11. EU Exit report

To ACCEPT the report

For Report

Presented by Helen Beck

Trust Board – 27 September 2019

Agenda item:	11			
Presented by:	Helen Beck, chief operating officer			
Prepared by:	Alex Baldwin, deputy chief operating officer			
Date prepared:	18 September 2019			
Subject:	EU Exit contingency planning			
Purpose:	x	For information		For approval

Executive summary:

This paper provides a brief update on the Trusts preparatory activity in advance of a no-deal EU Exit. It provides a high level summary of briefings received in the last 30 days.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
	x		

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

Previously considered by:	Scrutiny committee
Risk and assurance:	A lack of sufficient planning time given by national, regional and local organisations within our chain of authority. Competing and greater operational priorities at the time of announcement concerning winter pressures, flu etc
Legislation, regulatory, equality, diversity and dignity implications	

Recommendation: Scrutiny committee is asked to note the ongoing preparatory actions for EU Exit.

Summary

In preparation for a no deal EU Exit on 31 October the national team have established a series of regional briefing sessions.

Following the national web-ex of 16th July a regional briefing event was held on 16 August and focused on the impact of port contingency plans on health systems in the East of England. The key highlights are as follows:

- There are no expected port issues which will impact on the Suffolk health system. The Felixstowe traffic management system holds freight away from the port and there is low risk associated with stack arrangements or travel disruption.

- There are no issues expected at the two Essex airports (Stansted, Southend).

- The Essex seaports are at risk of disruption if the port of Dover becomes gridlocked. There is a high likelihood of travel disruption on the Kent road network in the event of delays at Dover which could cause congestion at the M25 J31 Thurrock interchange. This junction is the major interchange for the Essex ports and a major oil refinery which supplies 80% of the South East's fuel.

- There remain questions for the ambulance service on the likely impact to Suffolk if resource is moved to Essex in the event of delays in that area.

- We can expect daily sit rep reporting in addition to routine OPEL and evening reporting. The expectation is that this will be 7 days a week to commence from 21 October.

- We are expecting to receive communications guidance from the national team but to date this hasn't been cleared for release to us. We expect to provide a separate briefing session to the board once this is available.

In addition the Trust participates in routine Local Resilience Forum EU Exit teleconference, the most recent of which was held on 03 September. We have noted that all planning assumptions are at national level and are no more advanced that the EU Exit Operational Readiness Guidance released in December 18 on which our plans are based.

The East of England regional briefing session was held on 16 September and provided an opportunity for the national team to brief on current preparedness.

The clear message is that nationally health is as well prepared as any government department and probably more so given our experience in managing risk. The key threats as identified by the national team relate to operational capacity and social care provision.

As previously noted the Trust will manage any event EU Exit or otherwise via the C3 (command, control, co-ordination) plan. This provides provision for contingency and long term relief to operational teams managing escalated incidents for any sustained periods of time. It also includes provision for management of multiple concurrent incidents/issues.

We have also sought reassurance from our local authority partners on their EU Exit assumptions. Suffolk County Council Adult and Community Services (ACS) have assessed their EU national workforce as low risk for providers and social care staff. Currently 6% of their workforce are EU nationals. Like most providers their key risk is an accumulation of incidents, such as bad weather, fuel disruption or high levels of hospital discharge.

The Trust is engaged with local, system and regional colleagues to share best practice about EU Exit preparedness and to review system response to pressures faced by other partner agencies. It is expected that a system review of risk will take place in early October and lessons will be shared thereafter. In support the Trusts Operational EU Exit planning group will meet weekly between now and 31 October.

In summary and for reassurance, the Trust remains prepared in the event of an EU Exit with no deal and there has been no material change to our readiness.

Trust Board will be updated on any material changes to this status between now and 31 October.

12. Non-urgent patient transport update

To ACCEPT the report

For Approval

Presented by Helen Beck

Trust Board – 27 September 2019

Agenda item:	12			
Presented by:	Helen Beck, chief operating officer			
Prepared by:	Alex Baldwin, deputy chief operating officer			
Date prepared:	17th September 2019			
Subject:	Non-emergency patient transport (NEPTS)			
Purpose:	x	For information		For approval

Executive summary:

This paper provides and update on progress with management of the non-emergency patient transport service (NEPTS) contract held by E-Zec Medical Transport Services (E-Zec).

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
	x		

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

Previously considered by:	N/A
Risk and assurance:	
Legislation, regulatory, equality, diversity and dignity implications	*Patient safety*

Recommendation:
The Board is asked to note the contents of this report.

Introduction

The purpose of this paper is to provide the Trust Board with an updated position on the Non-Emergency Patient Transport Service (NEPTS) contract, held by E-Zec Medical Transport Services (E-Zec).

The GC9 process (Contract Management section NHSE Standard Contract) was started in May 2019 to address the performance issues at E-Zec. A Remedial Action Plan (RAP) was agreed with the provider and commissioners, including West Suffolk Foundation Trust in June 2019 with a trajectory set for recovery by November 2019 for underperforming KPI's.

Background and context

For some time the joint commissioners have had significant concerns regarding the quality and efficiency of service provided by E-Zec. An initial Red2Green review was held in February 2019 and a service delivery and improvement (SDIP) developed and agreed. This was followed by an assurance visit to E-Zec in May 2019 to understand how the SDIP was making improvement and change embedded. Unfortunately the commissioners were not assured that significant progress had been made or processes embedded and a performance notice was issue in May 2019. Subsequently a rapid improvement plan (RAP) was signed off by all parties in June 2019.

Since the agreement of the RAP weekly assurance calls have been taking place with representatives of the joint commissioners and E-Zec. The RAP includes work streams covering recruitment and retention, staff and vehicle tracking, rota and demand planning and communication, staff and patient engagement.

Some progress has been noted;

- Recruitment has been successful with full establishment of staff in place by end of August. This in advance of the original September deadline.
- Some improvements in staff morale has been reported and retention has also improved.
- There have been some improvements in communication between E-Zec and hospital staff although this is sporadic.
- 3RD party resource in being booked further in advance to alleviate some of the demand issues.

However, these improvements have not significantly impacted performance nor has it allowed a reduced engagement from Trust and CCG staff in managing delays day-to-day.

Performance

There are five key performance indicators that are being monitored under the RAP, as at the end of July E-Zec were compliant were one of the five.

A summary of the five KPI's, performance and required trajectory is provided below.

At the time of writing August KPI data is has not been released by E-Zec.

At a meeting of the associate commissioner on 16 August it was agreed that performance had not improved to the required level agreed within the RAP trajectory and the next steps of GC9 would be followed. As a result an exception report was issued to E-Zec on 23 August 2019 with an expectation that trajectory is met no later than 20 operational days thereafter. A full report is expected to be presented by E-Zec on 27th September.

The joint commissioners have the option to withhold up to 2% of the actual monthly value for each KPI/action breached up to a maximum of 10% of the actual monthly value. It has been agreed that financial penalty is unlikely to improve performance at this stage, however this remains a contractual option.

Table 1: RAP KPI performance July 2019

KPI no.	Key Performance Indicator	Target		Baseline	Jul-19 Month 1	Aug-19 Month 2	Sep-19 Month 3	Oct-19 Month 4	Nov-19 Month 5
SUF_LQR_001	In-bound Journeys - % Service Users arriving between 5 and 60 minutes prior to their booked appointment time.	95%	Actual		66.80%				
			Target	**66.64**	72.3	77.98	83.65	89.32	95
SUF_LQR_002b	Journey Times - % Service Users travelling within the Ipswich and East Suffolk CCG and West Suffolk CCG combined footprint on the vehicle between 0 and 60 minutes.	85%	Actual		80.07%				
			Target	**78.61**	79.89	81.17	82.45	83.73	85.01
SUF_LQR_003a	Outbound Outpatient Journeys - % Service Users waiting no more than 60 minutes after their booked and confirmed collection time.	95%	Actual		79.63%				
			Target	**83.41**	85.73	88.05	90.37	92.69	95.01
SUF_LQR_003b	Outbound Discharge & Transfer Journeys - % Service Users waiting no more than 60 minutes after their booked and confirmed collection time.	95%	Actual		72.23%				
			Target	**69.51**	74.6	79.69	84.78	89.87	95
SUF_LQR_008	Front Door and Assessment Area Discharges - % Service Users collected no more than 60 minutes after initial contact or requested time.	90%	Actual		75.00%				
			Target	**72.41**	75.93	79.45	82.97	86.49	90.01

Further options

The joint commissioners are considering a range of options to improve service performance for patients accessing non-emergency patient transport. In support, a visit to a high performing health economy which uses E-Zec is planned for October 2019. We are also engaged with Great Yarmouth and Waveney CCG who procured E-Zec at the same time and who report a contract delivered in compliance with KPI's.

The Trust will continue with the current monitoring and scrutiny of performance and Board will receive a further update in October.

13. Winter planning - tracking report

To ACCEPT the report

For Report

Presented by Helen Beck

Trust Board – 27 September 2019

Agenda item:	13			
Presented by:	Helen Beck, chief operating officer			
Prepared by:	Alex Baldwin, deputy chief operating officer Nicola Cottington, associate director of operations Sarah Watson, head of nursing Lesley Standing, head of operational improvement			
Date prepared:	20 September 2019			
Subject:	Winter planning			
Purpose:		For information	x	For approval

Executive summary:

This paper provides an update on winter planning including proposals for the utilisation of additional bed capacity for winter 2019/20 taking in to account the predicted demand for beds and physical space available. It also provides a summary of indicative costs and key operational milestones for delivery.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
	x		

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

Previously considered by:	Winter planning group
Risk and assurance:	Failure to provide quality care to patients who require admission to hospital. Reputational risks around failure to achieve required standards and targets. Risk to relationships with external agencies.
Legislation, regulatory, equality, diversity and dignity implications	

Recommendation: The board is asked to note the content of the paper and support the proposal outlined.

Background

The Trust can anticipate an increase in activity during the winter months driven as a consequence of diarrhoea & vomiting outbreaks, flu or exceptionally cold weather spells that inevitably lead to an increase in emergency admissions. In previous years, additional winter beds have been opened to meet this demand, in conjunction with initiatives to improve patient flow.

For winter 2018/19 the original plan agreed by Executive Directors was to retain the beds on G3 following the opening of the Cardiac Centre in November 2018, and open a therapy-led medically optimised winter ward on G9. Difficulty recruiting sufficient staff instigated a change in direction and a decision was taken to commission 20 beds in care homes rather than open G9. Demand during 2018/19 was higher than the planning assumptions that were applied. January 2019 saw 11% more attendances at ED (equating to 700 patients extra through the door year on year) and 10% more admissions (300 more patients admitted) than the previous January against a 4.5% predicted growth.

As a result of the above pressures the Trust was forced to open ward G9 for a significant part of the winter period. We attempted to only partially open the ward but at times it was fully open to 30 patients. We also moved the gynaecology ward F14 to F10 which had been vacated by respiratory when they moved to F8. This move provided an additional 10 surge beds which were planned to be open for short periods of time but in reality have been open intermittently since January. These 2 additional areas provided between 27 and 40 additional surge beds throughout January, February and March which has placed a significant burden on staffing across all disciplines.

G9 was opened at the end of December 2018 and remained open intermittently until June 2019. This created staffing challenges across the Trust with many wards below bay-based nursing levels on most days. The extended opening of G9 and the continued opening of the whole of G3 have also had financial impacts for the Medicine Division.

The aim for winter 2019/20 is to finalise plans early to enable the safe and timely implementation of additional capacity to meet demand.

Current demand

Demand into A&E from the west Suffolk system has been rising year on year with a further increase into West Suffolk Foundation Trust (WSFT.) In 2018/19 WSFT saw a 4.9% increase on attendance compared to 17/18, with WSCCG patients at WSFT increasing by 3.6%. However if the demand for patients referred directly to assessment wards by GP's is taken into account, there has been a 10% rise in demand at the front door.

The bed model and operational plans to deal with predicted demand for 19/20 is described below

Bed Model

Our assumptions are based on a predictive bed model which uses data from 2017/18 and 2018/19. This includes both hospital admissions and occupancy of additional community beds in 18/19. The model provides a summary of projected demand and bed requirement.

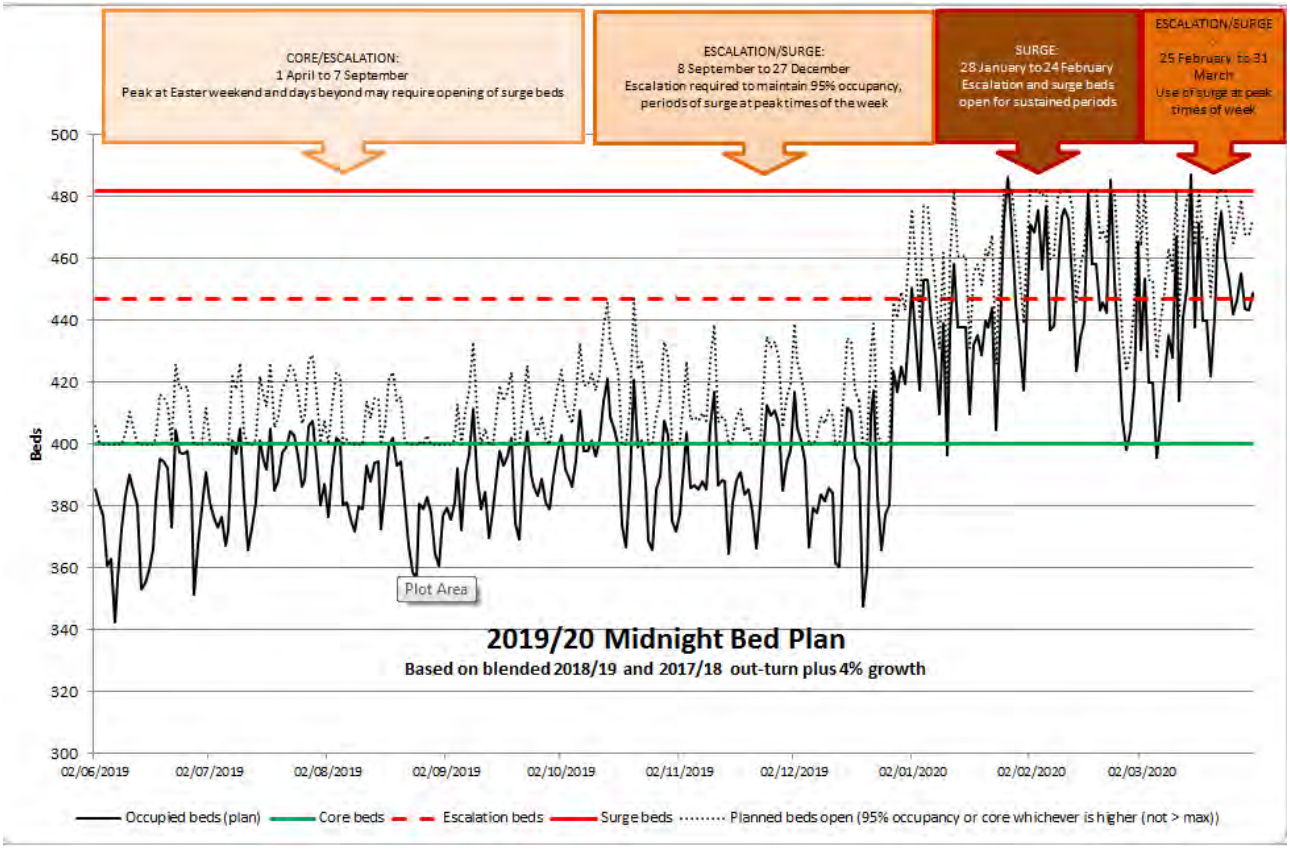
The model makes the following assumptions about our physical capacity:

- 13 beds on G3 are open for an additional 6 months of the year.
- 6 beds on F5 and F6 (12 in total) are reserved as escalation capacity (reflecting the plans for enhanced surgical assessment unit).
- AAU is empty at midnight daily.

- CDU have 6 patients at midnight daily.
- F10 is the designated escalation ward and will be opened to 25 beds.
- G9 is the designated surge ward and will be opened as required up to a maximum of 29 beds.
- The surge capacity on G1, G3 and F8 has been removed.
- 10 community beds are included as escalation capacity.
- The surgical elective programme continues as normal with no plan to release physical capacity or staff from F4.

A number of scenarios have been modelled as follows:

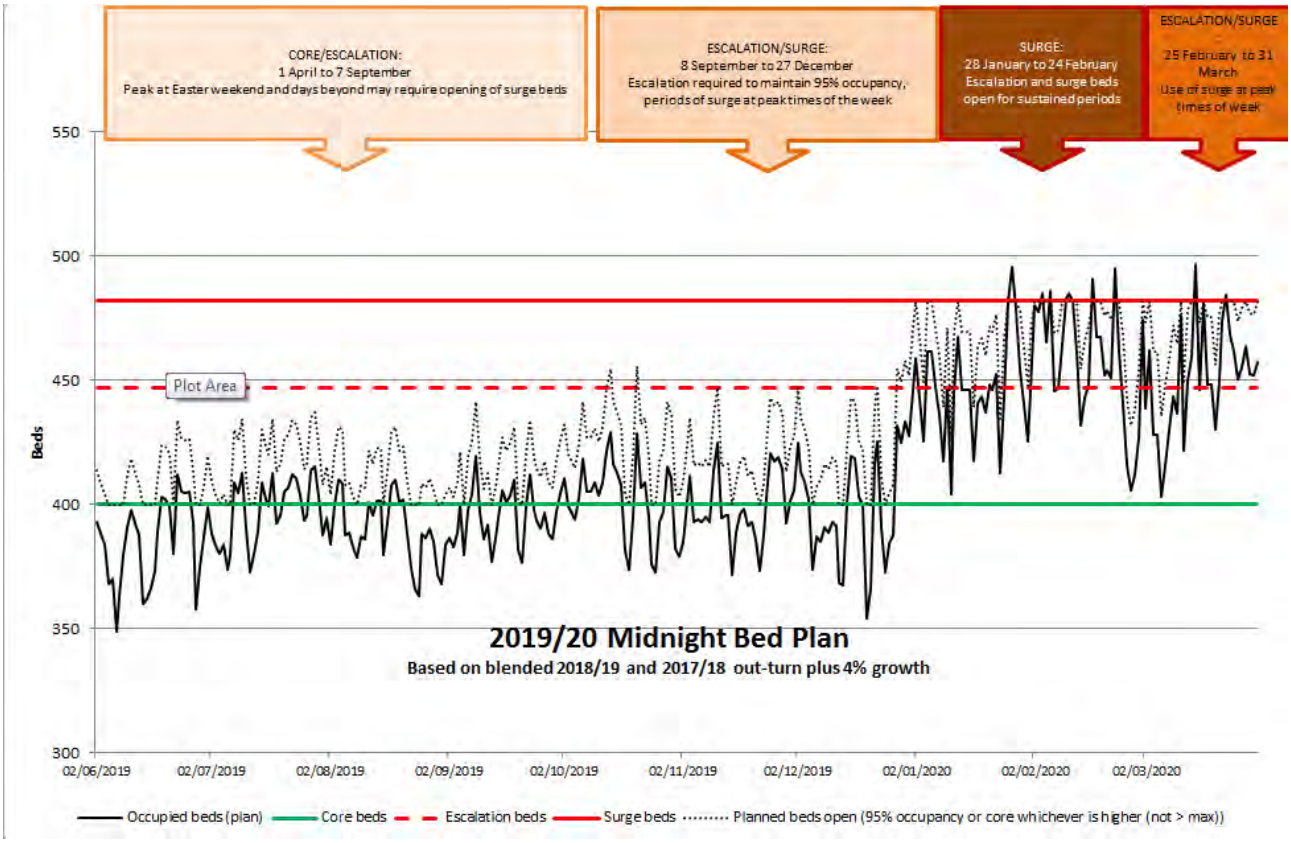
Initial bed modelling is based on a **4%** increase in demand in line with national assumptions;



In this scenario escalation beds will be required from September onwards in an ad-hoc way with robust escalation capacity required from 27 December. The model suggests surge capacity is required from 29 January until the end of March.

The Trust has a core bed base of 400. It has capacity for 47 escalation beds and 35 surge beds and a total bed base of **482**. The model predicts the maximum number of required beds as **487**.

Changing the demand profile to **6%** has the following impact.



The demand profile is unchanged but the maximum number of beds required increases to **497** and the frequency at which we exceed our capacity increases also. In this scenario the Trust would consider the use of AAU capacity overnight with the associated impact on patient experience and flow.

In a worst case scenario of a **9%** increase in demand the total number of beds required would be **511**; an increase in required bed capacity of **29,** equivalent to another ward.

Operational plan

In line with the demand assumptions above the operational plan for winter is as follows:

- 21 October 2019 – Gynae to have moved from F10 back to F14.
- 16 December 2019 – F10 to open as a medical escalation ward in preparation for significant increase in demand expected from 27 December.
- 1 January 2020 – 10 additional community beds available for admission avoidance and reablement support. This will be available until 31 March 2020.
- 27 January 2020 – G9 is opened as medical surge capacity in preparation for significant increase in demand expected from 29 January.

Weekly winter pressures meetings are already in place to monitor and co-ordinate the work streams to deliver additional capacity.

Demand management initiatives

Over and above the plan and assumptions set out above there are a number of demand management initiatives planned to mitigate some of the impact of increasing demand during this

period. These initiatives include admission avoidance schemes and more effective MDT management of patients once they are in hospital.

Virtual ward

The virtual ward initiative increases reablement support in the community with the view to managing patients at home in a "virtual" environment rather than in a hospital or community bed. This initiative is currently in a pilot phase but assessments suggest that up to 10 beds can be released on further roll-out of the initiative.

Extension of Pathway 1

Expansion of Pathway 1 as planned, to include the winter ward and also to include reciprocal arrangements with neighbouring CCG areas to expedite discharge of out of area patients. This is likely to reduce the number of stranded patient which in turn will improve flow through the hospital.

Frailty

The test and learn pilot has finished and whilst the formal assessment has not yet concluded there is evidence that demonstrates an increased zero day and reduced overall length of stay for patients who were assessed and managed via the unit. It is anticipated that the roll out of the model will commence at the beginning of October.

Surgical ambulatory emergency care (SAEC)

The SAEC model will deliver benefit via admission avoidance and a release of up to 12 surgical beds. Whilst these are included in the bed model as escalation capacity they can be used as required and the service will facilitate improved flow. However it will limit the ability for medicine to outlie patients in surgical beds and therefore needs to be managed in conjunction with increased admission avoidance via the medical ambulatory model.

Stranded patients' review

An enhanced approach to the review of super stranded patients is proposed in the lead up to winter. This will involve a multidisciplinary review of patients with a LOS over 21 days on the ward once a week. It is proposed that the MDT includes senior medical, nursing, therapy and social care staff who will meet with the ward manager, doctor and senior matron to review patients and agree plans for action. This will be led by the deputy chief operating officer.

Criteria led discharge

It is recognised that there is an opportunity to increase the volume of patients whose discharge is criteria led and managed by the nursing team. A pilot is currently underway on F8 and if successful we expect to roll it out to all wards prior to winter. This is particularly likely to improve our discharge rate at the weekend and will support the identification of golden patients which in turn improved flow.

Risk

There are risks associated with the operational plan. Recruitment of registered nurses is going well with limited vacancies projected by the end of October; however there remain a number of nursing assistant vacancies.

In addition to the financial impact which is set out below there is risk associated with delayed discharge, particularly relating to social care which could have significant impact on length of stay.

Finally, the impact of EU Exit, whilst mitigated as far as is possible, is a potential additional risk in a period when the health and social care system is most operationally stretched.

Costs

The costs associated with the above plan include £206k funding for G3 (to account for the unfunded beds which are currently open) £246k to open G9 and a similar figure for F10.

Funding for the additional community beds has been provided from system transformation funding.

These costs should be considered in conjunction with the Trusts overall financial position and recovery plans.

Conclusion

The Trust can anticipate an increase in demand through the winter period and has set out here a robust operational plan to manage that increase in activity as effectively as possible keeping in mind the need to manage patient safety at all times.

The Board is asked to consider these plans and approve their delivery.

10:20 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

14. Nurse staffing report

To ACCEPT a report on monthly nurse staffing levels

For Report

Presented by Rowan Procter

Trust Board – 27th September 2019

Agenda item:	14			
Presented by:	Rowan Procter, Executive Chief Nurse			
Prepared by:	Rowan Procter, Executive Chief Nurse, and Sinead Collins, Clinical Business Manager			
Date prepared:	20th September 2019			
Subject:	Quality and Workforce Report & Dashboard – Nursing			
Purpose:	X	For information		For approval

Executive summary:
The aim of the Quality and Workforce Report and Dashboard is to enhance the understanding ward and theatre staff have on the service they deliver, identify variation in practice, investigate and correct unwarranted variation and lead change to demonstrate value. This dashboard has been altered as of July 2019 report to give the Trust Board a quick overview staff levels and patient safety. It also complies with national expectation to show staffing levels within Open Trust Board Papers but further changes are required to fit in NQB requirements.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
	X	**X**	

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

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

Recommendation:
This paper is to provide overview of July and August's position about nursing staff and actions taken to mitigate, future plans and update on national requirements.
The dashboard provides summary of nursing staffing levels and effect on nurse sensitive indicators

NHSI Safer Staffing - National Quality Board Recommendations

'Developing workforce safeguards – October 2018' document released by NHSI. First Task & Finish Group meeting occurred at the beginning of September to be set up to get QIA methodology and review process. A follow-up meeting is required with HR leads before next meeting occurs to agree workforce plan next steps. Most areas highlighted to include by document have been completed in the August report, e.g. Outpatients.

Nursing vacancy accuracy position – July and August figures are still not completely accurate and continued work with HR, Finance and Operations to occur.

Healthroster implementation into community – A meeting with Allocate/Healthroster occurred 19th September to show the aspects available and to help build a business case to implement into the system. Conversations with John Connelly, PMO are occurring to consider with NHSI bid.

Overview of July and August nurse staffing position

Are we safe?
Matrons continue to have daily safety huddles and now on 7 day shift pattern to help provide safe staffing assurance

Assurance for community staffing has interim measures of daily calls with area leads and the local area managers and nursing leads, however for a more visual and accurate measure they will have to wait till later in year before HealthRoster can start to be implemented. Senior team members are actively working with team leads to implement safer staffing measures, as identified in WSFT rostering policy.

Complaints have seen a gradual decrease in July and August. So one complaint could cover numerous areas

Are we efficient?
The sickness has improved this month over July and August

The Heads of Nursing for Medicine, Surgery and Community meet with senior operational managers, West Suffolk Professionals Manager and the HealthRoster Lead on a weekly basis, to review forthcoming rosters with the aim to identify staffing deficits in a timely way. This ensures early identification of vacant shifts to WSP staff and provides an opportunity for proactive planning and mitigation of risk.

CHPPD figures similar to comparable wards in other hospitals.

In line with NQB standards – some areas/wards record on the Risk Register on Datix that there are staffing concerns and mitigated actions taken.

Future planning – Nursing staff

Overseas Nurses/Nursing Assistants

Month	Number of arrivals	
Jul-18	3	
Aug-18	4	
Sep-18	6	
Oct-18	9	
Nov-18	5	
Dec-18	0	
Jan-19	4	
Feb-19	7	
Mar-19	6	
Apr-19	0	
May-19	16	
Jun-19	14	
Jul-19	13	
Aug-19	0	No Overseas arrived in August due to the number of newly qualified due to start in September 2019
Sep-19	12	Due to arrive on 26 September 2019
Total	74	

Information as at 20 September 2019:
65 overseas nurses have passed their OSCE and are now working as Band 5 Nurses
6 OSCE booked for 16 October 19
2 OSCES booked for 18 October 2019
6 OSCES booked for 30 October 2019
4 OSCES booked for 31 October 2019
4 additional OSCES currently being booked for October 2019

12 further nurses due to arrive on 31 October 2019.

WSH Existing Staff:
1 WSH NA passed her OSCE on 3rd June 2019
1 WSH NA due to take her OSCE on 31 October 2019

QUALITY AND WORKFORCE DASHBOARD

Month Reporting	Jul-19		Establishment for the Financial Year 2019/20		Data for July 2019																	
					Workforce													Nursing Sensitive Indicators					
Trust	Ward/Area Name	Speciality	Current Funded Total Establishment Registered to Unregistered (WTE)		Fill rate Registered %		Fill rate Unregistered %		Bank Use %	Agency use %	Overall Care Hours Per Patient Day	Vacancies (WTE)		Sickness (%)	Annual Leave (%)	Maternity/Paternity Leave (%)	Pressure Ucer Incidences (Hospital Acquired)	Nursing/Midwifery Administrative Medication Errors	Falls (with Harm)	Red Incidents	Complaints	Compliments
			Registered	Unregistered	Day	Night	Day	Night				Registered	Unregistered									
WSFT	ED	Emergency Department	54.91	23.43	92.0%	113.3%	99.2%	160.6%	6.1%	9.2%	N/A	-14.10	-0.30	5.30%	13.40%	2.60%	N/A	12	1	2	4	9
WSFT	AAU	Acute Admission Unit	27.30	29.59	75.4%	50.0%	74.9%	100.0%	5.1%	1.4%	11.2	-2.70	5.10	2.20%	13.00%	5.00%	1	6	3	0	0	0
WSFT	F7	Short Stay Ward	22.84	30.94	65.5%	71.5%	100.1%	108.7%	13.0%	3.3%	6.1	-2.90	-3.70	5.00%	12.20%	5.10%	3	5	1	0	1	0
WSFT	CCS	Critical Care Services	41.07	1.88	101.3%	94.6%	N/A	N/A	2.4%	7.8%	26.0	-1.40	2.00	1.40%	15.40%	4.40%	2	3	0	0	0	5
WSFT	Theatres	Theatres	61.68	22.27	98.1%	98.9%	N/A	N/A	2.3%	0.0%	N/A	-2.20	1.00	8.50%	14.10%	0.90%	0	4	0	0	0	0
WSFT	Recovery	Theatres	21.23	0.96	147.0%	101.6%	48.8%	N/A	2.5%	0.0%	N/A	0.50	0.00	4.20%	15.90%	4.30%	0	0	N/A	0	0	0
WSFT	Day Surgery Unit	Theatres	28.43	8.59	56.4%	N/A	136.6%	N/A	0.8%	0.0%	N/A	-2.90	1.50	7.70%	12.10%	0.00%	0	0	0	0	0	0
	Day Surgery Wards		11.76	1.79					11.1%	0.0%		-1.60	0.10	5.70%	15.80%	0.00%						
WSFT	ETC	Opthalmology	TBC	TBC	TBC	TBC	TBC	TBC	0.5%	0.0%	N/A	TBC	TBC	0.60%	17.60%	2.50%	0	1	0	0	1	4
WSFT	Endoscopy	Endoscopy	TBC	TBC	157.4%	N/A	152.3%	N/A	0.0%	0.0%	N/A	TBC	TBC	5.40%	17.10%	2.00%	0	1	0		0	1
WSFT	Cardiac Centre	Cardiology	38.14	15.20	81.3%	83.9%	113.4%	106.5%	2.0%	0.0%	10.0	-3.80	2.50	3.60%	14.00%	3.70%	1	1	0	0	0	0
WSFT	G1	Palliative Care	23.96	8.31	70.1%	102.8%	102.9%	N/A	8.4%	2.1%	6.7	-1.40	0.90	6.90%	10.50%	5.00%	1	6	3	0	0	0
WSFT	G3	Endocrine & Medicine	TBC	TBC	122.7%	155.0%	162.3%	132.3%	10.6%	7.8%	6.3	TBC	TBC	5.50%	13.40%	0.00%	1	1	0	0	0	0
WSFT	G4	Elderly Medicine	19.16	24.36	83.0%	79.7%	89.3%	107.3%	15.6%	2.9%	5.6	-3.70	-0.90	6.00%	11.70%	4.30%	3	3	0	0	0	0
WSFT	G5	Elderly Medicine	18.41	22.66	87.3%	90.8%	90.7%	108.9%	17.1%	4.9%	4.8	-3.00	-3.90	6.00%	14.10%	5.30%	2	3	3	1	0	1
WSFT	G8	Stroke	23.15	28.87	81.3%	89.6%	92.3%	104.9%	12.4%	9.0%	6.4	-6.10	1.00	3.40%	14.40%	11.20%	1	2	2	1	2	1
WSFT	F1	Paediatrics	18.13	7.16	123.2%	164.7%	80.1%	N/A	13.9%	0.0%	8.5	-2.10	1.70	1.80%	16.30%	0.00%	N/A	0	N/A	0	0	2
WSFT	F3	Trauma and Orthopaedics	19.58	22.27	105.4%	94.9%	80.6%	104.1%	18.5%	8.7%	6.7	-6.00	-1.60	5.80%	14.20%	3.50%	0	5	2	1	0	0
WSFT	F4	Trauma and Orthopaedics	12.78	10.59	82.3%	95.6%	74.9%	106.7%	11.5%	3.4%	10.2	-2.30	-0.80	2.60%	15.30%	4.20%	0	1	1	0	0	1
WSFT	F5	General Surgery & ENT	19.58	14.51	99.2%	95.7%	94.2%	109.0%	6.9%	0.5%	5.5	1.00	-0.80	3.60%	13.50%	5.00%	1	3	2	0	1	7
WSFT	F6	General Surgery	19.57	14.51	106.2%	96.8%	97.1%	107.8%	6.9%	5.8%	5.2	-1.80	1.80	7.50%	18.80%	1.90%	0	2	0	0	0	0
WSFT	F8	Respiratory	19.90	20.13	114.8%	92.6%	98.1%	100.7%	6.8%	6.3%	7.0	-3.10	-1.80	4.10%	13.90%	0.00%	0	2	1	0	0	1
WSFT	F9	Gastroenterology	20.32	22.56	101.5%	99.0%	79.0%	129.3%	16.4%	0.0%	5.5	-3.50	-3.00	6.70%	13.70%	5.70%	1	3	1	0	1	0
WSFT	F11	Maternity															0	5	0	0	1	0
WSFT	MLBU	Midwifery Led Birthing Unit	49.58	13.89	92.1%	92.6%	78.0%	73.5%	9.8%	0.0%	N/A	2.60	0.40	7.90%	11.30%	5.00%	0	0	0	0	0	0
WSFT	Labour Suite	Maternity															0	1	0	0	0	2
WSFT	Antenatal Clinic	Maternity	TBC	TBC	TBC	TBC	TBC	TBC	3.0%	0.0%	N/A	TBC	TBC	12.00%	9.60%	0.00%	0	0	0	0	2	0
Community	Community Midwifery	Maternity	TBC	TBC	TBC	TBC	TBC	TBC	7.8%	0.0%	N/A	-3.00	0.00	7.50%	18.60%	7.60%	0	0	0	0	0	0
WSFT	F12	Infection Control	11.02	5.00	84.2%	90.5%	109.6%	103.2%	11.9%	1.1%	9.2	-1.90	0.90	5.70%	15.30%	0.00%	0	0	1	0	0	4
WSFT	F10	Gynaecology	11.18	1.00	113.0%	107.1%	N/A	N/A	34.6%	0.0%	8.0	-1.90	0.00	5.00%	12.00%	0.00%	0	4	0	0	0	1
WSFT	MTU	Medical Treatment Unit	7.04	1.80	91.9%	N/A	81.2%	N/A	9.4%	0.0%	N/A	-0.20	0.00	11.20%	13.30%	0.00%	0	0	0	0	0	0
WSFT	NNU	Neonatal	20.85	3.64	103.2%	84.0%	35.5%	61.3%	0.5%	0.0%	24.2	-1.60	-1.00	1.70%	18.50%	4.40%	N/A	0	N/A	0	0	11
WSFT	Outpatients	Outpatients	TBC	TBC	85.1%	N/A	116.2%	N/A	4.2%	0.0%	N/A	TBC	TBC	6.80%	14.20%	3.40%	0	0	0	0	0	0
WSFT	Radiology Nursing	Radiology	TBC	TBC	70.6%	N/A	140.5%	N/A	8.5%	0.0%	N/A	TBC	TBC	5.60%	7.90%	6.10%	0	0	0	0	0	2
Newmarket	Rosemary Ward	Step - down	12.34	13.47	118.9%	100.0%	102.8%	99.0%	7.4%	17.2%	5.9	-3.10	-0.40	4.70%	17.00%	0.00%	0	0	1	0	0	0
Glastonbury Court	Kings Suite	Medically Fit	11.50	12.64	122.5%	97.6%	99.3%	104.5%	8.7%	0.4%	4.8	-1.20	-0.60	5.90%	13.10%	0.00%	0	2	1	0	0	0
					97.76%	97.71%	98.65%	107.50%				-73.40	0.10	5.40%	14.15%	3.03%	17	76	23	5	13	52
					AVG	AVG	AVG	AVG				TOTAL	TOTAL	AVG	AVG	AVG	TOTAL	TOTAL	TOTAL	TOTAL	TOTAL	TOTAL

Trust	Team Name	Speciality	Current Funded Total Establishment Registered to Unregistered (WTE)		Patient facing contact (hrs)	Unplanned requests	Vacancies (WTE)		Sickness (%)	Annual Leave (%)	Maternity/Paternity Leave (%)	Pressure Ulcer Incidences (New)	Nursing/Midwifery Administrative Medication Errors	Red Incidents	Missed Visits	Complaints	Compliments
			Registered	Unregistered			Registered	Unregistered									
Community	Bury Town	Community Heath Team	17.59	5.60	1466.45	98	-2.97	-0.20	4.70%	Not available comprehensively till Healthroster implemented	Not available this month	6	1	0	0	0	0
Community	Bury Rural	Community Heath Team	10.00	1.20	805.15	48	-0.30	-1.00	0.72%			3	0	0	0	0	0
Community	Mildenhall & Brandon	Community Heath Team	12.59	3.91	881.65	69	-0.60	-0.11	7.24%			0	1	0	1	0	0
Community	Newmarket	Community Heath Team	8.10	2.75	616.17	37	0.00	0.00	2.21%			2	0	0	1	0	0
Community	Sudbury	Community Heath Team	18.03	8.36	1266.73	89	-4.40	-1.00	7.16%			8	1	0	2	0	0
Community	Haverhill	Community Heath Team	8.97	4.23	934.15	61	-1.60	0.00	5.83%			1	1	0	0	0	0
Community	Admission Prevention Service	Specialist Services	11.28	3.45	139.48	0	TBC	TBC	5.68%			0	2	0	0	0	0
Community	Specialist Services	Cardiac Rehab and Heart Failure	TBC	TBC	607.80	3	TBC	TBC	0.00%			0	0	0	0	0	0
Community	Children	Community Paediatrics	16.37	15.01	1262.47	1	0.00	-0.24	5.62%			N/A	0	1	0	0	0
					7980.05	406.00	-9.87	-2.55	4.35%	#DIV/0!	#DIV/0!	20	6	1	4	0	0
					TOTAL	TOTAL	TOTAL	TOTAL	AVG	AVG	AVG	TOTAL	TOTAL	TOTAL	TOTAL	TOTAL	TOTAL

Explanations	
	Fill Rate: an indication of patient safety - national target 80% (less than = red), Trust internal target 85% (equal and greater than = green)
	In vacancy column: - means vacancy and + means over established. Excludes maternity leave as separate column
	Sickness Trust target: <3.5%
	Annual Leave target: (12% - 16%)
	Maternity Leave: no target
	Medication errors are not always down to nursing and can be pharmacist or medical staff as well
	DSU has been split into ward and unit only by HR, that is why only a section has been split in this dashboard
	F10 (F14) gynae inpatients ward no of beds 16 and 2 SR - and have a ward attender section

Key	
N/A	Not applicable
ETC	Eye Treatment Centre
I/D	Inappropriate data
TBC	To be confirmed

QUALITY AND WORKFORCE DASHBOARD

Month Reporting	Aug-19		Establishment for the Financial Year 2019/20		Data for August 2019																	
					Workforce													Nursing Sensitive Indicators					
Trust	Ward/Area Name	Speciality	Current Funded Total Establishment Registered to Unregistered (WTE)		Fill rate Registered %		Fill rate Unregistered %		Bank Use %	Agency use %	Overall Care Hours Per Patient Day	Vacancies (WTE)		Sickness (%)	Annual Leave (%)	Maternity/Paternity Leave (%)	Pressure Ulcer Incidences (Hospital Acquired)	Nursing/Midwifery Administrative Medication Errors	Falls (with Harm)	Red Incidents	Complaints	Compliments
			Registered	Unregistered	Day	Night	Day	Night				Registered	Unregistered									
WSFT	ED	Emergency Department	54.91	23.43	94.4%	110.4%	83.9%	141.4%	7.7%	15.5%	N/A	-13.10	-4.30	6.00%	17.50%	1.30%	N/A	5	0	2	2	5
WSFT	AAU	Acute Admission Unit	27.30	29.59	77.3%	66.4%	79.3%	112.8%	5.2%	4.2%	17.2	-1.60	3.70	3.40%	16.30%	6.50%	0	4	0	0	0	0
WSFT	F7	Short Stay Ward	22.84	30.94	71.9%	89.3%	99.5%	112.6%	17.0%	2.9%	6.9	-1.90	-3.80	8.40%	14.30%	5.00%	1	2	6	0	0	0
WSFT	CCS	Critical Care Services	41.07	1.88	99.6%	96.4%	N/A	N/A	3.5%	5.4%	24.8	-1.40	2.00	2.40%	15.50%	4.30%	4	4	0	0	0	0
WSFT	Theatres	Theatres	61.68	22.27	92.1%	99.9%	N/A	N/A	2.8%	0.0%	N/A	-2.80	2.20	5.30%	18.80%	0.70%	0	2	0	0	0	0
WSFT	Recovery	Theatres	21.23	0.96	142.4%	105.8%	65.0%	N/A	0.8%	0.0%	N/A	0.50	0.00	1.10%	15.00%	4.30%	0	2	N/A	0	0	0
WSFT	Day Surgery Unit	Theatres	28.43	8.59	49.7%	N/A	134.4%	N/A	3.6%	0.0%	N/A	-8.00	0.90	10.80%	13.80%	0.00%	0	0	0	0	0	6
	Day Surgery Wards		11.76	1.79					10.3%	0.0%		-0.60	0.10	3.10%	24.30%	3.40%						
WSFT	ETC	Opthalmology	TBC	TBC	72.5%	N/A	155.3%	N/A	0.3%	0.0%	N/A	2.70	2.60	0.40%	18.90%	4.80%	0	1	0	0	1	3
WSFT	Endoscopy	Endoscopy	TBC	TBC	158.9%	N/A	143.7%	N/A	0.0%	0.0%	N/A	-4.60	1.00	3.20%	15.10%	2.00%	0	0	0	0	0	0
WSFT	Cardiac Centre	Cardiology	38.14	15.20	87.5%	86.5%	104.3%	114.8%	1.8%	0.0%	9.9	-3.80	2.50	2.50%	17.10%	4.10%	0	0	0	0	0	0
WSFT	G1	Palliative Care	23.96	8.31	81.2%	101.3%	73.0%	N/A	13.2%	3.7%	7.1	-1.90	0.90	7.00%	16.60%	4.80%	0	5	0	0	0	3
WSFT	G3	Endocrine & Medicine	TBC	TBC	114.0%	162.1%	136.3%	129.4%	9.5%	4.9%	6.0	0.60	4.60	7.40%	14.00%	0.00%	0	4	1	0	0	0
WSFT	G4	Elderly Medicine	19.16	24.36	73.0%	84.0%	95.0%	104.4%	20.9%	4.2%	5.5	-4.60	-1.00	5.70%	19.80%	3.50%	1	0	2	0	1	1
WSFT	G5	Elderly Medicine	18.41	22.66	91.0%	97.8%	85.6%	113.1%	21.9%	5.4%	5.4	-3.00	-3.80	5.30%	19.20%	3.30%	2	3	0	0	1	6
WSFT	G8	Stroke	23.15	28.87	84.9%	83.8%	101.2%	117.4%	14.5%	6.7%	7.0	-6.70	2.00	2.50%	15.40%	9.10%	1	2	2	0	0	0
WSFT	F1	Paediatrics	18.13	7.16	120.4%	100.8%	98.0%	N/A	14.8%	0.0%	22.4	-2.10	2.30	5.10%	14.20%	0.00%	N/A	1	N/A	0	0	0
WSFT	F3	Trauma and Orthopaedics	19.58	22.27	80.6%	97.5%	97.9%	100.8%	18.9%	9.5%	6.3	-5.00	0.40	2.80%	16.10%	2.60%	5	0	0	0	0	0
WSFT	F4	Trauma and Orthopaedics	12.78	10.59	76.5%	101.6%	67.3%	83.9%	8.8%	5.3%	9.9	-3.00	-0.80	2.50%	17.30%	4.20%	0	1	1	0	0	1
WSFT	F5	General Surgery & ENT	19.58	14.51	90.4%	95.7%	92.7%	98.0%	4.0%	0.3%	5.9	2.00	0.20	3.10%	15.00%	3.70%	0	0	1	1	0	0
WSFT	F6	General Surgery	19.57	14.51	97.8%	92.5%	89.4%	113.1%	4.3%	3.5%	5.2	-0.80	0.80	7.10%	12.70%	1.90%	1	0	0	0	0	0
WSFT	F8	Respiratory	19.90	20.13	106.6%	94.7%	95.1%	96.1%	10.5%	10.2%	7.2	-3.10	-2.40	5.70%	14.80%	0.00%	2	1	1	0	1	0
WSFT	F9	Gastroenterology	20.32	22.56	103.3%	93.5%	82.6%	125.5%	23.9%	0.5%	5.5	-3.50	-3.00	6.70%	14.60%	5.60%	0	5	0	0	0	0
WSFT	F11	Maternity	49.58	13.89	86.9%	89.0%	61.2%	65.9%	10.0%	0.0%	N/A	2.60	-0.70	8.70%	18.80%	3.50%	0	3	0	0	0	0
WSFT	MLBU	Midwifery Led Birthing Unit															0	0	0	0	0	0
WSFT	Labour Suite	Maternity															0	0	0	0	0	0
WSFT	Antenatal Clinic	Maternity	TBC	TBC	77.0%	N/A	54.8%	N/A	4.3%	0.0%	N/A	1.50	-0.40	2.80%	17.90%	0.00%	0	1	0	0	1	0
Community	Community Midwifery	Maternity	TBC	TBC	58.2%	N/A	62.2%	N/A	5.7%	0.0%	N/A	-4.10	0.00	7.70%	17.90%	6.80%	0	0	0	0	0	0
WSFT	F12	Infection Control	11.02	5.00	87.0%	93.2%	84.9%	103.2%	5.7%	1.0%	8.9	-1.90	0.90	6.50%	14.50%	0.00%	0	1	0	0	1	1
WSFT	F10	Gynaecology	11.18	1.00	121.2%	104.9%	N/A	N/A	28.3%	0.6%	10.9	-1.90	-1.00	1.50%	14.90%	0.00%	0	1	0	0	0	0
WSFT	MTU	Medical Treatment Unit	7.04	1.80	80.2%	N/A	59.3%	N/A	20.2%	0.0%	N/A	-0.20	-0.80	12.10%	23.90%	0.00%	0	0	0	0	0	0
WSFT	NNU	Neonatal	20.85	3.64	90.0%	82.8%	56.2%	61.3%	3.4%	0.0%	38.8	-1.40	-1.00	2.10%	16.10%	4.30%	N/A	1	N/A	0	0	4
WSFT	Outpatients	Outpatients	TBC	TBC	72.2%	N/A	68.6%	N/A	4.0%	0.0%	N/A	-0.30	-2.40	4.10%	20.20%	3.30%	0	0	0	0	0	0
WSFT	Radiology Nursing	Radiology	TBC	TBC	76.5%	N/A	128.1%	N/A	11.3%	0.0%	N/A	-0.40	-1.40	0.80%	13.10%	6.70%	0	0	0	0	0	0
Newmarket	Rosemary Ward	Step - down	12.34	13.47	128.1%	101.9%	103.1%	97.8%	5.2%	13.0%	6.0	-3.40	0.30	3.10%	18.20%	0.00%	0	0	1	0	0	1
Glastonbury Court	Kings Suite	Medically Fit	11.50	12.64	118.3%	95.9%	106.7%	104.8%	7.1%	0.4%	5.3	-1.20	-0.60	4.60%	14.70%	0.00%	1	0	0	0	0	0
					92.79% AVG	97.11% AVG	95.62% AVG	105.44% AVG				-76.40 TOTAL	0.00 TOTAL	4.75% AVG	16.66% AVG	2.93% AVG	18 TOTAL	49 TOTAL	15 TOTAL	3 TOTAL	8 TOTAL	31 TOTAL

Trust	Team Name	Speciality	Current Funded Total Establishment Registered to Unregistered (WTE)		Patient facing contact (hrs)	Unplanned requests	Vacancies (WTE)		Sickness (%)	Annual Leave (%)	Maternity/Paternity Leave (%)	Pressure Ulcer Incidences (New)	Nursing/Midwifery Administrative Medication Errors	Red Incidents	Missed Visits	Complaints	Compliments
			Registered	Unregistered			Registered	Unregistered									
Community	Bury Town	Community Heath Team	17.59	5.60	1472.97	103	-2.97	-0.20	3.36%	Not available comprehensively till Healthroster implemented	Not available this month	10	0	0	0	0	0
Community	Bury Rural	Community Heath Team	10.00	1.20	754.05	43	-1.00	-1.20	0.85%			4	0	1	0	0	0
Community	Mildenhall & Brandon	Community Heath Team	12.59	3.91	851.05	50	-0.60	-0.11	6.16%			1	1	0	1	0	0
Community	Newmarket	Community Heath Team	8.10	2.75	620.50	37	0.00	0.00	0.71%			6	0	0	0	0	0
Community	Sudbury	Community Heath Team	18.03	8.36	1280.15	83	-2.40	-1.00	2.13%			3	2	1	2	0	0
Community	Haverhill	Community Heath Team	8.97	4.23	854.77	66	-3.24	0.00	5.60%			2	1	0	0	0	0
Community	Admission Prevention Service	Specialist Services	11.28	3.45	143.35	0	TBC	TBC	10.27%			0	0	0	0	0	0
Community	Specialist Services	Cardiac Rehab and Heart Failure	TBC	TBC	609.17	6	TBC	TBC	0.00%			0	0	0	0	0	0
Community	Children	Community Paediatrics	16.37	15.01	1319.68	0	0.00	-0.24	5.38%			N/A	0	0	0	0	0
					7905.68 TOTAL	388.00 TOTAL	-10.21 TOTAL	-2.75 TOTAL	3.83% AVG	#DIV/0! AVG	#DIV/0! AVG	26 TOTAL	4 TOTAL	2 TOTAL	3 TOTAL	0 TOTAL	0 TOTAL

Explanations	
	Fill Rate: an indication of patient safety - national target 80% (less than = red), Trust internal target 85% (equal and greater than = green)
	In vacancy column: - means vacancy and + means over established. Excludes maternity leave as separate column
	Sickness Trust target: <3.5%
	Annual Leave target: (12% - 16%)
	Maternity Leave: no target
	Medication errors are not always down to nursing and can be pharmacist or medical staff as well
	DSU has been split into ward and unit only by HR, that is why only a section has been split in this dashboard
	F10 (F14) gynae inpatients ward no of beds 16 and 2 SR - and have a ward attender section

Key	
N/A	Not applicable
ETC	Eye Treatment Centre
I/D	Inappropriate data
TBC	To be confirmed

15. National patient survey report

To ACCEPT a report and action plan

For Report

Presented by Rowan Procter

Agenda item:	15			
Presented by:	Rowan Procter, executive chief nurse			
Prepared by:	Cassia Nice, head of patient experience			
Date prepared:	16 August 2019			
Subject:	CQC Inpatient Survey 2018			
Purpose:	X	For information		For approval

The survey was sent to 1250 adult patients from each trust who were inpatients throughout July 2018, counting back from the last day of July until 1250 patients had been selected for the sample. National benchmarking allows results to be categorised as having been within the 'better', 'about the same' or 'worst' performing Trusts in the country on each particular question.

To make any necessary improvements and share good practice, the patient and carer experience group will develop an action plan which is reported to and monitored by the patient experience committee.

The action plan will focus primarily on areas where there has been a deterioration in our own score from the 2017 survey.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
	X	**X**	**X**

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

Previously considered by:	None
Risk and assurance:	All acute and specialist trusts are required to participate in the survey following national criteria and centralised analysis.
Legislation, regulatory, equality, diversity and dignity implications:	
Recommendation: The Trust Executive Group are asked to receive the report and note the action plan	

CQC Inpatient Survey 2018

1. About this survey

- ✓ Involved 144 acute and specialist NHS trusts across England
- ✓ Responses were received from 76,668 people across the country
- ✓ National response rate was 45%
- ✓ 594 West Suffolk NHS Foundation Trust inpatients responded to the survey
- ✓ WSFT response rate was 50.42%

2. Methodology

This report shows how a trust scored for each question in the survey, compared with the range of results from all other trusts that took part.

The 'about the same,' 'better' and 'worse' categories are based on an analysis technique called the 'expected range' which determines the range within which the trust's score could fall without differing significantly from the average, taking into account the number of respondents for each trust and the scores for all other trusts.

3. Performance compared to other trusts

Better on 2 questions

- Q19. How would you rate the hospital food?
- Q47. After the operation or procedure, did a member of staff explain how the operation or procedure had gone in a way you could understand?

Worse on 0 questions

About the same on 61 questions

4. Performance compared to our own 2017 results

WSFT results were ***significantly higher** (improved) in comparison to 2017 results for 2 questions:

- Q6. How do you feel about the length of time you were on the waiting list before your admission to hospital?
- Q7. Was your admission date changed by the hospital?

WSFT results were ***significantly lower** (worsened) in comparison to 2017 results for 4 questions:

- Q48. Did you feel you were involved in decisions about your discharge from hospital?
- Q59. Were you given clear written or printed information about your medicines?
- Q63. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?
- Q71. Did you see, or were you given, information explaining how to complain to the hospital about the care you received?

*significant differences mean that the change in result is very unlikely to have occurred by chance

The areas identified as having deteriorated will be the focus for the coming year, with one of the points raised already having undergone increased focus: queries about medications and pharmacy experience are now included in the continuous inpatient satisfaction survey.

The patient experience committee will receive a full action plan at the meeting in December 2019, where this will be monitored.

5. Results – West Suffolk NHS Foundation Trust compared to all other trusts

↑ Highlights an improvement in our own score from previous year
↓ Highlights a deterioration in our own score from previous year
The absence of an arrow represents a maintained score, negligible difference (0.1) or a new question

Table 1: The Accident and Emergency Department

Question	Respondents	2018 Score	2018 Band	2017 Score	Change from 2017
3. While you were in the A+E Department, how much information about your condition or treatment was given to you?	338	8.1		8.3	
4. Were you given enough privacy when being examined or treated in the A+E Department?	375	8.8		9.0	

Table 2: Waiting List or Planned Admission

Question	Respondents	2018 Score	2018 Band	2017 Score	Change from 2017
6. How do you feel about the length of time you were on the waiting list before your admission to hospital?	164	8.7		7.9	↑
7. Was your admission date changed by the hospital?	167	9.3		8.8	↑
8. In your opinion, had the specialist you saw in hospital been given all of the necessary information about your condition or illness from the person who referred you?	166	9.2		9.2	

Table 3: Waiting to Get to a Bed on a Ward

Question	Respondents	2018 Score	2018 Band	2017 Score	Change from 2017
9. From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?	578	7.7		8.1	

Table 4: The Hospital and Ward

Question	Respondents	2018 Score	2018 Band	2017 Score	Change from 2017
11. While in hospital, did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex?	583	9.5		9.5	
13. Did the hospital staff explain the reasons for being moved in a way you could understand?	133	6.6		6.9	
14. Were you ever bothered by noise at night from other patients?	578	5.8		5.5	
15. Were you ever bothered by noise at night from hospital staff?	580	8.0		7.8	
16. In your opinion, how clean was the hospital room or ward that you were in?	585	9.1		9.1	
17. Did you get enough help from staff to wash or keep yourself clean?	335	8.0		8.5	
18. If you brought your own medication with you to hospital, were you able to take it when you needed to?	338	7.2		7.5	
19. How would you rate the hospital food?	555	6.5	Better	6.4	
20. Were you offered a choice of food?	574	8.6		8.9	
21. Did you get enough help from staff to eat your meals?	121	7.5		7.8	
22. During your time in hospital, did you get enough to drink?	564	9.6		9.6	
72. Did you feel well looked after by the non-clinical hospital staff (e.g. cleaners, porters, catering staff)?	522	9.3		9.3	

Table 5: Doctors

Question	Respondents	2018 Score	2018 Band	2017 Score	Change from 2017
23. When you had important questions to ask a doctor, did you get answers that you could understand?	507	8.3		8.2	
24. Did you have confidence and trust in the doctors treating you?	578	9.0		9.0	
25. Did doctors talk in front of you as if you weren't there?	579	8.6		8.9	

Table 6: Nurses

Question	Respondents	2018 Score	2018 Band	2017 Score	Change from 2017
26. When you had important questions to ask a nurse, did you get answers that you could understand?	497	8.6		8.6	
27. Did you have confidence and trust in the nurses treating you?	583	9.0		9.1	
28. Did nurses talk in front of you as if you weren't there?	584	9.2		9.2	
29. In your opinion, were there enough nurses on duty to care for you in hospital?	580	7.4		7.7	
30. Did you know which nurse was in charge of looking after you (this would have been a different person after each shift change)?	578	6.5		6.5	

Table 7: Your Care and Treatment

Question	Respondents	2018 Score	2018 Band	2017 Score	Change from 2017
31. Did you have confidence and trust in any other clinical staff treating you (e.g. physiotherapists, speech therapists, psychologists)?	353	8.8		8.6	
32. In your opinion, did the members of staff caring for you work well together?	541	8.8		8.8	
33. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?	579	8.4		8.4	
34. Were you involved as much as you wanted to be in decisions about your care and treatment?	580	7.3		7.6	
35. Did you have confidence in the decisions made about your condition or treatment?	579	8.3		8.4	
36. How much information about your condition or treatment was given to you?	555	9.0		8.9	
37. Did you find someone on the hospital staff to talk to about your worries and fears?	315	5.4		5.9	
38. Do you feel you got enough emotional support from hospital staff during your stay?	334	7.4		7.1	
39. Were you given enough privacy when discussing your condition or treatment?	576	8.6		8.4	
40. Were you given enough privacy when being examined or treated?	575	9.6		9.5	
42. Do you think the hospital staff did everything they could to help control your pain?	370	8.2		8.3	
43. If you needed attention, were you able to get a member of staff to help you within a reasonable time?	512	7.8		8.0	

Table 8: Operations and Procedures

Question	Respondents	2018 Score	2018 Band	2017 Score	Change from 2017
45. Beforehand, did a member of staff answer your questions about the operation or procedure in a way you could understand?	261	9.2		8.8	
46. Beforehand, were you told how you could expect to feel after you had the operation or procedure?	283	7.6		7.3	
47. After the operation or procedure, did a member of staff explain how the operation or procedure had gone in a way you could understand?	283	8.4	Better	7.9	

Table 9: Leaving Hospital

Question	Respondents	2018 Score	2018 Band	2017 Score	Change from 2017
48. Did you feel you were involved in decisions about your discharge from hospital?	558	6.9		7.3	↓
49. Were you given enough notice about when you were going to be discharged?	580	7.1		7.3	
51. Discharge delayed due to wait for medicines/to see doctor/for ambulance	552	6.7		6.5	
52. How long was the delay?	550	7.8		7.6	
54. After leaving hospital, did you get enough support from health or social care professionals to help you recover and manage your condition?	279	6.9		6.8	
55. When you left hospital, did you know what would happen next with your care?	475	6.8		6.8	
56. Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?	545	6.0		6.5	
57. Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?	380	8.5		8.5	
58. Did a member of staff tell you about medication side effects to watch for when you went home?	314	5.1		4.4	
59. Were you given clear written or printed information about your medicines?	354	7.8		8.4	↓
60. Did a member of staff tell you about any danger signals you should watch for after you went home?	393	5.4		5.5	

Table 9: Leaving Hospital *(continued)*

Question	Respondents	2018 Score	2018 Band	2017 Score	Change from 2017
61. Did hospital staff take your family or home situation into account when planning your discharge?	375	7.6		7.6	
62. Did the doctors or nurses give your family, friends or carers all the information they needed to help care for you?	359	6.5		6.7	
63. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	509	7.4		8.0	↓
64. Did hospital staff discuss with you whether you would need any additional equipment in your home, or any adaptations made to your home, after leaving hospital?	195	8.7		9.2	
65. Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital (e.g. services from a GP, physiotherapist or community nurse, or assistance from social services or the voluntary sector)?	285	8.2		8.6	
66. Was the care and support you expected available when you needed it?	345	8.5			

Table 10: Overall Views of Care and Services

Question	Respondents	2018 Score	2018 Band	2017 Score	Change from 2017
67. Overall, did you feel you were treated with respect and dignity while you were in the hospital?	576	9.1		9.2	
69. During this hospital stay, did anyone discuss with you whether you would like to take part in a research study?	505	1.1			
70. During your hospital stay, were you ever asked to give your views on the quality of your care?	494	1.2		1.6	
71. Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?	456	1.5		2.6	↓

16. Education report

To ACCEPT the report, including undergraduate training update

For Report

Presented by Kate Read

Board of Directors –27th September 2019

Agenda item:	16			
Presented by:	Kate Read, Deputy Director of Workforce (Interim)			
Prepared by:	Mr Peter Harris, Director of Medical Education, Lorna Lambert, Medical Education Manager, Denise Needle, Deputy Director of Workforce (Development), Diane Last, Non-Medical Clinical Tutor, Dr John Clark, Associate Clinical Dean & Denise Pora, Deputy Director of Workforce (Organisation Development).			
Date prepared:	20th September 2019			
Subject:	Education Report			
Purpose:	☑	For information		For approval

This report provides an update on education and training issues of strategic and service delivery importance for Board Members' information

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	Deliver for today	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
	☑	☑	☑

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

Previously considered by:	September 2018 Education and Training Trust Board paper
Risk and assurance:	Risk to patient safety due to lack of staff training and education, patient safety, correct staffing levels, staff morale, turnover etc. internal and external reputation. Staff perception of Education, Training & Development opportunities through the annual NHS Staff Survey. Medical Education - Royal College and HEEoE visits and assessments Results of annual GMC annual survey of training grade doctors
Legislation, regulatory, equality, diversity and dignity implications	Legislation & regulatory implications, linked to professional body requirements. Equality and health and safety legislation regarding skills, equipment and behaviours of all staff.

Recommendation: For information

Education and Training – Report for Trust Board Members 27th September 2019

This report demonstrates how Education and Training is contributing to the three priorities of the Trust's proposed Strategic Framework 'Our patients, our hospital, our future, together'.

Priority 1: Deliver for today

- A sharp focus on improving patient experience, safeguarding patient safety and enhancing quality.
- Continuing to achieve core standards

Undergraduate Medical Education

The Cambridge Graduate Course in Medicine continues to expand and we will be welcoming a further 40 students at the beginning of September who are embarking on their medical studies. Many of the West Suffolk Hospital medical staff are involved in teaching and training these students. We also delighted that so many students choose to stay on with us in their foundation years. This year Dr Jessica White has taken over from Dr Clark on his retirement as Director of the Graduate Course.

Postgraduate Medical Education

- **Reporting to HEEoE**
  No incidents reported since April 2019.
  The Trust reports to HEEoE on any fitness to practice concerns about doctors in training. Reports are required for:
  1. Serious incidents where the trainee has been named and investigated
  2. Complaints naming the doctor
  3. Concern about probity or conduct

- **SAS Tutor**
  Dr Zuleikha D'Souza (Speciality Reg, Cardiology) has replaced Boby Sebastian as SAS Tutor wef 01.05.19.

- **College Tutor for Paediatrics**
  Dr Binu Anand has stepped down from the above role in September 2019. With effect from 01.10.2019 Dr Rachel Shute and Clare Harrison are job sharing both have good experience in supervising and mentoring trainees.

- **College Tutor for Emergency Medicine**
  With effect from 01.01.2019 Mr Alain Sauvage has been replaced by Ravi Ayyamuthu for this role.

- **GP Training Programme Director**
  Dr Brendon O'Leary resigned from the above post and from 09.09.19 Dr Rebecca Cummins-Lagden will replace him. This is her first TPD post.

Nursing, Midwifery and Allied Health Professionals

- **Quality Performance Review (QPR) and student feedback**
  We have not been contacted by Health Education England since the submission of our last QPR report; this is due to be updated in September 2019. Despite completion of the HEE student survey in November 2018, no results have been received. This is due to problems with the new process. Concerns about this have been raised with HEE and modifications will be made to the process ready for this year's survey.

- **Student Numbers**
  We have been asked to increase our capacity of nursing and midwifery student placements to assist with the national shortage of nurses and midwives. Funding has been received to assist with this which has been utilised to employ a Clinical Practice Facilitator to monitor quality of student experience and assist in the promotion of coaching within placement areas. The grid below shows how we will increase our capacity by 34 within the next few months.

Department	Sept	Oct	Nov	Dec	Jan	Feb	March
G3	5						
MTU	1						
F5							
F6							
F8	+2						
G4							
G8							
G5		+3					
F9		+3					
F3			+2				
F4			+2				
F7						+3	
AAU							+2
Cardiac Unit						+3	
Child nursing	+2						
Midwifery		+4					
Learning Disability	+2						

	New placement areas
	Relaunch of existing coaching areas
	Move to coaching model
	Increased capacity agreed

- ***Multi-professional Pre-registration Students***

  All programmes are recruiting to the required numbers except adult nursing which remains below our requested number. We have seen an increase in the numbers of 'return to practice' adult nurses that we are being asked to host from UoS. We have 6 starting placement in the autumn which is an increase from our normal number of 2 or 3.

  We have increased our ODP student numbers from 4 to 6 starting in September 2019 as well as an increase in child and midwifery as indicated in the previous table.

- ***International Registered Nurses***

  Our overseas nurses continue to arrive in the UK to begin their OSCE preparation programme ready for NMC registration. The OSCE programme has been successful with the majority of nurses passing at the first attempt and all passing within two attempts.

Arrival Date	Numbers	Passed OSCE
28th June 2018	3	3
5th October	10	10
19th October	9	9
29th November	5	5
3rd January 2019	4	4
28th February	7	7
28th March	7	7
2nd May	10	10
30th May	11	10 (1 to take)
27th June	9	0
29th July	13	0
24th September	12	0
31st October	12	0

29th November	12	0
TOTAL	**124**	**65**

We continue to interview via Skype on a regular basis and have offered to approximately 50 nurses who will be arriving later this year or at the beginning of 2020.

- ***Nursing and Midwifery Council (NMC) Educational Standards***
  The new educational standards from the NMC come into effect in September 2019. The new standards set out the role of a newly registered nurse, the requirements of the training programme and the support and assessment required. The education team have been working closely with our educational providers regarding the re-approval of pre-registration programmes and the framework required to support students in practice. Workshops continue to be held across the acute and community settings.

Support Workforce/Other Staff Groups

- **Care certificate:**
  All health care support workers are required to complete a basic qualification to undertake their role. Care certificates are co-ordinated by the Nursing Directorate

- **Apprenticeship levy:**
  The Government Apprenticeship Levy, commenced in May 2017, our levy fund is currently £1.3 million, which includes a carry-over from last year.

  The Trust is now able to commission apprenticeship training, which allows the education provider the opportunity to draw down the cost of the training from the Levy.
  For apprenticeships we now have 92 individuals on the Digital Apprenticeship Service (DAS) account, with 2 having completed an apprenticeship. We spent £712,000.00 last year, and have £301,175 committed so far for 2019/20.

  We have apprenticeships across the following subjects;
  - Business Administration Level 2
  - Business Administrator Level 3
  - Health Pharmacy Services Level 2
  - Health Pharmacy Science Level 3
  - Operations/Departmental Manager Level 5
  - Engineering Manufacture Level 3
  - Engineering Technician Level 3
  - Senior Health Care Support Worker Level 3
  - Healthcare Assistant Practitioner Level 5
  - Registered Nurse Level 6
  - Team Leader/Supervisor Level 3
  - HR Support Level 3
  - HR Consultant/Partner Level 5
  - Mammography Associate Level 4
  - Infrastructure Technician Level 3
  - Chartered Management Degree Level 6

We are currently exploring the possibility of gifting some of our levy to our West Alliance partners who are not levy payers.

Priority 2: Invest in quality, staff and clinical leadership

- Invest in quality and deliver even better standards of care which, over time, should deliver an 'outstanding' CQC rating

Leadership development and talent management

- The 2030 Leaders Programme provides leadership development for aspiring senior leaders and is an important element in our talent management strategy. 21 clinical and non-clinical leaders from WSFT and West Suffolk CCG are participating in the 2019/20 programme; this includes five members of consultant medical staff. The 2030 Leaders Programme was launched in 2017 and this current programme runs until March 2020. We are exploring options with Alliance partners through the Local Workforce Advisory Group (LWAG) to run a similar programme within the West Suffolk system.

- Twenty-two of our most senior clinical and non-clinical leaders have participated in the WSFT key leaders programme to date. This programme is another part of our talent management strategy aimed at developing the capabilities needed to support leaders in some of our most crucial posts. Development activities include 360 feedback, one-to-one coaching and participation in a range internal and external leadership development programmes.

- The very successful Expert Navy programme for new band 7 ward managers and band 6 nurses aspiring to a ward leadership role is running again in 2019 and a programme has also been developed for Allied Health Professionals at band 6. These programmes are run by the Clinical Education Team in the Nursing Directorate and support succession management to middle level leadership positions.

- Fourteen WSFT staff, including six members of consultant medical staff, community matrons and local managers are participating in the One Clinical Community Leadership Development Programme which started in September 2019. The programme is aimed at those in a clinical or other senior leadership and who value the opportunity to develop their own skills with others in the local health economy in a collaborative and practical way. Dr Nick Jenkins is one of the programme sponsors along with senior colleagues from the West Suffolk Alliance.

- The Trust Summer Leadership Summit in June focussed on "Improving quality through compassionate, inclusive leadership". It was attended by over 70 senior trust leaders. The morning session focused on how we create a more inclusive culture and improve everyone's experience at work. In the afternoon participants reflected on and developed a shared understanding of what outstanding means for staff and the people we serve. They also learnt about new enablers of outstanding care from patient safety and quality improvement. An action plan to improve everyone's experience at work through addressing poor behaviour, including bullying and harassment, has been drawn from Summit participants' experience and suggestions. This is now being implemented.

- Trust Board members have undertaken the Trust's unconscious bias e-learning in support of the Trust's Inclusion Strategy objective to promote and support inclusive leadership at all levels of the trust. Feedback on the training has been excellent.

- A clinical leadership event for 30 junior doctors, organised by Dr Jane Sturgess, Consultant Anaesthetist, is was held in April. The day introduces participants to basic leadership concepts and to gain knowledge of the importance of clinical leadership. Feedback on the day was excellent and a further day will be held in October.

- A workshop, including leadership development for SAS and locally employed doctors, organised by Dr Zuleikha D'Souza, SAS doctors' tutor, will be held in November.

- A number of staff are participating on Management Apprenticeships at levels 3 and 5 using the national apprentice levy – both through external educational providers and an in-house programme.

- As part of our on-going Staff, Management and Leadership Development Programme over 200 staff will participate in mental health awareness training in 2019. This includes over 100 leaders who are participating on the Suffolk MIND two-day programme 'Mental Health for Managers' which provides participants with the tools to recognise when staff are experiencing mental health difficulties and provide appropriate support. A further 100+ staff have attended mental health awareness and emotional first aid training.

- The 5 O'clock club continues with regular bi-monthly meetings in 2019 providing speakers on either a leadership or quality improvement theme. In the summer the Dean of St Edmundsbury Cathedral, the Very Reverend Joe Hawes spoke about leadership and in September members heard from Ben Tipney, a former international athlete rowing for Great Britain, on human factors. Deputy Chief Constable of the Sussex Police Force, Joanne Shiner will be speaking in November.

Postgraduate Medical Education

- **HEE East of England Quality Improvement Performance Framework (QIPF)**
  No further comments have been received from Health Education England since the submission of our last QPR report. This is due to be updated in September 2019.

- **GMC National Training Survey 2019**
  Results showed the trust is performing well and scored top in the East of England for doctors' overall training satisfaction in acute trusts at 82%, a 3% increase on the previous year.

- **Career Advice**
  The annual Medical Careers Fair was held on the 18th September in the lecture theatre. Representatives from specialties across the hospital manned stalls offering advice and guidance to junior doctors and Cambridge undergraduate Medical students about future career aspirations.

  Education/Clinical Supervisors Training
  On June 5th WSH played host and delivered the new HEE Educational/Clinical Supervisor 'in-house' training to specialities from across the region. Faculty from WSH/HEE/DME's from Ipswich and Colchester delivered this training to 48 delegates. Feedback was very positive and encouraging. Future dates are Oct 18th 2019, February 11th & June 10th 2020.

- **Educational Supervisors for Trust Grade FY1 Doctors**
  To improve our chances of non-training doctors apply for future training posts all Trust Grade FY1 Doctors are allocated and supported by a trained Educational Supervisor. They act as a mentor, role model, careers advisor and source of support including using the electronic e-portfolio system to record evidence of competencies. On 30th July six joined the trust as part of the Preparing for Professional Practice week (PfPP). We plan to role this out to F2 Trust grade posts next year.

- **#2tired2drive Scheme**
  Requests made by Jr Dr's (Foundation, Career grade, Trust grade, SAS, & Locums – i.e. anybody below consultant level) can collect a key from switchboard for a room under this scheme. Between Nov 17 – Sept 19 total costs are £469.20 and the room used 25 times.

Nursing, Midwifery and Allied Health Professionals

- ***Learning Beyond Registration (LBR) Funding***
  £139,310.00 was received from HEE for LBR (CPD) funding which was been allocated in accordance with service need across the acute and community settings. Courses that do not fit the criteria set by HEE for LBR funding have been supported by the WiSH charity or funded via the non-medical student tariff.

We have secured Professor Nicola Botting as a keynote speaker at an event for our paediatric SALT team in the community. Professor Nicola Botting is a renowned expert in childhood speech and language disorders and often presents internationally.

An apprenticeship route into Occupational Therapy has been approved at UEA and the WSFT will be supporting 2 members of staff to undertake this programme.

- **Preceptorship**
  Preceptorship is a programme lasting one year that is offered to all newly registered non-medical professionals upon qualification. This is usually held twice a year, however due to the increase in newly registered nurses (including overseas) we are holding four programmes supporting approximately 109 newly registered professionals.

Support Workforce/Other Staff Groups

- **Work experience placement;**
  This service is co-ordinated by the Voluntary Services Department. We continue to offer both student volunteering and clinical shadowing for potential and future employees. In addition we also liaise with schools to off a limited opportunity for work placements for year 10/11's (15-16 year olds). We have had 63 Clinical Shadowing students and 5 Work Experience Students receive placements at WSFT from April this year

Priority 3: Build a joined up future

- Reduce non elective demand to create capacity to increase elective activity. Help develop and support new capabilities and new integrated pathways in the community

Nursing, Midwifery and Allied Health Professionals

- **Promoting WSFT to Potential Healthcare Students**

  We are planning for our annual Healthcare Professions conference for 6th form students and this year have secured Dr Lynne Wigens (Regional Chief Nurse) as a keynote speaker. The WSFT will also be holding an 'introduction to medical careers' workshop on the 16th September led by Dr Paul Siklos. This is aimed at year 10 students upwards who are interested in a career in medicine. This will include guidance with applications, personal statements, interviews and an opportunity to speak to medical students about their own experiences.

Support Workforce/Other Staff Groups

- **Health Ambassadors; (Career advice to schools and colleges)**
  The trust has a number of Health ambassadors who offer their services on top of already busy jobs. This service is co-ordinated by the Nurse education team, but involves many staff groups and professions

17. Interim people plan

To APPROVE the report recommendations

For Report

Presented by Kate Read

Trust Board – 27 September 2019

Agenda item:	17			
Presented by:	Kate Read, Interim Deputy Director of Workforce			
Prepared by:	Kate Read, Interim Deputy Director of Workforce			
Date prepared:	30 August 2019			
Subject:	Interim People Plan 2019: WSFT Review and Summary Work Stream Log			
Purpose:	✓	For information		For approval

Executive summary:

Interim People Plan 2019: WSFT Review and Summary Work Stream Log

1.0 The attached document provides a summary of the six themes set out in the Interim People Plan, and the associated WSFT workstreams which support the delivery of the plan. The themes are summarised as;

1.1 Making the NHS the best place to work
1.2 Improving our leadership culture
1.3 Addressing shortfall in nursing supply as well as shortages in other professions
1.4 Delivering 21 Century Care
1.5 A new workforce operating model
1.6 Developing the full people plan

2.0 The summary sets out the current and planned work streams which will be delivered across WSFT in order to ensure the workforce agenda, as outlined in the Interim People Plan, is delivered.

3.0 WSFT is already undertaking a wide variety of activities associated with the themes identified within the Interim People Plan and has robust processes in place to monitor and review progress.

4.0 The attached summary plan aims to collate and align the various workstreams to the themes set out in the Interim People Plan and provide a high level overview of the areas of work which directly contribute to the delivery of the plan.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
	✓	✓	✓

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

Putting you first

Previously considered by:	N/A
Risk and assurance:	HR policies and procedures, people practices, diversity and inclusion, leadership culture
Legislation, regulatory, equality, diversity and dignity implications	HR policies and procedures, equality, diversity and inclusion
Recommendation: The Board are asked to note the current and planned actions in order to ensure delivery against the agenda and themes set within the Interim People Plan.	

Summary Work Stream Log: Interim People Plan 2019

Theme 1: Making the NHS the best place to work					
Summary (Interim People Plan)	**Current Work Streams (WSFT)**	**Planned Work Streams (WSFT)**	**Leads for Future Actions (WSFT)**	**Review**	**Reporting**
Creating a healthy, inclusive and compassionate culture 1. Value and respect all 2. Tackling bullying and harassment, violence and abuse 3. Promoting equality and inclusion, widening participation Recognition that 2018 staff survey reported poorest workplace experiences amongst BAME colleagues including evidence of higher sickness levels	1.Trust inclusion strategy: including Equality Delivery System 2, Workforce Race Equality Standard, Workforce Disability Equality Standard and Gender Pay Gap 2. West Suffolk Wellbeing Plan 2019 – 2021 3. Staff supporters: including Trusted Partners, Tea and Empathy, Chaplaincy pastoral and spiritual support, Trust Executive Open Door, 4. Leadership summits 5. Overseas recruitment: Advocacy and pastoral support for overseas nurses 6. Publication of 'Protecting and improving your health and wellbeing, together' document 7. Appointment of consultant in Healthcare Public Health	1. Inclusion Objectives and Action Plan 2019 – 21 – including WRES, WDES and GPG action 2. Wellbeing Plan 2019 - 21 – including support for mental health, and safe working environments (this is a rolling action plan) and development of Occupational Health Service with provider; wellbeing at work workshops for medical staff 3. Promotion and further development of staff supporters e.g. further Trusted Partner Training 4. Bullying and harassment action plan from June 2019 Leadership Summit. 5. Sickness absence monitoring review, including split by protected characteristic 6.Mandatory Training for all recruiters to ensure the recruitment and selection process is bias free 7. International Medical Graduate support group	Denise Pora Denise Pora Paul Molyneux Denise Pora Denise Needle Denise Pora Denise Needle Kate Read Angie Manning Kate Read Malini Prasad	2020	Workforce Strategy Group (Quarterly TEG Report) Education Strategy Report (Annual – Sept Board) Wellbeing Plan Annual Board Report (Oct) EDI Annual Trust Board Report – includes WRES and WDES(Sept) Annual Gender Pay Gap Report
Enabling great development and fulfilling careers	1. Trust Talent Management and Leadership Development Strategies	1. One Clinical Community Leadership Development Programme, and exploring opportunities for Alliance Leadership	Denise Pora Denise Needle	April 2020	Workforce Strategy Group (Quarterly TEG

1. Providing education and training (including mandatory training) and career and professional development opportunities 2. Recognition of qualifications and training between and within NHS employers	2. Working across STP footprint to establish database of qualifications and roles, with a view to using as a talent pool for extended roles. 3. Working with HEE ACP lead to establish understanding of career pathways and enabling individuals to demonstrate ability to work at top of job description 4. Clinical Strategy Group established. 5. ACP group established to create WSH approved sign off process. 6. Driving streamlining work to ensure transfer of training records. 7. Clear career pathway through the apprenticeship route supporting progression from Band 2 to professional registration.	development programme with LWAG, 2. Further development of management apprenticeships 3. Continue to explore and contribute to STP wide working and collation of staffing and vacancy data. 4. Continue to contribute to streamlining, to facilitate cross region information sharing in respect of mandatory training 5. Continue to develop workforce strategy taking in to account outcomes from ACP group. Ensuring recognition of qualifications and experience has robust and transparent governance. Engagement in region wide approach	Diane Last Denise Needle Kate Read Helen Kroon Paul Morris Kate Read		Report) Education Strategy Report (Annual – Sept Board)
Ensuring everyone feels they have voice, control and influence 1. Whistleblowing and freedom to speak up 2. Physical and mental health and wellbeing and reducing sickness absence 3. Workload, work-life balance, clear and timely rotas, flexible working 4. Work environment 5. Support development of	1.West Suffolk Wellbeing Plan 2019 - 21 2. West Suffolk pilot on pension flexibility 3. Scrutiny / utilisation and changes implemented as a result of NHS Staff survey results 4. Flexible working policy in place, with addition of short shifts being offered through bank, plus trial of short shifts for permanent staff in Glastonbury Court and Rosemary ward 5. Electronic health roster used for nursing and medical staff. Rosters available 6 weeks in advance.	1. Health and wellbeing action plan 2019 2021. Develop business case to explore provision of clinical psychology services for all staff. 2. Review key recommendations of NHS Staff and Learner Mental Well Being Programme 3. Health roster roll out to all departments/wards	Denise Pora Paul Molyneux Grace Newman Denise Needle Len Rowland	April 2020	Health and Wellbeing Steering Group Better Working Lives Group Annual Board Report (Oct)

policy on pay (pensions, closing gender pay gap) 6. Staff engagement	6. Compliance with BMA charter 7. Active Freedom to speak up guardian 8. Staff supporters: including Trusted Partners, Tea and Empathy, Chaplaincy pastoral and spiritual support, Trust Executive Open Door				
Theme 2: Improving our leadership culture					
1. Focus on developing a positive, inclusive and people-centred culture that engages and inspires all our people 2. Clear focus on improvement and advancing equality of opportunity 3. Develop and spreadsheet of positive, inclusive, person-centred leadership culture across the NHS 4. Compassionate, inclusive leadership not from senior leaders alone but from everyone in leadership positions – or who aspires to be 5. Deliberate approach to talent management: identifying, assessing, developing and deploying individuals with the capacity and capability to make a difference in the most senior positions 6. Collaboration not competition	1. Inclusion Strategy and Action Plan 2. Trust Talent Management Strategy 3. Leadership Strategy and development opportunities 4. Support for individual professional development as part of PDP 5. Provision of placement for NHS Graduate Management Training Scheme 6. Improving People Practices A review of investigatory practices and procedures to ensure the following • Adhering to best practice • Embedding a “Just Culture” • The provision of appropriate training and resources • Safeguarding Health and Wellbeing • Detailed Board level oversight	1. Respond to NHSI/E targets for BME representation across workforce including at senior levels 2.Contribute to the development of STP/ICS wide talent pool 3.Explore opportunities for further system leadership development 6. To produce a comprehensive investigatory toolkit for managers involved in the investigatory process	Denise Pora Diane Last Denise Needle Kate Read Denise Pora Liz Houghton Angie Manning	April 2020	Workforce Strategy Group (Quarterly TEG Report) Education Strategy Report (Annual – Sept Board)

Theme 3: Improve Nursing Supply					
Addressing shortfall in nursing supply as well as shortages in other professions 1. Most pressing need is nursing supply 2. Address shortfall in doctors, including GPs and psychiatrists, paramedics, radiographers, genomic scientists and dentists 3. Increase pipeline of nurses 4. Develop Nursing Associate role 5. Develop pipeline of AHPs 6. Value specialty and associate specialist (SAS) doctors 7. Support our most senior doctors 8. Understand and pay attention to exit data at every level 9. Attract more people to join	1. Close working relationships between UoS and UEA to provide high quality placements and minimise attrition from nursing programmes 2. Attrition rates across nursing and midwifery for the 12 months Apr-March 2018/9 was 0.9% 3. Recruitment of ~100 NAs/RNs over financial year 2018/19 4. Establishment of pipeline of overseas nurses from Philippines (~10 per month) 5. Established return to clinical practice programme for nurses 6. Strong mentoring programme for student nurses 7. Investment of £139,000 in CPD 8. Workforce strategy group established to provide oversight of ACP, PA, extended roles workstreams 9. Currently piloting pension flexibility for senior staff/clinicians (earning over £85,000) 10. Influence streamlining programme to ensure effective transfer of mandatory training and movement of doctors around the healthcare system 11. Continue to support junior doctor workstreams. (2019 GMC Survey results show West Suffolk as no. 1 hospital out of 18 in terms of overall trainee	1. Launch #BeKnown recruitment advertising strategy 2. Increase shorter shift availability 3. Consider auto-enrolment on bank to provide opportunity to easily increase hours when needed 4. Introduce Nursing Associate programme (Dec 2020) 5. Explore guaranteed job offers for nursing students 6. Development of rotational placements 7. Establish workforce plan across acute, community and mental health in order to support wider health system workforce needs 8. Establish links with USAF to recruit NAs 9. Explore opportunities with HEE to both expand ACP roles and gain consistency on development and sign off of competencies	Tara Rose Paul Morris Kate Read Diane Last Sarah Watson Liz Houghton Sarah Shaw	April 2020	Workforce Strategy Group (Quarterly TEG Report) Education Strategy Report (Annual – Sept Board) Recruitment and Retention Steering Group (Quarterly, TEG Report)

	satisfaction) 12. Range of volunteering and work experience opportunities in place for young people 13. Utilisation of Health Ambassadors 14. Offer guaranteed an interview scheme				
Theme 4: Delivering 21 Century Care					
All local NHS systems and organisations to set out plans to make the NHS a better place to work as part of their NHS Long Term Plan implementation plans Integration of primary care and community health services will mean that staff are working in different ways, with a greater focus on preventative care and much stronger links between health and social care 1. Establishment of varied and richer skill mix 2. Development of multi-professional credentials 3. Increasing number of people joining 4. Reducing attrition in education and training 5. Improving retention 6. Short term increase in	1. Workforce strategy group established 2. Offer to expand PA workforce (Match funding) 3. Recruitment and retention group established with series of actions and workstreams 4. International recruitment underway, achieving ~10 RNs per month 5. Utilisation of health roster and allocate to improve efficiency of rostering systems 6. Introduction of MeApp to offer online Bank bookings 7. Vertical Integration with Primary Care 8. Digital exemplar, introduction of; medicbleep, meapp, health roster, allocate	1. Consider opportunities to expand skill mix through clinical strategy group. 2. Develop professional standards and clarity on JDs and competences 3.Understand current use of apprenticeship levy 5. Engage with STP and new Director of Workforce role re 5 year workforce plans 6. Establish range of support mechanisms for international medical graduates and SAS grade doctors 7. Provide two additional places for GP training as part of 2021 8. Expand use of health roster for community and AHPs 9. Establish rotational placements between acute, community, primary and mental health 10. Explore the opportunity to recruit clinical staff that have come to the UK as family members of the USAF doctors who	Denise Needle Kate Read Len Rowland Diane Last Kate Read Helen Kroon	April 2020	Workforce Strategy Group (Quarterly TEG Report) Education Strategy Report (Annual – Sept Board)

international recruitment 7. Local ICSs/STPs to develop five year workforce plans 8. Grow the medical workforce, retain our current doctors 9. Remove barriers to movement of staff, improve streamlining 10. Tech-enabled in house staff banks 11. Digital reform and transformation		work at the Trust by offering the support to enable them to register with the appropriate professional bodies. 11. Establish Trust doctor roles that provide joint experience of ED and AAU. 12. Explore the opportunities for Trust doctors to work in GP practices			
Theme 5. A new operating model for workforce					
Intended benefit of ICS is to pool capacity, spread good practice in recruiting, retaining, developing and deploying local workforce. Clarity on activities undertaken nationally, regionally, ICS and local employing organisations	1. West System Executive Group provides an existing forum to discuss local workforce issues 2.Engagement with NHSE/I Director of Workforce through HRD group 3. Excellent links across STP/LWAB/HEE re workforce agenda 4. Currently exploring vacancies, incentives and staff movement across STP to determine level at which future work streams should be actioned.	Opportunity to further explore workforce issues as part of West System Executive Group, LWAG, LWAB and STP-wide recruitment group.	Denise Needle Kate Read	April 2020	LWAB / LWAG (Monthly meetings) West System Executive Group (Quarterly workforce report) Workforce Strategy Group (Quarterly TEG Report)
Theme 6. Developing the full people plan (National NHS People Board to develop)					

NHSI Recommendations	Compliant Yes/NO/PART	Current Practice	Proposed Action
Adhering to best practice			
Policies adhere to the ACAS Code	YES	Disciplinary Policy and Grievance Policy both comply with the ACAS Code	Policies are compliant
Trust makes use of the ACAS Guidance	YES	Recommended guidance incorporated in policies	Revisit Guidance to ensure up to date practice
MHPS "principles of a good investigation" to apply to all investigations	PARTIAL	Non-medical investigations match MHPS where appropriate. Opportunity to improve the boundary between initial stage of exploring concerns and the case investigation report.	Develop an initial phase that determines if a case investigation is required.
Independence and objectivity at every stage of the process	YES	Trust Policies state the requirement for independence at each stage of the process and explains how this is achieved.	Policies are compliant
Applying rigorous decision making methodology	**Compliant Yes/NO/PART**	**Current Practice**	**Proposed Action**
Application of the "Just Culture" guide	PARTIAL	This guidance was produced primarily for investigations into patient safety incidents. However, the principles it uses are transferable to other investigations.	To produce a guidance document for mangers involved in investigations that is based on the "Just Culture" guide but that extends across other incidents.
Formal action is not always appropriate or necessary Give careful consideration to the context and prevailing factors around the incident	YES YES	Disciplinary and Capability Policies provide guidance for informal action and where this would appropriate.	Policies are compliant Develop an extended " Just Culture" guide that also covers non-patient safety incidents
Comprehensive, consistent decision making methodology	YES	Standard Investigation Documentation in place i.e. • Terms of Reference used for Case	Consideration of including a NED oversight of all potential dismissal cases.

		Investigation • Case Investigators Report to the Case Commissioner • Oversight of cases by the Executive HRD	
Ensure those involved are fully trained and competent.	**Compliant YES/NO/PART**	**Current Practice**	**Action Required**
Case Managers, Case Investigators and Panel Members must be trained. Competencies should include:- • Awareness of relevant aspects of good practice • Principles of a "Just Culture" • Appreciation of race and cultural considerations	PARTIAL	Trust currently Provides Training via Bevan Brittan, plus, Internal Training provided via Skills Plus, Expert Navy and AHP Development Programme. • Equality and Diversity mandatory training in place • Unconscious bias training in place	Dedicated training event commissioned from Bevan Brittan focusing on the "Just Culture" approach. To be held on 7th November 2019 Add the following items to current in-house training programme: • "Just Culture" guidance • Unconscious bias to be a requirement for those involved in Case Investigation
Assigning sufficient resources	**Compliant YES/NO/PART**	**Current Practice**	**Action Required**
Before commencing an investigation ensure the key people have the time and resources to support a timely procedure:- • The Case Manager • The Case Investigator • Other associated individuals	YES	Full consideration is given when appointing those involved in investigations	Processes are complaint
Decisions relating to Suspensions /Exclusions	**Compliant YES/NO/PART**	**Current Practice**	**Action Required**

• The decision must be taken by more than one person	YES	The manager taking the decision liaises with HR and where appropriate takes senior professional advice.	Policy and practice is compliant
• It should not involve anyone who has a conflict of interest	YES	Exclusion of medical staff complies with MHPS.	Policy and Practice is compliant
• It should be as a last resort where there is immediate safety or security issues	YES	Both medical and Non-medical policies advise suspension/exclusion is a last resort.	Policy and Practice is complaint
• Suspension should time bound and with full justification for doing so.	YES	Non-Medical suspensions are reported to the Board of Directors every month and are also overseen by the Executive HRD.	Policy and Practice is compliant
• Continued suspension should with senior management oversight and approval	YES	Medical cases are also overseen by a Non Executive Director	Policy and Practice is compliant
Safeguarding Health and Wellbeing	**Compliant YES/NO/PART**	**Current Practice**	**Action Required**
Employee's health and welfare should be continually assessed.	YES	Employee health is discussed as part of the investigation process, using OH & Care First	Practice is compliant
Professional/OH assessments should be used either on request from the employee or management referral.	YES	Management referrals to Occupational Health are made when there are health issues. Self referrals are also supported.	Practice is compliant
A communication plan should be in place with the employee being investigated. The plan should part of the terms of reference.	PARTIAL	This requirement is not formalised in the Trust procedures and therefore may not be consistent across the Trust	Proposed that a communication plan is included in the Terms of Reference
Communications should be timely; comprehensive; unambiguous; sensitive and compassionate.	PARTIAL	As Above	Proposed that this requirement is included in the Terms of Reference

Where an employee under investigation/disciplinary suffers any form of serious harm (mental or physical) - it should treated as a "never" event. This mean an independent investigation is commissioned and received by the board. Prompt action should be taken in response to the identified harm and its causes.	PARTIAL	This requirement needs further consideration	The Trust would need to agree the criteria for "serious harm" and what would be treated as a never event.
Board Level Oversight	**Compliant YES/NO/PART**	**Current Practice**	**Action Required**
Comprehensive data regarding investigations and disciplinary procedures should be collated and presented at Board level regularly. The data should include the following:- • number of procedures • reasons for the procedure • adherence to process • Justifications for suspensions/exclusions • Decision making relating to outcomes • Impact on patients/employees • Lessons learnt.	YES	The Trust Board currently receives monthly reports of Suspensions, Exclusions and MHPS cases. The HR Department also maintains a data base of all cases disciplinary, capability, grievance, bullying and harassment and whisleblowing. In addition the Executive Director of Workforce and Communications meets every two weeks with the senior HR staff to review their current cases.	To extend the current report to broaden the detail in line with the recommendations.

18. Annual reports:

To ACCEPT the reports

18.1. Equality

For Report

Presented by Kate Read

Trust Board Meeting – 27 September 2019

Agenda item:	18.1			
Presented by:	Denise Pora, Deputy Director of Workforce (Organisation Development)			
Prepared by:	Denise Pora, Deputy Director of Workforce (Organisation Development) and Ian Beck, Workforce Information Analyst			
Date prepared:	11 September 2018			
Subject:	Equality, Diversity and Inclusion Annual Report			
Purpose:		For information	X	For approval

Executive summary

This report provides an update on progress with our Inclusion Strategy and Action Plan in support of the Trust strategic framework. It also provides assurance that the Trust is meeting the requirements of the NHS Standard Contract, NHS Constitution and CQC as well as equalities legislation, including our Public Sector Equality Duty.

Inclusion Strategy

WSFT is developing and promoting an inclusive culture. This means we embrace all people irrespective of, for example, race, religion or belief, sex, gender identity or expression, sexual orientation, age, marital status, pregnancy, maternity or disability.

Our aim is to ensure WSFT is a place where everyone is confident and comfortable being their authentic and whole self, whether as a member of staff, volunteer, patient, service user or visitor. We strive to give equal access and opportunities to all and to get rid of discrimination and intolerance as an employer and as a service provider.

Inclusion objectives and action plan 2017 – 2019

Our Inclusion Action Plan in support of our Inclusion Strategy and September 2017 to August 2019 objectives has been completed and is attached at **Appendix 2**.

Inclusion objectives and action plan 2019 – 2021

Nine inclusion objectives are proposed to further progress our Inclusion Strategy over the next two years from September 2019 to August 2021 following a process of consultation with staff, patient representatives and the wider community, as well as a review of our performance against NHS standards and legal requirements. These are:

<u>For patients, service users and carers</u>

- Improve the experience and care of patients and service users experiencing mental distress, learning disabilities and/or neurodiversity*
- Improve the experience and care of people who are lesbian, gay, bisexual, trans and all other sexualities and gender identities

<u>For staff</u>

- Promote and support inclusive leadership at all levels of the trust
- Ensure recruitment and selection processes are bias free and inclusive
- Facilitate the voices of all staff, providing forums for individuals to come together, to share ideas, raise awareness of challenges, provide support to each other and feedback to the trust on issues of equality, diversity and inclusion
- Take action to support the mental health wellbeing of all staff

For patients, service users, carers and staff

- Promote a culture of inclusion in delivery of care to all patients and staff
- Improve information and data collected, in respect of protected characteristics in order to understand what action may be required
- Tackle bullying and harassment of and by staff and support staff to respectfully and successfully challenge problem behaviours

**Neurodiversity – neurological difference is recognised and respected as any other human variation. Neurological differences can include dyspraxia, dyslexia, attention deficit hyperactivity disorder, autistic spectrum, Tourette syndrome.*

We aim to have inclusive approach to all people at all times and, in addition, our inclusion objectives around specific protected characteristics provide an additional focus for two years. Our equality, diversity and inclusion plan sets out the action we will take to achieve our objectives.

The first draft of our plan for the next two years that starts to translate these objectives into action is given at **Appendix 1**. This includes action to address the issues arising from the Trust's performance against the NHS Workforce Race Equality Standard and the new NHS Workforce Disability Equality Standard. The Trust's Equality Delivery System (EDS2) was also reviewed and updated over the summer in consultation with stakeholders.

Key achievements since September 2018 Annual EDI Trust Board report

- The Trust LGB&T+ network was set up in October 2018 and has already achieved a lot under the leadership of its Chair, Nicola Cottington, Associate Director of Operations for Medicine. The network's achievements include:
    - Sponsoring WSFT's membership of the NHS Rainbow Badge initiative, through which staff give the message to patients, carers and visitors that WSFT is an open, non-judgemental and inclusive place for people that identify as LGBT+ and that they can talk to our staff about who they are, be open about their identity and how they feel. Wearing the badge also means staff commit to do their best to get support for the individual if they need it. So far over 500 staff have signed the NHS Rainbow badge commitment and are wearing the badge. We already have examples of staff being approached by LGB&T+ patients because they were wearing a badge.
    - With the support of the catering team, celebrated Pride month in June in Time Out restaurant and represented WSFT at Pride celebrations in Ipswich on 21st June 2019.
    - Launched and distributed rainbow lanyards, badges and clips for staff to demonstrate their commitment LGB&T+ inclusion over 600 items have been distributed to staff.
    - Hosted a homophobia awareness workshop for staff.
    - Launched a WSFT LGB&T+ network twitter account that has 122 followers.
    - Hosted a presentation from James Catton, Physicians Associate about health issues affecting LGB&T+ patients in July 2019.
- My Guide Training to help staff support patients with visual impairment has been provided for clinical staff, including foundation doctors by Eye Clinic Liaison Officer, Jen Bacon. Jen also arranged for the Trust Chair and CEO to participate in a guided walk around the WSH site to experience what it might be like to be visually impaired and have to navigate a hospital independently and raise awareness about sight loss in our setting.
- The first WSFT Equality, Diversity and Inclusion Champions were announced in May at the annual Shinning Lights Awards. The equality, diversity and inclusion award of excellence winner was Raleigh Ball, business analysist, for his work to establish the LGB&T+ network.

- Following the launch of the national NHS Workforce Disability Equality Standard (WDES) an Open Forum session was held for staff interested in improving the experience of disabled staff at work and a disabled staff network is being set up as a result. The group already has a list of areas where positive changes can be made.

- Understanding the experiences of all our patients is important to provide high quality and safe care. Head of Patient Experience, Cassia Nice, has amended our outpatient appointment letters to include a form to enable us to collect information about patients' protected characteristics – this also allows clinic staff to encourage completion confidentially.

- Four Trans Awareness workshops have been held, in support of implementation of our Supporting People Who Are Trans Policy. The workshops were delivered by the Kite Trust, an organisation that promotes the health, well-being and inclusion of young people, and were attended by clinical and non-clinical staff. The workshop is now a standard element on the Expert Navy programme for new and aspiring ward managers.

- An open forum session has been arranged for staff interested in exploring setting up a network to improve the experience of BME staff at WSFT.

- The summer 2019 WSFT Leadership Summit focussed on improving quality through compassionate, inclusive leadership. The morning session explored bullying and harassment and participants considered staffs' experiences through the lens of the characteristics protected by the Equality Act 2010. An action plan, based on participants' contributions before and during the session, is now being implemented.

- Trust Board members have completed the Trust unconscious bias e-learning training.

Future developments

The Interim NHS People Plan, in support of the NHS Long Term Plan, sets out a commitment to advancing equality of opportunity and working productively with key stakeholders across the protected characteristics. This includes creating a healthy, inclusive and compassionate culture and, as part of this, support is to be provided to NHS boards to set targets for BME representation across their workforce and develop implementation plans. This action will be taken forward as part of our 2019 – 2021 Inclusion Action Plan.

Board members will note that the creation of an inclusive culture is already at the core of our Inclusion Strategy and is addressed through our objectives and supporting action plan.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
	X	**X**	

Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
	X					X	X
Previously considered by:	n/a						

Risk and assurance:	Equality monitoring processes within Workforce and Communications Directorate
Legislation, regulatory, equality, diversity and dignity implications	• Compliance with the 2010 Equality Act and Public Sector Equality Duty • Workforce Race Equality Standard and Workforce Disability Equality Standard included in NHS standard contract and CQC well-led domain • Annual Gender Pay Gap reporting is a legal requirement
Recommendation: This report is presented for approval (including approval of our 2019 WRES and WDES reports before they are published).	

Annual equality, diversity and inclusion report 2019/20

Purpose of this report

- To update the Trust Board on progress being made towards the development of a culture of inclusion, as a service provider and an employer and
- To provide Board Members with assurance about the steps taken to meet the Trust's commitment to comply with the 2010 Equality Act, our Public Sector Equality Duty (PSED), equality, diversity and inclusion requirements of the NHS standard contract, NHS Constitution and CQC criteria.

Introduction - WSFT inclusion strategy

WSFT is developing and promoting an inclusive culture. This means we embrace all people irrespective of, for example, race, religion or belief, sex, gender identity or expression, sexual orientation, age, marital status, pregnancy, maternity or disability.

Our aim is to ensure WSFT is a place where everyone is confident and comfortable being their authentic and whole self, whether as a member of staff, volunteer, patient, service user or visitor. We strive to give equal access and opportunities to all and to get rid of discrimination and intolerance as an employer and as a service provider.

An inclusive culture supports our commitment to the provision of high quality, safe care for all members of the communities we serve and our ambition to support all our staff as set out in our strategic framework 'Our patients, our hospital, our future, together'.

Equality, diversity and inclusion objectives and action plan 2019 - 2021

Nine inclusion objectives are proposed for the two years from August 2019 to July 2021 through a process of consultation with staff, patient representatives and the wider community, as well as a review of our performance against the Workforce Race Equality Standard (WRES), the Workforce Disability Equality Standard (WDES), our 2018 staff survey results, our 2018 Gender Pay Gap Report, the NHS Equality Delivery System (EDS2), the Trust's Strategic Framework 'Our patients, our hospital, our future, together' and the requirements of the Equality Act (2010), including the Public Sector Equality Duty (PSED).

We aim to have inclusive approach to all people at all times and, in addition, our inclusion objectives around specific protected characteristics provide an additional focus for two years. Having been reviewed, it is appropriate that some of the objectives of the previous period are carried forward as work remains work to be done. Our proposed inclusion objectives for 2019 - 2021 are:

For patients, service users and carers

- Improve the experience and care of patients and service users experiencing mental distress, learning disabilities and/or neurodiversity*
- Improve the experience and care of people who are lesbian, gay, bisexual, trans and all other sexualities and gender identities

For staff

- Promote and support inclusive leadership at all levels of the trust
- Ensure recruitment and selection processes are bias free and inclusive
- Facilitate the voices of all staff, providing forums for individuals to come together, to share ideas, raise awareness of challenges, provide support to each other and feedback to the trust on issues of equality, diversity and inclusion
- Take action to support the mental health wellbeing of all staff

For patients, service users, carers and staff

- Promote a culture of inclusion in delivery of care to all patients and staff
- Improve information and data collected, in respect of protected characteristics in order to understand what action may be required
- Tackle bullying and harassment of and by staff and support staff to respectfully and successfully challenge problem behaviours

**Neurodiversity – neurological difference is recognised and respected as any other human variation. Neurological differences can include dyspraxia, dyslexia, attention deficit hyperactivity disorder, autistic spectrum, Tourette syndrome.*

Our equality, diversity and inclusion plan sets out the action we will take to achieve our objectives. The first draft of our plan for the next two years that starts to translate these objectives into action is given at **Appendix 1**.

The final version of our completed 2017 – 2019 action plan against our objectives for that period is provided at **Appendix 2.**

Governance of equality, diversity and inclusion

Development and implementation of our inclusion strategy is overseen by the Equality, Diversity and Inclusion Steering Group and an update is provided to the Patient Experience Committee for patient issues every six months. Staff issues are escalated to the Trust Executive Group as required. A report is made to the Trust Board annually. The LGB&T+ network, established in 2018, has become a formal sub-group of the EDI Steering Group.

Standards and external assurance

Equality Delivery System 2 (EDS2)

Implementation of the EDS2 is a requirement on both NHS commissioners and NHS providers. At the heart of the EDS2 is a set of 18 outcomes grouped into 4 goals. These focus on the issues of most concern to patients, carers, communities, NHS staff and Boards of Directors.

The four goals are:

- Better health outcomes
- Improved patient access and experience
- A representative and supported workforce
- Inclusive leadership

The WSFT EDS2 was reviewed, in consultation with staff, patient representatives and the wider community June to August 2019. This is an electronic document and a copy can be found on the Trust website by clicking here.

Workforce Race Equality Standard (WRES)

The Workforce Race Equality Standard (WRES) is included in the NHS standard contract and its main purpose is:

- To help local, and national, NHS organisations (and other organisations providing NHS services) to review their data against the nine WRES indicators.
- Produce action plans to close the gaps in workplace experience between white and Black and Ethnic Minority (BME) staff and
- To improve BME representation at the Board level of the organisation.

One issue of particular concern in the NHS currently is that BME staff are relatively more likely than white staff to enter the formal disciplinary process. This was highlighted in the **NHS England and NHS Improvement report '*A fair experience for all'*.** The goal set for the NHS is to ensure that the relative likelihood for BME staff entering the formal disciplinary process compared to white staff are within the non-adverse range of 0.8 – 1.25 (measured by WRES indicator 3). This indicator was 0.62 for WSFT in 2019 (0.29 in 2018 and 0.85 in 2017). It is important to note the numbers involved are very small with 3 BME staff entering the formal disciplinary process in 2019, 1 in 2018 and 2 in 2017.

A report showing WSFT performance against the WRES indicators is attached as **Appendix 3**. BME staff still report significantly higher levels of harassment, bullying and abuse from patients/ service users, relatives and the public. It is encouraging to note that the difference in the likelihood of BME and white candidates being appointed from a shortlist is narrowing, but work remains to eradicate it. Our inclusion Strategy Action Plan 2019 to 2021 details action to be taken (**Appendix 1**).

Workforce Disability Equality Standard (WDES)

The Workforce Disability Standard (WDES) was included in the NHS standard contract from April 2019 and its main purpose is to improve the experiences of disabled staff in the NHS. It comprises 10 metrics covering representation of disabled staff in the workforce and on the Trust Board, how the organisation facilitates the voices of disabled staff to be heard, comparison of the experience of disabled versus non-disabled staff around harassment bullying and abuse; opportunities for career progression or promotion, satisfaction with how individual's work is valued by the Trust; engagement and pressure from managers to attend work despite not feeling well enough to perform their duties. Disabled staff are also asked about the provision of reasonable adjustments.

A summary of the Trust's performance against the WDES indicators and action to be taken is provided at **Appendix 4**. The experience of disabled staff at work appears to be worse than that of non-disabled staff in all indicators where comparison is possible with the exception of experiences of harassment, bullying and abuse from patients/service users, relatives and the public; although this remains at unacceptable levels. The actions identified are included in the 2019 to 2021 Inclusion Strategy Action Plan (**Appendix 1**).

Gender Pay Gap (GPG) reporting

All employers with 250 or more employees are required by law to publish their gender pay gap each year on their own and the Government's website. The Trust published its second Gender Pay Gap report in March 2019. This showed that the 2018 mean average gender pay gap was 6.0%. This was 2.1% lower than the 2017 mean average gender pay gap of 8.1%. The 2018 median average gender pay gap was 23.5%. This was 0.7% lower than the 2017 median average gender pay gap of 24.2%.

The reasons for the gender pay gap remain the same as 2017. That is we have proportionately more men in more skilled, senior, higher paying jobs than we have women; in particular senior management roles and senior medical staff.

Bonus payments for gender pay gap reporting are made up of Clinical Excellence Awards (CEA) and Discretionary Points paid to consultant medical staff. No other bonus payments are made to Trust staff. The mean average bonus gender pay gap was 23.27%. This is a reduction of 9.83% compared to the 2017 figure of 33.1%. There was no gender pay gap based on the median average bonus payment in 2018. Click here to see a copy of the report published in March 2019

Actions to address the issues raised are highlighted in the Inclusion Strategy Action Plan 2019 – 21 at **Appendix 1**.

National Staff Survey 2018

For the second year an analysis was undertaken of the staff survey by the characteristics protected by the Equality Act 2010, where possible. That is: age, sex, sexual orientation, religion, disability, and race (no data on marriage and civil partnership or pregnancy and maternity or beliefs other than religious belief).

As in 2018 the overall results clearly showed that staff who are white British, heterosexual, without a disability of no religion or Christian are likely to be more satisfied with their experience of working at WSH than staff who are from an ethnic minority, LGB&T+, disabled or of a religion other than Christianity. Harassment, bullying and abuse are particular issues, both in terms of rates of bullying and the reluctance of staff to report it. This was one of the issues considered by the Trust senior leadership team at the Leadership Summit in June 2019 and action to address it is contained in the action plan resulting from the summit currently being implemented.

Key achievements since September 2018

The Trust LGB&T+ network was set up in October 2018 and has already achieved a lot under the leadership of its Chair, Nicola Cottington, Associate Director of Operations for Medicine. The network's achievements include:

- Sponsoring WSFT's membership of the NHS Rainbow Badge initiative, through which staff give the message to patients, carers and visitor that WSFT is an open, non-judgemental and inclusive place for people that identify as LGBT+ and that they can talk to our staff about who they are, be open about their identity and how they feel. Wearing the badge also means staff commit to do their best to get support for the individual if they need it. So far over 500 staff have signed the NHS Rainbow badge commitment and are wearing the badge. We already have examples of staff being approached by LGB&T+ patients because they were wearing a badge.

- With the support of the catering team, celebrated Pride month in June in Time Out restaurant and represented WSFT at Pride celebrations in Ipswich on 21st June 2019.

- Launched and distributed rainbow lanyards, badges and clips for staff to demonstrate their commitment LGB&T+ inclusion over 600 items have been distributed to staff.

- Hosted a homophobia awareness workshop for staff.

- Launched a WSFT LGB&T+ network twitter account that has 122 followers.

- Hosted a presentation from James Catton, Physicians Associate about health issues affecting LGB&T+ patients in July 2019.

My Guide Training to help staff support patients with visual impairment has been provided for clinical staff, including foundation doctors by Eye Clinic Liaison Officer, Jen Bacon. Jen also arranged for the Trust Chair and CEO to participate in a guided walk around the WSH site to experience what it might be like to be visually impaired and have to navigate a hospital independently and raise awareness about sight loss in our setting.

The first WSFT Equality, Diversity and Inclusion Champions were announced in May at the annual Shinning Lights Awards. The equality, diversity and inclusion award of excellence winner was Raleigh Ball, business analysist, for his work to establish the LGB&T+ network.

Following the launch of the national NHS Workforce Disability Equality Standard (WDES) an Open Forum session was held for staff interested in improving the experience of disabled staff at work and a disabled staff network is being set up as a result. The group already has a list of areas where positive changes can be made.

Understanding the experiences of all our patients is important to provide high quality and safe care. Head of Patient Experience, Cassia Nice, has amended our outpatient appointment letters to include a form to enable us to collect information about patients' protected characteristics – this also allows clinic staff to encourage completion confidentially.

Four Trans Awareness workshops have been held, in support of implementation of our Supporting People Who Are Trans Policy. The workshops were delivered by the Kite Trust, an organisation that promotes the health, well-being and inclusion of young people, and were attended by clinical and non-clinical staff. This workshop is now a standard element of the Expert Navy programme for new and aspiring ward managers.

An open forum session has been arranged for staff interested in exploring setting up a network to improve the experience of BME staff at WSFT.

The summer 2019 WSFT Leadership Summit focussed on improving quality through compassionate, inclusive leadership. The morning session explored bullying and harassment and participants considered the experiences staffs' experiences through the lens of the characteristics protected by the Equality Act 2010. An action plan, based on participants' contributions before and during the session, is now being implemented.

Trust Board members have completed the Trust unconscious bias e-learning training programme.

West Suffolk NHSFT equality and diversity profile 31 March 2019

Where it is possible to collect the data we have analysed the Trust's positon against the nine characteristics protected by the 2010 Equality Act: age, disability, gender identity or expression, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, sexual orientation. Other comparators (i.e. pay and working patterns) have also been used to highlight trends.

The Trust workforce appears more diverse than immediate local areas, and less diverse than the whole of England with the exception of Asian groups. Ethnic groups account for approximately 11% of total workforce and 8% of total staff survey of respondents, a slight increase on last year.

Whilst the White British group make up around 83% of the workforce, this is not necessarily reflected across all staff groups. In particular, the medical staff group has the smallest proportion of white groups and the highest proportion of minority groups, showing greater overall diversity within this group.

80% of the Trust's workforce is female, with the majority of these working in nursing, administrative and healthcare support posts. Male staff members represent 20% of the workforce with a slight majority in medical roles.

Female staff members work almost equally part-time and full-time, whilst most male staff members work full-time. Overall, 57% of Trust staff work full-time, with 43% working part-time.

Pay by gender split roughly reflects the male/female ratio of the Trust with the exception of bands 8 and above, where there is a larger proportion of male staff at senior level. There are no disclosed minority groups in Bands 8c-d and Band 9.

The majority of staff members are between the ages of 40-60, with a large number of staff having been with the trust between 5-10 years.

- Approximately 50% of the workforce falls within the 36 – 55 age bracket.
- There are 306 employees over 60, 15 of these are over the age of 71.
- The majority of staff have a length of service between 1-15 years.

As part of the Trust's processes for equality monitoring the Workforce and Communications Directorate record all formal investigations for disciplinary, capability, grievance, bullying, harassment and recruitment complaints. The factors being monitored are age, ethnicity, gender and disability to identify any trends that may indicate discrimination. On the basis of the data collected for 2018/19 we have not identified any trends that indicate discrimination.

A detailed breakdown of the Trust equality and diversity profile is provided at **Appendix 5.**

APPENDIX 1

Inclusion Action Plan 2019 to 2021 – First draft v.01

Objective	Action – by 31.8.21	Lead	Comments
Where actions are relevant to improving WSFT performance against the Workforce Race Equality Standard (WRES) or Workforce Disability Equality Standard (WDES) this is indicated against the objective.			
For patients, service users and carers			
1. Improve the experience and care of patients and service users experiencing mental distress those with learning disabilities and neurodiversity	Implement the Green Light Toolkit to better meet the needs of patients and service users who have learning disabilities and/or autism	Head of Patient Engagement	
2. Improve the experience and care of people who are lesbian, gay, bisexual, trans and all other sexualities and gender identities	Participate in the NHS Rainbow Badge Scheme to promote a message of inclusion to LGB&T+ patients, service users, and carers Promote the take up of screening by trans people Review and update policies relating to patients, service users and carers to ensure services, facilities and language is inclusive of all sexualities and genders	LGB&T+ network Superintendent Radiographer Breast imaging team/LGB&T+ network LGB&T+ network and owners of policies	WSFT joined scheme in June 2019
For staff			
3. Promote and support inclusive leadership at all levels of the Trust.	Review and update Equality, Diversity and Inclusion Mandatory Training by 31.12.19, enhance disability awareness training. ***WDES*** Increase compliance with mandatory Equality, Diversity and Inclusion training from 90% to 95% by 31.12.20. ***WRES, WDES and GPG***	Deputy Director of Workforce (Organisation Development)	Carried forward from 2017 – 19 plan

	Encourage Trust leaders throughout the organisation to develop awareness of their own unconscious bias and the potential it has to impact on their behaviour. Increase take up of unconscious bias e-learning. ***WRES, WDES and GPG.*** Unconscious bias e-learning to be mandatory for case investigators.	Deputy Director of Workforce (Organisation Development) Deputy Director of Workforce (Operations)	
4. Ensure that the recruitment and selection processes are bias free and inclusive	Complete implementation of action plan resulting from audit recruitment of BME staff. ***WRES*** Review and update policies relevant to the recruitment and selection of people with disabilities. ***WDES*** Achieve 'Disability Confident Employer' status and explore potential to become a 'Disability Confident Leader' ***WDES***	Deputy Director of Workforce (OD), Senior HR Manager and Medical Staffing Manager (Operational) Deputy Director of Workforce (OD) and Disabled Staff Network Members Deputy Director of Workforce (Operations)	All actions to be completed by 31.12.19. Carried forward from 2017 - 19 plan
5. Facilitate the voices of all staff, providing forums for individuals to come together, to share ideas, raise awareness of challenges, provide support to each other and feedback to the trust on issues of equality, diversity and inclusion.	Offer staff the opportunity and support to set up networks around Equality Act protected characteristics. Support the development of the Trust Disabled Staff Network. ***WDES*** Feedback results of 2019 Workforce Race Equality Standard and explore opportunities for a BME staff network. ***WRES*** International Medical Graduate Support Group ***WRES***	Deputy Director of Workforce (OD) Deputy Director of Workforce (OD) Deputy Director of Workforce (OD) Interim Deputy Director of Workforce and Consultant in Obs and Gynae	

6. Take action to support the mental health wellbeing of all staff	Provide access to training and awareness raising for managers and staff to support mental health wellbeing ***WDES***	Clinical Education Lead, Nursing Directorate and Deputy Director of Workforce (OD)	
For patients, service users, carers and staff			
7. Promote a culture of inclusion in the delivery of care to all patients and staff	Engage with staff, patients and service users to explore potential of WSH chapel to ensure it is an inclusive space for all. Identify, share and celebrate existing good practice within the Trust. Set targets for BME representation across the workforce and agree action to achieve these	Head of Patient Engagement Trust Librarian and Deputy Director of Workforce (OD) Trust Board Members/EDI Steering Group	
8. Tackle bullying and harassment of and by staff and support staff to respectfully and successfully challenge problem behaviours.	Implement the Trust 2019 Leadership Summit Action Plan to address poor behaviour and encourage staff to report it. ***WDES & WRES***	All Trust Leaders (monitoring through Directorate Performance Review process)	

APPENDIX 2

Inclusion Action Plan 2017 to 2019 – Final August 2019

Objective	Action – by 31/8/19	Lead	Update – August 2019
For patients, service users and carers			
1. Improve the patient experience and care of older age patients (including those with dementia).	Cognitive screening – review dementia screening within eCare; process to include single question and request for review/referral for memory assessment services via GP	Lead Nurse Dementia & Frail Elderly	Cognitive screening: single screening question, dementia AMT4 and delirium 4AT screening tools have been added to eCare clinical clerking and progress note workflow pages. Cognitive screening also forms part of the Comprehensive Geriatric Assessment (CGA) process. **COMPLETE**
	Add delirium screening to eCare	Lead Nurse Dementia & Frail Elderly	**COMPLETE**
	Dementia diagnosis: improve the referral pathway for memory assessment service	Lead Nurse Dementia & Frail Elderly, Consultant in Elderly Medicine	The pilot continues with referral of patients from Bury North that are under the care of the frailty team direct to memory assessment services. There is not capacity within the Memory Assessment Service to increase the number of referrals, so not able to open to generic hospital referral; memory assessment review is still requested via GP referral for all patients not seen by the frailty team.
	Frailty screening for all patients over 65		Frailty screening is completed and recorded on eCare for patients over 65; frailty score is also documented on the GP discharge summary. **COMPLETE**

	Train volunteers to become 'Ward Companions' to offer comfort, compassion and company for patients at the ends of their lives and their families.	Voluntary Services Manager	Voluntary services have increased their team to include 5 ward companion roles and they are continuing with the recruitment process to develop the team. **COMPLETE**
	Install orientation calendar clocks in all ward bays and clinical areas	Estates Manager	Installation of orientation calendar clocks in all ward bays and clinic areas **COMPLETE**
	Seek and act on feedback from carers, specific carer feedback forms within WSH carer packs. Provide quarterly reports of carer feedback	Lead Nurse Dementia & Frail Elderly	Feedback from carers is collated monthly, fed back via quarterly reports to clinical teams and Matrons, and is monitored by the Involving Family Carer Group. This feeds into the Patient & Carer Experience Group and a biannual report is submitted to the Patient Experience Committee. **COMPLETE**
	Participate in Suffolk Family Carers Carer Friendly Hospital Award	Lead Nurse Dementia & Frail Elderly	**COMPLETE**
	Work with e-care team to ensure implementation of the Accessible Information Monitoring Standard	Head of Patient Experience	Task and Finish Group reconvened to identify and action outstanding areas. Work programme agreed and posters throughout Trust. **Carry forward to 2019 – 21 plan**
For staff			
2. Promote and support inclusive leadership at all levels of the Trust.	Improve the understanding and recognition of managers and leaders cultural competence and of hidden and unconscious bias and its potential impact on patient care.	Deputy Director of Workforce (Organisation Development)	Unconscious bias session to be provided as part of Expert Navy ward manager leadership development programme. **COMPLETE**

			Unconscious bias and cultural competence training available to all staff since July 2018. Mandatory for those involved in the recruitment and selection process and award of Clinical Excellence Awards from 2019. Trust Board members have completed training. **COMPLETE.** Uptake to be monitored as part of Summer 2019 Leadership Summit Action Plan and then as BAU. Target has been increased but compliance around 85%. Left at 90%. Current compliance 90%. **Carry forward to 19 – 21 plan**
	Increase target for compliance with mandatory Equality and Diversity training from 80% to 90% by 1.4.18 and review with a view to increasing to 95% by 1.1.19		
3. Ensure that the recruitment interview process is bias free	Internal audit of recruitment interview process to seek to identify reason(s) for the reduced likelihood of shortlisted BME candidates being appointed by comparison to shortlisted white candidates. Identify action as appropriate.	Deputy Director of Workforce (Organisation Dev), Senior HR Manager and Medical Staffing Manager (Operational)	Audit report completed and action plan has been agreed and implementation underway. All actions to be completed by 31.12.19. **Carry forward to 19 – 21 plan**
	Explore the potential of recruiting and training cultural ambassadors to support the selection process.	Deputy Director of Workforce (Organisation Dev)	Meeting held with RCN and Executive Chief Nurse on 3.5.18. Not currently a viable option. Review again with RCN late 2018. Checked with RCN Jan 2019- not possible to amend the role to support the selection process. **COMPLETE**
4. Establish diversity network groups to provide a forum for individuals to come together, to share ideas, raise awareness of challenges, provide	Offer staff the opportunity and support to set up networks around Equality Act protected characteristics	Deputy Director of Workforce (Organisation Dev)	LGBT inclusion seminar held on 1.12.17 All staff invited to express an interest in participating in diversity networks June 2018. LGB&T+ Network established. **COMPLETE**

support to each other and feedback to the Trust			Open Forum held July 2019 for staff interested in forming a disabled staff network. First network meeting 26.9.19. **COMPLETE**
5. Close the gender pay gap	Identify and publish Gender Pay Gap data and identify any action annually	Deputy Director of Workforce (Organisation Dev)	GPG 2016/17 report published March 2018. Action plan: review Clinical Excellence Awards Policy and process to ensure any scope for bias on any basis is identified and removed. Updated policy agreed by TNC (M&D) – mandatory unconscious bias training for all committee members to be implemented in 2018, other agreed process changes in 2019 to be led by Medical Staffing Manager. New process from Oct 2019. **COMPLETE** GPG 2018 report to Trust Board February 2019. **COMPLETE.**
For patients, service users, carers and staff			
6. Promote a culture of inclusion in the delivery of care to all patients and staff	Develop a policy to help staff support people who are trans and take action to ensure it is implemented.	Deputy Director of Workforce (Organisation Development)	'Supporting people who are trans' policy and FAQ developed and published spring 2018. Trans Awareness Workshops held in November 2018 for Foundation doctors and open workshop for all staff. Further open workshops in 2019 and for Expert Navy participants and Trust HR team. **COMPLETE.** Training continues as BAU.
	Encourage patients and staff to support a culture of inclusion.	Deputy Director of Workforce (Organisation Development)	'Different Families, Same Care' poster campaign launched across Trust June 2018. **COMPLETE** Greensheet article by Head of Communications in June 2018, Pride Month, focusing on LGBT+ staff members. Activities to celebrate Suffolk

			Pride 2019 included launch of WSFT participation in NHS Rainbow Badge scheme by LGB&T+ network and article in Greensheet.
	Establish Shining Lights 'Equality, Diversity and Inclusion Champion' Award	Deputy Director of Workforce (Organisation Development)	Equality and Diversity Steering Group identifying criteria for award. Introduce for 2019 Shining Lights. **COMPLETE** now BAU.
	Promote 'Disabled Go' to patients and staff	Estates and Facilities Business Manager, Assistant Communications Manager, Deputy Director of Workforce (Organisation Development)	Improve signposting of 'Disabled Go' on Trust website, and promote via leaflets in outpatient clinics. Include details in selection interview letters. **COMPLETE**
	My Guide training for staff to support patients with visual impairment	Eye Clinic Liaison Officer and Deputy Director of Workforce (Organisation Development)	My Guide training provided in 2019 for: Foundation doctors, PGME Grand Round participants, Preceptorship Programme participants. Chair and CEO participated in guided walk around hospital site July 2019. **COMPLETE** training now BAU.
7. Improve information and data collected, in respect of protected characteristics, to ensure that the right services are delivered, and in order to improve patient experience and staff satisfaction.	Increase patient data collected on protected characteristics by adding a form to the back of outpatient appointment letters – also allows clinic staff to encourage completion confidentially.	Head of Patient Experience	**COMPLETE**
	Review how we analyse and use complaints data relating to protected characteristics	Head of Patient Experience	Complaints with relevance to E&D to be reviewed by Equality and Diversity Steering Group as arise on an ad hoc basis. **COMPLETE** now BAU
	Work towards 100% workforce sample for the NHS staff survey with particular concerted focus on BME staff who are generally less likely to complete the exercise	Deputy Director of Workforce (Workforce Development)	Letter to accompany 2018 NHS Staff Survey will encourage completion of demographic data by staff. **Carry forward to 2019 – 21 plan**

	Identify potential for additional patient data collection on protected characteristics via e-Care	Deputy Director of Workforce (Organisation Development)	Information team reviewing existing performance reports with protected characteristics currently collected to identify how the data might be used and possible extension. **Carry forward to 2019 - 21**
	Work with e-Care team to ensure data is collected through implementation of the Sexual Orientation Monitoring Standard	Deputy Director of Workforce (Organisation Development)	Sexual orientation: Solution made available by Cerner on 4.7.18 and implementation being monitored. Issues with implementation remain at April 2019. **Carry forward to 2019 – 21 plan**
	Roll out ESR self-service giving all staff access to update their personal details (including protected characteristics) and promote to staff. Campaign will focus on BME staff and those with a disability.	Deputy Director of Workforce (Workforce Development)	ESR self-service rolled out. **COMPLETE**
8. Tackle bullying and harassment of and by staff and support staff to respectfully and successfully challenge problem behaviours.	Promote 'Freedom to Speak Up, Freedom to Improve' campaign to all staff. Tackling Bullying and Harassment Campaign to be launched September 2018.	Executive Director of Workforce and Communications Deputy Directors of Workforce (OD and WD)	National Guardian, Freedom to Speak up presentation at 5 O'clock club on 11.1.18. **COMPLETE** 2017 NHS Staff Survey analysed by protected characteristics to identify areas for action. **COMPLETE** Trusted Partner role to be extended to include partners providing advice and information based on their own lived experience of characteristics protected by the Equality Act. 12 new Trusted Partners recruited and trained June/July 2018. Re-launch of role as part of Staff Supporters at the end of July followed by anti-bullying campaign starting in September 2018. Article in Greensheet publicising role July 2019 **COMPLETE**

	Leadership summit June 2019 focus on improving quality through compassionate inclusive leadership and improving everyone's experience at work by tackling poor behaviour, including bullying and harassment.	Deputy Directors of Workforce (OD and WD)	Update definition/examples of non-physical assault in Trust Management of Violence and Aggression Policy to include discriminatory language and abuse. **COMPLETE** 2018 NHS Staff Survey analysed by protected characteristics and fed back at Summit. **COMPLETE** **Action Plan in place foll**owing summit. **Carry forward to 2019 – 21 plan**
9. Embed equality and diversity in mainstream business processes	Explore the potential of recruiting and training cultural ambassadors to support mediation processes Include equality impact assessment as part of the standard business planning template Ensure impact on equality is considered appropriately in all reports put before the Trust Board and Trust Executive Group	Deputy Director of Workforce (Organisation Development)	Meeting held with RCN and Executive Chief Nurse on 3.5.18. Not currently a viable option. Review again with RCN late 2018. Contacted RCN in January 2019 – role cannot be amended to support the mediation process. **COMPLETE** **COMPLETE** EIA template on intranet and equality assessment included in WSH committee report template. **COMPLETE**

APPENDIX 3

Workforce Race Equality Standard Report 2019

Name and title of board lead for WRES:	Jan Bloomfield, Executive Director of Workforce and Communications
Name, title and contact details of lead manager for compiling this report:	Denise Pora, Deputy Director of Workforce (Organisation Development) denise.pora@wsh.nhs.uk
Name of commissioner this report has been sent to:	Giles Turner, Human Resources Business Partner, West Suffolk CCG
This report was signed off by the Trust Board on:	27th September 2019
Total Number of staff at 31.3.19 (permanent, fixed term and bank staff):	4936
Proportion of BME staff employed within the trust at 31.3.19:	10.9%
The proportion of staff who have self-reported their ethnicity:	94.2%
Period this data refers to:	31 March 2019
Workforce Race Equality Standard Indicators	
Actions to address areas for improvement are included in the **Trust's Inclusion Action Plan 2019 – 21** as indicated below.	
Relative likelihood of staff being appointed from shortlisting across all posts	2018 = shortlisted white candidates 1.60 times more likely to be appointed than BME candidates 2019 = shortlisted white candidates 1.43 times more likely to be appointed than BME candidates **Inclusion Action Plan 2019 – 2021: action under objectives 2 and 3.**
Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator is based on data from a two year rolling average of the current year and the previous year	2017 = BME staff less likely than white staff to enter the formal disciplinary process (0.85) 2018 = BME staff less likely than white staff to enter the formal disciplinary process (0.29) 2019 = BME staff less likely than white staff to enter the formal disciplinary process (0.62) **NB:** the numbers involved are very small. The numbers of BME staff entering the formal disciplinary process were: 2017 – 2, 2018 – 1, 2019 – 3.
Relative likelihood of staff accessing non-mandatory training and CPD	2018 = White staff less likely to access non-mandatory training and CPD compared to BME staff (0.63) 2019 = White staff less likely to access non-mandatory training and CPD compared to BME staff (0.57)

<table>
<tr><td></td><td colspan="3">NB: The relatively high proportion of BME staff who are doctors may impact on this indicator i.e. medical staff generally have greater access to non-mandatory training and CPD than other staff groups.</td></tr>
<tr><td rowspan="4">National NHS Staff Survey 2018 Indicator
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months</td><td>2017</td><td>2018</td><td>2019</td></tr>
<tr><td>White: 27.89</td><td>White: 26.52</td><td>White 27.00</td></tr>
<tr><td>BME: 24.00</td><td>BME: 41.86</td><td>BME: 42.00</td></tr>
<tr><td colspan="3">Inclusion Action Plan 2019 – 2021: action under objectives 5 and 8</td></tr>
<tr><td rowspan="4">National NHS Staff Survey 2018 Indicator
Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months</td><td>2017</td><td>2018</td><td>2019</td></tr>
<tr><td>White: 23.40</td><td>White: 18.53</td><td>White: 19.00</td></tr>
<tr><td>BME: 30.61</td><td>BME: 29.55</td><td>BME: 26.00</td></tr>
<tr><td colspan="3">Inclusion Action Plan 2019 – 2021: action under objectives 5 and 8</td></tr>
<tr><td rowspan="4">National NHS Staff Survey 2018 Indicator
Percentage believing that the trust provides equal opportunities for career progression or promotion</td><td>2017</td><td>2018</td><td>2019</td></tr>
<tr><td>White: 92.06</td><td>White: 88.83</td><td>White: 89</td></tr>
<tr><td>BME: 80.00</td><td>BME: 81.82</td><td>BME: 82</td></tr>
<tr><td colspan="3">Continue to work to ensure all staff receive at least annual appraisal and have access to information about career development opportunities and Inclusion Action Plan 2019 – 2021: action under objective 5</td></tr>
<tr><td rowspan="4">National NHS Staff Survey 2018 Indicator
Percentage staff personally experienced discrimination at work for manager/team leader or other colleague</td><td>2017</td><td>2018</td><td>2019</td></tr>
<tr><td>White: 5.87</td><td>White: 5.51</td><td>White: 8.00</td></tr>
<tr><td>BME: 17.65</td><td>BME: 15.91</td><td>BME: 14.00</td></tr>
<tr><td colspan="3">Inclusion Action Plan 2019 – 2021: action under objectives 5 and 8</td></tr>
<tr><td rowspan="4">Percentage difference between the organisations' board voting membership and its overall workforce</td><td>2017</td><td>2018</td><td>2019</td></tr>
<tr><td>White +16%</td><td>White +16.7%</td><td>White +16.6%</td></tr>
<tr><td>BME -9.9%</td><td>BME -10.2%</td><td>BME -10.9%</td></tr>
<tr><td colspan="3">The Trust board voting membership remains 100% white. Recruitment consultants are instructed to actively seek candidates from all possible sources from within the constituency to provide a diverse range of candidates for all board appointments.</td></tr>
</table>

APPENDIX 4

Workforce Disability Equality Standard Report 2019

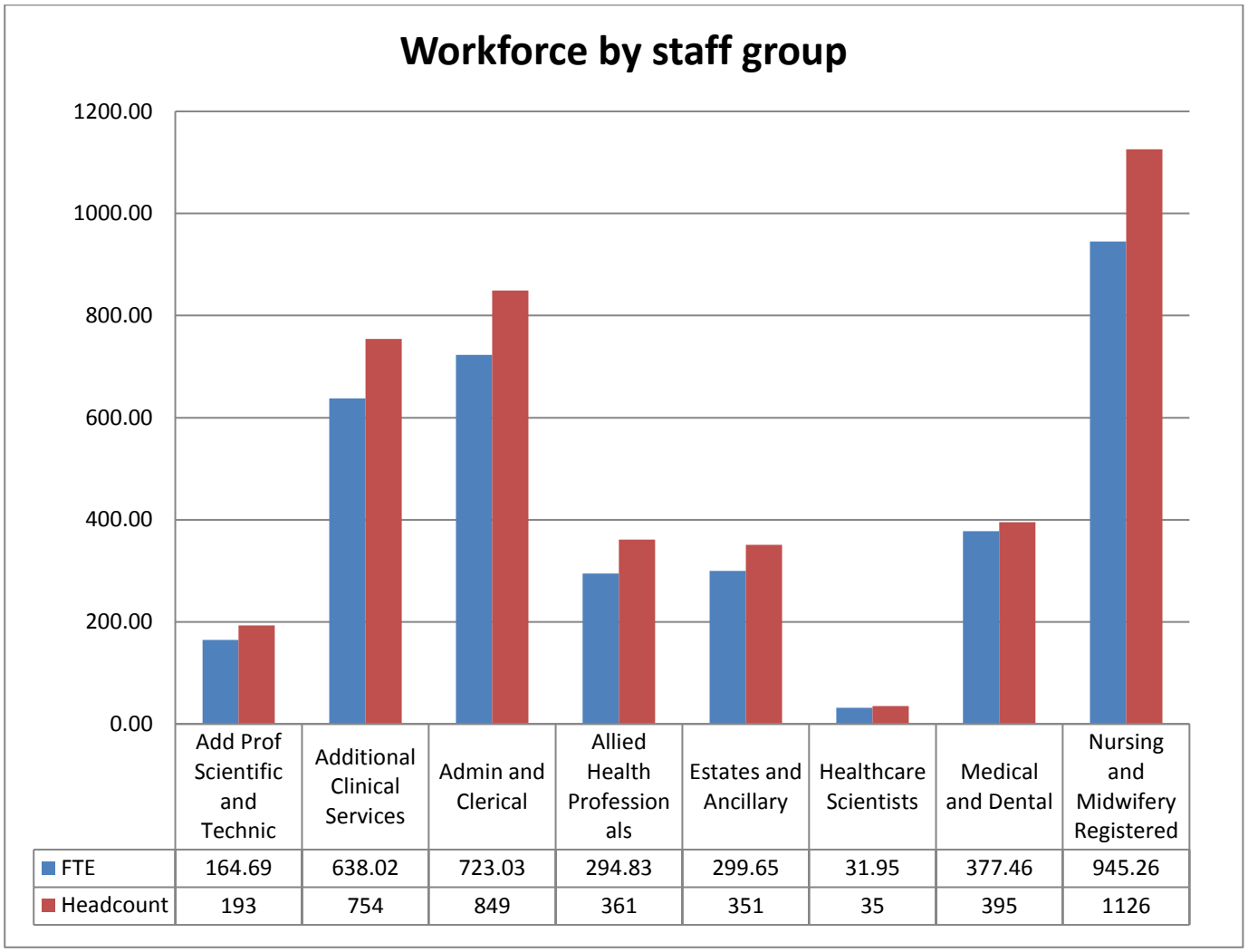
Name and title of board lead for WRES:	Jan Bloomfield, Executive Director of Workforce and Communications
Name, title and contact details of lead manager for compiling this report:	Denise Pora, Deputy Director of Workforce (Organisation Development) denise.pora@wsh.nhs.uk
Name of commissioner this report has been sent to:	Giles Turner, Human Resources Business Partner, West Suffolk CCG
This report was signed off by the Trust Board on:	27th September 2019
Total Number of staff at 31.3.19 (permanent, fixed term and bank staff):	4936
Proportion of disabled staff employed within the trust at 31.3.19:	3%
Period this data refers to:	31 March 2019
Workforce Disability Equality Standard Indicators	
Actions to address areas for improvement are included in the **Trust's Inclusion Action Plan 2019 to 21** as indicated below.	
Relative likelihood of disabled staff compared to non-disabled staff being appointed from shortlisting across all post.	1.03 non-disabled staff are slightly more likely to be appointed than disabled staff from shortlist. Inclusion Action Plan 2019 to 2021: action under objectives
Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.	0.0 no disabled staff entered the formal capability procedure in the period measured.
National NHS Staff Survey 2018 Indicator Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	**Disabled** 23.9% **Non-Disabled** 26.7% Inclusion Action Plan 2019 to 2021: action under objectives
National NHS Staff Survey 2018 Indicator Percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months	**Disabled** 14.8% **Non-Disabled** 10.4% Inclusion Action Plan 2019 to 2021: action under objectives
National NHS Staff Survey 2018 Indicator Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months	**Disabled** 20.4% **Non-Disabled** 18.4% Inclusion Action Plan 2019 to 2021: action under objectives
National NHS Staff Survey 2018 indicator Percentage of disabled staff compared to non-disabled staff saying that last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.	**Disabled** 28.2% **Non-Disabled** 42.4% Inclusion Action Plan 2019 to 2021: action under objectives

National NHS Staff Survey 2018 Indicator Percentage believing that the trust provides equal opportunities for career progression or promotion	**Disabled** 83.8% **Non-Disabled** 90.2% Inclusion Action Plan 2019 to 2021: action under objectives
National NHS Staff Survey 2018 Indicator Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	**Disabled** 21.7% **Non-Disabled** 18.0% Inclusion Action Plan 2019 to 2021: action under objectives
National NHS Staff Survey 2018 Indicator Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.	**Disabled** 45.9% **Non-Disabled** 55.8% Inclusion Action Plan 2019 to 2021: action under objectives
National NHS Staff Survey 2018 Indicator Percentage of disabled staff saying their employer has made adequate adjustment(s) to enable them to carry out their work	82.7%
National NHS Staff Survey 2018 Indicator The staff engagement score for disabled staff, compared to non-disabled staff and the overall engagement score of the organisation	**Disabled** 7.1 **Non-Disabled** 7.5 **Overall all staff Trust score** 7.4 **National average score for comparable Trusts** 7.0 Inclusion Action Plan 2019 to 2021: action under objectives
Has your Trust taken action to facilitate the voices of disabled staff in your organisation to be heard?	Yes, items in Greensheet staff newsletter, displays and open forum. Disabled staff network formed
Percentage difference between the organisation's Board voting membership and its organisation's overall workforce	No board members with a declared disability

APPENDIX 5
WSFT equality and diversity profile 31 March 2019

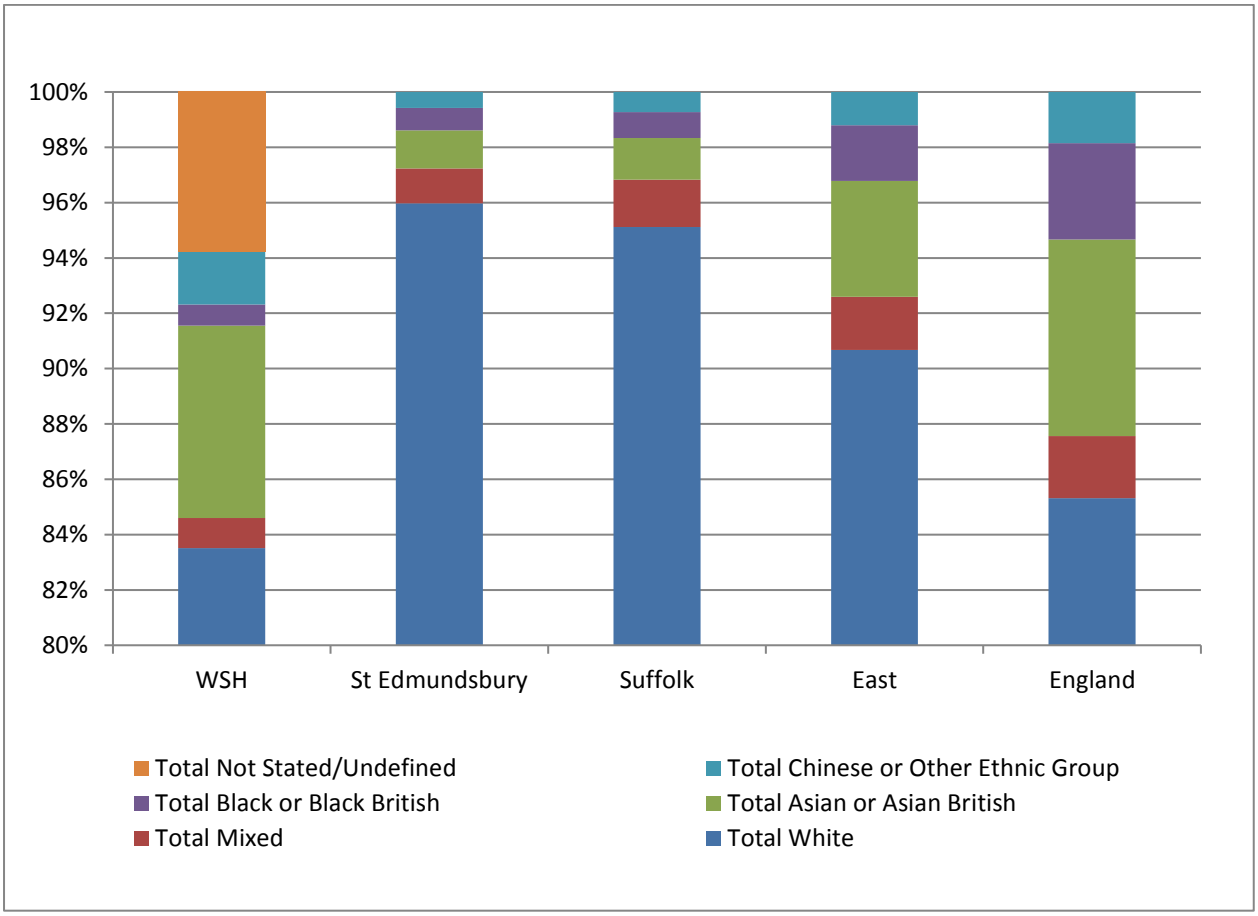
Workforce by staff group

The Trust's total headcount as of 31 March 2019 was approximately 4064. Nurses and midwives continue to be the largest single staff group, accounting for almost 30% of total staff in the Trust, followed closely by administrative and clerical and additional clinical services.



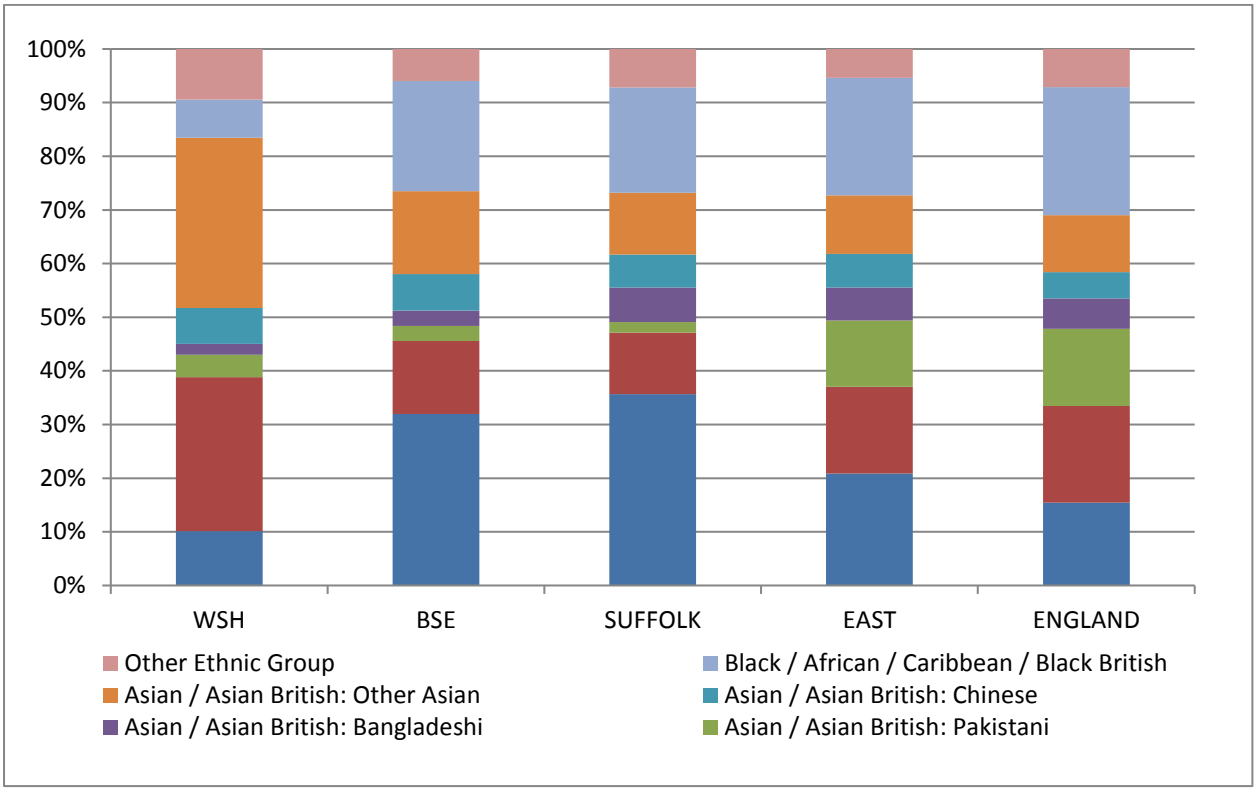
	Add Prof Scientific and Technic	Additional Clinical Services	Admin and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered
FTE	164.69	638.02	723.03	294.83	299.65	31.95	377.46	945.26
Headcount	193	754	849	361	351	35	395	1126

Population ethnicity



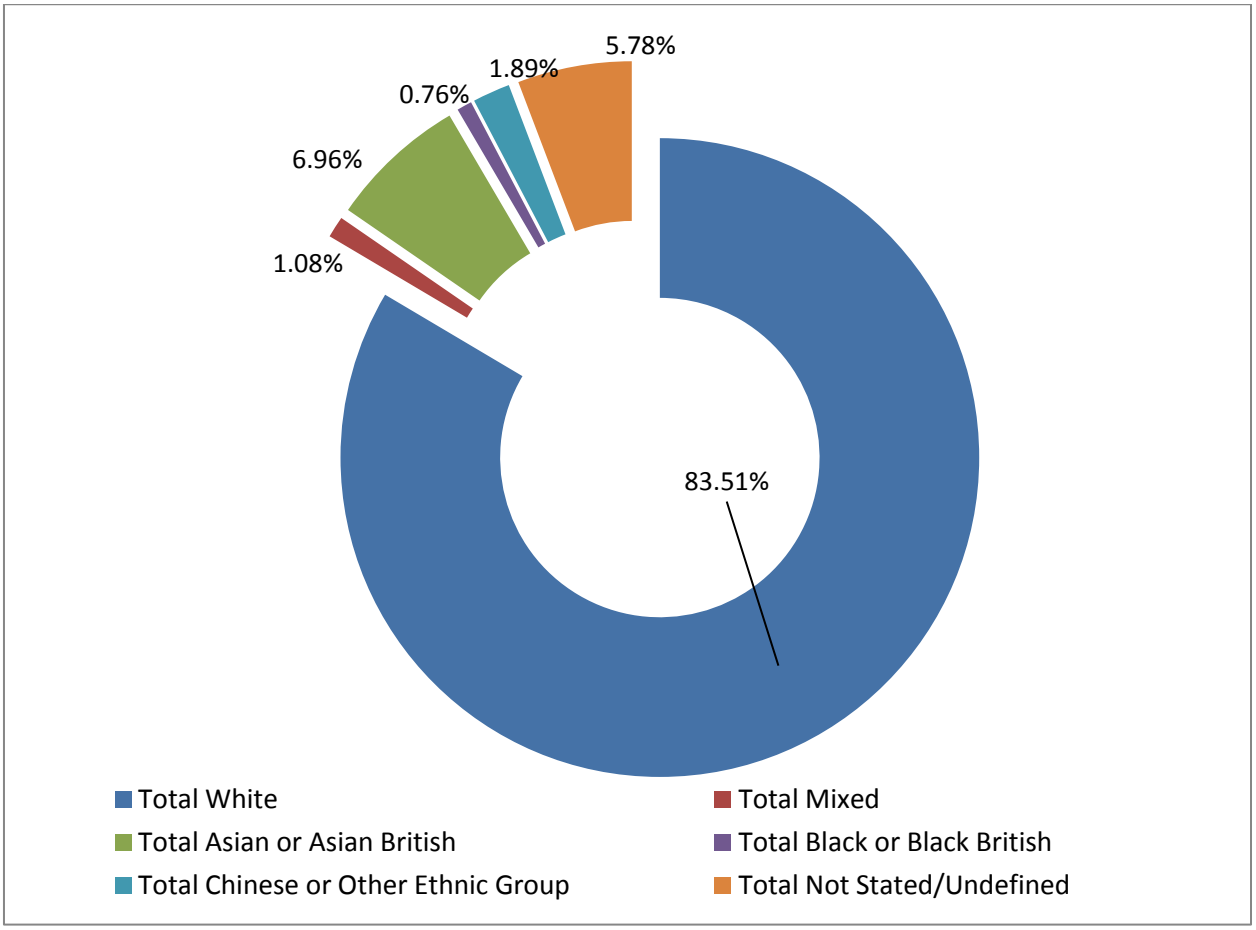
The chart above compares the overall ethnic profiles for the Trust, Bury St Edmunds, Suffolk, East of England and England as a whole. The Trust appears more diverse than the immediate local areas, however slightly less diverse when compared with England as a whole, with the exception of the Asian groups.

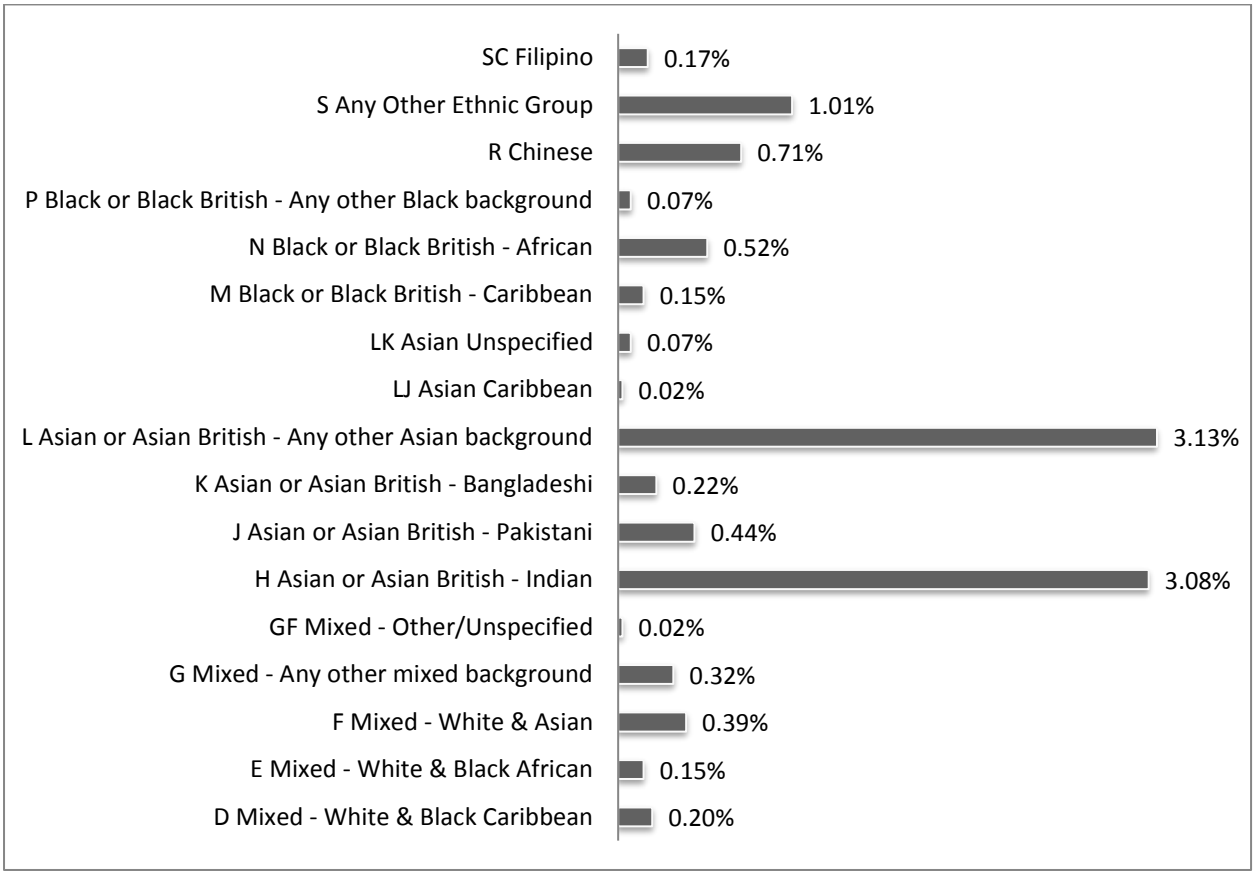
Minority group distribution



Workforce ethnicity breakdown

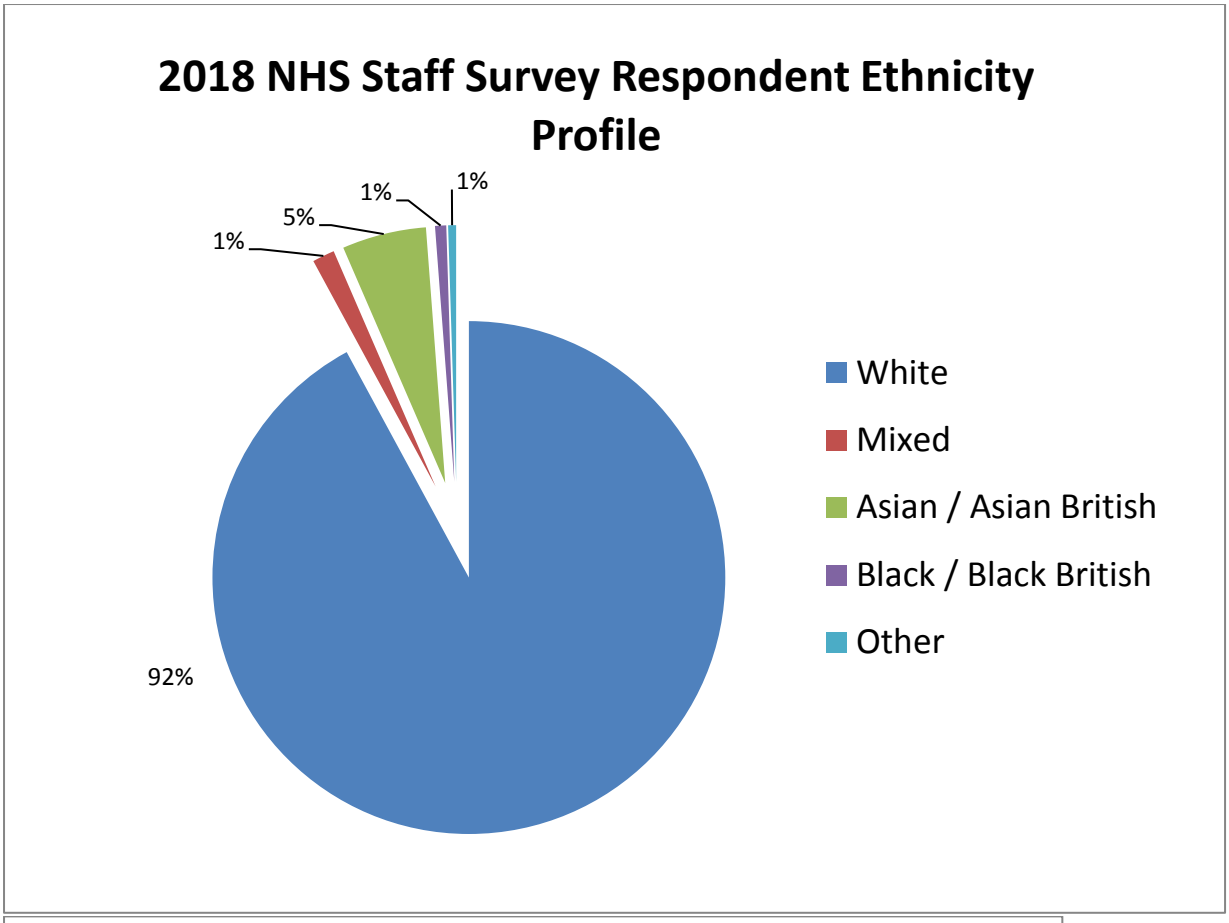
Overall, 10.7% of those staff choosing to disclose their ethnicity stated they were from a minority ethnic group. Currently 94.2% of the workforce has chosen to disclose their ethnicity.

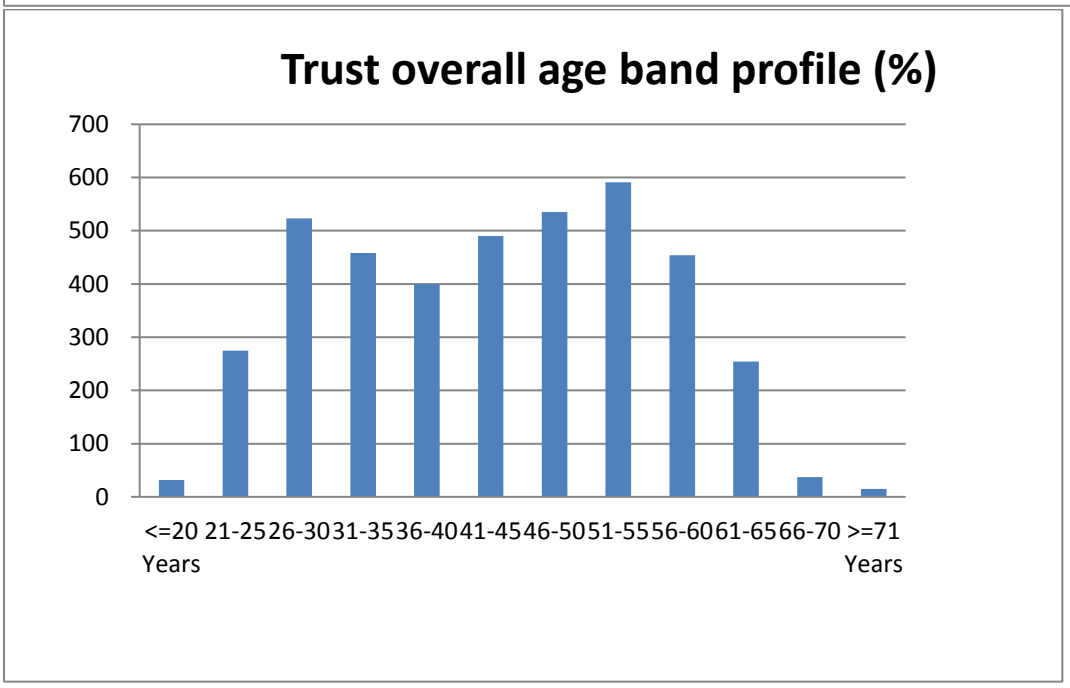




Staff Survey sample – ethnicity

Out of the 1250 eligible staff surveyed, 601 employees responded to the Staff Survey in 2018, giving a total response rate of 48% - above the Picker Institute average for Acute Trusts, which was 44%. The average response rate for England was 46%.
The chart below shows how our staff respondents described their ethnic background when completing the survey. In total 92% were recorded as white groups and 8% as minority.



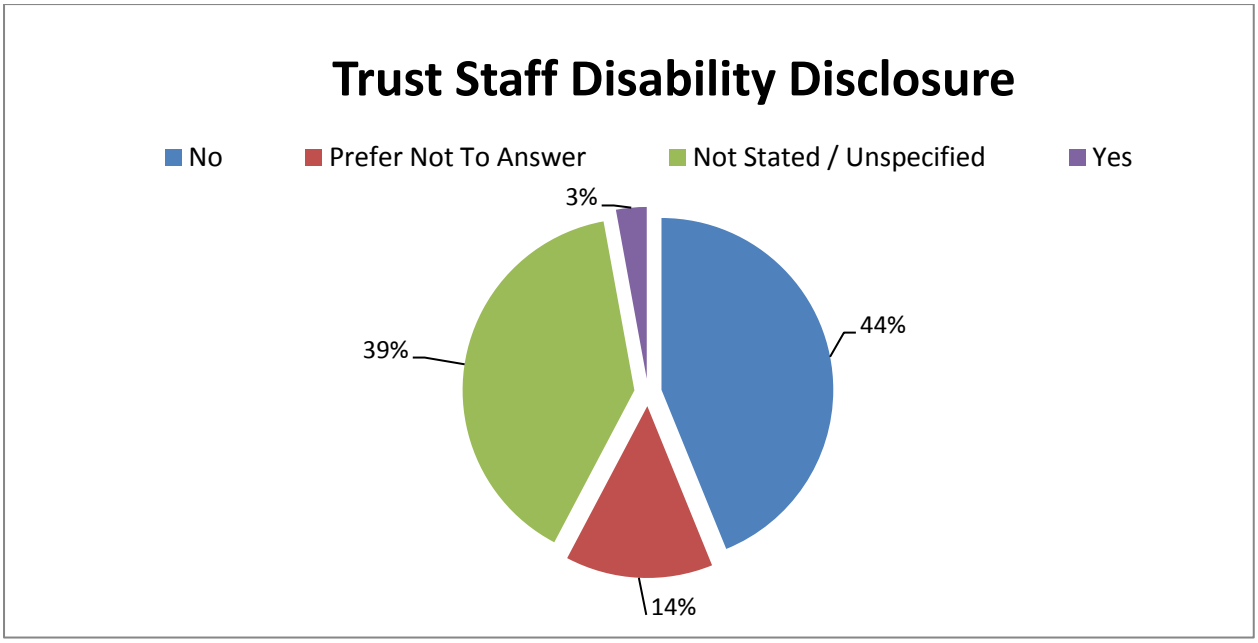


The average age for staff within the Trust is 44 years old. For female staff it is 44 and for male staff, 42.

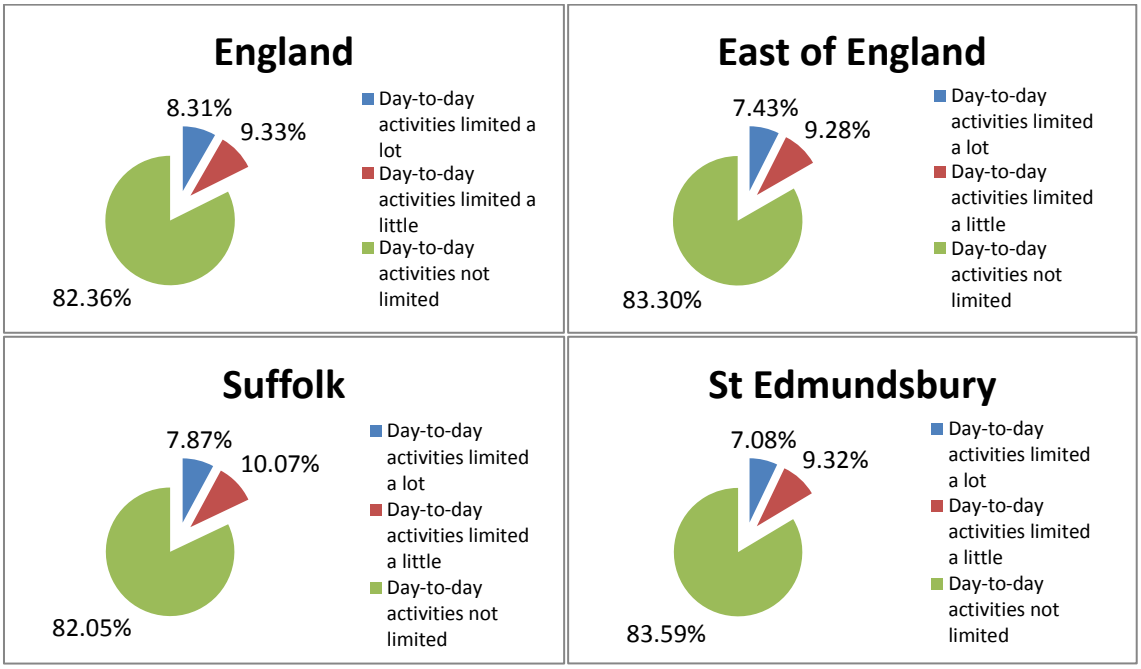
Disability

Trust disability data shows that more than a third of all staff have stated they have no disability. The number of staff whose disability status is not declared/ undisclosed has fallen by another 3%. However, it is noteworthy that data drawn from disclosures by applicants shows 3% of staff have a disability, whilst 2018 staff survey results set the figure at almost 20%.

This suggests a lack of confidence amongst applicants to declare a disability during recruitment and selection. This trend at WSFT is mirrored nationally and is being explored as part of our work to implement the Workforce Disability Equality Standard (WDES).



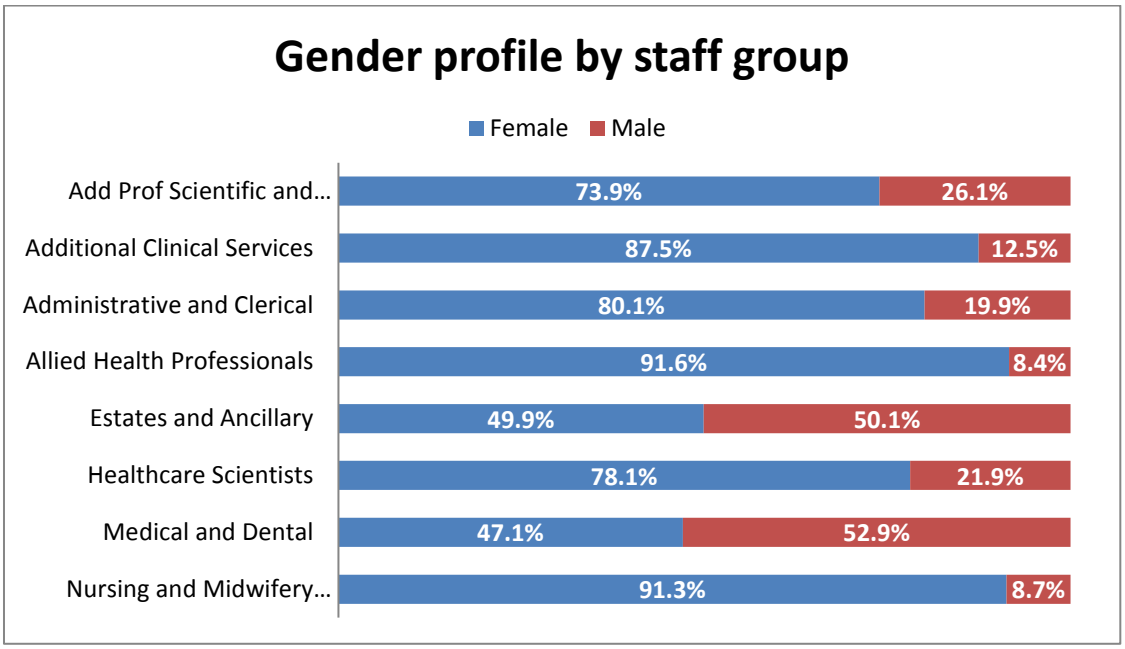
The data below shows the comparison between the locality, region and country as a whole in terms of the number of people who have either no disability/limitation with day-to-day activities, limited or more limited activity.



Gender

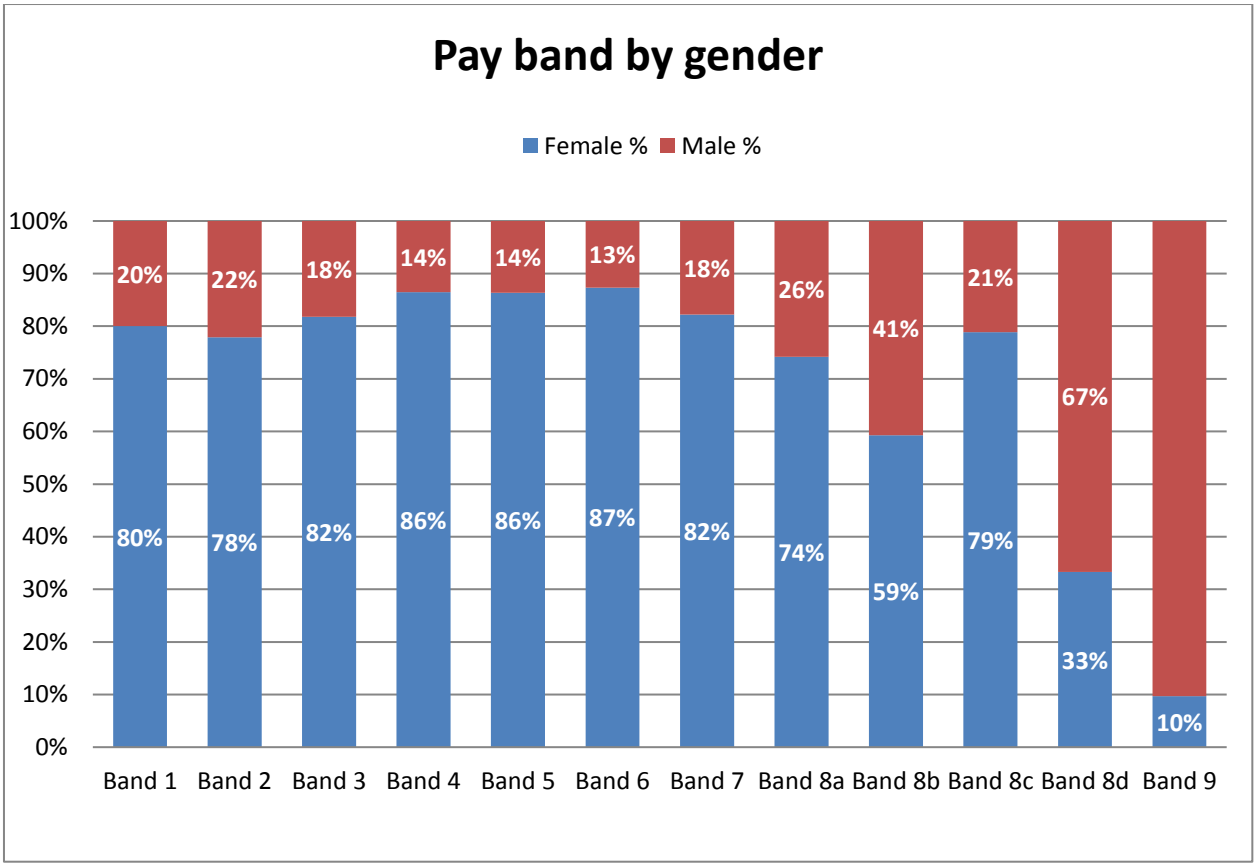
The gender split of the workforce remains reasonably constant; it comprises 80% female staff and 20% male staff. A similar distribution was seen in amongst the respondents to the Staff Survey.

The Trust has a consistently higher proportion of female staff compared to male staff with the exception of the medical and dental and estates and ancillary staff groups.



Pay

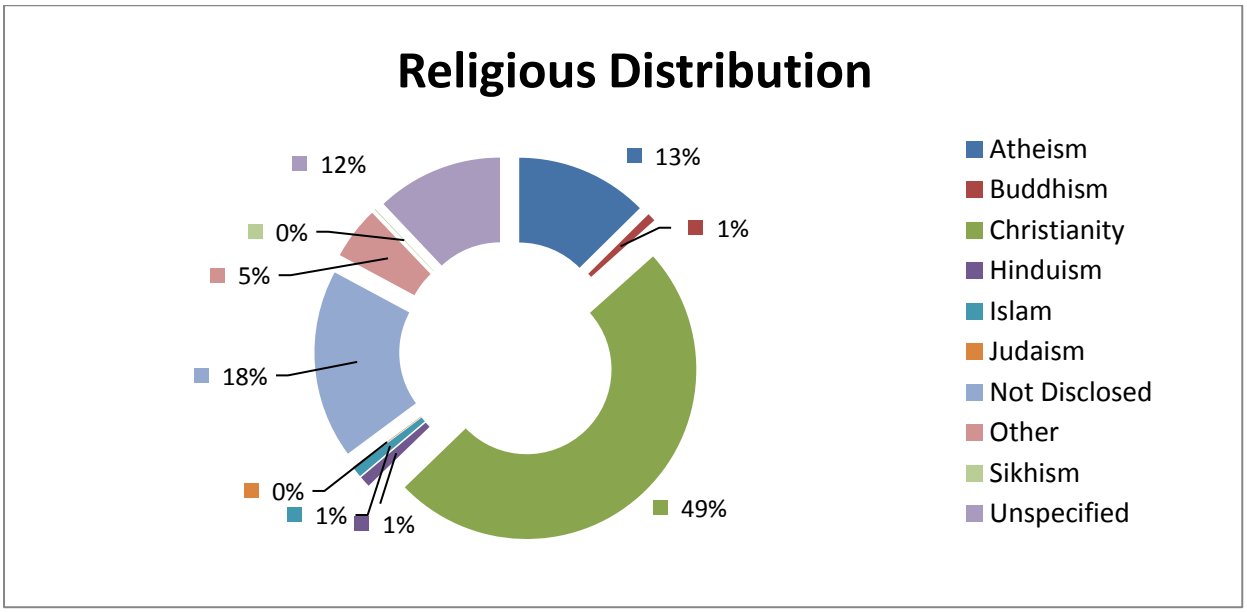
Pay band data by gender displays an approximate reflection of the Trust's 80/20 gender split. At band 8 and above the distribution of male/female staff at higher bands starts to change and we see an increase in the number of male senior staff.



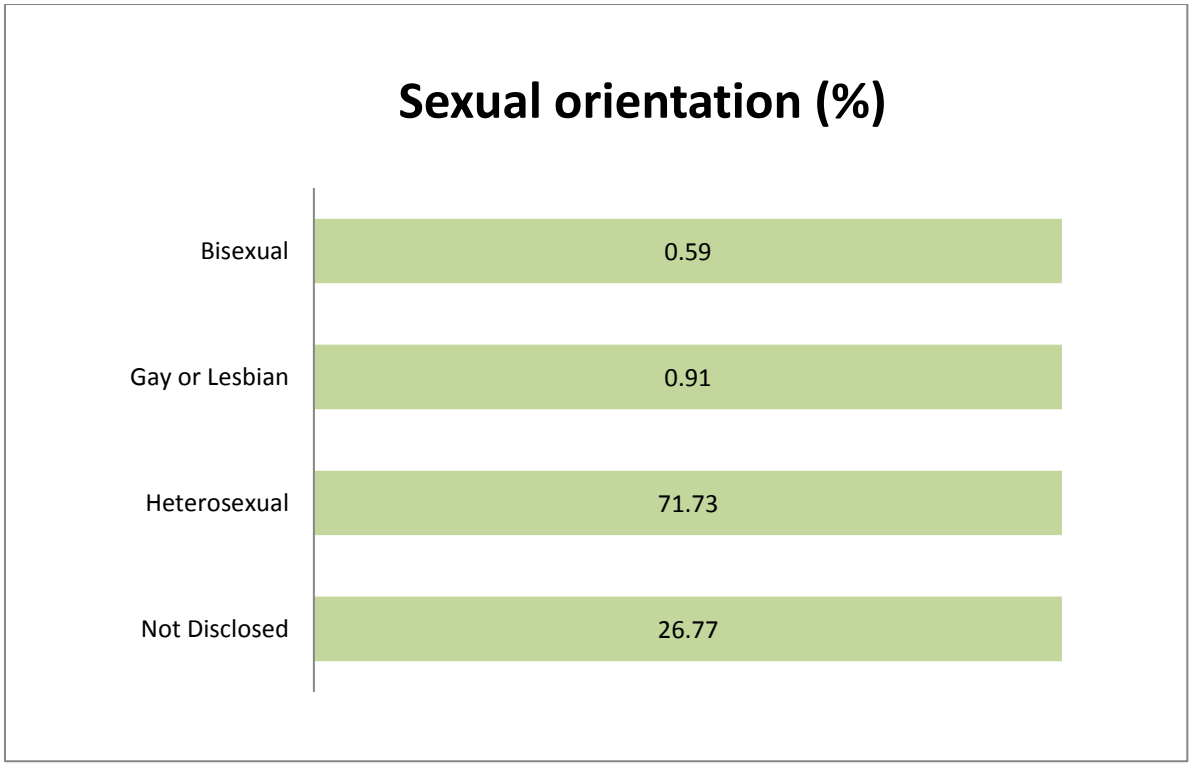
The differences in pay by gender are explored further in our Gender Pay Gap report. Click here to see our 2019 report.

Religion and belief and sexual orientation

There is no current benchmark for religion and sexual orientation.

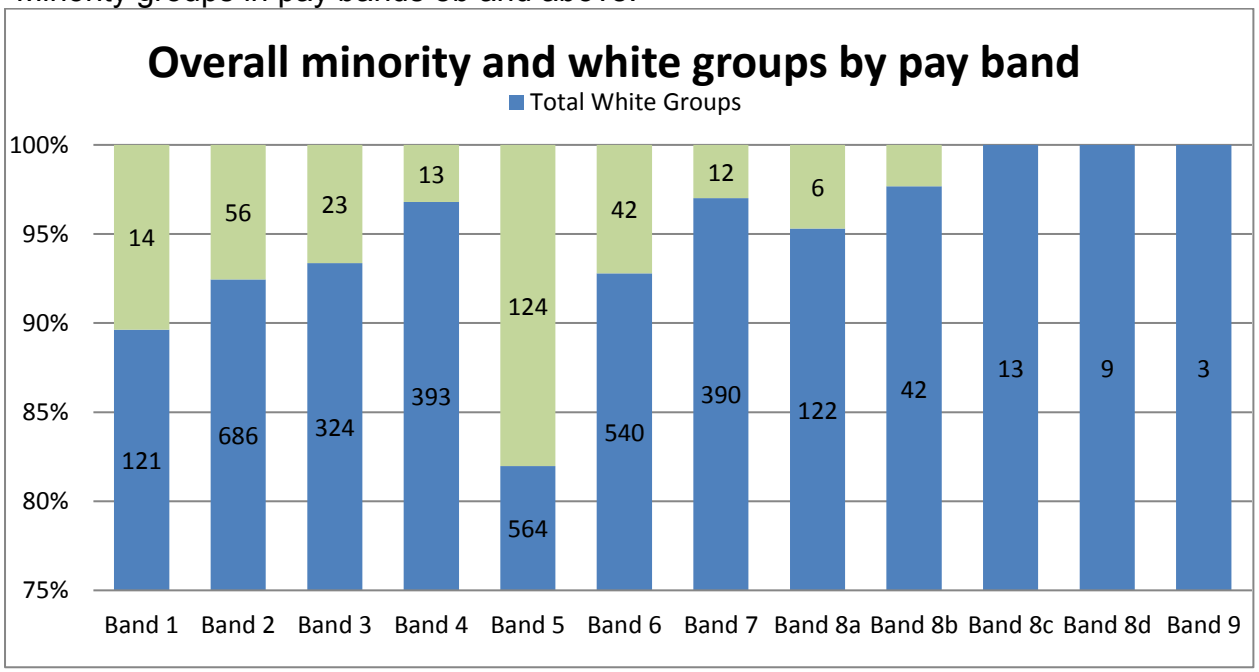


More staff have chosen to disclose their sexual orientation since last year. The number of staff choosing not to disclose their sexual orientation has fallen by 3.3%



Pay band by ethnicity

Bands 2 - 6 show the largest distribution of Minority groups. There are few disclosed Minority groups in pay bands 8b and above.



All staff, and therefore all protected groups, have nationally determined and locally agreed equal pay and related terms and conditions. The Trust is fully engaged with staff and unions and any potential or perceived unfairness in relation to pay and conditions are fully investigated with subsequent feedback to those concerned.

Performance Management

As part of the Trust's processes for equality monitoring the Workforce and Communications Directorate record all formal investigations for disciplinary, capability, grievance, bullying, harassment and recruitment complaints. The factors being monitored are age, ethnicity, gender and disability to identify any trends that may indicate discrimination. Sickness absence is monitored separately. In 2018/19 the Trust conducted a total of 48 formal investigations split into the categories listed in the table below.

	2018/19	2017/18	2016/17
Disciplinary	37	29	22
Capability	2	5	11
Grievance	8	4	3
Bullying and harassment	1	2	1
TOTAL	48	40	37

Analysis shows that 42 of the cases listed above involved White British or White European/ White Other staff, 2 cases were Asian staff, 1 was Black African and 3 were not disclosed. One of the cases involved a member of staff with a disability and the age range was from 25 to 71years old. No significant trends have been identified during the analysis.

Disciplinary cases: The proportion of cases between male and female staff is 10 male cases and 27 female cases. Three cases involved a member of staff from an ethnic minority and the rest were White British or White European/White Other. Fourteen cases went to dismissal and in one case for potential dismissal the employee resigned before the hearing. One dismissal was an employee from an ethnic minority. It should be noted that 19 of the above disciplinary cases involved a single investigation with one department that resulted in 4 dismissals and 15 formal warnings.

Capability cases: We had 2 cases and both were female. Neither of these cases involved an employee with a disability and they were 25 years old and 50 years old. Both employees were White British.

Grievances: We had 9 grievances raised, 4 from male employees and 5 from female employees. All 9 employees were White British.

Bullying and harassment case: We had 1 case involving a female employee and who was White British.

On the basis of the data collected for 2018/19 we have not identified any trends that indicate discrimination.

Data sources for this report

Electronic staff record (ESR) / Oracle BI
Standard workforce figures for staff groups as at 31-March-2019
Trust diversity statistics as at 31-March-2019, for protected characteristics

Office for National Statistics (ONS)
Census information 2011
Population ethnicity profile 2011

NHS Jobs Data sample of equal opportunities employment progress 2018/19

18.2. Infection prevention

For Report

Presented by Rowan Procter

Agenda item:	18.2			
Presented by:	Rowan Procter, Executive Chief Nurse			
Prepared by:	Sue Partridge, Consultant Microbiologist and Anne How, Lead Infection Prevention Nurse			
Date prepared:	July 2019			
Subject:	Infection Prevention and Control Annual Report, 2018-19			
Purpose:	x	For information		For approval

Executive summary:

The Health and Social Care Act (2008 – amended in 2015) Code of Practice on the Prevention and Control of Infections and Related Guidance requires the Director of Infection Prevention and Control (DIPC) to produce an annual report on the Trust's performance in respect of healthcare associated infections (HCAIs). This report covers the period April 2018-March 2019 and provides information on the progress being made to reduce HCAIs.

The format of this annual report is aligned with the criteria in the Code of Practice.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
	x	**x**	**x**

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

Previously considered by:	Infection Prevention and Control Committee, chaired by Stephen Dunn.
Risk and assurance:	Identified risks, such as the lack of isolation facilities, are noted on the Trust's Risk Register and are regularly reviewed by the Infection Prevention and Control Committee.
Legislation, regulatory, equality, diversity and dignity implications	The annual programme of the work of the Infection Prevention team ensures compliance with the ten criteria of the Code of Practice. Compliance with the Code of Practice is assessed by the Care Quality Commission.

Recommendation:
For information

Executive Summary

The Health and Social Care Act (2008) Code of Practice on the Prevention and Control of Infections and Related Guidance requires the Director of Infection Prevention and Control (DIPC) to produce an annual report on the Trust's performance in respect of healthcare associated infections (HCAIs). This report covers the period April 2018-March 2019 and provides information on the progress being made to reduce HCAIs.

The format of this annual report is aligned with the criteria in the Code of Practice.

Introduction

The strategic and operational aim of the Infection Prevention and Control service is to increase organisational focus and collaborative working to maintain standards and support compliance the ten criteria identified in the Health and Social Care Act 2008. The objective is to engage staff at all levels and to ensure effective leadership, in order to develop and embed a culture that supports effective Infection Prevention and Control within the Trust.

The Infection Prevention and Control Team (IPT) have worked in collaboration with operational leads and members of the Nursing and Quality teams to maintain an effective service in acute and community areas that has delivered a broad programme of work.

The programme of work has been supported and monitored by the Infection Prevention and Control Committee, which is chaired by the Chief Executive Officer. The Committee provides assurance to the Board through six-monthly reports to the Clinical Safety and Effectiveness Committee.

The following section of the report describes the annual programme of work in terms of compliance with the ten criteria of the Code of Practice. Compliance with the Code of Practice is assessed by the Care Quality Commission.

Compliance Criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion.
5	Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people.
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection to other people. (That all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling

	infection).
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

Criterion 1
Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment or other users may pose to them.

The Trust Board is committed to fulfilling their responsibility to minimise the risk of preventable infection. Risk assessments are regularly reviewed and updated. This includes an agreement to accept the red risk associated with isolation facilities so that the overall risk rating approved by CSEC is amber.

The Infection Prevention and Control Arrangements

The Chief Executive accepts, on behalf of the Board, responsibility for all aspects of Infection Prevention and Control within the Trust. This responsibility is delegated to the DIPC (who is also the Executive Chief Nurse). The DIPC works with the Infection Prevention Team.

The Infection Control Doctor provides expert microbiological and IPC advice and supports the DIPC and the IPT in the production of policies and procedures.

The Lead Infection Prevention Nurse has operational responsibility for management of the Infection Prevention Nurses and for ensuring that IP&C is embedded within the Trust. The Lead Nurse is a source of expert advice and is responsible for on-going development and evaluation of communication strategies at Trust and divisional levels aimed at promoting IPC policies, guidelines and procedures. The Lead IPN is line managed by the Executive Chief Nurse who is also the DIPC.

The IPN team comprises:
Lead IPN WTE 0.8, Band 8a
Two Infection Prevention nurses 1 WTE Band 6 & 1 0.8 WTE Band 6
Limited clerical support is provided by the Pathology Admin and Clerical staff
The Infection Prevention and Antibiotic audit nurses work closely with the IPNs. They are professionally accountable to the lead IPN, although they are managed within the Pharmacy Department, Clinical Support Services Division.
Band 7 WTE 0.8 (0.26 dedicated to Community IPN role)
Band 6 WTE 0.9 (increased from 0.8 to support service and practice development in the IPN role)

The Infection Prevention Doctor is a Consultant Microbiologist; a payment of 0.5 programmed activities is paid in respect of this role, although it is acknowledged that significantly more time is required that this to fulfil the role. Another Consultant Microbiologist acts ad Deputy IPD, without specific additional remuneration.

All members of the team undertake Continuous Professional Development as required by their respective registration bodies, and annual appraisal as required by the Trust. All are subject to revalidation by their respective professional bodies.

The Lead IPN is a member of the Suffolk Community Healthcare Infection Control Group and the Suffolk Community Water Safety Group.

Assurance Framework

The Trust Board receives reports from the IPC via CSEC, as described above. Additional reports, provided by other departments, inform the Board in respect of compliance with the 10 criteria and are referred to below.

ANNUAL PLAN

In addition to the regular activities described in subsequent sections, variable progress was made against the 2018-2019 Annual Plan in the following areas:

- It was not possible to undertake a formal programme of deep cleaning during 2018-19 because of the lack of a decant facility. Ad hoc deep cleans were undertaken when G9 was available
- Review of the Trust Antibiotic Treatment and Prophylaxis guidelines was undertaken. This is an on-going process which takes account of the availability of antimicrobial drugs, as well as epidemiological changes including the increase in antibiotic resistance.
- The Antimicrobial Management Team worked with other Trust staff with a view to meeting the requirements of National CQUIN target (see below).The IPT has been involved in planning for all major estates projects including AAU (in its different phases), the Cardiac Centre and the Theatre project (ongoing).

Criterion 2
Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infection

Inspections and audits not undertaken by the IPT are presented to Trust Board by the Hotel Services Manager. They include:

- Dashboard
- Monitoring Officer audits (See attached flow chart)
- Patient Environment Action Group (PEAG) audits
- Annual Patient Lead Assessments of the Care Environment (PLACE)

The Trust Water Management Group, at which the IPT are represented, considers matters relating to the supply and quality of water and water systems within the Trust. It reports to the IPCC.

The programme of testing for pseudomonas in augmented care areas continues. The scope of testing has been extended to include Children's Ward and Outpatients, and the MacMillan Day Unit. Significant remedial work has been undertaken (removal of redundant pipework, replacement and resupply of taps and showers) however some outlets continue to test positive. Further engineering solutions are undertaken where possible, however there are some outlets where the continued use of point of use filters is required.

A successful trial of Acetic Acid for eradication of pseudomonas from sink taps was undertaken on the Specialist Oncology unit. This procedure has now been rolled out to the Neonatal Unit.

Regular testing for Legionella is also undertaken
The IPT participated in an external Water Safety Audit undertaken by the Trust's specialist adviser in March 2019.

Criterion 3
Provide suitable accurate information to service users and their visitors

The IPT reports cases of Clostridium difficile, Gram negative bacteraemia (E. coli, Klebsiella and Pseudomonas) and Staphylococcus aureus bacteraemia (both meticillin-sensitive and meticillin-resistant) to the mandatory National Surveillance Scheme

1. C. difficile infection (CDI)

. Prior to her retirement the CCG Infection Prevention nurse used to attend the majority of the post-infection review (PIR) meetings; her replacement took up the post in July 2018.The Trust objective for hospital-attributable (by time-frame) cases of CDI for 2018-19 was 15. A total of 12 cases were reported, of which 3 counted against the trajectory. Cases are now deemed to fall into one of the following categories:

1. Lapse in care directly leading to acquisition of CDI (trajectory case)
2. Lapse in care with learning, but did not directly lead to acquisition of CDI
3. No lapse in care

A Post Infection Review meeting is held for each case; these are a valuable forum where notable practice is acknowledged as well as any lapses of care discussed and appropriate actions identified.
The CCG Infection Prevention Nurse Advisor attends the majority of PIR meetings and categorises the cases.

It should be noted that from April 2019 the attribution of CDI cases will change. Cases will be counted against the Trust objective if they meet any of the following definitions:

- 'Hospital onset healthcare associated' - Cases that are detected in the hospital two or more days after admission
- 'Community onset healthcare associated' - Cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks

The Trust objective for CDI cases has been increased to 20 in the light of these revised definitions

2. Meticillin-resistant Staph. aureus (MRSA) bacteraemia

One episode of hospital-acquired MRSA bacteraemia was reported. While this was deemed on clinical grounds to have been a contaminant in a patient known to be colonised with MRSA , the national definitions mean that the case is attributed to the Trust.

WSFT and the CCG are still required to conduct a PIR for all cases (this is no longer a national requirement for all trusts).
The nationally-set objective for these cases remains zero.

3. Meticillin-sensitive Staph aureus bacteraemia

Six cases were identified; all were deemed to be unavoidable by Post Infection Review meeting process. There were no common themes.

The presence of a senior clinician at PIR meetings is very helpful in understanding the course of events, and the support of clinical colleagues is gratefully acknowledged.

4. Gram negative bacteraemia.

There were a total of 182 cases of E. coli bacteraemia across community and Trust, of which 15 were attributable to the Trust by time-frame. It was noted that many of the in-patients had significant comorbidities. A Root Cause Analysis tool has been produced by Public Health England for investigation of these cases and reporting will be mandatory from April 2019, although no

objective for the number of cases has been set. This forms part of the national initiative to reduce Gram negative bloodstream infections.

There were 5 Klebsiella and 4 Pseudomonas bacteraemias attributable to the Trust; the only theme was urinary tract infection.
The Gram negative bacteraemias are reviewed monthly and reported to the Trust Board.
They are assessed when entered onto the data capture system to establish if there are any themes. Our data suggests that the only aspect which the Trust can influence relates to urinary catheter management. In light of this a quality improvement project was undertaken on two Medical wards to assess whether urinary catheters were being removed at the earliest opportunity (using the HOUDINI-C protocol). The audits confirmed that nurse lead removal is well established using the HOUDINI-C criteria. The results of this quality improvement project were presented at the Nursing Directorate Poster Showcase. The Trust has been participating in the catheter passport scheme in Suffolk in tandem with community services.

5. Surgical Site Infection Surveillance.

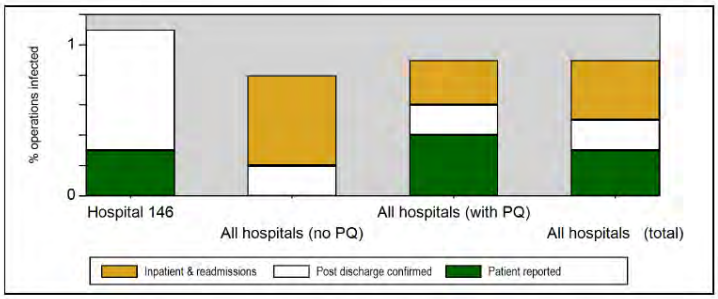
No surveillance was undertaken for general surgery
Surveillance of orthopaedic surgery was undertaken for two procedures: total hip replacement and total knee replacement.

Surveillance data is collected for all patients having the procedure during. Although it is only mandatory to submit data for one quarter of each year, the Orthopaedic department now collect this data continuously. This is undertaken by review of the clinical records for their admission and at the six week post-operative consultation, looking for evidence of infection. Some Trusts also use a patient questionnaire (PQ in the tables below) to collect information about infections that were managed elsewhere; this is extremely time-consuming and is not feasible for WSFT at the present time.

THR

Rate of SSI

Category	Hip replacement
Data between	Jan-2018 and Dec-2018
Hospital	West Suffolk Hospital [146]



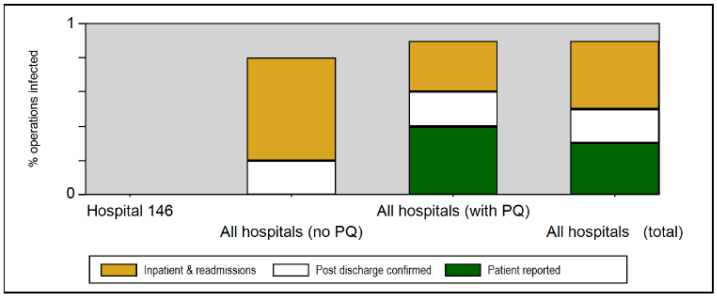
All hospitals* for the previous 5 years available (Jan-Mar 2014 to Oct-Dec 2018).

	No. operations	Patient questionnaire		Surgical Site Infection: Inpatient & readmissions		Post discharge confirmed		Patient reported		All SSI	
		No. given	% complete	No.	%	No.	%	No.	%	No.	%
Hospital 146	392	45	8.4	0	0.0	3	0.8	1	0.3	4	1.0
All hospitals (no PQ)	115439	No data	No data	720	0.6	207	0.2	No data	No data	976	0.8
All hospitals (with PQ)	206801	206801	76.5	574	0.3	506	0.2	881	0.4	1961	0.9
All hospitals (total)	322240	206801	0.0	1294	0.4	713	0.2	930	0.3	2937	0.9

*Please refer to 2.4 Definition of Terms at the back of the Summary report for an explanation of data included in the benchmark.

Rate of SSI

Category	Hip replacement
Data between	Jan-2019 and Mar-2019
Hospital	West Suffolk Hospital [146]



All hospitals* for the previous 5 years available (Jan-Mar 2014 to Oct-Dec 2018).

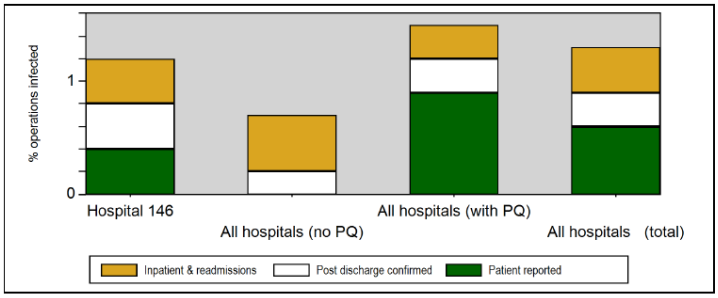
	No. operations	Patient questionnaire		Surgical Site Infection: Inpatient & readmissions		Post discharge confirmed		Patient reported		All SSI	
		No. given	% complete	No.	%	No.	%	No.	%	No.	%
Hospital 146	48	15	29.2	0	0.0	0	0.0	0	0.0	0	0.0
All hospitals (no PQ)	115439	No data	No data	720	0.6	207	0.2	No data	No data	976	0.8
All hospitals (with PQ)	206801	206801	76.5	574	0.3	506	0.2	881	0.4	1961	0.9
All hospitals (total)	322240	206801	0.0	1294	0.4	713	0.2	930	0.3	2937	0.9

*Please refer to 2.4 Definition of Terms at the back of the Summary report for an explanation of data included in the benchmark.

TKR

Rate of SSI

Category	Knee replacement
Data between	Jan-2018 and Dec-2018
Hospital	West Suffolk Hospital [146]



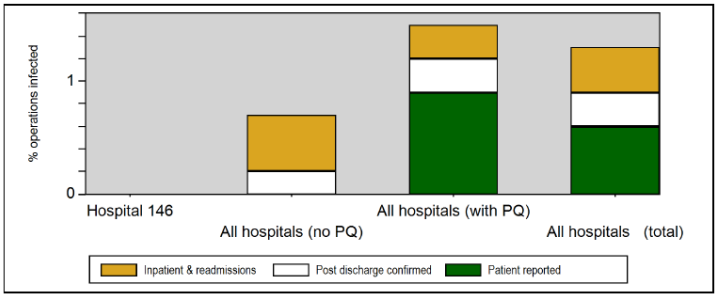
All hospitals* for the previous 5 years available (Jan-Mar 2014 to Oct-Dec 2018).

	No. operations	Patient questionnaire		Surgical Site Infection: Inpatient & readmissions		Post discharge confirmed		Patient reported		All SSI	
		No. given	% complete	No.	%	No.	%	No.	%	No.	%
Hospital 146	253	0	0.0	1	0.4	1	0.4	1	0.4	3	1.2
All hospitals (no PQ)	124199	No data	No data	628	0.5	283	0.2	No data	No data	1042	0.8
All hospitals (with PQ)	225913	225913	75.2	636	0.3	766	0.3	2122	0.9	3524	1.6
All hospitals (total)	350112	225913	0.0	1264	0.4	1049	0.3	2253	0.6	4566	1.3

*Please refer to 2.4 Definition of Terms at the back of the Summary report for an explanation of data included in the benchmark.

Rate of SSI

Category	Knee replacement
Data between	Jan-2019 and Mar-2019
Hospital	West Suffolk Hospital [146]



All hospitals* for the previous 5 years available (Jan-Mar 2014 to Oct-Dec 2018).

	No. operations	Patient questionnaire		Surgical Site Infection							
				Inpatient & readmissions		Post discharge confirmed		Patient reported		All SSI	
		No. given	% complete	No.	%	No.	%	No.	%	No.	%
Hospital 146	50	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
All hospitals (no PQ)	124199	No data	No data	628	0.5	283	0.2	No data	No data	1042	0.8
All hospitals (with PQ)	225913	225913	75.2	636	0.3	766	0.3	2122	0.9	3524	1.6
All hospitals (total)	350112	225913	0.0	1264	0.4	1049	0.3	2253	0.6	4566	1.3

*Please refer to 2.4 Definition of Terms at the back of the Summary report for an explanation of data included in the benchmark.

Criterion 4
Provide suitable accurate information on infection to any person concerned with providing further support of nursing/medical care in a timely fashion

Infection Prevention advice is available 24 hours a day from the IPNs or the duty consultant microbiologist.

To ensure that everyone is aware of their responsibilities the managers are responsible for ensuring that the suite of infection prevention & control posters is available for their staff and that there are leaflets or information available for their patients and visitors. The IPCT is responsible for ensuring that information is available for staff via the intranet site and for visitors/carers on the Trust website, this includes the latest Annual Report and Strategy.

Criterion 5
Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people

The IPT strategy has been developed based on the key principles of successful prevention and control techniques, which include:

- Assessment and proactive response to the risk of infection
- Ensuring effective working practices that avoid the risk of transmission
- Universal application of fundamental infection prevention and control techniques and practices
- Managing specific infectious agents in line with best practice

The key objectives for 2018-2019 were:

- To work effectively with the wider health and social care economies to reduce the incidence of health care associated infections and communicable diseases, with particular reference to the correct use of personal protective equipment. To work with colleagues across the whole health economy in respect of the quality premium to reduce Gram negative bloodstream infections.

- Continue to build a culture where staff are prepared to challenge and be challenged on clinical practice including hand hygiene and the use of personal protective clothing.
- Ensure, through a system of audit and observation, that our services provide a clean safe environment conducive to good infection prevention and control practice. The audit tools are reviewed and adapted annually. Work effectively with operational services and the training teams to strengthen and promote IPC education and training. Specific Mandatory Training and Induction sessions were provided for the cohort of nurses recruited from the Philippines.

Ensure effective risk assessment and risk management strategies are employed whenever and wherever a risk is identified, including out of hours. The team work closely with the bed flow team to ensure that the single rooms and the admissions to F12 are optimised. The team have been working closely with the eCare team to optimise the information staff can access in respect of Isolation both within the Capacity Management module and preparatory work in respect of the Cerner Infection Prevention Module. If this is successful the module will be launched in 2020. Potential benefits are already anticipated for recognising infection and triggering required actions. To review and improve elements of clinical practice. The topical treatments used to decolonise patients who are identified as being carriers of MRSA are now prescribed on eCare (previously a separate paper chart was required). This has simplified the act of prescribing and thereby supported the timely commencement of decolonisation treatment.

These objectives are supported by an annual development plan to strengthen the Trust's compliance with the Health and Social Care Act (2008) Code of Practice. The work plan is agreed and scrutinised by the Infection Prevention and Control Committee.
Updates on the progress of the work plan are presented at each meeting of the Infection Prevention and Control Committee. The Executive Team and the Board also receive monthly reports on the commissioner's infection control targets that include a year on year reduction in Clostridium difficile, zero tolerance of MRSA bacteraemia and a reduction in Gram negative bacteraemias.
Information regarding audit results and training compliance is also presented.

Criterion 6
Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection.

All WSFT receive mandatory training at induction and regularly thereafter; the frequency is determined by their role:

- Non-clinical staff undertake e-learning every three years (95% are up to date against a Trust target of 90%).
- Frontline Clinical staff (predominantly but not exclusively Nursing staff) receive annual classroom training (95% up to date against a Trust target of 90%).
- Consultants undertake annual e-learning. 95% are compliant (target 80%)

IP is a core element in Trust mandatory training.

All new staff job descriptions include the statement that 'it is the personal responsibility of the post holder to adhere to the West Suffolk NHS Foundation Trust policies and procedures outlined in the Infection Control Manual and any other Infection Control policies, procedures and practices which may be required from time to time'.

As part of IPC audit, if poor practice is noted than it is escalated to the area manager for resolution; this may be incorporated into the appraisal process.

Most clinical areas (Trust and Community) have an IP Link Practitioner who acts as a source of information and advice regarding appropriate practice. The Link Practitioners are supported by the

IPT and there are four training days a year, each focussing on a different topic. The most recent meetings have covered:

- Personal Protective Equipment
- Routes of Transmission
- Clostridium difficile
- IV Therapy: How to Get it right

Criterion 7
Provide or secure adequate isolation facilities

The Trust has an accepted risk noted on the Trust Risk Register regarding the low number of single rooms (circa 10% of available beds are single rooms) which is recognised as being the lowest in the region. Developments during 2018-2019 led to a net increase of two single rooms. The IPT worked with the Trust Design Team on plans (and their implementation) for the new Cardiac Centre and Ward. The Ward has doors on its bays, as well as a toilet in each bay. In addition the single rooms all have an en-suite toilet. This design – which is the preferred model for any future ward reconfigurations – meant that cases of influenza infection on the ward could be contained and it was not necessary to close the ward. This is in contrast to the previous year when the speciality was on G3 and was closed for 10 days to contain an Influenza outbreak

The IPT attend as a minimum the morning Safety Huddle and the Midday patient flow meeting, as well as other patient flow meetings as required. This is to ensure that staff managing this key function can access accurate information on available isolation facilities.

The IPN's visit the acute wards daily (Monday to Friday) in order to assess patients requiring isolation and those for whom monitoring is required, to ensure all measures to reduce onward transmission are in place. Up to date information on the status of patients who are isolated, or who should be isolated when there is capacity to do so, is recorded by the every weekday by the IPT. This information is supplied to the patient flow bed team.

Our commissioners have set a target of 95% compliance with Isolation and this is reported on a monthly basis via the Infection Prevention Dashboard. Compliance was particularly low (80%, 75% and 85%) in Q4 because of the number of patients with Influenza who could not be isolated because of lack of single room capacity

Criterion 8
Secure adequate access to laboratory support as appropriate

Microbiology services are provided by Public Health England as a subcontractor of North East Essex and Suffolk Pathology Services. The Microbiology laboratory is still on-site, pending a strategic decision by WSFT and ESNEFT Trust Boards about the provision of Pathology services. It has been agreed that WSFT will be a pilot site for the introduction of the eCare Infection Prevention module. Development work has commenced, including development of the necessary links with the Laboratory Information Management System.
The eCare module will offer significant advantages in surveillance of alert organisms and conditions, as well as procedures and devices. It will allow specific searches to be performed and the results provided to clinical areas and relevant teams (in addition to the IPT).

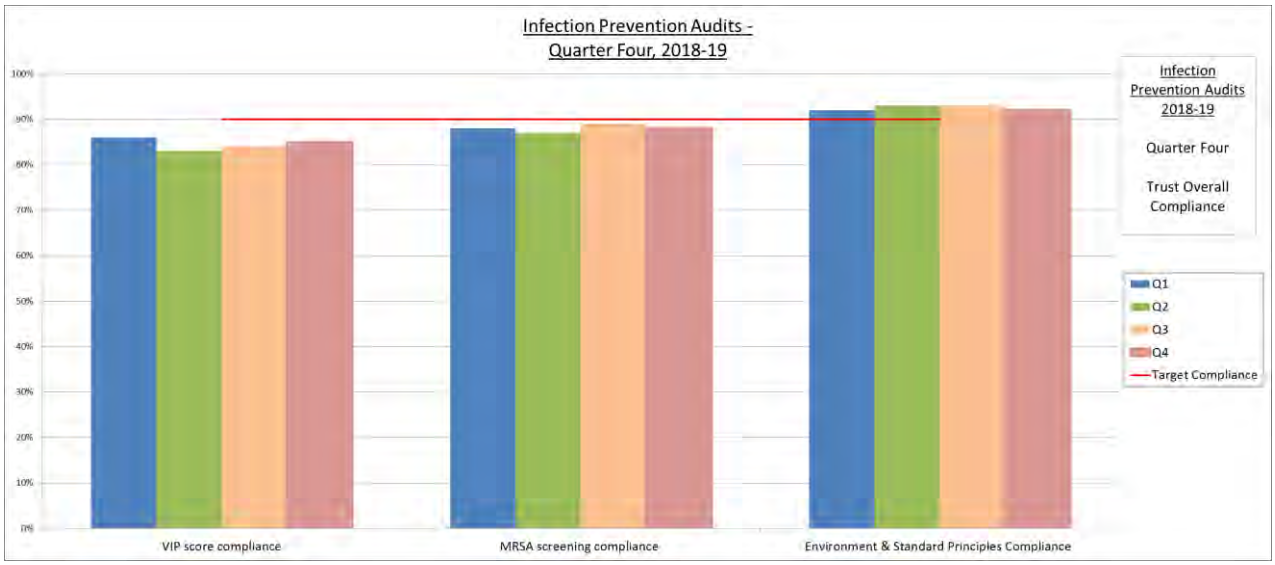
Criterion 9
Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections

Compliance with elements of the policies is assessed in the programme of Trust audits (High Impact Interventions and Hand Hygiene) and Infection Prevention audits. There is also a rolling programme of audits of compliance with Trust antibiotic treatment policies. These are reviewed quarterly and annually to direct patient safety initiatives.

HIIs and Hand Hygiene Audits

Indicator	Target	Red	Amber	Green	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
HII compliance 1a: Central venous catheter insertion	= 100%	<85	85-99	= 100	100	100	100	100	100	100	100	100	100	100	94	100
HII compliance 1b: Central venous catheter ongoing care	= 100%	<85	85-99	= 100	100	95	100	91	97	95	100	96	100	96	96	87
HII compliance 2a: Peripheral cannula insertion	= 100%	<85	85-99	= 100	100	100	100	100	100	100	96	96	100	98	100	96
HII compliance 2b: Peripheral cannula ongoing	= 100%	<85	85-99	= 100	100	98	97	100	96	88	100	100	100	98	99	99
HII compliance 4a: Preventing surgical site infection preoperative	= 100%	<85	85-99	= 100	100	100	100	100	100	100	100	95	100	100	100	100
HII compliance 4b: Preventing surgical site infection perioperative	= 100%	<85	85-99	= 100	100	100	100	100	100	100	100	100	100	100	100	100
HII compliance 6a: Urinary catheter insertion	= 100%	<85	85-99	= 100	100	100	100	100	100	100	100	100	100	91	100	100
HII compliance 6b: Urinary catheter on-going care	= 100%	<85	85-99	= 100	100	95	92	97	97	89	94	97	98	92	89	95
Hand hygiene compliance	= 95%	<85	85-99	= 100	100	99	99	99	100	100	100	99	98	100	100	99

Additional Infection Prevention Audits



Compliance with Visual Infusion Phlebitis scores has been below target since the launch of e-Care in May 2016. Both ad-hoc and formal training on how and why to complete this has been offered to wards and key groups of staff, and changes to e-Care have been made to request documentation of the care of the IV cannula in the nurse accountability that is completed each shift. Additional Quality Improvement projects have been undertaken by an FY2 Doctor to look at improving cannula documentation; however this has not yielded any significant improvements.

Following the audit, areas of non-compliance/poor performance are reported to the Ward manager and Matron and the findings discussed. If there are on-going issues identified in previous audits a formal meeting is held with the Ward Manager and Matron. Audit results and issues identified during the audits are discussed at the IPT/DIPC meeting.

The results of the audits are formally reviewed by the Lead IPN and Audit Nurse. If there are concerns then additional review of practice on the ward is undertaken and support given as necessary to improve practice. This process has continued in 2018/19, allowing any themes to be identified and appropriate actions taken.

For 2018/19 the community in-patient beds at Newmarket Hospital and King Suite, Glastonbury Court, were included in the Trust IP audit programme. In October 2018 the community nursing teams began an audit programme of High Impact Interventions.

Aseptic Non Touch Technique (ANTT)

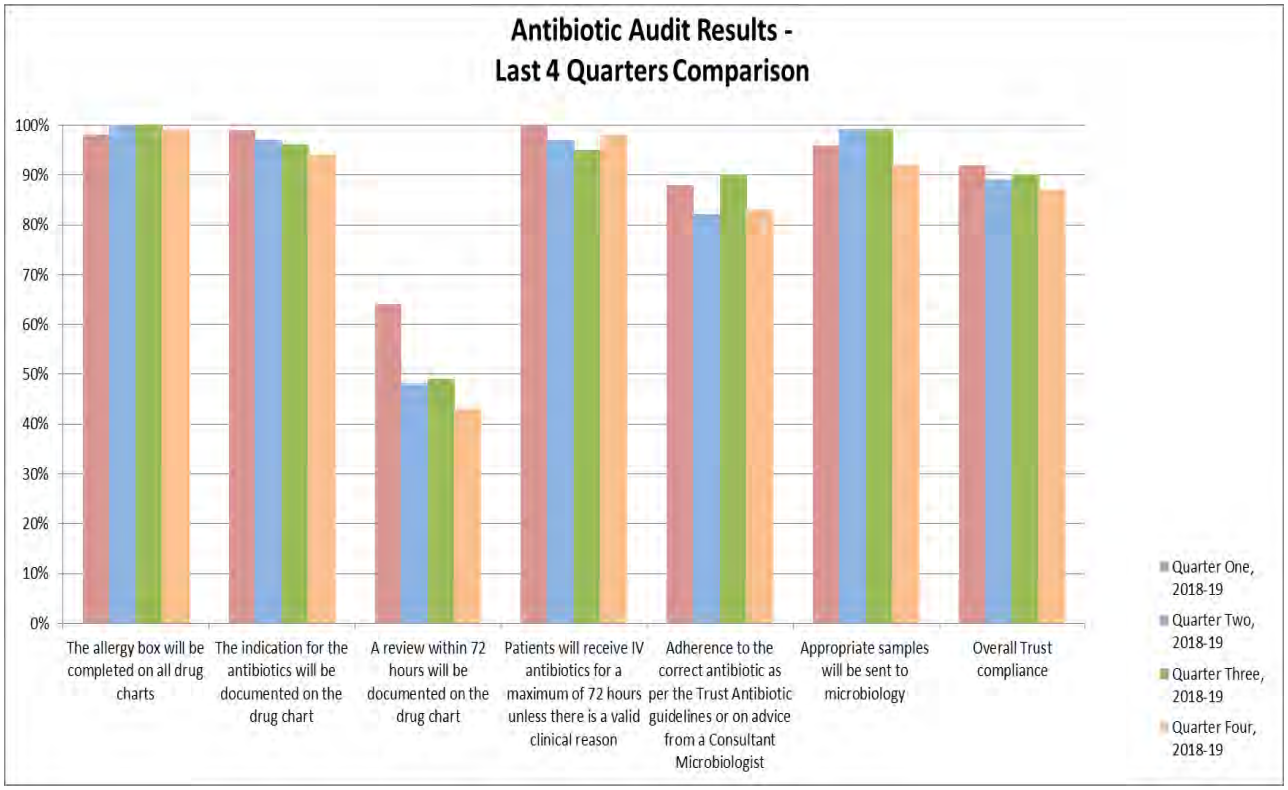
It is now 9 years since the ANTT training and assessment programme was introduced. At the end of 2018/19 the Trust compliance with ANTT assessments stands at 65.96%, with the standard being that all relevant staff are assessed every 3 years. Inconsistencies have been identified within the report, this has been reviewed by the Education and Training team but are yet to be resolved.

Owing to the requirement of implementing a new audit programme in the community, the roll out of ANTT training has been delayed until September 2019.

Work is on-going to apply for ANTT accreditation to demonstrate the work that has been done over the past 9 years.

ANTIMICROBIAL STEWARDSHIP

The rolling programme of audit has continued.



Overall results

The Trust was contractually required to achieve 98% compliance in 2018-19; however the Trust failed to achieve this in all quarters, with 92% compliance achieved in Quarter One, 89% compliance in Quarter Two, 90% in Quarter Three and 87% in Quarter Four.

Individual ward results are emailed to the Ward Manager, Senior Matron, Ward Consultants and Service Manager. Results are discussed at Antimicrobial Management Group, Infection Prevention & Control Committee, Matron Performance meetings and Divisional Governance meetings where required. The results have also been escalated to Dr Nick Jenkins, Medical Director.

Dr Jonathan Kerr joined the Trust in 2018 & was appointed to the role of Antibiotic Lead.

Achieving best prescribing practice:

- The availability of IV antibiotics within the global antibiotic market has continued to fluctuate over 2018-19; Trust guidelines were updated in a timely manner to reflect availability.
- The Antibiotic Audit Nurses and Antibiotic Pharmacist have begun regularly attending individual Ward Governance meetings to discuss with the Doctors, Ward Pharmacists and Ward staff to discuss non-compliances with a view to promoting best practice prescribing alongside Antimicrobial Stewardship.
- The Antimicrobial Management Team and the e-Care teams have worked with some of our junior doctor colleagues to develop an effective 72 hour review alert. This work is still on-going

and awaiting an e-Care update but in the absence of this we continue to recommend the use of the ##antibioticreview auto-text on ward rounds to support with the 72 hour review.

- Pharmacists incorporate antibiotic prescribing practice within the medical and surgical induction training sessions and Pharmacy alongside the Antibiotic Audit Nurses provide annual training on Antibiotic Stewardship to the Registered Nurses via the Mandatory Training platform.

- Ward Pharmacists are regularly updated on any changes to antibiotic supply that may affect prescribing practice by the Antimicrobial Pharmacist.

- Various electronic training packages that aid training in AMS are available within the Trust.

2018/19 AMR CQUIN

Part 2d – 'access' proportion consumption reached its target. Whilst both meropenem and overall consumption did not meet the required consumption reduction necessary to meet the CQUIN targets, a report was generated for the CCG; this provided details and rationalisation of the challenges faced at West Suffolk Hospital (NHS) including the local epidemiology for C. diff within this geographical locality and antibiotic restricted monthly supply following the worldwide shortages with Tazocin.

2019/20 AMR CQUIN

The previous year's sepsis and antibiotic consumption CQUIN targets have now been changed to NHS standard contract agenda items. The AMR CQUIN has now received new targets as follows:

- **CCG1a: AMR – lower urinary tract infections in older people**
    - This part of the CQUIN aims for trusts to achieve 90% compliance to NICE guidance for lower UTI (NG109) and PHE diagnosis of UTI guidance in terms of diagnosis and treatment, for antibiotic prescriptions for lower UTI in older people (65 years of age and over).
    - As part of this the trust should show compliance to:
        - Diagnosis of lower UTI based on documented clinical signs or symptoms
        - Diagnosis excludes use of urine dip stick
            - This will be particularly challenging to meet without the appropriate time to allow for a change management process to occur within the trust. Culture change is needed in daily practice to reach standards for the CQUIN.
        - Empirical antibiotic prescribed following NICE guideline (NG 109)
        - Urine sample sent to microbiology
    - Whilst there is some element of automation to data collection, e-Care's functionality does not permit for this fully. Therefore Pharmacists will be utilised to collect the data on a quarterly basis with any additional added through manual data extraction to reach the 100 patient minimum target.
- **CCG1b: AMR – Antibiotic prophylaxis in (elective) colorectal surgery**
    - This part of the CQUIN aims for trusts to achieve 90% compliance with surgical prophylaxis prescribing in elective colorectal surgery, being a single dose prescribed in accordance with local guidance.
    - E-Care automation through coding is more practical than for 1a. However an element of manual extraction from the Surginet add on is required.

Surgical prophylaxis audit

The trust conducted an audit looking at adherence to trust guidance for primary arthroplasty in 2018. This will be repeated at the end of 2019.

Criterion 10
Ensure, so far as is reasonably practical, that care workers are free of infection and are protected from exposure to infection that can be caught at work and that staff are suitably educated in the prevention and control of infection associated with the provision of health and social care.

Please see criterion 6 with respect to staff training.
Staff vaccination against influenza remained a national CQUIN target for 2018-19. The Trust achieved a vaccination rate of 75.1% against a target of 70-75%. The IPT were involved in the Trust's planning for the vaccination programme, which this year included community staff. Two of the IPT were peer vaccinators.

INCIDENTS –
1. Norovirus

See also Outbreak Table below

The outbreaks were reported as Serious Incidents Requiring Investigation and RCAs undertaken (organised by the Governance Department).
Learning from these investigations:
There were 4 Outbreaks in 2018-2019:
Two on G3 prior to the Cardiac speciality moving to the dedicated Cardiac centre. Both terminated in a timely manner and likely linked to patients admitted with chest pain who were incubating Norovirus and became symptomatic unexpectedly, no further outbreaks on G3 either whilst Winter Escalation or within the Cardiac Centre. The design of the new Cardiac Centre is in line with Infection Prevention recommendations to prevent the spread of infection and any further developments will follow this design. (See also prevention of transmission of Influenza)

The Outbreak on F8 in January 2019 was precipitated by staff illness with vomiting & diarrhoeal symptoms ahead of patients reporting illness. Staff are reminded at all inductions and at Mandatory training of the need to refrain from working until 48h symptom-free of either diarrhoea or Vomiting.

The Outbreak on G4 the index patient was admitted form a Nursing Home, the Nursing home subsequently was closed by PHE with patient with symptoms suspicious of Norovirus however the patient had already been admitted for another reason and developed symptoms within a bay. The Infection Prevention Team work closely with PHE Nurse team and participate in the East of England Io log system to alert colleagues both in the acute and community sector to areas affected by gastroenteritis. In 2018-2019 the team have worked closely with discharge planning colleagues in respect of patients admitted form Nursing Homes and their locations when PHE alert the Trust to closures both due to gastroenteritis and Respiratory illness.

Ward affected	Patients with symptoms	Reported Staff with Symptoms	Ward/ Bay closed	Ward / Bay opened	Days affected	Confirmed Noro	Comments
G3	9	3	15/10/2018	18/10/2018	4	3	Index case admitted with heart block was incubating Norovirus. Symptoms manifested 72h post admission
G3	10	2	31/10/2018	05/11/2018	5	3	Index case unable to be identified. Patient who first had symptoms had been an in patient for 14 days was not on the ward during earlier outbreak (admitted to CCU and transferred to ward after 19/10/18
G4	9	2	04/01/2019	12/01/2019	9 (plus partial between 31/12/18 to 4/1/19 = 14)		?Index case patient from Nursing Home symptomatic Day 4
F8	9	prior to outbreak staff reporting gastroenteritis	06/01/2019	11/01/2019	6		Unknown source, index patients had been admitted for significant period before symptomatic

2. Influenza

No wards were closed due to Influenza in 2018-2019. There were, however, bay closures notably on the Cardiac Centre which were contained due to the design of the ward; including doors on all bays, en-suite facilities in all single rooms and bays (other than the 4 bed Coronary Care area) and all bays have clinical hand wash basins. These features, which were absent on the previous Cardiac Ward which had to be closed for 10 days in 2017-2018, have limited any ongoing transmission and averted ward closure.

It did not prove possible, despite protracted negotiations with Public Health England and NEESPS, to introduce in-house testing for all WSFT patients during the 2018-19 influenza season. Local approval was, however, obtained for in-house molecular testing of patients on Critical Care and maternity because of the particular issues around isolation of these patients. The value of this ability was demonstrated and it is hoped that on-site molecular testing will be available for all our patients in 2019-20.

SUMMARY

Infection Prevention remains a high priority for the Trust. Significant monitoring and audit of a variety of measures is undertaken and reported at Board level.

The ability of modern diagnostic techniques to provide rapid results to support infection prevention measures was demonstrated by the partial introduction of molecular testing for influenza. There are other areas where similar technology could be introduced (such as rapid testing for gastrointestinal infection) and it is vital that the Trust has access to a properly-resourced pathology service which is responsive to the needs of the organisation. Without these developments it will not be possible to provide the best care of patients, and optimal infection prevention and control measures.

The main challenge remains the inadequacy of single room provision, both the number and the lack of rooms with en-suite toilets. The inexorable increase in the number of patients from whom multi-resistant organisms are cultured and who require isolation will be exacerbated if systematic screening for carriage of carbapenemase resistant enterobacteriacae is introduced (for discussion during 2019).
The benefit of having doors on bays was demonstrated by control of the spread of influenza on the cardiac ward. It is essential that the plan to incorporate the addition of these doors into ward refurbishments and new project continues.

18.3. Safeguarding children and adults

For Report

Presented by Rowan Procter

Trust Board – 27 September 2019

Agenda item:	18.3			
Presented by:	Rowan Procter Executive Lead for Safeguarding Children			
Prepared by:	Lisa Sarson Named Nurse Safeguarding Children			
Date prepared:	19th September 2019			
Subject:	Safeguarding Children			
Purpose:	x	For information		For approval

Executive summary:
Safeguarding children submits quarterly reports to the CCGs and biannual to the Clinical safety and effectiveness committee. This report is an annual report highlighting some of the challenges and progress over the last year.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
	x		

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

Previously considered by:	Quarterly reports that inform the annual report are considered by CCG and contribute to the health report to the Safeguarding Partnership (previously Suffolk Safeguarding Board) and Trust safeguarding children committee.
Risk and assurance:	Training compliance
Legislation, regulatory, equality, diversity and dignity implications	Intercollegiate: Roles and competencies for healthcare staff 2019 Working Together to Safeguard Children 2018

Recommendation:
To receive and approve.

Annual Report on Safeguarding Children

1. Introduction

The report will incorporate the information shared quarterly with the CCGs. Some evidence spans the financial year but audit results span the calendar year. Training figures will demonstrate where we currently are competent at the time this report will be received and the contrasting point for the previous year.

1.1 Background

New arrangements are in response to statutory guidance, Working Together to Safeguard Children 2018, whereby the three safeguarding partners (Local Authority, Police, and Clinical Commissioning Groups) have lead responsibility to safeguard and protect the welfare of children in Suffolk. This replaces the previous statutory responsibility held by LSCBs and will take effect from 29th September 2019.

Concerns are understandably high about serious youth violence, SEND, some children and young people living in unregulated settings, children off a school roll who are more vulnerable as a result, and young homeless people, to mention just a few.

In March 2019 (March 2018 in brackets) there were **456** (457) children in Suffolk subject to child protection plans; **268** (272) for neglect, **153** (148) for emotional abuse, **17** (10) for physical and **33** (18) for sexual abuse. It has been noted by health partners that low numbers of children are being examined and referred for examinations for suspected physical or sexual abuse and these audit results are being escalated for investigation amongst other safeguarding partners. There are approximately 868 Children in Care,1818 children open to Child in Need plans and 2126 Common Assessment Framework open cases in Suffolk.

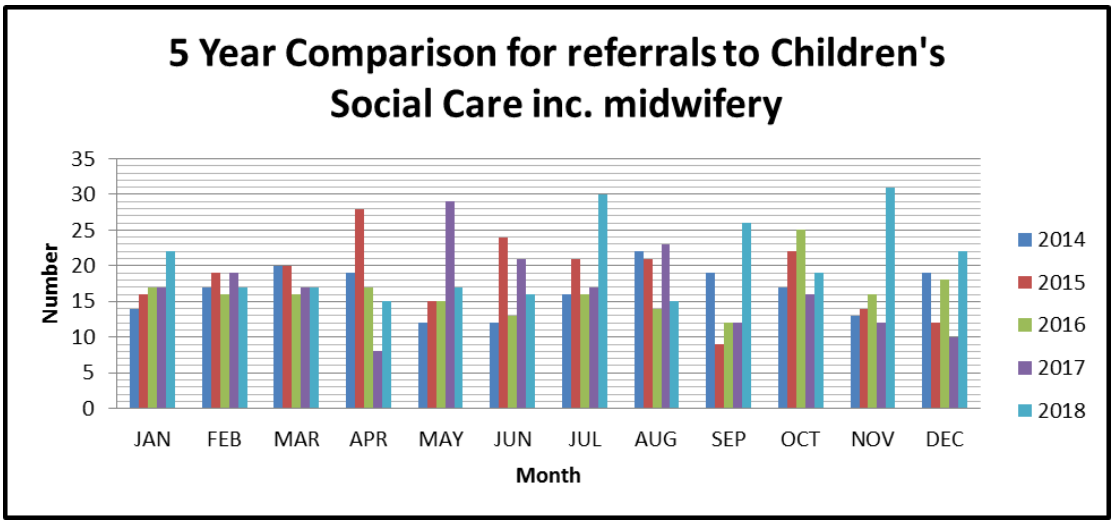
1.2 Activity

The average monthly attendance to the Emergency department is **1134**(1183**)** children under the age of 18 years and for the CAU **259**/month (340), a slight decrease to the previous year.

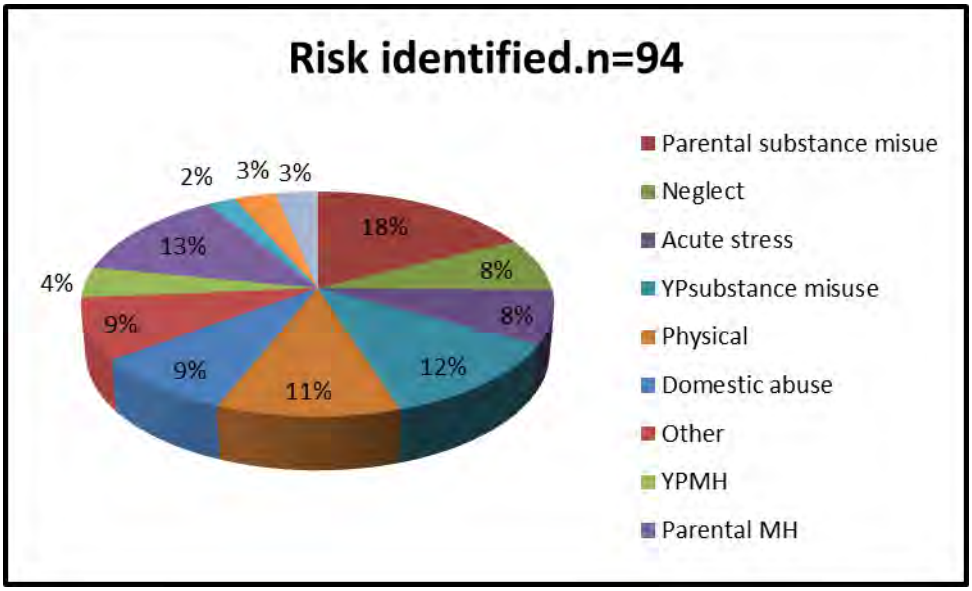
From the 1st April 2018-31st March 2019:

Total number of children seen in A&E (last year's figures) **13,608**(14,204)
Total number of children seen in Children's assessment Unit: **3104 (**4088**)**
Total number of referrals to CYPS including midwifery for 2018 243 (201**)**
Total number of referrals to CYPS excluding midwifery for 2018 97(67)
Total number of records researched for MARAC **2,133** (2,191)

1.3 Referrals



For the year 2018 (2017 in brackets) the Trust submitted **240**(201) known referrals; **146**(132) for midwifery and **94**(67) for other areas within the acute Trust. A total of (43) referrals were made by professionals working within community services. This does not include those referrals made by telephone without submission of a form or those from the psychiatric liaison team. There is no particular reason for the significant increase in referrals; midwifery continues to highlight parental mental health and refer for families who have had previous social care involvement whilst outside of midwifery some increase can be attributed to risk taking behaviour in young people (substance use, gang or County Line activity and sexual exploitation) The Named midwife completed a 'dip sample' audit to demonstrate quality of referrals and the Named Nurse annually audits all referrals that were sent electronically to the MASH. Both audit results have been submitted to the committee meeting, governance and utilised in the years training programme. The chart below shows some of the reasons for referral from general areas.



1.4 Safeguarding Children Arrangements:

The Executive Lead for safeguarding children is still Rowan Procter, Executive Chief Nurse. Other members working within the safeguarding structure are the Named Nurse for Safeguarding Children (acute 0.72WTE) Named Nurse Safeguarding Children (community 1WTE) Named Midwife (0.6WTE). The PAs for the Named Doctor for the Trust have been increased to 2 spanning acute and community services. Working alongside the perinatal mental health team, domestic abuse clinical liaison nurse, child death review team and fully appointed designate team ensures a robust structure for safeguarding children and young people within the health economy.

2. Safeguarding Children Policy:

2.1 Medical examinations for potential inflicted injuries

There have been 25 referrals to the hospital (26 last year) for examination of children for bruising/unexplained marks or faltering growth/issues of neglect from January – December 2018 and 11 in the community: had no further action taken; 5 were already open to social care and 6 had section 47 investigations by police and social care. The vast majority of these cases are babies under the age of twelve months and referred in by health visitors and/or GP's as per the Suffolk protocol for non- mobile infants.

An audit completed by a Registrar working with community paediatricians in the West was matched against a Freedom of Information request to the Multiagency safeguarding hub for physical abuse referrals. This audit highlighted that a low percentage of these children are being examined and escalated to the Designate team.

2.2 Sudden unexpected death in children

From the last annual report in October 2018 to date there has been 2 SUDICs- one involving a mother and her baby and the case is undergoing police investigation and one 17 year old girl which is awaiting Coroner's decision. The SUDIC protocol was also activated for a 17year old girl with type 1 diabetes who suddenly collapsed and was admitted to ITU. She did proceed to make a full recovery but there have been significant safeguarding concerns for her health and wellbeing both before the incident and afterwards and she now is in a residential placement.

The 'Working Together' 2018 set directives to employ Child Death Review nurses to co-ordinate the scrutiny of all child deaths and develop co-ordinated bereavement support to families. The Child Death Review processes will be overseen by a new national panel and learning disseminated in a more timely fashion. The CCGs are responsible for the funding of these posts and appointments have been made. WSHFT will have a 0.6WTE band 7 nurse who is co-located with the Named Nurse.

The Named Nurse (acute) has attended a Multiagency Learning Event for the death of a child with asthma (the second case within the same family) and contributed to the final publication of the Serious Case Review.

2.3 Incidents reported

- Managerial decisions for a 4 year old child presenting to the emergency department with a disclosure of sexual abuse. Clear guidance has been developed for both paediatrics and the Emergency department and highlighted in training.
- Inaccessibility of the Norfolk telephone referral process and the delays in response. This has been further reported externally to Designate teams within Suffolk and Norfolk

- Discharge of a baby with a 'mark' felt to be attributable to the chain of a dummy who presented a second time which has been addressed through training and direct clinician feedback.

2.4 Complaints

A complaint has been received spanning across community and acute Trust management for a child with autism and extreme food refusal. Father continues to challenge services being offered, the educational health care plan and was unhappy that a social care referral had been made. Whilst every effort has been made to make reasonable adjustments to encourage engagement with the family the threshold to re-refer to children's services remains low in order to safeguard the child.

3. Supervision

Supervision has been recognised by the new Intercollegiate document on Roles and Competencies for staff as part of the level 3 training and learning.

The Named Nurse for the community has reviewed supervision records and recommended time periods for staff to obtain their supervision i.e. within a minimum period of six months. It is now recommended that all grades of clinical staff receive supervision and this has increased the numbers overall which in turn initially affected the compliance percentage.

Supervision in the acute sector remains weekly on the paediatric unit and 'ad hoc' for other professionals.

4. Training

4.1

Level 1

Staff Group	September 2018	September 2019
A&E	94	95
Community midwifery	98	95
Hospital midwifery	98	96
Paediatrics	100	96
Neonatal unit	100	100
Trust medical staff perm & fixed	75	85
Trust nursing staff	95	94
Additional professionals	76	93
Additional clinical services	87	94
Admin & Clerical	91	94
AHP	97	96
Estates & facilities	96	94
Healthcare scientists.	90	97
Acute overall	89	**93**
Integrated Community Services	96	93

Level 2

Staff group	September 2018	September 2019
Nursing	95	91
Medical	78	84
A&E	96	95
Paediatrics	100	96
NNU	100	100
Hospital M/W	98	96
Community M/W	95	95
Acute overall	90	92
Integrated Community services		85

Level 3

Staff Group	September 2018	September 2019
A&E	85	85
Paediatrics	94	93
NNU	100	91
Hospital M/W	97	99
Community M/W	95	95
Acute overall	91	90
Integrated Community Services		73

4.2 The training strategy has been reviewed to ensure concordance with the new Intercollegiate guidance, approved by the safeguarding committee and presented to the Mandatory training Steering Group. A new proposal to offer yearly half day level 3 training to Integrated Community staff has been ratified and will commence in 2020. This is felt to be safer practice than the previous day's training over a three year period and should ensure that staff are compliant. There currently is a discrepancy between records held by the community Named Nurse and those being highlighted on ESR as non-compliant. This has been highlighted to the education and training team and the Executive Lead for safeguarding and is expected to be rectified for next month's training report.

For level 3 the staff without the competency for September is represented as follows:

A&E- 8 trained nurses and 6 nursing assistants
Paediatrics- 2 nursing assistants
NNU-1 nurse and 1 nursing assistant
Community midwifery- 2 midwives and
Hospital midwifery- 1 midwife

5. Recruitment, vetting procedures and allegations against staff

5.1 Two cases have been referred to the LADO; one involved a member of staff who was a victim of domestic abuse but her employment status was not affected. The other involved a bank nursing assistant who will not be re-employed.

5.2 98% of permanent staff have completed DBS checks.

5.3 There are no vacancies in ED. There is 1WTE band 5, 1WTE band 6 and 0.35WTE band 2

on paediatrics; 1 WTE band 5 and 1 WTE band 7 in NNU and 4.2WTE midwifery vacancies.

6. Interagency working

6.1 See referral information within the report.

6.2 The Named Nurse for the Community has established partnership meetings with the social care teams working with children with complex needs which will ensure concerns are being addressed and eliminate the 'drift' that can occur with such cases.

7. Information sharing

The Named Nurse Safeguarding Children now sits on the County Line Panel to share and receive information about young people involved in County Lines.

8. Actions for next year

These can be found in the attached development plan.

Safeguarding Children Development Plan 2019

Issue (and source)	Actions required	Lead	Timeframe	Progress
TRAINING All Trust staff will have attended training to the competency level assigned to their role in accordance to guidance in the 'Intercollegiate document on roles & competencies 2019. Target aim as per Trust mandatory training targets of > 90% completion for levels 1, 2& 3.	• Monthly reports to budget holders • Annual review of training strategy by NNSC and approved by WSHSCC • Compliance level agreed to be 90% in alignment with dashboard reporting to CCG. • Agenda item for clinical directorate performance management committees • Identify areas of poor compliance. Provide details of weaknesses to unit managers / performance management committees. • Training packages to be reviewed annually: Level 1&2 e-learning Level 3 Develop thematic learning packages for acute and community staff. Undergo analysis of need for paediatricians across acute and community sectors and tailor learning opportunities for latter part of 2019 and into 2020	MT team Lisa Sarson All committee members Clinical directors Named professionals Lisa Sarson/Jo Stroud Lisa Sarson/Jo Stroud	Ongoing May WSHSCC	COMPLETE Compliance level for community level 3 being addressed by accurate merger of records and notification to individuals and team leads. COMPLETE for level 1&2 Intercollegiate guidance sent to paediatricians for self- assessment of learning requirements against competencies required.
SUDIC	• Develop information sharing agreement with independent schools for young people attending with bullying, assaults, emotional ill health • Standard operating procedure for young people attending with emotional or safeguarding related problems and who do not wait to be assessed.	Lisa Sarson Lisa Sarson	Ongoing	**This has been agreed internally but awaiting approval of process and engagement from Independent school Board representative and Designate team** **SOP in place and developed by Lead paediatric nurse for ED**

Child Death Reviews *Working Together 2018*	• Assist with induction and development of CDR nurse employed and line managed by CCGs. • Child death reviews and LeDR reviews to be conducted by new postholder	Lisa Sarson/ Cindie Dunkling Post holder	September 2019	**Appointed** **Service to be developed and supported by WSHFT**
DOMESTIC ABUSE: Increased incidence of activity within the Trust;	• Record workload for MARAC presentations currently undertaken by specialist nurse • Review domestic abuse policy and midwifery guideline • Audit dip sample of cases for policy adherence and evidence of patient outcomes • Complete SOP for alert management. • Open telephone advice service for Community colleagues • Bite size training to acute staff • Co-ordinate honorary contract for volunteer trainer (ex- police domestic abuse advisor) • Obtain freephones through Safer Lives and Vodafone • Obtain picture books for those with learning disabilities or language restrictions. • Deliver DA training for community staff • Present service poster for nursing directorate display	Julia Dunn Julia Dunn/Hayley Rowan Julia Dunn Julia Dunn/Lisa Sarson Julia Dunn Julia Dunn Julia Dunn Julia Dunn Julia Dunn Julia Dunn Julia Dunn/Lisa Sarson	Ongoing August 2019 August 2019 August 2019 December 2019 June 2019	 Outstanding Complete Complete Complete Obtained Obtained
RECOMMENDATIONS FOLLOWING THE INDEPENDENT INSPECTION INTO DR MILES BRADBURY & GODDARD INQUIRY • Information for parents and patients • Training to include identifying someone who targets employment with easy access to vulnerable groups • Chaperone policy and identification of managerial lead • Transition policy • Appointment monitoring • Retention of documents and records • Datix recording of allegations	• Develop an information leaflet for patients and families their rights ,routes for challenge, expectations for behaviour and external sources of help • Review of chaperone policy to reflect national guidance. • Strengthen recording of chaperone presence or refusal. • Review transition policy to reflect national and professional guidance • Strengthen monitoring and recording of appointment scheduling. Implement pre and post clinic review.	Clinicians Named Professionals- Named Doctor to take lead. WSHSCC Clinicians/Named Doctor Alison Garters-Sister COPD Lead Adult OPD Lisa Sarson E-care lead	April 2018	Policy re-reviewed and published. Poster developed and trialled in COPD
Emerging Gang culture and County Lines within Suffolk	• Liaise with other Named Nurses re of YP developing a 'Toolkit' to aid recognition	Lisa Sarson	October 2018	COMPLETE

	presenting with potential gang or county line involvement. • Identify types of injuries YP have presented with • Engage with partners in developing and following countywide strategies to tackle gang culture and county line establishment	Lisa Sarson/Caroline Holt Named and Designate professionals	October 2018 Ongoing	Complete County Line panels in operation- NNSC to attend
AUDIT: <u>Internal:</u> • Audit of referrals for 2018 regarding potential inflicted injury (policy compliance) • Audit of referrals to MASH (excluding midwifery) 2018 • Dip sample audit of referrals for midwifery 2018	• Utilise audit tool to establish if policy compliant. Report to be presented at WSHSCC and paediatric governance. Utilise audit tool to establish if policy compliant. Report to be presented at WSHSCC and paediatric governance Utilise audit tool. Report to be presented at WSHSCC and maternity governance	Lisa Sarson/Named Doctor Lisa Sarson Hayley Rowan	August 2019 May 2019 May 2019	Complete Complete Complete
AUDIT: <u>External:</u> Sec.11 audit for the Local Safeguarding Board **Sec.11 Audit recommendations** • Increase awareness of Mental Capacity Act's relevance for 16-17 year olds • Use of threshold document in training and supervision	• Provide relevant evidence for audit to Designate team when requested and implement any recommendations from appraisal • Named professionals to attend training on MCA relevance • Liaise with adult safeguarding lead • Design educational tools for practitioners • Develop guidance for safeguarding microsite. • Utilise Threshold Matrix when considering the risk to children and young people in supervision and in referring to Multiagency safeguarding hub. • Demonstrate compliance by referral audit and outcomes received.	Lisa Sarson Named professionals Named professionals	December 2019	COMPLETE- presented to Board Workforce development team for SCC to commission bespoke training. Raised with Designate nurse for potential CCG commissioned training.

Trust Board – 27th September 2019

Agenda item:	18.3			
Presented by:	Rowan Procter			
Prepared by:	Helen Beard, Head of Nursing for Surgery and Adult Safeguarding Lead Julie Wiggin, PA to Deputy Chief Nurse, Head of Nursing for Surgery, Head of Nursing for Medicine and Project Support			
Date prepared:	19th September 2019			
Subject:	Safeguarding Adults Annual Report 2018 - 2019			
Purpose:	x	For information		For approval

Executive summary:
This report outlines the activity and progress of the Adult Safeguarding team in 2018 – 2019.
Key points include:

- An increase in safeguarding referrals from the previous year
- Increased focus on supporting patients with Learning Disability
- Activity to improve the position on PREVENT training across the organisation.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
	x		x

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

Previously considered by:	Adult Safeguarding Committee
Risk and assurance:	
Legislation, regulatory, equality, diversity and dignity implications	Care Act 2014

Recommendation:
Received this report for information.

Annual Report on Safeguarding Adults 2018

1. Introduction

This report overlaps with the quarterly reports provided to the Clinical Safety and Effectiveness Committee which is also shared with the CCG, and provides an overview of adult safeguarding referrals and issues related to the West Suffolk NHS Foundation Trust for the year ending 31st March 2019.

1.1 Internal Assurance

We continue to train Registered Nurses and other clinical and non-clinical staff on Trust induction and annually via Mandatory Training alongside ward based training when required. Throughout the year, work continued to raise awareness and improve staff knowledge of Safeguarding concerns and processes, assessing mental capacity and applying for Deprivation of Liberty Safeguarding (DoLS). In order to achieve this, there has been some focused work promoting increased visibility of the Adult Safeguarding Nurse on wards offering teaching, support and advice, Safeguarding champions bi-monthly meetings to promote information and share experiences, providing Ward Managers and Senior Matrons with a monthly report on the number of applications submitted per ward and promotion of the NHS Safeguarding App.

The Senior Matrons and Adult Safeguarding team also commenced spot check reviews of the Wards to ensure that mental capacity assessments (MCA) and DoLS have been completed appropriately. The results have been mixed, but there is an improving trend, especially with regard to completing the MCA prior to the DoLS. In addition, a monthly report of the numbers of MCAs demonstrates increasing numbers are being completed, which is a positive reflection of the promotion and training initiatives.

It is recognised, however, that there are still improvements to be made and support continues to be focussed to specific ward areas which have higher numbers of patients who lack capacity, to ensure teams are achieving accurate mental capacity assessments and applying for DoLS, as appropriate, and legally required.

The Mental Capacity (Amendment) Bill 2017-19 received Royal ascent in May 2019. The act follows the recommendations from the Law Commission and will create the new Liberty Protection Safeguards (LPS). LPS will replace the Deprivation of Liberty Safeguards (DoLS) and should be implemented by October 2020. It is envisaged that the LPS will be a self-governing process for NHS hospitals. This will likely require additional resources to manage the assessment and authorisation processes, as well as, the training of staff for the new processes.

With regard to adult safeguarding, the Suffolk Safeguarding Adults Board (SAB) have been working towards launching a framework of practice in April 2019. This framework will enable practitioners to consider the correct route of support for the cause of concern. This will assist practitioners to determine whether the concern is abuse or a care delivery issue.

Overall, there has been an increase in safeguarding referrals throughout the year from 2017 / 2018. The team have experienced more concerns being raised around financial abuse amongst the vulnerable. There are also increasing referrals regarding domestic abuse. The team also continue to raise awareness of increasing risks to vulnerable adults, including modern slavery, exploitation, hate crime, honour based violence, female genital mutilation (FGM), county lines and cuckooing, self-neglect and hoarding and cyber-crime and scamming.

In 2018 / 2019, there has been increased focus on the issue of self-neglect and hoarding following the outcome from a serious case review in the east of Suffolk. A self-neglect and hoarding referral has been introduced and the issue highlighted via mandatory training and ad hoc training sessions to specific teams.

WSFT remain below the compliance rate for PREVENT training at level 3. This remains at 77% at the end of Quarter 4, below the recommended compliance of 85%, however, basic awareness remains at 91%. There has been a big drive to improve this position throughout the year, with a

starting point of 20% at the beginning of Quarter 1. This has been achieved with training sessions being facilitated twice monthly with additional induction sessions and ad hoc training for individual teams. The Safeguarding team continue to promote compliance amongst all the Divisions as there has been increasing pressure from NHSE and the WSCCG to improve compliance due to the heightened risk of radicalisation within the locality.

In Quarter 3 2018 / 19, WSFT took part in the NHSI – Learning Disability Improvement Standards benchmarking review. This involved national data collection, commissioned by NHS Improvement (NHSI) and run by the NHS Benchmarking Network (NHSBN). The data collection was designed to fully understand the extent of Trust compliance with the recently published NHSI Learning Disability Improvement Standards and identify improvement opportunities.

The improvement standards reflect the strategic objectives and priorities described in national policies and programmes, in particular those arising from Transforming Care for People with Learning Disabilities Programme and the Learning Disabilities Mortality Review (LeDeR) programme. Compliance with these standards requires Trusts to assure themselves that they have the necessary structures, processes, workforce and skills to deliver the outcomes that people with learning disabilities, their families and carers, expect and deserve. It also demonstrates a commitment to sustainable quality improvement in developing services and pathways for people with learning disabilities. The standards review aims to collect data from a number of perspectives to understand the overall quality of care across learning disability services.

Once WSFT have received the benchmarking results, an action plan will be produced to improve the care and service of individuals with Learning Disability and autism. Key concerns identified during the benchmarking process relate to access to services and user involvement.

WSFT have continued to be actively involved with the Learning Disability mortality review – LeDeR, a national programme. In 2018, the local working group commenced identifying themes from the LeDeR reviews and working on a system wide action plan to improve the care and management of those individuals with learning disability. The overall priority is to improve the health and wellbeing of these individuals with the aim to increase their life expectancy. The main focus is on ensuring annual health reviews are performed and that there is a coordinated, joined up approach to managing their health and social needs**.** WSFT also started to forge links with the Norfolk LeDeR forums through this process. Due to the position of the West Suffolk Foundation Trust (WSFT), we have contact with both forums.

WSFT works closely with the Community Adult Safeguarding Lead for West Suffolk who is affiliated with ESNEFT. At the beginning of Quarter 4, WSFT produced an integrated action plan for 2019/ 2020 to set out our plans for focus and improvement. We also work closely with WSCCG Safeguarding Lead to ensure parity across the Alliance. See Appendix A for the most up to date version of the action plan.

1.2 External Assurance

WSFT report directly to WSCCG, with regard to Adult Safeguarding and to WSCCG and NHSE, with regard to PREVENT.

2. Adult Safeguarding Referrals made by the West Suffolk NHS Foundation Trust

There were a total of **152** referrals made to MASH in 2018/19 in comparison to**119** referrals made in 2017/18 and **82** referrals in 2016/17.

Quarter 1 April - Jun 2018

Safeguarding Adults Referrals Q1 2018/19	**Norfolk**	**Suffolk**	**No fixed Abode**	**Totals**
	6	35	1 sent to Suffolk	42
Welfare	3	9		12
Welfare/Emotional		2		2
Welfare/Physical	2	1	1	4
Welfare/Neglect		3		3
Welfare/Deprivation/Involuntary Isolation & Confinement		1		1
Welfare/Emotional/Financial		1		1
Financial		1		1
Physical		2		2
Sexual		1		1
Domestic Abuse/Violence	1	2		3
Domestic Abuse/Violence/Welfare		3		3
Domestic Abuse/Violence/ Self Neglect		1		1
Self-Neglect		3		3
Self-Neglect/Welfare		4		4
Involuntary Isolation & Confinement		1		1

Quarter 2 Jun – Aug 2018

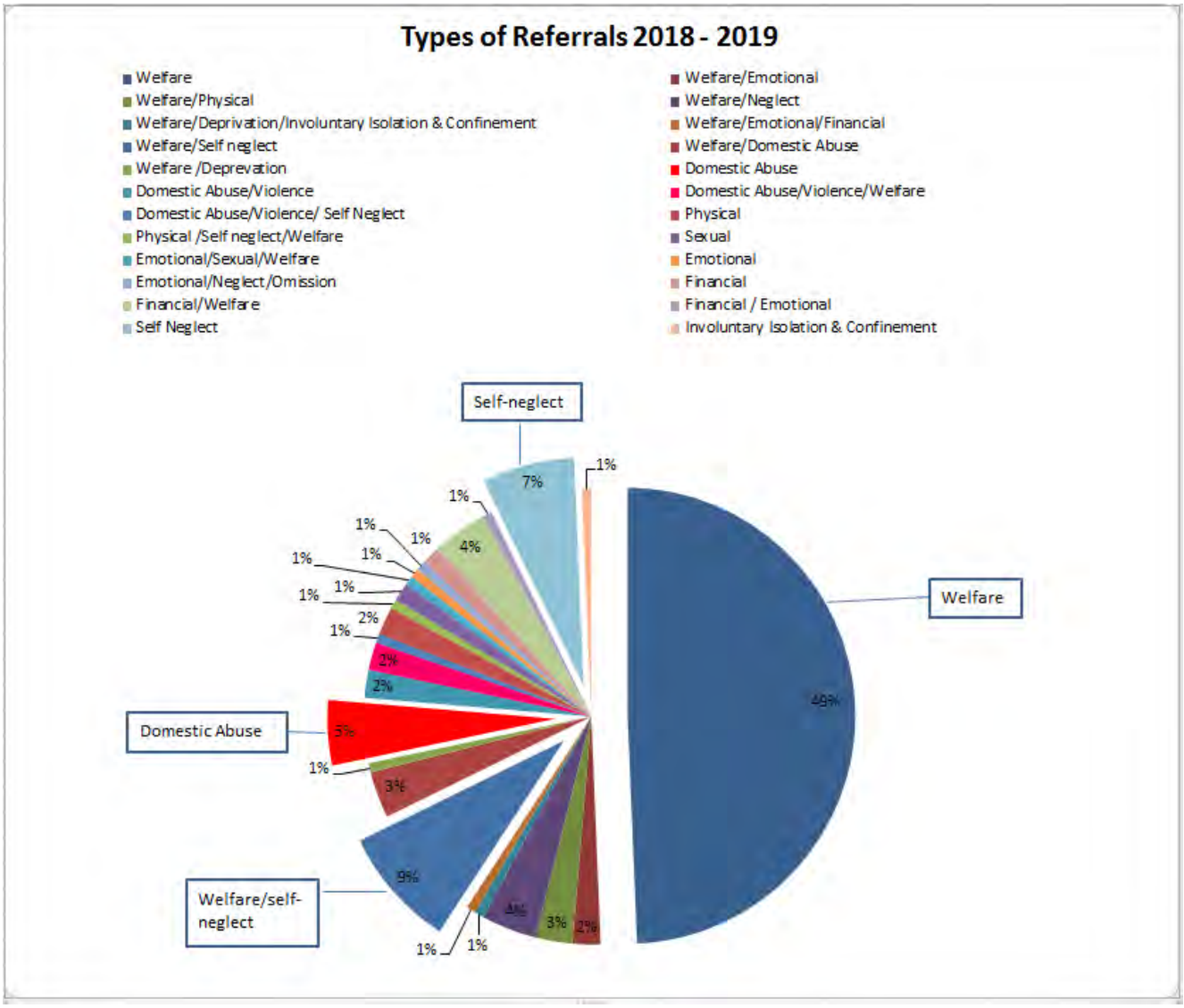
Safeguarding Adults Referrals Q2 2018/19	**Norfolk**	**Suffolk**	**Oxford**	**Totals**
	8	37	1	46
Emotional/Sexual/Welfare		1		1
Financial/Welfare		2		2
Neglect/Welfare	1	1		2
Physical	1			1
Welfare	3	18		21
Welfare/Self neglect	1	3	1	5
Welfare/Domestic Abuse	1	1		2
Self-Neglect	1	5		6
Domestic Abuse		6		6

Quarter 3 Sep – Dec 2018

Safeguarding Adults Referrals Q3 2018/19	**Norfolk**	**Suffolk**	**Cambridge**	**Totals**
	3	30	2	35
Physical /Self neglect/Welfare	-	1	-	1
Emotional	-	1	-	1
Financial/Welfare	1	2	-	3
Financial / Emotional	-	1	-	1
Financial	-	1	-	1
Welfare	2	19	2	23
Welfare/Self neglect	-	2	-	2
Welfare/ Emotional	-	1	-	1
Self-Neglect	-	1	-	1
Sexual	-	1	-	1

Quarter 4 Jan – Mar 2019

Safeguarding Adults Referrals Q4 2018/19	Norfolk	Suffolk	Cambridge	Totals
	1	27	1	29
Self neglect/Welfare		2		2
Emotional/Neglect/Omission		1		1
Financial/Welfare		1		1
Deprivation/ Welfare			1	1
Welfare	1	18		19
Welfare/Neglect		1		1
Domestic Abuse		1		1
Domestic Abuse/Welfare		3		3



The service that Julia Dunn, Domestic Abuse Clinical Liaison Nurse is now established and we can see this in the amount of Domestic abuse related referrals submitted. Domestic abuse victims are very often coerced or withdraw a complaint once they have been removed from a property and many cases can be hard to prove however we did report in Q4 that there had been an arrest made in one of Julia's cases.

3. Adult Safeguarding referrals made by others in relation to the West Suffolk NHS Foundation Trust

There were a total of 5 cases of safeguarding referrals made by others in relation to West Suffolk NHS Foundation Trust during 2018-2019.

3.1There were 2 cases in quarter 1.

1 This was part of a wider referral that was received from the ambulance services. There were concerns about West Suffolk hospital discharging a patient in a taxi without informing the care home he resides at.

The MASH determined that the referral did not meet the threshold to progress to a Section 42 Adult Safeguarding Enquiry.

Following this referral, the care home advised MASH that they had not been informed of the patients discharge and that the patient arrived during their busy schedule but will have heard him if he had used the buzzer but it appeared the patient did not use the buzzer to alert staff. With the information available, this referral will be taken as information only and was passed on to West Suffolk Hospital to look into and address accordingly.

The investigation concluded that this was not a Safeguarding concern, however there is learning to be taken from this incident that follow up advice should be offered to Nursing or Care homes if patients lack understanding. Verbal advice was given to the patient, but it is indicated in the notes that she had severe dementia and lacked understanding.

Referral Not Substantiated

2. The reason for the referral is alleged neglect with failure to provide information to a care home.

The investigation concluded that there were no failings regarding the care and treatment of the patient but there was no documentation to support that the team attempted to inform the care home of follow up advice. Verbal advice was given to the patient however, it is indicated that she had severe dementia and lacked understanding.

This is not a Safeguarding concern; however there is learning to be taken from this incident that follow up advice should be offered to Nursing or Care homes when the patient lacks understanding. This will be discussed with the team for action.

Action Plan				
Issue	Action	Lead	Date to be completed	Source of assurance
No follow up advice provided to carers	To share this incident with team Communicate the importance of ensuring follow up information is provided when an individual lacks capacity.	Clinical Service Manager	June 2018	Timely completion of discharge letters Evidence of shared learning

Referral not substantiated

3.2 There were 0 cases in quarter 2

3.3 There were 2 cases in quarter 3

1. The reason for the first referral was alleged inappropriate touching. PALS received a call from the patients care home stating that the patient suffers from dementia but had been very clear on reporting this incident following a stay in hospital.

On reviewing this incident and discussing with MASH it was established that the patient had been very confused during her stay. The patient has dementia and had been admitted with a head injury which caused delirium and she required assistance with ADLS including hygiene needs.

The MASH team met with the patient with the police and determined that there was no evidence that the patient had been abused. This case was closed by the MASH team and following a full review by the Chief Nurse and Ward Manager they were satisfied there was no cause for any further investigation.

Referral Not Substantiated

2. The reason for this referral is alleged physical restraint causing red marks to the patient. The red marks went away after a few minutes.

The investigation concluded that the staff involved independently informed the Safeguarding Adult lead that this case had been pre planned with a view that it may be challenging. Both felt the procedure went well and although the patient was initially reluctant to have the cannula was persuaded to agree. Both report that the patients hand was steadied and neither felt the patient was unduly distressed and did not feel he was restrained as he was compliant with persuasion methods.

Referral Not Substantiated

3.4 There was 1 case in quarter 4

The reason for this referral was alleged Physical abuse. The patient reported that a member of staff grabbed his arm resulting in a bruise.

A full investigation was completed. Statements were taken from all staff involved and there was no evidence to suggest how the patient received bruising to his arm. All appropriate treatment administered to patient prior to discharge.

Referral Not Substantiated

4. DOLs Applications

There were a total of **313** DoLS application made in 2018/19 in comparison to **198** applications made in 2017/18.

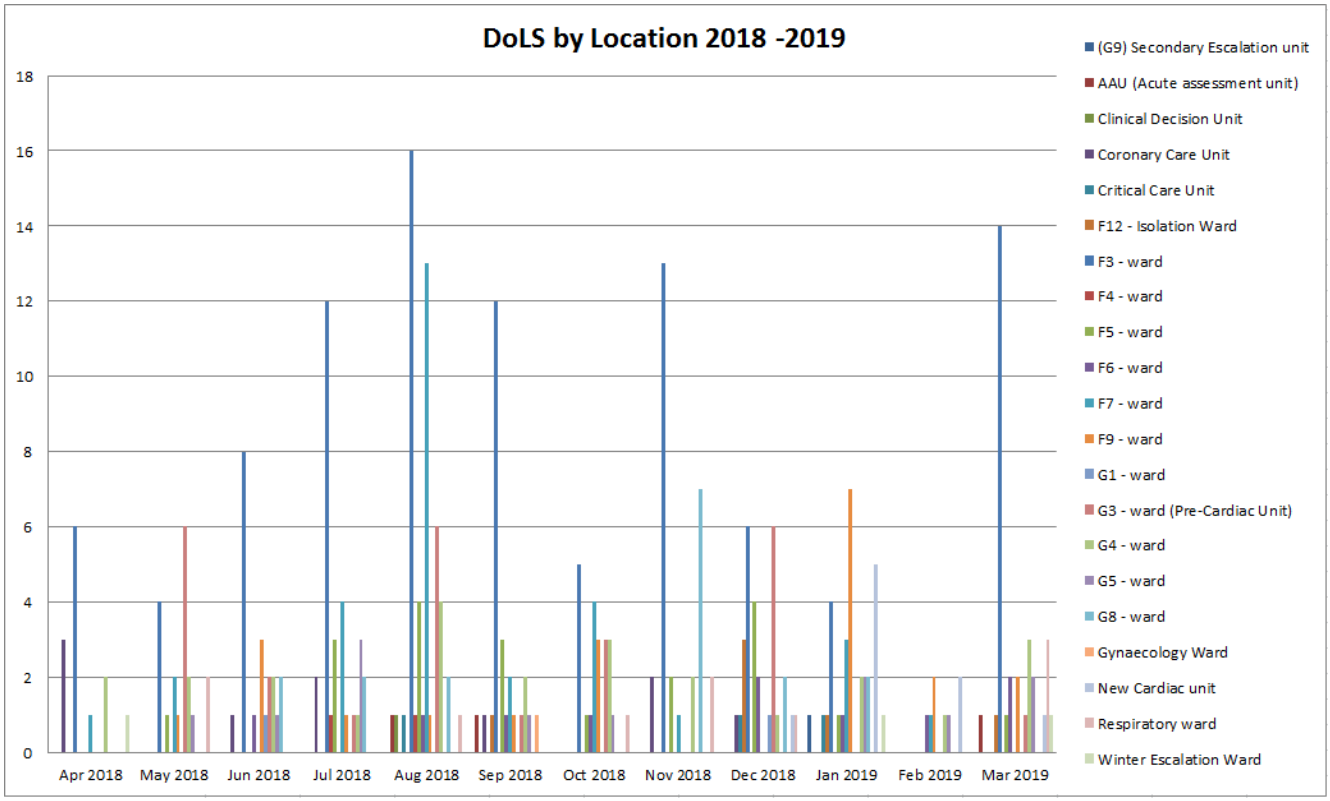
2018 / 19 Month	Total number applied for
April	13
May	19
June	21
July	30
August	52
September	27
October	22
November	29
December	29
January	31
February	8
March	32

2017 / 18 Month	Total number applied for
April	7
May	13
June	11
July	9
August	14
September	12
October	23
November	29
December	24
January	16
February	19
March	21

A Best Interest Assessor (BIA) undertook an assessment on 1 application during 2018/19 to establish whether a DoLS authorisation was required and concluded that the patient did not meet the requirements for a DoLS but did satisfy the criteria for detention under the Mental Health Act.

The graph below shows the locations of the DoLS applications

	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019	Total
(G9) Secondary Escalation unit	0	0	0	0	0	0	0	0	0	1	0	0	1
AAU (Acute assessment unit)	0	0	0	0	1	1	0	0	0	0	0	1	3
Clinical Decision Unit	0	0	0	0	1	0	0	0	0	0	0	0	1
Coronary Care Unit	3	0	1	2	0	1	0	2	1	0	0	0	10
Critical Care Unit	0	0	0	0	1	0	0	0	1	1	0	0	3
F12 - Isolation Ward	0	0	0	0	0	1	0	0	3	1	0	1	6
F3 - ward	6	4	8	12	16	12	5	13	6	4	0	14	100
F4 - ward	0	0	0	1	1	0	0	0	0	0	0	0	2
F5 - ward	0	1	0	3	4	3	1	2	4	1	0	1	20
F6 - ward	0	0	1	0	1	1	1	0	2	1	1	2	10
F7 - ward	1	2	0	4	13	2	4	1	0	3	1	0	31
F9 - ward	0	1	3	1	1	1	3	0	0	7	2	2	21
G1 - ward	0	0	1	0	0	0	0	0	1	0	0	0	2
G3 - ward (Pre-Cardiac Unit)	0	6	2	1	6	1	3	0	6	0	0	1	26
G4 - ward	2	2	2	1	4	2	3	2	1	2	1	3	25
G5 - ward	0	1	1	3	0	1	1	0	0	2	1	2	12
G8 - ward	0	0	2	2	2	0	0	7	2	2	0	0	17
Gynaecology Ward	0	0	0	0	0	1	0	0	0	0	0	0	1
New Cardiac unit	0	0	0	0	0	0	0	0	1	5	2	1	9
Respiratory ward	0	2	0	0	1	0	1	2	1	0	0	3	10
Winter Escalation Ward	1	0	0	0	0	0	0	0	0	1	0	1	3
Total	13	19	21	30	52	27	22	29	29	31	8	32	313



During August we carried out work to increase awareness and completed an audit for a base line figue. You can see this highlighted in the graphs above with 52 applications made in August. Likewise you can see the drop in applications during February

5. Training

Q1

Month	% of staff up to date with Adult Safeguarding Mandatory training
April 2018	91%
May 2018	92%
June 2018	91%

Month	% of staff up to date PREVENT training
April 2018	88%
May 2018	90%
June 2018	90%

Month	% of staff up to date WRAP training
April 2018	26%
May 2018	36%
June 2018	44%

Q2

Month	% of staff up to date with Adult Safeguarding Mandatory training
July 2018	90%
August 2018	91%
September 2018	91%

Month	% of staff up to date PREVENT training
July 2018	90%
August 2018	91%
September 2018	91%

Month	% of staff up to date WRAP training
July 2018	51%
August 2018	55%
September 2018	60%

Q3

Month	% of staff up to date with Adult Safeguarding Mandatory training
October 2018	91%
November 2018	90%
December 2018	90%

Month	% of staff up to date PREVENT training
October 2018	91%
November 2018	90%
December 2018	91%

Month	% of staff up to date WRAP training
October 2018	60%
November 2018	66%
December 2018	68%

Q4

Month	% of staff up to date with Adult Safeguarding Mandatory training
January 2019	91%
February 2019	91%
March 2019	91%

Month	% of staff up to date PREVENT training
January 2019	92%
February 2019	91%
March 2019	91%

Month	% of staff up to date WRAP training
January 2019	70%
February 2019	70%
March 2019	77%

Overall compliance has been maintained with mandatory training for Adult Safeguarding and basic PREVENT, on, or above the target of 90%. The training for the Workshop to raise awareness of PREVENT (WRAP) has maintained an upward trajectory but remains below the national target of 85% and the local target of 90%.

NHS West Suffolk NHS Foundation Trust

West Suffolk Foundation Trust
Adult Safeguarding Action Plan 2019 / 2020

Objective	Description of Action	Lead	Due Date	Status	Commentary / Assurance
Review and update Adult Safeguarding Mandatory Training to ensure relevant for acute and community services	• Review learning outcomes • Ensure relevance to current issues and concerns	Marilyn Harvey Tony Green	31 May 2019	Completed	
To improve compliance with Adult Safeguarding Mandatory training to the recommended Trust target of 90%	• Remind teams via Managers and Leads • Review reports to identify non- compliant groups	Helen Beard Marilyn Harvey	30 Jun 2019	Completed	
	• Provide updates to the Executive team via CSEC reports	Helen Beard	Quarterly		
Continue to promote key issues relating to Adult Safeguarding and vulnerable adults	• Raise awareness via adhoc teaching sessions, team meetings and Safeguarding Champion meetings	Helen Beard Marilyn Harvey Tony Green	Ongoing		
	• Promote use of social media to raise awareness of key issues	Helen Beard Marilyn Harvey Tony Green	Ongoing		
Raise awareness of 'Making Safeguarding personal'	• Promote via adhoc teaching sessions, team meetings and Safeguarding Champion meetings	Helen Beard Marilyn Harvey Tony Green	Ongoing		
Update the Safeguarding promotional poster to ensure fully	• Review content of poster • Update information and contacts • Liaise with Communication team regarding	Helen Beard Sinead Collins	31 May 2019	Completed	

integrated	design and distribution				
To achieve 90% compliance with WRAP training for all clinical and patient facing staff	• To achieve 85% by the end of May 2019	Helen Beard Marilyn Harvey	31 May 2019		
	• Coordinate twice monthly training sessions	Sinead Collins	30 Apr 2019	Completed	
	• Continue to facilitate requests for adhoc training sessions	Sinead Collins	30 Jun 2019	Completed	
	• Promote eLearning sessions	Helen Beard	31 May 2019	Completed	
	• Provide regular updates to NHSE and CCG on progress and compliance	Helen Beard	Monthly		
	• To gain confirmation of the training requirement from NHSE	Helen Beard	30 Jun 2019	Completed	
To raise awareness of the Adult Safeguarding Framework	• Incorporate into Mandatory training update	Marilyn Harvey Tony Green	31 May 2019	Completed	
	• Add the Framework to the Safeguarding pages on the intranet	Tony Green	31 May 2019	Completed	
	• Provide training to Site Managers and Tactical leads	Helen Beard	30 Sept 2019		
	• Update Senior Nurses and AHPs at NMCC	Helen Beard	31 May 2019	Completed	
	• Communicate changes via Green sheet, Corporate Managers, Communication team	Tony Green Marilyn Harvey	30 Sept 2019		
Improve compliance and accuracy of Mental Capacity Assessments	• Spot check audits to review as part of the quality improvement work	Helen Beard	Quarterly		
	• Feedback results to teams and via CSEC	Helen Beard	Quarterly		
	• Review of process in the Community setting	Marilyn Harvey	31 Jul 2019		

Improve compliance and accuracy of DoLS applications	• Spot check audits to review as part of the quality improvement work	Helen Beard	Quarterly		
	• Feedback results to teams and via CSEC	Helen Beard	Quarterly		
	• Review process following new directives on Liberty Safeguards	Helen Beard Tony Green Marilyn Harvey	31 Aug 2019		
Embed the Self neglect and hoarding policy	• Embed into Adult Safeguarding policy	Helen Beard	31 May 2019		
	• Plan and deliver training sessions with Safeguarding Champions, Community teams, ED and AMU teams, EIT and Discharge planning team	Tony Green Marilyn Harvey	Ongoing		
	• Raise awareness via Mandatory training	Helen Beard Tony Green Marilyn Harvey	Ongoing		
	• Update Senior Nurses and AHPS via NMCC	Helen Beard	31 May 2019	Completed	
Review the Safeguarding supervision policy and embed into practice	• Incorporate into the Trust Adult Safeguarding Policy	Helen Beard	31 May 2019		
	• Establish and pilot different staff supervision models	Marilyn Harvey	31 Aug 2019	Completed	
	• To develop a record of supervision	Marilyn Harvey	31 Aug 2019		
Review the NHSI Learning Disability benchmarking report	• Identify key issues for improvement from report	Helen Beard Tony Green Sinead Collins	30 Sep 2019		
	• Develop actions for improvement	Helen Beard Tony Green Sinead Collins	30 Sep 2019		

19. Consultant appointment

To NOTE the report

For Report

Presented by Kate Read

BOARD OF DIRECTORS – 27 September 2019

NHS West Suffolk NHS Foundation Trust

Agenda item:	19			
Presented by:	Jan Bloomfield, Executive Director of Workforce and Communications			
Prepared by:	Medical Staffing, HR and Communications Directorate			
Date prepared:	19th September 2019			
Subject:	Consultant Appointments			
Purpose:	X	For information		For approval

Executive summary:
Please find attached confirmation of Consultant appointments

Trust priorities]	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
	X	**X**	

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

Previously considered by:	Consultant appointments made by Appointment Advisory Committees
Risk and assurance:	N/A
Legislation, regulatory, equality, diversity and dignity implications	N/A

Recommendation:

For information only

Putting you first

POST:	Consultant in Anaesthetics
DATE OF INTERVIEW:	Thursday 8th August 2019
REASON FOR VACANCY:	New Post
CANDIDATE APPOINTED:	[redacted]
START DATE:	25th November 2019
PREVIOUS EMPLOYMENT:	[redacted]

QUALIFICATIONS:	[redacted]
NO OF APPLICANTS: **NO INTERVIEWED:** **NO SHORTLISTED:**	3 2 3

POST:	Consultant in Gastroenterology
DATE OF INTERVIEW:	12th September 2019
REASON FOR VACANCY:	Replacement
CANDIDATE APPOINTED:	[redacted]
START DATE:	January 2020
PREVIOUS EMPLOYMENT:	[redacted]
QUALIFICATIONS:	[redacted]
NO OF APPLICANTS: **NO INTERVIEWED:** **NO SHORTLISTED:**	2 2 2

20. Putting you first award

To NOTE a verbal report of this month’s winner

For Report

Presented by Kate Read

11:10 BUILD A JOINED-UP FUTURE

21. West Suffolk Alliance Report update

To ACCEPT the report

For Report

Presented by Kate Vaughton

West Suffolk NHS Foundation Trust Board Meeting
27 September 2019

Agenda item:	21			
Presented by:	Kate Vaughton, Director of Integration and Partnerships			
Prepared by:	Jo Cowley, Senior Alliance Development Lead			
Date prepared:	19/09/19			
Subject:	West Suffolk Alliance Update			
Purpose:	x	For information		For approval

Executive summary:

This paper provides an update to the Board on the progress and development of the West Suffolk Alliance and partnership working in our system.

Main Points:

This paper provides an update on:

- Alliance governance
- Locality plan update
- Primary Care Networks
- Social Prescribing
- Working together to change services
- Wider partner activity

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
	x	**x**	**x**

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

Previously considered by:	Monthly update to board
Risk and assurance:	
Legislation, regulatory, equality, diversity and dignity implications	
Recommendation: The Board is asked to note the progress being made.	

West Suffolk Alliance Update

West Suffolk NHS Foundation Trust Board

27th September 2019

1.0 Introduction

1.1 This paper updates the Board on the progress and development of the West Suffolk Alliance and partnership working in our system.

2.0 Alliance governance

2.1 **Lay member involvement in the Alliance** – Sally Kemp from Oliver and Company has been commissioned to run a lay member conference in December. She is working with the alliance team along with the Chair of West Suffolk Foundation Trust, a lay member from the West Suffolk Clinical Commissioning Group (CCG), the Patient Participation Lead from the CCG and the Assistant Director Families and Communities, West Suffolk Council to plan the event. The draft aims for the session are:

- To enhance relationships across the lay community as part of establishing a broader lay network within the West Suffolk Alliance;
- To share learning and perspectives about the current and future development of the Alliance;
- To work together on mapping the current lay involvement to support the development of a future framework for lay involvement in the West Suffolk Alliance

2.2. Invitees will include the lay community from the NHS, local authority councillors and others. A further planning meeting is due to be held in October.

2.3 **System Executive Group** – the System Executive Group (SEG) is the leadership group for the West Suffolk Alliance. It has been meeting on a two monthly cycle and continues to be well attended. The membership has grown from the original alliance membership (WSFT, NSFT, Suffolk County Council and the Suffolk GP Federation) to a much broader group, which includes district councils, leisure services, voluntary, and community sector leaders, local pharmacy committee and many others.

2.4 The 6th November SEG meeting is being turned over to a workshop style meeting where the group will be tasked with exploring progress to date and how it should change to ensure it is fit for purpose to meet the challenges and opportunities ahead for the alliance, for instance the development of the Integrated Care System and the system 5 year plan.

2.5 **Steering Group** – at its last meeting the Steering Group reviewed its purpose and membership to make sure it can fulfil the core functions:
- being a trusted adviser to SEG
- tracking the delivery plan and unsticking issues
- providing an early stage filter for issues and new initiatives.

2.6 It was agreed that the Steering Group should continue to bring together Locality and enabling leads and model alliance values and behaviours. At their next meeting the Steering Group will be joined by the Associate Workforce Transformation Lead from Health Education England to consider how we build the alliance workforce plan, linking through to the Integrated Care System 5 year strategy.

2.7 **Alliance input into the Integrated Care System (ICS) 5 year plan** – the alliance has provided updated information and content for the ICS system plan which is being finalised at the current time. We were also able to provide examples of good practice for the a ICS

wide list “50 good things”, and some colleagues chosen to speak at a large event which took place on the 13th September where examples of joint working were showcased.

3.0 Locality plan update

3.1. Activity within the Alliance continues to focus on the development of the Localities as a core building block for the delivery of the alliance strategy. Locality leads are as previously reported, with the exception of Bury Town, which now has Helen Beck in the leadership role. Each locality is working on their own plan, alongside alliance wide planning for the delivery of integrated care in the community. To support this a draft Integrated Neighbourhood Team (INT) maturity matrix is under development, with input from team leaders and senior managers. The matrix will set out the actions that need to be taken in each team, and allow teams to self-assess their level of maturity. The maturity matrix will feed into the alliance delivery plan and tracked through the alliance steering group.

3.2 **Place Based Needs Assessments** – Public health are developing place based needs assessment (PBNA) for each locality. These are available on the Healthy Suffolk website - https://www.healthysuffolk.org.uk/jsna/pbna.

3.3 To date PBNAs have been published for Mildenhall and Brandon and for Newmarket, with the rest due before the middle of October.

3.4 The PBNAs provide a broad range of information about health and wellbeing including the wider determinants of health, such as housing, education and poverty. The PBNAs help the INTs and the wider localities to identify priorities for action, for example they list the top five areas where there are opportunities to reduce emergency hospital admissions.

3.5 The information is sourced from public data, with the next iteration planned to include information from social care, financial information, for example, relating to hospital admissions and better data about the prevalence and severity of frailty issues, which are likely to be key issue for most INTs.

3.6 In West Suffolk the population health programme will provide additional information that will significantly enhance the PBNAs going forward. There is also synergy with the quality improvement approach, which should support action on the priorities identified for action either in the localities or across the wider system, e.g. into the hospital.

3.7 An update on each of the localities is attached as **Appendix 1** to this report**.**

4.0 Primary Care Networks

4.1 Primary Care Networks are now working on how they collaborate, including how they employ specialist clinical staff**.** It is still early days, but for example there is agreement that in West Suffolk social prescribing will be managed through Life Link – building on the success of that project rather than reinventing a new set of social prescribers. All six PCNs have now signed up to working with District and Borough colleagues to provider social prescribing at a practice level.

4.2 The clinical directors are considering their training needs and that of the wider PCN members.

4.3 **Organisational development for the Integrated Neighbourhood Teams – update**
Two programmes of support for the integrated system will be delivered this autumn.

4.4 The **One Clinical Community** is due to start on 1st October, all participants have now been identified and have been organised into their locality groups, and we have representatives from West Suffolk Foundation Trust, Community Services, Social Care and the Clinical Directors from the Primary Care Networks.

4.5 This programme is designed to give clinicians and senior managers protected time to work together on key priorities in their locality. Not only is this an opportunity to learn new and develop existing leadership skills, but it is a real opportunity to bridge some of the historic lack of join up in services and improve integration of those services across health and social care for the population within your area.

4.6 As we develop our Primary Care Networks across west Suffolk, the relationships and skills learnt will form a great foundation to move projects at pace for the benefit of our patients.

4.7 **Integrated Neighbourhood Teams (INTs)** training, which brings together team members from within each of the INTs for a two day programme, starting in October, complimenting the OCC training. The strategic objective is to improve the experience of integrated health and social care provision for those receiving support and those providing it.

4.8 The key outcomes for the sessions are to:

- Identify, share, and incorporate best practice across INTs
- Build a core "client approach" model to be used across INTs
- Define, develop, and share single core INT assessment framework

4.9 A new group has been set up in West Suffolk **– the Local Workforce Action Group LWAG)**. This brings together workforce and organisational development professions across alliance partners to plan and agree how together they will support delivery of the alliance strategy. The LWAG is a sub group to the ICS level group – the Local Workforce Action Board. One of the first actions of the group is to run a workshop session with the alliance steering group in October to agree priorities, recognise existing action and identify gaps in activity.

5.0 Social prescribing in West Suffolk

5.1. The SEG discussed social prescribing at their meeting in July 2019 and agreed that the social prescribing model that is being currently delivered in Haverhill, Brandon and Mildenhall should be rolled out across the whole of the alliance area. The Lifelink model will be embedded in each locality and Primary Care Network with an agreement across the CCG and PCNs around funding for a minimum of 12 – 21 months.

5.2. Evidence from the initial areas shows a strong link between social prescribing and a reduction in GP appointments/increase in wellbeing. The University of Essex are providing verification of the data and future monitoring will be brought in line with the NHSE outcomes framework and will include the Patient Activation Measure and ONS4 wellbeing scale.

6.0 Mental Health services in Haverhill

6.1 New ways of delivering mental health support in a primary care setting are being explored as part of the wider work being carried out by Alliance partners to implement the Suffolk Mental Health and Wellbeing Strategy. To improve our understanding of the needs presenting with GP practices an information gathering exercise was carried out in Haverhill for a period of two week. During this time mental health link workers were based within the GP surgeries within Haverhill working as part of the Primary Care team.

6.2 Following on from the initial pilot in Newmarket a full time experienced mental health Link Worker will be working in Haverhill GP practices, supported by other mental health experts (Psychiatrist/Psychologist), from 1st October 2019 and this will make more direct access to mental health services possible.

6.3 Below is an anonymised case study from this exercise, which has been used to inform the redesign of the community mental health model.

Mr Jones has been off work for some months with a back injury that is limiting his movement, and causing severe and chronic pain. It is preventing him playing football and

the usual things he does around the home. His employers are starting to ask when he is returning to work and Mr Jones is increasingly stressed by this. There is financial worry due to being on sick pay and he worries about not being able to pay the mortgage, and other debts, and look after his family.

Mr Jones is beginning to withdraw from those who care for him and to avoid going out. His mood is becoming low and he is feeling trapped by his situation. At the worst times there are thoughts of failure and suicide that frighten him. It seems that things will never get better. Mr Jones is familiar with his GP practice when it comes to his physical difficulties, but is uncomfortable about talking about his thoughts and feelings and doesn't want to report them to anyone.

The practice nurse is now trained to talk with people about their mental and emotional wellbeing as well as concerns about physical health. She is fully aware of the importance of considering this when people experiencing debilitating physical symptoms and brings it up at one of the routine check-ups. She is able to make him feel at ease and Mr Jones finds that he is able to talk with her about the impact of what is happening and get his support to refer to the new mental health Link Worker who is linked to the practice.

The mental health worker and Mr Jones come up with a plan that includes medication that works best with the painkillers he is already taking, support to access a debt counsellor who helps negotiate manageable payments and liaison with the employers. The mental health worker arranges for psychological help to be provided close to home to address the way that Mr Jones is seeing himself as a failure, the sense of hopelessness and inability to see a way forward. He learns that the suicidal thinking is the only way he has been able to think of solving his problems. They work on helping to see small steps as achievements and to increase the kind and range of activity he is involved in so that he can be less self-critical.

With this help Mr Jones begins to feel less of a failure, gains confidence in solving problems in different ways and that adjustment to his challenges is a success. He notices an improvement in the pain as his mood improves and anxiety reduces. All of the people involved in Mr Jones care work together and his experience feels joined up – doesn't have to keep repeating his story and feels well understood.

7.0 Sexual health update

7.1. At the last SEG meeting Sharon Jarrett from Public Health gave a presentation about the plans for these services. They are taking a system wide approach to make the best use of resources across a range of partners and commissions. The Sexual Health Board will drive this work through three workstreams: reproductive health, sexually transmitted infections and sexual health promotion.

7.2. In order to ensure that services are available to people in West Suffolk, there has been an increase in the numbers of School Nurses, and express on-line testing has been rolled out across the county.

8.0 Wider partner activity

8.1 **Local planning** – A wide ranging discussion at the SEG meeting in September considered the interface between structural planning for housing, roads etc. and the health needs of the population. The group heard from Ian Gallin, Chief Executive of West Suffolk Council and Tom Barker, Assistant Director, Planning and Communities, Mid Suffolk and Babergh Councils about how local plans are developed and the opportunities for the alliance to engage. The benefits of this are around a more structured approach to the planning of health provision alongside the potential to take advantage of planning gain finance. SEG agreed that this was a valuable area to take forward and that time at future meetings would be allocated to agree an approach.

8.2 **Realising Ambitions funding** – The Suffolk and North East Essex ICS made funding available through the Community Foundations to support delivery of the ICS Higher Ambitions. The amount for the West Suffolk alliance area was £430,000 and the alliance agreed the priorities for this funding should be improving mental health, reduction in obesity and tackling loneliness, all of these priorities to sit across all ages.

8.3 The application window is now closed, with the funding bids totalling more than double the amount allocated. The decision making panel will meet on the 10th October, with the Suffolk Community Foundation informing successful bidders shortly after. One of the advantages of working with SCF is that they have been able to signpost organisations to different sources of funding, as alternatives or additional to the Realising Ambitions pot, as well as their knowledge about the sector which will support the bidding panel in making their decisions.

8.4 The bidding panel is made up of experts around our three priority areas, as well as a member from the Community Engagement Group and locality leads.

9.0 Conclusion

The Trust is asked to note the progress being made through the West Suffolk Alliance and the Trust's wider partnership working.

integrated working

West Suffolk Alliance

Localities update

September 2019

integrated working

Mildenhall & Brandon Locality

PCN Clinical Director Dr Lee Bower & Locality Lead Dawn Godbold

Health and Wellbeing Hub planned to open Dec 2020 and to include:

- Social Prescribing
- Allied Health
- Health and Social Care
- Physical Activity agenda
- Maximise estate usage
- Education and leisure and public services partnership
- Releasing land for housing

Market Cross Frailty Test and Learn Project
Early identification of 25 frailest patients who are living in their own home, MDT needs assessment and proactive intervention

Targeted work with Mabbs Hall Care Home

Social prescribing scheme launched

Compassionate Communities work led by the hospice

Childhood Obesity project in Schools

Health Care Assistant project with Suffolk Primary Care

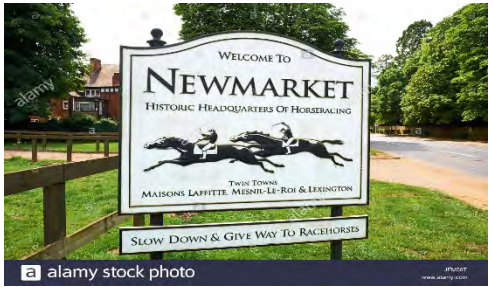
Discussions about possible co-location of services in Brandon Leisure Centre

Trialling local access and assessment pathway for social care referrals

Trusted Assessment workshop 5.8.19

integrated working

Newmarket Locality



PCN Clinical Director Dr Nick Rayner & Locality Lead Sandie Robinson

Three interlinked but separate priorities:

Locality Delivery Group – meets every two months – Chair Dr Nick Rayner

CYP working group – 1 meeting taken place. Lead Jo John, CYP Transformation lead. Currently mapping District Council activity and CYP model

INT working group – 1 meeting taken place. Lead Sandie Robinson. Awaiting outcomes of INT workshop 12 Sept

Health Care Assistant project with Suffolk Primary Care

Virtual Ward Test and Learn commencing November 2019

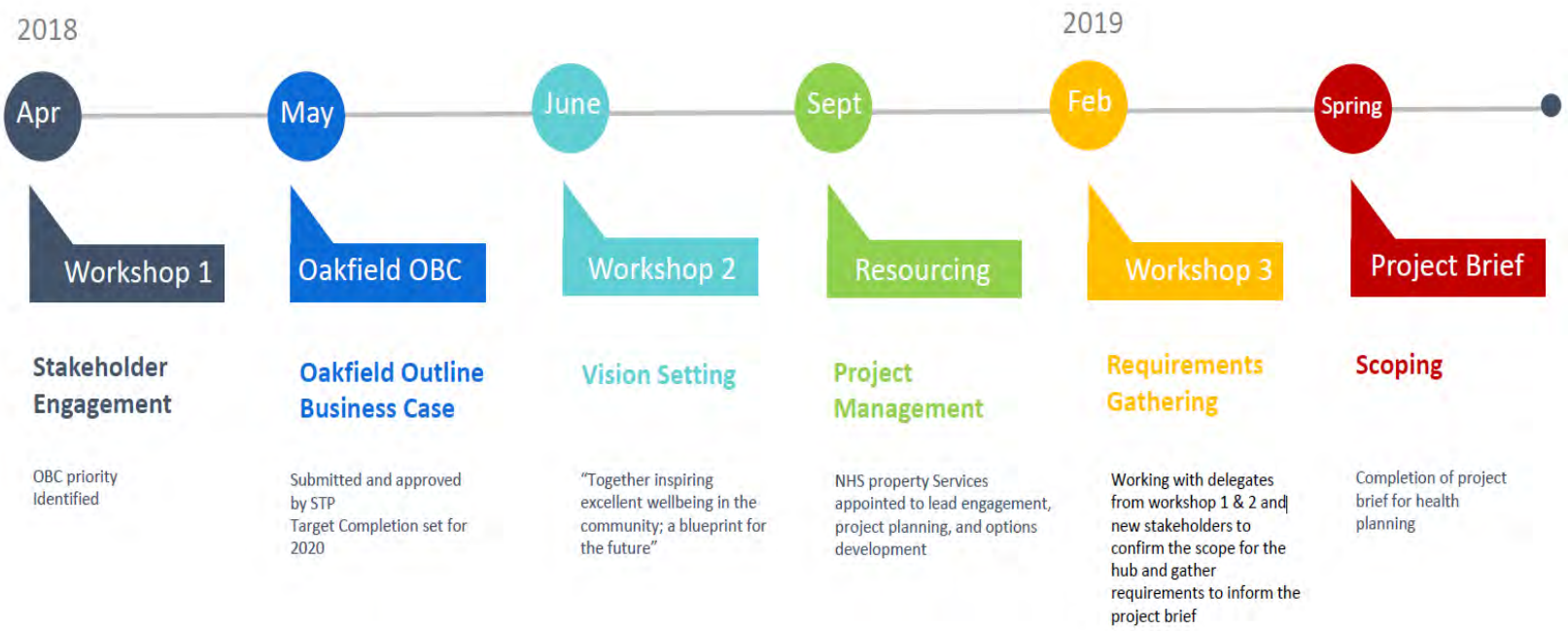
Integrated Neighbourhood Team now co-located and single line management for health and social care in place

Falls strength and balance programme in place through Abbeycroft Leisure

Newmarket Health & Wellbeing Hub

What has been done to date?

Timeline



Flack Associates, January 2019

"Together inspiring excellent wellbeing in the community; a blueprint for the future"

11

Newmarket Hub – keeping momentum!

WestSuffolkCCG Retweeted

Sandie Robinson @sandie_robinson · 5 Feb

West Suffolk alliance working at its best in Newmarket locality! Creative thinking and loads of energy #teamwestsuffolk @SteveDunnCEO @NHSWSCCG @WestSuffolkNHS

6 19

Jacqui Grimwood @JacquiAGrimwood · Feb 5

Great being part of collaborative working across the health system #wearewestsuffolk @SteveDunnCEO @blackc01 @sandie_robinson

2 7

integrated working

Sudbury Locality

PCN Clinical Director Dr Bahram Talebpour (Town), Drs Bob Morgan & Christopher Browning (Rural) & Locality Lead Rob Kirkpatrick

Key priorities from locality mapping:

1. **Forming an locality based Dementia Action Alliance –** two failed attempts historically but lots of interest to try again.
2. **Drug and Alcohol misuse –** Lead ACS Locality Manager. Mapping of data in progress
3. **Public Engagement –** Seeking locality engagement lead
4. **Social Prescribing –** not currently a project in Sudbury but voluntary sector organisations are keen

integrated working

Bury Town Locality

PCN Clinical Director Dr Mark Hunter & Locality Lead Helen Beck

Key priorities:

- **Demand management**
- **MDT coordination and risk stratifying top 50 rising risk**
- **Homelessness and street drinkers – Housing lead**
- **Trusted Assessment workshop 4.9.19**
- **Western Way Health and Wellbeing Hub development** – planning consent due early 2020. Public consultation now in place https://www.westsuffolk.gov.uk/council/wwd/

integrated working

Bury Rural Locality

PCN Clinical Director Drs Richard West & Jude Chapman & Locality Lead Lucy Pettitt

- First Meeting 24th July 2019
- Attended by 13 representatives of 11 different organisations
- Started discussions about strengths and areas of priorities for the locality area
- Next date to explore priorities further – 25th September 2019
- INT priority: Co-location, Boundaries and IT access

Haverhill Locality

integrated working

PCN Clinical Director Dr Firas Watfeh & Locality Lead Lois Wreathall

Clinician led priorities for the patients

- A series of 'evenings with' are planned, led by clinicians
- Anxiety
- Back and leg pain
- Diabetes
- Managing childhood asthma
- COPD
- Falls exercise and balance classes through Abbeycroft Leisure

Priorities for Haverhill identified to support the INT

- Mental health provision & full integration:
  - Additional full time link worker from 1 October
- Use of info link
- Smart card access for ACS staff
- Access to Addenbrookes data
- Active multi-agency nurse forums

11:20 GOVERNANCE

22. Trust Executive Group report

To ACCEPT the report and APPROVE the quality improvement framework

For Report

Presented by Stephen Dunn

Board of Directors – 27 September 2019

Agenda item:	22			
Presented by:	Dr Stephen Dunn, Chief Executive			
Prepared by:	Dr Stephen Dunn, Chief Executive			
Date prepared:	19 September 2019			
Subject:	Trust Executive Group (TEG) report			
Purpose:		For information	X	For approval

Executive summary

2 September 2019

Steve Dunn provided an **introduction** to the meeting. The work of the operational and estates teams was acknowledged for the opening on time of AAU (phase 2). This demonstrated the benefit to patients of the move of administrative staff from that area to Quince House that Quince house - providing clinical capacity within the main hospital. The recent refurbishments that have taken place in F3 and labour suite were also recognised as fantastic upgrades. It was noted that formal notification has been received that the CQC inspection will take place on 24 & 25 September, with the 'well led' inspection at the end of October.

Quality, operational and financial performance was reviewed from the recent Board papers. The focus of quality discussions included timely completion of duty of candour and RCA investigations for incidents. The focus on improving appraisal rates will also be maintained. It was recognised that we are struggling to meet increased demand, although we have seen improvements for 62 day cancer performance as well as diagnostics and endoscopy. RTT performance had dipped but we have seen a reduction with the overall numbers on the waiting list. We continue to review our capacity and what outsourcing capacity we can utilise. In relation to the ED standards, the average wait remains a challenge given the increased activity - we saw 600 more patients compared to the previous month. The deteriorating financial position as reviewed, with a forecast £5m overspend against plan. The drivers behind this deteriorating position were reviewed and, while it was recognised that while this pattern in demand/spend is also being seen in other acute hospitals across the region, it was clear that mitigating action must be taken. It was confirmed that work is being undertaken within the divisions with delivery plans to mitigate the overspend with a plan to be reported to the Board.

The **red risk report** was received. There were two new red risks relating to the hospital building infrastructure and use of medic bleep within specific locations within the building. Mitigating actions to control these risks were reviewed. No red risks were downgraded and one draft red risk was noted. The corporate and operation risks were also reviewed which are subject to executive review and discussion at divisional performance review meetings. The key strategic risks identified were:

- **System financial and operational sustainability** will impact of the quality of patient services (linked to operational performance and CIP planning and transformation)
- **Winter planning** to ensure safe staffing and capacity for winter.
- **Pathology services** – delivery of pathology services, including MHRA inspection and NEESPS accountability and control. These all have an impact on service delivery and patients services directly impacting of quality and sustainability of services.

The arrangements and preparations for the forthcoming **CQC inspection** were reviewed. Key areas for focused were discussed and it was noted that NHSE/I were supporting preparation with a mock well-led review.

The new quality improvement framework (**Freedom to improve: Delivering high quality safe care, together**) was reviewed and approved. The document aims to set out the steps we've already taken internally on that continuous quality improvement journey. It also looks ahead to where we're going next – we will be working with health and care partners to develop a whole system approach to quality improvement. The document is structured around the National Quality Board's seven steps to improving quality; to set out a framework within which our quality journey can be understood.

The **Patient safety and learning strategy** was also approved. It was noted that we will be a pilot site for the new national standards for the patient safety reporting framework.

The following **policy documents** were approved:

- management of medical devices
- welfare and management of patients presenting with mental health problems

16 September 2019

Steve Dunn provided an **introduction** to the meeting which provided an internal and external focus on issues and developments. It was recognised that the emerging finance position remains a concern – forecast £10M adrift of plan which with loss of provider sustainability funding would result in a year end deficit of £16M. A review of action being taken to prepare a recovery plan was discussed. Feedback was provided on discussion with Pauline Philip, National Director of Urgent and Emergency Care. This recognised the progress the Trust is making as part of the testing of the new ED standards. Reflecting on national meetings the focus on preparation for EU Exit remains a key focus.

An update was provided on the logistics of the **CQC inspection**. This included the number of inspectors and the programme for the two days. It was noted that meeting with clinical leaders would be structured to minimise disruption to patients.

The **surgical assessment unit** (SAU) business case was received and approved. The proposal supported establishing an SAU Monday to Friday 8 'til 8 and delivery of the national standard of review senior clinical review within 14 hours of admission (including weekend). The investment will be mitigated through releasing surgical capacity to deliver RTT activity and review of general surgeons job plans.

Received and approved the Trust's response to the **national interim people plan**. Also reviewed the Trust's governance for workforce and received reports from key forums. The terms of reference for the workforce strategy group were reviewed in the context of multiple forums within the Trust and ICS.

An update was received on the **Newmarket hospital transfer** planned for 30 September. It was noted that the Trust would need to take on outstanding debts for the site from NHSPS which would deteriorate our financial position, the medium term system benefit of owning this asset was considered to outweigh this financial impact. Work is underway, as part of the system, to develop a clinical vision for the site.

Received an update on the **primary care vertical integration** project, which in collaboration with a local primary care practice is proposed to bring this work under the responsibility of the Trust - providing the opportunity for seamless transition between primary, community and acute care. The learning from this project will be used to inform the future direction of this work. The development was welcomed by TEG members as providing exciting opportunities for patients and staff.

A paper was considered for how we review **our strategic framework** which will be five years old in spring 2020. It was agreed that this provides an opportunity to engage with patients, staff and partners to reflect local developments within the Alliance as well as national initiatives such as the NHS Long Term Plan. It was agreed to consider options to use co-production approach to support this review.

The following **policy documents** were approved:

- Procurement policy – updates accepted but recognised may need to be revisited post EU Exit
- Business continuity policy – strategic policy which sits above 'command, control and coordination (C3) plan'
- Discharge planning operational policy – including internal and system partner perspective to provide a resource pack for staff
- Noted change to the learning from deaths policy so that all deaths are not reviewed routinely but provides a more focussed approach to meet local and national requirements.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
	X	**X**	**X**

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

Previously considered by:	The Board receives a monthly report from TEG
Risk and assurance:	Failure to effectively communicate or escalate operational concerns.
Legislation, regulatory, equality, diversity and dignity implications	None

Recommendation:

1. The Board note the report
2. Approve quality improvement framework - Freedom to improve: Delivering high quality safe care, together

Freedom to improve

NHS
West Suffolk
NHS Foundation Trust

The freedom to improve

Delivering high quality, safe care, together

The freedom to improve

At the core of our strategic framework, 'Our patients, our hospital, our future, together', is a commitment to quality and closer working with health and care partners. Our vision is: 'to deliver the best quality and the safest care for our community'.

Indeed, we received an 'outstanding' rating for the quality of our care from the Care Quality Commission, reinforcing this vision. And, through closer working with our health and social care partners in what we refer to locally as the 'alliance', we are well on the way to joining up and integrating care. We are moving forward in delivering our vision.

Nevertheless, we know we're not perfect and that there are lots of opportunities to improve the quality and safety of our care. For the last few years we have been aligning our quality assurance and improvement systems, processes and leadership programmes with the Care Quality Commission's focus and approach; we want to make sure that quality improvement and assurance is truly part of our day-to-day activities. And as part of our quality journey, we've been introducing new tools and techniques into a variety of hospital projects to develop our quality improvement approach.

This document has two aims; the first is to set out the steps we've already taken internally on that continuous quality improvement journey. The second is to look ahead to where we're going next – we will be working with health and care partners to develop a whole system approach to quality improvement.

It's an exciting step. The national NHS Long Term Plan signals how local NHS organisations are increasingly focusing on population health and moving to integrated, joined-up systems. Here, this has been our 'west Suffolk way' for some time – supported by not just our Trust strategy but our local alliance strategy 'All about people and places'.

The Care Quality Commission document 'Quality improvement in hospital trusts' highlights that: 'True improvement comes when quality improvement is anchored in the system and its purpose'. This is so true, and has to be the next step in our quality journey. We are committed to investing in, and using, improvement science to further improve the quality of our care - right across the west Suffolk health and care and wider system.

Dr Stephen Dunn CBE, chief executive
Dr Nick Jenkins, medical director
Rowan Procter, executive chief nurse

West Suffolk NHS Foundation Trust

Delivering high quality, safe care, together

We are facing the same challenges as healthcare services nationally and internationally.

Rising demand from a population that is increasingly elderly and rising costs of providing services to people has an impact. In order to sustain our local NHS, we have to meet these challenges and find a way to still improve the quality of services we provide.

This is why delivering safe, effective, patient-centred care is a key ambition of our hospital and community services.

As our CQC inspections and national NHS staff surveys highlight, we have a culture that encourages innovation, experimentation and change, and empowers staff to give improvement a go.

We have a culture and environment where our staff are supported, as best we possibly can, to navigate the challenges they face. And over the last few years we have been developing our understanding of improvement science, so that we can further support staff to improve our quality of care.

Our quality

- In 2018, we were rated as 'outstanding' by the Care Quality Commission (CQC); this incredible achievement was a fitting acknowledgement of the hard work and compassion of our 4,500 staff
- We consistently remain in the top 10% of trusts nationally for our patient Friends and Family rating scores
- Cancer services across west Suffolk deliver some of the best early detection of cancer in the country and we have the best cancer survival rates in the region
- Our stroke, cardiac and respiratory services are amongst the best in the region, and country, in a number of national clinical audits
- We have delivered the best hip fracture care in England for the last two years (2018/2019)
- We are in the top 10 trusts in country in the National Early Inflammatory Arthritis Audit (NEIAA) for rheumatology
- We work with mothers to ensure some of the lowest caesarean section rates in the country
- Our management of children's asthma and type I diabetes is among the best in the region
- We are an NHS England Global Digital Exemplar, and are investing in digital technology
- We hold formal accreditations for anaesthetics, imaging services, endoscopy, IT, sterile services and our library
- Our catering services have a five star food hygiene rating, a Soil Association Food for Life bronze award, and an Eat Out Eat Well award
- We are rated by our staff as as one of the best places to work and receive care in the NHS
- We have been rated as the best in the region two years in a row for junior doctor training (2018/2019)
- We are the best general acute trust in the country for staff feeling empowered and having control over how they do their jobs (NHS staff survey 2018)
- The model hospital has rated us routinely as one of the five most efficient hospitals in the country highlighting how safe care is efficient
- In national audits, we were deemed to be providing 'outstanding' diabetes care to the people of West Suffolk.

Case study: Reducing long stays

It's important that, once a patient has had the hospital care they need, they aren't kept in hospital simply because arrangements can't be made for them to be cared for somewhere better. There's lots of evidence to show that actually people recover better, and more quickly, at home. We call these delays a 'delayed transfer of care'.

We've developed a new approach to help get people home quickly, and improve the quality of their experience; we simply bring staff from different organisations to work in teams together. This covers everyone from colleagues in therapy services, who can arrange ongoing treatment for the patient at home, to community and social care teams who can put extra support in place.

On our wards, daily board rounds and ward rounds being led by the most senior member of the team mean those who can make decisions about treatment and discharge are there. The teams use two NHS methods called the SAFER bundle and Red2Green days to make sure patients get all their tests and treatments as quickly as possible too – reducing the number of days patients spend just waiting. Anyone who has been in hospital for more than seven days is reviewed by the whole multi-agency team twice a week, to see what barriers are in place to getting them home.

The result? In west Suffolk, we now have the best delayed transfers of care numbers in the country.

Case study: good food

Good nutrition is crucially important for recovery from illness. If people are poorly enough to need to come in to hospital, we think they should have fresh food that tastes good while they are here.

So unlike many hospitals in England, all the catering for West Suffolk Hospital is done on-site by our award-winning catering team.

The catering department holds a five star food hygiene rating, a Soil Association Food for Life bronze award, and it won the first Eat Out Eat Well award bestowed by Suffolk County Council.

The team is focused on improving patient experience; they launched a digital tool that not only shows patients nutritional and dietary information for the food on offer, but images of the food to help those who may find reading difficult to make a choice about what they'd like to eat. Patients can also use it to provide instant feedback on their meals, so the team can gather more ideas about how to improve the service they offer.

The team also recognised that sometimes families want to celebrate with their relatives in hospital – perhaps a new birth, the end of some difficult treatment, or being given the all clear.

So the team designed a traditional afternoon tea menu; it can be catered for dietary requirements, including options for people who have difficulty swallowing, and an afternoon tea voucher can be bought as a gift, too.

Seven steps to improving quality

The National Quality Board has set out seven steps to improving quality.

These set out a framework within which our quality journey can be understood:

1. Setting a clear direction and priorities
2. Bringing clarity to quality
3. Measuring and publishing quality
4. Recognising and sharing quality
5. Maintaining and protecting quality
6. Building capacity
7. Staying ahead.

Our approach:

1. We will continue to set a clear direction and identify quality priorities each year
2. We have adopted the CQC's definition of quality, bringing clarity to quality by defining what high quality care looks like
3. We aim to measure and publish quality to monitor standards and benchmark performance in a way that supports our definition of quality
4. We share and publicise best practice to drive quality improvement across the Trust and the wider system
5. We seek to maintain and protect quality to ensure we deliver the best care; we will continue to act quickly when this is not the case
6. We are building capacity in our staff, to enhance their understanding of quality improvement techniques and human factors
7. We aim to stay ahead by developing quality improvement across our health and care, and public service, partners.

Setting a clear direction and priorities

Our vision, priorities and ambitions are set out in our strategic framework, *Our patients, our hospital, our future, together*. The Trust's vision is to: deliver the best quality and the safest care for our community. At this core is our commitment to quality and closer working with health and care partners.

Delivering quality improvement against this vision and strategy relies on commitment, consultation and co-operation from the ward to the Board.

We have been setting clear quality priorities every year to reflect our vision and strategy, and reporting on our progress through Board papers, our annual report, and our quality account.

Each year discussions take place with the Board of Directors, the Council of Governors and the Trust Executive Group in order to ensure quality priorities are identified to focus efforts for the coming 12 months.

We seek to ensure the quality priorities are appropriate, meaningful and reflect the things that we need to improve. Data and evidence also play a vital role; each year we will ask, where is there scope for improvement and in which areas is the quality gap the greatest?

Quality priorities for 2019-20

1. **Patient flow:**

   The Trust has made significant improvement to patient flow through a range of initiatives and focus on improvement; this includes 'Red2Green' and 'SAFER' onto all adult inpatient wards. The recent challenge of winter has highlighted the importance of maintaining this focus and ensuring that all recommended processes are fully embedded across the Trust.

   The transformation team are leading a planned ward by ward review of the initiatives, reviewing to what extent they are embedded and offering support to the ward staff.

   We will also take the opportunity to add in any new initiatives which will support patient flow within the hospital and community ahead of winter 2019-20.

2. **Human factors:**

   Research, case studies and national guidance illustrates how implementing the consideration of human factors in healthcare can reduce harm and improve both patient and staff safety, providing invaluable insights for all concerned with clinical quality.

3. **Quality improvement:**

   In 2018 the Trust co-designed a quality improvement framework with staff, to implement a structured approach to use quality improvement methods to drive continuous improvement in quality and outcomes.

   We are making quality improvement a quality priority to accelerate dissemination and adoption of improvement science knowledge, skills and application.

We will be updating our strategy for the next five years and to reflect the recently published national and local strategies such as the NHS Long Term Plan, the NHS People Plan, the local Integrated Care System (ICS) strategy, and the west Suffolk local alliance strategy – 'All about people and places' – amongst others. Pulling these threads together will be important, and, as we did when the original strategy was developed, we'll be seeking the views of partners, patients and our people.

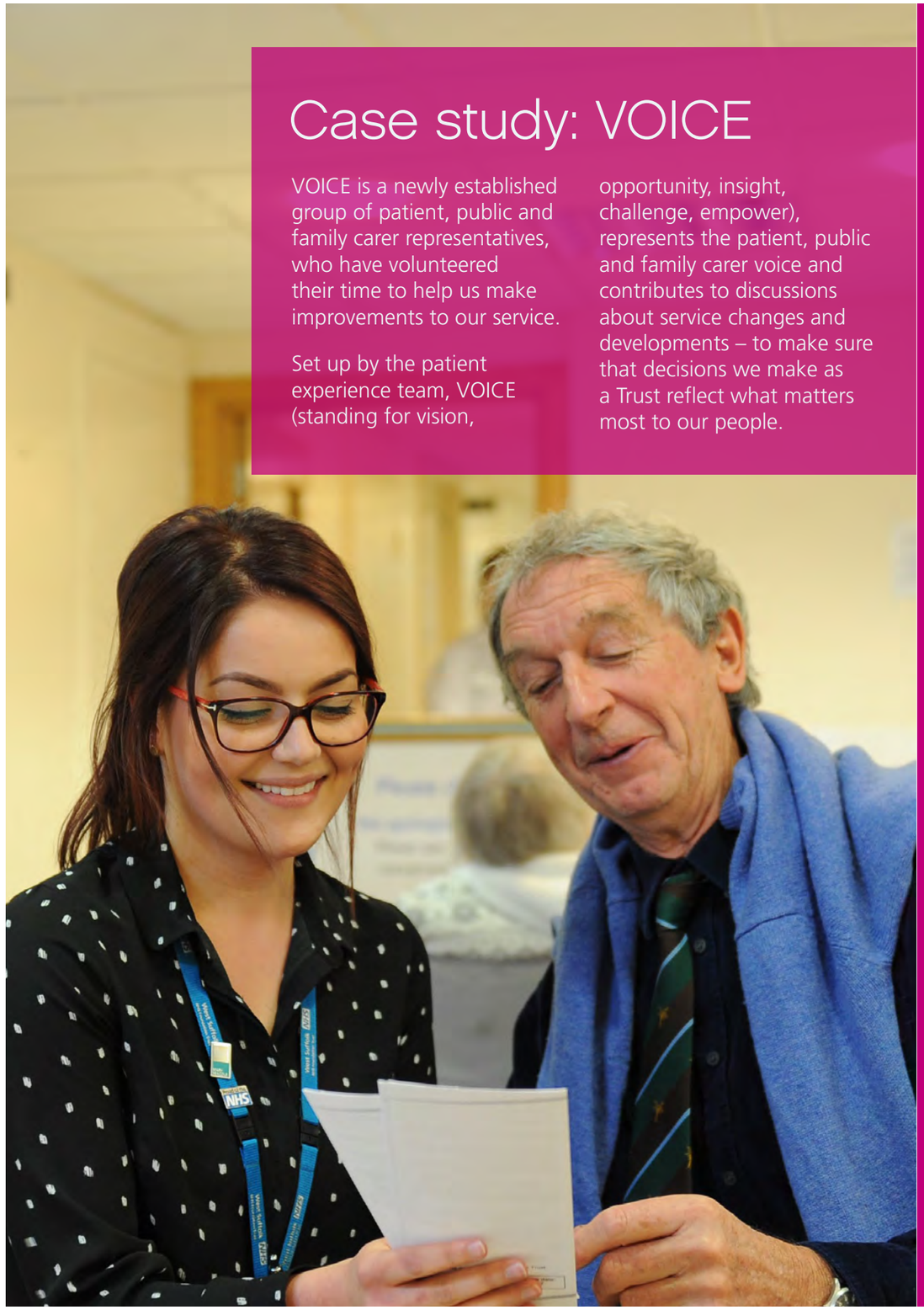
Naturally, the strategy detail will evolve to reflect how far we have come and the changing landscape of the NHS over the last few years.

But our vision, priorities and ambitions will no doubt inform the future framework and strategy.

Case study: VOICE

VOICE is a newly established group of patient, public and family carer representatives, who have volunteered their time to help us make improvements to our service.

Set up by the patient experience team, VOICE (standing for vision, opportunity, insight, challenge, empower), represents the patient, public and family carer voice and contributes to discussions about service changes and developments – to make sure that decisions we make as a Trust reflect what matters most to our people.



Bringing clarity to quality

There are many definitions of quality. The Care Quality Commission (CQC) has set out a definition and framework of what quality health and care services are, which we have adopted.

Locally we call this 'CREWS'. Are our services caring, responsive, effective, well-led, and safe?

The CQC's definition of quality

Caring: Staff involve and treat people with compassion, kindness, dignity and respect.

Responsive: Services are timely, equitable and efficient; responding to the needs of our population.

Effective: People's care, treatment and support achieve good outcomes, promote a good quality of life, and are based on the best available evidence.

Well-led: The leadership, management and governance of the organisation makes sure it is providing high-quality care, encouraging learning, innovation and sustainability, and that it promotes an open and fair culture.

Safe: People are protected from abuse and avoidable harm.

Our internal inspection processes have been aligned to these domains, as have our routine reporting and monitoring systems.

We have well-defined, quality assurance processes for setting the standards of what high-quality care actually looks like to us.

A key part of this is a thorough committee framework which plays a vital role in providing quality assurance to the Board, in what is a large and complex organisation.

Measuring and publishing quality

It's important that we monitor how effective we are, and study quality outcomes. We are, and will continue to be, open and transparent in how we share our progress, showing how we're doing against our quality priorities at public Board meetings and at multiple staff forums.

We do this by producing a monthly report, which we call the integrated quality and performance report (or 'IQPR'). It outlines how we're doing against each of the five CQC quality domains. Informed by quality improvement science we have started to use statistical process control (SPC) charts to measure our quality in this document, which makes it easier to focus on the things that need the most attention. By improving the ways we display data, it makes it easier for all our staff to see where we're making improvements and where we need to increase our efforts.

The CQC also uses data to monitor services. We use the CQC's 'Insight' data dashboard, which is shared monthly and provides trusts an overview of their risk and quality indicators from a CQC perspective. This gives some indication of the level at which the CQC rates each provider at that given time, and we present any stand-out points to our own Board to help focus areas of change.

Our annual quality account document demonstrates, to staff and our community, the progress we've made against our quality priorities over the year - and what we plan to improve in the coming year. This document will continue to demonstrate our commitment to participating in all relevant national audits, the outcomes of which provide another method of measuring the quality of our services.

Case study: hip fracture care

Hip fractures are cracks or breaks in the top of the thigh bone (femur) close to the hip joint. They're usually caused by a fall or an injury to the side of the hip, and are one of the most common serious injuries for older people.

A progressive integrated staff team, including doctors, specialist nurses, trauma practitioners, and orthopaedic, elderly medicine, and rehabilitation teams, ensure the patient is identified as soon as they attend the emergency department and that their immediate care and ongoing rehabilitation needs are identified. By working together and trying to make the process focus completely around the patient, the quality of care provided has gone from strength to strength.

Dr Mohanraj Suresh, lead geriatrician at WSFT, said: "Our elderly patients are sometimes very frail when they come to us, so rapid decisions about care and action are paramount to help them to regain mobility and a good quality of independent life"

The National Hip Fracture Database (NHFD) has rated our Trust as the top hospital in England, Wales and Northern Ireland for meeting best practice criteria for patients treated for a hip fracture – for two years running. The Trust achieved 94.3% against the best practice criteria in 2017, against an average of 57.1%, and 93.6% in 2018, against an average of 58.7%.

Case study: staff wellbeing

We've developed a holistic staff health and wellbeing programme to help colleagues look after their physical needs – including things like a musculoskeletal physiotherapy service, 'stop smoking' clinics on-site, hot food available for staff working night shifts, and more.

Recognising the pressures of working in the public sector, we are paying particular attention to protecting and improving the mental wellbeing of our staff, and trying to address the causes and symptoms of burnout. A newly established Better Working Lives Group, led by Paul Molyneux, the deputy medical director, is considering doctor burnout specifically. This includes running a series of mindfulness workshops to help give colleagues tools to help them tackle stress.

We're working with the mental health charity Suffolk Mind to train line managers to be confident to look after their teams' mental health, and sharing a wealth of information, websites and courses that staff can access .

We've established a 24/7 telephone and online counselling service, and introduced 'tea and empathy' on call – where wise, experienced colleagues make themselves available to provide a cup of tea and a listening ear to anyone who is having a really bad day.

And, we're trying to make it easier for colleagues to access general support. From exec open door drop-in sessions to new colleague 'trusted partners' and our Freedom to Speak Up Guardian, there are a wealth of options in place for staff to get any help they need.

Recognising and sharing quality

We know that quality improves by sharing best practice and great experiences, learning from incidents, near misses or great catches, and learning from deaths.

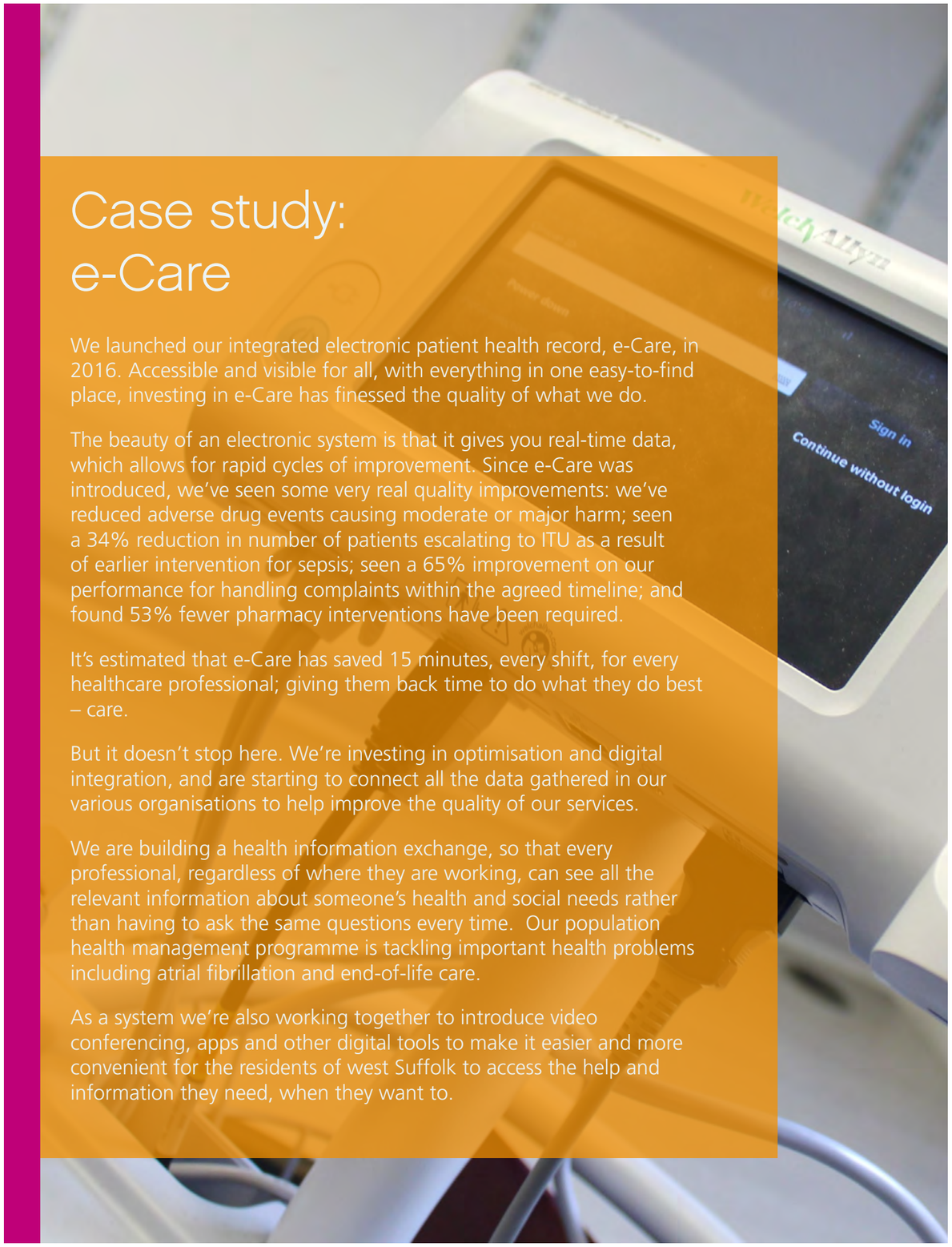
If this is done well, we not only improve the service and care we provide, but minimise safety risks and the chance of incidents occurring or reoccurring, which all contributes to quality improvement.

We recognise and share best practice across the organisation through corporate managers and divisional and departmental meetings and bulletins as well as through board reports, corporate communications such as Green Sheet, medical director's bulletin, and shared learning bulletin. We also have a 'Patient safety and learning strategy', which outlines key quality improvement principles:

- Putting safety first, being open and honest, and supporting patients
- Continually learning from incidents and excellence
- Collaborative working across the health economy
- Continuing to strengthen our culture, so that we support staff and help each other learn from mistakes, and tackle behaviour that goes against our values
- Integrating human factors and ergonomics into our work flows
- Further develop our nationally acclaimed learning from deaths framework.

The actions in our 'Patient safety and learning strategy' are all about effective and collaborative teamwork helping to deliver safe care, and improve what we do:

- Supporting delivery and measuring the outcomes of quality improvement projects through our quality improvement framework
- Taking part in regional and national collaboratives, and adopting best practice
- Training, educating and supporting staff to deliver safe and effective care through mandatory training, shared learning events, link practitioner forums and 'bitesize' teaching sessions
- Measuring key indicators of harm; using the national safety thermometer tool to look at pressure ulcers, falls, hospital acquired infections and venous thromboembolism, and review medication errors via our Drugs and Therapeutics Committee.
- Utilising technology, e.g. using trigger tools in our electronic patient care record (called e-Care) to identify patients at risk of deterioration early.
- Supporting the national 'Freedom to Speak Up' campaign, and give staff new ways to share concerns, e.g. an anonymous reporting phoneline
- Improving the support we give staff during and following a serious incident investigation and sharing lessons across the organisation
- Carry out Duty of Candour for patients promptly, sensitively and sympathetically.



Case study: e-Care

We launched our integrated electronic patient health record, e-Care, in 2016. Accessible and visible for all, with everything in one easy-to-find place, investing in e-Care has finessed the quality of what we do.

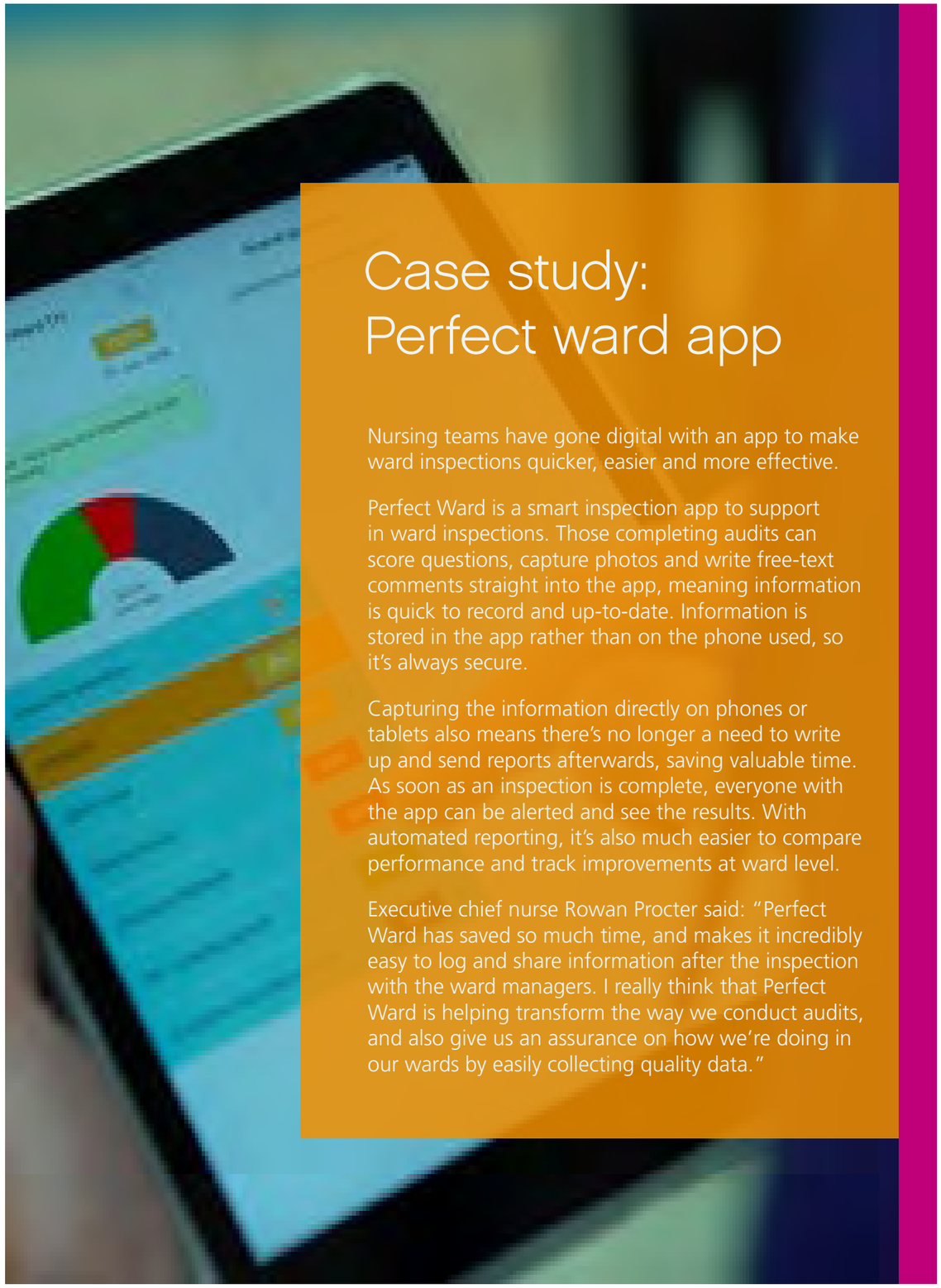
The beauty of an electronic system is that it gives you real-time data, which allows for rapid cycles of improvement. Since e-Care was introduced, we've seen some very real quality improvements: we've reduced adverse drug events causing moderate or major harm; seen a 34% reduction in number of patients escalating to ITU as a result of earlier intervention for sepsis; seen a 65% improvement on our performance for handling complaints within the agreed timeline; and found 53% fewer pharmacy interventions have been required.

It's estimated that e-Care has saved 15 minutes, every shift, for every healthcare professional; giving them back time to do what they do best – care.

But it doesn't stop here. We're investing in optimisation and digital integration, and are starting to connect all the data gathered in our various organisations to help improve the quality of our services.

We are building a health information exchange, so that every professional, regardless of where they are working, can see all the relevant information about someone's health and social needs rather than having to ask the same questions every time. Our population health management programme is tackling important health problems including atrial fibrillation and end-of-life care.

As a system we're also working together to introduce video conferencing, apps and other digital tools to make it easier and more convenient for the residents of west Suffolk to access the help and information they need, when they want to.



Case study: Perfect ward app

Nursing teams have gone digital with an app to make ward inspections quicker, easier and more effective.

Perfect Ward is a smart inspection app to support in ward inspections. Those completing audits can score questions, capture photos and write free-text comments straight into the app, meaning information is quick to record and up-to-date. Information is stored in the app rather than on the phone used, so it's always secure.

Capturing the information directly on phones or tablets also means there's no longer a need to write up and send reports afterwards, saving valuable time. As soon as an inspection is complete, everyone with the app can be alerted and see the results. With automated reporting, it's also much easier to compare performance and track improvements at ward level.

Executive chief nurse Rowan Procter said: "Perfect Ward has saved so much time, and makes it incredibly easy to log and share information after the inspection with the ward managers. I really think that Perfect Ward is helping transform the way we conduct audits, and also give us an assurance on how we're doing in our wards by easily collecting quality data."

Maintaining and protecting quality

Since our Together strategy was published, we have developed and embedded a robust quality surveillance programme.

It's designed to provide assurance to the Board that high quality care is being delivered across all services, and that areas requiring improvement can be quickly identified.

We know that there is much quality improvement to be gained by sharing and cascading learning from incidents, near misses or great catches, as well as learning from deaths.

If it's done well, we not only improve the service and care we provide, but minimise future risks and the chance of incidents reoccurring, which all builds into our picture of quality.

We use a variety of methods to assess the overall quality of what we're doing as a Trust, and to assure ourselves that we're safe:

- Every day, there is a multidisciplinary patient safety brief, led by a senior matron, that captures and communicates any patient safety issues.
- Weekly, an executive director, a non-executive director, and a Trust governor join the patient safety team for what we call a 'quality walkabout' in a clinical area. This provides an opportunity to check safety at a local level, but is also an opportunity for teams to share any concerns or ideas for improvement with Board members.
- The monthly quality group, co-chaired by the medical director and the executive chief nurse, reviews the output of assurance pathways and ongoing quality improvement initiatives.
- Each month, a document called the 'integrated quality and performance report' is produced, which pulls together a wide range of quality measures to temperature check how we're doing and map changes over time; it includes everything from how we're performing against national standards like cancer care, treatment times, or the emergency department, to patient nutrition scores and staff appraisal completion rates. This document goes to our public Board meeting to allow for the most transparent, open and honest discussions and challenges. We have started using statistical process control charts to measure our quality in this document, which makes it easier to focus on the things that need the most attention.
- Each quarter, a quality and learning report is provided to our Board to provide a summary of key learning points, trend analysis and opportunities for improvement that have arisen from incidents, risks, complaints, patient and family feedback, learning from death reviews and our quality walkabouts.
- Whenever guidance from the National Institute of Health and Care Excellence is issued or updated, we assess ourselves against it and monitor our practice through clinical audits.
- Every year we choose a number of quality priorities of things we're going to really try and improve or focus on over the coming year; these are shared across the Trust, and published in our annual report.

The Board also monitors quality through its performance management arrangements on a monthly basis. The board also receives assurance regarding quality within the organisation through the quality and risk committee and its three subcommittees, which ensure quality is delivered in a coordinated way to support safe, effective and patient-focussed healthcare. The subcommittees are:

(a) Clinical safety and effectiveness committee – ensuring clinical procedures and practices are effective in protecting patients, visitors and staff. This is achieved through reviewing compliance with national requirements, promoting best practice and ensuring effective identification and elimination or reduction of clinical risk

(b) Corporate risk committee – ensuring risk management, financial and workforce procedures are effective in promoting good business standards, protect the organisation, patients, visitors and staff, and comply with national standards and guidance

(c) Patient experience committee – ensuring exemplary customer and patient experience through the implementation of the improvement strategy and Patients First initiative.

Quality assurance framework

Systematic approach to governance across the organisation

Structures to review assurance activities in ward/department

Patient (user) engage ment

What do we do?

Proactive: ensuring patients are kept safe

- Incident report
- Risk assessment
- Clinical audits
- Compliance with best practice
- Reviewing patient experience
- Reviewing staff experience
- Freedom to Speak Up
- 'Just' culture
- Safety huddle & escalation calls
- Review of hospital deaths.

Reactive: acting and learning when we get it wrong

- Being open with patients and staff Structured reviews and investigations
- Identify areas for improvement, root causes and best practice
- Making changes to support and improve quality and safety
- Systematic approach – action planning.

How do we test its working?

- Quality walkabout
- Perfect Ward app
- Service and ward deep-dives
- CQC self-assessment – testing as part of 'business as usual'
- Workplace inspections
- 'Deep-dive' – safety alerts
- Review action plans from individual incidents and audits
- Executive lead serious incidents (SIs) and review of red risks
- Accreditations
- Transparent report of activities – local, divisional, Trust

Sharing learning from experience (good and bad)

- Local bulletins and briefings
- Always events
- Trust shared learning events
- Reporting and escalation
- Orange folders on wards

Quality presentations to Board committees

Reporting and escalation up through the division to the Board

Key groups to ensure we are learning and improving based on internal and external learning

Case study: harnessing talent

We know that to get the best of our people we need to support them to make the best of themselves.

We've introduced a swathe of leadership development opportunities for our staff, including: our leadership forum the Five o'clock Club, which invites guest speakers to share their thoughts on leadership and share learning; our west Suffolk 2030 leaders, which is open to consultant medical staff and band 7+ colleagues and offers leadership and quality improvement workshops, plus action learning and 360 feedback using the NHS Healthcare Leadership Model; and programme management development workshops on a range of topics like appraisal, recruitment and selection.

As well as this, we're a member of NHS Elect so our staff can access free training events, we support colleagues to attend Open University and East of England NHS Leadership Academy courses, and have given all staff free access to the prestigious Health Service Journal.

With coaching and mentoring opportunities also available, we pride ourselves on providing a raft of training, resources and learning opportunities for our leaders of today, and of tomorrow.

Building capacity

Because of our culture, staff have always been engaged in quality and making changes in their departments or areas to improve what we do.

They were doing it naturally, but in 2018, we sought to improve our understanding of the science around quality improvement, and invest in service improvement and leadership development.

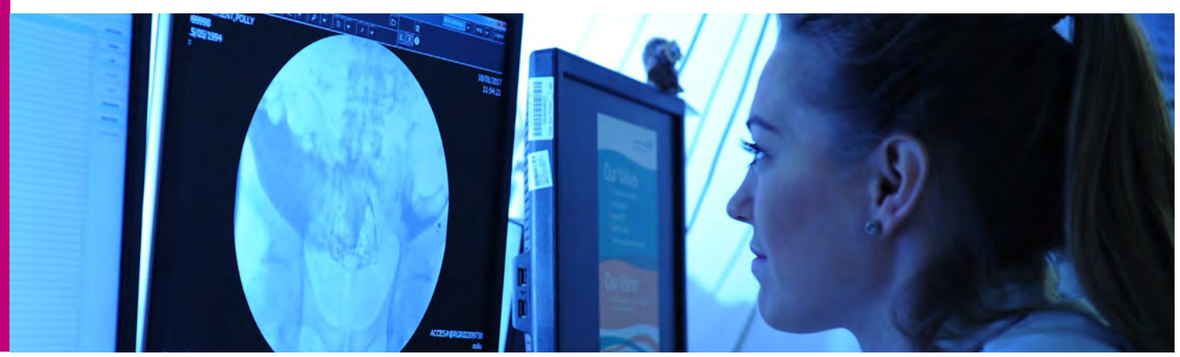
Led by Sue Deakin, one of our orthopaedic surgeons and clinical directors, we introduced a human factors programme in surgery, delivered by experts within the Trust. Human factors is a core concept behind quality improvement. It enhances clinical performance by creating a better understanding of the effects of everything from teamwork and tasks to equipment, workspace and culture on human behaviour. It takes that understanding, and applies the knowledge in a clinical setting.

We are rolling out human factors training across our organisation, made up of three key components:

- Awareness sessions, open to all staff, to increase understanding of human factors
- An in-depth session designed and developed with directorates to improve our incident investigation process
- Training for the Trust Board on the importance of human factors in service delivery and safety.

And the best healthcare organisations around the world take a structured approach to quality improvement itself - using scientific methods to test ideas, measure their effects and make the good ones stick. So we developed a quality improvement framework, co-designed with staff through a series of engagement events and activities. It was informed by evidence, and benchmarked against other NHS trusts that do quality improvement well.

Quality improvement (QI) as a formal term describes: 'the systematic use of methods and tools to achieve focused, measureable improvements in any dimension of quality'. It's not an end in itself, but an enabler to help work through a cycle. We have subscribed to the Institute of Healthcare Improvement's Model for Improvement.



Case study: steroid wristbands

When Dr Phil Riddell found a trend in incidents around missed steroid medications, he decided to do something about it. Phil thought we could care for these patients in a safer way; he created wristbands for patients who are long-term steroid users.

By making it easier to identify who is taking steroid medications on a long-term basis, all staff can clearly see the patient's needs – meaning that if they're transferred to a different ward, the chance of this vital medication being missed is reduced.

The pre-trial baseline of patients correctly identified as being on long-term steroid use was 55%. Following the wristband trial, we hope to see that number increase.

Case study: ITU patient profile

Helen Whiting, critical care nurse, identified a gap in the documentation available within the critical care unit, and created a patient profile form to help provide more patient-centred care for those patients who often can't share the information themselves.

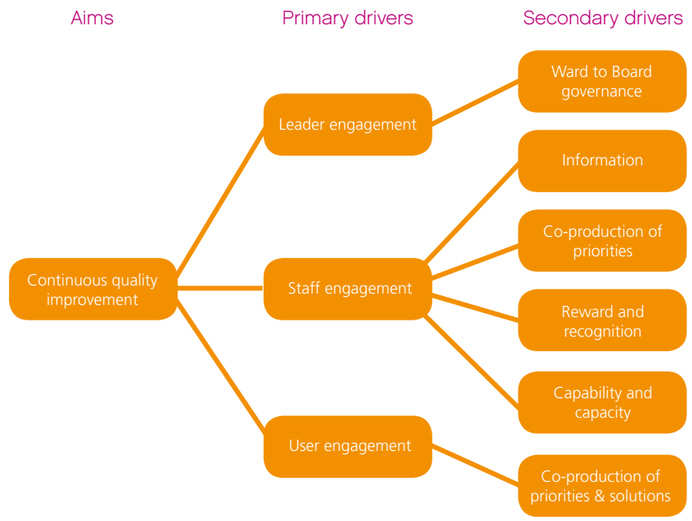
The Profile is a simple paper document that requires no additional work for the nursing team and patients and families/carers need minimal instructions to complete, that tells everyone involved in the person's care their preference, fears and anxieties.

It covers everything from their preferred food and what they like to be called, to whether they are right or left handed and what time they like to go to sleep.

Helen says: "I wanted to find a way of getting the personal information we need about patients to help provide more compassionate and patient-centred care, without creating additional work for staff. It's low-tech, quick to complete and read. It belongs to the patient and they can take it with them when they're discharged to use in other settings. It's a great way to empower patients and helps normalise things in a high pressured and invasive environment."

The Patient profile has been used in the critical care unit for a number of years, and is now being added to 'My Care Wishes' folders used in the community.

This is a driver diagram, one of the common tools used in quality improvement.



It starts on the left with what we are trying to achieve, and then lays out the drivers that will help us achieve it – the different factors that need to be in place.

For all the right people to be able to engage in improvement activity, the factors on the right hand side need to be addressed. We've been working hard since then to implement it. Some of the things we've done include:

- Designing a quality improvement training curriculum for staff, no matter where they work in the Trust
- Developing and training staff quality improvement coaches to support projects and colleagues in their own work areas
- Finding teams to take part in national patient safety collaboratives, applying QI methods to address well-recognised safety concerns
- Holding a regional QI conference, attended by clinical and corporate colleagues, representatives from our clinical commissioning group and other NHS trusts, and United States Air Force visitors from Royal Air Force Lakenheath.
- Subscribing to LifeQI, an online project management platform used by organisations around the world. It allows individuals and teams to plan, coordinate and measure the progress of their quality improvement ideas
- Creating a west Suffolk leadership and quality improvement faculty, which places quality improvement training in the leadership development programme offered to middle and senior managers. This is across both the Trust and local clinical commissioning group.

Excitingly, a portfolio of quality improvement projects has grown as a result – initiated and executed by frontline staff who have been able to use their experience and expertise to bring their improvement ideas to life.

Staying ahead

At the same time that we have been progressing on our quality improvement journey, the health and care system in the west of Suffolk has been evolving too.

An alliance of providers, made up of ourselves, the Suffolk GP Federation, Suffolk County Council, and Norfolk and Suffolk NHS Foundation Trust, has been working with a wide range of associate partners, including the district and borough councils, St Nicholas Hospice and a number of voluntary and community groups, to form an early and ambitious integrated care partnership.

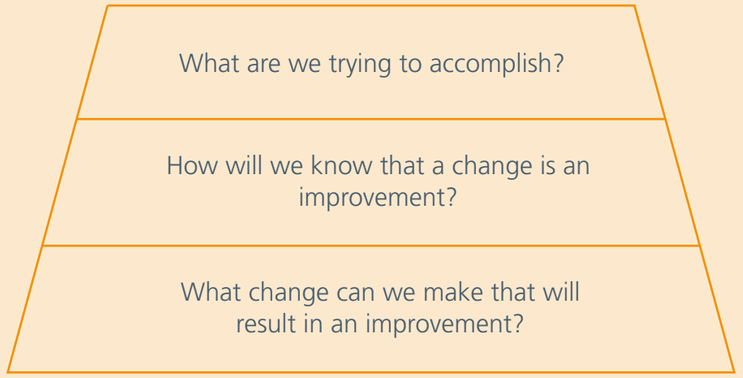
We know that the right way to do quality improvement is through an integrated care partnership, through a system-wide approach. The alliance is already showing examples of fruitful joint working, including an integrated pain management service and a successfully joined up approach to the provision of sexual health services. So the time is right to accelerate and expand the investment in and adoption of quality improvement in all our settings.

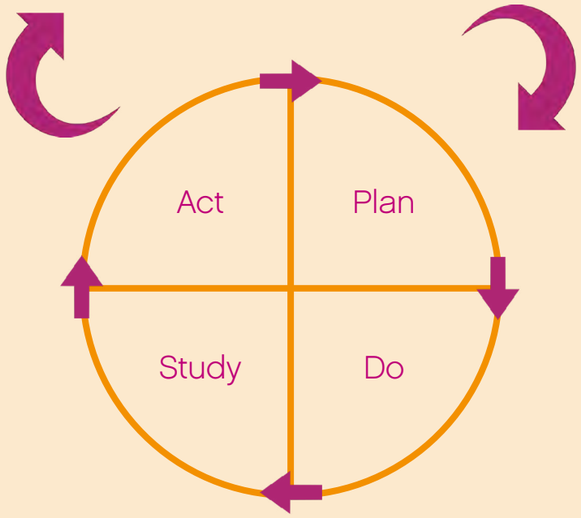
As an alliance we've recognised together that - as emphasised in a Care Quality Commission report that featured the Trust, 'Quality improvement in hospital trusts' - the journey to quality improvement maturity is a five year endeavour.

To do this at pace and scale, the system decided to jointly fund and commit to a collaborative partnership with the Institute of Healthcare Improvement. The Institute of Healthcare Improvement (IHI) is an international consultancy. It has worked with a host of NHS trusts in England that are considered exemplars in quality improvement.

The IHI helps health and care systems with what it describes as the 'triple aim' of: improving the health of the population; enhancing the experience of care (for those receiving it and those delivering it); and reducing the per capita cost of that care. The IHI advocates the model for improvement as a tool for guiding, planning and iterating improvement work.

Model for improvement:





The reach of the IHI partnership will extend to all in our system who choose to join us.

Our goal is to have leaders, staff and members of our community trained in the use of quality improvement methods and working across boundaries to coach and support teams, in whatever setting, to apply them.

The system will fund new roles in our small, central team of quality improvement specialists, who will shift their focus to work not just with us, but with the system, to facilitate the IHI partnership.

One of the early tasks will be to identify where we have existing assets; people with knowledge and experience that they are either putting to good use, but only in their own corner of the system, or which they aren't able to make use of in their current roles. Our leaders will be developed to confidently own quality improvement, to empower staff even more effectively, and to remove any barriers that limit their ability to test their best ideas.

The system executive group will form a new subcommittee to act as a forum for governing quality planning, control, assurance and improvement collectively, and the delivery of the quality improvement strategy will be overseen by it.

To reflect this shift to a system focus, we took a different attitude to defining our quality priorities in 2019/20; rather than selecting specific clinical topics, we have adopted the more holistic priorities of: patient flow, human factors and quality improvement itself. Each requires large-scale, multidisciplinary engagement to deliver.

By working together, we can also extend our reach with the people that matter most – the people in our communities. Using all our engagement channels across the system, including the public representation that our voluntary and community groups and Healthwatch Suffolk can offer, we can make sure our improvements and initiatives spread far and wide.

Our goal is to establish good quality improvement capability and capacity, in a way that all organisations can train in and have access to together. If we do this, we believe it will help our integrated care partnership to truly transform.

West Suffolk NHS Foundation Trust

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Putting you first

23. Audit Committee report

To APPROVE the report recommendations

For Approval

Presented by Angus Eaton

Trust Board Meeting – 27 September 2019

Agenda item:	23			
Presented by:	Angus Eaton, NED and Chair of the Audit Committee			
Prepared by:	Liana Nicholson, Assistant Director of Finance			
Date prepared:	September 2019			
Subject:	Audit Committee report - meeting held on 26 July 2019			
Purpose:		For information	X	For approval

Executive summary:

The Audit Committee was held on 26 July 2019. The key issues and actions discussed were:-

- **Board Assurance Framework 'deep dive' – '*Towards a West Suffolk System Estate Strategy*' -** The Committee received a presentation from Jacqui Grimwood (Estates and Facilities Development Manager). The Committee discussed at length the risk around the Estate structure and action plans in place to address the issues included in the presentation.
- **Internal Audit and Counter Fraud** - The Internal Audit Progress Report confirmed that two reports had been issued since the last report to the Committee; one relating to 2018/19 and one related to 2019/20. Both reports were rated as partial assurance and covered the following areas:
    1. **Data Security Protection Toolkit** (2018/19); and
    2. **Business Continuity** (2019/20).
- **External Audit Annual Audit Letter** - The 2018/19 Annual Audit Letter was reviewed:
    1. The auditors issued an unmodified true and fair opinion on the 2018/19 Financial Statements 28 May 2019;
    2. Although the Trust met its control total in 2018/19, due to the ongoing financial challenges faced by the Trust, the external auditors issued a qualified 'except for' Use of Resources opinion 28 May 2019; and
    3. The auditor issued an unmodified assurance report on the Quality Report 28 May 2019.
- **Audit Committee Annual Report** – The Committee approved the Annual Report to the Board summarising the work completed by the Committee over the past 12 months.
- **Review of Terms of Reference** – The Committee is required to review its Terms of Reference annually. Some minor amendments were made and were approved by the Committee.
- **Report to the Council of Governors** – the Committee approved the report to the Council of Governors on the performance of External Audit.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**		**Invest in quality, staff and clinical leadership**		**Build a joined-up future**		
	X		**X**		**X**		
Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	 *Deliver personal care*	 *Deliver safe care*	 *Deliver joined-up care*	 *Support a healthy start*	 *Support a healthy life*	 *Support ageing well*	 *Support all our staff*
	X	X	X				X
Previously considered by:	*This report has been produced for the monthly Trust Board meeting only*						
Risk and assurance:	*None*						
Legislation, regulatory, equality, diversity and dignity implications	*None*						

Recommendation:
The Board is asked to:

- Receive and note the Audit Committee report for meeting held on 26 July 2019
- Receive the Annual Report from the Audit Committee
- Approve the revised Audit Committee Terms of Reference

Audit Committee – 26 July 2019

Agenda item:	9.1			
Presented by:	Liana Nicholson, Assistant Director of Finance			
Prepared by:	Liana Nicholson, Assistant Director of Finance			
Date prepared:	11 July 2019			
Subject:	Audit Committee Annual Report			
Purpose:		For information	X	For approval

Executive summary:

The Audit Committee is required to produce an Annual Report detailing the work undertaken during a financial year. Attached is the report for the year ended 31 March 2019.

The Committee is asked to review the report and agree a final submission to the Trust Board.

Trust priorities	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
	✓	✓	✓

Trust ambitions	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
	✓	✓	✓	✓	✓	✓	✓

Previously considered by:	*N/A*
Risk and assurance:	*Sufficient.*
Legislation, regulatory, equality, diversity and dignity implications	*None directly relevant to this report but the work of the Committee provides the Trust with assurance on compliance in a number of areas.*

Recommendation:
The Audit Committee is asked to review and agree a final version for submission to the Trust Board.

1. Background

1.1 The Audit Committee of West Suffolk NHS Foundation Trust is established under Board delegation with approved Terms of Reference that are in line with those set out in the NHS Audit Committee Handbook.

1.2 This report covers the year from 1 April 2018 to 31 March 2019.

1.3 The Committee consists of a minimum of 3 Non-Executive Directors, one of whom has recent and relevant financial experience. The Committee has met on 4 occasions during the year to discharge its responsibility for scrutinising the risks and controls that affect all aspects of the organisation's business.

1.4 The meetings have also been attended, by invitation, by the Chief Executive, the Executive Director of Resources, the Executive Chief Nurse, the Deputy Chief Nurse, the Medical Director, the Trust Secretary and Head of Governance, the Assistant Director of Finance or Deputy Director of Finance, Internal Audit, External Audit and the Counter Fraud Service. The Chair of the Trust has also attended the Committee meetings.

1.5 The Committee focuses on all aspects of Corporate Governance including assurance on clinical governance and risk management.

1.6 This report deals with the Audit Committee meetings held between 1 April 2018 and 31 March 2019. Therefore, reports that are approved outside this period would be covered in the following year despite the subject matter of the report relating to the year. E.g. the annual report and accounts for 2018/19 will be reported in the year they were approved by the Committee i.e. 2019/20.

2. Meetings during 2018/19

2.1 There were 4 meetings of the Committee during 2018/19: 24 May 2018, 27 July 2018, 2 November 2018, and 25 January 2019 with the following member attendance.

Name	Title	Attendance / No. possible
Steve Turpie (Chair until 31 May 2018)	Non-Executive Director	1/1
Angus Eaton (Chair from 1 June 2018)	Non-Executive Director	4/4
Gary Norgate	Non-Executive Director	4/4
Alan Rose	Non-Executive Director	3/4
Richard Davies	Non-Executive Director	3/4
Catherine Waller	Honorary Non-Executive Director	1/2

2.2 There are no sub-committees of the Audit Committee. The Audit Committee is supported by the Quality and Risk Committee, the minutes of which are considered at every Audit Committee meeting.

3. Principal Review Areas

3.1 Annual Governance Statement

3.1.1 The Audit Committee reviewed the 2017/18 Annual Governance Statement for West Suffolk NHS Foundation Trust for the 12 months to 31 March 2018 and confirmed that it is consistent with the view of the Committee on the Trust's system of internal control.

3.1.2 The Audit Committee received the Head of Internal Audit opinion 2017/18 in May 2018 which concluded:

The organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective.

Specific issues highlighted were:

- Data Quality: 18 Weeks Referral to Treatment and Diagnostic Waits (Partial Assurance)

  At the time of the review the Corporate Access Policy had not been finalised or approved by the Executive. There were continuing problems with the data warehouse and reporting, which the Trust was working to address at the time of the audit. Manual validation checks were carried out for some, but not all, patients on the Patient Tracking Lists by services and the information team. Data quality and recording issues arising were fed back in an ad hoc manner which meant that lessons learnt were not shared across teams and services. There were also errors in clock stops that were observed and a significant delay in making a decision regarding a patient's care pathway was identified.

- Business Continuity and Disaster Recovery (Partial Assurance)

  Whilst the Trust had an Emergency Preparedness Strategy Framework, the Business Continuity strategy had yet to be published at the time of the review, as had the e-Care Business Continuity Plan. Additionally, staff were unaware of the Trust-wide business continuity plans and the local plans and no training had been provided. e-Care was not undergoing any restore checks to provide assurance that it could be restored in the event of unplanned downtime.

- GDPR – General Data Protection Regulations (Advisory but key improvements required)

  At the time of the review, the Trust had commenced an exercise of discovery and data mapping so that controls around the GDPR could be effectively implemented. Procurement of software was in progress, but at the time of the review there was no confirmed date by when it would be implemented and operational. Routine action tracking highlighted good progress on the closure of the actions raised, with the majority having been implemented.

3.1.3 The Audit Committee also reviewed the 2018/19 draft Annual Governance Statement for the 12 Months to 31 March 2019 in April 2019. The draft 2018/19 Head of Internal Audit Opinion was received at the same meeting. Issues highlighted relating to 2018/19 at the draft stage were North East Essex and Suffolk Pathology Service, Annual Leave Management, The Cambridge Graduate Course in Medicine and Data Security and Protection Toolkit.

3.2 Annual Accounts Approval

3.2.1 The Committee reviewed the draft accounting policies proposed and considered the significant accounting estimates and judgements in advance of the production of the accounts.

3.2.2 The Committee reviewed the 2017/18 Annual Accounts, Annual Report and the Letter of Representation for the 12 months to 31 March 2018 and recommended these for approval by the Trust Board.

3.3 Terms of Reference

3.3.1 The Committee is required to review its Terms of Reference (ToR) during the year.

3.3.2 A revised version of the Terms of reference was agreed at the meeting in July 2018.

3.3.3 The key requirements included in the Terms of Reference, and whether they have been met during the year, have been considered in the Appendix to this report.

3.4 Governance Documents

3.4.1 The Committee has a duty to undertake a review of the Trust's Governance Documents every other year, unless there are matters that require review at an earlier date. These comprise the Standing Orders, Standing Financial Instructions and The Scheme of Delegation. These were reviewed at the Audit Committee meeting on 25 January 2019.

3.5 Governance

3.5.1 In respect of Governance the committees responsibilities are set out in the terms of reference as:

- The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives. The Audit Committee will look to the Quality & Risk Committee for assurance on items of clinical quality and corporate risk, including: health & safety, research and information governance.

3.5.2 The Committee achieved this through a number of actions:-

- Monitor and review the Annual Governance Statement
- Receiving the annual Head of Internal Audit opinion
- Receiving the audit report of the External Auditors on the Annual Accounts
- Reviewing the effectiveness of the Board Assurance Framework (with support from internal audit)

3.5.3 Board Assurance Framework Deep Dive Reviews – during the 2018/19 financial year the Committee conducted deep dive reviews of key areas within the Trust:

- Risk Appetite Session - BDO made a presentation on risk appetite and made an example of the 'Cost Concordia' to illustrate the failings in an organisation can be due to culture and employees not feeling able to speak out. BDO suggested that the Committee should consider what they felt was a tolerable level of risk that they would accept in the Organisation.
- EU Exit – Alex Baldwin made a presentation to the Committee on an audit deep dive undertaken in the Trust with the internal auditors. The three areas of focus were risk and preparation, review of business continuity planning and local suppliers. The Trust

is planning for a no deal scenario and it was noted that the Trust is as prepared as it could be at this stage. This was followed by a question and answer session and time for reflection.

3.6 Charitable Funds Annual Accounts

3.6.1 The Board delegated authority to the Audit Committee to approve the Charitable Fund accounts for the full year to 31 March 2018. The committee approved the accounts at its January 2019 meeting.

3.7 Clinical Audit

3.7.1 A clinical audit progress report is presented to the Committee at every meeting by the Deputy Chief Nurse or their representative.

4. Other work undertaken

4.1.1 Internal Audit

4.1.1.1 The Committee received the following reports from the Internal Auditors:-

- Progress report at every meeting including implementation of recommendations
- 2018/19 Internal Audit Plan – March 2018
- 2018/19 Head of Internal Audit Opinion – May 2018
- 2019/20 Internal Audit Plan – January 2019

4.1.1.2 RSM were re-appointed as the Trust's Internal Auditors from 1 April 2019 for a period of 3 years.

4.1.2 External Audit

4.1.2.1 The Committee received the following reports from the External Auditors:-

- 2017/18 Report to Those Charged with Governance (ISA 260) - May 2018
- 2017/18 Report on the Quality Report to the Council of Governors - May 2018
- 2017/18 Annual Audit Letter - July 2018
- 2017/18 Charitable Fund Accounts Report to Those Charged with Governance (ISA 260) - January 2019
- 2018/19 External Audit Plan- January 2019

4.1.3 Counter Fraud

4.1.3.1 The Committee received the following reports from the Local Counter Fraud Specialist provided by RSM:

- Progress Report- all meetings
- Regular Fraud Notices
- Counter Fraud Annual Report 2017/18 – July 2018
- Fraud and Bribery Assessment – January 2019
- Counter Fraud Annual Plan 2019/20- January 2019

4.1.3.2 RSM were appointed as the Trust's Local Counter Fraud Specialists from 1 April 2019 for a period of 3 years.

5. Audit Committee Responsibilities – performance

5.1 As part of its responsibilities the Committee should assess its performance against its terms of reference not less than every 2 years. The Committee completed the HFMA self-assessment checklist in July 2018. This will be completed again in 2020.

6. Audit Committee Impact

6.1 It is important that the Audit Committee makes an impact on the Trust, particularly around ensuring the robustness of the Governance Structure.

6.2 In assessing this, it is important to note that the main reports submitted to the Committee by External and Internal Audit supported the robustness of the Governance structure.

6.3 There were a number of specific areas where the Committee undertook action to address issues or where specific items were raised and discussed amongst these were:

- The Committee received reports on losses and special payments at each meeting. Where levels of pharmacy losses exceeded the tolerance of 0.4% of issues a more detailed analysis was undertaken.
- The majority of other losses related to bad debts and patient property.
- The Committee received reports on waivers and critically reviewed the drivers behind the number of waivers.
- The Trust critically reviewed management responses to Internal and External Audit Reports to ensure risks were being managed adequately and in a timely manner.

6.4 The above items reflect that the Committee has had a positive impact on the governance arrangements of the Trust

7. Conclusion

7.1 This report highlights the main areas of work undertaken by the Audit Committee during the period. It demonstrates that the Committee operated effectively and had a positive impact on the Trust.

7.2 The Committee is asked to review the report, make any changes and approve a final version for submission to the Trust Board.

Appendix – Key requirement included in Terms of Reference

Para Ref	Requirement of Terms of Reference	Requirement Met?	Date
5.6	Committee to hold a private meeting with both Internal and External Audit.	✓	November 2018
6.1	Meetings will be held at least three times a year.	✓	May 2018, July 2018, November 2018, January 2019
8.1.1.2	Monitor and review the effectiveness of systems of internal financial and budgetary control and the integrity of reporting statements.	✓	Completed through Internal Audit reviews
8.1.1.3	Monitor and review the effectiveness of systems for ensuring the optimum collection of income.	✓	Completed through Internal Audit reviews
8.1.1.4	Monitor and review the effectiveness of risk management systems.	✓	Completed through Internal Audit reviews
8.1.1.5	Monitor and review the effectiveness of the Board Assurance Framework (BAF).	✓	Every meeting
8.1.1.6	Use of a 'deep dive' programme of reviews to test the BAF.	✓	Every meeting
8.1.1.7	Monitor and review the Quality Report assurance and review alongside the Annual Report and Accounts.	✓	May 2018 for the 2017/18 Quality Report
8.1.1.8	Monitor and review the systems for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements.	✓	Completed through relevant reviews throughout the year
8.1.1.9	Monitor and review the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud Authority.	✓	Completed through Counter Fraud reviews
8.1.4	Review the minutes from the Quality & Risk Committee.	✓	Every meeting
8.2 & 8.2.5	Review of the effectiveness and quality of the Internal Audit Function.	✗	Performance for 2018/19 considered as part of the tender process, however this will formally be completed going forward.
8.2.2	Review of the Internal Audit Strategy and Operational Plan.	✓	January 2019 for 2019/20 Audit Plan
8.2.3	Consideration of major findings of Internal Audit investigations and the effectiveness of the management response.	✓	Every meeting
8.3	Review of the effectiveness of the Counter Fraud Service.	✗	Performance for 2018/19 considered as part of the tender process, however this will formally be completed going forward.
8.3.2	Consideration of major findings of Counter Fraud investigations and the effectiveness of the management response.	✓	Every meeting

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Appendix – Key requirement included in Terms of Reference

Para Ref	Requirement of Terms of Reference	Requirement Met?	Date
8.3.4	Receipt and review of the annual review of work undertaken by the Counter Fraud Service.	✓	July 2018 for 2017/18.
8.4	Review of the effectiveness and quality of the External Audit Function, including their independence.	✓	July 2018 (for 2017/18 performance).
8.4.3 & 8.4.4	Review of the External Audit Plan, before the audit commences.	✓	January 2019 for the 2018/19 Audit.
8.4.5	Review reports from External Audit, together with management responses.	✓	May 2018
8.5.1	Review the Annual Report and Financial Statements of the Trust and the Charitable Funds, covering: • The Annual Governance Statement • Changes in, and compliance with, accounting policies • Explanation of estimates and provisions having a material effect • Unadjusted misstatements • Major judgemental areas • Schedule of losses and special payments • Significant adjustments resulting from the audit. These are reviewed prior to endorsement by the Board of Directors (for the Trust accounts).	✓	May 2018 for the Trust's 2017/18 Annual Report and Accounts. January 2019 for the 2017/18 Charitable Fund's Annual Report and Accounts.
8.6.1	Review changes to Standing Orders, Standing Financial Instructions and Scheme of Delegation.	✓	January 2019
8.7.1	Review Schedule of Waivers.	✓	July 2018, November 2018
8.7.2	Review schedules of losses and compensations.	✓	July 2018, November 2018
8.7.3	Monitor the process to ensure that Supply Chain Risk is identified and appropriate actions have been taken.	✓	April 2018
9.2	Review the Terms of Reference Annually.	✓	July 2018
9.3	Undertake a self-assessment of the Audit Committee performance (bi-annually).	✓	July 2018
9.4	Complete an Annual Report on activities of the Audit Committee.	✓	July 2019 (for review of 2018/19)

Audit Committee – 26 July 2019

Agenda item:	9.2			
Presented by:	Liana Nicholson, Assistant Director of Finance			
Prepared by:	Liana Nicholson, Assistant Director of Finance			
Date prepared:	11 July 2019			
Subject:	Annual Review of Terms of Reference			
Purpose:		For information	✓	For approval

Executive summary:

The Committee is required to review its Terms of Reference annually. The previous Terms of Reference are included within this report with some minor suggested highlights made using tracked changes. The Committee last completed a self-assessment exercise in July 2018 and issues highlighted by Members were incorporated within the Terms of Reference. The self-assessment exercise is required to be completed bi-annually.

The Terms of Reference adopted by the Trust are in line with the model Audit Committee Terms of Reference that are included within the HFMA Audit Committee Handbook.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
	✓	✓	✓

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

Previously considered by:	*The Terms of Reference were last reviewed in July 2018.*
Risk and assurance:	*The HFMA Audit Committee Handbook has been used to inform the review of the Terms of Reference.*
Legislation, regulatory, equality, diversity and dignity implications	

Recommendation:
The Committee is asked to review and approve or change the suggested amendments to the Committee's Terms of Reference.

AUDIT COMMITTEE TERMS OF REFERENCE

1 Constitution

1.1 The Board of Directors hereby resolves to establish a Committee of the Board to be known as the Audit Committee (the Committee). The Committee is a non-executive committee of the Board of Directors and has no executive powers, other than those specifically delegated in these Terms of Reference.

2 Aim

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

3 Scope

3.1 The Committee has overarching responsibility for monitoring specific elements of the systems and processes relating to governance, including financial systems, records and controls; financial information; compliance with law, guidance and codes of conduct; independence of internal and external audit; and the control environment (including measures to prevent and detect fraud). The Committee is responsible for providing an opinion as the adequacy of the integrated governance arrangements and Board Assurance Framework.

3.2 The Committee has a statutory role in respect of assurance, controls, compliance, data and probity. The aim is to ensure complete coverage while avoiding duplication by close liaison and cross-representation between these committees

4 Membership

4.1 The Committee shall be appointed by the Board of Directors from amongst the Non-executive Directors of the Trust and shall consist of no fewer than three members, one of whom has recent and relevant finance experience. One of the members will be appointed Chair of the Committee by the Board of Directors.

4.2 The Trust Chair will ensure that there is cross-representation by Non-executive directors on the Audit Committee and the Quality & Risk Committee and its Sub-Committees.

4.3 A quorum will be two members.

4.4 The Chair of the Trust shall not be a member of the Committee.

5 Attendance at Meetings

5.1 The Director of Resources and the Trust Secretary will normally attend all Committee meetings.

5.2 The Head of Internal Audit and a representative of the Trust's External Auditors will attend as necessary.

5.3 Other members of the Board of Directors have the right of attendance at their own discretion.

5.4 All other attendances will be at the specific invitation of the Committee.

5.5 The Committee will have the over-riding authority to restrict attendance under specific circumstances.

5.6 The Committee will meet with the External and Internal Auditors, without any other Board Director present at least once a year.

5.7 Attendance at meetings will be recorded as part of the normal process of the meeting. A record of attendance will be reported as part of the Committee's Annual Report.

6 Frequency of Meetings

6.1 Meetings will normally be held at least three times a year.

6.2 Special meetings may be convened by the Board of Directors or the Chair of the Committee.

6.3 The External Auditors or Internal Auditors may request a meeting if they consider that one is necessary.

7 Authority

7.1 The Board of Directors authorises the Committee to investigate any activity within its duties (as detailed below) and grants to the Committee complete freedom of access to the Trust's records, documentation and employees. This authority does not extend, other than in exceptional circumstances, to confidential patient information.

7.2 The Committee may seek any information (excluding confidential patient information, other than in exceptional circumstances) or explanation it requires from the Trust's employees who are directed to co-operate with any request made by the Committee.

7.3 The Trust Board authorises the Committee to obtain external professional advice or expertise if the Committee considers this necessary.

8 Duties and Responsibilities

The duties and responsibilities of the Committee are as follows:

8.1 Governance and Assurance

8.1.1 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives. The Audit Committee will look to the Quality & Risk Committee for assurance on items of clinical quality and corporate risk, including: health & safety, research and information governance.

In particular, the Committee shall independently monitor and review:

8.1.1.1 the Annual Governance Statement (AGS) and the assurance system for all other external disclosure statements such as declarations of compliance with the Care Quality Commission registration, and any formal announcements relating to the Trust's financial performance, together with any accompanying Head of Internal Audit opinion, external

audit opinion or other appropriate independent assurances, prior to endorsement by the Board of Directors.

8.1.1.2 the effectiveness of systems of internal financial and budgetary control and the integrity of reporting statements.

8.1.1.3 the effectiveness of systems for ensuring the optimum collection of income.

8.1.1.4 the effectiveness of risk management systems.

8.1.1.5 the effectiveness of the Board Assurance Framework (BAF).

8.1.1.6 The Committee will use a programme of 'deep dive' reviews to test the BAF and its priority areas as part of an assurance programme. The Committee's assessment of the effectiveness of the BAF should be included in the Committee's Annual Report to the Board of Directors.

8.1.1.7 the Quality Report assurance and review alongside the annual report and accounts.

8.1.1.8 the systems for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements, including the NHS Constitution, as set out in relevant guidance.

8.1.1.9 the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud Authority.

8.1.1.10 arrangements by which staff may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters, ensuring that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

8.1.2 In carrying out this work, the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

8.1.3 This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

8.1.4 The Committee will receive the minutes of the Quality & Risk Committee for the purpose of ensuring: that there is no duplication of effort between the two Committees; that no area of assurance is missed and; as part of its responsibility for reviewing the Annual Governance Statement prior to submission to the Board of Directors.

8.1.5 The Audit Committee shall ensure that there is a system for reviewing the findings of other significant assurance functions, both internal and external to the organisation and consider the implications to the governance of the organisation. These will include, but will not be limited to, NHS Improvement, any reviews by DH Arms length bodies or regulators/inspectors (CQC, NHS Resolution etc) and professional bodies with responsibility for the performance of staff or functions (eg Royal Colleges, accreditation bodies etc.)

8.1.6 In addition the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include the Quality & Risk Committee, its subcommittees and any other quality, risk, governance and assurance committees that are established. The conclusion of this review should be referred to specifically in the Committee's Annual Report to the Board of Directors.

8.1.7 The Committee will consider how its work integrates with wider performance management and standards compliance and include this within the Annual Report to the Board of Directors.

8.1.8 In reviewing the work of the Quality & Risk Committee and issues around clinical risk management, the Audit Committee will wish to satisfy themselves on the assurance that the Quality & Risk Committee gains from the clinical audit function.

8.1.9 The Audit Committee will receive assurance on the arrangements for clinical audit within the Trust, including the process by which clinical audits are selected and agreed actions implemented.

8.2 Internal Audit

The Committee shall ensure that there is an effective internal audit function established by management, which meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and the Board of Directors. An Internal Audit Charter will be agreed annually which will include objectives, responsibilities and reporting lines. This will be achieved by:

8.2.1 considering the appointment of the internal audit service, the audit fee and any questions of resignation and dismissal.

8.2.2 the review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Board Assurance Framework.

8.2.3 consideration of the major findings of internal audit investigations, the effectiveness of the management's response and ensuring co-ordination between the Internal and External Auditors to optimise audit resources.

The will include exception reports of management action beyond deadline and consideration of the findings of Internal Audit "testing" of completed actions.

8.2.4 ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the Trust.

8.2.5 assessing the quality of internal audit work on an annual basis.

8.2.6 Ensuring any material objection to the completion of an assignment which has not been resolved through negotiation is brought to the Committee by the Chief Executive Officer or Director of Resources with a proposed solution for a decision.

8.3 Counter Fraud

The Committee shall ensure that there is an effective counter fraud function established by management that meets the Standards set out by the NHS Counter Fraud Authority and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board of Directors. This will be achieved by:

8.3.1 consideration of the provision of the Counter Fraud service, the cost of the audit and any questions of resignation and dismissal.

8.3.2 consideration of the major findings of counter fraud work (and management's response).

8.3.3 ensuring that the Counter Fraud function is adequately resourced and has appropriate standing within the organisation.

8.3.4 receiving an annual review of the work undertaken by the counter fraud function.

8.4 External Audit

The Committee shall review the work and findings of the External Auditor appointed by the Council of Governors and consider the implications and management's responses to their work.

8.4.1 Consideration of the appointment, performance and cost effectiveness of the External Auditor, making a recommendation to the Council of Governors on appointment of External Audit.

8.4.2 To ensure that the External Auditor remains independent in its relationship and dealings with the Trust and to review the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements;

8.4.3 To review the annual audit plan and to discuss with the External Auditor, before the audit commences, the nature and scope of the audit.

8.4.4 As part of the audit plan, discuss with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee

8.4.5 To review External Audit reports, including value for money reports and management letters, together with the management response.

8.4.6 To consider where the external auditors might profitably undertake investigative and advisory work, taking into account relevant ethical guidance regarding the provision of non-audit services by the external audit firm.

8.4.7 To develop and implement policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance regarding the provision of non-audit services by the external audit firm; and

8.4.8 To assess the quality of external audit work on an annual basis.

8.5 Financial Reporting

8.5.1 The Audit Committee shall review the Annual Report and Financial Statements of the Trust and its Charitable funds before submission to the Board, to determine their completeness, objectivity integrity and accuracy. This review will cover but is not limited to:

- the wording in the Annual Governance Statement (AGS) and other disclosures relevant to the Terms of Reference of the Committee;

- changes in, and compliance with, accounting policies and practices;
- explanation of estimates and provisions having material effect;
- unadjusted mis-statements in the financial statements;
- major judgemental areas;
- the schedule of losses and special payments; and
- significant adjustments resulting from the audit.

8.6 Key Trust Documents

8.6.1 Review proposed changes to Standing Orders, Standing Financial Instructions, Scheme of Delegation and Matters Reserved to the Board for approval by the Board of Directors.

8.6.2 To examine the circumstances of any significant departure from the requirements of any of the foregoing, whether those departures relate to a failing, an overruling or a suspension.

8.6.3 To review the Standing Orders, Standing Financial Instructions, Scheme of Delegation and Matters Reserved to the Board on a two yearly basis for approval by the Board of Directors.

8.7 Other

8.7.1 Review compliance with Standing Orders and Standing Financial Instructions through a schedule of waivers

8.7.2 Review schedules of losses and compensations

8.7.3 Monitor the process to ensure that Supply Chain Risk is identified and appropriate actions have been taken.

8.7.4 Entries recorded in the gifts and hospitality register would be considered on an exception basis as reported by the panel considering the entries made.

9 Reporting, Accountability, Monitoring and Review of Effectiveness

9.1 The Minutes of Audit Committee meetings shall be formally recorded and submitted to the Board of Directors along with a report of its activities no less often than three times a year; The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

9.2 The Audit Committee shall review its terms of reference annually;

9.3 The Audit Committee shall carry out a self-assessment in relation to its own performance no less than once every two years, reporting the results to the Board of Directors;

9.4 An annual report of the activities of the Audit Committee shall be presented to the Board of Directors and the Council of Governors, identifying any matters in respect of which it considers that action or improvement is needed and making recommendations as to the steps to be taken.

9.5 A separate section of the Trust's annual report will describe the work of the committee in discharging its responsibilities.

9.6 The Committee will report to the Board planned future workload and priorities for approval.

9.7 The Committee will agree on an annual basis a reporting framework for all areas of it terms of reference. This determines standing items for the agenda and items for regular reporting.

9.8 Maintain and monitor performance against the agreed reporting framework.

9.9 Follow-up agreed actions to ensure these are implemented in a timely and effective manner.

Draft submitted to Audit Committee on 19 July 2019.

24. Digital board report

To ACCEPT the report, including update on community IT

For Report

Presented by Craig Black

Trust Board Meeting – 27 September 2019

Agenda item:	24			
Presented by:	Craig Black, Executive Director of Resources			
Prepared by:	Sarah Judge, Digital Operational Lead			
Date prepared:	19 September 2019			
Subject:	To receive update from Digital Board			
Purpose:	X	For information		For approval

Executive summary:
This paper confirms key points of interest raised and discussed at the Digital Board on 25 July 2019.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
	X	**X**	**X**

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

Previously considered by:	*Separate pillar group meetings and Digital Board.*
Risk and assurance:	*Full risks are reviewed at each meeting with any high level risks reported through to board assurance framework as appropriate.*
Legislation, regulatory, equality, diversity and dignity implications	*GDPR consideration is applied to all projects.*

Recommendation:
The Board is asked to note the update.

1. Background

1.1 In May 2016, the trust embarked on a major change programme to introduce a new electronic patient record (EPR). The programme was branded e-Care. Since our initial go-live, a rolling programme of additional functionality has continued.

1.2 In the last year the following additions and enhancements have been made:

- OpenEyes (new ophthalmology system) has been deployed to support the cataract pathway in the Eye Treatment Centre.
- Cerner Millenium (the main EPR in use across the Trust) is now live across theatres and anaesthetics both in main theatres and the Day Surgery Unit, including integrated bedside anaesthetic monitoring.
- Upgrades to Cerner Millennium functionality including recording of intra-venous fluids, management of deteriorating patients, improved clinical alerting and documentation for medical staff, and integration of radiology PACS viewing.
- Implementation of a new mortuary system, Eden.
- Medic Bleep has replaced non-urgent pagers across the West Suffolk Hospital.
- New cardiology EPR, Solus, has been deployed.
- In-house development of a clinical photography app.

1.3 The West Suffolk Hospital NHS Foundation Trust (WSFT) was one of 16 hospitals chosen to become a flagship Global Digital Exemplar (GDE). Our GDE programme is coming to an end with some programmes of work continuing – in particular the achievement of HIMSS level 6 and 7 accreditation.

1.4 Our GDE programme comprised of four pillars:

Pillar 1	Digital acute trust	Completing the internal journey of digitisation
Pillar 2	Supporting the integrated care organisation	Creating the digital platform to support the regional ambitions of integrated care and population health.
Pillar 3	Exemplar digital community	Building the organisation into a centre of digital excellence and acting as mentor and guide for other developing organisations.
Pillar 4	Hardware and infrastructure	Ensuring that we have a robust and compliant infrastructure at the foundation of the programme

As the GDE programme nears completion, Pillar 3 has now changed focus to concentrate on our digital programme in the community. The original aim to share our learning from digital implementations continues with four out of five blueprints submitted to NHS Digital for sharing across the NHS, several of which have been first of type in the UK.

2. HIMSS accreditation

2.1 Application for HIMSS 6 and 7 accreditation is a requirement of the GDE programme. Several of the ongoing projects will help us achieve HIMSS 6 accreditation and work continues to deliver on HIMSS 7 standards whilst these projects are ongoing. A focus for HIMSS 7 is the embedding and pervasive use of digital systems across the hospital and this is underway.

3. Pillar one

3.1 The e-Care team continues to work on the closed loop approaches for medication management and blood transfusion. ‘Closed loop’ is where digital systems can account for and track medication or blood products, from issue to patient administration. These projects

are complex and the digital board noted that the previously agreed deadline to apply for HIMSS 6, of which these are a requirement, would be delayed as a result.

3.2 The medication management project is working closely with NHS Digital and other trusts across the UK to determine the best approach to manage the medication catalogue and integration with pharmacy systems.

3.3 The 'closed loop' blood transfusion project is currently in procurement to find the most appropriate solution.

3.4 MModal (voice recognition software) go live has been postponed due to concerns with workflows and lack of quality in the voice recognition. A softer go live is likely, with roll-out to specialities that do not have administrative support initially.

3.5 The Medic Bleep go live was successful in June 2019. The digital board was provided with an review of the project and go live. In particular, the project experienced challenges with connectivity, bring-your-own-device and ongoing app development. There are now over 3000 users on the system, with 'baton roles' (passing of on-call virtual pagers) between staff working well. Emergency pagers (those using the 2222 system) remain. Ongoing optimisation will be necessary, particularly around messaging etiquette.

3.6 The project to embed e-Care across our maternity services is underway, with go live planned for spring 2020.

4. Pillar two

4.1 The population health programme continues, with the atrial fibrillation (AF) dashboard going live soon. This will amalgamate acute and GP health data to display where AF patients are located that are most at risk or not on treatment. It was noted that this was genuinely innovative and ground breaking.

4.2 The patient portal project has been on hold due to prioritising population health but will recommence shortly.

4.3 The trust's health information exchange (HIE) is behind schedule but additional resource has been recently allocated which should accelerate the project. Local data sharing agreements are progressing. As well as GP records, discussions are continuing about how this can be used in social care and mental health.

5. Pillar three

5.1 The community digital programme is a significant focus for the organisation. Additional support for the governance has also been provided with Helen Beck, chief operating officer, as chair of the Pillar 3 board meetings and Sarah Judge, digital operational lead, taking up the role of chief clinical information officer for community services.

5.2 There is a programme of work to refresh the ageing hardware across the community sites. Discussions around the community IT contract with NEL CSU are ongoing, as are discussions regarding the provision of support for SystmOne that is currently held by ESNEFT.

5.3 The programme is developing into defined workstreams, including for engagement/communication and transformation, providing structure and clarity to the many

5.4 In September 2019, e-Care went live on Rosemary ward at Newmarket hospital allowing staff to fully record patient care and treatment as well as benefitting from access to the comphrehensive electronic record. This is our first delivery of full e-Care access at a site remote from the main hospital.

6. Pillar four

6.1 A number of projects are rated red in this pillar, some of which have missed their completion dates due to resources in use on other projects such as Medic Bleep. There is currently a backlog of IT work.

7. Recommendation

6.1 The board is asked to note the report.

25. Council of Governors report

To ACCEPT the report

Presented by Sheila Childerhouse

Board of Directors – 27 September 2019

Agenda item:	25			
Presented by:	Sheila Childerhouse			
Prepared by:	Georgina Holmes, Foundation Trust Office Manager			
Date prepared:	4 September 2019			
Subject:	Report from Council of Governors meeting - 6 August 2019			
Purpose:	X	For information		For approval

This report provides a summary of the business considered at the Council of Governors meeting held on 6 August 2019. The report is presented to the board of directors for information to provide insight into these activities. Key points from the meeting were:

- The Chair reported that Garry Sharp had stepped down as a staff governor and she recorded her and the Council of Governors' thanks for his contribution whilst in this role. Dr Vinod Shenoy, who was the next highest polling candidate, had been invited to join the Council of Governors.
- A written report was received from the Chair which provided a summary of the focus of the meetings and activities that she had been involved in over the last three months.
- The Chief Executive's report provided an update on the challenges facing the Trust and recent achievements. Nick Jenkin's presented this report in his absence and highlighted the Shining Lights awards, medic bleep and the ongoing pressures on the hospital and the plans that were being put in place for winter.
- Responses to governors' issues raised were received and further discussion took place on a number of these.
- The finance and quality and performance reports were reviewed and questions asked on areas of challenge.
- A report was received from Denise Pora on the Trust's inclusion objectives.
- An update was received on pathology services and it was proposed that a two page summary of the final version of the pathology strategy should be produced for governors.
- An update was received on the Alliance and STP.
- It was noted that the annual report and accounts for 2018/19 were available on the Trust's website or a hard copy was available on request. Richard Jones thanked those governors who had reviewed and commented on the quality report.
- The annual audit letter and quality report limited assurance review were received. Matthew Weller from BDO attended the meeting to answer any questions.
- The Council of Governors agreed to the recommendation that BDO should remain in appointment as the Trust's external auditors until their current contract ended and that their contract should be extended for one further year at the same price (ending in 2020/21) after which a re-tendering exercise would be undertaken (starting July 2020).
- A report was received from the nominations committee and it was noted that the Chair and NEDs had attended individual appraisal feedback meetings.
- A report from the engagement committee was received, including a response to the issue they had

escalated relating to the changes made in the Courtyard Café

- Reports were received from the lead governor and staff governors.
- Future dates for Council of Governors meetings and the annual members meeting for 2019 and 2020 were noted.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
	X	X	X

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

Previously considered by:	Report received by the Board of Directors for information to provide insight into the activities and discussions taking place at the governor meetings.
Risk and assurance:	Failure of directors and governors to work together effectively. Attendance by non-executive directors at Council of Governor meetings and vice versa. Joint workshop and development sessions.
Legislation, regulatory, equality, diversity and dignity implications	Health & Social Care Act 2012. Monitor's Code of Governance.

Recommendation:

- The Board is asked to note the summary report from the Council of Governors.

26. Agenda items for next meeting

To APPROVE the scheduled items for the next meeting

For Approval

Presented by Richard Jones

Board of Directors – 27 September 2019

Agenda item:	26			
Presented by:	Richard Jones, Trust Secretary & Head of Governance			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	19 September 2019			
Subject:	Items for next meeting			
Purpose:		For information	X	For approval

The attached 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.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
	X	X	X

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

Previously considered by:	The Board receive a monthly report of planned agenda items.
Risk and assurance:	Failure effectively manage the Board agenda or consider matters pertinent to the Board.
Legislation, regulatory, equality, diversity and dignity implications	Consideration of the planned agenda for the next meeting on a monthly basis. Annual review of the Board's reporting schedule.

Recommendation:

To approve the scheduled agenda items for the next meeting

Scheduled draft agenda items for next meeting – 1 November 2019

Description	Open	Closed	Type	Source	Director
Declaration of interests	✓	✓	Verbal	Matrix	All
Deliver for today					
Patient story		✓	Verbal	Matrix	Exec.
Chief Executive's report	✓		Written	Matrix	SD
Integrated quality & performance report	✓		Written	Matrix	HB/RP
Finance & workforce performance report	✓		Written	Matrix	CB
Transformation report – Q2	✓		Written	Matrix	HB
Workforce plan – update on workstream to tackle high sickness levels.	✓		Written	Action point - 1707	KR
Risk and governance report, including risks escalated from subcommittees		✓	Written	Matrix	RJ
Invest in quality, staff and clinical leadership					
Nurse staffing report	✓		Written	Matrix	RP
Mandatory training report	✓		Written	Matrix	KR
Appraisal report	✓		Written	Matrix	KR
"Putting you first award"	✓		Verbal	Matrix	JB
Consultant appointment report	✓		Written	Matrix – by exception	JB
Safe staffing guardian report – Q2	✓		Written	Matrix	NJ
Freedom to speak up guardian – Q2	✓		Written	Matrix	KR
Antenatal and newborn screening	✓		Written	Matrix	HB
Organisational development update	✓		Written	Matrix	KR
Staff Health and Wellbeing annual update	✓		Written	Matrix	KR
Serious Incident, inquests, complaints and claims report		✓	Written	Matrix	RP
Build a joined-up future					
West Suffolk Alliance report	✓		Written	Matrix	KV/HB
Strategic update, including Alliance, System Executive Group and System Transformation Partnership (STP)		✓	Written	Matrix	SD
Governance					
Trust Executive Group report	✓		Written	Matrix	SD
Quality & Risk Committee report	✓		Written	Matrix	SC
Digital board report, including community IT update	✓		Written	Matrix	CB
Scrutiny Committee report, including networked pathology strategy		✓	Written	Matrix	GN
Confidential staffing matters		✓	Written	Matrix – by exception	JB
Use of Trust seal	✓		Written	Matrix – by exception	RJ
Agenda items for next meeting	✓		Written	Matrix	RJ
Annual review of governance		✓	Written	Matrix	RJ

Reflections on the meetings (open and closed meetings)		✓	Verbal	Matrix	SC

27. Use of Trust seal

To NOTE report

For Report

Presented by Richard Jones

Trust Board Meeting – 27 September 2019

Agenda item:	27			
Presented by:	Richard Jones, Trust Secretary & Head of Governance			
Prepared by:	Karen McHugh, PA			
Date prepared:	September 2019			
Subject:	Use of Trust's seal			
Purpose:	X	For information		For approval

Executive summary:

To note use of the Trust Seal, pursuant to Standing Order section 8. The Trust Seal was used on the following occasions:

Seal No. 133
West Suffolk NHS Foundation Trust lease to EE - Sealed by Craig Black, witnessed by Gemma Wixley (27 July 2019)

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
			X

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

Previously considered by:	None
Risk and assurance:	None
Legislation, regulatory, equality, diversity and dignity implications	WSFT's Standing orders

Recommendation:

To note the use of the Trust's seal

11:30 ITEMS FOR INFORMATION

28. Any other business

To consider any matters which, in the opinion of the Chair, should be considered as a matter of urgency

For Reference

Presented by Sheila Childerhouse

29. Date of next meeting

29.1. To NOTE that the next meeting will be held on Friday, 1 November 2019 at 9:15 am in Quince House, West Suffolk Hospital

For Reference

Presented by Sheila Childerhouse

29.2. To NOTE meeting dates for 2020/21

For Reference

Presented by Sheila Childerhouse

NHS
West Suffolk
NHS Foundation Trust

TRUST BOARD MEETING DATES

2020/21

Open (Public) Session commences 9.15am – 11.15am
Closed (Private) Session commences 11.30am – 1.00pm

Friday 31 January

Friday 28 February

Friday 27 March

Friday 24 April

Friday 22 May

Friday 26 June

Friday 31 July

No meeting in August

AMM - 22 September

Friday 2 October

Friday 6 November

Friday 4 December

Friday 29 January 2021

Friday 26 February 2021

Friday 26 March 2021

Board meetings are normally held in the Northgate Room, Quince House, WSFT, Hardwick Lane, Bury St Edmunds. IP33 2QZ.

Please check the website for location prior to the meeting.

RESOLUTION TO MOVE TO CLOSED SESSION

30. 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

Presented by Sheila Childerhouse