NHS
West Suffolk
NHS Foundation Trust

Board of Directors (In Public)

Schedule	Friday 27 September 2024, 9:15 AM — 4:15 PM BST
Venue	Education Centre Room 19
Description	A meeting of the Board of Directors
Organiser	Gemma Wixley

Agenda

AGENDA
Presented by Jude Chin

_WSFT Public Board Agenda - 27 Sept 2024.docx

9:15 AM — 1. GENERAL BUSINESS
Presented by Jude Chin

10:10 AM — 1.1. Welcome and apologies for absence - Craig Black , Paul Molyneux , Clement Mawoyo
To Note - Presented by Jude Chin

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

10:10 AM — 1.3. Minutes of the previous meeting - 26 July 2024
To Approve - Presented by Jude Chin

2024 07 26 July - Public Board Minutes - Draft - final.docx

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

Item 1.4 - Open Board Action Log - Complete.docx

10:10 AM — 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 - Alisons' story Please note this contains content about dying which some people may find upsetting To Review - Presented by Susan Wilkinson
10:10 AM	1.7.	Chief Executive's report To inform - Presented by Ewen Cameron Item 1.7 - CEO Board report - 27 September 2024 FINAL.docx
10:10 AM	2.	STRATEGY
10:30 AM	2.1.	Strategic Priorities Report For Approval - Presented by Ewen Cameron Item 2.1 Strategic priorities Board Sept 2024 coversheet.docx Item 2.1 Appendix A Strategic priorities s 2023-24 - year end report.docx Item 2.1 Appendix B NHS-Smokefree-Pledge.pdf Item 2.1 Appendix C Strategic priorities 2024-25 progress report.docx Item 2.1 Appendix C Strategic priorities COO trajectories.pptx
10:30 AM	2.2.	Future System board report To inform - Presented by Ewen Cameron Item 2.2 wsft public board Sept 24 FINAL.docx
10:30 AM		Comfort Break
10:40 AM	2.3.	SNEE ICB Joint Forward Plan (Dr Alexander Roydan, Deputy Director for Strategic, ICB) To inform - Presented by Jude Chin Item 2.3 WSFT SNEE ICB JFP paper - Sept 2024.docx

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11:00 AM 2.4. West Suffolk System Update Report
For Report - Presented by Peter Wightman

Item 2.4 WSFT report WSA final 09_24.docx

11:20 AM 2.5. Digital Board Report
To inform - Presented by Nicola Cottington

Item 2.5 Trust Board digital report Sep 2024 NC.docx

11:30 AM 3. ASSURANCE

3.1. IQPR Report
For Discussion - Presented by Jude Chin and Nicola Cottington

Item 3.1 IQPR Cover Sheet.docx

Item 3.1 IQPR one page summary Board Report July 2024.pptx

12:00 PM 3.2. Finance Report
To Assure - Presented by Jonathan Rowell

Item 3.2 M5 Finance Cover For Board.docx

Item 3.2 M5 Finance Report 2425 for Board FINAL.docx

12:00 PM Comfort Break

12:10 PM 4. PEOPLE AND CULTURE

4.1. Involvement Committee report
To Assure - Presented by Antoinette Jackson

Item 4.1 Involvement CKI August 2024 - FINAL.doc

4.1.1. Putting you First Award
To Assure - Presented by Jeremy Over

Item 4.1.1 PYF awards Sept24.pptx

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5. OPERATIONS, FINANCE AND CORPORATE RISK

12:25 PM **5.1. Insight Committee Report - Chair's Key Issues from the meeting**
To Assure - Presented by Antoinette Jackson

- Item 5.1 Insight CKI 21.08.24 FINAL (1).docx
- Item 5.1 Insight CKI updated 24.9.24.docx

6. QUALITY, PATIENT SAFETY AND QUALITY IMPROVEMENT

12:35 PM **6.1. Improvement Committee Report**
To Assure - Presented by Roger Petter

- Item 6.1 Improvement committee August 24 CKI.docx
- Item 6.1 Improvement Cttee CKIs September 24.docx

6.2. Response to the well let report
To inform - Presented by Jude Chin and Richard Jones

- Item 6.2 ConsultOne response - cover sheet.docx
- Item 6.2 ConsultOne recommendations report Improvement Sept 24.docx

6.3. Quality & Nurse Staffing Report July and August
For Report - Presented by Susan Wilkinson

- Item 6.3 Nurse Staffing Report July and August.docx

6.4. Maternity quality safety and performance Board report
Presented by Jude Chin and Susan Wilkinson

- Item 6.4 September 2024 Maternity quality safety and performance Board report v1.docx

7. GOVERNANCE

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7.1. Charitable Funds CKIs 22 Aug 2024 meeting MP Final
Presented by Michael Parsons

Item 7.1 - Charitable Funds CKIs 22 Aug 2024 meeting MP Final.docx

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1:00 PM 7.2. Board Assurance Framework
To Assure - Presented by Richard Jones

Item 7.2 BAF report to Board Sept 24.docx

1:10 PM 7.3. Governance Report
For Approval - Presented by Jude Chin and Richard Jones

Item 7.3 Governance report Sept 2024.docx

Item 7.3 Annex A NEDs responsibilities August 2024.doc

Item 7.3 Annex B Draft Board meeting agenda.docx

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8. OTHER ITEMS
Presented by Jude Chin

1:20 PM 8.1. Any other business
To Note - Presented by Jude Chin

8.2. Reflections on meeting
For Discussion - Presented by Jude Chin

8.3. Date of next meeting - 29th November 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

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SUPPORTING ANNEXES

To inform - Presented by Jude Chin

- SUPPORTING ANNEX Item 3.1 Board Report July 2024.pptx
- SUPPORTING ANNEX Item 7.3 Charitable Funds Terms of Reference July 2024 MP - Final Draft.docx
- SUPPORTING ANNEX Item 7.3 Insight Committee Terms of Reference Sept 2024 v2 Approved by INSIGHT.docx
- SUPPORTING ANNEX Item 7.3 Management Executive Group ToR Sept 2024.doc

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IQPR Full Report

To Note - Presented by Nicola Cottington

- SUPPORTING ANNEX Item 3.1 Board Report August 2024 KN edit.pptx

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AGENDA

Presented by Jude Chin

NHS
West Suffolk
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WSFT Board of Directors – meeting in public

Date and Time	Friday, 27 September 2024 9:15 – 13:45
Venue	Education Centre, rooms 19a&b, West Suffolk Hospital site, Bury St Edmunds IP33 2QZ

Time	Item	Subject	Lead	Purpose	Format
1.0 GENERAL BUSINESS					
09.15	1.1	**Welcome and apologies for absence**	Chair	Note	Verbal
09.20	1.2	**Declarations of Interests**	All	Assure	Verbal
	1.3	**Minutes of meeting** – 26 July 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 Story**	Chief Nurse	Review	Verbal/ Video
		Please note this contains content about dying which some people may find upsetting			
10.00	1.7	**CEO report**	Chief Executive	Inform	Report
2.0 STRATEGY					
10.10	2.1	**Strategic priorities report – year-end and progress report, including signing the NHS Smokefree Pledge**	Chief Executive	Approve	Report
10.20	2.2	**Future system board report**	Chief Executive	Assure	Report
10:30 Comfort Break					
10:40	2.3	**SNEE ICB joint forward plan (JFP) update**	Alexander Royan, Deputy Director for Strategic Analytics	Inform	Report
11:10	2.4	**System update report**	West Suffolk Alliance Director and Director of Integrated	Assure	Report

Time	Item	Subject	Lead	Purpose	Format
			Adult Health and Social Care		
	2.5	**Digital Board report**	Chief Operating Officer	Assure	Report
3.0 ASSURANCE					
11:30	3.1	**IQPR report** To consider areas for escalation *(linked to CKI reports from assurance committees)*	Executive leads	Review	Report
	3.2	**Finance report**	Acting CFO	Review	Report
12:00 Comfort Break					
PEOPLE, CULTURE AND ORGANISATIONAL DEVELOPMENT					
12.10	4.1	**Involvement Committee report** – Chair's key issues from the meetings	NED Chair	Assure	Report
	4.1	Putting You First Awards	Dir. HR and Communication	Review	Report
OPERATIONS , FINANCE AND CORPORATE RISK					
12.25	5.1	**Insight committee report** – Chair's key issues from the meetings	NED Chair	Assure	Report
QUALITY, PATIENT SAFETY AND QUALITY IMPROVEMENT					
12.35	6.1	**Improvement committee report** – Chair's key issues from the meetings	NED Chair	Assure	Report
	6.2	**Response to the well led report**	Trust Secretary	Approval	Report
	6.3	**Quality and nurse staffing report**	Chief Nurse	Assure	Report
	6.4	**Maternity services report**	Chief Nurse Karen Newbury Kate Croissant Simon Taylor	Approval	Report
7.0 GOVERNANCE					
	7.1	**Charitable Funds Committee report** –	NED Chair	Approval	Report

Time	Item	Subject	Lead	Purpose	Format
		Chair's key issues from the meetings			
13.00	7.2	**Board assurance framework**	Trust Secretary	Approval	Report
13:10	7.3	**Governance Report**	Trust Secretary	Approval	Report
8.0 OTHER ITEMS					
13.20	8.1	**Any Other Business**	All	Note	Verbal
	8.2	**Reflections on meeting**	All	Discuss	Verbal
	8.3	**Date of next meeting** Board meeting on 29 November 2024	Chair	Note	Verbal

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

Supporting Annexes

Agenda item	Description
3.1	IQPR
6.3	Maternity papers Annexes
7.3	Governance report – 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

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 - 26 July 2024

To Approve

Presented by Jude Chin

NHS
West Suffolk
NHS Foundation Trust

WEST SUFFOLK NHS FOUNDATION TRUST

DRAFT MINUTES OF THE
Open Board meeting

Held on Friday 26 July, 2024, 09:15 – 13:45
At the ABC Room, Newmarket Community Hospital

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
Antoinette Jackson	Non-Executive Director/SID (late)	AJ
Michael Parsons	Non-Executive Director (late)	MP
Roger Petter	Non-Executive Director/Maternity and Neonatal Safety Champion (late)	RP
In attendance:		
Richard Jones	Trust Secretary & Head of Governance	RJ
Pooja Sharma	Deputy Trust Secretary	PS
Anna Hollis	Deputy Head of Communications	AH
Simon Morgan	Associate Director of Communications, SNEE ICB (Item 2.5 only)	
Dan Spooner	Deputy Chief Nurse	DS
Cassia Nice	Head of Patient Experience & Engagement (Item 2.5 only)	CS
Karen Newbury	Director of Midwifery	KN
Kate Croissant	Clinical Director for Women & Children (Item 4.3.1 only)	KC
Simon Taylor	Associate Director of Operations, Women & Children & Clinical Support Services	ST
Ruth Williamson	FT Office Manager (minutes)	RW

Apologies:
Craig Black, Director of Resources,
Paul Molyneux, Medical Director,
Helen Davies, Associate Director of Communications,
Pete Wightman, West Suffolk Alliance Director
Michael Parsons, Non-executive Director
Clement Mawoyo, Director of Integrated Adult and Social Care Services
Nick Macdonald, Deputy Finance Director
Jonathan Rowell, Director of Financial Recovery
Sam Tappenden, Director of Strategy & Transformation

Governors observing: Andy Morris, Jane Skinner
Staff: Andy Morris, Karen Newbury, Kate Croissant
Members of the public: Dean Sharratt, HBSUK

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 24 May, 2024 were accepted as a true and accurate reflection of the meeting, subject to the following amendments: **Attendees –** Antoinette Jackson, Roger Petter, Michael Parson and Peter Wightman to be shown as attending the meeting late, having been delayed by a road traffic accident. **Item 3.1.1 – People and OD Highlight Report** – "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 **new** reporting method via RADAR". **Item 4.3 – Quality and nurse staffing report** - "**Un**social hours pay enhancements fill shifts quicker". **Item 4.3.1 – Maternity Services Report** - "The Board gave its agreement to the new approval process for **evidence and submission** for the Maternity Safety Incentive Scheme **and the role of the Improvement Committee**".	
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 will be received at September's Board Meeting and has been included in the forward plan. **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 3080 – Staff Story – Consideration to Sharing of Patient Stories with Staff – the Communications and Patient Advice Liaison teams are working together to enable sharing of patient stories. Noted the story from May's Board has been added to Totara, (the Trust's learning and performance management system) and been shared with the Care and Engagement Committee. **Matter Closed.** **Action Ref 3081 – People & OD Highlight Report, including FTSU Report – Active Bystander Training** – an appropriate date is being identified for this training and has been placed on the forward plan**.**	
1.5	**Questions from Governors and the public relating to items on the agenda**	
	The report details trust-wide the Cost Improvement Programmes (CIPs) identified and implemented. However, there is a lack of clarity on division specific CIPs. How does the Board gain assurance that these have been assessed for staff and service impact? This is done at various levels, depending on complexity. There is sign off by the service leads and a quality impact assessment panel, together with a governance process undertaken. **People reading the Board report regarding CIPs may be concerned how they will be affected as patients. How will clarity be provided?** The Trust is not in a position to share the nature of the CIPs more widely. The governance process will have been followed for each, to assess impact and would not have been approved if detrimental to the safety of the service. **How will the public be made aware of any impact on services?** If a significant change to service is proposed, this will be brought to the Board for discussion. **In the minutes of the last Board Meeting (24 May, 2024), there was a comment on the management of septic patients and door to needle time data being reported to the Improvement Committee. This was not included in the meeting pack. Is this in progress and when will this be available?** Work is in progress in this regard and will be reported to the August Improvement Committee. **In terms of patients first and the move to transfer 50% of elective orthopaedic work to Essex and Suffolk Elective Orthopaedic Centre (ESEOC) and the engagement work undertaken which advises that 38% of those spoken to advise**	

	they cannot go there, how will patients retain their legal right of choice? ESEOC is on today's agenda for discussion. However, a patient's right to choose will continue. **Who will be the gatekeepers in terms of this choice?** This happens at GP level and evidence of this exists. Patients can opt to seek treatment elsewhere at the point of referral.	
1.6	**Patient Story**	
	The Board heard Yvonne's story of her experience dealing with the Trust as a profoundly deaf woman, whose means of communication was through British Sign Language (BSL). This experience has been shared with staff. The focus of the story included Yvonne's experience during admission via the Emergency Department (ED) to the inpatient ward. The ability to appropriately communicate, (via sign language), was recognised as well as planning for a BSL interpreter to be available at appointments. It was highlighted that the essence of Yvonne's story was about independence. To a certain extent all patients suffered a loss of independence, but in this instance, it was multi-layered and question raised as to why she felt different to others. The universal outcome that the Trust should be striving for, on behalf of all patients, was to maximise their independence, before and after. It was noted that the Trust had clear guidance on the provision of interpreters. However, there were barriers to making this a smooth process. It was recognised that the Trust had patients with complex communication needs and the organisation was working to assist them. Noted work on equality, diversity and inclusion (EDI) issues would be undertaken as part of the "Belonging in the NHS" work. In terms of the challenge in ED, work was being undertaken with the Chief Nursing Information Officer & Digital Clinical Safety Officer on digital flags and reasonable adjustments. Question raised as to whether this work would be fed through the assurance process. Noted this would form part of the report to the Involvement Committee, but was in the early stages currently. This will also be incorporated into the EDI Meeting.	
1.7	**CEO Report**	
	Highlights from the report were noted. Sam Tappenden, Director of Strategy & Transformation and Jonathan Rowell, Director of Financial Recovery, have joined the	

	Trust and are playing a key role in addressing finance and transformation. The 'Virtual Bones' initiative, which enhances the efficiency of musculoskeletal injuries management and pathway referral and developed by the Trust's orthopaedic service, won the category of 'Improving Urgent and Emergency Care through Digital' at the HSJ Digital Awards 2024. The Putting You First Award winners were noted; Tara Coe; Ward Manager, F9; the Acute Assessment Unit team; Rebecca Amoss, Administration Manger, Integrated Therapies and Angus Turner, Service Desk Engineer, IT.	
2.0 STRATEGY		
2.1	**Strategic Priorities Report**	
	Noted the report detailed the year end position in terms of progress. It was highlighted that the description of success contained within the report was often against input measures and not March 2024 targets. Therefore, it was difficult to ascertain performance success. Whilst appreciating that today's report had been prepared for the May Board Meeting, the Trust should be able to clarify its end of year performance. It was queried where end of life (EOL) care ambitions linked to end of year progress. Achievement in terms of measurement against frailty and virtual ward was not stated and an update was requested. It was suggested that EOL data was difficult to extrapolate due to the business analysis systems used to identify and that lessons had been learned for this year. **Action: Updated Report to come to September Board.**	**EC**
2.2	**Future System Board Report**	
	It was advised that the letter anticipated, prior to the General Election, regarding funding was yet to be received and was not expected any time soon. It was acknowledged that this could be of concern, but NHS England and the Secretary of State have reported that the commitment to RAAC hospitals will be honoured. Therefore the programme currently remains on track. Question raised as to whether, in light of this delay, the risk ratings should be challenged It was advised that if the delay in confirmation of funding was likely to have a material impact in terms of changes to the capital envelope, then yes, but no material deviations from the accepted plan were anticipated at this stage. Noted that approval of a full business case would be required and if received by the beginning of 2027, would allow sufficient time to build the new hospital for the planned completion of 2030. Updates	

	on the plan and deadline will be provided. The new governance process for the future system programme will provide assurance.	
2.3	**System Update**	
	Question raised as to how the outcome of the prevention work conducted with the Howard Estate, on hypertension and atrial fibrillation was being monitored. Noted the impact on atrial fibrillation would take a couple of years to be seen. **Action: Updated report on this work to be provided to Board Meeting in September.** Noted the premise of the Decaffeination Project was that by replacing caffeinated coffee (a diuretic) with decaffeinated in care homes, this would reduce the number of falls and improve bladder health. The Trust is to join a system working group to look at implementation of same. **Request made that feedback be provided on the Top 3 challenges identified under the Adult Social Care Market Strategy be data driven rather than anecdotal and included in a report to the Board. West Suffolk Alliance Director to action.**	**PW** **PW**
2.4	**Collaborative Oversight Report**	
	Question raised regarding the comment made under corporate services, "scoping of these opportunities has commenced at executive level identifying CIP opportunities for WSFT when comparing their costings to ESNEFT" as to whether this implied that this Trust was not as positive in some services. It was advised that this was not the case and related to a piece of work carried out a couple of years previously relating to unit costs. It appeared, on face value, that some services appeared to be more efficiently delivered by ESNEFT. This was only based on what was in that cost centre. As an example, the corporate operations cost centre at this Trust has a larger budget, but the ESNEFT budget did not include Associate Directors of Operations. The report compiled by PA Consulting had highlighted some CIP opportunities for WSFT in this arena. Consideration of where efficiencies can be made is being undertaken. It was queried whether the analysis undertaken had resulted in a tangible programme of work. Noted exploration of this was ongoing.	
2.5	**ESEOC Report**	
	Simon Morgan, Associate Director of Communications, SNEE ICB and Cassia Nice, Head of Patient Experience & Engagement were in attendance to discuss the report. Noted a six-week engagement period, encompassing many communities within their own environments, had been undertaken.	

	Healthwatch hosted the survey and have conducted an analysis of the data. The final report is now in the public domain and details recommendations made. It was reported that there was a 35% negative response to the proposal, with transport being a key issue. West Suffolk is a rural location, with poor transport links. This includes areas such as Thetford who will have even further to travel for treatment. There was an element of fear of the unknown and concern at having to travel in the dark. The system has taken note of the travel issues. It was highlighted that many people spoken to were unaware that ESEOC would only be used for surgery, with pre and post care undertaken at this Trust. Consideration to be given as to how this is communicated. It was suggested that the matter of patient choice had not come up to a great extent within the engagement work. People were, in the main, pleased to have reduced waiting times. In choosing to remain with this Trust, there could be a difference in waiting times that patients would need to take in to account. Any communication in this regard would need to be open and transparent. Noted some patients would need to remain with the Trust due to their needs and the matter of equitability would need to be considered. The benefit of this move to the other specialties will be the benefit of additional capacity here at the Trust. It was asked if there were any specific proposals going to the Integrated Care Board (ICB) regarding transportation. It was noted that whilst a solution would be required, it was unclear as to whether this lay with the ICB. Discussions were being undertaken with Suffolk County Council regarding potential to finetune the service between Bury and Colchester in terms of staff transport. The voluntary network has provided a proposal, but this is in the early stages. The Board wished to acknowledge the work on engagement carried out by the Head of Patient Safety and Engagement and the team, which was undertaken in addition to their normal workload.	
3.0 PEOPLE AND CULTURE		
3.1	**Involvement Committee Report**	
	Noted the workplace strategy will come to the Board at a future date. Consideration of use of estate assets has been undertaken and strategy principles have been agreed. Funding is to be confirmed. A positive case study was received from Liza Asti, Professional Lead for Speech and Language Therapies, on work with staff in	

	response to the staff survey and development of an action plan, in coproduction with the team to address concerns. A red risk has been highlighted due to the lack of a robust corporate system to manage the quality and accuracy of patient information on paper and the web (circa 1200 documents). This is not a simple fix, but a working group is to be formed to look at this.	
3.1.1	**Freedom to Speak Up**	
	Jane Sharland (JS), Freedom to Speak Up Guardian (FTSU) presented the report. Noted the national job description for the guardian is being reviewed. A link for comments is provided via the website, or can be supplied to JS direct. Data received showed an increase in the number of concerns raised. This was seen as positive, with people feeling comfortable to raise issues. Noted anonymous reporting had dropped to 11% from 40% in Quarter 3. Again, this was seen as encouraging. Themes identified related to difficulty in relationships and staff incivility. Incivility training has been included within human factors training. Difficulties in relationships was with managers and staff feeling unsupported on issues such as child care and return from sick leave. This has continued to be addressed through Trust leadership programmes. Signposting to staff support networks has also proved beneficial. Recognising the comments made regarding childcare and sickness, it was advised that as the Trust moved toward financial recovery and the stringent oversight required, staff would need to be supported, with communication key, as there would be difficult conversations occurring. Noted concerns have been raised regarding staff communication with patients and use of an authoritative style, making some feel unable to challenge, particularly relating to care packages and discharge. Best interest decisions have to be robustly supported, prioritising safety over patient wishes, but there is a balance to allowing people to take risks. Bullying has been a theme in the quarter, including of some junior medical staff. However, it was seen as a step forward that staff were speaking up about these issues. Concerns have been raised that incidences of inappropriate sexual behaviour by a patient who lacks capacity were not always clearly documented. Staff involved have been encouraged by the Trust's adoption of the NHS Sexual Safety Charter.	

	A request has been made by the champions that the non-executive director with responsibility for FTSU review its inclusion in the new starter welcome meeting to encourage staff to speak up. Noted the Equality, Diversity and Inclusion (EDI) Survey has been sent to all champions to enable a gap analysis to be undertaken. Question raised as to whether a split existed between the protected characteristics. Noted this detail will be shared once available. Question raised as to whether staff chose to speak to the champion within their own section or outside. Noted it was a mix. The Board offered its thanks to JS for her work in increasing the visibility of the FTSU Guardian and, as a result a increase in reporting of complaints and a reduction in those being made anonymously. Noted JS had recently graduated with a Health and Management degree.	
4.0 ASSURANCE		
4.1	**Insight Committee Report**	
	Noted 18-week performance for paediatric SaLT was 79%. This was linked to system pressures and SEND demands. Whilst the neurodevelopmental delay pathway (NDD) within community paediatrics remained a red risk, improvements had been made. Negotiations undertaken with the ICB as funding is short term rather than long. In terms of Board assurance it was considered there was too much optimism and insufficient focus on the Cost Improvement Programme (CIP). There has been progress on schemes that the Trust is aware of, but a gap remains on long-term programmes yet to be identified. A deep dive was undertaken at the June Meeting on benefits realisation of investment decisions to explore whether decisions made were consistently evaluated and the appropriate action taken if investments were not achieving the benefits identified in their business case. In terms of strategic objectives it had not been clear within some cases how to measure outcomes and benefit, resulting in difficulties in ascertaining if benefits anticipated are being achieved. Consideration given to disinvestment in areas not working and evaluation of business cases. Workforce planning was discussed and how this is to be kept on track. The Director of Workforce and Communications was invited to the meeting to discuss. Noted discussion held on the non-admitted 4-hour target within the IQPR and whether this was sufficiently ambitious. This has been revised. Further work is to be done on the finance risk within the Board Assurance Framework (BAF). Discussions have been undertaken with the Deputy Director of Finance regarding financial recovery	

	and the Trust is looking at levels of assurance on the risk identified. Question raised as to whether the residual risk scoring was correct. It was advised that there was a disconnect between the controls being used to provide assurance and the actual financial position. **Action: Trust Secretary to consider controls being used.**	**RJ**
4.1.1	**Finance Report**	
	An adverse variance of £3.1million year to date was reported. Noted high level reasons for this, with the biggest theme being medical pay, with half of the year-to-date position attributable to additional contractual work off plan. As a consequence there has been significant escalation by the Integrated Care Board (ICB). On 30th July, a meeting will be held to decide on the controls to be implemented on the Trust's ability to spend money. The ICB have suggested an enhanced double lock. Noted the Interim Medical Director is leading on a piece of work regarding additional programmed activity and from 5 August a panel will be responsible for approving all extra contractual work. The executive team are aware of the potential cultural downside of such measures, some of which are counter to the Trust's culture, in particular to teams being empowered to make decisions which are now being removed. There are potential mitigations around transparency of why this is necessary and involving teams and leaders in the organisation in design of the processes and clear communication on the outcomes. It was felt that fairness and equity across the divisions, via central controls, would be seen as a positive. The last All Staff Briefing had been given over to finance and anecdotal feedback welcomed.	
4.2	**Improvement Committee Report**	
	It was reported that the Trust was seeking clarification regarding the level of training for staff and the impact of delivering the Oliver McGowan mandatory training (learning disabilities and autism) in order to understand how to progress compliance. Noted NHS England have proposed a pause to the CQUIN scheme for 24/25. The ICB have referred the decision to organisations to decide on reporting CQUIN in the contract. The Trust will continue with staff flu vaccinations. There has recently been a positive visit and inspection of the Pharmacy Department by the Home Office. A review of storage of drugs on the wards has resulted in renewal of drugs fridges. The potential wastage reduction is seen as a positive move.	

	A deep dive in to accreditations and licences has been undertaken, with an ongoing pilot in Endoscopy. The achievement of accreditation by Biochemistry was congratulated. It was felt that the level of assurance being obtained was increasing and noted that maternity papers would be included at next month's meeting.	
4.3	**Quality and nurse staffing report**	
	Noted registered nurses and midwifery vacancies had remained static. There had been a reduction in 15 whole time equivalent (WTE) nursing assistants. This may be attributable to leavers, but also internationally recruited nurses moving from a band 3 role to a Registered Nurse (RN) role after successful completion of their exams Nurse sensitive indicators/patient harms show an improvement, noting a potential for underreporting following the transition to RADAR. Additional staff support to increase confidence in use of the system is being provided. Concern expressed at the level of vacancies available for the newly qualified student nurse cohort, with 30% being placed compared to 90%. A full vacancy review has been conducted by the Deputy Chief Nurse, together with the Heads of Nursing and Matrons. A paper has been taken to the Management Executive Group (MEG) to look at recruiting to at risk areas such as maternity and this would increase the level to 64%. Next year and onward the levels of RNs will reduce due to the reduction in student numbers. International recruitment has also been paused, which will limit the ability to fully cover vacancies resulting from turnover. The Trust remains confident this will be absorbed in the normal run rate. Tracking of the situation will continue. Question raised as to whether the Trust was seeing a reduction in temporary staff. Noted for those newly qualified in September, they will not be available until October, but work is being undertaken on how to reduce the temporary spend. In terms of care hours per patient day (CHPPD), question raised as to the impact of the closure of the escalation ward, as an increase in care hours per day would not be anticipated following the cessation of staff spend. Noted CHPPD had not increased in June, compared to April and May, even though the escalation ward had closed. The trend of nursing hours and therapy in community, query raised as to whether the increase was necessarily negative. Noted that by moving more care into the community, an increase in activity would be expected. However, acute services were not shrinking as a result. Metrics to gain an understanding of nurse staffing in community compared to acute have not been available. There is a	

	safer nursing care tool equivalent for community. However the Trust awaits ratification of the tool, which has resulted in a pause in roll out. It was queried whether in terms of care hours, this was a good example of where the Trust was unable to understand the productivity gains from the staff cohort. In theory should it now know how many staff were deployed and to what outcome? Was this an interesting case study in which to gain understanding? Feedback received from users of RADAR expressed concern that the new system was more judgemental in nature and that this did not sit with the Trust's values of learning. Noted there had been changes in the data set used, driven by national requirements, but these needed to be tested. It was highlighted that a box was supplied for narrative on an incident. However, this was being looked at, as will only provide one person's view. An expert on human factors is assisting with this. The organisation is committed to adoption of just culture principles. **Action: Trust Secretary to look at wording used within RADAR to ensure focus on learning rather than judgement.**	**RJ**
4.3.1	**Maternity services report**	
	Noted a cultural survey has been undertaken, as part of the Perinatal Culture and Leadership Programme, with a response rate of 28%, (296 respondents). Listening to service users' voices is a requirement of Ockendon and the Maternity Incentive Scheme etc. Completion figures from friends and family was relatively low. Ideally, this would be championed through the service group. This has been raised with NHS Resolutions as is outside of the Trust's control and is independent. In order to provide assurance, the Trust is using every opportunity to enquire of service users. The CQC survey has been utilised to help form an action plan. The next step will be use of a culture coach to focus on learning, improvement of safety climate and speaking up. There will also be training of in-house culture champions. Noted below target for training on neonatal life support, due to high levels of sickness within a small team. Question raised as to whether this related to annual updates, or for those not having previously undertaken. Noted new starters were prioritised. This related to those on long term sick without an annual update. Noted staff are not taken from mandatory training to accommodate periods of staff shortages. The staff in question will be added to the first course available upon their return to work. Skills and drills continue.	

	Question raised as to whether staff can be brought in prior to induction so they are prepared. Noted mandatory training for junior doctors is organised for the induction period.	
4.4	**Audit Committee Report**	
	Noted no substantive issues raised, following completion of the audit. One unadjusted error identified by KPMG did not affect signoff. No significant findings on value for money noted.	
5.0 GOVERNANCE		
5.1	**Board assurance framework**	
	Risk appetites have been looked at and conversations are evolving. The agendas of assurance committees reflect risk and allow for a deep dive programme. Question raised as to whether the Trust had the same issue with capability and skills as with finance. There were a large number of red risks and it would be unusual for a Trust to have that many. Looking at the mitigating actions many have been progressed. These will be considered at the assurance committees and Management Executive Group. When looking at the financial risk, the mitigating actions would suggest the risk should be lower and question raised as to whether these should be considered by internal audit. Agreed in the first instance this be reviewed by the finance department. It was further questioned whether the Trust's assessment of the residual risk and mitigations was accurate and if so, sufficient? It was suggested for finance it was higher than 16 due to the impact on the Trust. The Trust needed to challenge itself to be objective. Annex B implied the level of assurance was reasonable. Discussion on risks had taken place at Insight. If including all the mitigations and ticking the actions, would it move; would the risk be the same? Looking at matters in the round was helpful to ascertain how the Trust could start to judge one individual risk in terms of others.	
5.2	**Governance Report**	
	Commercial Personal Accident Insurance - The Management Executive Group (MEG) has reviewed Trust arrangements for commercial personal accident insurance relating to staff during patient transfer. NHS Resolution confirm this is covered under their existing Employer's Liability Scheme. Therefore the recommendation was that this commercial cover cease. **The Board gave approval for cessation of commercial personal accident insurance.** ***Terms of Reference – Remuneration Committee*** - **The Board accepted the updated Terms of Reference for the**	

	Remuneration Committee, noting there had been no changes to the previous version. ***Annual Review of Committee Effectiveness*** **- The Board agreed the proposal for structuring of the annual Board committee effectiveness review. Consideration to be given to undertaking reviews on a bi-annual basis, with a more concise template and provision of a forward plan.** Suggestion made that a review of the results from the committees be undertaken in the format of a workshop as conducted by the Involvement Committee.	**RJ**
6.0 OTHER ITEMS		
6.1	**Any Other Business**	
	Paul Pearson (PP) – The Board offered its thanks and best wishes for the years ahead to Paul Pearson, Staff Side union representative for Unison on his retirement. PP was someone who cared very deeply about the organisation and who embodied partnership working in the NHS by leaders and staff. **Louisa Pepper (LP)** – Today's Board Meeting was LP's last, having come to the end of her term as non-executive director. LP was valued for her knowledge and wisdom and considered a great asset to the Trust and champion of its aims, with focus on patients and staff. The Board wished her well for the future.	
6.2	**Reflections on meeting**	
	No reflections noted.	
6.3	**Date of next meeting** 27 September, 2024.	

1.4. Action log and matters arising

To Review

Presented by Jude Chin

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
3063	Open	26/1/24	2.3	**West Suffolk Alliance and SNEE Integrated Care Board:** **ACTION**: With regards the virtual ward (VW), the emphasis was given to ensure continued focus on VW and engage NEDs to ensure continued focus on this with visibility in the UEC update at the next board. Also, to provide an opportunity for NEDs to engage with team. **ACTION**: It was noted that there is a need to include focus on the ICB activities/issues in this report in future reports. **ACTION**: It was also agreed to schedule update on the SNEE ICB Joint Forward Plan in May.	Virtual ward update included in UEC update for Board and NED visit to Virtual Ward being arranged **(COMPLETE)** Included in agenda report **(COMPLETE)** **The ICB have asked that this is received at the September meeting - this has been confirmed and included in the forward plan AGENDA ITEM**	PM/NC PW RJ	27/9/24 ~~24/05/2024~~	Complete	27/09/24
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. **Tracy Dowling, has been appointed as NED representative.**	JC	~~24/05/2024~~ 27/09/2024	Complete	27/09/24
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 and has been placed on the forward plan.**	JMO	29/11/24	Complete	27/09/24
3090	Open	26/7/24	2.1	**Strategic Priorities Report - End of Life Care** ambitions link to end of year progress required. Updated report to come to September Board.	**Today's (27.9.24) report, under agenda item 2.1 - Strategic Priorities Report refers.**	EC	27/09/24	Complete	27/09/24
3091	Open	26/7/24	2.3	**System Update** - Update on impact of work undertaken within community on hypertension and atrial fibrillation to come to September Board Meeting.	**Today's (27.9.24) report, under agenda item 2.4 - System Update refers.**	PW	27/09/24	Complete	27/09/24

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
3092	Open	26/7/24	2.3	**System Update** - Request that feedback to be provided on the Top 3 challenges identified under the Adult Social Care Market Strategy be data driven rather than anecdotal and included in report to the Board.	**Today's (27.9.24) report, under agenda item 2.4 - System Update refers.**	PW	27/09/24	Complete	27/09/24
3093	Open	26/7/24	4.1	**Insight Committee Report** - **Finance Risk in BAF** - Disconnect between controls being used to provide assurance and actual financial position. Consideration to be given to controls being used.	**BAF risk has been reviewed and updated through MEG and Insight. Update included in BAF report.**	RJ	27/09/24	Complete	27/09/24
3094	Open	26/7/24	4.3	**Quality and Nurse Staffing Report** - Wording used within RADAR to be looked at to ensure focus on learning rather than judgement.	**The patient safety team have confirmed that this relates to the new question set requirement for LFPSE and is a national requirement. Concerns have been escalated and fedback nationally. This will form part of the Trust's updated comms and FAQ set for communication to staff.**	RJ	27/09/24	Complete	27/09/24
3095	Open	26/7/24	5.2	**Governance Report** - **Annual Review of Committee Effectiveness** - Consideration to be given to undertaking reviews on a bi-annual basis, with a more concise template and provision of a forward plan.	**A review schedule has been developed which reflects the move to effectiveness reviews taking place every two years.**	RJ	27/09/24	Complete	27/09/24

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

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 - Alisons' story Please note this contains content about dying which some people may find upsetting

To Review

Presented by Susan Wilkinson

1.7. Chief Executive’s report

To inform

Presented by Ewen Cameron

Open Trust Board Committee	
Report title:	Chief Executive Report
Agenda item:	1.7
Date of the meeting:	Friday, 27 September 2024
Sponsor/executive lead:	Dr Ewen Cameron
Report prepared by:	Dr Ewen Cameron and Sam Green, Communication

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

The Trust continues at pace to deal with a difficult financial position and since the last meeting of the Trust's Board, we have been taking considerable steps to get back on a sustainable financial footing. I am grateful to our staff, who are balancing patient safety with the need to identify opportunities to deliver more cost-effective services. We have had to make some tough decisions and I do not underestimate the impact of these.

Despite this, we remain committed to improving our services for our communities and I share detail of some initiatives that support our patients below.

Performance

At the end of August, our reported position in-year was a £14 million deficit, which is £5 million worse than we planned to be at this point. This also takes us very close to our agreed £15.2 million planned deficit for the year. Therefore, we continue doing much work to identify opportunities to improve this situation, working with our colleagues to meet this challenge head on.

We have continued to make progress in our elective recovery. At the end of August, there were:

- 463 patients waiting more than 65 weeks, with the total cohort of patients to be treated by the end of September standing at 800 (this is compared to April 2024, when the cohort of patients who needed to be treated was 4,972).
- 53 patients waiting more than 78 weeks, of which 39 were capacity related breaches.

We have been improving how we use our theatre space to increase the efficiency of the process and see more patients. This includes a review of our theatre templates to create all-day operating, using the same theatre team, surgeon and anaesthetics all day to provide continuity and increased efficiency, and running additional lists on the weekends. Known as 'super Saturdays' – they focus on a particular specialty and reduce backlogs in that area, making a positive difference to our long-waiting patients.

Alongside this, we are continuing to make progress in expanding the number of procedures we offer as a 'day case'. This is where patients have their procedure and are discharged on the same day. Only last week our day surgery unit team completed the first same day discharge of a vaginal repair, where the patient had their procedure and was recovering on the ward by 10am and discharged home at 4pm. This is a perfect example of service innovation where we optimise our processes and care, which lead to better outcomes for our patients while helping us save inpatient beds for those who need them most.

Quality

To ensure our patients are supported by their clinicians in making decisions about their care that are right for them, I reported in July that we had started implementing Shared Decision Making at the Trust amongst our medical and dental workforce. 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 clinicians' expertise with what the patient knows best - their personal preferences, circumstances, goals, values, and beliefs. While a mandatory package of training was launched on 1 July for our medical and dental workforce, I'm pleased to say that we are now also rolling this out to other staff cohorts. From 1 October, all existing medical associate practitioners, advance care practitioners, allied health professionals and other healthcare professionals will be completing this training. This will help us deliver safe, more personalised and higher quality care, and ensure our patients get the care that is right for them.

There are also other initiatives that we are implementing, which are supported by our quality improvement team who help nurture, coach and guide numerous projects to improve the way we work day-to-day and the care we deliver. Some notable projects include improving our decision-making timings with PICC lines for our paediatric patients requiring long-term antibiotics, standardising chest drain procedures across our inpatient wards and reviewing all our community housebound diabetic patients.

These three projects are already delivering great results. So far, our paediatric patients are receiving their PICC line insertions within the target timespan 92% of the time compared to 67% before; incidents relating to chest drains have been reduced by 10% in the past 10 months due to the roll out of a comprehensive training package (which is being monitored to ensure the sustainability of these improvements); and, after having reviewed all our community housebound diabetic patients, we were able to safely discontinue 20 patients from this treatment, saving our district nursing teams 7,280 visits a year (equivalent to a cost saving of £323,378 a year). As part of this project, we were also able to identify those patients with very high and low glucose levels and commence insulin titration - adjusting the insulin dose to improve target blood glucose levels - to improve their health and reduce long-term complications.

On Monday, 16 September the Trust held its annual Patient Safety Summit. This event highlights the work that is ongoing across the Trust around patient safety, how we learn from when things do not go as planned and how we implement the improvements identified from our investigations. Alongside a packed agenda at the Drummond Education Centre at the West Suffolk Hospital, there were also numerous stalls across the site as part of the 'solution gallery'. It was fantastic to see our colleagues visiting the numerous stalls which promote the ways that patient safety is being enhanced in their areas, and learning about how they can bring these into their own departments.

The result of all this work means that the quality and safety of the care we provide improves, and as a result, the outcomes for our patients improve, and enhances their experience. That is why I was delighted to learn the Trust's results from the annual NHS Adult Inpatient Survey for 2023. The Trust was rated 8.5 out of 10 for overall experience, placing fifth highest in England for all acute and combined trusts, and second in the region behind Papworth for all trusts. The Trust also scored in the top two or top five in the region on most other criteria including admission and leaving the hospital, the hospital and ward, doctors, nurses, care and treatment, kindness, compassion, respect and dignity. The Trust also scored well on the support available when leaving hospital and

the food served. This is a hard earned but well-deserved achievement. Delivering our services to this standard takes a village, and I am very proud of everyone working in all services across our Trust as every member of staff contributes directly or indirectly to achievements like these.

Workforce

Whether it's presenting our staff 'Putting You First' awards to the recipients or seeing the vast number of long-service awards that are sent out to those that have achieved 20 years of service in the NHS, I love to celebrate our staff. Therefore, it was an absolute honour for myself and our executive chief nurse, Sue Wilkinson, to present one of our midwives with a special long service award. As we celebrate 50 years of our West Suffolk Hospital, one of our labour suite midwives, Diane Hele, has been working in the NHS since before the existing hospital opened in 1973. In those years she has worked in the theatre sterile supply unit at the old West Suffolk Hospital, then training as a registered nurse which she completed in 1977. From 1978, Diane trained as a midwife, completing this in 1980. Diane has worked in the NHS for 51 years, 44 of those as a midwife, which is a remarkable feat. It is truly people like Diane that make the NHS what it is, and she is a shining example of what public service in healthcare is all about.

I was also recently thrilled to learn that our preceptorship programme has been shortlisted in the Preceptorship Programme of the Year category for the Nursing Times Workforce Awards 2024. The project – 'To improve attendance of the multi-professional preceptorship programme' – aims to increase the engagement and attendance of study days by understanding what the barriers are to going to them. Making improvements in this area is very important, as preceptorship programmes are key to making sure our newly qualified nurses, midwives and other staff start their careers with the tools they need to thrive. This ultimately helps us retain these highly skilled colleagues so we can help them to continue to grow and go on to have successful and rewarding careers in the NHS.

On Friday, 13 September the Suffolk and North East Essex (SNEE) 'Can Do' Health and Care Awards 2024 took place, which celebrates the best of the health and care work that has happened in the area over the last year. Many of our teams were nominated across most of the eight categories and while none came home the ultimate winners, it was heartening to see how many were runners-up or received commendations for the work they've done. This includes the Trust's speech and language therapy team as a runner-up for the 'Healthier Lives Award' and Rachel Grimwood, our student and young volunteer coordinator, as a runner-up for the 'Young People's Champion Award'. Additionally, our virtual ward service and 'The Tablet Course' - a 'computer club' run by our speech and language therapy team and Realise Futures CIC to support those who have experienced a stroke or have aphasia/apraxia to explore how tech can support their needs - were highly commended for an 'Innovation in Health Award'. Congratulations to all those involved.

Future

On 1 August, the Trust marked an exciting milestone in our delivery of a new Community Diagnostic Centre (CDC) at the Newmarket Community Hospital. The centuries old tradition of 'topping out' commemorates the building reaching its tallest point. It has been remarkable to see the difference over the last eight months, from when we broke ground in January to now, as the building is watertight, and the inside is starting to come together rapidly. We remain in a position to finish construction in November and welcome our first patients before Christmas, which will be a wonderful moment.

Once fully open, the CDC will provide approximately 100,000 tests per year, including MRI, CT, X-ray, ultrasound, heart and lung scans as well as blood tests – all from a new, dedicated facility. This will help us deliver care closer to where our communities live and expand our diagnostic capacity to ensure we get our patients the treatments they need more quickly, which will ultimately help reduce health inequalities and improve outcomes.

Of course, we are still working hard to deliver a replacement West Suffolk Hospital on the Hardwick Manor site in Bury St Edmunds. As we await further news from the Government on its review of the New Hospital Programme, we are pushing forward with transformative projects which will make

sure we are ready to take advantage of all the opportunities this new facility offers. That is why we are looking at improving the way we work and how we use technology to deliver the high quality and safe care our communities need, when they need it. Virtual outpatient appointments are a way that our staff can see more patients and our patients can more easily access the care they need. Particularly those that may struggle to attend an in-person consultation due to childcare, work or transport restrictions. Our aim is to grow the number of virtual outpatient consultations that we conduct to 25%, so that we can keep up with the growing demand for our services and fully utilise the space available in the new healthcare facility.

And finally, it was fantastic to see so many of our community come down to The Apex in Bury St Edmunds for our Annual Members' Meeting, which focused on the 50th anniversary of the West Suffolk Hospital and the past, present and future of diagnostics. I enjoyed seeing so many of our services and our health and care partners represented at the healthcare marketplace, where attendees could learn more about our use of artificial intelligence, get their blood pressure tested or experience some virtual reality technology and how we use it in our education and training.

2. STRATEGY

2.1. Strategic Priorities Report

For Approval

Presented by Ewen Cameron

Open Trust Board Committee	
Report title:	**Strategic priorities**
Agenda item:	2.1
Date of the meeting:	27 September 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, this report provides a year-end position summarising progress against delivery for these priorities (**Appendix A**). As part of our smoking cessation commitment the Board is asked to sign the smoke free pledge.

The NHS Smokefree Pledge – Summary for WSFT Board

As discussed, and agreed at previous board meetings, WSFT has been working towards signing The NHS Smokefree Pledge (**Appendix B**). Progress on achieving this is also monitored through SNEE ICB and the system are keen that we now commit to The Pledge, along with ESNEFT.

We intend to launch our new approach to a smokefree site in the coming weeks with the signing of The Pledge and support from Public Health Suffolk, Swap to Stop and the Smokefree Generation Fund. Because of our system support and commitment, we are now confident that we can implement the important components needed to successfully deliver The Pledge requirements 'in support of a smokefree future'. This includes:

- Specialist expertise for smokefree site design with The National Social Marketing Centre
- Contribution to smokefree site design: signs, markings, advertising etc.
- A staff tobacco dependence adviser offer, including nicotine replacement therapy (NRT), Allen Carr and vape options.
- An outpatient and ED tobacco dependence support adviser offer (in line with the Cessation of Smoking Trial in the Emergency Department (CoSTED) trial method).
- Administrative support for the data submission requirements.
- Development and management time, and on-costs.

Alongside this is commitment from SNEE ICB to continue supporting delivery of the inpatient and maternity tobacco dependence programmes ensuring the NHS Long Term Plan requirements are met.

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 (**Appendix C**).

Action Required of the Board

The Board is asked to approve:

- Review the report and note progress
- Approve signing of the NHS Smokefree Pledge

Strategic priorities 2023-24 – year end report

1. **Plan and deliver against the priority areas for service pathway change** *Exec. lead – Paul Molyneux* *Operational delivery lead: Alex Baldwin*		
Measures of success	**Activities/progress in year**	**Status**
Frailty – deliver integrated frailty model leading to 10% reduction in falls and frailty related admissions by March 2024.	• 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.	Behind timeline: work on-going
Virtual ward – to deliver 103 virtual beds by March 2024.	• 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.	Behind timeline: work on-going
Urgent Community Response – increased service provision up to 7 day, 24hr service by March 2024.	• Extension of overnight care provided by EIT for patients on discharge. • Development of Advanced Clinical Practitioner (ACP) SOP in UCR service.	Measures of success achieved – embedding ongoing
Work to bring community and hospital services for children and young people closer together for the benefit of families using our 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.	Behind timeline: work on-going
Pilot of 15 session weeks – piloted in 1 surgical specialty (electives and OPD) by March 2024	• 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.	Behind timeline: work on-going

1. **Plan and deliver against the priority areas for service pathway change** *Exec. lead – Paul Molyneux* *Operational delivery lead: Alex Baldwin*		
Measures of success	**Activities/progress in year**	**Status**
Agreed 3-5 year project plan for delivery of transformation by March 2024	Objectives for 2024/25: ▪ Outpatients ▪ Urgent and emergency care (UEC) ▪ Integrated neighbourhood teams ▪ Developing our children and young people strategy ▪ Diabetes ▪ Service reconfiguration. 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.	Measures of success achieved – embedding ongoing

2. 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*		
Measures of success	**Activities/progress in year**	**Status**
Advanced care plans in place for 50% of patients at the end of life by March 2024	• Model of Care – Following on from completion of scoping exercise, focus groups are being established to take forward areas of opportunity. Moving forward with the following key areas; ○ Anticipatory/Just in case medicines policy (Linking with the ICS group). Launch of a system wide Family Administered Medicines policy for SNEE, with go live 7th October 24. ○ Education and literature (Linking with compassionate Charter). A steering group has been arranged for Suffolk, to work towards a compassionate charter with the support of Colchester who have been accredited as the first compassionate city in the country. ○ Virtual ward (Linking with WSFT and the Hospice) Work has commenced to embed SPC into the existing VW pathways with bi-weekly meetings. ○ Crisis planning and management – As per family administered medicines. ○ UCR, INT and Step-up (linking with age well) As per 24/7 support section. Work has commenced to link SPC with EIT and care homes. ○ Targeted work underway within Haverhill to support severely frail patients be more proactive included the completion of advanced care plans (ACPs) • Sourcing a solution to identification of people in their last year of life. – request to BI for required reports ○ New BI dashboard to be used to support the wider programme planning of work for FY24/25 ○ Data being presented in monthly Die Well domain meetings, needs further refinement although there is an on-going issue with the data feed which needs resolving. ○ Macmillan PEoLC Transformation Lead is also working on this across the SNEE ICB. Engaging with primary care to facilitate identification and reporting	Actions on-going
Virtual ward effectively utilised – end of life pathway in place and capacity to deliver by March 2024	• Virtual ward ○ Twice weekly palliative care consultant attendance at virtual ward MDT providing advice, support and clinical review when needed. ○ Specialist palliative care stream in VW being developed, alongside input of INT teams ○ Care homes frailty project also being supported to help avoid unwanted acute hospital admissions	Embedded palliative VW – BAU All other actions on-going

2. 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*		
Measures of success	**Activities/progress in year**	**Status**
70% of patients die in their preferred place of choice by March 2024	• 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 October 2024 • My Care Choices Register ○ Funding being sought to rollout My Care Choices Register (MCCR) across Suffolk to enable a digital solution for ReSPECT, Advanced care plans, personalised care, and support plans for residents in line with North East Essex. ○ This should enhance identification and documentation of patients at EoL across Suffolk, support start to adhere to patient wishes, where possible in relation to the preferred place of care (PPC) and preferred place of death (PPD)	All actions on-going
10% reduction in admissions within 48 hours of end of life by March 2024	• As per 24/7 Support section below.	All actions on-going
24/7 support for end of life patients and their relatives/ carers is available by March 2024	• BCF – Discharge funding ○ Funding has been agreed through the BCF Discharge fund, for a team of two RN and HCA modelled on EIT. ○ Linking specifically with EIT to support, discharges from WSFT, whilst supporting patients in their own place of residence and to die in their preferred place of care. • The post holders will support, the 2-hour response target whilst providing specialist support for the existing EIT team with advice and guidance.	All actions on-going
ReSPECT is in use 100% by March 2024	• Continue to roll out ReSPECT ○ 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. ○ ReSPECT planned rolled out on eCare for hospital inpatients.	All actions on-going

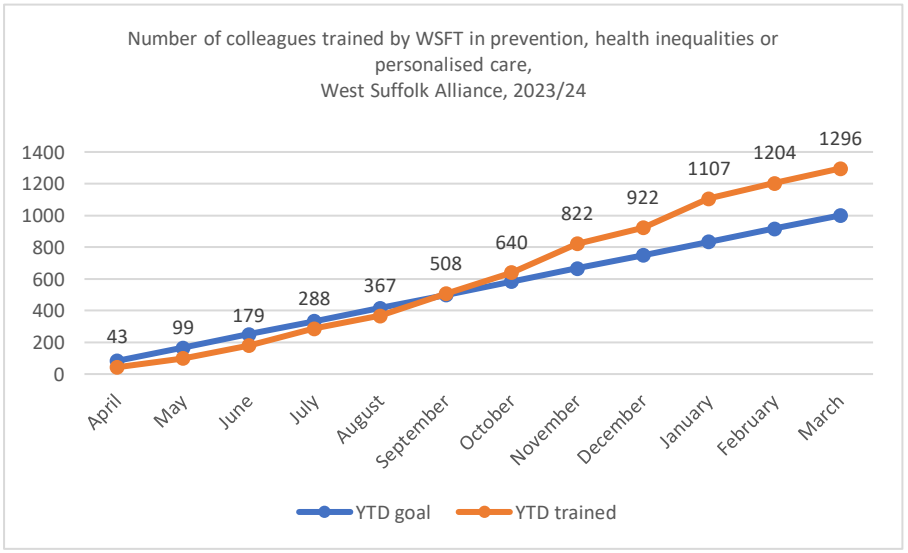
3. **Equality, Diversity and Inclusion** *Exec. lead – Jeremy Over*		
Measures of success	**Activities/progress in year**	**Status**
Prepare to deliver against the Inclusive Leadership and Anti-racism pledge by March 2024	• Inclusive Leadership Charter, Anti-racism pledge and National EDI improvement plan actions all integrated into the Inclusion workplan, with assigned action owners. Actions tracked and recorded every 6 weeks. • 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.	Measures of success achieved – actions ongoing
Action taken with feedback and learning for all EDI-related speak up concerns and reports of harassment, bullying, discrimination or abuse by March 2024	• EDI monitoring introduced for FTSU concerns to evaluate any trend data and patterns emerging. • All concerns actioned by FTSU Guardian, with feedback loop in place for all concerns raised.	Measures of success achieved – actions ongoing
Framework & guidance for reasonable adjustments published by March 2024	• Framework, guidance packs for managers and staff, and Trust wide centralised application process for workplace (reasonable) adjustments launched in June 2024. • NHSE funding grant awarded for the development and launch of an innovative assistive technology toolkit, guide and supporting user videos which were also launched in June 2024. This provides information on software packages that can assist colleagues with disabilities and show them how to use them.	Measures of success achieved – embedding ongoing
National EDI improvement plan measures	• 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. • WRES, WDES and Inclusion Workplan update reports provided to Involvement Committee so that relevant data can be reviewed and action areas prioritised (High Impact 1). • 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. Attendance at job fairs to widen recruitment from local communicates. (High Impact 2). • 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 Parent and Carers staff network launched. New governance and guidance issued.	Measures of success achieved – actions ongoing

4. **Line management development** *Exec. lead – Jeremy Over*		
Measures of success	**Activities/progress in year**	**Status**
No line manager with more than an agreed number of direct reports by March 2024	• Span of line management control data analysis undertaken at divisional level, with local action plans in place to address identified issues	Measures of success achieved – actions ongoing
Values-based line management standards agreed and published by December 2023	• Values based line management standards developed, reviewed by People and Culture Leadership Group, and being socialised for final publication and integration into Trust approaches/processes during Autumn 2024	Behind timeline: work on-going
Learning Hub launched by September 2023	• Learning Hub launched on 27 September 2023 with content continuing to be added. Phase 2 development planned for autumn 2024	Measures of success achieved
Coaching and mentoring framework agreed by September 2023	• 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 •	Behind timeline: work on-going
Line manager development package published and in delivery by December 2023	• 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	Measures of success achieved – actions ongoing
Appraisal completion rates at 90% by December 2023	• 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%	Behind target: work on-going
Improvement in staff survey indicators (longer-term)	• 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.	Measures of success achieved

5. 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*		
Measures of success	**Activities/progress in year**	**Status**
Prevention, health inequalities and personalised care strategy is approved by the board and published on the trust website	The prevention, health inequalities and personalised care strategy was approved and adopted by the Board in December 2023. The strategy is available on the trust website in the board papers. Full publication of the strategy is in hand with the public health and communications team.	Measures of success achieved

5. 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

Measures of success	Activities/progress in year	Status
1,000 colleagues trained in prevention, health inequalities or personalised care	With thanks to colleagues across the trust and SNEE ICB delivering the following training: • Health coaching skills and using the patient activation measure • Learning disabilities and autism • Making every contact count (MECC) • Treating tobacco dependence • Social prescribing • Personalised care • Personal health budgets and personalised care and support planning • Population health management, addressing health and healthcare inequalities • Shared decision making  This objective remains in 24/25 and to date (Sept 2024) is exceeding the monthly goal. We expect to exceed 1000 colleagues trained in 24/25 too.	Measures of success achieved

6. 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*		
Measures of success	**Activities/progress in year**	**Status**
Number of people who successfully quit for 4 weeks	We have: • **continued to expand the inpatient tobacco dependence** service rolling-out to 100% of inpatient areas and 100% of inpatient smokers in November 2023 ahead of the NHSE target of March 2024 (NHS Long Term Plan). • an additional adviser funded by SNEEICB and recruited in March 2024 to support additional inpatient capacity and further roll-out into community support. • identified 925 inpatient smokers to receive specialist smoking cessation support and advice of which 35 were unable to receive this for medical or other reasons, such as quick discharge. • supported 890 inpatients smokers with at least a specialist 'very brief advice – VBA' conversation about smoking cessation. • **supported 391 people to stop smoking**, making a quit attempt at the point of discharge from hospital (NHSE requires discharge date as quit date). • confirmed (CO validated or self-reported) **127 people remained smokefree at 28-days post discharge** (32% of those who set a quit date). In addition to this the maternity team have: • launched the specialist smoke-free pregnancy pathway in May 2023, ahead of the NHSE target of March 2024 (NHS Long Term Plan). • decreased the smoking at time of delivery (SATOD) rate from 11% to within the NHS Long Term Plan rate of <6%. • identified 521 people who smoked at booking and offered them advice and support on smoking cessation in pregnancy. • **supported at least 215 people who booked to declare that they remain smokefree at the time of delivery** (some births are still to come and some people birth at another hospital). The team have recently been shortlisted for a Health Service Journal Patient Safety Award, Suffolk and North East Essex smokefree pregnancy household pathway.	Measure of success achieved
Percentage of people who successfully quit who live in the 40% most deprived lower super output areas	Because people who live in more deprived areas are more likely to smoke and experience health inequalities, understanding more about this group is important. We know that: • 32% of people identified as an inpatient smoker were from the 40% most deprived areas. This has remained the case into 24/25 service delivery and future service development can expect this level of deprivation. • 21% of people from the 40% most deprived lower super output areas remained smokefree at 28-days post discharge. We continue to monitor these outcomes in 24/25 and to date we have: • Identified 737 inpatient smokers to receive specialist smoking cessation support. Of those who set a quit date and have an outcome recorded, 38% remain smokefree at 28-days post discharge with 34% of those living in the 40% most deprived lower super output areas.	Measure of success achieved

7. Review the structure and capacity of the change hub *Exec. lead – Nicola Cottington* *Operational delivery lead: Matt Keeling*		
Measures of success	**Activities/progress in year**	**Status**
Review the structure and capacity of the change hub with a recommendation for an expanded structure by October 2023. Implementation of new structure by April 2024	• 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 • 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 • 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	Measures of success achieved – actions ongoing
Propose a new joint director of strategy and transformation role by August 2023. if agreed, to be implemented by April 2024	• 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 • Appointment of executive director of strategy and transformation in Q4, start date June 2024	Measures of success achieved

The NHS Smokefree Pledge

As local health leaders we acknowledge that:

- Smoking is the leading cause of premature death, disease, and disability in our communities
- Smoking places a significant additional burden on health and social care services and undermines the future sustainability of the NHS
- Healthcare professionals have a key role to play in motivating smokers to try to quit and offering them further support to quit successfully
- Reducing smoking amongst the most disadvantaged in our communities is the single most important means of reducing health inequalities
- Smoking is an addiction starting in childhood with two thirds of smokers starting before the age of 18
- Smoking is an epidemic created and sustained by the tobacco industry, which promotes uptake of smoking to replace the tens of thousands of people its products kill in England every year

We welcome:

- The Government's ambition to make England smokefree by 2030 and tackle health inequalities in smoking prevalence
- The NHS Long Term Plan's commitment for all smokers in hospital, pregnant women, and long-term users of mental health services to be offered NHS funded tobacco dependence treatment by 2023-24
- NICE public health guidance on tobacco

In support of a smokefree future, _____ commits from _____to:

- Treat tobacco dependency among patients and staff who smoke in line with commitments in the NHS Long Term Plan and Tobacco Control Plan for England
- Ensure that smokers within the NHS have access to the medication they need to quit in line with NICE guidance on smoking in secondary care
- Create environments that support quitting through implementing smokefree policies as recommended by NICE
- Deliver consistent messages about harms from smoking and the opportunities and support available to quit in line with NICE guidance
- Actively work with local authorities and other stakeholders to reduce smoking prevalence and health inequalities
- Protect tobacco control work from the commercial and vested interests of the tobacco industry
- Support Government action at national level
- Publicise this commitment to reducing smoking in our communities and join the Smokefree Action Coalition (SFAC), the alliance of organisations working to reduce the harm caused by tobacco

Signed by:

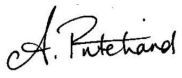
Chair

Chief Executive

Medical/Clinical Director

Endorsed by:

Amanda Pritchard, Chief Executive, NHS England



Prof Dame Helen Stokes-Lampard, Chair, Academy of Medical Royal Colleges

Prof Jim McManus, President, Association of Directors of Public Health

Prof Maggie Rae, President, Faculty of Public Health

Dr David Strain, Chair, BMA Board of Science

Gill Walton, Chief Executive, Royal College of Midwives

NHS England · Academy of Medical Royal Colleges · Association of Directors of Public Health · Faculty of Public Health · BMA · Royal College of Midwives

9th March 2022

Strategic priorities 2024/25
Progress report – September 2024

NHS West Suffolk NHS Foundation Trust

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

SMART action:
- 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).

Lead: Director of Strategy and Transformation (Sam Tappenden)

Measures of success	Activities/progress in last 2 months	Current Status *	For the next 2 months: Key risks / Deliverables & milestones	Anticipated future status *
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).	• Held initial workshop with colleagues in QI, Human Factors, OD, and comms teams • Collated examples of CQI being used in practice at WSFT to support cultural rollout • Started development of a long-term plan to develop a Quality Management System • Attended NHS IMPACT conference on 19th September in London with Improvement Directors • Reached out to our peers for advice, guidance, and support regarding a QI rollout • Initial scope of systems to manage and monitor CQI projects. • Exploring appetite for collaborative approach with ESNEFT and NSFT • Receiving external expert advice from a national expert in QI methodology and rollout • Started restructure of Quality Improvement Team	On track	**Key risks** • Losing commitment, enthusiasm, and motivation as a result of focus on financial sustainability • Limited capacity of teams to support CQI development **Deliverables & milestones** • Hold further development workshops with colleagues • Map out current approach to quality management. • Organise visits to our peer Trusts for ideas and sharing. • Develop plan for implementation of approach to CQI by April 2025.	On track

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

SMART action:

- 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)

Measures of success	Activities/progress in last 2 months	Current Status *	For the next 2 months: Key risks / Deliverables & milestones	Anticipated future status *
• 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.	• 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.		**Key risks** • N/A **Deliverables & milestones** • N/A	
• Increase in Urgent Community Response (UCR) activity by 10% by March 2025 compared to 23/24 baseline	• UCR activity is above the trajectory for the first month and is on track for a 10% increase. An increased number of 2 hour referrals made to Early Intervention Team (EIT) in July has contributed to this. • The increase in activity has not impacted negatively on performance against the 2 hour standard, in fact combined 2 hour response remains above the 70% target trajectory at 86%, with the Integrated Neighbourhood Teams (INT) achieving 90.68% and EIT achieving 75%. • 2 hour data reports have been added to the INT quality dashboards and are now reviewed monthly alongside other quality impact reports by Quality, Clinical and Operational Leads to monitor the impact of the increase in urgent care activity (Quality monthly meetings) and the aligned capacity required.	On track	**Key risks** • Workforce availability in context of double lock **Deliverables & milestones** • See trajectory (Powerpoint slide deck)	On track

Measures of success	Activities/progress in last 2 months	Current Status *	For the next 2 months: Key risks / Deliverables & milestones	Anticipated future status *
• Increase in virtual ward (VW) activity to 100 bed capacity and 80% occupancy by March 2025, monitoring a monthly trajectory towards this goal	• Virtual ward capacity is on trajectory of 40 beds in July 2024, however occupancy is slightly below plan at 76% against trajectory of 80%. • Average number of patients cared for on the virtual ward, bed days occupied and average length of stay (LOS) were the same as the previous period despite the impact of reducing agency nursing by 50% during the second half of July.	Some risk	**Key risks** • Ability to fully utilise capacity **Deliverables & milestones** • See trajectory (Powerpoint slide deck)	Some risk
• Respond to expected national community productivity measures when released	• Not yet published		**Key risks** • N/A **Deliverables & milestones** • **N/A**	
• 24/25 business plans in community and acute divisions reflecting ambitions above, signed off by 31st March 2024	• Divisional business plans have been signed off at Performance Review Meetings in May 2024.	Complete	**Key risks** • N/A **Deliverables & milestones** • N/A	N/A

SMART action:
- Improve productivity within acute services.

Exec sponsor: Chief Operating Officer (Nicola Cottington)
Operational delivery lead: Deputy Chief Operating Officer (Matt Keeling)

Measures of success	Activities/progress in last 2 months	Current Status *	For the next 2 months: Key risks / Deliverables & milestones	Anticipated future status *
• Improve capped theatre utilisation to 85% by March 25, monitoring a monthly trajectory towards this goal	**1.2% adrift of trajectory (11/08), forecasted to recover by March 2025, main driver:-** • Increased number of cases per list, this resulting in increased inter-case downtime and reduced capped utilisation, in July 24, delivered 1028 procedures, the highest number since February 2020, cases per list sitting at the top of the third quartile nationally. • Pest control issues in late June resulting in the loss of 107 procedures. • Increased surgical UEC demand, reducing elective bed base from 18 to 6 beds (w/b 26/08) resulting in increased pre-emptive cancellations and inability to backfill. • Unforeseen anaesthetic staff absence, resulting in the prioritisation of clinically urgent, long-waiting patients. **Highlights** • Late starts remain on a downward trajectory at 27 minutes (11/08) • 88% of available High Volume Low Complexity (HVLC) weekend lists picked up (n=32) • 2 x “Super” Saturdays scheduled for general surgery, 7th and 21st September. • Clinical agreement to book all appropriate lists to prospective 100%	Some risk – currently off trajectory	**Key risks** • Non-elective demand. • Important to consider capped theatre utilisation alongside other metrics including cases per list **Deliverables & milestones** • See trajectory (Powerpoint slide deck) • Creation of retrospective/planned activity dashboard • Implementation of “Charlesworth” Theatre productivity metric, provides a more balanced view of productivity. • Ongoing clinical chairship of theatres task and finish group • Daily activity reporting, enabling “live” learning • Service manager review of prospective lists, reducing risk of cancellation.	On track

Measures of success	Activities/progress in last 2 months	Current Status *	For the next 2 months: Key risks / Deliverables & milestones	Anticipated future status *
• Align 85% of high volume, low complexity (HVLC) theatre activity with GIRFT cases per list standards by March 2025	**Orthopaedic HVLC activity achieving trajectory, Ophthalmology 0.71 off trajectory, expecting to hit trajectory by March 2025.** • Ophthalmology delivering weekly HVLC list, 32% of lists delivering 8 cataracts. • Ophthalmology highest number of cases per list in region (Model Health 28/08) • 3 other specialties also delivering highest number of cases per list in region: plastics, urology and general surgery	Some risk – ophthalmology off trajectory	**Key risks** • Most productive ophthalmology locum leaving 31/10/24. • Chiller issues and temperatures in theatres, two occasions where temperatures exceeded 24 degrees, resulting in cessation of surgery, escalation route to Estates established. • Trauma demand- increased risk of conversion to trauma, reducing denominator and associated opportunity. **Deliverables & milestones** • See trajectory (Powerpoint slide deck)	On track
• Implement British Association of Day Surgery (BADS) recommended rates of day surgery for all specialties by March 2025	**Exceeding trajectory @ 84.3%** • Specialty breakdown (May 24- latest Model Health data) ○ Ophthalmology- 100% ○ Orthopaedics- 84.3% ○ General Surgery-82% ○ Gynaecology- 68.3% ○ Breast- 74.6% ○ ENT-96.3% ○ Urology- 86.6% ○ Vascular- 98.8%	On track – exceeding trajectory	**Key risks** • Only one static Faxitron machine for breast surgery and therefore day cases are often completed in Main theatre which increases risk of conversion. **Deliverables & milestones** • See trajectory (Powerpoint slide deck) • Focus on Breast and Gynaecology. • Moving to booking as day case by default, as unable to change classification should procedure listed as inpatient convert to day case.	On track

Measures of success	Activities/progress in last 2 months	Current Status *	For the next 2 months: Key risks / Deliverables & milestones	Anticipated future status *
• Respond to expected acute productivity measures and incentive scheme when released	• Not yet published		**Key risks** • N/A **Deliverables & milestones** • **N/A**	

• 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
	• Outpatient attendances, particularly first attendances which contribute towards the Elective Recovery Fund (ERF) threshold, are below trajectory. The bi-weekly outpatients meetings monitor and challenge clinic capacities and slot utilisation, with targeted discussion taking place with specialties with the largest variance (gynaecology, audiology, rheumatology, urology, cardiology). Reduced referrals in cardiology and rheumatology have been highlighted, in addition to clinical vacancies.
	• Patient Initiated Follow Up is meeting plan at 4%. The biggest improvements demonstrated so far are in: cardiology, dermatology, respiratory, urology and dietetics. ENT, T&O and vascular are already meeting the year end 5% target and we expect to meet the 5% target overall.
	• **Percentage of attendances that are first attendances or with a procedure** is measured at system level where the target is 46.2%. Within this, WSFT have a flat line target of 41.61% representing an increase on baseline. Current performance is 37.8% against this target. It is likely that increasing the percentage of first attendances will have a greater impact than introducing new services with procedures. Specialty specific work is progressing to ensure we are capturing all outpatient procedures, with further opportunities for clinic template optimisation as per the Getting It Right First Time (GIRFT) Further Faster Handbooks to increase first attendances.
	• Progress is reported through the joint WSFT/ESNEFT Elective Care Programme Board.
		Some risk – OPD attendances below trajectory	**Key risks**
			• Workforce availability due to reduction in temproary staff avaiability
			
			Deliverables & milestones
			• See trajectory (Powerpoint slide deck)
			• Outpatient attendances - Meeting ERF thresholds within existing budgets is a key divisionally led recovery ambition.
			• Percentage of attendances that are first attendances or with a procedure - Analysis of baseline data shows anaesthetics, respiratory physiology and general medicine to have the highest percentage values with clinical psychology, haematology and speech and language therapy the lowest. We expect to see an increase in the percentage in the second half of the year.
				Some risk

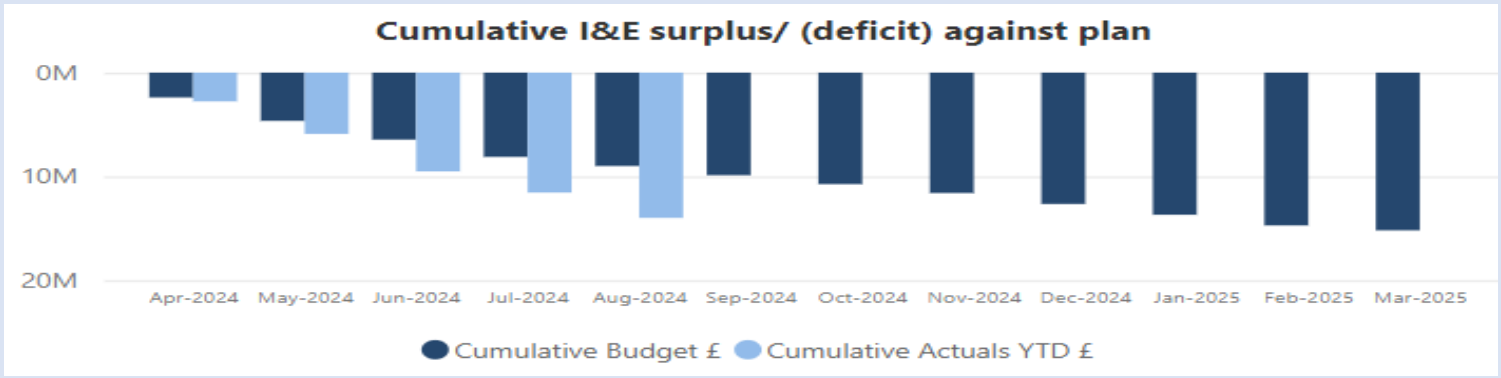
Priority: Delivery of long term sustainability for health and care in west Suffolk

SMART action:

- Deliver reduction in our underlying deficit.

Lead: Director of Finance (Jonathan Rowell)

Measures of success	Activities/progress in last 2 months	Current Status *	For the next 2 months: Key risks / Deliverables & milestones	Anticipated future status *
Delivery of agreed 2024/25 cost improvement plan leading to reduction in underlying deficit.	• £5m adverse to plan at end of M5 • Appointment of Director of Financial Recovery • Implementation of significant cost controls on pay and non-pay to reduce in year 'run rate' • ICB enforced 'Double lock' on recruitment and non-pay spend. • Development of Financial Recovery plan for the remainder of 2024/25 demonstrating signifcant underlying improvement	At Risk – achieving plan deficit is extremely challenging; considerable improvement in run rate expected	**Key risks** • Controls in place do not generate expected reductions • Pay awards are not fully covered by available funding • Winter pressures increase run rate above that planned **Deliverables & milestones** • Development and implementation of further financial recovery measures • Development of medium term recovery plan for 2025/26	Some risk – considerable improvement expected, but remaining structural deficit to be resolved.



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

SMART action:
- 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 (Ravi Ayyamuthu)
Operational delivery lead: Director of Operations for Future Systems Programme (Alex Baldwin)

Measures of success	Activities/progress in last 2 months	Current Status *	For the next 2 months: Key risks / Deliverables & milestones	Anticipated future status *
<u>Outpatients</u> • Transition 25% of appointments to virtual platform • Transition 25% of face to face appointments to peripheral locations	• Development of workshop and roadshows with first pan-trust workshop to take place on 25 September. Aim to increase usage of virtual and non face-to-face appointments. • Asset audit and peripheral demand assemmnet has been completed. Sudbury Community Health Centre has been identifed as pilot site location. Implementation plans are in development and managed via the West Suffolk Accomodation meeting.	**On track**	**Key risks** • Failure to procure Attend Anywhere virtual consulation software (or suitable alternative) due to current financial pressures. **Deliverables & milestones** • Trajectory for peripheral clinic increase in development.	**On track** Although failure to procure software solution would render the virtual consulation project at risk.
<u>UEC</u> • Develop a Target Operating Model (TOM) for future “emergency village” model of care	• TOM population has commenced based on FSP template.	**Some Risk** The target operating model is drafted however it is subject to TOM testing which is being undertaken by the digital team. Also awaiting clarification from NHP team on standardised TOM template.	**Key risks** • Lack of timely updates from NHP on sandardised TOM template. **Deliverables & milestones** • Ongoing development of the TOM.	**Some Risk** Anticipating a slow response from NHP.

Measures of success	Activities/progress in last 2 months	Current Status *	For the next 2 months: Key risks / Deliverables & milestones	Anticipated future status *
<u>Integrated Neighbourhood teams</u> • Supporting delivery of responsive and proactive care leading to 10% reduction in unnecessary admissions by March 25	• Shared service delivery project underway. • Co-produced vision for early intervention team (EIT), virtual ward (VW) and integrated neighbourhood teams (INTs) has been completed. • Pilot at Mildenhal has commenced – this will co-locate EIT, VW and urgent community response (UCR) services. • Early indication of impact – 35% increase in medication care plans recorded and achievement of 10% increase in compliant UCR clock stops (within 2 hours).	**On track**	**Key risks** • Availiability of point of care testing (POCT) • Flexibility to match workforce to demand given current financial pressures. • Provision of IV antibiotic services. **Deliverables & milestones** • To embed UCR performance improvements. • Roll out shared service delivery plan to all localities (to be concluded by Dec 24).	**On track**
<u>Childrens and Young People</u> • Develop a TOM for Children's and Young Peoples Services	• TOM population has commenced based on FSP template. • CYP workstream stopped in August 24 due to reallocation of the change hub to CIP delivery.	**At risk** The resource allocated to delivering this priority has been reasigned to CIP.	**Key risks** • Lack of resource to deliver measure of success. **Deliverables & milestones** • Completion of the TOM is at risk.	**At risk** Reprioritiastion of work means activity is paused indefinately.
<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	• Service offer is drafted and awaiting approval. • West Suffolk Diabetes Service Sepcification v2 has also been drafted.	**Some Risk** Delay to development of agreed way forward has led to some risk. However all parties are now committed to agreeing a sustainable solution and good progress is being made.	**Key risks** • Lack of clinical engagement in agreeing clinical model or specification. This is being appropriately mitigated through the West Integrated Diabetes Executive (WIDE). **Deliverables & milestones** • Finalise diabetes service offer. Align with service specification v2. • Scope primary care / community provision and map against current resources.	**On track**

Measures of success	Activities/progress in last 2 months	Current Status *	For the next 2 months: Key risks / Deliverables & milestones	Anticipated future status *
<u>Service reconfiguration</u> • Deliver test of change to demonstrate “left shift”. • Increase community phlebotomy provision by 25% compared to 23/24 baseline	• Funding has been approved for the health equity programme via the ICB. • Pilot at the New Bury Community Center has been agreed.	**At risk** The resource allocated to delivering this priority has been reasigned to CIP.	**Key risks** • Lack of resource to deliver measure of success. **Deliverables & milestones** • To agree staffing model and funding arrangements. • Development of recruitment and training package.	**At risk** Repriorotisation of work means this is delayed. Support being received from ICB transformation team.

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

SMART actions:

- 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)

Measures of success	Activities/progress in last 2 months	Current Status *	For the next 2 months: Key risks / Deliverables & milestones	Anticipated future status *
• Improvement in related WRES and WDES indicators in 2025 (exact scale of improvement to be agreed before first report in May 2024)	• 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 • 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	**At risk** • Exact scale for improvement to be agreed • Current Trust position impacting negatively on planned work in this area e.g. inclusive recruitment, externally commissioned work	**Key risks** • Prioritisation of key workstreams/activies in line with finance and 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 • Financial challeneges mean some externally commissioned activity now stopped • Not being seen as a priority by colleagues in the Trust **Deliverables & milestones** • Launch of EDI videos and cascade approach • EIA portal development to support easier completion and capturing of EIA information	**Some risk** Focused improvement can be made by prioritising very specific target improvement areas, although this is needs to be balanced with current financial recovery priorities and activities

• Improvement in related NHS staff survey indicators in 2025 (exact scale of improvement to be agreed before first report in May 2024)	*Q17a and Q17b (sexual harrassement) identified as indicators for tracking and improvement* • Sexual Safety Charter signed and Board approved • Actions within the Charter integrated and being prioritised as part of Inclusion Workplan	**Some risk** • Work planned in this area may take longer to implement / gain organisational traction given the priorities of the Trust currently	**Key risks** • Prioritisation of key workstreams/activies in line with finance and resource availability means impact may take longer, as many different approaches are needed at scale to have maximum impact • Not being seen as a priorty by colleagues in the Trust **Deliverables & milestones** • Progress actions identified in workplan	**Some risk** Focused improvement can be made by prioritising very specific target improvement areas, although this is needs to be balanced with current financial recovery priorities and activities
• ~~Reduction in patient complaints related to bullying, harassment, discrimination and accessibility of information~~	It is suggested that this metric is replaced with the one below, which is focused more specifically on the accessibility of information aspect of this original metric, and which is a pressing area of focus.			

Improvement to reasonable adjustment and accessible information recording and provision **for patients** in 2024/25	• 29 patient profiles have been completed since April 2024, designed for vulnerable patients or those lacking capacity. • The newly formed Patient Equity Oversight Group, which will have oversight of the reasonable adjustment working group for patients, is due to hold its first meeting in October 2024. The group will report to the Experience of Care & Engagement Committee and up to Involvement Committee. It will work alongisde its sister workforce group, Belonging to the NHS, to ensure cohesion. • Virtual interpreting via video platforms is being rolled out across the organisation to adhere to language related reasonable adjustments in a timely yet cost effective manner. • The Patient Environment Group is considering access recommendations made as a result of accessibility assessments of the physical hospital environment, produced by AccessAble. An update on priorities will be provided in the next update.	**At risk** • The means to record reasonable adjustments on patient records has been built, but the ability to provide these requires assessment of existing resource and financial feasibility.	**Key risks** • Loss of patient equalities officer vacancy will prolong practical progress of elements of this work. • Providing reasonable adjustments to patients will require staff training and awareness to all frontline staff on how to record and provide. • Patient portal changeover to new system requires patients to re-register (where the patient profile is hosted). • Accessibility recommendations will require prioritising and due consideration of risks versus financial implications. **Deliverables & milestones** • Patient Equity Oversight Group will monitor the delivery of reasonable adjustments for patients and service users • Minimum of 10% face-to-face interpreter bookings converted to video by April 2025 • Go-live of reasonable adjustments form on e-Care by December 2024 • Accessibility improvements to web content and software by March 2025 • Assessment/completion of the Equality Delivery System by March 2025	**Some risk** • Change freeze to e-Care is due. If blockages cannot be overcome then reasonable adjustments form go-live will be delayed. • Digital issues are delaying implementation of virtual interpreting in some areas.

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

SMART action:

- 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

Exec sponsor: Executive Chief Nurse (Sue Wilkinson)

Measures of success	Activities/progress in last 2 months	Current Status *	For the next 2 months: Key risks / Deliverables & milestones	Anticipated future status *
Development of personalised care and support plan datasets into e-Care, including integration of the patient profile by March 2025	• 29 patient profiles have been completed since April 2024, designed for vulnerable patients or those lacking capacity. • Looking into incorporating communication 'passports' into patient profiles for patients who have acquired disabilities due to a stroke or neurological condition.	**On track** The current patient profile template, which incorporates elements of the personalised care and support plan datasets, requires additional dataset incorporation	**Key risks** • Few completed patient profiles due to lack of dedicated resource, leadership of the project and staff awareness • Information overload – decisions are required surrounding what information is most useful and will be read/adhered to, acknowledging potential information overload on e-Care versus actual risks **Deliverables & milestones** • Review usability of current patient profile template to ensure maximum impact and benefit by December 2024	**On track** The new Patient Equity Group will monitor progress and escalate decision-making regarding suitable dataset collection through to Involvement for oversight

Measures of success	Activities/progress in last 2 months	Current Status *	For the next 2 months: Key risks / Deliverables & milestones	Anticipated future status *
Increase of 10% in recording of protected characteristics on patient records	• Some protected characteristics (disability*, race, religion or belief, sexual orientation) continue to be primarily recorded as 'unknown' or 'not stated' and the 10% target is not due to be met • Key stakeholders have been exploring ways for patients or proxies to self-record and update information • Links with primary care to explore how characteristics are recorded on the NHS spine and abilities within NHS App to self record or by proxy *Links to following measures surrounding reasonable adjustments for people with disabilities	**Some risk** This information is routinely recorded throughout patient check-in and referral, but there is risk of majority 'unknown' characteristics. We cannot vastly improve this without engagement from patients and colleagues.	**Key risks** • Loss of patient equalities officer vacancy will prolong practical progress of elements of this work • Inability to accurately benchmark local experience and health inequalities due to absence of this data • Patients' reluctance to disclose this information • Staff reservations to request this information **Deliverables & milestones** • Explore prompts on digital outpatient check-ins by March 25 • Explore integration into the new patient portal to support self-recording by March 25	**Some risk** The Patient Equity Group will monitor this measure and the related deliverables, including during roll-out of the new patient portal
Implement a reasonable adjustment policy by September 2024	• The newly formed Patient Equity Oversight Group, which will have oversight of the reasonable adjustment working group for patients, is due to hold its first meeting in October 2024. The group will report to the Experience of Care & Engagement Committee and up to Involvement Committee. It will work alongisde its sister workforce group, Belonging to the NHS, to ensure cohesion.	**At risk** A policy cannot be created until the scoping exercise is completed (to assess which reasonable adjustments we can provide across the organisation) therefore this measure will not be met by Sept 24	**Key risks** • Loss of patient equalities officer vacancy will prolong practical progress of elements of this work **Deliverables & milestones** • Providing reasonable adjustments to patients will require staff training and awareness to all frontline staff on how to record and provide.	**On track** Proposal to adjust this measure to March 2025 ahead of the new financial year, accounting for the required preparational work. At risk if no adjustment to deadline.

Measures of success	Activities/progress in last 2 months	Current Status *	For the next 2 months: Key risks / Deliverables & milestones	Anticipated future status *
Increase of 10% in reasonable adjustment needs recorded on e-Care by December 2024	• The ability to record reasonable adjustments has not yet been made live on the patient record and will not be until 2025 after the e-Care change freeze in November 2024	**At risk** There will not be 10% increase by this time	**Key risks** • Loss of patient equalities officer vacancy will prolong practical progress of elements of this work. • Providing reasonable adjustments to patients will require staff training and awareness to all frontline staff on how to record and provide. **Deliverables & milestones** • Go-live of reasonable adjustments form on e-Care by March 2025	**Some risk** Once the form is live on e-Care, staff training and education will be required to ensure adherence with reasonable adjustment provision. Proposal to adjust this measure to March 2025 alongside the policy above.
Improvements to booking and waiting procedures for those with reasonable adjustments by March 2025	• This success measure will be an objective for the new Patient Equity Group as part of the reaosnable adjustments work required. The first meeting is due to take place by the end of the calendar year.	**Some risk** This will require updates to the patient access policy and booking of procedures/appointments to suit those with additional needs	**Key risks** • Challenges with waiting list and allowing longer slots for appointments and booking procedures **Deliverables & milestones** • Explore how this works in pre-assessment unit who already make these reaonsable adjustments • Trial in additional area(s) to assess the wider impact by March 2025	**Some risk** Updates to the access policy can be considered in order to meet adjustments required, but strategic decision will need to be made as to whether this is deemed a 'reasonable' adjustment given the current pressures on waiting lists and outpatient appointments

Measures of success	Activities/progress in last 2 months	Current Status *	For the next 2 months: Key risks / Deliverables & milestones	Anticipated future status *
Accessibility improvements to web content and software by March 2025	• Procurement exercise has been completed and a contractor chosen to conduct the audit	**At risk** Due to current financial pressures there has been a query about the risks of retracting the audit and its associated cost	**Key risks** • Rescinding of the financial approval for the audit • The Equality and Human Rights Commission (EHRC) in England, Scotland and Wales and the Equality Commission for Northern Ireland (ECNI) in Northern Ireland will enforce the requirement to make public sector websites and mobile apps accessible (making them perceivable, operable, understandable and robust). • Organisations that do not meet the accessibility requirement or fail to provide a satisfactory response to a request to produce information in an accessible format, will be failing to make reasonable adjustments. This means they will be in breach of the Equality Act 2010 and the Disability Discrimination Act 1995. • The EHRC and ECNI can therefore use their legal powers against offending organisations, including investigations, unlawful act notices and court action. **Deliverables & milestones** • Approval of audit	**On track** If approved, the audit is ready to be undertaken
Assessment/completion of the Equality Delivery System by March 2025	• Services to assess have been identified and leads in these areas have been contacted.	**On track**	**Key risks** • Loss of patient equalities officer vacancy may prolong practical progress of elements of this work but at present this work has been prioritised. **Deliverables & milestones** • Creation of staff and patient surveys by December 2024 • Identify key groups to engage with, including health inclusion groups, by December 2024	**On track**

Measures of success	Activities/progress in last 2 months	Current Status *	For the next 2 months: Key risks / Deliverables & milestones	Anticipated future status *
Accessible guides and improvement plans for all Trust sites by September 2024	• All accessibility guides for West Suffolk Foundation Trust sites (West Suffolk Hospital, Newmarket Community Hospital and King Suite) have been completed and published • The action plan has been reviewed by the Patient Environment Group for consideration and prioritisation	**On track**	**Key risks** • Accessibility recommendations will require prioritising and due consideration of risks versus financial implications. **Deliverables & milestones** • Update on actions at Patient Environment Group in September 2024	**On track**

Priority: Supporting and developing leaders and managers

SMART actions:

- 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)

Measures of success	Activities/progress in last 2 months	Current Status *	For the next 2 months: Key risks / Deliverables & milestones	Anticipated future status *
Further targeted development and learning support for leaders and managers launched by December 2024	• Onboarding of new learning and coaching providers, bringing additional expertise and capacity (utilisation now paused) • 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) • 6 weekly events update shared with Corporate managers to promote portfolio and encourage engagement • Full HR policy review as part of the 'people project' – with full resource bank to follow linked to the employee lifecycle to support line managers access information	**Some risk** • Range of internally developed and delivered interventions progressing, although full agenda cannot be dleivered and use of external experitse paused, meaning all identified need cannot be met at pace	**Key risks** • Time to learn – the impact of leadership development interventions is dependant on individuals being released from operational activities • Prioritisation of extensive work needed to reach all staff across all areas • Lack of clear data (including workforce data) makes direct targeting of leaders at all levels / those most in need problematic **Deliverables / milestones** • 1 day manager training to be piloted – focus on core people management skills • Phase 2 development of Learning Hub to be progressed	**Some risk** Re-priotitiation of work means some activities are paused / delayed or postponed indefinately

Development and launch of managers' wellbeing toolkit by March 2025	• Focus groups taking place, finishing in August 24. Line managers resources to be incorporated as wellbeing learning modules on the Learning Hub	**On track**	**Key risks** • Potential slow down of timeline if staff resource has to contiue focusing on other work needed to support current change activities **Deliverables / milestones** • Further scoping of managers wellbeing toolkit and resources	**Some risk** Re-priotitiation of work means some activities are paused / delayed or postponed indefinately
Approach to succession planning and career development piloted by December 2024	• Trust wide approach and process for succession planning and career development being drafted in readiness for PCLG in September	**On track**	**Key risks** • Potential slow down of timeline if staff resource has to contiue focusing on other work needed to support current change activities **Deliverables / milestones** • Pilot groups to be identified for succession planning pilot. • Career development resources to be gathered for inclusion on the Learning Hub	**Some risk** Re-priotitiation of work means some activities are paused / delayed or postponed indefinately
Improvement in related NHS staff survey indicators in 2025 (exact scale of improvement to be agreed before first report in May 2024)	*NHS staff survey Q16b and WRES 4b/c (reducing discrimination from line managers and colleagues) identified as indicators for tracking and improvement* • Range of activities designed and in delivery will help to contribute to educating managers and support reducing discrimination *Improved NHS staff survey Q23b-d (impact of appraisals) identified as indicator for tracking and improvement* • Review of new appraisal process launched	**On track**	**Key risks** • Potential slow down of timeline if staff resource has to focus on other work needed to support current change activities **Deliverables / milestones** • EDI videos to be finalised and launched • Targetted trainng sessions booked and in delivery • Appraisal review to be comcluded and learning implemented	**Some risk** Re-priotitiation of work means some activities are paused / delayed or postponed indefinately

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

SMART action:

- 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:
  - Optimising use of population health management data to target capacity as a system
  - Optimising contacts with patients for prevention goals
  - Promoting healthy lifestyle choices

Lead: West Suffolk Alliance Director
Clinical lead: Clinical lead for public health

Measures of success	Activities/progress in last 2 months	Current Status *	For the next 2 months: Key risks / Deliverables & milestones	Anticipated future status *
<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	• ICB proposal for Health Equity has been approved and work started on implementation. High Level Oversight group due to meet next week to commence mobilisation plan to expand BP and AF workstreams in key high need areas. • Attended 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) • Work with libraries to issue / recall BP kits has progressed and due to go live in next few weeks • PHM dashboard created for HIPC by Becky Allen going through final checks before release • Next target group - those with no hypertension, aged between 40-80 who smoke or are obese (total cohort population of 77) – paused due to care coordinator moving on and health equity plan being finalised	On track	**Key risks** • Roll out of all Health Equity Plan will take time to implement but robust plan in place to action • Collective action from Primary Care **Deliverables and milestones:** • Libraries issuing and recalling BP machines • Implementation plan and timescales for delivery agreed with key immediate actions undertaken for health equity plan • Continuation of attending events to raise awareness and take BP's with appropriate actions in place • Move forward with next hypertension target group and action 77 patients	On track

Measures of success	Activities/progress in last 2 months	Current Status *	For the next 2 months: Key risks / Deliverables & milestones	Anticipated future status *
<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	• Improving data set to enable further evaluation tools required to release further ICB funds to extend this approach to more areas. • PHM utilised with Sudbury INT and PCN's from locality to identify key cohorts of patients where joined up approaches would benefit. Waiting lists from INTs to be priortised as well. Agreement to run workshops in rural areas to offer BP checks, health checks, vaccines etc and link to local organisations for additional support in childhood Asthma and mental health. Approach will continue with all other localities and PCN's over coming weeks.	On track	**Key risks** • PCN / INT disengagement due to collective action **Deliverables and milestones:** • To deliver all PCN / INT workshops to identify the localised need and opportunity to collaborate on key issues in evidence base – hypertension features in every single area as a key concern. • To embed the new dashboard from Becky Allen into workstreams • To create a dashabord to monitor progress of health equity plan specific activity.	On track
<u>Support Healthy lifestyle choices</u> • Complete blood pressure health promotion campaign with a reach of 50,000 people using WSFT media channels	Blood pressure (BP) awareness was promoted at Latitude Festival with a potential reach of 62,500 people. Credit card size health promotion materials have been distributed across WSFT community sites as part of the Q2 health promotion materials audit.  Between 18th July and 31st August 2024, the SiSu health check machine stationed in West Suffolk Hospital Courtyard Café completed 479 health checks, which includes BP. Know Your Numbers! Week from 2nd – 8th September achieved:	On track	**Key risks** There are currently no identified risks. **Deliverables & milestones** BP and tobacco dependence health promotion will be availble at WSFT annual members meeting. Further campaigns are planned to align with: - Stoptober in October - Men's health in November - New Year health promotion in January	On track

	Green Sheet = 31 clicks NextDoor = 8,111 impressions (view) Facebook = 2,933 impressions (view) **Total = 11,075**			
• Increase the impact of exercise referral pathways with Abbeycroft Leisure by 25% by March 2025	A new service specification was agreed and signed in June 2024. Clear seperation of old/existing pathways has happened with a tirage step implemented to facilitate this. New pathways are in development. Quarterly data is submitted to WSFT for analysis and review with Q1 underway now and Q2 data due at the end of September.		**Key risks** The main risk is achiveing appropriate referrals into the pathways from the idenitfied clinical groups. **Deliverables & milestones** Continue to work on new pathway development and produce an interim review of the Q1 and Q2 data findings.	
• 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	Smoking cessation referrals to Feel Good Suffolk (FGS) went live in July 2024 with 27 referrals to date (20/09/24). Development of weight management and exercise referral pathways is ongoing.		**Key risks** The main risk is FGS readiness and capacity to manage health referrals for weight management. **Deliverables & milestones** Continue to establish and embed the smoking cessation referral pathway. Further develop discussions about WSFT referrals into FGS weight management support.	

Key: Current Status / Anticipated future status

On track
Some risk
At risk

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- September 2024

Putting you first

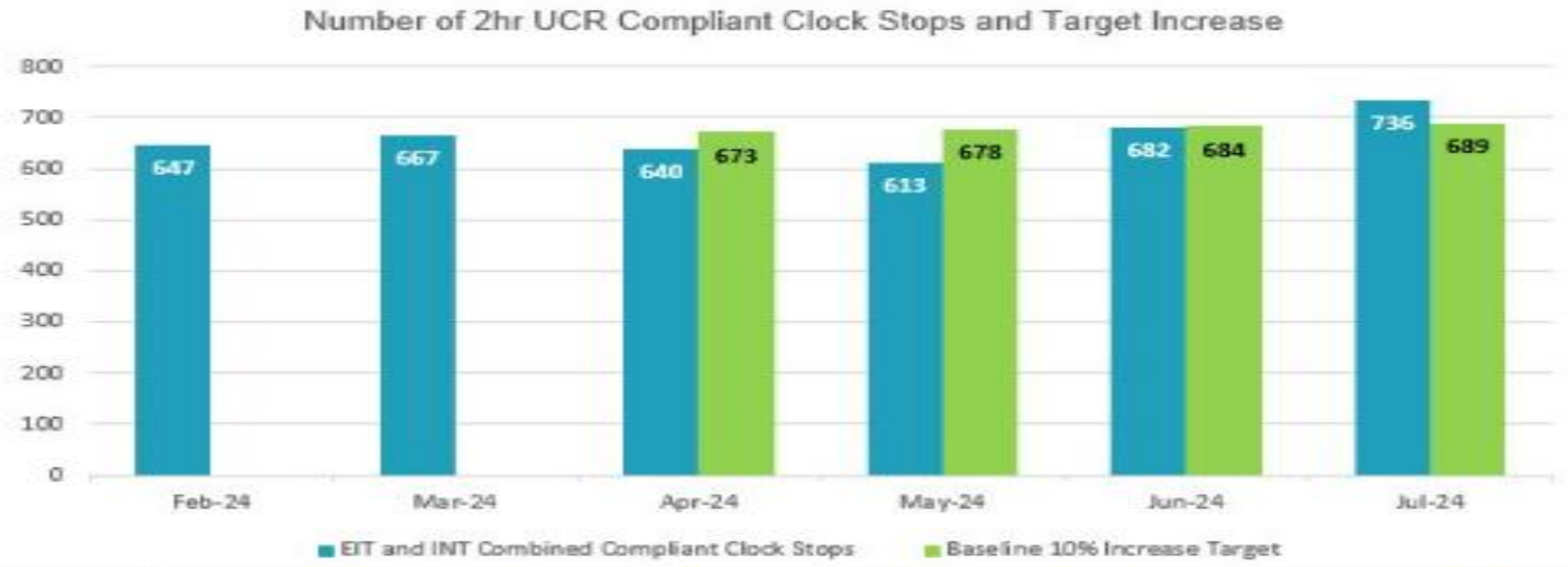
Action: Proactively grow our community services division

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 signed off at Performance Review Meetings in May 2024.

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	Feb-24				Mar-24				Apr-24				May-24				Jun-24				Jul-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	180	136	44	76%	201	158	43	79%	179	134	45	75%	175	115	60	66%	204	150	54	74%	217	162	55	75%
Total EIT*	564	511	53	90.60%	545	509	36	93.39%	563	506	57	89.88%	552	498	54	90.22%	569	532	37	93.50%	633	574	59	90.68%
Combined Total	744	647	97	86.96%	746	667	79	89.41%	742	640	102	86.25%	727	613	114	84.32%	773	682	91	88.23%	850	736	114	86.59%

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

Supporting narrative

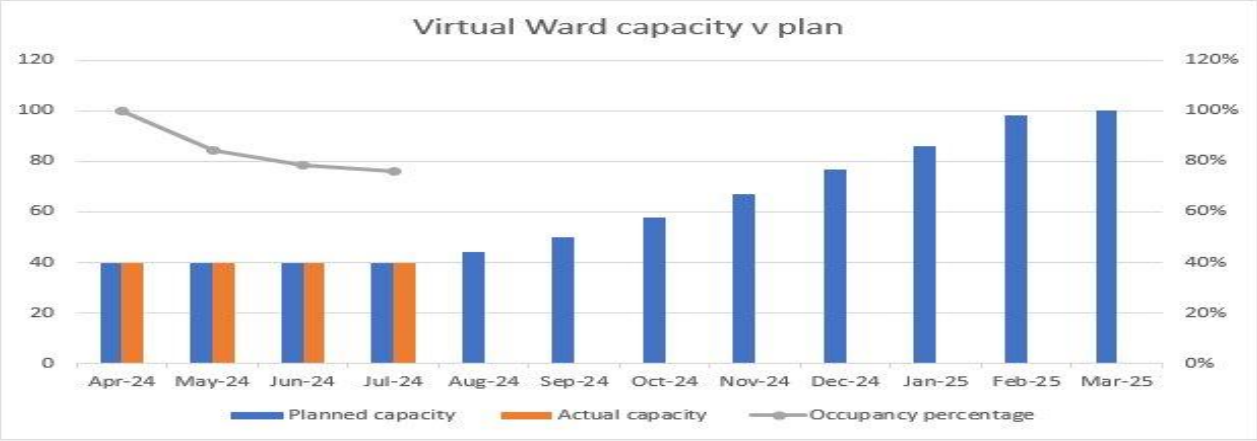
UCR activity is above the trajectory for the first month and is on track for a 10% increase. An increased number of 2 hour referrals made to Early Intervention Team (EIT) in July has contributed to this.

The increase in activity has not impacted negatively on performance against the 2 hour standard, in fact combined 2 hour response remains above the 70% target trajectory at 86%, with the Integrated Neighbourhood Teams (INT) achieving 90.68% and EIT achieving 75%.

2 hour data reports have been added to the INT quality dashboards and are now reviewed monthly alongside other quality impact reports by Quality, Clinical and Operational Leads to monitor the impact of the increase in urgent care activity (Quality monthly meetings) and the aligned capacity required.

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												



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

Supporting narrative

Virtual ward capacity is on trajectory of 40 beds in July 2024, however occupancy is slightly below plan at 76% against trajectory of 80%.

Average number of patients cared for on the virtual ward, bed days occupied and average length of stay (LOS) were the same as the previous period despite the impact of reducing agency nursing by 50% during the second half of July.

The Trust is reviewing the planned increase of headcount for virtual ward due to the financial recovery plan requirements, and exploring how to deliver the benefits of virtual ward in a more efficient and cost-effective way. An options appraisal will be presented at Management Executive Group (MEG) in September outlining future capacity within pathways and aligned clinical oversight.

NHS
West Suffolk
NHS Foundation Trust

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	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Total outpatient attendances	38202	38454	36327	38516								
PIFU	1515	1607	1379	1545								
Cons-led first attends (not measured seperately)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Cons-led follow up attends (not measured seperately)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Outpatient procedures	5902	5773	5560	5854								
First attends no procedure	7709	7812	7506	8045								
FU attends no procedure	23003	23920	22784	22880								
OP New/Proc ratio	37.20%	36.20%	36.40%	37.80%								
PIFU %	4%	4.20%	3.80%	4.00%								

Deliver the system specific activity targets for outpatients

Supporting narrative

- **Outpatient attendances**, particularly first attendances which contribute towards the Elective Recovery Fund (ERF) threshold, are below trajectory. The bi-weekly outpatients meetings monitor and challenge clinic capacities and slot utilisation, with targeted discussion taking place with specialties with the largest variance (gynaecology, audiology, rheumatology, urology, cardiology). Reduced referrals in cardiology and rheumatology have been highlighted, in addition to clinical vacancies. Meeting ERF thresholds within existing budgets is a key divisionally led recovery ambition.

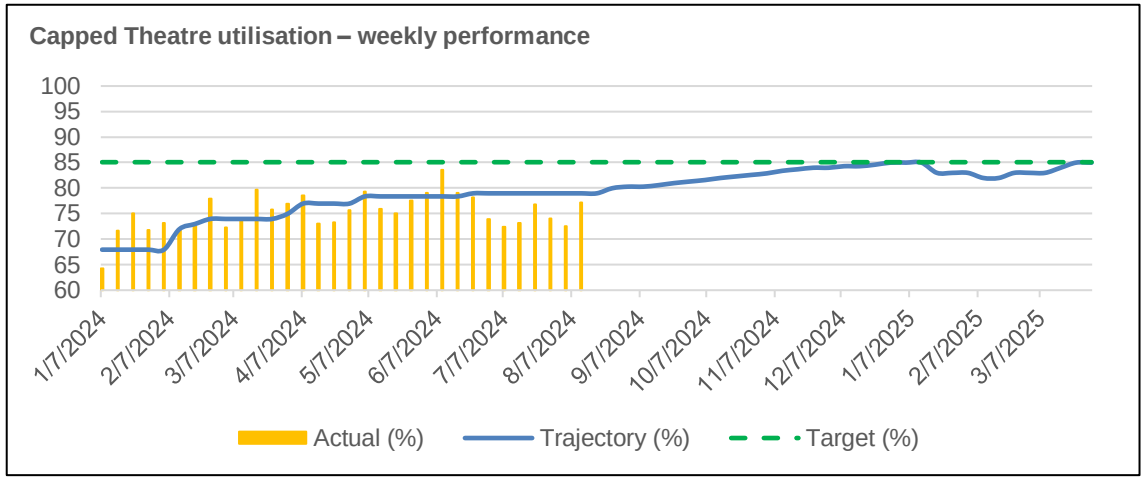
- **Patient Initiated Follow Up** is meeting plan at 4%. The biggest improvements demonstrated so far are in: cardiology, dermatology, respiratory, urology and dietetics. ENT, T&O and vascular are already meeting the year end 5% target and we expect to meet the 5% target overall.

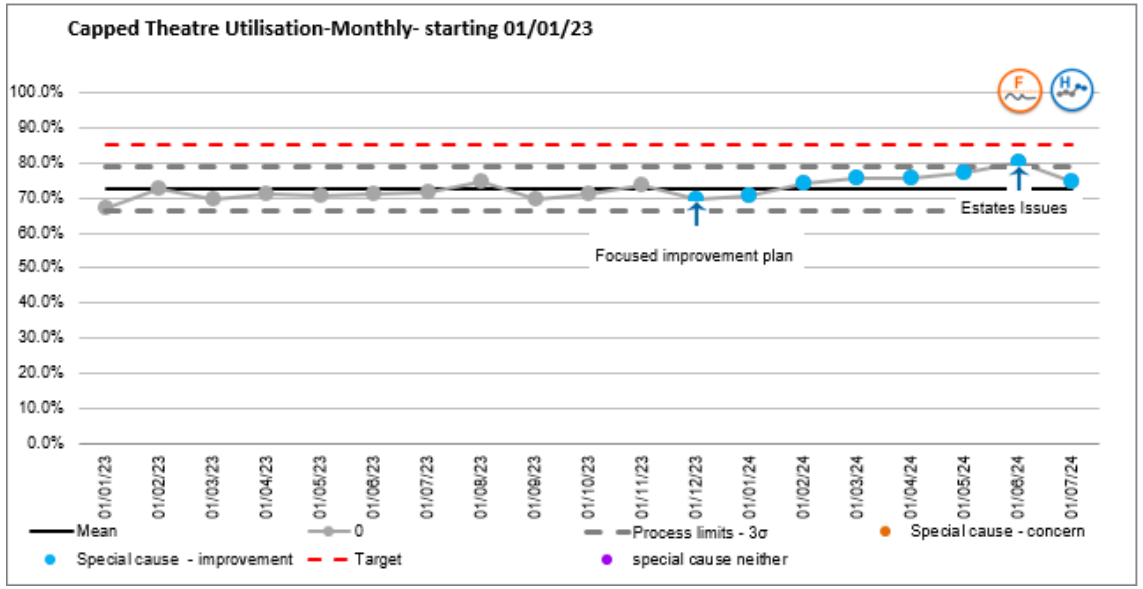
- **Percentage of attendances that are first attendances or with a procedure** is measured at system level where the target is 46.2%. Within this, WSFT have a flat line target of 41.61% representing an increase on baseline. Current performance is 37.8% against this target. It is likely that increasing the percentage of first attendances will have a greater impact than introducing new services with procedures. Specialty specific work is progressing to ensure we are capturing all outpatient procedures, with further opportunities for clinic template optimisation as per the Getting It Right First Time (GIRFT) Further Faster Handbooks to increase first attendances. Analysis of baseline data shows anaesthetics, respiratory physiology and general medicine to have the highest percentage values with clinical psychology, haematology and speech and language therapy the lowest. We expect to see an increase in the percentage in the second half of the year.

- **Progress is reported through the joint WSFT/ESNEFT Elective Care Programme Board.**

NB total outpatient attendances on previous slide includes all activity, whereas the outpatient procedures, the first attends and follow up no procedure is only for ERF activity and excludes other outpatient activity, e.g. maternity

Capped theatre utilisation- Target 85% by March 2025





1.2% adrift of trajectory (11/08), forecasted to recover by March 2025, main driver:-

- **Increased number of cases per list**, this resulting in increased inter-case downtime and reduced capped utilisation, in July 24, delivered 1028 procedures, the highest number since February 2020, cases per list sitting at the top of the third quartile nationally.
- Pest control issues in late June resulting in the loss of 107 procedures.
- Increased surgical UEC demand, reducing elective bed base from 18 to 6 beds (w/b 26/08) resulting in increased pre-emptive cancellations and inability to backfill.
- Unforeseen anaesthetic staff absence, resulting in the prioritisation of clinically urgent, long-waiting patients.

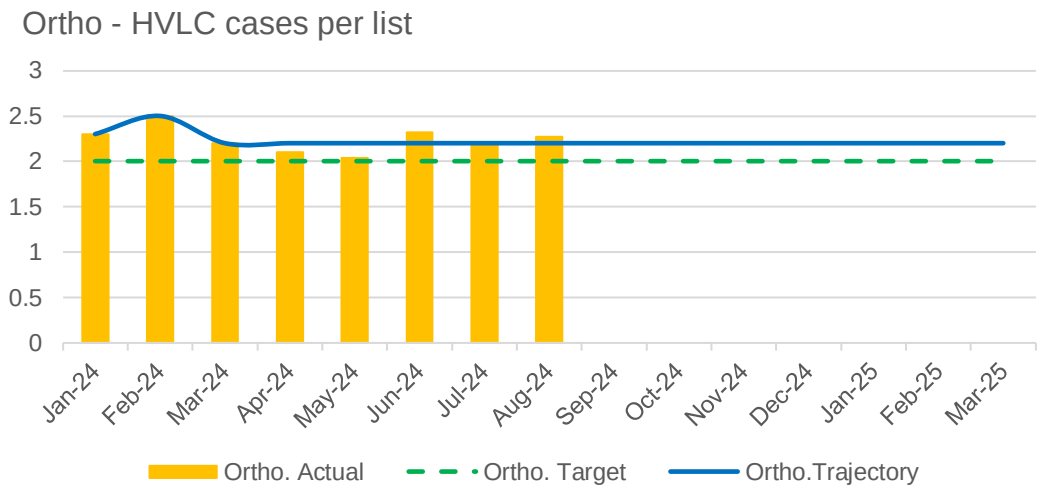
Highlights

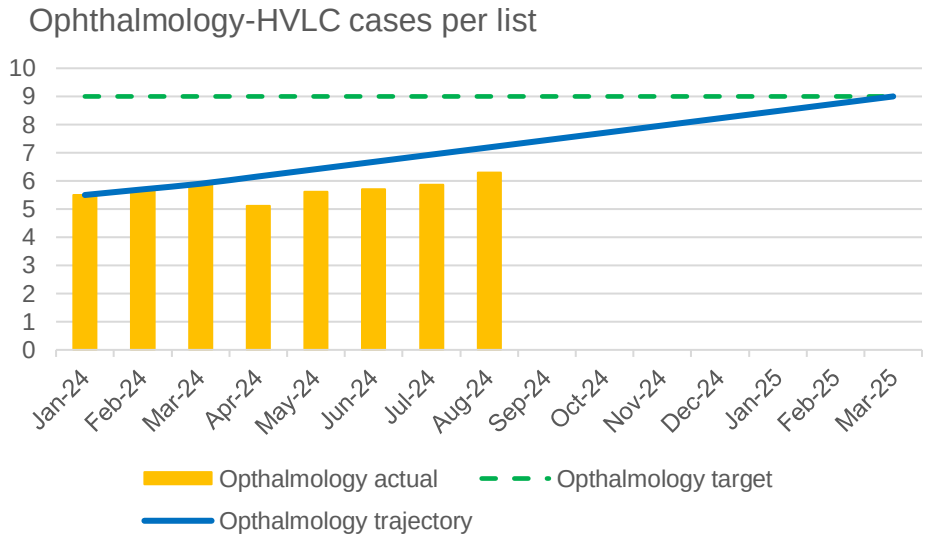
- Late starts remain on a downward trajectory at 27 minutes (11/08)
- 88% of available High Volume Low Complexity (HVLC) weekend lists picked up (n=32)
- 2 x “Super” Saturdays scheduled for general surgery, 7th and 21st September.
- Clinical agreement to book all appropriate lists to prospective 100%

Actions

- Creation of retrospective/planned activity dashboard
- Implementation of “Charlesworth” Theatre productivity metric, provides a more balanced view of productivity.
- Ongoing clinical chairship of theatres task and finish group
- Daily activity reporting, enabling “live” learning
- Service manager review of prospective lists, reducing risk of cancellation.

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





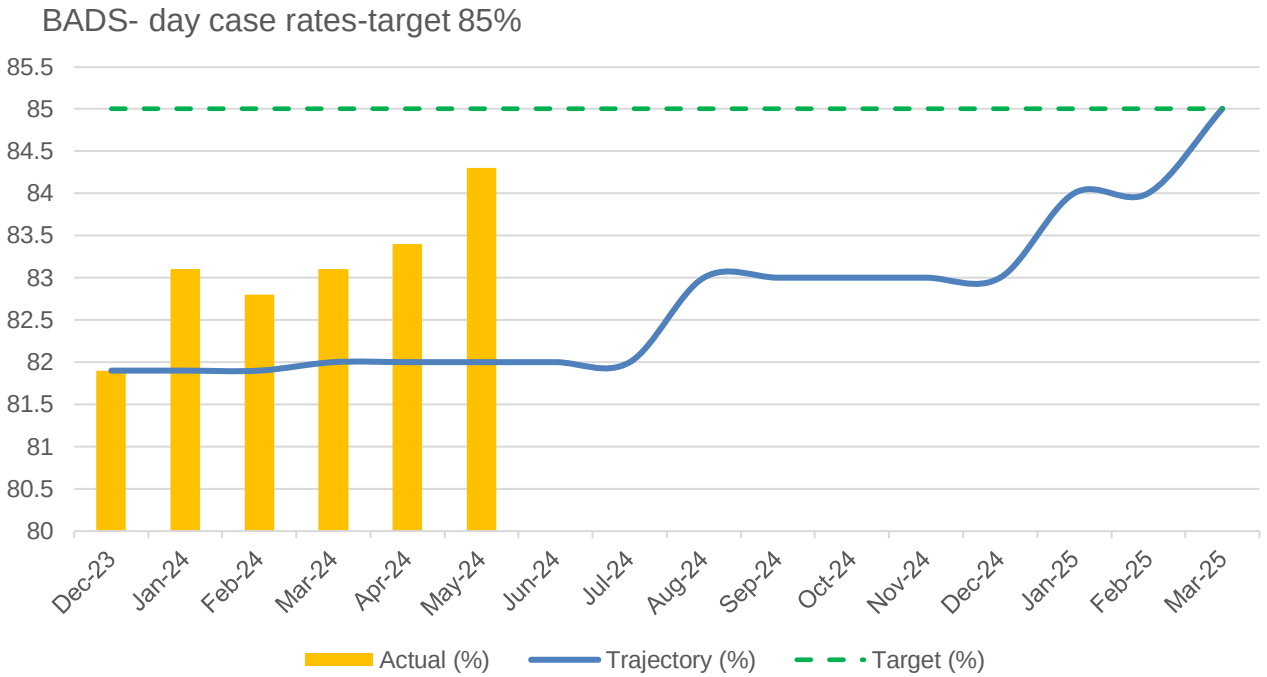
Orthopaedic HVLC activity achieving trajectory, Ophthalmology 0.71 off trajectory, expecting to hit trajectory by March 2025.

- Ophthalmology delivering weekly HVLC list, 32% of lists delivering 8 cataracts.
- Ophthalmology highest number of cases per list in region (Model Health 28/08)
- 3 other specialties also delivering highest number of cases per list in region: plastics, urology and general surgery

Risks

- Most productive ophthalmology locum leaving 31/10/24.
- Chiller issues and temperatures in theatres, two occasions where temperatures exceeded 24 degrees, resulting in cessation of surgery, escalation route to Estates established.
- Trauma demand- increased risk of conversion to trauma, reducing denominator and associated opportunity.

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



Exceeding trajectory @ 84.3%

- **Specialty breakdown (May 24- latest Model Health data)**
  - Ophthalmology- 100%
  - Orthopaedics- 84.3%
  - General Surgery-82%
  - Gynaecology- 68.3%
  - Breast- 74.6%
  - ENT-96.3%
  - Urology- 86.6%
  - Vascular- 98.8%

- Focus on Breast and Gynaecology.
- Moving to booking as day case by default, as unable to change classification should procedure listed as inpatient convert to day case.

Risks

- Only one static Faxitron machine for breast surgery and therefore day cases are often completed in Main theatre which increases risk of conversion.

2.2. Future System board report

To inform

Presented by Ewen Cameron

Committee	
Report title:	Future System Board Report
Agenda item:	Future System Board Report
Date of the meeting:	September 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 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 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 outcome of demand modelling. • 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 NHS Foundation Trust's (WSFT)'s plans to build a replacement hospital are part of the wider New Hospital Governmental programme.
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	More recently, the new Secretary of State for Health and Social Care, and Chancellor of the Exchequer, have jointly commissioned and launched a review into the New Hospital Programme. They have also both re-iterated their support for the replacement of RAAC hospitals and that RAAC schemes remain a priority. With this in mind, WSFT have continued their momentum.
2.4	The West Suffolk scheme remains among 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 that; 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. Solid progress against these goals has been achieved, specifically: • Application of the NHP demand model, along with its nationally derived assumptions for demographic and non-demographic rates of growth, have been completed and reported. The outputs are largely in line with previous iterations of the modelling although there are marginal changes in bed numbers and theatre capacity. The next step for this work is a workshop with

colleagues from our Integrated Care System, NHS East of England and New Hospital Programme to agree the conclusions and, therefore, substantially agree the “right sized” hospital.

- 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 and have agreed that they will affect a timely intervention if plans suggest an ‘overspend’.

- Having submitted our report on our readiness to develop an Outline Business Case (OBC), we have received positive feedback on its completeness and all indications suggest that it has been accepted and that the scheme can progress without hindrance. That said, the formal feedback report is due at the end of September.

- WSFT is one of four schemes (along with Milton Keynes, Hillingdon and Leighton) chosen as the basis for the construction of reference designs that will inform the wider Programme. This work has concluded that our scheme is already highly compliant with national standards, however, it also recognises the need for our project to be operational before the end of 2030 and that, consequently, scope for the adoption of later design features may be constrained.

- This alignment allows us to progress our Stage 2 (RIBA2) designs with confidence and we remain on track to complete these by November 2024.

- The terms describing how the Trust will interact with the New Hospital Programme and its allocated construction partner (known as the NHP agreement) was formally presented to the WSFT Executive Programme Board on 13th September. The session, supported with legal advice from Capsticks, allowed Trust Executives and Non-Executives the time to understand the content and implications of the agreement and to form a recommendation that will be put to the Trust Board in its private session (due to its commercially sensitive content).

- Enabling works continue in line with our plans, next steps are the completion of archaeological surveys and infiltration testing.

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 overall status of the project plan remains “green” with the previously identified risks associated with the transition of Government and the need for re-design and compromise materially lower than discussed last month.

3.3	**Progress on Site** 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 remains 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** As discussed above, the NHP Agreement has now been presented to the Executive Programme Board and a recommendation of how to positively progress will be put to the Board. The other strand of the NHP commercial strategy concerns the introduction of a new "Main Works Framework" (MWF) which seeks to recognise and address the need to ensure that the maximum number of construction partners are encouraged to support the wider national new hospital programme. As intuitively positive as this initiative is, there remains a question as to whether it will be ready in time to support those schemes that aim to be built by the end of 2030. The WSFT scheme remains highly supportive of the MWF but will also progress the development of an alternative strategy that utilises existing and established national construction frameworks.
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: • Agreed demand modelling with ICB, NHSE and NHP. • Made significant progress towards the conclusion of RIBA2 designs. • Received formal feedback on our OBC readiness submission with an expectation that we will seamlessly continue with the development of our detailed designs.

	• Confirmed use of Main Works Framework – or the alternative procurement strategy. • Agreed the way forward with the NHP agreement. • 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 progressively develop the increasingly detailed drawings required for our Outline Business Case. Enabling works aimed at discharging our planning conditions and preparing our site for construction continue positively in line with plans.
5.3	The status of the project to build a replacement West Suffolk Hospital remains Green.
6.	**Recommendations**
	The Trust Board are asked to note the content of this report.

Comfort Break

2.3. SNEE ICB Joint Forward Plan (Dr Alexander Roydan, Deputy Director for Strategic, ICB)

To inform

Presented by Jude Chin

Open Trust Board Committee	
Report title:	Annual refresh of the SNEE Joint Forward Plan 2024
Agenda item:	2.3
Date of the meeting:	27/09/2024
Sponsor/executive lead:	Richard Watson, Director for Strategy and Transformation and Deputy Chief Executive
Report prepared by:	Dr Alexander Royan, Deputy Director for Strategic Analytics

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 presents an update on the 2024 Joint Forward Plan (JFP) annual refresh exercise that too place earlier this year and provides a high level summary of the performance of the 22 core JFP indicators.

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

The National Health Service Act 2006 (as amended by the Health and Care Act 2022) requires ICBs and their partner trusts) to prepare a plan setting out how they propose to exercise their functions in the next five years. We are required to review and/or revise before the start of each financial year, which we have done so. ICBs and their partner trusts should agree processes for finalising and signing off the revised JFP. ICBs and their partner trusts are expected to be held to account for delivery of the JFP.

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

This year's JFP refresh exercise has been completed and the updated Joint Forward Plan has been published on the SNEE ICB website. ICB continues to work with its system partners in the delivery the of the JFP.

Action Required

This paper is for information only.

Risk and assurance:	

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

Annual refresh of the Joint Forward Plan and 2024-25

1.	**Introduction**
1.1	Last year, SNEE ICB and partner NHS Trusts / Foundation Trusts published a 2023-2028 Joint Forward Plan (JFP) in collaboration with local Health and Wellbeing Boards (HWBs). This describes the delivery priorities for SNEE ICB and how it intends to commission and manage services to achieve its aims.
2.	**Background**
2.1	We are required to publish our JFP before the start of each financial year, setting out how we intend to exercise our functions in the next five years. The annual review is an opportunity to update plans based on changes to national ambitions or local strategies, and to address the last year of the five-year look ahead. The JFP should reflect the NHS long term plan, local strategies and NHS 2024/25 priorities and operational planning guidance in context of populations health needs.
2.2	Through a process of coproduction, we have refreshed the JFP. Specifically, we reviewed NHSE JFP guidance, reviewed the draft operational planning guidance, worked with the various co-authors across the ICS to update their relevant sections, met with Executive leads and/or deputies for each target indicator, and consulted with stakeholders as required.
3.	**Detailed sections**
3.1	Minimal changes were made to the previous plan. This is a cumulative five-year delivery plan rolled forward to 2024-2029. Consequently, our priorities, most of which are long-term targets, have not changed.
3.2	Changes were made to the target indicators for maternity, elective waits, emergency department waiting times, dementia and hospital use by the elderly population (indicator removed). One indicator (LD health checks) was added, and another removed (over 65-year-olds bed use).
3.3	Adjustments to the text were made to capture the delivery plans for the national suicide prevention strategy; the dementia strategy; ICP strategy; minor adjustments to timelines; and replacement or removal of expired information (e.g. quotes and case studies).
3.4	The Joint Forward Plan underwent thorough an extensive engagement exercise in 2023. The programmes within the live well domains, aimed at fulfilling the objectives outlined in the JFP, will receive continued input from patient and public co-production where appropriate. As well as system-wide programs stemming from 2024/25 priorities operational planning guidance
4.	**Conclusion**
4.1	Please note that an updated JFP performance overview was presented at the System oversight assurance meeting in September24. The overall performance position has remained largely stable. Five targets have been reset as they are annual goals. Currently, 58% of targets are on track, 35% require some improvement, and 7% cannot be fully reported. Please see annex 1 for performance summary. Note that whilst there are 22 target indicators, some have been split for performance reporting, including elective waits, children's mental health (CAMHS and NDD), overweight and obese children (reception and year 6), blood pressure (identification and treatment), and AF (identification and stroke treatment). Currently there are **15 measures on track relative to target**, including: 1. Reduce each year the rate of emergency hospital admissions for falls people aged 65 over **(Yearly target has been reset)**

2. Increase each year the number of units of NHS dental activity delivered **(Yearly target has been reset)**
3. Halt recent increases in the number of overweight and obese children in reception by 2028 and maintain prevalence below the national average
4. Achieve a year on year reduction in hospital admission rates for MH conditions **(Yearly target has been reset)**
5. identify and reduce health inequalities among people with severe mental illness, by ensuring at least 90% of people, including those in all disadvantaged groups, receive a full annual physical health check and follow-up interventions by 2028
6. By 2028, reduce the number of deaths in under 75s considered preventable, reducing inequalities in our most deprived areas and amongst disadvantaged groups.
7. Consistently achieve the national smoking at time of delivery target of 6% or less. **(New)**
8. 80 percent of people high blood pressure are treated by 2028
9. By the end of 2024-25, 75% of people aged 14 and over on a learning disability register will have had an annual health check and a health action plan completed, with an aim towards everyone on the learning disability register to receive an annual health check and action plan by 2029
10. Ensure that no one waits more than 15 months for elective care by September 2024.
11. Increase by 10% each year the number of cases seen by the urgent community response service **(Yearly target has been reset)**
12. Increase our GP practice teams each year to meet the growing the demand **(Yearly target has been reset)**
13. More than 85% of people with atrial fibrillation are identified and 90% of those at high risk of stroke are treated by 2028
14. Reduce the number of acute hospital bed days utilised by people without criteria to reside that are discharged on complex pathways (1-3)
15. Reduce the hospital admission rate due to asthma of children or young persons living in the most deprived 20% of areas

There are **seven measures that require performance improvements**, as the current trends and the trajectory suggest we will not meet the target:

1. Halt recent increases in the number of overweight and obese children in year 6 by 2028 and maintain prevalence below the national average

2. Reduce the number of smokers in our population in line with only 5% of the population by 2030

3. 80% of people with high blood pressure are identified and treated by March 2025

4. Ensure that by March 2025, 78% of patients attending A&E services wait no longer than 4 hours in line with an ambition to return performance towards the national 95% standard
5. Ensure elective waits of more than one year reduce by March 2025

6. Increase the percentages of cancers diagnosed at stages 1 & 2 to 75 by 2028

7. By 2028, no child or young person waits more than 12 weeks for Child and Adolescent Mental Health Services (CAMHS).

	8. By 2028, no child or young person waits more than 18 weeks for Neurodevelopmental Diagnostic (NDD) Services, prioritising reductions in waiting times for ethnic minorities and those living in the 20% most deprived areas 9. Achieve the national 66.7% dementia diagnosis rate by the end of March 2025 as well as an increase in the number of dementia annual care plan reviews completed each year. There are **two that cannot be fully reported on** currently: For the following measures, performance is currently unclear as there has been a change in methodology and more data is required to evaluate our EOL performance: 1. Achieve a 5% year-on-year increase in the number of adults supported by community mental health services 2. Increase each year people identified at end of life
4.2	The JFP refresh for 2025-2030 is planned to commence January 2025 at the latest.
5.	**Recommendations**
	For WSFT to continue to collaborate as a key partner in the development and delivery of the SNEE Joint Forward Plan.

Annex 1. JFP performance

Domain	Target Indicator	Target	Current Performance	Rating
Age Well	Reduce each year the rate of emergency hospital admissions due to falls in people aged 65 and over	1,591.6 per 100k admissions (23/24)	346.2 per 100k admissions (Jun-24 YTD)	On track
Be Well	Increase each year the number of units of NHS dental activity delivered	1,054,369 units delivered (23/24 baseline)	252,195 (Jun-24 YTD)	On track
Be Well	Reduce number of overweight and obese children in reception by 2028	Reduce by 2028	21.1% reception (Mar-23)	On track
Feel Well	Achieve a year-on-year reduction in hospital admission rate for mental health conditions	204.5 per 100k admissions (23/24)	45.6 per 100k admissions (Jun-24 YTD)	On track
Feel Well	Identify and reduce health inequalities amongst people with severe mental illness, by ensuring at least 90% of people, including those in all disadvantaged groups, receive a full annual physical health check and follow-up interventions by 2028	90% by 2028	79.0% (Mar-24)	On track
Health Inequalities	By 2028, reduce the number of deaths in under 75s considered preventable, reducing inequalities in our most deprived areas and amongst disadvantaged groups	121.2 per 100k	21.5 per 100K (Jun-24	On track
Start Well	Consistently achieve the national smoking at time of delivery target of 6% or less	<=6%	4.6% (Jun-24)	On track
Start Well	Reduce the hospital admission rate due to asthma of children or young persons living in the most deprived 20% of areas	236.7 per 100k admissions (23/24)	30.0 per 100k admissions (Jun-24 YTD)	On track
Stay Well	80% of people with high blood pressure are treated by March 2025	64.4% (21/22 baseline)	71.2% (22/23) - 23/24 data not yet available	On track
Stay Well	By the end of 2024-25, 75% of people aged 14 and over on a learning disability register will have had an annual health check and 100% of those will have had a health action plan completed.	75% by March 2025	15.5% (Jun-24) - consistent with previous years	On track
Stay Well	Ensure that no one waits more than fifteen months for elective care by September 2024	Zero by Sep-24	1,212 (Jun-24)	On track
Stay Well	Increase by 10% each year the number of cases seen by the urgent community response service	28,770 (23/24 baseline)	10,061 (Jun-24)	On track
Stay Well	Increase our GP practice teams each year to meet the growing demand whilst increasing the number of trainees and apprentices	3,834 (23/24 baseline)	3,866 (May-24)	On track
Stay Well	More than 85% of people with atrial fibrillation are identified by 2028	83.8% (21/22 baseline)	86.7% (22/23) - 23/24 data not yet available	On track
Stay Well	More than 90% of those at high risk of stroke are treated by 2028	90.6% (21/22 baseline)	91.6% (22/23) - 23/24 data not yet available	On track
Stay Well	Reduce the number of acute hospital bed days utilised by people without a criteria to reside that are discharged on complex pathways (1-3)	42.0 average daily patients (23/24 baseline)	35.5 (Jun-24)	On track
Age Well	Achieve the national 66.7% dementia diagnosis rate by the end of March 2025	66.7% by March 2025	60.5% (Jul-24)	Requires improvement
Be Well	Reduce number of overweight and obese children in year 6 by 2028	Reduce by 2028	33.8% year 6 (Mar-23)	Requires improvement
Be Well	Reduce the number of smokers in our population in line with only 5% of the population being smokers by 2030	5% of population by 2030	14.9% (Mar-23)	Requires improvement
Start Well	By 2028, no child or young person waits more than 12 weeks for Child and Adolescent Mental Health Services (CAMHS)	100% by 2028	73.1% (May-24)	Requires improvement
Start Well	By 2028, no child or young person waits more than 18 weeks for neurodevelopmental diagnostic (NDD) services	100% by 2028	22.8% - combined NSFT ADHD/Suffolk Community ASD (Jul-24)	Requires improvement
Stay Well	80% of people with high blood pressure are identified by March 2025	66.8% (21/22 baseline)	68.9% (22/23) - 23/24 data not yet available	Requires improvement
Stay Well	By March 2025 ensure that 78% of patients attending A&E services wait no longer than 4 hours in line with an ambition to return performance towards the national standard of 95%	78% by March 2025	72.3% (Jun-24)	Requires improvement
Stay Well	Ensure that waits of more than one year are reducing by March 2025	5,590 (23/24 baseline)	5,852 (Jun-24)	Requires improvement
Stay Well	Increase the percentage of cancers diagnosed at stages 1 and 2 to 75% by 2028	75% by 2028	61.4% (Jan-24)	Requires improvement
Die Well	Increase each year the percentage of people identified as approaching the end of life	Increase each year	0.7% (May-24)	Unknown - limited data points
Feel Well	Achieve a 5% year-on-year increase in the number of adults supported by community mental health services	5% year on year increase	5,640 (Mar-24 rolling 12 months) - 24/25 data not yet available	Unknown - methodology change

2.4. West Suffolk System Update Report

For Report

Presented by Peter Wightman

Open Trust Board Committee	
Report title:	**West Suffolk Alliance System Update**
Agenda item:	2.4
Date of the meeting:	27 September 2024
Sponsor/executive lead:	Peter Wightman – Director West Suffolk Alliance
Report prepared by:	C King/M Shorter/P Wightman

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 attached paper provides a summary of the key items of business for west suffolk alliance at July and September Committee meetings.
SO WHAT? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*
The updates enables the Board to have sight of these activities and consider progress and opportunities
WHAT NEXT? *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*
This is described within the updates.
Action Required
To note

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

West Suffolk Alliance Committee reports	
1.	**Introduction**
1.1	**West Suffolk Alliance Update including Committee meetings of 9 July & 10 September**
2.	**Items brought to Committee for Agreement, Support and Discussion include:**
2.1	<u>July Committee meeting:</u> 1. Adult Social Care-Market Strategy 2. Community Referral and Communication Software 3. Diabetes deep dive 4. Start Well – Children Young People and First 1001 days updates 5. ICS Strategic programmes update with a focus on West Suffolk Alliance 6. Dental Care Priority Access 7. Interface Pharmacist Role 8. PCN – INT Integration Project <u>September Committee meeting:</u> 1. Place-based Active Suffolk 2. Suffolk County Council Transport update 3. Health Equity update 4. Haverhill Locality update 5. WSA Livewell Delivery Group updates on progress: • Stay Well – Elective Care • Stay Well Unscheduled care • Age well update • Die Well update 6. Discharge funding update
3.	**Detailed sections and key issues**
3.1	**Strategy for the Suffolk Adult Care-Market** received by Committee and support given for next steps. For return to Committee in November 2024 for update and final return March 2025. Alignment around different services to be considered including the localised Voluntary sector.
3.2	**Community Referral and Communication Software** – sub group being established to make recommendations for an approach working closely with Library services.
3.3	**Diabetes** – a comprehensive appraisal of work underway given. Good progress made at Practice level against key standards. Specialist nursing capacity issues remain with increasing demand across primary care and community team interface. For return to committee within 6 months.
3.4	**Children and Young People and First 1001 days** updates given. A more local multi-agency approach for West Suffolk Alliance for the First 1001 days was discussed.
3.5	**ICS Strategic programmes update provided.** Further work to consider how to align and interface discussed. ICS best in region for Hypertension and CVD work. Spirometry services currently of concern following cessation of the GP Federation service. An alternative is being mobilised.
3.6	**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 services for specific vulnerable patient groups and people needing urgent dental access. Service is accessed via NHS 111 or directly to the 4 practices.

3.7	**Interface Pharmacist Role -** The new team member has started in role and will support collaboration between primary care and the WSFT, focusing on safety and cost-effective prescribing
3.8	**PCN – INT Integration Project -** 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 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.
3.9	**Place-based Active Suffolk** • SCC's Active Suffolk team updated on the Sport England funded project proposal in Lakenheath with Lakenheath having identified nationally by Sport England for the project focus. The project aims to take a collaborative approach to increasing physical activity., Targets could include reducing childhood obesity, hypertension in adults (some 300 people). • Committee asked for the scope of project to extend beyond Lakenheath to spread the benefits of the extra funds as wide as possible.
3.10	**Suffolk County Council Transport update** • Noted the bus routes have changed to create new direct buses from Haverhill, Mildenhall and Sudbury to WSFT main hospital site (replacing the need for a bus to town and then to WSFT). The new routes have been popular and well used. The plans have included reduced rural stops which has led to some negative feedback. • Noted that options for resolving bus congestion at WSFT main site were being explored. • Suggestions were sought for further ideas for using of the residual national funding that is available. Members are asked to contribute ideas outside the committee. • Work is in progress to ensure use of electronic links to journey planner pages, including a dedicated health page with a variety of listings to include GP surgeries. Links to be included in WSFT outpatient communication.
3.11	**Health Equity update** • The Committee noted that the West Suffolk Equity Plan has been approved. The plan aims to improve health outcomes for target populations showing adverse variation for specific health indicators including neonatal health, asthma in children, smoking and COPD, hypertension and cancer screening. • Actions will include work in Bury St Edmunds, Mildenhall, Haverhill, Sudbury and Newmarket. • A smaller strategic group is coordinating implementation and will report regularly to the Alliance. *Further details attached as appendix 1*
3.12	**Haverhill Locality update** • Committee was asked to support the management of working with bordering Acute Trusts to support Suffolk, Essex and Cambridgeshire residents including transport. • Next steps include to continue building networks and infrastructure; implementing Health Equity plans and focus on antenatal care, schools and boundary connectors.

3.13	**Updates received from: Stay Well – elective care: Stay Well – Unscheduled Urgent Care; Age Well and Die well domain groups:** **Stay Well** – **Elective Care -** Key points from update: • New IT platform planned at WSFT will enable further progress on virtual outpatients (currently 21.3% vs 25% target) • Patient initiated follow up (4% vs 5% target) - working with targeted specialities • 3rd space: preparing for PSA to go-live in September • Diabetes – completing work on future model is essential **Stay Well Unscheduled care** • Early intervention team performance remains strong at over 70% target in 2 hours • Minor emergency care unit funding secured and due to open prior to winter • Level 1 falls pick up service commissioning complete and due to start Q3 **Age well update** • Continuing concern for long waiting times for Dementia Assessment (current wait = 6-8 months) which is adversely affecting the diagnosis rate and patient care. The Alliance Director is to escalate the response to this as West Suffolk is seen as a national outlier. An update to the October 9 Committee meeting is required. **Die Well update** • St Nicholas's hospice have opened 2 further beds increasing number to 8, supported by specialist palliative care. To increase to 12 in next 3 months. • More training for Care homes is planned to improve the number of patients with advanced care plans. Development priority is an electronic care coordination system in Suffolk for EoL. Digital are reviewing this and looking at March 2025 for implementation if possible. This is also part of possible Macmillan Social finance fund • Explore inclusion of children in End of Life (EoL) governance
3.14	**Discharge funding update:** • Most schemes are due to be evaluated at month 9. Better data links needed between SNEE and WSFT to monitor and evaluate. • There remain relatively low number of patients at WSFT not meeting criteria-to reside, further improvement is sought.
4.	**Next steps** As described above
5.	**Conclusion**
	Progress of particular note • Extra bed capacity live and used at St Nicholas Hospice • New direct bus routes to WSFT main site from market towns Two key areas of concern: • Limited reduction in NSFT memory assessment clinic waiting times and • Continuing challenges for diabetes specialist team capacity; limited progress commissioning new model across primary and secondary care
6.	**Recommendations**
	Board is asked to note the report

Appendix1 – Health Equity programme improvement goals

Area	Indicator	IMD 1-3 Population neighbourhood	Mar-24	Goal Mar 26 WSA rate
Children & young people	Asthma admissions per 000	Sudbury	272.8	166.9
Respiratory	Smoking prevalence	Haverhill	25.0%	15.5%
		Bury Town	24.0%	
		Sudbury	23.3%	
		Newmarket	22.5%	
		Mildenhall & Brandon	22.1%	
	People with COPD who smoked in last 12 mo.	Bury Town	35.6%	22.8%
		Newmarket	32.3%	
		Haverhill	28.9%	
		Sudbury	27.3%	
	COPD admissions per 000	Bury Town	611.9	345
		Sudbury	507.5	
Cardiovascular	% of expected population diagnosed with hypertension	Newmarket	53.2%	73%
		Sudbury	66.9%	
		Haverhill	67.1%	
		Mildenhall & Brandon	68.3%	
		Bury Town	68.9%	
	% with HT & BP managed	Bury Town	63.6%	67.1%
	40-74 healthcheck uptake	Newmarket	11.9%	18.3%
		Mildenhall & Brandon	12.7%	
		Bury Town	13.1%	
Cancer early diagnosis	Cervical screening uptake	Mildenhall & Brandon	62.8%	68.2%
		Newmarket	63.8%	
	Breast screening uptake	Mildenhall & Brandon	62.8%	69.8%
		Newmarket	63.8%	
		Bury Town	64.4%	

IMD1-3 refers to the populations living in Local Super Output Areas identified in national data sources as areas of highest social challenge. Number of residents by neighbourhood area is as follows:

- Sudbury (7,496)
- Haverhill (7,473)
- Bury Town (3,943)
- Mildenhall (2,743)
- Newmarket (2,451)

The goal is to seek to achieve the West Suffolk Alliance (WSA) average rates for these specific populations within 2 years – this is very challenging but reflects a stretch target and benchmark.

This data indicates the areas of greatest variation, drawn from a much larger dataset.

There are a series of actions at local level that are planned, working closely with community leaders, health and care professionals and VCSFE teams. WSA Committee will receive regular updates.

2.5. Digital Board Report

To inform

Presented by Nicola Cottington

Open Trust Board	
Report title:	Digital programme board report
Agenda item:	2.5
Date of the meeting:	27th September 2024
Lead:	Nicola Cottington, Chief Operating Officer
Report prepared by:	Liam McLaughlin, Chief Information Officer (CIO)

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

Executive Summary

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

The digital programme covers a wide range of projects and initiatives and the key deliverables are described. It describes the recent evaluation of the Trust against the Digital Maturity Assessment (DMA) framework.

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

The people, financial and technical resources are constrained and so it is essential to ensure that the digital initiatives support the Trust strategy, ambitions and plans, and deliver the expected benefits and organisational transformation.

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

The digital programme will continue to support and closely align with the Trust strategy.
The following action is planned and will be monitored through the Digital Board:

- Implementation of new Digital governance structure, including prioritisation and decision-making
- Review of Digital programme in light of financial recovery

Recommendation / action required

The report provides evidence and assurance that the digital programme is in line with Trust plans

Previously considered by:	This is based on a summary of the last Digital Board meeting held on 29th August 2024
Risk and assurance:	Risks are managed through the Pillar governance and through the Trust risk register
Equality, diversity and inclusion:	The Trust approach is considered to be "digital first but not digital only" ensuring that access to service is not limited by or to digital technologies
Sustainability:	Many digital initiatives support the sustainability agenda including tools to support remote working, reductions in the power and heat consumption of current technologies and cloud based services delivered from highly energy efficient data centres
Legal and regulatory context:	n/a

Digital Programme report

1.	**Introduction**
1.1	The digital programme and the digital service department support the Trust in providing a wide range of technical infrastructure, clinical systems and digital solutions to support the operation and transformation of the organisation
2.	**Background**
2.1	The digital programme consists of 5 main pillars of work: • Clinical systems – primarily e-Care, the main hospital patient record • Regional initiatives including population health management and the ICS shared care record • Community digital initiatives • Digital infrastructure and foundations • Optimisation
2.2	Additionally, the Future System Programme has a digital workstream which is considering and defining work requirements to support a smart hospital and outline that can be carried out in advance of the new hospital. This also includes initiatives to assess the digital capabilities and preparedness of both of staff and patient/carer communities. Several key digital staff are seconded to work on the FSP digital workstream.
2.3	Overall, resources to deliver the programme remain fully committed. There are a number of initiatives, mainly driven from a financial perspective, to explore projects and ongoing work that may be paused or stopped.
3.	**Detailed sections and key issues**
3.1	**Clinical systems - Pillar 1** A number of projects have been implemented since the last report with projects underway and 2 projects stopped: *Completed projects:* • Neo natal unit functionality and integration of medical devices into e-Care • Upgrades to the Ophthalmology, Endoscopy and implementation of the new Datawarehouse solution • First phase of the automated medicines dispensing cabinets • Enhanced virtual consultation platform

	In progress: • Transfer of critical care onto e-Care to enable a consistent medicines record • Implementation of the diabetes functionality in e-Care together with migration of historic data • Consolidation of the current patient portal offerings into the Oracle supported platform (PP UK/Zesty) *Stopped:* • The closed loop bloods solution (BIQ) has been stopped due to inability to implement a viable workflow • Revised outpatient functionality with e-Care has been stopped due to data quality concerns and in the light of a proposed new version in development by Oracle
3.2	**Regional initiatives - Pillar 2** WSFT operates Health Information Exchange (HIE) on behalf of the ICS delivering a shared care record solution for staff to support direct care. It joins up clinical information from primary care, community, secondary care, mental health and social care. It connects to neighbouring shared care record systems to give seamless clinical information especially covering patients who may move between different ICS providers. The governance for the programme is now being taken up by the ICS and therefore will no longer be reported at Pillar 2 Likewise, we no longer deliver the Population Health platform through Oracle/Cerner but now use the ICS wide solution. For these reasons, and as part of a wider review of digital governance, it was agreed that this pillar would no longer continue in its current form.
3.3	**Community digital initiatives – Pillar 3** The WSFT digital team that support the Community teams have been focused on a whole series of optimisations to the SystmOne platform that support their clinical and administrative processes. It includes many new and additional data capture templates for a whole range of community teams and services as well as new community units, pathways and careplans. This has been enabled as a result of having a digital resource dedicated to WSFT community optimisation. We have implemented the Electronic Prescription Service in Community enabling prescriptions to be produced digitally and have implemented a digital dictation solution to support community workflows and staff
3.4	**Digital infrastructure – Pillar 4** Work is continuing on the roll out and consolidation of critical network components right across the hospital and in specific community locations. This does require some short periods of downtime which is outlined in a detail plan of activity and is agreed with affected staff. Further work is planned to confirm the Wifi coverage based on RAAC work where is may have impacted signal strength and coverage. Additional we are looking to implement external access points that will deliver Wifi coverage between building to the rear of the site. We a progressing an upgrade to the data centre server infrastructure that will reduce the footprint and bring some efficiencies both in terms of licence usage but also in terms of power consumption. Trust cyber security measures remain at the heart of the work of the digital teams. This impacts not just the small cyber team but other infrastructure teams who implement critical patches and fixes that are identified as risks.

	The Data Security and Protection Toolkit (DSPT) is changing significantly to move to the new Cyber Assurance Framework (CAF) and we are working through the implications in order to prepare for the change. As part of number measures in digital to support the financial recovery, we are investigating the feasibility and cost benefits of moving back to NHS mail as our e-mail system.
3.5	**Optimisation – Pillar 5** Some 104 change requests have been completed including support for the new ReSPECT form and national paediatric early warning scores (PEWS) changes to support Martha's Law. The team work closely on the Junior Doctor rotation and provide at the elbow support and advice and guidance in the use of the wide range of systems. This is in addition to the formal digital training provided as part of their induction.
3.6	**Governance review** A revised governance structure for digital was approved, given that the current pillar structure was implemented to support the global digital exemplar (GDE) programme of work and investment priorities. The revised governance will focus not only on ensuring that "we do things right" but also that "we do the right things". The latter involves implementing a robust prioritisation and alignment process that will ensure work supports Trust initiatives and divisional priorities. This will be balanced with available resource given pressures on business as usual activities and mandatory industry and national requirements
3.7	**Digital Maturity Assessment** NHS England are into the second year of a framework to gather information to support a digital maturity assessment (DMA) of primary care, secondary care, community and ICS organisations. Whilst there was promise that improvements in digital maturity would be able to be compared year on year, because of significant changes to scope and granularity of the assessment, this has not been possible and a rebase lining has been presented. WSFT compares favourably to other organisations in the region with the second highest score across the 14 acute trusts in the East of England. The data was used to inform a section of the recently published Darzi report which highlights the challenge of improving digital maturity Darzi report - digital maturity https://assets.publishing.service.gov.uk/media/66e1b49e3b0c9e88544a0049/Lord-Darzi-Independent-Investigation-of-the-National-Health-Service-in-England.pdf#page=107
4.	**Next steps**
4.1	The digital programme will continue to support and closely align with the Trust strategy.
5.	**Conclusion**
5.1	The digital programme covers a wide range of projects and initiatives, and these are managed effectively through the pillar structure.
6.	**Recommendations**
	The report provides evidence and assurance that the digital programme is in line with Trust plans

3. ASSURANCE

3.1. IQPR Report

For Discussion

Presented by Jude Chin and Nicola Cottington

NHS West Suffolk NHS Foundation Trust

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

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

Executive summary:	The Integrated Quality and Performance Report (IQPR) uses the Making Data Count methodology to report on the following aspects of key indicators: 1. Compliance with targets and standards (pass/fail) 2. Statistically significant improvement or worsening of performance over time. Narrative is provided to explain what the data is demonstrating (what?), the drivers for performance, what the impact is (so what?) and the remedial actions being taken (what next?).

Executive summary:	The assurance committees have reviewed the metrics used in the IQPR and included the 2024/25 operational priorities in a refreshed suite from April 2024. Please refer to the assurance grid for an executive summary of performance. The following areas of performance are highlighted below for the board's attention: • 4 hour performance in the Emergency Department (ED) continues an improving trend and exceeded the monthly trajectory in July (72.77% against the trajectory of 70%), whilst ambulance handover and 12 hour waits are not demonstrating significant improvement yet. • There is significant improvement in the number of acute patients with no criteria to reside, but 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. • Virtual ward occupancy was 76% against the target of 80% within the current capacity of 40 beds. Occupancy and length of stay (LOS) has not been impacted by the reduction of agency utilisation. • Performance against the 28-day Faster Diagnosis Standard (FDS) is variable and there are specific recovery actions in place for skin, colorectal, breast and gynaecology in order to meet the target of 77% by March 2025. 62-day performance exceeded both trajectory and national target in June. • Paediatric Speech and Language Therapy waiting times are unlikely to demonstrate sustained improvement ahead of system wide plans and resource allocation in the context of the Suffolk SEND inspection action plan • 6-week diagnostic performance is variable; however, the Trust remains on track to achieve compliance by the national target of March 2025, with some risk relating to MRI, CT and ultrasound. This is partly due to the delay in the CDC opening (November 2024). • The Trust has committed to zero 65-week waits by the end of September and is on trajectory in July. However, due to industrial action and a pest control incident, it is predicted there will be low numbers of patients waiting more than 65 weeks at the end of September. A verbal update with a more specific number will be shared verbally at board.

NHS West Suffolk NHS Foundation Trust

	• Quality improvement projects are continuing to support timely nutritional assessments and management plans will continue and this will be monitored through the nutritional steering group and divisional performance review meetings and patient safety and quality group. Of note there is increasing improvement of assessments at 48 hours post admission. • On going quality improvement will continue within the maternity services regarding post partum haemorrhage and will be monitored through the maternity improvement board, performance review meetings and externally through the local maternity and neonatal system strategic meetings. Additional detail included in this pack regarding regional benchmarking and comparison. • The Clostridium Difficile data now includes both hospital onset healthcare associated (HOHA) and community onset healthcare associated cases COHA . Data suggests that incident rates are variable. The impact of the 6 key interventions is still embedding and will unlikely improve until Q3/Q4.
Action required / Recommendation:	To receive and approve the report

Previously considered by:	**Component metrics are considered by Patient Safety and Quality Group and Patient Access Governance Group.**
Risk and assurance:	BAF risk: 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
Equality, diversity and inclusion:	Monitoring of waiting times by deprivation score and ethnicity are monitored at ICB level. From June 2024, health inequalities metrics will be included in the IQPR.
Sustainability:	N/A
Legal and regulatory context:	NHS Act 2006, West Suffolk NHS Foundation Trust Constitution

Assurance Grid

June 2024	ASSURANCE: Pass (P)	Hit and Miss (?)	Not Met: Fail (F)
VARIANCE: Special Cause Improvement (H / L)		**INVOLVEMENT** Staff Sickness – Rolling 12 months Staff Sickness	**INSIGHT** Total average occupancy number 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 Incomplete 104 Day Waits Potential 65+ ww at end of Sept 2024
Deteriorating: Special Cause Concern (H / L)		**INSIGHT** Community Paediatrics 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 of attendances
% patients with no criteria to reside
Virtual Beds Trajectory
Total average occupancy percentage
Total average LOS per patient
28 Day Faster Diagnosis
Cancer 62 Days Performance
Community Paediatrics RTT Overall 104 Weeks Wait
IMPROVEMENT:
C-Diff Hospital & Community
INVOLVEMENT:
Mandatory Training

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, 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: RTT 78+ Week Waits, Potential 65+ ww at end of Sept 2024, Community Paediatrics RTT Overall 78 Weeks Wait
INVOLVEMENT – Well Led: Appraisal, Turnover

3.2. Finance Report

To Assure

Presented by Jonathan Rowell

Board of Directors – Public Board	
Report title:	Finance Board Report – August 2024
Agenda item:	
Date of the meeting:	27th September 2024
Lead:	Jonathan Rowell, Acting CFO
Report prepared by:	Nick Macdonald, Deputy Director of Finance

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

Executive Summary

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

The attached Finance Board Report details the financial position for month 5 (August 2024).

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 August is a deficit of £14m against a planned deficit of £9m. This results in an adverse variance of £5m YTD. For the month of August, the variance to plan worsened by £1.5m from the year-to-date position at the end of July.

Cost Improvement programme
We achieved our CIP target for April and May (£1.0m cumulatively) but failed to reach our June plan by £360k, July by £921k, and August by £631k (£1.0m against a plan of £1.63m). Our CIP became even more challenging from July onwards and remains at £1.63 per month for the remainder of 24-25.

Cash
Due to our adverse variance the Trust requires additional working capital and have applied for £17m of revenue support (both deficit and working capital) in quarter 3 as outlined at page 11 of the report.

We require Board approval to support this application albeit retrospectively since the application had to be submitted by 19th September.

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

While we continue to forecast meeting our Financial Plan, this will be extremely challenging.

WHAT NEXT? *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*
The Director of Financial Recovery has developed a Financial Recovery Plan which will be presented to the September Board.
Recommendation / action required
Review and approve this report. Approve our application for £17m additional working capital.

Previously considered by:	This paper was discussed at the September 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
August 2024 (Month 5)

Executive Sponsor: Jonathan Rowell, Acting CFO
Author: Nick Macdonald, Deputy Director of Finance

Executive Summary

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 August is a deficit of £14m against a planned deficit of £9m. This results in an adverse variance of £5m YTD (£3.4m at the end of July).

Our CIP programme is behind plan in August (£3.2m delivered against a plan of £5.1m). £1.9m adverse variance YTD.

The balance of the adverse variance relates to our recurring run rate exceeding our 24-25 budget before CIP, totalling £3.1m (non-recurring costs and credits largely even out).

In order to achieve our planned deficit of £15.2m we would need to improve our current run rate by £2.2m per month. Several controls and processes have been implemented and we expect to report significant improvement in run rate from October onwards. We aim to improve our run rate to £1.3m per month deficit by March 2025 but these actions alone will not meet the plan.

Cash continues to be challenging. The Trust has now received £9m of revenue support to date from DHSC. This is currently £800k below our planned deficit position to the end of September. The Trust will continue to apply for revenue support throughout 2024/25 and have now applied for £17m of revenue support (both deficit and working capital) to support our unplanned deficit in quarter 3 and require Board approval to support this application.

Deficit YTD £	**14.0M**	
Variance against plan YTD £	**-5.0M**	**Adverse**
Movement in month against plan £	**-1.6M**	**Adverse**
EBITDA Postion YTD £	**-4.8M**	**Adverse**
EBITDA margin YTD	**-3%**	**Adverse**
Cash at bank	**£7.6M**	

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)
Impairments									
Finance Costs	**0.4**	**0.4**	**0.0**	**2.2**	**2.2**	**0.0**	**6.6**	**6.6**	**0.0**
Depreciation	**1.4**	**1.4**	**0.0**	**7.0**	**7.0**	**-0.1**	**16.6**	**16.6**	**0.0**
EBITDA									
Expenditure									
Non-pay Costs	9.1	9.5	-0.3	47.3	48.7	-1.4	108.7	108.7	0.0
Pay Costs	22.5	23.4	-0.9	115.3	118.3	-3.0	273.5	273.5	0.0
Total	**31.6**	**32.8**	**-1.2**	**162.7**	**167.0**	**-4.3**	**382.3**	**382.3**	**0.0**
Income									
Other Income	3.3	3.0	-0.3	16.6	15.9	-0.7	39.2	39.2	0.0
NHS Contract Income	29.3	29.3	0.0	146.3	146.3	0.0	351.1	351.1	0.0
Total	**32.6**	**32.2**	**-0.3**	**162.9**	**162.2**	**-0.7**	**390.3**	**390.3**	**0.0**
EBITDA Position	**0.9**	**0.6**	**-1.5**	**0.2**	**4.8**	**-5.0**	**8.1**	**8.1**	**0.0**
Deficit/(Surplus)	**0.9**	**2.4**	**-1.6**	**9.0**	**14.0**	**-5.0**	**15.2**	**15.2**	**0.0**

Key Risks and Mitigations in 2024-25

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

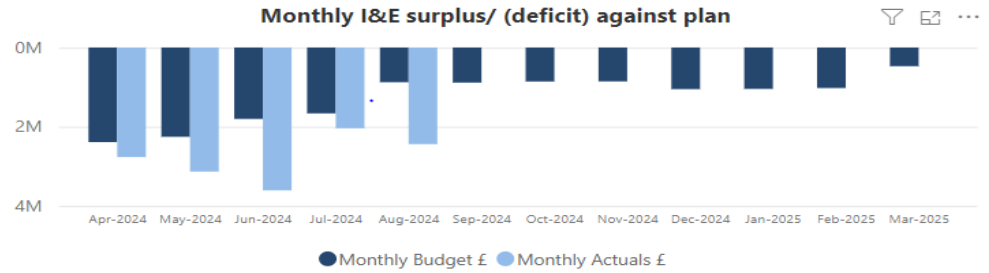
	Impact on YTD actuals at M5 Best case £'000	Impact on YTD actuals at M5 Worst case £'000	M5 FOT £'000
M5 position surplus / (deficit)			(14,002)
Recurring deficit of £2.4m as at M5			(17,166)
Cerner costs increase from M5			(1,108)
Unmitigated forecast without any risks			**(32,276)**
Within our control			
Non-recurring, unexpected, costs at £100k pm	0	(700)	
Identified CIP as forecast above recurring M5 CIP	1,000	0	
23/24 expected final ERF performance	0	(470)	
ERF performance (net of advice and guidance)	100	0	
Chemotherapy activity (NHSE) 23/24 adjustment in 24/25	0	(600)	
RAAC related costs reduce once completed (Dec 2024)	250	0	
CDC margin	250	0	
Seasonal costs as per reserves	0	(1,400)	
Lost margin from Elective activity (ESEOC 5 months)	0	0	
Winter pressure/UEC	0	(500)	
Outside of our control			
Inflationary costs unfunded (beyond M5 recurring position)	0	(180)	
Industrial Action costs funded (costs in M5 YTD position)	200	0	
Pay awards unfunded	0	(1,450)	
Total range before FRP (impact on proposed plan)	**1,800**	**(5,300)**	**(35,776)**
CIP delivery (meet £16.5m target) beyond current forecast	7,700	0	(28,076)
Impact of additional controls and unidentified actions	12,876	0	**(15,200)**

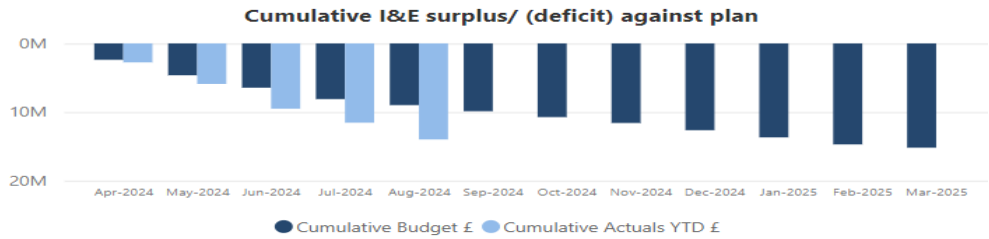
FINANCE REPORT – August 2024

Income and Expenditure Summary - August 2024

Board Report Item	Original Plan/ Target £000s	Actual/ Forecast £000s	Variance to Plan £000s F/(A)	
In month surplus/ (deficit)	-878	-2,443	-1,564	↓
YTD surplus/ (deficit)	-8,998	-14,002	-5,004	↓
Clinical Income YTD	146,288	146,316	28	↑
Non-Clinical Income YTD	16,569	15,877	-692	↓
Pay YTD	115,345	118,305	-2,961	↓
Non-Pay YTD	47,325	48,676	-1,351	↓
EBITDA YTD	187	-4,789	-4,976	↓
EBITDA %	0.1	-3.0	-3.1	↓

Income and Expenditure for 2024-25





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

Actions being implemented

A number of controls and processes have been put in place in line with the ten measures shared with the Board at the end of July.

A financial recovery plan has been developed and will be shared separately. These actions suggest a target of around £980k improvement per month but this requires further work up to be confidently quantified.

Meanwhile, we have set up a non-pay control panel (NPCP) for orders above £500, which started meeting at the beginning of August. The ICB has now introduced double lock arrangements for approval of items above £15k. The realised benefit is not visible yet, but we expect a decrease in the monthly run rate from October. The improvements from these actions will be tracked and reported through FRG, FAC and Insight.

We held financial recovery meetings with each Division in August and early September. At these meetings, ADOs presented their division's economic recovery plan (FRP) to the CEO and CFO and will share this with the ICB on 1st October.

M5 position

The adverse variance was £1.6m in August, which includes a shortfall of £0.6m against our monthly CIP target. The large adverse variance is partly due to the profiling of the budget and CIP. However, our recurring run rate in August was consistent with July despite a significant monthly increase relating to Cerner costs (£200k per month).

Run rate

Our rate of expenditure over income (run rate) is as below:

- April £2.8m (£2.3m recurring)
- May £3.1m (£2.9m recurring)
- June £3.6m (£3.1m recurring)
- July £2.1m (£2.4m recurring)
- August £2.4m (£2.4m recurring)

Movement in Risks and Mitigations

This table now represents the potential risks and mitigations that may adjust our run rate from the M5 position, with a summary of the value of the actions required to meet our planned deficit.

FINANCE REPORT – August 2024

High level reasons for variance from plan to August 2024	Monthly Variance					
	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Total YTD
	£'000	£'000	£'000	£'000	£'000	£'000
Non - Recurring						
ED expenditure relating to UEC improvement in 2324	150	0	0	0	0	150
Escalation ward unfunded (April and May)	155	115	0	0	0	270
Endoscopy Maintenance	0	0	90	0	0	90
Industrial action	0	0	130	0	0	130
Drug underspends (Exclude Medicine)	0	0	0	(72)	(13)	(85)
Rates Credit	0	0	0	(554)	0	(554)
Other non Clinical Income	0	0	0	0	197	197
Energy bills	(97)	(97)	78	(58)	(43)	(217)
	208	18	298	(684)	141	(19)
Recurring, but outside of our control						
Inflationary pressures	60	65	70	75	80	350
Private patient income	0	0	0	(152)	86	(66)
	60	65	70	(77)	166	284
Recurring, but we can improve						
Community Income shortfall	64	64	64	64	44	300
Community Equipment and Wheelchairs	0	160	80	0	119	359
CIP behind plan	0	0	360	921	631	1,912
ECW above plan	271	207	359	263	252	1,352
Back dated APA claims and salary arrears	126	200	145	100	34	605
Drugs within Medicine	100	100	100	(65)	(84)	151
Various mitigating (underspends) / overspends	(450)	225	169	(146)	262	60
ERF income	0	(160)	160	0	0	0
Winter	0	0	0	0	0	0
Total	**379**	**879**	**1,805**	**376**	**1,565**	**5,004**

** - actions are in place to improve against those areas of recurring overspend as per the table above, as outlined below

Community Income shortfall

- **Cause:** An under-recovery was incurred following the cessation of prior-year external investment in schemes to support improved patient flow and discharge.
  Action: We are working with Alliance partners to mitigate the financial risk to WSFT. Withdrawal of services would reduce capacity in some services to 2022/23 funded levels. If no mitigations are made, the FYE of this cost pressure is £768k. Alliance partners have been approached for continued shared funding and the Division has identified recurrent mitigations which will deliver at least £308k in 24/25.

Back dated APA claims and salary arrears

Stronger processes and controls should alleviate these backdated claims. Progress has been made and is visible; for example, July reported £100k and August's £34k.

Pay related costs

Agency and Bank staff are being used to support vacancies and sickness. Some divisions cannot reduce hours/shifts without impacting activity, and other staff costs are already committed to running the BAU. The vacancy control panel has put strong processes and controls in place since August and expects to see significant improvement from October.

ECW above plan

We have placed a panel to review all temporary pay expenditures before booking, especially on Extra Contracted Work (ECW). The reported figure shows gradual improvement. July's reported overspend was £263k vs. £252k in August.

ERF income

We are in ongoing discussions regarding our target of 109% baseline, which may influence our ability to earn additional income this way. In the meantime, we are reviewing our opportunities to earn extra income through ERF, against the costs of delivering this extra activity.

Private Patient income

There was significant neonatal and paediatric private patient income in 23/24, but this has not recurred in 24/25 due to a reduction in Tricare (USAF) patients YTD. It's possible that income may be realised later in the financial year.

Community Equipment and Wheelchairs

- **Cause:** Demand for Community Equipment (CES) has continued to increase in order to support timely discharge in support of seasonal plans, the utilisation of increased system pathway one capacity, to achieve community urgent and crisis response targets and patient flow through the escalation ward.
  Action: The Division will recover any aspect of the overspend incurred on behalf of Social Care, ESNEFT (acute) and Continuing Health Care patients, where costs incurred are higher than growth funding received. A significant element of the overspend is for equipment prescribed by Community Services. The Division is working with Alliance Partners to ensure an appropriate risk share following the removal of Hospital Discharge funding support and will ensure that CES is a key consideration in all future internal and external business cases.
- **Cause:** Increased demand for Wheelchair equipment has continued, following an increase in referrals (> 30% increase in the last 12 months)
  Action: The division will continue to invest in recycled equipment to contain cost increase as far as possible. Costs of more than £100k were avoided YTD, through refurbishment of wheelchairs. The Division is working with SNEE ICB to address the financial impact of growth and a request for non-recurrent investment to purchase additional refurbished equipment and parts will be made. We are reviewing the provision of equipment to care homes, and subject to QIA, will align local policy to the National Association of Equipment Providers guidance and national benchmarking.

CIP behind plan

See below

Cost Improvement Programme (CIP) 2024-25

A summary of progress against the CIP target of £16.5m is included below. This includes £1.4m of CIP relating to the FYE of CIPs that started in 2023-24.

In month progress (August)

The table below provides a summary of our most up to-date risk adjusted CIP plan. We achieved our CIP target for April and May (£1.0m cumulatively) but failed to achieve our June plan by £360k July by £921k and August by £631k (£996k against a plan of £1.627m).

The delivery of £996k in August was an improvement of £440k compared with July (£557k).

Our monthly CIP target increased by £155k in August to £1.627m and will remain at that level for the rest of the year.

Since July we have identified a further £200k of schemes.

Achieving the planned £16.5m CIP remains a significant risk. The Divisional Financial Recovery Meetings were held in August and early September. A thorough CIP review took place as a part of these meetings. Some new CIPs were identified and will be updated on the CIP tracker. Information on this should be available from the M6 Insight report and CIP tracker shortly.

Whilst around £13.6m of CIP schemes have been identified (FYE) after risk adjusting and incorporating time slippage, we would anticipate these schemes would deliver £8.8m of savings in 2425. This is currently £7.7m below our target.

In order to achieve this balance of our target of £16.5m for 24-25, we therefore need to identify a further £11m CIP (before RA, and notwithstanding slippage). There are currently 146 schemes in the pipeline that will help to close this gap.

Cost of time slippage in M1-5 is estimated at £1.7m however, further slippage due to 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 £3.3m CIP YTD against a target of £5.1m, (£1.8m 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 (£689k), PDC reduction (£996k) and non-current CNST premium reduction (£270k). Other new recurring schemes for 24/25 have contributed £1.3m YTD.

Division	Target £k	Identified 24/25 £k	Gateway 1 RA 60% £k	Gateway 2 RA 40% £k	Gateway 3 RA 20% £k	In delivery RA 0% £k	Plans 24/25 after RA £K	Time Slippage £k	Gap to Target £k	Pipeline PIDs
Medicine	2,211	593	-	-	58	520	579	(294)	(1,927)	9
Surgery	2,621	1,222	-	2	147	1,034	1,183	(201)	(1,639)	14
Women & Children	542	376	-	48	-	296	344	(112)	(310)	4
CSS	939	494	18	-	164	244	426	(50)	(563)	16
Community	1,613	1,209	236	130	277	55	698	(331)	(1,245)	22
Estates & Facilities	936	558	1	-	60	480	541	(60)	(454)	6
Corporate	4,838	1,146	0	-	156	950	1,107	(113)	(3,844)	6
Division Specific	**13,700**	**5,598**	**256**	**181**	**863**	**3,580**	**4,879**	**(1,161)**	**(9,982)**	**77**
TW - WRG Medical Staff	-	392	-	-	41	342	382	(51)	331	11
TW - WRG Nursing Staff	-	437	-	-	15	418	433	(31)	402	11
TW - WRG Other Staff	-	379	8	-	-	360	367	(29)	338	15
TW - Finance	-	2,400	-	-	-	2,400	2,400	-	2,400	-
TW - Procurement	-	817	317	-	-	25	342	(330)	12	8
TW - Pharmacy	-	713	-	-	5	707	712	(106)	606	3
TW - Discretionary Spend	-	71	-	-	-	71	71	(1)	70	-
TW - Strategy & Transformation	-	-	-	-	-	-	-	-	-	4
TW - Other	-	-	-	-	-	-	-	-	-	17
Trustwide Schemes	**-**	**5,210**	**325**	**-**	**61**	**4,323**	**4,708**	**(549)**	**4,159**	**69**
Degredation of Schemes	877	877				877	877	-	-	
Non Clinical Headcount Management	653	653				653	653		-	
ERF Stretch	750	750				750	750	-	-	
Unassessed Pipeline/E&F and IT Opportunities	520	520	520				520		-	
Stretch	**2,800**	**2,800**	**520**	**-**	**-**	**2,280**	**2,800**	**-**	**-**	**-**
Total	**16,500**	**13,608**	**1,100**	**181**	**923**	**10,183**	**12,387**	**(1,710)**	**(5,823)**	**146**

Budget Holding Division	Target £k	Identified 24/25 £k	Gateway 1 RA 60% £k	Gateway 2 RA 40% £k	Gateway 3 RA 20% £k	In delivery RA 0% £k	Plans 24/25 after RA	Time Slippage £k	Gap to Target £k	Pipeline PIDs
Community	1,613	1,442	298	130	277	135	840	(395)	(1,169)	28
Corporate	4,838	3,647	6	-	156	3,437	3,599	(130)	(1,369)	11
CSS	939	752	109	-	164	274	547	(146)	(537)	18
Estates & Facilities	936	720	5	-	60	632	697	(84)	(323)	9
Medicine	2,211	1,794	63	-	119	1,486	1,669	(516)	(1,058)	20
Surgery	2,621	1,869	65	2	147	1,519	1,733	(289)	(1,177)	20
Women & Children	542	479	34	48	-	314	396	(149)	(295)	5
To be agreed	-	105	-	-	-	105	105	-	105	35
Stretch	2,800	2,800	520	-	-	2,280	2,800	-	-	-
	16,500	**13,608**	**1,100**	**181**	**923**	**10,183**	**12,387**	**(1,710)**	**(5,823)**	**146**

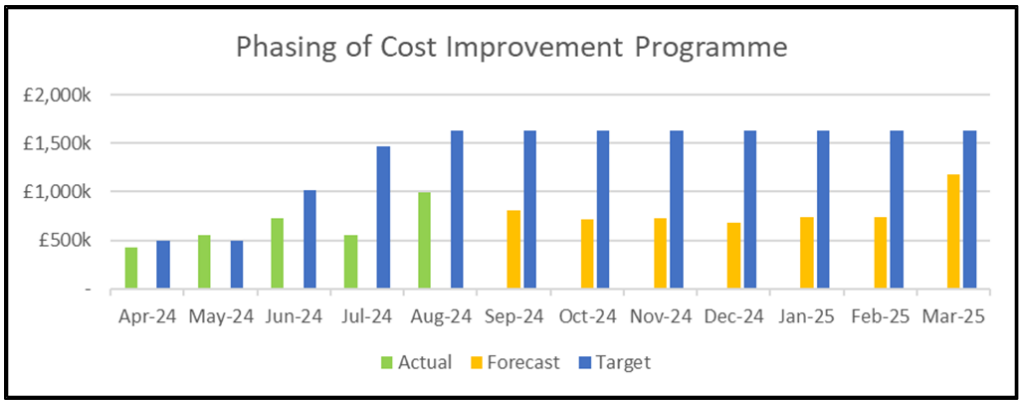
Table 1 – CIP achievement to date, with current forecast

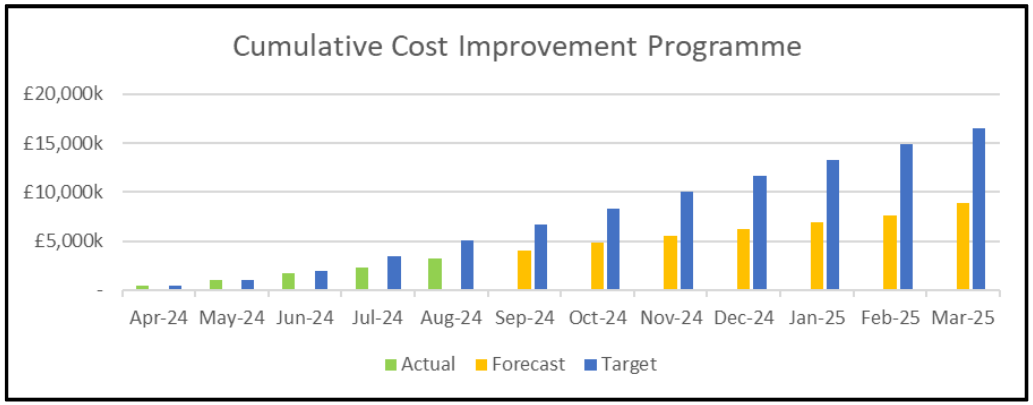
FINANCE REPORT – August 2024

Division	Target (2425 Schemes) £k	Target (2324 Schemes) £k	Annual Target £k	YTD Target YTD £k	YTD Actuals YTD £k	YTD Variance £k	FULL YEAR Annual Target £k	FULL YEAR Actuals/ Forecast 2024-2025 £k	FULL YEAR Variance £k	In Month Delivery Target	In Month Delivery Actuals	In Month Delivery Variance
Medicine	2,211	-	2,211	659	72	(587)	2,211	593	(1,618)	222	54	(167)
Surgery	2,027	594	2,621	782	430	(352)	2,621	869	(1,752)	263	94	(169)
Women & Children	542	-	542	351	276	(75)	542	365	(177)	27	1	(26)
CSS	845	94	939	280	159	(121)	939	457	(482)	94	45	(49)
Community	1,286	327	1,613	481	235	(246)	1,613	901	(712)	162	65	(97)
Estates & Facilities	674	262	936	279	408	129	936	637	(298)	94	285	191
Corporate	4,630	208	4,838	1,443	235	(1,208)	4,838	956	(3,882)	485	52	(433)
Division Specific	**12,215**	**1,485**	**13,700**	**4,275**	**1,815**	**(2,460)**	**13,700**	**4,778**	**(8,922)**	**1,346**	**597**	**(750)**
TW - WRG Medical Staff	-	-	-	-	79	79	-	468	468		56	56
TW - WRG Nursing Staff	-	-	-	-	141	141	-	343	343		41	41
TW - WRG Other Staff	-	-	-	-	89	89	-	364	364		23	23
TW - Finance	-	-	-	-	993	993	-	2,384	2,384		199	199
TW - Procurement	-	-	-	-	-	-	-	-	-	-	-	-
TW - Pharmacy	-	-	-	-	110	110	-	338	338	-	72	72
TW - Discretionary Spend	-	-	-	-	35	35	-	171	171	-	7	7
TW - Strategy & Transformation	-	-	-	-	-	-	-	-	-	-	-	-
TW - Other	-	-	-	-	-	-	-	-	-	-	-	-
Stretch	2,800	-	2,800	835	2	(833)	2,800	2	(2,798)	281	2	(279)
Total	**15,015**	**1,485**	**16,500**	**5,110**	**3,264**	**(1,846)**	**16,500**	**8,847**	**(7,653)**	**1,627**	**996**	**(631)**

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.

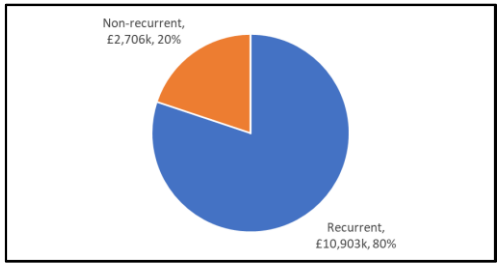
Graph 2&3 – Phasing of CIP targets over the year

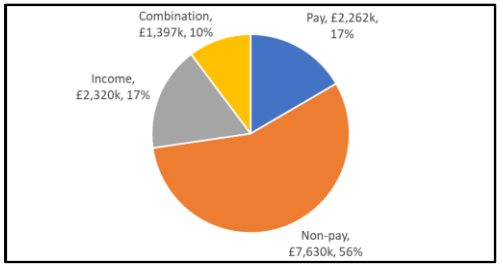




Graph 4&5 – Planned CIPs – Recurrent v Non-recurrent, Pay v Non-pay

Identified schemes – recurring vs non-recurring and pay vs non-pay





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FINANCE REPORT – August 2024

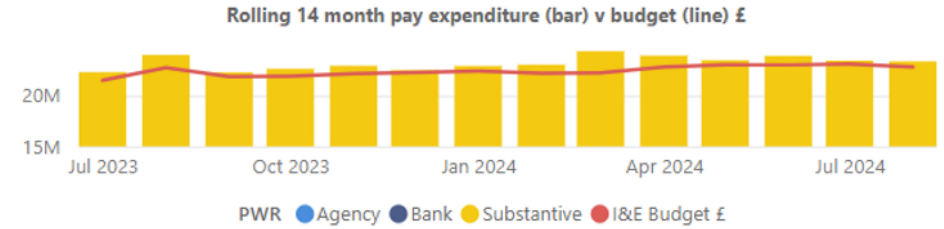
Workforce

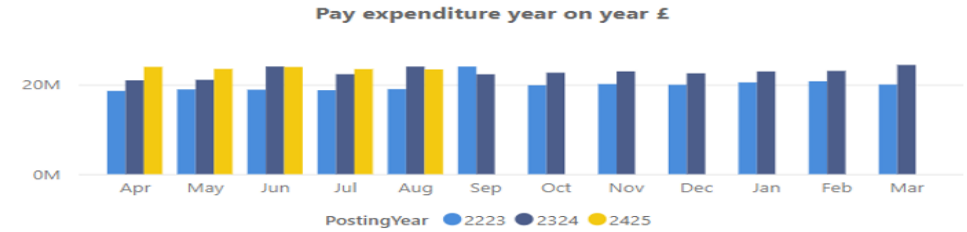
During August the Trust overspent by £0.9m on pay due largely to Extra Contracted Work (ECW), temporary staffing and backdated pay claims. We have now put in place a process to review all temporary pay requests.

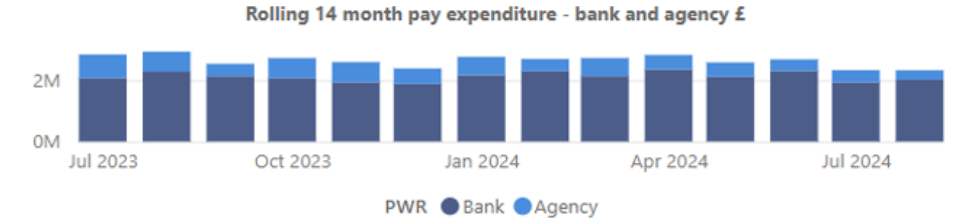
The pay related costs include an accrual of 2% in anticipation of pay awards (which are budgeted). Any variance from this will be reflected in the month these are paid. It is assumed pay awards will be fully funded and therefore budgets will align to any associated costs but we continue to await confirmation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

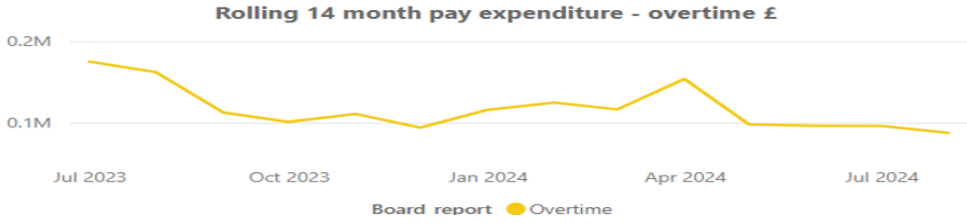
Pay Costs

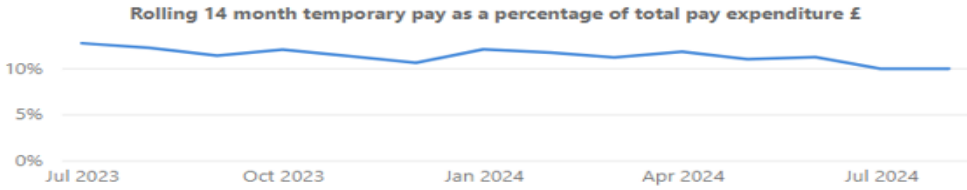
		Prior Month Actuals £000	In-Month Actuals £000s	In-Month Budget £000s	In-Month Variance £000s	YTD Actuals £000s	YTD Budget £000s	YTD Variance £000s
Substantive	Medical Staff	5,254	5,295	5,668	372	26,557	28,276	1,719
	Nursing	7,699	7,577	8,286	710	38,201	42,748	4,547
	Sci & Professional	1,064	1,074	1,152	78	5,387	5,742	355
	A&C	3,528	3,448	3,692	243	17,148	17,972	823
	AHP	2,194	2,228	2,321	93	11,124	12,109	985
	Prof & Tech	221	220	233	13	1,090	1,171	81
	Support Staff	798	795	857	61	4,006	4,424	418
	Other	524	411	422	11	2,083	1,986	-96
	Unallocated CIP	0	0	-527	-527	0	-1,294	-1,294
	Total	21,282	21,049	22,103	1,055	105,595	113,134	7,539
Additional Medical Sessions	Medical Staff	362	351	99	-252	1,887	535	-1,351
	Total	362	351	99	-252	1,887	535	-1,351
Bank & Locum Staff	Medical Staff	456	565	116	-450	2,767	593	-2,174
	Nursing	586	601	17	-584	3,285	77	-3,208
	Sci & Professional	35	29	4	-25	142	18	-124
	A&C	81	91	15	-77	414	67	-348
	AHP	14	19	0	-19	97	2	-95
	Prof & Tech	1	1	0	-1	3	0	-3
	Support Staff	297	261	83	-178	1,564	415	-1,150
	Other	0	1	0	-1	1	0	-1
	Total	1,471	1,568	234	-1,334	8,273	1,171	-7,102
Agency	Medical Staff	172	113	32	-81	788	158	-631
	Nursing	77	30	17	-14	355	84	-271
	Sci & Professional	10	17	10	-7	117	51	-66
	A&C	58	68	18	-51	304	89	-215
	Prof & Tech	79	85	-23	-108	455	86	-369
	Support Staff	0	3E-5	0	-3E-5	0	0	0
	Total	395	313	53	-260	2,020	467	-1,553
Overtime	Nursing	30	25	2	-22	153	12	-141
	Sci & Professional	11	12	5	-7	82	23	-59
	A&C	20	23	0	-23	141	2	-138
	AHP	12	9	0	-9	53	0	-53
	Prof & Tech	22	18	0	-18	102	0	-102
	Total	96	87	7	-80	531	38	-493
Total		23,606	23,369	22,498	-871	118,305	115,345	-2,961









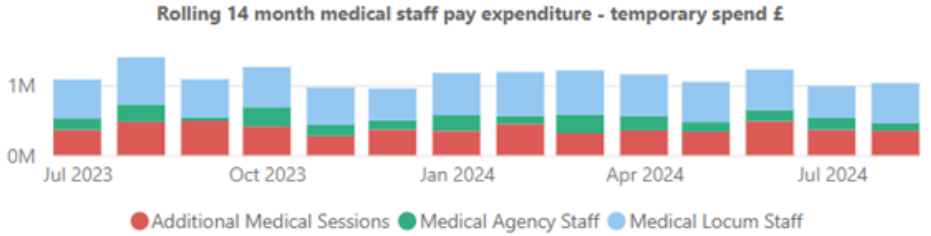


FINANCE REPORT – August 2024

Pay Costs (by Staff Type)

Medical Staffing, and in particular Extra Contracted Work (ECW) are the staff group with the most significant adverse variance. However, ECW dropped by £10k in August compared with July.

		Prior Month Actuals £000	In-Month Actuals £000s	In-Month Budget £000s	In-Month Variance £000s	YTD Actuals £000s	YTD Budget £000s	YTD Variance £000s
Medical Staff	Substantive	5,254	5,295	5,668	372	26,557	28,276	1,719
	Additional Medical Sessions	362	351	99	-252	1,887	535	-1,351
	Bank & Locum Staff	456	565	116	-450	2,767	593	-2,174
	Agency	172	113	32	-81	788	158	-631
	Total	6,244	6,324	5,914	-410	31,998	29,562	-2,437
Nursing	Substantive	7,699	7,577	8,286	710	38,201	42,748	4,547
	Bank & Locum Staff	586	601	17	-584	3,285	77	-3,208
	Agency	77	30	17	-14	355	84	-271
	Overtime	30	25	2	-22	153	12	-141
	Total	8,392	8,233	8,323	90	41,993	42,920	927
Sci & Professional	Substantive	1,064	1,074	1,152	78	5,387	5,742	355
	Bank & Locum Staff	35	29	4	-25	142	18	-124
	Agency	10	17	10	-7	117	51	-66
	Overtime	11	12	5	-7	82	23	-59
	Total	1,121	1,132	1,171	39	5,729	5,835	106
A&C	Substantive	3,528	3,448	3,692	243	17,148	17,972	823
	Bank & Locum Staff	81	91	15	-77	414	67	-348
	Agency	58	68	18	-51	304	89	-215
	Overtime	20	23	0	-23	141	2	-138
	Total	3,688	3,631	3,725	93	18,007	18,130	123
AHP	Substantive	2,194	2,228	2,321	93	11,124	12,109	985
	Bank & Locum Staff	14	19	0	-19	97	2	-95
	Overtime	12	9	0	-9	53	0	-53
	Total	2,220	2,256	2,321	65	11,274	12,111	836
Prof & Tech	Substantive	221	220	233	13	1,090	1,171	81
	Bank & Locum Staff	1	1	0	-1	3	0	-3
	Agency	79	85	-23	-108	455	86	-369
	Overtime	22	18	0	-18	102	0	-102
	Total	322	324	210	-114	1,649	1,256	-393
Support Staff	Substantive	798	795	857	61	4,006	4,424	418
	Bank & Locum Staff	297	261	83	-178	1,564	415	-1,150
	Agency	0	3E-5	0	-3E-5	0	0	0
	Total	1,095	1,057	940	-117	5,571	4,839	-732
Other	Substantive	524	411	422	11	2,083	1,986	-96
	Total	524	411	422	11	2,083	1,986	-96
Other	Bank & Locum Staff	0	1	0	-1	1	0	-1
	Total	0	1	0	-1	1	0	-1
Unallocated CIP	Substantive	0	0	-527	-527	0	-1,294	-1,294
	Total	0	0	-527	-527	0	-1,294	-1,294
Total		23,606	23,369	22,498	-871	118,305	115,345	-2,961



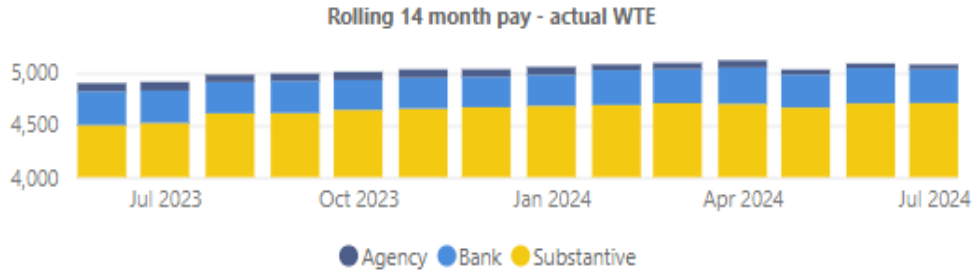
FINANCE REPORT – August 2024

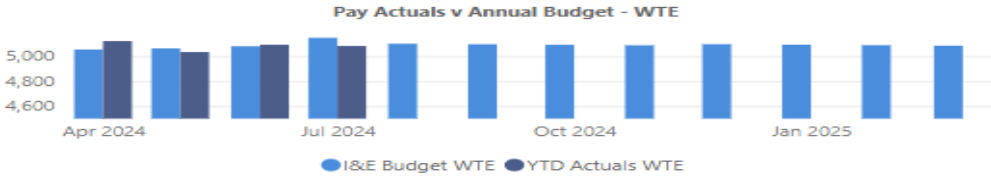
Workforce – WTEs

Agency staff appear to have been replaced with (cheaper) bank and locum staff. Overtime has continued to fall.

However, we are employing 125.2 substantive WTEs more than in same period last year, and 116.4 WTEs more in total.

		Prior Month Actuals WTE	Prior Yr Same Period Actuals WTE	In-Month Actuals WTE	YTD Actuals Average WTE
Substantive	Medical Staff	573.0	586.1	595.9	580.2
	Nursing	1,935.4	1,876.8	1,925.1	1,929.3
	Sci & Professional	273.6	276.0	273.5	274.5
	A&C	988.2	964.5	985.4	979.4
	AHP	535.0	509.7	546.3	543.8
	Prof & Tech	49.5	49.1	50.3	48.8
	Support Staff	283.6	276.3	286.5	283.1
	Other	73.1	74.1	75.0	66.7
	Unallocated CIP	0.0	0.0	0.0	0.0
	Total	4,711.4	4,612.8	4,738.0	4,705.7
Additional Medical Sessions	Medical Staff	24.4	17.6	20.3	16.3
	Total	24.4	17.6	20.3	16.3
Bank & Locum Staff	Medical Staff	53.5	38.5	47.9	45.8
	Nursing	143.1	132.9	152.6	162.4
	Sci & Professional	9.5	3.6	8.2	7.7
	A&C	27.8	29.7	29.6	27.5
	AHP	3.5	5.2	5.2	4.7
	Prof & Tech	0.2	0.2	0.2	0.2
	Support Staff	40.3	34.1	40.1	41.1
	Other	0.0		0.2	0.0
	Total	277.7	244.2	284.0	289.5
Agency	Medical Staff	10.0	12.6	8.3	10.0
	Nursing	11.0	29.2	4.0	9.5
	Sci & Professional	5.6	2.6	4.5	6.3
	A&C	5.7	8.9	8.8	7.7
	Prof & Tech	13.4	12.6	11.0	15.3
	Support Staff	0.0	4.8	0.0	0.0
	Total	45.7	70.7	36.6	48.8
Overtime	Nursing	6.7	20.7	5.9	7.1
	Sci & Professional	2.1	4.7	2.0	3.2
	A&C	4.1	4.5	5.4	6.1
	AHP	2.6	1.7	2.1	2.4
	Prof & Tech	6.2	6.2	5.4	5.9
	Total	21.7	37.8	20.7	24.6
Total		5,080.9	4,983.1	5,099.5	5,084.9



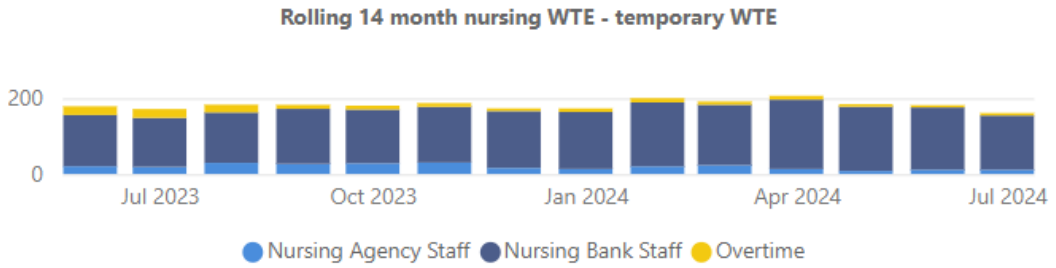


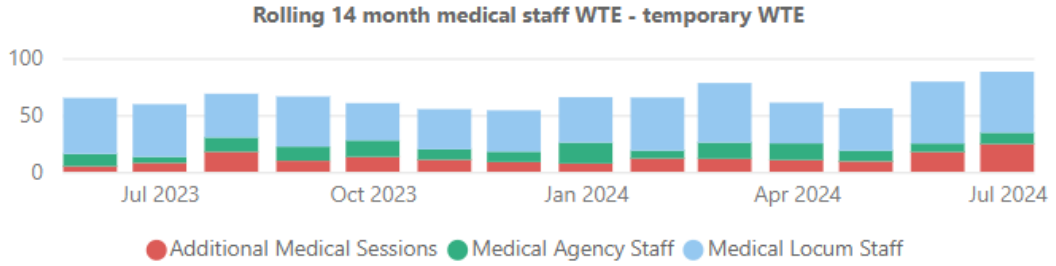
FINANCE REPORT – August 2024

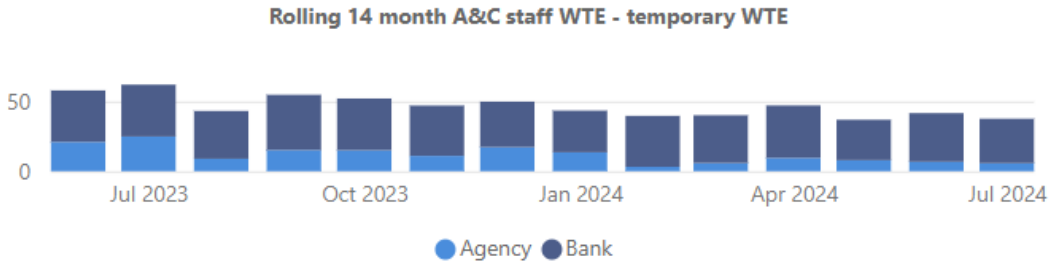
Workforce – WTE (by Staff Group)

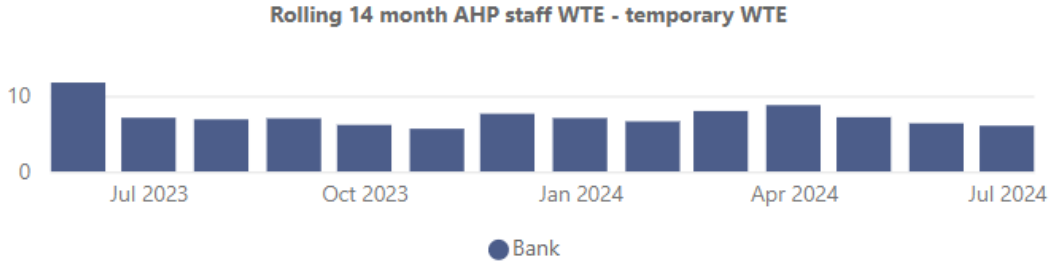
There appear to be 9.8 WTE more Substantive Medical Staff than in August 2023, as well as a significant increase in use of Extra Contracted Work (Additional Sessions), locums and agency staff. Total increase of 17.7 WTE (2.7%).

		Prior Month Actuals WTE	Prior Yr Same Period Actuals WTE	In-Month Actuals WTE	YTD Actuals Average WTE
Medical Staff	Substantive	573.0	586.1	595.9	580.2
	Additional Medical Sessions	24.4	17.6	20.3	16.3
	Bank & Locum Staff	53.5	38.5	47.9	45.8
	Agency	10.0	12.6	8.3	10.0
	Total	660.9	654.7	672.4	652.2
Nursing	Substantive	1,935.4	1,876.8	1,925.1	1,929.3
	Bank & Locum Staff	143.1	132.9	152.6	162.4
	Agency	11.0	29.2	4.0	9.5
	Overtime	6.7	20.7	5.9	7.1
	Total	2,096.2	2,059.6	2,087.6	2,108.3
Sci & Professional	Substantive	273.6	276.0	273.5	274.5
	Bank & Locum Staff	9.5	3.6	8.2	7.7
	Agency	5.6	2.6	4.5	6.3
	Overtime	2.1	4.7	2.0	3.2
	Total	290.7	287.0	288.2	291.6
A&C	Substantive	988.2	964.5	985.4	979.4
	Bank & Locum Staff	27.8	29.7	29.6	27.5
	Agency	5.7	8.9	8.8	7.7
	Overtime	4.1	4.5	5.4	6.1
	Total	1,025.8	1,007.7	1,029.2	1,020.7
AHP	Substantive	535.0	509.7	546.3	543.8
	Bank & Locum Staff	3.5	5.2	5.2	4.7
	Overtime	2.6	1.7	2.1	2.4
	Total	541.1	516.6	553.5	550.9
Prof & Tech	Substantive	49.5	49.1	50.3	48.8
	Bank & Locum Staff	0.2	0.2	0.2	0.2
	Agency	13.4	12.6	11.0	15.3
	Overtime	6.2	6.2	5.4	5.9
	Total	69.3	68.1	66.9	70.1
Support Staff	Substantive	283.6	276.3	286.5	283.1
	Bank & Locum Staff	40.3	34.1	40.1	41.1
	Agency	0.0	4.8	0.0	0.0
	Total	323.9	315.2	326.6	324.3
Other	Substantive	73.1	74.1	75.0	66.7
	Total	73.1	74.1	75.0	66.7
Other	Bank & Locum Staff	0.0		0.2	0.0
	Total	0.0		0.2	0.0
Unallocated CIP	Substantive	0.0	0.0	0.0	0.0
	Total	0.0	0.0	0.0	0.0
Total		5,080.9	4,983.1	5,099.5	5,084.9









FINANCE REPORT – August 2024

Statement of Financial Position – 31 August 2024

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2024	Plan 31 March 2025	Plan YTD 31 August 2024	Actual at 31 August 2024	Variance YTD 31 August 2024
	£000	£000	£000	£000	£000
Intangible assets	57,724	51,078	54,955	54,902	(53)
Property, plant and equipment	130,806	159,588	148,601	140,806	(7,795)
Right of use assets	11,624	9,512	10,744	10,809	65
Trade and other receivables	7,158	7,158	7,158	7,158	0
Total non-current assets	**207,312**	**227,336**	**221,457**	**213,675**	**(7,782)**
Inventories	4,640	4,600	4,600	4,911	311
Trade and other receivables	20,378	18,378	17,378	21,581	4,203
Non-current assets for sale	490	490	490	490	0
Cash and cash equivalents	9,315	1,107	2,908	7,624	4,716
Total current assets	**34,823**	**24,575**	**25,376**	**34,606**	**9,230**
Trade and other payables	(41,934)	(28,587)	(37,741)	(43,968)	(6,227)
Borrowing repayable within 1 year	(4,732)	(4,722)	(4,722)	(4,760)	(38)
Current Provisions	(58)	(58)	(58)	(59)	(1)
Other liabilities	(1,776)	(2,685)	(1,776)	(7,067)	(5,291)
Total current liabilities	**(48,500)**	**(36,052)**	**(44,297)**	**(55,854)**	**(11,557)**
Total assets less current liabilities	**193,635**	**215,859**	**202,536**	**192,427**	**(10,110)**
Borrowings	(44,048)	(39,160)	(42,164)	(42,315)	(151)
Provisions	(407)	(407)	(407)	(407)	0
Total non-current liabilities	**(44,455)**	**(39,567)**	**(42,571)**	**(42,722)**	**(151)**
Total assets employed	**149,180**	**176,292**	**159,965**	**149,705**	**(10,261)**
Financed by					
Public dividend capital	277,694	320,343	297,617	292,223	(5,394)
Revaluation reserve	11,941	11,941	11,941	11,941	0
Income and expenditure reserve	(140,455)	(155,992)	(149,593)	(154,459)	(4,867)
Total taxpayers' and others' equity	**149,180**	**176,292**	**159,965**	**149,705**	**(10,261)**

The above table shows the year-to-date position as at 31 August 2024.

The variance to plan of property, plant and equipment is due to the capital programme being below plan (see below). This also links to the public dividend capital, which has not been required to be draw down.

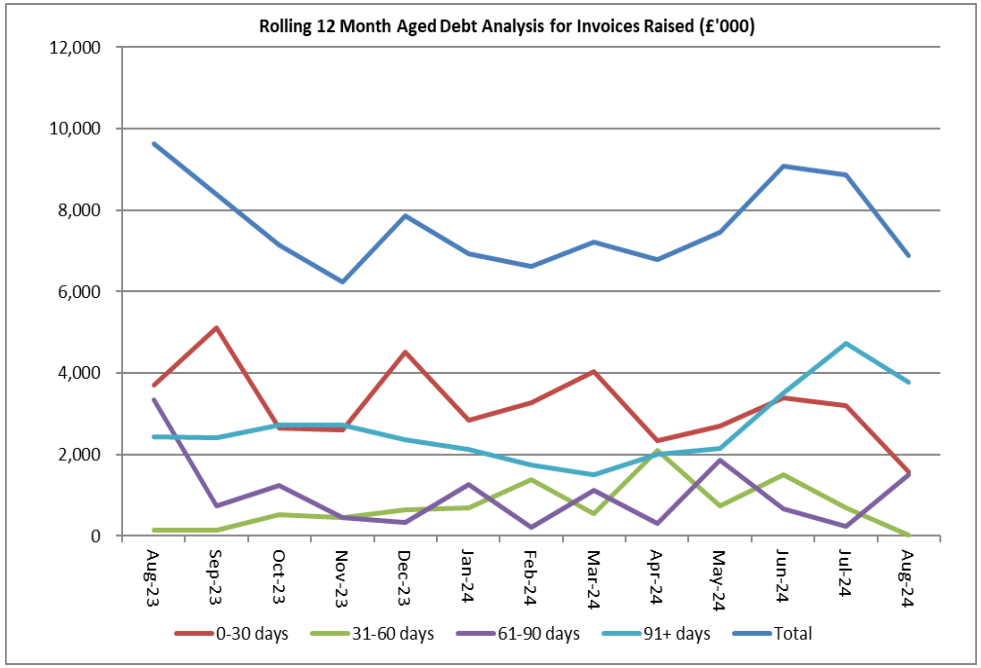
Trade and other receivables are higher than plan and this is due to an increase in pre-payments of £1.4m and aged debt with Health Education England of £2.4m and Suffolk County Council of £1.2m. There has also been good recovery of some aged debt.

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.

Deferred income is higher than plan, mostly due to £4.4m of income received from the ICB in relation to depreciation tariff funding. This has conversely increased our cash balance, although this cash is ring-fenced for spend on capital projects.

Debt Management

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



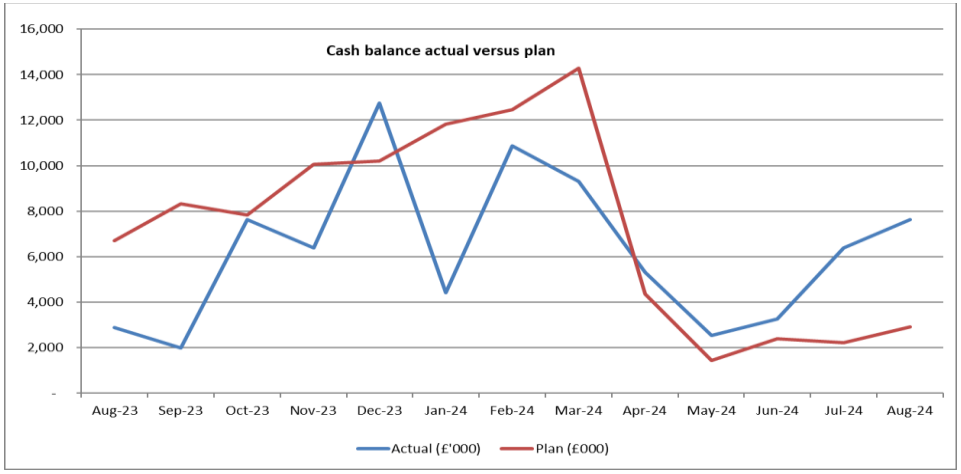
The overall level of sales invoices raised but not paid continues to remain stable and we have been working hard to reach resolution on some of the older debts in order to help the Trust's cash position.

Over 64% of the outstanding debts relate to NHS/WGA Organisations, with 53% of these types of debts being greater than 90 days old.

FINANCE REPORT – August 2024

Cash Balance for the year

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



The Trust's cash balance as at 31 July 2024 was £7.6m compared to a plan of £2.9m. This was made up of £4.4m of cash that is set aside to pay for capital projects and £3.2m for revenue payments. The £4.4m relates to depreciation funding received from the ICB, which is to be used for capital spend.

Our cash is being rigorously monitored to ensure that we have adequate cash reserves to match our expenditure. However, as the Trust continues to report a deficit, our cash position continues to deteriorate.

In order to ensure that the Trust has adequate cash support we have requested further revenue support of £6.8m for quarter 2 from DHSC. We have already received £3m in revenue support for quarter 1. We have successfully been awarded £4m for quarter 2 as at month 5. We are waiting to hear the outcome of our remaining request for the quarter 2 application. £2m has now been approved, therefore year to date we have applied for £9.8m in line with our planned deficit and received approval for £9m.

Due to the Trust continuing to be off plan, we require additional revenue support to aid the continuing deficit and to assist with working capital.

For quarter 3 of 2024/25 the Trust will require the following revenue support:

- October: £4m in deficit support and £5m in working capital support (£9m in total)
- November: £4m in deficit support
- December: £4m in deficit support

The deficit support is in line with the forecast set in the Financial Recovery Plan. Should this plan not be approved, we will need to revisit the revenue support that we are able to apply for and may need to request further working capital support, which will be much more challenging.

The £5m of working capital support requested for October relates to the cash required in order for the Trust to pay the pay award to all staff on the 25th October. The ICB will not be providing the Trust with the full amount of cash required to pay the pay arrears in October as the Trust has already received some of this cash as part of the monthly block payments. This cash has, however, already been used to pay the backlog of supplier payments.

The Board is asked to note the actions included in the Financial Recovery Plan around planned savings, the revised deficit and the Cash Strategy and in light of this, approve an application for a total of £17m in revenue support for quarter 3.

FINANCE REPORT – August 2024

Capital Progress Report

The Capital Plan for 2024/25 is £43m. £11.99m will be internally funded, with the remaining £31m being funded by PDC. Further PDC has been awarded for the New Hospital Programme of £6.4m since the original Capital Plan was set.

The year-to-date capital spend at month 5 is £13.2m. This is behind plan and is mainly due to spend on RAAC projects and general estates projects. However, it is still expected that the full capital programme will be completed by the end of March 2025. Due to the Trust's current cash position we are currently reviewing those projects that are internally funded to see whether any can be delayed.

Given the concerns over cash and the impact of our capital programme on our future I&E position (depreciation and PDC) we are currently reviewing our Capital Programme to try to reduce it wherever possible.

The table below shows the breakdown:

Capital Spend - 31st Aug 2024	**Year to Date - Month 5**			**Full Year**		
	YTD Forecast	**YTD Actual**	Variance to Plan	Full year Forecast	***Funding Split***	
Capital Scheme					***Internal***	***PDC Available***
	£000's	**£000's**		£000's	***£000's***	***£000's***
RAAC Programme	3,540	**993**	2,547	5,645		***5,900***
Newmarket CDC	6,749	**6,395**	354	10,583		***7,860***
New Hospital Programme* **	3,018	**2,626**	392	13,188		***15,694***
Digital Pathology	-	**13**	- 13	86		***86***
Image Sharing	-	**-**	-	345		***345***
CT Scanner*	-	**-**	-	1,104		***1,104***
Estates	3,112	**1,343**	1,769	4,229	***4,282***	
IM&T	922	**1,291**	- 370	2,033	***1,995***	***30***
Medical Equipment**	380	**219**	161	1,322	***1,322***	
Imaging Equipment	97	**363**	- 266	2,400	***2,400***	
UEC Capital	-	**-**	-	2,000	***2,000***	
Total Capital Schemes	17,818	**13,245**	4,573	42,934	***11,999***	***31,019***
Overspent vs Plan					***43,018***	
Underspent vs Plan						

* Late addition to Capital Plan - included in resubmission in June 2024
** This includes all equipment being purchased across the Trust
*** NHP budget is subject to change throughout the year and is fully funded by PDC

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Comfort Break

4. PEOPLE AND CULTURE

4.1. Involvement Committee report

To Assure

Presented by Antoinette Jackson

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Involvement Committee			Date of meeting: 20th August 2024		
Chaired by: Tracy Dowling - Non executive Director			**Lead Executive Directors: Jeremy Over and Sue Wilkinson**		
Agenda item 4.1	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
6.1	First for Staff Presentation and discussion exploring the relationship between financial recovery and the organisational culture – led by Jeremy Over, Sam Tappenden and Helen Davies	3. Partial	• Concerns identified by staff worried about what the changes may mean for them and their work • Concerns regarding need for honest formal communications about the scale of the financial challenge and approach to addressing this • Want transparency of decision making • Some staff understandably feel under pressure to deliver • Has changed the job of ward managers to be accountable for the ward budgets. • Clear that current culture does need to evolve to ensure financial accountability is considered alongside clinical and	• Ensure regular Pulse staff surveys • Clarify and develop organisational messaging on 'red lines' • Develop clear communications on what staff can expect regarding job security • Support development of triumvirate structures so leadership responsibility is shared in divisions • Develop business planning processes for medium term and in line with finance plan horizons • Be clear that next 6 months will be about grip and control • Start to work through what the target – culture needs to be for an organisation that can deliver expected quality, safety and performance standards within funding allocations • Consider the training and development needed to implement	1. Keep on Involvement Committee agenda 2. Escalation to executive management team to progress the actions 3. Escalate to Board regarding approaches to financial recovery and organisational development

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			performance accountability at all levels of the organisation • Clear that maintaining and developing a 'Just Culture' – and continuing to live the Trust values as these accountabilities are strengthened is vital	the actions and organisational development needed for financial recovery	
7.1	First for Patients Presentation from Cassia Nice – Summary of feedback from Healthwatch engagement with the public and patients regarding the transfer of some elective orthopaedic care to the ESEOC	2. Reasonable	• 54% responders were members of the public; 37% were patients on the orthopaedic waiting list at WSFT; 5% identified as family or carers of people on the waiting list • Mixed responses – 48% positive; 35% negative • Main concerns about transport – especially those living furthest from Colchester • People pleased to have shorter wait times	• Discussions regarding the engagement results to take place with the ICB and to include responsibility for leading the response to the engagement • WSFT still in discussion about the consequences of moving some orthopaedic activity and agreed that addressing the issues from the engagement needs to be part of these discussions about the practical impacts on patients • Clear that patients would still have the choice to elect to have their surgery at WSFT	2. To executive management team

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			• Concerns about clarity of information • Concerns for vulnerable people and accessibility		
8.1	Update from People and Culture Leadership Group	1. Substantial	Developing work re. values based leadership and management standards.	Bi-monthly reports from PCLG.	1.
8.2	Experience of Care and Engagement Report	2. Reasonable	Report from the work of the latest committee meeting.	Particular request to provide future updates to Involvement Committee re. the focus on Women's Health in the emergency pathway / department	1.
8.3	Quarterly Report – Guardian of Safe Working Hours (GSWH)	1. Substantial	No immediate safety concerns reported in this quarter.	Continued quarterly reporting in line with national terms and conditions	1.
8.4 & 8.5	Board Assurance Framework – risk report	2. Reasonable	Reflection and discussion on latest drafts of BAF statements in relation to capacity and skills, and staff wellbeing.	Regular reviews of BAF frameworks to reflect strategic risks and mitigation	1.
8.6	Committee Annual Evaluation Report	1. Substantial	Completion of annual evaluation with good engagement from members.	Areas for development identified: • Continued focus to preserve and protect cultural progress while managing financial pressures • Ensuring reviews and decisions align with Trust strategies, priorities,	1.

Originating Committee: Involvement Committee			Date of meeting: 20th August 2024		
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				values and financial parameters • Strengthening focus on patient engagement, including themes from feedback such as complaints and PALS • Develop focus on enhancing workforce productivity • Review processes in place to ensure public involvement in all service changes or redesigns as part of business-as-usual operations • Strengthen focus on the board assurance framework (BAF) risk allocated to the committee and ensuring this informs the focus assurance.	
9.1	Workforce KPs	2. Reasonable	• It was highlighted that 3 of the four KPI's are continuing to track above target. • Corporate areas need continued focus on appraisals. • Retention partner recruited,	Ongoing monitoring of workforce KPIs, in particular appraisal and mandatory training in light of the risk of these being deprioritised due to financial pressures.	1.

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			funded for 12 months from the ICB, working alongside ESNEFT • Training compliance has improved, achieving target for 10 consecutive months.		

**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.

4.1.1. Putting you First Award

To Assure

Presented by Jeremy Over

NHS
West Suffolk
NHS Foundation Trust

Putting You First awards

August / September 2024 winners

Board of Directors: 27 September 2024

Putting you first

Donna Page, senior ACP, AAU

Nominated by Joseph Deguara, AKI clinical nurse specialist

I would like to nominate Donna Page, Senior ACP at West Suffolk Hospital Foundation Trust, as a staff hero for her invaluable support as an advocate, mentor, friend, and role model during challenging times while working at WSH. Donna consistently championed my needs when I required nursing support, guiding me to address my weaknesses and build upon my existing strengths. She accompanied me throughout my university journey while balancing her work responsibilities. After many years of collaboration within multidisciplinary teams, Donna was the one who took the initiative to identify a crucial missing element in my development: my dyslexia. Following a series of assessments, it was confirmed that I am dyslexic. Thanks to her insight, I am now in a more advantageous position, fully aware of my strengths and weaknesses. Previously, I found myself questioning the reasons behind my struggles, but Donna was able to uncover the missing piece. I am immensely grateful to her, as she extends her support to everyone she encounters at work. Donna is truly selfless, offering help to all individuals, regardless of their age, nationality, gender, or whether they are patients or colleagues. She is consistently at the forefront, eager to assist. She genuinely deserves recognition for her outstanding contributions to the West Suffolk NHS Foundation Trust.

John Jopling, general porter

Nominated by Portia Midford, nursing assistant

John provided the most compassionate care towards a very distressed lady with dementia in ED the other day during a transfer to CT. He was gentle and listened to the patient as she tried to express her fears. The lady really warmed to John and it was lovely to see! Although the effects of John's care were short lasting due to her condition, for that 5 minutes, he made a difference to her state of mind. He is another kind soul and professional and a true credit to the portering department and WSH, in my opinion.

Responsive team

Nominated by Annemie Waaning, head of integrated therapies

This team, under Jenny McCaughan's leadership has been instrumental in reducing delays in getting patients home with Pathway 1 - patients now typically can go home in less than a day after referral to the team. They work under a huge amount of pressure every day, having to coordinate several elements of the discharge process as quickly and efficiently as possible, however whenever you walk into the office you are overwhelmed by the positive, can-do approach and smiles all round. Fabulous leadership from Jenny, who is always on the lookout for how the process can be improved. Thank you so much for all that you do for our patients!

Main theatres staff / Sterile services

Nominated by Kim Allan, clinical team manager

Following an infection prevention incident over the weekend, all staff in theatres and sterile services worked together to clear the room of contaminated sets and send over to SSD to be reprocessed. This was all done whilst maintaining an emergency service for emergencies, Obstetrics, and Trauma. The SSD team worked hard to turnaround the sets to reduce the numbers of potential cancellations in elective activity the following week. Great team work all round.

Nominated by Julie Pettitt, head of business, estates and facilities

Following the recent 'pigeon' incident in theatres the SSD team were faced with the unprecedented task of decontaminating every instrument set from the theatre sterile store. The enormity of the task was unlike anything the team had experienced before. It took a monumental effort by Angela Logan and her SSD team to complete this and return the department to business as usual in just 8 days. Each and everyone in the team willingly offered to help complete this enormous task, including volunteering to work longer shifts, staying on when their shifts had ended, coming in at 6am and working longer shifts at the weekends. All of this was achieved in house, and at the same time as managing the daily decontamination requirements from other departments in the trust. I would like to thank the Portering, Estates & Procurement teams for their support which was instrumental in SSD being able to complete this huge volume of work.

5. OPERATIONS, FINANCE AND CORPORATE RISK

5.1. 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: 21 August 2024**		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Jonathan Rowell**		
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Finance Accountability Group	**Current year** The Trust was £3.5m off plan year to date (YTD) by the end of month 4, with a deficit of £11.6m against a planned deficit of £8.1m. The CIP programme is behind plan by £1.2m YTD. Some of the progress that has been made against CIP is due to a non-recurring rates rebate of £550k. There has been a reduction in the run rate compared to June but expenditure is still £2.1m above income and to hit our target deficit of £15.2m requires and improvement in the run rate of £2.5m per month. Our cash position remains challenging although we have received £1m received	**4. Minimal**	The current measures that are in place are not delivering the pace of change needed to deliver against the Trusts financial plan and a more comprehensive financial recovery plan is required (see below)	See financial recovery item below	

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	support in Month 5 from DHSC and we have been advised we will receive £4.4 m from the ICB in relation to depreciation funding which will also help our cash position.				

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	Financial Recovery Plan Good progress has been made in implementing the control measures agreed at the July Insight Committee including the implementation of a non-pay control panel and controls on Extra Contractual Work spend. The controls are also helping identify further potential CIPs although there is a need to ensure we are not double counting between the control measures and the CIP programme. The ICB has introduced a double lock mechanism which requires their approval of all relevant non-pay spend over £15k. Any such requests will have gone through the Trust's own internal processes first.	**3 Partial**	The control measures are beginning to show some results but the pace of change and financial delivery needs significant improvement given the scale of the gap. Efforts are currently very focused on the current year but there is a need for a coherent Financial Recovery plan that takes a longer-term view of the transformation needed to ensure financial sustainability into the future. This needs also needs to embrace cash recovery and workforce planning. Consideration needs to be given to the any gaps in capacity and capability in the organisation that need to be addressed to deliver the plan	A comprehensive financial recovery plan to be considered by Insight on 19 September and Board on 27 September. An extensive communications plan to be developed alongside this, to explain the future direction of travel and what this means for the Trust and its workforce.	

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PAAG/IQPR	**65 and 78 week waits** The total waiting list size remains high with no signs of reducing. At the end of June, 60 patients were waiting more than 78 weeks. 46 of these were related to capacity, with the largest volumes within Urogynaecology. There are four 78 -week patients in Urogynae without a specific plan. Fifty-six patients have now been transferred to the Nuffield to have their surgery before the end of September. On the whole we are doing better than our forecast for the 65-week cohort as at the end of June. There are however a number of surgical specialities which are slightly above	**3.Partial**	Delivering the objective of no patients waiting over 65 weeks by September 2024 is the central focus of 2024/25 planning, – 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.	Additional activity, either in week or on Saturdays is in the planning stages with Gynaecology, with the patients not suitable for the Nuffield now being screened for weekend list suitability. Additional weekend lists are in place throughout the summer months.	1 No escalation

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	trajectory. There are plans in these services to reduce his with an increase in activity prior to the end of September.				

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PAGG/IQPR	**Cancer Targets** Performance against the 28-day Faster Diagnosis Standard (FDS) is still not being consistently met. 62-day performance is above the which is above the national ambition of 85%. Actions are focussed on the skin and lower GI pathways.	**3. Partial**	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 with FDS steering groups in Skin, Colorectal, Breast and Gynae to monitor performance and required transformational changes. Implement required changes into the Skin community pathway, improving on the community consultant review to reduce referrals. Implementation of post menopausal bleeding (PMB) pathway for people receiving HRT to be managed outside an Urgent Suspected Cancer referral by Q3. Implement risk stratification tools in Prostate to reduce unnecessary progression to MRI and/or biopsy.	1 no Escalation

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PAAG/IQPR	**Urgent and Emergency Care (UEC)** Ambulance Handovers within 30 min and non-admitted 4-hour performance are not reliably hitting target and 12-hour breaches are consistently missing the target too.	**3 Partial**	Patients do not have a good experience of they face significant delays and are 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. 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 the ability and capacity to offload ambulances.	The UEC recovery plan has a trajectory to achieve the 78% 4hr ED target by March '25. The following projects commenced in July '24. Pre booked next day returner slots to support minor injuries attending after 10pm Rapid Assessment for non-admitted patients with a consultant triaging to either assess and discharge them or to redirect to other services Ambulance patients who are fit enough to sit will be triaged in streaming to release ambulances. The Minor Emergency Care Unit is on track to open by end of August 24	1 No escalation

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Quality Assurance Panel Outcomes	Improvement Committee had previously raised with Insight Committee the risk of quality considerations not being considered fully in the CIP programme and other financial decision making. Insight requested a report on outcomes form recent Quality Impact Assessment (QIA) reviews. The Panel reviews and scrutinises QIAs for all CIP schemes or projects and then either approves or rejects the proposal. The report updated the committee on the schemes that had been considered over the last 4 weeks.	**1.Substantial**	The report showed that there is a robust process in place to scrutinise schemes before they are agreed. 14 schemes had been considered in the previous 4 weeks and the risks and mitigations of these had been considered. The report showed that one scheme had been rejected and further work on the business case had been requested. Some schemes had been approved, but with conditions or recommendations attached.	Insight will continue to receive reports to future meetings.	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?

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Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Insight Committee			Date of meeting: 18 September 2024		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Jonathan Rowell**		
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PAAG/IQPR	**Urgent and Emergency Care (UEC)** Ambulance Handovers within 30 min and non-admitted 4-hour performance are not reliably hitting target although 4-hour performance was above trajectory in July. 12-hour breaches are consistently missing the target too, although they are decreasing.	**3 Partial**	Patients do not have a good experience of they face significant delays and are 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 UEC recovery plan has a trajectory to achieve the 78% 4hr ED target by March '25. The following projects commenced in July '24. Pre booked next day returner slots to support minor injuries attending after 10pm Rapid Assessment for non-admitted patients with a consultant triaging to either assess and discharge them or to redirect to other services Ambulance patients who are fit enough to sit will be triaged in streaming to release ambulances. The Minor Emergency Care Unit is now due to open on 14 October 2024.	1 No escalation

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PAGG/IQPR	**Cancer Targets** Performance against the 28-day Faster Diagnosis Standard (FDS) is not being consistently met, however there was an increase in June 2024 to 74.5% against a target of 75%. The 62 day performance is above trajectory and above the national requirement of 70% by the end of March 2025. There is an emerging risk in relation to Breast clinics. Radiology support is reducing from September 2024 which means wait times could extend out to more than 7 weeks, without additional actions in place.	**3. Partial**	Achieving the FDS target of 77% and a 62-day performance of 70% by March 2025 are the key objectives for cancer in 2024/25 planning.	Continue with FDS steering groups in to monitor performance and required transformational changes. Review the impact of the changes made in the skin pathway. Review the future of the community pathway from March 2025. Implementation of new post - menopausal bleeding (PMB) pathway for people receiving HRT Implement risk stratification tools in Prostate to reduce unnecessary progression to MRI, biopsy or treatment regimens by Q3. Review radiological support to the Breast clinics.	1 no Escalation

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PAAG/IQPR	**65 and 78 week waits** The 78-week wait position for the end of July was 52 patients, with the majority within the sub speciality of Urogynaecology. At the end of July, we were on trajectory for our 65-week wait cohort. But the Trust will not reach zero by the end of September and will have approximately 112 patients waiting over 65 weeks. There are a number of specialities which are slightly above trajectory including Gynaecology, Orthopaedics and Plastics. There is mitigation in place for Orthopaedics and Plastics to reduce this gap but limited options for Gynaecology. There are currently 47	**3.Partial**	Delivering the objective of no patients waiting over 65 weeks by September 2024 is the central focus of 2024/25 planning, – 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.	Additional weekend lists are in place throughout the summer months. Continued focus on both data quality and administrative validation to ensure all patients still require their treatment.	1 No escalation

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	patients in total without a plan within Urogynaecology specifically. The total waiting list size remains high with no signs of reducing.				

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Finance Accountability Group	**Current year** The Trust was £5m off plan year to date (YTD) by the end of month 5, with a deficit of £14m against a planned deficit of £9m. The CIP programme is behind plan by £1.8 YTD. £3.3m has been delivered against a target of £5.1m. The run rate is still £2.4m above income and to hit the target deficit of £15.2m requires and improvement in the run rate of £2.5m per month. Our cash position remains challenging. We have received £7m support from DHSC but have not yet received more due to not meeting our workforce target. As the deficit increases the cash gap will widen.	**4. Minimal**	The additional control measures put in place are not yet delivering substantial reductions to the run rate but it is hoped the outcomes from these changes this will be more evident by October. Additional costs of the Cerner contract are showing in the run rate from July onwards.	See financial recovery item below	3 Escalate to Board

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Financial Recovery Plan	Work has continued on developing a financial recovery plan. The detailed work on this suggests that the Trust will not meet the plan for the year previously agreed with the ICB. The reasons for this are a mix of the cost base being higher than assumed and planned CIP savings not being achieved. Divisions are overspending against budget and only approximately 50% of CIP delivery is being achieved. CIP that is being achieved is addressing overspending and not necessarily reducing overall budgets.	**3 Partial**	A series of detailed actions have been identified for 24/25 which aim to achieve a run rate reduction and an improved outturn against current performance. These actions would need to be achieved in full, so this is not without risk. The actions will require difficult decisions to be made about some service areas There is an action plan for cash to minimise the additional cash requirements in year. This will be challenging for the organisation and staff will need to be supported through significant change.	The financial recovery plan will be considered by Board on 27 September and the ICB Finance Committee on 1 October. This plan focusses primarily on 24/25 and work to build on this will take place to address 25/26 and beyond. The aim for 25/26 will be to focus on a smaller number of high impact schemes. Some options for the future will require wider discussion with system partners including requesting support to deliver the actions in the plan. Additional support is being	3 Escalate to Board

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			There are gaps in capacity and capability in the organisation to manage the scale of change required.	explored on a fee contingent basis to support CIP maximisation in year. The Director of Strategy and Transformation is undertaking a restructure of the Programme Management Office and the Improvement team to better support the change required. An extensive communications plan will be implemented, to explain the future direction of travel and what this means for the Trust and its workforce. The Committee encouraged the Executive to be bold in tackling difficult issues sooner rather than later.	

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Roche Contract Extension	The Roche managed service contract ends on the 14th November 2024 and is the major supplier for Biochemistry and Blood Transfusion service. The Committee considered options for the future of the contract and the associated third-party suppliers	**2 Reasonable**	The committee noted the desirability of aligning with ESNEFT and others for a substantive procurement exercise in the future. The ICB also needs to be involved in procurement decisions at an early stage given the double lock process and there is a need to develop the process and working relationships on this.	The closed Board will consider the Committee's recommendations about the contract on 27 September. There needs to be better pre-planning on proposed extension renewals so the Board can consider the principle of extension or alternative tender processes well in advance, to allow time for a full procurement exercise where necessary. The contracts register needs developing and there is a need to align the consideration of future contracts alongside the ICB double lock process.	3 Escalate to Board

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6. QUALITY, PATIENT SAFETY AND QUALITY IMPROVEMENT

6.1. Improvement Committee Report

To Assure

Presented by Roger Petter

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Improvement Committee			Date of meeting: Wednesday 21st August 2024		
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5.1	Patient Quality & Safety Governance Group (PQSGG) Hospital Transfusion Group (HTC) Deteriorating Patient Group (DPG) Dementia Steering Group Drugs & Therapeutics Mortality Oversight Group End of Life Operational Group Mortuary & HTA Thrombosis Group	1	Regular monthly report using the Trust's 1-4 assurance level scale. Areas of partial assurance: - HTC – Closed Loop Blood Project. Project has been on-going since 2017. Closed Loop Blood delivery systems increase transfusion safety and improve compliance with regulatory requirements for traceability. Progression with the current supplier is no longer an option. Refund being secured. Further business case to be developed and presented including research of other Trusts systems and processes. HTC – The Blood Safety & Quality Regulations 2005 require	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

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			100% traceability of blood components. Incomplete traceability should be an exceptional risk and risks regulatory non-compliance. Quality Improvement Project commenced to improve results. Theatre incidents – reviewed by Safer Surgery Group. Transfusion CNS – covered by Divisional Senior Nurse Meeting. Sepsis Data – separated into individual elements of sepsis 6 bundle to track compliance. Antibiotic is positively improving despite not quite achieving 90% target. Early identification and implementation of sepsis 6 bundle will improve mortality and morbidity associated with sepsis. Paediatric Early Warning System may improve early recognition – commenced July 24. Sepsis awareness session held weekly		

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			in ED. Engagement with E OF E Sepsis Forum mirrors challenge of sepsis bundle within one hour. Two Hour monitoring to commence to provide assurance. DPG – BLS compliance training not improving. Compliance = 80% due in part to low medical compliance and 6-month rotation of junior doctors. Required so staff have the right skills & training to deliver effective care. Role breakdown of compliance to provided to next meeting. Dementia & Frailty Steering Group – NAD recommendations – work continues to improve outcome of national audit of dementia – SQID compliance averaging 97.5%. Further work using QI approach to improve		

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			4AT. This will improve identification of delirium. Drugs & Therapeutics – CQC Engagement Call. Recognition of limitation of pharmacy provision to support LD&A. Pharmacy Team are reviewing mitigation to address gap.		
5.2	Clinical Effectiveness Governance Group (CEGG) Updates from the meeting: - QI Update MBRACE report and peer review of BAME Mothers Shared Decision Making & Consent Policies	1	Six new NBP publications.	CEGG will continue to maintain oversight of all new items reported as emerging concerns through its framework.	1
7.1	Deep Dive – Shared Decision Making (SDM)	2	SDM is mandated by; - NHS Long Term Plan	The SDM Group is overseeing this work. Work is progressing for all NICE categories. SDM training	1

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	SDM is a process whereby patients and clinicians work together to make evidenced based decisions centred on patient values & preferences. This may be a test or to go ahead with surgery. SDM ensures individuals are supported to make decisions which are right for them.		CQC – will be assessed NICE – for adults, for C&YP without capacity End of Life GMC Nursing & Midwifery Council The Health & Care Professions Council of Standards of Proficiency	for medical & dental staff is mandated on ESR. SDM is incorporated in Midwives mandatory training. SDM training for ACP's and other healthcare professionals cannot be assured at this time. Some departments are not fully engaging with Concentric but this is a rolling programme. The quality of SDM training in primary care and the community cannot be assured.	
7.2	Corridor Care – where care is given in. corridors or non-bed spaces. CQC have 11 basic standards of care. Person centred care	1	Three areas used in the Trust: - Arrive by 9 QI Project – where patient is moved before 9am Mon – Fri against a patient being discharged. Discharge patient moved to a chair in a designated space or in-coming patient waits in a chair for the bed if patient	Analyse baseline data & impacts Develop a report with Information Team Continue to gather patient feedback Monitor incidents	1

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	Visiting & Accompanying Dignity & Respect Consent Safety Safeguarding from abuse Food & Drink Premises & Equipment Complaints Good Governance Staffing & Duty of Candour		being discharged is unable to sit. Clear clinical oversight & on-going QI project. ED RAT corridor – supports 3 patients when there is ambulance off load delays or departmental over-crowding. Privacy screens used & dedicated staff member to care for patients. Oversight by senior departmental member of staff. AAU corridor – supports 4 patients. Trust is in OPEL 4 – Trust escalation policy. Only used between 9-5pm. AAU Matron oversight & responsibility. Upward reporting – DCN. RADAR logged. HON or DHN visit.	Continue to gather staff feedback Capture patient outcomes To note – the Trust would prefer not to deliver any care in these areas, however the Trust meets the fundamental care standards.	
7.3	Learning Report Patient Safety & Experience	1	The Trust has championed patient safety since the introduction of NHS Patient	Safety Improvement Group to continue to have oversight of this subject. Monitor & review new &	1

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	The Patient Safety, Patient Experience & Mortality Teams have processes to identify opportunities for learning & change, whilst maintaining oversight of good governance practices. To ensure patients, their families and carers come first.		Safety Strategy. WSFT is committed to being open & candid with patients to demystify terminology around processes or where harm has been caused or where patients want to share their experiences. This underpins our desire to communicate with patients sooner, to learn and make changes to further develop safe & effective care.	established processes. Establish mortality per review process.	
7.4	Maternity Claims Scorecard Incidents & Complaints Scorecard claims are reviewed quarterly at the Maternity Quality & Safety & Maternity Neonatal Safety Champions meetings. Themes are analysed against other safety & quality data. Details of incidents & complaints	1	Report summarised claims from 1/4/23 – 31/12/23 alongside incident & complaint data from 1/1/24 – 31/3/24. Identifying themes & learning.	Safe practices & proactive assessment of women & babies to identify potential risk factors & anticipate complications & opportunities to escalate & offer management & treatment which may reduce the adverse effects on health & well-being of babies. Oversight to be maintained by Maternity Quality & Safety &	1

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	are reviewed monthly & improvements are identified.			Neonatal Safety Champions Meeting.	
7.5	Obstetric Anaesthetic Workforce Board Report Safe staffing of maternity services is one area of safety standards & actions expected for the Maternity Incentive Scheme. Report provides evidence of compliance with safe staffing requirements for obstetric anaesthesia with the WSFT Maternity Unit. Covers 1/10/23 – 31/3/24	1	The anaesthetic services prioritise covering obstetric anaesthetic bleep role & the rotas demonstrate 100% compliance for this period of audit.	Attendance at emergency obstetric MDT training days will be monitored to ensure staff initial attendance & thereafter annually. Any issues identified will be worked through to ensure a competent obstetric anaesthetist is always available. Maternity & Anaesthetic depts to compile 6-month reports on compliance.	1
7.6	Neonatal Medical Workforce Report Neonatal medical staffing in the WSFT Neonatal Unit is required to meet the standards set by te Association of Perinatal Medicine	1	The rotas were assessed against the standards from 1/10/23 – 31/3/24. There were 2 occasions where the weekday sessions on Mon/Wed or Fri were not covered. The	6 monthly reports on staffing levels against BAPM requirements	1

Originating Committee: Improvement Committee			Date of meeting: Wednesday 21st August 2024		
Chaired by: Louisa Pepper			Lead Executive Director: Susan Wilkinson Ravi Ayyamuthu		
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	for all tiers of staffing. The Maternity Incentive Scheme is in its 6th year & the requirement in unchanged from year 5 & the Trust meets the BAPM standards for safe staffing in the unit.		escalation is the on-call Paediatrician will attend the Neonatal Unit. This did not result in harm or any adverse outcomes. There is forward planning for retirements & upcoming vacancy rates are proactively managed to ensure gaps are covered. 87.5% Consultant Paediatricians have attended 8 hours of training in the last year. 2 Consultants are outstanding. Oversight of training by MDT lead educator and Neonatal clinical lead.	Neonatal lead to continue oversight of training, record keeping and compliance. Recruitment & retention of staff key to service of high-quality care. Any projected vacancies minimised by forward planning. All shortages to be managed effectively. Review of NNU consultant cover undertaken daily to ensure high standards are consistent throughout the week.	
7.7	Maternity Scorecard and Triangulation	1	Details of claims outlined by injury - volume and values and causes – volume and values. Complaints in Q4 = 2 Themes Q4	Improvement Committee will continue to maintain assurance oversight of items reported on a quarterly basis.	1

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			Unanticipated neonatal deterioration 1 hour following birth Birth choice discussions in presence of evolving risks Utilising most appropriate clinical escalation tools Themes led to learning of 4 key issues: - Senior Paediatrician to attend if significant meconium Regional CFM guidance not followed re guidance for neonates requires formal implementing with appropriate governance processes Urgent emergency messaging was used instead of emergency escalation		

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			Response to cardiac arrest on post-natal ward demonstrated actions put in place delivered an exemplary response. To note learning from Q4 included in Action Plan.		
7.8	Neonatal Staffing Report Report on progress towards meeting safe staffing standards within neonatal workforce. Standards outlined in British Association of Perinatal Medicine. Assessed using the Neonatal Clinical Review Group nursing workforce calculator. The calculator uses local data for activity, bed occupancy & staff to measure staff numbers to safely manage service. There is	1	Whilst the calculator is useful when applied to Neonatal staffing, it has limitations and doesn't consider Neonatal Transitional Care (NTC) & Neonatal Community Service (NCS). These services reduce separation of mother & baby and provide a safe alternative to routine admission and prolonged hospital stays. As not all units provide the NTC or NCS this results in an inequity of service	Regular reviews of staffing levels & skills mix to reflect the activity and acuity going forward. Allowance to be made for NTC and NCS. Band 6 QIS Neonatal Shift Leader to be supernumerary to supervise and oversee neonatal activity. Funding identified and recruitment to be commenced asap. This role identified in our previous Maternity Incentive	1

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	currently a shortfall in Qualified in Speciality trained staff of 9.4% projected to fall to 5.8% in near future. Vacancy rate of 1.46% WTE		and budgeting of neonatal services.	Scheme submission and will feature in this years. Action plan to be developed Neonatal calculator to be completed annually.	
8.1	Revision process for external incident reporting New governance framework currently being piloted for the management of incidents requiring external regulatory reporting. Reporting is – timely, accurate, owned and improvement focused.	2	RADAR – The Trust incident reporting system captures incidents affecting patients, staff & the organisation. Designated to enable analysis of themes, trends & highlight cases requiring specific investigation. There are also requirements to report some incidents externally – some of which are underpinned by regulatory/statutory requirements. Trusts must have clear & effective governance and management & accountability arrangements. In addition, there needs to be the ability to test	WSFT Incident Reporting process is sound & robust, however the governance arrangements for oversight & improvement focus needed structure. The framework provides that structure. Next steps Test pathway for RIDDOR reporting Liaise with Radiology to test pathway for IR(ME)R Review initial pilot	1

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			new & innovative ideas within a service whilst ensuring notifications are consistently submitted to external organisations as required.	Confirm other external regulatory reporting pathways for WSFT. Test pathway for full list of pathways. Feedback to Improvement Committee Dec 24	
8.2	RADAR Incident Reporting Outline of incident reporting data & how measures on new system are being developed.	2	RADAR captures incidents in 3 different formats; - Patient Safety Incidents Staff & Non-Patient Safety Incidents Reportable Occurrences Only Patient Safety Incidents are reported to Learning from Patient Safety Events. All 3 categories are used for local analysis & review. In addition, RADAR has a national	Reportable Occurrences is a new pathway of reporting for staff. KPI's are being developed. Workflow dashboard being introduced delivering a one-step report for leads. Implementation with a training package.	1

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			requirement to record pressure ulcers. It is therefore not possible to do a like for like comparison of the volume of incidents, however the total number of PSI's & RO's is improving.		
8.4	Review of Governance – WSFT Clinical Divisions. To ensure each WSFT clinical division operates effectively. Identify gaps & risks in governance & reporting structures & improve accountability, decision making & better resource allocation.	2	To assess & enhance the efficiency, compliance & effectiveness of the divisional governance & structure within the Trust.	Review over next 3-5 months the divisional governance arrangements with the aim to strengthen the decision-making processes, clarify roles & responsibilities & ensure robust oversight within the divisions. Report to Improvement in 3 months and thereafter on completion in 6 months.	1

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

Originating Committee: Improvement Committee			Date of meeting: 18 September 2024		
Chaired by: Roger Petter			**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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5.1	**Patient Quality & Safety Governance Group (PQSGG)** Updates received from: a) Claims and Litigation b) Human Factors update c) Duty of Candour d) Learning Disability e) Adult Safeguarding f) Safeguarding CYP g) Mental health Transformation	1-2, except 3 for item f) below	Regular monthly reports using the Trust's 1-4 assurance level scale. Areas of partial assurance relating to: a) the 'look back' function on Radar requires further work so that historical Datix info can be obtained, in order to meet insurance and civil claims obligations. d) eLearning for Tier 1 now live. No dates released from ICB re Tier 2 training. LD&A training will be a KLOE from regulatory bodies. e) Level 3 safeguarding training only offered to those with regular safeguarding	a) The Radar Oversight Group meets weekly to discuss this. d) Escalated to ICB regarding delay in Tier 2 training. Difficulties securing the right trainers. e) Current data suggests high compliance, but we need to ensure training is offered to all appropriate	1

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		3 (PARTIAL)	interventions. Possible gap in PREVENT and WRAP (Wellness Recovery Action Plans) training offered. f) Clinical photography issues not yet resolved: current image quality may not be accepted in a court of law.	staff. Following review with Mandatory Training Steering Group, further training may be added to the templates of most staff in the Trust. f) Dan Spooner to take forwards re trying to obtain funding for a suitable camera	
5.2	**Clinical Effectiveness Governance Group (CEGG)** Reports from: Clinical Audit Public Health Cervical Screening External Quality Visit (substantial assurance)	2	Areas of partial assurance: Clinical Audit – lack of assurance that clinical audit processes are being followed to maximise the benefit and learning arising. Plenty of audits are registered but the proportion completed is below expectation.	CEGG will continue to maintain oversight of all new items reported as emerging concerns through its framework. Risk relating to clinical audit participation will be added to CEGG risk log. This will be reviewed after the new MD is in post.	

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6.1 6.2	**Integrated Quality and Performance Report (IQPR)** Including **Performance Review Meetings (PRM Packs)** Uses Making Data Count methodology to report on 1) Compliance with targets and standards 2) Statistically significant improvement or worsening of performance over time	2	C diff data now includes both hospital onset healthcare associated (HOHA) and community onset healthcare associated (COHA) cases. Incidence rates are variable and there has been no significant reduction in rates since Sept 2023. Rates have increased nationally over the last two reporting years. Nutritional assessments - QIPs are continuing to support timely nutritional assessments. There is ongoing improvement of assessments at 48 hours post admission. Post-partum Haemorrhage (>1500 ml) - ongoing quality improvement within maternity services. This is one of the commonest obstetric emergencies and worldwide is	Impact of 6 key interventions for C diff is still embedding and will unlikely improve until Q3/Q4. Nutritional assessments will continue to be monitored through Nutritional Steering Group, divisional performance review meetings, and patient safety and quality group. Completing weight and nutritional assessments in a timely manner is difficult if patients are delayed in ED and so the ED staff are introducing a short assessment to help with this. The impact of this will be monitored. PPH rates will continue to be monitored through maternity	1

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			the leading cause of maternal death. It has implications for length of stay, additional treatments and costs, as well as interactions between mother and baby.	improvement board, performance review meetings, and externally through local maternity and neonatal system strategic meetings. 5 workstreams have been identified.	
7.1	**Deep Dive:** **Patient Safety Priorities – C difficile.** Verbal update from Dan Spooner rather than the planned deep dive presentation.	2	92 point action plan in place, under 6 headings: Hand hygiene; Antimicrobial stewardship; Environment; Isolation process; Community.	Amanda Devereux will be invited back to give an update on progress.	1
7.2	**ConsultOne** **Well-Led Response**	2	The Trust commissioned ConsultOne to undertake a well led review of leadership and governance at the Trust. They highlighted the following well-led strengths: Culture; First values; Staff wellbeing; Patient /	31 recommendations were made in the context of CQC Quality statements. Of these: 27 have been assessed as within an existing plan, including a timescale for delivery,	3: submission of response to the Board agreed

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			carer engagement activities; Governance structure and processes; Local partner working and integration. They highlighted the following well-led areas of focus: Ambition drive and focus; Strategy; Wider system partnering and collaboration; Clinical leadership; Accountability; Use of information; Risk management focus and profile.	2 are deferred for future action, including a timescale to revisit as part of 2025-26 objectives, 2 are complete The committee agreed the response and submission to the Board. It also agreed an update in April 2025 to review progress against the recommendations.	

**See guidance notes for more detail*

Guidance notes

The practice of scrutiny and assurance

	Questions regarding quality of evidence…	Further consideration…
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6.2. Response to the well let report

To inform

Presented by Jude Chin and Richard Jones

Open Trust Board Committee	
Report title:	Response to ConsultOne recommendations
Agenda item:	6.2
Date of the meeting:	27 September 2024
Sponsor/executive lead:	Richard Jones, Trust Secretary & Head of Governance
Report prepared by:	Richard Jones, Trust Secretary & Head of Governance

Purpose of the report:

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

Executive summary:

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

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

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

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

The report was issued in April for factual accuracy checking and discussed at the Board workshop on 26 April 2024. Below is extracted from the session delivered by ConsultOne:

Top well-led strengths highlighted by consultOne:

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

Top well-led areas of focus highlighted by consultOne:

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

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

The attached report considers each of the recommendations in the context of the CQC quality statements. Rather than creating a standalone action plan for the report this response aligns existing programmes of work to the ConsultOne recommendations.

Of the 31 recommendations:

- 27 have been assessed as **within an existing plan** – this includes reference to the plan and timescale for delivery
- 2 are identified as **deferred for future action** – this includes a proposed timescale to revisit
- 2 are **complete**

The report has been reviewed and reviewed by the management executive group and improvement committee prior to reporting to the Board.

Action required / Recommendation:

The committee is asked to **approve**:

- the response to the well led review
- that recognising that the programmes of work identified in the response will be monitored through existing arrangement that the Improvement Committee receive a progress update in April 2025.

  This will provide a holistic view of progress against the recommendations, including proposed responses and timescales for the two deferred recommendations.

Previously considered by:	Management Executive Group (11 September 2024) Improvement Committee (18 September 2024)
Risk and assurance:	CQC regulations FT Code of Governance
Equality, diversity and inclusion:	Recommendation in report
Sustainability:	Recommendation in report
Legal and regulatory context:	NHS Act 2006, West Suffolk NHS Foundation Trust Constitution

Response to ConsultOne recommendations

The recommendations are structured in the table below under the relevant CQC quality statements.

1. Shared direction and culture

We have a shared vision, strategy and culture. This is based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of people and our communities in order to meet these.

What this quality statement means

Leaders ensure there is a shared vision and strategy and that staff in all areas know, understand and support the vision, values and strategic goals and how their role helps in achieving them.
Staff and leaders ensure that the vision, values and strategy have been developed through a structured planning process in collaboration with people who use the service, staff and external partners.
Staff and leaders demonstrate a positive, compassionate, listening culture that promotes trust and understanding between them and people using the service and is focused on learning and improvement.
Staff at all levels have a well-developed understanding of equality, diversity and human rights, and they prioritise safe, high-quality, compassionate care.
Equality and diversity are actively promoted, and the causes of any workforce inequality are identified and action is taken to address these.
Staff and leaders ensure any risks to delivering the strategy, including relevant local factors, are understood and have an action plan to address them. They monitor and review progress against delivery of the strategy and relevant local plans.

Relevant ConsultOne recommendation (reference)	Status	Description	Exec. lead
The Trust should revisit its strategy and ensure that it has fully explored and received assurances over the clinical, workforce and financial sustainability of its vision including the new hospital build (5)	1.Within existing plan - BAF 4 Improvement (Mar '25)	At the Trust's MEG on 14th August 2024 it was agreed, in principle, to conduct a rewrite of the Trust's strategy to ensure it provides the organisation with clear direction for the foreseeable future. Aiming to have a refreshed strategy by January 2025. (specified action within BAF 4)	Sam Tappenden
The Trust should oversee finalisation of the overarching strategic framework ensuring interconnectivity of enabling strategies and then ensure that regular oversight of delivery is in place at Board level. (7)	1.Within existing plan - BAF 4 Improvement (Mar '25)	A review and/or refresh/development of enabling strategies would take place after the corporate strategy review, and aim to be completed by April 2025. (specified action within BAF 4)	Sam Tappenden
The Trust should ensure that its suite of strategies translate into divisional business plans and BAU activities and are subject to regular oversight of delivery. (8)	1.Within existing plan – Business planning refresh (Mar '25)	We are in the process of refreshing our approach to business planning and ensuring we have the mechanisms to drive alignment within the divisions. MEG approved a refreshed approach to business planning in September 2024 which will delivery plans by March 2025.	Sam Tappenden

2. **Capable, compassionate and inclusive leaders**

We have inclusive leaders at all levels who understand the context in which we deliver care, treatment and support and embody the culture and values of their workforce and organisation. They have the skills, knowledge, experience and credibility to lead effectively. They do so with integrity, openness and honesty.

What this quality statement means

Leaders have the experience, capacity, capability and integrity to ensure that the organisational vision can be delivered and risks are well managed.
Leaders at every level are visible and lead by example, modelling inclusive behaviours.
High-quality leadership is sustained through safe, effective and inclusive recruitment and succession planning.
Leaders are knowledgeable about issues and priorities for the quality of services and can access appropriate support and development in their role.
Leaders are alert to any examples of poor culture that may affect the quality of people's care and have a detrimental impact on staff. They address this quickly

Relevant ConsultOne recommendation (reference)	Status	Description	Exec. lead
The Trust should consider implementing a clinical leadership model, including the establishment of a clinical senate and a review of existing divisional triumvirate responsibilities. (1)	3.Defer – revisit as part of 2025-26 objectives	This will be revisited when the newly appointment medical director has had time to families themselves with the organisation.	Ravi Ayyamuthu
The Board should ensure that challenge is more impactful and holds executives to account for delivery of the Trust's objectives and targets (2)	1.Within existing plan – Board development plan (Oct '24)	The Board development plan includes a facilitated session on the working of the unitary Board. This is scheduled for October 2024 when the newly appointed NEDs are in post.	Jude Chin / Ewen Cameron
The Trust should review its current leadership development offer with a view to expanding this to all levels of management and equipping them for more devolved ways of working (3)	1.Within existing plan - People and Culture plan (Mar '25)	All leadership and management provision reviewed with 3 leadership programmes already available and bite-sized targeted learning for leaders and managers (clinical and non-clinical) at all levels available. (Linked to BAF 1)	Jeremy Over
The Trust should review its approach to succession planning and either reinforce it if necessary or raise its profile so that it is more widely socialised (31)	1.Within existing plan - People and Culture plan (Mar '25)	Career development and succession planning project just started and is being progressed (Linked to BAF 1)	Jeremy Over
The Board needs to ensure that it has sufficient senior leadership capacity to deliver the Trust's forward agenda (4)	4. Complete	Appointments now made for permanent medical director (Richard Goodwin) and director of strategy and transformation (Sam Tappenden). Additional resource also in place to support financial recovery (Jonathan Rowell). New NED appointments made, including associate.	Jude/Ewen
Trust executives should continue to take every opportunity to increase visibility, particularly informal, smaller group engagement with staff (25)	4. Complete	Integrated as part of the executive and board development programme is a focus for learning directly from patients and staff. Listening sessions have been held in TimeOut and executives are encouraged to undertake walkabouts and shadowing with Trust teams. This is now an established programme of work for the hospital and community services. This will be developed to capture feedback.	Jeremy Over
The Trust should continue to develop and roll out a wider suite of leadership development programmes to build management capacity and capability to deliver the forward agenda (30)	1.Within existing plan - People and Culture plan (Mar '25)	All leadership and management provision reviewed with 3 leadership programmes already available and bite-sized targeted learning for leaders and managers (clinical and non-clinical) at all levels available (Linked to BAF 1).	Jeremy Over

3. **Freedom to speak up**

We foster a positive culture where people feel that they can speak up and that their voice will be heard.

What this quality statement means

Staff and leaders act with openness, honesty and transparency.
Staff and leaders actively promote staff empowerment to drive improvement.
They encourage staff to raise concerns and promote the value of doing so. All staff are confident that their voices will be heard.
There is a culture of speaking up where staff actively raise concerns and those who do (including external whistleblowers) are supported, without fear of detriment.
When concerns are raised, leaders investigate sensitively and confidentially, and lessons are shared and acted on.
When something goes wrong, people receive a sincere and timely apology and are told about any actions being taken to prevent the same happening again.

Relevant ConsultOne recommendation (reference)	Status	Description	Exec. lead
The Trust should consider opportunities to provide further assurance on robustness of FTSU arrangements and build confidence in staff of the use of it (10)	1.Within existing plan – FTSU report to Involvement Committee (Mar '25)	<u>Already in place at time of ConsultOne review (FTSU guardian new in post at time of review):</u> The FTSU guardian and FTSU NED ad hoc meeting to discuss themes arising, cases if required and ongoing activities to promote speaking up in the Trust. Quarterly report to the Board, which includes data as reported to the NGO, themes and work being done to address issues. Also reports on the ongoing development of a Speaking Up culture, under the headings of the National Guardian's Office (NGO) Principles of Speaking Up for leaders and managers. NGO data sent directly to Workforce Director and FTSU NED for their info. Feedback survey sent to people who have raised concerns, regarding their speaking up experience. Robust FTSU policy in line with NGO guidelines. outreach to all wards and department including community teams. FTSU Guardian visits/ talk to teams, Communication by various media, including Green Sheet updates <u>New actions / work programmes</u>: (oversight by Involvement Committee and Board) -The next test of confidence will be the results from the 2024 NHS staff survey especially the 4 FTSU questions - FTSU guardian and FTSU NED now scheduled to meet regularly each month - Number of anonymous complaints now analysed and reported - Executives are undertaking staff listening events in time out. Themes arising from these to be triangulated with concerns raised directly to FTSU. Executive presence at new staff Welcome programme now includes mention of FTSU to assure Board support of speaking up. - A FTSU Communications Plan on a Page is being drafted by the Comms Team, which outlines all the ways in which speaking up is communicated to staff. - FTSU Guardian visits/ talks to team now include occasional night shift visits to reach night only workers. - Staff Facebook Group - FTSU Guardian now attending Involvement Committee who will review the Comms Plan when complete. - FTSU NED or other exec attending FTSU Champion Training or support sessions to re-iterate Exec support for speaking up	Jeremy Over

4. **Workforce equality, diversity and inclusion**

We value diversity in our workforce. We work towards an inclusive and fair culture by improving equality and equity for people who work for us.

What this quality statement means

Leaders take action to continually review and improve the culture of the organisation in the context of equality, diversity and inclusion.
Leaders take action to improve where there are any disparities in the experience of staff with protected equality characteristics, or those from excluded and marginalised groups. Any interventions are monitored to evaluate their impact.
Leaders take steps to remove bias from practices to ensure equality of opportunity and experience for the workforce within their place of work, and throughout their employment. Checking accountability includes ongoing review of policies and procedures to tackle structural and institutional discrimination and bias to achieve a fair culture for all.
Leaders take action to prevent and address bullying and harassment at all levels and for all staff, with a clear focus on those with protected characteristics under the Equality Act and those from excluded and marginalised groups.
Leaders make reasonable adjustments to support disabled staff to carry out their roles well.
Leaders take active steps to ensure staff and leaders are representative of the population of people using the service

Relevant ConsultOne recommendation (reference)	Status	Description	Exec. lead
The Trust should forensically identify existing pockets of poor culture and ensure that these are dealt with appropriately. (11)	1.Within existing plan - Assurance and monitoring reports on issues and actions received by Involvement Committee via subcommittees (Mar '25)	Trust staff survey data has been reviewed by HR business partners and action plans are in place to improve cultural and other metrics. WRES, WDES and other data have also been analysed with priority areas for focus identified and actions to address developed. A range of interventions are in place and in plan to support leaders and managers with equality, diversity and inclusion, e.g. launch of new approach and process to workplace adjustments; a focus on inclusive recruitment; manager training launched on 'Addressing bias, recognising privilege and becoming a proactive ally'.	Jeremy Over

5. **Governance, management and sustainability**

We have clear responsibilities, roles, systems of accountability and good governance. We use these to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate.

What this quality statement means

There are clear and effective governance, management and accountability arrangements. Staff understand their role and responsibilities. Managers can account for the actions, behaviours and performance of staff.

The systems to manage current and future performance and risks to the quality of the service take a proportionate approach to managing risk that allows new and innovative ideas to be tested within the service.

Data or notifications are consistently submitted to external organisations as required.

There are robust arrangements for the availability, integrity and confidentiality of data, records and data management systems. Information is used effectively to monitor and improve the quality of care.

Leaders implement relevant or mandatory quality frameworks, recognised standards, best practices or equivalents to improve equity in experience and outcomes for people using services and tackle known inequalities

Relevant ConsultOne recommendation (reference)	Status	Description	Exec. lead
The Trust should review how it uses both the CKI reports and source documents such as the IQPR, Finance Report and quality assurance papers to triangulate assurances at Board and committee level (12)	1.Within existing plan - BAF 8 Governance (Mar '25)	IQPR to be part of main body of Board papers from September 2024 board to enable greater visibility and scrutiny of integrated performance. Each assurance committee has completed annual review. The Governance BAF risk (8) includes an action which addresses this requirement in terms of triangulation of assurances.	Nicola Cottington
The Trust should set out more clearly the role of divisional management and develop and implement consistent divisional governance arrangements which fulfil that role (13)	1.Within existing plan - BAF 8 Governance (Mar '25)	The Governance BAF risk (8) includes an action to 'Review and development divisional governance structures'. The scope for this review was reported to Improvement in August with a timescale for delivery by January 2025.	Sue Wilkinson
The Trust should ensure that it has effective assurance flows from ward to board that link strategic priorities with delivery, risk and assurance. (14)	1.Within existing plan - BAF 4 Improvement (Mar '25)	The strategy will be embedded across the organisation, including in induction processes, performance reviews, in training etc. This will be an on-going process, starting from February 2025 (specified action within BAF 4).	Sam Tappenden
The Trust should seek to increase its grip and control through exercising greater performance management including a focus on improvement trajectories, agreed timelines and ownership of actions. (15)	1.Within existing plan - BAF 2 Capacity (Apr '25)	Linked to BAF Risk 2 (Capacity). Trust is constructing a performance and accountability framework which will enable exercise of greater oversight of Performance Review Meetings.	Nicola Cottington
The Trust needs to urgently review its approach to risk management including the profile of risk, the risk culture, resourcing of the risk management function and risk reporting and training. (16)	1.Within existing plan - BAF 8 Governance (Jan '25)	The Governance BAF risk (8) includes an action to 'Review effective implementation of Radar to support risk management (C3), including embedded BAF and risk culture, reporting and training'. This risk along with all other BAF risks is reviewed by the allocated assurance committee. The scope for this review will be reported to Improvement in September with a timescale for delivery by January 2025.	Sue Wilkinson

The Trust should ensure that it its Business Continuity Plans are up to date and that the Trust complies with the requirements of the annual EPRR return. (17)	1.Within existing plan - Corporate Risk Governance Group overseen by Insight (Dec '24)	Internal audit plan and part of work programme reporting to Corporate Risk Governance Group (Q3) with oversight by Insight	Nicola Cottington
The Trust should review the appropriateness of profile of the digital voice at Board and committee level. (18)	1.Within existing plan - Digital Maturity Matrix annual assessment to Digital Board (Mar '25)	Digital Maturity Matrix - annual assessment will monitor this and outcomes reviewed at digital board as part of its existing workplan which is reported to the Insight Committee.	Nicola Cottington
The Trust should review its BI capacity with a view to better supporting operational staff with their day-to-day information requirements. (19)	1.Within existing plan - financial recovery oversight (Mar '25)	A corporate review is scheduled for later in the year 2024/25 managed by DSTP (Sam T). This will be reported as part of financial recovery oversight arrangements.	Nicola Cottington
The Trust should ensure that it leverages the benefits of the data warehouse investment alongside BI business partnering arrangements to produce data led insightful reports which look to triangulate information to provide improved assurance. (20)	3.Defer – revisit as part of 2025-26 objectives	Data Warehouse in testing phase. Reviewing BI support to Divisions, specific plan to be identified. Also reflects risks regarding phase 2 rollout. Confirm timescale.	Nicola Cottington
The Trust should ensure that it has parity of reporting between quantitative and qualitative data from ward to Board and in particular ensure that the patient feedback is used more effectively to help improve and reshape services (21)	1.Within existing plan - experience of care strategy oversight by the Involvement Committee (Mar '25)	The delivery plan for the experience of care strategy supports this recommendation with oversight by the Involvement Committee. Includes division governance review and development of the experience of care committee.	Sue Wilkinson
The Trust should explore ways in which it can increase operational buy-in and ownership of complaints including active engagement in learning from these (27)	1.Within existing plan - experience of care strategy oversight by the Involvement Committee (Mar '25)	The delivery plan for the experience of care strategy supports this recommendation with oversight by the Involvement Committee.. Experience of care committee, divisional reporting and oversight by the Involvement Committee which reports to Board through CKIs.	Sue Wilkinson
The Trust should ensure that it is maximising the benefit and learning from its clinical audit programme (28)	1.Within existing plan - BAF 8 Governance (Apr '25)	The Governance BAF risk (8) includes an action to review the clinical audit programme. The scope for this review to be developed and overseen by CEGG with a timescale for delivery by March 2025.	Ravi Ayyamuthu

6. **Partnerships and communities**

We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.

What this quality statement means

Staff and leaders are open and transparent, and they collaborate with all relevant external stakeholders and agencies.
Staff and leaders work in partnership with key organisations to support care provision, service development and joined-up care.
Staff and leaders engage with people, communities and partners to share learning with each other that results in continuous improvements to the service. They use these networks to identify new or innovative ideas that can lead to better outcomes for people.

Relevant ConsultOne recommendation (reference)	Status	Description	Exec. lead
The Trust should ensure that the benefits from integration of services is maximised including closer links with primary care (6)	1.Within existing plan - Links to BAF 3 - Collaboration. (April '25)	A series of Board development workshops are planned to explore our strategic approach to collaboration, including with primary care. The intention will be to have a partnership strategy agreed by April 2025. More tactically, the EDoST has regular interface meetings with primary care and is actively exploring opportunities for greater collaboration (e.g. estate sharing). Links to BAF 3 - collaboration.	Sam Tappenden
The Trust should review its engagement activities to ensure that there are effective feedback loops in place to provide those inputting an understanding of impact. (22)	1.Within existing plan - experience of care strategy oversight by the Involvement Committee (Mar '25)	The delivery plan for the experience of care strategy supports this recommendation with oversight by the Involvement Committee.	Sue Wilkinson
The Trust should continue to focus on gaining an appropriate balance between staff and patient/families focus at Involvement Committee (23)	1.Within existing plan – Involvement development plan (Mar '25)	This is being addressed through a refocusing of the Involvement Comments forward plan including the response to the committee's effectiveness review for 2024	Jeremy Over
The Trust should seek to understand its relationship with ICS partners and reframe it where necessary so that trust and understanding is central to any relationship (24)	1.Within existing plan - Links to BAF 3 Collaboration - collaboration. (April '25)	A series of Board development workshops are planned to explore our strategic approach to collaboration, including with primary care. The intention will be to have a partnership strategy agreed by April 2025. More tactically, the EDoST has regular interface meetings with primary care and is actively exploring opportunities for greater collaboration (e.g. estate sharing). Links to BAF 3 - collaboration.	Sam Tappenden

7. **Learning, improvement and innovation**

We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research

What this quality statement means

Staff and leaders have a good understanding of how to make improvement happen. The approach is consistent and includes measuring outcomes and impact.
Staff and leaders ensure that people using the service, their families and carers are involved in developing and evaluating improvement and innovation initiatives.
There are processes to ensure that learning happens when things go wrong, and from examples of good practice. Leaders encourage reflection and collective problem-solving.
Staff are supported to prioritise time to develop their skills around improvement and innovation. There is a clear strategy for how to develop these capabilities and staff are consistently encouraged to contribute to improvement initiatives.
Leaders encourage staff to speak up with ideas for improvement and innovation and actively invest time to listen and engage. There is a strong sense of trust between leadership and staff.
The service has strong external relationships that support improvement and innovation. Staff and leaders engage with external work, including research, and embed evidence-based practice in the organisation.

Relevant ConsultOne recommendation (reference)	Status	Description	Exec. lead
The Trust should finalise its QI Strategy and develop an implementation plan which includes identifying and rolling out a Trust-wide QI methodology. QI projects should explicitly link with the Clinical Care Strategy and Trust Priorities. (26)	1.Within existing plan – Strategic priority 1 (Mar '25)	The Trust will have an agreed approach to Quality Improvement by April 2025. We will concurrently develop our approach to an integrated Quality Management System, ensuring that all four elements of quality are driven. All QI projects will be linked to our strategic objectives, and focused on agreed priority themes. Links to strategic priority which describes a range of measures to test whether the CQI approach is embedded	Sam Tappenden
The Trust should review its current management and oversight of research and innovation and ensure that the profile and management of this is commensurate with the Trust ambition in this area (29)	1.Within existing plan: - R&D CEGG work plan (Jan '25) - Innovation - BAF 4 (Jan '25)	CEGG's reporting schedule includes a suitable reporting on R&D, A refresh of the report content will ensure this is suitably robust (including annual report). Innovation changes link to BAF risk 4 - the refresh of Trust's strategy includes identifying innovation as a strategic priority for the Trust	Ravi Ayyamuthu

8. **Environmental sustainability – sustainable development**

We understand any negative impact of our activities on the environment, and we strive to make a positive contribution in reducing it and support people to do the same.

What this quality statement means

Staff and leaders understand that climate change is a significant threat to the health of people who use services, their staff, and the wider population.
Staff and leaders empower their staff to understand sustainable healthcare and how to reduce the environmental impact of healthcare activity.
Staff and leaders encourage a shared goal of preventative, high quality, low carbon care which has health benefits for staff and the population the providers serve, for example, how a reduction in air pollution will lead to significant reductions in coronary heart disease, stroke, and lung cancer, among others.
Staff and leaders have Green Plans and take action to ensure the settings in which they provide care are as low carbon as possible, ensure energy efficiency, and use renewable energy sources where possible.
Staff and leaders take active steps towards ensuring the principles of net zero care are embedded in planning and delivery of care. Low carbon care is resource efficient and supports care to be delivered in the right place at the right time.

Relevant ConsultOne recommendation (reference)	Status	Description	Exec. lead
The Trust should ensure that it retains appropriate oversight over its green sustainability strategy and plans (9)	1.Within existing plan - Links to BAF 4 Improvement (Mar '25)	As part of our strategic refresh we will explore whether we have the appropriate governance mechanisms in place to review the progress of delivery of all our strategies, including green sustainability. This will result in recommendations being agreed by January 2025. Linked to BAF 4. The Trust has a green plan, overseen by the Sustainability Group (chaired by Simon Taylor) and reported to Trust Board via the annual report, ICB via regular reporting. It's multidisciplinary, involving waste, catering, anaesthetics, digital, service delivery etc. The sustainability officer manages the actions and the programmes (such as green champions) which we are in the process of implementing	Sam Tappenden

6.3. Quality & Nurse Staffing Report July and August

For Report

Presented by Susan Wilkinson

Open Trust Board Committee	
Report title:	Quality & Nurse, staffing report: July and August 2024
Agenda item:	6.3
Date of the meeting:	27th September 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 July and August 2024. It complies with national quality board (NQB) 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 at expected level this period, achieving consistency with peer average in August.
- Summer inpatient establishment review is complete, and the output will be presented with the September/October board paper.
- Nurse sensitive indicators/patient harms have improved in this period.
- Total nursing spend is under budget for month five and forecast to be under budget at year end

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

Nurse Staffing Report – July and August 2024

1. Introduction

1.1 This paper illustrates how WSFT's nursing and midwifery resource has been deployed for the months of July and August 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 July and August 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 July and August 2024. 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 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%
Average fill rate July 2024	96%	90%	97%	101%
Average fill rate August 2024	94%	87%	96%	96%

Table 1

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

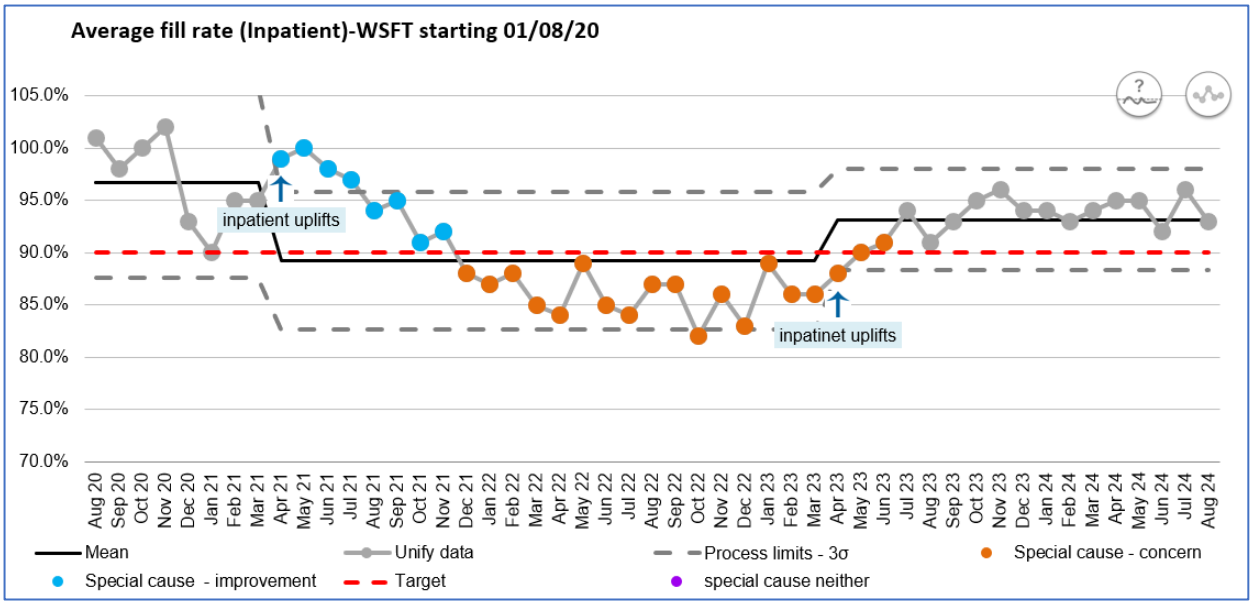


Chart 2

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). 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.

Model hospital data suggests that WSFT is in the lowest quartile nationally, when bench marking against all other organisations with inpatients beds (Appendix 2 for full data set). This suggests that WSFT provides less care hours per patient than many organisations. When compared to our peer organisations [those of a similar size and service provision] we also rank in the lowest quartile.

The mean CHPPD for peer organisations is 8.1, which was achieved in August. We have not met this for a significant number of months. CHPPD with WSFT is in special cause improvement which was anticipated following continued positive recruitment and the closure of the winter escalation ward during Q1.

Assurance can be given that our nursing establishment is fit for purpose through our biannual inpatient nursing review. Any reduction or controls on nursing establishment and fill rate are mitigated through a robust QIA process and oversight of the nursing and midwifery deployment group.

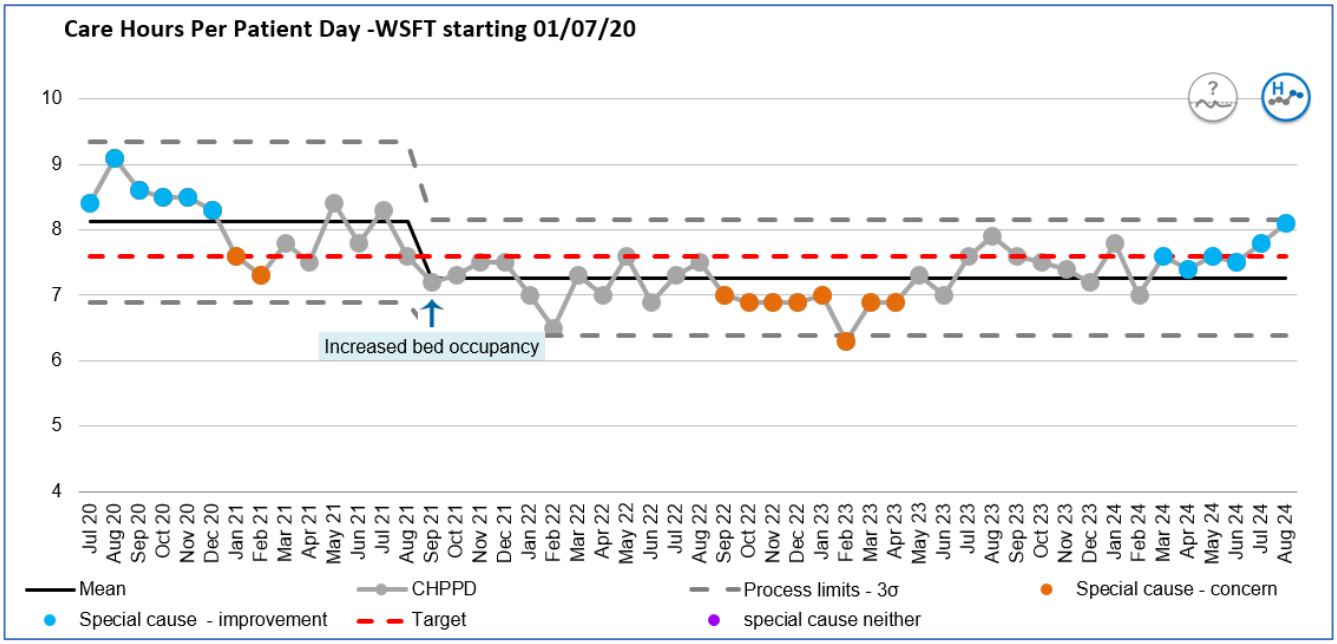


Chart 3

3.3 **Sickness**

During this period sickness rates for registered staff have reduced, while sickness in nursing assistant group have increased by approximately 0.5%. Overall sickness is below Trust ambition of <5%

	Jan-24	Feb-24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24
Unregistered staff (support workers)	7.23%	6.54%	5.69%	6.00%	6.22%	7.33%	7.95%	7.83%
Registered Nurse/Midwives	5.88%	4.52%	4.54%	4.14%	3.55%	3.72%	3.41%	3.37%
Combined Registered/Unregistered	**6.33%**	**5.19%**	**4.91%**	**4.75%**	**4.42%**	**4.88%**	**4.87%**	**4.78%**

Table 4

Chart 4

3.4 **Recruitment and Retention**

Vacancies: Registered nursing (RN/RM) and Nursing assistants (NA):

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 percentage has improved from 8.6% last report to 6.8% at M5.
- Total RN/RM vacancy rate has remained reasonably static at 6.7% at M5.
- Inpatient NA vacancy rate has declined from 10.9% to 13.5% in M5.
- Total NA vacancy has declined from 11.7% to 14.1% in M5.

Both total and inpatient RN/RM vacancy rates continue to improve and are in special cause improvement (appendix 3). Nursing assistant numbers are currently maintaining common cause variation with no significant improvement or decline. Substantive numbers of NAs has entered a point of concern. On review of WTE data, this movement is spread throughout the clinical areas, with no obvious theme or area of concern.

	Sum of Month 12	Sum of Month 1	Sum of Month 2	Sum of Month 3	Sum of Month 4	Sum of Month 5	WTE vacancy at M5
RN	701.6	706.3	712.4	716.2	715.3	713.6	**69.9**
NA	404.7	404.5	390.1	389.4	385.8	382.3	**55.0**

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 eighty-four 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. Currently there are no international nurses in training.

3.4.2 **New Starters**

	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24
RN	15	46*	20	17	8	8	16	16
NA	24	16	11	22	17	8	12	13

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 July, 16 RNs attended induction; of these; eleven were for the acute, four for bank services and one for community.
- In July, 12 NAs attended induction; of these; 9 NAs are for the acute Trust, one for bank services and two for community services.

- In August, 16 RNs attended induction; of these; five was for the acute, nine for bank services and two for midwifery.
- In August, 13 NAs attended induction; of these; 7 NAs are for the acute Trust, five for community services and one for midwifery.

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 5.4%. NA turnover also continues to improve on last reporting period from 13.6% to 10.9%

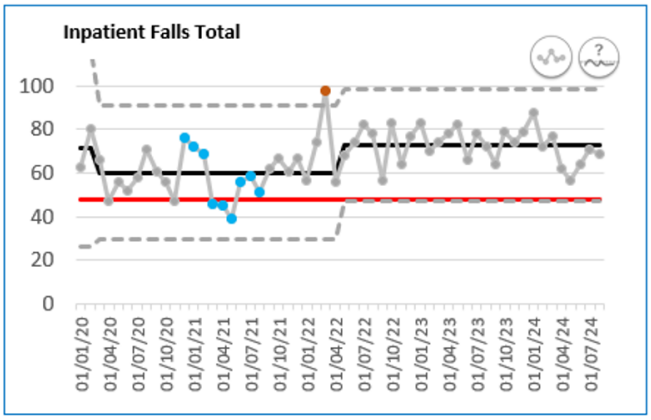
		Turnover	01/09/2023	-	31/08/2024			
Staff Group	Average Headcount	Avg FTE	Starters Headcount	Starters FTE	Leavers Headcount	Leavers FTE	LTR Headcount %	LTR FTE %
Nursing and Midwifery Registered	1,476.50	1,290.3614	73	60.6667	80	69.0933	5.4182%	5.3546%
Additional Clinical Services	606.50	511.6023	188	172.9133	73	55.7066	12.0363%	10.8887%

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). Improvement projects and oversight are reviewed through the patient quality and safety governance group (PQASG). Both incidents of pressure ulcers and falls have reduced in this period, with special cause improvement in falls per 1000 bed days. While still in common cause variation pressure ulcers in the acute setting have reduced for the past three months, caution around interpreting this as an improvement at this stage [for total incidents] as a change to reporting requirements was made earlier in April.



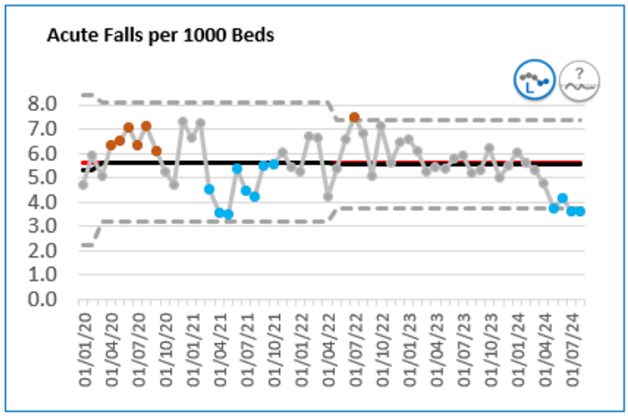
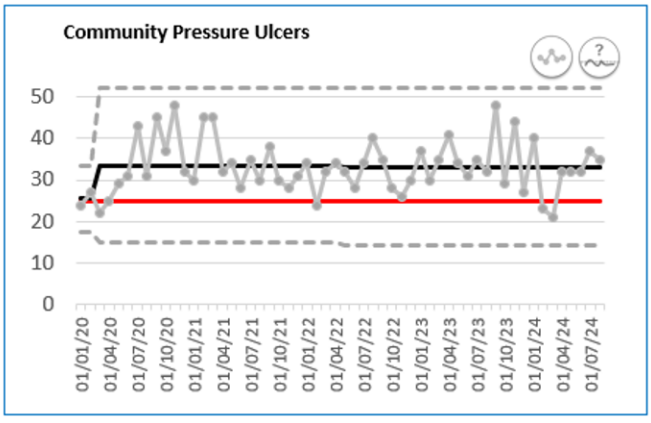


Chart 8 inpatient falls



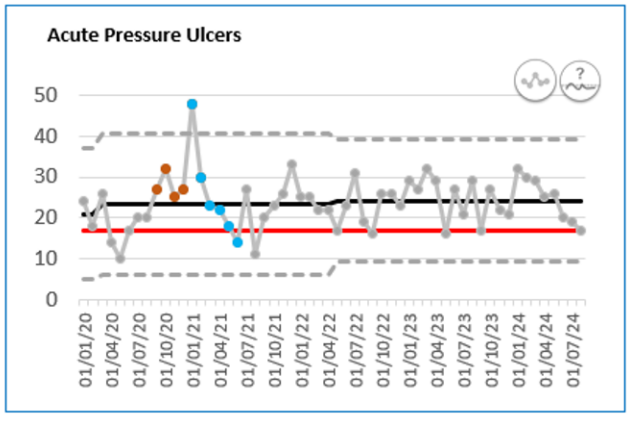


Chart 9 Pressure ulcers acquired in care.

3.6 **Compliments and complaints**

Ten formal complaints were received in July. Each complaint received this month related to a different ward/department. The most common theme of complaint this month was communication with patients. Twenty-five complaints were closed in July 10 were upheld, eight partially upheld and seven were not upheld. Thirty-seven compliments were received this month with ED receiving the highest amount.

Seventeen formal complaints were received in August. F11 received the highest number of complaints. The most consistent theme of these formal complaints was values and behaviours of staff. Twenty complaints were closed in August, 4 were upheld, 7 partially upheld and 9 were not upheld. Forty-two compliments were received this month with ED again receiving the highest amount.

Chart 10a and 10b demonstrates the incidence of complaints and compliments for this period. The number of complaints was below average in month seven, but has risen again in month eight, however compliments and positive feedback received continues in a sustained positive improvement.

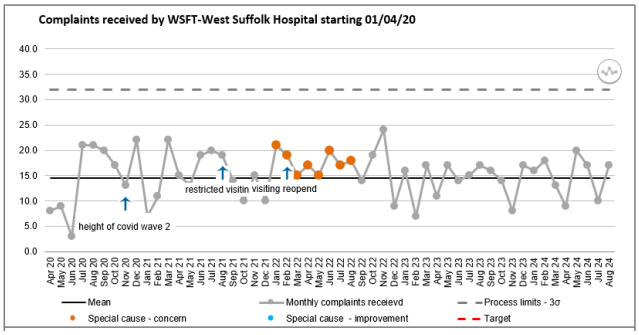


Chart 10a (complaints)

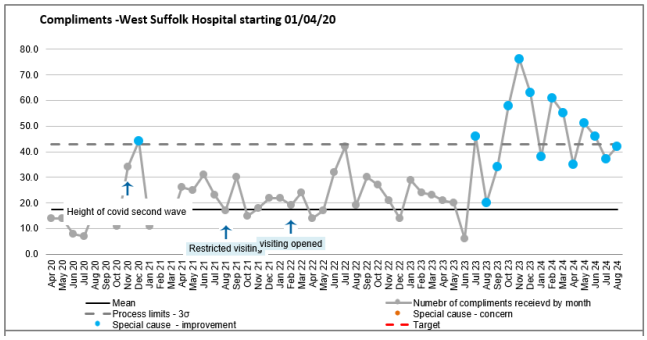


Chart 10b (compliments)

3.7 **Adverse staffing incidents**

Staffing shortfall incidents report is being built in RADAR. Data not available at the time of writing,

3.8 **Maternity services**

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

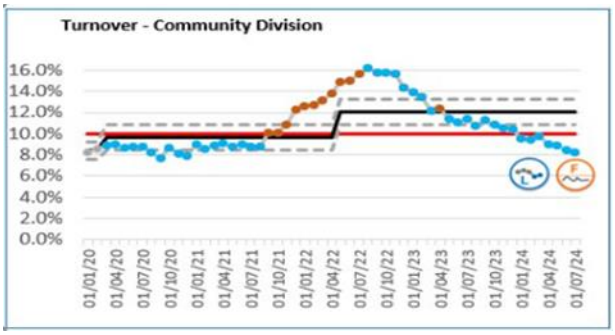
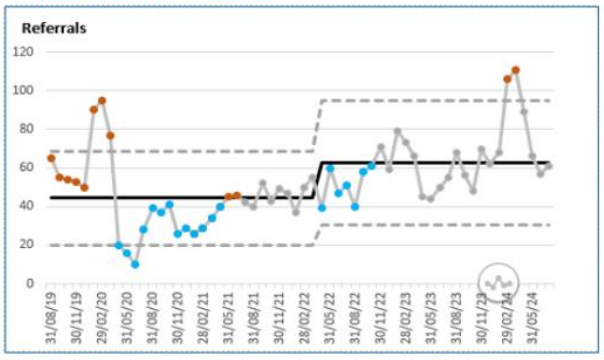
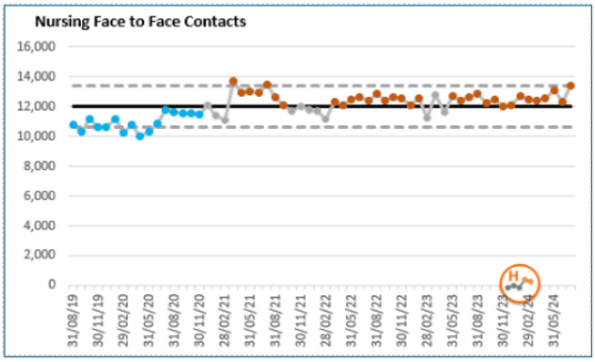
1:1 Care in Labour

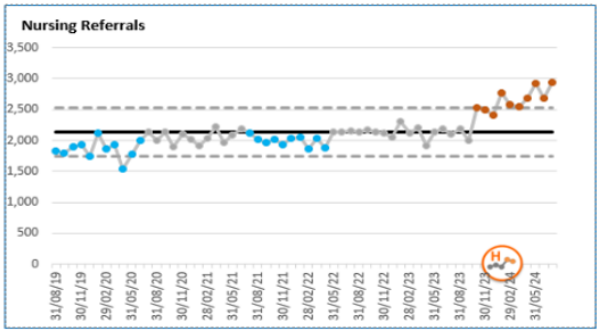
The recommendation comes from NICE's second guideline on safe staffing in the NHS, which gives advice on midwifery safe staffing levels for women and their babies on whatever setting they choose. This recommendation is also one of the 10 Safety Action published as part of the Maternity Incentive Scheme Year 5. Maternity services should have the capacity to provide women in established labour with supportive one-to-one care. This is because birth can be associated with serious safety issues and can help ensure that a woman has a safe experience of giving birth. Escalation plans have been developed to respond to unexpected changes in demand. In both July and August 2024 compliance against this standard was 100%.

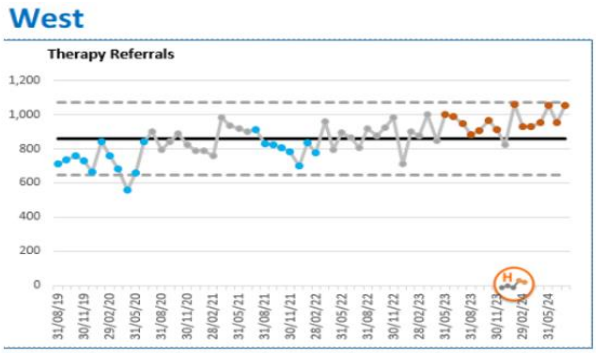
	Standard	April	May	June	July	August
Supernumerary Status of LS Coordinator	100%	100%	100%	100%	100%	100%
1-1 Care in Labour	100%	100%	100%	100%	100%	100%
MW: Birth Ratio	1:21	1:21	1:20	1:21	1:19	TBC
No. Red Flags reported	NA	0	0	2	1	3

Red Flag events

NICE Safe midwifery staffing for maternity settings 2015 defines Red Flag events as events that are immediate signs that something is wrong, and action is needed now to stop the situation getting worse (appendix 4). 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. In July 2024 1 red flag event was recorded and in August 2024 3 red flags events were recorded **Midwife to Birth ratio** Latest Birth Rate plus review undertaken in March 2023 shows that Midwife to Birth ratio at West Suffolk NHS Foundation Trust dropped 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 ratio in July was 1:19 • Midwife to birth ratio in August TBC (data not available at time of writing) **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 July and August 2024.
3.9	**Community and integrated neighbourhood teams (INT)** **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, and the report is pending. Sickness is variable across the division; in the past 2 months, sickness is much higher in our EIT, Virtual Ward and then INT teams. The turnover figure continues to reduce and is below the Trust target of 10%.   **Demand** Demand for most community services is rising demonstrated in the SPC charts below, which are examples of a few teams within the community division. With referrals above the average, INT teams are working at capacity, as the face-to-face contacts show consistent and sustained increase in demand. **Pulmonary Rehab**  





Temporary spending

The Division continues to monitor and control tightly the spend on temporary staff. Between April and July, average monthly usage of agency has equated to 2.99% of the Division's total pay bill. All long-term agency use is planned to cease at the end of August.

Actions

- A Quality Impact Assessment has been completed for the stopping agency nursing within the Division. The focus to maintain safety is to improve the bank fill rate, which is between 30-70%.
- Temporary spending continues to be closely monitored and controlled. Clear escalation processes in place to review safe staffing and approval of agency. The INT teams have volunteered to trial a predictive budget tool.
- INT teams continue to utilise the capacity dashboard used to support any staff moves and reviewed on weekly basis to review rosters for the 2 weeks ahead and to manage daily escalations for urgent issues relating to capacity.
-

4. Next steps/Challenges

4.1 **Nursing Resource oversight Group**

The Nursing Deployment Group continue to meet monthly to review best practice methods of deploying staff and to reduce the temporary nursing spend. Interventions include the commencement of a better rostering subgroup to fully utilise eRostering modules, stringent control over agency and overtime spend and reducing high-cost temporary nursing shifts. The reduction in temporary spend is demonstrated in the chart 11 below. Although in common cause variation the total temporary nursing spend has reduced month on month since April 2024.

Regular agency use has been all but eliminated in all areas, and sourcing high cost is managed by exception only.

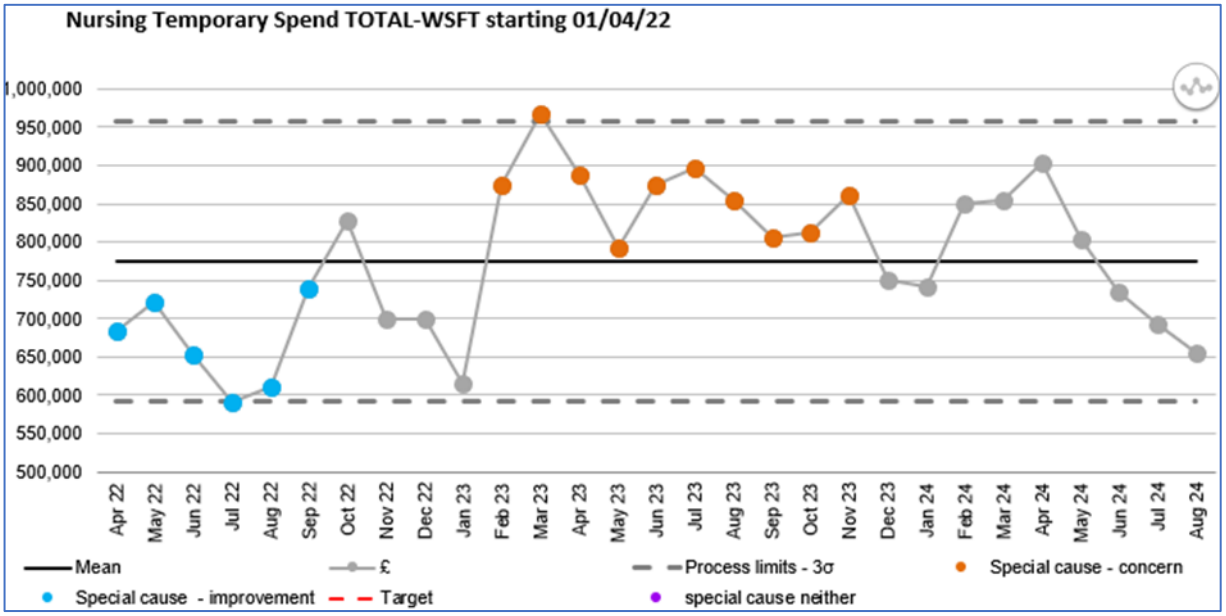


Chart 11

	Nursing spend came in underbudget in M5 and is currently forecast to end this financial year 46k under budget (table 12.). While this is encouraging, further focus on reducing run rate is required to achieve final ambitions.

Budget versus Actuals

	Values											
Analysis-1	In-M Bgt	In-M Act	In-M Var	YTD Bgt	YTD Act	YTD Var	FY Bgt	FY Act/FC	FY Var	WTE Bgt	WTE Act	WTE Var
Agency	16,737	30,282	(13,545)	83,685	354,895	(271,210)	200,844	528,239	(327,395)	0.01	4.03	(4.02)
Bank	19,686	625,858	(606,172)	88,411	3,437,361	(3,348,950)	235,500	7,605,444	(7,369,944)	0.27	158.44	(158.17)
Substantive	8,286,379	7,576,638	709,741	42,748,259	38,200,952	4,547,307	100,276,387	90,549,895	9,726,492	2,133.46	1,925.11	208.35
Grand Total	**8,322,801**	**8,232,778**	**90,024**	**42,920,355**	**41,993,208**	**927,147**	**100,712,731**	**98,683,578**	**2,029,152**	**2,133.74**	**2,087.58**	**46.16**

Table 12.

Additional schemes are in train to further contribute to the run rate including a review of supernumery provision, substantive pay practices, the delivery of the care certifcate training and a planned reduction in WTE within corporate nursing team as demonstarted below,

Schemes	YTD Actual	Forecasted Position 24/25
Rapid pool	£ 23,100	£ 77,000
Sunday LD reduction	£ 9,268	£ 101,374
Care Certificate Training	£ -	£ 18,000
Bank shifts pay for substantive staff	£ -	£ 46,667
Reduction in registered nursing shift fill rate (in-patients, daytime)	£ -	£ 236,928
Review of clinical education teams	£ -	£ 22,500
Total	**£ 32,368**	**£ 502,469**

4.2	**Establishment reviews** The summer Safer Nursing Care Audit (SNCT) is complete, and the review of current inpatient establishments are planned with the ward teams in September 2024. Audit data will be triangulated with nurse sensitive indicators [falls/pressure ulcers for example] and professional judgement as per NQB expectations/ The community safer staffing tool is currently under ratification so any review of our audit data will be paused until this national review is complete.
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 and changes to reporting measures. 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 there is early confidence that nursing will
6.	**Recommendations**
	For the board to take assurance around the daily mitigation of nurse and midwifery staffing and oversight of nursing and midwifery establishments,

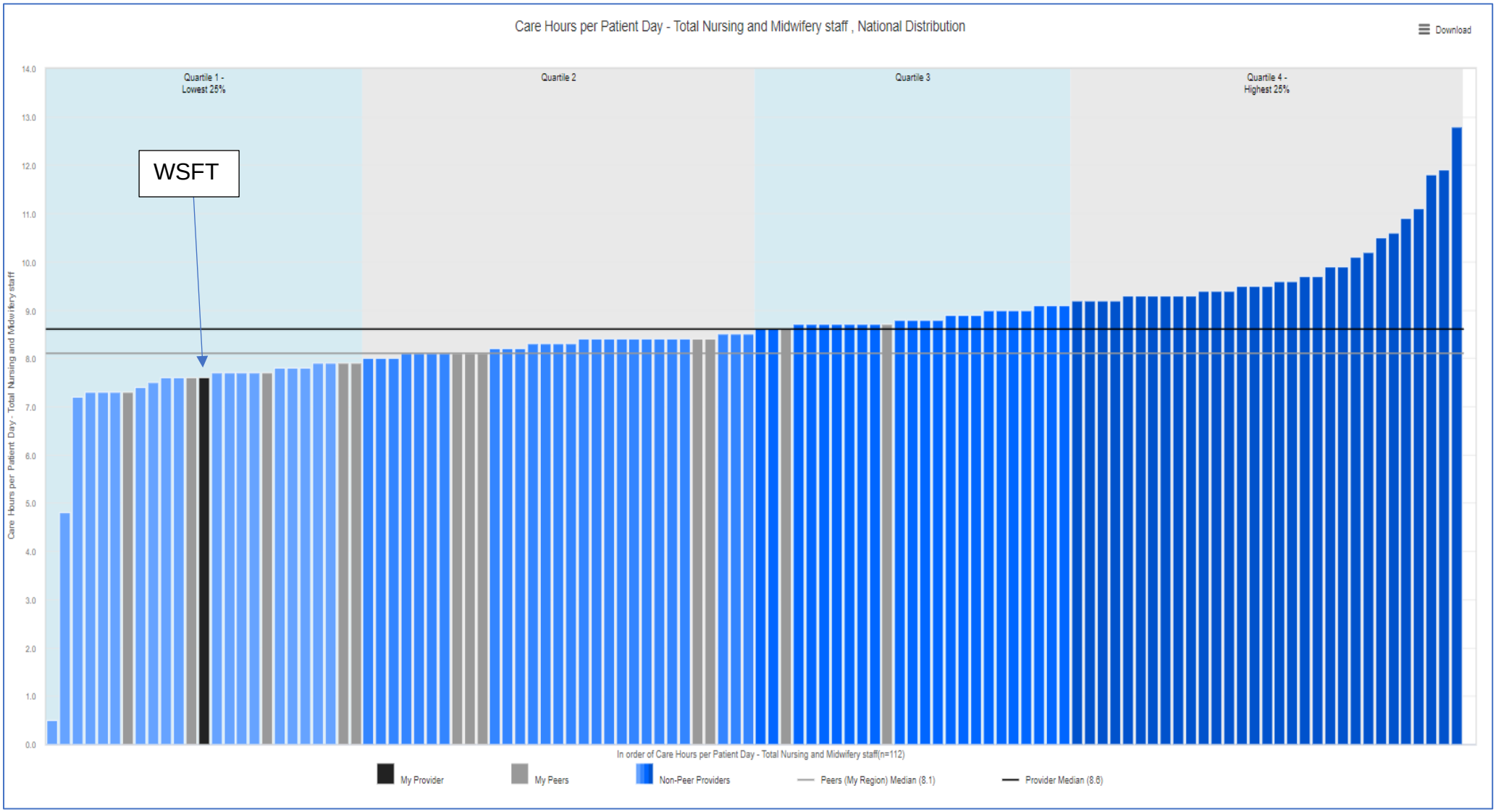
Appendix 1a. Fill rates for inpatient areas (July 2024) Data adapted from Unify submission.
RAG: Red <79%, Amber 80-89%, Green 90-100%, Purple >100

	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	RNs/RMN		Non registered (Care staff)		RNs/RMN		Non registered (Care staff)									
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average Fill rate RNs/RM %	Average fill rate Care staff %	Average Fill rate RNs/RM %	Average fill rate Care staff %	Cumulative count over the month of patients at 23:59 each day	RNS/RMs	Non registered (care staff)	Overall
Rosemary Ward	1422.75	1252.1667	1786.25	1690.25	1069.5	989	1426	1469.66667	88%	95%	92%	103%	920	2.4	3.4	5.9
Glastonbury Court	714	714.5	1071.25	1000.35	713	717	542.5	544.5	100%	93%	101%	100%	571	2.5	2.7	5.2
Acute Assessment Unit	2104.5	2207	1932	1703	1725	1685.833333	1386	1250	105%	88%	98%	90%	761	5.1	3.9	9.0
Cardiac Centre	1766.5	1609.5	1041.66667	802.81667	1782.5	1769.5	706	668.5	91%	77%	99%	95%	632	5.3	2.3	7.7
G10	1731	1459.5833	1743.5	1588.9167	1069.5	1035.5	1776.5	1843.75	84%	91%	97%	104%	707	3.5	4.9	8.4
G9	1735.5	1680	1426	1385	1426	1413	1062.833333	1166.33333	97%	97%	99%	110%	752	4.1	3.4	7.5
F12	563.5	681.5	329	309.75	690	667	322.9833333	301.75	121%	94%	97%	93%	240	5.6	2.5	8.2
F7	1650	1646.0833	1656	1475.6667	1391.5	1328	1759.5	1648.5	100%	89%	95%	94%	683	4.4	4.6	8.9
G1	1431.61667	1086.75	347	329.5	713	709.5	356.5	409	76%	95%	100%	115%	485	3.7	1.5	5.2
G3	1695	1437.5	1771	1743.5	1069.5	1059	1411	1614.25	85%	98%	99%	114%	864	2.9	3.9	6.8
G4	1736.5	1582	1781.5	1685	1060.5	991.5	1421	1569	91%	95%	93%	110%	896	2.9	3.6	6.5
G5	1537	1347.5833	1691.5	1504.6667	1069.5	1065.5	1426	1498.5	88%	89%	100%	105%	760	3.2	4.0	7.1
G8	2410.5	2006.9167	1782.5	1542	1632.75	1554.5	1069.5	1058	83%	87%	95%	99%	615	5.8	4.2	10.0
F8	1423	1423.3333	1742.68333	1620.5167	1069.5	1022.5	1426	1456.08333	100%	93%	96%	102%	723	3.4	4.3	7.6
Critical Care	2025.75	1996.25	347.5	135.5	2062.5	1874	0	30	99%	39%	91%	*	388	10.0	0.4	10.4
F3	1771	1612	1758	1593.5	1069.5	1071	1422.516667	1404	91%	91%	100%	99%	732	3.7	4.1	7.8
F4	868.5	987.16667	572	589.33333	667	655.5	388.5	400	114%	103%	98%	103%	633	2.6	1.6	4.2
F5	1647	1809.5	1422	1295.5	1069.5	1053	1069.5	963	110%	91%	98%	90%	698	4.1	3.2	7.3
F6	1736.5	1514.5	1712	1329.3333	1069.5	1080.5	1414.5	1312.5	87%	78%	101%	93%	942	2.8	2.8	5.6
Neonatal Unit	1215	1296	552	542	1020	950.5	636	612	107%	98%	93%	96%	116	19.4	9.9	29.3
F1	1730	1942.0833	698	597.25	1426	1426	0	21	112%	86%	100%	*	115	29.3	5.4	34.7
F14	1579	1728	365	364	744	742	0	0	109%	100%	100%	*	106	23.3	3.4	26.7
Total	34,494.12	33,019.92	27,528.35	24,827.35	25,609.75	24,859.83	21,023.33	21,240.33	**96%**	**90%**	**97%**	**101%**	**13339**	**4.3**	**3.5**	**7.8**
* planned hours are zero, so additional support used on ward to mitigate unfilled nursing hours																

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

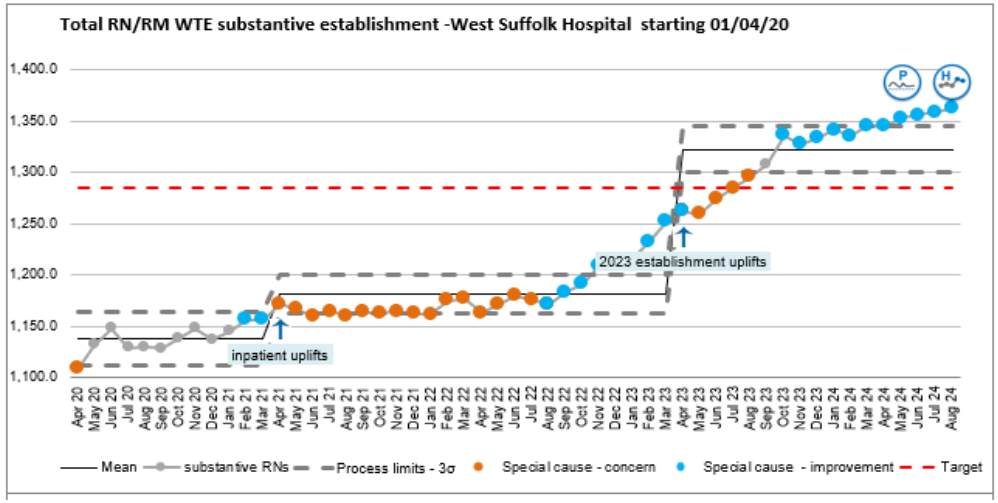
	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	RNs/RMN		Non registered (Care staff)		RNs/RMN		Non registered (Care staff)									
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned 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	1424	1243.25	1783.98333	1713.4833	1069.5	1015.666667	1418	1423.33333	87%	96%	95%	100%	452	5.0	6.9	11.9
Glastonbury Court	715	715.5	1078	983	713	712	542.5	548	100%	91%	100%	101%	384	3.7	4.0	7.7
Acute Assessment Unit	2404.5	2460.75	1995	1712.25	1771	1697	1380	1222	102%	86%	96%	89%	761	5.5	3.9	9.3
Cardiac Centre	1782.5	1564	1066	845.41667	1782.5	1679.5	713	673	88%	79%	94%	94%	632	5.1	2.4	7.5
G10	1719.5	1436	1773.5	1544.3333	1069.5	1046.75	1781	1673.5	84%	87%	98%	94%	707	3.5	4.6	8.1
G9	1754.5	1680	1412.25	1299.25	1402.5	1402.5	1069.5	1061	96%	92%	100%	99%	752	4.1	3.1	7.2
F12	563.5	674.25	353	350	713	596	345	413	120%	99%	84%	120%	240	5.3	3.2	8.5
F7	1665.5	1544.75	1720.5	1627	1403	1240	1782	1649	93%	95%	88%	93%	683	4.1	4.8	8.9
G1	1411.5	1125	356.5	282.5	701.5	699.5	356	452.083333	80%	79%	100%	127%	485	3.8	1.5	5.3
G3	1755.5	1534.25	1747	1585.75	1069.5	1070	1431	1385.16667	87%	91%	100%	97%	864	3.0	3.4	6.5
G4	1667.5	1536	1743.5	1519.75	1068.5	1023	1426	1328	92%	87%	96%	93%	896	2.9	3.2	6.0
G5	1644.5	1370	1771	1474.25	1069.5	1063.5	1421	1407	83%	83%	99%	99%	760	3.2	3.8	7.0
G8	2393	1921.9667	1771	1465.5	1702	1687.133333	1069.5	1059.5	80%	83%	99%	99%	615	5.9	4.1	10.0
F8	1414.5	1414.5833	1760	1495.5	1069.5	976.8333333	1426	1343.5	100%	85%	91%	94%	723	3.3	3.9	7.2
Critical Care	2307.5	2130.25	342.5	84.5	2380.5	2212.25	0	7.5	92%	25%	93%	*	388	11.2	0.2	11.4
F3	1771	1662.5	1927	1660.5	1069.5	1069.5	1426	1399	94%	86%	100%	98%	732	3.7	4.2	7.9
F4	832	900.58333	562.25	554	644	598	414	403	108%	99%	93%	97%	633	2.4	1.5	3.9
F5	1644.5	1751.75	1426	1258	1069.5	1032	1069.5	995.5	107%	88%	96%	93%	698	4.0	3.2	7.2
F6	1666.5	1515	1716.5	1448.75	1066	1055	1426	1319	91%	84%	99%	92%	942	2.7	2.9	5.7
Neonatal Unit	1409	1405	597	470	1008	1056	636	528	100%	79%	105%	83%	116	21.2	8.6	29.8
F1	1652.75	1900.5	713	658.5	1426	1393.5	0	0	115%	92%	98%	*	115	28.6	5.7	34.4
F14	1487	1600.4333	360	366.75	744	744	0	0	108%	100%	100%	*	106	22.1	3.5	25.6
Total	35,085.75	33,086.32	27,975.48	24,398.98	26,012.00	25,069.63	21,132.00	20,290.08	**94%**	**87%**	**96%**	**96%**	**12684**	**4.6**	**3.5**	**8.1**
* planned hours are zero, so additional support used on ward to mitigate unfilled nursing hours																

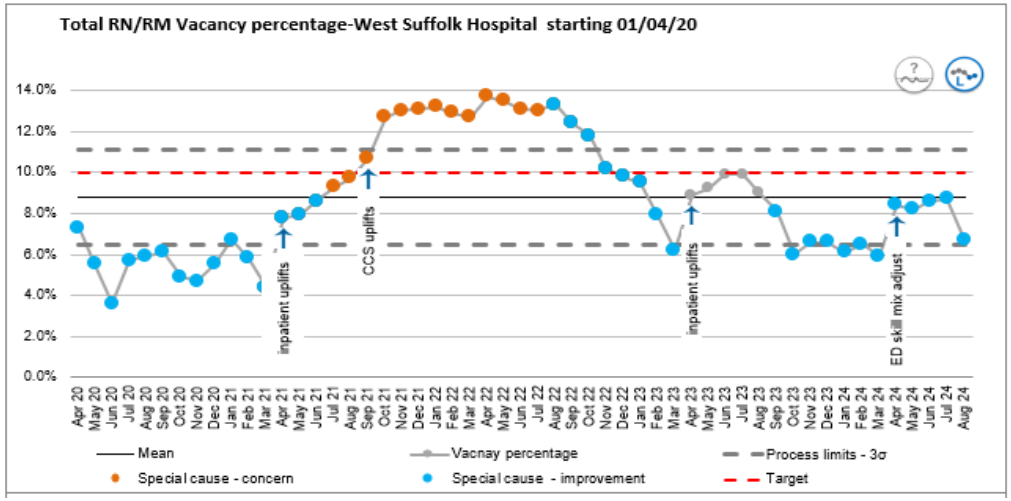
Appendix 2. CHPPD Model Hospital data



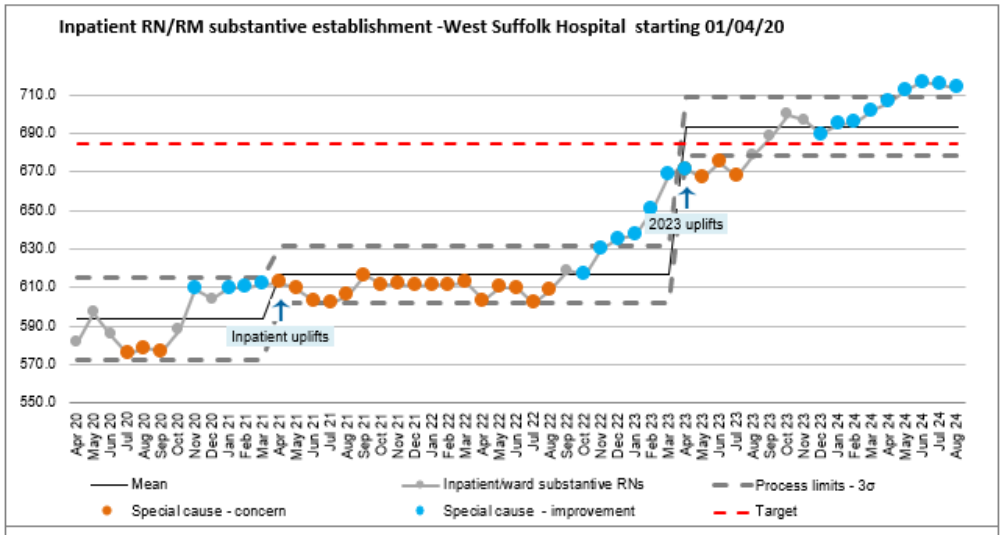
Appendix 3 WTE and Vacancy rates.

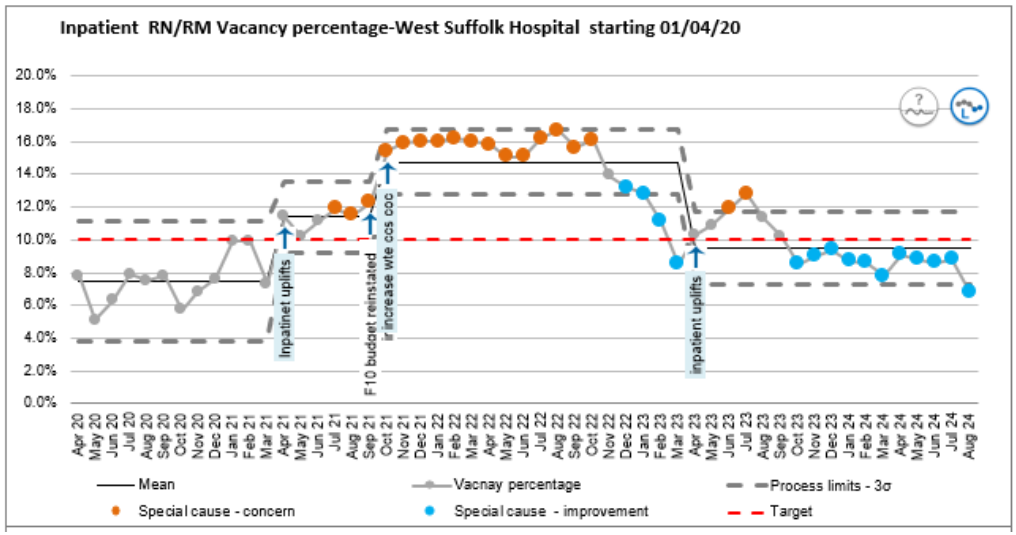
Trust Total RN/RM



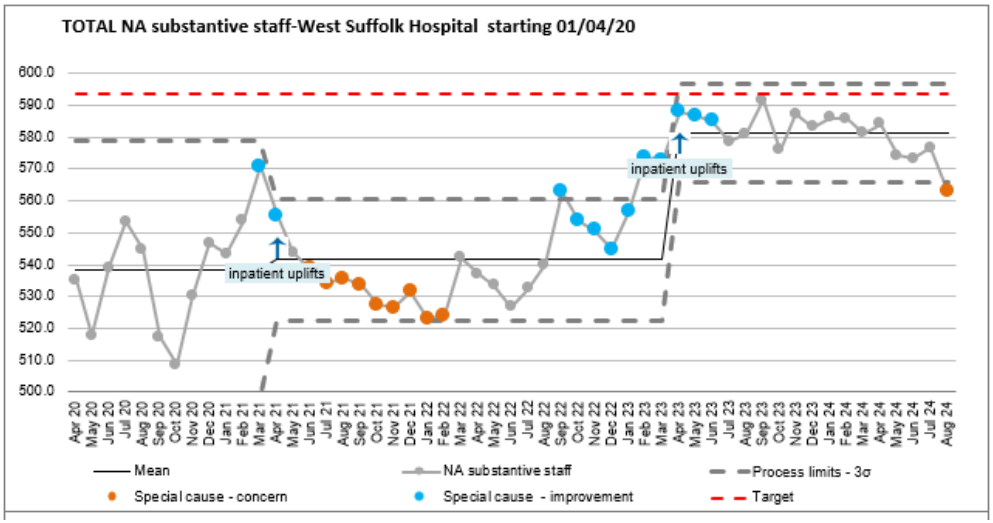


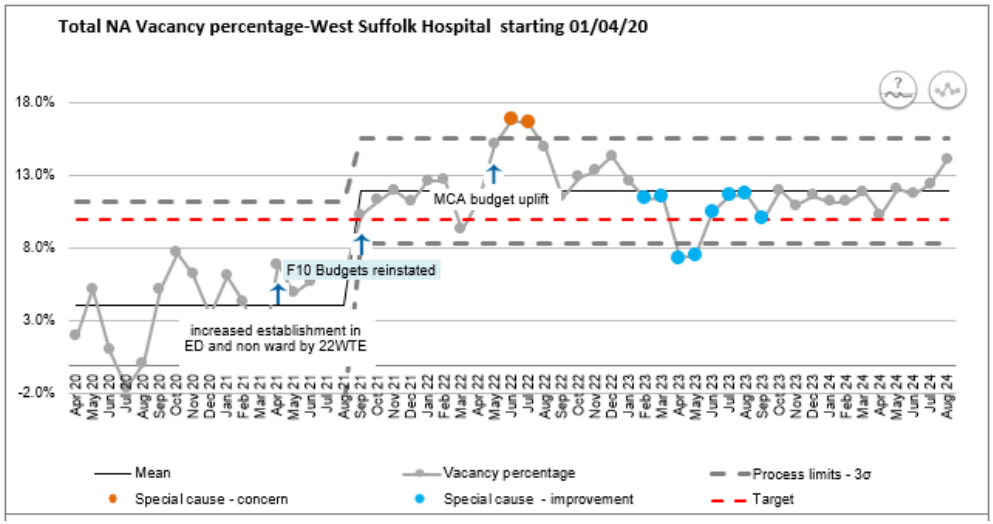
Inpatient RN/RM



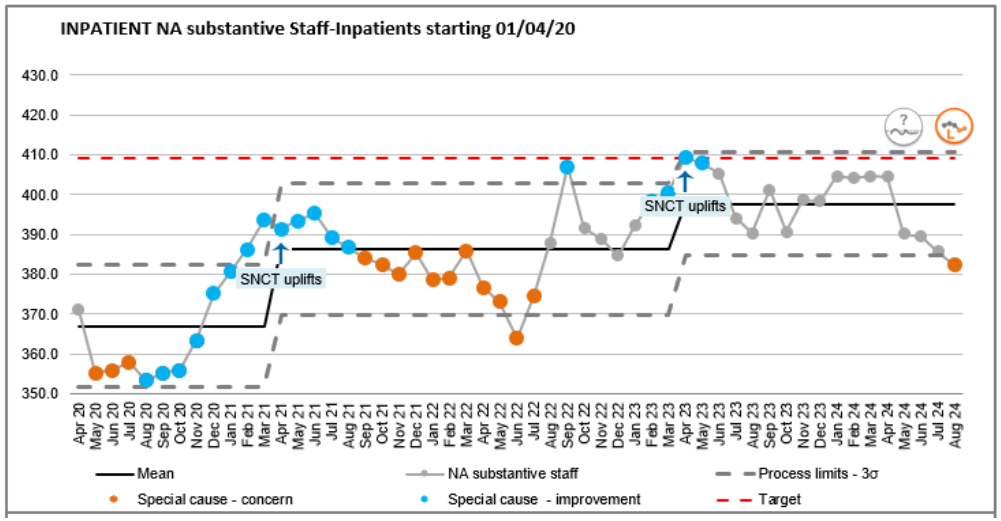


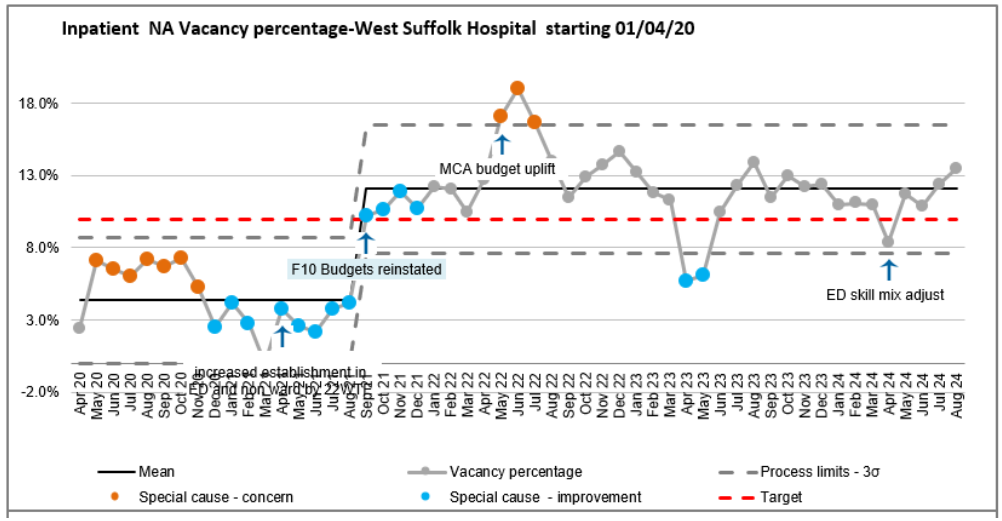
Total NA/unregistered.





Inpatient NA/unregistered.





Appendix 4. 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.

6.4. Maternity quality safety and performance Board report

Presented by Jude Chin and Susan Wilkinson

Open Trust Board	
Report title:	Maternity and Neonatal services - Maternity quality, safety, and performance report
Agenda item:	6.4
Date of the meeting:	27th September 2024
Sponsor/executive lead:	Sue Wilkinson, Executive Chief Nurse Ravi Ayyamuthu, Interim Medical Director & Executive Mat/Neo 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
- Training compliance for all staff groups in maternity related to the core competency framework.
- Reports approved by the Improvement Committee
- Closed Board reports;
    - Perinatal Mortality Report Q1 April – June 2024
    - Maternity and Neonatal Safety Investigations (MNSI) Q1 April – June 2024

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 of non-completion will be 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 Abbeygate community Midwifery Team on 30th July 2024, who came across as a happy well-functioning team which is well led and work effectively together. The team reported that have good relationships and interactions with the inpatient areas and the introduction of a community based daily safety huddle has been successful. Staffing was discussed and although there are currently some vacancies within the teams, the change to not being on-call for escalation in the unit has had a positive impact.

	Concerns were raised regarding the team's base and how this is shared with other departments. Noise levels and confidentiality are sometimes a concern in the open plan part of the office, however there is access to one closed office to mitigate this. Lack of car parking, clear signage and security was also raised; alternative suitable accommodation is currently being sought. The new lone-worker devices/app are in use, although not fully embedded in everyday practice. Monthly reports will be available to monitor utilisation and if this is found to be low, additional training will be provided. Cross-border working was discussed and how this causes potential issues with data recording, including accessing notes and results which can also lead to duplication of work. Roger visited the community midwifery team in Thetford on the 22nd August 2024, who also came across as a well-run, cohesive team. The team reported how the morning safety huddle works well to promote teamwork across the whole community. No safety concerns were raised; however, the lack of clinical space was discussed and how this impacts, capacity and therefore appointment times, cannot be extended, which would be the ideal with the increase of information due to be shared at every appointment and personalised care planning. The lone worker app is used however not consistently when the perceived risks are lower and to note some makes of phone need to be unlocked before activating the alert and therefore this could make it more difficult to use subtlety. The team reported that the hybrid way of working across the community and hospital has enhanced team working in both areas. The new on-call arrangements for homebirths were also positively discussed. In addition to this, both Board Safety Champions (executive and NED) meet with the perinatal leadership team to determine if Trust Board support is required and if so, the progress relating to this. Any escalations are captured on the Safety Champion action log and reviewed at the monthly Maternity/Neonatal Safety Champion meeting.
1.3	**Listening to Staff** The maternity and neonatal service continues to promote 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 a specific care assistant and support worker forum, which all provide an opportunity to listen to staff. On the back of 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 August 2024 divisional turnover rate is the lowest it has been since April 2020. 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, additional 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 has been reviewed and along with the perinatal quadrumvirate, in-house culture coaches will be continuing the work regarding our safety culture.
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	July Survey returns	% of discharged people provided feedback *	July Very good and good %	August Survey returns	August Very good and good %	% of discharged people provided feedback *
F11	55	19%	94.55%	41	95%	10%
Antenatal	11	NA	100%	36	88%	NA
Postnatal Community	18	NA	72.22%	29	86%	NA
Labour Suite	10	3%	100%	20	100%	65%
Birthing Unit	5	21%	100%	9	100%	56%
NNU	1	3%	100%	1	100%	2%
Transitional Care	4	NA	100%	0	-	NA

*Target of ≥30%

A strategy to increase the participation in the antenatal and postnatal survey was 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 an email survey, which 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 Maternity survey 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) chair has stepped down from their position at the beginning of this year. Since then, the MNVP has lacked both a chair and sufficient members to function effectively. The release of the Maternity and Neonatal Voices Partnership guidance in November 2023 provided our Local Maternity and Neonatal System with the opportunity to reassess and establish more sustainable services. In response, the Chair position was advertised and has now been filled, with the new post holder expected to commence in October 2024. The incoming MNVP Chair will be responsible for the re-establishment of the WSFT MNVP.

Two compliments were shared with the patient experience team in July 2024, related to the care received in Antenatal Clinic, Labour Suite/F11/ Neonatal Unit. In August 2024, two compliments were shared with the patients experience team related to the care received on Midwifery Led Birthing Unit and Labour Suite/ F11 ward for Maternity Service at WSFT.

In July 2024, the Trust received 1 PALS enquiry for Labour Suite related to pain relief in labour and in August 2024, six PALS enquiries were received by Maternity Service at WSFT related to patient care and communication.

In July 2024 one formal complaint was received and in August 2024, three formal complaints were received. On review of complaints received during this period the main themes were clinical treatment and communication.

1.5 **Reporting and learning from incidents**

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

One MNSI final report has been received containing safety recommendations. These have been captured in an action plan and subsequently a quality improvement programme in relation to this was launched earlier this month.

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

August 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	Newborn Feeding update
Midwives	93.71%	90.7%	98.26%	98.26%	60.12%	96.61%	65.43%	98.26%	99 %	96.61%
MCA/MSW	NA	NA	92.41%	92.41%	NA	95.92%	57.5%	92.41%	NA	95.92%
Consultant Obstetrician	68.75%	93.75%	94.12%	94.12%	50%	100%	56.25%	NA	100%	NA
Obstetric Registrar	33.3%	83.4%	91.67%	91.67%	16.6%	93%	33.3%	NA	*	NA
SHO/Core trainees	N/A	12.5%	87.5%	87.5%	N/A	100%	N/A	NA	NA	NA
Sonographer	NA	94.8%	NA	NA	NA	NA	NA	NA	NA	NA
Consultant Obstetric Anaesthetists	NA	NA	94.11%	94.11%	NA	NA	NA	NA	NA	NA
Obstetric Anaesthetists	NA	NA	94.73%	94.73%	NA	NA	NA	NA	NA	NA
Neonatal Consultants	NA	NA	NA	93.75%	NA	100%	NA	100%	NA	No Data
Neonatal Nurses	NA	NA	63%	63%	NA	97%	NA	96%	NA	No Data
Neonatal Doctors	NA	NA	NA	No Data	NA	93.75%	NA	100%	NA	No Data
ANNP/PA	NA	NA	NA	No Data	NA	100%	NA	100%	NA	No Data

*6 months to complete

Key

COLOUR CODE	MEANING	ACTIONS
	>90%	Maintain
	80-90%	Identify non-attendance and rebook; monitor until >90% for 3 months
	<80%	Urgent review of non-attendance and rebook; monitor monthly until >90% or direct management if <90%
	Not applicable to that staff group	Review criteria for training as part of annual review
	New training for that staff group	Review compliance trajectory after 3 months

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, however for some training elements this is reliant on individuals providing evidence of training compliance in their previous Trust.

Due to the new intake of junior doctors in August there is a lag time in place, however the majority are allocated time/training in their induction programme resulting in the favourable results above.

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 Board Meeting on the 24th May 2024, whereby some reports will be presented and approved by the Improvement Board sub-committee. 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 require escalation. Following reports were presented and approved at the Improvement Committee held on the 21st August 2024: • Maternity Incentive Scheme (MIS) Safety Action 4b, Obstetric Anaesthetic Workforce report • Maternity Incentive Scheme (MIS) Safety Action 4c, Neonatal Medical Workforce Report • Maternity Incentive Scheme Safety Action 4d, Neonatal Nursing staffing report • Maternity Claims Scorecard, incident, and complaint data Quarter 4 22/23 • Maternity Claims Scorecard, Incidents and Complaints Quarter 4 22/23
3	**Reports for CLOSED BOARD** Due to the level of detail required for these reports and subsequently containing possible patient identifiable information, the full reports will be shared at Closed board only.
3.1	**Perinatal Mortality Report Q1 April – June 2024** During the period of 1st April to 30th June 2024 the Trust notified Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE) of 3 perinatal deaths.Two other baby losses happened at other Trusts having had care in the early part of the pregnancy from the West Suffolk Maternity services. All the baby losses were reviewed in the immediate period after the birth and there were no immediate actions identified. All the losses were reported to MBRRACE within the required timeframes to date. During this reporting period there was one Perinatal Mortality Review completed using the Perinatal Mortality Review Tool (PMRT). Recommendations are being progressed and learning has been shared. All external reporting requirements were met during the period of time covered by this report, demonstrating sound processes are in place. This was reflected in the reporting and timely reviews for all cases reported over the last 4 quarters of this year. It is essential that this is maintained to demonstrate the Maternity Services are being responsive, compliant with national reporting requirements, providing bereaved families with timely responses to any concerns they may have and supporting good practice where this is noted. Parents were asked to contribute to the reviews by providing comments and questions to the PMRT meeting. The response to any questions are included in the PMRT report. The Trust was compliant with the Maternity Incentive Scheme Safety Action 1 requirements in this quarter.
3.2	**Maternity and Neonatal Safety Investigations (MNSI)/HSIB Q1 April – June 2024** All mandatory reporting to the Maternity and Newborn Safety Investigations (MNSI) – formerly Healthcare Safety Investigation Branch (HSIB) – and the Early Notification Scheme (ENS), have been completed during this period. In this reporting period, 1 case was referred and accepted by MNSI for investigation Due to normal scan results and the parents not having any concerns, this has been stepped down from MNSI and there will be a Trust Patient Safety review. In this reporting period we have met the requirements as set out in the Maternity Incentive Scheme – safety action 10. Where there is uncertainty, we have direct access to MNSI regional lead who supports us in decision making, we continue to foster a close working relationship with the MNSI team.
4.	**Next steps**
4.1	Reports will be shared with the external stakeholders as required. Action plans will be monitored and updated accordingly.

7. GOVERNANCE

7.1. Charitable Funds CKIs 22 Aug 2024 meeting MP Final

Presented by Michael Parsons

Open Trust Board	
Report title:	Charitable Funds Committee Key Issues (CKI) report
Agenda item:	7.1
Date of the meeting:	27 September 2024
Lead:	Michael Parsons, non-executive director and Charitable Funds Committee Chair
Report prepared by:	Michael Parsons, non-executive director and Charitable Funds Committee Chair

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 report summarises the key issues from the Charitable Funds Committee meeting held on 22 August 2024.
SO WHAT? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*
The proposed acquisition of a robot could be transformational – but the Trust will need to understand any financial risk in the event that the fundraising appeal does not raise sufficient funds (taking into account the significant balances held by the Charity).
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.
Recommendation / action required
The Board of Directors is asked to note the report.

Previously considered by:	NA
Risk and assurance:	-

Equality, diversity and inclusion:	-
Sustainability:	-
Legal and regulatory context:	-

Committee Key Issues (CKI) report

Originating Committee: Charitable Funds Committee			Date of meeting: 22 August 2024		
Chaired by: Michael Parsons			**Lead Executive Director:**		
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	Fundraising Report	Substantial	Noted excellent summary of recent fundraising activity, legacies notified, and upcoming priorities.		No escalation
6/7	Financial & Investment Reports	Substantial	Noted reports and agreed that CCLA (investment managers) would be invited to a future meeting to provide assurance on the investment strategy remained appropriate.		No escalation
10	Terms of Reference	Reasonable	Recommended to Board revisions to simplify ToR and clarify membership.	Board to be asked to confirm Exec membership of the Board as part of ToR approval.	3. Escalate to Board to approve
11	Robot Appeal	Reasonable	Discussed business case, fundraising appeal, existing funding (and anticipated legacy), tender process, and training. Agreed to proceed with appeal – subject to MEG reviewing the financial risk to Trust. CFC members agreed to review the draft campaign brochure.	MEG to review the financial risk to Trust, before appeal is launched.	2. Escalate to MEG

Originating Committee: Charitable Funds Committee			Date of meeting: 22 August 2024		
Chaired by: Michael Parsons			Lead Executive Director:		
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
AOB	Noted Richard Flatman, one of the new NEDs, would be taking over as CFC Chair and that Sue Smith had announced she would be leaving – Sue was thanked most sincerely and wholeheartedly for everything she has done for the Charity and WSFT. Recruitment is underway.	Reasonable			

**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?

7.2. Board Assurance Framework

To Assure

Presented by Richard Jones

Board of Directors	
Report title:	**Board Assurance Framework**
Agenda item:	7.2
Date of the meeting:	27 September 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 one risk: Improvement (4)

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 and scores updated by the Executive Director of Workforce and Communications and presented to the Involvement Committee
- **BAF 4 Improvement** – fully reviewed and updated by the Executive Director of Strategy and Transformation. The newly reviewed risk was reviewed at the last MEG and was presented at the Improvement Committee in September.
- **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 and have Executive sign off by the Chief Operating Officer.
- **BAF 7 Finance** – reviewed by the Deputy Finance Director to update the risk score, the executive commentary, cause and gaps in assurance in light of current financial position and findings of the financial diagnostic review
- **BAF 8 Governance** – reviewed by the Executive Chief Nurse to update the Executive summary, risk score causes and effects, the risk assurances and the actions. Presented at the Improvement Committee in August.
- **BAF 9 Patient engagement** - reviewed by the Head of Patient Experience & Engagement to update the cause and effects, the risk assurances the actions and the risk rating.
- **BAF 10 Wellbeing** - reviewed and scores updated by the Executive Director of Workforce and Communications and presented to the Involvement Committee

Based on the current assessments **four risks 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).**

- **Schedule review by the Board in early 2025** a review of the BAF and the current risk appetite levels

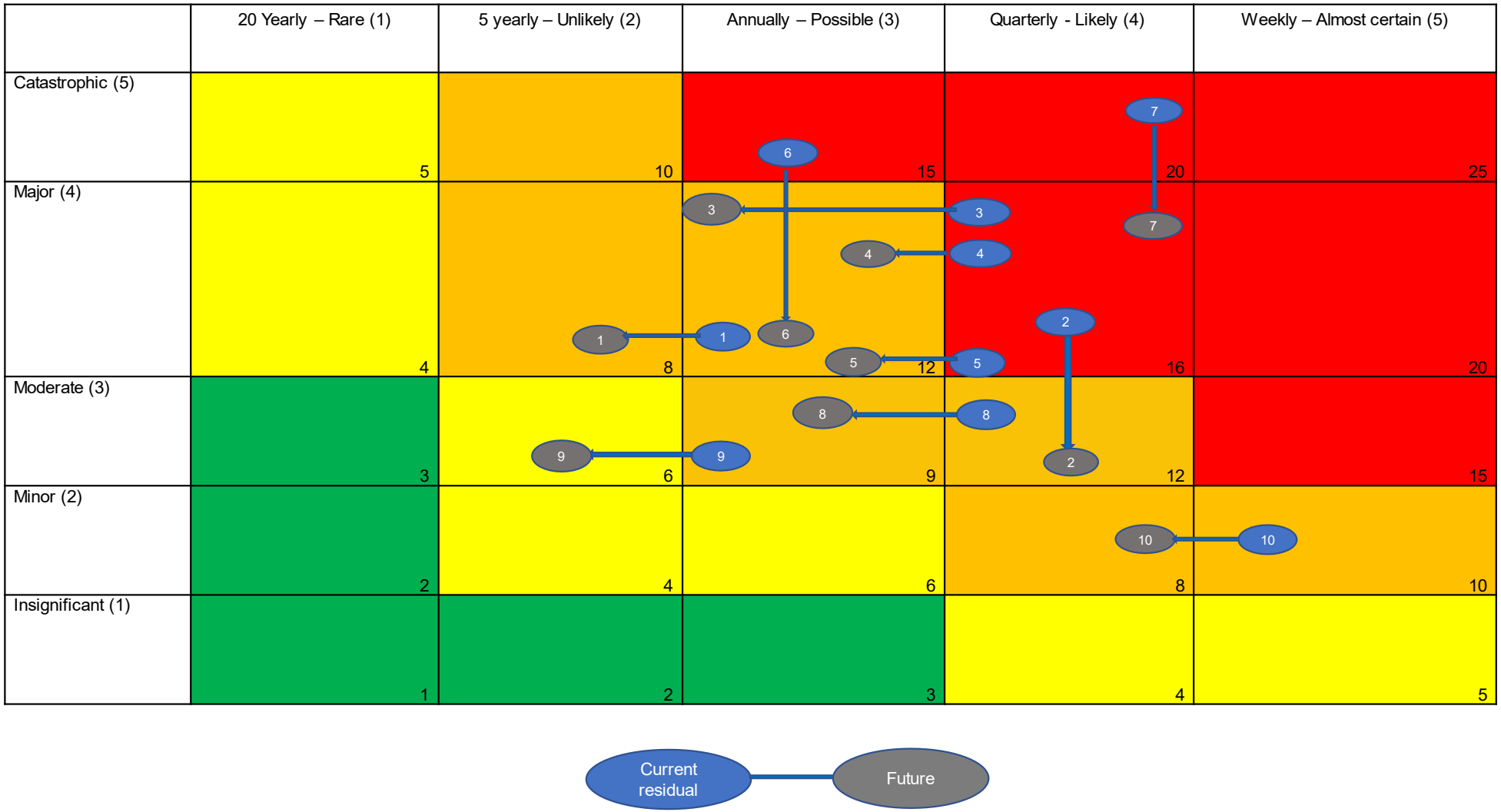
Action Required

1. **Note the report** and progress with the BAF review and development
2. **Approve the 'Next steps' actions**.

Previously considered by:	The Board of Directors

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

Annex A: BAF risk movement



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

Annex B: Risk themes – summary table

Risk Descriptions	Exec lead	Board comm.	Board committee review (MEG review)	Appetite Level and score	Current risk score	Future risk score (target date)	Future risk with 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	Aug 24 (Aug '24)	Cautious (9)	12	8 (Mar 25)	Yes	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 (Sep '24)	Cautious (9)	16	12 (Mar 25)	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	DST	Involvement	Planned for Oct '24 (Sep '24)	Open (12)	16	8 (2026)	No	Partial
BAF 4 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	DST	Improvement	Sep '24 (Sep '24)	Open (12)	16	12 (Mar 25)	Yes	Partial
BAF 5 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	COO	Improvement	Planned for Oct '24 (Sep '24)	Cautious (9)	16	12 (Dec 24)	No	Partial
BAF 6 [1] 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	Planned for Nov '24 (Oct '24)	Open (12)	15	12 (Dec 24)	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	Aug '24 (Sep '24)	Cautious (9)	20	16 (Mar 25)	No	Reasonable

Risk Descriptions	Exec lead	Board comm.	Board committee review (MEG review)	Appetite Level and score	Current risk score	Future risk score (target date)	Future risk with appetite?	Assur. level
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	Aug '24 (Aug '24)	Minimal (6)	12	9 (Jan 25)	No	Partial
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	Planned for Oct '24 (Oct '24)	Cautious (9)	9	6 (Dec 24)	Yes	Reasonable
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	Aug '24 (Aug '24)	Cautious (9)	10	8 (Mar 25)	No	Reasonable

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

7.3. Governance Report

For Approval

Presented by Jude Chin and Richard Jones

WSFT Board of Directors (Open)	
Report title:	**Governance report**
Agenda item:	7.3
Date of the meeting:	27 September 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 September 2024, as follows:

- Senior Leadership Team report
- Management Executive Group
- Council of Governors report, including NED responsibilities
- Update to Constitution
- Terms of reference
- Use of Trust's seal
- Agenda items for next meeting
- Future Board meeting dates

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 content of report as outlined above and to approve the following:

- amendments to the **Trust's Constitution**
- **terms of reference** for changes to be applied to the assurance committees, insight committee, management executive committee and charitable funds committee

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 September meet face-to-face. The session was used as a workshop to consider the Trust's strategy and the need for refresh and review. The feedback will be used to inform next steps as part of a programme to refresh the strategy.

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.

3. Council of Governors report

The Council of Governors met on 2 September 2024. The Council of Governors noted the appointment of Partner Governor, Evelin Hanikat (replacing David Brandon for Suffolk and North East Essex (SNEE) ICB). The appointment of five new non-executive directors (NEDs) (David Weaver, Alison Wigg, Dr Paul Zollinger-Read, Heather Hancock, Richard Flatman) and the return of Tracy Dowling from Mid and South Essex ICB was also noted.

The Chair reviewed the specific **NED individual responsibilities (Annex A)** and the Council of Governors noted the NEDs responsibilities, which are subject to further changes and refinement.

The Council of Governors received an update on **finance** by the acting chief finance officer and an overview of Trust's financial position was provided.

The Council of Governors received the feedback reports from chairs of the **board assurance committees and governor observers**. A summary of the agenda items was received with the committee's key issues and respective governor observers' reports providing highlight updates for the Council. The Council of Governors also received the audit committee's key issues report. The audit committee chair also presented the auditor's annual report to provide summary of the findings and key issues arising from 2023-24 audit of the Trust's annual report and accounts.

The Governors noted the report from **Nomination Committee** which highlighted that the 360° feedback reports for non-executive directors were reviewed and discussed. The terms of office for the NEDs were noted. The Council of Governors approved the terms of reference of the nominations committee. The Governors also noted the areas identified for improvement in the annual report of committee's effectiveness.

The Council of Governors received a report from the **Engagement Committee** to draw attention to ongoing work around re-writing of Trust's membership and engagement strategy and review of the terms of reference for the committee.

The Council of Governors received a report from the **Standards Committee** to note the findings from audit of skills held by Governors and update on Fit and Proper Persons Test and Disclosure and Barring Service checks. The Council of Governors approved the terms of reference of the standards committee. The Governors also noted the areas identified for improvement in the annual report of committee's effectiveness. The Standards Committee recommended one amendment to the Trust's Constitution for consideration by the Council relating to the duration of tenure for a Governor. **The Council of Governors approved proposed amendment to the Trust Constitution** which is considered in more detail under item 4 below.

The Council of Governors noted the **governance report**, including, Governor work programme 2024-25.

The Council in the closed meeting approved the appointment of Tracy Dowling as the Deputy Chair of the Trust for remainder of the term.

4. Proposed developments to constitution

The Council of Governors approved following amendments to the Trust's Constitution at its meeting in September. Legal advice has been sought on proposed amendments to the Constitution. This is to ensure that any changes do not undermine the Constitution as a legal instrument.

The Constitution currently makes provision for Governors (elected, both public and staff, or nominated) to hold office for a maximum of three terms or nine years. It was proposed to amend the Constitution so that a Governor who has reached the maximum term becomes eligible to stand for re-election after a break period of at least two years.

The following summarises the changes and the full constitution is providing in the supporting annexes for the meeting pack (Supporting annexes Annex B)

The Board is asked to approve the proposed changes which, with the existing Council approval, will then come into effect immediately.

a) Change to the Council of Governors tenure

Change description	Reference
Council of Governors - tenure To allow the change, a paragraph as set out below would be added to the Constitution. Would vary for each Governor constituency – public, staff and partner. *Notwithstanding paragraph 12.4, any individual may stand for re-election or re-appointment as a Governor provided that a period of at least two years has passed since the end of that individual's previous maximum term as Governor.*	Clause 12, p. 7 & 8

5. Terms of reference

5.1 Insight Committee

The updated terms of reference for Insight Committee were approved by the committee at its meeting in September.

As part of the review it is proposed that the following amendments are mirrored across the three assurance committees terms of reference:

With the membership section:

- The chair, other non-executive directors and chief executive have an open invitation to attend meetings of the committee
- Others in attendance by invitation: including Governor observers.

Note for attendees:
Board assurance committees are not public meetings and, occasionally, matters discussed may be confidential. Governor observers and other attendees must maintain confidentiality about what is discussed.

Within the monitoring of effectiveness and compliance section:

- In order to support the continuous improvement of governance standards, this committee is required to complete a self-assessment of effectiveness every two years

The Board is asked to approve:

- The updated Insight Committee terms of reference (Supporting Annex)
- The changes outlined above to the three assurance committees

**amendment around governors' observers is not applicable to charitable funds as governors do not observe this meeting*

5.2 Management executive committee

Following up from the recommendation made in the PA Consulting financial diagnostic review report and subsequent action plan *(a review should be completed of Terms of Reference across Board and sub-committees to strengthen Grip & Control and set expectations on financial reporting, risk, delegation of discussions)*, the Management Executive Group terms of reference were presented for discussion.

The Management Executive Group reviewed the terms of reference and recommending to the Board of Directors for approval. The terms of reference are attached in Supporting Annexes for approval.

5.3 Charitable funds committee

As part of periodical review, amendments were made to the committee terms of reference. The proposed changes were agreed by the committee and the terms of reference are attached in Supporting Annexes for the Board for approval.

Consideration is being given to the executive membership of the committee.

6. Use of Trust Seal

None to report.

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

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

8. Future Board meeting dates

The meeting dates for the Board of Directors for the next year are provided below. These along with other board committees have now been confirmed and will be shared with committee members.

- 31 January '25
- 28 March '25
- 23 May '25
- 25 June '25
- 26 September '25
- 28 November '25

NHS
West Suffolk
NHS Foundation Trust

Non-executive directors' responsibilities – August 2024

	Primary responsibilities	Responsibilities as required	Lead assurance roles (Bold indicates mandated)
Jude Chin **Chair and Non-executive director** **Fixed Term:** 4 July 2022 – 3 July 2023 **Appointed:** 1 June 2023 – 31 May 2026	• Board – Public, Closed (**Chair**) • Council of Governors (**Chair**) • Audit Committee (in attendance) • Remuneration Committee (**Chair**) Specialist committees: • *Option to attend any other Board committees* • ICS Chairs meeting • NHS Confederation Chairs group • NHSE (East of England) CEO and Chairs group	• Board Workshops • External relationships • Consultant appointments • 15-steps visits • Governor meetings with NEDs • Investigations and appeals	• Integrated care system • NHS England and Improvement • West Suffolk Alliance • NED link to CEO
Tracy Dowling **Non-executive director** **Term:** 1 November 2022 – 17 November 2023 **Reappointed:** 1 August 2024 – 17 August 2026	• Board meeting – Public, Closed • Deputy Chair • Remuneration Committee • Audit Committee Specialist committees: • Involvement Committee (**Chair)** • Improvement Committee • Member Collaborative Oversight Group	• Board Workshops • Consultant appointments • 15-steps visits • Council of Governors and Governor meetings with NEDs • Investigations and appeals	• Patient experience and public engagement • NED link to Director of Workforce, including OD

	Primary responsibilities	Responsibilities as required	Lead assurance roles (Bold indicates mandated)
Richard Flatman **Non-executive director** **Term:** 1 September 2024 – 31 August 2027	• Board meeting – Public, Closed • Remuneration Committee • Audit Committee Specialist committees: • Insight Committee • Charitable Funds Committee (**Chair**) • Member of SNEE ICB Finance Committee	• Board Workshops • Consultant appointments • 15-steps visits • Council of Governors and Governor meetings with NEDs • Investigations and appeals	• **Health and wellbeing guardian** • NED link to CFO
Heather Hancock **Non-executive director** **Term:** 1 September 2024 – 31 August 2027	• Board meeting – Public, Closed • Remuneration Committee Specialist committees: • Involvement Committee • Insight Committee • Charitable Funds Committee	• Board Workshops • Consultant appointments • 15-steps visits • Council of Governors and Governor meetings with NEDs • Investigations and appeals	• Equality, diversity and inclusion • NED link to Director of Strategy and Transformation
Antoinette Jackson **Non-executive director** **Term:** 1 November 2022 – 31 October 2025	• Board meeting – Public, Closed • Senior Independent Director • Remuneration Committee • Audit Committee Specialist committees: • Insight Committee (**Chair**) • Involvement Committee • Charitable Funds Committee	• Board Workshops • Consultant appointments • 15-steps visits • Council of Governors and Governor meetings with NEDs • Investigations and appeals	• **Board freedom to speak up guardian, including whistleblowing** • NED link to Director of Integrated Adult Health and Social Care

	Primary responsibilities	Responsibilities as required	Lead assurance roles (Bold indicates mandated)
Michael Parsons **Non-executive director** **Term:** 1 May 2023 – 30 April 2026	• Board meeting – Public, Closed • Audit Committee (**Chair**) • Remuneration Committee Specialist committees: • Insight Committee • Future System Executive Programme Board (**Chair**)	• Board Workshops • Consultant appointments • 15-steps visits • Council of Governors and Governor meetings with NEDs • Investigations and appeals	• **Security management** • NED link to Programme Director, Future Systems
Roger Petter **Non-executive director** **Term:** 1 Mar 2023 – 28 Feb 2026	• Board meeting – Public, Closed • Remuneration Committee • Audit Committee Specialist committees: • Improvement Committee (**Chair**) • Involvement Committee	• Board Workshops • Consultant appointments • 15-steps visits • Council of Governors and Governor meetings with NEDs • Investigations and appeals	• **Maternity and neonatal safety champion** • **Doctors' disciplinary** • NED link to Medical Director
David Weaver **Associate Non-executive director** **Term:** 1 September 2024 – 31 August 2027	• Board meeting – Public, Closed • Remuneration Committee Specialist committees: • Insight Committee • Improvement Committee • Future System Executive Programme Board	• Board Workshops • Consultant appointments • 15-steps visits • Council of Governors and Governor meetings with NEDs • Investigations and appeals	• Safeguarding adults and children • NED link to Chief Operating Officer
Alison Wigg **Non-executive director** **Term:** 1 September 2024 – 31 August 2027	• Board meeting – Public, Closed • Remuneration Committee Specialist committees: • Involvement Committee • Future System Executive Programme Board • Digital Programme Board	• Board Workshops • Consultant appointments • 15-steps visits • Council of Governors and Governor meetings with NEDs • Investigations and appeals	• Cyber security • NED link to CIO

	Primary responsibilities	Responsibilities as required	Lead assurance roles (Bold indicates mandated)
Paul Zollinger-Read **Associate Non-executive director** **Term:** 1 September 2024 – 31 August 2027	• Board meeting – Public, Closed • Remuneration Committee Specialist committees: • Improvement Committee • Charitable Funds Committee • Doctors' Revalidation Support Group	• Board Workshops • Consultant appointments • 15-steps visits • Council of Governors and Governor meetings with NEDs • Investigations and appeals	• Patient safety including learning from deaths • Theatre utilisation • NED Link to Chief Nurse

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

All NEDs can attend the assurance committees but only those specified above are members of the committee

All NEDs are members of the Remuneration Committee

Annex B: Scheduled draft agenda items for next meeting – 29 November 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
Strategic priorities – progress report	✓		Written	Action	CEO
Future System Board Report	✓		Written	Matrix	CB
Digital Board report	✓		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 - 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 - Management executive group report - Council of Governors report - Use of Trust's seal - Agenda items for next meeting	✓		Written	Matrix	RJ
Confidential staffing matters		✓	Written	Matrix – by exception	JMO
Board assurance framework report	✓		Written	Matrix	RJ
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					

8. OTHER ITEMS

Presented by Jude Chin

8.1. Any other business

To Note

Presented by Jude Chin

8.2. Reflections on meeting

For Discussion

Presented by Jude Chin

8.3. Date of next meeting - 29th November 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

To inform

Presented by Jude Chin

Assurance Grid

June 2024	ASSURANCE: Pass (P)	Hit and Miss (?)	Not Met: Fail (F)
VARIANCE: Special Cause Improvement (H / L)		**INVOLVEMENT** Staff Sickness – Rolling 12 months Staff Sickness	**INSIGHT** Total average occupancy number 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 Incomplete 104 Day Waits Potential 65+ ww at end of Sept 2024
Deteriorating: Special Cause Concern (H / L)		**INSIGHT** Community Paediatrics 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 of attendances
% patients with no criteria to reside
Virtual Beds Trajectory
Total average occupancy percentage
Total average LOS per patient
28 Day Faster Diagnosis
Cancer 62 Days Performance
Community Paediatrics RTT Overall 104 Weeks Wait
IMPROVEMENT:
C-Diff Hospital & Community
INVOLVEMENT:
Mandatory Training

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%

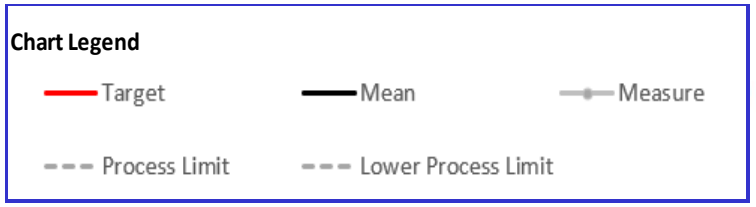
Currently this data is not available to the Trust, however the Information Team are working to resolve this.

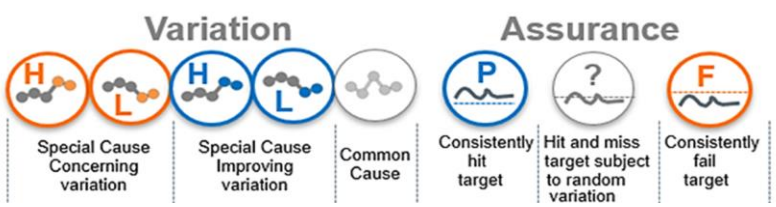
*Cancer data is 1 month behind

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, 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: RTT 78+ Week Waits, Potential 65+ ww at end of Sept 2024, Community Paediatrics RTT Overall 78 Weeks Wait
INVOLVEMENT – Well Led: Appraisal, Turnover

INSIGHT COMMITTEE METRICS

Urgent & Emergency Care summary

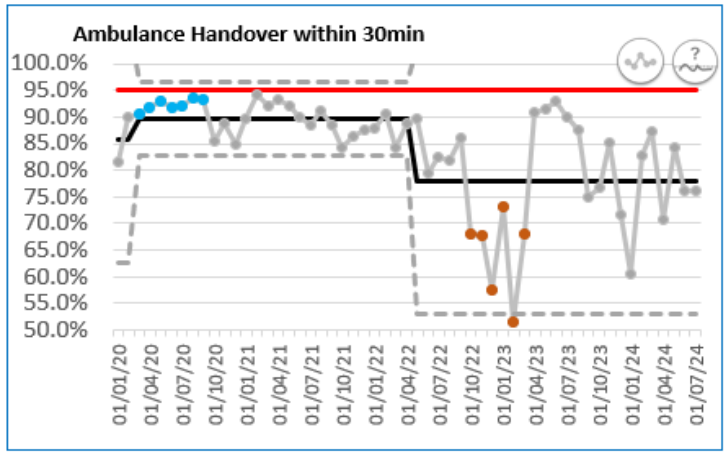


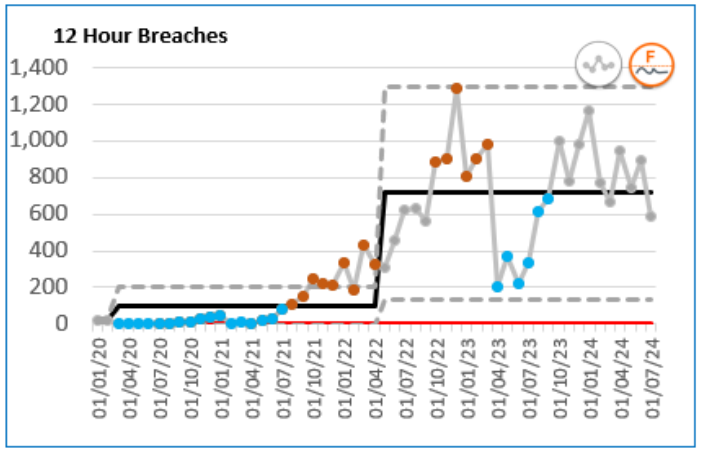


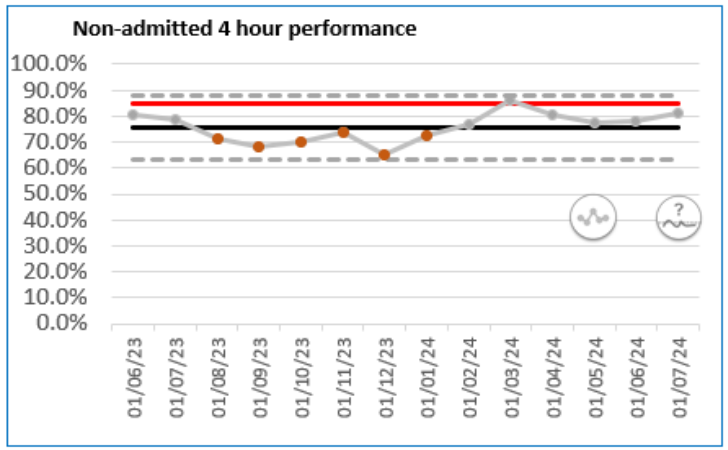
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Ambulance Handover within 30min	Jul 24	76.3%	95.0%			78.0%	53.0%	102.9%
12 Hour Breaches	Jul 24	588	0			714	137	1291
4 hour breaches	Jul 24	2344	0					
4 hour performance	Jul 24	72.8%	78.0%					
Non-admitted 4 hour performance	Jul 24	81.2%	85.0%			75.7%	63.4%	88.0%
12 hour breaches as a percentage of attendances	Jul 24	6.8%	2.0%			5.2%	1.0%	9.4%
Urgent 2 hour response	Jul 24	90.7%	70.0%			90.3%	82.6%	98.0%
Criteria to reside (Average without reason to reside) Acute	Jul 24	43				57	42	72
**Criteria to reside (Average without reason to reside) Community	Jul 24	34				19	13	24
% patients with no criteria to reside	Jul 24	10.8%	10.0%			13.2%	8.9%	17.4%
Virtual Beds Trajectory	Jul 24	40	40			40	40	40
Total average occupancy number	Jul 24	31.1	80.0			23.6	15.5	31.7
Total average occupancy percentage	Jul 24	76%	80%			72%	45%	100%
Total bed days on VW	Jul 24	755	-			610	325	896
Total average LOS per patient	Jul 24	8.0	14.0			9.7	3.8	15.7
Respiratory Bay average occupancy number	Jul 24	3.0	8.0			2.9	-0.8	6.5
Heart Failure Bay average occupancy number	Jul 24	6.8	12.0			5.4	1.6	9.2
IV Abx Bay average occupancy number	Jul 24	1.6	6.4			2.4	-0.9	5.7
Frailty Bay average occupancy number	Jul 24	3.2	16.0			2.8	-0.6	6.2

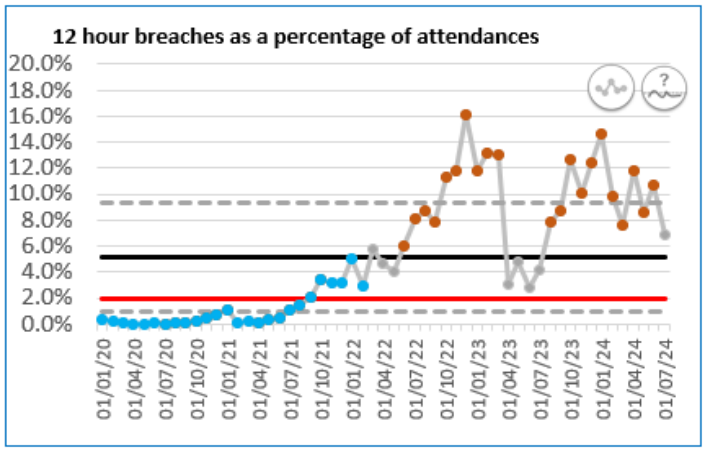
** Figures are for Glastonbury and Newmarket only, data not currently captured at Hazel Court.

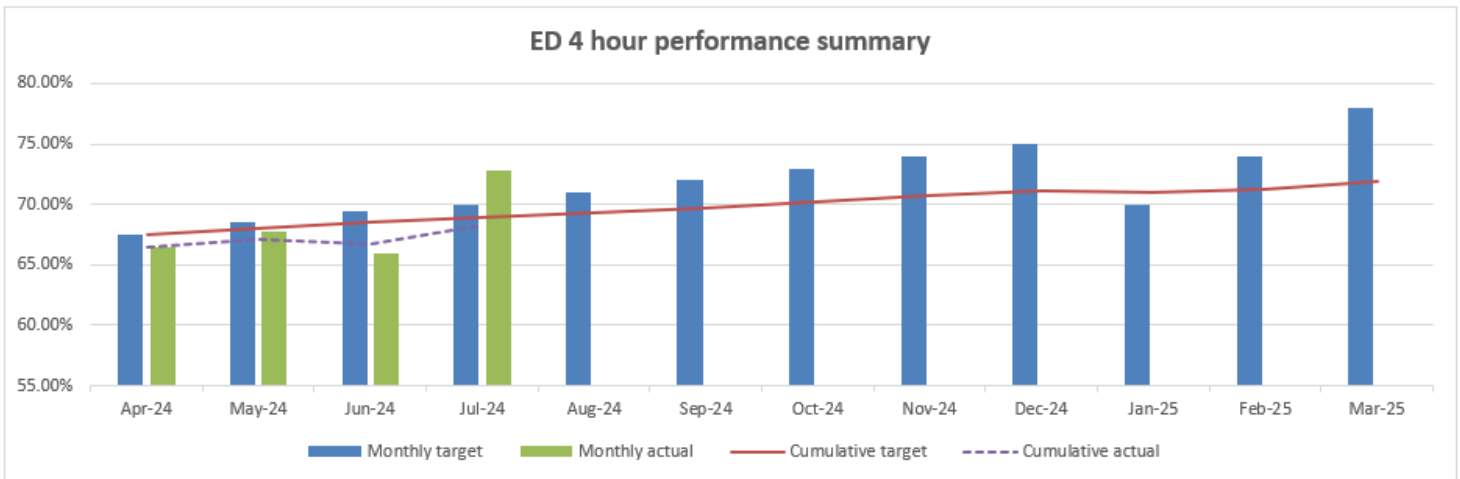
Urgent & Emergency Care: ED 4 Hour Performance





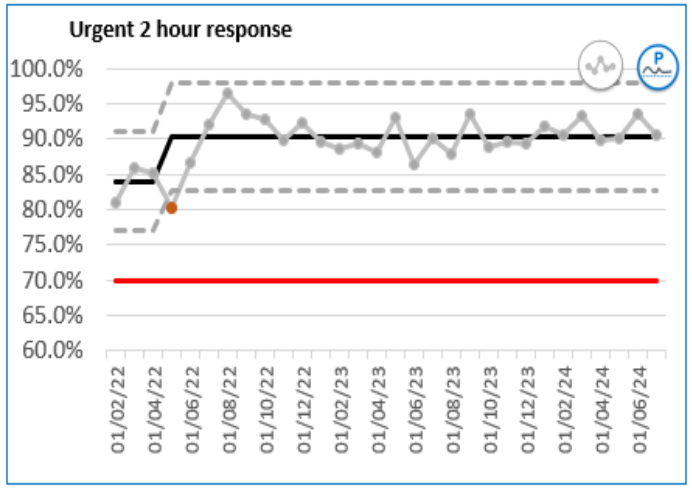


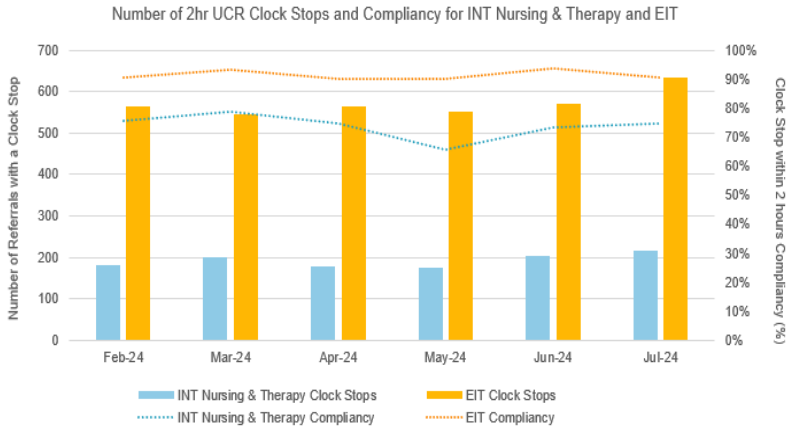


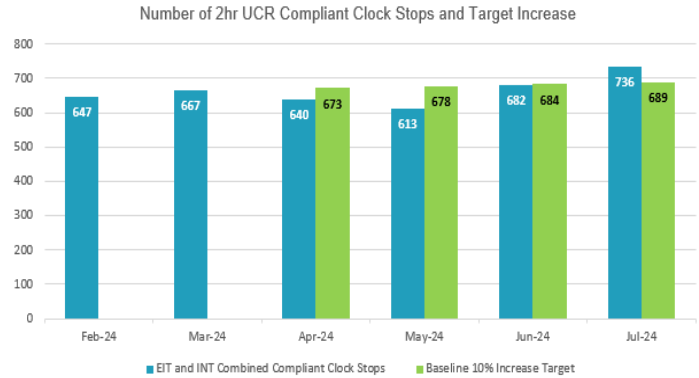


Urgent & Emergency Care

What	So What?	What Next?
No significant change demonstrated with Ambulance handover performance which remains a challenge. A factor contributing to this is Emergency Department patients with an increased length of stay waiting for a bed, this results at times in the need to cohort patients into escalation areas including the Rapid Assessment Triage Area , which reduces our ability and capacity to offload ambulances. The number of 12 hour breaches in the month of July demonstrates no significant change, although there were 305 less patients waiting longer than 12 hours in the department when compared to June. We continue not to meet this metric. The number of 12 hour breaches as a percentage of attendances shows no significant change, and remains concerning. Non-admitted performance demonstrates no significant change. July's 4-hour performance was 72.77%, meaning that we achieved and exceeded our trajectory of 70%.	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 Emergency Department standard will meet the national targets. Reaching the trajectory will keep us on track to achieve 78% by March for the 4 hour standard. Some patients are waiting longer in the Emergency Department than they should be and being nursed in escalation areas which makes for a poor patient experience.	Revised Urgent and Emergency Care action plan developed with a trajectory to achieve 78% 4hr Emergency Department target by March '25. An internal Urgent and Emergency Care delivery group with workstream leads is in operation. Weekly triumvirate performance meetings between the Emergency Department and Medical Division Senior Leaders with an associated action plan. Robust data and clinical review for periods of reduced performance to obtain learning to improve performance. Focussed work for improving overnight Emergency Department performance including: • Template guidance for Emergency Physician in Charge handover with clear actions for night • Focused leadership training for Registrars overnight to be included within study sessions • Support from the Organisational Development team in developing the leadership skills of the senior medical team within the Emergency Department. • Profiling of doctor's shift patterns in relation to activity within the department, using the ECIST Safecare tool. **Projects in July '24** • Pre booked next day returner Emergency Nurse Practitioner slots to support minor injuries attending after 10pm commencing 24th August. • 3-6pm Front Door Rapid Assessment for non admitted patients – consultant based at point of streaming/triage to assess & discharge or redirect to other services i.e. Same Day Emergency Care. Pilot completed, data being analysed, so far 18% of patients seen were discharged directly and 18% referred direct to speciality. Trial feedback very positive, potentially need to change hours to later in the day. Going forwards will continue as business as usual • Direct streaming to Same Day Emergency Care pilot, no issues identified will continue as business as usual. Data being analysed. The continuation of the rota for the Emergency Department leadership team to be solely based in department supporting performance. The Acute Admissions Unit also have a similar rota. Planning for Minor Emergency Care Unit continues – currently awaiting fire testing to be completed for supporting structure, Implementation date for Minor Emergency Care Unit likely end September '24 The use of agency ambulance personnel for reverse cohorting ceased at the end of June.







Team	Feb-24				Mar-24				Apr-24				May-24				Jun-24				Jul-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	180	136	44	76%	201	158	43	79%	179	134	45	75%	175	115	60	66%	204	150	54	74%	217	162	55	75%
Total EIT*	564	511	53	90.60%	545	509	36	93.39%	563	506	57	89.88%	552	498	54	90.22%	569	532	37	93.50%	633	574	59	90.68%
Combined Total	744	647	97	86.96%	746	667	79	89.41%	742	640	102	86.25%	727	613	114	84.32%	773	682	91	88.23%	850	736	114	86.59%

What

Community 2-hour response remains above 70% compliance target and referrals have increased. No significant change to performance.
2-hour Integrated Neighbourhood Team (INT) nursing/therapy response is sustained at 75%.

Compliance to achieve 2 hr response remains above 70% target

An increased number of in 2 hour referrals made to Early Intervention Team (EIT) this month has attributed in the urgent care compliance activity being above the 10% increase trajectory set

So What?

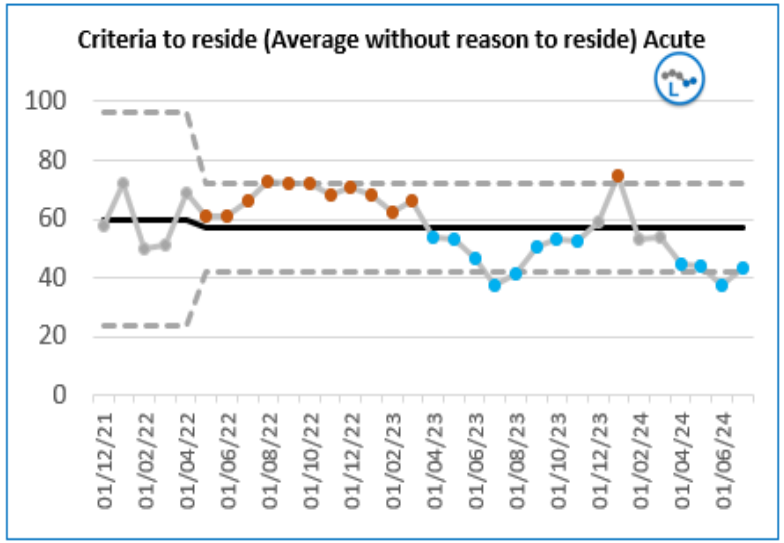
Continue to meet national target and also increase in referrals as per alliance plan. However, need to monitor community referrals that are "decision not to treat" due to capacity. These are cleric referrals, as the team are prioritising community referrals via the Care Co-ordination Centre (CCC) and acute/ ED work.

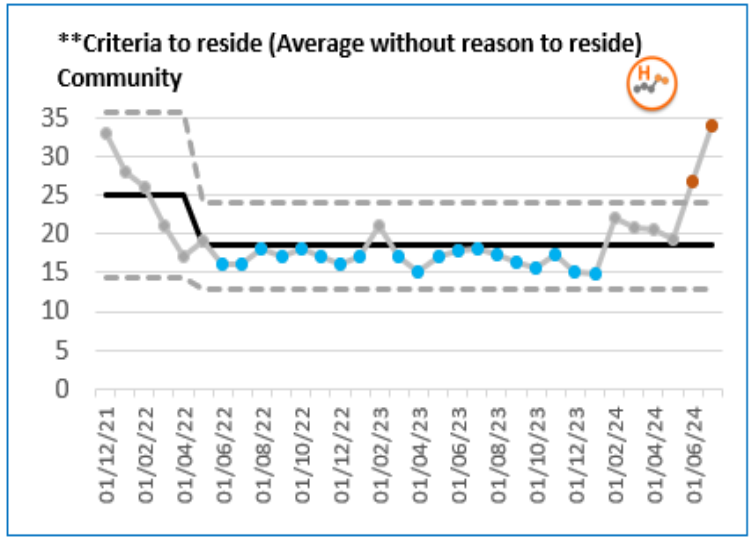
What Next?

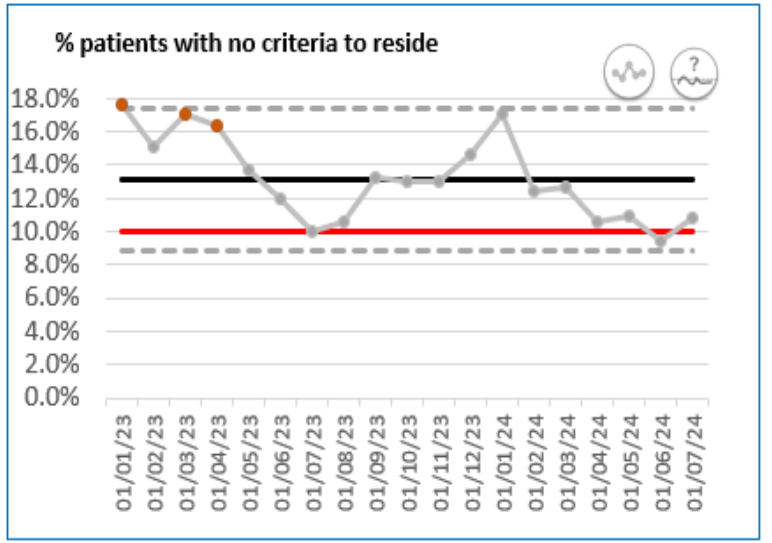
Progress Hub and spoke model: 6-week pilot with "community team" of EIT working from West Suffolk House from late September. Monitor impact on performance and productivity.

Escalation calls stepped up when capacity across INTs challenged.

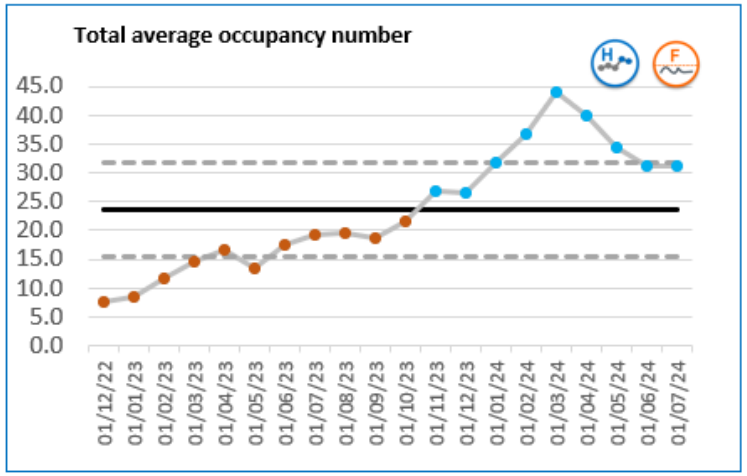
Urgent & Emergency Care: Criteria to reside

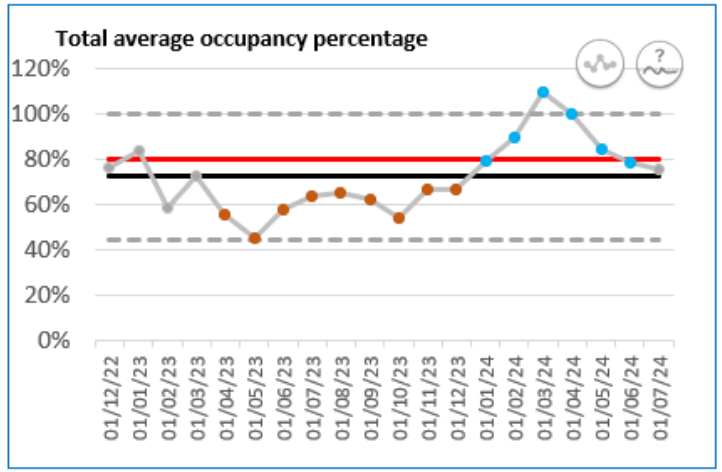


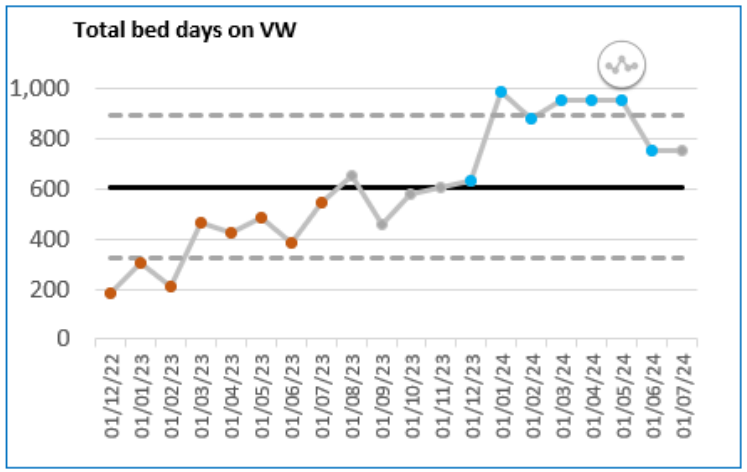


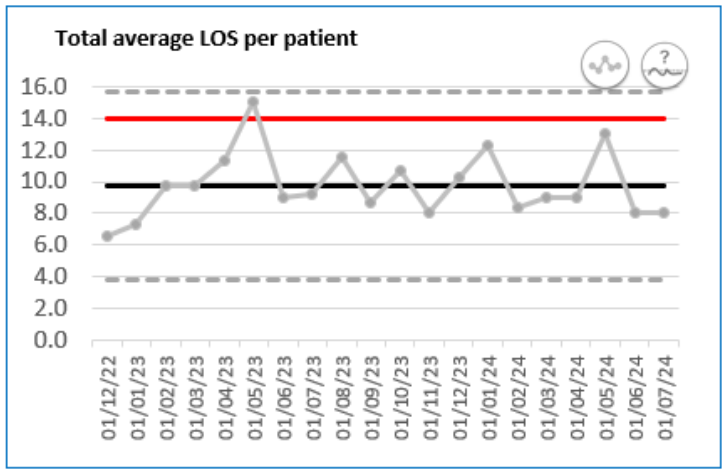


What	So What?	What Next?
The number of patients without criteria to reside in the acute has seen a slight increase in July which is reflected in the percentage moving just above the 10% target. The numbers of patients in community beds without criteria to reside increased again in July. As reported at last months meeting this continues to be a result of ongoing projects aimed at diverting patients from pathway 2 to pathway 1 and supporting more patients to return directly from the acute setting to their home environment. This has resulted in empty Community Assessment Beds (CAB's) which have been utilised by transferring 'non-traditional' CAB patients into these to support flow. The increased numbers of patients without reason to reside does not appear to be having a negative impact on overall CAB Length of stay (LOS).	Patients remaining in hospital longer without criteria to reside directly impacts on bed capacity and patient flow within the Trust. We continue to see less traditional CAB patients due to the ongoing work to convert pathway 2 patients who would have been the traditional CAB cohort to pathway 1 which has resulted in more "non-traditional" patients being transferred to community settings. The "non-traditional" cohort of patients arrive without having criteria to reside which is contributing to the increased figure we have seen in July.	Work continues on the five priority workstreams, with the overall impact of reducing patients in the Trust without criteria to reside. Highlights include: -Standardisation across CAB sites as to when a patient is deemed to no longer meet the criteria to reside and how this is determined as part of daily red to green meetings. -Focused work in CAB to reduce the time from when a patient is deemed to have no criteria to reside and is discharged -Identification of no criteria reside themes in CAB to inform workstream areas of focus. -Development of a CAB Standard Operating Procedure identification and referral mechanisms to improve timeliness of filling vacancies in CAB settings -Developing CAB exclusion checklist in order to support and streamline acceptance processes -Improving communications to manage patient and family expectation around discharge processes .



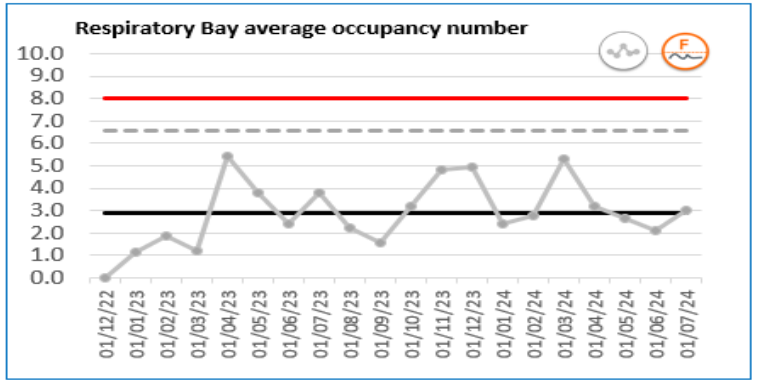


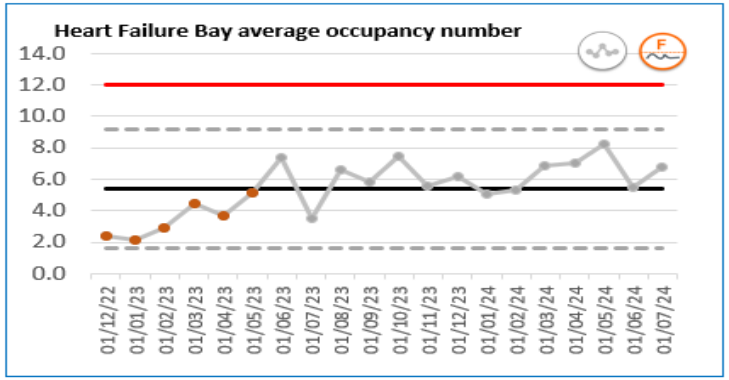


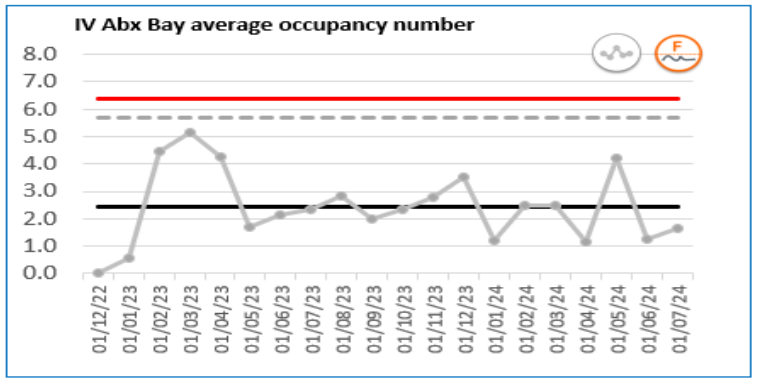


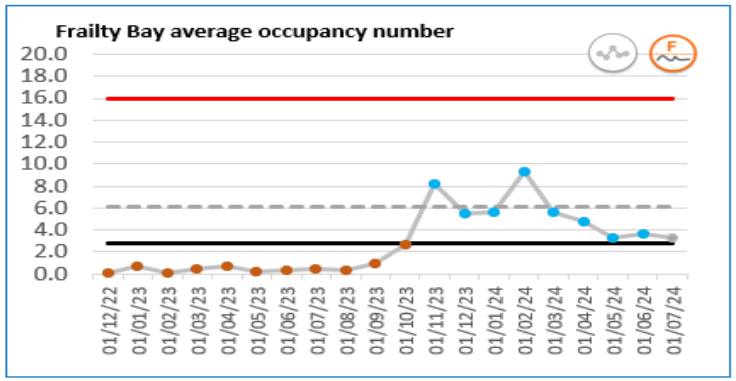
What	So What?	What Next?
Average number of patients cared for on Virtual Ward (VW), bed days occupied and average LOS were the same as the previous period despite the impact of reducing agency nursing by 50% during the second half of July. Average utilisation rate was 76% against target of 80%.	Virtual 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.	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 which will support increase in step ups from community settings. Wider rollout plan agreed.

Urgent & Emergency Care (TRUST – Virtual Ward)



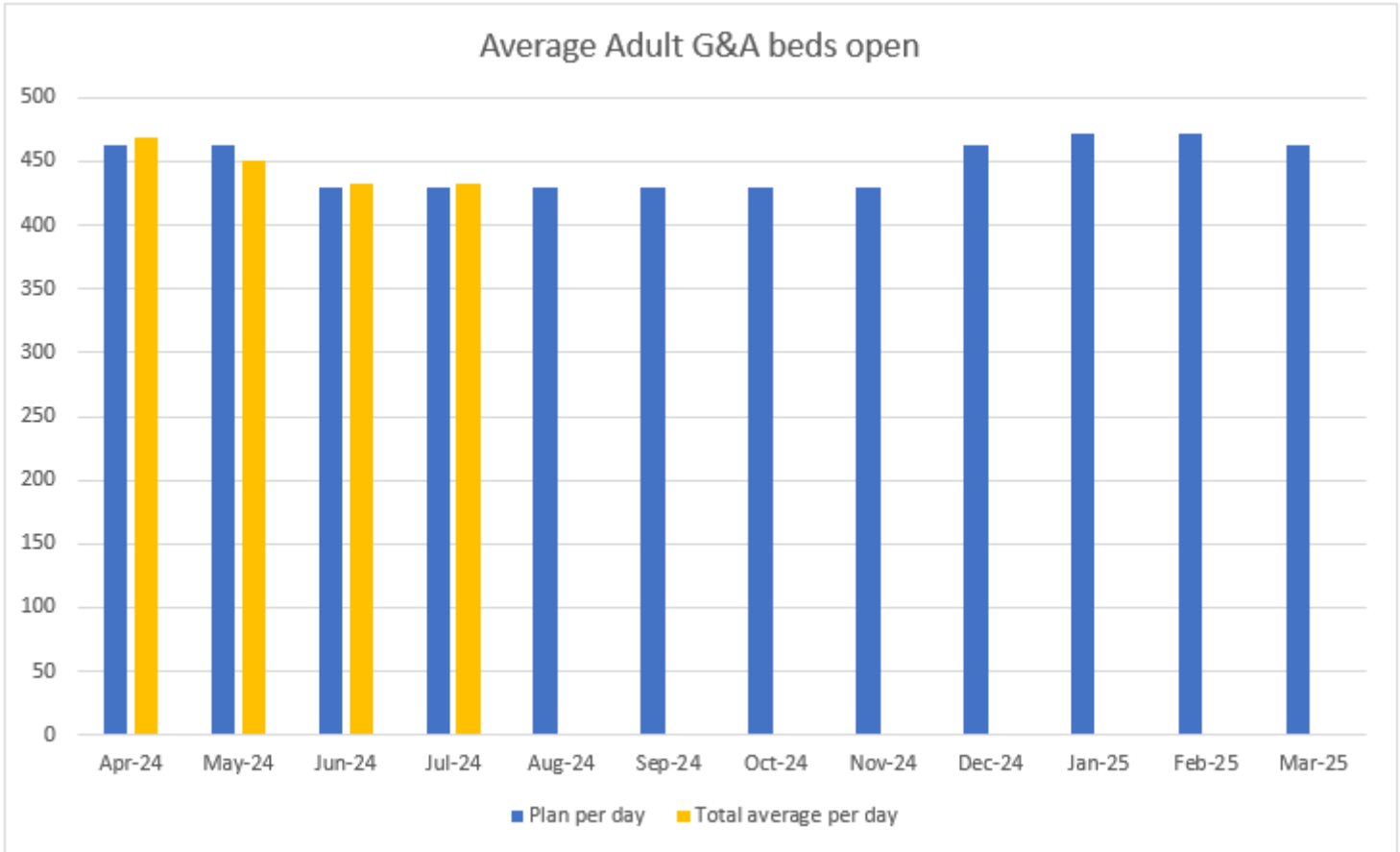




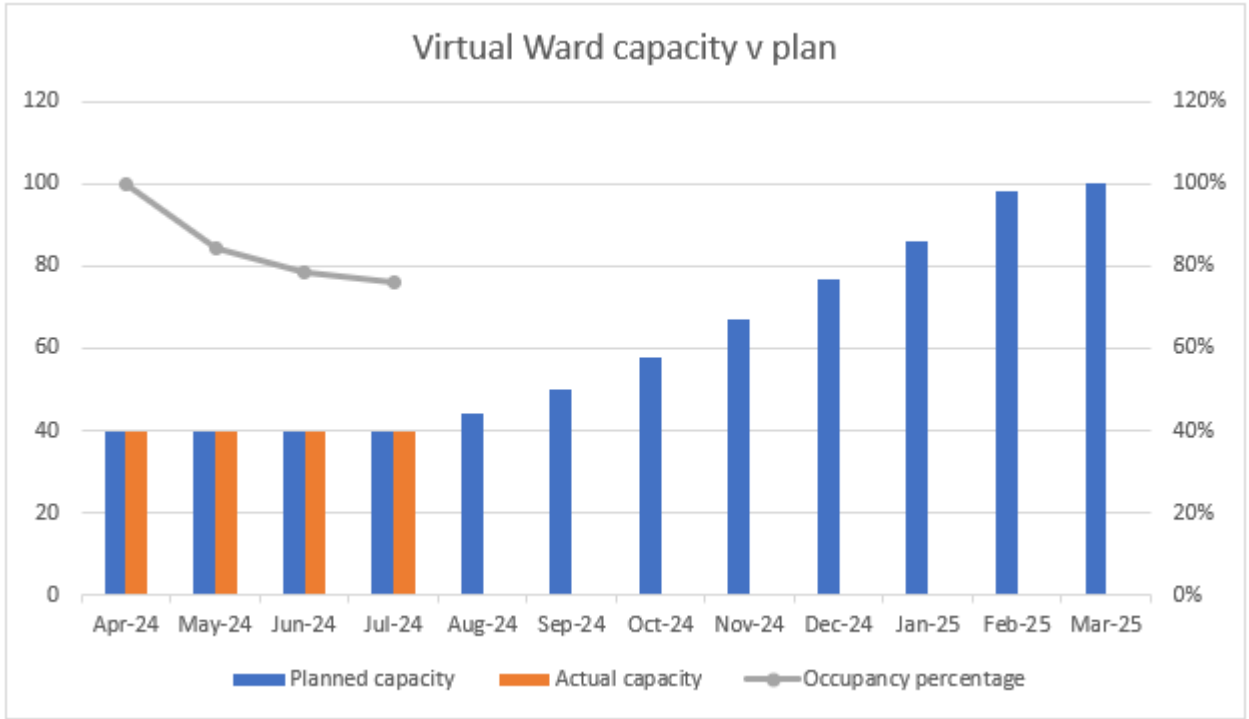


What	So What?	What Next?
Compared to June, average (ave) occupancy increased on respiratory, heart failure and Intra Venous Antibiotics (IV ABx) pathways. There was a small decrease in occupancy for frailty (3.7 June to 3.2 July). All four pathways are under monthly target: Respiratory: ave occupancy 3.0 against target of 5.0 Heart failure: ave occupancy 6.8 against target of 7.0 IV ABx: ave occupancy 1.6 against target of 4.0 Frailty: ave occupancy 3.2 against target of 6.0	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.	Key points from individual pathway development plans were provided in June PRM slides. Phased removal of agency nursing during July & August. No further investment for new posts due to Trust financial constraints. Recruitment into VW pathway teams largely completed. Impact is therefore on capacity to do nursing visits. B5 nurses new in post or recently appointed: c.7.60 WTE (c.43% of the 17.5 WTE in VW phase 2 plan). These nurses will enable the continued expansion of VW capacity until November 2024. Nurses have been recruited into INTs to enable integrated model of service delivery and release efficiencies. None of the Health Care Support Workers (HCSWs) or admin staff in VW phase 2 plan have been agreed or appointed.

Urgent & Emergency Care: Beds

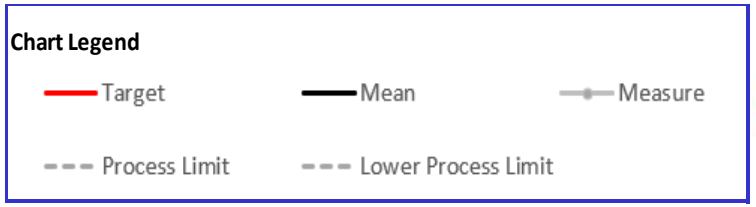


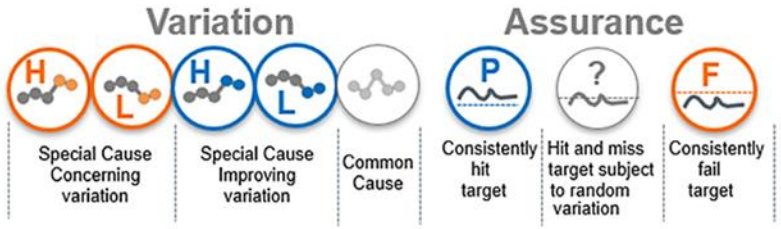
What	So What?	What Next?
Our actual average number of core beds open has decreased in line with plan, following the full closure of F9 as the winter escalation ward. We have been able to reduce the number of unfunded escalation beds open in July through following the Tactical Patient Flow Escalation Plan more robustly, though flow at times has proven challenging with multiple patients awaiting beds in the Emergency Department.	Maintaining core beds open as per plan is a key requirement of the NHS 2024/25 operational priorities and planning guidance. Delivering the plan maximises patient flow and reduces extended waits for admission from the Emergency department, contributing to reduced 12-hour waits and improved 4-hour performance. However, using escalation beds impacts on the ability of those areas being used to fulfil their primary purpose and uses unbudgeted staffing resources.	Use of Medical SDEC as an escalation area will be monitored through the daily capacity meetings in conjunction with the Medicine divisional leadership team to ensure it is in line with the Tactical Patient Flow Escalation Plan. Options for the future configuration of WSFT's General & Acute bed base were presented to MEG, in anticipation of the relocation of some orthopaedic elective activity to ESEOC. The option chosen will not increase bed numbers and therefore it is likely that the winter escalation ward will be required as per the current plan.



What	So What?	What Next?
Capacity is currently meeting target.	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.	Plans are in place to develop both capacity and occupancy as part of BAU activity. Post November, there will be no further expansion of VW capacity and therefore focus will be exclusively on occupancy. Clarity requested on Trust position re skill mixing of Phase 1 posts in line with pathway performance subject to appropriate HR process.

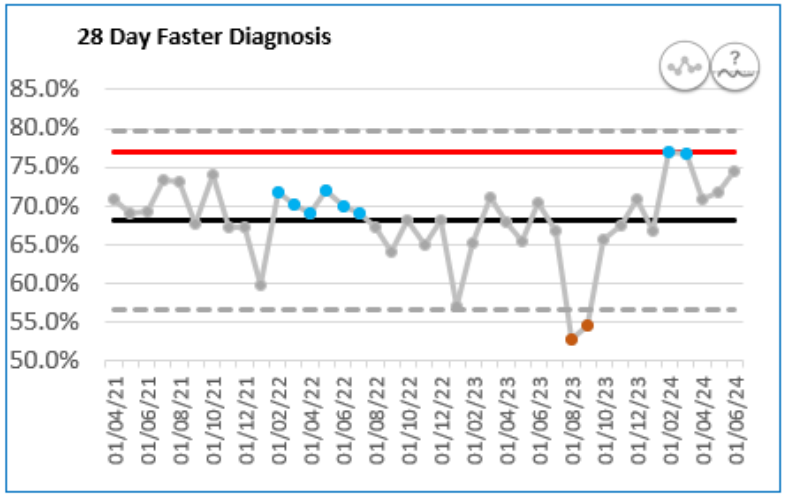
Cancer Access Summary

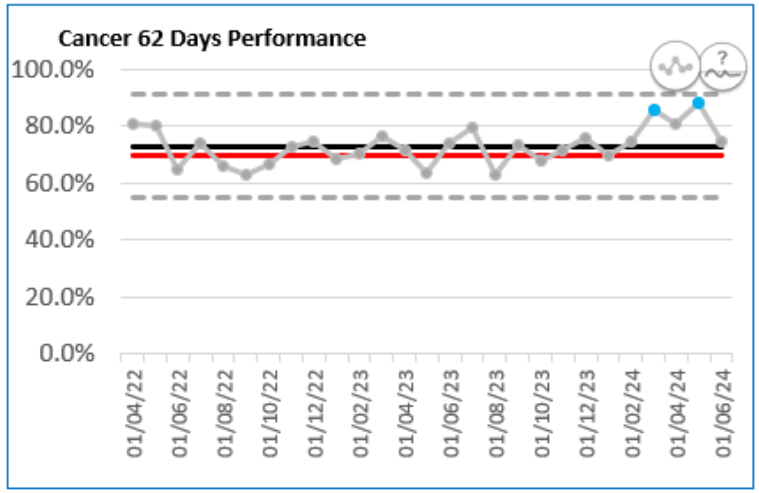


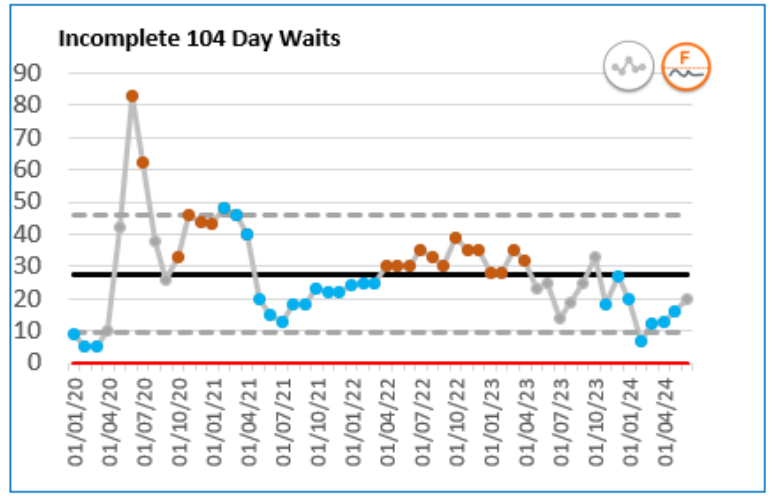


KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
28 Day Faster Diagnosis	Jun 24	74.5%	77.0%			68.2%	56.6%	79.7%
Cancer 62 Days Performance	Jun 24	74.8%	70.0%			73.1%	54.9%	91.2%
Incomplete 104 Day Waits	Jun 24	20	0			28	10	46

Cancer Access (Month Behind)

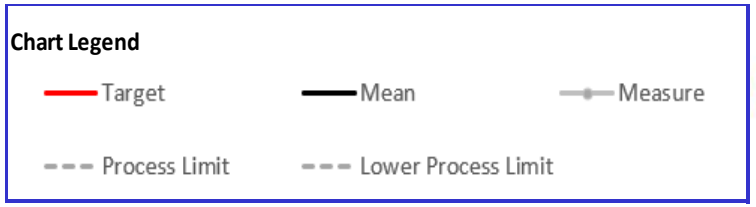


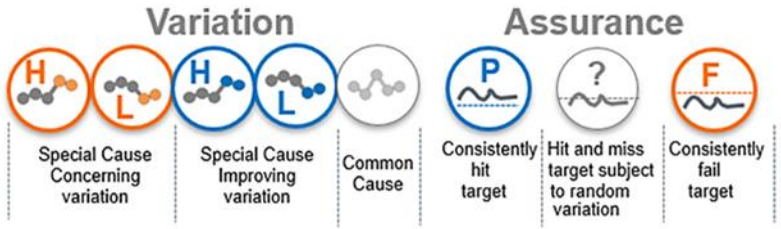




What	So What?	What Next?
Performance against the 28-day Faster Diagnosis Standard (FDS) is not being consistently met, however there was an increase in June 2024 to 74.5% against a target of 75%. The 62 day performance is above trajectory and above the national requirement of 70% by the end of March 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 with FDS steering groups in Skin, Colorectal, Breast and Gynae to monitor performance and required transformational changes as guided by the BPTP audits. Review the impact of the changes made in the skin pathway, such as reducing to one lesion and removing second review of benign lesions via AI. Work commencing on the future of the community pathway from March 2025. Implementation of post menopausal bleeding (PMB) pathway for people receiving HRT to be managed outside an Urgent Suspected Cancer referral by Q3. Implement risk stratification tools in Prostate to reduce unnecessary progression to MRI and/or progression to biopsy and/or progression to treatment regimens by Q3. Review radiological support to the Breast clinics, with external support withdrawing from October 2024 there is significant risk to delivery.

Elective Access: Summary

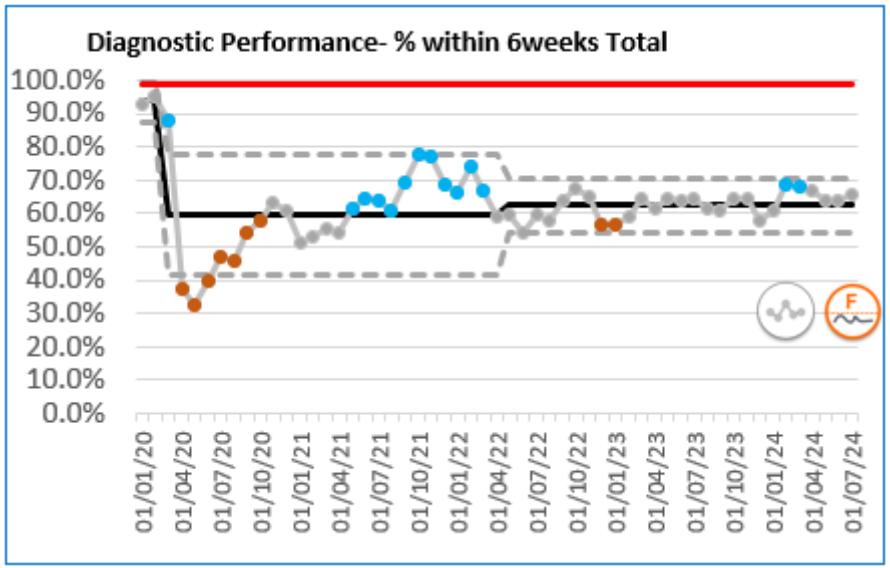




KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
RTT Waiting List	Jul 24	34703				32754	31377	34131
RTT 65+ Week Waits	Jul 24	510				505	332	677
RTT 78+ Week Waits	Jul 24	52	0			162	91	234
Potential 65+ ww at end of Sept 2024	Jul 24	1312	0			2376	279	4473

Community Paediatrics RTT Overall Waiting List	Jul 24	483	-			501	452	549
Community Paediatrics RTT Overall 52 Weeks Wait	Jul 24	0	-			1	-2	4
Community Paediatrics RTT Overall 65 Weeks Wait	Jul 24	0	-			0	0	1
Community Paediatrics RTT Overall 78 Weeks Wait	Jul 24	1	0			0	0	0
Community Paediatrics RTT Overall 104 Weeks Wait	Jul 24	0	0			0	0	0
RTT NDD Only Waiting List	Jul 24	62	-			79	53	105
RTT NDD Only 52 Weeks Wait	Jul 24	0	-			0	0	0
RTT NDD Only 65 Weeks Wait	Jul 24	0	-			1	0	2
RTT NDD Only 78 Weeks Wait	Jul 24	0	-			0	-2	2
RTT NDD Only 104 Weeks Wait	Jul 24	0	-			0	0	0

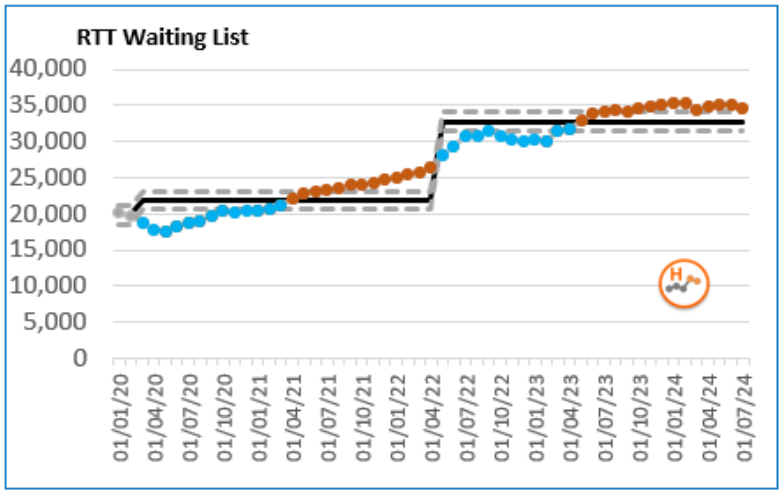
Elective Access

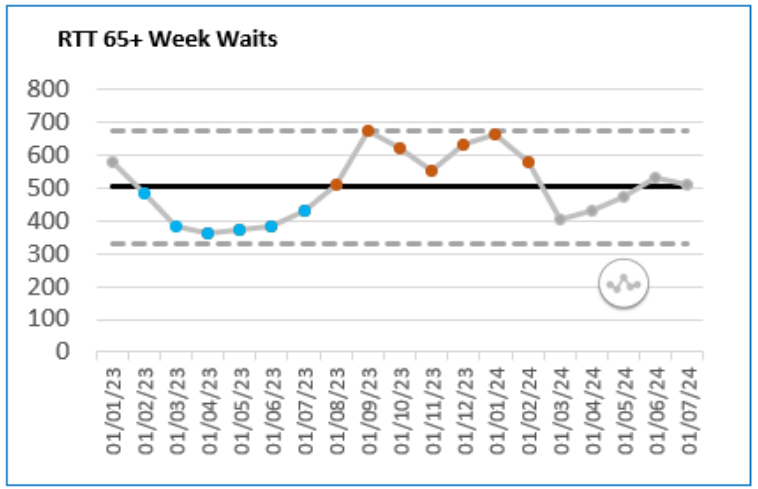


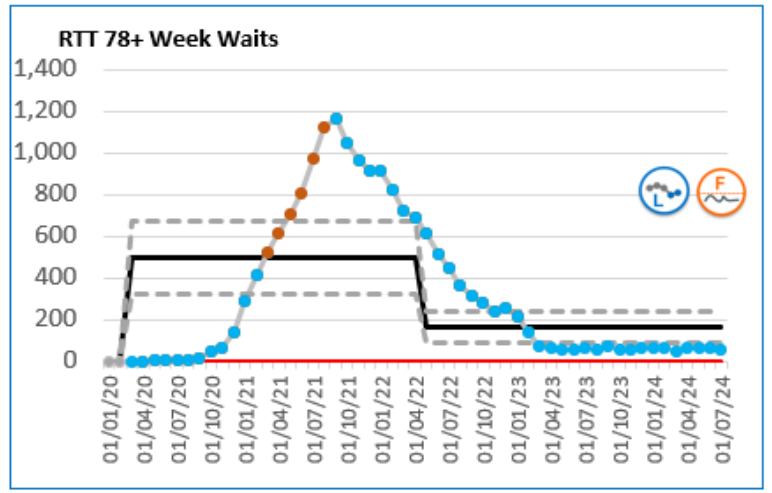
Diagnostics

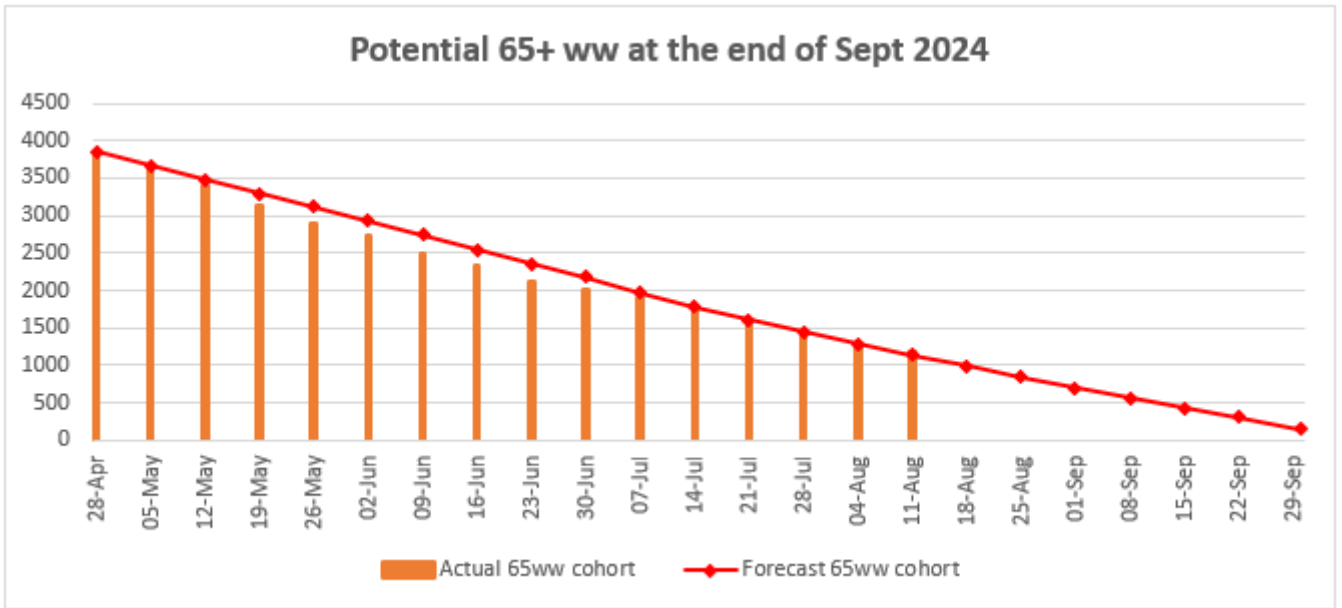
What	So What?	What Next?
Audiology - saw a 9.1% improvement in month, driven by validation, ENT secretaries having received training to support this activity during staff long term sickness. The DM01 trajectory has been refreshed, compliance expected in March 2025 as previously indicated, recognising a further sound-proofing room is required, a plan in train for Newmarket. **Urodynamics** and **cystoscopy** are still trending upwards, the recruitment of a new urology CNS supporting ongoing improvements, refreshed urology trajectories indicating compliance in January 2025. We are interviewing three fixed term consultants on 9th September which will further support diagnostic attainment. **MRI** – Common cause consistently failing target. Running at full capacity across seven days but current capacity insufficient. MRI 2 replacement programme commenced 27/11/23 is now completed but has a legacy impact on performance. There has been an additional small uplift in activity due to staff undertaking additional hours. This is not a sustainable capacity increase and there are staff welfare issues associated. MRI capacity will continue to deteriorate until the commencement of scanning at the CDC due to demand continuing to exceed capacity. **CT** – Currently not meeting DM01 compliance target due to impacts of the replacement programme. Our current DM01 position in lower than previously anticipated. This is due to and increase in inpatient and UEC demand displacing DM01 activity and impacting capacity for the longer waiting patients. A utilisation review has identified an opportunity for an additional 5 patients per week. **US** – A step increase in the recovery trajectory can be observed but has plateaued and remains statistically insignificant. Increased inpatient and UEC demand is compounded by recruitment challenges within the team. Performance remains vulnerable until recruitment improves. **DEXA** – It is still anticipated that we will be able to go live with our DEXA service in November 2024 to be sited at Newmarket Hospital, ceasing our contract with the mobile DEXA provider on go live. We await confirmation that we can extend the current mobile service for 3 months to cover this gap. **Endoscopy** – Priority has been given to patients on a cancer pathway requiring a rebalancing of capacity to support. Performance impacted by IA. Cohort of low complexity, low risk patients suitable of 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 March 2025 ambition of 95%. Additional activity delivery will be required to meet this target. A deep dive presentation was given to the Elective Care Programme Board (ECPB) in August and WSFT plans and trajectories were noted. Overall diagnostic performance may be impacted by financial recovery measures and workforce controls.	We continue to prioritise diagnostic activity for those most clinically urgent, using the space and staffing resource we have available as flexibly as possible. We continue to seek ways to improve the care we provide, enabling improved performance. Longer waiting times for diagnosis and treatment have a detrimental effect on patients. Delay in achieving DM01 compliance standards.	• Ongoing ENT secretary validation of audiology waiting list • Further development of Newmarket plan, site visit undertaken. • Introduction of further risk stratified pathways to reduce demand/triage. • Liaison with CUH regarding opportunities for joint working, there being an established relationship • Development of long-term workforce plan for urology and further exploration of provider collaboration- away day 26th July • Consultant recruitment 9th September 2024 • New urology CNS embedding into team, delivering urodynamic clinics **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 Q4 of 24/25 supported by CDC capacity. **US** – Staffing issues remain unresolved, and CDC capacity will not be realised until recruitment picture improves. Management team continue to review recruitment options aligned to CDC and cognisant of the workforce controls in place around financial recovery. **DEXA** – Once open the new service will increase DEXA capacity from 3 days per month to 3 days per week once staff are trained and the service is up and funning fully. This will allow quick recovery of DEXA DM01 compliance. **Endoscopy** – Anticipated compliance with the DM01 target ambition of 95% by March 2025. Actions focussed on increasing NE opportunities and review of core job planned capacity for medical and surgical consultant endoscopists. Alongside further work on reducing DNA's and increased productivity. Assessment being undertaken to understand how ERF might support increased insourced capacity and income generation. Work under way to remove constraints on the flexi banding pathway, the Endoscopy User Group has met and agreed a trial to increase points per list, further opportunities for increased general surgical support to endoscopy have been agreed with the surgical division. Financial recovery measures may impact additional hours worked to deliver performance improvements against the DM01 standard across multiple modalities. Further work is required to deliver core serviced on a sustentive staffing model rather than historic temporary staffing arrangements especially around core OOH acute service provision.

Elective Access: RTT



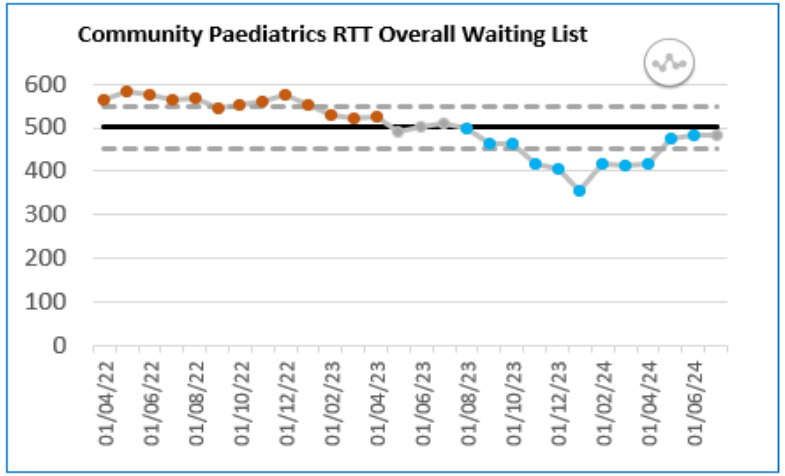


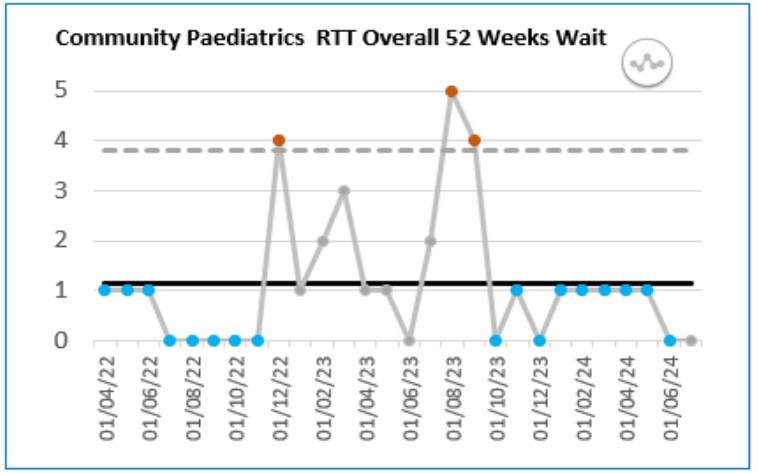


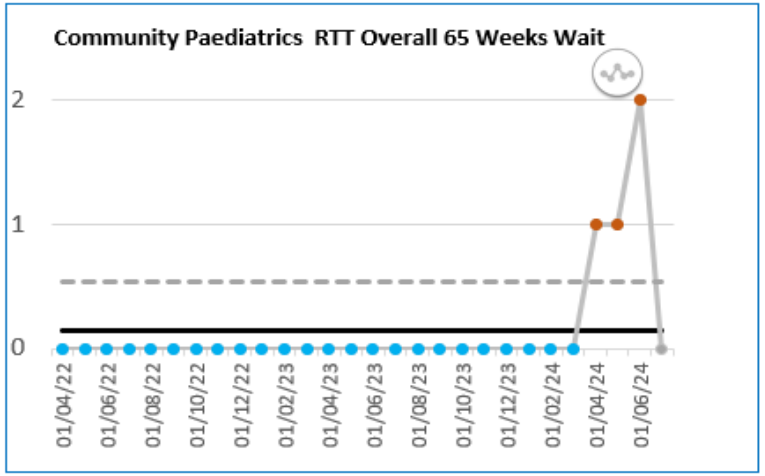


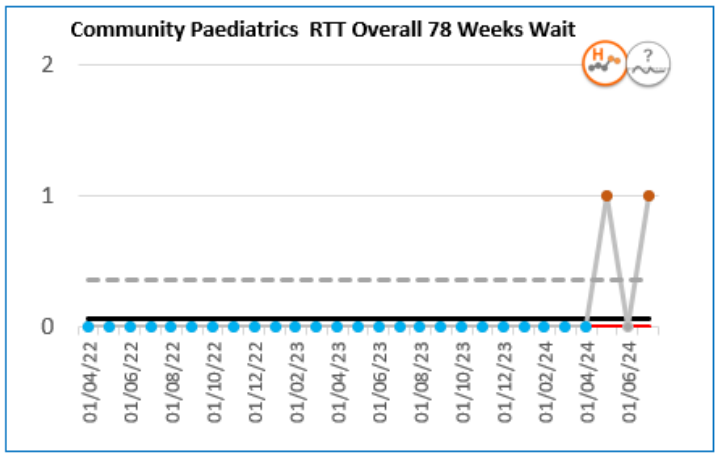
Elective Access: RTT

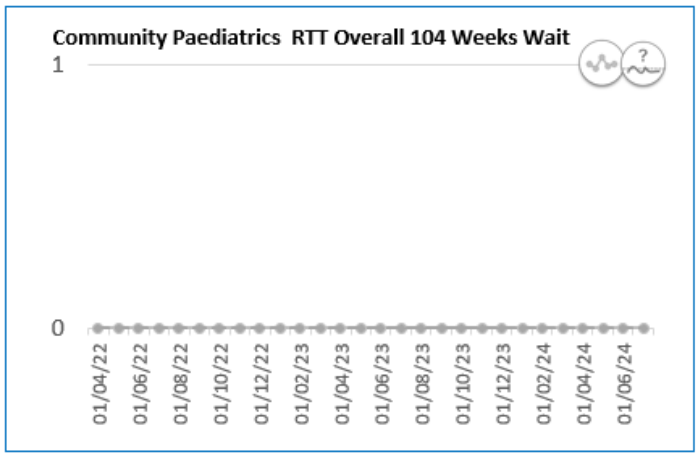
What	So What?	What Next?
The 78 week wait position for the end of July was 52 patients, with the majority within the sub speciality of Urogynaecology. At the end of July, we are on trajectory for our 65 week wait cohort. There are however a number of specialities which are slightly above trajectory including Gynaecology, Orthopaedics and Plastics. There is mitigation in place for Orthopaedics and Plastics to reduce this gap but limited options for Gynaecology. There are currently 47 patients in total without a plan within Urogynaecology specifically. 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.	Additional weekend lists are in place throughout the summer months. Continued focus on both data quality and administrative validation to ensure all patients still require their treatment.











What	So What?	What Next?
The impact of receiving and managing the backlog of neurodevelopmental (NDD) assessments for autism in school age children has increased waiting times within the service. Increased new referral numbers for this pathway in July. The longest waiters are being managed by outsourcing assessments within the ICB funded recovery plan (activity not shown on this slide until complete). The longest waiter shown above 78wks was sent from coordination provider but needs to be seen by our paediatricians rather than outsourced. In addition to the NDD pressure, the paediatric team continue to see increasing complexity with preschool pathway and in rising caseloads.	Children continue to wait longer for school age autism assessments due to high demand. 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 but this is challenging to manage responses. Children continue to be prioritised according to clinical need. Insufficient clinician capacity to triage volume of referrals received in usual timescale	Due to a high acceptance rate for school age autism assessments there is insufficient funding to clear the backlog of longest waiting children. ICB have agreed in principle to the additional funding needed (Circa 250k) and this will be agreed via contract meeting. Structured discussion with ICB to review paediatric capacity pressures in the context of the new NDD pathway proposals.

Elective Recovery Fund (ERF) threshold achievement

NHS England - 24/25 (Monthly - IQPR)

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

West Suffolk NHS
NHS Foundation Trust

All

All

Outpatient First

Mon	23/24	ERF	24/25	Var %
Apr	9,544	10,332	10,278	(0.5%)
May	9,660	10,457	10,314	(1.4%)
Jun	9,090	9,840	9,851	0.1%
Jul	10,165	11,004	10,630	(3.4%)
Aug	8,967	9,707		
Sep	9,544	10,332		
Oct	10,453	11,316		
Nov	9,891	10,707		
Dec	8,744	9,465		
Jan	10,345	11,199		
Feb	9,205	9,965		
Mar	9,365	10,138		
Total (YTD)	**38,459**	**41,634**	**41,073**	**(1.3%)**

July 2024

23/24	10,165
ERF	11,004
24/25	10,630
Var	(374)
Var %	(3.4%)

Daycase

Mon	23/24	ERF	24/25	Var %
Apr	2,191	2,373	2,435	2.6%
May	2,245	2,431	2,570	5.7%
Jun	2,084	2,257	2,265	0.4%
Jul	2,364	2,560	2,611	2.0%
Aug	2,109	2,284		
Sep	2,245	2,431		
Oct	2,459	2,663		
Nov	2,408	2,608		
Dec	2,056	2,227		
Jan	2,420	2,621		
Feb	2,219	2,404		
Mar	2,241	2,428		
Total (YTD)	**8,883**	**9,621**	**9,881**	**2.7%**

July 2024

23/24	2,364
ERF	2,560
24/25	2,611
Var	51
Var %	2.0%

Outpatient Follow Up

Mon	23/24	ERF	24/25	Var %
Apr	25,352	27,046	27,924	3.2%
May	25,659	27,373	28,140	2.8%
Jun	24,145	25,758	26,476	2.8%
Jul	27,000	28,804	27,886	(3.2%)
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)	**102,15**	**108,980**	**110,426**	**1.3%**

July 2024

23/24	27,000
ERF	28,804
24/25	27,886
Var	(918)
Var %	(3.2%)

Elective

Mon	23/24	ERF	24/25	Var %
Apr	256	277	270	(2.5%)
May	267	289	291	0.8%
Jun	247	267	232	(13.1%)
Jul	280	303	277	(8.7%)
Aug	256	277		
Sep	256	277		
Oct	284	307		
Nov	268	290		
Dec	249	269		
Jan	234	253		
Feb	244	264		
Mar	244	264		
Total (YTD)	**1,050**	**1,136**	**1,070**	**(8.7%)**

July 2024

23/24	280
ERF	303
24/25	277
Var	(26)
Var %	(8.7%)

Outpatient attendances that are a first attendance or with a procedure

All

All

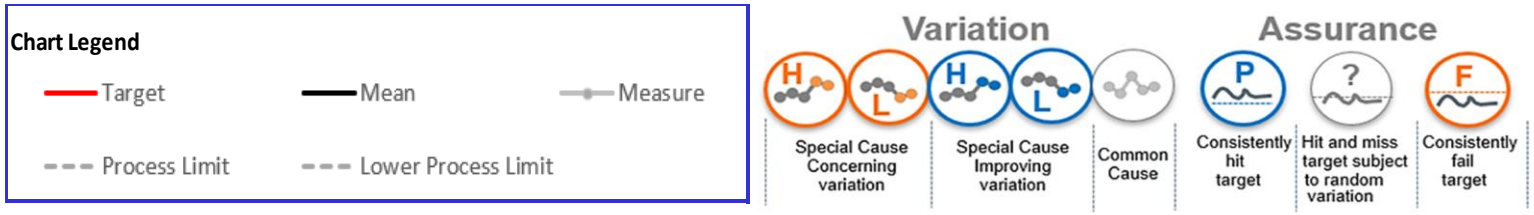
Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
23/24	37.4%	36.4%	36.6%	37.7%	37.9%	37.8%	35.9%	35.0%	36.3%	36.2%	37.1%	37.7%	**36.8%**
24/25	37.2%	36.2%	36.4%										**36.6%**

Target	**46.0%**
Month	**37.2%**
YTD	**36.6%**

Elective Access: Activity

What	So What?	What Next?
Day cases are meeting the required threshold to deliver the system level activity target of 108.09% of 2019/20 activity levels, however elective activity is 9% under in July, only slight improved on June. Outpatient follow ups have dropped below 2019/20 levels in July, having been over between April and June. These do not attract ERF unless they include a procedure. Outpatient attendances that are a first attendance or with a procedure show no significant change from the 2023/24 average.	Although achievement is measured in terms of value and at a system level, increasing absolute activity is required to achieve Elective Recovery Fund income and deliver on the objective to eliminate waits of >65 weeks by September 2024. Although there is no specific requirement to deliver a reduction in outpatient follow ups this year, doing so will support delivery of the other modalities on which the Elective Recovery Fund threshold is based and will support the new ambition of 46.2% of outpatients to either be first attendances or with procedures.	**W&C:** Financial support to gynae outpatient nursing business case required to maximise clinic usage, alternatives being explored including video clinics and Newmarket. Proposal to close lists that cannot be staffed has not impacted urogynae 65- week but effects are being experienced in other gynae subspecialties with the closure of day surgery unit lists. This is resulting in rapid access day case procedures being undertaken in main theatres. **Medicine:** • Increased operational support to increase outpatient clinic utilisation and booking rates with a focus on 65 week patients. • Additional respiratory new patient clinics to continue through August, focusing on new patients utilising resource of new consultant. • Further additional clinics to be booked in Gastro and Diabetes with long waiting lists. This is over the summer period to ensure activity remains high. **Surgery:** • Reinforcement and monitoring of Patient Initiated Follow Up. • Focus of efficiency project has commenced, plastics and ophthalmology, with positive impact seen. • Conversion of 2 follow up to new, or additional new appointment added to each clinic from August. • HVLC lists to be cohorted and booked to 100%. • 21 weekend lists booked until end October. • Formalisation of anaesthetic obstetric clinics delivering outpatient first attendances.

IMPROVEMENT COMMITTEE METRICS



KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
C-Diff Hospital & Community	Jul 24	11	0			7	-2	15
% of patients with Measured Weight	Jul 24	96.3%	-			90.2%	85.5%	95.0%
% of patients with a MUST/PYMS assessment completed within 24 hours of admission	Jul 24	90.2%	-			89.6%	82.6%	96.5%
% of patients with a MUST/PYMS assessment completed within 48 hours of admission	Jul 24	96.3%	-			93.2%	89.0%	97.3%
Post Partum Haemorrhage	Jul 24	8	-			8	-2	17

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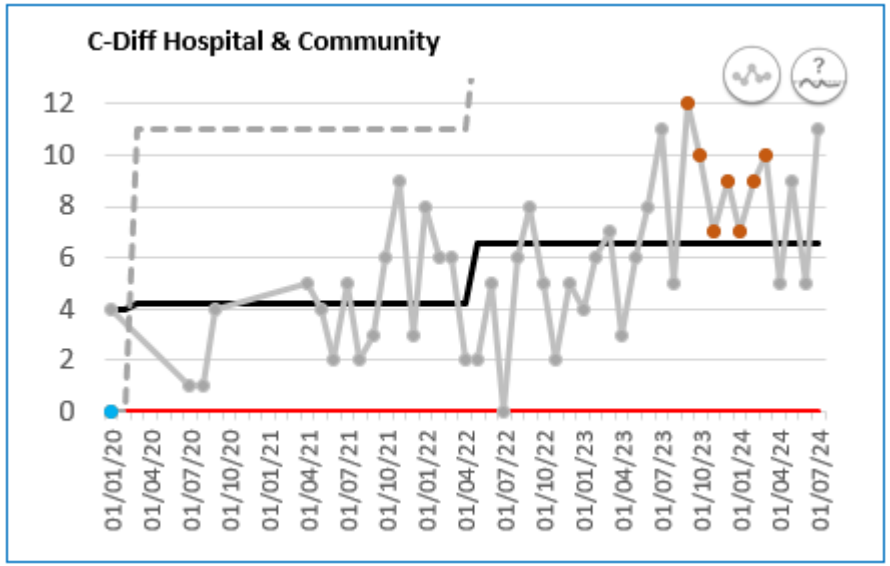

What	So What?	What Next?
There has been no significant reduction in rates since September 2023 due to the multifaceted issues surrounding *Clostridioides difficile* infection and therefore do not expect to see a significant change in performance for some time following the commencement of the quality improvement programme. The threshold set combines HOHA & COHA cases which provides the organisations measure for national/regional data and better demonstrates the impact on our patient group. It is recognised Nationally that the rates of *Clostridioides difficile* have increased significantly over the last two reporting years. Review of Ribotypes for 2024-25 cases; 26 patients, 18 different Ribotypes	Healthcare-associated infections (HCAIs) can develop either as a direct result of healthcare interventions such as medical or surgical treatment, or from being in contact with a healthcare setting. HCAIs pose a serious risk to patients, staff and visitors. They can incur significant costs for the NHS and may cause significant morbidity to those infected. As a result, infection prevention and control is a key priority for all NHS providers. The NHS Standard Contract 2024/25: Minimising Clostridioides difficile is now published with a WSH threshold of 91 (increased from 49 2023-24)	The situation is complex and has been identified as an organisational key priority, with escalations via patient quality & safety group and the improvement committee. The Quality Improvement Programme will run for at least 12 months once the measures are agreed. There are six subgroups which all have leads identified and are active. Some actions: • Environment & cleaning – Proposal to enhance clean ED & AAU, logistics & process to be confirmed – September 2024 • Audit & Governance – review of policies and guidelines. Currently working with Ecare team to support with audits with monthly report provision (form browser for Bristol Stool Chart) • CDI retrospective analysis report is currently under analysis, report currently being written – August 24 • Other work streams – review of Ribotypes & GP area association – timeline in progress September 2024. ICB to contact the Field Epidemiology Service with current observations – followed by community pharmacist for Suffolk & North-East Essex for antimicrobial education – discuss with ICB – August 2024

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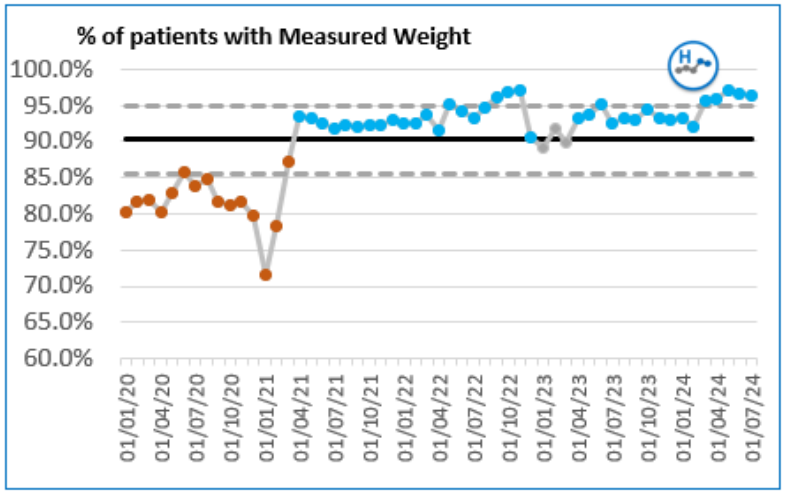

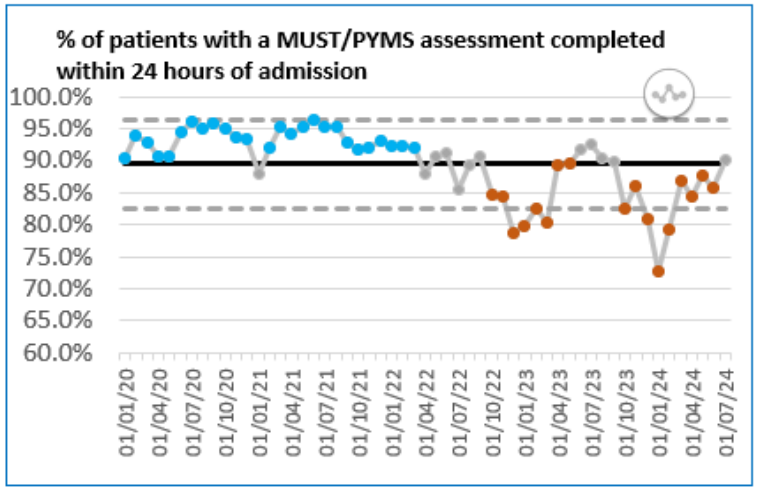

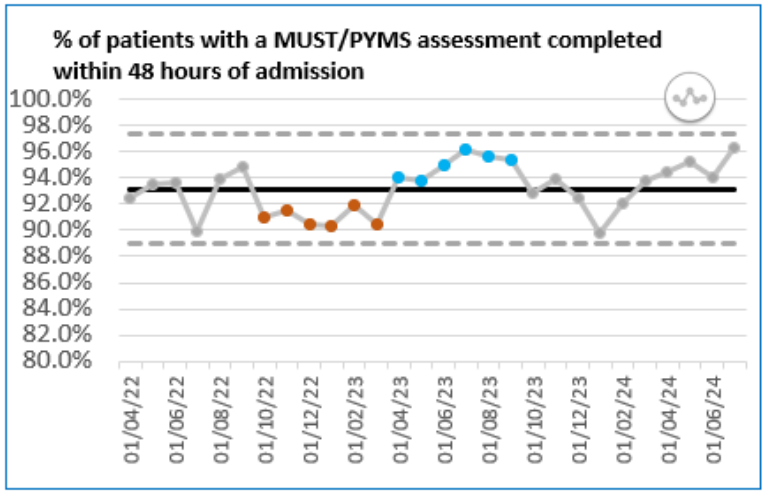

What	So What?	What Next?
All aspects of Nutrition are monitored via the audit process and also through patient feedback. This is an area for continual improvement and raising awareness of the importance to the teams. MUST assessment within 24hours has steadily increased since January 2024 although not yet a sustained improvement. MUST score completion within 24 hours at 90% target for July. It is challenging for teams to achieve weighing patients and completing the full nutritional assessment within 24hrs, if the patient is delayed in the Emergency Department, awaiting a ward bed. To mitigate this and identify risk earlier, the ED team are introducing a short assessment to support patient care and enable intervention if delays are occurring in admission to wards.	Nutrition and hydration is a fundamental element of care and continues to be an area of focus and improvement for all the teams in the Trust. There is improved awareness that this will underpin a positive experience and outcome for the patients in our care. There are plans in place to renew the reporting process to capture the timeliness of assessments when patients are admitted to a ward. This will provide teams with the opportunity to improve the compliance and accuracy of this important metric and earlier identification of risk. There are recurrent delays in receiving this data set due to issues with the data warehouse implementation. Confirmation of a start date for this remains outstanding and has been escalated.	• Monitor introduction of short assessment in ED and observe the impact on this – October 2024 • Information team to change reporting metrics to ensure each ward area is being accurately monitored for compliance – To seek assurance and gain a start date for this – Escalated May 24, Aug 24 • Continue to share the data with teams monthly to provide awareness to the teams where areas of improvement need to be made or highlight improvements made • Monitor for incidents or complaints raised regarding nutritional intake or support at department level to gain assurance. • 'Food is medicine' workshop to be delivered in September 2024 a collaboration between nursing and estates team

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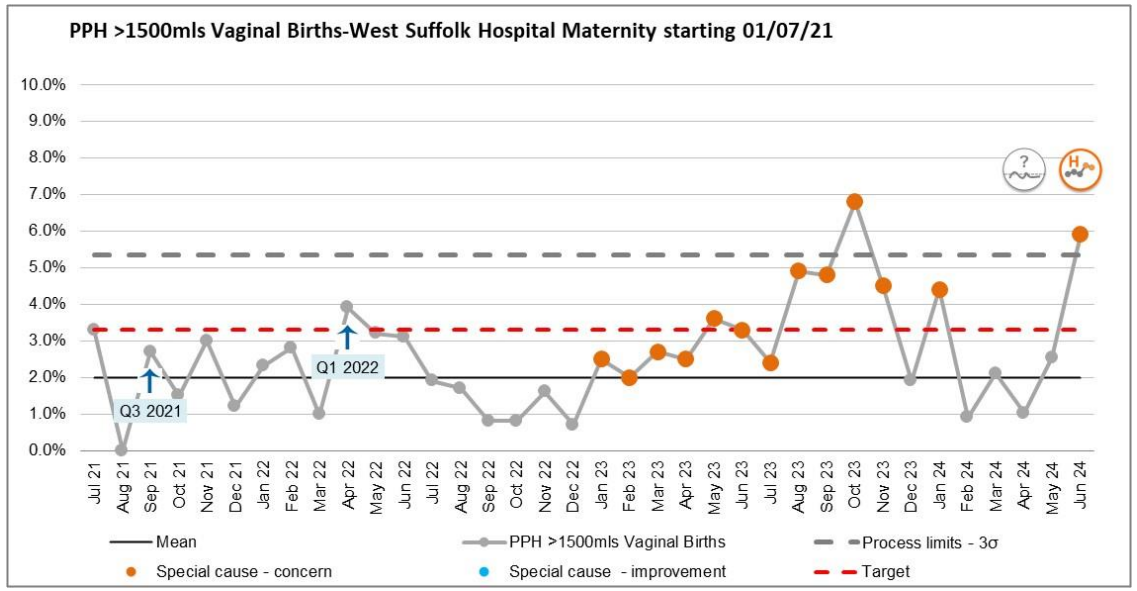
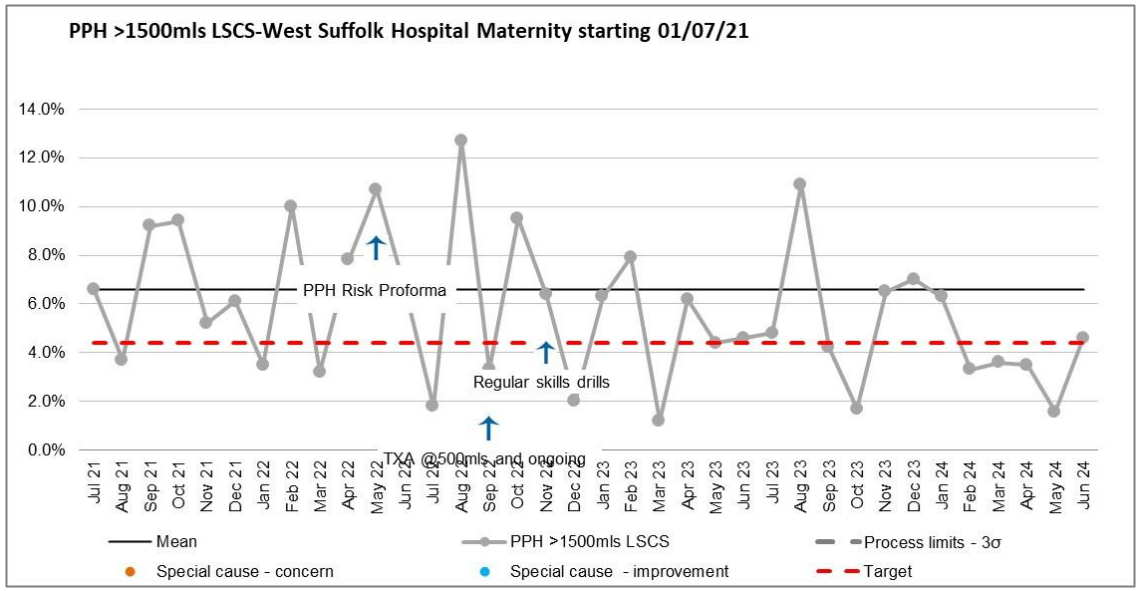




What	So What?	What Next?
Post-partum Haemorrhages (PPH) (>1500 mls) for Lower Section Caesarean Sections (LSCS) and Vaginal Births. The NMPA (National Maternity and Perinatal Audit)targets based on 2022 data are not being consistently met.	Severe bleeding after childbirth - postpartum haemorrhage (PPH) - is the leading cause of maternal mortality world-wide. Each year, about 14 million women experience PPH resulting in about 70,000 maternal deaths globally (WHO 2023) PPH is one of the most common obstetric emergencies and requires clinical skills, with prompt recognition of the severity of a haemorrhage and emphasise communication and teamwork in the management of these cases. Following a PPH there is the potential increase of length of stay and additional treatment and financial implications for the organisation and family. Family bonding time is affect as well as subsequent related issues for example; postnatal depression, establishing breast feeding etc.	Quality Improvement 3rd cycle launched 5 workstreams identified; Anaemia, Training, Risk, Equipment/Estates and Medication Continue engagement with Local Maternity and Neonatal System and Regional QI projects regarding PPH Undertake 'so what' review, in relation to PPH The Regional team to remove the NMPA targets and monitor regional trends.

Regional year to date data- June 2024

Safe

NHS England East of England

Maternity Data - East of England Collection

Site: Regional Year to date view

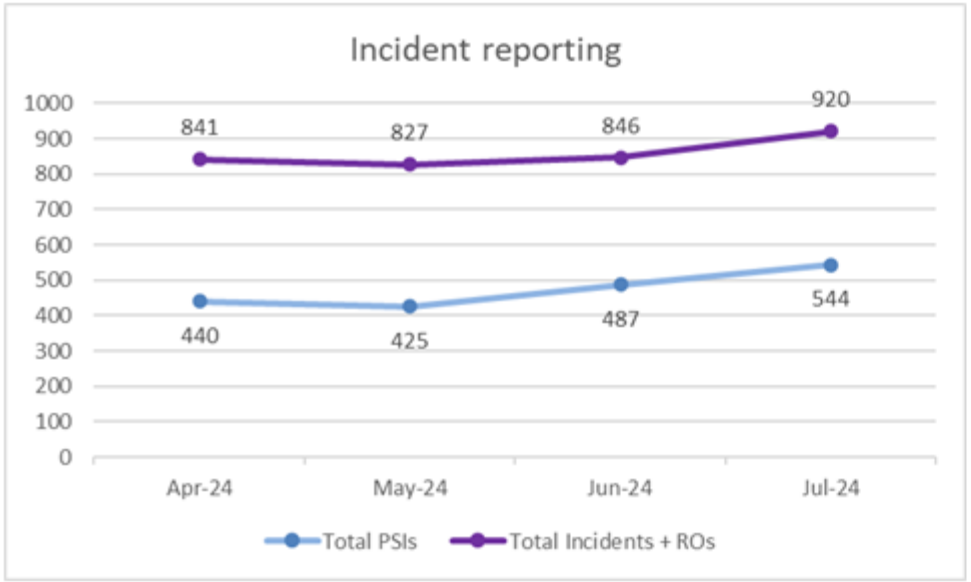
Metrics in grey are automatically calculated

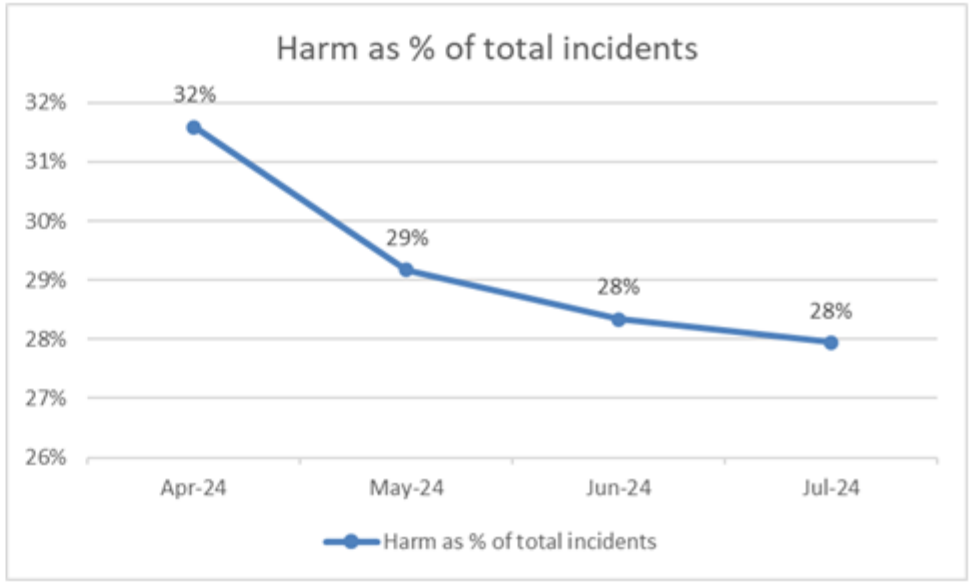
These figures represent to compiled 'Year to date' of each measure from April 2024. Trust in size order by births to aid valid comparison

Metric	Metric ID	Description	Target	C&P Addenbrooke	BLMK Luton and	N&W Norfolk and	H&WE East and	MSE Broomfield	H&WE Watford	H&WE Princess	MSE Basildon	C&P Peterborou	BLMK Milton Keynes	SNEE Colchester	SNEE Ipswich	MSE Southend	BLMK Bedford	SNEE West Suffo	N&W Queen	C&P Hinchingbro	N&W James Paget	Regional year to date
MOH ≥ 1500mls	MH001	All single, term, vaginal births		802	700	698	558	544	597	505	493	493	448	799	447	437	356	318	268	310	203	8976
	MH002	Single, term, vaginal births - with Massive Obstetric Haemorrhage		34	20	27	23	30	24	22	16	15	12	20	12	7	3	10	6	16	5	302
	MH003	% Vaginal Birth - Massive Obstetric Haemorrhage		4%	3%	4%	4%	6%	4%	4%	3%	3%	3%	3%	3%	2%	1%	3%	2%	5%	2%	3.4%
	MH004	All single, term caesarean births		460	588	408	423	365	367	365	387	387	363	303	245	280	241	186	160	169	149	5846
	MH005	Single, term caesarean births -with Massive Obstetric Haemorrhage		16	16	17	11	11	15	9	11	9	23	16	7	6	4	6	8	5	5.0	195
	MH006	% Caesarean birth - Massive Obstetric Haemorrhage		3%	3%	4%	3%	3%	4%	2%	3%	2%	6%	5%	3%	2%	2%	3%	5%	3%	3%	3.3%

What	So What?	What Next?
The above data is submitted to the regional team from individual maternity units. The NMPA targets have been removed by the Regional team. Massive Obstetric Haemorrhage (MOH) rates at the WSFT are in line with regional average (financial year to date).	This demonstrates WSFT performance benchmarked against all other trust in the region	Continue engagement with Local Maternity and Neonatal System and Regional QI projects regarding PPH Continue to monitor

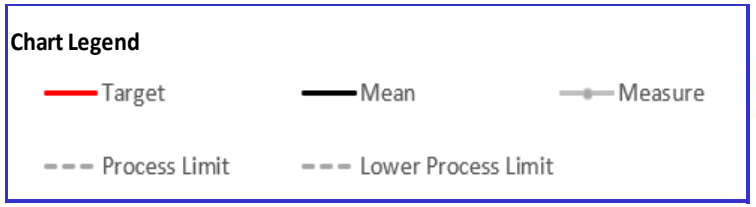
Safe

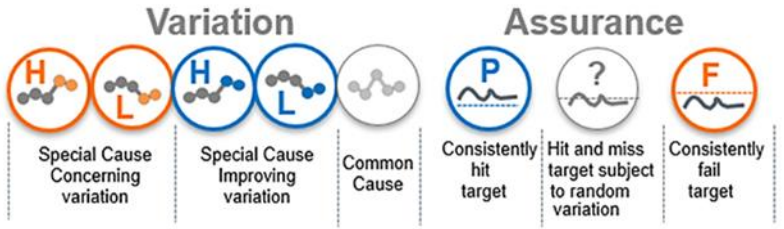




What	So What?	What Next?
New indicators 1 + 2: Total incidents + ROs / Total PSIs reported This provides a measure of system usage. We are aiming for a high number which shows a good reporting safety culture. Although the figures remain consistent, it is recognised that currently the overall rate of reporting on Radar is currently lower than previously on Datix which is attributed to the use of a new risk management system in the Trust. There has been an IT fault which has subsequently been fixed and some system issues to save and complete an incident report form which has impacted on the overall reporting. An online training programme was developed and accessible for all staff on Totara. 'At the elbow' support is available for colleagues from the patient safety team. New indicator 2: Harm as a % of total PSIs reported This provides a measure of safety and we are aiming for a low percentage. A healthy reporting culture will report near miss / no harm incidents regularly to enable system learning. This measure is provided at a regional level to our ICB. This is a measure of all patient harm (not just serious harm). There remains insufficient data to make any meaningful conclusions at this time but all measures will be kept under close scrutiny as part of the reporting to PQASG.	Incident data from April 2024 is not comparable with that previously included in the IQPR and therefore we cannot make direct comparison because we are using two different systems. In addition, incidents are now reported across two 'event types' : Incidents and Reportable occurrences (ROs). For this reason, the SPC charts cannot be produced until there are sufficient data periods to use the 'making data count' methodology.	The patient safety team are working closely with colleagues to ensure the timely and accurate reporting of PSI and RO, providing guidance and support. A training package was developed to assist colleagues to report and investigate incidents on the Radar system and the Radar team are assisting colleagues by aiding and triaging requests which are submitted to the general enquiries mailbox. These are reviewed and actioned at the Radar Oversight Group (ROG) to provide continuous system optimisation. The patient safety team are reviewing the quarterly thematic analysis report which is shared at Patient Safety and Quality Governance Group to ensure it analyses the data to allow for learning outcomes to be shared widely with the clinical divisions and the specialists leads. Metrics for measuring safety into improvement are being developed with the QI team and will be reviewed at the new safety improvement group – due to launch in September 2024.

Mortality Summary

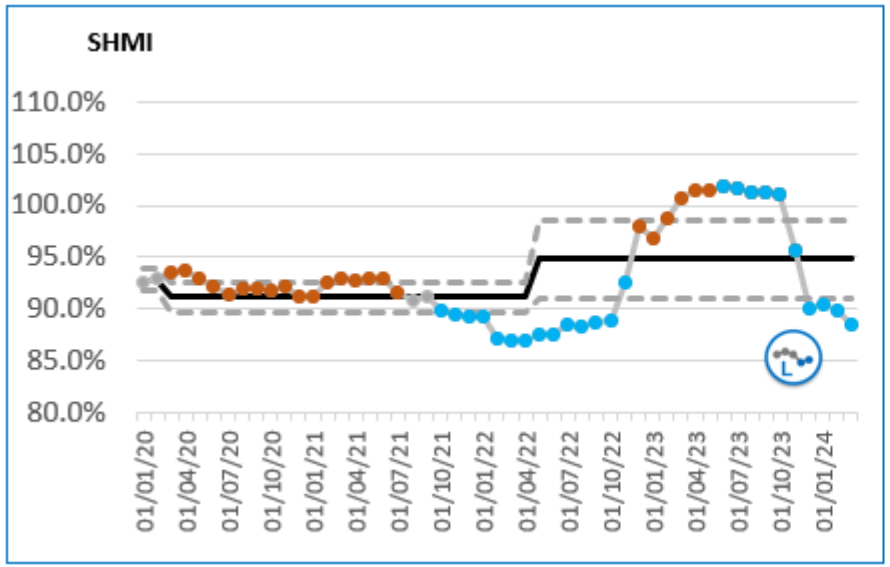


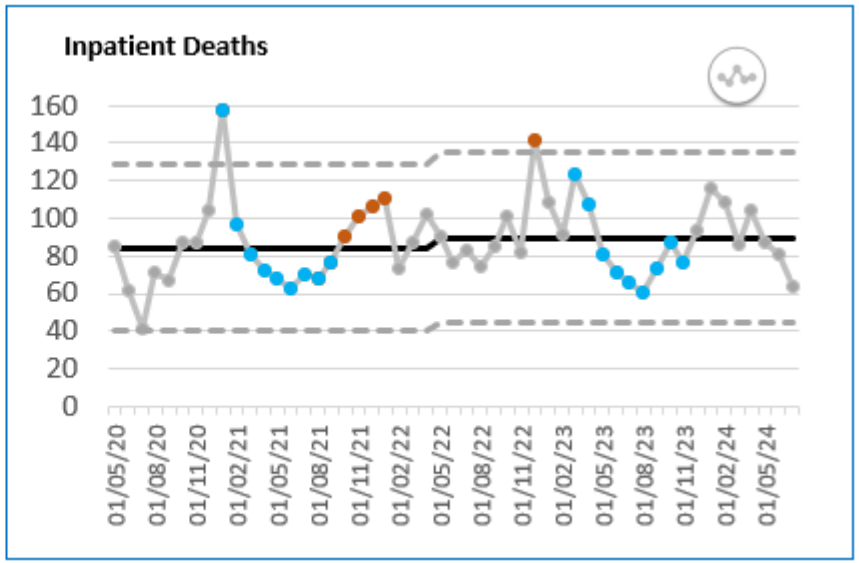


KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
SHMI	Mar 24	88.4%				94.8%	91.0%	98.6%
Inpatient Deaths	Jul 24	64				90	44	135

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

Mortality



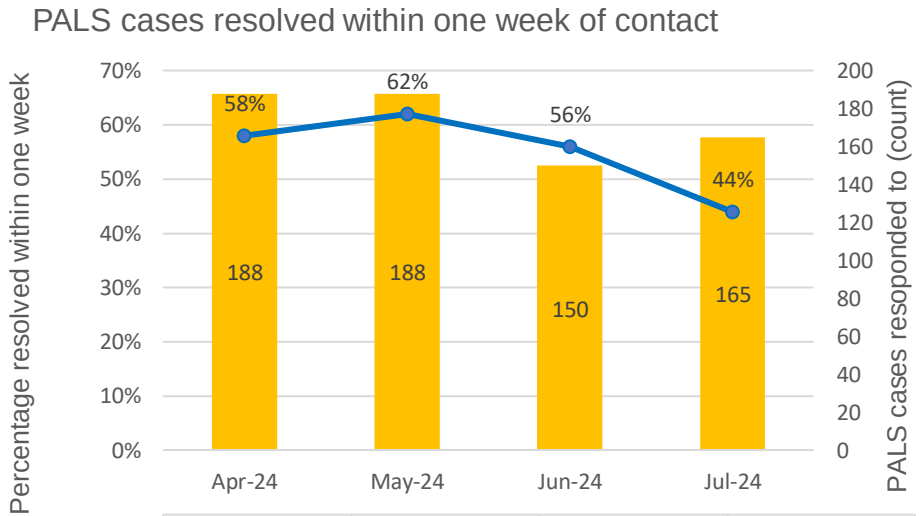


What	So What?	What Next?
The data is showing that the SHMI is returning to where we would expect it to be now the error with coding has been resolved	This is important as it shows the Trust has a below expected SHMI for our patient mix which is reassuring that the care we are providing is good and in comparison with other providers we have more patients who survive to discharge in a particular diagnostic group	Our Trust has a flag against the data on the national SHMI database alerting users to the issues with the data caused by coding inaccuracies. As our coding practices return to normal and the historic data falls off the timeline this flag can be removed

INVOLVEMENT COMMITTEE METRICS

Safe

	Apr-24	May-24	Jun-24	Jul-24
Active complaints	33	36	42	27
Closed complaints	24	17	11	25
	Apr-24	May-24	Jun-24	Jul-24
Count responded to	24	17	11	25
% extended	50%	76%	90%	80%
Count extended	12	13	10	20
% Complaints responded to late	15%	11%	9%	64%
Count responded to late	2	2	1	16
	Apr-24	May-24	Jun-24	Jul-24
% resolved in one week	58%	62%	56%	44%
Total PALS resolved Count	188	188	150	165



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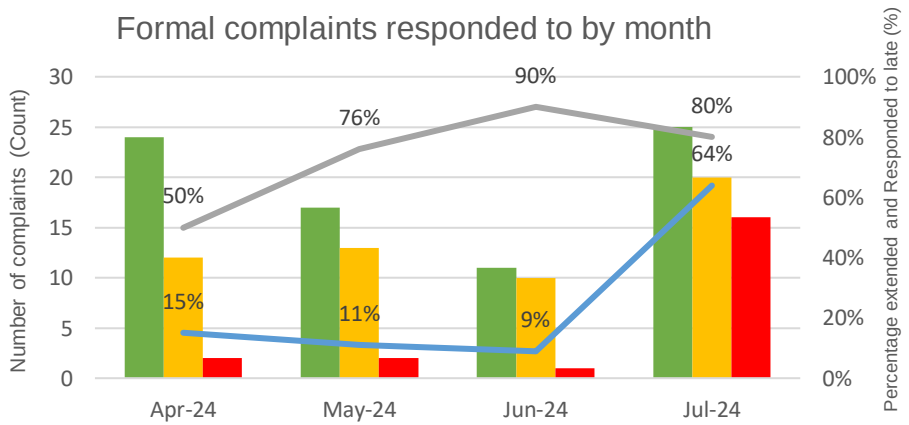

	Apr-24	May-24	Jun-24	Jul-24
Count responded to	24	17	11	25
Count extended	12	13	10	20
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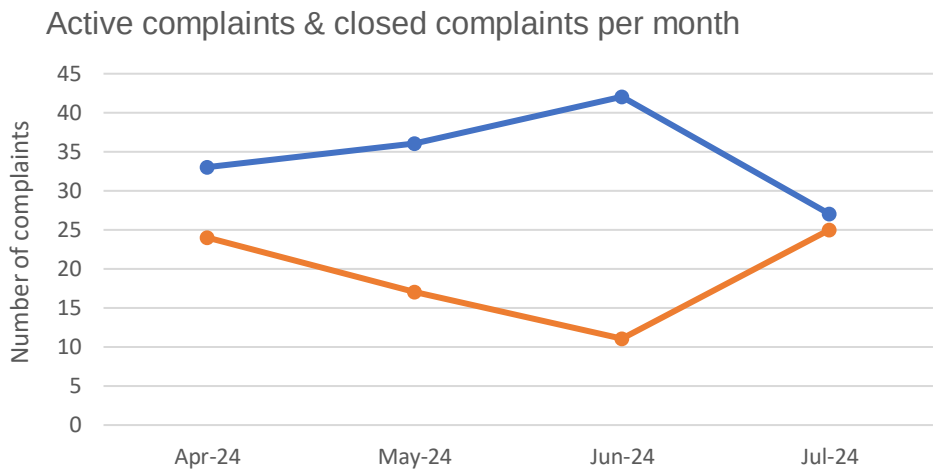
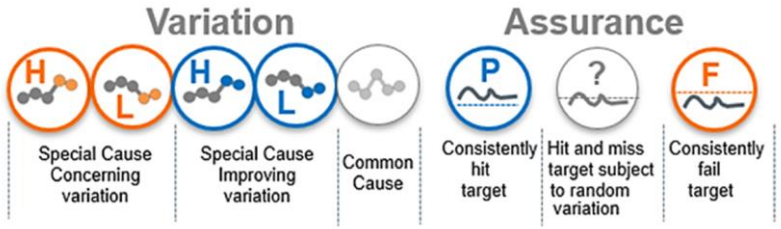


	Apr-24	May-24	Jun-24	Jul-24
Active complaints	33	36	42	27
Closed complaints	24	17	11	25

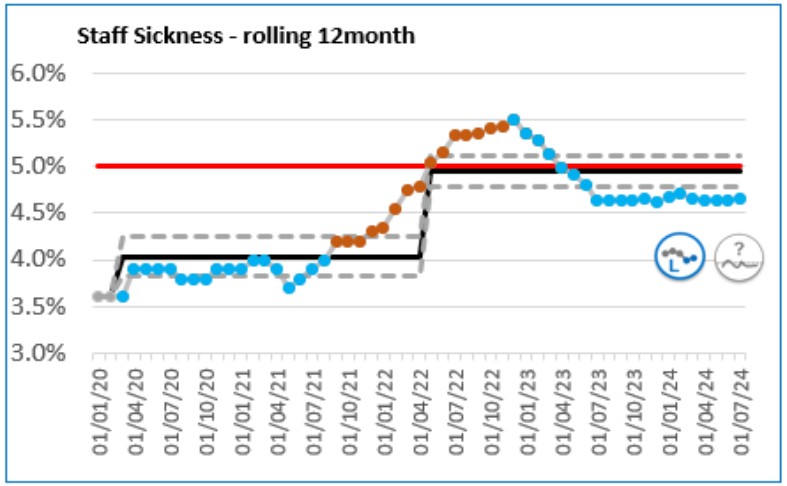
Safe

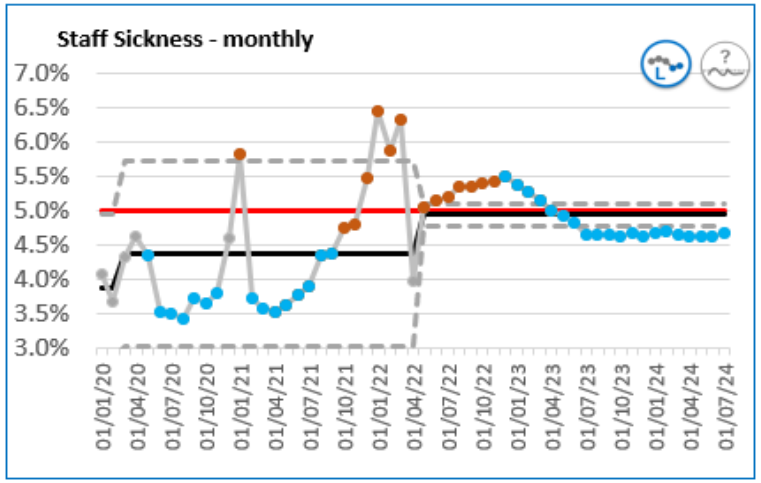
What	So What?	What Next?
165 PALS cases received for July of which 72 cases (44%) were resolved within one week. The volume received is average for this time of year however cases resolved within one week is lower than expected. PALS have experienced a higher number of complex cases requiring additional investigation which has impacted this number and we will continue to monitor data for improvements. At the time of reporting we had 27 open complaints for the Trust in total, across all divisions. In July the complaints team resolved 25 complaints which helped reduce this figure. Of the 25 complaints that were responded to, 16 were classified as late due to unprecedented sickness across the team. Furthermore, amendments were required to responses at sign off stage, which equated to 75% of the total extended complaints. This was an anomaly but a risk with a small team, though is extremely rare. Of the 25 that were responded to, 20 were extended (80%) which is greater than we would expect, with a high proportion of these still being late for the reasons mentioned above which is outside of our standard. It is worth noting that extensions are in line with our policy and national regulations, whereby complaints can be extended with the agreement of the complainant. Whilst the volume of complaints extended are below expected standards, this doesn't appear to impact the complainant satisfaction levels as the current first-time resolution rate remains high at 92%. Previous months (April-June) shown in the dataset reflect a total of 5 late complaints over the 3 months, averaging at 12%.	The complaints responded to has increased due to implementing new working strategies with staff to obtain their comments in a more timely manner, whereby we remind staff that the due date for their response is coming up rather than only informing them once overdue. This is working well and we are receiving staff investigations at an earlier stage since implementing this step, resulting in a better closure rate in the past month.	The PALS team have been tasked to achieve 75% of cases to be resolved within 1 week by the end of the year calendar year. A shorter version of the PALS form has been implemented in RADAR to capture queries which don't need investigation, such as advice, signposting or general feedback for more streamlined recording. The first PDSA cycle of the QI test and learn project has been completed within the complaints team for increased early resolution meetings, as opposed to written responses, which found that the criteria was too narrow. This has been amended for the second PDSA cycle to allow more complaints to be considered for a meeting. 1 meeting has been completed from the first cycle which saw the complaint closed within 13 working days. The QI project continues. Regarding extensions, we will continue to monitor this data closely and are forecasted to improve the extension and lateness rates. We are also implementing contingency plans to ensure where sickness does occur the wider team can ensure complainants are updated. To support divisional ownership, learning and improved response rates we are implementing revised processes in formal complaints which will enable: • Early divisional accountability for the complaint investigation • Divisionally driven actions and learning • Senior leader involvement in effective closure of and learning from complaints These should be fully implemented by December 2024 and QI methodology will be utilised alongside the existing project to achieve improvement in both performance and complainant satisfaction, as well as increased learning opportunities from complaints.

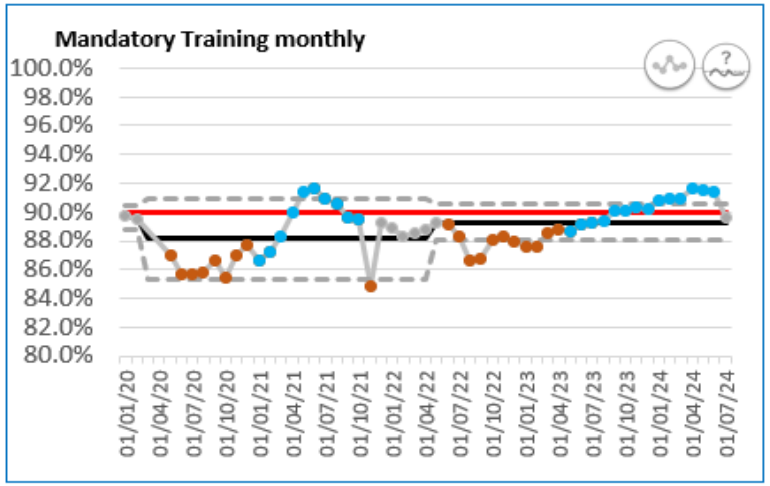


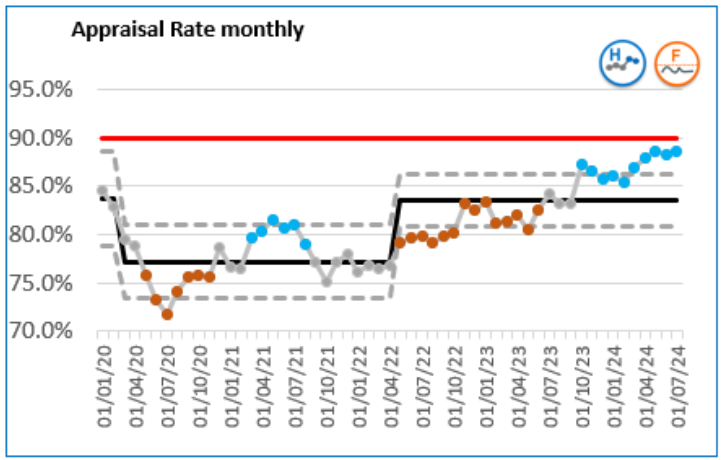
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Staff Sickness - rolling 12month	Jul 24	4.7%	5.0%	L	?	4.9%	4.8%	5.1%
Staff Sickness - monthly	Jul 24	4.7%	5.0%	L	?	4.9%	4.8%	5.1%
Mandatory Training monthly	Jul 24	89.6%	90.0%		?	89.3%	88.1%	90.5%
Appraisal Rate monthly	Jul 24	88.6%	90.0%	H	F	83.6%	80.9%	86.3%
Turnover rate monthly	Jul 24	7.5%	10.0%	L	F	11.0%	10.1%	11.9%

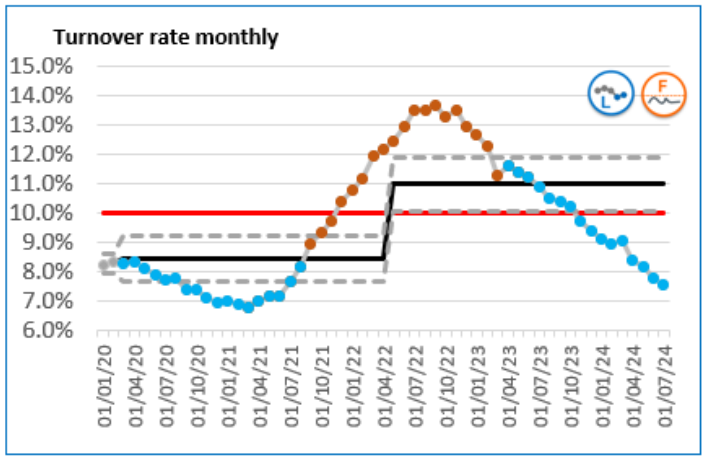
Well Led











What	So What?	What Next?
Three out of our four key performance indicators continue to record an improving variation with mandatory training marginally dropping below target. Sickness – achieving target at 4.7% versus 5% target. Mandatory training – first month in the last year to drop below target, marginal drop to 89.6% versus 90% target. Appraisal – consistently failing target, slight improvement on last month (+0.3%). Turnover – achieving target, sustained improvement since November 2022.	These workforce key performance indicators directly impact on staff morale, staff retention, and therefore, patient care and safety. Additionally, improvements in these workforce key performance indicators will strengthen our ability to be the employer of choice for our community and the recognition as a great place to work.	Maintain improvements in staff attendance and continue to monitor at department level. Recover the target compliance of mandatory training ensuring areas and staff groups are identified where further focus and support may be required. Continued analysis of appraisal data to support and challenge areas in need of action and improvement. Maintain focus on the delivery of our people and culture plan and priorities.

CHARITABLE FUNDS COMMITTEE

Terms of Reference

1. Purpose of the Committee

1.1. The Trust Board hereby resolves to establish a committee to be known as the Charitable Funds Committee (the committee), to make and monitor arrangements for the control and management of the Trust's Charitable Funds in accordance with any statutory or other legal requirements or best practice required by the Charity Commission and Fundraising Regulator.

1.2. The committee has no executive powers other than those specifically delegated in these terms of reference.

2. Level of Authority

2.1. The Charitable Funds Committee will act on behalf of the Trust in satisfying the duties and responsibilities of the Corporate Trustee (The Board of Directors) in managing the charitable and other funds held on Trust. The powers of the Trustees are set out in the Trust Deed.

2.2. The committee is authorised by the Corporate Trustee to initiate 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 Corporate Trustee to obtain legal and other expert professional advice and to secure the attendance of experts and external representatives or persons with relevant experience/expertise if it considers it necessary.

2.3. The committee has authority to make decisions and must act in accordance and in compliance with the Trust Standing Orders, Standing Financial Instructions and Scheme of Delegation.

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

3. Duties and responsibilities

The Charitable Funds Committee is authorised to ensure that the Charity's fundraising strategies and underpinning policies, leadership and behaviours are aligned with those of the Trust, with the aim of ensuring that the Board is discharging its responsibilities as corporate trustee of the funds held on trust. It must ensure that there is an effective governance, risk management and internal control systems in place to ensure that duty is undertaken properly and prudently and to ensure compliance with the Trustee Act 2000, the Charities Act 2011 and 2016 and any other regulations or standards issued by the Charity Commission and Fundraising Regulator.

3.1. The key responsibilities of the committee shall be:

The committee oversees the management, investment and disbursement of the charitable funds held on Trust, specifically:

Governance

- Review and approve all policies and procedures pertaining to the management of charitable funds
- To determine the strategy for Charitable Funds in line with the Trust's objectives, subject to the approval of the Trust Board.
- The Committee as part of the strategy, will consider the approach to fundraising, the investment of funds, the approach to expenditure and the approval of procedures associated with the use of Charitable Funds.
- To continuously review how the Charity could operate more efficiently
- To ensure the information held by the Charity Commission is kept up to date and reviewed by the committee on a regular basis
- Adhere to the principles and responsibilities of trusteeship as defined by the Charity Commission.
- Consider any internal or external audit reports of charitable funds, (including the adequacy of any management response) in liaison with the Audit Committee.

Investment

- Consider any changes in investment strategy and policy, making recommendations to the Board of Directors.
- Review performance of current investments in respect of both income and capital appreciation.

Fundraising

- Establish and oversee the implementation of a fundraising strategyReview the fundraising methods used and ensure that they are acceptable in terms of a health / public body context.
- To monitor the fundraising performance
- To ensure that there are procedures in place to co-ordinate the fundraising activities of the Trust
- To consider whether the Trust should undertake major fundraising appeals and establish the appropriate framework to ensure that any appeal is properly managed.

Expenditure

- To agree the expenditure strategy and policies of the Funds within the framework of the Governing Document which defines the purposes for which the charity has been established.
- To monitor compliance with the strategy and policies and ensure that the wishes of the donors are met.
- To consider and as appropriate approve Charitable Fund bids in accordance with the relevant procedures.

Reporting

- To determine the format of the performance information it requires in managing the Charitable Fund in the most effective manner. This will include information on fundraising, expenditure and investment.

Audit and Accounts

- To oversee submission of the Charity Annual Report and Accounts prior to submission to the Audit Committee and Trust Board ensure these are submitted in the appropriate form and within the required legislative timetable
- To receive and consider any Internal and External Audit Reports on Charitable Funds and monitor any action being taken to address matters of concern raised.
- To consider any other return required by the Charity Commission or other statutory body.
- To ensure that sound financial control is exercised, assets are safeguarded from fraud, that all income due to the Charity is received and that no breaches of relevant legal and other regulations occur.

Other

- To develop formal links with outside voluntary organisations, such as the League of Friends, to ensure a co-ordinated approach.
- To maintain a strong link to the Trust's Investment Panel and the Capital Strategy Group through the presence of the Chief Operating Officer and Director of Resources.

Powers and duties of Fundholders

- The Fundholder for an individual fund will be a senior staff member as delegated by the Charitable Funds Committee.
- All Fundholders must be employees of West Suffolk NHS Foundation Trust.
- Individual Fundholders hold a delegated responsibility from the Trustees for the individual funds under their stewardship.
- The income and property of the fund must be applied in furtherance of the purpose of the Charity and for no other purpose.
- The Fundholder has a delegated responsibility to ensure that the donor's wishes are complied with.
- The Fundholder has a responsibility in complying with the Standing Orders, Standing Financial Instructions and Scheme of Delegation of West Suffolk NHS Foundation Trust.
- The Fundholder must comply with the authorisation levels as set out in the Charitable Funds policy.

4. Membership

4.1. Membership of the committee will comprise:

Two non-executive directors, one of whom will chair the meeting

Executive Leads:

- Director of Resources
- Chief Operating Officer
- Director of Workforce and Communications.

Others in attendance would be:

- Head of Fundraising
- Assistant Director of Finance
- Charitable Fund Accountant
- Trust Office Executive Assistant (for minuting purposes)
- Patient/carer representative
- Staff representative

Other Members

The chair, other non-executive directors and chief executive have an open invitation to attend meetings of the committee.

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

4.3. The committee may ask any other officials of the organisation or representatives of external partners, the Head of Internal Audit or a representative of the Trust's External Auditors to attend to assist it with its discussions on any particular matter. The committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

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

5. Quorum

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

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

5.3. Virtual attendance will count towards quorum.

6. Frequency of meetings

6.1. The committee shall operate as follows:

- The committee will meet at least on a quarterly basis.
- The committee chair may convene an ad-hoc meeting if there is urgent business to transact.
- Papers will be sent out by the Trust Office at least 5 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 does not have a subcommittee.

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

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

9. Accountability and reporting arrangements

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

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

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

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 biannually (once in two years) and advise the Trust Board of any suggested amendments to these terms of reference which would improve the trust governance arrangements.

11. Ratification of terms of reference and review arrangements

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

Date approved by the Charitable Funds Committee: 22 August 2024
Date approved by the Board of Directors:
Next review date: July 2025

Sources of further information supporting the committee in the exercise of its responsibilities

The following guidance is available from the Charity Commission:

• NHS Charities Guidance
• Board Members' role in managing funds held by their NHS body
• Consultation on draft guidance on NHS charities: Glossary
• Guidance for corporate Trustees and trustee bodies on managing NHS charitable Funds
• NHS charities and independence indicators and evidence
• Trusts and trusteeship under NHS acts 1946-2006
• Consultation on draft guidance on NHS charities: power to compromise
• Consultation on draft guidance on NHS charities: www.gov.uk/government/publications/nhs-charities- guidance

The following guidance is available from the Fundraising Regulator

- Code of Fundraising Practice

https://www.fundraisingregulator.org.uk/code-offundraising-practice/code-of-fundraising-practice

TERMS OF REFERENCE

INSIGHT COMMITTEE

1. Purpose of the Committee

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

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

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

2. Level of Authority

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

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

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

3. Duties and responsibilities

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

- Gain assurance on the Trust's financial controls, budget management and strategic financial planning
- Receive detailed financial and operational reports and risk assessments linked to Trust strategy and strategic priorities
- Receive reports on financial and operational efficiency, noting trends, exceptions and variances against plans on a Trust-wide and divisional basis and to seek assurance relating to any major performance variations as appropriate

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

4. Membership

4.1. Membership of the committee will comprise:

Executive Leads:
- Director of Resources
- Chief Operating Officer

Other Members
- At least two non-executive directors, one of whom will chair the meeting
- Chief Nurse
- Medical Director

The Chair, other Non-executive directors and Chief Executive have an open invitation to attend meetings of the committee.

Others in attendance by invitation would be:

Attendees who are not members of the committee but who will be reporting to the committee on risks and assurances within their remit include the following:
- Deputy Director of Finance
- Deputy Chief Operating Officer
- Deputy Director of Workforce, Organisational Development and Learning
- Head of Access
- Associate Director of Quality Improvement
- Deputy Chief Nurse
- Deputy Medical Director
- Chief information officer
- Trust Secretary
- Governor observers.

**Board assurance committees are not public meetings and, occasionally, matters discussed may be confidential within the Trust. Governor observers and other regular attendees must maintain confidentiality about what is discussed.*

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

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

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

5. Quorum

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

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

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

6. Frequency of meetings

6.1. The committee shall operate as follows:

- The committee will meet monthly until agreed otherwise
- Items for the agenda should be submitted to the committee secretary a minimum of 6 working days prior to the meeting. Papers on other matters will be put on the agenda only with the prior agreement of the chair
- The monthly meetings will have a forward plan that balances a focus on the scrutiny and performance of the work of the subcommittees listed below and deep dives into specific performance issues identified through the assurance process, in order to gain deeper understanding of the causes, the actions being taken to remediate issues and the process of improvement
- Papers will be sent out by the committee secretary at least 4 days before each meeting.
- Membership and terms of reference will only be changed with the approval of the committee and ultimately the Board.

7. Sub Committees

7.1. The committee shall receive regular reports from:

- Financial Accountability Committee, including: capital strategy group, investment panel and contracts & procurement panel
- Sustainability net zero steering group
- Patient Access Governance Group, including: urgent and emergency care group and elective access meetings
- Corporate Risk Governance Group, including: health & safety committee, medical devices committee, trust resilience group and information governance steering group
- Other speciality committees as required.

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

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

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

9. Accountability and reporting arrangements

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

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

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

10. Monitoring effectiveness and compliance with Terms of reference

10.1. In order to support the continuous improvement of governance standards, this committee is required to complete a self-assessment of effectiveness biannually (once in two years) and advise the Trust Board of any suggested amendments to these terms of reference which would improve the trust governance arrangements.

11. Ratification of terms of reference and review arrangements

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

Date approved by the Insight Committee: September 2024
Date approved by the Board of Directors:
Next review date: August 2025

Management Executive Group meeting

Terms of reference

1. Purpose

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

1.2 This includes:

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

2. Level of authority

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

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

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

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

3. Duties and responsibilities

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

3.2 Strategy and business planning:

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

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

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

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

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

3.2.6 Review the Trust's financial controls, budget management and strategic financial planning.

3.3 Developing culture, values and behaviours

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

3.3.2 Role model leadership against agreed values and behaviours.

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

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

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

3.4 Delivery and performance

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

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

3.4.3 Review the cost improvement programme, including delivery and timeframes.

3.5 Risk and governance

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

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

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

3.5.4 Review financial reporting and risk assessments against financial risks linked to Trust strategy and objectives.

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

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

4. Membership

4.1 Members:

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

4.2 In attendance at the meetings will be:

- Trust Secretary

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

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

5. Quorum

5.1 A quorum is required of three executive directors and two from the remaining membership. Deputies do have a vote and count in calculating whether a meeting is quorate.

6. Frequency of Meetings

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

7. Sub-committees

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

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

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

9. Accountability and reporting arrangements

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

9.2 The Management Executive Group may refer matters to other fora for review and to help shaping.

10. Monitoring effectiveness and compliance with Terms of reference

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

11. Ratification of terms of reference and review arrangements

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

Date approved by the Management Executive: 11 September 2024
Date approved by the Board of Directors:
Next review date:

IQPR Full Report

To Note

Presented by Nicola Cottington

Assurance Grid

August 2024	ASSURANCE: Pass (P)	Hit and Miss (?)	Fail (F) — Not Met
VARIANCE: Special Cause Improvement (H / L)		**INSIGHT** % Patients with No Criteria to Reside **INVOLVEMENT** Staff Sickness – Rolling 12month Staff Sickness Turnover	**INSIGHT** Incomplete 104 Day Waits RTT 78+ Week Waits **INVOLVEMENT** Appraisal
VARIANCE: Common Cause	**INSIGHT** 4 Hour Breaches Urgent 2 Hour Response - EIT	Please see box to right	**INSIGHT** 12 Hour Breaches 4 Hour Performance Respiratory Bay Average Occupancy Number Heart Failure Bay Average Occupancy Number IV Abx Bay Average Occupancy Number Frailty Bay Average Occupancy Number
Deteriorating — Special Cause Concern (H / L)		**INSIGHT** Total Average Occupancy Percentage Community Paediatrics RTT Overall 78 Weeks Wait	**INSIGHT** Total Average Occupancy Number

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 of Attendances
Total Average LOS per Patient
28 Day Faster Diagnosis
Cancer 62 Days Performance
Community Paediatrics RTT Overall 104 Weeks Wait
IMPROVEMENT:
C-Diff Hospital & Community
INVOLVEMENT:
Mandatory Training

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%

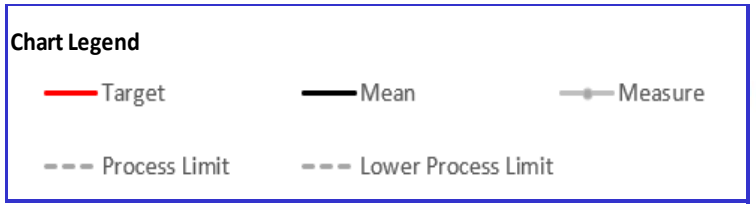
Currently this data is not available to the Trust, however the Information Team are working to resolve this.

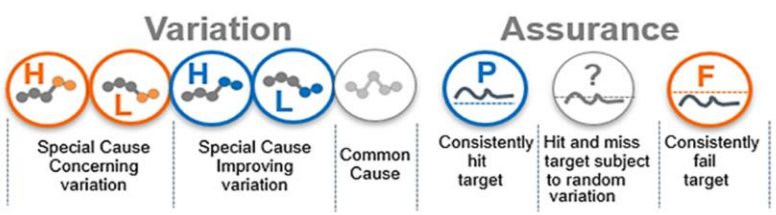
*Cancer data is 1 month behind

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, 4 Hour Performance, Total Average Occupancy Number, Total Average Occupancy Percentage, 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: RTT 78+ Week Waits, Community Paediatrics RTT Overall 78 Weeks Wait
INVOLVEMENT – Well Led: Appraisal

INSIGHT COMMITTEE METRICS

Urgent & Emergency Care summary

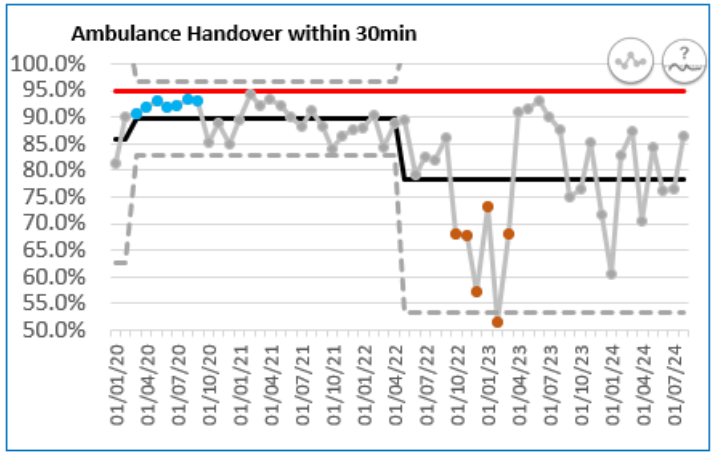


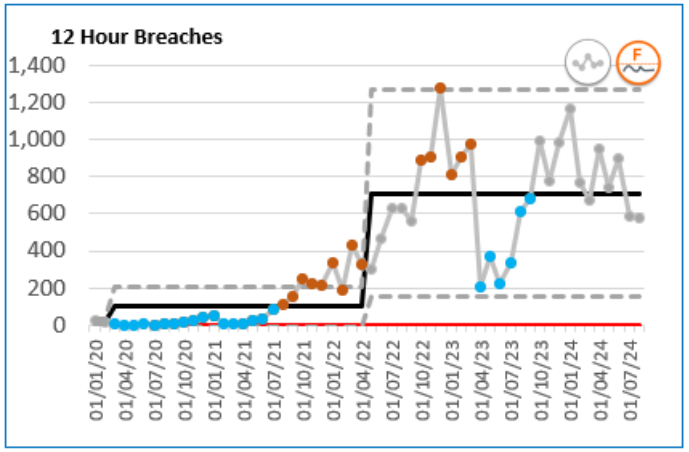


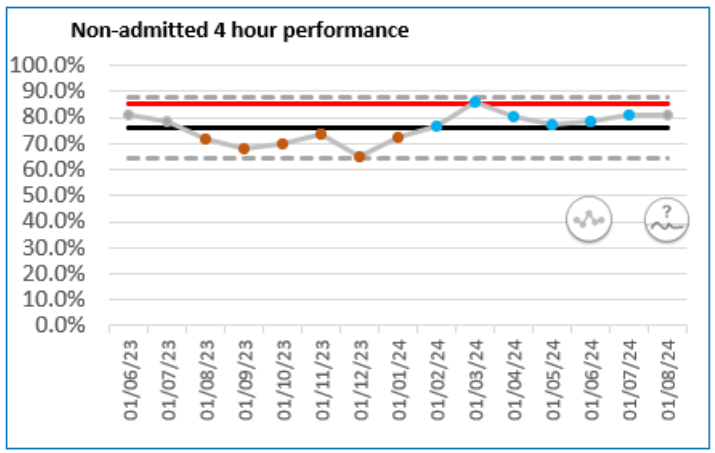
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Ambulance Handover within 30min	Aug 24	86.5%	95.0%			78.3%	53.3%	103.3%
12 Hour Breaches	Aug 24	581	0			709	153	1266
4 hour breaches	Aug 24	2476	0			2720	2001	3439
4 hour performance	Aug 24	69.6%	78.0%			66.2%	55.9%	76.4%
Non-admitted 4 hour performance	Aug 24	81.0%	85.0%			76.1%	64.6%	87.6%
12 hour breaches as a percentage of attendances	Aug 24	7.1%	2.0%			5.2%	1.1%	9.4%
Urgent 2 hour response - EIT	Aug 24	91.7%	70.0%			90.4%	82.9%	97.9%
Criteria to reside (Average without reason to reside) Acute	Aug 24	38				56	41	71
**Criteria to reside (Average without reason to reside) Community	Aug 24	35				19	14	25
% patients with no criteria to reside	Aug 24	9.5%	10.0%			13.0%	8.7%	17.2%
Virtual Beds Trajectory	Aug 24	40	40					
Total average occupancy number	Aug 24	26.3	80.0			23.7	15.4	32.0
Total average occupancy percentage	Aug 24	66%	80%			72%	44%	99%
Total bed days on VW	Aug 24	861	-			639	295	983
Total average LOS per patient	Aug 24	8.5	14.0			9.8	4.0	15.5
Respiratory Bay average occupancy number	Aug 24	1.4	8.0			2.8	-0.8	6.5
Heart Failure Bay average occupancy number	Aug 24	4.1	12.0			5.3	1.4	9.3
IV Abx Bay average occupancy number	Aug 24	1.9	6.4			2.4	-0.8	5.6
Frailty Bay average occupancy number	Aug 24	4.3	16.0			2.9	-0.5	6.2

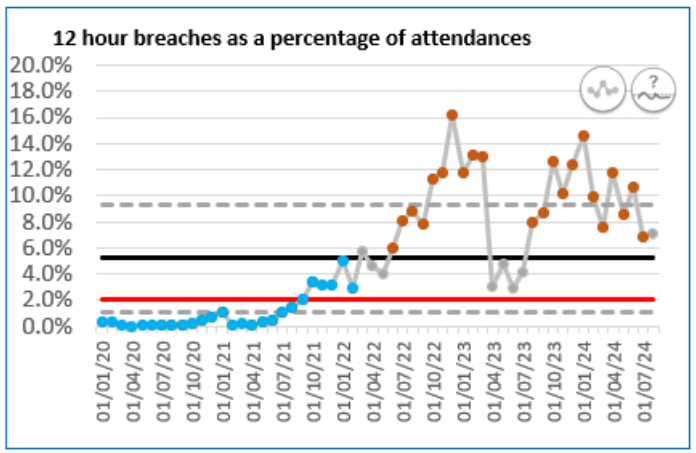
** Figures are for Glastonbury and Newmarket only, data not currently captured at Hazel Court.

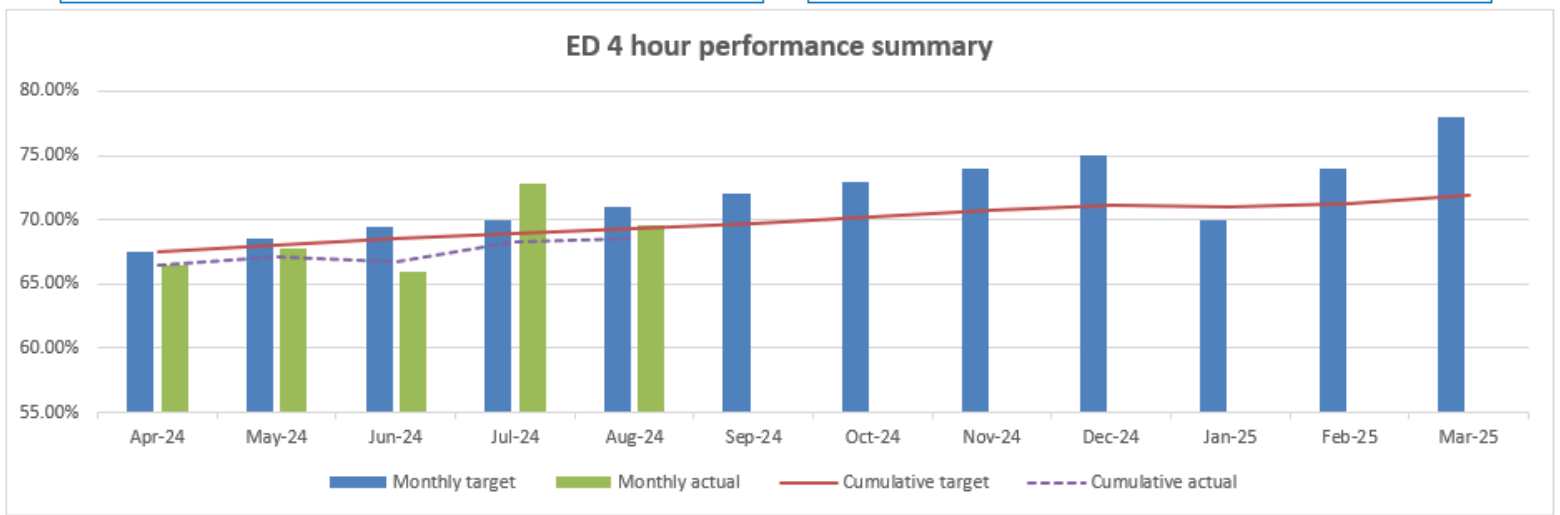
Urgent & Emergency Care: ED 4 Hour Performance







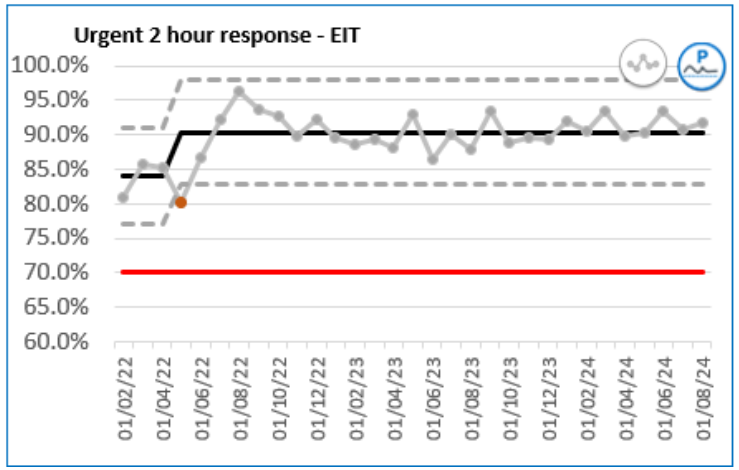


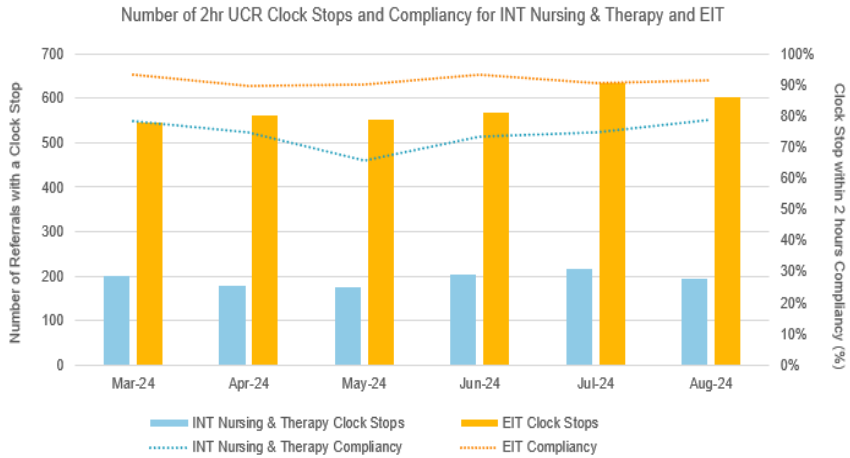


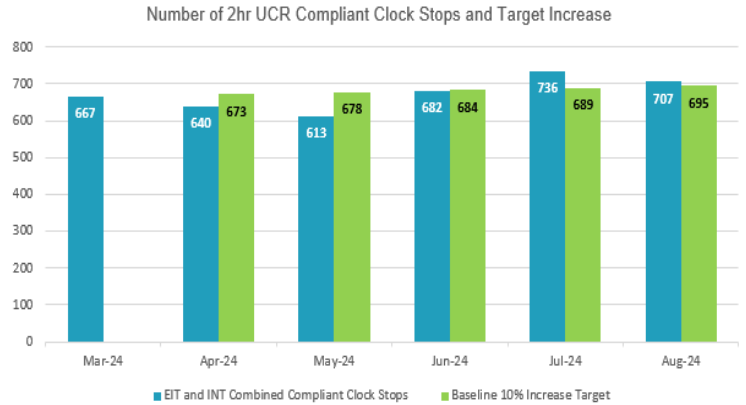
Urgent & Emergency Care

What	So What?	What Next?
30 minute Ambulance handover performance shows no significant change and continues to remain a challenge. The factors contributing to this include the number of patients in the Emergency Department with an increased length of stay waiting for a bed, resulting in the need to cohort patients into escalation areas including the Rapid Assessment Triage Area, which then reduces our ability and capacity to offload ambulances. The number of 12 hour length of stay breaches in the month of August demonstrates no significant change, with 581 patients breaching. We continue not to meet this metric. The number of 12 hour breaches as a percentage of attendances shows no significant change, remaining a concern. Non-admitted performance demonstrates no significant change and was 80.95% for the month of August. The Emergency Department 4 hour performance dropped below our in-month trajectory of 71% to 69.6 %.	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 Emergency Department standard will meet the national targets. Reaching the trajectory will keep us on track to achieve 78% by March for the 4 hour standard. Some patients are waiting longer in the Emergency Department than they should be and being nursed in escalation areas, making for a poorer patient experience.	Revised Urgent and Emergency Care action plan developed with a trajectory to achieve 78% 4hr Emergency Department target by March '25. An internal Urgent and Emergency Care delivery group with workstream leads is in operation. Weekly triumvirate performance meetings between the Emergency Department and Medical Division Senior Leaders with an associated action plan. Robust data and clinical review for periods of reduced performance to obtain learning to improve performance. Focussed work for improving overnight Emergency Department performance including: • Template guidance for Emergency Physician in Charge handover with clear actions for night • Focused leadership training for Registrars overnight to be included within study sessions • Support from the Organisational Development team in developing the leadership skills of the senior medical team within the Emergency Department. • Profiling of doctor's shift patterns in relation to activity within the department, using the Emergency Care Improvement Support Team (ECIST) Safecare tool. **Projects in August/September '24** • Pre booked next day returner Emergency Nurse Practitioner slots to support minor injuries attending after 10pm commenced 24th August - pilot continues.. • 3-6pm Front Door Rapid Assessment for non admitted patients – consultant/registrar based at point of streaming/triage to assess & discharge or redirect to other services i.e. Same Day Emergency Care. Successful pilot completed. Continuing as business as usual with an increase in hours 1-6pm and planned for future 1pm to midnight. The continuation of the rota for the Emergency Department leadership team to be solely based in department supporting performance. The Acute Admissions Unit also have a similar rota. Enhanced support for last 10 days of September including twilights and weekends, The Minor Emergency Care Unit (MECU) is being delivered on 29th September with a go live date planned for the 14th October.

Urgent & Emergency Care: UCR







Team	Mar-24				Apr-24				May-24				Jun-24				Jul-24				Aug-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	201	158	43	79%	179	134	45	75%	175	115	60	66%	204	150	54	74%	217	162	55	75%	194	153	41	79%
Total EIT*	545	509	36	93.39%	563	506	57	89.88%	552	498	54	90.22%	569	532	37	93.50%	633	574	59	90.68%	604	554	50	91.72%
Combined Total	746	667	79	89.41%	742	640	102	86.25%	727	613	114	84.32%	773	682	91	88.23%	850	736	114	86.59%	798	707	91	88.60%

*Using CSDS figures

What

Community 2-hour response remains above 70% compliance target. No significant change to performance.

ED data has been amended so now focuses on EIT capacity and performance. Target of 80% has been set and just below this target.

So What?

Continue to meet national target and also increase in referrals as per alliance plan.

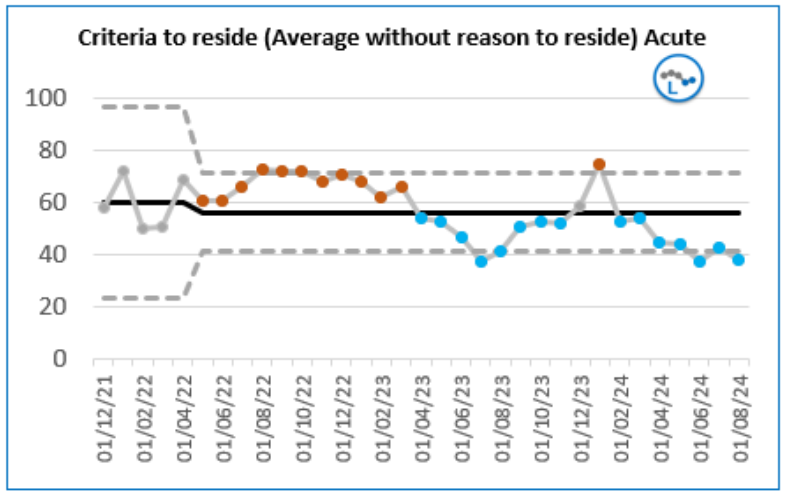
What Next?

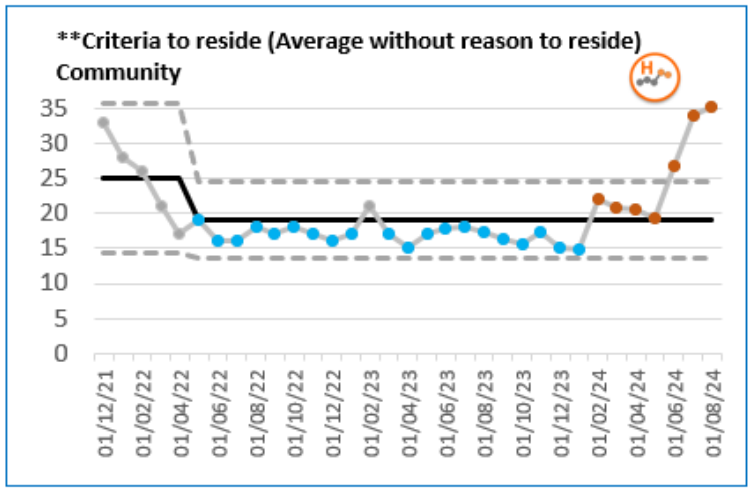
Liaised with IT and information team regarding AAU 4-hour response data. They are aiming to get this added to eCare in early October and EIT will then start to report on this target.

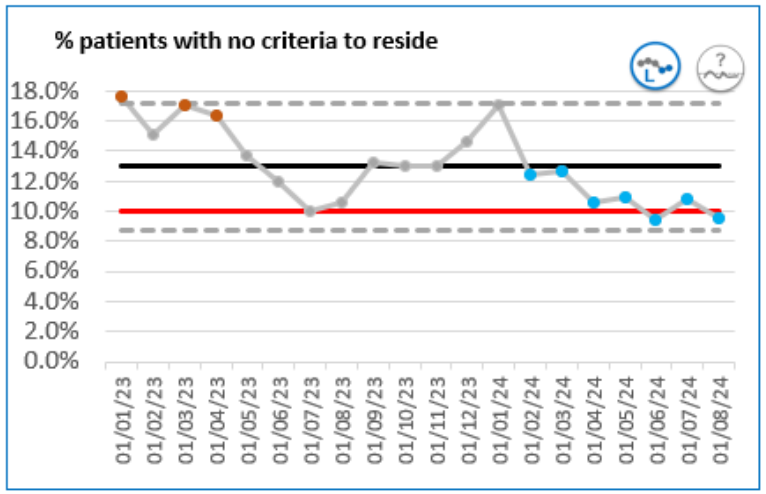
Pilot move for EIT "community therapy and daytime nursing service" to West Suffolk House to commence 1st October for 6 weeks. Will need to track effect on performance for community and ED.

Will monitor community referrals that are "decision not to treat" due to capacity. These are cleric referrals, as the team are prioritising community referrals via the Care Co-ordination Centre (CCC) and acute/ ED work.

Urgent & Emergency Care: Criteria to reside

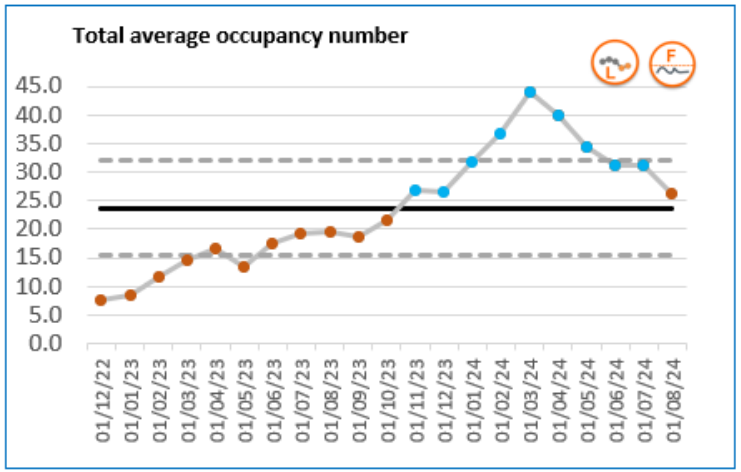


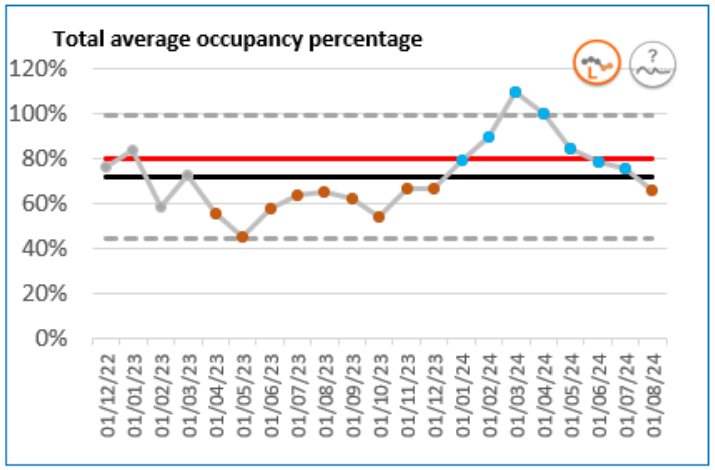


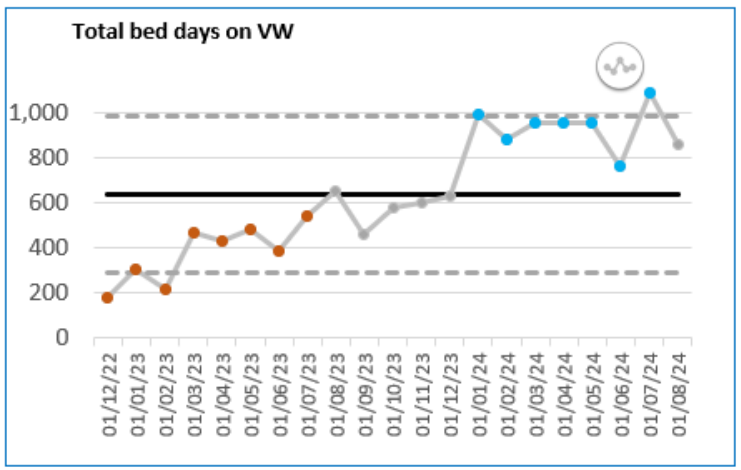


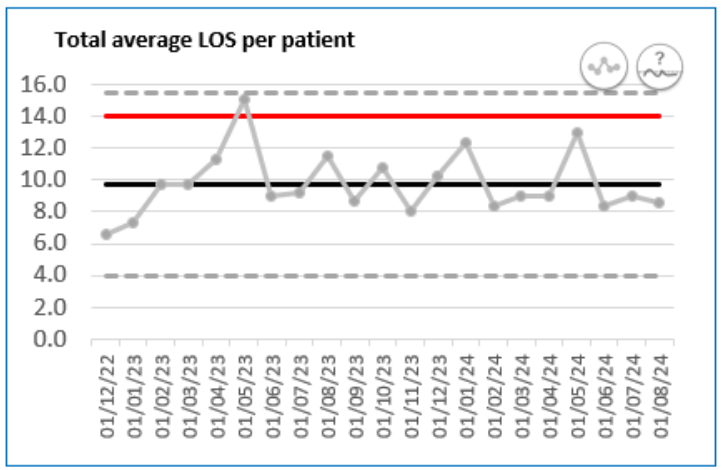
What	So What?	What Next?
August saw a decrease in the average number of patients in the acute setting without reason to reside. This is directly reflected in the % figure which is down to 9% from 11% in July. Throughout August we have continued to see availability in pathway 2 community assessment beds which has enabled the Transfer of Care Hub to transfer a cohort of "non-traditional" patients from the acute setting without reason to reside who are waiting for care or require further assessment or interventions prior to discharge. This however has had a negative impact on the numbers of patients in the community beds without criteria to reside. Please note the community assessment beds from August include patients at Hazel Court CAB and the interim D2A beds funded via the hospital discharge fund.	Patients remaining in hospital longer without criteria to reside directly impacts on bed capacity and patient flow within the Trust. Longer length of stay leads to greater deconditioning and loss of independence.	5 workstreams aiming to reduce the numbers of patients without criteria to reside and improve flow and discharge delays in both acute and community settings – reporting into the Programme Board for Community Adult Services on a monthly basis. Additional work to develop a Standard Operating Procedure for patients moving to CAB alongside acceptance criteria for both CAB and interim beds is being undertaken. A singular TOCH referral is being launched on the 30th September 2024, the aim is to make referring into the TOCH for supported P1-3 discharges easier for referrers, reducing delays and confusion in referrals. A third Stepping Home flat is now fully functioning providing additional capacity for patients waiting for house clearance, deep cleaning or other housing issues before returning home or to their onward discharge destination.

Urgent & Emergency Care (TRUST – Virtual Ward)

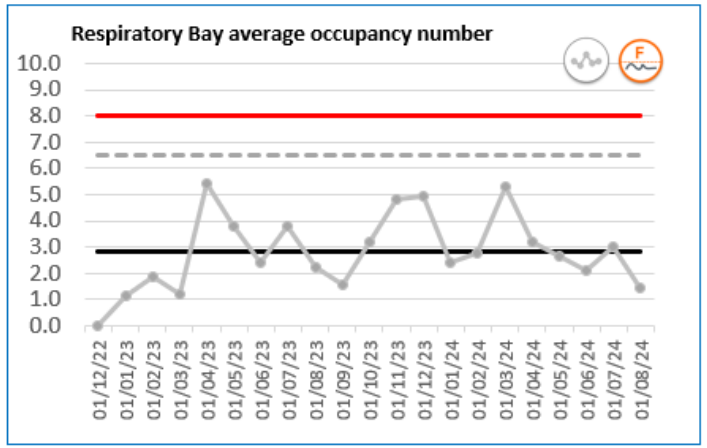


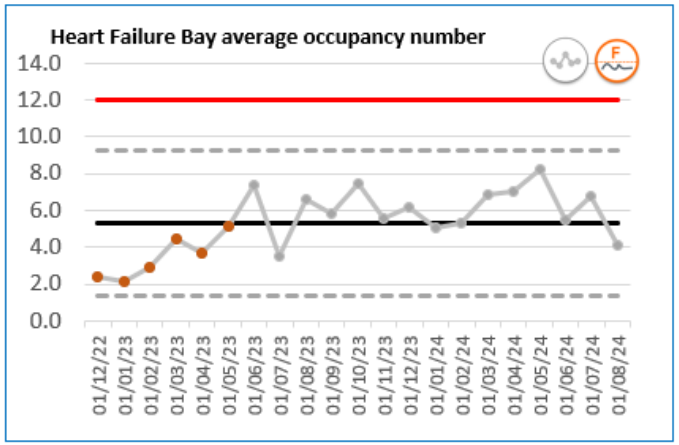


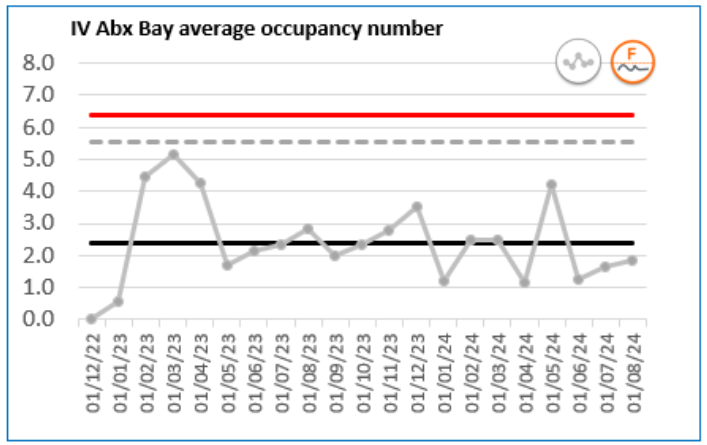


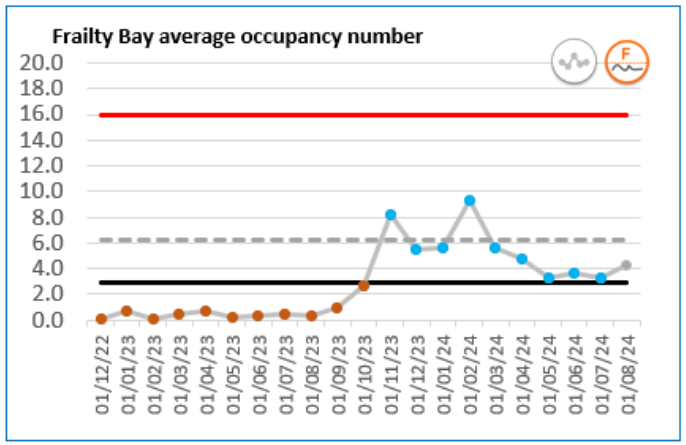


What	So What?	What Next?
Bed occupancy across Community Assessment (CAB) has been maintained above 90% this month. Length of stay (LOS) has been maintained across all CABs for several months and performs extremely well against the national benchmark of 28 days.	Bed occupancy supports transfer from the acute Trust with patients not having to wait for a bed due to lack of bed capacity. Bed occupancy has been achieved through flexible working i.e. transferring patients who would not traditionally be offered community assessment Reduced length of stay supports patient flow, making beds available for patients from the acute Trust who do not require an acute bed. Reduced length of stay improves the patient experience., returning them to their preferred discharge destination in a timely manner	Monthly reporting and discussion at the unit governance meeting. The 5 workstreams to maximise utilisation for Interim and CAB capacity to report to Project Board Sept 2024 Paper to propose future modelling options for CAB and Interim to be completed mid-end October. To improve communication with patients and relatives – patient information leaflet highlighting expectations, to be given to patients and relatives prior to transfer to CAB. Currently with the communications team.



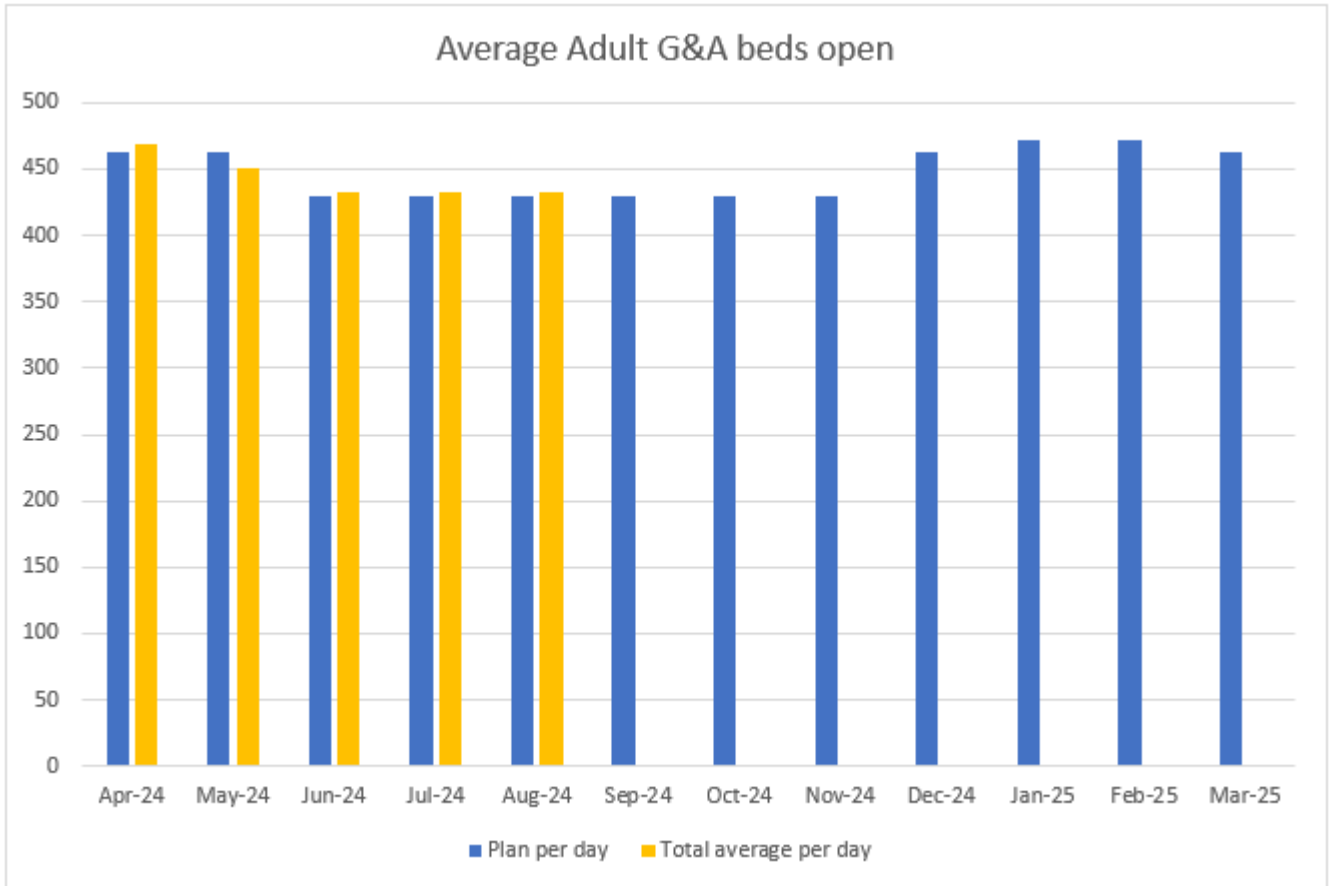




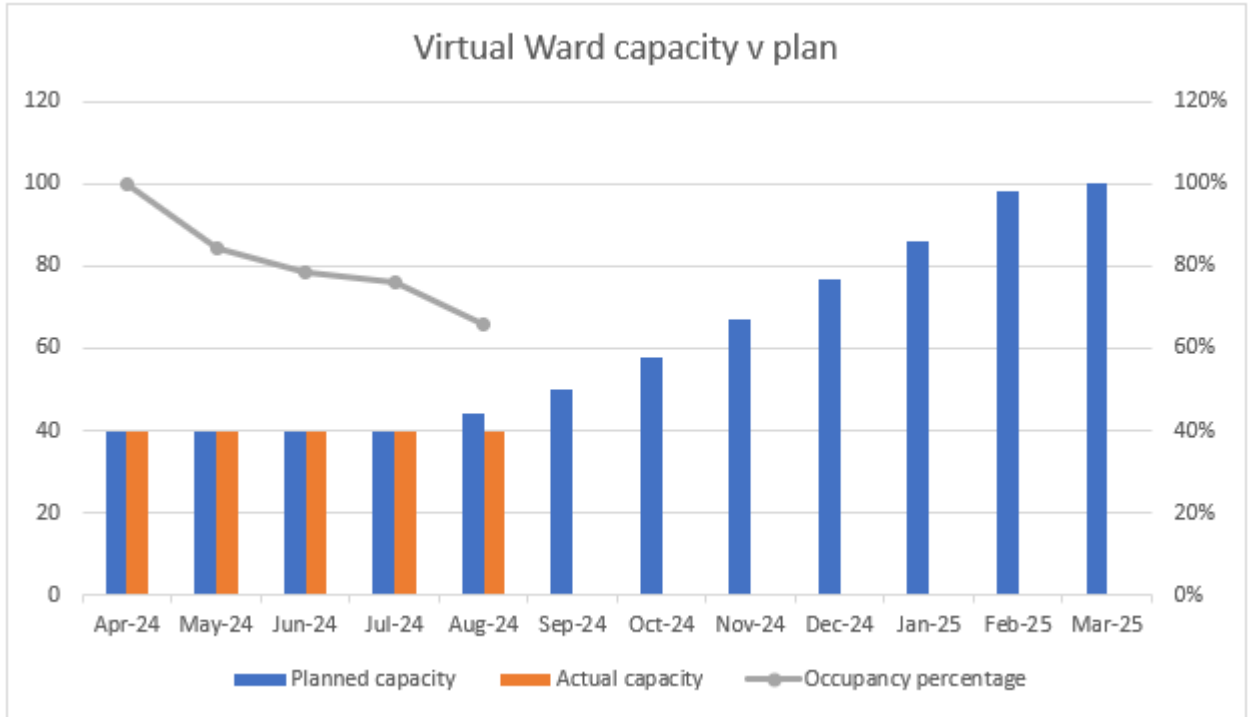


What	So What?	What Next?
Average pathway occupancy during August: Respiratory: average occupancy 1.4 patients (decrease from July) Heart failure: average occupancy 4.1 patients (decrease from July) IV ABx: average occupancy 1.9 patients (decrease from July) Frailty: average occupancy 4.3 patients (increase from July)	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.	Key points from individual pathway development plans were provided in June PRM slides. Agency nursing has been ceased with no further investment for new posts due to Trust financial constraints. Impact is therefore on capacity to do nursing visits.

Urgent & Emergency Care: Beds

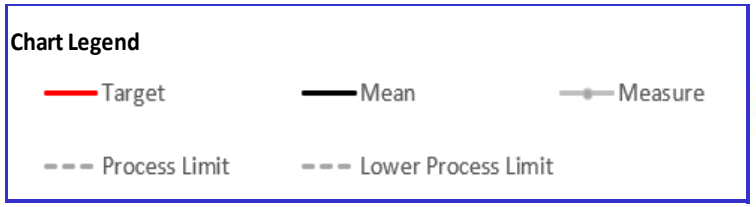


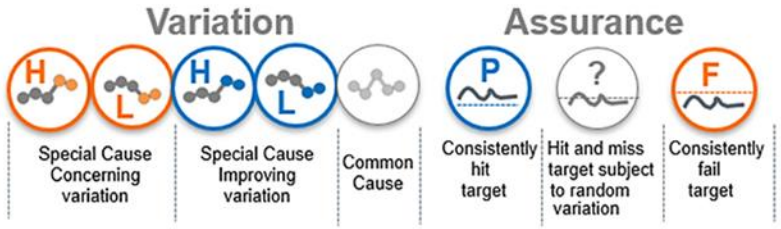
What	So What?	What Next?
Our actual average number of core beds open has decreased in line with plan, following the full closure of F9 as the winter escalation ward. We have been able to maintain the reduction in the number of unfunded escalation beds open in August through following the Tactical Patient Flow Escalation Plan more robustly, though flow at times has proven challenging with multiple patients awaiting beds in the Emergency Department.	Maintaining core beds open as per plan is a key requirement of the NHS 2024/25 operational priorities and planning guidance. Delivering the plan maximises patient flow and reduces extended waits for admission from the Emergency department, contributing to reduced 12-hour waits and improved 4-hour performance. However, using escalation beds impacts on the ability of those areas being used to fulfil their primary purpose and uses unbudgeted staffing resources.	Use of Medical SDEC as an escalation area is monitored through the daily capacity meetings in conjunction with the Medicine divisional leadership team to ensure it is in line with the Tactical Patient Flow Escalation Plan. Given current numbers of patients waiting >12 hours and for admission in the Emergency Department, it is likely that the planned increase in bed capacity through use of a winter escalation ward will be required.



What	So What?	What Next?
Average occupancy on the Virtual Ward reduced from 76% (July) to 66% in August largely due to constraints in nursing capacity.	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.	Post November, there will be no further expansion of Virtual Ward capacity and therefore focus will be exclusively on occupancy (especially step-ups) and the delivery of a sustainable operating model. Options for the development of virtual care will be presented to Management Executive Group during October with recommendations.

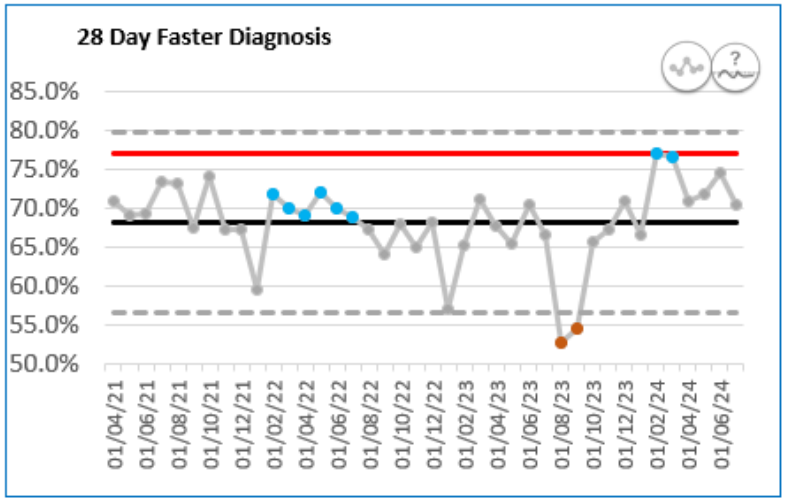
Cancer Access Summary

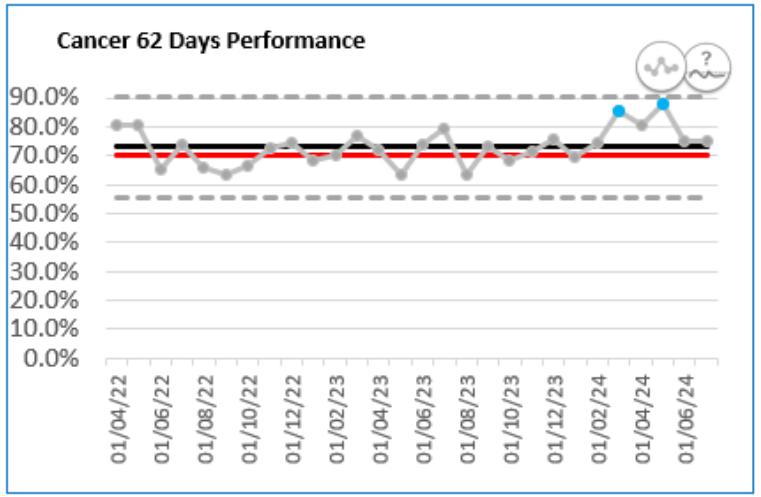


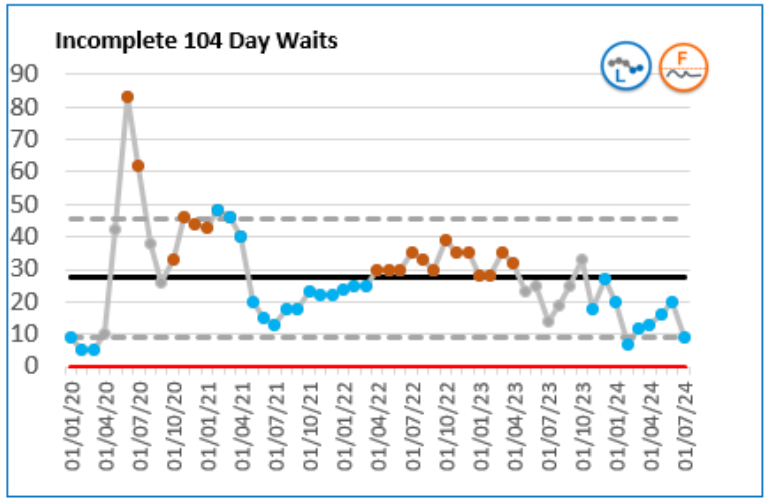


KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
28 Day Faster Diagnosis	Jul 24	70.4%	77.0%			68.2%	56.7%	79.7%
Cancer 62 Days Performance	Jul 24	75.0%	70.0%			73.1%	55.6%	90.6%
Incomplete 104 Day Waits	Jul 24	9	0			27	9	46

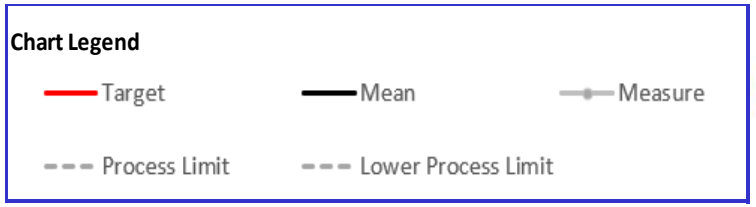
Cancer Access (Month Behind)

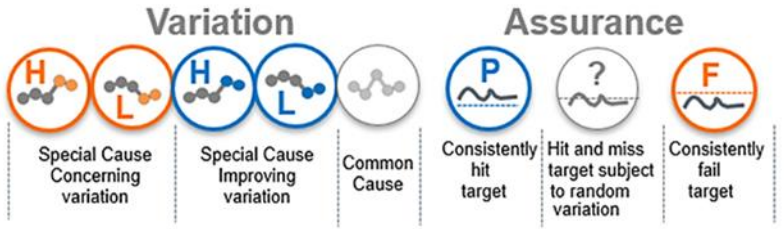






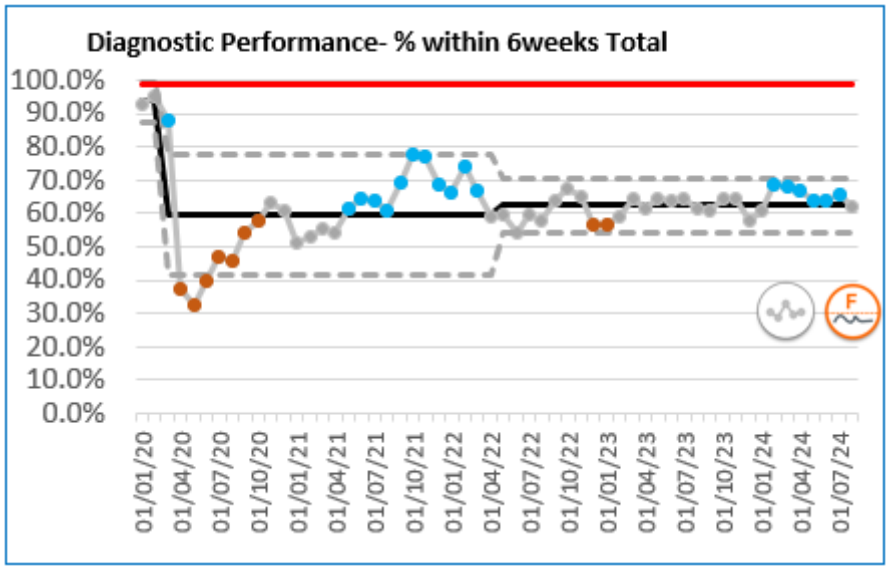
What	So What?	What Next?
Performance against the 28-day Faster Diagnosis Standard (FDS) is not being consistently met, with performance dropping to 70% in July, which is below the trajectory of 75%. Continued challenges with the skin pathway, compounded by an increase in referrals over the summer has the biggest impact on performance, with reduced performance also noted in Gynaecology and Breast. The 62 day performance is above trajectory and above the national requirement of 70% 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 with FDS steering groups in Skin, Colorectal, Breast and Gynae to monitor performance and required transformational changes as guided by the BPTP audits. Review the impact of the changes made in the skin pathway, such as reducing to one lesion and removing second review of benign lesions via AI. Work commencing on the future of the community pathway from March 2025. Implementation of post menopausal bleeding (PMB) pathway for people receiving HRT to be managed outside an Urgent Suspected Cancer referral by Q3. Monitor the impact of the implementation of risk stratification tools in Prostate to reduce unnecessary progression to MRI and/or progression to biopsy and/or progression to treatment regimens. Review radiological support to the Breast clinics, with external support withdrawing from October 2024 there is significant risk to delivery.





KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
RTT Waiting List	Aug 24	33887				32795	31389	34201
RTT 65+ Week Waits	Aug 24	463				503	333	673
RTT 78+ Week Waits	Aug 24	53	0			159	90	227
Potential 65+ ww at end of Sept 2024	Aug 24	741	0					
Community Paediatrics RTT Overall Waiting List	Aug 24	565	-			503	448	557
Community Paediatrics RTT Overall 52 Weeks Wait	Aug 24	2	-			1	-2	4
Community Paediatrics RTT Overall 65 Weeks Wait	Aug 24	0	-			0	0	1
Community Paediatrics RTT Overall 78 Weeks Wait	Aug 24	1	0			0	0	0
Community Paediatrics RTT Overall 104 Weeks Wait	Aug 24	0	0			0	0	0
RTT NDD Only Waiting List	Aug 24	74	-			78	51	105
RTT NDD Only 52 Weeks Wait	Aug 24	0	-			0	0	0
RTT NDD Only 65 Weeks Wait	Aug 24	0	-			1	0	1
RTT NDD Only 78 Weeks Wait	Aug 24	0	-			0	-1	2
RTT NDD Only 104 Weeks Wait	Aug 24	0	-			0	0	0

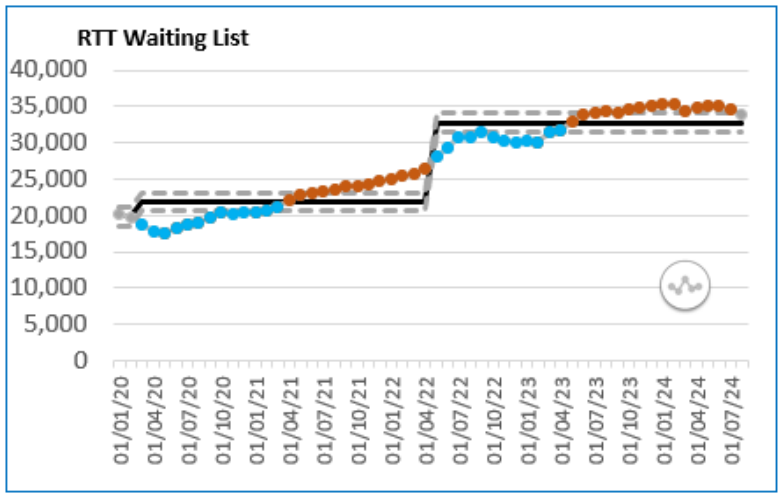
Elective Access

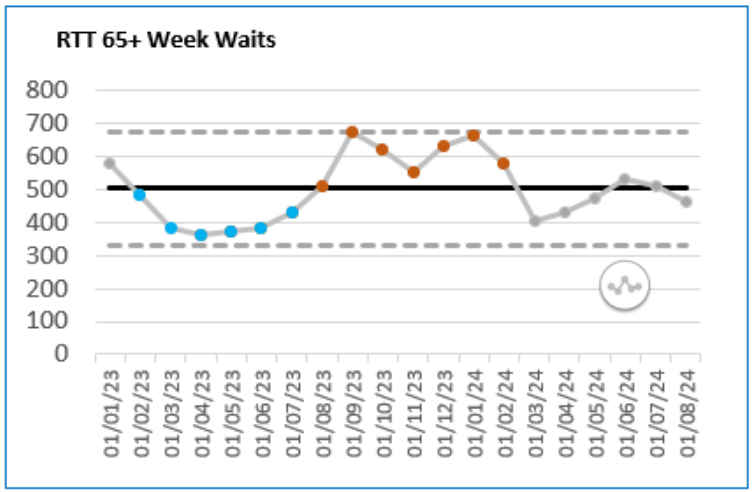


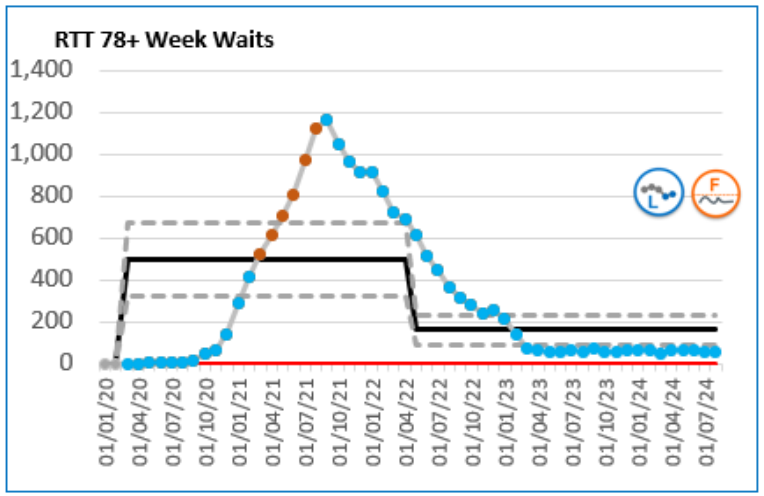
Diagnostics

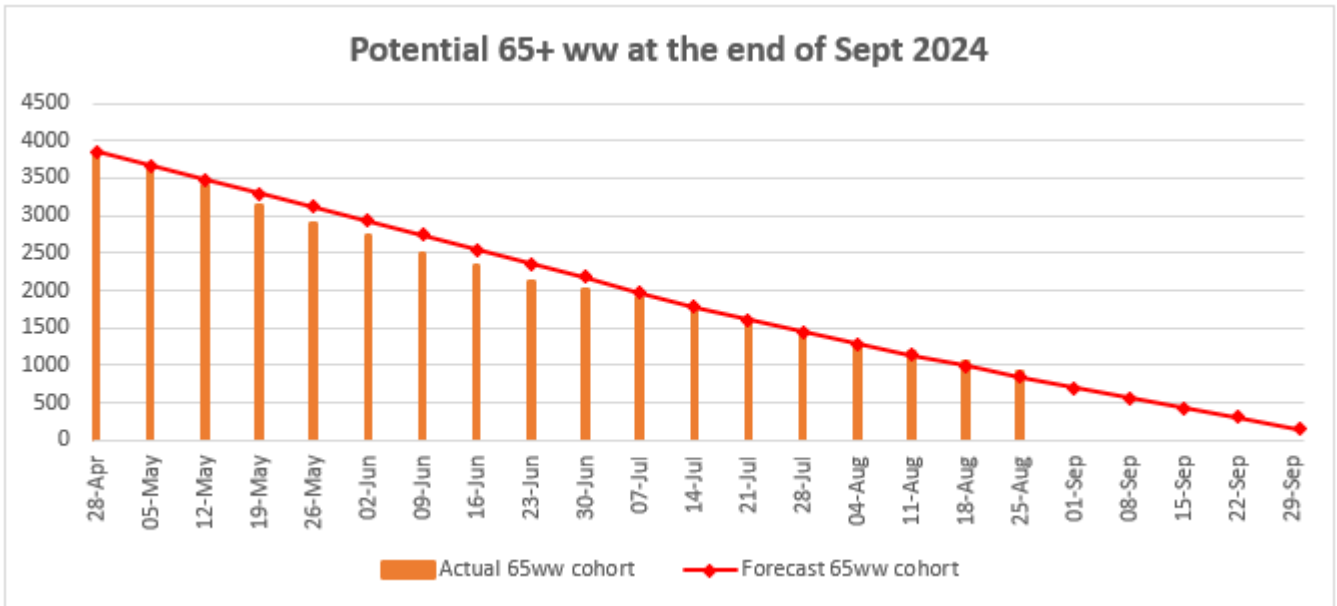
What	So What?	What Next?
MRI – Common cause consistently failing target. Running at full capacity across the seven days but current capacity insufficient. MRI 2 replacement programme commenced 27/11/2023 is now completed but has a legacy impact on performance. There has been an additional small uplift in activity due to staff undertaking additional hours. This is not a sustainable capacity increase and there are staff welfare issues associated. MRI capacity will continue to deteriorate until the commencement of scanning at the CDC due to demand continuing to exceed capacity. CT – Currently not meeting DM01 compliance target due to impacts of the replacement programme. Our current DM01 position is lower than previously anticipated. This is due to an increase in inpatients and UEC demand displacing DM01 activity and impacting capacity for the longer waiting patients. A utilisation review has identified an opportunity for an additional 5 patients per week. US – A step increase in the recovery trajectory can be observed but plateaued and has deteriorated in month. Increased inpatient and UEC demand is compounded by recruitment challenges within the team. Performance remains vulnerable until recruitment improves. DEXA – We will not be able to go live with out DEXA service in November 2024 due to estates delays relative to ventilation and fire protection works. Anticipated go live now March 2025. Approval to be sought for extension of temporary mobile cover to bridge to new opening date. Endoscopy – Priority has been given to patients on a cancer pathway requiring a rebalancing of capacity to support. 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. However, consistent improvements have been demonstrated to date. Impact of financial recovery will likely delay DM01 target compliance to August 2025. Overall diagnostic performance may be impacted by financial recovery measures and workforce controls. Audiology saw a 6.7% reduction due to LT sickness in addition to AL within the ENT secretarial team The DM01 trajectory has been refreshed, compliance expected in March 2025 as previously indicated. Urodynamics and cystoscopy have also seen a reduction in performance (8.9%/3.7%), driven by an increased need for TP biopsies in additional to AL. The urology trajectories indicating compliance in January 2025.	Longer waiting times for diagnosis and treatment have a detrimental effect on patients. Delay in achieving DM01 compliance standards. We continue to prioritise diagnostic activity for those most clinically urgent, using the space and staffing resource we have available as flexibly as possible. We continue to seek ways to improve the care we provide, enabling improved performance.	MRI – Mitigations including the delivery of 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 Q4 of 24/25 supported by CDC capacity. US – Staffing issues remain unresolved, and CDC capacity will not be realised until recruitment picture improves. Management team continue to review recruitment options aligned to CDC and cognisant of the workforce controls in place around financial recovery. DEXA – Once open the new service will increase DEXA capacity from 3 days per month to 3 days per week once staff are training and service is up and running fully. This will allow quick recovery of DEXA DM01 compliance. Endoscopy – Anticipated compliance with the DM01 target ambition of 95% by August 2025. Financial recovery measures may impact additional hours worked to deliver performance improvements against the DM01 standard across multiple modalities. Further work is required to deliver core services on a substantive staffing model rather than historic temporary staffing arrangements especially around core OOH acute service provision. Development of long-term workforce plan for urology and further exploration of provider collaboration- away day 26th July Consultant recruitment 9th September 2024 Ongoing ENT secretary validation of audiology waiting list Introduction of further risk stratified pathways to reduce demand/triage. Liaison with CUH regarding opportunities for joint working, there being an established relationship

Elective Access: RTT





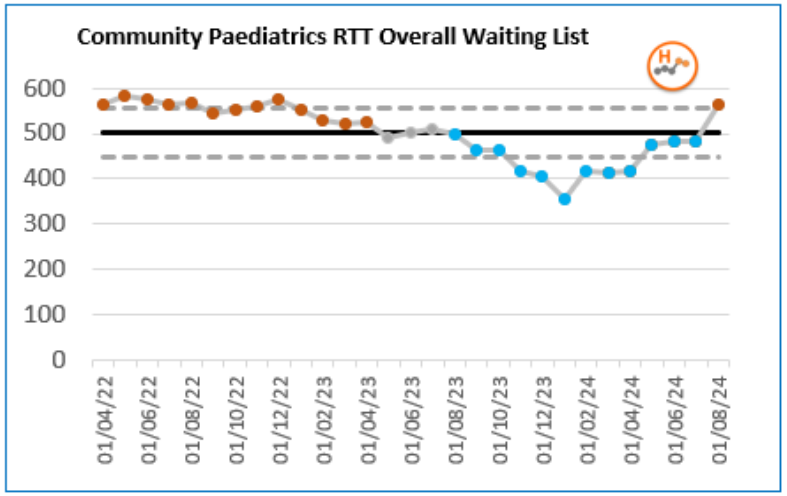


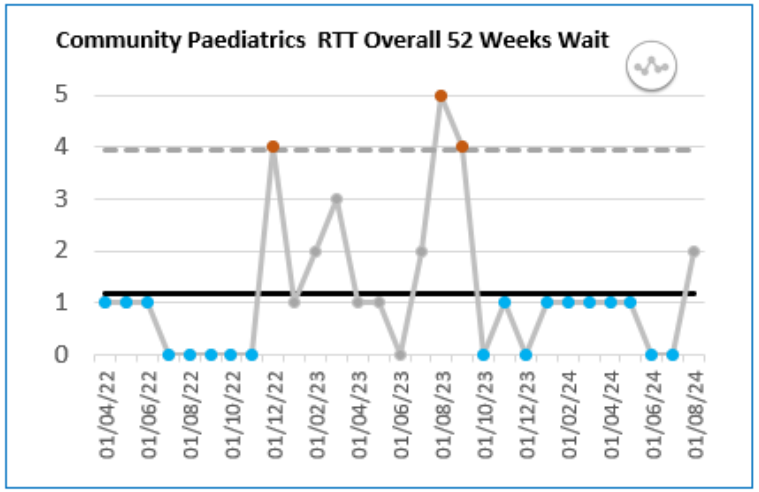


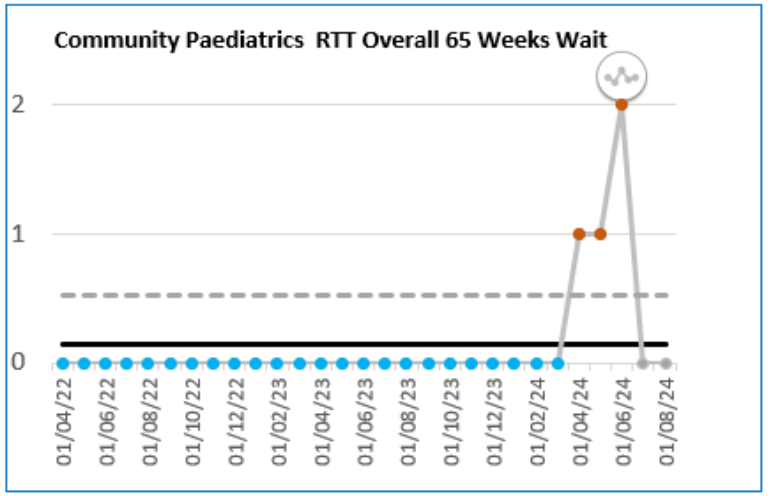
Elective Access: RTT

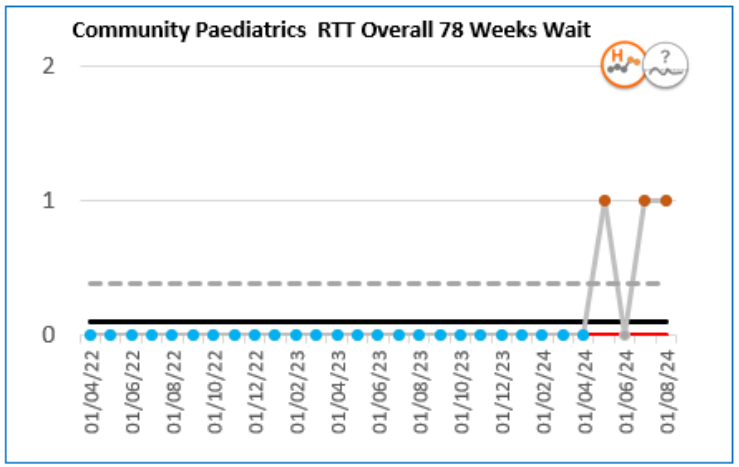
What	So What?	What Next?
The volume of actual 65 week waits has reduced this month. The total volume of patients in the 65 week wait cohort is now above trajectory, with both Orthopaedics and Gynaecology unable to hit a 0 position. The total number of 78 week waits reduced, with a number of capacity breaches continuing in Gynaecology. The total waiting list size remains high.	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.	Trajectories for Orthopaedics and Gynaecology to be rebased with a revised clearance date. Benefits and sustainability of sending Gynaecology patients to the Nuffield to be reviewed and next steps to be agreed from October onwards.

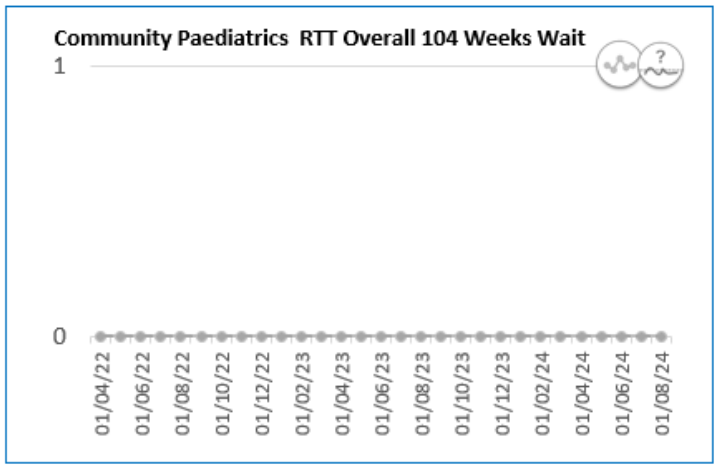
Elective Access (Community Paediatrics)











What	So What?	What Next?
The impact of receiving and managing the backlog of neurodevelopmental (NDD) assessments for autism in school age children (not shown here) has impacted on capacity as some children have transferred to community caseload due to complexity. Increased new referral numbers for the pathway in July. The longest waiters are being managed by outsourcing assessments within the ICB funded recovery plan. In addition to the NDD pressure, the pediatric team continue to see increasing complexity with preschool pathway and in raising caseload.	Children continue to wait longer for school age autism assessments due to high demand. Signposting to support services is undertaken as appropriate. Referral enquiries relating to waiting times are sent into a dedicated email inbox via Care Coordination Centre but this is challenging to manage responses. Children continue to be prioritised according to clinical need. Insufficient clinical capacity to triage volume of referrals received in usual timescale.	Due to high acceptance rate for school autism assessments there has been further funding granted by the ICB to clear the longest waiters. Structured discussion with ICB to review paediatric capacity pressures in the context of the new NDD pathway proposals has been requested. Options to manage demand and capacity being explored formally.

NHS England - 24/25 (Monthly - IQPR)

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

West Suffolk NHS
NHS Foundation Trust

All

All

Outpatient First

Mon	23/24	ERF	24/25	Var %
Apr	9,544	10,332	10,278	(0.5%)
May	9,660	10,457	10,314	(1.4%)
Jun	9,090	9,840	9,851	0.1%
Jul	10,165	11,004	10,645	(3.3%)
Aug	8,967	9,707	9,226	(5.0%)
Sep	9,544	10,332		
Oct	10,453	11,316		
Nov	9,891	10,707		
Dec	8,744	9,465		
Jan	10,345	11,199		
Feb	9,205	9,965		
Mar	9,365	10,138		
Total (YTD)	47,426	51,341	50,314	(2.0%)

August 2024

23/24	8,967
ERF	9,707
24/25	9,226
Var	(481)
Var %	(5.0%)

Daycase

Mon	23/24	ERF	24/25	Var %
Apr	2,191	2,373	2,435	2.6%
May	2,245	2,431	2,569	5.7%
Jun	2,084	2,257	2,265	0.4%
Jul	2,364	2,560	2,614	2.1%
Aug	2,109	2,284	2,326	1.8%
Sep	2,245	2,431		
Oct	2,459	2,663		
Nov	2,408	2,608		
Dec	2,056	2,227		
Jan	2,420	2,621		
Feb	2,219	2,404		
Mar	2,241	2,428		
Total (YTD)	10,992	11,905	12,209	2.5%

August 2024

23/24	2,109
ERF	2,284
24/25	2,326
Var	42
Var %	1.8%

Outpatient Follow Up

Mon	23/24	ERF	24/25	Var %
Apr	25,352	27,046	27,924	3.2%
May	25,659	27,373	28,140	2.8%
Jun	24,145	25,758	26,476	2.8%
Jul	27,000	28,804	28,063	(2.6%)
Aug	23,819	25,410	25,070	(1.3%)
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)	125,974	134,390	135,673	1.0%

August 2024

23/24	23,819
ERF	25,410
24/25	25,070
Var	(340)
Var %	(1.3%)

Elective

Mon	23/24	ERF	24/25	Var %
Apr	256	277	270	(2.5%)
May	267	289	293	1.5%
Jun	247	267	232	(13.1%)
Jul	280	303	274	(9.6%)
Aug	256	277	277	0.0%
Sep	256	277		
Oct	284	307		
Nov	268	290		
Dec	249	269		
Jan	234	253		
Feb	244	264		
Mar	244	264		
Total (YTD)	1,306	1,413	1,346	0.0%

August 2024

23/24	256
ERF	277
24/25	277
Var	0
Var %	0.0%

Outpatient attendances that are a first attendance or with a procedure

All

All

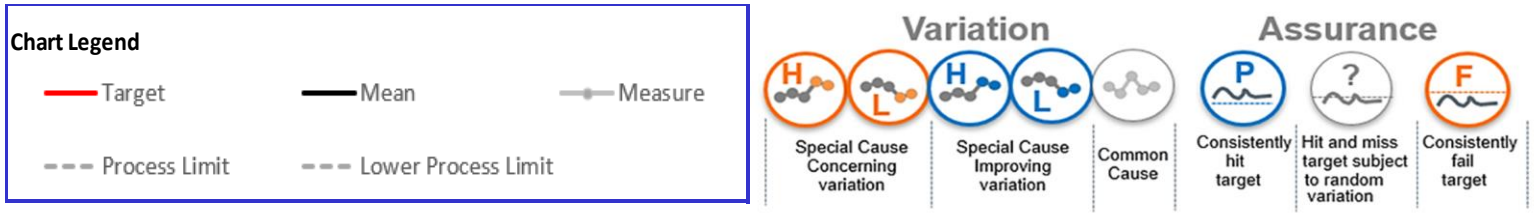
Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
23/24	37.4%	36.4%	36.6%	37.7%	37.9%	37.8%	35.9%	35.0%	36.3%	36.2%	37.1%	37.7%	**36.8%**
24/25	37.2%	36.2%	36.4%	37.8%									**36.9%**

Target	46.0%
Month	37.8%
YTD	36.9%

Elective Access: Activity

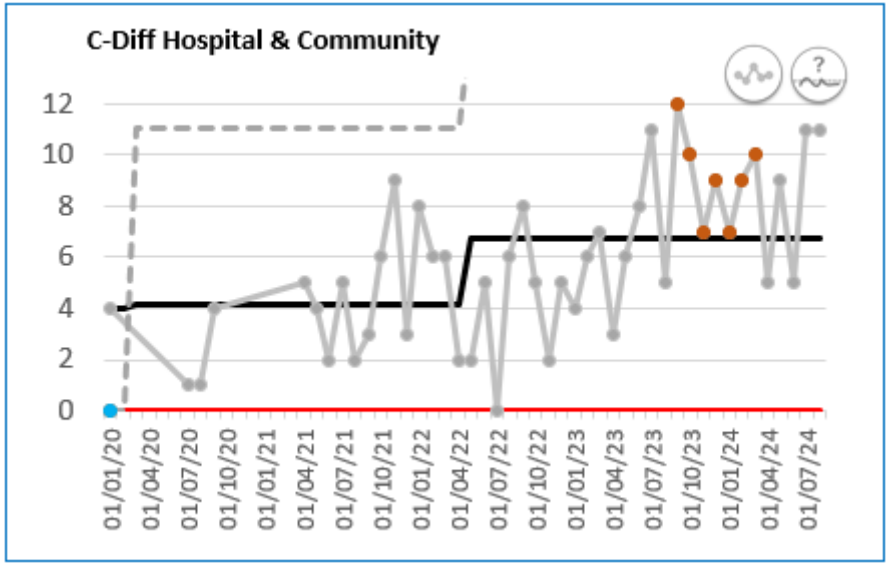
What	So What?	What Next?
Day cases are meeting the required threshold to deliver the system level activity target of 108.09% of 2019/20 activity levels, and elective activity has recovered in August to 0.4% ahead. Outpatient follow ups have dropped below 2019/20 levels in July and August, having been over between April and June. These do not attract ERF unless they include a procedure. Outpatient first attendances (that do attract ERF), have decreased further to 5% behind plan in August. Outpatient attendances that are a first attendance or with a procedure show no significant change from the 2023/24 average, though have increased in August from July's percentage.	Although achievement is measured in terms of value and at a system level, increasing absolute activity is required to achieve Elective Recovery Fund income and deliver on the objective to eliminate waits of >65 weeks by September 2024. Although there is no specific requirement to deliver a reduction in outpatient follow ups this year, doing so will support delivery of the other modalities on which the Elective Recovery Fund threshold is based and will support the new ambition of 46.2% of outpatients to either be first attendances or with procedures.	**W&C:** Ensuring sufficient beds available to deliver increased uro-gynae activity, with a continued focus of general paediatrics Patient Initiated Follow Up (PIFU) and assessing impact of winter staffing requirements on outpatient activity. **Medicine:** • Division to review outpatient ERF opportunities (new outpatient activity). • Further Faster outpatient checklist being reviewed within specialties to ensure baseline is standardised. • Dermatology enacting focussed recovery plan for cancer/elective waits which will increase activity. • Respiratory activity now above ERF threshold following new consultant recruitment. • Trial of 12 point endoscopy lists in September to increase activity. • **Surgery:** • Reinforcement and monitoring of Patient Initiated Follow Up. • Increased delivery of HVLC lists. • Continuation of weekend lists. • All lists booked to 90% - 100%. • Specialty level ERF tracker and identification of shortfall. • Delivery of ERF plan.

IMPROVEMENT COMMITTEE METRICS



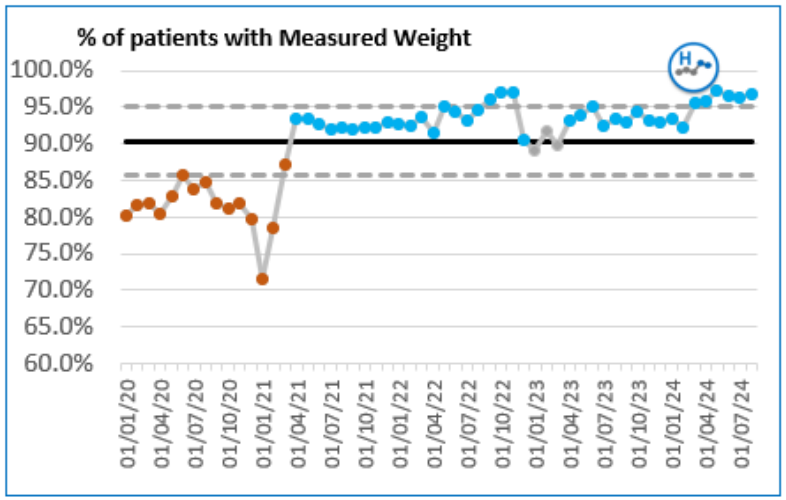
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
C-Diff Hospital & Community	Aug 24	11	0			7	-2	15
% of patients with Measured Weight	Aug 24	96.8%				90.4%	85.7%	95.0%
% of patients with a MUST/PYMS assessment completed within 24 hours of admission	Aug 24	89.6%				89.6%	82.7%	96.4%
% of patients with a MUST/PYMS assessment completed within 48 hours of admission	Aug 24	95.2%				93.2%	89.1%	97.3%
Post Partum Haemorrhage	Aug 24	8				8	-2	17

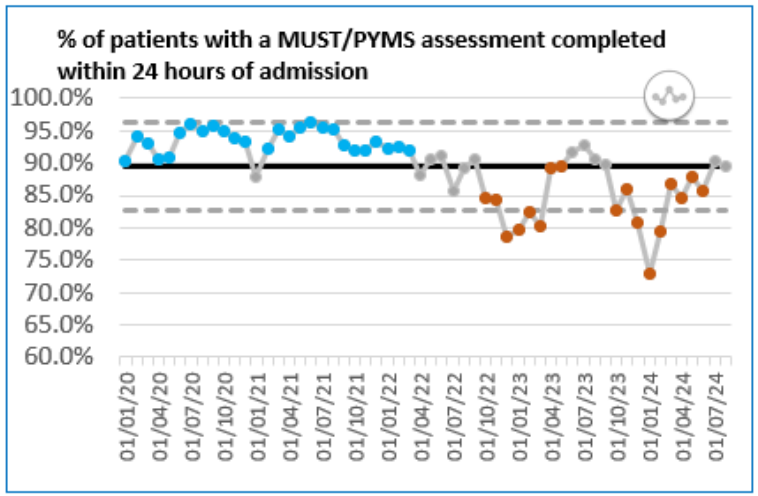
Safe

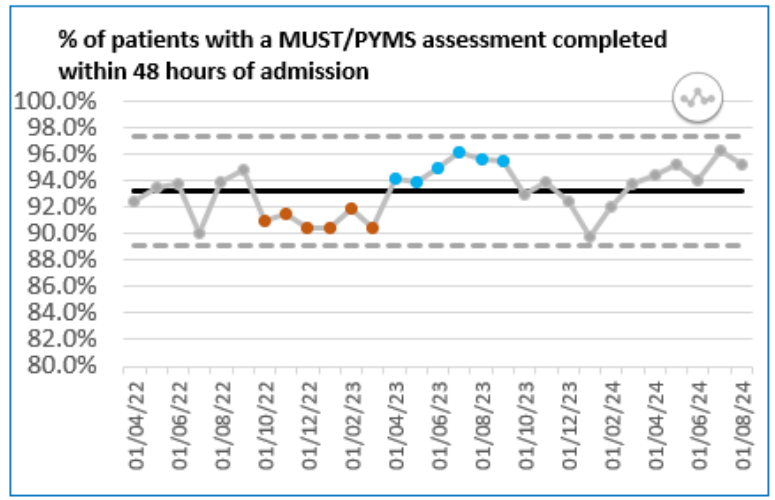


What	So What?	What Next?
There has been no significant reduction in rates since September 2023 due to the multifaceted issues surrounding *Clostridioides difficile* infection. Rates of C-diff are in common cause variation indicating no predictable or sustained achievement of performance The threshold set combines HOHA & COHA cases which provides the organisations measure for national/regional data and better demonstrates the impact on our patient group. It is recognised Nationally that the rates of *Clostridioides difficile* have increased significantly over the last two reporting years. The NHS Standard Contract 2024/25: Minimising Clostridioides difficile is now published with a WSH threshold of 91 (increased from 49 2023-24). Incident rates tracking close to this at M5	Healthcare-associated infections (HCAIs) can develop either as a direct result of healthcare interventions such as medical or surgical treatment, or from being in contact with a healthcare setting. HCAIs pose a serious risk to patients, staff and visitors. They can incur significant costs for the NHS and may cause significant morbidity to those infected. As a result, infection prevention and control is a key priority for all NHS providers.	The situation is complex and has been identified as an organisational key priority, with escalations via patient quality & safety group and the improvement committee. The Quality Improvement Programme will run for at least 12 months once the measures are agreed. There are six subgroups which all have leads identified and are active. Some actions: • QI oversight meeting – Project Manager & oversight chair to be identified – October 2024. • Regular oversight meetings to be planned – October 2024 • Environment & cleaning – Enhance clean of ED in phases, discussed with Matron who will discuss logistics with domestic staff – target sluices, commonly touched areas, de-clutter where possible of counter tops for ease of cleaning. • AMS – Hard stop to go live 7th October 2024. • Project manager confirmed (September '24) to support pace and progression of improvement plan • Deputy chief nurse to review sub group membership to improve KPI monitoring

Safe



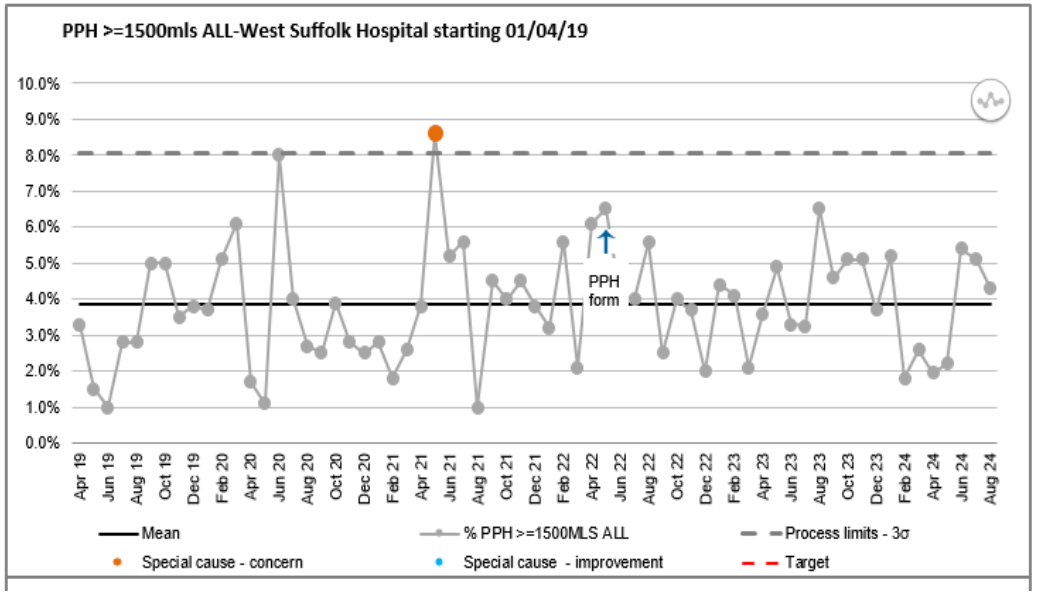


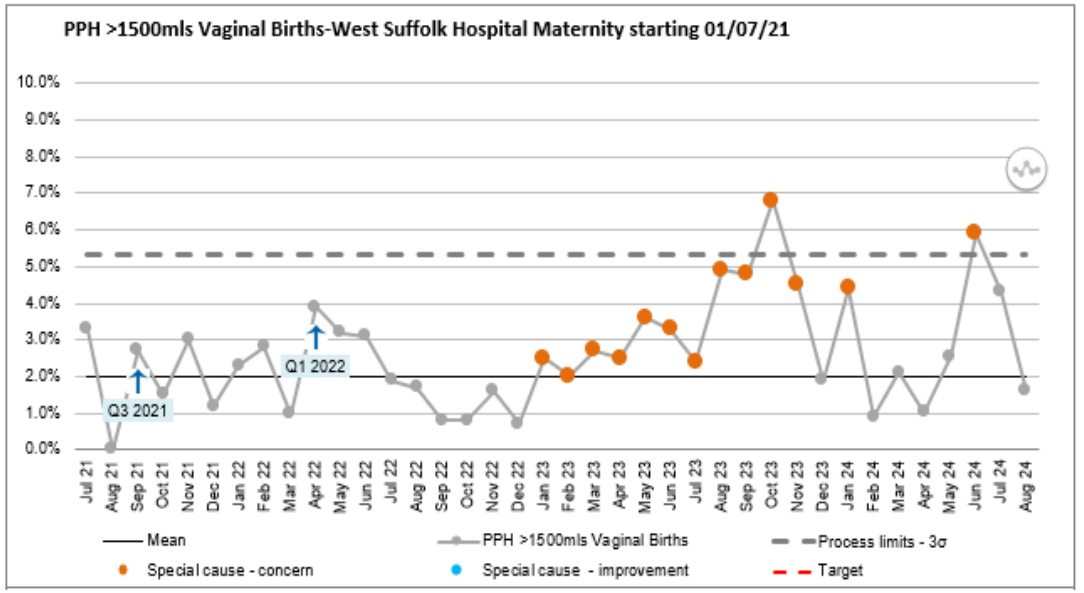


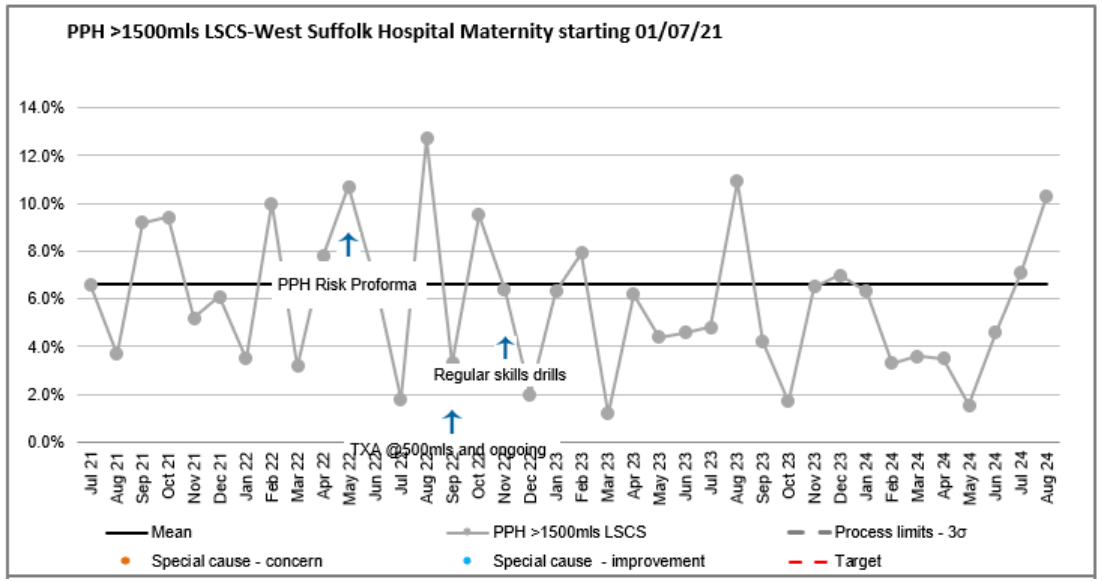
What	So What?	What Next?
% measured weights during inpatient stay: Consistent achievement of weights above 95%. % risk assessments: Moving out of cause for concern into common cause variation for past two months. Driven in part by improvements in flow within UEC pathway	Nutrition and hydration is a fundamental element of care and continues to be an area of focus and improvement for all the teams in the Trust. There is improved awareness that this will underpin a positive experience and outcome for the patients in our care. There are plans in place to renew the reporting process to capture the timeliness of assessments when patients are admitted to a ward. This will provide teams with the opportunity to improve the compliance and accuracy of this important metric. There are recurrent delays in receiving this data set due to issues with the data warehouse implementation. Confirmation of a start date for this remains outstanding and has been escalated.	• Engage and focus on activities to improve the UEC performance and continue to monitor these improvements against the nutrition assessment data. • Monitor introduction of short assessment in ED and observe the impact on this – October 2024 • Information team to change reporting metrics to ensure each ward area is being accurately monitored for compliance – To seek assurance and gain a start date pending • Continue to share the data with teams monthly to provide awareness to the teams where areas of improvement need to be made or highlight improvements made • Monitor for incidents or complaints raised regarding nutritional intake or support at department level to gain assurance. • 'Food is medicine' MDT workshop to be delivered in September 2024

Safe

Post-partum haemorrhages (PPH) above 1500mls







Safe

What	So What?	What Next?
The data illustrates that overall, the PPH incidence are in common cause variation. From February 2024 to May 2024, the incident rate declined and dropped below the target of 3%. However, the data from June 2024 onwards shows an increase in incidents for both Lower Section Caesarean Sections (LSCS) and Vaginal Births, resulting in an overall rate of 4.3 %. The NMPA (National Maternity and Perinatal Audit)targets based on 2022 data are not being consistently met.	Severe bleeding after childbirth - postpartum haemorrhage (PPH) - is the leading cause of maternal mortality world-wide. Each year, about 14 million women experience PPH resulting in about 70,000 maternal deaths globally (WHO 2023) PPH is one of the most common obstetric emergencies and requires clinical skills, with prompt recognition of the severity of a haemorrhage and emphasise communication and teamwork in the management of these cases. Following a PPH there is the potential increase of length of stay and additional treatment and financial implications for the organisation and family. Family bonding time is affected as well as subsequent related issues for example; postnatal depression, establishing breast feeding etc.	Quality Improvement 3rd cycle launched 5 workstreams identified; Anaemia, Training, Risk, Equipment/Estates and Medication (in progress) Continue engagement with Local Maternity and Neonatal System and Regional QI projects regarding PPH Site visits to maternity units with acceptable range of PPH (Q3 2024) Undertake ‘so what’ review, in relation to PPH The Regional team to remove the NMPA targets and monitor regional trends.

Regional year to date data- July 2024

Safe

NHS England East of England

Maternity Data - East of England Collection

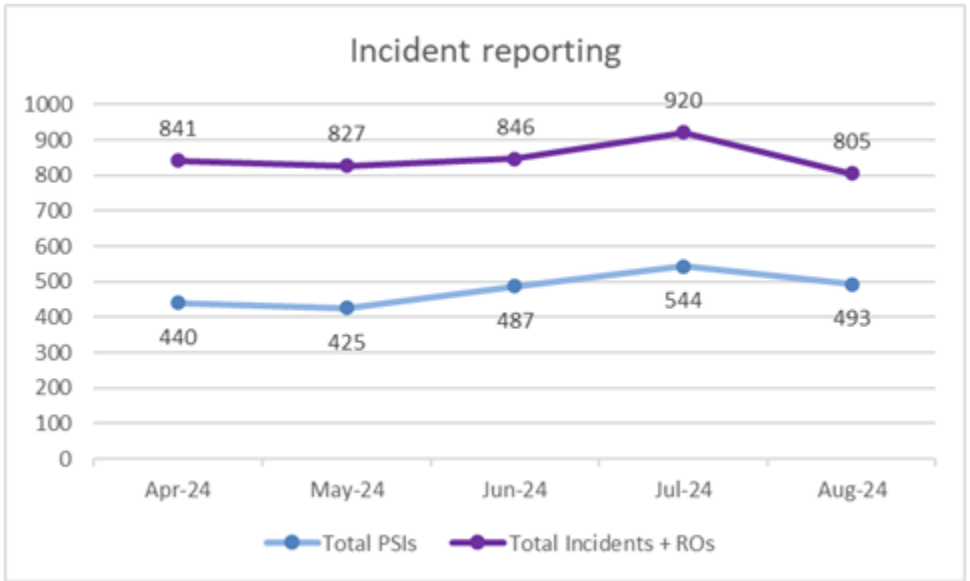
Site: Regional Year to date view (April - July 2024)

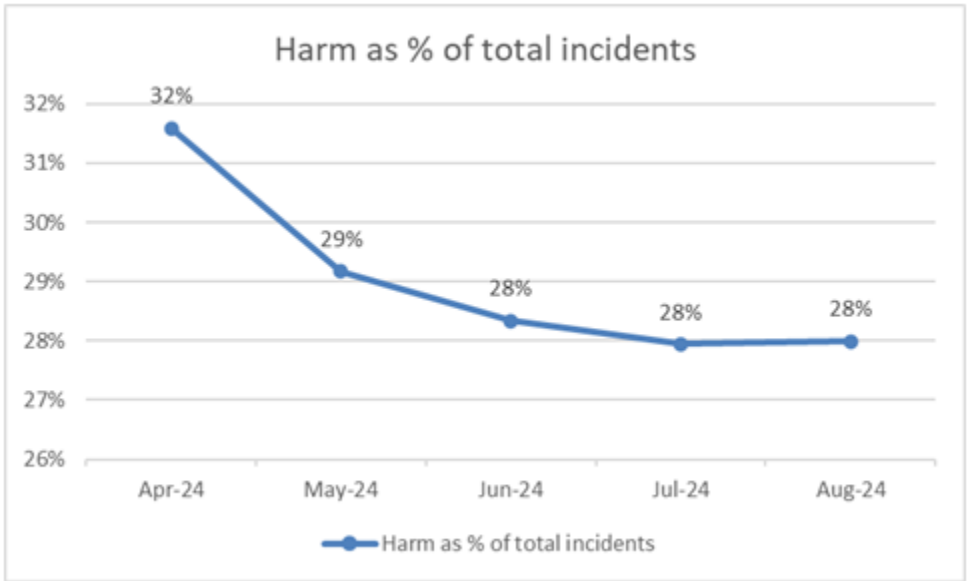
Metrics in grey are automatically calculated

	Metric	Metric ID	Description	Target	SNEE West Suffolk	Regional year to date
	MOH ≥ 1500mls	MH001	All single, term, vaginal births		433	**11688**
		MH002	Single, term, vaginal births - with Massive Obstetric Haemorrhage		15	**392**
		MH003	% Vaginal Birth - Massive Obstetric Haemorrhage		3%	**3.4%**
		MH004	All single, term caesarean births		228	**7731**
		MH005	Single, term caesarean births -with Massive Obstetric Haemorrhage		9	**268**
		MH006	% Caesarean birth - Massive Obstetric Haemorrhage		4%	**3.5%**

What	So What?	What Next?
For additional assurance and benchmarking the above data is submitted to the regional team from individual maternity units. The NMPA targets have been removed by the Regional team. Massive Obstetric Haemorrhage (MOH) rates at the WSFT are in line with regional average (financial year to date).	This demonstrates how WSFT compares with regional peers	Continue engagement with Local Maternity and Neonatal System and Regional QI projects regarding PPH Continue to monitor SPC to be generated once a 12 months of data is available.

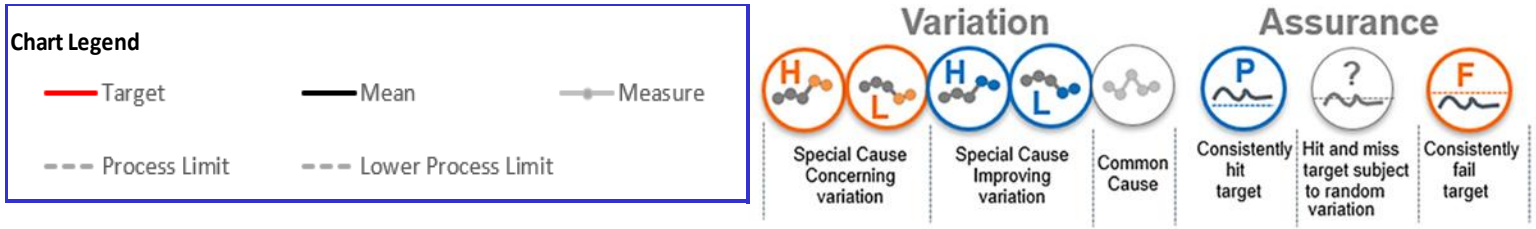
Safe





What	So What?	What Next?
The number of reported patient safety incidents (PSI) and reportable occurrences (RO) continue to be stable but overall reduced when compared with reporting on Datix. This is scrutinised at the Radar Oversight Group (ROG). Harm as a % percentage of total reported PSI is a measure of safety and demonstrates we are reporting low harm and near miss events as well as incidents which are attributed to harm. The low percentage is a good indicator of safe care.	An in-depth six month analysis report is being prepared for discussion at ROG and for inclusion in the patient safety report for the PSQGG (due this month). The report will provide a like for like comparison of reporting figures for areas and subject (where available). The report will highlight areas where reporting is markedly down and where areas have embraced and are reporting more incidents and ROs via Radar. Through this analysis can encourage more reporting with the goal to reduce the percentage of harm indicator.	The report will allow the patient safety team to work closely with those areas to understand what the enablers and barriers are for our current reporting trends. We will also engage with subject matter leads to ensure triangulation of data to ensure this is representative of our current safety climate. The patient safety team have refreshed the quarterly thematic analysis report which is shared at PQASG to ensure it analyses the data to allow for learning outcomes to be shared widely with the clinical divisions and the specialists leads. This will report will be combined include quarterly incident data for analysis. Metrics for measuring safety into improvement are being developed with the QI team and will be reviewed at the new safety improvement group, due to launch in October 2024 following the patient safety summit which was held in September.

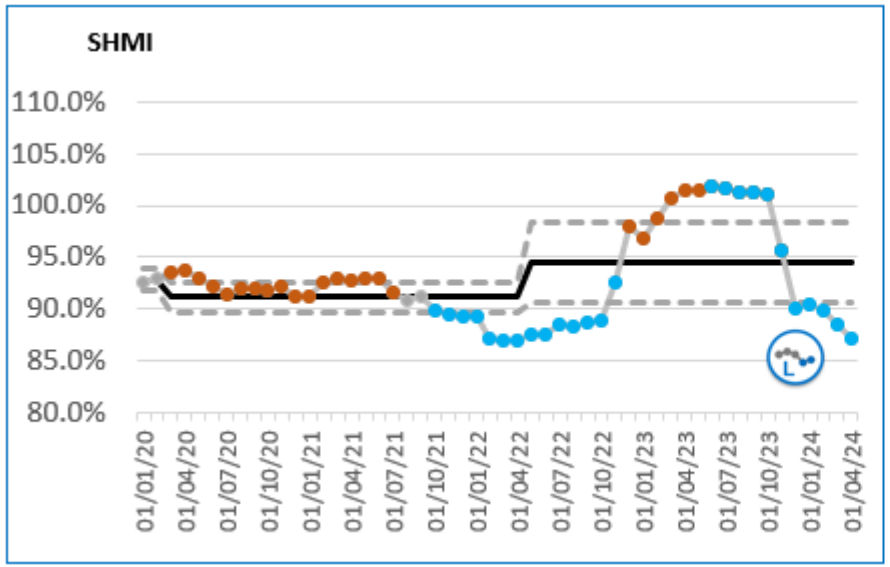
Mortality Summary

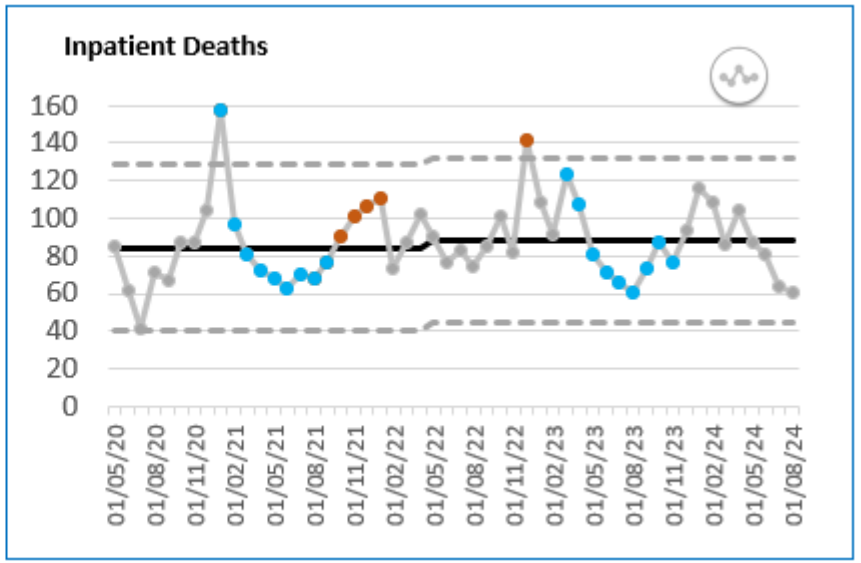


KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
SHMI	Apr 24	87.1%				94.5%	90.7%	98.3%
Inpatient Deaths	Aug 24	61				89	45	132

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

Mortality





What	So What?	What Next?
The data is showing us that the SHMI data for WSH is on a low special cause improving variation. This is showing that the variation from the coding error is now falling back to where it would have likely been. Inpatient deaths is within expected common variation and within range fair range of the mean. The flag alert on the WSH data narrative has now been removed from the SHMI database because we are back to normal variation.	This is important as it shows the Trust has a below expected SHMI for our patient mix. This is reassuring that the care we are providing is good, and in comparison with other providers we have more patients who survive to discharge in a particular diagnostic groups.	Our Trust will continue to monitor variation and investigate any change that is not expected common cause variation.

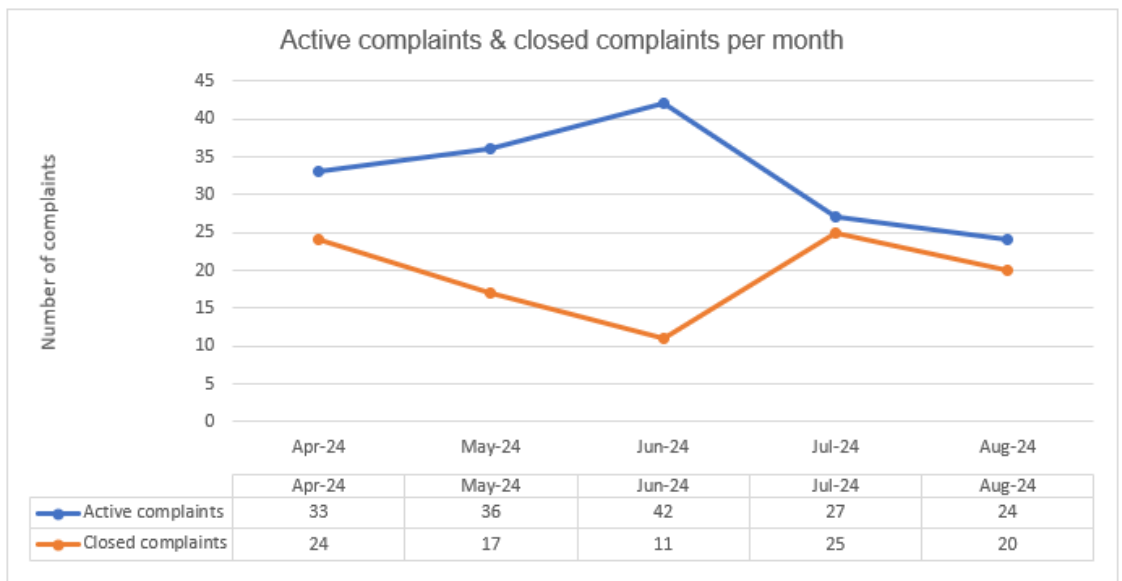
INVOLVEMENT COMMITTEE METRICS

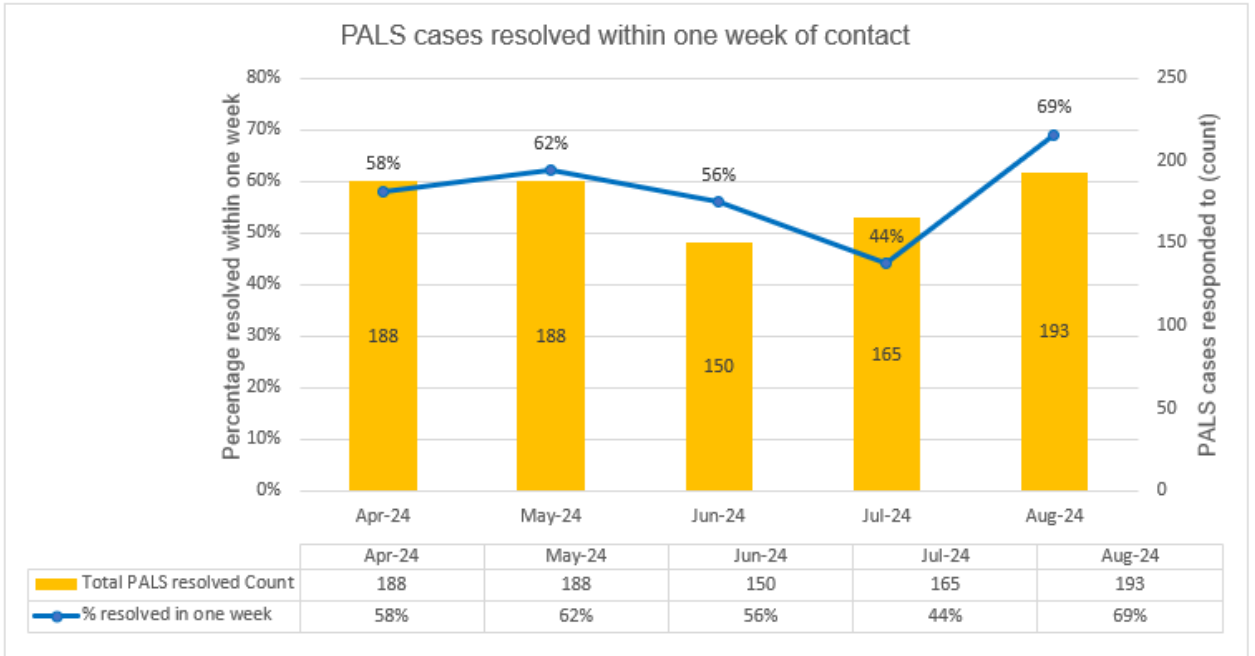
Safe

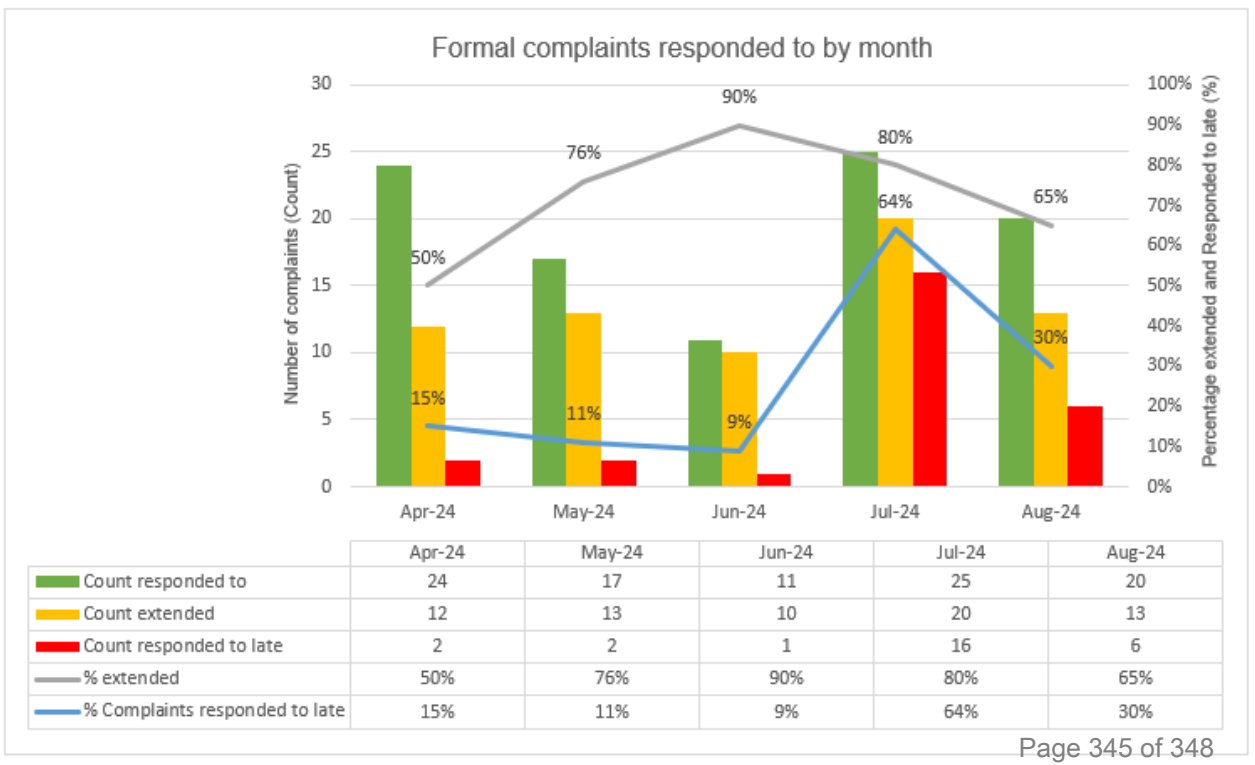
	Apr-24	May-24	Jun-24	Jul-24	Aug-24
Active complaints	33	36	42	27	24
Closed complaints	24	17	11	25	20

	Apr-24	May-24	Jun-24	Jul-24	Aug-24
Count responded to	24	17	11	25	20
% extended	50%	76%	90%	80%	65%
Count extended	12	13	10	20	13
% Complaints responded to late	15%	11%	9%	64%	30%
Count responded to late	2	2	1	16	6

	Apr-24	May-24	Jun-24	Jul-24	Aug-24
% resolved in one week	58%	62%	56%	44%	69%
Total PALS resolved Count	188	188	150	165	193

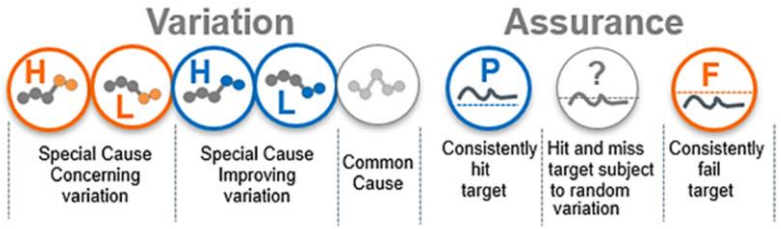






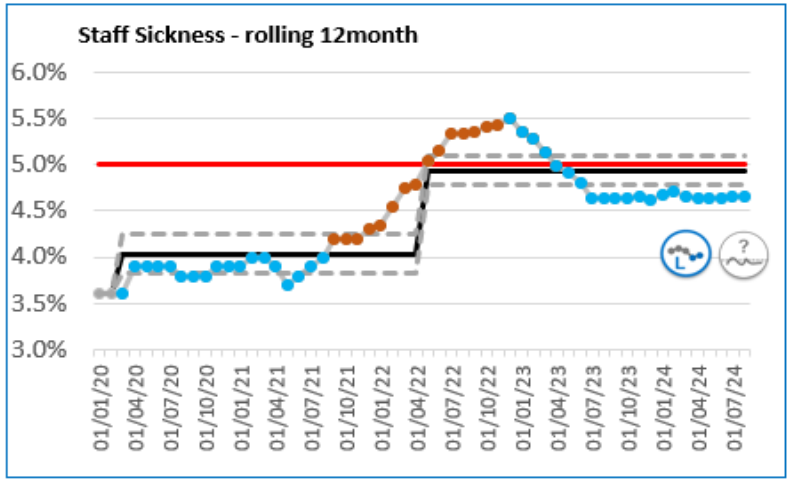
Safe

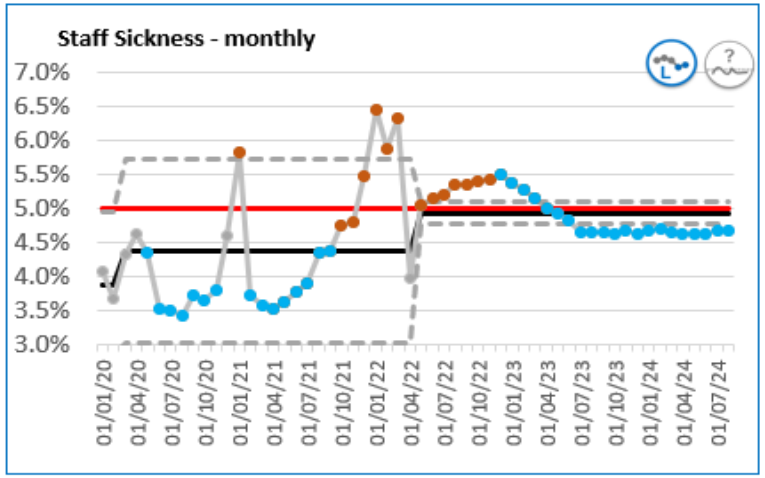
What	So What?	What Next?
193 PALS cases resolved within August with 69% closed within one week. This is the highest amount of cases resolved within one week for this financial year and nearing our target of 75%. When analysing the data, the average time for resolution is 10 days. The team historically had not been logging all activity due to the time taken to record on RADAR and so improvements have been made to a shorter version of the PALS form to ensure activity is logged accurately. At the time of reporting we had 24 open complaints for the Trust in total, across all divisions. In August the complaints team resolved 25 complaints which helped reduce this figure. Of the 25 complaints that were responded to, 6 were classified as late. 2 of these complaints we were waiting for SJR's to be completed and the further 4 late complaints were due to complainants being dissatisfied with the length of time for a response. This was due to waiting for clinical staff responses. Of the 20 that were responded to, 65% were extended, which is greater than we would expect, however these extensions are in line with our policy and national regulations, whereby complaints can be extended with the agreement of the complainant. Whilst the volume of complaints extended are below expected standards, this doesn't appear to impact the complainant satisfaction levels as the current first-time resolution rate remains high at 92%. We will continue to monitor the overall picture with aims to improve all metrics alongside our investigating colleagues and sign off at the Trust Office.	The PALS team have introduced new working methods to ensure time is taken to accurately record PALS activity which doesn't require full investigation. The team are constantly providing support, advice, information and guidance to patients and their loved ones on a daily basis which doesn't always require investigation, however can take a considerable amount of time. The complaints team continue to implement and adapt the new strategy of obtaining staff responses in a more timely manner, whereby we remind staff that the due date for their response is coming up rather than only informing them once overdue. This is working well and we are receiving staff investigations at an earlier stage.	The PALS team are continuing to work towards reaching their goal of a minimum of 75% resolved within 1 week by the end of December 2024. August's data reflects that they are on course to achieve this. Further amendments to the PALS RADAR form are being considered for more streamlined recording. The second PDSA cycle of the QI test and learn project has been completed within the complaints team for increased early resolution meetings, as opposed to written responses. There were no successful meetings for a number of varied reasons (Complaint was inappropriate for a meeting, lack of staff engagement or had already been through a previous learning pathway). For the third PDSA cycle, we will issue Trust wide comms about the project and also issue information on the medical directors bulletin with an aim to increase engagement. This will be issued before October 2024 and before the 3rd PDSA cycle starts. To support divisional oversight, we have adapted our sign off process to ensure divisional leads and service managers etc. have input into the draft responses prior to going for exec sign off. This appears to be working well with good engagement at this stage of the process. Regarding extensions, we will continue to monitor this data closely and are reviewing our own working methods, in particular how we prioritise cases where we have received all staff responses and can begin drafting reports. The performance of this is influenced by investigating colleagues and sign-off for which we will monitor and make improvements to our process as sustainable long-term solutions become apparent.

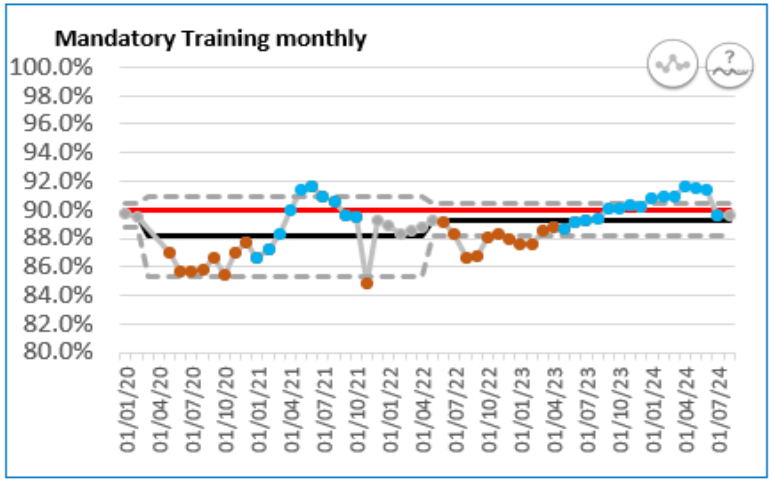


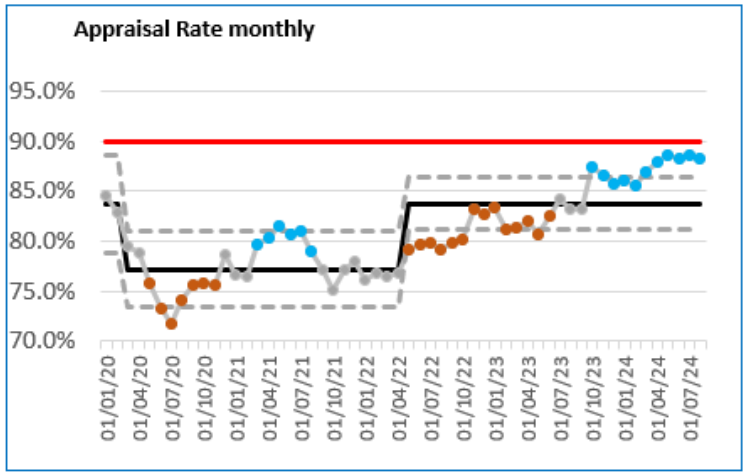
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Staff Sickness - rolling 12month	Aug 24	4.7%	5.0%	L	?	4.9%	4.8%	5.1%
Staff Sickness - monthly	Aug 24	4.7%	5.0%	L	?	4.9%	4.8%	5.1%
Mandatory Training monthly	Aug 24	89.7%	90.0%		?	89.3%	88.1%	90.5%
Appraisal Rate monthly	Aug 24	88.2%	90.0%	H	F	83.8%	81.1%	86.4%
Turnover rate monthly	Aug 24	7.3%	10.0%	L	?	10.8%	10.0%	11.7%

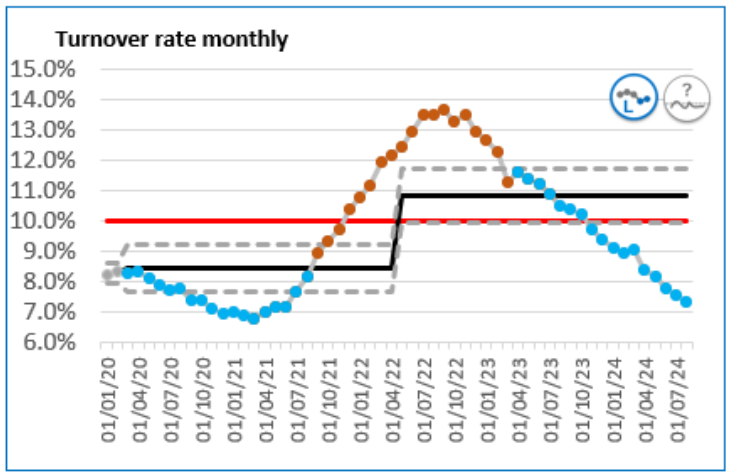
Well Led











What	So What?	What Next?
Three out of four of our key performance indicators continue to record an improving variation with mandatory training marginally below target. Sickness – achieving target at 4.7% versus 5% target. Mandatory training – slightly below target at 89.7%. Appraisal – consistently failing target, 88.2% versus 90% target. Turnover – achieving target, sustained improvement since November 2022.	These workforce key performance indicators directly impact on staff morale, staff retention, and therefore, patient care and safety. Additionally, improvements in these workforce key performance indicators will strengthen our ability to be the employer of choice for our community and the recognition as a great place to work.	Maintain improvements in staff attendance and continue to monitor at department level. Recover the target compliance of mandatory training ensuring areas and staff groups are identified where further focus and support may be required. Continued analysis of appraisal data to support and challenge areas in need of action and improvement. Maintain focus on the delivery of our people and culture plan and priorities.