NHS
West Suffolk
NHS Foundation Trust

Board of Directors (In Public)

Schedule	Friday 26 July 2024, 9:15 AM — 1:30 PM BST
Venue	ABC Room, Newmarket Hospital, Exning road, CB8 7GJ
Description	A meeting of the Board of Directors will take place on Friday 26 July 2024 at 9:15am.
Organiser	Gemma Wixley

Agenda

AGENDA
Presented by Jude Chin

_WSFT Public Board Agenda - 26 July 2024.docx

1. GENERAL BUSINESS
   Presented by Jude Chin

9:15 AM — 1.1. Welcome and apologies for absence - Craig Black , Paul Molyneux , Clement Mawoyo, Helen Davies, Michael Parsons, Peter Whightman, Sam Tappenden, Jonathan Rowell
To Note - Presented by Jude Chin

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

9:20 AM — 1.3. Minutes of the previous meeting - 24 May 2024
To Approve - Presented by Jude Chin

2024 05 24 May - Public Board Minutes - Draft.docx

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

Item 1.4 Matters Arising - Complete - Open Board.pdf

Item 1.4 Matters Arising - Open - Open Board.pdf

9:25 AM	1.5.	Questions from Governors and the Public relating to items on the agenda To Note - Presented by Jude Chin
9:45 AM	1.6.	Patient story - Video - Yvonnes' story To Review - Presented by Susan Wilkinson
10:00 AM	1.7.	Chief Executive's report To inform - Presented by Ewen Cameron Item 1.7 CEO Board report - July 2024 FINAL (002).docx
	2.	STRATEGY
	2.1.	Strategic Priorities Report For Approval - Presented by Ewen Cameron Item 2.1 - Strategic priorities Board July 2024 coversheet.docx Item 2.1 Strategic priorities 2023-24 - year end report.docx Item 2.1 Strategic priorities 2024_25 - progress report July 24.docx Item 2.1 Strategic priorities 2024_25 Progress report July 2024 sustainability for health and care July 24 trajectories.pptx Item 2.1 Strategic priorities 2024_25 Progress report July 2024_survey data.docx
10:10 AM	2.2.	Future System board report To Assure - Presented by Ewen Cameron Item 2.2 wsft public board July 24 FINAL.docx
10:30 AM		Comfort Break
10:40 AM	2.3.	West Suffolk System Update Report To Assure - Presented by Ewen Cameron Item 2.3 WSFT cover sheet.docx Item 2.3 System update WSA Committee report Jun _Jul 24_.docx

	2.4.	Collaborative Oversight Report To Assure - Presented by Nicola Cottington Item 2.4 Collaborative oversight report SNEEPC July 2024.docx
	2.5.	ESEOC Report and Presentation (Simon Morgan, Associate Director of Communications, SNEE ICB and Cassia Nice, Head of Patient Engagement & Experience, WSFT in attendance) To Assure - Presented by Nicola Cottington Item 2.5 ESEOC cover paper July 2024 v2.docx Item 2.5 WSFT Board report - ESEOC engagement - July 2024.docx
	3.	PEOPLE AND CULTURE
11:20 AM	3.1.	Involvement Committee report To Assure - Presented by Antoinette Jackson Item 3.1 CKI Involvement june 2024 FINAL.docx
11:35 AM	3.1.1.	People and OD highlight report, including FTSU report To Assure - Presented by Jeremy Over Item 3.1.1 WSFT FTSUG report Q1 2024 2025 FINAL.doc
11:50 AM		COMFORT BREAK
	4.	ASSURANCE
12:00 PM	4.1.	Insight Committee Report - Chair's Key Issues from the meeting To Assure - Presented by Antoinette Jackson Item 4.1 INSIGHT CKI report 15 May 2024 FINAL AJ.docx Item 4.1 INSIGHT CKI report 19 June 24 FINAL.docx Item 4.1 INSIGHT IQPR assurance committee summary report May 2024.pptx

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12:05 PM 4.1.1. Finance Report, including 2024/25 budget and capital programme
For Approval - Presented by Ewen Cameron

Item 4.1.1 M3 Finance Cover 2425.docx

Item 4.1.1 M3 Finance Report 2425 for Board 26072024 FINAL.docx

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12:15 PM 4.2. Improvement Committee Report - Chair's Key Issues from the meeting
To Assure - Presented by Louisa Pepper

Item 4.2 Improvment CKI Board assurance committee Jun 24 CKI (004).docx

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12:20 PM 4.3. Quality and Nurse Staffing Report
To Assure - Presented by Susan Wilkinson

Item 4.3 Nurse Staffing Report FINAL May and June.docx

12:30 PM 4.3.1. Maternity & Neonatal Services
Karen Newbury, Kate Croissant & Simon Taylor in attendance
To Approve - Presented by Susan Wilkinson

Item 4.3.1 July 2024 Maternity quality safety and performance Board report (006)KN comments.docx

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12:40 PM 4.4. Audit Committee Report
To Assure - Presented by Jude Chin

Item 4.4 - Audit committee report.docx

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5. GOVERNANCE

12:45 PM 5.1. Board Assurance Framework
To Assure - Presented by Richard Jones

Item 5.1 BAF report to Board July 24.docx

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12:55 PM 5.2. Governance Report
For Approval - Presented by Richard Jones

Item 5.2 Governance report July 2024.docx

1:05 PM 6. OTHER ITEMS
Presented by Jude Chin

1:10 PM 6.1. Any other business
To Note - Presented by Jude Chin

1:15 PM 6.2. Reflections on meeting
For Discussion - Presented by Jude Chin

6.3. Date of next meeting - 27th September, 2024

Annual Members Meeting - 24 September 2024
To Note - Presented by Jude Chin

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

SUPPORTING ANNEXES
Presented by Jude Chin

IQPR Full Report
To Note - Presented by Nicola Cottington

Item 4.1 annex - Insight IQPR PAGG update Jul24 (1).pptx

Maternity paper Annexes

Presented by Susan Wilkinson

Item 5.2 Annex A Board Remuneration and Nomination Committee ToR July 2024.docx

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Remuneration and Nomination Committee Terms of Reference

Presented by Richard Jones

Item 5.2 Annex A Board Remuneration and Nomination Committee ToR July 2024.docx

Item 5.2 Annex B Draft Board meeting agenda.docx

AGENDA

Presented by Jude Chin

WSFT Board of Directors – Public Meeting

Date and Time	Friday, 26 July 2024 9:15 – 13:45
Venue	ABC Room Newmarket Hospital, Exning Rd, CB8 7JG

Time	Item	Subject	Lead	Purpose	Format
1.0 GENERAL BUSINESS					
09.15	1.1	**Welcome and apologies for absence** – CB, PM	Chair	Note	Verbal
09.20	1.2	**Declarations of Interests**	All	Assure	Verbal
	1.3	**Minutes of meeting** – 24 May 2024	Chair	Approve	Report
	1.4	**Action log and matters arising**	All	Review	Report
09:25	1.5	**Questions from Governors and the public relating to items on the agenda**	Chair	Note	Verbal
09.35	1.6	**Patient or Staff Story**	Chief Nurse	Review	Verbal/ Video
10.00	1.7	**CEO report**	Chief Executive	Inform	Report
2.0 STRATEGY					
10.10	2.1	**Strategic priorities report**	Chief Executive	Approve	Report
10.20	2.2	**Future system board report**	Chief Executive	Assure	Report
10:30 Comfort Break					
10:40	2.3	**System update**	West Suffolk Alliance Director and Director of Integrated Adult Health and Social Care	Assure	Report
11:00	2.4	**Collaborative oversight report**	Chief Operating Officer	Assure	Report
11:10	2.5	**ESEOC report and Presentation**	Chief Operating Officer	Assure	Report/presentation

Time	Item	Subject	Lead	Purpose	Format
			Simon Morgan ICB Communication Director & Cassia Nice WSFT Head of Patient Engagement		
3.0 PEOPLE AND CULTURE					
11.30	3.1	**Involvement Committee report** – Chair's key issues from the meetings	NED Chair	Assure	Report
11:50 Comfort Break					
4.0 ASSURANCE					
12.00	4.1	**Insight committee report** – Chair's key issues from the meetings	NED Chair	Assure	Report
	4.1.1	**Finance report**	Ewen Cameron	Assure	Report
12.25	4.2	**Improvement committee report** – Chair's key issues from the meetings	NED Chair	Assure	Report
12.45	4.3	**Quality and nurse staffing report**	Chief Nurse	Assure	Report
	4.3.1	**Maternity services report**	Chief Nurse Karen Newbury Kate Croissant Simon Taylor	Approval	Report
13.00	4.4	**Audit committee report**	NED Chair	Assure	Report
5.0 GOVERNANCE					
13.10	5.1	**Board assurance framework**	Trust Secretary	Assure	Report
13:20	5.2	**Governance Report**	Trust Secretary	Approval	Report
6.0 OTHER ITEMS					
13.30	6.1	**Any Other Business**	All	Note	Verbal
	6.2	**Reflections on meeting**	All	Discuss	Verbal
	6.3	**Date of next meeting** - Annual members	Chair	Note	Verbal

Time	Item	Subject	Lead	Purpose	Format
		meeting on 24 September 2024 - Board meeting on 27 September 2024			
		Resolution The Trust Board is invited to adopt the following resolution: “that representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicly on which would be prejudicial to the public interest” Section 1(2) Public Bodies (Admission to Meetings) Act 1960			

Supporting Annexes

Agenda item	Description
4.2	IQPR full report
4.4.1	Maternity papers Annexes
5.2	Remuneration and Nomination Committee terms of reference

Guidance notes

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

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

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

1. GENERAL BUSINESS

Presented by Jude Chin

1.1. Welcome and apologies for absence - Craig Black , Paul Molyneux , Clement Mawoyo, Helen Davies, Michael Parsons, Peter Whightman, Sam Tappenden, Jonathan Rowell

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 - 24 May 2024

To Approve

Presented by Jude Chin

NHS
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NHS Foundation Trust

WEST SUFFOLK NHS FOUNDATION TRUST

DRAFT MINUTES OF THE
Open Board meeting

Held on Friday 24 May,2024, 09:15 – 13:30
At the Drummond Centre, WSFT

Members:		
Name	**Job Title**	
Jude Chin	Trust Chair	JC
Ewen Cameron	Chief Executive Officer	EC
Nicola Cottington	Executive Chief Operating Officer	NC
Sue Wilkinson	Executive Chief Nurse	SW
Ravi Ayyamuthu	Interim Medical Director	RA
Jeremy Over	Executive Director of Workforce and Communications	JO
Louisa Pepper	Non-Executive Director/Deputy Chair	LP
Nick Macdonald	Deputy Director of Finance	NMc
Michael Parsons	Non-Executive Director	MP
Roger Petter	Non-Executive Director/Maternity and Neonatal Safety Champion	RP
Clement Mawoyo	Director of Integrated Adult and Social Care Services	CM
Peter Wightman	West Suffolk Alliance Director	PW
In attendance:		
Richard Jones	Trust Secretary & Head of Governance	RJ
Pooja Sharma	Deputy Trust Secretary	PS
Anna Hollis	Deputy Head of Communications	AH
Jane Sharland	Freedom to Speak to Speak Up Guardian	JS
Dan Spooner	Deputy Chief Nurse	DS
Sharon Farthing	Clinical Service Manager (shadowing Dan Spooner)	SF
Justyna Skonieczny	Deputy Head of Midwifery (Item 4.3.1 only)	JS
Kate Croissant	Clinical Director for Women & Children (Item 4.3.1 only)	KC
Ruth Williamson	FT Office Manager (minutes)	RW
Apologies: Craig Black, Director of Resources, Paul Molyneux, Medical Director, Helen Davies, Associate Director of Communications, Antoinette Jackson, Non-Executive Director/Senior Independent Director		
Governors observing: Val Dutton, Tom Murray, Andy Morris, Liz Steele, Florence Bevan, Gordon McKay		
Staff: Andy Morris, Charlotte Humphreys, WSFT.		
Members of the public: -		

1.0 GENERAL BUSINESS		
1.1	**Welcome and apologies for absence**	**Action**
	The Trust Chair (JC) welcomed all to the meeting and apologies for absence, detailed above, were noted.	
1.2	**Declarations of interest**	
	There were no declarations of interest for items on the agenda.	
1.3	**Minutes of the previous meeting**	
	The minutes of the previous meeting on 22 March 2024 were accepted as a true and accurate reflection of the meeting.	
1.4	**Action Log and matters arising**	
	Action Ref 3063 – West Suffolk Alliance and SNEE Integrated Care Board – at the request of the ICB, the presentation has been deferred to July's Board Meeting. **Action Ref 3075 – Collaborative Oversight Group Report - Appointment of non-executive director (NED) to group** – a substantive appointment will be delayed until a full cohort of NEDs is in place. In the interim, current NEDs to attend on an ad hoc basis. **Action Ref 3076 – Improvement Committee Report – Working with the Alliance** – update will be provided to July Board.	
1.5	**Questions from Governors and the public relating to items on the agenda**	
	<u>Q. re. Sepsis Screening</u> **Mortality rates have increased, with a decline in Sepsis screening within the Emergency Department (ED). Does the Board have sufficient assurance in the diagnostics to address this?** The Improvement Committee recently received a report on the Summary Hospital-level Mortality Indicator (SHMI) from the Associate Medical Director for Patient Safety & Quality. The deterioration in mortality is believed to be due to patients not being coded and it takes a year for uncoded patients to be removed from the stats. There is nothing to suggest this is a performance issue. The SHMI should return to a normal level next month. Whilst the IQPR does show a declining picture, only 2/3 patients were in the ED with neutropenic sepsis. June's report will include door to needle time data. It was highlighted that when looking at the Top 10 diagnoses for sickness, Neutropenic Sepsis patients were the highest risk group. Noted as part of the assurance process, reports go through the	

	Improvement Committee and governors were welcome to observe these meetings. Q2 re. Maternity **Is the Trust addressing the latest report to do with mothers and problems in giving birth (Birth Trauma Enquiry), as part of the work on Ockenden?** As the report has only recently been published, a gap analysis is being conducted with the intention of assisting those who have experienced a previous traumatic birth with any further pregnancies. This will be reviewed on a regular basis.	
1.6	**Staff Story**	
	A video was presented of Mark Pendlington (MP), High Sheriff of Suffolk, talking about the end-of-life care received by his mother whilst a patient in the Trust. MP's mother was admitted as an emergency prior to Christmas and remained a patient until her death several weeks later. Whilst at her bedside, MP witnessed the work of the Trust, including its charity, MyWiSH. He was impressed with the quiet professionalism shown and unconditional love. On Christmas Day, the charity had left a present by his mother's bedside table. A lover of stationery, they were both very pleased to open a moleskin notebook. Such care and attention on a very busy day. On learning that toast and marmalade was a favourite, this too appeared, along with a blanket for the bed containing his mother's favourite colours. It was the little things that mattered. In the latter stages, MP was with his mother 24/7 and the charity provided him with a "goody bag", containing a bottle of water, comb, toothpaste and mints. He too was being cared for. As people of faith, they had found the chaplaincy marvellous. The palliative care team too offered quiet sympathy. MP, in his role of High Sheriff, had felt it appropriate and a privilege to return to the Trust to formally thank those involved in the care of his mother and advised that he would be forever grateful. MP was invited to open the Butterfly Garden, a dedicated space for end-of-life patients and their families, funded by the charity and was keen to encourage people to donate to the work undertaken by MyWiSH. MP wished to acknowledge the focus on patients and relatives. Even with industrial action, the resilience of the team to rise to the challenge was noted. He urged everyone not to forget their	

	humanity, nor to let the process dominate. Simple acts of humanity meant so much. Another son at his mother's bedside had appeared lonely, but the charity was gently looking after him. The overall view was that you will be looked after. Question raised if the experience of the family could have been even better if the mother had been supported to die at home. It was acknowledged that there was more work to be done in recognition of patients in end-of-life care, so as not to over medicalise them. Work undertaken as part of the RESPECT roll out will encourage such conversations. It was agreed that these were important messages and should be shared with the organisation. In getting things right, it made such a difference to patients and their relatives. The importance of interplay between humanity and systems was stressed and how these were nurtured in the organisation's culture. Work is being undertaken on a thematic report not just from complaints and incidents, but also from compliments. **Action: Communications to consider how to share patient stories with staff.**	**AH**
1.7	**CEO Report**	
	Ewen Cameron (EC), Chief Executive Officer provided the highlights of the report. ***Urgent and Emergency Care*** – there has been a huge amount of work to achieve the nationally mandated target of seeing 76% of patients in our ED within four hours by 31 March 2024. In March 74% was achieved. ***Cancer*** – data from March shows the Trust is the highest performing NHS provider in the East of England in terms of 62-day Referral to Treatment performance targets, with 85.5% of patients having a confirmed cancer diagnosis and treatment being started within that timeframe. This is significantly above the national ambition of 70%. **Achievement for Hip Fracture Care** - the latest data from the National Hip Fracture Database (NHFD) confirms that the Trust's patients are receiving some of the best hip fracture care in England and Wales. **Proposal to move some planned elective orthopaedic activity to the Essex and Suffolk Elective Orthopaedic Centre (ESEOC) -** the forthcoming General Election had given concern that engagement with the West Suffolk population would be paused.	

	However, the Trust has been given permission to continue with engagement work. **The Call 4 Concern initiative, what sort of data will be collected. How will we prove it is working well**? A large number of referrals is not anticipated. The aim is to add an additional layer of safety. The Critical Care Outreach Team will be monitoring effectiveness. Provision of quantitative data will be difficult due to the low numbers anticipated, but will be discussed at the Deteriorating Patient Group, thus providing assurance. **Will Call 4 Concern merge with Martha's Rule or remain separate?** They will be linked, but the intention is not to lose one for the other. Call 4 Concern is for families concerned that they are not being heard. Martha's Rule is a legal framework for obtaining a second opinion. The Trust has applied to be a test site for Martha's Rule. **The recognition of work by the orthopaedic team, how do we ensure a consistency of approach when some work is moved to Colchester?** The Trust will be integrating pathways through partnership working. A joint meeting was held last week with clinical leads and multi-disciplinary teams (MDTs), with the aim of comparing practice and establishing a benchmark. **Reference has been made to the Trust's strategic response to the PA Consulting diagnostic review. The Insight CKI expresses concern on the quality of the initial response. What are the timescales for the Board receiving a proposed strategic plan?** This is anticipated for the July Board Meeting. **What further work do the executives need to do to get to a strategic response level?** There have been challenges in progressing this work and further work is required. **Is the timeframe of the response being ready for the next Board Meeting realistic?** Yes it is. The next iteration will go to Insight Committee on 17 June. Recommendations made in the report are already being actioned. It is the wider, cultural piece that is being worked on.	

2.0 STRATEGY		
2.1	**Future System Board Report**	
	Noted the cover sheet was prepared by Gary Norgate, Programme Director, Future System. The General Election on 4 July will result in a delay to receipt of the capital budget definition. There is concern that a new administration may take the decision to delay some capital programmes altogether. The Trust has received assurance that all is being done by NHS England to ensure progress. **Prior to the announcement of the Election, reports in the media and from NHS Providers suggested a reduction in funding. Was this scaremongering, or was there a genuine threat to all programmes?** Noted there were two cohorts of hospitals involved, those with RAAC and those without. The risk in not replacing RAAC was so great, it was not anticipated that there would be a threat to the programme. The urgency of timing was understood centrally. However, it could not be said that funding would not be reduced and therefore some compromises may be required. To get the hospital built by 2030 would be a challenge. Any extensions would require further discussion by the Board. The risk was understood. **The planned new hospital was considered the right size, was this supported by the system as a whole?** There are two issues that may affect size, the funding envelope and further national discussions on demand modelling. There were many gateways to be gone through. The work undertaken by the Future System team in this regard has been extensively scrutinised and understood to be in the right ball park. Discussions will continue. **Is the Trust able to start the outline business plan?** The next step will be the outline business case baseline and the Future System team is working on this.	
2.2	**System Update**	
	Clement Mawoyo (CM), Director of Integrated Adult Health and Social Care presented the report in Peter Wightman's absence. The following highlights were noted. ***Approach to partnership working at locality level***. Strong recognition that improving relationships within neighbourhood teams is important.	

	Primary Care Strategy for 24/25 supported at Alliance Committee. This will be presented at Integrated Care Board (ICB) June/July for ratification. Important to emphasise that the strategy has been coproduced with professionals and patients. ***Progress on targets in joint forward plan*** - this links in with the Alliance Delivery Plan and targets have been included in both. Now looking to share the delivery plan with teams. The role of voluntary sector in terms of prevention sector plays a pivotal role. Working with Community Action Suffolk to formulate a model to enable strength-based approach to focus on prevention. This is an ambition for WSFT and providing care closer to home. CEO of Community Action Suffolk is working with WSFT. Noted the Trust has an active volunteer section, who make a significant contribution to the care of patients. The Trust is in the process of recruiting a new lead for the voluntary services team and the scoping of opportunities forms part of that role.	
3.0 PEOPLE AND CULTURE		
3.1	**Involvement Committee Report**	
	Next meeting to be held on 19 June, 2024.	
3.1.1	**People and OD Highlight Report, including FTSU Report**	
	Putting You First Awards (PYF) – approval given to the three awards detailed. **<u>One of the PYF recipient's roles is not widely known. How did the Trust use such opportunities to communicate career opportunities externally</u>?** Work is currently being undertaken with the Communications Team on how to communicate career opportunities. ***People, Culture & Workforce Priorities*** – much work has been undertaken on the new plan for 24/25. Final engagement being undertaken and will be presented to the Involvement Committee in June for ratification. The content is developmental. Given the significance of the Trust's financial situation, this has been reflected in the plan, together with national requirements. ***Improving the Lives of Doctors in Training*** – NHS England have communicated additional expectations to try and rectify issues for junior doctors when rotating. Updates on these will be taken to the Involvement Committee. ***Statutory and Mandatory Training***. NHS England have initiated work to optimise, rationalise and reform mandatory training. The Trust will focus on quality of training rather than quantity. ***NHS Sexual Safety Charter*** – NHS England have launched its first ever sexual safety in the workplace charter for the NHS. A question	

	on this subject was added to the 2023 staff survey. This Trust's scores were slightly lower than the national average. In the last 12 months 4% of the workforce confirmed that they had been subject to unwanted attention, equating to 106 members of staff. The Trust will need to gain an understanding of what is happening and what lies behind the responses. It should be noted that this is not unique to West Suffolk, but a national issue. This has been included as a priority within the People and Culture Plan for this year and beyond. There are 10 actions within the charter, both reactive and proactive, that the Trust is committed to delivering. It was suggested that of the 106 who had responded affirmatively, there would be further who did not participate. This equated to 1 in 20 staff. Whilst appreciating that not only women were affected by this, 80% of the Trust's workforce was female. **Will the actions in the charter make a difference to these statistics, or are more actions required?** The actions will start to make a difference, but as part of the engagement work with colleagues they will also be asked what would make a difference. It was suggested that this went beyond the specifics in the charter. This was a matter of how the Board created a working environment that was respectful and enabled staff to call out such behaviour. Sexual harassment and abuse flourished when a lack of respect existed. Noted the percentage of unwanted attention in relation to patients and relatives was 1 in 10. The Board needed to be clear that the sort of behaviours described and experienced would not be tolerated and establish an environment where individuals felt safe to call them out, together with a mechanism for dealing with them. **Action: Active bystander training to be incorporated in to a Board Development Workshop, facilitated by HR.** **How does the Trust communicate externally to enable patients and relatives to understand what is acceptable behaviour?** Nursing colleagues advise that it is inpatient wards that experience this more than others. It was not often reported as staff tended to accept the behaviour. However, reports have been received of racism and low-level micro aggressions. The Trust is looking at allyship in nursing and will include racism, misogyny and microaggression. Addressing the shame of victims was as important as the Board talking openly about such matters. Noted some patients cognitive problems resulted in behaviour deemed unacceptable. Support for	**JMO**

	the staff member experiencing such behaviour should be paramount. **At times, when it is one person's word against another's it can be difficult to ascertain what has happened. How does the Trust envisage instigating a robust investigative system to impose sanctions where needed?** Experience has shown that much time and resource is required for such matters. It was not just about investigating and reaching a decision, it was also about how people were supported through what can be a traumatic process. It was also believed important to consider support to patients. Noted a working group was looking at the policy and patient experience feedback was being sought and at how situations such as a trauma response can be deescalated. **The Board formally approved the endorsement of the charter, recognising the need for further work.** **The uptake for leadership training exceeds availability. Is this due to capacity or suitability?** Noted this was a capacity issue. **If this training is achieving its intended objectives, was there a case for increasing resources?** The new programmes require evaluation, including inclusivity and equality of access and participation for all groups. ***Freedom to Speak Up (FTSU) Guardian Update*** Jane Sharland, (JS), Freedom to Speak Up Guardian was in attendance at the meeting to present her report. An increase in the number of concerns raised was noted. This was seen as a positive step in staff feeling able to raise issues. Noted the number of anonymous reports had reduced to normal levels. Work is being undertaken with the Organisational Development Manager on identifying barriers to speaking up. The main themes recognised were lack of communication, particularly in terms of major changes for staff shifts, pay and use of emails as a communication method, relationships and incivility, estates and facilities issues. The Associate Director of Operations, Estates and Facilities has advised that the reporting method for these has improved. Eight patient safety issues have been investigated and worked through. These numbers are low compared to staff issues and believed to be due to the robust reporting method via RADAR.	

	Results from the staff survey relating to raising concerns show results similar to last year. The average score is low, with a third of staff stating they did not feel safe to raise a concern. Progress is being made, but there is further work to be done. The Guardian is attending out of hour shifts in order to engage with night workers. **The FTSU discussions total 72 issues, but 45 contacts. What is the reason for the difference?** These can fall in to more than one category as the reason for the discussion and in this instance there were 45 contacts, but 72 issues identified. Noted that racial discrimination and sexual harassment were not reported and request for consideration of inclusion made. **Of the number reporting anonymously, is there any correlation between these the nature of the concern?** Noted this had not been considered previously. **Agreed correlation between anonymous reporting and nature of concern and identification of patterns to be reflected in next FTSU Board Report.** **The number of doctors reporting is lower than nursing staff. Doctors have clinical and educational supervisors that may be being approached first. Was there a reason for the difference?** Every profession has line management. The reason for coming to the Guardian may be due to having spoken up previously and not being content with the outcome or not sure what to do and have come to the Guardian direct. In many cases these reports do go back to line management for dealing with. Noted that one of the feedback examples was from a doctor and this was positive. One of the ways to promote the positive impact of speaking up was to ask people if their stories can be shared.	**JS**
4.0 ASSURANCE		
4.1	**Insight Committee Report**	
	Report noted. A review of the metrics used in the IQPR has been undertaken. Feedback welcomed by the Chief Operating Officer. **In order to help identify performance more easily, agreed that the latest IQPR summary be included within the Insight CKI report.**	**RJ/AJ**

4.1.1	**NHS 2024/25 Priorities and Operational Planning Guidance**	
	Noted the submission was made prior to this meeting and Insight Committee, due to the shortened timescales. Whilst for information, discussion and debate was welcomed. The Trust would need to challenge itself as to the level of ambition. Focus was required on the need to increase elective capacity and better use of resource, in terms of theatre utilisation etc. Its priority was to treat more patients and reduce waiting times and resultant level of harm. **Were the 32 national objectives the most challenging to achieve?** They are. The urgent and emergency care objective, whilst an improvement was shown in March it was difficult to achieve. 65 weeks was also a challenge. Plans are in place, but the Trust has been advised to make these based on the assumption of no further industrial action. There were also financial constraints. In relation to diagnostic recovery, there had been a delay from the original plan for the opening of the Clinical Diagnostic Centre. Benefit will be received from this in terms of available capacity ahead of the formal opening. MRI is area of risk. **Does the delay in moving to the East Suffolk and Essex Orthopaedic Centre affect the Trust's diagnostic recovery?** A delay will have an impact on theatre capacity at the Trust, with some patients waiting longer, but will not impact on specific targets. **The 4-hour standard, a key focus of Urgent and Emergency Care (UEC) planning and the shift of the UEC Performance Governance Group to Alliance level, how material will that be to achievement of the 78% target?** To date, governance of UEC performance has been internally focused. This move will signal a broader appreciation of other partners, opening the Trust up to challenge from Alliance partners as it moves forward.	
4.1.2	**Finance report**	
	Noted the outturn for last year has not been included in today's paper. The revised plan for a deficit of £6.3m landed Month 12, subject to audit. The Trust met its revised plan for last year. The budget and plan for 24/25 was agreed at an £18.9m deficit. At a recent extraordinary Board Meeting approval was given to amend the sum to £15.2m, predicated on the achievement of a 4% Cost Improvement Programme (CIP) of £16.5m.	

	In Month 1, whilst the CIP target was met, an overspend resulted in a £2.8m deficit, rather than the £2.4m planned due to non-recurring cost pressures in April. **In terms of ERF offsetting and extra contractual work, how will this income be appropriately reflected at divisional level?** Noted reporting on ERF is to be fed through the Insight Committee. **Has the £4m cash request, made in March, been received?** A response is awaited and anticipated this week.	
4.2	**Improvement Committee Report**	
	Noted two deep dives undertaken, c-Diff in March and post-partum haemorrhage in April. A letter has been received from the CQC regarding the paediatric audiology service and quality of care. Response to questions raised is required by 30th June, 2024.	
4.3	**Quality and nurse staffing report**	
	Safer Staffing – overseas recruitment has been paused due to challenge of placing in vacancies, indicative of positive vacancy rates. This will be reviewed in Quarter 3, in order to provide work for the 35 students due to qualify in October. In terms of emerging risk, the take up of university places has reduced, by almost half for the next intake. The review of winter safer staffing has been completed. No action to be taken, the audit tool used has changed. The CIP target of £865k was exceeded by £65k in Month 12, due mainly to a focus on temporary nursing staff. This has not affected quality indicators nor adversely impacted on patients. It was suggested that there appeared to be a disconnect between the figures achieved and feedback from nurses on the wards that they felt short-staffed. Noted the need to mitigate risk continued on a daily basis. The winter ward remained open and support was required to support UEC flow issues. Redeployment was regularly discussed. **In terms of overnight nursing fill rates, care staff are showing at over 100%. Is this to compensate for the deficits in the registered nurse rates?** Social hours pay enhancements fill shifts quicker. When showing over 100% for care staff, this is due to the need for one-to-one care, not currently in the establishment. Some of the incentives are being removed and there has been some reaction from staff to this,	

	as some will have built a reliance on these. Communication will be key. **<u>The third Clinical Negligence Scheme for Trusts (CNST) audit reflects a deficit within the community nursing workforce. What are the next steps in this regard</u>?** The community teams have engaged with the CNST to ensure the data is reliable. Further validation is taking place and no further action will be taken until that is completed. The Board offered its thanks to the nursing directorate for all its work in exceeding achievement of its CIP target.	
4.3.1	**Maternity services report**	
	Kate Croissant (KC), Clinical Director for Women and Children and Justyna Skonieczny (JS), Deputy Head of Midwifery, presented the report. Noted changes have been made to the approval process for the Maternity Incentive Scheme, with 10 key safety actions required to be achieved. Reporting pathways have been altered. Previously this has been via an internal governance process, the Trust Maternity Safety Champion and Board. The changes mean that this can now go via a sub-committee, (Improvement) to provide assurance with a final sign-off to Board. Concern expressed at the already heavy agenda for this meeting. This will be added to the meeting workplan, with the first sign-off taking place in February 2025. **<u>To understand improvements made against the Trust's CQC rating of requires improvement, is it right to reduce the amount of scrutiny</u>?** In moving to the Improvement Committee this will provide more scrutiny, particularly as on occasion time is limited for discussion at Board. Further there will be an opportunity for escalation to Board as required. All data goes through the Local Maternity and Neonatal System (LMNS). There are multiple routes for assurance. **The Board gave its agreement to the new approval process for the Maternity Safety Incentive Scheme.** **<u>The Service User Feedback and Healthwatch Suffolk Maternity Care and Support Service demonstrate an improvement and benchmark well. What is our level of ambition, as results still appear low in terms of positive feedback</u>?** Further engagement with service users will be beneficial in order to shape the service and adapt to users' needs.	

	Some of the training compliance figures are red. What is the reason for this? Noted in terms of core trainees, they rotate every four months, starting in April. They will achieve 100%, but all cannot be trained immediately. For neonatal nurses, skills and drills, a new set of requirements were published requiring redesign. This training was paused for a couple of months due to unprecedented situations, but is now up and running and plans are in place to achieve as soon as possible. **The work undertaken with Healthwatch, have we looked at this from an Equality, Diversity and Inclusivity (EDI) perspective?** An EDI midwife is now in post and is looking at some of the reviews through an EDI lens. The first thematic review has been undertaken and user engagement undertaken. The team is also looking at vulnerable groups to focus on continuity of care in order to reduce any risk of harm. **Forty-one out of 124 responses received relate to this Trust, are there any themes to be identified and how do we learn and share?** The survey looked at services across the region. A summary of the report was only published last month. Improvements have been seen, but the comments are being reviewed to glean any learning. **Themes and commentary from the Healthwatch report to be included in a future report to the Board.**	**KN**
4.4	**Audit Committee Report**	
	Noted a deep dive had been undertaken on procurement. The Insight Committee has been tasked with looking at the procurement dashboard as part of its regular reporting. The audit plan has been agreed for the year and assurance provided by the auditors. Progress made on audit recommendations, but further work to be done. Noted an error within the Standing Financial Instructions. Trust Management Executive should read Management Executive Group. **Following recommendation by the Audit Committee, the Board gave its approval to the Scheme of Reservation and Delegation of Powers (SoD) and Standing Financial Instructions (SFIs).**	

5.0 GOVERNANCE		
5.1	**Board assurance framework**	
	Noted 10 strategic risks have been identified. In terms of the financial risk, the Financial Accountability Committee (FAC) have reviewed these in detail and will report to Insight, demonstrating a change in the way the BAF and risks are understood. **Individual risks are seen at relevant committees. When will the whole BAF be received for review?** It is anticipated that this will be ready in time for the next Board meeting in July.	
5.2	**Governance Report**	
	Report noted. The improvement plan to address the findings of the Well Led report, structured around the recent CQC guidance, is planned to come to Board in July	
6.0 OTHER ITEMS		
6.1	**Any Other Business**	
	None noted.	
6.2	**Reflections on meeting**	
	The patient story - it is good to hear of the positive as well as the negative.	
6.3	**Date of next meeting** 26 July 2024.	

1.4. Action log and matters arising

To Review

Presented by Jude Chin

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
3076	Open	22/3/24	4.3	**Improvement Committee Report** - Look at how the Trust can work with the Alliance, to provide oversight on areas at the WSFT primary care interface.	Update to be provided to July Board. **PW and NC met 26.6.24 to discuss. Clinically-led meeting being arranged by end of July to discuss process for primary care/Trust interface, to report into Alliance Stay Well domain.**	PW/NC	26/07/24	Complete	26/07/24
3082	Open	24/5/24	3.1.1.	**People & OD Highlight Report, including FTSU Report** - Correlation between anonymous reporting and nature of concern and identification of patterns to be reflected in next FTSU Board Report	**Today's report refers (26.7.24).**	Jane Sharland	26/07/24	Complete	26/07/24
3083	Open	24/5/24	4.1	**Insight Committee – PA Consulting** - Include latest IQPR summary within the Insight CKI report	**Included in today's report (26.7.24)**	RJ/AJ	26/07/24	Complete	26/07/24
3084	Open	24/5/24	4.3.1	**Maternity Services Report – Healthwatch Report** -Themes and commentary from the Healthwatch report to be included in a future report to the Board**.**	**Healthwatch Report and action plan to be taken to the Involvement Committee at the end of October, 2024.**	Karen Newbury	26/07/24	Complete	26/07/24

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

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
3063	Open	26/1/24	2.3	**West Suffolk Alliance and SNEE Integrated Care Board:** **ACTION**: With regards the virtual ward (VW), the emphasis was given to ensure continued focus on VW and engage NEDs to ensure continued focus on this with visibility in the UEC update at the next board. Also, to provide an opportunity for NEDs to engage with team. **ACTION**: It was noted that there is a need to include focus on the ICB activities/issues in this report in future reports. **ACTION**: It was also agreed to schedule update on the SNEE ICB Joint Forward Plan in May.	Virtual ward update included in UEC update for Board and NED visit to Virtual Ward being arranged **(COMPLETE)** Included in agenda report **(COMPLETE)** **The ICB have asked that this is received at the September meeting - this has been confirmed and included in the forward plan.**	PM/NC PW RJ	27/9/24 ~~24/05/2024~~	Green	
3075	Open	22/3/24	2.3.1	**Collaborative Oversight Group Report** - The requirement for a Non-Executive Director (NED) in the oversight group was agreed. Chair to consider who to be appointed to the role.	**Substantive appointment to be delayed until appointment of new non-executive directors currently being undertaken. In the interim, current NEDs to attend on an ad hoc basis.**	JC	~~24/05/2024~~ 27/09/2024	Green	
3080	Open	24/5/24	1.6	**Staff Story** - Comms to give consideration to sharing of patient stories with staff	**The communications team creates and shares film content which often includes patients stories and going forward it will work with the patient experience team to share the patient stories used in Board more broadly, where appropriate. The high sheriff interview needs cutting and editing in order to be shared more broadly because it is too long in its current form, we will review that with the patient experience team. In the meantime the film has been shared with the experience of care and engagement committee, nursing and midwifery clinical council and on the Learning Hub via Totara.**	Anna Hollis	26/07/24	Green	
3081	Open	24/5/24	3.1.1.	**People & OD Highlight Report, including FTSU Report** - Active bystander training to be incorporated in to a Board Development Workshop, facilitated by HR.	**Appropriate date being identified for this training.**	JMO	29/11/24	Green	

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

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

To Note

Presented by Jude Chin

1.6. Patient story - Video - Yvonnes' story

To Review

Presented by Susan Wilkinson

1.7. Chief Executive’s report

To inform

Presented by Ewen Cameron

Trust Board Committee 26th July 2024	
Report title:	**CEO report**
Agenda item:	1.7
Date of the meeting:	Friday, 26 July 2024
Sponsor/executive lead:	Dr Ewen Cameron
Report prepared by:	Dr Ewen Cameron and Sam Green

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

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

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

Performance

Since our last meeting, the Trust has recruited two new Board members and five new non-executive directors. They will each bring their expertise to help the Trust build a positive and successful future.

We welcomed our first executive director of strategy and transformation, Sam Tappenden, in June. Recruiting to this role was one of our strategic objectives for 2023/24, and Sam will help us make transformative changes and improvements in a wide range of areas. Sam joins us from East and North Hertfordshire Health and Care Partnership where he was director of development. In addition, we welcomed Jonathan Rowell in July, who takes on the position of director of financial recovery for a 12-month secondment from NHS England. Jonathan has more than 25 years' experience in NHS finance.

We are in a significant period of financial constraint and cost savings are critically important over the next three years. Together Sam and Jonathan will be working with our teams to help recover our financial position. While this is a sizeable challenge and one being felt across the NHS, patient safety will always be a central focus.

The Trust has also recruited five new non-executive directors from a great pool of talented candidates. They are:

- David Weaver: David has 35 years' experience in leadership positions in the financial services sector, where he advised and financed technology and growth companies. David is currently chair of the Orbit Group, which manage more than 47,000 homes in the midlands and the east of England.
- Alison Wigg: Alison has non-executive director experience within the East of England Ambulance Service NHS Trust and has chaired the strategic digital investment committee for the Suffolk and North East Essex Integrated Care Board (SNEE ICB), as well as more than 30 years' experience in global telecoms. Alison is currently a Board member for Suffolk Libraries and a STEM ambassador to promote science and technology in schools.
- Dr Paul Zollinger-Read C.B.E.: Paul worked as a GP in Braintree for almost 25 years, during which he became the chief executive officer of various primary care trusts in the east of England. Paul was also the former director of primary care at the East of England Strategic Health Authority and Bupa's chief medical officer. Paul currently holds several non-executive positions in health organisations.
- Heather Hancock: Heather trained as a scientist and has risen to board-level roles at biopharma company GSK and BMI Healthcare, before becoming chief executive officer for Promatica Digital. Heather is currently chief strategist and change maker for healthcare consulting service, The Conclusion People.
- Richard Flatman: Previously of Deloitte and group chief finance officer for London Southbank University Group, Richard is currently a non-executive director, senior independent director and chair of the audit and risk committee at South West London and St George's Mental Health Trust. Richard is also vice chair and chair of the audit and finance committee for South Bank Academies and Multi Academy Trust.

As you can see, everyone above has tremendous amounts of experience from various sectors of the economy.

We are working to build a strong cost improvement programme (CIP) that focuses not just on reducing spending, but improving efficiencies in how we work. The benefits of which will be seen not just in the overall financial position, but in the quality of the services we provide for our patients, staff, and visitors too.

At the end of June, we finished the month with a £9.5 million deficit. This is significant as we planned to finish 2024/25 with a £15.2 million deficit, therefore, we are £3.1 million over where we wanted to be at that point in the year. While we hit our CIP targets for the first three months, this

significantly increases from £507,000 a month to more than £1.5 million a month until the end of year, which will take considerable effort to achieve.

Achieving our CIP is crucial, and we will undoubtedly have to take some difficult decisions, that being said, there are positives we can highlight. Our pharmacy teams have worked hard during 2023/24 to implement a programme of medicines optimisation, which includes using biosimilar medicines and generic medicines to reduce our spending, as well as reducing the wastage of medicines and improving our procurement practices. During 2023/24, the team identified a £1 million CIP, with the first swap to a biosimilar medicine due to provide £250,000 to £300,000 of savings every year. We spent almost £29 million on medicines alone in 2023/24, so it is important that we spend every pound wisely.

We have also been improving how efficiently we use our theatres, particularly for planned elective operating sessions. Under NHS England's Getting It Right First Time (GIRFT) programme, trusts are expected to achieve 85% capped theatre utilisation, which supports NHS England's priorities and planning guidance to secure sustainable elective recovery. Over the past five years, the Trust has improved its capped and uncapped theatre utilisation rates, and thanks to a concerted effort from our surgery teams, we are expected to achieve 83.4% in 2024/25 for capped and 92% for uncapped. This means we are much better at using our time, staff, and resources to ensure we are seeing as many patients as possible, improving productivity and reducing running costs.

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

- 532 patients waiting more than 65 weeks (this is compared to April 2023, when the cohort of patients who needed to be treated was 15,878). We are now working towards eliminating 65 week waits by the end of September
- 60 patients waiting more than 78 weeks, of which 43 were capacity related breaches.

Quality

To ensure our patients are supported by their clinicians in making decisions about their care that are right for them, the Trust recently began implementing Shared Decision Making. This is a professional duty set out by the General Medical Council (GMC), with the National Institute for Health and Care Excellence (NICE) also mandating that all NHS organisations promote this process. These conversations bring together a clinician's expertise with what the patient knows best - their personal preferences, circumstances, goals, values, and beliefs. We made a mandatory training e-learning module available to our doctors on 1 July, which will also form part of induction training for all new doctors that join the Trust. Our public health teams are in the process of rolling this out to other clinical staff cohorts later this year.

I would like to take the time to thank one of our Trust charities – Friends of West Suffolk Hospital – who have generously funded numerous projects across the Trust with a series of grants. Totalling almost £90,000, this funding was made possible through donations and legacies from the local community, as well as funds raised by volunteers in their shop at the West Suffolk Hospital. We will share news on these in due course.

Workforce

Despite the pressure that the Trust is under, our colleagues continue to be innovative, creating and implementing new initiatives to improve patient safety and the quality of the care we provide. This is perfectly demonstrated through multiple team award nominations and successes.

Our surgical nursing teams have been shortlisted under the 'Theatre and Surgical Nursing Award' category for this year's Nursing Times Awards, for the work they are doing to improve patients' recovery from hip fracture surgery by providing targeted nutritional supplementation. Our maternity service has been shortlisted for an HSJ Award under the category of 'Safety

Improvement through Technology', for their use of social media to help women and pregnant people best understand the choices they have around their birth and care, as well as promoting health advice antenatally and postnatally.

In addition, the 'Virtual Bones' initiative, which enhances the efficiency of musculoskeletal injuries management and pathway referral, won in the category of 'Improving Urgent and Emergency Care through Digital' at the HSJ Digital Awards 2024.

These are incredible achievements and testament to our staff's commitment to improving patient care. Congratulations to those who have won and best of luck to those teams shortlisted.

It is fantastic to see our Trust's thriving staff networks – the REACH, Pride, disability and parent and carer networks support colleagues and offer the opportunity to connect over shared experiences and identities. Our Pride staff network marked Pride Month in June, underlining the Trust's commitment to making this an inclusive and respectful place in which to work, or be cared for.

To support the health and wellbeing of our workforce, in June, the organisational development team launched the Trust's first 'workplace adjustments' package. This new suite of resources will help support colleagues with diverse needs. Created in collaboration with the disability staff network, it contains helpful resources designed to support the identification, implementation, and future amendments of adjustments for colleagues with health conditions. It is incredibly important that we do all we can to protect and improve the health and wellbeing of our workforce and enable all to flourish in their roles.

With this year being the 50th anniversary of the West Suffolk Hospital, we have recently revived the historical society. Originally formed in 2019 but unfortunately petered out during Covid-19, this gives our staff the opportunity to share stories about the Trust and delve into the archives to uncover the history behind this hospital, which has provided care for our communities for half a century. With the first meeting taking place on 12 August, I hope this continues as another unique part of the social fabric of the West Suffolk NHS Foundation Trust.

Future

From mid-May to 30 June, the Trust along with SNEE ICB, carried out public engagement on plans to move approximately 60% (around 1,500 operations a year) of planned elective orthopaedic services from the West Suffolk Hospital to the new, state of the art centre in Colchester. The centre, which is due to open later in 2024, will be called the Essex and Suffolk Elective Orthopaedic Centre (ESEOC), and will be housed in a new building called the Dame Clare Marx Building.

The engagement was carried out through an online survey, outreach events and mini exhibitions, where members of the public were able to ask questions and find out more about the proposal. The engagement was also promoted at local libraries, GP practices, supermarkets, and local community groups. It finished with more than 2,200 responses, and the results are being independently analysed by Healthwatch Suffolk, with the corresponding report expected to be published very soon. Once this has been published and we have taken stock of the findings, we will provide an update on our plans going forward.

Significant progress is being made to deliver a new Community Diagnostic Centre (CDC) at the Newmarket Community Hospital. Construction began in early 2024, and the project is now more than halfway done, with the interior spaces beginning to take shape. Due to be completed by early-November 2024, the first patients are expected to be seen before Christmas 2024.

This facility will provide a wide range of diagnostic tests, such as MRI, CT and ultrasound scans, and blood and lung function tests. Around, 100,000 tests are expected to be carried out a year, which will not only help us reduce waiting times, but importantly, improve patient outcomes, and provide the care our communities need, closer to home.

To deliver on these ambitions we need the workforce. I was delighted to see how popular the recent West Suffolk Community Training Academy was, which offers those in our local communities with no prior experience in the health or care sector the opportunity to gain these skills and experience an exciting and rewarding career in the NHS. The first cohort have completed masterclasses, are currently finishing their placements, and will be preparing for or will have gone through their guaranteed interview for a position within the Newmarket CDC, the wider Trust or within primary care. This is one of the ways in which we collaborate with our local education system and health partners to build new pathways into the NHS. I look forward to meeting the successful applicants when this new facility is up and running.

While we frequently work across the Suffolk and North East Essex Integrated Care System (SNEE ICS), particularly with our ICB partners, we have been working very closely with the East Suffolk and North Essex NHS Foundation Trust (ESNEFT) for some time. We have recently formalised this collaborative approach with the formation of the Suffolk and North East Essex Provider Collaborative at a joint Board meeting on 4 June. A key milestone, this strengthens the governance arrangements between our organisations and will ensure we use our resources as efficiently as possible, reducing replication in key areas and capitalising on economies of scale, with the ultimate goal of delivering a single system approach to healthcare.

Over the year, the focus of this will be in five areas: clinical services; elective recovery; efficiencies at scale; digital; and development. Example workstreams include producing an integrated care system clinical strategy, increasing our diagnostics workforce, reviewing our corporate services, looking for digital opportunities across the system and the formation of a collaborative project management function.

On 24 September, we have our healthcare event and Annual Members' Meeting at The Apex in Bury St Edmunds. This gives us the opportunity to give our local communities insight and access to a range of the Trust's services, other local health and care services, as well as an update on how we've done over the past year. This year, the event will focus on the West Suffolk Hospital's 50th anniversary and how we are developing and improving our diagnostic imaging. It will start at 3.30pm, featuring stalls from our teams and health and care partners, with a talk from 5.30pm to 6.35pm. Attendees will have the opportunity to ask any questions to our presenters and executive team and light refreshments will be on available. All are welcome and it is free to attend. I look forward to seeing you there.

2. STRATEGY

2.1. Strategic Priorities Report

For Approval

Presented by Ewen Cameron

Board of Directors	
Report title:	**Strategic priorities**
Agenda item:	2.1
Date of the meeting:	26 July 2024
Sponsor/executive lead:	Ewen Cameron, Chief Executive
Report prepared by:	Ewen Cameron, Chief Executive

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

Executive Summary

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

s:

In 2023/24, we agreed 5 priorities:

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

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

The report provides a year end position summarising progress against delivery for these priorities.

Many of the priorities remain for 2024/25 but, through engagement with the Senior Leadership Team and Board, we have produced a set that build on the progress made in 2023/24.

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

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

Progress and plans for the next two months are described in the report.

Action Required of the Board

The Board is asked to approve:

- Review the report and note progress

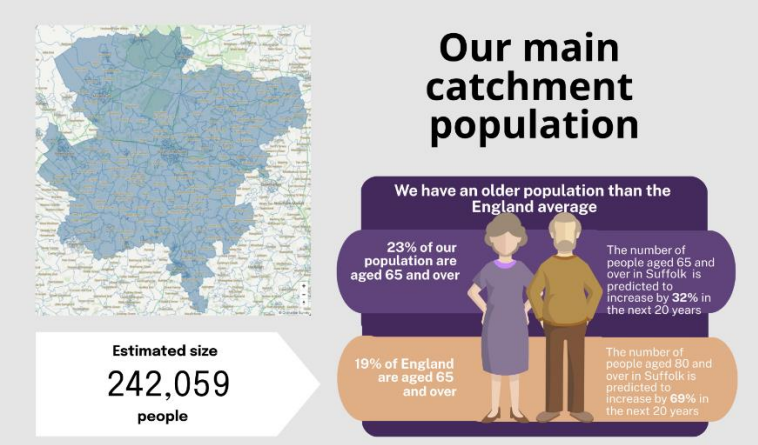
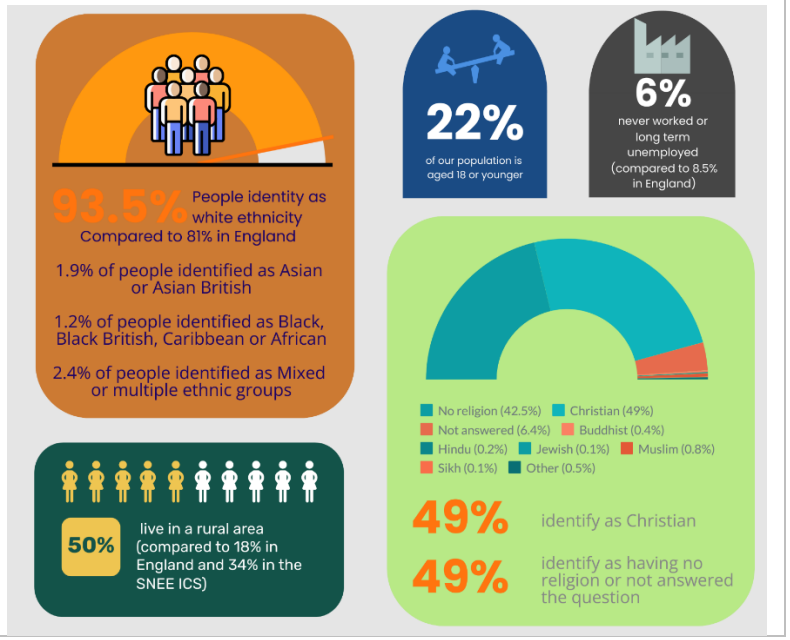
Strategic priorities 2023-24 – year end report

Action	Activities/progress in year	Measures of success
Plan and deliver against the priority areas for service pathway change *Exec. lead – Paul Molyneux* *Operational delivery lead: Alex Baldwin*	**Frailty –** Integrated frailty action plan has been developed – focus on proactive community identification / management and reactive acute service. In reach reablement to acute wards has been agreed. Acute frailty hub plan is being rolled out. Trust and alliance partners aligned around a single plan. **Virtual ward –** Revised roll out plan for clinical pathways and associated capacity increase has been agreed. Arrangements are in place to transfer governance to community division effective 1 Feb 24. Agreement in place for onboarding patients residing in South Norfolk which is a significant development. **Urgent Community Response –** Extension of overnight care provided by EIT for patients on discharge. Development of Advanced Clinical Practitioner (ACP) SOP in UCR service. **CYP services –** Service review is being finalised with input from community and alliance partners. Recommendations include service improvement, governance arrangements (including rethink review feedback) and direction on future service structures. **15 session weeks –** Agreement in place to move to 11 sessions p.w. with T&O and plastics specialties. Detailed productivity plan has been developed in conjunction with NHS England regional improvement team. **Transformation plan –** Objectives for 2024/25: ▪ Outpatients ▪ Urgent and emergency care (UEC) ▪ Integrated neighbourhood teams ▪ Developing our children and young people strategy ▪ Diabetes ▪ Service reconfigurtation. Delivery against these objectives will be measured through the 2024-25 priorities: • **Deliver 2024-25 priority areas for service pathway change as identified by the Clinical and Care Strategy.** • **Continue to deliver and embed 2023-24 priorities which are multi-year. Transition to business as usual will be supported by the Change Hub.**	• Frailty – deliver integrated frailty model leading to 10% reduction in falls and frailty related admissions by March 2024. • Virtual ward – to deliver 103 virtual beds by March 2024. • Urgent Community Response – increased service provision up to 7 day, 24hr service by March 2024. • Work to bring community and hospital services for children and young people closer together for the benefit of families using our services • Pilot of 15 session weeks – piloted in 1 surgical specialty (electives and OPD) by March 2024. • Agreed 3-5 year project plan for delivery of transformation by March 2024.

Action	Activities/progress in year	Measures of success
Collaborate to provide seamless care at the right time and in the right place for end-of-life patients *Exec. lead – Sue Wilkinson* *Clinical delivery lead: Mary McGregor* *Operational delivery lead: Sharon Basson*	• Model of Care – Following on from completion of scoping exercise – Focus groups being established to take forward areas of opportunity. o Moving forward with the following key areas; o Anticipatory/Just in case medicines policy (Linking with the ICS group). o Education and literature (Linking with compassionate Charter). o UCR, INT and Step-up (linking with age well) o Work has commenced to link SPC with EIT and care homes. o Review underway to understand the EOL activity within UCR and how this can be monitored and improved if required. o Virtual ward (Linking with WSFT and the Hospice) o Work has commenced to embed SPC into the existing VW pathways with bi-weekly meetings. o Crisis planning and management • Sourcing a solution to identification of people in their last year of life. – request to BI for required reports o New BI dashboard to be used to support the wider programme planning of work for FY24/25 o Data being presented in monthly Die Well domain meetings, needs further refinement o Macmillan PEoLC ICB lead is also working on this across the ICB. Engaging with primary care to facilitate identification and reporting • Continue to roll out ReSPECT o Linking the new Macmillan post and the WSA Personalised care manager to help support the model of care focus group around ReSPECT, Personalised care and additional funding/benefit support such as SR1, Grants, blue badge schemes etc. o ReSPECT planned rolled out on eCare for hospital inpatients • Virtual ward o Twice weekly palliative care consultant attendance at virtual ward MDT providing advice, support and clinical review when needed. o Specialist palliative care stream in VW being developed, alongside input of INT teams	• Advanced care plans in place for 50% of patients at the end of life by March 2024 • Virtual ward effectively utilised – end of life pathway in place and capacity to deliver by March 2024 • 70% of patients die in their preferred place of choice by March 2024 • 10% reduction in admissions within 48 hours of end of life by March 2024 • 24/7 support for end of life patients and their relatives/ carers is available by March 2024 • ReSPECT is in use 100% by March 2024

Action	Activities/progress in year	Measures of success
	○ Care homes frailty project also being supported to help avoid unwanted acute hospital admissions • Family Administered Medicines (FAM) Project ○ Supports patients to die in their preferred place by increasing their access to good symptom control ○ Process agreed across the ICS- relaunch planned for Autum 2024	
Equality, Diversity and Inclusion *Exec. lead – Jeremy Over*	• Inclusive Leadership Charter, Anti-racism pledge and National EDI improvement plan actions all integrated into the Inclusion workplan, with assigned action owners. Actions tracked and recorded every 6 weeks • Board awareness raising of EDI undertaken, including EDI objectives as part of appraisal and Board development sessions undertaken • New non-medical appraisal process launched with the requirement for an EDI objective to be included for all colleagues • All concerns actioned by FTSU Guardian • EDI monitoring introduced for FTSU concerns to evaluate any trend data and patterns emerging • TRAC recruitment system introduced which supports inclusive recruitment practices and Two Ticks guarantee interview scheme commitment made. Recruitment training for managers includes aspects of inclusive recruitment, although further work planned to on reducing bias • Guide, process and Trust wide application process for workplace (reasonable) adjustments launched in June 2024, including an innovative assistive technology guide • Greater focus on data analysis and evaluation to inform decision making, including the development of data sets across all protected characteristics • Equality Impact Assessment guidance and process reviewed and piloted prior to finalisation and launch in summer 2024 • Staff networks revitalised, with executive sponsors assigned and regular meetings with chairs for peer support and consideration of intersectionality issues. New governance and guidance issued • New Parent and Carers staff network launched • Positive action statement included with all learning and development programmes to encourage participation by all • Additional resources included on the Learning Hub to support learning around a wide range of EDI issues, including inclusive leadership • EDI a core theme integrated within all WSFT leadership programmes, strengthened latterly with reference to tackling sexual harassment as part of creating an inclusive environment	• Prepare to deliver against the Inclusive Leadership and Anti-racism pledge by March 2024 • Action taken with feedback and learning for all EDI-related speak up concerns and reports of harassment, bullying, discrimination or abuse by March 2024 • Framework & guidance for reasonable adjustments published by March ’24 • National EDI improvement plan measures

Action	Activities/progress in year	Measures of success
Line management development *Exec. lead – Jeremy Over*	• Span of line management control data analysis undertaken at divisional level, with local action plans in place to address identified issues • Values based line management standards developed and being socialised for final publication and integration into Trust approaches/processes • Coaching and mentoring framework drafted with change of staffing delaying the final document. Progress made with launching 2 coaching programmes and a range of bite-sized sessions in order to grow our internal coach pool and coaching expertise amongst staff and managers in general terms • Learning Hub launched on 27 September 2023 with content continuing to be added. Phase 2 development planned for autumn 2024 • Aspiring Leadership, Stepping into Leadership, Operational Leadership and Coaching and Mentoring programmes all launched in October 2023. Strategic Leadership programme in development ready for launch autumn 2024. • Management skills webinars launched and being delivered every month. Leadership skills sessions delivered every month. • Operational essentials launched for senior operations managers. • Team development interventions delivered for over 22 teams in 2023/24, an increase from 13 teams in 2022/23. Enquiries/bookings for 2024/25 already at 17 teams • HRBP's worked with divisions to improve appraisal rates. 85.7% at December 2023 demonstrated an improved variation however still below target. New non-medical appraisal framework and paperwork launched January 2024. Continued increase in June 2024 to 88.31% • Welcome to the Trust relaunched, with a clear focus on living the Trust's values • Staff survey results for 2022/23 showed all 9 scores had improved compared to 2022, with 5 of the 9 in a significant way. 7 of the 9 are better than the national average, although 2 are lower.	• No line manager with more than an agreed number of direct reports by March 2024 • Values-based line management standards agreed and published by December 2023 • Coaching and mentoring framework agreed by September 2023 • Learning Hub launched by September 2023 • Line manager development package published and in delivery by December 2023 • Appraisal completion rates at 90% by December 2023 • Improvement in staff survey indicators (longer-term)

Action	Activities/progress in year	Measures of success
Launch the WSFT Prevention, health inequalities and personalised care strategy by 31st August 2023 Train colleagues in prevention, health inequalities or personalised care by 31st March 2024. *Exec. lead – Paul Molyneux* *Clinical delivery lead: Helena Jopling*	The prevention, health inequalities and personalised care strategy was approved and adopted by the Board in December 2023. 668 colleagues had been training in PHIPC topics by 31 December 2023. Topics include: • Health coaching • Learning disability and autism awareness • Smoking cessation • Making every contact count 	• Prevention, health inequalities and personalised care strategy is approved by the board and published on the trust website • 1,000 colleagues trained in prevention, health inequalities or personalised care 

Continue and expand the inpatient tobacco dependence service, supporting 350 people to stop smoking by March 2024, 40% of whom will live in the most deprived areas *Exec. lead – Paul Molyneux* *Clinical delivery lead: Jessica Hulbert*	<u>Acute inpatients</u> Through collaborative working with SNEE ICB and Suffolk County Council Public Health and Communities team, WSFT established a tobacco dependence team in early 2023. By November 2023, the team was successfully seeing all people admitted to West Suffolk Hospital who smoke, well ahead of the March 2024 deadline. The team uses an opt-out approach, whereby people can decline help at the point that a tobacco dependence adviser visits them to discuss smoking cessation options. Provisional outcomes for April 2023 to March 2024 include: • 925 inpatients were offered smoking cessation support • around half of people opted out of making a quit attempt. Every person who opted out still received very brief advice, harm reduction information and/or support for temporary abstinence for a smokefree stay instead. • 32% of people were from the 40% most deprived areas • 33% of people successfully quit and remained smokefree at 4-week follow-up • 23% of people who lived in the 40% most deprived areas successfully quit. <u>Maternity</u> With the benefit of strong partnership commitment, the smokefree maternity pathway was established in May 2023, seeing 100% of pregnant people who smoke and offering support to all their household members who smoke too. Again, this was well ahead of the NHS Long Term Plan deadline of March 2024. The service delivers all the mandated requirements of Element 1: Reducing smoking in pregnancy of the Saving Babies Lives Care Bundle. The pathway is offered at the pregnancy booking appointment on an opt-out basis. It continues until 6-weeks post-birth. The first people who have followed the pathway since it started have only just recently given birth, so the quality and outcome	• Number of people who successfully quit for 4 weeks • Percentage of people who successfully quit who live in the 40% most deprived lower super output areas

	measures will become clearer during 2024-25. However, early indications are: • around 20% of pregnant people who book with the Trust each month smoke (approximately 50 people per month) • there is a 50/50 split between people who have recently quit, who go onto a surveillance pathway, and people who are currently smoking, who go onto the treatment pathway • around 60% of smokers make at least one quit attempt during their pregnancy smoking at the time of delivery – the principal national outcome measure - has reduced from 11% to close to the national target of <6%. <u>Feel Good Suffolk</u> The Trust has supported the development of a new approach to providing community-based healthy behaviours services, being pursued by Suffolk County Council in partnership with the 5 district and borough councils in Suffolk. The new service is delivered under the brand Feel Good Suffolk and covers smoking cessation, adult weight management and physical activity services. The Trust's public health team has provided specialist advice and consultancy during the planning, design, go-live and post-live development phases. This has included epidemiology, advice on the smoking cessation service model, providing shadowing for Feel Good Suffolk advisors with the tobacco dependence team, and the creation of a quality and clinical governance framework for the partnership. We will continue to support Feel Good Suffolk in 2024-25, as part of our board strategic objectives, by ensuring a good level of referrals from WSFT services. <u>Smokefree site</u> The Trust has built on human factors research and stakeholder engagement, which was conducted during 2022-23, to establish a comprehensive tobacco control plan and a smokefree site	

Action	Activities/progress in year	Measures of success
	implementation plan. The smokefree site working group has included patient representation, staff representation and West Suffolk Council. In 2024-25, the Trust will be ready to sign the NHS Smokefree Pledge and implement a comprehensive, compassionate approach to achieving a smokefree site at West Suffolk Hospital. We will build on the learning generated during implementation at West Suffolk Hospital to tailor and extend the approach to the Trust's other premises.	
Review the structure and capacity of the change hub *Exec. lead – Nicola Cottington* *Operational delivery lead: Matt Keeling*	• 6-month review of the structure and function of the West Suffolk Change Hub presented at SLT in October 2023. • SLT supported future focus of change hub on implementation of clinical and care strategy • Board and renumeration committee approval for executive director of strategy and transformation post to be established • Executive director of strategy and transformation role advertised in December 2023 • Identified Future Systems Clinical & Care Strategy priorities for 24/25 • Delivery of a portfolio of programmes presented at Corporate PRM including Focus on Flow as part of seasonal response. • Following self-assessment of the NHS Impact methodology by the Change Hub, this was built on with wider input, at SLT • Appointment of executive director of strategy and transformation in Q4, start date June 2024 • Identification of metrics, milestones and measurement of benefits has been challenging with 2023/24 objectives as these were not always clearly defined and measured prospectively. • Objectives and deliverables linked to Future Systems Clinical and Care Strategy priorities finalised and presented to Senior Ops Forum in Q4. • UEC recovery plans consolidated into a 'Patient Flow Improvement Core Resilience Team (CRT) delivered in Q4 and evolved into a UEC Delivery Group for 2024/25, linked to the SNEE UEC Forward Plan	• Revised structure in place by April 2024 • Explore options in relation to leadership and support to the transformation and change function

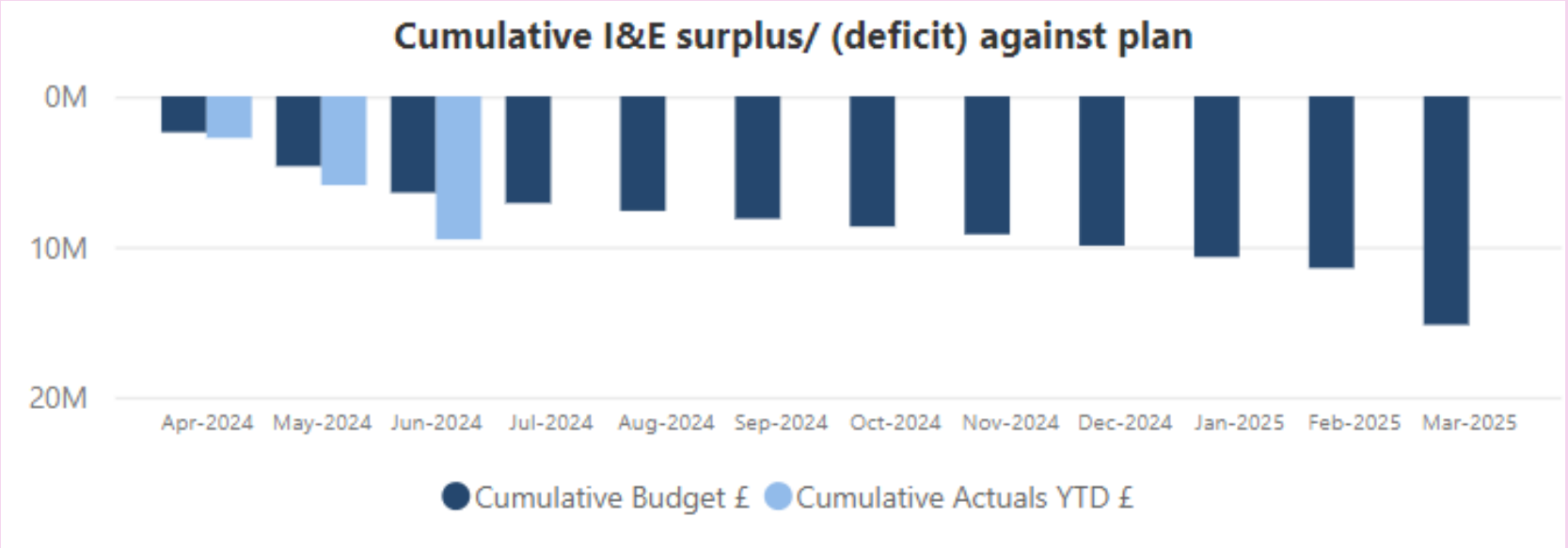
Strategic priorities 2024/25
Progress report – July 2024

SMART actions	Measures of success	Activities/progress in last 2 months	For the next 2 months: - Key risks - Deliverables/milestones
Priority: **Delivery of long term sustainability for health and care in west Suffolk**			
• Plan to implement the components of NHS IMPACT (building a shared purpose and vision; investing in people and culture; developing leadership behaviours; building improvement capability and capacity and embedding improvement into management systems and processes). *Exec sponsor: Director of Strategy and Transformation*	There are a range of measures to test whether the CQI approach is embedded: • Consistent methodology agreed. • Number of staff trained in CQI. • % of staff reporting improvement is critical to the Trust's culture. • Establishment of CQI faculty. • Number of CQI champions recruited. • Tangible benefits delivered in priority areas (e.g. reduction in HAIs).	• Attended NHS IMPACT conference with system partners. • Met with WSFT colleagues in QI, Human Factors, OD, and comms teams to start scoping. • Explored appetite for collaborative approach with ESNEFT and NSFT.	• Conduct stocktake of work done on CQI to date. • Hold scoping workshop with WSFT teams. • Develop plan for implementation of approach to CQI by April 2025.

SMART actions	Measures of success	Activities/progress in last 2 months	For the next 2 months: - Key risks - Deliverables/milestones
Priority: **Delivery of long term sustainability for health and care in west Suffolk**			
• Proactively grow our community services division through: - new, community-focussed clinical pathways in line with the implementation of the clinical and care strategy (see related action below) - shift of resources and activity from acute divisions to community division - productivity improvements within community services *Exec sponsor: Chief Operating Officer (Nicola Cottington)* *Clinical delivery lead: Clinical Lead for Quality and Safety, Community and Integrated Therapies Division (Karen Line)* *Operational delivery lead: Associate Director of Community Paediatric Services (Nic Smith-Howell) and Associate Director of Community Adult Services (Kevin McGinness)*	• In line with national direction, reduce overall workforce growth to 0% net growth, recognising the need to grow community services to support the planned transfer of activity from the acute hospital. • Increase in Urgent Community Response (UCR) activity by 10% by March 2025 compared to 23/24 baseline • Increase in virtual ward (VW) activity to 100 bed capacity and 80% occupancy by March 2025, monitoring a monthly trajectory towards this goal • Respond to expected national community productivity measures when released • 24/25 business plans in community and acute divisions reflecting ambitions above, signed off by 31st March 2024	• WTE growth monitored through finance and workforce reports • Compliance against UCR 2 hour target since March 24 remains significantly above 70% target. • Achievement of 10% increase in activity over 24/25 remains on track. • VW occupancy and bedbase trajectory on track through April/May. • National Community productivity measures not published as yet. • Business plans signed off at Performance Review Meetings	• Continue to monitor WTE in the divisions, ensuring robust control for recruitment. • Continue recruitment to VW using phase 2 funding where appropriate to achieve 100 bed trajectory. • Review workforce requirement and deployment to contineu to achieve 10% increase in activity over 24/25 • Shared Services project commenced in Mildenhall to enhance productivity across VW and UCR response commenced April 24. • Monthly business plan monitoring and escalation through Divisional Boards to PRM where necessary.

• Improve productivity within acute services.
 	
Exec sponsor: Chief Operating Officer (Nicola Cottington)
Operational delivery lead: Deputy Chief Operating Officer (Matt Keeling)
	• Improve capped theatre utilisation to 85% by March 25, monitoring a monthly trajectory towards this goal
	• Align 85% of high volume, low complexity (HVLC) theatre activity with GIRFT cases per list standards by March 2025
	• Implement British Association of Day Surgery(BADS) recommended rates of day surgery for all specialties by March 2025
	• Respond to expected acute productivity measures and incentive scheme when released
	• Deliver the system specific activity targets for outpatients, driven by the outpatient transformation programme including:
	  • 25% of appointments delivered virtually
	  • 16% of first attendances managed through Advice and Guidance
		• Capped utilisation remains on upward trajectory, delivering 79.9% against target against target of 79%
		• March 24- BADS day case rates were 83.1% (latest data), now top of third quartile and 3rd best in region
		• GIRFT HVLC in orthopaedics saw dip from 87.5% to 71% (Q1) of all HVLC lists, this driven by estates issues in theatres.
		• Ophthalmology delivering 28% of HVLC lists on target, 1.3 cases behind trajectory.
		• New operational planning target: % of outpatient attendances that are first attendances or include a procedure. System target 46.0%, WSFT Apr 24 delivery of 37.0% (2023/24 total 36.8%).
		• Virtual (remote) appointments 20.7% in May 24, Advice & Guidance (now renamed to Specialist Advice) 8.7% in May 24
		• Quarterly milestones will be developed for for virtual appointments for next report.
		• System-wide outpatient imporvement collaborative launched, repprting perfomamnce into SNEE Elective Care Programme Board and Alliance Stay Well domain.
			• Development of retrospective versus planned automated dashboard (Aug 24)
			• Agreement from clinical leads to book all HVLC lists to 100% (Aug 24)
			• Return of F6 ward, enabling elective bedbase to increase from 12-18 beds (3 bed deficit) (Jul-24)
			• Splitting of capacity report by division enabling greater oversight over surgical bedbase (Jul-24)
			• Risk- summer period and need for reduction in bank/agency spend in theatres- review of projected delivery being undertaken and cost benefit analysis
			• Resurgence of COVID-19 infection, may result in more clinical cancellations and increased capacity constraints due to IPC.
			• Outpatient productivity –review of coding opportunities, e.g. in cardiology which may be under-reporting.
			• Remote appointments - commence on Video Consultations using the existing platform with lunchtime events and other communications to launch roll out.
			• Specialist Advice – reponses to ‘top tips’ received from Dietetics, Dermatology, Paediatrics, Ophthalmology, Cardiology and Pathology. Now working with Primary Care to implement.
			• Increasing control and oversight of outpatient transformation – review of internal governance structures

SMART actions	Measures of success	Activities/progress in last 2 months	For the next 2 months: - Key risks - Deliverables/milestones
Priority: **Delivery of long term sustainability for health and care in west Suffolk**			
• Deliver reduction in our underlying deficit. *Exec sponsor: Director of Resources*	• Delivery of agreed 2024/25 cost improvement plan leading to reduction in underlying deficit.	• £3.1m adverse to plan at end of M3 • Appointment of Director of Financial Recovery • Establishment of Recruitment approval group	• Implementation of non-pay and further pay controls • Likely implementation of ICB enforced triple lock • Development and implementation of further financial recovery measures



SMART actions	Measures of success	Activities/progress in last 2 months	For the next 2 months: - Key risks - Deliverables/milestones
Priority: **Delivery of long term sustainability for health and care in west Suffolk**			
• Deliver 2024-25 priority areas for service pathway change as identified by the Clinical and Care Strategy. • Continue to deliver and embed 2023-24 priorities which are multi-year. Transition to business as usual will be supported by the Change Hub. *Exec sponsor: Executive Medical Director (Paul Molyneux)* *Operational delivery lead: Director of Operations for Future Systems Programme (Alex Baldwin)*	<u>Outpatients</u> • Transition 25% of appointments to virtual platform. • Transition 25% of face to face appointments to peripheral locations. <u>UEC</u> • Develop a Target Operating Model (TOM) for future "emergency village" model of care. <u>Integrated Neighbourhood teams</u> • Supporting delivery of responsive and proactive care leading to 10% reduction in unnecessary admissions by March 25. <u>Childrens and Young People</u> • Develop a TOM for Children's and Young Peoples Services. <u>Diabetes</u> • Deliver an integrated service model leading to 5% decrease in admissions of patients with complications of diabetes and 50% reduction in length of stay differential between patients with diabetes and people without. <u>Service reconfiguration</u> • Deliver test of change to demonstrate "left shift". • Increase community phlebotomy provision by 25% compared to 23/24 baseline.	<u>Outpatients</u> • Project plan agreed with OPD Senior Transpomation Ops Manager. Builds on GIRFT Further, Faster plan. Trajectory agreed against current baseline (20%, 23-24) • Peripheral location work has commenced with initial asset audit. This is likely to be completed at the end of Q1. <u>UEC</u> • TOM population has commenced based on FSP template. <u>Integrated Neighbourhood teams</u> • Commencement of project. • Baseline assessment of curent service underway. <u>Childrens and Young People</u> • TOM population has commenced based on FSP template. <u>Diabetes</u> • Review of potential service models is nearing completion. Decision on preferred model is expected by end of Q1. <u>Service reconfiguration</u> • Agreed project TOR for phlebotomy service. • Review of attendance data to identify optimal location for community service(s).	<u>Outpatients</u> • Key risk associated with Zesty implmentation and transfer from current DrDoctor platorm – delay of at least 6 weeks anticiapted. • Trajectory for peripheral clinic increase will be developed when asset audit complete. <u>UEC</u> • Completion of the TOM <u>Integrated Neighbourhood teams</u> • To agree trajectory based on project objectives and baseline assessmnet. <u>Childrens and Young People</u> • Completion of the TOM is expected by end of September 24. <u>Diabetes</u> • Confirm preferred service model and agree implementation plan. <u>Service reconfiguartion</u> Development of Howard Estate pilot and identifiaction of additional community locations linked to asset audit.

SMART actions	Measures of success	Activities/progress in last 2 months	For the next 2 months: - Key risks - Deliverables / milestones
Priority: Creating an inclusive culture where everyone belongs and reducing inequalities in experience for service users			
• Proactively focus on reducing bullying, harassment and discrimination, particularly allyship, inclusive leadership practices and behaviours, inclusive recruitment processes, and reducing health inequalities • Embed Equality Impact Assessments into patient and staff facing decision making, policies, strategies, processes, and business activities • Embed guidance and processes for workplace adjustments for patients and staff, including implementation of a digital passport and digital adjustments toolkit for staff, and accessibility of information for patients *Lead: Executive Director of Workforce & Communications (Jeremy Over)*	• Improvement in related WRES and WDES indicators in 2025 (exact scale of improvement to be agreed before first report in May 2024) • Improvement in related NHS staff survey indicators in 2025 (exact scale of improvement to be agreed before first report in May 2024) • Reduction in patient complaints related to bullying, harassment, discrimination and accessibility of information	• Launch of a Trust wide approach and managers guidelines for workplace adjustments, including centralised information repository and unique digital assistive toolkit • Launch of staff development session *'Recognising bias, understanding privilege and becoming a proactive ally'*, including for SLT (July) and Board colleagues (Oct). Range of team sessions also booked. • Three EDI videos in development to enhance learning around EDI; to include managers cascade guide • Further development of EIA approach, guidance and forms • Staff network guides fully revamped • WRES/WDES data submitted by end of May • Completion of workforce health and wellbeing and inclusive leadership sections of EDS return • Sexual saftey signed and actions embedded into inclusion and health and wellbeing workplans • Additonal resources on the Learning Hub	**Key risks** • Prioritisation of key workstreams/activies in line with resource availability means impact may take longer, as many different approaches are needed at scale to have maximum impact • Staff engagement in this area as a key part of their own work priority **Deliverables/milestones** • Prioritisation of work on inclusive recruitment to reduce biases, including launch of implicit bias training for all recruiting managers and upskilling HR colleagues on recuitment biases • Launch of EDI videos and cascade approach • EIA portal development to support easier completion and capturing of EIA information • Suite of 'quick / how to guides' on a range of EDI topics

SMART actions	Measures of success	Activities/progress in last 2 months	For the next 2 months: - Key risks - Deliverables / milestones
Priority: Creating an inclusive culture where everyone belongs and reducing inequalities in experience for service users			
• Ensuring personalised care can be given by knowing patients' individual needs and making reasonable adjustments • Enabling the Trust website to comply with accessibility legal requirements • Improving the patient information process to ensure availability in differing formats, from leaflets to signposting to clinic letters • Involving underrepresented communities in decisions and care to better understand inequalities and improve outcomes *Lead: Sue Wilkinson, Executive Chief Nurse*	• Development of personalised care and support plan datasets into e-Care, including integration of the patient profile by March 2025 • Increase of 10% in recording of protected characteristics on patient records • Implement a reasonable adjustment policy by September 2024 • Increase of 10% in reasonable adjustment needs recorded on e-Care by December 2024 • Improvements to booking and waiting procedures for those with reasonable adjustments by March 2025 • Accessibility improvements to web content and software by March 2025 • Assessment/completion of the Equality Delivery System by March 2025 • Accessible guides and improvement plans for all Trust sites by September 2024	• A document is provided which provides information on protected characteristics of those who have completed the inpatient survey over the past 2 months • 20 patient profiles have been completed within the last 2 months • The new equality, diversity and inclusion group for patients and the public is being established which will have oversight of the reasonable adjustments policy • A meeting has taken place with key stakeholders to establish a new approach to the way we provide patient information, and how to improve the accessibility of our public facing information • The recommendations from AccessAble's accessibility review have been put forward to the Patient Environment Group to be discussed at a meeting on 24 July and also shared with the Future System Programme team	**Key risks** • Reduced uptake due to potential document completion fatigue with upcoming orthopaedic centre public engagement • Reasonable adjustments development work unable to progress in Q1 but set to achieve target in timeframe set out • Board financial approval of accessibility improvement funding **Deliverables/milestones** • AccessAble assessments underway • Reasonable adjustments categories integrated into e-Care – complete • Draft ToR for formation of new patient and public EDI group overseeing these actions inc. reasonable adjustments

SMART actions	Measures of success	Activities/progress in last 2 months	For the next 2 months: - Key risks - Deliverables / milestones
Priority: Supporting and developing leaders and managers			
• Continue to develop, grow and embed a holistic and inclusive package of learning and development support for all line managers, staff members and teams, including using coaching based conversations and enhancing digital capabilities • Provide practical guidance and easy access to information on how to manage, support and develop colleagues, including the development of a managers 'wellbeing toolkit' • Develop a cohesive approach to succession planning and career development, supporting the growth of leaders, and those in business-critical roles *Lead: Executive Director of Workforce & Communications (Jeremy Over)*	• Further targeted development and learning support for leaders and managers launched by December 2024 • Development and launch of managers' wellbeing toolkit by March 2025 • Approach to succession planning and career development piloted by December 2024 • Improvement in related NHS staff survey indicators in 2025 (exact scale of improvement to be agreed before first report in May 2024)	• Onboarding of new learning and coaching providers, bringing additional expertise and capacity • Leadership practice and skills sessions launched covering range of topics every month (face to face) • Management skills webinars covering a range of topics every month (online) • New dates for existing 3 leadership programmes for 2025 launched • Operational management essentials underway targeted at Ops Managers • New look coaching programme and bite-sized modules launched • Significant increase in team development activity and support being provided (15 enquiries / bookings over past 2 months) • Increase in requests for individual 360 feedback assessments • Values based line management standards drafted and being socialised • L&D intranet pages being developed to support communication • 6 weekly events update shared with Corporate managers to promote portfolio and encourage engagement • Leadership programme alumni launched to suport continued learning and peer support • Trust wide approach and process for succession planning and career development being drafted in readiness for PCLG in September • Full HR policy review as part of the 'people project' – with full resource bank to follow linked to the employee lifecycle	**Key risks** • Time to learn – the impact of leadership development interventions is dependant on individuals having time to learn and reflect away from operational pressures • Prioritisation of extensive work needed to reach all staff across all areas • Lack of clear data (including workforce data analytics) makes direct targeting of leaders at level and those most in need problematic **Deliverables / milestones** • Launch of Strategic Leadership programme • 1 day manager training to be piloted – focus on core people management skills • Evaluation framework for L&D provision being developed • Scoping of managers wellbeing toolkit and resources • Phase 2 development of Learning Hub to be progressed

SMART actions	Measures of success	Activities/progress in last 2 months	For the next 2 months: - Key risks - Deliverables / milestones
Priority: A step change in delivery on prevention and proactive care			
As part of the WS Alliance, WSFT will play its role in achieving the SNEE ICS goals for identification and management of cardiovascular disease for the West Suffolk population • 80% of the expected number of people with high blood pressure (BP) are diagnosed by 2029 *(71.4% March 23 – goal 74.5% Mar 25)* • 80% of the total number of people already diagnosed with high BP are treated to target as per NICE guidelines by 2029 *(64.2% March 23 – goal 70% Mar 25)* • 85% of the expected number of people with Atrial Fibrillation (AF) are detected by 2029 (*target TBC)* • 90% of patients with AF who are already known to be at high risk of a stroke to be adequately anticoagulated by 2029 (*target TBC)* We will do this by: (a) Optimising **use of population health management data** to target capacity as a system (b) Optimising **contacts with patients** for prevention goals (c) Promoting **healthy lifestyle choices** *Exec sponsor: West Suffolk Alliance Director* *Clinical lead: Clinical lead for public health*	<u>Use of Population health management data</u> • Reconciliation of hospital data on hypertension with GP practices (Mar 25) • Good use of Trust PHM data in alliance work with target communities <u>Optimise Trust contacts with patients</u> • Community health teams work with those patients on their caseloads where GP practices are seeking improvements in BP & AF recording and management <u>Support Healthy lifestyle choices</u> • Complete blood pressure health promotion campaign with a reach of 50,000 people using WSFT media channels • Increase the impact of exercise referral pathways with Abbeycroft Leisure by 25% by March 2025 • Participate in design and success of Feel Good Suffolk (FGS) includes support with exercise, smoking cessation and weight management to achieve high levels of appropriate WSFT referrals	PHM reconcilliation process complete <u>Hypertension identification</u>: • Attending weekend events to promote healthy lifestyles; multiple BP checks taken, many referred to their GP for continued care. • BP machines live in the community and being used • Be Well bus started in community settings (with BP machine) <u>Planning</u> • Improving data set to enable furtehr evaluation tools required to release further ICB funds to extend this approach to more areas. <u>Feel Good Suffolk</u> • FGS quality and clinical governance framework has gone live. One new Abbeycroft pathway to be in place by the end of June.	• Finalise ICB proposal & mobilise full Health inequalities plan once agreed which will expand BP, AF workstreams in high need areas • PCN and INT workshops to commence with agreed priorities set by PHM data to roll out integrated approached – likely to focus in some part on BP and AF. • Pilot libraries to issue/recall mobile BP kits. • Next target group - those with no hypertension, aged between 40-80 who smoke or are obese (total cohort population of 77)

NHS
West Suffolk
NHS Foundation Trust

Strategic Priorities update

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

Executive sponsor for actions: Nicola Cottington, chief operating officer

Delivery leads:

Matt Keeling, deputy chief operating officer

Moira Welham, associate director of operations for surgery and anaesthetics

Kevin McGinness, associate director of operations for community and integrated therapies (adult)

Nic Smith-Howell, associate director of operations for community paediatric therapies

Progress report- May 2024

Putting you first

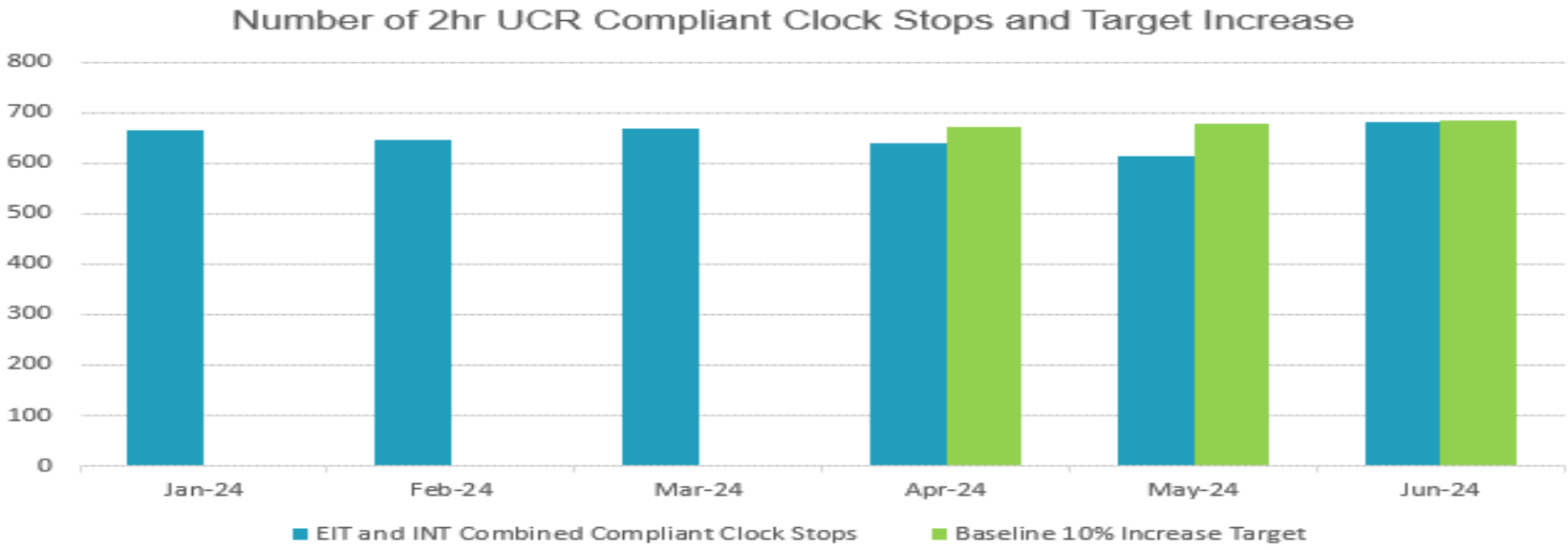
Action: Proactively grow our community services division

NB the measure of overall 0% net workforce growth (planned shift in activity from acute to community), will be reported through finance and workforce reporting. Divisional business plans have been to Performance Review Meetings with specific objectives being revised and presented in May 2024 for sign off.

Progress report- May 2024

Putting you first

Increase in Urgent Community Response (UCR) activity by 10% by March 2025 compared to 23/24 baseline (March 24 baseline)

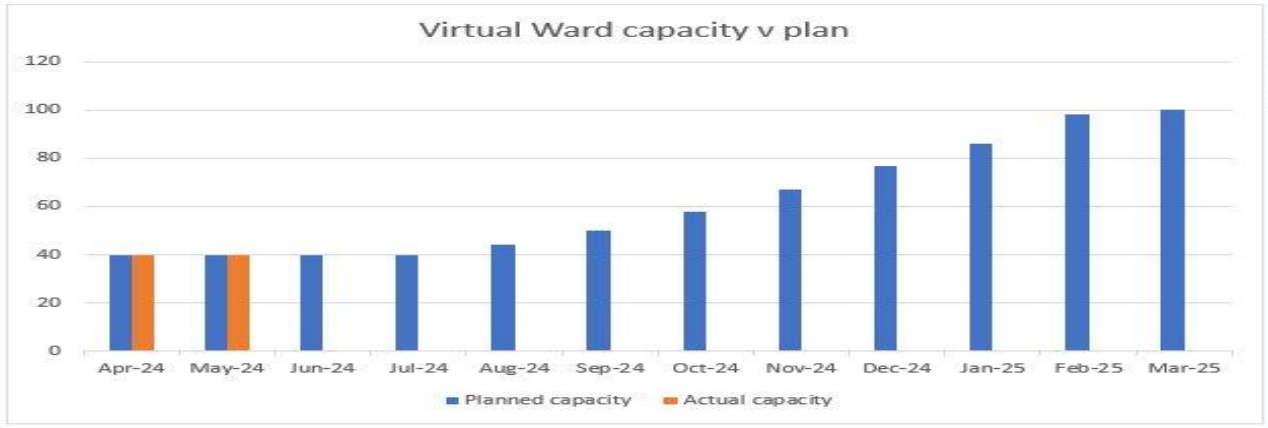


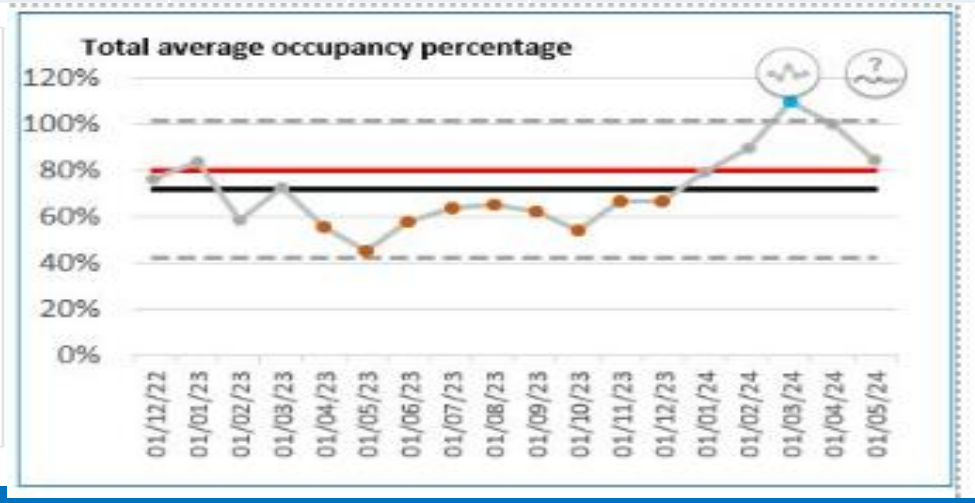
Team	Dec-23				Jan-24				Feb-24				Mar-24				Apr-24				May-24			
	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant
Total INT Nursing & Therapy	177	123	54	69%	199	143	56	72%	180	136	44	76%	201	158	43	79%	179	134	45	75%	175	115	60	66%
Total EIT*	464	415	49	89.44%	569	522	46	91.90%	564	511	53	90.60%	545	509	36	93.39%	563	506	57	89.88%	552	498	54	90.22%
Combined Total	641	538	103	83.93%	768	665	102	86.59%	744	647	97	86.96%	746	667	79	89.41%	742	640	102	86.25%	727	613	114	84.32%

*Using CSDS figures

Increase in virtual ward activity to 100 bed capacity and 80% occupancy by March 2025

Pathway	End March 2024 baseline	Planned capacity end May 2024	Planned capacity end Jun 2024	Planned capacity end Jul 2024	Planned capacity end Aug 2024	Planned capacity end Sept 2024	Planned capacity end Oct 2024	Planned capacity end Nov 2024	Planned capacity end Dec 2024	Planned capacity end Jan 2025	Planned capacity end Feb 2025	Planned capacity end Mar 2025
Frailty	6	6	6	6	10	10	10	10	15	15	20	20
Respiratory	5	5	5	5	5	5	6	6	7	8	10	10
IV ABx	4	4	4	4	4	5	6	8	8	8	8	8
AKI	5	5	5	5	5	5	5	5	6	7	10	12
Cardiology	7	7	7	7	7	9	10	12	15	15	15	15
General med inc liver/oncology	11	11	11	11	11	11	11	11	11	15	15	15
Diabetes	0	0	0	0	0	0	0	2	2	5	5	5
T&O/surgery	2	2	2	2	2	5	5	8	8	8	10	10
Paediatrics	0	0	0	0	0	0	5	5	5	5	5	5
TOTAL CAPACITY	40	40	40	40	44	50	58	67	77	86	98	100
OCCUPANCY TARGET	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
NB: excludes COPD AA cases												





NHS
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Action: Improve productivity within acute services

Progress report- May 2024

Putting you first

Deliver the system specific activity targets for outpatients

West Suffolk NHS Foundation Trust

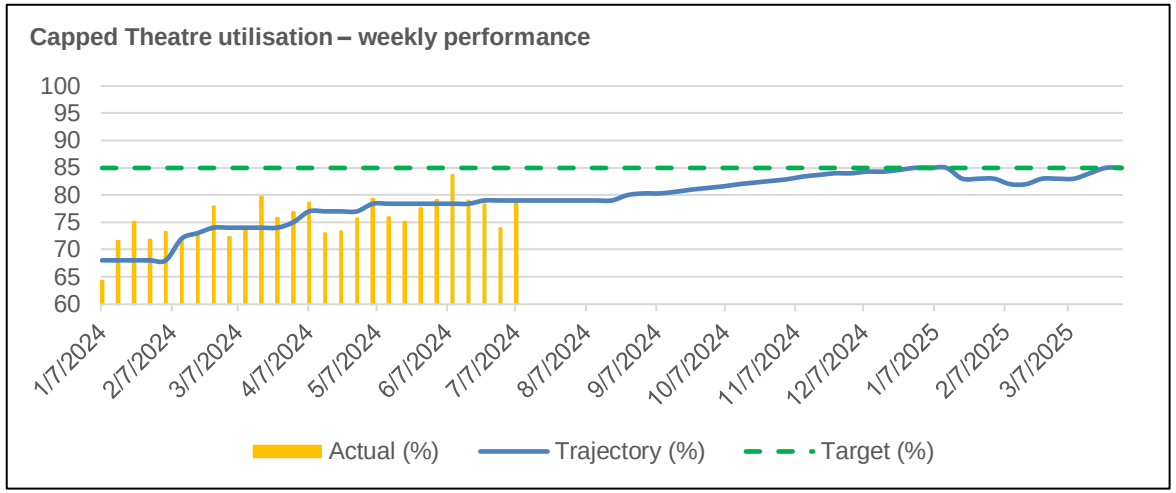
Submitted trajectory 2024/25

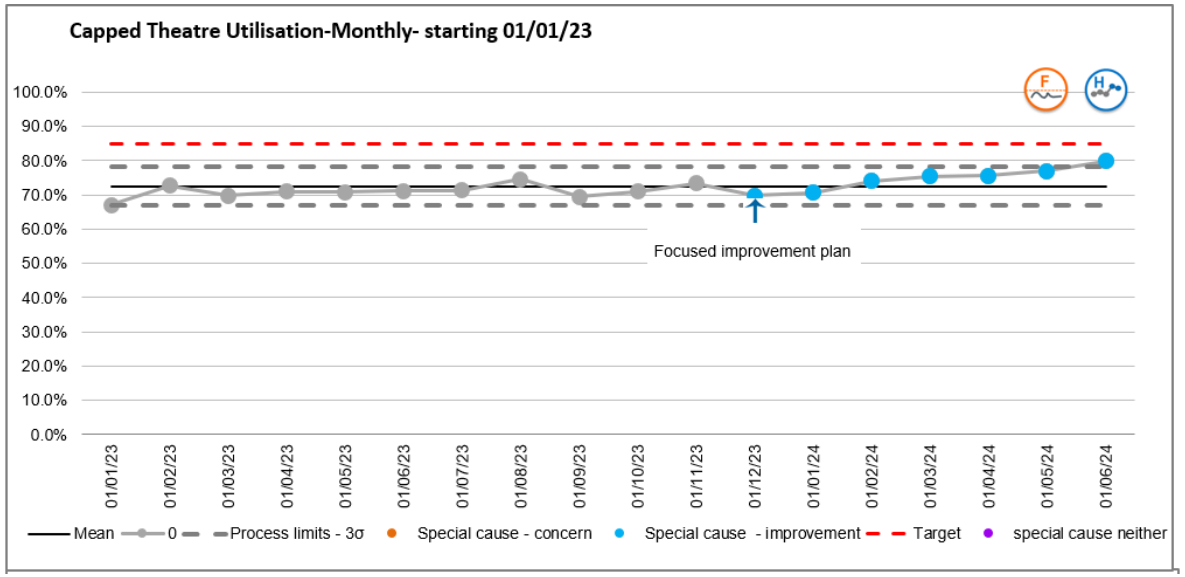
	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Total outpatient attendances (all TFC; consultant and non consultant led)	43,907	44,438	41,817	46,761	41,252	43,907	48,088	45,500	40,223	47,591	42,347	45,235
Number of episodes moved or discharged to patient initiated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

Actuals to date 2024/25

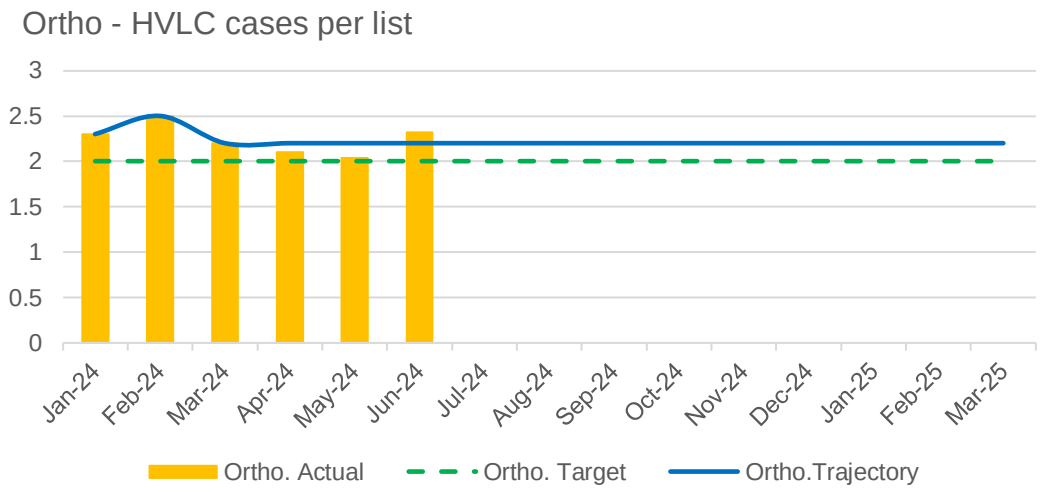
	Apr-24	May-24	Jun-24
Total outpatient attendances	38185	38223	35165
PIFU	1515	1607	1379
Cons-led first attends	N/A	N/A	N/A
Cons-led follow up attends	N/A	N/A	N/A
Outpatient procedures	5902	5594	
First attends no procedure	4924	6226	
FU attends no procedure	18773	19891	
OP New/Proc ratio	37.20%	35.90%	
PIFU %	3.97%	4.20%	3.92%

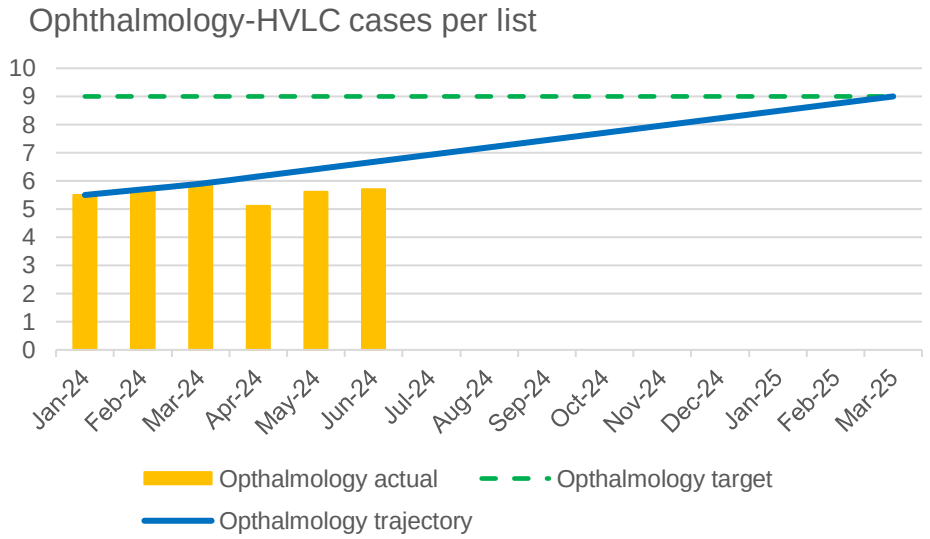
Capped theatre utilisation- Target 85% by March 2025



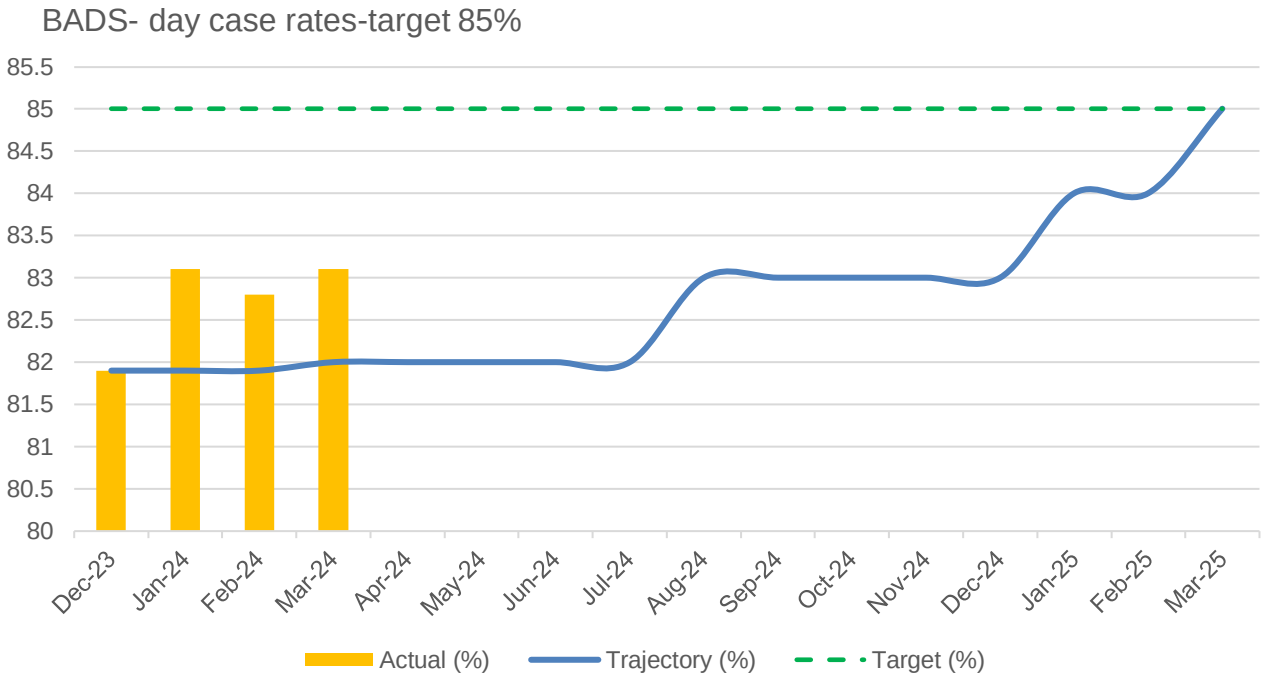


Cases per list -Align 85% of high volume, low complexity (HVLC) theatre activity with GIRFT cases per list standards by June 2025





British Association of Day Surgery (BADS) day case rates-Target 85% by March 2025

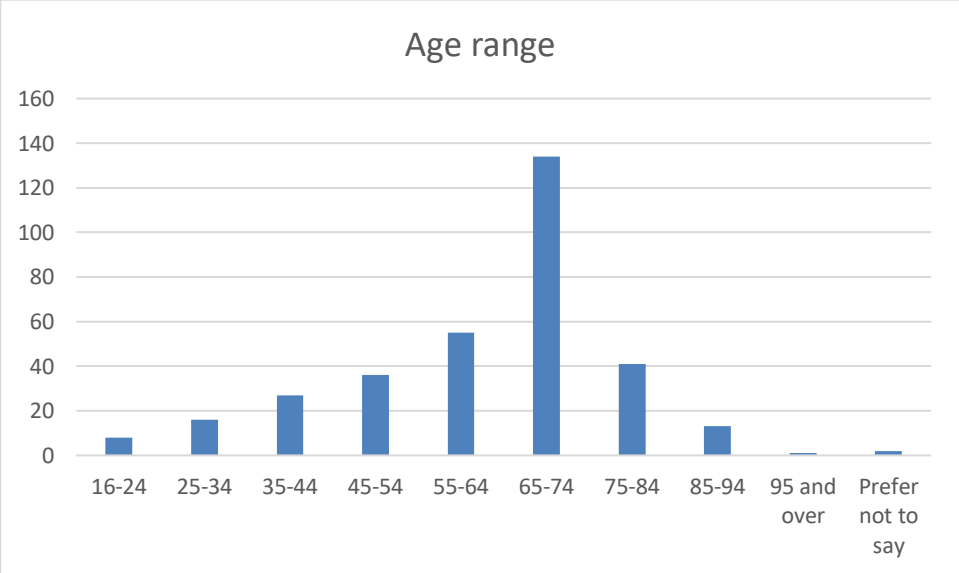


Strategic priorities 2024/25

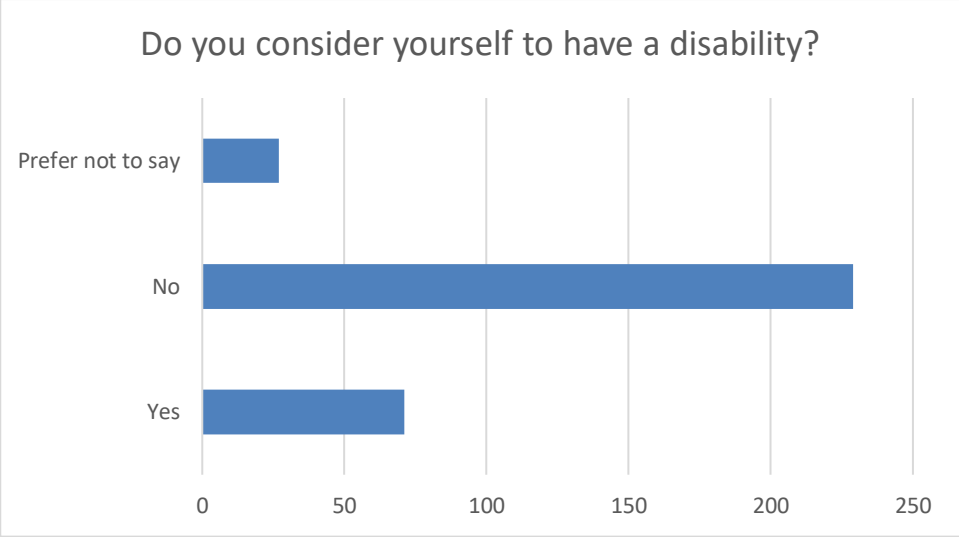
Priority: Creating an inclusive culture where everyone belongs and reducing inequalities in experience for service users

Progress report July 2024 – supplementary information

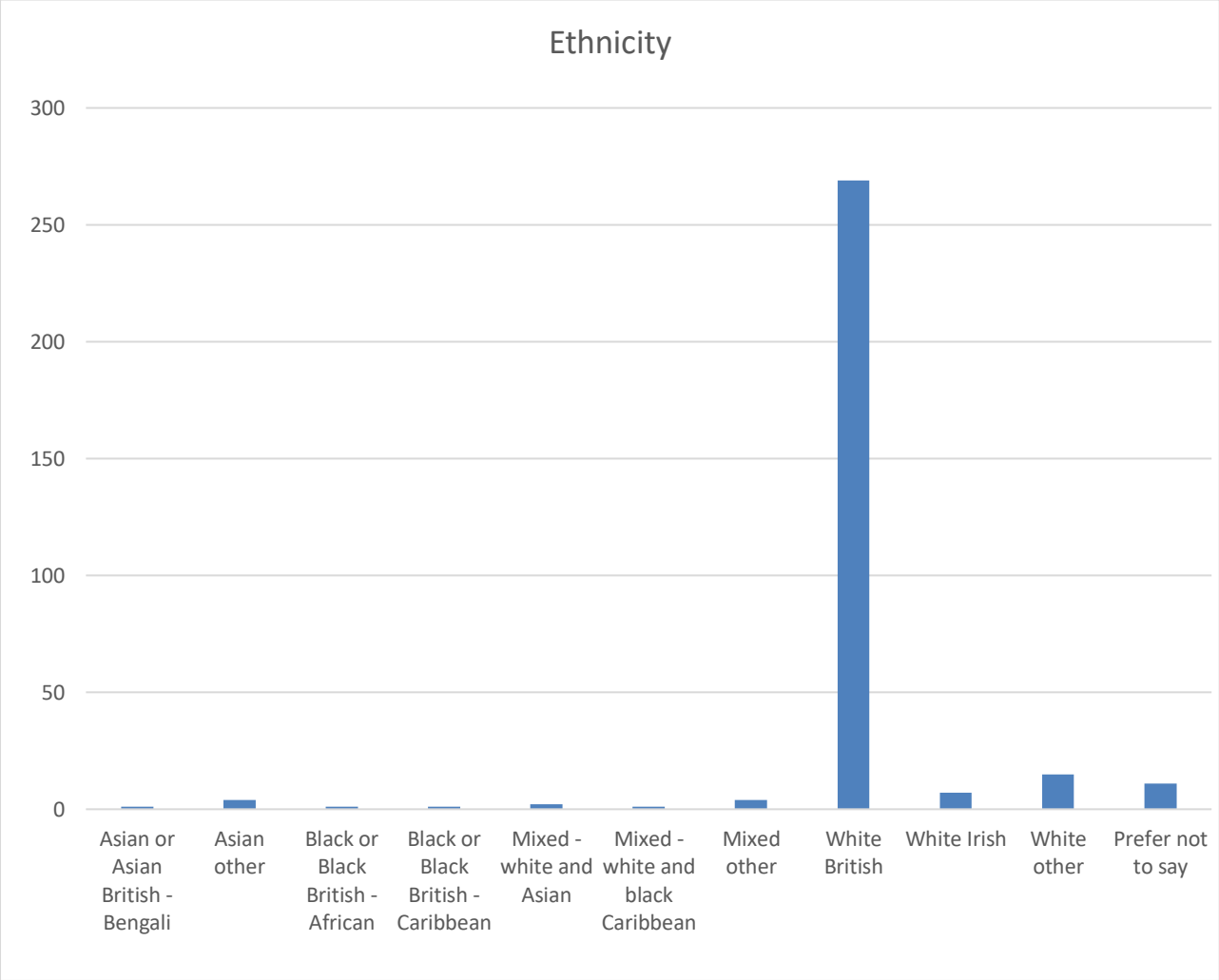
The information below provides information on protected characteristics of those who have completed the inpatient survey over the past 2 months. A total of 756 patients completed the survey between 19 May and 19 July 2024; the number of patients who chose to respond to each question is listed below:



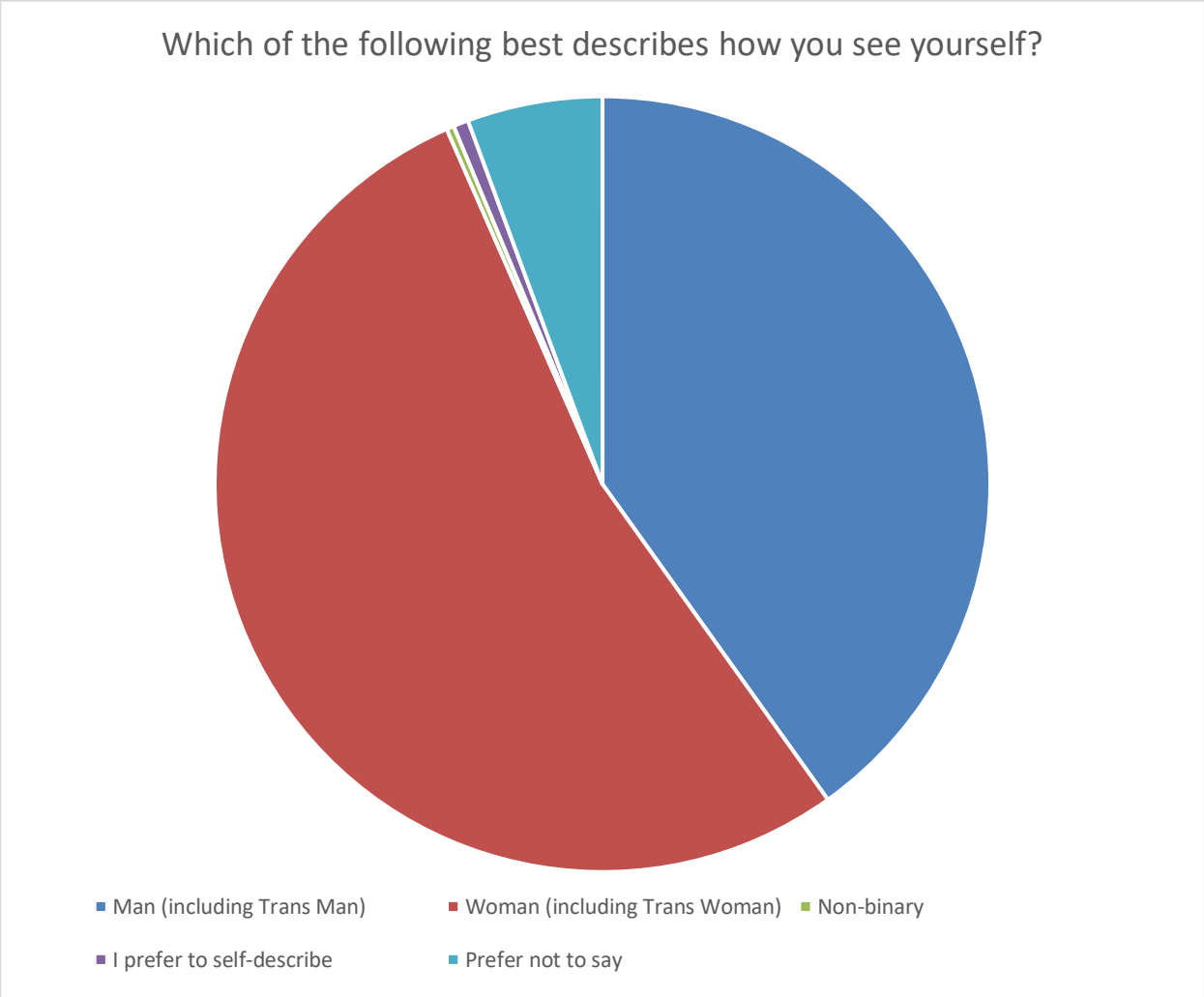
Number of survey respondents who answered this question: 333/756



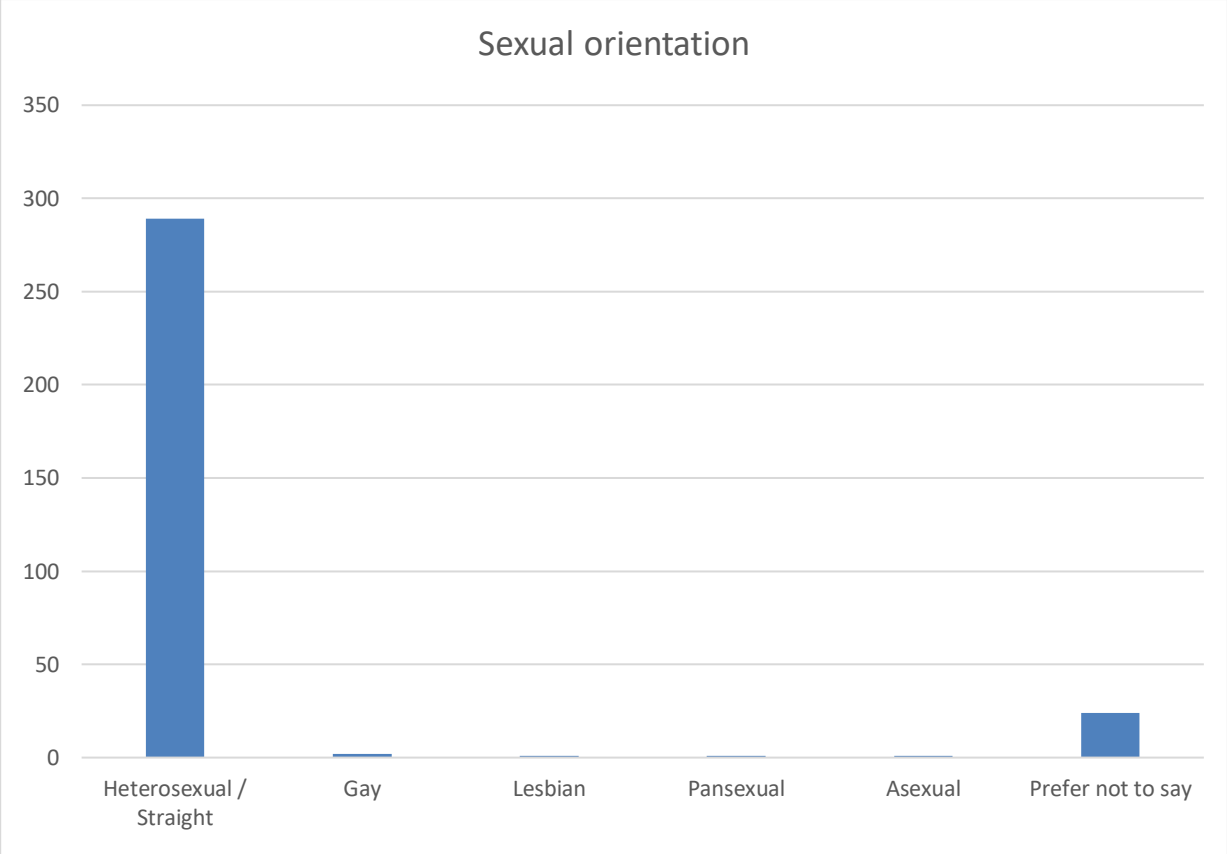
Number of survey respondents who answered this question: 327/756



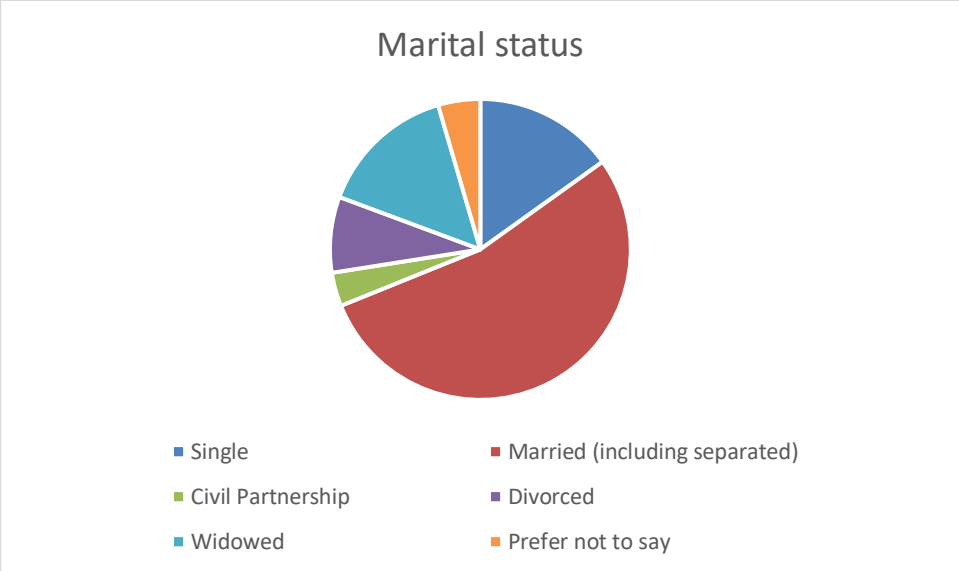
Number of survey respondents who answered this question: 316/756

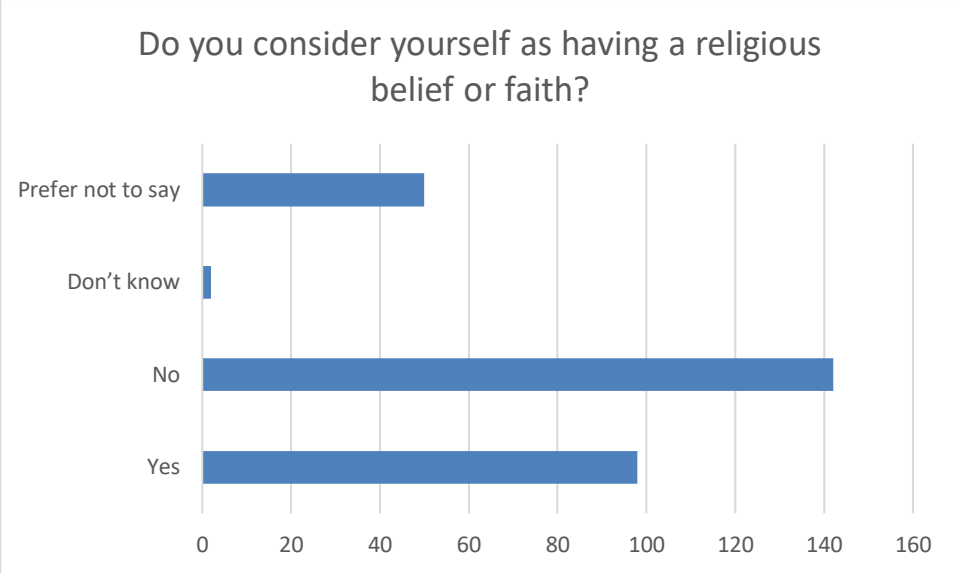


Number of survey respondents who answered this question: 319/756

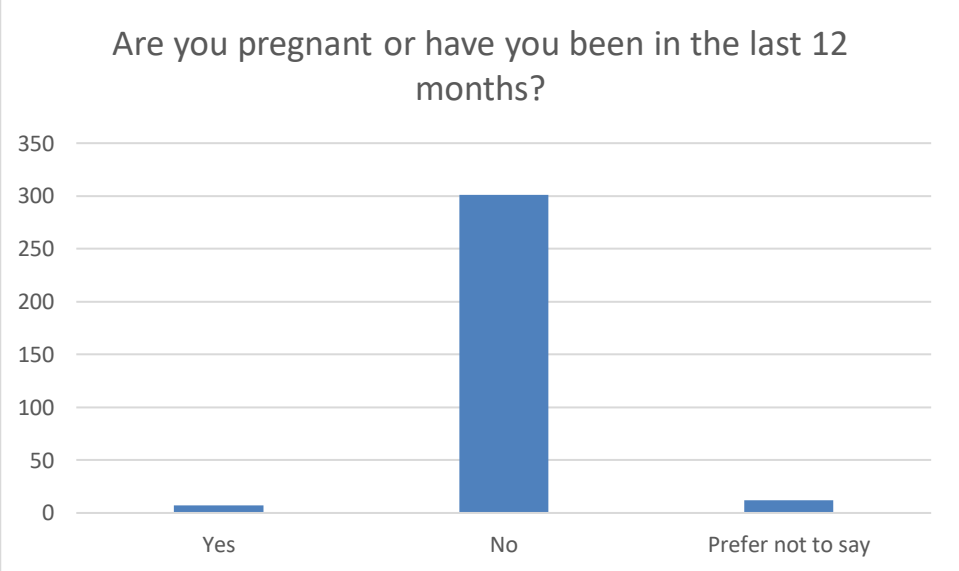


Number of survey respondents who answered this question: 318/756





Number of survey respondents who answered this question: 292/756



Number of survey respondents who answered this question: 320/756

2.2. Future System board report

To Assure

Presented by Ewen Cameron

Public Trust Board Committee	
Report title:	Future System Board Report
Agenda item:	2.2
Date of the meeting:	July 2024
Sponsor/executive lead:	Ewen Cameron
Report prepared by:	Gary Norgate

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

Executive Summary
WHAT? *Summary of issue, including evaluation of the validity the data/information*
This report provides an update on the Trust's plans to build a replacement hospital under the terms of the national New Hospital Programme.
SO WHAT? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*
This is a critical project as it directly addresses the risks associated with the Trusts RAAC infrastructure and provides the basis for the continuity of care and the ability of the Trust to keep pace with the needs of the community that it serves.
WHAT NEXT? *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*
The next steps for the project are the conclusion of the discussion around the size and scope of the new hospital and, therefore, the required budget and its ongoing impact on the operational cost of both the Trust and the Integrated Care System (ICS). This output will then form the basis for the creation of an outline business case, securing full planning permission and the appointment of a build partner.
Action Required
The Board are asked to note the content of this report.

Risk and assurance:	
Equality, Diversity and Inclusion:	

Sustainability:	
Legal and regulatory context	

Future System Board Report

1.	**Introduction**
1.1	The following paper aims to update the Board on progress being made towards the building of a new hospital in West Suffolk. Specifically, the paper highlights: • Agreed next steps for our project. • The plan to engage potential construction partners. • Progress made towards confirming detailed designs; and • Progress being made on site to ensure readiness to build.
2.	**Background**
2.1	As reported previously, West Suffolk Foundation Trust's plans to build a replacement hospital are part of the wider Governmental programme that aims to build "40 new hospitals by 2030".
2.2	In May 2023 an announcement that seven new schemes, predominantly those hospitals constructed from reinforced aerated autoclaved concrete (RAAC), have been included in the New Hospital Programme (NHP) and will be 'prioritised' to ensure they are completed in the most efficient way.
2.3	This announcement has caused some of the other, more complex, schemes (e.g. those representing significant service re-configuration and therefore requiring extensive public consultation) to slip beyond the previously announced 2030 deadline.
2.4	The West Suffolk scheme remains a priority and is the most advanced of the RAAC projects. Consequently, WSFT are the only RAAC Trust to; have had its strategic case (SOC) "agreed"; to have received funding for the development of its outline business case (the second of three mandatory cases) and to have received funding for enabling works that support full planning permission and the ability to commence construction.
3.	**Detailed sections and key issues**
3.1	**Executive Summary:** At the last Board, we stated the following goals for the forthcoming period: • We will have received our NHP letter confirming capital budget and project milestones. • We will have received the latest H2.0 design drop – including the template for our OBC baseline paper. • We will have agreed the contractual means through which to engage a construction partner. • We will be significantly advanced in a re-run of the demand and capacity modelling exercise (applying the latest innovations made to the central model). • We will have a complete set of RIBA2 co-ordinated 1:500 designs. • The new access road will be complete. Solid progress against these goals has been achieved, specifically: • Whilst we have received our NHP letter confirming our next steps the confirmation of capital budgets was delayed due to the General Election. To mitigate the risk of producing designs deemed unaffordable, the team have been working closely with colleagues from the New Hospital programme. We have received and completed the template aimed at establishing a baseline for progressing the development of an Outline Business Case (OBC). We expect comment / confirmation of areas for future focus by the end of July. • We have reviewed our outline design for a new hospital with the New Hospital Programme design team and concluded that we have a high degree of alignment with the central "Hospital 2.0" (H2.0) model hospital (H2.0 are the centrally produced principles of design for new hospitals).

- This alignment allows us to progress our Stage 2 (RIBA2) designs with confidence and we remain on track to complete these by November 2024.
- We have now entered our local circumstances and assumptions into the latest version of the national demand model. A joint report on the consequences will be produced by the end of July.
- We have received confirmation of funding for the next stage of our design process (Stage 3 of the Royal Institute of British Architects journey – RIBA3).
- Development of a national commercial strategy continues, including the method which The West Suffolk project will procure developer resources for the RIBA3 design phase.
- The West Suffolk Trust Board will soon be asked to formally agree both a) the framework and process through which the New Hospital programme will procure the construction partners that will build the "40 new hospitals" (known as the Major Works Framework), and b) the terms describing how the Trust will interact with the New Hospital Programme and its allocated construction partner (known as the NHP agreement).
- The new temporary access road has been completed. The temporary access road will connect the old hospital site on Hardwick Lane to the Hardwick Manor development site.

3.2

Project Plan

SOC Approved - OBC Baseline approved	**90 days**	**Tue 21/05/24**	**Mon 23/09/24**
RIBA2 (Core Design Team Castons, Ryder, Hoare Lea, Sweco, Adcuris, etc)	**230 days**	**Mon 05/02/24**	**Fri 20/12/24**
Pre Construction Services Agreement	30 days	Tue 24/09/24	Mon 04/11/24
RIBA3 (Core Design Team Castons, Ryder, Hoare Lea, Sweco, Adcuris, etc)	**155 days**	**Mon 11/11/24**	**Fri 13/06/25**
Reserved Matters / Full Planning	87 days	Mon 15/09/25	Tue 13/01/26
Other Work Streams	**480 days**	**Mon 25/03/24**	**Fri 23/01/26**
OBC (inc.NTE)	65 days	Mon 16/06/25	Fri 12/09/25
NTE Commercial Review	61 days	Mon 15/09/25	Mon 08/12/25
1 month review / reflection / FLOAT	20 days	Tue 09/12/25	Mon 05/01/26
OBC Approval	136 days	Mon 26/01/26	Mon 03/08/26
RIBA4	146 days	Mon 16/06/25	Mon 05/01/26
GMP	110 days	Tue 06/01/26	Mon 08/06/26
FBC	180 days	Wed 14/01/26	Tue 22/09/26
FBC Approval	110 days	Wed 23/09/26	Tue 23/02/27

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

- The team have now completed and submitted the "OBC Baseline" documentation. This submission comprised of more than 70 documents that summarised, precisely, the progress we have made and, therefore, our current readiness to develop an outline business. Initial feedback has been positive, and we expect confirmation of our progression by the end of July.
- Following the release of detailed NHP design documents, our technical team have been working with the NHP team to test the extent to which our own co-produced designs comply with the national standards. The good news is that our previous engagement with NHP throughout our design process has ensured a tight alignment, meaning minimal re-work and the prompt and confident progression of 1:200 designs. The designs remain due by end of October, after which all appropriate reports will be written.
- As a RAAC Trust we (NHP, Trust, NHS England) are all focussed on delivering a new hospital by the end of 2030. This remains a challenging deadline and does not allow for any abortive effort. Consequently, the early engagement of building contractors in the design process is seen as essential. With this in mind, we are working towards engaging said contractors in the RIBA3 design process which means procuring a "pre-construction services agreement" by November.
- Remaining on track for a new hospital in 2030 is dependent upon continuing to progress with stage 4 designs whilst the outline business case is approved.

	The overall status of the project plan remains "green" with the most significant risks stemming from delays resulting from the transition of Government and insufficient capital necessitating re-design and compromise. At the time of writing both are considered of low likelihood.
3.3	**Progress on Site** • Our access road, connecting our existing site to the new Hardwick Manor site is now complete and will allow us to close the access to Sharp Road and complete the second phase of our buffer tree planning (allowing c. two years of growth before construction commences). The new road is an extension to an existing road near the education centre between Car Park E and Rowan House. It must be noted that this will not be our final access road to the new hospital. However, the temporary access road does mean that we can minimise disruption to our neighbours and bring construction vehicles and contractors through our own site until our construction compound is ready, which will be when we begin building our new hospital. This is anticipated to be in the latter half of the decade. Our programme of enabling works (i.e. those early activities that can or need to be completed in advance of the main construction) continues with full support from NHP. In the next three months the focus will be upon: • Ground source heat pump test bore holes • Infiltration and soil testing • Further archaeological excavations • The development of designs of active cycle and pedestrian paths. • The detailed design of the power network • The confirmation of scope for projects such as the digital staff hub, the main equipment room, Endoscopy suite at the Newmarket site; and the renovation of Hardwick Manor.
3.4	**Commercial** There are two primary strands to the NHP commercial strategy: Introduction of a new "Main Works Framework" – under normal circumstances, suppliers for major NHS capital projects are procured using existing frameworks such as Procure 23[1]. However, the sheer scale and complexity of the New Hospital Programme means that a new, bespoke framework is required. Named the "Main Works Framework" (MWF). This new means of procuring services aims to address the issues raised by suppliers and thus maximise market capacity. There are currently 23 Main Works Contractors indicating an intention to bid for the MWF. Once the framework is complete, suppliers will be allocated to Trusts who will then conclude contracts that will govern the delivery of the project. This process is a departure from the usual Trust lead procurement and as such may represent a commercial risk. To mitigate this risk and to make Trust's comfortable with the proposed framework and associated process, several communications and engagements are planned to include a legal briefing session for our respective legal teams on July 22nd.This session is a legal briefing to external law firms who may be asked by one of more Trusts to advise on the New Hospital Programme Commercial Strategy. The purpose of the session is to introduce the Commercial Strategy for the programme, including the Main Works Partnership and NHP Agreement, from a legal perspective. Capsticks will be attending and representing WSFT.

[1] Frameworks describe a common set of terms and conditions that have been established to govern the way in which services are delivered throughout the NHS. Common frameworks allow the central vetting of potential suppliers and remove the need for individual Trusts to design contracts and run detailed procurement processes for everything that they wish to buy – reducing risk and cost and improving consistency, standards and quality

	The second strand to the commercial framework is the "NHP Agreement". This document aims to set out the rules for how the Trust, the NHP and the main works contractor will interact throughout the full business case and construction phases of the project. Some of the key points within the agreement are: • Signature of the agreement by the Trust is a condition of funding. • A Trust can withdraw from the agreement but in doing so would be removing itself from the NHP and its funding would be reviewed on that basis. • The agreement is not a contract – parties cannot sue each other for breach. There is a process for the resolution of disputes and ultimately issues would be escalated to NHS England for resolution. • Trusts must sign no later than the submission of their OBC. • Parts of Hospital 2.0 (H2.0, the centrally produced principles of design for new hospitals) are mandated for use. Trusts and Contractors must not derogate from these designs without prior approval. • NHP has a right to mandate H2.0, make "best for programme" decisions and embark on a series of resolution steps to assist failing schemes (ultimately, they could step in and take on management). • Trusts may require NHP to fund additional costs resulting from intervention notices, best for programme decisions and any defects associated with H2.0. Legal advice of the nature of the agreement has already been sought and the final version of the agreement will be discussed in detail on the Executive Panel (Chaired by a non-executive director) before recommendations are put to Trust Board for ratification.
3.4	**Finance** Our project has three primary budgets: • **Team budget** – this covers the costs of the direct future system team. Spending remains in line with budget and funding has been confirmed for 24/25. • **Professional fees budget** – this is a two-year budget covering the costs of architects and advisors that underpin the development of our business cases. Spending remains in line with budget and funding for the development of our OBC throughout 24/25 has been confirmed. We have now also received confirmation of funding for stage 3 of our design process. • **Enabling works budget** – this covers the costs of specific pre-construction tasks such as the construction of our compensatory habitat and the creation of active access routes. Spending remains in line with approved plans and funding covers our named projects (buffer planting, access road etc.) throughout 24/25. Outside of budget management, the discussion concerning ongoing "revenue affordability" has been escalated to both NHP and NHS Director of Finance and discussions relating to a national solution are ongoing.
4.	**Next steps**
4.1	By the time of our next meeting, we will have: • Completed demand modelling and understand the implications of our design, scale and scope. • Received feedback on our OBC readiness submission with an expectation that we will seamlessly continue with the development of our detailed designs. • Confirmed compliance with H2.0 principles and co-produced any design changes with stakeholders from across our system. • Understood the nature of the NHP agreement and be able to make clear and informed recommendations to the WSFT Trust Board. • Continued to progress enabling works in line with project plan. • Received further clarification on the scale of our capital budget.

5.	**Conclusion**
5.1	The building of a replacement West Suffolk Hospital remains a priority within the New Hospital Programme.
5.2	The Trust will soon have confirmation of its capital budget and will commence writing of an OBC baseline report whilst progressing the development of increasingly detailed drawings. Enabling works aimed at discharging our planning conditions and preparing our site for construction continue positively in line with plans.
5.3	The status of the project to build a new West Suffolk project remains Green.
6.	**Recommendations**
	The Trust Board are asked to note the content of this report.

Comfort Break

2.3. West Suffolk System Update Report

To Assure

Presented by Ewen Cameron

Open Trust Board Committee	
Report title:	**West Suffolk System Update**
Agenda item:	2.3
Date of the meeting:	26th July 2024
Sponsor/executive lead:	Peter Whightman Director of Integration
Report prepared by:	Peter Whightman

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

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

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

West Suffolk Alliance Update including Committee meetings of 11 June and 9 July

June 11 meeting:

1. Health Inequity update

1.1. Work continues in the Howard estate. Data relating to other target ward areas is being undertaken to guide the focus of the next stages of the work. A final paper is to return to Committee in September 2024.

2. Newmarket Locality update

2.1. A comprehensive snapshot of local data for 23/24 was provided and highlighted how the partnership was forming. Concerns had been raised around the number of MASH referrals made from the VCSFE which has led to MASH attending the Locality meeting to support the group. Further details attached **Appendix 1**

3. Suffolk Community Foundation

3.1. Opportunities to access grants awarded by the Suffolk Community Foundation were discussed. This included a new grant programme – The Smoke Free Generation Fund – focusing on Suffolk. The Alliance agreed to work with Suffolk Community Foundation to optimise access to grant funding opportunities across all 6 INTs and plan next steps for schemes when grant funding ends.

4. Suffolk Libraries

4.1. Suffolk Libraries provided information as to the level of support that can be available to WSA to build capacity and meet Wellbeing needs of the Suffolk population including menopause and Children and Teens support. Support for the loan of equipment i.e. Blood pressure cuffs/machines to assist PCN's is also available.

4.2. Following this presentation, the Alliance have met with Suffolk Libraries to consider how we can activate the hyperlocal approach against our priorities to support delivery across our system.

5. Decaffeination project

5.1. A research study based on a joint investigation by Care England and Stow Healthcare, in partnership with University Hospitals of Leicester NHS Trust in April 2024 was presented which demonstrated a reduction in falls and improvements in bladder health by the replacement of decaffeinated coffee provided in Care homes. A request to Committee members was made to join a working group to develop the project across the system. A working group has now been formed to mobilise a project with providers across the SNEE system that can be actively evaluated and monitored.

6. Quality update

6.1. One GP practice had been rated as requires improvement now showing as good following sustained improvement through their action plan. A further CQC visit is awaited.

6.2. Medicines Optimisation issues: lack of retinal screening for hydroxychloroquine; however, a service variation is being put in place to commence this pathway in September 2024. Ongoing national shortage of medications is due to return to Committee in September.

July 9 WSA Committee meeting

1. Adult Social Care-Market Strategy

1.1. SCC are developing a strategy for the Suffolk Adult Care-Market. Committee members provided comments and support for next steps. For return to Committee in November for update with final return for agreement in March 2025. Agreed to understand feedback from INT's regarding the top 3 challenges and strengths for each area. Alignment around different services to be considered and include the localised Voluntary sector. A dedicated workshop with Alliance members is proposed for 4 November (tbc).

2. Community Referral and Communication Software

2.1. A presentation was provided which identified the opportunities to better connect partners with regards to a shared service directory and referral platform to improve communication, relationships, and trust across staff within West Suffolk Alliance and thereby facilitate successful community connections and healthy living. Other areas of good practice were identified. Committee agreed to pause and review options to agree the best way forward.

3. Diabetes

3.1. A comprehensive appraisal of the current work underway in Diabetes was provided. Good progress has been made at practice level with regards to 8 care processes and treatment targets. Lead clinician is working with other practices showing variation.

3.2. Specialist nursing capacity issues remain and a core problem is increasing demand and the need for improved work across primary care and community team interface. A new model for primary and secondary care joint-work is being developed based on the "Super 6 model" to define roles and commission General practice and WSFT in line with this.

4. Start Well – Children Young People and First 1001 days

4.1. Project updates were given. Committee members offered support to help increase Education involvement including Head teachers and pastoral leads for CYP mental health provision. Discussions possible to consider a front-door team in each locality to reduce the number of referrals and thereby improve early intervention and reduction of demand on secondary services.

4.2. Progress on the work in the First 1001 days was provided to consider a more local multi-agency approach in WSA with the possibility to focus the Committee meeting in October around 2 specific areas. (TBC)

5. ICS Strategic programmes update with a focus on WSA

5.1. Further work to consider how to align and interface was discussed. The ICS is best in region for Hypertension and CVD work.

5.2. Noted that spirometry services are currently a concern, following cessation of the GP Federation service. An alternative is being mobilised.

6. Director update

6.1. **Primary Care Network Pilot:** A national pilot involving primary care networks aimed at fostering innovation and creative thinking in general practice over a two-year period will commence in the Autumn. Current stage is to select 1-3 PCNs across the ICB following expressions of interest.

6.2. **Dental Care Priority Access:** A priority access service for dental care has started across the ICB. There are four practices in West Suffolk offering the service which includes urgent services and services for specific vulnerable patient groups.

6.3. **Interface Pharmacist Role:** The recruitment of an interface pharmacist was noted as a step towards enhancing the collaboration between primary care and the West Suffolk Trust, focusing on safety and cost-effective prescribing

7. PCN – INT Integration Project

7.1. Work has been progressing with Haverhill PCN and the Integrated Neighbourhood Team to focus on a single common issue that can support an MDT approach to improvement. Population Health Management Data has given us the steer to deliver change with the severely frail population in the Haverhill area. The integrated approach is now designing its next steps and interventions to be delivered to inform change. This has resulted in all PCN's across the 6 Localities agreeing to an invitation to follow suit and enable an integrated approach to change in the West Suffolk Alliance.

8. Review of Committee T'sOR

8.1 Review taking place September meeting

Appendix 1 : Newmarket focus

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2.4. Collaborative Oversight Report

To Assure

Presented by Nicola Cottington

Committee/Group	
Report title:	Suffolk and North East Essex Provider Collaborative report
Agenda item:	2.4
Date of the meeting:	26 July 2024
Lead:	Nicola Cottington, Chief Operating Officer WSFT
Report prepared by:	Nicola Cottington, Chief Operating Officer WSFT Stephanie Rose, Programme Director Provider Collaborative WSFT/ESNEFT

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

Executive Summary

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

This report presents a document to enable board scrutiny of developments of the Suffolk and North-East Essex Provider Collaborative (SNEE PC) and receive assurance of ongoing progress against the key priorities as agreed with the Collaborative Oversight Group on 4 June 2024. The papers presented are for information only and issues to note are captured in this summary report.

This report contains updates on:

- Clinical services programme update
- Elective recovery programme update
- Efficiencies at scale programme update
- Digital programme update
- Development programme update
- Resources
- Communications

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

The report meets the ask of The 2019 NHS Long Term Plan which sets out a "duty to collaborate" which was further developed in Working Together at Scale (2021), by providing the Trust board a methodical report of progress in this area.

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

The MoU once drafted will be presented to the Collaborative Oversight Group for ratification alongside a further refined work programme with timescales and outputs.

Recommendation / action required
No action required aside from the boards continued support with providing a supportive culture for the provider collaborative to mature and deliver against the workplan agreed.

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

Suffolk and North East Essex Provider Collaborative report

1. Introduction

1.1 The WSFT and the East Suffolk & North Essex NHS Foundation Trust (ESNEFT) have been developing a collaborative approach over the past three years, including board to board workshops, joint working within functions including procurement, and mutual aid for specific clinical pathways. Following the appointment of dedicated resource, a programme director in January 2024, significant developments have taken place including the development of a workplan for 2024-25 and the formation of the Collaborative Oversight Group which held their first meeting on 4th June 2024 and approved the naming of the provider collaborative- the Suffolk and North East Essex Provider Collaborative (SNEE PC) and the focus areas for 2024-25:

1. Clinical Services
2. Elective Recovery
3. Digital
4. Efficiencies at Scale
5. Development

The purpose of this paper is to provide an update to board members on the development of SNEE PC and the programmes of work.

2. Background

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

2.2 On 4th June, the Collaborative Oversight Groups agreed the priorities for SNEE PC for 2024-25, a programme senior responsible officer (SRO) from each provider was assigned to the priority areas of work (table 1) to enable collaborative working relations to develop at an executive level. The ambition is that we are in time able to appoint one overall programme SRO as the provider collaborative reaches the maturity to enable this

Table 1- SROs for SNEE PC work plan

Programme	Senior Responsible Officers
Clinical Services	Executive Medical Director/s WSFT & ESNEFT
Elective Recovery	Director of Operations- Elective Care ESNEFT Deputy Chief Operating Officer WSFT
Efficiencies at Scale	Director of Strategy & Transformation WSFT Director of Strategy, Research and Innovation ESNEFT

	Digital	Chief Information Officers WSFT & ESNEFT or Director of Digital and Logistics ESNEFT/ Director of Resources WSFT
	Development	Director of Workforce & Communications WSFT Director of People and Organisational Development ESNEFT

3. Detailed sections and key issues

3.1 **Clinical services programme update**

<u>The Unscheduled Care Coordination Hub (UCCH)</u>

The UCCH is a system-wide capability that plays a key role in delivering the vision of Suffolk and North-East Essex's (SNEE's) emergency and urgent care community – *'People receive the right care, in the right place, first time, every time.'* The UCCH's primary purpose is to improve the timeliness of care and support category three (C3) to category five (C5) patients who have contacted the East of England Ambulance Service NHS Trust (EEAST) for urgent care (either via 999 or 111). By doing so, the patient will receive care from the most appropriate teams in a timely way and avoid accident and emergency (A&E) attendance and unnecessary admission.

The UCCH directly contributes to delivery of the NHS Urgent and Emergency Care (UEC) Recovery Plan and 24/25 planning assumptions including national performance standards. It is recognised as one of ten high impact performance improvement interventions by NHS England (NHSE) which is informing practice across the region with the support of EEAST.

Funding has been secured to continue the delivery of this service until 31 March 2025 and work is underway to explore how the UCCH can be developed to:

a) Further enhance the SNEE systems urgent care response to C3-5 patients overnight
b) Evolve into the SNEE system's Single Point of Access (SPOA) – another of the 10 high impact performance improvement interventions.

To sustain the UCCH model into a SPOA, hosting arrangements were reviewed and the UCCH Steering group agreed to a collaborative hosting arrangement with Practice Plus Group (PPG) to be the host provider and ESNEFT and WSFT both collaborating parties under the proviso of SNEE PC. An MoU was drawn up to set-out the roles and responsibilities of all parties on 20 May 2024 and this has been signed off by the WSFT Management Executive Group and is being presented to ESNEFT Executive Management Committee this week for approval.

SNEE PC continues to support this service by providing the joint chairs of the UCCH Steering Group and ensuring access to community-based pathways and services.

<u>Virtual Wards</u>

The Virtual Wards service commenced in SNEE in November 2022 with the aim to provide hospital level care to acute patients in their own home, this service is clinically led and enabled by remote monitoring.

Our current position is as follows:

- WSFT total capacity: 40
- ESNEFT total capacity: 106
- Total= 146 beds (reduced)
- Ambition to achieve >80% occupancy
    - WSFT occupancy 87.5%
    - ESNEFT occupancy 80.2%
    - SNEE occupancy 84.5%

The SNEE system is currently at an 84.5% occupancy against an 80% target. Our ambition, as per the NHS planning guidance 2024-25 is to achieve 40-50 beds per 100,000 population and we are currently at 15 beds per 100,000. In order to achieve this target, the following actions are in place:

- Discussions on the need to prioritise funding for virtual wards to enable increased capacity in line with NHSE planning trajectory, ESNEFT has reduced funding for this service in 2024-25
- A system wide evaluation is taking place for virtual wards focusing on strengths, benefits realisation, increase clinician confidence and referrals
- Comms support has been requested to increase referrals from primary care, community teams as well as surgery and potentially trauma and orthopaedics
- Transport provision is being addressed for virtual wards patients to enable same day radiology or face to face review

Eyecare Services

The Suffolk and North-East Essex ICB (SNEE ICB) approached the provider collaborative to discuss the continued challenges in contracting for eye care services and a meeting took place to agree how we can ensure a sustainable service across our population. It is recognised that the SNEE PC is at an emerging/developing maturity status and that the workplan for the financial year had been approved and did not feature clinical services transformation of eye care services however, it was recognised that developing this service model e.g. a single point of access and a referral platform is required to reduce variations in the service provision for eye care across our system
Collectively it was agreed for the ICB to procure a short-term contract e.g., 2 + 1 years, which would allow some time to continue discussions, for the provider collaborative to mature and focus on the other clinical priority areas e.g., urology services. In the interim, sharing of best practice will take place between the two providers to enable the good practice at WSFT to be shared with the colleagues at ESNEFT to reduce variations in the service offering across our population.

Urology Services

A position paper on urology services across WSFT and ESNEFT was presented to the Collaborative Executive Group and the following recommendations were approved:

It is recommended that if ESNEFT and WSFT are to effectively collaborate on the delivery of urology services across Suffolk and North Essex, this should be approached via a staged process to allow time to engage with stakeholders, build trust within the teams and to ensure that decisions are informed and managed both effectively and consistently with how the Provider Collaborative approaches clinical pathway transformation. A sequential process is recommended:

1. Leadership and role models are essential for any kind of transformational change to happen and to be sustained therefore executive sponsors and leads should be identified from both Providers to lead and champion this work.

2. Full baseline assessment should be undertaken including but not limited to demand vs capacity modelling, model health system, GiRFT data and activity data to help inform this project and to provide a metric by which to track and report the benefits of any changes.

3. A stakeholder group should be established to take forward this work (this could be the same stakeholders as present at the workshop on 22nd November with some possible additions). The remit of this group would need clearly defining at the onset of this work and part of the remit could be the sharing of good practice and processes already established within the two Providers.

4. A response should be generated in relation to the action from the GiRFT visit on 13th September 2023 clarifying the situation in regard to prostate robotic pathways within SNEE.

5. The SNEE system could capitalise on the paediatric surgery model at ESNEFT to be the trailblazer for this initiative nationally. Work to date has shown that this model has a positive impact on elective recovery plans, patient experience and continued and professional development of clinical staff including anaesthetists.

6. The paper 'Vision for SNEE urology services' should be revisited once collaborative work is underway and trust and relations have been built between the urology departments at the two Providers.

Recommendations one and three are complete and recommendation two is underway and a stakeholder workshop is being planned to progress this work.

Service Sustainability Listing

The aim of this project is to map and compare the services across WSFT and ESNEFT to help guide prioritisation for service planning but also to assess the services we run across both providers to see if there are services that both providers do exceptionally well and there is an opportunity to capitalise on this or services where only one provider performs well and to identify how do we share learning, skills transfer, mutual aid and approach development. This work has commenced, and the assessment has started on the highest activity specialities within both providers as illustrated in table 2. A more detailed report will be available for the next board update.

Table 2- high activity areas of focus

Top speciality areas of focus
General Internal Medicine
Ophthalmology
Clinical Oncology
Trauma & Orthopaedics

	General Surgery	
	Midwifery	
	Paediatrics	
	Cardiology	
	Gastroenterology	
	Dermatology	
	Gynaecology	

3.2 **Elective recovery programme update**

Essex and Suffolk Elective Orthopaedic Centre (ESEOC)

Our largest collaborative project to date is the ESEOC and the planned go live date is 21st October 2024, the highlight report on project achievements for the latest reporting period is cited below.

Mobilisation working group

- Principles of joint mobilisation and commissioning and access protocols have been agreed with MTX
- Currently minimal activities that overlap with a 21 October go live
- ESNEFT will act as sub-contractor to MTX –ESNEFT will have to tightly manage all access and activities in advance
- Plan and dependencies have been shared
- Insurance and liability to be ironed out – likely to be a payment to the supplier.

Model of care working group

- Gate-way review undertaken on 2 July
- Most services have green level assurance
- Housekeeping/Recovering are Amber due to risk around staffing
- Pulling together corporate induction plan to commence around last week of September
- Sterile Services Department (SSD) feasibility study has been completed and further designs are required to understand options and likelihood of undertaking the mitigating action before ESEOC can open. Outsourcing remains an option but come with risks.
- Fed to Fed -We now have a Fed-to-Fed connection between ESNEFT to WSH, this means we can seamlessly communicate via teams/SharePoint in ESEOC channels set up by ESEOC team. This will enable easy access for WSFT permitted colleagues. This supports collaborative work of joint MDT's and referral management.
- Public engagement events closed in West Suffolk and over 2000 responses. Paper to be taken to HOSC 17/7/24
- WSFT staff consultation closes 9 July 24
- Medirota data sharing agreement signed off between WSHFT and ESNEFT
- Sub Specialty variation completed
- Theatre Dry run plan confirmed - awaiting dates
- Theatre Trajectory - Presented at Steering Broad
- Staff allocation template with staff populated according to skill mix and staff numbers - October Opening

Diagnostics Workforce

SNEE PC is working closely with the following networks:

East Coast Pathology Network (ECPN)
Eastern Diagnostic Imaging Network (EDIN)
Eastern Gastrointestinal Endoscopy Network (EGEN)
Eastern Physiological Sciences Network (EPSN)

The collective ambition is to target sustainability in the pathology network thus increasing the maturity score for the EDIN network against this element for which they are currently rated as pre-emergent (table 3). There is a network development date in November 2024 and two projects are currently being scoped for the SNEE PC to jointly lead with the EDIN.

Table 3- extract from EDIN maturity matrix

Workforce	Workforce Strategy	**Developing**	EDI has been included within the People Plan and will go live in Q2 2024. There will be an associated project plan which will develop and deliver the elements of the people plan.	**Maturing**
	Recruitment & Retention	**Maturing**	Recruitment tool kit has now gone live within ECPN. EDI plan has been ratified at the Steering Board and encouragement of a diverse panel at interviews is being exercised.	
	Training and Education	**Maturing**	The talent map is in draft awaiting review and final ratification at the July Steering Board. ECPN are hosting a Regional POCT study day online on 5th June	

					2024 which is pan-network across 4 patches and includes approx. 70 delegates. Admin and Clerical apprenticeships are being discussed at trusts with the network linked in to support accessibility of training.	
			Sustainability in Workforce	**Pre-emergent**	This key topic will feature as one of the workshops at the next offsite network development event in Nov 2024.	

3.3

Efficiencies at scale programme update

We are delighted to have the new executive director for strategy and transformation in post at WSFT whom will be one of the SROs for this program.

Corporate Services

A cost comparison review has taken place of WSFT and ESNEFT, this sets out the findings of a cost comparison exercise undertaken by Marchina Limited, which looks at the difference in cost of similar services between the WSFT and ESNEFT Trusts. The aim of the exercise was to inform the Trusts' Cost Improvement Programmes through identifying any areas where the service costs at one site were significantly higher than at the other sites. Scoping of these opportunities has commenced at executive level identifying CIP opportunities for WSFT when comparing their costings to ESNEFT.

Pharmacy Manufacturing

Work continues strongly on the production and quality assurance (QA)/ quality control (QC) trajectory for chemotherapy manufacturing at Colchester on behalf of WSFT patients.
At a regional level the Regional Aseptic Review group has unofficially confirmed that two providers are interested in each hosting a sub-regional manufacturing hub (ESNEFT and the Queen Elizabeth Hospital NHS Foundation Trust at King's Lynn). An options appraisal (of formats for satisfying future pharmacy manufacturing demand) has been presented to the joint committee. Interested providers have been

	in informal discussions, pending the approval by the joint committee. Once secured the next step will be to meet with East of England Regional team + national team representatives to discuss the development of feasibility work; and the development of a strategic outline case (SOC) level business case for the region.
3.4	**Digital programme update** A meeting with SROs has been scheduled to form this work programme. There has been a significant development in this space to support collaborative working across the two providers. We now have a Fed-to-Fed connection between ESNEFT to WSFT. This means the following: An ESNEFT administrator can set up MS teams channels/SharePoint and invite WSFT colleagues into the channel. The channel can store files, documents spreadsheets etc. and can be a shared folder with no barriers for the channel membership (but abiding through the usual MS Teams protocols of editing rights etc.) This development will provide a secure shared site to conduct multi-disciplinary team meetings and to conduct referral management processes. The governance and data sharing of channels has been signed off. In addition to the MS Teams/SharePoint – trust policies can be accessed via a hyperlink from the team's channel as they are hosted on SharePoint. The first project this will be set-up for will be ESEOC and further work is ongoing to enable WSFT to be an administrator for a MS teams' channel/SharePoint. Once this is successfully implemented this will be the enabling function supporting collaborative working across ESNEFT and WSFT. Following two years of work this is a significant milestone for staff working across the two hospital providers.
3.5	**Development programme update** **<u>Governance</u>** Following the Collaborative Oversight Group on 4th June 2024 an MoU is in development for SNEE PC which will further strengthen the governance arrangements in place and enable the providers to take the learning from the ESEOC project and to create some guiding principles which set out how the SNEE PC will operate and govern. The existing Collaborative Executive Group continues to meet on a monthly basis and provides assurance to the newly established Collaborative Oversight Group. The CEG is continually reviewing reporting lines and has recently agreed the addition of system oversight of the New Hospital Programme (NHP) to its roles and responsibilities. Since established this group has been able to respond quickly to system requests, reduce duplication in effort through facilitating swift decision making and to ensure visibility of all collaborative activities between the two providers. The impact of this is noticeable with the ICB recently commenting how pleased they are to have this level of senior support and commitment which has been difficult to facilitate up to now with individual providers.
3.6	**<u>Resources update</u>** Resources are key in the delivery of the SNEE PC Workplan and the project management offices (PMO) and transformation teams at ESNEFT and WSFT have held an initial meeting with the following agreement:

	- To develop a standardised approach to PMO - To ensure informed decision making at every level - To provide consistency and visibility across the portfolio of collaborative work Further work is underway to capture benefits realisation for existing collaborative projects to ensure reporting is aligned and for new collaborative projects to agree a standardised approach to benefits tracking and reporting lines. A follow-up workshop is being organised to facilitate this work and to share best practice across teams. There is recognition that once the collaborative PMO function is operational, there is a need to then review how this can be expanded to support business planning and CIP profiling.
3.7	**Communications update** The COG approved the name of the Provider Collaborative- Suffolk and North-East Essex Provider Collaborative in June 2024. Awareness of the SNEE PC and our workplan is ever increasing within both providers and externally as we continue to collaborate with other provider collaboratives both within our region and nationally.
4.	**Next steps**
4.1	There is an imminent need to start formal communications with all staff at WSFT and ESNEFT and external stakeholders on our priorities and this is planned for Autumn 2024 in the following formats: - Online staff updates will be presented across both sites - Joint (ESNEFT and WSFT) governors meeting in September 2024 - Trust websites and intranet pages - SNEE ICB website - NHS England provider collaborative webpage
4.2	A logo and branding for the SNEE PC are being presented to the Collaborative Executive Group on 18th July for approval.
4.3	The MoU once drafted will be presented to the Collaborative Oversight Group for ratification alongside a further refined work programme with timescales and outputs.
5.	**Conclusion**
5.1	To summarise, assurance can be given that all five programmes of work are progressing well within SNEE PC and programme SROs have been appointed. Work continues at pace to enhance governance arrangements and communication will be a large area of focus going into the Autumn.
6.	**Recommendations**
	No action required aside from the boards continued support with providing a supportive culture for the provider collaborative to mature and deliver against the workplan agreed.

2.5. ESEOC Report and Presentation (Simon Morgan, Associate Director of Communications, SNEE ICB and Cassia Nice, Head of Patient Engagement & Experience, WSFT in attendance)

To Assure

Presented by Nicola Cottington

Public Trust Board meeting	
Report title:	Essex and Suffolk Elective Orthopaedic Centre proposal and engagement
Agenda item:	2.5
Date of the meeting:	26th July 2024
Lead:	Nicola Cottington, chief operating officer
Report prepared by:	Simon Morgan, associate director of communications, Suffolk and North East Essex Integrated Care Board

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

Executive Summary

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

The paper seeks to appraise the board of the public engagement exercise regarding the proposal for patients across west Suffolk to benefit from the facilities at the Essex and Suffolk Elective Orthopaedic Centre (ESEOC) at Colchester.

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

It is proposed that approximately 55% (1,300-1,500) elective orthopaedic procedures currently undertaken at West Suffolk Hospital, would be relocated to ESEOC. All remaining elective orthopaedic surgery, all trauma and all paediatric orthopaedic surgery would remain at West Suffolk Hospital. The proposed benefits include reduction of waiting times, ring-fenced capacity for elective care and the opportunity for patients to be treated at a centre of excellence.

The six-week public engagement exercise was led by Suffolk and North East Essex Integrated Care Board (SNEE ICB) and supported by West Suffolk NHS Foundation Trust (WSFT) and took place from 20 May to 30 June 2024. This included a survey undertaken by Healthwatch Suffolk, eight in-person mini exhibitions, two online events, locality meetings, outreach pop-up stands, press coverage and social media campaigns.

2,218 responses to the survey were received. 48% of respondents were positive about the proposal overall, with the main benefits identified as reducing waiting times and reducing the risk of cancellations. 35% of respondents were negative about the proposal overall, with the most common reason identified as additional time or distance to travel.

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

Healthwatch Suffolk recommends the system considers the following:

- Transport and travel
- Communication with patients
- Access, choice, flexibility, and patients' rights
- Carers/family visits
- Support for vulnerable people
- Sharing the learning

A final decision on the proposals will be made by SNEE ICB on 30th July 2024.

Recommendation / action required
The board is requested to consider the public feedback ahead of the ICB Board decision on 30 July 2024.

Previously considered by:	Suffolk Health Overview and Scrutiny Committee 18th July 2024
Risk and assurance:	BAF Risk 2: Capacity: The Trust fails to ensure the health and care system has the capacity to respond to the changing and increasing needs of our communities BAF Risk 3: Collaboration: The Trust fails to work effectively with our partners to ensure the greatest possible contribution to preventing ill health, increasing wellbeing, and reducing health inequalities
Equality, diversity and inclusion:	An equality and health inequalities impact assessment was undertaken in relation to the engagement exercise
Sustainability:	Travel and transport concerns highlighted through engagement which could have a sustainability impact.
Legal and regulatory context:	Public Sector Equality Duty Equality Act 2010 Legal advice obtained on duty to engage

A proposal for West Suffolk patients to benefit from state-of-the-art facilities at Essex and Suffolk Elective Orthopaedic Centre (ESEOC).

Information in this report was produced on behalf of:

Director or Assistant Director:	Nicola Cottington, Chief Operating Officer, West Suffolk NHS Foundation Trust
By:	Simon Morgan, Associate Director of Communications, NHS Suffolk and North East Essex ICB
Date Submitted:	12 July 2024

Introduction

1. This paper is to appraise the boards of the NHS Suffolk and North East Essex ICB West Suffolk NHS Foundation Trust about the six-week engagement exercise which sought views from the public on a proposal for patients across west Suffolk to benefit from state-of-the-art facilities at ESEOC in Colchester.

2. This paper provides the boards with an overview of the background, case for proposed change, the approach taken for the public engagement exercise, key themes of feedback received, as well as next stages in the process, prior to a final decision on the proposals being made by the Suffolk and North East Essex Integrated Care Board on 30 July 2024.

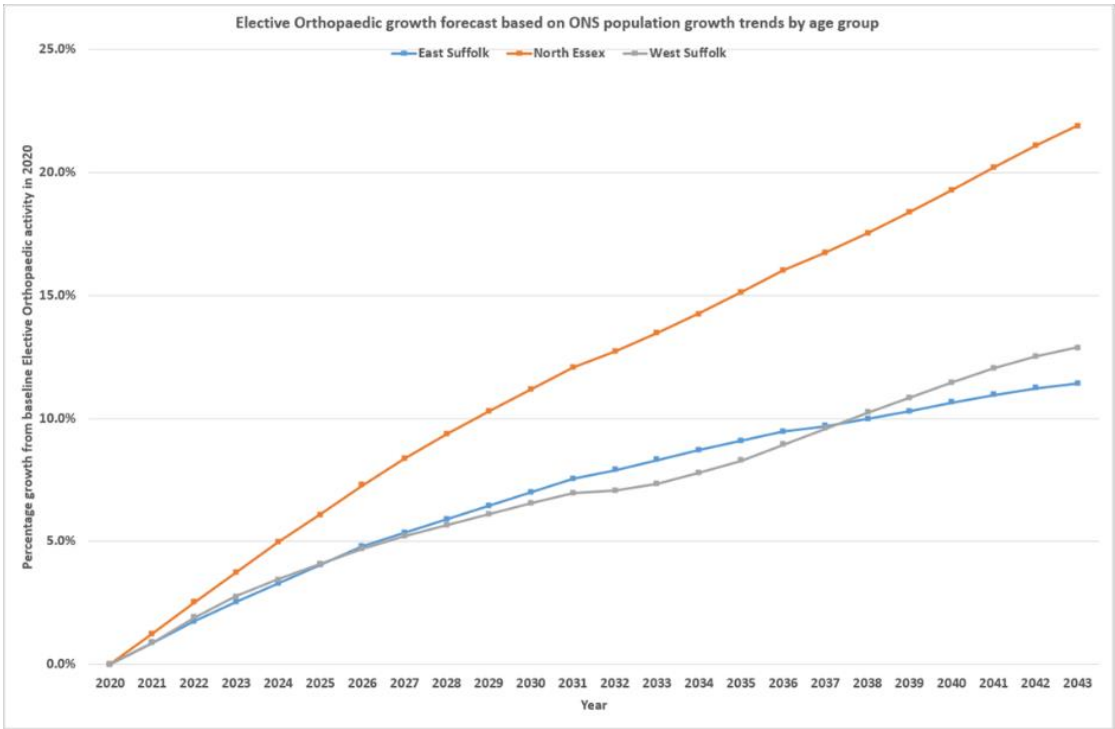
Background

3. The COVID-19 pandemic led to unprecedented levels of disruption to elective hospital care across the country. In England, the waiting list for procedures increased by 61% from 4.57 million before the pandemic in February 2020 to 7.47 million at the start of 2024. This was largely because most routine care stopped during the pandemic.

4. Recognising predicted future growth rates, the need for increased elective surgical capacity for the orthopaedic service is clear. Even without further COVID-19 surges, additional elective surgical capacity is required to reduce excessive waiting times for patients.

5. Figure 1 shows the growth forecast expected for elective orthopaedic procedures across Suffolk and north east Essex.

Figure 1: Elective Orthopaedic growth forecast across SNEE



6. Being on such a lengthy waiting list for treatment, with many patients experiencing pain for a long period of time, significantly and adversely impacts on a person's physical and mental wellbeing. This is exacerbated further in a situation when a patient's treatment is cancelled.

7. When it opens during the autumn of 2024, ESEOC will treat patients from across Suffolk and north east Essex. For these patients, it will mean reduced waiting times for surgery which may prevent their condition from worsening as well as a reduced risk of short-notice cancellations because clinicians at ESEOC would not deal with accident and emergency patients.

What was being proposed during the engagement exercise?

8. Based on the capacity available to West Suffolk NHS Foundation Trust (WSFT), it is proposed that approximately 55% of orthopaedic elective surgical procedures (1,300-1,500[1] per annum) from West Suffolk Hospital in Bury St Edmunds should be relocated to ESEOC, approximately 30 miles away or an hour's drive from the hospital's Hardwick Lane site.

9. ESEOC is a surgical hub that is 'ring fenced', meaning that patients should not have their operations cancelled when hospitals face intense emergency pressures. In addition, it is proposed that approximately 750 day-cases relocate to ESOEC, releasing much needed day case capacity for other activity at West Suffolk Hospital.

10. Furthermore, it is proposed that all complex knee revision surgery would be performed at ESEOC.

11. The remaining 45% of orthopaedic elective activity would stay at West Suffolk Hospital. A suggested sub-specialty split is detailed below. Under this proposal, all remaining elective orthopaedic activity, orthopaedic trauma surgery and

[1] Number may fluctuate dependent on case mix.

paediatric orthopaedic activity would remain at WSFT. These figures are indicative due to ongoing discussions to finalise the financial/activity model pertaining to this project

Figure 2: An indicative breakdown of procedures by surgery location (based on 2023 activity numbers[2]:

Procedures	Volume of activity to move to ESEOC	Volume of activity to remain at West Suffolk Hospital
Hip	80% (232)	20% (58)
Knee	80% (252)	20% (63)
Upper limb	50% (160)	50% (160)
Foot and Ankle	25% (28)	75% (84)
Shoulders	40% (35)	60% (50)
Day case procedures i.e., arthroscopies, removal of metal work	50% (750)	50% (750)
TOTAL INDICATIVE THROUGHPUT (CASES)	**(55%) 1,457**	**(45%) 1,165**

N.B. The above is subject to change due to the waiting list case mix, complexity and ongoing dialogue pertaining to an agreed financial model. It does not include paediatric procedures, recognising these are out of scope.

Benefits to patients

12. Should this proposal receive approval, there would be several benefits to patients across west Suffolk. These include:

- **Waiting times** – By moving to ESEOC the WSFT predicts its patients will see reductions in wait times for surgery.

- **Primary Focus on Elective Care** – Delivering surgery via a surgical hub will enable teams to focus solely on the delivery of elective excellence, reducing length of stay.

- **Revision expertise** – concentrated in a regional hub; all knee revision surgery being directed here.

- **Centre of excellence** – high quality services provided by specialist teams within Europe's largest elective orthopaedic centre

- **Increased capacity** – by using this facility in addition to all available WSFT theatre capacity, additional capacity will be created, enabling more patients to be treated across all surgical specialities.

- **Training centre** – allowing the surgeons of tomorrow to be trained locally and within the system.

- **Free up an operating theatre at WSFT** – This will allow clinicians to conduct more work on elective recovery which will mean more capacity for patients to be seen faster.

[2] Numbers may fluctuate dependent on case mix and complexity.

Approach to patient and public involvement

13. In March 2024, the ICB Board gave its approval for a six-week public engagement exercise to take place between Monday 20 May to Sunday 30 June 2024, led by the ICB with strong support from WSFT and Healthwatch Suffolk.

14. The ICB engaged with the Suffolk Health and Overview Scrutiny Committee and NHS England on the engagement approach – both were in support.

15. Healthwatch Suffolk was commissioned to independently analyse and report on the findings of the engagement survey. Healthwatch Suffolk staff also attended engagement events and helped promote the survey to their community contacts.

16. There were six main objectives to the public engagement exercise:

    a) To develop and deliver an effective and inclusive exercise which allows people to give their views on the impact it will have on them;

    b) To share with the public a clear narrative that describes the reasons for the proposal;

    c) To actively engage and develop relationships with stakeholders to increase their understanding of the system's aims to reduce the waiting list and meet the demand of the growth of the population by the proposal;

    d) To incorporate ideas/suggestions from patients/the public into plans;

    e) To have due regard to the need to reduce inequalities;

    f) To meet the requirements of the Public Sector Equality Duty – to eliminate discrimination and promote equality of opportunity for people with protected characteristics.

17. An Equality and Health Inequalities Impact Assessment, as well as a travel impact assessment, was completed prior to the engagement period by WSFT in line with the Public Sector Equality Duty and has been available in the public domain throughout. This assesses the potential impact of the changes to various inclusion groups, including those with protected characteristics under the Equality Act (2010).

18. As part of the engagement exercise, the following activities took place to capture views from local people:

Survey

19. Healthwatch Suffolk developed a survey to gather the views. This was co-produced with local people and patient participation groups. Please see the Section on "Key Findings" below which describes the survey and the development approach taken.

Public facing leaflet

20. An A5 document which sets out what the proposal is, why it is being proposed and how it will benefit patients was produced. This document was available in various formats including easy read, electronic, paper copy and audio. Paper copies were also available and shared at events.

Text messages to everyone on the orthopaedic waiting list

21. Two SMS messages were sent from WSFT to all patients on the orthopaedic waiting list (~4000) throughout the period. The first was sent on week commencing 20 May as follows:

West Suffolk NHS is proposing to move around 55% of planned orthopaedic surgery to a new state-of-the-art centre based on the Colchester Hospital site. To find out more about the plans please [click here].
It is very important that our patients can give feedback about these plans. Have your say by [completing the survey]. If you would like a survey in a different format, please contact Healthwatch Suffolk on 0800 448 8234.
Please note that plans for your surgery will continue as discussed with the team caring for you, and you should await contact from your care team to discuss individual circumstances, including where your surgery might take place. If you have any concerns, you can contact PALS on 01284 712555 or PALS@wsh.nhs.uk.

22. A second was sent week commencing 24 June as follows:

It's not too late to have your say about plans to move around 55% of planned orthopaedic surgery from West Suffolk Hospital to the new centre in Colchester. Please take part in our engagement survey to give feedback on how this could impact you or those you care about by following this link [link] or contacting Healthwatch Suffolk for free on 0800 448 8234. You have until 30 June to take part.

Mini exhibitions

23. Mini exhibitions were organised (as opposed to traditional town hall format meetings) so people could have one-to-one discussions with lead clinical consultants, NHS communications and engagement staff and learn more about the proposal from exhibition stands. They were also invited to complete a survey at each venue and were able to take information away with them. The mini exhibitions took place at the following venues:

- Saturday 8 June, 10-12noon, The Apex, Bury St Edmunds, Charter Square, Bury St Edmunds IP33 3FD
- Tuesday 11 June, 10-12noon, Newmarket Racing Centre, Fred Archer Way, Newmarket CB8 8NT
- Tuesday 11 June, 2.30-4.30pm, Innovation Centre, Croxton Rd, Thetford IP24 1JD
- Wednesday 12 June, 6-8pm, Haverhill Arts Centre, High Street, Haverhill CB9 8AR
- Thursday 13 June, 2-4pm, Kingfisher Leisure Centre, Station Road, Sudbury CO10 2SU
- Friday 14 June, 5-7pm, New Bury Community Centre, 1 Charles Pl, Bury St Edmunds IP32 6TD
- Tuesday 18 June, 10-12noon, Main Hall, St John's Centre, St John's Close, Mildenhall IP28 7NX
- Tuesday 25 June, 2-4pm, Brandon Leisure and Health Hub, Church Road, Brandon IP27 0JB

24. Different locations, days and times of the day were chosen to accommodate the needs of local people and add flexibility to the engagement offer. The total number of people who visited our mini exhibitions was 290.

Online events

25. Two online events took place, at 5pm on Wednesday 5 June and 10am on Saturday 15 June, which allowed local people to access the sessions without needing to travel. Clinical colleagues from WSFT and the West Suffolk Alliance

director were present and available to answer people's questions about the proposal. Recordings of the online events were uploaded onto the ICB's website - Essex and Suffolk Elective Orthopaedic Centre public engagement 2024 - NHS Suffolk and North East Essex ICB

Locality meetings

26. Representatives from the NHS across Suffolk have attended several existing locality meetings and community groups to speak to members about the proposal and the engagement. The meetings included partner organisations and stakeholders from the Voluntary, Community, Social Enterprise and Faith sectors across west Suffolk and south Norfolk. During each meeting, representatives shared the case for change and outlined how people were able to share their feedback. At the end of the agenda item, representatives invited questions from the groups they visited and encouraged stakeholders to spread the word amongst their networks. Please see Appendix 1 for a list of the locations and groups visited.

Outreach pop-up stands in supermarkets/libraries and GP surgeries

27. Outreach and pop-up stands were organised in busy areas of high footfall. These included supermarket entrances, libraries, shopping areas and community hubs. Colleagues from within the system spoke to passers-by and invited them to complete a survey. These locations were purposefully chosen as the most effective ways of reaching our intended audiences.

How we communicated the engagement

Advertorial in local press promoting the proposal

28. A half page advertorial was placed in the Bury Free Press titles (Newmarket Journal, Mildenhall, Bury, Thetford, Haverhill, Diss and Suffolk Free Press editions).

29. This editorial advert explained what was being proposed and how people could give their views - Sponsored feature: Have your say on a proposal for local patients (suffolknews.co.uk)

30. The same advert appeared on the social media platforms of Iliffe (which publishes the Bury Free Press titles). This helped to further amplify the coverage.

31. Dates of advertisement and social media campaigns – 16-23 May and 6-13 June.

32. Figures 3 and 4 show the reach this advertorial had.

Figure 3 - 16 May 2024

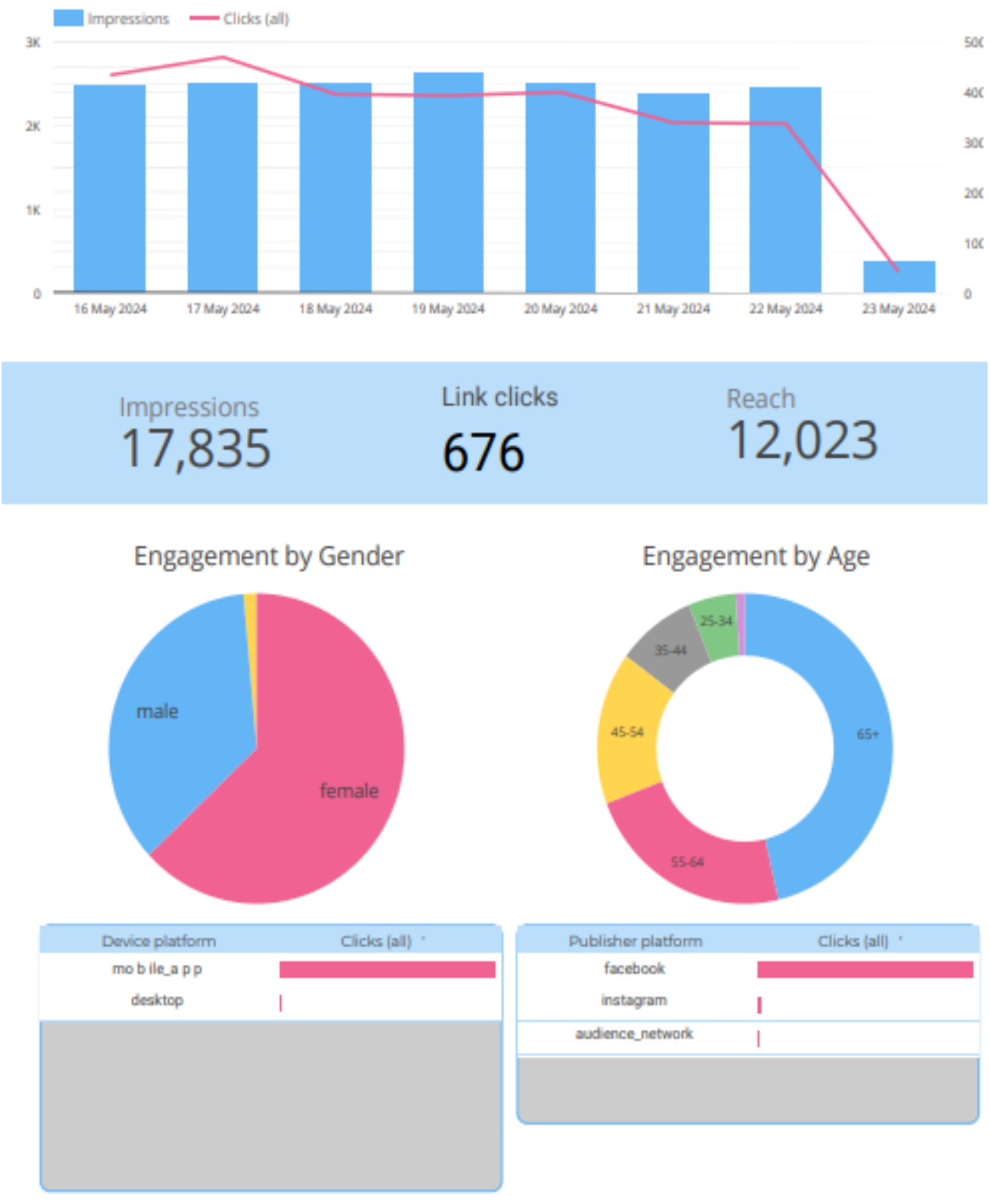
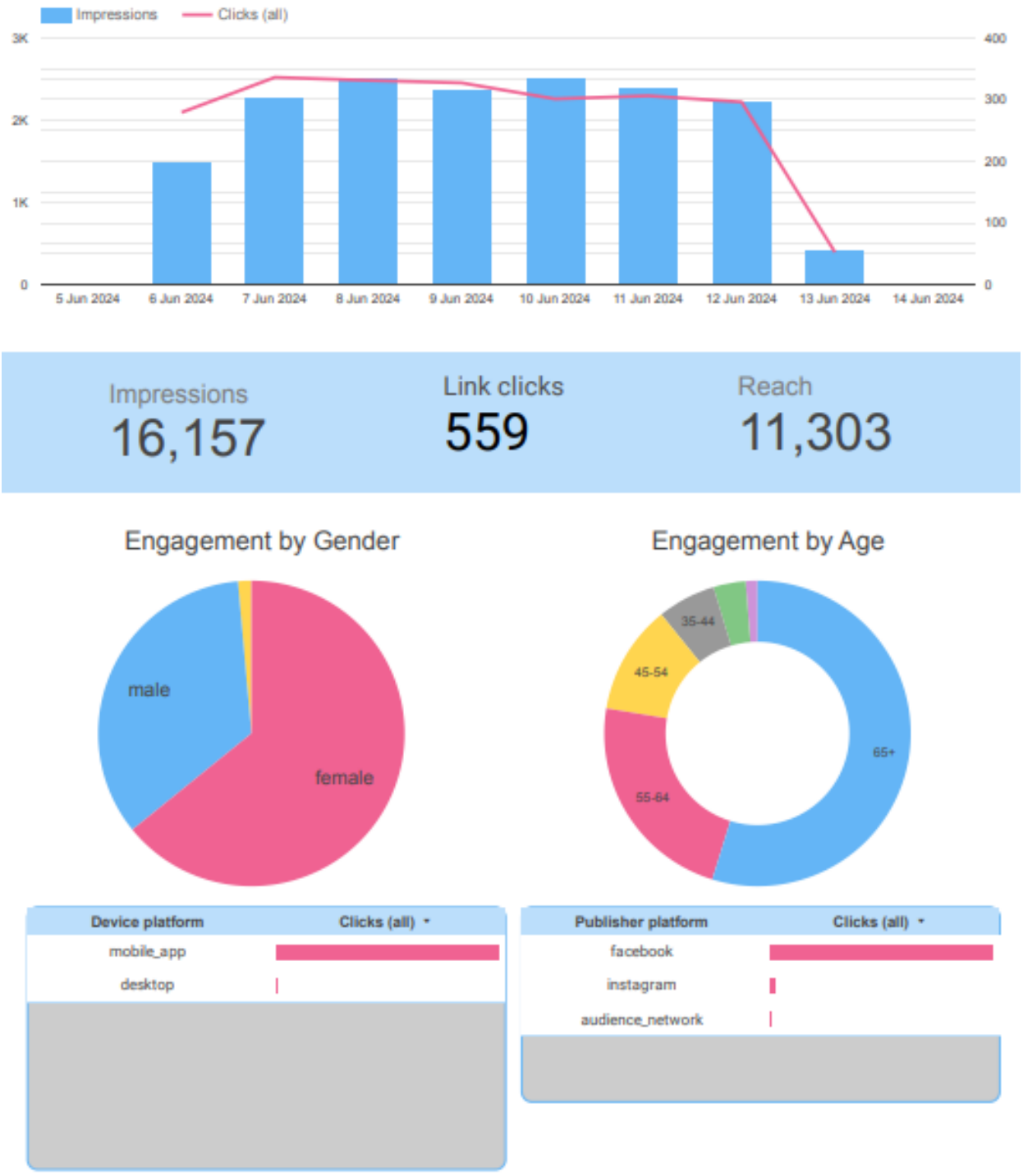


Figure 4 - 6 June 2024



Press releases

34. Three press releases were issued by the ICB which included links to the engagement page of its website and the Healthwatch Suffolk survey. These press releases were timed to be issued at the start of the engagement period as well as midway through the process. A third release was published in the week of the closing date to remind people. Each press release had quotes from clinical leads as well as those colleagues responsible for the engagement exercise and are included below:

14 May 2024 - Views sought from west Suffolk patients on orthopaedic proposal - NHS Suffolk and North East Essex ICB

10 June 2024 - Still time to give views on West Suffolk Hospital orthopaedic surgery move proposal - NHS Suffolk and North East Essex ICB

25 June 2024 - Orthopaedic proposal deadline is 30 June – please give your views by then - NHS Suffolk and North East Essex ICB

Media coverage and press releases

35. In addition to the editorial advert, there was widespread coverage (both in print and broadcast) which reported the engagement in local and regional media outlets. Examples of coverage are below:

- 19 March – BBC - West Suffolk Hospital plan to move operations to Colchester - BBC News
- 20 March – EADT - Bid to cut surgery waiting times using Colchester Centre | East Anglian Daily Times (eadt.co.uk)
- 20 March – Suffolk News - Hundreds of operations at West Suffolk Hospital in Bury St Edmunds could be moved to new Essex and Suffolk Elective Orthopaedic Centre at Colchester Hospital (suffolknews.co.uk) Suffolk News includes Bury Free Press, Newmarket Journal, Haverhill Echo, Diss Express, Mildenhall and Thetford editions of BFP and Suffolk Free Press
- 20 March – Healthwatch Suffolk – New NHS plans aim to reduce orthopaedic elective care waits in west Suffolk by transferring care to north Essex - Healthwatch Suffolk
- 20 March – Colchester Gazette – Colchester Hospital new unit could welcome Suffolk patients | Gazette (gazette-news.co.uk)
- 26 March – EADT – West Suffolk Hospital patients willing to travel to Essex | East Anglian Daily Times (eadt.co.uk)
- 14 May – Suffolk News – https://www.suffolknews.co.uk/bury-st-edmunds/news/how-to-have-your-say-on-plans-to-move-hundreds-of-operations-9366028/
- 20 May – BBC News - West Suffolk views sought on NHS procedures moving to Essex - BBC News
- 21 May - Proposed move of surgeries to Essex and Suffolk Orthopaedic Centre | Gazette (gazette-news.co.uk)
- 28 May – Second story on ITV Anglia – walk round centre, interview with Andrew Dunn, promotion of engagement
- 8 June – Bury Free Press - https://www.suffolknews.co.uk/bury-st-edmunds/news/first-public-engagement-on-plans-to-move-hundreds-of-operati-9369693/
- 12 June – BBC Radio Suffolk – https://www.bbc.com/news/articles/cljj5yd59gdo

ICB stakeholder briefings

36. Information about the proposals were shared in fortnightly stakeholder briefings that go to all ICB stakeholders and shared among all councillors within the west Suffolk area as well as strategic partners and members of the public.

- Edition 1 - https://sway.cloud.microsoft/O6JxewOaIHAQ5w5d
- Edition 2 - https://sway.cloud.microsoft/EYcW7nm0z9d4Je4m
- Edition 3 - NHS Suffolk and North East Essex - Stakeholder and councillor briefing - 26 June 2024 (cloud.microsoft)

Posters

37. To increase local awareness about the engagement events, specially produced posters were place in local shops, community centres, public houses and other facilities in towns and villages in west Suffolk. E-flyers that promoted the engagement were also produced and shared on social media and templated materials allowed system partners to promote the outreach stands.

Community Facebook pages

38. A mixed response was received to the request of posting details about the engagement on local community Facebook pages. Some administrators allowed this to happen – and we remain grateful for their support. Other groups rejected the request, which we of course respect. Those groups which did support us meant we were able to gain further reach into local communities.

Communications toolkit

39. A toolkit was developed in conjunction with local Patient Participation Groups within Suffolk. This included consistent messaging about the engagement exercise, the case for change and template news articles and social media posts. In addition artwork for the posters and social media assets were included. A set of slides for GP/hospital waiting room screens was also developed. The toolkit and screen slides were shared with hospital and GP waiting room areas as well as councillors, patient groups, stakeholders and staff via the ICB stakeholder briefing. Thanks to colleagues from the Botesdale PPG for support in developing this resource.

Virtual tour

40. As part of our approach to involve people, the Director of the Essex and Suffolk Elective Orthopaedic Centre agreed to feature in a short film. This gave viewers an update on how building work is progressing at the centre.

Involving seldom heard communities

41. The NHS in Suffolk has been in touch with several support groups which represent seldom heard groups within the county to promote the engagement and to ask for details and the link to the survey to be shared with their membership. The system is grateful to BME Suffolk, BSE4BL, Aspire Black Suffolk, Ace Anglia, Anglo Chinese Cultural Exchange, Communities Together East Anglia, Bury Multicultural Women's Group, PHOEBE and Suffolk Refugee Support among many others for their support.

42. A reminder about the closing date for responses was shared with them during the final week of the engagement. Other groups that we engaged with included Thetford U3A, Hard of Hearing Club in Haverhill, Breathe Easy Support Group, Haverhill Terrific Tuesday Dementia Support Group, Jam Community Pot, Chronic pain support group, Lymphodema support group, Cancer Services User Group, Woolpit Traveller site visit, 'Legs Matters' public health event.

43. We have also been in touch with prominent local community representatives and have shared our stakeholder briefings with them for their awareness.

44. While the engagement survey did attract a high number of responses, 127 people did not state their ethnicity.

Health Scrutiny Committee

45. The ICB remains grateful for the support it has received from Suffolk Health Scrutiny Committee. It has previously discussed the proposed approach for an engagement exercise with the Chairman, Vice Chairman and Business Manager (Democratic Services) Officer, who in turn arranged for informal views to be obtained from the wider Committee membership at an early stage. The Committee also received information formally at its meeting on 17 April including details of the proposed engagement plan. During the Health Scrutiny Committee meeting on 17 July, NHS representatives informed members about some of the main areas of feedback from the engagement exercise as well as outlined the next steps and recommendations.

Responses

46. Healthwatch Suffolk was appointed to oversee the process of gathering responses. This ensured an independent approach was taken to gathering responses and analysing findings and trends of data.

47. A total of **2,218** responses to the survey were received between 20 May and the close of the engagement on the 30 June.

Design of survey

48. Co-production of the survey took place in April and May 2024. Healthwatch Suffolk worked with the Suffolk and North East Essex ICB and WSFT to define the objectives and key topics for the engagement, and to ensure that communication of the survey was accessible to as many people as possible. The West Suffolk PPG Chairs Collaborative Network shared a draft with their members for comment, resulting in additional questions focussed on travel and patient choice.

Data collection

49. Healthwatch Suffolk hosted the anonymous feedback form on its website with signposting links from the ICB's main web page as well as links from social media posts. This supported translation of the survey using built-in Google translate. Paper copy forms were also made available for use in communities, as well as a flyer using a QR code. A paper copy Easy Read format was also produced. Healthwatch Suffolk engagement officers were available to support independent capture of people's experiences at events hosted by the ICB.

Reporting

50. Healthwatch Suffolk will produce a summary PDF report and PowerPoint summary about people's views and experiences to be shared with NHS leaders and the public. The report will be published on Healthwatch Suffolk's website and shared with the SNEE ICB and WSFT boards.

Key findings

51. The following section provides an overview of key themes across the survey.

Five main positive findings from the data:

- 48% of respondents were positive about the proposal overall. In the free text data, the most common reason for positivity was the impact ESEOC would have on reducing wait times and the risk of cancellations. This was mentioned by 30% of respondents.

- People living in some postcode district areas such as Sudbury and Lavenham (CO10, 75%), Stowmarket and Stowupland (IP14, 62%), Hadleigh and Milden (IP7, 64%) and Eye and Thorndon (IP23, 59%) were more likely to be positive about the proposal overall.
- Many people already have the support they need to be able to travel to ESEOC. 64% said that they would get a lift from family or friends.
- People who were already waiting for elective surgery at WSFT were much more likely to be positive overall (59%) than members of the public not on waiting lists (40%). They were also:
    - more likely to say they would get a lift to ESEOC (73% compared to 54%).
    - less likely to indicate distance from their home was important for their choice of provider (48% compared to 67%).
- In the free text data, 13% of people said they were motivated by receiving their operation quickly, rather than the distance they needed to travel. For people who are waiting for a long time, or living with pain, they may prioritise having their operation sooner over other considerations.

Five areas of concern:

- 35% respondents were negative about the proposal overall. 17% were neither positive nor negative. In the free text data, the most common reason for negativity was the additional time or distance to travel. This was mentioned by 47% of respondents.
- Travel and transport were the top concerns in the survey. 12% of people currently waiting for elective care at WSFT said that they did not know how they would travel to ESEOC. This figure was 25% for members of the public not waiting for elective care.
- 28% of respondents said in the free text comments they would find it difficult or impossible to get a lift to ESEOC. Common reasons for this included not feeling they could ask their family or friends to travel the increased distance to ESEOC, or not having close friends or contacts local to them to ask for a lift.
- 7% said that they would use public transport to get to ESEOC. However, when the survey advised people that they could not drive or use public transport after surgery, 83% of those said they could not get a lift home or were unsure.
- In addition to their travel options, people felt that the proposal and increased distance to travel would have an impact on:
    - their family or carers being able to visit them (15%)
    - travel cost (11%),
    - being able to arrive on time for early appointments, or driving home in the dark or winter months (5%),
    - the environment (1%).

Demographics:

52. The following section provides a summary of who has responded to the survey (figures from Healthwatch Suffolk).

- People were asked to identify whether they were currently waiting for elective care, were a carer, or a member of the public:
  - 54% (1,204) of people who responded to the survey were members of the public not caring for someone waiting for elective care or waiting for elective care themselves.
  - 37% (822) were patients waiting for elective orthopaedic care at WSFT.
  - 5% (110) were carers or relatives of someone waiting for elective care.
  - 2% (47) were patients waiting for elective orthopaedic care at another provider.
  - 1.4% (31) were patients for waiting for elective orthopaedic care at ESNEFT

- 80% of responses were from people aged 55 or above. This comprised:
  - 18-24 0.3% (7)
  - 25-34 2% (47)
  - 35-44 6% (123)
  - 45-54 9% (189)
  - 55-64 22% (443)
  - 65-74 31% (637)
  - 75-84 26% (521)
  - 85-94 4% (72)
  - 95+ 0.1% (3)

  Total 2,042

- 42% (941) identified an additional support need including having difficulties with mobility, a long-term condition or illness, a physical disability, mental health difficulty, sensory impairment, learning disability, autism or dementia.

- 95.4% of responses are from people who identified as White English/ Welsh/ Scottish/ Northern Irish. Other ethnic groups in the response were:

Category	**Number**	**Number**
White - English/Welsh/Scottish/Northern Irish/British	95.4%	1919
White – Any other White background	2.2%	44
White – Irish	0.9%	19
Mixed / Multiple ethnic groups – White and Black Caribbean	0.3%	6
Mixed / Multiple ethnic groups – Any other mixed/multiple	0.2%	4
Mixed / Multiple ethnic groups – White and Black African	0.2%	4
Mixed / Multiple ethnic groups – White and Asian	0.1%	3
Asian / Asian British - Indian	0.1%	3

Asian / Asian British – Any other Asian background	0.1%	3
Black / African / Caribbean / Black British - African	0.1%	2
Black / African / Caribbean / Black British - Caribbean	0.1%	2
Asian / Asian British - Chinese	0.05%	1
Asian / Asian British - Bangladeshi	0.05%	1
White – Gypsy or Irish Traveller	0.05%	1
Total answered		**2012**
Did not answer		206

206 people did not report their ethnicity and are not included in the percentages above.

Area

The survey has received responses from many areas across the system and beyond. These included:

Area	Postcode	Number	Percentage
Bury St Edmunds (south, west and town centre)	IP33	258	11.87%
Diss, Winfarthing	IP22	240	11.04%
Sudbury, Lavenham	CO10	230	10.58%
Ixworth, Thurston	IP31	191	8.79%
Elmswell, Cockfield	IP30	152	6.99%
Stowmarket, Stowupland	IP14	146	6.72%
Newmarket, Ashley	CB8	133	6.12%
Mildenhall, Culford	IP28	132	6.07%
Haverhill, Barnardiston	CB9	127	5.84%
Bury St Edmunds (north and east)	IP32	113	5.20%
Brandon, Lakenheath	IP27	106	4.88%
Thetford, Barnham	IP24	91	4.19%
Barrow, Shimpling	IP29	64	2.95%
Eye, Thorndon	IP23	51	2.35%
Hilborough, Feltwell	IP26	23	1.06%
Thorpe Abbotts, Pulham Market	IP21	13	0.60%
Hadleigh, Milden	IP7	11	0.51%

Ely (east and city centre), Barway	CB7	9	0.41%
Burwell, Waterbeach	CB25	8	0.37%
Needham Market, Creeting St. Mary	IP6	8	0.37%
Halstead	CO9	6	0.28%
North East Ipswich	IP4	6	0.28%
Felixstowe, Trimley St. Martin	IP11	5	0.23%
Banham, Larling	NR16	4	0.18%
Woodbridge, Melton	IP12	4	0.18%
Bures, Alphamstone	CO8	4	0.18%
South East Ipswich, Ravenswood	IP3	3	0.14%
North West Ipswich, Akenham	IP1	3	0.14%
Attleborough, Little & Great Ellingham	NR17	3	0.14%
Fulbourn, Great and Little Wilbraham	CB21	2	0.09%
Colchester	CO1	2	0.09%
Watton, Shipdham	IP25	2	0.09%
Copdock, Belstead	IP8	2	0.09%
Saxmundham	IP17	2	0.09%
Harleston, Mendham	IP20	2	0.09%
Ely (west), Aldreth	CB6	1	0.05%
South West Ipswich, Belstead	IP2	1	0.05%
Witham	CM8	1	0.05%
South Lowestoft	NR33	1	0.05%
Beccles, Worlingham	NR34	1	0.05%
North Lowestoft	NR32	1	0.05%
Greenstead, Highwoods	CO4	1	0.05%
Harlow, Old Harlow	CM17	1	0.05%
Shotley Peninsula: Capel St Mary, Chelmondiston	IP9	1	0.05%
Villages N and E of Dereham: Bawdeswell, Bylaugh	NR20	1	0.05%
Coggeshall, Earls Colne	CO6	1	0.05%
Clacton-on-Sea, Jaywick	CO15	1	0.05%
Brightlingsea, Wivenhoe	CO7	1	0.05%
Tiptree, Kelvedon	CO5	1	0.05%
Bungay, Topcroft	NR35	1	0.05%
Aldeburgh	IP15	1	0.05%
Kirton, Nacton	IP10	1	0.05%
Total answered		2,173	100.00%

Next stage

53. The engagement exercise concluded on Sunday 30 June 2024. The Integrated Care Board and the board of WSFT will consider the public feedback collated before a final decision is made by the ICB Board on Tuesday 30 July.

Recommendations from independent analysis

In light of the feedback received, Healthwatch Suffolk recommends that the system considers the following:

To avoid inequality of access, it would be important for the system to consider:

- **Transport and travel** – finding solutions for those without the means to travel to ESEOC, making sure people can get to their surgery (proactive solutions, help with travel costs or access to information about possible reimbursement).
- **Communicate to patients about what the ESEOC is** and help them to know what to expect from going there (e.g., where it is geographically, what would happen when they are there, car parking charges). Ensuring this is accessible to all.
- **Access, choice, flexibility and patient rights** – the system needs to clarify who is able to receive their operation at West Suffolk Hospital and who would receive it at ESEOC. Who could choose to stay at WSFT and who would decide? How would people ask? Primary Care would need to be equipped with this knowledge so they can pass this on to patients at the point of referral.
- **Carers/family visits** – ensure consideration is given towards visiting (both for carers and for families) particularly those who are vulnerable patients who will have their procedure at ESEOC. Ensuring there is support in place so they can stay nearby overnight, dependent on the patient's length of stay.
- **Support for vulnerable people** – ensure there is support available for vulnerable people (such as those living with dementia or a learning disability). Ensuring the environment is as friendly as possible if they need accessible support.
- **Share the learning** – ensure learning from public feedback relating to issues such as transport, travel, access, carer needs, communications and support for those who are vulnerable, are used in the development of any future centralised care hubs.

Appendices

Appendix 1 – Groups and locations attended

DATE	VENUE	NO. OF ATTENDEES
W/C 6 MAY		
Thursday 9 May, 2.00pm-3.30pm	Sudbury Locality meeting	38
W/C 13 MAY		
Monday 13 May, 10.00am-11.00am	SNEE PPG Chairs Network	4 PPG Chairs
Tuesday 14 May, 9.30am-11.00am	Health & Wellbeing Network	21
Tuesday 14 May, 5:30pm - 7:00pm	Legs Matters' public health event	
Wednesday 15 May, 1.30pm	Mildenhall & Brandon locality meeting	15 (representatives from Suffolk Police, CAB, Council, PCN, Grove Surgery, Food banks, CAS)
Wednesday 15 May, 2pm	NHS England regional assurance workshop	42
W/C 20 MAY		
Wednesday 22 May, 2.15pm	Sporting Memories Meeting	52
Thursday 23 May, 10.30am-12.30pm	Newmarket locality meeting	30
Thursday 23 May, 10.30am-12.30pm	Outreach stand	30
Thursday 23 May, 1.30pm-2.00pm	West Suffolk Council briefing	5
Friday 24 May, 10.30am - 12pm	Traveller site visit	1
W/C 27 MAY		
Wednesday 29 May, 10.00am-12.00pm	Outreach stand	66 people spoken to and a further 92 surveys taken for distribution in community centres etc.
Wednesday 29 May and Thursday 30 May	Outreach stand	Day 1 - Spoke to circa 71 people and included 150 leaflets in packs
Thursday 30 May, 10.00am-1.00pm	Outreach stand	Circa 40 people
Friday 31 May, 9.30am	Cancer Services User Group	6 spoken to

Saturday 1 June, 8.00am-12.30pm	Outreach stand	Circa 30 - all had received the text to those on the waiting list
W/C 3 JUNE		
Monday 3 June, 9.00am-11.00am	Outreach stand	111
Monday 3 June, 10.00am-1.00pm	Outreach stand	Cancelled - 30 paper surveys given at another Stowmarket venue
Monday 3 June, 1.30pm	Bury locality meeting	Email sent to all attendees with toolkit, survey, posters and locality meeting presentation
Monday 3 June, 7.00pm	Lymphoedema support group	17
Tuesday 4 June, 9.00am	Babergh Councillors briefing	4
Tuesday 4 June, 10:00am	Outreach stand	Paper surveys at Lakenheath Practice, Brandon library, Brandon GP Surgery, Boots Pharmacy
Wednesday 5 June, 9.30am-11.30am	Outreach stand	
Wednesday 5 June, 10.30-12noon	North East Essex Town and Parish Meeting	16
Wednesday 5 June, 5pm	Online public meeting	8
Thursday 6 June, 10.00am-12.00pm	Outreach stand	25
Thursday 6 June, 10.30am-12.30pm	Thetford PLACE Meeting	17
Friday 7 June, 9.00am-11.00am	Outreach stand	10
Saturday 8 June, 10.00am-12.00pm	Mini Exhibition	150
W/C 10 JUNE		
Monday 10 June, 10.00am-1.00pm	Outreach stand	3
Tuesday 11 June, 10.00am-12.00pm	Mini exhibition	
Tuesday 11 June, 2.30pm-4.30pm	Mini exhibition	10

Wednesday 12 June, 10:00am - 12:00pm	Outreach stand	23
Wednesday 12 June, 10.00am-1.00pm	Outreach stand	5
Wednesday 12 June, 6.00pm-8.00pm	Mini exhibition	6
Thursday, 13 June, 11:00am - 12:30pm	Outreach stand	20
Thursday 13 June, 2.00pm-4.00pm	Mini exhibition	50
Thursday 13 June, 5.00pm-6.00pm	Governors briefing	16
Friday 14 June, 5.00pm-7.00pm	Mini exhibition	30
Saturday 15 June, 10.00am	Online public meeting	0
W/C 17 JUNE		
Monday 17 June 9 - 10am	West Suffolk Hospital entrance	25
Monday 17 June, 10.00am-1.00pm	Outreach stand	30
Tuesday 18 June, 10.00am-12.00pm	Mini exhibition	10 people attended. 25 surveys handed out at Morrison's and 50 given to Julie on St John's Centre reception to go to other groups.
Wednesday 19 June, 10.30am-12.00pm	Communication hub meeting	30
Wednesday 19 June, TIME TBC	Haverhill locality meeting – venue tbc	40
Thursday 20 June, 3.00pm-4.00pm	Chronic pain support group	12
W/C 24 JUNE		
Monday 24 June, 10.00am-11.00am	Jam Community Pot	12
Monday 24 June, 11.00am-1.00pm	Outreach stand	10
Tuesday 25 June, 11.00am-2.00pm	Haverhill Terrific Tuesday Dementia Support Group	17
Tuesday 25 June, 2.00pm-4.00pm	Mini exhibition	14
Wednesday 26 June, 1.30pm-2.30pm	Breathe Easy Support Group	5

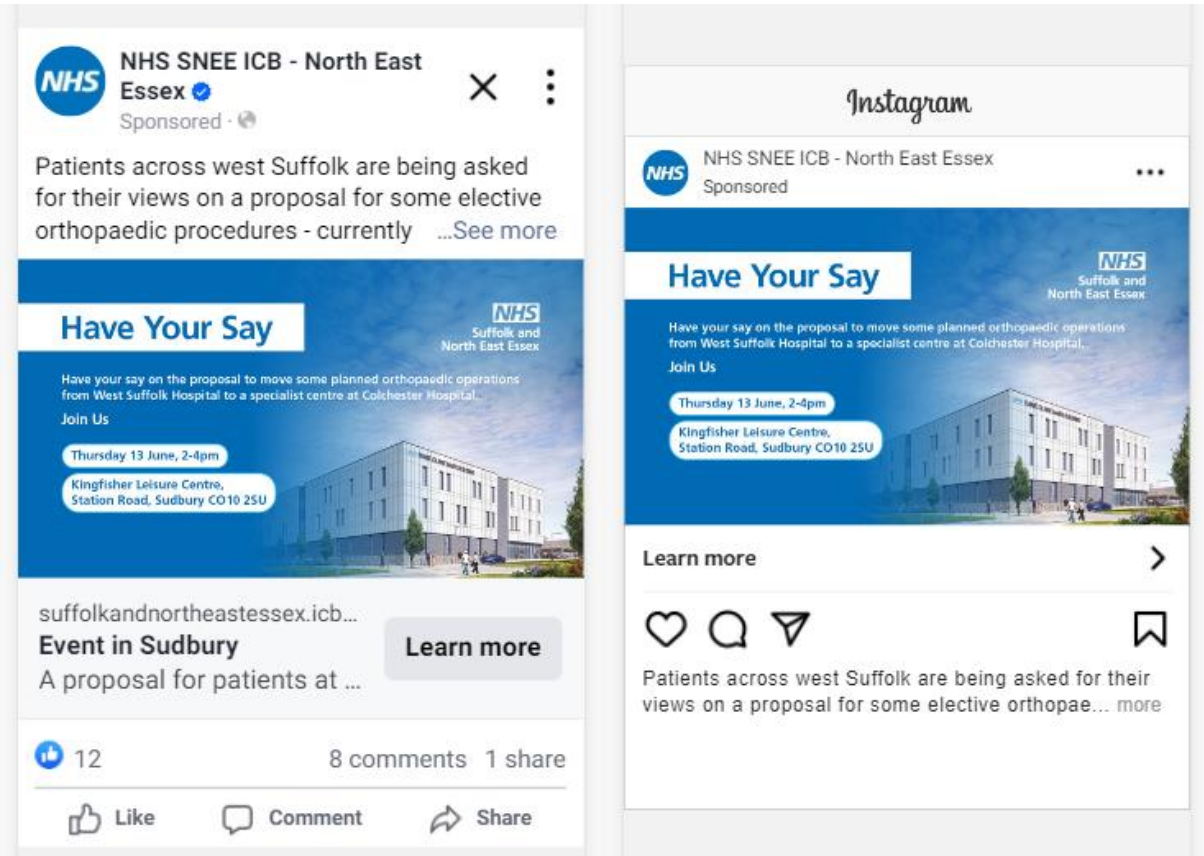
Wednesday 26 June, 3.00pm-4.00pm	Hard of Hearing Club	16
Thursday 27 June, 10.00am-11.30am	Thetford U3A	8 and 20 surveys taken to U3A monthly meeting taking place on 28 June
Thursday 27 June, 10.00am-12.00pm	Outreach stand	16 and 24 taken away to neighbours
Friday 28 June, 10.00am-12.00pm	Outreach stand	

Appendix 2 – Promotion of engagement using social media

To support the ESEOC engagement the ICB ran a Meta ads campaign between 21 May and 25 June 2024. A total of £480 was allocated for the campaign.

Ad creative

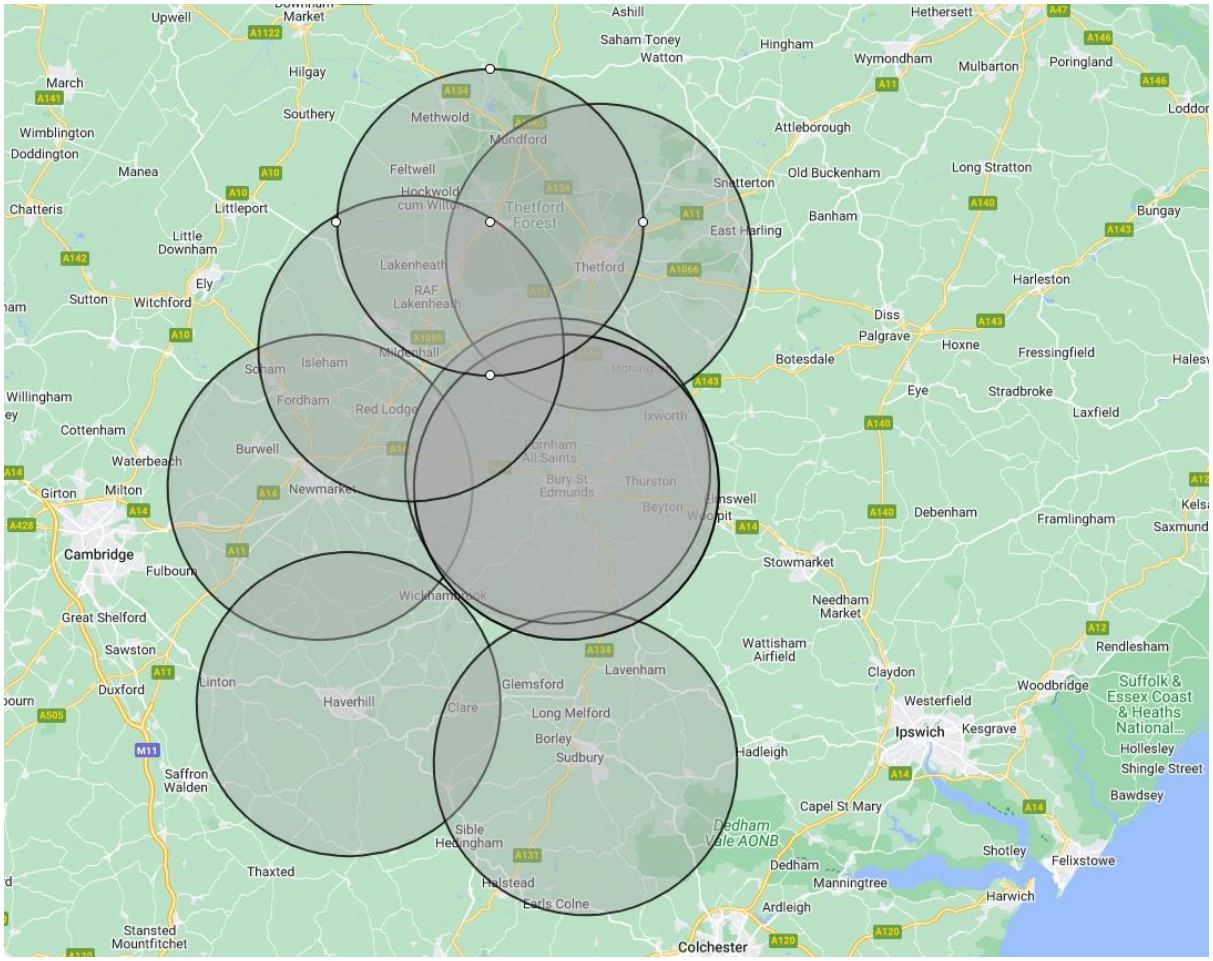
The ICB ran eight ads: each one promoting one of the mini exhibitions. Here is a preview of how some of the ads were displayed.



Targeting

The target audience was all people aged 18 and over living within an eight mile radius of one of the mini-exhibition venues. A map showing the coverage of the ads:

-



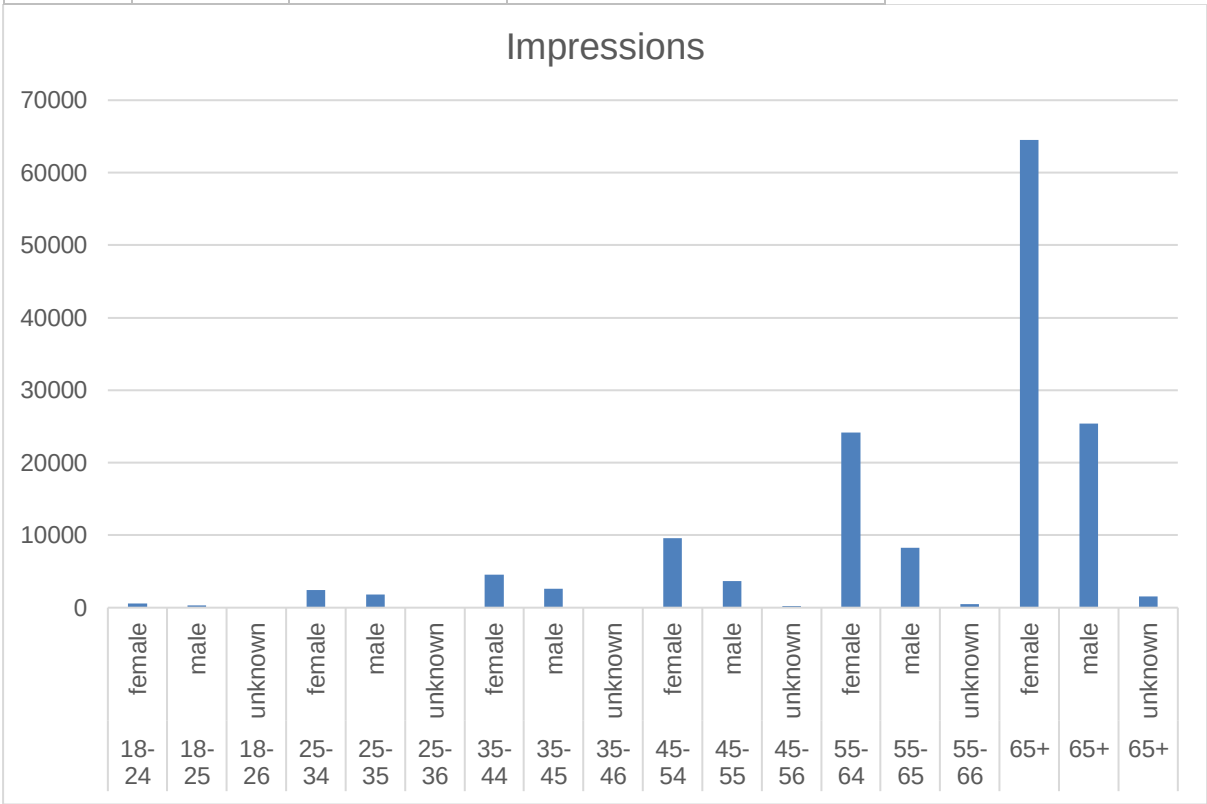
Results

Total number of people reached: 56,374
Total number of impressions (the number of times the ads were seen): 150,316
Total number of clicks through to the web page from the ads: 1,713
A breakdown of impressions by age and gender below.

Age	Gender	Impressions	Impressions (% of total)
18-24	female	548	0.36
18-25	male	346	0.23
18-26	unknown	15	0.01
25-34	female	2474	1.65
25-35	male	1776	1.18
25-36	unknown	78	0.05

35-44	female	4567	3.04
35-45	male	2597	1.73
35-46	unknown	69	0.05
45-54	female	9555	6.36
45-55	male	3705	2.46
45-56	unknown	246	0.16
55-64	female	24169	16.08
55-65	male	8234	5.48
55-66	unknown	509	0.34
65+	female	64496	42.91
65+	male	25412	16.91
65+	unknown	1520	1.01

Most of the ads were seen by females. The age range which was most frequently exposed to the ads was 65+.



Ends

3. PEOPLE AND CULTURE

3.1. Involvement Committee report

To Assure

Presented by Antoinette Jackson

Item 3.1 Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Involvement Committee			Date of meeting: 19 June 2024		
Chaired by: Antoinette Jackson			Lead Executive Director Jeremy Over / Susan Wilkinson		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation**: 1. No escalation 2. To other assurance committee / SLT 3. Escalate to Board
Workplace Strategy	The Committee received a draft Workplace Strategy which considered aspects of the future use of the Trust's Estate in the context of the new hospital programme. The Strategy sets out objectives for the future based on agile working, shared staff workhubs, corporate service integration, and shared environments. Whilst it has been developed by members of the Future System programme team, the 'operationalisation' of the strategy will become part of business as usual activity.	**2 Reasonable**	The strategy is a response to the demands of the new hospital programme which will require us to prioritise the use of administrative space in the new hospital, as well planning how we will provide quality staff working and welfare facilities. The strategy sets a future principle of non-clinical teams being based at an alternative location to the West Suffolk Hospital site which will involve significant change and opportunity for those affected.	The Committee agreed to recommend the principles of the strategy to the Board whilst noting funding needed to be identified and a proper programme management structure would need to be put in place. It was proposed the strategy would be overseen by the People and Culture committee which currently does not have finance and estate representation so this will need review.	3. Escalate to Board

Originating Committee: Involvement Committee			Date of meeting: 19 June 2024		
Chaired by: Antoinette Jackson			Lead Executive Director Jeremy Over / Susan Wilkinson		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation**: 1. No escalation 2. To other assurance committee / SLT 3. Escalate to Board
Speech and language service – staff survey case study	The Committee heard a case study demonstrating how one service had worked with staff in response to the staff survey and developed an action plan in co-production with staff to address concerns.	**1 Substantial**	Liza Asti demonstrated how the Speech and Language service achieved significant improvement in staff engagement in the survey and future results improved dramatically.	The service will continue its work to engage staff and address area of underperformance. The Committee were keen that the good practice of this case study was widely shared as an example of how to engage effectively with staff in a practical way.	3 Escalate to Board
Patient Experience Annual Quality report (2023-24)	177 formal complaints had been received during the 12-month period. The Committee were pleased to see that 95% of complaints were resolved at first point of contact. 2 complaints were referred to the Parliamentary and Health service Ombudsman (PHSO). One was partially upheld and one is still being investigated. This latter complaint was also referred to the Local	**2 Reasonable**	The top six complaint themes (in descending order of prevalence) were as follows: 1. Communications 2. Patient care including nutrition/hydration 3. Clinical treatment in medical services 4. Clinical treatment in surgical services 5. Staff values & behaviours 6. Clinical treatment in obstetrics & gynaecology	Further, planned actions, particularly in response to the national surveys include: 1. Creation of further patient and service user focus groups related to survey topics 2. Additional, local survey monitoring in-year to provide more frequent insights and assurance 3. Review of the structure and resourcing to support	1.no escalation

Originating Committee: Involvement Committee			Date of meeting: 19 June 2024		
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Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
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	Government Ombudsman and was not upheld by them. Work is ongoing to engage with people with protected characteristics to ensure our complaints process is accessible and our services meet the diverse needs of the community we serve. 3 national surveys showed the Trust was performing as well or better than other Trusts on all questions. 599 compliments were received by the patient experience team (figure does not include compliments that that have been received by teams but not shared with the patient experience team).		In addition to case-specific responses and actions, organisational actions in response to themes include: • Focus on improved communications between ward teams and relatives • Enhancements to the approach in maternity services to support those who have suffered baby-loss beyond 13 weeks • Additional support in the emergency department at times of increased demand on the service • A number of training and policy related improvements including the sharing of unwelcome news, discharge processes, patient falls and communication skills	professional development in midwifery 4. Expansion of the contribution made by our volunteers to support those in inpatient care 5. Improvements to the environment in the waiting areas in ED	

Originating Committee: Involvement Committee			Date of meeting: 19 June 2024		
Chaired by: Antoinette Jackson			Lead Executive Director Jeremy Over / Susan Wilkinson		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation**: 1. No escalation 2. To other assurance committee / SLT 3. Escalate to Board
Complaints QI project	A complaints quality improvement project is underway based on a target of meeting with 50% of complainants early on in the complaint process. The first PDSA cycle will take place in July 2024.	**1 Substantial**	It is hoped that meeting people early will help provided a more personalised service and earlier resolution of issues	Involvement Committee will have quarterly updates with a fuller evaluation reports the beginning of the 25/26 financial year.	1 No Escalation
People and Culture Plan 2024/25	The executive director of workforce and communications presented a plan for 2024/25. This has been developed to address areas for action highlighted by the national staff survey and to support the Trust's strategic priorities.	**1 Substantial**	The committee approved the plan on behalf of the Trust Board.	Implementation and monitoring of the people and culture plan over the course of 2024/25, including sharing of the priorities and progress with staff.	1 No Escalation
IQPR metrics	Three of the four workforce-related metrics are better than target: turnover, sickness and mandatory training. The fourth, appraisal, is missing target by 2% (88 vs 90%).	**2 Reasonable**	The metrics provide good evidence of overall workforce stability and compliance with statutory knowledge and skills training. Appraisal participation is high but falling just short of the 90% target.	Continued focus on appraisal participation rates through division and corporate performance review discussions.	1. No Escalation

Originating Committee: Involvement Committee			Date of meeting: 19 June 2024		
Chaired by: Antoinette Jackson			**Lead Executive Director Jeremy Over / Susan Wilkinson**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
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Experience of Care and Engagement Committee	The committee provided feedback on their recent meeting highlighting substantial assurance on the personalised complaints processes and the engagement of community voices. A red risk was highlighted on the lack of a robust corporate system to manage the quality and accuracy of patient information in paper and on the web.	**3 Partial**	There is a risk that patient information developed by clinical teams and published by the Trust (in leaflet and electronic form) is not up to date due to the size of the library (c.1200 documents) and the associated resource requirements to maintain it.	A working group to be set up to look at the information issue. Finding a corporate solution is not straightforward give the range and breadth of patient information provided	3.Escalate to Board
Board Assurance Framework, domain 1: capability and skills	A draft of a new BAF statement for this strategic risk was presented and discussed by the committee.	**2 Reasonable**	The statement sets out the risks, assurance, gaps and controls in relation to our role as an educator of the healthcare workforce, staff recruitment and retention, and the changing demand and complexity of healthcare provision and their impact on the workforce.	Review and agreement of revised risk scores.	1 No Escalation

Guidance notes

The practice of scrutiny and assurance

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

Assurance level

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

3.1.1. People and OD highlight report, including FTSU report

To Assure

Presented by Jeremy Over

Freedom to Speak Up: Guardian's Report Q1. 2024 – 2025. April, May June 2024.

Introduction: What is the role and purpose of the FTSU Guardian?

The National Guardian's Office (NGO) provides a universal job description (see attachment) for FTSU Guardians. All FTSU Guardians are expected to abide by and be appointed in line with the principles of the Universal Job Description which states:

Freedom to Speak Up Guardians help: • Protect patient safety and the quality of care • Improve the experience of workers • Promote learning and improvement.

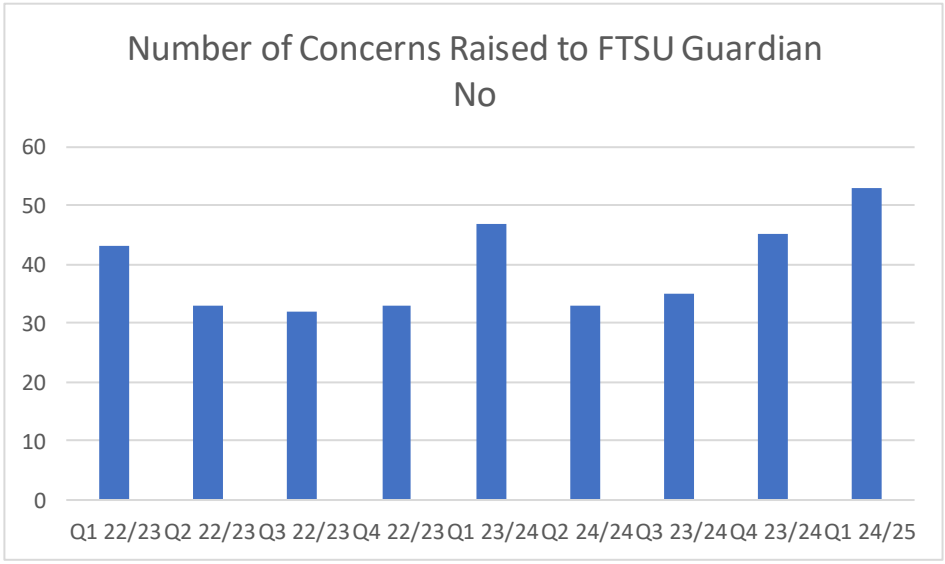
By ensuring that: • Workers are supported in speaking up • Barriers to speaking up are addressed • A positive culture of speaking up is fostered • Issues raised are used as opportunities for learning and improvement.

The NGO is now starting a review of this job description. If you have any comments to make or ideas for improvement, please send to freedomtospeakup.mailbox@wsh.nhs.uk or contact the NGO directly: enquiries@nationalguardianoffice.org.uk

Data Sent to National Guardian's Office

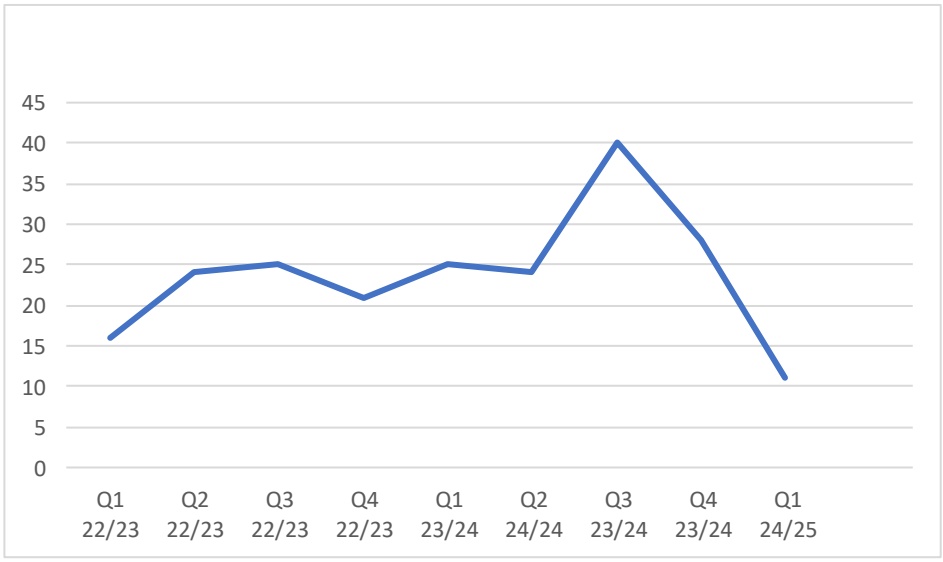
FTSU Guardian's for each organisation are required to submit data around the concerns raised to them each quarter. (NGO Guidance, 20240). This is to inform the NGO's understanding of the implementation and utilisation of the Guardian role and the themes and trends in speaking up. It is also felt that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

In WSFT the number of concerns raised with the Guardian has increased from the previous quarter to from 45 to 53.



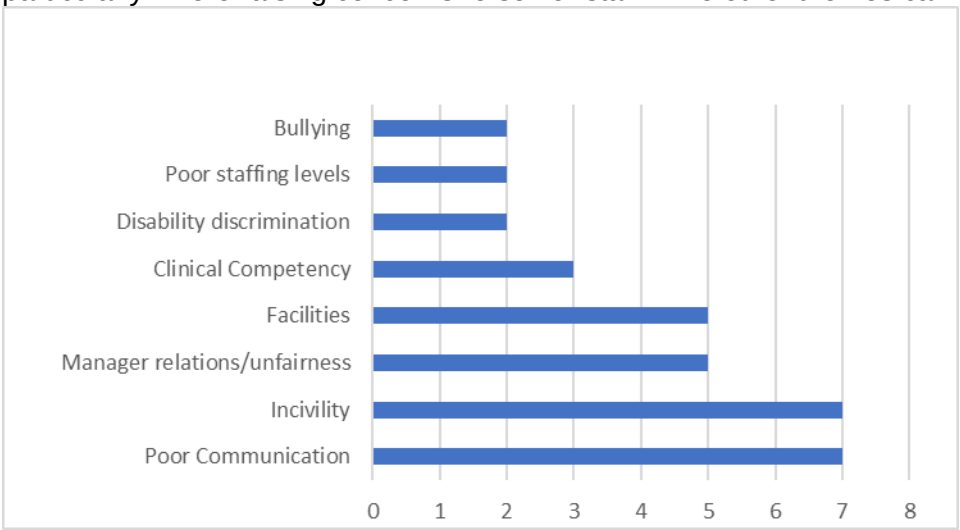
Anonymous Reporting

An increase in anonymous reporting had been noted in previous quarters (40% in Q3, 28% Q4, 2023/24). However, in Quarter 1 24/25, the percentage of anonymous reporting has dropped again to 11%, bringing it below the levels seen over the previous 18 months, and close to the National Average for anonymous reporting.
Confidence to speak up openly relies on the psychological safety culture in the Trust. Work has continued to support psychological safety of staff and communicating this through training and other outreach. This drop in anonymous reporting, while there has been an increase in reporting overall, is encouraging as it is a sign of increasing confidence amongst colleagues to speak up openly.

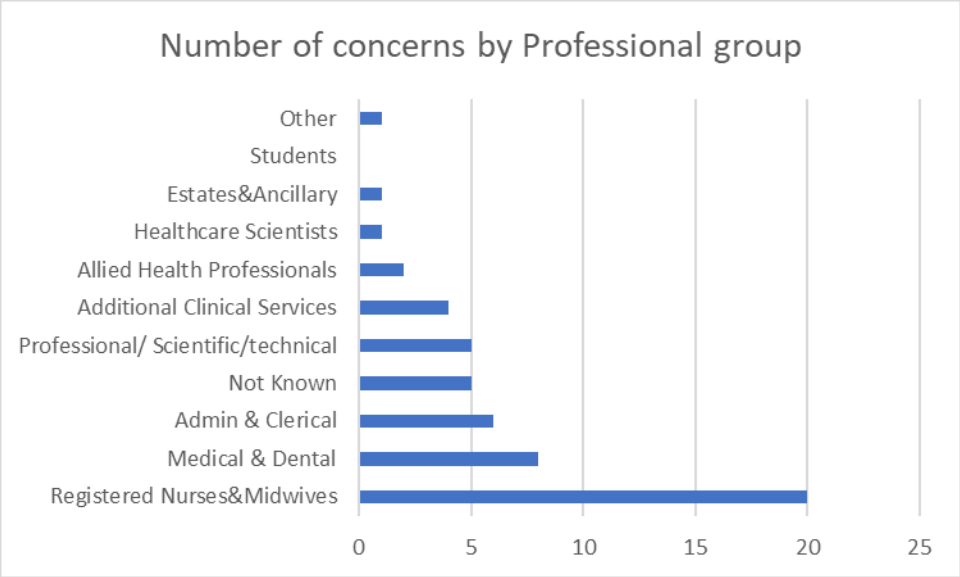


Anonymous reporting themes

The overall anonymous reporting for 2023/2024 was 28%. Themes within anonymous reporting were looked at over the last four quarters. The most recurring themes for anonymous reporting over this period were issues around poor communication, incivility, and manager relations, particularly where raising concerns re senior staff. The other themes can be seen below:

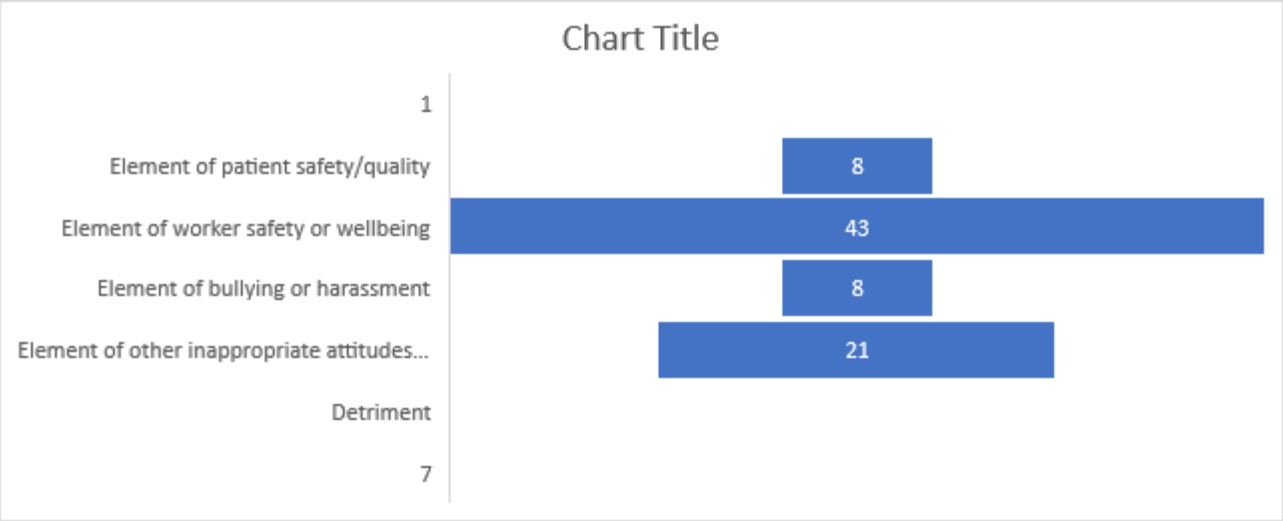


The Guardian, working with the Trust's Speak Up champions, continues to tackle barriers to speaking up and to assure staff that detriment to those who do speak up will not be tolerated in the Trust. The Guardian is also working closely with the wellbeing team to understand barriers to speaking up highlighted in their work, and how to provide appropriate re-assurance.



Looking at the worker groups who have used FTSU service, the largest group raising concerns was nurses and midwives, which mirrors the national trend, but there has been a doubling of concerns raised by medical staff, from four last quarter to eight. This does not include responses to a separate medical staffing survey.

What were people speaking up about?



Themes from Q1. 2024/2025

- Difficulties in relationships between staff and incivility have continued to be a theme in this quarter. There was an element of worker safety or wellbeing in 81% of concerns raised.
- Difficulties in relationships with managers, some staff reporting they feel unsupported with issues around childcare, long term sickness and phased return, and poor communication regarding management changes.
- Communication – concerns have been raised regarding some staff communication with patients and relatives where it has been felt the Patient First value was not fully upheld. The importance of communication style, with complaints citing that an authoritative style has had the effect of patients feeling they have no choice around care packages and discharge. Views have been raised that there is a requirement for patient consultation and robust following of procedure for Best Interests decisions.
- Bullying, including of some junior medical staff has been a theme this quarter. Staff speaking up about these issues is a step forward for speaking up becoming business as usual.
- Incivility and difficult relationships between staff members.
- Parking issues, especially around salary sacrifice for Band 2 and 3.
- Inappropriate sexual behaviour. Concerns raised that these are not always clearly documented when patient lacks capacity. Importance of recognising impact of inappropriate behaviour even if not deliberate and offering the appropriate support.
- There were eight patient safety related concerns raised. This equates to 15% of concerns raised. The national figure is 19% Each of these cases has been investigated and addressed individually. The Trust has a patient safety team and robust systems in place for reporting these issues such as our Radar system.

Summary of learning points

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

- The importance of communicating effectively, in order for staff to feel supported by managers continues to be a learning point. This will continue to be addressed in individual cases and by the Trusts leadership programmes. Staff support networks such as the Disability Network and Parent and Carer network are also of value in signposting staff to support for inclusive and equitable solutions to issues. The Trust has launched a Workplace Adjustment Package designed to support all colleagues with long term conditions. This resource has been created based on valuable feedback from across the workforce including via FTSU and consists of a guidance document and a form and dashboard for recording agreed reasonable adjustments.

- The need for continued work to encourage a Speaking up culture in all areas of the Trust, making speaking up 'business as usual' and to break down barriers to raising concerns including the fear of detriment.

- A focus needs to be maintained on building and maintaining professional relationships and civility. The importance of civility, and the Trust value of 'respect' needs to be reiterated throughout all levels of leadership. The Values Based Line Management Standards Framework will support this.

- The importance of clear documentation of behavioural issues to support and protect staff. Staff feel encouraged by the Boards adoption of the NHS Sexual Safety Charter.

Feedback on the Freedom to Speak Up Process

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

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

  The guardian was very approachable and understanding of my concerns, thanking me for raising them. I was kept regularly updated as able, and also had contact to check in whether I had received updates from the colleagues that were contacted directly about my concerns.

  I found this to be a very positive experience and would certainly advise others to use the service

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

Principle 1: Value Speaking Up:

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

What's going well:

- Ongoing support from board and SLT for Freedom to Speak Up
- CEO or director for workforce & communications, attend FTSU champions 'meet and greets'.
- **Non-executive director for FTSU attended champion training.**

Next Steps:

- **Non-executive director for FTSU to review FTSU contribution to the Trust's welcome session for new members of staff.**

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

What's going well:

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

Next steps : **FTSU message to be re-iterated by exec attending Trust's welcome session**

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

What's going well:

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

- Champion support sessions established
- **EDI Survey sent to FTSU champions with a view to identify and address any gaps.**

Next steps:

- FTSU Guardian to continue to visit wards and departments including community sites
- Ongoing development of FSTU champion network
- **FTSU Communication Plan being developed by Guardian with support of Communications Team.**
- Culture continues to improve to enable psychological safety in all teams. It is hoped this will be achieved through continued FTSU training and promotion, and work undertaken around values and behaviours. FTSU Guardian to work with OD Manager – Health & Wellbeing, to consolidate psychological safety training and ensure appropriate governance around champions.

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

What's going well:

- Increased promotion regarding Trust's stance on protecting staff who speak up and a zero-tolerance approach to detriment. Focus on psychological safety in welcome session.
- Individuals are thanked for speaking up, and told they are they are helping to identify areas of learning and improvement
- Champions offer valuable support by listening to colleagues, especially during times of pressure
- All leaders complete 'Listen Up' mandatory training
- Leadership programmes are now in place which will support listening skills and promotion of Speaking Up culture as business as usual.

Next steps:

- Senior Leaders to complete 'Follow Up' training.

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

What's going well:

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

Next steps:

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

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

What's going well:

- Full-time dedicated FTSU Guardian in post, registered with NGO

- Foundation training completed and reflective conversation completed with Guardian mentor.
- On-going support from Guardian Mentors and Community of Practice
- **Guardian has undertaken Human Factors Training**

Next Steps:

- FTSU Guardian to undertake coaching and mentoring training.

Principle 7: Barriers to speaking up are identified and tackled

What's going well:

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

Next Steps:

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

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

What's going well:

- New FTSU policy , in line with NGO guidance, adopted and adapted to suit WSFT easily available online on the Trust's intranet, Freedom to Speak Up section.
- FTSU Guardian working closely with NGO and local area FTSU Guardian network to ensure adherence with national policies and processes.
- Working with Communications and Information Governance Team, Website and Intranet information on FTSU has been updated to reflect current contacts.

Next Steps:

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

.

References:

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

NGO, Universal Job Description

20180213_ngo_freedom_to_speak_up_guardian_jd_march2018_v5.pdf (nationalguardian.org.uk)

Workplace adjustments - West Suffolk NHS Intranet (wsh.nhs.uk)

COMFORT BREAK

4. ASSURANCE

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

To Assure

Presented by Antoinette Jackson

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Insight Committee			**Date of meeting: 15 May 2024**		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Craig Black**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
PAGG/IQPR	The Committee discussed the fact that caseloads in Paediatric Speech and Language therapy remained high. Compliance with 18 weeks performance was 79.8% with 87 children waiting over 18 weeks and the longest wait at 43 weeks.	**3 Partial**	The trial for the preschool complex needs pathway is proving effective but caseloads remain high A system-wide approach is needed to respond to the levels of need and the link to the SEND inspection action plan for the area which needs to consider sufficiency of provision.	The ICB will update on plans for a programme of review at the May 2024 contract meeting, in the context of the Suffolk SEND inspection action plan. The service will also be engaging with the Joint Strategic Needs Assessment which is programmed to happen before the end of December 24 as this links to resources needed to respond to increased SEND demand. The waiting times for paediatric speech and language therapy will not reduce until the system response is agreed and resources aligned to that.	2 Escalate to ICB contract meeting

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Operational Planning Guidance 24/25	The Committee focused its discussion on the Operational Planning guidance and the trajectories the Trust has set over 24/25. The guidance contains 32 national operational targets with which the SNEE ICB needs to comply. As a provider Trust within the geography, we need to identify our own targets and trajectories across elective activity, diagnostics, cancer and urgent and emergency care.	**2 Reasonable**	Many of the targets are continuations or enhancements of those targets the Committee has been tracking during 23/24 and the Trust did not achieve all of those targets so additional activity or performance improvements will be required in 24/25. All performance expectations are planned to be met, with the exception of the absolute elective activity targets where we are not forecast to reach 108.09% of 2019/20 levels. However, this is achieved when taking into account the Value Weighted Activity (VWA) calculation. In 2023/24 we did not achieve the original 107% ambition, but did reach the threshold through VWA.	Insight Committee endorsed the proposals for onward reporting in detail to Public Board on 24 May 2024. Insight will continue to monitor progress against performance monthly. The opening of the Community Diagnostic Centre in November will contribute to performance delivery and the benefits of this need to be maximised	3 To be presented to Board on 24 May

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			The 65-week wait target has been extended to Sept 2024. This will require the backlog 407 patients to be cleared as well as new patients reaching that threshold. We are modelling a static position for people waiting more than 52 weeks. The key risks to delivery include ensuring the changes introduced in 23/24 are followed through in the new financial year; managing bed allocations between elective and urgent and emergency care; managing the requirement to keep whole time equivalent staffing numbers static and the demands of our financial recovery plan. Meeting these targets is crucial to patient safety as they will be a more risk of harm the longer they wait for treatment.		

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Community Paediatrics - Neurodevelopmental Disorders pathway (NDD) update	The Committee received an update on the progress had been made to deal with the system-wide backlog of referrals from the Barnardo's co-ordination service. There is not enough clinical resource to meet the demand and so the ICB committed £660k of non-recurrent funding to WSFT to support dealing with the backlog of 586 children who had not been triaged by the Barnardo's service. The focus is the first cohort of children whose cases were received by Barnardo's before September 2023	**2 Reasonable**	The service remains as a red risk Over 11% of the backlog has waited more than 65 weeks for an appointment. There remains concern about impact on the wider pathway of delays in the Norfolk and Suffolk NHS Foundation Trust. There are also concerns about the impact of demand on the resilience and well-being of the team.	The procurement to find external providers was successful and two have been identified and the triage process started ahead of schedule. It is due to conclude in November 2024. The SNEE ICB is being supportive and on-going liaison is happening at system level to ensure there is focus on the capacity of the core NDD service as well as the backlog. WSFT will also be hosting a NDD Transformation Project lead who will support the system to develop of a future service model.	Escalate to Board for information

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Board Assurance Framework **(BAF)**	The Committee considered the draft assessment of the Finance Risk within the BAF	**3 Partial**	There appeared to be a mismatch between some of the more optimistic scores and the lack of effective financial controls demonstrated through the budget setting process.	The Financial Accountability Committee to review the risk template and update this for reporting back to Insight Committee. Insight to undertake deep dives into the risks and mitigations on a rolling programme. Chair of the Audit Committee to and Trust Secretary to give consideration to the role of the Audit Committee to ensure the work of both committees was complementary	3 escalation to Board for information

Originating Committee: Insight Committee			Date of meeting: 15 May 2024		
Chaired by: Antoinette Jackson			Lead Executive Director: Nicola Cottington/Craig Black		
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Finance Accountability Committee	**2024/25 budget** In response to a request from SNEE ICB the Board have agreed to an additional £2.8m savings in 24/25 to reduce the budgeted deficit to £15.2m. This requires a Cost Improvement Programme of £16.5m which is the equivalent of 4%. The new initiatives identified to bridge this gap need integrating with the updated action plan, which tackled the PA consulting report and original plan for a deficit of £18m. This will enable performance monitoring against planned trajectories.	**3 Partial**	The CIP target will be challenging and will need sustained focus. It will be imperative to move the schemes through the gateway process in a timely way and tack the timing of the cost improvements being delivered. As a scheme may have go-ahead through the gateway process but the benefits may not be realisable immediately depending on the complexity of the implementation plan. This remains a significant risk for the Trust.	Insight will review the progress against plan at each meeting. The Executive team is reviewing what additional support may be required to support the programme.	3 Escalate to Board

Originating Committee: Insight Committee			Date of meeting: 15 May 2024		
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	Month 1 performance In Month 1 there was an adverse performance against plan of £370k this relates to the April costs of UEC improvement; the escalation ward being open; and backdated APA claims		These appear to be non-recurrent costs. There appears to be a mismatch between what has been budgeted and the plans for the escalation ward which concerned the committee.	The Executive team need to review how this mismatch has occurred. Work is being undertaken to ensure there are no backdated APA claims in future	

Guidance notes

The practice of scrutiny and assurance

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

Assurance level

1. Substantial	Taking account of the issues identified, the board can take substantial assurance that this issue/risk is being controlled effectively. There is substantial confidence that any improvement actions will be delivered.
2. Reasonable	Taking account of the issues identified, the board can take reasonable assurance that this issue/risk is being controlled effectively. Improvement action has been identified and there is reasonable confidence in delivery.
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Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Insight Committee			**Date of meeting: 19 June 2024**		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Craig Black**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:** **SO WHAT?** *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
Finance Accountability Committee	**24/25 Budget Month 2 report** There was a £1.3m variance against planned budget in Month 2.	**3 Partial**	It is concerning to be off plan already in the financial year. Half of this amount is non-recurrent. Inflationary pressures and backdated APA's in medical staffing are drivers of the additional costs. The escalation ward is now closed although there is concern that this might drive costs elsewhere.	Further scrutiny of the increases in Additional Programmed Activities in consultant job plans is being undertaken by the Workforce Resource Group Insight Committee will be undertaking a deep dive into bed allocation at a future meeting. The future of ward F9 will need consideration at the end of the RAAC decant programme.	Escalate to Board for information
	Financial Plan and CIP programme The committee consider the consolidated financial plan to address the deficit of £15.2m in 24/25. Good progress had been made in first two months against the CIP plan but the scale of CIP required is challenging.	**3 Partial**	The good progress made is encouraging but there is a significant amount of CIP still to be identified and the targets for delivery are more challenging in coming months. This remains a significant risk to achieving the agreed financial plan.	The Committee expressed concern about the scale of CIP project still to be identified and request intervention to increase the pace on identifying projects to enable implementation in year.	Escalate to Management Executive Team for action. Board to be advised of risk

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Referral from Improvement Committee	**Patient Safety** Improvement Committee drew the Insight Committee's attention to the need to ensure the quality pf patient care is considered alongside financial implications of the CIP programme.	**2 Reasonable**	It is important to balance quality and safety issues alongside the financial imperatives the Trust faces.	Chief Nurse and Medical director to be involved in the quality assurance process of CIP schemes.	No escalation
Deep Dive - benefit realisation of investment decisions	The committee undertook a deep dive to explore whether the benefit of investment decisions were consistently evaluated and appropriate action taken if investments were not achieving the benefits identified in their business case. The Investment Panel's terms of reference include evaluating the	**3 Partial**	The deep dive highlighted a need for clearer business cases which articulated the benefits to be achieved and how these would be assessed. Clinical input is needed in this process to ensure clinical benefits are properly assessed. Digital projects in particular need clearer benefits realisation processes and greater clarity of the costs and benefits of bespoke IT solutions.	Investment Panel to review remainder of investments to assess whether they are achieving agreed outcomes and if disinvestment may be appropriate. Improvements need to be made to business case processes and these	Escalate to the investment Panel and Digital Board. To note the Invetsment Panel will convene the next benefits

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	benefits of investments of 36 funded schemes in last two years only 18 had been reviewed to assess whether benefits had been achieved. The remaining 18 were approved as cost pressures at Management Executive Group as part of budget setting on 14th February 2024 and had therefore not yet been evaluated. The deep dive also looked at work force planning in the context of the growth in staff numbers and the need to keep whole time equivalent staff numbers the same or lower by the end of the financial year.		When financial savings are promised, relevant budgets should be reduced to reflect the benefits to be realised. There should be explicit decision making around disinvesting in initiatives that are not achieving benefits. There is a need to develop better workforce planning to keep track of staff numbers and to ensure resource is aligned to need and achieving agreed outcomes.	need to be developed for digital projects. Further discussions are need on work force planning and the Director of People and communications to be invited to the next Insight Committee	realisation session on 19th July and monthly thereafter.

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PAGG/IQPR	There is still inconsistent performance across the range of operational targets. The committee discussed in particular: **Cancer Targets** All were on trajectory in month **65 and 78 week waits** There was an increase in patients waiting over 65 weeks between March and April but the total cohort is on trajectory to be treated by the end of September 2024. The total number of 78 week waits remains static with capacity breaches in gynaecology. CT is also off trajectory	**3 Partial**	Patients are at increased risk of harm the longer they wait for treatment The committee were given detailed trajectories against which performance will be measured in subsequent meetings.	Urogynae engagement with the Nuffield in Ipswich is continuing. The Surgical division has plans to mitigate forecast deficits Further information has been requested on CT trends over the last 12 months.	Escalate to COO to review non-admitted target

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	Dermatology Due to staffing shortages the service will not be offering new patients phototherapy or Isotretinoin. **Urgent and Emergency Care (UEC)** 12 hour breaches as a percentage of attendance is consistently above 2% 4 hour performance is just under trajectory Ambulance handover performance is still problematic Further information has been requested on CT trends over the last 12 months, as it is not meeting its target.		Patients will be offered alternative treatments and may access these ones when the staffing situation has improved Patients do not have a good experience of they face significant delays and re at risk of harm. There is a lack of flow out of the ED and some patients are waiting longer than acceptable for a specialist bed. The Committee asked for non-admitted performance targets to be reviewed to see if we should be more ambitious with a target of 90% not 80%.	GPs are being informed and patients will be seen as and offered alternative treatments Work continues with alliance partners to focus on the UEC recovery plan, with a new structure to be operational by the end of June. The Minor Emergency Care Unit is predicted to be delivered by the end of July/early August. We await formal feedback from the NHSE Improvement team, who visited in May 2024 to review UEC pathways. Chief Operating Officer to be asked to review non-admitted target.	

Guidance notes

The practice of scrutiny and assurance

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Assurance Grid

March 2024		ASSURANCE: Pass (P)	Hit and Miss (?)	Fail (F) — Not Met
VARIANCE	Special Cause Improvement (H / L)		**INVOLVEMENT** Staff Sickness – Rolling 12months Staff Sickness Mandatory Training	**INSIGHT** Virtual Ward Total average occupancy number Incomplete 104 Day Waits RTT 78+ Week Waits **INVOLVEMENT** Appraisal Turnover
	Common Cause	**INSIGHT** Urgent 2 hour response	Please see box to right	**INSIGHT** 12 Hour Breaches Respiratory Bay average occupancy number Heart Failure Bay average occupancy number IV Abx Bay average occupancy number Frailty Bay average occupancy number Diagnostic Performance - % within 6weeks Total
Deteriorating	Special Cause Concern (H / L)		**INSIGHT** Paediatric RTT Overall 78 Weeks Wait	

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

INSIGHT:
Ambulance Handover within 30min
Non-admitted 4 hour performance
12 hour breaches as a percentage or attendances
% patients with no criteria to reside
Virtual Ward Total average occupancy percentage
Virtual Ward Total average LOS per patient
28 Day Faster Diagnosis
Cancer 62 Days Performance
Paediatric RTT Overall 104 Weeks Wait
IMPROVEMENT:
INVOLVEMENT:
Overdue Responses

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

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

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

*Cancer data is 1 month behind

Items for escalation based on those indicators that are failing the target, or are worsening and therefore showing Special Cause of Concerning Nature by area:
INSIGHT - Urgent & Emergency Care: 12 Hour Breaches, Virtual Ward Total average occupancy number, Respiratory Bay average occupancy number, Heart Failure Bay average occupancy number, IV Abx Bay average occupancy number, Frailty Bay average occupancy number
Cancer: Incomplete 104 Day Waits
Elective: Diagnostic Performance - % within 6weeks Total, Paediatric RTT Overall 78 Weeks Wait
INVOLVEMENT – Well Led: Appraisal, Turnover

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

For Approval

Presented by Ewen Cameron

Board of Directors – Public Board	
Report title:	Finance Board Report – April 2024
Agenda item:	4.1.1
Date of the meeting:	26th July 2024
Lead:	Nick Macdonald, Deputy Director of Finance
Report prepared by:	Nick Macdonald, Deputy Director of Finance

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

Executive Summary

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

Income and Expenditure position

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

The reported I&E for the year to June is a deficit of £9.5m against a planned deficit of £6.4m. This results in an adverse variance of £3.1m YTD. For the month of June the variance to plan worsened by £1.8m from the year to date position at the end of May.

Cost Improvement programme

We achieved our planned CIP in April and May but fell short by £360k in June as the target increased to £1.0m. Our CIP becomes even more challenging from July onwards.

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

Whilst we continue to forecast meeting our Financial Plan this will be extremely challenging. Our underlying position is significantly worse than plan, and the phasing of our CIP also increases going forwards.

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

We have appointed a Director of Financial Recovery who has highlighted a number of actions that can be implemented quickly and will have the most impact. A fuller financial recovery plan is also being developed.

Recommendation / action required

Review and approve this report

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

Guidance notes

The practice of scrutiny and assurance

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

FINANCE REPORT
June 2024 (Month 3)

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

Executive Summary

This report focusses on the 2024-25 financial performance. In 2024-25 the Trust has planned for an I&E deficit of £15.2m after delivering a Cost Improvement Programme of £16.5m (4%)

The reported I&E for the year to June is a deficit of £9.5m against a planned deficit of £6.4m. This results in an adverse variance of £3.1m YTD (£1.8m adverse variance in June).

Our CIP programme is behind plan at June (£1.6m delivered against a plan of £2.0m). This represents £400k of the adverse variance.

The balance of the adverse variance relates to our run rate exceeding our 24-25 budget before CIP, totalling £2.7m.

As at Q1 we continue to forecast achieving our planned deficit of £15.2m but this will be extremely challenging.

Key Risks and Mitigations in 2024-25

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

	Impact on position Best case £'000	Worst case £'000
Within our control		
23/24 final ERF performance	0	(300)
ERF for advice and guidance	300	0
ERF	1,000	0
CIP under delivery (£13.7m target)	0	(5,200)
Time slippage against Risk adjusted CIP	0	(1,500)
Stretch CIP	0	(2,800)
Staffing growth above budget	0	0
RAAC related costs	1,000	0
CDC margin	500	0
Lost margin from Elective activity (6 months)	0	(1,150)
Winter pressure/UEC	500	(500)
	3,300	(11,450)
Outside of our control		
Inflationary costs unfunded	0	(3,200)
Industrial Action costs unfunded	200	0
Utilities (if budgets have been overstated)	500	0
	700	(3,200)
Total range (impact on proposed plan)	**4,000**	**(14,650)**

Financial Summary

	In-Month Budget £m	In-Month Actuals £m	In-Month Variance £m F/(A)	YTD Budget £m	YTD Actuals £m	YTD Variance £m F/(A)	Annual Budget £m	Forecast £m	Forecast Variance £m F/(A)
EBITDA									
Income									
NHS Contract Income	29.3	29.2	0.0	87.7	87.8	0.0	351.1	351.1	0.0
Other Income	3.3	3.0	-0.2	9.7	9.4	-0.3	37.2	37.2	0.0
Total	**32.5**	**32.2**	**-0.3**	**97.5**	**97.2**	**-0.3**	**388.3**	**388.3**	**0.0**
Expenditure									
Pay Costs	23.0	23.9	-0.9	69.6	71.3	-1.8	274.1	274.1	0.0
Non-pay Costs	9.4	10.0	-0.6	28.8	29.8	-1.1	106.1	106.1	0.0
Total	**32.4**	**33.9**	**-1.6**	**98.3**	**101.1**	**-2.8**	**380.3**	**380.3**	**0.0**
EBITDA Position	**0.1**	**1.7**	**-1.8**	**0.9**	**4.0**	**-3.1**	**8.0**	**8.0**	**0.0**
Depreciation	**1.4**	**1.4**	**0.0**	**4.2**	**4.2**	**0.0**	**16.2**	**16.2**	**0.0**
Finance Costs	**0.5**	**0.5**	**0.0**	**1.4**	**1.3**	**0.0**	**7.0**	**7.0**	**0.0**
Impairments									
Deficit/(Surplus)	**1.8**	**3.6**	**-1.8**	**6.4**	**9.5**	**-3.1**	**15.2**	**15.2**	**0.0**

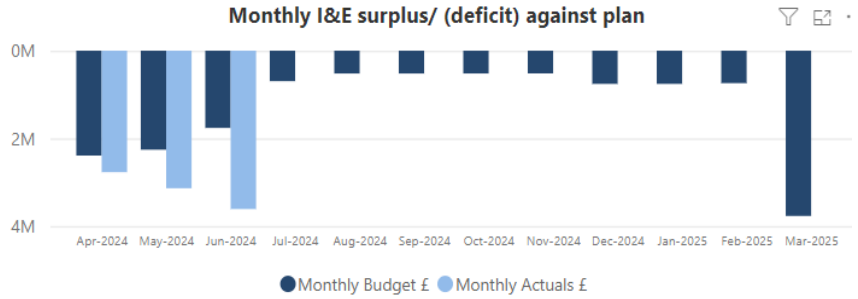
Deficit YTD £	**9.5M**	
Variance against plan YTD £	**-3.1M**	**Adverse**
Movement in month against plan £	**-1.8M**	**Adverse**
EBITDA Postion YTD £	**-4.0M**	**Adverse**
EBITDA margin YTD	**-4%**	**Adverse**
Cash at bank	**£3.3M**	

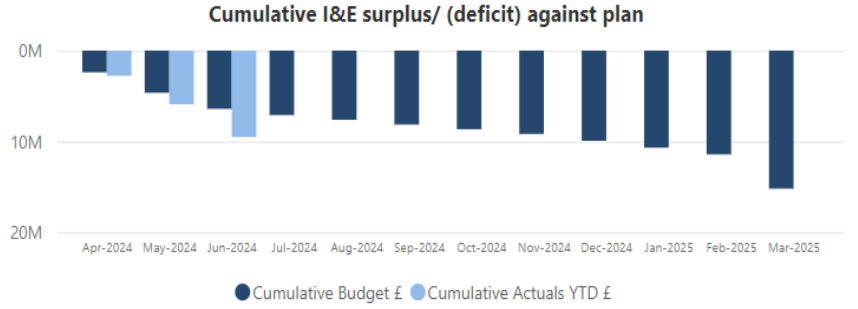
FINANCE REPORT – June 2024

Income and Expenditure Summary - June 2024

Board Report Item	Original Plan/ Target £000s	Actual/ Forecast £000s	Variance to Plan £000s F/(A)	
In month surplus/ (deficit)	-1,806	-3,611	-1,805	↓
YTD surplus/ (deficit)	-6,454	-9,517	-3,063	↓
Clinical Income YTD	87,745	87,773	29	↑
Non-Clinical Income YTD	9,826	9,395	-430	↓
Pay YTD	69,595	71,331	-1,736	↓
Non-Pay YTD	28,870	29,809	-939	↓
EBITDA YTD	-895	-3,971	-3,077	↓
EBITDA %	-0.9	-4.1	-3.2	↓

Income and Expenditure for 2024-25





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

Plan

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

M3 position

Our reported position as at the end of June was a deficit of £9.5m against our planned deficit of £6.4m – ie an adverse variance of £3.1m. In the month of June the adverse variance was £1.8m

High level reasons for variance from plan to June 2024	Apr-24 £'000	May-24 £'000	Jun-24 £'000	YTD £'000
ED expenditure relating to UEC improvement in 2324	150	0	0	150
Escalation ward unfunded (April and May)	155	115	0	270
Backdated APA claims and salary arrears	126	200	145	471
Drugs within Medicine	100	100	100	300
Industrial action	0	0	130	130
Endoscopy Maintenance	0	0	90	90
Community Income shortfall	64	64	64	192
Community Equipment and Wheelchairs	0	160	80	240
Inflationary pressures	60	65	70	195
CIP behind plan	0	0	360	360
ECW above plan	271	207	359	837
Energy bills	(97)	(97)	78	(116)
Various mitigating M1 underspends/overspends	(450)	225	169	(56)
ERF income	0	(160)	160	0
Total	**379**	**879**	**1,805**	**3,063**

CIP

We achieved our CIP target for April and May (£1.0m cumulatively) but failed to achieve our June plan by £360k (£650k against a plan of £1.0m).

Run rate

Our rate of expenditure over income (run rate) has worsened during Q1:

- April £2.8m
- May £3.1m
- June £3.6m

Forecast

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

FINANCE REPORT – June 2024

Cost Improvement Programme (CIP) 2024-25

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

In month progress (June)

The table below provides a summary of our most up to-date risk adjusted CIP plan (9th July 2024).

Whilst around £12.8m of CIP schemes have been identified (FYE) after risk adjusting and incorporating time slippage, we would anticipate these schemes would deliver £8.5m of savings in 2425. This is currently below 50% of our target.

Division	Target £k	Identified 24/25 £k	Gateway 1 RA 60% £k	Gateway 2 RA 40% £k	Gateway 3 RA 20% £k	Plans 24/25 after RA £k	Time Slippage £k	RA forecast 24/25 after slippage £k	Gap to Target £k	Number of Pipeline PIDs
Medicine	2,211	473	-	-	378	378	(206)	172	(2,039)	11
Surgery	2,621	1,214	-	-	971	971	(44)	927	(1,694)	27
Women & Children	542	354	2	48	216	266	(2)	264	(278)	8
CSS	939	676	98	-	345	443	(77)	366	(573)	21
Community	1,613	819	189	-	277	466	(166)	300	(1,313)	23
Estates & Facilities	936	598	111	-	256	367	(99)	268	(667)	9
Corporate	4,838	1,072	280	-	298	578	(225)	353	(4,485)	10
Division Specific	**13,700**	**5,207**	**680**	**48**	**2,742**	**3,470**	**(818)**	**2,652**	**(11,048)**	**109**
TW - WRG Medical Staff	-	255	28	-	148	176	(18)	159	159	14
TW - WRG Nursing Staff	-	399	-	-	319	319	-	319	319	10
TW - WRG Other Staff	-	237	9	17	149	175	(6)	170	170	15
TW - Finance	-	2,400	-	-	1,920	1,920	-	1,920	1,920	-
TW - Procurement	-	817	327	-	-	327	(204)	123	123	9
TW - Pharmacy	-	538	79	-	272	351	(49)	302	302	8
TW - Discretionary Spend	-	71	-	-	57	57	-	57	57	1
TW - Change Hub	-	-	-	-	-	-	-	-	-	4
TW - Other	-	-	-	-	-	-	-	-	-	16
Trustwide Schemes	**-**	**4,717**	**443**	**17**	**2,865**	**3,325**	**(277)**	**3,048**	**3,048**	**77**
Stretch:								-		
Reduction in degradation of schemes	877	877	877	-	-	877	(219)	658	(219)	
Non-clinical vacancy management (from 01/07)	653	653	653	-	-	653	-	653	-	
ERF stretch	750	750	750	-	-	750	(188)	563	(188)	
Cease clinical care helpline (from 01/10)	150	150	150	-	-	150	-	150	-	
Opportunities in E&F and IT	370	370	370	-	-	370	-	370	-	
Stretch Schemes:	**2,800**	**2,800**	**2,800**	**-**	**-**	**2,800**	**(407)**	**2,393**	**(407)**	**-**
Total	**16,500**	**12,724**	**3,923**	**65**	**5,608**	**9,595**	**(1,502)**	**8,093**	**(8,407)**	**186**

Data as at cob: 09/07/24

Stretch schemes are not risk adjusted

Budget Holding Division (incl Trust Wide schemes)	Target £k	Identified 24/25 £k	Gateway 1 RA 60% £k	Gateway 2 RA 40% £k	Gateway 3 RA 20% £k	Plans 24/25 after RA £k	Time Slippage £K	RA Forecast 24/25 after slippage £k	Gap to Target £k	Number of Pipeline PIDs
Medicine	2,211	1,452	146	-	869	1,015	(297)	718	(1,493)	25
Surgery	2,621	1,850	77	-	1,326	1,403	(92)	1,311	(1,310)	46
Women & Children	542	450	39	48	219	305	(25)	280	(261)	11
CSS	939	930	199	-	347	545	(140)	405	(533)	33
Community	1,613	1,053	259	-	324	583	(210)	373	(1,240)	38
Estates & Facilities	936	612	117	-	256	373	(102)	271	(665)	15
Corporate	4,838	3,578	287	17	2,267	2,570	(229)	2,341	(2,497)	18
	13,700	**9,925**	**1,124**	**65**	**5,608**	**6,794**	**(1,095)**	**5,699**	**(7,999)**	**186**

In order to achieve our target of £16.5m for 24-25, a further £8.4m CIP needs to be delivered (notwithstanding slippage), which translates to broadly a further £11.5m needing to be identified urgently. There are currently 186 schemes in the pipeline that will contribute to closing this gap
Cost of time slippage in Q1 is estimated £1.5m however, further slippage due to timeframes of implementation would further heighten the challenge, therefore it is important to identify opportunities and that all schemes are moved to gateway 3 (delivery) ASAP.

The Trust has delivered £1.6m CIP YTD against a target of £2m, (£0.4m behind plan). It is important to note that the majority of the 24/25 delivery YTD is due to the full year benefit of 23/24 schemes (£407k), PDC reduction (£527) and non-current CNST premium reduction (£270k). Other new recurring schemes for 24/25 have contributed £425k YTD

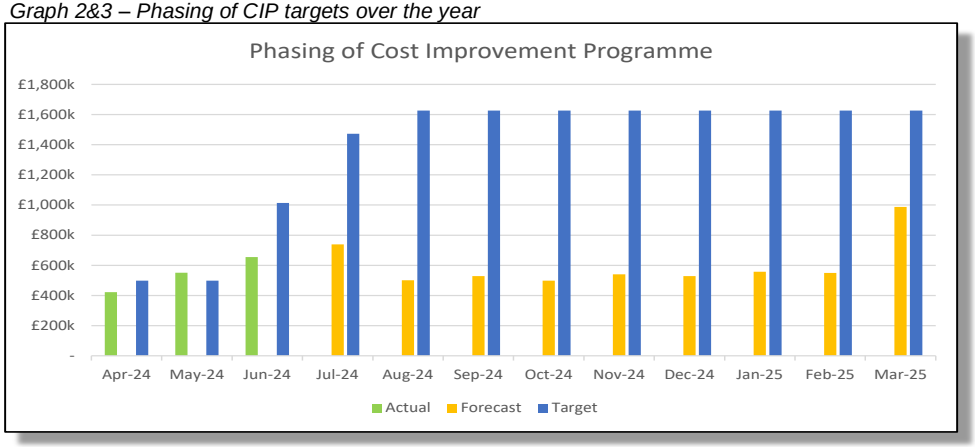
FINANCE REPORT – June 2024

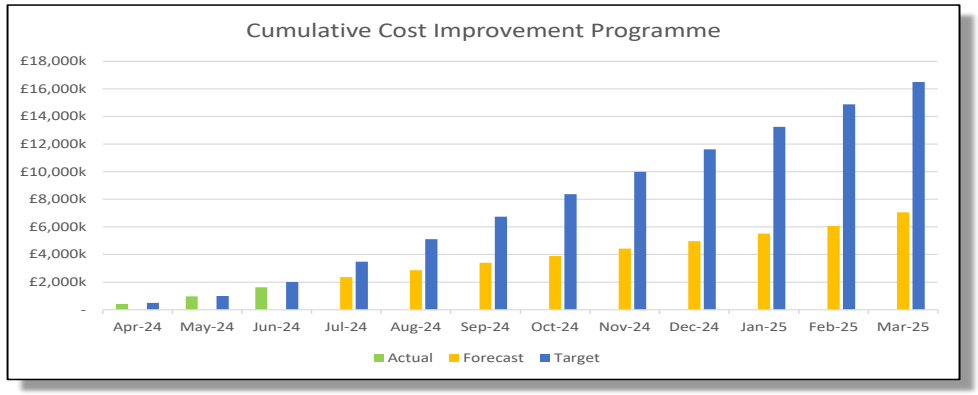
Table 1 – CIP achievement to date, with current forecast

Division	Target (2425 Schemes) £k	Target (2324 Schemes) £k	Annual Target £k	YTD			In-Month Delivery		
				Target YTD £k	Actuals YTD £k	Variance £k	Target	Actuals	Variance
Medicine	2,211	-	2,211	237	13	(224)	101	4	(97)
Surgery	2,027	594	2,621	281	246	(35)	120	95	(25)
Women & Children	542	-	542	299	270	(29)	282	270	(12)
CSS	845	94	939	101	70	(31)	43	25	(18)
Community	1,286	327	1,613	173	106	(67)	74	42	(32)
Estates & Facilities	674	262	936	100	82	(19)	43	12	(31)
Corporate	4,630	208	4,838	519	159	(360)	222	3	(219)
Division Specific	**12,215**	**1,485**	**13,700**	**1,711**	**947**	**(764)**	**885**	**452**	**(434)**
TW - WRG Medical Staff	-	-	-	-	-	-		-	-
TW - WRG Nursing Staff	-	-	-	-	64	64		35	35
TW - WRG Other Staff	-	-	-	-	49	49		16	16
TW - Finance	-	-	-	-	527	527		130	130
TW - Procurement	-	-	-	-	-	-	-	-	-
TW - Pharmacy	-	-	-	-	21	21	-	14	14
TW - Discretionary Spend	-	-	-	-	21	21	-	7	7
TW - Change Hub	-	-	-	-	-	-	-	-	-
TW - Other	-	-	-	-	-	-	-	-	-
Stretch	2,800	-	2,800	300	-	(300)	128	-	(128)
Total	**15,015**	**1,485**	**16,500**	**2,011**	**1,629**	**(382)**	**1,014**	**654**	**(360)**

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

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

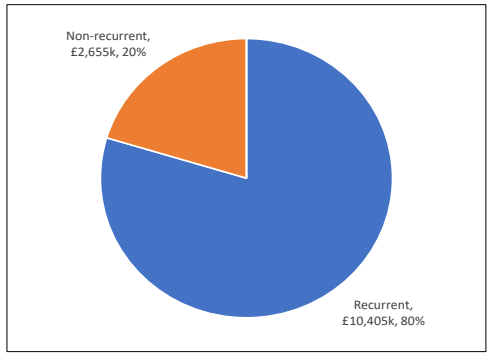


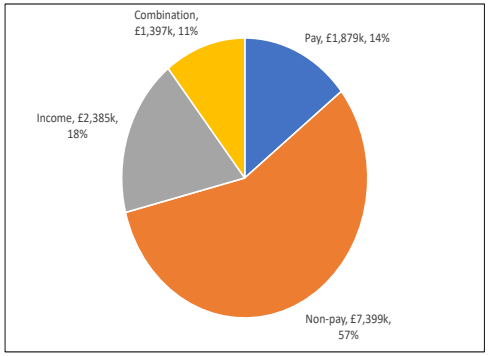


Graph 4&5 – Planned CIPs – Recurrent v Non-recurrent, Pay v Non-pay

The full year benefit of identified schemes as at 19th July have increased since 30th June by £336k to £13.060m.

Recurring vs non-recurring and pay vs non-pay





FINANCE REPORT – June 2024

Statement of Financial Position – 30 June 2024

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2024	Plan 31 March 2025	Plan YTD 30 June 2024	Actual at 30 June 2024	Variance YTD 30 June 2024
	£000	£000	£000	£000	£000
Intangible assets	57,724	51,078	56,063	56,033	(29)
Property, plant and equipment	130,806	159,588	140,253	136,559	(3,694)
Right of use assets	11,624	9,512	11,096	11,133	37
Trade and other receivables	7,158	7,158	7,158	7,158	0
Total non-current assets	**207,312**	**227,336**	**214,569**	**210,883**	**(3,686)**
Inventories	4,640	4,600	4,600	4,737	137
Trade and other receivables	20,378	18,378	17,378	27,216	9,838
Non-current assets for sale	490	490	490	490	0
Cash and cash equivalents	9,315	1,107	2,397	3,268	871
Total current assets	**34,823**	**24,575**	**24,865**	**35,711**	**10,846**
Trade and other payables	(41,934)	(28,587)	(37,454)	(50,607)	(13,153)
Borrowing repayable within 1 year	(4,732)	(4,722)	(4,722)	(4,944)	(222)
Current Provisions	(58)	(58)	(58)	(55)	3
Other liabilities	(1,776)	(2,685)	(1,776)	(1,670)	106
Total current liabilities	**(48,500)**	**(36,052)**	**(44,010)**	**(57,276)**	**(13,266)**
Total assets less current liabilities	**193,635**	**215,859**	**195,424**	**189,318**	**(6,106)**
Borrowings	(44,048)	(39,160)	(43,415)	(43,485)	(70)
Provisions	(407)	(407)	(407)	(407)	0
Total non-current liabilities	**(44,455)**	**(39,567)**	**(43,822)**	**(43,892)**	**(70)**
Total assets employed	**149,180**	**176,292**	**151,602**	**145,426**	**(6,176)**
Financed by					
Public dividend capital	277,694	320,343	286,610	283,494	(3,116)
Revaluation reserve	11,941	11,941	11,941	11,941	0
Income and expenditure reserve	(140,455)	(155,992)	(146,949)	(150,009)	(3,060)
Total taxpayers' and others' equity	**149,180**	**176,292**	**151,602**	**145,426**	**(6,176)**

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

The variance to plan of property, plant and equipment is due to the capital programme being slightly below plan (see below). This is largely off-set by the variance in the PDC reserve where PDC funding has not yet been drawn down to fund capital spend.

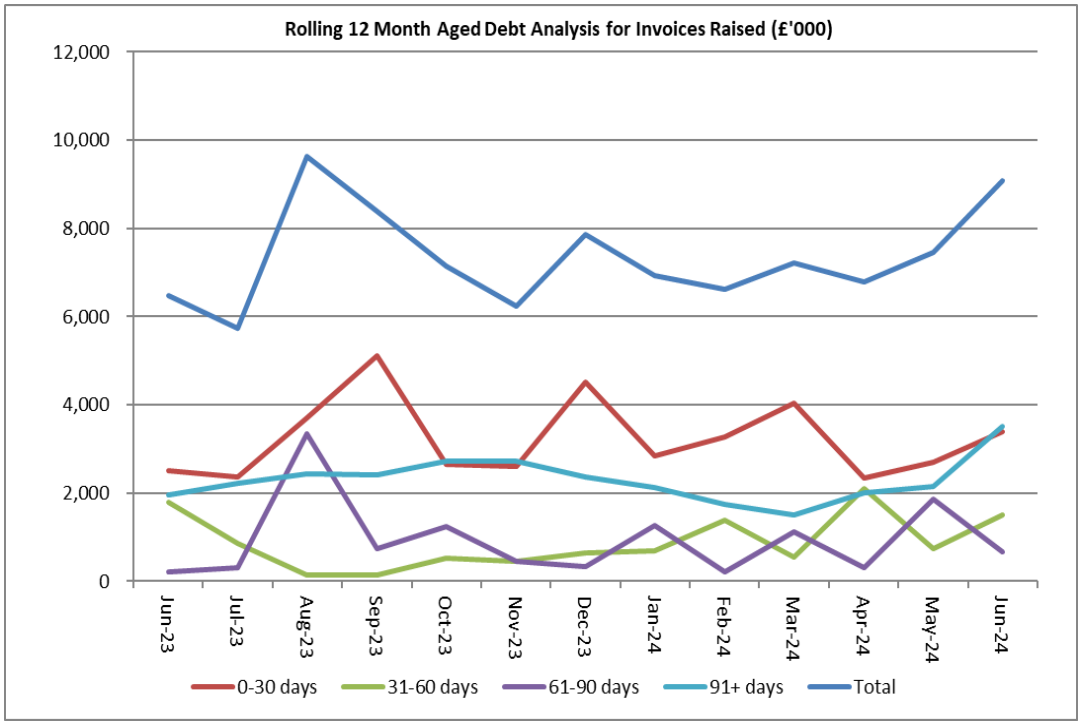
Trade and other receivables are higher than plan and this is due to an increase in pre-payments of £1.4m, an increase in aged debt with ESNEFT of £2m and an increase in the VAT receivable of £1.8m. There was also an increase in aged debt within 30 days as at 30 June.

Trade and other payables have largely increased due to aged trade creditors which we are currently unable to pay due to our low cash position. There has also been an increase in expenditure accruals.

The increase in receivables and payables off-set to show a £3m adverse variance, which is in line with the Trust reporting a deficit £3.1m higher than plan.

Debt Management

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



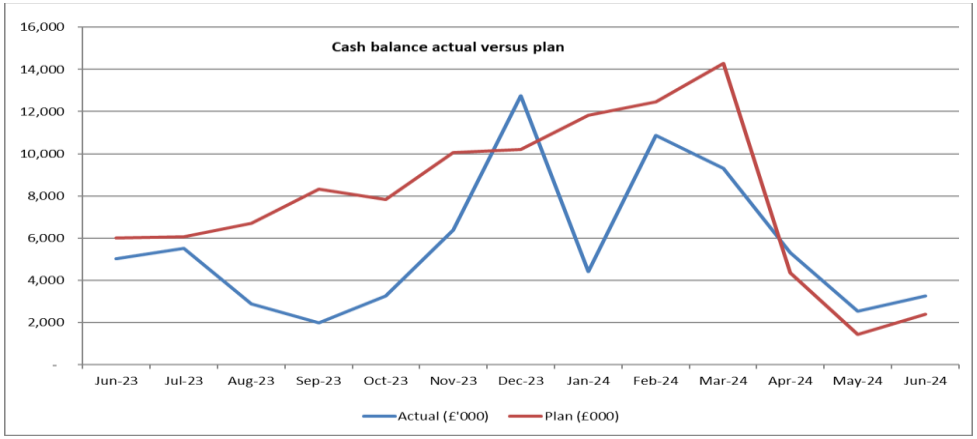
The overall level of sales invoices raised but not paid continues to remain stable and we have been working hard to reach resolution on some of the older debts in order to help the Trust's cash position.

Over 74% of the outstanding debts relate to NHS/WGA Organisations, with 28% of these types of debts being greater than 90 days old.

FINANCE REPORT – June 2024

Cash Balance for the year

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



The Trust's cash balance as at 30 June 2024 was £3.3m. This was made up of £533k of cash that is set aside to pay for capital projects and £2.8m for revenue payments.

Our cash forecast suggests we have enough cash until the end of July. We plan to only pay key suppliers and NHSE guidance suggests we should not prioritise paying NHS invoices. Suppliers who are not prioritised may therefore offer worse terms or withdraw services/be unwilling to supply essential consumables. In the meantime, dealing with unpaid suppliers and prioritising individual payments becomes very labour intensive, and stressful, for the AP team.

We have requested cash support for our planned deficit position. So far we have received £6m, but have requested a further £3.8m to the end of Q2 in line with our planned phased deficit of £9.8m to September.

However, our current adverse variance requires additional working capital which is a separate application. We successfully made similar applications in 23/24. The application process is significant and receives detailed external scrutiny and challenge, not least as to why we have an adverse variance and what we are doing to improve it. There is also an unbudgeted cost of 3.5% attached to any agreed funding.

Meanwhile we have approached the ICB for a cash advance. They have supported this in the past (including in 23/24) but to date they have no spare cash available to support WSFT.

Capital Progress Report

The Capital Plan for 2024/25 has been set at £36.65m. £11.99m will be internally funded, with the remaining £24.65m being funded by PDC.

The year to date capital spend at month 3 is £7.78m. This is behind plan and is mainly due to spend on RAAC projects. However, it is still expected that the full capital programme will be completed by the end of March 2025. The table below shows the breakdown:

Capital Spend - 30th June 2024	Year to Date - Month 3			Full Year		
					Funding Split	
Capital Scheme	YTD Plan	**YTD Actual**	Variance to Plan	Full year Plan	*Internal*	*PDC Available*
	£000's	**£000's**		£000's	*£000's*	*£000's*
RAAC Programme	2,504	**238**	2,266	5,900		***5,900***
Newmarket CDC	3,859	**4,138**	- 279	7,860		***7,860***
New Hospital Programme**	2,856	**1,648**	1,208	9,354		***9,354***
Digital Pathology	-	**14**	- 14	86		***86***
Image Sharing	-	**-**	-	345		***345***
CT Scanner	-	**-**	-	1,104		***1,104***
Estates	898	**627**	271	*4,283*	***4,283***	
IM&T	465	**814**	- 349	*1,994*	***1,994***	
Medical Equipment	335	**208**	127	*1,322*	***1,322***	
Imaging Equipment	90	**97**	- 7	*2,400*	***2,400***	
UEC Capital*	-	**-**	-	*2,000*	***2,000***	
Total Capital Schemes	11,007	**7,784**	3,223	36,648	***11,999***	***24,649***
Overspent vs Plan					***36,648***	
Underspent vs Plan						

* Late addition to Capital Plan - included in resubmission in June 2024
** NHP budget is subject to change throughout the year and is fully funded by PDC

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

To Assure

Presented by Louisa Pepper

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Improvement Committee			Date of meeting: Wednesday 19th June 2024		
Chaired by: Louisa Pepper			**Lead Executive Director: Susan Wilkinson Ravi Ayyamuthu**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
5.1	Patient Quality & Safety Governance Group (PQSGG) Updates from: - Safeguarding Adults Safeguarding Children & Young People Mental Health Transformation Group Duty of Candour Learning Disabilities Steering Group Human Factors Update	1	Regular monthly report using the Trust's 1-4 assurance level scale. Areas of partial assurance: - Due to increasing referrals re POT, LADO & Sec 42 enquiries, improved governance is required to provide assurance and enquiry into these cases. Draft policy completed. Full SOP & governance process by Aug 24. The Trust was seeking clarification regarding the level of training for staff and the impact of delivering the Olive McGowan training (learning disabilities and autism) to understand how to progress compliance. National & local increase in demand for mental health beds	PQASG will continue to maintain oversight of all items reported as emerging concerns through its reporting framework. No actions or escalations for Improvement Committee.	1

Originating Committee: Improvement Committee			Date of meeting: Wednesday 19th June 2024		
Chaired by: Louisa Pepper			Lead Executive Director: Susan Wilkinson Ravi Ayyamuthu		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
			for formal & informal mental health patients. Impacts length of stay & patient flow. Raised with ICB & partners. Joint crisis protocol being drafted by task & finish group. Two band 7 mental health practitioners funded by the system to support this. Under 18's in mental health crisis. Peripatetic funding support discontinued by the ICB April 24. Therefore the Trust is now unable to access funding for skilled support for 1:1 observation for our complex young peopleThere has also been an assumption that an acute paediatric setting is a place of safety whilst alternative placements are sought, which can take some time.. ICB negotiations on-going. Work with West Suffolk professionals to explore care & support agencies.		

Originating Committee: Improvement Committee			Date of meeting: Wednesday 19th June 2024		
Chaired by: Louisa Pepper			Lead Executive Director: Susan Wilkinson Ravi Ayyamuthu		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
			Crisis model under review by system. Duty of Candour – Trust compliance with 10-day delivery of written/verbal duty of candour decreased in Q4, following a decrease in Q3. It is not now a statutory obligation but should be applied as soon as is reasonably practical. DOC audit to be shared widely with Divisions. Review of data sets. Q1 work re improvement on-going. Support to the Trust from Patient Quality & Safety Team on-going.		
5.2	Clinical Effectiveness Governance Group (CEGG)	1	Three new NBP publications. Retained swabs following invasive procedures. Nutrition	CEGG recommends no CQUINS added to ICB contract for formal monitoring. CQIN 1&12 to remain	1

Originating Committee: Improvement Committee			**Date of meeting: Wednesday 19th June 2024**		
Chaired by: Louisa Pepper			**Lead Executive Director: Susan Wilkinson Ravi Ayyamuthu**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
	Updates from the meeting: - CQUIN Accreditation & Licences CEGG development Plan Review of Risk Log – 4 risks		Management. Patients at Risk of Self Harm. CQUIN: - NHS England have proposed pausing the scheme for 24/25. ICB have referred the decision to organisations to decide reporting CQUIN in contract. No financial penalty or incentive either way. In 23/24, all CQUIN achieved by the Trust except:- Staff Flu Vaccinations (we performed better than many Trusts) & Pressure Ulcers in the community. CQUIN supports improvements in the quality of care. Previously CQUIN funding was granted or withheld depending on full or partial CQUIN achievement. CQUIN indicators will continue to be published as a non-mandatory list. No data will be collected by NHS England. WSFT Clinical Leads feel that	with local oversight & project support (12). CEGG will continue to maintain oversight of all new items reported as emerging concerns through its framework.	

Originating Committee: Improvement Committee			Date of meeting: Wednesday 19th June 2024		
Chaired by: Louisa Pepper			**Lead Executive Director: Susan Wilkinson Ravi Ayyamuthu**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:** **SO WHAT?** *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
			additional scrutiny via contractual reporting is unlikely to improve already good performance. CEGG Development plan is a work in progress.		
5.3	Transfer of Care Group (TOCG) Update regarding development and progress.	2	Transfer of patients back to their home or other healthcare facility is complex and requires numerous systems and processes to work together to ensure care is communicated well and supported by internal systems.	Engagement with key stakeholders is on-going. All sub-groups reporting every three months. Discharge summaries work on-going. Improvement is supported by a QI project.	1
6.15	Home Office Visit and Inspection of the Pharmacy re compliance	2	The pharmacy is licenced by the Home Office to dispense controlled drugs to St Nicholas	The visit was positive, and the Home Office undertook a comprehensive inspection. In	1

Originating Committee: Improvement Committee			Date of meeting: Wednesday 19th June 2024		
Chaired by: Louisa Pepper			Lead Executive Director: Susan Wilkinson Ravi Ayyamuthu		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
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	in respect of pharmaceutical storage and distribution.		Hospice. Periodically the Home Office carry out inspections looking at a vast number of compliance issues concerning the storage, dispensing of drugs and the overall governance of the department.	preparation for this a review was undertaken on the storage of drugs on wards, this has led to the replacement of many drugs fridges and it is anticipated that this will lead to an improvement of and reduction in drugs being inappropriately stored and therefore disposed of.	
6.2	Deep Dive – Accreditations & Licences Process. Development of a process to provide oversight & assurance for WSFT clinical department accreditation. Aim is a process where all clinical departments undertaking accreditation: - Provide an assurance report to CEGG at an agreed frequency. Have an identified escalation route to highlight & address concerns requiring action to	2	Accreditations underpin quality in health and social care provision to ensure consistency in the delivery of healthcare, services to patients and commissioners. Accreditation builds confidence in standards & quality initiatives. Accredited assessment services help promote quality performance requirements – regulatory & non-regulatory and verify they are met. CQC use accreditation schemes to inform inspection activity. A Trusts participation in	Clinical support Division are piloting the process for oversight of clinical accreditation using UKAS in Pathology, ISAS in Radiology & JAG in Endoscopy. Paper to management Exec Committee setting out proposed pathways & a request for all relevant departmental accreditations in that division. Subject to pilot, all accreditations held by WSFT or those that are	1

Originating Committee: Improvement Committee			Date of meeting: Wednesday 19th June 2024		
Chaired by: Louisa Pepper			**Lead Executive Director: Susan Wilkinson Ravi Ayyamuthu**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:** **SO WHAT?** *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
	enable successful award of accreditation. Record & manage risks which may have an adverse impact on achieving accreditation. Clinical Support have agreed to trail the process.		accreditation schemes is reflected in the areas of well led and Effective.	working towards will fall within this framework. Where an accreditation body listed does not form part of WSFT aspirational development, the reasons will be considered and understood. CEGG will provide regular updates on progress with this as part of its development programme updates to the Improvement Committee.	
7.2	Learning from recent inquest challenges. To ensure the inquest process at WSFT reviews patient deaths leading to an inquest we can demonstrate learning and service improvements relating to care and experience of patients, carers and staff, thereby avoiding a Preventing Future	1	Clear pathway to review all deaths subject to an inquest with colleagues from Patient Experience, Learning from Deaths, Patient Safety and Legal Teams. This will mean: - Families will feel listened to, their questions answered and where	Adopt process. Review & evaluate process in 6/12 months to assess impact & effectiveness. Success will be measured in the low number of witnesses called to give evidence, No surprises for staff on day of inquest and continued level of PFD reports issued by the Coroner.	1

Originating Committee: Improvement Committee			Date of meeting: Wednesday 19th June 2024		
Chaired by: Louisa Pepper			Lead Executive Director: Susan Wilkinson Ravi Ayyamuthu		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
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	Death (PFD) Report from the Coroner		possible service improvements initiated and delivered. Staff can review and reflect on the care provided ahead of the inquest. Trust can triangulate learning from various sources. Trust can avoid reputational damage & loss of confidence when a PFD report is issued.		

**See guidance notes for more detail*

Guidance notes

The practice of scrutiny and assurance

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

Assurance level

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

4.3. Quality and Nurse Staffing Report

To Assure

Presented by Susan Wilkinson

Public Board	
Report title:	Quality and Workforce Report & Dashboard – May and June 2024
Agenda item:	4.3
Date of the meeting:	26th July 2024
Sponsor/executive lead:	**Susan Wilkinson**
Report prepared by:	**Daniel Spooner: Deputy Chief Nurse**

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

Executive Summary

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

This paper reports on safe staffing fill rate, contributory factors and quality indicators for inpatient areas for May and June 2024. It complies with national quality board recommendations to demonstrate effective deployment and utilisation of nursing and midwifery staff. The paper identifies planned staffing levels and where unable to achieve, actions taken to mitigate where possible. The paper also demonstrates the potential resulting impact of these staffing levels. It will go onto review vacancy rates, nurse sensitive indicators, and recruitment initiatives within the sphere of nursing resource management. This paper also demonstrates how nursing directorate is supporting the Trust's financial recovery ambitions, following a nursing deployment group established to provide oversight for nursing resource utilisation.

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

- Overall RN vacancy rate is positive causation/trend.
- Turn over for RN/RM remains under 10%
- Combined RN and NA fill rates above 90% continues this in this period and is in common cause variation and above this ambition consistently over the past 12 months.
- CHPPD is just below expected levels and we didn't see the anticipated increase following closure of escalation ward in May.
- Summer inpatient establishment reviews to commence in July 2024
- Nurse sensitive indicators/patient harms have improved in this period [noting potential underreporting following transition to RADAR]
- Challenges in having positions to recruit a full quota of the student nurses qualifying in September 2024 due to positive vacancy rate

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

To continue to embed and monitor temporary spend and achievement of CIP whilst monitoring any potential safety implications.
Continued focus on recruitment and retention on nursing assistants

Action Required

For assurance around the daily mitigation of nurse and midwifery staffing and oversight of nursing and midwifery establishments.

No action from board required.

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

Quality and Nurse Staffing Report – May and June 2024

1. Introduction

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

2. Background

2.1 The National Quality Board (NQB 2016) recommend that monthly, actual staffing data is compared with expected staffing and reviewed alongside quality of care, patient safety, and patient and staff experience data. The trust is committed to ensuring that improvements are learned from and celebrated, and areas of emerging concern are identified and addressed promptly. This paper will identify safe staffing and actions taken in May and June 2024. The following sections identify the processes in place to demonstrate that the Trust proactively manages nurse staffing to support patient safety.

3. Key issues

3.1 **Nursing Fill Rates**

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

	Day		Night	
	Registered	Care Staff	Registered	Care staff
Average fill rate Jan 2024	91%	86%	98%	99%
Average fill rate Feb 2024	90%	84%	97%	102%
Average fill rate March 2024	93%	92%	92%	98%
Average fill rate April 2024	92%	88%	96%	104%
Average fill rate May 2024	93%	88%	95%	103%
Average fill rate June 2024	94%	90%	97%	100%

Table 1

Average fill rates have moved out of a declining picture in July 2023. Fill rates over 90% is in common cause variation but has maintained a level above 90% for the 12 months as demonstrated in Chart 2.

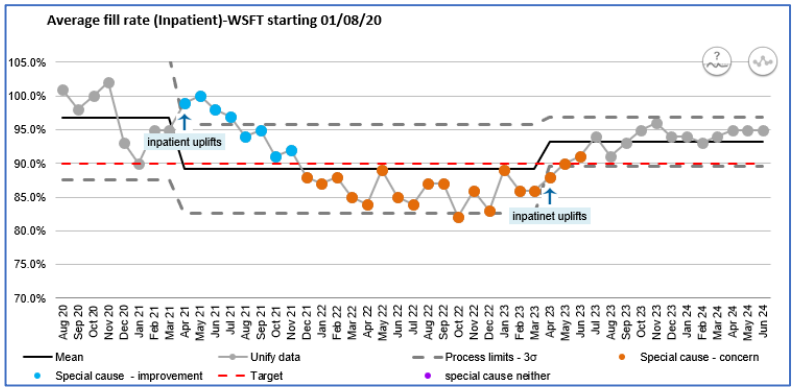


Chart 2

3.2 **Care hours per patient day**

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

Using *model hospital*, the average recommended CHPPD for an organisation of our size is 7.6. Chart 3 (below) demonstrates our achievement of this. Since August 2021 we are not achieving this consistently and further demonstrates the staffing challenges over recent years however we have achieved close to this recommendation consecutively over the last four months.

CHPPD can be affected adversely by opening additional beds either planned or emergency escalation, as the number of available nurses to occupied beds is reduced. Periods of high bed occupancy can also reduce CHPPD. It is expected that while the winter ward (F9) was open this would decreased the likelihood of achieving the expected CHPPD for the organisation of our size. The winter/seasonal pressures ward was opened in a planned response to 'winter pressures' on 17th December 2023 and closed mid May during this reporting period. CHPDD has maintained similar levels in May and June , although above the trust average for the past 4 months. The benefits of closing the winter ward on CHPPD have not been fully realised, this is likely to be driven by continued staffing of escalation areas during this period.

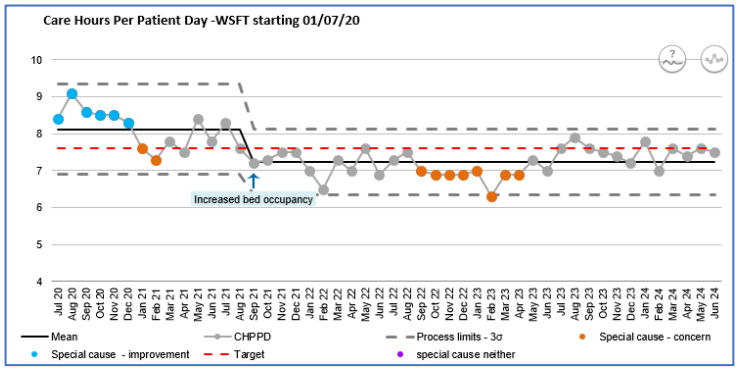


Chart 3

3.3 **Sickness**

Sickness rates have increased across both months within the unregistered staff group and have remained reasonably static in the RN/RM staff group. Overall sickness is below Trust ambition of <5%

	Nov-23	Dec-23	Jan-24	Feb-24	Mar 24	Apr 24	May 24	Jun 24
Unregistered staff (support workers)	6.57%	7.36%	7.24%	6.50%	5.66%	5.99%	6.20%	7.21%
Registered Nurse/Midwives	5.95%	5.96%	5.90%	4.43%	4.49%	4.20%	3.55%	3.72%
Combined Registered/Unregistered	**6.16%**	**6.43%**	**6.34%**	**5.11%**	**4.87%**	**4.78%**	**4.41%**	**4.85%**

Table 4

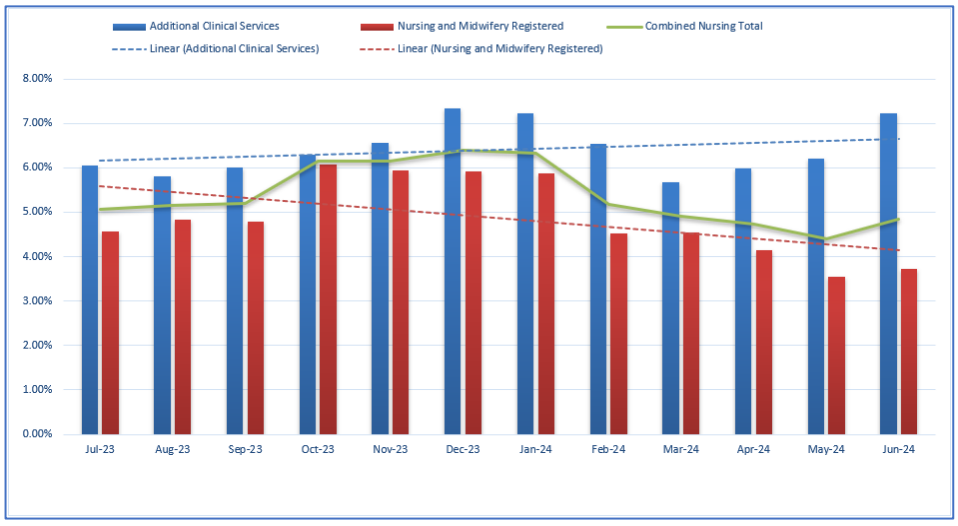


Chart 4

3.4 **Recruitment and Retention**

Vacancies: Registered nursing (RN/RM):

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

- Inpatient RN/RM vacancy% rate has improved from 9.1% last report to 8.6% at M3.
- Total RN/RM vacancy rate has remained reasonably static at 8.6% at M3.
- Inpatient NA vacancy rate has declined from 8.4% to 10.9% in M3.
- Total NA vacancy has declined from 10.3% to 11.7% in M3.

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

	Sum of Month 10	Sum of Month 11	Sum of Month 12	Sum of Month 1	Sum of Month 2	Sum of Month 3	WTE vacancy at M3
RN	694.8	695.3	701.6	706.3	712.4	716.2	**67.3**
NA	404.7	404.2	404.7	404.5	390.1	389.4	**47.8**

Table 5 Inpatient actual substantive staff WTE.

3.4.1 **International Recruitment**

As per plan, the Trust successfully achieved its target of the recruitment of 84 international nurses for 2023/24. As planned, the last cohort of internationally educated nurses arrived at the end of June. There are no more internationally recruited nurses left arrive. The decision to pause this funded program will be reviewed in Q3 to restart or extend the pause depending on the predicted strength of the workforce for the remainder of 2024/25

3.4.2 **New Starters**

	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun24
RN	15	46*	20	17	8	8
NA	24	16	11	22	17	8

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

- In May, 8 RNs completed induction; of these; 6 were for the acute, 2 for bank service.
- In May, 17 NAs completed induction; of these; 11 NAs are for the acute Trust, 2 for bank services including community bank, 4 for community services.

- In June, 8 RNs completed induction; of these; 1 was for the acute, 3 for community, 1 for community bank services and 3 midwifery preceptors.
- In June, 8 NAs completed induction; of these; 8 NAs are for the acute Trust.

3.4.3 **Turnover**

On a retrospective review of the last rolling twelve months, turnover for RNs continues to positively be under the ambition of 10%. RN turnover improved to 6.3%. NA turnover also continues to improve on last reporting period from 14.9% to 13.6%

		Turnover	01/07/2023	-	30/06/2024			
Staff Group	Average Headcount	Avg FTE	Starters Headcount	Starters FTE	Leavers Headcount	Leavers FTE	LTR Headcount %	LTR FTE %
Nursing and Midwifery Registered	1,468.50	1,281.0914	73	59.7600	96	80.6000	6.5373%	6.2915%
Additional Clinical Services	612.00	515.6790	217	200.4333	91	69.8200	14.8693%	13.5394%

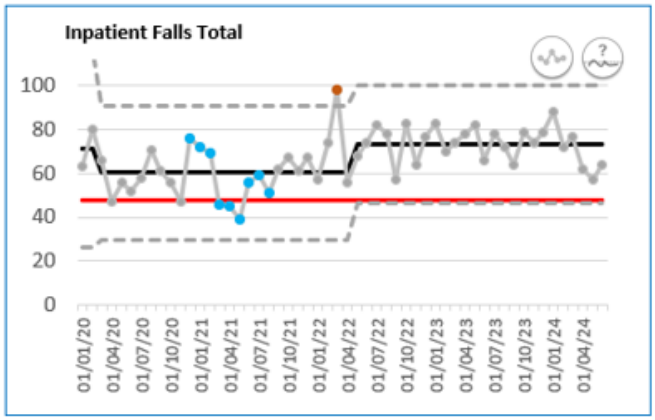
Table 7. (Data from workforce information)

3.5 **Quality Indicators**

Falls and acquired pressure ulcers.

Both falls and pressure ulcers incidents remain in common cause variation (chart 8 & 9). A full narrative around this quality measure and interventions can be found in the IQPR. Improvement projects and oversight are completed through the patient quality and safety governance group (PQSGG). Both incidents of pressure ulcers and falls have reduced in this period, with special cause improvement in falls per 1000 bed days. Assumptions around improvement following introduction of RADAR in April should be made with caution. Concerns regarding low reporting since the introduction of RADAR has

been raised and discussed at PQSGG and additional exploration and training is to be offered to ensure that low reporting is not due to knowledge gaps in using the new incident reporting system.



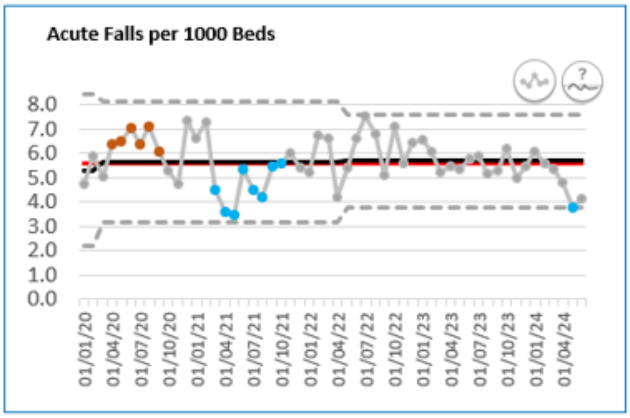
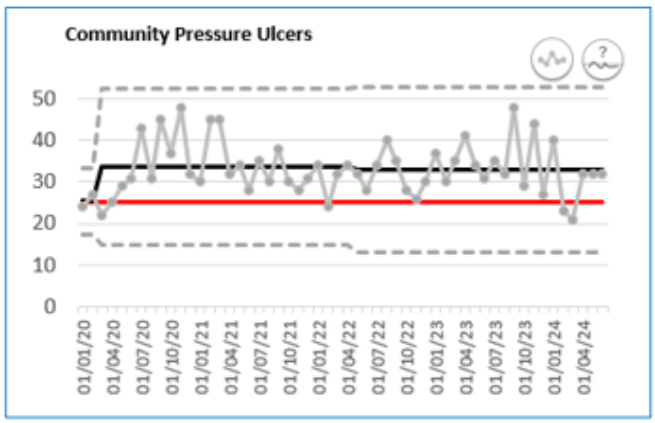


Chart 8 inpatient falls



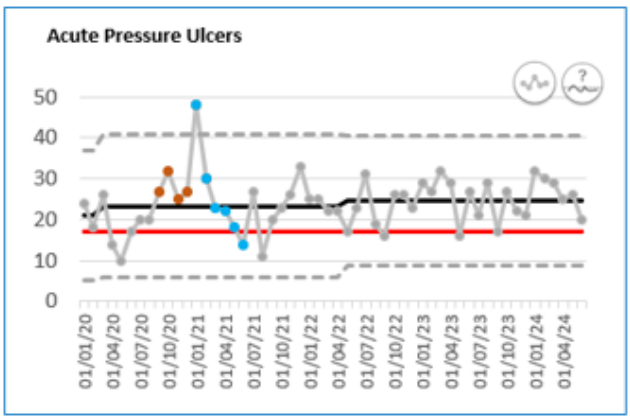


Chart 9 Pressure ulcers acquired in care.

3.6 **Compliments and complaints**

20 formal complaints were received in May. ED received the highest number of complaints. The most common theme of complaint this month was clinical treatment. 51 compliments were received this month, which ED received the highest number.

17 formal complaints were received in June. Gastroenterology received the highest number of complaints. The most consistent theme of these formal complaints was communication. 46 compliments were received this month with ED receiving the highest amount.

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

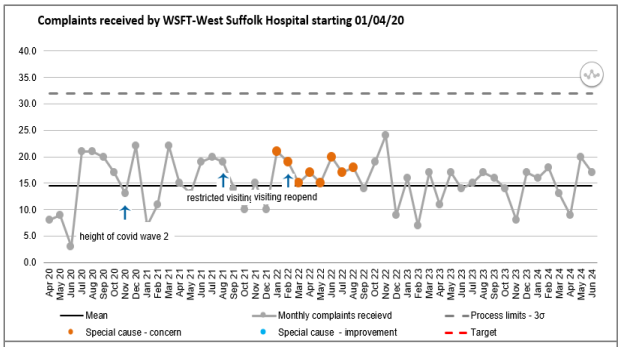


Chart 10a (complaints)

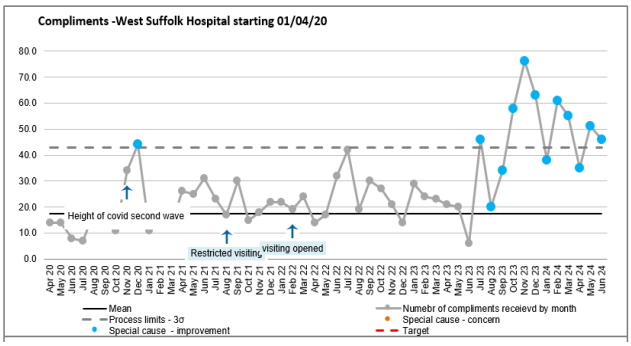
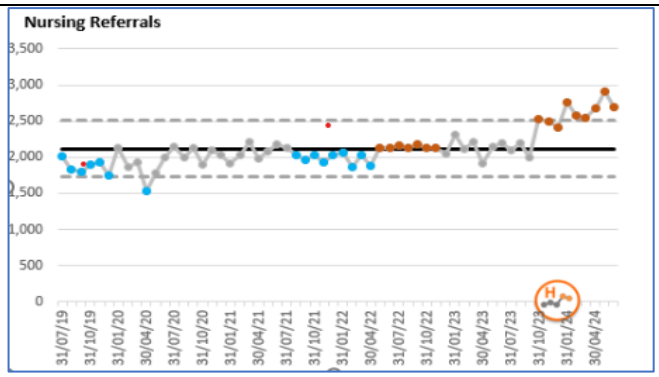


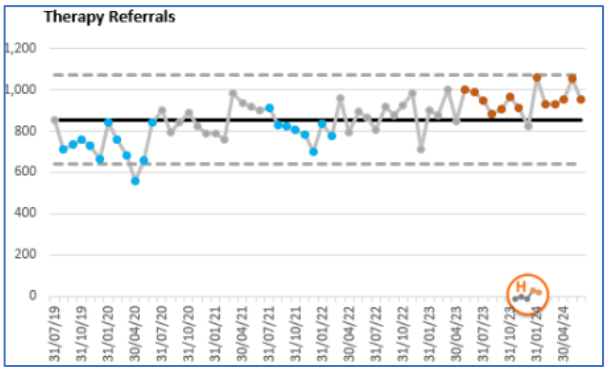
Chart 10b (compliments)

3.7 **Adverse staffing incidents**

	Staffing incidences are captured on Datix with recognition of any red flag events that have occurred as per National Quality Board (NQB) definition (Appendix 3). Nursing staff are encouraged to complete a RADAR incident as required, so any resulting patient harm can be identified and if necessary, reviewed retrospectively. For this paper only those that meet NQB recommendations of a 'red flag' are included. Staffing not related to nursing are also excluded. Due to the transition to RADAR this report remains outstanding: In June only 9 incidents were reported regarding nurse staffing. This is lower than before RADAR implementation. On review, no incidents resulted in patient harm, although delays in the provision of care were identified.
3.8	**Maternity services** A full maternity staffing report will be attached to the maternity paper as per CNST requirements. **Red Flag events** NICE Safe midwifery staffing for maternity settings 2015 defines Red Flag events as events that are immediate signs that something is wrong, and action is needed now to stop the situation getting worse. Action includes escalation to the senior midwife in charge of the service and the response include allocating additional staff to the ward or unit. Red Flags are captured on RADAR and highlighted and mitigated as required at the daily Maternity Safety Huddle. In April 2024 the Trust introcuded a new reporting system RADAR, due to the changes in system data is not yet available. **Midwife to Birth ratio** Latest BirthRate plus review undertaken in March 2023 shows that Midwife to Birth ratio at West Suffolk NHS Foundation Trust reduced to 1:21. The ratios are based on the Birthrate Plus® dataset, national standards with the methodology and local factors, such as % uplift for annual, sick & study leave, case mix of women birthing in hospital, provision of outpatient/day unit services, total number of women having community care irrespective of place of birth and primarily the configuration of maternity services. • Midwife to birth rate in May was 1:20 • Midwife to birth ratio in June was 1:21. **Supernumerary status of the labour suite co-ordinator (LSC)** This is one of the Maternity Incentive Scheme Year 6 Safety Actions requirements and was also highlighted as a 'should' from the CQC report in January 2020. The band 7 labour suite co-ordinator should not have direct responsibility of care for women. This is to enable the co-ordinator to have situational awareness of what is occurring on the unit and is recognised not only as best but safest practice. 100% compliance against this standard was achieved in both May and June 2024
3.9	**Community and integrated neighbourhood teams (INT) demand** In the INT teams the number of referrals being received by the teams continues to be a special cause for concern meaning an above average rate of referrals since October 2023, and since April 23 for the therapists.

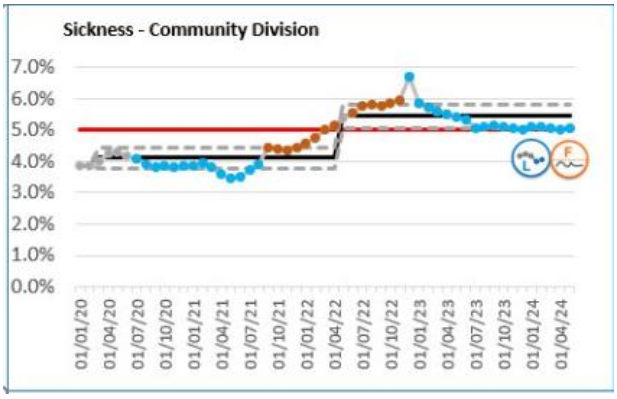
	Standard	January	February	March	April	May	June
Supernumerary Status of LS Coordinator	100%	100%	100%	100%	100%	100%	100%
1-1 Care in Labour	100%	100%	100%	100%	100%	100%	100%
MW: Birth Ratio	1:21	1:21	1:21	1:19	1:21	1:20	1:21
No. Red Flags reported		4	3	0	TBC	TBC	TBC

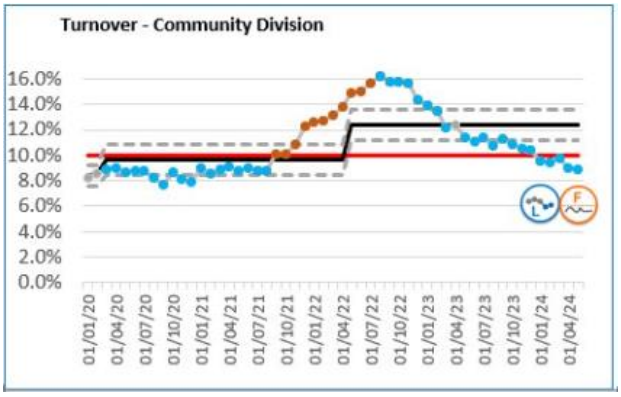




Sickness & Turnover

No significant change in sickness rates. Sickness is almost at trust target. HR have completed an internal audit of sickness rates across all departments, with the full report pending. The turnover figure continues to reduce and is just below the Trust target of 10%, sitting at 8.9% for May 2024.





What next for community teams

- Nationally the CNSST (Community Nursing Staffer Staffing Tool) has been paused for secondary beta testing. The national team at NHSE have also established a clinical reference group. The evaluation is expected in September. Once results are published, we can evaluate and decide how to proceed with the workforce modelling for nursing within INTS.
- Temporary spending continues to be closely monitored & controlled. Clear escalation processes in place to review safe staffing and approval of agency.
- INT teams: The capacity dashboard is utilised daily; it is used to support any staff moves and reviewed on weekly basis to justify if any temporary spending on staffing will be needed in next 2 weeks

4.	**Next steps/Challenges**
4.1	**Nursing Resource oversight Group** The Nursing Deployment Group continue to meet to review best practice methods of deploying staff and to reduce the temporary nursing spend. Interventions include the commencement of a better rostering subgroup to fully utilise eRostering modules, stringent control over agency and overtime spend and reducing high-cost temporary nursing shifts. 24/25 CIP programmes currently costed and in train are indicated below with CIP assumptions. • Removal of Rapid response pool: £55k • Reduced high-cost shift availability: £77k. • Reduced WTE of education team: £108k Additional schemes are being scoped and are awaiting finical impact before submission to QIA process
4.2	**Establishment reviews** The second iteration for this year of the Safer Nursing Care Audit (SNCT) is planned to commence on 1st July 2024 as per usual seasonal schedule. Workshops providing audit training were completed in June.
4.3	**Healthcare support worker role profile review,** As mentioned in the last report, positive engagement with staff side colleagues has resulted in formal acceptance of our intention to proceed with this project. Following successful assessment of

	competence, staff within scope, will move to band 3 positions and see the impact of this within their pay from June 2024. The positive work completed with WSFT and staff side has meant that this project can progress.. Most recent records indicate a lower number of staff than anticipated that progressed into band 3 roles, with very low numbers of staff working purely with WSP registrations. • 70% of substantive staff in scope • 25% of WSP workers Additional communications to these staff have been released to ensure all staff are aware and engaged in the process.
4.4	**Student Nurse recruitment** WSFT has a positive reputation for student recruitment and traditionally recruits approximately 90% of students that have trained here. This reflects the positive and supportive experience student nurses receive at WSFT. In September/October 2024 approximately 44 students will be obtaining nursing registration. It was recognised in May, that due to a positive vacancy rate only 35% of students were able to secure employment within WSFT on qualification. Not recruiting students that have been trained and supported for the last three years impacts on both staff morale and potentially trust reputation, which historically has been positive. Coupled with the significant decline in student nurses that will be qualifying in the next three years opportunities to exploit all recruitment possibilities were scoped. A full review of all clinical areas [that recruit newly qualified nurses] was completed with the clinical teams, workforce and finance representatives and the Deputy Chief Nurse. Opportunities to recruit at risk were identified. A full paper was taken and agreed at Management Executive Group which was supported to commence recruitment of students into posts not traditionally back filled substantively but do require filing with temporary staff. The risk was mitigated to reflect the current financial challenges and using the proposed methodology student recruitment will likely increase to 70%. While this is significantly less than previous years it will increase opportunities to future proof nursing establishments and provide some opportunities to reduce temporary staffing cover. To ensure grip and control and eliminate any over establishment a follow up review will be conducted early in Q3 to understand the impact and success of this initiative.
5.	**Conclusion**
5.1	Registered nurse recruitment continues positively and the trust vacancy rate for both inpatient and total nurses and midwives is consistently under 10%. Nursing assistant recruitment has remained static, it is hoped that the work to align the national job profiles will contribute to further improvement of recruitment and retention of this staff group. Nurse sensitive indictors [falls, pressure ulcers] have seen improvements in this period however this may be in part driven by a transition to a new reporting system. This is being monitored through PQSGG and will escalate to Improvement as required. Corporate nursing and the clinical nursing teams remain committed to providing safe levels of staffing whilst also addressing the financial challenge faced by the organisation and have identified additional CIP in this period. Further schemes and potential opportunities are being scoped to understand the financial and safety impact these would provide.
6.	**Recommendations**
	For the board to take assurance around the daily mitigation of nurse and midwifery staffing and oversight of nursing and midwifery establishments,

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

	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	RNs/RMN		Non registered (Care staff)		RNs/RMN		Non registered (Care staff)									
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average Fill rate RNs/RM %	Average fill rate Care staff %	Average Fill rate RNs/RM %	Average fill rate Care staff %	Cumulative count over the month of patients at 23:59 each	RNS/RMs	Non registered (care staff)	Overall
Rosemary Ward	1427.0	1275.3	1778.8	1610.8	1069.5	1049.3	1421.5	1437.5	89%	91%	98%	101%	955	2.4	3.2	5.6
Glastonbury Court	714.0	709.0	1077.0	1011.0	713.0	713.5	542.5	542.5	99%	94%	100%	100%	576	2.5	2.7	5.2
Acute Assessment Uni	2079.5	2182.5	2326.0	1862.3	1736.5	1743.0	1403.0	1324.0	105%	80%	100%	94%	761	5.2	4.2	9.3
Cardiac Centre	1771.8	1563.8	1060.5	935.0	1782.5	1654.7	709.0	751.5	88%	88%	93%	106%	632	5.1	2.7	7.8
G10	1779.0	1466.6	1777.5	1540.1	1058.0	1041.3	1771.0	1717.5	82%	87%	98%	97%	707	3.5	4.6	8.2
G9	1725.0	1601.0	1394.5	1337.5	1386.5	1373.5	1069.5	1091.5	93%	96%	99%	102%	752	4.0	3.2	7.2
F12	540.5	685.5	333.5	324.0	651.0	627.3	349.8	386.3	127%	97%	96%	110%	240	5.5	3.0	8.4
F7	1713.5	1521.5	1759.5	1591.5	1368.5	1298.5	1765.5	1752.0	89%	90%	95%	99%	683	4.1	4.9	9.0
G1	1417.0	1139.5	356.5	287.5	712.7	699.2	356.5	348.5	80%	81%	98%	98%	485	3.8	1.3	5.1
G3	1782.5	1554.0	1770.5	1675.6	1069.5	1055.0	1069.5	1435.0	87%	95%	99%	134%	864	3.0	3.6	6.6
G4	1785.5	1628.0	1793.5	1601.0	1069.5	1046.5	1426.0	1534.0	91%	89%	98%	108%	896	3.0	3.5	6.5
G5	1598.5	1443.8	1705.8	1434.6	1023.5	1072.0	1414.0	1442.5	90%	84%	105%	102%	760	3.3	3.8	7.1
G8	2438.0	1970.1	1690.5	1603.9	1614.5	1579.0	1058.0	1114.8	81%	95%	98%	105%	615	5.8	4.4	10.2
F8	1371.5	1398.9	1587.5	1488.0	1058.0	977.5	1403.0	1435.8	102%	94%	92%	102%	723	3.3	4.0	7.3
Critical Care	2496.0	2094.0	363.3	190.3	2495.0	2131.8	0.0	0.0	84%	52%	85%	*	388	10.9	0.5	11.4
F3	1644.5	1462.0	2139.0	1822.8	1069.5	1055.0	1426.0	1422.0	89%	85%	99%	100%	732	3.4	4.4	7.9
F4	941.0	966.8	609.5	643.8	713.0	655.5	540.5	389.5	103%	106%	92%	72%	633	2.6	1.6	4.2
F5	1701.0	1713.6	1426.0	1263.0	1069.5	1034.8	1069.5	1060.5	101%	89%	97%	99%	698	3.9	3.3	7.3
F6	1787.0	1355.8	1763.5	1425.8	1069.5	1002.1	713.0	1143.5	76%	81%	94%	160%	942	2.5	2.7	5.2
Neonatal Unit	1279.0	1217.0	725.5	583.5	1116.0	900.0	744.0	612.0	95%	80%	81%	82%	116	18.3	10.3	28.6
F1	1749.5	2012.8	713.0	680.0	1426.0	1426.0	0.0	0.0	115%	95%	100%	*	115	29.9	5.9	35.8
F14	1544.5	1666.7	372.0	372.5	744.0	743.5	0.0	0.0	108%	100%	100%	*	106	22.7	3.5	26.3
F9	1288.0	1288.0	1288.0	847.6	966.0	715.5	966.0	956.2	100%	66%	74%	99%	744	2.7	2.4	5.1
Total	36,573.75	33,915.85	29,811.25	26,131.83	26,981.67	25,594.25	21,217.83	21,897.08	**93%**	**88%**	**95%**	**103%**	**14123**	**4.2**	**3.4**	**7.6**

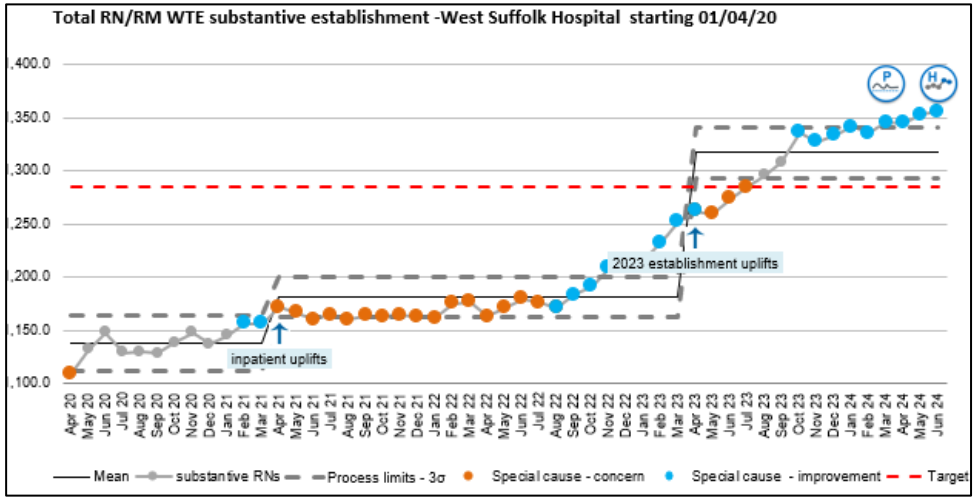
* planned hours are zero, so additional support used on ward to mitigate unfilled nursing hours

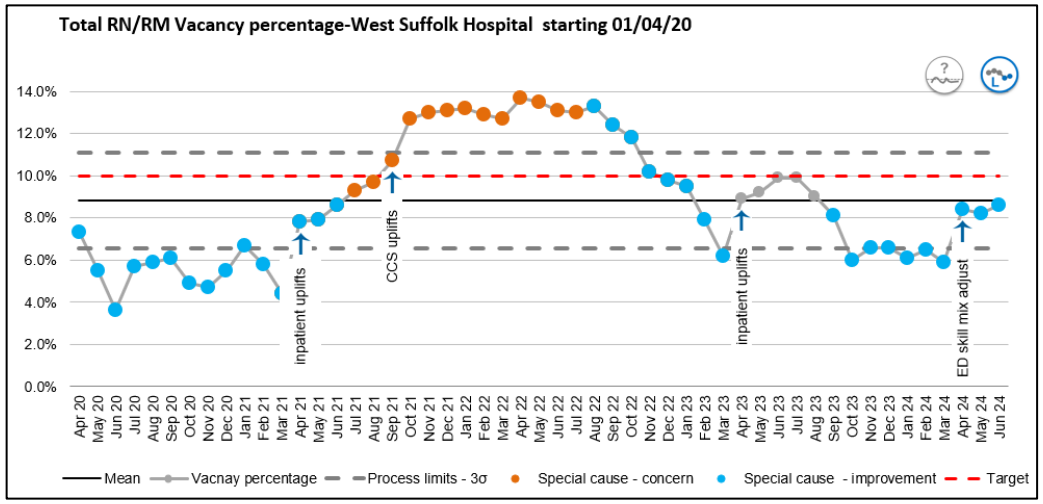
Appendix 1. Fill rates for inpatient areas (June 2024) Data adapted from Unify submission.

	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	RNs/RMN		Non registered (Care staff)		RNs/RMN		Non registered (Care staff)									
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average Fill rate RNs/RM %	Average fill rate Care staff %	Average Fill rate RNs/RM %	Average fill rate Care staff %	Cumulative count over the month of patients at 23:59 each day	RNS/RMs	Non registered (care staff)	Overall
Rosemary Ward	1386	1236.5	1724.25	1565.25	1033	919.5	1380	1449	89%	91%	89%	105%	902	2.4	3.3	5.7
Glastonbury Court	691	690.25	1037.75	956.75	690	691	525	513	100%	92%	100%	98%	530	2.6	2.8	5.4
Acute Assessment Unit	2035.5	2119.9167	2112.5	1691.75	1622.5	1662.5	1322.5	1247.75	104%	80%	102%	94%	761	5.0	3.9	8.8
Cardiac Centre	1721	1599	1012	812.5	1713.5	1606.5	678.5	701.5	93%	80%	94%	103%	632	5.1	2.4	7.5
G10	1713.5	1434.75	1721.25	1383.75	1023.5	1023.5	1713.5	1603	84%	80%	100%	94%	707	3.5	4.2	7.7
G9	1678.5	1591	1312.5	1258	1380	1354	1035	1181.5	95%	96%	98%	114%	752	3.9	3.2	7.2
F12	529	668	356.5	312	635.5	613.5	333.5	368	126%	88%	97%	110%	240	5.3	2.8	8.2
F7	1664	1474	1702	1481.6667	1322.5	1248.5	1702	1672	89%	87%	94%	98%	683	4.0	4.6	8.6
G1	1383.5	1060.75	345	322.75	690	679.5	345	322	77%	94%	98%	93%	485	3.6	1.3	4.9
G3	1685.5	1474.5	1702	1653.25	1035	1035	1368.5	1381.66667	87%	97%	100%	101%	864	2.9	3.5	6.4
G4	1732.5	1512	1727	1582	1035	986.5	1380	1489	87%	92%	95%	108%	896	2.8	3.4	6.2
G5	1518	1381.5	1592.5	1451.4	1035	1034.5	1380	1417	91%	91%	100%	103%	760	3.2	3.8	7.0
G8	2219.5	1958.95	1725.5	1602.0833	1552.5	1541.033333	1035	1028.5	88%	93%	99%	99%	615	5.7	4.3	10.0
F8	1385	1386.5833	1677.75	1488.0833	1035	928.8333333	1373.5	1377.25	100%	89%	90%	100%	723	3.2	4.0	7.2
Critical Care	2221.25	1941.75	153	161	2334.5	2034.5	0	62.5	87%	105%	87%	*	388	10.2	0.6	10.8
F3	1725	1563	1817	1722.5	1000	1046.5	1380	1394.5	91%	95%	105%	101%	732	3.6	4.3	7.8
F4	846	945.5	368.75	439	552	563.5	360	360	112%	119%	102%	100%	633	2.4	1.3	3.6
F5	1610	1701.1667	1380	1203	1035	1066.25	1035	1085	106%	87%	103%	105%	698	4.0	3.3	7.2
F6	1697	1411.5	1711	1327.75	1035	1012.333333	1019	1019.16667	83%	78%	98%	100%	942	2.6	2.5	5.1
Neonatal Unit	1224	1043.75	714.5	589	1080	1004.5	716.5	462	85%	82%	93%	64%	116	17.7	9.1	26.7
F1	1637	1854.25	690	755.25	1380	1369.5	0	16.25	113%	109%	99%	*	115	28.0	6.7	34.7
F14	1410	1564.5	348	347.5	720	717	0	0	111%	100%	100%	*	106	21.5	3.3	24.8
Total	33,712.75	31,613.12	26,930.75	24,106.23	24,939.50	24,138.45	20,082.50	20,150.58	**94%**	**90%**	**97%**	**100%**	**13280**	**4.2**	**3.3**	**7.5**
* planned hours are zero, so additional support used on ward to mitigate unfilled nursing hours																

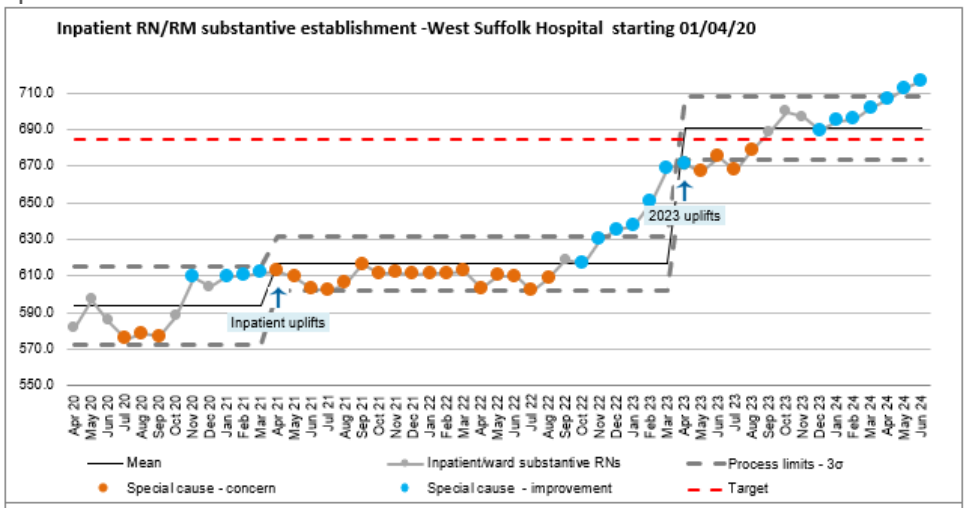
Appendix 2 SPC charts.

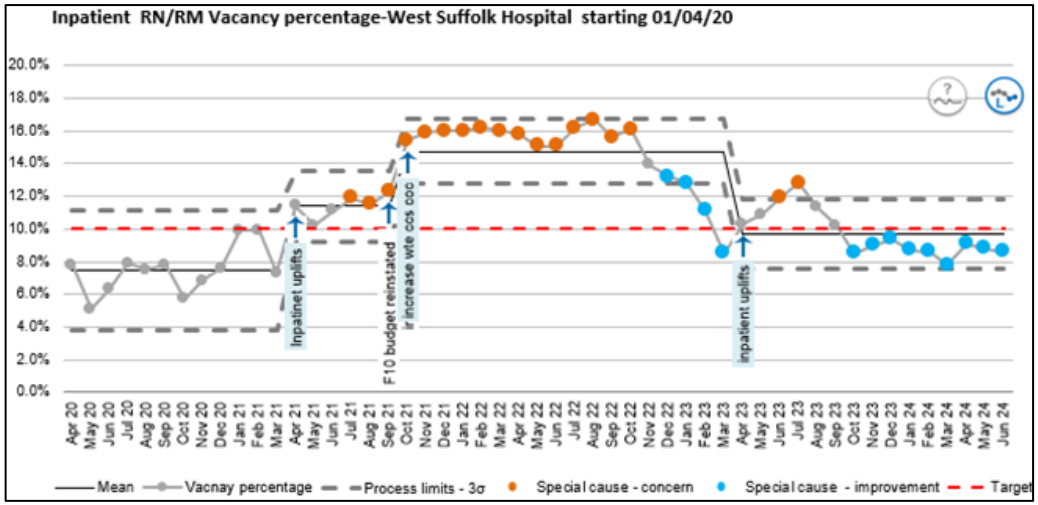
Trust Total RN/RM



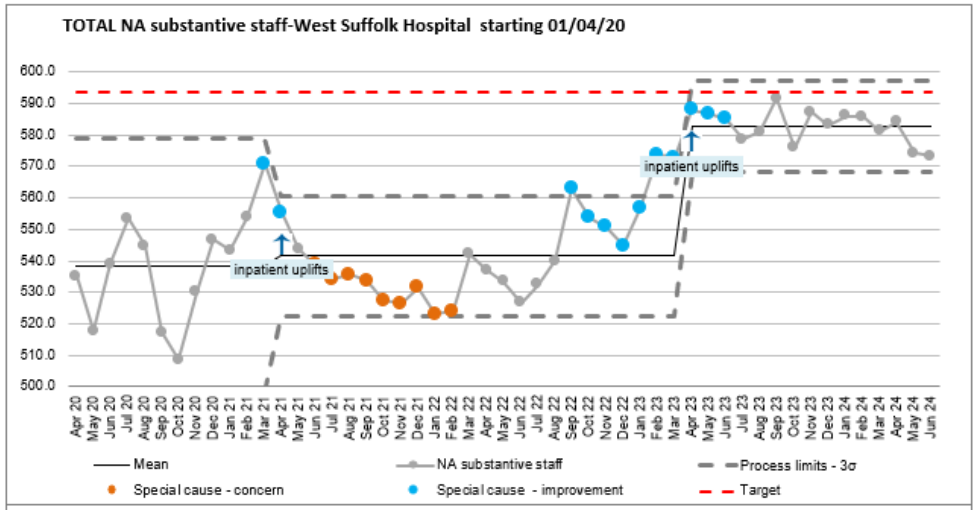


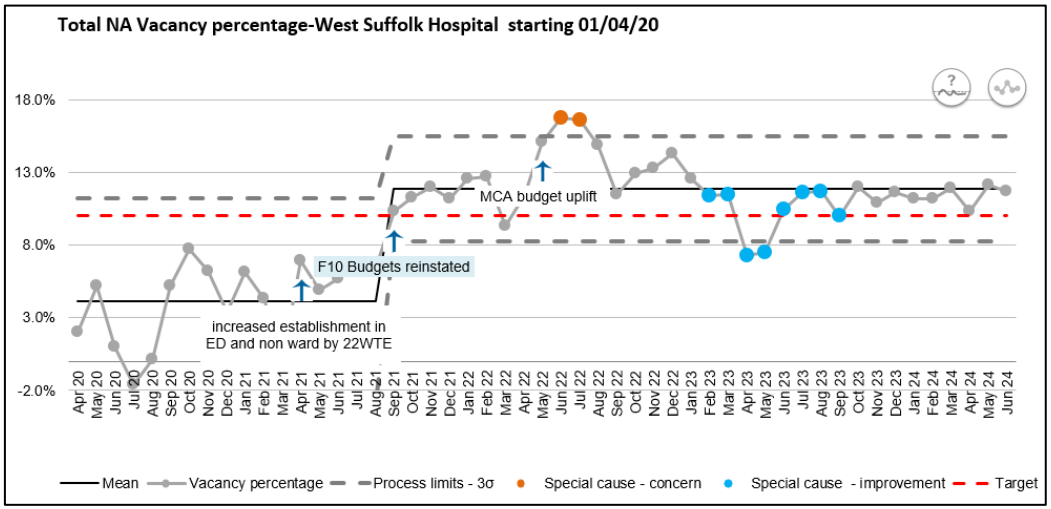
Inpatient RN/RM



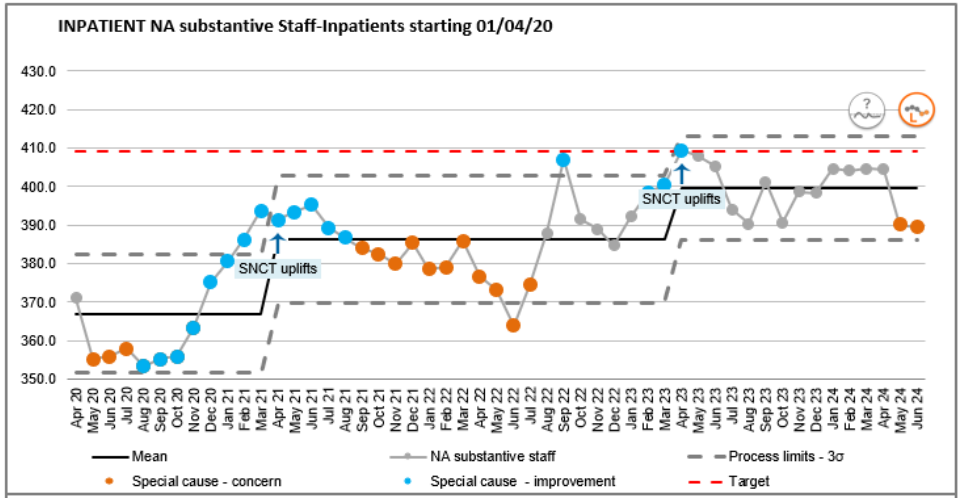


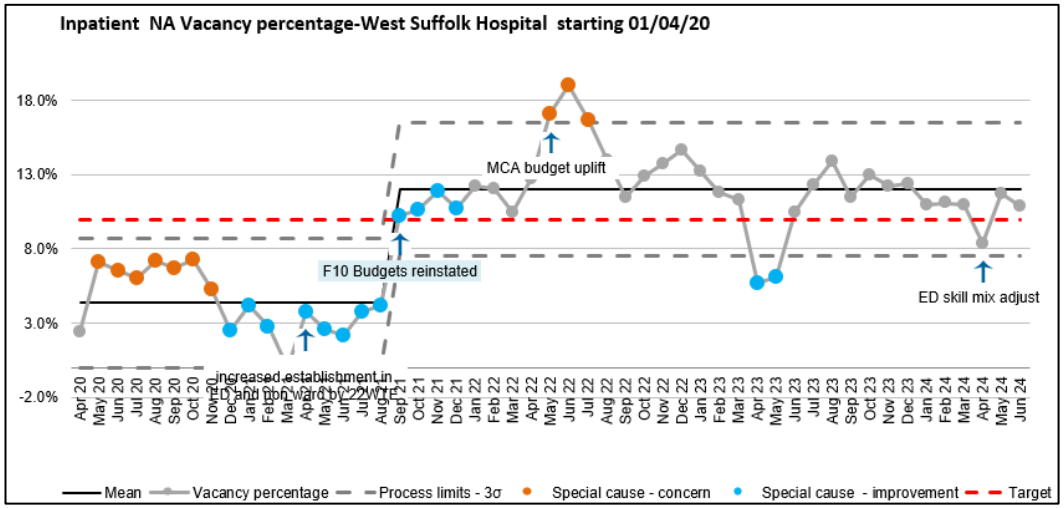
Total NA/unregistered.





Inpatient NA/unregistered.





Appendix 3: Red Flag Events

Maternity Services

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

Acute Inpatient Services

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

4.3.1. Maternity & Neonatal Services

Karen Newbury, Kate Croissant & Simon Taylor in attendance

To Approve

Presented by Susan Wilkinson

Open Trust Board Meeting	
Report title:	Maternity quality, safety, and performance report - Maternity and Neonatal services
Agenda item:	4.3.1
Date of the meeting:	26th July 2024
Sponsor/executive lead:	Sue Wilkinson, Executive Chief Nurse Paul Molyneux, Medical Director & Executive MatNeo Safety Champion
Report prepared by:	Karen Newbury, Director of Midwifery Justyna Skonieczny Head of Midwifery

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

Executive Summary

WHAT?

This report presents a document to enable board scrutiny of Maternity services and receive assurance of ongoing compliance against key quality and safety indicators and provide an update on Maternity quality & safety initiatives in line with the NHS Perinatal quality surveillance Model (Dec 2020).

This report contains:

- Maternity improvement plan
- Safety champion feedback from walkabout
- Listening to staff
- Service user feedback
- Reporting and learning from incidents
- Maternity Dashboards
- Training compliance for all staff groups in maternity related to the core competency framework.

SO WHAT?

The report meets NHSE standard of perinatal surveillance by providing the Trust board a methodical review of maternity and neonatal safety and quality.

WHAT NEXT?

Action plans will be monitored and any areas for non-completion, escalated as appropriate.
Quarterly, bi-annual and annual reports will evidence the updates.
As applicable reports will be shared with external stakeholders as required.

Action Required

For assurance and information only.

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

Maternity quality, safety, and performance report

1.	**Detailed sections and key issues**
1.1	**Maternity and Neonatal improvement plan** The Maternity and Neonatal Improvement Board (MNIB) receives the updated Maternity improvement plan monthly. This has been created through an amalgamation of the original CQC improvement plan with the wider requirements of Ockenden, Maternity and Newborn Safety Investigations, external site visits and self-assessment against other national best practice (e.g., MBRRACE, SBLCBv2, UKOSS). In addition, the plan has captured the actions needing completion from the 60 Supportive Steps visit from NHSE and continues to be reviewed by the MNIB monthly. It has been agreed with the exit from the Maternity Safety Support Programme (MSSP) that NHSE regional team and ICS (Integrated Care System) will be invited to attend the MNIB monthly for additional assurance and scrutiny. NHSE and the ICS, with the national chief midwife in attendance, undertook a 60 Supportive Steps visit in December 2023, to provide a systematic review of the Trust's maternity and neonatal service. The response to the day's feedback was overwhelmingly positive, and the necessary steps outlined in the recommendations are being actively pursued and incorporated into the Maternity and Neonatal Quality and Safety action plan. The impact of these changes is being closely monitored through various channels such as the Maternity and Neonatal Improvement Board, training trackers, dashboards, clinical auditing, and analysis of clinical outcomes for specific pathways. The Trust remains dedicated to making sustained improvements in quality and safety for women, babies, their families, and the staff working within the teams. Both NHSE and the ICS have mutually agreed that a follow-up visit will not be necessary, and have decided to transition to annual visits, with the next one scheduled for December 2024.
1.2	**Safety Champion feedback** The Board-level champion undertakes a monthly walkabout in the maternity and neonatal unit. Staff have the opportunity to raise any safety issues with the Board level champion and if there are any immediate actions that are required, the Board level champion will address these with the relevant person at the time. Individuals or groups of staff can raise the issues with the Board champion. An overview of the Walkabout content and responses is shared with all staff in the monthly governance newsletter 'Risky Business'. Roger Petter our Non-Executive Maternity and Neonatal Safety Champion visited the Midwifery Led Birthing Unit on the 30th of April 2024 and spoke to some senior members of staff. In general, good multidisciplinary team working was reported with a good awareness of service provision throughout the person's whole pregnancy journey and not just birth. Individualised care planning was articulated, including an MDT approach for those people who request care outside of guidance. There were no safety concerns raised. On the 23rd of May, 2024 Roger visited ward F11, which is the antenatal and postnatal ward. Roger spoke to a wide variety of staff and to two service users.

In general, most staff reported no safety or other concerns at all, and were happy with their working environment, safety on the ward and the support for both staff and patients. The ward had a good atmosphere and was calm, organised, and well-run.

The two service users were both full of praise for the support and care which they had received.

Partners staying overnight was raised in relation to them not always following the code of conduct that they are requested to adhere to. Reminders have been posted on social media.

A review of partners staying overnight is due to be undertaken later this year, capturing service user, partner and staff views.

The other concern raised was regarding the planned band 2 uplift to band 3. The Trust framework does not fully align with the national midwifery framework. A gap analysis has taken place comparing the two frameworks and individual staff members. Where staff do not meet the requirements for the national midwifery framework, an individualised development plan will be in place.

1.3 **Listening to Staff**

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

On the back of recent retention data from the national and regional teams, it is recognised that the majority of midwives are leaving the profession 2-5 years after qualification. Our recruitment and retention lead has offered all band 6's a 'stay conversation' and continues to update line mangers and the senior leadership team of any themes identified so that solutions can be sought.

The National Staff Satisfaction Survey results were published at the end of February 2024. The quadrumvirate are reviewing the findings and subsequent action plan, however, the focus will be on the SCORE Culture Survey results as this had a higher response rate, as well as providing in-depth information regarding our workforce, specific to roles, teams and work settings.

SCORE Culture Survey is the final component of the Perinatal Culture & Leadership Programme with the aim of nurturing a positive safety culture, enabling psychologically safe working environments, and building compassionate leadership to make work a better place to be and is included in the requirements for NHS Resolutions Maternity Incentive Scheme. All staff across Women's & Children were invited to participate in the survey and the data collection phase has been completed with the teams achieving a response rate of 49%. The data is currently being reviewed and the next steps planned.

1.4 **Service User feedback**

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

Ward/Dept	May Survey returns	March Very good and good %	June Survey returns	April Very good and good %
F11	60	91.67%	57	96.49%
Antenatal	11	72.73%	42	97.62%
Postnatal Community	8	87.50%	10	80%
Labour Suite	21	90.48%	8	100%
Birthing Unit	14	100%	13	100%
NNU	1	100%	2	100%
Transitional Care	9	100%	12	92.86%

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

The strategy to increase the participation in the antenatal and postnatal community survey were relying on the introduction of a SMS survey response. Due to financial constraints, it has not been possible to pursue this, however a solution has been found via email survey and a trial of this commenced early October 2023. Despite this there has been a noticeable decrease in the numbers of survey responses across all areas. The Maternity team are working closely with the Patient Engagement team and the recently appointed Parent Education and Patient Experience Lead Midwife to resolve this issue.

In addition to the FFT, feedback is gained via our PALS, CQC and Healthwatch surveys. The maternity service has also noted increased volume of feedback received via social media. To note our Maternity and Neonatal Voice Partnership (MNVP) at present does not have a chair, nor enough members to enable its function. The Local Maternity and Neonatal System are responding to this by advertising a lead for the MNVP, system wide, who will then support the return of our MNVP.

In April 2024 the Be Well Bus programme was launched across Suffolk and North East Essex as a one-stop shop to offer health and wellbeing support to women antenatally and postnatally. On-board there is representation from different health, care and community organisations who can offer assistance, guidance, signpost as well as provide health education. In addition to this we are utilising this opportunity to gather service users' feedback to help shape our future service but also to co-produce our action plan in response to the Healthwatch and CQC survey

Two compliments were shared with the patient experience team in May 2024 and three in June 2024 for Maternity Service at WSFT.

In May 2024 one formal complaint was received and none received in June 2024. On review of complaints received during this period the main themes were patient care and communication.

1.5 **Reporting and learning from incidents**

During May and June 2024 there was 0 cases that met the referral criteria to the Maternity and Newborn Safety Investigations (MNSI).

The maternity service is represented at the Local Maternity and Neonatal System (LMNS) monthly safety forum, where incidents, reports and learning are shared across all three maternity units.

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

1.6 **Maternity dashboards**

What?	So What?	What Next?
Increased rate of predominantly 3rd degree tears:	Birth trauma can have a devastating impact on the woman/birthing person and their families. It is a recognised risk of vaginal births. The current standards are for spontaneous vaginal births (SVD) <2.5% and Instrumental births of 6.3%. Physical, psychological, financial implications for the person, family and Trust. Interferes with the precious first hour	Re-launch of Obstetric anal sphincter Injury (OASI) bundle, this includes: 1. Anetnatal education- will increase service users awarness of perineal trauma and action to take to reduce the risk of of it occuraing during birth. 2. Manual perineal protection- effective comminication with the women to encourage a slow and quided birth. 3. Episiotomy if clinically indicated- performated at an angle of 60 degrees from midline at crowning.

	after birth	4. Systematic examination post birth even if the perineum appears intact.

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

June 2024 Staff Group	Saving Babies Lives 1,2,5,6	GAP/GROW	Maternity Emergencies / PROMPT	Skills and Drills	Personalised Care	Safeguarding	Care in labour & Immediate Postnatal	Neonatal Life Support	Fetal Heart Surveillance	FM Case studies
Midwives	95.24%	98.29%	97.62%	97.62%	42.69%	93.5%	48.26%	96.62%	95%	94%
MCA	NA	NA	100%	100%	NA	95.89%	39.02%	NA	NA	NA
Consultant Obstetrician	58.82%	94.1%	94.12%	94.12%	35.29%	100%	47.06%	NA	100%	94%
Obstetric Registrar	20%	100%	100%	100%	0%	82%	10%	NA	100%	100%
SHO/Core trainees	N/A	100%	100%	100%	N/A	95%	N/A	NA	NA	NA
Sonographer	NA	85%	NA	NA	NA	NA	NA	NA	NA	NA
Consultant Obstetric Anaesthetists	NA	NA	93.75%	93.75%	NA	NA	NA	NA	NA	NA
Obstetric Anaesthetists	NA	NA	94.11%	94.11%	NA	NA	NA	NA	NA	NA
Neonatal Consultants	NA	NA	NA	93.75%	NA	94%	NA	100%	NA	NA
Neonatal Nurses	NA	NA	NA	34%	NA	100%	NA	80%	NA	NA
Neonatal Doctors	NA	NA	NA	No data	NA	100%	NA	100%	NA	NA
ANNP	NA	NA	NA	No data	NA	100%	NA	100%	NA	NA

There has been a noticeable improvement in the training compliance during the reporting period, and efforts are still underway to raise the compliance further. Additional training sessions were introduced this year in response to the launch of the Six Core Competency Framework version 2, and although compliance in these areas is improving, it has not yet been graded as it has not been in place for 12 months.
Data collection regarding compliance is not yet robust, but processes have now been put into place to try and resolve this. Due to high levels of sickness in a relatively small team, the neonatal nurses are below target for the neonatal life support, however skills drills have been delivered and those who are non-compliant will be rostered to attend the full-day course at the next opportunity.

2. Reports

Year 6 of the NHS Resolution Maternity Incentive Scheme was launched in April 2024 with ten key Safety Actions to be achieved and maintained by the Maternity and Neonatal Services provided by West Suffolk NHS Foundation Trust.
Whilst there have been some minor changes to the safety requirements for this year in some of the Safety Actions, one of the key changes has been to the processes and pathways for Trust committee and Board oversight.

This has afforded the Trust the opportunity to optimise the reporting structures and assurance processes to ensure that each report has appropriate oversight and approval during this time. Reports to provide assurance in each Safety Action can be monthly, quarterly, six-monthly, annually or as a one-off oversight report at the end of the reporting period for sign-off prior to submission. Many of the reporting processes are embedded into business as usual for the services so are continued out with the Maternity Incentive Scheme (MIS).

	The updated process was agreed at the last Board Meeting (24th May 2024), whereby some reports will be presented and approved by the Board sub-committee, the Improvement Committee. The Improvement Committee will provide an overview and assurances to the Trust Board that reports have been approved and any concerns with safety and quality of care or issues that need escalating. Following reports were presented at the Improvement Committee held on the 16th of July 2024: • Maternity Incentive Scheme (MIS) Safety Action 5, Bi-Annual Report on Midwifery Workforce • Maternity Incentive Scheme (MIS) Safety Action 4a Obstetric Workforce Report • Maternity Claims Scorecard, incident, and complaint data Quarterly Review
3.	**Next steps**
3.1	Reports will be shared with the external stakeholders as required. Action plans will be monitored and updated accordingly.

4.4. Audit Committee Report

To Assure

Presented by Jude Chin

Trust Board of Directors	
Report title:	**Chair's Key Issues (CKI) report for Audit Committee**
Agenda item:	4.4
Date of the meeting:	26 July 2024
Sponsor/executive lead:	Craig Black, Executive Director of Resources
Report prepared by:	Liana Nicholson, Assistant Director of Finance

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

Executive summary:	The report highlights the key issues that emerged from the Audit Committee meeting held on 20 and 25 June 2024. An Extraordinary Audit Committee was held on 20 June to approve the 2023/24 Annual Report and Accounts. This was set to ensure that the Deputy Director of Finance could attend in the absence of the Director of Resources. The Annual Report and Accounts were recommended for approval by the Trust Board. Continued positive progress on implementing Internal Audit recommendations. Good progress with the Internal Audit Plan for 2024/25.
Action required/ recommendation:	None.

Board Assurance Committee CKI Report - Audit Committee (20/06/24 and 25/06/24)

Agenda Item	Details	Level of Assurance* 1. Substantial 2. Reasonable 3. Partial 4. Minimal	Comments	Action / Escalation
External Audit (KPMG)	Received KPMG's Report to those charged with Governance (ISA260) and Annual Audit Report	Substantial	Audit nearing completion and on track to meet the deadline. KPMG noted that there was just one unadjusted audit error, otherwise a very clean position with no other issues or amendments to the draft accounts. KPMG did not note any significant findings in relation to their VFM work.	
Annual Report and Accounts 2023/24	Approved the 2023/24 Annual Report and Accounts	Substantial	Both the Annual Report and Accounts were recommended for approval by the Trust Board.	Trust Board
Internal Audit (RSM)	Head of Internal Audit Opinion 2023/24	Reasonable	Head of Internal Audit opinion issued, noting an 'adequate and effective framework' being in place. Noting that any Internal Audit Reports issued with a 'partial assurance' opinion have been highlighted in the AGS.	
Internal Audit (RSM)	Update on delivery of internal audit plan and implementation of recommendations	Reasonable	Noted that the 2023/24 audit plan was now fully complete and all reports have been issued. Continuing good progress with 2024/25 audit plan. Positive progress with implementation outstanding audit actions, although more work to continue in this area.	Executive

Agenda Item	Details	Level of Assurance* 1. Substantial 2. Reasonable 3. Partial 4. Minimal	Comments	Action / Escalation
LCFS (RSM)	LCFS Annual Report 2023/24		Noted that the Counter Fraud functional standard return had been submitted and the Trust was awarded an overall rating of 'green'. The LCFS annual benchmarking report has been issued and will be presented at the next Audit Committee.	Audit Committee
Losses & special payments	Summary of losses and special payments made in 2023/24	Reasonable	A high level report on the key areas where losses and special payments had occurred during 2023/24, noting that pharmacy stock losses (for expired and damaged drugs) was the highest area. Also noted that a large late payment fee was incurred by the Trust due to processes not being adhered to and the expenditure for an IT contract being incurred without a purchase order. This particular area of focus will be picked up as part of the key controls audit performed by RSM.	Audit Committee
Waivers	Annual review of waivers issued in 2023/24	Reasonable	A total of 28 waivers were issued during 2023/24, totalling £2.3m. This was slightly lower than the prior year.	

Assurance level

1. Substantial	Taking account of the issues identified, the board can take substantial assurance that this issue/risk is being controlled effectively. There is substantial confidence that any improvement actions will be delivered.

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

5. GOVERNANCE

5.1. Board Assurance Framework

To Assure

Presented by Richard Jones

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

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

Executive Summary

WHAT?

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

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

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

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

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

All of the BAF risk assessments have either recently been reviewed and updated. The Management Executive Group (MEG) now undertake scheduled reviews of the individual risks within the BAF, this supports reporting into the Board assurance committees.

The following **summarises changes since the last report**:

- **BAF 1 Capability** - reviewed by the executive to update the risk scores and the assurances. The risk is still being reviewed and will be presented and signed off at the People and Culture leadership group prior to reporting to the Involvement Committee
- **BAF 2 Capacity** - reviewed by the executive to update the risk scores, the assurances and the actions. The risk needs to be presented and signed off at the next Patient Access Governance Group prior to reporting to the Insight Committee
- **BAF 3 Collaboration** - reviewed by the executive to update the risk scores, causes and effects, the risk assurance and the risk actions. The risk will need to be presented and signed off at Involvement Committee
- **BAF 5 Digital** – reviewed by the CIO and the Deputy CIO to review and update the risk scores, causes and effects, the risk assurance and the risk actions. The risk will be presented at the Digital Board
- **BAF 6 Estates** - reviewed by the ADO to update the risk scores, cause and effects, the risk assurances and the risk actions. The risk will need to be signed off by the executive before forward reporting to the relevant committee
- **BAF 7 Finance** – being reviewed by the Deputy Finance Director to update the risk score in light of current financial position and findings of the financial diagnostic review
- **BAF 9 Patient engagement** - reviewed by the Head of Patient Experience & Engagement to update the cause and effects, the risk assurances and the actions. This is still work in progress and will need to be signed off by the Executive prior to reporting to the Involvement Committee.

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

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

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

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

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

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

- **Review by the responsible Board committee** to include:
  - MEG review of risks on scheduled basis
  - Review through relevant Board assurance committees to consider assurance on controls and actions (including reflection on the defined **risk appetite).**

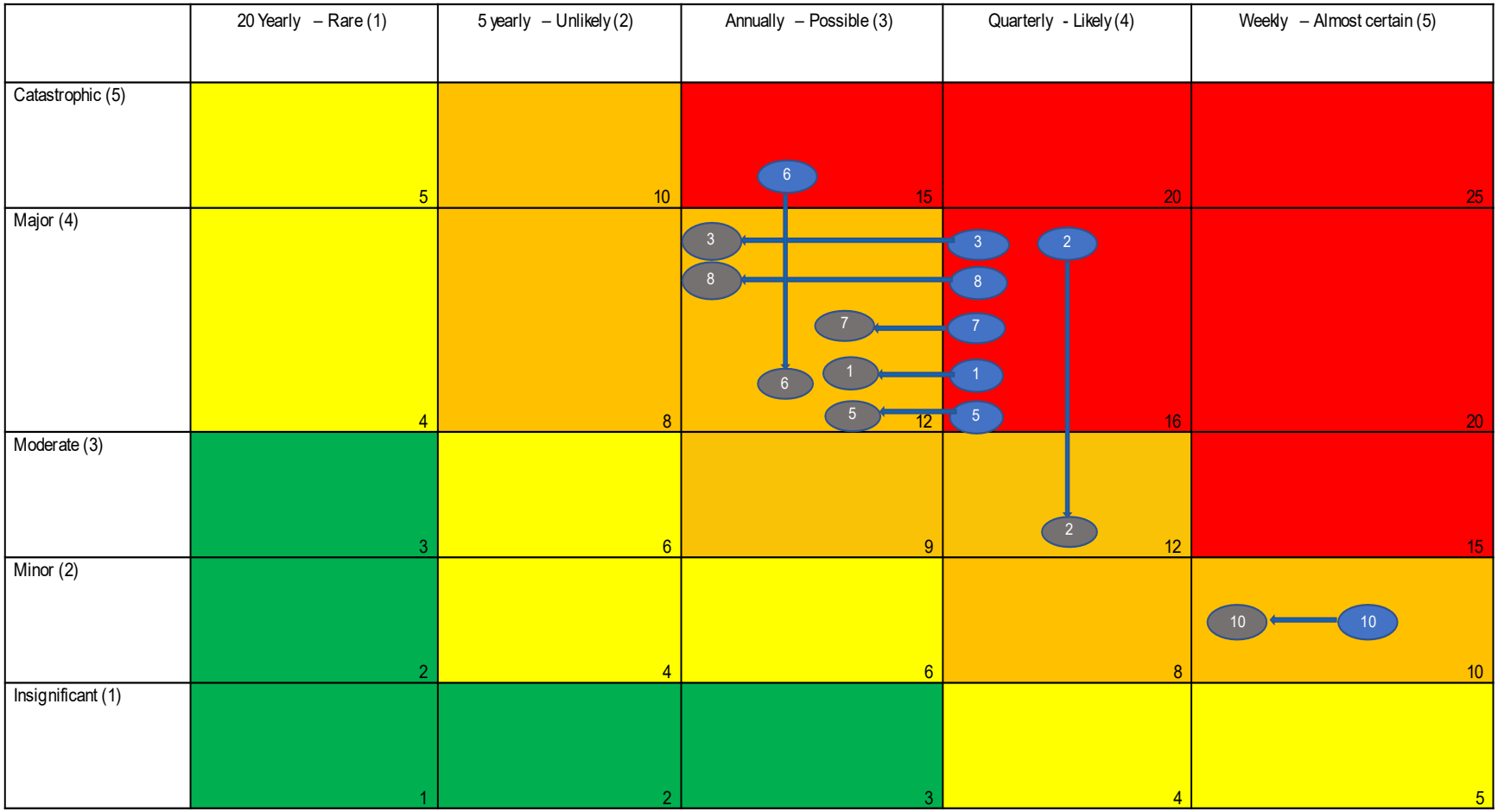
Action Required

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

Previously considered by:	The Board of Directors

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

Annex A: BAF risk movement



Current residual — Future

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

Annex B: Risk themes – summary table

Risk Descriptions	Exec lead	Board comm.	Assurance Committee review	Appetite Level and score	Current risk score	Target risk score	Within risk appetite?	Assur. level
BAF 1 Fail to ensure the Trust has the capability and skills to deliver the highest quality, safe and effective services that provide the best possible outcomes and experience (Inc developing our current and future staff)	HR&C	Involvement	May 24	Cautious (9)	16	12	No	Adequate
BAF 2 The Trust fails to ensure that the health and care system has the capacity to respond to the changing and increasing needs of our communities	COO	Insight	Jul '24	Cautious (9)	20	12	No	Partial
BAF 3 The Trust fails to work effectively with our partners to ensure the greatest possible contribution to preventing ill health, increasing wellbeing and reducing health inequalities	DoI	Involvement		Open (12)	16	8	No	Partial
BAF 4 [1] Fail to ensure the Trust continuously seeks to improve, learn, and transform the way we work, to guarantee that Trust activities can safely and sustainably deliver for our patients, our staff and for the future	COO	Improvement		Open (12)	tbc	tbc	tbc	tbc
BAF 5 [1] Fail to ensure the Trust implements secure, cost effective and innovative approaches that advance our digital and technological capabilities to better support the health and wellbeing of our communities	DoR	Improvement		Cautious (9)	16	12	No	Partial
BAF 6 [2] Fail to ensure the Trust estates are safe, fit for purpose while maintained to the best possible standard so that everyone has a comfortable environment to be cared for and work in today and for the future	DoR	Trust Board		Open (12)	15	12	Yes	Reasonable
BAF 7 Fail to ensure we manage our finances effectively to guarantee the long-term sustainability of the Trust and secure the delivery of our vision, ambitions, and values	DoR	Insight	Jun '24	Cautious (9)	16	12	No	Reasonable
BAF 8 Fail to ensure the Trust has the appropriate governance structures, principles and behaviours to help us safely deliver the best quality and safest care for our local population (our vision) and ambitions (for patients, staff and the future) in the right way	ECN	Improvement	Jul '24	Minimal (6)	16	8	No	Partial

Risk Descriptions	Exec lead	Board comm.	Assurance Committee review	Appetite Level and score	Current risk score	Target risk score	Within risk appetite?	Assur. level
BAF 9 [1] Fail to effectively engage and communicate with our patients and the public, reducing inequality and responding to the needs of our communities	ECN	Involvement		Cautious (9)	tbc	tbc	tbc	tbc
BAF 10 [1] Fail to ensure the Trust can effectively support, protect and improve the health, wellbeing and safety of our staff	HR&C	Involvement		Cautious (9)	10	10	No	Reasonable

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

5.2. Governance Report

For Approval

Presented by Richard Jones

WSFT Board of Directors (Open)	
Report title:	**Governance report**
Agenda item:	5.2
Date of the meeting:	26 July 2024
Sponsor/executive lead:	Richard Jones, Trust Secretary
Report prepared by:	Richard Jones, Trust Secretary Pooja Sharma, Deputy Trust Secretary

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

Executive Summary

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

This report summarises the main governance headlines for July 2024, as follows:

- Senior Leadership Team report
- Management Executive Group
- Council of Governors report – NED recruitment
- Proposal for timing the board committee annual effectiveness reviews
- Terms of reference – Remuneration and Nomination Committee
- Annual report and accounts 2023-24, including quality accounts and self-certification
- Use of Trust's seal
- Agenda items for next meeting

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

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

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

The items reported through this report will be actioned through the appropriate routes.

ACTION REQUIRED

The Board is asked to note the report and approve:

- Note receipt of the report
- Approve the recommendation from MEG to cease commercial personal accident insurance for staff during patient transfers as now confirmed by NHS Resolution that this is covered under existing Employers Liability Scheme
- Approve the terms of reference of Board Remuneration and Nomination Committee
- Agreeing proposal for structuring the annual board-committee effectiveness reviews

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

Governance Report

1. Senior Leadership Team report

The Senior Leadership Team meeting in July delivered its leadership role in shaping strategy and culture with a focus on "Recognising bias, understanding Privilege and becoming a proactive ally". Group work was undertaken to support engagement and help shape the organisational approach.

An update was also provided on the financial position and the measures being put in place to support the organisational response.

2. Management Executive Group

The Management Executive Group is established as the most senior executive forum within the Trust. Meeting takes place three times in a monthly, including corporate performance review meetings.

MEG approved the recommendation to cease commercial personal accident insurance for staff during patient transfers as now confirmed by NHS Resolution that this is covered under existing Employers Liability Scheme. As insurance is one of the matters reserved for the Board (SFI 23) so the Board are asked to approve this recommendation.

3. Council of Governors report

The Council of Governors met on 26 June 2024 to approve the appointment of new non-executive directors. The interviews were held on 18 June and 21 June 2024 to appoint up to five NEDs, (three, plus up to two associate NEDs) and a number of candidates were agreed by the interview panel for recommendation to the Council.

At present, the Board has two NED vacancies with a further vacancy arising at the end of Louisa Pepper's term (31 August 2024). Heather Hancock, Richard Flatman and Alison Wigg were appointed to take up these vacancies.

The two remaining candidates David Weaver and Paul Zollinger-Read were appointed as Associate NEDs. These will operate with full NED responsibilities as non-voting members of the Board and will be appointed to future NED vacancies.

Based on the approval of the Council, steps are taken to support onboarding of the successful candidates, including completion of appropriate fit and proper person checks and consideration of start dates. The Chair is reviewing specific individual responsibilities (e.g. committee chair roles; guardian/lead roles) across the full cohort of non-executives directors.

4. Proposal for structuring the annual board-committee effectiveness reviews

For some time, the Board has had a structure in place so that board assurance committees self-assess and evaluate their effectiveness annually. The timing of these assessments has been varied and feedback has been that it would be more streamlined to undertake this work across all Board committees in a single period. While this will mean that individuals who are members of multiple committees will receive multiple self-assessment questionnaires to complete this will be undertaken in a structured way to allow time for these assessments:

- **May** - circulation of review templates to the committee members and regular attendees
- **June** - collate responses and analyse to draft annual effectiveness review reports
- **July/August** - presentation of reports at relevant committee
- **September** - report to the Board highlighting areas of focus and improvement actions

The Board is asked to approve the recommendation to move to the new self-assessment cycle.

5. Terms of reference - Board Remuneration and Nomination Committee

As part of the periodical review, the terms of reference for Board Remuneration and Nomination Committee were reviewed by the committee members. No changes were noted to the terms of reference and were approved by the Committee Chair (via chair's action).

The Board is asked to approve the Board Remuneration and Nomination Committee terms of reference (Supporting annexes Annex A).

6. Annual report and accounts 2023-24, including quality accounts and self-certification

As outlined in the report from the audit committee, recommendation was made for approval of the annual report and accounts and reports from the auditors. Following completion and reporting of all testing by the external auditors these documents were approved by the Board on 25 June 2024 and submitted to NHSE within national requirements.

Prior to making public the annual report and accounts the Trust is legally required to lay the document before Parliament. This took place on 19 July 2024.

The annual report and accounts and quality accounts are available on the Trust's website via:

https://www.wsh.nhs.uk/Corporate-information/Information-we-publish/Annual-reports.aspx

NHS England has two self-certification requirements which follow a similar structure and content to previous years and sit alongside the general condition 6 certificate. These were approved by the Board as part of the annual report approval arrangements on 25 June.

The Board is required to report its approval of the annual statements and certifications at a public meeting. The full certificates are available on our website via the link below:

NHSE Self-Certification 2023-24 (wsh.nhs.uk)

7. Use of Trust Seal

None to report.

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

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

6. OTHER ITEMS

Presented by Jude Chin

6.1. Any other business

To Note

Presented by Jude Chin

6.2. Reflections on meeting

For Discussion

Presented by Jude Chin

6.3. Date of next meeting - 27th September, 2024

Annual Members Meeting - 24 September 2024

To Note

Presented by Jude Chin

RESOLUTION

The Trust Board is invited to adopt the following resolution:

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

SUPPORTING ANNEXES

Presented by Jude Chin

IQPR Full Report

To Note

Presented by Nicola Cottington

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May 2024 IQPR and Patient Access Governance Group Report

Report to Insight Committee

Putting you first

Exceptions reported via the May 2024 IQPR

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Assurance Grid

March 2024		ASSURANCE: Pass	Hit and Miss	Fail (Not Met)
VARIANCE	Special Cause Improvement		**INVOLVEMENT** Staff Sickness – Rolling 12months Staff Sickness Mandatory Training	**INSIGHT** Virtual Ward Total average occupancy number Incomplete 104 Day Waits RTT 78+ Week Waits **INVOLVEMENT** Appraisal Turnover
VARIANCE	Common Cause	**INSIGHT** Urgent 2 hour response	Please see box to right	**INSIGHT** 12 Hour Breaches Respiratory Bay average occupancy number Heart Failure Bay average occupancy number IV Abx Bay average occupancy number Frailty Bay average occupancy number Diagnostic Performance - % within 6weeks Total
Deteriorating	Special Cause Concern		**INSIGHT** Paediatric RTT Overall 78 Weeks Wait	

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

INSIGHT:
Ambulance Handover within 30min
Non-admitted 4 hour performance
12 hour breaches as a percentage or attendances
% patients with no criteria to reside
Virtual Ward Total average occupancy percentage
Virtual Ward Total average LOS per patient
28 Day Faster Diagnosis
Cancer 62 Days Performance
Paediatric RTT Overall 104 Weeks Wait
IMPROVEMENT:
INVOLVEMENT:
Overdue Responses

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

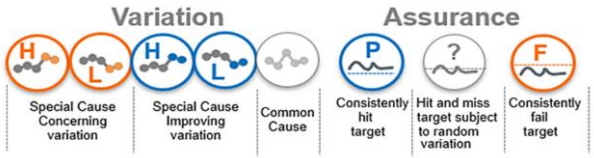
- Urgent appointments within 48 hours
- Routine appointments within 2 weeks
- Increase the % of patients with hypertension treated to NICE guidelines to 77% by March 2024
- Increase the % of patients aged 25-84 years old with a CVD risk score of >20% on lipid lowering therapies to 60%

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

*Cancer data is 1 month behind

Items for escalation based on those indicators that are failing the target, or are worsening and therefore showing Special Cause of Concerning Nature by area:
INSIGHT - Urgent & Emergency Care: 12 Hour Breaches, Virtual Ward Total average occupancy number, Respiratory Bay average occupancy number, Heart Failure Bay average occupancy number, IV Abx Bay average occupancy number, Frailty Bay average occupancy number
Cancer: Incomplete 104 Day Waits
Elective: Diagnostic Performance - % within 6weeks Total, Paediatric RTT Overall 78 Weeks Wait
INVOLVEMENT – Well Led: Appraisal, Turnover

Urgent and Emergency Care indicators



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KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Ambulance Handover within 30min	May 24	84.2%	95.0%			78.1%	52.0%	104.2%
12 Hour Breaches	May 24	743	0		F	712	137	1287
4 hour breaches	May 24	2827	0					
4 hour performance	May 24	67.7%	78.0%					
Non-admitted 4 hour performance	May 24	77.3%	80.0%			75.1%	61.4%	88.7%
12 hour breaches as a percentage of attendances	May 24	8.6%	2.0%			5.1%	1.0%	9.1%
Urgent 2 hour response	May 24	90.2%	70.0%		P	90.2%	82.5%	97.8%
Criteria to reside (Average without reason to reside) Acute	May 24	44	-			58	44	73
**Criteria to reside (Average without reason to reside) Community	May 24	19	-			18	13	22
% patients with no criteria to reside	May 24	10.9%	10.0%			13.5%	9.2%	17.9%
Adult G&A Beds Open Vs Plan	May 24	451	463					
Virtual Beds Trajectory	May 24	40	40					
Total average occupancy number	May 24	34.5	80.0			22.7	14.2	31.2
Total average occupancy percentage	May 24	84%	80%			72%	42%	101%
Total bed days on VW	May 24	959	-			594	307	882
Total average LOS per patient	May 24	13.0	14.0			9.9	4.1	15.8
Respiratory Bay average occupancy number	May 24	2.6	8.0			2.9	-0.9	6.8
Heart Failure Bay average occupancy number	May 24	8.2	12.0			5.3	1.7	8.9
IV Abx Bay average occupancy number	May 24	4.2	6.4			2.5	-0.6	5.7
Frailty Bay average occupancy number	May 24	3.3	16.0			2.7	-0.9	6.4

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

Ambulance Handovers within 30 min and non-admitted 4-hour performance are not reliably hitting target, 12-hour breaches are failing with common cause variation

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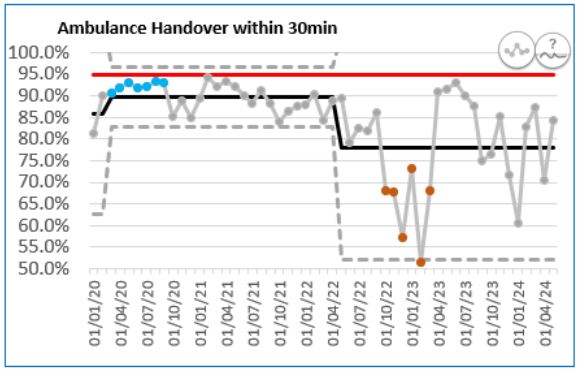

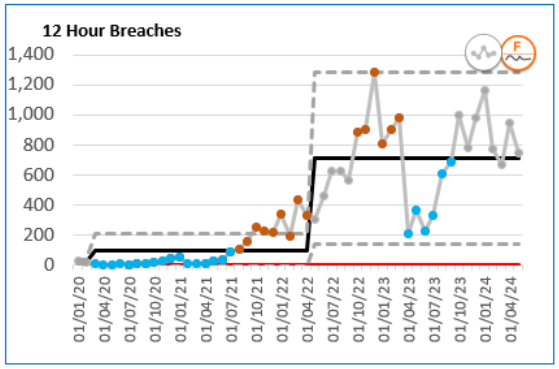

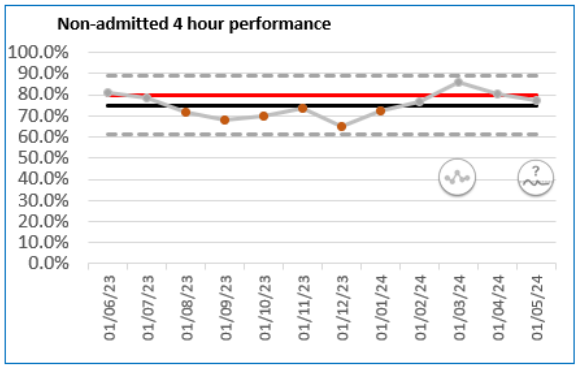

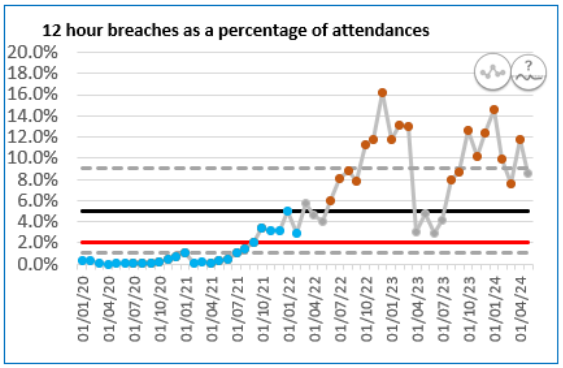

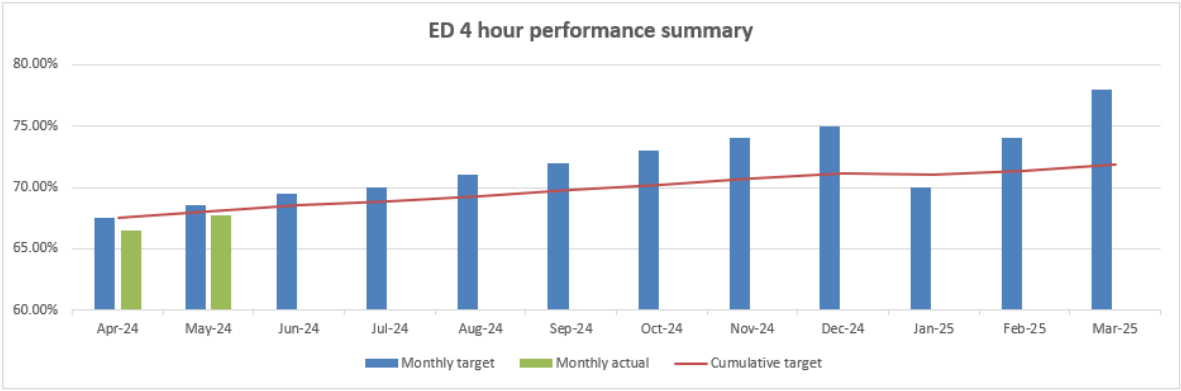

Actions are focussed on clinical leadership alongside improvement projects to deliver our UEC trajectory, including a Minor Emergency Care Unit

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What	So What?	What Next?
Ambulance performance continues to show no significant change, although there is a 15% improvement on the month of April. Achievement of the metrics remains challenging with contributing factors including overcrowding within the Emergency Department (ED) by patients with an increased length of stay, resulting in the need to cohort patients into escalation areas including Rapid Assessment Triage Area (RAT), which reduces our ability and capacity to offload ambulances. The number of 12 hour breaches in the month of May demonstrates no significant change. The number of 12 hour breaches as a percentage of attendances shows no significant change. Although no significant change is demonstrated with non-admitted performance, there was a slight drop when compared with April, however, admitted performance saw an improvement of 6% to 31.63% when compared to April. 4 hour performance was 67.71%, although this was 0.79% off trajectory (68.5%).	Meeting the Urgent and Emergency Care (UEC) performance metrics is key to ensuring that our patients receive timely, safe care. Achieving the ambulance handover metrics and the 78% 4 hour ED standard will meet the national targets.	Revised UEC action plan developed with trajectory to achieve 78% 4hr ED target by March '25. Internal UEC delivery group with workstream leads to commence – meeting 21/06/24. ED Tri to Divisional Tri weekly performance meetings with associated action plan. Robust data and clinical review for periods of reduced performance to obtain learning to improve performance. Focussed work for improving overnight ED performance including: • Template guidance for EPIC to ERIC handover with clear actions for night • Focused leadership training for Registrars overnight to be included within study sessions • Support from OD team in developing leadership skills in senior team • Review of current shift patterns Implementation of projects to commence in July '24 • Pre booked next day returner ENP slots – support minor injuries attending after 10pm • Rapid Assessment for non admitted patients – consultant based at point of streaming/triage to assess & discharge or redirect to other services i.e. SDEC between 3-6pm As from July new rota for ED leadership team to be solely based in ED supporting performance. AAU also have similar rota. Divisional senior management support placed in ED for last two weeks of June to support need for improved performance Planning for MECU continues – currently awaiting fire testing to be completed for outer walls expecting initial report 11th July. Implementation date for MECU likely end August '24

The % patients not meeting the criteria to reside is not reliably hitting target, with five improvement workstreams identified

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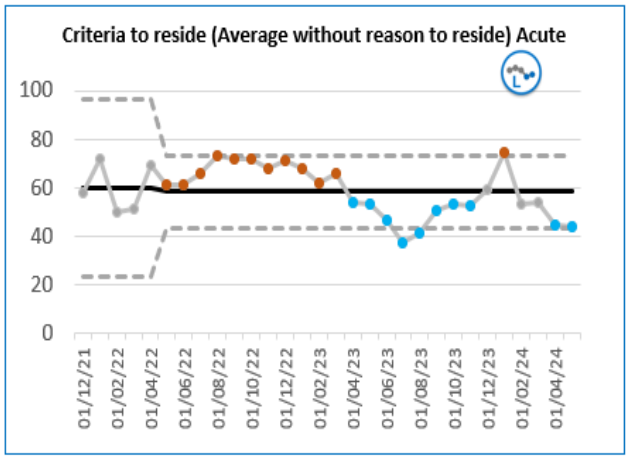

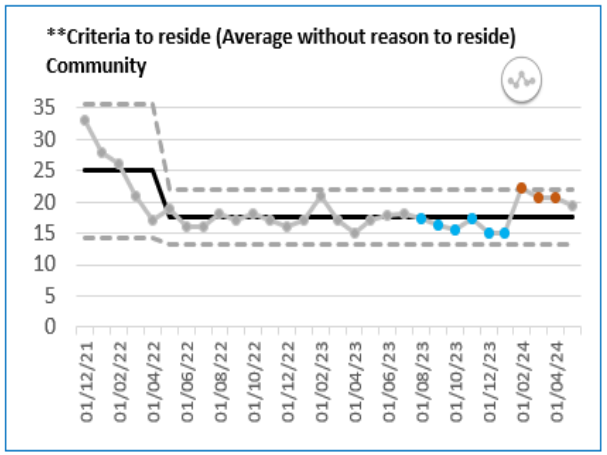

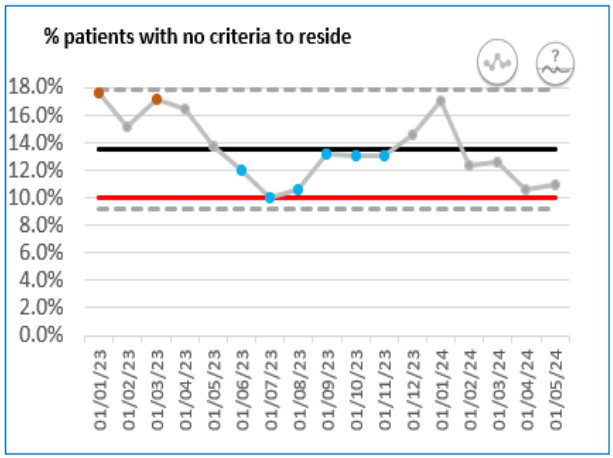

What

There is no significant improvement yet in the number of acute patients with no criteria to reside, although we expect the existing projects to demonstrate this in the new 3 months. There is a deteriorating trend in the number of patients in community bedded settings who do not meet the criteria to reside, partly driven by these beds being used differently, meaning that some patients arrive without criteria to reside because they are awaiting care or another placement".

This change in Community Assessment Bed (CAB) usage does not appear to have directly impacted overall Length of Stay (LOS), and in May we have seen the largest number of admission and discharges to and from our CAB's than in the preceding 12 months.

So What?

Patients remaining in hospital longer without Criteria to reside directly impacts on bed capacity and patient flow within the Trust. Increase numbers of vacancies within CAB bed bases gives flexibility to support patient flow, however this has led to a change within the cohort of patients in CAB, which has subsequently increased numbers of patients in CAB's with no criteria to reside. This is expected to continue as we continue to encourage the use of Pathway1(P1) discharge routes and getting patients back to their own environments.

What Next?

There have been 5 priority workstreams agreed to take forward, with the overall aim of reducing patients remaining in hospital without criteria to reside. These are in brief below, timescales for all actions will be discussed at the Divisional programme board on the 16th of July :

1.Therapy acute – reduction in length of time between No Criteria to Reside and referral for discharge pathway
2.P1 – improve utilisation of available P1 therapy assessment slots Tuesday – Saturday
3.CAB – reduction in time between discharge from therapy and final discharge (for traditional CAB patients)
4.Future modelling of D2A beds and CAB – to improve our overall Pathway 2 offer (P2)
5.Out of County (OOC) – work towards a reduction of delays for OOC pathways, however specifically looking at Norfolk and Waveney.

2-hour Urgent Community Response standard is being consistently met, though staffing and acuity have been noted as challenging in-month

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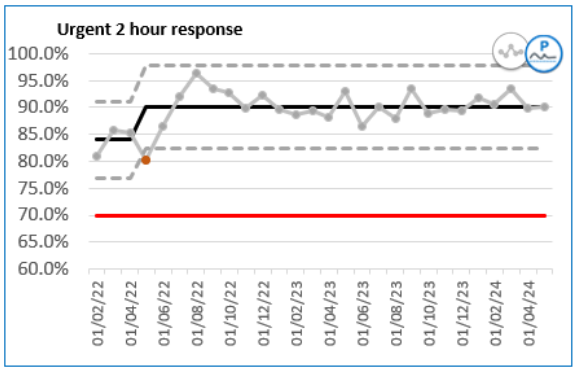

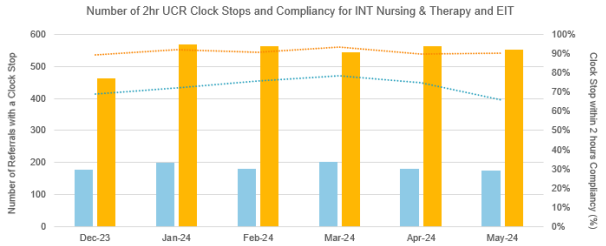

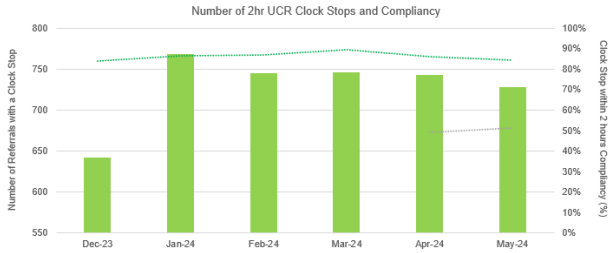

Team	Dec-23				Jan-24				Feb-24				Mar-24				Apr-24				May-24			
	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant	Total referrals with a RTT clock stop	Compliant	Breaches	% Compliant
Total INT Nursing & Therapy	177	123	54	69%	199	143	56	72%	180	136	44	76%	201	158	43	79%	179	134	45	75%	175	115	60	66%
Total EIT*	464	415	49	89.44%	569	522	46	91.90%	564	511	53	90.60%	545	509	36	93.39%	563	506	57	89.88%	552	498	54	90.22%
Combined Total	641	538	103	83.93%	768	665	102	86.59%	744	647	97	86.96%	746	667	79	89.41%	742	640	102	86.25%	727	613	114	84.32%

*Using CSDS figures

What	So What?	What Next?
2-hour Integrated Neighbourhood Team(INT) response has reduced from 75% to 66% Overall joint compliance is achieved at 84.32%	The reduction in 2-hour nursing response compliance indicates capacity is challenged; sickness remains at 5%, INT use of temporary staffing is being monitored, teams have reported higher acuity patients in teams for example the number of patients requiring multiple syringe drivers	Clinicians to be reminded to report capacity concerns / reasons for breaches that have potential for patient harm to be reported via RADAR and reports to be reviewed for themes via Community Clinical Governance Steering group on monthly basis

Virtual Ward occupancy exceeded target in May but is not being reliably met, with plans to increase in June through a nursing home onboarding pilot

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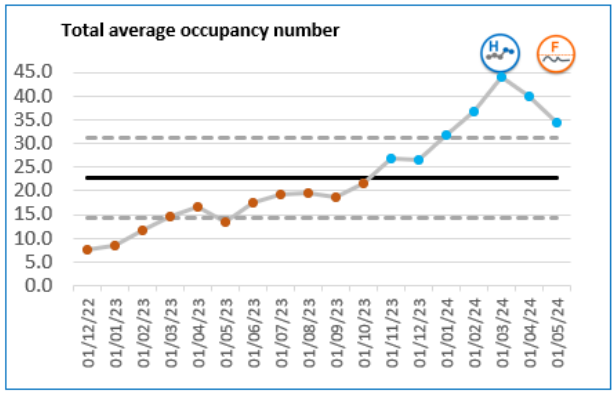

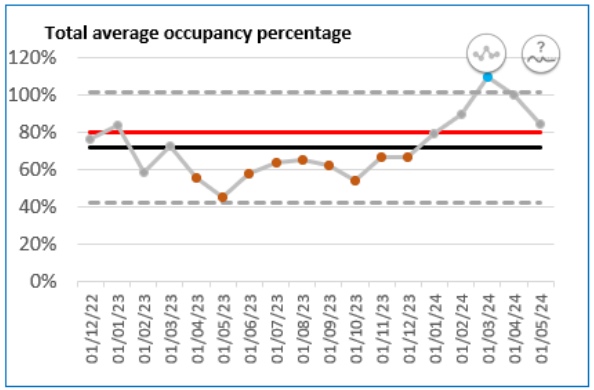

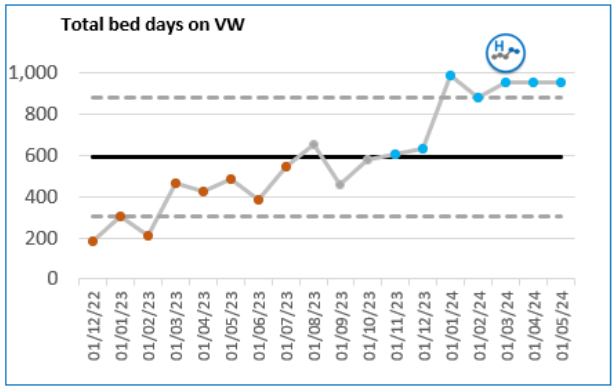

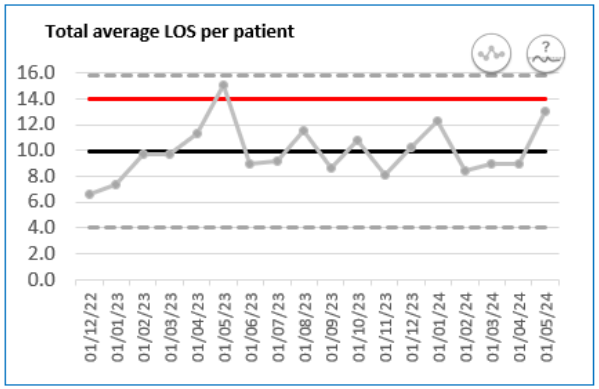

What	So What?	What Next?
Average number of patients cared for on Virtual Ward (VW) decreased slightly during May (compared to April) with no identified reason. However, occupancy target of 80% was achieved. Capacity is currently 40 patients excluding COPD Admission Avoidance (AA) (50 patients inclusive of COPD AA).	Virtual Ward capacity is crucial in ensuring adequate capacity to enable patient flow in West Suffolk and strategic ambition of caring for patients at or near home wherever possible. Appropriate length of stay is important to facilitate effective patient flow across Trust.	Capacity trajectory and occupancy targets for 2024/25 agreed. Pilot to assess and onboard patients in nursing homes direct to VW commenced on 11 June 2024 as planned. Test & learn in Mildenhall & Brandon locality underway to develop integrated service delivery model. Wider rollout plan agreed. Length of Stay (LOS) audit completed showing that 82% of long stay patients are due to clinical need. Recommendations to avoid delays in discharge being reviewed at VW governance meeting on 24 June 2024

Virtual Ward respiratory and IV Abx occupancy is below trajectory, with criteria expanded in response

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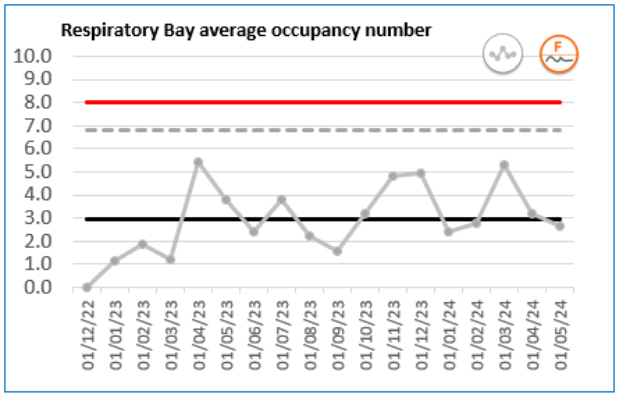
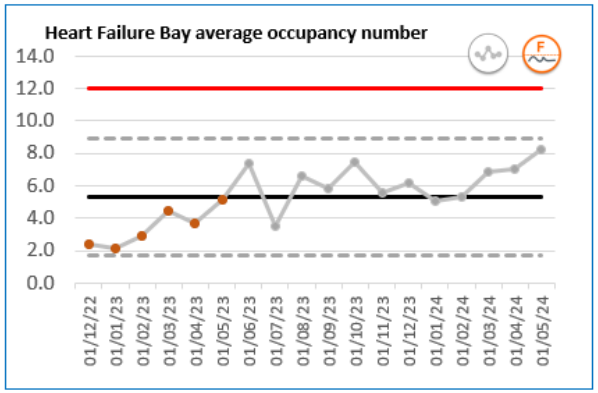
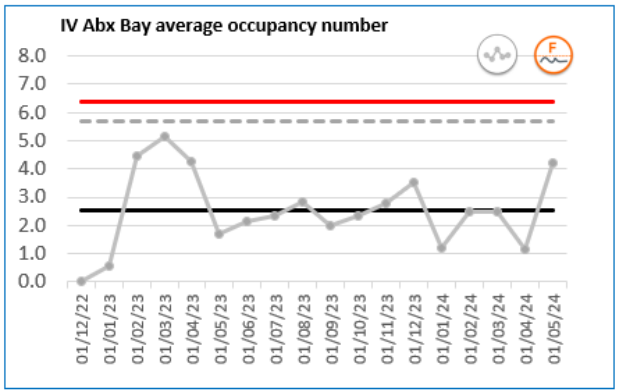
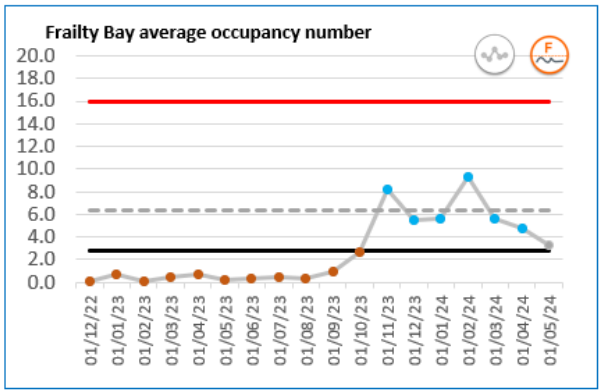


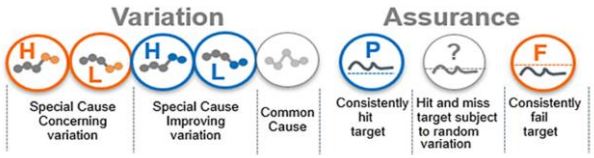






What	So What?	What Next?
Occupancy on respiratory pathway is significantly under target. Consultants for VW/respiratory have completed review of pathway and agreed expansion of criteria to increase utilisation. Occupancy on frailty pathway was under target this month. Occupancy on the heart failure and Intra Venous (IV) Antibiotic (Abx) pathways are on track to achieve agreed trajectory.	Targets are in place to ensure that the capacity created on the Virtual Ward is fully utilised, maximising capacity for acuity unwell patients and enabling patients to be cared for at or near home.	Resp: implement agreed changes to pathway and staffing model. Heart failure: pathway recently reviewed. Actions agreed to improve pathway for 'step up' referrals. IV ABx: pathway review underway to expand patient cohorts. Approach to be agreed by 15 July 2024. To consider community delivery of IVs and expansion of pathway to oral ABx. Frailty: pilot to assess and onboard patients in nursing homes direct to this pathway now underway.

Cancer, elective and diagnostic access standards indicators



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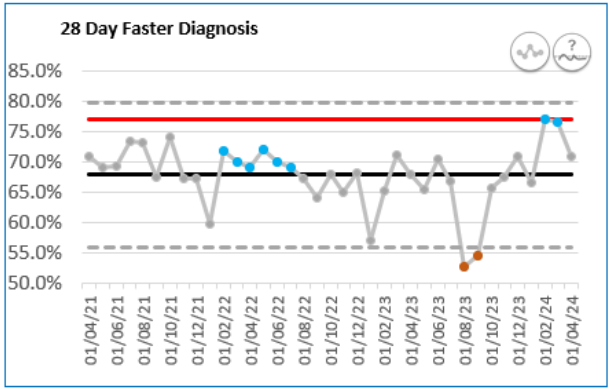
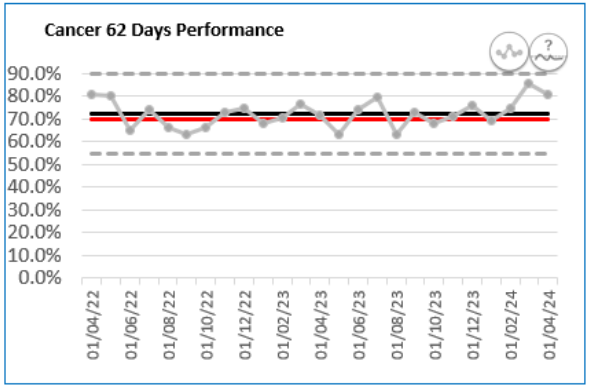
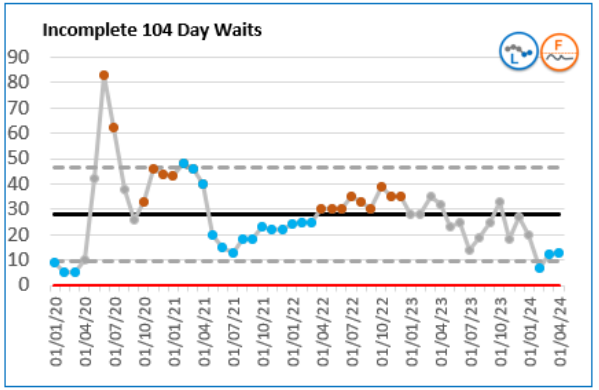
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
28 Day Faster Diagnosis	Apr 24	70.8%	77.0%			67.9%	56.0%	79.8%
Cancer 62 Days Performance	Apr 24	80.8%	70.0%			72.4%	55.0%	89.7%
Incomplete 104 Day Waits	Apr 24	13	0			28	10	46
Diagnostic Performance- % within 6weeks Total	May 24	63.9%	99.0%			62.2%	53.6%	70.9%
RTT Waiting List	May 24	35141				32578	31149	34007
RTT 65+ Week Waits	May 24	476				503	322	684
RTT 78+ Week Waits	May 24	62	0			171	95	247
Potential 65+ ww at end of Sept 2024	May 24	2664	0					
Community Paediatrics RTT Overall Waiting List	May 24	474	-			502	450	554
Community Paediatrics RTT Overall 52 Weeks Wait	May 24	1	-			1	-2	4
Community Paediatrics RTT Overall 65 Weeks Wait	May 24	1	-			0	0	0
Community Paediatrics RTT Overall 78 Weeks Wait	May 24	1	0			0	0	0
RTT NDD Only Waiting List	May 24	88	-			90	82	97
RTT NDD Only 52 Weeks Wait	May 24	0	-			0	0	0
RTT NDD Only 65 Weeks Wait	May 24	1	-			1	1	1
RTT NDD Only 78 Weeks Wait	May 24	1	-			1	-2	3
RTT NDD Only 104 Weeks Wait	May 24	0	-			0	0	0

Cancer FDS performance has dropped and is not consistently met, with actions focussed on the skin and lower GI pathways

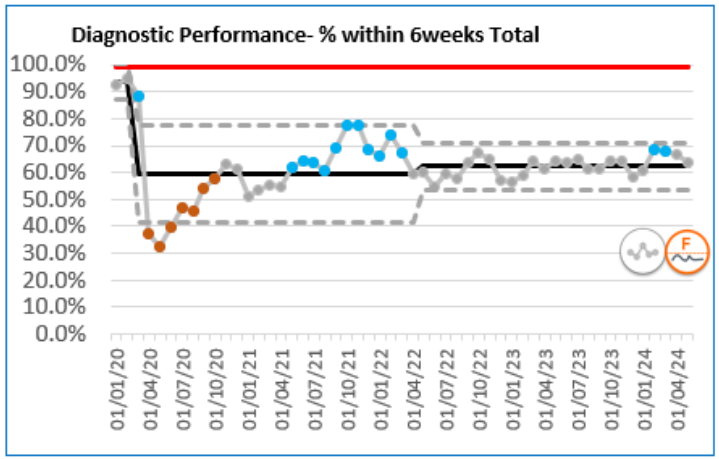






What	So What?	What Next?
Performance against the 28-day Faster Diagnosis Standard (FDS) is not being consistently met, however the standard was met in February 2024 and March 2024 above 75%, there has been a drop to 70.8% in April due to challenges in Lower GI investigations and delays with photography and review in Skin. The 62 day performance is at 80.8%, which is above the national ambition of 70% performance by the end of March 2025.	Achieving the FDS target of 77% and a 62-day performance of 70% March 2025 are the key objectives for cancer in 2024/25 planning.	Continue FDS steering groups in Gynaecology, Breast, Colorectal and Skin as the focus areas. We will continue to monitor these actions and re-audit against the BPTP for improvements. Specific actions that are still live include: • Review the current community pathway for Skin AI, with a view to reducing the demand this is placing on secondary care, initial meeting 26/06/24. • Continuation of insourced Dermatology activity to be presented to MEG on the 03/07/2024. • Implement the cancer alliance priorities, with specific focus on Gynaecology HRT and Urology re-stratification in line with national objective by Q3.

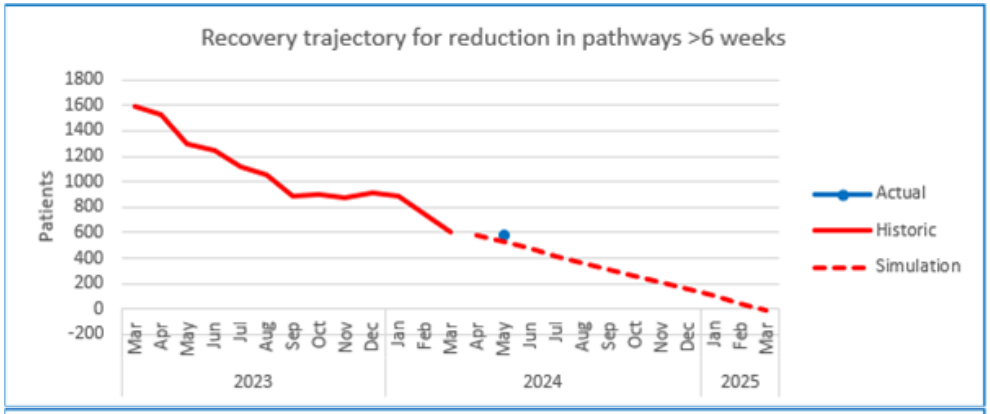
The current focus of recovery against the DM01 diagnostic standard is endoscopy

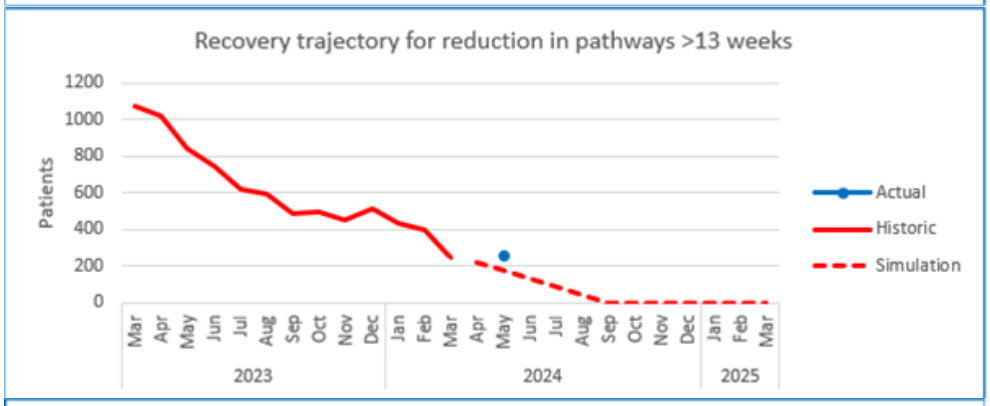


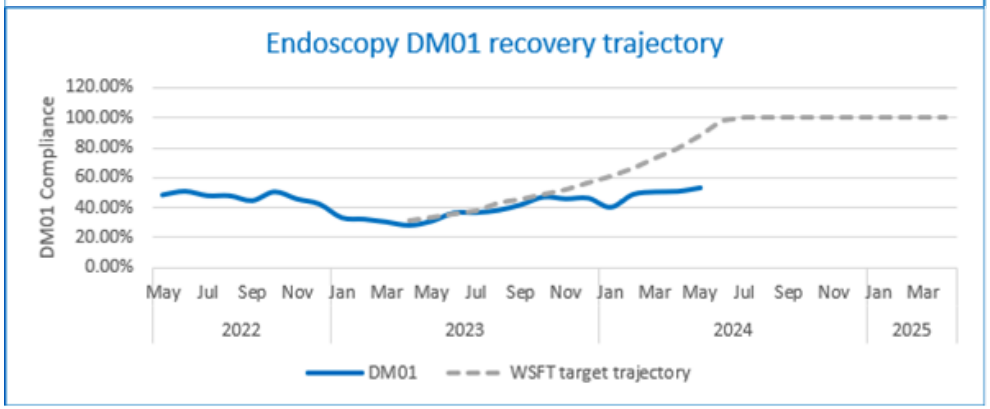
West Suffolk NHS Foundation Trust

What	So What?	What Next?
MRI – Common cause consistently failing target. Running at full capacity across the seven days but current capacity insufficient. MRI 2 replacement programme commenced 27/11/2023 – temporary mobile capacity in place to mitigate. Programme delays due to unforeseen ground works, completion date 22/06/24. **CT** – Currently not meeting DM01 compliance target due to replacement programme but expected to return to full compliance now this has been completed. DM01 has been impacted by increased 28-day FDS demand resulting in a slower recovery than anticipated and increased inpatient and ED demand. **US** – A step increase in the recovery trajectory can be observed but has plateaued and remains statistically insignificant. Increased inpatient and ED demand. **Endoscopy** – Priority has been given to patients on a cancer pathway requiring a rebalancing of capacity to support. Performance at risk from further IA. Cohort of low complexity, low risk patients suitable for outsourcing and nurse endoscopists (NE) has been exhausted with limited scope for flexing of the criteria with outsourced provider. This has led to a compound effect and a plateauing of DM01 performance. However, consistent reductions in the number of patients waiting over 13 weeks and 6 weeks can be demonstrated and are slightly above trajectory currently to meet the March 2025 ambition of 95%. Additional activity delivery with be required to meet this target.	Longer waiting times for diagnosis and treatment have a detrimental effect on patients. Delay in achieving DM01 compliance standards.	**MRI** – Mitigations including the delivery of the CDC will see MRI reaching DM01 compliance in February 2025. **CT** – Impact from CT replacement programme is now expected to recover. With an expected return to DM01 compliance by Q1 of 24/25. **US** – Staffing issues resolved and performance now expected to improve. **Endoscopy** – Current trajectory being revised due to impact of cancer demand and case mix limitations with IS provider. Anticipated compliance with DM01 target ambition of 95% by March 2025. Actions focussed on increasing NE opportunities and review of core job planned capacity for medical and surgical consultant endoscopists. Alongside further work on reducing DNA's and increasing productivity. Assessment being undertaken to understand how ERF might support increased insource capacity and income generation.

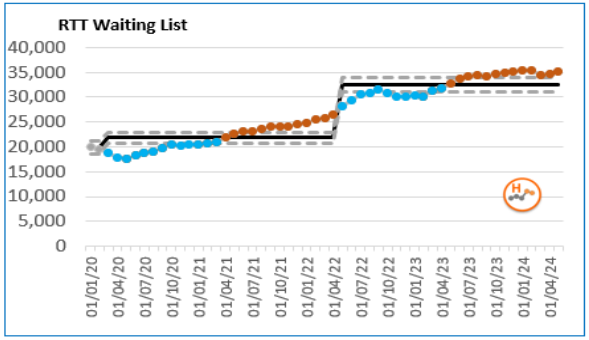
Endoscopy is slightly behind trajectory for reducing 6week waits which will delay achievement of the performance trajectory

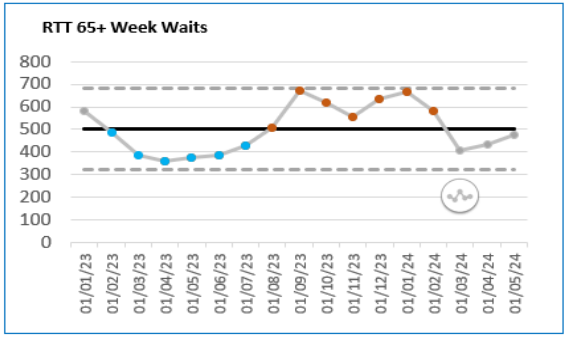


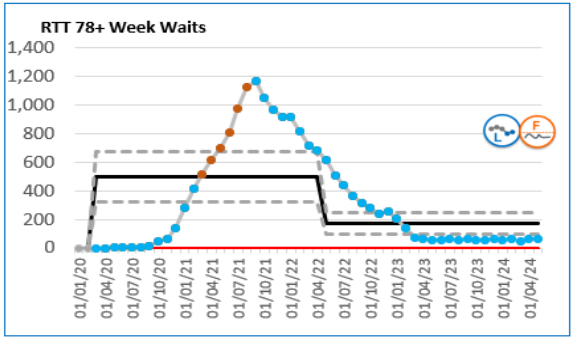


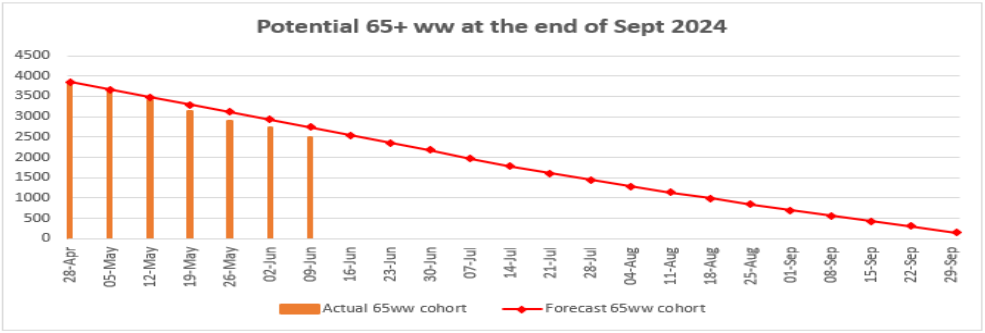


Elective recovery has been mitigated in surgical specialties, with gynaecology still a risk to 0 65 week waits by end September, though additional outsourced activity has started



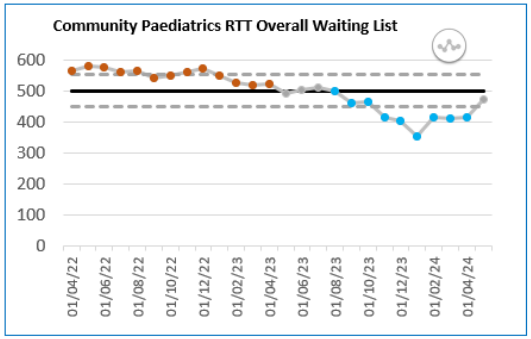


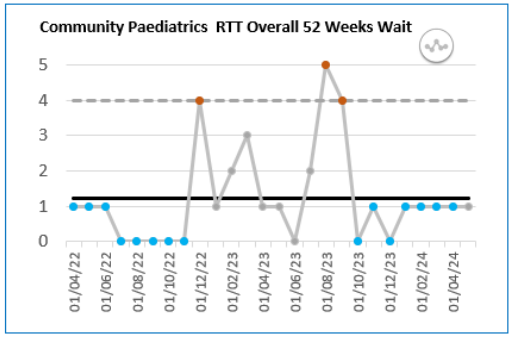


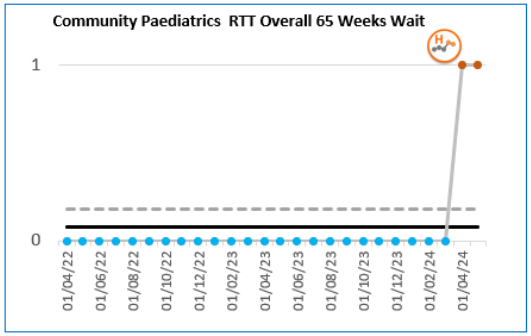


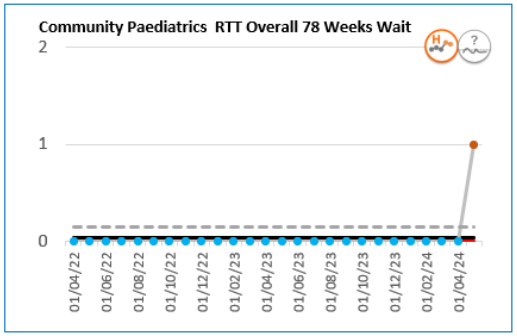
What	So What?	What Next?
There was an increase in patients waiting over 65 weeks from April to May, although the total cohort of 65ww to be treated prior to the end of September 2024 is on trajectory overall, with the deficit in Plastics, ENT and General Surgery now mitigated and Orthopaedics gap significantly reduced. Gynaecology are over trajectory by 31 currently, there is an on-going risk to both 78 and 65ww within Gynaecology, which is not fully mitigated. The total number of 78 week waits remains static with capacity breaches in Gynaecology. The total waiting list size remains high with no signs of reducing.	Delivering the objective of no patients waiting over 65 weeks by September 2024 is the central focus of 2024/25 planning, delivering an improved set of outcomes and experience for our patients – as patients are at increased risk of harm and/or deteriorating the longer they wait. This increases demand on primary and urgent and emergency care services as patients seek help for their condition.	Urogynaecology continues to be the area with 78ww capacity breaches, patients have started to be transferred to Nuffield, with the next step to review the shortfall, as many patients are not suitable to transfer, and pull together a plan to mitigate this gap, which includes the feasibility of weekend working. Surgery have plans to mitigate their deficit with weekend lists and no dropped lists over the summer months. An ICB wide review of pre-outpatient demand with a review to reducing variance and demand.

Paediatric long elective waits represent the patients transferred on the neurodevelopmental disorders pathway









What	So What?	What Next?
Paediatric waiting times for initial assessments have increased due to higher levels of demand than the service has capacity. The longest waiters are being managed by outsourcing assessments within the ICB funded recovery plan which are not recorded in this report until the assessment plan has been completed. Some long waiters over 65 and 78 weeks have been taken into the paediatricians caseload due to risks identified at the triage stage by the external provider.	Children continue to wait longer for school age autism assessments due to high demand. The paediatric team continue to prioritise those children needing earlier assessment and those on priority pathways (safeguarding and children in care) alongside caseload management of those with complex needs. Signposting to support services is undertaken as appropriate. Referral enquiries relating to waiting times are sent into a dedicated email inbox via the Care Coordination Centre	Due to a high acceptance rate for school age autism assessments there is insufficient funding to clear the backlog of longest waiting children. This has been flagged to the ICB and early engagement to submit a further business case for more funding is proposed in July. The plan will however clear the majority of children waiting longest, who will have received their assessment with outsourced provider, by the end of November 24. Structured discussion with ICB to review paediatric capacity pressures has also been held and timeline for action to be determined.

The Elective Recovery Fund thresholds are being met for daycases and elective and narrowly missed for new outpatients

West Suffolk NHS Foundation Trust

Outpatient First

Mon	23/24	ERF	24/25	Var %
Apr	9,544	10,182	10,216	0.3%
May	9,660	10,305	10,249	(0.5%)
Jun	9,090	9,697		
Jul	10,165	10,844		
Aug	8,967	9,566		
Sep	9,544	10,182		
Oct	10,453	11,152		
Nov	9,891	10,551		
Dec	8,744	9,328		
Jan	10,345	11,036		
Feb	9,205	9,820		
Mar	9,365	9,990		
Total (YTD)	19,204	20,487	20,465	(0.1%)

May 2024

23/24	9,660
ERF	10,305
24/25	10,249
Var	(56)
Var %	(0.5%)

Daycase

Mon	23/24	ERF	24/25	Var %
Apr	2,191	2,342	2,426	3.6%
May	2,245	2,400	2,565	6.9%
Jun	2,084	2,228		
Jul	2,364	2,527		
Aug	2,109	2,255		
Sep	2,245	2,400		
Oct	2,459	2,629		
Nov	2,408	2,574		
Dec	2,056	2,199		
Jan	2,420	2,587		
Feb	2,219	2,373		
Mar	2,241	2,397		
Total (YTD)	4,435	4,743	4,991	5.2%

May 2024

23/24	2,245
ERF	2,400
24/25	2,565
Var	165
Var %	6.9%

Outpatient Follow Up

Mon	23/24	ERF	24/25	Var %
Apr	25,352	27,046	27,595	2.0%
May	25,659	27,373	27,243	(0.5%)
Jun	24,145	25,758		
Jul	27,000	28,804		
Aug	23,819	25,410		
Sep	25,352	27,046		
Oct	27,767	29,621		
Nov	26,272	28,027		
Dec	23,225	24,776		
Jan	27,479	29,315		
Feb	24,451	26,085		
Mar	24,875	26,537		
Total (YTD)	51,011	54,418	54,838	0.8%

May 2024

23/24	25,659
ERF	27,373
24/25	27,243
Var	(130)
Var %	(0.5%)

Elective

Mon	23/24	ERF	24/25	Var %
Apr	256	273	269	(1.6%)
May	267	285	293	2.8%
Jun	247	264		
Jul	280	299		
Aug	256	273		
Sep	256	273		
Oct	284	303		
Nov	268	287		
Dec	249	265		
Jan	234	250		
Feb	244	260		
Mar	244	260		
Total (YTD)	523	558	562	2.8%

May 2024

23/24	267
ERF	285
24/25	293
Var	8
Var %	2.8%

All

All

Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
23/24	37.4%	36.4%	36.6%	37.7%	37.9%	37.8%	35.9%	35.0%	36.3%	36.2%	37.1%	37.7%	**36.8%**
24/25	37.0%												**37.0%**

Target	46.0%
Month	37.0%
YTD	37.0%

This lower table shows delivery against the target of 46% of outpatient attendances to be first appointments or appointments with procedures

In monetary terms the Elective Recovery Fund thresholds are being met overall, led by daycases and elective procedures, with outpatients below threshold

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	Apr	May	Total
ERF Target	5,908,232	6,043,018	**11,951,250**
ERF Actual	5,934,549	5,983,974	**11,918,523**
ERF Variance	26,318	(59,045)	**(32,727)**
ERF Variance %	0.4%	(1.0%)	**(0.3%)**

Point of Delivery	Apr	May	Total
Daycase			
ERF Target	2,072,290	2,123,663	**4,195,953**
ERF Actual	2,148,773	2,187,317	**4,336,090**
ERF Variance	76,482	63,654	**140,137**
ERF Variance %	3.7%	3.0%	**3.3%**
Elective			
ERF Target	1,224,197	1,276,021	**2,500,218**
ERF Actual	1,251,213	1,280,493	**2,531,707**
ERF Variance	27,017	4,472	**31,489**
ERF Variance %	2.2%	0.4%	**1.3%**
Outpatient F/U Procedure			
ERF Target	614,855	622,292	**1,237,148**
ERF Actual	631,269	609,922	**1,241,191**
ERF Variance	16,414	(12,370)	**4,044**
ERF Variance %	2.7%	(2.0%)	**0.3%**
Outpatient New Attendance			
ERF Target	1,747,827	1,768,967	**3,516,793**
ERF Actual	1,643,272	1,673,951	**3,317,223**
ERF Variance	(104,554)	(95,016)	**(199,570)**
ERF Variance %	(6.0%)	(5.4%)	**(5.7%)**
Outpatient New Procedure			
ERF Target	249,063	252,075	**501,138**
ERF Actual	260,022	232,291	**492,312**
ERF Variance	10,959	(19,785)	**(8,826)**
ERF Variance %	4.4%	(7.8%)	**(1.8%)**

Division	Apr	May	Total
Clinical Support			
ERF Target	49,691	50,308	**99,999**
ERF Actual	44,529	50,851	**95,380**
ERF Variance	(5,162)	543	**(4,619)**
ERF Variance %	(10.4%)	1.1%	**(4.6%)**
Community			
ERF Target	235,910	239,123	**475,033**
ERF Actual	224,474	237,824	**462,298**
ERF Variance	(11,436)	(1,298)	**(12,735)**
ERF Variance %	(4.8%)	(0.5%)	**(2.7%)**
Medicine			
ERF Target	1,380,986	1,406,353	**2,787,338**
ERF Actual	1,307,952	1,378,458	**2,686,410**
ERF Variance	(73,033)	(27,895)	**(100,928)**
ERF Variance %	(5.3%)	(2.0%)	**(3.6%)**
Surgical			
ERF Target	3,689,976	3,784,417	**7,474,393**
ERF Actual	3,816,897	3,761,686	**7,578,583**
ERF Variance	126,922	(22,731)	**104,190**
ERF Variance %	3.4%	(0.6%)	**1.4%**
Women & Children			
ERF Target	551,670	562,818	**1,114,488**
ERF Actual	540,697	555,154	**1,095,852**
ERF Variance	(10,973)	(7,663)	**(18,636)**
ERF Variance %	(2.0%)	(1.4%)	**(1.7%)**

activity

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NHS Foundation Trust

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activity

The Board Assurance Framework risk on capacity has been reviewed and accepted by PAGG

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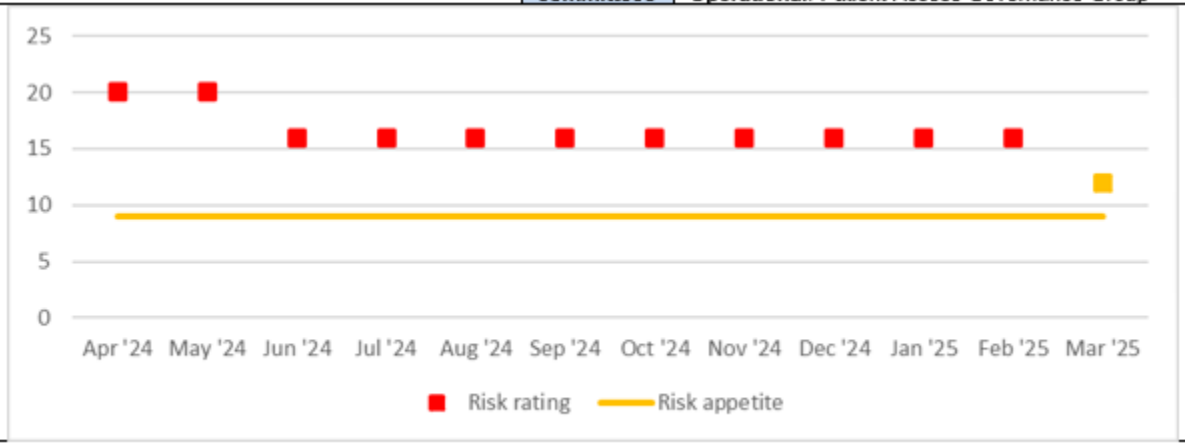
Section A: 'At a glance' summary

Risk description		Inherent risk score	Current risk score	Future risk score	Assurance level for controls	Assurance level for improvement actions *(if outside to risk appetite)*	
Capacity (Ref: 02): The Trust fails to ensure that the health and care system has the capacity to respond to the changing and increasing needs of our communities		Major x Weekly = Red (20)	Major x Quarterly = Red (16)	Moderate x Quarterly = Amber (12)	Partial	Partial	
Executive commentary	There is a robust structure to manage time-limited loss of capacity, including RAAC and industrial action but less assurance in relation to longer term capacity planning.	**Risk appetite statement**	WSFT will have an open risk appetite to capacity driven by a need to balance demand, productivity, patient safety and understand service delivery implications while promoting innovation, better outcomes and encompassing wider service improvements.			**Risk appetite rating**	Cautious (9)
Lead director	Chief Operating Officer	**Oversight committees**	**Board**: Insight **Operational**: Patient Access Governance Group			**Last reviewed**	May 2024
Risk trajectory							

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West Suffolk NHS Foundation Trust

Section B: Control and assurance assessment

Risk – Key 'causes' and 'effects'	Existing Risk Controls	Assurance / Evidence 1st Line	Assurance / Evidence 2nd Line	Assurance / Evidence 3rd Line	Assurance & Control Gaps	Assurance level for controls
Cause: C1) Unexpected loss of existing capacity- e.g. RAAC failure, pandemics and industrial action C2) Lack of transformational change to support delivery of clinical and care strategy for Future System programme C3) Lack of funding or productivity improvements to support additional capacity C4) Lack of system agreed clinical model of care and joined up strategy with partners C5) Failure to undertake sufficient workforce planning across the health and care system Effect: E1) Patient harm due to delays in diagnosis and treatment E2) Inability to meet current and future population health and care needs E3) Regulatory intervention as a result of not meeting NHS performance standards E4) People being treated in an inappropriate setting and an unsustainable future model	C1) Command, control and co-ordination (C3) plan in place Core Resilience Team (CRT) in place for RAAC and stood up for other incidents including pandemic, industrial action Future System Programme for build of new hospital to fully mitigate RAAC risk	CRT and strategic meetings to manage incidents	Annual EPRR core standards review Performance Review Meetings including operational standards and business plans RAAC risk review meetings and RAAC updates to board Annual EPRR core standards review report to Corporate Risk Governance Group, Insight and Board	Incident response structure at system, regional and national level including ICB System Control Centre National new hospitals programme prioritises RAAC hospitals Annual EPRR core standards review at system and regional level	Opportunity for greater integrated patient dispersal planning across region in the event of RAAC failure	Partial
	C2) Future system programme, including implementation of the clinical care strategy by change hub and communication/engagement workstream	Divisional Boards Departmental meetings	Future System programme board and updates to Trust Board	External reviews of clinical and care strategy as part of Future System business case development New Hospitals Programme filter work through KPMG	Staff engagement in shift of care closer to home as part of clinical and care strategy Skills and expertise in delivering major programmes of change	Minimal
	C3) Annual response to NHS planning guidance, supported by Divisional business planning Investment in service delivery business cases where Elective Recovery Fund (ERF) income will offset costs Utilisation of non-recurrent and recurrent funding opportunities to develop sustainable services, for example developing community services Focus on productivity within strategic priorities to deliver additional capacity within constrained financial envelope	Divisional Boards Departmental meetings Patient Access Governance Group Performance Review Meetings including operational standards	Insight committee for oversight of financial and operational performance	Internal audit programme in relation to key areas of operational delivery Well-led review System and regional performance management framework	Underpinning plans to deliver productivity assumptions	Minimal

The Board Assurance Framework risk on capacity has been reviewed and accepted by PAGG

West Suffolk NHS Foundation Trust

Risk – Key 'causes' and 'effects'	Existing Risk Controls	Assurance / Evidence 1st Line	Assurance / Evidence 2nd Line	Assurance / Evidence 3rd Line	Assurance & Control Gaps	Assurance level for controls
E5) Unsustainable workforce to provide capacity	C4) Cross reference to BAF 3 collaboration for controls and actions					
	C5) Workforce workstream as part of Future System Programme Apprenticeship programme Close working with education providers Working with local communities as an anchor institution, for example the Community Diagnostic Centre training academy	Divisional business plans include workforce planning	Future System programme board People and Culture Committee	ICB workforce planning at system level	Full integration of workforce planning and importance of culture, values and behaviours, in all operational plans	Partial

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

Planned actions (mitigations)	Summary of progress	Owner	Delivery date	Action status	Impact on future risk score
Ward and theatre configuration plans to maximise Elective Recovery Fund income whilst maintaining sufficient capacity for emergency demand	Work being led by Associate Directors of Operations, working cross-divisionally	NC	June 2024	Green	Amber- risk rating of 16 (major x quarterly)
Recruitment of director of strategy and transformation to support delivery of transformation plan and review of transformation capacity and capability	Not yet started	ST	Q2	Not yet started	Amber- risk rating of 16 (major x quarterly)
Productivity focus within strategic priorities, with explicit objectives relating to theatre and outpatient productivity; also part of implementation of clinical and care strategy, to release financial benefits	Capped theatre utilisation ahead of trajectory at 78.6% BADS day case rates on trajectory at 81.9% Orthopaedics exceeding target for High Volume, Low Complexity procedures cases per list against Getting It Right First Time (GIRFT) standards at 87.5% Ophthalmology is below target, but on trajectory, with 5% of activity compliant with GIRFT cases per lists standards. Many non-complex cases are directed to private sector capacity, meaning it is more challenging to increase cases per list for the more complex patients, however the Division has a plan to achieve trajectory by March 2025.	NC	March 2025	Green	Amber- risk rating of 12 (moderate x quarterly)
Inclusion of workforce planning module and other workforce content in operational management development programme	Programme commenced April 2024	NC	First programme completes		

Maternity paper Annexes

Presented by Susan Wilkinson

BOARD REMUNERATION AND NOMINATION COMMITTEE

Terms of Reference

1. Purpose of the Committee

1.1. The Board Remuneration and Nomination Committee (known as "the committee" in these terms of reference) is established by the Board of Directors for the purpose of:

- The nomination of the Chief Executive and other Executive Directors for the Trust
- The determination of the remuneration, terms of service and allowances for the Chief Executive and other Executive Directors
- The appointment and removal of the Trust Secretary does not fall within the scope of this committee but is a matter for the Chief Executive and Chair jointly[1]

1.2. The committee is accountable to the Board of Directors and any changes to these terms of reference must be approved by the Board of Directors.

1.3. When appointing the Chief Executive, the committee shall be the committee described in Schedule 7,17(3) of the National Health Service Act 2006 (the Act). When appointing other executive directors the committee shall be the committee described in Schedule 7,17(4) of the Act[2].

2. Level of Authority

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

[1] *The NHS Foundation Trust Code of Governance* Monitor July 2014 p 58

[2] NHS Act 2006 Schedule 7 17(3) It is for the non-executive directors to appoint or remove the Chief Executive.

(4) It is for a committee consisting of the chairman, the chief executive and the other non-executive directors to appoint or remove the executive directors.

[1] *The NHS Foundation Trust Code of Governance* Monitor July 2014 p 58

[2] *The NHS Foundation Trust Code of Governance* Monitor July 2014 p 58

3. Duties and responsibilities

The key responsibilities of the committee shall be to:

3.1. Regularly review the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board, making use of the output of the board evaluation process as appropriate and make recommendations to the Board and, where relevant, the Council of Governors, with regard to any changes.

3.2. Give full consideration to succession planning for executive board directors in the course of its work, taking into account the challenges and opportunities facing the Trust, and the skills and expertise needed on the Board in the future.

3.3. Keep under review the leadership needs of the Trust, with a view of ensuring the continued ability of the Trust to undertake its obligations under the terms of its licence.

3.4. Be responsible for identifying and appointing candidates to fill executive Board vacancies as and when they arise.

3.5. Before any new appointment is made by the Board, evaluate the balance of skills, knowledge, experience and diversity on the Board, and, in the light of this evaluation, prepare a description of the role and capabilities required for new appointments to the Board. In identifying suitable candidates the committee shall:

- Consider its advertising strategy and the need for external search consultants to support the search
- Consider candidates from a wide range of backgrounds
- Consider candidates on merit and against objective criteria and with due regard for the benefits of diversity on the Board.

3.6. Make recommendations to the Board concerning formulating succession plans for executive directors and in particular for the key role of Chief Executive.

3.7. Take decisions on any matters relating to the continuation in office of any executive director at any time including the suspension or termination of service of an executive director as an employee of the Trust subject to the provisions of the law and their service contract.

3.8. Select members of the committee to form an appointments panel which will be responsible for making recommendations on the appointment of Executive Directors.

REMUNERATION

The committee shall:

3.9. Have responsibility for setting the remuneration policy for all executive directors and senior managers not on agenda for change or clinical contracts, including pension rights and any compensation payments. No director shall be involved in any decisions as to their own remuneration.

3.10. In determining such a policy, take into account all factors which it deems necessary including relevant legal and statutory requirements, the provisions and recommendations of the Code and associated guidance. The objective of such policy shall be to attract, retain and motivate executive management of the

quality required to run the Trust successfully without paying more than is necessary, having regard to the risk appetite of the Trust and alignment to the Trust's long strategic term goals.

3.11. When setting remuneration policy for executive directors, review and have regard to pay and employment conditions across the Trust and the NHS, especially when determining annual salary increases.

3.12. Review the ongoing appropriateness and relevance of the remuneration policy.

3.13. Within the terms of the agreed policy and in consultation with the chair or chief executive, as appropriate, determine the total individual remuneration package of each executive director and the CEO.

3.14. Obtain reliable, up-to-date information about remuneration in other Trusts of comparable scale and complexity. To help it fulfil its obligations, the committee shall have full authority to appoint remuneration consultants and to commission or purchase any reports, surveys or information which it deems necessary.

3.15. Monitor, and assess the output of the evaluation of the performance of individual executive directors, and consider this output when reviewing changes to remuneration levels.

3.16. Advise upon and oversee contractual arrangements for executive directors, including but not limited to termination payments to avoid rewarding poor performance.

3.17. Review and agree the policy for authorising claims for expenses from the directors.

3.18. Scrutinise the recommendations of the Clinical Excellence Awards committee

3.19. Where appropriate, to authorise any redundancy payments, settlements and compromise agreements as determined within current NHS rules on severance payments, including such payments which require final approval by HM Treasury/NHS Improvement

3.20. Have responsibility for setting and overseeing implementation of the Trust's pension deferral policy.

4. Membership

Membership of the committee will comprise of:

4.1. The chair and all non-executive directors. the committee will be chaired by the chair or one of the other non-executive directors.

4.2. The chief executive shall be a member of the committee for the appointments or removal of executive directors only as described in Schedule 7,17 (4) of the Act (see also paragraph 1.3 above).

4.3. The chief executive, director of workforce and Trust Secretary will be in attendance at its meetings, as and when appropriate and necessary.

4.4. The committee can request the attendance of any other director or senior manager if an agenda item requires it.

4.5. Members will be required to attend as a minimum 75% of the meetings per year.

5. Quorum

5.1. The quorum necessary for the transaction of business shall be three non-executive directors. For matters relating to executive board appointments (other than the appointment of the chief executive), the quorum shall include the chief executive.

6. Frequency of meetings

6.1. The committee shall operate as follows:

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

7. Sub-Committees

7.1. The committee may constitute sub-groups/speciality committees to ensure the actual work with regard to broad scope of committee is executed and delivered in an appropriate manner that is transparent, inclusive and effective.

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

8.1. The committee shall be supported by the Trust office with regard to arrangements for meetings and circulation of minutes/administrative support.
8.2. The Trust Secretary shall arrange for the proceedings and resolutions of all committee meetings to be minuted, including the names of those present and in attendance.
8.3. Draft minutes of the committee meetings shall be circulated promptly to all members of the committee.
8.4. The committee will provide an annual report to the Board.
8.5. The committee shall have access to sufficient resources to carry out its duties, including access to the Trust secretariat for assistance as required;
8.6. It shall be provided with appropriate and timely training, both in the form of an induction programme for new members and on an on-going basis for all members;
8.7. It will give due consideration to laws and regulations, the provisions of the FT Code of Governance and any other applicable rules, as appropriate;

9. Accountability and reporting arrangements

9.1. The committee chair shall report to the Board on its proceedings, as appropriate, after each meeting on all matters within its duties and responsibilities;

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9.3. When appointing a chief executive, the committee shall report their decision to appoint to the Council of Governors for approval prior to reporting to the Board.

9.4. The committee shall produce a report to be included in the Trust's annual report about its activities, the process used to make appointments and explain if external advice or open advertising has not been used. Where an external search agency has been used, it shall be identified in the annual report and a statement made as to whether it has any connection with the Trust;

9.5. The report referred to in 9.4 above should include a statement of the Board's policy on diversity, including gender, any measurable objectives that it has set for implementing the policy, and progress on achieving the objectives.

10. Monitoring effectiveness and compliance with Terms of reference

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

11. Ratification of terms of reference and review arrangements

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

Date approved by the Board Remuneration & Nomination Committee: approved via chair's action.
Date approved by the Board of Directors:
Next review date: July 2025

Remuneration and Nomination Committee Terms of Reference

Presented by Richard Jones

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Date approved by the Board Remuneration & Nomination Committee: approved via chair's action.
Date approved by the Board of Directors:
Next review date: July 2025

Annex B: Scheduled draft agenda items for next meeting – 25 September 2024

Description	Open	Closed	Type	Source	Director
Declaration of interests	✓	✓	Verbal	Matrix	All
Patient/staff story	✓	✓	Verbal	Matrix	Exec.
Chief Executive's report	✓		Written	Matrix	EC
Organisational development plan	✓		Written	Matrix	JMO
System update: - West Suffolk Alliance and SNEE Integrated Care Board (ICB) - Wider system collaboration - Collaborative oversight group	✓		Written	Matrix	 PW / CM All execs
SNEE ICB joint forward plan (JFP) update	✓		Written	Matrix	ICB
Strategic priorities – progress report	✓		Written	Action	CEO
Future System Board Report	✓		Written	Matrix	CB
Digital Board report, including review of the digital strategy	✓		Written	Matrix	CB
Insight Committee – committee key issues (CKI) report - Finance report	✓		Written	Matrix	AJ / NC / SW
Involvement Committee – committee key issues (CKI) report - People and OD Highlight Report o Putting you First award o Staff recommender scores o appraisal performance, including consultants (quarterly) - Safe staffing guardian and FTSU reports - National patient and staff survey and recommender responses - Education report - including undergraduate training (6-monthly) - National patient survey reports - Annual complaint report - Medical Revalidation annual report - Clinical Excellence Awards Scheme annual report	✓		Written	Matrix	NED / JMO
Improvement Committee – committee key issues (CKI) report - Maternity services quality and performance report - Nurse staffing report - Quality and learning report, including mortality and quality priorities	✓		Written	Matrix	LP / SW / PM
Audit committee – committee key issues (CKI) report	✓		Written	Matrix	MP
Serious Incident, inquests, complaints and claims report		✓	Written	Matrix	SW

Governance report, including - Senior Leadership Team report - Council of Governors report - Register of interests - Well led improvement priorities (via Improvement Committee) - Use of Trust's seal - Agenda items for next meeting - Board meeting dates for 2025	✓		Written	Matrix	RJ
Confidential staffing matters		✓	Written	Matrix – by exception	JMO
Board assurance framework report	✓		Written	Matrix	RJ
Annual report and quality accounts		✓	Written	Matrix	EC/CB
Non-executive directors responsibilities report	✓		Written	Matrix	RJ
Reflections on the meetings (open and closed meetings)	✓	✓	Verbal	Matrix	JC
Annexes to Board pack: - Integrated quality & performance report (IQPR) – annex to Board pack - Others as required					