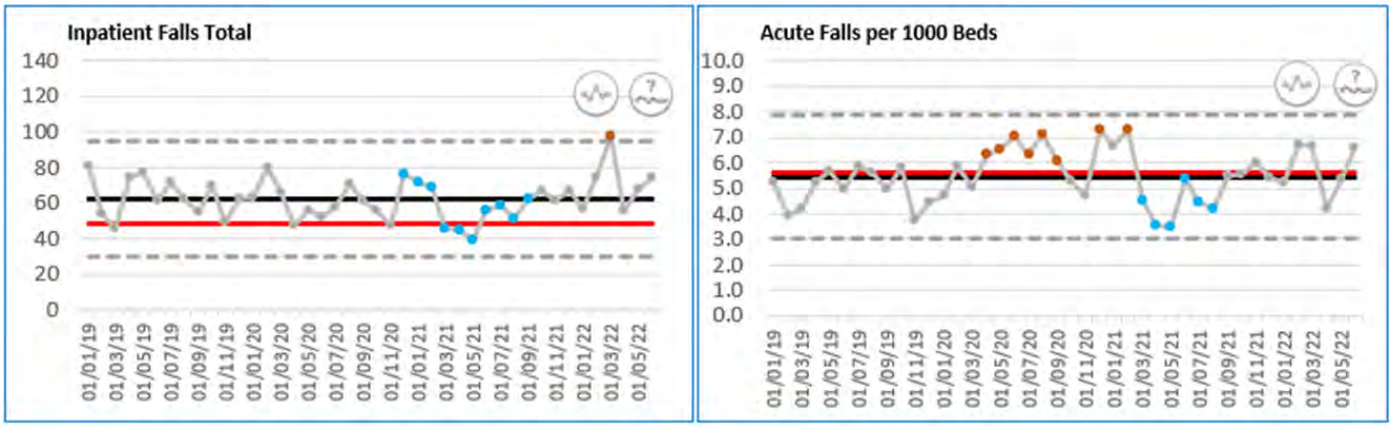
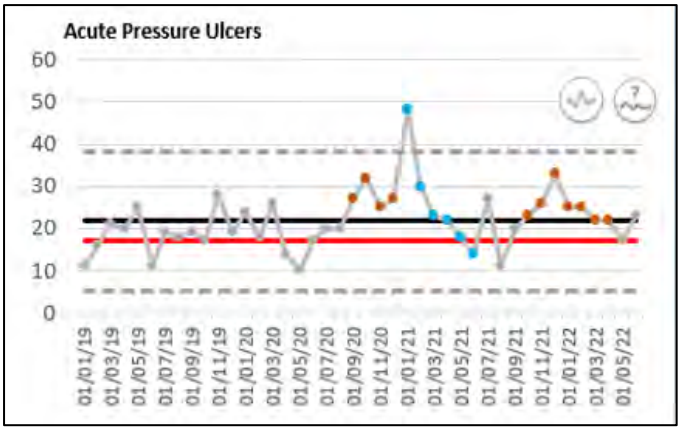


Chart 8

Pressure Ulcers

HAPU within the acute saw a fifth month of decline in May with a small increase in June. Areas of high incidences have been identified and bespoke, training days have been delivered alongside local quality improvement projects to focus on areas of concern, ensuring that improvement initiatives are appropriate to that clinical environment



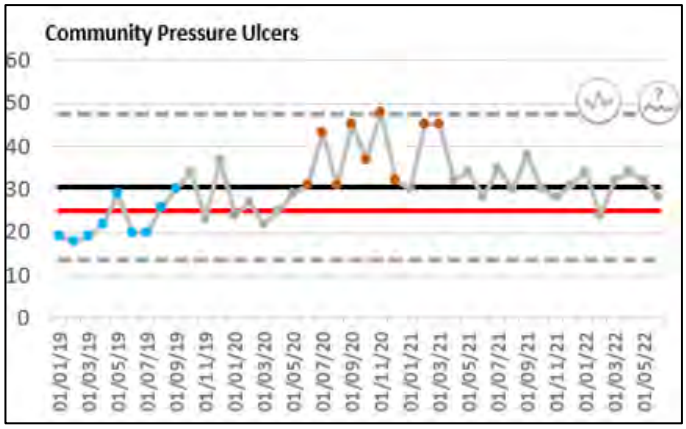


Chart 9a

8. Compliments and Complaints

In May the average number of calls to the clinical helpline was 117 and 119 per day in June. The reduction in accessing the patient helpline is in keeping with the return to normal visiting times, however high numbers still indicate a positive need for the service

Fifteen new complaints were received in May. The medical division received nine complaints. Surgical, Women & Children and Clinical Support divisions each received two complaints. The emergency department received three complaints. The endoscopy department received two complaints in total.

Twenty new complaints were received in June. This is the highest number of complaints received in 2022/23 so far and the highest number since January 2022 when twenty one complaints were received. The medical division received nine complaints. Five complaints were received for the surgical division. Women & Children, integrated community services and clinical support divisions each received two complaints. The emergency department received three complaints. G10 was the second highest area, receiving two complaints. Conversely this month saw the highest number of compliments in 2022/23

Table 10. demonstrates the incidence of complaints and compliments for this period.

	Compliments	Complaints
December 2021	22	10
January 2022	22	21
February 2022	19	19
March 2022	24	15
April 2022	14	17
May 2022	17	15
June 2022	32	20

Table 10

9. Adverse Staffing Incidences

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

- In May there were 15 Datixs recorded for nurse staffing that resulted in a Red Flag event (see table 11.). No harm is recorded for these incidents at the time.

- In June there were 38 Datixs recorded for inpatient nurse staffing that resulted in a Red Flag event (see table 11). No harm is recorded for these incidents

Red Flag	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	June 22
Registered nursing shortfall of more than 8 hours or >25% of planned nursing hours	10	5	9	16	10	1	7
>30-minute delay in providing pain relief	4	2	3	1	6	1	-
Delay or omission of intention rounding	12	6	5	8	2	-	5
<2 RNs on a shift	5	4	3	8	6	-	5
Vital signs not recorded as indicated on care plan	1	2	2	4	3	1	-
Unplanned omissions in providing medication	1	3	2	2	-	-	-
Lack of appointments (local agreed red flag)	0	1	0	0	-	1	3
Delay in routine care (new descriptor)	-	-	10	12	17	11	18
Impact not described	-	-	-	2	-	-	-
Total	33	24	34	53	44	15	38

Table 11.

10. Maternity Services

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

The maternity service has experienced increasing challenges this month and this is reflected in the number of red flag events, Midwife to birth ratio and the supernumery status of the labour suite coordinator. This is now recognised as a national staffing crisis and the maternity team will be responding to regional and national assurances around staffing mitigation.

	Standard	November	December	January	February	March	April	May	June
Supernumerary Status of LS Coordinator	100%	100%	99%	99%	99%	98.3%	100%	100%	98.8%
1-1 Care in Labour	100%	100%	100%	100%	99.5%	100%	100%	100%	100%
MW: Birth Ratio	1:28	1:26	1:23	1:28	1:27	1:28	1:26	1:27.5	1:25
No. Red Flags reported		3	43	46	27	40	6	9	24

Red Flag events

NICE Safe midwifery staffing for maternity settings 2015 defines Red Flag events as events that are immediate signs that something is wrong and action is needed now to stop the situation getting worse. Action includes escalation to the senior midwife in charge of the service and the response include allocating additional staff to the ward or unit. Appendix 4 illustrates red flag events as described by NICE. Red Flags are captured on Datix and highlighted and mitigated as required at the daily Maternity Safety Huddle;

- There were nine red flag events in May. No harm was recorded as in impact of these incidents
- There were twenty-four red flag events in June. No harm was recorded as in impact of these incidents.

Midwife to Birth ratio

Midwife to Birth ratio was 1:27.5 in May and 1:25 in June, this has been achieved consistently for the past six months, where the unit has achieved this best practice metric of <1:28, or Birth-rate Plus recommendation of 1:27.7.

1:1 was achieved 100% in both May and June

Supernumerary status of the labour suite co-ordinator

This is a CNST 10 steps to safety requirement and was highlighted as a ‘should’ from the CQC report in January 2020. The band 7 labour suite co-ordinator should not have direct responsibility of care for any women. This is to enable the co-ordinator to have situational awareness of what is occurring on the unit and is recognised not only as best but safest practice however this requirement is currently under review by CNST

as more clarification is required towards the meaning of supernumerary states, this is due to be published in May 2022.

- In May 100% compliance against this standard was achieved
- In June 98.8% compliance was achieved.

11. Community & Integrated services division

12.1 Demand

Demand within the community setting can be illustrated by the number of referrals each service receives. Chart 12a and 12b are examples of the rise in demand for both community nursing and community therapy experienced in the last year. This will have a direct impact on nursing and therapy capacity and the ability to respond to rising demands.

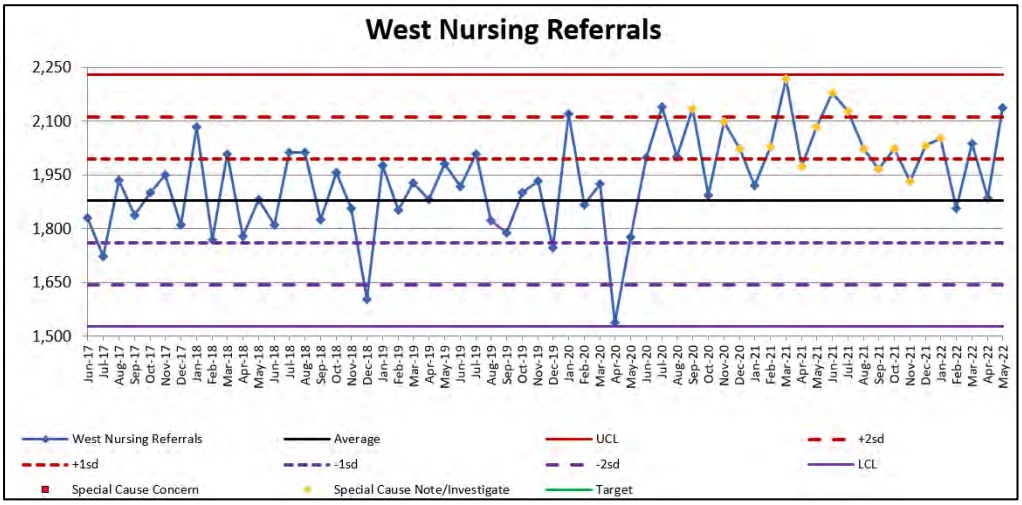


Chart 12a

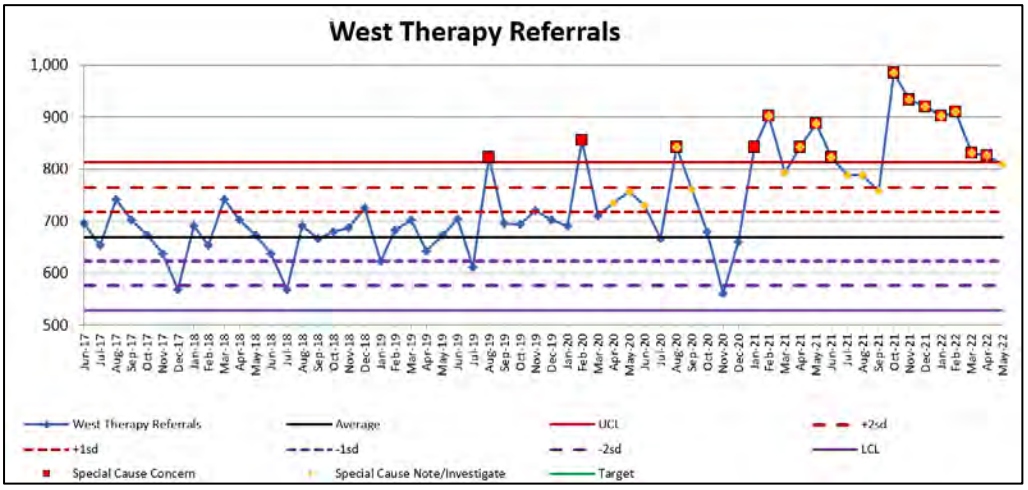


Chart 12b

12.2 Prioritisation of nursing patients

All patients are prioritised using rag rated care plans. This allows the senior team to identify, from the 120-140 number of visits expected to occur that day, which are most urgent and require prioritisation. This allows the team to have flexibility when managing nursing/therapy resource and can defer low urgency visits to the following day. There is currently no automated method to calculate the care hours. Care plan hours are calculated manually, and balanced against WTE staffing levels. Long term plans include the sourcing a license for a national modelling tool to support better demand and capacity modelling.

12.3 Sickness-

Month	Community
January	7.09%
February	7.11%
March	8.89%
April	4.62%
May	5.39%

12.4 Vacancies in CHTS

Role	Vacancy percentage		
	Last reported	May	June
RNs	23%	23%	20%
Physiotherapists	23%	23%	19%
Occupational therapists	11%	11%	16%
Generic workers /unregistered	16%	18%	15%

12.5 Ongoing actions being taken by division

- Piloting Integrated Neighbourhood Coordinator manually extract number of care plans per day & hours of workforce available.
- Follow surge plan & national OPAL policy
- CHTs to work with HealthRoster team to ensure accuracy of reporting, so that staffing fill rates can be accurately reported
- Scoping of Flexible Pool matching Acute plans for staffing mitigation

12. Biannual staffing review

In June the summer round of Safer Nursing Care Tool audit has been commenced for inpatient ward areas with an anticipated outcome to be presented to the executive team in September.

The SNCT has historically been limited to inpatient areas. The Shelford group have ratified and published the tool for use within emergency departments. The Trust has obtained the necessary licence and trained appropriate staff to conduct this review for implementation in September.

13. Recommendations and Further Actions

- Note the impact of super surge capacity planning on nurse staffing and possible implications for patient care this month. However, surge staffing returned to BAU at the end of this reporting period
- Note the information on the nurse and midwifery staffing and the impact on quality and patient safety
- Note the content of the report and that mitigation is put in place where staffing levels are below planned.
- Note that the content of the report is undertaken following national guidelines using research and evidence-based tools and professional judgement to ensure staffing is linked to patient safety and quality outcomes.

Appendix 1. Fill rates for inpatient areas (May 2022): Data adapted from Unify submission

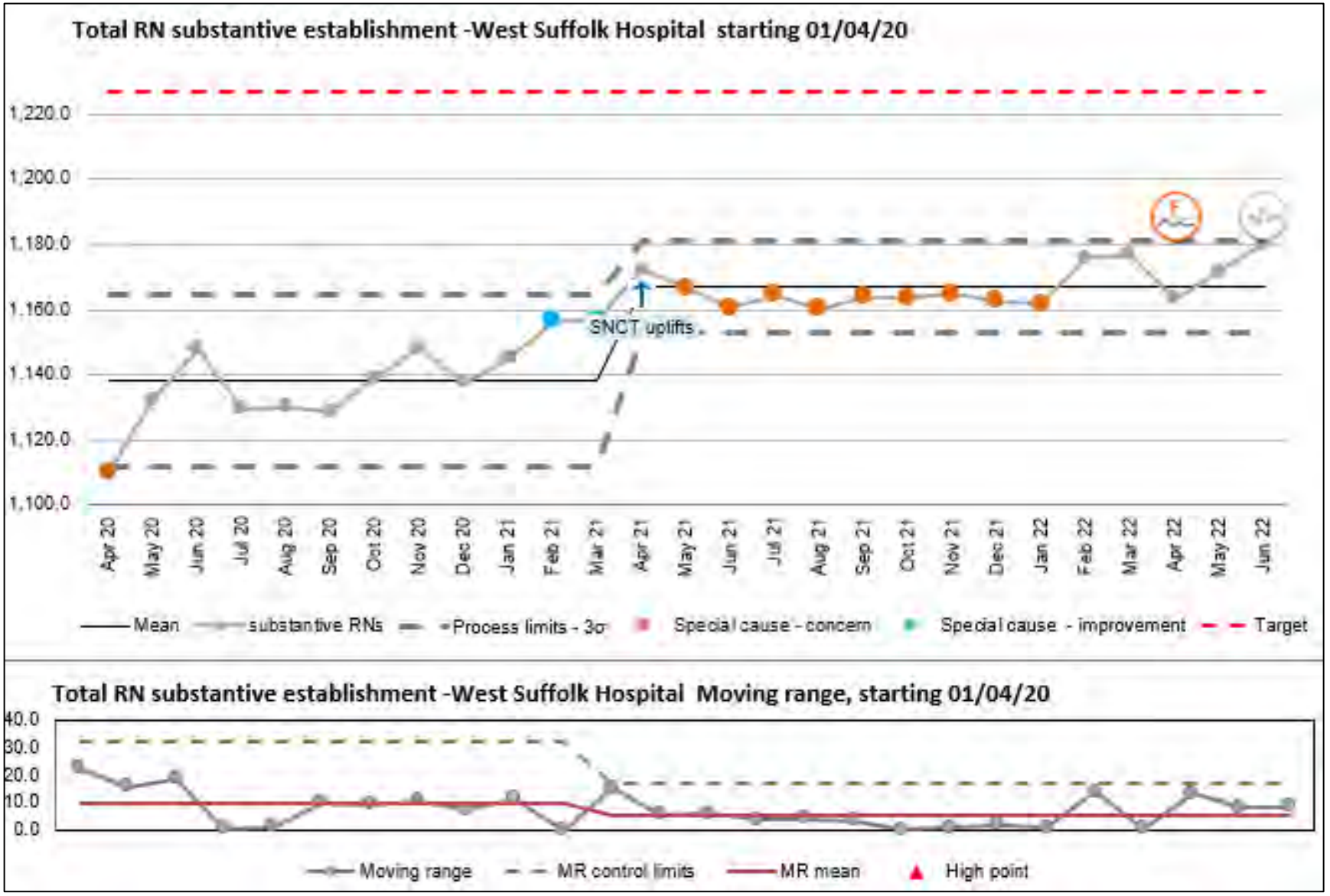
RAG: Red >79%, Amber 80-89%, Green 90-100%, Purple >100%

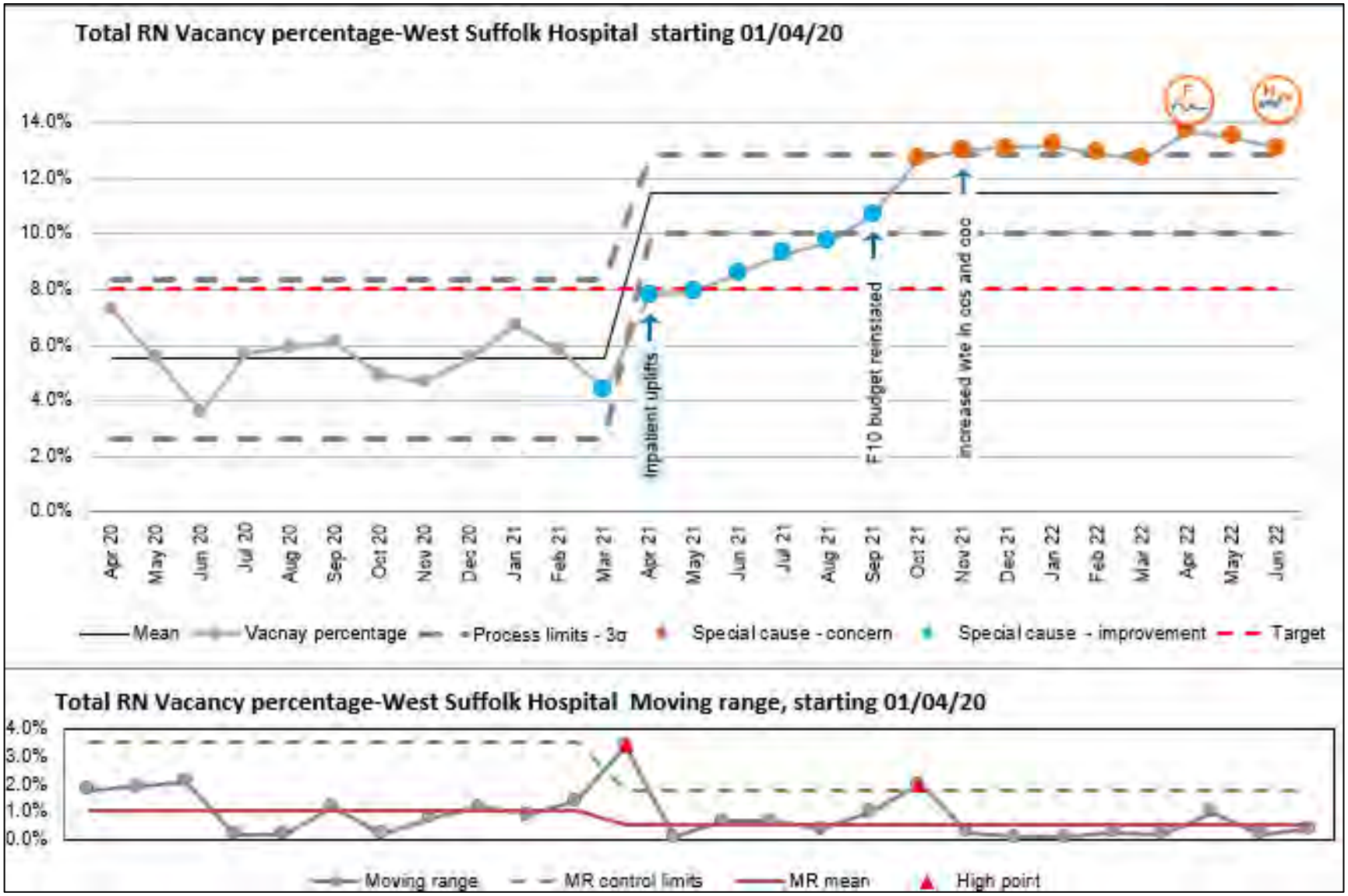
	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	RNs/RMN		Non registered (Care staff)		RNs/RMN		Non registered (Care staff)									
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned 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	993.5	981.98333	1982	1455.5	1069.5	931.5	1391.5	1264.83333	99%	73%	87%	91%	452	4.2	6.0	10.3
Glastonbury Cour	715	713	1059.5	1048	708	703.5	542.5	551.5	100%	99%	99%	102%	384	3.7	4.2	7.9
Acute Assessmen	2133.5	1868.25	2484	1613.0833	1782.5	1735.25	1368.5	1249.25	88%	65%	97%	91%	761	4.7	3.8	8.5
Cardiac Centre	2758	2439.5	1317.5	1037.5	1782.5	1506.5	713	632.5	88%	79%	85%	89%	632	6.2	2.6	8.9
G10	1426	1110.5	1426	1240.5	1069.5	771.5	1418	1303	78%	87%	72%	92%	707	2.7	3.6	6.3
G9	1426	1293.25	1419.5	1220.75	1420.5	1214.75	1069.5	1187	91%	86%	86%	111%	752	3.3	3.2	6.5
F12	551	614.75	352.5	353.5	713	414	356.5	464.333333	112%	100%	58%	130%	240	4.3	3.4	7.7
F7	1777.5	1347.9167	1723.5	1404.4167	1421.5	1102	1769	1531.5	76%	81%	78%	87%	683	3.6	4.3	7.9
G1	1421.98333	1081.5	356.5	287.5	713	713	345	283	76%	81%	100%	82%	485	3.7	1.2	4.9
G3	1788	1349	1774.25	1502.4167	1069.5	1013.5	1069.5	1331	75%	85%	95%	124%	864	2.7	3.3	6.0
G4	1777.5	1279.5	1826.5	1577	1064	888	1422	1271.5	72%	86%	83%	89%	896	2.4	3.2	5.6
G5	1759.5	1389	1765.5	1305	1022.5	1045	1426.5	1341.01667	79%	74%	102%	94%	760	3.2	3.5	6.7
G8	2497	1547.5833	1782.5	1530.3333	1777	1301	1069.5	1109	62%	86%	73%	104%	615	4.6	4.3	8.9
F8	1442	1453.5	2128	1761	1040.5	874	1426	1322.5	101%	83%	84%	93%	723	3.2	4.3	7.5
Critical Care	2852	2735.5	341	186.58333	2852	2655.75	0	128	96%	55%	93%	*	388	13.9	0.8	14.7
F3	1771	1510	2072.5	1521.5	1069.5	1056	1420.5	1353.5	85%	73%	99%	95%	732	3.5	3.9	7.4
F4	966	874	958	509	713	655	609.5	575	90%	53%	92%	94%	633	2.4	1.7	4.1
F5	1782.5	1421.75	1426	1028	1069.5	945	1067.25	940.583333	80%	72%	88%	88%	698	3.4	2.8	6.2
F6	2013	1745	1652	1148.5	1414.5	1139.5	713	758	87%	70%	81%	106%	942	3.1	2.0	5.1
Neonatal Unit	1092	1308	360	646.75	924	948	240	276	120%	180%	103%	115%	116	19.4	8.0	27.4
F1	1218	1407.5	713	785.5	1069.5	1196	0	118.666667	116%	110%	112%	*	115	22.6	7.9	30.5
F14	776	803	312	264.5	744	768.5	0	12	103%	85%	103%	*	106	14.8	2.6	17.4
Total	34,936.98	30,273.98	29,232.25	23,426.83	26,509.50	23,577.25	19,437.25	19,003.68	**87%**	**80%**	**89%**	**98%**	**12684**	**4.2**	**3.3**	**7.6**
* planned hours are zero, so additional support used on ward to mitigate unfilled nursing hours																

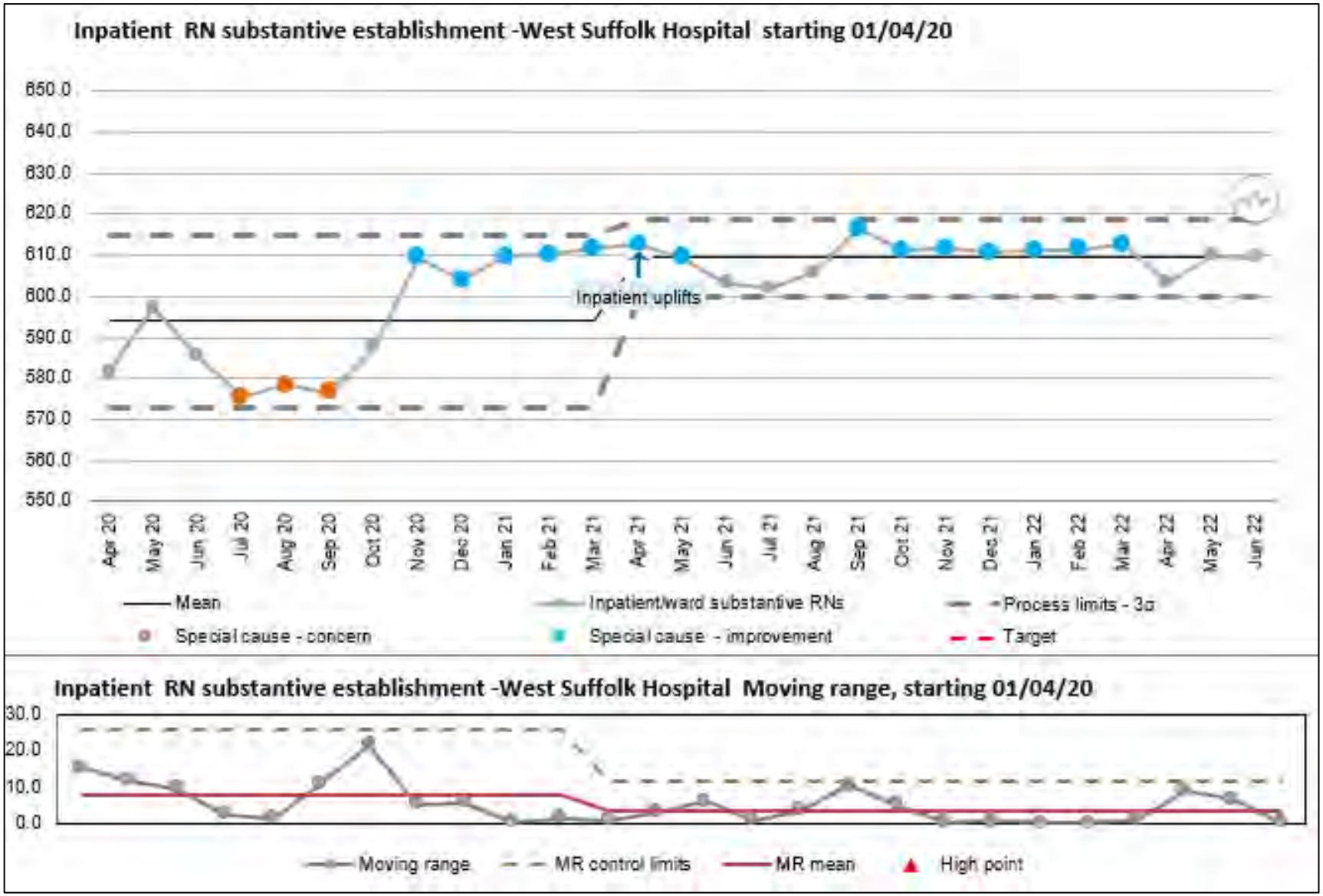
Appendix 1. Fill rates for inpatient areas (June 2022): Data adapted from Unify submission

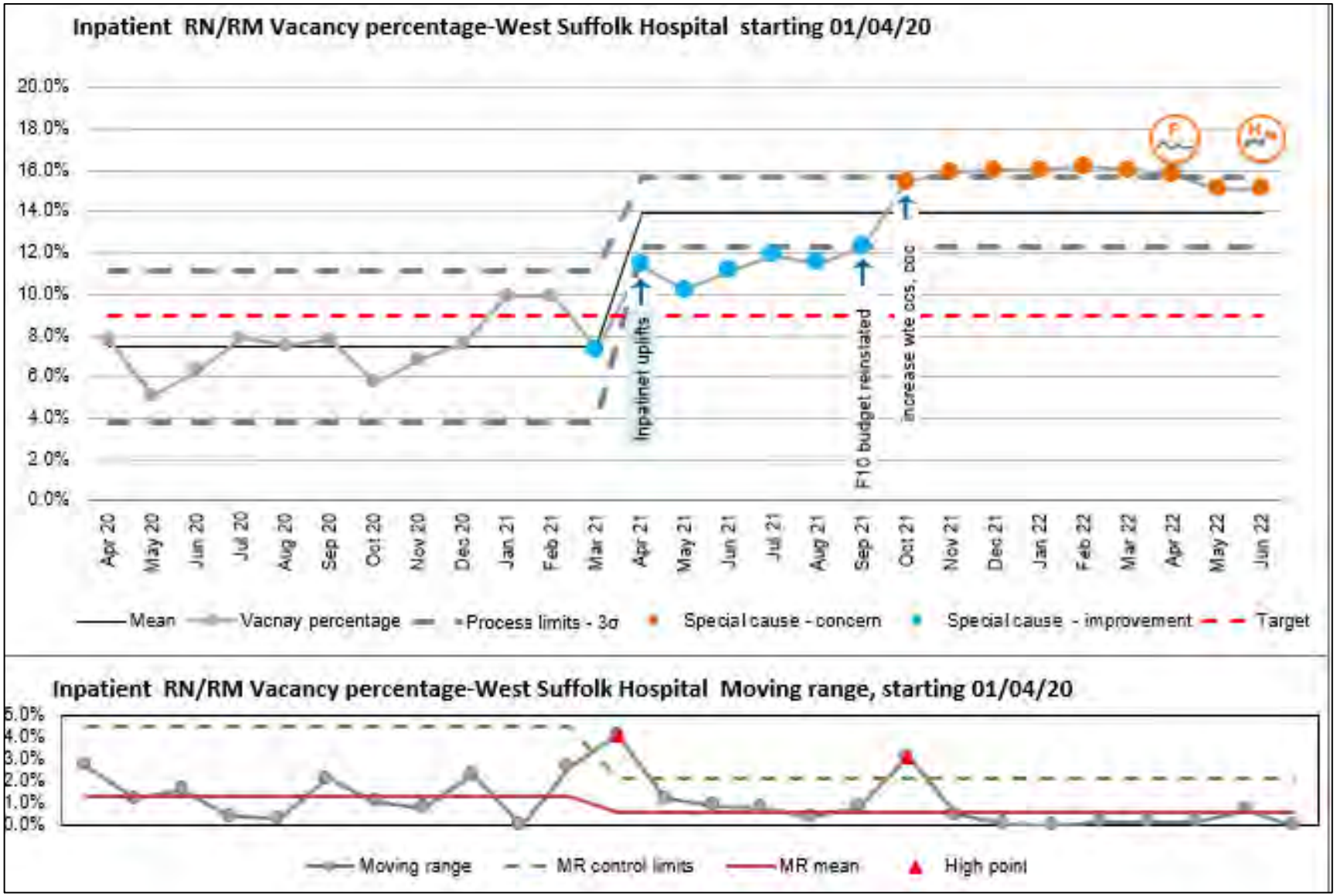
	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	RNs/RMN		Non registered (Care staff)		RNs/RMN		Non registered (Care staff)									
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average Fill rate RNs/RM %	Average fill rate Care staff %	Average Fill rate RNs/RM %	Average fill rate Care staff %	Cumulative count over the month of patients at 23:59 each day	RNS/RMs	Non registered (care staff)	Overall
Rosemary Ward	921	884	2024	1332.5	943	920	1356	1101.5	96%	66%	98%	81%	683	2.6	3.6	6.2
Glastonbury Cour	691.5	695	1014	995.5	690	687	525	521	101%	98%	100%	99%	502	2.8	3.0	5.8
Acute Assessmen	2060	1767	2389	1267	1713.5	1589.75	1357	1080.16667	86%	53%	93%	80%	761	4.4	3.1	7.5
Cardiac Centre	2767.5	2434	1246.5	1065.8	1725	1506.5	680.5	545	88%	86%	87%	80%	632	6.2	2.5	8.8
G10	1380	1107.8333	1369	1045.25	1035	783	1380	1215.83333	80%	76%	76%	88%	707	2.7	3.2	5.9
G9	1376	1216.25	1364	1020.2	1380	1138.5	1031.5	1100	88%	75%	83%	107%	752	3.1	2.8	6.0
F12	540.5	674.5	345	164.5	690	555.75	345	259.5	125%	48%	81%	75%	240	5.1	1.8	6.9
F7	1725	1424.75	1702.5	1243	1376	1096	1725	1358	83%	73%	80%	79%	683	3.7	3.8	7.5
G1	1376.75	974.5	345.25	210.75	690	690	345	275.5	71%	61%	100%	80%	485	3.4	1.0	4.4
G3	1725	1338.5	1726	1345.5	1035	946.25	1023.5	1328.5	78%	78%	91%	130%	864	2.6	3.1	5.7
G4	1741.25	1377	1770.5	1422.4167	1035	793.5	1397.5	1256.5	79%	80%	77%	90%	896	2.4	3.0	5.4
G5	1737	1456.25	1725.5	1283.5	1035	934.5	1374.5	1275.75	84%	74%	90%	93%	760	3.1	3.4	6.5
G8	2405.5	1531.75	1723	1371	1725	1231.416667	1035	929	64%	80%	71%	90%	615	4.5	3.7	8.2
F8	1379.48333	1327.5	2051	1340.8333	1035	827.0833333	1368.5	1154.75	96%	65%	80%	84%	723	3.0	3.5	6.4
Critical Care	2663	2316.75	330	68	2708	2244	0	50	87%	21%	83%	*	388	11.8	0.3	12.1
F3	1721.75	1453.2833	2068.5	1464.5	1035	1033	1380	1288	84%	71%	100%	93%	732	3.4	3.8	7.2
F4	943	857	943	667	690	658.5	598	570	91%	71%	95%	95%	633	2.4	2.0	4.3
F5	1723	1307.8333	1380	1078	1035	926	1026	956	76%	78%	89%	93%	698	3.2	2.9	6.1
F6	1935.38333	1715.8333	1601	1134	1370	1093.5	690	695	89%	71%	80%	101%	942	3.0	1.9	4.9
Neonatal Unit	1044	1254.25	360	718.5	948	960	168	204	120%	200%	101%	121%	116	19.1	8.0	27.0
F1	1180.75	1451.5	684.25	598	1035	1219	0	91.5	123%	87%	118%	*	115	23.2	6.0	29.2
F14	752	779	312	266	720	720.5	0	24	104%	85%	100%	*	106	14.1	2.7	16.9
Total	33,789.37	29,344.28	28,474.00	21,101.75	25,648.50	22,553.75	18,806.00	17,279.50	**87%**	**74%**	**88%**	**92%**	**13033**	**4.0**	**2.9**	**6.9**
* planned hours are zero, so additional support used on ward to mitigate unfilled nursing hours																

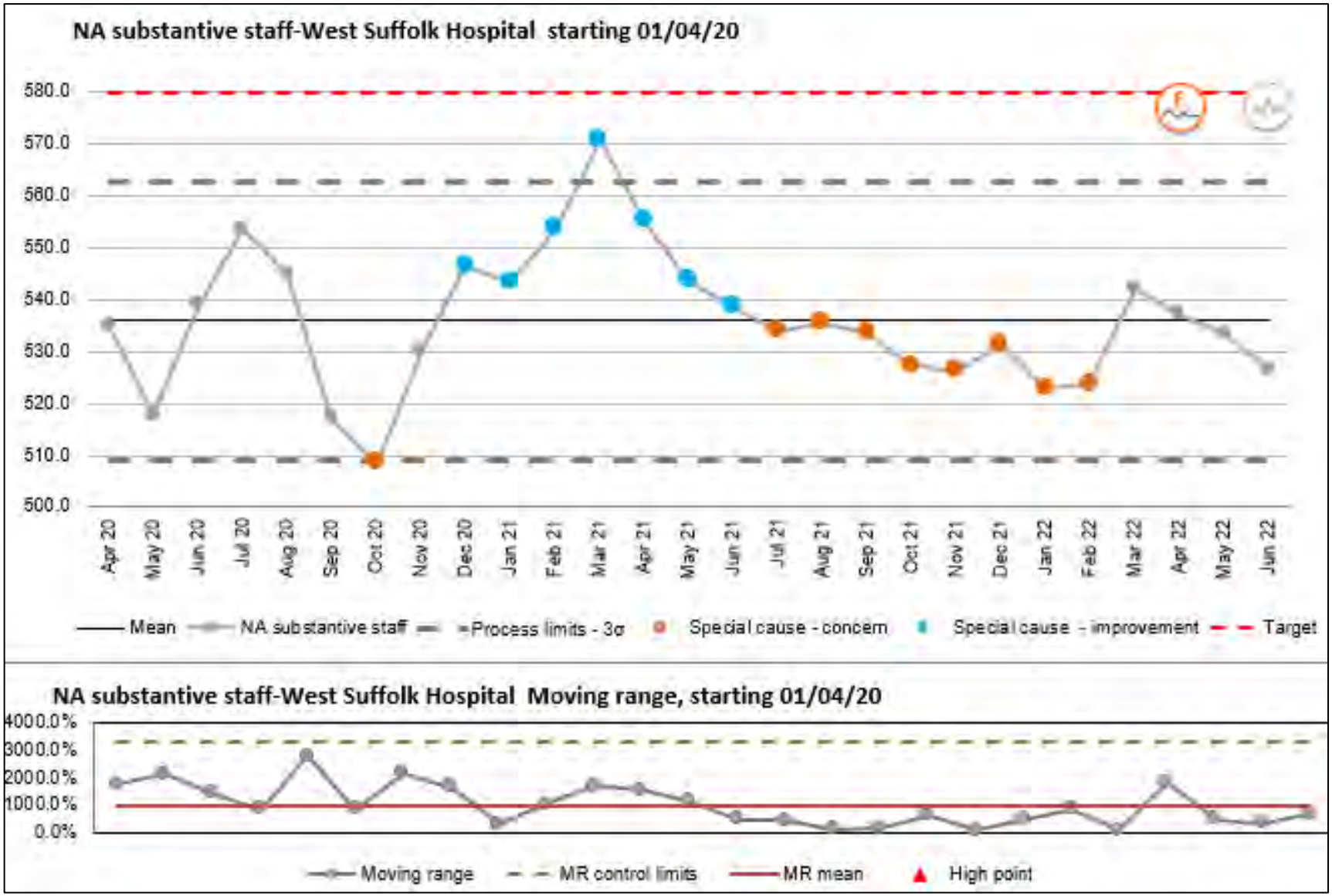
Appendix 2 SPC charts

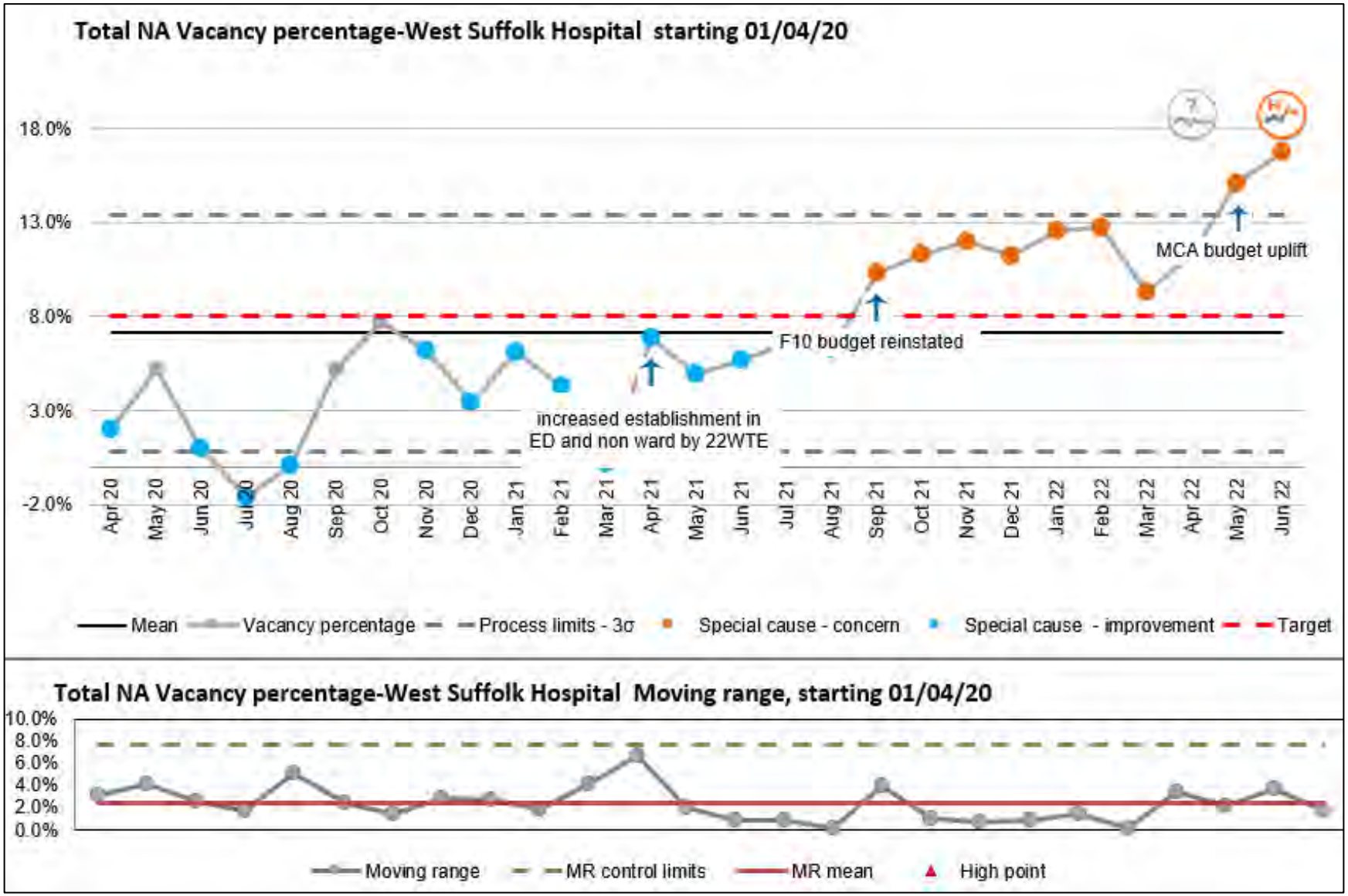



Total RN Vacancy percentage-West Suffolk Hospital starting 01/04/20
14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
Inpatient uplifts
F10 budget reinstated
increased wte in ccs and ooo
Apr 20
May 20
Jun 20
Jul 20
Aug 20
Sep 20
Oct 20
Nov 20
Dec 20
Jan 21
Feb 21
Mar 21
Apr 21
May 21
Jun 21
Jul 21
Aug 21
Sep 21
Oct 21
Nov 21
Dec 21
Jan 22
Feb 22
Mar 22
Apr 22
May 22
Jun 22
Mean
Vacnay percentage
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target
Total RN Vacancy percentage-West Suffolk Hospital Moving range, starting 01/04/20
4.0%
3.0%
2.0%
1.0%
0.0%
Moving range
MR control limits
MR mean
High point


Inpatient RN substantive establishment -West Suffolk Hospital starting 01/04/20
650.0
640.0
630.0
620.0
610.0
600.0
590.0
580.0
570.0
560.0
550.0
Inpatient uplifts
Apr 20
May 20
Jun 20
Jul 20
Aug 20
Sep 20
Oct 20
Nov 20
Dec 20
Jan 21
Feb 21
Mar 21
Apr 21
May 21
Jun 21
Jul 21
Aug 21
Sep 21
Oct 21
Nov 21
Dec 21
Jan 22
Feb 22
Mar 22
Apr 22
May 22
Jun 22
Mean
Inpatient/ward substantive RNs
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target
Inpatient RN substantive establishment -West Suffolk Hospital Moving range, starting 01/04/20
30.0
20.0
10.0
0.0
Moving range
MR control limits
MR mean
High point


Inpatient RN/RM Vacancy percentage-West Suffolk Hospital starting 01/04/20
20.0%
18.0%
16.0%
14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
Inpatinet uplifts
F10 budget reinstated
increase wte ccs, ooc
Apr 20
May 20
Jun 20
Jul 20
Aug 20
Sep 20
Oct 20
Nov 20
Dec 20
Jan 21
Feb 21
Mar 21
Apr 21
May 21
Jun 21
Jul 21
Aug 21
Sep 21
Oct 21
Nov 21
Dec 21
Jan 22
Feb 22
Mar 22
Apr 22
May 22
Jun 22
Mean
Vacnay percentage
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target
Inpatient RN/RM Vacancy percentage-West Suffolk Hospital Moving range, starting 01/04/20
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
Moving range
MR control limits
MR mean
High point


NA substantive staff-West Suffolk Hospital starting 01/04/20
580.0
570.0
560.0
550.0
540.0
530.0
520.0
510.0
500.0
Apr 20
May 20
Jun 20
Jul 20
Aug 20
Sep 20
Oct 20
Nov 20
Dec 20
Jan 21
Feb 21
Mar 21
Apr 21
May 21
Jun 21
Jul 21
Aug 21
Sep 21
Oct 21
Nov 21
Dec 21
Jan 22
Feb 22
Mar 22
Apr 22
May 22
Jun 22
Mean
NA substantive staff
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target
NA substantive staff-West Suffolk Hospital Moving range, starting 01/04/20
4000.0%
3000.0%
2000.0%
1000.0%
0.0%
Moving range
MR control limits
MR mean
High point


Total NA Vacancy percentage-West Suffolk Hospital starting 01/04/20
18.0%
13.0%
8.0%
3.0%
-2.0%
Apr 20
May 20
Jun 20
Jul 20
Aug 20
Sep 20
Oct 20
Nov 20
Dec 20
Jan 21
Feb 21
Mar 21
Apr 21
May 21
Jun 21
Jul 21
Aug 21
Sep 21
Oct 21
Nov 21
Dec 21
Jan 22
Feb 22
Mar 22
Apr 22
May 22
Jun 22
F10 budget reinstated
increased establishment in ED and non ward by 22WTE
MCA budget uplift
Mean
Vacancy percentage
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target
Total NA Vacancy percentage-West Suffolk Hospital Moving range, starting 01/04/20
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
Moving range
MR control limits
MR mean
High point

Appendix 3. Inpatient ward by ward vacancies (June 2022): Data adapted from finance report

Jun-22										
Ward/Department	Register Nurses/Midwives				Ward/Department	NA/MCA				Combined RN/NA
	Actual establishmet	Budgetted establishment	Vacancy rate (WTE)	Vacancy percentage %		Actual Establishment	Budgeted Establishment	Vacancy rate (WTE)	Percentage Vacancy %	Total Vacancy %
AAU	25.6	30.1	4.6	15.1	AAU	18.4	28.3	9.9	35.1	24.8
Accident & Emergency	55.4	69.5	14.1	20.3	Accident & Emergency	30.0	34.5	4.5	12.9	17.8
Cardiac Centre	34.5	40.7	6.2	15.2	Cardiac Centre	14.1	15.7	1.6	10.2	13.8
Glastonbury Court	11.8	11.7	-0.1	-1.0	Glastonbury Court	10.5	12.6	2.2	17.2	8.4
Critical Care Services*	45.0	50.0	5.0	10.0	Critical Care Services	2.8	1.9	-0.9	-48.9	7.8
Day Surgery Wards	12.4	11.0	-1.4	-13.1	Day Surgery Wards	2.9	3.9	1.0	26.0	-3.0
Gynae Ward (On F14)	14.2	14.1	-0.1	-0.6	Gynae Ward (On F14)	2.0	2.0	0.0	0.0	-0.5
Neonatal Unit	20.4	20.6	0.2	1.1	Neonatal Unit	9.7	10.1	0.4	4.0	2.1
Rosemary ward	15.4	15.4	0.0	0.3	Rosemary ward	20.3	27.0	6.7	24.9	15.9
Recovery Unit	23.4	27.3	3.9	14.2	Recovery Unit	0.9	0.9	0.0	1.2	13.8
Ward F1 Paediatrics	21.9	24.1	2.2	9.2	Ward F1 Paediatrics	7.0	7.7	0.7	9.2	9.2
Ward F12	8.6	11.9	3.3	27.8	Ward F12	5.1	5.9	0.7	12.1	22.7
Ward F3	21.6	22.2	0.6	2.6	Ward F3	22.7	25.8	3.1	12.2	7.8
Ward F4	12.7	13.6	0.9	6.9	Ward F4	12.1	14.6	2.6	17.4	12.3
Ward F5	19.0	22.2	3.2	14.3	Ward F5	13.4	18.1	4.7	25.8	19.4
Ward F6	22.1	26.6	4.4	16.7	Ward F6	13.9	17.4	3.4	19.7	17.9
Ward F7 Short Stay	18.6	24.9	6.4	25.5	Ward F7 Short Stay	19.0	25.8	6.8	26.2	25.9
Ward F9 (now G5)	19.0	21.8	2.8	12.8	Ward G5	18.2	23.2	5.0	21.5	17.3
Ward G1 Hardwick Unit	29.8	29.6	-0.2	-0.8	Ward G1 Hardwick Unit	9.9	10.5	0.6	5.8	0.9
Ward G3	20.2	22.1	1.9	8.4	Ward G3	23.2	23.0	-0.3	-1.1	3.5
Ward G4	18.2	22.1	3.9	17.7	Ward G4	17.2	23.5	6.3	26.9	22.4
Ward G8	20.0	32.7	12.7	38.8	Ward G8	18.0	20.6	2.6	12.5	28.6
Renal Ward - F8	18.4	19.5	1.1	5.5	Renal Ward - F8	20.5	25.8	5.3	20.4	14.0
Ward G10	14.4	19.0	4.6	24.2	Ward G10	18.4	24.1	5.7	23.7	23.9
Respiratory Ward - G9	17.8	23.7	5.9	24.8	Respiratory Ward - G9	17.1	18.0	0.9	5.2	16.3
Total	540.4	626.2	85.9	**13.7**	Total	347.3	420.8	73.4	**17.5**	**15.2**
Hospital Midwifery	50.7	58.9	8.2	13.9	Hospital Midwifery	16.7	28.5	11.8	41.4	22.9
Community Midwifery	18.1	19.1	1.0	5.4	Community Midwifery	5.8	7.5	1.7	22.7	0.0
Midwifery management	12.3	13.3	1.0	7.5						
Continuity of Carer Midwifery*	17.5	31.0	13.5	43.5						
Total	98.6	122.3	23.7	**19.4**	Total	22.5	36.0	13.5	**37.5**	**23.5**

Appendix 4:

Ward by Ward breakdown of Falls and Pressure ulcers March and April 2022

HAPU

May 2022	Cat 2	Cat 3	Unstageable	Total
Information Governance Department	1	0	0	1
Renal Ward	1	0	0	1
Rosemary Ward	1	0	0	1
Cardiac Centre - Ward	1	0	1	2
Critical Care Unit	2	0	0	2
G8 - Stroke Ward	2	0	0	2
F7	2	0	0	2
Acute Assessment unit (AAU)	1	0	1	2
G3 - Endocrine and General Medicine	2	1	0	3
G4 - ward	2	0	1	3
Total	15	1	3	19

June 2022	Cat 2	Cat 3	Unstageable	Total
Cardiac Centre - Ward	1	0	0	1
F10	1	0	0	1
F3 - ward	1	0	0	1
G1 - ward	0	0	1	1
G10	1	0	0	1
Gastroenterology Ward	1	0	0	1
F7	1	0	0	1
Acute Assessment unit (AAU)	1	0	0	1
Early Intervention Team	1	0	0	1
G3 - Endocrine and General Medicine	2	0	0	2
G8 - Stroke Ward	2	0	0	2
Renal Ward	2	0	0	2
G4 - ward	1	1	1	3
Respiratory Ward	5	0	1	6
Total	20	1	3	24

Falls

May 22	None	Negligible	Minor	Moderate	Major	Total
CHT Bury Town	1	0	0	0	0	1
Critical Care Unit	1	0	0	0	0	1
Emergency X-ray	1	0	0	0	0	1
F4 - ward	1	0	0	0	0	1
Emergency Department	1	0	0	0	0	1
Major Assessment Area (MAA)	0	0	1	0	0	1
F5 - ward	1	0	0	0	0	1
G1 - ward	2	0	0	0	0	2
G4 - ward	1	0	1	0	0	2
Glastonbury Court	2	0	0	0	0	2
F6 - ward	2	0	0	0	0	2
Cardiac Centre - Ward	2	0	1	0	0	3
F12 Isolation Ward	2	0	1	0	0	3
G8 - Stroke Ward	2	0	1	0	0	3
Respiratory Ward	2	0	2	0	0	4
F3 - ward	7	0	0	0	0	7
Acute Assessment unit (AAU)	6	0	1	0	0	7
G3 - Endocrine and General Medicine	7	0	1	0	0	8
Gastroenterology Ward	6	0	2	0	0	8
Renal Ward	7	0	1	0	0	8
F7	8	1	3	0	0	12
G10	10	0	3	0	0	13
Rosemary Ward	6	1	5	2	1	15
Total	78	2	23	2	1	106

June 22	None	Negligible	Minor	Major	Total
CHT Bury Rural	0	1	0	0	1
Wheelchair Services	0	0	1	0	1
Major Assessment Area (MAA)	1	0	0	0	1
Physiotherapy Department	0	1	0	0	1
F12 Isolation Ward	2	0	0	0	2
Glastonbury Court	2	0	0	0	2
Support to go home	1	0	1	0	2
Cardiac Centre - Ward	2	0	1	0	3
G1 - ward	3	0	0	0	3
Emergency Department	1	2	0	0	3
Gastroenterology Ward	3	1	0	0	4
Renal Ward	3	1	0	0	4
G8 - Stroke Ward	3	1	1	0	5
Respiratory Ward	4	0	1	0	5
F6 - ward	3	0	2	0	5
G4 - ward	4	1	1	0	6
Rosemary Ward	5	0	1	1	7
Acute Assessment unit (AAU)	6	0	1	0	7
F3 - ward	2	2	4	0	8
G10	8	0	0	2	10
G3 - Endocrine and General	7	2	2	0	11
F7	12	2	2	0	16
Total	72	14	18	3	107

Appendix 5: Red Flag Events

Maternity Services

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

Acute Inpatient Services

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

4.6. Maternity services

4.6.1. Maternity services: quality & performance report

To Assure

Presented by Susan Wilkinson

Trust Open Board – 22 July 2022

Agenda item:	4.6.1			
Presented by:	Sue Wilkinson, Executive Chief Nurse/ Paul Molyneux, Interim Medical Director & Executive MatNeo Safety Champion/ Karen Newbury, Head of Midwifery, Justyna Skonieczny – Deputy Head of Midwifery, Simon Taylor Associate Director of Operations, Women & Children and Clinical Support Services & Kate Croissant, Deputy Clinical Director.			
Prepared by:	Karen Newbury, Head of Midwifery			
Date prepared:	14th July 2022			
Subject:	Maternity quality, safety and performance report			
Purpose:		For information	X	For approval

Executive summary:
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 of the attached papers have been through internal governance process including the Maternity and Neonatal Safety Champions and the Local Maternity and Neonatal Set Board.

Proposed reporting framework
The proposed Trust governance process has been reviewed due to the number of papers requiring oversight and strict reporting timescale. It is proposed that all applicable papers are:

Developed through internal governance arrangements for the service
- Received and approved by the Local Maternity and Neonatal Board (including NED and Exec oversight from the Maternity and Neonatal Safety Champions)
- Received by the Board for information. This will be in the form of an appropriate summary, including relevant commentary from the local board. The detailed reports to be received as an annex to the full board pack. Consideration was given to reporting via the Improvement Committee but this would impact on the strict reporting timescales.

The Board is asked to **approve** the proposed reporting framework.

This report contains:
- Maternity improvement plan
- Safety champion feedback from walkabout
- Listening to staff
- Service user feedback
- CQC Maternity Survey
- Reporting and learning from incidents
- Maternity Dashboards (Annex A)
- Ockenden Assurance Visit by NHSE/I Regional and National Team
- Saving Babies Lives Element 4 – fetal monitoring compliance report (Annex B)
- NHS England Maternity Self-Assessment (Annex C)

Maternity improvement plan
The Maternity Improvement Board receives the updated Maternity improvement plan on a monthly basis. This has been created through an amalgamation of the original CQC improvement plan with the wider requirements of Ockenden, HSIB, external site visits and self-assessment against other national best practice (e.g. MBRRACE, SBLCBv2, UKOSS). In addition, the plan has captured the actions needing completion from the 60 Supportive Steps visit from NHSE/I and

continues to be reviewed by the Maternity Improvement Board every two weeks. To note; completion of actions has been hindered due to the high demand on clinicians to work clinically due to Covid absences.

Safety Champion Walkabout feedback
The Board-level champion undertakes a monthly walkabout in the maternity and neonatal unit. Staff have the opportunity to raise any safety issues with the Board level champion and if there are any immediate actions that are required, the Board level champion will address these with the relevant person at the time.

Individuals or groups of staff can raise the issues with the Board champion. An overview of the Walkabout content and responses is shared with all staff in the monthly governance newsletter 'Risky Business'

The Safety Champion Walkabout took place on the 20th May on the maternity unit & 30th June 2022 in one of the community midwifery bases. Discussions raised:

- New staff reported a really welcoming environment and how they enjoy working on the unit
- Positivity regarding the recruitment of new Maternity Care Assistants and ward clerks.
- 'Red phone' is still not in place on Labour suite
- Staffing below template
- Staff moves to accommodate staffing, including being called in for escalation
- Balancing act of maintaining skills in all areas, whilst supporting own area of work in times of high staff absence.
- Difficulties in completing mandatory training, including attendance to 30mins fetal monitoring review sessions.
- Lack of clinic space in the community to enable more face to face appointments and parent education classes.
- Difficulty in using e-Care is some community settings due to poor connectivity
- Due to many changes over the last two years there is a potential for the community to feel isolated
- Positive feedback regarding the psychology team
- Positive feedback regarding the PMAs (Professional Midwifery Advocate) really valued and doing a fantastic job

In response to the concerns raised;

- e-care connectivity issues to be discussed with the e-care team at a meeting later this month.
- Recruitment of midwives and care assistants is ongoing, including international recruitment of midwives. There is a national shortage of midwives and therefore the team are always looking at ways to increase the workforce, through recruitment and retention initiatives, including virtual events, staff support, pastoral care, robust exit interviews, staff focus groups, all staff unit meetings.
- Clinical space in the community is under review, in addition to being escalated to the Local Maternity and Neonatal System (LMNS) for their support.

Listening to Staff
The National Staff Satisfaction Survey results were published in April 2022 and the triumvirate team have collated an action plan in response to this A very short temperature check survey will be sent to all midwifery staff later this month.

In addition to the Freedom to Speak up Guardians, Safety Champions, Professional Midwifery Advocates, Unit Meetings and 'Safe Space' volunteers have now come forward to participate in focus groups to take ideas forward that arose from the last midwifery staff survey late last year.

The focus groups will also be planning the Maternity Listening Event as recommended by the Ockenden final report.

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. I-pads have been ordered to enable easy access to completing the survey. Due to be in place by August 22.

Ward/Dept	May Survey returns	May FFT score	June Survey returns	June FFT Score
F11	22	100	23	100
Antenatal	16	100	5	100
Postnatal Community	11	100	6	100
Labour Suite	0		0	
Birthing Unit	15	100	0	
NNU	0		0	

0 compliment was shared with the patient experience team for women & children's division for logging in May & June 2022.

In May and June 2022, a total of 7 PALS enquiries and 2 complaints were received for maternity and 0 PALS enquiry and 1 complaint for NNU.

CQC Maternity Survey
The survey was completed on women who gave birth in and around February 2021 to a maximum number of 300 women who were offered surveys. The Trust had a 64% response rate to the national survey – this was increased from 2019. 2 areas improved since last survey, 3 areas decreased since last survey. Compared with other Trusts, we were about the same with 1 area better than expected and 1 area somewhat better than expected. There were no areas worse than other Trusts.

5 areas where we were deemed to be best included: being asked about mental health at antenatal appointments, being informed about coronavirus restrictions and implications, being able to see and speak to a midwife during labour, no delays in discharges and help and advice from a healthcare professional during the first 6 weeks after birth.
5 areas for improvement were identified which included: partners and visitors being able to be with the mothers, help and advice with feeding, having a choice about where postnatal care took place, being listened to in the period after the birth and active support and encouragement with infant feeding in the first 6 weeks after birth.

It is recognised that the Covid 19 pandemic had a profound effect on our ability to provide face to face care, particularly in the community setting and staffing shortages impacted on the support we were able to give at times. Additional peer support is being introduced to support infant feeding on the wards and in the community.

The survey report has been shared with the MVP and LMNS

Reporting and learning from incidents
During May and June 2022 there was one case that was referred HSIB, however they declined to investigate due to normal MRI results. A Patient Safety Review was undertaken and no safety recommendations were identified.

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.

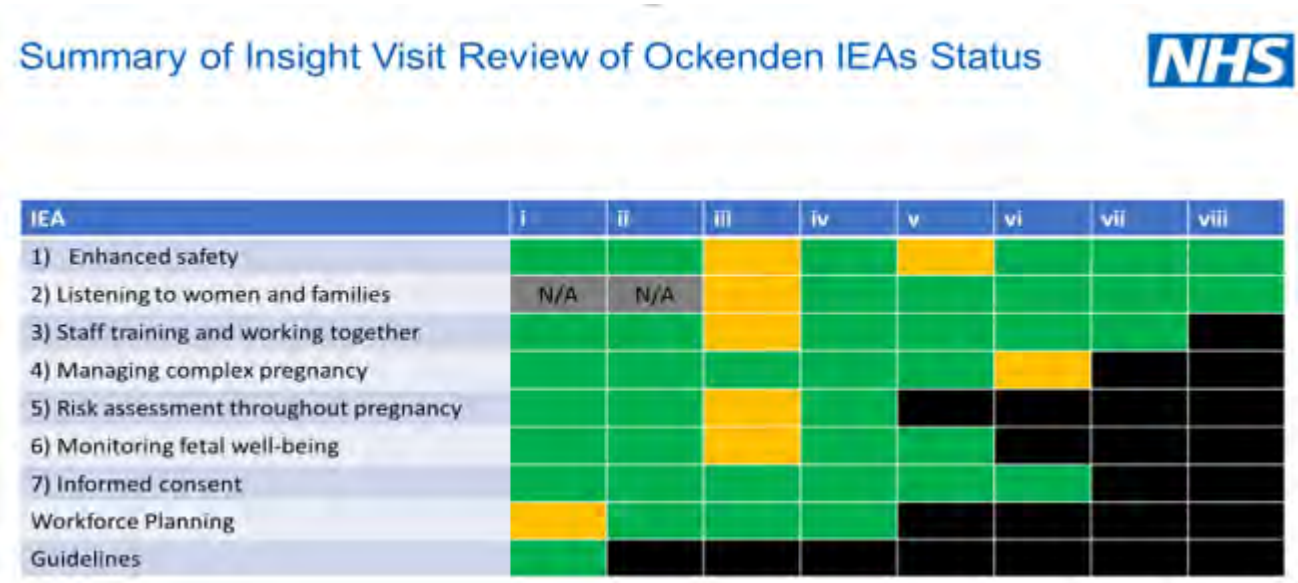
Indicators	Narrative
Decision to delivery times for grade 2 sections	In majority of cases the delay was within 15 minutes of the recommended timeframe. There is an ongoing Quality Improvement Project to improve this by having a target of 30 minutes for a transfer. Some longer delays were due to Obstetric Theatre being already occupied, but it was considered acceptable to wait. Some were reported for a good clinical reason such as difficulties in anaesthesia etc.
Induction of labour	Policies have been reviewed to ensure National Guidance is followed and slight reduction in rate has been noted.
Post-partum haemorrhages >1500mls	In line with increase of caesarean section and induction of labour, however QI project continues. The Trust governance team has undertaken a thematic review for all cases in Feb 22 to identify any further learning, final report is imminent, however initial learning has been implemented. When reporting rates to LMNS and region, preterm, multiple pregnancies are excluded in line with their criterion.
Carbon Monoxide monitoring at 36 weeks	Improvement noted in compliance however still below the expected level. Digital midwife working closely with smoking cessation midwife to identify issues in compliance data collection.
Appraisal compliance	This reflects Covid absence; time and availability of staff to complete. Going forward line managers to have greater oversight of when appraisals due, this will be supported by correct data on ESR regarding line manager.
Total women delivered who breastfed within first 48 hours	New breastfeeding peer supporters have now completed their training, awaiting start dates.
Swab count compliance	Issues with data entry in electronic documentation. Digital midwife and team have increased presence on Labour suite to support maternity team in correct process. All incorrect data entry is investigated to ensure no concerns with care. Data entry slowly improving.

Ockenden Assurance Visit by NHSE/I Regional and National Team
The Ockenden initial report on services at Shrewsbury and Telford NHS Trust was published in December 2020. An Insight visit to West Suffolk Hospital NHS Trust services was completed on the 17 May 2022.

The purpose of the visit was to provide assurance against the progress of the 7 immediate and essential actions from this first Ockenden report. The Insight Visit Team used an appreciative enquiry and learning approach to foster partnership working to ensure that the actions taken to meet the Ockenden recommendations were embedded in practice.

Emerging themes from conversations were organised under the immediate and essential actions headings. The recommendations and actions have been added to the over-arching Maternity Quality and Safety Action and Improvement plan.

The below table is an overview of the evidence seen:



Key to RAG rating

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

Saving Babies Lives Element 4 – fetal monitoring compliance report (Annex B)
Executive summary:
The report outlines the details of the Trust's Maternity Services compliance with the Saving Babies Lives element 4 Effective Fetal Monitoring in labour and thereby compliance with the year 4 Maternity Incentive Scheme Safety Action 6 and Safety Action 8 in respect of fetal monitoring training.

Intervention 1: The Trust has two methods for fetal monitoring training and does not yet consistently meet the 90% target in all staff groups. A plan is in place to improve individual compliance. Training programmes will be changing from 2023.

Intervention 2: The compliance with risk assessment for fetal monitoring in labour demonstrates that this is embedded in practice.

Intervention 3: The documentation of fetal heart reviews in labour - fresh ears and fresh eyes – has poor compliance in some aspects, particularly in the first stage of labour. However, escalation of concerns and 2-person reviews in the second stage, has high compliance. Documentation issues are to be addressed with individuals to identify how improvements can be made.

Intervention 4: The obstetric lead for fetal monitoring has had limited opportunities to undertake the role fully and it is not possible to demonstrate this in the roster. With changing personnel expected in August 2022, and appointment of consultants, it is planned to enhance this role and, with the midwife lead, to have more involvement in cases where there has been an adverse outcome and fetal monitoring may have been a factor. There is evidence of learning being shared through the local risk and governance newsletter. Sharing of learning locally and with the LMNS and completion of actions will be further enhanced and embedded.
The two cases that have had an adverse outcome in the last year have not identified any issues with the fetal monitoring part of the care.

Actions have been put in place to address training compliance, programmes for training and improved documentation moving forward. These will be monitored and reported as part of the quality and governance agenda.

NHS England Maternity Self-Assessment (Annex C)
The Trust completed the Self-Assessment document in January 2021: this has been updated as actions and controls have been put in place. The most recent update has been completed in June 2022. The self-assessment tool includes 160 areas some of which are maternity specific and some relate to Trust wide areas.

The 7 main sections are:

- *Directorate/Care Group infrastructure and leadership;*
- *Multi-professional team dynamics;*
- *Governance infrastructure and Ward-to-Board accountability;*
- *Application of National Standards and Guidance;*
- *Positive safety culture across the Directorate and Trust;*
- *Comprehension of Business/contingency plans impact on quality;*
- *Meeting the requirements of Equality and Diversity Legislation and Guidance*

The Maternity Service has currently assessed itself as having evidence of full compliance (green) in 127 areas, partially compliant (amber) in 21 areas and non-compliant (red) in 12 key areas of safety. The 12 areas of non-compliance are as follows:

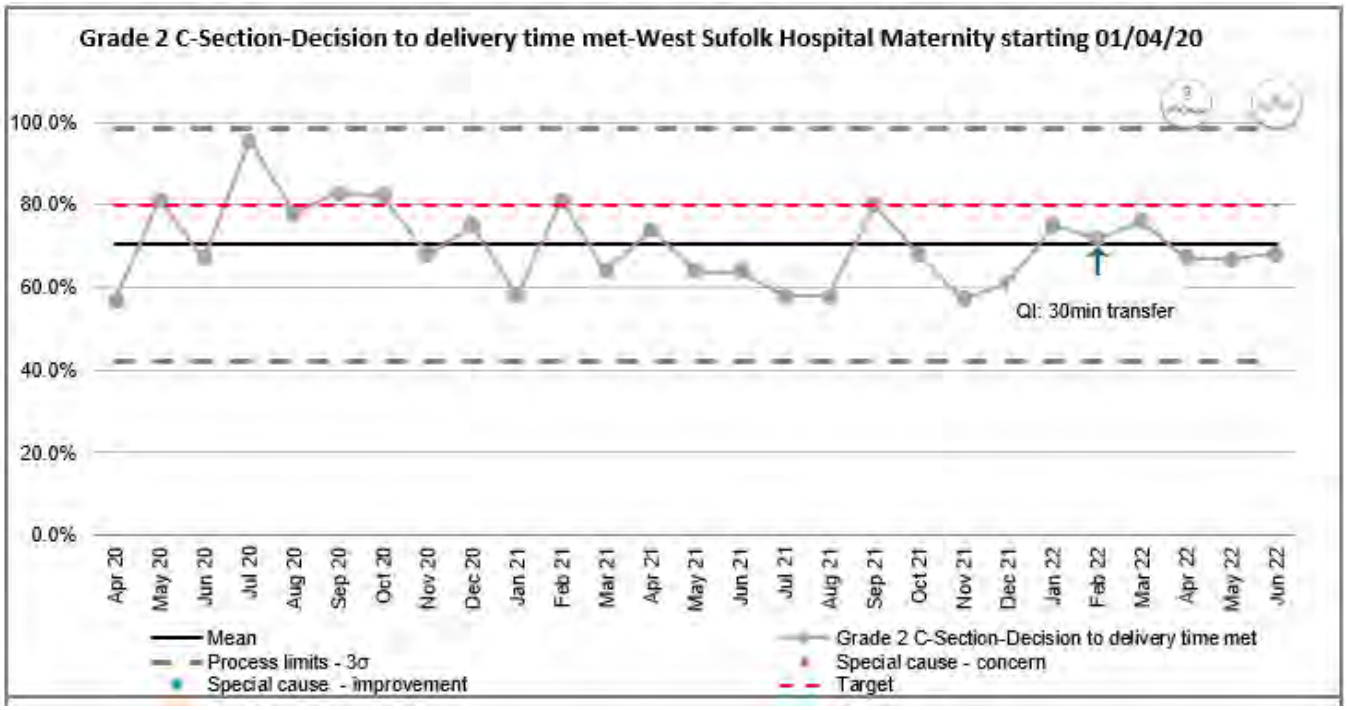
- 4 areas of the non-compliant sections relate to having a Director of Midwifery (DOM) in post
- 4 relate to having local Trust learning forums/conferences on patient safety, safety summits and reporting back to the Division from safety summits
- 3 relate to having Trust-wide Swartz rounds in place with multi-professional input and leadership for the forums
- 1 relates to having an in-date business plan in place.

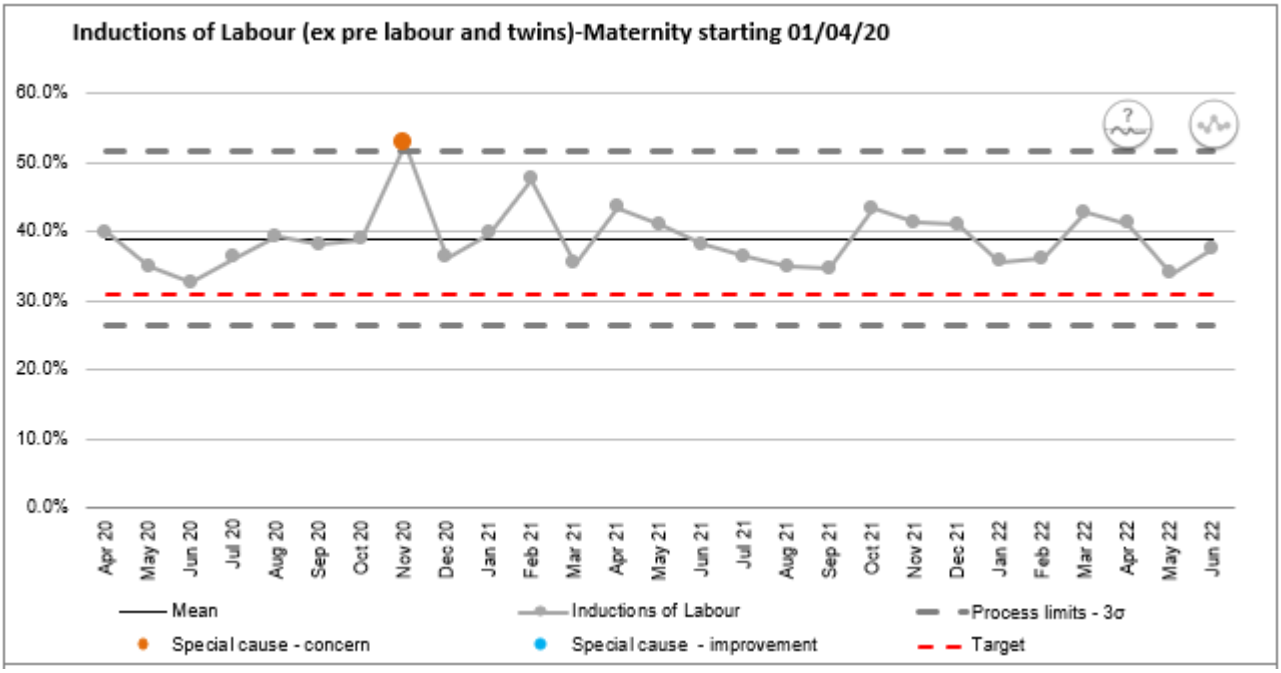
The maternity related area of non-full compliance has been captured in the overarching Quality and Safety Action plan and review fortnightly via the Maternity Improvement Board.

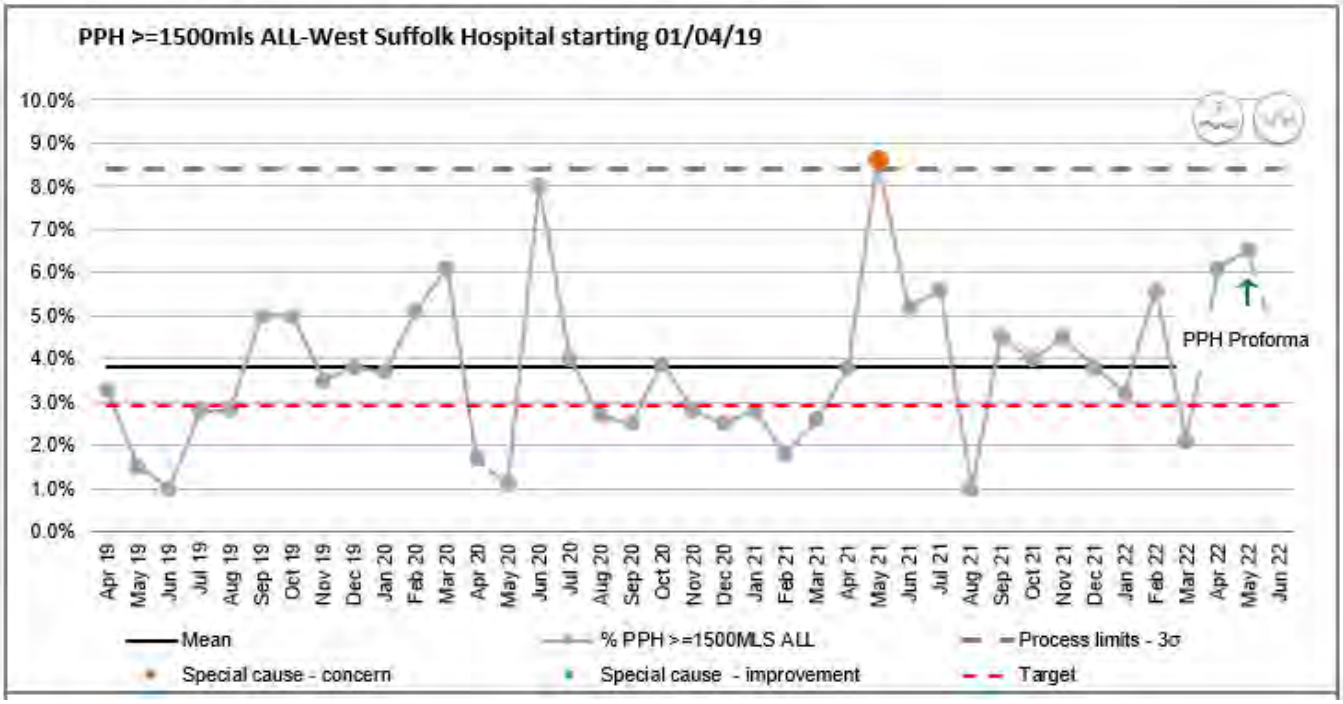
Trust priorities	**Deliver for today**		**Invest in quality, staff and clinical leadership**		**Build a joined-up future**		
	X		X		X		
Trust ambitions	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
Previously considered by:							
Risk and assurance:							
Legislation, regulatory, equality, diversity and dignity implications							
Recommendation: The Board to discuss content							

Annex A

Maternity Dashboard SPC Charts;






PPH >=1500mls ALL-West Suffolk Hospital starting 01/04/19
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7.0%
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5.0%
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PPH Proforma
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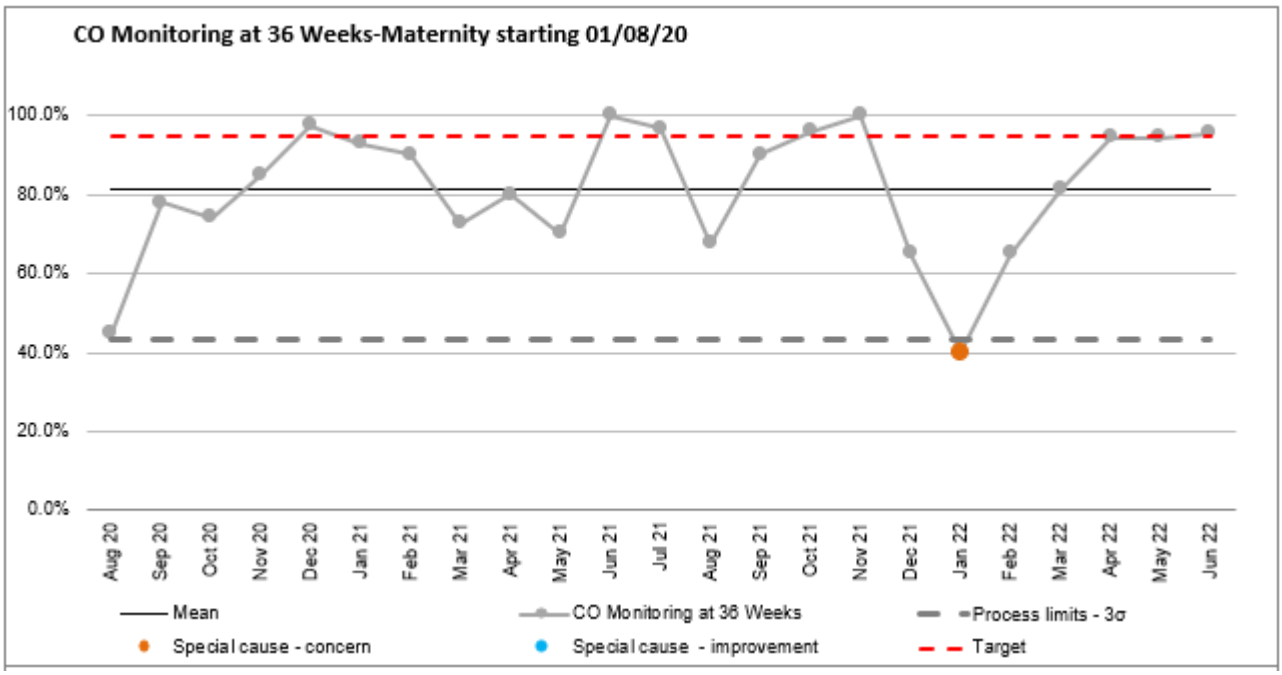
% PPH >=1500MLS ALL
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target


CO Monitoring at 36 Weeks-Maternity starting 01/08/20
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80.0%
60.0%
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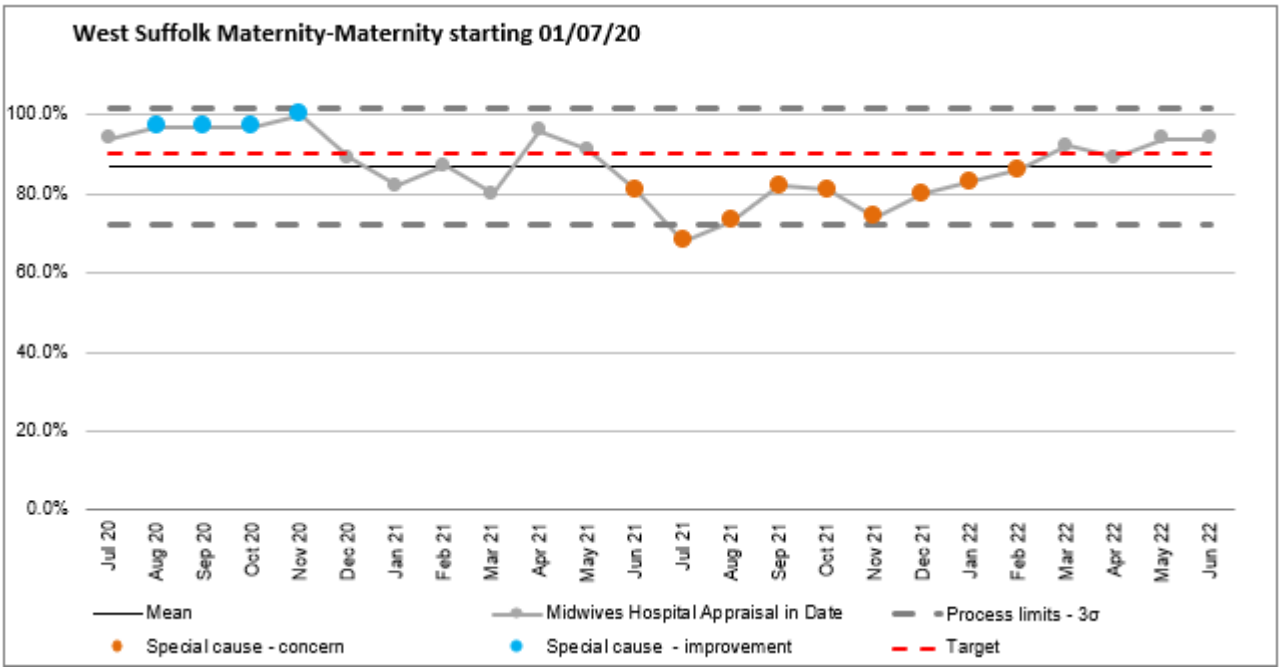
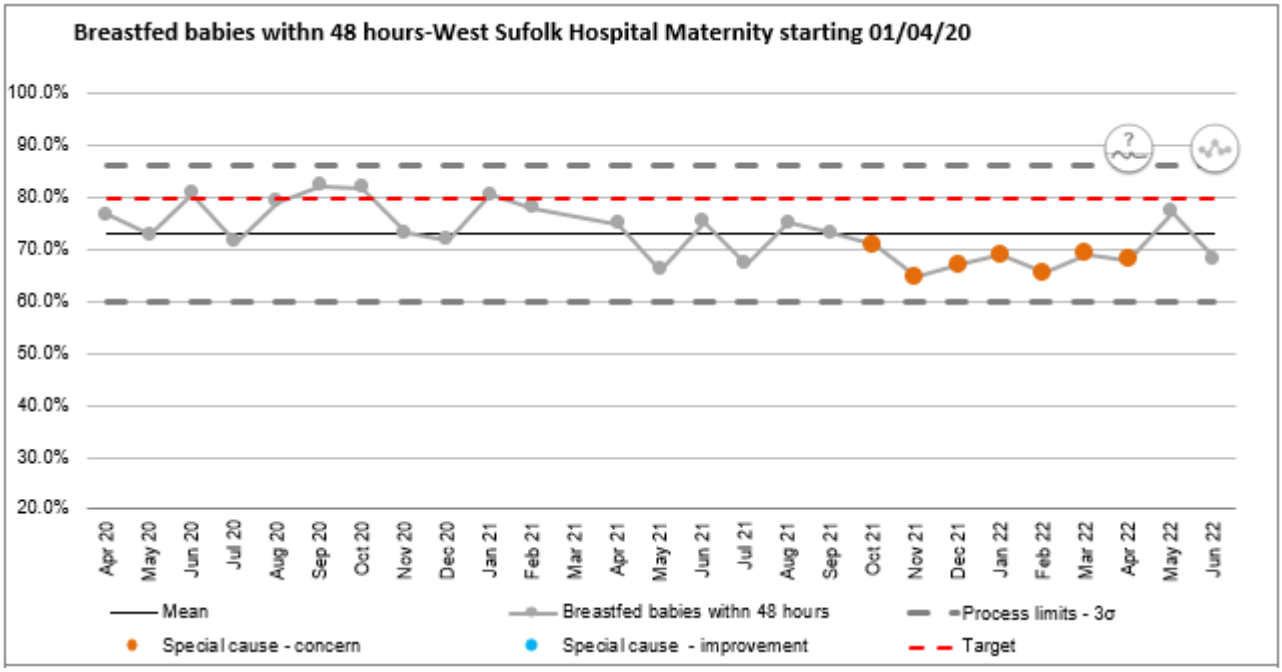
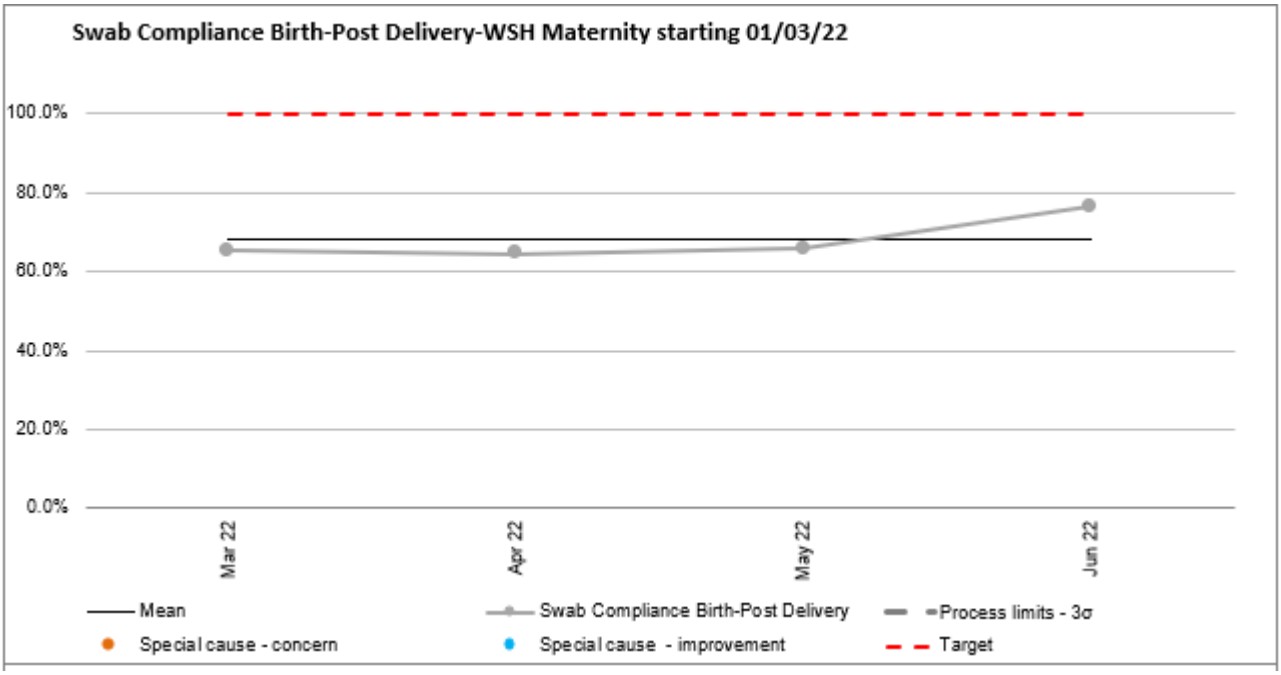
CO Monitoring at 36 Weeks
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target

Appraisal rates – midwives hospital






Swab Compliance Birth-Post Delivery-WSH Maternity starting 01/03/22
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80.0%
60.0%
40.0%
20.0%
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Mar 22
Apr 22
May 22
Jun 22
Mean
Swab Compliance Birth-Post Delivery
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target

4.6.2. Maternity safety support programme

To inform

Presented by Susan Wilkinson

Trust Open Board – Friday 22 July 2022

Agenda item:	4.6.2			
Presented by:	Sue Wilkinson, Executive Chief Nurse/ Paul Molyneux, Interim Medical Director & Executive MatNeo Safety Champion/ Karen Newbury, Head of Midwifery			
Prepared by:	Karen Newbury – Head of Midwifery & Beverley Gordon – Project Midwife			
Date prepared:	June 2022			
Subject:	Report to request to exit NHS England/Improvement Maternity Safety Support Programme (MSSP)			
Purpose:	x	For information		For approval

Executive summary:

West Suffolk NHS Foundation Trust entered the NHS England / Improvement Maternity Safety Support programme (MSSP) following the CQC's inspection of WSFT maternity services on 24th September 2019 and was issued a 29a warning notice on 14th November 2019. Following further CQC unannounced inspections on 13th April 2021, the CQC has revised ratings for the WSFT site in the Well-led domain from inadequate to requires improvement. All other domains reviewed remained the same, however the CQC reported they had seen evidence of progression, significant change and culture improvement. The triumvirate were aligned on the challenges to quality and sustainability within the service and had plans in place to address them. This meant that steps had been taken to improve the stability and effectiveness of the leadership of the service. However, at the time of the inspection, the new leadership team was in its infancy. The changes needed to be sustained and embedded before the full impact and effectiveness could be assured but early indications were positive.

In January 2022 the Trust entered the Sustainability phase of the MSSP as quality and safety improvement plans and actions were being addressed. The Maternity Improvement Advisor (MIA) reduced the level of support visits whilst maintaining oversight of progress. Sustainability plans were in place and tested to ensure the improvements were sustained and embedded as business as usual. External peer reviews from NHSE/I had taken place in October 2021(Sixty Supportive Steps to Safety) and May 2022 (Ockenden – one year on).

This paper identifies the supporting evidence for this improvement as well as ongoing work to continue to improve the quality and safety of Maternity services to facilitate the Trust to exit the MSSP

Key points outlined in this paper are:

- The process for entering and exiting the MSSP
- Completed actions from the 2019 CQC visit as detailed in the CQC report April 2021
- Improved Governance Structure and Framework
- Leadership Structure and sustainability
- Workforce structure and sustainability
- Compliance with Ockenden (part 1), Morecombe Bay, CNST, Maternity Self-assessment & 60 Supportive Steps, Ockenden (final report)
- Sustainability Action Plan

Next Steps

The Maternity Services will continue to provide evidence to the Trust Board, NHS England and other external partners to support their continued commitment to quality and safety and progress towards a sustained improvement in key aspects of care and services.

Introduction

West Suffolk NHS Foundation Trust entered the NHS England / Improvement Maternity Safety Support programme (MSSP) following the CQC's inspection of WSFT maternity services on 24th September 2019 and was issued a 29a warning notice on 14th November 2019. Following a further CQC unannounced inspection on 13th April 2021 and subsequent submission of evidence, the CQC has revised ratings for the WSFT in the Well-led domain from inadequate to requires improvement. Although the Trust has not met the full requirement criteria to exit the MSSP, significant improvement has been made and sustained over a period of time.

The NHS England / Improvement Maternity Safety Support Programme (MSSP)

The overall objective of the MSSP is to deliver a maternity safety support initiative, led by NHS England/ Improvement. The CQC supports this through the provision of intelligence to identify priorities for improvement and assurance that required changes have been made. NHSE/I then provide a programme of support that is designed to be flexible and adaptive to meet the individual needs of the Trust's improvement journey.

Criteria for entry to the MSSP are maternity services which have:

- An overall rating of inadequate
- An overall rating of requires improvement with an inadequate rating for either Safe and Well-Led or a third domain
- Been issued with a CQC warning notice
- Dropped their rating from a previously outstanding or good rating to requires improvement in the Safety or Well Led domains
- DHSC or NHS England /Improvement request for a review of services or inquiry
- Been identified to CQC with concerns by HSIB

A Maternity Improvement Advisor (MIA) was allocated to the West Suffolk NHS Foundation Trust to work with the executive clinical directors and divisional leaders to support the delivery outcomes identified in the CQC Report.

Criteria for leaving the programme is a CQC improved rating by at least one in the safe & well led domains. This has not been achieved but with external recognition of the significant progression made by improving from inadequate to requires improvement in the 'well led' domain, the Trust seeks to exit the programme with support of this formal paper being presented to the Executive Committee.

Supporting evidence to exit MSSP

A number of reviews and self-assessments have taken place as part of the Trust's support programme and assurance processes. The key results, recommendations, actions and progress reports are included as a summary below:

1. The West Suffolk NHSFT Maternity Services CQC Inspection 2019 Action Plans

Five action plans were developed in response to the CQC's section 29a warning notice issued on 14th November 2019 and a further must do action plan relating to other aspects of the CQC's inspection of WSH maternity services on 24th September 2019 was initiated and monitored via departmental governance meetings, Trust Improvement Programme/Board and CQC meetings. Following the CQC unannounced visit on13th April 2021, evidence was reviewed which confirmed that the Trust was now complaint with all aspects of the 29a warning notice.

The remaining actions continue to be progressed with monthly monitoring via internal and external Governance processes. It should be noted that these actions are part of the overall quality and safety improvement plan and the aim is for all aspects to be 'business as usual' rather than exception reporting.

2. Governance Structure and Framework

The roles and responsibilities for all staff working within the governance framework have been reviewed. Medical and midwifery staff with specific roles within governance are clearly defined with job plans and PA's reflecting the commitment to improve through organisational change and learning.

The risk and governance framework has been developed and approved by the Board in June 2021.This

replaced the previous maternity risk management strategy to ensure that all the elements of clinical governance are included. This outlines the structure, processes and people involved in promoting quality and safety through learning.

The Trust was involved in being a pilot site for the updated serious incident framework – Patient Safety Incident Response Framework (PSIIRF) and this process is now in place across the Trust including maternity and neonatal services. The incident management pathways now incorporate this, identifying when a Patient Safety Incident Investigation (PSII) is required. The Trust governance and reporting processes have been reviewed and the maternity and neonatal framework is reflective of the Trust's policies and procedures whilst maintaining the need for reporting to external bodies such as Mothers and Babies Reducing Risk through Audit and Confidential Enquiries across the UK (MBRRACE-UK), Healthcare Safety Investigation Branch (HSIB) – Maternity reporting criteria and NHS Resolution (NHSR) Early Notification (EN) when indicated.
A joint LMNS-wide standard operating procedure (SOP) was developed and agreed to provide external specialist opinion on MDT SI panels from a neighbouring LMNS. Learning is also shared at the LMNS safety forum, at Maternity HSIB quarterly meetings and at meetings with the CCG.

National reports and recommendations from MBRRACE, HSIB and other organisations are reviewed within the Trust and where a gap analysis identifies areas where improvements are required, actions that are required to achieve this are raised as part of the Quality and Safety plans for the Maternity Services.
Guidance from national bodies such as NICE, RCOG, and RCM are also used as a basis for changing practice when required.

A number of strategies are used to support shared learning which include 'Take Five' communications, Risky Business Newsletters, ward meetings and MDT forums where learning is shared.

3. Leadership Structure and sustainability
Over the last year the triumvirate has been strengthened to ensure there is sustainability with succession plans in place. A deputy Clinical Director is being appointed, all senior staff have attended leadership workshops and coaching sessions. A deputy Head of Midwifery was appointed in July 2021 to enhance the senior midwifery leadership team. Three midwifery matrons are in post covering maternity inpatient services, outpatient services and Divisional Governance. A structural chart can be found in Appendix 1.

Development of a Midwifery consultant post is underway, and progress is being made on having a sustainable dedicated operations support for maternity services; Consultants have completed leadership training in order to effectively lead on certain aspects of the service and there are ongoing discussions about equitable allocation of PA's to undertake these roles and fulfil their responsibilities to the role.

There is currently a review of how we may move forward with a Director of Midwifery within the Trust but in the interim the Head of Midwifery has direct access and reporting responsibilities to Trust Board.

Obstetric consultants have been appointed to lead roles for labour ward, risk and governance, fetal monitoring, antenatal care, audit, guidelines, training and education, antenatal and newborn screening, perinatal mortality and morbidity, GROW, diabetes (joint working) maternal medicine and Saving Babies Lives. Equivalent PA's have been funded to undertake these additional roles. The role of the Clinical Lead for obstetrics has been maintained with overall responsibility for quality and safety within the maternity services.

Specialist clinics are led by obstetric consultants for women at higher risk of preterm labour, women who are at greater risk of fetal complications such as growth, maternal medicine, diabetes and multiple pregnancies. Midwifery staff have been appointed into specialist roles – safeguarding, bereavement, perinatal mental health, diabetes, antenatal and newborn screening, fetal monitoring, practice development midwives x2, and newborn feeding. Professional Midwifery Advocates (PMA's) are allocated dedicated time to fulfil their roles in providing support to midwives when required.

A Clinical Director (CD) was appointed to the Division from another Division in the Trust. This has been a positive appointment, providing a fresh eyes and independent oversight of the services. This has also raised the profile and visibility of maternity services at Trust Board as the CD is also a Deputy Medical Director which gives further support to the Maternity Services at Board level.

The Medical Director and the non-executive director are the Maternity Board Level Safety Champions and have further enhanced the Trust oversight of maternity services. The Chief Nurse has provided significant, consistent and essential support to maternity and neonatal services.

4. Workforce Structure and sustainability

The Risk and Governance, Quality and Safety team has undergone some changes to personnel and job titles over the last year with the appointment of a Clinical Quality and Governance Matron, supported by 2 Clinical Risk Midwives, a Clinical Quality and Effectiveness midwife, Quality and Safety failsafe officer, risk lead obstetrician, and lead for neonatal care.

The Maternity Education and Training strategy and 3-year plan is led by the training and education leads which include the Deputy Head of Midwifery, Practice Development Midwives, Obstetric training lead, Obstetric Anaesthetic lead and the Neonatal trainers and Neonatal PDN.

The operational team for the Division has been further enhanced within the last year by updating the roles and responsibilities and appointment of personnel into new posts to support the processes required to demonstrate effective management of the services.

All aspects of the clinical workforce are continuously reviewed as part of the Maternity Incentive Scheme (MIS- CNST), Ockenden and against the professional standards from the governing bodies, Birthrate+ and professional bodies such as British Association of Perinatal Medicine (BAPM)All business cases to support an enhancement of staffing levels are submitted through the Trust processes for approval prior to advertisement and appointment to posts.

The Trust currently has gaps in the midwifery workforce and has experienced difficulty with recruitment of band 6 midwives.

In a recent survey of Paediatric Medical staff by the ODN, it was noted that the service does not currently have a Tier 1 member of staff dedicated to neonatal care 7 days a week during day time hours. This is being escalated.

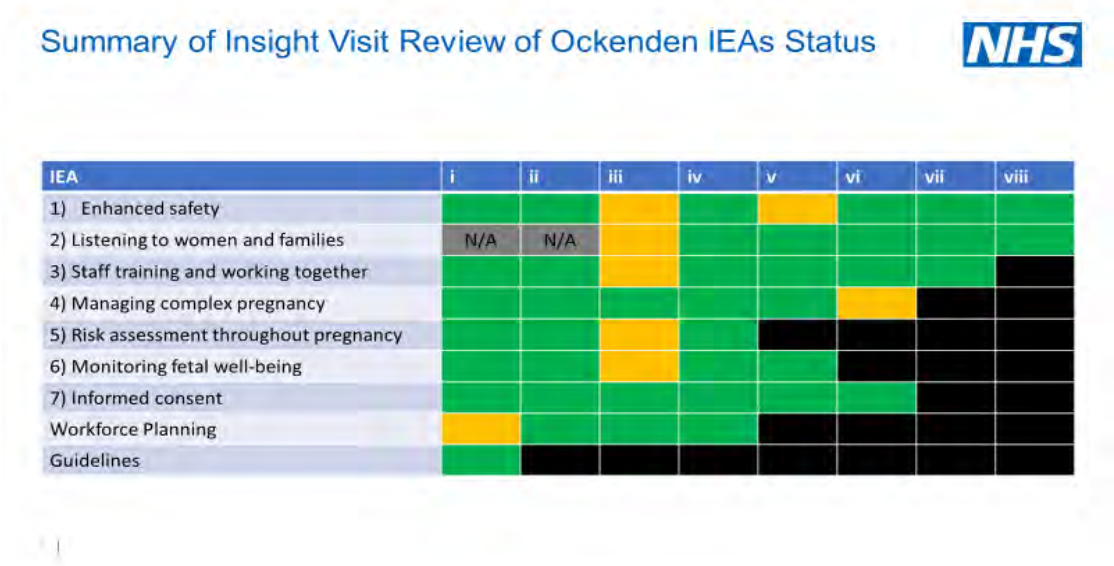
The NNU is now aligned with the maternity management structures rather than being directly managed by paediatrics.

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

The Ockenden initial report on services at Shrewsbury and Telford NHS Trust was published in December 2020. An Insight visit to West Suffolk Hospital NHS Trust services was completed on the 17 May 2022. The purpose of the visit was to provide assurance against the progress of the 7 immediate and essential actions from this first Ockenden report. The Insight Visit Team used an appreciative enquiry and learning approach to foster partnership working to ensure that the actions taken to meet the Ockenden recommendations were embedded in practice.

Emerging themes from conversations were organised under the immediate and essential actions headings. The recommendations and actions have been added to the over-arching Maternity Quality and Safety Action and Improvement plan.

The below table is an overview of the evidence seen:



Key to RAG rating

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

6. Ockenden final report 2022

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

Section 1: Workforce Planning and Sustainability
Section 2: Safe Staffing
Section 3: Escalation and Accountability
Section 4: Clinical Governance Leadership
Section 5: Clinical Governance - Incident Investigation and Complaints Handling
Section 6: Learning from Maternal Deaths
Section 7: Multidisciplinary Training
Section 8: Complex Antenatal Care
Section 9: Preterm Birth
Section 10: Labour and Birth
Section 11: Obstetric Anaesthesia
Section 12: Postnatal Care
Section 13: Bereavement Care
Section 14: Neonatal Care
Section 15: Supporting Families

Evidence has not yet been signed off against any of the recommendations (blue) but the current assessment to date is that we have assurances of being on track with compliance (green) in 28 areas, partial assurances (amber) in 53 areas, and no current evidence of compliance (red) in 3 areas. There are 8 areas where the assessment has not yet been confirmed.

The 3 areas of non-compliance or lack of evidence of compliance, include having a core team of trained midwives for HDU care; having a visible supernumerary clinical skills facilitator in clinical practice, and having

clear pathways, escalation and risk assessment when IOL is delayed due to high activity and shortage of staff.

The Trust is awaiting national and regional guidance on the realisation of these recommendations at a local, regional and national level. In anticipation of this guidance being in line with the original recommendations, an improvement and action plan has been prepared and leads have been allocated. Regular reports will be submitted outlining progress being made against the recommendations in the final report.

7. Morecambe Bay Recommendations and review of maternity service

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

5 out of the 18 recommendations	**Compliant**
13 out of the 18 recommendations	**Partially Compliant**

The remaining recommendations 19-44 were related to the Trust's wider Governance strategies and other external agencies and Health Care managers to enhance governance and safety processes on a local, regional and national level:

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

8. Maternity Incentive Scheme (MIS - CNST)

The Trust has participated in the Maternity Incentive Scheme since year 1, undertaking a self-assessment against the 10 safety actions as they have evolved. In 2019, the Trust submitted a statement indicating that they were compliant with all 10 safety actions in Year 2 of the scheme. During the CQC review in September 2019, the Trust was asked to review this compliance alongside the evidence required. Subsequently, the Trust declared compliance with only 8 out of 10 of the safety actions and funding received was returned to NHSR.

Year 3 submissions were delayed several times due to Covid 19 and this was completed in July 2021. The Trust submitted evidence to the Trust Board to confirm full compliance against 4 out of the 10 safety actions. The reasons for non-compliance with 6 safety actions related to Board papers not being submitted within the prescribed timeframe (and not as a result of non-compliance with the clinical elements) and reaching the threshold for assurance of processes being embedded such as in certain elements of Saving Babies Lives, MDT training and the Labour Ward Coordinator being supernumerary. Since this time, actions required to promote safety in these key areas has been included in the overarching quality and safety plans. The Trust is confident that the submission for year 3 is reflective of the Trusts compliance.

Year 4 MIS Safety Actions were re-launched in May 2022 and the Trust is working towards ensuring that the Trust can provide evidence of their commitment to safety within the appropriate timeframes. The Trust currently expects to be able to provide compliance in 7 out of 10 areas. The areas where evidence of non-compliance may be challenging have been escalated to the Safety Champions and Trust Board. One aspect of the safety actions is compliance with the Maternity Services Data Set (MSDS) which is reliant on the Trusts Maternity Information System being aligned to the NHS Digital requirements. Work with updating E-care continues but data will be extracted from July births and bookings and the issues may not be resolved within this timeframe.

The Trust will be kept informed of progress against the 10 safety actions through Board reports and identify areas of concern with safety.

9. Maternity Safety Self-Assessment (NHS England)
The Trust completed the Self-Assessment document in January 2021: this has been updated as actions and controls have been put in place. The most recent update has been completed in June 2022. The self-assessment tool includes 160 areas some of which are maternity specific and some relate to Trust wide areas.

The 7 main sections are:

- *Directorate/Care Group infrastructure and leadership;*
- *Multiprofessional team dynamics;*
- *Governance infrastructure and Ward-to-Board accountability;*
- *Application of National Standards and Guidance;*
- *Positive safety culture across the Directorate and Trust;*
- *Comprehension of Business/contingency plans impact on quality;*
- *Meeting the requirements of Equality and Diversity Legislation and Guidance*

The Maternity Service has currently assessed itself as having evidence of full compliance (green) in areas, partially compliant (amber) in 21 areas and non-compliant (red) in 12 key areas of safety. The 12 areas of non-compliance are as follows:

- 4 areas of the non-compliant sections relate to having a Director of Midwifery (DOM) in post
- 4 relate to having local Trust learning forums/conferences on patient safety, safety summits and reporting back to the Division from safety summits
- 3 relate to having Trust-wide Swartz rounds in place with multiprofessional input and leadership for the forums
- 1 relates to having an in-date business plan in place.

10. 60 supportive steps to Safety
The 'Sixty Supportive steps to Safety' visit was undertaken by NHSE regional team on 21st October 2021. 15 immediate safety issues were identified. The NHSE regional team reviewed our progress towards the safety actions whilst undertaking their Ockenden Assurance visit on the 17th May 2022 and were assured that only two out of the 15 actions were not fully achieved. The two areas that requires further attention are:

- Setting up a Maternity Triage area: this will be implemented when the current roof work is complete
- Embedding Local Safety Standards for Invasive Procedures (LoCSSIPs) in accordance with National Safety Standards for Invasive Procedures (NatSSIPs) by ensuring that the information system supports completion of these mandatory areas of safety each time they are required.
-

Sustainability Action plan

The Trust will maintain oversight of all safety and improvement plans that are in place within maternity and neonatal services. The annexe attached to this paper outlines the principles and progress of the plan at the point of exiting the programme. The information and progress from the Trust's Maternity Action and Improvement Plan will be presented as part of the Governance and Safety reports submitted to the Maternity and Neonatal Safety Champions and the Trust Board via the following governance processes:

- Clinical and Quality dashboards monitoring clinical data and outcomes and compliance with quality and safety standards
- Maternity Quality and Safety Action and Improvement plan
- Maternity and Neonatal Safety Champions walkabouts and meetings, and attendance of Safety Champions at MVP meetings, Board meetings, MIB and Trust Board.
- Monitoring of key safety actions through quarterly reports to Board to provide assurance of safety and governance processes e.g. Perinatal mortality reviews and reporting to MBRRACE; training and education plans, sessions and attendance reports; submission of cases for review by HSIB and reporting to NHSR EN scheme; compliance with local transitional care guidance and review of all babies who are born at or around term who are admitted to the neonatal unit (NNU); and submission of assurance against the standards laid out in the elements of Saving Babies Lives.
- Oversight of key successes and concerns at Maternity Improvement Board (MIB)

- The Triumvirate present the Maternity Quality, Safety and Performance Board report which is supported by the Chief Nurse and the Trust Medical Director.

In addition, the following pathways will provide internal and external oversight:

- LMNS – Perinatal Quality Surveillance Principle 1 details are submitted to the LMNS Board – currently through the RPQOG but in future through the agreed PQSM dashboard.
- Regional oversight – attend rotating quarterly meetings; MIB, Safety Champions, Quality & Safety Meeting.
- HSIB quarterly meetings

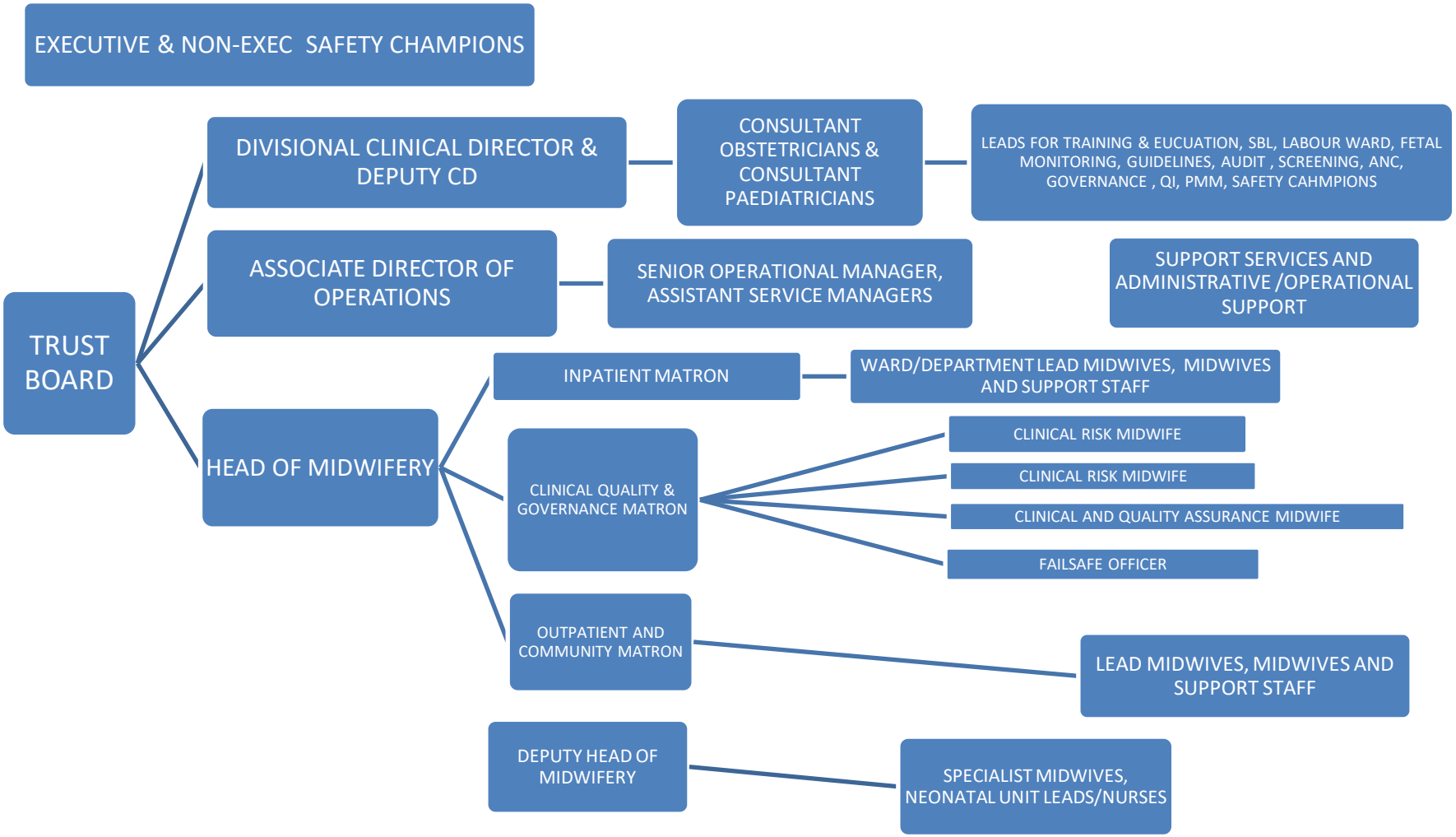
In addition, the MNSC members will attend Regional and National Patient Safety Forums and MatNeoSip meetings and ODN (COG) meetings when these take place.

Trust priorities	**Deliver for today**		**Invest in quality, staff and clinical leadership**			**Build a joined-up future**	
	x					**x**	
Trust ambitions	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
	x	x	x	x	x		

Previously considered by:	
Risk and assurance:	
Legislation, regulatory, equality, diversity and dignity implications	

Recommendation: The Trust is asked to receive this report and confirm that the information meets the required threshold for a timely exit from the MSSP.

Appendix 1 Organisational Chart demonstrating Leadership structures



Annexe – Summary of Sustainability Plan

Action ID Sustainability Action Plan	Sustainability Action Plan	RAG Rating
1. CQC	Progress is being monitored through the overarching Materenity Quality and Safety Action and Improvement Plan	
2. Governance structure and framework	Continue to monitor governance processes through Board repots, external national reporting and LMNS forums with oversight on the PQSM . Ensure processes for shared learning are embedded and demonstrate that any changes are embedded in practice. Links to all other improvement plans and assurances of safe working practices.	
	Continue current stafing allocation to Governance and Practice Development roles to enable going safety and quality standards.	
3. Leadership strcuture and sustainability	Continue with a programme of suscession planning for leadership roles, ensure that leadership courses/forums/training are availabile for all staff in lead roles and wishing to succeed to lead roles. Continue to support clinicians with adequate administrative staff.	
	Review of Obstetric lead roles, ensuring PA allocation is adequate to fulfill the role effectively. Adaquate operations support for maternity services. Develop consultant midwife role. Administrative staff to support all lead roles.	
	Maternity Service Safety and Quality performance to be scrutinised via internal governance process, maternity & neonatal safety champions, Trust Board, LMNS & Regional team.	
4. Workforce structure and sustainability	Described in MIS year 4 Board reports regarding gaps in workforce in Paediatrics and Midwifery staffing. Active recruitment plans needed to recruit midwives to maintain safe staffing standards	
5. Ockenden 2020	Progress is being monitred through the overarching Maternity Quality and Safety action and improvement plan and interventions are being embedded to improve safety. Linked to SBL actions	

6. Ockenden final report 2022	The assessment and actions needed against the fnal report are being managed through the agreed template with leads allocated to each area of safety. All interventions required to improve safety are being overseen and monitored through the governance processes and linked to SBL actions. Insight visit recommendations to be included in Q&S improvement plan	
7. Morecambe Bay recommendations	Assesment and actions required against the recommendations form part of the overarching Maternity Quality and Safety action and Improvement plan. Interventions and processes required to improve safety and quality of care are being embedded.	
8. Maternity Incentive Scheme Year 4 - CNST	Progress is being made against demonstrating compliance with 10 safety actions. Deadlines for completion of key steps being met, escalation of areas where compliance with the safety actions may be at risk. Linked to SBL actions	
9. Maternity Self-assessment	Progress and sustainability of actions and improvements required as part of the self-assessment are linked to the overarching Maternity Quality and Safety Action and Improvement plan	
10. 60 Supportive steps to safety	Progress and sustainability of actions and improvements made since the 60 steps was undertaken is monitored through the Maternity Quality and Safety Action and Improvement Plan. Remaining actions are being progressed and embedded	

4.7. Involvement Committee Report - June 2022 Chair's key issues

To Assure

Presented by Alan Rose

Board of Directors – Friday 22 July 2022

Report Title:	4.7 - Chair's Key Issues Report – Involvement Committee
Lead:	Alan Rose, Deputy Chair and Chair of Involvement Committee
Report Prepared by:	Alan Rose & Jeremy Over
Previously Considered by:	N/A

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

Executive Summary
This report provides an overview of the key issues and assurance arising from the most recent meeting of the Involvement Committee of the Board on 20 June 2022.
Action Required of the Board
To note the report.

Risk and assurance:	Relevant BAF risk: *If we do not value our workforce and look after their wellbeing and development, particularly in the context of the Covid pandemic, this may affect patient safety and quality of care due to lower levels of staff engagement and morale and staff choosing to leave WSFT*
Equality, Diversity and Inclusion:	The Committee is responsible for providing scrutiny and assurance on behalf of the Board in relation to the development of a diverse and inclusive culture at WSFT
Sustainability:	N/A
Legal and regulatory context	The Committee's responsibilities align with a number of domains of the Care Quality Commission regulatory framework, including "well-led".

Chair's Key Issues

Originating Committee	Involvement Committee	Date of Meeting	20 June 2022
Chaired by	Alan Rose	Lead Executive Director	Jeremy Over

Item	Details of Issue	For: Approval/ Escalation/Assurance	BAF/ Risk Register ref.	Paper attached?
Staff Physiotherapy Service	- Review of this service delivered by senior physiotherapist Mike Chatten; - Relatively rapid on-site response times and assessments; - Good linkages to related services, such as Manual Handling and the Psychology team, as well as onward referrals to specialist consultants; - Good anecdotal feedback on quality of service and its "value" in reducing staff absence through injury.	**Good assurance for Board, ongoing development to focus on: reducing risk reliance on single-handed provision, improving awareness and access for Community staff and eliciting more structured service feedback.**	BAF Risk 6 (Workforce wellbeing)	No
Patient Safety Partners	- Lucy Winstanley, head of patient safety presented this interim update on implementation of this national framework; - Linked to ICS and aiming to be in place by Oct 2022; - Discussion of how we relate this to general improved awareness of our safety culture across the entire workforce; - This initiative is one component of the wider Patient Engagement Programme described below.	**Partial Assurance for Board, as details not yet fully clear and considerable work to be completed to meet deadline; consider cross-ICS recruiting & roles? Task & Finish Group in place to drive this initiative.**	BAF Risk 1 (Governance structures: Safety & Quality)	No
Patient Engagement Programme	- Anna Wilson, managing the VOICE Group, discussed progress of this programme overseen by Cassia Nice, head of patient experience; - We are wanting to strengthen our policy and programme across this area and this is being worked-on with an ambitious set of 10 sub-projects over 2 years;	**Good Assurance for Board that this wide-ranging theme is being professionally managed**	BAF Risk 1 (Governance structures: Patients & Service-Users)	No

Originating Committee	Involvement Committee	Date of Meeting	20 June 2022
Chaired by	Alan Rose	Lead Executive Director	Jeremy Over

Item	Details of Issue	For: Approval/ Escalation/Assurance	BAF/ Risk Register ref.	Paper attached?
	- e.g. Embedding Patient Engagement as part of co-production in a revised Business Case template and change toolkits; - e.g. A range of initiatives related to "accessibility of information"; - e.g. a revamp of the VOICE group, including reaching-out to communities, as much as 'bringing people in' to talk about issues; - Close links with the ICS's "People & Communities Strategy". - Good use of the "driver diagram" approach to change that is being used in a variety of internal projects	**and structured; Board (in public) should receive selected updates as specific components achieve maturity.**		
West Suffolk Review: Organisational Development (OD) Tracker	- The Committee (on behalf of the Board) will receive regular updates on progress of the five themes, with RAG-rated assessments; - Current progress assessed as satisfactory, with Chair/NED/CE recruitments over the Summer regarded as important components; - "What matters to You – 2" being worked on and Jeremy foresees this having explicit 'values' and 'behavioural' components, as we seek to support the living-out of our values and positive changes in behaviours across the organisation	**Good Board Assurance so far but, as previously noted, a mutual awareness that this is a journey of continuous improvement; as Board members, we are increasingly aware of the importance of every single interaction we have with others in shaping the culture change.**	BAF Risk 6 (Workforce wellbeing)	No
Next time: (15/8/22)	- Patient Experience/Complaints/Incidents learning processes			
Date Completed and Forwarded to Trust Secretary		**11 July 2022**		

5. GOVERNANCE

5.1. Governance report

To inform

Presented by Richard Jones

Board of Directors – 22 July 2022

Report Title:	Item 5.1 - Governance Report
Executive Lead:	Richard Jones, Trust Secretary
Report Prepared by:	Richard Jones, Trust Secretary Pooja Sharma, Deputy Trust Secretary
Previously Considered by:	N/A

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

Executive Summary

This report summarises the main governance headlines for May 2022, as follows:

1. Chair recruitment
2. Senior Leadership Team report
3. Audit committee, including annual report and terms of reference
4. Board development/seminar sessions
5. Joint governors and directors working group
6. Suffolk & North East Essex Integrated Care System (SNEE ICS)
7. Board assurance framework (BAF) summary and risk report
8. Use of Trust seal
9. Information governance steering group (IGSG) – terms of reference
10. Draft agenda items for the next Board meeting

Annex A: Audit committee annual report and terms of reference

Action Required of the Board

To note the report and approve:

- Audit committee annual report and terms of reference
- IG steering group delegated authority

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

Governance Report

1. Chair recruitment

You may be aware that the Trust has been recruiting for a new chair. Over the last couple of weeks, a recruitment process - including candidate-led discussion panels (made up of staff and close stakeholders) and interviews - has been taking place.

On this occasion, the interview panel and the council of governors have decided not to recruit any of the candidates. You will be aware that as well as the chair, there are several senior posts which need recruiting to, including non-executive directors (NEDs) and a permanent chief executive. Considering these forthcoming changes, coupled with us not recruiting to the chair role at this time, the nominations committee of the council of governors has recommended that Jude Chin remains in post as chair for the next 12 months, which he has accepted.

This will provide stability and continuity whilst we move forward with recruiting additional NEDs and a permanent chief executive.

2. Senior leadership team (SLT) report

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

SLT considered a number of strategic issues in its recent meetings, which has included discussion of: discharge processes and pathways; operational recovery plans; senior allied health professional representation; NHS benchmarking information; mental health service and alliance; and the Western Way business case.

3. Audit committee

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

At its last meeting it considered:

- BAF assurance – deep dive session on the new IQPR
- Review of draft annual governance statement (AGS) which will form part of the annual report and accounts 2021-22
- Internal audit and counter fraud plans for 2022-23 – approved
- Final Head of Internal Audit opinion was received
- RSM internal audit progress report – including management action progress
- Governance and assurance committee reports and issues for consideration
- Losses, waivers, debt write-offs and special payments

The committee also received and considered its annual report and reviewed its terms of reference. These are appended to this report for approval.

4. Board development/seminar sessions

A Board development session as held on 5 July 2022 facilitated by Integrated Development. The session is included discussion on our ability to create the change we need over the course of the next ten years.

The Board's commitment to coproduction was emphasised and it was agreed that options be developed to support the change ambitions with the senior leadership team (SLT) for Board consideration and approval.

The session considered individuals understanding of organisations and our unconscious beliefs about leadership. This included use of three different lenses to view organisation structures:

- **mechanical** - focus on analytical, rational processes, e.g. structure, vision, strategic planning, implementation
- **social** - focus on irrational processes e.g. micro-politics, relationships, group dynamics, moods, gossip
- **constant flux** - focus on the organisation as part of its constantly changing environment

An approach to organisational mapping was also considered which assigned a phase of development for a range of aspects of organisational working and behaviour:

- Phase 1: The hierarchical organisation
- Phase 2: The institutional organisation
- Phase 3: The collaborative organisation
- Phase 4: The learning organisation

Source: R Brian Stanfield, The Art of Focused Conversation (2000)

At the end of the session a briefing was provided on progress and next steps for the community diagnostic centre (CDC) business case.

5. Joint governors and directors working group

A further meeting of joint governors and board directors working group took pace on 9 June. The focus of discussion included:

- Progress with the Trust's response to the West Suffolk Review, structured around the organisational development strategy
- Review of the staff survey finding, both locally and nationally
- Reflections on experience and learning from the events covered by the review by one of our NEDs
- consideration of working group forward plan.

6. Suffolk & North East Essex Integrated Care System (SNEE ICS)

In collaboration with colleagues in ESNEFT Craig Black and Nick Hulme up their seats on the ICS Partnership Board (ICB), which is responsible for NHS strategic planning and allocation decisions. Each organisation also have a place on the SNEE Integrated Care Partnership (ICP), which brings together a wider set of system partners to develop the strategy to address the broader health, public health and social care needs of the local population. https://www.sneeics.org.uk/

7. Board assurance framework (BAF) summary and risk report

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.

The Board has an approved risk appetite statement which supports the organisation's approach to risk mitigation. BAF and red risks are allocated to Board governance committee for oversight. The process to manage and maintain this oversight is being further strengthened.

A summary of the BAF is provided in Appendix A.

8. Use of Trust Seal

Seal No. 153 – Deed of rectification relating to the land on the west side of Horsecroft Road, Bury St Edmunds between West Suffolk NHS Foundation Trust and Christopher John Horace Brown & Rupert Jeremy Christopher Brown - Sealed by Craig Black, witnessed by Ruth Williamson (11 July 2022).

9. Information governance steering group (IGSG) – terms of reference

A recent audit of the responsibilities highlighted the need for the IGSG to be given delegated authority from the Trust Board on information governance matters and policy approval.

10. Agenda Items for the Next Meeting (Appendix B)

Appendix A 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.

Appendix A: Board assurance framework

Background

The Board assurance framework is a tool used by the Board to manage its principal strategic risks.

Focusing on each risk individually, the BAF documents the key controls in place to manage the risk, the assurances received both from within the organisation and independently as to the effectiveness of those controls and highlights for the board's attention the gaps in control and gaps in assurance that it needs to address in order to reduce the risk to the lowest achievable risk rating.

Appendix 1 shows the allocation of the BAF risks to each of the Board's assurance committees.

Appendix 2 provides supporting detail of current mitigating actions and the most recent assurances relating to those actions.

The role of the assurance committees

Board assurance committees are responsible for considering all relevant risks within the BAF and the corporate risk register as they related to the remit of the committee, as part of the reporting requirements, and to report any areas of significant concern to the audit committee or the board as appropriate. The committees will be responsible for recommending changes to the BAF relating to emerging risks and existing entries within their remit for the executive to consider. When the target risk in the BAF is met, a full report will be made to the committee recommending its removal from the BAF, which will the committee will consider and make an appropriate recommendation to the Board.

Risk Appetite Statement

The Trust's risk appetite statement has been reviewed and is being used as a tool to determine which risks should be prioritised by the board for controls assurance purposes. Where the Trust has a cautious view of risk (green to yellow), and the current risk is higher than this, this risk will be reviewed more frequently and in greater depth by the board and its committees. When a target risk is achieved and this is lower than the Trust's risk appetite, the Board will consider the removal of a risk from the Board Assurance Framework, though it will remain on the Trust's risk register for ongoing executive management.

Current risk profile

All but one of the BAF risks are red. All of the red risks are outside the Trust Board's agreed risk appetite.

The amber risk relates to digital transformation. Assessed at Annual x Major = Amber, this has achieved its target risk and is within the Trust Board's agreed risk appetite.

Red Risk Report

This report now also includes an update on the corporate and operational **red risks** previously reported separately.

Risk No.	Title	BAF Y/N	Risk level (current)	Risk Subcategory
24	Potential failure of the main building structure and front residencies structure (Oak, Cedar, Birch, Larch, Pine, Willow)	N	Red	Corporate Risk
4168	Impact of Managing COVID-19 (Coronavirus) on Trust business as usual activity	N	Red	Corporate Risk
4499	Provision of thrombectomy service for stroke patients in our region	N	Red	Corporate Risk
4724	Staffing shortfalls	N	Red	Corporate Risk
4917	Missing samples causing a delay to getting results to the right patient at the right time.	N	Red	Operational Risk
5092	Capacity and demand of the e-Care Meds Team	N	Red	Operational Risk
5136	Saving Not Signing Documents on e-Care	N	Red	Corporate Risk
5148	Aging MRI scanners	N	Red	Operational Risk
5151	No availability of a second obstetric team outside the hours of 8am and 8pm Mon-Fri	N	Red	Operational Risk
5230	Delay in Discharge Summaries being sent out	N	Red	Operational Risk
5381	Disharmonious working within Plastic Surgery team	N	Red	Operational Risk

All red risks are reviewed every 3 months with the relevant Executive.

The timescale for the remediation work for the **main building structure (risk 24)** was reviewed at the relevant assurance committee on 4 July 2022.

The original RAAC work programme was scheduled assumed that three decant wards would be available. Unfortunately, the programme has largely been working with just one decant ward due to operational pressures and capacity issues. Planning is now in place to deliver the programme with two decant ward by May 2024.

Future reporting arrangements

The Board assurance committees will update the board at every meeting when they receive updates on any of the BAF strategic risks. The BAF risks have been allocated to the relevant assurance committee and governance/specialist group.

Appendix 1

Allocation of BAF Risks to Board Sub-Committees

BAF risk	**Board assurance committee** (Exec. lead)	**Governance (specialist) committee** (Specialist lead)
1. If we do not establish effective governance structures, systems and procedures over safety and quality, this will lead to poor standards of care to all patients and service users, potential harm, service failure, reputation damage, poor patient experience and regulatory action	**Improvement** (Sue Wilkinson)	**Patient Safety and Quality** (Dan Spooner)
2. If we do not manage emergency capacity and demand in the context of Covid activity and delivery of the RAAC remediation plan, this will affect our ability to deliver safe, effective and efficient services and care to patients	**Insight** (Nicola Cottington)	**Urgent and emergency care group** (Alex Baldwin)
3. If we do not deliver elective access standards based on clinical priorities in the context of Covid activity, this will affect our ability to deliver safe, effective and efficient services and care to patients	**Insight** (Nicola Cottington)	**Patient access** (Alex Baldwin)
4. If we do not progress our programme of work for digital adoption, transformation and benefits realisation, the digital infrastructure will become obsolete and vulnerable to cyber-attack, resulting in poor data for reporting and decision support, digital systems failure, loss of information and inability to provide optimum patient care, safety and experience [Risk is being considered for de-escalation by Insight Committee]	**Digital programme board** (Nick Macdonald)	**Digital board** (Liam McLaughlin)
5. External financial constraints (Revenue and Capital) impact on Trust and system sustainability and model of service provision in the west Suffolk system *(even when services delivered in the most efficient way possible).* This includes failure to identify and deliver cost improvement and transformation plans that ensure sustainable clinical and non-clinical services while delivering the agreed control total	**Insight** (Nicola Cottington + Nick Macdonald)	**Finance and workforce** (John Connelly (operational) / Charlie Davies (finance))
6. If we do not value our workforce and look after their well-being, particularly in the context of the Covid-19 pandemic, this may affect patient safety and quality of care due to lower levels of staff engagement and morale, and staff choosing to leave WSFT	**Involvement** (Jeremy Over)	**Senior Leadership Team** (Denise Pora/ Claire Sorenson)
7. If we do not implement the estates strategy to provide an adequately maintained building environment suitable for patient care caused by the deteriorating state of Trust buildings, lack of access to capital to fund the remediation programme, this may result in potential harm incidences, capacity pressures and improvement notices	**Core Resilience Team Red Risk Oversight Committee** (Craig Black)	**Core Resilience Team** (Barry Moss)

Appendix 2

Summary mitigating actions and gaps in assurance

	Residual Risk	Target Risk
1. Failure to maintain and further strengthen effective governance structures, systems and procedures over safety and quality, leading to poor standards of care to all patients and service users, potential harm, service failure, reputation damage, poor patient experience and regulatory action (BAF 1)	Quarterly x Major = Red	Annual x Major = Amber

Description of additional controls required (actions being taken)	Lead
Safe staffing - see separate BAF risk	-
Build assurance dashboard and framework for quality indicators to support development of ward accreditation programme	Sue Wilkinson
Development programme for ward managers and matrons to support ward accreditation	Sue Wilkinson
Align accreditation framework and KPIs with Nursing, midwifery and AHP strategy	Sue Wilkinson
Co-produce nursing, midwifery and AHP strategy to meet current and future system needs (reflecting the updated Trust strategy - pending)	Sue Wilkinson
Develop patient safety and learning strategy	Lucy Winstanley
Quarterly review of the CQC Insight publication with actions to address outlying indicators overseen by Insight Committee	Rebecca Gibson
IQPR refresh project (this will enable reinstatement of the previously listed control "IQPR including key quality indicators (including community) – reported to open board and also reported to Insight Committee. This supports timely identification, escalation and action to address issues of concern".	Sue Wilkinson
Review 2021/22 Quality Priorities and develop 2022/23 quality priorities through the Improvement Committee with Board sign-off as part of the Annual Report/Quality Accounts	Richard Jones
Review to be undertaken of the structure and strategies for quality, safety and experience of care	Sue Wilkinson

Assurances

- Organisational Framework for Governance approved by Board September 2021
- Serious incidents, complaints, claims and inquests report to board (every meeting)
- Maternity reporting to Board and attendance of head of midwifery (every meeting)
- Quality reporting to Board on key performance indicators e.g. infection prevention and control, maternity (every meeting)
- Learning from Deaths report to board
- Monthly breakdown of nurse staffing levels reported to board
- Programme of IPB external reviews
- External review of maternity services (CCG, region and CQC) – supportive (June '21)
- Maternity external support – reported as part of maternity plans to IPB
- Regulatory PSIRF sign-off of WSFT framework
- Internal audit reporting:
    - Responsive internal audit programme linked to IPB assurance requirements (draft programme for 2021/22)
    - Risk Management - Reasonable Assurance (Nov 2020)
    - CQC Improvement Plan – Stage 1 Substantial Assurance (Nov 2020)
    - Data Quality – Paused Activity and Recovery Reasonable Assurance (Jan 2021)
    - Fit and Proper Persons - Partial Assurance (Jan 2021)

	Residual Risk	Target Risk
2. If we do not manage emergency capacity and demand in the context of Covid activity and delivery of the RAAC remediation plan, this will affect our ability to deliver safe, effective and efficient services and care to patients	Weekly x Major = Red	Quarterly x Moderate = Amber

Description of additional controls required (actions being taken)	Lead
Operational and staffing plans to safely deliver winter escalation and surge capacity (see separate BAF risk)	Nicola Cottington
Implementation of: length of stay and discharge programme supported by ECIST to include system out of hospital capacity programme, frailty programme, the application of right to reside	Nicola Cottington
Transformation initiatives: - review of home IV therapy to inform business case (Apr 21) - expansion of the virtual ward concept	Nicola Cottington
Implement final versions of new ED access standard in line with national roll out	Nicola Cottington
Submitted a range of bids for funding to support admission avoidance and improved hospital flow – funding schemes to be implemented	Nicola Cottington

Assurances

- Access and performance reporting arrangements to Board e.g. IQPR, operational report and transformation report (qrtly)
- External monitoring of stranded and super stranded and medically optimised for discharge
- Monitoring of bed utilisation
- Attain report – informs and validates the decant plans to support RAAC remediation
- NHSE/I oversight meeting (quarterly)
- Internal audit reporting:
    - Civil Contingencies Act - Advisory (July 2020)
    - Risk Management - Reasonable Assurance (Nov 2020)
    - Data Quality – Paused Activity and Recovery Reasonable Assurance (Jan 2021)
    - COVID-19 Financial Governance & Key Financial Controls - Reasonable Assurance (Jul 2020)
    - Private and Overseas Patients - Reasonable Assurance (Nov 2020)

	Residual Risk	Target Risk
3. If we do not deliver elective access standards based on clinical priorities in the context of Covid activity, this will our ability to deliver safe, effective and efficient services and care to patients ***(emergency standard is considered separate BAF entry)***	Weekly x Major = Red	Quarterly x Moderate = Amber

Description of additional controls required (actions being taken)	Lead
Theatre 1 recommissioned (delayed due to RAAC remediation and Covid)	Nicola Cottington
Outpatient transformation programme with focus on digital and embedding of Covid learning – delivering benefits to key milestones. Advice and guidance virtual consultation PIFU	Nicola Cottington
Development of longer term contract for additional Orthopaedic capacity with the BMI	Nicola Cottington
Continue to progress opportunities to fund an elective hub at Newmarket	Nicola Cottington
Development of Ophthalmic injection suite	Nicola Cottington
Development of an additional clinical area within the JFDU	Nicola Cottington
Improve operational efficiency in line with the GIRFT HVLC	Nicola Cottington
Develop business case for community diagnostic hub at Newmarket	Nicola Cottington

Assurances

- Board reports and monitoring (every meeting)
- Weekly SNEE activity level review
- Cancer and diagnostics activity progress against trajectory (monthly)
- Internal audit reporting:
    - Data Quality – Paused Activity and Recovery Reasonable Assurance (Jan 2021)
    - COVID-19 Financial Governance & Key Financial Controls - Reasonable Assurance (Jul 2020)
    - Private and Overseas Patients - Reasonable Assurance (Nov 2020)

	Residual Risk	Target Risk
4. If we do not progress our programme of work for digital adoption, transformation and benefits realisation, the digital infrastructure will become obsolete and vulnerable to cyber-attack, resulting in poor data for reporting and decision support, digital systems failure, loss of information and inability to provide optimum patient care, safety and experience	Annual x Major = Amber	Annual x Major = Amber
Description of additional controls required (actions being taken)	Lead	
Preparation 2022/23 digital programme plan with funding envelope to Digital Programme Board review	Craig Black	
Agreed plan for the delivery of HIMSS 6 and 7 (with key external organisational dependencies) with NHSD/NHSX. To include closed loop blood and medication	Sarah Judge	
Deliver programme for population health management in the west of Suffolk, working with local partners and Cerner to develop the solution	Helena Jopling	
Deployment of new Antivirus solution to support further strengthening of Cyber Security defences	Rob Howorth	
Ensure engagement with ICS process to secure HSLI funding for developments in the west of Suffolk	Craig Black	
Review of digital governance structure/framework	Liam McLaughlin	
Key deliverable to support Future System programme: - Support for the Future systems engagement fortnight - Commission first services from an offsite data centre - Engagement with architects and surveyors on development of a digital twin for the new buildings	Craig Black	
Regular updates from Pillar Groups to Digital Board and onto Trust Board: - Pillar Group 1 Acute Developments - Pillar Group 2 (Wider Health Community [SNEE]) - Pillar Group 3 Community Developments - Pillar Group 4 Infrastructure	Craig Black	
Assurances		
• Digital Programme Board reporting to Board, including NED membership (quarterly) • Cyber Essential Plus audit report • Cyber security penetration test report • Data Security and Protection Toolkit assessment		

	Residual Risk	Target Risk
5. External financial constraints may impact on Trust's sustainability through tariff, contract and pattern of service provision in the west Suffolk system resulting in inequitable allocation of resources to meet the care and service need of the local community	Quarterly x Major = Red	Quarterly x Major = Red

Description of additional controls required (actions being taken)	Lead
Delivery of year end position (Board reporting) with escalation as required	Nick Macdonald
Agree financial position with (including anticipated funding for 22-23) with the system and regional team	Nick Macdonald
Agree budget position internally	Nick Macdonald
Finalise CIPs to deliver financial plan for 2022/23 (dependent on response to system/ regulatory framework)	Nick Macdonald
Review divisional business plans (underpinned by sustainable clinical models) to reflect the requirements to deliver additional backlog activity)	Nicola Cottington
Develop a system-wide information strategy with underpinning tools to improve performance monitoring	Nick Macdonald
Respond to national guidance for operational planning cycle for 2022/23	Richard Jones

Assurances

Internal – level 2

- Monthly reporting to Board through finance and performance reports (monthly)
- Operational plan approved by Board
- Controls and assurance for internal efficiency set out in CIPs

External - level 3

- Control total agreed with NHSE/I
- Delivery of year end position
- Alliance partnership working for services in west Suffolk – Alliance strategy

	Residual Risk	Target Risk
6. If we do not value our workforce and look after their wellbeing and development, particularly in the context of the Covid-19 pandemic, this may affect patient safety and quality of care due to lower levels of staff engagement and morale and staff choosing to leave WSFT	Quarterly x Major = Red	Annual x Major = Amber

Description of additional controls required (actions being taken)	Lead
Development of next iteration of People Plan in support of the new WSFT strategy and reflecting national priorities	Jeremy Over
Evaluation of additional staff support measures during pandemic and agreement of next steps	Jeremy Over
Implementation of lessons learned from external review of whistleblowing matters	Jeremy Over
Establish Mandatory staff vaccination implementation group and deliver action plan	Jeremy Over

Assurances

- Safer staffing - trust-wide establishment review approved by Board (Jan '21)
- Approved WSFT people plan, with monthly reporting to Board
- Vacancy levels – reported monthly
- National staff survey – reported to board
- Friends and family and staff recommender scores

	Residual Risk	Target Risk
7. If we do not implement the estates strategy to provide an adequately maintained building environment suitable for patient care caused by the deteriorating state of Trust buildings, lack of access to capital to fund the remediation programme, this may result in potential harm incidences, capacity pressures and improvement notices *[Linked to structural risk assessment (ref. 24) rated as Red]*	Quarterly x Major = Red	Annual x Major = Amber

Description of additional controls required (actions being taken)	Lead
Implementation of controls associated with red risk re RAAC planks (Datix 24) potential failure of the main building structure and front residencies structure (Oak, Cedar, Birch, Larch, Pine, Willow): - Emergency planning - Assessment and repair - Remediation (failsafe installation) - Communication - Research and development - Site and system risk (including continued occupation of WSH site)	Craig Black
Deliver approved capital programme for 2021/22, including key capacity developments	Craig Black
Confirmation of capital loan funding for 2021-22-, trust has sought approval for an up lift in the budget and is awaiting confirmation	Craig Black
Sudbury asset disposal as part of agreed plan	Craig Black
Secure capacity as part of one public estate (OPE) development at six hubs across West Suffolk	Craig Black
Communication strategy for structural risk based on agreed remediation plan with clinical model to support capacity requirements (linked to Attain work)	Craig Black

Assurances

- Reporting to Board (monthly)
- Monthly risk review meeting – monitors progress and escalates issues/concerns
- Legal opinions on activity undertaken (latest Jan 2021)
- Regional office Charles Hanford (pending) - Charles undertakes a quarterly review of performance in completing the surveys etc. to report to the national oversight group
- Engagement in 'best buy' hospital forums ongoing (ongoing)
- EPRR feedback from exercise Hodges (Oct 20)
- Internal audit reporting:
    - Civil Contingencies Act - Advisory (July 2020)
    - Risk Management - Reasonable Assurance (Nov 2020)

Annex A: Scheduled draft agenda items for next meeting – 30 September 2022

Description	Open		Closed	Type	Source	Director
Declaration of interests	✓		✓	Verbal	Matrix	All
General Business						
Patient/staff story	✓		✓	Verbal	Matrix	Exec.
Chief Executive's report	✓			Written	Matrix	CB
Culture						
Organisational development plan, including freedom to speak up guardian	✓			Written	Matrix	JMO
Report of the West Suffolk Review – Governor/Director working group	✓			Written	Matrix	RD
Strategy						
Asset-based approach to change	✓			Written	Matrix	CB
Future System Board Report	✓			Written	Matrix	CB
Nurse staffing strategy review	✓			Written	Matrix	SW
Strategic update, including Trust strategy next steps, Alliance, System Executive Group, Integrated Care System, Integration report	✓			Written	Matrix	CB
Digital programme board report (qrtly)	✓			Written	Matrix	NM
Annual report and accounts 2021-22	✓			Written	Matrix	CB/NM
Assurance						
Annual report and accounts			✓	Written	Matrix	CB/NmacD/RJ
Report from 3i Committees: Insight, Improvement & Involvement	✓			Written	Matrix	RD / AR / JC
Insight Committee Report - Finance and workforce report - Operational report - IQPR	✓			Written	Matrix	NM/NC/RD
Involvement Committee Report - People and OD Highlight Report o Putting you First award o Staff recommender scores o Appraisal - National patient survey report and response - Equality annual report - Education report - including undergraduate training (6-monthly)	✓			Written	Matrix	JMO/AR
Improvement Committee Report - Maternity services quality and performance report (inc. Ockenden) - Nurse staffing report - Quality and learning report	✓			Written	Matrix	SW / PM

Description	Open		Closed	Type	Source	Director
- Annual reports via Improvement – R&S, infection prevention and safeguarding children						
Integrated quality & performance report (IQPR) – annex to Board pack	✓			Written	Matrix	NM/NC/SW/PM
Serious Incident, inquests, complaints and claims report			✓	Written	Matrix	SW
Annual report and accounts (draft)			✓	Written	Matrix	NM/RJ
Governance						
Governance report, including - Use of Trust's seal - Senior Leadership Team report - FT membership strategy - General condition 6 and Continuity of Services condition 7 certificate - Audit Committee report - Remuneration committee report - Board assurance framework and risk report - Agenda items for next meeting	✓			Written	Matrix	RJ
Confidential staffing matters			✓	Written	Matrix – by exception	JMO
Reflections on the meetings (open and closed meetings)	✓		✓	Verbal	Matrix	JC

6. OTHER ITEMS

6.1. Any other business

To Note

6.2. Reflections on meeting

For Discussion

6.3. Date of next meeting - 30 September 2022

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

7. Annexes for information:

To inform

4.3 - IQPR

Integrated Quality and Performance Report Report

Agenda Item:				
Presented By:	Nicola Cottington & Sue Wilkinson			
Prepared By:	Information Team			
Date Prepared:	May-22			
Subject:	Integrated Quality and Performance Report			
Purpose:	X	**For Information**		**For Approval**

Executive Summary:

The Board is asked to note the following exceptions in relation to performance:

- Significant decline in 12 hour time of arrival performance in the emergency department continues due to capacity issues. Actions include implementing Virtual Ward, Criteria to Admit and increasing Same Day Emergency Care (SDEC).

-Significant increase in Covid inpatients since January 2022 with high nosocomial transmission within the wards. Lateral flow testing is being used to effectively manage outbreaks.

- Two week wait performamce for cancer referrals continues to be below target, however there has been a significant improvement in breast symptomatic performance.

-The number of patients waiting over 104 weeks for a planned procedure is in line with trajectory and the number of patients over 78 weeks continues to demonstrate signifiacnt reduction. This is due to increased capacity including mutual aid and a focus on theatre productivity.

-Significant deterioration in diagnostic access performance continues due to high demand, staffing constraints and downtime affecting ageing machines. Plans are being enacted to CT replace scanners and recovery trajectories are being updated.

-IPC- following two montsh of cause for concern rate returning to expected levels. Decline in Sepsis screening for Neutropenic patienst although small sample size (n=5)

-Harm free care: continued imprvement in acute HAPU, increase in falls on last month although inkeeping with trust aveerage

-VTE complaince following interventions last month and data cleansing within DSU and AAU.

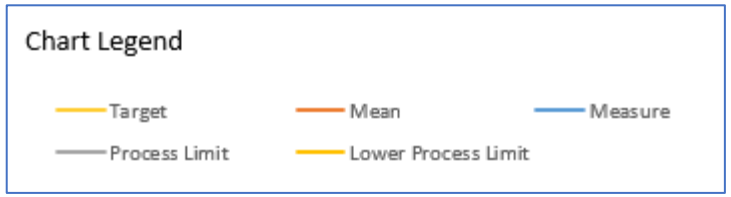
[Please indicate Trust priorities relevant to the subject of the report]	**Delivery for Today**	**Invest in Quality, Staff and Clinical Leadership**	**Build a Joined-up Future**
	X		

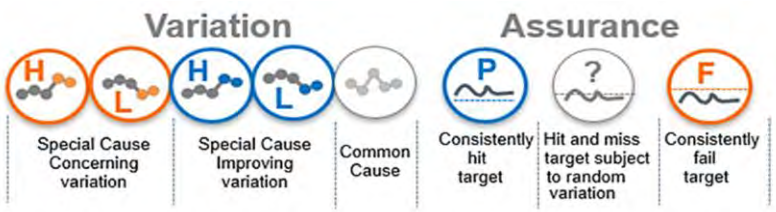
Trust Ambitions [Please indicate ambitions relevant to the subject of the report]	Deliver personal care	Deliver safe care	Deliver joined-up care	Support a healthy start	Support a healthy life	Support ageing well	Support all our staff
		X	X				X

Previously Considered by:	
Risk and Assurance:	
Legislation, Regulatory, Equality, Diversity and Dignity Implications	

Recommendation:

That Board note the report.

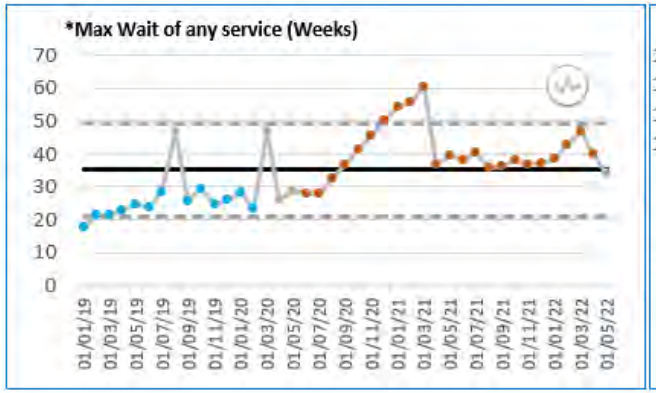


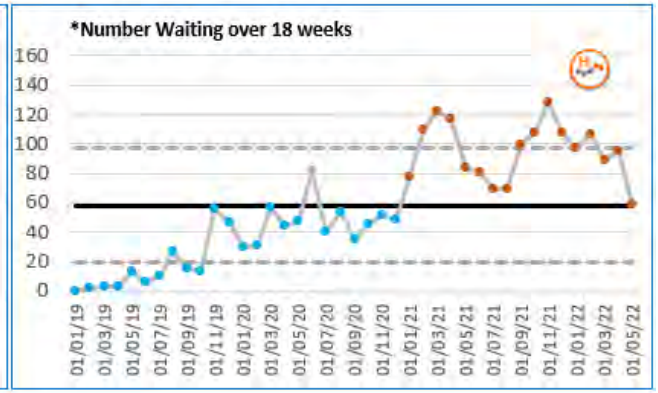


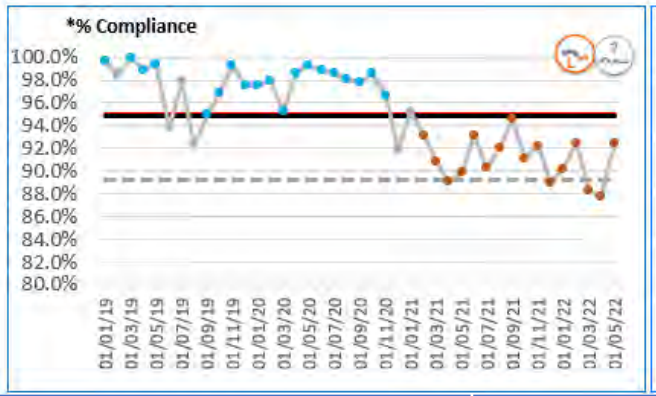
KPI	Latest month	Performance	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
*Max Wait of any service (Weeks)	May 22	34	-			35	21	49
*Number Waiting over 18 weeks	May 22	59	-	H		58	19	97
*% Compliance	May 22	92.4%	95.0%	L	?	94.9%	89.2%	100.6%
Urgent 2 hour response	May 22	72.3%	70.0%					

*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.

Community Access







Summary

Wheelchairs:
Wheelchair service 18 weeks compliancy is 86% with longest wait of 40 weeks. Target is 95% compliance. Improvement on previous month
Complexity of patients that have experienced long waits post COVID
Continual supply chain issues (combination of Brexit and COVID) of critical wheelchair parts with waits of up to 24 weeks.
Additional work to achieve personal wheelchair budget (PWB) having a detrimental impact on 18 week target.
Shortage of team support worker and admin to support PWB
UCR:
Reducing compliance but within 70% threshold
Increased sickness mainly in the nursing team resulting in capacity issues. With capacity issues there was also less accurate triage and human error to 'stop clock'.

Action

Wheelchairs:
Shorter assessment appointments.
Waiting list reports/pathways of care are being checked against pause reasons
Overtime and Bank work being utilised

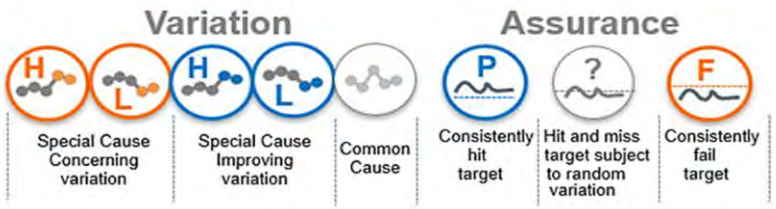
Weekly order report of overdue items and options for substitutes.

Refurbished equipment is being maximised to help manage supply chain issues.
Division to fund 1 x WTE Team Support Worker in interim whilst longer term investment from Trust is sought from a business case for x 2 team support workers
UCR:
Further training on triage and data input.
Alliance funding to extend shift cover at weekends will help improve numbers of 2 hours referrals

Assurance

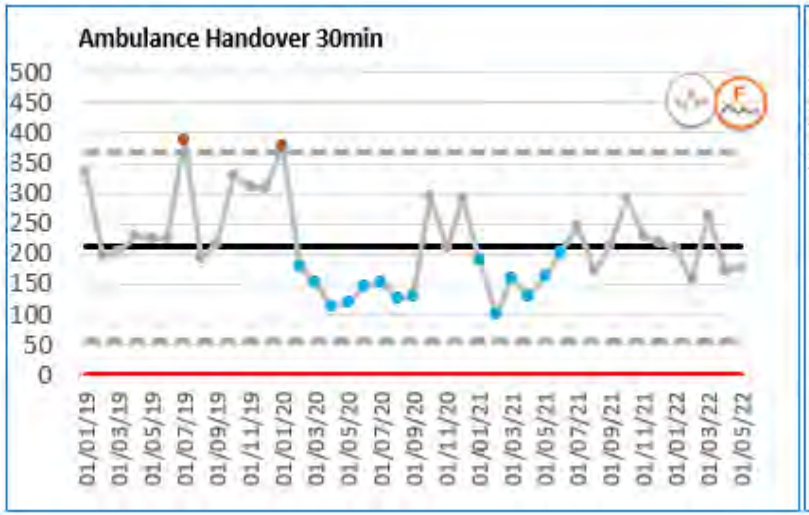
Wheelchairs:
Paper presented at PAGG on 24th June
Monitoring stats on a weekly basis
Reviewing PTL from 9 weeks +
Escalation to business unit meeting and divisional board to PAGG

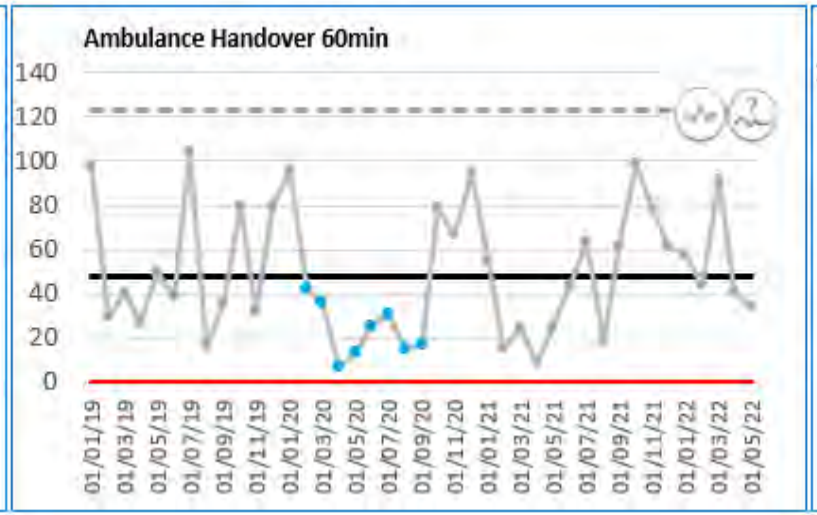
UCR:
Through constant data monitoring with exceptions escalated via business unit meeting to divisional board.

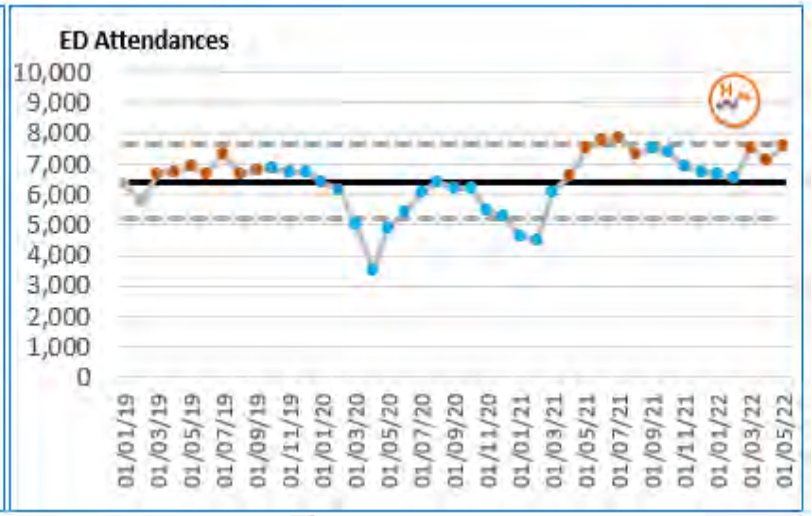


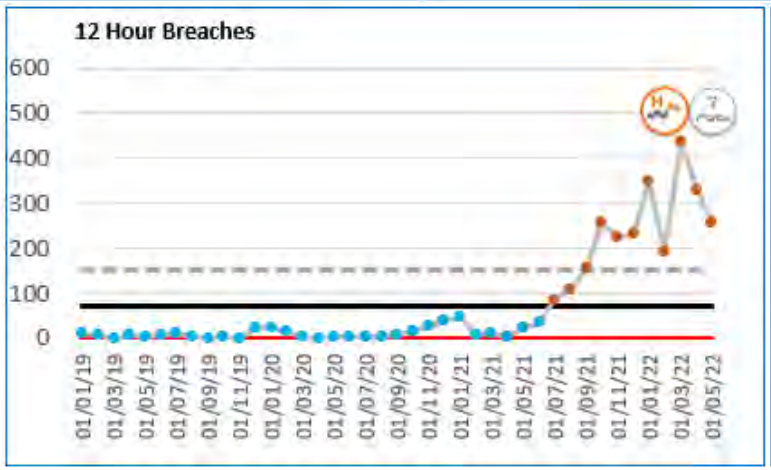
KPI	Latest month	Performance	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Ambulance Handover 30min	May 22	175	0			213	57	369
Ambulance Handover 60min	May 22	34	0			48	-27	123
ED Attendances	May 22	7615	-			6432	5208	7656
12 Hour Breaches	May 22	255	0			73	-7	152
Criteria to reside (numbers without reason to reside) Acute	May 22	47	-					
Criteria to reside (numbers without reason to reside) Community	May 22	14	-					

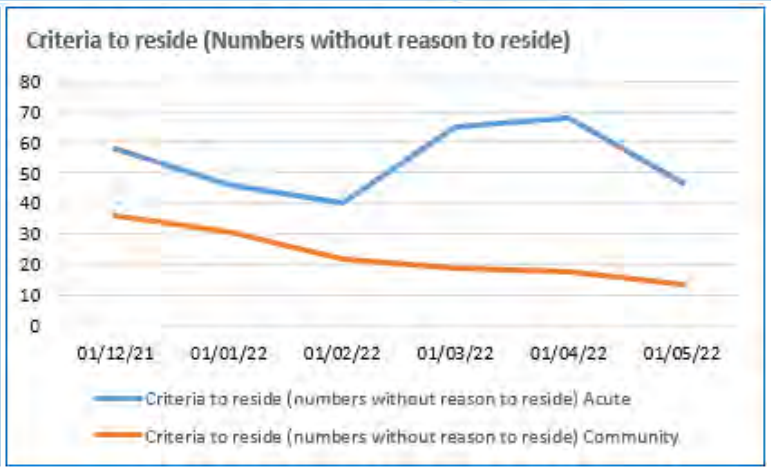
Urgent & Emergency Care





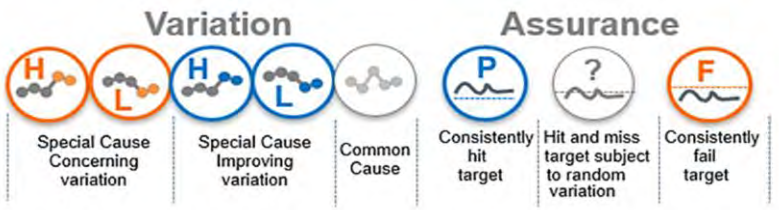






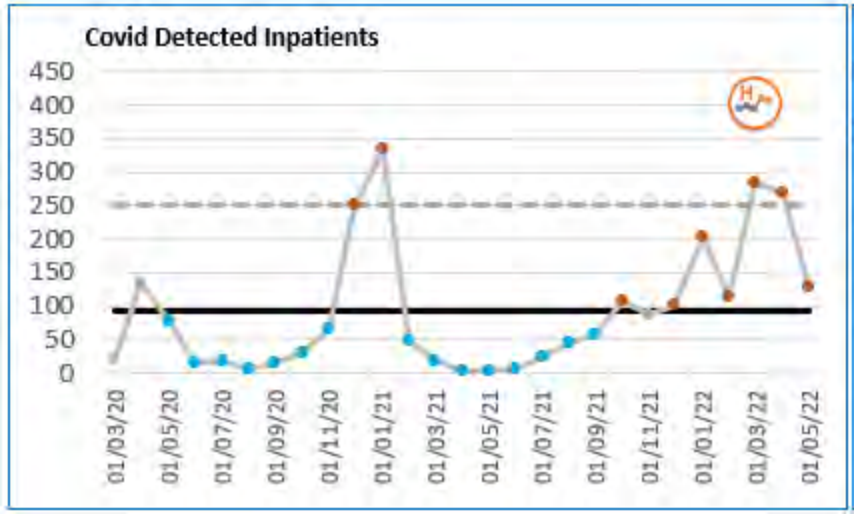
Summary	Action	Assurance
Reason to Reside - May figures show improvement from April despite the continued challenges with care capacity in the home care market. Block commissioned and additional spot purchase beds continue to be utilised to expedite discharge and provide step up admission avoidance from the community. Significant variation continues to be seen within ED's 12 hour LOS. Factors including lack of capacity due to RAAC work and numbers of patients with no reason to reside remain key components in ability to achieve this metric.	Reason to Reside - Capacity in reablement care services continue to be closely monitored in order to enhance pathway one discharges and admission avoidance. Development of a formal Delirium pathway continues with input from Alliance system partners. The Transfer of Care Hub (ToCH) review concludes at the end of June with a formal report and recommendations to follow. Actions to reduce 12 hr LOS with focus on SDEC and workstreams within UEC including virtual ward, criteria to admit and development of hot clinics. Risk remains to achievement of this metric due to the capacity lost for the RAAC programme.	UEC metrics monitored via patient access insight group and through WSFT UEC steering group. System and Alliance focus on building capacity to enhance transfer of care arrangements through the Alliance Operational Delivery Group and the SNEE Urgent and Emergency Care group.

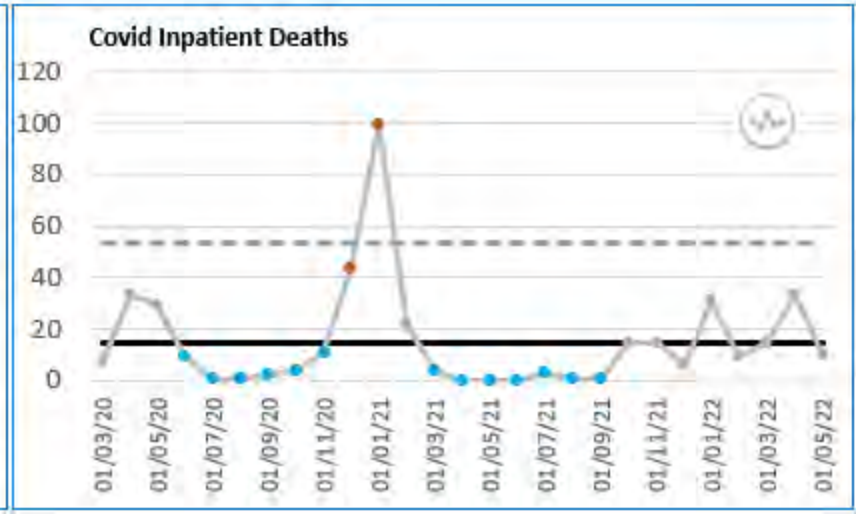
Covid Summary



KPI	Latest month	Performance	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Covid Detected Inpatients	May 22	130	-	H		92	-68	251
Covid Inpatient Deaths	May 22	10	-			15	-23	53

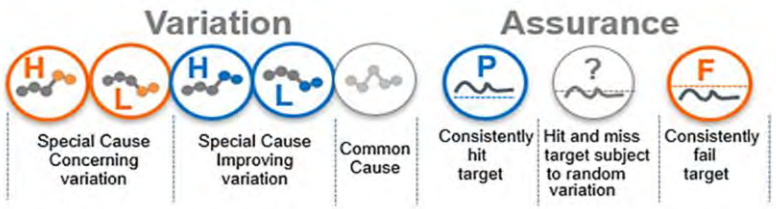
Covid





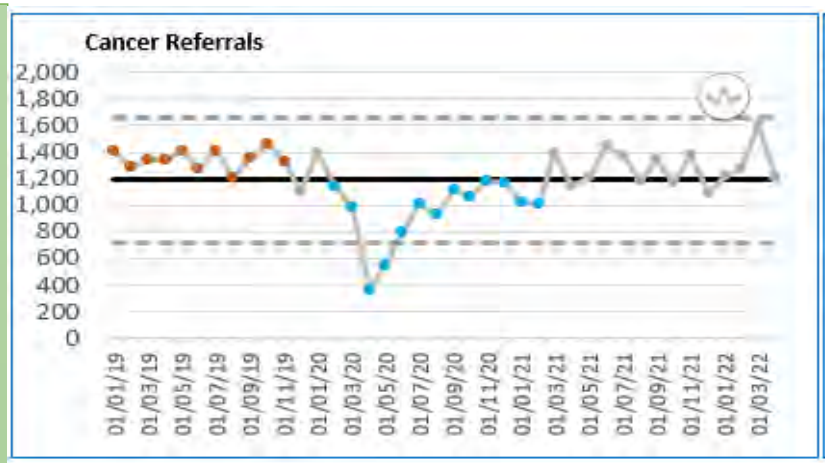
Summary	Action	Assurance
Following increasing trend seen from January 2022. Covid inpatient numbers have reduced on month. this is driven by both reducing community prevalence and also a reduction in swabbing regime implemented in May 2022 We have seen high incidents in nosocomial transmission within our wards. This is driven by our estate, poor ventilation and proximity of patients within the ward	Internal IMTs continue with well established interventions to reduce onward transmission. However consistent assurance has reduced external attendance Using LFTs to maintain vigilance in outbreak has resolved ward/bay closures for efficiently reducing the impact on flow capacity Covid capacity reduced to single ward G10	Oversight of outbreaks and potential nosocomial transmission continues by IPC team Oversight and responses to changes in guidance, identified and managed through weekly CRT

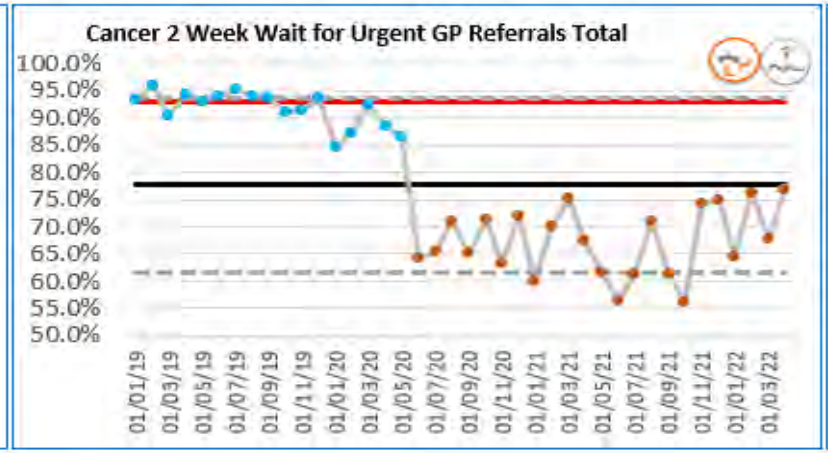
Cancer Access Summary (Month Behind)

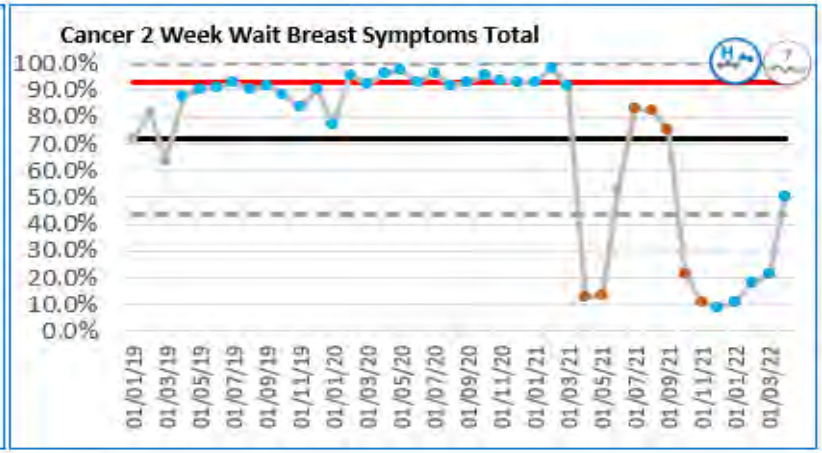


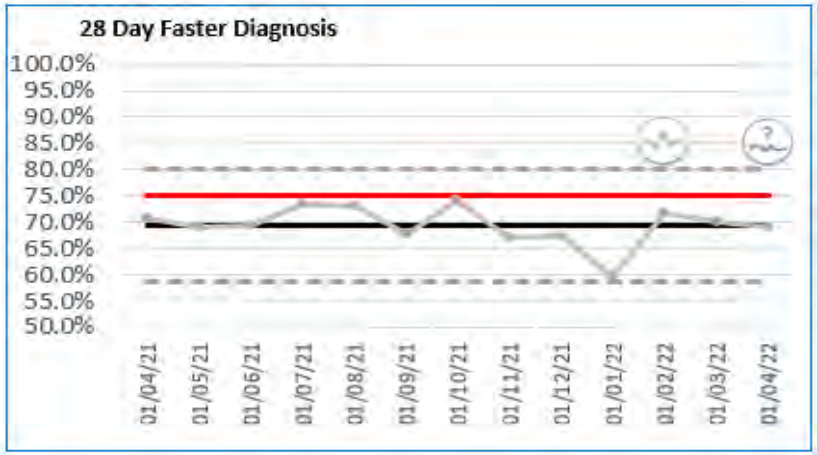
KPI	Latest month	Performance	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Cancer Referrals	Apr 22	1203	-			1191	724	1659
Cancer 2 Week Wait for Urgent GP Referrals Total	Apr 22	76.8%	93.0%	L	?	77.6%	61.5%	93.8%
Cancer 2 Week Wait Breast Symptoms Total	Apr 22	50.0%	93.0%	H	?	72.1%	43.9%	100.2%
28 Day Faster Diagnosis	Apr 22	69.0%	75.0%		?	69.4%	58.8%	80.0%
Cancer 62 Day GP Referrals Total	Apr 22	79.3%	85.0%		?	75.9%	56.6%	95.2%
Cancer 62 Day Screening	Apr 22	84.2%	90.0%		?	89.6%	64.2%	115.0%
Incomplete 104 Day Waits	Apr 22	30	0		F	23	5	40

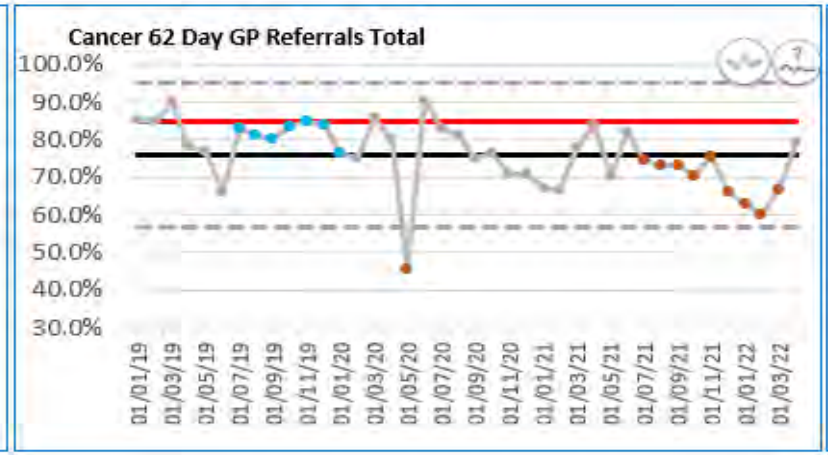
Cancer Access (Month Behind)

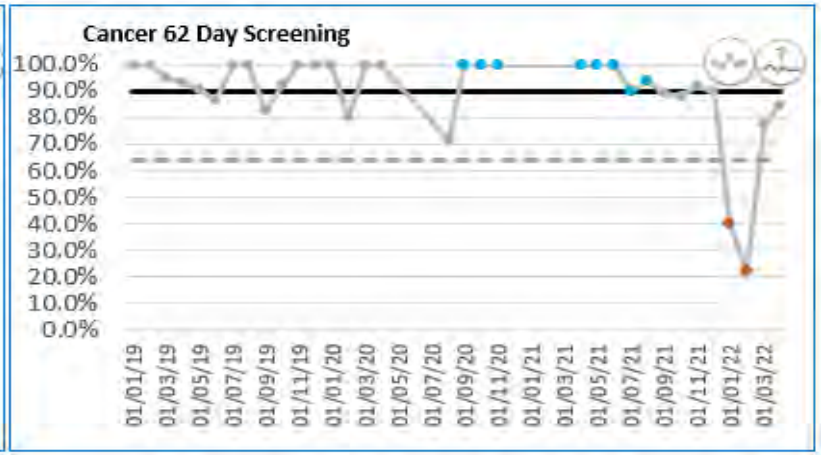


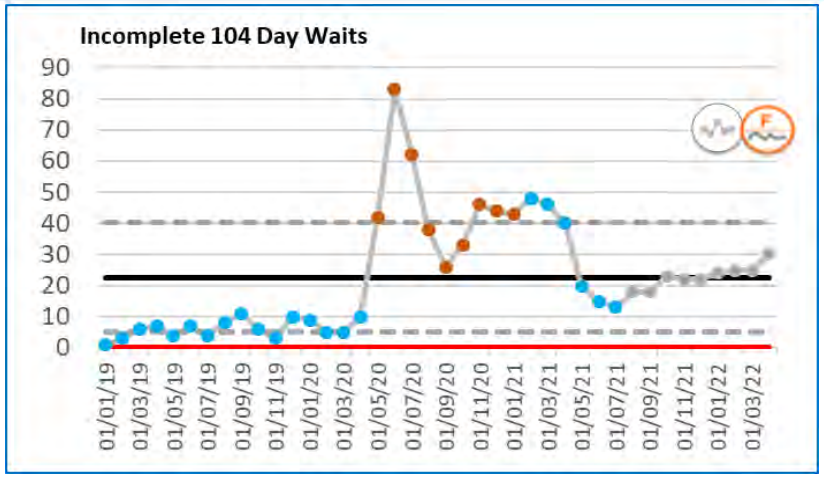






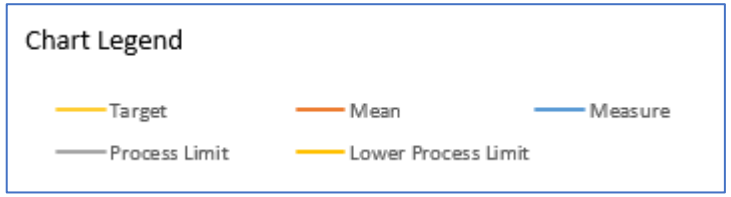


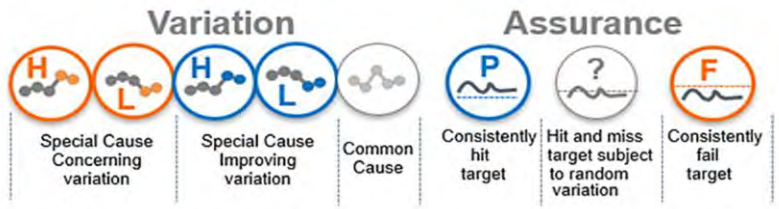




Cancer Access (Month Behind)

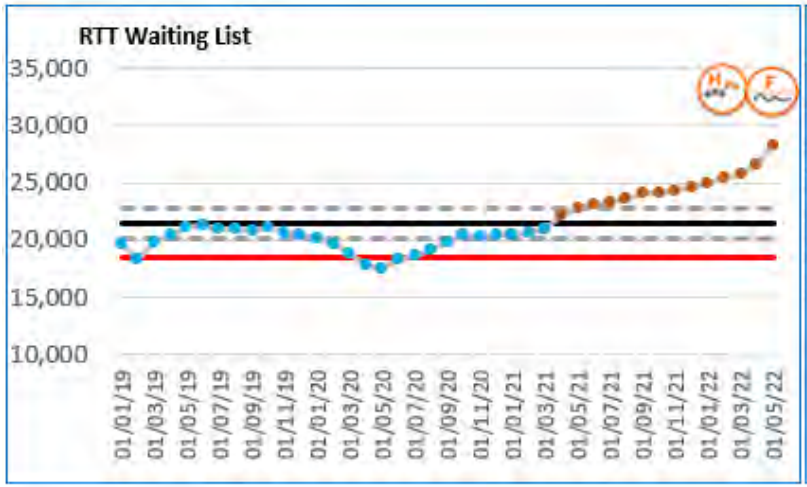
Summary	Action	Assurance
Cancer referral numbers demonstrated no significant reduction, following a large increase in March, which impacts on the 2 week wait performance. Breast referral numbers however did decrease which has supported the significant improvement in the Breast symptomatic performance. 28 day performance is not showing significant improvement, and is now behind trajectory, the increase in referrals in March would have had an impact on this performance for April. This performance will be impacted in later months due to backlog of CT virtual colonoscopy. 62 day performance continued to improve in line with the recovery trajectory, however this is likely to be impacted in future months due to the CT virtual colonoscopy backlog. 62 day screening performance shows no significant improvement and is below target. It is important to note that the numbers are small and equates to just 9 patients with 1 treated over 62 days.	A full recovery action plan is in place, this includes additional activity and transforming pathways, this is currently being refreshed in line with the CTC constraints. The cancer team will be working with the wider ICS to manage the implementation of the new Faster Diagnosis Framework for SNEE Non Specific Symptoms (NSS), Best practice treatment pathways for 2022/23 and development of the SNEE wide 5 and 10 year cancer strategy.	Recovery is monitored through local Cancer PTL meeting as well as SNEE wide Cancer Board and Cancer alliance level forums. Performance against trajectory is monitored via insight committee.

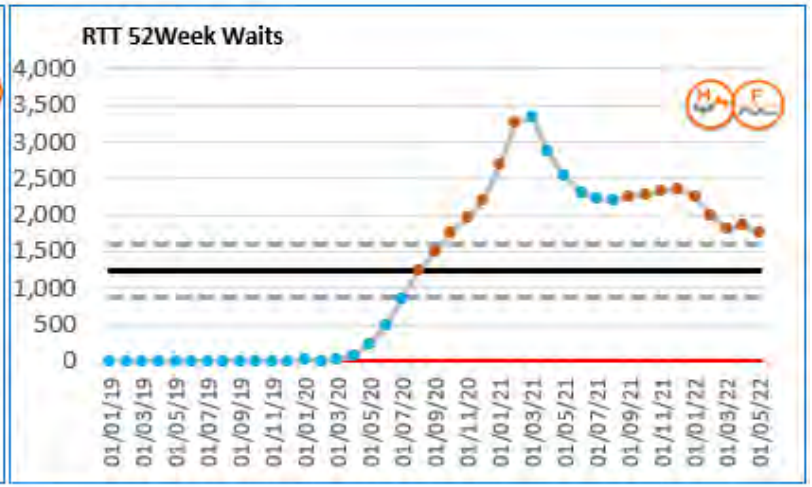


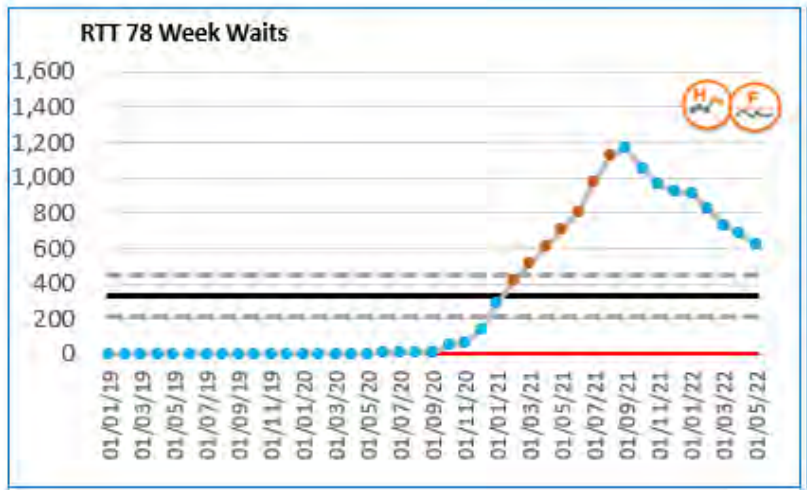


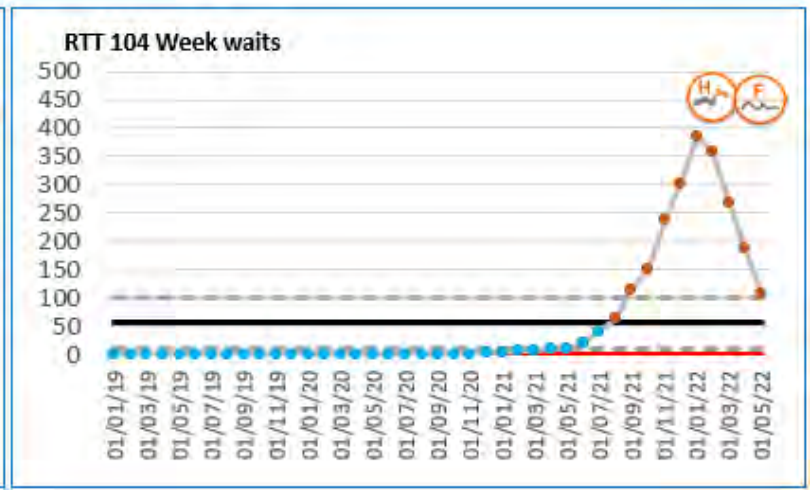
KPI	Latest month	Performance	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
RTT Waiting List	May 22	28175	18500			21484	20195	22773
RTT 52Week Waits	May 22	1758	0			1235	881	1589
RTT 78 Week Waits	May 22	617	0			331	217	445
RTT 104 Week waits	May 22	107	0			55	11	100
2 week wait rapid chest pain	May 22	97.9%	95.0%			99.4%	97.0%	101.9%
Diagnostic Performance- % within 6weeks Total	May 22	59.9%	99.0%			71.1%	57.6%	84.7%
Elective Operations (Excluding Private Patients & Community)	May 22	908	-			759	434	1085
Cancelled Operations	May 22	29	0			19	-5	42

Elective Access

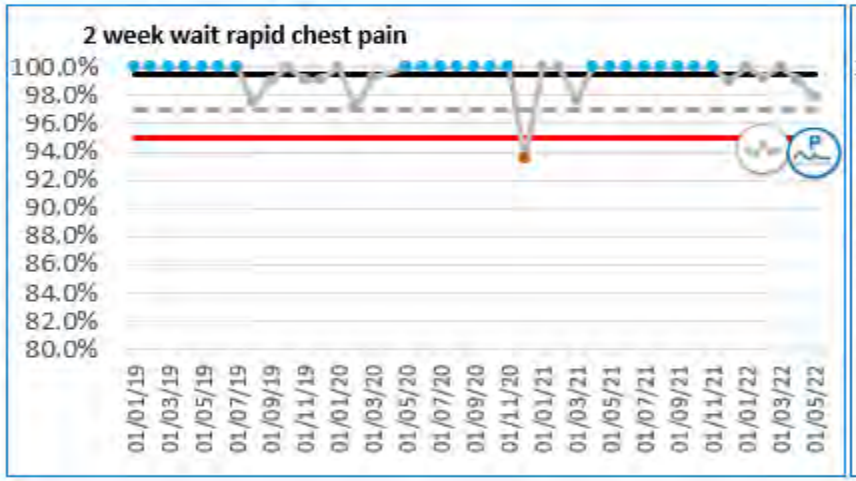








Summary	Action	Assurance
The total waiting list size continues to fail the standard, causing significant cause for concern. The number of patients over 104 week waits continues to fail to meet the target of zero, however is in line with the predicted trajectory. The number of patients waiting over 78 weeks similarly fails to meet the target of 0 but continues to demonstrate significant reduction and is below trajectory.	The focus remains on the longest waiting patients and the trajectory to reduce the 104 week wait to 0 by the end of June and beginning the focus on the 78 week wait reduction. Actions to achieve this, include; extended theatre lists, weekend working, theatre productivity, use of the independent sector and mutual aid as well as an focus on activity targets.	Progress against trajectory and action plans are monitored at the weekly access meeting, which feeds into the insight committee at WSFT. This position is also reporting across the ICS within the SNEE recovery and restoration board.


2 week wait rapid chest pain
100.0%
98.0%
96.0%
94.0%
92.0%
90.0%
88.0%
86.0%
84.0%
82.0%
80.0%
01/01/19
01/03/19
01/05/19
01/07/19
01/09/19
01/11/19
01/01/20
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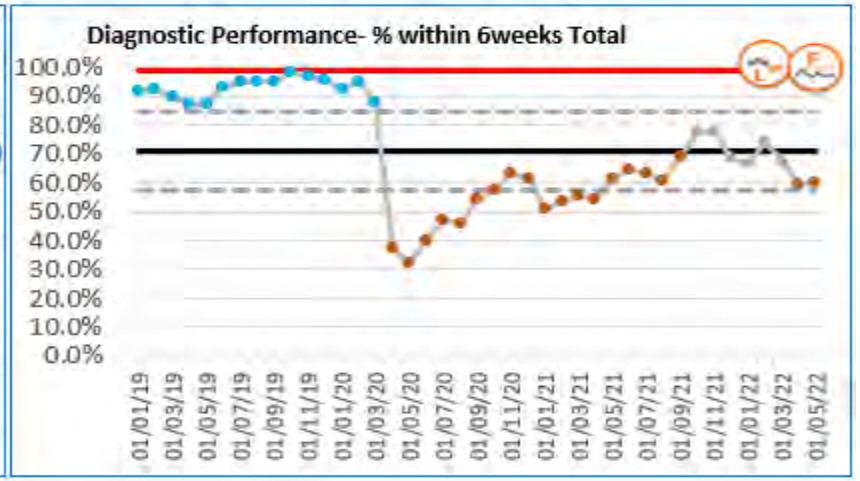
Diagnostic Performance- % within 6weeks Total
100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
01/01/19
01/03/19
01/05/19
01/07/19
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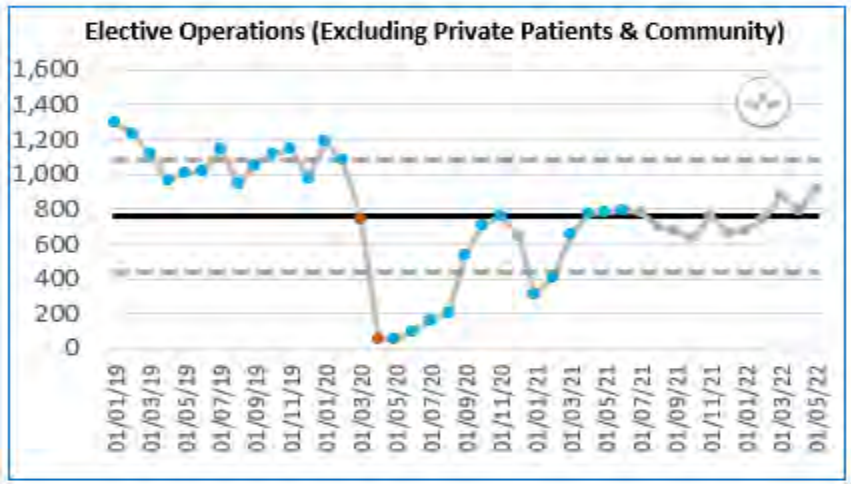
Elective Operations (Excluding Private Patients & Community)
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1,200
1,000
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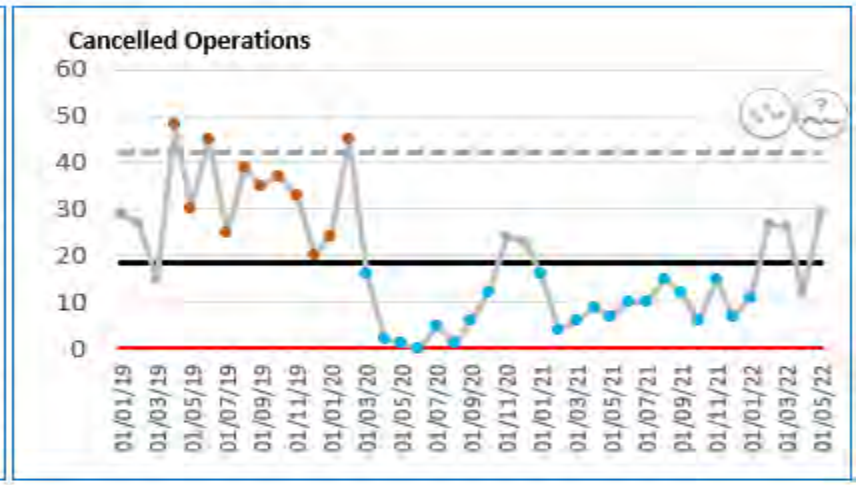
01/05/22


Cancelled Operations
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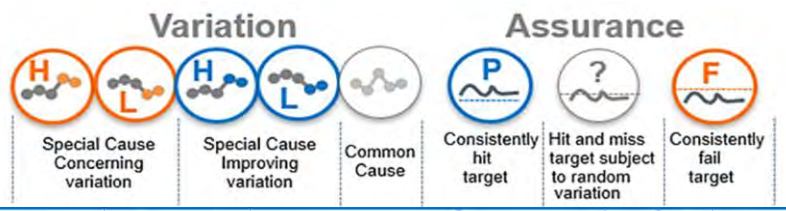
01/03/22
01/05/22

Diagnostic Access

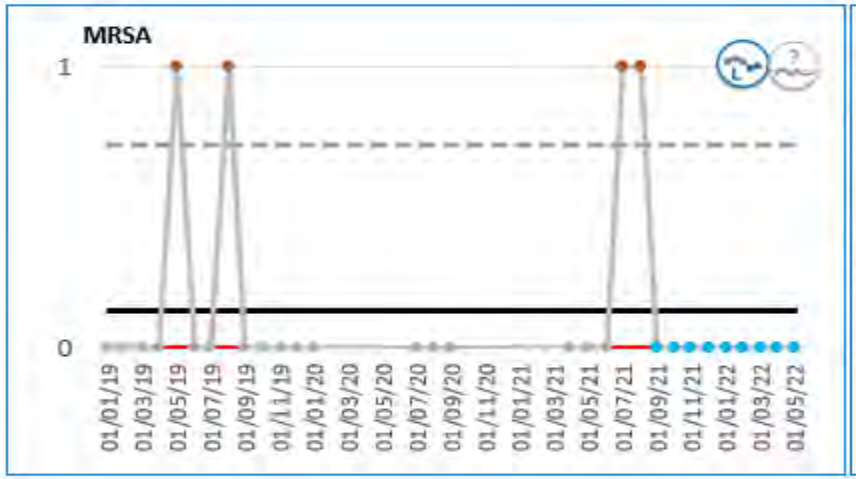
Summary	Action	Assurance
The SPC chart indicates special cause concerning variation for diagnostic performance with consistent failure to meet the 6 week target. CT activity has been adversely impacted by significant down time again in May. The supplier has been actively engaged in resolving the problem but this has resulted in a consequential impact on cancer diagnostic pathways. Recovery of the CTC position is anticipated by the end of October 2022 but this is contingent on no further CT downtime. MRI activity continues to be been impacted by a high demand for inpatient imaging owing to patient acuity and admissions with progressive disease leading to the cancellation of outpatient activity. In ultrasound, ongoing vacancies constrain capacity despite active recruitment and the use of agency staff where available. Two sonographers are due to start in August 2022 and following training and induction should have a material impact on US performance. Endoscopy performance has been constrained by staff vacancies meaning some weekend sessions cannot be utilised	• A third CT scanner has been approved and is on order. This will assist in supporting recovery and provide resilience to unplanned scanner downtime. Increased staffing levels from July will allow greater utilisation of CT3 including additional weekend lists • A replacement for CT2 has been agreed and a procurement plan is being established. Potential suppliers have been engaged and an order is due to be placed. • Options for mobile MRI capacity continue to be explored but performance will continue to be challenged without additional resource. A business case is being prepared around the options for a third MRI scanner but capital funding constraints may make this unachievable within the 2022/23 financial year. More flexible options are being explored as part of this case but scanner availability is known to be extremely limited. • The business case for the Community Diagnostic Centre at Newmarket Community Hospital, with the aim of increased MRI and CT capacity as the particular focus, is progressing with the deadline of presentation for internal and ICS approval of mid-July. • A staff consultation (non-medical) is planned to progress 7 day working across radiology, much of which is sustained on voluntary basis at present. The staffing business case has been approved by the division and will now progress to investment panel. • A recovery trajectory for endoscopy has been formulated to meet the national target. Work is now under way to understand the options to make this performance sustainable and to what extent insourcing capacity will need to feature in this plan. Network funding has been applied for to support the provision of additional scopes and a recent open day has resulted in the recruitment to all current vacancies.	Ongoing performance will be monitored at the weekly CSS access meeting and the Elective Access Insight Meeting.

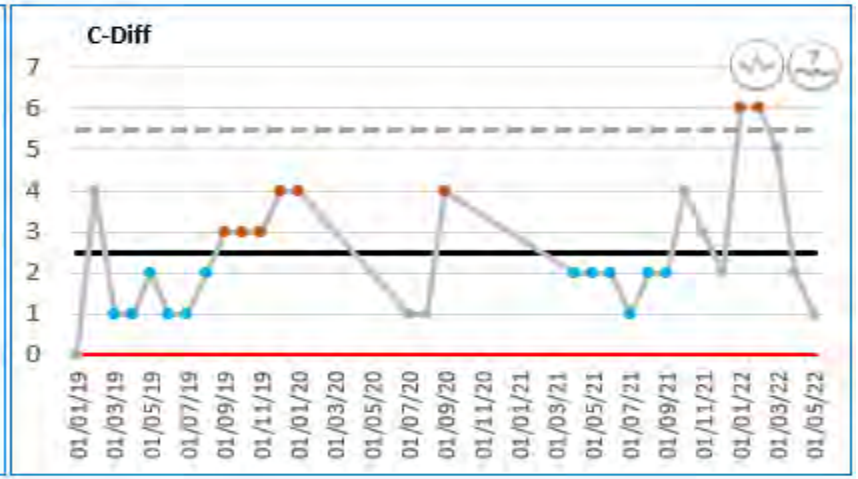
Safe- Summary

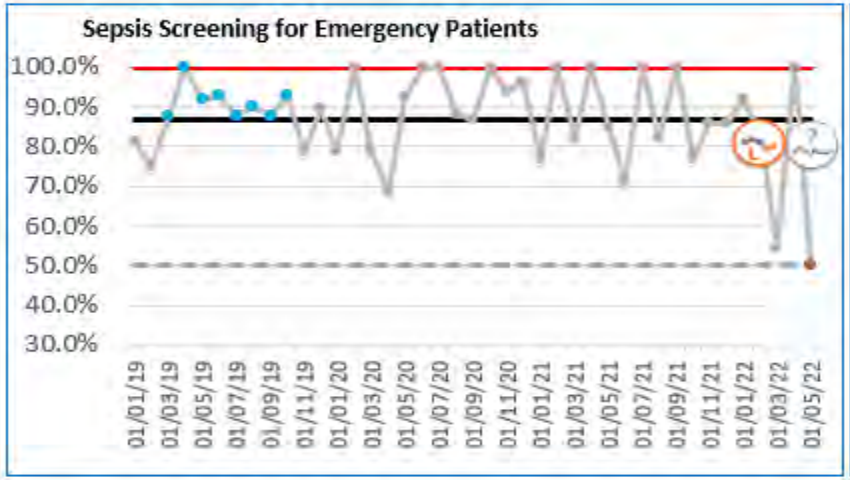


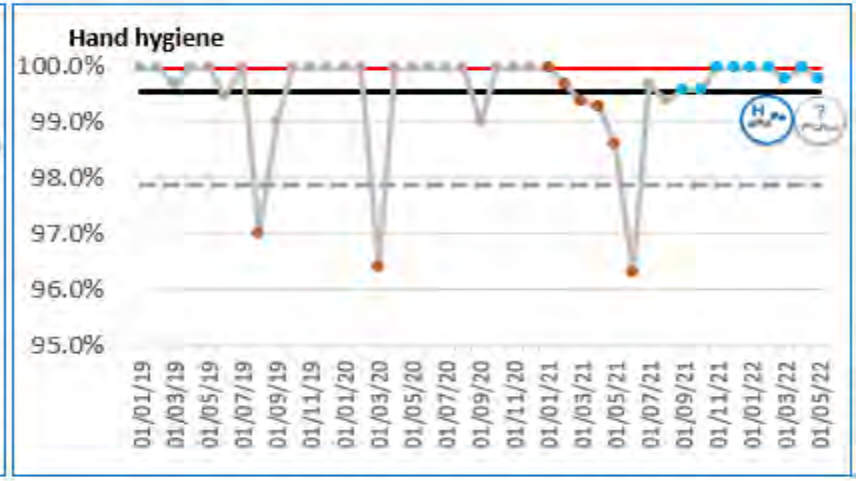
KPI	Latest month	Performance	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
MRSA	May 22	0	0	L	?	0	0	1
C-Diff	May 22	1	0		?	3	0	5
Hand hygiene	May 22	99.8%	100.0%	H	?	99.6%	97.9%	101.2%
Sepsis Screening for Emergency Patients	May 22	50.0%	100.0%		?	86.2%	48.1%	124.3%
VTE - all inpatients	May 22	97.4%	95.0%		?	95.8%	93.6%	98.0%
Mixed Sex Breaches	May 22	3	0		?	4	-7	14
Community Pressure Ulcers	May 22	32	5		F	31	13	48
Acute Pressure Ulcers	May 22	17	5		F	22	5	38
Acute Pressure Ulcers per 1000 Beds	May 22	1.4	5.6		P	2.1	0.6	3.5
Inpatient Falls Total	May 22	68	48		?	62	29	95
Acute Falls per 1000 Beds	May 22	5.4	5.6		?	5.4	3.0	7.8
Nutrition - 24 hours	May 22	90.6%	95.0%		?	90.5%	85.7%	95.3%
Patient Safety Incidents per 1,000 OBDs	May 22	67.0	-			65.4	52.1	78.8
Patient Safety Incidents Reported	May 22	848	-	H		737	584	890
Patient Safety Incidents Resulting in Harm	May 22	176	-	H		148	111	186
Verbal Duty of Candour	May 22	11	0	H	?	5	-1	10
Written Duty of Candour	May 22	4	3		?	5	-1	11
Within 10 Days Duty of Candour	May 22	40.0%	-			57.4%	15.0%	99.8%
New Complaints	May 22	17	-			16	2	31
Closed Complaints	May 22	15	-			14	-2	31
Overdue Responses	May 22	1	0	L	?	8	-6	21

Safe









Summary	Action	Assurance
Sepsis This data shows patients at risk of neutropenic sepsis under the oncology/haematology team. The statistics for May show a total of 5 patients that required a door to needle time of under 1 hour. 3 of these were in ED, 2 were AOS. 2 patients had a door to needle time of over 1 hour, but by 12 minutes and 15 minutes. Consistent performance with MRSA Bacteraemia. C.Diff rates, although not a consistent trend, levels are improving.	Monthly meetings had between ED Education Nurse and Sepsis Nurse to discuss sepsis compliance. Review of PIR paperwork continues, IPC & Microbiology team have met with CCG colleagues to carry out initial review. Sluice audit commenced as part of C.diff action plan. External visit organised from Deputy DIPC from North West Anglia with actions identified. Review of cleaning wipes/products with HoN's, purchasing dept and CCG and re-launch once products finalised.	Data will continue to be monitored and reports into the deteriorating patient group for oversight SEP. Monitored through audit and reporting into the IPC committee.

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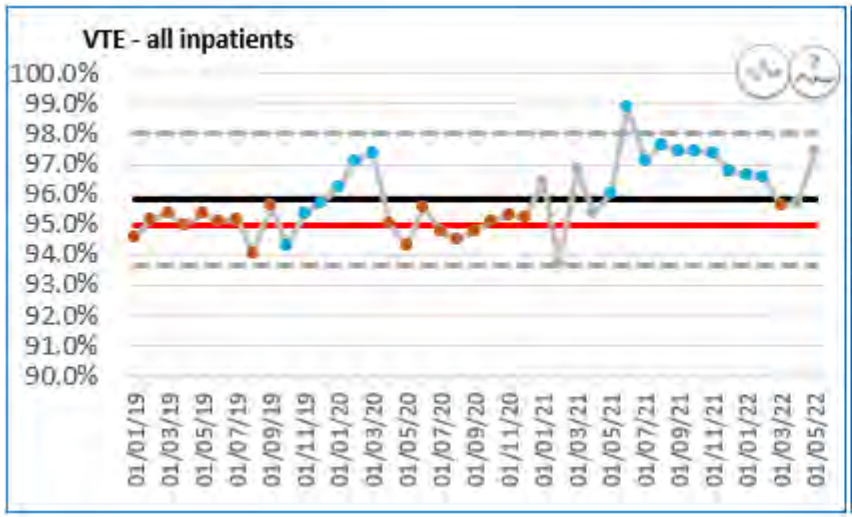

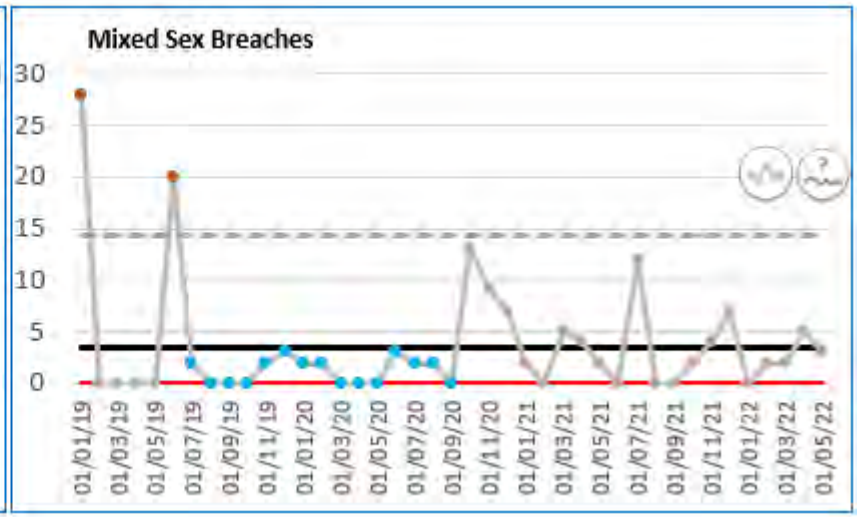

Summary	Action	Assurance
VTE performance is improved this month to 97.43%. This is largely due to improvement on those wards which were poorly performing last month that is G9, F 14. Data corrections were applied this month to these areas to exclude patients discharged from AAU within 14 hours and to exclude local anaesthetic patients from individual assessments. There has been a small improvement in DSU compliance but no improvement in AAU It is also noted that the small number of home birth patients do not appear to be getting these assessments.	There are still groups of patients in DSU who are recorded as no compliant as the anaesthetic type is not recorded and action is being taken to address this. In AAU there appears to be variation between the clinician's completion which will be reviewed with the CD. This has been discussed with Obstetrics who have confirmed that these assessments are needed and they are reviewing this. Early indications are that this is a data capture problem.	VTE performance and management is review and overseen by the Patient Quality and Safety Governance Group.

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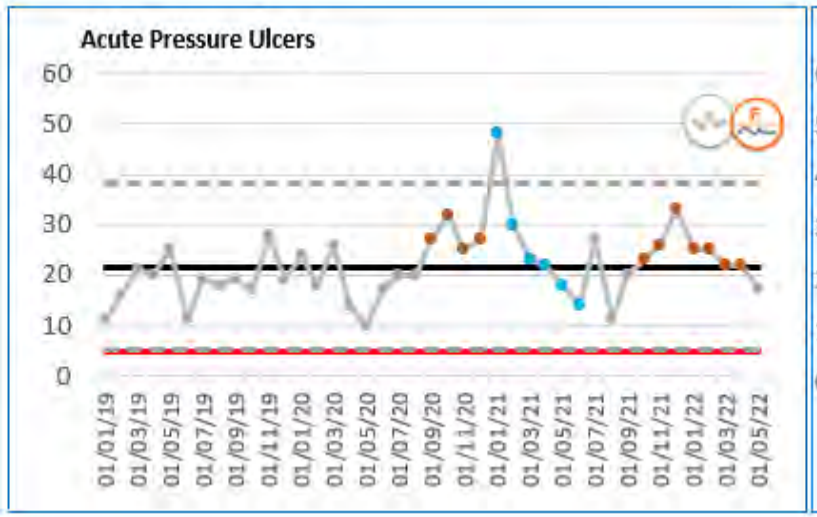

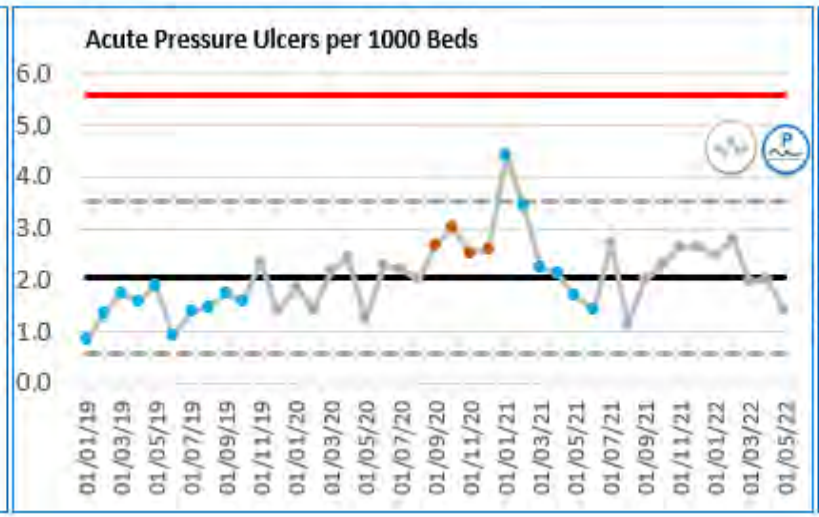

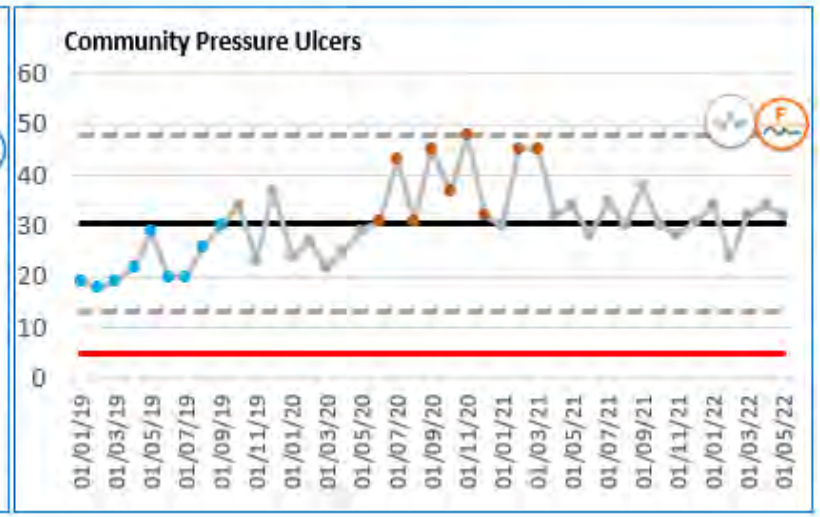

Summary	Action	Assurance
Acute HAPU has seen a reduction in incidents over five consecutive months. While this is positive, incident rates are higher than for the same period in previous years. This may be driven by the pandemic and the effect on both patient presentation and staff absences Recruitment to the TVN has been completed and opportunities for improvement projects and increased ward training has commenced.	Wards with high incidents have been identified and development days are being introduced in June and will encompass both ward training and bespoke QI methodology aiming to reduced prevalence. TVN training videos “TVN shorts” now live and accessible to all staff.	Incidents and improvement plan monitored through the Patient Safety and Quality Governance Group.

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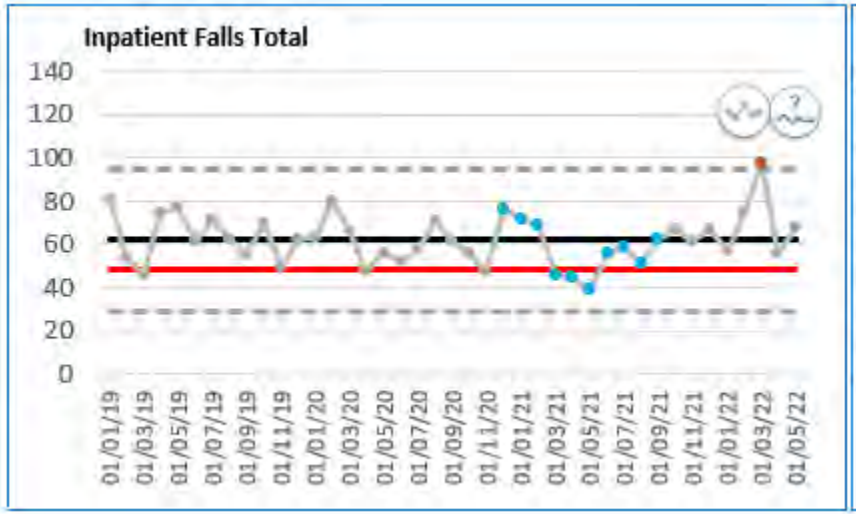

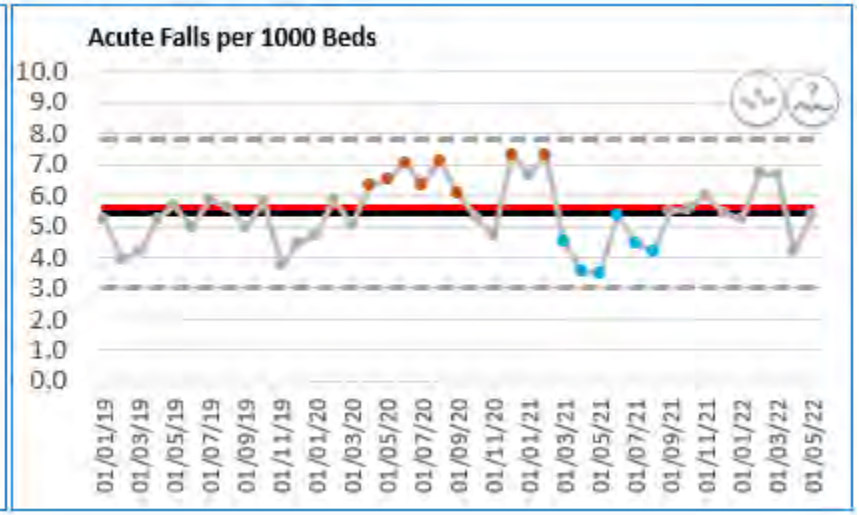

Summary	Action	Assurance
There was an increase in the number of falls reported in May compared to April. In May there were 23 falls reported with minor harm, 2 moderate (#pubic rami and #clavicle) and one with major harm (fractured neck of femur). During the month of May there were 16 repeat fallers with 14 patients having two falls and 2 patients having four falls in the reporting month.	A report was presented to the patient quality and safety governance group in June A dementia, delirium and falls training course has been created and the aim to deliver the course at least once a month to staff.	The falls group meets bimonthly and receives multiple measures related to falls including the above data. The falls improvement plan is reviewed and updated. The falls group report quarterly to the Patient quality and safety governance group.

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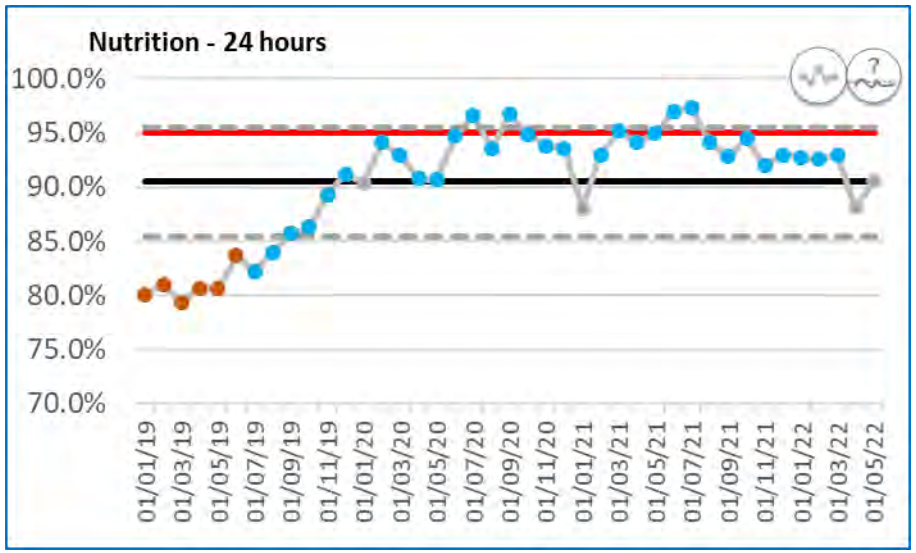

Summary	Action	Assurance
Nutrition assessment (MUST) within first 24 hours There has been a decline of 4% in compliance for April to an overall figure of 89%. The results have been driven by a few wards with poor compliance which could be attributed to staffing deficits.	Nutrition and Dietetics: Regular MUST training is available to all ward staff in person and online. Uptake has been poor due to staff pressures and priorities. Nursing: Matrons and Ward Managers review monthly with the Heads of Nursing. Compliance is promoted amongst the teams. Tenable audits also monitor compliance.	Figures of compliance are taken to the NMCC meeting to encourage better uptake. Monthly reviews of audit data Feedback to teams and promotion of positive performance Audit results presented at the Nutrition Steering Group.

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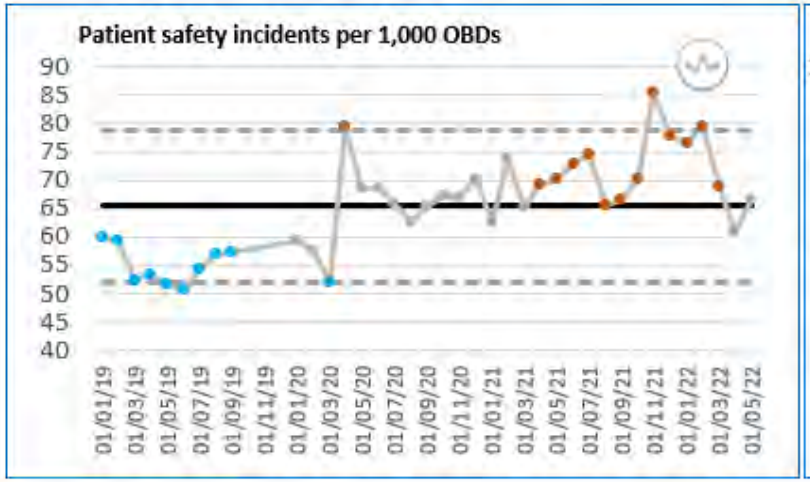
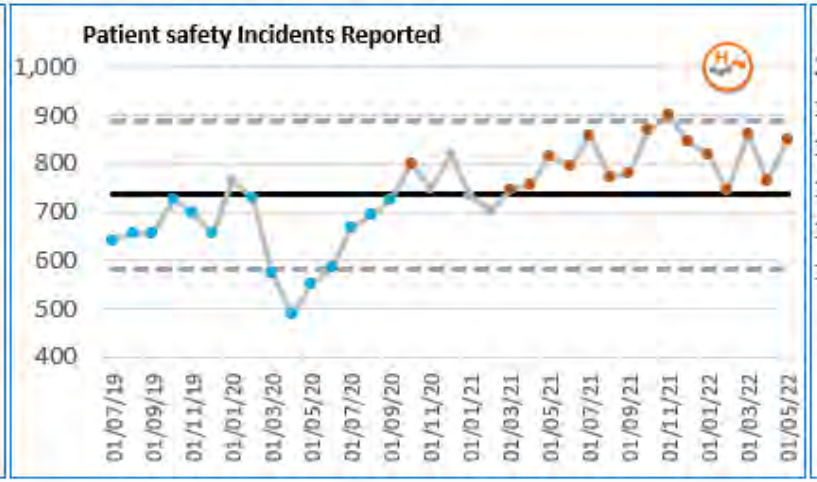
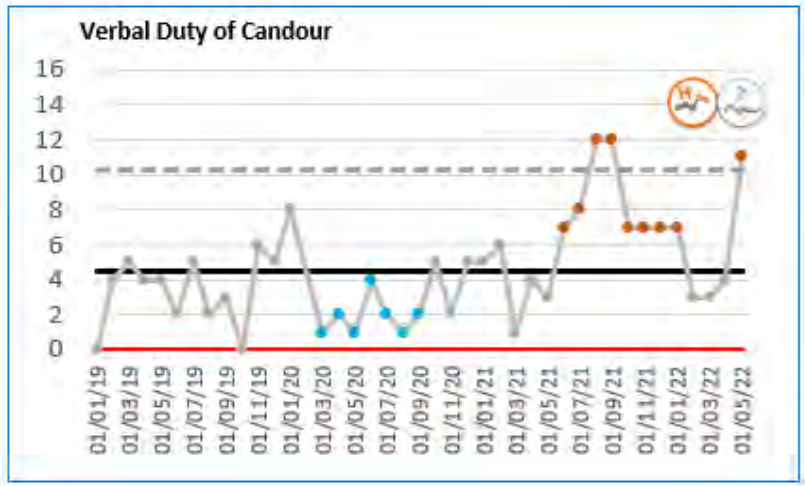
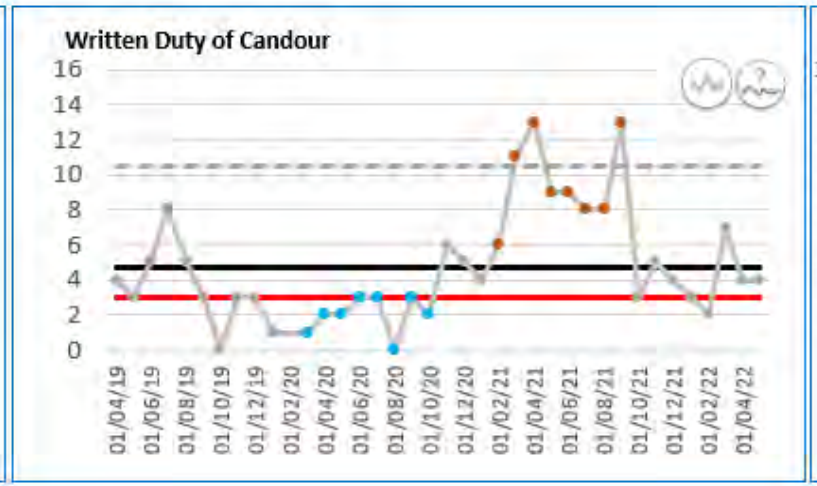
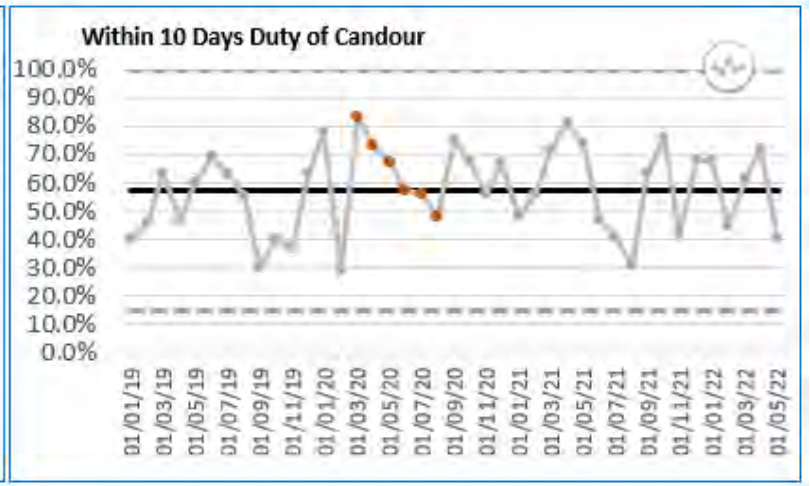




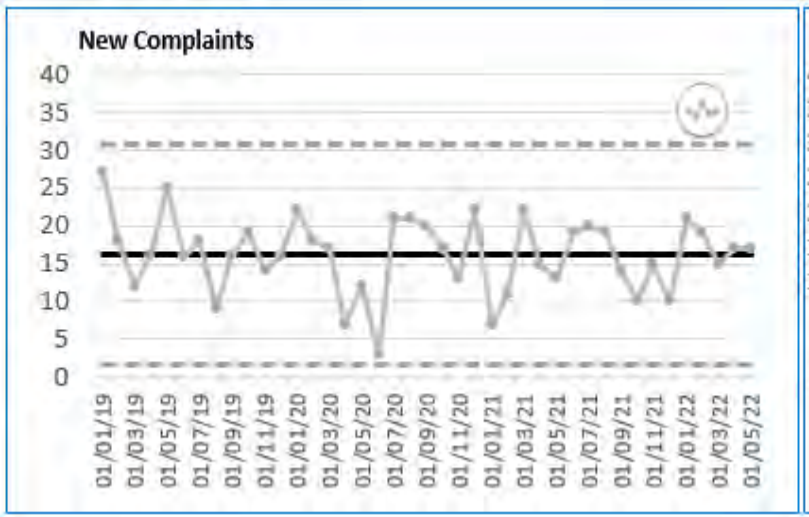


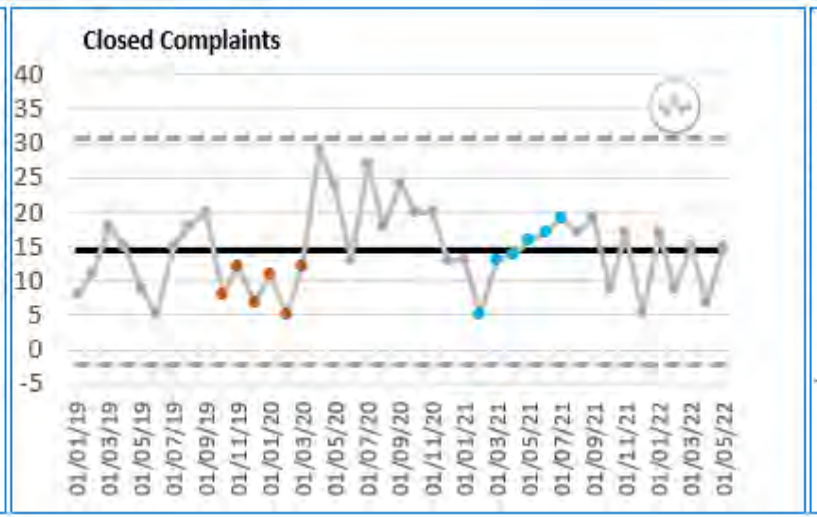


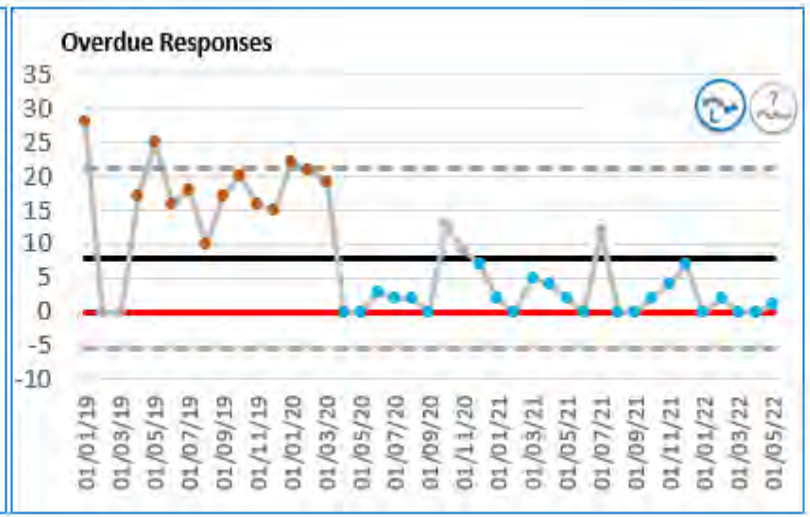


Summary	Action	Assurance
Higher reported number of incidents demonstrates mature safety culture. Increase patient safety incidents with harm represent higher number of pressure ulcers and falls reported. Thematic analysis of Q3 data triangulated with work of specialist groups such as falls. Q4 analysis in progress. DoC data not statistically significant as completion remains variable. This is due to the administration of the process and staff ability to complete the task. Work continues through the task and finish group to address both issues.	Continue to report data but use this alongside quality indicator which represent safety culture. Produce a quarterly thematic report of highest themes reported. Develop meaningful indicators to monitor assurance with timely completion of duty of candour.	Quarterly reporting to the patient safety and quality governance group for both incidents and Duty of Candour. Task and finish group established. Quality improvement project recorded on Life QI. Panel (Exec / CCG sign-off for investigation reports) includes specific oversight of patient involvement in report completion.

Safe

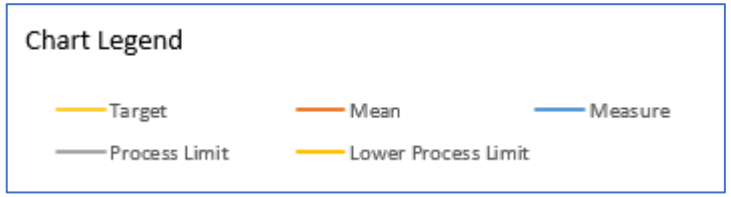


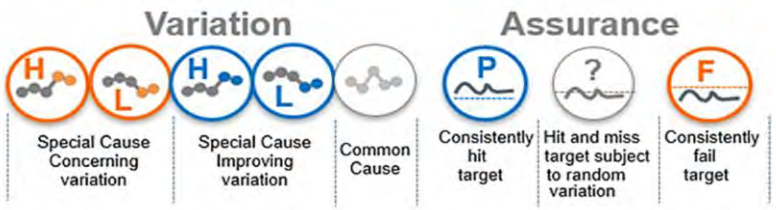




Summary	Action	Assurance
A stable month in terms of complaints logged. Whilst we resolved 2 less that received, we are managing to update complainants regularly on the progress of their complaint.	We have recruited additional staff within PALS and Patient Experience that will help with complaint responses and reduction of overdue responses.	Reduction of overdue responses.

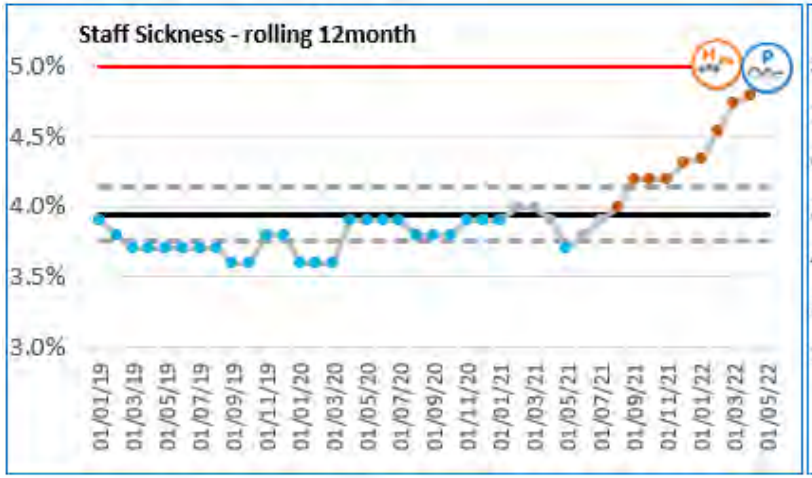
Well Led - Summary

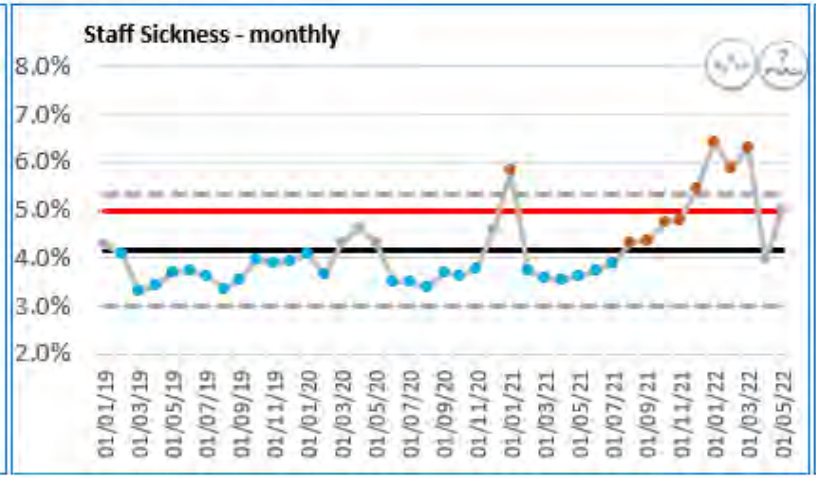


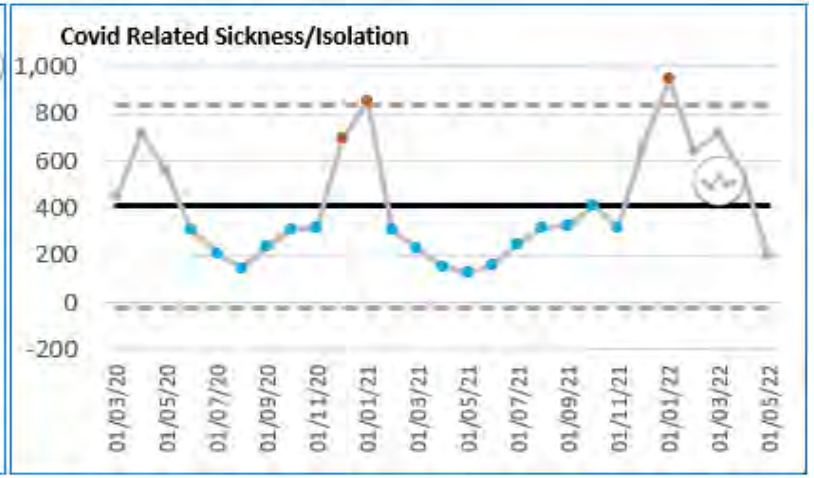


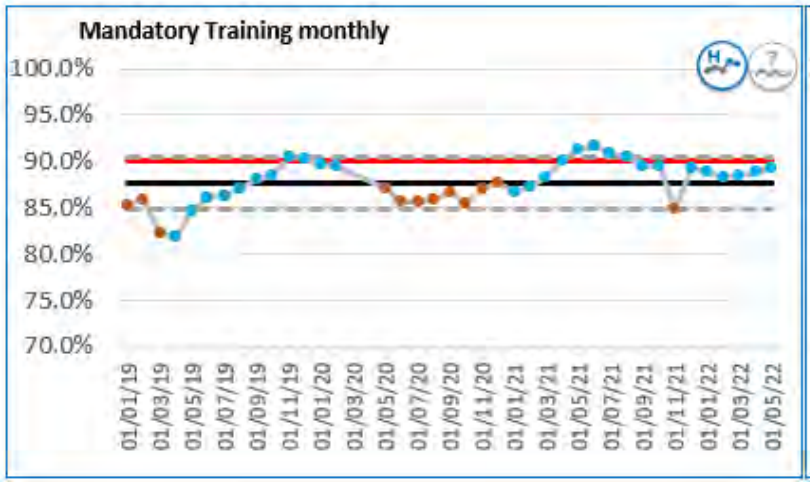
KPI	Latest month	Performance	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Staff Sickness - rolling 12month	May 22	5.0%	5.0%	H	P	3.9%	3.8%	4.1%
Staff Sickness - monthly	May 22	5.0%	5.0%		?	4.2%	3.0%	5.3%
Covid Related Sickness/Isolation	May 22	198	-			410	-20	839
Mandatory Training monthly	May 22	89.3%	90.0%	H	?	87.7%	84.9%	90.5%
Appraisal Rate monthly	May 22	79.2%	90.0%		F	78.3%	74.3%	82.3%
Turnover rate monthly	May 22	12.5%	10.0%	H	P	8.3%	7.7%	9.0%

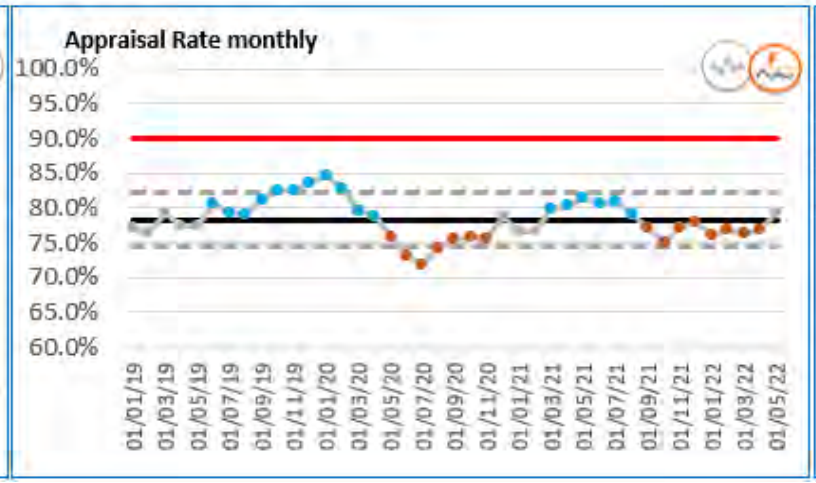
Well Led

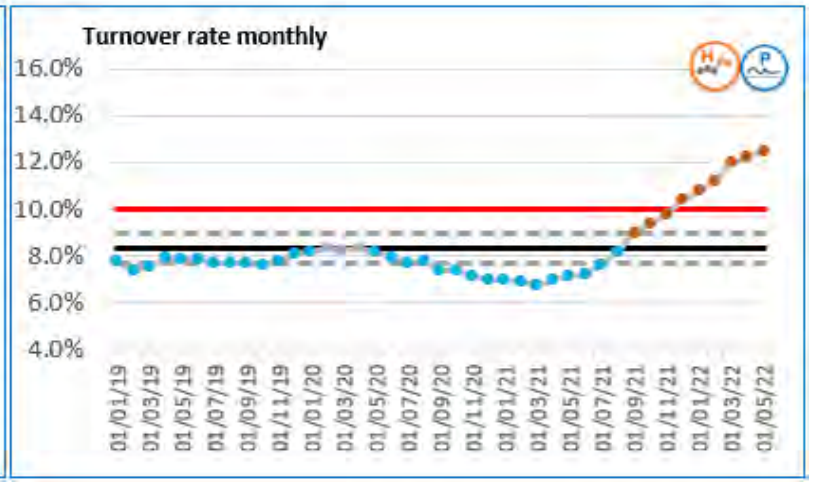












Summary

Sickness absence, 12 month rolling, remains at 5% and monthly sickness for May was 5%. Mandatory training compliance increased slightly and now sits just below target at 89.3%. Appraisal compliance remains well below target although compliance did increase in May to 79.2% from 76.8% in April. Turnover continues on a concerning upward trajectory.

Action

We continue to monitor absence and still await national guidance on future payments for Covid-19 related sickness absence and isolation payments.
Appraisal guidance is being rewritten to focus on the quality conversation and not the paperwork, highlighting more wellbeing conversation prompts for line managers.
We continue to review turnover data, focussing on areas of concern.

Assurance

Sickness absence is monitored on a daily basis on the Sitrep and at the Strategic meeting twice weekly.
All workforce KPI's are monitored on a monthly basis at the Finance and Workforce Committee, with escalation to the Insight Committee, if required.
Increased divisional analysis of workforce KPI's will form part of the reintroduced PRM meetings.

4.4 - Improvement committee - Supporting Annexes

NHS
West Suffolk
NHS Foundation Trust

Improvement committee – 13 June 2022

Quality & learning report	Patient safety and quality teams

Executive summary
Previously reported to the Board, this report is now presented to the Improvement committee and includes the following sections: • Incidents and investigations • Learning from deaths • Patient and public feedback • National patient safety learning • Staff feedback This report provides examples of learning points and improvements, that have arisen from activities in the period since the last report. As we seek to embed PSIRF throughout the organisation, a key learning point has been that the process for translating recommendations into improvement work and for monitoring ongoing actions and improvement work are not yet effective. These need to be a focus for this year and support is sought from the divisions and specialist groups to engage fully with this.
This report does **not** provide updates on the patient safety & learning strategy implementation plan and major projects. These are provided in a separate report on an alternating meeting schedule.

1. Learning from incidents

1.1 Reports approved since last meeting

The new EIR process enables incidents of concern that were reported as green to be escalated to the weekly panel for consideration of investigation method. This provides an opportunity for learning **before** a serious harm incident occurs.

Since the last report there have been 11 reports (including two PSIIs) approved at panel:

WSH-IR-77201 Delayed diagnosis of a fractured neck of femur (PSII)	WSH-IR-77845 Missed fracture
WSH-IR-75893 Delay in the treatment of a patient with renal stones (PSII)	WSH-IR-78785 Fall
WSH-IR-80247 Delay in Diagnosis of lung cancer	WSH-IR-78692 Fall
WSH-IR-71174 Care of a learning disability patient	WSH-IR-81263 Fall
WSH-IR-80985 Antepartum stillbirth	WSH-IR-72505 Fall
WSH-IR-78769 Antepartum stillbirth	

Learning / improvement highlighted: Appropriate use of NEWS, imaging requests at weekends, falls care plans, handover when consultants leave the trust, in utero management of growth restricted babies, supporting smoking cessation, involvement of carers for patients in long term care settings, fluid balance and discharge planning.

Involving the patient and families during the review and report writing process allows them to raise (and have responses to) their concerns either within the report itself or through a sperate (but linked) complaints process where appropriate. This included: Visiting restrictions during Covid, long waits in ED for expected patient and catheter care.

The approval process is undertaken by a panel which confirms:

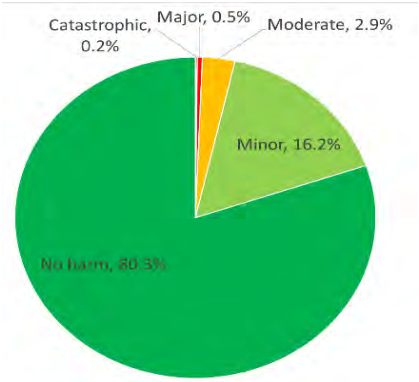
- Opportunity for patient / family input into review (wherever possible should be **during** not **after** report is drafted) and is the final version written in such a way as to be supportive and respectful as well as informative and understandable?
- Do recommendations reflect the findings? It should be possible to see how one leads to the other.
- Are actions clearly 'owned' by a relevant group (e.g. specialist committee or department/team).

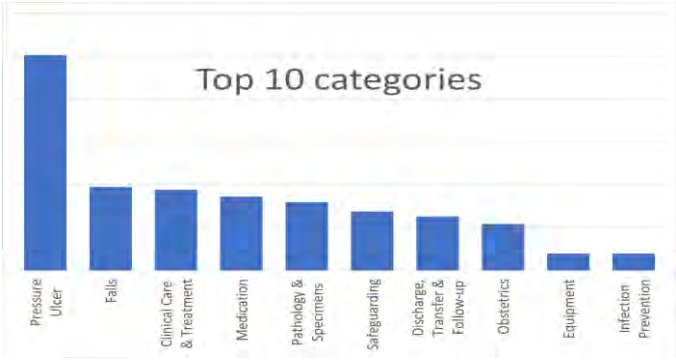
Safety recommendations will be aggregated with other investigations and linked with appropriate improvement work/projects. The Action Oversight Group will be responsible for overseeing this process and will report on progress in future iterations of this report.

1.2 Quarterly thematic review of incidents reported

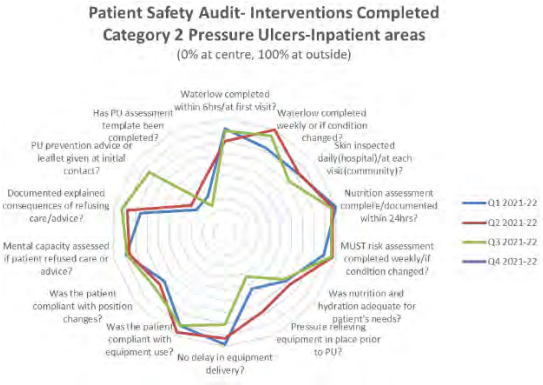
The most recent thematic review examined incidents reported in Q3. The detailed report has been presented to the Patient quality & safety governance group and data from all three completed quarterly thematic reviews contributed to the data-set for our year two PSIRP. Findings from the thematic reviews included the following:

Most incidents reported are no harm (including near miss). High reporting especially of near misses is indicative of a good safety culture.





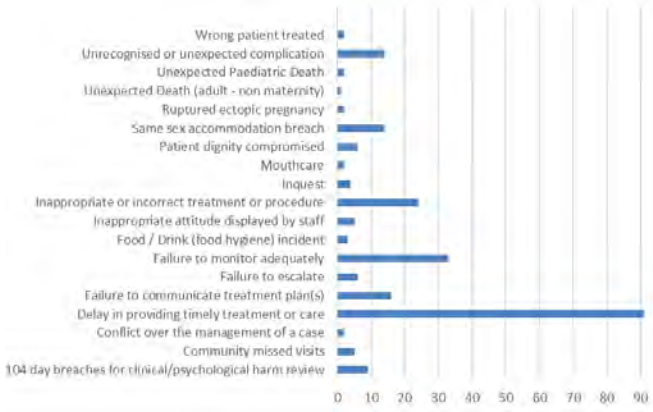
The top four incident types each quarter are routinely Pressure ulcers (including already present at beginning of community care episode or admission to hospital), Falls, Clinical care & treatment and Medication



Category 2 and 3 pressure ulcers are subject to an ongoing patient safety audit to identify key themes in their development within our service (see diagram). These are reviewed at the pressure ulcer & complex wound group, which agrees appropriate actions and monitors these.

The Clinical care & treatment category remains challenging to analyse overall for key trends and themes due to the number of different sub-categories and issues/topics included within.

Key themes within the highest reporting sub-category *Delays in providing timely treatment or care* include: transfers, capacity / staffing issues, obstetrics delays, diagnostic delays, cancelled procedures and medication administration.



An increase in *Pathology & Specimens - mislabelled samples* over the winter months reflected higher volumes of swabbing / testing activity with Covid-19 and laboratory staff reporting all issues so learning could be captured more effectively. Feedback was positive as ward managers found this reporting made it easier to identify specific issues and address them in a timelier way.

The Trust uses Datix to record safeguarding referrals and DoLS applications within its Safeguarding

category leading to higher reporting numbers in this category.

Obstetrics are a high reporting team including the reporting of 'obstetric triggers' (e.g. post-partum haemorrhage or 2nd/3rd degree tears). This enables trend analysis, and recently resulted in a patient safety incident investigation when a rise in PPHs was noted.

Nationally, the top four reported incident categories (most recent report is 2020-21) were:

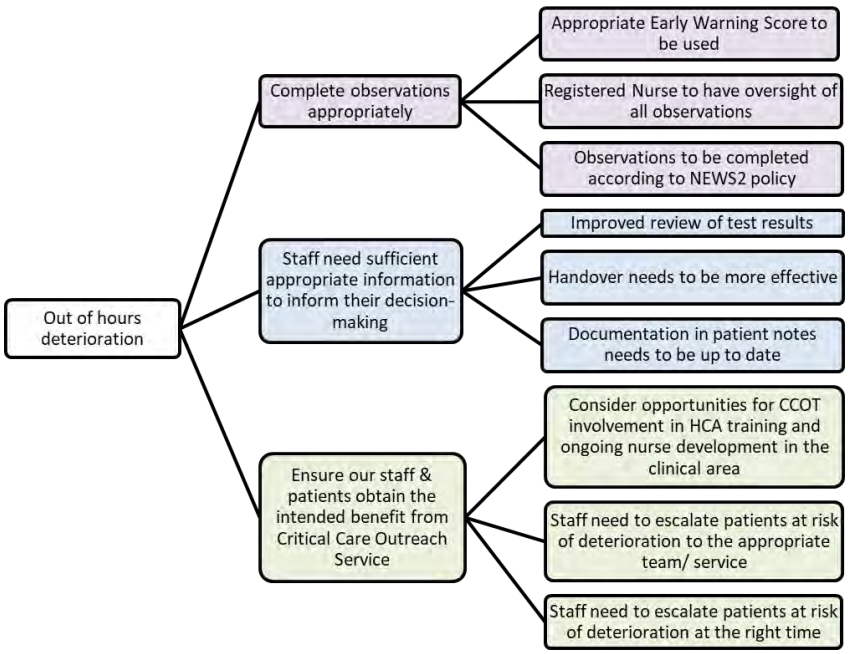
Implementation of care and ongoing monitoring / review, Patient accident, Treatment or procedure and *Access, admission, transfer, discharge*.

A direct correlation with the national reported data cannot easily be made as our local codes have to be mapped to the national codes and the national explorer tool has not been updated since 2020. It is anecdotally recognised however that pressure ulcers and falls are the highest reported incident types in most acute and community NHS trusts.

1.3 Patient safety improvement plans / projects

There are a number of ongoing patient safety improvement projects registered on our LiveQI system. An example driver diagram is shown below with links to the national safety programmes.

'*Out of hours deterioration where assessment was delayed and timely recognition of deterioration was not escalated appropriately'* was identified as one of the priorities in our year one PSIR plan and four PSIIs were completed on the subject. There is also an ongoing clinical audit and the work programme is being overseen by the Deteriorating patients committee



Managing deterioration is one of the Improvement objectives in the NHS Patient Safety Strategy (2019).

NHS England » The NHS Patient Safety Strategy

CQUIN CG3: *Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions* sets a target for 60% of all unplanned critical care unit admissions from non-critical care wards of patients aged 18+, having a NEWS2 score, time of escalation and time of clinical response recorded.

B1477_ii_CQUIN-scheme-for-2022-23_-annex-indicator-specifications_version-4.pdf (england.nhs.uk)

2. Learning from Deaths

What's going well

- Many examples of excellent communication with family and relatives by junior doctors, when explaining care and treatment
- Regular comment upon excellent care provided by palliative care team who see patients quickly following referral and are supportive of clinical nursing and medical teams as well as families at the end of a patient's life

Opportunities for improvement

- Multiple bed moves impacting on quality of care received by patients particularly at the end of their life
- Inability to fast track discharge enabling those who wish to die at home to do so

- Impact of reduced staffing and increased workload on the ability to perform timely nursing assessment
- Lack of assurance that sick patients receive the same excellent care during the weekend or out of hours as they can expect during daylight week day hours
- Delayed recognition a patient is reaching end of their life, such that active treatment continues when, with the benefit of hindsight, it was likely to be futile with resultant delay in referral to palliative care
- Continuing active treatment also when it has been recognised that the patient is dying, and they and their family have agreed a plan for palliative care with the ward team, which could impact on the patient's quality of life in their last few days

Plans for 2022/23

- Review of the mortality processes within the Trust to develop streamlined processes to:
  - Respond to deaths where the medical examiner, the family, our staff or other stakeholders have raised concerns about patient care.
  - Manage communication with bereaved families to avoid unnecessary multiple points of contact, provide opportunities for responding to family feedback and share findings of reviews with the families in a timely fashion.
  - Provide a structured reporting framework to provide divisional, specialty and board assurance and share learning with the clinical teams through a new mortality oversight group and a mortality dashboard.

LfD data 2021/22	Deaths			
	Total	With SJR* completed	With investigation** completed	Judged as >50% preventable***
Apr21-Jun21	202	44	5	1
Jul21-Sep21	215	33	3	3
Oct21-Dec21	297	26	2	1
Jan22-Mar22	277	11	3	1

** SJR - Structured Judgement Review **PSII or PSR ***PSII only (National reporting requirement)*

3 Patient and public feedback

25 complaints were responded to in March and April. Repeating themes include pain management and communication with families (especially during Covid-related reduced visiting opportunities).

The nationally award-winning clinical helpline service, unique to West Suffolk, is now a permanent fixture for inpatient services providing families with updates on the patient's condition and ensuring any updates to the ward about specific patient needs (with consent). The multidisciplinary team handles around 5000 calls per month, contributing to releasing time to care on the wards. The Trust was also one of the highest performing for keeping patients in contact with their loved ones throughout the pandemic (CQC inpatient survey, 2020). Although the virtual visiting service is not in such high demand, we still continue to run the service through our PALS team.

Other learning points included: bladder care guidance in maternity care, security of patient's belongings, parental involvement in care of children, mobilising patients in ED, service delays in primary care and care of end of life patients.

The Patient Experience team work closely with the Patient safety team to ensure any incidents of concerns identified through complaints are captured and recorded and collaborate to produce timely feedback on investigations to the complainants.

4 Staff feedback

In Q4 there were nine contacts made with the Freedom to Speak up Guardians (FTSU) which had an element of patient safety/quality report. The majority of these safety concerns related to shortage of staffing or staff being moved from their usual area of work. FTSU have been working with the Deputy Chief nurse and this has led to some changes and reorganisations.

Patient transport was another area where concerns were raised that patients were left waiting for long periods without sufficient care. To mitigate the risks here, it has been agreed that outpatients can use the discharge waiting area where care and refreshments will be available.

The regular FTSU report to the Board provides more details.

NHS
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Improvement Committee – 13 June 2022

Agenda item:				
Presented by:	Rebecca Gibson (Head of Compliance & Effectiveness)			
Date prepared:	June 2022			
Subject:	CQC Future new model of assessment			
Purpose:	X	For information		For approval

Executive summary

This report seeks to raise organisational awareness of the changes in the future CQC assessment framework and provide an overview of the model. No action required at this time – for information only.

Background

In 2021 the CQC issued a new strategy https://www.cqc.org.uk/sites/default/files/Our_strategy_from_2021.pdf which set out ambitions under four themes:

- **People and communities**
  Regulation that's driven by people's needs and experiences, focusing on what's important to people and communities when they access, use and move between services
- **Smarter regulation**
  Smarter, more dynamic and flexible regulation that provides up-to-date and high-quality information and ratings, easier ways of working with us and a more proportionate response
- **Safety through learning**
  Regulating for stronger safety cultures across health and care, prioritising learning and improvement and collaborating to value everyone's perspectives
- **Accelerating improvement**
  Enabling health and care services and local systems to access support to help improve the quality of care where it's needed most

Smarter regulation – The CQC have been consulting upon and sharing their new assessment framework for some time now although there is still no 'change-over date' published.

It has been suggested that an 'early adopter' approach might be used (*the model we participated in for PSIRF*) however this has not been confirmed.

The structure has been shared widely and is not expected to radically change but it should be recognised that it is **still in draft** at this time

CQC model now and in the future

NOW	FUTURE
Assessment frameworks (multiple) Ongoing monitoring but inspections schedule based on previous rating Inspection: gather evidence using KLOEs (Single point in time) Develop judgements (offline) Publish narrative inspection report Line-up judgements against ratings characteristics	Single assessment framework Ongoing assessment of quality and risk Not just inspection - variety of options (multiple points in time) – more time spent in higher risk services Team assigns score based on evidence found Ratings updated, short statement published
Different for NHS trusts, Social care, GPs, dental services, ambulance trusts, etc	Single assessment framework assesses providers, local authorities and integrated care systems
Key questions / Key Lines of enquiry / Prompts	Key questions / Quality statements

New model

Aligned with "I" statements, based on what people expect and need, to bring these questions to life and as a basis for gathering structured feedback

Expressed as "We" statements; the standards against which we hold providers, LAs and ICSs to account

People's experience, feedback from staff and leaders, feedback from partners, observation, processes, outcomes

Data and information specific to the scope of assessment, delivery model or population group

Example

'I' statement: When I move between services, settings or areas, there is a plan for what happens next and who will do what, and all the practical arrangements are in place.

'We/quality' statement: We work in partnership with others to establish and maintain safe systems of care in which people's safety is managed, monitored and assured, especially when they move between different services.

Evidence categories
Observation (care and care environment)
Feedback from people / People's experience
Feedback from staff and leaders
Feedback from partners
Processes

Quality statement	Score
Learning culture	2
Safe systems, pathways and transitions	3
Safeguarding	2
Involving people to manage risks	2
Safe environments	3
Infection prevention control	3
Safe and effective staffing	2
Medicines optimisation	2
Total score for the safe key question	**19**
Maximum possible score for the safe key question (8x4)	**32**
Percentage score for safe (19/32)	**59%**

25-38% = inadequate
39-62% = requires improvement
63-87% = good
>87% = outstanding

Scoring example

Safe • Learning culture • Safe systems, pathways and transitions • Safeguarding • Involving people to manage risks • Safe environments • Safe and effective staffing • Infection prevention and control • Medicines optimisation	**Responsive** • Person-centred care • Care provision, Integration, and continuity • Providing information • Listening to and involving people • Equity in access • Equity in experiences and outcomes • Planning for the future
Effective • Assessing needs • Delivering evidence-based care and treatment • How staff, teams and services work together • Supporting people to live healthier lives • Monitoring and improving outcomes • Consent to care and treatment	**Well-led** • Shared direction and culture • Capable, compassionate and inclusive leaders • Freedom to speak up • Governance and assurance • Partnerships and communities • Learning, improvement and innovation • Environmental sustainability • Workforce equality, diversity and inclusion
Caring • Kindness, compassion and dignity • Treating people as individuals • Independence, choice and control • Responding to people's immediate needs • Workforce wellbeing and enablement	

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Improvement Committee - 11 July 2022

Sub-committee	Patient Quality & Safety Governance Group
Lead	Daniel Spooner (Deputy Chief Nurse)
Date of sub-group meeting:	22 June 2022

The role of the Insight sub-groups are to review performance information against KPIs to identify deteriorating trends and/or areas where the Trust is a potential outlier or underperformer or where there is otherwise scope for improvement.

1. Groups / oversight reporting

1.1 Groups / oversight considered at May's meeting

- Drugs and Therapeutics
- Falls
- Pressure Ulcers
- Infection Prevention & Control Committee

1.2 Escalation of emerging concerns or new positive assurance from sub-groups

Drugs and Therapeutics

- Lack of extravasation policy outside of chemotherapy
- Medication Incidents (No Harm). Possible false assurances

Falls

- Falls Increase - Trust is seeing an increase in the number of average falls reported. Previously the average was circa 70/80 but this has increased to over 100.
- Post Fall Form - HD reported that a pilot will be starting on F7 using a new post fall form. This should assist with documentation compliance and post fall evaluations.

Pressure Ulcers

- Improved establishment of TVN team.
- Increased incidents in F7 and G9
- MRI pathway block.

Infection Prevention and Control Committee

- Increase in Clostridium Difficile cases (March) followed by reduction in cases (April/May).
- Nosocomial COVID cases
- Current establishment/resource within IPT

2. Information flows received at June's meeting

See Annex 1 for dashboard / charts for new/emerging/established variance only.

2.1 Data items

Data item	New / Emerging variation?
Medication incidents "no harm" Annex 1	Emerging
Extravasation policy	New
Falls incidents (inpatient and CAB): Annex 2	Emerging
Increased referrals to TVNs (data to be monitored next Q)	New
Increased incidents in F7 and G9 Annex 3	New
Increase in C-Diff Cases (Annex 4)	New
Nosocomial Covid19 transmission	New
IPC resource	New

2.2 Narrative for new / emerging variation

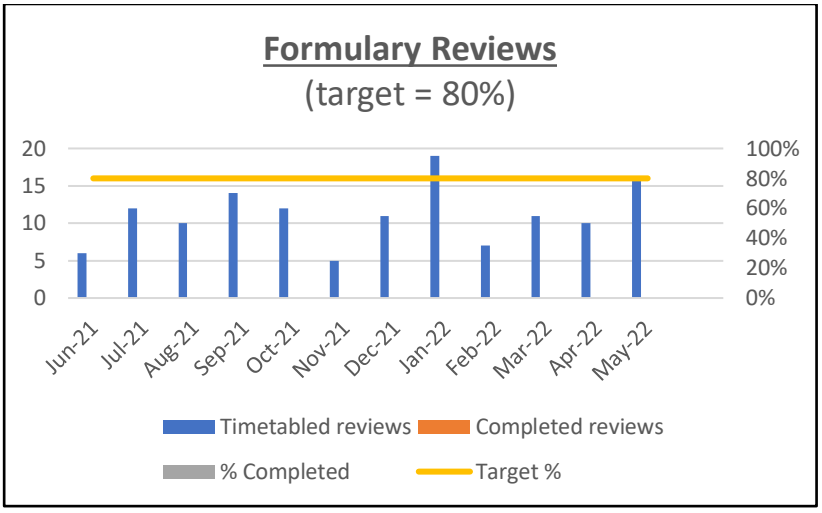
Data item	Narrative
Medication Incidents	The committee has noted that whilst the percentage of no harm incidents is generally well above the target of 85% this may an artefact of the way that incidents are recorded. A proportion of reported incidents are non-patient-specific and as such do not cause harm (e.g. controlled drug counting errors) but are included in the incident totals, so artificially elevating the no harm percentage. Discussions have taken place and it has been agreed that for the next report non-patient-specific incidents will be removed from the reported figures.
Extravasation Policy	Investigation of incidents involving *Ferinject* (iron) Injection has identified that the trust does not have a general extravasation guideline (the existing guideline only covers chemotherapy agents).
Falls average	Trust is seeing an increase in the number of average falls reported. Previously the average was circa 70/80 but this has increased to over 100. This was a special cause of variation in March. Possibly driven by large staffing absences. Preceding two months has returned to average
Increased Acute Referrals to TVN	High incidents of referrals to the TVN, not always appropriate and should be managed locally by the clinical teams. Increase ability to provide training may improve this. Plan to measure referral frequency to assess impact of improved training provision
Targeting QI intervention to high incidence areas	In recent months we have noticed a spike in pressure ulcers particularly on ward F7, also G9 who have had deterioration of wounds and a steady report of new pressure ulcers. As an immediate action, harm free care development days provided which will bring together staff from both of these wards and focus on harm i.e. medications management, falls and pressure ulcers. Have been commenced Alongside this bespoke QI projects, will be delivered in these areas.
MRI pathway, community PU suspected osteomyelitis	Concerns around the progression of this pathway for patients requiring an MRI. Particularly around the ownership and interpretation of the MRI. Group is exploring the virtual ward for clinical oversight.
Increase in Clostridium Difficile cases	Increase of Clostridium Difficile cases associated to G8 Stoke Ward at this time. Likely cause, cannot rule out 'environmental contamination'. Lack of side room capacity with competing needs – not always able to isolate patients. Ward decanted elsewhere, cleaned and fogged. Removal of un-necessary posters, review of information racks and decluttering of surfaces particularly around the reception area encouraged. Malfunctioning macerator changed for a re-furbished macerator. Wipes for cleaning commodes reviewed Assurance: Continued surveillance and reporting. Regular weekly Trust walk about from IPC and Microbiology Infection Control Doctor have commenced. Monthly walk about with Estates colleagues. Review of PIR paperwork and processes supported by CCG colleagues is in progress. Review of process for data capture locally within IPT. Plan to introduce ICNET over time in to routine IPC working.
Nosocomial COVID cases	Increase in community prevalence nationally by 50% on the back of a decrease in testing with EoE number of patients admitted in last 7 days increase by 30% (as of 15/06/22) RAAC plank work limiting the wards that are available to use – e.g. moving wards out of environments that are significantly challenging.

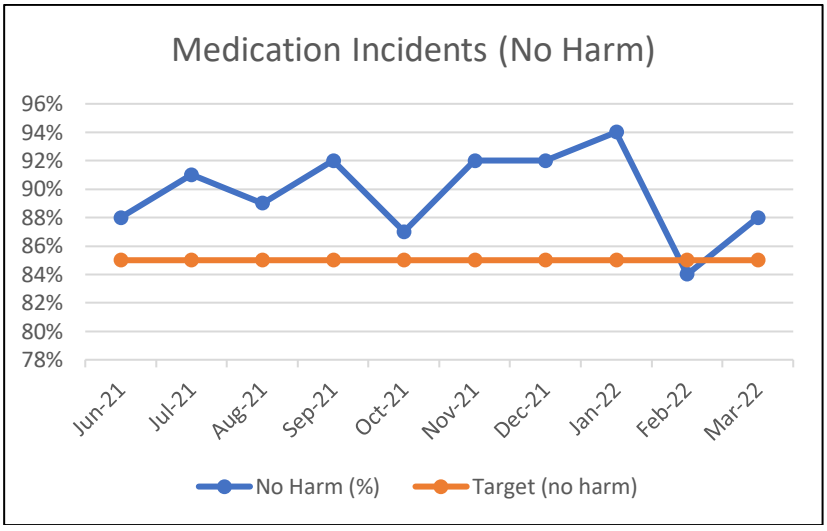
Data item	Narrative
	Business case for 'air scrubbers' being looked in to. Implementation of process when positive cases occur in the bays – 8+ days, swab rest of bay, if no further positive, open, if further positive, close for 7 days initially. Review according to capacity challenges which usually brings 'compromises' from an IPC perspective

2.3 Progress / update on previously reported / established variance

Data item	Date highlighted	Update statement
Bed Rail Policy	Sept 2021	Policy available on intranet. Bed rail education added to the HCWS falls induction presentation, To add to the nursing falls e-learning.
Assistive Technology	Sept 2021	Policy now on intranet. F3 have trialled a bathroom monitor in three toilets, this has now been returned to the sales representative. Decision required on how whether all wards require the bathroom monitors and how many to order.
Staff training	Sept 2021	Dementia, delirium and falls training session launched (4hr training session, held face-to-face, positive feedback following first three sessions) Training sessions being held for G9 and F8, combining areas identified within Datix -falls, pressure areas, deterioration of patients -EWS, CREWS, MEOWS and medication. Four sessions planned -all staff due to attend.
Post Fall Protocol	Sept 2021	Policy has been updated with slight change of wording- change 'consider CT' to Order CT for patient on anticoagulation. Include the NICE algorithm for when to scan post head injury into the policy
Gap Analysis of falls	Sept 2021	To re-review the previous analysis and update it and then circulate to the falls group members
Frequent Fallers	Sept 2021	QI project registered, highlighted at last falls group meeting. Meeting to be arranged. QI attending next falls meeting in March. Falls MDT looking at frequent fallers in progress of being set up
Covid Curtains	March 2022	Meeting held to discuss and review the use of curtains between bed spaces. Case being written for the consideration at CRT of whether the curtains should be continued to be used. CRT confirmed planned removal
New PU incidence monitoring	**ongoing**	March 22 – May 22 100 New PU (Community) 66 New PU (Acute) Dec 21 – Feb 22 87 New PU (Community) 82 New PU (Acute) Sept 21– Nov 21 82 New PU (Community) 75 New PU (Acute)
MRI pathway, community PU osteomyelitis	**ongoing**	To scope how the virtual ward may support this pathway

Annex 1: Pharmacy Data set for emerging variance





Annex 2: Falls indents

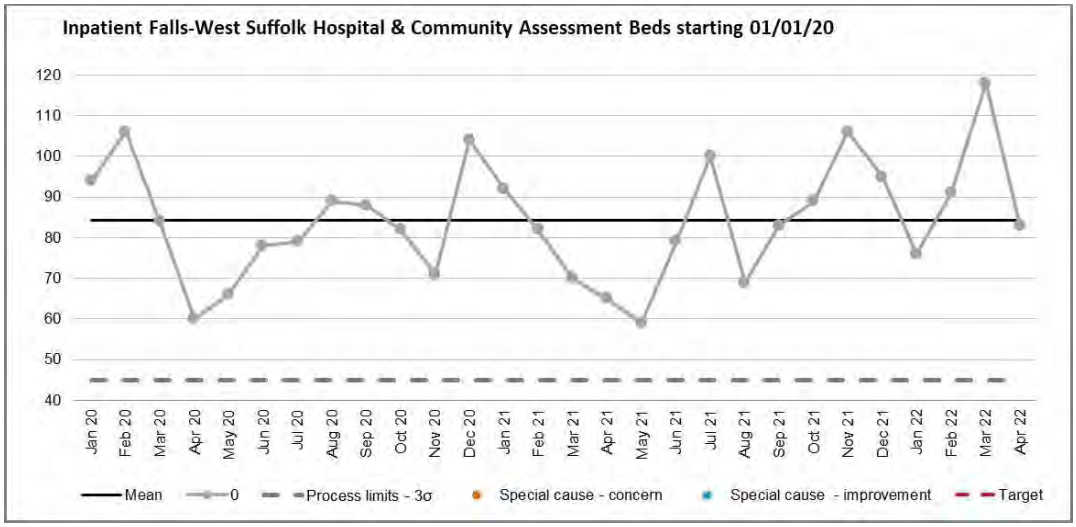


Table to show falls with level of January- May 2022

	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022
None	47	62	78	57	78
Negligible	7	8	13	10	2
Minor	22	21	24	13	23
Moderate	0	0	1	1	2
Major	0	0	1	1	1
Catastrophic	0	0	1	0	0
No value	0	0	0	0	0
Total	76	91	118	82	106

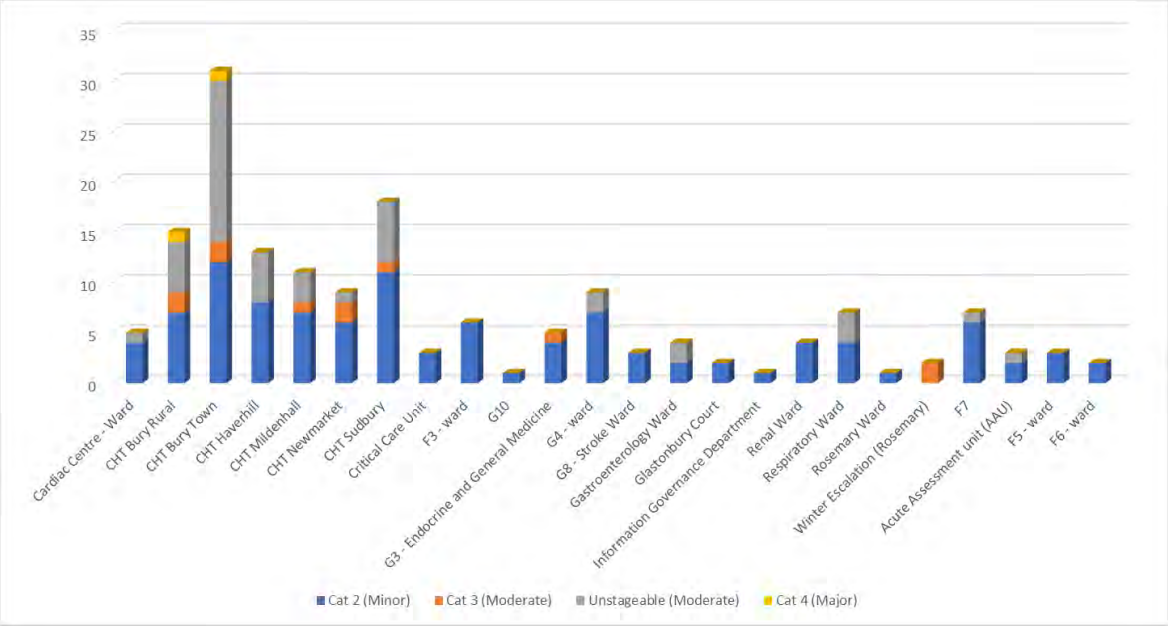
Falls per 1000 bed days January - May 2022

December	5.42
January	5.23
February	6.73
March	6.64
April	4.2

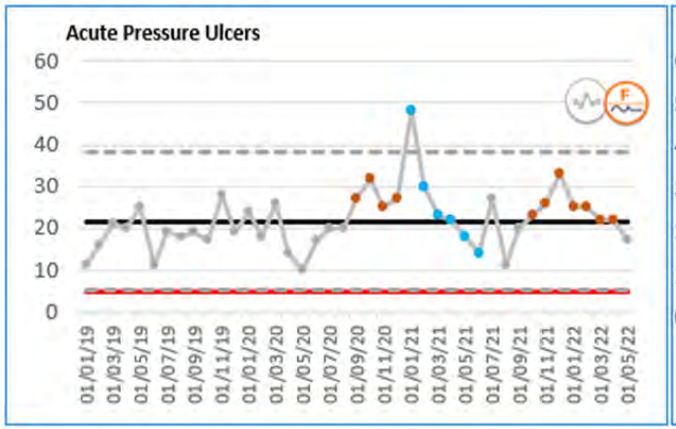
Annex 3: Pressure Ulcer Incidents

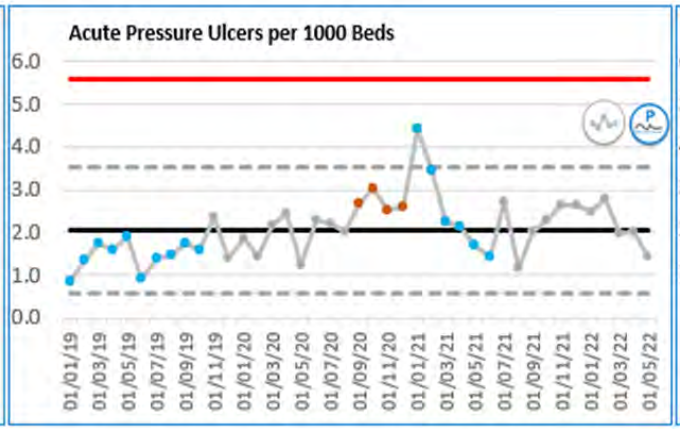
Last Quarters Pressure Ulcer Incidence Acute and Community Combined (CHART 1)

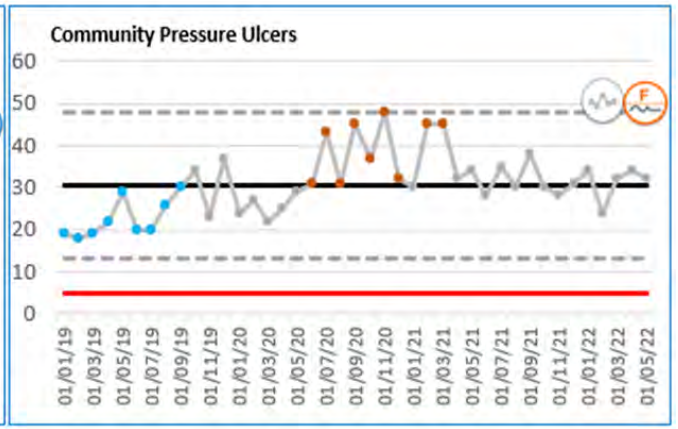
	March 2022	April 2022	May 2022	Total
New Pressure ulcer	55	60	51	166
Pressure ulcer present on admission	107	105	115	327
Total	162	165	166	493



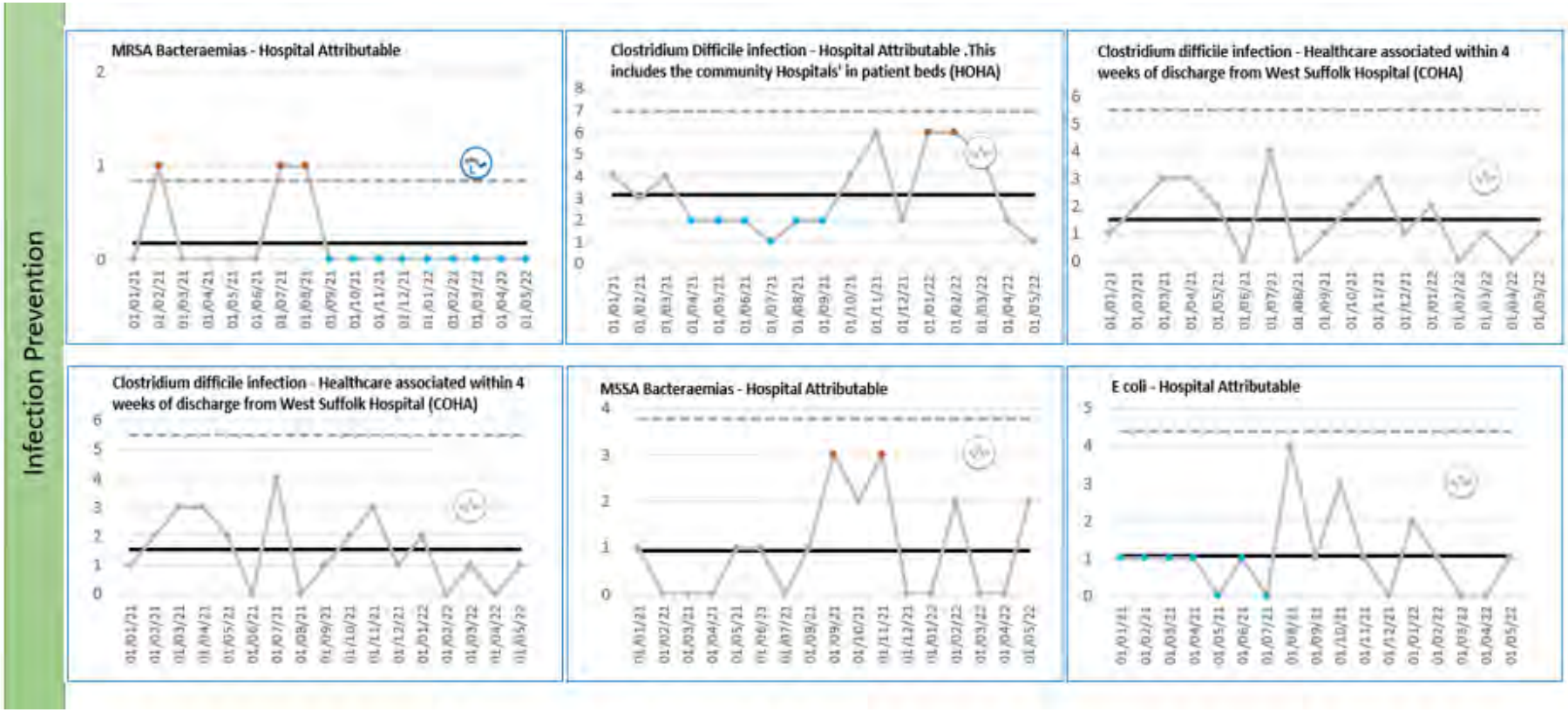
Taken from IQPBR for additional context







Annex 4: IPC


Infection Prevention
MRSA Bacteraemias - Hospital Attributable
Clostridium Difficile infection - Hospital Attributable .This includes the community Hospitals' in patient beds (HOHA)
Clostridium difficile infection - Healthcare associated within 4 weeks of discharge from West Suffolk Hospital (COHA)
Clostridium difficile infection - Healthcare associated within 4 weeks of discharge from West Suffolk Hospital (COHA)
MSSA Bacteraemias - Hospital Attributable
E coli - Hospital Attributable

Annex 5: Full minutes of meeting

NHS West Suffolk NHS Foundation Trust

MINUTES/ACTION NOTES OF
Patient Quality and Safety Governance Group
22 June 2022
TEAMS

MEMBERS			
Core Members		**Attendance**	**Apols**
Daniel Spooner (Chair) **(DS)**	Deputy Chief Nurse	✓	
Nichole Day **(ND)**	Deputy Director of Nursing CCG	✓	
Michael Wigg **(MW)**	Clinical Quality Lead for Suffolk and NEE CCG	✓	
Lucy Winstanley **(LW)**	Head of Patient Safety	✓	
Julie Head **(JH)**	Head of Nursing Deteriorating Patients		✓
Rebecca Gibson **(RG)**	Head of Compliance & Effectiveness	✓	
Joy Kirby **(JK)**	Assistant Director Clinical Quality NHSI	✓	
Karen Line **(KL)**	Clinical Lead for Quality and Safety, Community & Integrated Service Division	✓	
Jude Chin **(JC)**	Interim Chair		
Natasha Rivers **(NR)**	QI manager	✓	
Jenny Kerr **(JK)**	Pt Safety Manager corporate Division	✓	
Patricia Mills **(PM)**	Consultant Anaesthetist		✓
Other Members			
Simon Whitworth **(SiWh**)	Chief Pharmacist	✓	
Helen Dockerill **(HD)**	Falls Lead	✓	
Daniel Harvey **(DH)**	Tissue Viability Nurse	✓	
Amanda Devereux **(AD)**	Infection Prevention	✓	
Sue Wilkinson **(SW)**	Executive Chief Nurse	✓	
Amy Forrester **(AF)**	Quality support officer	✓	
In attendance			
Julie Wiggin - (Notes) **(JW)**	PA to Deputy Chief Nurse		

		ACTION
1	**APOLOGIES**	
	As noted above	
2	**MINUTES OF LAST MEETING 25 MAY 2022**	
	The minutes were agreed as a true and accurate account.	
3	**ACTION SHEET / MATTERS ARISING**	
	Action 35 – IPCC- Pull some metrics together for future reporting into a template. Amanda suggested that they could use the action plan that is being worked through following a CCG external visit. It includes a clear strategy and risk assessment. **Update 23/03/2022** - Action rolled over DS asked AD if she could include in the report some SPC charts on traditional infections such as CDIF, MRSA, VRE etc **Action complete**	

		ACTION
	Action 36 – PU - DH to update the group on the long lie pathway at Pressure Ulcer groups next iteration. **Update 23/03/2022 -** DH was not in attendance Action rolled over DS would like to see more SPC charts in the report. There is data from the last quarter but it would be useful to see a trend analysis for a clearer picture overall. DS to speak to DH about the Pressure ulcer report outside of this meeting. **Update22/06/2022 –** DH reported that this is in progress and is awaiting input from the frailty team. **Action ongoing**	
	Action 37 – D&T – JH to send Simon the workstreams for the deteriorating patient group for Simon to have a look at and consider if this would help with the attendance to D&T **Update 22/06/2022** – SiWh reported that there has been a lot of discussion in D&T on how to improve attendance. Unfortunately, D&T is so wide ranging that, although this method was considered, it was felt that it would be too difficult to split the group and maintain the range of discussions they currently get so will not be making any changes. **Action complete**	
	Action 38 - D&T - Intravenous Pump Library - Concerns over future changes and whether the pumps will need to be changed for the whole trust which will have huge consequences for the Trust SiWh and JH to discuss further outside of this meeting **Update received from Simon outside of the meeting on 23/06/2022.** SiWh and JH met to discuss the Intravenous Pump Library and there is now a dedicated project implementation group managed through EBME looking at the implementation of the full range of pump libraries. **Action complete**	
	Action 55 – IPCC - AD to speak to Luke and Dan Greaves to complete a review on the usage of the air scrubbers so far **Update 22/06/2022** - AD reported Dan Greaves is liaising with DS and putting a business case together to increase the number of scrubbers in the Trust to 10. This will involve Estates to take the majority of the case forward. DS reported that at present it is unclear which business case route it will go down, whether it will be able to go down a quick win or a full business case this will be dependent on the amount of cost that is involved. **Action ongoing**	
	Action 57 – Falls - AD and HD to meet to discuss the issue of the Covid curtains **22/06/2022** – HD reported that a meeting has taken place and the issue has been taken forward. AD reported in the IPCC report that the Covid curtains will be removed. **Action complete**	
	Action 58 – Falls - HB to produce 2 SPC charts for the next meeting, 1 for the falls and 1 for the 1000 bed days **Action complete**	
	Action 59 – PU - DS to speak to DH about the Pressure ulcer report and including trend analysis around the IQPBR data. **22/06/2022** - DS and DH have not met up to discuss. The data for PU is in the report but DS would like to meet to look at best practice on how to represent the data through SPCs. Brian Aldiss will be able to provide the data. **Action ongoing**	
	Action 75 – PQASG - EOL - JW to contact Mary McGregor with full details and reporting templates to report End of life (EOL) separately from LFD. **Action complete**	
	Matters Arising DS reported that some of these meeting clash with the Deteriorating Patient group and the Drugs and Therapeutics and many staff attend the same meetings. There is also a clash in July with the PU meeting. **Action** – JW to look at the scheduling to ensure there are no clashes going forward.	**JW (79)**

		ACTION
	Matters Arising RG reported that many of these actions relate to data and SPC charts. At the last Improvement committee, it was discussed that the IQPR contains indicators from some of the specialist groups but not all. RG and Nikki Yates (NY) took an action to create a separate list of relevant measures for each specialist committee, not to make the IQPR any bigger but to ensure the Trust has a representative sample across all of the committees. Part of that will be to look at how data is made available. RG further reported that she has a meeting scheduled with NY later this week to discuss further. Emails will be sent out to specialist groups to ask what their current measures are and she will update the group at the next meeting. **Action –** RG to update the group on the list of relevant measures for each specialist group at the next meeting.	**RG (80)**
4	**Drugs and Therapeutics**	
	Report received from and presented to the group by Simon Whitworth. **<u>Emerging concerns</u>** **Ferinject Injections –** SiWh reported that an emerging concern is the reinject injections for a couple of reasons • Cost of how it is used • High rate of extravasation reactions which leads to permanent staining of patients (staining is a known side effect) • The Trust has an old chemotherapy extravasation policy but not a general one Pharmacy has been working with the specialities to produce a specific general policy but this has been challenging due to staffing availability however. Work is ongoing but it does need to be addressed. SiWh confirmed that Pharmacy have looked for assistance from the plastics team and are looking at other Trusts to see if they have a general extravasation policy in place. Pharmacy are looking at other ways to solve this issue but will come back to this group if they continue to have problems. **Action** – SiWh to update the group on the ferinject injections and extravasation policy at the next iteration or come back to the group earlier if there continues to be issues. **Review of D&T committee** – Previously discussed in matters arising action 37. Attendance at the D&T committee, although consistent, is not as high as they would like. There is a number of key staff who make up the core members and then other staff who attend when required. The D&T committee would like to propose looking at the quorum of the committee and attendance list to designate those who are core members and those who are not and to monitor attendance. **Medication Incidents** - SiWh reported that pharmacy reviewing how we report medication incidents. He confirmed that at all medication incidents are reviewed on a monthly basis and then, for documentation, consider if the incident is harm or no-harm. The Trust is a high reporter of incidents but a number of medication incidents are not patient specific but are procedural incidents that will not cause any harm and raises the no-harm percentage. It has been agreed for Pharmacy to report on next month only on patient specific incidents to see if there is a difference in the figures. **Formulary review** – SiWh reported delays in keeping up to date with formulary reviews due to staffing shortfalls This is not a patient safety issue but is a quality issue and is labour intensive however, pharmacy currently has a 26% vacancy rate and they are behind with the reviews and is becoming increasingly challenging to complete. **E-Care Medicines Management** - SiWh reported that pharmacy continue to monitor the red risk for e-Care medicines management team which remains a red risk for the Trust. This is also being looked at through the CRC and at executive level. **Intravenous Pumps** – For information: SiWh reported this is a large piece of work that pharmacy is struggling with but there is a larger project planned with the roll out of the new bbraun pumps.	**SiWh (81)**

		ACTION
	There is a plan in place to roll over the existing pump libraries and developing further moving forward. RG queried if the D&T Committee currently have an agenda item where they review current audit programmes, identification of actions to review medication safety audits. SiWh confirmed that these audits currently come under the medication safety officer rather than the D&T committee. If there were any items that required escalation the medication safety officer would escalate them to the committee. Any escalations would be added to the agenda but it is not a standard agenda item. Any audit programmes to be agreed would be approved through the divisional audit structure. LW commented that this sits with the no harm medication incidents and there is something that could be done around thematic analysis at D&T. Looking at the medications highlighted as cause for concern as part of PSIRF in the patient safety audit together with no harm incidences. Rather than investigate every no harm incident locally the patient safety team can do something with D&T in terms of themes. **Action** - LW to progress with Sam and propose something for agenda **Items for Escalation -** Ferenjet injections and extravasation policy to be aware of.	**LW (82)**
5	**Falls**	
	Report received from and presented to the group by Helen Dockerill. HD reported that additional scoops have been purchased for G8, G3 and G9. The falls report for March and April show an increase in the number of falls reported including falls with ham. The Falls committee spent some time looking at their QI project that they are about to launch and have identified the primary drivers which include • Training and education • Frequent fallers • Falls assessments • Falls prevention • Post fall management Discussions were also held on bringing the thematic quarterly review into the Falls group for data consistency. The Falls policy is out of date and is currently being reviewed and will include additional sections that reviews from incidences have highlighted. The Falls group discussed how they can be actively involved with the layout and planning of the new hospital in terms of falls prevention and risk which will also be added to the QI work. **<u>Emerging concerns</u>** **Falls Increase** - HD reported that the Trust is seeing an increase in the number of falls reported. Previously the average was circa 70/80 but this has increased to over 100. **Post Fall Form** - HD reported that a pilot will be starting on F7 using a new post fall form. This should assist with documentation compliance and post fall evaluations. **Family's** - The Trust has received a few concerns from family's about not being informed that a relative has had a fall. This is an area that is now being focused on through any training. HD reported that she has linked up with Maggie Woodhouse to provide some additional training sessions for dementia, delirium and falls training. This is a 4-hour face to face session and will be rolled out on a monthly basis. As well as these sessions there is specific training for G9 and F8 and some focus work at Rosemary ward. ND queried if the Alliance Falls group would be re-starting again following the pandemic so learning from incidents could be shared and discussed. LW confirmed that the Trust Falls group has expanded its membership and then there was an overlap with the Alliance Falls Group. The Trust Falls group is meeting, community were invited to join but it is very different to the acute. KL confirmed that there is no falls group in the community. RG reported that the Trust is looking to have a CCG and wider colleagues quality assurance visit on falls, frailty and dementia and frail	

		ACTION
	elderly this may provide an opportunity for the Trust to show what we do and visitors will be able to walk through the hospital to see it live. DS informed HD that the SPC chart included in the report can be provided for her going forward because the SPC chart that is used for the IQPBR is slightly different and does not suggest an upward trend which changes the narrative a little. Going forward the SPC chart should be provided for HD to produce some narrative. HD reported that one of the challenges is whether to use data reported to the board, which does not include all falls such as assisted falls, or the data used in her report for this group which does include all of the slips, trips and assists recorded through Datix. She feels that the assists to floor are just as important and learning can be taken from those incidents. DS confirmed that what is reported to IQPBR can be influenced and if the assists to floor should be measured they can be included, it would mean that there are more than 2 slides for falls. However only reportable falls (not assists to the floor should be reported externally). LW feels that the difference in data is a commonality for all the groups reporting and there is a big piece of work around the Trust efficiently using the data that there is and asked if there could be a time priority on it. DS agreed and informed that as HD is the expert in falls she should be informing the board what is being measured and provide the narrative and value to the data. KL commented that she is trying to prepare her reports for PRM but the data is not consistent and different versions of SPC and better coordination of the data flow would be welcomed. NR informed the group that the quality improvement team are working alongside specialist groups and looking to make sure the SPC and data that is being collected is reflective. The life QI system automatically picks up shifts and trends in the data and some of the consistency should start to join up as they work with the groups. DS asked if HD's report could include one to the life QI reports as an appendix. **Action –** NR to provide HD a Life QI report to be added as an appendix to the next report for Falls. **Items for Escalation -** There were no items for escalation.	**NR / HD (83)**
6	**Pressure Ulcers**	
	Report received from and presented to the group by Dan Harvey. **<u>Emerging concerns</u>** DH reported that the last quarter saw a high spike of Hospital; acquired Pressure ulcers (HAPU) in January but since then the figures are steadily coming down. There were 66 new HAPU reported in March against 82 previously. **QI Intervention to high incidence areas** - DH reported that the Tissue Viability team are adopting more QI measures. Two areas F7 and G9 have been problematic. F7 have historically been an assessment ward which had a quick turnaround of patients. Due to constraints in flow, patients are on F7 for longer periods of time. G9 has a similar problem although they are not having as many HAPUs but a lot of deterioration patients. The team have provided some harm free development days that look at falls, medicine management and PU. F7 and G9 have been joined together for these development days looking at their harms and their data. Following that NR will be looking at more QI measures and individual projects. DH would like to roll this kind of development out to the rest of the Trust and would like to mix medical and surgical wards together because surgical wards tend to have issues when medical patients are on surgical wards and vice versa. The next areas to look at will be F3 and G4. **MRI Pathway** – Previously raised at this group for patients with PU needing MRI with suspected Osteomyelitis. There is currently no pathway to signpost them under a consultant led team. At Cambridge they have a bone MDT that includes a microbiologist, orthopaedics, plastic surgeon and medics. Here the plastics surgeon is not in a position to go ahead with this kind of pathway. As a Trust we need to look at whether this can be achieved in house or if a decision is made to signpost these patients to other areas. As patients are admitted DH can ask the doctor on the ward to order the MRI the issue is with community patients who are not admitted. The number of patients is relatively small but early detection is key and can very often be life and death in	

		ACTION
	most cases. DS queried if this could be included in the virtual ward. The virtual ward will have medical support. Dr Yew has recently been identified as the virtual ward clinical lead. RG and LW have a meeting with Dr Yew and will ask if this could be covered by the Virtual ward. **Action** - RG and LW to link with Dr Yew to explore if the pathway for community patients requiring an MRI with suspected Osteomyelitis could be cared for under the Virtual Ward. **TOTO Mattress**- DH reported that the Trust is trialling the TOTO turning mattress for 3 6 months' rent free. This is an automated mattress that regular repositions patients over a 24-hour period. Tissue Viability will determine which patients have the greatest need and would benefit from that kind of turning system. **Increased ward referrals** – DH reported that Tissue viability team are receiving upwards of 300 referrals a month many of these are fairly simple and should be managed on the wards. With the volume of referrals and other issue it has been difficult to do training with staff. DH reported that there is a new recruitment in the community and the team have been able to provide more training, organised more link days, development days and DH has created some short videos that will be accessed on Totara. The videos last for a minute to minute and a half and will be on basic wound care, simple dressing techniques and all of these will help with bring the referrals down. Communication for the videos will be going out shortly. DH reported that the PU group meeting will be having a QI overhaul to be more concise DS commended DH on the different measures that have been taken from the bespoke training for wards to the videos. He asked if DH could include the QI reports in his next report for the group. Also, like falls, the Trust can provide DH with the SPC charts so that everyone is looking at the same data. He also asked if the number of referrals received each month could be measured as a way to see how successful the interventions have been. **Action** – DH to measure the number of referrals received each month for the next iteration **Items for Escalation -** MRI pathway	**RG/LW (84)** **DH (85)**
7	**Infection Prevention and Control Committee**	
	Report received from and presented to the group by Amanda Devereux. AD reported that there have been no changes on red risk register for things that currently cannot be changed such as the Air Scrubbers. There has been an increase in the number of CDIFF cases and the Trust is trending above the national rates and trending very high for Nosocomial cases. AD further reported that there are 3 items that she would like to raise at this meeting as follows: • Increase in CDIFF cases • Nosocomial COVID cases • Current Establishment for IPT **<u>Emerging concerns</u>** **CDIFF** - AD reported that CDIFF cases rose in March which can be seen in the SPC chart in the report. Many of the cases were on G8 and whilst the normal action is to decant the ward the Trust were not able to do so immediately on this occasion due to capacity issues but were able to decant 3 days later. The ward was fogged, decluttered and a general clear up. The AMS team provided further adhoc teaching and completed more audits. Since then you can see in the chart that the rates have dropped. The CCG were initially informed of the increase in cases and an IMT meeting was held with a plan to clean and fog the ward. For assurance the following measure have been put in place: • Continued surveillance and reporting • Regular weekly walkabouts with IPC team and microbiologist • Monthly walkabouts with estates • Review of PIR paperwork with CCG – streamlining paperwork is in progress • Visit from Karen Eagan on 20 July • Review of the process for data capture • Introduce ICNET to routine IPC working	

		ACTION
	AD reported that the data capture ICNET will allow the Trust to pick up themes and trends in a timelier manner with more accurate data. AD informed the group that some of the numbers are not quite accurate such as E.coli bacteraemia for example which has been escalated. ND asked if there was any analysis being looked at in terms of antibiotic usage. SiWh confirmed that the Trust has done a lot of work with the antibiotic policies and there have been several changes making sure that the right antibiotic is being used. There will be a component of environment, antibiotic and use of pro-biotic is being changed as well and all of these will help. AD confirmed that there has also been a lot of work completed with the nurses on the wards as well as a QI project and link nurse days providing training on CDIFF and AMS. AMS have an online meeting with nurses around the country to share their experiences and good practices. LW queried that with the some of the assurance visits not taking place due to work constraints if there was another way these could be picked up by the matron team or patient safety team. DS replied that he would support this as on G8 it was an opportunistic intervention where the learning made a significant difference and something that he would like to be considered for all areas, although unsure of how easy it would be to implement, but should be considered in collaboration with the Ops team. AD commented that it is also about the IPCT becoming more visible and one of the ways they have achieved this is by developing a quick sluice audit which puts them on the wards on a regular bases and thereby more visible. **Nosocomial cases –** AD Reported that there has been a review of swabbing, changes to the guidance as well as challenges with capacity. NHS England confirmed that the increase in community prevalence nationally has gone up by circa 50% but in the East of England 30%. However, the Trust is at the top end of the leader board with nosocomial cases. Significant factors for this are: • Lack of ventilation • Lack of doors on bays • Bed spacing in bays • RAAC plank work limiting ward availability AD reported that the Trust is also swabbing more than some other trusts for example Addenbrookes are only swabbing symptomatic patients and on discharge but WSH are swabbing on days 0, 3 and 5. WSH is also swabbing contacts of patients in bays on 8 days plus so will be capturing more cases than other Trusts. King Suite has had 2 outbreaks despite being single rooms and the decision has been made to transfer any positive patients to WSH unless end of life to try to prevent further transmission. Capacity challenges compromises with infection prevention process and what the IPC team would like to do and what they are able to do is very different. **Establishment resource** –A business case has been written and there is a bd 7 secondment in post which will now be advertised as a substantive post. The team currently have no admin but have been supported as much as possible from the governance team with weekly meetings with LW and JK. AD reported that the PIR notification paperwork is currently being reviewed and the Trust is behind with the COVID outbreak national reporting due to lack of resources. ND asked if ICS would be able to help with resources in the interim, they could help look at JDs, help with some admin whilst the Trust is getting people into posts. **Action** – AD and ND to meet to explore admin support from the ICS. **Further news** – AD reported that the issue with the Covid curtains was taken to Corporate Risk Committee (CRC) where it was agreed they should be taken down. The curtains will stored appropriately and the rails will be removed although there will be a cost implication to remove the rigid rails and patients will have to be removed from the bay when they are removed. **Items for Escalation -** There were no items for escalation.	**AD / ND (86)**
8	**ISSUES FOR REFLECTION AND ESCALATION TO IMPROVEMENT GROUP**	
	• IPCC – CDIFF / nosocomial rates • D&T – Ferenjet injections and extravasation policy	

		ACTION
	• PU – MRI Pathway for patients with suspected Osteomyelitis	
9	**ANY OTHER BUSINESS**	
	No other business	
10	**DATE OF NEXT MEETING**	
	Wednesday 20 July 2022 14.00 – 15.30 reports due 13July	

NHS West Suffolk NHS Foundation Trust

Improvement Committee – 11 July 2022

Subject:	Patient safety strategy development and implementation
Presented by:	Lucy Winstanley – Head of Patient Safety & Quality

Background

We designed our Patient safety strategy to **inform staff** what patient safety is, what the **national strategy** is and to introduce what **we are doing locally** as well as where to **find more information**

Update on progress

- Final draft now complete
- Communications team have input into strategy design and linking to trust strategy
- 'Go live' of new trust intranet (where this document will be available) in June
- Strategy implementation plan first draft using trust objectives template and 'what good looks like'

Plans

Strategy will be launched in September as part of WSFT Patient safety month. World patient safety day is on the 17th September. https://www.who.int/world-patient-safety-day-2022

Our Communications team are developing a comms framework to include flyers for wards / departments, all staff briefing by Head of Patient safety & quality, intranet banner and walkabouts.

Patient safety microsite on intranet will have links to patient safety training offerings, relevant source materials, policies and guidelines, learning bulletins and updates on the strategy implementation plan.

Strategy implementation plan will be overseen by a new safety strategy oversight group which consists of the patient safety specialists and other key safety roles across the organisation including (when in post) our patient safety partner(s). This group will report quarterly to the Improvement committee. Note - this is different to our safety improvement group (SIG) which is responsible for taking learning and recommendations from our patient safety investigations and overseeing their implementation journey.

Table 1- Strategy Implementation plan objectives v1

Objective	What good looks like
First for patients	
Patient safety incident response framework (PSIRF)	The organisation understands the importance of overseeing system structures and processes to drive the right behaviours. A Patient safety incident response plan is maintained which uses key sources of insight to prioritise incident responses to maximise future learning. The plan is developed in consultation with key stakeholders. The learning arising is translated into measurable, sustainable and effective improvements.
Being Open and the Duty of candour	There is a culture of openness and a willingness to acknowledge when things go wrong. Patients are provided with a timely and honest apology, kept informed and offered the opportunity for their voice to be included in any review or investigation. Staff are offered guidance and support as the organisation recognises the impact of difficult conversations upon their wellbeing.

Objective	What good looks like
Framework for involving patients in patient safety	Patients are at the centre of their care planning and treatment choices through partnership and structured and informed shared decision making process as described in national publications. Patient safety partners are employed by the organisation with a formal role to support and contribute to a healthcare organisation's governance and management processes for patient safety
National Patient Safety Alerts	The organisation has a structured process to respond swiftly to national safety alerts, can evidence their ongoing compliance and has systems to risk assess and escalate any non-compliance
National Patient Safety Improvement Programmes	The organisation makes best use of the opportunities available through wider systems collaboration on key safety projects
First for staff	
Patient Safety Syllabus	The organisation makes available and maintains oversight of uptake of a programme of safety learning for all staff relevant to their role
Just and Restorative culture	Staff feel supported to raise concerns and report incidents which they have been involved in without fear of reprisal and for their concerns to be taken seriously
Patient safety Intranet microsite	All staff can access an up-to-date maintained microsite providing information and guidance on patient safety including (but not limited to) the following: learning outcomes, improvement opportunities, training offerings, relevant policies and guidelines and contact details for named leads
First for the future	
Patient Safety Specialists	Named safety leads in an organisation participate in a joined up framework of patient safety work programmes with structured lines of reporting to enable assurance, oversight and escalation.
Learning from patient safety events (LfPSE)	The organisation uploads all its patient safety incidents to the national reporting system through a compliant risk management vendor (e.g. Datix) in a timely manner and uses any feedback reports and/or benchmarking data provided to improve patient safety

TRUST STRATEGY

Strategy for Patient Safety 2022-2026

For use in:	
For use by:	
For use for:	
Document owner:	
Status:	

Contents

1. Background

Patient safety is about maximising the things that go right and minimising the things that go wrong in healthcare. It is integral to the NHS' definition of quality in healthcare, alongside effectiveness and patient experience.

"Are they safe?" is one of the five key questions in the CQC assessment framework underpinned by the following key lines of enquiry.

- Safeguarding and protection from abuse
- Managing risks
- Safe care and treatment
- Medicines management
- Track record
- Learning when things go wrong

National context

In July 2019 the NHS issued 'The National Patient Safety Strategy: Safer culture, safer systems, safer patients' with the ambition to achieve its safety vision "to continuously improve patient safety."

To do this the strategy states that the NHS will build on two foundations: a **patient safety culture** and a **patient safety system**.

Three strategic aims support the development of these foundations – insight, involvement and improvement.

Insight – to improve understanding of safety by drawing intelligence from multiple sources of patient safety information

Involvement - equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system

Improvement - designing and supporting programmes that deliver effective and sustainable change in the most important areas

https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy

Local context

West Suffolk NHS Foundation Trust (WSFT) has recently launched its new five-year strategy: 'First for our patients, first for staff and the future'.
The Trust strategy sets out 3 ambitions:

- First for patients
- First for staff
- First for the future

To help realise its vision:

"to deliver the best quality and safety care for our community"

You can read our Trust strategy here: https://www.wsh.nhs.uk/News-room/news-posts/First-for-our-patients-staff-and-the-future-%E2%80%93-launch-of-our-five-year-strategy.aspx

At the very heart of this strategy is using "feedback, learning, research and innovation to improve care and outcomes". Our patients are at the centre of everything we do. The quality of care that we provide to them is our driving force, and we will apply this safety and learning strategy to drive forward continuous improvement.

2. Purpose of this document

This publication provides details of the national strategy and safety initiatives, how these foundations and principles are being and will continue to be developed locally. It will also explain what you can do within your role to be part of this initiative.

This strategy is the WSFT realisation of the national strategy and its local implementation using the principles and tools of continuous improvement. It forms an integral part of our trust strategy.

Setting out our Safety Strategy

We put safety first for patients and staff.

We seek to learn when things go wrong and create a culture of learning and improvement.

Whilst this is a SAFETY strategy, it is based on a 'just culture' approach which ensures FAIRNESS and RESPECT. Staff, patients, carers and families are supported to be involved which requires INCLUSIVITY and an open approach means that TEAMWORK is essential.

It is written for our staff, our patients and their families / carers.

It also helps us to work with our partners, our stakeholders and the wider health economy that we form a part of.

3. National strategy

3.1 Key points of the national strategy

The 'NHS Patient Safety Strategy: Safer culture, safer systems, safer patients' was issued in July 2019 and most recently updated in February 2021

https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/

It sets out how the NHS will achieve its safety vision '*to continuously improve patient safety*' by building on two foundations: a **patient safety culture** and a **patient safety system**. Three strategic aims will support the development of both:

- **Insight** - improving understanding of safety by drawing intelligence from multiple sources of patient safety information
- **Involvement** - equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system
- **Improvement** - designing and supporting programmes that deliver effective and sustainable change in the most important areas.

3.2 National strategy key projects / initiatives

3.2.1 Patient safety specialists

The NHS patient safety strategy committed to establishing "patient safety specialists to lead safety improvement across the system."

Patient safety specialists are the lead patient safety experts in healthcare organisations, working full-time on patient safety. They are the 'captains of the team' and provide dynamic, senior leadership, visibility and expert support to the patient safety work in their organisations. They support the development of a patient safety culture and safety systems, and have sufficient seniority to engage directly with their executive team.

More details can be found here https://www.england.nhs.uk/wp-content/uploads/2020/08/identifying-patient-safety-specialists-v2.pdf

3.2.2 Learn from patient safety events (LFPSE)

In 2023 the LfPSE will replace the current National Reporting and Learning System (NRLS) and Strategic Executive Information System (StEIS) to provide a modernised national electronic system which enables:

- Organisations, staff and patients to record the details of patient safety events, contributing to a national NHS wide data source to support learning and improvement.
- Providers to access data about recorded patient safety events submitted by their teams, in order to better understand their local recording practices and culture, and to support local safety improvement work.

3.2.3 Framework for involving patients in patient safety

The national patient safety strategy also committed to a framework to provide guidance on how the NHS can involve people in their own safety as well as improving patient safety in partnership with staff: maximising the things that go right and minimising the things that go wrong for people receiving healthcare.

Supporting patients to be involved in their own safety and creating the patient safety partner (PSP) role are two important ways to make real what Don Berwick called for when he said that "*patients and their carers should be present, powerful and involved at all levels of healthcare organisations from wards to the boards of trusts*".

PSPs are patients, carers, family members or other lay people who are recruited to work in partnership with staff to influence and improve the governance and leadership of safety within an NHS organisation. As such, they perform a very different role from that of the traditional NHS volunteer who acts as, for example, a hospital guide or befriends and supports patients

3.2.4 Patient safety syllabus

Incident investigation has moved from looking to identify root causes and therefore blame to understanding how systems can better improve and enhance safety. Health Education England (HEE) together with NHS England and NHS Improvement and the Academy of Medical Royal colleges have produced a patient safety syllabus to help us think differently about patient safety. To do this we need to deal with risks before they can cause harm, create a positive safety culture, recognise everyone has a part to play in patient safety and build safer systems.

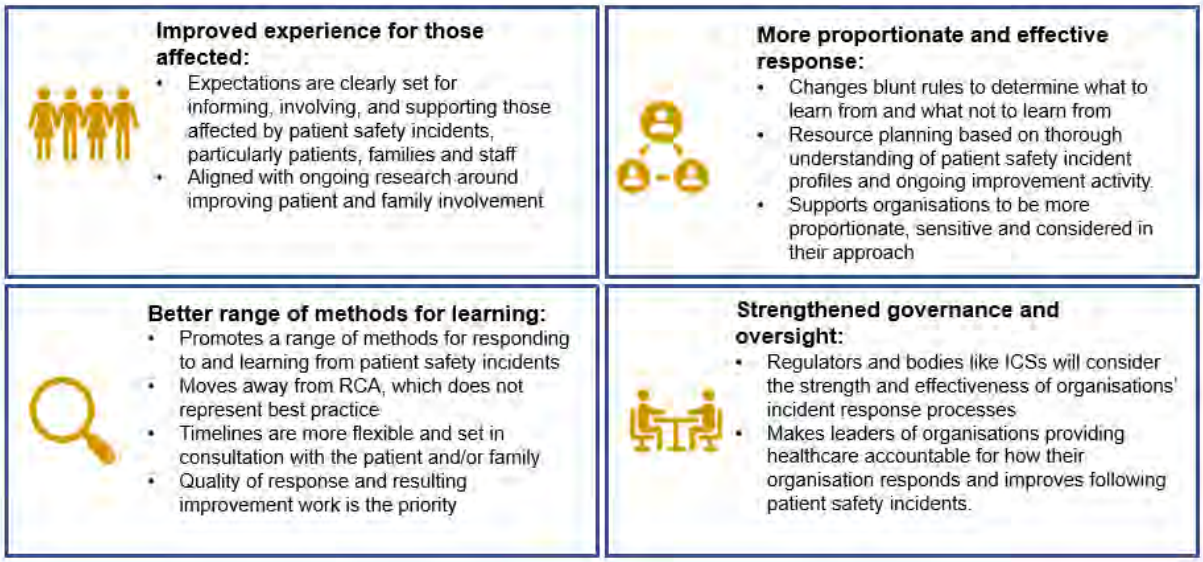
The NHS Patient Safety Syllabus will provide training for all staff at all levels. It will provide training for use directly by staff in the NHS and focus on four key areas:

1. Systems	2. Safety culture
Complex way our jobs fit together to provide what patients need	Attitudes, beliefs and values that influence our work every day.
3. Risk	**4. Raising concerns**
How hazards can threaten the safety of our patients	Listening to patients and observing how they get on in our complex organisations

A link to the syllabus can be found here
https://www.e-lfh.org.uk/programmes/patient-safety-syllabus-training/

3.2.5 Patient Safety Incident Response Framework (PSIRF)

The PSIRF will support the NHS to operate systems, underpinned by behaviours, decisions and actions, that assist learning and improvement. It also allows organisations to examine incidents openly, without fear of inappropriate sanction, supporting those affected with the goal of improving services. It aims to achieve:



3.2.6 National patient safety alerts

New or under-recognised patient safety issues that require national action are identified through clinical review of incidents reported to the national reporting system and other sources. On occasion this will result in the issue of a National Patient Safety Alert that sets out actions which healthcare organisations must take to reduce the risk.

More detail on the pathway followed to decide if a patient safety issue, resources or intervention meet the criteria for an NHS Improvement Patient Safety Alert can be found here:

https://www.england.nhs.uk/wp-content/uploads/2020/08/Alert_decision_flowchart-1.pdf

3.2.7 National patient safety improvement programmes

The national patient safety improvement programmes (SIPs) collectively form the largest safety initiative in the history of the NHS. They support a culture of safety, continuous learning and sustainable improvement across the healthcare system.

SIPs aim to create continuous and sustainable improvement in settings such as maternity units, emergency departments, mental health trusts, GP practices and care homes. SIPs are delivered by local healthcare providers working directly with the national patient safety improvement programmes team and through 15 regionally-based patient safety collaboratives.

The SIPs support continuous and sustainable improvement through:

Promoting positive safety **CULTURE**, encouraging staff to gain insight and share learning from good and poor practice	Supporting **EVIDENCE-BASED**, quality improvement methodology, ensuring change is consistently measured and evaluated
Growing **QUALITY IMPROVEMENT CAPABILITY** in trusts and local healthcare systems so they can continue to improve	Enabling regional and local health systems to identify improvement priorities and share learning to enable **SYSTEM-LEVEL CHANGE**.

A list of the current SIPS can be found here:

https://www.england.nhs.uk/patient-safety/patient-safety-improvement-programmes/

4. Local implementation of national strategy

4.1 Current and future local implementation of national strategy

First for patients; First for staff; First for the future

At West Suffolk NHS Foundation Trust, we are on a journey to maximise the things that go well in healthcare by continuously learning and improving.

As an organisation we support the national patient safety strategy foundations of **insight** (different sources of information), **involvement** (people including staff and patients) and **improvement** (measurable change) and are working to ensure patient safety is considered when things go right, as well as wrong in healthcare. We will do this by driving a safety culture where everyone has a voice to ensure our patients are at the core of everything we do, when the care has been exemplary or not has we had hoped. We will be open and candid with our patients and each other to ensure we are reciprocal to change.

4.1.1 Driving a new approach to patient safety

The Trust took part in the pilot scheme for the patient safety incident response framework (PSIRF). As an early adopter of PSIRF we have been able to assume a new approach to how we respond to and learn from reported patient safety incidents.

This has given us flexibility to be proactive rather than reactive to patient safety incidents. Incidents are still defined by level of harm; but we don't need something serious to happen to undertake an investigation. Using different sources of insight to understand where there may be risk and undertaking comprehensive investigations we seek to understand how we need to change **before** serious harm occurs.

From year one onwards we have the opportunity to make decisions on our local priorities. Future 'patient safety incident response plans' (PSIRPs) will be developed using combined insight from multiple sources including;

- Quarterly analysis of in-year incidents to highlight key risks
- Review of key themes arising from patient experience/ claims / inquests / mortality reviews
- Cross-organisational workshops to seek comment on areas of risk which have been escalated from the divisions
- Pharmacy review of priority medication-based incident types

We will also review the previous year's key risks to ascertain how we can move the identified learning into improvement. We may remove a risk from the PSIRP where robust systems are in place to manage the risk and oversee planned improvements.

4.1.2 Being open and transparent when things don't go as planned

Staff work hard to provide services which are safe and high quality. However, it is a fact that despite this, sometimes things do go wrong and incidents occur. All healthcare professionals have a professional responsibility to be open and honest with patients when things go wrong. This is called 'duty of candour'.

Evidence suggests that openness is welcomed by patients, who are more likely to forgive errors when they are discussed fully in a timely and thoughtful manner and that being open can decrease the trauma felt following an incident.

Being open supports a culture of openness, honesty and transparency, and includes apologising and explaining what happened. Being open is a process rather than a one-off event and is about being open, honest and transparent with patients in a compassionate and respectful way if something goes wrong with their treatment or care that causes or has the potential to cause harm and distress.

At WSFT, we are committed to these principles or openness and honesty and this forms a central pillar of the culture and ethos of our organisation and our approach to patient safety.

4.1.4 Implementing a just and restorative culture

Our people & organisational development report established during 2020-21, is a regular board report which enables the focus on how we support our people, grow our culture and develop leadership at all levels. We aim to support all colleagues to speak up safely as part of a culture focused on staff support, well-being and learning.

We recognise that participating in a patient safety investigation can affect staff emotional and psychological wellbeing. We want to support staff in any way we can. Alongside the existing support mechanisms (line managers, occupational health, staff wellbeing service), we will seek to develop opportunities such as peer support processes and facilitated groups where staff can share their experiences in a safe, supportive space.

4.1.5 Learning from patient safety events

The ‘learn from patient safety events’ (LFPSE) is a centralised system for the recording and analysis of patient safety events in health and care, launched by NHS England and NHS Improvement in July 2021. This service will replace the current National Reporting and Learning System (NRLS) offering better support for staff from all health and care sectors to record safety events, and providing greater insight and analysis to aid national and local safety improvement.

Currently WSFT reports incidents to the NRLS via our Datix incident system. The requirement to report incidents **will not change** but the method for doing so ,and the details of how to report, may change in future. Staff will be kept up-to-date with any changes and there will be opportunities for involvement in any future reporting system redesign.

4.1.6 Involving patients in patient safety

There are two parts to this framework.

- The first, is to involve patients in their own safety.

  We can do this by asking patients directly if they have questions about their care and by ensuring that we give clear information in an accessible format.

  We can encourage patients and their families or carers to raise concerns about symptoms.

  They know best what is normal for them and can often pick up subtle signs of physiological deterioration before staff or monitoring systems.

- The second is the recruitment of two patient safety partners by September 2022.

  This is different to a hospital volunteer, or a member of staff as they will join the Trust on the basis of an agreement regarding mutual expectations, rather than a signed contract of employment. This role is new for the whole NHS and will be reviewed regularly at both local and national level.

  There will be a role description, recruitment process, appropriate training and support via a clear line management structure.

  The role will initially involve joining selected safety related committees where the perspective they bring would be particularly valuable.

4.1.7 Developing our own patient safety training programme

At WSFT we plan to develop our own patient safety training programme which complements the patient safety syllabus and considers how systems work; looks at what is a just culture; how human factors are integral to safety; and how we can use systems based investigation to understand where we need to direct change.

The roll out of the national patient safety syllabus will add a central patient safety education resource to support all members of our organisation to understand the principles of patient safety and enable them to become involved and contribute to improvements in patient safety. This will be covered in more detail on our patient safety intranet microsite

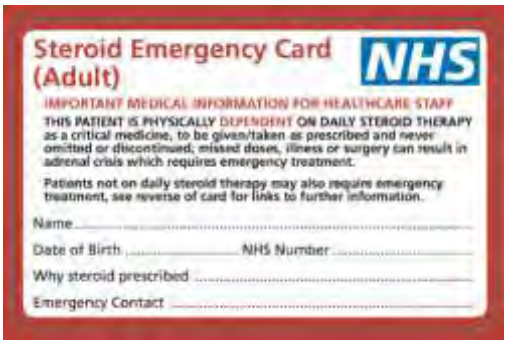
4.1.8 Using national patient safety systems

Incidents can happen when there are not strong systems in place to reduce the risk. When we report our incidents on Datix they feed into a country-wide system which drives the national development of solutions to common incident events.

Case study: Steroid emergency card to support early recognition and treatment of adrenal crisis in adults

"Delay in assessment and management of patient with Addisonian crisis: Presented to A/E on GP advice with history that should have raised concerns for Addisonian crisis - self-discharged as not seen for several hours. Re-presented 3 days later on GP advice as U+E / BP consistent with Addisonian crisis."

"Patient admitted, on long term steroids. Developed urosepsis so dose doubled. Patient has been refusing medications (oral) for last 5 days including oral prednisolone dose. At risk of Addisonian crisis but prednisolone dose not reviewed or converted to S/C dexamethasone for 5 days."


Steroid Emergency Card (Adult)

NHS

IMPORTANT MEDICAL INFORMATION FOR HEALTHCARE STAFF

THIS PATIENT IS PHYSICALLY DEPENDENT ON DAILY STEROID THERAPY as a critical medicine, to be given/taken as prescribed and never omitted or discontinued; missed doses, illness or surgery can result in adrenal crisis which requires emergency treatment.

Patients not on daily steroid therapy may also require emergency treatment, see reverse of card for links to further information.

Name .....

Date of Birth ..... NHS Number .....

Why steroid prescribed .....

Emergency Contact .....

"Asked by nursing staff to review patient who was drowsy and hypotensive. This lady is a long-term steroid user and daughter had asked nurse why steroids had been withheld. On review of drug chart, oral prednisolone was stopped prior to synacthen test. This had not been reinstated after the morning blood tests"

"Renal transplant admitted via ED under orthopaedics with fractured femur. Steroids omitted whilst patient acutely unwell and having surgery - risk of Addisonian crisis. (Note steroids given intraoperatively therefore risk recognised by anaesthetic staff)"

4.1.9 Participating in national patient safety improvement programmes (SIPs)

There are five national SIPS:

- Managing Deterioration Safety Improvement Programme (ManDetSIP)
- Maternity and Neonatal Safety Improvement Programme (MatNeoSIP)
- Medicines Safety Improvement Programme (MedSIP)
- Adoption and Spread Safety Improvement Programme (A&S-SIP)
- Mental Health Safety Improvement Programme (MH-SIP)

Exploring to opportunities to participate in our local patient safety collaboratives will form part of our patient safety strategy implementation plan.

4.1.10 Setting and tracking our own local patient safety priorities

As part of PSIRF we develop a patient safety incident response plan (PSIRP) which details our top risks on which we will undertake a patient safety incident investigation, led by one of our patient safety investigators.

Our PSIRP includes national priorities for investigation and also details the other investigation methods we will undertake for other harms, such as falls and pressure ulcers, and externally reportable pathways including those in maternity.

The national patient safety specialist action plan is translated into locally managed priority projects supported by our patient safety specialists and informed by national workshops and patient safety forums.

In addition to these nationally led projects, our PSIRP identifies our top risks for investigation with examples such as discharge planning, medicines management and deteriorating patients. [see link to PSIRP on intranet]. The learning from these reviews provide the basis for our safety improvement programmes both locally and organisation wide.

<table>
<tr>
<td>The Trust uses ‘LiveQI’ as a project management system which can help manage and track patient safety improvement projects. Further information and support is available from QI@wsh.nhs.uk</td>
<td> 
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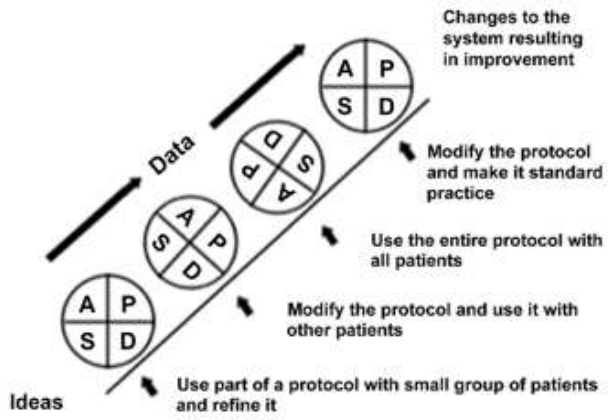
<tr>
<td> 
</td>
<td>Using a ‘Plan Do Study Act’ method small improvement ideas can be adapted, scaled up and communicated to enable system improvements and shared learning.

Examples of projects can be found on the QI microsite on our WSFT intranet</td>
</tr>
</table>

Case study: Quality improvement project showing the move from safety learning into safety improvement

Patient X originally independent on insulin became more frail and admitted to hospital. Whilst an inpatient hospital staff did insulin for him so he lost his independence.

Community district nursing (DN) support was required for patient on discharge.

Increasing number of patients on caseload means less time for each patient, and therefore higher risk of readmissions.

QI project idea - to review diabetics on caseload using a multi-disciplinary team approach which includes GP, district nurses and acute specialist diabetes team.

This should improve quality of care & safety of patients on diabetic caseload and enable independence for patients to take care of their own health needs with family support.

Outcomes - Patient X took 6 months of coaching and teaching to become independent to do own injections. Phone call follow ups from DN. Wife can call if need any help but so far not needed any additional support.

Before review took place had caseload (over last 12 months) of 16 patients now reduced to 8 patients.

Getting to know patients better and have more of a holistic approach & better quality wrap around care, and outcomes for patients & nursing teams. These reviews enabled relevant coaching to support patients and onward monitoring and in-turn reducing number of complications associated patients with diabetes.

More information on this QI project available from the LiveQI system and the community matrons

5. Further information

5.1 Growing our team to drive patient safety improvement

Everyone has a responsibility for patient safety in their role and support and guidance is available through policies, training and our patient safety microsite.

Our executive director lead for patient safety is the executive chief nurse (ECN). The ECN works in collaboration with the wider executive team to ensure a system based approach to clinical risk management and patient safety.

Our patient safety specialists are the associate medical director of patient safety, head of patient safety & quality, clinical quality & governance matron (maternity) and our patient safety incident investigators.

The central patient safety team is made up of incident investigators, divisional patient safety managers, our falls lead, our inquest manager and our administrators. The central team works closely with our divisional leads, wider safety and quality partners and clinical leads who are specialists in safety fields such as the medication safety officer, head of deteriorating patient, medical devices safety officer and other key leads.

5.2 Our intranet site

With the launch of a new refreshed intranet; an expanding range of patient safety resources will be available. We will develop this as a project as part of the strategy implementation.

5.3 What we can all do for patient safety

Everyone has a responsibility to deliver high quality and safe care to the best of their ability. On the occasion when this is not possible we need to understand why. You can help improve patient safety by reporting incidents, understanding risks in your environment, being open and candid with your patients and your colleagues, raising concerns, and helping shape improvement in your own area to help drive change.

Quality improvement priorities for 2022-23

Our quality priorities are driven by our strategy and set out key improvements we aim to deliver the measures that we will use to understand progress and success. These measures are open further review and development as we progress delivery.

Delivering our strategy

- Use feedback, learning, research and innovation to improve our care and outcomes
- Collaborate to provide seamless, accessible care at the right time and in the right place

Priorities for quality improvement

- Improve care and outcomes for patients through:
  - Effective response to new and emerging guidance
  - Evidence shared learning from incidents to reduce patient harm
- Ensure patients and families experiences are captured and listened to in order to help us to improve through delivery of our experience of care strategy

Measuring our progress and providing assurance

Safe and high quality care

- Deliver improvements through our patient safety incident response framework (PSIRF)
- Deliver improvements as measured by the CQUIN indicators for 2022-23
- Through shared learning deliver improvements to reduce patient harm
- Effectively respond to national reports to support quality improvements
- Develop our quality assurance framework to support systematic quality improvement
- % of patients recommending WSFT as a place receive care
- % of staff recommending WSFT as a place to receive care

Experience of care

- Deliver improvements through the experience of care strategy
- Celebrate good practice and share learning for experience improvements
- Ensure equality of access and the use of the accessible information standard (AIS) to improve the experience for all service users
- Provide opportunities for patients, carers and families to give feedback in a variety of accessible ways, and ensure this is listened to and acted upon
- Improve opportunities for patients to become involved with decisions affecting care, services and developments across WSFT
- % of patients recommending WSFT as a place to receive care

4.6.1 - Maternity services quality and performance board report - Supporting annexes

Report Title	**Report for compliance with Saving Babies Lives - Element 4 Effective Fetal Monitoring in Labour**
Report for	Approval and Information
Report from	Maternity Services
Lead for Safety Action	Emma Butcher, Fetal Monitoring Lead Midwife Jac Reeves, Fetal Monitoring Lead Consultant Obstetrician
Report Authors	Emma Butcher, Fetal Monitoring Lead Midwife Beverley Gordon, Project Midwife In collaboration with the Maternity Training faculty and administrative support and Quality, Risk and Governance Team
Report presented for information and approval	Maternity Quality and Safety Group – 20th June 2022
	Maternity and Neonatal Safety Champions – 23rd June 2022
	Trust Board – 22nd July 2022
Date of Report	May 2022
Risk and assurance:	There are no financial or healthcare risks associated with this report which outlines the Trust's position against National reporting frameworks for the review of Perinatal losses. The details contained within this may contain sensitive information regarding aspects of care with regard to perinatal losses within the Trust which may cause concern for the Trust and individuals involved in that care. Assurance is given that these details have been shared with individual mothers and families as part of our duty of candour and with staff as part of individual and team learning.
Legislation, regulatory, equality, diversity and dignity implications	The information contained within this report has been obtained from the use of regulated National and local reporting platforms. There are no equality and diversity issues related to this report and confidentiality has been maintained by removing patient identifiable information from the report.

Executive summary:

The report outlines the details of the Trust's Maternity Services compliance with the Saving Babies Lives element 4 Effective Fetal Monitoring in labour and thereby compliance with the year 4 Maternity Incentive Scheme Safety Action 6 and Safety Action 8 in respect of fetal monitoring training.

Intervention 1: The Trust has two methods for fetal monitoring training and does not yet consistently meet the 90% target in all staff groups. A plan is in place to improve individual compliance. Training programmes will be changing from 2023.

Intervention 2: The compliance with risk assessment for fetal monitoring in labour demonstrates that this is embedded in practice.

Intervention 3: The documentation of fetal heart reviews in labour - fresh ears and fresh eyes – has poor compliance in some aspects, particularly in the first stage of labour. However, escalation of concerns and 2-person reviews in the second stage, has high compliance. Documentation issues are to be addressed with individuals to identify how improvements can be made.

Intervention 4: The obstetric lead for fetal monitoring has had limited opportunities to undertake the role fully and it is not possible to demonstrate this in the roster. With changing personnel expected in August 2022, and appointment of consultants, it is planned to enhance this role and, with the midwife lead, to have more involvement in cases where there has been an adverse outcome and fetal monitoring may have been a factor. There is evidence of learning being shared through the local risk and governance newsletter. Sharing of learning locally and with the LMNS and completion of actions will be further enhanced and embedded. The two cases that have had an adverse outcome in the last year have not identified any issues with the fetal monitoring part of the care.

Actions have been put in place to address training compliance, programmes for training and improved documentation moving forward. These will be monitored and reported as part of the quality and governance agenda.

Recommendation:
This report is submitted for review and approval at the Maternity & Gynaecology Quality and Safety Group and then the Maternity and Neonatal Safety Champions Group and presented for information to the Divisional Board. Following this, the report will be presented at the Trust Board meeting and the Local Maternity and Neonatal Service (LMNS) Board.

The Trust board is asked to receive this report as evidence of progress being made towards embedding Saving Babies Lives element 4 Effective Fetal Monitoring.

1. Introduction

The importance of working and training together as a multidisciplinary team (MDT) has never been more important. In this report, we outline the progress made by the Maternity Services to address competency and confidence in effectively monitoring fetal wellbeing in pregnancy and labour. This report provides evidence with the specific morning aspects of the Saving Babies Lives Care Bundle v2 Element 4 Effective fetal Monitoring during labour.

2. Standards to be met – Saving Babies Lives Care Bundle v2 (2019)

Element 4. Effective fetal monitoring during labour

Interventions

4.1 All staff who care for women in labour are required to undertake annual training and competency assessment on cardiotocograph (CTG) interpretation and use of auscultation. Training should be multidisciplinary and include training in situational awareness and human factors. The training and competency assessment should be agreed with local commissioners (CCG) based on the advice of the Clinical Network. No member of staff should care for women in a birth setting without evidence of training and competence within the last year.

4.2 There is a system agreed with local commissioners (CCG) based on the advice of the Clinical Network to assess risk at the onset of labour which complies with NICE guidance47, irrespective of place of birth. The assessment should be used to determine the most appropriate fetal monitoring method.

4.3 Regular (at least hourly) review of fetal wellbeing to include: CTG (or intermittent auscultation (IA)), reassessment of fetal risk factors, use of a Buddy system to help provide objective review for example 'Fresh Eyes', a clear guideline for escalation if concerns are raised through the use of a structured process. All staff to be trained in the review system and escalation protocol.

4.4 Identify a Fetal Monitoring Lead for a minimum of 0.4 WTE per consultant led unit during which time their responsibility is to improve the standard of intrapartum risk assessment and fetal monitoring.

Continuous Learning

4.5 Maternity care providers must examine their outcomes in relation to the interventions, trends and themes within their own incidents where fetal monitoring was likely to have been a contributory factor.

4.6 Individual Trusts must examine their outcomes in relation to similar Trusts to understand variation and inform potential improvements.

4.7 Maternity providers are encouraged to focus improvement in the following areas: a. Risk assessment of the mother/fetus at the beginning and during labour. b. Interpretation and escalation of concerns over fetal wellbeing in labour.

Process Indicators

i. Percentage of staff who have received training on CTG interpretation and auscultation, human factors and situational awareness

ii. Percentage of staff who have successfully completed mandatory annual competency assessment

Outcome Indicators

i. The percentage of intrapartum stillbirths, early neonatal deaths and cases of severe brain injury* where failures of intrapartum monitoring are identified as a contributory factor.

*Using the severe brain injury definition as used in Gale et al. 2018

Implementation

Trusts must be able to demonstrate that all qualified staff who care for women in labour are competent to interpret CTG, use the Buddy system at all times and escalate accordingly when concerns arise or risks develop. This includes staff that are brought in to support a busy service from other clinical areas such as the postnatal ward and the community, as well as locum, agency or bank staff (medical or midwifery).

Intervention 1: Owing to a lack of formal assessment it is not possible to be prescriptive about the exact nature of either training packages or indeed competency assessment. However, training packages should adhere to the following principles:

• Include multidisciplinary and scenario-based training – this should involve all medical and midwifery staff who care for women in birth settings.
• Teaching about fetal physiological responses to hypoxaemia, the pathophysiology of fetal brain injury, and the physiology underlying changes in fetal heart rate (FHR). In addition, the impact of factors such as fetal growth restriction and maternal pyrexia.
• Effective fetal monitoring in low risk pregnancies, including the role of IA in initial assessment, in established labour and indications for changing from IA to CTG.
• Interpretation of CTG including:
  - normal CTG o impact of intrapartum fetal hypoxia on the FHR
  - Significance of abnormal CTG patterns o interpretation in specific clinical circumstances (such as previous caesarean sections, breech and multiple pregnancy).
• Interventions that can affect the FHR (such as medication) and those that are intended to improve the FHR (such as oxygen).
• Additional tests of fetal wellbeing that help clarify fetal status and reduce the false positive rate of CTG.
• Channels of communication to follow in response to a suspicious or pathological trace, risk management strategies including governance and audit.
• Application of NICE fetal monitoring recommendations for low risk women. Trust uses FIGO guidelines which replicate NICE guidance for low risk intrapartum care.
• Training in situational awareness and human factors to enable staff to respond appropriately to evolving, complex situations.
• Provision of adequate training is a Trust priority – as a minimum all staff should receive a full day of multidisciplinary training (following the principles outlined above) each year with reinforcement from regular attendance at fetal monitoring review events. Competency assessment: all staff will have to pass a formal annual competency assessment that has been agreed by the local commissioner (CCG) based on the advice of the Clinical Network. The assessment should include demonstrating a clear understanding of the areas covered in training (see principles above), for example, fetal physiology, recognition of abnormal CTGs and use of IA and situational awareness. Trusts should agree a procedure with their CCG for how to manage staff who fail this assessment.

The Year 4 requirements for MIS include having a planned annual training day which will include
Fetal monitoring and surveillance (in the antenatal and intrapartum period)

Maternity Obstetric Emergencies
Neonatal life support

Fetal monitoring and surveillance (in the antenatal and intrapartum period)
Should be consistent with the Ockenden Report (2021) recommendations, and include as a minimum:

- Risk assessment
- Intermittent auscultation
- Electronic fetal monitoring
- System level issues e.g. human factors, classification, escalation and situational awareness
- Use of local case histories
- Using their local CTG machines

More than 90% of each of the relevant staff groups who provide intrapartum care should attend the annual training session and be assessed as competent.

Local Response to Intervention 1

a) Training and Education Sessions

Midwives and doctors should attend 4 hours of training and education sessions either face to face or on Teams, per year. Two 30-minute sessions are facilitated by the obstetric and midwifery leads each week. These sessions have been in place since September 2020. It is recommended that staff need to attend at least one hour per quarter but some staff, due to leave and rotas will do more in some months than others so the compliance will be worked out over the whole year with a sense check every quarter. Some staff will have joined and some will have left within each period so it is important that this is taken into consideration.
Student midwives and student doctors also attend the training sessions but are not included in the compliance reports.

b) K2 online training and assessment

In addition, all midwives and obstetricians providing intrapartum care must complete the K2 modules and assessment programmes each year. Staff providing intrapartum care need to complete all of the intrapartum modules and pass the assessment module.

Intervention 2: The MBRRACE-UK Perinatal Confidential Enquiry report recommended the national development of a standardised risk assessment tool. As this has not yet been developed the procedure should comply with NICE guidance. A case example based upon NICE guidance has been provided in Appendix E, however further assessment tools may be developed in the future.

Local Response to Intervention 2

All women in labour will have a risk assessment at the start of labour to determine the type of fetal monitoring that is required from the start of labour. The risk assessment is completed electronically on E-care and will be updated and the method of monitoring reviewed at each hourly assessment – either fresh eyes or fresh ears.

Intervention 3: The principle underlying this intervention is that fetal wellbeing is assessed regularly (at least hourly) during labour through discussion between the midwife caring for the fetus and another midwife or doctor. This discussion should be documented using a structured proforma. This review should be more than a categorisation of the CTG (or IA). The discussion should include evaluation of the FHR (CTG or IA), review of risk factors such as persistently reduced fetal movements before labour, fetal growth restriction, previous caesarean section, thick meconium, suspected infection, vaginal bleeding or prolonged labour and should lead to escalation if indicated. Introduce a Buddy system to pair up more and less experienced

midwives during shifts to maximise continuity of care and provide accessible senior advice and fresh eyes, with protocol for escalation of any concerns.

Local Response to Intervention 3

If intermittent auscultation is the chosen and correct method of monitoring fetal wellbeing in labour, a fresh ears assessment will be undertaken every hour. If electronic fetal monitoring is indicated, an hourly fresh eyes assessment is undertaken. Fresh Ears and Fresh Eyes are conducted hourly in the first stage of labour and every 30 minutes during the second stage of labour. Fresh Eyes and Fresh Ears can be completed by a Core Band 6 Midwife, Labour Suite Coordinator, Maternity Bleep Holder or Obstetrician. Concerns are escalated to the Labour Suite Coordinator or Obstetrician. Difference of opinions are discussed and a third person's opinion is sought.
There is also a central monitoring system which allows for independent review of electronic fetal monitoring recordings at a distance and provide additional support to best practice.

Intervention 4: Some Trusts may choose to extend the remit of the Practice Development Midwife to fulfil the role of Fetal Monitoring Lead, whereas others may wish to appoint a separate clinician. The critical principle is that the Fetal Monitoring Lead has dedicated time when their remit is to support staff working on the labour ward to provide high quality intrapartum risk assessments and accurate CTG interpretation. The role should contribute to building and sustaining a safety culture on the labour ward with all staff committed to continuous improvement.

Local Response to Intervention 4

Obstetric and midwifery leads are in place fulfilling the lead fetal monitoring roles. The Midwife is allocated 15 hours per week and the consultant is allocated 2 hours per week.
Job descriptions are available for both roles.

Monitoring

A. Percentage of staff who have received training on intrapartum fetal monitoring in line with the requirements of Safety Action eight, including: intermittent auscultation, electronic fetal monitoring, human factors and situational awareness.

B. Percentage of staff who have successfully completed mandatory annual competency assessment.

Note: An in-house audit should have been undertaken to assess compliance with these indicators. Each of the following groups should be attending the training: The compliance required is the same as safety action eight i.e. 90% of maternity staff which includes 90% of each of the following groups:

- 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 theatre midwives who also work outside of theatres.

The Trust to identify any shortfall in reaching the 90% threshold and commit to addressing this as soon as possible.
Trust Board should minute in their meeting records a written commitment to facilitate local, in-person, fetal monitoring training when this is permitted.

WSH Guidelines:
Antenatal Observations
Fetal Monitoring
Maternity Training and Education
Reduced Fetal Movements
Risk Assessment in Labour

3. Results

The results on compliance with each intervention are recorded below:

Intervention 1 Fetal Monitoring Training

a) Training and Education Sessions

Professional Group	% Attendance May to July 2021	% Attendance August to October 2021	% Attendance November 2021 – January 2022	% Attendance February to April 2022
All Midwives	43%	28%	38%	57%
Obstetric Consultants	73%	53%	33%	33%
Obstetric Registrars and other obstetric trainees	22%	100%	66%	55%

b) K2 online training and assessment

In addition, all midwives and obstetricians providing intrapartum care must complete the K2 modules and assessment programmes each year. Staff providing intrapartum care need to complete all of the intrapartum modules and pass the assessment module.

Professional Group	% Compliance for IP and assessment modules February 2022	% Compliance for IP and assessment modules March 2022	% Compliance for IP and assessment modules April 2022	
All Midwives	86.1%	90.6%	82%	
Obstetric Consultants & Obstetric trainees	81%	76.2%	90%	

Intervention 2 Risk Assessment

	Week 1	Week 2	Week 3	Week 4
Feb 2022 MLBU	**80%**	**100%**	**100%**	**100%**
LS	**100%**	**80%**	**100%**	**100%**
Mar 2022 MLBU	**100%**	**100%**	**100%**	**80%**
LS	**100%**	**100%**	**80%**	**80%**
Apr 2022 MLBU	**100%**	**100%**	**100%**	**100%**
LS	**100%**	**100%**	**100%**	**100%**

This demonstrates a high standard of intrapartum risk assessment within the Trust.

Intervention 3 Compliance with Fresh Ears and Fresh Eyes structured reviews in labour

February 2022					
No.	**Standard**	**Target**	**Findings**	**Comments**	
1.	Fresh ears performed every hour by two registered professionals in the first stage of labour.	100%	3/5	60%	
2.	Fresh ears performed every 30 mins by two registered professionals in the second stage of labour.	100%	3/4	75%	
3.	Escalated if concerned with IA	100%	3/4	75%	
4.	Fresh eyes review completed every hour by two registered professionals in the first stage of labour.	100%	11/11	100%	
5.	Fresh eyes review completed every 30 mins by two registered professionals in the second stage of labour.	100%	4/4	100%	
6.	Concerns escalated if appropriate.	100%	7/7	100%	
7.	Hourly classification stickers applied & completed in full.	80%	8/11	72%	
8.	Intrapartum care review completed hourly in the first stage of labour	100%	10/11	90%	
9.	Intrapartum care review completed every 30 mins in the second stage of labour	100%	4/4	100%	
10.	Any concerns with fresh care elements escalated for review	100%	6/6	100%	

March 2022					
No.	**Standard**	**Target**	**Findings**	**Comments**	
1.	Fresh ears performed every hour by two registered professionals in the first stage of labour.	100%	3/3	100%	
2.	Fresh ears performed every 30 mins by two registered professionals in the second stage of labour.	100%	2/2	100%	Very difficult to find notes to audit criteria
3.	Escalated if concerned with IA	100%	3/3	100%	
4.	Fresh eyes review completed every hour by two registered professionals in the first stage of labour.	100%	13/17	76%	
5.	Fresh eyes review completed every 30 mins by two registered professionals in the second stage of labour.	100%	10/13	76%	
6.	Concerns escalated if appropriate.	100%	13/15	86%	
7.	Hourly classification stickers applied & completed in full.	80%	10/16	62%	
8.	Intrapartum care review completed hourly in the first stage of labour	100%	13/16	81%	
9.	Intrapartum care review completed every 30 mins in the second stage of labour	100%	11/14	78%	
10.	Any concerns with fresh care elements escalated for review	100%	14/14	100%	

April 2022					
No.	**Standard**	**Target**	**Findings**	**Comments**	
1.	Fresh ears performed every hour by two registered professionals in the first stage of labour.	100%	7/8	87%	
2.	Fresh ears performed every 30 mins by two registered professionals in the second stage of labour.	100%	7/8	87%	
3.	Escalated if concerned with IA	100%	8/8	100%	
4.	Fresh eyes review completed every hour by two registered professionals in the first stage of labour.	100%	10/12	83%	
5.	Fresh eyes review completed every 30 mins by two registered professionals in the second stage of labour.	100%	6/9	66%	
6.	Concerns escalated if appropriate.	100%	12/12	100%	
7.	Hourly classification stickers applied & completed in full.	80%	8/12	66%	

8.	Intrapartum care review completed hourly in the first stage of labour	100%	10/12	83%	
9.	Intrapartum care review completed every 30 mins in the second stage of labour	100%	6/9	66%	
10.	Any concerns with fresh care elements escalated for review	100%	8/8	100%	

These demonstrate variable results in some aspects of reviews being undertaken. Some issues relate to documentation completion and this should be addressed with individuals. The positive aspect of these results is that concerns are escalated appropriately.

Intervention 4 Fetal Monitoring Leads

The fetal monitoring lead midwife has been a specified role since July 2020 and has 15 hours allocated to this. These are indicated as 'management' days on the roster. The job description was updated and approved 2021. The post holder has changed in February 2022 and additional responsibilities have resulted in an increased emphasis on fetal monitoring at MDT meetings.
The fetal monitoring lead consultant has been in place since January 2021 but the sessions have not been allocated as a PA until April 2021. Two hours per week are allocated to the role. The work undertaken in this role is not currently specified on the roster but is indicated as attendance at the training sessions. The job description has been approved.

Process Indicators

For the period between May 2021-May 2022 there have been 2 incidences of adverse outcomes where fetal monitoring may have been considered as a contributory factor. In these cases, both babies received therapeutic cooling at a tertiary unit. Both cases were reported to HSIB for investigation.

There were no recommendations from HSIB regarding fetal monitoring in the first case. The Trust is awaiting a response from HSIB as to whether the second case will be subject to their investigation. This case involved a shoulder dystocia which may have been a contributory factor to the poor condition at birth and it would be difficult to ascertain whether the shoulder dystocia or concerns with fetal monitoring caused the outcome. The initial investigation by the Trust did not raise concerns with fetal monitoring and no learning around fetal monitoring was identified.

In another case, appropriate risk assessment was used and there no concerns with fetal monitoring in the intrapartum period. However, the baby was born in poor condition and required resuscitation and subsequent therapeutic cooling at a tertiary unit. The cause of this outcome is not clear but fetal monitoring was not considered as a contributory factor. The baby had no significant hypoxic ischaemic encephalopathy as a result.

This report has highlighted the use of appropriate risk assessment.

Moving forward the fetal monitoring consultant and midwife will be involved in the initial review when adverse outcomes occur and fetal monitoring may have contributed to the outcome.

4. Conclusions

Intervention 1: The Trust has 2 elements to fetal monitoring training. K2 is an online platform covering physiological responses to hypoxia, the pathophysiology of fetal brain injury, the physiology underlying changes with the fetal heart rate, effective fetal monitoring in low risk pregnancies and CTG interpretation. This also includes competency assessments. In January 2023 the Trust will be replacing K2 with annual face to face training for fetal monitoring. This will run alongside obstetric emergencies and neonatal resuscitation and will include competency assessments with all elements of fetal monitoring and the use of local equipment. Local CTG Case Reviews occur twice weekly and include situational awareness and human factors. They provide further teaching on fetal physiology, risk assessment, multidisciplinary working and further channels of communication to follow in response to changes or concerns with fetal monitoring.
The training provided by the Trust is compliant with recommendations from the Ockenden Report (2021).

Intervention 2: The Trust demonstrates compliance with intrapartum risk assessments and has a system in place to ensure this is reviewed on admission and then hourly in the first stage of labour and every 30 minutes in the second stage of labour. Compliance for intrapartum risk assessment is monitored and reported on a weekly basis via Tendable®, a platform used by the Trust to ensure safety standards are met across the Trust.

Intervention 3: The Trust has a system in place for fetal monitoring care reviews. Intrapartum fetal monitoring is reviewed by another professional hourly in the first stage of labour and every 30 minutes in the second stage of labour. Compliance is audited on a monthly basis and a rolling action plan is in place to improve compliance. Audit findings are included on the Quality Dashboard and presented at the Quality and Safety Meeting. Findings are also discussed fortnightly with the Maternity Improvement Board.

Intervention 4: The Trust has an appointed fetal monitoring midwife and consultant. The fetal monitoring lead midwife attends handovers on Labour Suite which provides an opportunity to update staff on current and changing practices within fetal monitoring. They can be used for fresh eyes and fresh ears which facilitates learning and discussion and raises the profile of effective fetal monitoring in labour.

Content:

The content of the training sessions meets the requirements and the output from the training sessions are shared in monthly newsletters from the meetings and the Maternity Risky Business Newsletters.

Attendance:

Attendance at the training and education sessions has fallen short of the 90% target for all professionals involved in intrapartum care. It is felt this has been due to staffing levels and impact of Covid 19. Moving forward the Trust is actively recruiting midwives including recruitment from overseas. Compliance for all Mandatory Training is discussed at staff appraisals and staff compliant with all elements of mandatory training are paid an additional 12 hours.

Leads:

Due to there being limited time since the PA was put in place for the lead consultant, it has not been possible to demonstrate the overall input into the fetal monitoring training sessions on the rosters at this current time.

Individual cases of perinatal mortality and morbidity have an immediate case review and urgent actions are addressed. Information is shared with the staff through 'Take Five' communications and Risky Business Newsletters.
External review is to be implemented for all serious incidents where HSIB are not involved. Reports from PMRT and HSIB have actions in place to address issues arising that relate to fetal monitoring and these are monitored through the Maternity Risk and Governance staff in order that assurance of improvement can be demonstrated.

5. Monitoring of compliance

Training compliance is recorded on the Maternity Quality Dashboard each month. The Leads for fetal monitoring are identifying staff who are not completing the required attendance at sessions and completion of the K2 modules and escalating these to the line managers of the staff members to facilitate an improvement in performance.
Training compliance is discussed as part of the Head of Midwifery Quality and Performance Board report and as part of the reporting to the LMNS on a quarterly basis.

6. Recommendations

Once the Fetal Monitoring Obstetric Lead is in place in August 2022, there will be a change to the timings of the Fetal Monitoring Case Review Meetings to accommodate the obstetric team commitments within the Trust.

The Trust aims to liaise with other Trusts within the LMNS to share learning from Fetal Monitoring Case Reviews.

The Trust requires a formal process to involve the Fetal Monitoring Lead Obstetrician and Midwife in cases where fetal monitoring has been identified as a contributory factor in adverse outcomes. Their input would be included in the formal report and enable learning within the Trust.

The maternity department has a new robust system in place to identify and address issues with staff who are non-compliant with fetal monitoring training – see below.

West Suffolk NHS
NHS Foundation Trust

Mandatory e-learning Training

Process for staff who are non-compliant

Email from PDM team informing staff member that they are out of date with their mandatory training. 3-week deadline set.

Line manager for the individual will be copied into this email.

↓

If the individual has not completed the required training by the 3-week deadline (PDM team to update line manager), the line manager must set a date and time to hold a meeting within 7 days to discuss expectations and requirements of employment. To establish any barriers and support required

↓

Meet with the individual and provide a further 1-week deadline for completion and inform them the next process will be escalation to appropriate matron for a formal discussion

↓

If the individual remains non-compliant by the defined time frame set by their line manager, their matron will be informed and a letter must to be sent from the relevant matron inviting the individual for a formal meeting to discuss non-compliance. This must include the formal process that now needs to take place.

Should completion take place prior to this meeting then no further action will be required

7. Actions required

ACTION	LEAD	DATE FOR COMPLETION	EVIDENCE OF COMPLETION
Formalise Fetal Monitoring Case Review Meetings to accommodate the obstetric team commitments within the Trust.	Obstetric Clinical Lead	30/9/22	Programme for learning events in place
LMNS shared learning events for Fetal Monitoring Case Reviews.	LMNS/|FM leads	30/9/22	Programme of LMNS learning events
Incident Management processes to include Fetal Monitoring Lead Obstetrician and Midwife in cases where fetal monitoring has been identified as a contributory factor in adverse outcomes. Report to include how immediate learning is shared	Quality, Governance Leads with FM leads	30/9/22	Process embedded
Improve compliance with training requirements	Clinical leads and Midwifery Matrons	Monitored monthly – aim to review 30/9/22 with progress	Improved compliance
Plan training programme for 2023/2024	Training leads	31/10/22	Training programme agreed and in place

Classification: Official

Publication approval reference: PAR807

Item 4.6.1 Annex C - Wsftmaternity-Self-Assessment-Tool-V6
June 22 (002)

Maternity services system learning
Maternity self-assessment tool

Version 6, 19 July 2021

Introduction

This Safety Self-assessment tool has been designed for NHS maternity services and private maternity providers to allow them to self-assess whether their operational service delivery meets national standards, guidance, and regulatory requirements. Organisations can use the tool to inform the trust's maternity quality improvement and safety plan and so keep the trust board and commissioners aware of their current position.

The tool has been developed in response to national review findings, and recommendations for good safety principles within maternity services. This version of the tool has been further influenced by the findings of the Ockenden review, 7 features of safety culture and the emerging themes from services on the safety support programme and the areas CQC found to be outstanding in other maternity services across England.

Please use this tool to as a benchmark for your organisation in the core principles of good safety standards within Maternity services.

The tool

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
Directorate/care group infrastructure and leadership	**Clinically-led triumvirate**	Trust and service organograms showing clinically led directorates/care groups		Organogram
		Equal distribution of roles and responsibilities across triumvirate to discharge directorate business such as meeting attendance and decision-making processes		Job planning and required PA allocation has improved the distribution of roles and responsibilities within the service.
	Director of Midwifery (DoM) in post **(current registered midwife with NMC)**	DoM job description and person specification clearly defined		
		Agenda for change banded at 8D or 9		
		In post		
	Direct line of sight to the trust board	Lines of professional accountability and line management to executive board member for each member of the triumvirate		JD
		Clinical director to executive medical director		
		DoM to executive director of nursing		No DoM in post, but HoM has direct access to the Chief Nurse
		General manager to executive chief operating officer		

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Maternity services standing item on trust board agenda as a minimum three-monthly Key items to report should always include: • SI Key themes report, Staffing for maternity services for all relevant professional groups • Clinical outcomes such as SB, NND HIE, AttAIN, SBLCB and CNST progress/Compliance. • Job essential training compliance • Ockendon learning actions		Open and Closed Board minutes
		Monthly review of maternity and neonatal safety and quality is undertaken by the trust board [Perinatal quality surveillance model]		Reporting 3 monthly through Trust board and LMNS as per Ockenden recommendations.
		Monthly review of maternity and neonatal safety and quality is undertaken by the trust board [Perinatal quality surveillance model]		Safety Champion Minutes
		There should be a minimum of three PAs allocated to clinical director to execute their role		Job plan
	Collaborative leadership at all levels in the directorate/ care group	Directorate structure and roles support triumvirate working from frontline clinical staff through to senior clinical leadership team		
		Adequate dedicated senior human resource partner is in place to support clinical triumvirate and wider directorate Monthly meetings with ward level leads and above to monitor recruitment, retention, sickness, vacancy and maternity leave		Departmental Meeting minutes Diary entries
		Adequate senior financial manager is in place to support clinical triumvirate and wider directorate		Organogram
		Monthly meetings with all ward level leaders and above to monitor budgets, ensure updated and part of annual budget setting for each area		Diary entries

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Adequate senior operational support to the delivery of maternity services in terms of infrastructure and systems that support high quality service delivery aligned with national pathways		ADO JD
		From governance and senior management meetings that all clinical decisions are made collaboratively by multiprofessional groups		Quality & Safety Meeting minutes. Woman's Directorate, Maternity Labour Ward Forum, Maternity Risk meeting, Maternity Services Forum, Women Services Guidelines Group, MIB.
		Forums and regular meetings scheduled with each professional group are chaired by the relevant member of the triumvirate, eg senior midwifery leadership assembly		Woman's Directorate, Maternity Labour Ward Forum, Maternity Risk meeting, Maternity Services Forum, Women Services Guidelines Group.
		Leadership culture reflects the principles of the '7 Features of Safety'.		https://for-us-framework.carrd.co/
	Leadership development opportunities	Trust-wide leadership and development team in place		Organisational development team trust wide

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Inhouse or externally supported clinical leadership development programme in place		Leadership modules (ELMS): Appraisal Coaching for leaders Collaboration and influence Developing and delegating effectively Developing resilience of self and team Essential conversations Feedback conversations Leading and facilitating change Leading the team/clinical unit Recruitment and selection Setting objectives Managing Finance (in development) HR module comprising of managing bullying & harassment, capability, disciplinary, absence & probation (in development) Bespoke leadership development and coaching programme commissioned from external providers for Band 7 and Band 8 Midwives.

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Leadership and development programme for potential future talent (talent pipeline programme)		Personalised Development plans Expert Navy course Deputy CD role developed to assist with succession planning.
		Credible organisations provide bespoke leadership development for clinicians/ frontline staff and other recognised programmes, including coaching and mentorship		QI coaching, 360, external coaching and mentorship for leadership team
	Accountability framework	Organisational organogram clearly defines lines of accountability, not hierarchy		Organogram
		Organisational vision and values in place and known by all staff		Trust website You Tube
		Organisation's behavioural standards framework in place: Ensure involvement of HR for advice and processes in circumstances where poor individual behaviours are leading to team dysfunction. [Perinatal Surveillance model]		Guidelines needed Close working relationship with RCM who are offering
	Maternity strategy, vision and values	Maternity strategy in place for a minimum of 3–5 years		Strategy in draft format and shared with MVP. Implementation planned for Q3 2022/3
		Strategy aligned to national Maternity Transformation Programme, local maternity systems, maternity safety strategy, neonatal critical care review, National Ambition for 2025 and the maternity and children's chapter of the NHS Long Term Plan		Maternity action plan in place – strategy to be developed to reflect national priorities

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Maternity strategy, vision and values that have been co-produced and developed by and in collaboration with MVP, service users and all staff groups.		Maternity action plan in place – strategy to be developed to reflect national priorities
		Demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services [Ockenden Assurance]		F&FT results MVP meeting minutes Healthwatch, CQC, MVP service user surveys
		Maternity strategy aligned with trust board LMNS and MVP's strategies		Strategy being developed scheduled completion date 30/09/2022
		Strategy shared with wider community, LMNS and all key stakeholders		Strategy being developed scheduled completion date 30/09/2022
	Non-executive maternity safety champion	Non-executive director appointed as one of the board level maternity safety champions and is working in line with national role descriptor		NED for maternity services appointed 10/11/2020
		Maternity and neonatal safety champions to meet the NED and exec safety champion to attend and contribute to key directorate meetings in line with the national role descriptor		Monthly SCM
		All Safety champions lead quality reviews, eg 15 steps quarterly as a minimum involving MVPs, service users, commissioners and trust governors (if in place)		15 steps MVP meetings
		Trust board meeting minutes reflect check and challenge on maternity and neonatal services from non-executive safety champion for maternity services		March Meetings onwards

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		A pathway has been developed that describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence from floor to Board and through the local maternity system (LMS) and MatNeoSIP Patient Safety Networks. [MIS]		Safety Champion walkabouts, Risky Business, RPQOG shared with LMNS
Multiprofessional team dynamics	**Multiprofessional engagement workshops**	Planned schedule of joint multiprofessional engagement sessions with chair shared between triumvirate, i.e. quarterly audit days, strategy development, quality improvement plans		Clinical audit meetings including Anaesthetics and Medical teams
		Record of attendance by professional group and individual		Meeting minutes
		Recorded in every staff member's electronic learning and development record		The education team record attendance of staff to the PROMPT training days and completion of e learning electronically and CTG MT training. The trust record MT electronically.
	Multiprofessional training programme	Annual schedule of job essential maternity-specific training and education days, that meet the NHS England and NHS Improvement Core Competency framework as a minimum published and accessible for all relevant staff to see		TNA
		A clear Training Needs analysis in place that identifies the minimum hours of training required for each professional group and by grade/ seniority		TNA
		All staff given time to undertake mandatory and job essential training as part of working hours		
		Full record of staff attendance for last three years		Attendance sheets
		Record of planned staff attendance in current year		Spreadsheet
		Clear policy for training needs analysis in place and in date for all staff groups		TNA
		Compliance monitored against training needs policy and recorded on roster system or equivalent		ESR

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Education and training compliance a standing agenda item of divisional governance and management meetings		Quality Dashboard
		Through working and training together, people are aware of each other's roles, skills, and competencies (who does what, how, why and when) and can work effectively together, thus demonstrating "collective competence". [7 Steps]		MDT PROMPT and CTG training
		Individual staff Training Needs Analysis (TNA) aligned to professional revalidation requirements and appraisal		TNA
	Clearly defined appraisal and professional revalidation plan for staff	All job descriptions identify individual lines of accountability and responsibility to ensure annual appraisal and professional revalidation		JD
		Compliance with annual appraisal for every individual		Compliance with appraisal completion is monitored monthly via the quality and safety action plan and dashboard. Compliance improved for all professional groups.
		Professional validation of all relevant staff supported by internal system and email alerts		ESR/ individual emails with line manager Cc'd
		Staff supported through appraisal and clearly defined set objectives to ensure they fulfil their roles and responsibilities		Standardised form
		Schedule of clinical forums published annually, eg labour ward forum, safety summit, perinatal mortality meetings, risk and governance meetings, audit meetings		Meeting schedule circulated

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Multiprofessional clinical forums	HR policies describe multiprofessional inclusion in all processes where applicable and appropriate, such as multiprofessional involvement in recruitment panels and focus groups		Recruitment policy reflects diversity and equality. Multiprofessional inclusion for interviews occurs, particularly for senior roles. Eg: deputy HoM, Governance posts, Consultant Obstetricians
	Multiprofessional inclusion for recruitment and HR processes	Organisational values-based recruitment in place		Recruitment principles based on diversity and questions based around Trust values
		Multiprofessional inclusion in clinical and HR investigations, complaint and compliment procedures		Trust policies regarding HR investigations complaints and compliance support diversity
		Standard operating procedure provides guidance for multiprofessional debriefing sessions following clinical incidents or complaints		SOP in place
		Debriefing sessions available for all staff groups involved following a clinical incident and unusual cases in line with trust guideline and policy		SOP in place
		Schedule of attendance from multiprofessional group members available		Proforma
	Multiprofessional membership/ representation at	Record of attendance available to demonstrate regular clinical and multiprofessional attendance.		Terms of reference includes membership. Minutes of meetings

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Maternity Voices Partnership forums	Maternity Voice Partnership involvement in service development, Quality Improvement, recruitment and business planning through co-production and co-design		MVP involved in service development and in recruitment and business planning through co-production and co - design
		Quality improvement plan (QIP) that uses the SMART principle developed and visible to all staff as well as Maternity Voice Partnership/service users		MVP minutes
	Collaborative multiprofessional input to service development and improvement	Roles and responsibilities in delivering the QIP clearly defined, ie senior responsible officer and delegated responsibility		QI midwife in post JD
		Clearly defined and agreed measurable outcomes including impact for women and families as well as staff identified in the QIP		Labour ward forum utilise staff and service users to co-design clinical pathways
		Identification of the source of evidence to enable provision of assurance to all key stakeholders		Guidelines
		The organisation has robust repository for collation of all evidence, clearly catalogued and archived that's has appropriate shared access		Shared electronic drive
		Clear communication and engagement strategy for sharing with key staff groups		LMNS, MVP, Board Meeting – minutes. Take 5, Risky Business, Infographics
		QIP aligned to national agendas, standards and national maternity dataset and national maternity quality surveillance model requirements		QIP underpinned by national standards such as Keeping mothers and babies together and Better Births

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Weekly/monthly scheduled multiprofessional safety incident review meetings		Diary entries weekly MDT. Reports following Safety incident review
	Multiprofessional approach to positive safety culture	Schedule in place for six-monthly organisation-wide safety summit that includes maternity and the LMNS		Trust to do LMNS Monthly Safety forum
		Positive and constructive feedback communication in varying forms		Educational supervisors and PMA, risk newsletter, perinatal and audit meetings, Take 5 GREATIX
		Debrief sessions for cases of unusual or good outcomes adopting safety 2 approach		Daily Safety Huddle PMA
		Senior members of staff make sure that more junior staff have opportunities to debrief and ask questions after experiencing complex clinical situations, and that they learn from theirs and others' experience. [7 steps to safety]		PMA, PDM, case reviews
		Schedule of focus for behavioural standards framework across the organisation		Trust values
	Clearly defined behavioural standards	Application of behavioural standards framework in trust-wide and directorate meetings, with specific elements the focus each month		Patient stories at directorate and divisional meetings.
		Unsafe or inappropriate behaviours are noticed and with HR support corrected in real time, so they don't become normalised. [7 steps]		Trust policies in place
		All policies and procedures align with the trust's board assurance framework (BAF)		Trust policies and guidelines

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
Governance infrastructure and ward-to-board accountability	**System and process clearly defined and aligned with national standards**	Governance framework in place that supports and promotes proactive risk management and good governance		Maternity risk management policy in place
		Staff across services can articulate the key principles (golden thread) of learning and safety		Just culture/learning discussed at risk and other departmental meetings
		Staff describe a positive, supportive, safe learning culture		Whistleblowing Aug 2021. Repeat staff survey/ dedicated listening event and recent Ockenden Insight Visit 17/5/2022 demonstrate improvement in culture and leadership engagement.
		Robust maternity governance team structure, with accountability and line management to the DoM and CD with key roles identified and clearly defined links for wider support and learning to corporate governance teams		Organogram and maternity risk management policy in place

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Maternity governance structure within the directorate	Maternity governance team to include as a minimum: Maternity governance lead (Current RM with the NMC) Consultant Obstetrician governance lead (Min 2PA's) Maternity risk manager (Current RM with the NMC or relevant transferable skills) Maternity clinical incident leads Audit midwife Practice development midwife Clinical educators to include leading preceptorship programme Appropriate Governance facilitator and admin support		Job plans
		Roles and responsibilities for delivery of the maternity governance agenda are clearly defined for each team member		JD
		Team capacity able to meet demand, eg risk register, and clinical investigations completed in expected timescales		Maternity risk framework
		In date maternity-specific risk management strategy, as a specific standalone document clearly aligned to BAF		Updated 2021
	Maternity-specific risk management strategy	Clearly defined in date trust wide BAF		
	Clear ward-to-board framework aligned to BAF	Perinatal services quality assurance framework supported by standardised reporting requirements in place from ward to board		Board minutes
		Mechanism in place for trust-wide learning to improve communications		Risk newsletter, Take 5, safety huddle, staff briefings, governance boards

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Proactive shared learning across directorate	Mechanism in place for specific maternity and neonatal learning to improve communication		
		Governance communication boards		Information and learning boards in all clinical areas.
		Publicly visible quality and safety board's outside each clinical area	- Roof work	Due to essential building works these have temporarily been reduced/removed.
		Learning shared across local maternity system and regional networks		
		Engagement of external stakeholders in learning to improve, eg CCG, Strategic Clinical Network, regional Director/Heads of Midwifery groups		
		Well-developed and defined trust wide communication strategy to include maternity services in place and in date. Reviewed annually as a minimum.		
		Multi-agency input evident in the development of the maternity specification		
Application of national standards and guidance	**Maternity specification in place for commissioned services**	Approved through relevant governance process		Trust and LMS commissioners with input from divisional team
		In date and reflective of local maternity system plan		LMNS
		Full compliance with all current 10 standards submitted		Significant work undertaken to improve compliance. Increase to compliance with 7 of 10 standards.
	Application of CNST 10 safety actions	A SMART action plan in place if not fully compliant that is appropriately financially resourced.		NHSR action plan

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Clear process defined and followed for progress reporting to LMS, Commissioners, regional teams and the trust board that ensures oversights and assurance before formal sign off of compliance		
		Clear process for multiprofessional, development, review and ratification of all clinical guidelines		Guideline group and Quality & Safety meetings
	Clinical guidance in date and aligned to the national standards	Scheduled clinical guidance and standards multiprofessional meetings for a rolling 12 months programme.		
		All guidance NICE complaint where appropriate for commissioned services		
		All clinical guidance and quality standards reviewed and updated in compliance with NICE		
		All five elements implemented in line with most updated version		Audits
	Saving Babies Lives care bundle implemented	SMART action plan in place identifying gaps and actions to achieve full implementation to national standards.		Audit reports
		Trajectory for improvement to meet national ambition identified as part of maternity safety plan		Audit reports
		All four key actions in place and consistently embedded		Audit reports
	Application of the four key action points to reduce inequality for BAME women and families	Application of equity strategy recommendations and identified within local equity strategy		
		All actions implemented, embedded and sustainable		
	Implementation of 7 essential learning actions from the Ockendon first report	Fetal Surveillance midwife appointed as a minimum 0.4 WTE		JD
		Fetal surveillance consultant obstetrician lead appointed with a minimum of 2-3 PAs		JD
		Plan in place for implementation and roll out of A-EQUIP		
	A-EQUIP implemented	Clear plan for model of delivery for A-EQUIP and working in collaboration with the maternity governance team		

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Training plan for transition courses and succession plan for new professional midwifery advocate (PMA) A-EQUIP model in place and being delivered		
		Service provision and guidance aligned to national bereavement pathway and standards		Bereavement Guideline
	Maternity bereavement services and support available	Bereavement midwife in post		JD
		Information and support available 24/7		Information 24/7 All midwives mandatory training support through midwifery manager on call
		Environment available to women consistent with recommendations and guidance from bereavement support groups and charities		Bereavement suite
		Quality improvement leads in place		QI midwife
	Quality improvement structure applied	Maternity Quality Improvement Plan that defines all key areas for improvement as well as proactive innovation		
		Recognised and approved quality improvement tools and frameworks widely used to support services		
		Established quality improvement hub, virtual or otherwise		
		Listening into action or similar concept implemented across the trust		
		Continue to build on the work of the MatNeoSip culture survey outputs/findings.		Regional structure established and regional neonatal project manager appointed who along with the neonatal lead will support Matneo activities

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	MatNeoSip embedded in service delivery	MTP and the maternity safety strategy well defined in the local maternity system and quality improvement plan		
	Maternity transformation programme (MTP) in place	Dynamic maternity safety plan in place and in date (in line with spotlight on maternity and national maternity safety strategy)		
Positive safety culture across the directorate and trust	**Maternity safety improvement plan in place**	Standing agenda item on key directorate meetings and trust committees		Via CPPS, Women and Children's Divisional Board, Monthly risk meetings, Maternity and neonatal safety champions meetings
		FTSU guardian in post, with time dedicated to the role		Trust has a number of identified Speak up Champions including one in training for Women's services.
	Freedom to Speak Up (FTSU) guardians in post	Human factors training lead in post		1 consultant and 2 senior midwives
	Human factors training available	Human factors training part of trust essential training requirements		PROMPT
		Human factors training a key component of clinical skills drills		PROMPT
		Human factors a key area of focus in clinical investigations and formal complaint responses		

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Multiprofessional handover in place as a minimum to include Board handover with representation from every professional group: • Consultant obstetrician • ST7 or equivalent • ST2/3 or equivalent • Senior clinical lead midwife • Anaesthetist And consider appropriate attendance of the following: • Senior clinical neonatal nurse • Paediatrician/neonatologist? • Relevant leads form other clinical areas eg, antenatal/postnatal ward/triage.		Handover tool
	Robust and embedded clinical handovers in all key clinical areas at every change of staff shift	Clinical face to face review with relevant lead clinicians for all high-risk women and those of concern		Twice daily MDT ward round
		A minimum of two safety huddles daily in all acute clinical areas to include all members of the MDT working across and in maternity services as well as the opportunity to convene an urgent huddle as part of escalation process's		Once daily safety huddle Need to change am handover to safety huddle
	Safety huddles	Guideline or standard operating procedure describing process and frequency in place and in date		SOP to complete
		Audit of compliance against above		Audit of daily huddles
		Annual schedule for Swartz rounds in place		
	Trust wide Swartz rounds	Multiprofessional attendance recorded and supported as part of working time		
		Broad range of specialties leading sessions		

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Trust-wide weekly patient safety summit led by medical director or executive chief nurse		
	Trust-wide safety and learning events	Robust process for reporting back to divisions from safety summit		
		Annual or biannual trust-wide learning to improve events or patient safety conference forum		
		Trust board each month opened with patient story, with commitment to action and change completed in agreed timeframes		
		In date business plan in place		
Comprehension of business/ contingency plans impact on quality. **(ie Maternity Transformation plan, Neonatal Review, Maternity Safety plan and Local Maternity System plan)**	**Business plan in place for 12 months prospectively**	Meets annual planning guidance		
		Business plan supports and drives quality improvement and safety as key priority		
		Business plan highlights workforce needs and commits to meeting safe staffing levels across all staff groups in line with BR+ or other relevant workforce guidance for staff groups		Business plans
		Consultant job plans in place and meet service needs in relation to capacity and demand		Job plans
		All lead obstetric roles such as: labour ward lead, audit lead, clinical governance lead and early pregnancy lead are in place and have allocated PAs in job plans		Job plans
		Business plans ensures all developments and improvements meet national standards and guidance		
		Business plan is aligned to NHS 10-year plan, specific national initiatives and agendas.		

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Business plans include dedicated time for clinicians leading on innovation, QI and Research		
		That service plans and operational delivery meets the maternity objectives of the Long Term Plan in reducing health inequalities and unwarranted variation in care. Note the Maternity and Neonatal Plans on Pages 12 & 13.		
Meeting the requirements of Equality and Inequality & Diversity Legislation and Guidance's.	**That Employment Policies and Clinical Guidance's meet the publication requirements of Equity and Diversity Legislation.**	Assess service ambitions against the Midwifery 2020: Delivering expectations helpfully set out clear expectations in relation to reducing health inequalities, parts 3.1, 4.1 and 4.3 of the documents.		Continuity of Carer action plan submitted to meet the requirements of 35% of all women booked onto CoC by March 2021 to include 35% BAME women booked onto CoC.
		Refer to the guidance from the Royal College of Midwives (RCM) Stepping Up to Public Health, (2017). Utilise the Stepping up to Public Health Model, Table 10 as a template.		Incorporate into the booking assessment

Key lines of enquiry	Kirkup recommendation number
Leadership and development	2, 3, 4, 5, 6, 7, 10, 11, 12, 13, 14, 15, 16, 17, 18
Governance: Covers all pillars of Good governance	2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18
Quality Improvement: application of methodology and tools	5, 6, 9, 12, 13, 15, 16, 17, 18
National standards and Guidance: service delivery	2, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18

Safety Culture: no blame, proactive, open and honest approach, Psychological safety	2, 3, 4, 5, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18
Patient Voice: Service user involvement and engagement through co-production and co-design. MVP and wider	6, 9, 11, 12, 13, 15, 17, 18
Staff Engagement: Harvard System two leadership approach, feedback and good communication tools	2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18
Business Planning: aligned with LMNS plans and the National Maternity Transformation agenda, Maternity safety strategy and the Long term plan	8, 9, 10, 14, 15, 16, 17, 18

Key supporting documents and reading list

1. NHS England National Maternity review: Better Births. February 2016; https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

2. Royal College of Obstetricians and Gynaecologists Maternity Standards 2016; https://www.rcog.org.uk/globalassets/documents/guidelines/working-party-reports/maternitystandards.pdf

3. NHS England NHS Long Term Plan: January 2019; https://www.longtermplan.nhs.uk/

4. Report of the Investigation into Morecambe Bay March 2015; https://www.gov.uk/government/publications/morecambe-bay-investigation-report

5. Royal College of Midwives. Birth-rate plus tools; https://www.rcm.org.uk/media/2375/working-with-birthrate-plus.pdf

6. Royal College of Midwives State of Maternity Services 2018; https://www.rcm.org.uk/media/2373/state-of-maternity-services-report-2018-england.pdf

7. NHS England. Spotlight on Maternity: Safer Maternity care. 2016; https://www.england.nhs.uk/signuptosafety/wp-content/uploads/sites/16/2015/11/spotlight-on-maternity-guide.pdf

8. Department of Health Safer Maternity care. The National Ambition. November 2017; https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/560491/Safer_Maternity_Care_action_plan.pdf

9. NHS Resolution. Maternity Incentivisation Scheme 2019/20; https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/

10. NHS staff survey. (2018); https://www.nhsstaffsurveys.com/Page/1064/Latest-Results/2018-Results/

11. Maternity Picker Survey. 2019; https://www.picker.org/wp-content/uploads/2014/10/Maternity-4-pager-for-website-ARe-V2-18122018.pdf

12. National Maternity Perinatal Audit. (NMPA) report; https://www.hqip.org.uk/resource/national-maternity-and-perinatal-audit-nmpa-clinical-report-2019/#.XdUiX2pLFPY

13. Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK. (MBRACE) report; https://www.npeu.ox.ac.uk/mbrrace-uk

14. Organisations Monthly Maternity Dashboards; https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set/maternity-services-dashboard

15. Organisational Maternity and Neonatal Cultural Score Survey; https://improvement.nhs.uk/documents/5039/Measuring_safety_culture_in_matneo_services_qi_1apr.pdf

16. NHS England Saving babies lives Care bundle. V2 March 2019; https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf

17. 7 Features of safety in maternity services framework; https://for-us-framework.carrd.co/

18. Ockendon Report: investigation into maternity services at Shrewsbury and |Telford NHS hospitals 2020; https://www.gov.uk/government/publications/ockenden-review-of-maternity-services-at-shrewsbury-and-telford-hospital-nhs-trust

19. Perinatal Surveillance Model; https://www.england.nhs.uk/wp-content/uploads/2020/12/implementing-a-revised-perinatal-quality-surveillance-model.pdf

20. Maternity Incentive Scheme; https://resolution.nhs.uk/wp-content/uploads/2021/03/Maternity-Incentive-Scheme-year-3-March-2021-FINAL.pdf

5.1 - Governance report - Supporting annexes

Audit Committee – 29 June 2022

Agenda item:	Item 6.3			
Presented by:	Liana Nicholson, Assistant Director of Finance			
Prepared by:	Liana Nicholson, Assistant Director of Finance			
Date prepared:	20 June 2022			
Subject:	Audit Committee Annual Report			
Purpose:		For information	X	For approval

Executive summary:

The Audit Committee is required to produce an Annual Report detailing the work undertaken during a financial year. Attached is the report for the year ended 31 March 2022.

The Committee is asked to review the report and agree a final submission to the Trust Board.

Trust priorities	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
	✓	✓	✓

Trust ambitions	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
	✓	✓	✓	✓	✓	✓	✓

Previously considered by:	*N/A*
Risk and assurance:	*None to note.*
Legislation, regulatory, equality, diversity and dignity implications	*None directly relevant to this report but the work of the Committee provides the Trust with assurance on compliance in a number of areas.*

Recommendation:
The Audit Committee is asked to review and agree a final version for submission to the Trust Board.

1. Background

1.1 The Audit Committee of West Suffolk NHS Foundation Trust is established under Board delegation with approved Terms of Reference that are in line with those set out in the NHS Audit Committee Handbook.

1.2 This report covers the year from 1 April 2021 to 31 March 2022.

1.3 The Committee consists of a minimum of 3 Non-Executive Directors, one of whom has recent and relevant financial experience. The Committee has met on 5 occasions during the year to discharge its responsibility for scrutinising the risks and controls that affect all aspects of the organisation's business.

1.4 The meetings have also been attended, by invitation, by the Chief Executive, the Executive Director of Resources, the Executive Chief Nurse, the Deputy Chief Nurse, the Medical Director, the Trust Secretary and Head of Governance, the Assistant Director of Finance or Deputy Director of Finance, Internal Audit, External Audit and the Counter Fraud Service. The Chair of the Trust has also attended some Committee meetings.

1.5 The Committee focuses on all aspects of Corporate Governance including assurance on clinical governance and risk management.

1.6 This report deals with the Audit Committee meetings held between 1 April 2021 and 31 March 2022. Therefore, reports that are approved outside this period would be covered in the following year despite the subject matter of the report relating to the year. E.g. the Annual Report and Accounts for 2021/22 will be reported in the year they were approved by the Committee i.e. 2022/23.

2. Meetings during 2021/22

2.1 There were 5 meetings of the Committee during 2021/22: 30 April 2021, 25 June 2021 (for the approval of the 2020/21 accounts only), 30 July 2021, 5 November 2021 and 1 March 2022, with the following member attendance:

	Title	Attendance / No. possible
Angus Eaton (Chair until May 2021)	Non-Executive Director	1/1
Christopher Lawrence (Chair from June 2021)	Non-Executive Director	4/4
Alan Rose	Non-Executive Director	4/5
Richard Davies	Non-Executive Director	5/5
Louisa Pepper	Non-Executive Director	5/5
David Wilkes	Non-Executive Director	1/1

2.2 There are no sub-committees of the Audit Committee.

3. Principal Review Areas

3.1 Annual Governance Statement

3.1.1 The Audit Committee reviewed the 2020/21 Annual Governance Statement for the Trust for the 12 months to 31 March 2021 in April and June 2021 and confirmed that it was consistent with the view of the Committee on the Trust's system of internal control. Note that the Annual Governance Statement for 2021/22 was reviewed in April and June 2022.

3.1.2 The Audit Committee received the Head of Internal Audit opinion 2020/21 in April 2021 and June 2021 which concluded:

The organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective.

Specific issues highlighted were:

- Nursing – Temporary Staffing and Rostering (Partial Assurance)

  The audit identified two policies that had not been reviewed in line with the review timeline, along with issues with system processes such as retrospective input of shifts on Healthroster, non-compliance with the Trust's defined lead time and bank staff not always being sought before agency referrals. Furthermore, it was identified that audit trails of overtime requests and authorisation were not maintained and there were no controls in place to provide assurance that staffing decisions around temporary staffing were being considered appropriately.

- Data Quality – Harm Reviews and Long Waiting Patients (Partial Assurance)

  Weaknesses in both control design and application were identified throughout the review. Although the Clinical Harm and Prioritisation Policy had been shared across the Trust, the Policy was not being implemented in practice.

- Fit and Proper Persons (Partial Assurance)

  Significant areas of non-compliance with the Trust procedures was identified during this audit. Specifically, instances of missing documentation on personnel files was noted, along with evidence of checks being performed on professional qualifications of Directors in post.

3.2 Annual Accounts Approval

3.2.1 The Committee reviewed the draft accounting policies proposed and considered the significant accounting estimates and judgements in advance of the production of the accounts.

3.2.2 The Committee reviewed the 2020/21 Annual Accounts, Annual Report and the Letter of Representation for the 12 months to 31 March 2021 and recommended these for approval by the Trust Board.

3.3 Terms of Reference

3.3.1 The Committee is required to review its Terms of Reference (ToR) during the year.

3.3.2 A revised version of the Terms of reference was agreed at the meeting in July 2021.

3.3.3 The key requirements included in the Terms of Reference, and whether they have been met during the year, have been considered in the Appendix to this report.

3.4 Governance Documents

3.4.1 The Committee has a duty to undertake a review of the Trust's Governance Documents every other year, unless there are matters that require review at an earlier date. These comprise the Standing Orders, Standing Financial Instructions and The Scheme of Delegation. These are due to be reviewed in 2022.

3.5 Governance

3.5.1 In respect of Governance the Committee's responsibilities are set out in the terms of reference as:

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

3.5.2 The Committee achieved this through a number of actions:-

- Monitor and review the Annual Governance Statement
- Receiving the annual Head of Internal Audit opinion
- Receiving the audit report of the External Auditors on the Annual Accounts
- Reviewing the effectiveness of the Board Assurance Framework (with support from Internal Audit);
- Receiving the 3is Chair's Report.

3.5.3 Board Assurance Framework Deep Dive Reviews – ordinarily 'Deep Dive' reviews are presented at every Audit Committee. However during 2021/22 none were performed. Instead, in depth discussions were held around the new Governance Structure at every meeting. The Deep Dive reviews will commence in 2022/23.

3.6 Charitable Funds Annual Accounts

3.6.1 The Board delegated authority to the Audit Committee to approve the Charitable Fund accounts for the full year to 31 March 2021. The Committee approved the accounts at its November 2021 meeting.

4. Other work undertaken

4.1 Internal Audit

4.1.1 The Committee received the following reports from the Internal Auditors:-

- Progress report against the Audit Plan at every meeting including implementation of recommendations
- 2020/21 Head of Internal Audit Opinion – April 2021 and June 2021
- 2021/22 Internal Audit Plan – April 2021

4.1.2 Following discussion at the Audit Committee and a review of the current audit market, RSM were re-appointed as the Trust's Internal Auditors from 1 April 2022 for a period of 3 years.

4.2 External Audit

4.2.1 The Committee received the following reports from the External Auditors:-

- 2020/21 Report to Those Charged with Governance (ISA 260) - June 2021
- 2020/21 Auditors Annual Report – November 2021
- 2020/21 Charitable Fund Accounts Report to Those Charged with Governance (ISA 260) - November 2021
- 2021/22 External Audit Plan – March 2022.

4.2.2 BDO resigned as the Trust's auditors during 2021/22 due to independence issues. Due to the current status of the external audit market, it became necessary to receive support from NHSE/I to appoint new External Auditors. After discussion with the Council of Governors in October 2021, KPMG were appointed at the Trust's External Auditors in November 2021 for 3 years. An extension was granted to the audit of the 2021/22 Annual Accounts to enable KPMG to take on the appointment. The deadline for the audited accounts submission is 31 July 2022. The normal audit timetable will resume for the 2022/23 Annual Accounts.

4.3 Counter Fraud

4.3.1 The Committee received the following reports from the Local Counter Fraud Specialist provided by RSM:

- Progress Report- all meetings
- Regular Fraud Notices
- Counter Fraud Annual Report 2020/21 – July 2021
- Counter Fraud Work Plan 2021/22 – April 2021

4.3.2 RSM were re-appointed as the Trust's Local Counter Fraud Specialists from 1 April 2022 for a period of 3 years.

5. Audit Committee Responsibilities – performance

5.1 As part of its responsibilities the Committee should assess its performance against its terms of reference not less than every 2 years. The Committee completed the HFMA self-assessment checklist in March 2020 and the self-assessment is being completed for the Committee meeting in June 2022.

6. Audit Committee Impact

6.1 It is important that the Audit Committee makes an impact on the Trust, particularly around ensuring the robustness of the Governance Structure.

6.2 In assessing this, it is important to note that the main reports submitted to the Committee by External and Internal Audit supported the robustness of the Governance structure.

6.3 There were a number of specific areas where the Committee undertook action to address issues or where specific items were raised and discussed, including:

- The Committee received a report on losses and special payments. This report is reviewed on an annual basis.
- The Committee received a report on waivers and critically reviewed the drivers behind the number of waivers. This report is reviewed on an annual basis.
- The Committee received reports for the approval of debt write offs.
- The Trust critically reviewed management responses to Internal and External Audit Reports to ensure risks and actions were being managed adequately and in a timely manner.
- The Committee received a report on the Supply Chain risks.

6.4 The above items reflect that the Committee has had a positive impact on the governance arrangements of the Trust

7. Conclusion

7.1 This report highlights the main areas of work undertaken by the Audit Committee during the period. It demonstrates that the Committee operated effectively and had a positive impact on the Trust.

7.2 The Committee is asked to review the report, make any changes and approve a final version for submission to the Trust Board.

Appendix – Key requirement included in Terms of Reference

Para Ref	Requirement of Terms of Reference	Requirement Met?	Date
5.6	Committee to hold a private meeting with both Internal and External Audit.	✓	November 2021
7.1	Meetings will be held at least three times a year.	✓	April 2021, June 2021, July 2021, November 2021, March 2022
9.1.1.2	Monitor and review the effectiveness of systems of internal financial and budgetary control and the integrity of reporting statements.	✓	Completed through Internal and External Audit reviews and opinions
9.1.1.3	Monitor and review the effectiveness of systems for ensuring the optimum collection of income.	✓	Completed through Internal and External Audit reviews and opinions
9.1.1.4	Monitor and review the effectiveness of risk management systems.	✓	Completed through Internal Audit reviews and opinions
9.1.1.5	Monitor and review the effectiveness of the Board Assurance Framework (BAF).	✓	Every meeting
9.1.1.6	Use of a 'deep dive' programme of reviews to test the BAF.	×	No deep dive sessions were held – instead in depth discussions were held around the new Governance structure.
9.1.1.7	Monitor and review the Quality Report assurance and review alongside the Annual Report and Accounts.	**N/A**	There was no requirement for the Trust to produce a Quality Report during 2021/22.
9.1.1.8	Monitor and review the systems for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements.	✓	Completed through relevant reviews throughout the year
9.1.1.9	Monitor and review the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud Authority.	✓	Completed through Counter Fraud reviews
9.1.4	Review the minutes from the Trust's other Board Assurance Committees.	✓	Every meeting – 3is Chair's Report is now presented at each meeting
9.2 & 9.2.5	Review of the effectiveness and quality of the Internal Audit Function.	✓	Completed and brought to the Committee in November 2021.
9.2.2	Review of the Internal Audit Strategy and Operational Plan.	✓	April 2021 for 2021/22 Audit Plan (final plan)
9.2.3	Consideration of major findings of Internal Audit investigations and the effectiveness of the management response.	✓	Every meeting
9.3	Review of the effectiveness of the Counter Fraud Service.	✓	Completed and brought to the Committee in November 2021.

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Appendix – Key requirement included in Terms of Reference

Para Ref	Requirement of Terms of Reference	Requirement Met?	Date
9.3.2	Consideration of major findings of Counter Fraud investigations and the effectiveness of the management response.	✓	Every meeting
9.3.4	Receipt and review of the annual review of work undertaken by the Counter Fraud Service.	✓	July 2021 for 2020/21.
9.4	Review of the effectiveness and quality of the External Audit Function, including their independence.	**N/A**	BDO resigned during 2021/22 due to independence. KPMG were appointed in November 2021.
9.4.3 & 9.4.4	Review of the External Audit Plan, before the audit commences.	✓	March 2022 for the 2021/22 Audit.
9.4.5	Review reports from External Audit, together with management responses.	✓	June 2021
9.5.1	Review the Annual Report and Financial Statements of the Trust and the Charitable Funds, covering: • The Annual Governance Statement • Changes in, and compliance with, accounting policies • Explanation of estimates and provisions having a material effect • Unadjusted misstatements • Major judgemental areas • Schedule of losses and special payments • Significant adjustments resulting from the audit. These are reviewed prior to endorsement by the Board of Directors (for the Trust accounts).	✓	June 2021 for the Trust's 2020/21 Annual Report and Accounts. November 2021 for the 2020/21 Charitable Fund's Annual Report and Accounts.
9.6.1	Review changes to Standing Orders, Standing Financial Instructions and Scheme of Delegation.	✓	N/A for 2021/22 as the review is complete bi-annually. This review is currently underway
9.7.1	Review Schedule of Waivers.	✓	July 2021 – reviewed annually
9.7.2	Review schedules of losses and compensations.	✓	July 2021 – reviewed annually
9.7.3	Monitor the process to ensure that Supply Chain Risk is identified and appropriate actions have been taken.	✓	July 2021 – reviewed annually
10.2	Review the Terms of Reference Annually.	✓	July 2021
10.3	Undertake a self-assessment of the Audit Committee performance	✓	July 2020 – completed for June

Appendix – Key requirement included in Terms of Reference

Para Ref	Requirement of Terms of Reference	Requirement Met?	Date
	(bi-annually).		2022
10.4	Complete an Annual Report on activities of the Audit Committee.	✓	July 2021 (for review of 2020/21)

Audit Committee – 29 June 2022

Agenda item:	Item 6.4			
Presented by:	Liana Nicholson, Assistant Director of Finance			
Prepared by:	Liana Nicholson, Assistant Director of Finance			
Date prepared:	20 June 2022			
Subject:	Annual Review of Terms of Reference			
Purpose:		For information	✓	For approval

Executive summary:

The Committee is required to review its Terms of Reference annually. The previous Terms of Reference are included within this report with some suggested highlights made using tracked changes.

The Terms of Reference adopted by the Trust are in line with the model Audit Committee Terms of Reference that are included within the HFMA Audit Committee Handbook. Updates have also been made to ensure that the Terms of Reference are in line with the UK Corporate Governance Code requirements.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
	✓	✓	✓

Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
	✓	✓	✓	✓	✓	✓	✓

Previously considered by:	*The Terms of Reference were last reviewed in July 2021.*
Risk and assurance:	*The HFMA Audit Committee Handbook has been used to inform the review of the Terms of Reference.*
Legislation, regulatory, equality, diversity and dignity implications	

Recommendation:
The Committee is asked to review and approve or change the suggested amendments to the Committee's Terms of Reference and recommend that the Board adopts the revised Terms of Reference.

AUDIT COMMITTEE TERMS OF REFERENCE

1 Constitution

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

2 Aim

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

3 Scope

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

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

4 Membership

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

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

4.3 A quorum will be two members.

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

5 Attendance at Meetings

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

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

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

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

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

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

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

6 Access

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

7 Frequency of Meetings

7.1 Meetings will normally be held at least three times a year.

7.2 Special meetings may be convened by the Board of Directors or the Chair of the Committee.

7.3 The External Auditors or Internal Auditors may request a meeting if they consider that one is necessary.

8 Authority

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

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

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

9 Duties and Responsibilities

The duties and responsibilities of the Committee are as follows:

9.1 Governance and Assurance

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

In particular, the Committee shall independently monitor and review:

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

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

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

9.1.1.4 the effectiveness of risk management systems.

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

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

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

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

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

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

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

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

9.1.4 The Committee will receive the minutes from the Trust's other Board Assurance Committees for the purpose of ensuring: that there is no duplication of effort between the two Committees; that no area of assurance is missed and; as part of

its responsibility for reviewing the Annual Governance Statement prior to submission to the Board of Directors.

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

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

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

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

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

9.2 Internal Audit

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

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

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

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

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

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

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

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

9.3 Counter Fraud

The Committee shall ensure that there is an effective counter fraud function established by management that meets the Standards set out by the NHS Counter Fraud Authority and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board of Directors. This will be achieved by:

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

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

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

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

9.4 External Audit

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

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

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

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

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

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

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

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

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

9.5 Financial Reporting

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

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

9.6 Key Trust Documents

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

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

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

9.7 Other

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

9.7.2 Review schedules of losses and compensations.

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

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

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

10 Reporting, Accountability, Monitoring and Review of Effectiveness

10.1 The Minutes of Audit Committee meetings shall be formally recorded and a summary of the minutes, which includes a report of the Committee's activities, is submitted to the Board of Directors no less often than three times a year; The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

10.2 The Audit Committee shall review its terms of reference annually;

10.3 The Audit Committee shall carry out a self-assessment in relation to its own performance no less than once every two years, reporting the results to the Board of Directors;

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

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

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

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

10.8 Maintain and monitor performance against the agreed reporting framework.

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

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