NHS
West Suffolk
NHS Foundation Trust

Board of Directors (In Public)

Schedule	Friday 26 June 2020, 9:15 AM — 11:20 AM BST
Venue	Via video conferencing
Description	A meeting of the Board of Directors will take place on Friday, 26 June 2020 at 9:15. The meeting will be held virtually via electronic communications
Organiser	Karen McHugh

Agenda

AGENDA
Presented by Sheila Childerhouse

9:15 GENERAL BUSINESS
Presented by Sheila Childerhouse

1. Resolution
   The Trust Board is invited to adopt the following resolution:
   "That representatives of the press, and other members of the public, be excluded from the meeting having regard to the guidance from the Government regarding public gatherings."
   For Reference - Presented by Sheila Childerhouse

2. Apologies for absence
   To NOTE any apologies for the meeting and request that mobile phones are set to silent
   For Reference - Presented by Sheila Childerhouse

3. Declaration of interests for items on the agenda
   To NOTE any declarations of interest for items on the agenda
   For Reference - Presented by Sheila Childerhouse

4. Questions from the public relating to matters on the agenda
   To RECEIVE questions from members of the public of information or clarification relating only to matters on the agenda
   Presented by Sheila Childerhouse

5. Review of agenda
   To AGREE any alterations to the timing of the agenda.
   For Reference - Presented by Sheila Childerhouse

6. Minutes of the previous meeting
   To APPROVE the minutes of the meeting held on 29 May 2020
   For Approval - Presented by Sheila Childerhouse

   Item 6 - Open Board Minutes 2020 05 29 May Draft.docx

7. Matters arising action sheet
   To ACCEPT updates on actions not covered elsewhere on the agenda
   For Report - Presented by Sheila Childerhouse

   Item 7 - Action sheet report.doc

8. Chief Executive's report
   To RECEIVE a report on current issues
   For Report - Presented by Stephen Dunn

   Item 8 - Chief Exec Report Jun '20.doc

9:40 DELIVER FOR TODAY

9. COVID-19 report
   To RECEIVE a briefing
   For Report - Presented by Helen Beck

9.1. COVID infection prevention and control assurance framework
   To receive a report
   For Report - Presented by Susan Wilkinson

   Item 9.1 - COVID IPC assurance framework.docx

10. Integrated quality and performance report
   To APPROVE a report
   For Approval - Presented by Helen Beck and Susan Wilkinson

   Item 10 - Performance Report June 2020.doc

   Item 10 - Performance Trust Board Report June V3.0.pdf

11. Finance and workforce report
To ACCEPT the report
For Report - Presented by Craig Black

Item 11 - Finance and workforce report cover sheet - M02.docx

Item 11 - Finance Report- May 20 FINAL.docx

10:30 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

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12. Nurse staffing report
To ACCEPT the report
For Report - Presented by Susan Wilkinson

Item 12 - Nurse staffing report June 2020.docx

Item 12 - Nursing WSFT Dashboard - May 2020 Final.xls

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13. Medical revalidation annual report
To accept the report
For Report - Presented by Nick Jenkins

Item 13 - Responsible Officer Annual Report 19-20.doc

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14. Trust improvement plan
To APPROVE the report
For Approval - Presented by Susan Wilkinson

Item 14 - Trust improvement report.docx

Item 14 Annex A - Trust improvement plan.pdf

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15. Consultant appointment report
To ACCEPT the report
For Report - Presented by Jeremy Over

Item 15 - Consultant appointment report - June 2020.doc

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16. Putting you first award
To NOTE a verbal report of this months winner
For Reference - Presented by Jeremy Over

11:00 BUILD A JOINED-UP FUTURE

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17. Pathology services report
To RECEIVE the report
For Report - Presented by Craig Black and Nick Jenkins

Item 17 - Pathology Update Paper - Trust Board June 2020.doc

11:10 GOVERNANCE

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18. Trust Executive Group report
To ACCEPT the report
For Report - Presented by Stephen Dunn

Item 18 - TEG report.doc

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19. Charitable Funds committee report
To ACCEPT the report
For Report - Presented by Alan Rose

Item 19 - Charitable Funds Board Report.docx

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20. Quality & Risk committee report
To ACCEPT report
For Approval - Presented by Sheila Childerhouse

Item 20 - Quality and Risk Committee.docx

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21. General condition 6 and Continuity of Services condition 7 certificate
To ACCEPT the report
For Approval - Presented by Richard Jones

Item 21 - NHSI Certification June 20.doc

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22. Agenda items for next meeting
To APPROVE the scheduled items for the next meeting
For Approval - Presented by Richard Jones

Item 22 - Items for next Board meeting.doc

11:20 ITEMS FOR INFORMATION

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23. 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

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24. Date of next meeting
To NOTE that the next meeting will be held on Friday, 31 July 2020 at 9:15am in West Suffolk Hospital
For Reference - Presented by Sheila Childerhouse

RESOLUTION TO MOVE TO CLOSED SESSION

25. 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
For Reference - Presented by Sheila Childerhouse

9:15 GENERAL BUSINESS

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DRAFT

MINUTES OF BOARD OF DIRECTORS MEETING

HELD ON 29 MAY 2020 AT WEST SUFFOLK HOSPITAL
Via Microsoft Teams

COMMITTEE MEMBERS			
		Attendance	**Apologies**
Sheila Childerhouse	Chair	•	
Helen Beck	Chief Operating Officer	•	
Craig Black	Executive Director of Resources	•	
Richard Davies	Non Executive Director	•	
Steve Dunn	Chief Executive	•	
Angus Eaton	Non Executive Director	•	
Nick Jenkins	Executive Medical Director	•	
Gary Norgate	Non Executive Director	•	
Jeremy Over	Executive Director of Workforce and Communications	•	
Louisa Pepper	Non Executive Director	•	
Rowan Procter	Executive Chief Nurse	•	
Alan Rose	Non Executive Director	•	
In attendance			
Georgina Holmes	Trust Office Manager *(minutes)*		
Richard Jones	Trust Secretary		
Tara Rose	Head of Communications		
Kate Vaughton	Director of Integration and Partnerships		
Francesca Crawley	Guardian of Safe Working Hours		
Governors in attendance (observation only)			
Peter Alder, Florence Bevan, June Carpenter, Judy Cory, Gordon McKay, Joe Pajak, Jane Skinner, Liz Steele, Martin Wood			

Action

GENERAL BUSINESS

20/93 RESOLUTION

The board agreed to adopt the following resolution:
"That representatives of the press, and other members of the public, be excluded from the meeting having regard to the guidance from the Government regarding public gatherings."

20/94 APOLOGIES FOR ABSENCE

There were no apologies for absence.

- The Chair referred to the fact that this would be the last board meeting for Rowan Procter, Gary Norgate and Tara Rose. She thanked them for everything they had contributed to WSFT and wished them all the best for the future int their new roles.
- Nigel Beeton, Imaging Services Manager, was retiring today after 40 years of service. He had always exemplified the best of WSFT and been very supportive of his team.

20/95 DECLARATION OF INTERESTS FOR ITEMS ON THE AGENDA

There were no declarations of interest.

20/96 QUESTIONS FROM THE PUBLIC RELATING TO MATTERS ON THE AGENDA

Q Could assurance be given that where possible social distancing was being observed and reinforced by staff in the hospital? From experience this did not appear to be the case particularly with staff smoking on the heath or walking around the grounds of the Trust.

A It was important that staff adhered to social distancing rules and set an example. They were regularly reminded in briefings etc and this message would continue to be reinforced.

Q There appeared to be health inequality issues facing BAME staff during the pandemic. What was WSFT doing for its BAME staff and was there any current data to show that COVID was having a greater impact on its BAME staff as was the case nationally?

A There was a national, regional and local focus on this. This had been discussed by WSFT's strategic group and BAME staff were involved in any decisions that were made which was very important. The Trust had responded to the evidence and ensured that staff risk assessments were continually updated to reflect any information or guidance.
One of the positive things that had come out of the COVID crisis was the formation of a BAME group.

Q How long would the BMI be undertaking surgery etc on behalf of WSFT?

A This would be addressed under agenda item 9.

20/97 REVIEW OF AGENDA

The agenda was reviewed and there were no issues.

20/98 MINUTES OF MEETING HELD ON 24 APRIL 2020

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

20/99 MATTERS ARISING ACTION SHEET

The ongoing actions were reviewed and the following noted:

- Item 1822 – Provide a summary of the proposed amended process for duty of candour and confirm when this will be implemented. The interim Chief Nurse would be made aware of this when she joined the Trust next week.

The completed actions were reviewed and there were no issues.

20/100 CHIEF EXECUTIVE'S REPORT

- COVID appeared to have passed the peak of the projected initial surge; staff had responded brilliantly in preparing for this and the organisation had been in a well-placed position to respond. It was important to continue to thank staff for everything they were doing and remember that this was having a profound effect on a number of them. The warm weather had made it more challenging when wearing PPE and for patients on the wards.
- The Trust was now planning to try to resume an element of normal activity but this would be new normal which was likely to be the case for the next 12-18 months depending on a vaccine, herd immunity or better treatment.

- As well as the increase in testing people with symptoms there was also a plan to introduce antibody testing. The necessary validation process was underway in the laboratory.
- The Trust continued to ensure that staff were supported during this period which was also part of the CQC action plan. This plan had not been lost sight of, although a number of items were being addressed in a different way in order to respond to COVID alongside this, eg pathology,

DELIVER FOR TODAY

20/101 COVID-19 REPORT

- Numbers were currently reducing and the Trust was settling into a reduced level of capacity for COVID patients.
- It was recognised that staff from across the organisation, including clinicians, nurses and operational managers had stepped out of their comfort zones and worked hard to support the Trust and their colleagues; this had been especially difficult due to the fast-moving pace.
- A new staff risk assessment was issued yesterday (version 5) which would require a risk assessment to be repeated for significant numbers of staff; this was an example of the changes that were constantly being made.
- PPE continued to be closely monitored and supplies were improving. At no point had any member of staff been asked to deliver care to a patient without the appropriate level of PPE. Currently there were seven different types of mask, all of which required to be fit tested.
- Staff testing had raised a considerable amount of concern. The Trust was currently not routinely testing asymptomatic staff members in line with national guidance. A detailed review of this had been undertaken and a decision had been made not to do this. The reasons for this had been published on the staff intranet and the Trust would continue to follow national guidance.
- Recovery planning continued; this was now in phase two and starting to deliver additional diagnostic activity and addressing backlogs in diagnostics for cancer patients.
- The six week diagnostic target had been badly affected and may be an ongoing issue, as patients would be dealt with in accordance with clinical priority and not just length of wait.
- The Trust was also planning for phase three of the recovery plan. It had submitted a plan for these, however this required further work as it had only been given 48 hours' notice. Therefore, a more detailed piece of work was being undertaken which included six key elements, as detailed in the report, which would have a negative impact on capacity.
- A capital bid had been submitted to enable additional operational capacity in a modular form at Newmarket and additional wards at WSFT, but it was not known what the approval process for these bids was. If additional funding was not received the Trust would not be able to deliver the routine activity that it had previously been able to.
- The current contract with the independent sector was set to end on 30 June, however there were national and local negotiations to try to extend this until the end of the financial year.

Q If numbers were reducing, would COVID and non-COVID patients be nursed in the same environment?

A No, this would have to be worked around.

Q With regard to patients being asked to isolate pre-admission, how would this be communicated externally to ensure there was not a surge in dissatisfaction from the public?

A A plan was being worked on across the ICS and then fed into the regional picture. When it was better understood what was achievable this could be communicated regionally.

There was also an issue with people not wanting to come to hospitals and a regional communication would be undertaken around this. The ICS was having discussions about how to communicate to the public on this and were in liaison with external organisations.

Q How was the community included in the recovery plans? The organisation was now in a changed world and had learned a lot about how to deliver services to patients in different ways, therefore it needed to ensure that the plan was ambitious enough in what it was trying to achieve as well as operationally managing its way out of the situation.

A The recovery plan would include this transformation change approach internally and in the community, eg outpatient video or telephone consultations/physio and refining clinical pathways. A piece of work was being undertaken to capture all the changes and what staff would like to keep or what they would like to return to how it was before.

Q Would this include workforce wellbeing?

A This was being included as part of the plan.

Q Had the fact that there was a very realistic probability that there would be another COVID peak, which could be bigger than expected, been factored into the recovery plan?

A Helena Jopling had updated the model through to next April. It was expected to be a challenging time and beds would need to continue to be allocated for COVID activity for the rest of the year, however it was not known when the surges would occur. The Trust would normally be looking at winter planning at this time of year and COVID beds were being including as part of this. Some of this would determine how much elective activity it would be possible to achieve.

A How was the Trust ensuring that it did not lose any follow-up activity during this period?

Q One of the first things that the information team did was to add additional codes onto e-Care. This meant that it was able to record where patients' pathways were delayed due to their own choice as a result of COVID, or WSFT's choice due to COVID. As a result there was a list of patients whose care had been delayed due to the COVID situation who would be picked up again as the situation allowed.

20/102 INTEGRATED QUALITY & PERFORMANCE REPORT

- This report was in a different format to usual as normal performance did not exist and there was a different type of performance. Data was provided where possible

but this required some context to interpret it. A way of providing meaningful cancer activity data had not yet been worked out.

- Emergency department attendances had been low but were now increasing.
- Monthly staff sickness figures for March and April were shown in the report, together with details of weekly figures which gave an oversight of sickness rates as a result of COVID. However, these were average figures across the organisation and there would be hotspots. A daily review of staffing across the Trust was undertaken to maintain safe staffing levels, and this had been possible throughout this period.

Q Was the Trust still seeing a regular trend of issues raised through Datix, or was COVID having an effect on the number of issues being raised and was there a cause for concern?

A Issues raised through Datix were reviewed on a weekly basis. Based on the number of patients and available beds this suggested that issues continued to be reported which was positive. Even though there had been high levels of sickness in some areas and an increase in bank and agency staff, issues were still being reported. No issues specifically relating to COVID had been reported, eg lack of PPE, which was a positive sign.

Q Although national guidance was not to investigate red complaints in detail, could some indication be provided as to when the patient experience team would have enough resource to enable them to do these investigations so that complaints would be thoroughly reviewed?

A The patient experience team was now fully resourced and had nearly got through the back log and had responded to more complaints than indicated in this report.

Q Whilst recognising that numbers may be small, how was duty of candour being impacted by COVID and how could the 73% decrease in duty of candour be explained?

A A full report was taking place and red incidents continued to be investigated as before. The Trust continued to ensure that lessons were learned as quickly as possible; the same was the case with red complaints. Rowan Procter met on a weekly basis with the head of patient safety and patient experience manager to review all complaints and any urgent action required.

The duty of candour issues related to the community and whether it was appropriate for these to be undertaken separately or when the next home visit took place. In one case it had been deemed that duty of candour should not take place as it would cause more stress to family; the CCG had been agreement with this decision.

- Keeping in Touch; staff were very pleased to be a part of this as it meant that they felt worthwhile and were able to help other people whilst they were shielding at home. It was considered that this should become part of business as usual as the keeping in touch line received approximately 200 calls a day which relieved the wards of this work and made a positive impact on families. The team were also able to speak to relatives for much longer than ward staff would be able to. Feedback from patients and families had been very positive.

  The continuation of a keeping in touch service had been included in a business case and it was suggested that this could be a role for staff on long-term sick leave which would help to keep them engaged.

- The board approved the recommendation that the following should reported to the board moving forward:
  1. New complaints
  2. Closed complaints
  3. Overdue responses
  4. Average daily calls answered by the help line

20/103 FINANCE AND WORKFORCE REPORT

- The audit process for last year was currently being undertaken and there had been no surprises, therefore the end of year position was as reported to the board last month.
- The month one position was breakeven and further details would be provided in the closed board meeting.
- The principal during the current situation was that whatever the Trust spent would be covered by income. All NHS providers had now moved to block contracts, which WSFT had been on for some time.
- Income as a result of block contracts was being estimated nationally rather than through local CCGs. All COVID expenses were being reimbursed.
- The position at the end of April would be the same at the end of May and June. It was expected that this would be extended through to the end of the financial year which meant that Trusts would have a bottom line of zero.
- It was proposed that future board reports should focus more on the underlying position. Looking forward to 2021/22 the expectation was that the financial regime would return to normality, therefore from a board perspective looking at the underlying position would be more useful. As it started to look to the future it would need to consider business cases.
- The capital allocation was likely to be significantly less than originally suggested, therefore this was being reviewed to look at other sources of funding that might be available.
- The cash position at the end of April was strong at £24m.

Q The report showed that there had been a significant decrease in activity but an increase in bank and agency staff. How could the board be assured that the Trust was maintaining control of efficiency and value for money?

A Comparing current performance with previous performance was not particularly helpful. Efficiency/productivity was significantly lower than before, ie average number of staff per occupied bed had greatly increased due to COVID. There was a need to understand how to determine whether efficient use was being made of public resources and this came down to judgement more than comparing metrics, as there was no reference point.

It was currently not possible to prove anything on this to the board but the organisation was trying to ensure a level of control and continuing to scrutinise requests for expenditure and appointment of staff, eg additional locums, doctors etc. As the Trust started to look forward the underlying position, without COVID expenses, would be a more useful way of looking at financial performance.

Q Rather than rely on judgement, in order to provide assurance that the Trust remained efficient could it start to look at what would be expected in terms of a level of efficiency in the current circumstances and report against these, ie actual performance vs what would be expected, including narrative and rationale?

A The additional sessions reflected cover in place around Critical Care and ensuring seven day a week cover and sufficient senior cover, eg 24/7 anaesthetist cover and reflect different patterns of work that had been put in place to manage the current situation.

This would be important as the Trust moved into the new normal as it would not just be staffing for activity but for 'just in case' and at a speed that did not necessarily correlate with efficiency. The Trust was currently staffing at a level that would not normally be tolerated. A decision would need to be made as to how much this continued, taking into account staff wellbeing; this was likely to be considered locally and nationally.

Action: Spend on COVID compared to other organisations to be provided to a future board meeting, together with trend information as the Trust moved through the next few months. **C Black**

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

20/104 NURSE STAFFING REPORT

Q Was the Trust working through how to encourage staff to take their annual leave?

A Performance measures were normally in place to manage this but during COVID behaviours had changed, ie staff weren't able to go away anywhere or some people wanted to take leave as they did not want to be at work. The senior matrons were working through this as it could be an issue in the future.

- The need to take annual leave was being communicated across all staff groups. However, the Trust needed to be aware of the way in which staff had supported the organisation. There had been more flexibility around the amount of leave that could be carried forward, whilst stressing that it was still important for staff to take annual leave for their own wellbeing.

20/105 QUALITY & LEARNING REPORT

- Due to COVID the content of this report for the next quarter may need to be changed, ie no quality walkabouts had taken place.

Q Was the patient lost to surveillance (WSH-IR-53046) discovered as a result of the investigation into this or was it another incident? Had the purge of messages been changed from 45 to 28 days?

A It was confirmed that this related to a previous incident that the board had previously discussed.

20/106 TRUST IMPROVEMENT PLAN

- This report was an update on the improvement plan which remained a focus; assurance around this would continue to be provided to the board.
- The improvement governance framework provided in annex C was explained; this would be a sustainable model and would not be not be person dependent

Q In terms of the SRO improvement clusters, it was important not to lose the horizontal management across the organisation; how would this be ensured?

A This was recognised and there would be cross organisational work which would be reported by cluster.

- How things were shaped around this and where different responsibilities would sit with the improvement programme board and where this fitted into the overall governance of this needed to be considered.

Action: identify NEDs to sit on the improvement programme board and consider how they linked in. **S Childerhouse**

20/107 SAFE STAFFING GUARDIAN REPORT

- Francesca Crawley, Guardian of Safe Working Hours, gave her unreserved thanks to the junior doctors throughout COVID as their rotas had been totally different and they were having to work different shifts/hours with people they didn't know, and in different teams.
- The junior doctors were very keen for their mess to be reinstated, as the current facility was not fit for purpose and was away from the main hospital. It had been agreed there would be a new mess when the new emergency department was built. They had £40k which they would be happy to put into the refurbishment of the original mess, then the equipment could be moved into the new mess in the emergency department.
- Craig Black explained that it may not be possible to provide all the current facilities eg showers. There were a number of options that Francesca Crawley and the junior doctors needed to decide on.
- Nick Jenkins was not aware of the issues with 'wagons on wheels' and would follow this up outside the meeting. He confirmed that space for a surgical juniors' communal office was already being followed up.
- The board supported the recommendations in this reports subject to further discussion with Nick Jenkins and Craig Black.

Q Was the high number of additional locums in emergency department required before COVID, or were they being used to help manage COVID?

A This was due to understaffing, the ability to recruit to this area and a lack of junior trainees. The HR department was working hard to recruit middle grades but this was very difficult in the emergency department as they required a lot of skills. There should be fewer gaps after August.

- The board thanked the junior doctors for all their support and work during this challenging time.

20/108 EDUCATION REPORT – INCLUDING UNDER GRADUATE TRAINING

Q How effective had the undergraduate medical students been who had qualified early in order to join the NHS workforce?

A The 22 FIY1s had settled in well and were working alongside FY1s; 18 would be remaining at WSFT in August. This meant there would be a cohort of experienced FY1s, which could be very helpful particularly if there was an increase in COVID patients later in the year.

CUHT were responsible for these students until the end of July and they continued to receive educational and welfare support. However, they were not receiving face to face teaching which would normally be the case, but they were receiving online teaching, although this was different.

Q Was the visit requested by Health Education England a result of the CQC report, or a routine visit?

A This was a result of the CQC report. They had requested further information which had been provided.

- The board received and noted the content of the annual library report.

20/109 CONSULTANT APPOINTMENT REPORT

The board noted the following appointments:-

Dr May Richardson - Consultant in Clinical Oncology
Dr Samantha Clayton - Consultant in Anaesthesia

20/110 PUTTING YOU FIRST AWARD

Jeremy Over read out the citations for the following members of staff who received Putting You First Awards in May:

June Westerman, district nurse, Mildenhall community team
June has been a district nurse for a number of years and is currently with the Mildenhall community team. Over a number of months, she worked very closely with a team of sheltered accommodation carers, to teach them how to monitor the diabetes of a patient living in her own home and to administer the patient's insulin.

This has been of great benefit to the patient as she no longer needs to wait for the district nursing team to visit her twice daily to administer insulin, and is able to go about her usual activities, which is very important to her.

This work is supported by a framework to ensure safety and has taken quite some time to pull together. June has really gone the extra mile to achieve this and make sure that all the carers have received training, often starting work before her shift in order to be able to capture the night staff. The work demonstrates wonderful person-centred care and service development.

Danielle Bourdiec, booking coordinator, medical staffing
Over the last few months, Danielle has been working on reducing agency rates for medical staffing, with some very impressive results. This has been achieved whilst new in role, and training another member of staff in her old role.

Even though her workload is high, Danielle still has time to ensure she helps our doctors. In an email of thanks she received from Paul Molyneux, he commented: "If there was an award for going the extra mile, I would without question nominate you!"

The board congratulated June and Danielle and thanked them for all their hard work and going the extra mile.

BUILD A JOINED-UP FUTURE

20/111 PATHOLOGY SERVICES DISAGGREGATION

- The board were already of aware the notice from ESNEFT around the disaggregation of NEESPS. This report gave details of areas that needed to be addressed in the next few months.

- The real focus was to ensure clinical engagement with laboratory staff so that the solution was driven by these staff and they had a sense of ownership and would make a success of future plans.
- Discussions were currently taking place with ESNEFT. It was very important to come up with an arrangement that was not dissimilar to the networking arrangements that had previously been envisaged and that the relationship with ESNEFT continued through the new model. It was also important to do this both from an ICS and regulator perspective.
- The GP work that was currently with NEESPS came up for renewal in October; this needed to be disaggregated and WSFT needed to work with ESNEFT and the CCGs to come up with a partnership arrangement.
- A key part of the solution would be staffing of the laboratory and a lot of work was being undertaken around what the staffing model would look like, the level of vacancies and if it would be possible to recruit to and fund these.
- Pathology would be a priority for investment given the previous issues in the laboratory. Investment would be required to meet accreditation requirements and the necessary level of staffing.

Q What about the timeframe of 31 October given the other challenges of the Trust; when would it be possible provide the board with information about the gaps in recruitment, finances etc?

A It was hoped to have more meaningful information within the next month. This would also be discussed by the scrutiny committee.

Action: provide board with further information on timescales, recruitment, finances etc. **C Black**

- The clinical team was also looking at networking arrangements and it was intended to deploy key members of the board to support these working relationships over the next few months.

Q What was staff morale like in the pathology department at WSFT, considering the pressure they were under from the requirements of COVID, the high number of vacancies and a change of ownership structure?

A Consultants were excited and saw this as a real opportunity and have passed this onto the laboratory managers. However, the rest of the team were still concerned about the changes. Work was being undertaken to alleviated anxieties around the TUPE process.

Q What was the view of the microbiology department, were they keen to be included in any future change?

A The aim was to avoid microbiology staff having to TUPE to ESNEFT then to WSFT but it was not known if this would be possible. The government's actuary department needed to assess their pensions before this could be progressed.

20/112 DIGITAL BOARD REPORT

- A huge amount of work was going on in the IT department, some of which was detailed in this report.

- The roll out of hardware into the community continued and nearly all WSFT community staff now had a smart phone. Work on upgrading the infrastructure in the community was also being undertaken. This remained a focus, although responding to COVID had caused some of this work to be delayed.

Q What about welfare within the community IT team?

A This was regularly followed up. A number of staff within IT were shielding and working from home which could be isolating, therefore Teams meetings took place with these staff and this remained a focus of the management team.

GOVERNANCE

20/113 TRUST EXECUTIVE GROUP REPORT

The board received and noted the content of this report.

20/114 AUDIT COMMITTEE REPORT

- The 2019/20 Audit Plan was complete and all reports had been finalised.
- A deep dive on Freedom to Speak Up had identified a number of significant findings. The executive team were following this up and addressing the issues.

20/115 COUNCIL OF GOVERNORS REPORT

- The board approved the amendments to the Membership Strategy for 1 April 2019-31 March 2021.
- The Chair thanked the governors for their participation in Teams meetings during this period and adapting to different ways of working.

20/116 TRUST CONSTITUTION UPDATE

- The purpose of this was to allow the Council of Governors to operate in the same way as the board of directors. The proposed changes were solely focussed around electronic communication and enabling governors to have authority to make decisions electronically.
- Following legal advice, a process had been put in place for governors to vote via an email ballot. They had unanimously supported the proposed change, with the majority of votes coming from public governors.
- The board approved the amendments to the Trust Constitution.

Action: update Constitution to reflect agreed changes. **R Jones**

20/117 REVIEW OF NED RESPONSIBILITIES

- The board noted the changes to NED responsibilities due to Gary Norgate leaving. These would be reviewed when the new NED was appointed.

20/118 AGENDA ITEMS FOR NEXT MEETING

The board received and noted the content of this report.

ITEMS FOR INFORMATION

20/119 ANY OTHER BUSINESS

- A video showing highlights of Rowan Procter's time at WSFT was played. She thanked everyone and wished them well for the future.

20/120 DATE OF NEXT MEETING

Friday 26 June at 9.15am.

RESOLUTION TO MOVE TO CLOSED SESSION

20/121 RESOLUTION

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

7. Matters arising action sheet

To ACCEPT updates on actions not covered elsewhere on the agenda

For Report

Presented by Sheila Childerhouse

Board of Directors – 26 June 2020

Agenda item:	7			
Presented by:	Sheila Childerhouse, Chair			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	19 June 2020			
Subject:	Matters arising action sheet			
Purpose:		For information	X	For approval

The attached details action agreed at previous Board meetings and includes ongoing and completed action points with a narrative description of the action taken and/or future plans as appropriate.

- Verbal updates will be provided for ongoing action as required.
- Where an action is reported as complete the action is assessed by the lead as finished and will be removed from future reports.

Actions are RAG rating as follows:

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

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 received a monthly report of new, ongoing and closed actions.
Risk and assurance:	Failure effectively implement action agreed by the Board
Legislation, regulatory, equality, diversity and dignity implications	None

Recommendation:
The Board approves the action identified as complete to be removed from the report and notes plans for ongoing action.

Ongoing actions

Please note – the nine actions 'paused' during COVID-19 response will be reported to the Board in July.

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1822	Open	28/2/20	Item 8	Provide a summary of the proposed amended process for duty of candour and confirm when this will be implemented	Duty of candour (DoC) response has improved for March, with only one DoC outstanding relating to a pressure ulcer in the community. It is recognised that we need to update of duty of candour procedures to reflect the general duty of candour (irrelevant of the level of harm). This is ongoing but has been delayed as a result of the need to engage with relevant clinical staff **AGENDA ITEM**	SW	26/6/20 ~~27/03/2020~~	Green
1840	Open	24/4/20	Item 11	CQC improvement plan - schedule regular updates, including review of 'paused' improvements in July '20. Agreed to add to improvement reference 6, 30, 46, 62 that the review of historic harm is paused as staff are focused on COVID activities.	Update made to the wording of the plan regarding review of historic harm. Review of plan included in forward plan for Board, including review of 'paused' improvements in July. **AGENDA ITEM**	SW	31/07/20	Green
1841	Open	24/4/20	Item 17	Agreed to add to the COVID governance document NED and governor activities during COVID as well as the workings for the Remuneration Committee.	The additions have been made to the document and a review of the arrangements will be received by the Board in July '20	RJ	31/07/20	Green
1846	Open	29/5/20	Item 19	Provide an update on the pathology investment requirement along with plans and timescales for disaggregation (via discussion at Scrutiny Committee)	**Agenda item**	NJ	26/06/20	Green

Closed actions

None to report

8. Chief Executive’s report

To RECEIVE a report on current issues

For Report

Presented by Stephen Dunn

Board of Directors – 26 June 2020

Agenda item:	8			
Presented by:	Steve Dunn, Chief Executive Officer			
Prepared by:	Steve Dunn, Chief Executive Officer			
Date prepared:	19 June 2020			
Subject:	Chief Executive's Report			
Purpose:	X	For information		For approval

Executive summary:

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

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 report to Board summarising local and national performance and developments
Risk and assurance:	Failure to effectively promote the Trust's position or reflect the national context.
Legislation, regulatory, equality, diversity and dignity implications	None

Recommendation:

To receive the report for information

Chief Executive's Report

This report will be received at our fourth Board meeting during the national response to COVID-19 and with the lockdown in place the meeting will not be open for the public attend. To **maintain transparency**, we continue to invite our Governors to observe the Board meeting using Microsoft Teams and we have provided the opportunity through our website for the public to ask questions relating to matters on the agenda.

As you are reading this, you have no doubt witnessed the **Black Lives Matter movement** which has occupied our television screens over the last few weeks. The unlawful killing of George Floyd has shocked people all over the world and seen many more stand together to fight both the legacy and the ongoing reality of injustice, racism and discrimination. The movement is even having an impact very close to us in Suffolk, with protests being held in Ipswich and Bury St Edmunds last weekend. It's clear to see that individuals across this country and all the world are determined to change how black people, and other people of colour, are treated in everyday life. This is a determination that needs our support. What is more, it is clear that COVID-19 has taken a disproportionate toll on our Black, Asian and Minority Ethnic colleagues and this has been a cause of very real anxiety which we have been trying to respond to through our enhanced risk assessments and sensitivity to staff's needs. It seems more than ever before that we need to show leadership and support for those that are disadvantaged as a result of the colour of their skin.

As a Trust, we are exceptionally proud of the diversity of our staff, our volunteers and our patients. We could not do all that we do without the dedication and commitment of all our staff, whatever their background - I sincerely mean this. The NHS belongs to us all and is there for all of us in our time of need. The NHS should role-model the type of society we want and the respect and appreciation of all, whatever the job you do or whatever your background. Our Trust and our NHS belongs and serves communities of all backgrounds, cultures and skin colours. And that's why we need to collectively listen to the experiences of Black, Asian and Minority Ethnic people, because it is clear that we still do not appreciate the challenges they have faced or face, nor supported them to fulfil their potential.

It's clear from the protests across the globe that people have not been listened to properly and injustice and discrimination are still rife. All too often we are guilty of making assumptions about other people and not taking the time to truly understand what it is like to walk in their shoes.

As a Trust, we must be there for our colleagues who suffer inequality in their lives because of the colour of their skin. And I know that we can always do more to listen and, importantly, to act. I want to hear the voice and stories of our staff because we want to make things better and help make our Trust and our society more inclusive and tolerant. It's not always easy speaking up when you feel the odds are against you. That is why I am delighted to hear that a BAME staff network is launching here at WSFT and I want to thank and support those who have stepped forward to make this happen, because hopefully it will help to make us an even better and safer place to work. I know that a network is not THE solution, but a framework to develop solutions. I understand that not everyone will be ready to join now but may have concerns, ideas and suggestions, so I encourage staff to share those directly with me or with colleagues and line managers.

Finally, I just want to say, on a very personal note, that I am here for our staff and I will always try to help to make things better. I enjoy visiting and speaking to teams across the hospital and the community and really do appreciate that our staff work so hard every day to care for anyone who needs us. If you're reading this and you're not from a BAME background, I encourage you to become an ally in this movement we're seeing all over the globe, and we can do this by reading, by learning and most importantly, listening. Let's be the change we want to see.

As part of our **response to COVID-19** we continue to take a wide range of actions to support patients, carers and our staff, recent examples of these include:

- Informed staff that we will now be re-swabbing all patients who initially received a negative COVID result on day seven of their hospital admission
- Provided a timely reminder of the tips available for home workers but also for those managing home workers
- Signposted staff to join a virtual forum specifically aimed to support staff of Black, Asian and Minority Ethnic backgrounds
- Given staff information about the new mandatory NHS face coverings and surgical masks
- Confirmed that every member of staff who receives a positive COVID-19 swab test result must gain occupational health clearance before returning to work
- Reminded staff of the uniform policy and etiquette
- Updated the HR frequently asked questions
- Asked staff to tell us what works for them, in the trust-wide survey
- Announced the RECOVERY trial results for Dexamethasone
- Published a letter to all NHS staff from the National Guardian Freedom to Speak Up and Interim Head of Workforce Race Equality Standard
- Signposted staff to virtual meeting guidance

Many of you will have seen the Government's announcement stating that from Monday, 15 June all staff in hospitals in England will be **provided with surgical masks** which they will be expected to wear, and all visitors and outpatients must wear face coverings at all times. Below is a summary of the process we put in place across the whole Trust, including West Suffolk Hospital, Newmarket Community Hospital, and community bases.

What staff did from Monday, 15 June:

- On Monday when staff arrived to work from 6.30am onwards, they were provided with a fluid-resistant surgical mask (FRSM) at each entrance to the hospital sites and community bases
- All staff to wear a face covering at all times on site, except those areas that are officially designated as COVID-secure workplaces (COVID-secure areas will be identified over the coming weeks)
- Staff were reminded that FRSMs do not replace existing social distancing guidelines or good hand hygiene practices
- It was emphasised that the implementation of surgical masks site-wide does not override any existing PPE requirements
- It was confirmed that staff working from home do not need to wear a mask, and any staff member who can work from home, should do so.

It was also confirmed for that:

- Surgical masks are for single use, or single session use, for a maximum of four hours. They should not be touched once they are on, and should never be allowed to dangle around the neck after or between use
- When discarded they must be put in designated waste bins, which will be clearly signposted and placed around hospital sites
- If the mask becomes wet, damaged or visibly soiled it must be changed
- The masks must be removed and disposed of properly before eating and drinking, and a new one must then be put on afterwards.

Patients and visitors are also expected to wear their own homemade face coverings on attendance to hospital – if they do not arrive with one we will supply them a surgical mask for safety, but we

would encourage all patients to supply their own face coverings before they book or arrange any appointment.

I would like to thank and praise the staff who responded so quickly to prepare for this change but also to all our staff for responding so well to allow us to delivery these new requirements – we cannot take for granted just how amazing our staff are.

The Trust has seen huge take-up from **staff for COVID-19 antibody tests**, with the team receiving hundreds of request forms each day. The booking team are contacting staff back for antibody test appointments.

Now that **COVID levels have become more stable** we are starting to think about moving to a recovery phase. This is where normally you would aim to get things back to where they were before an incident occurred. However, we want to make sure we don't lose the good work we have achieved and just go back to 'how it was before'. We think this is an opportunity to learn collectively from our experiences and try to build an improved future as a Trust and as a workplace. We want this to be an opportunity for every member of staff to have their say. We want to hear from staff, whatever area of the Trust they work in: community, acute, and corporate areas. A whopping 600 staff have shared their views so far using a comprehensive, and confidential survey.

The information and suggestions gathered from this important work will inform and feed into multiple work streams, including the refresh of our future strategy, our COVID recovery plans, quality improvement, and our focus on wellbeing. It will even influence how we work in the plans for the new hospital.

The feedback we receive from staff and our response form an important part of the **Trust improvement plan** to address our identified priorities, including the CQC findings. An update on the improvement plan forms part of the agenda for the Board meeting and provides a clear emphasis on targeted and timely action to deliver improvement in a transparent manner. The change in the report structure is also underpinned by a strengthened governance framework with significant internal quality assurance and monitoring.

We are starting to trial the return of **limited visiting arrangements** in light of NHS guidance and have worked with colleagues across the Trust, including our infection prevention, public health, ethics, and clinical teams, to ensure we have an agreed, safe way forwards, that will also comply with test and trace, and social distancing requirements. We hope the specific guidance and timetable in place for the trial will offer visitors clear information and options for visiting, while minimising any risks to patients, visitors and staff. If the trial is successful we will look to roll it out to all the other non-COVID inpatient areas, and details of timings will be communicated to you and the wider community as and when this is about to happen. Visitors will still not be permitted in COVID-affected areas other than specific cases.

I urge our community to continue to **adhere Government to advice including social distancing** to protect themselves, others and allow us to continue to meet the needs of our patients and population.

I am sure I speak for everyone when I say we are immensely grateful to Nick Finch, who has completed his three-year term as our **Freedom to Speak Up Guardian** at WSFT. He has provided immeasurable support for members of staff who have concerns at work, and has been a champion for 'speaking up' throughout his time as guardian. A process to recruit our Trust's next Guardian will be shared shortly.

After several months of uncertainty caused by the pandemic, community staff based at Darbishire House in Bury St Edmunds last week moved to a **new base at West Suffolk House**. This building

is shared by colleagues from partner organisations including West Suffolk Council and the clinical commissioners, and will support the journey towards ever-closer partnership working for the benefit of patients. Staff on the move include members of the Bury Town and Bury Rural community teams, community matrons, specialist nurses from the chronic obstructive pulmonary disease service and business support colleagues. Achieving this move has been a true joint effort, from the nurses, therapists, generic workers and support colleagues based at Darbishire, and the facilities, estates and IT staff enabling them to set up safely in a new base. Volunteers also helped to manage securely the considerable archive of documents held at the building.

The coronavirus outbreak has meant remote working has become the norm for community staff, so the number of them going into the new base at any one time will be limited to support safe working. Colleagues from partner organisations based at West Suffolk House, which is on Western Way, have ensured the building has been reconfigured to allow social distancing rules to be observed. While many council and commissioning staff are currently based at home, this move will allow our health teams much closer working relationships looking to the future with people involved in providing care and support to our community.

The West Suffolk Community view in e-Care, also known as the health information exchange or HIE, has been widely used across the acute hospital during the last couple of months. This provides access to information contained in the GP records within the e-Care patient record. The number of views of patient records has moved from 4,000 a month in May 2019, to over 15 thousand in May 2020! The need to share the GP records has accelerated over recent weeks, and the e-Care team have been working to connect more GP records to e-Care. Now it is possible to view records from all GP surgeries in Suffolk, the majority of those in north east Essex, and almost 70% of those in mid and south Essex. This work continues and once complete for these regions, e-Care users will have access to over 2 million patient records.

There is much to reflect on in my report this month but I wanted to find a moment to remember the sad death of **1st Lt. Kenneth Allen** last week. We have sent our support and solidarity with everyone in Lakenheath after this tragic event. Kenneth was based at Lakenheath after arriving in Suffolk in February but sadly died after his plane crashed on Monday last week. We have a long history of working closely with staff at RAF Lakenheath and would like to pass on our condolences to Kenneth's family.

9:40 DELIVER FOR TODAY

9. COVID-19 report

To RECEIVE a briefing

For Report

Presented by Helen Beck

9.1. COVID infection prevention and control assurance framework

To receive a report

For Report

Presented by Susan Wilkinson

Board of Directors – 26th June 2020

Item No:	9.1			
Presented by:	Sue Wilkinson, Executive Chief nurse			
Prepared by:	Anne How Lead nurse Infection Prevention / Rebecca Gibson, Compliance Manager			
Date prepared:	19 June 2020			
Subject:	NHSE ICT assurance framework			
Purpose:	x	For information		For approval

Background

On the 19th June the CQC wrote to all nominated individuals at NHS acute and mental health trusts setting out how the Emergency Support Framework (ESF) will be rolled out.

https://content.govdelivery.com/accounts/UKCQC/bulletins/2919849

The ESF had previously been introduced from 1st May in adult social care, primary medical services and some independent services, including services for people with a learning disability and/or autism, independent ambulance providers and independent dialysis units.

https://www.cqc.org.uk/guidance-providers/how-we-inspect-regulate/emergency-support-framework-what-expect

The letter sets out that from 22 June, ESF conversations will focus on establishing whether trusts have full assurance on IPC in the COVID-19 emergency and recovery scenarios. The use of the NHSE/I guidance is not mandatory, but if a trust chooses not to use it, the CQC would expect organisations to demonstrate how their board has assured itself using other equally rigorous methods.

WSFT is using the NHSE ICT assurance framework. The most recent version of guidance, v1.2 (22 May 2020) can be found following this hyperlink.

https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/C0542-IPC-Management-checklist-v1-2.pdf

This is supported by a board assurance framework (also updated 22 May 2020)

https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/C0542-IPC-Board-Assurance-Framework-v1-2.pdf .

The document sets out how the framework can be used to assess measures taken, in line with the current guidance, and assure directors of infection prevention and control, medical directors and directors of nursing. It can be used to provide evidence and also as an improvement tool to optimise actions and interventions and thus support organisations to maintain ten quality standards each underpinned by a number of key lines of enquiry (see Table 1)

Table 1 Infection prevention and control board assurance framework

Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users
Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections
Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance
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
Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people
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

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

The CCG have also independently sought assurance of WSFT progress with this document and it was agreed at the Execs meeting on 27 May that this board paper would be provided to the CQC and CCG (after the board meeting) to provide that assurance.

A review of the document (which is in the structure of a self-assessment document) has been undertaken by the relevant leads including Infection Prevention & control, Estates, Housekeeping, Patient Flow, Staff training, Purchasing, Discharge planning and Risk management in the format.

Quality standard	Key lines of enquiry	Compliance	How would we evidence this?	Gaps in assurance	Mitigating actions

Initial non/partial compliance identified are as follows:

- Ventilation
- Timely receipt of testing results
- Isolation

See Annex 1 for more details

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:	Executive Directors meeting
Risk and assurance:	As per attached assurance framework
Legislation, regulatory, equality, diversity and dignity implications	NHSE

Recommendation:

1. Receive for information and identification of any non or partial compliance **requiring urgent action**
2. Acknowledge any **known long-term non-compliance** (e.g. around side-room provision)
3. Ensure all relevant **risk register entries** are up-to-date and accurately reflect any non or partial compliance
4. Agree this report provides **suitable assurance** for submission to CCG and CQC

Annex 1- Non/partial compliance

Ventilation

Standard: Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections - review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission.

WSFT status:

Not all areas have forced ventilation and therefore rely on natural ventilation via windows being open. Air circulation is minimal however as there are restrictors on windows in place as per CAS alert EFA/2013/002.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/217019/EFA-2013-002-Window-restrictors.pdf

There are no fans in use in any waiting areas. Windows are open where possible however installing a forced ventilation system to all required areas would need major investment with significant associated costs.

Timely receipt of testing results

Standard: Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people - for patients with new-onset symptoms, it is important to achieve isolation and instigation of contract tracing as soon as possible.

WSFT status:

Although the initial taking of swabs is undertaken promptly, the trust has an allocation of only 50 'in-house' tests per week. All other tests have to be sent off site. Use of the in-house test is prioritised daily by Clinical need. This impacts on the ability to undertake testing in the most timely manner.

The trust has requested, via a number of routes, additional equipment and consumables which could increase capacity, but these have not yet been made available..

Isolation

Standard: Provide or secure adequate isolation facilities - patients with possible or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate.

WSFT status:

Within the limits of the estate, areas are designated in order of greatest ability to comply with the guidance. F7 is the only acute ward with doors to bays and the greatest number of single rooms and therefore is the designated is the acute Covid ward. G4 furthest away from any other ward area and a standalone facility is the other Covid receiving ward.

The Cardiology ward areas also do have sliding glass doors to the bay entrances but it would hard to relocate this ward to be able to convert it into an isolation ward and so this is probably not an option.

Single rooms are prioritised according to the risk of the infection; this forms the main element of the duty IPN workload. Side room occupancy lists are completed daily and circulated. Sheeting has been installed to provide a barrier to bays and the ability to install doors is actively being pursued. In the meantime temporary doors have been installed on F1 Paediatric area and within the Emergency Department.

A feasibility study is planned with regards to installing doors to ward bay entrances. Prior to this a separate study is currently underway looking into creating an isolation ward on G9.

10. Integrated quality and performance report

To APPROVE a report

For Approval

Presented by Helen Beck and Susan Wilkinson

Trust Board – 26 June 2020

Agenda item:	10			
Presented by:	Sue Wilkinson, Interim executive Chief Nurse Helen Beck, Chief Operating Officer			
Prepared by:	Jo Rayner			
Date prepared:	19 June 2020			
Subject:	Performance Report			
Purpose:	x	For information		For approval

Executive summary:

An interim performance report for Board to remain updated during the management of Covid – 19.

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

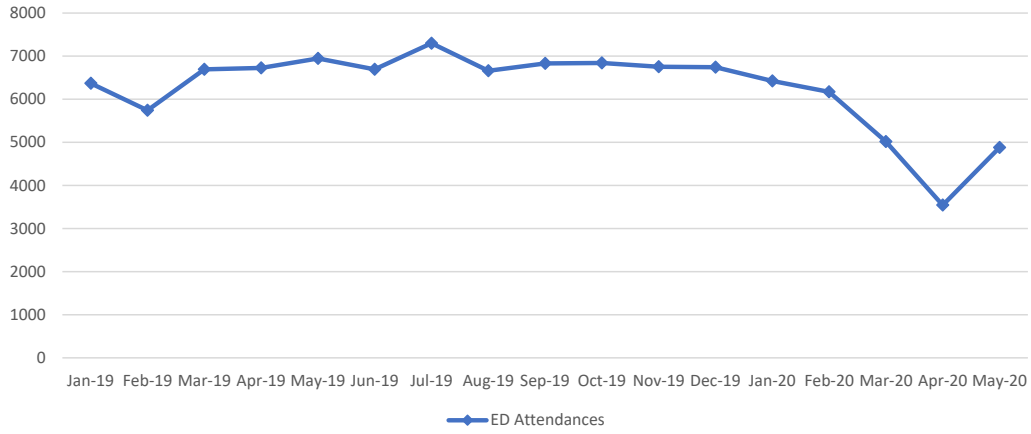
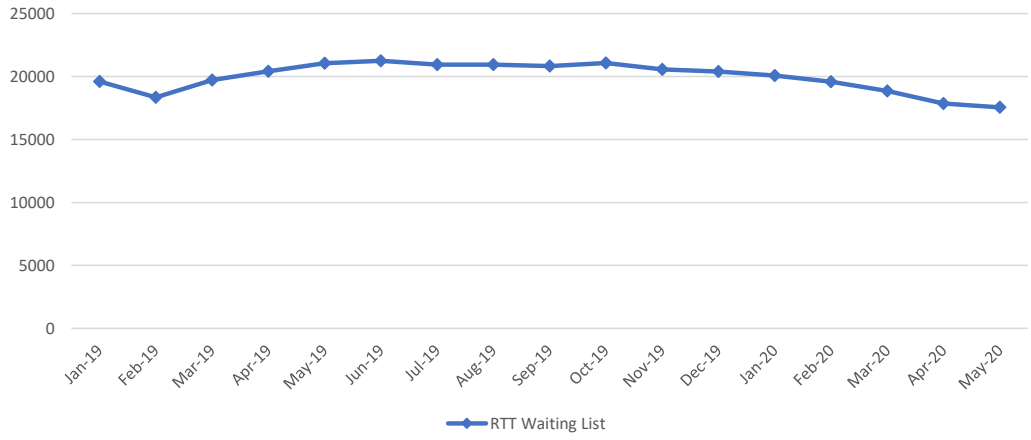
Previously considered by:	-
Risk and assurance:	-
Legislation, regulatory, equality, diversity and dignity implications	-

Recommendation:

To Board note the report.

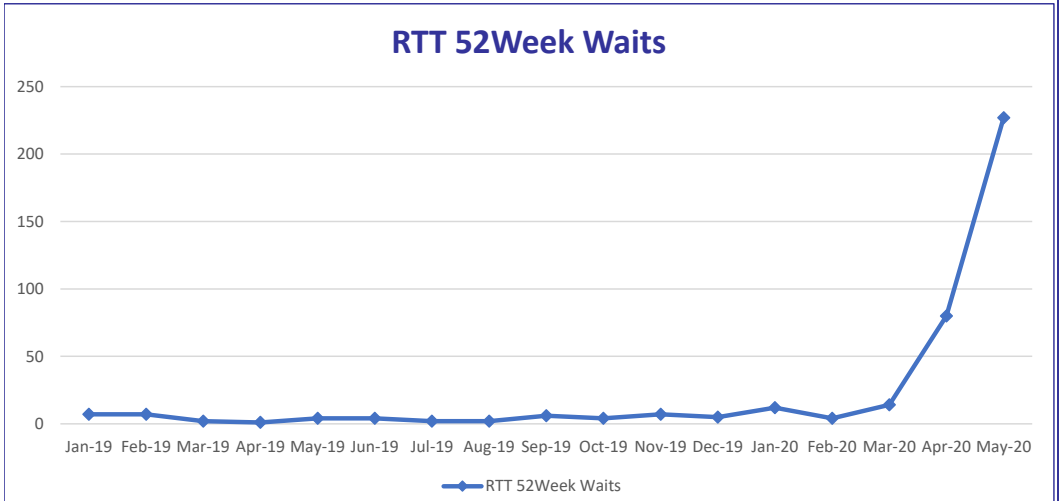
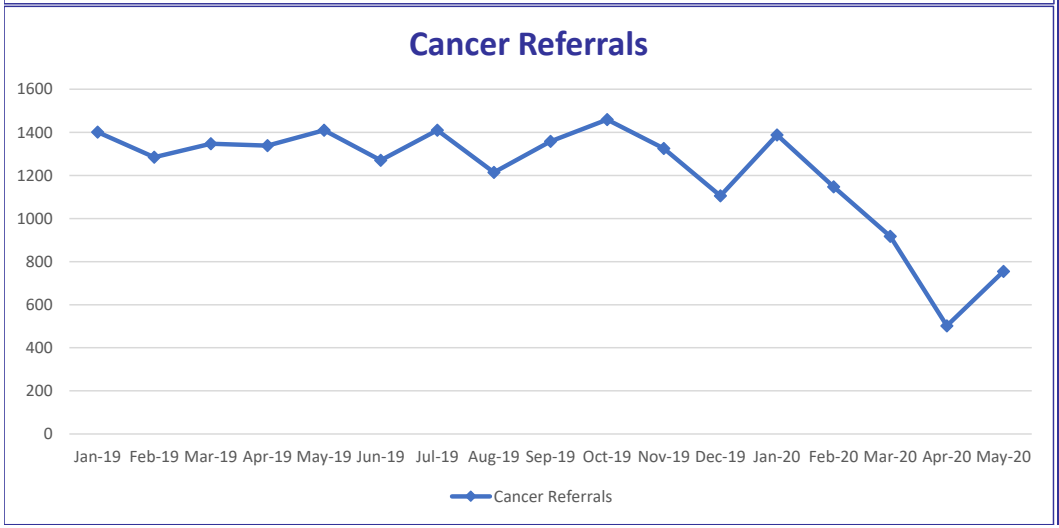
Performance Report to Board - June 2020

NHS West Suffolk NHS Foundation Trust

Board Report KPIs	Narratives
ED Attendances 	There were 4880 attendances in ED in May compared to 3542 in April (an increase of 37.8%) although this is still significantly lower that our pre-covid attendances. Patients arriving by ambulance increased from 1340 in April to 1721 in May (an increase of 28.43%.) 1453 patients were admitted in May compared to 1051 in April (increase of 402 patients which is 38.2%.)
RTT Waiting List 	The overall waiting list size has slightly decreased again in May from April. The main reason for this is the reduction in referrals, which were around half of what we would usually expect in May. In addition whilst surgery has been significantly reduced, patients who are not on elective pathway have been managed virtually when possible which has helped maintain a certain level of non-admitted pathway closures.

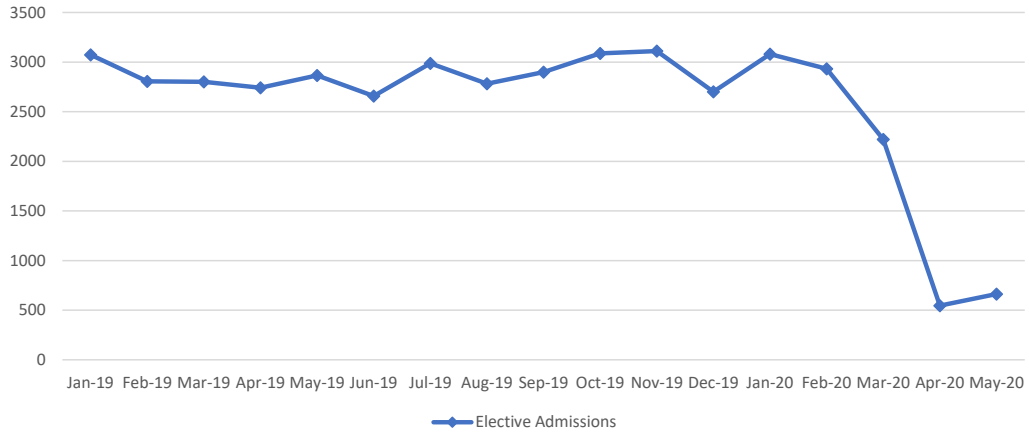
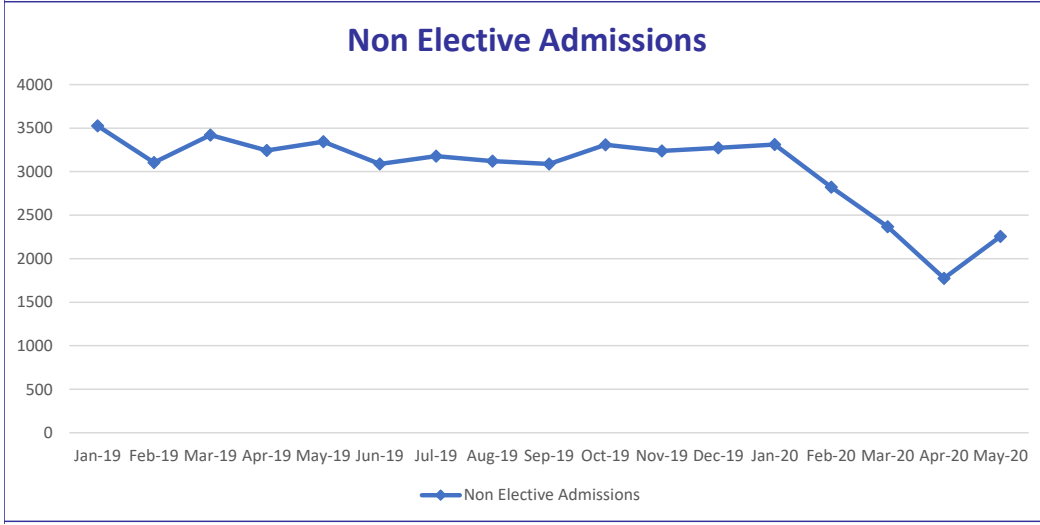
Performance Report to Board - June 2020

NHS West Suffolk NHS Foundation Trust

Board Report KPIs	Narratives
	As expected the number of 52 week waits continues to rise, around half of these patients are within Trauma and Orthopaedics and waiting surgery. As we move forward in the recovery planning, there will continue to be minimal oppourtunity to operate on routine patients such as those that have been delayed and patients will be treated based on clinical requirements rather than waiting times. The planned opening of the day surgery unit and the plans for the BMI to commence Orthopaedic surgery will help with some of the very long waits, however the 52 week wait position is not expected to reduce over the coming months.
	Positively the number of patients referred for potential cancer has slightly increased in May. There are very close links between the hospital, primary care and the cancer alliance to ensure we are all working together to encourage patients to attend if they have concerns around cancer.

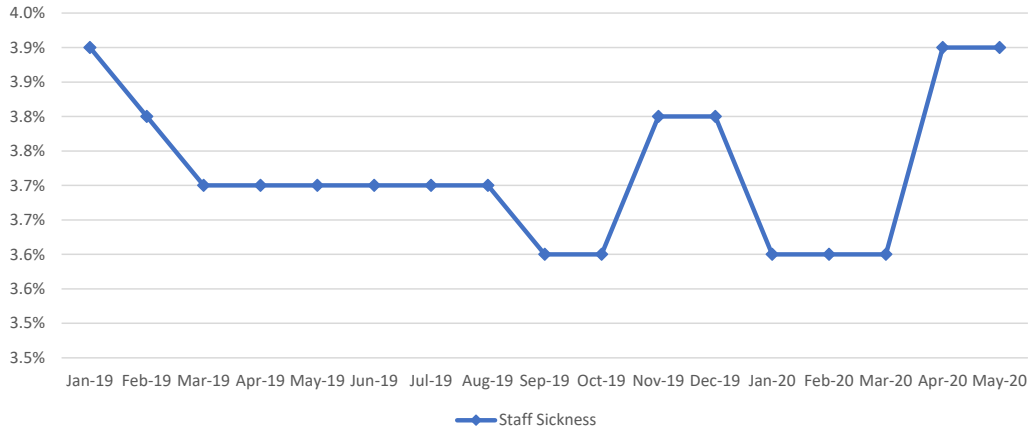
Performance Report to Board - June 2020

NHS West Suffolk NHS Foundation Trust

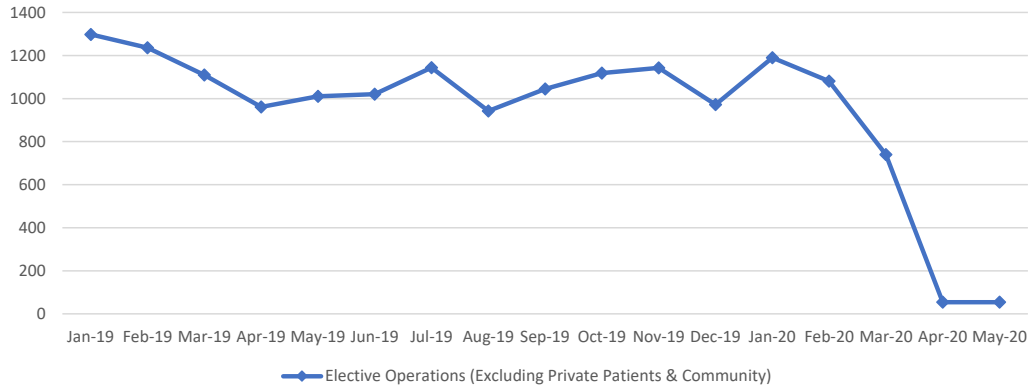
Board Report KPIs	Narratives
	There is still limited capacity to treat patients surgically, however there are plans in place to improve this position over the coming weeks. An additional main theatre lists, predominantly for cancer patients has been in place since the 8th June and there are plans to open the day surgery unit from the 13th July, which will help. However numbers of list and utilisaton of those lists will continue to be reduced due to infection prevention requirements. Endoscopy was able to recommence in May, for patients who have been referred on a cancer pathway again this has been on very reduced lists, but there are plans to start a 2nd list from July onwards, which will double the amount being carried out currently, but still be significantly less than the usual throughput.
	Non elective admissions were 2255 in May which is an increase from 1775 in April but still not significantly lower than pre COVID levels. The number of patients with query COVID symptoms also fell from 333 patients in April to 295 in May.

Performance Report to Board - June 2020

NHS West Suffolk NHS Foundation Trust

Board Report KPIs	Narratives
Staff Sickness 	The Trust's 12 month cumulative absence as at May 2020 was 3.9% which is consistent with April 2020. At the end of March 2020, prior to COVID-19, the Trust's 12 month cumulative run rate for absence was 3.6%. Early indicators for staff sickness levels in June 2020 are running at a reduced rate which will potentially result in a slightly reduced cumulative absence % at the end of June 2020.
Covid Related Sickness/Isolation 	This chart illustrates the number of staff absent from work with COVID-19 related sickness absence/isolation. In May 2020 there were 553 staff who reported absent from work due to COVID-19 related sickness/isolation which was a reduction from April 2020 which saw 721 staff report absent from work due to COVID-19 related absence/isolation.

Performance Report to Board - June 2020

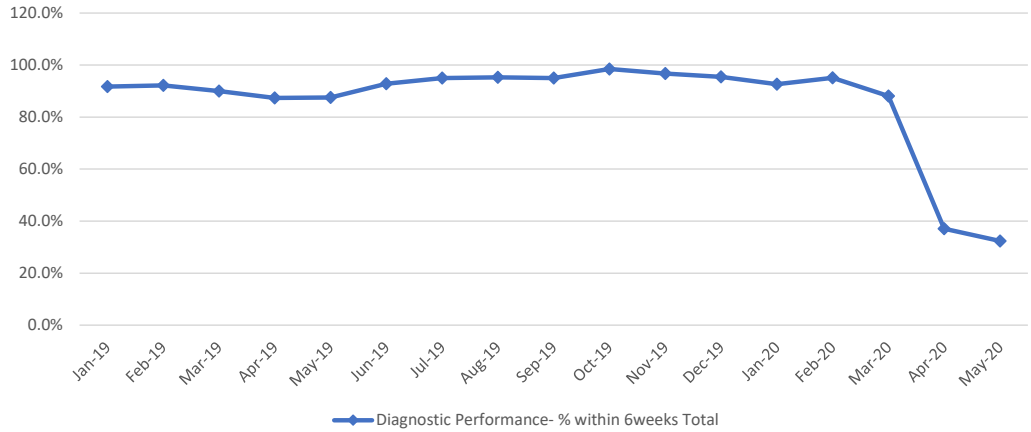
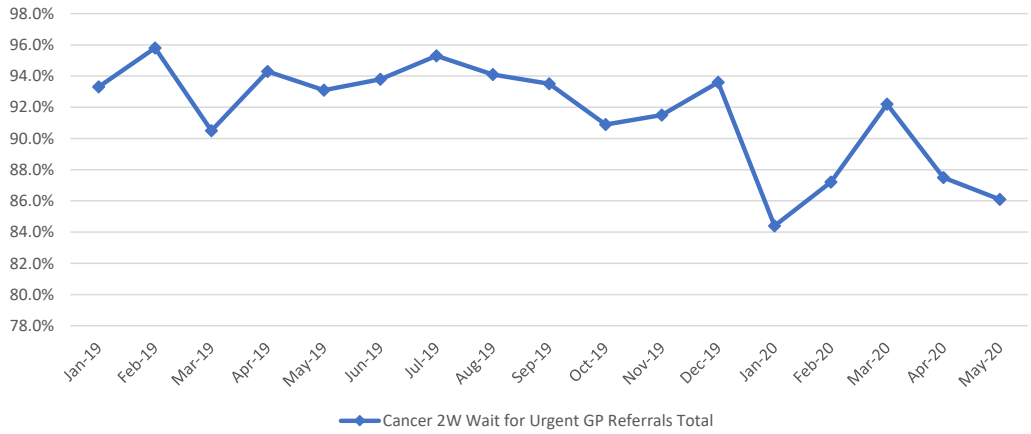
Board Report KPIs	Narratives
Elective Operations (Excluding Private Patients & Community) 	There is still limited capacity to treat patients surgically, however there are plans in place to improve this position over the coming weeks. An additional main theatre lists, predominantly for cancer patients has been in place since the 8th June and there are plans to open the day surgery unit from the 13th July, which will help. However numbers of list and utilisaton of those lists will continue to be reduced due to infection prevention requirements.
Covid Detected Patients 	The number of covid detected patients has fallen in line with the national picture.

Performance Report to Board - June 2020

Board Report KPIs	Narratives
Covid Deaths 	The number of covid deaths has fallen in line with the national picture.
Covid Datix 	The Datix incident system captures all incident which relate to the care of a patient or member of staff who has or is suspected to have COVID-19 including incidents which are not related to the management of COVID (e.g. a fall or medication incident) as well as those directly related to the COVID status (e.g. a PPE or patient transfer incident) The patient safety team working with the Executive Chief Nurse have a structured review and oversight process in place for all incidents during the COVID-19 response.

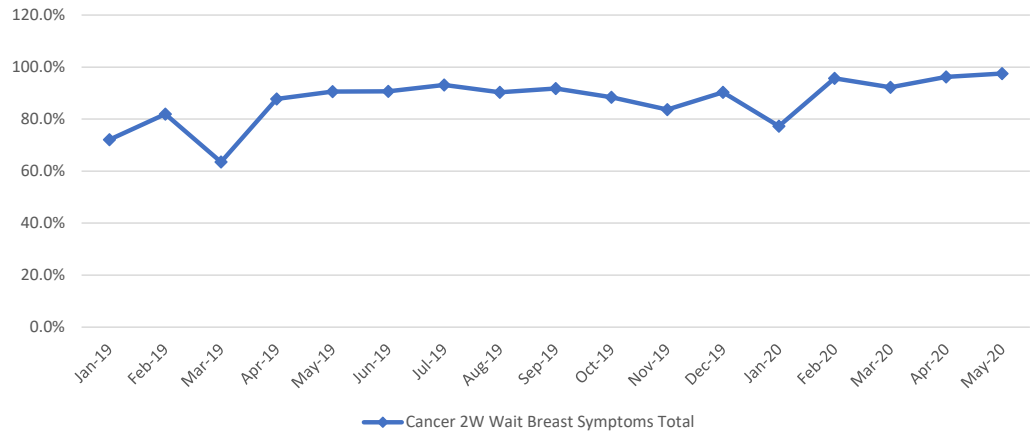
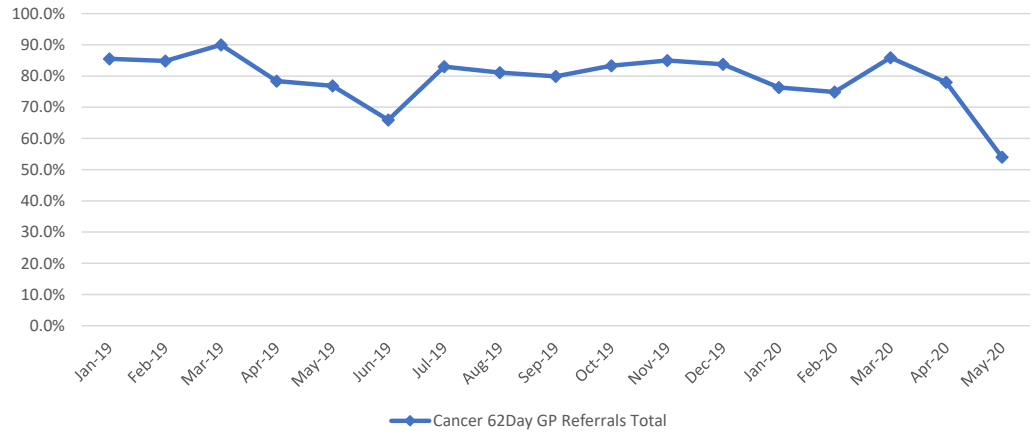
Performance Report to Board - June 2020

NHS West Suffolk NHS Foundation Trust

Board Report KPIs	Narratives
Diagnostic Performance- % within 6weeks Total 	Diagnostic performance – continues to be directly affected by the measures required to maintain social distancing which has reduced available capacity to around 40% of normal. Endoscopy has restarted urgent procedures and is gradually increasing its available capacity as more lists are introduced as staff return to the unit from deployment elsewhere. All diagnostic areas are working on utilising their current capacity as efficiently as possible whilst also exploring other options for increasing capacity in the future.
Cancer 2W Wait for Urgent GP Referrals Total 	The 2WW standard has not been achieved, prodominantly due to the ceasing of endoscopist services for 7 weeks as per national guidance. Now that this has recommenced, patients on both a Upper and Lower GI pathway will be seen over 2 weeks. In addition restrictions due to social distancing measures in outpatients mean that Skin particularly are not able to see as many patients face to face and therefore this waiting list is extended to 3-4 weeks.

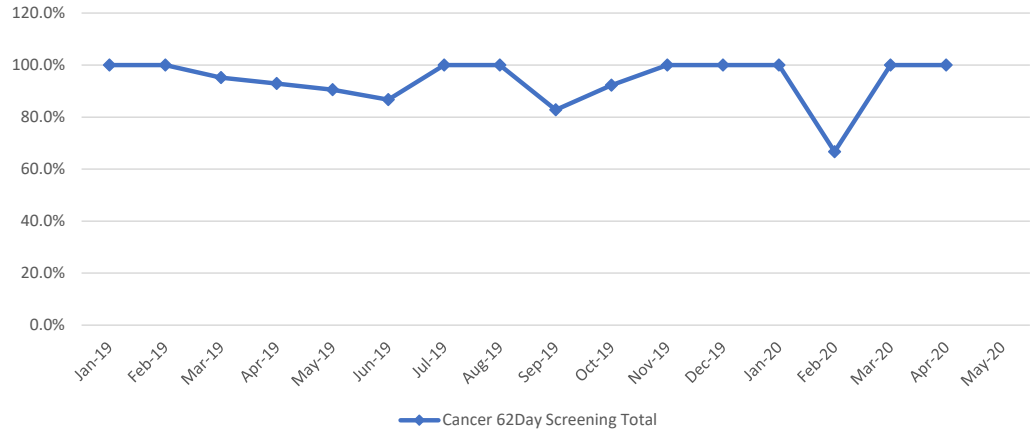
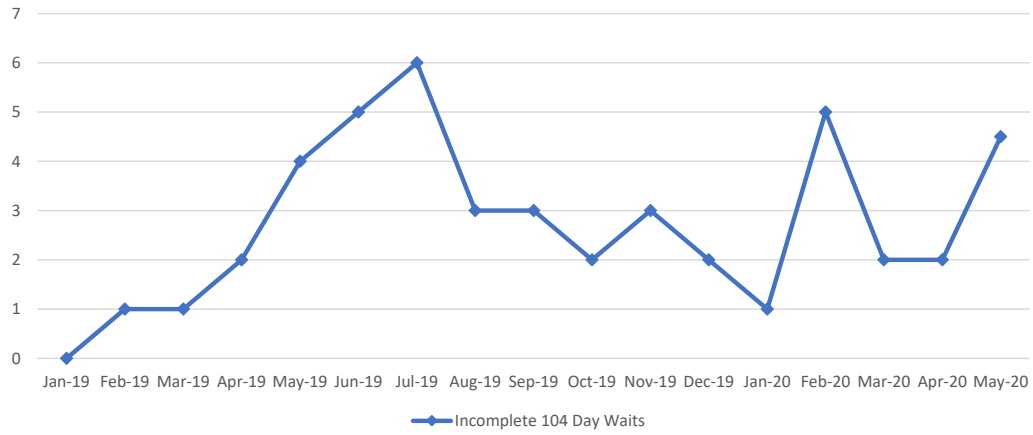
Performance Report to Board - June 2020

NHS West Suffolk NHS Foundation Trust

Board Report KPIs	Narratives
Cancer 2W Wait Breast Symptoms Total 	Standard achieved.
Cancer 62Day GP Referrals Total 	Treatment numbers are significantly lower than normal, - currently there have been 25 treatments recorded, with 14.5 breaches allocated across specialities. This is to be expected as diagnosis has been delayed and patients have been treated in accordance with the greatest clinical need. This standard will not be recovered over the next few months due to the significant diagnostic delays within Endoscopy particularly.

Performance Report to Board - June 2020

NHS West Suffolk NHS Foundation Trust

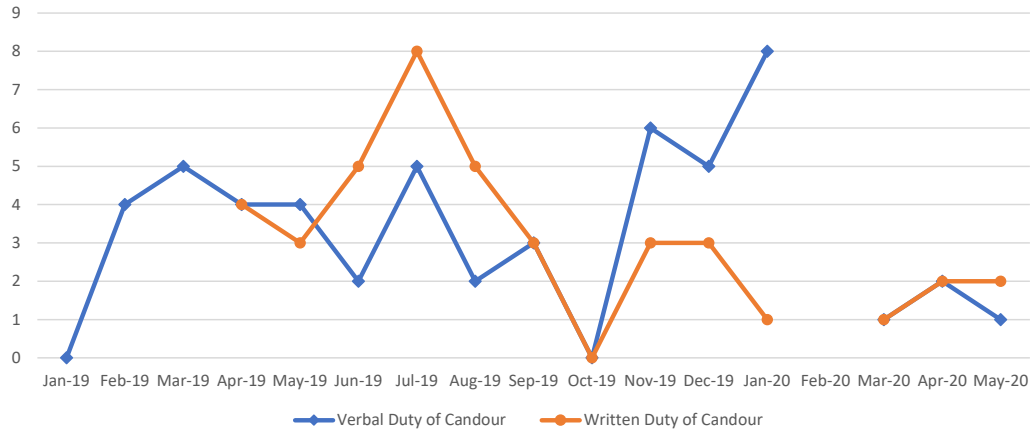
Board Report KPIs	Narratives
Cancer 62Day Screening Total 	Standard achieved.
Incomplete 104 Day Waits 	Currently there are 4.5 breaches reported for treatment over 104 days in May. 2 in Skin due to patient choice delays, 0.5 in Colorectal due to delay in diagnosis (patient treated at Tertiary centre), 1.5 in Haematology - diagnosis delay and patient choice. 0.5 in Urology due to delay in surgery (covid19 related) at tertiary centre. The number of patients on the cancer PTL over 104 days continues to be higher than normal, therefore it is expected that the number treated over 104 days will remain high than normal for the next few months.

Performance Report to Board - June 2020

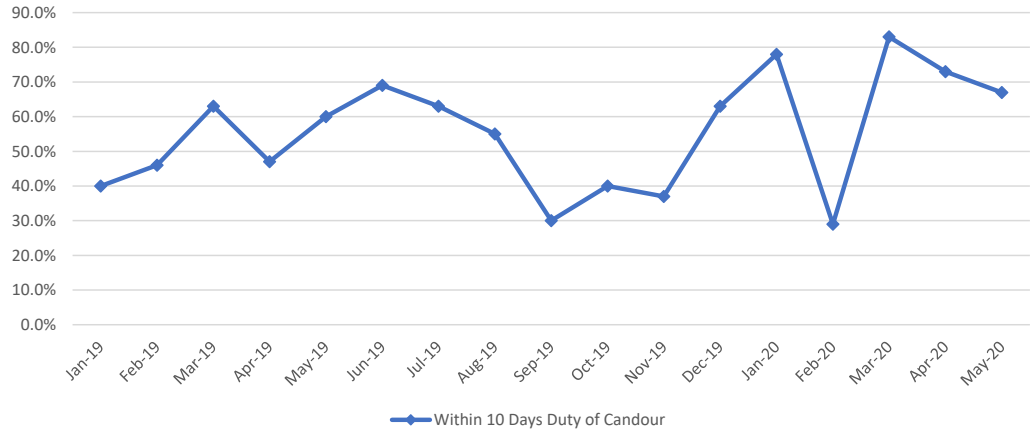
NHS West Suffolk NHS Foundation Trust

Board Report KPIs	Narratives

Duty of Candour



Within 10 Days Duty of Candour



Two charts are provided which measure 1). a count of how many cases are still overdue (both verbal and written) at the end of the reporting month and 2). timely completion of verbal DoC against the national requirement of 10 working days Reported using an SPC chart). There has been an improvement in completion rates in 2020 with only one verbal and two written still outstanding from Apr20 and earlier at the date of this report. The overall timeliness of completion fluctuates month on month although (with the exception of February) has shown a marked improvement in 2020 compared to 2019.

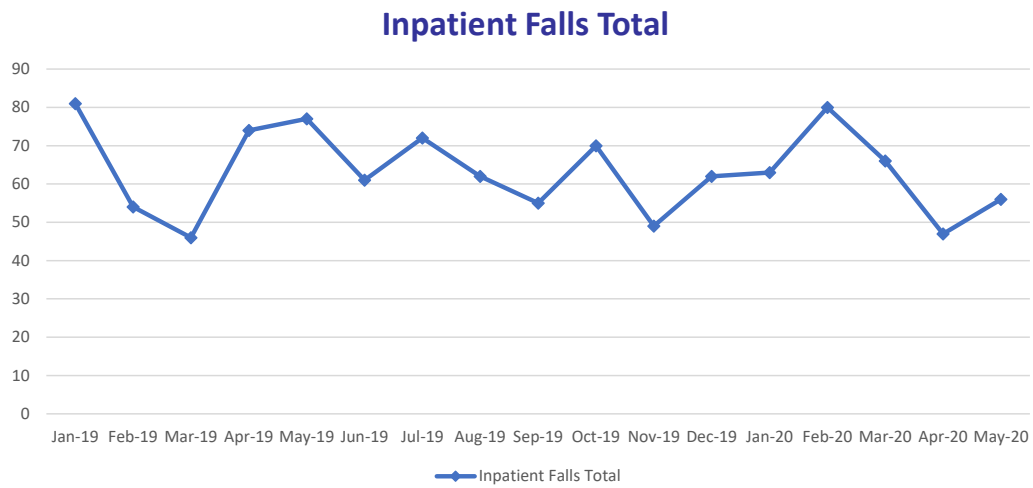
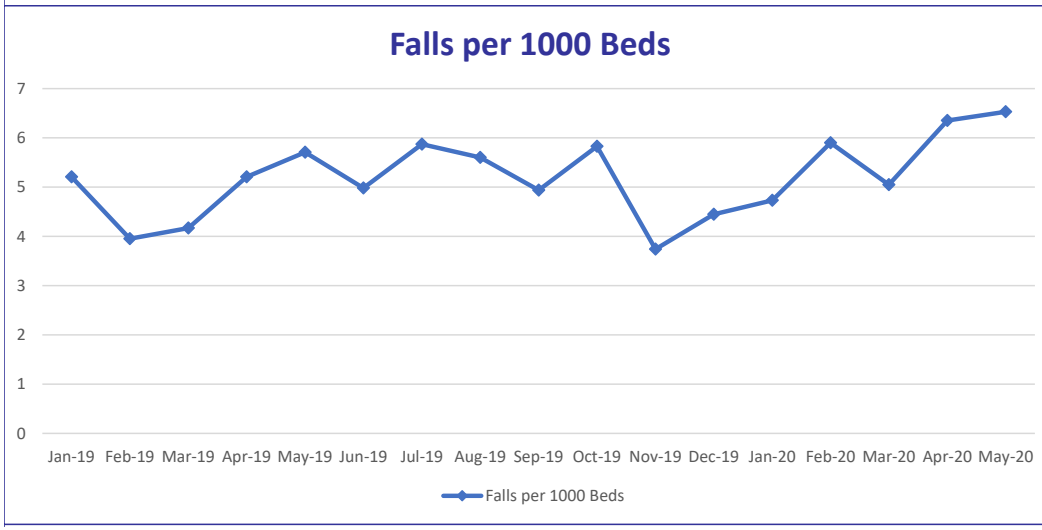
In 2019 options to improve all three DoC indicators were discussed. This is a multi-faceted issue with separate issues relating to different professions, different divisions and even record-keeping and it has been suggested that it might benefit from a QI-style improvement plan. This will be progressed with the support and guidance of the QI lead who has previously been providing clinical care in Critical Care during the COVID response. The CQC Improvement plan (for DoC) has been written although some actions are being updated to take account of the impact of COVID-19.

The closed Board report Serious incidents, complaints, claims and inquests now includes a section on decisions not to undertake DoC. This enable Exec / NED oversight and challenge (if required) for these decisions

The CCG requested and were sent, data on DoC completion (and reasons for non-completion) for the year 2019-20. Further details were included in the quarterly Quality & learning report provided to the May20 Trust Board.

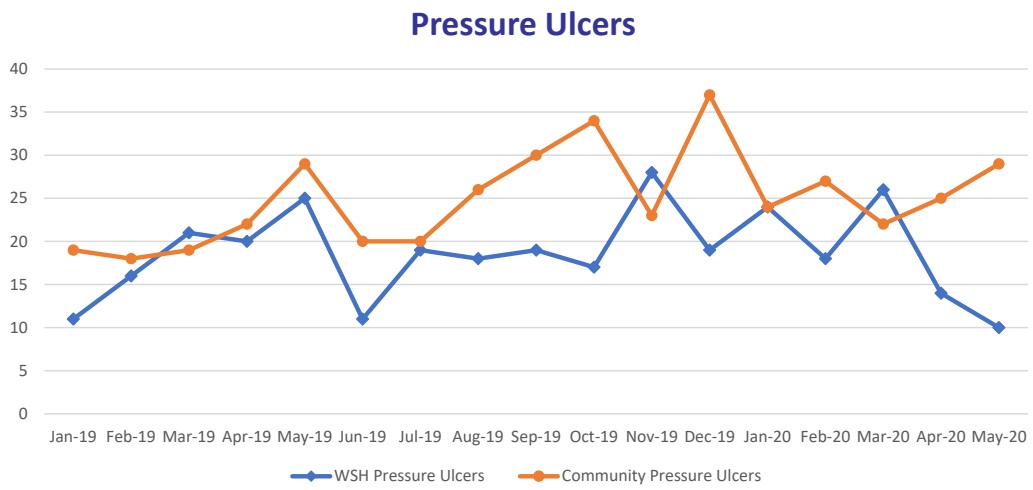
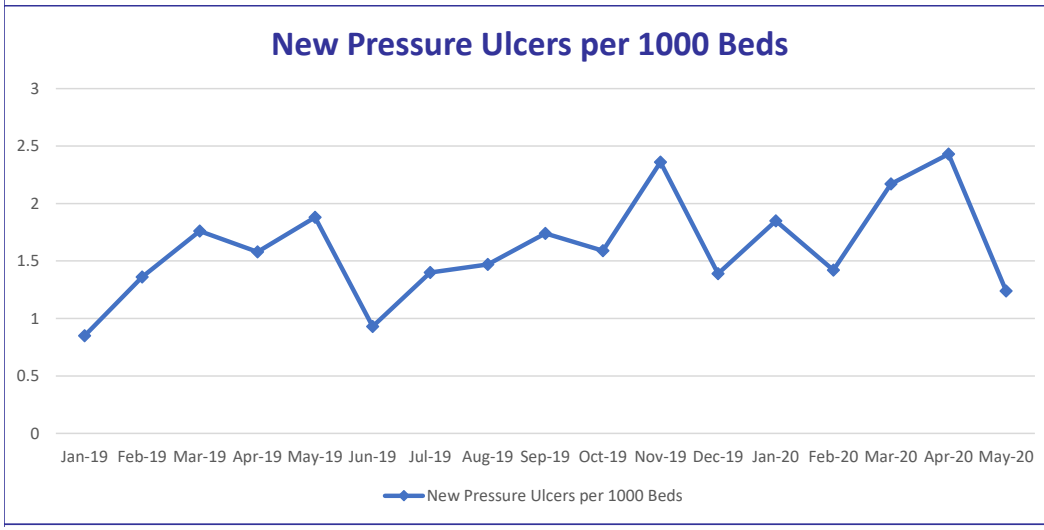
Performance Report to Board - June 2020

NHS West Suffolk NHS Foundation Trust

Board Report KPIs	Narratives
 	In place to improve Falls prevention: Lying and standing BP task activated for all patients over 65 admitted to in-patient areas. All wards have a falls champion Frequent fallers symbols are now in place behind the patients' bed space on the wall. Red gripper socks are being used for those patients at high risk of falls.. COVID impact: Planned falls awareness week was put on hold andfFalls group postponed Bay based nursing has not always been happening in the positive covid bays due to the risk of viral load. We have been completing a covid perfect ward audit. All incidents continued to be reviewed on a daily basis. Q1 developments Falls practitioner appointed Pilot of new falls equipment to begin in July on G5 Perfect Ward audit recommenced week beginning 13th May 2020

Performance Report to Board - June 2020

NHS West Suffolk NHS Foundation Trust

Board Report KPIs	Narratives
	Inpatient numbers are lower than normal but when expressed as a percentage of occupied bed days they are similar to previous months, community numbers are similar to previous months" Redeployment significantly affected the capacity of the TV service resulting in an extremely limited resource with the remaining fulltime TVN attempting to respond to referrals across both acute and community areas. Much of the support and advice has been remote however following triage, continuity of visiting acute patients to support wound care needs and pressure area management was performed
	

Performance Report to Board - June 2020

Board Report KPIs	Narratives
New Complaints 	Improvement of the complaints journey continued into May as we reduced our overall complaints by over 50% compared to March, meaning we can effectively manage complainant's expectations and provide more detailed responses into concerns raised. 12 complaints received in May 2020. 7 of these complaints have been resolved first time with no second letter received. All throughout May, we continued to triage complaints and RAG rate for severity. This then indicated whether we would aim to provide a response based on notes and documents on E-Care. Any Red rated complaints were put on hold. Our decision remained the same to not escalate complaints to relevant staff members, in line with NHS England and NHS Improvement guidance.
Closed Complaints 	A slight reduction in volume of complaints closed however following from the data cleanse work we completed in March and April, this included some quick wins and the more complex cases remained. 100% of complaints received in May were acknowledged within 3 working days and continue to this rate into June.

Performance Report to Board - June 2020

Board Report KPIs	Narratives
Overdue Responses 	5 complaints remain open with 4 reporting as overdue however when acknowledging each complaint we advised that we would accept the complaint however due to COVID-19, we are unable to provide a timescale in which the complainant would receive a response. We felt it necessary to accept the complaint and place on hold due to the nature of these complaints that mainly related to end of life care rather than providing a generic, less detailed response. Complainants have been kept updated with any progress. We therefore feel that these are not overdue however will be reported as overdue until we can provide them with a definitive response timescale.
Average daily calls answered by the helpline 	Introduction of the clinical helpline proved a huge success with 80% of calls being directed to this team and an average of 166 calls per day answered by the clinical team. The remaining 20% were answered by our PALS/ Non-Clinical team, answering general questions. Opening hours remained at 8am-8pm, 7 days a week. Positive feedback from relatives, patients and ward staff about the success of the helpline service. We will review the opening hours in June when staff start to return back to normal roles.

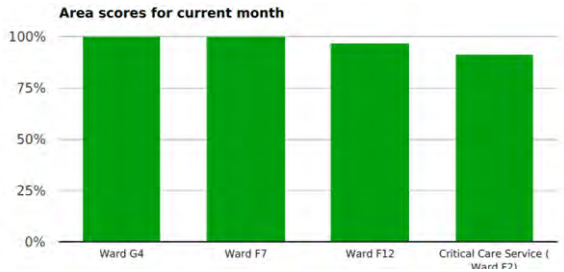
Performance Report to Board - June 2020

NHS West Suffolk NHS Foundation Trust

Board Report KPIs	Narratives
Acuity Measure - to be determind	Demand and acuity has been increasing over May, with a decrease in COVID demand and an increase in general medical and surgical emergencies. This has led, at times, to capacity pressures and the increase in demand for bank staff to provide additional support. Anecdotally, there is an increase in patients with high acuity due to delayed presentation, and this has been seen across many specialities. The Nursing acuity and dependency dashboard has been trialled during May. This has been developed by the Informatics team in conjunction with nursing and the information team. This is providing the senior nursing staff with information as to which areas have the greatest acuity, dependency or operational demand. The metrics are pulled from eCare and provide the team with a visual tool to aid the provision of staff to the areas of most need. This will be launched Trust wide following the trial and refinement.
Perfect ward May 2020 Report Inspection section Area scores for current month	During the pandemic we are undertaking alternative audits, for the COVID wards we have worked with our audit supplier and have a bespoke audit to cover Confirmed or suspected cases, Hand hygiene, PPE, Patient Safety, Signage and Staff awareness. During the inspection month there were 4 COVID-19 identified areas, below are the score results, the senior teams have been working with the areas that have scored in the amber region, it is to be noted that this was at the beginning of the pandemic and I would expect it to improve as we continue through this new way of working.

	Category	Score this month	Score last 12
1	Confirmed or Suspected Cases	100% (12)	100% (27)
2	Hand Hygiene	90% (20)	84% (44)
3	PPE	100% (27)	97% (65)
4	Patient Safety	0% (0)	0% (0)
5	Signage	100% (7)	75% (16)
6	Staff Awareness	98% (28)	97% (63)

Numbers in brackets show number of questions score is calculated from.



11. Finance and workforce report

To ACCEPT the report

For Report

Presented by Craig Black

Board of Directors – 26 June 2020

Agenda item:	11			
Presented by:	Craig Black, Executive Director of Resources			
Prepared by:	Nick Macdonald, Deputy Director of Finance			
Date prepared:	22nd June 2020			
Subject:	Finance and Workforce Board Report – May 2020			
Purpose:		For information	x	For approval

Executive summary:
The planned surplus for the year is to break even which will include receiving all FRF and MRET funding associated with meeting its control total. The Trust met its plan to break-even in May.

The Trust has been reimbursed with all costs relating to COVID 19.

Given the unusual nature of the current financial year our focus in future Board reports will be on our underlying income and expenditure position in readiness for 2021-22.

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:	*This report is produced for the monthly trust board meeting only*
Risk and assurance:	*These are highlighted within the report*
Legislation, regulatory, equality, diversity and dignity implications	*None*

Recommendation:
The Board is asked to review this report.

FINANCE AND WORKFORCE REPORT
May 2020 (Month 2)

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

Financial Summary

I&E Position YTD	£0m	break-even
Variance against Plan YTD	£0m	on-plan
Movement in month against plan	£0m	on-plan
EBITDA position YTD	£6.8m	adverse
EBITDA margin YTD	16%	adverse
Total PSF Received	£6.8m	accrued
Cash at bank	£23.4m	

Executive Summary

- The planned surplus for the year is to break even. This will include receiving all FRF and MRET funding associated with meeting the Trusts Financial Improvement Trajectory (FIT – formerly "Control total").
- The Trust has been reimbursed with all costs relating to COVID 19
- Given the unusual nature of the current financial year our focus in future Board reports will be on our underlying income and expenditure position in readiness for 2021-22

Key Risks in 2020-21

- Delivery of £8.7m CIP programme
- Capturing all COVID 19 related costs and being fully reimbursed for these

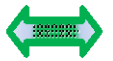
SUMMARY INCOME AND EXPENDITURE ACCOUNT - May 2020	May 2020 Budget £m	May 2020 Actual £m	May 2020 Variance F/(A) £m	Year to date Budget £m	Year to date Actual £m	Year to date Variance F/(A) £m
NHS Contract Income	17.9	18.4	0.4	36.2	36.1	(0.1)
Other Income	2.8	2.9	0.1	6.0	6.1	0.1
Total Income	**20.8**	**21.2**	**0.5**	**42.2**	**42.2**	**(0.0)**
Pay Costs	17.6	17.0	0.5	33.1	32.5	0.6
Non-pay Costs	4.4	6.5	(2.1)	12.9	14.5	(1.6)
Operating Expenditure	**21.9**	**23.6**	**(1.6)**	**46.0**	**47.0**	**(1.0)**
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0
EBITDA excl STF	**(1.2)**	**(2.3)**	**(1.2)**	**(3.8)**	**(4.8)**	**(1.0)**
Depreciation	0.7	0.7	(0.0)	1.3	1.3	0.1
Finance costs	0.3	0.3	0.0	0.7	0.7	(0.1)
SURPLUS/(DEFICIT)	**(2.2)**	**(3.4)**	**(1.2)**	**(5.8)**	**(6.8)**	**(1.0)**
Provider Sustainability Funding (PSF)						
PSF / FRF/ MRET/ Top Up	2.2	3.4	1.2	5.8	6.8	1.0
SURPLUS/(DEFICIT) incl PSF	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

FINANCE AND WORKFORCE REPORT – May 2020

Contents:

Key:

Performance better than plan and improved in month	
Performance better than plan but worsened in month	
Performance worse than plan but improved in month	
Performance worse than plan and worsened in month	

Performance better than plan and maintained in month	
Performance worse than plan and maintained in month	
Performance meeting target	✓
Performance failing to meet target	✗

FINANCE AND WORKFORCE REPORT – May 2020

Income and Expenditure Summary as at May 2020

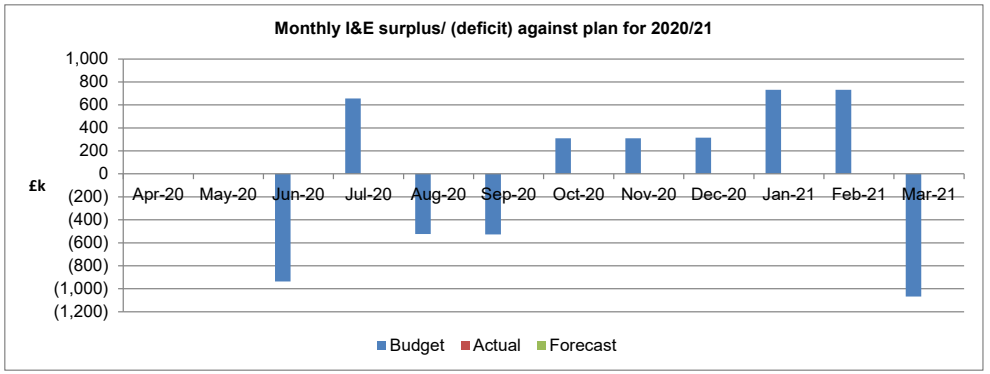
The reported I&E for May is break even, in line with NHSI guidance. Due to COVID-19 we are receiving a top up payment that includes MRET and FRF and ensures we break even. The value of this for May was £3.4m (£6.8m YTD).

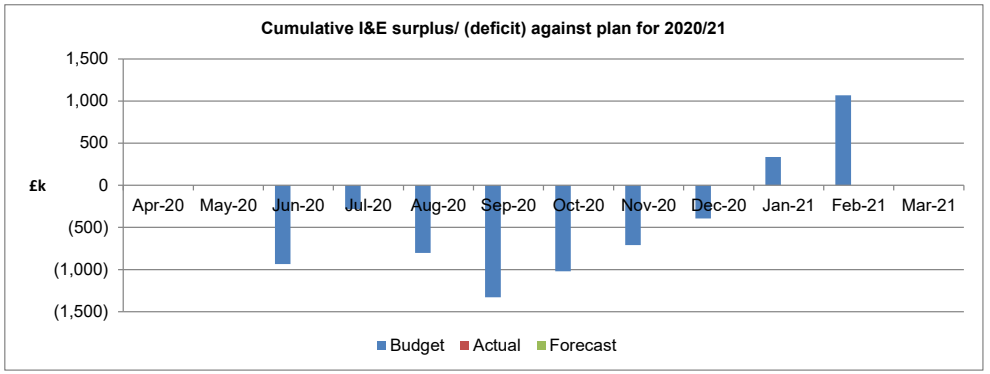
We anticipate this arrangement continuing until at least October 2020.This funding is forecast to increase our income by £10m more than our plan, but we also anticipate expenditure of £10m more than plan. The result is that we forecast to break even, in line with our Financial Improvement Trajectory (FIT).

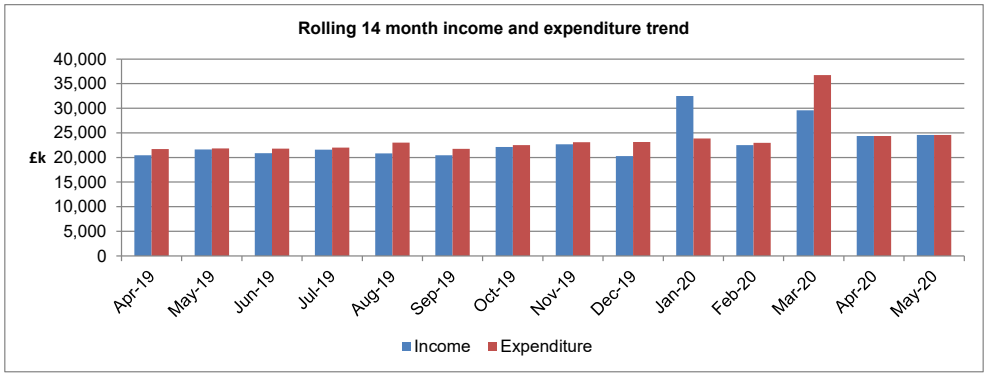
However, the extent to which the overspend on expenditure is recurring will impact on our run rate for 2021-22, (for instance underachieved CIP). We continue to analyse our recurring expenditure in order identify and to take action to improve any pressures that would otherwise arise in 2021-22, and will report on this in the coming months.

Summary of I&E indicators

Income and Expenditure	Plan/ Target £000'	Actual/ Forecast £000'	Variance to plan (adv)/ fav £000'	Direction of travel (variance)	RAG (report on red)
In month surplus/ (deficit)	0	0	0	⇔	Green
YTD surplus/ (deficit)	0	0	0	⇔	Green
Forecast surplus/ (deficit)	(0)	0	0	⇔	Green
EBITDA (excl top-up) YTD	(2,187)	(3,384)	(1,197)	↓	Red
EBITDA %	(10.5%)	(15.9%)	(5.4%)	↓	Red
Clinical Income YTD	(75,829)	(75,423)	(406)	↑	Amber
Non-Clinical Income YTD	(9,856)	(11,122)	1,267	↑	Green
Pay YTD	33,073	32,487	585	↑	Green
Non-Pay YTD	14,937	16,484	(1,547)	↓	Red
CIP Target YTD	1,498	1,015	(483)	↓	Red







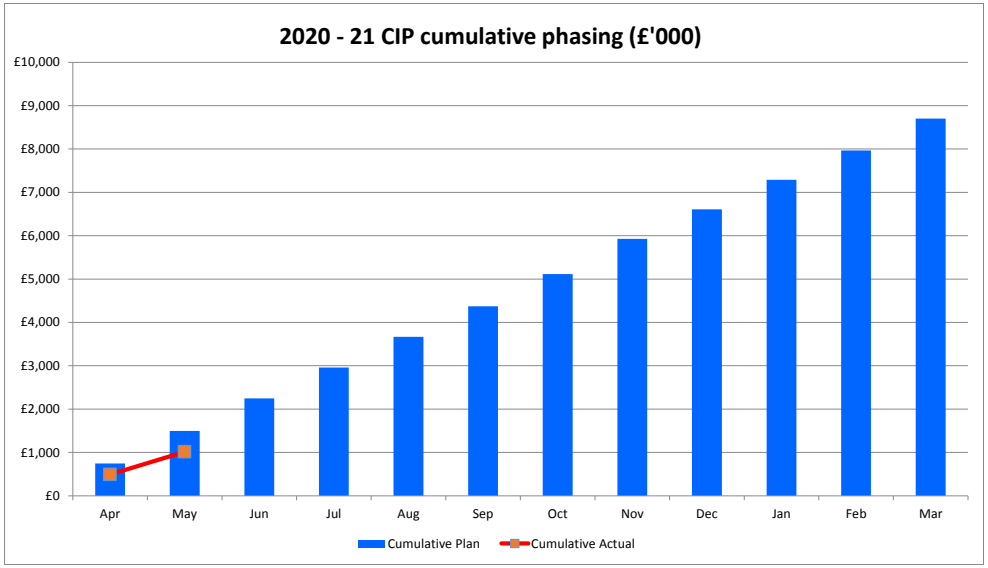
FINANCE AND WORKFORCE REPORT – May 2020

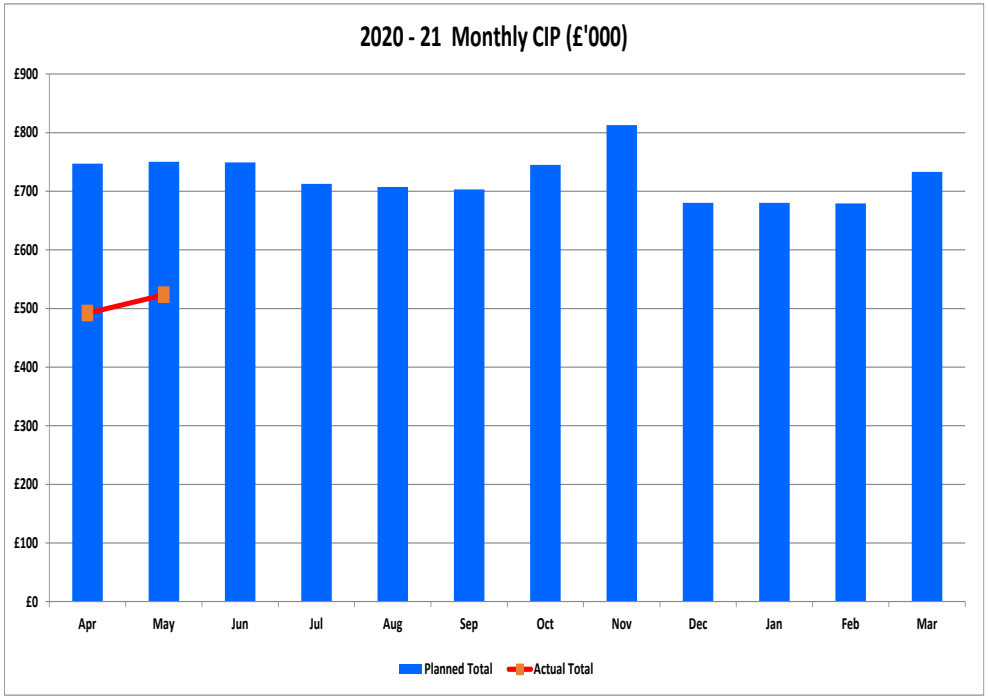
Cost Improvement Programme (CIP) 2020-21

In order to deliver the Trust's control target in 2020-21 we needed to deliver a CIP of £8.7m (3.4%). The plan for April was £1.498m (17.2% of the annual plan) and we achieved £1.015m (11.7%). This represents a shortfall of £482k.

Recurring/Non Recurring	2020-21 Annual Plan	Plan YTD	Actual YTD
	£'000	£'000	£'000
Recurring			
Outpatients	254	28	9
Procurement	366	61	59
Activity growth	200	33	33
Additional sessions	363	61	-
Community Equipment Service	510	85	41
Drugs	367	61	46
Estates and Facilities	30	6	2
Other	1,050	155	168
Other Income	388	65	-
Pay controls	260	43	55
Service Review	16	5	5
Staffing Review	819	119	102
Theatre Efficiency	302	50	-
Contract Review	50	8	-
Workforce	-	-	-
Consultant staffing	-	-	-
Agency	-	-	-
Unidentified CIP	1,268	211	-
Recurring Total	**6,242**	**991**	**520**
Non-Recurring			
Pay controls	647	141	132
Other	1,805	363	363
Estates and Facilities	6	2	-
Non-Recurring Total	**2,458**	**506**	**495**
Total CIP	**8,700**	**1,498**	**1,015**
	17.2%	11.7%	(482)

Division	Divisional	YTD Var	Unidentified	Unidentified
Medicine	2,555	(123)	43	255
Surgery	2,029	(136)	34	203
W&C/CSS	1,847	(27)	0	0
Community	1,422	(84)	21	125
E&F	516	(84)	77	464
Corporates	331	(28)	37	221
Stretch	0	0	0	0
Total	**8,700**	**(482)**	**211**	**1,268**

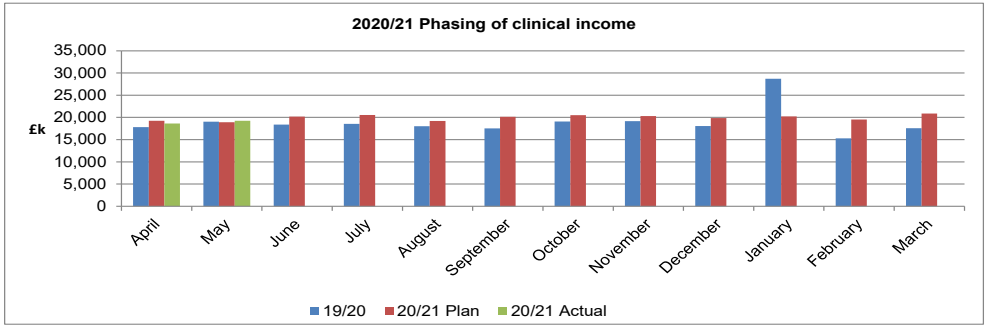




FINANCE AND WORKFORCE REPORT – May 2020

Income Analysis

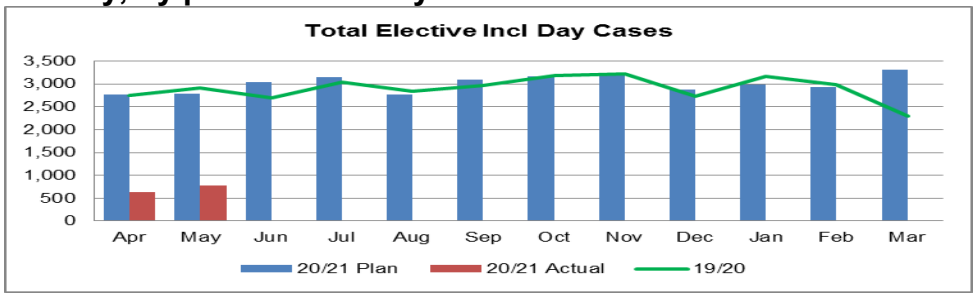
The chart below demonstrates the phasing of all clinical income plan for 2020-21, including Community Services. This phasing is in line with phasing of activity.

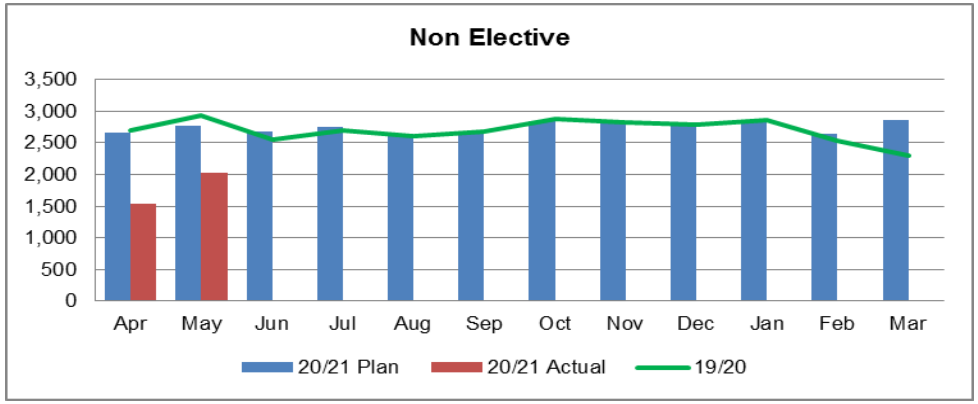


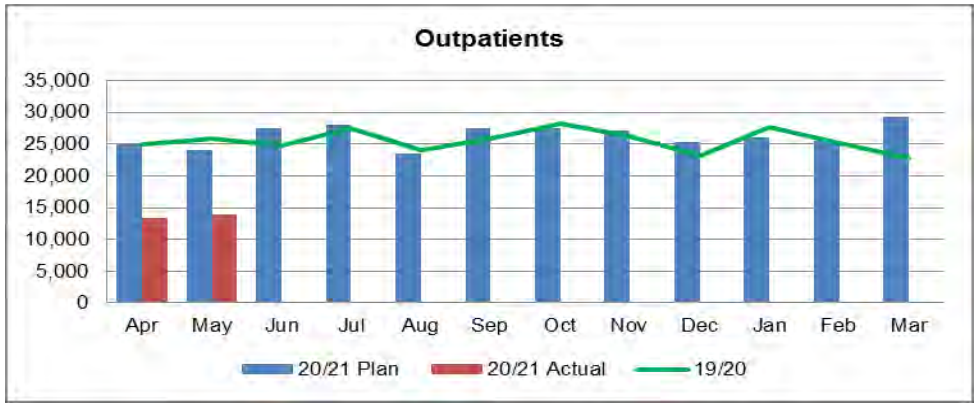
The income position was ahead of plan for May. The income was based on the national agreed block payments as set out by NHS England, these were put in place to give Providers assured income during the coronavirus period.

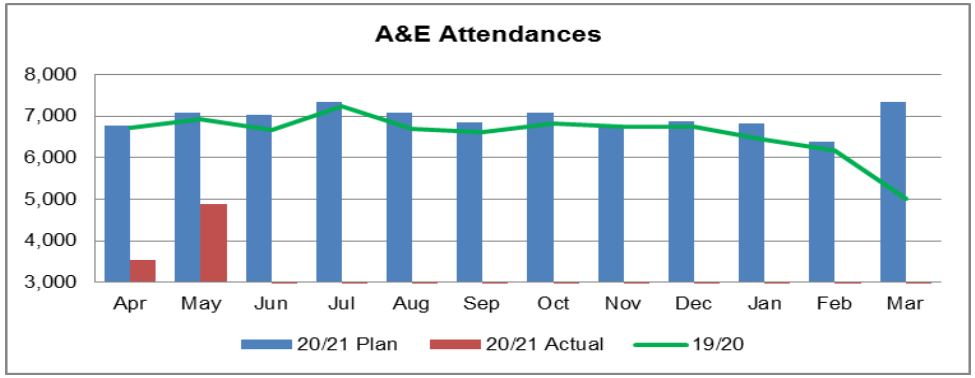
	Current Month			Year to Date		
Income (£000s)	Plan	Actual	Variance	Plan	Actual	Variance
Accident and Emergency	1,037	758	(280)	2,029	1,330	(699)
Other Services	2,547	7,468	4,920	5,654	15,411	9,757
CQUIN	176	123	(54)	350	230	(120)
Elective	2,764	523	(2,242)	5,364	894	(4,471)
Non Elective	6,591	6,355	(235)	13,018	12,092	(926)
Emergency Threshold Adjustment	(346)	(346)	0	(687)	(687)	0
Outpatients	2,929	1,234	(1,695)	5,970	2,328	(3,642)
Community	2,988	2,988	0	5,976	5,976	0
Total	**18,687**	**19,102**	**415**	**37,674**	**37,574**	**(100)**

Activity, by point of delivery



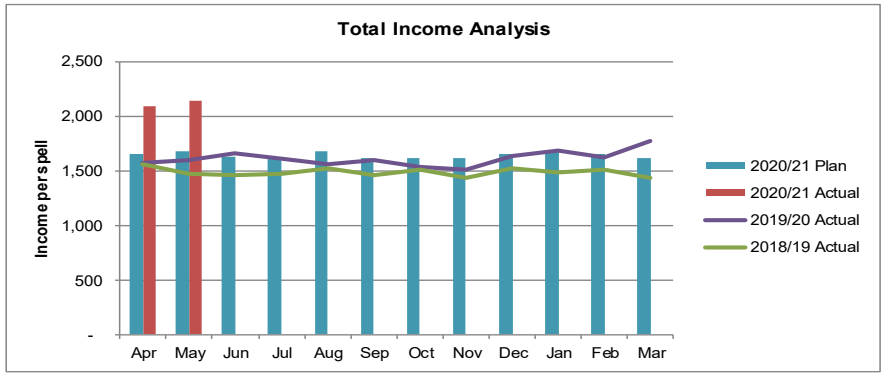


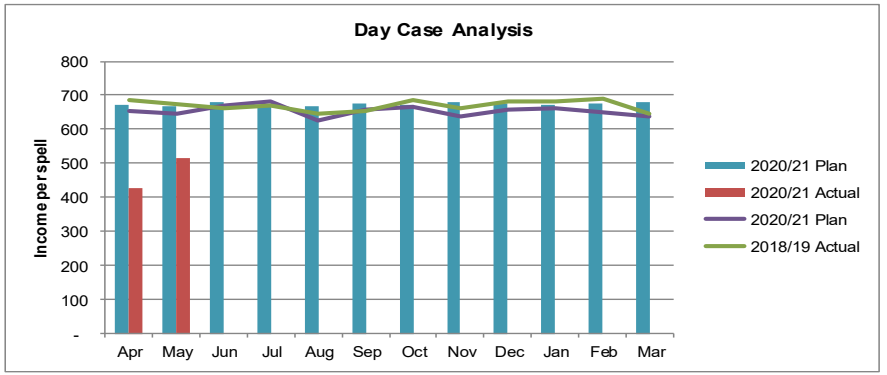


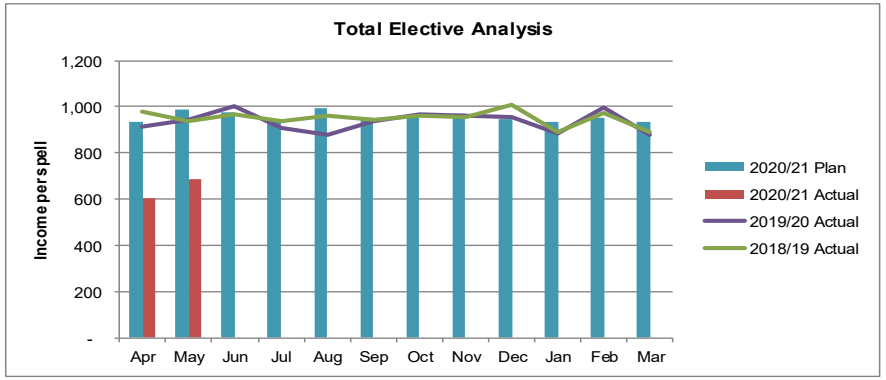


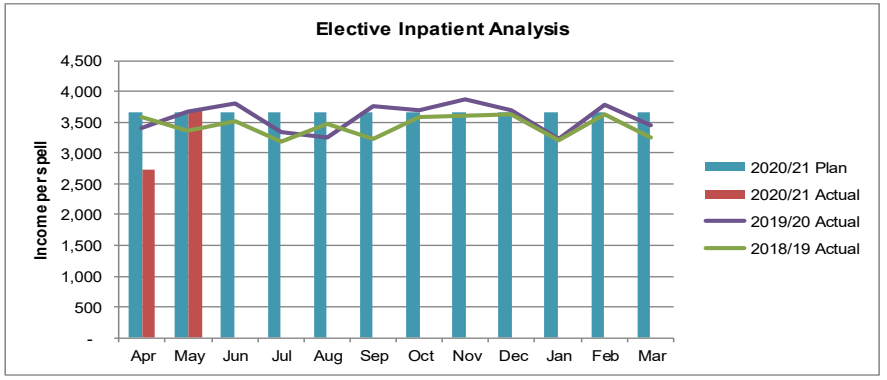
FINANCE AND WORKFORCE REPORT – May 2020

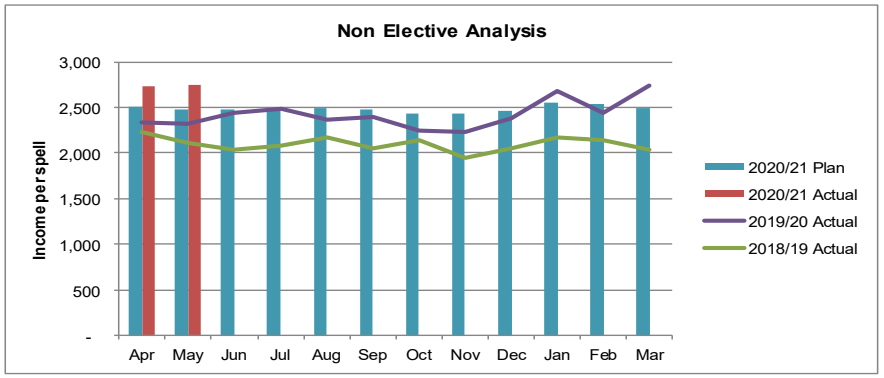
Trends and Analysis

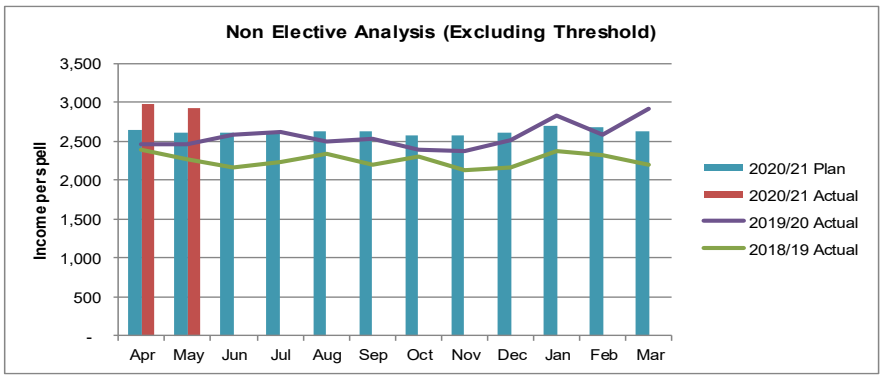












FINANCE AND WORKFORCE REPORT – May 2020

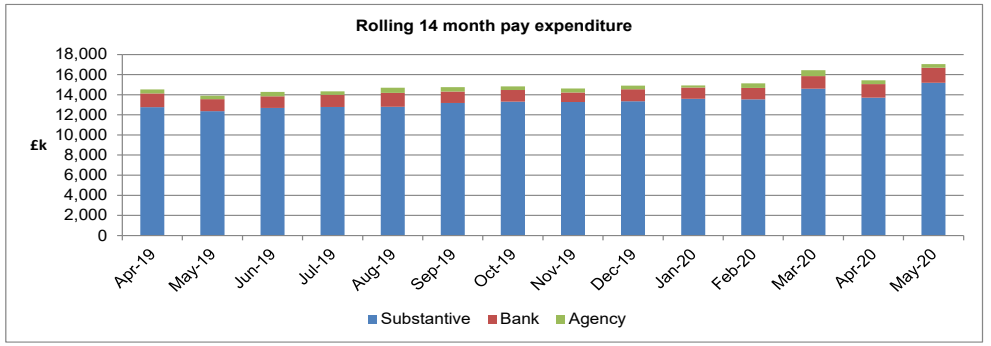
Workforce

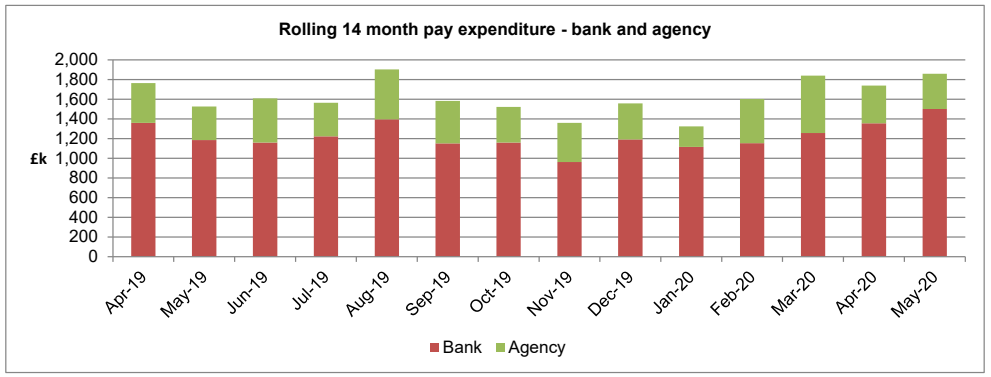
Monthly Expenditure (£)				
As at May 2020	May-20	Apr-20	May-19	YTD
	£000's	£000's	£000's	£000's
Budgeted Costs in-month	15,512	0	14,452	31,030
Substantive Staff	15,187	13,703	12,371	28,891
Medical Agency Staff	237	151	99	388
Medical Locum Staff	262	289	139	551
Additional Medical Sessions	378	264	272	642
Nursing Agency Staff	69	170	190	239
Nursing Bank Staff	406	424	393	829
Other Agency Staff	52	61	53	113
Other Bank Staff	189	199	126	389
Overtime	200	113	184	313
On Call	65	66	69	131
Total Temporary Expenditure	1,858	1,738	1,525	3,597
Total Expenditure on Pay	17,046	15,442	13,897	32,487
Variance (F/(A))	(1,534)	(15,442)	556	(1,458)
Temp. Staff Costs as % of Total Pay	10.9%	11.3%	11.0%	11.1%
memo: Total Agency Spend in-month	358	383	342	741

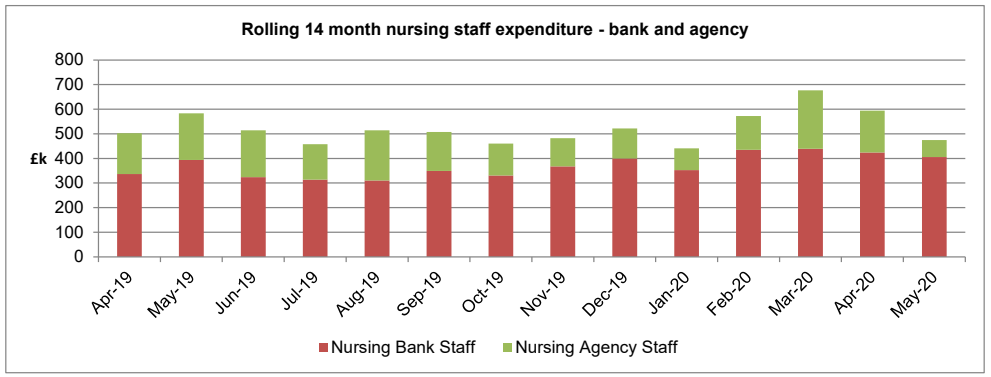
Monthly WTE				
As at May 2020	May-20	Apr-20	May-19	YTD
	£000's	£000's	£000's	£000's
Budgeted WTE in-month	4,048.1	0.0	3,931.5	8,063.3
Substantive Staff	3,751.2	3,713.2	3,406.0	7,464.4
Medical Agency Staff	18.7	22.0	8.2	40.7
Medical Locum Staff	18.4	26.4	13.1	44.8
Additional Medical Sessions	6.5	(0.5)	11.6	6.0
Nursing Agency Staff	9.9	24.4	26.6	34.3
Nursing Bank Staff	115.4	129.3	100.2	244.6
Other Agency Staff	10.0	13.7	8.0	23.7
Other Bank Staff	73.2	79.2	57.8	152.4
Overtime	51.4	30.0	49.4	81.4
On Call	5.1	5.6	6.4	10.7
Total Temporary WTE	308.7	330.1	281.4	638.7
Total WTE	4,059.9	4,043.2	3,687.4	8,103.1
Variance (F/(A))	(11.8)	(4,043.2)	244.1	(39.8)
Temp. Staff WTE as % of Total WTE	7.6%	8.2%	7.6%	7.9%
memo: Total Agency WTE in-month	38.6	60.1	42.8	98.8

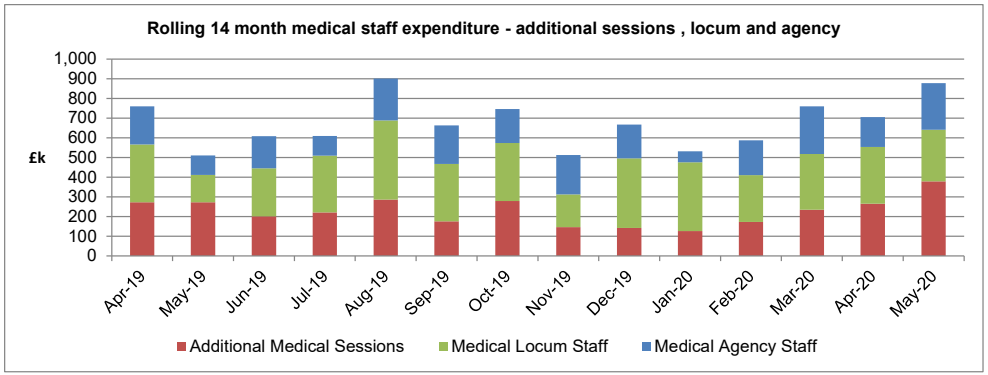
Pay Trends and Analysis

During May the Trust underspent by £509k on pay (£585k YTD).

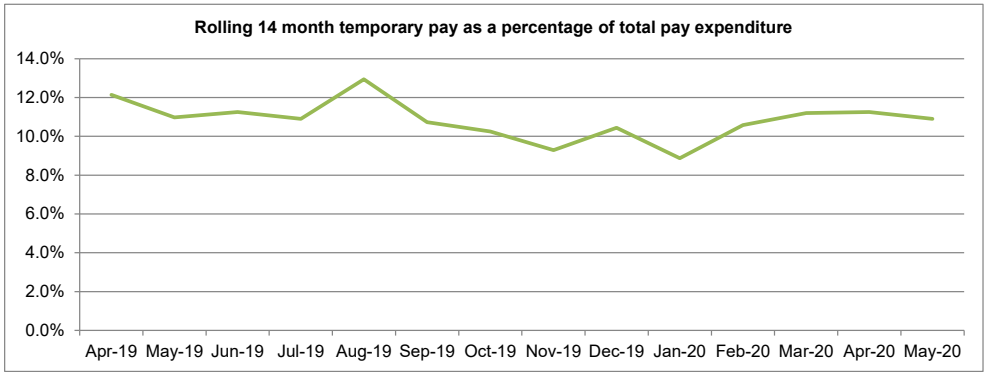


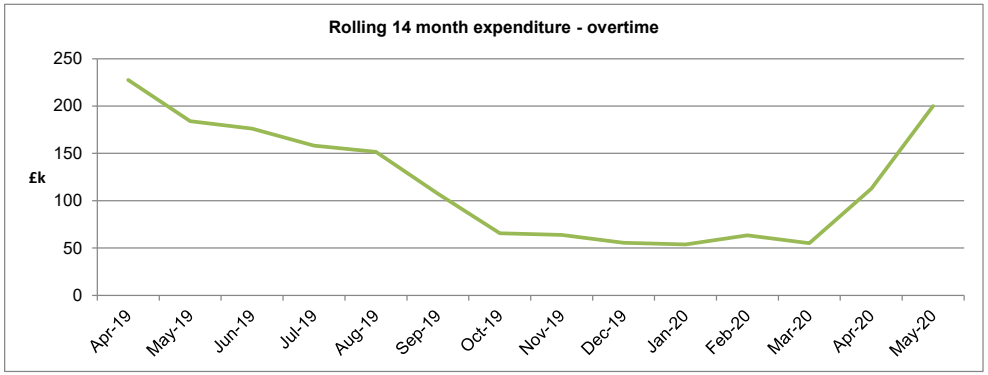






Expenditure on Additional Sessions was £378k in May (£264k in April)





FINANCE AND WORKFORCE REPORT – May 2020

Income and Expenditure Summary by Division

	Current Month			Year to date		
	Budget	Actual	Variance F/(A)	Budget	Actual	Variance F/(A)
MEDICINE	£k	£k	£k	£k	£k	£k
Total Income	(7,209)	(5,231)	(1,978)	(14,724)	(9,722)	(5,002)
Pay Costs	4,208	3,748	460	8,416	7,438	978
Non-pay Costs	1,138	1,134	4	2,783	2,428	354
Operating Expenditure	**5,346**	**4,882**	**464**	**11,199**	**9,867**	**1,332**
SURPLUS / (DEFICIT)	**1,863**	**349**	**(1,514)**	**3,525**	**(145)**	**(3,670)**
SURGERY						
Total Income	(5,291)	(2,523)	(2,768)	(10,437)	(4,416)	(6,021)
Pay Costs	3,351	3,117	235	6,694	6,184	510
Non-pay Costs	1,045	532	514	2,064	1,130	935
Operating Expenditure	**4,397**	**3,648**	**749**	**8,758**	**7,314**	**1,445**
SURPLUS / (DEFICIT)	**895**	**(1,125)**	**(2,020)**	**1,679**	**(2,897)**	**(4,576)**
WOMENS AND CHILDRENS						
Total Income	(1,897)	(1,414)	(483)	(3,784)	(2,878)	(906)
Pay Costs	1,424	1,353	71	2,822	2,658	164
Non-pay Costs	167	144	23	341	315	26
Operating Expenditure	**1,591**	**1,497**	**94**	**3,163**	**2,973**	**190**
SURPLUS / (DEFICIT)	**306**	**(83)**	**(389)**	**621**	**(95)**	**(716)**
CLINICAL SUPPORT						
Total Income	(806)	(525)	(281)	(1,631)	(977)	(654)
Pay Costs	1,616	1,448	168	3,258	2,997	261
Non-pay Costs	1,084	964	119	2,209	2,056	153
Operating Expenditure	**2,700**	**2,412**	**287**	**5,468**	**5,053**	**415**
SURPLUS / (DEFICIT)	**(1,894)**	**(1,888)**	**6**	**(3,837)**	**(4,076)**	**(239)**
COMMUNITY SERVICES						
Total Income	(3,505)	(3,517)	12	(7,009)	(7,024)	15
Pay Costs	2,522	2,552	(31)	5,043	4,993	50
Non-pay Costs	930	1,250	(321)	1,861	2,341	(480)
Operating Expenditure	**3,451**	**3,803**	**(352)**	**6,904**	**7,334**	**(430)**
SURPLUS / (DEFICIT)	**54**	**(286)**	**(339)**	**105**	**(310)**	**(415)**
ESTATES AND FACILITIES						
Total Income	(420)	(523)	103	(841)	(1,087)	246
Pay Costs	901	804	97	1,801	1,702	100
Non-pay Costs	612	503	109	1,225	1,011	214
Operating Expenditure	**1,513**	**1,307**	**206**	**3,026**	**2,712**	**314**
SURPLUS / (DEFICIT)	**(1,093)**	**(784)**	**309**	**(2,185)**	**(1,626)**	**560**
CORPORATE						
Total Income	(3,805)	(10,856)	7,052	(9,567)	(22,837)	13,270
Pay Costs	3,533	4,024	(491)	5,038	6,515	(1,477)
Non-pay Costs	(591)	1,996	(2,588)	2,451	5,216	(2,765)
Capital Charges and Financing Costs	993	1,019	(26)	1,985	1,957	28
Operating Expenditure	**3,935**	**6,020**	**(2,086)**	**9,474**	**11,731**	**(2,257)**
SURPLUS / (DEFICIT)	**(130)**	**4,836**	**4,966**	**93**	**11,107**	**11,014**
TOTAL						
Total Income	(22,932)	(24,589)	1,657	(47,992)	(48,941)	949
Pay Costs	17,555	17,046	509	33,073	32,487	585
Non-pay Costs	4,384	6,524	(2,139)	12,934	14,496	(1,562)
Capital Charges and Financing Costs	993	1,019	(26)	1,985	1,957	28
Operating Expenditure	**22,932**	**24,589**	**(1,656)**	**47,992**	**48,941**	**(948)**
SURPLUS / (DEFICIT)	**0**	**0**	**0**	**0**	**0**	**0**

Medicine (Sarah Watson)

The division reports an adverse variance of £1.51m in May (£3.67m YTD).

Clinical income is behind plan in month by £2.0m. This is driven by the reduced activity across the Trust as a result of the COVID 19 pandemic. This reduction is witnessed across both elective and non-elective activity within Medicine. However, this loss of divisional income is offset within the Corporate division due to the guarantees over the block contract.

Also as a result of COVID 19, the division is underspent against budget for Pay costs (£460k) in May. The following wards were used by the Trust to treat either confirmed or suspected COVID patients: F12, F7, F10, F9 & G4. The cost for these wards will be reclaimed under COVID 19 funding provisions. As such, the costs for these wards have not been met by the division in month, causing the underspend. It should be noted that as long as these (or other) wards are being used for the same purpose, it is anticipated that these underspends will continue.

The division is also recording a £4k underspend on non-pay. This is the net of COVID-19 driven underspends (either through reduced activity, through reclaiming costs or through unmet CIPS) and the correction of an accrual from the prior month.

Surgery (Simon Taylor)

The division reports an adverse variance of £2.02m in May (£4.58m YTD).

COVID has had a significant effect on Surgery, with the need to open extra critical care capacity and needing to stop nearly all elective work to support the COVID response. As a result income based is £2.77m below plan in month (£6.02m YTD).

Pay was underspent by £235k in month (£510k YTD) due to fewer additional sessions being needed for elective work, as well as delays in planned enhancements to certain services. It is anticipated that this will be spent later in the financial year to support recovery.

Non-pay has also underspent by £514k in month (£935k YTD) due to fewer patients in surgical beds or being treated in theatres and clinics. Much of this underspend relates to theatres and should be spent later in the year to support recovery.

Surgery missed its CIP plan in month two and still has not identified a full plan due to COVID planning took precedence. Further to this, the effect COVID is anticipated to have in theatres and clinics means some CIP schemes will not be achievable, until normal service is possible.

Women and Children's (Darin Geary)

The division reports an adverse variance of £389k in May (£716k YTD)

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The elective, non-elective and outpatient work performed under NHS contract dropped by around 35% because of COVID. This led to NHS activity being £483k off plan in month (£906k YTD).

Pay reported a £71k underspend in-month (£164k YTD) as many of the activity related pay spends reduced because of the lower activity levels.

Non-pay costs reduced in month as the reduced activity levels have impacted on the amount of orders processed.

Clinical Support (Darin Geary)

The division reports a favourable variance of £6k in May (£239k adverse variance YTD).

Income for Clinical Support reported £281k behind plan in-month because outpatient activity was behind plan by around 56% and radiology activity was behind plan by around 78%. This represents an increase in activity over the last month. The Division is behind its income plan by £654k YTD.

Pay reported a £168k underspend in-month (£261k YTD) as many of the activity related pay spends reduced because of the lower activity levels.

Non-pay reported a £119k underspend in-month (£153k YTD) as consumable usage reduced in line with activity.

Community Services (Michelle Glass)

The division reports an adverse variance of £339m in May (£415k YTD).

Income reported a £12k over recovery in month (£15k YTD) and the Division currently expect to achieve income in line with budget in 20-21. Where income is linked to a cost and volume contract, the Division will track and forecast the impact of COVID on the activity levels.

There was an in-month over spend on pay of £31k (£50k underspend, YTD). The Division continue to require agency staff to cover some vacant roles in order to ensure service resilience, support patient flow and manage demand across the services. Through the use of bank and some staff redeployment, the Division is managing the impact of vacancies at this time and is actively recruiting to vacancies.

Non-pay reported an adverse variance of £321k in May (£480k YTD). The in-month position reflects an over spend on Community Equipment and associated activity costs, required to support the facilitation of hospital discharge, to enable patients to remain independent at home and to support End of Life patients at home. A significant proportion of these costs will be recovered in June, with additional external funding secured to support End of Life patients, including the provision of equipment.

The Division will also recover costs incurred to provide equipment for patients in recently commissioned community beds. We have put in place a number of initiatives, such as providing clinical advisor capacity to ensure utilisation of recycled special equipment and undertake frequent core stock product reviews to ensure the most effective products are available to prescribers and relaunched the 'return, recycle, reuse' campaign. Other one off costs were incurred to further support home and mobile working across our teams.

Statement of Financial Position at 31 May 2020

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2020	Plan 31 March 2021	Plan YTD 31 May 2020	Actual at 31 May 2020	Variance YTD 31 May 2020
	£000	£000	£000	£000	£000
Intangible assets	40,972	48,993	38,116	34,760	(3,356)
Property, plant and equipment	110,593	147,050	116,121	121,630	5,509
Trade and other receivables	5,707	5,707	5,707	5,707	0
Total non-current assets	**157,272**	**201,750**	**159,944**	**162,097**	**2,153**
Inventories	2,872	3,000	3,000	3,004	4
Trade and other receivables	32,342	20,666	20,666	24,398	3,732
Cash and cash equivalents	2,441	1,510	18,010	23,388	5,378
Total current assets	**37,655**	**25,176**	**41,676**	**50,790**	**9,114**
Trade and other payables	(33,692)	(23,000)	(23,961)	(33,042)	(9,081)
Borrowing repayable within 1 year	(58,529)	(11,364)	(58,281)	(58,349)	(68)
Current Provisions	(67)	(67)	(67)	(67)	0
Other liabilities	(1,933)	(1,000)	(20,000)	(19,129)	871
Total current liabilities	**(94,221)**	**(35,431)**	**(102,309)**	**(110,587)**	**(8,278)**
Total assets less current liabilities	**100,706**	**191,495**	**99,311**	**102,300**	**2,989**
Borrowings	(52,538)	(59,241)	(53,676)	(53,488)	188
Provisions	(744)	(744)	(744)	(741)	3
Total non-current liabilities	**(53,282)**	**(59,985)**	**(54,420)**	**(54,229)**	**191**
Total assets employed	**47,424**	**131,510**	**44,891**	**48,071**	**3,180**
Financed by					
Public dividend capital	74,065	160,844	74,225	74,065	(160)
Revaluation reserve	6,942	6,942	6,942	6,942	0
Income and expenditure reserve	(33,583)	(36,276)	(36,276)	(32,936)	3,340
Total taxpayers' and others' equity	**47,424**	**131,510**	**44,891**	**48,071**	**3,180**

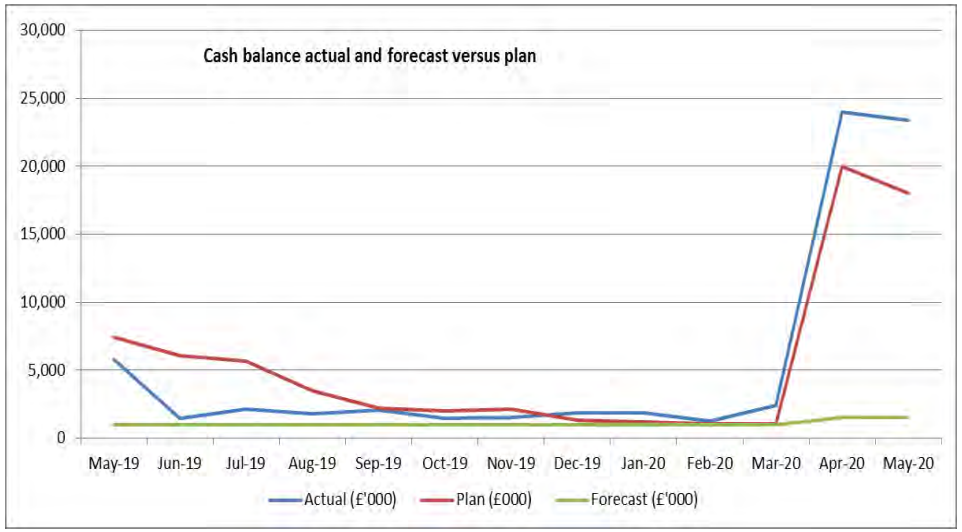
There has been little movement in the balance sheet since the year end. The most notable movements are as follows (cash movement is included separately):

Trade and Other Receivables
Receivables have decreased since April and this is mainly due to debts with NHS Organisations not accruing due to the current cash arrangements within the NHS and items being paid in advance and in block payments.

Other liabilities
Contract payments are currently being received in advance during the current pandemic. These receipts are shown against other liabilities.

Cash Balance Forecast for the year

The graph illustrates the cash trajectory since May 2019. The Trust is required to keep a minimum balance of £1m.



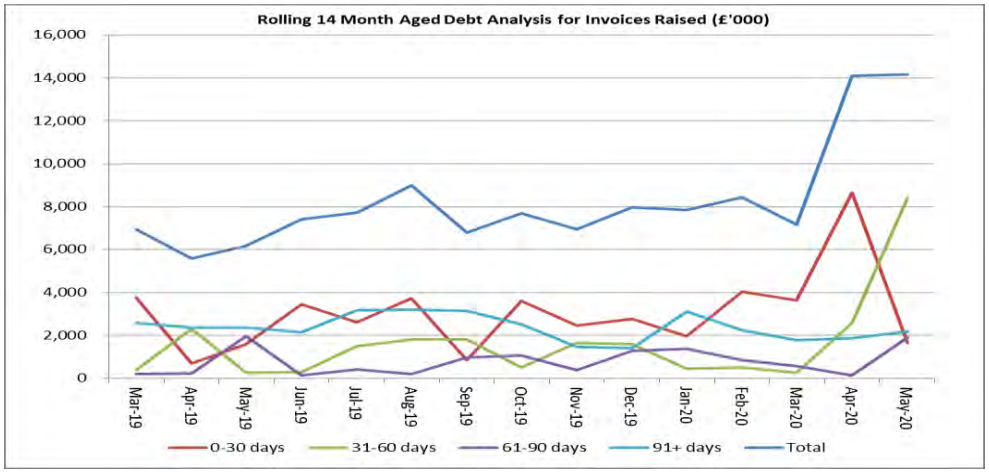
The cash balance has increased significantly and this is due to the current cash regime within the NHS. Contract payments have been paid in advance to ensure that there are adequate cash balances across the NHS and to ensure that payments to suppliers can be made quickly to keep the supply chain in full flow.

The cash position continues to be rigorously monitored on a daily basis during the current pandemic. Cash flow forecasts are required to be submitted to NHS England every fortnight to ensure that adequate cash reserves are being held within the NHS. Based on current forecasts, the Trust is not expecting to require any revenue support during 2020/21. Capital support will be required to support the Capital Programme.

FINANCE AND WORKFORCE REPORT – May 2020

Debt Management

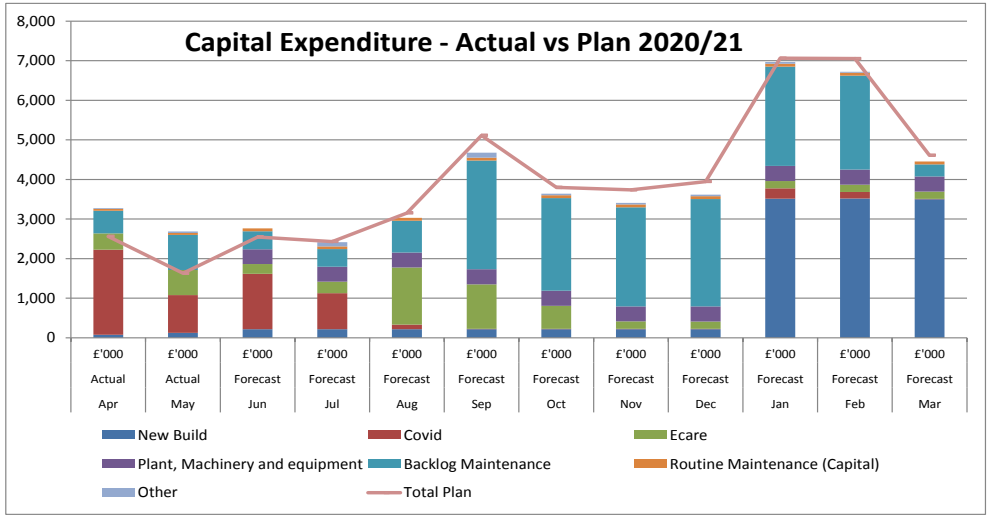
The graph below shows the level of invoiced debt based on age of debt.



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

The overall level of sales invoices raised but not paid has remained stable since April. There still remains £5.5m owed from NHS England in relation to 2019/20 over performance, which has not yet been paid and is now showing within the 31-60 days category. Amounts owed in less than 30 days have decreased significantly and it is mainly historic debts that remain outstanding. Over 90% of these outstanding debts relate to NHS Organisations, with 12% of these NHS debts being greater than 90 days old. We are actively trying to agree a position with the corresponding NHS Organisations for these debtor balances.

Capital Progress Report



	Apr Actual £'000	May Actual £'000	Jun Forecast £'000	Jul Forecast £'000	Aug Forecast £'000	Sep Forecast £'000	Oct Forecast £'000	Nov Forecast £'000	Dec Forecast £'000	Jan Forecast £'000	Feb Forecast £'000	Mar Forecast £'000	Total 2020-21 £'000
New Build	76	126	216	216	217	216	216	217	216	3,516	3,517	3,500	12,249
Covid	2,151	951	1,397	909	116	10	10	10	10	260	167	10	6,001
Ecare	408	636	247	291	1,441	1,124	581	186	186	185	185	183	5,653
Plant, Machinery and equipment	0	0	375	380	380	380	380	380	380	380	380	380	3,795
Backlog Maintenance	572	884	456	442	801	2,748	2,342	2,501	2,711	2,511	2,375	307	18,650
Routine Maintenance (Capital)	50	50	72	72	72	72	72	72	72	72	72	72	820
Other	20	39	0	103	0	125	40	40	40	40	21	0	468
Total / Forecast	**3,277**	**2,686**	**2,763**	**2,413**	**3,027**	**4,675**	**3,641**	**3,406**	**3,615**	**6,964**	**6,717**	**4,452**	**47,636**
Total Plan	**2,562**	**1,632**	**2,546**	**2,430**	**3,151**	**5,113**	**3,799**	**3,734**	**3,945**	**7,063**	**7,053**	**4,608**	**47,636**

The initial capital budget for the year was approved at the Trust Board Meeting in January as part of the operational plan process. Following a request from NHSI a revised capital plan was prepared and submitted. The figures shown above reflect the changes. Overall the capital programme has a reduction of £1.1m as a result of the review.

The Coronavirus pandemic has had a significant impact on the capital programme both in terms of the items on the capital programme and the timing. The ED scheme is to start later in the year and the capital programme reflects this change. The figures shown are as submitted to NHSI. The forecast is currently in line with the plan.

10:30 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

12. Nurse staffing report

To ACCEPT the report

For Report

Presented by Susan Wilkinson

Trust Board – 26 June 2020

Agenda item:	12			
Presented by:	Susan Wilkinson, Executive Chief Nurse			
Prepared by:	Susan Wilkinson, Executive Chief Nurse, and Duane M. Elmy, Business Manager			
Date prepared:	June 2020			
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. It also complies with national expectation to show staffing levels within Open Trust Board Papers both inpatient and non-inpatient areas.

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 May'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
Provides an update on implementation of NHSI Document 'Developing workforce safeguards – October 2018'

Introduction

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

West Suffolk NHS Trust is committed to ensuring that levels of nursing staff, which includes Registered Nurses, Midwives and Nursing Associates and Assistant Practitioners, match the acuity and dependency needs of patients within clinical ward areas in the Trust. This includes ensuring there is an appropriate level and skill mix of nursing staff to provide safe and effective care using evidence based tools and professional judgement to support decisions. The National Quality Board (NQB 2016) recommend that on a monthly basis, actual staffing data is compared with expected staffing and reviewed alongside quality of care, patient safety, and patient and staff experience data. The trust is committed to ensuring that improvements are learned from and celebrated, and areas of emerging concern are identified and addressed promptly.

For the months of March/April and May the NHS has had to deal with the Coronavirus outbreak. Coronavirus has become a global health emergency. Matrons and Heads of Nursing and Midwifery reviewed staffing on a daily basis to ensure; sufficient ward care capacity, to support the surge in critical care capacity, with appropriate estate, equipment, expertise and support in place to deal with the increase demands that coronavirus has created.

The pandemic resulted in a need to provide general bed capacity, both COVID and non-COVID, to meet requirements rather than speciality based inpatient bed models. This required a flexible, pragmatic and staged approach with an emphasis on multi-professional team-working supported by, where possible, ratio and speciality approach. Healthcare staff and nursing teams were deployed to ward areas and were required to work outside of their usual practice/ wards. This was recognised to be an additional cause of anxiety for many. Any changes in working practice were supported to ensure safe practice, safe patient care and staff wellbeing. Appropriate supervision and delegation of care was provided. Orientation to, and support in the ward environment was key. Skills have been developed with day-to-day supervised practice.

During this period we have endeavoured to manage staff efficiently and effectively and this has enabled us to ensure any initial shortfalls have been mitigated.

People Productivity

The following sections identify the processes in place to demonstrate that the Trust proactively manages nurse staffing to support patient safety (See UNIFY Report).

Nursing Fill

The monthly unify data return has been paused during the pandemic. However we have continued to complete the return. See below for exception reporting detail.

Rate and Care Hours per Patient Day (CHPPD)

REPORTING ON < 80 % and > 100 %

WARD NAME	AV FILL RATE-REG NURSE-DAY	AV FILL RATE-NON REG-DAY	AV FILL RATE-REG NURSES NIGHT	AV FILL RATE-NON REG-NIGHT	NARRATIVE
F7	106.6 %	90.7 %	104.6 %	98.7 %	F7- Covid Ward High acuity and patients requiring NIV and chest drains; therefore, registered nurses increased.
F8	104.5%	94.0 %	90.1 %	100.3 %	F8 experienced a Covid Outbreak resulting in high staff sickness. Skill mix flexed to ensure ward cover.
F12	82.9%	126.7%	96.8%	137.4%	F12 has been a Covid Ward with high acuity. Registered nurses- staff sickness, isolating and shielding- Skill mix flexed to ensure ward cover. There was a requirement to boost staffing at night due to high acuity and level of patient specials/ increased observations required (very confused wandering patient)
F9	99.4 %	86.1 %	97.1 %	106.2 %	Covid Ward with high acuity requiring increased staffing at night. This ward has now returned to being a Gastro Ward. Specials required for detox patients.
G1	81.5%	89.4%	102.4%	147.4%	2 night shifts in May required additional NAs. The ward has the fill rate recorded as 106.4 %? Specials (1-2-1) nursing support was required for confused patients.
G3	99.4 %	97.7%	100%	135.5 %	High acuity. Observations. Increased staffing required at night.
G4	88.8 %	89.1 %	96.6 %	112.2 %	G4 – Covid Ward with EOL care. High acuity requiring increased staffing at night.
G5	99.5 %	94 %	103.3 %	123 %	High acuity. High number of confused patients and high risk of falls. Increase in observation/specials levels required.

Cardiac Centre	84.6 %	102.5%	90.3 %	103.9 %	Non-registered increased due to decrease in registered nurses due to sickness/isolating.
G8	93.5 %	98.0 %	99.4 %	105.2 %	High acuity. Patients at risk of falls. Increase in observations required.
AAU	92.9 %	66.5 %	79.1 %	98.6 %	AAU attendance decreased throughout May and therefore staffing requirements decreased.
A & E	103.3 %	109.6 %	138.9 %	200.6 %	May attendances continued with Covid, RAT continued to be in use and a return of pre covid activity. The data shown does not consider staff who are shielding as this is not recorded under sickness. Also, x2 RN and x2 NA worked in winter escalation so ED backfilled.
F10	95.7 %	104.1 %	96.7 %	129.0 %	High acuity. Used as a step down from positive Covid. Increase in observations and therefore staffing flexed.
G9	42.5 %	61.5 %	58.9 %	58.9 %	Covid Outbreak on G9 resulting in its closure. Staffing therefore decreased with staff redeployed to other wards.
Critical Care Services (CCS)	61.6%	78.9%	53.5%	18.1%	There is a large discrepancy of planned against actual, as there have been optional and additional shifts opened up on the healthroster to accommodate the additional registered and non-registered support that was required during the COVID period. In May, this was split to determine the Critical Care staff from the support deployed to assist from Endoscopy, Specialist teams, fixed term recruitment and seconded posts from the Wards. This has been a massive movement of staff to accommodate training and the support of the established Critical Care team. The Team have also embraced additional roles to support them during this period. It is also important to note, that CCS have needed to change their shift pattern slightly to accommodate the donning and doffing of PPE within the shift change over period. A further reflection was the need to staff 2 physical spaces, thus splitting the team. There has been an ongoing balance of skill mix and safety during this period and this has resulted in the

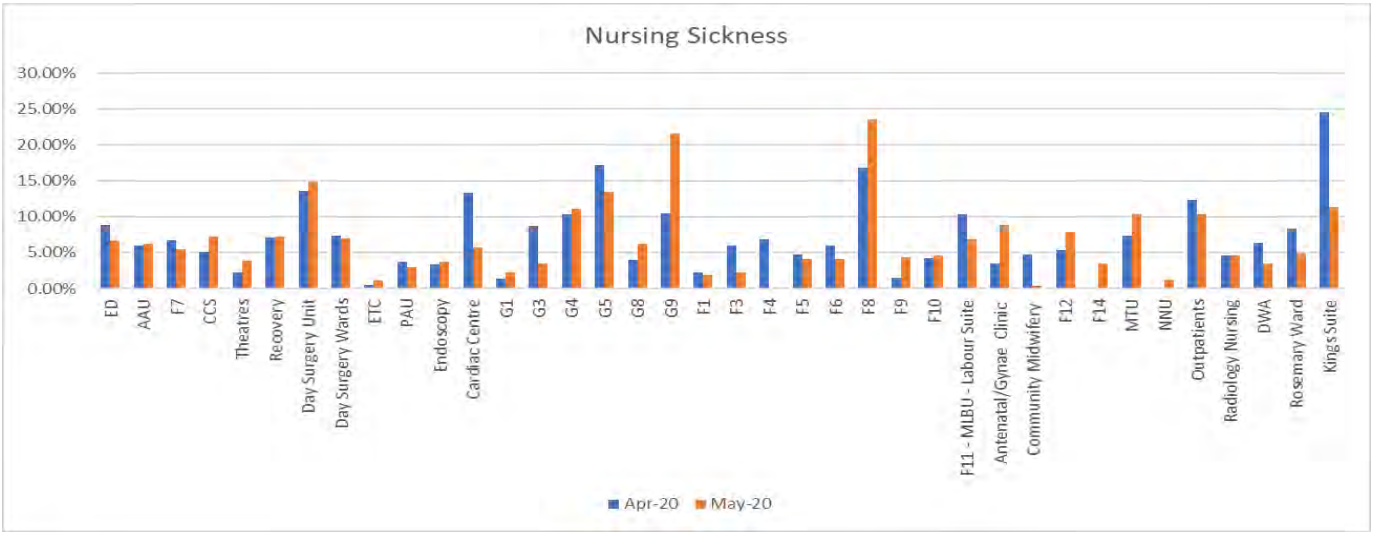
					increased need to have additional staff to support the service
Recovery	22%	0.2%	17%	0%	The large discrepancy of planned against actual is again due to optional and additional shifts being opened up on the healthroster. This was done to accommodate the Day Surgery Ward and Recovery teams to be based in Recovery but support Critical Care or Theatres, as the need arose. The 3 teams have worked well together to support other teams and provide a 24 hour, 7 days a week service, which is not usually within the roster template on either of the areas.
F3	91.5%%	109.3%	93.5%	104.8%	There has been an uplift in the non-registered fill to accommodate new starters.
F5	104.5%	91.9%	104.3%	98.7%	F5 has seen an increase in acuity and dependency due to taking the majority of emergency surgical cases, as well as, the elective colorectal cases whilst F6 was used as the COVID Surgical ward.
F6	95.9%	81.9%	96.6%	112.8%	F6 was used as the Surgical COVID ward during this period. Due to the ward being split to accommodate cohorted positive patients and step down negative patients, it was necessary to increase staffing levels at night to allow for separation of the staff.
F4	147.7%	79.6%	105.1%	238.7%	Due to a change in the focus of Ward F4 from an elective Ward to an emergency surgical / trauma ward, there was a need to uplift the establishment temporarily to reflect the acuity and dependency. This uplift was agreed by the Executive Chief Nurse and shifts have been filled by staff who have been deployed from other services or temporary staff. Specifically this is evident in the increased fill rate of shifts by registered staff in the day and non-registered at night.
Rosemary Ward	174.7%	125.8%	103.3%	127.8%	We have increased our core bed bas by 14 beds to support the COVID pandemic. Therefore there was a need to increase the establishment. by an extra RN each day and an NA Night each day, along with some NA day shifts daily. This will automatically

					take us over our roster template establishment. During the month of May we have had two supernumerary RNs for a couple of weeks each. We also had Outpatients staff re-deployed to us which resulted in some weekday shifts being oversubscribed with staff. However this enabled staff to undertake additional training and had a positive impact on our patients' experience. To enable our upskilling and refresh skilling of the staff to safely accommodate sub-acute patients we were able to book experienced acute agency staff to support temporarily in a PDN role. This was agreed but not included in our roster template
F11	110.7%	91.4%	100%	80.4%	Preceptors commenced and therefore supernumerary for 2 weeks hence overfill
F1	127.4%	127.4%	117.2%	207%	Uplift of staff due to COVID designated area having to be staffed independently to ward

Sickness

Chart 1 shows that sickness levels during April and May for staff have risen due to the COVID pandemic. There is ongoing work to address our increase in sickness levels, with a new staff support team, made up of clinical psychologists and psychological therapist already working at the Trust. These are available for 1-2-1 support. A robust risk assessment is in place to support our vulnerable staff.

Chart 1 – Sickness Percentage by Staff Group



This data does include all non-availability of staff due to self-isolation or shielding.

Patient Flow and Escalation

Good patient flow is central to patient experience, clinical safety and reducing the pressure on staff. It is also essential to the delivery of national emergency care access standards.
(NHSI 2017).

Table below shows for the month of April and May the Opel status of the trust each day. There was no need to open escalation capacity during the month of May.

OPEL Data

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
April 2020 - OPEL Status	OPEL 1	OPEL 1	OPEL 1	OPEL 1	OPEL 1	OPEL 1	OPEL 1	OPEL 1	OPEL 1	OPEL 1	No Data	OPEL 1	OPEL 1	OPEL 1	OPEL 1	OPEL 1	OPEL 1	OPEL 1	OPEL 1	OPEL 1	OPEL 1	OPEL 1	OPEL 1	OPEL 1	OPEL 1	OPEL 1	OPEL 1	OPEL 1	OPEL 1	OPEL 1	
May 2020 -OPEL Status	OPEL 1	OPEL 1	OPEL 1	OPEL 1	OPEL 1	OPEL 1	OPEL 1	OPEL 1	OPEL 1	OPEL 1	OPEL 1	OPEL 1	OPEL 1	OPEL 1	OPEL 1	OPEL 1	OPEL 1	OPEL 1	OPEL 1	OPEL 1	OPEL 1	OPEL 1	OPEL 1	OPEL 1	OPEL 1	OPEL 1	OPEL 1	OPEL 1	OPEL 1	OPEL 1	OPEL 1

Recruitment and retention

The Overall Trust position for registered nursing in May shows a shortfall of approximately 67.16 WTE (7.9% shortfall) and a non-registered shortfall of approximately 33.76 WTE (6% shortfall).

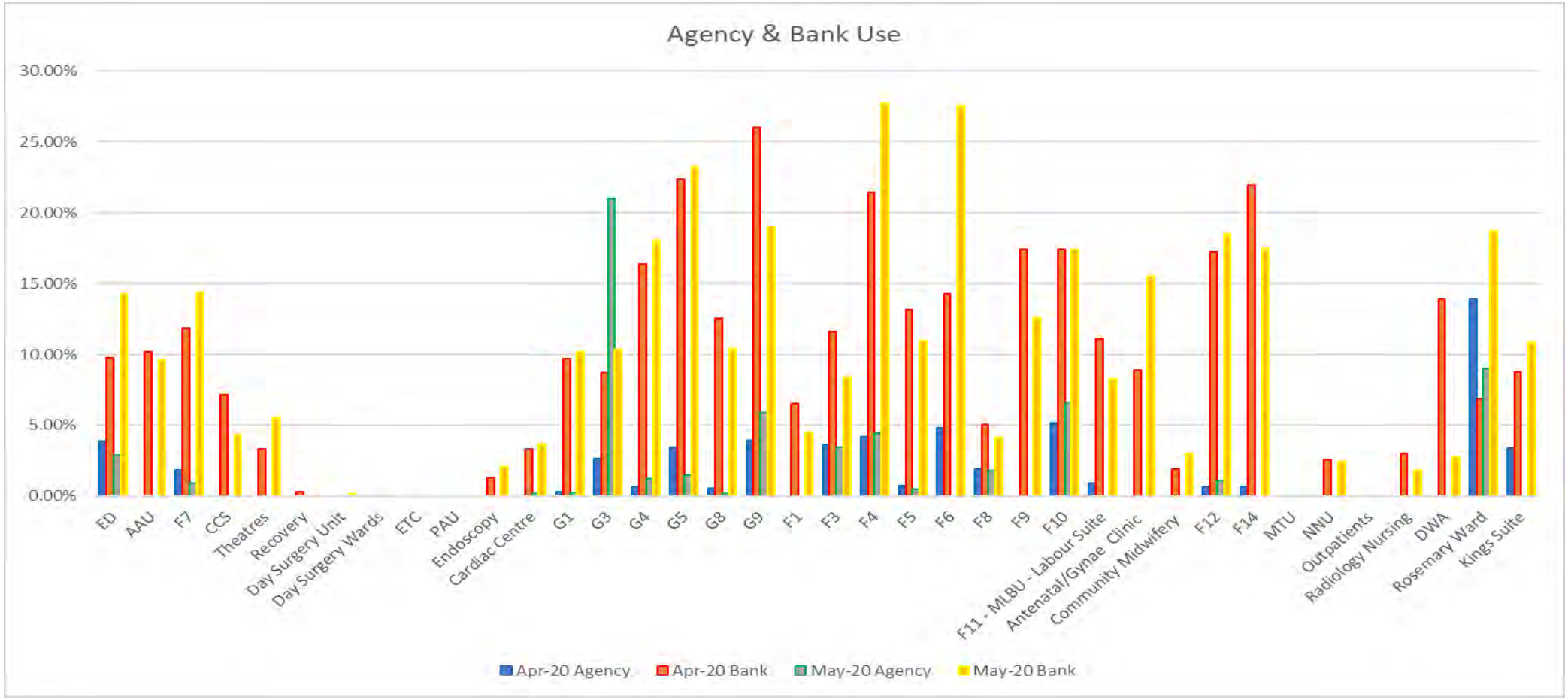
Within the non-registered workforce, we have a number of overseas nurses who have had their OSCES assessment cancelled in April and May due to COVID-19.

Community Health Team as below:-

		Registered	Unregistered
Community	Bury Town	-1.00	0.00
Community	Bury Rural	-1.80	-0.50
Community	Mildenhall & Brandon	TBC	TBC
Community	Newmarket	-2.90	0.10
Community	Sudbury	-4.85	-1.20
Community	Haverhill	1.00	0.00
Community	Admission Prevention Service	TBC	TBC
Community	Specialist Services	-0.08	N/A
Community	Children	0.00	0.00

Financial Sustainability

Should a ward need to use agency usage this is agreed first by the Chief Nurse on a case by case basis.



Falls

51 inpatient falls were recorded in April 2020 and this increased to 57 in May 2020.

There is ongoing work to continue to improve our prevention of falls with the Bay Based nursing initiative and 1-1 nursing for very high-risk patients, however due to staffing vacancies this has not always been possible.

May 2020 Data

IQPR – Inpatient Falls					
	None (no harm caused)	Negligible (minimal injury requiring no treatment)	Minor (injury requiring minor treatment)	Moderate	Total
Cardiac Centre - Ward	3	0	2	0	5
F10 Winter Escalation	0	0	1	0	1
F12 Isolation Ward	3	0	0	0	3
F4 - ward	0	0	0	1	1
F5 - ward	0	0	2	1	3
F6 - ward	0	0	1	0	1
F9 - ward	1	0	0	0	1
G1 - ward	1	1	0	0	2
G3 - Endocrine & General Medicine	3	0	0	0	3
G4 - ward	4	1	2	0	7
G5 - Ward	4	1	2	0	7
G8 - ward	3	1	0	0	4
G9 Winter Surge	1	0	0	0	1
Glastonbury Court	4	0	0	0	4
Respiratory Ward	2	0	1	0	3
Rosemary Ward	4	0	0	0	4
F7	5	0	0	0	5
Acute Assessment unit (AAU)	2	0	0	0	2
Total	40	4	11	2	57

April 2020 Data

IQPR – Inpatient Falls						
	None (no harm caused)	Negligible (minimal injury requiring no treatment)	Minor (injury requiring minor treatment)	Moderate	Major (injury leading to long-term incapacity / disability)	Total
Cardiac Centre - Ward	2	0	3	0	0	5
CHT Newmarket	1	0	0	0	0	1
F10 Winter Escalation	1	0	0	0	0	1
F12 Isolation Ward	0	1	0	0	0	1
F5 - ward	2	0	0	0	0	2
F6 - ward	2	0	0	0	0	2
F9 - ward	2	0	1	0	0	3
G1 - ward	0	0	1	0	0	1
G3 - Endocrine & General Medicine	0	2	0	0	0	2
G4 - ward	3	0	0	0	0	3
G5 - Ward	2	0	1	0	0	3
G8 - ward	1	1	0	0	0	2
G9 Winter Surge	6	0	0	1	0	7
Glastonbury Court	4	0	0	0	0	4
Respiratory Ward	0	0	1	0	0	1
Rosemary Ward	7	0	0	0	0	7
F7	3	0	0	0	0	3
Acute Assessment unit (AAU)	0	0	1	0	0	1
Physiotherapy Department	0	0	1	0	1	2
Total	36	4	9	1	1	51

Pressure Ulcers

For the month of April 2020 there were 24 new pressure ulcers and May 2020 there were 11 new pressure ulcers (all categories).

Patient, carer and staff feedback in relation to safe staffing levels

Compliments and Complaints

April 2020	14 Compliments and 8 complaints
May 2020	14 Compliments and 9 complaints

QUALITY AND WORKFORCE DASHBOARD

Month Reporting	May-20		Establishment for the Financial Year 2019/20		Data for May 2020																	
			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) - Number = Under Establishment + Number = Over Establishment		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	103.3%	138.9%	109.6%	200.6%	14.2%	2.9%	N/A	-0.70	0.10	6.70%	10.50%	1.90%	N/A	0	0	1	3	1
WSFT	AAU	Acute Admission Unit	31.44	28.33	92.9%	79.1%	66.5%	98.6%	9.6%	0.0%	33.8	1.31	-1.06	6.20%	9.60%	3.00%	0	2	0	0	0	0
WSFT	F7	Short Stay Ward	22.84	30.94	106.6%	104.6%	90.7%	98.7%	14.4%	0.9%	15.2	-0.60	-8.50	5.50%	10.70%	0.00%	2	2	0	0	1	0
WSFT	CCS	Critical Care Services	43.38	1.88	62%	53%	N/A	N/A	4.3%	0.0%	32.6	1.47	0.00	7.20%	10.20%	0.00%	2	0	0	0	0	0
WSFT	Theatres	Theatres	61.29	22.27	100.0%	100.0%	N/A	N/A	5.6%	0.0%	N/A	-3.72	-1.00	3.90%	10.90%	5.00%	N/A	3	0	0	0	0
WSFT	Recovery	Theatres	21.90	0.86	22.0%	17.0%	N/A	0.0%	0.0%	0.0%	N/A	-1.01	-0.43	7.20%	15.40%	0.00%	0	0	N/A	0	0	0
WSFT	Day Surgery Unit	Theatres	31.15	10.04	16.0%	N/A	4.0%	N/A	0.2%	0.0%	N/A	-1.15	-0.82	14.80%	4.60%	0.00%	0	0	0	0	0	0
	Day Surgery Wards		11.45	1.64					0.0%	0.0%		0.69	0.00	7.00%	6.50%	0.00%						
WSFT	ETC	Opthalmology	11.00	7.72	42.0%	N/A	42.0%	N/A	0.0%	0.0%	N/A	0.00	-0.36	1.10%	10.50%	6.40%	N/A	0	0	0	0	0
WSFT	PAU	Pre-assessment	16.60	11.93	40.0%	N/A	72%	N/A	0.0%	0.0%	N/A	0.91	0.04	3.00%	8.00%	4.40%	N/A	0	0	0	0	0
WSFT	Endoscopy	Endoscopy	32.40	19.00	133.0%	N/A	113.0%	N/A	2.1%	0.0%	N/A	-7.80	-5.70	3.80%	8.40%	2.30%	N/A	0	0	0	0	0
WSFT	Cardiac Centre	Cardiology	40.68	15.73	84.6%	90.3%	102.5%	103.9%	3.7%	0.2%	12.0	-2.62	1.43	5.7%	13.40%	3.30%	2	0	0	0	0	0
WSFT	G1	Palliative Care	25.62	12.13	81.5%	102.4%	89.4%	147.4%	10.2%	0.3%	13.9	1.05	-1.60	2.20%	10.10%	7.00%	0	4	0	0	0	0
WSFT	G3	Endocrine & Medicine	19.51	25.56	99.4%	100.0%	97.7%	135.5%	10.4%	21.0%	8.9	0.63	2.85	3.50%	10.80%	0.50%	0	0	0	0	0	0
WSFT	G4	Elderly Medicine	19.16	24.36	88.8%	96.6%	89.1%	112.2%	18.0%	1.2%	8.1	-1.50	-0.50	11.10%	12.70%	1.40%	0	2	0	0	0	0
WSFT	G5	Elderly Medicine	19.39	25.76	99.5%	103.3%	94.0%	123.0%	23.2%	1.5%	8.9	-12.50	-14.32	13.50%	10.80%	0.00%	1	3	0	0	0	0
WSFT	G8	Stroke	27.50	20.61	93.5%	99.4%	98.0%	105.2%	10.4%	0.2%	11.4	-1.04	6.48	6.20%	11.60%	0.00%	1	0	0	0	0	0
WSFT	G9	Escalation	5.24	11.19	42.5%	58.9%	61.5%	55.6%	19.0%	5.9%	5.4	-0.78	7.49	21.50%	9.20%	0.00%	1	0	0	0	0	0
WSFT	F1	Paediatrics	20.73	6.02	127.4%	117.2%	127.4%	N/A	4.5%	0.0%	45.4	-0.60	-0.50	1.90%	14.10%	7.30%	N/A	1	N/A	0	0	0
WSFT	F3	Trauma and Orthopaedics	22.15	25.83	91.5%	93.5%	109.3%	104.8%	8.4%	3.5%	10.1	-5.2	-4.12	2.20%	13.50%	3.60%	0	4	0	0	0	0
WSFT	F4	Trauma and Orthopaedics	15.76	12.92	147.7%	105.1%	79.6%	238.7%	27.7%	4.4%	8.4	-1.7	-3.65	5..5%	8.20%	0.00%	0	1	1	0	1	1
WSFT	F5	General Surgery & ENT	22.16	12.93	104.5%	104.3%	91.9%	98.7%	11.0%	0.5%	7.9	-2.0	2.44	4.10%	13.00%	2.60%	0	0	1	0	1	11
WSFT	F6	General Surgery	24.34	14.77	95.9%	96.6%	81.9%	112.8%	27.5%	0.0%	14.2	-2.7	-1.60	4.10%	15.30%	6.90%	1	3	0	0	0	0
WSFT	F8	Respiratory	20.23	18.88	77.4%	58.7%	85.4%	89.7%	4.2%	1.8%	33.0	-3.45	0.85	23.60%	12.60%	0.00%	1	1	0	1	0	0
WSFT	F9	Gastroenterology	20.32	22.56	99.4%	97.1%	86.1%	106.2%	12.6%	0.0%	9.2	-2.40	-3.30	4.40%	8.00%	6.90%	0	1	0	0	0	0
1	F10	Escalation	14.70	20.30	95.7%	96.7%	104.1%	120.0%	17.4%	6.6%	11.5	0.00	0.00	4.60%	10.50%	0.00%	0	2	0	0	1	0
WSFT	F11	Maternity	59.17	15.63	111.0%	100.0%	91.0%	80.0%	8.3%	0.0%	N/A	-9.69	-0.24	6.90%	10.00%	5.40%	0	2	0	0	1	0
WSFT	MLBU	Midwifery Led Birthing Unit															0	0	0	0	0	0
WSFT	Labour Suite	Maternity															0	1	0	0	0	0
WSFT	Antenatal/Gynae Clinic	Maternity	9.53	3.51	90.0%	N/A	61.0%	N/A	15.5%	0.0%	N/A	0.39	-0.40	8.80%	14.00%	0.00%	N/A	0	0	0	0	0
Community	Community Midwifery	Maternity	34.56	3.78	66.0%	N/A	47.0%	N/A	3.0%	0.0%	N/A	-3.66	0.04	0.40%	11.80%	3.60%	0	0	0	0	0	0
WSFT	F12	Infection Control	11.02	5.00	82.9%	96.8%	126.7%	137.4%	18.5%	1.1%	12.6	-2.50	0.00	7.80%	11.60%	0.00%	0	0	0	0	0	0
WSFT	F14	Gynaecology	12.60	1.53	104.0%	100.0%	83.0%	N/A	17.5%	0.0%	23.9	-2.60	0.00	3.50%	5.20%	0.00%	0	1	0	0	0	0
WSFT	MTU	Medical Treatment Unit	7.20	2.00	79.0%	N/A	49.0%	N/A	0.0%	0.0%	N/A	0.00	0.52	10.30%	8.80%	6.10%	0	2	0	0	0	0
WSFT	NNU	Neonatal	21.40	3.64	113.0%	92.0%	58.0%	56.0%	2.5%	0.0%	25.3	-2.96	0.00	1.30%	10.00%	7.60%	N/A	2	N/A	0	1	0
WSFT	Outpatients	Outpatients	9.30	22.90	81.0%	N/A	115%	N/A	0.0%	0.0%	N/A	0.50	-6.40	10.30%	15.60%	0.00%	N/A	0	0	0	0	0
WSFT	Radiology Nursing	Radiology	3.30	10.00	95.0%	N/A	92.0%	N/A	1.9%	0.0%	N/A	-0.60	-2.00	4.60%	5.60%	3.60%	N/A	1	0	0	0	1
WSFT	DWA	Discharge Waiting area	1.20	2.00	91.0%	N/A	87.0%	N/A	2.8%	0.0%	N/A	-0.20	0.00	3.50%	11.30%	0.00%	0	0	0	0	0	0
Newmarket	Rosemary Ward	Step - down	12.34	13.47	174.7%	103.3%	125.8%	127.8%	18.7%	9.0%	12.3	-1.40	1.40	4.80%	10.80%	3.70%	0	2	0	0	0	0
Glastonbury Court	Kings Suite	Medically Fit	11.50	12.64	102.7%	96.2%	93.2%	93.7%	10.8%	0.0%	7.6	0.90	-0.90	11.30%	11.30%	0.00%	0	0	0	0	0	0
			781.81	848.97	90.21% AVG	92.63% AVG	85.60% AVG	114.59% AVG	10.70% AVG	1.60% AVG	16.16 AVG	-67.16 TOTAL	-33.76 TOTAL	6.72% AVG	10.66% AVG	2.43% AVG	11 TOTAL	40 TOTAL	2 TOTAL	2 TOTAL	9 TOTAL	14 TOTAL
												92.09%	94%									

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	1,797.90	66	-1.00	0.00	8.38%	Not available comprehensively till Healthroster implemented	*Not available this month*	11	2	0	1	0	0
Community	Bury Rural	Community Heath Team	10.00	1.20	770.10	27	-1.80	-0.50	0.34%			1	0	0	0	0	0
Community	Mildenhall & Brandon	Community Heath Team	12.59	3.91	998.73	46	TBC	TBC	8.93%			1	0	0	0	0	0
Community	Newmarket	Community Heath Team	8.10	2.75	454.20	33	-2.90	0.10	22.09%			3	0	0	0	0	0
Community	Sudbury	Community Heath Team	18.03	8.36	1,513.68	49	-4.85	-1.20	17.59%			10	1	0	0	0	0
Community	Haverhill	Community Heath Team	8.97	4.23	978.23	71	1.00	0.00	5.30%			2	0	0	0	0	0
Community	Admission Prevention Service	Specialist Services	11.28	3.45	73.38	0	TBC	TBC	0.00%			0	0	0	0	0	0
Community	Specialist Services	Cardiac Rehab and Heart Failure	TBC	TBC	70.78	0	-0.08	N/A	0.00%			0	0	0	0	0	0
Community	Children	Community Paediatrics	16.37	15.01	1,254.10	3	0.00	0.00	1.10%			N/A	0	0	0	0	0
					7911.12 TOTAL	295.00 TOTAL	-8.63 TOTAL	-1.60 TOTAL	7.08% AVG	#DIV/0! AVG	#DIV/0! AVG	28 TOTAL	3 TOTAL	0 TOTAL	1 TOTAL	0 TOTAL	0 TOTAL

Please Note Re Yellow Cells Above
data not submitted this month

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	Nov-19		Establishment for the Financial Year 2019/20		Data for November 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							N/A						N/A					
WSFT	AAU	Acute Admission Unit	27.30	29.59																		
WSFT	F7	Short Stay Ward	22.84	30.94																		
WSFT	CCS	Critical Care Services	41.07	1.88			N/A	N/A														
WSFT	Theatres	Theatres	61.68	22.27			N/A	N/A			N/A						N/A					
WSFT	Recovery	Theatres	21.23	0.96				N/A			N/A								N/A			
WSFT	Day Surgery Unit	Theatres	28.43	8.59		N/A		N/A			N/A											
	Day Surgery Wards		11.76	1.79																		
WSFT	ETC	Opthalmology	TBC	TBC		N/A		N/A			N/A						N/A					
WSFT	PAU	Pre-assessment	TBC	TBC		N/A		N/A			N/A						N/A					
WSFT	Endoscopy	Endoscopy	TBC	TBC		N/A		N/A			N/A						N/A					
WSFT	Cardiac Centre	Cardiology	38.14	15.20																		
WSFT	G1	Palliative Care	23.96	8.31				N/A														
WSFT	G3	Endocrine & Medicine	TBC	TBC																		
WSFT	G4	Elderly Medicine	19.16	24.36																		
WSFT	G5	Elderly Medicine	18.41	22.66																		
WSFT	G8	Stroke	23.15	28.87																		
WSFT	F1	Paediatrics	18.13	7.16				N/A									N/A		N/A			
WSFT	F3	Trauma and Orthopaedics	19.58	22.27																		
WSFT	F4	Trauma and Orthopaedics	12.78	10.59																		
WSFT	F5	General Surgery & ENT	19.58	14.51																		
WSFT	F6	General Surgery	19.57	14.51																		
WSFT	F8	Respiratory	19.90	20.13																		
WSFT	F9	Gastroenterology	20.32	22.56																		
WSFT	F11	Maternity	49.58	13.89							N/A											
WSFT	MLBU	Midwifery Led Birthing Unit																				
WSFT	Labour Suite	Maternity																				
WSFT	Antenatal/Gynae Clinic	Maternity	TBC	TBC		N/A		N/A			N/A						N/A					
Community	Community Midwifery	Maternity	TBC	TBC		N/A		N/A			N/A											
WSFT	F12	Infection Control	11.02	5.00																		
WSFT	F14	Gynaecology	11.18	1.00			N/A	N/A														
WSFT	MTU	Medical Treatment Unit	7.04	1.80		N/A		N/A			N/A											
WSFT	NNU	Neonatal	20.85	3.64													N/A		N/A			
WSFT	Outpatients	Outpatients	TBC	TBC		N/A		N/A			N/A						N/A					
WSFT	Radiology Nursing	Radiology	TBC	TBC		N/A		N/A			N/A						N/A					
WSFT	DWA	Discharge Waiting area	TBC	TBC		N/A		N/A			N/A											
Newmarket	Rosemary Ward	Step - down	12.34	13.47																		
Glastonbury Court	Kings Suite	Medically Fit	11.50	12.64																		
					#DIV/0! AVG	#DIV/0! AVG	#DIV/0! AVG	#DIV/0! AVG				0.00 TOTAL	0.00 TOTAL	#DIV/0! AVG	#DIV/0! AVG	#DIV/0! AVG	0 TOTAL	0 TOTAL	0 TOTAL	0 TOTAL	0 TOTAL	0 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						Not available comprehensively till Healthroster implemented	Not available this month						
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Community	Sudbury	Community Heath Team	18.03	8.36													
Community	Haverhill	Community Heath Team	8.97	4.23													
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Community	Specialist Services	Cardiac Rehab and Heart Failure	TBC	TBC													
Community	Children	Community Paediatrics	16.37	15.01								N/A					
					0.00 TOTAL	0.00 TOTAL	0.00 TOTAL	0.00 TOTAL	#DIV/0! AVG	#DIV/0! AVG	#DIV/0! AVG	0 TOTAL	0 TOTAL	0 TOTAL	0 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
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	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

13. Medical revalidation annual report

To accept the report

For Report

Presented by Nick Jenkins

Board of Directors – 26 June, 2020

ITEM NO:	13
PRESENTED BY:	Dr Nick Jenkins, Medical Director
PREPARED BY:	Paul Molyneux, Deputy Medical Director/Nick Jenkins, Responsible Officer and Medical Director
DATE PREPARED:	June 2020
SUBJECT:	Responsible Officer Annual Report 2020
PURPOSE:	To update the Board on the status of Medical Revalidation and Appraisal.
STRATEGIC OBJECTIVE:	Invest in quality, staff and clinical leadership

EXECUTIVE SUMMARY:

Boards have statutory duties in respect of medical appraisal and revalidation, and are required to receive an Annual Report from the appointed Responsible Officer.

This Annual Report outlines the Trust position as of June 2020, updates the Board on recent developments in appraisal and revalidation and asks for confirmation that it is satisfied the West Suffolk NHS Foundation Trust is compliant with current regulations.

The report highlights areas where progress has been made, and further work that will be required to ensure both timely and appropriate appraisal of all Senior doctors with a prescribed connection to this Trust.

The number of doctors with whom the Trust has a prescribed connection as of March 2020 was 276

Matters resulting from recommendations made in this report	**Present**	**Considered**
Financial Implications	Yes / ~~No~~	Yes / ~~No~~
Workforce Implications	Yes / ~~No~~	Yes / ~~No~~
Impact on Equality and Diversity impact	~~Yes~~ / No	~~Yes /~~ No
Legislation, Regulations and other external directives	Yes / ~~No~~	Yes / ~~No~~
Internal policy or procedural issues	Yes / ~~No~~	Yes /~~No~~

Risk Implications for West Suffolk NHS Foundation Trust Appraisal and revalidation are key mechanisms by which assurance is gained regarding high-quality medical care and leadership: without satisfactory processes in place poor performance may go unrecognised and unmanaged.	**Mitigating Actions** (Controls): • Regular monitoring of appraisal compliance, satisfactory revalidations and deferral rates • Escalation process for failure to comply with appraisal requirements • Management of conduct / capability issues using *Maintaining High Professional Standards* process
Level of Assurance that can be given to the Board from the report based on the evidence Sufficient	
Recommendations: • The Board are asked to accept the Annual Report, note the contents and approve it for submission to the higher-level Responsible Officer.	

Background

Medical revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care to patients, improving patient safety and increasing public trust and confidence.

Provider organisations have a statutory duty to support their Responsible Officer in discharging their duties under the Responsible Officer Regulations, and it is expected that provider Boards will oversee compliance by:

- Monitoring the frequency and quality of medical appraisals in their organisation
- Checking there are effective systems in place for monitoring the conduct and performance of their doctors
- Confirming that feedback is sought at suitable intervals from patients so that their views can inform the appraisal and revalidation process for their doctor
- Ensuring that appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

Governance Arrangements

Individual doctors are responsible for ensuring they undertake annual appraisal and have a prescribed connection with a designated body. The Responsible Officer (RO) is responsible for evaluating the doctor's performance based on evidence provided through appraisal and other mechanisms, and making a recommendation to the General Medical Council (GMC) every five years about their fitness to practice. Trust Boards have a responsibility to ensure the RO is provided with adequate resources to fulfil their statutory function.

Doctors have a fixed appraisal month and it has been made clear that they should conduct their appraisal at the latest by the end of the fixed appraisal month. In line with other organisations, failure to complete the appraisal process within three months of the fixed month now counts as a formal 'missed appraisal'. Doctors may agree reasons for delay with the RO, but this is only approved if there is a compelling reason such as long-term sick leave/maternity leave.

The status of every doctor is continually reviewed and updated and doctors are reminded of upcoming appraisal with sufficient notice to complete and submit their appraisal documentation to their appraiser in good time for the appraisal interview. Any doctor who is non-compliant with appraisal or revalidation processes is identified early and sent escalating reminders and interventions. The General Medical Counsel has now developed a more formal mechanism for dealing with non-engagement through a non-engagement concern letter. If the Responsible Officer

notifies the GMC of non-engagement, as set out in their criteria, the GMC will put the doctor under notice. If sufficient progress is not made by the Doctor to engage in appraisal, the GMC may bring forward the revalidation date to allow the Responsible Officer to submit a recommendation of non-engagement. If a recommendation of non-engagement is made, the GMC will begin the process of removing the doctor's license to practice. To date, however, this escalation process has not been required due to the high level of completion in a timely fashion.

Appraisal processes have been well-established for many years. Appraisers are trained and receive top-up training at intervals of at least once a year. This takes the form of an afternoon workshop to highlight key developments in appraisal/revalidation, discuss difficult issues around appraisals and support each other as appraisers. Appraisers also receive individual feedback from each appraisee within three months of the appraisal

The annual appraisal includes:

- Preparation by the doctor which should include reflection on the full scope of their professional activities, not only their clinical work but private practice, voluntary activities, educational supervisor or appraiser roles and any external professional activities. The doctor must upload a range of suitable supporting evidence applicable to each role.

- An assessment by the Appraiser of the whole of the doctor's professional activities, which should be supported by evidence. The appraiser will review among other things scope of work, activity, patient outcomes, complaints and incidents, colleague and patient feedback, health and probity.

- A review of the personal development plan from the previous year, achievements and challenges, and the development of a new PDP to address the learning needs and career development of the doctor.

- Declarations by the Appraiser and Appraisee that the doctor continues to practice in accordance with the obligations of the General Medical Council *Good Medical Practice* Framework

- An appraisal summary which describes how the appraiser has evaluated the doctor against their professional roles, and what topics were discussed. The summary is an opportunity to describe the doctor's fitness for *purpose* compared to their fitness to *practice*. Although the appraisal process is generally confidential between appraiser and appraise, the summary is often requested by other employers or organisations for which the doctor provides services and is therefore written so it can be shared by the appraisee.

The Trust has a system in place which ensures that all doctors have suitable pre-employment checks.

The Trust submits quarterly information to NHS England about appraisal activity including whether the Responsible Officer has sufficient resources to undertake the role, and also submits an Annual Organisational Audit (ORSA).

Responsible Officer

The RO is appointed by the Board and is normally the Medical Director, as at the West Suffolk NHS Foundation Trust. As RO, Dr Nick Jenkins has undertaken all the required training and ongoing training required by NHS England to fulfil this role. His own appraisal includes evaluation against this role and includes provision of supporting evidence to the higher-level RO. The RO makes recommendations to the GMC regarding revalidation, and can either make a positive recommendation, or recommend deferral or non-engagement.

Medical Appraisal Lead

The Medical Appraisal Lead at the West Suffolk NHS Foundation Trust is the Deputy Medical Director, Dr Paul Molyneux, who has undertaken Case Investigator training as well as Responsible Officer Training. The SAS doctors have a Lead appraiser, Dr Zuleikha D'Souza, who ensures this group are suitably advised and supported, even if they only work here for a short period.

Progress in 2019-20

a) Continue to monitor appraisal uptake/rates of completion. The 47 doctors outstanding appraisals at the point of suspension, mostly due shortly before the suspension. Efforts are ongoing to ensure the remaining 47 doctors complete their appraisals in the near future. They are sent a formal letter which forms part of their revalidation evidence and must be discussed with their appraiser. If there is no progress, there is now formal process for referral to the General Medical Council to begin the process of non-engagement that ultimately could result in them being removed from the Register

b) Continue to recruit and train new appraisers. No new appraisers were recruited at present we have sufficient. Training was provided by either the Deputy Director of Workforce using a model provided by the University of East Anglia, or an external trainer with more than a decade of experience in appraiser training. We have sufficient experienced appraisers to allow for all doctors requiring an annual appraisal to be appraised

c) Provide appraisers with enhanced training through annual Appraiser Training Workshop. The latest workshops took place in May and June 2019

d) Recognition of Appraiser role through job planning. Appraisers now receive a 0.125 PA allocation in recognition of the work required to be an appraiser. Previously, there was an anomaly whereby the Educational Supervisor role was recognised with a PA allocation but the appraiser role was not. The roles are now both equitably remunerated.

e) The Revalidation Support Group is now fully established and meets every other month. Membership of the Group comprises the Responsible Officer, Lead Appraiser, a non-Executive Director, two senior appraisers and the Executive Director of Workforce and Communications. The Group quality assures previous Appraisals for Doctors approaching revalidation to assist the Responsible Officer in making a recommendation to the GMC. Any issues identified in previous appraisals are also fed back to both appraiser and appraise. Furthermore, the Group also writes a personal e mail to the Doctor confirming successful revalidation, but also identifying, acknowledging and highlighting particular areas of good practice. This has been well received.

Current Suspension of Revalidation and Appraisal due to Covid Pandemic

Responsible Officers were notified by the GMC in March 2020 that both Appraisal and Revalidation would be suspended with immediate effect due to the Covid Pandemic. Subsequent guidance has partly clarified the position in regard to both Appraisal and Revalidation, although further more detailed guidance is awaited.

Appraisal has been suspended for the next 12 months. Those Consultants with an overdue appraisal at the point of this suspension have been contacted and asked to complete this appraisal in the near future, to reduce the potential for an even bigger gap in appraisal. This has been communicated to all consultants.

Those Consultants with Revalidation due in the next 12 months have had their revalidation date moved forward 12 months.

Medical Appraisal Activity

229 doctors were appraised during this period.

Delayed appraisals are detailed in the table below.

47 overdue were agreed by the RO – sick, maternity leave, understanding of Allocate system or appraiser not available in time (sick or A/L)

Consultants	Completed	130		
	Not submitted	16		
	Total consultants		146	
Staff Grades	Completed	12		
	Not submitted	4		
	Total Staff Grades		16	
Fix term & Locum Clinical Fellows & Trust Doctors	Completed	87		
	Not submitted	27		
	Total temporary		114	
	Total			276

The total number of trained appraisers at 31st March 2019 was 49. At present we have a sufficient number of appraisers.

Revalidation Activity

The number of recommendations made between April 2019 and March 2020 was 80

Positive recommendations	73
Deferrals	7
Non-engagements	0
Late recommendations	0

Development Plan / Issues for 2019-20

1. From August 2019 we moved from the electronic Appraisal System, SARD, to the new System, Allocate. The Allocate system took over the functions of job planning, appraisal and electronic rostering.

2. Appraisers received training in the use of the new Allocate System. Previous appraisals will remain available for review by the appraise/appraiser and the Revalidation Support Team, to ensure the entire appraisal cycle for each revalidation epoch is accessible

3. No agreement was reached with Allocate on the collation of 360 patient feedback. At present these are collated by a Bank staff member

4. Given the results of the senior Doctor Burnout Survey last year, the Better Working Lives Group is exploring how to bring a discussion of wellbeing at work into the Appraisal discussion. One option being is to encourage the appraisee to complete a validated self-administered wellbeing at work survey and bring the results into the appraiser discussion. Appraisers will also be asked to undergo the training in mental health wellbeing at work offered through Suffolk Mind to facilitate any discussion that might arise around the issue of burnout at work

5. The Allocate System does not offer an opportunity to require uploading of a mandatory training record. Mandatory training is not now part of the appraisal.

14. Trust improvement plan

To APPROVE the report

For Approval

Presented by Susan Wilkinson

Trust Open Board – 26 June 2020

Agenda item:	14			
Presented by:	Sue Wilkinson, Executive Chief Nurse			
Prepared by:	Sue Wilkinson, Executive Chief Nurse Dan Spooner, Deputy Chief Nurse John Connelly, PMO Rebecca Gibson, Compliance Manager Richard Jones, Trust Secretary			
Date prepared:	19 June 2020			
Subject:	Trust improvement plan			
Purpose:		For information	X	For approval

Following publication of the CQC inspection report and quality summit we have continued to develop an improvement plan to address the CQC findings and wider improvement priorities for the Trust.

At the meeting in May the Board approved a governance framework to support the improvement processes and governance at the Trust to operate across three interdependent workstreams:

1. CQC improvement
2. Covid-19 recovery
3. Quality improvement (QI)

It was agreed that the workstreams can be managed more inclusively and efficiently under a single governance framework. The project management support for the delivery of the framework being provided by the programme management office (PMO) with executive oversight and leadership.

The agree framework is now being delivered through structured oversight and internal quality assurance monitoring by:

- ***Subject lead quality review meetings*** – these meetings are operational and provide review and challenge with an opportunity to update on progress
- ***Senior responsible office (SRO executive) cluster meetings*** – these meetings are operational and provide senior oversight and challenge as well as an appropriate escalation forum. The cluster meetings review and update the underpinning actions to delivery the required improvement
- ***Improvement programme board*** – a Board-committee which will meet on the 1 July to review terms of reference and its operating framework with its first operational meeting taking place on 13 July. The membership includes non-executives, executives and senior leaders from across the Trust as well as representation from the CCG.

The oversight and quality assurance framework ensures effective delivery of the agreed improvement actions to the defined timescales. A summary report is provided in **Annex A** describes progress against the 32 “must” CQC findings. The “should” CQC findings will be addressed through the forward workplan of the improvement programme board.

The report demonstrates good progress against the plan with all but nine improvement areas rated as green or black (see key below). The next round of SRO cluster meetings will be used to review progress and forward plans in these areas. The outcome of these reviews will be reported to the improvement programme board. Three of the amber improvement areas relate to the implementation of the patient safety & improvement framework (PSIRF) which has been subject to national delay. Action is no in place to progress this programme. Two amber improvement areas are linked to the mandatory training

recovery plans which have been impacted for existing staff during our COVID response but through our recovery plans this is being addressed.

In order to continue to monitor the improvement plan we will work through the following status categories:

Status	Description
Red	Action beyond due date
Amber	Action at risk of missing due date
Green	Action on target for delivery by due date
Black	Action implemented, assurance testing ongoing
Blue	Action implemented and assurance evidence that action is embedded with agreed cycle of ongoing assurance

An assessment of the learning from our improvement actions will be undertaken to ensure that identified best practice is systematically applied across the Trust. This will ensure that we appropriately apply improvement and best practice in all services and divisions.

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, TEG and execs						
Risk and assurance:	Failure to effectively address concerns raised in CQC report						
Legislation, regulatory, equality, diversity and dignity implications	Regulatory requirements						

Recommendation

The Board to:

1. Note progress with implementation of the agreed oversight and quality assurance framework for the improvement plan. The product of the first meeting of the improvement programme board will be reported to the Board in July.

2. Note the updated Trust improvement plan summary report (Annex A)

Annex A: WSFT Improvement plan - status summary report

Version date: 22nd June 2020

Finding no.	Improvement required	Improvement action	Executive lead	Project lead	Overall status	Project end date	Current status / overall RAG rationale
1	The trust must take definitive steps to improve the culture, openness and transparency throughout the organisation and reduce inconsistencies in culture and leadership. To include working relationships and engagement of consultant staff across all services.	1. Implement Trust-wide staff engagement project to elicit feedback to inform decision-making, including establishment of a BAME Staff Network. 2. Establish an executive team development programme, including 360. 3. Utilise the medical engagement scale to better understand and support improvement for the factors underpinning clinical engagement. 4. Establish a staff psychological support service to enhance well-being support for our teams. 5. Provide an organisational development update to the Board.	Stephen Dunn	Jeremy Over	Green	30.11.20	On track for completion November 20 based on QA Meeting with Jeremy Over
2	The trust must ensure the culture supports the delivery of high quality sustainable care, where staff are actively encouraged to speak up raise concerns and clinicians are engaged and encouraged to collaborate in improving the quality of care.	1. Recruitment a new Lead Freedom to Speak Up Guardian, who in turn will develop a network of Speak Up ambassadors. 2. Implement lessons learned from external review of whistle blowing matters	Stephen Dunn	Jeremy Over	Green	30.11.20	On track for completion November 20 based on QA Meeting with Jeremy Over
3	The trust must ensure that processes for incident reporting, investigation, actions and learning improve are embedded across all services and that risks are swiftly identified, mitigated and managed. The trust must ensure that incident investigations and root cause analysis are robust and that there are processes for review, analysis and identification of themes and shared learning.	1. Review of current incident pathways and their compliance to highlight areas for improvement. Include the outcome of this review in the design of new pathways as an integral element of the implementation of the Patient safety & improvement framework (PSIRF) 2. Ensure all divisions are supported to achieve these outcomes through the central patient safety / clinical governance team	Susan Wilkinson	Lucy Winstanley	Amber	31.10.20	Overall RAG progression Amber subject to PSIRF implementation which has now recommenced. Trust is an early adopter of national PSIRF programme.
4.1	The trust must ensure that processes for governance and oversight of risk and quality improvement become consistent across the organisation. - clinical audit is monitored and reviewed to drive service improvement.	1. Review and define opportunities to improve the current organisational pathways for recording and reporting on local and national audit participation including consideration of a new bespoke audit information system. 2. Working with divisions, develop a structure to enable the inclusion of audit actions within wider divisional improvement plans 3. Widen the scope of clinical effectiveness to address all elements of national best practice including but not limited to NICE guidance, Royal college publications, HSIB and other national best practice publications	Nick Jenkins	Lucy Winstanley	Green	31.10.20	Progressing the effective management of NICE guidance and clinical audit. Additional resource being put in place to support further rollout.
4.2	The trust must ensure that processes for governance and oversight of risk and quality improvement become consistent across the organisation. - mortality reviews are monitored and reviewed to drive service improvement.	1. Set up the National Medical Examiners service which will review all deaths and agree a reporting pathway into the trust for any cases requiring further review. 2. Supported by the appointment of a Learning from deaths (LfD) caseload manager; implement the LfD strategy including the specific action to streamline and centrally capture learning from local M&M reviews	Nick Jenkins	Jane Sturgess	Green	31.10.20	All ME Officers in post. MEs all recruited, some start dates have been delayed and plans are in place to manage service pending all being in post.

Finding no.	Improvement required	Improvement action	Executive lead	Project lead	Overall status	Project end date	Current status / overall RAG rationale
4.3	The trust must ensure that processes for governance and oversight of risk and quality improvement become consistent across the organisation. - incidents are monitored and reviewed to drive service improvement.	1. Through participation in the national pilot for the implementation of the Patient safety & improvement framework (PSIRF) design pathway for monitoring, investigation and review of outcomes from incident reporting 2. Implement the trust patient safety & learning strategy developed in 2019	Susan Wilkinson	Lucy Winstanley	Amber	31.10.20	See No 3
4.4	The trust must ensure that processes for governance and oversight of risk and quality improvement become consistent across the organisation. - complaints are monitored and reviewed to drive service improvement.	1. Undertake NHSE&I patient experience framework assessments across the whole Trust 2. Review of divisional reporting of actions and learning from complaints, including accurate recording of service improvement linked directly to changes as a result of feedback	Susan Wilkinson	Cassia Nice	Amber	31.10.20	Project Status Amber as audit of improvement actions required. Patient Experience Managers for Complaints and PALS in post together with Patient Experience Administrator
5	The trust must ensure that effective process for the management of human resources (HR) processes, including staff grievances and complaints, are maintained in line with trust policy. To include responding to concerns raised in an appropriate and timely manner and ensuring support mechanisms in place for those involved.	The management of HR processes, including investigations, will be strengthened by embedding the following in practice: 1. Monitoring time lines for each case 2. Reviewing cases that are not progressing in a timely fashion, taking action where possible. 3. Actions to be recorded on the database and effectiveness reviewed at subsequent fortnightly Case Review meetings. 4. Escalate cases where there is a significant delay to the Executive Director of Workforce for review in regular meeting with Deputy Director of Workforce 5. Consider use of external investigators where there is a lack of internal investigatory resources 6. HR Policies will be reviewed to ensure a more kind and compassionate approach that is aligned to a 'just' culture.	Jeremy Over	Claire Sorenson	Green	31.10.20	The status is green as work is on track for completion by October 2020. Elements of this work are complete i.e. Just Culture training carried out by Trust solicitors. Further tasks to embed a just and learning culture in the Trust are now starting up (post Covid-19).
6	The trust must ensure that robust processes are embedded for patient follow up appointments and those on surveillance pathways. To include systems and process for regular oversight and assurance that patients are not being lost to follow up across all specialties within the organisation.	1. Design process for follow up booking 2. Recruit two new members of staff in TAC for all ward booking follow ups. Write SOP for Endoscopy. 2. Update all relevant Standard Operating Practices for Follow Ups and Surveillance. Write SOP for Endoscopy. 3. Identify and deliver any training needs within each specialty and Endoscopy 4. Design process for virtual surveillance booking of patients 5. Clinic Patients Missing Follow Ups - e-Care work 6. Prepare Communications piece for Green Sheet/Staff Briefing 7. Agree Go-Live date and communicate to all relevant parties	Helen Beck	Angela Price	Green	31.3.21	Processes in place. QA review also ascertained that Covid-19 holding statement and clear plan are also in place to pause safely. Actions are therefore essentially complete.
7	The trust must take definitive steps to ensure that the information used to monitor, manage and report on quality and performance is accurate, valid, reliable, timely and relevant.	The main themes from the actions plans are: 1. RTT Reporting – update to the reporting solutions to remove as many as possible of the manual workarounds within RTT reporting. Requires support from Cerner on technical fixes and testing by the WSFT Information Team. 2. RTT Training – working with users of the system and patient pathway trackers to ensure accurate information recorded relating to RTT pathways. 3. Data Quality – work to ensure there is a programme in the organisation to focus specifically on DQ. 4. Theatres Information – development of the initial theatres dashboard after end user pilot to version 2.	Craig Black	Nickie Yates	Amber	31.12.20	The Overall RAG is Amber as there is a clear plan but there are resourcing issues to be resolved and some of the face to face actions cannot be completed during the pandemic. The RTT Reporting workstream is mainly complete. The Theatres Information workstream has continued and is on track. The RTT Training and Data Quality work streams are paused due to resourcing issues and the requirement to be on site during the pandemic.

Finding no.	Improvement required	Improvement action	Executive lead	Project lead	Overall status	Project end date	Current status / overall RAG rationale
8	The trust must continue to develop information technology systems and integration across the community services	1. Submit Business case for approval at Trust Board 2. Appoint Project Manager 3. Establish programme reporting governance to Digital Board 4. Undertake technical reviews at Community Sites 5. Undertake infrastructure upgrades including service migration, provision of laptops and remote access solution 6. Monitor programme delivery	Craig Black	Mike Bone	Green	31.12.20	The Overall RAG is green. Whilst Community project implementation has been heavily impacted by pandemic, work has recommenced June 20 and on track for December 20 completion
9	The trust must continue to take action to improve performance against national standards such as the 18 week referral to treatment (RTT) standard, six week diagnostic standard ad access standards related to suspected and confirmed cancer management	1. Develop business cases for Orthopaedics, Ophthalmology, General Surgery and Gynaecology 2. Business Cases to include up to date demand and capacity models, outline plans and costings to reduce current backlog, whilst balancing demand to enable the services to meet the national standard. 3. Continue to update Action Plans for all other specialities on a monthly basis 4. Review and monitor plans at new RTT steering group meeting with the ADO's, Weekly Access Meeting and Cancer PTL Meeting 5. Develop comprehensive action plan for Endoscopy now demand and capacity exercise complete for review at new bi-weekly Endoscopy oversight meeting	Helen Beck	Hannah Knights	Green	31.3.21	The Overall RAG is green as there is a clear plan and a realistic completion date but the work has been impacted by Covid-19. Clear plans being developed as part of Corvid recovery phase 3.
10	The trust must ensure that the duty of candour is carried out as soon as reasonably practicable, in line with national guidance	1. Continue to highlight key areas of non (or late) compliance via the IQPR and divisional performance reporting pathways. 2. Seek staff feedback on reasons for non (or late) compliance with DoC to identify opportunities for improvement using QI methods 3. Enable staff to fully achieve the remit of the Being Open framework through provision of training and support recognising that the patient / family conversations can be emotive and distressing both for the families but also the clinicians providing that message on behalf of the organisation	Susan Wilkinson	Lucy Winstanley	Amber	31.10.20	The Overall RAG is Amber as the Duty of Candour work is integral to PSIRF Implementation (see No 3 also) and will be a key focus of that work. All actions therefore switched to Amber with end date 31.10.20. The Trust Board has maintained oversight of compliance and addressed performance issues as part of ongoing incident review process.
11	The trust must ensure effective processes are in place to meet all the requirements of the fit and proper persons regulation	1. Put in place clear procedures that ensure full compliance with all FPP requirements and record keeping, including recruitment, ongoing declarations and appraisal. 2. Implement structured reporting and audit of compliance through the audit committee.	Jeremy Over	Angie Manning	Green	31.7.20	Assurance testing being undertaken for most recent executive (acting) and NED appointments
12	The trust must ensure that mandatory training attendance, including training on safeguarding of vulnerable children and adults, improves to ensure that all staff are aware of current practices and are trained to the appropriate level	1. Build, review and implement the mandatory training recovery plan with tracking to ensure 90% compliance	Jeremy Over	Denise Pora	Amber	31.05.21	The Overall RAG is Amber as mandatory training has continued for new starters but not for existing staff for the duration of the pandemic and through a risk based approach the current Mandatory Training Recovery Plan is presently being reviewed as the work is being restarted.

Finding no.	Improvement required	Improvement action	Executive lead	Project lead	Overall status	Project end date	Current status / overall RAG rationale
13	The trust must ensure staff complete patient risk assessment to identify patients at risk of deterioration and risk assessments for day to day care activities.	Put eCare change requests in place to amend: 1) Changes to triage form, mandate safeguarding concerns yes/no box 2) Changes to triage form, mandate falls history/risk of yes/no box, to then generate ED falls assessment if yes ticked 3) Changes to ED safety checklist, to mandate all fields, to add n/a column, to move pressure area assessment from 2nd hr to 1st hr, to add drop down box on pressure area assessment to choose from skin intact, DTI, category 1-4 (to be able to choose more than one) 4) To mandate observation, pain score fields on triage form for both adult & paediatrics 5) To communicate changes to staff 6) To complete weekly audits to monitor compliance 7) To request compliance data from the information team 8) To have 1-1 with staff which are non-compliant 9) Add to perfect ward 10) Monitor through weekly compliance audits and regular communications with ED staff re changes and be proactive with feedback re further changes	Susan Wilkinson	Ian Pridding	Green	31.8.20	Overall RAG is green and on track. Patient safety checks being included on perfect ward app
14	The trust must ensure staff record medication temperatures and escalate any concerns in line with its medications policy.	1) Pharmacy to audit all fridge temperatures in Emergency Department. Actions to address issues resulting from temperature audit: - Introduction of trays into the fridge to keep stock together to minimise time looking for drugs - Pharmacy Assistant responsible for stock replenishment to return all excess fridge stock to pharmacy to improve airflow within the unit - Assess requirement of rigid cold blocks in fridge and remove if unnecessary - Installation of more accurate external fridge thermometers on advice of pharmacy - Request monthly audits from pharmacy to ensure continued compliance 2) Ambient temperature monitoring Ensure appropriate systems and processes are in place to monitor ambient room temperatures in areas where drugs are stored and appropriate escalation processes where required. Actions to address issue: - Installation of thermometers in all rooms used for storage of drugs. - Introduction of ambient room temperature checking on to existing fridge temperature checks - Compliance to be audited within monthly perfect ward assessments 3) Escalation of increased temperatures Ensure appropriate escalation of increased temperatures to Unit Manager to ensure appropriate action taken Actions to address issues	Susan Wilkinson	Dona Bowd	Green	30.6.20	Overall RAG is green. Daily recording in place on wards with matron rounds then checking completion through Perfect Ward App.

Finding no.	Improvement required	Improvement action	Executive lead	Project lead	Overall status	Project end date	Current status / overall RAG rationale
15	The trust must ensure that staff records in relation to equipment and medication checks are completed.	1) Review of documentation for equipment and medication checks Departmental review of existing documentation with a view to simplifying checklists and improve compliance. 2) Review of online checking duplication of paper and online checking was causing confusion and impact on compliance. 3) Long term strategy to replicate improved paper checklist on to the online system. 4) All changes communicated to staff via email and hot topic	Susan Wilkinson	Dona Bowd	Green	31.07.20	Paper format - Infection prevention to revisit plan to meet with IT re replicating updated electronic forms on to the online checking system.
16	The trust must improve medicines management, particular in respect of management of controlled drugs, storage of patients' own medications and monitoring ambient room temperatures in drugs rooms.	<u>Controlled drugs and storage of patients own mediciation</u> 1. Review of existing policiies (confirmed as fit for purpose) 2. Ensure staff awareness of procedures and put in place systematic review of compliance 3. Ensure effective action is taken to address individual or themes of non-compliance <u>Ambient room temperatures</u> 1. Email communication to all staff to remind to escalate high temperatures to Unit Manager (regular escalations since communication.) 2. Issue included in weekly hot topics discussed at all handovers. 3. Unit manager informs pharmacy of any escalations to ensure appropriate actions if required. 4. Long term strategy: Trust wide consideration of centralised temperature monitoring	Susan Wilkinson	Simon Whitworth	Green	31.10.20	Overall RAG green as actions now mainly complete - wards have reported broken lockers, repairs made by facilities. Audit of compliance being implemented through PerfectWard App to embed practice through the leadership of the heads of nursing

Finding no.	Improvement required	Improvement action	Executive lead	Project lead	Overall status	Project end date	Current status / overall RAG rationale
18	The trust must ensure that all bank and agency staff have documented local inductions.	West Suffolk Professionals 1. A generic trust induction checklist is to be enhanced and re-implemented for all new agency and bank workers. This will be followed up with a local area induction to be completed during first worked shift. 2. Agency and Bank workers will complete local area induction on the commencement of their first shift. 3. If additional shifts are undertaken in different areas, it is the expectation of the trust that a local induction will be conducted for each new area worked. 4. All bank staff training is to be reviewed and recorded on OLM. Medical Staffing 1. All Agency staff are given induction booklets before their first day, which they are required to sign and return a statement confirming they have read and understood this on their first day. 2. Bank medical staff are formed by current training and trust doctors, therefore are covered by local induction process. Ad hoc audits will be undertaken by WSG and MS with findings reported to HRD on a quarterly basis	Jeremy Over	Holly Randall / Helen Beard	Green	31.12.20	Overall RAG green with one remaining amber action: HR to check with CDS what is focus on OLM. Assurance process to be agreed
19	The trust must ensure that medicines are stored securely within the main and day surgery theatre department.	1. Identify storage requirement and purchase cupboards 2. Local audits planned whilst areas accessible re Covid-19 3. Identify cupboard locations and estates to hang cupboards 4. Risk assessments can then take place 5. Perfect Ward App to be introduced to ensure compliance	Helen Beck	Irene Fretwell	Green	31.10.20	Overall RAG green. Weekly QA call through June with Project Lead.
20	The trust must improve monitoring ambient room temperatures in drugs rooms.	1. MDT meeting to access temperature monitoring options available 2. Prepare baseline assessment of ambient temperatures in Clinical Area 3. Investigation cost associated with automated temperature monitoring equipment and Air conditioning 4. Ordering of Max/Min room temperature thermometers 5. Creation of Ambient temperature monitoring record book for clinical areas 6. Creation of Ambient temperature monitoring email address for wards to use to report temperature exclusions 7. Distribution of max/min room temperature thermometers to inpatient clinical areas 8. Ordering of second batch of Max/Min room temperature thermometers 9. Distribution of second batch of max/min room temperature thermometers to inpatient clinical areas 10. Creation of MedicBleep ambient temperature reporting message group 11. Creation of Perfect Ward monitoring tool for Ambient temperature monitoring 12. Completion of Risk Assessment of actions if high ambient temperatures recorded	Susan Wilkinson	Simon Whitworth	Complete	28.2.20	Overall RAG is plan complete. Trust Guidance now in place for managing adverse ambient temperatures and this is also a risk assessment tool. As an additional action, the perfect ward App will be introduced to ensure compliance with requirement around recording temperature monitoring. Action implemented, assurance testing ongoing.

Finding no.	Improvement required	Improvement action	Executive lead	Project lead	Overall status	Project end date	Current status / overall RAG rationale
21	The trust must improve monitoring of women's records and ensure that a greater number of records are audited monthly.	Audit programme to be put into place including sampling methods and timescales	Susan Wilkinson	Karen Newbury	Complete	28.2.20	Action implemented, assurance testing ongoing. This will establish an appropriate audit sample size.
22	The trust must ensure that carbon monoxide monitoring assessments and records are in line with trust policy..	Monitor compliance through audit and (when required) action to address non-compliance	Susan Wilkinson	Karen Newbury	Complete	28.2.20	Action implemented, assurance testing ongoing. Recognised that pandemic has impacted on our ability to deliver this monitoring - this is mitigated through appropriate referral to the smoking cessation advisor.
23	The trust must ensure that women are asked about domestic violence in line with trust policy.	Monitor compliance through audit and (when required) action to address non-compliance	Susan Wilkinson	Karen Newbury	Complete	28.2.20	Action implemented, assurance testing ongoing.
24	The trust must ensure that they implement a nationally recognised monitoring vital observations tool for women attending triage on labour suite and the maternity day assessment.	1. Project plan for the implementation of MEOWS first in the maternity areas (complete) and then in the wider hospital for peripartum ladies (including the wider group of miscarriage, termination and ectopic pregnancies) 2. Continue to monitor compliance through audit and (when required) action to address non-compliance	Susan Wilkinson	Karen Newbury	Complete	28.2.20	Action implemented, assurance testing ongoing
25	The trust must ensure they implement a national recognised monitoring vital observations tool for new born babies on the labour suite and F11 ward.	1. Project plan for the implementation of NEWTTS (complete) 2. Continue to monitor compliance through audit and (when required) action to address non-compliance	Susan Wilkinson	Karen Newbury	Complete	28.2.20	Action implemented, assurance testing ongoing
26	The trust must ensure they carry out daily checks of resuscitation equipment.	1. Key actions are to remove paper checking of resuscitation equipment and replace with electronic checking	Susan Wilkinson	Karen Newbury	Complete	31.1.20	Action implemented, assurance testing ongoing
27	The trust must ensure clinical guidelines are up to date.	1. Through the divisional leadership review and update all clinical guidelines and issue through the approval pathway 2. Put in place systematic system to support the management, reporting and monitoring of clinical guidelines across the Trust to ensure they are kept up to date	Susan Wilkinson	Divisional Triumvirate	Amber	31.10.20	29/36 guidelines updated in maternity. Project plan being prepared to roll-out new technology to support management of clinical guidelines.
28	The trust must ensure patients can access the service when they need it and receive the right care promptly in line with national targets.	See No 9	Helen Beck	Helen Beck with ADOs	Green	31.3.21	See No 9

Finding no.	Improvement required	Improvement action	Executive lead	Project lead	Overall status	Project end date	Current status / overall RAG rationale
29	The trust must ensure diagnostic test results are available in a timely manner.	Review reporting arrangements for relevant diagnostics services. Ensure appropriate escalation procedures are in place for delays. Address the negative impact of COVID on diagnostic testing and reporting.	Helen Beck	Helen Beck	Amber	31.12.20	Through the Board reports and divisional PRMs performance is monitored against 6-week diagnostics standards. Compliance is being delivered for all diagnostics other than endoscopy. The monthly PRMs also include radiology reporting times and prior to COVID the Trust was achieving good performance. There is an SOP in place to escalate imminent OPD appointments for which results are not available to prioritise them on reporting queue prior to the patients appointment. **Monitoring systems are effective and in place. The diagnostic testing and reporting forms part of the phase 3 recovery plan for COVID - availability of additional resource will impact on timescale for delivery.**
30	The trust must ensure there is an effective process in place for monitoring patients requiring a follow up appointment and for those on surveillance pathways.	See No 6	Helen Beck	Angela Price	Green	31.03.21	See No 6
31	The trust must ensure staff complete and record patient pain assessments in patient records.	1. Issue reminder to teams regarding the importance of undertaking pain assessments for end of life patients 2. Review of core template on SystmOne to ensure that it is fit for purpose 3. Written guidance on completion of core assessment template on SysmOne 4. Share written guidance with clinical teams 5. Identify SuperUsers to support training on the correct use of the core template and embedding within teams 6. Update staff via CREWS divisional quality report 7. Include audit of completion of Pain Assessment via Perfect Ward App	Helen Beck	Michelle Glass	Green	31.12.20	Overall RAG is Green with one Red item re Crews divisional quality report / Newsletter which has been reintroduced as part of Covid-19 recovery. Also one Green item is regarding providing evidence re use of Perfect ward App
32	The trust must ensure all staff complete mandatory training including safeguarding training.	See No 12	Jeremy Over	Denise Pora	Amber	31.5.21	See No. 12

15. Consultant appointment report

To ACCEPT the report

For Report

Presented by Jeremy Over

Board of Directors – 26 June 2020

Agenda item:	15			
Presented by:	Jeremy Over, Executive Director of Workforce and Communications			
Prepared by:	Medical Staffing, HR and Communications Directorate			
Date prepared:	19th June 2020			
Subject:	Consultant Appointments			
Purpose:	x	For information		For approval

Executive summary:
Please find attached confirmation of Consultant appointments.

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**	

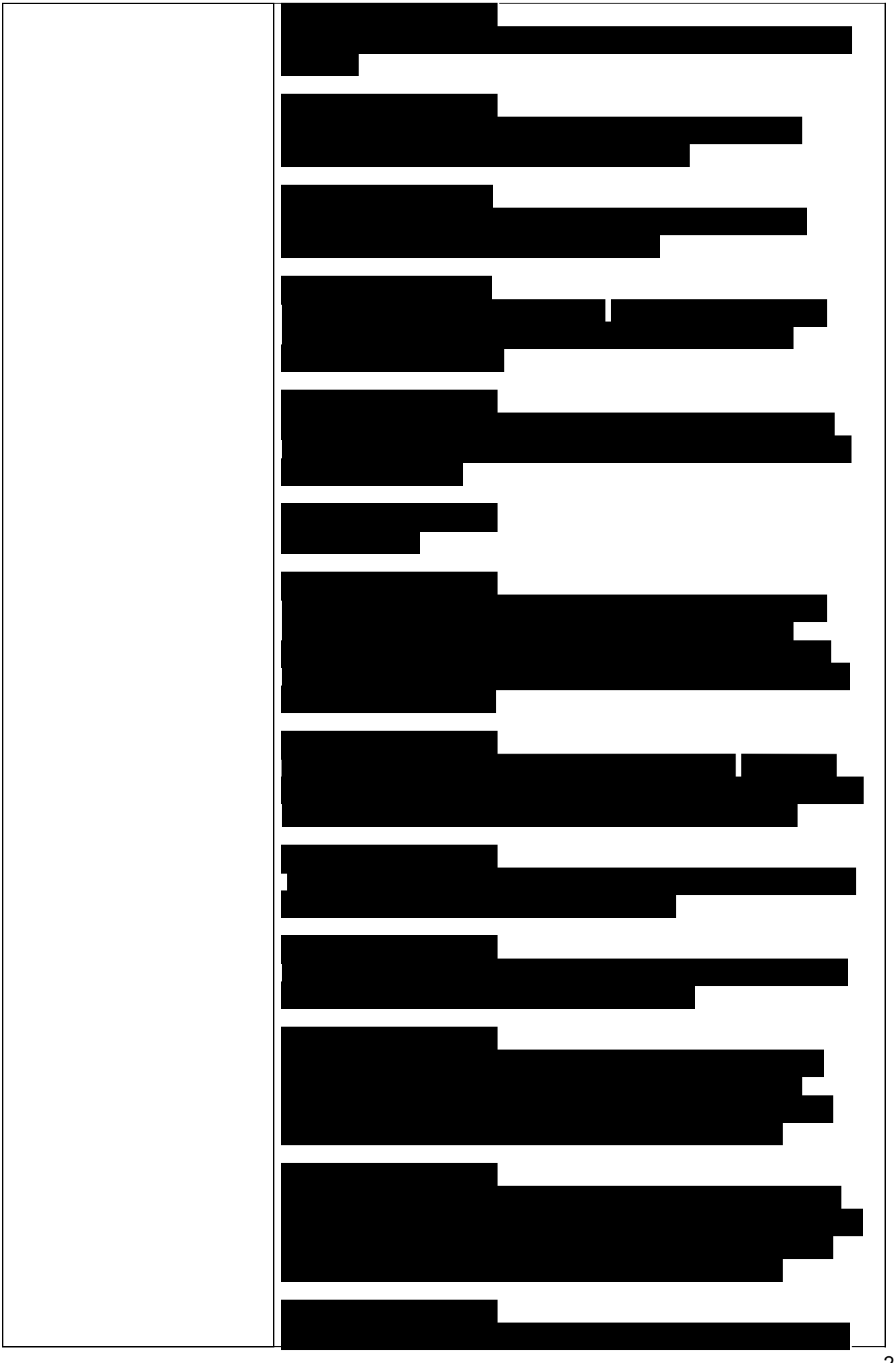
Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
	x	x	x	x	x	x	x

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

POST:	Consultant in Plastic Surgery
DATE OF INTERVIEW:	Monday, 8th June 2020
REASON FOR VACANCY:	New
CANDIDATE APPOINTED:	[redacted]
START DATE:	To be confirmed
PREVIOUS EMPLOYMENT:	[redacted]



[redacted]	[redacted]
[redacted]	[redacted]
NO OF APPLICANTS: **NO OF INTERVIEWED:** **NO OF SHORTLISTED:**	3 3 1

16. Putting you first award

To NOTE a verbal report of this months winner

For Reference

Presented by Jeremy Over

11:00 BUILD A JOINED-UP FUTURE

17. Pathology services report

To RECEIVE the report

For Report

Presented by Craig Black and Nick Jenkins

Trust Board – 26 June 2020

Agenda item:	17			
Presented by:	Craig Black, Executive Director for Resources Dr Nick Jenkins, executive Medical Director			
Prepared by:	Darin Geary – Interim Associate Director of Operations, Women & Children and Clinical Support Services			
Date prepared:	21st June 2020			
Subject:	**Pathology Update**			
Purpose:	✓	For information		For approval

This paper provides an update on the progress with the NEESPS dissolution and other pathology updates.

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:	
Legislation, regulatory, equality, diversity and dignity implications:	
Recommendation:	**1.** Note the contents of this report

Introduction

In April 2020, ESNEFT (East Suffolk & North East Essex NHS Foundation Trust) announced that the current NEESPS (North East Essex & Suffolk Pathology Service) networking arrangement with WSFT (West Suffolk NHS Foundation Trust) will cease no later than 31st October 2020. The reason provided was the continued 'divergent views on the approach to deliver the [pathology] strategy'.

A joint working group has been set-up between ESNEFT and WSFT to oversee the transition and to work on finding an alternative solution to the current arrangements. This paper provides an update on the work of the Joint Working Group and other pathology updates.

NEESPS Joint Working Group

Updates on the various sub-groups is as follows:

HR

This group is responsible for the development of the staff consultation document for the TUPE of staff from ESNEFT to WSFT. Agreement has now been reached about which roles are in-scope for the consultation and the proposed plans for each role including the cross-network roles.

The staff consultation document is tabled for approval by the NEESPS Pathology Governance Board (a new group formed to oversee the governance of the dissolution) on 23rd June, followed by sign-off by the NEESPS Joint Working Group on 25th June 2020. The 90 day staff consultation is due to commence on 30th June 2020.

Contracting

A revised list of contracts has been shared and work has commenced to review each contract to ascertain its remaining duration, whether it relates only to one trust or to both, and what future alternative arrangements needs to be considered.

The contracting group are involved with other areas including ICT, equipment and logistics.

One significant contract for consideration is the community pathology contract commissioned by West Suffolk CCG which is due to expire at the end of October 2020. A meeting took place between WSFT, ESNEFT and both WSCCG and IESCCG's to discuss the future strategy for procurement of the contract by the CCG's. It was acknowledged that the CCG's did not want to destabilise the viability of pathology provision on both sites and following positive discussions, it was agreed for WSFT and ESNEFT to submit a paper outlining the options available for this contract. The paper has now been submitted with a clear preferred option from WSFT that ESNEFT provide North East Essex and Ipswich and East Suffolk community pathology and WSFT provides West Suffolk community pathology. Unfortunately, following review of the paper by ESNEFT, they declined from committing to a preferred option.

Community phlebotomy was also discussed at the above meeting. This service has changed considerably over time and has historically had a complex and increasingly opaque commissioning arrangement behind it. Options include no action, clarify existing commissioning arrangements and restructure the commissioning arrangements for phlebotomy.

Finance Sub-group

Discussions are on-going to confirm current West Suffolk lab pay and non-pay costs; agree principles for asset transfer and net book values; confirm and agree indirect and shared costs; and agree principles regarding outstanding NEESPS costs.

ICT Sub-group

WSFT IT has agreed a representative for the sub-group. The group is to produce an infrastructure diagram to demonstrate the dependencies and relationships between each system and to work on an SLA with ESNEFT for Lab IT support.

Exploration of the options for the laboratory information management system (LIMS) and Quality Management System (QMS) are continuing. The preferred option for the LIMS is to enter into an agreement with ESNEFT to continue to use the current LIMS (WinPath).

Next Steps

Project Support

The recruitment process has started for the Pathology Transformation Manager at WSFT. This key post will be responsible for the planning, implementation and effective delivery of pathology transformation as we look to introduce a different networking model for pathology in the future. In addition, we have secured project management support to assist the operational, clinical and laboratory teams with tracking the progress already made and support the planning of the WSFT sub-groups.

Risk Management and Governance

A risk register has been commenced to identify current and potential risks for each of the work groups. This will be reviewed monthly and key risks escalated to the Pathology Escalation Group.

PHE Transfer to ESNEFT

WSFT have requested involvement in the transfer process of PHE staff to ESNEFT, as agreements made in this process will have an impact on WSFT when the West Suffolk based PHE staff transfer to WSFT from ESNEFT in due course.

We are continuing to explore whether it is possible to transfer West Suffolk based PHE staff directly to WSFT by 31st October.

NEESPS Strategic Board

The above group has not met since February due to the COVID pandemic. However, this group has now restarted and the next meeting is on Monday 22nd June 2020.

COVID Antigen (PCR) Testing

WSFT have agreed to change the supplier for COVID swab tests for both staff and patients. We have been using the PHE laboratory at Cambridge University Hospitals for patient swabs and Eurofins in Germany for staff swabs but turnaround times have varied from 48 hours to over 5 days. Testing will transfer to Source BioScience in Nottingham for all COVID swabs.

COVID Antibody Testing

Antibody testing commenced two weeks ago with over 1200+ staff having now been tested. Around 14.6% have come back as positive which is in line with national average.

11:10 GOVERNANCE

18. Trust Executive Group report

To ACCEPT the report

For Report

Presented by Stephen Dunn

Board of Directors – 26 June 2020

Agenda item:	18			
Presented by:	Steve Dunn, Chief Executive			
Prepared by:	Richard Jones, Trust Secretary			
Date prepared:	19 June 2020			
Subject:	Trust Executive Group (TEG) report			
Purpose:	X	For information		For approval

1 June 2020

Steve Dunn provided an **introduction** to the meeting which reflected on the COVID position and response. Recognising the new 'normal' as part of COVID recovery. The work and response of the whole team was recognised.

A formal report was received on **COVID** which confirmed that the command and control management structure was still in place as a level 4 emergency incident. The arrangements for staff swabbing and antigen testing were discussed. An update was provided on the phase 3 recovery planning which will take the organisation through until April 2021. The capacity requirements for these plans were discussed, including capital bids to provide additional surgical capacity.

The **integrated quality and performance report** was reviewed, recognising that he normal report that this as based on interim reporting arrangements during the COVID response. It was noted that in terms of access standards we are reviewing patients on a clinical basis rather than time waiting to ensure those that are clinically urgent are seen.

Caution was noted on the interpretation of month 1's figures from the **finance and workforce report**. Discussion took place on CIP planning and delivery for 2020/21 and beyond as well as capital expenditure.

The **red risk report** was received, this included 'top risks' for pathology services, building structure and COVID. There were no additional red risks and one draft risk which is subject to review. One red risk was downgraded as a result of mitigating action taken (transfer of haemoglobinopathy screening for pregnant women).

The Trust's **improvement plan**, which was approved by the Board, was received. Discussion took place on the need to ensure an effective response to address the CQC concerns while responding to COVID and significant emphasis was placed on the work being undertaken to engagement with and listen to staff. TEG supported the proposed quality priorities for 2020/21 – staff engagement, human factors and quality improvement.

An update was received on progress with **pathology disaggregation** and the future options for networking with service providers.

15 June 2020

A virtual workshop was held to consider some significant changes in how we can support patient safety and quality at WSFT and to help shape these potential changes. The feedback from the session will be used to shape the next steps to ensure we get the best possible structure at the end of the process.

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: The Board to note the report							

19. Charitable Funds committee report

To ACCEPT the report

For Report

Presented by Alan Rose

Trust Open Board Meeting – 26th June 2020

Agenda item:	19			
Presented by:	Alan Rose, Non-Executive Director			
Prepared by:	David Swales, Technical Accountant			
Date prepared:	15 June 2020			
Subject:	Charitable Funds Board Report			
Purpose:	X	For information		For approval

Executive summary:

The Charitable Funds Committee met on 29th May 2020. The key issues and actions discussed were:-

- The Committee was updated on current and future fundraising events. Whilst many events have had to be cancelled the work of the fundraising team is primarily focussed on Covid 19 issues. This is both in terms of raising money and ensuring that staff and patients are supported during the pandemic. The charity has received over £121k of Covid 19 donations including £70k from the NHS Charities Together appeal.
- There are plans to use some of the money to provide psychology and other therapy support to staff. It was noted that this could be required for some time.
- Other initiatives such as calm rooms, TVs in side rooms and care packages have been well received.
- The Committee discussed the RS property this had not sold as the access to the flat was difficult and that this was deterring potential buyers. Discussions are to be held by the executors with the freeholders about alternative options.
- The Committee was advised of the latest position regarding the investment performance. Initially the value of the investment dropped significantly as a result of concerns over coronavirus. However since then there has been a gradual recovery of the market and the majority of the loss has been recovered. The value of the investment stands at approximately the same as in November 2019.
- The Committee requested a report on the level of bank balances held and whether there was a need to make further investments.
- The Committee noted the establishment of the Covid19 fund.

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:	Charitable Funds Committee						
Risk and assurance:	None						
Legislation, regulatory, equality, diversity and dignity implications	None						
Recommendation: The Trust Board is asked to consider the report of the Charitable Funds Committee							

20. Quality & Risk committee report

To ACCEPT report

For Approval

Presented by Sheila Childerhouse

Quality & Risk Committee Report – Friday 26 June, 2020

Agenda item:	20			
Presented by:	Sheila Childerhouse, Chair			
Prepared by:	Ruth Williamson, PA			
Date prepared:	22 June, 2020			
Subject:	Quality and Risk Subcommittee Reports			
Purpose:		For information	X	For approval

Executive summary

In light of the current pandemic and the requirement for those due to make a presentation to be elsewhere within the Trust, the decision was made to cancel the June meeting.

Reports from the subcommittees of the Quality and Risk Committee were received. These reports are submitted for assurance and governance.

a. <u>Corporate Risk Committee (15.5.2020)</u>

As part of approach to the pandemic, a Covid-19 update report to be included in the regular reporting agenda and within a formal governance structure.

Committee Reports:

Health & Safety Committee Report – Solutions sought regarding the lifting/removing of window restrictors to improve ventilation/viral load in Covid positive areas. Tactical/risk-based approach to be taken to Strategy Group for consideration.

Increase in assaults on staff noted. In-depth look at trends being undertaken.

Information Governance Steering Group – 44 standards for Data Security & Protection Toolkit 19/20, completed. Outcome "standards exceeded". Three actions highlighted by internal audit; all completed prior to submission.

Workforce report (Clinical Workforce Strategy/Equality & Diversity/Health & Wellbeing Steering groups) – query raised as to report structure and inclusion of community elements. This is to be discussed.

Trust Resilience Report – no report available at time of meeting due to work being undertaken for Covid-19.

Regular Reports:

Review of Improvement Plan - COVID-19 and WSH building structure issues had been added to the top risks for the Trust, along-side system financial and operational sustainability, winter planning, pathology services. Proposal being put together to go forward with a "light" audit on a case by case basis, excluding Covid-19 positive areas.

Central Alerting System (CAS) – extension granted on some due dates and work is on-going. Audit of closed alerts has not progressed due to pandemic. These are being reviewed on a case by case basis.

NHS Resolution – litigation claims report – noted number of claims has reduced. Assurance given to committee that there is a robust process for alerting the comms team to any claims likely to attract media attention.

b. <u>Clinical Safety & Effectiveness Committee – (8.6.20)</u>

Following a review of the reporting structure and format of the meeting, it was felt that there was now sufficient time to consider the matters at hand.

Committee Reports:

Blood Transfusion – three risks highlighted: impact of Covid on compliance and quality improvement programmes resulting in some being paused; NEESPS Pathology Network is to dissolve and work is being undertaken to ensure a smooth transition; temperature monitoring system remains at risk of failure.

Infection Prevention & Control Committee – Estates looking at options in relation to issue of doors on ward bays. The committee wished to pass on their thanks to the team for their hard work, flexibility and adaptability in the current climate.

Medications Management and D&T Committee – concerns expressed regarding social distancing within the dispensary. Work being undertaken in this regard.

Point of Care Testing – department has been experiencing a particular busy period. In 3 weeks, 90 staff have been trained on blood gas analysers, a not insignificant achievement given the social distancing issues. Implementation of Covid POC testing in A&E and AAU has been confirmed.

Pressure Ulcers – department numbers had reduced due to redeployment during pandemic with a resultant impact on delivery of service. However, team now together bar one member of staff on secondment.

Thrombosis Committee – threshold of 95% has been maintained. Number of alerts have reduced from 2000 to 1000.

Deteriorating Patient & Resuscitation Group – noted that for cardiac arrest patients any chest compressions are to be completed by staff in full FFP3.

Regular Reports:

Quality Improvement Plan Safety & Effectiveness – quality priorities are being revisited.

Incident Reporting Assurance Report – noted if a comprehensive Day 60 required, the CCG will undertake. It is anticipated that this will revert back to the Trust in July.

Safeguarding Adults Committee, including Learning Disabilities - noted increase in domestic abuse referrals. For those patients with learning difficulties Trust looking at capacity assessments to ensure in patient's best interests whether to be swabbed.

c. Patient Experience Committee – (12.6.20)

Committee/Group Items for Escalation:

Equality, diversity and inclusion: concerns raised regarding staff with a BAME background during the pandemic, resulting in the setting up of a BAME network for Staff. This will link in the CQC response and learning work. Consideration to be given on how to increase the diversity of groups interacting with the Trust as part of work on patient experience

Regular Reports:

Complaints Annual Report – 208 complaints received and responded to for the 2019/20 period, compared with 157 in 2018/19. Main topics related to patient care on wards and clinical treatment/surgery outcomes. The patient experience team have worked with these areas in order to gain learning. Consideration of how actions captured and quality improvement taken forward is being undertaken.

Clinical Helpline Update: noted instigation of clinical helpline team to liaise with relatives, via the Net Call system. This has been a significant achievement for both patients and staff. Extension of this helpline after Covid is under consideration.

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*
		X					
Previously considered by:	-						
Risk and assurance:	-						
Legislation, regulatory, equality, diversity and dignity implications	-						
Recommendation: To receive report for information and assurance.							

21. General condition 6 and Continuity of Services condition 7 certificate

To ACCEPT the report

For Approval

Presented by Richard Jones

Board of Directors – 26 June 2020

Agenda item:	21			
Presented by:	Steve Dunn, Chief Executive			
Prepared by:	Richard Jones, trust Secretary & Head of Governance			
Date prepared:	22 June 2020			
Subject:	Certificate for NHS Improvement licencing			
Purpose:		For information	X	For approval

Executive summary:

NHS Improvement has two self-certification requirements for approval by the Board as part of the annual reporting arrangements. These follow a similar structure and content to previous years and sit alongside the general condition 6 certificate which formed part of the annual report approval on 19 June 2020 (Annex B).

The Board is required to approve the following annual statements and certifications as part of our licencing submissions to NHS Improvement. These are set out below and in greater detail within **Annex A**:

1. **Corporate Governance statement - *Confirmed***
   A range of statements are detailed coving compliance with corporate governance best practice; effective systems and processes; and having the correct personnel in place.

   It is proposed to indicate that the requirement has been met. This is supported by a range of assurances including annual governance assessment; internal and external audit opinions; review by external agencies, including performance and management information reported to the Board and its subcommittees.

2. **Training of governors - *Confirmed***
   The Board is asked to confirm that it is satisfied that during 2019/20 it provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure governors are equipped with the skills and knowledge they require.

   It is proposed to indicate that the requirement has been met. This is supported by the working and information received at the Council of Governors, its subcommittees and workshops; training provided during the year; and governor attendance at external events. This compliance position is supported by details in the Annual Report:

   - Governor training day with external trainer – governance, assurance and the role of governors; quality, accountability and relationship with the Board; effective questioning and challenge; governor feedback and action planning.
   - Governors were invited to attend quality presentations to the Trust's quality and risk committee on 28 June 2019, 27 September 2019 and 13 December 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
Previously considered by:	General condition 6 and Continuity of Services condition 7 certificate approval as part of Annual Report & Accounts. Governor commentary, including training, approved for inclusion in Annual Quality Report.						
Risk and assurance:	Governance and risk management framework underpinned by policy and procedures. Internal and external audit review of control environment. Annual governance review. Internal and External Audit opinions as part of Annual Report and Accounts.						
Legislation, regulatory, equality, diversity and dignity implications	Set out in NHS Improvement Licence						

Recommendation:

1. The Board approve the six corporate governance statements and certification for training of governors (**Annex A**)
2. The Board receive in public session the general condition 6 and continuity of cervices condition 7 certificates (**Annex B**).

Annex A

Corporate Governance Statement

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

1	Corporate Governance Statement	Response	Risks and mitigating actions
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	

5 The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	**Confirmed**	
6 The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	**Confirmed**	

Signed on behalf of the board of directors, and having regard to the views of the governors

Signature	**Signature**
Name Sheila Childerhouse	**Name** Dr Stephen Dunn

Certification on governance and training of governors

The Board are required to respond "Confirmed" or "Not confirmed" to the following statement. Explanatory information should be provided where required.

2 Training of Governors

The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.

Confirmed

Signed on behalf of the Board of directors, and having regard to the views of the governors

Signature		Signature	
Name	Sheila Childerhouse	**Name**	Dr Stephen Dunn
Capacity	Chairman	**Capacity**	Chief Executive
Date	26 June 2020	**Date**	26 June 2020

Annex B General condition 6 and Continuity of Services condition 7 certificate

A. For Condition G6 – Systems for compliance with licence conditions and related obligations

Question 1

Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	**Confirmed**

Requirements to comply - Guidance on Condition G6 (extract from Monitor Licence)

1. The Licensee shall take all reasonable precautions against the risk of failure to comply with:
   (a) the Conditions of this Licence,
   (b) any requirements imposed on it under the NHS Acts, and
   (c) the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.

2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include:
   (a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and
   (b) regular review of whether those processes and systems have been implemented and of their effectiveness.

B. For continuity of service – availability of resources

Question 2

After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	**Confirmed**

OR

After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.	

OR

In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.	

In making the above declarations, the main factors which have been taken into account by the Board of Directors are as follows:

- Following a comprehensive inspection in 2019 the Trust's overall rating was downgraded to 'requires improvement' as a consequence of a reduction in the ratings in four core services (medical care, surgery, maternity and outpatients) with another core area (urgent and emergency) maintaining the same rating as awarded in 2016. The community services (adults, children and young people and inpatient services) were all rated as 'good'.

- After making enquiries, the directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. In addition, the Trust has a borrowing arrangement in place with the Department of Health and Social Care (DHSC) to support its liquidity position. If the Trust no longer existed health services funded by the DHSC would still be provided. For this reason, the directors continue to adopt the going concern basis in preparing the accounts.
- The control total for 2019/20 was achieved with an adjusted surplus of £102k reported.
- During 2019/20 the Trust borrowed £17.9 million from DHSC. £8.2 million of this was for capital investment and £9.7 million for revenue support. It is probable that the Trust will require further borrowing in the next year to fund further capital projects.
- The expectation is that income will be forthcoming from NHS England during 2020/21 in order to deliver the control total in the current climate. The Trust is forecasting to achieve a break-even position in 2020/21 after taking into account the receipt of MRET and Provider Sustainability Funding.

- All liabilities are ultimately underwritten by DHSC as confirmed by statute therefore the Trust accounts are prepared on a going concern basis.
- In a national survey, the CQC also reported that our emergency department is performing better than most in the country in several areas of urgent and emergency care
- We were named one of 40 CHKS Top Hospitals for 2019 in the leading data-driven awards that have been running for 18 years
- The Royal College of Physicians national lung cancer audit reported that WSFT demonstrated a 40.1% one-year survival rate for this serious disease, a higher average rate than the regional and national rates of 34.6% and 37% respectively
- Our role was also acknowledged by our commissioners the West Suffolk Clinical Commissioning Group, in its achievement of the best cancer survival rates in the east of England
- The Macmillan Unit, which cares for people with cancer, has scored highly in its MQEM (Macmillan Quality Environment Mark) accreditation reassessment, maintaining an overall score of 4 (very good) and retaining its high standards
- Our state-of-the art acute assessment unit (AAU) is now fully completed and was officially opened
- A change in legislation allowed the ownership of Newmarket Community Hospital to be transferred to the WSFT from NHS Property Services this year
- We were pleased that the percentage of people responding to the annual NHS staff survey increased by four per cent to 52%, which is also above the national average of 48%. There were many positive indicators for us, with a staff engagement score equal to the best in the country; and the morale and safety culture scores close to the highest national scores. Eight of the 11 themes in the survey had an improved score, three of those showing significant improvement, three were unchanged, and our community staff expressed the highest level of satisfaction across the Trust, a tribute to their leaders
- Our staff gave us a vote of confidence In the NHS Staff Friends and Family Test, with 92% of staff surveyed saying they would recommend the WSFT as a place to receive treatment,

the seventh highest percentage in England. In addition, 79% said they would recommend it as a place to work, which is the tenth highest percentage in the country

- As part of our commitment to staff welfare, we opened three new accommodation blocks at the Bury St Edmunds site
- This year we made significant strides in managing the many nursing vacancies we had across the hospital, which was putting added pressure on staff to maintain quality, safe patient care. Our vacancy rate was also addressed by the launch of our imaginative, responsive #BeKnown recruitment campaign, which is a long-term project to attract people to apply to us in any professional capacity and ensure the work of the Trust is fully supported
- Our training and education team has been recognised in two national award schemes this year. Once again we achieved the highest score in the East of England for doctors' overall training satisfaction in acute trusts. The doctors at our Trust surveyed in the General Medical Council's (GMC) national training survey 2019 rated their overall satisfaction at 82%, a three per cent increase on last year
- And a longstanding partnership between WSFT and West Suffolk College has seen us shortlisted for Health and Science Apprenticeship provider of the year category in the FE Week and AELP AAC Apprenticeship Awards 2020

22. Agenda items for next meeting

To APPROVE the scheduled items for the next meeting

For Approval

Presented by Richard Jones

Board of Directors – 26 June 2020

Agenda item:	22			
Presented by:	Richard Jones, Trust Secretary & Head of Governance			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	19 June 2020			
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 – 31 July 2020

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
COVID-19 report	✓		Written	Action	HB
Integrated quality & performance report	✓		Written	Matrix	HB/SW
Finance & workforce performance report (including staff recommender and appraisal)	✓		Written	Matrix	CB
Risk and governance report, including risks escalated from subcommittees		✓	Written	Matrix	RJ
Invest in quality, staff and clinical leadership					
Nurse staffing report	✓		Written	Matrix	SW
Nurse staffing strategy review	✓		Written	Matrix	SW
Safe staffing guardian report – Q1	✓		Written	Matrix	NJ
Consultant appointment report	✓		Written	Matrix – by exception	JO
"Putting you first award"	✓		Verbal	Matrix	JO
Trust improvement plan report	✓	✓	Written	Standing item	SW
Integration report – Q1	✓		Written	Matrix	KV
National patient survey report	✓		Written	Matrix	SW
Serious Incident, inquests, complaints and claims report		✓	Written	Matrix	SW
Appraisal and mandatory training report	✓		Written	Matrix	JO
Build a joined-up future					
Pathology services report	✓	✓	Written	Matrix	CB/NJ
Strategic update, including Alliance, System Executive Group and Integrated Care System (ICS)		✓	Written	Matrix	SD
Governance					
Trust Executive Group report	✓		Written	Matrix	SD
Review of COVID governance arrangements	✓		Written	Matrix	RJ
Scrutiny Committee report		✓	Written	Matrix	GN
Confidential staffing matters		✓	Written	Matrix – by exception	JO
Use of Trust seal	✓		Written	Matrix – by exception	RJ
Agenda items for next meeting	✓		Written	Matrix	RJ
Reflections on the meetings (open and closed meetings)		✓	Verbal	Matrix	SC

11:20 ITEMS FOR INFORMATION

23. 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

24. Date of next meeting

To NOTE that the next meeting will be held on Friday, 31 July 2020 at 9:15am in West Suffolk Hospital

For Reference

Presented by Sheila Childerhouse

RESOLUTION TO MOVE TO CLOSED SESSION

25. 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

For Reference

Presented by Sheila Childerhouse