NHS
West Suffolk
NHS Foundation Trust

Board of Directors (In Public)

Schedule	Friday 29 May 2020, 9:15 AM — 11:30 AM BST
Venue	Via video conferencing
Description	A meeting of the Board of Directors will take place on Friday, 29 May 2020 at 9:15. The meeting will be held virtually via electronic communications
Organiser	Karen McHugh

Agenda

AGENDA
Presented by Sheila Childerhouse

Agenda Open Board 29 May 2020.docx

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

NHS
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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

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5. Review of agenda
   To AGREE any alterations to the timing of the agenda. Please note the following agenda reports have been postponed: quality and performance, mandatory training.
   For Reference - Presented by Sheila Childerhouse

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6. Minutes of the previous meeting
   To APPROVE the minutes of the meeting held on 24 April 2020
   For Approval - Presented by Sheila Childerhouse

   Item 6 - Open Board Minutes 2020 04 24 April Draft.docx

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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

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

   Item 8 - Chief Exec Report May '20.doc

9:40 DELIVER FOR TODAY

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

   Item 9 - COVID-19 report v2.doc

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

    Item 10 - Board Performance Report May 2020.doc

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

    Item 11 - Finance and workforce report Cover sheet - M01.docx

    Item 11 - Finance Report- April 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 Rowan Procter

    Item 12 - Nurse Staffing Dashboard May 2020 board.pdf

    Item 12 - WSFT Dashboard - April 2020 Final.xls

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13. Quality and learning report – Q4
    To ACCEPT the Q4 report
    For Report - Presented by Rowan Procter

    Item 13 - Quality and Learning report Q4 - May 2020.docx

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14. Trust improvement plan
    To APPROVE the report
    For Approval - Presented by Rowan Procter

    Item 14 - CQC improvement report.docx

    Item 14 Annex A - CQC improvement plan 20-05-29.docx

    Item 14 Annex B Status Summary Action Plans 200526 v2.pdf

    Item 14 Annex C - Improvement governance framework.docx

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15. Safe staffing guardian report
    To APPROVE the report for Q4
    For Approval - Presented by Nick Jenkins and Francesca Crawley

    Item 15 - Safe staffing guardian report cover sheet.doc

    Item 15 - Safe staffing Guardian Quarterly Report Quarter 4.docx

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16. Education report - including undergraduate training
    To APPROVE the report
    For Approval - Presented by Jeremy Over

    Item 16 - Education report - Board May 2020.docx

    Item 16 - WSFT LKS Annual Report 2018-2019.docx

    Item 16 - WSFT LKS Annual report 2018-2019 appendices.pptx

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17. Consultant appointment report
    To NOTE this month
    For Report - Presented by Jeremy Over

    Item 17 - Consultant appointment report - May 2020.doc

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

    Item 19 - Pathology Services - Trust Board May 2020.doc

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20. Digital board report
    To ACCEPT the report, including IM&T strategy update
    For Report - Presented by Craig Black

    Item 20 - Trust board - digital update - May 2020 v2.doc

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NHS Foundation Trust

11:10 GOVERNANCE

21. Trust Executive Group report
To ACCEPT the report
For Report - Presented by Craig Black

Item 21 - TEG report.doc

22. Audit Committee report
To ACCEPT the report
For Report - Presented by Angus Eaton

Item 22 - Audit Committee Report May 2020.doc

23. Council of Governors report
To RECEIVE report and APPROVE the updated Foundation trust membership
For Approval - Presented by Sheila Childerhouse

Item 23 - CoG Report to Board May 2020.doc

24. Trust constitution update
To APPROVE the updated constitution
For Approval - Presented by Richard Jones

Item 24 - Trust constitution amendments.doc

Item 24 Appendix - WSFT Amendments to Constitution report.pdf

25. Review of NED responsibilities
To ACCEPT the report
For Report - Presented by Sheila Childerhouse

Item 25 - NED responsibilities.doc

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

Item 26 - Items for next Board meeting.doc

11:20 ITEMS FOR INFORMATION

27. 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

28. Date of next meeting
    To NOTE that the next meeting will be held on Friday, 26 June 2020 at 9:15 am in West Suffolk Hospital
    For Reference - Presented by Sheila Childerhouse

RESOLUTION TO MOVE TO CLOSED SESSION

29. 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

AGENDA

Presented by Sheila Childerhouse

Board of Directors

A meeting of the Board of Directors will take place on **Friday, 29 May 2020 at 9:15**. The meeting will be held virtually via electronic communications

Sheila Childerhouse
Chair

Agenda (in Public)

9:15 GENERAL BUSINESS		
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."	Sheila Childerhouse
2.	**Apologies for absence** To note any apologies for the meeting and request that mobile phones are set to silent.	Sheila Childerhouse
3.	**Declaration of interests for items on the agenda** To note any declarations of interest for items on the agenda	Sheila Childerhouse
4.	**Questions from the public relating to matters on the agenda** (verbal) To receive questions from members of the public of information or clarification relating only to matters on the agenda	Sheila Childerhouse
5.	**Review of agenda** To agree any alterations to the timing of the agenda. Please note the following agenda reports have been postponed: quality and performance and mandatory training.	Sheila Childerhouse
6.	**Minutes of the previous meeting (attached)** To approve the minutes of the meeting held on 24 April 2020	Sheila Childerhouse
7.	**Matters arising action sheet (attached)** To accept updates on actions not covered elsewhere on the agenda	Sheila Childerhouse
8.	**Chief Executive report (attached)** To receive a report on current issues	Steve Dunn
9:40 DELIVER FOR TODAY		
9.	**COVID-19 report (attached)** To receive a briefing	Helen Beck
10.	**Integrated quality and performance report (attached)** To approve a report	Rowan Procter / Helen Beck
11.	**Finance and workforce report (attached)** To accept the report	Craig Black
10:30 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP		
12.	**Nurse staffing report (attached)** To accept the report	Rowan Procter

13.	**Quality and learning report – Q4 (attached)** To accept the Q4 report	Rowan Procter
14.	**Trust improvement plan (attached)** To approve the report	Rowan Procter
15.	**Safe staffing guardian report (attached)** To approve the report for Q4	Nick Jenkins & Francesca Crawley
16.	**Education report - including undergraduate training (attached)** To approve the report	Jeremy Over
17.	**Consultant appointment report (attached)** To accept the report	Jeremy Over
18.	**Putting you first award (verbal)** To note a verbal report of this month's winner	Jeremy Over
11:00 BUILD A JOINED-UP FUTURE		
19.	**Pathology services disaggregation (attached)** To receive the report	Craig Black & Nick Jenkins
20.	**Digital board report (attached)** To accept the report, including IM&T strategy update	Craig Black
11:10 GOVERNANCE		
21.	**Trust Executive Group report (attached)** To accept the report	Craig Black
22.	**Audit Committee report (attached)** To accept the report	Angus Eaton
23.	**Council of Governors report (attached)** To receive report and approve the updated Foundation Trust membership strategy	Sheila Childerhouse
24.	**Trust constitution update (attached)** To approve the updated constitution	Richard Jones
25.	**Review of NED responsibilities (attached)** To accept the report	Sheila Childerhouse
26.	**Agenda items for next meeting (attached)** To approve the scheduled items for the next meeting	Richard Jones
11:20 ITEMS FOR INFORMATION		
27.	**Any other business** To consider any matters which, in the opinion of the Chair, should be considered as a matter of urgency	Sheila Childerhouse
28.	**Date of next meeting** To note that the next meeting will be held on Friday, 26 June 2020 at 9:15 am in West Suffolk Hospital	Sheila Childerhouse

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For Reference

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6. Minutes of the previous meeting

To APPROVE the minutes of the meeting held on 24 April 2020

For Approval

Presented by Sheila Childerhouse

DRAFT

MINUTES OF BOARD OF DIRECTORS MEETING

HELD ON 24 APRIL 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		
Kate Vaughton	Director of Integration and Partnerships		
Governors in attendance (observation only)			
Florence Bevan, June Carpenter, Jayne Gilbert, Joe Pajak, Liz Steele, Martin Wood			

Action

GENERAL BUSINESS

The Chair welcomed everyone to the meeting and recognised the challenges of meeting via Teams. She paid tribute to staff, as the hospital was a very different place to how it was a month ago. She also thanked the senior management team for all their work and the NEDs for everything there were doing, in particular Louisa Pepper who had taken on chairing the Ethics group and Angus Eaton who was a member of this group; also the role of Richard Davies in supporting the medical teams.

20/69 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."

20/70 APOLOGIES FOR ABSENCE

There were no apologies for absence.

20/71 DECLARATION OF INTERESTS FOR ITEMS ON THE AGENDA

There were no declarations of interest.

20/72 QUESTIONS FROM THE PUBLIC RELATING TO MATTERS ON THE AGENDA

Q Did the exercise that took place three of four years ago where WSFT prepared for incident such as this have an impact on how it had prepared for this pandemic? Also what was the one element that would be the greatest challenge or require the greatest effort if things deteriorated?

A To be addressed in the Chief Executive's report.

Q Could the board provide assurance that when the Trust moved into the recovery process it would ensure that patients were contacted so that they did not end up as lost to follow up?

A It was confirmed that this was the plan. Some patients would have had their appointments via video conference but as these were not documented there was more chance of them being contacted twice rather than being lost. The Trust was very mindful of ensuring there were no lost to follow ups.

20/73 REVIEW OF AGENDA

The agenda was reviewed there were no issues.

20/74 MINUTES OF MEETING HELD ON 27 MARCH 2020

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

20/75 MATTERS ARISING ACTION SHEET

- The board were approved the new 'paused' category that had been introduced during COVID and would be applied to actions where appropriate. The actions would be reviewed and an update provided to the board meeting in July.

The ongoing actions were reviewed and the following issue raised:

- Item 1830 - Review and consider board agenda and report structure; provide greater focus on staffing/people over transactional issues.

  Action: reinforce the fact that this was following a review of appropriate governance throughout this period. **R Jones**

The completed actions were reviewed and the following issues raised:

- Item 1752 - Noted overview of nutrition performance in the IQPR and quarterly learning reports. However, agreed that need a clear plan, including timescales, to deliver improvement (including feedback from the F9 pilot).

Q The pilot was on hold so should this be showing as complete?

A Performance in this area had improved as nutritional assessments were being undertaken. Therefore, it was proposed that the new interim chief nurse should consider whether it was still necessary to progress the pilot.
Action: to remain open until the data had been reviewed and a decision made. **R Procter**

- Item 1827 - Provide assurance on the action to address staff sickness in theatres.
  Action: to remain open until this could properly reviewed and actions put in place. It was important that the board should not lose sight of this.

20/76 CHIEF EXECUTIVE'S REPORT

- The world had become a very different place over the last couple of months. There had been over 18,000 deaths in the UK, which was an increase of approximately 8,000 in the year. This was attributable partly due to COVID and also to people not coming forward and seeking medical help for other symptoms. Therefore, the public needed to be encouraged to continue seek medical advice where appropriate.
- Currently social distancing measures had helped and the first peak appeared to be flattening and reducing. The focus was now on preventing a second peak when social distancing guidelines started to be relaxed.
- In terms of preparation the Chief Executive was very proud of what the organisation and system had done to prepare the hospital and community to cope with COVID. Attendance and admissions had nearly halved and the Trust had managed to create appropriate social distancing capacity.
- Staff sickness had almost doubled but the lower activity levels had meant that the Trust had been able to manage.
- Most routine activity had been suspended and where possible outpatient follow-ups etc had been undertaken by telephone, and some community meetings online. This had meant that transformation had happened in days or weeks, rather than months or years. It was not known how long some aspects of the current situation would last, but it was likely to be for at least a year therefore this needed to be fully embedded as the new way of working post COVID.
- The board's thoughts went out to the 27 families who had experienced the death of a member in WSFT. To date 46 people had recovered and been discharged but the hospital continued to treat over 100 patients with COVID.
- He thanked the local community for all their support for the Trust. Staff were very appreciative of this and for all the gifts and donations from the public.
- The greatest challenge to the Trust was PPE, it currently had enough but at times stock had been low. The PPE it received was based on assessments of patients in the Trust. The board would be reflecting on this as it had profound consequences in its duty of care to staff and patients

Q The transformation of outpatients would be critical moving forwards. Was the Trust measuring the appropriate indicators, ie effect on outcomes, logistics etc, so that it was able to understand whether to continue with these changes or not?

A This would be addressed under the Trust improvement plan.

Q What extra steps were being taken with the rapid discharge of medically fit patients to ensure that this did not create additional risk or potential patient harm?

A This would be addressed later in the agenda.

Q Was there a risk that WSFT's stock of PPE would be purloined by other Trusts? Could the board be assured that the logistical measures that the government had put in place would ensure that the Trust's staff had appropriate levels of PPE?

A It was not possible to give guarantees around stock levels of PPE. A delivery had now arrived from Turkey and further deliveries were expected. Currently the Trust had good supplies of masks but the main issue was gowns. The Trust had a dashboard of PPE stocks which was reviewed daily and it was considering a range of measures to ensure appropriate use of PPE and introducing more clarity on what

should be worn in which areas. A piece of work was also being undertaken on what the Trust would do if stocks of certain items ran out or became very low.

PPE safety officers were being appointed from within the Trust to ensure that people were wearing appropriate PPE in the right areas and were not hoarding it. If necessary staff would be challenged in a kind and supportive manner. To date there had been no instances of staff claiming they did not have enough PPE but some people were wearing more than the guidance suggested, probably due to anxiety.

The Trust had risk assessed a variety of options of different equipment manufactured by individuals or organisations which had no kite marks or guarantees of safety. It currently had good stocks of face masks which meant that it could continue to use appropriately approved products. It had been agreed that it would continue to properly fit test all masks and use the full range of safety measures. The Trust had made it clear to the unions that it was in a reasonable position at the moment but it was starting to think about the unthinkable and engage them in the process, eg staff wearing PPE for a longer period of time.

The number of wards designated to COVID patients was starting to be reduced which would reduce the level of requirement for PPE. However, if necessary wards could be turned back into COVID wards.

DELIVER FOR TODAY

20/77 COVID-19 REPORT

- Over the last couple of days the Trust had started to see an increase in the number of patients attending the emergency department (ED) which was a positive sign. There had also been a significant increase in the number of two week wait cancer referrals which was a good sign that people were starting to come back in to the hospital.
- Community capacity was still working at the same pace and reporting an amber position. There was good system support and joined up working. Daily calls took place with the community teams and for the first time in the last two days an assessment of care home capacity and community capacity within the system.
- Non-COVID sickness levels of staff had reduced considerably and were currently at 2.26%.
- Details of the modelling undertaken by Helena Jopling were given in the report
- The management structure that had initially been put in place to prepare for COVID had now moved into a responsive phase with a tactical structure being the main focus of the Trust's response. There was also a team focussing on PPE and working to ensure good stocks were available.
- The clinical group was led by Andrew Dunn, clinical director for surgery, who was doing an excellent job. The group met daily, Monday to Friday, and worked through difficult clinical issues, feeding back information both upwards and downwards.
- Details of cancer services were given in the report. The main concern was the national guidance around the ability to undertake endoscopy procedures. All referrals were being clinically assessed as to whether there was the opportunity to undertake a different test.
- Other cancer patients were being clinically reviewed and worked through; currently the Trust did not have significant backlogs and was keeping on top of cancer activity as far as possible. This week some lists had started to be done at

the BMI, beginning with breast cancer surgery; skin cancer surgery would also be done from next week.

- For assurance purposes during COVID the patient experience team had set up a call line which was supported by clinicians. During this period approximately 200-250 calls were being received a day. Ten complaints had been received; the Trust had contacted these people to say that during this period investigations of complaints were on hold. They had all understood this and some had even withdrawn their complaint. All emails received by the patient experience team were answered within 24 hours and team was working seven days a week, twelve hours a day. The clinical teams consisted of staff, ie consultants, midwives and physio and occupational therapists, who were having to self-isolate for twelve weeks and working from home. E-care had been a very good platform for assisting with this; team meetings and where necessary one to one meetings also took place on a regular basis
- Clinical incident reporting continued and there did not appear to be a lack of reporting. These were reviewed with the patient safety manager and actions taken where necessary.
- The communications team had done an excellent job in creating the intranet site for staff and were in discussion about sharing this with the GP community. The communications team were also providing guidance on what could and could not be communicated externally.
- The workforce team were working hard and providing regular updates. A lot of work was being undertaken around the physical and mental wellbeing of staff and providing appropriate support to individuals, as well as providing education and training to Trust leaders and managers.
- Sickness absence was currently at 6.95%; 4.69% of this figure was either due to COVID or self-isolating. Staff now had access to testing facilities but this was dependent on the stage at which they were showing symptoms. There were some concerns around the quality of testing services at the national sites at Stansted and Copdock and Helen Beck had requested data on false negatives. Testing at WSFT or ESNEFT provided a better quality of service.
- Estates and IT had also worked extremely hard to deliver schemes and provide support to the organisation including the rapid creation of additional beds at Newmarket
- The Trust was now looking at the recovery plan and the impact of the shut down in terms of activity and backlog and also ensuring the transformation that had taken place continued.

Q A lot of activity to manage the COVID crisis was being undertaken by a number of individuals. How was the Trust ensuring that it understood where the critical points of failure were, eg relying on an individual to do a lot of work in one area and how was it mitigating for them being unable to work? Also what was meant by recovery in the day to day operation of the Trust?

A With regard to recovery the Trust needed to get to a new normal, which would be different from the previous normal. There would be a need to effectively run two parallel streams, ie COVID and non-COVID, possibly regionally. Recovery would focus on getting clinically urgent and elective patients back into the system. It was the system's responsibility to get people back into hospital and WSFT needed to be prepared and have the capacity to manage this when it happened. Conversations about this were also beginning to happen at Integrated Care System (ICS) level.

Action: An update on recovery including the management of COVID and non-COVID patients to be provided to the next board meeting. **H Beck**

Each of the groups set up to manage the COVID situation, eg tactical command cell, had a backup for the individuals leading these and everyone continued to social distance. Teams had also been established and worked the same shift pattern and each had a lead commander and deputy who could provide backup.

Q How was the Trust managing outpatients who did not have access to the internet?

A The primary method of communication was via telephone but if a patient still needed to be seen at the hospital arrangements could be made, however a risk assessment would be undertaken versus coming into hospital or staying at home.

Q Re endoscopy and early diagnosis of cancer, what plans were there for the reduction of restrictions on endoscopy over the next few weeks and months and how would WSFT manage the backlog as it moved into the recovery phase?

A It was considered that endoscopies presented a high risk to clinicians undertaking them which meant that there was a reluctance to do these unless absolutely necessary. Therefore these were being managed in a different way, eg looking at FIT testing as an alternative approach, CT scans and other options. Currently no routine endoscopy surveillance was being undertaken; there would need to be a plan to bring two week waits back into the system and then routine surveillance. The Trust was exploring the use of the BMI which would slightly increase capacity.

20/78 FINANCE AND WORKFORCE REPORT

- The Trust achieved the control the total and returned a small surplus for 2019/20.
- There had been a significant increase in borrowing repayable within one year but this was offset by a reduction in long term borrowing. This reflected the national announcement that current borrowing would be converted to public dividend capital (PDC). Therefore there would be a significant increase in PDC and a reduction in loans.
- The cash positon at the year-end was £2.5m and had improved significantly since then.
- The board noted and commended the organisation for achieving the cost improvement programme (CIP), the large proportion of which was recurring.

Q What were the trends in bank and agency and additional sessions during this period where there was no elective activity and would this reduce in the next few months?

A In March this was a reflection on the preparations for COVID which meant a relaxation in restrictions around temporary staff. Where staff were self-isolating vacancies were covered by temporary staff and this situation was expected to continue for the next few months at least. Although the number of beds on a ward had been reduced this did not reduce the requirement for staff, particularly in COVID areas of the hospital which put a greater burden on nursing staff especially if they were in full PPE which created a significant requirement for additional staff. As the Trust moved into recovery the challenge would be to regain control of this.

It was noted that the use of temporary staff was likely to be higher in April than March as there were now consultants on every ward seven days a week which had resulted in additional sessions. An additional number of anaesthetists were also available 24 hours, seven days a week which again resulted in additional sessions.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

20/79 TRUST IMPROVEMENT PLAN

- The aim of this report was to provide assurance that work continued on the plan and the Trust was not losing sight of the issues as a result of the focus required on COVID. Each item had been reviewed and identified as able to continue, partial or paused.
- There was an executive lead for each item and once the plan had been approved by the board it would be submitted to the NHSEI and the CQC.

Q This report focussed on actions in response to the CQC plan; would the COVID recovery plan review this and consider whether actions would need to change?

A There would need to be a review depending on national guidance that came out during and post recovery. Previously discussions about the plan were based on CQC findings and also the Trust's own reflection, but there would be a wider plan when things returned to whatever the new normal looked like.

Q This plan showed positive intent but could it include a date by which time the board would review each of the paused activities in light of COVID surges? Was this still the latest position or should all these actions be paused; the rationale for COVID status did not justify the reason for pauses? Did the the activity around COVID mean that the review of follow-ups should be paused?

A The priority had been to ensure that a process was in place to make certain that people currently going through the system were not lost. The review to determine whether there had been any harm to patients in the past had been paused because the individuals involved in this were now focussed on managing COVID. Surveillance programmes had all been paused in line with national guidance. RTT targets etc were also paused during COVID, however the Trust continued to ensure that patients would not being lost during this period.

Action: The items that were paused would be kept under review and updated on a regular basis. The reason for pausing the review of harm to patients in the past to be included in the plan. The plan and paused actions to come back to the board for review in July. **R Procter**

20/80 NHS RESOLUTION - MATERNITY INCENTIVE SCHEME

- This was part of the quarterly return and was a national requirement.
- Some of the cases referred to in this report would be discussed in the closed board meeting as the detail could make individuals identifiable.

20/81 FREEDOM TO SPEAK UP GUARDIAN REPORT

- The board received and noted the content of this report and improvements required as a result the CQC report. This would be discussed by the audit committee later today.

Q There had been some concern from members of staff about PPE, was this being fed back appropriately and was this being captured in terms of COVID plans?

A A member of the executive team accompanied by a clinician undertook daily walkabouts where they recorded any issues or concerns on a feedback sheet which was then fed back to the appropriate COVID group. Any other intelligence received

about an issue or concern was also actioned. The level of anxiety appeared to be reducing and people were more comfortable about what they were supposed to do with regard to PPE.

20/82 CONSULTANT APPOINTMENT REPORT

The board noted the following appointments:-

Dr Gyongyi Rabai, Consultant in Geriatrics
Dr Frances Nelson, Acute Consultant in Paediatrics
Dr Mohamed Marikar, Acute Consultant in Paediatrics

20/83 PUTTING YOU FIRST AWARD

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

Louise Ellis, estates and facilities monitoring officer:
Louise carries out unannounced audits in clinical areas to ensure that the hospital maintains an excellent, clean and safe environment for healthcare in line with the National Specification for Cleanliness - not always an easy job, as Louise has to manage the expectations of those who may not always receive a positive audit outcome.

Louise also coordinates the Trust's annual PLACE assessment, the national assessment of the care environment, and identifies patient assessors to assess how the environment supports the provision of clinical care. She is required to have a vast knowledge base around PLACE and spends many hours reading, understanding and interpreting data to be collected so that she can pass this on to the assessors. Louise leads the whole PLACE programme in a meticulous, professional and positive manner. She supports the housekeeping teams across the Trust and always has time to talk to our patients about their experiences.

Louise is a dedicated, hardworking ambassador for the Trust and, in my opinion, one of our 'unsung heroes'.

Tracey Thynne (formerly of the SALT team at WSFT):
During the time Tracey spent in the SALT team, she demonstrated exceptional leadership and commitment to patient care. She led by example, taking on a large daily caseload and acting as a sounding board for every other member of the team.

Tracy never expected her colleagues to undertake something she would not be willing to do herself, handling complex patients with professionalism and expertise. She was infinitely supportive of newly qualified staff and SALT assistants, and guided many successful therapists through the rigours of dysphagia competencies through her methodical and meticulous approach.

Although Tracey has now moved from the SALT team to a role supporting the educational development of AHPs, I feel recognition for her contribution to our team is overdue.

The board congratulated Louise and Tracey on their commitment to their roles within the Trust and the exceptional contribution they made.

BUILD A JOINED-UP FUTURE

20/84 INTEGRATION REPORT

- This report outlined what was being done in response to COVID and how the Alliance was working as part of this. There had been excellent clinical input and uptake from the different organisations.
- Good relationships with care homes were in place but there were still individual organisations overseeing the operational response. The challenge was to bring this together on a daily basis and look at the issues and ensure that care homes were linked into this. In the past ten days more rigour had been put into this with providers and primary care joining community team meetings every morning. This was improving operational management and co-operation and ensuring that care homes were part of the system and knew where they could go for support.
- Primary care was working with the local authority on safeguarding and shielded patients.
- Virtual consultations were in place across all practices and each care home. There were now iPads in each care home to enable virtual consultations to be undertaken community teams. All except six care homes now had nhs.net accounts which enabled confidential information to be shared.
- There was a lot of positive action around the Newmarket beds and GPs were taking a different approach to supporting beds in the community which should be able to be replicated in the new primary care contract.
- The new mental health crisis line went live last Wednesday working with voluntary sector partners using the primary care model.
- The contract with the Glemsford practice had been signed at the end of March and as of next week there would be weekly meetings to gather more detail around implementation and thinking around benefits realisation.
- The next step was to look at recovery across the system and what the structure could be moving forward. The system was now working in a very different way and leaders from all sectors would be involved how to take this forward.
- NEDs had attended some of the team meetings which had been very helpful in keeping them informed on what was happening in the community.

Q What extra steps were being taken with the rapid discharge of medically fit patients to ensure that this did not create additional risk or potential patient harm?

A Through enhanced work and contact with care homes and system colleagues. Community teams had worked hard to more actively support care homes in their care of patients.

GOVERNANCE

20/85 GOVERNANCE ARRANGEMENTS DURING COVID REPONSE

- This report would be a live document which would evolve as the response evolved and would come back to the board in July with a formal response. Any substantial changes would reported to the board in the meantime.
- The document referred to key areas, eg integrated quality and performance report (IQPR), and would be discussed at the audit committee meeting this afternoon to provide focus on what this should look like during the early stage of the COVID response.

Action: include the activities that the NEDs were undertaking and involvement of governors in attending board and Council of Governor meetings during this period; also the delay in decisions by the Remuneration Committee. **R Jones**

Q Why wasn't there an IQPR in the papers for the board meeting today?

A There was a danger that the board could have taken false reassurance on what the situation looked like. The organisation looked very different today to a month ago and the IQPR was not accurately reflected the things that were reflective of the activity of the organisation. Activity was also now being undertaken in a different way and the data collection processes needed to catch up with the way in which activity was being delivered.

20/86 TRUST EXECUTIVE GROUP REPORT

The board received and noted the content of this report.

20/87 REMUNERATION COMMITTEE REPORT

The board received and noted the content of this report.

20/88 USE OF TRUST SEAL

The board received and noted the content of this report.

20/89 AGENDA ITEMS FOR NEXT MEETING

The board received and noted the content of this report.

ITEMS FOR INFORMATION

20/90 ANY OTHER BUSINESS

- The Chair thanked the executive directors and their teams for all their work everything they had done and achieved during the past month.

20/91 DATE OF NEXT MEETING

Friday 29 May at 9.15am.

RESOLUTION TO MOVE TO CLOSED SESSION

20/92 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 – 29 May 2020

Agenda item:	7			
Presented by:	Sheila Childerhouse, Chair			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	22 May 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.**	RP	26/6/20 ~~27/03/2020~~	Green
1836	Open	27/3/20	Item 10	Develop the learning report to include benchmarking data when available	Feedback requirement to the team who will take this on board but are restricted by the ability to obtain reliable benchmarking information. This has been escalated to the CCG. **AGENDA ITEM**	RP	26/06/20	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**	RP	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 June '20	RJ	31/07/20	Green

Closed actions

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1839	Open	24/4/20	Item 9	Provide update on COVID recovery in terms of the move to a new 'normal' – including COVID and non-COVID activity streams	**Agenda item**	HB	29/05/20	Complete

8. Chief Executive’s report

To RECEIVE a report on current issues

For Report

Presented by Stephen Dunn

Board of Directors – 29 May 2020

Agenda item:	8			
Presented by:	Steve Dunn, Chief Executive Officer			
Prepared by:	Steve Dunn, Chief Executive Officer			
Date prepared:	22 May 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 third 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.

I have sent a **personal message to staff** wishing them well and stressing the importance of finding some downtime from the pressures of work at the moment – I've found that staying in touch with my family and friends virtually in time out of work has really helped me feel connected to them; sometimes I even forget they're not in the room with me by the time the conversation is over!

And staying connected to loved ones is no less important to our patients, even with visiting restrictions in place. If you follow our social media accounts on Twitter or on Facebook, you will no doubt have seen the huge smile on one of our patients' faces as he receives a video call from a loved-one at home. That gentleman and his family won't be the last beneficiaries of our new Keeping in Touch team – a team that is dedicated to ensuring patients are able to connect with the people that matter most to them. Seeing a familiar face can make a huge difference when you're unwell. Patients are away from their own home surrounded by people they've never met before, with the current requirement for PPE making staff feel more remote to them perhaps, so video calls and similar technology can truly benefit a huge amount of our patients.

On the subject of PPE, this is something that's never far away from the news. I'm really pleased that we are working closely with our colleagues throughout the NHS system and while levels of stock of PPE change rapidly, we currently have good supplies of equipment. We are working to give staff more regular updates in the daily staff briefings about the PPE 'state-of-play'. By doing this, we hope they feel more informed and reassured.

I just want to say what a joy it is to see how well colleagues treat each other every single day in this hospital. As you know, I enjoy my walks around the Trust and despite these times being quite uncertain, and sometimes even scary, I see members of staff really looking after each other. This can be as simple as a smile or a knowing nod – things that can brighten the day of a colleague. This compassion also shows in the way you care about the vulnerable and unwell people we see through our doors and in the community, who need us now more than ever.

Over the previous month we have taken a wide range of actions to support patients, carers and our staff, these include:

- Alerted staff to the nationally updated COVID-19 symptoms
- Uploaded palliative care best practice guidance for the acute setting
- Published an escalation plan for oxygen usage
- Given staff a roundup of all the new Trust COVID-19 SOPs and guidelines created since the start of the pandemic
- Announced the arrival of Metavision (ITU) medical notes now available in e-Care
- Reassured and informed staff about the Tiger Eye goggles safety notice
- Announced the phased return of services in outpatients
- Updated staff about government guidance on working safely during COVID-19
- Reminded staff of the importance of regular, socially-distanced breaks
- Refreshed the fit testing drop-in times on the COVID-19 staff zone
- Signposted staff to the new personalised helpline for Filipino NHS staff
- Supported socially distancing with a change to meeting room arrangements
- Helped staff to take care of their voice during video calls and when wearing a mask

- Warned staff about COVID-19 scams and fraud.
- Provided staff with PPE updates – with more details about uniform, PPE and equipment on our COVID-19 staff zone.
- Offered staff more guidance on downloading and using Microsoft Teams – the COVID-19 staff zone has a whole section on virtual meetings
- Ensured that managers complete up-to-date risk assessments for all staff
- Offered nursing, AHP and operating department staff opportunities at the Papworth Hospital surge centre
- Reiterated the importance of home working wellbeing – more guidance is on the COVID-19 staff zone

Managing our response to COVID-19 has meant we've needed to put some structures in place that are a little different to normal. That might mean you're hearing about terms or groups that you wouldn't usually. This is a summary to try and explain what these are, and how they fit together.

The C3 plan

As a Trust, we have something called a 'command, control and coordination plan', also known as a 'C3' plan. It covers the arrangements we use when responding to an incident that might affect our business as usual, or stop us from delivering services in the way we would normally. Responding to COVID-19 falls into that category, which means we've followed the C3 plan and put some structures in place to help.

Putting that into practice

In the first instance, you might hear the terms: strategic, core resilience team, and tactical:

Strategic commander: The strategic commander has overarching responsibility for the Trust's response to COVID-19. Our strategic commander is Helen Beck. Supported by exec colleagues, Helen holds a strategic group that considers and approves recommendations from the core resilience team (CRT), and tactical group.

Tactical: Looks after the day-to-day issues, i.e. things that need action immediately. It also decides how to put strategic group decisions into practice, and implements them. It has a few sub-groups underneath:

- Operational: how we put decisions into practice in a way that works
- Resources: managing things like PPE stocks
- Divisional operational command centres (DOCCs): this is a technical name for the teams looking after specific operational areas – there's one for surgery, community, medicine, women and children service, and patient flow. You can contact them directly for ops issues related to these areas.

Core resilience team: Looks after the 'mid-term' issues. It's also divided into sub-groups:

- Clinical: made up of clinical colleagues from across the Trust. It covers things like making sure we're following and implementing the right clinical guidelines.
- Community: community teams face very different challenges to acute colleagues, so this group looks at those specifically. It includes how we link with other providers, like care homes.
- Workforce: all things 'staff', including wellbeing and risk assessments, linking in with occupational health.
- Future planning: considers how we're going to turn services back on, in what order, and what support the Trust might need moving forward.

- Ethical: a group to temperature check some of the difficult decisions we've had to make. For example the temporary suspension of, and then reinstating, home births

Since our COVID-19 response began the role of various groups has changed, and some new ones have been added as we've gone along.

Last week, the government published guidance for all employers called **'working safely during COVID-19'.** As a hospital and as a place of work, we have already implemented many physical and social changes across all services over the past few months, and we are all affected. As we look to the future, and start planning how to recommence services, we will be using government guidance to continue to support social distancing and how we adapt as an organisation.

Firstly, it's crucial to emphasise the core messages in the latest guidance, some of which are as before:

1. The **risk assessment process** that is in place from occupational health still applies – which considers any underlying health conditions and actions that might need to be taken to protect you
2. **Social distancing** is just as important – avoid being less than two metres face-to-face with people outside of your household
3. Still **work from home if you can** – only travel to work if you can't work from home and your workplace is open, avoiding public transport if at all possible.

We are working with staff and managers to support our collective effort by following this advice.

We are now transitioning into the **recovery stage of COVID-19 planning in outpatients**, which will involve the outpatients department at West Suffolk Hospital, and outreach clinics.
As we start to bring patients who need face-to-face appointments back into the hospital, we need to ensure that safety measures are adhered to and therefore outpatients will look and work differently, e.g. one-way systems etc.

The location of **breast cancer surgery** at the Trust has been temporarily migrated to the nearby BMI St Edmunds Hospital, developing a unique joint-working opportunity between the two hospitals. In preparation a team headed by senior matron Mark Manning and infection prevention nurse Anne How were supported by fit testers and delivered a training session for theatre and ward staff at the BMI hospital. The training included PPE guidance in line with our Trust's practice as well as general COVID-19 awareness with all theatre staff being test fitted for FFP3 by the team. All staff at BMI welcomed the opportunity to make a difference with this new partnership and engaged with the training and support that the Trust's team were able to provide. Three patients per day every Thursday and Friday will receive surgery at the BMI location, with a theatre nurse practitioner and a surgeon provided by our Trust.

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 have to include in my report my thanks to **Gary Norgate** who after six years as a non-executive director at the Trust is talking on a new role to support the development of the case for the new hospital – a key priority for us moving forward.

It is also with great sadness this month that **we wish Rowan well** as she leaves for a new challenge at the Orwell Housing Association - I know that we all wish Rowan the very best in her new endeavours. Ensuring we maintain professional leadership is especially important at this time and I am pleased that Sue Wilkinson has been appointed as interim chief nurse. Sue will be on secondment for six months from the East and North Hertfordshire NHS Trust, where she is

currently based as deputy director of nursing. Sue brings many years of senior nursing experience, with a clear focus on quality, professional care for patients, and the welfare of staff. I have no doubt that Sue will continue to lead our nursing directorate with the care, compassion and success that we have been used to seeing over the last few years, and welcome her expertise at this challenging time.

Finally, I wanted to take the opportunity to say **thank you** to our community and our amazing staff. As always, in responding to this challenge our greatest asset is our staff and as ever they have responded amazingly to allow us to plan, prepare and respond to the demands placed upon us. And we continue to work to ensure that we do everything that we can to look after them! As part of the COVID-19 response, we've established a sub-group specifically to look at our workforce and staff support. That group is helping us develop a wider offer of preventative and restorative support strategies, including yoga sessions, mindfulness sessions, mindful walks on health and (social distancing) exercise classes.

9:40 DELIVER FOR TODAY

9. COVID-19 report

To RECEIVE a briefing

For Report

Presented by Helen Beck

Board of Directors – 29 May 2020

Agenda item:	9			
Presented by:	Helen Beck, Executive Chief Operating Officer			
Prepared by:	Helen Beck, Executive Chief Operating Officer			
Date prepared:	26 May 2020			
Subject:	COVID-19 Report			
Purpose:	X	For information		For approval

Executive summary:
As outlined in the previous board updates, the Covid-19 pandemic continues to overshadow all other activity within the Trust.

This paper aims to outline the current situation within the Trust and the plans to return to a new normal over the coming months.

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**

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

Recommendations:

1. *To note the content of this report*

Covid-19 Planning and Response

May Board Update

Introduction

Covid activity levels at WSFT appear to have passed the initial peak and the Trust is moving into phase two of its response. As part of this phase we are working to increase levels of planned activity, specifically focussing on urgent and cancer diagnostic procedures and treatments, as well as developing our phase three plans which will aim to bring further routine activity on line from the end of July 2020.

All of this activity needs to be undertaken in line with new guidance for the management of clinical activity in the light of Covid and also the workplace requirements to support social distancing. This paper aims to outline the current situation within the Trust and the plans to return to a new normal over the coming months.

Current Capacity Situation

Critical Care capacity

At the time of writing the Trust has maintained the 2 separate critical care areas for Covid and non Covid patients. There are currently four patients in each unit with only one confirmed Covid positive patients and three awaiting results. The requirement to maintain both units places pressure on our anaesthetic and critical care teams and we have therefore included in our phase 2 plans, recently submitted to NHSE/I, that we revert back to our usual critical care capacity and make use of the regional surge capacity at Royal Papworth should demand escalate. If agreed this would release significant capacity to support other non Covid activity.

General and Acute Bed Capacity

During May we have managed to maintain social distancing in ward bays where we do not have a positive Covid result. Where patients have tested positive we have had to increase occupancy back to six bedded bays to maintain flow through the hospital.

As overall numbers of Covid patients have declined, (currently 19 confirmed and 19 awaiting results by symptomatic) we have converted some wards back to being non covid. At the current time Wards G4, F6, F8 and F12 are designated as Covid capacity providing a total of 67 beds out of 301 open beds.

The table below demonstrates an increase in ED attendances and emergency admissions over the month of May, although not to previous levels. Stranded and super stranded patient numbers also remain low and ED performance against the new standards has continued to be well below the nominal 200 minute target.

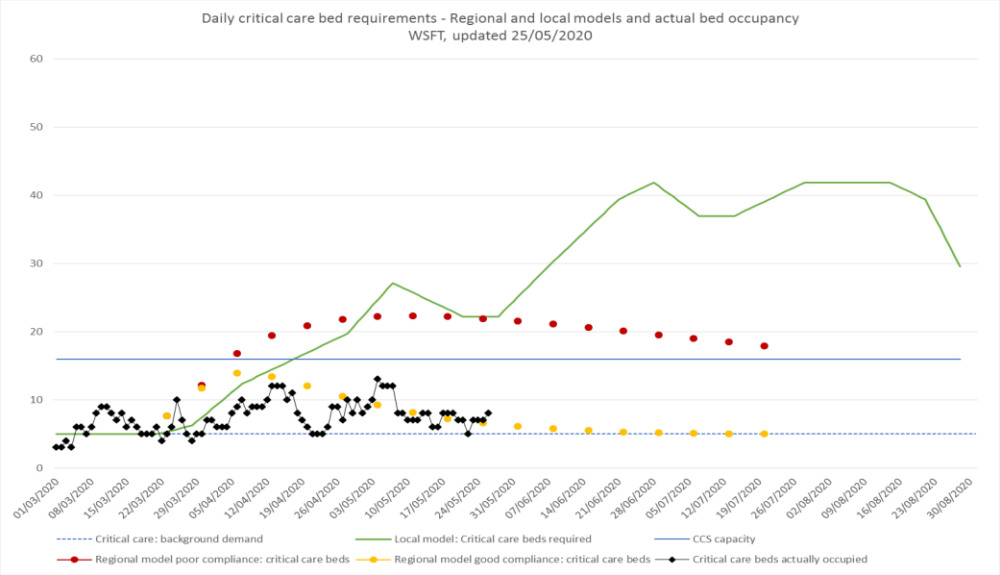
DoW	Date	ED Attendances	Average Journey Time (minutes)	Number of 12 hr waits	Stranded Patients 7+ Days	Stranded Patients 14+ Days	Stranded Patients 21+ Days	Ambulance Arrivals	Emergency Admissons (Via ED)	Discharges	AEC Admissions
Friday	01/05/2020	130	143	0	86	37	21	48	44	56	7
Saturday	02/05/2020	144	164	0	93	38	20	66	55	23	8
Sunday	03/05/2020	136	175	0	86	38	20	57	44	34	5
Monday	04/05/2020	161	162	0	85	38	20	63	64	55	16
Tuesday	05/05/2020	151	143	0	85	38	20	46	44	56	14
Wednesday	06/05/2020	132	139	0	84	38	18	49	43	54	8
Thursday	07/05/2020	122	139	0	81	36	18	43	30	74	10
Friday	08/05/2020	149	145	0	83	38	19	58	44	74	6
Saturday	09/05/2020	181	143	0	88	39	21	65	52	28	4
Sunday	10/05/2020	157	150	0	99	41	22	56	38	26	0
Monday	11/05/2020	179	153	1	97	42	24	60	56	46	12
Tuesday	12/05/2020	154	164	1	91	42	21	57	55	69	13
Wednesday	13/05/2020	148	166	0	87	39	23	60	57	64	4
Thursday	14/05/2020	160	138	0	84	41	23	55	50	61	9
Friday	15/05/2020	154	161	0	80	42	20	53	41	68	8
Saturday	16/05/2020	148	127	0	77	38	17	53	43	41	5
Sunday	17/05/2020	147	144	0	80	42	17	49	42	36	0
Monday	18/05/2020	184	142	0	78	37	17	57	57	52	9
Tuesday	19/05/2020	155	141	0	78	37	17	69	54	60	7
Wednesday	20/05/2020	143	145	0	84	39	17	51	47	60	8
Thursday	21/05/2020	163	154	0	79	33	17	55	63	64	11
Friday	22/05/2020	167	153	0	77	30	18	61	49	65	10
Saturday	23/05/2020	167	146	0	79	31	19	45	49	35	3
Sunday	24/05/2020	155	150	0	76	33	19	51	36	32	2
Monday	25/05/2020	171	143	0	89	35	19	50	51	28	1

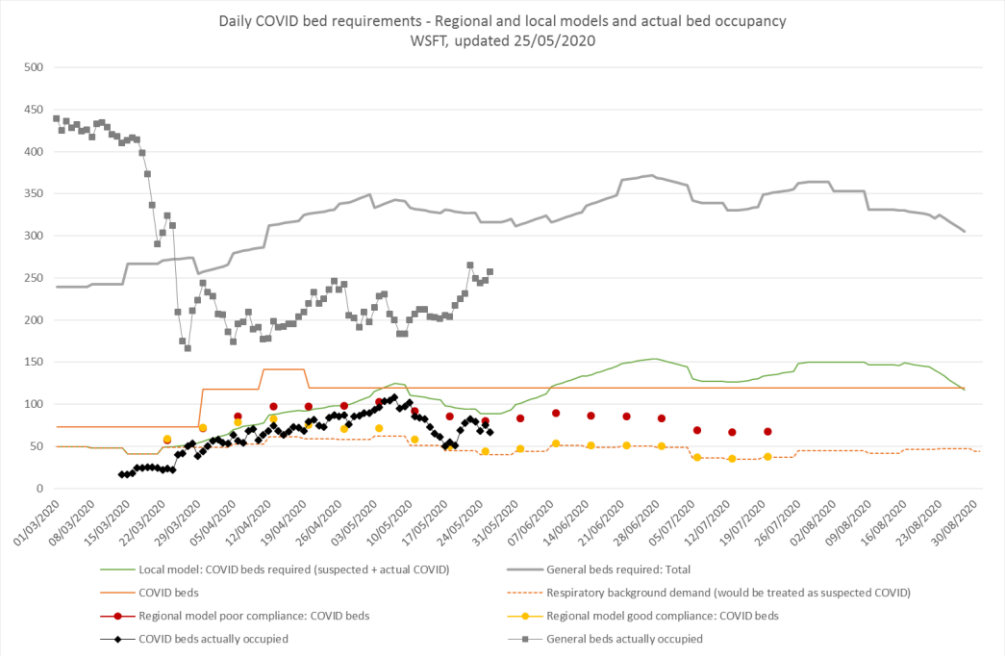
Community Capacity

Our community teams continue to report their activity status as Opel 2 with no significant concerns around their workload. In preparation for a potential surge in demand the community teams have assessed all patients on their caseload as red, amber or green to determine where they can safely reduce levels of care if required. Additional community beds have been procured by the system and at the current time we have an excess of capacity above demand.

Activity Modelling and Actuals

Members of the board will be aware of the modelling work undertaken by Helena Jopling to support planning assumptions at WSFT. The tables below show the latest actuals overlaying the modelling. The first table shows critical care capacity and the second general and acute bed capacity. The actuals include symptomatic patients awaiting results.





The small peak in Covid numbers during w/c 20th May is not linked to an increase in Covid admissions at this time and is probably due to a lag in discharges over the early part of that week which increased bed occupancy temporarily. Non Covid admission numbers are increasing but have not yet reached previous levels.

Management Structures

As outlined in last month's report we have established a number of command and control structures outside of our usual Trust operational arrangements, to enable us to respond to the national emergency status of the pandemic. We initially set these up to be operational from 8:00-20:00 7 days per week but as activity levels have declined we are planning to reduce the hours on site with effect from 1st June. The revised hours will be 8:00 -18:00 Monday- Friday and 10:00-16:00 Saturday and Sunday with on call cover outside of these hours. The frequency of the other groups has also reduced from daily to three times per week which should reduce the Covid burden and allow clinical and operational teams to start to pick up other activities which were put on hold due to Covid.

PPE

The provision of adequate stocks of PPE has continued to be a significant challenge for the Trust, however we have continued to be able to provide appropriate PPE to staff in accordance with national guidance. Overall the situation with the national supply chain is improving but this has resulted in further changes to the types of FFP3 masks supplied and therefore the need to fit test staff again. We have also secured 60 reusable masks and filters as well as 50 protective hoods for a trial. The hoods will need to be issued on an individual basis for those who are unable to use any other forms of PPE, as they cannot be effectively cleaned between each use. We are currently developing SOPS for the use, allocation, cleaning, storage and maintenance of these reusable items, which may prove to be a better option in the long run than the continuously changing supply of single use items.

The supply of gowns and scrubs is now more stable although our purchasing team do monitor stocks on a daily basis.

Workforce and Wellbeing Group

Measures to support staff, such as free parking, free hot drinks and free food at night, remain in place at the current time.

My Wish has supported staff through the creation of a number of “Calm Rooms” across the site where staff can take a break and relax during this busy and stressful time. A Calm Room has also been provided at Newmarket Hospital as well as additional outdoor furniture for staff.

The Coronavirus microsite is added to and updated daily and provides details of a wide range of mental health support measures for staff.

Staff swabbing

All symptomatic staff or those in contact with symptomatic family members can now easily access swabbing at a range of sites to suit themselves.

There is currently some debate about the routine swabbing of asymptomatic staff with several staff groups requesting access to this. The issue has been considered by our experts in public health and microbiology who have concluded that we should continue to follow national guidance, which is not to undertake routine swabbing of all staff at this time.

We are also optimistic that antigen testing may soon be available for NHS and care home staff across Suffolk. This will determine if people have previously contracted Covid but at this stage it is not known if this confers immunity.

Estates and IT

The Estates team continue to work extremely hard to support us during this pandemic. The additional beds at Newmarket hospital were handed over to the Trust on 21st May as planned. Recognising how hot it is within our ward areas during the summer we realise that in designated Covid areas, where staff are working in full PPE for extended periods, the situation is likely to become unbearable. A limited number of air conditioning units have therefore been ordered for up to four wards. These will be in place and operational within the next week. Sadly, the power supply to the site does not allow for us to provide air conditioning to any more wards but a trial is planned for ward F7 to see if we can increase natural ventilation whilst still complying with the health and safety requirements relating to window openings. If this is successful the estates team will roll this out across the site.

Recovery Planning

We are gradually bringing more diagnostic and urgent services back on line as capacity and guidance allows. We are using theatre, endoscopy and outpatient facilities at the local BMI hospital to support this as part of the national procurement of all independent sector capacity.

All planned admissions are swabbed for Covid and instructed to self-isolate for 14 days, in accordance with national guidance, to reduce the risk of spread of the virus within the hospital setting.

Detailed plans are currently being developed to determine our capacity going forward considering the new ways of working due to Covid.

There are 6 key elements which are being factored into these plans:

1. Bed capacity due to the social distancing requirements
2. Availability of a reliable PPE supply chain
3. Reduced productivity due to the ways of working such as donning and doffing PPE, social distancing in waiting rooms, ventilation requirements
4. Availability of anaesthetic drugs and other key supplies
5. Workforce restrictions
6. Testing and tracking capabilities

Many of these issues have significantly reduced our capacity to deliver diagnostic procedures, surgical treatments and face to face outpatient appointments or therapeutic interventions.

We have submitted very high-level plans which include the ongoing use of the independent sector capacity as well as capital bids for 2 additional modular wards on the main site and two theatres and wards on the Newmarket site. We are currently unclear as to the time line or approval process to progress these bids but are clear that without this additional capacity we are only likely to be able to deliver circa 40-50 % of our previous elective activity.

Detailed plans will be presented to the next scrutiny committee for more detailed review.

10. Integrated quality and performance report

To APPROVE a report

For Approval

Presented by Rowan Procter and Helen Beck

Trust Board – 29 May 2020

Agenda item:	10			
Presented by:	Helen Beck, COO, and Rowan Procter, Executive Chief Nurse			
Prepared by:	Jo Rayner			
Date prepared:	29 May 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:

That Board note the performance in the report and accept this as an interim reporting method.

An Interim Approach to Performance Reporting to Board

Introduction

The Integrated Quality and Performance Report is the accepted method to report performance to the Board. Many of the metrics are currently not relevant as the Trust responds to COVID and relevant national guidance making the IQPR not fit for purpose at the current time. For this reason the IQPR has not been reported to Board since the COVID response began. An interim performance report is present below for consideration.

Performance

Metric	March 2020	April 2020	Supporting Commentary
ED attendances	5,020	3,542	There were 3,542 attendances in ED in April which was a reduction of 30% on March. Patients arriving by ambulance fell but not by as significantly as our overall attendance (a fall of 331 patients – 19.8%) However, the percentage of overall patients who arrived by ambulance was higher in April than in March. 1,051 patients were admitted in April compared to 1,403 in March (fall of 352 patients -25.1%) but the percentage of attendances admitted overall rose from 27.9% in March to 29.7% in April.
RTT Waiting list	18,858	17,859	Overall total patients have decreased, partly due to lack of referrals and partly due to managing patients differently. However as expected the overall patients over 18 weeks has risen from 4,731 end of March to 5,915 end of April, with the largest increase being in services that treat patients surgically
52 week waits	14	80	Large increase of 52 week breaches from 14 at the end of March to 80 at the end of April. The largest increase within Trauma and Orthopaedics, General Surgery, Ophthalmology and Gynaecology as expected as patients are not currently being surgically treated. Roll out of welfare/harm reviews for these patients in process
Cancer Activity	ND	ND	Cancer referrals are still down from what we would usually see, there has been a steady increase in most specialities in April, Breast symptomatic particularly hasn't dropped to the lower levels of others. Primary care colleagues have sent patient communications across the ICS to ensure patients are aware they should attend GP's if they are concerned.
Activity - outpatient	ND	ND	Large reduction in numbers of outpatient appointments due to inability to see patients face to face and clinical rota's impacted 'normal' clinical activity. Plan in place to start seeing more patients in main OPD from the 26th May.
Activity – elective	2,220	541	Elective activity was only limited towards the end of March so the number of treatments was only slightly dropped, however in April only 50 elective surgery patients were treated, in comparison to 923 for April 2019. From the 26th March 2020 the only patients treated in theatre have been emergencies, cancer and some clinically urgent patients. There is a plan to increase this slightly from June, but this will only be a slight increase in capacity for cancer patients.

Staff sickness	3.6%	3.9%	The Trust's 12 month cumulative absence for year ending March 2020 was 3.6% which is consistent with January and February 2020. In April 2020 the reported 12 month cumulative absence figure was 3.9%; the increase due to COVID-19 related sickness absence. These figures are averaged over a whole 12 month period however, looking at recent individual weekly periods, the weeks ending 18/04/20 and 25/04/20 absence was 6.95% and 7.03% respectively. Of this, absence directly attributed to COVID-19 was 4.69% and 4.51% respectively. The Trust's 12 month cumulative absence trend will continue to rise into May 2020 due to COVID-19 related sickness absence.
Theatres – Elective operations (exc private patients)	740	54	Activity undertaken in in line with national and Royal College guidance and prioritisation. COVID restrictions impacting significantly on through put in theatres at this stage of the pandemic. Experience to date demonstrates at least a 50% reduction in productivity. This may improve but equally could be impacted (positively or negatively) by other extrinsic factors such as changes in PPE supply, guidance, staffing levels etc.
COVID numbers	21	150	This is the number of admitted patients who tested positive for COVID.
Acuity measure	n/a	n/a	Following an initial dip in activity at the beginning of the lockdown period, over recent weeks, clinical areas have seen rising acuity, in particular, in the clinical areas caring for patients with COVID -19. Anecdotally, teams are reporting that many of these patients require high levels of care and management and are at high risk of rapid deterioration. It is also important to acknowledge that staff are dealing with this increasing workload in full PPE and have been managing deficits within the teams due to self-isolation, sickness and shielding. As a result of the pandemic, there appears to have been a rise in late presentation, specifically patients presenting with heart failure and strokes, where assistance has not been sought early enough to limit the progression of the condition. There is also some anecdotal evidence in the surgical division, who have seen a rise in the number of patients presenting acutely unwell with bowel obstruction, also likely due to late presentation.
Number of datix – Covid reason	n/a	n/a	No specific concerns related to COVID have been raised through a review of delay incidents (delay in treatment, delay in diagnosis). 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.
Diagnostic performance	88.2%	37.2%	Endoscopy has been directly impacted by COVID activity/restrictions and ability to undertake diagnostic endoscopy limited to emergency procedures only at the outset of the pandemic. Some endoscopy now being undertaken but much reduced from pre-COVID levels even with planned support from the independent sector. (Radiology) – directly impacted by COVID activity/restrictions. However, all modalities have been able to continue with emergency, urgent and cancer work. Obstetric ultrasound has continued albeit with some

			restrictions in line with national and Royal College guidance. Some routine activity is being introduced slowly particularly in community settings.
Cancer performance	See notes	n/a	62 day 85.2% against 85% standard. 2WW – 92.2% against 93% standard. April performance is not yet available, however it will be around 80% for 62 day and 87% for 2WW. The numbers for April are a lot smaller, and the area with the most patients booked past 2 weeks is Colorectal. May and June performance will worsen for 2WW as we slowly start to see patients for their straight to test Endoscopy as this service was on hold for 6 weeks so all the patients have been waiting in excess of 2 weeks.
New complaints	n/a	n/a	See below
Closed complaints	n/a	n/a	See below
Overdue responses	n/a	n/a	See below
Average daily calls answered by the helpline	n/a	n/a	See below
Duty of candour (within 100 days)	83%	73%	There has been an improvement in completion rates in 2020 with only two verbal and 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.

COVID-19 ward Audit

During the pandemic we are undertaking alternative audits, for the COVID wards we have worked with our audit supplier and have a bespoke audit. There are 6 section categories that the audit cover;

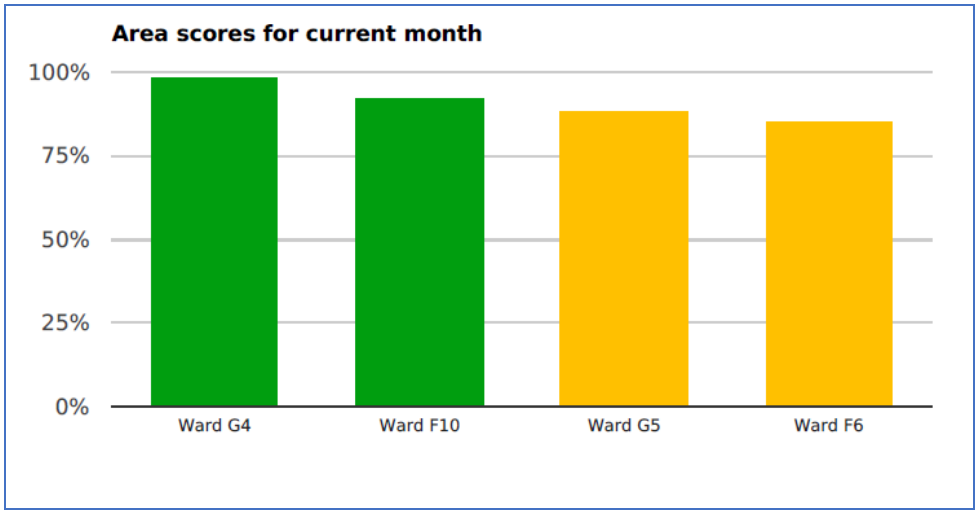
1. Confirmed or suspected cases
2. Hand hygiene
3. PPE
4. Patient Safety
5. Signage
6. Staff awareness

Inspection section

	Category	Score this month	Score last 12
1	Confirmed or Suspected Cases	100% (13)	100% (15)
2	Hand Hygiene	84% (19)	79% (24)
3	PPE	97% (30)	95% (38)
4	Patient Safety	0% (0)	0% (0)
5	Signage	67% (12)	57% (14)
6	Staff Awareness	95% (28)	96% (35)

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

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.



Complaints

- Reduced emails by 250 to 0 (Zero)
- Responses to emails within 24 hours
- Complaints reduced from 130 down to 83 (Current reduction of 47 / c37%)
- 10 complaints received since COVID-19
- 3 existing complainants withdrawn due to COVID-19 pressures.
- All complaints have been contacted and updated.
- Pledge to meet respond to complaints within agreed SLA's with immediate effect
- Aim to reduce response times back to 25 days when COVID-19 situation eases
- Forecasted that by end of May we will be under 65 complaints, a 50% reduction since March

The summary below will give an update on complaints progress since 16th March, with changes made and new processes implemented to improve complaints management and the complaints journey.

As of 16th March, the feedback mailbox had over 250 emails backlogged with some emails dating back to 2019. We also had over 130 active complaints, with complainants experiencing minimal contact and updates due to staff shortages. Between the team we adopted an operating rhythm of "everything in, everything out" on the same day to improve the complaints journey. We reviewed how the feedback mailbox was managed and made some simple changes to categorise the emails to work more effectively. The feedback mailbox is now up to date, with all contacts receiving a response within 24 hours. To tackle the active complaints, we set up a data cleanse team between the complaints and PALS administrators. We organised and categorised the open complaints where we were in a position to provide the outcome report or if we were still awaiting staff responses. We then contacted all 130 complainants with a holding letter to apologise for the delay and provide them with either an agreed date in which they will receive a response by or to advise that we are still awaiting responses from staff and it will be on hold until COVID-19 situation eases. 22 out of 83 open complaints are on hold as they have not yet been sent to staff and will only be escalated once COVID-19 pandemic has eased. We have received responses for 19 complaints from staff and are able to respond to, we are on track to get these completed by the end of April as agreed with the complainants within the holding letter. The remaining complaints are either awaiting consent, with staff for responses or awaiting local resolution meetings, which have been postponed.

Since COVID-19, we have ring-fenced any new complaints received during this period from w/c 9th March. Since this date, we have received 10 complaints. 4 of these complaints, we have accepted and have placed on hold due to their RAG status being red or relating to poor end of life care. The remaining 6 complaints are all Green rated complaints and have been responded to with information gained from E-care and/or provided an apology about perceived staff behaviour.

Since we wrote to all complainants to provide them with an update, 3 complainants have responded to withdraw their complaint due to acknowledging the current pressures on the NHS. At the end of May we expect to be under 65 complaints, a 50% reduction within 8 weeks.

Keeping in Touch

Now running a 7 day, 8am-8pm entirely remote service
PALS operational hours as above on the frontline of the telephone line (14 people now deployed into PALS in total with varying shifts) and also running a live webchat service on the Trust website ◦All weekday shifts (including up until 8pm, which is not considered unsocial hours so no enhanced pay necessary) are covered by re-deployed staff within their usual hours so no extra cost
Clinical helpline team, made up of 22 all shielding and redeployed staff members, operational hours as listed above ◦Team are providing updates to relatives on how their loved one in hospital is Getting 'regulars' phoning for updates, which speaks for itself in demonstrating that it is working
Majority of callers to clinical helpline tend to be elderly husbands or wives of our inpatients, who are also shielding at home, so the team are also making sure they are okay and getting the support they need

One clinician per day is responsible for phoning COVID19+ staff and household members to give them their result and provide advice

Rostered from next week onwards are clinical staff that are shielding:
- 12 registered nurses
- 3 consultants
- 1 FY1
- 1 registered midwife
- 3 physiotherapists
- 2 occupational therapists

On average there are 200 calls a day being managed by this help line and not calling the wards.

It is recommended that moving forward we report to the Board;
1. New Complaints
2. Closed Complaints
3. Overdue responses
4. Average daily calls answered by the help line

Next Steps

For May Board, the metrics have been populated where they are available and an overview narrative has been provided for each. For June Board onwards, all the metrics will be provided and will have supporting commentary to provide the Board with insight for each area.

11. Finance and workforce report

To ACCEPT the report

For Report

Presented by Craig Black

Board of Directors – 29 May 2020

Agenda item:	11			
Presented by:	Craig Black, Executive Director of Resources			
Prepared by:	Nick Macdonald, Deputy Director of Finance			
Date prepared:	22nd May 2020			
Subject:	Finance and Workforce Board Report – April 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 April.

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
April 2020 (Month 1)

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	£4.2m	adverse
EBITDA margin YTD	21%	adverse
Total PSF Received	£4.2m	accrued
Cash at bank	£24m	

Executive Summary

- The planned surplus for the year is to break even. This will include receiving all FRF and MRET funding associated with meeting its 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

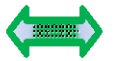
SUMMARY INCOME AND EXPENDITURE ACCOUNT - April 2020	April 2020 Budget £m	April 2020 Actual £m	April 2020 Variance F/(A) £m	Year to date Budget £m	Year to date Actual £m	Year to date Variance F/(A) £m
NHS Contract Income	18.2	17.7	(0.5)	18.2	17.7	(0.5)
Other Income	3.2	3.2	0.0	3.2	3.2	0.0
Total Income	**21.4**	**20.9**	**(0.5)**	**21.4**	**20.9**	**(0.5)**
Pay Costs	15.5	15.4	0.1	15.5	15.4	0.1
Non-pay Costs	8.5	8.0	0.6	8.5	8.0	0.6
Operating Expenditure	**24.1**	**23.4**	**0.7**	**24.1**	**23.4**	**0.7**
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0
EBITDA excl STF	**(2.7)**	**(2.5)**	**0.2**	**(2.7)**	**(2.5)**	**0.2**
Depreciation	0.7	0.6	0.1	0.7	0.6	0.1
Finance costs	0.3	0.4	(0.1)	0.3	0.4	(0.1)
SURPLUS/(DEFICIT)	**(3.7)**	**(3.4)**	**0.2**	**(3.7)**	**(3.4)**	**0.2**
Provider Sustainability Funding (PSF)						
PSF / FRF/ MRET/ Top Up	3.7	3.4	(0.2)	3.7	3.4	(0.2)
SURPLUS/(DEFICIT) incl PSF	**0.0**	**(0.0)**	**(0.0)**	**0.0**	**(0.0)**	**(0.0)**

FINANCE AND WORKFORCE REPORT – April 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 – April 2020

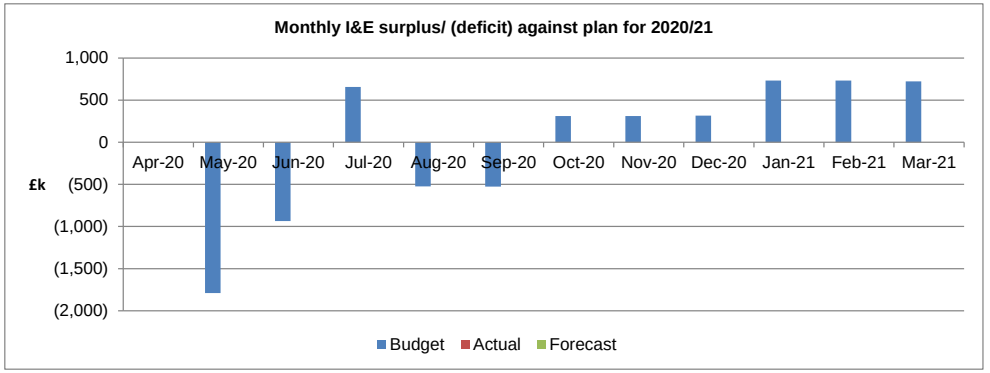
Income and Expenditure Summary as at April 2020

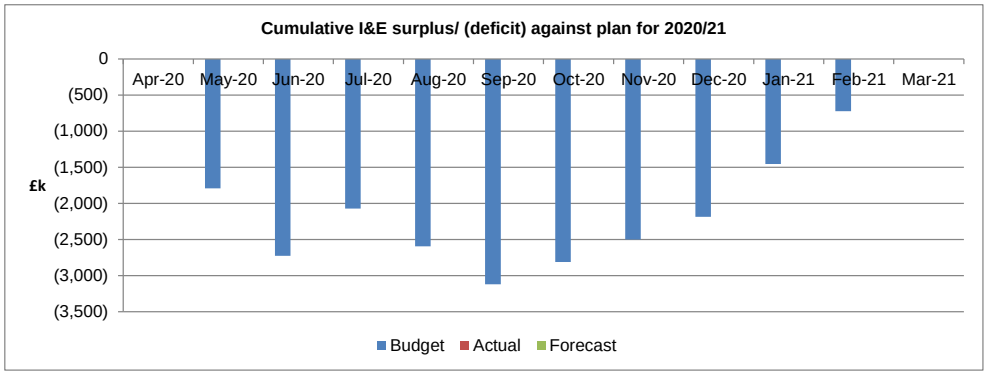
The reported I&E for April is break even, in line with NHSI guidance. Due to COVID-19 we are receiving a top up payment that includes MRET and FRF and ensures we break even. The value of this for April was £3.4m.

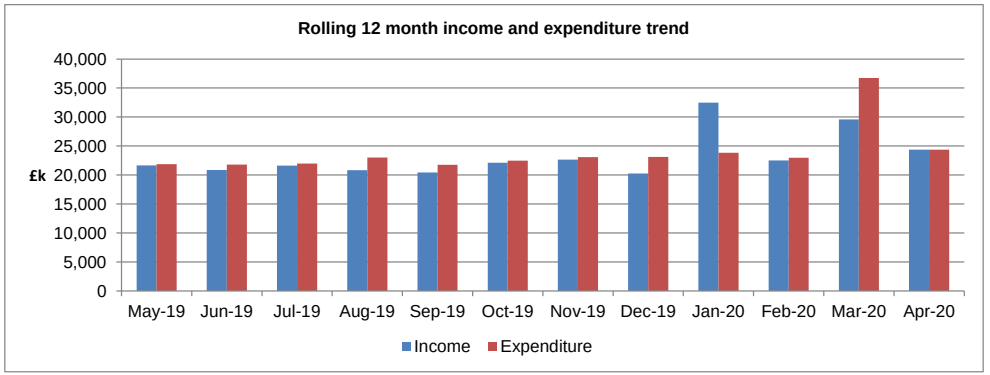
We anticipate this arrangement continuing until at least October 2020.

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)		Amber
YTD surplus/ (deficit)	0	(0)	(0)		Amber
Forecast surplus/ (deficit)	(0)	0	0		Green
EBITDA (excl top-up) YTD	(3,655)	(3,434)	221		Green
EBITDA %	(17.1%)	(16.4%)	0.7%		Green
Clinical Income YTD	(38,225)	(37,084)	(1,140)		Red
Non-Clinical Income YTD	(5,831)	(5,751)	(80)		Amber
Pay YTD	15,522	15,442	81		Green
Non-Pay YTD	9,546	8,922	624		Green
CIP Target YTD	747	492	(255)		Amber







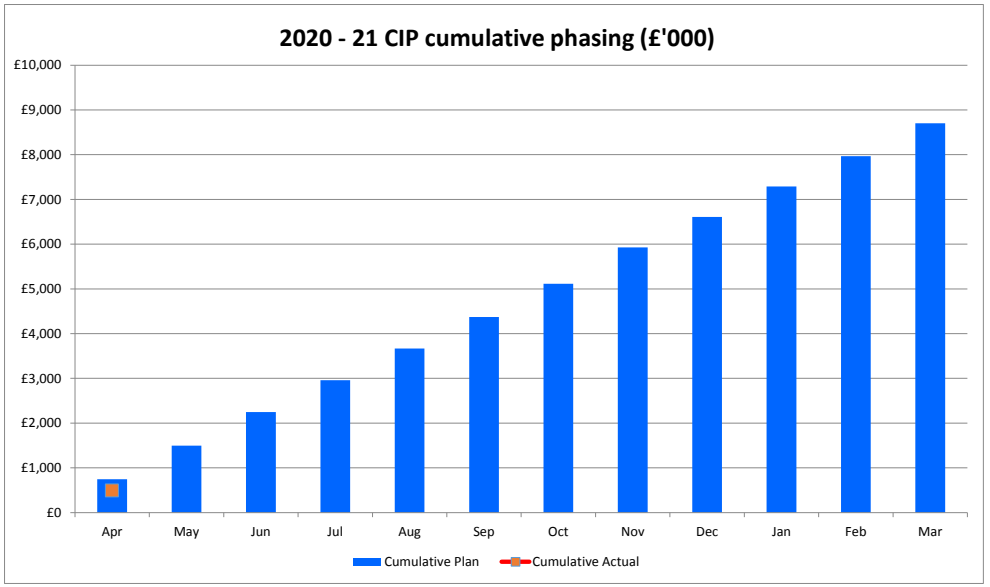
FINANCE AND WORKFORCE REPORT – April 2020

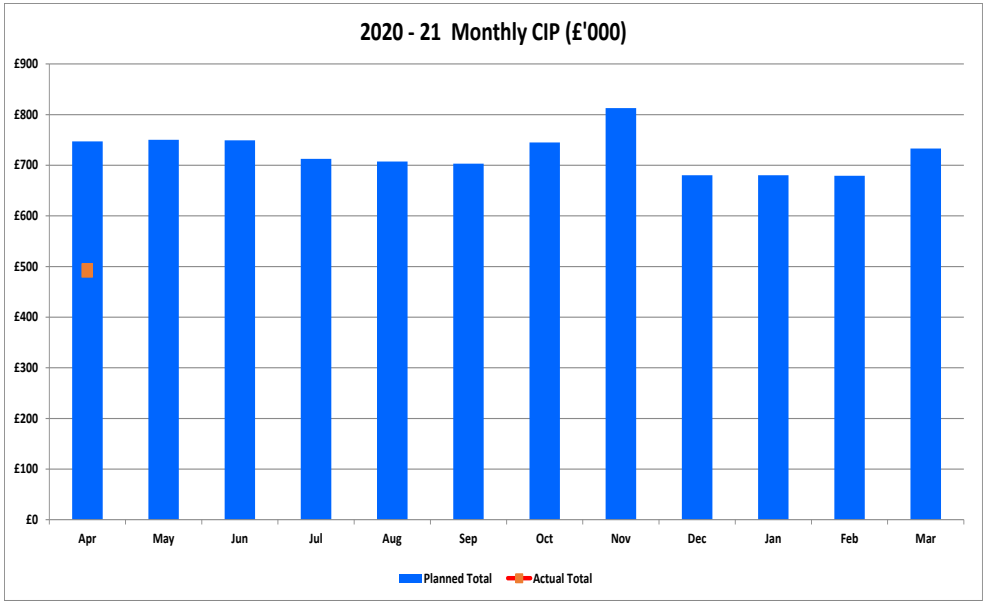
Cost Improvement Programme (CIP) 2020-21

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 747k (8.6% of the annual plan) and we achieved £492k (5.7%). This represents a shortfall of £255k.

Recurring/Non Recurring	2020-21 Annual Plan	Plan YTD	Actual YTD
	£'000	£'000	£'000
Recurring			
Outpatients	254	14	5
Procurement	366	31	30
Activity growth	200	17	17
Additional sessions	363	29	-
Community Equipment Service	510	43	24
Drugs	367	31	21
Estates and Facilities	30	3	1
Other	2,710	226	233
Other Income	388	32	-
Pay controls	260	22	9
Service Review	16	3	3
Staffing Review	819	59	51
Theatre Efficiency	302	25	-
Contract Review	50	4	-
Workforce	-	-	-
Consultant staffing	-	-	-
Agency	-	-	-
Unidentified CIP	1,268	106	-
Recurring Total	**7,902**	**643**	**393**
Non-Recurring			
Pay controls	647	70	65
Other	145	34	34
Estates and Facilities	6	1	-
Non-Recurring Total	**798**	**105**	**99**
Total CIP	**8,700**	**747**	**492**
	8.6%	5.7%	(255)

Division	Divisional Target £'000	YTD Var £'000	Unidentified plan £ YTD	Unidentified plan £ year
Medicine	2,555	(63)	21	255
Surgery	2,029	(67)	17	203
W&C/CSS	1,847	(14)	0	0
Community	1,422	(50)	10	125
E&F	516	(42)	39	464
Corporates	331	(20)	18	221
Stretch	0	0	0	0
Total	**8,700**	**(255)**	**106**	**1,268**

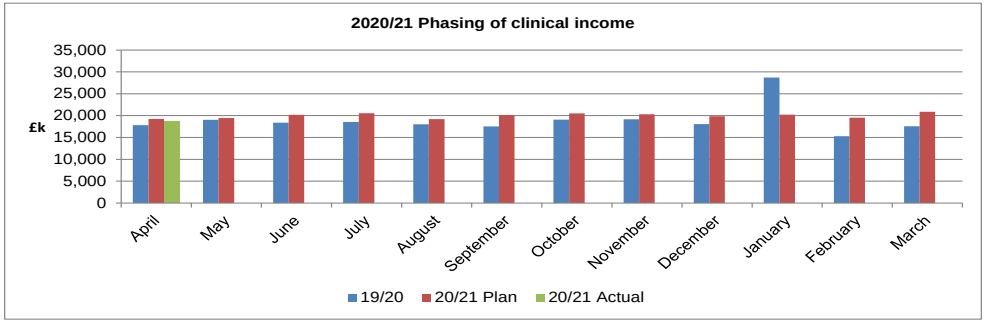




FINANCE AND WORKFORCE REPORT – April 2020

Income Analysis

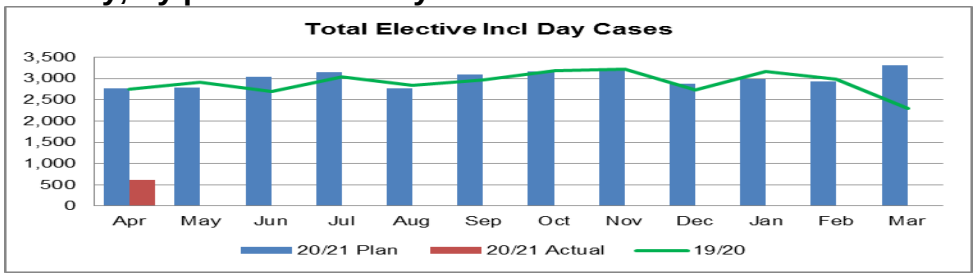
The chart below demonstrates the phasing of all clinical income plan for 2020-21, including Community Services. This phasing is in line with phasing of activity.

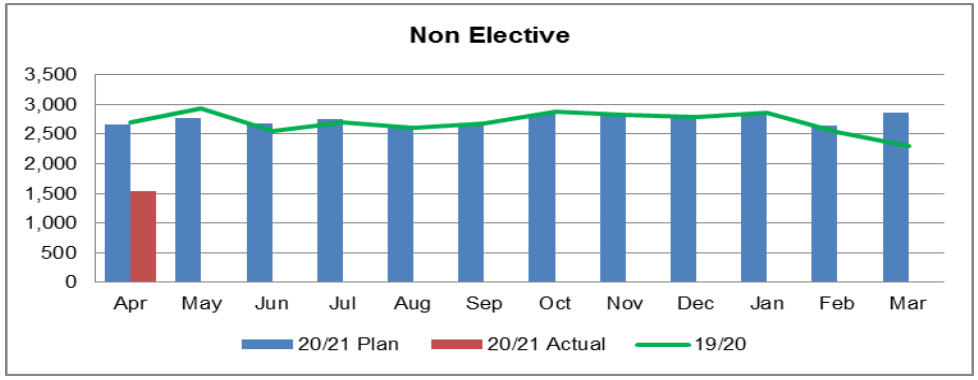


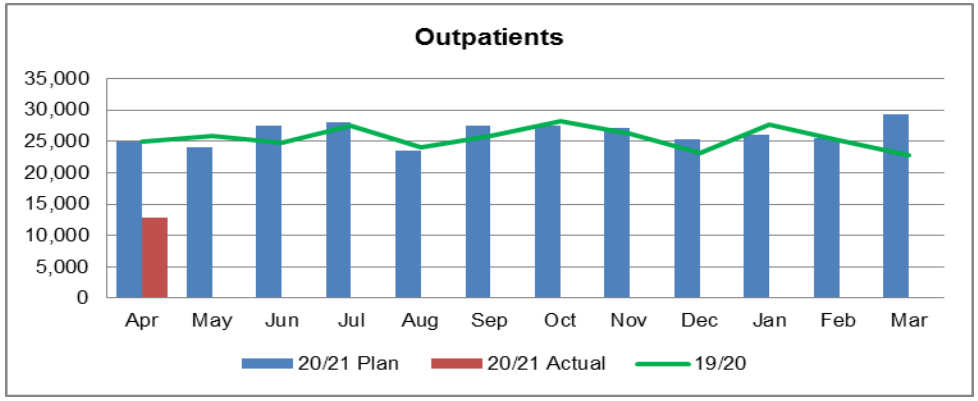
The income position was slightly under plan for April. The income was based on the national agreed block payments as set out by NHS England, these were put in place to give Providers assured income during the coronavirus period.

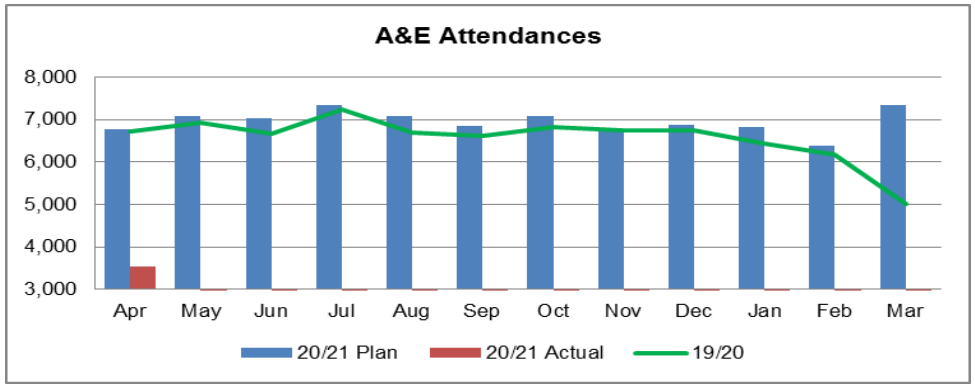
	Current Month			Year to Date		
Income (£000s)	Plan	Actual	Variance	Plan	Actual	Variance
Accident and Emergency	992	573	(419)	992	573	(419)
Other Services	3,106	8,029	4,923	3,106	8,029	4,923
CQUIN	173	106	(67)	173	106	(67)
Elective	2,600	369	(2,231)	2,600	369	(2,231)
Non Elective	6,427	5,719	(708)	6,427	5,719	(708)
Emergency Threshold Adjustment	(341)	(341)	0	(341)	(341)	0
Outpatients	3,041	1,029	(2,013)	3,041	1,029	(2,013)
Community	2,988	2,988	0	2,988	2,988	0
Total	**18,987**	**18,472**	**(515)**	**18,987**	**18,472**	**(515)**

Activity, by point of delivery



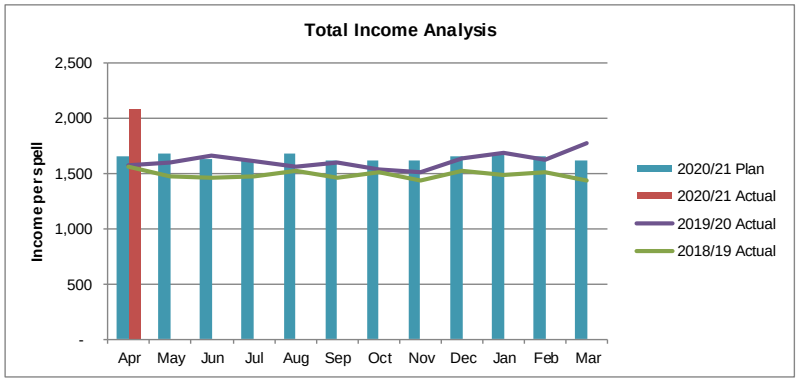


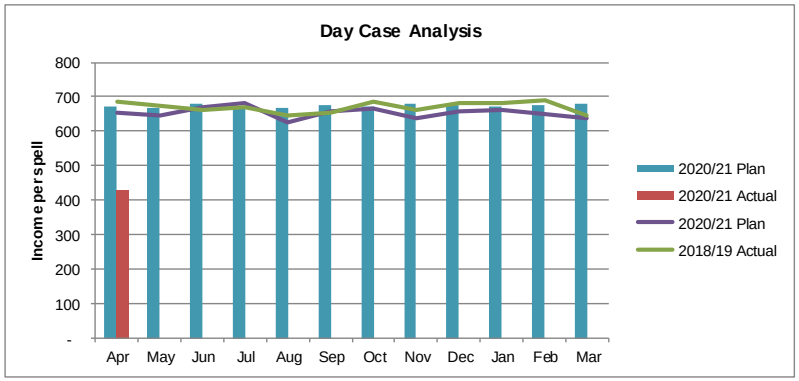


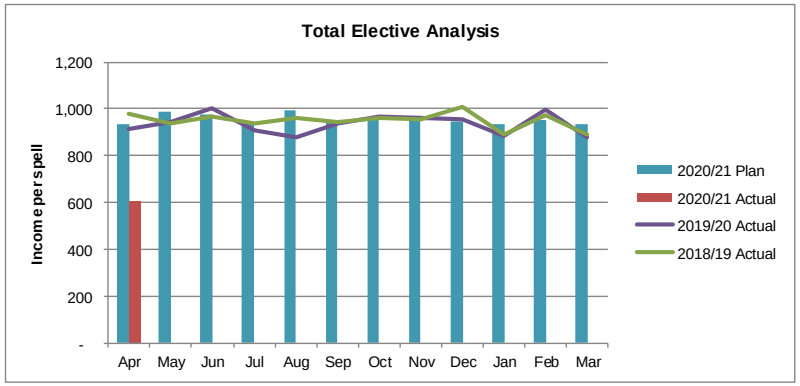


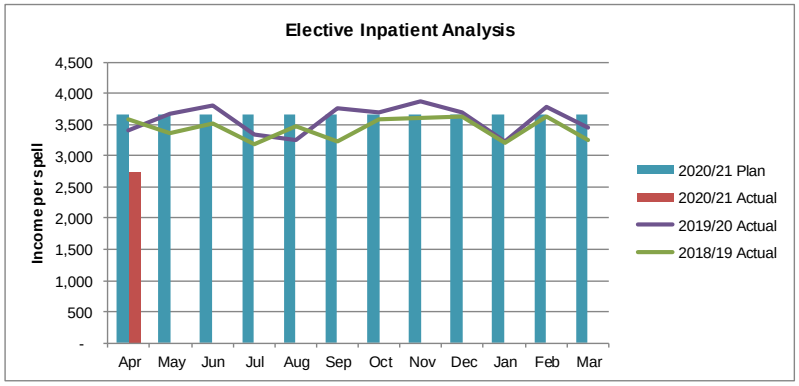
Trends and Analysis

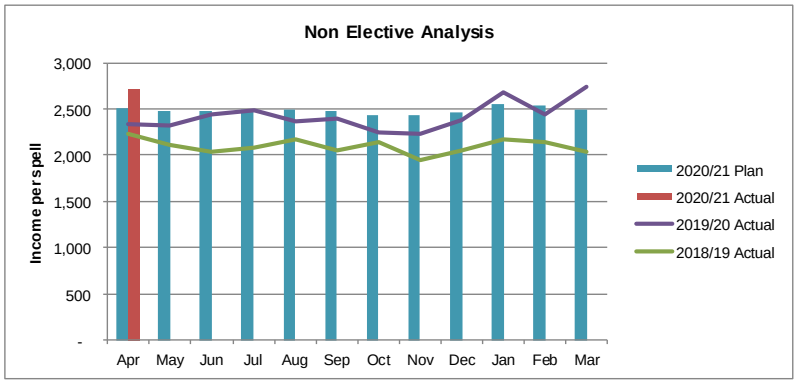
FINANCE AND WORKFORCE REPORT – April 2020

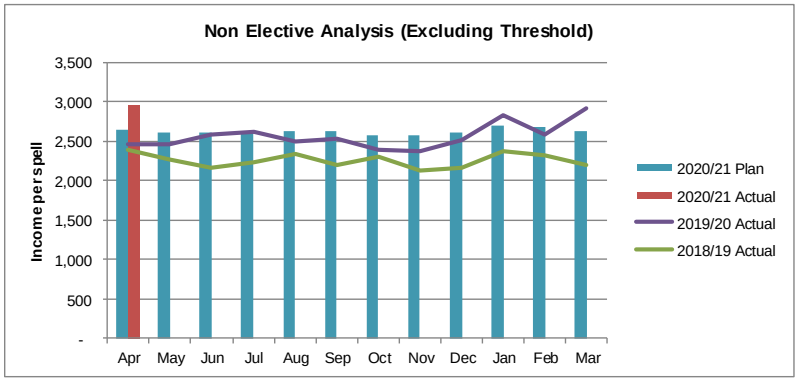












FINANCE AND WORKFORCE REPORT – April 2020

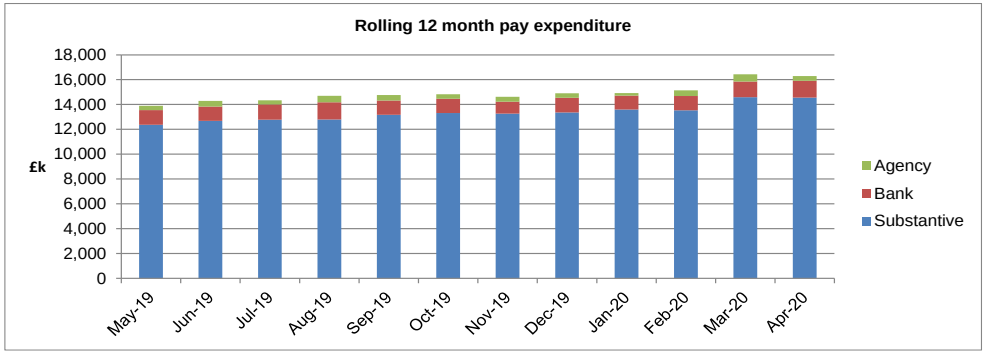
Workforce

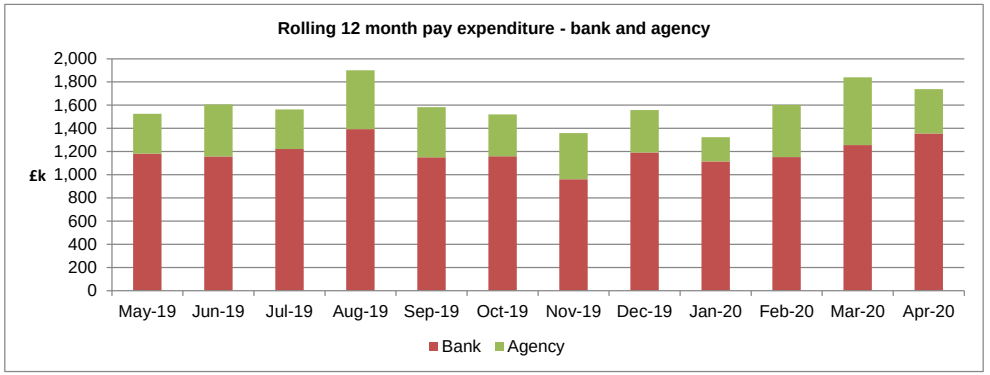
Monthly Expenditure (£)				
As at April 2020	Apr-20	Mar-20	Apr-19	YTD
	£000's	£000's	£000's	£000's
Budgeted Costs in-month	15,522	14,491	14,405	15,522
Substantive Staff	14,549	14,593	12,758	14,549
Medical Agency Staff	151	242	193	151
Medical Locum Staff	289	283	294	289
Additional Medical Sessions	264	234	272	264
Nursing Agency Staff	170	237	166	170
Nursing Bank Staff	424	439	336	424
Other Agency Staff	61	105	44	61
Other Bank Staff	199	173	157	199
Overtime	113	55	228	113
On Call	66	71	72	66
Total Temporary Expenditure	1,738	1,840	1,763	1,738
Total Expenditure on Pay	16,288	16,433	14,520	16,288
Variance (F/(A))	(765)	(1,942)	(115)	(765)
Temp. Staff Costs as % of Total Pay	10.7%	11.2%	12.1%	10.7%
memo: Total Agency Spend in-month	383	584	403	383

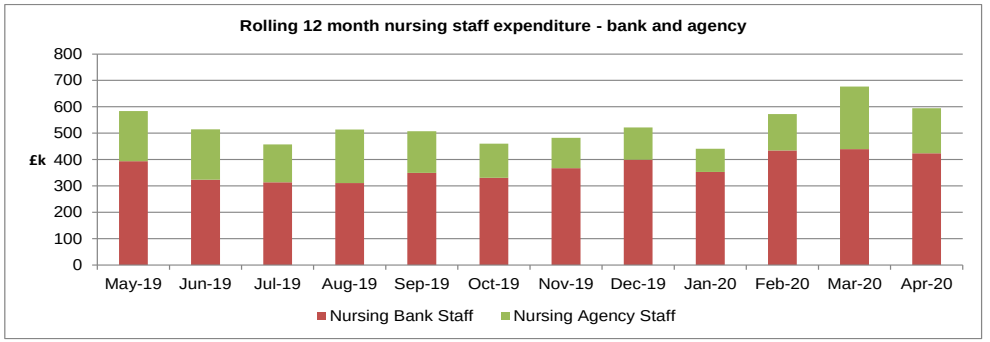
Monthly WTE				
As at April 2020	Apr-20	Mar-20	Apr-19	YTD
	£000's	£000's	£000's	£000's
Budgeted WTE in-month	4,042.5	3,888.5	3,914.6	4,042.5
Substantive Staff	3,713.2	3,706.5	3,466.0	3,713.2
Medical Agency Staff	22.0	9.8	13.6	22.0
Medical Locum Staff	26.4	28.5	38.6	26.4
Additional Medical Sessions	(0.5)	10.4	11.8	(0.5)
Nursing Agency Staff	24.4	32.0	26.1	24.4
Nursing Bank Staff	129.3	132.0	104.4	129.3
Other Agency Staff	13.7	23.0	10.3	13.7
Other Bank Staff	79.2	69.8	65.7	79.2
Overtime	30.0	14.6	63.4	30.0
On Call	5.6	6.4	7.1	5.6
Total Temporary WTE	330.1	326.6	341.0	330.1
Total WTE	4,043.2	4,033.1	3,807.0	4,043.2
Variance (F/(A))	(0.7)	(144.6)	107.7	(0.7)
Temp. Staff WTE as % of Total WTE	8.2%	8.1%	9.0%	8.2%
memo: Total Agency WTE in-month	60.1	64.9	50.0	60.1

Pay Trends and Analysis

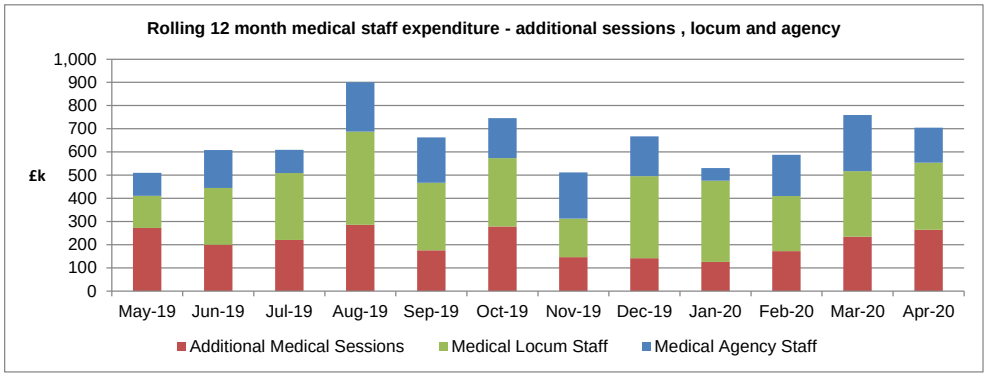
During April the Trust underspent by £81k on pay.



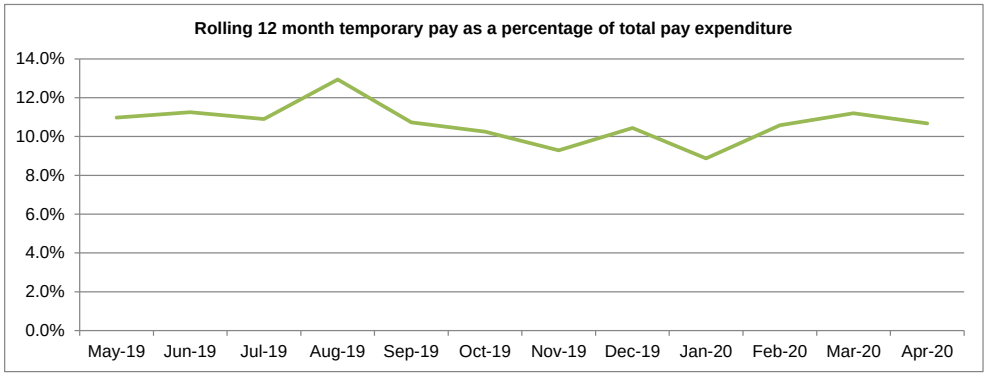


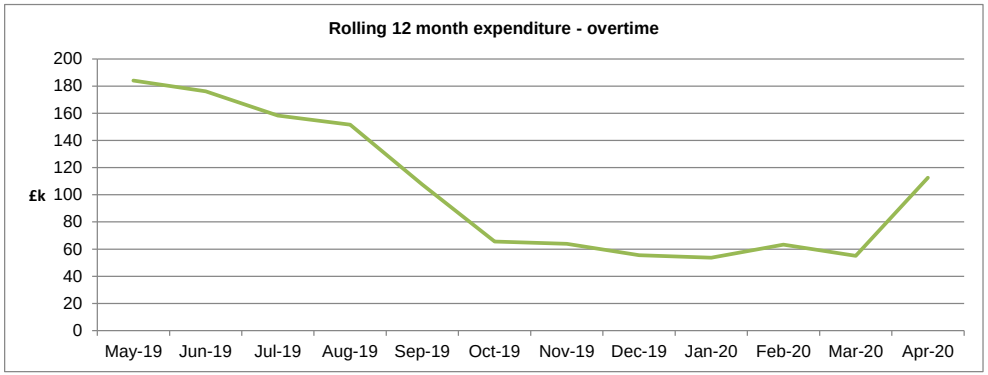


FINANCE AND WORKFORCE REPORT – April 2020



Expenditure on Additional Sessions was £264k in April (£234k in March)





FINANCE AND WORKFORCE REPORT – April 2020

Income and Expenditure Summary by Division

Divisional Financial Perfomance - April 2020	Current Month		
	Budget	Actual	Variance F/(A)
MEDICINE	£k	£k	£k
Total Income	(7,515)	(4,491)	(3,024)
Pay Costs	4,208	3,690	518
Non-pay Costs	1,645	1,294	350
Operating Expenditure	5,853	4,985	868
SURPLUS / (DEFICIT)	1,663	(493)	(2,156)
SURGERY			
Total Income	(5,146)	(1,893)	(3,253)
Pay Costs	3,348	3,067	280
Non-pay Costs	1,019	598	421
Operating Expenditure	4,367	3,665	701
SURPLUS / (DEFICIT)	779	(1,772)	(2,552)
WOMENS AND CHILDRENS			
Total Income	(1,887)	(1,464)	(423)
Pay Costs	1,398	1,305	93
Non-pay Costs	174	171	3
Operating Expenditure	1,572	1,476	96
SURPLUS / (DEFICIT)	315	(12)	(327)
CLINICAL SUPPORT			
Total Income	(825)	(452)	(373)
Pay Costs	1,642	1,549	93
Non-pay Costs	1,126	1,092	34
Operating Expenditure	2,768	2,640	128
SURPLUS / (DEFICIT)	(1,943)	(2,188)	(245)
COMMUNITY SERVICES			
Total Income	(3,505)	(3,507)	2
Pay Costs	2,522	2,441	81
Non-pay Costs	932	1,090	(159)
Operating Expenditure	3,453	3,531	(78)
SURPLUS / (DEFICIT)	51	(25)	(76)
ESTATES AND FACILITIES			
Total Income	(420)	(564)	143
Pay Costs	901	898	3
Non-pay Costs	612	507	105
Operating Expenditure	1,513	1,405	108
SURPLUS / (DEFICIT)	(1,093)	(842)	251
CORPORATE			
Total Income	(5,762)	(11,981)	6,219
Pay Costs	1,505	2,491	(986)
Non-pay Costs	3,037	3,515	(477)
Capital Charges and Financing Costs	993	643	350
Operating Expenditure	5,535	6,006	(471)
SURPLUS / (DEFICIT)	228	5,976	5,748
TOTAL			
Total Income	(25,060)	(24,352)	(708)
Pay Costs	15,522	15,442	81
Non-pay Costs	8,545	8,267	277
Capital Charges and Financing Costs	993	643	350
Operating Expenditure	25,060	24,352	708
SURPLUS / (DEFICIT)	0	(0)	(0)

Medicine (Nicola Cottington)

The division reports an adverse variance of £2.156m in April.

Clinical income is behind plan in month by £3.0m. This is driven by the reduced activity witnessed 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 (£518k) in April. During April, the following wards were used by the Trust to treat either confirmed or suspected COVID patients: F12, F7, F10, F9, G4 & G5. The cost for these wards in the month 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 £350k underspend on non-pay, £120k of which will be reversed in M2. The majority of the underlying £230k underspend is driven by COVID 19, primarily through reduced activity (reduction in drugs and other consumables).

Surgery (Simon Taylor)

The division reports an adverse variance of £2.552m in April.

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. This has resulted in Surgery under achieving the Clinical Income plan by £3,253k. However, this loss of divisional income is offset within the Corporate division due to the guarantees over the block contract.

Pay was underspent by £280k due to less additional sessions being needed for elective work and also 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 significantly by £421k, which relates to reduced activity in wards, 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 one and currently has not identified a full plan, this is because COVID planning took precedence. Further to this due to the effect COVID is anticipated to have in theatres and clinics some of surgery's' CIP schemes will not be achievable, until normal service is possible.

Women and Children's (Darin Geary)
In April, the Division reported an adverse variance of £327k.

The elective, non-elective and outpatient activity performed under NHS contract dropped by around 35% because of COVID. This led to NHS activity being £441k below plan.

Pay reported a £93k underspend in-month as many of the activity related pay spends reduced because of the lower activity levels.

Non-pay costs continued at the budgeted rates. It is expected that these costs will reduce in May as the reduced activity levels impact on the amount of orders processed.

Clinical Support (Darin Geary)
In April, the Division reported an adverse variance of £245k.

Income for Clinical Support reported £373k behind plan in-month because outpatient activity declined by around 75% and radiology activity declined by around 90%. This led to the adverse total income variance of £373k.

Pay reported a £93k underspend in-month as many of the activity related pay spends reduced because of the lower activity levels.

Non-pay reported a £34k underspend in-month due to a favourable accounting adjustment.

Community Services (Michelle Glass)
The division reported an adverse variance of £76k in month.

Income reported a £2k over recovery in month 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 under spend on pay of £81k. Whilst 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, the current level of expenditure on agency is within the available budget for permanently funded posts. 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 key vacancies including a number of Band 5 Nursing and AHP posts.

Non-pay reported an adverse variance of £159k in April. The in-month position reflects an over spend on Community Equipment and associated activity costs, required to support both the facilitation of hospital discharge and to enable patients to remain independent at home. 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. In addition, a one off cost was incurred for the purchase of Healthcare beds in the Community; this cost will be recovered. Other one off costs were incurred at the start of the year in response to further support home and mobile working through best use of available IT solutions, mobile phones and other required equipment.

Statement of Financial Position at 30 April 2020

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2020	Plan 31 March 2021	Plan YTD 30 April 2020	Actual at 30 April 2020	Variance YTD 30 April 2020
	DRAFT £000	£000	£000	£000	£000
Intangible assets	40,972	48,993	37,028	41,291	4,263
Property, plant and equipment	110,593	147,050	114,491	110,970	(3,521)
Trade and other receivables	5,707	5,707	5,707	5,707	0
Total non-current assets	**157,272**	**201,750**	**157,226**	**157,968**	**742**
Inventories	2,872	3,000	3,000	3,059	59
Trade and other receivables	32,342	20,666	20,666	38,171	17,505
Cash and cash equivalents	2,441	1,510	20,010	23,961	3,951
Total current assets	**37,655**	**25,176**	**43,676**	**65,191**	**21,515**
Trade and other payables	(33,692)	(23,000)	(23,509)	(35,118)	(11,609)
Borrowing repayable within 1 year	(58,529)	(11,364)	(58,313)	(58,282)	31
Current Provisions	(67)	(67)	(67)	(67)	0
Other liabilities	(1,933)	(1,000)	(20,000)	(28,040)	(8,040)
Total current liabilities	**(94,221)**	**(35,431)**	**(101,889)**	**(121,507)**	**(19,618)**
Total assets less current liabilities	**100,706**	**191,495**	**99,013**	**101,652**	**2,639**
Borrowings	(52,538)	(59,241)	(53,538)	(53,488)	50
Provisions	(744)	(744)	(744)	(741)	3
Total non-current liabilities	**(53,282)**	**(59,985)**	**(54,282)**	**(54,229)**	**53**
Total assets employed	**47,424**	**131,510**	**44,731**	**47,423**	**2,692**
Financed by					
Public dividend capital	74,065	160,844	74,065	74,064	(1)
Revaluation reserve	6,942	6,942	6,942	6,942	0
Income and expenditure reserve	(33,583)	(36,276)	(36,276)	(33,583)	2,693
Total taxpayers' and others' equity	**47,424**	**131,510**	**44,731**	**47,423**	**2,692**

The figures as at 1 April 2020 are based on the draft Accounts which are currently subject to audit. The plan figures are based on a re-drafted plan which assumes that the Trust will achieve a breakeven position for 2020/21.

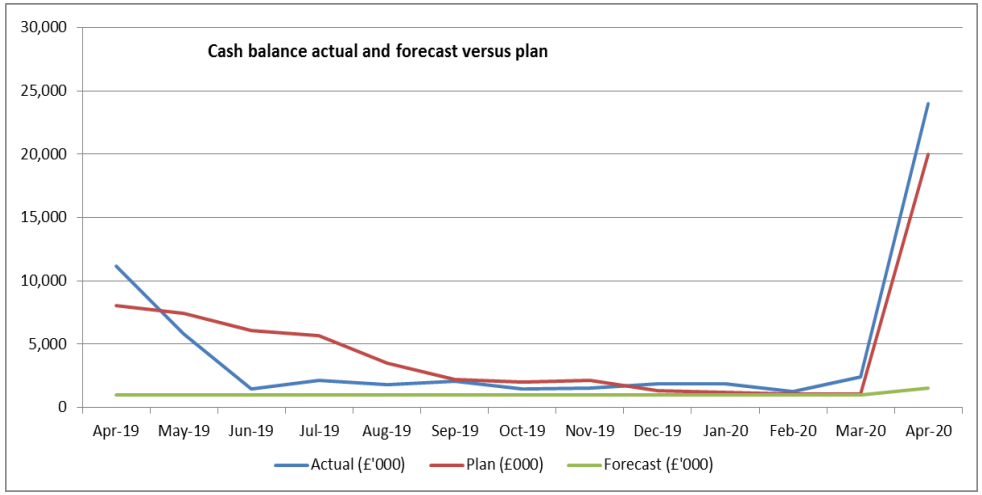
There has been little movement in the balance sheet since the year end. The most notable movements are as follows:

Trade and Other Receivables
Receivables have increased by £5.8m since March. This is mainly due to income that we have accrued to be received through 'top-up' funding from NHS England, which is being given to NHS Organisations during the current pandemic to ensure that the NHS achieves a break-even position in 2020/21.

Cash
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 is adequate cash balances across the NHS. The receipts in advance are shown against other liabilities.

Cash Balance Forecast for the year

The graph illustrates the cash trajectory since April 2020. The Trust is required to keep a minimum balance of £1m.

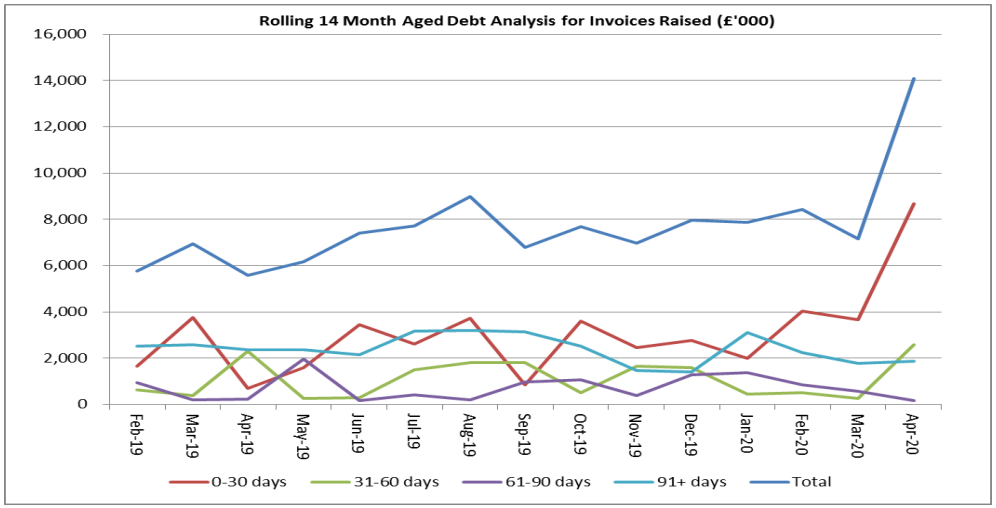


The cash position continues to be rigorously monitored on a daily basis during the current pandemic. Cash flow forecasts are required to be submitted to NHS England every fortnight to ensure that adequate cash reserves are being held within the NHS. Due to the current cash regime, the Trust is holding a larger balance of cash than expected to ensure that all payments can be made and to keep the supply chain in full flow. 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 – April 2020

Debt Management

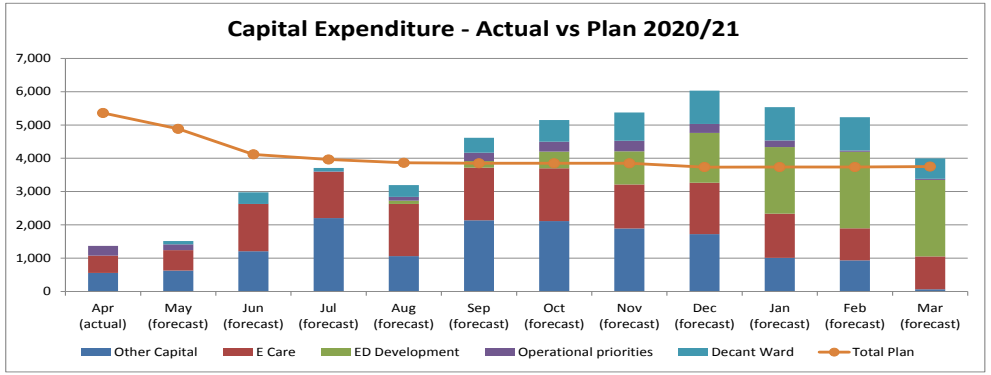
The graph below shows the level of invoiced debt based on age of debt.



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 increased by £7.7m since March. This is mainly due to accruals that were made at the year-end for over performance of activity, which have now been raised as invoices. This also includes nearly £2m of income expected in relation to COVID-19 cost reimbursement. Over 90% of these outstanding debts relate to NHS Organisations, with 18% 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 Forecast £'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
E Care	520	615	1,419	1,389	1,564	1,581	1,584	1,317	1,539	1,326	960	988	14,802
ED Development	0	0	0	0	100	200	500	1,000	1,500	2,000	2,300	2,300	9,900
Operational priorities	289	170	3	15	115	250	300	315	265	200	35	30	1,987
Decant ward	0	100	350	100	350	450	650	850	1,000	1,000	1,000	616	6,466
Other Schemes	558	629	1,208	2,204	1,064	2,136	2,115	1,895	1,725	1,009	937	65	15,545
Total / Forecast	1,367	1,514	2,980	3,708	3,193	4,617	5,149	5,377	6,029	5,535	5,232	3,999	48,700
Total Plan	5,359	4,884	4,117	3,964	3,863	3,851	3,851	3,851	3,735	3,737	3,737	3,751	48,700

The initial capital budget for the year was approved at the Trust Board Meeting in January as part of the operational plan process.

In common with other Trusts, NHSI have requested that a review of capital expenditure be undertaken. Guidance has been issued in terms of a methodology to prioritise existing schemes. The programme shown above is prior to any agreed reduction in the Capital Plan. This review is being undertaken and is due to be submitted at the end of May.

The original plan was set prior to the coronavirus pandemic and it assumed that the ED Development would be in progress. However the actual capital expenditure for the month is considerably lower than originally envisaged.

Should there be a significant change to the plan then the phasing will have to be reassessed in line with the latest projections. It is likely that capex will remain at the current level for May.

10:30 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

12. Nurse staffing report

To ACCEPT the report

For Report

Presented by Rowan Procter

Trust Board – 29 May 2020

Agenda item:	12			
Presented by:	Rowan Procter, Executive Chief Nurse			
Prepared by:	Rowan Procter, Executive Chief Nurse, and Duane M. Elmy, Business Manager			
Date prepared:	May 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 November's and December'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'

Overview of April's nurse staffing position

Are we safe?

Due to COVID-19 and the need to maintain social distancing the structure of the Acute Daily Safety Huddles has changed and whilst this continues with a focus on Senior Matrons and Zone Holders operating the 'buddy' system, to maintain good oversight of staffing across inpatient areas over the 7-day period this has been taking place virtually via email communication and Medic Bleep.

The pilot involving West Suffolk Professionals working on Saturday mornings and when establishment staffing levels allow on a Sunday. It is reported to be of benefit, allowing Senior Matrons to delegate contact to Nurse Agencies, however this has been dependent on and will be subject to the availability of WSP colleagues. This pilot will require evaluation with WSP senior colleagues and if appropriate a business case will be required to substantiate this role within WSP.

Some of our community colleagues have ceased working with paper duty rosters, some areas have moved to Allocate Healthroster which allows for better oversight and planning of rotas; the work continues to include all areas of the community.

Senior clinicians are actively supporting those teams with high vacancy rates and agency approval has remained with the executive chief nurse. Since early May agency bookings do not get processed prior to 72 hour of the shift beginning and then only with the approval of the executive chief nurse. This has reduced agency use and has made the shifts visible on MeApp for our cohort of bank staff.

Agency however continues to be block booked in advance of the 72-hour rule for some areas in order to maintain patient safety; however, approval for this is required from the Executive Chief Nurse.

Work has also commenced around developing a process of cross working for community teams and Community Inpatient Beds, to increase resilience across this Division.

Both inpatient escalation areas remain open, with established nursing teams and experienced Ward Managers and Senior Matrons in situ.

Staffing vacancies are 50 WTE registered nurses, however there is an additional 4.2 WTE NAs which is used to relieve pressure within the organisation. It is to be noted that due to the OSCE centres closing during the pandemic there are circa 20 overseas nurse currently counted in the NA factor.

Sickness rates have increased this month and range from 24.6% to 0% with an average of 6.99%.

The booking and taking of annual leave are a real concern where only 2 of the identified areas have allocated/taken enough annual leave (1.5% - 17.10% - Average 9.33%). The required amount of leave required to be taken in any one month is 16%-18% in order that the leave can be spread over the holiday year. This is a result of the reduced staffing number and the additional constraints of maintaining safe staffing levels during the COVID-19 pandemic.

Even with the current pandemic we have seen a reduction in Hospital acquired Pressure Ulcer Incidences (reduced from 27 to 24) along with a reduction in medication administration incidences (68 to 37).

However there has been a marked drop in compliments (36 to 8) and complaints have risen (12 to 14).

Are we responsive?

The Heads of Nursing for both acute and community continue to meet with the Matron team in order to maintain an oversight of staffing etc. This oversight and the Matron's oversight and 2nd approval of Healthroster prior to its release has resulted in an overall improvement in roster management; however, it remains a challenge with the current vacancies across the acute and community.

At present there is a close link with the Heads of Nursing and WSP, where there has been a joint effort in facilitating the recruitment and processing of registered nurses, Health Care Assistants and AHCP. This has to date resulted in the processing of 18 registered nurses and 20 health care assistants; along with an ongoing programme of shadow shifts for these staff.

There has been an emphasis on filling community vacancies in order to reduce their current shortfall and to allow for the opening of more acute beds to facilitate the flow through the acute trust. During induction active canvassing of staff to identify staff suitable for this environment takes place.

CHPPD figures similar to comparable wards in other hospitals; however, these do show an increase due to the bed base being reduced within the trust.

QUALITY AND WORKFORCE DASHBOARD

Month Reporting	Apr-20		Establishment for the Financial Year 2019/20		Data for April 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)		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	88.6%	111.0%	104.3%	166.8%	9.8%	3.9%	N/A	-10.10	0.50	8.80%	5.50%	1.90%	N/A	1	0	0	2	4
WSFT	AAU	Acute Admission Unit	27.30	29.59	93.2%	81.0%	73.8%	85.9%	10.2%	0.0%	59.1	4.80	-3.90	6.00%	8.20%	3.00%	0	1	0	0	0	0
WSFT	F7	Short Stay Ward	22.84	30.94	111.0%	92.8%	101.2%	98.6%	11.8%	1.8%	14.5	-2.00	-0.80	6.70%	8.10%	0.00%	4	4	0	0	0	0
WSFT	CCS	Critical Care Services	41.07	1.88	42.3%	43.4%	100.0%	100.0%	7.2%	0.0%	10.6	15.80	4.50	5.10%	10.30%	0.00%	2	2	0	0	1	0
WSFT	Theatres	Theatres	61.68	22.27	49.0%	49.6%	100.0%	100.0%	3.3%	0.0%	N/A	0.80	-1.80	2.30%	4.90%	4.10%	N/A	0	0	0	0	0
WSFT	Recovery	Theatres	21.23	0.96	121.3%	47.4%	18.8%	0.0%	0.3%	0.0%	N/A	-0.90	0.50	7.10%	10.50%	0.00%	1	0	N/A	0	1	0
WSFT	Day Surgery Unit	Theatres	28.43	8.59	21.0%	16.0%	3.0%	3.0%	0.0%	0.0%	N/A	-1.80	-1.50	13.60%	6.70%	0.00%	0	0	0	0	0	0
	Day Surgery Wards		11.76	1.79					0.0%	0.0%		-1.20	0.10	7.40%	2.90%	0.00%						
WSFT	ETC	Opthalmology	11.10	5.00	32.3%	100.0%	59.6%	100.0%	0.0%	0.0%	N/A	2.40	-1.70	0.50%	10.70%	7.00%	N/A	0	0	0	0	0
WSFT	PAU	Pre-assessment	14.80	8.60	34.7%	N/A	58%	N/A	0.0%	0.0%	N/A	-6.40	-2.20	3.80%	10.10%	4.90%	N/A	0	0	0	0	0
WSFT	Endoscopy	Endoscopy	32.40	19.00	112.0%	N/A	108.1%	N/A	1.3%	0.0%	N/A	-7.80	-5.70	3.40%	17.10%	2.40%	N/A	0	0	0	0	0
WSFT	Cardiac Centre	Cardiology	38.14	15.20	85.3%	86.0%	88.2%	88.9%	3.4%	0.0%	17.8	3.00	-1.80	13.3%	11.10%	3.30%	0	0	0	0	1	1
WSFT	G1	Palliative Care	23.96	8.31	99.3%	113.2%	95.7%	100.0%	9.7%	0.3%	10.6	1.70	0.80	1.40%	8.40%	5.00%	1	2	0	0	0	0
WSFT	G3	Endocrine & Medicine	18.70	21.90	93.1%	93.5%	100.0%	138.5%	8.7%	2.7%	6.5	1.00	4.10	8.70%	8.70%	0.00%	2	3	0	0	0	0
WSFT	G4	Elderly Medicine	19.16	24.36	84.8%	88.7%	87.5%	94.9%	16.4%	0.6%	13.9	4.90	-1.10	10.40%	13.60%	1.40%	0	1	0	0	1	1
WSFT	G5	Elderly Medicine	18.41	22.66	84.6%	86.8%	66.3%	115.7%	22.4%	3.5%	13.0	4.90	-1.10	17.20%	8.90%	0.00%	3	3	0	0	0	0
WSFT	G8	Stroke	23.15	28.87	93.1%	99.2%	103.4%	105.6%	12.5%	0.6%	12.5	2.80	2.80	4.00%	13.40%	0.60%	7	1	0	0	0	0
WSFT	G9	Escalation	2.00	4.70	93.0%	101.9%	94.7%	104.4%	26.0%	3.9%	10.4	10.80	13.70	10.50%	11.00%	0.00%	1	4	1	0	2	0
WSFT	F1	Paediatrics	18.13	7.16	116.1%	119.9%	113.5%	N/A	6.5%	0.0%	42.7	4.50	3.30	2.30%	14.80%	6.20%	N/A	2	N/A	0	1	0
WSFT	F3	Trauma and Orthopaedics	19.58	22.27	70.5%	83.0%	108.8%	110.7%	11.6%	3.6%	27.7	-2.9	4.60	6.00%	10.20%	3.70%	0	1	0	0	1	0
WSFT	F4	Trauma and Orthopaedics	12.78	10.59	61.2%	49.6%	39.7%	100.0%	21.4%	4.2%	5.0	3.0	1.30	6.80%	8.40%	0.00%	0	0	0	0	0	0
WSFT	F5	General Surgery & ENT	19.58	14.51	106.6%	100.8%	93.8%	107.1%	13.2%	0.7%	8.3	2.1	-1.10	4.70%	13.90%	2.00%	0	0	0	0	1	0
WSFT	F6	General Surgery	19.57	14.51	89.2%	85.7%	81.6%	93.3%	14.3%	4.8%	24.6	0.2	-4.00	6.00%	9.60%	4.80%	0	0	0	0	0	0
WSFT	F8	Respiratory	19.90	20.13	89.1%	90.4%	113.4%	97.3%	5.0%	1.9%	11.8	1.60	2.40	16.80%	5.10%	0.00%	1	1	0	0	0	0
WSFT	F9	Gastroenterology	20.32	22.56	98.6%	94.3%	82.6%	105.0%	17.4%	0.0%	11.6	1.80	-1.60	1.50%	1.50%	5.90%	1	0	0	0	0	0
1	F10	Escalation	14.70	20.30	99.4%	89.1%	97.4%	128.1%	17.4%	5.2%	15.8	3.90	-2.50	4.20%	9.90%	0.00%	0	2	0	0	0	1
WSFT	F11	Maternity															0	2	0	0	0	0
WSFT	MLBU	Midwifery Led Birthing Unit	49.58	13.89	100.0%	95.0%	79.0%	85.0%	11.1%	0.9%	N/A	12.70	-0.30	10.30%	7.30%	5.70%	0	0	0	0	0	0
WSFT	Labour Suite	Maternity															0	1	0	1	0	0
WSFT	Antenatal/Gynae Clinic	Maternity	4.70	1.60	97.2%	100.0%	68.9%	100.0%	8.9%	0.0%	N/A	1.20	0.00	3.50%	14.00%	0.00%	N/A	0	0	0	0	0
Community	Community Midwifery	Maternity	30.90	0.70	63.6%	N/A	51.3%	N/A	1.9%	0.0%	N/A	-1.40	0.00	4.70%	6.60%	3.50%	0	0	0	0	0	0
WSFT	F12	Infection Control	11.02	5.00	90.0%	83.7%	126.8%	137.0%	17.2%	0.7%	12.4	2.00	-1.90	5.30%	15.00%	0.00%	0	2	0	0	2	0
WSFT	F14	Gynaecology	11.18	1.00	101.8%	91.3%	92.3%	N/A	21.9%	0.7%	26.3	0.30	0.00	0.00%	12.90%	0.00%	0	1	0	0	0	0
WSFT	MTU	Medical Treatment Unit	7.04	1.80	81.9%	N/A	67.3%	N/A	0.0%	0.0%	N/A	0.60	-0.90	7.40%	14.20%	5.90%	0	0	0	0	0	0
WSFT	NNU	Neonatal	20.85	3.64	108.4%	93.6%	56.7%	73.3%	2.6%	0.0%	#	1.30	-1.10	0.00%	4.80%	7.60%	N/A	2	N/A	0	1	1
WSFT	Outpatients	Outpatients	9.30	22.90	3.2%	N/A	100%	N/A	0.0%	0.0%	N/A	-0.30	-7.00	12.30%	10.50%	0.00%	N/A	0	0	0	0	0
WSFT	Radiology Nursing	Radiology	3.30	10.00	95.0%	N/A	91.9%	N/A	3.0%	0.0%	N/A	0.20	-2.00	4.60%	10.60%	3.50%	N/A	0	0	0	0	0
WSFT	DWA	Discharge Waiting area	1.20	2.00	85.1%	N/A	58.2%	N/A	13.9%	0.0%	N/A	-0.20	0.00	6.30%	16.30%	0.00%	0	0	0	0	0	0
Newmarket	Rosemary Ward	Step - down	12.34	13.47	133.0%	101.1%	115.3%	97.4%	6.8%	13.9%	10.8	-0.90	-1.00	8.30%	8.60%	3.80%	0	1	0	0	0	0
Glastonbury Court	Kings Suite	Medically Fit	11.50	12.64	90.9%	75.4%	74.2%	101.2%	8.8%	3.4%	13.2	-2.00	2.20	24.60%	13.10%	0.00%	1	0	0	0	0	0
					84.31% AVG	87.41% AVG	81.81% AVG	100.02% AVG	9.99% AVG	1.51% AVG	17.23 AVG	50.40 TOTAL	-4.20 TOTAL	6.99% AVG	9.93% AVG	2.27% AVG	24 TOTAL	37 TOTAL	1 TOTAL	1 TOTAL	14 TOTAL	8 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	1529.13	69	-1.00	0.00	1.54%	Not available comprehensively till Healthroster implemented	***Not available this month***	3	0	0	0	0	0
Community	Bury Rural	Community Heath Team	10.00	1.20	808.63	23	-1.80	-0.50	15.76%			6	0	0	0	0	0
Community	Mildenhall & Brandon	Community Heath Team	12.59	3.91	977.80	52	-2.00	-1.00	11.83%			0	0	0	0	0	0
Community	Newmarket	Community Heath Team	8.10	2.75	710.27	29	-1.90	0.10	6.77%			5	1	0	0	0	0
Community	Sudbury	Community Heath Team	18.03	8.36	1513.98	56	-5.95	-1.20	19.41%			10	2	0	1	0	0
Community	Haverhill	Community Heath Team	8.97	4.23	823.10	41	-2.50	0.00	13.62%			1	1	0	0	0	0
Community	Admission Prevention Service	Specialist Services	11.28	3.45	81.22	1	-0.80	0.00	0.00%			0	0	0	0	0	0
Community	Specialist Services	Cardiac Rehab and Heart Failure	TBC	TBC	239.62	3	***TBC***	***TBC***	0.00%			0	0	0	0	0	0
Community	Children	Community Paediatrics	16.37	15.01	1251.92	2	-1.00	0.00	0.24%			N/A	0	0	0	0	0
					7935.67 TOTAL	276.00 TOTAL	-15.95 TOTAL	-2.60 TOTAL	7.69% AVG	#DIV/0! AVG	#DIV/0! AVG	25 TOTAL	4 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						
Community	Bury Rural	Community Heath Team	10.00	1.20													
Community	Mildenhall & Brandon	Community Heath Team	12.59	3.91													
Community	Newmarket	Community Heath Team	8.10	2.75													
Community	Sudbury	Community Heath Team	18.03	8.36													
Community	Haverhill	Community Heath Team	8.97	4.23													
Community	Admission Prevention Service	Specialist Services	11.28	3.45													
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
	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

13. Quality and learning report – Q4

To ACCEPT the Q4 report

For Report

Presented by Rowan Procter

Trust Open Board – 29th May 2020

Agenda item:	13			
Presented by:	Rowan Procter – Executive Chief Nurse			
Prepared by:	Governance Department			
Date prepared:	May 2020			
Subject:	Quality and Learning report			
Purpose:	X	For information		For approval

Executive summary:

This report provides a summary of key learning points, trend analysis and opportunities for improvement that have arisen from in the quarter ending 31/03/20.

Information has been obtained from the following data sources:

- Investigation of serious incidents and resultant action plans
- Thematic analysis of incidents at all grades for the quarter
- 'Learning from deaths'
- Review of complaints received and responded to within the quarter
- Review of claims received and settled within the quarter
- Themes arising from the PALS service
- Risk assessments created or updated within the quarter
- Other soft intelligence gathered within the quarter

Key highlights in this report are as follows:

- Learning from Deaths Q4 report
- Green incident thematic reviews
- Duty of Candour summary
- Theme report on '*Improving patient safety through reduction in (VTE) alert overrides and introduction of reassessment*

Please note:

- Key performance indicators (KPIs) relating to the subjects listed above are reported separately in the Open Board Integrated Quality & Performance report (IQPR).
- Assurance reporting including Executive-led walkabouts and table top exercises and 'Deep dive' audits are provided to the Board sub-committees CSEC, PEC and CRC.
- Escalation (including serious new incidents, Red complaints, claims and dated inquests of concern) are reported separately to the Closed Board.

NB: This is not a COVID-19 specific report however certain elements will have changed as a consequence of changing practices during the current response. Where that is the case it is indicated within the relevant section of the report.

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

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
		X	X				X
Previously considered by:							
Risk and assurance:							
Legislation, regulatory, equality, diversity and dignity implications							
Recommendation: The Board to note this report							

Activity within the quarter

This will include some or all of the following sources: completed SI investigations, aggregated incident investigations, complaints responses, themes from PALS enquiries, settled claims, learning from deaths, Executive walkabouts and table-top exercises and concluded inquests.

1. Learning themes from investigations in the quarter

SI RCA reports submitted in Q4

There were 11 SI reports submitted in Q4. There were no reports which were collaborations with another organisation in the quarter. All cases which included a patient's death have the final report reviewed by the 'learning from death' group to determine preventability (this is still outstanding for the two relevant cases in this table which are scheduled for the June LfD meeting).

In Q4 no cases were reported to the HSIB (Healthcare Safety Investigation branch) for external investigation. In 2020 the first HSIB reports which relate to the care of a WSFT patient have been issued and future reports will contain a summary of the learning, local review of content and any actions arising from these reports.

Incident details	Learning
WSH-IR-52649 Intrauterine death	Following thorough investigation the investigation agreed it was possible that underlying pre-eclampsia may have been a contributory factor, although it was noted that the placental findings did not show any under perfusion of the placenta, usually associated with this condition. Overall the clinical and post mortem findings were not entirely consistent, but there was sufficient evidence to consider maternal mal perfusion as at least a possible cause of baby's growth impairment and death with no other possible underlying cause such as (infection or congenital viral infection) being identified. **Root causes** After careful consideration of this very sad outcome there were no care delivery problems which were felt to have contributed to the incident. However there were learning points for staff identified which have been included in the action plan. The post mortem report showed evidence of fetal asymmetric growth restriction possibly associated with maternal mal perfusion as the underlying cause.

Incident details	Learning
	Lessons learned Although staff followed the current guidance in their care and management, with the benefit hindsight gives us, it was agreed that the team midwives could have considered an earlier appointment as part of more individualised care however it was agreed it probably would have not changed the outcome in this case. **Actions** • Discuss and review the case with the community teams as future learning point of the importance of individualising a woman's care. **Shared learning pathways** Highlight the incident to all staff via Risky Business
WSH-IR-53183, WSH-IR-53514 and WSH-IR-54550 Swelling and staining following Ferinject (ferric carboxymaltose) administration through cannula	Two initial cases (and a third later identified) in different clinical areas. Whilst not reported as major harm, the repeating nature of this event led to reporting as an SI with initial mitigations put into place immediately including an SOP for the management on iron infusion, to mitigate all risks of harm, including skin staining and anaphylaxis **Root causes** Skin staining following extravasation of Ferinject is a known adverse effect of the drug. Lack of cannula care, and visual observation whilst the Ferrinject infusion was in progress due to a lack of knowledge of the risks involved when administering Ferrinject in regard to skin staining. **Lessons Learnt**: Better understanding of the complications of Ferinject infusion = further teaching for the nurses administering the drug (information leaflet created for both patients and staff). Best practice = new cannula always to be used (pink or blue in size). Information leaflets to be provided to the patient prior to administration and the detail to be discussed with the patient. **Actions** • Creation of a Trust Ferinject patient information leaflet to give to all patients prior to their infusion, outlining the risk of staining should Ferinject extravasate. • Creation of an interim 'Ferinject Administration Guide' in advance of a more comprehensive 'Intravenous Iron Infusion Policy' to outline the process to follow when prescribing, administering and monitoring intravenous iron infusions. This is to include: • Recommendation that: o only pink or blue cannula can be used for administration of Ferinject. o new cannula is inserted prior to infusion of Ferinject, regardless of how old the previous cannula was. o sodium chloride 0.9% flush is prescribed to be administered immediately after the Ferinject infusion has completed. o Ferinject is only administered within hours when there are adequate nursing and medical staff available to deal with any adverse effects as a result of the infusion. • Explore with e-Care team the potential for a 'hover over' pop-up on Ferinject to indicate that the patient should be informed about the risk of staining if it were to extravasate.

Incident details	Learning
WSH-IR-53581 Category 4 Pressure ulcer	**Root causes** Underlying co-morbidities, particularly cardiac issues which delayed wound healing and negated the potential for surgical intervention. Lack of clinical decision making and senior nursing review/oversight of wound healing/lack of progress. **Lessons Learnt** The importance of a comprehensive initial pressure ulcer assessment being performed by a qualified nurse. The importance of correct pressure ulcer classification and documentation. The importance of a regular wound assessment and supporting images. The importance for regular and accurate risk assessments and actions from same. The necessity of clinical leadership within the community nursing team for patients with complex health needs. The importance of having a Community Matron involved with patients with multiple health needs. The importance of communication between departments within WSFT. The importance of MDT co-ordination of care for patients with multiple co-morbidities. **Actions** • SBAR Handover to be introduced, promoting escalation of concerns and DN review (pilot underway). • Complex Pt discussion at Monthly Quality Meetings between Senior Matron/Team Lead/Local Area Manager • Mandatory training/education review • District nurses (DNs) to develop and deliver educational programme for team with support from Tissue viability (TV) re: pressure ulcer classification • Urgent training across community teams by TV to focus on wound categories and fundamental wound care. • Embed pain assessments into care plans **Shared learning pathways** • Case study review at Professional Nurse Forum – Mar 2020 • Head of Nursing to meet with DNs involved to review report/learning • DN to discuss with team at team meeting. • Update teams via above training and CREWS newsletter.
WSH-IR-53670 Category 4 Pressure ulcer	**Root causes** • Declining mobility – patient known to have multiple falls resulting in the provision of equipment to support transfers. • Decreased appetite and weight loss. • Incontinence, contributing to tissue breakdown. • General deterioration and rapidly increasing frailty. **Lessons learned** • The pressure ulcer continued to decline despite satisfactory efforts by the nursing team to prevent deterioration. • The patient was known to be mentally alert and able to make independent decisions; the non-concordant pathway should have been utilised to support decision making. • Several contributory factors are evident, but ultimately the gentleman's old age, general decline in health and frailty were key factors in the progression of the pressure ulcer.

Incident details	Learning
	Actions • Pressure ulcer and pressure relieving equipment study days for 2020 have been arranged by the Tissue Viability Team. Community staff to be encouraged and supported to attend. • Additional tissue viability training to teams around the categorisation of pressure ulcers. • The importance of regular and clear communication between the whole MDT to ensure patient care is provided timely and efficiently. • Peer support and discussion to be made available for staff when incidents such as this occur. **Shared learning pathways** Update teams CREWS newsletter
WSH-IR-52831 Neonatal death	**Root causes** The post mortem findings were consistent with death being secondary to an acute asphyxia event, the reason for this could not be established. Post mortem noted raised cord coiling index of 0.72. Literature surrounding cord coiling indexes is controversial. It has been said to be linked to poor perinatal outcome, however this is not universally accepted Following the in-depth review of the care and management of mother and acknowledging the very sad death of baby, although there were areas for learning for staff which have been included in the action plan they were not thought to have contributed to the outcome **Lessons learned** Staff must use the appropriate emergency call out system when contacting medical staff in an emergency. Medical staff should document any changes in management plans in the records so that the staff in the antenatal clinic is aware and appropriate action can be taken. **Shared learning pathways** • Email to all medical staff that they should document any changes in management plans in the records so that the antenatal clinic staff are aware and the appropriate action taken. • Highlight to all staff on 'Take 5' daily multi-professional huddle that staff must use the appropriate emergency call out system when contacting medical staff urgently.
WSH-IR-54924 Norovirus ward closure / Influenza outbreak concurrently on the same ward.	**Root causes** Lack of a physical barrier to bays. No ensuite facilities within bays and no handwashing facilities. Index patient with influenza was cognitively impaired and was suffering from delirium and was non-compliant with isolation. Ward team were managing two concurrent outbreaks (Norovirus / Influenza) but there was only specific data collection sheet through which symptomatic patients and specimens are captured for Norovirus but not Influenza and some cases were not escalated to the Infection Prevention Team until 6th Jan. **Lessons Learned** Respiratory Viral swabs are routinely tested at Addenbrookes Hospital with an expected result in 48 to 72 hours however this can be a much longer timeframe. The ward reopened on 3rd Jan with (unbeknown to the organization) swab result outstanding which were then found to be positive for Influenza on 4th Jan requiring a second closure. An in house test would have avoided this as all results would have been available in a timely manner. Outbreaks are managed by a specified Infection Prevention Nurse (IPN) to

Incident details	Learning
	provide continuity which is an essential part of successfully managing an outbreak, other infection prevention tasks are managed by other members of the team. This work flow whereby the laboratory results and requests were dealt with by a different IPN from the designated outbreak nurse meant the outstanding respiratory viral swabs were not documented. To prevent this occurring in the future the outbreak nurse will oversee all of the respiratory virus swab information. Additionally there was not a defined ward data collection sheet for Influenza. Whilst Norovirus outbreaks are managed every winter and have a set of resources, Influenza is less frequent in requiring ward closure at WSH and does not have a dedicated data collection or resource 'box'. **Recommendations**: Provision of doors to bays (recorded on Trust risk register RR627 Management of outbreaks).It has been agreed by the Trust management team that the provision of doors on bays will be included in any new builds or refurbishment of wards. If an area is closed due to Influenza any further respiratory viral swabs that are required will be undertaken using the in house laboratory test (results are available within 1 hour Mon to Friday 9 -5 and at the weekend on Saturday 9-1pm) under the direction of the Infection Prevention Nurses or the Matron of the day). If treatment is indicated outside of these testing hours this should commence ahead of formal testing and not be delayed. All other measures should be instituted and not delayed, testing then to be carried out at the next opportunity as stated above. The IPN overseeing an Influenza outbreak will also manage viral swab requests and results.
WSH-IR-54871 Fall resulting in #NoF	**Root causes** Frailty of the patient with a history of falls including being cared for in an unfamiliar environment **Lessons learned** Observations not taken immediately after fall. Falls re-assessment not completed immediately after fall. **Shared learning pathways** Reflective teaching session in regard to the Importance of review and observations when a frail patient falls it is of utmost importance to complete these vital post fall, and falls re-assessment to ensure safe care and best practice.
WSH-IR-54875 Failure to escalate post confirmation of an adverse arterial blood gas. Patient subsequently died	**Root causes** Patient was uncooperative at times: leading to difficulties carrying out investigations and treatment. This made treatment decisions challenging, and decisions regarding treatment were delayed. **Lessons learned** Earlier decisions around escalation ceilings would have been beneficial in view of co-morbidities and poor baseline. Formal capacity assessment not completed as per policy **Actions** • Review junior doctor handbook regarding type two respiratory failure and treatment • Include type two respiratory failure and relevant treatment and capacity issues on FY1 'management of the deteriorating patient' study day • Review and amend nursing assistant and registered nurse induction pack (regarding patient deterioration), with clearer instructions around those

Incident details	Learning
	patients requiring NEWS or CREWS observation measurements • Explore the possibility of a visual aid (such as a wrist band) in order to highlight those patients that are not on the usual NEWS scoring (I.e. for those on CREWS or other) and what e-Care can offer with regard to an alert when patients wrist band has been scanned in order to direct the user to the correct early warning system **Shared learning pathways** • Medical bulletin reminder for doctors regarding when and how to carry out formal capacity • Escalation and discussion at the learning from death meeting due to thematic issues around realistic ceilings of care and resuscitation
WSH-IR-55154 Fall resulting in #NoF Patient subsequently died	**Root causes** Confused frail patient who got up looking for a bathroom and lost his balance and fell, his confusion may not have been helped by the movement from different wards. Known to suffer with several co-morbidities, unfortunately developed a chest infection and did not recover well from surgery and subsequently died. **Lessons learned** Completion of the post fall care plan **Actions** • To consider avoiding multiple ward moves for a patient with confusion. **Shared learning pathways** To be discussed at ward meeting and included in the staff briefing
WSH-IR-53046 Patient lost to Aneurysm Surveillance. Subsequent scan identified need for urgent surgical intervention. Patient had operation but suffered a cardiac arrest and died	This patient's incident investigation is part of a larger Trust investigation into clinical surveillance of patients across the Trust. This has included a significant lookback and audit process to ensure that all potential patients that could be lost to surveillance within the Trust have been identified and reviewed. The larger investigation has made a number of recommendations and actions that cover the same topic as this patient's investigation **Actions** • Develop and introduce an internal professional standard for a surveillance pathway • Implement requirement and process for trust wide regular audit of Trust surveillance pathways • Ensure additional monitoring checks within the surveillance pathway for venous disease, carotid artery and popliteal are in place • Look into the feasibility of a standardised trust wide safety net for surveillance pathways across the Trust • Investigate whether are able to produce a report that shows results that have not been opened within message centre within the 45 day window • Review content of clinicians' e-Care training to ensure it includes message centre filtering and timescales • Make required change within e-Care to switch from 45 to 90 day purging • Review communication processes around changes to clinical practice in e-Care • Implement local governance processes into the Vascular Team for WSFT activity, including regular meetings with Service Management, team meetings and review of incidents, complaints, claims and routine audit • Recruit Vascular Specialist Nurse and additional administrative resource • Review Vascular Service contract for allocated admin time and governance activities during their schedule at WSFT

Incident details	Learning
	• Develop a SOP for vascular virtual surveillance clinic pathway and process. **Shared learning pathways** • Share this report openly with the family and offer face to face feedback if requested • Direct feedback to all clinicians involved in the investigation • Learning bulletin to be developed, summarising the outcome of the case and learning • Outcome of the case and learning to be sent to all clinical specialty teams, including their administration and service managers • Trust wide circulation of outcome of the case and learning to all clinical staff that order investigations and non-clinical administration support (via the Secretaries Forum) • Discussion of learning at Clinical Directors Meeting • Feedback via Cerner user forums the issues we have had with results notifications and message centre

2. Learning from Deaths (COVID-19 specific update)

The Learning from deaths (LfD) group, meets monthly to oversee the process associated with all learning aligned to LfD. Since March this has moved to a virtual meeting with a distribution of the papers and collation of feedback / questions from the membership to collate an “issues ongoing” report. It is hoped to reintroduce the meeting itself through the use of the Microsoft TEAMs application in June

Implementation of the NICE guidance NG142 *End of life care for adults: service delivery* has also been paused and will be revisited later in the year.

Case reviews continue albeit at a slower pace with some members of the team returned to full clinical roles in the current time. In addition, the Poor care review pathway has changed (due to the appointment of Paul Morris to the role of DoN at James Paget) and there is also a reduction in turnover. Where a death raises a significant concern (either through LfD review or through the Datix incident reporting system) these cases are still being escalated to consider if they meet the criteria of a serious incident. Poor cases are being referred to the Head of deteriorating patient for peer review in the interim to ensure there is not a delay in escalation and it is anticipated that a return to the structured Poor care review process can re-start in June.

The implementation of the Medical Examiner role had been paused due to the impact of COVID-19 although six successful appointments have been made from the clinical specialties of Anaesthetics, General Surgery, Radiology, Pain Medicine, Paediatric Oncology and General Practice.

There have been conversations ongoing as to how and when this service can be introduced recognising that, whilst it is a new process to be set up, MEs might actually be helpful in streamlining processes whilst providing some scrutiny and educational support for junior doctors.

Most recently guidance has been received from the National Medical Examiner (in late May) stating that all acute trusts should resume their work on Medical Examiner implementation as soon as possible as this is a priority for NHS England and NHS Improvement.

Publication of the first edition of the LfD bulletin is imminent. This contains articles on the following subjects:

- Learning from Deaths: What Matters to Families
- Clinical vignette - Transfusion
- Compassionate phone communication / Telling someone they are dying
- Cremation form completion during COVID-19
- Thematic learning: Delayed recognition of end of life
- Proper and prompt reporting to the Coroner

Q4 data will be available in the next iteration of this report and will be available for the national mandatory reporting schedules.

3. Quality Walk About from Q4

During Q4 there were a total of **9 executive-led quality walkabout visits** in the following areas:

- Medical wards: F8 – respiratory, ED, AAU, G1, G9, F12, F10
- Specialty areas – Endoscopy and Theatres

The areas are chosen by the patient safety and quality team to cover a variety of settings across the hospital including medical wards, surgical wards, speciality areas and community settings. During this quarter the walkabouts ceased to continue as of 3rd March due to the Coronavirus pandemic to reduce visitation to ward areas.

However prior to this, some **key points** from the quarter have included:

Raising positives from **ED** including a full complement of staffing, good relationship between the floor coordinator and the HALO to improve efficient flow and the new performance measures captured on the live screen. Consideration of examples of innovative practice on **F8,** such as the drug round tabards in use and clearly dedicated, caring and compassionate staff on **G1.** As always the walkabouts have highlighted areas for **improvement** such as improving compliance with basic checks, redesigning storage options and facilitating badge access to locked areas in endoscopy and theatres.

Actions which had been identified during previous quarters had been captured centrally using Datix. It has been discussed that capturing the walkabout and any actions identified would be better monitored and reported via the **perfect ward**. This has been assigned to the incoming interim chief nurse to consider on their appointment. Outstanding actions from previous walkabouts have been uploaded to Datix however due to the volume of actions and the broad scope it has been difficult to quantify and many actions have been superseded due to further walkabouts and local action planning.

The purpose of walkabouts has evolved from its starting point and although it now allows the membership to gain a sense of the area and provide an opportunity for the staff to link with the executive team, NEDs and governors it does require timely reporting and a complex process to ensure the information from the walkabout is shared and disseminated. Due to the unplanned break it is an opportunity to further review the process to ensure the scope and outcome of the walkabouts are as efficient as possible providing assurance of safety and quality in the organisation. The opportunity to incorporate the walkabout schedule into the future plans for **ward accreditation** will continue to be considered as part of the planning for 2020/21.

5. Learning from Excellence ('Greatix')

In August 2019 the Trust launched 'Greatix; set up to capture excellent practice, positive incidences and ideas, and share them across the Trust. This is based on the national concept of learning from excellence which explains that *'Safety in healthcare has traditionally focused on avoiding harm by learning from error. This approach may miss opportunities to learn from excellent practice. Excellence in healthcare is highly prevalent, but there is no formal system to capture it. We tend to regard excellence as something to gratefully accept, rather than something to study and understand.'* https://learningfromexcellence.com

Individuals continue to be personally thanked for their contribution and later in 2020/21 there is a ambition to review the output of GREATix to look for themes / ideas / best practice that can be shared to drive quality improvement.

6. Other learning themes

Green incident thematic reviews

During the COVID-19 response the requirement to complete an investigation for all green incidents has been removed to allow clinicians to focus on patient facing care. Instead the following is taking place:

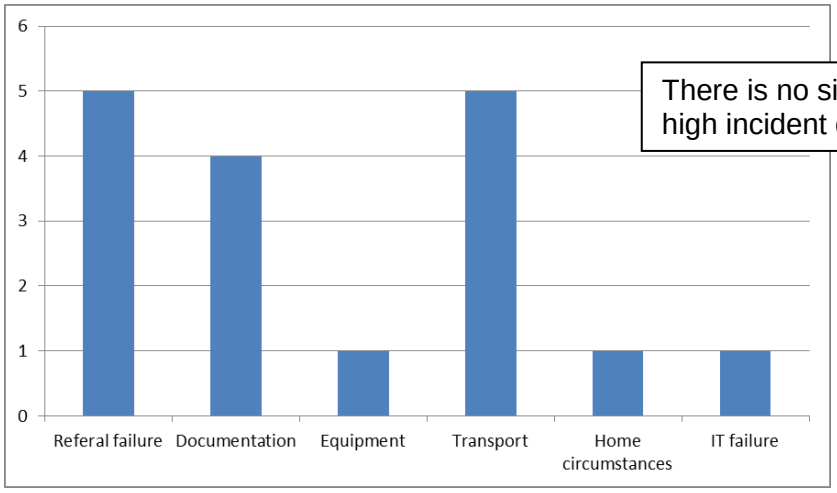
- All incidents reviewed daily at matron-led safety huddle and weekly by Executive Chief Nurse and acting Head of Patient Safety
- All patient safety incidents uploaded to the NRLS
- Thematic data reviews (see this report).
- Weekly (and in future monthly) reports emailed to divisional triumvirate containing:
    - COVID-19 linked incidents reported in the last 7 seven days (Mon-Sun)
    - Last 7 days reported Incidents numbers by location, by severity
    - SI and Amber incidents in progress
    - Significant active risks
    - Duty of candour status
- Message to all staff that continued reporting during this time is greatly appreciated.

Initial output of thematic data reviews has noted the following:

- Common themes: falls, medications, discharges, pathology, imaging.

Falls effect of Covid screens on wards – poor visibility through screens, reduced staff activity in bay?

Discharges: failure to refer to outside parties, transport, poor documentation.

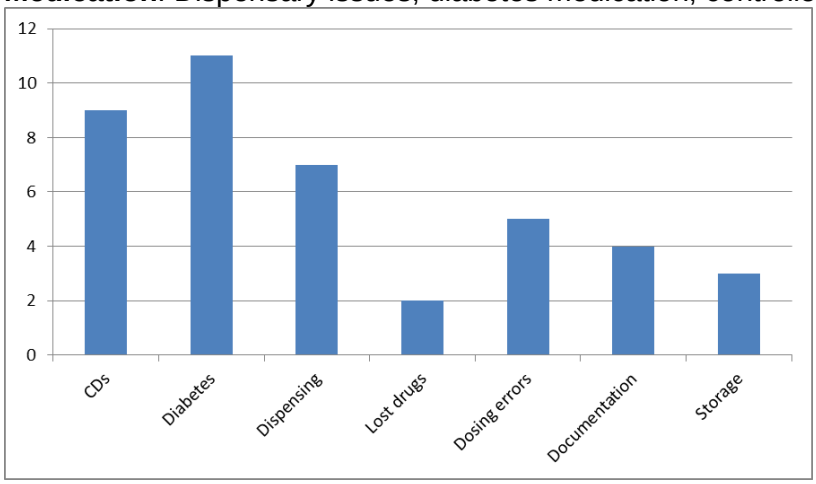


There is no single location having a high incident of discharge events.

Pathology: Delays in reporting (5 events), IT issues (2 events), Samples incorrectly labelled (not lab issues)

Imaging: Cannula issues causing extravasation (3 events)

Medication: Dispensary issues, diabetes medication, controlled drugs



Dispensary: main theme lack of checks? 1. CDs sent to incorrect location (internal to external) 2. Requisition correct but incorrectly dispensed (wrong strength) 3. Incorrect number of tablets (Rivaroxaban) dispensed (shortage on TTO) 4. Incorrect labelling – dosage/frequency 5. Incorrect formulation issued (impossible dose ordered and issued 3 times)	**Diabetes**: themes – education and checking 1. Confusion between IR/MR oral preparations (wrong type given) 2. Syringe driver not changed (over 24 hrs, 2 separate locations and separate patients – education?) 3. VRII set to incorrect rate. 4. Oral medication given to wrong patient (was scanner used?) 5. Insulin given twice (blamed on IT) 6. Patient sent home with another patient's insulin (not checking with discharge note?) 7. Incorrect insulin type prescribed. 8. VRII infusion issue (was leaking – under-dosing as a result)

Duty of Candour

As part of the annual ICS reporting the CCG have asked trusts to provide statistics on our DoC completion rates and reasons for non-completion for the period APR-19 to MAR-20.

Events requiring DoC	DoC Discharged		Main Reasons for Not Discharging DoC
	Yes	No	
231	184	47 (80%)	Patient deceased, DoC not appropriate (25) Communication being addressed via complaints and/or claims process (6) Extended time expired between incident date and reporting date (5) No address or point of contact available (2) All other reasons (including no reason documented) (9)

We have requested that the data for our ICS peers (ESNEFT, EPUT, NSFT and EEAST) is shared.

The most common reason for not undertaking DoC is when a patient has died soon after the reported event. This is most often relating to Category 3 / 4 pressure ulcers which may often develop / deteriorate as a natural progression of end of life. It is considered inappropriate to contact an already grieving family at this time when the event itself had little or no impact on the sad outcome.

If a patient dies and there is a consideration that the reported event was causative (e.g. in a reported SI), a duty of candour conversation with the family would still be required and its completion would be considered as part of the 'Day two' (clinical review) and 'Day five' (follow up review) SI meetings.

Where a complaints or PALS contact is already in place it is advantageous to maintain a single point of contact with the complainant or family and not duplicate the PALS and DoC pathways whilst still maintaining the principles of Being Open (see Trust policy PP197).
http://staff.wsha.local/TrustPolicies/PP197 BeingOpen-TheDutyofCandour.pdf

DoC compliance is reported monthly to the Board in the IQPR and there is Executive oversight of its timely completion. In addition the closed board receives a monthly update on any case for which it was agreed not to undertake DoC and the reasons for it.

The trust's Patient Safety & Learning strategy addresses DoC in one of its seven key principles: 'Being open and honest'. This describes four key actions:

1. Carry out duty of candour for patients promptly, sensitively and sympathetically.
2. Report via the IQPR and CDs meetings.

3. Continue to support ‘freedom to speak up’ by promoting staff guardians
4. Give opportunity for patients, families and carers to participate in SI investigations. Ensure open communication channels throughout process.

Within our CQC improvement plan there is a specific element (finding Ref. 10) that seeks, using quality improvement methods to look at WHY we do not always have timely DoC completion (which is likely to be multifactorial) not just HOW. (see separate CQC improvement plan Board paper for more details).

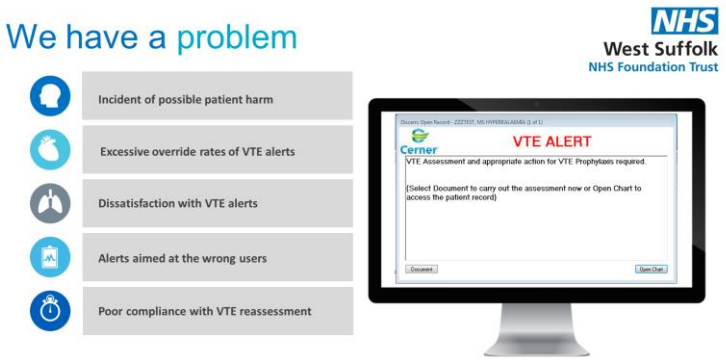
Subject / Theme	Improving patient safety through reduction in alert overrides and introduction of reassessment
Source	Action from an SI
Risk register entry	N/A
Trust owner	eCare optimisation team

(With thanks for information and screenshots from Powerpoint presentation provided by Dr Emma Cameron, Clinical Information Fellow)

Summary of learning and areas for improvement in this topic

In July 2019 a change request was submitted to review options to prevent overuse of the alert override options available when completed the VTE assessment and management plan.

This request was made following the investigation of a serious incident where a patient’s VTE assessment alert was overridden over fifty times before completion over a period of three days. As a result it is possible that correct treatment was overlooked. Action from this incident is to review any options within eCare to reduce likelihood of further incidents.



Previously, in April 2019 a change request was submitted to create a VTE reassessment within 24 hours of initial assessment. This was to align with NICE recommendations for all medical, surgical and trauma patients to be reassessed for risk of VTE.
https://www.nice.org.uk/guidance/ng89

Change request: Prevention of excessive overrides of VTE assessment form

Aim: prevent overuse of the alert override options within the VTE assessment form

NICE guidance [NG 89]: assess all patients to identify the risk of VTE and bleeding as soon as possible after admission or by the time of first consultant review

Data showed us:

The following changes were implemented following review by thrombosis committee:

- VTE alert present in SmartZone from decision to admit patient (previous alert only displayed at >4hrs after admission)
- Close chart pop-up alert continues to fire if VTE assessment not completed at >4hrs after admission
- Option to “return to chart” added to VTE alert to allow user to review patient information before completing assessment
- Removal of open chart VTE alert (now in SmartZone) to reduce alert fatigue
- Safety dashboard implemented to show patient lists level view of completed / incomplete VTE assessments

Re-evaluate:
Planned repeat reports on number of VTE alerts fired and overridden + assessments completed at time of discharge

Possible further changes:

- Addition of reminder to 1st consultant review note to as prompt to ensure VTE assessment completed
- Notify clinicians of overrides using a report to identify staff / ward targets for further education, training and encouragement to complete VTE assessment

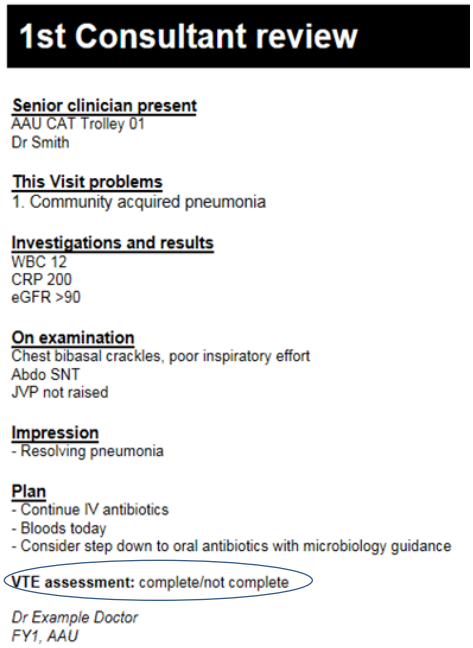
Change request: Repeat VTE assessment

Aim: encourage VTE re-assessment to align with NICE guideline recommendations that all patients should be reassessed for risk of VTE

Data showed us:
Minimal data available on VTE reassessments as no formal method to do this within e-Care that is measureable / reportable

The following options are under review:

- Build VTE reassessment PowerForm to include simple yes/no confirmation of VTE review or trigger full reassessment
- Add VTE reassessment pop-up alert or SmartZone alert
- Add prompt to **1st consultant review note template** to reassess VTE
- Increase user education around need for VTE reassessment to increase engagement
- Notify clinicians of compliance with reassessments using a report to identify staff / ward targets for further education, training and encouragement to complete VTE reassessment



1st Consultant review

Senior clinician present
AAU CAT Trolley 01
Dr Smith

This Visit problems
1. Community acquired pneumonia

Investigations and results
WBC 12
CRP 200
eGFR >90

On examination
Chest bibasal crackles, poor inspiratory effort
Abdo SNT
JVP not raised

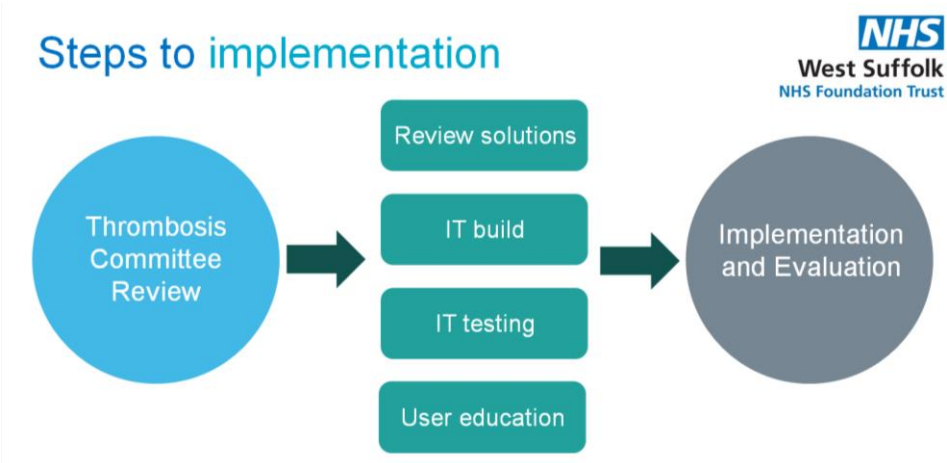
Impression
- Resolving pneumonia

Plan
- Continue IV antibiotics
- Bloods today
- Consider step down to oral antibiotics with microbiology guidance

VTE assessment: complete/not complete

Dr Example Doctor
FY1, AAU

Future steps and actions required



Actions around creation of repeat VTE assessments and the re-evaluation of the changes we have made to prevent overrides have stalled somewhat in the context of COVID-19, and prior to that, the planned change freeze for phase 4 go live.

Additionally, some actions do not lie with the e-Care team e.g.

- increasing user education and engagement,
- generation of reports and feedback to clinicians on performance as targets for training etc.
- need for a more clinical steer / drive possibly from the thrombosis committee with buy-in from clinical directors and departments.

A copy of Dr Cameron's full presentation is available on request.

7. Mitigated red risks

No downgraded or closed red risks for Q4

8. Learning from RIDDOR incidents

During Q4 the number of incidents reported to the HSE under RIDDOR reduced by 2 from the previous quarter (3 incidents). Learning and mitigation included:

- Moving and handling training
- Additional Staff training

14. Trust improvement plan

To APPROVE the report

For Approval

Presented by Rowan Procter

Trust Open Board – 29 May 2020

Agenda item:	14			
Presented by:	Rowan Procter, Executive Chief Nurse			
Prepared by:	Richard Jones, Trust Secretary John Connelly, PMO Rebecca Gibson, Compliance Manager			
Date prepared:	22 May 2020			
Subject:	CQC Improvement plan			
Purpose:		For information	X	For approval

Following the Quality Summit in March WSFT committed to developing an improvement plan to address the specific findings and overarching themes from the CQC inspection visit.

The improvement plan (Annex A) has been updated to reflect the impact of COVID-19 upon business as usual activities in the organisation and, where applicable, what interim measures are in place. Initial timeframes were allocated pre-COVID and, through the oversight process, these are being updated. Where a new deadline has been confirmed these are highlighted otherwise they remain provisional

The first iteration of the plan identified a number of actions as 'paused'. Following feedback from NHSE/I this has been updated to reflect:

- if a plan or parts therein are simply delayed, changed to '**able to continue**' or '**partial**'
- if only the final auditing element of the plan was outstanding, changed to '**implemented pending assurance**'
- where '**interim measures/actions**' are in place due to COVID.

Oversight, monitoring and assurance

The programme management office (PMO) is reviewing all plans and a summary status report is appended to this report (Annex B). This details a total of 471 individual actions to address the CQC concerns, 77% of which are on-track or complete (pending assurance). The remainder are being reviewed to confirm status and any remedial action required.

For those improvement plans categorised as '**implemented pending assurance'**, an assurance model has been agreed with the CCG which is achievable during the COVID response e.g. where different practices have been put in place as part of the COVID response. The first iteration of this assurance model has been approved at Executive director level and is now being signed off by the CCG quality team with an intention to begin testing from 1st June.

Contained within the main plan are five actions which relate specifically to the **Maternity Section 29A notice** (refs. 21-25). The audit data for these indicators has been provided to the CQC since initial notice. In April, a full submission of the improvement plans was made to the CQC. Initial feedback from the CQC local relationship manager noted that this has provided a suitable level of assurance that the required changes have become embedded however the opportunity to 'lift' the warning notice will take some time as a consequence of the CQC's own new ways of working during COVID-19.

A proposal for an **integrated improvement framework** is outlined in Annex C. This is structured based on PMO methods to deploy an integrated improvement tracker and the use of improvement cluster groups at the executive-lead level. The processes and governance outlined in this paper are consistent with the Trust's cost improvement programme methods, which has delivered year-on-year cost improvement targets and the highest internal audit rankings, based on effective and inclusive

engagement across the organisation with a singular and inclusive improvement method.

It is proposed to bring forward the timeframe for establishing the proposed improvement processes and governance at the Trust to operate across three interdependent workstreams:

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

The work streams can be managed more inclusively and efficiently under a singular improvement governance framework. Central to this framework is establishing the Improvement Programme Board as a subcommittee of the Board.

The programme board would be chaired by the Chief Executive and its membership include NED(s), executives, senior leaders and representation from the CCG. In the first instance the focus of the board will be on the CQC improvement plan but recognising its scope extends beyond this to the wider system agendas of COVID recovery and QI methods the future membership could also be extended to include Alliance and system partners.

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 the updated CQC improvement plan and summary status report (Annexes A and B respectively)

2. Approve the immediate establishment of the proposed integrated improvement framework (Annex C), including establishing the Improvement Programme Board as a subcommittee of the Board. Formal terms of reference for the improvement programme board to be received at the June meeting

Annex A: CQC improvement plan

Ref	CQC finding	Exec	Overview of planned improvement	Evidence for delivery	Monitoring and assurance	COVID status	Initial date	Interim measure details	New date
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.	CB	RTT: • Implement Cerner service pack to fix current manual workarounds (once tested by other organisation). • e-Care RTT training programme to improve RTT information data quality • Update Data Quality Strategy to include provision for routine auditing of RTT information held in e-care, with a feedback cycle to users included. Theatres: • Theatres dashboard uses Power BI tool, (more intuitive and self-service tool for users). • Incorporate theatre utilisation figure into next iteration of IQPR	RTT reporting has a reduced number of fixes included in the processing steps. RTT audit data (subject to DQ Strategy and DQ Manager in place) Theatre utilisation dashboard version 2 developed	Surgical Divisional Board will receive output of audits and this will be shared with all the specialties that have an RTT waiting list and/or utilise theatres Theatre utilisation dashboard is to be presented to scrutiny committee to determine what if any of the theatres indicators should be presented to Board via the IQPR.	Partial	SEPT '20		DEC '20
8	The trust must continue to develop information technology systems and integration across the community services	CB	Proposal to invest £2.26M to provide Community Health Staff Information Technology and uplift IT Revenue by close to £600K to sustain this. On authority of the CFO project been initiated with appointment of a Project Sponsor (Exec Director), Technical Lead and Project Manager. Community Sites will be subject to technical survey (planning for change) ahead of infrastructure Implementation and Service Migration. By end FY20/21 all Community Staff will have up to date technology, access via modern networks and will see a notable reduction in downtime and service interruptions. Once this modern technical platform is in place then the ability to	Project Initiation Document will set scope and timeline Weekly Project RAG Reports will document progress, record issue and confirm milestones Monthly Project Highlight Reports will confirm progress, manage risks and issues and report on finances Project Exception Reports/Plans will document any variation away form critical path	Project Board is chaired by Chief Operating Officer (COO) and reports via Pillar 3 Programme Board to Trust Digital Board Project Team meets fortnightly is heavily engaged with users and will deliver workstreams Project Manager will generate Weekly RAG reports and monthly Highlight reports	Partial	OCT '20		DEC '20

Ref	CQC finding	Exec	Overview of planned improvement	Evidence for delivery	Monitoring and assurance	COVID status	Initial date	Interim measure details	New date
			commence far wider service integration and leverage many of the advanced technologies use at the West Suffolk Hospital become possible. Project Board and a Project Team formed. Project Initiation Document and draft Project Plan for sign off at the Project Board.						
68	The trust should ensure that facilities for audiology assessments in the Ipswich child development centre improve.	CB	Business case submitted and work in progress to build new pod on site as part of Site improvement works (anticipate in place Summer 2020)	Completion of pod	Updates from Estates to NSH and from NSH to MG	Able to continue	MAY '20		JUL '20
4.1 41 65	(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. (41) The trust should ensure that appropriate action plans to address national audit shortfalls are implemented and effectively monitored. (65) The trust should ensure that governance and oversight are strengthened to ensure performance and local audit are monitored and measured to improve practice.	NJ	Review of Governance and oversight team and function to include within this local audits required to inform quality assurance will be formulated.	There will need to be structured evidence collected centrally demonstrating implementation into clinical practice of trustwide learning from clinical audit.	This will be monitored and reported by the quality/patient safety/clinical learning team.	Partial	JUL '20		DEC '20
4.2	The trust must ensure that processes for governance and oversight of risk and quality improvement	NJ	The trust learning from deaths strategy contains specific elements relating to M&M reviews as part of a wider plan to share	There will need to be structured evidence collected centrally	This will be monitored and reported by the quality/patient safety/clinical learning	Partial	JUL '20		DEC '20

Ref	CQC finding	Exec	Overview of planned improvement	Evidence for delivery	Monitoring and assurance	COVID status	Initial date	Interim measure details	New date
	become consistent across the organisation. - **mortality reviews are monitored and reviewed to drive service improvement.**		learning with the primary aim "*move from learning into action*"	demonstrating implementation into clinical practice of trustwide learning from mortality reviews.	team.				
33	The trust should ensure that consultant and team communication is improved in relation to the North East Essex and Suffolk Pathology Services (NEESPS). The trust should ensure that a review of the current working environment, equipment and processes within Pathology services is undertaken to identify and address any immediate ongoing concerns.	NJ	Regular meetings with pathology leadership team - execs, Scrutiny Committee, ESNEFT and NEESPS leadership. Face-to-face communication with lab teams. Written updates on progress to pathology clinical leadership. There will also need to be an estates review of working environment and equipment.	Evidence of the enhanced communication and the estates review as well as results from medical engagement scale.	This will be monitored at Scrutiny Committee and will be an ongoing piece of work.	Partial	MAR '20		TBC
43	The trust should consider displaying information on how patients and visitors can lead healthier lives.	NJ	1. Improved permanent resourcing for the public health team a. a new half time public health coordinator post has been established, repurposing time from an existing role. The role needs to be recruited to. 2. Understand the potential barriers in medicine and the drivers of success elsewhere a. The public health consultant will work with the medicine triumvirate to explore any barriers and understand whether an active decision has been made not to display health promotion materials b. The public health coordinator will establish relationships with	Delivery will be evidenced by the action plan being completed. The provision of health promotion materials in clinical areas is an ongoing need, not a one-off objective, and it is only one of a number of methods used to promote healthy lifestyles and raise brand awareness for OneLife, so the deliverables are qualitative rather than quantitative.	This needs working up as there isn't a governance mechanism for delivery of the partnership workplan at the moment. The plan does make provision for a small number of indicators to be added to the board integrated quality and performance report to promote and celebrate its impact, which hasn't been done yet, and none of the subcommittees currently has responsibility for assuring the trust's work on prevention and health promotion. Both these gaps will be addressed as part of this work.	Partial	DEC '20		TBC

Ref	CQC finding	Exec	Overview of planned improvement	Evidence for delivery	Monitoring and assurance	COVID status	Initial date	Interim measure details	New date
			service managers and administrators in the other clinical services and understand how the areas showing good practice are achieving it 3. Create an action plan a. A collaborative plan will be agreed with the medicine leadership team, based on the learning that is generated b. The public health coordinator will solve any problems with consistent supply and distribution of health promotion materials that are found in the other clinical services	The action plan will include mechanisms for maintaining ongoing provision. We will then establish a quarterly 'walkabout' audit of the estate to measure how well it works.					
6 30 46 62	(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. (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. (46) The trust should ensure effective processes are in place for oversight of referral to treatment times across all specialties with action plans in place to improve the specialties	HB	Review, Identify and design process for follow up and surveillance bookings. Revision of SOPs to include new processes and escalation in the event of capacity gaps. Consideration of feasibility to produce a report of all unbooked patients with follow up appointment as the clinic outcome code. To implement and facilitate training to all specialities on the new processes for Follow Ups and Surveillance patients.	Recruitment of 2 members of staff in TAC for ward follow up booking - Completed use of message centre consult template to replace paper clinic outcome slips - change request submitted use of specialty worklists on e-Care for PA/Service managers to track patients they are unable to book - change request submitted SOPS generated - for each specialty on Booking processes, use of message centre, use of worklists	Relevant service manager to oversee worklists to monitor capacity this will then be reported into individual division weekly RTT meetings, and escalated to weekly Access meeting if required.	Interim measures	FEB '20	Surveillance patients are paused safely as they are all kept on the waiting list/managed in the same way as they are normally are. All patients remain with the Trust. Any cancelled patients are recorded so using a new cancellation code 'Covid19' so that cancelled patients can safely be identified. A lot of patient appointments have either been deferred and booked later in the year or moved to telephone appointments.	DEC '20

Ref	CQC finding	Exec	Overview of planned improvement	Evidence for delivery	Monitoring and assurance	COVID status	Initial date	Interim measure details	New date
	where national standards are not being met. (62) The trust should consider a system to monitor the average waiting times for a follow up appointment.			Virtual Clinics to be set up for each specialty by Service manager Audit of e-Care follow up list Training to be given on Booking of Follow Ups & Surveillance patients and using Worklists/Message Centre					
928	(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 (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.	HB	Business cases to be developed for Orthopaedics, Ophthalmology, General Surgery and Gynaecology which will include up to date demand and capacity models, which will shape the direction of the business cases. The business cases are expected to outline plans and costs to reduce the current backlog and balance the demand to enable the services to meet the national standard. Action plans for all other specialities will continue to be updated on a monthly basis and will be discussed at the new RTT steering group meeting with the ADO's. A comprehensive action plan is under development for Endoscopy now not that demand and capacity has been completed and this will be discussed and reviewed at the new bi-weekly Endoscopy oversight meeting.	A reduction in the overall RTT waiting list size. Increase in compliance to national standard to that of the national average. Reduction in 52 week breaches. Compliance with national diagnostic standard. Reduction in cancer PTL size and compliance with national standard back to 85% by July.	Monthly RTT steering group meeting, weekly access meeting, Cancer PTL meeting, Cancer steering group meeting with the CCG.	Interim measures	MAR '20	Plans are in place to ensure that patients can be picked up safely in the recovery phase after a safe pause as the patients are all kept on the waiting list/managed in the same way as they are normally are. All patients remain with the Trust. Any cancelled patients are done so using a new cancellation code 'Covid19' so that cancelled patients can safely be identified. A lot of patient appointments have either been deferred and booked later in the year or moved to telephone appointments	OCT '20
19	The trust must ensure that medicines are stored securely within the main and	HB	Implement Drug Security plan. - Replacing locks, identifying and cutting new keys, fitting of	All drugs security devices installed. Training and	1.Execution of Project plan monitored by senior leads	Implemented pending	May '20		TBC

Ref	CQC finding	Exec	Overview of planned improvement	Evidence for delivery	Monitoring and assurance	COVID status	Initial date	Interim measure details	New date
	day surgery theatre department.		keypads and ordering of storage cabinets. - Standard Operating Procedure (SOP) for each area ratified at surgical Divisional Board. - Changes in practices & procedures will be disseminated to key stakeholders & service users. - Update of risk register to reflect all the above	monitored adherence to SOPs embedded and active. Risk registers reflect compliance in security of medicines within theatres department.	2.Standard Operating procedure ratified by surgical steering group	assurance			
29	The trust must ensure diagnostic test results are available in a timely manner.	HB	Confirmation that there are currently no delays in providing patients with test results Time to test results reported at divisional Performance Review Meeting with escalations to the Board. Endoscopy results immediately available Radiology Imaging consistently meets the 6 week reporting standard from request to test Process in place to prioritise the reporting of outpatient imaging in time for the outpatient appointment.	Time to test reported at monthly divisional PRM and board level	Details of all listed activities to be provided to CQC by COO	Implemented pending assurance	Complete		Complete
31	The trust must ensure staff complete and record patient pain assessments in patient records.	HB	Provide updated written guidance on completion of core assessment template where the Pain tool sits. Follow up with training for SystmOne Superusers to roll out to teams. Audit process to be agreed and rolled out via Governance Steering Group.	Completion of pain assessments	Via Perfect ward app, Include in CREWS updates, Divisional PRM and CQC improvement plan governance	Partial	MAR '20		DEC '20
42	The trust should ensure team meetings are undertaken to share information with ward staff.	HB	To ensure that team meetings regularly occur within all clinical areas to enable teams to have the opportunity to discuss and learn from the performance of the	Minutes from team meetings. Increased staff knowledge of current issues to service. Key	Key issues from team meetings to be reported at divisional board. Minutes/action plans from team meetings to be	Interim measures	OCT '20	Face to face meetings paused to maintain social distancing requirements. Important information to all staff shared through	TBC

Ref	CQC finding	Exec	Overview of planned improvement	Evidence for delivery	Monitoring and assurance	COVID status	Initial date	Interim measure details	New date
			service.	performance indicators for areas displayed for staff. Audit data from Perfect Ward.	displayed for staff within clinical area.			pathways such as Intranet and daily COVID-19 briefing circulation.	
44	The trust should continue to work to reduce the number of bed moves at night for non-clinical reasons.	HB	Revised SOP and improved performance as evidenced by a reduction in non-clinical bed moves after 10pm.	Evidence of agreed SOP and performance metrics which demonstrate a reduction in non-clinical bed moves after 10pm.	Monthly review of performance report at FLAG (flow action group).	Implemented pending assurance	FEB '20		TBC
61	The trust should consider security enabled doors in the paediatric outpatient department.	HB	The department will undertake a risk assessment of security within the childrens' outpatient department. In parallel, options for installing security enabled doors or a locking function to the current doors will be explored with the Estates and Facilities department. The most appropriate solution will be identified through the requirements in the risk assessment. The risk assessment will be completed and ratified through the Departmental Clinical Governance by the end of February, with a full solution in place by the end of April 2020.	1. Risk Assessment on the risk register 2. Ratification of the risk assessment evidenced in Paediatric Clinical Governance minutes 3. Security solution in place as guided by the risk assessment	Regular review of the Risk Assessment as part of departmental risk management process	Partial	MAY '20		DEC '20
66	The trust should ensure that processes are in place and effective to monitor compliance with best practice and national guidance relevant to the service.	HB	Audit programme to be considered to monitor adherence and effectiveness of guidance.. ICPS will liaise with corporate / clinical governance leads to establish more robust interface with the group to consider relevance of published guidance/updates (e.g. NICE)	Audit programme Central trust record for NICE held on Datix	ICPS Leads will continue to review current guidelines and practices in place and monitor at service meetings. Services will continue to monitor incident themes and any complaints and this in turn will be	Partial	MAR '20		OCT '20

Ref	CQC finding	Exec	Overview of planned improvement	Evidence for delivery	Monitoring and assurance	COVID status	Initial date	Interim measure details	New date
			with community service pathways.		reviewed by the ICPS Integrated Working Forum and Service Management Group				
67	The trust should ensure records are maintained to show cleaning has been completed in line with cleaning schedules.	HB	Systems in place already but practice to be reinforced to ensure compliance with cleaning standards. Clinicians have responsibility for cleaning the equipment they have used, which is in line with guidance Perfect Ward app to be reviewed and updated for use with community paediatric teams to assist with audit of standards.	Rotas for main reception areas are recorded by receptionists. If there are no clinics on a given day, then the clinic room cleaning requirement should be crossed off the cleaning schedule.	A formal environmental audit programme will be established when the perfect ward app is adapted and available for use in community paediatric services main bases. A Review of compliance is otherwise undertaken on an ad hoc basis alongside H&S or lead walk rounds.	Implemented pending assurance	OCT '20		OCT '20
73	The trust should ensure that all senior leaders have the skills to access and use patient outcome data to improve services.	HB	Provide training and guidance to senior leaders on the use of patient outcome data. Quality 2:1's with senior leaders to include a focus on the monitoring of the use of patient outcome data. Senior leaders to be supported to roll out learning to all staff on the unit. MDT review of outcome data to ensure it provides robust information around patient outcomes measures Consultation with patients and stakeholders around outcome measures meaningful to them	MDT review of outcome data Stakeholder consultation outcome Final agreed new outcome measure dashboard	Reports to Business Unit meeting	Partial	OCT '20		DEC '20
12	(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	JO	We know that hospitals where staff feel more engaged and supported have better outcomes, lower mortality, reduced infections, fewer mistakes and are more efficient, (M West, 2012: King's Fund). This is why supporting and staff and growing the best culture is crucial for our	Staff Survey and Medical Engagement Scale scores Collated feedback and ideas from staff Evidence of staff suggestions put into practice	Reporting to Trust Executive Committee Reporting to Trust Board of Directors Consultation with and feedback from staff representatives - staff governors and union representatives	Partial	DEC '21		NOV '20

Ref	CQC finding	Exec	Overview of planned improvement	Evidence for delivery	Monitoring and assurance	COVID status	Initial date	Interim measure details	New date
	staff across all services. (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.		future. An overarching cultural improvement plan, informed by what staff think and feel, will be developed. It will involve the following approaches: 1. More and better listening to staff feedback to inform how we lead and improve 2. Focused and better support for specific issues and teams identified in the CQC report 3. Greater focus on leadership development and continuous learning across WSFT to ensure we have the best culture						
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.	JO	1. To undertake a review of HR policies to ensure that they are kinder and more compassionate 2. To use the HR Case Review meetings to include, policy compliance, staff support and learning points. 3. To implement the "Just Culture" approach to HR processes in accordance with the national guidelines "Improving People Practices".	1. Policy reviews will be developed in partnership with union representatives and presented at "Trust Council" for ratification. 2. Learning Points and agreed actions will be shared with Trust Council and the Trust Negotiating Committee (Medical & Dental) 3. Implementation programme for embedding the Just Culture approach to be in place with recorded milestones and process for evaluation of impact.	Reporting to Trust Board; consultation and feedback from staff; union representatives and from Staff Governors; and the Health and Wellbeing Steering Committee.	Partial	DEC '20		DEC '20

Ref	CQC finding	Exec	Overview of planned improvement	Evidence for delivery	Monitoring and assurance	COVID status	Initial date	Interim measure details	New date
11	The trust must ensure effective processes are in place to meet all the requirements of the fit and proper persons regulation	JO	Non-adherence to F&PP (excluding those due to length of service of board member) will be formulated into an action plan to enable both ED and NED F&PP pathways and record keeping are appropriate and robust. Initial focus will be on the non-executive directors pathway and a local review will be undertaken.	A fully completed F&PP file for every appointee	HR will undertake a review of the F&PP files on an annual basis. Executive and NED appraisal compliance will be monitored in line with standard trust process. Annual compliance report to the Audit Committee	Implemented pending assurance	Complete		Complete
12 32 48 63 70	(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 (32) The trust must ensure all staff complete mandatory training including safeguarding training. (48) The trust should ensure a higher percentage of staff complete mandatory training including PROMPT. (63) The trust should continue to improve mandatory training completion rates to meet the trust's target completion rate of 90%. (70) The trust should continue to improve mandatory training in key skills to all staff to meet trust targets.	JO	• Review of mandatory training subjects, renewal period and delivery methods. • Ongoing streamlining of junior doctors induction process to include, working with other trusts to transfer existing compliance and supported e-learning on site. • Review of community training data following concerns raised as to accuracy of the data (identified an overwriting of data). • Safeguarding Children Level 3 change to yearly, not three yearly. • PROMPT training compliance to be included in wider midwifery training review • Implementation of ESR Manager Self Service will enhance local availability of MT reports and individual compliance • Data cleansing of OLM career management following mandatory training review • Meetings with community leads to ensure mandatory training requirements are correct • Applicant Portal (allows applicants to access their ESR record) launched. Portal allows	A monthly mandatory report is taken from the trusts HR system (electronic staff record - ESR). This is reported in a number of ways; line managers receive a compliance report outlining all staff, using a RAG system, subject compliance is also reported to the subject matter experts , and the trust board receive monthly reports though the IPQR reporting process.	Monthly directorate meetings review compliance levels. In addition a quarterly appraisal and mandatory board report, including progress with the recovery plan, is reported and discussed at board level.	Partial	AUG '20		DEC '20

Ref	CQC finding	Exec	Overview of planned improvement	Evidence for delivery	Monitoring and assurance	COVID status	Initial date	Interim measure details	New date
			applicants to access and complete their mandatory e-learning training prior to their start date and confirm and track their recruitment status. Any training which has been completed at a neighbouring Trust which is part of the Streamlining project will show on the applicant's portal as already compliant. • Review of Induction programmes (acute and community) with implementation of changes to content of training and delivery. This should enable a balance between staff being trained appropriately and safely whilst minimising delays in starting in the workplace.						
18	The trust must ensure that all bank and agency staff have documented local inductions.	JO	West Suffolk Professionals • 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. Agency and Bank workers will complete local area induction on the commencement of their first shift. 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. • All bank staff training is to be reviewed and recorded on OLM. Medical Staffing • All Agency staff are given induction booklets before their first day, which they are required	West Suffolk Professionals - Local inductions will be recorded using a standard template issued to the worker on appointment which will be signed by both the individual and the area manager once local induction has been completed. Medical Staffing - Signed confirmations are filed on their personal files.	Ad hoc audit checks will be undertaken by both the West Suffolk Professionals and Medical Staffing teams to ensure compliance. This will be reported to the HR Director on a quarterly basis. The first report will be produced in quarter 2.	Partial	SEPT '20		DEC '20

Ref	CQC finding	Exec	Overview of planned improvement	Evidence for delivery	Monitoring and assurance	COVID status	Initial date	Interim measure details	New date
			to sign and return a statement confirming they have read and understood this on their first day. • Bank medical staff are formed by current training and trust doctors, therefore are covered by local induction process.						
34	The trust should ensure that effective processes are in place to promote and protect the health and wellbeing of all staff.	JO	The Trust has a comprehensive Health and Wellbeing plan overseen by the Health and Wellbeing Steering Committee. Action in the plan to support mental wellbeing will be reviewed and updated as necessary to ensure the emotional and mental wellbeing of staff is supported during times of significant stress e.g. staff involved in investigations, disciplinary and grievance processes, coronor's cases. Action identified will build on that in finding 5. specifically actions to ensure a just culture undertaken as part of our improving people practices plan.	West Suffolk Wellbeing Plan 2019 - 221: staff health and wellbeing evaluation framework and dashboard. Metrics used: NHS staff survey (morale, health and wellbeing themes), sickness absence (anxiety, stress, depression, other psychiatric illness).	Reported to WSFT Health and Wellbeing Steering Group (quarterly), Trust Executive Group (six monthly), Trust Board (annually	Implemented pending assurance	Complete		Complete
45	The trust should continue to promote the freedom to speak up (FTSU)guardian so that all staff understand what the role is and know who their guardian is.	JO	Internal audit review of robustness of processes and compliance with FTSU Policy, including the FTSU Guardian to identify additional management actions to support understanding and awareness of the role. Review of methods of communication Trust uses to promote a positive culture to speak up to be undertaken jointly with the National Guardian's Office as part of WSFT 'improving culture' plan Review role of FTSU Guardian to identify options to increase	NHS Staff Survey 2019 - overall report and RAG reports for divisional/staff group data. RSM Audit Report findings. PRM Meeting notes FTSU Guardian reports to Trust Board Report of NGO review	(1) Trust Audit Committee (2) Trust Executive Group (3) Trust Board	Partial	JUN '20		DEC '20

Ref	CQC finding	Exec	Overview of planned improvement	Evidence for delivery	Monitoring and assurance	COVID status	Initial date	Interim measure details	New date
			promotion of the role to all staff throughout the Trust Build on and spread existing good practice in promoting FTSU Guardian role e.g. use of posters promoting role and discussions at regular team meetings, events including induction Analyse 2019 NHS Staff Survey RAG report results to identify departments and/or staff groups with a score 3% or greater score below the Trust average for questions relevant to FTSU. Continue implementation of Improving Everyone's Experience Action Plan launched Sept19						
55 64 71	(55) The trust should ensure that appraisal rates are met for staff. (64) The trust should continue to improve appraisal completion rates to meet the trust's target completion rate of 90%. (71) The trust should continue to improve appraisal completion rates to meet the trust's target completion rate of 90%.	JO	• Dedicated support to areas struggling to reach 90% from Workforce and HR as well as executive support to improve uptake. • Trust working towards ESR manager self – service which gives managers the responsibility to log appraisals for their own staff. This will remove the potential for appraisal information to be mislaid. • Implementation of agenda for change pay progression policy which will require all staff to have an up to date appraisal recorded on ESR, before they can progress an increment. • Support managers/ appraisers with on-going delivery of both refresher and initial appraiser training sessions. • Raise profile of appraisal compliance throughout the trust	A monthly appraisal report is taken from the trusts HR system (electronic staff record - ESR). This is reported in a number of ways; line managers receive a compliance report outlining all staff, using a RAG system, senior managers also receive this report to see directorate compliance levels, and the trust board receive monthly reports though the IPQR reporting process.	monthly divisional appraisal report to line managers (includes, individual staff appraisal information, RAG ratings, and compliance figures by department and division), monthly board reporting through IPQR, quarterly report on actions to improve compliance as part of quarterly Appraisal and mandatory training board report	Partial	SEPT '20		DEC '20

Ref	CQC finding	Exec	Overview of planned improvement	Evidence for delivery	Monitoring and assurance	COVID status	Initial date	Interim measure details	New date
			• Investigate possibility of an appraisal dashboard in Greensheet. • Ongoing work with Trusts across region to achieve best possible data transfer through Electronic Staff Record system appraisal data.						
3 4.3 39	(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. (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. (39) The trust should ensure shared learning from never events with staff across the hospital.	RP	Implementation of the WSFT local Patient Safety & Learning (PS&L) strategy with specific reference to key principle 4. 4. 'Continually learning and improving' AND local implementation of the NHSI's Patient safety incident response framework (PSIRF)	1. reports to meetings listed below 2. minutes of meetings below 3. completion of NHSI's PSIRF 'readiness assessment' template 4. updated Incident reporting policy 5. copies of shared learning documents (bulletins, agendas, committee reports, etc.)	PS&L strategy implementation plan will be reported to the Quality group in a monthly basis. There is a standalone implementation plan that sets out PSIRF progress will be reported to Trust Board via the Quality & Risk committee. PSIRF is also subject to external monitoring as it is a system wide project led by the Director of Nursing and Quality Suffolk (East and West) and North East Essex CCGs)	Partial	JUN '20		DEC' 20
4.4 35	(4.4) The trust must ensure that processes for governance and oversight of risk and quality improvement become	RP	Weekly monitoring by Executive and monthly by the Board Additional staff appointments	1. tracking spreadsheet 2. monthly Board report	Weekly review of compliance	Able to continue	MAY '20		OCT '20

Ref	CQC finding	Exec	Overview of planned improvement	Evidence for delivery	Monitoring and assurance	COVID status	Initial date	Interim measure details	New date
	consistent across the organisation - complaints are monitored and reviewed to drive service improvement. (35) The trust should ensure that complaints are responded to in a timely manner, within trust policy.								
10	The trust must ensure that the duty of candour is carried out as soon as reasonably practicable, in line with national guidance	RP	Implementation of the WSFT local Patient Safety & Learning (PS&L) strategy with specific reference to key principle 2. 'Being open and honest'. which describes four key actions: 1. Carry out duty of candour for patients promptly, sensitively and sympathetically. 2. Report via the IQPR and CDs meetings. 3. Continue to support 'freedom to speak up' by promoting staff guardians 4. Give opportunity for patients, families and carers to participate in SI investigations. Ensure open comms channels throughout process. NB: This has an overlap (but is not directly the same as) CQC ref 3+4.3 with regard to the implementation of the NHSI's Patient safety incident response framework (PSIRF) The DoC project will include looking at WHY we do not have timely DoC completion (which is likely to be multifactorial) not just HOW.	1. IQPR DoC indicators (timeliness, verbal overdue, written overdue) 2. minutes of meetings below 3. updated Being Open policy	PS&L strategy implementation plan will be reported to the Quality group on a monthly basis. There is a standalone implementation plan that sets out the details NB: Completion of DoC with Executive oversight through open and closed Board reports continues unchanged during COVID-19 response.	Partial	MAY '20		DEC '20
13	The trust must ensure staff complete patient risk	RP	e-Care change requests put in place to amend:	Staff compliance data for new safety	Review of audit data in ED governance meetings	Implemented	APR '20		OCT '20

Ref	CQC finding	Exec	Overview of planned improvement	Evidence for delivery	Monitoring and assurance	COVID status	Initial date	Interim measure details	New date
	assessment to identify patients at risk of deterioration and risk assessments for day to day care activities.		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	checklist will be used to complete staff 1-1 Perfect ward data Weekly audits of 10 patients to monitor compliance		pending assurance			
14 20	(14) The trust must ensure staff record medication temperatures and escalate any concerns in line with its medications policy. (20) The trust must improve monitoring ambient room temperatures in drugs rooms.	RP	1) Pharmacy to audit all fridge temperatures with in Emergency Department. The maximum temperatures reached are as expected for drug fridges. Some temperatures were almost certainly due to the door being open whilst trying to find stock. Action to address issue resulting from temperature audit: - Introduction of trays into the fridge to keep stock together to	Outcome and recommendations from pharmacy temperature audit Communications to staff via email and hot topics. Examples of escalations from staff to unit manager (email examples available) Examples of	Daily checks of fridge and ambient room temperatures. Monthly perfect ward audits. Outcomes of pharmacy audits.	Implemented pending assurance	Complete		Complete

Ref	CQC finding	Exec	Overview of planned improvement	Evidence for delivery	Monitoring and assurance	COVID status	Initial date	Interim measure details	New date
			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 store and appropriate esclation 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:	escalations from unit manager to pharmacy (email examples available)					

Ref	CQC finding	Exec	Overview of planned improvement	Evidence for delivery	Monitoring and assurance	COVID status	Initial date	Interim measure details	New date
			- Email communication to all staff to remind to escalate high temperatures to Unit Manager (regular escalations since communication.) - Issue included in weekly hot topics discussed at all handovers. - Unit manager informs pharmacy of any escalations to ensure appropriate actions if required. 4) Long term strategy: Trust wide consideration of centralised temperature monitoring						
15 16	(15) The trust must ensure that staff records in relation to equipment and medication checks are completed. (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.	RP	1) Review of documentation for equipment and medication checks Departmental review of existing documentation with a view to simplifying checklists and improve compliance. Actions: - Conducted a review of documentation in January - Removed unnecessary extra checklist for daily paediatric checks - Simplification of resus checks including reduction of date checking from weekly to monthly. - Inclusion of back stacks checking into resus one checklists 2) Review of online checking Duplication of paper and online checking was causing confusion and impact on compliance. Decision taken to remove requirement for online checking while improved paper checks were embedded within the normal practices of the department. Long	Improved checklists Emails and hot topics communication to staff	Completed checklists Perfect ward provides assurance for compliance with completion of checklists Monthly audit for quality of checks	Partial	MAR '20		OCT '20

Ref	CQC finding	Exec	Overview of planned improvement	Evidence for delivery	Monitoring and assurance	COVID status	Initial date	Interim measure details	New date
			term strategy to replicate improved paper checklist on to the online system. - All changes communicated to staff via email and hot topics						
21 22 23 24 25 60	(21) The trust must improve monitoring of women's records and ensure that a greater number of records are audited monthly. (22) The trust must ensure that carbon monoxide monitoring assessments and records are in line with trust policy. (23)The trust must ensure that women are asked about domestic violence in line with trust policy. (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. (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. (60) The trust should ensure that women's pain scores are consistently completed.	RP	To adhere with the requirements of Section 29A warning notice Audits to measure compliance with key standards to be introduced / continued with sufficient volume to allow meaningful interpretation. 2020/21 audit programme to be developed and implemented. New Clinical and Quality Assurance midwife post to be responsible for the development and implementation of the audit programme and associated quality improvements	Audit programme Audit reports JD for CQA midwife	Local monitoring at Women's health Governance	Partial	FEB '20		TBC
26	The trust must ensure they carry out daily checks of resuscitation equipment.	RP	Ward Manager on F11 to check daily. Labour Suite co-ordinators to check daily. Service manager to check weekly compliance in all areas.	Outcome of compliance checks	Reporting of compliance checks to Women's Health Governance	Partial	JAN '20		OCT '20

Ref	CQC finding	Exec	Overview of planned improvement	Evidence for delivery	Monitoring and assurance	COVID status	Initial date	Interim measure details	New date
27	The trust must ensure clinical guidelines are up to date.	RP	Business Case for Clinical effectiveness midwife/ safety/audit midwife to be completed. Bank Band 7 midwife to undertake role in the meantime.	Survey all guidelines to produce spreadsheet of out of date guidelines/ due to expire soon. Chase up/allocate guidelines. Collate feedback	Approval via clinical governance	Partial	FEB '20		DEC '20
36	The trust should ensure all staff follow infection prevention and control procedures and bare below the elbow guidance at all times.	RP	Reminder to all staff of how to challenge visiting staff (i.e. not just department staff).	Positive audit results	weekly review and where there are failings weekly audit and ward manager and senior matron attend a meeting with the ECN to discuss improvement plan	Able to continue	FEB '20		OCT '20
37	The trust should ensure that cleaning chemicals hazardous to health are stored in an appropriate locked location.	RP	All wards will have access to a locked location in order to safely store cleaning chemicals hazardous to health. Staff will be aware of their responsibilities under COSHH and adhere to policy.	Perfect ward/peer review inspections will evidence rate of compliance for each ward area; with the aim of meeting a 100 % target.	Perfect ward to be completed monthly and shared with the Matrons/HoN at performance meeting. Where compliance is <100 an action plan will be completed.	Partial	FEB '20		OCT '20
38	The trust should ensure that all sharps and syringes are stored securely away from patients and visitors.	RP	Perfect ward update to ensure audited and where required actions put into place. Linking in with workplace inspection programme	Perfect ward/peer review inspections will evidence rate of compliance for each ward area; with the aim of meeting a 100 % target.	Monthly audit will need to meet a 100% compliance rate. Results will be shared at the matrons/HoN quality meetings and if the target is < 100% an action plan will be put into place.	Partial	FEB '20		OCT '20
40	The trust should display safety thermometer data and utilise this to improve services. Note: Nationally the NHS Safety Thermometer has been scheduled to end in Apr20 following conclusion of national consultation on its continued usefulness as a tool for measuring Harm	RP	Ward accreditation programme (as per NHSI) will be supported by a review of nursing quality metrics including data distribution, display and data sharing, use in improvement not just performance and reporting via IQPR and other pathways is planned, led by HoNs and supported by Governance. this will link into the ongoing wider	Accreditation project updates Updated IQPR metrics (expected to be in place later in 2020/21 reporting cycle) will provide further source of assurance to Board	Ward accreditation working group report to Quality group	Partial	AUG '20		OCT '20

Ref	CQC finding	Exec	Overview of planned improvement	Evidence for delivery	Monitoring and assurance	COVID status	Initial date	Interim measure details	New date
	Free care		review of the IQPR led by the Performance team						
47	The trust should ensure that the labour suite coordinator is supernumerary.	RP	Business Case for supernumerary Labour Suite co-ordinators to be completed.	Submission and approval of Business case	Once post holders are in place	Able to continue	FEB '20		OCT '20
49	The trust should ensure team meetings are held to share information with ward staff.	RP	Minutes of applicable meetings to be e-mailed to all staff. Unit meeting to commence from Feb20 and held monthly thereafter on first Thursday of the month. All staff to be e-mailed date/time/venue.	Minutes of meetings Copies of emails demonstrating distribution of same	Can be evidenced to provide assurance if required	Interim measures	MAY '20	Face to face meetings paused to maintain social distancing requirements. Important information to all staff shared through pathways such as Intranet and daily COVID-19 briefing circulation. 'Risky Business' and 'Take Five' are still being produced and circulated	OCT '20
50	The trust should ensure there is effective audit of the use of the World Health Organisations (WHO) and five steps to safer surgery checklist and take actions on results that do not meet trust standards.	RP	All checklists are audited. Action plans to address non-compliance to be recorded more transparently within Maternity central action plan documents	Results on the Maternity Dashboard	Dashboard presented at Women's Health Governance & Performance Meetings on a monthly basis. Theatre manger given the results to feedback to individuals.	Able to continue	FEB '20		OCT '20
51	The trust should ensure that staff report all incidents in line with trust policy.	RP	List of reportable incidents to be next to each computer on Labour Suite/F11/MDAU/Birthing Unit.	Incident reporting data is available through central Datix records.	Trustwide oversight of incident reporting patterns including highlight of potentially low reporting areas	Able to continue	JAN '20		TBC
52	The trust should ensure that they close incident investigations within trust deadlines.	RP	Reminder to all senior staff at all meetings/e-mail/Take 5. Risk midwife to check on a weekly basis for compliance.	Incident reporting data is available through central Datix records.	Trustwide oversight of incident reporting patterns including timeliness of turnaround	Able to continue	JAN '20		TBC
53	The trust should consider displaying safety performance information.	RP	White board to be placed in Labour Suite staff room to display information. Board on F11 corridor to be updated with current results.	Whiteboard in place	F11 noticeboard to be checked regularly to ensure data is current	Partial	FEB '20		OCT '20
54	The trust should ensure that action plans are created and followed for national and	RP	Business Case for Clinical effectiveness (CE) midwife/ safety/audit midwife to be	Job description Audit programme	Monthly clinical governance meeting updates.	Able to continue	FEB '20		OCT '20

Ref	CQC finding	Exec	Overview of planned improvement	Evidence for delivery	Monitoring and assurance	COVID status	Initial date	Interim measure details	New date
	local audits.		completed. Once audits presented, action plan created and updated monthly at clinical governance.	(local and national) Action plans (recorded more transparently within Maternity central action plan documents)					
56	The trust should ensure that processes are in place for the supervision of midwives. NB: Clarification, Supervision of Midwives was withdrawn nationally in 2018 and replaced with PMA (Professional Midwifery Advocates. This is no longer a statutory requirement although considered best practice	RP	Discuss with regional lead regarding implementation of the A-EQUIP Model. Business case for Professional Midwifery Advocates and training.	Copy of Business case Outcome of benchmarking exercise	Outcome of benchmarking will be reviewed locally within Maternity management to agree implementation	Partial	JUL '20		OCT '20
57	The trust should ensure the collection of friends and family data in all areas.	RP	New Patient Experience team in place will support collection	Data available	In quality report and local reports	National Pause	JAN '20		OCT '20
58	The trust should ensure consumable equipment is not opened prior to use to prevent infection prevention and control risks.	RP	Seek clarification to ensure trust local practice conforms to Resus Council national requirements Ensure staff are aware of requirements Ensure relevant policies reflect national best practice requirements	Statement from Resus Council and/or copy of relevant national guidance referenced within local policies	Standard Infection prevention audit programme on Perfect Ward reported to Women's Health Governance	Able to continue	FEB '20		OCT '20
59	The trust should ensure an evidence-based bereavement care pathway is put in place.	RP	Business case for Bereavement midwife to be completed. Bereavement Care pathway to be reviewed by bereavement midwife in conjunction with all applicable professional, in line with current evidence based guidance.	Updated care pathway	Presentation of updated pathway to Womens Health Governance	Able to continue	FEB '20		OCT '20
69	The trust should consider using an acuity tool to	RP	Implementation of metrics and a method for gathering and	Acuity tool data Minutes of meetings	Via Business Unit and Divisional Board	Interim measure	MAY '20	COVID specific acuity pathways in place for	DEC '20

Ref	CQC finding	Exec	Overview of planned improvement	Evidence for delivery	Monitoring and assurance	COVID status	Initial date	Interim measure details	New date
	assess whether there were enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.		reporting data for analysis around patient acuity, levels of patient harm and safe staffing.	Output of LAM/HoN review.	Meetings.	s		Community care	
72	The trust should ensure that patients individual needs and preferences are taken into account when planning care.	RP	Consider the provision of support to meet the personal, cultural and spiritual preferences/needs of patients. Establish a process around gathering this information and how to share with team. Appoint 'Individualising Patient Care' champions to share and drive this initiative.	Outcomes from Patient Satisfaction Survey/Perfect Ward audit/Quality Assurance Visits.	Ward Clinical Governance Meeting minutes. Business Unit Meeting minutes. Divisional Governance Steering Group Meeting minutes.	Partial	APR '20		DEC '20
74	The trust should ensure that individual goals and outcome measures are routinely monitored and audited to improve care.	RP	Current outcome measures to be reviewed and launched/re-launched, with involvement around progress/achievement of goals with patient/family/colleagues.	Agreed functional tools/outcome measures to be assessed on admission to inpatient beds, during admission and upon discharge.	Ward Clinical Governance Meeting minutes. Business Unit Meeting minutes. Divisional Governance Steering Group Meeting minutes.	Partial	OCT '20		DEC '20

Annex B: WSFT CQC Action Plans - Status Summary Report

Version Date: 26th May 2020

Finding No.	Description	Executive Lead	Project Lead	Must/ Should	Total No. Actions	Plan Version	No. Actions Complete	No. Actions On Track	No. Actions Late/Risk	No. Actions Late/Risk	No. Actions Unknown	Initial Project End Date	Revised Project End Date	Late & Unknown Action Details	Exec Action Required?	Exec or other Action Required
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.	Stephen Dunn	Jeremy Over	MUST	**15**	26.2.20	**2**	**13**	**0**	**0**	**0**	**31.12.20**	**30.11.20**		No	
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.	Stephen Dunn	Jeremy Over	MUST	**As Above**	26.2.20	**See No.1**	**See No.1**	**See No.1**	**See No.1**	**See No.1**	**31.12.20**	**30.6.21**	See No. 1	No	
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.	Rowan Procter	Lucy Winstanley	MUST	**13**	20.3.20	**3**	**8**	**2**	**0**	**0**	**30.6.20**	**31.10.20**	Table top review of incident pathways / complete audit to establish comoliance. Address findings	Yes	See Nos. 4.3 & 39 which will be incorporated in to a single plan. RG to confirm when complete.
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.**	Nick Jenkins	Lucy Winstanley	MUST	**15**	20.3.20	**2**	**13**	**0**	**0**	**0**	**31.7.20**	**31.12.20**		No	
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.**	Nick Jenkins	Jane Sturgess	MUST	**11**	17.4.20	**6**	**5**	**0**	**0**	**0**	**31.7.20**	**31.12.20**	Revised end date 31.12.20	No	
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.**	Rowan Procter	Lucy Winstanley	MUST	**9**	13.5.20	**4**	**0**	**5**	**0**	**0**	**30.6.20**	**31.3.21**	Implementation of patient safety and learning strategy. National PSIRF projects go live	No	See Nos. 3 & 39 which will be incorporated in to a single plan. RG to confirm when complete.
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.**	Rowan Procter	Cassia Nice	MUST	**6**	20.3.20	**4**	**1**	**1**	**0**	**0**	**31.5.20**	**31.10.20**		No	PMO to check appointees commenced. Escalate if necessary
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.	Jeremy Over	Claire Sorenson	MUST	**6**	22.5.20	**3**	**2**	**1**	**0**	**0**	**31.12.20**		HR Policy Review to ensure kind and compassionate approach. To produce investigation tool kit for managers	No	PMO to review plan with JO to determine items can be progressed / delivered
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.	Helen Beck	Angela Price	MUST	**24**		**0**	**24**	**0**	**0**	**0**	**28.2.20**	**31.12.20**		No	
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.	Craig Black	Nickie Yates	MUST	**20**	9.3.20	**1**	**6**	**0**	**1**	**12**	**30.9.20**	**31.12.20**	- Cerner RTT - RTT Training - e-VAF DO Managers - Banding DO Manager - Appoint Data Quality Manager - Review Theatre Dashboard - Update Theatre Dashboard based on audit	No	PMO to review plan with RG / NY. Escalate if necessary.
8	The trust must continue to develop information technology systems and integration across the community services	Craig Black	Mike Bone	MUST	**4**	26.5.20	**0**	**3**	**1**	**0**	**0**	**31.10.20**	**31.12.20**		No	

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	Helen Beck	Helen Beck	MUST	**29**	9.3.20	**0**	**21**	**8**	**0**	**0**	**31.3.20**	**31.10.20**	- RTT Steering Assurance - Paediatric Action Plan data refresh - Endoscopy Demand & Capacity review - Post polypectomy and cancer resection surveillance guidance with Surgery - MRI Recovery Action Plan - Cancer pathway review - Cancer PTL Meeting - Cleanse e-Care W/L	No	PMO to review with DG
10	The trust must ensure that the duty of candour is carried out as soon as reasonably practicable, in line with national guidance	Rowan Procter	Lucy Winstanley	MUST	**12**	10.3.20	**1**	**10**	**1**	**0**	**0**	**31.5.20**	**31.12.20**	Agree responsibilities for undertaking DoC	No	
11	The trust must ensure effective processes are in place to meet all the requirements of the fit and proper persons regulation	Jeremy Over	Angie Manning	MUST	**1**		**0**	**1**	**0**	**0**	**0**	**TBC**	**31.7.20**	NED Recruitment pathway RJ/AM	No	
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	Jeremy Over	Denise Pora	MUST	**4**	26.5.20	**1**	**0**	**2**	**1**	**0**	**31.8.20**	**31.5.21**	Mandatory Training Recovery Compliance / Develop tracking - alert process re 90% compliance levels. See also 32, 48, 63, 70	Yes	Midwifery rates keep this Red but aiming to achieve compliance in 12 months. Needs exec review and support
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.	Rowan Procter	Ian Pridding	MUST	**9**	14.3.20	**6**	**2**	**1**	**0**	**0**	**30.4.20**	**31.10.20**	Awaiting assurance from info team re robustness of data	No	
14	The trust must ensure staff record medication temperatures and escalate any concerns in line with its medications policy.	Rowan Procter	Dona Bowd	MUST	**8**		**7**	**1**	**0**	**0**	**0**	**TBC**	**31.10.20**		No	
15	The trust must ensure that staff records in relation to equipment and medication checks are completed.	Rowan Procter	Dona Bowd	MUST	**6**		**5**	**1**	**0**	**0**	**0**	**31.3.20**	**31.10.20**		No	
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.	Rowan Procter	Simon Whitworth	MUST	**7**		**3**	**1**	**2**	**0**	**1**	**31.3.20**	**31.10.20**	Develop Meds M/t Ward and Patient Locker Inspections	No	PMO to review with SW
17	Obsolete	Obsolete	Obsolete	Obsolete	**Obsolete**							**Obsolete**	**Obsolete**			
18	The trust must ensure that all bank and agency staff have documented local inductions.	Jeremy Over	Holly Randall / Helen Beard	MUST	**7**	26.5.20	**0**	**6**	**1**	**0**		**30.9.20**	**31.12.20**	Recording inductions for bank and agency staff	Yes	
19	The trust must ensure that medicines are stored securely within the main and day surgery theatre department.	Helen Beck	Irene Fretwell	MUST	**67**	12.3.20	**46**	**21**	**0**	**0**	**0**	**TBC**	**31.10.20**		No	
20	The trust must improve monitoring ambient room temperatures in drugs rooms.	Rowan Procter	Simon Whitworth	MUST	**14**	20.3.20	**12**	**1**	**1**	**0**	**0**	**TBC**	**31.10.20**	S Whitworth complete risk assessment if high ambient temperature recorded	No	PMO to review with SW
21	The trust must improve monitoring of women's records and ensure that a greater number of records are audited monthly.	Rowan Procter	Karen Newbury	MUST	**8**	20.3.20	**8**	**0**	**0**	**0**	**0**	**28.2.20**			No	Ongoing Assurance
22	The trust must ensure that carbon monoxide monitoring assessments and records are in line with trust policy..	Rowan Procter	Karen Newbury	MUST	**See No. 21**	20.3.20	**See No. 21**	**See No. 21**	**See No. 21**	**See No. 21**	**See No. 21**	**28.2.20**			No	
23	The trust must ensure that women are asked about domestic violence in line with trust policy.	Rowan Procter	Karen Newbury	MUST	**See No. 21**	20.3.20	**See No. 21**	**See No. 21**	**See No. 21**	**See No. 21**	**See No. 21**	**28.2.20**			No	
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.	Rowan Procter	Karen Newbury	MUST	**See No. 21**	20.3.20	**See No. 21**	**See No. 21**	**See No. 21**	**See No. 21**	**See No. 21**	**28.2.20**			No	
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.	Rowan Procter	Karen Newbury	MUST	**See No. 21**	20.3.20	**See No. 21**	**See No. 21**	**See No. 21**	**See No. 21**	**See No. 21**	**28.2.20**			No	
26	The trust must ensure they carry out daily checks of resuscitation equipment.	Rowan Procter	Karen Newbury	MUST	**4**	13.2.20	**2**	**2**	**0**	**0**	**0**	**31.1.20**	**31.10.20**			
27	The trust must ensure clinical guidelines are up to date.	Rowan Procter	Karen Newbury	MUST	**2**	13.2.20	**0**	**0**	**0**	**0**	**2**	**28.2.20**	**31.12.20**	Bank Midwife / CQC Budget Set	No	
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.	Helen Beck	Helen Beck with ADOs	MUST			**See No.9**	**See No.9**	**See No.9**	**See No.9**	**See No.9**	**31.3.20**	**31.10.20**	See No 9	No	
29	The trust must ensure diagnostic test results are available in a timely manner.	Helen Beck	Helen Beck	MUST			**N/A**	**N/A**	**N/A**	**N/A**	**N/A**			*Processes already in place*	No	*No further action required*

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.	Helen Beck	Angela Price	MUST			See No.6	See No.6	See No.6	See No.6	See No.6	28.2.20	31.12.20	See No 6	No	
31	The trust must ensure staff complete and record patient pain assessments in patient records.	Helen Beck	Michelle Glass	MUST	7	16.4.20	5	1	0	1	0	31.3.20	31.12.20	Newsletter last produced Dec '19. Revised end date 31.12.20	No	
32	The trust must ensure all staff complete mandatory training including safeguarding training.	Jeremy Over	Denise Pora	MUST	0		See No.12	See No.12	See No.12	See No.12	See No.12	31.8.20	31.12.20	See No. 12	No	
33	The trust should ensure that consultant and team communication is improved in relation to the North East Essex and Suffolk Pathology Services (NEESPS). The trust should ensure that a review of the current working environment, equipment and processes within Pathology services is undertaken to identify and address any immediate ongoing concerns.	Nick Jenkins	Darin Geary	SHOULD	4		0	0	4	0	0	TBC	TBC	The PMO has worked up an action plan with DG following meeting with NJ	No	PMO to progress with DG particularly with able to continue elements for Covid-19 duration. PMO to create plan document.
34	The trust should ensure that effective processes are in place to promote and protect the health and wellbeing of all staff.	Jeremy Over	Denise Pora	SHOULD	1	2.3.20	0	1	0	0	0	TBC	31.12.20		No	
35	The trust should ensure that complaints are responded to in a timely manner, within trust policy.	Rowan Procter	Cassia Nice	SHOULD	7		2	3	0	2		31.5.20	31.12.20	Agency backfill / senior nurse team undertaking complaint writing	No	Update from Rowan Procter
36	The trust should ensure all staff follow infection prevention and control procedures and bare below the elbow guidance at all times.	Rowan Procter	Anne How	SHOULD	8	20.4.20	2	6	0	0	0	28.2.20	31.10.20		No	
37	The trust should ensure that cleaning chemicals hazardous to health are stored in an appropriate locked location.	Rowan Procter	Lucy Winstanley	SHOULD	12	3.3.20	6	6	0	0	0	TBC	31.10.20		No	
38	The trust should ensure that all sharps and syringes are stored securely away from patients and visitors.	Rowan Procter	Lucy Winstanley	SHOULD	7	15.4.20	4	3	0	0	0	TBC	31.10.20		No	
39	The trust should ensure shared learning from never events with staff across the hospital.	Rowan Procter	Lucy Winstanley	SHOULD	2	20.3.20	0	2	0	0	0	30.6.20	31.10.20		No	See Nos. 3 & 4.3 which will be incorporated in to a single plan. RG to confirm when complete.
40	The trust should display safety thermometer data and utilise this to improve services.	Rowan Procter	Natalie Bailey	SHOULD	6	13.2.20	1	5	0	0	0	31.8.20	31.10.20		No	
41	The trust should ensure that appropriate action plans to address national audit shortfalls are implemented and effectively monitored.	Nick Jenkins	Suzette De Coteau-Atuah	SHOULD	0		See No. 4.1	See No. 4.1	See No. 4.1	See No. 4.1	See No. 4.1	31.7.20	31.12.20	See 4.1	No	
42	The trust should ensure team meetings are undertaken to share information with ward staff.	Helen Beck	Sarah Watson	SHOULD	3	12.3.20	0	1	2	0	0	31.10.20		SM's to confirm face to face meetigs happening and evidence at Board. Not do-able during Covid-19	No	
43	The trust should consider displaying information on how patients and visitors can lead healthier lives.	Nick Jenkins	Helena Jopling	SHOULD			0	0	0	0	0	31.12.20	TBC	No Action Plan	No	PMO to develop action plan
44	The trust should continue to work to reduce the number of bed moves at night for non-clinical reasons.	Helen Beck	Alex Baldwin	SHOULD	3		0	3	0	0	0	28.2.20	31.10.20		No	
45	The trust should continue to promote the freedom to speak up guardian so that all staff understand what the role is and know who their guardian is.	Jeremy Over	Denise Pora	SHOULD	9		1	8	0	0	0	30.6.20	31.12.20		No	
46	The trust should ensure effective processes are in place for oversight of referral to treatment times across all specialties with action plans in place to improve the specialties where national standards are not being met.	Helen Beck	Hannah Knights	SHOULD			See No.9	See No.9	See No.9	See No.9	See No.9	31.3.20	31.10.20	See No. 9		
47	The trust should ensure that the labour suite coordinator is supernumerary.	Rowan Procter	Karen Newbury	SHOULD	2	13.2.20	1	0	0	1		28.2.20	31.10.20	Budget setting / CQC Saving babies lives / CNST	No	
48	The trust should ensure a higher percentage of staff complete mandatory training including PROMPT.	Jeremy Over	Karen Newbury	SHOULD	3	26.5.20	1	1		1		31.8.20	31.12.20	Red: Prompt needs to be 90% Unknown: PDN needs support	No	
49	The trust should ensure team meetings are held to share information with ward staff.	Rowan Procter	Karen Newbury	SHOULD	4	14.2.20	1	3	0	0	0	31.5.20	31.10.20		No	
50	The trust should ensure there is effective audit of the use of the World Health Organisations (WHO) and five steps to safer surgery checklist and take actions on results that do not meet trust standards.	Rowan Procter	Karen Newbury	SHOULD	3	13.2.20	2	1	0	0	0	28.2.20	31.10.20		No	

51	The trust should ensure that staff report all incidents in line with trust policy.	Rowan Procter	Karen Newbury	SHOULD	1	13.2.20	1	0	0	0	0	31.1.20			No	
52	The trust should ensure that they close incident investigations within trust deadlines.	Rowan Procter	Karen Newbury	SHOULD	1	13.2.20	1	0	0	0	0	31.1.20			No	
53	The trust should consider displaying safety performance information.	Rowan Procter	Karen Newbury	SHOULD	3	13.2.20	2	1	0	0	0	28.2.20	31.10.20		No	
54	The trust should ensure that action plans are created and followed for national and local audits.	Rowan Procter	Karen Newbury	SHOULD	4	13.2.20	0	0	0	4		31.7.20	31.10.20	National & Local Audits	No	
55	The trust should ensure that appraisal rates are met for staff.	Jeremy Over	Denise Pora	SHOULD	1	14.2.20	0	0	1	0	0	30.9.20	31.12.20		No	
56	The trust should ensure that processes are in place for the supervision of midwives.	Rowan Procter	Karen Newbury	SHOULD	3	13.2.20	0	3	0	0	0	30.7.20	31.10.20		No	
57	The trust should ensure the collection of friends and family data in all areas.	Rowan Procter	Karen Newbury	SHOULD	2	13.2.20	0	2	0	0	0	31.1.20	31.10.20		No	
58	The trust should ensure consumable equipment is not opened prior to use to prevent infection prevention and control risks.	Rowan Procter	Julie Head	SHOULD	2	13.2.20	0	2	0	0	0	28.2.20	31.10.20			
59	The trust should ensure an evidence-based bereavement care pathway is put in place.	Rowan Procter	Karen Newbury	SHOULD	4		2	0	0	2		28.2.20	31.10.20		No	
60	The trust should ensure that women's pain scores are consistently completed.	Rowan Procter	Karen Newbury	SHOULD	See No. 21	20.3.20	See No. 21	See No. 21	See No. 21	See No. 21	See No. 21	28.2.20				
61	The trust should consider security enabled doors in the paediatric outpatient department.	Helen Beck	Darin Geary	SHOULD	4	12.3.20	3	0	0	0	1	31.5.20	31.10.20	Item 4 unknown. Security solution in place dependent to risk assessment recomm	No	JC to follow up with Darin Geary
62	The trust should consider a system to monitor the average waiting times for a follow up appointment.	Helen Beck	Helen Beck	SHOULD			See No.6	See No.6	See No.6	See No.6	See No.6	28.2.20	31.12.20	See No. 6		
63	The trust should continue to improve mandatory training completion rates to meet the trust's target completion rate of 90%.	Jeremy Over	Denise Pora / Michelle Glass	SHOULD	0		See No.12	See No.12	See No.12	See No.12	See No.12	31.8.20	31.12.20	See No. 12	No	PMO to create plan with MG
64	The trust should continue to improve appraisal completion rates to meet the trust's target completion rate of 90%.	Jeremy Over	Denise Pora / Michelle Glass	SHOULD	See No. 55	14.2.20	See No.55	See No.55	See No.55	See No.55	See No.55	30.9.20	31.12.20	See No. 55	No	
65	The trust should ensure that governance and oversight are strengthened to ensure performance and local audit are monitored and measured to improve practice.	Nick Jenkins	Michelle Glass / Nic Smith-Howell	SHOULD	6	14.2.20	0	6	0	0	0	31.7.20	30.11.20	Plan updated 21/05 end date with revised end date (Trust approval of audit plan) 31/10 BAU Reporting in Divisional Governance from November 20	No	PMO to engage MG re plan
66	The trust should ensure that processes are in place and effective to monitor compliance with best practice and national guidance relevant to the service.	Helen Beck	Michelle Glass / Nic Smith-Howell	SHOULD	5	14.2.20	0	0	0	0	5	31.5.20	31.10.20	Nice Update	No	PMO to engage MG re plan
67	The trust should ensure records are maintained to show cleaning has been completed in line with cleaning schedules.	Helen Beck	Michelle Glass / Nic Smith-Howell	SHOULD	4		0	4	0	0	0	31.10.20	31.10.20		No	
68	The trust should ensure that facilities for audiology assessments in the Ipswich child development centre improve.	Craig Black	Nic Smith-Howell	SHOULD	4	9.3.20	3	0	1	0	0	31.5.20	31.7.20	Risk: Update 21/05/20: There is a timeframe delivery risk re flooring supplier from Holland so now looking at alternatives. Nic SH to obtain update from estates (Luke Goldfinch). Timeframe extended to 30/06/20 and reportedd as amber	No	
69	The trust should consider using an acuity tool to assess whether there were enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.	Rowan Procter	Sharon Basson	SHOULD	11	20.4.20	2	0	0	9	0	31.5.20	31.12.20	Revised end date 31.12.20	No	PMO to support delivery plan post Covid-19
70	The trust should continue to improve mandatory training in key skills to all staff to meet trust targets.	Jeremy Over	Denise Pora / Michelle Glass	SHOULD	0		See No.12	See No.12	See No.12	See No.12	See No.12	31.8.20	31.12.20	See No. 12	No	PMO to identify plan with MG
71	The trust should continue to improve appraisal completion rates to meet the trust's target completion rate of 90%.	Jeremy Over	Denise Pora / Michelle Glass	SHOULD	See No. 55	14.2.20	See No.55	See No.55	See No.55	See No.55	See No.55	30.9.20	31.12.20	See No. 55	No	PMO to identify plan with MG
72	The trust should ensure that patients individual needs and preferences are taken into account when planning care.	Rowan Procter	Sharon Basson	SHOULD	13	20.4.20	3	0	10	0	0	30.4.20	31.12.20	Revised end date 31.12.20	No	
73	The trust should ensure that all senior leaders have the skills to access and use patient outcome data to improve services.	Helen Beck	Michelle Glass / Nic Smith-Howell	SHOULD	8	20.4.20	0	0	0	8	0	31.10.20	31.12.20	Revised end date 31.12.20	No	

74	The trust should ensure that individual goals and outcome measures are routinely monitored and audited to improve care.	Rowan Procter	Sharon Basson	SHOULD	**13**	20.4.20	**2**	**0**	**0**	**11**	**0**	**31.10.20**	**31.12.20**	Revised end date 31.12.20	No	

Total Actions 471	161	204	44	41	21
Total Actions (%)	**34%**	**43%**	**9%**	**9%**	**4%**

100%

Annex C: Improvement governance framework

The proposal outlined in this paper is to drive systematic, risk managed, continuous improvement at the Trust with the deployment of an integrated improvement tracker and the incorporation of improvement cluster groups with executive level reporting to manage improvements effectively.

The process and governance outlined in this paper are consistent with the Trust's cost improvement programme, which has delivered year on year cost improvement targets and the highest internal audit rankings, based on effective and inclusive engagement across the organisation with a singular and inclusive improvement methodology and approach.

It is proposed to bring forward the timeframe for establishing the proposed improvement processes and governance at the Trust to operate across three interdependent workstreams:

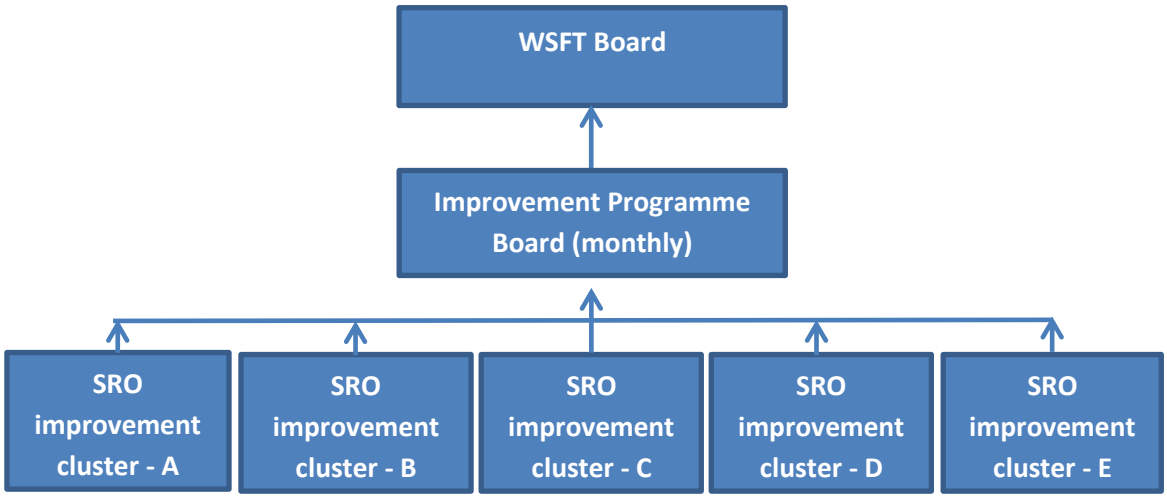
1. CQC improvement
2. Covid-19 recovery
3. Quality improvement (QI) methods programme

The work streams can be managed more inclusively and efficiently under a singular improvement governance framework. Central to this framework is establishing the Improvement Programme Board as a subcommittee of the Board.

Whilst there are clear challenges for clinical leaders assigned to the Covid-19 response, the shape of the working world is never going to be the same again post Covid-19 and the level of expected change post Covid-19 is going to raise many risks and issues for the Trust that need to be captured effectively and managed promptly particularly regarding quality and safety

Bringing forward improvement governance planning and implementation to manage all three workstreams under an integrated framework will provide a strong and positive signal for regulators that the Trust has the capability to learn lessons effectively

Governance: Improvement reporting governance framework



Issues for consideration:

Improvement programme board

Provides a focus for continuous and sustainable improvement planning, delivery and assurance. A governance structure must be put in place to provide oversight of CQC improvements but provide flexibility to incorporate the requirements for Covid recovery and QI methods going forward.

The programme board would be chaired by the Chief Executive and its membership include NED(s), executives, senior leaders and representation from the CCG.

In the first instance the focus of the board will be on the CQC improvement plan but recognising its scope extends beyond this to the wider system agendas of COVID recovery and QI methods the future membership could also be extended to include Alliance and system partners.

SRO improvement cluster

Structuring these around the executive leads as senior responsible officers (SRO) will work well for the CQC improvement plan. Similarly, SROs can be appointed for wider system-based improvements.

Progress and reporting will follow the programme management office (PMO) gateway approach (Annex 1)

PMO resource

The PMO scope will be extended to include improvement, applying consistent improvement methodology across quality and cost improvement programmes. Immediate change to PMO scope will ensure the Trust can manage and process relevant improvement matters arising from CQC findings in the first instance. Moving forward this can incorporate quality improvement methods and the Covid-19 recovery through a single improvement governance programme.

The resource requirements for this will be assessed and considered in the context of other areas of work across the Trust.

Annex 1: Approval Gateways (DRAFT)

There are three proposed approval gateways which are designed to ensure that the Improvement Programme Board has clear sight on the real time status of improvement plans and associated risks and issues.

The approval gateways are presented below:

Gateway 1 – Executive SRO approves the initial Project Improvement Brief, Benefits Realisation Plan and Outline Project Plan

- The Improvement Project Briefs, Benefits Realisation Plan and Outline Project Plan for improvement initiatives which are divisional are approved / signed by the Project Manager/Lead, Associate Director of Operations (ADO) and Clinical Director (CD).
- The Improvement Project Briefs, Benefits Realisation Plan and Outline Project Plan for improvement initiatives which are cross cutting across the organisation are approved / signed by the assigned Project Manager/Lead, Operational Lead and Clinical Director Lead.
    - The leads for cross cutting schemes are assigned executively at Gateway 3 meeting

  The Project Brief includes relevant information regarding:

    - Project Aims
    - Project Description
    - Project Scope
    - Project Assumptions
    - Project Impact on other Divisions / Dependencies
    - Project Resource Requirement
    - Project Approvals

- The Benefits Realisation Plan includes the specified benefits expected from the scheme which are monitored by PMO / SRO through the monthly assurance meeting (Gateway 2)

  The Benefits Realisation Plan includes relevant information regarding:

    - List of Key Benefits (Quality and other) including target realisation dates
    - Key Project Risks / Issues and mitigations
    - Project Constraints
    - Monitoring KPI’s
    - Approvals

Gateway 2 – Monthly SRO improvement cluster takes place ten days prior to and preparation for the Improvement Programme Board (Execs Meeting - Gateway 3).

- The Cluster Meeting membership includes the SRO and Project Leads reviewing monthly updates to:
    - Cluster Summary (Improvement Plans)
    - Risks and issues logs
    - Delivery Plans
    - Benefits Tracking
    - Achievements (Greens) / Challenges (Amber) / Escalations (Red)
    - Executive decisions
    - Next Steps

The project manager will use a standard highlight report which will briefly cover achievements, challenges and matters for escalations from the last month and next steps. The project manager will also present the updated Risks and Issues log for review in the meeting. Key executive decisions required will be requested in the meeting.

- The ground work and engagement underpinning the success of the programme will take place stage as updates regarding the progression of the project plans by the project manager are presented and reviewed at this point in the Gateway 2 meeting.
    - To draw a parallel, there are often criticisms that the TSG is 'toothless' which are unfounded in the sense that if the level of required rigour / sweat is taking place at this stage and there is real clarity and transparency for the executives at the Gateway 3 meeting to support effective and meaningful executive decision making.

Version Control
In preparation for the monthly Gateway 2 Cluster meeting with the SRO, the PMO will prepare the version controlled SRO Cluster Summaries for the monthly meeting with each SRO.

The SRO Cluster Summary will be prepared as an 'Inputs' sheet for the SRO Cluster Meeting.

- The 'inputs' sheets are updated in the SRO Cluster meeting
- The project manager for the SRO Cluster will then save down the changes in an 'Outputs' sheet from the SRO Cluster meeting
- The Executive SRO confirms they are satisfied with the contents of the 'Outputs' sheet from the SRO Cluster meeting
- The 'Outputs' sheet is then returned to the PMO and the central Tracker (T1) is then updated by the PMO
- T1 is then ready for submission to the Gateway 3 meeting as a log for all changes from all SRO Cluster meetings during the last month

The process above presents a risk managed version-controlled approach so that the integrity of the centrally held tracker (T1) is maintained in a situation where there are a number of SRO Cluster meetings drawing from the same version-controlled source in preparation for the SRO Cluster and T1 will also need updating after each monthly SRO

Cluster meeting. T1 user access will be limited to the PMO. T1 reader only access can be offered on a wider basis.

Similarly, a centrally held risk log will be maintained to ensure effective oversight. The maintenance of the SRO Cluster Risk and Issues Logs by the project managers is essential as the WSFT Improvement Tracker, is the key reporting document for presentation in the monthly Gateway 3 Improvement Programme Board, which will include an overall risk rating regarding the delivery for the overall programme based on the progression of the individual improvement schemes through the relevant gateways. The progress of the improvement schemes is managed on a Red to Green basis with RAG applied to each of the categories within their respective gateways including:

- Gateway 1: Assumptions, Dependencies, Delivery Plan
- Gateway 2: Risks, Issues
- Gateway 3: Quality Impact Assessment

Gateway 3 – Improvement Programme Board to approve monthly update and plan

    - The Improvement Summary is reviewed also using 'Red to Green' methodology and so the following are reviewed
        - Project progress / updates since last meeting
        - Key risks and issues and mitigations
        - Key Decisions
        - Agree next steps / actions

- SROs / executives have been engaged with a rigorous process through Gateway 2 and have the detailed information at hand from the updated T1 to manage any detailed queries effectively within the Gateway 3 meeting
- The Gateway 3 meeting may include partners from the CQC and CCG as examples and the high level T2 Report is used for presentation purposes in this meeting
- The Gateway 3 Forum may also be the place to manage the cross-cutting conversation rather than develop a further set of governance meetings pre-Gateway 3 and this will need thinking through
- The Improvement Programme Board is minuted and will be managed using an action log to provide effective governance for the meeting

15. Safe staffing guardian report

To APPROVE the report for Q4

For Approval

Presented by Nick Jenkins and Francesca Crawley

Trust Board – 29 May 2020

Agenda item:	15			
Presented by:	Dr Nick Jenkins, Executive Medical Director			
Prepared by:	Francesca Crawley, Guardian of Safe Working Hours			
Date prepared:	May 2020			
Subject:	Safe Staffing Guardian Report – Quarterly Report January – March 2020			
Purpose:		For information	x	For approval

Executive summary:

The purpose of the safe staffing guardian report is to provide evidence and assurance of safe rostering and compliance with contractual requirements, to highlight any difficulties which have arisen, and to explain how they are being addressed.

The report is compiled by the Guardian of Safe Working Hours (GSWH), a role appointed as part of the new national junior doctor contract.

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

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

Previously considered by:	N/A
Risk and assurance:	Patient and staff safety
Legislation,regulatory, equality, diversity and dignity implications	Routine reporting to Board is stipulated within the terms and conditions of the 2018 Junior Doctor contract.

Recommendation: For the board to approve the quarterly report.

QUARTERLY REPORT ON SAFE WORKING HOURS

DOCTORS AND DENTISTS IN TRAINING

1st January 2020 – 31st March 2020 Executive Summary

Introduction

The purpose of the report is to provide evidence of safe rostering and compliance with the TCS, to highlight any difficulties which have arisen, and to explain how they are being addressed. A system of Exception Reporting is in place and uses Allocate software.

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

All trainees taking up appointments are on the New Contract. Locally employed Doctors are on contracts that mirror the new Contract.

Summary data

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

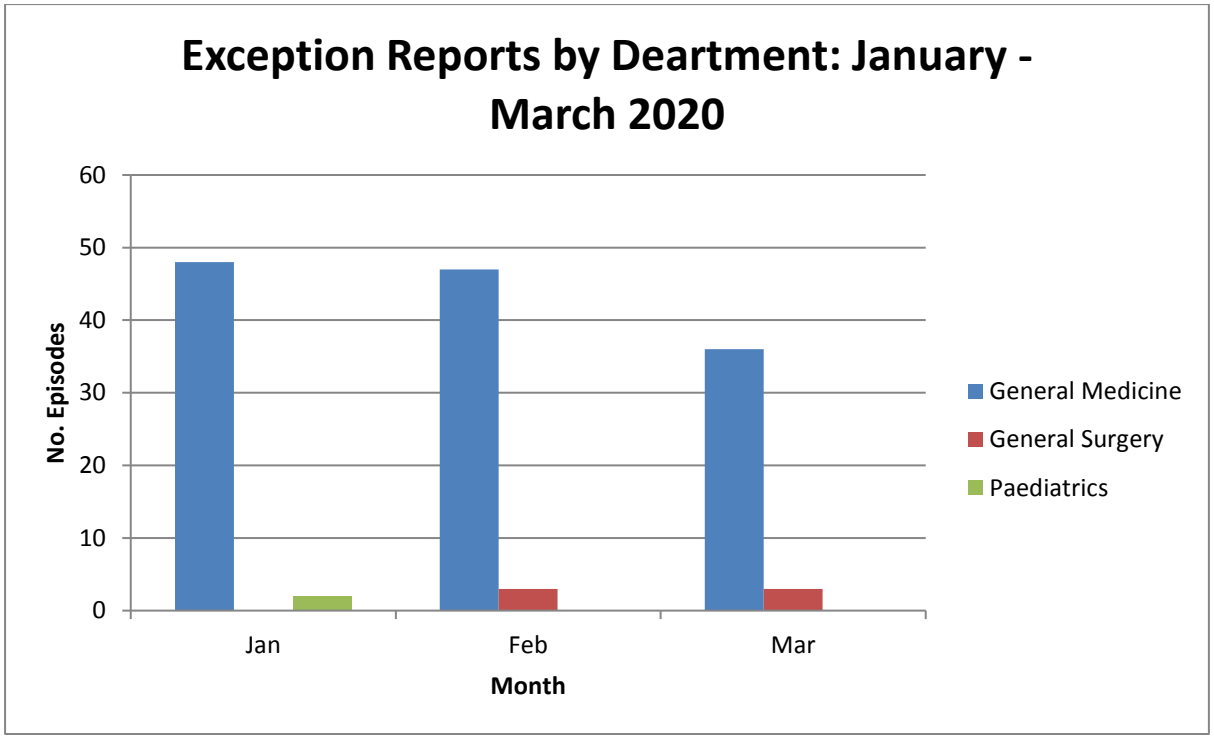
1. Exception reporting: 1st January – 31st March 2020

a) Exception reports (with regard to working hours)

The purpose of exception reporting is to ensure prompt resolution and/or remedial action to ensure that safe working hours are maintained. If there are consistent problems a work schedule review should be carried out. A process is in place on Allocate for the Junior Doctors to fill in the report, which at present requires discussion with a consultant before, during or the day after the period of situation occurred. A narrative of the situation which led to exceeding the contractual obligation is also required. Details are sent to the Guardian and Clinical /Educational Supervisor.

Exception Reports by EXCEPTION TYPE						
Department	Grade	Pattern of Hours worked	Educational Opportunities or available Support	Support available during Service Commitments	Hours of Work	Total overtime hours claimed
Medicine	F1	0	2	0	89	152:30
	F2	0	0	1	25	40
	GP/ST/CT	0	4	0	17	25
	ST3+	0	0	1	0	0
Surgery	F1	0	0	0	2	3:30
	F2	0	0	0	4	8:45
	GP/ST/CT	0	0	0	0	0
	ST3+	0	0	0	0	0
Woman & Child	FY2	0	0	0	1	1
	GP/ST/CT	0	0	0	1	1
	ST3+	0	0	0	0	0
Psychiatry/ off site	F1	0	0	0	0	0
Total		**0**	**6**	**2**	**139**	**231.75**

Exceptions reports by month and department



b) Work schedule reviews for period 1st January – 31st March 2020

Work schedule reviews for individuals may be requested by either the doctor, or the education/clinical supervisor, the service manager or the guardian, in writing.

2) Immediate Safety Concerns: 1st October – 31st December 2019

As outlined in the Terms and Conditions, immediate safety concerns (ICS) should be reported (orally) as an ISC to the consultant in charge on the day of the incident, a datix to be completed and then an exception report submitted within 24 hours.

There have been no ISC in this period.

3) Locum Bookings: 1st January – 31st March 2020

TABLE 1: Shifts requested between 1st January – 31st March 2020 by 'reason requested'

Locum Bookings by REASON REQUESTED										
Department	**Rota Compliance and Induction Cover**	**Leave (Annual, Carers, Study and Interview, bereavement)**	**Maternity and Paternity Leave**	**Sickness and Reduced Duties**	**Extra**	**COVID-19 Additional Dependency**	**COVID-19 Sickness**	**COVID-19 Self-Isolation**	**Vacancy**	**Grand Total**
Anaesthetics	12	1		10	2			5		30
Emergancy Medicine	14	79	8	15	231			11	144	502
ENT					2		1			3
General Medicine	80	12		15	107			12	34	260
General Surgery	2	23		38	1		1		23	88
Haematology										0
Microbiology										0
Obs & Gynae				21	1			2	4	28
Ophthalmology	2			9					4	15
Paediatrics	1			60				4	3	68
Radiology										0
T&O				2						2
Urology		6			3					9

TABLE 2: Shifts requested between 1st January – 31st March 2020 by 'Agency / In house fill'

Filled by NHS / Agency		
Department	**NHS**	**Agency**
Anaesthetics	30	
Emergancy Medicine	361	141
ENT	3	
General Medicine	260	
General Surgery	88	
Obs & Gynae	28	
Ophthalmology	15	
Paediatrics	62	6
T&O	2	
Urology	9	
Grand Total	858	147

4) Vacancies – 1st January – 31st March 2020

HR has provided details of current junior doctor vacancies:

Department	Grade	Jan	Feb	Mar
Emergency	ST3+	5	4	2
Anaesthetics	ST3+	1	1	1
Medicine	ST3+	0	1	0
Medicine	FY2	0	2	1
Obs & Gynae	ST3	1	1	1
General Surgery	ST1-2	1	2	2
Total		**8**	**11**	**7**

5) Fines – 1st January – 31st March 2020

There is a system of financial penalty now in place where exception reporting demonstrates the following:

- a breach of the 48-hour average working week across the reference period agreed for that placement in the work schedule
- a breach in the maximum 72-hour limit in any seven days
- the minimum 11 hours rest requirement between shifts has been reduced to fewer than 8 hours.

Total breach fines paid by the Trust from August 2017 to date are £13,137.75 and the Guardian Fund currently stands at £7,033.14

Matters Arising

1. The response of the junior doctors to covid has been tremendous. They have accepted new rotas with more weekends without complaint. Many of them were unable to rotate in April and again, were very professional about this.

2. The attendance of a wider group of junior doctors at the monthly GOSW meeting continues to be productive, resulting in less confrontation and more progress. We have done this via Teams since covid. Paul Molyneux, chair of the BWLG, continues to be very supportive.

3. We have deferred the breakfast club launch until after covid. The trust is offering free food at night, free parking and free tea and coffee, so juniors are currently feeling well looked after.

4. There is definite progress on spending the £30,000 'Fight Fatigue' money. The JDF had negotiated use of the physio gym. We have asked the MD and FD if the juniors could repurpose the 'old' mess (by MRI) until a new one is available via the ED build. This could be refurbished via the 'fight fatigue' money and would provide a much better alternative to the current option in the old residences (which is absolutely not fit for purpose)

5. The space utilisation group agreed that a room off F6 can be used as a surgical juniors communal office. Since the surgical assessment unit moved, this room is underused. The surgical juniors currently have a small office with 3 computers for 8-9 of them, making working efficiently impossible. Again, this has been delayed due to covid and one of the JDF is going to pick this up with the service manager for surgery. It would allow admin to be done whilst socially distancing- a real problem in all of the current junior doctor offices.

6. There is a shortage of computers on the wards. This has worsened with attempting to socially distance, as most of the available computers are in small offices. There was a project to purchase more mobile computers ('wagons on wheels') which was put on hold due to covid. Purchasing these would help considerably.

7. The issue with the internal medical trainees (IMT- 3 year program which has replaced CMT) getting to clinic was improving, but again is on hold due to the difficulties restarting face to face clinics during covid.

16. Education report - including undergraduate training

To APPROVE the report

For Approval

Presented by Jeremy Over

Board of Directors – 29th May 2020

Agenda item:	16			
Presented by:	Jeremy Over (Executive Director of Workforce & Communications)			
Prepared by:	Mr Peter Harris, Director of Medical Education, Lorna Lambert, Medical Education Manager, Denise Needle, Deputy Director of Workforce (Development), Diane Last, Non-Medical Clinical Tutor, Dr Jessica White, Associate Clinical Dean & Denise Pora, Deputy Director of Workforce (Learning & Organisation Development).			
Date prepared:	20th March 2020			
Subject:	Education Report			
Purpose:	☑	For information		For approval

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

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

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

Previously considered by:	September 2019 Education and Training Trust Board paper
Risk and assurance:	Risk to patient safety due to lack of staff training and education, patient safety, correct staffing levels, staff morale, turnover etc. internal and external reputation. Staff perception of Education, Training & Development opportunities through the annual NHS Staff Survey. Medical Education - Royal College and HEEoE visits and assessments Results of annual GMC annual survey of training grade doctors
Legislation, regulatory, equality, diversity and dignity implications	Legislation & regulatory implications, linked to professional body requirements. Equality and health and safety legislation regarding skills, equipment and behaviours of all staff.

Recommendation: For information

Education and Training – Report for Trust Board Members

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

Priority 1: Deliver for today

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

Undergraduate Medical Education

- The Cambridge Graduate Course in Medicine continues to thrive at the West Suffolk Hospital. 40 students started at the end of September 2019. The current final years are firmly embedded on the medical and surgical wards, and in the Emergency Department. After their finals in April they will return to the Hospital for their Apprenticeship Block, during which students get to practice the skills needed to transition to their Foundation jobs. This has proved a very successful attachment. Two new CGC Tutors have been appointed – Dr Jon Buckler and Dr Katie Keller.

Postgraduate Medical Education

- Reporting to HEEoE
  One incident reported on up to January 2020.
  The Trust reports to HEEoE on any fitness to practice concerns about doctors in training.
  Reports are required for:
  1. Serious incidents where the trainee has been named and investigated
  2. Complaints naming the doctor
  3. Concern about probity or conduct

- College Tutor for Medicine
  Dr Mark Sykes (Consultant Rheumatologist) is stepping down from this role from 30th April.
  Dr Suresh Mohanraj is due to take up this role.

- Interim FTPD
  Dr Francesca Crawley (Consultant Neurologist) has temporarily taken on this role from Dr Kaushik Bhowmick (Consultant Intensivist) due to COVID-19. Dr Crawley was FTPD for 8 yrs so has a wealth of knowledge/experience in this role.

Nursing, Midwifery and Allied Health Professionals

- **Quality Performance Review (QPR) and student feedback**
  The Quality Performance Review has recently been updated to reflect the CQC report. We continue to investigate any concerns raised by students around placements and programme experience in partnership with our university colleagues. We have spoken to students following the CQC report but no major concerns have been raised. Health Education England have requested a visit to the WSFT and the date for this is yet to be confirmed

  Pre-registration Numbers

  We remain concerned about adult nurse student numbers. Despite an increase in capacity that would allow us to support more adult nurse students, the universities were unable to recruit sufficient numbers to meet our requests. We continue to work with the universities to promote the WSFT as a place to work and train. We have been asked to place extra midwifery students within the Trust and our child nurse student numbers remain steady. We have seen an increase in the number of ODP students since September 2019 although we anticipate that this may reduce in 2020. Recruitment to all other programmes remains steady.

  International Registered Nurses

Although we have suspended interviews for overseas nurses wishing to come to the UK, we continue to support those that are on the OSCE programme or are due to arrive in the next three months. To date 109 have passed their OSCE and are now working as registered nurses within the Trust. We also have two nursing assistants that have gained their NMC registration. One overseas nurse from the 136 that have arrived has returned to the Philippines. We continue to have a 100% pass rate for the OSCE programme. We have 5 USAF nurses that will be joining the OSCE programme in the near future.

Nursing and Midwifery Council (NMC) Educational Standards

The new educational standards from the NMC came into effect in September 2019. The new standards set out the role of a newly registered nurse, the requirements of the training programme and the support and assessment required. Practice supervisor and practice assessor training continues to be offered to staff within both the acute and community settings. The new nursing programme sees an increase in clinical skills training during the three year programme. The education team is working with the clinical skills team to implement a training programme across all three years of training

Support Workforce/Other Staff Groups

- **Care certificate:**

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

Please see below Care Certificate activity for the period April 2019 to March 2020:

190	Care Certificate starts
24	Staff left before 12 weeks completion date so did not achieve
14	New staff who joined the trust with a Care Certificate
132	Care Certificate completions

- **Apprenticeship levy:**

The Trust is now able to commission apprenticeship training, which allows the education provider the opportunity to draw down the cost of the training from the Levy.
For apprenticeships we now have 114 individuals on the Digital Apprenticeship Service (DAS) account, with 19 apprentices having completed a non-clinical apprenticeship and 6 clinical apprenticeship. This number may have been higher as we have several members of staff who are waiting to complete their end point assessment which have not taken place due to hold ups from the universities with the national end point assessment.

Our current funds are £1.440, 109 the trust has spent £392,345 since March 2019 and estimated plan spend for the next 12 months is £261,053.

We have apprenticeships across the following subjects;

- Business Administration Level 2
- Business Administrator Level 3
- Health Pharmacy Science Level 3
- Operations/Departmental Manager Level 5
- Engineering Manufacture Level 3
- Senior Health Care Support Worker Level 3
- Healthcare Assistant Practitioner Level 5
- Registered Nurse Level 6
- Team Leader Level 3
- Level 7 Senior Leaders Master's Degree

- Infrastructure Technician – Level 3
- Building Surveying BSc
- Level 6 Management

The trust where nominated from West Suffolk College to the AAC Apprenticeship Awards, the nomination was in the category of Health and Science Apprenticeship Provider of the year. The annual apprenticeship conference/awards night took place in March in Birmingham, the trust received second place.

Priority 2: Invest in quality, staff and clinical leadership

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

Leadership development and talent management

- A clinical leadership event for around 30 junior doctors was organised by Dr Jane Sturgess, Consultant Anaesthetist in October 2019. The day introduces participants to basic leadership concepts and to gain knowledge of the importance of clinical leadership. Feedback on the day was excellent.

- Ten members of trust staff who were part of the first cohort undertaking an in-house Management Apprenticeships at level 3 using the national apprentice levy completed the programme in January 2020. Seven achieved distinction, two a merit and one a pass.

- Fourteen WSFT staff, including six members of consultant medical staff, community matrons and local managers participated in the seven month One Clinical Community Leadership Development Programme sponsored by West Suffolk Alliance Partners. The programme ran from October 2019 to March 2020 and feedback has been very positive.

- The current 2030 Leaders Programme, providing leadership development for aspiring senior leaders comes to an end in April 2020. 21 clinical and non-clinical leaders from WSFT and West Suffolk CCG have participating in the 2019/20 programme.

- The very successful Expert Navy programme for new band 7 ward managers and band 6 nurses aspiring to a ward leadership role is running again in 2020 and a programme has also been developed for Allied Health Professionals at band 6. These programmes are run by the Clinical Education Team in the Nursing Directorate and support succession management to middle level leadership positions.

- Development work resulting from the summer 2019 Leadership Summit and the resulting 'improving everyone's experience' action plan continues. A pilot workshop managing conflict taking a mind-set approach was run in February 2020 and work is in hand to offer this development more widely.

- The Trust Winter Leadership Summit in December 2019 focussed on developing a whole system workforce for the 21st Century. It was attended by around 70 senior leaders who addressed a range of issues including how we support all our staff to develop their careers, transforming roles and the working environment with technology, Designing and embedding new roles to improve patient care and making WSFT the best place to work.

- The 5 O'clock club continues with regular bi-monthly meetings providing speakers on either a leadership or quality improvement theme. In 2020 speakers will include Jonathan Warren, Chief Executive and Dr Dan Dalton, Chief Medical Officer of Norfolk and Suffolk Foundation Trust speaking about their leadership journey, and Ali Hannon a non-binary comedy

performer and speaker. Ali will be speaking on gender and this meeting will be hosted by the Trust LGB&T+ network as part of our Suffolk Pride 2020 celebrations in June.

Postgraduate Medical Education

- Career Advice
  A Medical Careers Fair was scheduled for 17th September in the lecture theatre with representatives from specialties across the hospital invited to man stalls. The purpose is to offer advice and guidance to junior doctors about future career aspirations. A large number of Medical students usually attend who find this event very useful. Inlight of recent changes alternative methods are being looked into as a way of delivering this.

- Education/Clinical Supervisors Training
  Faculty from WSH/HEE/DME's from Ipswich and Colchester delivered training on Oct 18th 2019 and Feb 11th 2020 to 79 delegates from specialties across the region. Feedback was very positive and encouraging. Future dates are June 10th, September 11th and Nov 27th 2020 (could be offered as online learning instead of face to face).

- Educational Supervisors for Trust Grade FY2 & LED Doctors
  6 Educational Supervisors were successfully recruited to support our Trust Grade FY2 Doctors wef 01.02.2020. They are Dr Balendra Kumar (Associate Specialist), Dr Tito Eduardo Junco Russeau (Consultant Geriatrician), Dr Jaspreet Sadana, (Consultant Anaesthetics), Dr Zuleikha D'Souza (Consultant Cardiologist), Dr Sarahn Smith (Consultant Radiologist) and Dr Mirela Marinescu (Consultant Cardiologist). Each allocated up to 4 TG FY2 Dr's to act as a mentor, role model, careers advisor and source of support including using the electronic e-portfolio system to record evidence of competencies. If successful plans to roll this out to LED Dr's from August 2020.

Nursing, Midwifery and Allied Health Professionals

CPD funding

We are waiting for information regarding our HEE CPD funding allocation for 2020/2021. The government has also announced that additional funding for each NHS nurse, midwife and AHP - £1,000 training budget over three years. This will be managed by the Clinical Education Lead and a database is being developed to track spending. We are waiting for further guidance to be published.

Upskilling programme

To meet the needs of band 2's and 3's within the community, Support to go Home and Early Intervention Teams, the education team have planned an upskilling programme that will allow staff to gain additional skills and knowledge to better meet service need. This will start in March 2020.

Bespoke courses

Following feedback we have commissioned the following programmes for staff:

- Mental health and emotional first aid workshop
- Mental health for young people
- Non-medical prescribers update
- Central venous access for community staff
- Bariatric training for community staff

Support Workforce/Other Staff Groups

- **Work experience placement;**

  This service is coordinated by the Student and Young Volunteer Coordinator. We continue to offer student volunteering to students aged 16-19, clinical shadowing opportunities to students interested in a future healthcare career and adults interested in a career change in healthcare. In addition we offer limited non-clinical work experience placements for students aged 15-16. We liaise with tutors in local schools and colleges to promote the

opportunities we offer young people. In this financial year we have had 150 students attend the student volunteer, clinical shadowing and work experience placements.

- **Health Ambassadors; (Career advice to schools and colleges)**

Please see above

Priority 3: Build a joined up future

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

Nursing, Midwifery and Allied Health Professionals

- **Promoting WSFT to Potential Healthcare Students**

We have undertaken the following health ambassador activity since April 2019

	Events at WSFT	External Events	Number of pupils engaging with HAs
Q1	3	4	129
Q2	3	7	158
Q3	4	9	285
Q4	4	12	TBC
Total	**14**	**32**	**572**

Health and Care Academy

As part of a HEE regional initiative the WSFT will be launching a Health and Care Academy. The junior academy will be held 3 times this year for students aged 14 – 15. This will be a half day programme incorporating information about health and care careers. The first event will be held on the 31st March and is fully booked. The senior academy (age 16 – 18 years) will be 10 sessions held over a 3 months and will include life skills, clinical skills and career advice. The programme will conclude with presentations from the students to demonstrate their learning. The first cohort will start in April with a second cohort planned for September.

Support Workforce/Other Staff Groups

- **Library Annual Report and Appendices 2018/19:**

Please find attached the annual library report, which outlines activity of the library and information services and includes a detailed explanation of the transition arrangements from the annual Library Quality Assurance Framework to the new Quality Improvement Outcomes Framework. (Appendix A)

Board Education Meeting – Library Annual Report April 2018 – August 2019

Agenda item:	WSFT Library Annual Report April 2018 to August 2019			
Presented by:	Denise Needle			
Prepared by:	Laura Wilkes			
Date prepared:	October 2019			
Subject:	WSFT Library			
Purpose:		For information	√	For approval

Executive summary:
A summary of the main service developments, innovations and positive impact of the Library and Information Service April 2018 to August 2019. An explanation of the transition from the Library Quality Assurance Framework to a new Quality and Improvement Outcomes Framework and how the Library will continue to demonstrate its alignment to WSFT and Alliance values and the on-going development and delivery of a high quality library service. It will celebrate achievement and expansion of the service, but also highlight barriers to continued success, including workforce and funding issues.

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

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

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

Recommendation:
- Board acknowledgement of the Library Annual Report for April 2018 to August 2019.

West Suffolk Foundation Trust Library Annual Report 2018/19

This report covers the period 1st April 2018 to 31st August 2019.

The Library and Information Centre is referred to as the Library, West Suffolk Foundation Trust as WSFT, Health Education England as HEE. Library and Knowledge Services are referred to as LKS.

The primary drivers for the Library service are:

Our patients, our hospital our future, together – West Suffolk NHS Foundation Trust Strategic Framework for the Future (published July 2015)

West Suffolk Alliance Strategy 2018-2023

Suffolk and North East Essex Integrated Care System (ICS) Operational Plan 2019/20

The Library Strategy 2016-2020

*Knowledge for healthcare: a development framework for NHS library and knowledge services in England 2015 – 2020 (*published by Health Education England 2015)

NHS Long Term Plan

The Topol Review: Preparing the NHS workforce to deliver the digital future

Quality Assurance

Since 2015, the Library has achieved 100% full compliance with the required criteria in the annual HEE Library Quality Assurance Framework (LQAF), which acts as accreditation of our service as a high quality library and knowledge (LKS) service.

During 2019/20 HEE are replacing the LQAF with the Quality and Improvement Outcomes Framework (QIOF) which signals a step change to help LKS staff both to improve service delivery and to better articulate the positive outcome of our work.

The QIOF makes a fundamental shift in emphasis focusing on outcomes rather than process, and it places a responsibility on the organisation served to also demonstrate that it recognises the business-critical role of LKS in mobilising knowledge and evidence to enable healthcare staff to deliver the best quality care to their communities. Part of that recognition is providing adequate resourcing and senior stakeholder engagement in the strategic development of the service.

As the Outcomes are more impact-focussed, the 'scoring' element of the framework has changed significantly. Rather than looking at compliance, there are six quality outcomes and a scale of development, ranging from 0 (not developed) to Level 4 (highly developed). Each level has 'low, medium or high' sub-levels, see Appendix 1.

The Library will carry out a self-evaluation against the Outcomes for the period April 2019 to March 2020. HEE LKS Leads will validate the self-evaluation reports as part of the QIOF assessment. As such, there will be no % compliance because the QIOF is a maturity model whose aim is to measure development rather than achievement. Our baseline assessment (expected to be a mid-Level 2) will form part of the strategic planning process which will also map to the WSFT Strategic Plan currently in development for 2020.

The Library's standing in the QIOF directly feeds into the quality improvement outcomes for other areas of education and training within WSFT, so we do not develop the service in isolation, but with a view to supporting high quality learning environments for all healthcare learners in the organisation and in partner organisations in the West Suffolk Alliance.

As a result of the transition from LQAF to QIOF, the Library was not required to submit a quality assurance submission in 2019 but has still continued to achieve and expand the service during the period covered by this report.

Core Services

We provide a traditional library service in terms of lending books and obtaining research articles, delivering user education and training and inductions. We also provide a much-used and popular physical space for study and relaxation for all staff.

Our traditional methods of data collection do not, however, truly reflect the range and depth of work we undertake, particularly in relation to the Embedded Library Service (ELS), knowledge mobilisation and support for innovation.

We have reviewed our statistical collection methods and we now record all activity on a separate log which enables us to track activity outside of core services and gives a more accurate picture of library usage.

Appendix 2 shows an overall increase in our workload, with increased loans, both to and from other libraries, more article requests, an increase in library inductions and a significant increase in the number of evidence searches we have carried out – almost double the amount in 2018. This is due, in large part, to our increased direct involvement with Allied Health Professional teams as part of the ELS.

Online resources

The Library is not confined to the Drummond Education Centre. A significant amount of library expenditure is used for online resources, so that we can take the Library to our staff, regardless of where they are located.

We select a range of resources to cover all clinical staff at WSFT, and we also invest in databases and online journals that support non-clinical staff in their roles, in particular, management and leadership.

We now also offer a virtual library service to our colleagues in the West Suffolk Alliance and we have arranged for them to be able to access our online resources to support their practice and job roles.

Embedded Library Service (ELS)

The ELS continues to go from strength to strength, with additional requests for services across a range of teams.

Appendix 3 details the type of work and the time spent providing the ELS.

Whilst this is an integral part of our service offer and much appreciated and used by staff, given current staffing and funding levels, we have reached saturation point and will struggle to expand this service to Community and Alliance colleagues without additional funding and staffing.

One of the consequences of expanding the ELS is the significant increase in the number of synthesised and summarised evidence searches we produce. This is a high quality service which

is time-consuming and relies heavily on the professional skills and experience of the librarians. However, the ELS has allowed us to embed into teams so that we gain a much deeper understanding of what they do as clinicians, which in turn informs our searches, meaning we find the best available evidence but also understand more fully the needs of our colleagues and produce high quality evidence summaries.

Patients

- **Voice banking**

The Library has expanded its reach into direct support for patients with Motor Neurone Disease (MND) who wish to 'bank' their voices for future use. To our knowledge, this is the first time an NHS LKS has expanded into direct patient support via clinical referrals.

The work we have undertaken with patients with MND is detailed in Appendix 4.

- **Health Literacy Awareness training**

The Library is now able to offer Health Literacy Awareness training to all staff and volunteers, having completed 'train the trainers' courses throughout 2018/19. This awareness training will support staff to gain knowledge and understanding of the scope and impact of low health literacy amongst the population we serve, as well as offering practical tools and resources to help address non-compliance with medication, encourage healthier lifestyles and effectively promote public health campaigns. Health Literacy Awareness Training will be available as a quarterly Skills Plus session beginning February 2020.

Innovation and mobilisation of knowledge and evidence

Following the AHP Showcase in early 2018, the Library organised and staged another Showcase in June 2019 highlighting the innovative work of our colleagues from the Nursing Directorate.

We showcased 30 posters from across the acute and community sector and hosted a very successful day. The Showcase posters can be viewed at http://www.eel.nhs.uk/WSFTinnovation This event had a positive impact in mobilising knowledge and evidence across our acute, community and West Suffolk Alliance sectors.

Support all our staff

The Library provides a service for all staff regardless of learning status and role. Some examples of how we play a part in supporting staff health and wellbeing include:

Equalities collection – books based on race, sex, LGBT+ and disability

Health and Wellbeing collection – self-help books on a variety of topics and a Mood Bosting collection for mental wellbeing

Health and Wellbeing Marketplace events

LGB&T+ Network – active allies

Disability Network – active member

Functional Maths course – funded by UNISON but open to all staff, six learners obtained a maths qualification in 2019

Monthly Pop-Up Libraries in Time Out to highlight health and wellbeing issues

Period Box - in partnership with the Urogynaecology Clinical Nurse Specialist we collect and distribute free sanitary items across the WSFT site for staff, patients and visitors.

Impact statements detailing our positive impact can be found in Appendix 5.

Finances

The Library continues to operate within budgetary constraints and to deliver a meaningful CIP annually. We also generate a moderate income from the sale of drinks and snacks in our popular social area.

However, the Library budget has reduced significantly since the introduction of tariff funding. Our external funding from HEE is no longer ring-fenced in the Learning Development Agreement but is now subsumed into a general tariff fund.

An additional request for a CIP places an extra burden on already stretched finances, particularly at a time when student numbers across all disciplines have at least doubled. We are now reliant on the Co-Medical and Education Committee (CMET) to fund most of our resource subscriptions.

Non-pay resource allocation from tariff equates to about £36,000 per annum and in 2019 we received additional funding, via CMET, of £16,883 or 8% of the total CMET allocation (excluding staffing costs).

There is no current financial scope for expanding the Library team to meet the information needs of community and Alliance partnerships and to expand the ELS in-line with demand, which places further constraints on service development and expansion, and staff development.

Conclusion

The first outcome measure in the QIOF calls for evidence that WSFT enables their workforce to freely access proactive LKS that meet organisational priorities within the framework of Knowledge for Healthcare. This means, in practice, that the Library needs to demonstrate that we align our services and resources to organisational objectives and we engage and consult with senior stakeholders to identify, review and evaluate LKS developments.

This level of trust granted by WSFT to the Library to deliver a high quality service is appreciated and valued, but going forward we would welcome more involvement from senior stakeholders both to inform our service development and also to ensure we continue to align the service to WSFT and Alliance objectives as we move to a more integrated way of working.

In order for the trust to achieve a QIOF level above 2, we would need to demonstrate active executive/board level involvement through a robust governance system.

Our first QIOF self-evaluation will be submitted in June 2020 covering the period April 2019 to March 2020. We will report on its outcome and what measures we have put in place to develop the service or address any gaps in provision in our next Annual Report in 2020/21.

NHS
West Suffolk
NHS Foundation Trust

Library Annual Report 2018/19

Appendices

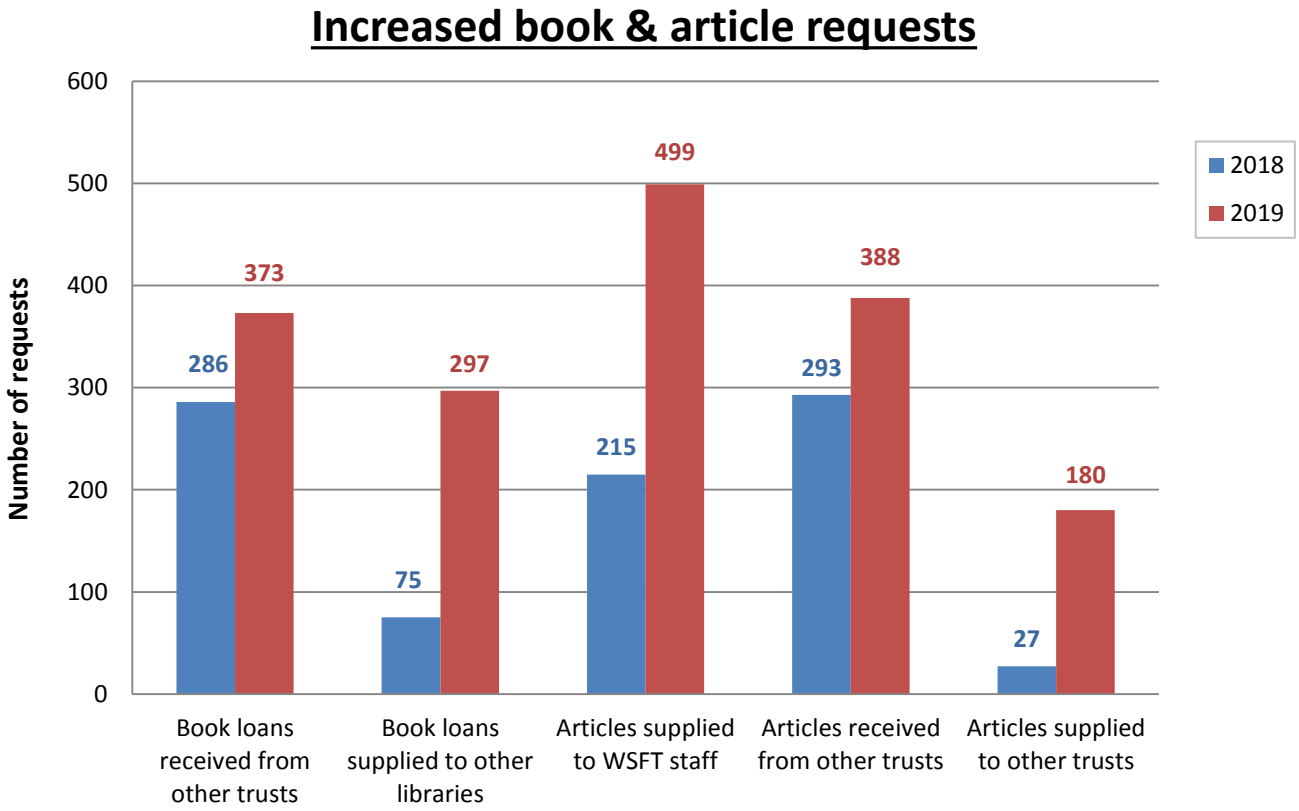
Putting you first

Appendix 1

Quality and Improvement Outcomes Framework for NHS Funded Library and Knowledge Services in England, 2019

https://kfh.libraryservices.nhs.uk/wp-content/uploads/2019/07/Quality-and-Improvement-Framework-2019-Overview.pdf

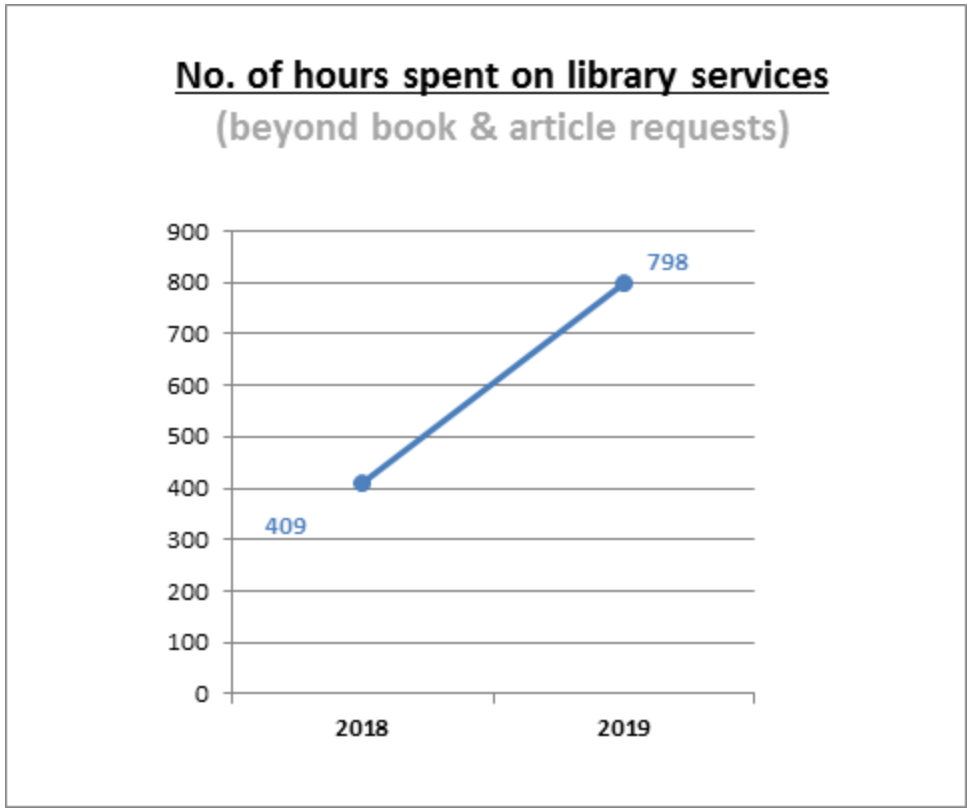
Appendix 2


Increased book & article requests
Number of requests
600
500
400
300
200
100
0
2018
2019
286
373
75
297
215
499
293
388
27
180
Book loans received from other trusts
Book loans supplied to other libraries
Articles supplied to WSFT staff
Articles received from other trusts
Articles supplied to other trusts

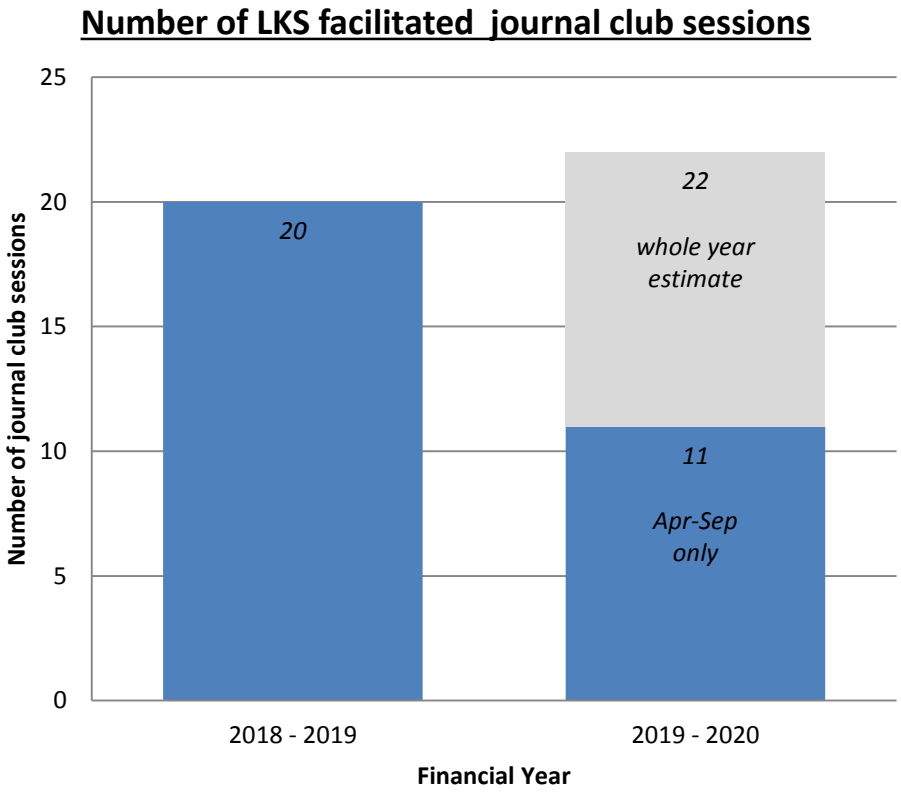
Appendix 2

Types of service provided by 3 WTE Librarians include:

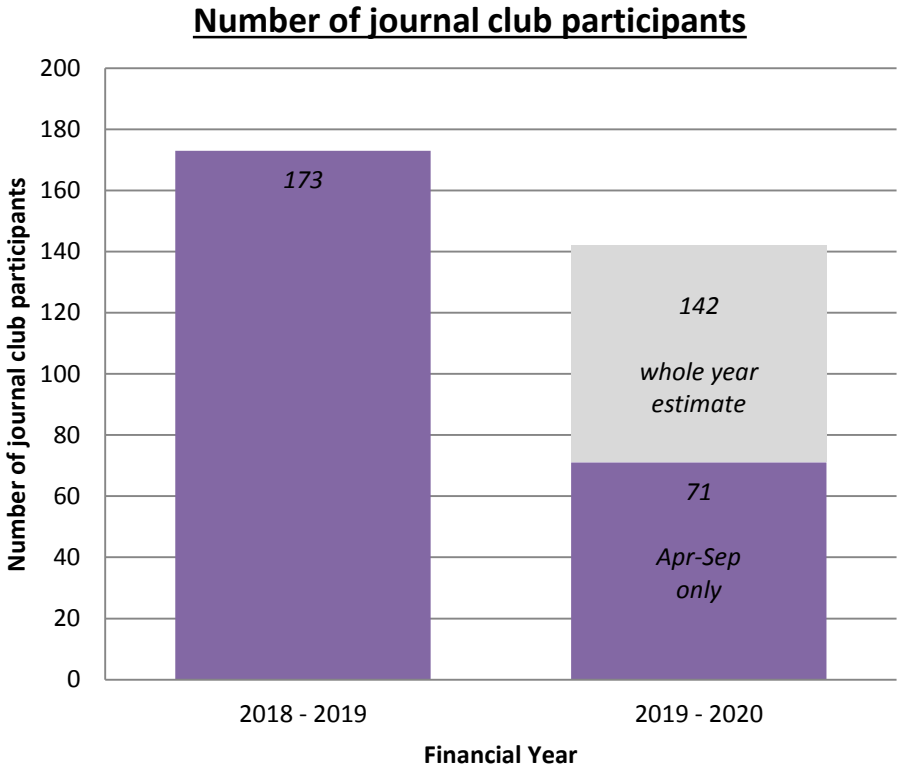
- Evidence searches
- Facilitated journal clubs
- Library inductions
- Attending clinical team meetings & providing post-meeting support with evidence searches
- Support for publication and conferences
- Information and digital literacy training (e.g. voice banking)
- Knowledge mobilisation
- Research support



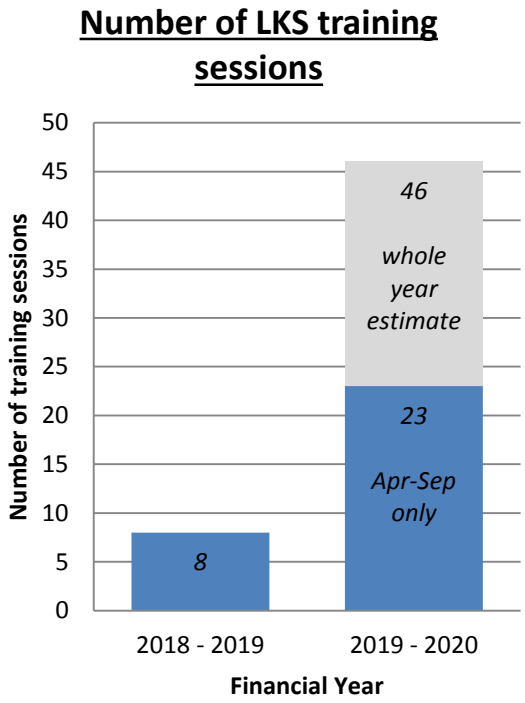
Appendix 3

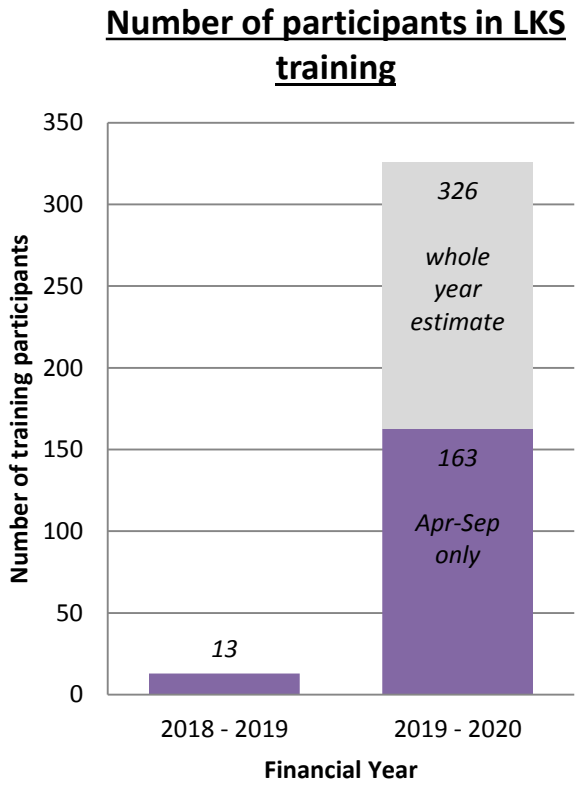

Number of LKS facilitated journal club sessions
25
20
15
10
5
0
Number of journal club sessions
20
22
whole year estimate
11
Apr-Sep only
2018 - 2019
2019 - 2020
Financial Year

Appendix 3

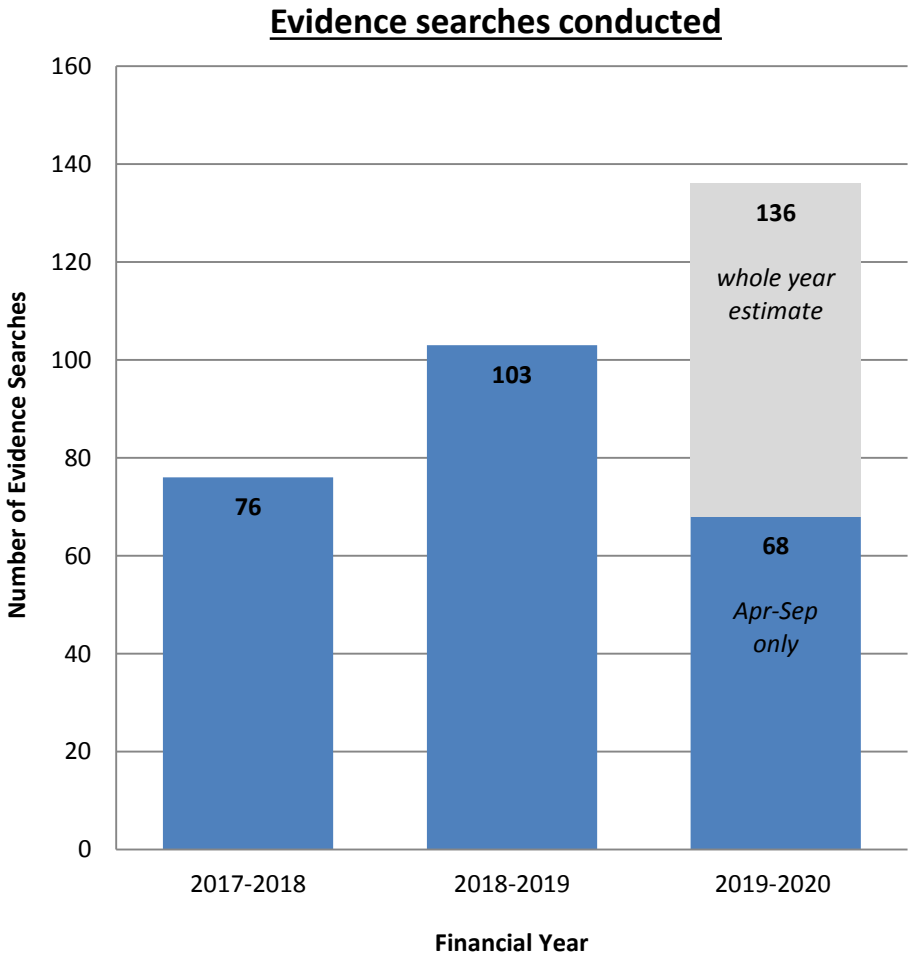

Number of journal club participants
200
180
160
140
120
100
80
60
40
20
0
Number of journal club participants
173
142
whole year estimate
71
Apr-Sep only
2018 - 2019
2019 - 2020
Financial Year

Appendix 3


Number of LKS training sessions
Number of training sessions
50
45
40
35
30
25
20
15
10
5
0
46
whole year estimate
23
Apr-Sep only
8
2018 - 2019
2019 - 2020
Financial Year


Number of participants in LKS training
Number of training participants
350
300
250
200
150
100
50
0
326
whole year estimate
163
Apr-Sep only
13
2018 - 2019
2019 - 2020
Financial Year

Appendix 3


Evidence searches conducted
160
140
120
100
80
60
40
20
0
Number of Evidence Searches
76
103
136
whole year estimate
68
Apr-Sep only
2017-2018
2018-2019
2019-2020
Financial Year

Appendix 4

[Empowering Patients with MND to Have a Voice]

[How a Suffolk Grandfather with Motor Neurone Disease has Banked his Voice]

Appendix 5

Positive Impact

http://www.eel.nhs.uk/wsftPositiveImpact

17. Consultant appointment report

To NOTE this month

For Report

Presented by Jeremy Over

Board of Directors – 29 May 2020

Agenda item:	17			
Presented by:	Jeremy Over, Executive Director of Workforce and Communications			
Prepared by:	Medical Staffing, HR and Communications Directorate			
Date prepared:	21st May 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 Clinical Oncology
DATE OF INTERVIEW:	Thursday 30th April 2020
REASON FOR VACANCY:	New
CANDIDATE APPOINTED:	[redacted]
START DATE:	To be confirmed
PREVIOUS EMPLOYMENT:	[redacted]

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

POST:	Consultant in Anaesthesia
DATE OF INTERVIEW:	Thursday, 21st May 2020
REASON FOR VACANCY:	New
CANDIDATE APPOINTED:	[redacted]
START DATE:	To be confirmed
PREVIOUS EMPLOYMENT:	[redacted]

[redacted]

	[redacted]
QUALIFICATIONS:	[redacted]
NO OF APPLICANTS: **NO OF INTERVIEWED:** **NO OF SHORTLISTED:**	2 1 1

18. 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

19. Pathology services disaggregation

To RECEIVE the report

For Report

Presented by Craig Black and Nick Jenkins

Trust Board – 29 May 2020

Agenda item:	19			
Presented by:	Craig Black, Executive Director for Resources, and Dr Nick Jenkins, Executive Medical Director			
Prepared by:	Darin Geary – Interim Associate Director of Operations, Women & Children and Clinical Support Services Karl Love – Lead Clinician for Pathology Linda Johnston – Interim Senior Operations Manager for Women & Children and Clinical Support Services			
Date prepared:	26th May 2020			
Subject:	**Pathology Future Planning**			
Purpose:	✓	For information		For approval

Executive Summary

On 27th 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.

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 briefly outlines the areas that are being considered, some of the challenges and some of the opportunities that will need to be explored which are:

- Changing networking model
- Contracts
- Quality and governance
- Workforce
- Information Technology
- Procurement
- Estates
- Financial considerations
- Opportunities for future collaboration

There has been extremely limited investment in the Pathology department at WSH since partnership working commenced back in May 2014, with some departments using very dated lab equipment which is difficult to maintain as suppliers can only offer basic maintenance contracts, and repairs are hard to obtain.

Some investment is required to improve the working environment within the laboratory; to improve staffing level across all disciplines to enable the department to obtain and maintain UKAS accreditation; to maintain the current LIMS and obtain a robust QMS. As the investment in staff and equipment develops, the department will be able to continue to collaborate with ESNEFT to benefit from efficiencies of bulk purchasing, whilst also networking with other regional and national trusts.

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

On 27th 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.

The cessation of the current partnership arrangement presents an opportunity for the Trust to radically improve the provision of pathology services within WSFT and its associated stakeholders. To fully exploit this opportunity, the Trust should seek to deliver the following:

- To fundamentally improve the working environment within the laboratory;
- To invest in staffing levels, across all disciplines, to enable the department to obtain and maintain UKAS (United Kingdom Accreditation Service) accreditation;
- To enable accreditation to go hand in hand with a necessary upgrade of equipment and facilities, to make the department much more attractive to prospective employees;
- To enable the department to recruit, train, develop and retain optimum staffing levels to support both in and out of hours demands, whilst meeting the required turnaround times targets.
- To seek to continue to collaborate with ESNEFT within a contracting alliance framework, for the procurement of equipment, IT solutions, consumables and possibility some shared staffing arrangements.
- To allow the Trust, once accredited, to seek to form alliances with other accredited laboratories, as part of its service development.

This paper briefly outlines the areas that are being considered, some of the challenges and some of the opportunities that will need to be explored.

Changing our networking model

In September 2017, NHSI wrote to all Trusts calling for the establishment of 29 'networks' to provide Pathology services to Trusts across England. This was in response to a series of reports reviewing NHS Pathology in England, chaired by Lord Carter of Coles (2006, 2008 and 2016) which called for acute hospital trusts to collaborate to drive out unwarranted variation and reduce costs across Pathology services.

NHSI have defined networking through several models, published within a 'commercial structure and operational guide'. These are:

- Collaboration across two organisations with a single operational management team
- Alliance contracting
- Unit organisation hosted by one trust
- Joint venture partnership (limited liability partnership)
- Joint venture partnership (limited company by shares or guarantee)
- Community interest company
- Outsourcing

The network model during The Pathology Partnership (tPP) and NEESPS has been a unit organisation hosted by one trust. This involved the transfer of staff from non-host trusts to the host trust under Transfer of Undertakings (Protection of Employment) regulations (TUPE). All contracts, finance systems, liabilities and responsibilities also transferred to the host trust and are shared through the joint venture agreement.

As outlined in this paper, this model has not worked for WSFT over the last six years. For WSFT to acquire full control of the operational delivery, governance and quality elements of the laboratory analytical service provided at WSH, this model needs to be replaced with an alliance contracting model. This would enable WSFT to approach other trusts (e.g. ESNEFT) and pathology networks (e.g. Eastern Pathology Alliance), where suitable, to enter into an alliance agreement, setting out agreed shared areas of cooperation, with each Trust taking the lead on a designated area. Each member trust remains responsible for its staff and its own quality accreditation. This model would also satisfy the networking instructions from NHSI.

Areas for Consideration

Contracts

As the host trust for NEESPS, ESNEFT are responsible for the contracts that were novated from the previous networking arrangements with The Pathology Partnership (tPP) in 2017, as well as new contracts that have been set-up since.

WSFT, as joint owner of NEESPS, has previously experienced difficulty in obtaining information about existing contracts and their associated costs with this information only being shared last year.

A revised list of contracts has been shared as part of the joint working group 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 arrangement needs to be considered.

One significant area for consideration is the community pathology contract commissioned by West Suffolk Clinical Commissioning Group (WSCCG) which is due to expire at the end of September 2020. NEESPS are currently the contract provider with work being processed at WSH. There is a similar contract commissioned by Ipswich and East Suffolk Clinical Commissioning Group (IESCCG) which is also due to expire on the same date. This work is processed at Ipswich and Colchester Hospitals.

WSFT needs to maintain their current proportion of community work. The pathology department already has a strong working relationship with GPs in the WSCCG catchment area and have existing electronic requesting and reporting processes in place. Options include a joint tendering arrangement with ESNEFT for both WSCCG and IECCG contracts (preferred option); WSFT to tender independently for the WSCCG contract or for WSFT to tender for this work with different trust/provider.

Quality & Governance

The approach to quality and governance by NEESPS has been to separate them from operations. This approach has led to an overall lack of ownership of delivery of pathology services and resulted in a disconnection with the governance structures with WSFT. The lack of joint governance arrangements was identified during both the MHRA (Medicines and Healthcare products Regulatory Agency) and the histology UKAS visits to WSH.

Our aim is for pathology governance to be fully re-established through the current WSFT Clinical Support Services governance structures, giving full accountability back to the Division. This includes having an overall pathology quality and training lead, with speciality leads in each discipline who should also have some form of operational role.

WSFT have lost all of our laboratory accreditations during the period when pathology services were provided by tPP and NEESPS. With the correct governance structures and investment in workforce it is anticipated that full accreditation across all pathology disciplines could be achieved in two years.

Workforce

There has been a significant reduction in the staffing establishment over the last six years since the inception of the first pathology partnership. The original plan was to move community pathology work away from WSH which would then require less staffing resource on-site. However, the changes to the level of work were never implemented but there was a significant reduction in the staffing levels which have never recovered as NEESPS have continued to experience challenges with recruiting staff across all three sites.

The main aim is that following a consultation process, all staff working at the WSH site that are employed by both ESNEFT and Public Health England (PHE) will transfer under TUPE arrangements to WSFT. This will enable WSFT to have more control on the recruitment of staff; succession planning; use of temporary staff and support mechanisms available for staff.

To ensure the establishment of a resilient service, capable of providing timely, compliant and accredited laboratory service, a new staffing structure has been developed. This structure now needs to be fully costed and a business case developed for its approval.

Information Technology

Laboratory Information Management system:

WSFT currently uses WinPath as its LIMS. This is owned by the partnership and hosted by ESNEFT. It is not used at the Ipswich Hospital and is only used in the Histology department at Colchester Hospital. Full validation of the current version of WinPath was not completed.

Options being considered for WSFT are:

- to enter into an agreement with another network to share their LIMS
- to purchase our own LIMS or version of WinPath
- to enter into an agreement with ESNEFT to continue to use the current LIMS (preferred option)

Sharing a LIMS with ESNEFT would enable results to be distributed electronically across sites once implemented at Ipswich and Colchester and support business continuity during periods of service failure.

In addition, WSFT currently have a link with Cambridge University Hospital using the national pathology exchange (NPEX) which allows the transfer of microbiology results for COVID testing between each organisation's LIMS. Going forward it is vital that WSFT are able to maintain and develop further links using NPEX.

Quality Management System (QMS):

To successfully achieve and maintain UKAS accreditation, it is vitally important laboratory staff have appropriate access to an electronic QMS which is a formalised system that documents processes, procedures and responsibilities for achieving quality policies and objectives. A QMS helps to coordinate and direct organisational activities to meet departmental and regulatory requirements and improve its effectiveness and efficiency on a continuous basis. Q-Pulse Enterprise (QPE) is currently used by NEESPS and Public Health England, who provide microbiology technical services to NEESPS for all three sites.

Similar to the LIMS above, options include continuing to share QPE with ESNEFT or using another QMS from another network. However, there a number of departments at WSFT, including Point of Care Testing, Pharmacy and Radiology, who have expressed an interest in using an electronic QMS and so obtaining our own QMS is being explored.

Procurement

NEESPS staff based at WSH use ESNEFT's procurement system Integra to raise orders. Concerns have been raised with low sign off values, convoluted methods for ordering non-catalogue items, issues with running out of supplies for WSH and unpaid suppliers declining to deliver goods due to outstanding invoices.

Procurement functions will need to transfer to WSFT. However, to achieve economies of scale and support standardising processes, agreement should be reached with ESNEFT to form a procurement alliance for equipment and consumables. Either ESNEFT or WSFT could take the lead on this strategic procurement which would deliver greater value for money. It may also be possible to extend this procurement alliance further in the future resulting in further efficiencies.

Estates

During the current partnership arrangement, WSFT have been responsible for the estate. The pathology department remains 'landlocked' within an outdated 1970's building and space has been an issue for over a decade.

Any solution for the future needs to be considered alongside planning for the new hospital. However, the laboratory cannot continue to operate effectively within the current estate if it is to improve workflow, achieve and maintain the required turn-around-times (TATs).

Priority areas for improvement include:

- Works to facilitate a safe containment level 3 facility and Autoclave replacement for Microbiology services.
- Works to build a dedicated specimen reception which opens onto a main hospital corridor. This will remove the need for non-pathology staff to enter the department when dropping off specimens. Secured restricted access to the rest of the laboratory can then put into place.
- Minor works to cellular pathology lab to facilitate organisation of large and small samples in readiness for the introduction of rapid processing to support achievement of the new cancer 28-day target.
- Refurbishment of the pathology storage/GP prep area.

Separate from these works, several areas of pathology require repairs and redecoration. Upon consultation with Estates at WSFT, it is recommended a fund be agreed to facilitate such works.

Financial considerations

As joint owners, WSFT are responsible for 28% of the planned operating costs for NEESPS. Whilst WSFT are aware of the level of funding that they have contributed during the last three years, it has been difficult to obtain a detailed analysis of the financial model and its associated costs. Although, it is noted that financial reporting for NEESPS has improved over the last year.

As both organisations work through the dissolution and the future networking arrangements, it is important to have full disclosure and transparency surrounding financial considerations.

Whilst it is anticipated that there will no significant changes to the operating model of the current service, additional investment will be required to address the services quality and regulatory compliance as outlined above.

Opportunities for future collations

Once regulatory compliance, service stability and an improvement in quality have been achieved, WSFT could look to further collaborate with ESNEFT and other Trusts. Options for further collaboration include:

- Sharing good clinical and technical practices with neighbouring accredited laboratories
- Research and development
- Digital Pathology Network.

Conclusion

There has been extremely limited investment in the Pathology department at WSH since partnership working commenced back in May 2014.

The Microbiology and Histopathology departments are using very dated lab equipment which is difficult to maintain as suppliers can only offer basic maintenance contracts, and repairs are hard to obtain.

Some investment is required to improve the working environment within the lab. This will be limited to essential work only as the Trust moves forward with plans for a new hospital build. The provision of an externally facing specimen reception is key to limiting non-pathology staff access to the busy and crowded department.

Staffing levels across all disciplines are low and investment is required to enable to the department to obtain and maintain UKAS accreditation. Once on the way to accreditation and following necessary upgrade of equipment and facilities, the department will be much more attractive to prospective employees. The department will then be able to recruit, train, develop and retain optimum staffing levels to support both in and out of hours demands, whilst meeting the required TAT targets.

As the investment in staff and equipment develops, the department will be able to continue to collaborate with ESNEFT to benefit from efficiencies of bulk purchasing, whilst also networking with other regional and national trusts. Once accredited the Trust would seek to form alliances with other accredited laboratories, for example Chelmsford labs, as part of its service development.

A review of major IT solutions is also required. The Trust should aim to maintain the current LIMS at least in the short-term, whilst appraising other suitable offerings. Likewise, a robust QMS solution needs to be secured to support all pathology disciplines and possibly colleagues in other areas of WSFT. The QMS will be vital in the accreditation process which will then support staff recruitment and retention, and service development.

20. Digital board report

To ACCEPT the report, including IM&T strategy update

For Report

Presented by Craig Black

Trust Board Meeting – 29 May 2020

Agenda item:	20			
Presented by:	Craig Black, Executive Director of Resources			
Prepared by:	Sarah Judge, Digital Operational Lead			
Date prepared:	22 May 2020			
Subject:	To receive update from Digital Board			
Purpose:	X	For information		For approval

Executive summary:
This paper highlights the digital response to the COVID-19 pandemic.

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:	*Representatives from the GDE group and departmental leadership.*
Risk and assurance:	*Full risks are reviewed at each meeting with any high level risks reported through to board assurance framework as appropriate.*
Legislation, regulatory, equality, diversity and dignity implications	*GDPR consideration is applied to all projects.*

Recommendation:
The Board is asked to note the update.

1. Background

1.1 It is customary for the update from the Digital Board to highlight areas of achievement and ongoing projects that continue our progress towards digital accreditation and our global digital exemplar (GDE) programme.

1.2 Until March 2020, this work was continuing and we were aiming for a 'go live' of our maternity services into e-Care as well as enhancements to our digitised medicines administration process in early May. We made the difficult decision to put these projects on hold in order that we could focus our efforts on supporting the Trust's response to the COVID-19 pandemic.

1.3 This paper reflects the enormous amount of work that has taken place in order to support our clinicians, allow staff that can work from home to do so and to help provide our patients with the best experience we can offer in these challenging times.

2. Digital response to the COVID-19 pandemic

2.1 The COVID-19 response has resulted in unprecedented demand for urgent response from a wide range of services across the IT department. Although we can represent some of this work in numbers, the response has highlighted the exceptional dedication and commitment of individuals, the focus on helping frontline staff, and collaboration, teamwork and flexibility to support each other.

2.2 Infrastructure

The technical teams have built and deployed over 75 laptops to assist with remote access (accessing Trust systems securely when not on site), and 24 workstations to assist clinical use.

The team have repurposed and rebuilt 24 iPads and carts in order to support the 'keeping in touch' programme and allow patients to contact family and carers.

The requirement for staff to work off site resulted in over 300 new users being set up for remote access, mostly in the first two weeks of restrictions, and we now have over 250 staff accessing the Trust systems remotely, on average, at any one time.

2.3 Support services

Despite an increase of 30% in calls (up to 250 a day) to the Helpdesk daily, the technical team have responded magnificently and reduced the overall list of calls by 90% with only 30-40 calls now outstanding at the end of each day. This has allowed us to be more responsive to urgent needs. They have also supported 23 different requests for equipment moves to support the expansion of critical care and the core resilience team.

2.4 Virtual consultations

The department has supported an accelerated programme of work to provide video consultation capabilities across all of our outpatient clinics and community services. All 26 of our community healthcare teams have access to support via a 'train the trainer' programme in the use of video consultations. A dedicated video consultation booking hub has been set up for outpatient appointments, and in the last week of April, 300 video consultations took place across the Trust. We are now moving into supporting the use of digital tools to provide patient consultations as part of business as usual, and developing options for group sessions.

2.5 Virtual meetings

The use of video conferencing is now part of our normal working day and we have rapidly deployed Microsoft Teams to support this. Over 700 licenses have been issued out to Trust staff and use of this tool is continuing to rise. We have been able to support our colleagues to run departmental and business meetings whilst maintaining social distancing. Our

community staff are utilising the Teams solution that is now inbuilt into NHSmail services and we have been supporting its use for team meetings and keeping in touch. It is pleasing that there are hundreds of one-to-one calls taking place on Teams, helping to keep our staff that are working from home in touch with the organisation.

2.6 Our digital clinical systems

e-Care, our electronic patient record (EPR), has been invaluable in supporting our clinical response to COVID-19. We have designed, built, tested and implemented over 30 requests for changes to e-Care in response to COVID-19 and built over 200 virtual bed spaces, two new clinics, an escalation ward at Newmarket hospital, and an additional 9-bedded ITU in the system. All clinics have been reconfigured to allow scheduling of telephone or video appointments and 23 new integrated observation machines have been deployed to support clinical care.

In addition, over 150 new or returning staff have been trained in how to use e-Care.
It is also important to remember that these digital solutions are able to support the remote clinical patient experience teams, who are taking an average of 200 calls a day. These teams are accessing e-Care from home in order to support and provide information to families who are not able to visit their relative in hospital.

2.7 Health information exchange

The health information exchange (HIE) has allowed us to have immediate visibility of COVID-19 test results as we have a direct link to the EPIC EPR in use at Addenbrookes. Within e-Care, our use of this shared information continues to rise, with over 10,000 instances of GP records being viewed within e-Care in April 2020 (up from 4,000 in April 2019). All of the GP practices across the whole of Suffolk now have a two-way link between their clinical records and our e-Care records, which allows for real-time sharing of clinical information; our clinicians now have potential access to over 650 000 GP records through our HIE. We are currently working on linking the GP practices in north east Essex.
In addition, the expansion of the HIE into GP practices in mid and south Essex, and Hertfordshire and west Essex is accelerating.

A new integration server hosted by West Suffolk will be acting as a regional hub to connect patient records at the acute hospitals across Suffolk, Essex, Hertfordshire, initially focused on sharing of core information related to COVID-19 patients. The expansion into the London HIE (OneLondon) for potential access to 8.7 million patient records, including all the major tertiary centres, is now planned. This is moving HIE from a West Suffolk centred model to becoming a key platform for record sharing across the East of England joining up all the main health and social care systems.

2.8 Staff

Our staff have been extraordinarily flexible, especially in the first few weeks of the COVID-19 response; nearly a third of our staff have worked in a different role, or team, within the department in order to support remote access needs, deployment of Teams, e-Care changes, helping with iPads or technical assistance. The management team have instigated daily resourcing and response-management meetings, although these are now reducing and we are beginning to revert to business as usual where it is appropriate to do so.

We are re-planning our 2020/21 projects so we can continue our digital programme, whilst still remaining flexible to support the evolving demands of the organisation.

3 Recommendations

3.1 The board is asked to note the report.

11:10 GOVERNANCE

21. Trust Executive Group report

To ACCEPT the report

For Report

Presented by Craig Black

Board of Directors – 29 May 2020

Agenda item:	21			
Presented by:	Craig Black, Director of Resources			
Prepared by:	Richard Jones, Trust Secretary			
Date prepared:	22 May 2020			
Subject:	Trust Executive Group (TEG) report			
Purpose:	X	For information		For approval

Executive summary

4 May 2020

The meeting was held virtually using MS Teams. Craig Black provided an **introduction** to the meeting emphasising the focus on our COVID response. This recognised that colleagues across the Trust have varying levels of stress and react differently to this situation. The focus of staff support as part of the organisational response was recognised and supported.

An update was provided on the Trust's **COVID response** recognising that TEG members were actively engaged in the structures and activities which are supporting our response. An overview of the key aspects of our response reviewed, including testing, modelling and capacity, PPE and work with care homes. Discussion took place on the early steps being taken to plan for recovery to a 'new normal'.

Quality, operational and financial performance was reviewed from the recent reports. The financial report set out the year end position which was consistent with achieving our control total – a significant achievement for staff across the Trust. The financial pressure as a result of CIVID were discussed, including the increased use of bank and agency staff.

The **red risk report** was received, this included 'top risks' for pathology services, building structure and COVID. There were no new red risks and one draft risk which is subject to review. Discussion took place on the response to the notice received from ESNEFT to end the current pathology contractual arrangements. It was emphasised that we are working with ESNEFT to ensure service continuity and through a clinically-led response consider the options for future service delivery and networking.

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.

The Trust has prepared a plan to make a loss of £14.6m in 2020-21, which does not meet the Financial Improvement Trajectory (FIT, previously Control Total) proposed by NHSI. As a result we will forfeit MRET and FRF totalling £8.8m, meaning our planned deficit is £23.4m. In order to meet this plan the Trust would need to deliver a CIP of £8.7m for 2020-21 (3.4%). Clinical Directors and ADOs within each of the Clinical Divisions have signed off their **income targets and expenditure budgets** for 2020-21. A capital programme of £48.7m has also be prepared for 2020-21.

A report regarding the **building structural risk** was received. While capacity allowed, during the COVID response, remedial works and additional surveying has been prioritised.

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 <u>note</u> the report							

22. Audit Committee report

To ACCEPT the report

For Report

Presented by Angus Eaton

Trust Board Meeting – 29 May 2020

Agenda item:	22			
Presented by:	Angus Eaton, NED and Chair of the Audit Committee			
Prepared by:	Liana Nicholson, Assistant Director of Finance			
Date prepared:	20 May 2020			
Subject:	Audit Committee report - meeting held on 24 April 2020			
Purpose:		For information	X	For approval

Executive summary:

The Audit Committee was held on 24 April 2020. The key issues and actions discussed were:-

- **Board Assurance Framework 'deep dive' – 'Quality and Performance Reporting during COVID' –** This session was led by Joanna Rayner. A discussion was held around the information requirements of the Trust Board during the current pandemic and what board reporting should focus on. It was noted that the Trust is already in early-stage discussions around what the focus on current reporting should be, including a focus on recovery planning, tracking activity, impact on resources and the impact on finances. It was agreed that a draft proposal should be taken to the Trust Board in May.

- **Governance and Assurance – Draft Annual Governance Statement** – Discussions were held around what significant control issues should be included in this Statement for 2019/20 and also the impact of COVID. The areas highlighted to be included were:

  - CQC Report and underlying internal controls associated with their investigations
  - Building structure
  - Pathology on-going risk
  - Access including RTT and cancer treatment
  - Relationships with key-staff groups.

  The final iteration of the Annual Governance Statement will be presented to the Board and Audit Committee in June.

- **Internal Audit and Counter Fraud** - The Internal Audit Progress Report confirmed that the 2019/20 Audit Plan was complete and all reports had been finalised. Follow-up of recommendations had been slightly delayed due to COVID, although four outstanding recommendations had been cleared.

  The report also included the proposed 2020/21 Audit Plan, which also incorporated a plan of when the audits will likely take place during the year. The phasing was being discussed with the Trust to ensure that the programme could stay on track to be delivered during the current pandemic. Two additional reviews were agreed to be completed as a result of COVID around

Financial Governance and Key Controls and compliance against COVID legal advice, including specific documentation of decision making. The Committee agreed for these items to be added to the plan for 2020/21. All audits will be completed virtually where possible for the time being. The Committee approved the 2020/21 Internal Audit Plan.

Internal Audit also presented their Head of Internal Audit Opinion for 2019/20. Internal Audit confirmed that their opinion is that the Trust has an adequate and effective control framework for risk management, governance and internal control, however their work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective.

Counter Fraud presented their Workplan for 2020/21, which was approved by the Committee. Counter Fraud noted that any fraud risks in relation to COVID are being constantly monitored and discussed with the Trust and the Workplan may be adapted throughout the year to address any fraud risks that arise as a result.

- **External Audit** – External Audit provided an update on their 2019/20 Audit Plan and the upcoming audit. They confirmed that they had not identified any further audit risks from their planning. External Audit confirmed that although the audit deadline has been extended, they will be working to the original timetable, although the audit will be completed entirely remotely. They also stated that, as a result of COVID, they will be completing an additional risk assessment on going concern to ensure that the Trust has adequate arrangements in place to continue as a going concern during the current pandemic.
- **Financial Reporting** – A paper was presented to the Committee on year end accounting issues and updates to the 2019/20 timetable. The key changes were discussed being:
  - Changes to the timetable, with the audit deadline now being 25th June
  - IFRS16 (accounting for leases) has been deferred
  - The Trust is no longer required to produce a Quality Report for 2019/20
  - £46.6m of Interim loans held with DHSC will be converted into PDC during 2020/21 and therefore will be shown as a current liability on the Trust's balance sheet.

An update to the going concern disclosure proposed to be included in the draft Accounts was also presented, along with a summary of the Trust's significant accounting estimates, which was a requirement of External Audit to be considered by the Committee.

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

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

Previously considered by:	*This report has been produced for the monthly Trust Board meeting only*
Risk and assurance:	*None*
Legislation, regulatory, equality, diversity and dignity implications	*None*
Recommendation: The Board is asked to: • Receive and note the Audit Committee report for meeting held on 24 April 2020.	

23. Council of Governors report

To RECEIVE report and APPROVE the updated Foundation trust membership

For Approval

Presented by Sheila Childerhouse

Board of Directors – 29 May 2020

Agenda item:	23			
Presented by:	Sheila Childerhouse			
Prepared by:	Georgina Holmes, Foundation Trust Office Manager			
Date prepared:	21 May 2020			
Subject:	Report from Council of Governors, 6 May 2020			
Purpose:		For information	X	For approval

This report provides a summary of the business considered at the Council of Governors meeting held on 6 May 2020 via Microsoft Teams. The report is presented to the board of directors for information to provide insight into these activities. Key points from the meeting were:

- Due to COVID social distancing requirements the public were excluded from to attending this meeting.
- The Chair explained that the Constitution did not account for meetings of the Council of Governors taking place virtually, therefore it would not be possible to make any decisions at this meeting. A paper proposing changes to the Constitution would be considered later on the agenda.
- The Chair paid tribute to all staff for their work in preparing for COVID and their willingness to work in a different way and in different roles. This had led to the achievement of transformation which at other times would have taken months or years. An update was also given on the NED recruitment process.
- The Chief Executive's report provided an update on the particular challenges currently facing the Trust due to COVID and paid tribute to staff for all their work during this very difficult time. He referred to the work that was continuing around the development of a business case for a new hospital and the process for this.
- A presentation was received on COVID; this had been the main focus of the organisation over the past few months. Plans for moving into the recovery phase were now being considered and it was recognised that we would be moving towards a 'new normal' with COVID and non-COVID activities.
- The summary finance and workforce report was received and the key points highlighted.
- The Trust improvement report was received; a number of actions had been paused as a result of the need to focus on COVID; but work continued on actions that it was considered should not be paused. The plan was reviewed on a regular basis to ensure that focus was not lost.
- An update was provided on pathology services and plans for a way forward.
- A proposal for a process to amend the Constitution to enable the Council of Governors to make decisions virtually during situations such as COVID was received and support was given that this should be progressed.
- A report was received from the Engagement committee and the amendments to the Membership Strategy and terms of reference noted. These amendments reflected changes required as a result of social distancing due to COVID. The updated Membership strategy would be submitted to the board for approval on 29 May (**Appendix A**).

- Reports were received from the lead governor and staff governors.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**		**Invest in quality, staff and clinical leadership**		**Build a joined-up future**		
	X		X		X		
Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	 *Deliver personal care*	 *Deliver safe care*	 *Deliver joined-up care*	 *Support a healthy start*	 *Support a healthy life*	 *Support ageing well*	 *Support all our staff*
	X	X	X	X	X	X	X
Previously considered by:	Report received by the Board of Directors for information to provide insight into the activities and discussions taking place at the governor meetings.						
Risk and assurance:	Failure of directors and governors to work together effectively. Attendance by non executive directors at Council of Governor meetings and vice versa. Joint workshop and development sessions.						
Legislation, regulatory, equality, diversity and dignity implications	Health & Social Care Act 2012. Monitor's Code of Governance.						

Recommendation:

The Board is asked to:

- To note the summary report from the Council of Governors.
- To approve amendments to the Membership Strategy for 1 April 2019-31 March 2021 (Appendix A)

Appendix A

Membership Engagement Strategy

April 2019 to March 2021

Engagement Strategy

Contents Page **Page**

1. Introduction

West Suffolk NHS Foundation Trust is committed to being a successful membership organisation and strengthening its links with the local community.

We recognise that we need to commit significant resources both in time and effort to developing our membership and engaging with the public and this strategy sets out the actions that we will take in support of this.

1.1 Purpose of strategy

This strategy outlines our vision and the methods we intend to use to maintain and build a representative and engaged public and staff membership. It also outlines our future plans in terms of recruitment and engagement and how we will measure the success of our membership and future engagement.

Delivery of the future plans set out in this strategy will be achieved through an agreed development plan with defined responsibilities and timescales for delivery.

This is an evolving strategy and will be subject to change as lessons are learnt.

1.2 Engagement objectives

Our vision for engagement within the Trust must underpin the organisational vision, priorities and ambitions. We should support the organisation in achieving the Trust's strategy with our aspirations for engagement.

Deliver for today
• Increase understanding amongst the public and members of the Trust's strategy and the range of services offered by it, including current changes in health services and the challenges the Trust and local health and care services are facing • Maintain our existing membership base and ensure that it reflects the diversity of our local communities
Invest in quality, staff and clinical leadership
• Actively engage with the public and members to understand their views and aspirations for the Trust, including how it can develop and improve • Through our representative membership learn from, respond to and work more closely with our patients, public, staff and volunteers to develop and improve our services
Build a joined up future
• Deliver a range of engagement events and activities to focus on engagement and communicating the strategic plans for the Trust • Strengthen engagement with users of community services and staff delivering these services • Through the range of events and contacts promote wellbeing

Through these objectives the Trust will develop a thriving and influential Council of Governors which is embedded in the local community, is responsive to the aspirations and concerns of the public and members, and works effectively with the Board of Directors.

2.0 The membership

Our Membership allows us to develop a closer relationship with the community we serve. It provides us with an opportunity to communicate with our members on issues of importance about our services.

We recognise that for the membership to be effective and successful, we must provide benefits and reasons for people to join us.

Our members will:

- be kept up to date with what is happening at the Trust by receiving the members' newsletter;
- be able to stand for election as a governor;
- have the opportunity to vote in the elections to the Council of Governors;
- be able to learn more about our services by attending member events, including Council of Governor meetings;
- have the opportunity to be included in consultation events on hospital and service developments – both internally for staff and externally for our patients and public;
- have the opportunity to pass on their views and suggestions to governors;
- be invited to attend the Annual Members' Meeting.

Membership is free and there is no obligation for members to get involved apart from receiving the newsletter.

2.1 Becoming a member

Our potential members can be drawn from the following:

- public, including patients who live within our membership area (**public members**)
- staff who are employed by the Trust, or individuals that meet the criteria under 2.2.2 (**staff members**)

An individual who satisfies the criteria for membership of the staff constituency may not become or continue as a member of the public constituency. Members can join more than one foundation Trust.

All members must be 16 years of age or over.

A person can become a member by:

- completing a membership application form, which is available on our website, by request from the membership office or from the hospital's main reception;
- joining 'online' via the Trust's website at www.wsh.nhs.uk;
- e-mailing membership. foundationtrust@wsh.nhs.uk;
- calling the membership office on 0370 707 1692.

2.2 Defining our membership

2.2.1 Public

Patients and members of the public who reside in the following areas are eligible to join our public constituency: Babergh (all wards); Braintree (selected wards); Breckland (selected wards); East Cambridgeshire (selected wards); Forest Heath (all wards); Ipswich (all wards); Kings Lynn and West Norfolk (selected wards); Mid Suffolk (all wards); South

Norfolk (selected wards); St Edmundsbury (all wards); Suffolk Coastal (all wards) and Waveney (all wards).

Appendix 1 provides a detailed breakdown of eligible wards for our public constituency. Public members are recruited on an opt-in basis.

As we continue to develop and provide more services in community settings the Trust recognises that this may mean that services grow beyond the current boundaries of the organisation. Therefore the Trust expanded its membership area in 2016/17 and will continue to review this on an annual basis to ensure it is representative of the area served by the Trust.

2.2.2 Staff

To be eligible to be a staff member, people must either:

- be employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or have been continuously employed by the Trust under a contract of employment for at least 12 months; or

- exercise functions for the purposes of the Trust, without a contract of employment, continuously for a period of at least 12 months. For clarity this does not include individuals who exercise functions for the purposes of the Trust on a voluntary basis.

All staff automatically become members unless they choose to opt-out of the scheme.

3.0 Recruitment of members

We wish to encourage and develop a strong sense of community involvement with the membership. Therefore, we will continue to actively recruit new members.

Our aim is to have a membership that is informed and engaged in our activities and members who feel part of our organisation.

3.1 Methods of recruitment

Our initial membership recruitment drive began as an integral part of our consultation process.

While we undertook some direct mail recruitment campaigns in the early days, more recently we have found that the most effective method of recruitment is face to face. This can be done internally within hospital or out in the community.

While social distancing is being applied as part of the COVID-19 response it will not be possible to undertake our usual face-to-face engagement activities. Changes in working practices as a result of COVID-19 will also impact on the nature of engagement activities e.g. greater use of telephone consultations will mean that more patients receive their care and treatment without the need to come onto the hospital site. Recognising this there will be a need to review how changes to patient pathways may impact on our approaches to engagement, with the expectation of a greater focus on digital engagement in the future.

Methods of recruitment used in the past include:

- attending public meetings and events including festivals, stands in sports & healthy living events and recruitment fairs;
- targeted recruitment of staff members' friends and family;

- using local newspapers;
- on-line recruitment through the Trust's website;
- through a mail-shot to all households in the membership area;
- in-house e.g. Courtyard Café, Friends shop and outpatients

3.2 Who is responsible for recruiting members?

The Board of Directors has overall responsibility for the membership strategy.

The Engagement Committee of the Council of Governors advises on where the Trust should focus its effort on recruitment to ensure we have a balanced membership, and it is the responsibility of all governors and the FT Office Manager to actively recruit members.

Staff and volunteers are also encouraged to recruit members; for example family members, friends or patients and members of the public visiting the Trust.

3.3 Recruitment plan

We aim to recruit new members year on year to maintain our public membership at the current numbers of engaged members. As part of the recruitment plan experience has shown that engaging with the public is a very effective way of recruiting new members and gaining their views on West Suffolk Hospital and the service we provide in the community (covering both the west and east of the county).

3.3.1 Public members

Direct recruitment plan

- active engagement and recruitment within the hospital and other healthcare environments e.g. courtyard café, out-patient clinics and healthy living centres
- providing literature to staff working in community settings to share with service users and their families
- public education events e.g. "medicine for members"
- voluntary organisations – ensuring inclusion from ethnic and marginalised groups of people
- education facilities e.g. school talks and college events
- local non-NHS patient groups e.g. support groups
- sports organisations e.g. leisure centres, rugby and football clubs
- PALS office
- Work with partner organisations to establish best practice in membership recruitment e.g. NHS Providers and other NHS FTs.
- Encourage former staff members to become public members on leaving the Trust

Indirect recruitment plan

- development of digital communication; particularly to assist in increasing engagement with younger people and ethnic groups.
- website
- consider inclusion with other patient information e.g. bedside lockers for inpatient areas
- posters and leaflets in clinic and outpatient areas
- posters in GP surgeries, dentists, opticians and pharmacists

Media coverage

- membership newsletter

- local newspaper coverage e.g. the Bury Free Press and East Anglian Daily Times (EADT)
- local radio e.g. Radio Suffolk, Radio West Suffolk
- community newsletter coverage, including Parish Council and local Council information/resource guides

3.3.2 Staff

Staff are automatically members unless they choose to opt-out. New members to the Trust will receive information from HR in their induction pack explaining the benefits of membership. An individual who satisfies the criteria for membership of the staff constituency may not become or continue as a member of the public constituency.

We will seek to ensure that no more than 1% of staff opt-out of membership.

4.0 Engaging with public and members

Engagement with our members is as important as recruitment, to ensure that we have an effective and active membership. We will work with the patient experience team to ensure that Governors contribute to and support the range of engagement activities undertaken by the Trust (as set out in the new Experience of Care Strategy).

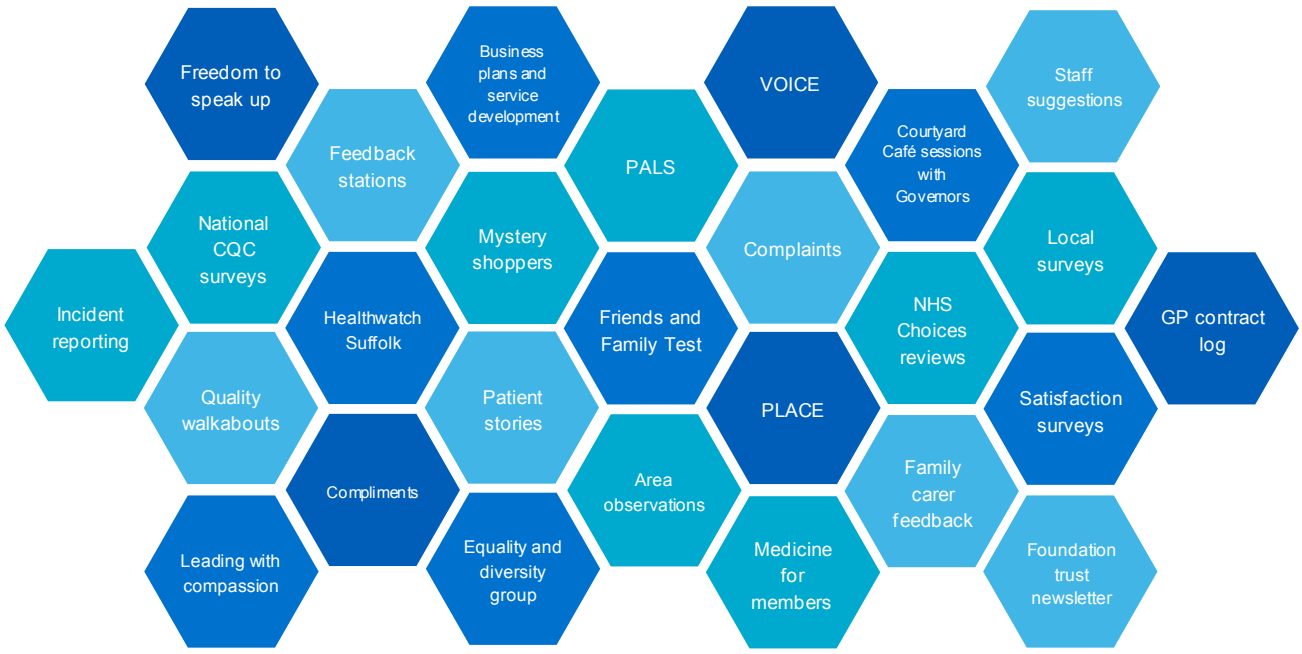


Figure 1: Feedback collection methods from Experience of Care Strategy

4.1 Members' newsletter

The membership newsletter is distributed to all members.

Staff are able to access the newsletter via a link which is included in weekly staff bulletin (Green Sheet) when it is published on the website.

Hard copies are also available in key staff areas including Time Out and in patient waiting areas.

The newsletter provides an opportunity to communicate key issues and developments, including news and "dates for the diary".

4.2 Public and Member events

When COVID-19 social distancing requirements allow it is expected to continue to hold regular events for the public and members. Suggestions for topics will be based on the most popular areas of interest of the members and by the views of governors. Subjects may also be chosen from topical issues, such as quality accounts.

These events will be advertised in the members' newsletter and on the website. They will also be advertised in the weekly staff bulletin ("Green Sheet") and by posters displayed within the Trust.

Members who have expressed an interest in a particular service or area of interest will be invited to relevant activities.

4.3 Staff involvement

Staff members will be encouraged to take part in public and member events, as it is an opportunity for departments to raise awareness of the services they provide, to highlight benefits of being treated at the Trust and to answer questions from members. It will also be a chance for us to receive valuable feedback from the public and our members.

4.4 Engagement plan

Positive engagement with our members is extremely important. The Engagement Committee of the Council of Governors have considered how we can most effectively engagement with our membership.

As described member recruitment and engagement are often most effective when undertaken together. Therefore the direct recruitment plans set out in section 3.3.1 will also in effect provide effective engagement activities. Future engagement plans with our members will also include:

- the members' newsletter to be distributed to all members
- development of digital communication
- review how changes to patient pathways as a result of COVID-19 may impact on our approaches to engagement
- regular member events with suggestions from governors of recommendations from their members for future member events e.g. "medicine for members"
- staff governors holding staff member engagement sessions
- staff governors to communicate to staff via the "Green Sheet"
- greater use of electronic communication with members
- the annual members' meeting – this is an opportunity for members to hear more about the Trust's achievements plus the opportunity to ask questions
- working with partner organisations to establish best practice in membership engagement e.g. NHS Providers and other NHS FTs
- through active engagement gathering information on patients and the public's expectations and/or experiences of the service we provide in the hospital and community e.g. Courtyard café, quality walkabouts and area observations. The results of which are fed back to the Patient & Carers Experience Group.

The Trust is responsible for the delivery of community services in the west of Suffolk and the engagement delivery plan continues to be developed to ensure a focus on the care we provide in the community and in partnership with the West Suffolk Alliance.

The Trust also has a role to play in promoting prevention and a healthy lifestyle. This will be done by working with our partners to engage with the public in promoting prevention and a healthy lifestyle.

5.0 The membership register

We maintain a register of staff and public members and this is available to the public. All members are made aware of the existence of the public register and have the right to refuse to have their details disclosed (General Data Protection Regulation.).

The public register is maintained on our behalf by Civica and contains details of the member's name and the constituency to which they belong. Eligible members of the public constituency who complete a membership application form will be added to the register of members.

The staff register is maintained by the Trust's HR department. Eligible staff will automatically be added to the register, unless they 'opt out'.

The public register is validated prior to any mailing to ensure that it remains accurate. Details of members who have moved away or died are removed from the register.

6.0 Monitoring success

The membership strategy will be monitored on behalf of the Board of Directors by the Engagement Committee of the Council of Governors.

The FT Office Manager and the Engagement Committee will also undertake a key role in leading and managing the implementation of this strategy and its future development.

An annual review of the strategy will take place by the Engagement Committee.

6.1 How will the success be measured?

The success of the strategy will be measured by the following criteria:

Criteria	**As at** 31 March 2020	**Target** (Mar 2021)
1. Achievement of the recruitment target: a. Total number of Public members b. Staff opting out of membership	 **6295** **<1%**	 6,000 <1%
2. Achieve a representative membership for our membership area, Priorities for action: a. Age – recruitment of under 50s b. Engagement and recruitment events in all market towns of Membership area (Thetford, Newmarket, Stowmarket, Haverhill and Sudbury)	 **1212** **20%**	 1,250 100% (40%)
3. An engaged membership measured by: a. number of member events b. member attendance – total all events c. annual members' meeting attendance (each year)	 **2** **362*** **295 (2019)**	 6 (3) 800* (400) 200

* Includes people attending Annual Members' Meeting
Figures shown in brackets have been adjusted due to COVID-19

A review of the membership recruitment targets will take place each year as part of the annual plan submission to NHS Improvement.

Appendix 1

PUBLIC CONSTITUENCY OF THE TRUST

Patients and members of the public who reside in the following areas are eligible to join our public constituency:

Babergh:	Alton, Berners, Boxford, Brett Vale, Brook, Bures St Mary, Chadacre, Dodnash, Glemsford and Stanstead, Great Cornard (North Ward), Great Cornard (South Ward), Hadleigh (North Ward), Hadleigh (South Ward), Holbrook, Lavenham, Leavenheath, Long Melford, Lower Brett, Mid Samford, Nayland, North Cosford, Pinewood, South Cosford, Sudbury (East Ward), Sudbury (North Ward), Sudbury (South Ward), Waldingfield.
Braintree:	Bumpstead, Hedingham and Maplestead, Stour Valley North, Stour Valley South, Upper Colne, Yeldham
Breckland:	Conifer, East Guiltcross, Harling and Heathlands, Mid Forest, Thetford-Abbey, Thetford-Castle, Thetford-Guildhall, Thetford-Saxon, Watton, Wayland, Weeting, West Guiltcross
East Cambridgeshire:	Bottisham, Burwell, Cheveley, Dullingham Villages, Fordham Villages, Isleham, Soham North, Soham South, The Swaffhams
East Suffolk:	Aldeburgh, Beccles North, Beccles South, Blything, Bungay, Carlton, Carlton Colville, Deben, Felixstowe East, Felixstowe North, Felixstowe South, Felixstowe West, Framlingham, Fynn Valley, Gunton & Corton, Grundisburgh, Hacheston, Halesworth, Harbour, Kesgrave East, Kesgrave West, Kessingland Kirkley, Kirton, Leiston, Lothingland Martlesham, Melton, Nacton & Purdis Farm, Normanston, Orford & Eyke, Oulton, Oulton Broad, Pakefield, Peasenhall & Yoxford, Rendlesham, Saxmundham, Southwold & Reydon, St Margaret's, The Saints, The Trimleys, Tower, Wainford, Wenhaston & Westleton, Whitton,Wickham Market, Woodbridge Worlingham, Wrentham.
Ipswich	Alexandra, Bixley, Bridge, Castle Hill, Gainsborough, Gipping, Holywells, Priory Heath, Rushmere, St John's, St Margaret's, Sprites, Stoke Park, Westgate, Whitehouse, Whitton.
King's Lynn and: West Norfolk	Denton
Mid Suffolk:	Bacton & Old Newton, Badwell Ash, Barking & Somersham, Bramford & Blakenham, Claydon & Barham, Debenham, Elmswell & Norton, Eye, Fressingfield, Gislingham, Haughley & Wetherden, Helmingham & Coddenham, Hoxne, Mendlesham, Needham Market, Onehouse, Palgrave, Rattlesden, Rickinghall & Walsham, Ringshall, Stowmarket Central, Stowmarket North,

	Stowmarket South, Stowupland, Stradbroke & Laxfield, The Stonhams, Thurston & Hessett, Wetheringsett, Woolpit, Worlingworth.
South Norfolk:	Bressingham and Burston, Diss and Roydon
West Suffolk:	Abbeygate, All Saints, Bardwell, Barningham, Barrow, Brandon East, Brandon West, Cavendish, Chedburgh, Clare, Eastgate, Eriswell & the Rows, Exning, Fornham, Great Barton, Great Heath, Haverhill East, Haverhill North, Haverhill South, Haverhill West, Horringer and Whelnetham, Hundon, Iceni, Ixworth, Lakenheath, Kedington, Manor, Marham Park, Market, Minden, Moreton Hall, Northgate, Pakenham, Risby, Red Lodge, Risbygate, Rougham, Southgate, St Marys, Severals, South, St Olaves, Stanton, Westgate, Wickhambrook, Withersfield

24. Trust constitution update

To APPROVE the updated constitution

For Approval

Presented by Richard Jones

Board of Directors – 29 May 2020

Agenda item:	24			
Presented by:	Richard Jones, Trust Secretary			
Prepared by:	Richard Jones, Trust Secretary			
Date prepared:	22 May 2020			
Subject:	Trust constitutional amendments			
Purpose:		For information	X	For approval

The Board are asked to review the attached supporting paper and the recommended amendments to Annex 7 (Standing Orders for the Practice and Procedure of the Council of Governors) of the Trust's Constitution to allow the Governors at the discretion of the Chairman to:

(1) attend meetings of the Council of Governors by electronic communication methods;

(2) vote and make decisions where not physically present at a meeting (electronically by e-mail voting or by postal voting); and

(3) pass written resolutions.

These amendments are required to allow the Council of Governors (CoG) to undertake its statutory functions, role and obligations and to continue in a 'business as usual' way during the COVID emergency.

We have taken legal advice on the approach being adopted to amend the constitution and the changes themselves. Given the public health emergency, we are undertaking an email ballot of our Governors for the amendments to the Constitution. This approach has been deemed appropriate by our legal advisers and the results of the ballot will be available at the Board meeting.

With Governor and Board approval of the amendments the updated Constitution will come into immediate effect.

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:	Council of Governors. Trust's legal advisors.

Risk and assurance:	Council of Governors unable to undertake its statutory duties.
Legislation, regulatory, equality, diversity and dignity implications	Trust Constitution. Health & Social Care Act 2012. NHSI's Code of Governance.

Recommendation:

The Board is asked to approve the amendments to the Trust Constitution

SUBJECT:	Ballot to amend the Trust's constitution
PREPARED BY:	Richard Jones, Trust Secretary & Head of Governance
FOR:	**Approval** of the Proposed Amendments to Annex 7 (Standing Orders for the Practice and Procedure of the Council of Governors) of the Trust's Constitution

During this time of the Coronavirus pandemic public health emergency and social distancing, as with many other public bodies, the Trust needs to adjust normal working practices in order for it to complete its statutory functions, roles and obligations, and to continue in a 'business as usual' way.

Accordingly, for the Council of Governors (CoG) to be able to continue to meet and to take important decisions, it must arrange to meet remotely during this time of social distancing whilst face-to-face formal meetings are impossible or impractical.

The proposed amendments to the Constitution will give the Governors the opportunity to:

1. attend formal meetings by electronic communication methods;

2. vote and make decisions where Governors are not physically present at a meeting (i.e. electronically by e-mail voting or by postal voting); and

3. pass written resolutions.

The proposed amendments allow the Chair to engage these alternative meeting and voting options at their absolute discretion. The Chair's discretion applies regardless of whether these alternative methods apply to the mode of attending a meeting by the entire CoG or for a select number of Governors to attend by alternative methods. If the Chair exercises their discretion to hold a postal or e-mail vote, the method selected will be the only method of voting on the issue.

The power to make amendments to the Constitution is detailed at paragraph 46.2 of the Constitution. Amendments to the Constitution made under paragraph 46.1 take effect as soon as the conditions in that paragraph are satisfied. The conditions being that more than half of the members of the Council of Governors of the Trust approve the amendments; and more than half the members of the Board of Directors of the Trust approve the amendments.

In this instance, the changes are not in relation to the powers or duties of the CoG, but simply extent the flexibility afforded to the CoG in the way in which it exercises its functions. Accordingly, the decision does not require approval by the Members of the Trust.

The proposed amendments

The proposed amendments relate to **Annex 7, Standing Orders for the Practice and Procedure of the Council of Governors**, of the Constitution (the "**Proposed Amendments**") in summary are as follows:

- SO 3.7 allows for notice of a meeting to be delivered to each Governor by e-mail communication to the valid email address of each Governor.

- SO 3.10 allows for agendas and supporting papers to be dispatched by either post or e-mail to the Governors.

- SO 3.11 states that where the meeting is convened by electronic communication, a public notice of the time and place of the meeting and public part of the agenda does not have to be displayed at the Trust's office. Notices will still appear on the Trust's web site.

- SO 3.17 details what is meant be electronic communication i.e. by means of an electronic communications network or by other means in an electronic form. Further that it is in the Chair's absolute discretion for a meeting of the CoG to be held either: (a) exclusively be electronic communication; or (b) where a select number of Governors are present at the meeting by electronic communication whilst the majority attending are physically together.

  A meeting convened by electronic communication is deemed to be held where the Governors resolve it to be held, alternatively in the absence of such a resolution, it is deemed to have taken place at the location where a majority of the Governors attending the meeting are physically present, or in the default of such a majority the place at which the Chair is physically present. Further the quorum of the meeting must be present and maintained throughout during a meeting convened by electronic communication and the minutes of the meeting must state that it was held by electronic communication.

- SO 3.25 allows a vote to be held by e-mail vote or by way of written resolution at the discretion of the Chair.

- SO 3.30 details that at the discretion of the Chair, the Chair may specify in a notice of a meeting any matter which requires approval by a written resolution. Such matters that as may be approved by written resolution require at least three - quarters of the Governors, and a majority of the elected Governors to approve the written resolution in a timescale imposed in the notice.

- SO 3.31 outlines the Special Provisions relating to the Chair exercising their discretion to call a postal or e-mail vote, which can be exercised at any time, and for any reason. The votes are to be returned to the Trust Secretary or other relevant employee of the Trust administering or counting the e-mail votes by the deadline date. Where the Chair exercises their discretion to hold an email vote, this e-mail vote will form the only method of voting. An individual Governor may only cast one vote unless a second further vote is required owing to the previous vote not being passed. Once a postal or e-mail vote has been cast by a Governor, the vote cannot be revoked or altered in any way.

- SO 3.31.4 provides the Protocol for voting by post, whereby the Trust Secretary is to publish:

- a notice of the postal vote stating the details of the motion;
- the date and time at which postal votes are required to be sent out to the Governors; and
- the address including the date and time by which they must be received by the Trust Secretary, including the contact details of the Trust Secretary.

As soon as is reasonably practicable on or after the publication of the notice of the postal vote, the Trust Secretary is to deliver to, or send by post to the usual place of residence of every Governor, so as to be available to him at least 7 clear days before the deadline date:

- a ballot paper (with ballot paper envelope);
- an ID declaration form (if required);
- information about the motion to be voted on;
- a covering return envelope providing the address for the return of the ballot paper;
- a pre-paid postage envelope for return to that address; and
- clear instructions so as to get the authenticated vote to the Trust Secretary by the deadline date.

- SO 3.31.6 provides the Protocol for voting by e-mail, whereby the Trust Secretary is to email:

  - a notice of the e-mail vote to the valid email address of every Governor stating the details of the motion, date and time at which the e-mail votes are required to be returned;
  - the e-mail address for return of the e-mail vote; and
  - contact details of the Trust Secretary.

  As soon as reasonably practicable on or after the e-mail of the notice of the email vote, the Trust Secretary is to email to the valid email address of every Governors at least 7 clear days before the deadline date, the instructions as to how the Governor is to cast their vote (and related documentation i.e. a ballot paper, information about the motion, ID declaration form (if required)).

The text of the Proposed Amendments are appended to this report (Annex).

A meeting of the Board of Directors is due to take place on Friday 29th May 2020 where the Directors will vote on the Proposed Amendments.

The Proposed Amendments to the Constitution will only take effect if more than half of the members of the Council of Governors of the Trust approve the amendments; and more than half the members of the Board of Directors of the Trust approve the amendments to the Constitution.

ANNEX 7 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

1. INTERPRETATION

1.1 Save as otherwise permitted by law, at any meeting the Chairman of the trust shall be the final authority on the interpretation of Standing Orders (of which he should be advised by the Chief Executive or Secretary).

1.2 Any expression to which a meaning is given in the National Health Service Act 2006 ("2006 Act") or in the Constitution shall have the same meaning in these Standing Orders.

2. THE COUNCIL OF GOVERNORS

2.1 **Composition of the Council of Governors -** The composition of the Council of Governors shall be in accordance with the Constitution.

2.2 **Appointment of the Chairman and members –** The Chairman is appointed by the Council of Governors, as set out in the Constitution.

2.3 **Terms of Office of the Chairman and members-** The regulations setting out the period of tenure of office of the Chairman and members and for the termination or suspension of office of the Chairman and members are contained in the Constitution.

2.4 **Appointment and Powers of Deputy Chairman –** subject to Standing Order 2.5 below; members of the Council of Governors may appoint one of the Non- Executive Directors, to be Deputy Chairman for such period, not exceeding the remainder of his term as a Non-Executive Director of the trust, as they may specify on appointing him.

2.5 Any Non-Executive Director so appointed may at any time resign from the office of Deputy Chairman and the Council of Governors may thereupon appoint another Non Executive Director as Deputy Chairman in accordance with the provisions of Standing Order 2.4.

2.6 Where the Chairman of the trust has died or has ceased to hold office or where he has been unable to perform his duties as Chairman owing to illness or any other cause, the Deputy Chairman shall act as Chairman until a new Chairman is appointed or the existing Chairman resumes his duties, as the case may be, and references to the Chairman in these Standing Orders shall, so long as there is no Chairman able to perform his duties, be taken to include references to the Deputy Chairman.

3. MEETINGS OF THE COUNCIL OF GOVERNORS

3.1 *Admission of the Public and the Press* – The public and representatives of the press shall be afforded facilities to attend all formal meetings of the Council of Governors but shall be required to withdraw upon the Council of Governors (including a majority of the public Governors present at the meeting) resolving as follows:

"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"

3.2 The Chairman (or Deputy Chairman) shall give such directions as he thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the trust's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Council of Governors (including a majority of the public Governors present at the meeting) resolving as follows:

"That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Council of Governors to complete business without the presence of the public"

3.3 Nothing in these Standing Orders shall require the trust to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place, without the prior agreement of the Council of Governors.

3.4 **Calling Meetings** – Meetings of the Council of Governors shall be held at such times and places as the Council of Governors may determine.

3.5 The Council of Governors will hold at least four meetings each year, one of which is the Annual Members Meeting.

3.6 The Chairman of the trust may call a meeting of the Council of Governors at any time. If the Chairman refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of members of the Council of Governors, has been presented to him or her, or if, without so refusing, the Chairman does not call a meeting within seven days after such requisition has been presented to him at the trust's headquarters, such one-third or more members may forthwith call a meeting.

3.7 **Notice of Meetings** - Before each meeting of the Council of Governors, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chairman or by an officer authorised by the Chairman to sign on his behalf shall be delivered to every Governor, by e-mail to the valid email address or sent by post to the usual place of residence of each Governor, so as to be available to him at least five days before the meeting.

3.8 Want of service of the notice on any Governor shall not affect the validity of a meeting.

3.9 In the case of a meeting called by Governors in default of the Chairman, the notice shall be signed by those Governors and no business shall be transacted at the meeting other than that specified in the notice.

3.10 Agendas will be sent by post or e-mail to Governors five days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be dispatched no later than three days before the meeting, save in emergency. A notice shall be presumed to have been served one day after posting or delivery of e-mail.

3.11 Before each meeting of the Council of Governors a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the trust's office at least three days before the meeting~~.~~, save where the meeting is convened by electronic communication.

3.12 **Setting the Agenda** - The Council of Governors may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted. (Such matters may be identified within these Standing Orders or following subsequent resolution shall be listed in an Appendix to the Standing Orders).

3.13 A Governor desiring a matter to be included on an agenda shall make his request in writing to the Chairman at least 10 (ten) clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than ten days before a meeting may be included on the agenda at the discretion of the Chairman.

3.14 **Petitions** - where a petition has been received by the trust the Chairman of the Council of Governors shall include the petition as an item for the agenda of the next Council of Governors meeting.

3.15 **Chairman of Meeting** - At any meeting of the Council of Governors, the Chairman, if present, shall preside. If the Chairman is absent from the meeting the Deputy Chairman, if there is one and he is present, shall preside. If the Chairman and Deputy Chairman are absent another Non Executive Director as the members present shall choose who shall preside.

3.16 If the Chairman is absent temporarily on the grounds of a declared conflict of interest the Deputy Chairman, if present, shall preside. If the Chairman and Deputy Chairman are disqualified from participating, such Governor from the Public Constituency as the Governors present shall choose by majority vote who shall preside.

3.17 **Meetings: electronic communication -** In this SO, "electronic communication" means a communication transmitted (whether from one person to another, from one device to another or from a person to a device or vice versa): (a) by means of an electronic communications network; or (b) by other means but while in an electronic form.

3.17.1 In the Chairman's absolute discretion, a meeting of the Council of Governors may be held by way electronic communication. A meeting of the Council of Governors held by way of electronic communication can be (a) held exclusively by electronic communication; or (b) where a select number of Governors are present at the meeting by way of electronic communication whilst the majority attending are physically present at the meeting of the Council of Governors.

3.17.2 A Governor in electronic communication with the Chairman and all other parties to a meeting of the Council of Governors or of a committee or sub-committee of the Governors shall be regarded for all purposes as personally attending such a meeting provided that, but only for so long as, at such a meeting he has the ability to communicate interactively and simultaneously with all other parties attending the meeting including all persons attending by way of electronic communication.

3.17.3 A meeting at which one or more of the Governors attends by way of electronic communication is deemed to be held at such a place as the Governors shall at the said meeting resolve. In the absence of such a resolution, the meeting shall be deemed to be held at the place (if any) where a majority of the Governors attending the meeting are physically present, or in default of such a majority, the place at which the Chairman of the meeting is physically present.

3.17.4 Meetings held in accordance with this SO are subject to SO 3.37 (Quorum). For such a meeting to be valid, a quorum must be present and maintained throughout the meeting.

3.17.5 The minutes of a meeting held in this way must state that it was held by electronic communication and that the Governors were all able to hear each other and were present throughout the meeting.

~~3.16~~3.18 **Notices of Motion** – A member of the Council of Governors desiring to move or amend a Motion shall send a written notice thereof at least 10 (ten) clear days before the meeting to the Chairman, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any Motion being moved during the meeting, without notice on any business mentioned on the agenda.

~~3.17~~3.19 **Withdrawal of Motion or Amendments –** A Motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and consent of the Chairman.

~~3.18~~3.20 **Motion to Rescind a Resolution –** Notice of Motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the member who gives it and also the signature of four other Governors. When any such Motion has been disposed of by the Council of Governors, it shall not be competent for any Governor other than the Chairman to propose a Motion to the same effect within six months however the Chairman may do so if he considers it appropriate.

~~3.19~~3.21 **Motions -** The mover of a Motion shall have a right of reply at the close of any discussion on the Motion or any amendment thereto.

~~3.20~~3.22 When a Motion is under discussion or immediately prior to discussion it shall be open to a member to move:

- An amendment to the Motion,
- The adjournment of the discussion or the meeting
- That the meeting proceed to the next business (*)
- The appointment of an ad hoc committee to deal with a specific item of business
- That the Motion be now put (*)
- A Motion resolving to exclude the public (including the press).

* In the case of sub-paragraphs denoted by (*) above to ensure objectivity Motions may only be put by a member who has not previously taken part in the debate and who is eligible to vote.

No amendment to the Motion shall be admitted if, in the opinion of the Chairman of the meeting, the amendment negates the substance of the Motion.

~~3.21~~3.23 **Chairman's Ruling -** Statements of members of the Council of Governors made at meetings of the Council of Governors shall be relevant to matter under discussion at the material time and the decision of the Chairman of the meeting on questions of order, relevancy, regularity and any other matters shall be final.

~~3.22~~3.24 **Voting -** every question at a meeting shall be determined by either a majority of the votes of the Governors present, qualified to vote on the issue and voting on the question unless the Constitution requires otherwise. In the case of the number of votes for and against a Motion being equal, the Chairman of the meeting, or the person presiding over that issue if the Chairman is absent, shall have a second or casting vote.

~~3.23~~3.25 All questions put to the vote shall, at the discretion of the Chairman of the meeting, be determined by oral expression or by a show of hands, unless at the discretion of the Chairman, a vote is held by postal or e-mail vote, or by way of written resolution. A paper ballot may also be used if a majority of the Governors present so request. At all times, no Governor may vote by proxy.

~~3.24~~3.26 If at least one-third of the Governors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each governor voted or abstained.

~~3.25~~3.27 If a Governor so requests, his or her vote shall be recorded by name upon any vote (other than by paper ballot).

~~3.26~~3.28 In no circumstances may an absent Governor vote by proxy. Absence is defined as being absent at the time of the vote.

3.29 A person attending the Council of Governors to represent a Governor during a period of incapacity or temporary absence without formal appointment as a Governor may not exercise the voting rights of the Governor. A person's status when attending a meeting shall be recorded in the minutes.

3.30 **Written resolution** - at the discretion of the Chairman, the Chairman may specify in a notice of a meeting any matter which requires approval by a written resolution and such a matter may be approved in writing provided that at least three quarters of the Governors, and a majority of the elected Governors, approve the resolution in writing within the timescale imposed in such a notice.

3.31 **Special provisions relating to the Chairman exercising their discretion to call a postal or e-mail vote**

3.31.1 The Chairman's discretion to hold a postal or e-mail vote may be exercised at any time, and for any reason.

3.31.2 If the Chairman exercises their discretion to hold a postal or e-mail vote, then the Governors must vote by post or e-mail by sending their postal or e-mail vote back to the Trust Secretary or an employee of the trust holding a paid appointment or office within the trust who is administering and counting the postal or e-mail votes by the Deadline Date. For the avoidance of doubt, if the Chairman exercises their discretion to hold a postal or e-mail vote, this postal or e-mail vote will form the only method of voting and no meeting will be held.

3.31.3 An individual Governor may only cast one vote unless a second further vote is required owing to the previous vote not being passed. Once a postal or e-mail vote has been cast by a Governor, the vote cannot be revoked or altered in any way.

3.31.4 **Protocol for voting by post** - The Trust Secretary is to publish a notice of the postal vote stating:

3.31.4.1 the details of the Motion;

3.31.4.2 the date and time at which postal votes are required to be sent out to the Governors;

3.31.4.3 the address for return of postal votes including the date and time by which they must be received by the Trust Secretary ("**Deadline Date**"); and

3.31.4.4 the contact details of the Trust Secretary.

3.31.5 As soon as reasonable practicable on or after the publication of the notice of postal vote, the Trust Secretary is to deliver to, or send by post to the usual place of residence of every Governor, so as to be available to him at least 7 (seven) clear days before the Deadline Date, the following information:

3.31.5.1 a ballot paper and ballot paper envelope (ballot paper envelope must have clear instructions to the Governor printed on it, instructing the Governor to seal the ballot paper inside the envelope once the ballot paper has been marked);

3.31.5.2 an ID declaration form (if required);

3.31.5.3 information about the Motion to be voted on; and

3.31.5.4 a covering return envelope providing:

3.31.5.4.1 the address for the return of the ballot paper printed on it;

3.31.5.4.2 pre-paid postage for return to that address;

3.31.5.4.3 clear instructions, either printed on the covering return envelope or elsewhere, instructing the Governor to seal a completed ID declaration form (if required) and the ballot paper envelope, with the ballot paper sealed inside it and return to the Trust Secretary by the Deadline Date.

3.31.6 **Protocol for voting by e-mail** – The Trust Secretary is to email a notice of the email vote to the valid email address of every Governor stating:

3.31.6.1 The details of the Motion;

3.31.6.2 The date and time at which the e-mail votes are required to be sent out to the Governors;

3.31.6.3 The e-mail address for return of e-mail votes includes the date and time by which they must be received by the Trust Secretary; and

3.31.6.4 The contact details of the Trust Secretary.

3.31.7 As soon as is reasonably practicable on or after the e-mail of the notice of the e-mail vote, the Trust Secretary is to e-mail to the valid e-mail address of every Governor, so as to be available to him at least 7 (seven) clear days before the Deadline Date, the following information:

3.31.7.1 a ballot paper attachment in accessible electronic format with clear instructions as to how to cast their vote by e-mail;

3.31.7.2 an ID declaration form (if required);

3.31.7.3 information about the Motion; and

3.31.7.4 a covering email providing:

3.31.7.4.1 the e-mail address for return of the ballot paper;

3.31.7.4.2 clear instructions for the Governor as to how to return their e-mail vote to the Trust Secretary by the Deadline Date.

~~3.27~~3.32 **Minutes -** The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it.

~~3.28~~3.33 No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

~~3.29~~3.34 Minutes shall be circulated in accordance with Governors' wishes. Where providing a record of a public meeting the minutes shall be made available to the public as required by Code of Practice on Openness in the NHS.

~~3.30~~3.35 **Variation and Amendment of Standing Orders –** will be undertaken in accordance with paragraph 46 of the Constitution.

~~3.31~~3.36 **Record of Attendance –** the names of the Chairman and Governors present at the meeting shall be recorded in the minutes.

~~3.32~~3.37 **Quorum –** No business shall be transacted at a meeting unless at least one third of the whole number of the Governors are present, the majority of whom are from the public constituency. If at any meeting there is no quorum within 30 minutes of the time fixed for the start of the meeting, the meeting shall stand adjourned for 7 days and upon reconvening, those present shall constitute a quorum.

~~3.33~~3.38 If the Chairman or Governor has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see Standing Orders 6 or 7) he shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. The meeting must then proceed to the next business.

4. ARRANGEMENTS FOR DELEGATION

4.1 **Committees –** The Council of Governors shall agree from time to time to the delegation of matters for consideration by committee, or sub-committees which it has formally constituted in accordance with the Constitution. The constitution and terms of reference of these committees or sub-committees and their specific powers shall be approved by the Council of Governors. Such committees and subcommittees shall be advisory only and not decision-making.

4.2 **Overriding Standing Orders –** If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Council of Governors for action or ratification. All members of the Council of Governors and staff have a duty to disclose any non-compliance with these Standing Orders to the Chairman as soon as possible.

5. COMMITTEES

5.1 Subject to any guidance or best practice advice as may be issued by Monitor, the Council of Governors may and, if directed by Monitor, shall appoint committees of the Council of Governors to assist it in the proper performance of its functions, consisting wholly or partly of the Chair, Governors, and others, including Advisers.

5.2 A committee appointed under Standing Order 5.1 may, subject to such directions as may be given by the Council of Governors, appoint sub-committees consisting wholly or partly of members of the committee.

5.3 These Standing Orders, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Council of Governors with the terms “Chairman” to be read as a reference to the Chairman of the committee, and the term “Governor” to be read as a reference to a member of the committee as the context permits. There is no requirement to hold meetings of committees, established by the Council of Governors in public.

5.4 Each such committee shall have such terms of reference and powers and be subject to such conditions as the Council of Governors shall decide and shall be in accordance with the 2006 Act, the Constitution, and any best practice advice and/or guidance issued by Monitor, but the Council of Governors shall not delegate to any committee any of the powers or responsibilities which are to be exercised by the Council of Governors at a formal meeting.

5.5 Where committees are authorised to establish sub-committees they may not delegate their powers to the sub-committee unless expressly authorised by the Council of Governors.

5.6 Any committee or sub-committee established under this Standing Order 5.1 may call upon outside advisers to assist them with their tasks including any Advisers, subject to the advance agreement of the Board of Directors.

5.7 The Council of Governors shall approve the appointments to each of the committees which it has formally constituted.

5.8 Where the Council of Governors is required to appoint persons to a committee to undertake statutory functions, and where such appointments are to operate independently of the Council of Governors, such appointments shall be made in

accordance with applicable statute and regulations and with best practice advice and/or guidance issued by Monitor.

5.9 Where the Council of Governors determines that persons who are neither Governors, nor Directors or Officers of the Trust, shall be appointed to a committee, the terms of such appointment shall be determined by the Council of Governors subject to the payment of travelling expenses and other allowances being in accordance with such sum as may be determined by the Board of Directors.

5.10 The Council of Governors may appoint members to serve on joint committees with the Board of Directors or committees of the Board of Directors on the request of the Chair.

5.11 The Secretary or his deputy will attend all meetings of the Committees in support of them.

6. DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

6.1 **Declaration of interests –** The Constitution and the trust's Code of Conduct requires Governors to declare interests which are relevant and material to the Council of Governors of which they are a member. All existing Governors should declare such interests. Any Governors appointed subsequently should do so on appointment.

6.2 Interests which should be regarded as "relevant and material" are:

6.2.1 Directorships, including non-executive directorships held in private companies or public limited companies (with the exception of those of dormant companies).

6.2.2 Ownership, part-ownership or directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.

6.2.3 Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.

6.2.4 A position of trust in a charity or Voluntary Organisation in the field of health and social care

6.2.5 Any connection with a voluntary or other organisation contracting for NHS services

6.2.6 To the extent not covered above, any connection with an organisation, entity or company considering entering into or having entered into a financial agreement with the NHS Foundation Trust, including but not limited to, lenders or banks.

6.2.7 Any other commercial interest in the decision before the meeting

6.3 At the time Governors' interests are declared, they should be recorded in the Council of Governors minutes. Any changes in interests should be declared at the next Council of Governors meeting following the change occurring.

6.4 Governors' directorships of companies likely or possibly seeking to do business with the trust should be published in the Council of Governors Annual Report. The information should be kept up to date for inclusion in succeeding annual reports.

6.5 During the course of a Council of Governors meeting, if a conflict of interest is established, the member concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

6.6 There is no requirement in the Code of Conduct for the interests of Governors' spouses or partners to be declared. However Standing Order 7 requires that the interest of members' spouses, if living together, in contracts should be declared. Therefore the interests of Governors' spouses and cohabiting partners should also be regarded as relevant.

6.7 If Governors have any doubt about the relevance of an interest, this should be discussed with the Chairman. Financial Reporting Standard No 8 (issued by the Accounting Standards Council) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

6.8 **Register of Interests –** The Secretary will ensure that a register of interests is established to record formally declarations of interests of members. In particular the register will include details of all directorships and other relevant and material interests which have been declared by both elected and appointed members.

6.9 These details will be kept up to date by means of an annual review of the register in which any changes to interests declared during the preceding twelve months will be incorporated.

6.10 The register will be available to the public and the Secretary will take reasonable steps to bring the existence of the register to the attention of the local population and to publicise arrangements for viewing it.

7. DISABILITY OF CHAIRMAN AND MEMBERS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST

7.1 Subject to the following provisions of this Standing Orders, if the Chairman or a Governor has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the trust at which the contract or other matter is the subject of consideration, he shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

7.2 The Council of Governors may exclude the Chairman or a member of the Council of Governors from a meeting of the Council of Governors while any contract, proposed contract to other matter in which he has a pecuniary interest, is under consideration.

7.3 Any remuneration compensation or allowances payable to the Chairman or a member of the Council of Governors by virtue of the Constitution shall not be treated as a pecuniary interest for the purpose of this Standing Order.

7.4 For the purpose of this Standing Order the Chairman or a member of the Council of Governors shall be treated as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

a. He, or a nominee of his, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or

b. He is a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration;

And in the case of married persons living together the interest of one spouse shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

7.5 The Chairman or a member shall not be treated as having a pecuniary interest in any contract, proposed contract or any other matter by reason only:

a. of his membership of a company or other body, if he has no beneficial interest in any securities of that company or other body; or

b. of an interest in any company, body or person with which he is connected which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a member in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

7.6 Where the Chairman or a member of the Council of Governors has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and the total nominal value of these securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company body, whichever is the less, and if the share capital is of more than one class, the total nominal value of shares of any one class in which he has beneficial interest does not exceed one-hundredth of the total issued share capital of that class, this Standing Order shall not prohibit him/her from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it, without prejudice however to his duty to disclose his interest.

7.7 The Standing Order applies to a committee or sub-committee as it applies to the trust.

8. SENIOR INDEPENDENT DIRECTOR

8.1 The Council of Governors is entitled to be consulted by the Board of Directors on the appointment of the Trust's Senior Independent Director.

8.2 The role of the Senior Independent Director is as set out in the Trust's "Senior Independent Director Role Specification" as amended from time to time. For the avoidance of doubt the "Senior Independent Director Role Specification" does not form part of the Constitution.

9. LEAD GOVERNOR AND DEPUTY LEAD GOVERNOR

9.1 The appointment of the Lead Governor and Deputy Lead Governor will be made from those Governors who have been elected as Governors from the Public Constituency.

9.2 The role of the Lead Governor is as set out in the Trust's "Lead Governor Role Specification" as amended from time to time. For the avoidance of doubt the "Lead Governor Role Specification" does not form part of the Constitution.

9.3 The Deputy Lead Governor will take up the role and responsibilities of the Lead Governor on a temporary basis, in the event the Lead Governor is absent for any reason.

25. Review of NED responsibilities

To ACCEPT the report

For Report

Presented by Sheila Childerhouse

Board of Directors – 29 May 2020

Agenda item:	25			
Presented by:	Sheila Childerhouse, Chair			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	22 May 2020			
Subject:	Non-executive responsibilities report			
Purpose:	X	For information		For approval

This report sets out updated NED responsibilities and lead roles to ensure that key activities receive appropriate non-executive review and challenge.

The update includes relocation of roles held by Gary Norgate who is stepping down as a NED at the end of May. Some of these responsibilities have been retained by the Chair pending appointment of a replacement NED. These will be reviewed later in the year.

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

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

Previously considered by:	Reviewed with NEDs
Risk and assurance:	Failure to provide relevant NED leadership and challenge to key responsibilities
Legislation, regulatory, equality, diversity and dignity implications	None

Recommendation:

To receive the report for information

Non-executive directors' responsibilities (June 2020)

NHS West Suffolk NHS Foundation Trust

	Primary responsibilities	Responsibilities as required	Lead assurance roles
Sheila Childerhouse **Chair and Non-executive director** **Term:** 1 Jan 2018 - 31 Dec 2020	• Chair Board – Public, Closed (**Chair**) • Quality & Risk Committee (**Chair**) • Scrutiny Committee • Remuneration Committee • Council of Governors (**Chair**) *Option to attendance any other Board committees* • ICS chairs meeting (Chair) Pending appointment of new NED: • Digital Programme Board • 2nd Clinical Safety & Effectiveness Committee (only attend if Richard Davies unavailable) • *Improvement Programme Board (provisional new meeting)*	• Board Workshops • External relationships • Consultant appointments • Quality walkabouts • Governor meetings with NEDs • Investigations and appeals • CCG Board meetings	• Integrated care system • NHS England and Improvement • NED link to CEO • NED link to Director of Integration and Partnerships
Richard Davies **Non-executive director** **Term:** 1 Mar 2017 – 29 Feb 2020 **Reappointed:** 1 March 2020 – 28 Feb 2023	• Board meeting – Public, Closed • Audit Committee • Quality & Risk Committee • Remuneration Committee Subcommittees of Q&RC: • Clinical Safety & Effectiveness Committee • Learning from deaths group (Chair)	• Board Workshops • Consultant appointments • Quality walkabouts • Revalidation Support Group • Council of Governors and Governor meetings with NEDs • Investigations and appeals	• Senior Independent Director, including whistleblowing • NED link to Medical Director • Patient safety, including learning from deaths • Safeguarding children

	Primary responsibilities	Responsibilities as required	Lead assurance roles
Angus Eaton **Non-executive director** **Term:** 1 Jan 2018 – 31 Dec 2020	• Board meeting – Public, Closed • Audit Committee (**Chair)** • Remuneration Committee (**Chair**) • Charitable Funds Committee • Ethics Committee	• Board Workshops • Consultant appointments • Attend Q&RC • Quality walkabouts • Council of Governors and Governor meetings with NEDs • Investigations and appeals	• NED link to Director of Finance • NED link to Director of Workforce & Communications • Staff health and wellbeing • Risk management • Procurement - moved from Gary
Louisa Pepper **Non-executive director** **Term:** 1 September 2018 – 31 Aug 2021	• Board meeting – Public, Closed • Audit Committee • Quality & Risk Committee • Remuneration Committee • Scrutiny Committee (**Chair**) • Ethics Committee (**Chair**) Subcommittees of Q&RC: • Corporate Risk Committee • 2nd Patient Experience Committee	• Board Workshops • Consultant appointments • Quality walkabouts • Council of Governors and Governor meetings with NEDs • Investigations and appeals	• NED link to Chief operating office • Access, including RTT • Security • Emergency preparedness, resilience and response (EPRR) – including COVID response
Alan Rose **Deputy Chair and Non-executive director** **Term:** 1 April 2017 – 31 March 2020 **Reappointed:** 1 April 2020 – 31 March 2023	• Board meeting – Public, Closed • Audit Committee • Quality & Risk Committee • Scrutiny Committee • Remuneration Committee • Charitable Funds Committee (**Chair**) • Clinical Excellence & Discretionary Awards Committee Subcommittees of Q&RC: • Patient Experience Committee • 2nd Corporate Risk Committee	• Board Workshops • Consultant appointments • Quality walkabouts • Council of Governors and Governor meetings with NEDs • Investigations and appeals	• Deputy Chair • NED link to Chief Nurse • Patient experience and public engagement • Safeguarding - adults • End of life (moved from Richard)
Vacant position	*To be reviewed following appointment*		

26. Agenda items for next meeting

To APPROVE the scheduled items for the next meeting

For Approval

Presented by Richard Jones

Board of Directors – 29 May 2020

Agenda item:	26			
Presented by:	Richard Jones, Trust Secretary & Head of Governance			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	23 May 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.

Please note that an additional Board meeting will take place on 19 June 2020 to approve the annual report and accounts.

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 – 26 June 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/RP
Finance & workforce performance report, including appraisal report (with consultants)	✓		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	RP
7-day services report	✓		Written	Matrix	NJ
Medical revalidation annual report	✓		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	RP
Serious Incident, inquests, complaints and claims report		✓	Written	Matrix	RP
Build a joined-up future					
General condition 6 and Continuity of Services condition 7 certificate	✓		Written	Matrix	RJ
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
Charitable Funds committee report	✓		Written	Matrix	AR
Board assurance framework review		✓	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

27. 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

28. Date of next meeting

To NOTE that the next meeting will be held on Friday, 26 June 2020 at 9:15 am in West Suffolk Hospital

For Reference

Presented by Sheila Childerhouse

RESOLUTION TO MOVE TO CLOSED SESSION

29. 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