NHS
West Suffolk
NHS Foundation Trust

Board of Directors (In Public)

Schedule	Friday 29 November 2024, 9:15 AM — 1:45 PM GMT
Venue	Education Centre
Description	A meeting of the Board of Directors
Organiser	Gemma Wixley

Agenda

AGENDA
Presented by Jude Chin

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

10:10 AM — 1.1. Welcome and apologies for absence - Richard Goodwin
To Note - Presented by Jude Chin

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

_WSFT Public Board Agenda - 29 Nov 2024.docx

10:10 AM — 1.3. Minutes of the previous meeting - 27 September 2024
To Approve - Presented by Jude Chin

Item 1.3 - 2024 09 27 September Draft minutes Final - v2.docx

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

Item 1.4 - Board action points - Open.pdf

Item 1.4 Board action points - Closed.pdf

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 - Jacki King Staff/patient Hybrid story (Lucie Johnson in attendance) 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 - November 2024 v4.docx
10:10 AM	2.	STRATEGY
10:30 AM	2.1.	Future System board report To inform - Presented by Ewen Cameron Item 2.1- FSP wsft public board Nov 24.docx
10:30 AM		Comfort Break
10:40 AM	2.2.	West Suffolk System Update Report For Report - Presented by Peter Wightman Item 2.2 WS Alliance report Nov 24.docx
	2.3.	Collaborative Oversight Group To Assure - Presented by Sam Tappenden Item 2.3 Board Provider Collaborative Update 29th November 2024.docx
11:00 AM	2.4.	Digital Board Report To inform - Presented by Nicola Cottington Item 2.4 Trust Board digital report Nov 2024 NC (002).docx
11:10 AM	3.	ASSURANCE

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

- Item 3.1 IQPR Cover Sheet.docx
- Item 3.1 Board Report September 2024 One page summary.pptx

11:40 AM 3.2. Finance Report
To Assure - Presented by Jonathan Rowell

- Item 3.2 Finance Board Paper - Month 7 Cover Sheet.docx
- Item 3.2 M7 Finance Report for Board.pptx

11:40 AM Comfort Break

11:50 AM 4. PEOPLE, CULTURE AND ORGANISATIONAL DEVLEOPMENT

12:05 PM 4.1. Involvement Committee Report - Chair's Key Issues from the meeting
To Assure - Presented by Tracy Dowling and Jeremy Over

- Item 4.1 INVOLVEMENT CKI report b 16 Oct 2024 FINAL TD.doc

4.2. People and OD Highlight Report
To Assure - Presented by Jeremy Over

- Item 4.2 - GOSW ANNUAL REPORT 2023-2024.docx
- Item 4.2 FTSUG appendix - FTSU COMMS PLAN 2024 - FINAL.docx
- Item 4.2 WSFT FTSUG report Q2 2024 2025 FINAL.doc
- Item 4.2 PYF awards Nov24.pptx

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5. OPERATIONS, FINANCE AND CORPORATE RISK

5.1. Insight Committee Report
Presented by Antoinette Jackson and Nicola Cottington

- Item 5.1 INSIGHT CKI report 16 Oct 2024 AJ.docx

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6. QUALITY, PATIENT SAFETY AND QUALITY IMPROVEMENT

12:15 PM **6.1. Improvement Committee Report**
To Assure - Presented by Roger Petter, Susan Wilkinson and Richard Goodwin

Item 6.1 IMPROVEMENT CKI report c 16 Oct 2024 FINAL RP.docx

6.2. Quality & Nurse Staffing Report
For Report - Presented by Susan Wilkinson

Item 6.2 Nurse Staffing sept.October FINAL.docx

6.3. Maternity quality safety and performance Board report
Presented by Susan Wilkinson

Item 6.3 November 2024 Maternity quality safety and performance Board report final copy.docx

Item 6.3 WSFT executive summary MSDS compliance Updated Nov 24_.docx

7. GOVERNANCE

7.1. Audit Committee report
For Report - Presented by Michael Parsons and Jonathan Rowell

Item 7.1 AUDIT CKI report 1 Oct 2024 MP.docx

7.2. Board Assurance Framework
For Approval - Presented by Richard Jones

Item 7.2 BAF report to Board Nov 24.docx

7.3. Governance Report

Item 7.3 Governance report Nov 2024.docx

8. OTHER ITEMS
Presented by Jude Chin

12:40 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 - 31st January 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

9. SUPPORTING ANNEXES
To inform - Presented by Jude Chin

Item 2.3 Collaborative Oversight Group
Presented by Sam Tappenden

Item 2.3 - Appendix A - Provider Collaborative Governor's Briefing.pptx

Item 3.1 IQPR Full Report
To Note - Presented by Nicola Cottington

Item 9 Appendix 3.1 Board Report September 2024.pptx

Item 7.3 Annex A FT membership and engagement strategy - DRAFT v5
Presented by Richard Jones

Item 7.3 Annex A FT membership and engagement strategy - DRAFT v5.docx

Item 7.3 Annex B Governor election engagement programme.docx

Item 7.3 Annex C Draft Board meeting agenda.docx

AGENDA

Presented by Jude Chin

1. GENERAL BUSINESS

Presented by Jude Chin

1.1. Welcome and apologies for absence - Richard Goodwin

To Note

Presented by Jude Chin

1.2. Declaration of interests for items on the agenda

To Assure

Presented by Jude Chin

WSFT Board of Directors – meeting in public

Date and Time	Friday, 29 November 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** – 27 September 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
10.00	1.7	**CEO report**	Chief Executive	Inform	Report
2.0 STRATEGY					
10.10	2.1	**Future system board report**	Chief Executive	Assure	Report
	2.2	**System update report**	West Suffolk Alliance Director and Director of Integrated Adult Health and Social Care	Assure	Report
10:30 Comfort Break					
10:40	2.3	**Collaborative oversight group**	Director of strategy and transformation	Assure	Report
10:55	2.4	**Digital board**	Chief Operating Officer Liam McLaughlin in	Assure	Report

Time	Item	Subject	Lead	Purpose	Format
			attendance		
3.0 ASSURANCE					
11:05	3.1	**IQPR report** To consider areas for escalation *(linked to CKI reports from assurance committees)*	Executive leads	Review	Report
	3.2	**Finance report** ACTION 3103 - Finance Report - Community Equipment and use of community discharge funding to be taken to Insight Committee for consideration of impact on patient flow. NC	Acting CFO	Review	Report
11:35 Comfort Break					
4.0 PEOPLE, CULTURE AND ORGANISATIONAL DEVELOPMENT					
11.50	4.1	**Involvement Committee report** – Chair's key issues from the meetings	NED Chair	Assure	Report
	4.2	**People and OD Highlight Report** Guardian of safe working annual report -	Dir. HR and Communication Francesca Crawley	Review	Report
5.0 OPERATIONS , FINANCE AND CORPORATE RISK					
12.15	5.1	**Insight committee report** – Chair's key issues from the meetings	NED Chair	Assure	Report
6.0 QUALITY, PATIENT SAFETY AND QUALITY IMPROVEMENT					
12.25	6.1	**Improvement committee report** – Chair's key issues from the meetings	NED Chair	Assure	Report
	6.2	**Quality and nurse staffing report**	Chief Nurse	Assure	Report
	6.3	**Maternity services report**	Chief Nurse Karen Newbury Kate Croissant Simon Taylor	Approval	Report

Time	Item	Subject	Lead	Purpose	Format
7.0 GOVERNANCE					
12:50	7.1	**Audit Committee report** – Chair's key issues from the meetings	NED Chair	Approval	Report
12.50	7.2	**Board assurance framework**	Trust Secretary	Approval	Report
13:00	7.3	**Governance Report**	Trust Secretary	Approval	Report
8.0 OTHER ITEMS					
13.10	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 31 January 2025	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

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.

1.3. Minutes of the previous meeting - 27 September 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 27 September, 2024, 09:15 – 13:45
At the Education Centre, WSFT

Members:		
Name	**Job Title**	
Jude Chin	Trust Chair	JC
Ewen Cameron	Chief Executive Officer	EC
Nicola Cottington	Executive Chief Operating Officer	NC
Sue Wilkinson	Executive Chief Nurse	SW
Ravi Ayyamuthu	Interim Medical Director	RA
Jeremy Over	Executive Director of Workforce and Communications	JO
Antoinette Jackson	Non-Executive Director/SID	AJ
Michael Parsons	Non-Executive Director	MP
Roger Petter	Non-Executive Director/Maternity and Neonatal Safety Champion	RP
Peter Wightman	West Suffolk Alliance Director	PW
Jonathan Rowell	Acting Chief Finance Officer	JR
Sam Tappenden	Director of Strategy & Transformation	ST
Alison Wigg	Non-Executive Director	AW
Richard Flatman	Non-Executive Director	RF
Heather Hancock	Non-Executive Director	HH
Paul Zollinger-Read	Associate Non-Executive Director	PZR
David Weaver	Associate Non-Executive Director	DW
In attendance:		
Richard Jones	Trust Secretary & Head of Governance	RJ
Pooja Sharma	Deputy Trust Secretary	PS
Helen Davies	Associate Director of Communications	HD
Dan Spooner	Deputy Chief Nurse	DS
Alexander Royan	Deputy Director for Strategic Analytics, SNEE ICB (Item 2.3 only)	AR
Liam McLaughlin	Chief Information Officer (Item 2.5 only)	LMc
Karen Newbury	Director of Midwifery (Item 6.4 only)	KN
Kate Croissant	Clinical Director for Women & Children (Item 6.4 only)	KC
Simon Taylor	Associate Director of Operations, Women & Children & Clinical Support Services (Item 6.4 only)	ST
Ruth Williamson	FT Office Manager (minutes)	RW
Apologies: Craig Black, Director of Resources, Paul Molyneux, Medical Director,		

Clement Mawoyo, Director of Integrated Adult and Social Care Services.
Governors observing: Anna Conochie, Public Governor and Tom Murray, Public Governor
Staff: Simon Taylor, Karen Newbury, Kate Croissant, Chris Todd (Associate Director of Operations, Estates & Facilities), Anna Hollis (Acting Head of Communications), Justyna Skonieczny, Deputy Head of Midwifery, Jessica Hulbert, Public Health Manager, Nicholas Monioudis, Medical Student, Rachael Morgan, Medical Student
Members of the public: Suzanne Day, Bury Free Press.

1.0 GENERAL BUSINESS		
1.1	**Welcome and apologies for absence**	**Action**
	The Trust Chair (JC) welcomed all to the meeting and apologies for absence, detailed above, were noted.	
1.2	**Declarations of interest**	
	There were no declarations of interest for items on the agenda.	
1.3	**Minutes of the previous meeting**	
	The minutes of the previous meeting on 26 July, 2024 were accepted as a true and accurate reflection of the meeting, subject to the following amendment: Item 4.1.1 – Finance Report "…Noted high level reasons for this, with the biggest theme being medical pay, with half of the year-to-date position attributable to additional **extra** contractual work off plan…"	
1.4	**Action Log and matters arising**	
	The completed actions were noted. ***Action Ref 3081 – People & OD Highlight Report, including FTSU Repot - Bystander training.*** Placed on forward plan. Date to be agreed. ***Action Ref 3094 – Quality and Nurse Staffing Report – RADAR Wording*** – this continues to be reviewed. Users becoming more familiar with system. The Governance Group monitor and update forms, reporting to the Improvement Committee.	
1.5	**Questions from Governors and the public relating to items on the agenda**	
	At the Annual Members' Meeting a rumour was heard that there would be a 4% reduction in staff to help balance the budget. If this is the case, will it be top down, bottom up, or in wards/establishment? The Trust has a large deficit and workforce costs are a significant part of its expenditure. There will be an impact on staff, but there is no current plan in place to reduce the workforce by 4%.	
1.6	**Patient Story**	

	The Board heard a pre-recorded story from the wife of a patient who had passed away at the Trust in November 2020. Diagnosed in 2018 with inoperable cancer, an emergency admission took place in November 2020, due to infection. There was a delay in recognising the seriousness of the husband's condition and a lack of communication with the family (and Covid visiting restrictions in place at the time), and he was heavily sedated at the time the family arrived, resulting in an inability for them to say a meaningful goodbye. An inquest into the death was held in April 2024. The wife's feedback has provided learning for the Trust. It was acknowledged that at times it could be challenging to recognise patients are at end of life and to give families the time they need. Call4Concern is now in operation, where anyone can raise a concern and seek advice from a peripatetic team about a patient's condition. The Trust has improved its communication with families, having honest conversations to enable time to say goodbye. It is important for staff to know their patient, their relatives and their situation and to keep the family updated. RESPECT provides an opportunity for discussion with patients and families in order to understand what is important to them so that their wishes can be respected. This story will be presented at other meetings so that the learning will continue. Noted the out of hours radiologist had not fully appreciated the findings on the CT scan of 22 November against the background of the husband's medical history. This meant the signs of perforation within the abdomen were not reported, leading to the family not really understanding why the husband's condition had deteriorated so swiftly and why there was confusion once the cause of death had been given. There is now an updated system whereby the radiology out of hours service can ask for scans to be available which is more straightforward and quicker for obtaining results. Question raised as to ability to evidence improvement in patient communication. Noted this was difficult as was multifaceted, with lots of individuals involved. Under the Patient Safety Incident Review Framework, (PSIRF), the Trust reviews complaints alongside incidents rather than in isolation. It was acknowledged that three and a half years was too long for a family to wait for an inquest in order to obtain solace. Inquests often create a barrier to open and honest conversations between a Trust and families. Noted the Trust has strengthened its governance process on inquests, with a monthly inquest review meeting being held. At this meeting, chaired by the Chief Nurse and Medical Director, a key person is identified to communicate with the family prior to inquest. Those waiting for a date are	

	provided with a point of contact and the Trust is proactive in its communication. Question raised as to what the Trust's expectation was when sending the husband home the day before. Noted the intention was for him to continue on the palliative pathway. Chemotherapy was planned. This was an acute event during Covid. He had a three-week old baby. The Die Well Domain is looking at levels of patients coming into hospital and dying within forty-eight hours. How stressful the making of this video was, was acknowledged and the Board wished to pass on its grateful thanks and condolences. **Action: Chair to send thank you to patient's wife for story and its importance in effecting change in end-of-life care at the Trust.**	**JC**
1.7	**CEO Report**	
	Report taken as read. Highlights noted below: ***Theatre Efficiencies – "Super Saturdays"*** – patients receiving operations focusing on a particular speciality in order to reduce backlogs in that area. ***NHS Adult Inpatient Survey for 2023*** – this Trust has been placed fifth highest in England for all acute and combined trusts. Thanks were offered to all staff for their contribution. Question raised as to whether the regulators and Integrated Care Board, when looking at this organisation, in the context of its financial position, took in to account awards such as this? It was understood that this and other examples of excellence were recognised by the system. ***Community Diagnostic Centre, Newmarket*** - work on the new centre is nearing completion and it was hoped would be operational prior to Christmas, 2024. ***New Hospital Programme*** – noted RAAC hospitals were not included in the government review of the new hospital programme. ***Annual Members' Meeting*** – this had been well attended on 24 September 2024, and highlighted some of the great developments in diagnostics.	
2.0 STRATEGY		
2.1	**Strategic Priorities Report**	
	The updated report was noted. It was stated that priorities had been set before the financial position was known and a number were off track due to capacity constraints. Question raised as to whether targets/time scales	

	should be reviewed to recognise the financial position. Noted that the Board Development Day, to be held on 25 October 2024, would include a review of the strategy. Noted two of the priorities, equality, diversity and inclusion (EDI) and line management development had been discussed at a recent Involvement Committee meeting and the impact of culture and finance were included in the key indicator report from that meeting. Some actions have been deferred, due to the need to reduce expenditure, but it was crucial that the Trust did not stop the entirety of its activity but find ways to continue in financial prudence. It was highlighted that within the 23/24 report there were a number of key actions ongoing. Could the Board be assured that these would be aligned and embedded in the 2024/25 plan? Noted some were, but some were not for completion in a year. These would need to be crosschecked. **Action: CEO to undertake review of priorities, with particular regard for those that will assist with focus on financial recovery.** In terms of quantifiable measures of success, it was advised that the commentary was not explicit in detailing the current position in terms of achievement. Noted the Director of Strategy and Transformation had been asked to look at this. ***NHS Smoke Free Pledge*** Question raised as to whether the Trust had the infrastructure in place to deliver on this pledge. Was it clear on how this would be dealt with and who would speak to patients found smoking on site? Jessica Hulbert, Public Health Manager, advised that there was the infrastructure in place, using the Tobacco Dependence Team and Maternity, who were delivering an enhanced programme to help pregnant people to stop smoking. Suffolk County Council were in receipt of specific funding to help encourage people to stop smoking, and they were working with the Trust and providing resources, including trained stop smoking staff. Those providing this service will work out of the Emergency Department, a high traffic area. The approach will use compassion rather than reprimand. The Trust was also in the process of looking at provision of vapes, shown to be the most effective method to stopping smoking as per the “Swap to Stop” national scheme. It was understood there was a cultural readiness for this pledge and that it would be successful. This pledge had been discussed at the September Improvement Committee meeting and received peer to peer challenge. There would need to be a shift in culture so that people felt empowered to action.	**EC**

	The Board gave its approval to signing of the NHS Smokefree Pledge.	
2.2	**Future System Board Report**	
	The announcement that RAAC hospitals would not be included in the new hospital programme review was welcomed. Significant progress has been made. It was understood that at November's Board Meeting, feedback and progress on the outline business case could be reported. The comment in the report "Outside of budget management, the discussion concerning ongoing "revenue affordability" has been escalated to both the NHP and NHS Director of Finance and discussions relating to a national solution are ongoing" was queried. Noted this related to the amount of capital available to build. The General Election and potential review had delayed a decision on this. There were revenue consequences of the dividend payable on capital. Further, future healthcare costs were likely to be more significant in coming years. More work was to be done to see if additional work could be carried out in the community. It was queried whether this should be escalated. Noted it had been on several occasions and would continue to be so until receipt of the business case approval.	
2.3	**SNEE ICB Joint Forward Plan Update**	
	Alexander Royan, (AR) Deputy Director for Strategic Analytics, SNEE ICB, was in attendance to provide an update on the joint forward plan (JFP), a nationally mandated document for all ICBs to set out their priorities for the system. Noted the JFP refresh was published later than planned due to a delay in receipt of the operational planning guidance. Fifteen measures were on track and nine required improvements from NHS England. Of the nine measures off track, question raised as to which were of most concern? It was understood the ones relating to broad government policy, such as stopping smoking and paediatric obesity, as they were hard to control. It was acknowledged that in terms of public health it was more difficult to influence a metric not entirely under the control of the NHS. In light of this, how integrated and joined up was the public health grant received by councils? This could not be confirmed and that councils were seeing a reduction in budgets. **Action: AR to consider integration of Public Health grants received by local councils and respond outside of the meeting.**	**AR**

	In terms of the plan's relationship with operational planning guidance, to what extent could it be further localised in the refresh? The reason for inclusion of the operational planning guidance was to ensure no cut across between the two. It would be interesting to see how the future shift agenda developed to enable embedding in the strategic framework. This would be covered in the refresh process. Noted the ICB were providing additional support to deal with the level of demand for the neurodevelopmental delay pathway. Did it have a long-term strategy to deal with the level of demand? Noted the ICB were working on a long-term solution, including recruitment of a project manager, to test a model for young people and children's healthcare as a whole. It was highlighted that the target indicator "achieve a year-on-year reduction in hospital admission rate for mental health conditions" was rated green. If this related to acute care, (which it did) there had been six admissions of mental health patients and therefore the rating was queried. Was there any ambition to go further? Noted the "achieve a 5% year on year increase in the number of adults supported by community mental health services" progress was shown as unknown due to a data issue. To go beyond this ambition would require a conversation with the Senior Responsible Officer for Mental Health. The reduction in hospital admissions was being treated green, with caution, the target was to achieve a year-on-year reduction and at this stage could only comment on the first quarter. It was assumed that in terms of mental health admissions, those in the Emergency Department were excluded. However, some of these patients were waiting a long time there. It was agreed consideration of these patients be included in the refresh. Included in the seven measures that required performance improvements was no. 6, "Increase the percentages of cancers diagnosed at stages 1 & 2 to 75 by 2028". Question raised as to whether this was cancer specific. It was felt that if all in one this could skew the data. Noted work was being undertaken by the ICB on how to better diagnose for all cancer tumour sites and therefore the measure was not cancer specific. Question raised as to how the Trust's strategy refresh would be aligned to that of the ICB. Noted the Trust's senior leadership team had met the previous week where this was discussed. The next step will be to undertake an engagement exercise with internal and external stakeholders to restate the requirements of the organisation. A request to re-examine the aging well domain was made as this was more than having an advanced care plan. Alex Royan will take on board feedback from today's meeting for the JFP refresh.	

2.4	**System Update**	
	The report was noted and highlights detailed. ***Bus routes*** – discussion undertaken with Suffolk County Council, resulting in a change of bus routes from Mildenhall, Sudbury and Haverhill, allowing direct access to the Trust, rather than having to change in Bury St Edmunds. ***Dental Commissioning*** - substantial progress has been made. Four practices, (two in Haverhill and one in Sudbury and Mildenhall), on a sessional basis, will undertake treatment for those most in need, i.e. cancer patients and those calling 111. ***Heath Equity*** – approval has been granted for the West Suffolk Equity Plan, which 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 Bury St. Edmunds, Mildenhall, Haverhill, Sudbury and Mildenhall. Thanks were offered to the Trust's Public Health Team for supply of relevant data to aid this work. ***Primary Care*** and the impact on access to services was highlighted as a cause for concern. It was hoped that the NHS Plan would help provide some positive messaging. The low rate of smoking cessation and incidence of hypertension in Newmarket was highlighted and reason queried. Noted this was unknown currently. The town was a unique profile, with a presentation recently made to the Alliance. Further information would become available as time went on. Question raised as to how far the Trust's remit extended into adult, social and disabled care interfacing with councils. Noted the statutory responsibility for delivery lays with Suffolk County Council. However, the Alliance would be collaborating on a joint project, including the Department for Work and Pensions (DWP) regarding correlation of those not working and use of NHS Services. In terms of specialist nursing capacity issues for diabetes in the community, question raised as to whether there was anything the Board could do to assist. Noted this related to clinical services transformation and a turnover in clinical leadership within Diabetes at the Trust. Until such time as this was settled, further action could not be taken.	

2.5	**Digital Board Report**	
	Liam McLaughlin, Chief Information Officer, attended the meeting to present the report. ***Projects*** – consolidation of two complimentary patient portals being undertaken. **Action: It was agreed that the performance and impact of projects undertaken on patients and staff be included in future reports to the Board. Chief Operating Officer.** ***Governance Review*** – a prioritisation and alignment process is to be implemented, to ensure the Trust is not only doing things right, but the right things. ***Digital Maturity Assessment*** – noted the Trust scored the second highest of 14 acute trusts. This data was used to inform a section of the recently published Darzi report. Question raised as to the framework used to assess cyber security risks and management of associated cyber security risks from the supply chain. Use of the data security protection tool kit was mandated and the move in June to another supplier noted. Differences will be assessed. The scope of the Cyber Assessment Framework (CAF) was vast and would be introduced gradually. The Trust was looking as to how best to identify the risks associated with the supply chain. Question raised as to the impact of the two projects stopped under Pillar One. Noted one, outpatient functionality, was due to a redesign by the provider. As a result, it was decided not to change at this stage and to make cost savings. The other, regarding blood transfusion, was an issue of integration between a potential new provider and the Trust's patient record system. An alternative will need to be sourced. Noted the Trust has a robust process to ensure safe transfusions, with two transfusion nurses employed by the Trust. The process is safe and the project undertaken was to further improve on this. In terms of the change control process, currently this was transactional rather than through identification via divisional governance. Noted the EPR usability survey was to be repeated. This would provide staff with the ability to request change that would bring value for money.	**NC**

3.0 ASSURANCE		
3.1	**IQPR Report**	
	C-difficile – data suggests that incident rates are variable. Reasons are multi-faceted; cleaning, hand hygiene, antibiotic	

	prescribing etc. The Trust will continue to monitor levels of infection and take improved measures to reduce. It was noted that this was a nationwide issue, with increased levels of infection. The Trust has gained assurance from the Chief Nurse of the Integrated Care Board (ICB) that it is doing all it can to minimise. Noted indicators are delegated to the assurance committees for in-depth discussion and challenge. Today's report was an opportunity for the Board to see in the round. Noted turnover not meeting target was incorrect. **Action: Data supplied to be checked. Chief Operating Officer.** Reference made to twelve-hour breaches as a percentage of attendances, linked to the non-admitted four-hour performance and the wide fluctuations of figures on a daily basis. How could the Trust stabilise these? Noted further detail was contained in the Insight CKI. A significant variation was seen on a daily basis. Capacity and flow had an effect on fluctuations. It was difficult to analyse the Emergency Department (ED) on a daily basis and therefore better to look at trends. The Trust has a comprehensive urgent and emergency care delivery plan which was scrutinised at local and alliance level. Noted the Trust did not have an urgent treatment centre in place, which many of its well performing peers did. The Trust was piloting a minor emergency care unit from the middle of October. This will stream patients with minor injuries to a different space. In terms of patient discharge, the Trust has had many waiting who no longer require hospital treatment. This figure is reducing, strengthened by interdivisional working. An issue remains with patients to be discharged out of county.	**NC**
3.2	**Finance Report**	
	Noted at Month 5, a significant adverse variance to budget remained. Noted the Cost Improvement Programme (CIP) performance had seen a £400k increase compared to the previous month. The pay position showed evidence in Month 4 of the premium temporary spend reducing and further evidence of same in Month 5. The CIP delivery forecast has improved from £7.7million forecast outturn to £8.8million. The Trust is working hard on this, undertaking recovery actions with the divisions. In terms of cash, due to its adverse variance, the Trust requires additional working capital and has applied for £17million revenue support (both deficit and working capital) in Quarter Three. Even	

	with recovery actions, the deficit is anticipated to be greater than planned and will have a direct impact on cash required. The Trust is managing the situation and expects receipt of these monies in a timely fashion, but with mitigations in place if not. **Due to the deadline for application of 19th September, the Board gave its retrospective approval to the application for revenue support in the sum of £17million.** It was questioned whether the additional monthly costs in respect of the Trust's electronic patient record provider had come as a surprise. Noted these costs were within the budget, but not the run rate. Expenditure approval had been granted in the March private Board. Income shortfall in terms of community equipment, such as wheelchairs was noted. Question raised as to how the Trust was working with the ICB to address this? Noted significant spend on equipment for discharge and greater rigour required on use of community discharge fund. **Action: Community Equipment and use of community discharge funding to be taken to Insight Committee for consideration of impact on patient flow. Chief Operating Officer.** The importance of communication with staff to ensure engagement was stressed. Noted a communication had been sent this week clarifying the processes in place. Exec drop-in sessions are being held in Time Out and information included in the All-Staff Updates.	**NC**
4.0 PEOPLE, CULTURE AND ORGANISATIONAL DEVELOPMENT		
4.1	**Involvement Committee Report**	
	Noted a discussion had taken place on organisational culture and finance, together with the concerns of staff and the need for communication. Further, a discussion about the element of cultural change for accountability throughout the organisation was undertaken. This discussion was not completed at the meeting and will remain on the agenda, with further discussion planned at the Management Executive Group (MEG). The transfer of some elected orthopaedic care to the Essex and Suffolk Elective Orthopaedic Centre (ESEOC) and areas of key concern for the local population was discussed; travel in winter, if need to use public transport and the cost of travel. Some patients wanted reassuring that they could still come this Trust for treatment should they so wish. Further work is being carried out with the ICB in terms of response. It was understood from patient engagement work that travel was more of a concern for those not on waiting list. For those who were and in pain, this was not such a concern.	
4.2	**Putting You First Awards**	
	Nominations noted, representing the very best of the organisation. Winners details will be shared.	

5.0 OPERATIONS, FINANCE AND CORPORATE RISK		
5.1	**Insight Committee Report**	
	Noted the Improvement Committee had previously raised with Insight the risk of quality considerations not being considered fully in the CIP programme and other financial decision making. Reports were requested on outcomes from the recent Quality Impact Assessment reviews. Noted there was a robust process in place to scrutinise schemes prior to approval. The Roche Contract extension was discussed in closed Board meeting, was cited as an example of a tender process coming late in the day, without the opportunity to take an alternative approach. Question raised as to whether there was a new target for the sixty-five weeks wait. Noted the national target remains at zero and one it will not meet. The Trust was not alone in having patients in excess of sixty-five and seventy-eight week waits by the end of September. Industrial action and a contamination incident in the Trust resulting in the sterile services store being out of action had affected elective work. However, the Trust has been asked both regionally and nationally to agree an end date and this is being worked on. The Insight Committee will be kept updated. Some cancellations of uro-gynae work at the independent provider were due to lack of anaesthetic cover and these will need to be rescheduled. The focus is on treating sixty-five weeks as soon as possible those waiting the longest.	
6.0 QUALITY, PATIENT SAFETY AND QUALITY IMPROVEMENT		
6.1	**Improvement Committee Report**	
	An issue with basic life support training compliance had been discussed in detail. This was largely due to new staff inductions and staff turnover. Noted those staff undertaking the higher level of training did not require the basic and this data was to be cleansed. Deep dive in to shared decision making for marginalised groups or those lacking capacity undertaken and use of the software package Concentric. Noted work was ongoing, as part of a rolling programme. Noted the Trust had undertaken a review of corridor care and how CQC standards of care were to be met. Reason for level of assurance that clinical audit processes are being followed to maximise the benefit and learning was questioned and if there would be a programme to catch up on this. It was advised that this related to local and departmental audits, rather than national and regional. These audits were not being completed, often due to staff moving on from the Trust or the	

	requirement to undertake in personal time. The intention was that these be used for the individual's portfolio and audit but were also being used for mandatory training. Recent industrial action had had an effect. It is more important to be able to demonstrate a change in delivery of care. The Clinical Effectiveness Governance Group is working on this.	
6.2	**Response to the Well Led Report**	
	Noted the review had been through the Management Executive Group (MEG) and Improvement committee. Of the thirty-one actions, twenty-seven fell within an existing plan; two had been deferred for future action and two identified as complete. The Improvement Committee considered the report and felt it to be a reasonable approach. The committee will receive an update in April 2025, including the deferred items, one of which is clinical lead structure, (awaiting commencement of the new Medical Director) and data warehouse (embedding in terms of implementation). Thanks were offered to the Trust Secretary and team for the work involved in assimilating the actions. The need to remember the themes of the report was stressed. When reviewing progress in April request made to consider stakeholder views. If only self-assessing, some of the issues may continue. Noted the individual recommendations were framed within the CQC quality statement. At the review in April, more work on self-assessment against this statement will have taken place. External stakeholder review can be taken into account. **Action: Update on actions to come to April, 2025 Board. In the interim, work to ensure on track to be undertaken by the Improvement Committee. Trust Secretary.**	**RJ**
6.3	**Quality and Nurse Staffing Report**	
	Noted an improvement seen on the registered nurse whole time equivalent (WTE); achieving a vacancy rate of under 10% and the same for turnover. Concern noted on nursing support staff and ability to obtain a consistent trend and to lower turnover. The Care Certificate Programme is helping to address some of these concerns. The care hours per patient day (CHPPD) is the only benchmarking tool against other organisations. However, this is not a measure of safety and also not the most appropriate tool to be used as the Trust could not be expected to deliver the same as a large teaching organisation. When compared to peer organisations of a similar size and service provision, the Trust ranks in the lowest quartile. In the context of finance, the nursing directorate is fully engaged in reducing high-cost temporary spends.	

	Question raised as to what should be taken from the CHPPD ranking, when placed alongside the results of the Trust's latest patient experience survey results. Noted the Trust could take comfort that the service being provided reflected improvements in patients feeling there are sufficient staff. The low fill rates and higher turnover for nursing assistants was noted, together with greater than average sickness levels. Question raised as to what more could be done to assist this cohort. It was understood that high levels of sickness and turnover are often a result of the high-pressure nature of the role. The Trust has paused international nursing recruitment, diverting its attention to care support workers. The Care Certificate Programme is helping and includes regular visits to ensure staff are being supported. It was highlighted that nursing staff are totally engaged and dedicated to the provision of good patient care. Ward managers have been instrumental in bringing staff with them and this was reflected in the level of care. There will be times of staff shortages, but the directorate is supportive of each other and always puts patients first. Query raised as to where the Trust stood in comparison to its peers in terms of infections, pressure ulcers etc. It was noted that a review of nurse sensitive indicators was undertaken, looking at areas of nursing influence. Noted the number of falls were on an improving trend per patient bed day but below the national average. Bed days are hard to compare due to the handover to RADAR and current lower levels of reporting. Staff are being supported in use of the system and there were no concerns regarding quality. Thanks were given to the nursing team for the way they had engaged with the current financial situation and ideas provided to address.	
6.4	**Maternity Services Report**	
	Simon Taylor, Associate Director of Operations, Women & Children and Clinical Support Services, Karen Newbury, Director of Midwifery and Kate Croissant, Clinical Director, Women and Children in attendance to present the report. Noted Promotion of Health, Opportunity, Equality, Benevolence and Empowerment, (PHOEBE), a charity offering specialist advice, information, casework, advocacy and support and counselling services to black and ethnic minority women and children, based in Ipswich, have agreed to support the Trust in the delivery of antenatal education to this cohort. Acknowledged that it was often challenging to obtain service user feedback, during what is a busy and emotional time. The recently appointed Parent Education and Patient Experience Lead Midwife	

	is working closely with the Patient Engagement Team to address this.	
7.0 GOVERNANCE		
7.1	**Charitable Funds Committee Report**	
	Noted role of Chair for this committee has now passed to Richard Flatman, non-executive director. Noted that following discussion at the Management Executive Group, the Medical Director and Chief Nurse were added on the membership of the Charitable Funds Committee in order to provide a clinical perspective. The committee agreed to proceed with the appeal to purchase a robot for the Trust, subject to review of the financial risk by MEG. **Action: Management Executive Group to provide assurance on the underwriting risk to the organisation and provide a recommendation to the Board. Trust Secretary.** Noted potential for collaboration with ESNEFT on particular fundraising campaigns. It was advised that Sue Smith, Head of Fundraising, was leaving the Trust. The Board expressed thanks for all the hard work.	**RJ**
7.2	**Board Assurance Framework (BAF)**	
	The Board received an update and noted that regular reporting on the Board Assurance Framework (BAF) is being undertaken at the Management Executive Group (MEG), alongside visibility at the assurance committees. Discussions at the assurance committees to be refined in order to ensure not duplicated. Noted amended wording of BAF 4 not reflected in today's document. **Action: new wording requested to be actioned. Trust Secretary.** Dissonance between the risk score and experience in organisation and mitigations under BAF 7 acknowledged. This has been discussed at Insight Committee and MEG. **Action: Access to individual BAFs to be provided for Board members within Convene. Trust Secretary.**	**RJ** **RJ**
7.3	**Governance Report**	
	The Board approval was sought for an adjustment to the Trust's Constitution. 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 by the Council of Governors 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.	

	Question raised as to how the Trust would continue to encourage new members to become governors, achieving a balance with more underrepresented groups and those with protected characteristics. Noted work has been undertaken with the patient experience and engagement team and Integrated Care Board in this regard, but there was more work to be done. The Council of Governors' Engagement Committee was refreshing its strategy to reflect the engagement work to promote and attract a diverse pool of candidates for elections. Agreed to defer decision and further discussion to be undertaken at the November Council of Governors' meeting on how to address this concern of the Board. **Action: Provide assurance on the plan for how to attract different groups to the role of Governor as part of the next elections. Trust Secretary.** **The Board gave its approval for changes to the effectiveness to be applied to the assurance committees, Insight committee, Management Executive Group and Charitable Funds Committee.**	**RJ**
8.0 OTHER ITEMS		
8.1	**Any Other Business**	
	Helen Davies, Associate Director of Communications – noted this was the last Board Meeting for Helen Davies who was leaving the Trust. The Board offered its thanks for her hard work and much valued strategic advice. Noted Anna Hollis would be stepping up as Acting Head of Communications.	
8.2	**Reflections on meeting**	
	In light of hot drinks not being provided at meetings, request for a longer break to enable attendees to purchase from the canteen was made.	
8.3	**Date of next meeting** 29 November 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
3100	Open	27/9/24	2.3	**SNEE ICB Joint Forward Plan Update** - Consideration of integration of Public Health grants received by local councils.	**Meeting taking place on 25 November, 2024 to discuss. Verbal update to be provided at Board.**	ST (Alex Royan)	29/11/24	Green	
3105	Open	27/9/24	7.1	**Charitable Funds - Robot Appeal -** Management Executive Group to provide assurance on the underwriting risk to the organisation and provide a recommendation to the Board.	**This is scheduled for discussion at Management Executive Group on 27/11. Verbal update to be provided at Board.**	RJ	29/11/24	Green	

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery	Date Completed
3098	Open	27/9/24	1.6	**Patient Story -** Thank you to be sent to relative (Alison Sawyer) for her story and its importance in effecting change in end of life care.	**Letter sent.**	JC / SW	29/11/24	Complete	29/11/24
3099	Open	27/9/24	2.1	**Strategic Priorities Report - Alignment of ongoing actions with 24/25 plan** - undertake a review of priorities, with particular regard for those that will assist with focus on financial recovery.	**An update on this will be provided at the meeting reflecting the approach to this in the context of the strategy refresh and other reporting mechanisms.**	EC	29/11/24	Complete	29/11/24
3101	Open	27/9/24	2.5	**Digital Board Report -** Performance and impact of projects undertaken on patients and staff to be included in future reports to the Board.	**This is a work in progress – we are planning to improve the articulation of benefits at business case stage. A revised digital governance structure is being implemented. Propose to close as board action and incorporate in digital updates to open and closed board in future.**	NC	29/11/24	Complete	29/11/24
3102	Open	27/9/24	3.1	**IQPR Report** - Turnover not meeting target is incorrect. Data supplied to be checked	**Report checked and was correct. Making Data Count methodology used in IQPR assurance grid and turnover chart represented this as an improving trend (blue dots) but "hit and miss" (not failing) in relation to the target. Whilst the target was met in September and for the previous six months, the previous variation over the last two years means we cannot yet state this will achieve every month, based on statistical analysis.**	NC	29/11/24	Complete	29/11/24
3103	Open	27/9/24	3.2	**Finance Report** - Community Equipment and use of community discharge funding to be taken to Insight Committee for consideration of impact on patient flow.	**Deep dive on community equipment service (CES) received by Insight on 16th October including impact of discharges and virtual ward on CES, and the impact on flow of any restrictions. Given financial impact of increase, actions agreed to seek resolution.**	NC	29/11/24	Complete	29/11/24
3106	Open	27/9/24	7.2	**Board Assurance Framework - BAF 4 -** new wording requested to be actioned	**BAF risks updated.**	RJ	29/11/24	Complete	29/11/24
3107	Open	27/9/24	7.2	**Board Assurance Framework -** Access to individual BAFs to be provided for Board members within Convene.	**The individual BAF risks are received and reviewed by the allocated assurance committee. A copy of these is also available via the Board of Directors' document library on Convene**	RJ	29/11/24	Complete	29/11/24
3108	Open	27/9/24	7.3	**Governance Report - Constitution Update - Term of Office** - provide assurance on the plan for how to attract different groups to the role of Governor as part of the next elections.	**A summary of the engagement activities that will be undertaken and overseen by the Council of Governors' membership and engagement committee is detailed in the Governance Report.**	RJ	29/11/24	Complete	29/11/24

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 - Jacki King Staff/patient Hybrid story (Lucie Johnson in attendance)

To Review

Presented by Susan Wilkinson

1.7. Chief Executive’s report

To inform

Presented by Ewen Cameron

Public Board Committee	
Report title:	**CEO 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, CEO and Sam Green, Communications

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

While the Trust's financial position continues to be very challenging, we have taken rapid, focused and sometimes difficult actions to control our finances. I thank my colleagues for their hard work and contribution - there have recently been positive signs of progress against our Financial Recovery Plan, our cost improvement programme and additional measures in place to reduce spend. Returning to financial sustainability is hard but necessary, and we continue taking considerable steps to get back on a sustainable financial footing.

At the same time, we continue to provide excellent care to our patients and community, in our patient-facing care and through all our teams who support it.

Performance

Finances

At the end of October, our reported position in-year was a £18.9 million deficit, which is £7.9 million worse than we planned to be at this point. Therefore, we continue doing much work to identify opportunities to improve this situation, working with our colleagues to meet this challenge head on.

We are seeing improvement in our financial recovery. The measures we have implemented, such as slowing recruitment, reducing temporary and agency staff spend and usage, theatre utilisation and medicines optimisation will remain in place.

There are no plans to cease any core patient services in the hospital or our community services.

While key announcements for health and care in the Autumn Budget were positive – growth in day to day and capital spending – the broader economic challenges remain and we must strive to be more sustainable, innovative and as productive as possible now and in the future.

Elective recovery

We have continued to make progress in our elective recovery. At the end of October 2024:

- 221 patients over 65 weeks - 184 of these are capacity related.
- 16 patients over 78 weeks – this is the lowest number reached since September 2020 and demonstrates the progress we are making on the longest waiting patients.

The focus now is on reducing the 65 week waits by the end of December, with the national aim to reduce to 0 by 22 December.

It is fantastic that since 11 November we are now able to provide high-quality elective care at both the new, purpose-built Essex and Suffolk Elective Orthopaedic Centre facility in Colchester as well as our main West Suffolk Hospital site. This increased activity in November has had a positive impact on our overall waiting list position in orthopaedics and will ensure our orthopaedic elective patients receive the care they need more quickly, so they can get back to their lives much sooner.

I know our teams have all worked extremely hard to support this project in collaboration with East Suffolk and North Essex NHS Foundation Trust colleagues. Thank you to all involved.

This new centre is the largest centre of its kind in Europe and solely dedicated to planned orthopaedic surgery. It has eight theatres, three wards, 72 inpatient beds, and the capacity to complete around 10,000 operations each year, which will help us bring down our waiting times.

Urgent and emergency care

Our performance against the 4-hour standard was 64.8% against a trajectory of 73.0% in October 2024.

Inpatient flow has been challenging – although average length of stay (LOS) benchmarks well compared to regional/national peers, we did see an increase in the number of patients with LOS's of more than 14 and 21 days in October. Increased admissions and lower discharges have also meant that patients have unfortunately been waiting longer for admission in the emergency department than we would like. To address this, we have established the Minor Emergency Care Unit, which opened in October, which will free up space within the main emergency department footprint to reduce waits and overcrowding.

Cancer

The focus for 2024/25 is to improve our faster diagnosis performance to 77% - having cancer confirmed or ruled out by day 28 - and 70% of patients having their cancer treatment by day 62.

The latest position (September 2024) is:

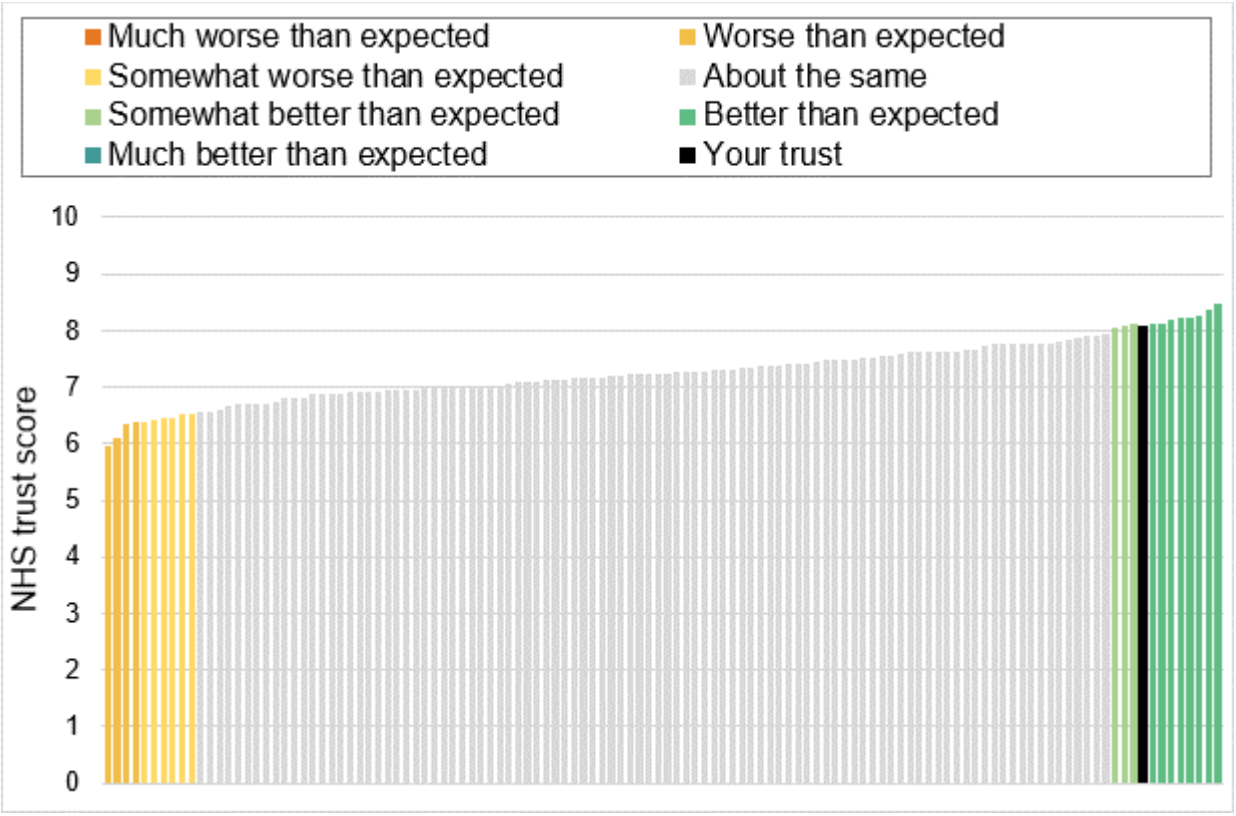
- 66.2% of patients had cancer ruled out or confirmed within 28 days, this is behind the national standard and our internal Trust trajectory.
- 71% of patients were treated within 62 days, this is above the national requirement for 2024/25.

Quality

I was delighted to hear about the positive results we received from the NHS Adult Inpatient Survey 2023 in September this year, where we placed fifth nationally for all combined and acute trusts. Additionally, recently we received our results from the Care Quality Commission's annual Urgent and Emergency Care Survey 2024, which is also completed by our patients. Despite ongoing pressures, our urgent and emergency care (UEC) colleagues placed ninth nationally for type 1 services, an incredible achievement, of which I am very proud. In no areas did we score worse than expected, and in many areas, we scored somewhat better, better, or much better than expected.

The areas we scored highest in focused on the communication our colleagues provide to our patients, about their journey, their condition, treatments and options available to them, as well as information about any medications they are given. I was also glad to hear that our patients scored us highly for the amount of time our colleagues spent with them. This shows that while some patients experience longer waits than we would like, the care they receive is high quality, which given the pressure our colleagues are under, is testament to their dedication and commitment to upholding standards.

As you can see from the graph below, our position (the black line), is amongst the best in the country.



In our pathology teams, our healthcare scientists are doing innovative work to improve our ability to support fast, accurate diagnosis and treatment. Our cellular pathology team have maintained UKAS accreditation since 2012, where they have recently began transitioning over to digital reporting, which will improve they access they have to cases, reducing the time taken for a second opinion when required. Our microbiology team achieved UKAS accreditation in December 2023 and have since implemented new molecular analysers which has greatly reduced the time it takes for them to get results from days to just hours - a huge improvement. Additionally, our biochemistry team achieved UKAS accreditation in March 2024. They have since implemented Serum Free Light Chain testing in-house, which greatly improves the patient pathway and means we can get the results we need, more quickly. All our pathology teams work incredibly hard to make sure that our patient-facing teams can provide the highest quality care possible, by continually improving and adapting.

In spring this year, we contacted our close system partners, the East Suffolk and North Essex NHS Foundation Trust, for assistance in helping us clear our backlog of patients waiting for surgical paediatric urology treatment. Following close work between our two services, I am delighted that we have been able to cut our waiting times for treatment from almost a year, to approximately six months. This has enabled dozens of our patients to make the choice to have their care more quickly elsewhere. Working as a system in this way gives us great flexibility to share capacity and find creative solutions which allow our patients to get the care they need more quickly.

Workforce

As I have said before, our staff are our greatest asset. We are very fortunate to work alongside colleagues who routinely go above and beyond to sustain and improve our services. It is therefore one of my favourite parts of my role, to go out and present our Putting You First Awards which recognise the achievements of individuals and teams. Recently, I was able to present the awards to our theatre and sterile service teams for their hard work during a recent infection prevention event to keep our services going earlier this year. Their efforts ensured that we were able to resume seeing patients more quickly and keep any cancellations to a minimum.

I was also pleased to present a Putting You First Award to our responsive team, who have been instrumental in reducing delays in getting our patients home sooner via Pathway 1 (where patients receive care in their usual place of residence). The team have worked incredibly hard and under significant pressure to facilitate patients typically returning home to continue their recovery just a day after they are referred to the team. Their hard work and success also mean that patients needing inpatient care coming into our urgent and emergency services can be seen more quickly, which is critically important.

Visiting teams across the Trust provides me with insight into the breadth and scope of the work our teams carry out every day. Recently, I visited our research team, who gave me a detailed look into the work they're carrying out. Despite the size of our Trust, our teams have been praised numerous times for their ability to recruit participants to the trials they're carrying out, as well as the number of trials they conduct. There are more than 35 trials currently being recruited to across more than 20 specialties, with many more active follow up trials and several studies being established. Just some examples of the trials we are conducting include, but are not limited to:

- Testing different existing treatments for other conditions that could be re-purposed to slow the progression of Motor Neurone Disease. This is a devastating neurological disorder, which currently has only one licensed drug in the UK that extends life by only two to three months.
- Trialling the drug, Vicadrostat, in patients with chronic kidney disease treated with Empagliflozin, to test whether this new treatment helps lower the risk of kidney disease or heart disease worsening and then needing dialysis or kidney transplantation.
- Trialling how we manage Traumatic Pneumothoraces (an abnormal collection of air in the pleural space between the lung and the chest wall) in the emergency department, comparing different treatment options for a collapsed lung-insertion of a chest drain compared to conservative management.

It is hugely important work they carry out, as this gives our patients greater choice in the care they receive, as well as the option to take part in research should they wish, which ultimately helps us improve the care we provide.

On Friday, 22 November, I was delighted to attend the annual awards in honour of Hannah Seeley, a midwife at our Trust who sadly passed away in 2012. This annual occasion is a way that we recognise the hard work and achievements of colleagues in our maternity service over the past year. I would like to congratulate Diane Hele, Kate Jones and Claire Jones, who all very deservedly won Midwife of the Year, Support Worker of the Year and Student Midwife of the Year respectively.

Future

With all our colleagues, I welcome the announcement in the Autumn Budget that confirmed the rebuilding of the West Suffolk Hospital will continue at pace. While waiting for further details, we continue to progress our plans and engagement with the national team, colleagues and community.

Meanwhile, work to maintain the current West Suffolk Hospital continues. We are in the final stages of our RAAC infrastructure programme, and our estates team continually assess our buildings to ensure they are safe for our patients, visitors and staff.

We are making strong headway with our project to deliver a new Community Diagnostic Centre at our Newmarket Community Hospital. Having broken ground in January, we are due to complete the build in December and see our first patients before Christmas. This facility, which has been constructed with modern, low carbon building techniques and materials, has also allowed us to install 120 solar panels across the site, which will generate a significant proportion of the CDC's energy requirements, helping us progress the NHS's net zero ambitions.

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.

We have upgraded our Patient Portal this month with registration for the new Patient Portal going live on 19 November. So far more than 6,000 patients have registered. Designed to make managing their health information easier and more convenient, the new portal will provide an enhanced experience, allowing patients to access their health information whenever and wherever they need it.

Those already using the NHS App, will be able to access the new portal with their existing NHS App login details. If patients aren't yet using the NHS App, we recommend registering before signing up for the new Patient Portal, because these credentials are required to log in.

Only patients currently registered for the existing portal and patients with an upcoming outpatient appointment will be sent a registration text message to register for the new portal. However, if you have any other questions, please email Patientportal@wsh.nhs.uk.

2. STRATEGY

2.1. Future System board report

To inform

Presented by Ewen Cameron

Public Trust Board	
Report title:	Future System Board Report
Agenda item:	2.1
Date of the meeting:	29th November 2024
Sponsor/executive lead:	Ewen Cameron
Report prepared by:	Gary Norgate

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

Executive Summary
WHAT? *Summary of issue, including evaluation of the validity the data/information*
This report provides an update on the Trust's plans to build a replacement hospital under the terms of the national New Hospital Programme.
SO WHAT? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*
This is a critical project as it directly addresses the risks associated with the Trusts RAAC infrastructure and provides the basis for the continuity of care and the ability of the Trust to keep pace with the needs of the community that it serves.
WHAT NEXT? *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*
The next steps for the project are the conclusion of the discussion around the size and scope of the new hospital and, therefore, the required budget and its ongoing impact on the operational cost of both the Trust and the Integrated Care System (ICS). Stage 2 of the Royal Institute of British Architect's (RIBA) design process will be complete in December. These outputs will then form the basis for the creation of an outline business case, securing full planning permission and the appointment of a build partner.
Action Required
The Board are asked to note the content of this report.

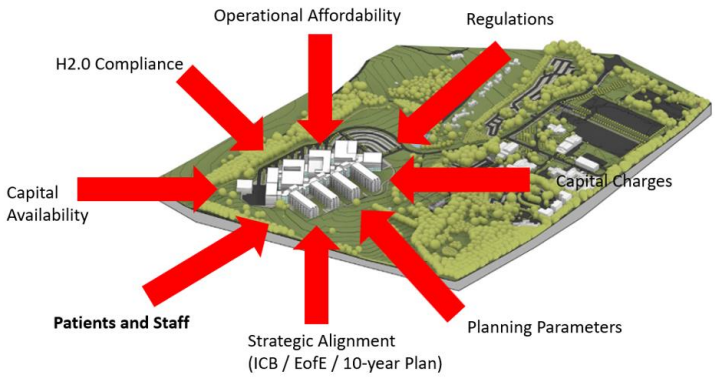
Risk and assurance:	

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

Future System Board Report

1.	**Introduction**
1.1	The following paper aims to update the Board on progress being made towards the building of a new hospital in West Suffolk. Specifically, the paper highlights: • Agreed next steps for our project. • The 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 Foundation Trust's plans to build a replacement hospital are part of the wider Governmental programme that aims to build "40 new hospitals by 2030".
2.2	In May 2023 an announcement that seven new schemes, predominantly those hospitals constructed from reinforced aerated autoclaved concrete (RAAC), have been included in the New Hospital Programme (NHP) and will be 'prioritised' to ensure they are completed in the most efficient way.
2.3	This announcement has caused some of the other, more complex, schemes (e.g. those representing significant service re-configuration and therefore requiring extensive public consultation) to slip beyond the previously announced 2030 deadline.
2.4	More recently, the incoming Government announced a review of the New Hospital Programme. This review is underway, however, it has been confirmed that the plans to replace RAAC hospitals sit outside of its scope and that as such the progress of the West Suffolk scheme will be unaffected.
2.4	The West Suffolk scheme remains a priority and is 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** In previous Board papers, we quoted the following as key deliverables: • Complete demand modelling and understand the implications of our design, scale and scope. • Receive feedback on our OBC readiness submission with an expectation that we will seamlessly continue with the development of our detailed designs. • Confirm compliance with H2.0 principles and co-produced any design changes with stakeholders from across our system. • Understand 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:

	• Following the completion of a formal roundtable involving representatives from NHP, East of England NHSE and our Integrated Care Board, our demand and capacity conclusions were largely agreed. Since this session, we have had separate meetings to; explore the means of ensuring through which we can flex future physical capacity to meet actual demand with and revisit the assumptions underpinning our forecasts to ensure we are all aligned. With this work complete, we are now in the final stages of finalising the "right sized hospital" and understanding its consequent operational costs. • We have now received the formal report on our OBC readiness. It helpfully highlights the key areas upon which we should concentrate in order to develop a successful OBC but does not indicate any significant concerns or "show-stoppers". Consequently, we are now moving ahead with the completion of said business case. • As one of the four "pathfinder" schemes, we are working closely with NHP design guardians to maximise compliance with the model "Hospital 2.0".This alignment allows us to progress our Stage 2 (RIBA2) designs with confidence and we remain on track to complete these by December 2024. • Having gained Trust Board agreement to the terms for how we will work with both NHP and our building contractor, we are now awaiting the final version prior to signing. This clears the way for us to submit an OBC on its completion. • Enabling works continue in line with our plans, next steps are the completion of archaeological surveys and phase 2 of our buffer planting.
3.2	**Personnel:** Following a long period of stability in the team we are now experiencing three significant changes in key personnel. Jacqui Grimwood retired in September and has now been replaced by Franzisca Empl who will assume leadership of our technical and commercial workstreams. Franzisca joins us from the Department of Education where she had been leading on the building of new schools. Dr. Helena Jopling will leave us at the end of November to focus on her work as a Public Health Consultant, shortlisting for a new Clinical Lead has been completed and interviews are scheduled to be complete in December. Gary Cole is leaving to take up a new Medical Education role for North West Anglia Trust, a new workforce lead role that reflects our move towards the submission of an OBC has been advertised and we have received 21 high quality applicants. Interviews are scheduled for this month and we expect to appoint early December. Please join me in thanking our departing members and wishing them and their replacement every future success. Given the changes in the team, now seems a good time to be reviewing the effectiveness of our Programme Management and consequently, Q5 (the organisational development experts) have agreed to re-run a workshop designed to assess the maturity and efficacy of our Programme and its governance. This exercise will provide a view of our progress since the initial assessment as well as assurance that we continue to be "well-run".
3.3	**Royal Institute of British Architects Stage 2 Design:** Stage 2 designs will see our new hospital drawn to the 1:200 scale and provide detail on how services will be positioned within the new hospital as well as how they interact with utilities and the fabric / grid of the building. This stage forms part of our critical path (the longest sequence of tasks in the overall project plan that define the end date) and its timely delivery is essential. With this in mind, I am delighted to report that, following a series of discussions with stakeholders and co-production leads from across the Trust / System, we remain on track for a December delivery. The design will bring together our co-produced local requirements with the standards prescribed by the national "Hospital 2.0" (H2.0). Although we are work with a site with strict planning parameters, we

	are confident that we can be highly compliant with said standards – this compliance will ensure our progress to the next stage of design is unhindered. Completion of RIBA2 will represent a significant milestone and although there will remain scope for future changes, it will provide a solid basis for a review of "where we are" in terms of scale, scope, and cost.
3.4	**Right Sized Hospital**  The picture above illustrates the different, sometimes competing, factors that impact, and are impacted by, the scale of the hospital that we build. With this complexity in mind in mind, we have been working with members of; the national programme; NHSE East of England, SNEE ICB, West Suffolk Foundation Trust and the Midlands and Lancashire. Commissioner Support Unit to finalise the modelling of future service demand and how this drives the future schedule of accommodation / capacity. Following a highly constructive "Roundtable" at the beginning of November, we have held two additional workshops to explain and explore; 1) how the modular H2.0 design will allow us to flex capacity and ensure it is provided efficiently (neither too much or too little available at any given time) and 2) the extent to which our ambitions to mitigate demand and improve productivity are appropriately stretching and in-line with other similar Trusts who have completed the modelling process. The outcome is a set of agreed challenges that we will 'run' through the model in the coming weeks in order to understand their impact on capital and operational costs. We expect to use the resultant debate to conclude the "right sized hospital" in time for this scale to be reflected in our RIBA Stage 3 designs.
3.5	**Transformation** Clearly future growth in demand is a key determinant of the size of hospital that we need to build, however, with pressures on operational cost, the availability of resources and the need for our design to remain congruent with the direction of travel prescribed within the NHS East of England Strategy and emerging 10-year plan (i.e. more services provided closer to the home and digitally), it is clear that the Trust needs to improve productivity and exploit its new assets to the greatest possible extent. The necessary changes are broadly prescribed within the Trust's clinical and care strategy which we have used to define a set of "throughput assumptions" for each department. These assumptions reduce the amount of future capacity required and their realisation is therefore essential if the new hospital is to be both affordable and efficient. Consequently, the Programme Team are working with the Trusts Director of Strategy and Transformation to establish the plans and resources which will ensure we move smoothly towards the full and timely implementation of the clinical and care strategy.
3.6	**Finance** The Programme is progressing within its NHP allocated budget and is fully funded to deliver RIBA stages 2 and 3 as well as its Outline Business Case. Although the West Suffolk Scheme is outside of the Governmental review of the New Hospital Programme, the capital budget remains undefined, and we are relying on our NHP colleagues to

	inform us if our designs and associated costs stray beyond the amounts that are likely to be allocated. Although the West Suffolk Scheme remains committed to the use of the emerging "Main Works Framework" (the national procurement framework that is designed to ensure maximum market participation), it is highly likely to require construction partner support before said framework is fully available. Consequently, it has been agreed that we will use traditional procurement routes for securing construction design services for RIBA Stage 4. A tender document is currently being developed with support from Crown Commercial Services and a short form business case is being constructed for NHP to award an appropriate budget.
4.	**Next steps**
4.1	By the time of our next meeting, we will have: • Agreed demand modelling with ICB, NHSE and NHP. • Finalised and published RIBA2 designs. • Significantly progressed the completion of a tender for the procurement of RIBA stage 4 design services. • Signed 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 new West Suffolk project remains Green.
6.	**Recommendations**
	The Trust Board are asked to note the content of this report.

Comfort Break

2.2. West Suffolk System Update Report

For Report

Presented by Peter Wightman

Public Board Committee	
Report title:	**West Suffolk Alliance Update**
Agenda item:	2.2
Date of the meeting:	November 12, 2024,
Sponsor/executive lead:	Peter Wightman – Director West Suffolk Alliance
Report prepared by:	Carol King, Alliance Operations Manager – West Suffolk Alliance

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 October and November meetings
SO WHAT? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*
Board members are asked to note progress identified
WHAT NEXT? *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*
Actions are managed through the Alliance Committee process.
Action Required
Note the Report

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

West Suffolk Alliance Update

1.	**Introduction**
1.1	West Suffolk Health and Well Being Alliance Committee held meetings on 9 October and 12 November 2024.
3.	**Key themes**
3.1	**PARTNERSHIP BUILDING PROGRESS** • Workshops are being held for each neighbourhood area to build PCN and INT joint working, supported by PHM data. • Cross-system **Frailty workshop** held 25 September involving health and care professionals and VCSFE partners • **Alliance partnership event** scheduled for 2 December to develop together local system priorities for 2024/25 • NSFT has appointed new Director leader for **West Suffolk's mental health services.** Due to start December 2024. : Director of Operations; Director of Nursing, and a Medical Director. Opportunity to improve alignment within West Suffolk system. • **Open referral platform:** the Committee supported the need for a single platform for residents and professionals to to access to VCFSE. Alliance partners seeking an income source to present business case to future committee • Noted concerns regarding **National Insurance** for employers in the care sector and VCSFE sector. • **Haverhill Health Centre** works nearing completion to optimise space and integration of services to enable better use of the facility • An asset utilisation study carried out for **Sudbury Health Centre** has identified areas of low utilisation to explore opportunities with local partners in need of space
3.2	**HEALTH INEQUALITIES AND WIDER DETERMINANTS** • **Citizen's advice support service** approved by Committee. Service is a continuation of current service which provides enhanced 1-1 support to clients not able to access normal routes through CAB top optimise access to benefits and support. • The Committee received a presentation on Suffolk-wide **Reduced Inequalities Through Better Housing Programme.** This is a time limited programme for housing colleagues to work with NHS partners to make improvements to housing for high need members of the community. Committee agreed next steps to connect with the programme • **Trasport to Essex & Suffolk Elective Orthopaedic Centre (ESEOC) travel -** Committee considered and agreed the proposed approach to travel costs for West Suffolk patients opting for surgery at ESEOC.
3.3	**CHILDREN AND YOUNG PEOPLE** • **First 1001 days** update report was given with key issues and risks identified. This includes commissioning the charity Phoebe to work support from Black and Ethnic Minority communities • **Children and Young people's team** described work to review the ADHD and mental health crisis pathway and sought input from partners to this work.
3.4	**PHYSICAL ACTIVITY COMMISSIONING** • Committee received and supported an **evaluation report on the West Suffolk Integrated Health and Leisure Pathways.** The service has demonstrated both high levels of continued participation and improvement of individual wellbeing scores. The funding source for the project expires in March 2025 and Alliance partners were asked to work together to fund its continuation. • Committee agreed a proposal to establish a **physical activity commissioning partnership.** This will include a combined approach between NHS and Council commissioners to future commissioning of physical activity providers including evaluation, seeking continuation of successful schemes.
3.5	**CARE MARKET STRATEGY**

	The Committee received update on the strategy. The draft explains priorities, provides data and feedback from key stakeholders to date. The work will monitor progress via a Market Position Statement to include work with micro Enterprises. Workforce development join-up includes partnerships with Colleges and Training providers. Follow-up will provide a coordinated approach with the ICB. Further discussions with the ICB and SCC to ensure full links to CHC commissioning.
3.6	**SUDBURY LOCALITY** Sudbury locality members provided an update. There was particular focus on concerns regarding the support being provided to people with mental health challenges. This included Kernos Centre offering 2500 – 3000 counselling sessions annually and Number 72 (The Family and Community Network) | Support in Sudbury
3.7	**SAFEGUARDING** Safeguarding annual review report was received and recommendations discussed and supported.
4.	**Next steps**
4.1	Actions relating to the above are managed through the Alliance Committee
5.	**Conclusion**
5.1	Good progress continues to be made with regards to the West Suffolk Alliance working.
6.	**Recommendations**
	Board is asked to note the report

2.3. Collaborative Oversight Group

To Assure

Presented by Sam Tappenden

Private Board	
Report title:	**Progress update on the Suffolk and North Essex Provider Collaborative**
Agenda item:	
Date of the meeting:	23 October 2024
Executive lead:	Sam Tappenden, Executive Director of Strategy and Transformation
Report prepared by:	Sam Tappenden Executive Director of Strategy and Transformation Stephanie Rose Programme Director, Suffolk and North Essex Provider Collaborative

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 West Suffolk NHS Foundation Trust (WSFT) and the East Suffolk and North Essex NHS Foundation Trust (ESNEFT) have been developing a collaborative approach over the past three years under the 'Suffolk and North Essex Provider Collaborative.' This report presents an update to Board regarding the development of the Suffolk and North-East Essex Provider Collaborative (SNEE PC). The Trust is obliged to meet the needs of the 2019 NHS Long Term Plan which sets out a 'duty to collaborate', which was enhanced in NHSE's guidance regarding provider collaboratives in 'Working Together at Scale (2021)'.
SO WHAT? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*
As the provider collaborative matures and our collective work programme develops, it is important the Board maintains oversight in the development of our relationship with ESNEFT as an important strategic stakeholder in the SNEE system. There are considerable opportunities and risks in engaging with ESNEFT as part of the Provider Collaborative, and it is important that Board is appraised of development progress, particularly in the context of the ICB's sustainability review.
WHAT NEXT? *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*
A Memorandum of Understanding (MoU) is being finalised and will be shared with the West Suffolk NHS Foundation Trust (WSFT) Management Executive Group (MEG) and the East Suffolk and North Essex NHS Foundation Trust (ESNEFT) Executive Management Committee (EMC). The MoU is expected to be presented to WSFT MEG for approval on 4th December.
Action(s) required
The Board are asked to note the contents of **Appendix A** which is a joint ESNEFT-WSFT Governor's Briefing which was delivered on the 13th of November. The briefing provides useful context, a summary of development progress, key work streams across the collaborative.

2.4. Digital Board Report

To inform

Presented by Nicola Cottington

Trust Board	
Report title:	Digital programme board report
Agenda item:	2.4
Date of the meeting:	29th November 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. A new governance structure for the digital programme has previously been approved by the Digital Board, with a revised steering group structure aligned to the Trust and digital strategy.

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 by end of January 2025
- Review of Digital programme is underway and actions arising from re-prioritisation will be monitored through Digital Board

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 23rd October 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 services 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 now consists of 4 main pillars of work: • Clinical systems – primarily e-Care, the main hospital patient 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. The impact of not being able to replace staff from posts that have become vacant is being felt. Following challenge at the digital board, a subsequent review is underway of all projects to clarify which are required, which are nearing completion, those that can be stopped or paused and those requiring further clarification of benefits.
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 a number of projects stopped or on hold. The main work can be summarised: *Completed projects:*

	• Implementation of the diabetes functionality in e-Care together with migration of historic data enabling the Trust to save in the region of £30k • Label printing in the community (e.g. to support sample collection) to ensure that samples are able to be processed quickly and effectively by the pathology lab *In progress:* • Transfer of critical care onto e-Care to enable a consistent medicines record • Consolidation of the current patient portal offerings into the Oracle supported platform (PP UK/Zesty) to make it easier for patients to access information in one place • Next phase of automated medicines dispensing cabinets in ED to improve the safety, security and efficiency of medicines administration • Continued roll out of the e-Consent/Shared decision-making approach by department to facilitate informed decision-making between patients and clinicians *Stopped/on hold:* • Oncology MDT solution stopped due to the difficulty of viable integration options • Integration between Pharmacy stock control system and e-Care • Results management awaiting definition of required workflows • Extension of the Endoscopy Management Systems to include Bronchoscopy
3.2	**Community digital initiatives – Pillar 3** The WSFT digital team that support the Community teams have been working on the contract renewal for the digital solution to support Virtual Wards. This is as a result of the incumbent supplier (Current Health) withdrawing from the remote monitoring market. Although ESNEFT have been invited to be involved. due to capacity constraints as a result of their EPR they have not been able to contribute but the contract does enable them to take the same solution at a future time.
3.3	**Digital infrastructure – Pillar 4** The extensive Cyber Hygiene report currently presented at the quarterly Information Governance Steering group will be given wider circulation. Compliance with the Data Security and Protection Toolkit (DSPT) remains the key priority followed by an assessment of our compliance against the replacement Cyber Assurance Framework (CAF) due for submission in June 2025.
3.4	**Optimisation – Pillar 5** The optimisation team continues to support change requests both in terms of clarifying requirements but also advising on the development of the change and ultimately providing clinical support when changes are implemented. The change request process is being reviewed to ensure it aligns with the Trust objectives and requirements. However, as part of the previous National EPR Usability survey, the ability to influence and change functions and features of an EPR were seen as a really positive aspect of engagement and use of the EPR.

3.5	**Oracle Health roadmap** As a key partner with the Trust, Oracle Health propose to hold a roadmap session that describes some of the resources and solutions that they will be able to offer as result of being part Oracle. Oracle operates in many vertical markets and functional sectors (eg Finance, HR, construction, retail etc) and is recognised as one of the big three or four leading technology providers. This will be the subject of further review, feedback and actions following the workshop.
3.6	**Governance review** The revised governance structure for digital, approved at the last board meeting is in the process of being implemented. This will result in new reporting lines through Insight committee and the structure of the Pillars will change to be aligned with the patient, staff and futures direction of the Trust strategy. A key part of this will be the establishment of a prioritisation mechanism that will assess the 'value' of digital initiatives taking into account all the resources (financial, people and technical) required to deliver the defined and agreed benefits.
3.6	**Digital Maturity Assessment** Formal DMA feedback is planned in regional workshops in the coming months. Further improvements are planned to address our weaker areas which include strengthening the representation and connection to the Trust board.
3.7	**Cyber Security Strategy** The Cyber Security Strategy has been developed with and is aligned to both ESNEFT and SNEE ICB. It emphasises the importance of considering not just products, but also the people involved in cybersecurity. WSFT has a strong cyber security awareness across the Trust but there is always more work to be done in this area as new threats emerge in an increasingly volatile world. The cyber security strategy is built around the principle of security by design, aiming to make the organisation more aware of cyber security risks and actions and deal with them up front before they become blockers. The strategy is intended to improve awareness and ensure security is considered early in all that we do and embedded within the organisation's culture.
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

Public Trust Board Committee	
Report title:	**Integrated Quality and Performance Report**
Agenda item:	3.1
Date of the meeting:	29th November 2024
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) continued to deteriorate (67.7% against the trajectory of 72%), and ambulance handover and 12-hour waits are not demonstrating significant improvement yet. The Urgent and Emergency Care recovery plan is monitored at departmental, Trust, system, and regional levels. New projects starting in October include the extension of Front Door Rapid Assessment by consultants, protecting the Rapid Assessment area from being bedded, the opening of Minor Emergency Care Unit (MECU) and pre booked returner slots for minor injuries that can be assessed the next morning. • Significant improvement in the number of acute patients with no criteria to reside continues, however the number of patients in community bedded settings who do not meet the criteria to reside is not yet improving, 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 continues to not consistently meet the target of 80% within the current capacity of 42 beds. Planned expansion of the virtual ward has been paused and options for the development of virtual wards will be presented to Management Executive Group in November. • 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 July. • 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; this is partly due to the delay in the CDC opening (December 2024). The Trust is reviewing the trajectory to meet the national target date for overall compliance by March 2025.

	• The Trust had committed to zero 65-week waits by the end of September. There has been a significant improvement in the total volume of patients over 65 weeks, with reductions made during the month of September due to additional weekend activity and outsourced Gynaecology activity. The target to reach 0 by the end of September 2024, was however missed. This is due the long standing capacity and demand challenge in Gynaecology in addition to challenges in surgical specialities, particularly Orthopaedics with access to theatres for various reasons, such as contamination of sterile services and roof leaks. • Nutritional assessments will continue to be a focus of quality improvement. The introduction of the new shortened assessment for the emergency department will be monitored for effectiveness. 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. • 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 the impact of these interventions are expected to impact in Q3/Q4. • To note new metrics and data relating to patient experience and patient advice and liaison are included. This data will be presented in making data count format once enough data points are completed.
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

August 2024		ASSURANCE: Pass (P)	ASSURANCE: Hit and Miss (?)	ASSURANCE: Fail (F) — Not Met
VARIANCE	Special Cause Improvement (H / L)		**INVOLVEMENT** Staff Sickness – Rolling 12months Staff Sickness Turnover	**INSIGHT** RTT 78+ Week Waits **INVOLVEMENT** Appraisal
VARIANCE	Common Cause	**INSIGHT** 4 Hour Breaches Urgent 2 hour response – EIT Total average LOS per patient	Please see Right	**INSIGHT** 12 Hour Breaches 4 Hour Performance Total average occupancy number Respiratory Bay average occupancy number Heart Failure Bay average occupancy number IV Abx Bay average occupancy number Frailty Bay average occupancy number Incomplete 104 Day Waits
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
Total average occupancy percentage
28 Day Faster Diagnosis
Cancer 62 Days Performance
Community Paediatrics RTT Overall 104 Weeks Wait
IMPROVEMENT:
C-Diff
INVOLVEMENT:
Mandatory Training

*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, 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

3.2. Finance Report

To Assure

Presented by Jonathan Rowell

Board of Directors – Public Board	
Report title:	Finance Report – as at October 2024 (M7)
Agenda item:	3.2
Date of the meeting:	29th November 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 7 (October 2024).

Income and Expenditure position
We agreed a planned I&E deficit of £15.2m after delivering a Cost Improvement Programme of £16.5m (4%). However, our financial recovery plan forecasts a deficit of £28.5m.

The reported I&E for the year to October is a deficit of £18.9m against a planned deficit of £11.0m. This results in an adverse variance of £7.9m YTD (£6.2m at the end of September).

Efficiencies
Our combined CIP programme and Financial Recovery Plan (FRP) is behind plan for the year to October (£8m against a plan of £11.5m). £3.5m adverse variance YTD.

Cash
Due to our adverse variance the Trust requires additional working capital and have applied for £17m of revenue support in line with our FRP in quarter 3. To date we have only received £2.1m of this request. Continuing to receive revenue support through 2024/25 is critical for the Trust's working capital and our ability to pay critical suppliers on time.

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

The revised forecast (£28.5m deficit) remains challenging and has some risks. However, we are expected to improve on this wherever possible.

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

The FRP aims to improve our recurring run rate as we plan for 25-26 and therefore all recurring savings made in 24-25 will help ensure a robust plan to improve our financial position for 25-26.
Recommendation / action required
Review and approve this report

Previously considered by:	This paper was discussed at the November Insight Committee
Risk and assurance:	Financial risk
Equality, diversity and inclusion:	n/a
Sustainability:	Financial sustainability
Legal and regulatory context:	Financial reporting

	[Insert report title]
1.	**Introduction**
1.1	
2.	**Background**
2.1	
2.2	
2.3	
3.	**Detailed sections and key issues**
3.1	
3.2	
4.	**Next steps**
4.1	
4.2	
5.	**Conclusion**
5.1	
6.	**Recommendations**
	[Insert same wording you have on your cover sheet]

Guidance notes

The practice of scrutiny and assurance

	Questions regarding quality of evidence…	**Further consideration…**
What?	**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!

Deepening **understanding** of the evidence and ensuring its **validity**		
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?

WSFT Monthly Finance Report

2024-25 - October 2024 (M7)

For : Trust Board

Putting you first

Executive Summary as at October 2024

NHS West Suffolk NHS Foundation Trust

Revenue

The reported I&E for the year to October is a deficit of £18.9m against an external planned deficit of £11m. This results in an adverse variance of £7.9m YTD. The in-month position includes the net cost of pay awards (c £1m YTD), partially offset by increased ERF (£400k YTD).

In October, the Board agreed a financial mitigation Recovery plan, which outlined a best-case outturn position of £25.5m, and a likely case of £28.5m. In month 7, the trust is £0.7m better than the anticipated FRP trajectory, with additional ERF and an agreement with NHSE for 23/24 chemotherapy income accounting for £900k of improvement against the plan.

Efficiencies

Our original CIP programme is behind plan by £2.9m for the year to October. However, we have also delivered £1,372k of savings in line with our Finance Recovery Plan (YTD plan of £942k).

For ease of monitoring and reporting we will now aggregate the efficiencies from the revised CIP and FRP programmes. The combined schemes were planned to deliver £5.6m YTD (£19.8m full year), with actual delivery of £6.6m YTD, a favourable variance of £1.0m YTD. Progress against all efficiencies is reviewed by the Financial Recovery Group each week.

Capital

The Capital Plan for 2024/25 is £44m. £12m will be internally funded, with the remaining £32m being funded by PDC. Further PDC has been awarded for the New Hospital Programme of £7.4m along with a further £1.1m for a CT Scanner at Newmarket CDC since the original Capital Plan was set.

YTD capital spend at Month 7 is £22.3m. This is behind plan, mainly due delayed expenditure on RAAC projects, Newmarket CDC and general estates projects. However, it is still expected that the full capital programme will be completed by the end of March 2025. Despite this, given concerns over cash and the impact of our capital programme on our future I&E position (depreciation and PDC), we have reviewed our Capital Programme, particularly where internally funded, to see whether any expenditure and related payments can be reduced or delayed.

Cash

The Trust's cash balance as at 31 October 2024 was £18.3m compared to a plan of £1.1m. This was made up of £2.8m of cash that is set aside to pay for capital projects and £15.5m for revenue payments. This includes an advance of £8.3m received from the ICB for the pay award expenditure for the rest of 2024/25, depreciation funding and funding for Newmarket CDC. This high cash position is at a point in time and does not reflect the underlying position.

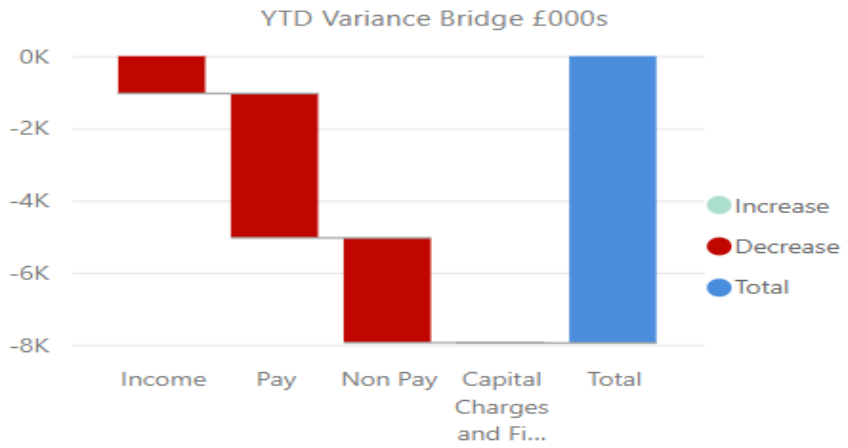
Cash is being rigorously monitored to ensure that we have adequate cash reserves to match our expenditure. However, as the Trust continues to report a deficit, our cash position continues to deteriorate. To date, the Trust has received £9m in revenue (deficit) support across quarters 1 and 2 and £2.1m in working capital revenue support in quarter 3. The Trust originally asked for £17m of revenue support for quarter 3 and to date has only received £2.1m of this request. The request was in line with the Financial Recovery Plan. Continuing to receive revenue support through 2024/25 is critical for the Trust's working capital and our ability to pay critical suppliers on time.

M7 position and forecast

Our formal forecast remains as per our initial plan at £15.2m deficit. However, our financial recovery plan forecast a deficit of £28.5m

	In-Month Budget £m	In-Month Actuals £m	In-Month Variance £m F/(A)	YTD Budget £m	YTD Actuals £m	YTD Variance £m F/(A)	Annual Budget £m	Forecast £m	Forecast Variance £m F/(A)
EBITDA									
Income									
NHS Contract Income	37.5	36.9	-0.6	213.8	213.3	-0.6	365.4	365.4	0.0
Other Income	3.2	3.6	0.4	23.1	22.6	-0.5	39.1	39.1	0.0
Total	**40.8**	**40.5**	**-0.2**	**236.9**	**235.9**	**-1.0**	**404.5**	**404.5**	**0.0**
Expenditure									
Pay Costs	30.6	30.9	-0.3	168.5	172.5	-4.0	286.8	286.8	0.0
Non-pay Costs	9.5	10.7	-1.2	66.5	69.4	-2.9	110.1	110.1	0.0
Total	**40.1**	**41.6**	**-1.5**	**235.1**	**242.0**	**-6.9**	**396.8**	**396.8**	**0.0**
EBITDA Position	**0.7**	**1.1**	**-1.7**	**1.8**	**6.1**	**-7.9**	**7.7**	**7.7**	**0.0**
Depreciation	**1.4**	**1.4**	**0.0**	**9.7**	**9.8**	**0.0**	**16.6**	**16.6**	**0.0**
Finance Costs	**0.4**	**0.4**	**0.0**	**3.1**	**3.1**	**0.0**	**6.2**	**6.2**	**0.0**
Impairments									
Deficit/(Surplus)	**1.1**	**2.9**	**-1.7**	**11.0**	**18.9**	**-8.0**	**15.2**	**15.2**	**0.0**

Deficit YTD £	**18.9M**	
Variance against plan YTD £	**-8.0M**	**Adverse**
Movement in month against plan £	**-1.7M**	**Adverse**
EBITDA Postion YTD £	**-6.1M**	**Adverse**
EBITDA margin YTD	**-3%**	**Adverse**
Cash at bank	**£18.3M**	



Income and Expenditure Summary - October 2024

The adverse variance was £1.7m in October, which includes a shortfall of £0.6m against our monthly CIP target. However, our position was impacted significantly as a result of pay awards that were paid during October. This resulted in £150k per month deficit, and a shortfall of £900k YTD. There may also be further pressures once outstanding payments to junior doctors and increments are made during November.

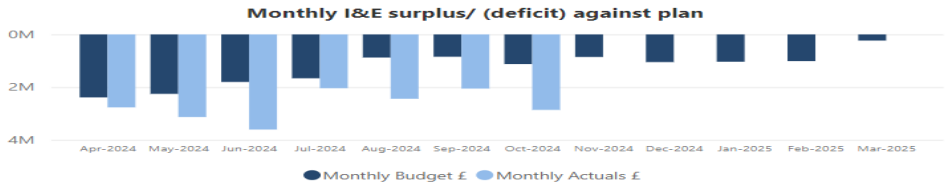
However, our recurring run rate in October was around £100k better than in September and would have been £250k better without the pay award issue. This reduction in run rate is largely as a result in a drop in staffing numbers (73.5 WTEs in total during October).

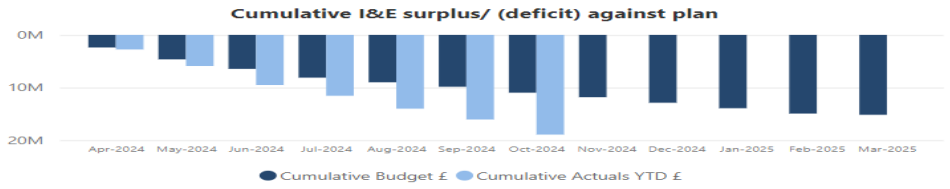
Board Report Item	Original Plan/ Target £000s	Actual/ Forecast £000s	Variance to Plan £000s F/(A)	
In month surplus/ (deficit)	-1,127	-2,866	-1,739	↓
YTD surplus/ (deficit)	-10,973	-18,924	-7,951	↓
Clinical Income YTD	213,826	213,269	-556	→
Non-Clinical Income YTD	23,066	22,586	-480	↓
Pay YTD	168,536	172,540	-4,003	↓
Non-Pay YTD	66,527	69,430	-2,902	↓
EBITDA YTD	1,828	-6,114	-7,942	↓
EBITDA %	0.8	-2.6	-3.4	↓

Adverse variance > 1% ↓

Adverse variance within 1% →

On plan or favourable variance ↑





High level reasons for variance from plan to October 2024	Monthly Variance							
	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Total YTD
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Non - Recurring								
ED expenditure relating to UEC improvement in 2324	150	0	0	0	0	0	0	150
Escalation ward unfunded (April and May)	155	115	0	0	0	0	0	270
Endoscopy Maintenance	0	0	90	0	0	0	0	90
Industrial action	0	0	130	0	0	(311)	0	(181)
Drug underspends (Exclude Medicine)	0	0	0	(72)	(13)	60	0	(25)
Rates Credit	0	0	0	(554)	0	0	0	(554)
Other non Clinical Income	0	0	0	0	197	0	0	197
ERF income *	0	0	0	0	0	0	(409)	(409)
Pay award backdated M1-6 (0.6% beyond funding)	0	0	0	0	0	0	904	904
Bad debts written off							143	143
Energy bills	(97)	(97)	78	(58)	(43)	0	47	(170)
	208	18	298	(684)	141	(251)	685	415
Recurring, but outside of our control								
Inflationary pressures	60	65	70	75	80	85	90	525
Pay award M7 onwards (0.6%)	0	0	0	0	0	0	151	151
Private patient income	0	0	0	(152)	86	35	40	9
	60	65	70	(77)	166	120	281	685
Recurring, but we can improve								
Community Income shortfall *	64	64	64	64	44	46	28	374
Community Equipment and Wheelchairs *	0	160	80	0	119	42	87	488
CIP behind plan	0	0	360	921	631	773	627	3,312
ECW above plan *	271	207	359	263	252	181	148	1,681
Back dated APA claims and salary arrears *	126	200	145	100	34	0	25	630
Drugs within Medicine *	100	100	100	(65)	(84)	240	65	456
Various mitigating (underspends) / overspends *	(450)	225	169	(146)	262	57	(207)	(90)
ERF income *	0	(160)	160	0	0	0	0	0
Winter *	0	0	0	0	0	0	0	0
Total Variance	**379**	**879**	**1,805**	**376**	**1,565**	**1,208**	**1,739**	**7,951**
*** Recurring adverse variance YTD within our control (excl CIP)**								**3,539**

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

Variance Analysis and Actions

West Suffolk NHS Foundation Trust

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.

Pay Awards
The cost pressure in relation to unfunded pay awards appears to be a national problem at around 0.6% in providers. A national exercise is underway to confirm the scale of this issue. If funding is not received our forecast of £28.5m may be at risk. There are also likely to be further pressures when the remaining pay awards are made during November for junior doctors and increments.

Pay Costs
The vacancy control panel has put strong processes and controls in place since August and we have seen an improvement of around £250k in October due to a reduction in WTEs.

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.

ERF income
We have now recognised £409k YTD ERF income

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.

Actions, Finance Recovery Plan and Run Rate

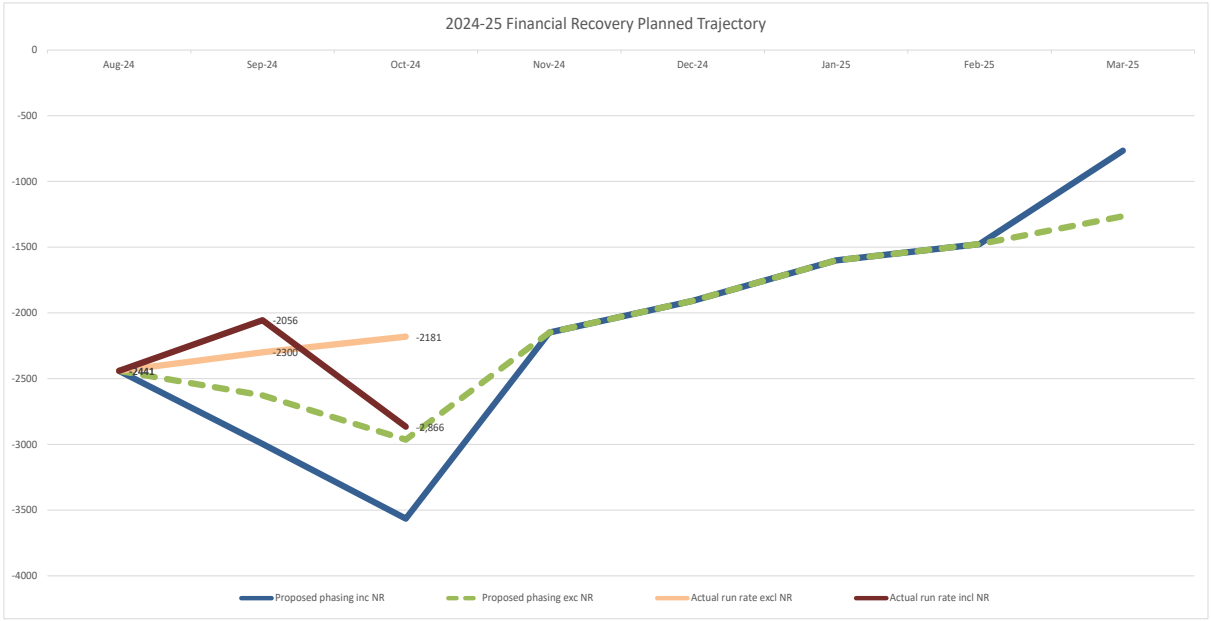
West Suffolk NHS Foundation Trust

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. It is anticipated that these will improve our position by £5.7m by the end of 2024-25. Performance against these 10 actions is reviewed weekly at the Financial Recovery Group (FRG) and is included within the Efficiencies section of this report.

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 this has been shared with the ICB. These actions totalling £5.3m formed part of the Financial Recovery Plan (FRP) and progress against this is reviewed weekly at FRG and is included within the Efficiencies section of this report.

In October we have started to see the impact of the Vacancy Control Panel as posts where recruitment has been paused have become vacant and have not been backfilled. This contributed around £250k savings in October.



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)
- September £2.1m (£2.3m recurring)
- October £2.9m (£2.18m recurring, £2.03m recurring without pay awards)

Reconcile M7 actual to FRP trajectory	£'000
FRP planned deficit for October	(3,565)
October anticipated costs didn't arise	
Removed risk of losing Chemo income	600
Optimism bias	89
Adjusted FRP for October	(2,876)
Actuals	2,866
Additional ERF (£409k YTD)	279
Bad debt write off above FRP	(43)
Pay awards worse than FRP	(1,055)
Revised CIP ahead of FRP	274
FRP actions ahead of plan	281
10 actions ahead of FRP	184
Other	90
	2,876
Unexplained	0

Key Risks, Mitigations and Escalations

This table represents the potential risks and mitigations that may adjust our run rate from the M7 position, with a summary of the value of the actions required to meet our planned deficit

	Impact on YTD actuals at M7 Best case £'000	Impact on YTD actuals at M7 Worst case £'000	M7 FOT £'000
M7 position surplus / (deficit)			(18,900)
Recurring deficit of £2.2m as at M7			(11,000)
Unmitigated forecast without any risks			**(29,900)**
Within our control			
Non-recurring, unexpected, costs at £100k pm	0	(500)	
Further identified CIP and Divisional FRP	1,000	0	
23/24 expected final ERF performance	0	0	
ERF performance (net of advice and guidance)	0	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	(1,000)	
Lost margin from Elective activity (ESEOC)	0	0	
Winter pressure/UEC	0	(500)	
Outside of our control			
Inflationary costs unfunded (beyond M7 recurring position)	0	(100)	
Industrial Action costs funded (income in M6 position)	0	0	
Pay awards not fully funded (M1-12, paid in M8)	0	(500)	
Total range before FRP (impact on proposed plan)	**1,500**	**(3,200)**	**(31,600)**

CIP delivery (meet £16.5m target) beyond current forecast	7,700	0	(23,900)
Impact of additional controls and unidentified actions	9,000	0	(14,900)

Any in month Movement in Risks and Mitigations

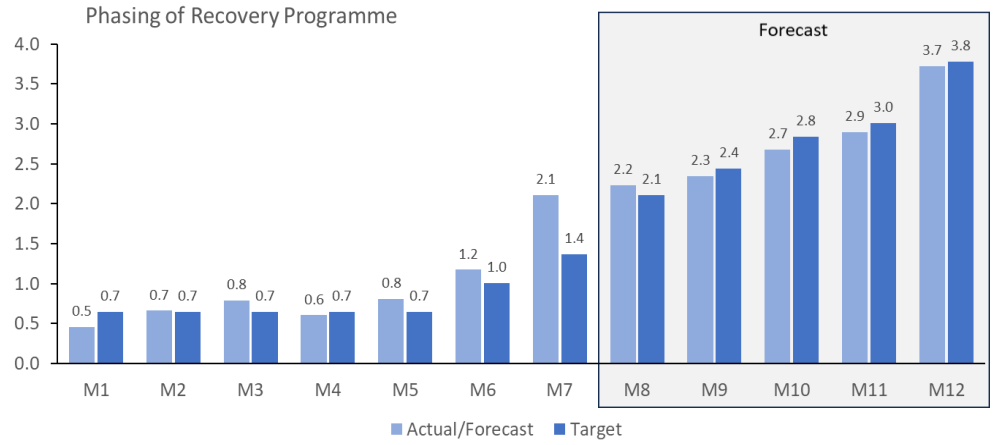
- Pay awards have become clearer but there is still risk associated with junior doctors and increments that may arise in November

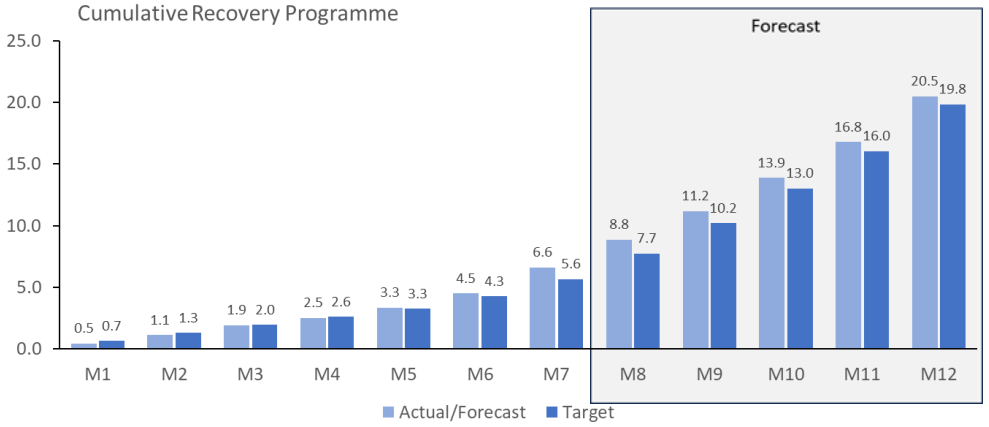
Efficiencies as per Finance Recovery Plan

The combined revised CIP and FRP schemes planned to deliver £5.6m YTD, with actual delivery of £6.6m YTD, a favourable variance of £1.0m YTD.

The M7 delivery totals £2.1m against a plan of £1.4m, a favourable variance of £739k

Division	Target (2425 Schemes)	Target (2324 Schemes)	Annual Target	YTD			FULL YEAR			In-Month Delivery		
				Target YTD	Actuals YTD	Variance	Annual Target	Actuals/ Forecast 2024-2025	Variance	Target	Actuals	Variance
CIP (revised in line with FRP)												
Community	1,286	327	1,613	804	503	(301)	1,613	1,226	(387)	162	103	(59)
Corporate	4,630	208	4,838	2,413	1,925	(488)	4,838	3,645	(1,193)	485	324	(161)
CSS	845	94	939	468	481	13	939	742	(197)	94	86	(8)
Estates & Facilities	674	262	936	467	540	73	936	806	(129)	94	57	(37)
Medicine	2,211	0	2,211	1,035	322	(713)	2,211	1,076	(1,135)	235	67	(168)
Surgery	2,027	594	2,621	1,307	946	(361)	2,621	1,408	(1,213)	263	151	(112)
Women & Children	542	0	542	406	304	(102)	542	384	(158)	27	17	(10)
Trust Wide (not division specific)	2,800	0	2,800	1,396	214	(1,183)	2,800	424	(2,376)	280	208	(71)
CIP Target Adjustment (per FRP)	(7,700)	0	(7,700)	(3,607)	0	3,607	(7,700)	0	7,700	(900)	0	900
Total CIP	**7,315**	**1,485**	**8,800**	**4,690**	**5,235**	**546**	**8,800**	**9,712**	**912**	**740**	**1,013**	**274**
FRPs												
Community	881	0	881	0	111	111	881	881	0	0	111	111
Corporate	200	0	200	0	26	26	200	200	(0)	0	26	26
CSS	600	0	600	0	35	35	600	600	0	0	35	35
Estates & Facilities	300	0	300	0	40	40	300	300	0	0	40	40
Medicine	1,349	0	1,349	13	22	9	1,349	1,349	(0)	13	22	9
Surgery	523	0	523	0	50	50	523	523	0	0	50	50
Women & Children	835	0	835	0	10	10	835	835	0	0	10	10
To be agreed	0	0	0	0	0	0	582	582	0	0	0	0
Total FRPs	**4,687**	**0**	**4,687**	**13**	**294**	**281**	**5,269**	**5,269**	**0**	**13**	**294**	**281**
Ten Actions												
01 - Non-Pay Control Panel	490	0	490	140	152	12	490	490	0	70	152	82
02 - Non-Pay Procurement Catalogue Masking	300	0	300	50	93	43	300	93	(207)	50	93	43
03 - Temporary Medical Staffing Spend	140	0	140	40	91	51	140	140	0	20	66	46
04 - Temporary Nursing Staffing Spend	500	0	500	0	97	97	500	511	11	0	97	97
05 - Interim and Contract staff Spend	60	0	60	10	18	8	60	18	(42)	10	18	8
06 - Vacancy Control Panel Pause during August-24	1,760	0	1,760	160	67	(93)	1,760	1,760	0	160	67	(93)
07 - Other temporary spend (non-medical, non-nursing)	210	0	210	60	90	30	210	210	0	30	31	1
08 - Review of Trust Contracts (SLA, maintenance contracts)	150	0	150	0	0	0	150	150	0	0	0	0
09 - Income and ERF review	870	0	870	169	169	0	870	870	0	130	130	0
10 - Review of 24/25 planned 'investments'	1,269	0	1,269	300	300	0	1,269	1,269	0	150	150	0
Total Ten Actions	**5,749**	**0**	**5,749**	**929**	**1,078**	**149**	**5,749**	**5,512**	**(237)**	**620**	**804**	**184**
	17,751	**1,485**	**19,236**	**5,632**	**6,607**	**975**	**19,818**	**20,492**	**675**	**1,373**	**2,112**	**739**





Efficiencies – Original Cost Improvement Programme

Cost Improvement Programme (CIP) 2024-25
A summary of progress against the CIP target of £16.5m is included in the efficiencies summary above. This includes £1.4m of CIP relating to the FYE of CIPs that started in 2023-24.

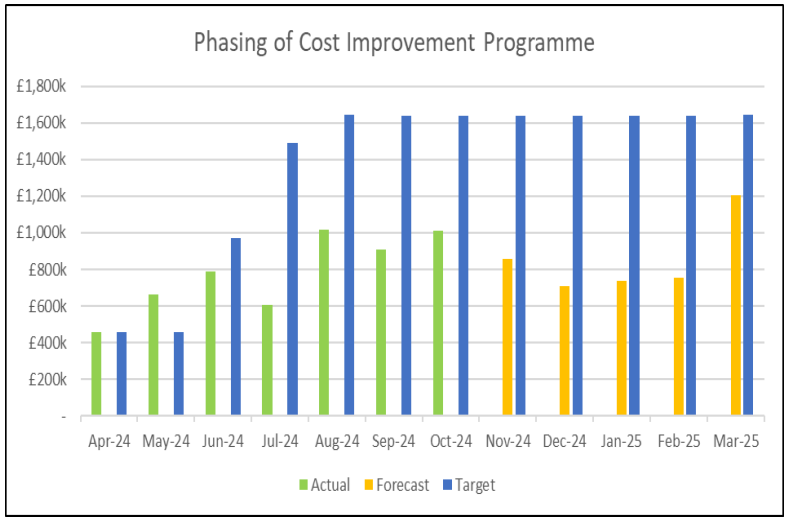
In month progress (October)
Our monthly CIP target is now £1.6m and will remain at that level for the rest of the year.

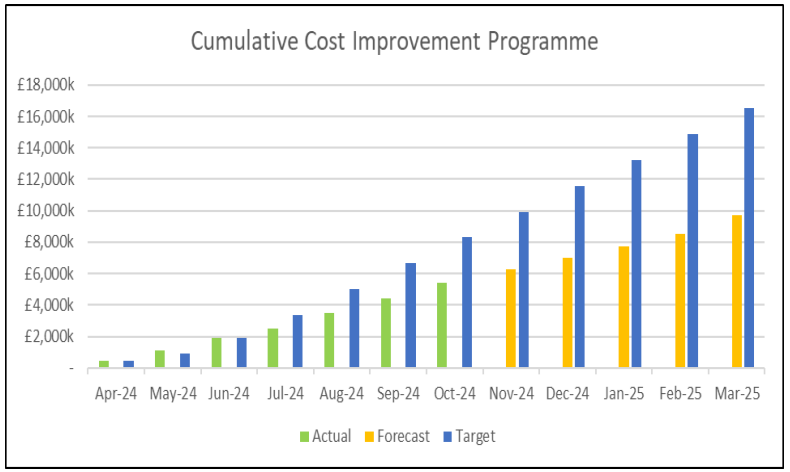
During October we delivered £1m, a shortfall of £0.6m. YTD we have delivered £5.4m against a plan of £8.3m, an adverse variance of £2.9m

We identified a further a further £425k of schemes during October.

After risk adjusting and incorporating time slippage, we would anticipate the CIP would deliver £10.3m of savings in 2425. This is currently £6.2m below our target. There are currently 167 schemes in the pipeline that will contribute to closing this gap.

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	600	3	-	4	588	595	(265)	(1,882)	9
Surgery	2,621	1,215	22	-	147	976	1,145	(168)	(1,644)	16
Women & Children	542	382	-	-	64	302	366	(113)	(289)	3
CSS	939	542	22	-	5	480	507	(58)	(490)	21
Community	1,613	1,193	236	-	277	256	769	(596)	(1,440)	26
Estates & Facilities	936	558	1	-	60	480	541	(64)	(458)	6
Corporate	4,838	1,364	34	-	156	1,084	1,274	(175)	(3,740)	9
Division Specific	**13,700**	**5,854**	**319**	**-**	**713**	**4,166**	**5,197**	**(1,440)**	**(9,943)**	**90**
TW - WRG Medical Staff	-	452	24	-	32	352	408	(79)	329	9
TW - WRG Nursing Staff	-	168	2	-	-	162	165	(7)	158	9
TW - WRG Other Staff	-	421	10	-	-	396	406	(28)	378	16
TW - Finance	-	2,400	-	-	-	2,400	2,400	-	2,400	-
TW - Procurement	-	1,222	479	-	-	25	504	(698)	(194)	10
TW - Pharmacy	-	713	-	-	-	713	713	(72)	641	10
TW - Discretionary Spend	-	71	-	-	-	71	71	(1)	70	-
TW - Strategy & Transformation	-	-	-	-	-	-	-	-	-	4
TW - Other	-	-	-	-	-	-	-	-	-	19
Trustwide Schemes	**-**	**5,448**	**515**	**-**	**32**	**4,120**	**4,667**	**(885)**	**3,782**	**77**
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**	**14,102**	**1,354**	**-**	**745**	**10,565**	**12,665**	**(2,325)**	**(6,160)**	**167**



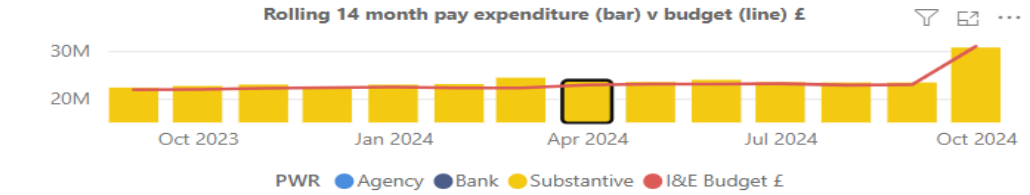


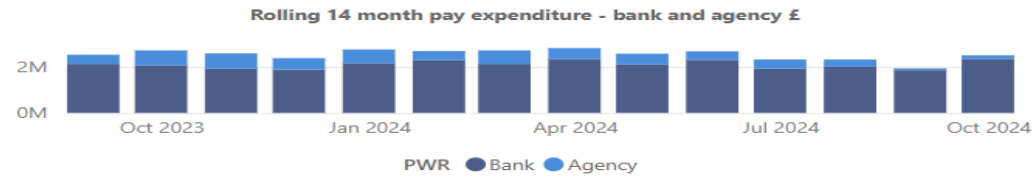
Workforce

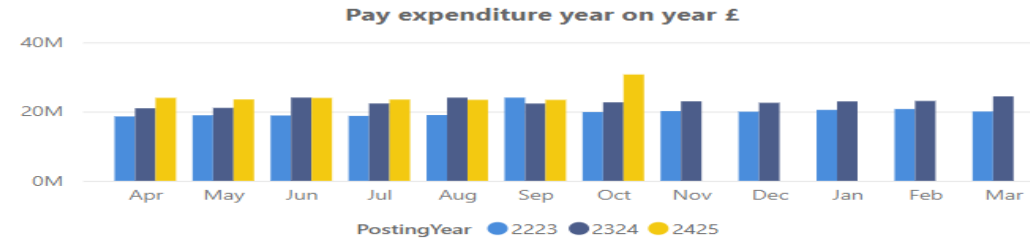
During October the Trust overspent by £0.3m on pay due largely to Extra Contracted Work (ECW) and locum medical staff. We have now put in place a process to review all temporary pay requests.

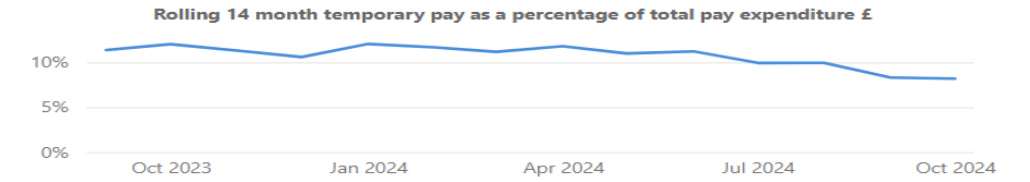
The pay related costs include pay awards. The shortfall in funding of pay awards has created an adverse variance of £1.05m in October (£900k in back dated payments). There may be further cost pressures in November when Junior Doctors and increments are fully paid too.

		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	5,412	8,649	8,767	119	40,617	42,707	2,090
	Nursing	7,690	9,493	10,548	1,054	55,385	61,590	6,205
	Sci & Professional	1,066	1,328	1,455	127	7,781	8,338	557
	A&C	3,465	4,417	4,713	296	25,030	26,354	1,324
	AHP	2,245	2,803	3,042	238	16,173	17,601	1,428
	Prof & Tech	229	281	313	33	1,599	1,720	121
	Support Staff	814	977	1,095	118	5,798	6,392	595
	Other	499	429	571	142	3,011	2,980	-30
	Unallocated CIP	0	0	-595	-595	0	-2,472	-2,472
	Total	21,421	28,377	29,909	1,532	155,393	165,211	9,818
Additional Medical Sessions	Medical Staff	278	254	105	-148	2,419	738	-1,680
	Total	278	254	105	-148	2,419	738	-1,680
Bank & Locum Staff	Medical Staff	463	857	324	-534	4,088	1,032	-3,055
	Nursing	611	750	22	-728	4,645	116	-4,529
	Sci & Professional	49	33	5	-28	225	27	-198
	A&C	104	85	14	-71	602	95	-507
	AHP	15	22	0	-21	134	2	-131
	Prof & Tech	0	1	0	-1	5	0	-5
	Support Staff	264	253	108	-144	2,081	606	-1,475
	Other	0	0	0	0	1	0	-1
	Total	1,507	2,000	473	-1,527	11,780	1,879	-9,902
Agency	Medical Staff	62	64	32	-33	914	221	-694
	Nursing	3	28	17	-12	387	117	-269
	Sci & Professional	21	5	10	5	144	72	-72
	A&C	61	26	18	-8	391	125	-266
	Prof & Tech	-66	37	17	-20	426	120	-306
	Support Staff	0	0	0	0	1	0	-1
	Total	81	161	93	-68	2,262	654	-1,608
Overtime	Nursing	25	15	3	-12	192	17	-175
	Sci & Professional	1	12	6	-6	95	34	-62
	A&C	14	21	1	-20	175	3	-171
	AHP	12	21	0	-21	86	0	-86
	Prof & Tech	16	19	0	-19	137	0	-137
	Other	0	0	0	0	0	0	0
	Total	67	87	9	-78	685	54	-631
Total		23,355	30,879	30,590	-289	172,540	168,536	-4,003







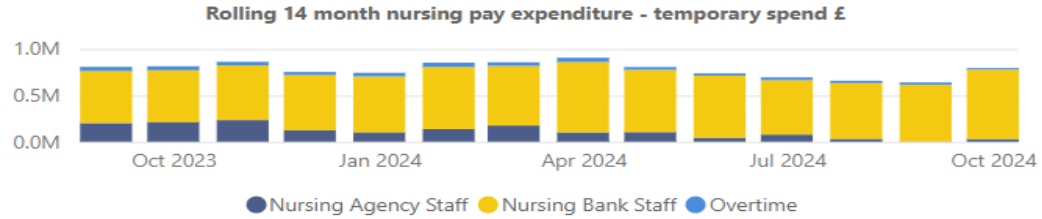


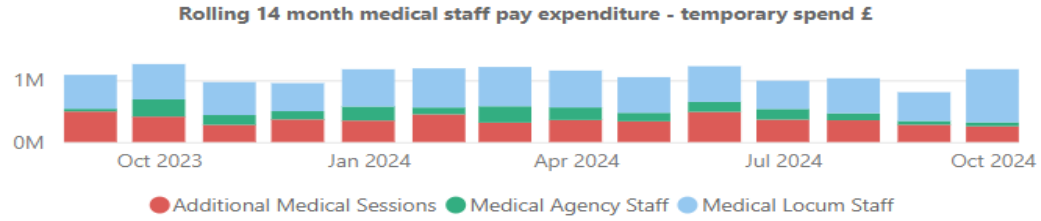
Pay Costs (by Staff Type)

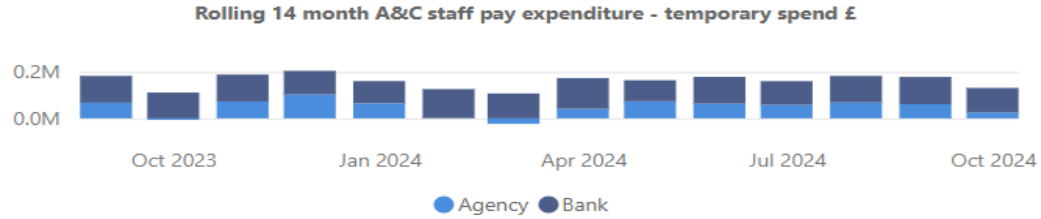
Medical Staffing, and in particular Extra Contracted Work (ECW) are the staff group with the most significant adverse variance. However, ECW dropped by £24k in October compared with September.

In month, medical locum costs are high due to back dated pay awards

		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	5,412	8,649	8,767	119	40,617	42,707	2,090
	Additional Medical Sessions	278	254	105	-148	2,419	738	-1,680
	Bank & Locum Staff	463	857	324	-534	4,088	1,032	-3,055
	Agency	62	64	32	-33	914	221	-694
	Total	6,215	9,824	9,228	-596	48,038	44,698	-3,340
Nursing	Substantive	7,690	9,493	10,548	1,054	55,385	61,590	6,205
	Bank & Locum Staff	611	750	22	-728	4,645	116	-4,529
	Agency	3	28	17	-12	387	117	-269
	Overtime	25	15	3	-12	192	17	-175
	Total	8,329	10,286	10,589	303	60,609	61,841	1,232
Sci & Professional	Substantive	1,066	1,328	1,455	127	7,781	8,338	557
	Bank & Locum Staff	49	33	5	-28	225	27	-198
	Agency	21	5	10	5	144	72	-72
	Overtime	1	12	6	-6	95	34	-62
	Total	1,137	1,378	1,475	97	8,244	8,470	226
A&C	Substantive	3,465	4,417	4,713	296	25,030	26,354	1,324
	Bank & Locum Staff	104	85	14	-71	602	95	-507
	Agency	61	26	18	-8	391	125	-266
	Overtime	14	21	1	-20	175	3	-171
	Total	3,643	4,548	4,746	198	26,198	26,578	380
AHP	Substantive	2,245	2,803	3,042	238	16,173	17,601	1,428
	Bank & Locum Staff	15	22	0	-21	134	2	-131
	Overtime	12	21	0	-21	86	0	-86
	Total	2,272	2,846	3,042	196	16,393	17,603	1,211
Prof & Tech	Substantive	229	281	313	33	1,599	1,720	121
	Bank & Locum Staff	0	1	0	-1	5	0	-5
	Agency	-66	37	17	-20	426	120	-306
	Overtime	16	19	0	-19	137	0	-137
	Total	179	338	330	-8	2,167	1,840	-327
Support Staff	Substantive	814	977	1,095	118	5,798	6,392	595
	Bank & Locum Staff	264	253	108	-144	2,081	606	-1,475
	Agency	0	0	0	0	1	0	-1
	Total	1,079	1,230	1,203	-27	7,880	6,998	-881
Other	Substantive	499	429	571	142	3,011	2,980	-30
	Overtime	0	0	0	0	0	0	0
	Total	499	429	571	142	3,011	2,980	-30
Other	Bank & Locum Staff	0	0	0	0	1	0	-1
	Total	0	0	0	0	1	0	-1
Unallocated CIP	Substantive	0	0	-595	-595	0	-2,472	-2,472
	Total	0	0	-595	-595	0	-2,472	-2,472
Total		23,355	30,879	30,590	-289	172,540	168,536	-4,003





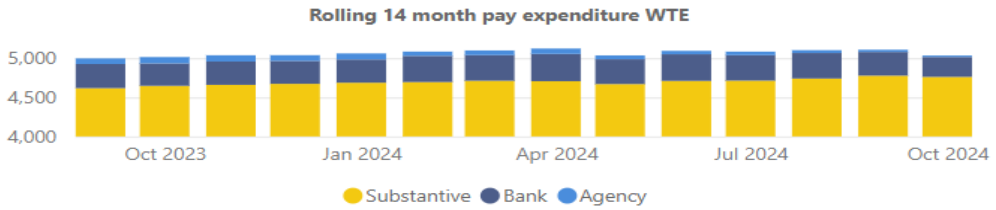


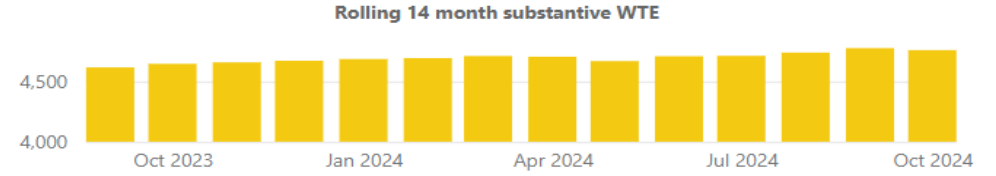
Workforce - WTEs

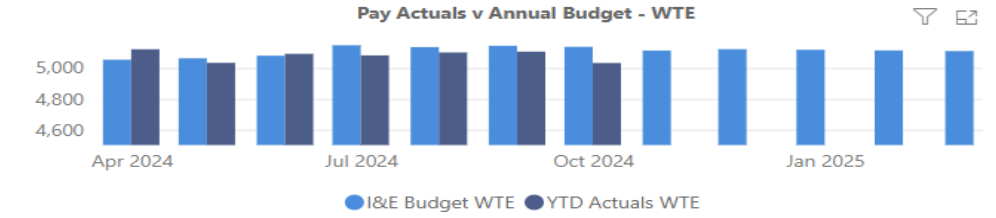
Agency, bank and overtime continue to fall, alongside a reduction in substantive staff (15 WTEs). In total we are reporting a reduction of 73.5 WTEs in October.

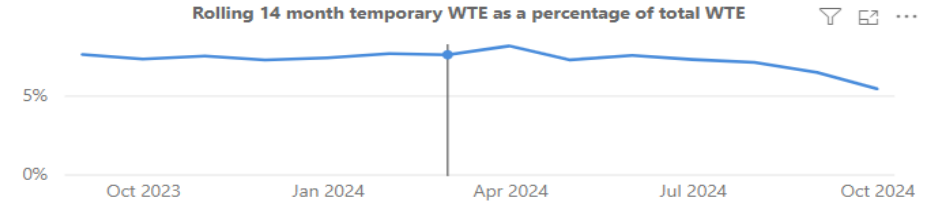
However, we are employing 113.4 substantive WTEs more than in October 2023, and 18.3 WTEs more in total.

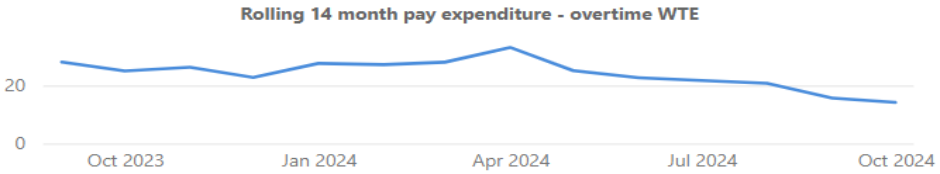
		Prior Month Actuals WTE	Prior Yr Same Period Actuals WTE	In-Month Actuals WTE	In-Month Budget WTE	In-Month Variance WTE	YTD Actuals Average WTE	YTD Budget Average WTE	YTD Variance Average WTE
Substantive	Nursing	1,953.3	1,912.1	1,953.3	2,135.7	182.4	1,936.1	2,133.0	196.9
	A&C	993.4	971.9	978.3	1,035.4	57.1	981.2	1,026.9	45.7
	Medical Staff	584.9	551.7	586.3	626.7	40.4	581.7	620.5	38.7
	AHP	553.6	536.0	556.4	593.7	37.3	547.0	597.9	50.9
	Support Staff	288.2	282.2	290.9	316.9	26.0	284.9	321.5	36.5
	Sci & Professional	274.0	275.0	275.2	297.5	22.3	274.5	297.7	23.1
	Other	74.5	70.2	68.6	83.0	14.4	68.1	56.4	-11.7
	Prof & Tech	53.0	46.3	49.8	56.4	6.6	49.5	54.2	4.7
	Unallocated CIP	0.0	0.0	0.0	-28.6	-28.6	0.0	-24.0	-24.0
	Total	4,774.9	4,645.4	4,758.8	5,116.7	357.9	4,723.2	5,084.1	360.9
Additional Medical Sessions	Medical Staff	14.4	13.1	16.9	4.3	-12.5	16.1	8.2	-8.0
	Total	14.4	13.1	16.9	4.3	-12.5	16.1	8.2	-8.0
Overtime	Other	0.0		0.0	0.0	0.0	0.0	0.0	0.0
	Sci & Professional	1.8	4.0	1.2	0.0	-1.2	2.7	0.0	-2.7
	Nursing	3.2	10.4	2.1	0.0	-2.1	5.8	0.0	-5.8
	A&C	3.0	4.0	2.8	0.0	-2.8	5.2	0.0	-5.2
	AHP	2.9	1.9	3.9	0.0	-3.9	2.7	0.0	-2.7
	Prof & Tech	4.7	4.7	4.1	0.0	-4.1	5.4	0.0	-5.4
	Total	15.6	24.9	14.1	0.0	-14.1	21.8	0.0	-21.8
Agency	Support Staff	0.2	1.4	0.0	0.0	0.0	0.0	0.0	0.0
	Sci & Professional	1.8	7.5	0.8	0.0	-0.8	4.9	0.0	-4.9
	A&C	10.2	16.6	1.6	0.0	-1.6	7.2	0.0	-7.2
	Medical Staff	6.0	14.5	5.5	1.9	-3.6	8.8	1.9	-6.9
	Nursing	1.8	28.0	3.8	0.0	-3.8	7.6	0.0	-7.6
	Prof & Tech	8.4	14.5	7.3	0.0	-7.3	13.1	0.0	-13.1
	Total	28.4	82.5	19.1	1.9	-17.1	41.6	1.9	-39.7
Bank & Locum Staff	Other	0.1		0.0	0.0	0.0	0.0	0.0	0.0
	Prof & Tech	0.1	0.2	0.3	0.0	-0.3	0.2	0.0	-0.2
	AHP	4.0	4.3	4.7	0.0	-4.7	4.6	0.0	-4.6
	Sci & Professional	14.1	4.7	8.0	0.0	-8.0	8.6	0.0	-8.6
	Support Staff	29.3	30.5	17.5	3.3	-14.1	36.1	3.3	-32.7
	Medical Staff	40.3	32.8	26.2	7.4	-18.8	42.2	7.5	-34.7
	A&C	32.3	33.0	22.3	2.5	-19.9	27.5	2.5	-25.0
	Nursing	151.6	141.8	143.8	0.3	-143.5	158.2	0.3	-157.9
	Total	271.7	247.3	222.7	13.5	-209.2	277.4	13.6	-263.8
Total		5,105.0	5,013.2	5,031.5	5,136.4	104.9	5,080.1	5,107.8	27.7







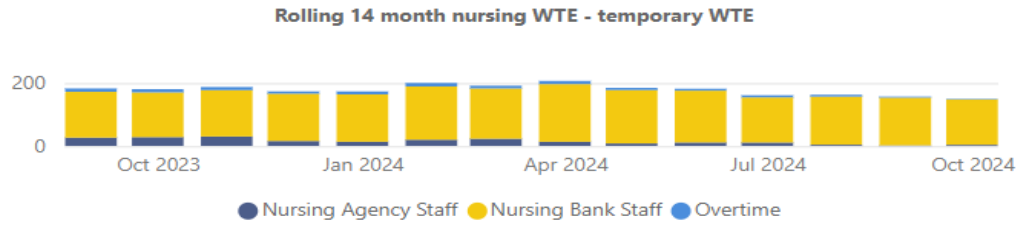


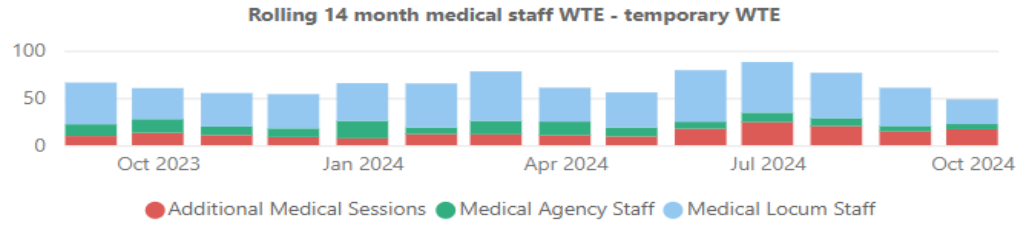


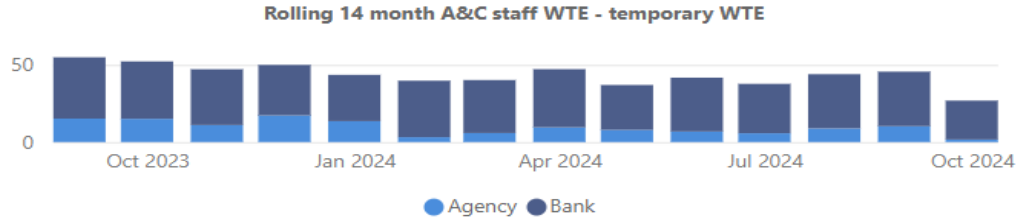
Workforce - WTE (by Staff Group)

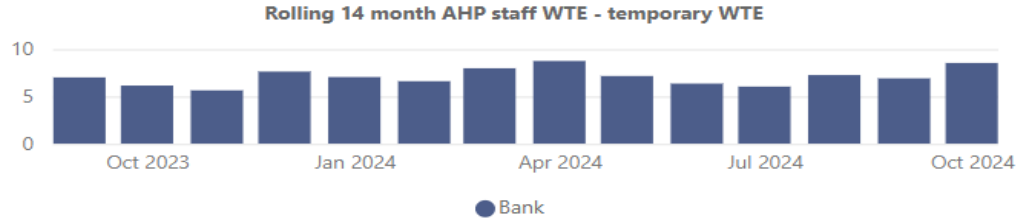
There appear to be 34.6 WTE more Substantive Medical Staff than in October 2023, with a small reduction in the use of temporary medical staff (Extra Contracted Work, locums and agency staff). Total increase of 22.7 WTE (3.7%).

		Prior Month Actuals WTE	Prior Yr Same Period Actuals WTE	In-Month Actuals WTE	YTD Actuals Average WTE
Medical Staff	Substantive	584.9	551.7	586.3	581.7
	Additional Medical Sessions	14.4	13.1	16.9	16.1
	Bank & Locum Staff	40.3	32.8	26.2	42.2
	Agency	6.0	14.5	5.5	8.8
	Total	645.6	612.1	634.8	648.8
Nursing	Substantive	1,953.3	1,912.1	1,953.3	1,936.1
	Bank & Locum Staff	151.6	141.8	143.8	158.2
	Agency	1.8	28.0	3.8	7.6
	Overtime	3.2	10.4	2.1	5.8
	Total	2,109.8	2,092.3	2,103.0	2,107.7
Sci & Professional	Substantive	274.0	275.0	275.2	274.5
	Bank & Locum Staff	14.1	4.7	8.0	8.6
	Agency	1.8	7.5	0.8	4.9
	Overtime	1.8	4.0	1.2	2.7
	Total	291.7	291.3	285.2	290.7
A&C	Substantive	993.4	971.9	978.3	981.2
	Bank & Locum Staff	32.3	33.0	22.3	27.5
	Agency	10.2	16.6	1.6	7.2
	Overtime	3.0	4.0	2.8	5.2
	Total	1,038.9	1,025.5	1,005.1	1,021.1
AHP	Substantive	553.6	536.0	556.4	547.0
	Bank & Locum Staff	4.0	4.3	4.7	4.6
	Overtime	2.9	1.9	3.9	2.7
	Total	560.5	542.1	564.9	554.3
Prof & Tech	Substantive	53.0	46.3	49.8	49.5
	Bank & Locum Staff	0.1	0.2	0.3	0.2
	Agency	8.4	14.5	7.3	13.1
	Overtime	4.7	4.7	4.1	5.4
	Total	66.2	65.6	61.5	68.4
Support Staff	Substantive	288.2	282.2	290.9	284.9
	Bank & Locum Staff	29.3	30.5	17.5	36.1
	Agency	0.2	1.4	0.0	0.0
	Total	317.6	314.1	308.4	321.0
Other	Substantive	74.5	70.2	68.6	68.1
	Overtime	0.0		0.0	0.0
	Total	74.5	70.2	68.6	68.1
Other	Bank & Locum Staff	0.1		0.0	0.0
	Total	0.1		0.0	0.0
Unallocated CIP	Substantive	0.0	0.0	0.0	0.0
	Total	0.0	0.0	0.0	0.0
Total		5,105.0	5,013.2	5,031.5	5,080.1









Statement of Financial Position – 31 October 2024

West Suffolk NHS Foundation Trust

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2024	Plan 31 March 2025	Plan YTD 31 October 2024	Actual at 31 October 2024	Variance YTD 31 October 2024
	£000	£000	£000	£000	£000
Intangible assets	57,724	51,078	53,847	53,806	(41)
Property, plant and equipment	130,806	159,588	156,601	148,357	(8,244)
Right of use assets	11,624	9,512	10,392	10,483	91
Trade and other receivables	7,158	7,158	7,158	7,158	0
Total non-current assets	207,312	227,336	227,998	219,804	(8,194)
Inventories	4,640	4,600	4,600	4,893	293
Trade and other receivables	20,378	18,378	18,378	20,611	2,233
Non-current assets for sale	490	490	490	490	0
Cash and cash equivalents	9,315	1,107	1,107	18,347	17,240
Total current assets	34,823	24,575	24,575	44,341	19,766
Trade and other payables	(41,934)	(28,587)	(34,006)	(54,532)	(20,526)
Borrowing repayable within 1 year	(4,732)	(4,722)	(4,722)	(4,557)	165
Current Provisions	(58)	(58)	(58)	(58)	0
Other liabilities	(1,776)	(2,685)	(2,685)	(9,686)	(7,001)
Total current liabilities	(48,500)	(36,052)	(41,471)	(68,833)	(27,362)
Total assets less current liabilities	193,635	215,859	211,102	195,312	(15,790)
Borrowings	(44,048)	(39,160)	(41,338)	(41,554)	(216)
Provisions	(407)	(407)	(407)	(406)	1
Total non-current liabilities	(44,455)	(39,567)	(41,745)	(41,960)	(215)
Total assets employed	149,180	176,292	169,357	153,352	(16,005)
Financed by					
Public dividend capital	277,694	320,343	309,051	300,787	(8,264)
Revaluation reserve	11,941	11,941	11,941	11,941	0
Income and expenditure reserve	(140,455)	(155,992)	(151,635)	(159,376)	(7,742)
Total taxpayers' and others' equity	149,180	176,292	169,357	153,352	(16,006)

The table shows the year-to-date Statement of Financial Position as at 31 October 2024.

The variance to plan of property, plant and equipment is due to the capital programme being below plan. This also links to the public dividend capital, which has not yet been drawn down to the extent planned.

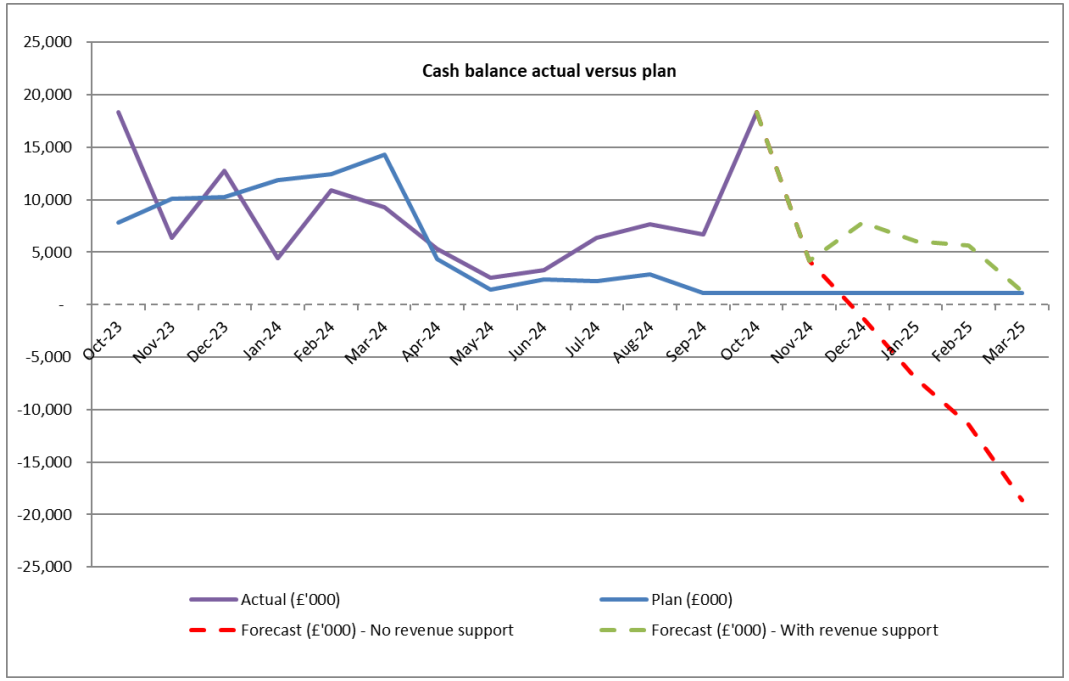
Trade and other receivables are higher than plan and this is due in the main to an increase in accrued income. There has been good recovery of some aged debt, with overall trade debtors reducing by £2m during 2024/25 to month 7.

Trade and other payables have increased due to aged trade creditors which we are currently unable to pay within expected timescales due to our low cash position. There has also been an increase in accruals in relation to the pay award. The increase in cash supports this movement in part, however the cash balance is currently overinflated due to advanced funding received from the ICB, as noted below.

Deferred income (other liabilities) is higher than plan, mostly due to £2.7m of income received from the ICB in relation to depreciation tariff funding and £3.6m received in advance for the 2024/25 pay award. There is also £2m received in advance for funding for Newmarket CDC.

Cash balance for the year

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



The Trust's cash balance as at 31 October 2024 was £18.3m compared to a plan of £1.1m. This was made up of £2.8m of cash that is set aside to pay for capital projects and £15.5m for revenue payments. The cash position is masked by an advance of £8.3m received from the ICB for the pay award expenditure for the rest of 2024/25, depreciation funding and funding for Newmarket CDC.

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

The cash forecast has been added to the graph to show the forecast cash position if the Trust were to continue to receive revenue support in 2024/25 and the forecast position if the Trust does not receive any further revenue support. If revenue support is not received in line with the Financial Recovery Plan then the Trust will be overdrawn by £18.6m as at 31 March 2025.

To date, the Trust has received £9m in revenue (deficit) support across quarters 1 and 2 and £2.1m in working capital revenue support in quarter 3. However, DHSC is not awarding any further revenue support to the Trust due to the fact that our current plan does not show our new forecast deficit and because we are not on track with our workforce plan. We are continuing discussions with NHSE (both nationally and regionally) to ensure that the Trust does receive revenue support in the coming months.

The Trust originally asked for £17m of revenue support for quarter 3 and to date has only received £2.1m of this request. The request was in line with the Financial Recovery Plan. Continuing to receive revenue support through 2024/25 is critical for the Trust's working capital and our ability to pay critical suppliers on time.

The Trust has also developed a Cash Oversight Group to help manage and forecast the Trust's cash position, which will start to meet in the coming weeks.

Better Payment Practice Code (BPPC) – Month 7

West Suffolk NHS Foundation Trust

October 2024		
Better Payment Practice Code	**Total bills paid YTD Performance Number**	**Total £ paid YTD Performance £'000**
Non NHS		
Total bills paid in the year	5,111	62,219
Total bills paid within target	2,778	52,420
Percentage of bills paid within target	***54%***	***84%***
NHS		
Total bills paid in the year	440	3,163
Total bills paid within target	141	690
Percentage of bills paid within target	***32%***	***22%***
Total		
Total bills paid in the year	5,551	65,382
Total bills paid within target	2,919	53,110
Percentage of bills paid within target	**53%**	**81%**
Previous month performance	**50%**	**79%**

The table shows the Trust's current performance against the Better Payment Practice Code. The Code measures the performance of invoices being paid within 30 days. The standard requires that 95% of invoices are paid within the 30 day target.

The performance is measured over the year and the table shows the Trust's performance at month 7. There is a slight improvement in our BPPC as we were able to pay some more invoices quicker due to our slight injection of cash from the ICB in October.

As our cash position continues to deteriorate, so does our BPPC performance.

Capital progress report

Capital Spend - 31st Oct 2024	Year to Date - Month 7			Full Year		
	YTD Forecast	YTD Actual	Variance to Forecast	Full year Forecast	Funding Split	
Capital Scheme					Internal	PDC Available
	£000's	£000's		£000's	£000's	£000's
RAAC Programme	4,484	2,442	2,042	5,900		5,900
Newmarket CDC	10,448	9,434	1,014	10,583		7,860
New Hospital Programme***	4,156	3,895	261	13,313		16,740
Digital Pathology	-	13	- 13	86		86
Image Sharing	-	-	-	345		345
CT Scanner*	1,104	1,104	-	1,104		1,104
Estates	3,620	1,916	1,704	2,831	4,282	
IM&T	1,244	1,595	- 351	2,033	1,995	30
Medical Equipment**	596	443	153	694	1,322	
Imaging Equipment	1,757	1,443	314	1,757	2,400	
UEC Capital	-	-	-	2,000	2,000	
Total Capital Schemes	27,409	22,286	5,123	40,646	11,999	32,065
Overspent vs Plan					44,064	
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

The Capital Plan for 2024/25 is £44m. £11.99m will be internally funded, with the remaining £32m being funded by PDC. Further PDC has been awarded for the New Hospital Programme of £7.4m since the original Capital Plan was set along with £1.1m for a CT Scanner at Newmarket CDC.

The year-to-date capital spend at month 7 is £22.3m. This is behind plan and is mainly due to spend on RAAC projects, Newmarket CDC and general estates projects. However, it is still expected that the full capital programme will be completed by the end of March 2025. The Newmarket CDC project has had a small delay but the expenditure is expected to pick up in November as the project nears completion.

Despite this current expectation, given concerns over cash and the impact of our capital programme on our future I&E position (depreciation and PDC), we are continually reviewing our Capital Programme, particularly where internally funded, to see whether any expenditure and related payments can be reduced or delayed.

Comfort Break

4. PEOPLE, CULTURE AND ORGANISATIONAL DEVLEOPMENT

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

To Assure

Presented by Tracy Dowling and Jeremy Over

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Involvement Committee			**Date of meeting: 16th October 2024**		
Chaired by: Tracy Dowling - Non-executive Director			**Lead Executive Directors: Jeremy Over and Sue Wilkinson**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
6.1	**First for Staff** Presentation and discussion exploring arrangements for lone worker safety in the community	2. Reasonable	• Active work with community teams seeking to improve routine use of lone worker devices • Technology part of policy arrangements to keep staff safe – also includes risk assessments; visiting in pairs	• Further work with teams including community midwives to ensure alarms are embedded into routine use. • Include identifying staff who never use the devices to explore why • Need to understand how devices are funded – follow up By Chief Operating Officer	1. No escalation
6.2	**First for Staff** A framework of quality assurance for responsible officers and revalidation	1. Substantial	• Clear framework and evidence of continuous improvement (Peer review visit from Milton Keynes NHS Foundation Trust)	• Some input to enhance the submission data from Jermey Over; and support from Nicola Cottington to revise the section on reporting to the Board • Submission approved by the Committee	1. No escalation Submission approved on behalf of the Board
7.1	**First for the Future** Finance, workforce, culture and engagement. Review of draft presentation for staff communications	2. Reasonable	• Constructive discussion building on the presentation. Multiple elements of feedback given to refine the presentation	• Executive directors and Head of Communications to revise and test with a small group of staff I advance of trust wide staff briefing and team engagement sessions / Town Hall type events	1. No escalation; however Board members should all have sight of

Originating Committee: Involvement Committee			**Date of meeting: 16th October 2024**		
Chaired by: Tracy Dowling - Non-executive Director			**Lead Executive Directors: Jeremy Over and Sue Wilkinson**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
	regarding the financial recovery planning and the impact on staff and the organisation			• Involvement Committee reaffirmed the need for two-way communication mechanisms; and for some urgency as lack of communications causes paralysis and fear among staff.	the presentation and key messages
7.2	Veteran's Aware Accreditation Plan	2. Reasonable	• Excellent presentation from Philippa Lakins, Organisation Development Lead on work she has led to secure accreditation as a 'Veteran's Aware' NHS provider	• Action Plan in progress to secure accreditation by end October 2024; with progress expected by October 2025 to maintain accreditation	1. No escalation but return to Involvement Committee for further assurance of progress in June 2025
8.1	**First for Patients** CQC Inpatient Annual Survey Results	1. Substantial	• The Trust was 2nd highest rated in the region (Royal Papworth rated 1st) and 5th highest in England for acute and community combined trusts. • The committee was assured that the drive to continue to improve is strong	• Further work in progress to support ○ Patients getting a good night's sleep ○ Virtual ward information ○ Doctors including patients in conversations about them	1. No escalation

Originating Committee: Involvement Committee			**Date of meeting: 16th October 2024**		
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Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			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
8.2	ED&I Thematic Review (Maternity Services)	1. Substantial	• Karen Newbury (Director of Midwifery) and Daniela Turner (ED&I Lead Midwife) presented a confidential report detailing learning from a thematic review exploring causation and complications for women from Black, Asian and minority ethnic groups at West Suffolk Foundation Trust	• The Committee was assured by the detail, sensitivity and learning implemented by the West Suffolk midwifery service; in partnership with third sector organisations in West Suffolk. • As a result of the thematic review changes to clinical practice and enhanced community support for Black, Asian and minority ethnic women has been established	1. No escalation
8.3	Maternity service user feedback and subsequent co-produced action plan	1. Substantial	• Jacki Brown, (Parent Education and Patient Experience Lead Midwife) presented results of the CQC 2023 and Healthwatch Suffolk 2024 Maternity Care Surveys. • The responses were positive with a continuous quality improvement approach taken to responding to service user's themes	• The Committee was assured that actions have been taken with respect to: 1. Involvement of partners / carers in maternity care and delivery – as much as they wish 2. Pain relief during labour and birth 3. Parenting classes 4. Birth partner/ significant other staying overnight 5. Staffing to ensure staff can take breaks	1. No escalation

Originating Committee: Involvement Committee			**Date of meeting: 16th October 2024**		
Chaired by: Tracy Dowling - Non-executive Director			**Lead Executive Directors: Jeremy Over and Sue Wilkinson**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
8.4	Publication and maintenance of patient information leaflets	3. Partial	• A solution to the issue of producing and maintaining leaflet content has been identified		1. No escalation
9.1	Update from People and Culture Leadership Group	1. Substantial	• Report assures progress with recruitment, staff development and workforce planning	• Bi-monthly reports from PCLG.	1. No escalation
9.2	Experience of Care and Engagement Report	2. Reasonable	• Report from the work of the latest committee meeting.	• Clear actions in progress regarding overseas visitors; end of life communications; communications regarding medications and availability of religious texts for patients.	1.No escalation
9.3	Update on formal complaints quality improvement project	1. Substantial	• Mid point report received. QI project to continue to year end.	• Continued quarterly reporting in line with national terms and conditions	1.No escalation
9.4	Board Assurance Framework – Patient Engagement	3. Partial	• Risk relating to the Head of Patient Engagement leaving the Trust in December are defined; risks regarding patient and public engagement requirements identified.	• Update to next meeting on measures to mitigate factors causing immediate risk increases.	1.No escalation

Originating Committee: Involvement Committee			**Date of meeting: 16th October 2024**		
Chaired by: Tracy Dowling - Non-executive Director			**Lead Executive Directors: Jeremy Over and Sue Wilkinson**		
Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
9.5	Board Assurance Framework - Collaboration	Carried Forward to next meeting	• The recently appointed Director of Strategy and Transformation is in the process of rewriting the risks and actions for this BAF; including redefining the risk. Assurance is therefore minimal as a lot of work is needed to understand and address this risk.	• Director of Strategy and Transformation to continue work with colleagues to progress this area of risk. • Agreed to put the proposed BAF – Collaboration as an early item on the next meeting agenda to thoroughly review this and support the work Sam Tappenden is doing.	1. No escalation
9.6	Internal Audit Reporting Q3 Report	1. Substantial	• Report received from Richard Jones demonstrating level of assurance for audits this committee has oversight responsibility for.	• Actions in progress as planned.	1. No escalation
10.0	IQPR extract for Involvement Committee including Workforce KPIs	2. Reasonable	• It was highlighted that 2 of the four workforce KPI's are continuing to track above target. • New patient experience report included	• Ongoing monitoring of workforce KPIs, in particular appraisal and mandatory training.	1.No escalation

**See guidance notes for more detail*

Guidance notes

The practice of scrutiny and assurance

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

Assurance level

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

4.2. People and OD Highlight Report

To Assure

Presented by Jeremy Over

NHS
West Suffolk
NHS Foundation Trust

ANNUAL REPORT AUGUST 2023 - JULY 2024 ON ROTA GAPS AND VACANCIES:

DOCTORS AND DENTISTS IN TRAINING

This report covers the twelve month period (1st August 2023 – 31st July 2024 inclusive). During that time there have been periodic (4 monthly) reports from which this summary is drawn.

Introduction

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

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

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

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

Summary data

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

Putting you first

Exception Reporting

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

EXCEPTION REPORTS BY DEPARTMENT (August 2023 – July 2024)			
Period (inclusive) **Specialty**	August 2023 – November 2023	December 2023 – March 2024	April 2024 – July 2024
Surgery	63	96	26
Medicine	203	88	198
Woman & Children	3	12	0
TOTAL	**269**	**196**	**224**

Exception Reporting: accuracy

It is clear that not all doctors' exception report.

Patterns of Exception Reporting

Various reasons for exception reporting are detailed using the Allocate system and these are generally about workload or particularly sick patients. There are some ER around missed educational opportunities, normally due to the ward being too busy for the doctor to attend local teaching and a few around lack of support (mainly out of hours).

Work Schedule Reviews.

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

Fines

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

Vacancies by quarters:

VACANCIES BY QUARTERS – AUGST 2023 – JULY 2024					
Department	**Grade**	August – November 2023	December 2023 – March 2024	April – July 2024	Average gaps
Emergency	SpR	5	4.25	5	4.75
	GPST1	0.4	0	0.2	0.2
General Surgery	SpR	3	0.75	0.6	1.45
Anaesthetics	SpR/SAS	5	3.5	3.75	4.08
ENT	SpR	0	0.2	0.2	0.13
	GPST1	0	0	0.25	0.08
Medicine	IMT/SpR	1.4	1.65	0.3	1.11
Obs & Gynae	ST3+	0.2	1	0	0.4
	GPST1	0	0	0.2	0.06
T&O	ST3+	0.2	0.4	0.4	0.33
Ophthalmology	SAS	1	1	1	1
Paediatrics	F2/GPST	1.2	1	0.6	0.93
	SpR	0.25	0.25	0.6	0.36
Total		17.65	13.3	13.1	14.88

Key issues from host organisations and actions taken

In this reporting year there have been 658 ER, 633 related to hours, 11 to educational opportunities, 10 to service support available to the doctor, 4 to patterns of work and one immediate safety concern. The ISC related to volume of work in surgery over a weekend, but was not completed as the doctor did not provide requested follow up information.

Overtime was given for 313 requests and time off in lieu (TOIL) for 260. 439 ER were from medicine.

From August 7th 2024- Nov 8th 2024 there have been 216 ER, very similar to the number received for the same period in 2023 (211, although the 2023 period included 7 days of industrial action when no ER were received).

Summary

The Resident Doctors have asked me to highlight that the pressure on them continues to increase, with frequent gaps in rotas (mainly due to short term sickness, some due to no doctor in a post). Escalated rates have been removed (which may well make filling shifts harder, especially last minute), and locum shifts seem to be advertised less frequently and with more scrutiny, meaning there is less flexibility in the system when colleagues are sick at last minute and the wards are already at minimum staffing. In addition, they are frequently moved between medical wards and can start on one ward and then be moved to another an hour later. This is not good for patient flow or care or the wellbeing of the Residents as looking after patients you do not know is very difficult and takes longer than working on your base ward.

The Resident Doctors appreciate the financial pressure that the trust is under but patient safety is of paramount importance to them and working in such stressful circumstances is resulting in moral distress/ injury. (Moral injury is a result of the institutional and resource constraints healthcare staff face, meaning they often cannot provide the high level of care they want and expect to be able to deliver).

They have asked me to thank the service managers, rota coordinators and medical staffing for working hard to reduce the safety risk to the patients and thepersonal cost to the residents.

In the 2024 GMC trainee survey, WSFT remains the highest in the acute trusts in the region for ‘overall satisfaction’, but it is noticeable that we have 8 more red outliers and 3 fewer green outliers (red= bottom 25th quartile, green= top 25th quartile), indicating that trainee doctors are less satisfied with training than in 2023.This is likely to be a reflection of many things, including the industrial action which was ongoing at the time of the survey, but also the rota gaps and pressure on service delivery.

Freedom to speak up guardian – communications plan

Objectives

Policy objective

Make speaking up business as usual and highlight where raised concerns result in improvement.

Improve all staff awareness of freedom to speak up (FTSU), understand and remove barriers to speaking up, foster a culture of speaking up within the Trust.

Behaviour

Support staff to speak up when they feel that they are unable to in other ways.

Communications objectives

- Raise awareness of FTSU across the organisation using Trust communication channels.
- Raise awareness of and drive responses to the NHS staff survey - improve responses to question 20 (A and B) and 25 (A and B) - 80% and 70% for question 20, and 70% and 60% for question 25 respectively over three years.
- Drive recruitment and training of 60-80 new and diverse FTSU champions by the end of the year, with one from each integrated neighbourhood team.
- Drive completion of speaking up and listening up training to 94% each year.

Planning

Internal communications and engagement campaign with messaging targeted at how, why, and when to speak up, and examples of how the Trust has responded positively to speaking up.

Master takeaway

- Speaking up is the right thing to do, and you will be welcomed, encouraged, and thanked for speaking up.
- Get involved – become a FTSU champion and help to grow the culture of speaking up across the West Suffolk NHS Foundation Trust.

Target audiences

- General staff - all colleagues, all occupational groups
- Managers / heads of teams
- Staff networks.

Communications outcomes - Know / Feel / Do

General staff:

Know:

- Who the FTSU Guardian is, and how to contact them.
- The FTSU Guardian is there to listen, you will be supported to speak up.
- You can get more involved and become a FTSU champion to strengthen the culture of speaking up across the Trust.
- Colleagues will have received the NHS staff survey by email, or via paper copies and should complete it – it includes questions in relation to speaking up.

Feel:

- Speaking up is valuable and it will be worth it to speak up.
- It is safe to speak up and you can personally help to foster the culture of speaking up across the Trust.

Do:

- When something is concerning you, you should speak up about it.
- Take the opportunity to become a FTSU champion for your team and become actively involved in growing the FTSU network.
- Have your voice heard - complete the NHS staff survey including FTSU related questions.

Managers / heads of teams

Know:

- The FTSU Guardian is there to support you and your team with any issues; they can attend any team meetings to discuss their role and how they can support colleagues.
- Fostering a respectful team environment is part of your role; create a safe environment for speaking up within your team and encourage all to speak with respect and empathy to each other.
- Be open and cooperate with the Guardian if concerns are raised.
- Your team members may wish to become champions, support them to do this.
- Colleagues will have received the NHS staff survey by email, or via paper copies – it includes specific questions in relation to speaking up.

Feel:

- Empowered to promote FTSU within your teams – encouraging your team to speak up is a positive thing.
- Confident to cooperate with the FTSU Guardian as required.

Do:

- Role-model speaking up, ask your team for their opinions, speak up yourself, and demonstrate that you value speaking up by listening, thanking the speaker, and acting on concerns raised by your team.
- Support colleagues who have spoken up about something.
- Complete the mandatory speaking up and listening up training and encourage your team colleagues to do the same.
- Allow ringfenced time for FTSU champion training and duties.
- Encourage your colleagues to take time to complete the NHS staff survey.

Staff networks

Know:

- Who the FTSU Guardian is, and how to contact them.
- That the FTSU Guardian is there to listen and support colleagues with any issues.
- As a member of a staff network, you have a unique perspective and strength to support others as a FTSU champion.
- Colleagues will have received the NHS staff survey by email, or via paper copies – it includes specific questions in relation to speaking up.

Feel:

- Speaking up is valuable and it will be worth it to speak up.
- It is safe to speak up and you can personally help to foster the culture of speaking up in your network.
- Empowered to be a champion to support others in your network and promote diversity within the FTSU champion network.

Do:

- When something is concerning you, you should speak up about it.
- Act as a conduit for the FTSU Guardian within your network, and for anyone who approaches the network with an issue.
- Take the opportunity to become a FTSU champion for your network and become actively involved in growing the FTSU network.
- Encourage your network colleagues to have their voices heard by completing the NHS staff survey including questions 20 and 25.

Channels and tactics

- Staff briefing – general reminders plus raising concerns button permanently added to email.
- All staff update – presentation on FTSU for ‘Speak Up Month’ once yearly plus updates when necessary.

- Visits and drop ins to each area of the hospital and community sites including integrated neighbourhood teams and night shifts to introduce self and encourage speaking up.
- Emails from the FTSU guardian in areas that have not had visits yet to arrange this.
- Collateral review - look at messaging around the hospital and review posters etc. Where are the posters right now and where would they make the biggest impact?
- Communications team to doorstep people around the Trust asking about FTSU messaging and FTSU culture to gauge understanding.
- Staff Facebook page – reposts from Green Sheet content plus reminders of the Guardian's location / any night shifts plus regular social posts reminding staff about the value of speaking up.
- FTSU slides on Time Out TV.
- Guardian to present at staff welcome and inductions (communications to support with presentations).
- Engagement with staff networks – visits to network meetings and regular contact with network leads.
- Stories to develop for internal Green Sheet channel:
    - Video/written content with step-by-step information on reporting something to the Guardian
    - Case studies of successful actions and resolutions following speaking up
    - Content explaining 'what can I speak up about?'
    - Meet the champions.

Key dates

Action	Responsibility	Date	Completed
Speak Up Month • All staff update • Green Sheet content – general item • Stand in Time out	Jane/Comms	1-31 October	Yes
Quarterly Board reports	Jane	July 2024 November 2024 January 2025 April 2025	Yes Due
Green Sheet news item following quarterly Board reports (four per year)	Comms	September 2024 December 2024 February 2025 May 2025	Yes Due

Staff networks – attend each network to share news once a year	Jane	Ongoing	REACH yes Disability yes
Guardian to visit every ward and department, including integrated neighbourhood teams within first year	Jane	Ongoing	Ongoing
Be available on night shifts (four times a year)	Jane	04/07/2024 24/10/2024 13/02/25 TBC	Yes Yes
General information poster – issued to each team visited; in place in key staff areas	Communications to design; Jane to issue direct to teams	Ongoing	Yes - ongoing
Attend new staff welcomes and inductions	Communications to support with slides, Jane to present	Regular dates throughout the year	Yes - ongoing

Evaluation

- Systematically record all concerns raised through Freedom to Speak Up, in line with guidance from the National Guardian Office.
- Regularly review themes or trends and raise with HR, equality leads and staff side and patient safety.
- Provide quarterly figures to the Quality and Safety Committee.
- Review the annual staff survey results including identification of any ‘hot spots’.
- Review the Freedom to Speak Up evaluations following conclusion of concerns raised.
- Monitor engagement with the FTSU Guardian and corporate account in relation to posts on staff Facebook group.
- Monitor and review total link clicks in relation to FTSU stories in Green Sheet.
- Monitor and review engagement comments in relation to FTSU in all staff updates.
- Monitor percentage completion of the mandatory speak up eLearning package for all workers.
- Monitor percentage completion of the listen up eLearning package for managers.
- Review number of contacts with champions at regular network meetings.
- Review number of champions each year.

West Suffolk NHS Foundation Trust

Freedom to Speak Up: Guardian's Report Q2. 2024 – 2025. July, August, September 2024

NGO National Data Report.

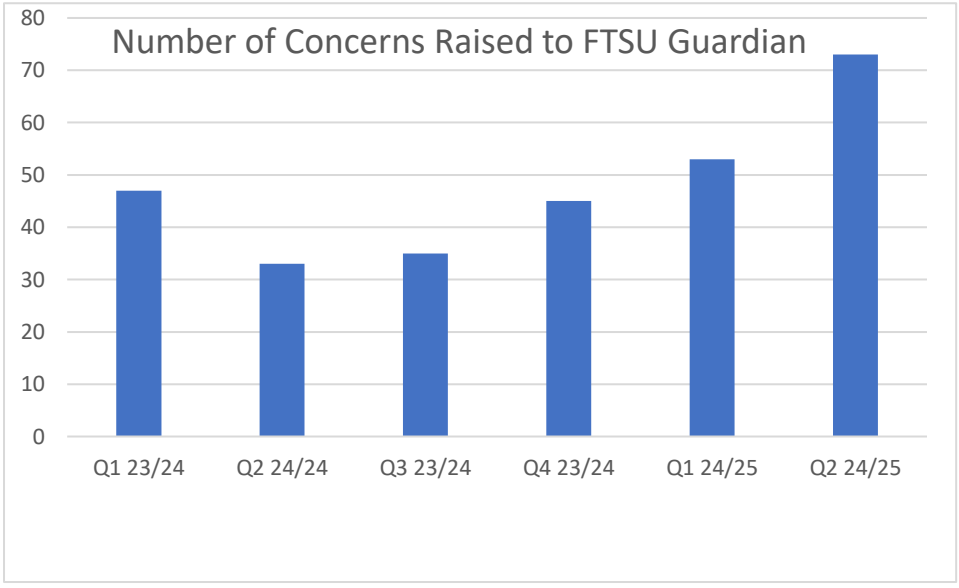
The role of Freedom to Speak Up guardians and the National Guardian were established in 2016 following the events at Mid-Staffordshire NHS Foundation Trust and recommendations from Sir Robert Francis' Freedom to Speak Up Inquiry. There are now over 1,200 Freedom to Speak Up Guardians in NHS primary and secondary care and independent sector organisations, national bodies and elsewhere that ensure workers can speak up about any issues impacting on their ability to do their job.

The National Guardians Office (NGO) released their annual Speaking Up Data Report (NGO, 2024) for 2023-24 just after the submission of the last FTSU report, so I will highlight some of these findings here and include comparisons as appropriate. Over 30,000 cases have been raised with Guardians - a 27.6 per cent increase on last year. 90 percent of cases are from NHS foundation trusts.

Data Sent to National Guardian's Office

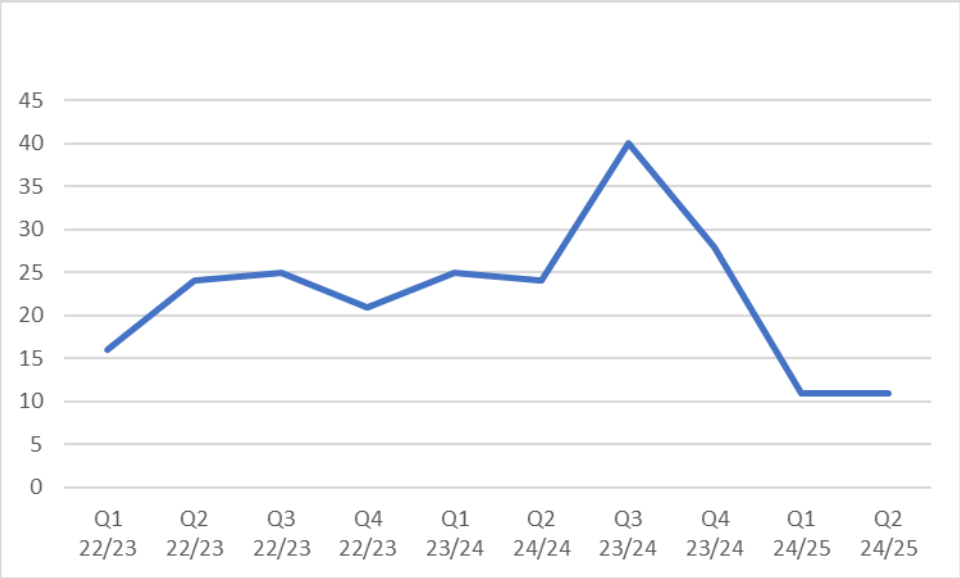
FTSU Guardian's for each organisation are required to submit data around the concerns raised to them each quarter. (NGO Guidance, 2024). This is to inform the NGO's understanding of the implementation and utilisation of the Guardian role and the themes and trends in speaking up. It is also felt that observing that the guardian actively submits data may increase workers confidence in the effectiveness of the guardian route and potentially increase confidence in choosing to speak up.

On average, NHS trusts reported 36.3 cases in each quarterly submission. Average cases per 1000 workers in Acute and Community Trusts was 17.5. In WSFT the number of concerns raised with the Guardian in Quarter 2 was 73. (12 per 1000 employees). This is a considerable increase from the previous quarter. The main reason for this was the high number of concerns (21) raised around the proposed reduction in the staff psychological support service which will be discussed further later in the report.



Anonymous Reporting

Whilst it is important to have an option for anonymous reporting, the NGO acknowledges in its report the challenges for organisations in investigating anonymous cases due to limited information and the difficulty in providing feedback. The percentage of anonymous concerns is an indicator for how confident staff feel to speak up. Confidence to speak up openly relies on the psychological safety culture in the Trust. Work has continued to support psychological safety of staff and communicating this through training and other outreach. In Quarter 2, the percentage of anonymous reporting remained the same as previous quarter, at 11 percent. Nationally the figure was 9.5%



Anonymous reporting themes

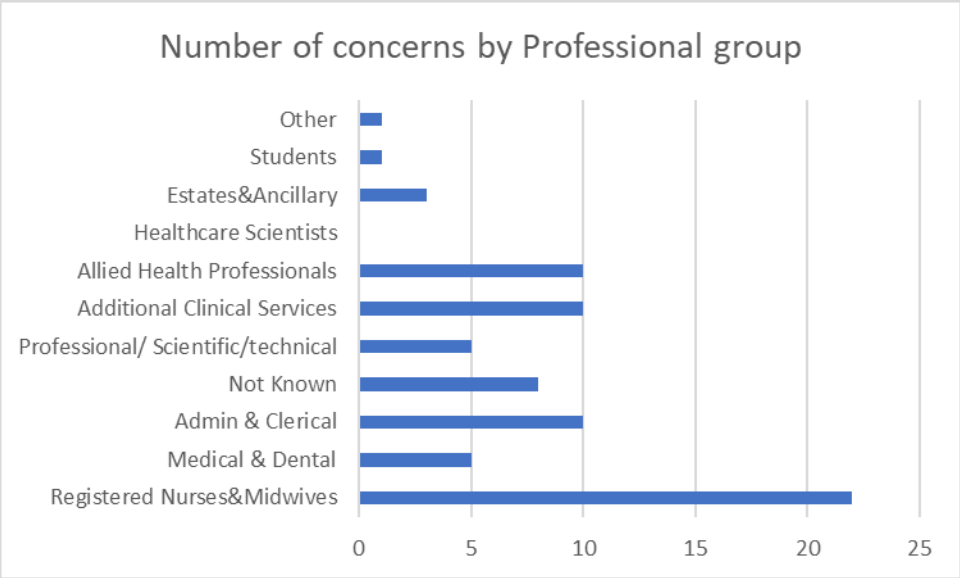
The main focus of anonymous reporting this quarter were complaints against communication style of senior staff including rudeness, incivility, and inappropriate language by named staff. There were two anonymous concerns raised around perceived unfairness around flexible working, including working from home. These anonymous reports are taken seriously and each one was investigated as far as possible.

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

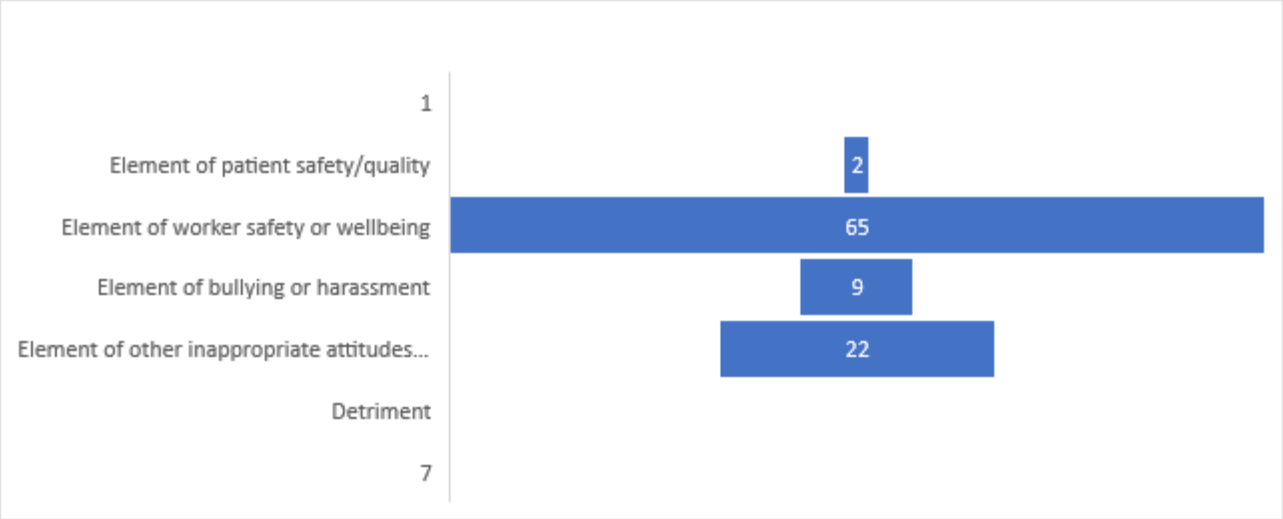
Who is speaking up?

Looking at the worker groups who have used FTSU service, the largest group raising concerns was nurses and midwives,(30%) which mirrors the national trend (28.3%) and is not surprising as nursing and midwifery make up the largest proportion of staff.

The most notable change from previous quarters is that the percentage of unregistered support staff (recorded under Additional Clinical Services) raising concerns has increased from 7.5% to 13%.



What were people speaking up about?



The NGO annual data report states ‘Many of the cases raised with guardians highlight the pressures on the healthcare system. People have spoken up about systemic matters, in particular staffing levels and the impact this is having on wellbeing as well as other issues including incivility between colleagues, and patient safety concerns’.
This is reflected in our own Trust, with 80 percent of cases involving an element of staff safety or wellbeing last year and over 90 percent in this quarter.

Themes from Q2. 2024/2025, with learning and actions

Every Freedom to Speak Up concern is dealt with on an individual basis and raised with the appropriate senior leader**.** However, the Trust continues to address broad themes raised via FTSU,

and accepts the information gained as a gift to support future learning and development to help support improvements across the organisation.

Patient safety concerns comprised only 3 percent of concerns raised. The national figure is 19% Each of these cases has been investigated and addressed individually. The Trust has a patient safety team and robust systems in place for reporting these issues.

Theme: Staff Wellbeing - Concerns around the proposed reduction in the staff psychology support services were the largest group of concerns this quarter. Following a Trust-wide communication, 21 colleagues contacted FTSU to express their support for the continuation of a staff psychology service in its current form. It was a privilege that many of these colleagues shared very personal stories to illustrate the benefits they felt from their interactions with the service. Each of these was responded to with thanks, and their views collated and provided (with consent) to the Director of Workforce and Communications and the CEO. Following this, a full response, explaining the rationale and conclusions was forwarded from the director of workforce by the Guardian to all those who had spoken up about this situation to ensure feedback was provided.

Learning and Action: The staff psychology service has supported many of our colleagues since Covid. It was clear that is a highly valued service by those that had received support from it. The stories and evidence of these colleagues were listened to and carefully considered by the executive team. Examples such as these had been instrumental in influencing the decision to retain a significant majority of funding for this service in future, rather than closing the service completely. Going forward the exact scope and delivery of this revised service is being consulted upon with the staff psychology team.

Theme: Communication by management. Examples include lack of face to face communication regarding procedural changes.

Learning and Action: The importance of effective communication continues to be a learning point. Each individual case has been investigated and addressed and ongoing leadership training aims to support communication skills and strategies across the Trust. Management Skills Webinars being offered to colleagues will include training on how to support a psychologically safe environment.

Theme: Bullying. The percentage of concerns where an element of bullying is mentioned has remained 12% from 15% last quarter, compared with the national average of 20%. In the 2023 NHS Staff Survey only half (51.8%) of workers experiencing harassment, bullying or abuse at work18 said that themselves or a colleague had reported the incident.

Learning and Action: The Trust's Respect for others - West Suffolk NHS Intranet policy states: 'As part of its commitment to equality and diversity, West Suffolk NHS Foundation Trust is committed to promoting and ensuring a working environment where colleagues are treated with courtesy and respect and wants to support a working environment and culture in which bullying and harassment is unacceptable'.

Staff feeling able to speak up about bullying is an important step to achieve this.

Each case reported has been investigated and addressed, and those speaking up about it have been offered support.

Theme: Incivility and poor working relationships.

Learning and Action: A focus continues to be maintained on building and maintaining professional relationships and civility. The importance of civility, and the Trust value of 'respect' needs to be reiterated throughout all levels of leadership. The Values Based Line Management Standards Framework, which has been developed based on the analysis of behaviours a range of colleagues across the Trust have described as being desirable for each of our values, will support this. (Values-based Manager and Leader Behaviour Framework - West Suffolk NHS Intranet). In addition, Civility Saves Lives training has been incorporated into the Human Factors programme.

Theme: Environment. Some concerns were raised about the air conditioning on some wards and about food and drink facilities at night. Building alterations while staff in situ.

Learning and Action: Estates have investigated temperature control systems.

Improved vending facilities for night staff. Response from facilities: 'We now have a frequent and reliable stock for the vending in courtyard café – this is meals prepared as part of the daytime cook that we then chilled-down. This food can be purchased and reheated in a microwave that's near to where colleagues work (we don't have central microwaves). I've had positive feedback from the Junior Doctors, and this was rightly a regular concern of theirs as it would other colleagues'.

The importance of considering stress from noise and disruption on staff from building works. The case brought involved a situation where alterations had to be made urgently, but nevertheless, the need to give adequate notice and ideally move staff to alternate accommodation before works begin, was highlighted by the Wellbeing lead.

Theme: Staff expressed concerns around Incident reporting on RADAR system, regarding training and technical issues. Some staff raised concerns that some of the questions seemed to ask the person submitting the report to investigate or suggest who was at fault and they did not feel happy doing that.

Learning and action: The need to support staff with a new system was recognised and more training sessions were offered. Regarding technical issues when submitting a RADAR report, IT are currently working on these issues. The patient safety team can support colleagues to submit report in the meantime.

The concerns re questions were raised with the Patient safety team who explained that the questions are set by NHS England as we are required to report to the national Learning from Patient Safety Events (LFPSE) database. The national team analyse patient safety events which are then used to formulate patient safety alerts. The question set cannot be changed, however, we and many other organisations have fed back to the national team that the question set is not conducive with creating a positive patient safety culture. Also there have been communications activities around the patient safety team, with pieces in the Green Sheet highlighting members, raising awareness and re-assuring colleagues of the approachability and support of the patient safety team.

There was a mis-conception expressed by some staff that one needs to be of a certain banding to submit a report on RADAR. There perhaps needs to be further communication around this as any staff member can submit an incident on RADAR. This will be added to the RADAR FAQ document

on the intranet that everyone is responsible for submitting patient safety incidents. This is also included in the patient safety welcome to the trust presentation and as part of the online patient safety education programme on Totara.

Feedback on the Freedom to Speak Up Process

Following closure of each FTSU case, the person speaking up is sent an evaluation form to report their experience of the process. The themes emerging from the FTSU process evaluation indicated once again that it was a positive experience being able to talk to an independent and impartial person

The figures below show a summary of evaluations received in Q2.

- Eight responses were received to the FTSU feedback survey for Quarter 2. 5 respondents said they would speak up again. Two respondents said maybe, and one said no.
- Free text comments and other feedback received verbally and via email was generally positive. Feedback taken from the form and email responses include:

Easy, anonymous and supportive, thank you

It was quick, easy and anonymous. It feels like I have been able to make a difference because of my observation rather than because of what job title I hold.

Our experience was satisfactory and so supportive, not just for us, for all staff.

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

Principle 1: Value Speaking Up:

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

What's going well:

- Ongoing support from Board and SLT for Freedom to Speak Up
- Non-executive director for FTSU attended champion training.

Next Steps:

- Non-executive director for FTSU to review FTSU contribution to the Trust's welcome session for new members of staff., by February 2025. Programme in place for an executive to attend each FTSU champion training and refresher training.

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

What's going well:

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

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

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

What's going well:

- FTSU continues to be promoted throughout the Trust. Training sessions by FTSU Guardian for preceptorship, new starter Welcome and student training programmes.
- FTSU guardian visiting wards and departments, including community teams, increasing awareness of FTSU and encouraging recruitment of champions as widely as possible.
- 'Speak Up' and Listen Up' mandatory training is promoted, and we have high numbers of staff completing this (94% and 91% respectively)
- Focus on inclusion and reaching those who may be less likely to speak up
- All staff meeting FTSU Guardian at Welcome Session.
- Champion Gap analysis completed and active recruitment undertaken in areas lacking champions.
- Champion support sessions established
- Working with Wellbeing and EDI leads to develop governance structure for all champions, by March 2025

- FTSU Communication Plan has been developed by Guardian with support of Communications Team (appendix – attached)

Next steps:

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

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

What's going well:

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

Next steps:

- Senior Leaders to complete 'Follow Up' training.

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

What's going well:

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

Next steps:

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

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

What's going well:

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

Next Steps:

- FTSU Guardian enrolled on Coaching Professional apprenticeship. Starts January2025

Principle 7: Barriers to speaking up are identified and tackled

What's going well:

- Regular and ongoing face to face sessions for speak up training.
- Inclusion training session offered for FTSU champions.
- EDI data collection form has been created by Guardian and OD Manager – EDI, and is now established as part of the FTSU process.
- EDI gap analysis has completed for champion network. EDI Survey sent to FTSU champions with a view to identify and address any gaps. There were 38 responses out of 55 champions. Results of this have been discussed with the Trusts EDI lead and plans in place to increase diversity within the champion team. EDI review to be repeated Spring 2025

Next Steps:

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

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

What's going well:

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

Next Steps:

- New FTSU Guardian with NED to undertake FTSU reflection and planning tool to ensure ongoing adherence with National policies and processes – this has begun by Guardian and NED working together
- NGO are undertaking a review of Guardian job description. WSFT will review and adopt changes as appropriate. July 2025

References:

NGO, February 2024, Recording Cases and Reporting Data (nationalguardian.org.uk)

NGO, July 2024 FTSU-Case-Data-Annual-Report-23-24-1.pdf

NHS
West Suffolk
NHS Foundation Trust

Putting You First awards

October / November 2024 winners

Board of Directors: 29 November 2024

Putting you first

Sarah Ward, Rebecca Clark and Michael Bardell, paediatric speech and language therapists

Nominated by Kimberley Downing, pathway lead for PSCN

Sarah, Rebecca and Mike have worked together to provide support for a family whose baby was discharged to community services and expected to pass away within a few days, though this period extended beyond this time. They have worked sensitively with the family to provide nurturing and supportive care to make the time this family shared as comfortable as possible. Often these situations can be very 'medicalised' but I was proud to hear how the team had focused also on allowing the family to make memories and enjoy 'normal' moments - from advice on how to create the best position for the all-important cuddles to encouraging non-nutritive sucking for bonding and soothing. Rebecca, Mike and Sarah really embody the Trust value of teamwork and being first for patients - considering the holistic picture as well as supporting each other to provide the best quality care in a very difficult situation. All while continuing their 'business as usual'.

Rachel Wickson, highly specialist speech and language therapist, integrated community paediatric services

Nominated by Annabel Kay, highly specialist speech and language therapist

Rachel organised work with a local expressive arts company, Gecko Theatre, for our upper school students at Thomas Wolsey Ormiston Academy in summer 2024. She supported the workshops over several weeks, and the project culminated in a student-led polished performance of the piece they had created with Gecko. Parents and school staff attended to watch the video which showed students' diverse abilities off well. Students reported enjoying participating, and it linked with themes in their learning plans as well as supporting them to practice communication, interaction, physical movement and creativity. Staff and parent feedback was very positive She found this as a funded opportunity rather than at a cost to the NHS or school, which was even more impressive! This is one example of the creative, 'go-the-extra-mile' and holistic approach Rachel takes to her work. She has managed this and other projects (supporting student Speech and Language Therapists, developing our online training for parents and school staff) alongside welcoming me as a new colleague and the work that entails. She's not one to shout about her achievements, so we're doing it for her.

Anna Troughton, learning and development lead, workforce & OD

Nominated by Gina Suddaby, learning and development lead - coaching and mentoring

Anna has been the most helpful and supportive colleague and now friend as I have moved into the NHS from the private sector. Her selfless support, wisdom and knowledge have supported me though these first 6 months. Despite how busy she is, she will step in and help as short or no notice and has recently covered an entire day's training when I was off sick meaning the students didn't miss their day of learning. Anna is calm, collected, organised, passionate and genuine, she projects support and confidence to others and those attributes and skills along with her long service in the NHS is an asset to our team. Thank you, Anna.

5. OPERATIONS, FINANCE AND CORPORATE RISK

5.1. Insight Committee Report

Presented by Antoinette Jackson and Nicola Cottington

Board assurance committee - Committee Key Issues (CKI) report

West Suffolk NHS Foundation Trust

Originating Committee: Insight Committee			**Date of meeting: 16 October 2024**		
Chaired by: Antoinette Jackson			**Lead Executive Director: Nicola Cottington/Jonathan Rowell**		
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
Contracts and Procurement Panel	The Contracts and Procurement Panel was created in November 2022 in recognition of the lack of forward planning and governance around the award and extension of contracts and the number of contracts being renewed or extended at short notice. Insight Committee asked for assurance that the process for timely tendering and award of such contracts was robust. Contracts are managed on the Atamis database. Whilst improvements have been made, this database does not yet include 100% of contracts (with a	3 Partial	If procurement processes are not robust there is a risk that the Trust will not deliver value for money and the best outcomes. The fact that the Atamis database is not comprehensive means there is still a risk of issues emerging late in the day, particularly over the next 5 months before comprehensive tracking is in place. The timeframe to implement an alternative solution isn't always factored into the tendering process, so the likely lead time has now been added to the database to the database to aid proper forward planning.	There is an action plan in place to address the deficiencies in the recoding of contracts and the lead in time to the procurement process. The original Terms of Reference (ToR) of the Panel to be reviewed, to include consideration of efficacy, value for money and the specification of each contract. This also includes a review of Membership to include IT and Medical Staff representation. The opportunities to remove or renegotiate existing contracts to deliver savings at pace is also being reviewed.	3 Escalate to Board

Originating Committee: Insight Committee			Date of meeting: 16 October 2024		
Chaired by: Antoinette Jackson			Lead Executive Director: Nicola Cottington/Jonathan Rowell		
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
	particular shortfall in relation to IT contracts). There are currently 420 contracts on this database, of which around 60 will be due for renewal in the next 12 months.		Both internal and external factors can cause delays to the procurement process (such as stakeholders not engaging in the project early enough or suppliers being slow to respond.	WSFT host the Collaborative Procurement Hub (CPH) and meetings are in place to ensure the Trust is maximising the support and benefits that they can provide. The wider procurement capacity required by the Trust will be considered in the review of Corporate Services As the majority of contracts will be captured by the double lock arrangement with the ICB, a process will be agreed to discuss high-level approval in principle, before the tender process commences. This will help avoid unnecessary work on detail if approval is not forthcoming.	

NHS West Suffolk NHS Foundation Trust

Originating Committee: Insight Committee			Date of meeting: 16 October 2024		
Chaired by: Antoinette Jackson			Lead Executive Director: Nicola Cottington/Jonathan Rowell		
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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Community and Wheelchair Equipment Service	**Community Equipment** Community Equipment Services have incurred a YTD cost pressure of £328k This is a mix of rising costs and growth in demand. Demand pressures include activity to help achieve WSFT and ESNEFT's community urgent and crisis response targets; increased activity in relation to hospital discharges; the ordering of increasingly complex equipment to enable step down to community services and to help people remain in their home environment for longer; supporting choice to stay at home at the end of life; and the growth of the Virtual Ward.	**2 Reasonable**	The service is important to enable timely discharge from hospital to support seasonal plans, community urgent and crisis response targets and patient flow through escalation ward. The Trust is commissioned to deliver the service on behalf of other providers so an equitable mechanism for sharing risk and growth pressures is needed.	The service has comprehensive action plan in place to reduce the run rate of the service. Recovery of the community "block" element of overspend being negotiated with ESNEFT. Recovery of Social Care, ESNEFT (acute) and ICB costs is already in place within the contract. In the longer term, a review is needed as to how the Trust agreed to contract terms which did not share risk more effectively. Insight will receive a further update report in November.	2 Escalation to ESNEFT and ICB on contractual issues.

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	The CES is also incurring cost pressures that are linked to contractual inflation. Some cost are recovered from commissioners proportionally but not from ESNEFT for those services that are commissioned on a "block" basis. **Wheelchair Services** Increased demand for Wheelchair Equipment (aligned to performance recovery), has incurred a YTD cost pressure of £155 £143k of additional costs were avoided YTD, through refurbishment of wheelchairs.		Increased demand is driven by an increase in referrals	There is also an action plan in place for this service. This includes prioritisation of recycled equipment to contain cost increases as far as possible and work with SNEE ICB to address the financial impact of growth that has been significantly above the levels provided in growth funding for 2024/25.	

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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. 12-hour breaches are considerably above the target of 2% of all attendances, though they have improved further on July's position – halving the number seen in January 2024. The four-hour performance trajectory was narrowly missed in August – 69.6% against a plan of 71.0%.	3 Partial	Patients do not have a good experience if 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 discussed in previous Insight meetings is being implemented and has a trajectory to achieve the 78% 4hr ED target by March '25. The Minor Emergency Care Unit opened on 14 October 2024.	1 No escalation

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PAGG/IQPR	**Virtual ward** Virtual ward (VW) occupancy is showing a deterioration, having decreased over six consecutive months back to December 2023 levels. Average occupancy on the Virtual Ward reduced from 76% (July) to 66% in August largely due to constraints in nursing capacity.	3 Partial	During the month there were a small number of long stays (complex patients) resulting in an increase in bed nights occupied (increase from 755 in July to 861 in August). This is also reflected in the small increase in length of stay from the previous month. Appropriate length of stay is important to facilitate effective patient flow across Trust. Virtual Ward capacity is crucial in enabling patient flow and achieving the strategic ambition of caring for patients at or near home wherever possible.	A Pilot to assess and move patients in nursing homes direct to the Virtual Ward commenced in June. There will be evaluation and review with local partner (Stowhealth Care). A rollout plan (including potential for direct onboarding by primary care colleagues) is under development. An integrated service delivery model has been implemented in Mildenhall. VW nursing visits are now managed via Integrated Neighbourhood Team (INT) in this locality. There is a plan in place for wider rollout into other INTs.	3 Escalate to Board

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PAGG/IQPR	**Cancer Targets** Performance against the 28-day Faster Diagnosis Standard (FDS) is not being met, and performance has not consistently met the 75% target in any month of 2024/25. Continued challenges with the skin pathway, compounded by an increase in referrals over the summer has had the biggest impact on performance, with reduced performance also noted in Gynaecology and Breast.	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.	Radiological support to breast clinics, which are critical to delivery of the Faster Diagnosis Standard will be reviewed by the Management Executive Group in October. With external support withdrawing from October 2024 there is significant risk to performance recovery and to delayed diagnosis.	3 Escalate to Board

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PAAG/IQPR	**65 and 78 week waits** Although the volume of actual 65 and 78 week waits has reduced this month, the number of patients in the 65 week wait cohort is now above trajectory, with both Orthopaedics and Gynaecology unable to hit a zero position by the end of September deadline. The target is now 239 patients over 65 weeks at the end of October and zero by December 2024.	**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.	Trajectories for Orthopaedics and Gynaecology are to be rebased with a revised clearance date. The benefits and sustainability of sending Gynaecology patients to the Nuffield to be reviewed and next steps to be agreed.	1 No escalation

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Deep Dive Bed Occupancy	The Committee requested this depp dive to understand the process for balancing bed allocation for UEC and Elective recovery. A comprehensive plan for UEC improvement is being delivered at system, place and provider level, across acute and community services, alongside elective activity. Day-to-day decisions on flow and capacity are managed through the Command, Control and Co-ordination (C3) plan and Tactical Patient Flow Escalation Plan. This plan includes the use of escalation capacity when there are no beds available and there is a material risk to patient safety, addressing the	2 Reasonable	Failing to plan for the winter period or planning without the lessons learned from previous years will lead to longer waits for admission to hospital and for discharge to a more appropriate care setting, a continuously overcrowded Emergency Department an increase in risks to patient safety as well as staff wellbeing. Under-delivering elective activity will result in increased risk of harm from prolonged waits, as well as risks to delivery of the financial recovery plan, which is predicated partly on Elective Recovery Fund income. The elective and non-elective bed allocations were reviewed by the Management Executive Group in	Current plans for winter include use of a winter escalation ward as in previous years. Bed modelling has been refreshed and indicates that to avoid the costs of opening a winter escalation ward, non-elective length of stay will need to reduce by an average of almost 1 day through the winter months. Decisions are also taken dynamically at tactical level and in exceptional circumstances a decision may be taken at joint strategic level to reduce elective programme activity for a period of days. Activity for long waits, clinically urgent and cancer pathway patients would always be prioritised in these circumstances.	1 no escalation

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	expectations set out in NHS England's supplementary guidance on "Principles for providing safe and good quality care in temporary escalation spaces".		August 2024 to agree their nominal size, balancing the two priorities within the physical size and resource constraints of the WSFT estate.	Although a specific length of stay reduction workstream has been established, there is insufficient evidence yet to establish whether this will achieve the saving required. All improvement initiatives, particularly those using external or specific funding, should be assessed for tangible evidence of benefits realisation, and where that evidence is insufficient should have their funding considered for reallocation to proven schemes but which can be scaled up, to cover increased costs.	

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Finance Accountability Group	**Current year** The Trust was off plan year to date (YTD) by the end of month 6, with a deficit for the year to September of £16.1m against a planned deficit of £9.8m. This resulted in an adverse variance of £6.2m YTD (compared to £5.0m at the end of August). There has been a small improvement in the monthly run rate of £300k. The CIP programme is behind plan for the year to September (£4m against a plan of £6.7m). This is £2.7m adverse variance YTD. The trust has applied for £9m of cash support but at the time of the meeting had only received £2.1m	**3 Partial**	The additional control measures put in place in the Financial Recovery Plan (FRP) are delivering small improvements to the run rate to date and further improvement is expected but this is not yet evident. At month 6, the trust is £0.6m better recurrently than anticipated in the FRP trajectory. Although considerable risk remains, in particular, winter pressures and the impact of pay awards. The latter is now projected to be significantly higher than expected, with a £3.3m unfunded potential pressure against £1.45m, anticipated in the FRP. This is a pressure across the system and is being raised nationally.	PA consulting have been appointed to assess deliverability of the Financial Recovery plan and to help identify any further measures that could be adopted. More detail on the CIP tracker to be reported to the next meeting of Insight. A report on the emerging 25/26 financial plan will be reported to the November Board meeting.	3 Escalate to Board

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	In September the Board agreed a new financial mitigation recovery plan.		Agreement has been reached with ESNEFT about the financial arrangements in 24/25 for the East Suffolk Elective Orthopaedic Centre which has removed a financial risk in the current year		

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Internal audit report	**Progress against action from Internal Audit reports** The Committee noted that there were still outstanding actions from an internal audit in May 2021 into Surveillance Patient Processes. It was suggested that IT system limitations had prevented the actions being taken forward.	**3 Partial**	The agreed actions need to be reviewed to understand whether they are achievable and, if not, assess what actions can be undertaken to address the underlying concerns raised by the original audit. The format of reporting on the audit plan to the assurance committees does not give detail on the actions themselves, just the number that are outstanding which makes it harder to understand the scale of issue that is outstanding.	Further report to Insight in November 2024. Trust Secretary to review format of future Internal Audit reports to the assurance committees.	1 no escalation

NHS
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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?

5.1

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.

6. QUALITY, PATIENT SAFETY AND QUALITY IMPROVEMENT

6.1. Improvement Committee Report

To Assure

Presented by Roger Petter, Susan Wilkinson and Richard Goodwin

NHS West Suffolk NHS Foundation Trust

Board assurance committee - Committee Key Issues (CKI) report

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5.1	**Patient Quality & Safety Governance Group (PQSGG)** Updates received from: <u>Infection Prevention and Control (IPC) Committee</u> C Diff rates variable and unpredictable. Emerging ribotype 955 is more serious, more transmissible and more difficult to clean from the environment. UKHSA recommends fogging as part of cleaning regime. FFP3 Fit Testing compliance poor. Concern given the need for measles and Mpox preparation	3	Ceiling target from ICB is 91 which equates to <8 cases per month. Following a review of the literature a decision model relating to the use of HPV fogging for cleaning post C-Diff infection, it was agreed to cease routine fogging and focus on robust deep cleaning. The Trust currently has no fogging equipment fit for purpose, so for now the current deep-clean will continue.	Project manager identified, will receive support from DCN to continue to progress the improvement programme Housekeeping Lead will appraise options, to be presented to IPCC. Similar challenges across the system so DCN will discuss SNEE collaborative training.	1

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5.1	**PSQGG** <u>Nutrition Steering Group</u> Slight decline in MUST assessments within 24-48 hours, though overall improvement over 6/12. Increased number of incidents relating to parenteral nutrition (eg rate / route / regime / management of line)	2	Good nutrition affects physical and mental health as well as recovery from illness and surgery.	Food Is Medicine workshop in October Parenteral nutrition has been limited to specific wards where training will be mandatory. Training sessions planned.	1
5.1	**PSQGG** <u>Falls Steering Group</u> Falls are in common cause variation. Falls per 1000 bed days are improving. Most falls are low or no harm.	2	Falls potentially harm patients and affect recovery and length of stay. Ensure patients are risk assessed and mitigation is in place to reduce harm.	Bed rails risk assessments are now in place. Trolley assessments to be adapted for care of patients in ED and DSU on trolleys. Competency development for support staff to measure standing	1

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				and lying bp for patients at risk of falls. Engagement in Falls Steering Group improved. Falls with severe harm data set requested	
5.1	**PSQGG** <u>Pressure Ulcer Prevention Group</u> Reduction in pressure ulcers seen in acute services (ongoing since Feb 2024). Incidence in community is in common cause variation.	2	Some reduction could reflect changes to RADAR reporting, but ongoing decline since Feb 24. Increased training has been offered, and a reporting deep dive is being undertaken to provide additional assurance.	TVN team is developing a QIP to develop consistency in pressure ulcer documentation.	1
5.1	**PSQGG** <u>Patient Safety Group</u> Reduced reporting could result from improvements <u>or</u> the	2	Improvement trends in reporting could reflect a drop in reporting,	Follow up and monitoring will occur with PSQGG and DCN and	1

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	change in reporting to RADAR. Groups with a decrease in reporting will be targeted for analysis.		rather than a drop in incidents/ reportable occurrences.	through the RADAR implementation group.	
	A patient safety summit was held in Sept 2024 "Getting it right for patients and staff: place, service and pathway"	1	We need a clear strategy for patient safety.	This theme will guide a formal improvement programme: the Head of Patient Safety will collaborate with the Director of Strategy and Transformation.	
5.1	**PSQGG** <u>Diabetes Information Flow</u> Workforce challenges around service provision Work has started with the QI team to monitor improvements in diabetes care. There is no	2	Increased demands on outpatient, inpatient and community services due to increased nos with DM and at high risk of developing DM. Clear KPIs will evidence improvements. Insulin treatment	Recruitment has improved and new staff start in November. Transition to E-roster for the clinical team has been successful and this will also help support service improvement. To report in December. HON to review mandatory training.	1

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	current suite of mandatory training for insulin administration.		is a common theme in treatment incidents.		
	Trust currently has no insulin self-administration policy. Pharmacy capacity to lead on this has been an issue	3	Risk to food-insulin gap, and also not in line with patient centred care and patient autonomy.	DCN to discuss at next D&T meeting.	2 – DS to discuss at next D&T meeting
5.2	**Clinical Effectiveness Governance Group (CEGG)** Reports from: <u>NICE compliance</u> A new monthly meeting to review publications issued, compliance with baseline assessment and guideline compliance. Between April 2020 and June 2024, 161 publication updates, of which 49 still outstanding for review.	3	. Meetings will help to escalate as needed, address compliance issues, mitigate risks, implement required actions	Longer term, RADAR is being considered to help manage this.	1

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5.2	**CEGG** <u>Guidelines Editorial Group (GEG)</u> This group reviews guidelines and policies prior to publication on the trust intranet. Since Oct 2023 it has reviewed 60 guidelines: 47 approved and published; 8 needed minor amendments; 5 required major amendments.	3	Two main concerns: 1 – variation in review undertaken. Most members of the group have reviewed <5 guidelines, whilst one member has reviewed 51. Concerns if this member stops. 2 – Reforming GEG has been positive but there are still 41 guidelines >6/12 out of date. The information governance team has limited influence to get authors to update their guidelines.	In the future, GEG will report to the Information Governance steering group rather than CEGG. Medical staff will be awarded a certificate / CPD point for reviews with the aim of improving involvement.	1
5.2	**CEGG** <u>Anaesthesia Clinical Services Accreditation (ACSA)</u> First report as part of CEGG's aim to strengthen oversight of	3	ACSA scheme is voluntary, but it provides QI through peer review of performance, and is supported by CQC. Multiple benefits of subscription include	Many of the standards yet to be rated depend on audit data. Progress and areas of challenge will be reported by CEGG,	1

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			SO WHAT? *Describe the value* of the evidence and what it means for the Trust, including importance, impact and/or risk*	**WHAT NEXT?** *Describe action to be taken (tactical/strategic) and how this will be followed-up (evidence impact of action)*	**Escalation:** 1. No escalation 2. To other assurance committee / SLT **3.** Escalate to Board
	accreditation trust-wide. Ambition is to achieve accredited status by 2025. 148 out of 151 standards must be met. 53.3% are currently met and a further 21.7% in progress.		structured support, engagement in QI and service development, access to a network of accredited departments and an ACSA online portal, and comparison with local regional and national standards.	including how the challenge has been escalated.	
5.2	**CEGG** Clinical Audit Poster Competition First prize awarded to a team from G3 for "Inpatient mental capacity assessment and documentation"	2	A national campaign to promote the benefit of clinical audit and QI. There was limited uptake of the competition, reflected in the low uptake in clinical audit reported last month.		1
6.1 6.2	**Integrated Quality and Performance Report (IQPR)** Including **Performance Review Meetings (PRM Packs)**	2	C diff data shows rates are in common cause variation; there has been no significant reduction in rates since Sept 2023. Rates have increased nationally over the last two reporting years. WSH set threshold is 91 and our	C diff is an organisational key priority. QIP will run for at least 6/12 once measures are agreed. Regular oversight meetings planned. Environment and cleaning plans in place. DCN to	1

Originating Committee: Improvement Committee			Date of meeting: 16 October 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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	Three key areas for the Trust are C diff rates, nutritional assessments and PPH.		incidence rates are tracking close to this already and only in 2nd quarter. Nutritional assessments – percentage of patients with measured weight is consistently >95%. Nutritional assessments within 48 hours now moving into common cause variation. This will improve experience and outcomes for our patients. Post-partum Haemorrhage (>1500 ml) - ongoing quality improvement within maternity services. This is one of the commonest obstetric emergencies and worldwide is the leading cause of maternal death. It has implications for length of stay, additional treatments and costs, as well as interactions between mother and	review subgroup membership to improve KPI monitoring. Plans in place to capture the timeliness of assessments when patients are admitted to a ward. This will improve the accuracy and compliance of this metric. No start date yet set and this has been escalated. Focus on UEC performance and monitor impact of the short ED assessment. PPH rates will continue to be monitored, and a QI 3rd cycle has been launched. Ongoing engagement with LMNS and Regional QI projects. 5 workstreams have been identified.	2

Originating Committee: Improvement Committee			Date of meeting: 16 October 2024		
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			baby. Overall, PPH incidence is in common cause variation but with an increase since June 2024. Massive Obstetric Haemorrhage (MOH) is in line with regional rates.		
6.1, 6.2	**IQPR** and **PRM** Patient Safety Incidents (PSI) and Reportable Occurrences (RO)	1	Numbers remain stable, but overall, less than numbers reported on Datix. This is scrutinised at Radar Oversight Group (ROG). We are reporting low harm and near miss events which is a good indicator of safe care.	A 6-month analysis is being prepared for discussion at ROG to help understand current reporting trends and ensure data is triangulated to reflect our safety climate.	1
6.1, 6.2	**IQPR** and **PRM** Mortality Data	1	SHMI data shows that the variation from the previous coding error is resolving. The Trust has a below expected SHMI for our patient mix.	Data will continue to be monitored	1

Originating Committee: Improvement Committee			Date of meeting: 16 October 2024		
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Agenda item	**WHAT?** *Summary of issue, including evaluation of the validity the data**	**Level of Assurance*** 1. Substantial 2. Reasonable 3. Partial **4.** Minimal	**For 'Partial' or 'Minimal' level of assurance complete the following:**		
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			Inpatient deaths are within expected common variation. This gives good assurance of our care outcomes.		
6.4	**C difficile Update** We are the third lowest performing Trust nationally and the lowest regionally. No significant reduction in rates over the last year.	3	This is a key priority, due to the risk to patients, staff and visitors, the morbidity associated with infection, and the costs to the NHS. Threshold of cases 2024-25 has been set at 91, as at end Sept we had reported 50. Numerous factors could be driving the rates, including no empty decant ward (RAAC), limited side room availability, cessation of fogging, cessation of probiotics use etc.	QIP started in March with 6 sub-groups. These include: Antimicrobial stewardship, Environment and cleaning, Governance and audit, Hand hygiene, Isolation, additional workstreams for update Feb 2025. Progress has been slower than planned, but it is anticipated this will improve with the identification of a project manager and oversight group chair	1
7.1	**Deep Dive:** **CQC single assessment framework – Critical Care**	2	. Last inspection was "good" overall, but "Requires Improvement" in the Responsive	.	1

Originating Committee: Improvement Committee			Date of meeting: 16 October 2024		
Chaired by: Roger Petter			Lead Executive Director: Susan Wilkinson, Ravi Ayyamuthu		
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	Critical Care is one of the CQC 12 Core Areas. Last inspected 2016 so a likely CQC target. Rated "Good" overall at that time		KLOE. Concerns around sideroom visibility, utilising PACU for extended periods of time and single sex accommodation breaches. Areas of challenge include staffing restructure & staffing levels, including dedicated pharmacist on risk register; patient flow leading to delayed discharges; ongoing work around delayed admission to CCU	CYP is another Core Area which was last inspected in 2016, and a deep dive into this is planned.	
7.2	**Maternity Incidents Update** Summary of Maternity claims scorecard from 01/04/13 to 31/06/24, and Incident and Complaint data 01/04/24 to 31/06/24. Themes and learning arising	2	In the last 10 years maternity claims for the Trust are about £31.15 million, with the average claim approx 1 million. No new claims in the reporting period. Themes from Incidents Q1 24/25: Term admissions to NNU; Obstetric anal sphincter injury;	All actions identified should be progressed and if any changes to practice are instigated, these should be audited within 6/12 to ensure new practices are embedded.	

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			PPH; Newborn screening incidents. Themes from complaints Q1: 1 complaint regarding care on postnatal ward with delayed identification of urinary retention. 10 responses received through PALS, but none proceeded to a formal complaint. Themes from mortalities: extreme preterm labour; birth before the threshold of viability; term stillbirth.	No actions relating to the deaths in this reporting period. Care is taken to ensure learning occurs from outcomes. .	

**See guidance notes for more detail*

West Suffolk NHS Foundation Trust

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.

6.2. Quality & Nurse Staffing Report

For Report

Presented by Susan Wilkinson

NHS
West Suffolk
NHS Foundation Trust

Public Board Committee	
Report title:	Nursing, safe staffing report: September and October 2024
Agenda item:	6.2
Date of the meeting:	November 29th 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	FIRST FOR PATIENTS	FIRST FOR STAFF	FIRST FOR THE FUTURE
Please indicate Trust strategy ambitions relevant to this report.	☒	☒	☒

Executive Summary
WHAT? *Summary of issue, including evaluation of the validity the data/information*
This paper reports on safe staffing, fill rate, contributory factors, and quality indicators for inpatient areas for the months of September and October 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, through the nursing and midwifery deployment group.
SO WHAT? *Describe the value of the evidence and what it means for the Trust, including importance, impact and/or risk*
• Overall RN/RM vacancy rate is positive causation/trend. • Inpatient RN/RM vacancy rate continues in positive causation/trend. • Turn over for RN/RM remains under 10% • Nurse sensitive indicators/patient harms have improved in this period. Falls moving into special cause improvement. • Nursing spend is under budget for month seven and forecast to be under budget at year end • 1% rise in sickness for registered nurses in M7 • Inpatient establishment analysis complete and included in appendices
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 – September and October 2024

1. Introduction

1.1 This paper illustrates how WSFT's nursing and midwifery resource has been deployed for the months of September and October 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 September and October 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 September and October 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 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%
Average fill rate Sept 2024	90%	87%	96%	95%
Average fill rate October 2024	87%	85%	93%	93%

Table 1

Planned versus actual staffing 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.This month average overall fill rate is 90%.

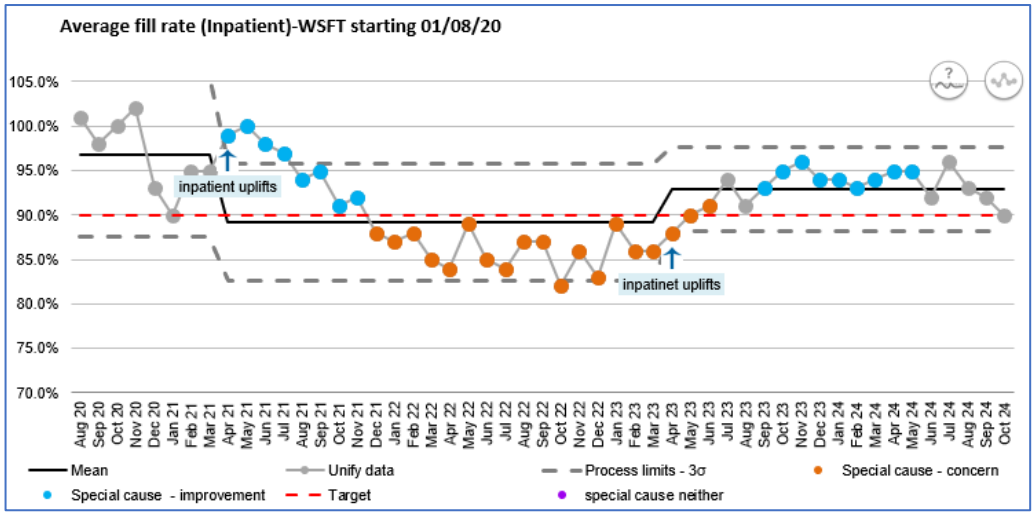


Chart 2

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 1a/b). 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 8.5.

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.

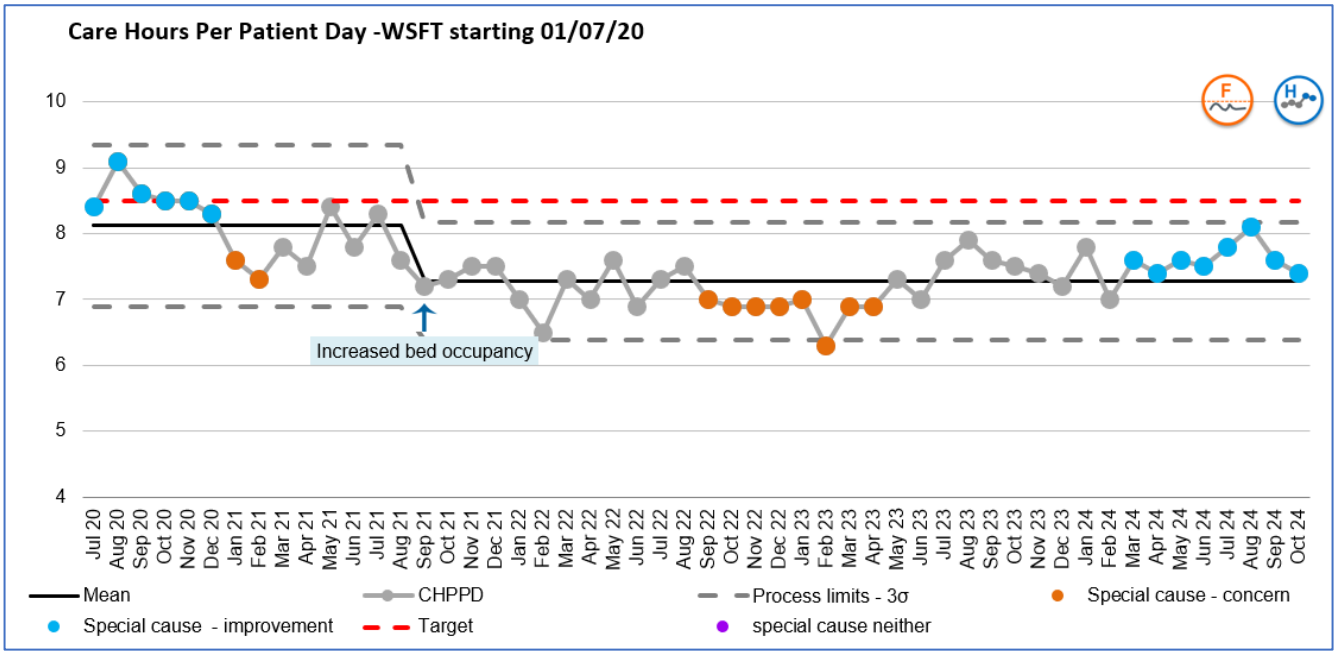


Chart 3

3.3 **Sickness**

For this period sickness rates for registered nurses increased by 1% from previous reporting period. This is the highest sickness rate this year for registered nurses.

	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24	Oct 24
Unregistered staff (support workers)	5.69%	6.00%	6.22%	7.33%	7.95%	7.83%	6.94%	7.25%
Registered Nurse/Midwives	4.54%	4.14%	3.55%	3.72%	3.41%	3.37%	3.70%	4.79%
Combined Registered/Unregistered	**4.91%**	**4.75%**	**4.42%**	**4.88%**	**4.87%**	**4.78%**	**4.71%**	**5.55%**

Table 4

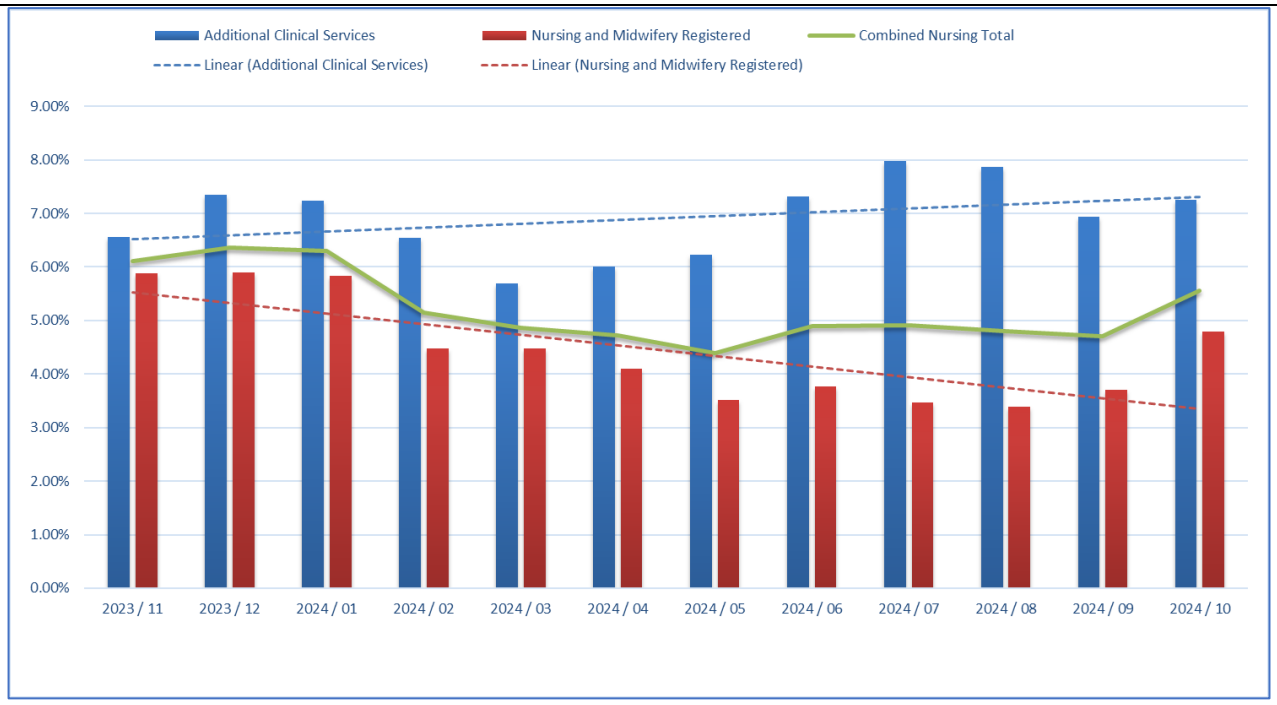


Chart 4

3.4.1 **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 8.9 last report to **7.2%** at M7.
- Total RN/RM vacancy rate has improved from 8.1% to **6.7%** at M7.
- Inpatient NA vacancy rate has remained static in in M7 at **12.4%**
- Total NA vacancy has improved from 13.5% to **12.9%** in M7.

Both total and inpatient RN/RM vacancy rates and WTE continue to improve and are in special cause improvement (appendix 3). The vacancy rate for NAs remains consistent and in common cause variation, despite actual WTE having two points of special cause of concern.

	Sum of Month 2	Sum of Month 3	Sum of Month 4	Sum of Month 5	Sum of Month 6	Sum of Month 7	WTE vacancy at M5
RN	712.4	716.2	715.3	713.6	727.5	729.6	57
NA	390.1	389.4	385.8	382.3	388	380.3	53.9

Table 5 Inpatient actual substantive staff WTE.

3.4.2 **New Starters**

In this period, we saw the 2024 qualifying cohort of student nurses join the organisation. Traditionally WSFT recruits approximately 90% of students that train here, a reflection of a supportive educational environment. This year due to a positive vacancy position, we were only able to recruit 60% of the qualifying cohort. Where possible students were recruited at risk into maternity leave posts to improve future recruitment and to reduce temporary back fill. It is important to note that during the SNCT output review, it was confirmed that due to expected turnover, all students are now in permanent positions.

	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24	Oct 24
RN	20	17	8	8	16	16	19	24
NA	11	22	17	8	12	13	11	16

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

- In September, 19 RNs attended induction; of these; 11 were for the acute, 3 for bank services and 5 for community.
- In September, 11 NAs attended induction; of these; 8 NAs are for the acute Trust, 1 for bank services and 2 for community services.

- In October, 24 RNs attended induction; of these; 9 was for the acute, 8 bank staff, 3 for midwifery and 4 for community teams.
- In October, 16 NAs attended induction; of these; 13 NAs are for the acute Trust, 2 for community services and 1 for bank services

3.4.3 **Turnover**

On a retrospective review of the last rolling twelve months, turnover for RNs continues to positively be under the ambition of 10%. RN turnover improved to 4.37%. NA turnover also continues to improve on last reporting period from 10.9% to 7.78%

		Turnover	01/11/2023	-	31/10/2024			
Staff Group	Average Headcount	Avg FTE	Starters Headcount	Starters FTE	Leavers Headcount	Leavers FTE	LTR Headcount %	LTR FTE %
Nursing and Midwifery Registered	1,507.50	1,321.2735	76	64.2667	67	57.8000	4.4444%	4.3746%
Additional Clinical Services	604.00	510.3266	156	144.6000	53	39.6933	8.7748%	7.7780%

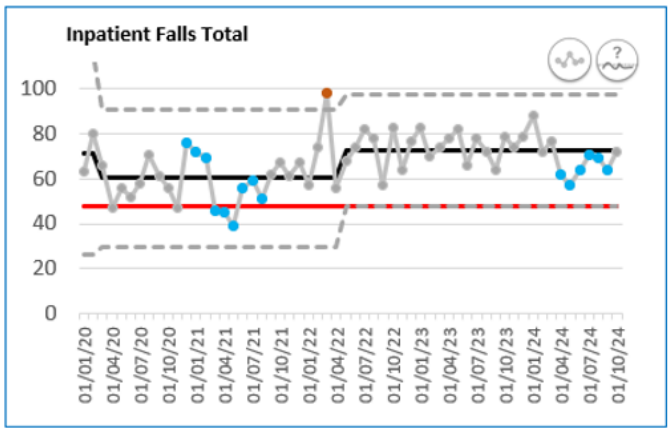
Table 7. (Data from workforce information)

3.5 **Quality Indicators**

Falls and acquired pressure ulcers.

Improvement projects and oversight of these quality indicators are reviewed through the patient quality and safety governance group (PQASG).

Falls per 1000 bed days and overall falls have moved into special cause positive improvement in this period and suggests that current grip and control of nursing deployment is not adversely affecting patient care. Pressure ulcers remains in common cause variation and incidents have been below expected average for four out of the past five months within the acute site.



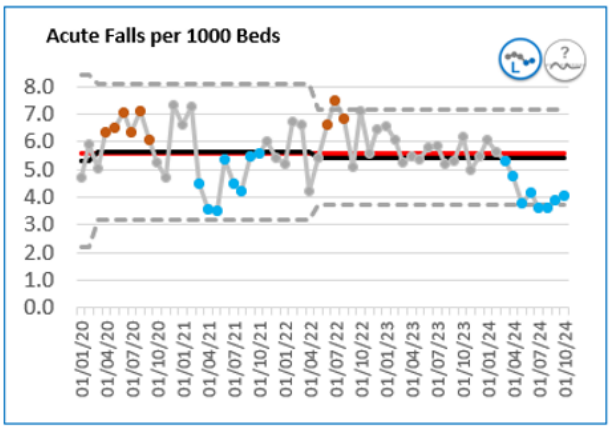
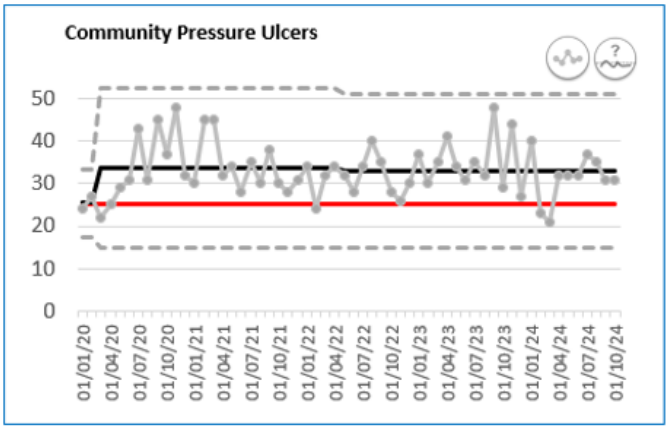


Chart 8 inpatient falls



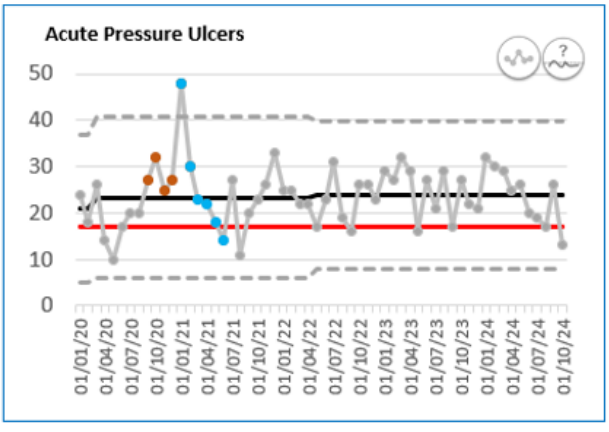


Chart 9 Pressure ulcers acquired in care.

3.6 **Compliments and complaints**

26 formal complaints were received in September. The emergency department received the highest number of complaints this month with a total of 5. Community paediatric SLT, the eye treatment centre and ward F14 each received 2 formal complaints. The most consistent theme this month was communication, with a total of 6 formal complaints being listed under this subject. These related to communication with patients and inadequate information provided.

19 formal complaints were received in August. The emergency department received the highest number of complaints with a total of 3. Ward G10 and the acute assessment unit also each received 2 formal complaints this month. The most consistent theme this month was patient care with 5 complaints listed under this subject. These complaints related to care needs not being adequately met.

Chart 10a and 10b demonstrates the incidence of complaints and compliments for this period. The number of complaints was high for September but remains in common cause variation. However, compliments and positive feedback received, continues in a sustained positive improvement.

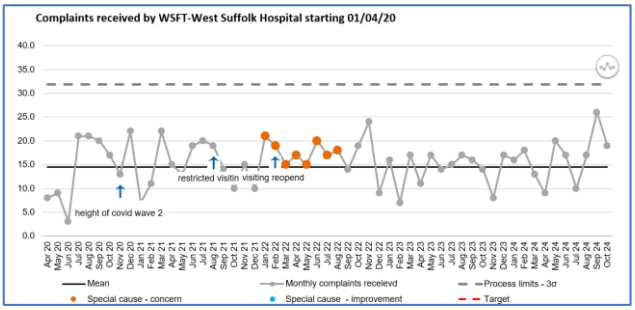


Chart 10a (complaints)

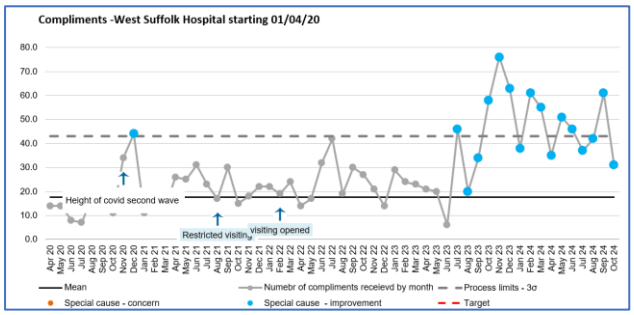


Chart 10b (compliments)

3.7 **Adverse staffing incidents**

Staffing shortfall incidents report is being built in RADAR. Data not available at the time of writing. A RADAR update/change is required to support consistent documentation of NQB red flag events. The change request has been through RADAR oversight group and will be 'live' week of 25.11.24. Heads of nursing have reviewed all patient harms and providing assurance that that staffing levels have not contributed to harm. In addition, staffing is reviewed three times a day with the matron team to further mitigate staffing shortfalls and to respond to any 'red flag'.

3.8 **Maternity services**

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

	Standard	April	May	June	July	August	September	October
Supernumerary Status of LS Coordinator	100%	100%	100%	100%	100%	100%	100%	100%
1-1 Care in Labour	100%	100%	100%	100%	100%	100%	100%	100%
MW: Birth Ratio	1:21	1:21	1:20	1:21	1:19	1:24	1:23	1:19
No. Red Flags reported	NA	0	0	2	1	3	2	0

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 1 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 September and October 2024 compliance against this standard was 100%.

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

- September two red flags event were reported, this was due to delay in induction of labour process.
- October no red flag event recorded.

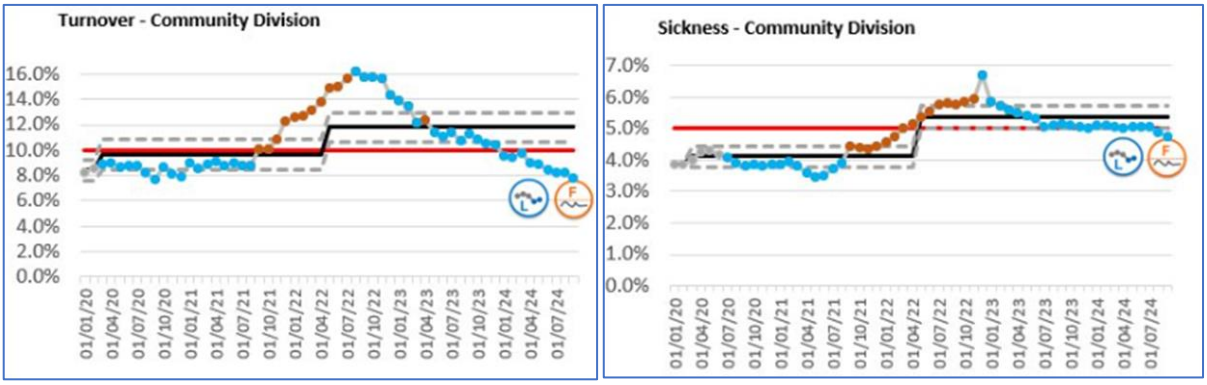
Midwife to Birth ratio
Latest BirthRate plus review undertaken in March 2023 shows that Midwife to Birth ratio at West Suffolk NHS Foundation Trust dropped to 1:21. The ratios are based on the Birthrate Plus® dataset, national standards with the methodology and local factors, such as % uplift for annual, 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.

- September midwife to birth ratio was 1:23, this was due to increase acuity and number of births during the month
- October midwife to birth ratio was 1:19.

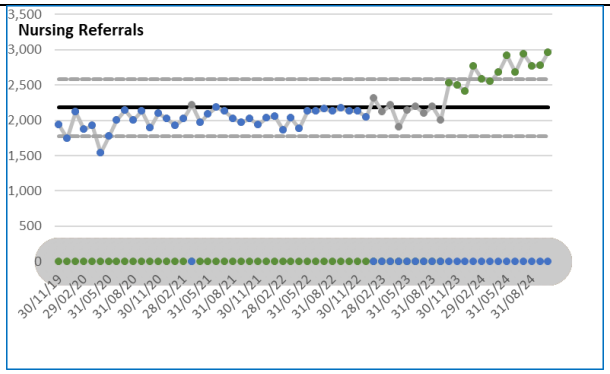
Supernumerary status of the labour suite co-ordinator (LSC)
This is one of the Maternity Incentive Scheme Year 6 Safety Actions requirements and was also highlighted as a 'should' from the CQC report in January 2020. The band 7 labour suite co-ordinator should not have direct responsibility of care for 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 September and October 2024.

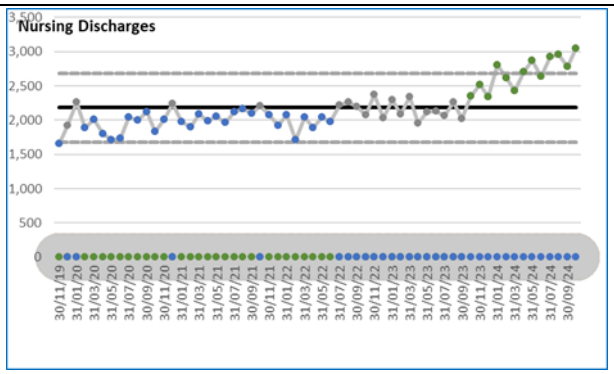
3.9 **Community and integrated neighbourhood teams (INT)**

Sickness & Turnover
Special cause improvement in both sickness and turnover and under trust target ambition. Some areas observed high sickness in October as demonstrated in trust total in section 3.3



Demand
The statistical process charts, below show that demand for community services continues to increase, this has been a significant trend for the past year. Mitigation to manage such demand is effective caseload management, this is demonstrated in the increasing discharge profile from the case management list.





Temporary spending

The division continues to monitor and control use of temporary all agency nursing ended in August, which affected the virtual ward capacity the most. This is contributing to delays in onboarding of patients because of the high number of vacancies and lack of bank staff with virtual ward skills. Plans to upskill the community nursing teams to support virtual ward is in train, however there is some lag in achieving this.

Actions

- Temporary spending continues to be closely monitored & controlled. There is continued work to improve the accuracy of HealthRoster reporting for MDT such as the INTS and all INTS and virtual ward are in the process of reviewing and updating their templates.
- THE INTS , EIT and Virtual ward are involved in a shared services integration projects aimed at reducing duplication and improving effectiveness, this is going well, it is complex and will take time to complete.
- HR have reviewed sickness rates and are offering more sickness absence training and work with team managers on supportive practices, such as clinical supervision.
- INT teams continue to utilise the daily capacity dashboard use 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. Total temporary nursing spend has moved into positive cause improvement in M6. An expected spike in spend is seen in M7 due to the 5% agenda for change increase and pay arrears.

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

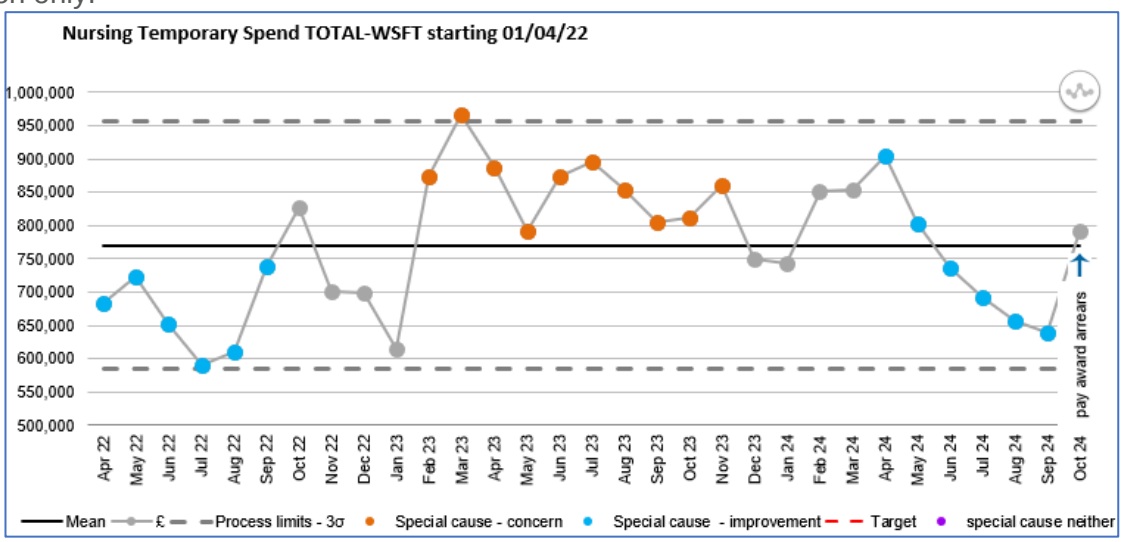


Chart 11

Nursing spend came in underbudget in M7 and is currently forecast to end this financial year under budget (table 12.). While this is encouraging, further focus on reducing run rate is required to achieve final ambitions.

	Values											
Pay Category	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	28,428	(11,691)	117,159	385,723	(268,564)	200,844	529,900	(329,056)	0.01	3.82	- 3.81
Bank	11,443	732,987	(721,545)	56,524	4,610,017	(4,553,493)	104,613	7,348,936	(7,244,324)	-	139.80	- 139.80
Substantive	10,040,718	8,982,524	1,058,194	57,565,792	52,520,729	5,045,063	98,858,125	89,899,229	8,958,896	2,059.08	1,881.18	177.90
Grand Total	**10,068,898**	**9,743,940**	**324,958**	**57,739,475**	**57,516,469**	**223,006**	**99,163,582**	**97,778,066**	**1,385,516**	**2,059.09**	**2,024.80**	**34.29**

Table 12.

Additional schemes are in train to further contribute to the run rate including a review of supernumery provision, the delivery of the care certifcate training.

Schemes	YTD Actual	Total
Rapid pool	£ 38,500	£ 77,000
Sunday LD reduction	£ 36,533	£ 101,007
Care Certificate Training	£ -	£ 18,000
Bank shifts pay for substantive staff	£ -	£ 46,667
Reduction in registered nursing shift fill rate (in-patients, daytime)	£ -	£ 197,440
Review of clinical education teams	£ 3,750	£ 22,500
Total	**£ 78,783**	**£ 462,614**

4.2 **Establishment reviews**

The summer Safer Nursing Care Audit (SNCT) is complete, and the analysis and review has been concluded with the clinical teams. The full paper and outcome can be found in (appendix 5). In summary two areas have been identified as potential opportunities to amend nursing establishments.

- Ward F8. Potential reduction in 1 RN per long day seven days a week. This equates to the removal of 2.58 WTE with a budget reduction of £95, 872 for 25/26. However, this ward may feature in the ward reconfiguration and may require maintenance of current establishment if ward footprint changes. Recommendation to confirm adjustment on completion on ward configuration project. Ward is currently not filling these posts.
- F12. Reduction of 1 NA per long day seven days a week. On review of budget this has already been removed in budget setting for this year, so no additional savings. However, the SNCT supports this decision retrospectively.

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 continue to meet this while maintain patient safety.

6. Recommendations

For the board to take assurance around the daily mitigation of nurse and midwifery staffing and oversight of nursing and midwifery establishments,

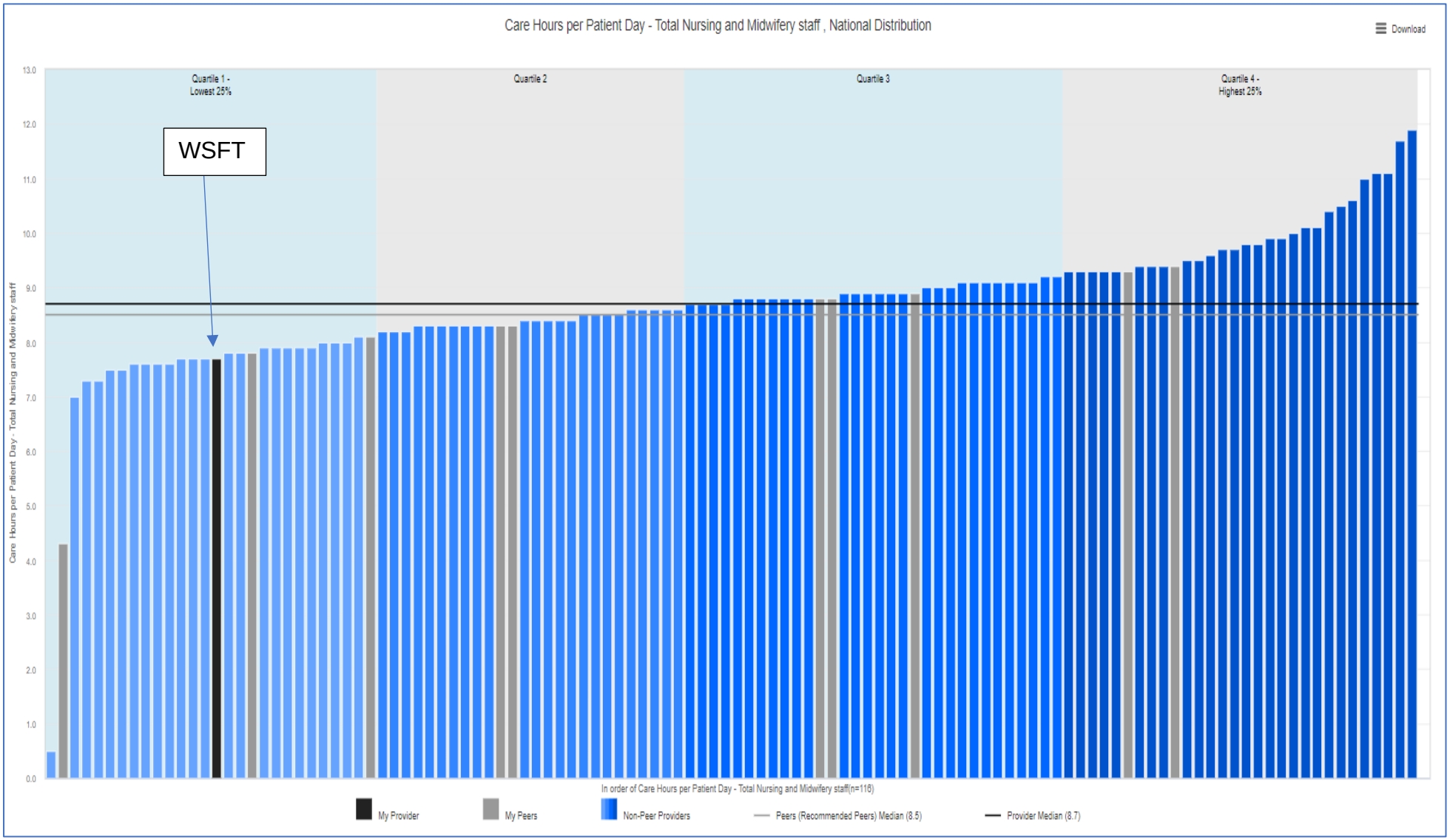
Appendix 1a. Fill rates for inpatient areas (September 2024) Data adapted from Unify submission.
RAG: Red <79%, Amber 80-89%, Green 90-100%, Purple >100

	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	1367.25	1107.6667	1715.75	1693.5	1034.5	885.5	1380	1489.5	81%	99%	86%	108%	452	4.4	7.0	11.5
Glastonbury Court	689.5	690.75	1030.5	983.5	690	690	525	516	100%	95%	100%	98%	384	3.6	3.9	7.5
Acute Assessment Unit	2546.5	2453.25	1924	1669.75	1725	1670	1356.5	1244.5	96%	87%	97%	92%	761	5.4	3.8	9.2
Cardiac Centre	1719.5	1520.5	1028.8	820.55	1725	1529.25	688.5166667	665.516667	88%	80%	89%	97%	632	4.8	2.4	7.2
G10	1668	1388.75	1721.5	1554.75	1035	1036.75	1709	1651.48333	83%	90%	100%	97%	707	3.4	4.5	8.0
G9	1654	1610	1376.5	1283	1334	1322.5	1035	1022.66667	97%	93%	99%	99%	752	3.9	3.1	7.0
F12	527	688.5	345	279.5	678.5	676	345	191	131%	81%	100%	55%	240	5.7	2.0	7.6
F7	1713.5	1472.5	1666.75	1468.5	1380	1267	1725	1572	86%	88%	92%	91%	683	4.0	4.5	8.5
G1	1380	1022.8333	345	274.5	690	692	345	333.5	74%	80%	100%	97%	485	3.5	1.3	4.8
G3	1616	1372.5	1725	1459	1035	1012	1375	1383	85%	85%	98%	101%	864	2.8	3.3	6.0
G4	1678	1445	1696	1366.5	1035	943	1322.5	1183	86%	81%	91%	89%	896	2.7	2.8	5.5
G5	1627	1316.5	1712	1400.5	1023.5	1013.5	1380	1331	81%	82%	99%	96%	760	3.1	3.6	6.7
G8	2273	1825.7833	1721.5	1406.5833	1564	1498.466667	1035	1011.5	80%	82%	96%	98%	615	5.4	3.9	9.3
F8	1380	1393.8333	1713.5	1448.5	1023.5	853.9166667	1380	1343.91667	101%	85%	83%	97%	723	3.1	3.9	7.0
Critical Care	1978.5	1954.75	330	125.25	1947	1861.5	0	0	99%	38%	96%	*	388	9.8	0.3	10.2
F3	1702	1515.5	1713.5	1519	1034.5	1009	1380	1393.5	89%	89%	98%	101%	732	3.4	4.0	7.4
F4	805	742.25	590.5	564.75	625	556	382.5	336.5	92%	96%	89%	88%	633	2.1	1.4	3.5
F5	1342	1301.8333	1380.5	1279.5	1035	989.5	1031	1046	97%	93%	96%	101%	698	3.3	3.3	6.6
F6	1499.5	1372	1704	1267.25	1035	1041	1357	1261.5	91%	74%	101%	93%	942	2.6	2.7	5.2
Neonatal Unit	2115	1560.25	451	486	1080	1078	713	437	74%	108%	100%	61%	116	22.7	8.0	30.7
F1	1751.5	1965	688.25	625.25	1379.5	1372.766667	0	0	112%	91%	100%	*	115	29.0	5.4	34.5
F14	360	360	360	336.5	720	720	0	0	100%	100%	100%	*	106	10.2	3.2	13.4
Total	33,392.75	30,079.95	26,939.55	23,312.13	24,829.00	23,717.65	20,465.02	19,413.08	**90%**	**87%**	**96%**	**95%**	**12684**	**4.2**	**3.4**	**7.6**
* planned hours are zero, so additional support used on ward to mitigate unfilled nursing hours																

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

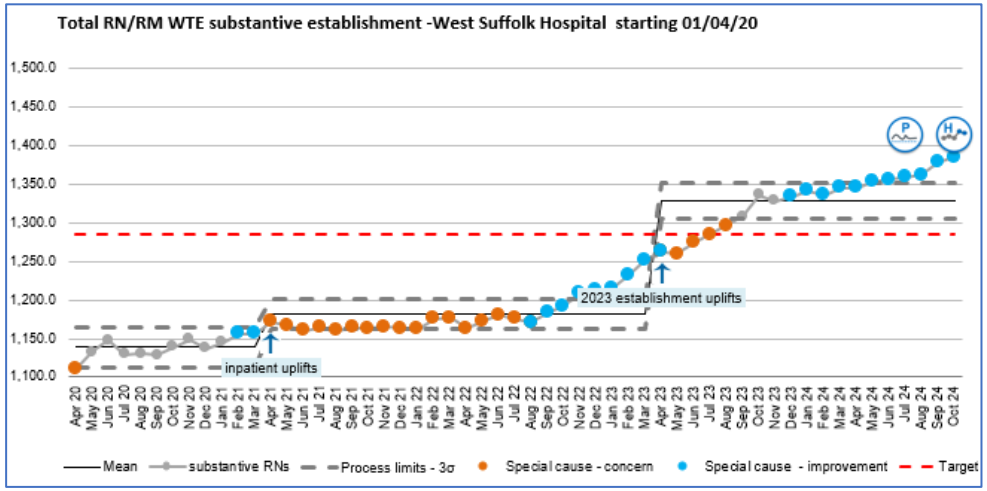
	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	RNs/RMN		Non registered (Care staff)		RNs/RMN		Non registered (Care staff)									
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned 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	1427.25	1193.75	1788	1736.5833	1069.5	999	1426	1405.25	84%	97%	93%	99%	986	2.2	3.2	5.4
Glastonbury Court	716.5	717	1079.5	1006	713	713	543.5	541	100%	93%	100%	100%	576	2.5	2.7	5.2
Acute Assessment Unit	2580	2616.65	1994.5	1749	1783.5	1758.5	1394	1325.5	101%	88%	99%	95%	761	5.7	4.0	9.8
Cardiac Centre	1713.5	1532.25	1054	808.5	1782.5	1581.5	713	667	89%	77%	89%	94%	632	4.9	2.3	7.3
G10	1751.5	1390.6667	1757	1465.5	1069.5	1046.5	1771	1591.5	79%	83%	98%	90%	707	3.4	4.3	7.8
G9	1783	1549	1426	1227	1414.5	1345.5	1069.5	1045	87%	86%	95%	98%	752	3.8	3.0	6.9
F12	563.5	699.5	350	275.5	701.5	593.5	343.5	315	124%	79%	85%	92%	240	5.4	2.5	7.8
F7	1759.5	1447.5	1759.5	1530.5	1403	1196	1782.5	1469	82%	87%	85%	82%	683	3.9	4.4	8.3
G1	1416	1016	356.5	241	713	701	356.5	368	72%	68%	98%	103%	485	3.5	1.3	4.8
G3	1736.5	1495	1733.5	1458.5	1069.5	1045.25	1426	1397.75	86%	84%	98%	98%	864	2.9	3.3	6.2
G4	1783	1449.5	1782.5	1480	1069.5	828	1426	1334	81%	83%	77%	94%	896	2.5	3.1	5.7
G5	1709.5	1436.9833	1771	1409.1667	1069.5	1033.5	1426	1349.66667	84%	80%	97%	95%	760	3.3	3.6	6.9
G8	2366.5	1802.2	1776.75	1500.25	1633	1487.333333	1069.5	1054.5	76%	84%	91%	99%	615	5.3	4.2	9.5
F8	1421	1402.8333	1749	1518.5	1067	800.75	1426	1442.75	99%	87%	75%	101%	723	3.0	4.1	7.1
Critical Care	2622.5	2280.75	276.5	145	2491	2315.25	0	11	87%	52%	93%	*	388	11.8	0.4	12.2
F3	1759.5	1540.25	1782.5	1488.5	1069.5	1058	1426	1431.5	88%	84%	99%	100%	732	3.5	4.0	7.5
F4	979	842	713	565	713	634	621	369.5	86%	79%	89%	60%	633	2.3	1.5	3.8
F5	1563.5	1411.5	1427.5	1274.5	1069.5	1045	1069.5	1058	90%	89%	98%	99%	698	3.5	3.3	6.9
F6	1693.5	1410	1736.5	1376.75	1069.5	1046.5	1423.016667	1230.5	83%	79%	98%	86%	942	2.6	2.8	5.4
Neonatal Unit	2221.5	1624.6667	463	474	1116	1020	744	528	73%	102%	91%	71%	116	22.8	8.6	31.4
F1	1827	1917.3333	713	631	1426	1336	0	46	105%	88%	94%	*	115	28.3	5.9	34.2
F14	372	385.5	372	365.5	744	742.5	0	0	104%	100%	100%	*	106	10.6	3.4	14.1
Total	35,765.75	31,160.83	27,861.75	23,726.25	26,257.00	24,326.58	21,456.52	19,980.42	**87%**	**85%**	**93%**	**93%**	**13410**	**4.1**	**3.3**	**7.4**
* planned hours are zero, so additional support used on ward to mitigate unfilled nursing hours																

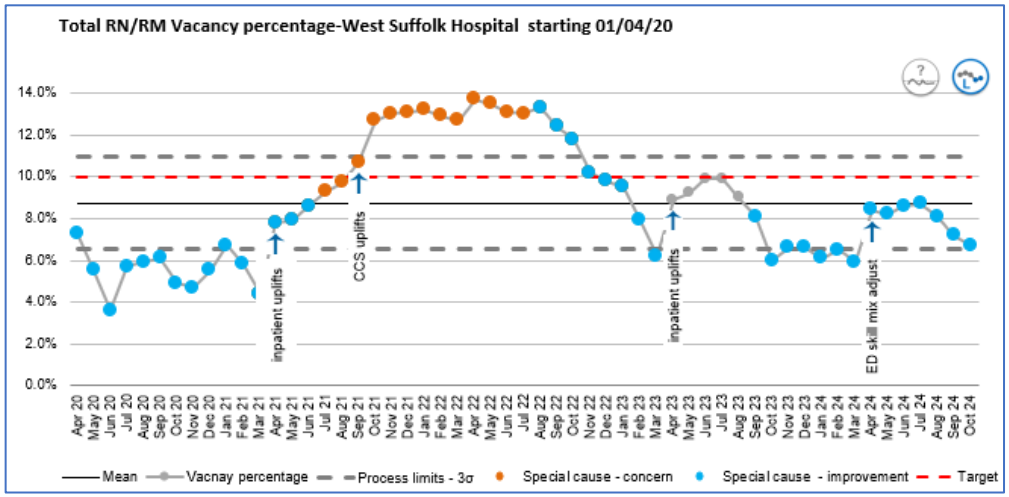
Appendix 2. CHPPD Model Hospital data (August data most recent)



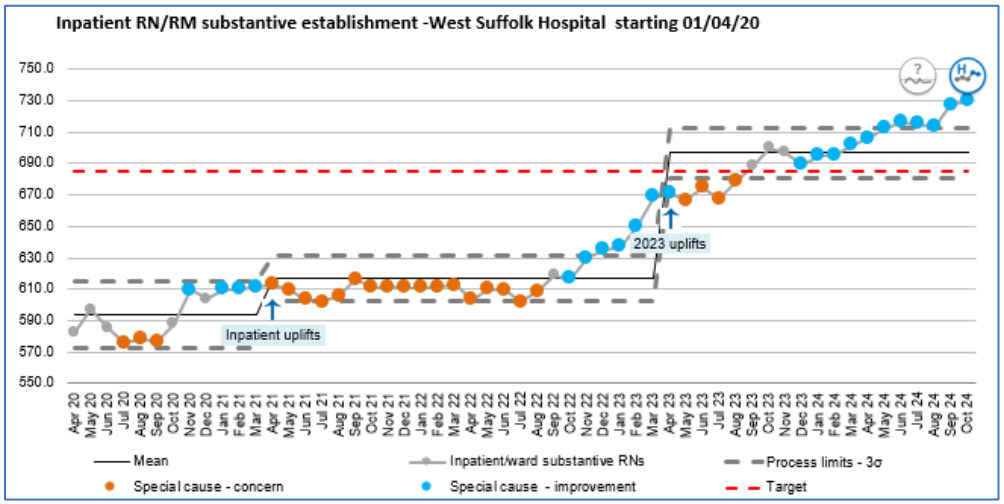
Appendix 3 WTE and Vacancy rates.

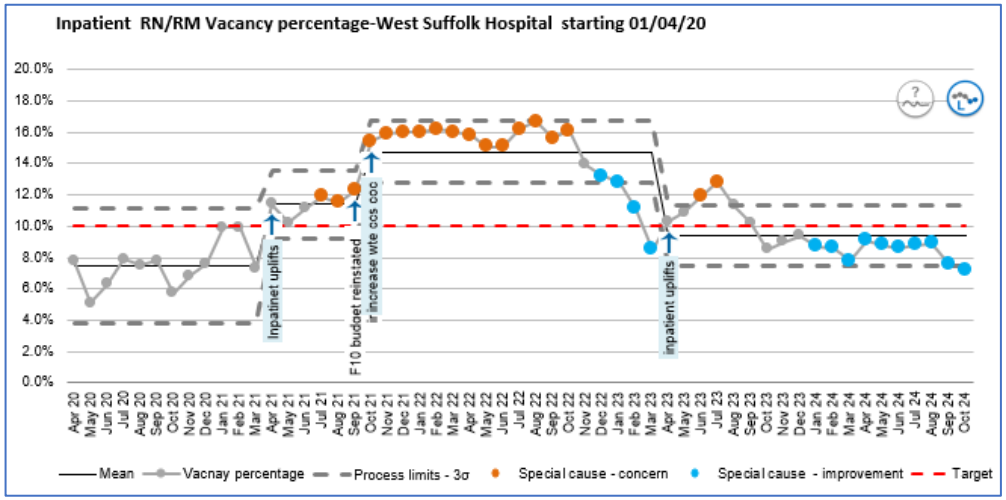
Trust Total RN/RM



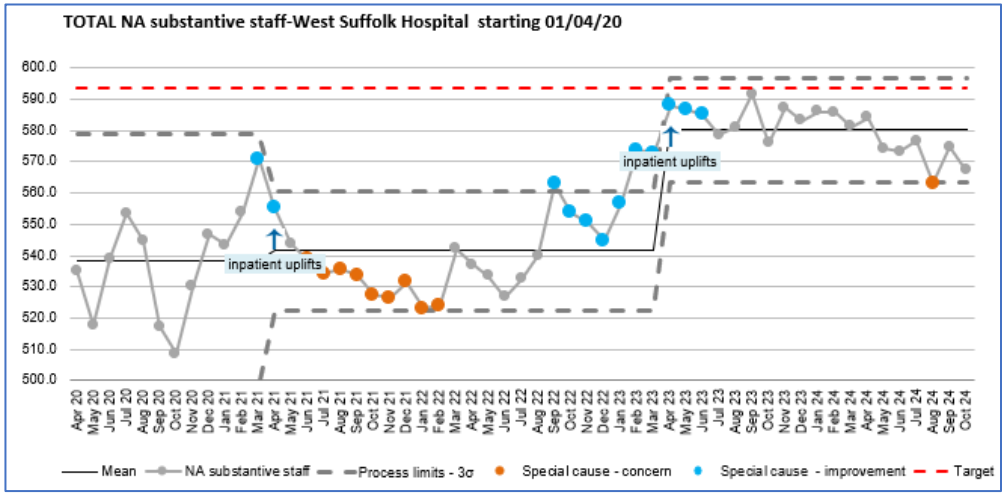


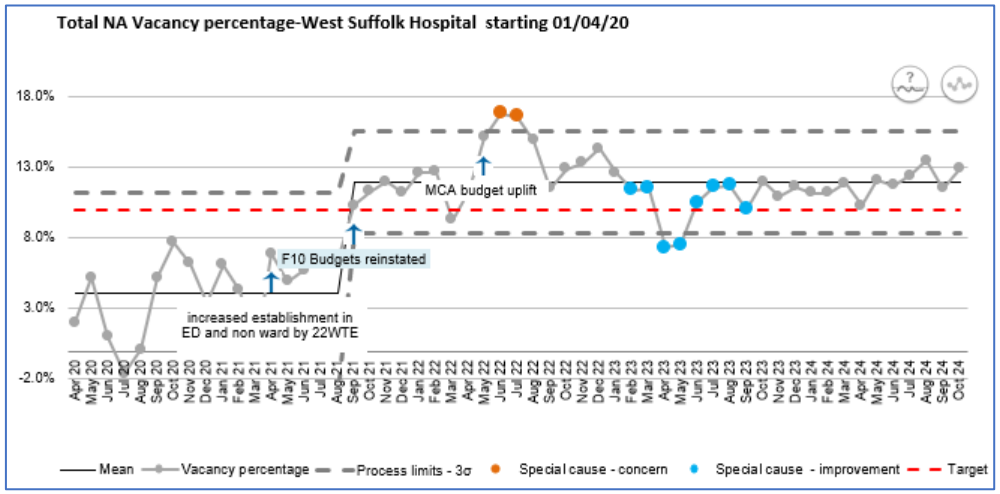
Inpatient RN/RM



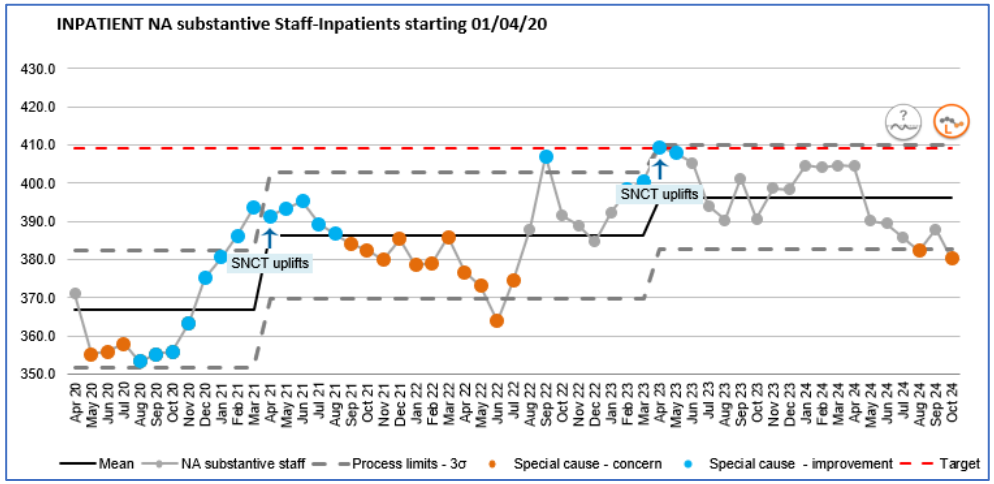


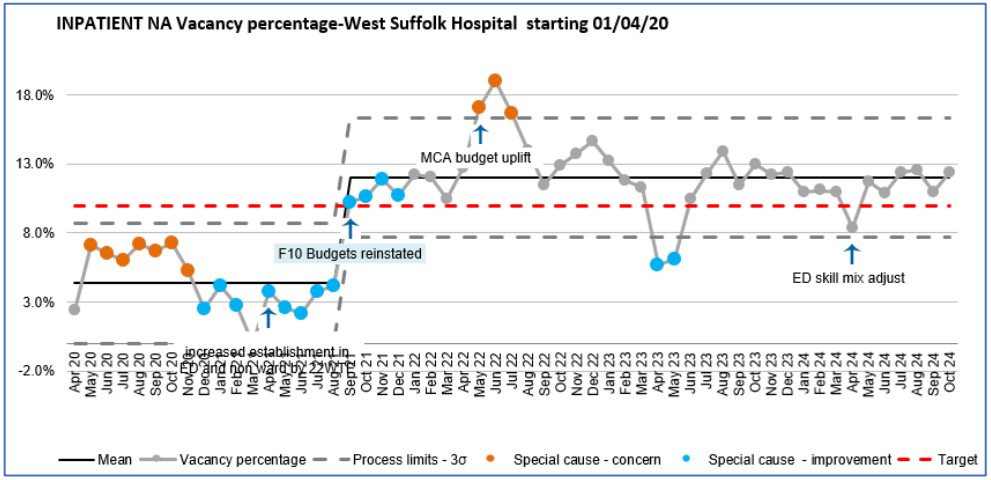
Total NA/unregistered.





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.

Appendix 5

Involvement Committee	
Report title:	**Adult Inpatient establishment review 2024**
Agenda item:	
Date of the meeting:	18th December 2024
Sponsor/executive lead:	Susan Wilkinson
Report prepared by:	Daniel Spooner

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 aim of this establishment review is to provide the board with assurance that the current nursing establishment is fit for purpose and meets the needs of our patients and staff at West Suffolk Foundation Trust (WSFT). This review provides recommendations for adjustments in establishments where appropriate. This establishment review used nationally endorsed and evidence-based tools to audit patient acuity and dependency within our inpatient areas and community assessment beds. Data was triangulated with clinical/professional judgement and nurse sensitive indicators (pressure ulcers, falls and medication incidents) as per the expectations from the National Quality Board and NHSE. The review focused on 17 adult inpatient areas within the trust. No additional investment is required following this round of audit. 2 wards have been recommended to potentially reduce establishments • F8: 2.56 WTE Registered nursing = £95,872 [pending ward reconfiguration project] • F12: 2.56 WTE Nursing assistants: Already removed from budgets. 3 wards require a third round of audit Q4 to assess potential changes to establishment. • F7 • G1 • F5 12 areas no change to current establishment.

Action required/ recommendation:	For the board to receive assurance that a robust review of the adult inpatient areas has been undertaken as part of the biannual inpatient staffing review.

Previously considered by:	To be taken through involvement group for detailed discussion [timing of involvement means it is presented here first]
Risk and assurance:	Assurance of the expectation of the national quality board when setting inpatient establishments
Equality, diversity and inclusion:	Ensuring the right staff in the right place at the right time, meeting the needs of our patients
Sustainability:	Productive deployment of nursing workforce and best use of resource
Legal and regulatory context:	Compliance with Regulation 18 and 12 of CQC, and health and social care act

Biannual inpatient nursing establishment review

1. Introduction

1.1 Following the Francis Report (2013) and the government's published response to the inquiry, 'Hard Truth's', it is expected that boards receive assurance on the Nurse Staffing Position bi-annually. In November 2013, the National Quality Board (NQB) published staffing guidance, which was strengthened by the publication of NICE guidance (2014), which supported providers and commissioners to make the right decisions about nursing, maternity staffing capacity and capability. The expectations set out in the guidance aimed to create a supportive environment where staff are able to provide compassionate care, of high quality and with the best possible outcomes for patients.

This national guidance was further supported by the NQB (2016) to support NHS providers to deliver the '*right staff, with the right skills, in the right place at the right time'.* This document contains recommendations to support trusts in making informed, safe and sustainable workforce decisions, and identifies examples of best practice in the NHS.

It is well considered in nursing research and literature that appropriate staffing levels and the right skill mix both influences, and significantly impacts patient safety and patient harms (Needleman, 2017; Aiken et al 2017). However, despite these recommendations, variations in ward geography, skill mixes and patient profiles, there is no agreed national standard for nurse-to-patient ratios (NICE, 2014). This can lead to ambiguity around establishment settings and workforce planning and difficulty bench marking organisations. In 2018,NHSI published the 'developing work force safeguards' document to provide recommendations to support making safe and sustainable workforce decisions. Robust staffing establishments reviews should triangulate evidence-based tools with professional judgement and patient outcomes, to ensure the right staff are in the right place at the right time (Figure 1).

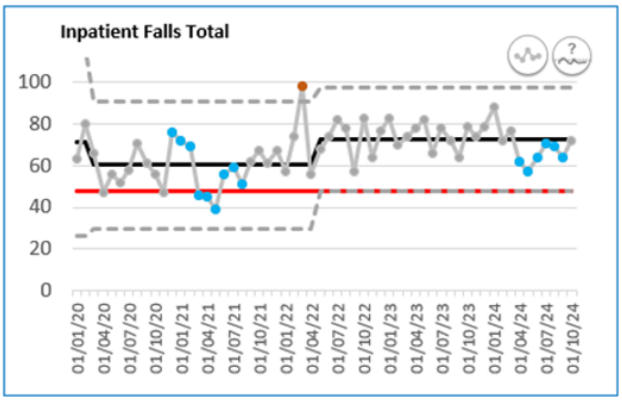
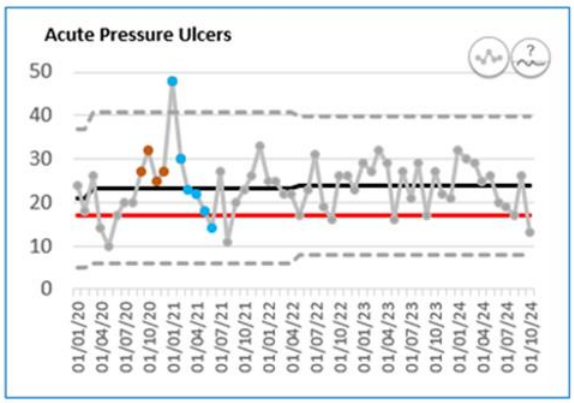
This staffing review has used these principles within these recommendations to inform the outcomes of this establishment review process. Since July 2020, all inpatient areas with West Suffolk Foundation Trust (WSFT) have conducted this review biannually as required by NQB. This is the second review since the publication and release of the updated licence in November 2023

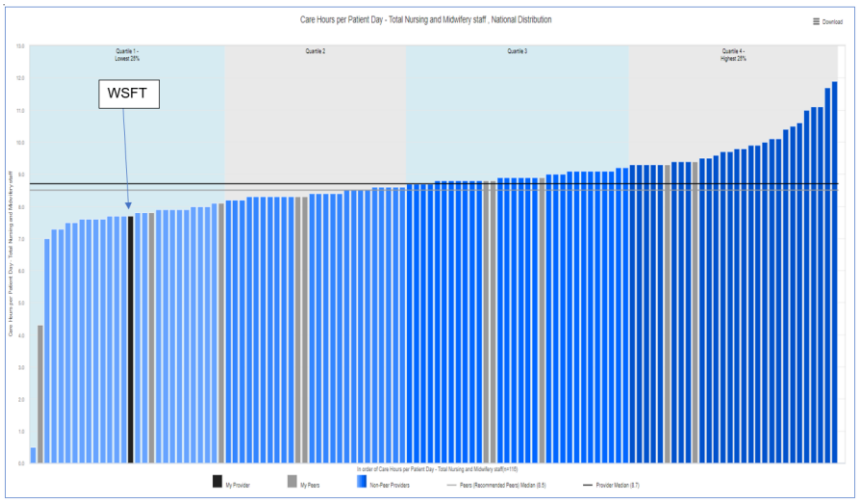
Figure 1. Taken from 'Developing Workforce Safeguards' (NHSI, 2018

2. Background

2.1 <u>The Tool</u>

The Safer Nursing Care Tool (SNCT), developed by the Shelford group, is the only nationally endorsed staffing tool by NICE and NHSE. The Safer Nursing Care Tool has been developed to help NHS hospital staff measure patient acuity and dependency to inform evidence-based decision making on staffing and workforce provision. The tool, when allied to nurse sensitive indicators (NSIs) like falls and pressure ulcers, offers a reliable method against which to deliver evidence-based workforce plans. It uses an assessment of patient acuity and dependency scores and applies a nominal multiplier to suggest a whole time equivalent (WTE) to a ward/department (appendix 1). This WTE is then applied to skill mix ratio of registered nurses (RNs) and nursing assistants (NAs) to propose an appropriate work force.

2.2	Staff Training To ensure reliability in data collection three senior staff from each ward were selected to be responsible for audit and data collection. In recognition of staff turnover, virtual workshops were provided to the prospective audit teams to ensure that subjective interpretation of patient acuity and dependency was reduced as much as possible. The virtual workshops were rolled out two weeks before the audit commenced using the updated audit scenarios and scoring (SNCT, 2023).
2.3	Methodology To note that since the licence was updated, the SNCT now more adequately capture patients that require enhanced or 1:1 or 2:1 care. The tool suggests recommended establishments if enhanced care was included in establishment setting. Current establishment setting at WSFT does not include enhanced care, any staff required to provide enhanced in addition to ward establishment are requested through WSP bank services and increase temporary nursing spend. There are a number of limitations to the SNCT which will affect the output and WTE recommendations of such a review (Griffiths et al, 2020) for example: • The SNCT does not consider the nuances of ward activity, for example clinics based within wards or ward attenders. • Additional specialist or peripatetic roles with wards (stroke outreach), are not considered. • Layout and geography of ward environments, variations in side room provision, and ward footprint may dictate additional nursing requirements not captured in the SNCT. • Small wards or those with a majority of side rooms will often result in a proposed under establishment. Because of these variations it is important that the output of the SNCT is triangulated with professional clinical judgement and NSIs. This approach is advocated by the authors of the SNCT and the expectations within the developing workforce safeguards document (NHSI, 2018).On completion of the audit. The Deputy Chief Nurse, met individually with the participating areas and reviewed the output in conjunction with Nurse Sensitive indicators (NSIs) and applied professional judgement to the WTE output. This resulted in one of four recommendations for the ward. • Uplift in WTE • Reduction in WTE • No change to establishment • Additional action [skill mix review/audit oversight]
3.1	Nurse Sensitive indicators Within the review with the Deputy Chief Nurse (DCN), each ward's NSI were reviewed to understand if current ward provision is providing consistent and safe care. Areas where there are escalating patient harms may be indicative of a substandard ward establishment. Trust wide NSI are not currently escalating as indicated in the IQPR, however the data below was reviewed at an individual ward level. An example can be found in Appendix 2.  Chart 2a Inpatient falls SPC  Chart 2b Hospital acquired pressure ulcers.

3.2	Care Hours Per Patient Day (CHPPD) CHPPD is benching marking data that allows comparison of the average amount of nursing hours available to a patient both nationally and also across peer organisations. Despite the uplifts to nursing received in 2021 and 2023 WSFT inpatient nursing provision tracks at the lowest quartile nationally and also among peer organisations. Model hospital data illustrates this below (chart 3). This would suggest that WSFT is not overly established with nursing hours despite investment in the last 4 years.  Chart 3. Model Hospital data: CHPPD
4.	**Output**
4.1	A full summary of each ward review can be found in appendix 1. The individual ward summary illustrates current WTE of both nursing and support staff and the output of the last two audits. The SNCT now illustrates the expected establishment two ways. 1) If enhanced care/1:1 care was to be included in establishment setting. 2) If enhanced care/1:1 care was not included in current establishment setting. This is current practice. A summary of each ward's review includes bed base, geography and nuanced ward activity. This triangulated with the professional judgement of senior nurses and patient outcomes forms the basis of the recommendation. To clarify the output of the SNCT tool is not the answer to establishment levels in isolation and should be considered with patient outcomes and professional judgment in equal measure. The overall output of this audit and subsequent recommendations are illustrated below. 2 wards identified to potentially reduce budgeted establishments. • F8: 2.56 WTE Registered nursing = £95,872 [once ward reconfiguration project is complete] • F12: 2.56 WTE Nursing assistants: Already removed from budgets. 3 wards have been identified as requiring another round of audit to fully confirm any changes . • F7 • G1 • F5 12 areas no change to current establishment planned.
5	**Next steps**
5.1	• Share outcomes with clinical teams to inform budget setting for 25/26 • Plan next round of SNCT audit for Q4
6.	**Recommendations**
	• Amend budget for 25/26 for the area identified as requiring change, in time for budget setting. • Winter SNCT to be planned for January 2025 • Continue to monitor NSI through regular staffing board paper

Appendix 1: Triangulation and recommendations

i) Acute assessment unit

This emergency medical admissions unit consists of 23 assessment spaces, including 5 high dependency bays where cardiac monitoring can occur. This area receives patients directly from general practice referrals and also from the emergency department. This is a rapid assessment area that ensures patients have their first assessment by the medial team prior to admission to the main inpatient wards. Also, within the AAU there is an ambulatory emergency care (AEC) service. This area is comprised of a waiting area, 'fit to sit' reclining chairs and assessment areas. Staffing for this area was removed from the WTE to ensure trollied area was only included in the SNCT comparison. AAU consistently staffs an additional 6-8 escalation beds are overnight which is not included in budget.

The SNCT applies a higher multiplier for assessment units in recognition of the acute nature of presenting patients and the higher patient turnover of such an area. For the purpose of assessing the assessment beds the staff required for ESDEC has been removed. The SNCT suggests a marginal over establishment of 1.2 WTE suggesting that the current establishment is roughly equal to the needs of the department. On review of expected acuity split there is less 1A than expected [those patients that are acutely unwell], this may be due to protracted LOS in ED or possible overscoring.

				February/March 2024				July / August 2024				Difference to current budget (not including 1:1 care)	Difference to current budget if (1:1 care included)
				Includes provision for staffing for 1-1		Provision for staffing for 1-1 seperately		Includes provision for staffing for 1-1		Provision for staffing for 1-1 seperately			
Wards	RN	NA	Budget at 2024	FTE	CHPDD	FTE	CHPDD	FTE	CHPDD	FTE	CHPDD		
AAU*	20.5	19.2	39.8	30.5	5.68	29.51	5.58	38.6	5.41	38.6	5.35	1.2	1.2

Recommendation: No change to current establishment. Split out escalation roster to ensure overfill is not masking fill rates Limit next audit to Ward manager, Matron and 1 x B6 due to some inconsistent data results.

ii) Ward F3 Trauma and orthopaedics

F3 is a Trauma & Orthopaedic ward with thirty-four beds within its footprint: consisting of five six bedded bays and three additional side rooms. Additional ward activity includes emergency ENT assessment and a trauma assessment room. F3 also specialises in the care of spinal injury patients. The ward team also deliver a cervical collar washing service twice a week that requires a bed and two trained staff.

In April a Nursing assistant was removed from each long day at budget setting in April 2024. This was removed as the ward worked consistently without the 6th NA and were able to maintain safe provision of care. There has been no increase in harms since April on review. While the ward is currently providing a good level of care including a leading provider of neck of femur fracture care. The ward manager feels that any additional staff would not be

beneficial and likely be used to support other areas to mitigate risk. There is a significant difference with winter and summer audit data, so another audit would be required to assess need with full confidence.

Wards	RN	NA	Budget at 2024	February/March 2024				July / August 2024				Difference to current budget (not including 1:1 care)	Difference to current budget if (1:1 care included)
				Includes provision for staffing for 1-1		Provision for staffing for 1-1 seperately		Includes provision for staffing for 1-1		Provision for staffing for 1-1 seperately			
				FTE	CHPDD	FTE	CHPDD	FTE	CHPDD	FTE	CHPDD		
F3	21.8	23.5	45.3	43.6	7.02	39.2	6.3	50.16	6.48	49.95	6.45	-4.6	-4.8

Recommendation: No change to current establishment, third review in Q3/4 may to fully inform any changes/uplift in establishment.

iii) Ward F4 elective Surgery

F4 is a twenty-five bedded elective ward for a number of specialities including orthopaedics, ENT, general surgery, urology and gynaecology. Staffing levels are matched to elective activity, which often reduces at weekends. Staffing can vary depending on list activity and this is reduced when needed to ensure appropriate staffing to match activity. SNCT suggest accurate data collection and expectation of patient acuity.

SNCT suggest and opportunity to reduce staffing by 3.3 WTE. However, the SNCT does not capture the high turnover and admission and discharge within this area. The ward can often admit/discharge 10-17 patients per day. This is intensive nursing need. The ward has already adjusted skill mix to utilise Nursing associates where possible.

Wards	RN	NA	Budget at 2024	February/March 2024				July / August 2024				Difference to current budget (not including 1:1 care)	Difference to current budget if (1:1 care included)
				Includes provision for staffing for 1-1		Provision for staffing for 1-1 seperately		Includes provision for staffing for 1-1		Provision for staffing for 1-1 seperately			
				FTE	CHPDD	FTE	CHPDD	FTE	CHPDD	FTE	CHPDD		
F4	13.1	9.8	22.9	16.7	4.26	16.68	4.26	19.6	4.73	19.6	4.73	3.3	3.3

Recommendation: No change to establishment

iv) Ward F5 (elective and emergency surgery)

F5 is a thirty-three bedded surgical ward, five bays of six beds and three side rooms, which specialises in elective major bowel surgery, urology and major abdominal surgery. The ward also houses a same day emergency care (SDEC) service which includes a waiting room and additional bay of up to 6 patients. The waiting room and arrivals to the ward are assessed and cared for by the ward staff. This activity would not be captured in the SNCT as this only accounts for inpatient beds. The SNCT suggests that an opportunity to reduce staffing by 8.1 WTE, despite removing WTE required for SDEC.

Professional judgement suggests that this would be too high and the SNCT doesn't pick up the additional activity. However, a smaller reduction possibly 1RN per day may be possible.

Wards	RN	NA	Budget at 2024	February/March 2024				July / August 2024				Difference to current budget (not including 1:1 care)	Difference to current budget if (1:1 care included)
				Includes provision for staffing for 1-1		Provision for staffing for 1-1 seperately		Includes provision for staffing for 1-1		Provision for staffing for 1-1 seperately			
				FTE	CHPDD	FTE	CHPDD	FTE	CHPDD	FTE	CHPDD		
F5*	23.0	20.4	40.7	31.4	4.91	30.81	4.82	32.63	4.52	32.63	4.52	8.1	8.1

*Adjusted as additional staff/activity within ledger (SDEC staffing removed)

Recommendation. Potential opportunity to reduce staffing establishment. will need another round of audit to confirm decision making in Q4.

v) Ward F6 (Emergency Surgery)

F6 is a thirty-three bedded emergency surgical ward, compromising of three, six-bedded bays and three side rooms and accepts emergency general surgery patients. High acuity ward with a higher degree of 1A patients as expected. SNCT is a far reflection of ward activity, although possibly would expect a higher number of 1C patients that recorded. On review of patient harms, there is no increasing picture suggesting current establishment is meeting needs. SNCT suggests a small reduction in WTE, equating to a single shift.

Wards	RN	NA	Budget at 2024	February/March 2024				July / August 2024				Difference to current budget (not including 1:1 care)	Difference to current budget if (1:1 care included)
				Includes provision for staffing for 1-1		Provision for staffing for 1-1 seperately		Includes provision for staffing for 1-1		Provision for staffing for 1-1 seperately			
				FTE	CHPDD	FTE	CHPDD	FTE	CHPDD	FTE	CHPDD		
F6	21.6	20.4	42.0	40.9	5.44	39.09	5.2	39.18	5.04	38.96	5.01	3.1	2.8

Recommendation: No change to establishment. Currently meeting needs of the patient group

vi) Ward F7 (short stay emergency medicine)

F7 is a short stay medical ward with an intended length of stay (LOS) for up to seventy-two hrs. It has a total of thirty-four beds; there are five bays with six beds in each bay and there are four side rooms. Historically there has been a higher WTE on this area than a general medical ward in recognition of the high turnover and short stay nature of this ward. However, in the current climate the ward has not been able to fully function with the high turnover and short LOS model. There is a higher proportion of 1C patients, often in the acute phase of delirium or sepsis requiring enhanced observation, this is evidenced within the difference of 1.92 WTE if funding for enhanced care was provided. Work within the UEC pathway should aim to return this unit to a high turnover short stay environment [which is not reflected in this round of audit].

Wards	RN	NA	Budget at 2024	February/March 2024				July / August 2024				Difference to current budget (not including 1:1 care)	Difference to current budget if (1:1 care included)
				Includes provision for staffing for 1-1		Provision for staffing for 1-1 seperately		Includes provision for staffing for 1-1		Provision for staffing for 1-1 seperately			
				FTE	CHPDD	FTE	CHPDD	FTE	CHPDD	FTE	CHPDD		
F7	24.9	25.8	50.7	50.5	6.3	49.64	6.2	47.2	6.1	45.8	5.92	4.9	3.5

Recommendation: No change to establishment: To trial period of reduced NA at night until next audit in Q4 to assess quality impact. Possible reduction opportunity after results of Q4.

vii) Ward F8 (renal)

F8 is a twenty-seven-bed general medical ward with a renal focus. In April 2023 an uplift in registered nurse's numbers was implemented to support a service improvement intention to increase ITU step down's. This would have increased ward acuity and nursing task time. During the last year the frequency of this intention has been minimal and not impacting on the nursing workload. On review of audit data there is regular use of enhanced care/1-1. This is reflected in the difference in output if enhanced care was included in budget setting. As the increase in acuity has not been realised in the past two audits, there is an opportunity to reduce establishment to previous levels. However, this ward may feature in the ward reconfiguration program and confirmation of a reduced establishment can only be made once this has been finalised. For example an increased footprint will negate the argument for reducing nursing numbers.

Wards	RN	NA	Budget at 2024	February/March 2024				July / August 2024				Difference to current budget (not including 1:1 care)	Difference to current budget if (1:1 care included)
				Includes provision for staffing for 1-1		Provision for staffing for 1-1 seperately		Includes provision for staffing for 1-1		Provision for staffing for 1-1 seperately			
				FTE	CHPDD	FTE	CHPDD	FTE	CHPDD	FTE	CHPDD		
F8	20.7	23.4	44.1	40.1	6.28	39.08	6.12	40.08	6.21	36.87	5.71	7.2	4.0

Recommendation: Reduction in 1 x RN long day 7 days a week. (2.58 WTE) if no impact of ward reconfiguration.
Cost saving: **£95,872**

viii) F12 (isolation)

F12 is an eight bedded isolation ward. All beds are single side rooms with ensuite facilities. It is well understood in nursing literature that nursing an increased number of single rooms decreases efficiency and increases nursing workload, as patients are not able to be observed in a single environment like a multiple bedded bay for example. An uplift to this ward was implemented in April 2023 to increase the NA by 1 LD, this was agreed to provide

increase resilience to the ward as any short notice absence. On review there is potential to reduce this as the NA support has not been utilised./ On review of the budget this has already been removed from the budget in 24/25. The SNCT supports this.

Wards	RN	NA	Budget at 2024	February/March 2024				July / August 2024				Difference to current budget (not including 1:1 care)	Difference to current budget if (1:1 care included)
				Includes provision for staffing for 1-1		Provision for staffing for 1-1 seperately		Includes provision for staffing for 1-1		Provision for staffing for 1-1 seperately			
				FTE	CHPDD	FTE	CHPDD	FTE	CHPDD	FTE	CHPDD		
F12 (single s/r calc)	11.9	5.2	17.1	11.9	6.25	11.45	6.03	14.94	7.8	14.94	7.8	2.2	2.2

Recommendation: No further change to establishment.

ix) Ward F14 (Gynaecology)

F14 is a gynaecology ward that has eight beds, compromising of a four bedded bay, a two bedded bay and two side rooms. Additional activity within the ward includes ward attenders to various ward-based clinics like the early pregnancy assessment (EPU), termination of pregnancy (TOP) clinic and emergency assessment of patients referred from the community or the emergency department. These ward attenders can present throughout the twenty-four-hour period.

The SNCT output advises a reduction in staffing however, it should be noted that this ward would fall into the 'small ward' category and its nursing need may not be fully captured in the SNCT. This is one of the weaknesses within the SNCT. Any further reduction in nursing would result in lone working or inability to run clinic services out of the ward.

Wards	RN	NA	Budget at 2024	February/March 2024				July / August 2024				Difference to current budget (not including 1:1 care)	Difference to current budget if (1:1 care included)
				Includes provision for staffing for 1-1		Provision for staffing for 1-1 seperately		Includes provision for staffing for 1-1		Provision for staffing for 1-1 seperately			
F14*	8.1	2.6	10.6	8.5	4.34	8.52	4.34	7.18	4.48	7.18	4.48	3.5	3.5

Recommendation: No change to establishment

x) Ward G1 (acute oncology)

G1 is a ten bedded medical oncology ward comprised of all single rooms, and one additional room ring fenced for assessment of acute oncology/haematology admissions. This is occasionally used as surge capacity if required. The staff rotate between the day unit and the mobile oncology unit. The WTE for these additional areas have been removed so the audit WTE comparison is based on ward provision only. The SNCT suggests a reduction of 2.4 WTE. Discussions regarding removal of 1 RN were had with clinical team. The average fill rate for this area is 71% suggesting that the fourth RN is seldom filled, and patient harms are not adversely affected. This is often mitigated by moving staff from the day unit. Concerns raised from the clinical team regarding the changing landscape of acute oncology services. Due to the increase in increased immunotherapy provision and the shift to managing more complex side effects it was felt that the reduction of staff in this area would not be appropriate at this time.

				February/March 2024				July / August 2024				Difference to current budget (not including 1:1 care)	Difference to current budget if (1:1 care included)
				Includes provision for staffing for 1-1		Provision for staffing for 1-1 seperately		Includes provision for staffing for 1-1		Provision for staffing for 1-1 seperately			
Wards	RN	NA	Budget at 2024	FTE	CHPDD	FTE	CHPDD	FTE	CHPDD	FTE	CHPDD		
G1* (single s/r calc)	15.5	5.2	20.6	18.9	6.59	18.27	6.37	23.76	8.23	22.97	7.96	-2.4	-3.2

Recommendation: No change to current establishment, monitor fill rate over next 6 months and ward acuity. Revisit reduction next audit.

xi) Ward G3 (gen med)

G3 is a thirty-three bedded general medical ward with a focus of diabetes and endocrinology ward. There SNCT suggest that the current establishment is very close to SNCT recommendations, if not including 1:1 care provision. On review of the audit data, it is consistent with the ward profile, suggesting reliability of audit date is good.

				February/March 2024				July / August 2024				Difference to current budget (not including 1:1 care)	Difference to current budget if (1:1 care included)
				Includes provision for staffing for 1-1		Provision for staffing for 1-1 seperately		Includes provision for staffing for 1-1		Provision for staffing for 1-1 seperately			
Wards	RN	NA	Budget at 2024	FTE	CHPDD	FTE	CHPDD	FTE	CHPDD	FTE	CHPDD		
G3	20.7	22.8	43.5	53.2	6.82	44.56	5.72	48.65	6.61	44.23	6.01	-0.7	-5.2

Recommendation: No Change to current establishment. Consider overall usage of 1:1 provision in next 6 months to see if a cost saving to temporary staffing spend would be possible if increases to budget was made to accommodate this consistent need.

xii) Ward G4 (gen med)

G4 is a thirty-two bedded medical ward that compromises of five, six bedded bays and two side rooms. The patient profile here is predominately care of the elderly with a high number of patients that are cognitively impaired, requiring complex discharge process and high levels of physical care needs. The SNCT suggests that the ward is over established by 2.2 WTE. On review of the audit data there is a high proportion of patients needing 1:1 or enhanced supervision. If this was to be included in the budget the ward would be 5.5 WTE under establishment

Wards	RN	NA	Budget at 2024	February/March 2024				July / August 2024				Difference to current budget (not including 1:1 care)	Difference to current budget if (1:1 care included)
				Includes provision for staffing for 1-1		Provision for staffing for 1-1 seperately		Includes provision for staffing for 1-1		Provision for staffing for 1-1 seperately			
				FTE	CHPDD	FTE	CHPDD	FTE	CHPDD	FTE	CHPDD		
G4	20.7	23.3	44.0	55.0	7.49	45.08	6.14	49.49	7.68	41.8	6.49	2.2	-5.5

Recommendation: No Change to current establishment. Consider overall usage of 1:1 provision in next 6 months to see if a cost saving to temporary staffing spend would be possible if increases to budget was made to accommodate this consistent need.

xiii) Ward G5 (gen med)

G5 is an acute general medical ward with a gastroenterology focus, containing thirty-three beds made up of five, six bedded bays and three side rooms for patients. There are many complex patients on this ward due to the nature of the speciality also including patients requiring support with detox pathway. SNCT suggests that the ward is understaffed by 4.9 WTE with a small increase when considering 1:1 care. This would equate to approximately and additional shift day and night. On review with the clinical team, when planned staffing is achieved safe levels of staffing are achieved. The clinical team felt no additional resource is required other than filling current planned staffing.

Wards	RN	NA	Budget at 2024	February/March 2024				July / August 2024				Difference to current budget (not including 1:1 care)	Difference to current budget if (1:1 care included)
				Includes provision for staffing for 1-1		Provision for staffing for 1-1 seperately		Includes provision for staffing for 1-1		Provision for staffing for 1-1 seperately			
				FTE	CHPDD	FTE	CHPDD	FTE	CHPDD	FTE	CHPDD		
G5	20.0	24.1	44.1	51.4	6.58	51.23	6.55	49.55	6.31	49.01	6.24	-4.9	-5.5

Recommendation: No change to current establishment. Review next round of audit to assess if SNCT output is consistently high.

xiv) Ward G8 (stroke)

G8 is a thirty bedded Acute Stroke Unit compromising of twenty-four stroke beds and six general medicine beds. Within the allocated stroke beds there and four hyper acute stroke beds. Staffing requirements for stroke units are informed by the British Association of Stroke Physician (BASP) standards recognising the intensive nursing and patient care required in both the acute phase of a stroke and the subsequent rehabilitation phase. G8 received significant funding in April 2021(£217,875.63) to uplift staffing to better meet the BASP standards. While the current planned staffing and skill mix is not fully achieving these standards the output of SNCT suggests that the current provision is meeting the needs of the patient group. It is important to note that during this audit there was a period of reduced occupancy due a covid outbreak, however the previous audit had a similar output.

				February/March 2024				July / August 2024				Difference to current budget (not including 1:1 care)	Difference to current budget if (1:1 care included)
				Includes provision for staffing for 1-1		Provision for staffing for 1-1 seperately		Includes provision for staffing for 1-1		Provision for staffing for 1-1 seperately			
Wards	RN	NA	Budget at 2024	FTE	CHPDD	FTE	CHPDD	FTE	CHPDD	FTE	CHPDD		
G8	31.0	20.7	51.7	53.7	8.33	50.43	7.83	54.48	8.43	51.06	7.9	0.6	-2.8

Recommendation: No change to current establishment: Review average output at next audit to fully assess need acknowledging the similar outputs for previous two audits but the low bed occupancy in this round.

xv) Cardiac Centre

The cardiac centre comprises of, fifteen cardiac inpatient beds, seven Coronary Care Unit (CCU) beds (four beds in the bay and three side rooms). These beds are designated to patients with acute cardiac issues, who require high dependency nursing and an increase in nurse-to-patient ratio. In addition, the ward has the ability to provide remote cardiac monitoring (telemetry) to 20 patients that may be cared for anywhere within WSH. This is roughly 10 patients per day around the organisation plus remote monitoring of 5 HDU/monitoring beds in AAU. Patients on remote monitoring are reviewed every 4 hours by a registered nurses from within the ward establishment. This additional remote work is not reflected in the SNCT audit. Additional activity captured within the ward includes regular transfers to Papworth as per ACS pathway, supporting cath lab staffing to ensure lists are not cancelled. The SNCT suggest the unit is over established by 4.6 WTE. Given the additional clinical activity described within the unit any reduction would not be recommended at this time.

				February/March 2024				July / August 2024				Difference to current budget (not including 1:1 care)	Difference to current budget if (1:1 care included)
				Includes provision for staffing for 1-1		Provision for staffing for 1-1 seperately		Includes provision for staffing for 1-1		Provision for staffing for 1-1 seperately			
Wards	RN	NA	Budget at 2024	FTE	CHPDD	FTE	CHPDD	FTE	CHPDD	FTE	CHPDD		
Cardiac / G7*	28.3	12.9	41.2	38.0	7.37	37.71	7.31	37.96	7.38	36.67	7.13	4.6	3.3

**cath lab staffing not included in this provision*

Recommendation: No changes to current establishment,

xvi) G9 (respiratory)

Ward G9 is a 27 bedded respiratory medicine ward with a 6 bedded HDU bay provision for the management of acute respiratory failure. The ward layout is larger than the general medical beds as was a new build in 2019. The patient bays are larger and have ensuite facilities in each bay. On review of the audit data appears comparable with the patient demographic identifying a regular through put of level 2 patients, likely those that are in acute respiratory failure and require NIV for example. SNCT is comparably close to current establishment and when considering 1:1 care provision, should be meeting the needs of the department.

				February/March 2024				July / August 2024				Difference to current budget (not including 1:1 care)	Difference to current budget if (1:1 care included)
				Includes provision for staffing for 1-1		Provision for staffing for 1-1 seperately		Includes provision for staffing for 1-1		Provision for staffing for 1-1 seperately			
Wards	RN	NA	Budget at 2024	FTE	CHPDD	FTE	CHPDD	FTE	CHPDD	FTE	CHPDD		
G9	24.8	18.0	42.8	44.5	6.91	43.46	6.75	42.75	6.69	41.11	6.43	1.7	0.0

Recommendations: No change to current establishment

xvii) G10 2021

G10 is a general medical ward that was opened to receive patients in 2021. There has been previous investment in this ward in recognition in the large footprint of the ward, almost double of the standard F and G wards. The large footprint increases inefficiency and also visibility of patients. In times of covid spikes this ward is often dedicated to this patient group due to the beneficial environment of space and bay doors. The ward has seen some increases in falls (Q4, 23/24) and has introduced 'baywatch' QI project, without need for additional staff at times of high enhanced care needs. The SNCT suggests that a large number of patients require enhanced specials. This is 3.5 more WTE than previous audit. Another round of audit would be needed to understand if this was a consistent theme.

				February/March 2024				July / August 2024				Difference to current budget (not including 1:1 care)	Difference to current budget if (1:1 care included)
				Includes provision for staffing for 1-1		Provision for staffing for 1-1 seperately		Includes provision for staffing for 1-1		Provision for staffing for 1-1 seperately			
Wards	RN	NA	Budget at 2024	FTE	CHPDD	FTE	CHPDD	FTE	CHPDD	FTE	CHPDD		
G10	20.7	25.9	46.6	50.2	6.59	44.56	5.86	53.59	7.01	45.02	5.89	1.5	-7.0

Recommendation: No change to current establishment: observe enhanced care needs in next round of audit

xviii) Kings suit & Glastonbury court

These two areas our community assessment beds (CAB). The patient profiles are those are medically optimised and do not need acute care and are either waiting for rehab or onward care setting placement. The SNCT is licenced and validated for acute inpatient so to place any assessment using this tool's output would not be appropriate. However, it is helpful to track the unit's acuity and dependency. By doing this we were able to identify a change in patient dependency in previous audits resulting in an uplift in the past. As pathway one discharges now bypass these areas, the dependency of Rosemary ward increased. The data has not been presented here for the reasons described. However, a formal review was completed with the clinical teams.

Recommendations: No change to establishments

Appendix 2: Ward review example: Summer ’24 Safer Nursing Care Tool ward review Triangulation data

WARD:_____F3_____

Banding	WTE Budget	WTE actuals (including maternity, LTS, secondms)
B7	1	0.80
B6	5.83	5.82
B5	14.98	14.50
B4	1	1
TOTAL REG	22.81	22.12
B3	22.54	21.95
B2	1	1
TOTAL UNREG	23.54	22.95
COMBINED (RN/NA) TOTAL	46.53	45.07

Nurse Sensitive indicators			
	Falls	HAPU	Medication incident
Oct-23	4	1	2
Nov-23	7	2	3
Dec-23	5	2	8
Jan-24	3	2	6
Feb-24	5	3	1
Mar-24	4	1	2
Apr-24	0	2	3
May-24	0	3	2
Jun-24	2	1	0
Jul-24	3	1	2
Aug-24	3	0	3

Comments/Additional activity/ward changes etc
Band 5 Lucy on MAT leave 1.0 WTE due back August 2025. Band 3 Emma on MAT leave 0.77 WTE due back April 2025. Band 3 Gavin long term sick since 12th August, in regular contact. Nov. 23 - 7 falls same patient. Dec/Jan – high medication incidents. Trend noted of prescription errors and TTO incidents e.g – home with tinz and no SPOA completed by DWA. Involved in QI project in discharge process on e-care. Indicator D/C summary completed. Pre discharge check list live on 28th Oct for F3 and G4. Of late new junior Dr’s some prescription errors. Support and education provided. Had band 5 1.0 WTE resignation Friday, TRAC completed Weds. A/W outcome. To raise 0.6 WTE band 2 – covered with Gerry. TRAC completed 4.10.24. A/W outcome.

6.3. Maternity quality safety and performance Board report

Presented by Susan Wilkinson

Public Trust Board Committee	
Report title:	Maternity quality, safety, and performance report
Agenda item:	6.3
Date of the meeting:	29th November 2024
Sponsor/executive lead:	Sue Wilkinson, Executive Chief Nurse Richard Goodwin 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 and Neonatal 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
- Maternity Services Data Set compliance report (annex A)
- Closed Board reports;
    - Perinatal Mortality Report Q2 July-September 2024
    - Maternity and Neonatal Safety Investigations (MNSI) Q2 July-September 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, SBLCBv3, 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) in October 2022, 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 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. To date, four actions are incomplete from the December 2023 visit, however significant progress has been made and the target dates should be met.

Action	Lead	Update	Start date	Target date	RAGB
Digital personalised care plans	Digital Midwife	Content agreed via engagement with service users across LMNS. Paper copy to be launched whilst awaiting digital build.	11/12/23	31/01/25	
Access to specialist training	Outpatient matron	Specialist training funded by LMNS and due for completion 31/01/25	11/12/23	31/01/25	
Information leaflets to be reflective of the 'Rebirth Report' (to use language approved by service	Clinical Effectiveness midwife	Rebirth language adopted by Trust. Updating of leaflets has commenced.	March 2024	31/01/25	

	users/non-blame or judgmental)					
	Introduction of Neonatal supernumerary shift co-ordinator	Head of Midwifery	Currently out to advert.	11/12/23	31/03/25	

The impact of all 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 31st January 2025.

1.2 **Safety Champion feedback**

The Board-level safety champion undertakes a monthly walkabout in the maternity and neonatal unit. Staff can 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 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 was unable to undertake a walkabout in September due to staffing issues, however he visited the Obstetric theatre on the 24th October 2024. Several staff positively engaged with Roger and reports of healthy relationships between theatre staff and maternity staff were given, supported by theatre staff attending the morning and afternoon maternity huddles, embracing open communication between the two areas. In addition to this, collaborative working on quality improvement programmes has fostered a better understanding of each other's roles. Two areas for development were identified. Firstly, the notification of theatre staff of pending grade 2 caesarean sections or forceps deliveries. This will be captured in the QI work regarding transfer to theatres. The second area for development is the preparedness of the non-obstetric theatre for the elective lists regarding the resuscitaire availability and its readiness for use. This has been actioned with the relevant area managers.

In addition to this, both Board Safety Champions (executive and NED) meet with the perinatal leadership team at least bi-monthly 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 all staff accessing the Freedom to Speak up Guardians, Safety Champions, Professional Midwifery/Nursing Advocates, Unit Meetings and 'Safe Space'. In addition to this there are maternity and neonatal staff focus groups, and specific care assistant and support worker forum, which all provide an opportunity to listen to staff.

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

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

SCORE Culture Survey is the final component of the Perinatal Culture & Leadership Programme with the aim of nurturing a positive safety culture, enabling psychologically safe working environments, and building compassionate leadership to make work a better place to be and is included in the requirements for NHS Resolutions Maternity Incentive Scheme. All staff across Women's & Children were invited to participate in the survey with a response rate of 49%. An external culture coach then met with targeted groups to gain further understanding of the survey results. This feedback has been reviewed and the following aspirations identified.

1. Develop a strong and effective communication ethos,
2. Create a strong sense of belonging for all across the service
3. Culture is embedded and prioritised as how we do things here.

The perinatal quadrumvirate and in-house culture coaches are continuing the work regarding our safety culture and aspirations.

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	September Survey returns	% of discharged people provided feedback *	September Very good and good %	October Survey returns	October Very good and good %	% of discharged people provided feedback *
F11	47	13%	93.62%	41	95.12%	12%
Antenatal	4	NA	100%	23	82.61%	NA
Postnatal Community	7	NA	100%	21	90.48%	NA
Labour Suite	13	45%	100%	5	100%	25%
Birthing Unit	6	35%	100%	4	100%	57%
NNU	1	0%	100%	2	100%	10%
Transitional Care	5	NA	100%	1	100%	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 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 increase the number of responses.

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, new Chair has been appointed and commenced in their role in October 2024. The incoming MNVP Chair will be responsible for the re-establishment of the WSFT MNVP.

No compliments were shared with the patient experience team related to maternity and neonatal service in September 2024. In October 2024, two compliments were shared with the patients experience team related to the care received on Midwifery Lead Birthing Unit and community midwifery team for Maternity Service at WSFT.

In September 2024, the Trust received four PALS enquiry for Antenatal Clinic and Jade community midwifery team related to the communication and in October 2024, eight PALS enquiries were received by Maternity Service at WSFT related to communication.

In September 2024 two formal complaint was received related to patient care and values & behaviours and in October 2024, one formal complaint was received. On review of complaints received during this period the main themes were clinical treatment and patient care. The actions relating to complaints are captured on our quarterly review of legal claims, incidents and complaints. In addition to this the more detailed actions are captured on the maternity and neonatal action spreadsheet which is reviewed at monthly departmental quality and safety meetings. Any delays or concerns with completion of actions are escalated to line managers and if not resolved to the safety champions.

1.5 **Reporting and learning from incidents**

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

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

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

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

OCT 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	97.08%	88.5%	90.53%	90.53%	78.44%	95.95%	81.07%	90.53%	96%	95.95%
MCA/MSW	NA	NA	91.89%	91.89%	NA	91.89%	67.5%	91.89%	NA	91.89%
Consultant Obstetrician	81.25%	88.23%	94.12%	94.12%	52.94%	100%	58.82%	NA	100%	NA
Obstetric Registrar	66.67%	75%	91.67%	91.67%	15.38%	100%	33.33%	NA	91%	NA
SHO/Core trainees	N/A	87.5%	100%	100%	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	94.1%	94.1%	NA	NA	NA	NA	NA	NA
Obstetric Anaesthetists	NA	NA	91.7%	91.7%	NA	NA	NA	NA	NA	NA
Neonatal Consultants	NA	NA	NA	87.5%	NA		NA	93.5%	NA	No Data
Neonatal Nurses	NA	NA	86%	86%	NA	95%	NA	96%	NA	95%
Neonatal Doctors	NA	NA	NA	No Data	NA		NA	100%	NA	No Data
ANNP/PA	NA	NA	NA	No Data	NA		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**
2.1	**Maternity Services Data Set (Annex A)** In April 2024, NHS Resolution published year 6 of the Maternity Incentive Scheme which included ten safety actions which Trusts need to embed as evidence of standards for care and services. Safety Action 2 asks Trusts - **Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?** The required measures of compliance are: 2.1 Was your Trust compliant with at least 10 out of 11 MSDS-only Clinical Quality Improvement Metrics (CQIMs) by passing the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2024? 2.2 Did July's 2024 data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. The Trust has received confirmation from NHS England that it has met all the required elements for this safety action.
2.2	**Reports approved by the Improvement Committee** 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 Board sub-committee, the Improvement Committee. The Improvement Committee will provide an overview and assurances to the Trust Board that reports have been approved and any concerns with safety and quality of care or issues that need escalating. Following reports were presented and approved at the Improvement Committee held on the 16th October 2024: • Maternity Claims Scorecard, and Triangulation Quarter 1 23/24 • Maternity Claims Scorecard, Incidents and Complaints Review Quarter 1 23/24
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 Q2 July- September 2024** During the period of 1st July l to 30th September 2024 there were no perinatal deaths in the Trust which required notification to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE). One baby died at another unit and will be reportable by that Trust. During this reporting period there were two Perinatal Mortality Reviews completed using the Perinatal Mortality Review Tool (PMRT). They were approved by the Trust patient safety review panel. Recommendations are being progressed and learning has been shared. All other reporting and completion dates are being met. Parental involvement continues to play a very important part in making improvements to safety and quality.
3.2	**Maternity and Neonatal Safety Investigations (MNSI) Report Q2 July – September 2024** In this period, no mothers or babies have required reporting to the Maternity and Newborn Safety Investigations (MNSI) – formerly Healthcare Safety Investigation Branch (HSIB) – and the Early Notification Scheme (ENS). One report has been completed by MNSI. The findings have been shared with the family, the staff and the wider team members. In this reporting period we have met the requirements as set out in the Maternity Incentive Scheme – safety action 10.
4.	**Next steps**
4.1	Reports will be shared with the external stakeholders as required. Action plans will be monitored and updated accordingly.

Trust Board Committee	
Report title:	**Compliance with Maternity Services Data Set (MSDS) submissions**
Agenda item:	6.3 Maternity Services
Date of the meeting:	29th November 2024
Sponsor/executive lead:	Ravi Ayyamuthu, Interim Medical Director & Maternity and Neonatal Safety Champion Sue Wilkinson, Chief Nurse
Report prepared by:	Andrew Powell, W&C Senior Information Analyst Emma Wright, Digital Midwife Beverley Gordon, Project Midwife Karen Green, Clinical Quality and Governance Matron

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?
In April 2024, NHS Resolution published year 6 of the Maternity Incentive Scheme which included ten safety actions which Trusts need to embed as evidence of standards for care and services. Safety Action 2 asks Trusts - **Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?** The required measures of compliance are: 2.1 Was your Trust compliant with at least 10 out of 11 MSDS-only Clinical Quality Improvement Metrics (CQIMs) by passing the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2024? 2.2 Did July's 2024 data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001) The Trust has received confirmation from NHS England that it has met all the required elements for this safety action – see appendix 1 for full details.
SO WHAT?
A combination of accurate inputting of information into the systems against the requirements for the Maternity Services Data Set and effective management and validation of the data has led to a consistent standard being maintained. The final report has been published on the NHS England scorecard confirming the Trust's compliance.
WHAT NEXT?*)*
Both clinical and information teams will continue to provide and manage Maternity data to the required standards ensuring that input and output is accurate and validated.
Action Required
The Trust is asked to receive this report for information and confirmation of the required standards being met.

Appendix 1

Maternity Services Data Set information for Maternity incentive scheme (CNST) Year 6: Safety Action 2

The table below summarises the number of criteria met by each maternity service provider, by month. For Y6, there are two criteria to meet on MSDS data submission.
This scorecard will be updated and published each month.

The final results for the CNST MIS Y6 SA2 assessment, using July 2024 data, are now available in this scorecard.
As July 2024 is the CNST MIS SA2 assessment month, provisional August figures have not been included to minimise the risk of confusion. Provisional figures will be included again from next month.

Assessment Month: Final data

Organisation Name

WEST SUFFOLK NHS FOUNDATION TRUST

Notes:

All figures are Final and **the CNST MIS Y6 SA2 assessment is on Final July 2024 data**.

Provisional figures will be included again from November, with the publication of final August and provisional September data.

All Provisional figures are subject to change and will be reassessed after the final submission window has closed.

Table colour coding:
GREEN = Both criteria passed
ORANGE = One criterion passed

Organisation Name	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024
WEST SUFFOLK NHS FOUNDATION TRUST	2	2	2	2	2	2

Organisation Name

WEST SUFFOLK NHS FOUNDATION TRUST

Reporting Period

July 2024

NHS England

1.

CQIMApgar

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMApgar	5	155			Passed
CQIMDQ14	170	185	91.9		Passed
CQIMDQ15	165	165	100.0		Passed
CQIMDQ16	155	165	93.9		Passed
CQIMDQ24	155	155	100.0		Passed

CQIMBreastfeeding

Indicator	Numerator	Denominator	Rate	Result
CQIMBreastfeeding	120	170	70.6	Passed
CQIMDQ08	170	170	100.0	Passed
CQIMDQ09	170	185	91.9	Passed

CQIMPPH

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ10	170	185	91.9		Passed
CQIMDQ11	70	170	41.2		Passed
CQIMDQ12	10	170	5.9		Passed
CQIMPPH	10	170		48	Passed

CQIMPreterm

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ09	170	185	91.9		Passed
CQIMDQ22	165	165	100.0		Passed
CQIMDQ23	155	165	93.9		Passed
CQIMPreterm	10	165		66	Passed

CQIMTears

Indicator	Numerator	Denominator	Rate	Rate p/1000	Result
CQIMDQ14	170	185	91.9		Passed
CQIMDQ15	165	165	100.0		Passed
CQIMDQ16	155	165	93.9		Passed
CQIMDQ18	120	165	72.7		Passed
CQIMDQ20	5	115	4.3		Passed
CQIMTears	5	115			Passed

Notes: The most recent reporting period is based on provisional data. Provisional figures are subject to change and will be reassessed after the submission window closes.

CQIMVBAC

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ14	170	185	91.9	Passed
CQIMDQ15	165	165	100.0	Passed
CQIMDQ16	155	165	93.9	Passed
CQIMDQ18	120	165	72.7	Passed
CQIMDQ26	165	165	100.0	Passed
CQIMDQ27	235	245	95.9	Passed
CQIMDQ28	105	235	44.7	Passed
CQIMVBAC	5	10	50.0	Passed

CQIMRobson01

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ30	170	185	91.9	Passed
CQIMDQ31	170	170	100.0	Passed
CQIMDQ32	160	170	94.1	Passed
CQIMDQ33	170	170	100.0	Passed
CQIMDQ34	120	170	70.6	Passed
CQIMDQ36	155	170	91.2	Passed
CQIMDQ37	55	155	35.5	Passed
CQIMDQ38	170	170	100.0	Passed
CQIMDQ39	170	170	100.0	Passed
CQIMRobson01	5	20	25.0	Passed

CQIMRobson02

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson02	15	30	50.0	Passed

CQIMRobson05

Indicator	Numerator	Denominator	Rate	Result
CQIMRobson05	10	15	66.7	Passed

CQIMSmokingBooking

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ03	245	185	132.4	Passed
CQIMDQ04	210	245	85.7	Passed
CQIMDQ05	20	210	9.5	Passed
CQIMSmokingBooking	20	210	9.5	Passed

CQIMSmokingDelivery

Indicator	Numerator	Denominator	Rate	Result
CQIMDQ06	170	170	100.0	Passed
CQIMSmokingDelivery	5	170	2.9	Passed

2.

EthnicityDQ

Indicator	Numerator	Denominator	Rate	Result
EthnicityDQ	235	245	95.9	Passed

Organisation Name

WEST SUFFOLK NHS FOUNDATION TRUST

Reporting Period

July 2024

Measures on this page are for information purposes only, and will not be assessed as part of the Maternity Incentive Scheme.

From the publication of June 2024 data, we introduced a new site code recording data quality measure.
Further Data Quality measures will be added to this page in future in accordance with Maternity and Neonatal Programme priorities.

The most recent reporting period is based on provisional data. Provisional figures are subject to change and will be reassessed after the submission window closes.

Continuity of Carer Data Quality measures

MCoC i

Indicator	Numerator	Denominator	Rate	Result
COC_DQ04	210	210	100.0	Passed

MCoC ii

Indicator	Numerator	Denominator	Rate	Result
COC_DQ05	25	25	100.0	Passed

Birth Site Code Recording Data Quality measure

Actual Site of Delivery recorded

Indicator	Numerator	Denominator	Rate	Result
ActualDeliverySiteDQ	170	170	100.0	Passed

This new metric specifically looks at the Organisation Site Identifier of actual place of delivery (OrgSiteIDActualDelivery) field in the MSD401 Baby's Demographics and Birth Details table. This is the organisation site identifier of the baby's actual place of birth. Site code level data will enable more granular MSDS analysis including de-duplication of birth records, and also assist MBRRACE-UK in producing more effective peer comparison groups that take into account different levels of care.

The data to be recorded in this field should be either a 5-digit alphanumeric ODS code for a valid site that was open and active on the birth date, or one of the three valid default codes for Home (ZZ201), In transit (ZZ777), or Non-NHS organisation (ZZ888). ODS site codes can be found using the ODS Search Portal. This guidance also applies for the other SiteID fields in the MSDS.

The required pass rate for the Birth Site Code Recording Data Quality measure is 90%.

Denominator: All births reported by a trust in the reporting month
Numerator: From the denominator, the number of births where a valid MSD401.OrgSiteIDActualDelivery is recorded

7. GOVERNANCE

7.1. Audit Committee report

For Report

Presented by Michael Parsons and Jonathan Rowell

NHS West Suffolk NHS Foundation Trust

Board assurance committee - Committee Key Issues (CKI) report

Originating Committee: Audit Committee			Date of meeting: 1st October 2024		
Chaired by: Michael Parsons			**Lead Executive Director: Jonathan Rowell**		
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
Progress report on Internal Audit plan 2024/25 (RSM)	Update on delivery of internal audit plan and implementation of recommendations.	Reasonable	The Committee considered two final reports that had been issued, both with positive opinions: Data Security & Protection Toolkit and DBS Checklist. The Committee agreed to vary the audit plan to defer (to later in the year) the divisional governance structure audit, and to bring forward the consultant job planning process audit. The Committee also reviewed progress with implementation of recommendations.	Welcomed ongoing reduction in outstanding audit actions, although requires continuing focus by management to address the overdue actions.	2 -> Management Executive

Originating Committee: Audit Committee			Date of meeting: 1st October 2024		
Chaired by: Michael Parsons			**Lead Executive Director: Jonathan Rowell**		
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
Progress report on Counter Fraud activity (RSM)	Discussion on CF activities, including results from national benchmarking reports.	Substantial	The Committee considered a review of declarations of interest and gifts and hospitality and noted very strong comparative performance in the national fraud benchmarking report on declaration of interests. The relatively low level of fraud referrals at WSFT compared to national benchmarking was discussed. RSM reported that there had been an increase in referrals this year and they were confident staff were aware of the routes to report. In relation to the national fraud best practice report, RSM reassured the Committee that they received strong support for counter fraud activity at WSFT.	NHS Counter Fraud Authority are running a national exercise on procurement around due diligence and contract management.	1. No escalation

Originating Committee: Audit Committee			Date of meeting: 1st October 2024		
Chaired by: Michael Parsons			**Lead Executive Director: Jonathan Rowell**		
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
Single Tender Waivers	Consideration of single tender waivers in 2023/24 and national benchmarking comparisons.	Substantial	Use of waivers at WSFT continues to decline (in number and value) and performs well in relation to national benchmarking.		1. No escalation
Supply Chain Risk	Considered the annual report on risk in WSFT's supply chain.	Reasonable	The Committee welcomed the comprehensive report, and the approach set out for high-risk suppliers. Systematic weakness in financial strength of pharma companies was an issue recognised nationally, with little WSFT could do. The rating for one local supplier would be considered further by Executive Director Finance.		2 -> ED Finance

NHS West Suffolk NHS Foundation Trust

Originating Committee: Audit Committee			Date of meeting: 1st October 2024		
Chaired by: Michael Parsons			**Lead Executive Director: Jonathan Rowell**		
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
Debt write-offs	Consideration of two high-value debt write-offs.	Reasonable	The Committee authorised the write-off of two invoices, amounting to £80k – this would impact the financial system as no bad debt provision had been made for these invoices. Finance would be reviewing processes as both invoices had been managed outside Finance systems / overview.		2 -> ED Finance / COO
Contractual arrangements for Internal Audit / Counter Fraud and External Audit	Considered the performance of current contractors and discussed options for extension / retendering. RSM would be willing to extend their Internal Audit / Counter Fraud contract; however KPMG have declined to continue as External Auditor.	Reasonable	Concern was expressed about the challenge in securing interest in the external audit commission as the big forms (who have the necessary expertise) find consultancy work more profitable than audit work.	Finance to develop proposals. Appointment of new External Auditor is matter for Council of Govenrors.	Proposals for both contracts to be taken through appropriate governance.

**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.

7.2. Board Assurance Framework

For Approval

Presented by Richard Jones

Board of Directors	
Report title:	**Board Assurance Framework**
Agenda item:	7.2
Date of the meeting:	29 November 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 2 Capacity** – reviewed and scores updated by the Chief Operating Officer and presented to MEG and the Insight Committee in September.
- **BAF 3 Collaboration** – reviewed and scored updated by the Executive Director of Strategy and Transformation. The newly reviewed risk was reviewed at MEG in October and was also presented to the Involvement Committee.
- **BAF 5 Digital** – reviewed by the Chief Operating Officer and presented to MEG in October.
- **BAF 6 Estates**- reviewed by the Associate Director of Estates and Facilities to update the assurance levels for controls. The risk was presented to MEG in October
- **BAF 7 Finance** – reviewed by the Finance Director to update the assurance and controls as well as the Executive summary and presented to MEG in October.
- **BAF 9 Patient engagement** - reviewed by the Head of Patient Experience & Engagement and the Executive Chief Nurse to update the actions and the risk rating. The risk was presented to MEG in October and 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:

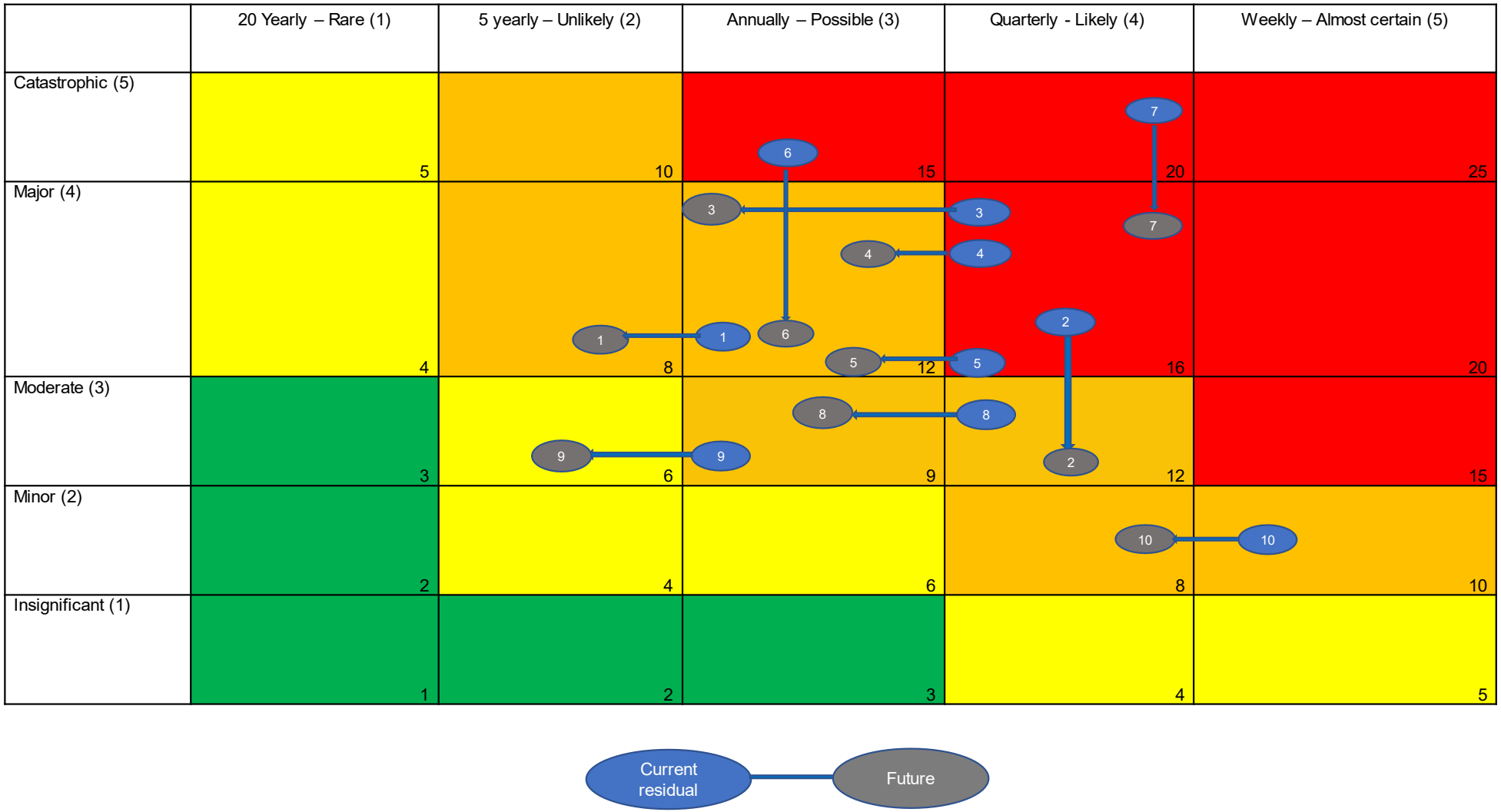
- **Review by the responsible Board committee** to include:
  - MEG review of risks on scheduled basis
  - Review through relevant Board assurance committees to consider assurance on controls and actions (including reflection on the defined **risk appetite).**
- **Schedule review by the Board in early 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	Planned for Dec 24 (Nov '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	Oct '24 (Oct '24)	Open (12)	16	8 (2026)	No	Partial
BAF 4 There is a risk that the Trust does not have the capacity, capability, or commitment to change the way it provides health and care services, which could lead to a failure to respond to changing demand pressures, unsustainable services, and/or not delivering major projects, which would worsen operational pressures, quality of care, and financial viability.	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	Oct '24 (Oct '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	Sep '24 (Sep '24)	Cautious (9)	20	16 (Mar 25)	No	Partial

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	Planned for Dec '24 (Nov '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	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	Planned for Dec '24 (Nov '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

WSFT Board of Directors (Open)	
Report title:	**Governance report**
Agenda item:	7.3
Date of the meeting:	29 November 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 November 2024, as follows:

- Senior Leadership Team report
- Management Executive Group
- Council of Governors report
- Update to Constitution
- Urgent decisions by the Board
- Use of Trust's seal
- Agenda items for next meeting

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

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

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

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

ACTION REQUIRED

The Board is asked to note the content of report and to **APPROVE** the following:

- the Trust's **membership and engagement strategy**
- amendment to the **Trust's Constitution**.

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

Governance Report

1. Senior Leadership Team report

The Senior Leadership Team meet on 18 November. The session received an update on the financial position for month 7 as part of the financial recovery plan.

A summary was provided on the 'First for the Future' strategy refresh, including feedback from the Board's review. Breakout groups were used to consider initial feedback, how to engage staff and presenting a unified voice on our strategic direction. The draft staff briefing pack was also reviewed and feedback captured.

2. Management Executive Group

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

3. Council of Governors report

The Council of Governors met on 19 November 2024. The Council of Governors noted the resignation of Partner Governor, Elspeth Lees. Thanks were recorded for her contribution.

The Council of Governors received the feedback reports from chairs of the **board assurance committees and governor observers**. A summary of the agenda items was received with the committee's key issues and respective governor observers' reports providing highlight updates for the Council. The Council of Governors also received the audit committee's key issues report.

The Governors noted the report from **Nomination Committee** which highlighted the discussions that took place at the meetings on 10 October and 11 November 2024. The terms of office for the NEDs were noted and NED remuneration approved.

The Council of Governors received a report from the Engagement Committee to draw attention to key discussions and outcomes from the committee's workshop and meetings. The Council endorsed the **council of governors' membership and engagement strategy** for Board of Directors for approval (**Annex A**). The Council of Governors approved the terms of reference of the Council of Governors' Membership and Engagement Committee.

The Council of Governors received a report from the **Standards Committee** to note the update on Fit and Proper Persons Test and Disclosure and Barring Service checks. The Council of Governors approved the code of conduct and procedure for managing governor conduct and standards. The Governors noted the Board would further consider the proposed changes to the Trust's constitution. The Council also noted the Governors' work programme 2025.

The Council in the closed meeting received an update on **financial recovery plan**. The Council approved the appointment of Ernst & Young Global Limited (EY) as the Trust's external auditors from 1 April 2025 for a 5-year period.

4. Proposed developments to constitution

The Council of Governors approved amendments to the Trust's Constitution at its meeting in September. Legal advice was sought on the proposed amendments 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 provided in the supporting annexes for the meeting pack (Supporting annexe: *Item 7.3 – WSFT Constitution*)

Constitution - Change to the Council of Governors tenure	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

The Board received and considered this request at its meeting in September but sought assurance on the arrangements to attract different groups to the Governor role as part of the next elections.

Annex B sets out the indicative communication and engagement programme. The Councils' Standards Committee and Membership and Engagement Committee will oversee and develop these activities with the involvement of key system partners and stakeholder networks. Board oversight will be provided through the Involvement Committee which will receive reports on the programme of activities and updates on progress when the campaign starts in 2026.

Recommendation

With this additional assurance on the engagement activities the Board is asked to **APPROVE** the proposed changes which, with the existing Council approval, will then come into effect immediately.

5. Urgent decisions by the Board

Following presentation of the Roche managed service contract to the Board in September, approval was received as an urgent approval of the final contract in October. The approval was received electronically communication with all Board members.

6. Use of Trust Seal

None to report.

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

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

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 - 31st January 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

9. SUPPORTING ANNEXES

To inform

Presented by Jude Chin

Item 2.3 Collaborative Oversight Group

Presented by Sam Tappenden

NHS
Suffolk and North East Essex
Provider Collaborative

Suffolk and North-East Essex Provider Collaborative Workplan 2024-25

Dr Tim Leary FRCA
Interim Chief Medical Officer/ Joint Chair Collaborative Executive Group
East Suffolk and North Essex NHS Foundation Trust

Sam Tappenden
Executive Director of Strategy and Transformation
West Suffolk NHS Foundation Trust

NHS
Suffolk and
North East Essex
Provider Collaborative

Setting priorities

As a collaborative the following five strategic priorities have been agreed by the Collaborative Oversight Group in June 2024:

- Elective recovery
- Clinical services
- Efficiencies at scale
- Digital
- Development

Programmes have been established for each of these priorities and programme SROs agreed as illustrated below. Each programme is:

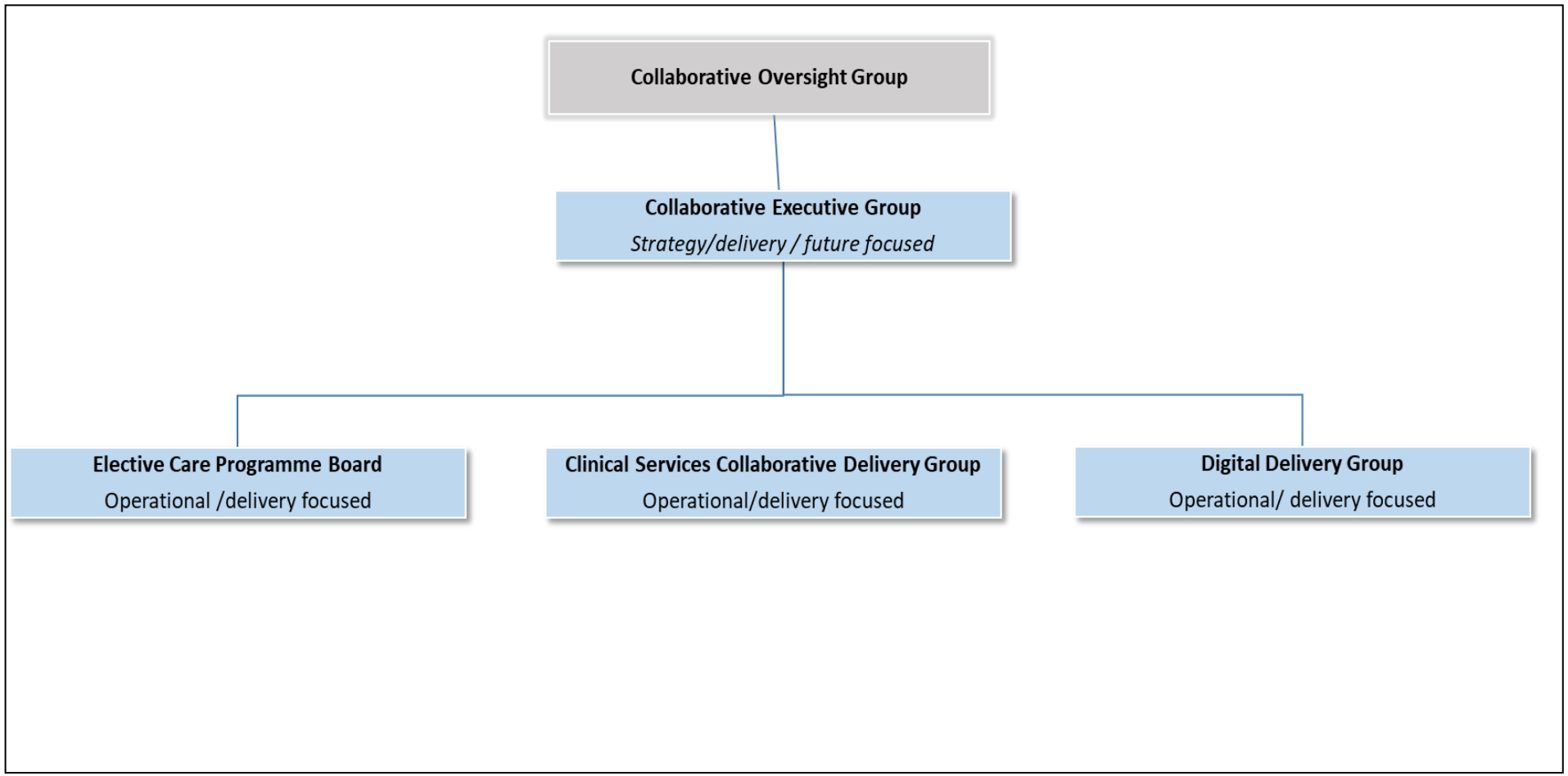
- Reviewing reporting lines
- Establishing delivery groups (where required)
- Implementing RAID (risks, actions, issues and decisions) registers

Programme	Programme SROs
Clinical Services	Chief Medical Director/s WSFT & ESNEFT
Elective Recovery	Director of Operations- Elective Care ESNEFT Deputy Chief Operating Officer WSFT
Efficiencies at Scale	Director of Strategy & Transformation WSFT Director of Strategy, Research and Innovation ESNEFT
Digital	Chief Information Officers WSFT Director of Digital and Logistics ESNEFT
Development	Director of Workforce & Communications WSFT Director of People and Organisational Development ESNEFT

NHS
Suffolk and
North East Essex
Provider Collaborative

Assurance

The boards of ESNEFT and WSFT have appointed a Collaborative Oversight Group, membership includes a non-executive director from each provider to have oversight of all collaborative activity. The below table illustrates the reporting lines established to ensure assurance and delivery of the workplan.



NHS
Suffolk and
North East Essex
Provider Collaborative

Workplan for 2024-25

Key Priorities 2024/25- Clinical Services Programme

2024/25 Work Plan

The Clinical Services Programme works through a structured and methodical process to assess the current state and to identify, prioritise and implement opportunities for improvement to patients' clinical outcome and experience.
Our objectives are to deliver sustainable clinical excellence underpinned by collaboration and partnership across WSFT and ESNEFT. Improvements will be delivered through a combination of system led schemes and specialty clinical networks.

Priority*	Project identified as focus area in 2024/25	Timescale**
Medium	Develop a mechanism for identifying and assessing the outcome for patients who access our services (for example trauma, intensive care, stroke, urology, ophthalmology, ENT)	Q3- Q4 FY 2024/25
High	Agree an approach to embed the voice of clinicians, patients and communities in collaborative service development	Q2-Q3 FY 2024/25
Medium	Collaborate with ICB clinical strategy development	Q2- Q4 FY 2024/25
Medium	To provide executive support to the Unscheduled Care Coordination Hub and access to community-based pathways and services	Ongoing
High	To establish a clinical services collaborative delivery group	Q3 FY 2024/25

**Priority as agreed by the Collaborative Executive Group*
***Timescales show the breadth of specific action delivery dates, timescales may alter depending on additional actions being added to each project*

Process to identify 24/25 priorities:

The clinical services programme SROs and program director undertook a review of:

- Existing collaborative clinical services projects
- Our priorities as a Suffolk and North-East Essex system
- The maturity matrix domains and actions required to mature as a collaborative within the clinical services portfolio

The immediate priority is to focus on specialties for which validated outcome data exists that clinical teams own, trust and accept and to develop a means by which we can identify and measure the outcomes for patients across SNEE for these specialities alongside the establishment of our first collaborative group for clinical services.

Governance:
This domain holds a detailed project workbook that captures milestones and KPIs for the projects listed above. Oversight of delivery will be monitored through the Collaborative Clinical Services Delivery Group which, when established will report into the Collaborative Executive Group.

Key Priorities 2024/25- Elective Recovery Programme

2024/25 Work Plan

As part of the provider collaborative, the Elective Recovery Programme will bring the providers together to address unwarranted variation and inequality in access and experience across the population of Suffolk and North-East Essex. This will focus on populations, improving resilience, and ensuring that these improvements will be delivered through a combination of system-led schemes, specialty clinical networks, and trust-level performance improvement initiatives. This programme will focus on key actions within the National Operational Planning guidance, to provide clear direction and ensure a collaborative system-wide approach to managing elective recovery alongside quick roll out of examples of good practice.

Priority*	Project identified as focus area in 2024/25	Timescale**
High	To deliver the national priorities of eliminating elective care waits of 65 weeks, and 95% of diagnostic tests delivered within 6 weeks (by March 2025).	Q4 FY 2024-25
High	To deliver a transformation and improvement programme to achieve agreed targets in Specialist Advice, DNA rates, Remote Attendances, Reducing Follow Up Attendances, Patient Initiated Follow Up, Capped Theatre Utilisation and BADS Day case Rates.	Q4 FY 2024-25
High	To reduce orthopaedic waiting times through the mobilisation of a surgical hub (ESEOC)	Q3 FY 2024/25 – Q1 FY 2025/26
High	To develop and communicate a SNEE wide access policy	Q2-Q3 FY 2024/25
Medium	To develop and deliver referral optimisation for general surgery, gynaecology and dermatology	Q4 FY 2024/25
Medium	To deliver a programme of speciality and service specific deep dives aligned to GiRFT areas of focus	Ongoing

**Priority as agreed by the Collaborative Executive Group*
***Timescales show the breadth of specific action delivery dates, timescales may alter depending on additional actions being added to each project*

Process to identify 24/25 priorities:
The elective care programme board met on 19th September 2024 to review:

- Existing collaborative elective recovery projects
- Our priorities as a Suffolk and North-East Essex system alongside nationally set targets
- The maturity matrix domains and actions required to mature as a collaborative within the elective recovery portfolio

The immediate priority is delivering our national operating planning targets and ensuring the mobilisation of the elective orthopaedic centre.

Governance:
This domain holds a detailed project workbook that captures milestones and KPIs for the projects listed above. Oversight of delivery will be monitored through the already established Elective Care Programme Board (ECPB) which will undertake a governance review to provide highlight reports into the Collaborative Executive Group for all collaborative activity.

Key Priorities 2024/25- Efficiencies at Scale Programme

2024/25 Work Plan

This programme is focused on the identification of opportunities for the Trusts to work in a more collaborative way to support each other and achieve system-wide efficiencies, productivity improvements and quality benefits thus enabling cost savings to be made through the realisation of economies of scale.

Priority*	Project identified as focus area in 2024/25	Timescale**
High	Corporate Services Review across our providers	Q1 FY 2024/25 – Q2 FY 2025/26
Low	Review the analysis and reconciliation opportunity within ESNEFT & WSFT	Q2-Q3 FY 2024/25
High	Devise a process for embedding provider collaborative activity into provider CIP and business planning	Q2-Q4 2024/25
Medium	Sub-region Medicines Manufacturing centre	TBC

**Priority as agreed by the Collaborative Executive Group*
***Timescales show the breadth of specific action delivery dates, timescales may alter depending on additional actions being added to each project*

Process to identify 24/25 priorities:
The efficiencies at scale programme SROs and program director undertook a review of:

- Existing collaborative CIP projects underway
- Our priorities as a Suffolk and North-East Essex system (need for financial sustainability within the system, delivery against CIP programmes)
- The maturity matrix domains and actions required to mature as a collaborative within the efficiencies at scale portfolio

The immediate priority is to support financial sustainability through a comprehensive review of our corporate services functions.

Governance:
This domain holds a detailed project workbook that captures milestones and KPIs for the projects listed above. Oversight of delivery will be managed through the Collaborative Executive Group with decision making at the Collaborative Oversight Group due to the strategic nature of this programme.

Key Priorities 2024/25- Digital Programme

2024/25 Work Plan

This programme will set the context for how we will work collaboratively in the digital space to deliver benefit to our patients, staff and the wider population alongside ensuring the infrastructure is in place to support collaborative working across the two providers through shared infrastructure, seamless transfer of clinical data and single operating procedures and policies through the DSPT (data security and protection toolkit).

Process to identify 24/25 priorities:

An engagement workshop took place on 16th September 2024 on workplan development.

Focus will be on areas of common infrastructure and on how information is shared (continuing the success of previous sharing).

The group agreed, for the remainder of this financial year, to develop opportunities, create a base line, decide what systems to put in place and their functions and to develop a plan for the next year.

Priority*	Project identified as focus area in 2024/25	Timescale**
High	To develop a collaborative digital delivery group	Q2-Q3 FY 2024/25
High	To organise an initial staff engagement workshop	Q2 FY 2024/25
High	To review the commonality of all third-party digital contracts for opportunities	Q3-Q4 FY 2024/25
High	To review the anchor tenancy model	Q3-Q4 FY 2024/25
High	To identify opportunities (including CIP for 2025-26)	Q4 FY 2024/25

**Priority as agreed by the Collaborative Executive Group*
***Timescales show the breadth of specific action delivery dates, timescales may alter depending on additional actions being added to each project*

Governance:
This domain will hold a detailed project workbook that captures milestones and KPIs for the projects listed above. Oversight of delivery will be monitored through the collaborative digital delivery group (to be established) which will report into the Collaborative Executive Group each month.

Key Priorities 2024/25- Development Programme

2024/25 Work Plan

This programme is focused on developing the maturity of the provider collaborative as an entity and the staff and infrastructures that form the collaborative. This programme will act as an enabler for all programmes of activity within the provider collaborative.

Priority*	Project identified as focus area in 2024/25	Timescale**
High	Enhance comms to governors on the work of the collaborative	Q3 FY 2024/25
Medium	Develop a memorandum of understanding between providers	Q2– Q4 FY 2025/26
High	Appointment of a PMO lead	Q3– Q4 FY 2024/25
High	Expansion of the Workforce Analytics Tool across both providers	Q2-Q3 FY 2024/25
Medium	Organisational Development and a joint coaching proposal to be developed	Q2– Q3 FY 2024/25

**Priority as agreed by the Collaborative Executive Group*
***Timescales show the breadth of specific action delivery dates, timescales may alter depending on additional actions being added to each project*

Process to identify 24/25 priorities:

It has not been possible to convene the programme senior responsible officers for this programme therefore projects have been assigned based on the wider needs of all five programmes within the provider collaborative workplan and further work is required to scope the opportunities present from results of the staff survey in 2023, speak up culture and exploring how we can increase the use of volunteers as we enter the winter period.

Governance:
This domain will hold a detailed project workbook that captures milestones and KPIs for the projects listed above. Oversight of delivery will be managed through the reporting and regular review of the maturity matrix to the Collaborative Executive Group who will provide assurance to the Collaborative Oversight Group.

Plan on a Page – Key objectives

2024/25 Work Plan

CLINICAL SERVICES

- To develop a mechanism for identifying and assessing the outcomes for patients who access our services(for example trauma, intensive care, stroke, urology, ophthalmology and ENT)
- To agree an approach to embed the voice of clinicians, patients and communities in collaborative service development
- To collaborate with ICB clinical strategy development
- To provide executive support to the unscheduled care coordination hub and access to community-based pathways and services
- To establish a clinical services collaborative delivery group

ELECTIVE RECOVERY

- To deliver the national priorities of eliminating elective care waits of 65 weeks, and 95% of diagnostic tests delivered within 6 weeks (by March 2025)
- To deliver a transformation and improvement programme to achieve agreed targets in specialist advice, DNA rates, remote attendances, reducing follow up attendances, patient initiated follow up, capped theatre utilisation and BADS day case rates.
- To reduce orthopaedic waiting times through the mobilisation of a surgical hub (ESEOC)
- To develop and communicate a SNEE wide access policy
- To develop and deliver referral optimisation for general surgery, gynaecology and dermatology
- To deliver a programme of speciality and service specific deep dives aligned to GiRFT areas of focus

DEVELOPMENT

- To enhance comms to the governors on the work of the collaborative
- To develop a memorandum of understanding (MoU) between the providers
- To appoint a PMO lead
- To expand the workforce analytics tool
- To develop a proposal for joint coaching and organisation development

EFFICIENCIES AT SCALE

- To undertake a corporate services review across our providers
- To review the analysis and reconciliation opportunity within ESNEFT & WSFT
- To embed provider collaborative activity into provider CIP and business planning
- To deliver a sub-region medicines manufacturing centre

DIGITAL

- To develop a collaborative digital delivery group
- To organise an initial staff engagement workshop
- To review the commonality of all third-party digital contracts for opportunities
- To review the anchor tenancy model
- To identify opportunities (including CIP for 2025-26)

NHS
Suffolk and
North East Essex
Provider Collaborative

Highlight report- October 2024

Highlight Report – Suffolk and North Essex Provider Collaborative
Reporting Period – October 2024
SRO - Sam Tappenden WSFT/ Dr Shane Gordon ESNEFT

NHS Suffolk and North East Essex Provider Collaborative

Programme Funding (£)	Overall Programme Status	Risk Status	Cost Status	Spend against plan (YTD)
£ N/A	Green	N/A	N/A	N/A

Programme Description

As a collaborative the following five strategic priorities have been agreed; elective recovery, clinical services, efficiencies at scale, digital and development for 2024-25.

Key Achievements this Month

1. On 1 October, the Collaborative Oversight Group approved:
    - The workplan for 2024/25 including timescales and outcomes
    - The development of a proposal for organisational development
    - Directors of Finance to be included to the Group's membership
    - The development of an MoU.
2. The second digital collaborative delivery group meeting was held on 21 October where terms of reference were agreed for the group, the RAID (risks, actions, issues and decision) log was adopted and a shared teams site has been established.
3. Shortlisting for the PMO lead took place and two candidates are to be interviewed for the role
4. Nursing, health and safety and business performance teams met and agreed to work collaboratively on fit-testing and mattress decontamination under the efficiencies at scale programme for 2025-26.
5. A total of 97 WSFT paediatric patients have now been seen by ESNEFT paediatric urology team, a case study is being prepared and the teams are to present to the next Collaborative Oversight Group
6. A temporary interim arrangement has been agreed for 36% of WSFT activity to move to ESEOC whilst ICB led discussions continue on capacity, WSFT staff job plans in place from 21 October.
7. Discussions have commenced on undertaking some collaborative commissioning Intentions in this business planning round for 2025/26

Next Period (action/deliverables)

1. Case studies to be produced for elective recovery, digital and clinical services to support comms and presentations to trust staff updates
2. Interviews for PMO lead on 14 November
3. Paper to be taken to WSFT Management Executive Group on 23 October and ESNEFT Executive Management Committee (EMC) on 6th November on MoU development
4. First draft of MoU to be prepared
5. Timeline to be produced for the development of a finance risk and gain share model to feature within the MoU
6. Clinical Services Programme SRO meeting 4 November
7. Briefing on the provider collaborative for ESNEFT and WSFT governors on 13 November
8. Digital collaborative delivery group 18 November which will include a session on reviewing job roles and titles to support with recruitment.
9. WSFT future hospital planning meeting on 19 November

What is needed from the Collaborative Executive Group

Support for WSFT digital team in gaining access to Atamis (procurement software) contract information to support digital collaboration.

Highlight Report – Suffolk and North Essex Provider Collaborative
Reporting Period – October 2024
SRO - Sam Tappenden WSFT/ Dr Shane Gordon ESNEFT

NHS Suffolk and North East Essex Provider Collaborative

Project status

Priority	Programme	Project	Timeline	RAG
High	Clinical Services	Agree an approach to embed the voice of clinicians, patients and communities in collaborative service development	Q2-Q3 FY 2024/25	
High	Clinical Services	Establish a clinical services collaborative delivery group	Q3 FY 2024/25	
High	Efficiencies at Scale	Devise a process for embedding provider collaborative activity into provider CIP and business planning	Q2-Q4 2024/25	
High	Digital	To develop a collaborative digital delivery group	Q2-Q3 FY 2024/25	
High	Digital	To organise an initial staff engagement workshop	Q2 FY 2024/25	
High	Digital	To review the commonality of all third-party digital contracts for opportunities	Q3-Q4 FY 2024/25	
High	Digital	To identify opportunities (including CIP for 2025-26)	Q4 FY 2024/25	
High	Elective Recovery	To deliver the national priorities of eliminating elective care waits of 65 weeks, and 95% of diagnostic tests delivered within 6 weeks (by March 2025).	Q4 FY 2024-25	
High	Elective Recovery	To deliver a transformation and improvement programme to achieve agreed targets in Specialist Advice, DNA rates, Remote Attendances, Reducing Follow Up Attendances, Patient Initiated Follow Up, Capped Theatre Utilisation and BADS Day case Rates.	Q4 FY 2024-25	
High	Elective Recovery	To develop and communicate a SNEE wide access policy	Q2-Q3 FY 2024/25	
High	Development	Enhance comms to governors on the work of the collaborative	Q3 FY 2024/25	
High	Development	Appointment of a PMO lead	Q3– Q4 FY 2024/25	
High	Development	Expansion of the Workforce Analytics Tool across both providers	Q2-Q3 FY 2024/25	
Medium	Clinical Services	Develop a mechanism for identifying and assessing the outcome for patients who access our services (for example trauma, intensive care, stroke, urology, ophthalmology, ENT)	Q3- Q4 FY 2024/25	
Medium	Clinical Services	Collaborate with ICB clinical strategy development	Q2- Q4 FY 2024/25	
Medium	Clinical Services	To provide executive support to the Unscheduled Care Coordination Hub and access to community-based pathways and services	Ongoing	
Medium	Elective Recovery	To develop and deliver referral optimisation for general surgery, gynaecology and dermatology	Q4 FY 2024/25	

Highlight Report – Suffolk and North Essex Provider Collaborative
Reporting Period – October 2024
SRO - Sam Tappenden WSFT/ Dr Shane Gordon ESNEFT

NHS
Suffolk and North East Essex
Provider Collaborative

Project status

Priority	Programme	Project	Timeline	RAG
Medium	Elective Recovery	To deliver a programme of speciality and service specific deep dives aligned to GiRFT areas of focus	Ongoing	
Medium	Efficiencies at Scale	Sub region medicines manufacturing centre	TBC	
Medium	Development	Develop a memorandum of understanding between providers	Q2– Q4 FY 2025/26	
Low	Efficiencies at Scale	Review the analysis and reconciliation opportunity within ESNEFT & WSFT	Q2-Q3 FY 2024/25	
Medium	Development	Organisational Development and a joint coaching proposal to be developed	Q2– Q3 FY 2024/25	
High	Digital	To review the anchor tenancy model	Q3-Q4 FY 2024/25	
High	Elective Recovery	To reduce orthopaedic waiting times through the mobilisation of a surgical hub (ESEOC)	Q3 FY 2024/25 – Q1 FY 2025/26	

An opportunity to shape the future

Item 3.1 IQPR Full Report

To Note

Presented by Nicola Cottington

Assurance Grid

August 2024		ASSURANCE: Pass (P)	ASSURANCE: Hit and Miss (?)	ASSURANCE: Fail (F) – Not Met
VARIANCE	Special Cause Improvement (H / L)		**INVOLVEMENT** Staff Sickness – Rolling 12months Staff Sickness Turnover	**INSIGHT** RTT 78+ Week Waits **INVOLVEMENT** Appraisal
VARIANCE	Common Cause	**INSIGHT** 4 Hour Breaches Urgent 2 hour response – EIT Total average LOS per patient	Please see Right	**INSIGHT** 12 Hour Breaches 4 Hour Performance Total average occupancy number Respiratory Bay average occupancy number Heart Failure Bay average occupancy number IV Abx Bay average occupancy number Frailty Bay average occupancy number Incomplete 104 Day Waits
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.

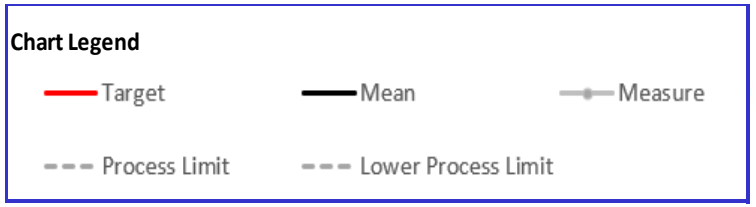
INSIGHT:
Ambulance Handover within 30min
Non-admitted 4 hour performance
12 hour breaches as a percentage of attendances
% patients with no criteria to reside
Total average occupancy percentage
28 Day Faster Diagnosis
Cancer 62 Days Performance
Community Paediatrics RTT Overall 104 Weeks Wait
IMPROVEMENT:
C-Diff
INVOLVEMENT:
Mandatory Training

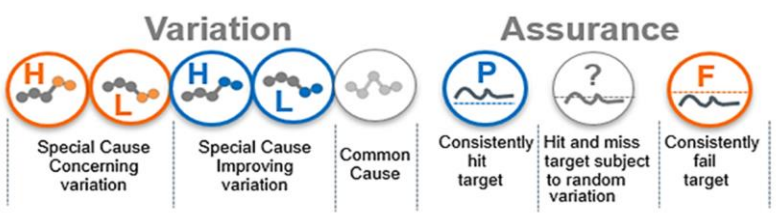
*Cancer data is 1 month behind

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, 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

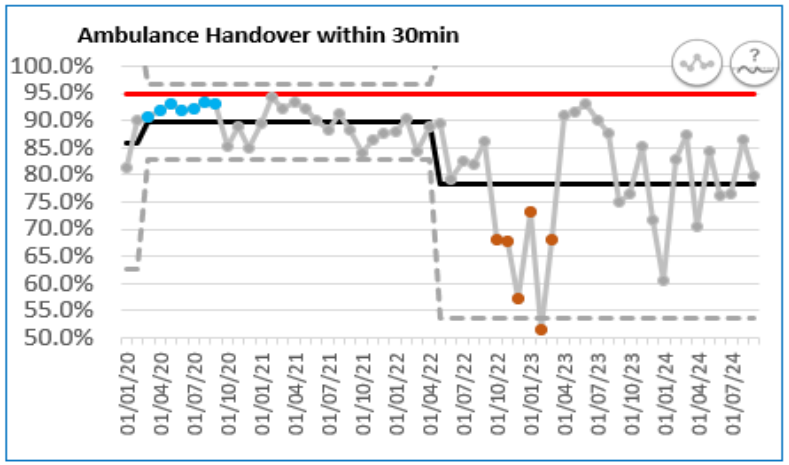


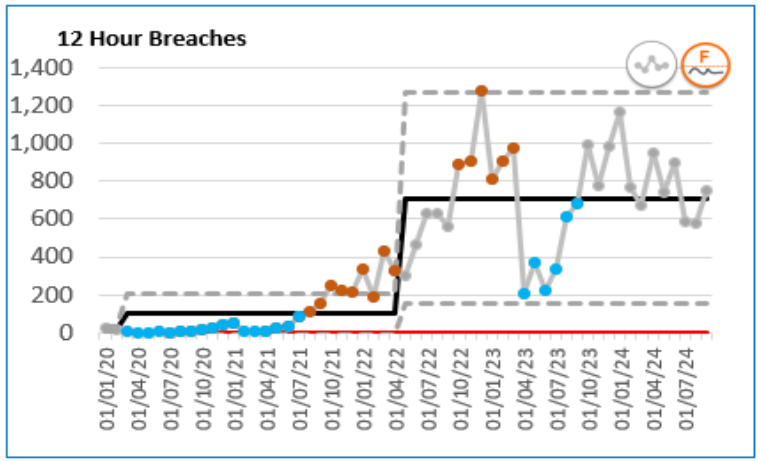


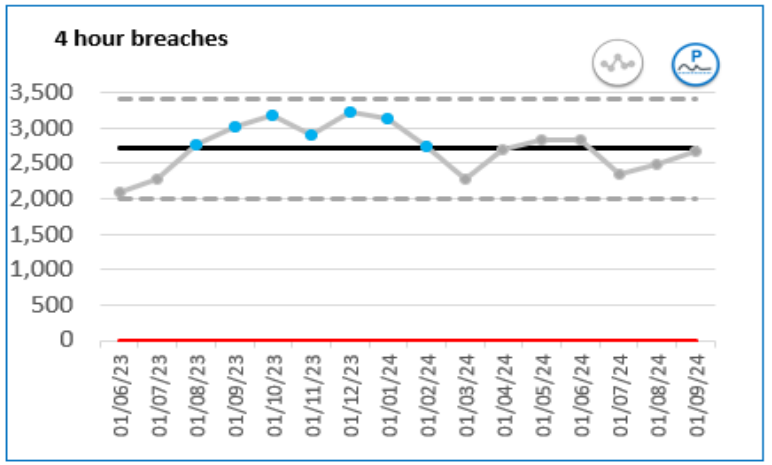
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Ambulance Handover within 30min	Sep 24	79.7%	95.0%			78.3%	53.6%	103.1%
12 Hour Breaches	Sep 24	753	0			711	158	1264
4 hour breaches	Sep 24	2669	0			2717	2011	3422
4 hour performance	Sep 24	67.7%	78.0%			66.3%	56.4%	76.1%
Non-admitted 4 hour performance	Sep 24	77.0%	85.0%			76.1%	64.7%	87.5%
12 hour breaches as a percentage of attendances	Sep 24	9.1%	2.0%			5.3%	1.2%	9.5%
Urgent 2 hour response - EIT	Sep 24	95.4%	70.0%			90.5%	83.0%	98.1%
Criteria to reside (Average without reason to reside) Acute	Sep 24	45	-			56	41	71
**Criteria to reside (Average without reason to reside) Community	Sep 24	33	-			34	30	38
% patients with no criteria to reside (acute)	Sep 24	11.3%	10.0%			12.9%	8.6%	17.2%
Virtual Beds Trajectory	Sep 24	40	40					
Total average occupancy number	Sep 24	24.5	80.0			21.8	14.3	29.2
Total average occupancy percentage	Sep 24	61%	80%			67%	42%	92%
Total bed days on VW	Sep 24	741	-			643	301	986
Total average LOS per patient	Sep 24	7.7	14.0			9.3	4.8	13.7
Respiratory Bay average occupancy number	Sep 24	0.9	8.0			2.5	-0.7	5.7
Heart Failure Bay average occupancy number	Sep 24	3.8	12.0			5.0	0.8	9.2
IV Abx Bay average occupancy number	Sep 24	3.0	6.4			2.4	-0.6	5.3
Frailty Bay average occupancy number	Sep 24	2.2	16.0			2.6	-1.2	6.4

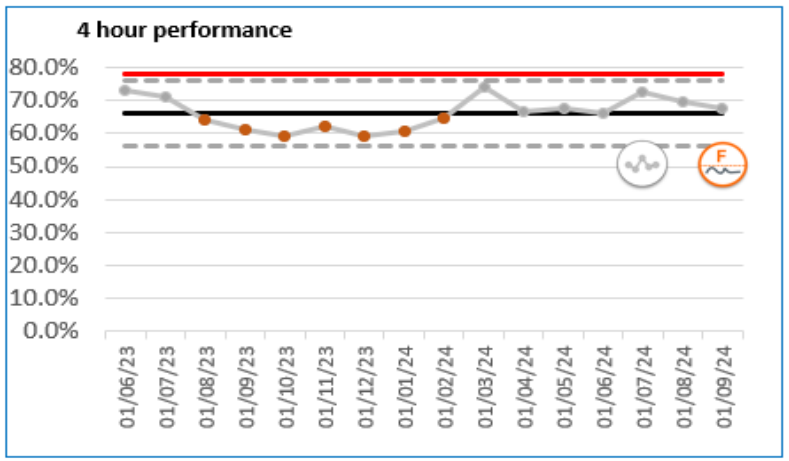
** Figures are for Glastonbury and Newmarket only, data not currently captured at Hazel Court.

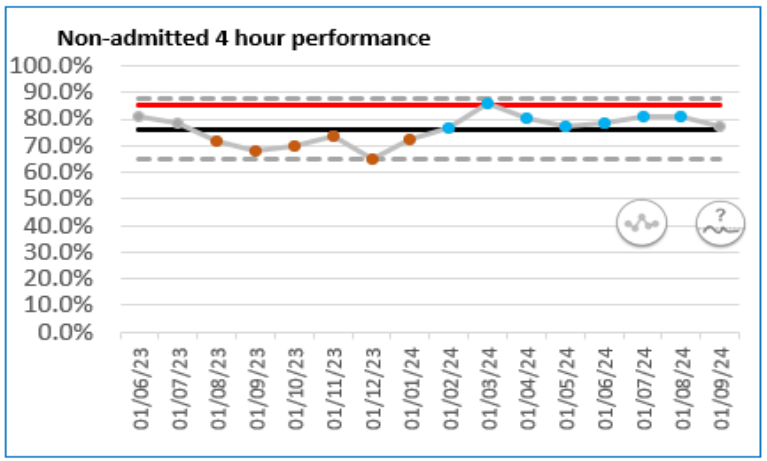
Urgent & Emergency Care: ED 4 Hour Performance

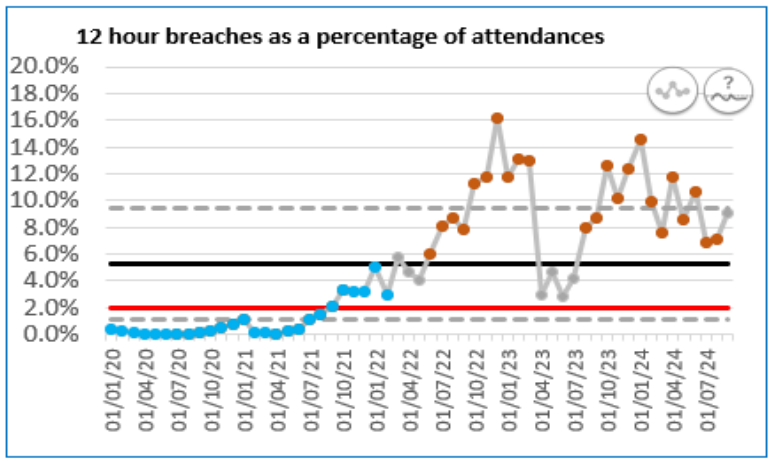


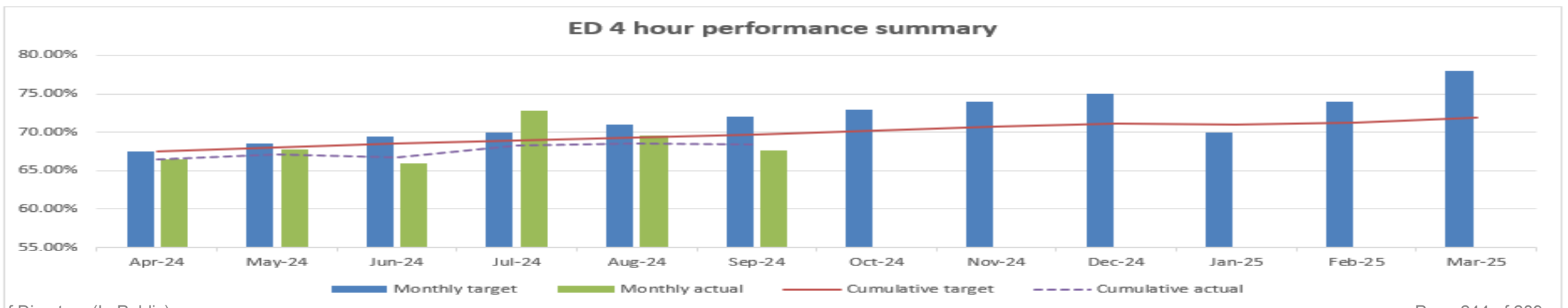












Urgent & Emergency Care

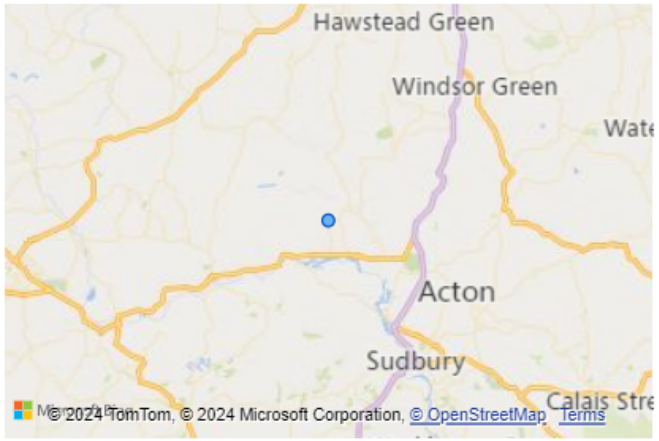
What	So What?	What Next?
No significant change is demonstrated in 30 minute Ambulance handover performance, and this continues to remain a challenge. The factors contributing to this include the number of patients in the Emergency Department with an increased length of stay waiting for a bed, which results 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 September demonstrates no significant change. There with 753 patients breaching, which is 172 more than in August. We continue not to meet this metric. The number of 12 hour breaches as a percentage of attendances shows no significant change, and remains a concern. Non-admitted performance demonstrates no significant change and was 79.37% for the month of September. The Emergency Department 4 hour performance remained below our in-month trajectory, achieving 67.66% on a target of 72%.	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 continues: • 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. • Doctor's shift patterns in relation to activity within the department, have been modelled using the Emergency Care Improvement Support Team (ECIST) Safecare tool. Plans to adjusts cover slightly to support evenings more, proposed adjustments currently being assessed for compliance. **Projects in October '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. One consultant recruited which will enable some additional cover for this. • MECU opened on 14th October, running well with data collected and being analysed weekly. • Cardiology Clinic Hot Slots - appointments reserved for Emergency Department patients in order that they can be discharged with the knowledge they will quickly be assessed by a Cardiologist. • 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. • Focussed work on protecting the Rapid Assessment Triage Area in order that it can function in the mornings.

Community Access Glemsford Surgery

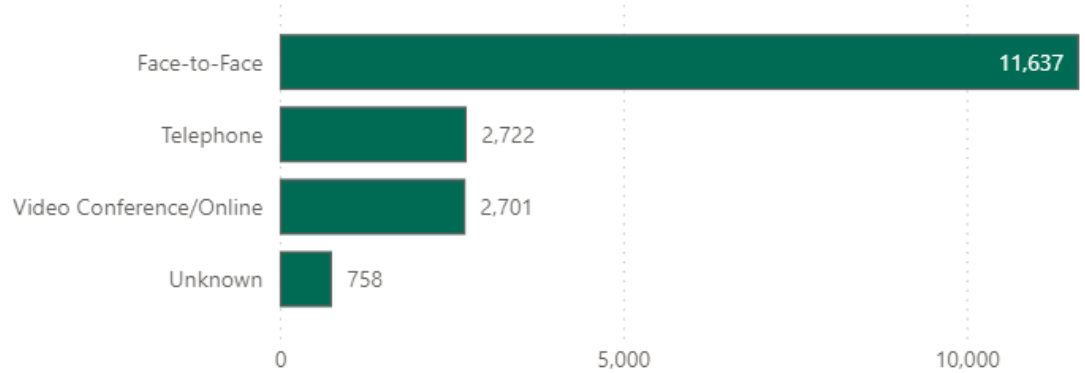
Practice Appointments

Refreshed on 01/10/2024, Data coverage up to 01/08/2024

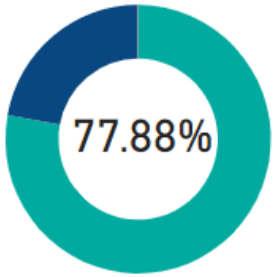
Alliance: All | PCN: WGGL PCN | Practice: Glemsford



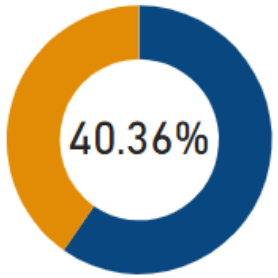
Practice appointments by contact mode



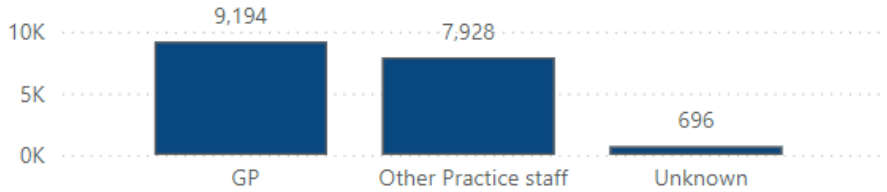
Seen within 2 weeks



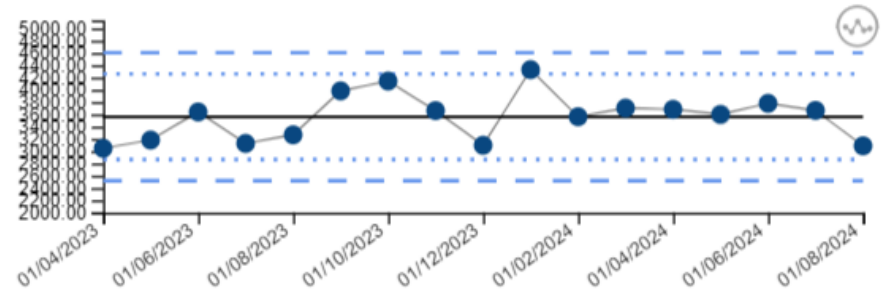
Seen within 48 hours



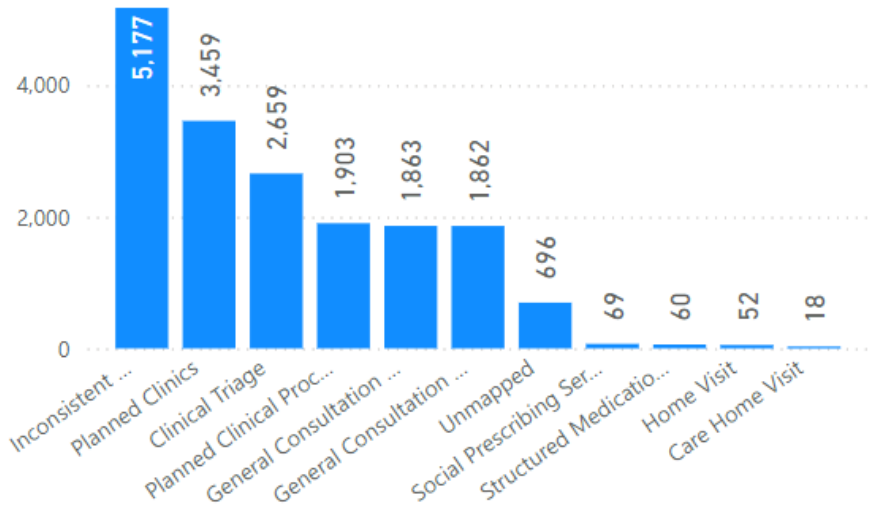
Practice appointments by health care professional type



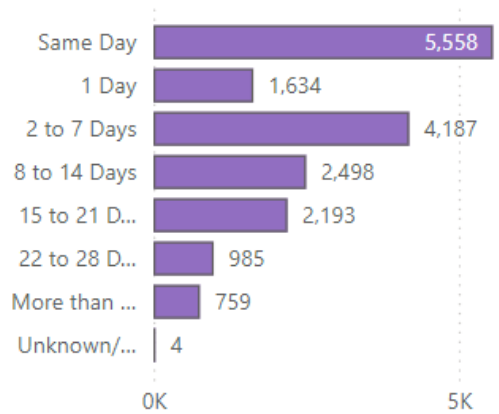
Total appointments by month



Sum of Total Appointments by National Category

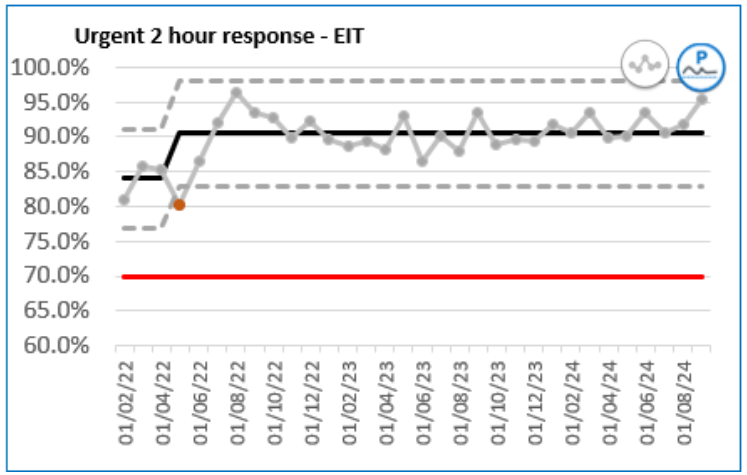


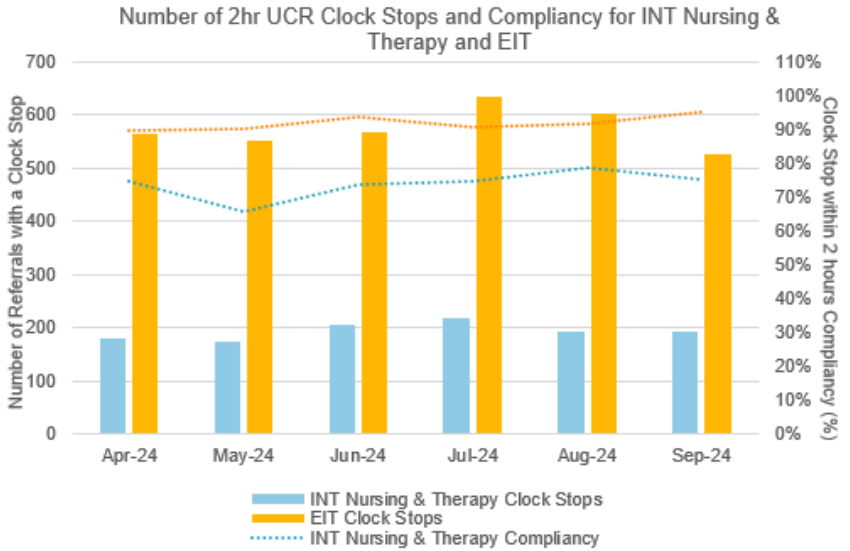
Appointments by wait time

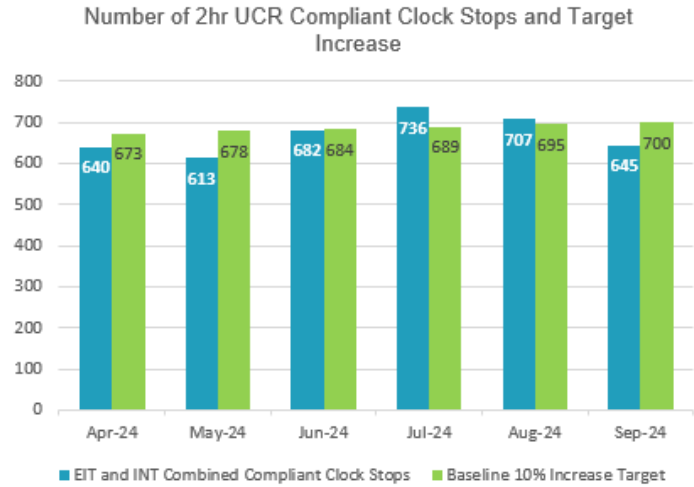


Produced by ICB

Urgent & Emergency Care: UCR







Team	Apr-24				May-24				Jun-24				Jul-24				Aug-24				Sep-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	179	134	45	75%	175	115	60	66%	204	150	54	74%	217	162	55	75%	194	153	41	79%	191	144	47	75%
Total EIT*	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%	525	501	24	95.43%
Combined Total	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%	716	645	71	90.08%

Urgent & Emergency Care: UCR

What

Whilst data shows improved 2-hour performance, the number of referrals accepted reduced significantly from 604 in August, to 525 in September. All referrals via the Care Coordination Centre (CCC) were accepted, Cleric rejections are at a peak. This impacts total number of referrals received.(Ambulance referrals declined are not added to SystmOne due to time and number of organisations involved.) The manual rejection chart, shows 75 Cleric (ambulance) referrals declined due to capacity. This is the highest number of rejections on record (Previous rejections: August 36, July 33, June 17.5, May 18.5).
Overall responsiveness to Emergency Department (ED) referrals remained largely unchanged at 55%. 40% of breaches were as a result of the patient not being ready for assessment. Excluding these, response is at 74%

1. Overall INT (Integrated neighbourhood team) nursing 2 hour compliance remains above KPI of 70% within this 2 teams did drop below 70% compliance (Newmarket and Bury Rural)

2. Combined INT and EIT (Early Intervention Team) compliance fell short of the 10% increased activity trajectory by 55, with fewer referrals for urgent care recorded with clock starts by EIT this month

3. Overall INT 2 week compliancy had a sustained increase at 81% however when considering INT therapy compliancy alone therapy 2 week compliance is 43%

4. INT overall 18 week compliance above KPI of 95%. Within this, Newmarket, Bury Town, Haverhill and Bury Rural therapy were reported to be below KPI for 18 week waiting. The data presented is questioned as zero breaches in Newmarket would = 100%. These separate teams are reporting smaller numbers and therefore produce greater % differences.

So What?

Community response remains responsive to accepted referrals, but fewer patients are being seen. As per Trust guidance the team are focussing on CCC community referrals and ED. There is now limited capacity with current staffing to accept ambulance referrals.

The team have started a pilot working from West Suffolk House, which further impacted productivity due to the separation of ED and community sub-teams, although there are many benefits to being community based.

Team has 1.8 WTE vacancy in registered therapy and 1 band 4 on long- term sick that impacted ED capacity.

1. Sustained Compliance to the 2 hour response activity has been maintained in INTs by cancelling and/or deferring less urgent work – In August up to 22 hours per day of non-urgent care and up to 7 hours per day of 'amber' (visits that are required within 48hr) have been recorded by INTs as cancelled or postponed to prioritise urgent care. Postponing of planned care takes clinical and administrative time, can affect staff morale as they wish to provide best care, and need to manage patient expectation. For EIT with the reduced headcount, UCR demand is now not being fully met or able to meet 10% proposed increase in urgent care activity.

2. The INTs compliancy is measured combining nursing and therapy. There is a workstream with INT managers and Specialists therapists to improve the lower slower therapy response.

3. INT sickness levels have increased which is impacting on compliance

What Next?

Team will undergo consultation to move to West Suffolk House: performance will likely stabilise once teething issues addressed.
Continue focused work with ED to ensure appropriate referrals to release capacity for proactive work. EIT ED staff to base in ED as able
AAU (Acute Assessment Unit) response time data – aiming to record from November.
Working with Integrated Neighbourhood Teams (INTs) and virtual ward on a shared service delivery to further enhance Urgent care Response(UCR).
Daytime support worker consultation planned to merge with responsive team to create larger, more resilient workforce with efficiencies of travel time.

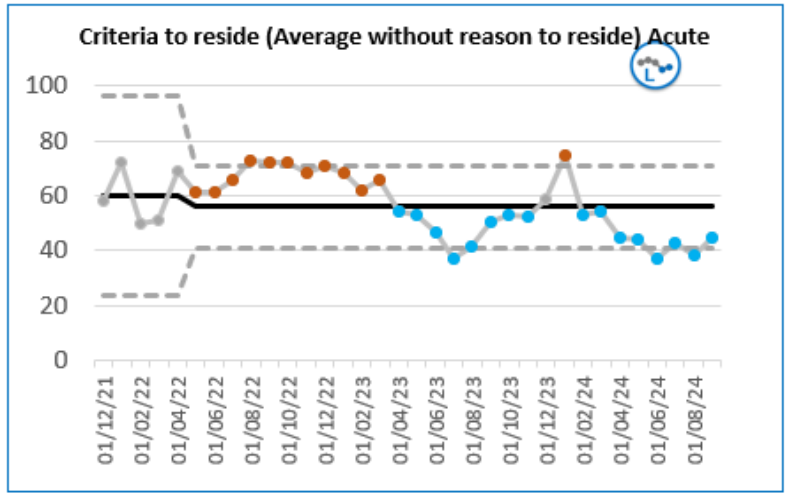
1. Teams are instructed to report when clinicians have concern that patient care is sub-standard or if any harm is suspected due to longer waits. Reports reviewed/investigated by INT Specialist Therapists and Team Managers will be reported and reviewed monthly through the Division's Clinical Governance group.

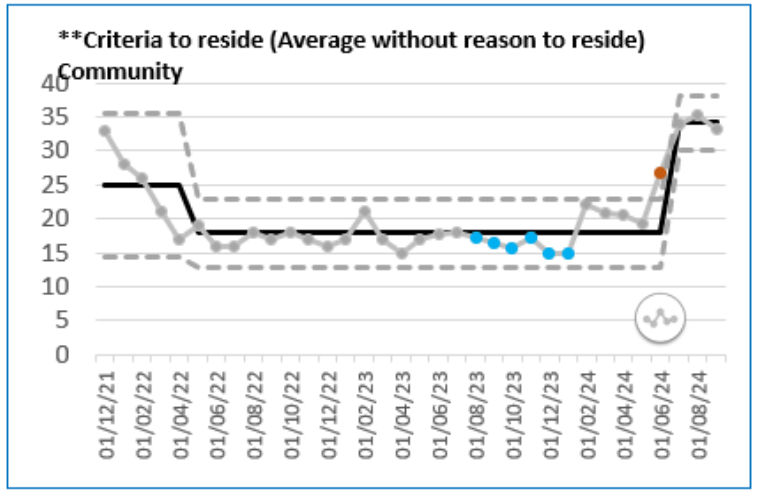
2. Local audit of the impact of cancellation / postponement of nursing visits to be completed and shared (November).

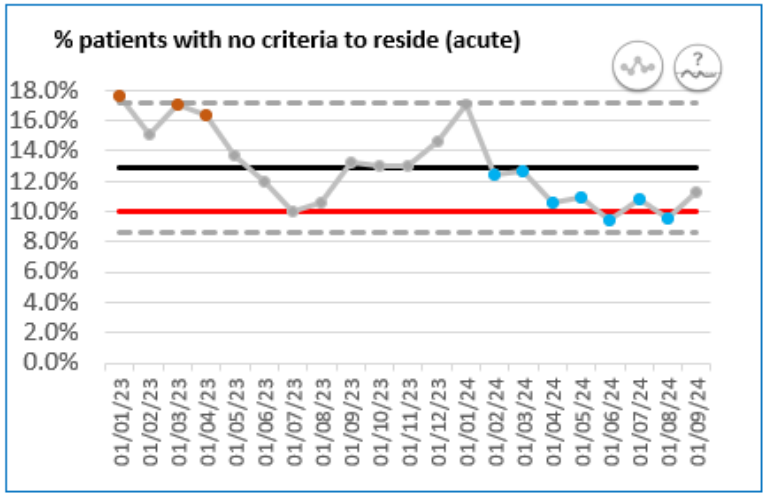
3. INT therapy working collaboratively with ASC therapy and Trusted Installer to increase efficiency support with work as competency and patient need allows – ongoing and reviewed monthly.

4. Initiative trialled in Haverhill to contact patients on waiting list to report November. Next month we should to see an increase in 2 week compliance.

5. Sickness and absence support with HR.

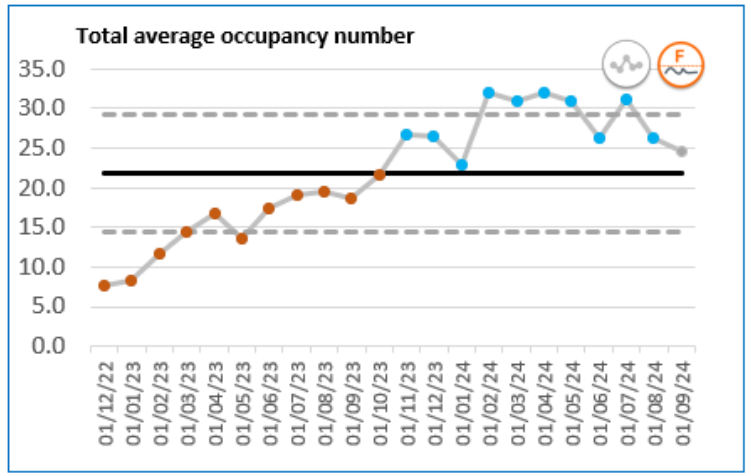


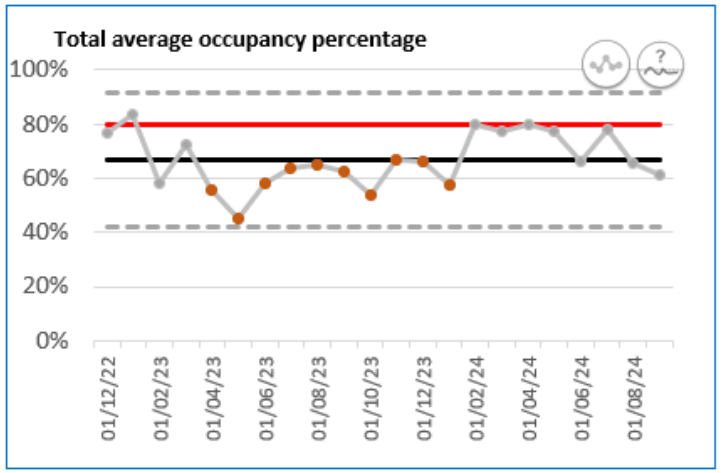


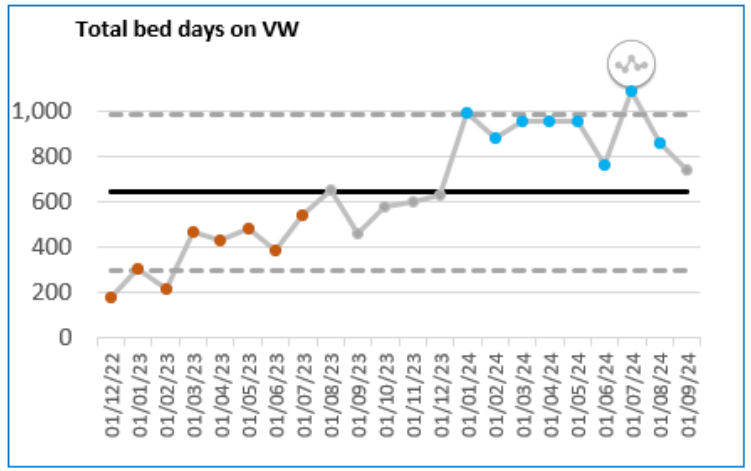


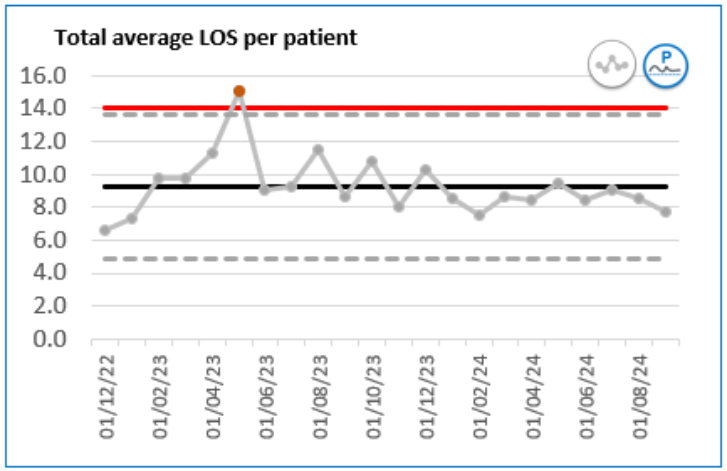
What	So What?	What Next?
Data for acute criteria to reside remains stable, continuing the trend of improvement. In July and August, there was an increase in the number of vacant beds in community assessment bed bases (CAB) which had enabled the transfer of patients who did not have criteria to reside to wait their onward discharge pathway. From the middle of September, the number of vacant beds decreased, reducing the ability to move patients from the acute – this is reflected in the bed occupancy percentages for all CAB settings which have increased in September. Community reason to reside figures have reduced slightly from 35 in August to 33 in September.	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.	The singular Transfer of care Hub (ToCH) referral form was launched on the 30th September with the aim of making referral into the TOCH for supported P1-3 discharges easier for referrers and reducing delays in allocating patients to the correct team. Whilst the change has created additional workload for ToCH teams the early feedback on the process is positive. A Trusted Assessor model four-week trial commenced with Rosemary ward on the 7th October with the aim to streamline referral and acceptance processes. Initial feedback is positive – a halfway review meeting is scheduled for 23/10/24. Escalation and communication channels are being reviewed across the TOCH, hospital Tactical team and Alliance partners to ensure timely escalation of issues and capacity challenges. Work to review pathway 2 capacity and modelling future requirements continues.

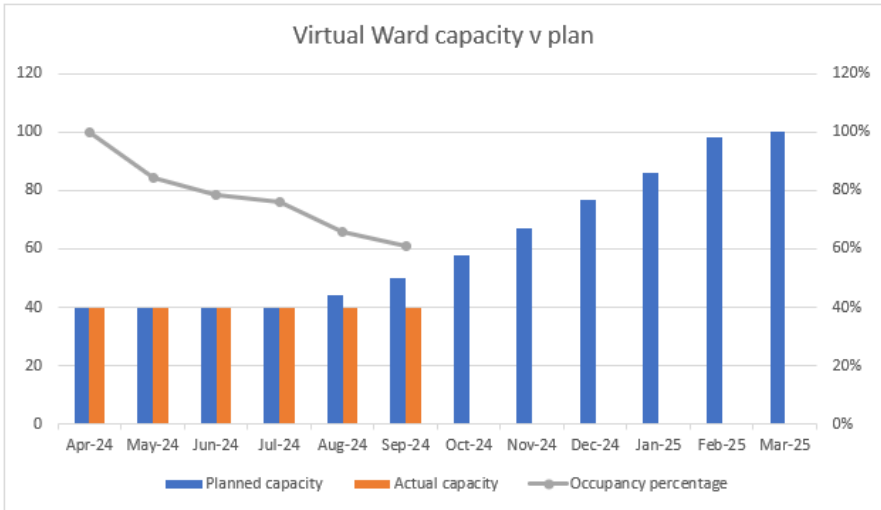
Urgent & Emergency Care (TRUST – Virtual Ward)











What

Average occupancy on the Virtual Ward reduced from 66% (August) to 61% (September) due to constraints in nursing capacity. The available nursing capacity has affected the number of patients who could be onboarded for virtual care this month. The home visiting nursing capacity element of VW specifically is impacted by vacancies, ceasing of agency, sickness and skill mix. These difficulties may also be reflected in the reduction in bed nights occupied (decrease from 861 to 741).
Average length of stay decreased from 8.5 (August) to 7.7 (September) due to an enhanced focus on reducing LOS across all pathways.
The Integrated service delivery model implemented as the pilot area in Mildenhall has enabled VW home visits to be managed through the locality-based team. Learning from the pilot has been captured.

So What?

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.

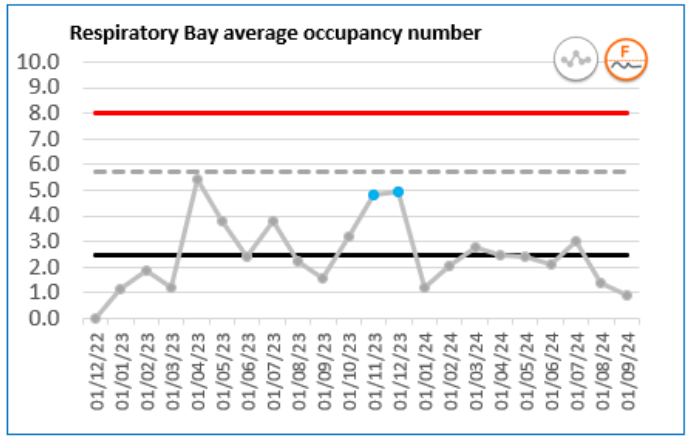
Appropriate length of stay
is important to facilitate effective patient flow across Trust.

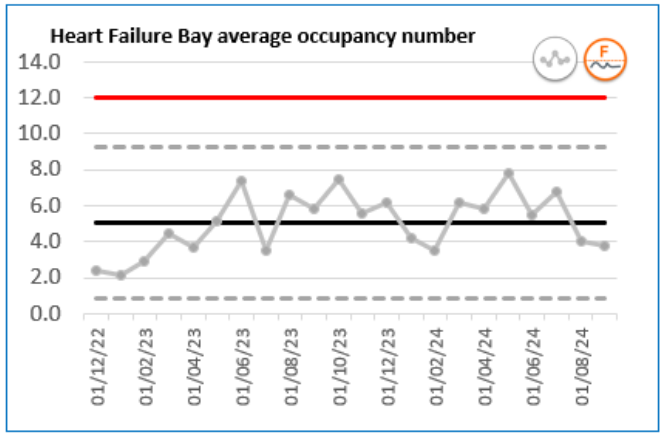
What Next?

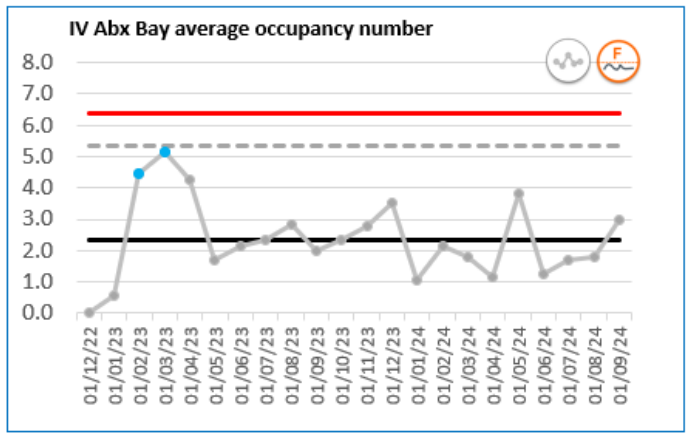
Evaluation and review of nursing home pilot in collaboration with local partner (Stowhealth Care) completed. High level next steps agreed with wider expansion to be enabled by integrated delivery model (timeline tbc with Shared Service Delivery project timeframe).

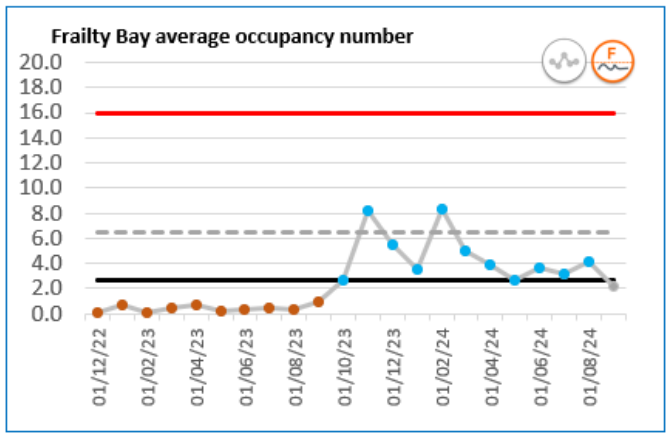
Process to enable step-up onboarding of patients to VW who have been urgently assessed by a community-based clinician to go live during October.

Learning from the pilot area of integrated service delivery for VW to be shared (October 2024). Wider rollout planned to other INTs via Shared Service Delivery project over the next 3 months.



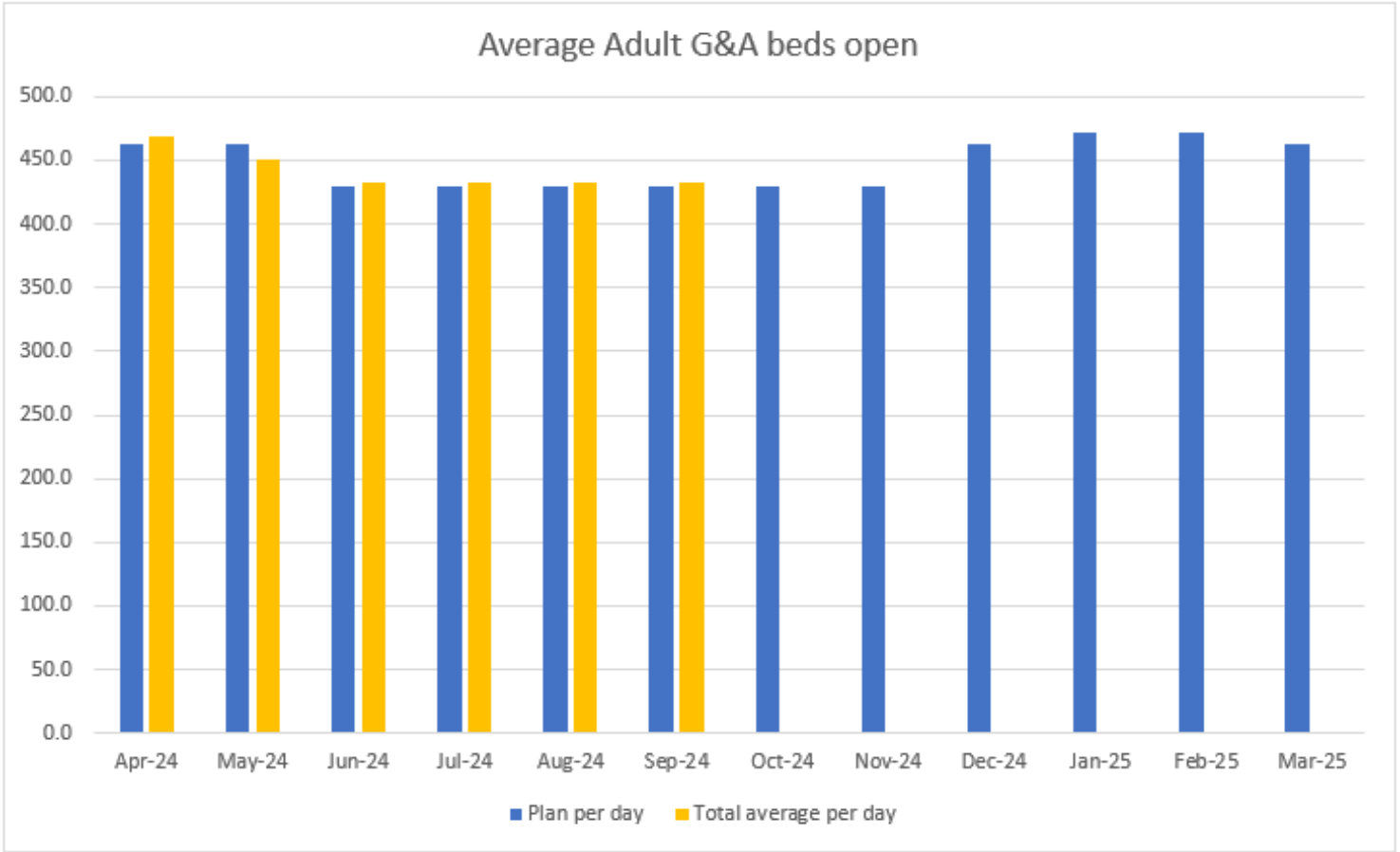






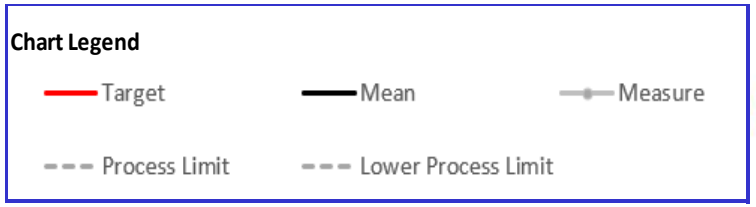
What	So What?	What Next?
Average pathway occupancy during September: Respiratory: average occupancy 0.9 patients (decrease from August) Heart failure: average occupancy 3.8 patients (decrease from August) Intravenous Antibiotics: average occupancy 3.0 patients (increase from August) Frailty: average occupancy 2.2 patients (decrease from August)	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.	Expansion in substantive workforce and use of agency has ceased awaiting a review of virtual ward- There will be a paper coming to MEG which will consider the future plan and model on 13th November. There has been a significant impact on capacity to do nursing visits and therefore on capacity to safely onboard patients.However it should be noted that occupancy targets were not met prior to this restriction on agency and expansion. Nursing capacity will be enhanced in late October due to implementation of (i) volunteer delivery of medications to patient homes and (ii) prescribing of subcutaneous furosemide (Both of these initiatives will reduce number of nursing visits). (iii) continuation of integration model.

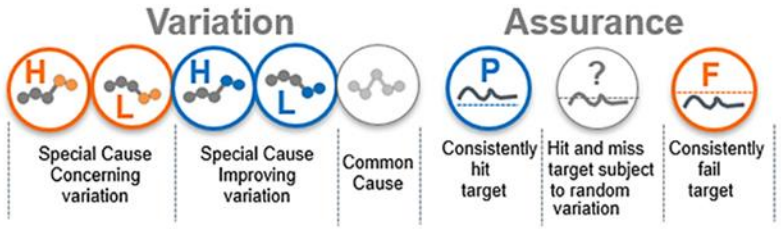
Urgent & Emergency Care: Beds



What	So What?	What Next?
Our actual average number of core beds open remains in line with plan. Use of escalation beds has increased by an average of 2 in September, given increased unmet demand, as 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.

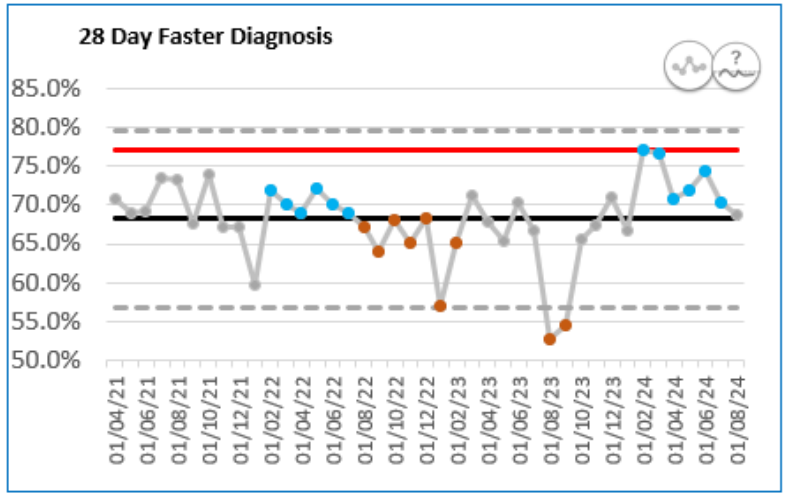
Cancer Access Summary

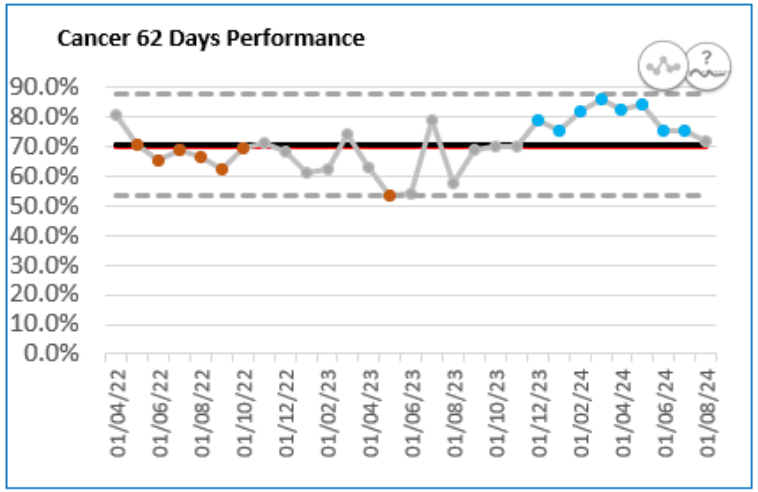


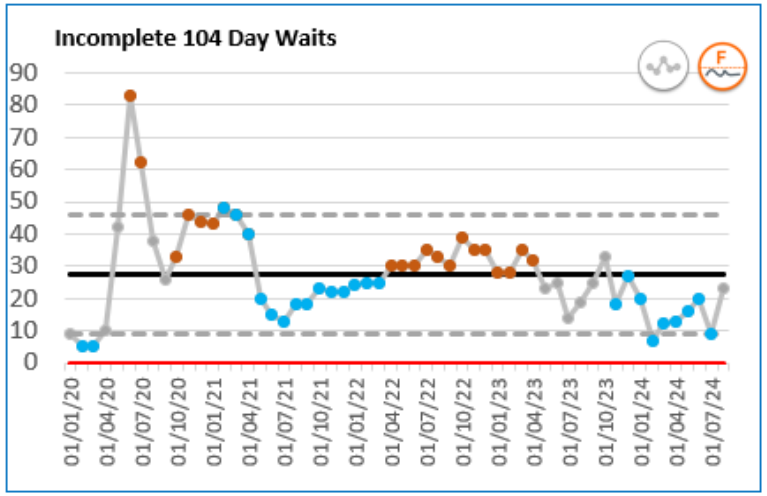


KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
28 Day Faster Diagnosis	Aug 24	68.6%	77.0%			68.2%	56.9%	79.6%
Cancer 62 Days Performance	Aug 24	72.0%	70.0%			70.6%	53.5%	87.6%
Incomplete 104 Day Waits	Aug 24	23	0			27	9	46

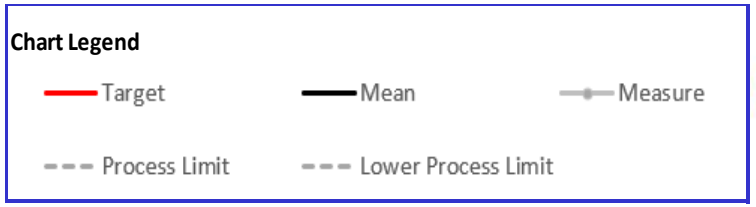
Cancer Access (Month Behind)

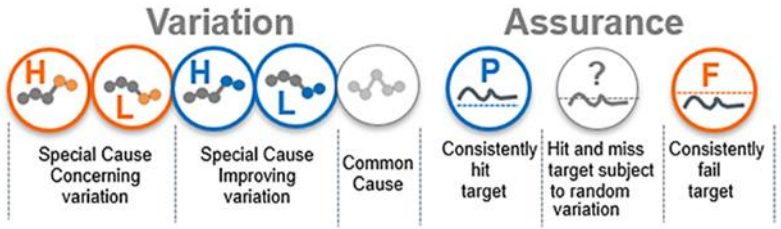






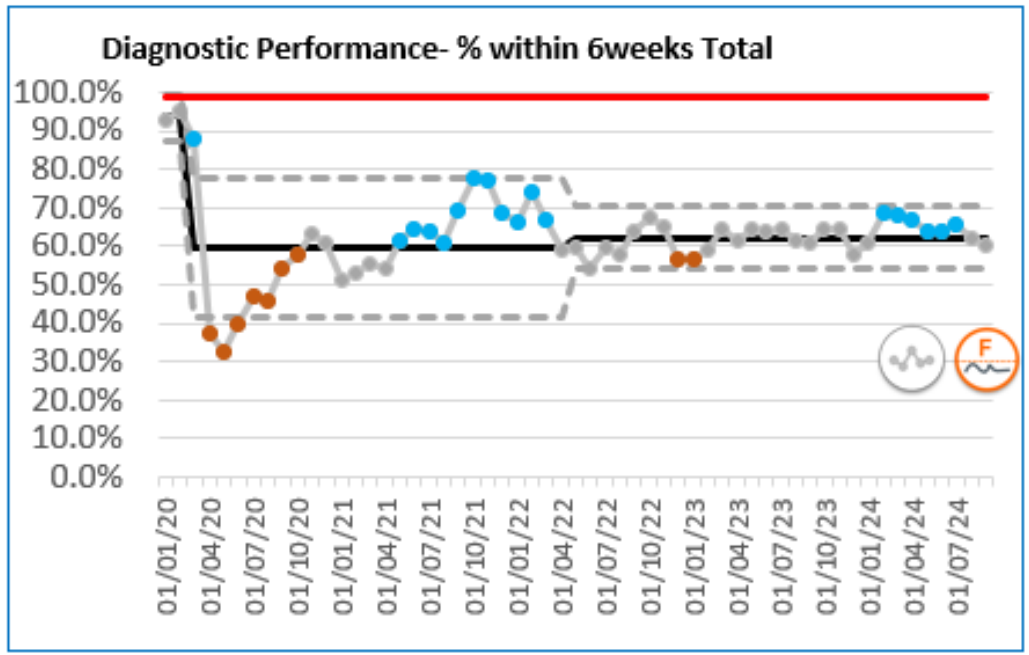
What	So What?	What Next?
The Faster Diagnosis performance continues to drop and is below national standard and our internal trajectory. The drivers for this performance in August is directly related to a reduction in Breast activity due to radiological shortages and reduction in agency due to the Trust financial position and a continued reduction in Skin performance due to increases in demand across the summer, ceasing of insourcing and sickness within the photography team for the teledermatological pathway. The 62 day performance remains above trajectory.	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. Skin continues to be an area of focus, with the following actions in place for support both FDS and 62 day performance: • Recruitment underway for additional nurse associate to support photography clinics • Training additional bank member to undertake photography approved for 4 weeks (November). • Additional 6 month fixed term consultant starts W/C 4th November • Visit to Colchester hospital scheduled for 5th November • WSFT Skin Cancer meeting to take place 3rd December to review current pathway and amend where appropriate. Seek financial approval for radiological support on a monthly basis, with the full business case for substantive staff due to go to investment panel imminently. 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.





KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
RTT Waiting List	Sep 24	33868	-			32832	31474	34190
RTT 65+ Week Waits	Sep 24	192	-			488	290	686
RTT 78+ Week Waits	Sep 24	35	0			154	86	222
Potential 65+ ww at end of Dec 2024	Sep 24	1727	-					
Community Paediatrics RTT Overall Waiting List	Sep 24	538	-			504	449	559
Community Paediatrics RTT Overall 52 Weeks Wait	Sep 24	1	-			1	-2	4
Community Paediatrics RTT Overall 65 Weeks Wait	Sep 24	0	-			0	0	1
Community Paediatrics RTT Overall 78 Weeks Wait	Sep 24	1	0			0	0	0
Community Paediatrics RTT Overall 104 Weeks Wait	Sep 24	0	0			0	0	0
RTT NDD Only Waiting List	Sep 24	75	-			78	55	100
RTT NDD Only 52 Weeks Wait	Sep 24	0	-			0	0	0
RTT NDD Only 65 Weeks Wait	Sep 24	0	-			1	0	1
RTT NDD Only 78 Weeks Wait	Sep 24	0	-			0	-1	1
RTT NDD Only 104 Weeks Wait	Sep 24	0	-			0	0	0

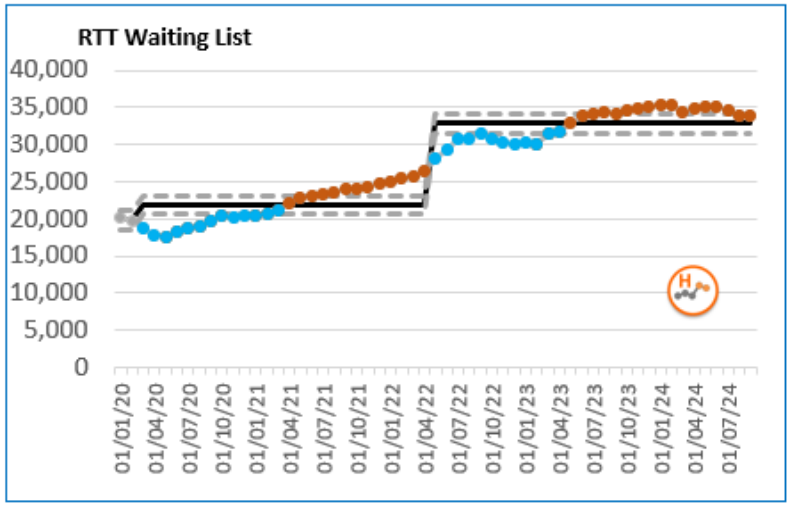
Elective Access

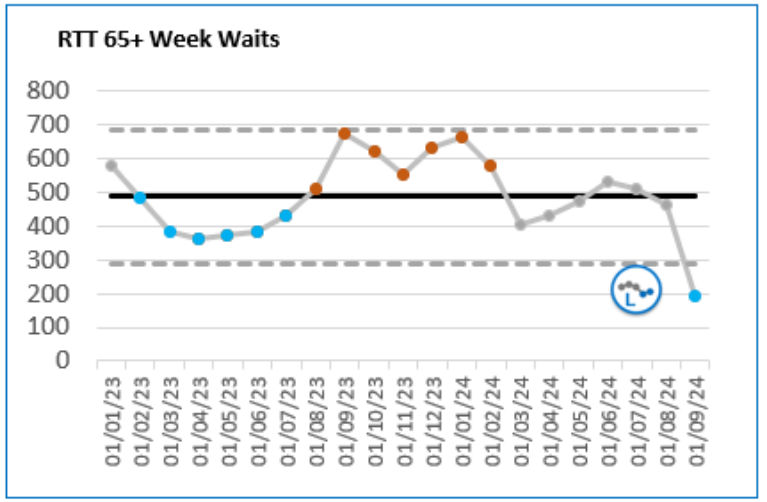


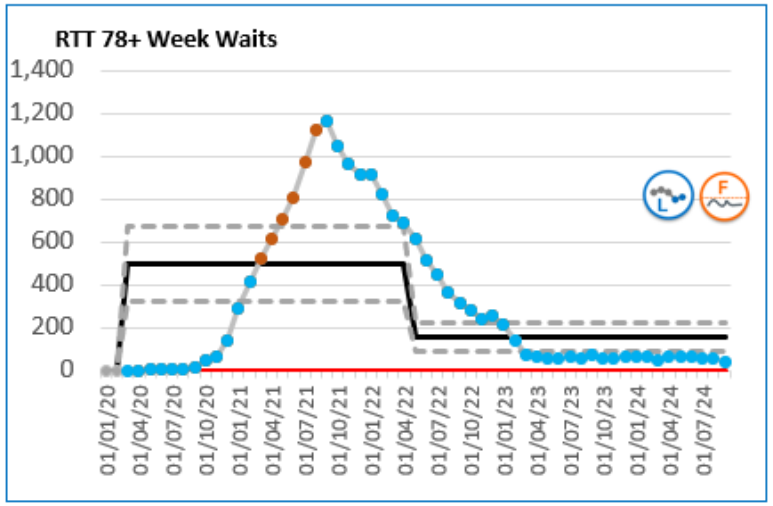
Diagnostics

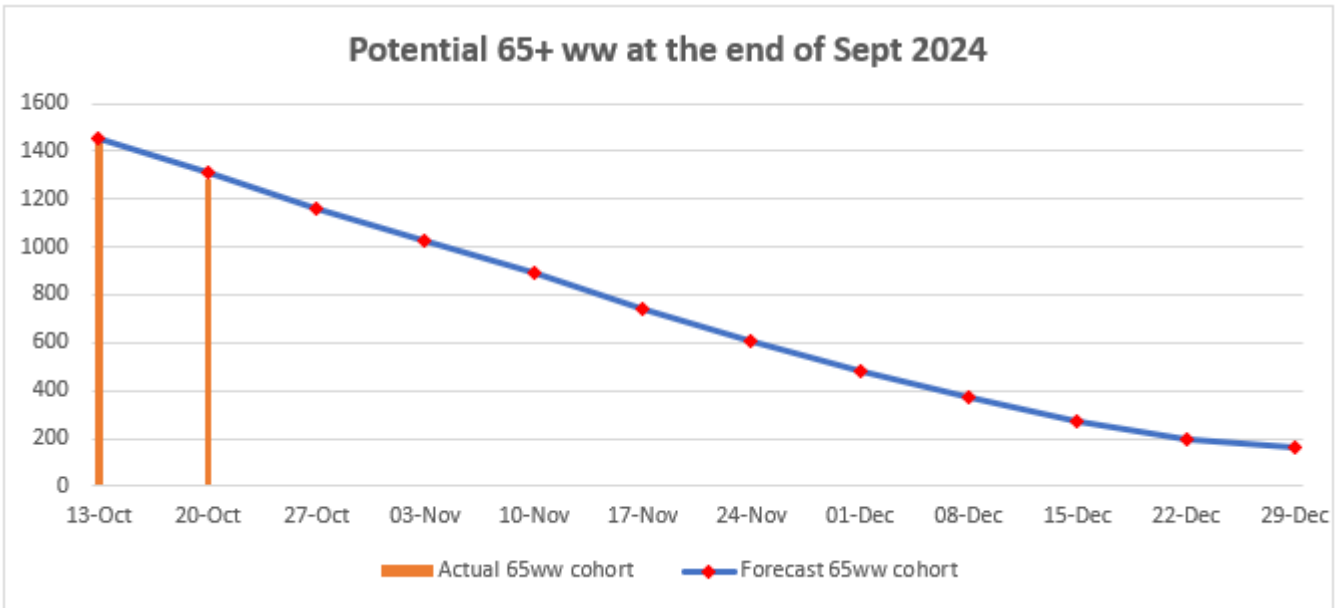
What	So What?	What Next?
All DM01 metrics seeing an improvement in month, Urodynamics achieving 100%, Cystoscopy improving by 11.5%, Audiology by 5.2%. Audiology will not achieve until March 2025 due to environmental and administrative constraints, Urology remaining on an upward trajectory. **MRI** – Common cause constituently failing target. Running at full capacity across the seven days but current capacity insufficient. MRI 2 replacement has a legacy impact on performance. The reduction in voluntary additional hours has seen an effect on capacity and DM01. 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 inpatient and UEC demand displacing DM01 activity and impacting capacity for the longer waiting patients. The reduction in voluntary additional hours has seen an effect on capacity and DM01. **US** – With varying factors DM01 attainment prediction is difficult to describe. Temporary staffing controls are compounded by recruitment challenges within the team. Agency support has been enabled for vascular US due to clinical risk, but MSK US is without this support. Performance remains vulnerable until recruitment improves, including capacity at the CDC. **DEXA** – We will not be able to go live with our DEXA service in November 2024 due to estates delays relative to ventilation and fire protection works. Anticipated go live now end of March 2025. Approval given 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. This has lef to a compound effect and a plateauing of DM01 performance. Impact of financial recovery is being seen on DM01 target compliance. Colonoscopy and Gastroscopy trajectories have reversed with the reduction in weekend and additional lists. Flexisigmiodoscopy is predicted to improve once NE's commence haemorrhoidal banding	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 • Embedding of Straithcans risk stratification. • Commencement of new consultant- Jan-25 • Diagnostic activity delivered by Urology CNS. **MRI** – Mitigations including the delivery of the CDC will see MRI reaching DM01 compliance in July 2025. **CT** – The delivery of the CDC will see CT reaching DM01 compliance in March 2025. **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 form 3 days per month to 3 days per week once staff are trained and the service is up and running fully. This will allow quick recovery of DEXA DM01 compliance. **Endoscopy** – Currently an unmitigated flat line trajectory of around 60% DM01 performance can be described. This assumes no further uptake in additional work. This could be further improved if criteria at the system outsource provider InHealth can be adjusted thereby increasing the cohort of patients that could be managed there. Additionally contractual discussions are taking place with Circle Health Group (CHG) in BSE which if productive could see capacity for around 25% of our waiting list. Financial recovery measures are having an 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.

Elective Access: RTT



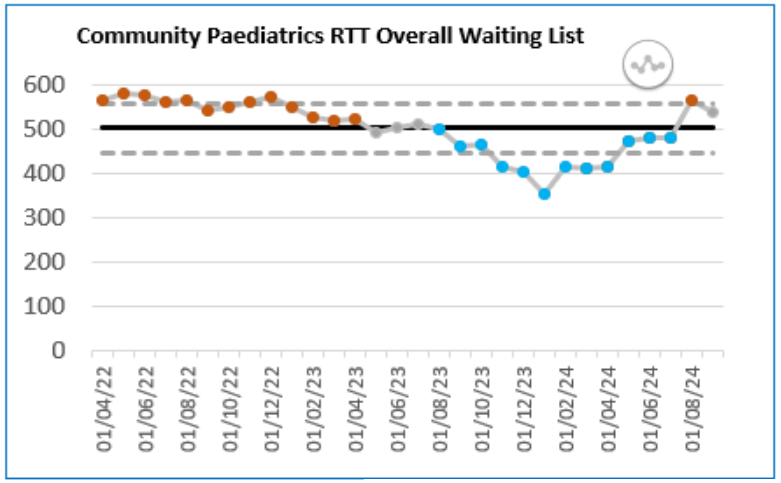


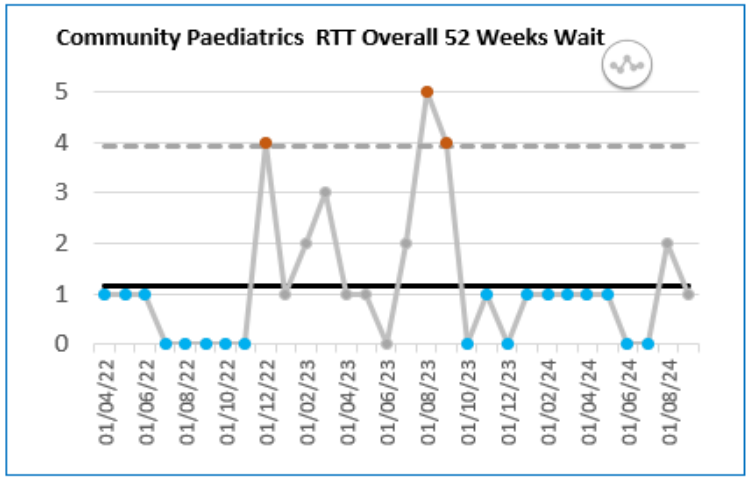


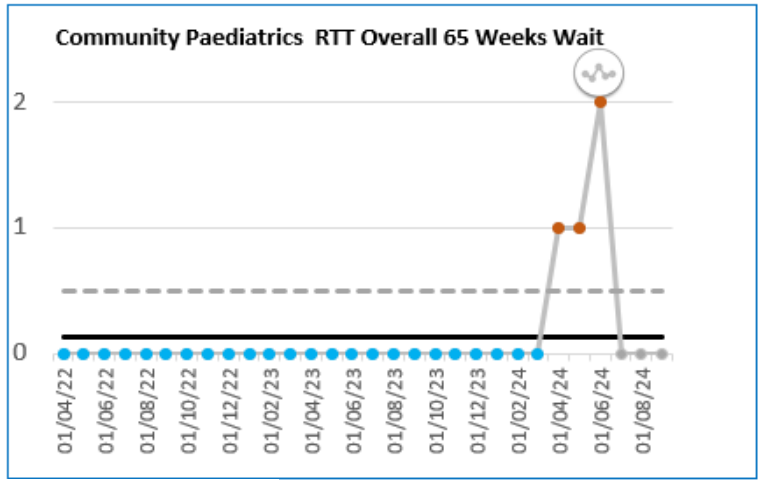


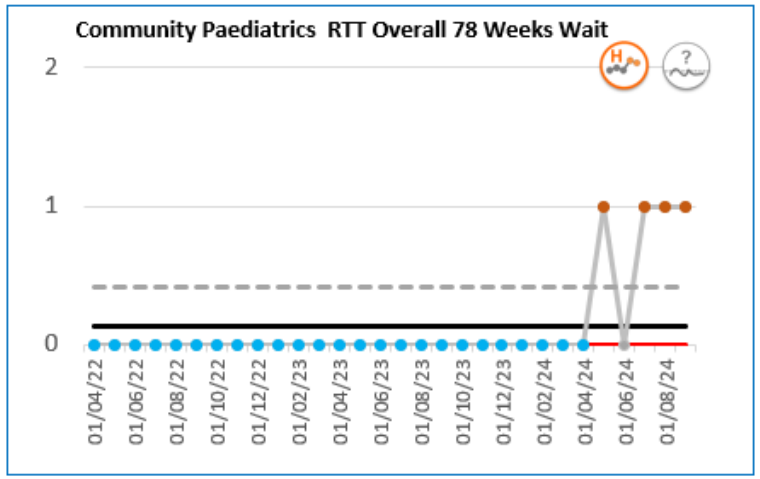
Elective Access: RTT

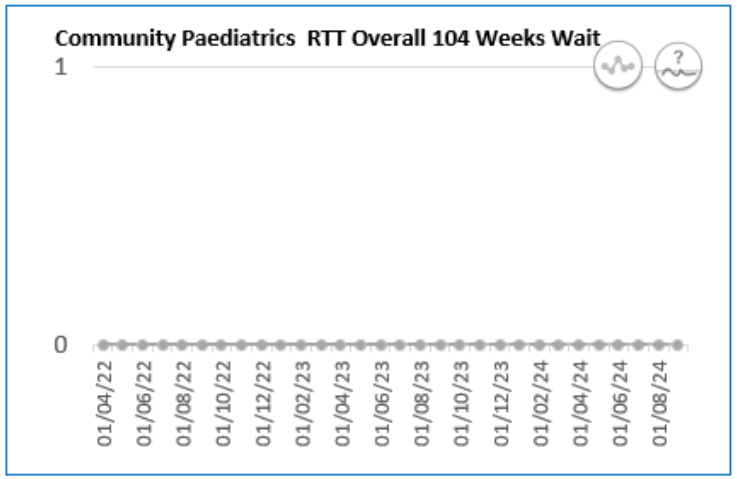
What	So What?	What Next?
We have seen a significant improvement in the total volume of patients over 65 weeks, with reductions made during the month of September due to additional weekend activity and outsourced Gynaecology activity. The target to reach 0 by the end of September 2024, was however missed. This is due the long standing capacity vs demand challenge in Gynaecology in addition to challenges in surgical specialities, particular Orthopaedics with access to theatres for various reasons, such as contamination of sterile services and roof leaks. The volume of patients over 78 weeks has reduced this month, however we are yet able to achieve 0 for capacity related Gynaecology breaches. The total waiting list remains high, but has stabilised, and does not appear to be continuing to rise.	Delivering the objective of no patients waiting over 65 weeks by the revised date of December 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.	Finalise and agree 65ww trajectories by division. Extend the Nuffield contract to enable more Gynaecology patients to be transferred in November and December. Go live with Orthopaedic centre due for the 11th November, which will increase Orthopaedic capacity. Weekend lists to continue across the next 3 months, to both support 65 weeks and elective recovery funding access. Business case for Dermatology to be presented to November investment panel, with a proposal to re-commence insourcing.











What

There is an overall rising trend in the size of the paediatric team's RTT waiting list. This is due to peak referral season from schools having recently occurred, exacerbated by significant staffing shortages. This is likely to deteriorate further given expected staff retirements over upcoming months.

Administrative limitations may have had an impact on correct RTT clock stopping. CCMT's longest RTT wait as at 30 Oct is 38 weeks, excluding ICB backlog cases.

So What?

Clinical time will be focused on preschool children and those with the greatest medical needs. This will result in lengthening waits for autism assessments, with consequential delays in the wider Suffolk educational and social services system. Parents and children will struggle to obtain the support they need for full educational and social attainment without this support.

What Next?

A 6-point pressure mitigation action plan is in place to reduce the worst effects of this operational demand:

- Reconsider current service contractual commitments
- Reconsider current service commitments to social care
- Skill mix current clinical team to mitigate national paediatrician shortages
- Directly engage with schools to highlight referral criteria and aim to reduce unnecessary referrals
- Encourage and support ICB's development of right to choose framework for NDD referrals in Suffolk
- Encourage and support ICB's development of new neurodevelopmental disorders pathway for Suffolk

These actions have varying lead times of 3 to 18 months before impact will be felt.

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	9,545	10,333	10,278	(0.5%)
May	9,660	10,458	10,314	(1.4%)
Jun	9,090	9,841	9,851	0.1%
Jul	10,165	11,004	10,645	(3.3%)
Aug	8,967	9,708	9,241	(4.8%)
Sep	9,545	10,333	9,835	(4.8%)
Oct	10,454	11,317		
Nov	9,891	10,708		
Dec	8,744	9,466		
Jan	10,345	11,200		
Feb	9,206	9,966		
Mar	9,365	10,138		
Total (YTD)	**56,972**	**61,675**	**60,164**	**(2.5%)**

September 2024

23/24	9,545
ERF	10,333
24/25	9,835
Var	(498)
Var %	(4.8%)

Daycase

Mon	23/24	ERF	24/25	Var %
Apr	2,191	2,373	2,434	2.6%
May	2,245	2,431	2,568	5.6%
Jun	2,084	2,257	2,264	0.3%
Jul	2,364	2,560	2,614	2.1%
Aug	2,109	2,284	2,331	2.0%
Sep	2,245	2,431	2,424	(0.3%)
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)	**13,237**	**14,337**	**14,635**	**2.1%**

September 2024

23/24	2,245
ERF	2,431
24/25	2,424
Var	(7)
Var %	(0.3%)

Outpatient Follow Up

Mon	23/24	ERF	24/25	Var %
Apr	25,353	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	27,001	28,804	28,063	(2.6%)
Aug	23,819	25,411	25,395	(0.1%)
Sep	25,353	27,046	26,131	(3.4%)
Oct	27,767	29,622		
Nov	26,273	28,028		
Dec	23,225	24,777		
Jan	27,480	29,316		
Feb	24,452	26,086		
Mar	24,876	26,537		
Total (YTD)	**151,33(**	**161,440**	**162,129**	**0.4%**

September 2024

23/24	25,353
ERF	27,046
24/25	26,131
Var	(915)
Var %	(3.4%)

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	287	3.7%
Oct	284	307		
Nov	268	290		
Dec	249	269		
Jan	234	253		
Feb	244	264		
Mar	244	264		
Total (YTD)	**1,562**	**1,690**	**1,633**	**3.7%**

September 2024

23/24	256
ERF	277
24/25	287
Var	10
Var %	3.7%

All

All

Fiscal Year	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
23/24	36.8%	35.9%	36.0%	37.1%	37.2%	37.2%	35.2%	34.4%	35.9%	35.6%	36.5%	37.2%	**36.2%**
24/25	36.6%	35.6%	35.9%	37.2%	38.1%								**36.7%**

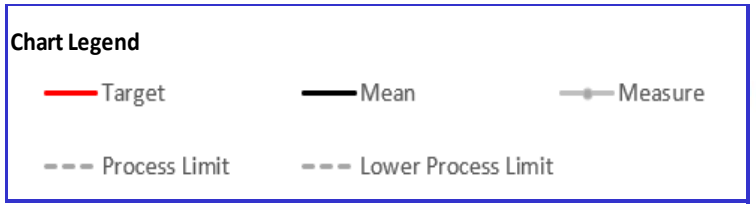
Target	**46.0%**
Month	**37.2%**
YTD	**36.7%**

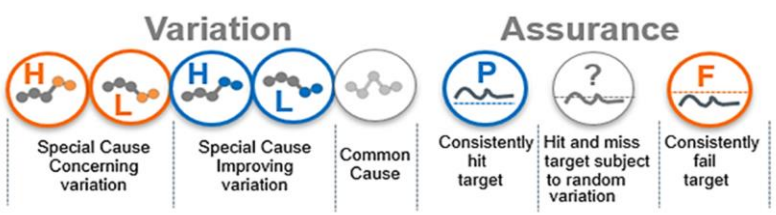
Elective Access: Activity

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 year to date, though the September monthly position has slipped to 0.3%. Elective activity has shown its best performance this year in September at 3.7% ahead, closing the year to date gap to 3.7% behind . Outpatient follow ups continued to decrease below 2019/20 levels in September, having been over between April and June. These do not attract ERF unless they include a continued their 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 and are showing three consecutive months of improvement.	Although achievement is measured in terms of value and at a system level, increasing absolute activity is required to achieve Elective Recovery Fund income as part of our Financial Recovery Plan and deliver on the objective to eliminate waits of >65 weeks by 22 December 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.	**Surgery:** • Reinforcement and monitoring of Patient Initiated Follow Up (PIFU) • Increased delivery of High Volume Low Complexity lists • Continuation of weekend lists • All lists booked to 90 -100% • Specialty level Elective Recovery Fund (ERF) tracker and identification of shortfall, assuring delivery of ERF plan • Development of specialty level dashboard, go live 21 October 2024 **Women's & Children's:** • Gynaecology: expansion of elective inpatient activity through weekend lists, potential for further increase should inpatient bed base be reconfigured as part of ESEOC backfill. • Paediatrics: Continued focus on general paediatrics PIFU and assessing impact of winter staffing requirements on outpatient activity. **Medicine:** • Engagement with PA Consulting regarding outpatient ERF opportunities. • "Further Faster" outpatients checklists shared with specialties – focus on closing gaps in Neurology. • Continued focus on Dermatology, linked to reducing elective and cancer waiting times. • Addition of 1 new patient and removal of 2 follow ups to all clinic templates in five specialties starting on 01 November 2024.

IMPROVEMENT COMMITTEE METRICS

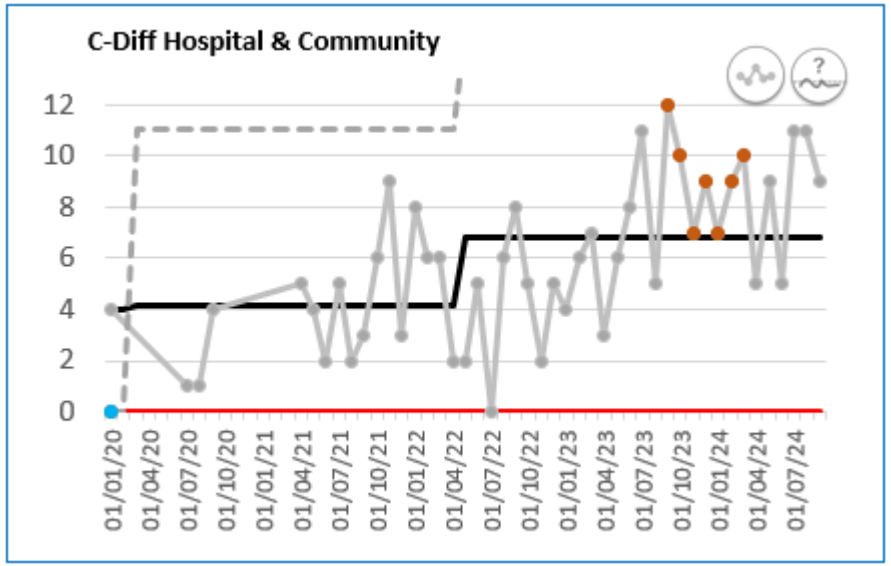
Safe- Summary





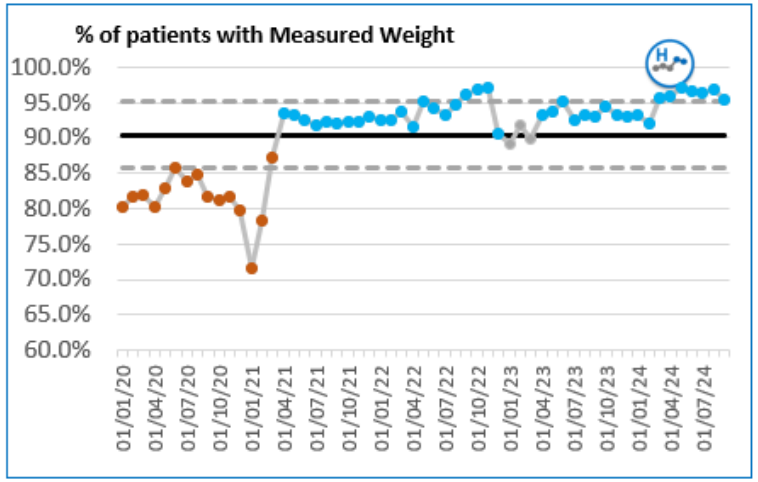
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
C-Diff Hospital & Community	Sep 24	9	0			7	-1	15
% of patients with Measured Weight	Sep 24	95.3%				90.5%	85.8%	95.1%
% of patients with a MUST/PYMS assessment completed within 24 hours of adm	Sep 24	64.9%				89.1%	81.3%	97.0%
% of patients with a MUST/PYMS assessment completed within 48 hours of adm	Sep 24	82.0%				92.9%	87.7%	98.0%
Post Partum Haemorrhage	Sep 24	8				8	-1	17

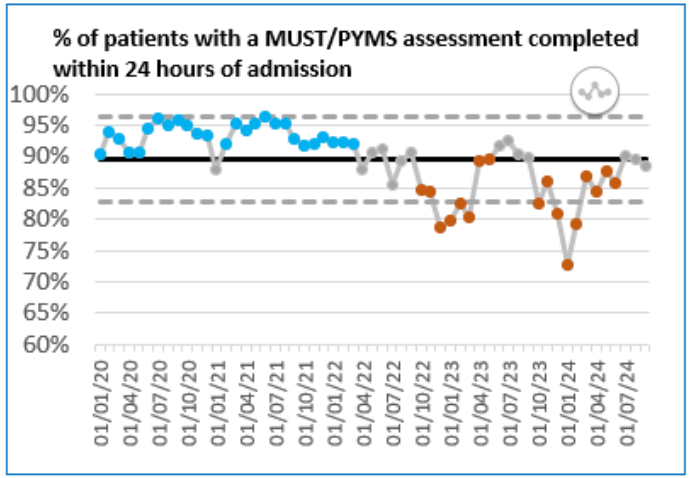
Safe

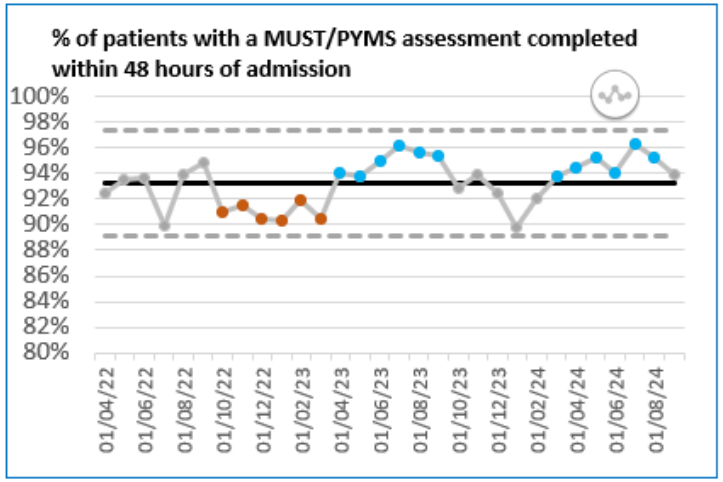


What	So What?	What Next?
Incidents of *Clostridioides difficile* in the community and acute hospital is in common cause variation following a period of increase in early 2024 There has been no significant reduction in rates since September 2023 due to the multifaceted issues surrounding the cause and drivers of infection. This data threshold set combines HOHA & COHA cases which provides the organisations measure for national/regional data and better demonstrates the impact on our patient group and community. It is recognised Nationally that the rates of *Clostridioides difficile* have increased significantly over the last two reporting years.	Healthcare-associated infections (HCAIs) can develop either as a direct result of healthcare interventions such as medical or surgical treatment, or from being in contact with a healthcare setting. 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 cases 2024-25.	The situation is complex and has been identified as an organisational key priority, with escalations via patient quality & safety group and attendance at the improvement committee March & October 2024. The Quality Improvement Programme has commenced and will run for at least 12 months - April 2025. Actions include: • Repeat hand hygiene audit following the bite-size hand hygiene powerpoint with voice over distribution – shared at the all staff briefing – November 2024 • Audit of patients who have more than one positive c.diff result – November 2024 • Further review of ribotypes by HOHA, COHA, COCA allocation and location (ward or community setting) – November 2024 • Review/complete cleaning poster – November 2024 • Cleaning of ED target areas followed by rolling programme – November 2024 onwards

Safe







What

There has been a slight decline in compliance with nutrition assessments being completed within 24 hrs and 48hrs of admission, moving into common cause variation.

This correlates with Urgent and Emergency care pressures, which delay the completion of these assessments due to delays in transfer to the base wards. The Emergency Department have commenced a screening assessment tool to identify those most at risk in the initial period to address this.

On review of the data, the specialist areas who take direct admissions from ED have good compliance with the metric. The compliance in Paediatrics is poor due to issues with achieving an accurate weight and small numbers of patients.

- 91% being achieved by the adult in patient areas alone
- 88.4% when adult and paediatrics inclusive.

There is increased focus on improving all aspects of nutrition and hydration with an initiative commenced by the Deputy Chief Nurse and Associate Director of Operations for Estates and Facilities. A multi professional workshop has been conducted exploring a variety of workstreams to improve the care and experience of patients with regard to eating and drinking.

So What?

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.

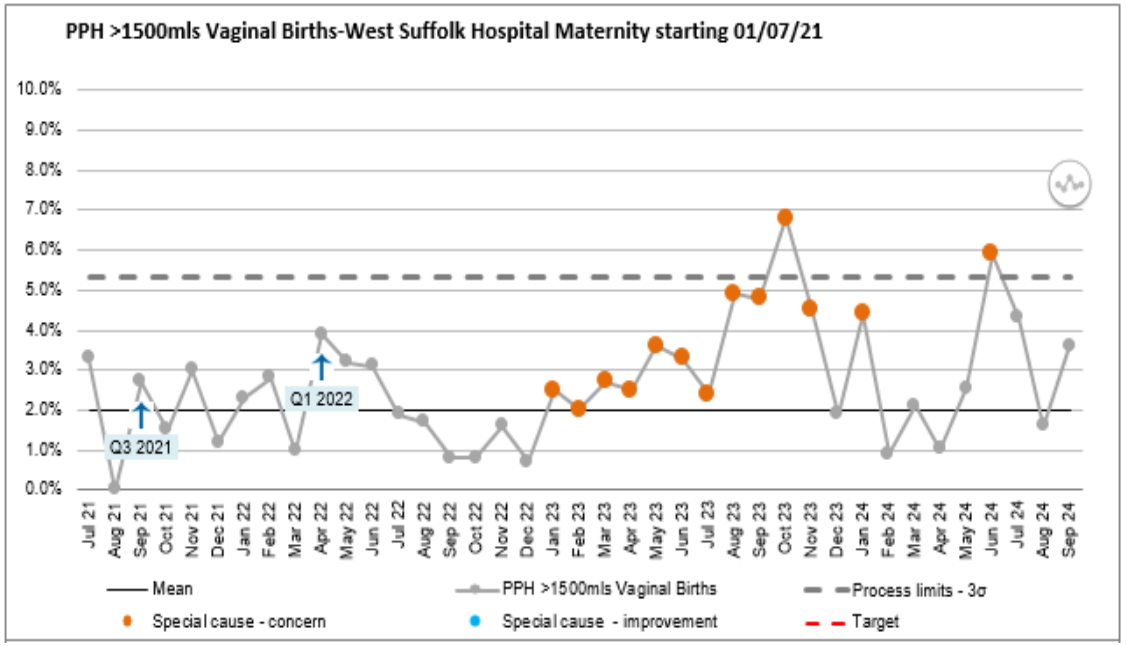
There are plans in place to renew the reporting process to capture the timeliness of assessments when patients are admitted to a ward. This will provide teams with the opportunity to improve the compliance and accuracy of this important metric. There are recurrent delays in receiving this data set due to issues with the data warehouse implementation. Confirmation of a start date for this remains outstanding and has been escalated numerous times.

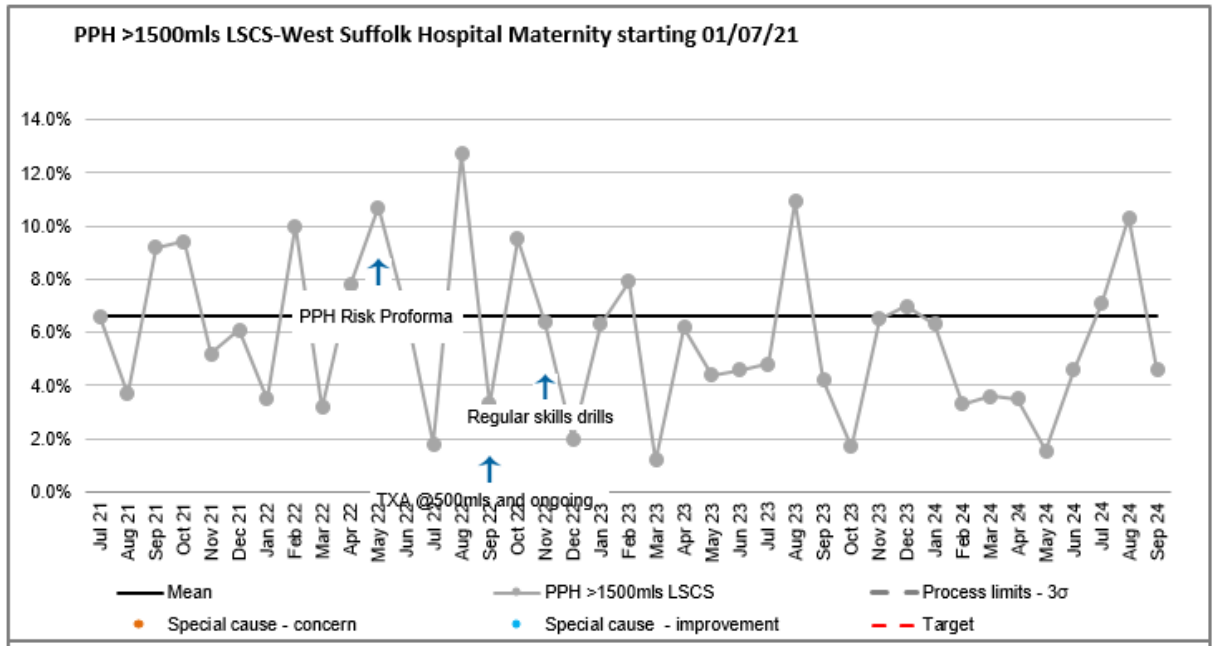
What Next?

- 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
- Monitor for incidents or complaints raised regarding nutritional intake or support at department level to gain assurance.
- To commence improvement work streams following the 'Food as medicine' workshop which was completed in September.

Safe

Post-partum haemorrhages (PPH) above 1500mls





What

Previous targets were set by The NMPA (National Maternity and Perinatal Audit)using 2022 data. Due to significant changes in practice (increased induction of labour and elective caesarean births) these targets have been removed as they are no longer relatable to the service.

Incident rates of PPH is in common cause variation in both vaginal and caesarean births.

Massive Obstetric Haemorrhage (MOH) for vaginal births at WSFT is in line with regional average (financial year to date).

Massive Obstetric Haemorrhage (MOH) for caesarean birth is above the regional average to date.

So What?

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)

Following a PPH there is the potential increase of length of stay, additional treatment and financial implications for the organisation and family.

Following a PPH there is an increased risk of psychological impact, exacerbation of mental health issues as well as affecting family bonding time, which can have irreversible consequences.

Exposure of psychological trauma to patients and our staff.

What Next?

Quality Improvement 3rd cycle launched

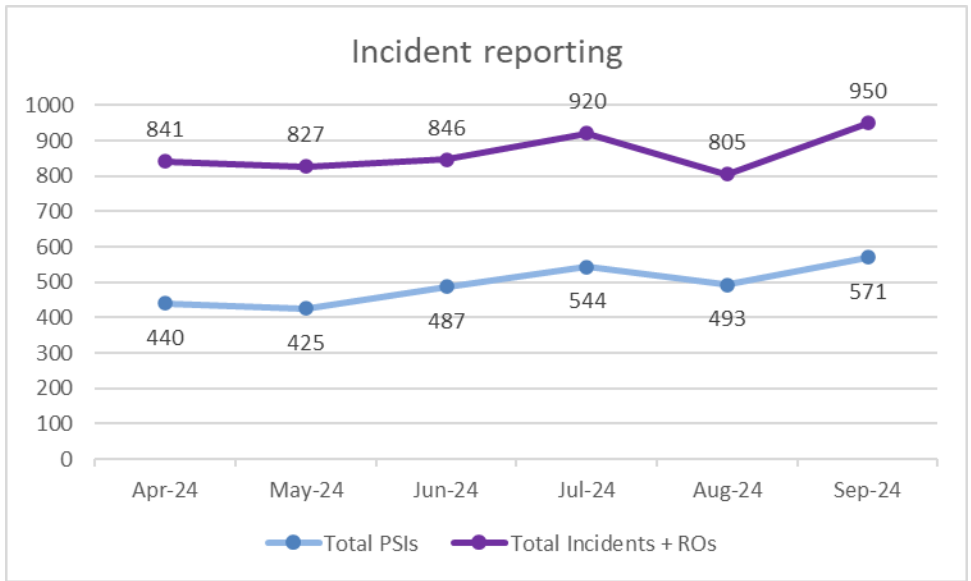
5 workstreams identified; Anaemia, Training, Risk, Equipment/Estates and Medication

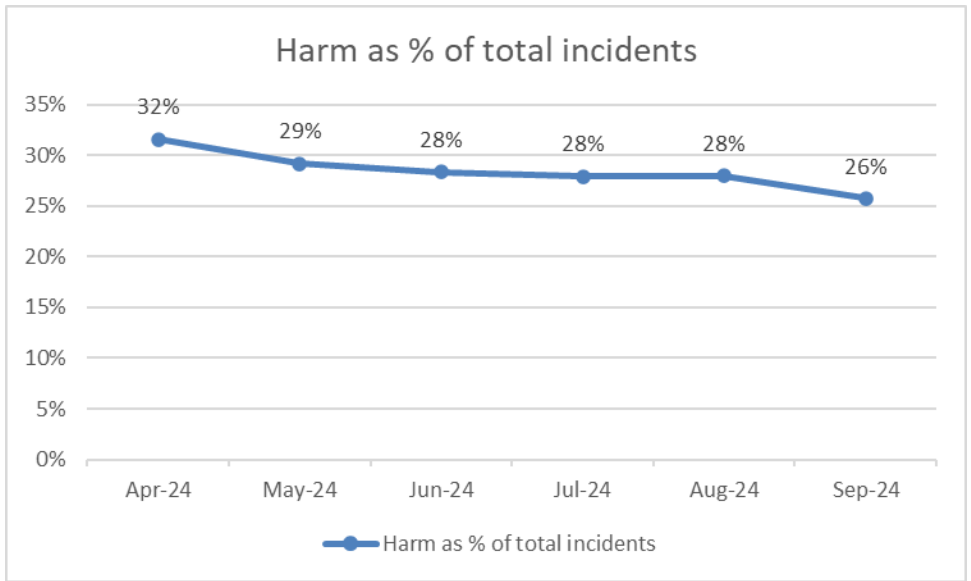
Continue engagement with Local Maternity and Neonatal System and Regional QI projects regarding PPH

Undertake 'so what' review, in relation to PPH to be presented to the Improvement committee in November 2024.

With the removal of nationally set targets, to monitor performance in line with maternity units across the region.

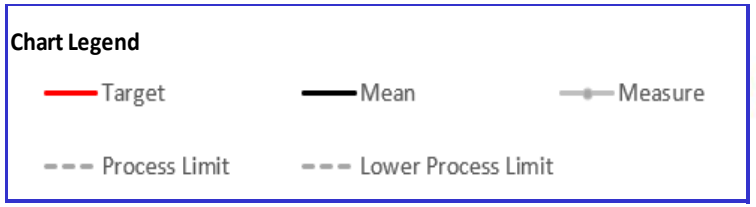
Safe

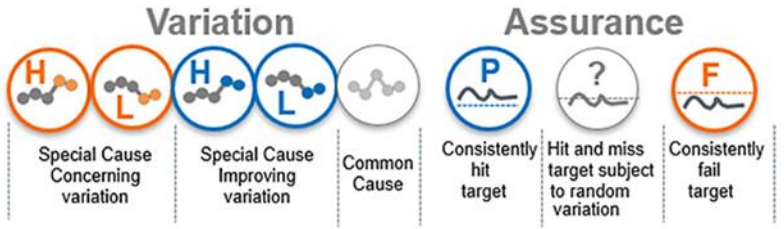




What	So What?	What Next?
The number of reported patient safety incidents (PSI) and reportable occurrences (RO) has increased, together with a reduction in harm as a percentage of total incidents. Harm as a % percentage of total reported PSI is a measure of safety and demonstrates we are reporting low harm and near miss events as well as incidents which are attributed to harm. The low percentage is a good indicator of safe care. This data is scrutinised at the Radar Oversight Group (ROG). This month we have seen an increase in security incidents, information governance incidents and incidents relating to discharge, transfer and follow up arrangements. The number of incidents relating to clinical care and treatment, falls and medication has reduced.	The rejuvenated patient safety quarterly analysis report is being prepared for discussion at ROG and for inclusion in the patient safety report for the patient safety and quality governance group (PSQGG). 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 are reporting more incidents and ROs via Radar. This will help us measure safety and culture in more depth and allow us opportunity to analysis interaction with the Radar system.	The patient safety team will work closely with areas of low and high reporting 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. 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. Following the patient safety summit which was held in September, a QI programme will be launched to take forward our chosen topic which is 'Getting it right for patients and staff – place, service, pathway'. The Head of patient safety will work with the QI team and executive director for strategy and transformation to plan and progress this workstream. Reporting and measurement of safety actions and areas for improvement are being reviewed as part of the divisional governance project, led by HoN for medicine, Head of patient safety and the deputy trust secretary.

Mortality Summary

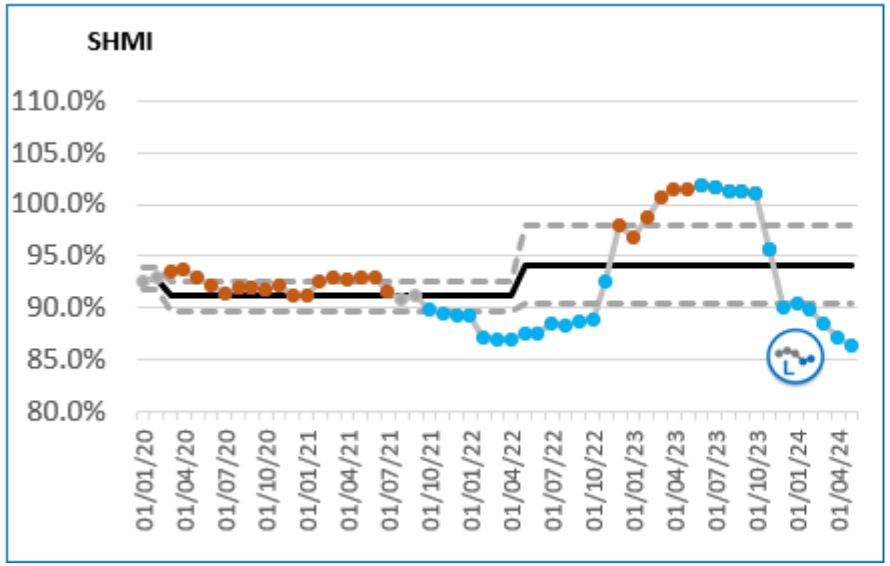


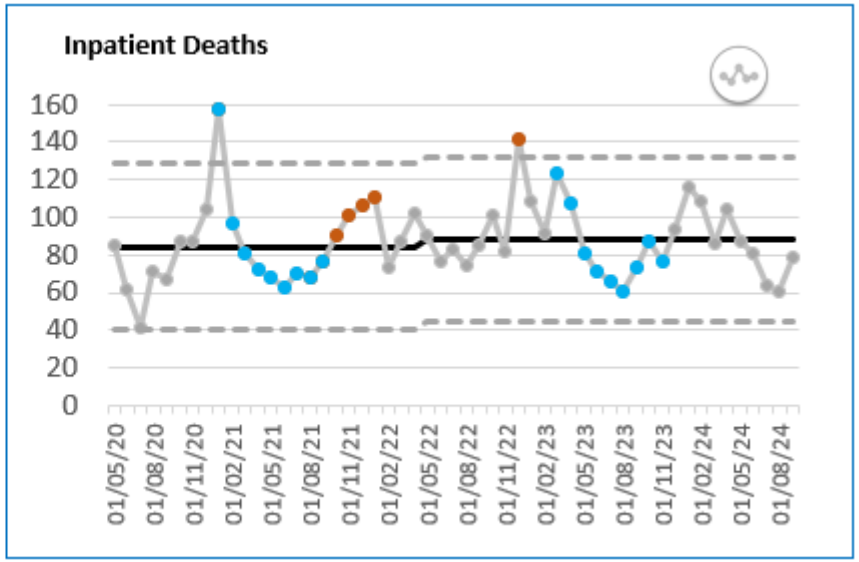


KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
SHMI	May 24	86.5%				94.2%	90.5%	97.9%
Inpatient Deaths	Sep 24	79				88	44	132

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 any variation in both SHMI and Inpatient Deaths, and investigate any change that is not expected common cause variation.

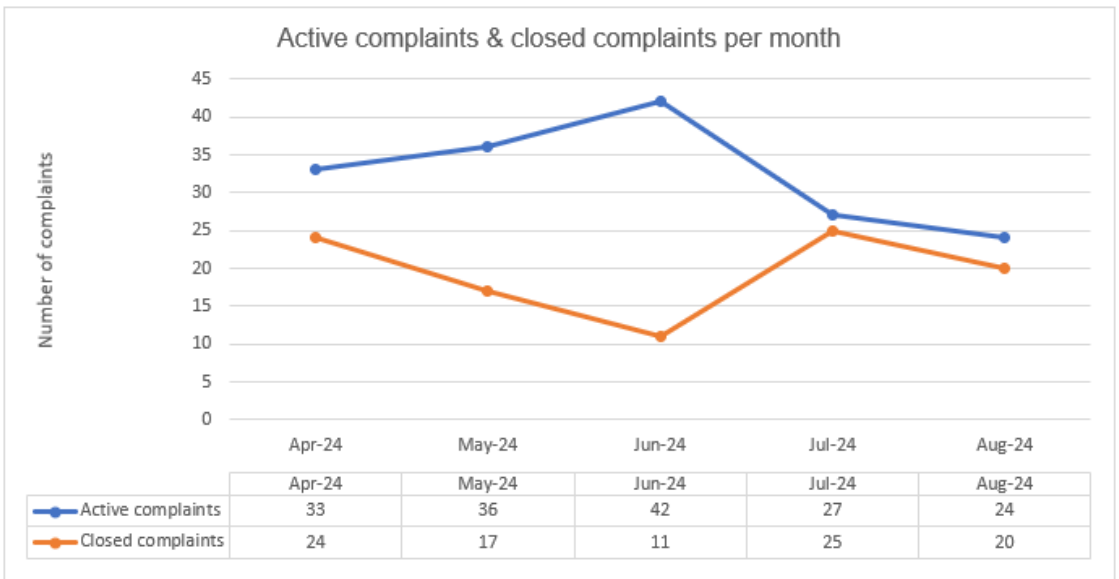
INVOLVEMENT COMMITTEE METRICS

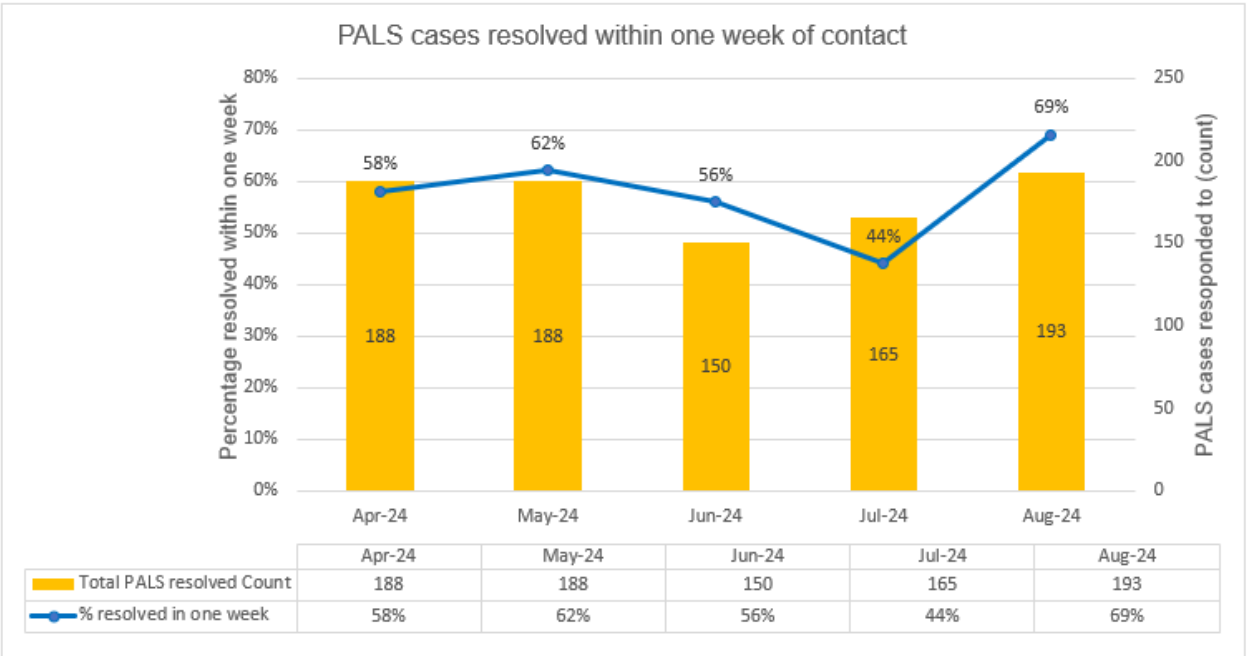
Safe

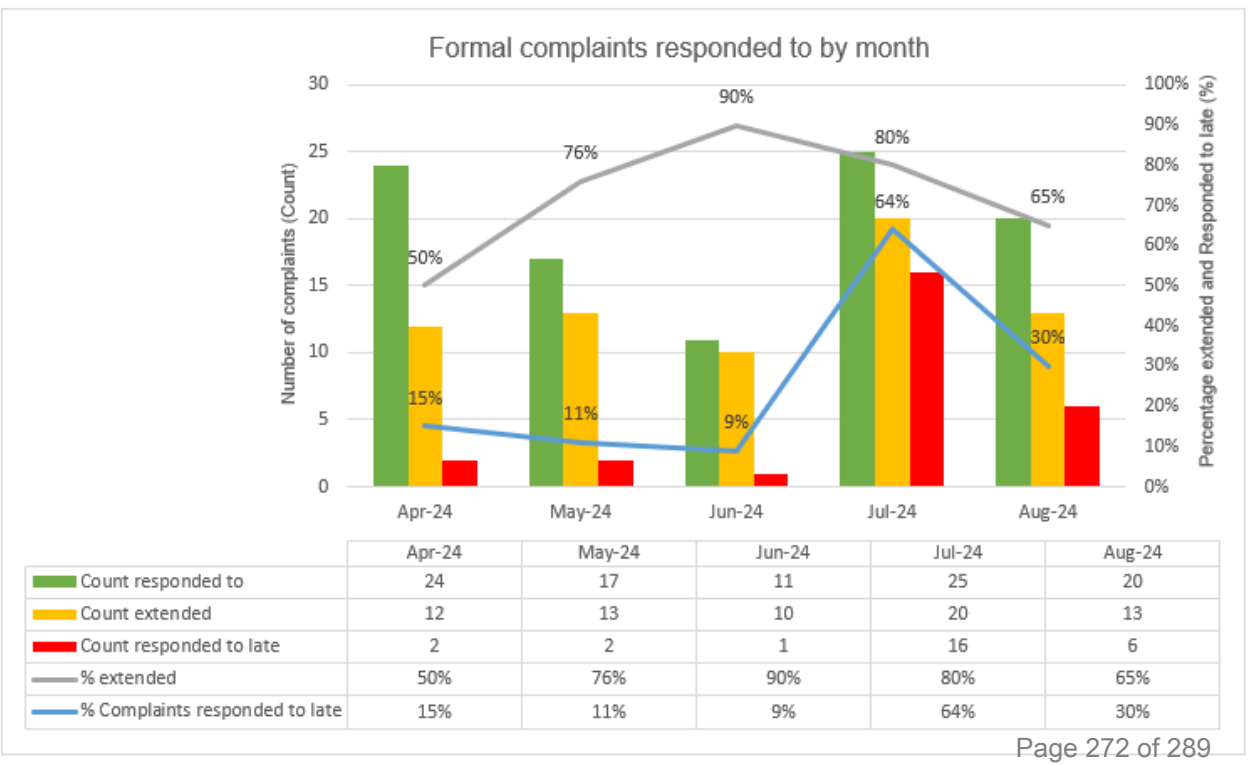
	Apr-24	May-24	Jun-24	Jul-24	Aug-24
Active complaints	33	36	42	27	24
Closed complaints	24	17	11	25	20

	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

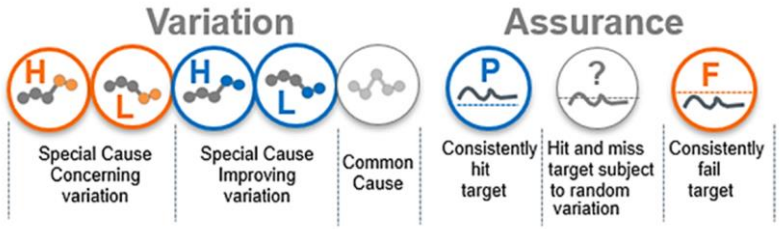






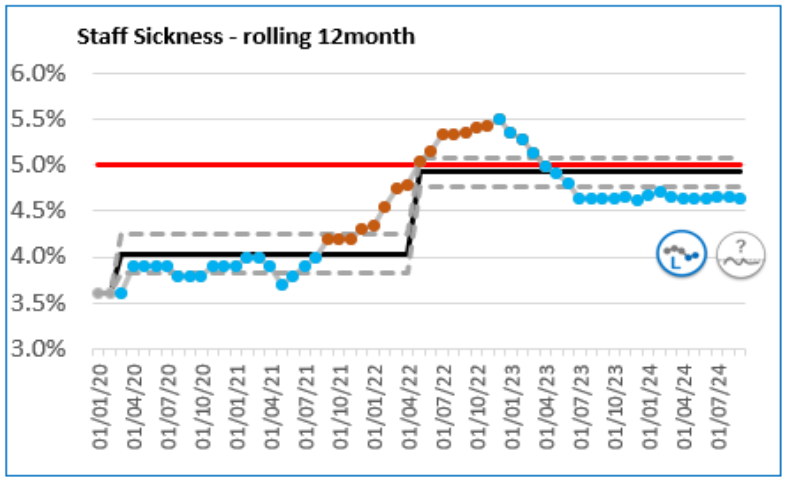
Safe

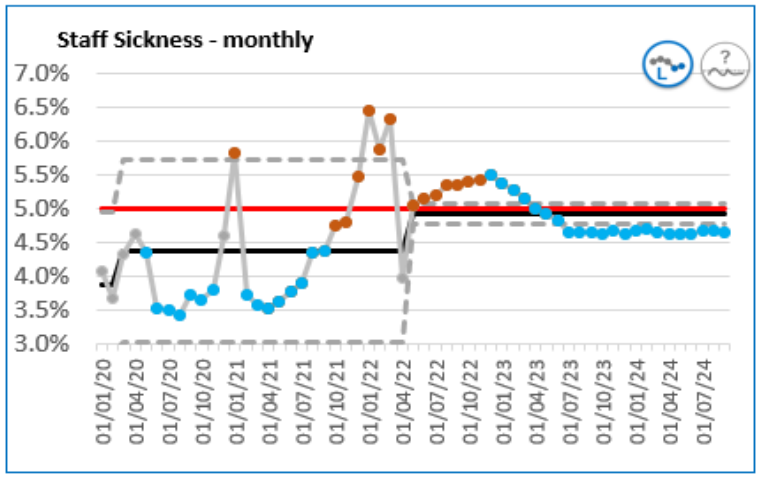
What	So What?	What Next?
193 PALS cases resolved within August with 69% closed within one week. This is the highest amount of cases resolved within one week for this financial year and nearing our target of 75%. When analysing the data, the average time for resolution is 10 days. The team historically 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.

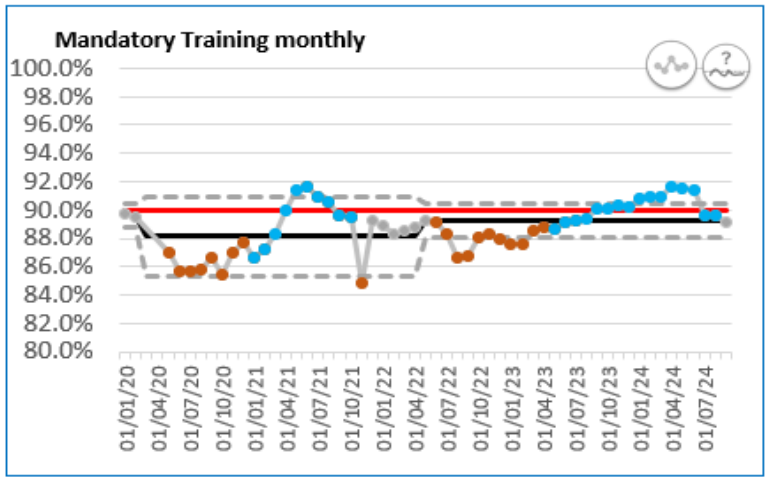


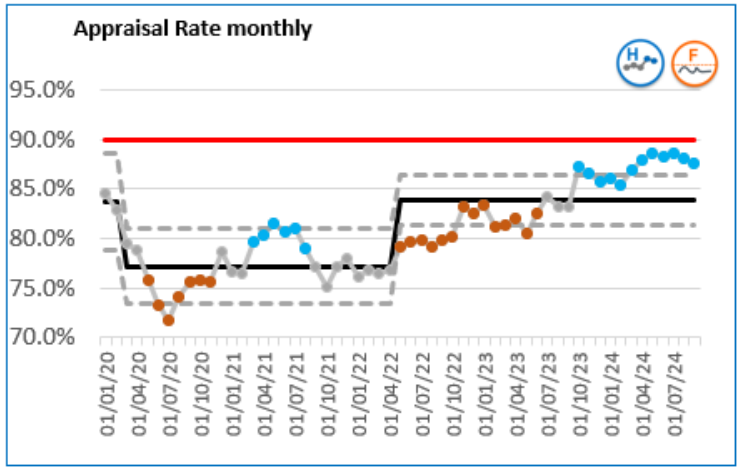
KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
Staff Sickness - rolling 12month	Sep 24	4.6%	5.0%	L	?	4.9%	4.8%	5.1%
Staff Sickness - monthly	Sep 24	4.6%	5.0%	L	?	4.9%	4.8%	5.1%
Mandatory Training monthly	Sep 24	89.2%	90.0%		?	89.3%	88.1%	90.5%
Appraisal Rate monthly	Sep 24	87.7%	90.0%	H	F	83.9%	81.3%	86.5%
Turnover rate monthly	Sep 24	7.0%	10.0%	L	?	10.7%	9.8%	11.6%

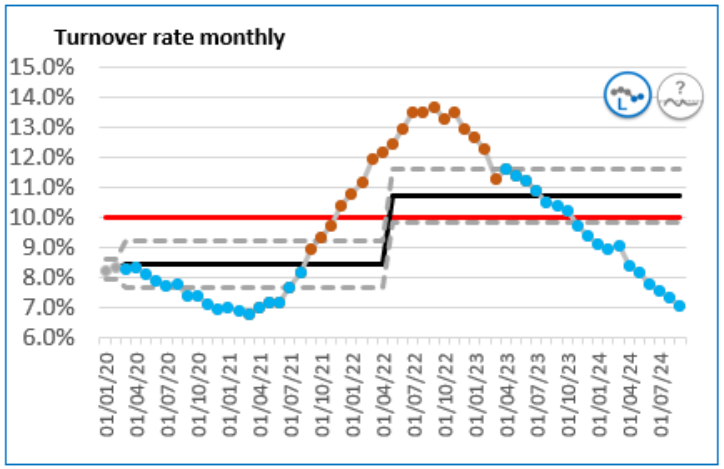
Well Led











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 4.6% versus 5% target. Mandatory training – slightly below target at 89.2%. Appraisal – consistently failing target, 87.7% 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.

Item 7.3 Annex A FT membership and engagement strategy - DRAFT v5

Presented by Richard Jones

West Suffolk NHS Foundation Trust Council of Governors' membership and engagement strategy

An engagement strategy for the interests of the Foundation Trust's members and the public

Table of content

1.	**Introduction** As a Foundation Trust (FT), West Suffolk NHS Foundation Trust is accountable to the local community, the patients it cares for and the people it employs through its membership. A 'member' is defined as any person registered as a member of the Trust and authorised to vote in elections to select Governors. Being a 'member' of an NHS FT provides the general public and staff with the opportunity to participate and get involved with their local hospital. Those living in communities that are served by the Trust can become members with the membership community being made up of public (including patients/carers) and staff members. From these members, Governors are elected to the Council of Governors to represent members' interests. We recognise the need to commit resources, both in time and effort, to developing our membership and engaging with the members and the public and the strategy sets out the actions that we will take in support of this. The Council of Governors' Membership and Engagement Committee will undertake a key role in leading and managing the implementation of this strategy and its future development. The Committee will monitor the progress against this strategy and other related actions, and report to the Council of Governors as appropriate. The steps and actions underpinning the delivery of this strategy will be led by Foundation Trust Office which includes Trust Secretary, Deputy Trust Secretary and Foundation Trust Office Manager. The FT Office will engage others to develop an annual programme of activities and events to support the progress of this strategy. It is important to understand the scope of this membership engagement, which focusses on engaging with the FT members - existing members and potential new members. This enables Governors to canvass the opinion of these groups (such as patients, staff and the public) on the Trust's objectives, priorities and strategy. This compares with the Trust's wider experience of care and engagement strategy which focuses on how the Trust meets its statutory requirements surrounding involving patients and our local people and communities who receive, or may receive, care from WSFT in the future. This includes wider stakeholder engagement to ensure people are involved in decisions about service change, development and improvements to patient experience, led by employees of the Trust. While related, they serve different purposes within the organisation. Understanding this difference, will help to effectively tailor this strategy to meet the needs of FT members.
2.	**Defining our membership** The membership of WSFT is split into public and staff constituencies. **The Public Constituency**: The Trust has a single Public Constituency. The area of the Public Constituency is made up of all local government electoral areas/wards of Suffolk, Norfolk, Cambridgeshire and Essex. **The Staff Constituency**: The Staff Constituency will comprise a single class. The Trust maintains a membership database for public members and staff details are taken from the Electronic Staff Record. Staff are members unless they choose to opt out.

	On 31 March 2024 there were 6,552 public members and 5,461 staff members, giving a total of 12,013 members.
3.	**Purpose of the Strategy** For the Trust to meet its responsibilities to stakeholders, including patients, staff, the community and system partners, the board of directors should ensure effective engagement with them, and encourage collaborative working at all levels with system partners. The purpose of this strategy is to outline our vision and methods to: - Develop our membership and ensure it is representative - Communicate with members and the public - Engage with members and the public to understand and facilitate feedback from members of the public to the Trust Membership and engagement strategy objectives are detailed in section 5.
4.	**Key Drivers for member, patient and public engagement** The Council has two main duties in legislation[1] (Health and Social Care Act 2012), included at paragraph 16 of the Trust Constitution, and as most recently described in the Code of Governance for NHS provider trusts 2022: *NHS foundation trusts are public benefit corporations and their boards of directors have a framework of local accountability through members and a council of governors. The NHS foundation trust council of governors is responsible for holding the non-executive directors individually and collectively to account. In turn, NHS foundation trust governors are accountable to the members who elect them and must represent their interests and the interests of the public. (Code of Governance)* *In fulfilling the Code's requirements of good governance, it states: Satisfactory engagement between the board of directors, the council of governors and members of foundation trusts, and patients, service users and the public is crucial to the effectiveness of trusts' corporate governance approach.* Section C, 5.15 (NHS foundation trusts only) *Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.* Health and Social Care Act 2012 empowers patients and gives a new focus to public health; it extends the duty of governors to represent the interests of the public as well as membership. NHS England's Your statutory duties and Addendum to Your statutory duties: A reference guide for NHS foundation trust governors, published October 2022 reiterates this expanding role.
5.	**Role of Council of Governors**

[1] https://www.legislation.gov.uk/ukpga/2012/7/part/4/enacted

	Members' views and opinions are heard through the Council of Governors. This strategy enables and supports the Council of Governors to carry out one of their statutory duties to fulfil their role - *representing the interests of the members of the NHS foundation trust and the public* which can be achieved through engagement. Governors are responsible for engaging with the local community and the public to promote the benefits of becoming a member of the Trust. They act as representatives of the members and the public, ensuring that their views and concerns are considered by the Trust's board of directors. Governors help raise awareness about the Trust and encourage people to join as members through various outreach activities. This can include attending community events, speaking to local groups, and utilising the Trust's communication channels to support developing a diverse and representative membership that reflects the demographics of the local community.
6.	**Oversight of membership engagement** (role of Board, Council of Governors and the Committee) The Board of Directors has an overall responsibility for the membership of the Trust. The Council of Governors is responsible for reviewing the Trust's membership and membership engagement. The Council of Governors will contribute to and support the delivery of strategy with support from the FT office. The Membership and Engagement Committee works to deliver the responsibilities of the strategy for the Council of Governors; reporting plans and findings to the Council.
7.	**Objectives of the strategy** The Trust is committed to being a successful membership organisation and strengthening its links with the local community. To achieve this vision, our strategy sets out three overarching objectives. These objectives form the framework by which we hold ourselves to account. The objectives recognise and build on the Trust's FIRST values, frameworks and processes which the Trust has in place to grow, engage and involve its membership.
	Objective 1: **Develop our membership** *We aim to:* - *Build and maintain an active membership* - *Ensure our membership is representative of the community we serve.*
	Objective 2: **Communicate with our membership and the public** *We aim to:* - *Sustain, review and improve communication with our members and the public to keep them informed through engaging communications that reflect their interests* - *Promote the work of the Trust's Governors, as representatives of our members and the public.*
	Objective 3: **Engage with members and the public to understand their interests**

	We aim to: - *Sustain, review and improve engagement activities with our members and the public* - *Ensure effective mechanisms are in place to capture feedback from members, patients and public* - *Use feedback mechanisms to enable Governors to canvass the opinion of members and the public on the Trust's forward plan, including its objectives, priorities and strategy.*
8.	**Existing activities to deliver objectives** Positive engagement with our members is extremely important. The Membership and Engagement Committee of the Council of Governors have considered how we can most effectively engage with our membership. Member recruitment and engagement are often most effective when undertaken together. Therefore, direct recruitment plans will also in effect provide effective engagement activities. Methods of engagement and communication used at present: • Area observations • 15 steps ward visits • Environmental reviews • Observing VOICE meetings • Membership on Experience of Care and Membership and Engagement Committee • Courtyard café events • Medicine for members • Annual members meeting • Trust members' newsletter • Other community events • Print and digital campaigns • Invitations to key events run by the Trust or partner organisations • Staff governors to communicate to staff via the "Green Sheet". Future vision of engagement plans with our members will also include: • Greater use of Trust's electronic communication with members • Identification of underrepresented groups to recognise areas for better engagement. • staff governors to explore new ways of engaging with staff and to raise the profile of staff governors e.g. holding staff member engagement sessions • working with partner organisations to establish best practice in membership engagement e.g. NHS Providers and other NHS FTs. **Recruitment plan** We aim to recruit new members to maintain our number of engaged public members. As part of the recruitment plan, experience has shown that engaging with the public is a very effective way of recruiting new members and gaining their views on services we provide at the West Suffolk Hospital, Newmarket Hospital and in the community. Methods of recruitment used at present include: • attending public meetings and events including festivals, stands in sports & healthy living events and recruitment fairs • on-line recruitment through the Trust's website • in-house e.g. Courtyard Café

	• public education events e.g. “medicine for members”. *Media coverage at present:* • Trust website and intranet • membership newsletter, Trust leaflets and messages • social media • emails to both staff and public members.
9.	**Membership and engagement development plan** A development plan to set out the steps we will take each year to implement the strategy will be developed and overseen by the Membership and Engagement committee so that it is clear how we will put our plans into action.
10.	**Evaluating impact and monitoring success** The progress on delivery of the membership and engagement strategy will be monitored on behalf of the Board of Directors by the Membership and Engagement Committee of the Council of Governors. The Membership and Engagement Committee will undertake the detailed monitoring of implementation evaluating success and impact and will report regularly to the Council of Governors. The FT Office and Membership and Engagement Committee will undertake a key role in leading and managing the implementation of this strategy and its future development. **Measures of success** The success of the strategy will be measured by the following criteria: • Membership diversity and inclusion of underrepresented groups • Membership numbers • Member attendance at annual members’ meeting • Number of events where governors or WSFT have a presence • Quality and quantity of feedback and responses to surveys and engagement with members/patients/public • ‘You said, we did’ examples **Continuous Learning** To ensure that both members and the Trust get the best out of membership, members will be able to provide feedback at any stage, for our learning and improvement into all membership initiatives. **Email**: foundationtrust@wsh.nhs.uk **Telephone:** 01284 713224 The Trust will also actively seek to learn lessons through: - Membership survey - Governor survey - Feedback forms at events - Membership database reports (e.g. meeting/event attendance, membership growth, membership demographics)

11.	**Governance of the strategy** The Membership and Engagement Committee will undertake the detailed monitoring and review progress against the objectives of this strategy reporting back on progress at the Council of Governors through an update from the committee chair. The Council will endorse the strategy and recommend to the Board for approval. This will be reviewed on a regular basis. An interim annual review of the strategy will be undertaken by the Membership and Engagement Committee with periodical reviews of the development plan by the Membership and Engagement Committee. The committee will also review progress against the objectives of this strategy quarterly reporting back on progress at the Council of Governors through an update from the committee chair.
12.	**Resources to support delivery of the strategy** The FT Office and Membership and Engagement Committee will undertake a key role in leading and managing the implementation of this strategy and its future development. The delivery of the strategy will be supported by various stakeholders including the Council of Governors, Executive Team, Foundation Trust Office, Communication team and Patient Experience and Engagement Team.

Approved by:
Council of Governors' Membership and Engagement Committee: 29 October 2024
Council of Governors:
Trust Board:

Annex 1 Becoming a member

Public membership

Any person aged 16 or over who lives within the membership area is eligible to be a public member. Public members are recruited on an opt-in basis.

Membership is completely free and gives everyone the chance to keep up to date with our news and to have a say about our work.

Contact the Foundation Trust membership office:

- Email: foundationtrust@wsh.nhs.uk
- Telephone: 01284 713224
- Online link here or https://secure.membra.co.uk/join/westsuffolk
- Request form from the membership office or from the hospital's main reception

Staff membership

All WSFT staff who are employed by the Trust under a contract of employment which has no fixed term; has a fixed term of at least 12 months; or have been continuously employed by the Trust under a contract of employment for at least 12 months are eligible to become staff members unless they choose to opt out.

Staff who exercise functions for the purposes of the Trust, without a contract of employment, continuously for a period of at least 12 months are also eligible to become staff members unless they choose to opt out. This does not include individuals who exercise functions for the purposes of the Trust on a voluntary basis.

Contact procedures for members:

Contact details for the Foundation Trust office are detailed above as well on the website.

Annex B: Governor elections engagement programme

Background

The Standards Committee met on 7 August 2024 and recommended an amendment to the Trust's Constitution for consideration by the Council relating to the duration of tenure for a Governor (Constitution clause 12. Council of Governors – tenure) - *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.*

The Council of Governors discussed in their meeting on 2 September and recommended the amendment to the Board of Directors for approval.

The Board in their meeting on 27 September considered the proposed amendment, and a query was raised regarding plans to maintain a balance between retaining expertise and bringing in fresh perspectives and encouraging diversity on the Council of Governors.

Recognising that this was not a time critical decision as the next governor elections are due in 2026, the Board agreed that clarification be provided in terms of how the Trust delivery the engagement programme for the Governor elections.

This report provides an outline of the engagement activities which will be undertaken as part of the next Governor elections. This builds on the range of activities undertaken previously but will also be informed by discussions with the West Suffolk Alliance and other relevant partners. The proposal will be developed with the Council of Governors through the Standards Committee and Membership and Engagement Committee.

Proposal

To maintain key role of governors in WSFT, it is essential to attract a diverse pool of candidates for elections. The previous engagement plan included communication and engagement with members and the public, prior to the formal elections and during the nomination period. The Trust recognises that Governor election as well as an important opportunity for us to secure adequate Governor nominations are an important opportunity to strengthen engagement with a diverse field of interest. The proposed approach aims to:

- Strengthen connection between the Trust, its members, and the wider public
- Effectively communicate the role and work of our governors
- Engage underrepresented groups
- Collaboration with partner organisations.

The proposed programme of activities includes:

- Targeted mailings to increase awareness and encourage applications e.g. election promotion flyers
- Promote awareness and understanding of governor roles through election communication and briefing materials, including members newsletter, social media, the Trust's website and others
- Conduct targeted communication to members who have previously expressed interest in the standing as a governor
- Collaborate with partner organisations e.g. Healthwatch Suffolk to promote elections and Trust initiatives
- Create an inclusive and representative pool of candidates, through targeted campaigns, collaboration with internal and external partners, and an emphasis on

meaningful engagement. This includes working with the Trust, Alliance and ICB engage teams to:
    - engage with networks for underrepresented groups
    - encourage participation through patient experience and engagement team leveraging their expertise and networks to reach diverse groups
    - Working with the VOICE network, staff forums, promotion with WSFT community teams and Healthwatch Suffolk for circulation to the community groups/organisations they support
- Publicise elections through newsletters (e.g. FT members' newsletter, green sheet, and staff briefings)
- Host briefing events for potential governor candidates to provide detailed insights into the role
- Schedule member and public engagement events to promote elections and interest, such as Courtyard café engagement sessions at WSH and NMH, medicine for members events, annual members meeting, charity events and other community activities
- Newsletters, Trust's social media, website and other channels to keep members informed
- Communication and support through regular updates and reminders to members about the nomination process to secure sufficient and diverse candidates for elections.

<u>Enhanced focus for 2026 elections:</u>

- Continue providing effective communication and resources to encourage sufficient nominations and interest in elections
- Further strengthen existing relationships and community links by collaborating with the West Suffolk Alliance, ESNEFT, and other local groups like Healthwatch to enhance outreach and share best practices
- Collaborating with Trust's patient experience and engagement team and Integrated Care System (ICS) engagement leads to maximise outreach impact and exploring joint projects
- Promote the profile of Trust initiatives and engage with Healthwatch and other similar local organisations to improve community links
- Encourage engaged membership that reflects the diversity of our population
- Utilise the refreshed Council of Governors' membership and engagement strategy as a framework that outlines key engagement priorities alongside key activities to be used as the Governor support tool for supporting in their outreach activities.

Annex B: Scheduled draft agenda items for next meeting – 31 January 2025

Description	Open	Closed	Type	Source	Director
Declaration of interests	✓	✓	Verbal	Matrix	All
Patient/staff story	✓	✓	Verbal	Matrix	SW / JMO
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 ST ST
Future System Board Report	✓		Written	Matrix	CEO
Digital Board report	✓		Written	Matrix	JR
Insight Committee – committee key issues (CKI) report - Finance report	✓		Written	Matrix	AJ / NC / JR
Financial recovery plan – 2025-26		✓	Written	Action	CEO
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 report - National patient and staff survey and recommender responses - Education report - including undergraduate training (6-monthly)	✓		Written	Matrix	TD / 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	RP / SW / RG
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 - 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					